# Rural Hospitals: The Past, Present and Future

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# Objectives

- Understand recent trends, data and key risk for rural hospitals across the US
- Explore the impact of H.R. 1 (OBBB) and RHTP on rural hospitals
- Discuss the future of rural hospitals considering workforce supply and demand and technological advancements

# My Story and Background

20+ years in anesthesia services and anesthesia management supporting rural/community hospitals

- Manage anesthesia services at over 100 rural/community hospitals in 6 States
- What I've learned "up close":
  - Rural hospitals run on thin margins and thinner staffing
  - Anesthesia coverage is a gatekeeper service: if you can't staff anesthesia, you can't run ORs, L&D, endoscopy, or many trauma/emergent procedures
  - What "best practices" look like when you don't have "big city" resources (standardization, staffing models, call coverage design, transfer protocols, data)

# Why do Rural Hospitals Matter?

- About 35% of U.S. community hospitals are rural
- Rural hospitals account for only ~8% of discharges, reflecting smaller size and lower volumes (which drives financial fragility)
- About 46 million people live in rural areas (KFF definition), and most (88%) live in a county with a hospital

# Why do Rural Hospitals Matter?

- Rural hospitals are often one of the largest employer in their communities if not the largest
- After a rural hospital closes, residents often travel many miles farther for emergency services and inpatient care

“A hospital closure isn’t a healthcare event. It’s an economic event, a workforce event, and a community survival event.”

**When a rural Hospital fails, the town often follows!**

# A Look Back: The Recent Past

**Closures and conversions have been persistent for two decades**

- Since January 2005, there have been 195 rural hospital closures and conversions (110 complete closures + 85 conversions).
- 62 closures since 2017
- Only 10 rural hospitals opened in the same period
- Hundreds remain at risk of closure

Maternity services disappearing

- Nationally, less than half (41%) of rural hospitals still offer labor & delivery (and in 12 states, < 1/3 do).

# Key Financial Indicators

- Over 40% of rural hospitals had negative operating margins in 2023
- Rural operating margin: 3.1% vs. urban 5.4%
- Reimbursement shortfalls continue to erode stability
- Medicaid and Medicare underpayments accelerated in 2023

# Summary of Recent Financial Struggles

- Rural hospitals disproportionately rely on Medicare/Medicaid
- $130B in Medicare/Medicaid underpayments nationwide (2023)
- Medicaid cuts could jeopardize hundreds of rural facilities
- Uncompensated care burden remains high

# The Present: Impact of the OBBB

- Major federal policy proposal aimed at reducing federal healthcare spending
- Includes substantial Medicaid funding cuts
- Restructures provider payments and allowable reimbursements
- Creates new compliance and reporting requirements for rural facilities

**The overall cuts to Medicaid are expected to reduce funding in rural areas by roughly $155 billion**

# The Present: Impact of the RHTP

- CMS announced a **$50B Rural Health Transformation Program (RHTP)** across five years (2026–2030).
- California's first-year award is about **$233.6M**.

Many analysts note RHTP is meaningful, but it may not fully offset broader financing headwinds tied to Medicaid/coverage policy changes.

# OBBB Impact Summary

Uncertainty!

“Whatever the final version is, rural systems need predictability.”

# The Quiet Crisis for Rural Hospitals

- Hospital labor costs increased by **>$42.5B from 2021–2023**, reaching **$839B**, **~60%** of the average hospital's expenses; hospitals spent **~$51.1B** on contract labor in 2023.
- This matters for rural hospitals because they often pay "city wages" (or locums premiums) with "rural revenue."
- Ability to recruit and retain talent is often dependent on paying wages to lure specialist and CRNAs from big cities.
- Reimbursement is disproportionately reliant on Medicare and Medicaid compared to other hospitals in larger cities.

# The Future of Rural Healthcare and Rural Hospitals

**Continued financial stressors to persist in near future**

- Costs: labor + supplies + purchased services remain elevated (use AHA "Costs of Caring" as a credible umbrella).

Rural vulnerability:

- Chartis estimates **46% of rural hospitals** have negative operating margins, and **432** are vulnerable to closure

California is the canary in the cool mine!

