Because of their propensity to deliver low-cost, high-quality primary care, rural hospitals have much to offer, both in serving their communities and in filling an essential niche within the nation’s healthcare system overall. However, many rural hospitals face growing financial burdens that are causing them to contemplate mergers, affiliations, or collaborations with larger, regional health systems.\textsuperscript{a} From 2005 to 2012, 121 of the 1,492 rural hospitals (8 percent) were part of a merger, and anecdotal information gathered from leading consulting firms and researchers indicate the percentage will increase.\textsuperscript{b}

Frequently, it is the rural hospital that initiates the move to become part of a larger system, by seeking to deepen an existing relationship or obtain the protection to be gained through acquisition by a regional health system, or—as a new model—by membership in a quasi-system made up of a consortium of rural hospitals.

An acquisition by a larger health system, in particular, can succeed or fail depending on various factors, including the financial circumstances of the rural hospital, the market in which the hospital is located, and the disposition of the large health system. One constant is certain, however: Integrating a rural hospital into a multihospital system either as an owned or affiliated

\textsuperscript{a} “Rural Hospitals: Managing a Web of Affiliation,” Peter Salisbury, hfm blog, May 22, 2014.

entity brings unique challenges from not only a financial but also a cultural and clinical perspective. Only by understanding and accommodating the unique features of rural hospitals and their value to the future of healthcare business can health systems truly benefit from integrating such an organization into its delivery network as a contributor to the continuum of care.

Challenges and Benefits

Rural hospitals tend to have aging and shrinking populations with high percentages of families with low incomes, creating financial challenges that make investments in aging plants and other capital projects difficult.

The lack of capital funding for such investments also contributes to another challenge: Rural hospitals often are perceived as being unable to deliver the same level of quality as their deeper-pocketed urban counterparts because of the “look” of their facilities. Nonetheless, several analyses have found that rural health care offers a good value, with quality being as high as in urban settings and the costs to Medicare being slightly less. In particular, rural hospitals and their associated clinics often are capable of delivering cost-effective, high-quality primary care, which can be highly beneficial to a regional health system.

In terms of cultural readiness, rural hospitals typically have in place all the components of a primary care continuum, and their relatively smaller footprints and their staff’s familiarity with their communities can set the stage for collaborative care. Many are designated as critical access hospitals (CAHs) by the Centers for Medicare & Medicaid Services (CMS). A rural hospital may have on-campus or remote community-based clinics, staffed by providers who may also work in the hospital’s emergency department (ED). It is also common for rural hospitals to utilize telemedicine and make use of advanced care practitioners. Some offer the additional benefit of owning or having a close relationship with a skilled nursing facility.

The size of rural hospitals can be an advantage, as it enables more nimble decision making and creativity in dealing with staff shortages and scarce resources. Flexibility can translate into willingness to do things differently. Despite this advantage, however, rural hospitals don’t always have adequate human resources to meet the new business model of health care. Backup for key positions does not always exist, and if a key position is vacated (e.g., business office manager), the organization will use existing staff to cover the work while a replacement is recruited, leaving little time for coordination of special projects such as developing automated reporting tools or defining and executing a consumer-driven strategy. Larger hospitals and systems would bring to the table the project coordination and other human resource infrastructure that rural hospitals often lack, at the same time

The Typical Rural Hospital

According to the North Carolina Rural Health Research Program, a typical rural hospital:

> Has 25 beds and an average daily census of seven
> Employs 321 FTEs
> Offers surgical, obstetric, and swing bed services, but does not have an intensive care unit, a skilled nursing facility, a psychiatric unit, or a rehabilitation unit
> Offers outpatient services such as cardiac rehabilitation and breast cancer screening but not hospice, home health, or chemotherapy
> Is located in a county with a median population of 27,980, with 16.8 percent of that population over the age of 65
> Serves a population with an average per capita income of $32,781, with 17.5 percent below the federal poverty level and Medicare patients representing 31 percent of charges
> Has a total margin of 2.7 percent and 58 days of cash on hand
> Receives 52 percent of revenue from patient deductions/allowances and 69.3 percent of total revenue from outpatient care

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c. See, for example, Rural Relevance Under Healthcare Reform: A Performance Based Assessment of Rural healthcare in America, Average, April 25, 2012. This study calculated the average cost per Medicare beneficiary including all inpatient, outpatient, and physician services and found that this average cost amounted to $7,638 for a patient living in urban area versus $7,369 for a patient living in a rural area.

benefiting from the cost-effective, high-quality primary care that rural hospitals offer.

