

# FQHC Roles and Opportunities Related to Rural Hospital Financial Distress and Closure



## INTRODUCTION

Over the past decade or more, demographic and economic pressures have drastically impacted the healthcare landscape in rural communities across the country. With long-term out-migration toward more urban areas, the population in many rural areas has become smaller and older. As the population shrinks, it becomes more difficult for rural hospitals to cover their operating expenses, given that there are fewer patients to support the fixed and variable costs associated with expensive hospital care. At the same time, older populations tend to have higher health care needs, often requiring more intensive services and a wider range of specialty care, which are difficult to support in rural areas.

According to The Cecil B. Sheps Center for Health Services Research at the University of North Carolina, 176 rural hospitals have closed since 2005, and the rate of closure has accelerated since 2010.<sup>1</sup> In 2013, there were 2,322 short-term rural acute care hospitals serving the general population. By 2020, approximately 103 had closed, almost 5% of the 2013 total.<sup>2</sup>

In this environment, the entire spectrum of rural health care providers—primary care providers, specialists, hospitals, and long-term care providers—are challenged to serve their communities in a sustainable manner. This publication provides a high-level examination of the lived experiences of Federally Qualified Health Centers (FQHCs)<sup>3</sup> that serve rural communities, particularly in the context of rural hospital financial distress and closure. Utilizing a recently conducted national assessment of rural FQHCs, it seeks to document health centers' experiences with hospital distress and closure over the past five years and to evaluate the extent to which these centers have and can play an instrumental role in preserving access to care under these difficult circumstances.

## OVERVIEW OF FQHCs SERVING RURAL COMMUNITIES

In 2019, 606 rural FQHCs operated 5,054 sites across rural America. Together, they served more than 9.1 million patients (one in five rural residents) through 36.1 million visits.<sup>4</sup> At the median, rural FQHCs served 9,665 patients through more than 37,000 visits, employed 77 full-time equivalent (FTE) staff members, and generated \$11.3 million in annual revenues.

Located in all 50 states and territories, rural FQHCs are most heavily concentrated in the Southeast and Midwest. The following map<sup>5</sup> shows the density of FQHC rural site locations across the country.

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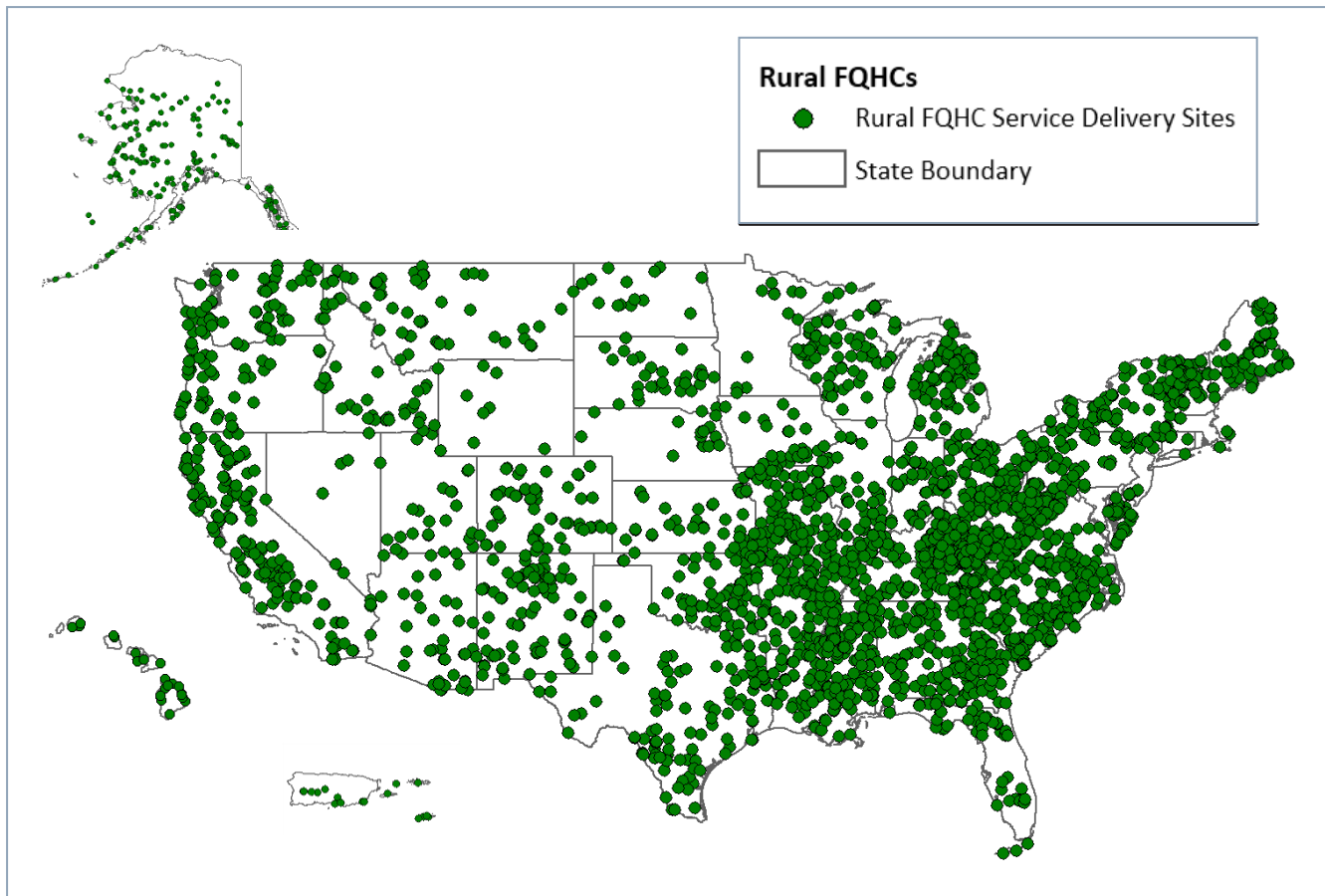
1. 176 Rural Hospital Closures: January 2005 – Present. Accessed February 26, 2021. The Cecil B. Sheps Center for Health Services Research at the University of North Carolina, <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>.