# The Future: Workforce Supply and Demand

CRNAs are a core rural access solution:

- CRNAs account for **>80% of anesthesia providers in rural counties**.
- Currently, estimates are that there is a roughly a 10% anesthesia provider shortage in the US
- CRNA shortage has been acutely felt by hospitals since Covid with average compensations rising from:
  - $235,000 in 2021 to
  - $270,000 in 2024 (a 15% increase 3 years)

# The Future: Workforce Supply and Demand

Physician Anesthesiologist make up just under 20% of anesthesia care in rural hospitals.

Physician anesthesiologist average compensation is also increasing:

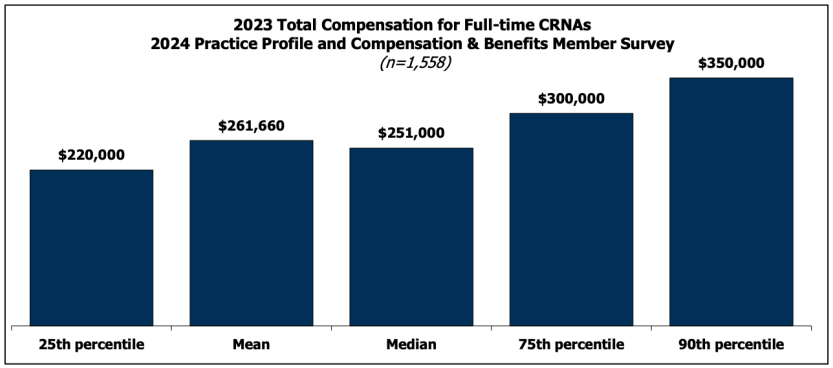
- $466,000 in 2021to
- $508,000 in 2024 ( a 9% increase)

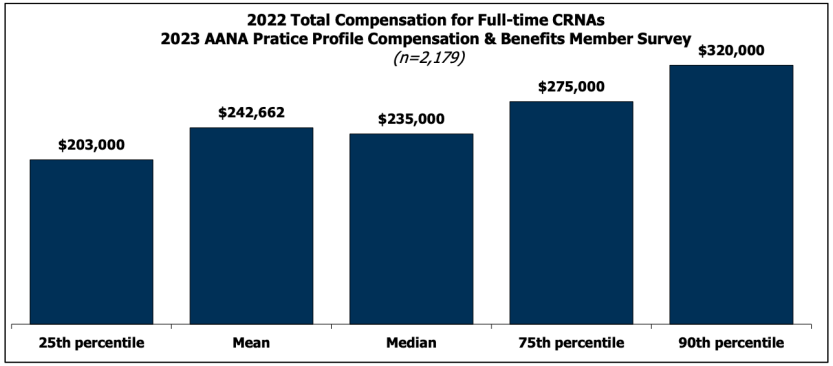
Anecdotally, since 2024 we have seen more rapid compensation increases in physician compensation, but data is still out.

**CRNA COMPENSATION (2022 and 2023)**

The median total compensation for full-time employee CRNAs in 2023 was $251,000; this is up from $235,000 in 2022, an increase of about 7%.

*Compensation reported by CRNAs includes income from all employment arrangements/sources of income.*



