# A Fraying Safety Net:

*Rural hospitals continue to close, leaving behind patients with no options for care within their communities*

PREPARED BY ALTRUIS™

# A FRAYING SAFETY NET: RURAL HOSPITALS CONTINUE TO CLOSE, LEAVING PATIENTS AND COMMUNITY CLINICS IN THE LURCH

Rural hospitals are in jeopardy. That's such a familiar statement that those unaffected find it easy to ignore. Don't. We're seeing dramatic increases in the number of rural hospital closures. Those that remain open continue to struggle.

Roughly 46 percent of rural hospitals operate in the red, up from 40 percent in 2017.[1] This trend is expected to continue, raising questions about just how much access rural dwellers will have to quality, affordable care. Patients can turn to local safety-net clinics, but these clinics are under tremendous pressures of their own. They can drive even farther to get basic care, but this is associated with poorer outcomes.

Or they simply don't get the care they need. The National Rural Health Association warns that nearly 12 million patients are at risk of losing direct access to care.[2]

It's a puzzle not easily solved. Let's start with the struggling rural hospitals.

## Rural hospital financial stability

A recent analysis from Navigant looked at the financial viability of rural hospitals. It found 21 percent—430 hospitals across 43 states—at high risk of closure. Of high-risk rural hospitals, 64 percent are considered essential to their communities based on their trauma status, service to vulnerable populations, location and/or economic impact.[3]

If they close, their obituaries will be added to a growing list. An estimated 101 rural hospitals in 27 states have closed between January 2010 – March 12, 2019, according to the North Carolina Rural Health Research Program4.

The threat of closure looms and the trend is accelerating: A 2018 report by the U.S. Government Accountability Office found that 64 rural hospitals closed between 2013 and 2017, more than twice the number in the previous five-year period.[5] And just for context, consider this: Forty-two rural hospitals closed from 2014 through 2016; three opened during the same time period.[6]

1 The Chartis Center for Rural Health, 2019 http://www.ivantageindex.com/wp-content/uploads/2019/02/Chartis-Center-for-Rural-Health_PI-Safety-Net_02.05.19.pdf

2 The National Rural Health Association www.ruralhealthweb.org/advocate/save-rural-hospitals

3 "RURAL HOSPITAL SUSTAINABILITY: New Analysis Shows Worsening Situation for Rural Hospitals, Residents", Navigant, Feb. 2019 www.navigant.com/-/media/www/site/insights/healthcare/2019/navigant-rural-hospital-analysis-22019.pdf

4 "Access to Care: Populations in Counties with No FQHC, RHC, or Acute Care Hospital" https://www.ruralhealthresearch.org/publications/1162

5 RURAL HOSPITAL CLOSURES, GAO, Aug. 2018 https://www.gao.gov/assets/700/694125.pdf

6 GAO report Aug 2018

# FACTORS DRIVING CLOSURE

So why are so many hospitals closing or at risk of doing so? Various factors contribute, and with the help of the GAO, the Kaiser Family Foundation and a few other experts, we've identified several:

- **Socioeconomic pressure:** Areas served by rural hospitals have higher than average rates of poverty, and more people are likely to be uninsured. They also have high rates of Medicare and Medicaid coverage. And the population of these areas is shrinking.[7,8]
- **Flight of the insured:** Privately insured patients often go elsewhere for care. This not only hurts revenue; it fosters the mis-perception of poor quality.[9]
- **Margin over mission:** Corporate business decisions, rather than assessment of local needs, can drive closures.[10] According to the GAO report, for-profit rural hospitals represented 11 percent of the rural hospitals in 2013 but accounted for 36 percent of the rural hospital closures from 2013 through 2017.[11]
- **Medicare cuts:** Reductions in nearly all Medicare reimbursements as well as bad debt payments. From the GAO report: "According to stakeholders, Medicare bad debt cuts have been one of the most important factors contributing to the recent increase in rural hospital closures." [13]
- **Medicaid expansion:** States that increased Medicaid eligibility and enrollment saw fewer rural hospital closures.[14]


### Healthcare Systems Divesting Properties in Rural Areas

"We're no longer a non-urban, or for some of you all a rural, hospital company," Wayne Smith, CEO of Tennessee-based Community Health Systems (CHS) told potential investors earlier this year. CHS strategically decided to pull out of rural communities with fewer than 50,000 people. Not so long ago, that was the community CHS primarily served.[12]

