

THE IMPACT OF THE PANDEMIC ON RURAL HOSPITALS

- Most rural hospitals have experienced lower profit margins or losses on patient services during the pandemic due to higher costs, lower service volumes, and inadequate payments from private payers. Margins on patient services are likely to continue to worsen in 2021 and 2022 due to continued increases in costs and lower payments.
- Small rural hospitals have experienced the most severe financial impacts. They have been able to continue operating during the pandemic despite losses on patient services because of the significant federal assistance they have received. However, this assistance is only temporary.
- More than 600 rural hospitals – over 30% of the total – are at risk of closing in the future because the payments they receive are less than the cost of delivering services. 200 of those hospitals are at risk of closing within 2-3 years. Rapid action is needed to prevent these closures before the funds they received during the pandemic have all been spent.
- Proposals to create global hospital budgets, eliminate sequestration, eliminate inpatient services, and expand Medicaid will not solve the serious problems facing small rural hospitals. The only way to ensure that residents of small rural communities have access to affordable, high-quality healthcare is to pay adequately and appropriately for the services delivered by their local hospitals.

Rural Hospital Closures Prior to and During the Pandemic

One of the many lessons of the coronavirus pandemic has been the importance of having adequate hospital capacity available in every community. When a disaster or emergency occurs in one place, hospitals elsewhere can provide backup support, but in a national emergency such as the pandemic, that may not be possible.

Unfortunately, many communities did not have a local hospital available during the pandemic because over 150 rural hospitals across the country had closed between 2005 and 2019. For many of these communities, the closest hospital is now more than a half hour away.

An additional 19 rural hospitals closed their doors in 2020, more than any year in the previous decade. These closures were not caused by the pandemic, but by financial problems that existed long before the pandemic began. However, these communities lost their hospitals at the worst possible time.

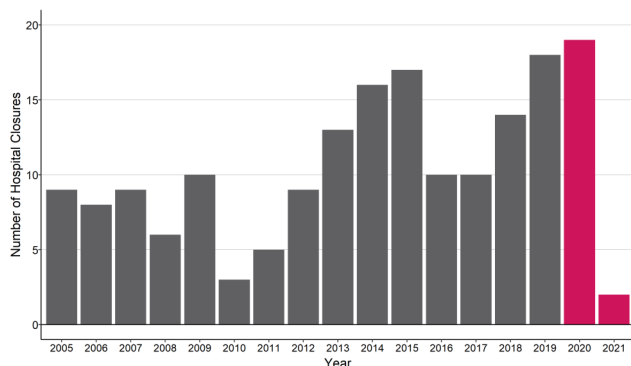
Only two rural hospitals closed in 2021, but this does not mean there will continue to be fewer closures in the future. The reason the number was smaller in 2021 than in previous years was the special financial aid hospitals received during the pandemic.

The Impact of the Pandemic on Patient Services at Rural Hospitals

The First Year of the Pandemic (2020)

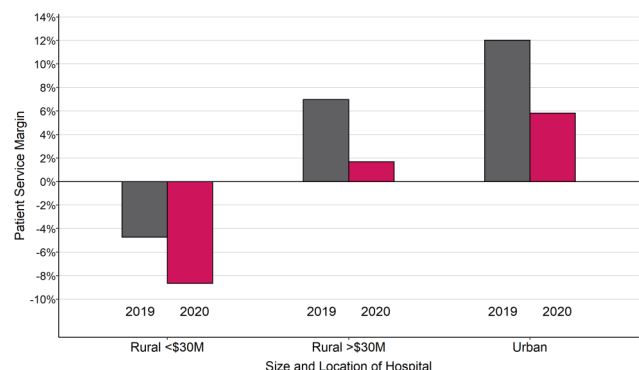
Most rural hospitals experienced lower margins on patient services¹ (i.e., lower profits or greater losses) during their 2020 fiscal year than during the previous year.² This was most problematic for small rural hospitals.³ The majority of small rural hospitals were losing money on patient services prior to the pandemic, so the lower margins during the initial year of the pandemic pushed them even further into the red. In contrast, even though larger rural hospitals and urban hospitals also experienced lower margins, most of them continued to generate profits on patient services overall.

Rural Hospital Closures



Source: University of North Carolina, Cecil G. Sheps Center for Health Services Research

Change in Median Margins on Patient Services



"Rural < \$30M" are hospitals with less than \$30 million in total annual expenses.

