Hospital
This report was prepared by the Virginia Hospital & Healthcare Association:
Jay Andrews, Vice President, Financial Policy
Barbara Brown, Ph.D., Vice President
Sheila Gray, Vice President, Communications & Public Relations
Steven Hill, Director of Communications
Betty Long, Vice President
The Honorable David Nutter, Regional Director for Community Outreach
Paul Speidell, Vice President
David Vaamonde, Research Associate
Rural hospitals are the lifeblood of much of Virginia. They provide emergency medical care to those in need and the preventative health care that sustains communities. Rural hospitals employ tens of thousands of people and drive local economies through their payrolls, purchases and infrastructure investments. They are essential to attracting and keeping businesses and economic development because it would be highly unlikely that a major employer will locate in a community that does not have readily available hospitals and health care. Rural hospitals support local schools, higher education and workforce development with their need for technical skills and training necessary to manage and operate today’s modern health services. They also drive a sense of community by being both a sponsor and a beneficiary of charitable works and support.

Unfortunately, by practically every measure, Virginia’s rural hospitals are under stress. The loss of non-health care job engines has led to population loss, an increased elderly population and rising levels of poverty. There are also higher levels of uninsured patients and bad debt and lower levels of commercially insured patients. This means that rural hospitals and health providers are seeing more patients covered by public health programs in which reimbursements are well below costs. There are greater numbers of patients with chronic conditions, which are difficult and expensive to treat. With the health system and surrounding communities under stress, it is becoming increasingly difficult to attract and retain qualified medical professionals.

**Bottom line: half of Virginia’s rural hospitals are operating in the red, some of them for multiple years.** In the short-term, these losses mean less investment in people, equipment and facilities. If unaddressed over the long-term, these losses will lead to aging infrastructure, obsolete technology and equipment, abandonment of practices and services and eventually the closing of facilities. **We cannot let this happen.**

We encourage you to read “No Margin for Error” and the story it tells. We must solve the challenges that confront our rural hospitals and health care system. The future of Virginia’s rural communities is intertwined with the future of Virginia’s rural hospitals. Let’s work together to ensure that future is bright.

John L. Fitzgerald  
Chairman

Sean T. Connaughton  
President/CEO

An alliance of hospitals and health delivery systems

ADVANCING EXCELLENCE IN HEALTH CARE AND HEALTH
Virginia's hospitals and health systems are vital to our Commonwealth and its communities. They provide critical health care to all who need it, regardless of their ability to pay. That includes $600 million in free and discounted care in 2012 alone. Nearly every Virginian is within a 20-mile drive of a hospital, which is staffed 24 hours a day, seven days a week, 365 days a year by 123,508 dedicated health professionals. Hospitals and health systems provide surge capacity to care for large numbers of patients in the event of a disaster. They also offer a wide array of benefits to their communities, from mobile clinics to programs designed to fight chronic disease, parenting classes and health career camps, among others. Particularly in rural areas, hospitals and health systems are the health leaders in their communities.

Hospitals and health systems also are among the state's largest employers and economic engines. This is particularly true in rural communities. In more than 80 percent of rural Virginia counties health care is one of the top five largest employers. Rural hospitals and health systems are tremendous assets to their communities.

Unfortunately, rural hospitals and health systems today face unexpected challenges. While health care providers are taking significant steps to weather the changes wrought by new laws and regulations and evolving market forces, their thin or negative margins have forced difficult decisions. One hospital in Virginia has closed while others have cut back service lines, jobs and other resources that once benefitted our rural communities.