CAHs have demonstrated significantly lower readmission rates than are seen in other post-acute care settings, and according to HCAHPS reports, CAHs outperform larger and urban hospitals in all categories of patient safety—important attributes in an integrated care model. Rural hospitals’ higher staffing ratios coupled with a comparatively compact space (i.e., facility) that has on-site physicians, respiratory therapy, laboratory, and radiology allow for acute changes in condition to receive immediate attention. Add to these attributes rural hospitals’ ability to care for patients close to home, and the possibility of partnership becomes a natural discussion.

Creating a Partnership
So how can rural and urban organizations work together to achieve mutually beneficial goals? Health systems that are contemplating acquisitions of or partnerships with rural hospitals should keep in mind the following principles.

Avoid creating the unintended consequences of the “us versus them” mentality. The importance of adhering to this principle can be underscored with a case example of a health system that was targeting a CAH for acquisition. The health system’s leadership presented recommendations for eliminating positions and instituting other organizational changes within the CAH based on a comparison of the CAH with benchmarks (e.g., salary/benefit per FTE, nursing cost per adjusted inpatient day, physician relative value units, etc.) for five other hospitals in the system, without acknowledging the extent to which the CAH was not comparable with the other hospitals. This move created mistrust among the CAH’s local management and staff, who perceived it as indicating a lack of understanding of the unique challenges of a low-volume, rural provider.

A better approach is to establish a working relationship and a voice for the specific challenges and needs of the rural facility at the system board level. Total revenues for a typical rural hospital are typically less than those of a single department within an urban hospital. Likewise, the number of FTEs at a large urban hospital alone can exceed the total service area for a rural hospital.

To better understand the position of their rural hospitals, some health systems have developed advisory councils composed of rural hospital administrators who meet monthly to identify and solve problems. A representative of the advisory council also is included on the larger health system’s board, thereby giving the rural constituency a voice in strategic and fiscal decisions, even though the rural hospital makes only a small contribution to the health system’s overall revenue.

### TYPICAL CRITICAL ACCESS HOSPITAL PROFITABILITY BY PATIENT SETTING

<table>
<thead>
<tr>
<th></th>
<th>Gross Charges</th>
<th>Payment (Reimbursement)</th>
<th>Direct Costs</th>
<th>Contribution Margin</th>
<th>Indirect Costs (Overhead Allocation)</th>
<th>Total Margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>$8,200,531</td>
<td>$4,991,532</td>
<td>$2,494,534</td>
<td>$2,496,998</td>
<td>$2,429,492</td>
<td>$67,506</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$35,669,064</td>
<td>$18,985,684</td>
<td>$8,951,055</td>
<td>$10,034,629</td>
<td>$6,654,660</td>
<td>$3,379,969</td>
</tr>
<tr>
<td>Swing</td>
<td>$1,856,571</td>
<td>$2,072,537</td>
<td>$1,008,686</td>
<td>$1,063,851</td>
<td>$1,022,918</td>
<td>$40,933</td>
</tr>
<tr>
<td>Total</td>
<td>$45,726,167</td>
<td>$26,049,753</td>
<td>$12,454,275</td>
<td>$13,595,478</td>
<td>$10,107,070</td>
<td>$3,488,408</td>
</tr>
</tbody>
</table>

Source: Wipfli: Used with permission. Data from an actual hospital.

Published in hfm magazine, November 2015 (hfma.org/hfm).
Avoid overemphasizing expense reductions. CAHs are reimbursed on cost by Medicare and in some states by Medicaid, and it is plausible in some cases that a CAH might be reimbursed for only 50 percent of its costs, so it is very possible that cost saving opportunities exist. Nonetheless, developing a strong working relationship should be the priority, and focusing too early on a cost reduction strategy could be counterproductive in this respect.