2. Freeman, V.A., et al (March 2015). The 21st Century Rural Hospital: A Chart Book. The Cecil B. Sheps Center for Health Services Research at the University of North Carolina, <https://www.shepscenter.unc.edu/wp-content/uploads/2015/02/21stCenturyRuralHospitalsChartBook.pdf>, p.7.

3. FQHCs are outpatient clinics that qualify for specific reimbursement systems under Medicare and Medicaid. They include federally-funded health centers known as “Section 330 grantees” and those that meet certain federal requirements, but do not receive federal grant funding, known as “Look-Alikes.” In this document we refer to both types of FQHCs as “health centers.”

4. Unless otherwise noted, data on rural FQHCs in this publication is sourced from the Health Resources and Services Administration's Uniform Data System database and from Financial and Operating Trends of Rural Federally Qualified Health Centers, 2016 – 2019, Capital Link, 2021.

5. Rural FQHC sites as of December 28, 2020, Health Resources & Services Administration, Data Explorer. <https://data.hrsa.gov/tools/data-explorer>.



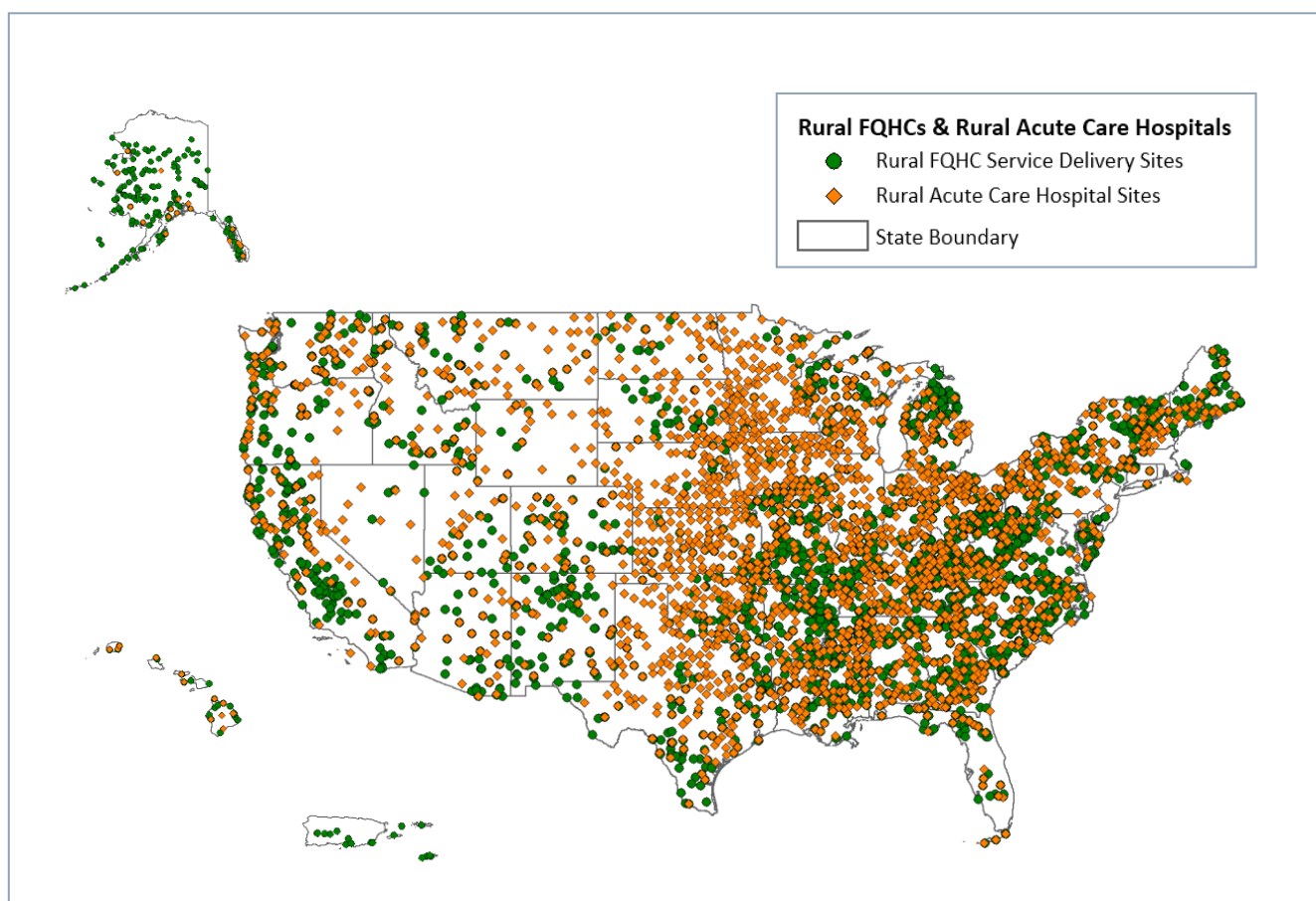
While rural hospitals have been closing at an accelerating pace, rural FQHCs have been mostly holding their own and increasing their number of sites. Between 2016 and 2019, rural FQHC sites increased by 22%, while patients and visits increased by 6.7% and 9.5% respectively. The number of rural FQHC organizations, however, declined by 2%. However, this decline—a decrease of 25 organizations—only occurred between 2018 and 2019. The site growth, in combination with the decline in rural organizations, may indicate consolidation within the sector, with growth driven primarily by the remaining health center organizations rather than new entrants into the industry.