Going forward, policymakers must be aware that these facilities are at risk. Even seemingly minor policy changes could represent the proverbial straw that breaks the camel's back for rural hospitals. For example, Virginia's rural hospitals are projected to experience federal cuts of $183 million in fiscal years 2015 and 2016. When it comes to public policies affecting these facilities, there is no room for error. We must ensure our rural hospitals have the resources they need to continue providing access to high quality care.
VIRGINIA'S RURAL HOSPITALS

1 - Augusta Medical Center
2 - Bath Community Hospital
3 - Buchanan General Hospital
4 - Carilion Franklin Memorial Hospital
5 - Carilion Giles Memorial Hospital
6 - Carilion New River Valley Medical Center
7 - Carilion Stonewall Jackson Hospital
8 - Carilion Tazewell Community Hospital
9 - Clinch Valley Medical Center
10 - Danville Regional Medical Center
11 - Dickenson Community Hospital
12 - Halifax Regional Hospital
13 - Johnston Memorial Hospital
14 - LewisGale Alleghany Hospital
15 - LewisGale Montgomery Hospital
16 - LewisGale Pulaski Hospital
17 - Lonesome Pine Hospital
18 - Memorial Hospital
19 - Mountain View Regional Medical Center

20 - Norton Community Hospital
21 - Page Memorial Hospital
22 - Pioneer Hospital of Patrick County
23 - Rappahannock General Hospital
24 - Riverside Shore Memorial Hospital
25 - Riverside Tappahannock Hospital
26 - Sentara RMH Medical Center
27 - Russell County Medical Center
28 - Smyth County Community Hospital
29 - Southampton Memorial Hospital
30 - Southern Virginia Regional Medical Center
31 - Southside Community Hospital
32 - Twin County Regional Healthcare
33 - Shenandoah Memorial Hospital
34 - VCU Community Memorial Healthcenter
35 - Warren Memorial Hospital
36 - Winchester Medical Center
37 - Wythe County Community Hospital
Virginia Health Information, from which hospital designations were pulled for VHHA’s “Prepared to Care” report (September 2014), allows hospitals to self-select their designation as rural or urban. The Centers for Medicare & Medicaid Services (CMS) on the other hand, defines a hospital as rural based on its distance from another hospital. Under CMS definitions, a hospital is rural if it meets one of four criteria:

1. Located at least 35 miles from another like hospital.

2. Located between 25 and 35 miles from a like hospital and it meets one of these two criteria:
   
   - No more than 25 percent of residents who become inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients are admitted to other like hospitals located in the 35-mile radius of the hospital, or if larger within its service area.
   
   - The hospital has fewer than 50 beds and would meet the 25 percent criterion above if not for the fact that some beneficiaries or resident were forced to seek specialized care outside the service area due to the unavailability of necessary specialty services at the hospital.

3. It is located between 15 and 25 miles from like hospitals but because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each of two out of three years.

4. Because of distance, posted speed limits and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.

Much of this report is focused on economic issues facing rural hospitals. As governmental insurers’ (Medicare and Medicaid) payment policies are different for CMS-designated rural hospitals than they are for urban hospitals, this report defines a hospital as rural based on its CMS designation.
CRITICAL COMMUNITY ASSETS

In Virginia, 37 hospitals meet the federal criteria to be considered “rural.” They are located in 34 counties from Southwest Virginia to the Eastern Shore. Not only do they provide critical health care that would not be available without them, but they typically are large employers and economic engines for their communities.

As Virginia’s rural communities have smaller patient populations than their urban counterparts, rural hospitals tend to be smaller as well. Rural hospitals and health systems have an average of 85 beds per county, compared to a statewide average of 215 beds per county.

