

The Impact of the Pandemic on Rural Hospitals

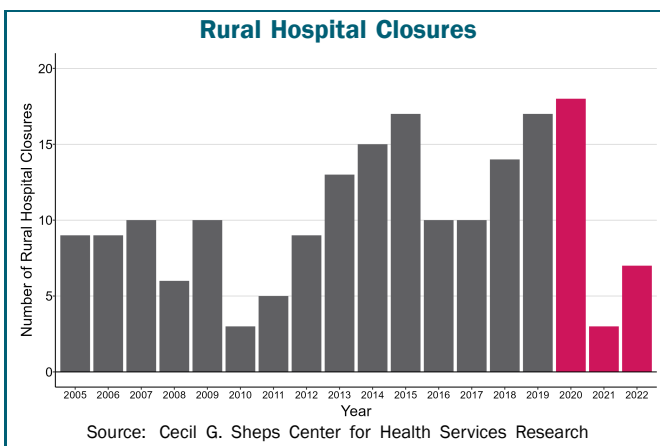
- Most rural hospitals experienced lower profit margins or losses on patient services during the pandemic due to higher costs, lower service volumes, and inadequate payments from private payers. Margins on patient services continued to worsen in 2022 due to continued increases in costs and lower payments.
- Small rural hospitals experienced the most severe financial impacts. They were able to continue operating during the pandemic despite losses on patient services because of the significant federal assistance they received. However, this assistance was only temporary.
- More than 600 rural hospitals – 30% of the total – are at risk of closing in the future because the payments they receive from health insurance plans are less than the cost of delivering services. Because they will no longer have federal pandemic funding to offset the losses, over 300 of those hospitals are at risk of closing within 2-3 years.
- Eliminating inpatient services (as required for Rural Emergency Hospital status), expanding Medicaid, creating global hospital budgets, or eliminating sequestration 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 was 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 18 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.

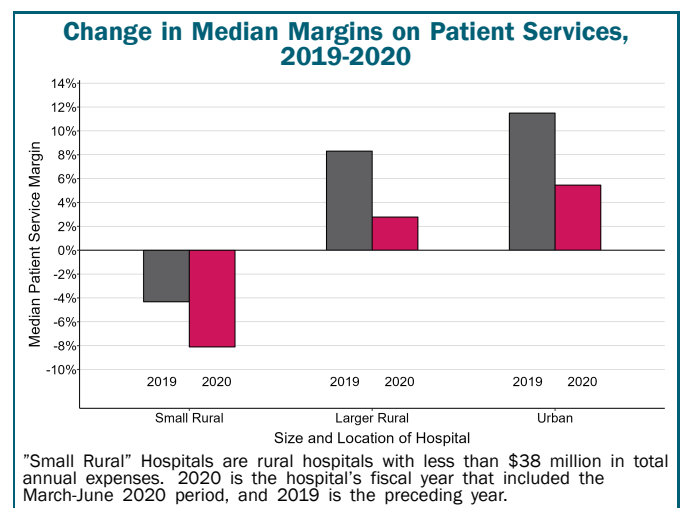


Three rural hospitals closed in 2021 and 7 more closed in 2022. Although fewer hospitals closed than in 2020, this does not mean there will continue to be fewer closures in the future. The reason for fewer closures recently is the special financial aid hospitals received during the pandemic.

The Impact of the Pandemic on Patient Services at Rural Hospitals

The First Year of the Pandemic (2020)

Most rural hospitals¹ experienced lower margins on patient services² during their 2020 fiscal year than during the previous year.³ This was most problematic for small rural hospitals (those with less than \$38 million in total annual expenses).⁴ 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.