#### Rural FQHC Organization Growth and Expansion, 2015-2019

FQHC Organization Growth and Expansion	2016	2017	2018	2019	2018-2019 Growth Rate	2016-2019 Growth Rate
<b>S330 + LAL</b>	616	619	631	606	-4%	-2%
<b>Service Sites</b>	4,148	4,464	4,983	5,054	1%	22%
<b>Patients</b>	8,556,679	9,014,319	9,843,027	9,132,834	-7%	7%
<b>Visits</b>	33,007,526	35,341,621	38,650,224	36,132,510	-7%	9%

## RURAL HOSPITALS AND RURAL FQHCS LARGELY SERVE THE SAME COMMUNITIES

As indicated in the map<sup>6</sup> below, rural hospitals and rural FQHCs are located in close proximity to each other, with both serving as key assets in their shared communities. This close proximity is not surprising, given that they focus on different parts of the medical care spectrum, with FQHCs focused on primary and preventive care and hospitals focused on emergent and acute care, with some specialty services.



Given their generally overlapping service areas, it would appear that rural hospitals and FQHCs would have a mutual interest in collaborating to ensure ongoing services for the community in a financially sustainable manner. Clearly, in some communities these collaborations are strong, as evidenced by examples provided by FQHCs in a recent assessment described below—while in other cases, the relationships appear distant at best.

## IMPACT OF RURAL HOSPITAL CLOSURE

When rural hospitals close it affects not only the residents' access to health care, but it also leads to significant job loss, both at the hospital and throughout the community as the negative economic effects ripple through the local economy. Furthermore, communities without adequate access to care have a difficult time attracting new businesses and new residents, extending the negative downward spiral in these communities.