7 J. Wishner et al., A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies Kaiser Family Foundation, 2016 www.kff.org/report-section/a-look-at-rural-hospital-closures-and-implications-for-access-to-care-three-case-studies-issue-brief/

8 Dranove D, et al. The Impact of the ACA's Medicaid Expansion on Hospitals' Uncompensated Care Burden and the Potential Effects of Repeal. Commonwealth Fund issue brief 2017 www.commonwealthfund.org/publications/issue-briefs/2017/may/impact-acas-medicaid-expansion-hospitals-uncompensated-care

9 Wishner, KFF

10 Wishner, KFF

11 GAO report Aug 2018

12 "Troubled Tennessee Hospital Chain Says It's On The Way Out Of Rural Areas" By Blake Farmer Nashville Public Radio Jan. 9, 2019

13 GAO report Aug 2018

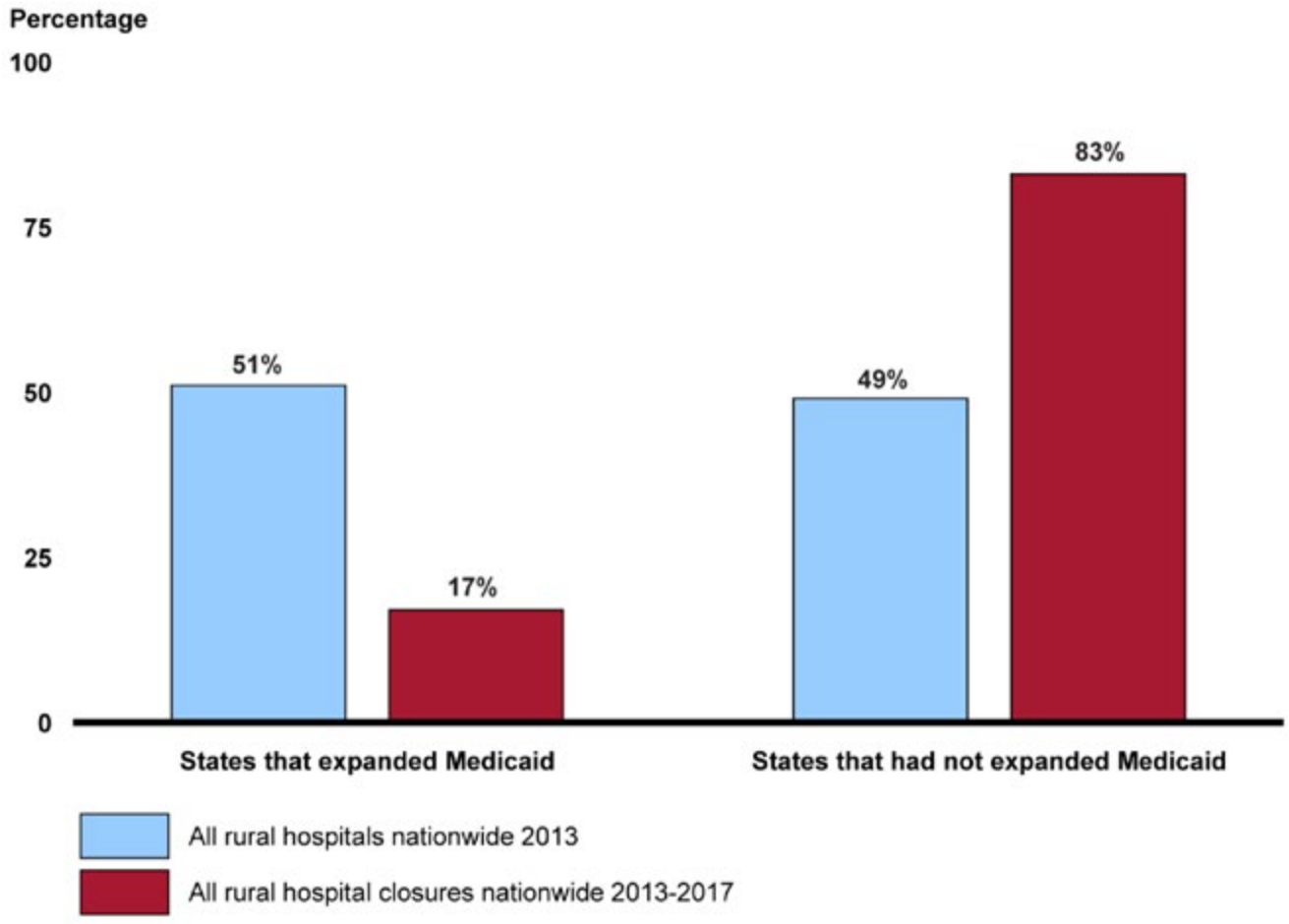
14 GAO report Aug 2018

# SO, WHAT STRENGTHENS HOSPITAL PERFORMANCE?

The two primary factors that likely strengthened the financial viability of rural hospitals were the increased Medicaid eligibility and enrollment under the Affordable Care Act.[15]

A 2018 Health Affairs study found that Medicaid expansion was associated with improved hospital financial performance and "substantially lower likelihoods of closure, especially in rural markets and counties with large numbers of uninsured adults before Medicaid expansion."[16]

## Percentage of Rural Hospitals in 2013 Relative to Percentage of Rural Hospital Closures from 2013 to 2017




Source: GAO analysis of Department of Health and Human Services (HHS) and HHS-funded data. | GAO-18-634

Note: Hospitals were defined as general acute care hospitals in the United States, and a hospital closure as a cessation of inpatient services. Rural was defined using the Federal Office of Rural Health Policy's definition (areas in (i) a non-metropolitan county, (ii) a metropolitan county, but with a Rural-Urban Commuting Area code of 4 or higher, or (iii) in one of 132 large and sparsely populated census tracts with a Rural-Urban Commuting Area code of 2 or 3).

Medicaid expansion status is as of April 2018.

15 GAO report Aug 2018

16 GAO report Aug 2018 f

# WHAT IT MEANS TO PATIENTS

When a rural hospital closes, patients have one less option for obtaining care--and one less option is a lot in rural communities. Twenty-three percent of rural respondents in a Pew survey said access to good doctors and hospitals is a major problem in their community, versus 18 percent of urban and 9 percent of suburban residents.[17]

