



Assessing Indiana’s Rural Hospital Finances A White Paper

Policy & Legislative Committee of the Indiana Rural Health Association

Introduction

“Rural hospitals have been in ‘a slow-burning crisis for decades,’” says University of Pennsylvania Leonard Davis Institute of Health Economics (Penn LDI) Senior Fellow Paula Chatterjee.¹ Over 600 rural hospitals in the United States are at risk of closing due to the cost of delivering services being more than the payments received by health insurance, lack of workforce, and hospitals not receiving funding to cover those losses.²

Rural hospitals face great challenges: declining in-patient volumes; fee-for-service payment systems; reputation/local perception; and level of care.³ The *Future Healthcare Journal* found that “payment systems based on fee-for-service do tend to systematically disadvantage smaller hospitals, especially so in markets with a single dominant payer.”⁴ The *Future Healthcare Journal* also found that the perceptions of less “prestigious”/specialized opportunities, less benefits, undesirable/longer hours, and lower salaries available may hinder securing workforce in smaller hospitals.⁴ As of 2018, 48% of rural beneficiaries’ hospital admissions were in urban-located hospitals.³ Penn LDI found that patients bypassing local hospitals to receive care at an urban facility farther away, due to a real or perceived higher level of care, also decreases potential revenue.¹

About 150 rural hospitals have closed throughout the country since 2005, and more than 200 are now at immediate risk of closure.² The American Hospital Association reported 19 rural hospital closures in 2020, which is a record high for closures⁵. Nationally, hospital revenues have declined tremendously due to the COVID-19 pandemic, as people were not receiving preventive and specialty health care services. Furthermore, costs continued to increase, and the healthcare workforce decreased.⁶ Overall, Indiana hospitals were no different.

The Center for Healthcare Quality and Payment Reform reported that 13% of Indiana’s rural hospitals are at risk of closure and 11% are at risk of immediate closure².

Impact of COVID-19 on Hospital Costs

¹ <https://ldi.upenn.edu/our-work/research-updates/rural-hospitals-are-smaller-and-make-less-money-than-urban-facilities/>

² https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf

³ https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch3_SEC.pdf

⁴ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7032574/>

⁵ <https://www.aha.org/press-releases/2022-09-08-new-aha-report-finds-rural-hospital-closures-threaten-patient-access-care>

⁶ <https://www.aha.org/fact-sheets/2020-04-24-fact-sheet-financial-challenges-facing-hospitals-and-health-systems-result>

Due to COVID-19, hospitals across the country are facing significant financial challenges and, even with the Public Health Emergency coming to an end, hospital costs for contract labor, medication, and medical supplies added extreme burden to hospital financial situations.⁷ According to the American Hospital Association and data collected by health care data consultant company, Syntellis Performance Solutions, hospital expenses increased by 17.5% from 2019 to 2022.⁸ Even with the temporary suspension of Medicare automatic payment reductions known as sequestration and other pieces of federal legislation designed to alleviate the burdens of the COVID-19 pandemic, many agencies, such as the Kaiser Family Foundation (KFF) and the American Hospital Association (AHA), found that these approaches may not target hospitals that have been disproportionately impacted, including rural facilities.⁹ ¹⁰ Further legislative proposals and regulatory changes, such as amendments to sequestration and 340B, that do not specifically account for the challenges addressed in this paper for rural hospital systems, particularly critical access hospitals that may serve as the only point of care for many rural citizens within dozens of miles, will further exacerbate the financial struggle for rural facilities to continue operation.

Prior to 2019, hospitals were already suffering from workforce shortages and the demands of COVID-19 led to hospitals utilizing more contract labor, increasing overall hospital labor expenses by 20.8%.¹¹ Contract nurses went from an average weekly pay of \$1,896 in January 2020 to \$3,792 in December 2021 with stabilization occurring in January 2023 at a weekly pay of \$3,077¹²—an overall increase of 257.9% between 2019 and 2022.⁹

Non-labor costs have also increased due to inflation. Hospitals have experienced a 16.6% increase per patient for non-labor expenses for things like medications, medical supplies, and purchased services.⁸ According to the U.S. Department of Health and Human Services (HHS), pharmaceutical companies raised the price of their medications by 8.5% from 2021 to 2022¹³ and showed an increase of 19.7% for drug expenses per patient from 2019 to 2022.⁸ The cost for hospital supplies and equipment also increased 18.5% per patient from 2019 to 2022.⁸ From quarter one in 2021 to 2022, 75% of Indiana hospitals have paid up to 15% more than average on critical medical supplies like syringes, gloves, and other personal protective equipment (PPE).¹⁴

Rural Hospital Margins

Federal COVID-19 relief funds improved rural hospital financial performance; however, when reviewing the hospitals' median operating margins minus the relief funds, the margins actually decreased during the period of the pandemic.¹⁵ According to MedPAC, rural hospitals across the country reached a record high of 6.4% in 2020 for all-payer total margin, which is attributed to the Public Health Emergency (PHE) funds. However, without PHE funds, Critical Access Hospitals (CAHs) would have reached only 2.1%³.

