



## HOSPITALS

### Challenges and Solutions

### The Future of Rural Health Care

Few topics are as emotional and personal as health care. Imagine your child breaking an arm playing football in the backyard, your mother calling to relay some bad news about your father's health after a visit to the doctor or your sibling telling you about an upcoming battle with cancer. Fear, anger, sorrow, uncertainty and other emotions flood over you instantly. It's inevitable that everyone will face health care issues in one form or another.

But rural Americans are suffering unique health care challenges that urban residents typically do not face. Simply accessing health care can be a significant hurdle for many. Even more challenging may be finding affordable care.

#### Defining Rural

The U.S. Census Bureau identifies two categories of urban areas: the first is an urbanized area of 50,000 or more people, including cities and metropolitan areas; the second is an urban cluster of at least 2,500 and less than 50,000 people, including suburbs and large towns. Rural encompasses all population, housing, and territory not included within either of the designated urban area definitions. According to 2010 census data, approximately 20% to 25% of the U.S. population lives in rural areas.

Typical demographic trends of rural areas include lower median incomes, a high proportion of seniors, higher acuity levels and lower life-expectancies. Based on 2010 census data, per capita income is on average \$7,417 lower in rural areas than in urban areas, and rural Americans have a higher likelihood of living below the poverty level. According to the Rural Health Foundation, nearly 24% of children in rural areas live in poverty. And as younger residents leave home to attend colleges and universities, or seek employment in urban centers, the remaining population in the rural communities they leave behind becomes older. The fastest growing age cohort in rural America are residents 85 years old and above.<sup>1</sup>

Rural populations typically have high numbers of lower income and aged residents, and there are specific ailments that impact these communities at a higher rate than urban communities. Obesity, lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease are statistically 1. "The Demographics of Aging," <http://transgenerational.org/aging/demographics.htm>

more common in rural areas. Finally, the gap between urban and rural life expectancies is growing. According to a 2014 study published in American Journal of Preventive Medicine, consistent overall increases in U.S. life expectancy was noted during the past 40 years, from 70.8 years in 1970 to 78.7 years in 2010. However, the study reveals the rural-urban gap widening from 0.4 years in 1969 to 1971 to 2 years in 2005 to 2009.<sup>2</sup>

To make matters worse, the providers of rural health care suffer alongside the populations they serve. From reimbursement cuts to a suffocating regulatory environment, smaller facilities located outside urban and suburban population centers have a more difficult path to managing cash flow and scaling fixed costs. This article will focus on two of the primary challenges that both residents and providers face in rural communities.

#### Challenge One: Access to Health Care

In most U.S. cities, access to physicians and hospitals is a quick drive, a cheap public transit fare, or a taxi ride away. However, people in rural settings are likely to live further away from health care providers, particularly specialist services. Additionally, the deficiency of dependable transportation can be a barrier. Transportation services that exist in urban areas are often lacking or non-existent in rural areas.

Besides the geographical barriers to accessing health care, there are fewer providers. As noted earlier, about 20% to 25% of the population is rural; however, only about 10% of physicians practice in these communities.<sup>3</sup> Ask any rural hospital or skilled nursing CEO to list the top issues in the industry; most would likely tab finding qualified staff as a key concern. Per "Healthy People 2010: A Companion Document for Rural Areas," a project funded by the Office of Rural Health Policy, more than 33% of rural Americans live in "health professional shortage areas," and nearly 82% of rural counties are classified as "medically underserved areas."

