Financially Fragile Rural Hospitals:
Mergers and Closures

Mark Holmes

Rural hospitals serve as major sources of health care and employment for their communities, but recently they have been under increased financial stress. What are the causes of this stress, and how have hospitals and their communities responded?

I was raised in a small town in Michigan. I was lucky enough to have a hospital in my community, and we used it. I went there when I fell off my dresser at age 8 years, and we took my grandmother there after she fell down the stairs in our house. It was our hospital, and the community valued it. Like our school system and the fall festival, the hospital was a large part of who we were as a town.

Since 2010, however, there are at least 42 rural communities across the country—including 2 in North Carolina—that no longer have that resource. [Editor's note: At the time this article was written, there had been 42 hospital closures since 2010; in the intervening months, at least 3 more hospitals have closed.] In some places, the hospital has been converted to another kind of health care facility, such as a long-term care facility or a clinic. In other communities, the building remains empty. The residents need to find another place to get their care, and if they need emergency care, they must hope to get to the next closest hospital quickly. Although hospital closures are nothing new, the recent pace is unprecedented; the National Rural Health Association has reported that the number of rural hospital closures in the past year was more than in the previous 15 years combined [1].

Why Are We Seeing More Rural Hospital Closures?

The number of rural hospital closures is accelerating for many reasons. The most commonly cited reason is the Patient Protection and Affordable Care Act of 2010 (ACA) and/or each state's decision regarding Medicaid expansion. It is certainly true that rural hospitals generally depend on public insurance programs (Medicare and Medicaid) more than do urban hospitals. This is largely a result of the demographics of rural communities, which are generally poorer and more elderly than urban areas, but we also know that commercially insured residents (whose care can generate higher reimbursement for the hospital) are more likely to bypass their local hospital [2]. In other words, rural hospitals face a compounded reimbursement challenge—a lower reimbursement market combined with the fact that those whose care could yield higher reimbursement are more likely to go to a different hospital.

Rural populations are generally more likely to be uninsured, and the execution of 2 of the most visible coverage provisions of the ACA—the insurance marketplace and Medicaid expansion—have generally *exacerbated* this coverage disparity. Early estimates suggest that, despite higher eligibility, rural populations had lower take-up rates in the federally facilitated marketplace, and state-specific decisions to expand Medicaid have generally been more common in states that are more predominantly urban; that is, rural states have been less likely to expand Medicaid, meaning rural hospitals have been less likely to see an increase in coverage [3]. Furthermore, more rural hospitals have closed in states that have not expanded Medicaid (N = 33) than in those that have (N = 9) [4]. Although there are more rural hospitals in states that have not expanded Medicare than in states that have, the closure rate is higher in the former group (2.3% versus 1.0%) [4, 5]. It is important to note, however, that Southern states have seen the bulk of hospital closures, and those states have been less likely to expand Medicaid. Thus it is difficult to accurately determine whether it is the expansion decision per se that has led to higher closure rates, or whether states that have not expanded Medicaid have other factors leading to higher closure rates; this is an important question on which many researchers are currently working.

Other factors are important contributors too. Rural hospitals have long been some of the most financially fragile hospitals. In study after study, we have found that rural hospitals—especially the smallest rural hospitals—have the lowest profitability and liquidity, meaning they are financially fragile [6]. In other words, many of those hospitals that have closed were struggling for years, and recent

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Rural Hospitals Face Many Challenges in Transitioning to Value-Based Care

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In North Carolina and across the country, a sea change is underway that is transforming how health care services will be delivered and paid for in the decades to come. Hospitals and health care systems are reorganizing to prepare for value-based care—preventive, coordinated, high-quality care that is focused on improving the overall health of communities. The struggle for hospital executives is how to position hospitals for the future while still providing care in a volume-based payment system. Balancing finances during this time of tremendous change requires hospital leaders to make difficult decisions. Hospitals must innovate, restructure, become more efficient, and continuously improve care in order to protect the community's health safety net. This transition is particularly challenging for rural hospitals.

There are 56 hospitals in North Carolina in counties that are classified as rural. These hospitals tend to have a higher-than-average mix of Medicare (48%), Medicaid (17%), and uninsured patients (10%), and they generally serve populations that have lower incomes, more chronic health issues, and low health literacy. Safety-net hospitals care for more Medicare, Medicaid, and uninsured patients; as a result, they experience lower (often negative) operating margins (the difference between reimbursement and expenses). For North Carolina's safety-net hospitals caring for high proportions of Medicare, Medicaid, and uninsured patients, average patient margins in fiscal years 2012 and 2013 were the lowest in the last 9 years [1].

Without Medicaid expansion or other solutions to provide insurance coverage for uninsured patients, and with additional cuts to Medicare and Medicaid reimbursement, the forecast for all hospitals in North Carolina is one of continuing challenges. This future will continue to include mergers, shared services partnerships, realignment or reorganization of services toward outpatient and ambulatory care, conversion of acute care hospitals into community-focused health care organizations, and in some cases, hospital closures. According to the research firm The Advisory Board Company, hospitals in states that did not expand Medicaid will see their profit margins drop precipitously by 2021 [2].

Rural hospitals have weathered this storm before. The Balanced Budget Act of 1997 led many small hospitals to successfully restructure as critical access hospitals (CAHs). Since then, 23 small rural hospitals in North Carolina have transitioned to CAHs. Implementation of the Patient Protection and Affordable Care Act of 2010 has dramatically accelerated the pace of such changes. In response to declining admissions, most hospitals outside of major metropolitan areas have joined integrated health systems or regional health networks. Partnership arrangements offer better access to capital for facility renovations and improvements in technology, as well as access to cost-saving efficiencies. According to membership data from the North Carolina Hospital Association, the number of independent hospitals in North Carolina has dwindled since 2012—from 24 to 18—with many of the remaining independent hospitals actively seeking health system partners.