The reductions in margins on patient services during the initial months of the pandemic were due to three different factors:

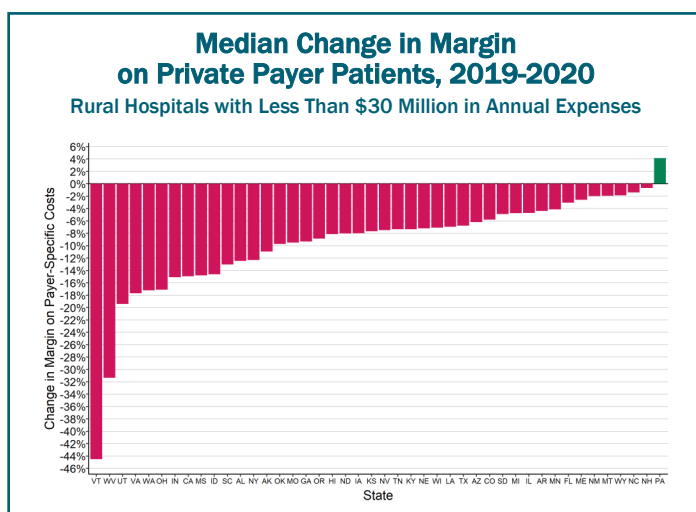
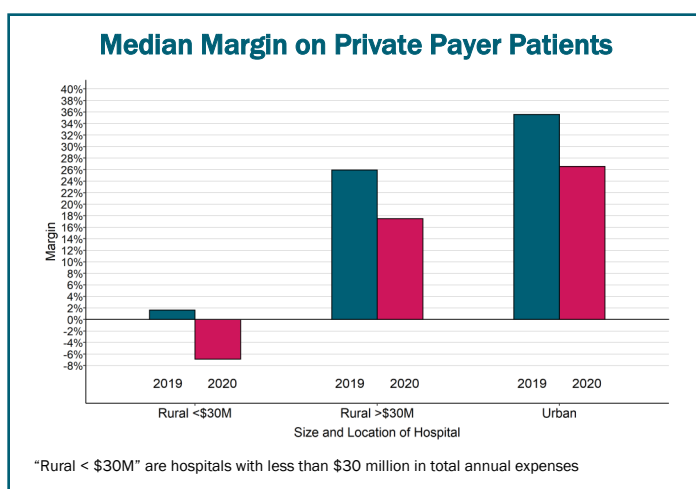
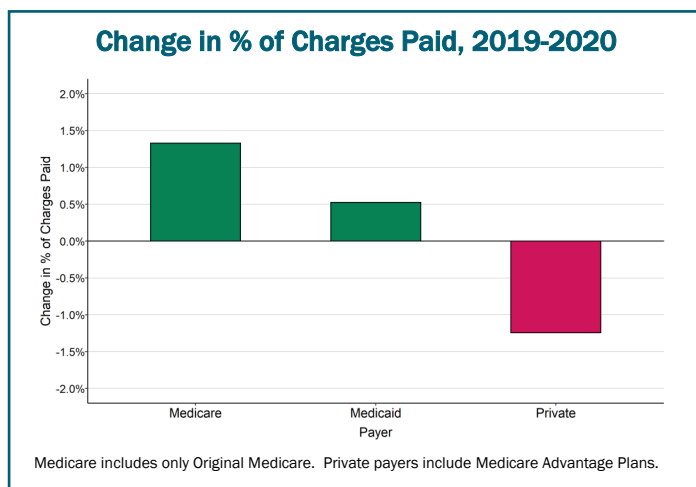
- Higher Costs of Delivering Services.** The costs of delivering patient services increased due to the high costs of acquiring personal protective equipment and other COVID-related expenses on top of the normal annual growth in the costs of supplies and personnel. Patient service costs increased by a median of 3% at rural hospitals in 2020, but the increase was over 7% for many hospitals.
- Fewer Services Delivered.** At most rural hospitals, the volume of patient services decreased. This was due to a combination of patients delaying care and reduced ability of hospitals to deliver services due to pandemic restrictions and shortages of staff and supplies. Total charges for services delivered (the best measure of overall service volume available) decreased by a median of 2%, which suggests that the number of services at most hospitals decreased by 2% or more.⁴ For one-fourth of rural hospitals, charges decreased by more than 7%.
- Inadequate Payments for Services by Private Payers.** Private health insurance plans paid a *smaller* percentage of rural hospitals' charges and costs during the initial year of the pandemic. In contrast, Medicare payments to rural hospitals *increased* during the pandemic because of the suspension of federal sequestration reductions during the portion of the year in which the Public Health Emergency was in effect. Also, since Medicare pays Critical Access Hospitals based on their actual costs, they received an additional increase in Medicare payments if they experienced an increase in costs. The majority of rural hospitals also received higher Medicaid payments as a percentage of their charges during the initial year of the pandemic, although this varied significantly by state and by hospital.