Compounding these issues is the rate at which rural health care facilities are shutting down. The National Rural Health 2. "Widening Rural-Urban Disparities in Life Expectancy, U.S., 1969-2009," [http://www.ajpmonline.org/article/S0749-3797\(13\)00590-4/pdf](http://www.ajpmonline.org/article/S0749-3797(13)00590-4/pdf)

3. "Primary Care: Current Problems And Proposed Solutions," <http://content.healthaffairs.org/content/29/5/799.full>

Association recently teamed with the University of North Carolina and iVantage, a health analytics firm, to conduct a study that identifies current and potential rural hospital closures.<sup>4</sup> The ultimate goal is to identify potential closings before they occur. The research targeted approximately 2,000 rural hospitals across the country, and labeled 210 as “most vulnerable” with another 463 labeled as “at risk.” Those dubbed “most vulnerable” could close any day, while “at risk” ratings are reserved for hospitals that may only last another few years without adjustment. Ultimately, closing these sites will not only have a negative impact on the access to care in the service area, but also eliminate a top employer in the community.

## Challenge Two: Affordability

With a new presidential administration on the horizon, the future of the Affordable Care Act (ACA) is unclear. The general purpose of the ACA was to create more affordable health insurance for the uninsured, thereby reducing the drain on the health care system created by caring for the uninsured. According to “The Affordable Care Act and Insurance Coverage in Rural Areas,” a 2014 report, rural populations have a larger proportion of low-income residents who could potentially benefit from the ACA to receive health insurance coverage.

However, approximately 66% of uninsured rural individuals live in states that chose not to expand Medicaid. In some states that chose to expand, the enrollment has far exceeded the projections, which has caused strain on the Medicaid funds from the state. Additionally, several national insurers have pulled out of the ACA state exchanges as their losses piled up. In some cases, to offset losses, premiums on employer-provided insurance plans have increased, creating strains on small businesses subsidizing these plans to employees. Limited employment opportunities combined with mounting health care premiums continue to drive costs higher. Ultimately, these factors equate to rural individuals having fewer affordable health insurance choices.

Aside from the ACA complications, Medicare payment systems and reimbursement practices typically do not acknowledge the distinctive situations of small and rural hospitals. These hospitals are disproportionately impacted by the continual cuts to Medicare reimbursements, including the bad-debt program and disproportionate-share hospital payments. At some facilities, the average age of plant for health care and hospital facilities far exceeds acceptable levels. Improvements to the physical plant and the demand for new information systems climbs, yet access to capital financing can be limited. Reinvesting in the facility is difficult with dwindling revenues and limited financing options.

## Solutions and Paths Forward

Though the landscape seems bleak, not all hope is lost. Many

4. “Rural Relevance - Vulnerability to Value,” iVantage Health Analytics, 2016.

rural health facilities are using rural clinics, allowing them to open smaller yet impactful health care facilities across their service areas. This model allows for easier access to general care, but still limits the ability to access specialty care, such as cancer treatment centers or heart specialists. Accessibility is also being driven by new delivery methods, like telehealth, online prescription subscriptions and delivery services and 24/7 on-call doctors via the internet. Supplementing hands-on care with technology should allow greater access as long as communities become connected.

Health care organizations must also address affordability in expense reductions. Specialized consulting groups, such as Health Care Resource Group, focus on working with smaller rural facilities to navigate through difficult waters and improve operations.

A thoughtful capital structure is a good way for hospitals to address expense reductions through minimizing debt service payments. Several financing programs are available to rural hospitals that can address the need to reinvest in their facilities through expansion, acquisition, rehabilitation, or even a modern replacement facility and meet the needs of the community. The USDA Community Facilities Program is reserved for rural nonprofit organizations, including hospitals and skilled nursing facilities, and provides below market fixed-rate, long-term, non-recourse financing for construction and refinance. Other non-recourse financing solutions include the Federal Housing Administration (FHA) Sec. 242 mortgage insurance programs, which also provide agency-insured, long-term, fixed-rate debt at relatively high leverage points.

The aforementioned challenges in rural communities impact a significant portion of the U.S. on a daily basis. Simply accessing affordable health care is something the majority of the nation may take for granted. Without strategic financial action, our rural health care system will continue to face obstacles that severely inhibit community members from receiving necessary care.



*Brett Murphy is a vice president with Lancaster Pollard in Chicago. He may be reached at [bmurphy@lancasterpollard.com](mailto:bmurphy@lancasterpollard.com).*