Virginia’s rural hospitals had nearly 150,000 inpatient admissions in 2012. Yet, even with these admissions, the smaller patient bases of rural communities limit rural hospitals’ abilities to offer a full complement of services often found in more populous areas. For example, the statewide average of service lines offered in Virginia’s hospitals is 31; rural hospitals average about 27 service lines. Some service lines (open-heart surgery, invasive cardiac surgery and neurosurgery) are not offered in all rural hospitals because they require highly specialized clinicians and/or equipment. No rural hospital offers transplant services. Nonetheless, Virginia’s rural hospitals provide a tremendous range of service lines per facility, including:
The rural hospitals offering these services are not operating in a vacuum. They are a critical part of the broader health care system in their area, which sometimes crosses state lines. For example, larger Virginia rural hospitals may offer more comprehensive services than the local hospitals in another state near the Virginia border. Some of those out-of-state patients will rely on Virginia's rural facilities for important care perhaps unavailable in their local facility. While patients from North Carolina, Tennessee, Kentucky, Maryland and West Virginia may find that a Virginia hospital is closer than a facility in their own state, conversely, some of Virginia's rural hospitals may not offer the full complement of services to provide critical care in their communities, and alternatively, may refer stabilized patients elsewhere when necessary. The value of a rural Virginia hospital is that Virginians can access their hospital immediately, be cared for effectively and, if necessary, stabilized and then transported to a larger facility with more comprehensive services. In all of these cases, our rural hospitals are an essential frontline service for necessary care and play a pivotal role in their communities.

LARGE EMPLOYERS

Virginia's hospitals tend to be among the largest employers wherever they are located, and in rural areas this is even more frequently the case. In 82 percent of Virginia's rural counties, health care is among the top five largest employers. In some communities, the impact is even more dramatic. For example, in Alleghany County, health care accounts for 47 percent of all jobs.

CMS Rural-Designated Counties with Health Care as Their Largest Employer

- Largest Employer: 82%
- Second Largest Employer: 12%
- Third Largest Employer: 9%
- Fourth Largest Employer: 6%
- Fifth Largest Employer: 32%
- Not a top 5 Employer: 23%
Altogether, Virginia’s rural hospitals employ more than 17,546 full-time equivalents (FTEs) and contract with an additional 750 FTEs. They also have a positive downstream effect on other portions of the economy. Statewide, every hospital job creates an additional two jobs in the local economy. These jobs are not ordinary jobs. Typically they require advanced education and training, they are not easily outsourced and they pay well above average wages, providing even greater benefit.

1 Hospital Job 2 Local Economy Jobs

Beyond their own economic activity, rural hospitals enhance communities’ economic development capabilities. The presence of a viable hospital is often an influential factor in a business’ decision to locate in a given area. Rural hospitals help to maintain a healthy, productive workforce for the entire community. It is highly unlikely that major employers will move into areas without access to such care.

COMMUNITIES OPPOSE HOSPITAL CLOSINGS

All of these factors contribute to the strong support of rural communities for their hospitals and health systems. For example, in recent years three hospitals in Virginia have closed. Two have since reopened after strong advocacy by their local communities. The third is the most recent closure and is currently the focus of ongoing community efforts to reopen the facility. Whether the facility ultimately reopens as it was, in a revised form or not at all, the community’s strong advocacy demonstrates its devotion to its local hospitals.
UNIQUE CHALLENGES

Every hospital and health system has experienced challenges stemming from the passage of the Affordable Care Act, including payment reductions, increased regulatory burdens and changing incentives. Likewise, congressional actions to reduce the national deficit have reduced government health care payments to many health care providers. State actions, such as withholding Medicaid inflation payment increases and opting not to expand coverage, exacerbate these challenges for all Virginia hospitals and health systems. Changing demand, expensive technology and unpredictable revenues also contribute to the challenges that all hospitals face. In addition to these obstacles, rural hospitals confront other difficulties more unique to their geographic areas.

