



With Impending Funding Crises, Rural Hospitals Need a Medicaid Expansion Lifeboat to Stay Afloat

Two hundred rural hospitals are at immediate risk of closing, and another 600 rural facilities are at high risk of closing in the future.¹ The end of emergency COVID-19 hospital funding, together with other looming threats, represents a major potential rural hospital crisis. Rural hospitals in states that have expanded Medicaid coverage have more sustainable median operating margins (1.6%) compared with rural hospitals in nonexpansion states (-0.3%).² Uncompensated care, or services performed by hospitals or health care providers that are not reimbursed by some type of health insurance, is a primary reason for hospitals having worse operating margins and moving toward closure. Since 2010, uncompensated care has increased by 50% at rural hospitals, disproportionately driven by Medicaid nonexpansion states.³ Any states that have not expanded Medicaid can expect a wave of rural hospital closures in 2023.

Rural hospitals are essential to the health and economic well-being of rural communities.⁴ However, they are a dying breed among health care facilities. Since 2010, at least 134 rural hospitals have closed across the United States, with several hundred more vulnerable to closing in the future.⁵ The people from the rural communities surrounding these closed hospitals have to drive substantially farther for care or to deliver newborns and are left without emergency departments. These alarming closure rates are preventable disasters that have been years in the making. Rural hospital closures have led to crumbling health care systems and diminished health for the surrounding communities. After a reprieve during the first couple years of the pandemic, record rural hospital closures may pick up again in 2023 as three funding crises emerge:

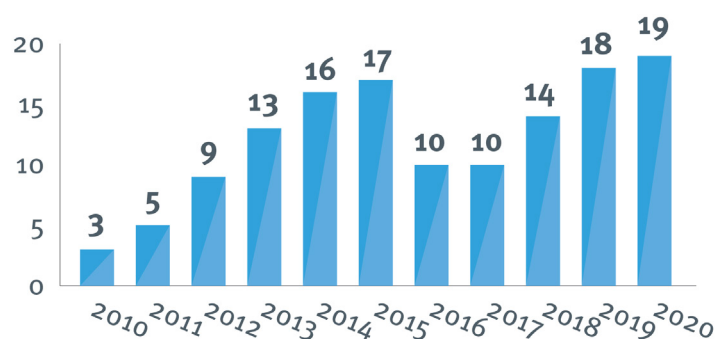
1. **COVID-19 funding for rural hospitals has ended.**
2. **Uncompensated care costs will increase when the public health emergency ends.**
3. **Possible economic recession could accelerate rural hospital closures even further.**

A new era of rural hospital closures is coming. Medicaid expansion is a critical, proven solution to salvaging rural health care systems that states cannot afford to pass up.

Rural hospital closures accelerated preceding the pandemic

The alarming number of rural hospital closures tells just part of the hospital story in rural America. The Sheps Center for Health Services Research classifies closures into two eras, 2005-2010 and 2010-present. While the second era is more than twice as long as the first era, closures more than tripled during the second era in part due to the aftermath of the 2008-2009 recession.⁶ These closures accelerated in recent years before the start of the COVID-19 pandemic, as seen in Figure 1 below. After that, the federal government provided temporary financial assistance to rural hospitals, and closure rates dropped.⁷

Figure 1. Rural Hospital Closures, 2010-2020



As seen above, 2020 set the rural hospital closure record for this era. Right as rural communities needed health care services and infrastructure the most, they were collapsing in many places. None of the states with the most rural hospital closures between 2010 and 2020 had adopted Medicaid expansion at that time (Oklahoma and Missouri implemented Medicaid expansion in 2021):⁸

Rural Hospital Closures



*states that implemented Medicaid expansion in 2021

Impact of hospital closures on communities

Many communities, especially in states without Medicaid expansion, have been left stranded following this decade of rural hospital closures. These closures have a direct impact on patients and communities. For example, during that decade, affected states lost a significant number of total available hospital beds with staff on hand to attend to patients:⁹

Available Beds Lost



*while its population grew by over 500,000

Beyond hospital walls, rural hospital closures have far-reaching consequences in surrounding communities:

- » The median distance people must travel to access health care services increases by approximately 20 miles.
- » Ambulance travel times increase 76%.