6. Rural FQHC sites: Health Resources & Services Administration, Data Explorer (December 28, 2020) <https://data.hrsa.gov/tools/data-explorer>. Rural acute care hospital sites: The Cecil B. Sheps Center for Health Services Research at the University of North Carolina, <https://www.shepscenter.unc.edu/?s=hospital+list+2019>.



For example, a hospital seeking to curb its operating losses, may close its obstetrics department. As a result, given the lack of OB services in the area, young families, businesses, and providers choose to relocate. This situation exacerbates the already existing problem of low population growth and further limits access to care and job opportunities in these communities. And so the negative spiral continues.

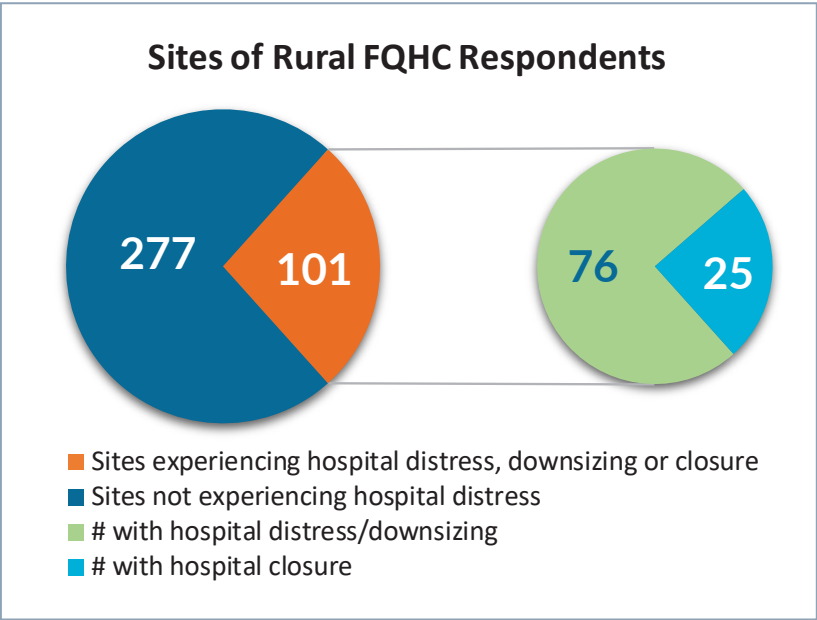
Despite these challenges, the fact remains that a sizable portion of the population lives in rural America and requires access to health care services. According to the US Department of Agriculture, the population in non-metro (rural) counties stood at 46.1 million in July 2019, accounting for 14% of all residents spread across 72% of the Nation’s land area.<sup>7</sup> Health care providers—especially mission-based, nonprofit providers—have a unique opportunity and responsibility to find creative ways to serve rural populations in ways that are effective and sustainable.

## NATIONAL ASSESSMENT OF FQHC ROLES AND OPPORTUNITIES IN THE CONTEXT OF HOSPITAL FINANCIAL DISTRESS AND CLOSURE

In September 2020, Capital Link conducted an assessment of rural FQHCs’ experience with hospital financial distress, downsizing, and closure. The purpose of this assessment was to gain initial insight into the “state of play” between health centers and hospitals facing this difficult issue. This balance of this brief reports on the responses received from 34 FQHCs operating a total of 277 sites in rural communities.