TOUGH FINANCIALS

A recent Reuters news article reported:

*Moody’s Investors Service reported hospital revenue growth and operating margins are at all-time lows. Fitch Ratings wrote that the Affordable Care Act has accelerated the transition of patients out of the hospital and into clinics by tightening reimbursements and emphasizing technology.*


These are challenges for all hospitals. However, by virtue of a less dense patient population in their geographic area, rural hospitals typically are smaller in size, resulting in more modest financial assets and reserves. In 2012, seven of Virginia’s 37 rural hospitals had negative net worths, threatening their viability.
Likewise, margins in rural hospitals often are negative. When they are positive, frequently they are razor thin. Of the 37 rural hospitals in Virginia, 17 had positive operating margins in 2012 and 20 had negative operating margins. (Operating margins, the recognized indicator of financial stability for any organization or industry, exclude revenue from investments, financial instruments and other non-operating sources because these are the financial reserves of an organization. The reserves sustain an organization in downward cycles as well as provide the capital needed to reinvest, which is essential in a capital intensive sector such as health care. Without these reserves, the costs of borrowing would escalate as bond ratings dropped.) In other words, more than half of Virginia’s rural hospitals are operating in the red, some for several years.

**VIRGINIA RURAL HOSPITAL OPERATING MARGINS**

![Diagram showing 2012 operations with 17 positive and 20 negative, average - 0.53 percent.]

These figures illustrate the fragile nature of our rural hospitals’ finances and their tenuous ability to withstand public policies that negatively affect their margins.
A reasonable analogy might be that of a stone tossed into a body of water. Standing on the coast and lofting a rock into the ocean causes ripples, but they are quickly absorbed in the breadth of the water. The same rock, splashing into a pond, could cause reverberations from one shore to the other. Between their smaller scope and thin margins, even the smallest negative changes are amplified and can cause major repercussions for rural hospitals and health systems.

![Image of a child throwing a rock into a pond](image)

It is for this reason that a number of Virginia’s smaller hospitals have joined health systems. Typically the health systems can infuse capital and provide a financial backstop, helping to maintain the viability of the smaller facility. However, overall economic concerns remain.

**WORKFORCE**

Rural hospitals experience unique challenges in adequately staffing their facilities. Although they may have fewer patients, the same number of providers per bed is often necessary to provide the same high quality care available elsewhere in the Commonwealth. Moreover, the aging population that contributes to a growing demand for health care also will continue thinning the ranks of providers as health professionals reach retirement age. Because of the difficulty of attracting new physicians to rural areas, the physician population in these areas continues to age out at a higher rate. According to a 2012 study by the Virginia Department of Health Professions, 20 percent of all physicians intend to retire in the next five years. This puts additional pressure on rural communities to maintain and attract physicians.
Recruiting health care providers is also difficult in rural areas. Drawing physicians, especially those in more specialized fields, to rural areas can be a struggle. The more limited population may not offer a critical mass of patients sufficient to sustain a physician practice.

Consequently, rural hospitals frequently will pay a stipend to recruit independent doctors to an area or must provide income guarantees to ensure their services are available in a community. Similar approaches are sometimes necessary for nurses and other clinical staff.

Some rural hospitals are establishing or expanding clinical training programs. The effort is intended to develop “home grown” providers who will stay in the area once their training is complete. However, federal funding to support such efforts is limited, so such training programs compete for rural hospitals’ diminishing resources. Additionally, the federal government instituted a freeze on residency slots in 1997. Even though Virginia has dramatically increased its medical education capacity in recent years, a medical school graduate cannot practice medicine without completing a residency program. Those who find residency slots in other states are more likely to remain in those states for their post-residency work rather than returning to Virginia. The same can be said of the shortage of clinical training opportunities for those in nursing schools. While hospitals have funded some of these additional training programs on their own, it is not enough. In order to ensure we have an adequate workforce, Virginia must expand the clinical training opportunities for our graduates.

**PATIENT & PAYER MIX**

Virginia’s rural communities have faced significant economic disruption over the last 25 years. The once-prominent manufacturing, textile and mining industries have suffered, leading to an emigration of younger residents looking for work. Demographically, rural areas in Virginia often include older, sicker and less educated populations than some other areas. The following map shows Virginia’s medically underserved areas. It is clear that these areas frequently overlap with the Commonwealth’s rural areas. Less access to care often results in poorer patient health.
In these areas, the hospital tends to become the hub for care. That can mean providing the care directly or, as discussed earlier, subsidizing physician care to ensure it is available in the community. However, with thin or negative margins, rural hospitals cannot meet the demand for ongoing care.