The primary reason overall patient service margins at rural hospitals decreased was higher losses on patients insured by private health plans (including Medicare Advantage plans).⁵ The losses on patients insured by private health plans hurt the smallest rural hospitals the most because they were already receiving low payments from private payers prior to the pandemic. Although hospitals of all sizes experienced lower margins on private payer patients during the pandemic, for most small rural hospitals, the reductions meant they lost money providing services to these patients.

The reductions in margins on patients with private insurance were much higher in some states than others, reflecting both differences in payments by different insurance plans and differences in the payers providing insurance in each state.

The Second Year of the Pandemic (2021)

Financial data for 2021 are not yet available for all hospitals. At most of the hospitals for which data are available, total charges increased above pre-pandemic levels, reflecting a combination of higher volume and higher amounts charged per service to cover higher costs. However, costs increased as much or more than charges, and payments from private payers continued to be lower



as a percentage of charges. As a result, patient service margins were still lower in 2021 than in 2019 for most rural hospitals, and small rural hospitals continued to have higher losses on patient services.

The Third Year of the Pandemic (2022)

It seems likely that the costs of operating rural hospitals will be significantly higher in 2022 than in 2021. Inflation and supply chain problems are making everything more expensive, and the national staff shortages in healthcare have forced rural hospitals to pay much higher amounts to hire and retain staff and to pay high rates for temporary workers to fill vacancies. On top of higher costs, the 2% sequestration reduction in Medicare payments is scheduled to resume in 2022. Both of these factors will push hospitals' margins on patient services lower in 2022 and subsequent years.

The Impact of the Pandemic on Total Profit Margins at Rural Hospitals

One might expect that the higher losses on patient services in 2020 would have caused more rural hospitals to close in 2021. That didn't happen because rural hospitals' total margins improved.⁶ In fact, the largest improvements occurred at the smallest rural hospitals, despite the greater losses on patient services.

Hospitals had higher total margins even with lower margins on patient services because of the large amounts of government aid they received during the pandemic. The federal government provided several different types of financial assistance to hospitals in an effort to offset the negative impacts of the pandemic:

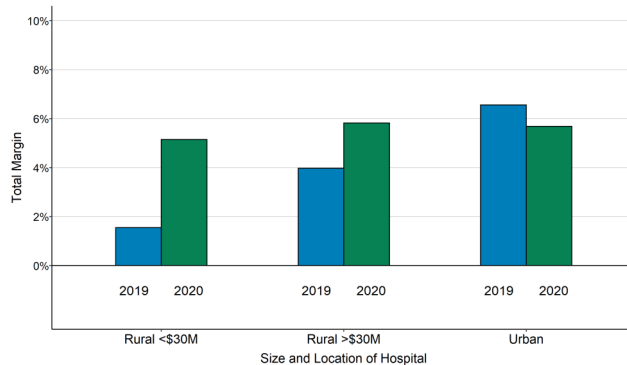
- Provider Relief Fund (PRF).** Congress authorized \$178 billion in PRF funding to cover financial losses and unexpected costs incurred by hospitals and other healthcare providers during the pandemic. The initial funds received by hospitals were equivalent to at least 2% of their 2018 patient revenue. Additional amounts were then provided for hospitals that serve a large number of low-income patients, hospitals that treated a large number of COVID-19 patients, and hospitals that had losses or higher costs between July 2020 and March 2021. The median award for rural hospitals was about \$5 million, but large rural hospitals received much larger awards.
- American Rescue Plan (ARP) Rural Funds.** Congress also authorized \$8.5 billion in ARP funds specifically for hospitals and other providers that serve patients in rural areas to help cover lost revenue and costs associated with COVID-19. The median award for rural hospitals was about \$1 million.
- Paycheck Protection Program (PPP).** Congress authorized \$659 billion for PPP loans to businesses and non-profit organizations, including hospitals, if they had 500 or fewer employees. These loans were forgiven (i.e., converted into a grant) if the hospital maintained payroll and compensation levels during the initial months of the pandemic. The median amount received by rural hospitals that were eligible and applied was about \$2 million.
- Advance Payments from Medicare.** If a hospital requested it, the Centers for Medicare and Medicaid Services (CMS) provided an advance on the Medicare payments the hospital would expect to receive for services it delivered in future months. Not every hospital re-

quested an advance, but most of those that did received millions of dollars in advance payments. These payments were not grants, but loans intended to help improve cash flow for the hospital during the pandemic. Hospitals have to repay these funds to CMS by the end of 2022.