### National Assessment Results

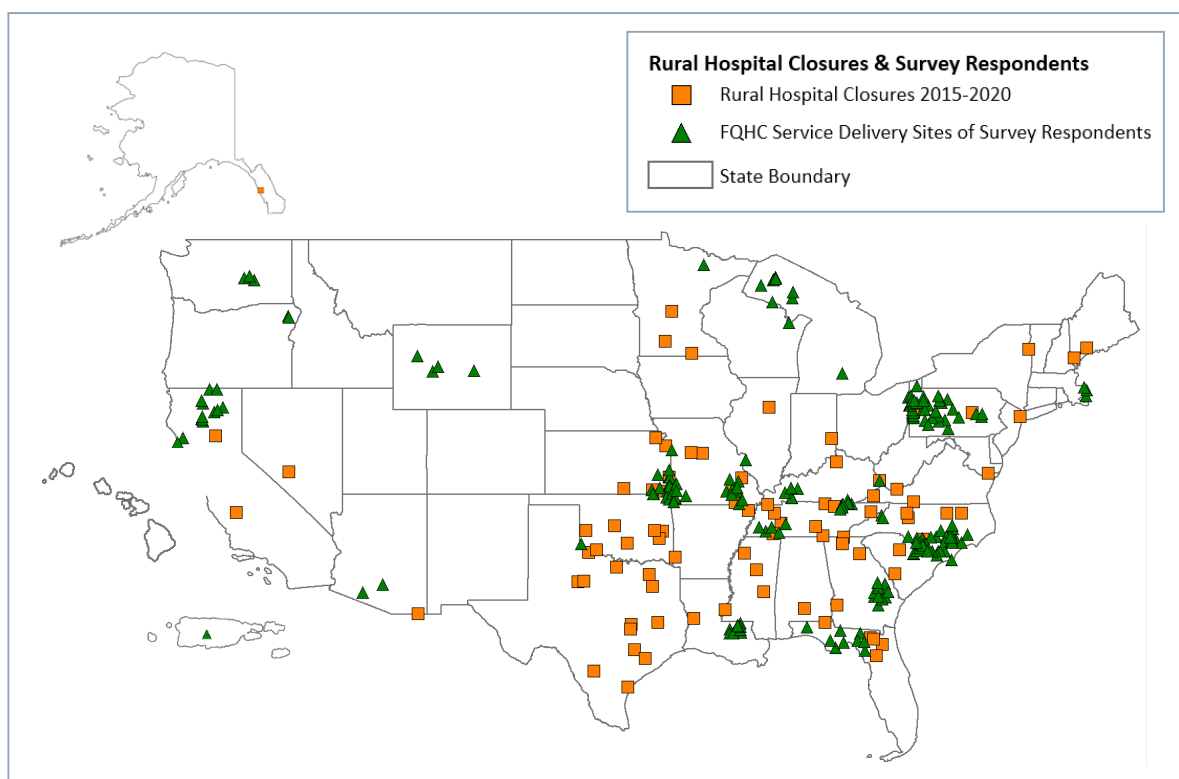
Respondents were asked about their experience with hospital financial distress or closure in their communities. They reported that 101 sites (36% of their total sites) experienced hospital distress/downsizing or closure since 2015. As indicated in the chart below, 76 experienced financial distress or downsizing (27% of total) and 25 experienced closure (9% of total).



7. Economic Research Service, United States Department of Agriculture. ERS Charts of Note. <https://www.ers.usda.gov/data-products/charts-of-note/charts-of-note/?topicId=4e8a0642-e40d-4299-906e-906bbaaf9e4d#:~:text=The%20U.S.%20population%20in%20nonmetro,of%20the%20Nation's%20land%20area.>

According to the Sheps Center, during this time period, 70 rural hospitals closed.<sup>8</sup> Based on this data, it would appear that FQHC respondents were reporting on experiences with more than one-third of these closures (36%). The following map<sup>9</sup> indicates the proximity of the health center respondents compared to the closed hospitals.

Between 2015 and 2019, 9.2% of rural hospitals (196) were deemed to be “at risk” by Sheps Center<sup>10</sup>. Based on the responses from FQHCs indicating that, collectively, 76 of their sites had experienced financial distress or downsizing, it is likely that these experiences were related to approximately 39% of these at-risk hospitals.



Assessment results also showed that of the health center sites experiencing hospital distress and closure, 40% had some level of involvement in working with the struggling hospitals to preserve services in the community. This involvement included the following activities:

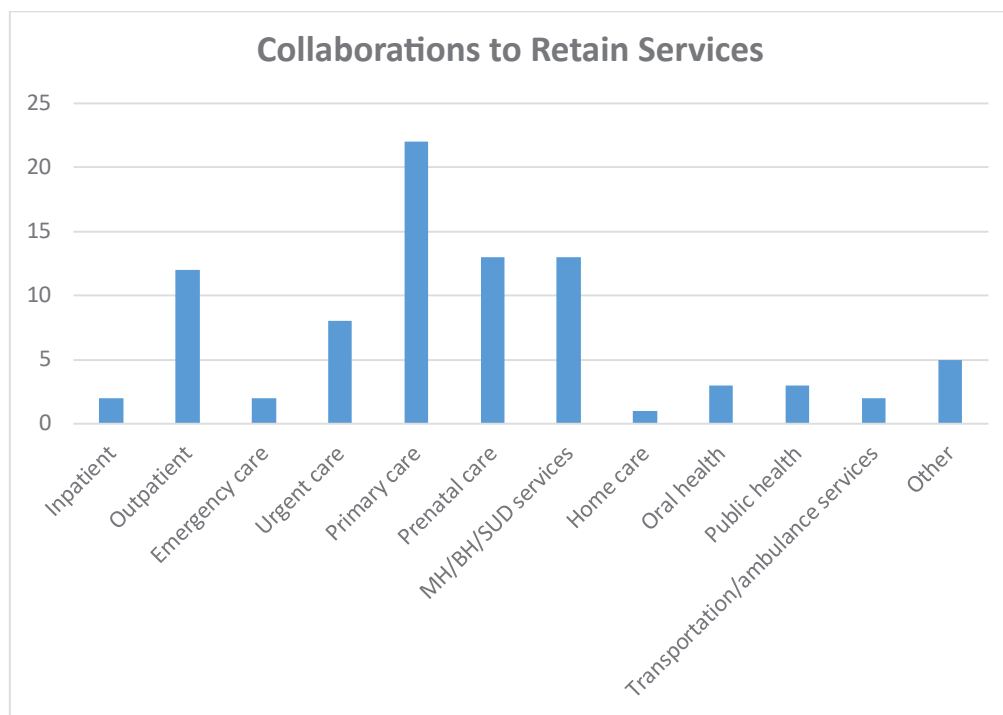
- 12% assumed at least some services
- 8% acquired buildings/facilities
- 20% collaborated in other ways to retain access to services in the community