- » Death rates increase 8.7% for time-sensitive conditions, 11.3% for people of color, and 12.6% for rural people experiencing poverty.¹⁰
- » Elderly and low-income individuals are more likely to forgo or delay needed care due to transportation issues.¹¹
- » Per capita income decreases an average of 4% as hospital closures leave surrounding economies without higher-wage jobs.¹²

“[T]hose who can least afford a loss of access to care are the most vulnerable to a loss of access to care.”

*– The Chartis Group,
Pandemic Increases Pressure on
Rural Hospitals and Communities¹³*

COVID-19’s Perfect Storm: Uninsurance and Closed or Crowded Facilities

In 2019, the rural uninsured rate was almost twice as high in Medicaid nonexpansion states (21.5%) compared with Medicaid expansion states (11.8%).¹⁴ This left rural communities in nonexpansion states vulnerable to further disaster once COVID-19 became pervasive just a year later and patients, especially uninsured individuals, had limited options for care. Residents of rural communities that lost hospitals in previous years were forced to delay treatment or to seek treatment elsewhere, overloading providers and hospitals in other communities. In rural hospitals in western Tennessee, patients waited days in emergency room hallways for an available bed, even a bed located on the opposite end of the state.¹⁵

An associate chief of staff at Vanderbilt University Medical Center described the dire situation: “We were down to a bare-bones number of hospital beds to support communities, and there was almost no slack in the system.”¹⁶

While this scenario played out across the country, the grave consequences were disproportionately felt in rural communities that lost their hospital facilities. A Politico investigation found that among the 50 counties nationwide with the highest COVID-19 deaths per capita, 24 counties were within 40 miles of a hospital that had closed and almost all 50 counties were in rural areas.¹⁷

*As one resident of Brownsville, Tennessee, put it,
“Really, our emergency room is in the back of an ambulance.”¹⁸*

Impact of Delivery Room and Pediatric Closures on Pregnant Patients, Families and Kids

Pregnant patients, families, and kids trying to access essential care or deliver newborns in rural communities face impossible options to access care when obstetric or pediatric providers close. For example, pediatric provider closures in Oklahoma have forced some families to drive hundreds of miles to Memphis, Tennessee; St. Louis; or Rochester, Minnesota, just for their child to receive care.¹⁹ Just as rural hospital closures have hurt rural communities in recent years, obstetric care units have also been eliminated, creating “maternity deserts,” with 9% of rural counties across the country losing all obstetric services from 2004 to 2014 and 53 additional counties losing obstetrics care from 2014 to 2018.²⁰ These service losses are in addition to the 53% of rural counties that never had obstetric care services available for their residents.²¹

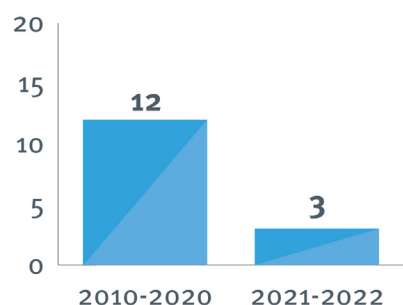
These obstetric provider closures mean fewer people will receive necessary prenatal care due to travel distances, increasing the likelihood of maternal and infant mortality and other dangerous complications, such as severe anemia, gestational diabetes, or a baby in a breech position.²² Earlier in 2022, rural hospitals in Kemmerer and Rawlins, Wyoming, announced they have been forced to close their labor and delivery services due to financial struggles. Now residents of those areas needing labor and delivery services will have to travel over an hour to Evanston, Wyoming, during potentially emergent situations, an even worse option when roads are closed for multiple days because of harsh winter conditions.²³

*As described by a mother of a kindergartner with a connective tissue disorder,
“We’re always preparing for battle.
It’s just a question of where we’re going to fight.”²⁴*

Temporary COVID-19 aid funding slowed hospital closures

As COVID-19 threatened patients’ lives and hospitals’ capacity and resources, legislation passed by Congress in response to the pandemic offered rural hospitals a temporary reprieve. Pandemic relief funds slowed hospital closures to the lowest point since 2010. Figure 2 (next page) shows the sharp decrease in the average number of hospital closures in the years following the pandemic outbreak compared with the average number of annual closures during the previous decade.²⁵

Congressional and administrative responses to COVID-19, including through the Families First Coronavirus Response Act; the Coronavirus Aid, Relief, and Economic Security Act of 2020; and the

Figure 2. Average Annual Rural Hospital Closures, 2010-20 vs. 2021-22

American Rescue Plan of 2021, provided temporary funding relief for rural hospitals. Details on the funding sources, amounts, and end dates for this temporary funding can be found in the appendix.