Analyze where the rural hospital is making money from a service-line perspective. Although each market is unique, with geographic variances determining many of the differences among markets, it is not surprising among rural hospitals to see that inpatient services cover indirect costs and outpatient services drive profitability and the ability to subsidize other necessary services/loss leaders. Data from actual CAHs depicted in the exhibit on page 84 illustrate this point.

Looking more closely at specific service lines, the data from these CAHs suggests that 80 percent of the outpatient volume for a typical CAH is distributed among four service lines: gastrointestinal, general surgery, ophthalmology, and—where physicians are available—orthopedics. Wisconsin Hospital Association data on annual procedures, winnowed down to hospitals with less than 25 beds, reveal that, among these four service lines, a handful of procedures account for 80 percent of the services—specifically endoscopy, cataract surgery, and hernia repair. The most common procedures provide an optimal starting point for a concentrated effort on operational efficiency and quality in providing local primary care.

Focus on optimizing the role of the rural provider’s primary care clinic and its payment advantages. Primary care is the engine of today’s value-based care model. First and foremost, therefore, a health system evaluating a rural hospital and its market should gauge whether there is adequate access to primary care, before turning its attention to opportunities for increasing payment. Consider the following analysis, which a rural hospital conducted to evaluate whether it was effectively capturing the primary care market served by four rural health clinics.

Factors developed by the Centers for Disease Control and Prevention (adjusted for demographic characteristics of the service area) were used to estimate the market size (population × annual clinic visit factor × primary care visit factor) and the number of visits to a primary care clinic that should be expected, given the populations of the service areas within the market—as shown in the exhibit below. The clinic visit factor is the expected number of clinic visits per 100 people in the population and the primary care visit factor is the percentage of those total clinic visits that are specifically for primary care. Two hypotheses were developed: One was that, in the secondary service area, the population was not being serviced by the hospital—or anyone else—because of the area’s remoteness and lack of available services.

RURAL HOSPITAL ESTIMATE OF MARKET SHARE, USING FACTORS DEVELOPED BY THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Population, 2013</th>
<th>CDC Factors</th>
<th>Projected Clinic Visits, 2013</th>
<th>Actual Clinic Visits, 2013</th>
<th>Estimated Market Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Service Area</td>
<td>23,440</td>
<td>X 3.22</td>
<td>X 55.5%</td>
<td>43,217</td>
<td>42,679</td>
</tr>
<tr>
<td>Secondary Service Area</td>
<td>40,746</td>
<td>X</td>
<td></td>
<td>75,124</td>
<td>3,308</td>
</tr>
</tbody>
</table>

Note: In this example, the hospital clinic is seeing only 3,308 of the expected 75,124 primary care visits at the only clinic in the secondary service area. Because there are no other clinics, this large gap suggests that many people are not going to see their doctor at all. Additional data on the larger-than-expected number of emergency department visits also support this hypothesis.
As the industry moves toward population health and a geographic strategy, financial metrics should focus heavily on the overall performance. A more global focus on overall metrics also will foster collaboration rather than fueling an “us versus them” mentality.

In either case, however, it is clear that a significant portion of the population was accessing primary care within clinics in the primary service area, which represent their most likely option for primary care. Specifically, the number of visits from people living in secondary service area was significantly lower than what would be expected. If there were better access to care (i.e., a clinic), then the number of actual visits would be closer to the number of expected visits. This scenario suggests an opportunity for improving the rural hospital’s revenue stream, the care of the population overall, and potentially tertiary care services for the affiliated urban hospital.

Rural hospitals have options to develop on-site physician clinics that are certified by CMS as provider-based clinics and provider-based rural health clinics (RHCs).

The primary advantage of provider-based status is that it can offer an opportunity for increased payment for services furnished to Medicare beneficiaries without certain volume requirements. In some instances, increased payments of 50 percent are possible. Those payments include the hospital facility payment under the CAH rate for the outpatient hospital services and a separate payment for physician services under the Medicare physician fee schedule, with a potential for the resulting payment to be substantially greater than the global fee schedule payment for traditional freestanding clinics, even taking into account a payment reduction for the hospital site-of-service.