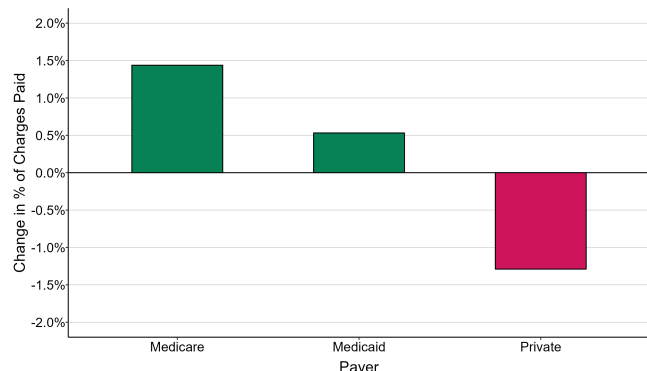
The reductions in margins on patient services during the initial months of the pandemic were due to three different factors:

- **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 3.5% at small rural hospitals in 2020, but the

increase was over 8% for one-fourth of the hospitals.

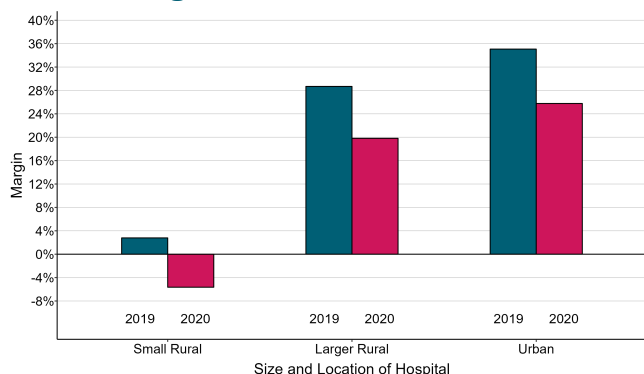
- **Fewer Services Delivered.** At most rural hospitals, the volume of patient services decreased. This was caused by a combination of patients delaying care and reduced ability of hospitals to deliver services due to pandemic restrictions and shortages of staff and supplies. Total charges for services delivered (the best measure of overall service volume available) decreased by a median of 2% at small rural hospitals, which suggests that the number of services at most of the hospitals decreased by 2% or more.⁵ For one-fourth of small rural hospitals, charges decreased by more than 8%.
- **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 Critical Access Hospitals are paid by Medicare 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.

Change in Percentage of Charges Paid, 2019-2020



"Medicare" includes only Original Medicare. Medicare Advantage plans are included with "Private" payers. The change shown is the difference between the fiscal year that included March-June 2020 and the preceding year.

Median Margin on Patients With Private Insurance



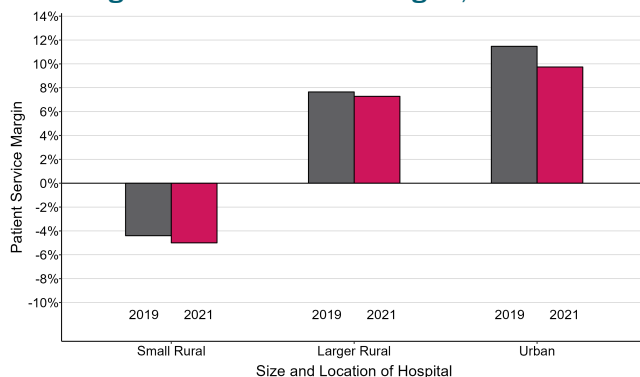
"Small" rural hospitals are rural hospitals with less than \$38 million in total annual expenses. 2020 is the hospital's fiscal year that included the March-June 2020 period, and 2019 is the preceding year. The margin shown is the difference between the revenues received from private health plans (including Medicare Advantage plans) and the cost of the services delivered to patients insured by those plans, divided by the cost.

The primary reason overall patient service margins at rural hospitals decreased during the pandemic was higher losses on patients insured by private health plans (including Medicare Advantage plans).⁶ 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 patients with private insurance during the pandemic, at most small rural hospitals, the reductions meant they lost money providing services to these patients.

The Second Year of the Pandemic (2021)

In the second year of the pandemic, total charges at most hospitals increased above pre-pandemic levels, reflecting a combination of a higher volume of services and higher amounts charged per service to cover higher costs. However, the cost of delivering services also increased significantly compared to pre-pandemic levels, and at most small rural hospitals, revenues increased by less than the increase in costs. As a result, patient service margins at small rural hospitals remained lower than they were prior to the pandemic.