For example, rural populations confront chronic conditions and other health challenges that are difficult to keep in check. In Virginia's rural areas, age-adjusted disease rates often are notably higher than the statewide average:

- Diabetes deaths: 30 percent higher
- Heart disease deaths: 34 percent higher
- Chronic lower respiratory disease deaths: 59 percent higher
- Births without prenatal care: 31 percent higher
Rural hospitals and health systems attempt to meet these challenging needs in a variety of ways, including:

- Emergency care and transport;
- Chronic disease management;
- Palliative care;
- Health education;
- Ancillary health services such as pharmacy, rehabilitation, physical therapy among others; and
- Jobs that stimulate the economy.

Despite these efforts, demand for affordable care exceeds supply. One only has to see a few photographs of rural Virginians lined up for free care at the annual Remote Area Medical (RAM) clinic to appreciate how deep this need runs in Virginia.
Rural areas often have a lower socioeconomic status, which can be a significant indicator of health status. Less wealth often translates to poorer health. In Virginia’s rural areas, the numbers are remarkable:

<table>
<thead>
<tr>
<th>Socioeconomic Factor</th>
<th>VIRGINIA RURAL AVERAGE</th>
<th>VIRGINIA TOTAL AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Capita Income</td>
<td>$22,777</td>
<td>$35,707</td>
</tr>
<tr>
<td>Low Income (&gt; $25,000) Households</td>
<td>32%</td>
<td>52%</td>
</tr>
<tr>
<td>Total Population In Poverty (2012 est.)</td>
<td>19%</td>
<td>18%</td>
</tr>
<tr>
<td>Age 25+ Not Graduating High School</td>
<td>78%</td>
<td>12%</td>
</tr>
<tr>
<td>Age 65+</td>
<td>58%</td>
<td>58%</td>
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<td>67%</td>
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<td>50%</td>
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</tbody>
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These numbers mean local providers must treat poorer, older, sicker and therefore more costly patients who more often rely on government programs designed to assist with health financing for the elderly and poor. These programs, including Medicare (the federal program for the elderly and disabled) and Medicaid (the federal-state partnership to assist the poor and very sick), typically pay below the cost of providing care.
In Virginia, Medicaid pays about 68 cents on the dollar of what it costs to care for a hospital inpatient. Federally, Medicare pays closer to 90 percent of costs. The uninsured, of course, pay very little if anything for their care.

![Diagram showing paid costs to care for a hospital inpatient by insurance status: Medicaid 68%, Medicare 90%, Uninsured < 5%.]

Rural hospitals treat a higher percentage of patients with government-funded care. In Virginia, nearly 80 percent of our rural hospitals’ patients are either uninsured or have government-funded health care benefits.

![Pie chart showing rural hospital payer mix by admissions: 74% Average Commercially Insured, 17% Average Medicare, 9% Average Medicaid, 1% Average Other Governmental, 58% Average Other: Uninsured, Self-Pay, and Workers’ Compensation.]
$394 MILLION IN FINANCIAL COMMUNITY BENEFIT

As a result, hospitals and health systems provide many services that support the community but represent a financial loss for the organization. For 2012, Virginia’s rural hospitals reported:

- Charity care: $98 million
- Medicaid payment shortfalls: $70 million
- Medicare payment shortfalls: $65 million
- Bad debt expenses: $106 million
- Subsidized health services: $13 million
- Health professions education: $13 million

They also paid $29 million in taxes. In total, this represents a financial community benefit of $394 million in areas that tend to be more economically depressed than the state as a whole.