Alternatively, facilities certified as RHCs are paid under an alternative, cost-based payment system for treating Medicare and Medicaid beneficiaries. There are very specific and often-changing requirements for facilities to qualify as a RHC, but generally, the clinic must be located in a rural area that has a currently “underserved designation,” provide mostly outpatient primary care services, utilize a mid-level practitioner for at least 50 percent of the time the clinic is open, and perform six basic lab tests (chemical examinations of urine, hemoglobin or hematocrit, blood sugar, examination of stool specimens, and pregnancy tests and primary culturing for transmittal to a certified laboratory). There is a distinct payment advantage for provider-based RHCs that are part of a small (under-50 bed) hospital compared with those that are independent clinics. Specifically, Medicare/Medicaid RHC payments can represent an 80 to 100 percent increase over traditional fee-for-service payments—a payment advantage that is intended to promote expansion of primary care services.

In markets with low population density, where government payers predominate, such certifications can help minimize the losses from delivery of primary care services and improve the viability of a small number of specialty care provider clinics.

Consider capital allocations in the big picture. There are different approaches to allocating capital across a system. The range of these differences is

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e. Underserved-area designation must be current, meaning the designation is made or updated within four years and meets criteria for being any of the following: a geographic health professional shortage area, a population-based health professional shortage area, a geographic medically underserved area, and a governor-designated shortage area. Areas designated as population-based medically underserved areas do not qualify.
exemplified in two examples of actual approaches used by two health systems.

For a seven-hospital system, in which just one of the hospitals is a CAH, the emphasis for all major capital-planning decisions, including facility replacement planning, is on equality: All hospitals are required to maintain financial ratios consistent with the rating agency medians that are reflected in the system’s credit rating. The CAH was subject to this requirement at a time when it was deciding on plans for a replacement facility. The CAH was in a strong position, with 450 days cash on hand and approximately $25 million to contribute to the project. However, with the additional debt, the operating margin was projected to be negative, and the cash position would fall to 150 days cash on hand. These two projected outcomes were sufficient for the facility development project to be put on hold.

The second health system, which comprises five rural hospitals and one urban tertiary care center, evaluates capital options based on both the strategic value of the project and the accretive benefit to the system overall. The exhibit above illustrates key financial ratios of one of the health system’s CAHs and the system overall before and after a $26 million debt issuance for construction of a new facility to replace the CAH’s facility, assuming no change in market share or service offering. Upon discussion and further analysis of the accretive value offered by the new facility, which included improved access to primary care services and expansion of orthopedic specialty clinics, the system’s board approved the decision to move forward with the project.

As the industry moves toward population health and a geographic strategy, financial metrics should focus more heavily on the overall performance rather than a one-size-fits-all standard for individual hospitals. A more global focus on overall metrics also will foster collaboration rather than fueling an “us versus them” mentality—resulting in a truly unified approach.

A Foundation for Tomorrow’s New Care Models

Rural hospitals’ size and inherent focus on primary care delivered in outpatient settings provides a ready-made foundation for developing new models of care, if they receive the right support and resources. Careful planning and analysis can help ensure a smooth transition for rural and urban health systems as they create partnerships.

About the author

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### Table: Financial Ratios Before and After a $26 Million Debt Issuance for Construction of a Critical Access Hospital (CAH) Replacement Facility

<table>
<thead>
<tr>
<th>Financial Ratio</th>
<th>Before Project</th>
<th>After Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Margin Percentage</td>
<td>-71%</td>
<td>4.5%</td>
</tr>
<tr>
<td>EBITDA Margin Percentage</td>
<td>8.5%</td>
<td>10.6%</td>
</tr>
<tr>
<td>Days Cash on Hand</td>
<td>165.0</td>
<td>220.0</td>
</tr>
<tr>
<td>Maximum Annual Debt Service</td>
<td>1.1</td>
<td>4.9</td>
</tr>
<tr>
<td>Debt-to-Capitalization Percentage</td>
<td>62.0%</td>
<td>35.6%</td>
</tr>
</tbody>
</table>

Source: Wipfli: Used with permission. Data from an actual hospital client.
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