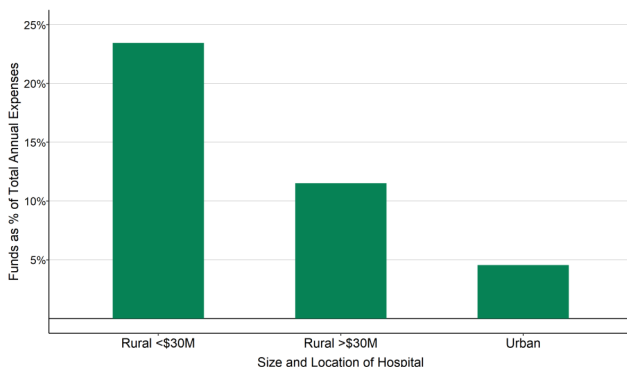
All of this funding helped rural hospitals stay afloat during the pandemic, particularly the small rural hospitals that needed help the most. Although bigger hospitals received larger amounts of funds in *absolute* terms, small rural hospitals received more funds in *relative* terms. For example, Federal Provider Relief Fund awards were equivalent to more than 20% of total expenses at small rural hospitals, but less than 15% for larger rural hospitals and less than 5% for most urban hospitals.

However, hospitals can only keep the funds from the Provider Relief Fund and the American Rescue Plan if they are used "for health care related expenses or lost revenues that are attributable to coronavirus." The Provider Relief Fund awards were so large that most small hospitals were only able to use a portion of the funds in 2020. Since the pandemic has continued into 2022, hospitals will be able to recognize additional portions of the funds in 2021 and 2022, but it is possible that some hospitals will have to return a portion of the funds.

Change in Median Total Margin 2019-2020



Provider Relief Fund Awards as % of Total Hospital Expenses



Pandemic Aid Makes Rural Hospitals Appear Healthier Than They Really Are

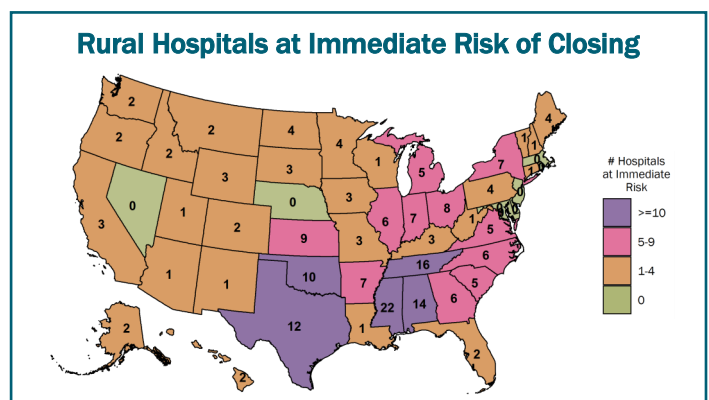
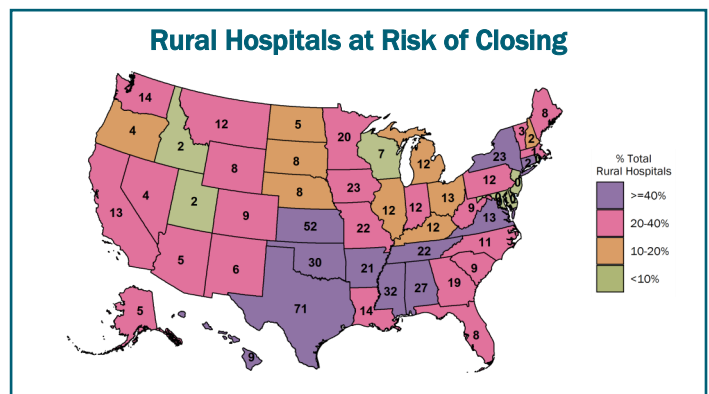
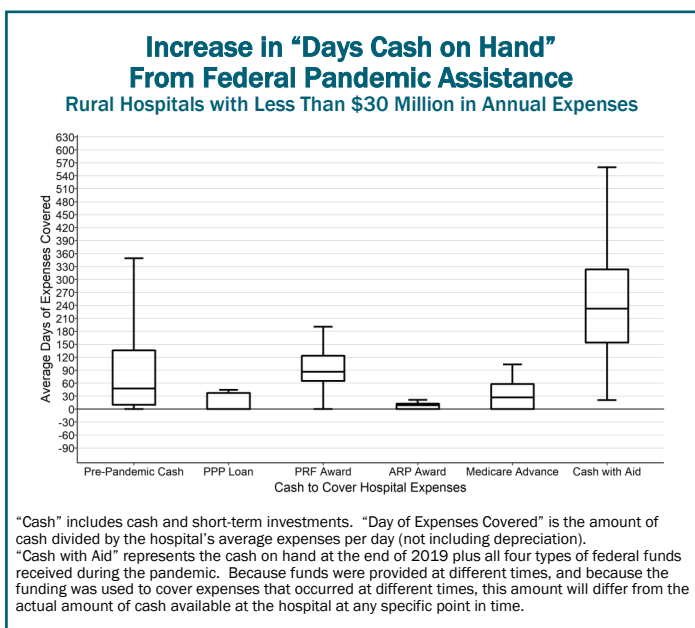
A disadvantage of the large, one-time funding awards and advance payments is that they make small rural hospitals appear stronger financially than they really are. For example:

- “Days cash on hand” is a misleading measure of financial health.** “Days cash on hand” is a metric commonly used to assess the financial health of a hospital; it represents the number of days that the hospital could cover its expenses if it received no additional revenues beyond the cash and short-term investments that it already has. Prior to the pandemic, most small rural hospitals had less than two months of cash on hand, and many had less than 30 days. By the end of their 2020 fiscal years, most small rural hospitals had more than 6 months of cash on hand. However, 1-2 months of that amount represented the payment advances from Medicare; as those advances are repaid, there will be a corresponding decrease in the hospitals’ cash on hand. In addition, a hospital will only be able to keep all of the Provider Relief Fund and American Rescue Plan funds it received if it incurs corresponding losses or higher costs due to COVID-19. Those losses and costs will reduce the hospital’s cash reserves, offsetting the increase resulting from the awards. Consequently, days cash on hand in future years will decrease significantly from the levels in 2020-2021.
- Total margins are a misleading measure of financial health.** Similarly, many rural hospitals will report high total margins in 2021 and 2022 when they recognize the Provider Relief Fund, American Rescue Plan, and Paycheck Protection Loans as revenue. However, this does not mean that the hospitals’ services have suddenly become more profitable. Their total margins will decrease again after all of the federal funds have been used or returned.

Hundreds of Rural Hospitals Are at Risk of Closing

Hundreds of rural hospitals were at risk of closing prior to the pandemic because of persistent losses on patient services and insufficient or unsustainable funding from other sources to offset these losses. These losses will likely be greater in the future than they were prior to the pandemic due to the higher costs that all hospitals, particularly small rural hospitals, have been experiencing. The financial problems facing these hospitals were temporarily reduced by the financial aid provided during the pandemic, but the problems have not been eliminated.

- More than 600 rural hospitals – over 30% of all rural hospitals in the country– are at risk of closing within the next 6 years.**⁷ Most of these are small rural hospitals that provide not only emergency care, inpatient care, and outpatient services, but also primary care, rehabilitation, and long-term care services for their communities. Moreover, most of the hospitals are located in isolated communities, where closure of the hospital would mean residents could not obtain essential healthcare services without traveling long distances. Millions of people could be directly harmed if these hospitals close, and people in all parts of the country could be affected through the impacts on workers in agriculture, energy, and other industries.
- 200 of these hospitals are at immediate risk of closing, i.e., they could be unable to pay for their expenses within 2-3 years.**⁸ Fewer rural hospitals are at immediate risk of closing than prior to the pandemic because of the higher cash reserves generated by the federal pandemic aid. However, there are still many hospitals that do not have the financial resources to cover their financial losses for more than a few years.



Almost every state has at least one rural hospital at immediate risk of closure, and in 16 states, 5 or more rural hospitals are at immediate risk. In the majority of states, 25% or more of the rural hospitals are at risk of closing, and in 11 states, 40% or more are at risk.