And keep in mind that rural safety net providers serve a population that is older, poorer and sicker, with a higher incidence of chronic disease.[18, 19] These chronic diseases also typically require access to specialists for ongoing care and health monitoring. Unfortunately, those specialties are usually the first to be divested in the interest of saving overhead costs. While telemedicine can do much to resolve health monitoring, it is not a substitute for emergency access should health declines happen unexpectedly.


17 "How far Americans live from the closest hospital differs by community type," Pew Research Center Dec. 2018 www.pewresearch.org/fact-tank/2018/12/12/how-far-americans-live-from-the-closest-hospital-differs-by-community-type/

18 Chronic Disease Disparities by County Economic Status and Metropolitan Classification, Behavioral Risk Factor Surveillance System, 2013, Preventing Chronic Disease, September 2016

19 Chartis, 2019

*Here are some of the implications for patients:*

**Longer distances:** As it stands today, those living in rural areas must drive much farther than their suburban and urban counterparts to the nearest hospital.[20] Greater travel time to hospitals is associated with higher risk. For example, one study found that longer travel time to hospitals is associated with higher mortality rates for coronary artery bypass graft patients.[21]

**Fewer providers:** Regardless of hospital closures, rural communities already face difficulty recruiting and retaining providers; a hospital closure means even more will leave the area. Some healthcare providers and other hospital employees move away following a closure; others remain but commute elsewhere for work.[22]

**Reduced access to obstetric services:** Since 2011, 18 rural hospitals offering OB services have closed, and 134 others stopped offering OB services.[23] One study finds that more than half of rural counties lack hospital obstetric services.[24] Higher-risk, preterm births are more likely in counties without obstetric units.[25]

**Loss of primary care:** When an emergency department closes, it not only affects emergent care, it also leads to reduced access to a primary source of care for many rural patients. A hospital closing can also exacerbate gaps in access to specialty care.[26]

**Community repercussions:** A rural hospital is often one of the largest employers in the community, providing higher-wage jobs.[27] In fact, according to one estimate, a critical-access hospital creates 170 jobs and generates $7.1 million in annual salaries, wages and benefits.[28] Another study found a 4 percent drop in per capita income and an increase in the unemployment rate of 1.6 percentage points.[29] The job losses are a blow, as is the shrinking tax base, and the loss of a hospital — and a major employer — can make it harder to attract business to the area.