The services that health centers were able to preserve in the community are detailed in the following chart, the most prevalent being primary care, prenatal services, mental health/behavioral health/substance use disorder (MH/BH/SUD) services, and general outpatient services.

8. 176 Rural Hospital Closures: January 2005 – Present. The Cecil B. Sheps Center for Health Services Research at the University of North Carolina, <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>.

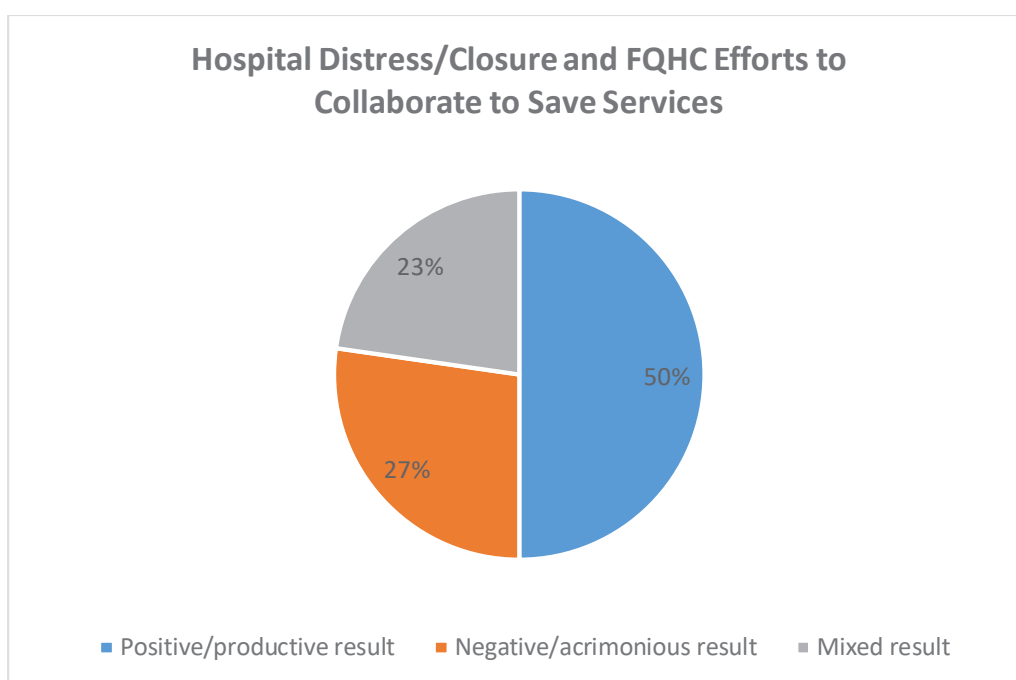
9. Data from Capital Link assessment conducted in September 2020; and 176 Rural Hospital Closures: January 2005 – Present. The Cecil B. Sheps Center for Health Services Research at the University of North Carolina, <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>.

10. Trends in Risk of Financial Distress among Rural Hospitals, 2015 to 2019. The Cecil B. Sheps Center for Health Services Research at the University of North Carolina, <https://www.shepscenter.unc.edu/product/trends-in-risk-of-financial-distress-among-rural-hospitals-2015-to-2019/>.