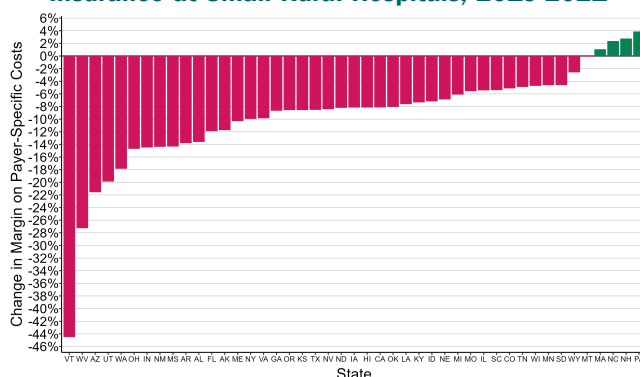
Change in Patient Service Margins, 2019-2021



"Small" rural hospitals have less than \$38 million in annual expenses. 2020 is the hospital's fiscal year that included the March-June 2020 period; 2021 is the year that followed that, and 2019 is the year that preceded it.

Payments from private payers continued to be the primary cause of the reduction in margins for small rural hospitals. The reductions were much higher in some states than others, reflecting both differences in payments by different health plans and the different insurance companies in each state.

Change in Median Margin on Patients with Private Insurance at Small Rural Hospitals, 2019-2021



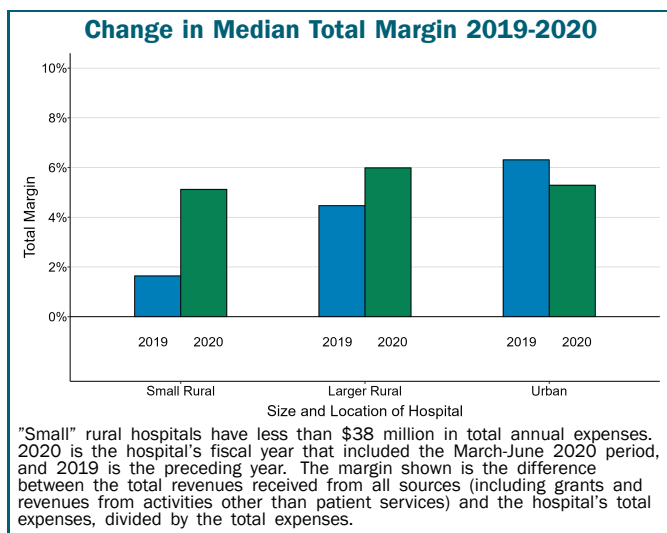
"Small" rural hospitals have less than \$38 million in total annual expenses.

The Third Year of the Pandemic (2022)

Inflation and supply chain problems made everything more expensive in 2022, and the national staff shortages in health-care 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 resumed in the second half of 2022. Both of these factors pushed hospitals' margins on patient services lower in 2022 and will likely also do so in 2023.

Pandemic Impact on Total Profit Margins

One might have expected 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.⁷ In fact, the largest improvements occurred at the smallest rural hospitals, despite the greater losses on patient services.



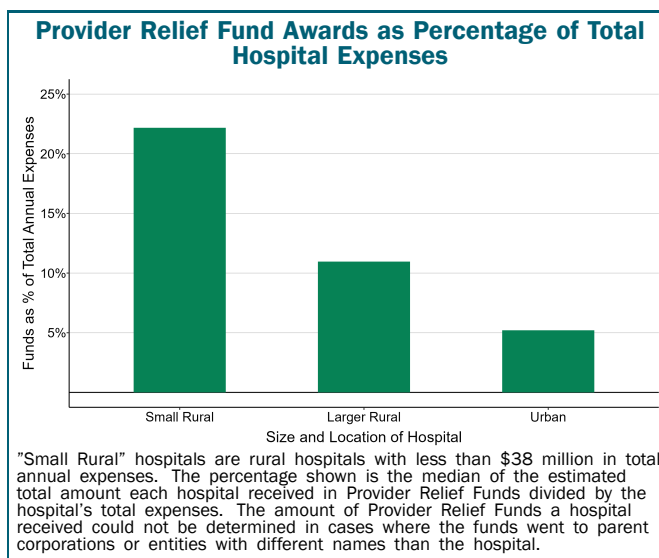
Hospitals had higher total margins even with lower margins on patient services because of the large amounts of government aid they received during the pandemic. The federal government provided several different types of financial assistance to hospitals in an effort to offset the negative impacts of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