⁷ <https://www.aha.org/costsofcaring>

⁸ https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2_Feb%202023.pdf

⁹ <https://www.kff.org/coronavirus-covid-19/issue-brief/funding-for-health-care-providers-during-the-pandemic-an-update/>

¹⁰ <https://www.aha.org/topics/covid-19-coverage-and-reimbursement>

¹¹ <https://www.kaufmanhall.com/insights/research-report/special-workforce-edition-national-hospital-flash-report>

¹² <https://www.beckershospitalreview.com/compensation-issues/the-state-of-travel-nurse-pay-5-trends-to-know.html>

¹³ <https://aspe.hhs.gov/reports/prescription-drug-price-increases>

¹⁴ <https://www.ihconnect.org/member/newsroom/Pages/survey101022.aspx>

¹⁵ <https://www.kff.org/health-costs/issue-brief/rural-hospitals-face-renewed-financial-challenges-especially-in-states-that-have-not-expanded-medicare/>

*Hospital Payer Mix and Margins*¹⁶

Hospital payer mix represents how a hospital is paid for services and is comprised of various insurances, Medicare, Medicaid, out-of-pocket payments, and any other form of payment. For federal health insurance types (Medicare FFS as well as Medicaid, CHIP, and Indigent), hospitals receive only a small percentage of the actual cost for the service. For Indiana rural hospitals, the average share of patient costs for Medicare FFS, Medicaid, CHIP, and Indigent, Uninsured Charity Care, and Private/Other is 29.3%, 16.7%, 1.32%, and 53.8%, respectively. Private/Other payers cover the highest percentage of hospital service costs; however, rural residents are less likely to have private health insurance (68.8% in urban vs. 62.2% in rural) and are more likely to be uninsured (13.7% in urban vs. 14.4% in rural) or receive public coverage (19.1% in urban vs. 26.3% in rural)¹⁶. Therefore, the payer mix of most rural hospitals is less likely to adequately cover the cost of providing care for their communities.

*Payer Shares of Hospital Operating Margins*¹⁷

The operating margin for a hospital is a measurement of financial health, informing hospital leadership whether expenses are acceptable.¹⁸ Hospital operating margin is the total of the hospital's profit and loss and are determined by the hospital's total expenses based on the following categories: Medicare FFS, Medicaid, CHIP, and Indigent, uninsured charity care, bad debt, Private/Other, and Non-patient services. On average, rural hospital margins for Medicare FFS, Medicaid, CHIP, and Indigent, and Private/Other are -0.4%, -0.2%, and 18.6%, respectively. Uninsured charity care is provided to qualifying patients who have no means to pay for care. For rural hospitals, the overall operating margin on uninsured charity care is -1.2%. Bad debt accrues from patients who do not have health insurance or are unable to pay for services. On average, Indiana's rural hospital's bad debt is -3.2%. Ultimately, the overall average operating margin for Indiana's rural hospitals is 7.5% with the lowest operating at -11.7%.

Conclusion

The cost of healthcare has been under extreme scrutiny in recent years. Based on the information provided in this paper, it is evident that there are significant challenges that may hinder the nation's ability to effectively lower these costs while ensuring the viability and survivability of the critical rural healthcare infrastructure. In 2021, the American Hospital Association published the "AHA Future of Rural Health Care Task Force Final Recommendations" article. In this document, there are several recommendations for consideration that address the antiquated reimbursement model. Many of the flexible funding programs and payment models outlined in the article can serve as a starting point for revising Indiana's rural healthcare infrastructure. Shifting the way rural healthcare delivery is supported will require significant research, investment, and collaboration from all parties involved. "Federal policy alone will not ensure the future of rural health care. Creative thinking and innovation on a state, community and institutional level are essential to the operation transformation of rural health care in America – as well as the improved health of rural residents."¹⁹

¹⁶ <https://www.cdc.gov/nchs/data/nhsr/nhsr176.pdf>

¹⁷ <https://ruralhospitals.chqpr.org/Data4.html>

¹⁸ https://www.bluewaterhealth.ca/sites/default/files/Bluewater_Health_Performance_Total_Margin.pdf

¹⁹ <https://www.aha.org/2021-05-17-final-recommendations-future-rural-health-care-task-force-may-2021>