Of those that provided insight into their experience in working with struggling local hospitals:

- 50% characterized the experience as positive and/or a productive outcome for the community
- 27% characterized the experience as negative or acrimonious
- 23% characterized the result as “mixed”



## Comments from Respondents

Below is a collection of comments from assessment respondents, representing positive, negative, and mixed results:

### POSITIVE COMMENTS:

“Our local hospital wanted to transition out of providing outpatient maternity services for low-income women and we worked out a transfer and takeover of that service that is involved in around 800 births a year.”

– [CA Rural FQHC](#)

“During the last five years, numerous hospitals have either closed or downsized. For the remaining hospital, we have taken over one of their primary care clinics and their OB/GYN clinic in order to keep them solvent. For the communities that lost hospitals, we were able to repurpose the hospital in one location to an urgent care and moderately complex lab. At another community, we expanded services and added another moderately complex lab. Clinics in these locations had to “skill up” as many emergent patients present daily. We also had to stock supplies for various emergency situations. We were able to retain about 2/3 of the jobs in the locations affected. In one of the locations, the ambulance is 20 minutes away and we have worked with the ambulance district to house their team at our clinic three days per week. In all situations, we had little notice or time to prepare.” – [MO Rural FQHC](#)

“Our organization has great relationships with our community partners. In [one] county, we work closely with the hospital to provide pre-natal care, SUD, and Mental Health and Long-Term Primary Care. We also work in [another] county where the hospital was closed to provide health fairs, SUD/Mental Health, Prenatal and OBGYN services for the community.” – [TN Rural FQHC](#)

“We have experienced nine hospitals in financial distress in our communities. Some things have been sudden and others slow moving. Most things are collaborative at least from the outside view.” – [GA Rural FQHC](#)

“We worked collaboratively with the critical access hospital that was experiencing financial distress and with another out-of-town community hospital. We also involved the community to understand their desires for local hospital services and we used the forum to educate the community about health care misconceptions on Medicare/Medicaid and other localized topics. The hospital has been able to maintain jobs, build credibility with the community and increase financial stability. Our FQHC provides the majority of primary care in the area and the out-of-town hospital is providing select management services through a MOU arrangement.”

– [WA Rural FQHC](#)

“For one of the hospital closures that affected our community, we worked collaboratively with the hospital prior to its closure to maintain primary care, urgent care, and prenatal care services and to retain most of those jobs. We ended up hiring their CEO, COO and Quality Director along with most of their medical staff. We continue to occupy the clinic within the original hospital, along with another hospital who absorbed the Emergency Department. The result to date has been successful, but the closure of the hospital was extremely traumatic for the community. Overall, we grew more than 30% to 61,000 patients—an exciting but very stressful experience—and we’re not done yet!” – [KS Rural FQHC](#)



## NEGATIVE COMMENTS:

“Our hospital was part of a ‘nonprofit’ hospital system that spent several years cutting services to prepare to be sold to HCA. The changes to our hospital were made suddenly and most happened after the hospital system repeatedly assured that the change would not be made; then the hospital made the changes anyway. Prior to the sale, the Labor and Delivery unit was closed, 24/7 general surgery coverage was discontinued, orthopedic services were dramatically reduced, GYN surgery was reduced, anesthesia support outside of the OR was reduced, clinical and administrative staffing levels were repeatedly reduced. After the sale, HCA has continued to cut staffing levels and services. The result is that our hospital is currently still open, but no one who is paying attention believes that it will stay open. Our FQHC has retained jobs and made incremental increases in staff and services over the past several years, but not in direct response to changes at the hospital. Our hospital has much more limited services than it had five years ago. It is no longer seen as a community partner, but as part of a corporation that cares only about its profits.” – *NC Rural FQHC*

“Hospital mergers and downsizing have been a significant issue for our community, impacting its safety, economy, and viability. Our hospital has undergone two acquisitions in 10 years, each worse than the previous. We have lost OB, ICU, and Med/Surg over those years. We now have a shell of an ER remaining with inconsistent imaging and lab services, offering shoddy and unreliable care. The pandemic has exposed how vulnerable our communities are without a functioning hospital. Critical care and testing have been delayed, putting lives at great risk. FQHCs have had to step into this vacuum, serving and protecting those with minimal resources. Unfortunately, without the infrastructure and resources, FQHCs will not be able to sustain these efforts for much longer. Many of the same factors that made rural hospitals extinct endanger FQHCs as well.” – *TN Rural FQHC*

“In 2016, one CAH in our area opted to discontinue delivery services. They had spoken to us on and off over the course of time they were considering this. There were a couple public meetings where the communities were able to speak against it. Then we heard nothing for months, then the decision was made to close and it was gone. They did not ask for data, or a last appeal. We lost two physician staff immediately due to this decision. And unfortunately we were increasing our prenatal numbers and they did not give it a second thought.” – *CA Rural FQHC*