- **Provider Relief Fund (PRF).** Congress authorized \$178 billion in Provider Relief Fund (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 nonprofit organizations, including hospitals, if they had 500 or fewer em-

ployees. 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 requested 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 had 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 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 could only keep the funds from the Provider Relief Fund and American Rescue Plan if they were 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 continued into 2022, hospitals were able to recognize additional portions of the funds in 2021 and 2022, but it is possible that some hospitals will have to return some of the funds they received.

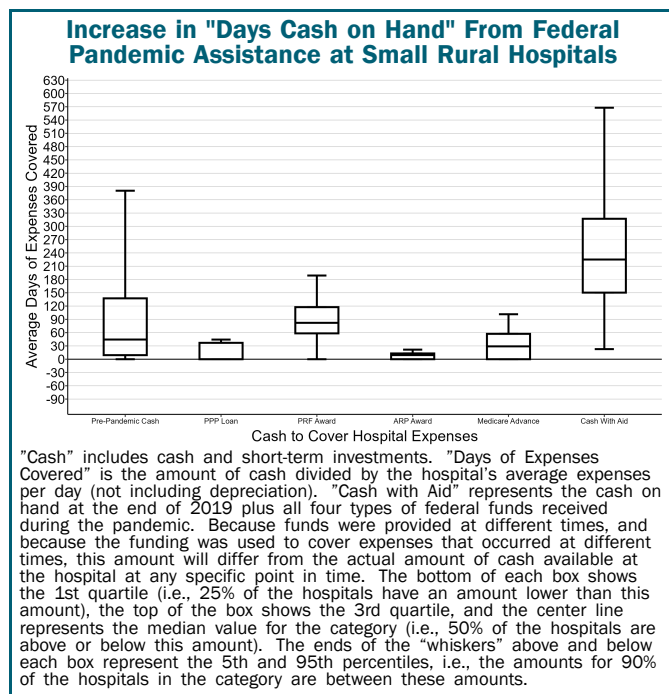
Pandemic Aid Made Rural Hospitals Appear Healthier Than They Really Are

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 were repaid, there was a corresponding decrease in the hospitals' cash on hand. In addition, a hospital was only able to keep all of the Provider Relief Fund and American Rescue Plan funds it received if it incurred corresponding losses or higher costs due to COVID-19. Those losses and costs reduced 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.