20 Pew, 2018

21 Chou S, Deily ME, Li S. Travel distance and health outcomes for scheduled surgery. Med Care 2014;52:250–7

22 Wishner, KFF

23 Chartis, 2019

24 Hung, P., et al. Access to Obstetric Services In Rural Counties Still Declining, With 9 Percent Losing Services, 2004–14 Health Affairs 2017 36:9, 1663-1671

25 Kozhimannil KB, et al. Association Between Loss of Hospital-Based Obstetric Services and Birth Outcomes in Rural Counties in the United States. JAMA. 2018;319(12):1239–12470

26 Wishner, KFF

27 Eilrich, F.C., et al. "The Economic Impact of Recent Hospital Closures on Rural Communities." National Center for Rural Health Works. August 2015

28 Doeksen, et al. "Economic Impact of a Critical Access Hospital on a Rural National Center for Rural Health Works" Oct. 2016 http://ruralhealthworks.org/wp-content/uploads/2018/04/CAH-Study-FINAL-101116.pdf

29 Holmes GM, et al. The effect of rural hospital closures on community economic health. Health Serv Res.

# NEW THREATS, OLD CHALLENGES

Rural hospitals that remain won't have it easy. They've long faced an array of challenges, and newer ones will only exacerbate their financial instability and the economic health of their communities, according to an American Hospital Association report.[30] The report identified three categories of challenges—emergent, recent and persistent. Note that most of these will also put pressure on other safety-net providers, including FQHCs.

## Emergent challenges

- Opioid epidemic
- Violence in communities
- Medical surge capacity
- Cyber threats

## Recent challenges

- Care delivery shifts
- Behavioral health
- Economic and demographic shifts
- High cost of drugs
- Regulatory burden
- Insurance coverage
- Medicaid expansion
- Health plan design

## Persistent challenges

- Low patient volume
- Payer mix
- Patient mix
- Geographic isolation
- Workforce shortage
- Aging infrastructure
- Limited access

30 AHA Rural Report, 2019 www.aha.org/system/files/2019-02/rural-report-executive-summary-2019.pdf

# LOOMING DSH CUTS

In October 2019, Congress is slated to start phasing in $4 billion in Medicaid Disproportionate Share Hospital (DSH) cuts, which are scheduled to begin Oct. 1, 2019.[31] The AHA, among others, has called on congressional leaders to delay the cuts. From the AHA's letter:

> *The Affordable Care Act (ACA) reduced payments to the Medicaid DSH program under the assumption that uncompensated care costs would decrease as health care coverage increased. Unfortunately, the coverage rates envisioned under the ACA have not been fully realized, and tens of millions of Americans remain uninsured. In addition, Medicaid underpayment continues to pose ongoing financial challenges for hospitals treating our nation's most vulnerable citizens.* [32]

Perhaps the biggest issue affecting any safety net provider is uncertainty around Medicaid.

31 "These states have the most rural hospitals at 'high risk' of closure," FierceHealthcare Feb. 2019 www.fiercehealthcare.com/hospitals-health-systems/more-than-one-five-rural-hospitals-at-high-risk-for-closing-report

32 AHA letter www.aha.org/system/files/2019-02/190219-aha-congress-medicaid-dsh.pdf

# MEDICAID UNDERMINED? SECTION 1115 WAIVERS

States continue to use Section 1115 Medicaid demonstration waivers to restrict access to the program. In theory, states are supposed to use the waivers to create demonstration projects that improve Medicaid and/or CHIP programs. That's often not the case. This threatens patient health and intensifies the financial crisis safety net providers already face.