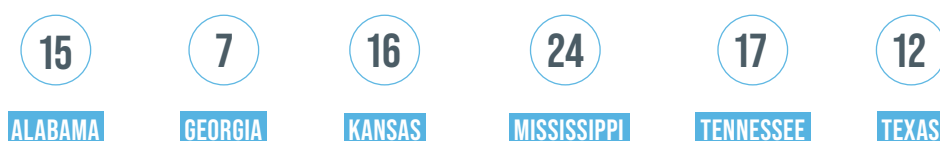
These large amounts of funding had a demonstrable impact as rural hospital closures went from a record high in 2020 to just a few closures in 2021 and 2022. However, much of this funding was specific to the COVID-19 emergency and is not available on the recurring basis that rural hospitals and communities need it to be to keep improving their operating margins.

At a hospital in the Mississippi Delta, the chief financial officer noted that even after the hospital received \$11 million from COVID-19 relief legislation in 2021, the hospital remained \$10 million in the red due to perennial financial losses. The federal relief forestalled closure, but the hospital board was still forced to let the lone local neurosurgeon's contract expire, leaving the Mississippi Delta without access to neurosurgery.²⁶ Since then, relief funds have lessened, and that Mississippi hospital and others like it may be in jeopardy next year with new impending crises for rural hospitals and communities. Indeed, as of October 2022, the hospital was also forced to close their labor and delivery services, redirecting patients to a hospital 45 minutes away.²⁷

Imminent rural hospital crises

The same circumstances that led 134 rural hospitals to close from 2010 to 2020 also left hundreds more vulnerable to closure due to financial losses and sparse financial reserves. As mentioned above, 200 rural hospitals are currently at immediate risk of closing, and 30% of the United States' total rural hospitals are at high risk of closing in the future. This includes the following numbers of facilities at immediate risk in Medicaid nonexpansion states:²⁸

Rural Hospital at Immediate Risk of Closing



While every state has rural hospitals vulnerable to closure, facilities in states without expanded Medicaid coverage are worse off, and these nonexpansion states often have higher numbers of hospitals at immediate risk of closing. A hospital does not have to close completely before a reduction in available health care providers and services starts to create negative effects in the community. Communities around vulnerable rural hospital have lower rates of primary care and mental health access and higher rates of premature deaths than rural areas without hospitals facing possible closure.²⁹ In the next year, several crises could push at-risk hospitals to close, deepening health disparities and access issues in communities that can least afford it. Normally, it takes several years for hospitals to reach the closure breaking point with the following notable indicators occurring:

1. Operating margins and revenues experience persistent declines for one to three years prior to closure.
2. Operating margins and revenues experience further sharp declines in the 12 months prior to closure.³⁰

However, the crises facing rural hospitals — and thus rural areas — next year may accelerate closure timelines. Those crises are the end of COVID-19 funding, a likely increase in uncompensated care, and a possible economic recession.

COVID-19 aid funding has ended

The temporary COVID-19 funding effort helped prove that additional investment in these facilities can reduce their closures and prevent rural communities from suffering from further limited access to critical care. However, this funding was a stopgap measure, not a permanent investment, and its effects will likely show only a temporary reprieve. Since hospitals typically endure years of financial problems before closure, as described above, substantial investments in rural hospitals need to be consistent year after year. The COVID-19 aid funding was significant, yet it decreased the percentage of rural hospitals operating in the red by only 6%. This modest improvement may be quickly reversed now that the pandemic has slowed and temporary relief funding has ended.

Uncompensated care will likely increase

When the federal COVID-19 public health emergency ends, likely in early 2023, all people currently enrolled in Medicaid coverage will go through a renewal process that reassesses their eligibility after several years where millions of people maintained their insurance through emergency continuous coverage requirements. Because this process was delayed for three years as an emergency measure, it is projected that these redeterminations will result in 15 million people losing their Medicaid coverage. Although some people will transition their coverage to other options, such as the marketplace, it is projected that roughly 6.8 million people could lose their coverage altogether

despite still being eligible for Medicaid. People in Medicaid nonexpansion states, in which income eligibility thresholds for adults are shockingly low, will be at higher risk of losing coverage.³¹

All those people becoming uninsured in 2023 will drive up hospital uncompensated care, a primary reason for hospital closures. As mentioned above, uncompensated care has increased by 50% at rural hospitals since 2010.³² Medicaid expansion is one of the best steps nonexpansion states can take to address looming uncompensated care increases. When states started expanding Medicaid in 2014, their uncompensated care costs dropped significantly, supporting hospitals, providers, and state budgets. For example, Louisiana's rural hospital uncompensated care costs dropped by 55% after the state's expansion in 2016.³³ In contrast, states that have not implemented Medicaid expansion are more likely to have fewer covered residents and higher uncompensated care costs.