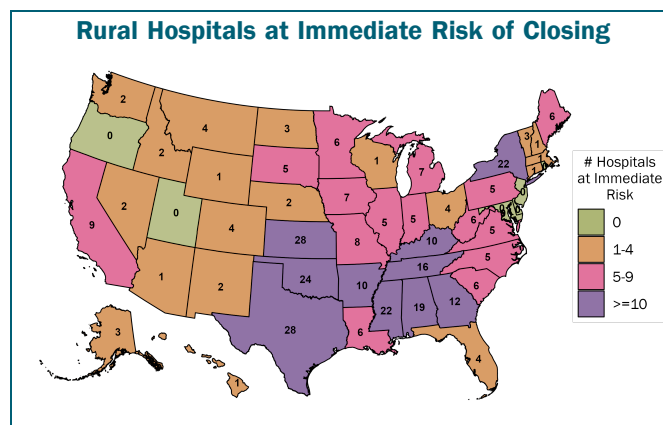
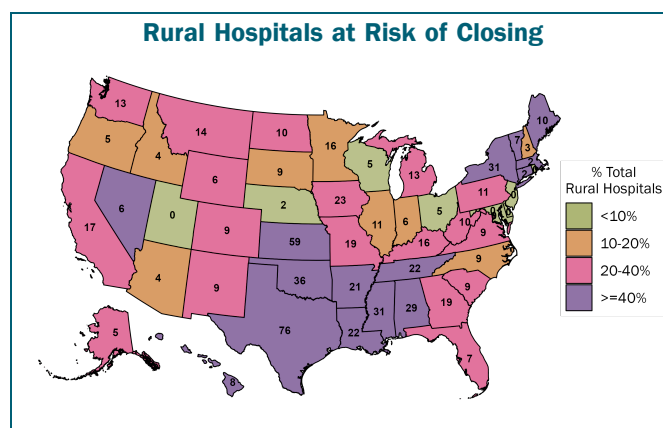
- **Total margins are a misleading measure of financial health.** Similarly, many rural hospitals reported high total margins in 2021 because of the Provider Relief Fund, American Rescue Plan, and Paycheck Protection Loans they received, and this was also true for many hospitals in 2022. However, this does not mean that the hospitals' services suddenly became 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. The 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 – 30% of all rural hospitals in the country – are at risk of closing within the next 6-7 years.⁸** 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.
- **Over 300 of these hospitals are at immediate risk of closing, i.e., they could be unable to pay for their expenses within 2-3 years.⁹** These hospitals were able to cover their costs during the pandemic because of the cash reserves generated by the federal pandemic aid. However, now that the federal funds have ended, losses on patient services will quickly exhaust the small financial reserves at these hospitals.



Almost every state has at least one rural hospital at immediate risk of closure. In more than half of the states, 25% or more of the rural hospitals are at immediate or high risk of closing, and in 15 states, 40% or more are at risk.

The financial assistance provided during the pandemic provided a temporary window of opportunity to fix the problems facing rural hospitals and prevent these closures from occurring. However, that window is rapidly closing.

Most Proposed "Solutions" Won't Work

The most commonly proposed solutions would not actually solve the problems facing rural hospitals, and some of the policies would make problems worse:

- **Conversion to a "Rural Emergency Hospital."** 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.
- **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 in 2020, but it would do nothing to address increases in costs that hospitals are now 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.

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 in [A Better Way to Pay Rural Hospitals](#).

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 is low payments from private insurance plans and Medicare Advantage plans.

It will cost about \$4 billion per year to prevent closures of the at-risk hospitals and preserve access to rural healthcare services. This would increase total national healthcare spending by only 1/10 of 1%. 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 delays in treatment will cause residents of the communities to need even more services in the future.

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

1. A hospital is described as a "rural hospital" here if it is located in an area that is [classified as rural by the Health Resources and Services Administration](#). Based on the revised definition established in 2021, an area is rural if either (1) it is in a county classified as "non-metropolitan" by the U.S. Office of Management and Budget (OMB); or (2) it is in a county classified as "metropolitan" and is either (a) in a census tract with a Rural-Urban Commuting Area (RUCA) Code of 4.0 or higher, or (b) in a census tract with a RUCA Code of 2 or 3 that is at least 400 square miles in area and has a population density of 35 persons per square mile or less, or (3) in a county classified as "metropolitan" that does not contain any urbanized area (which is defined by the U.S. Census Bureau as an incorporated place with 2,500 or more residents).
2. 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.
3. 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.
4. "Small" rural hospitals had total annual expenses less than \$38 million, the median amount in 2021, so half of all rural hospitals are this size.
5. 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.
6. 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 policies individuals purchase on insurance exchanges. As a result, low payments by private payers have a disproportionate impact on the hospitals' overall margins.
7. 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.
8. 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.
9. A hospital is classified as being at *immediate* risk if (1) the hospital's patient services margin and total margin (excluding pandemic grants) are 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.

Data current as of July 2023