*Here's a brief update:*

- **Work requirements:** Perhaps most significant is the continued push for work requirements; Kentucky plans to roll out its plan later this year. Expect other states to follow suit.
- **Lockouts:** We've seen several waiver proposals that "lockout" provisions. These would block patients from Medicaid and potentially penalize patients who miss premium payments and work requirements. Last year, the AMA voted to opposes such matter.[33]
- **Retroactive coverage:** Several states have won—or are seeking—waivers to abolish retroactive Medicaid coverage, which gave most patients 90 days of Medicaid coverage prior to their application date, depending on their state of residence. While all waivers involve some amount of administrative complexity, Indiana's demonstration is more complex than others approved to date. The program has multiple parts, including four different Medicaid benefit packages for the populations covered by the waiver (aside from premium assistance for employer-sponsored insurance). It also requires administering and tracking a number of elements, such as premium payments or co-payments, compliance with healthy behaviors, health savings account balances and rollover funds, presumptive eligibility determinations, and services that would have been covered retroactively for certain groups. For example, most newly eligible adults with income from 0-138% FPL who fail to promptly contribute monthly to a Personal Wellness and Responsibility (POWER) health savings account may be excluded from coverage and not have the ability to re-enroll for six months, regardless of eligibility.
- **Lifetime limits:** The threat of lifetime limits on Medicaid continues to loom.
- **Partial expansion:** A few states have sought waivers to limit coverage to individuals at 100 percent of the federal poverty level (FPL), instead of the full 138 percent. The Kaiser Family Foundation found that this could mean in less coverage overall, and less coverage in Medicaid, compared to full Medicaid expansion. [34]

We are seeing push back in some of these areas. In a few states, including Maine, Michigan, New Hampshire and New Mexico, governors and legislatures who took office in January are trying to roll back some of the more draconian measures.[35] At the federal level, the Medicaid and CHIP Payment and Access Commission (MACPAC) has asked the administration to delay approving states' requests to implement Medicaid work requirements.[36]

33 "'Partial Medicaid Expansion'" with ACA Enhanced Matching Funds: Implications for Financing and Coverage Kaiser Family Foundation Feb 20, 2019 www.kff.org/medicaid/issue-brief/partial-medicaid-expansion-with-aca-enhanced-matching-funds-implications-for-financing-and-coverage

34 "States Are Reconsidering Restrictive Medicaid Waiver Policies," Center on Budget and Policy Priorities,

35 Feb. 25, 2019 www.cbpp.org/blog/states-are-reconsidering-restrictive-medicaid-waiver-policies

36 MACPAC letter www.macpac.gov/wp-content/uploads/2018/11/MACPAC-letter-to-HHS-Secretary-Regarding-Work-Requirements-Implementation.pdf

# KEEPING THE DOORS OPEN: HARDER THAN EVER

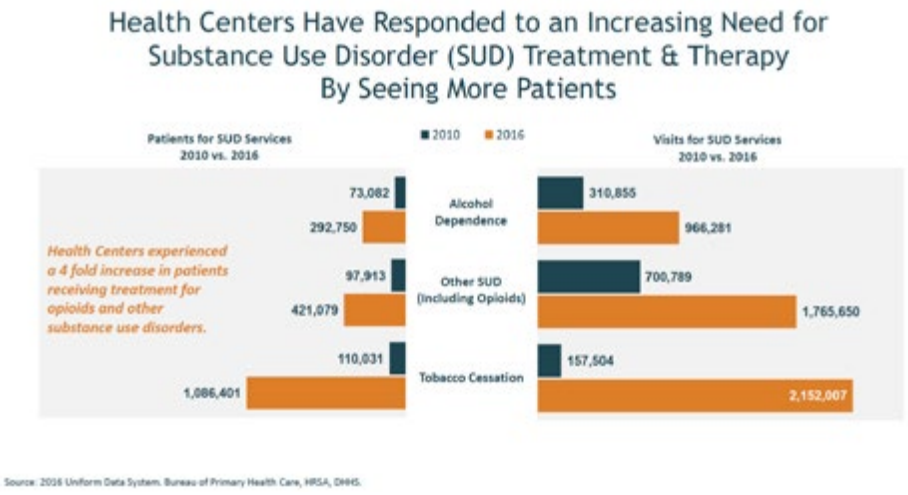
Medicaid aside,safety net providers face an array of unique challenges to keeping their doors open, be they clinics or hospitals. Here are a few:

- **ACA unintended consequences:** Despite a reduction in charity care, the overall impact of the ACA is unclear, according to one the study. The reasons? Bad debt from high-deductible plans and between payments and costs of care in Medicare and Medicaid.[37] Moreover, the elimination of penalties for being uninsured will result in anywhere from 2.8 million to 13 million fewer Americans with coverage, and a 3 percent to 13 percent rise in premiums for bronze plans. [38]

- **Disparities in cost of care:** The Network for Regional Healthcare Improvement has published a multi-region analysis looking at total cost of care and cost drivers across the U.S. The numbers are still being crunched, but one takeaway appears to be that, as you move out of the more densely populated metro areas, total cost of care increases, but quality drops. [39]

- **Immigration crackdown:** Most of the uninsured are citizens. However, non-citizens, including lawfully present and undocumented immigrants, are significantly more likely to be uninsured than citizens. [40] Changes in immigration policy have led immigrant families — often regardless of legal status — to turn away from Medicaid and CHIP. [41] If these families do seek care it will be self-pay, which often means a write-off for the safety-net provider.