An economic recession might be on the horizon

Economists project that the United States may experience a recession in 2023, which could jeopardize millions of jobs and cause a further increase in coverage losses and uncompensated care costs. State budgets will feel pressure as less revenue comes in and unemployment insurance claims increase. This pressure could cause state policymakers to make drastic spending cuts to hospital funding that would in turn accelerate rural hospital closures as more financial losses accumulate.

Medicaid expansion is a vital solution to help communities weather these crises

The crises described above will impact every state's vulnerable rural hospitals. However, the impact on rural hospitals in Medicaid nonexpansion states will likely be more severe. Rural hospitals, which provide critically needed health care, are already dealing with declining populations from surrounding areas, worsening poverty and health status, and other issues unique to rural areas. When states fail to expand Medicaid coverage, these hospitals are even more likely to close. Since 2010, the eight states with the highest numbers of rural hospital closures have rejected Medicaid expansion. Additionally, a rural hospital being located in a Medicaid expansion state decreases the likelihood it will close by an average of 62%.³⁴

Medicaid expansion also makes budgetary and economic sense for states preparing for these crises. Federal funding pays for 90% of Medicaid expansion, which would help alleviate state budget pressures if a recession occurs, overcome the recent loss of COVID-19 aid, and help prevent coverage losses after the public health emergency ends. Instead of considering harmful spending cuts during a recession, states should draw down federally funded investment in Medicaid to ensure residents maintain health and financial security, to create jobs in health care, and to support at-risk rural hospitals and providers.

The need to address these crises is urgent, and there is still time for states to act. If states move quickly, a Medicaid expansion could be implemented soon enough to provide rural hospitals with support right as these factors come in to play.

Appendix: Temporary COVID-19 Funding for Rural Hospitals and Providers

Funding source	Details	Amount	End date
COVID-19 Accelerated and Advance Payment (CAAP) program ³⁵	This program quickly delivered funds to impacted providers during national emergencies and provided additional flexibilities to critical access hospitals (CAHs), a specific designation of rural hospitals.	\$12 billion total	October 8, 2020
Federal Office for Rural Health Policy funding (Coronavirus Aid, Relief and Economic Security (CARES) Act) ³⁶	Existing Small Rural Hospital Improvement Program (SHIP) grantees received funding to support their responses to the public health emergency.	\$150 million total (\$80,000 per hospital)	1-time funding
Health Resources & Services Administration funding (American Rescue Plan (ARP)) ³⁷	This funding helped providers stay open, maintain their workforce, and overcome lost revenues and higher expenses.	\$7.5 billion total (\$170,700 average payment)	1-time funding
Health Resources & Services Administration funding (ARP) ³⁸	Existing SHIP grantees received funding to support COVID-19 testing and mitigation.	\$398 million total (\$258,376 each to 1,540 rural hospitals and CAHs)	1-time funding
Health Resources & Services Administration funding to Rural Health Clinics (RHCs) ³⁹	This funding provided RHCs with support for COVID-19 testing.	\$225 million (May 2020) and \$9.3 million (December 2020) for 4,549 RHCs, totaling over \$50,000 per clinic	1-time funding
Rural tribal funding (CARES Act) ⁴⁰	This funding assisted tribes in preparing and responding to COVID-19 in their communities.	\$15 million total (up to \$300,000 per tribe)	1-time funding
Provider Relief Fund (CARES Act) ⁴¹	This funding supported providers with health care expenses and lost revenues related to COVID-19 treatment.	\$4.1 million per CAH (median), \$9.1 million per rural and community hospital (median)	No longer accepting claims

Note: The above list does not include the Paycheck Protection Program, which provided necessary funding to businesses to keep their workforce employed until the program ended on May 31, 2021.⁴²

Endnotes

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