The financial assistance provided during the pandemic provides a window of opportunity to fix the problems facing rural hospitals and prevent these closures from occurring. However, that window will rapidly close if action isn't taken quickly.

Most Proposed “Solutions” Won’t Work

Policies that are typically proposed to help rural hospitals would not solve their financial problems, and some would make them worse:

- **Creating Global Budgets.** A global budget based on the hospital’s revenues prior to the pandemic would have protected the hospital from losses in revenues due to lower service volume, but it does nothing to address increases in costs that hospitals are facing, nor would it eliminate losses caused by inadequate payments.
- **Eliminating Sequestration Reductions.** Higher Medicare payments would be beneficial for rural hospitals, but eliminating the 2% sequestration reduction would only increase the margin at a typical rural hospital by about one-half percent, far short of the losses most small rural hospitals are facing.
- **Creating “Rural Emergency Hospitals.”** Requiring rural hospitals to eliminate inpatient services would increase their financial losses while reducing access to inpatient care for local residents. Residents of rural communities would have had even more difficulty finding a hospital bed during the pandemic if there were fewer hospitals providing inpatient care.
- **Expanding Medicaid Eligibility.** Making more patients eligible for Medicaid would help low-income patients afford better care and it would reduce a portion of hospitals’ losses on uninsured patients and bad debt. However, *uninsured* patients are not the primary cause of losses at most rural hospitals; most losses are caused by low payments for *insured* patients.

How to Prevent Rural Hospital Closures

The only way to ensure residents of rural communities have access to affordable, high-quality healthcare is to pay adequately and appropriately for the services delivered by small rural hospitals. Health insurance plans need to provide *standby capacity payments* to hospitals to support the fixed costs for maintaining essential services as well as paying *service-based fees* that are adequate to cover the costs incurred when services are delivered. Details on how such a payment system would work are available at www.RuralHospitals.org.

Every payer will need to change the way it pays small rural hospitals, but the biggest changes must be made by private health insurance companies. Although most payers are underpaying small rural hospitals, the biggest cause of negative margins in most small rural hospitals in most states is low payments from private insurance plans and Medicare Advantage plans.

It will cost about \$3 billion per year to prevent closures of the at-risk hospitals and preserve access to rural healthcare services. This represents an increase of only 1/10 of 1% in total national healthcare spending. Most of the increase in spending will support primary care and emergency care, not inpatient or ancillary services, since the biggest causes of losses at most small rural hospitals are underpayments for primary care and emergency services. Moreover, spending would likely increase even if hospitals close because reduced access to preventive care and prompt treatment will cause residents of the rural communities to need even more services in the future.

Paying adequately now to preserve local services is the best way to invest resources and to improve the health of rural residents.

Data updated in May 2022

1. Data on costs and revenues were obtained from the Hospital Cost Reports that hospitals are required to submit annually to the Centers for Medicare and Medicaid Services. The patient service margin is the difference between the revenues received from patient services and the cost of delivering those services, divided by the cost.
2. Because fiscal years end at different times for different hospitals, the pandemic started during the last quarter of the fiscal year for some hospitals and during the first half of the fiscal year for others.
3. “Small” rural hospitals are those with less than \$30 million in total annual expenses. About half of all rural hospitals are this size.
4. Charges for individual services are typically increased each year to cover higher costs, so a decrease in total charges would mean that the volume of services had decreased by even more.
5. Contrary to popular belief, private health plans are the largest payers at rural hospitals, not (traditional) Medicare and Medicaid. This includes Medicare Advantage plans as well as employer-sponsored insurance and the plans individuals purchase on insurance exchanges. As a result, low payments by private payers have a disproportionate impact on the hospitals’ overall margins.
6. A hospital’s total margin includes income that is not directly related to the hospital’s services to patients, such as grants from government and charitable sources and earnings on investments, real estate, and parking facilities. Many small rural hospitals are operated by public hospital districts or local governments that cover losses on patient services through taxes on local residents.
7. A hospital is classified as being at *risk of closure* if (1) either the hospital’s margin on patient services or its total margin (excluding pandemic grants) is negative and (2) the hospital’s net assets (excluding buildings and equipment but including pandemic grants) could not sustain similar losses for more than 6 years.
8. A hospital is classified as being at *immediate risk* if (1) the hospital’s total margin (excluding pandemic grants) is negative and (2) neither the hospital’s current net assets nor total net assets (excluding buildings and equipment but including pandemic grants) could sustain similar losses for more than 3 years.