Hospitals are committed to providing high quality care to all patients, regardless of their ability to pay. Consequently, hospitals must balance these money-losing patients with positive revenues from patients whose payments at least cover the cost of their care. For Virginia’s rural hospitals, that averages approximately 17 percent of their patient population.
In a perfect world, the attraction of higher paying jobs with health benefits would address many of the issues confronting rural areas’ unique payer mix. Despite spending millions to attract and maintain industries across rural Virginia, there are insufficient employment opportunities that provide health benefits to balance out the payer mix and keep an effective and crucial economic development lifeline functioning. With such a significant proportion of patients whose payments do not cover the cost of their care, rural hospitals may not be able to fully offset the unmet costs of this care. Combined with razor thin or negative margins, there is little cushion for rural hospitals to absorb further losses through additional cuts to government payments. Hospital and health system executives are faced with difficult decisions related to maintaining service availability in a community, the broader financial sustainability of the organization and the balance between those demands.

FAILING PUBLIC POLICIES

Recognizing the unique challenges of health care in a rural community, Congress has attempted to ease the burden on rural providers. This includes targeted programs with higher payments, such as the Critical Access Hospital (CAH), Low-Volume Hospital (LVH) and Medicare-Dependent Hospital (MDH) programs. However, payments to CAHs have been reduced recently due to deficit reduction efforts. Likewise, the LVH and MDH programs face annual expiration dates. The resulting annual debate as to whether Congress will renew these programs creates additional uncertainty that makes planning very difficult for rural hospitals that avail themselves of the programs.

To offset costs associated with treating the uninsured, Medicare and Medicaid patients, hospitals that serve a higher percentage of these patients receive Disproportionate Share Hospital (DSH) funding. The Affordable Care Act (ACA) cut Medicare and Medicaid DSH funding with the expectation that the law’s provisions to increase coverage would offset these cuts as hospitals’ levels of uncompensated care and bad debt decreased. However, states that do not expand coverage are still subjected to these cuts. Consequently, hospitals in a state like Virginia will continue to face significant uncompensated care costs of providing treatment to the uninsured, and, at the same time, experience further cuts to reimbursements.
Moreover, Congress has enacted other hospital cuts in recent years. These include cuts to help drive down the national debt (called the “sequester”), reduce payments intended to help offset hospital bad debt and other reductions.

For fiscal years (FY) 2015 and 2016 alone, Virginia’s rural hospitals are projected to experience federal cuts of $183 million. These rural areas already face precarious economic situations. These cuts will be extremely challenging for rural hospitals.

At the state level, medical inflation – as measured by the Virginia Department of Medical Assistance Services – still increases around 2.5 percent a year. Although hospitals have worked diligently to reduce their cost structures, each time the state opts to withhold inflation increases or to decrease Medicaid rates as it has for FY 2015, it diminishes rural hospitals’ ability to successfully continue their delicate balancing act. With inpatient payment rates around 68 cents on the dollar of cost, Medicaid payments are better than no pay at all. However, they still fall far short of covering the cost of care and are projected to continue declining under current law.
MOVING FORWARD

Rural hospitals and health systems continue to work creatively to reduce their costs and maintain service availability for patients. In some cases, rural hospitals are renovating or building new facilities to increase emergency department access and the availability of outpatient services, while others have been forced to continue making cuts in order to maintain services where they can. Some of them have exhausted the easy, the medium and even the tougher alternatives to cutting service line availability and staff hours. They are running out of options.

Policymakers’ decisions at both the state and federal level affect all providers. However, rural providers often possess less financial flexibility to adapt to changes that negatively affect their bottom line. Virginia’s rural hospitals and health systems are strongly committed to maintaining high quality care for all patients. Virginia must remain ever vigilant to the challenges rural hospitals face as they strive to fulfill this mission. If we do not, these critical providers will be forced to make more tough decisions that negatively affect patient access to care and local economies. They no longer have a margin for error.

We welcome comments and questions regarding this and future reports. Please contact VHHA or your local hospital for more information.