“Our local district hospital has survived one bankruptcy and then over the past four years began a severe financial downfall that put the labor and delivery department in jeopardy of closure. Community advocacy kept the department open but the financial well-being of the hospital continued to suffer. I was an advocate to keep the department open as its closure means a 1.5-hour drive for our patients to deliver at the next closest hospital. Part of the strategy was to pass a parcel tax, which needed a supermajority. I was a vocal advocate for the tax and lent my picture, quotes and name to lead the campaign. It passed with five votes over the two-thirds vote needed. Unfortunately, at the same time the district board was soliciting a hospital system to take over the operations of the district hospital. [A large hospital system] eventually was the only bidder and after a 90% yes vote by the district voters [the hospital system] came in to lease the hospital facility on July 1, 2020. Prior to taking over, [the hospital system] negotiated the terms and then reportedly threatened to walk away if Labor and Delivery (L&D) remained open. The department was closed and now women have to travel 1.5 hours to deliver their babies. Our center has picked up some of the things that L&D nurses did for our patients like fetal monitoring (a work in progress); we have to do Rogham injections through a local

pharmacy. We transfer patients to OB [at a clinic 1.5 hours away] at about 28 weeks; we offer gas cards for prenatal care and assistance with hotel stipends for families who have the financial need. I know there have been ER deliveries, though the hospital will not confirm it. I believe there may have been as many as four since April and one other delivery on the side of the road en route to the hospital.” – *CA Rural FQHC*

“In 12 of the 18 communities we serve, the hospitals struggled financially (five) or closed (seven). In the case of hospital closure, it was devastating and unexpected in the community. The county dropped even further down on the RWJF rankings. Two hospitals were bought out by a regional hospital, who promptly closed one of them. In another case, the hospital survived but unexpectedly closed labor and delivery. Although the hospital had four full-time OB-GYNs, with average deliveries of over 50 per month, the new hospital owner maintained that L&D lost money. Of the four OB-GYNs, we were able to retain one; the other three moved away.” – *SC Rural FQHC*

## MIXED COMMENTS:

“We have worked with six hospitals facing financial distress or downsizing. Some changes were planned in advance; mostly things are acrimonious. Those that are trying to hang on are very defensive. I did some practice acquisitions six years ago to help save the services and relieve the hospital of the financial burden. We rent significant space to support the hospital facilities.” – *MI Rural FQHC*

“As an FQHC located in a poor rural community, we acquired five practices from our local hospital as a way to retain more primary care services within our county. Unfortunately, the hospital closed the local Obstetrics Unit which negatively impacted our ability to maintain our Women’s Care Services.” – *PA Rural FQHC*

“The purchase of the local hospital by our FQHC occurred suddenly. The hospital was having difficulties and COVID-19 was the last obstacle that made it close. There were rumors that another hospital in a neighboring state was going to purchase it and close it, so our health center stepped in to try to keep a hospital in our rural area.” – *WV Rural FQHC*

“We’ve dealt with three cases of hospital financial distress and one closure. The closure occurred suddenly. We worked with the local hospital to avoid closure in one instance. In one county a local provider closed its office and we assumed the practice with the utilization of a mobile unit. This allowed community members access to primary care without leaving the community. We provide SUD and MH services as well.” – *OK Rural FQHC*

## CONCLUSION

As rural communities continue to experience financial stress in their health care delivery systems, it's critical that health centers and hospitals increase their capacities to collaborate in order to preserve critical systems of care to the extent feasible. From the perspective of health centers, the effort to collaborate over the last five years has had mixed result, but is not without considerable bright spots. Positive results include the willingness of health centers to take over certain practices and services and collaboration on the retention of significant services and jobs in the community, both at hospitals and health centers. Many of the negative outcomes reported included situations in which the hospitals had been sold to for-profit entities. Closure of labor and delivery services in particular appears to have been quite prevalent and problematic.

The results of this initial assessment provide insight into the recent experiences of rural FQHCs and focus attention on the issues and potential solutions that have emerged. In light of these findings, perhaps health centers and hospitals serving rural America will be inspired to find creative and mutually productive ways of working together to better serve their communities. Certainly, rural communities benefit when key institutions are able to work together to preserve and provide a range of needed services in a financially sustainable manner. To the extent that FQHCs and hospitals succeed in this endeavor, their communities benefit—and the long-term viability of both organizations is strengthened as well.