In light of these challenges, many rural hospitals are policy changes (such as a cut in Medicare reimbursement) were enough to push them into closure. "Health reform" is sometimes used synonymously with "the ACA," but market-based health reform was moving ahead well before the ACA was enacted. For example, accountable care organizations (ACOs) are often viewed as one of the key provisions of the ACA, and they were thought to be one of the means through which Medicare would bend the cost curve. But by the time Medicare announced its first Pioneer ACOs, 150 private ACOs were already operating [7].

Market-based health reforms had started before the ACA was enacted and have continued since. These reforms have spurred a consolidation in the health care industry—especially hospitals—and many rural hospitals have been merged or acquired. Meanwhile, other trends such as a population decrease in rural areas and a shift away from acute care in the inpatient setting have been disadvantageous for rural hospitals, as they have led to shrinking markets.

Mergers and Hospital Closures

When a hospital is financially challenged, it may sometimes merge with (or be acquired by) a larger hospital system. A recent study during the 2005–2012 period found that hospitals with lower profitability and higher debt—that is, financially fragile hospitals—were more likely to merge [8]. Merging hospitals experienced a decrease in operating margin—meaning they were even less profitable—and generally they had lower salary expenses, likely as a result of eliminated management positions. Thus, even though a challenged hospital may find that a merger is a viable option, its finances generally worsen after a merger, and some of the best-paying management positions—and, likely, the community-mindedness of the hospital—may evaporate. It is too early to tell whether these merged hospitals are more likely to close.

Unsurprisingly, a hospital closure generally has a nega-

transforming their operations to prepare for a future of risk-based, accountable care. In Wadesboro, Charlotte-based Carolinas HealthCare System (CHS) replaced the 100-year-old Anson Community Hospital with a new medical home facility designed to promote a shared commitment between care providers, patients, and the community. While the hospital includes 15 inpatient rooms, the majority of its services are oriented to outpatients, with 24-hour emergency care and other traditional hospital services, as well as access to primary care physicians, wellness and prevention education facilities, patient navigation services, and pharmacy assistance. As part of an integrated health system, the new role for Anson Community Hospital is primary care; secondary acute care and intensive care are provided at CHS hospitals in Monroe (approximately 28 miles away) and Charlotte (approximately 55 miles away) [3].

In Burke County, CHS Blue Ridge announced plans in June 2014 to transition the hospital in Valdese to an outpatient health center and to transfer inpatient care to its nearby Morganton campus [4]. This realignment of services is not unique. In Watauga County, the Appalachian Regional Healthcare System strategically examined health care services provided by Watauga Medical Center in Boone and those of nearby Blowing Rock Hospital, along with the health needs of the communities; as part of a long-term strategy, health system administrators decided to transition Blowing Rock Hospital from a CAH to a post-acute care and rehabilitation center as of October 2013 [5].

The success of health care service transitions, restructuring, and partnerships in these examples illustrates the importance of rural hospitals to their communities. North Carolinians need hospitals in order to retain access to vital health and wellness services. Rural hospitals are also essential to local economies, as they provide jobs, stimulate local purchasing, and help attract industry and retirees. Because of this, the closure of a hospital can be detrimental to the health and economy of a rural community [6].

The status quo in health care is not a viable strategy for the future. North Carolina's hospitals—rural and urban—must continue to innovate, restructure, become more efficient, and improve care to meet their mission to ensure around-the-clock access to quality medical care and to protect the health of patients and the community. NCMJ

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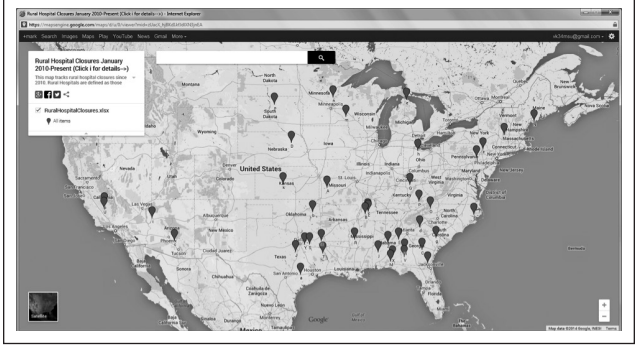
tive effect on the community. Access to care is diminished, which can sometimes lead to visible, real, and personal costs, such as a death due to delay in receiving care. There are also economic effects of hospital closures. A hospital is often one of the largest employers in a rural community, and previous research has shown that a closure leads to a short-run decrease in per-capita income and an increase in the unemployment rate [9]. If a community loses its only hospital, the cost can be permanent; one estimate suggests this cost is a $703 decrease in the per-capita income of a community (in 1990 dollars—approximately $1,300 today) [9]. Given the average rural county population, this translates to roughly $30 million lost from rural county residents as the result of a closed hospital.

Because of these costs, the North Carolina Rural Health Research Program is tracking rural hospital closures across the country (See Figure 1). Although many such closures are covered in news media, not all are. Therefore, news alerts are supplemented by data-sharing partnerships with the National Rural Health Association and the Office of Rural Health Policy, along with state associations and other stakeholders, which allow us to include as many rural hospital closures as can be identified. A map indicates known rural hospital closures and contains key information on each clo-

FIGURE 1.
Screenshot of Rural Hospital Closure Website



sure, including what the building has become (eg, a long-term care facility, free-standing emergency department, or school). If you want to find out more, or if you know of a hospital closure, visit http://bit.ly/ruralclosures to see the most up-to-date map and list of hospitals. NCMJ

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