On the Brink: Rural and Safety-Net Hospitals by Stephen M. Kindseth

While the Coronavirus Aid, Relief and Economic Security Act and the Paycheck Protection Program and Health Care Enhancement Act provided $175 billion in relief funds to health care providers generally, those funds were not devoted solely to hospitals and were distributed based on various criteria that did not correspond to financial need. Consequently, many rural and safety-net hospitals[1] still face extraordinarily daunting financial challenges. Bankruptcy and other insolvency professionals focusing on health care providers would be well-served to better understand the nuanced dynamics involved.

Even before the COVID-19 pandemic, rural and safety-net hospitals lacked financial stability. In rural communities throughout America, a staggering 44% of hospitals lost money in 2018; that followed 2017, when 40% operated at a loss. *USA Today* reported last month that "more than 800 rural hospitals faced financial peril before the pandemic took hold." As to safety-net hospitals, the Medicaid and CHIP Payment and Access Commission wrote to the U.S. Department of Health and Human Services (HHS) and congressional leaders on April 30, 2020, stating that disproportionate-share hospitals[2] account for 19% of total hospital net patient revenue, but accounted for 31% of hospitals' uncompensated care costs in 2017. Safety-net hospitals have been further burdened in those 14 states that still have not expanded their Medicaid programs under the Affordable Care Act (ACA), leaving a significant portion of their populations without any health care coverage. Although repeatedly postponed, $4 billion in cuts in Medicaid disproportionate-share hospital payments — intended to partially offset uncompensated care costs incurred by hospitals that treat Medicaid and uninsured populations — remain on the horizon.

The COVID-19 pandemic has severely exacerbated an already dire situation. In addressing the crisis, hospitals have faced higher costs as they prepared for the anticipated surge of patients by purchasing extra supplies and equipment, remodeling rooms or constructing alternative locations, or setting up drive-thru clinics. Compounding matters, hospitals face reimbursement uncertainty due to (1) the administrative and billing challenges in capturing the COVID-19-related services provided, and (2) the disparity between the actual out-of-pocket costs and the reimbursement amounts, even if obtained. It is also unclear how much of the actual cost will ultimately be recovered for telehealth services and services provided in nontraditional spaces — both precipitated by COVID-19.

Most significantly, though, is the loss of revenue generated from "non-essential" services. All hospitals depend on high-margin services such as elective surgery to enable them to make ends meet. As recently reported by the American Hospital Association, about $160 billion of the $200 billion in revenue losses estimated to be experienced by hospitals in the four months from March through June 2020 will come from reduced services, including "surgeries, various levels of cancelled non-elective surgeries and outpatient treatment, and reduced emergency department services."[3]

Insolvency professionals may certainly assist hospitals in undertaking measures to mitigate the adverse financial impact of COVID-19. Decision-makers should possess, on a rolling basis, current information on cash-flow performance (including verification of receivables and accrued costs) and cash-flow projections based on reasonable assumptions incorporating an operations model that conforms to the "new normal." With this knowledge, goals should be set and then the operations conformed. Clinical services projected to be unprofitable should be restructured or eliminated. Capital projects should be reevaluated as well. Growth areas — such as telehealth services — should be aggressively explored, developed and integrated.

Hospitals also need to work toward reestablishing their profit base: the provision of non-urgent, non-COVID-19-related services. For truly elective procedures, success will depend largely upon the public's confidence in health care providers' ability to provide such services with virtually no risk of exposure to SARS-CoV-2.[4] This will not be an easy task. Scheduling will have to conform to social distancing requirements, which means far greater spacing between patients. Waiting rooms will need to be effectively managed, or reliance upon them eliminated altogether. The effectiveness of these efforts will then need to be communicated to the public to build trust and enable patients to choose to move forward with elective medical care.

There are plenty of reasons for skepticism. Confidence will not be gained automatically when states start to relax their social-distancing restrictions. Patients will be apprehensive to seek non-urgent-related care due to concerns of contracting COVID-19. A significant percentage of elective procedures are for senior citizens who, considering their vulnerability to COVID-19, would be more inclined to postpone procedures until our society is entirely past this health crisis. The expansion of non-urgent services could be further hindered if coronavirus infections surge again as social-distancing restrictions are lifted.

Moreover, relief funds allocated to health care providers did not specifically target financial need. Rather, the net patient revenue metric used to distribute general hospital funding favored providers with a higher share of commercially insured patients. Even distributions based on Medicare metrics left safety-net hospitals with proportionately less or no assistance. Although HHS recently announced that it had begun disbursing $10 billion in relief funds to hospitals, health clinics and community health centers located in rural areas, the extent that this will alleviate their financial issues is unclear and no relief funds have targeted safety-net hospitals.

Specific legislative measures need to be taken immediately. Additional federal assistance should be directed to support safety-net hospitals. Even just distributing subsequent relief based on admissions or patient days rather than net patient revenues would allocate a greater proportion to safety-net hospitals. The critical hospital access designation — providing more generous reimbursement for inpatient and outpatient services — could be expanded. Although admittedly unlikely, the remaining hold-out states should adopt the ACA Medicaid expansion. The Medicaid disproportionate share hospital payment cuts under the ACA should be further postponed or permanently reduced. In the absence of specifically targeted supplemental financial support, many rural and safety-net hospitals serving the most vulnerable in our society will cross over or drift deeper into insolvency and face bankruptcy or closure.

---

[1] In 2000, the Institute of Medicine defined safety-net hospitals as hospitals that, by mission or mandate, provide care to a substantial share of vulnerable patients regardless of their ability to pay. Inst. of Med., *America's Health Care Safety Net: Intact but Endangered* (National Academics Press 2000). This definition has been criticized for being overly inclusive for policy-making decisions by not limiting the scope to those facing significant financial instability and unreimbursed costs. Tyler N. A. Winkelman & Katherine Diaz Vickery, "Refining the Definition of US Safety-Net Hospitals to Improve Population Health" (Aug. 7, 2019), *available at* https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2747473.

[2] The Health Resources and Services Administration (HRSA), an agency of HHS, describes "disproportionate-share hospitals" as those that "serve a significantly disproportionate number of low-income patients and receive payments from the Centers for Medicaid and Medicare Services to cover the costs of providing care to uninsured patients."

[3] Am. Hosp. Ass'n, Hospitals and Health Systems Face Unprecedented Financial Pressure Due to COVID-19 (May 2020), *available at* https://www.aha.org/system/files/media/file/2020/05/aha-covid19-financial-impact-0520-FINAL.pdf (last visited May 12, 2020).

[4] SARS-CoV-2, which stands for "severe acute respiratory syndrome coronavirus 2," is the specific strain of coronavirus which causes the coronavirus disease known as COVID-19. World Health Org., Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It, *available at* https://www.who.int/ (last visited May 12, 2020).