- **Opioid epidemic:** Nearly 70 percent of community health centers said they saw more patients with prescription opioid use disorder (OUD); [42] 63 percent reported an increase in the number with nonprescription OUD. Between 2010 and 2016, they experienced a four-fold increase in patients receiving treatment for opioid substance use disorders. [43]




- **Physician shortages:** By 2030, demand for physicians could exceed supply by as much as 121,300.[44] The patient-to-primary-care-physician ratio in rural areas are already significantly lower than in urban and suburban areas. Moreover, 65 percent of all health professional shortage areas are in rural America.[45]

So how will safety-net clinics meet these challenges? They need to construct their own net — a net of tools, resources and expertise to help them remain viable.

# BUILDING A NET FOR THE SAFETY NET

Community health centers need a team of specialists who not only excel in revenue cycle management, but also have access to the right technology to reduce billing cycles and increase collections. And this team needs to understand the nuances of FQHCs, CMHCs and RHCs.

Altruis can help. Among the tools we can provide are:

**Chronic care management (CCM):** CCM focuses on keeping a person as healthy as possible, not merely addressing illness. This improves outcomes, lowers costs, and enhances patient satisfaction. For rural providers, coordinating care is essential. They serve a population with a higher incidence of chronic disease. By taking a coordinated, whole-person approach, CCM can address root causes of chronic illness--or at least keep chronic conditions in check. This approach is also ideal for dealing with the opioid epidemic. Traditional separation of substance use disorder treatment and mental health services undermines successful care coordination.

Altruis' Chronic Care Management is a turnkey solution lets you include chronic care management and transition care management services without adding staff or adding to your current workload. Our care delivery and coordination team acts as an extension of your organization.

**Medical Billing :** Altruis works directly with payers on our clients' behalf, developing relationships that enable us to more quickly resolve issues and prevent them in the future. Our provider clients see a reduction in the rate of errors and denials, improving productivity and efficiency while saving significant time and money.

**Retroactive reimbursement:** A significant percentage of self-pay patients are eligible for Medicaid coverage--or they will become eligible while under your care. Once these patients are successfully enrolled, their Medicaid coverage can be applied retroactively to cover care provided in the months preceding their application. Altruis RetroPay™ creates new revenue streams by automating the process that identifies Medicaid coverage and retroactively billing payers, strengthening patient satisfaction while boosting revenue that otherwise would have been written off as bad debt. (As we note above, some states have or are trying to remove retroactive Medicaid coverage through section 1115 waivers, so providers need to jump on this ASAP.)

It all comes down to this: You need a revenue cycle partner that works on contingency and can bring all these solutions together without additional burden or cost. The right partner will work with your current workflows and EHR systems to tailor revenue cycle management to your center's specific needs.

That's what we do at Altruis. See how we can help. Visit us at https://altruis.com/what-we-do/ or contact us for a free 30 minute assessment.

Altruis exists to serve providers with the most innovative revenue cycle management (RCM) technologies and services that deliver on the promise of healthier revenue—enabling our clients to remain focused and expand on their mission of patient care. As a leading medical billing service, Altruis manages all aspects of billing, claims, denials, AR management, and payment posting. As a true RCM partner, Altruis develops technologies that enhance reimbursement, help providers meet value-based care requirements, and ease the administrative burden for staff and patients. To learn more about how Altruis delivers healthier revenues for a healthier mission, visit www.altruis.com.

1-"Millions more Americans were uninsured in 2017", CNN Money, Tami Luhby January 16, 2018 https://money.cnn.com/2018/01/16/news/economy/uninsured-Americans/index.html

2-"Federally Qualified Health Centers Troubled By Rising Competition" ,Jacqueline LaPointe: https://revcycleintelligence.com/news/federally-qualified-health-centers-troubled-by-rising-competition

3-"No safe harbor: Why the dynamic healthcare market threatens to leave some FQHCs lost at sea" by Christopher DeMarco, PhD, MBA; Daniel D'Orazio, MBA. Sage Growth Partners, November 2017.

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