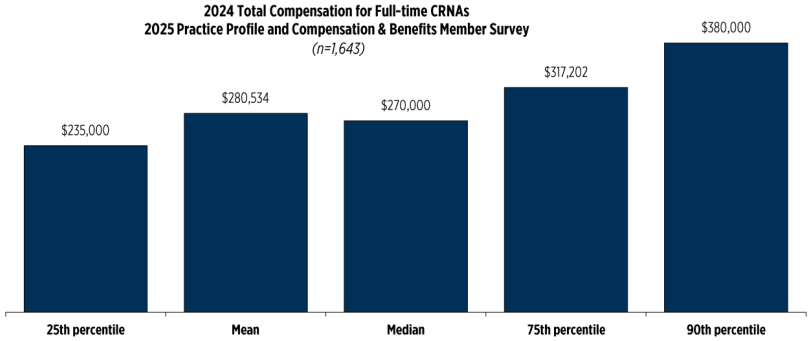



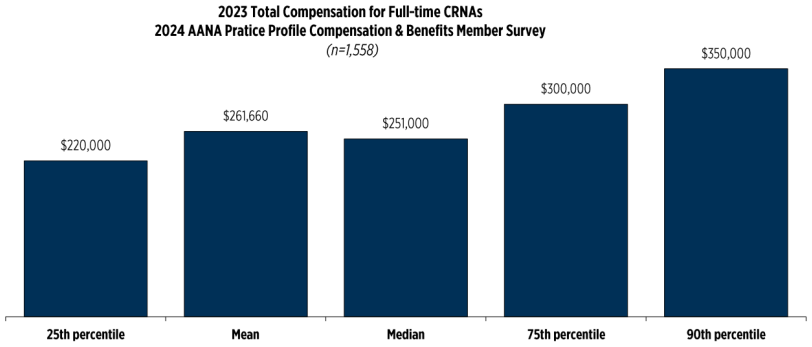

*NOTE: Statistics are based on full-time CRNAs with total compensation greater than $1,000 and less than $600,000.*

## CRNA COMPENSATION (2024 and 2023)

The median total compensation for full-time employee CRNAs in 2024 was $270,000; this is up from $251,000 in 2023, an increase of about 8%.

*Compensation reported by CRNAs includes income from all employment arrangements/sources of income.*




*NOTE: Statistics are based on full-time CRNAs with total compensation greater than $1,000 and less than $600,000.*

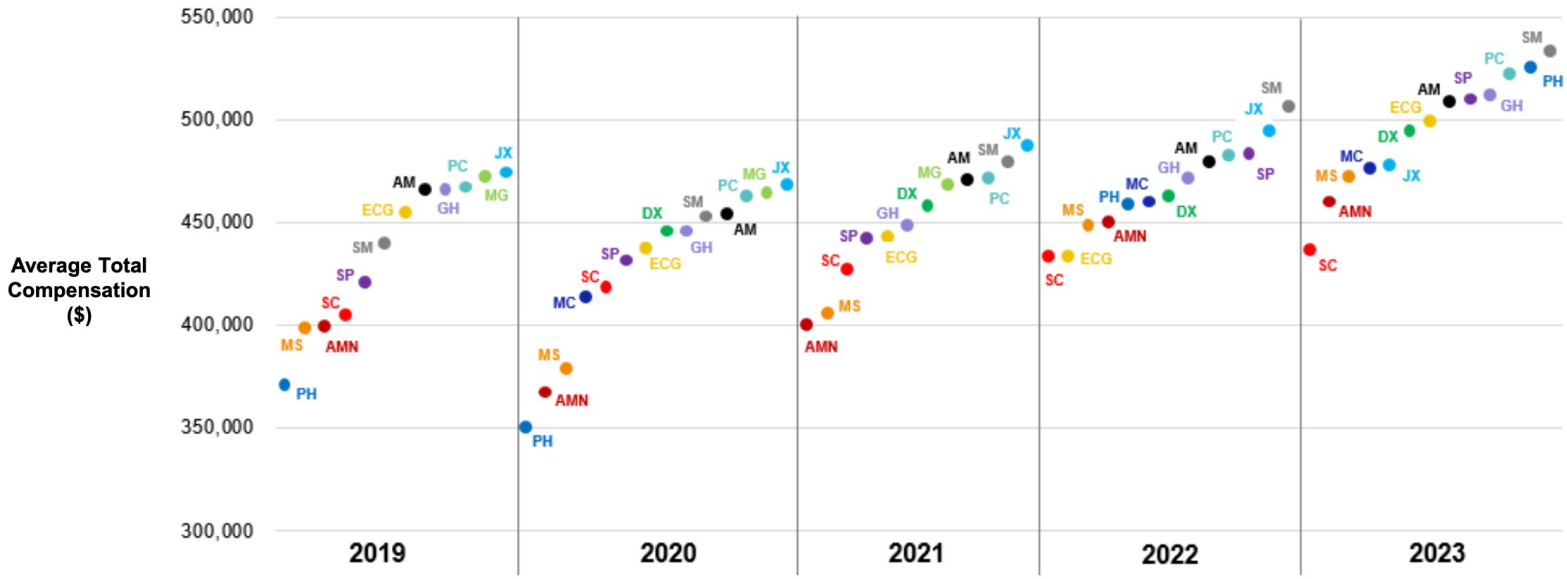
*Means, medians, and percentiles reflect only respondents who reported income in the listed category (total compensation).*

# Anesthesiologist Total Compensation, 2019–2023 – *continued*

| Count | Source | Estimate ($000s) 2019 | 2020 | 2021 | 2022 | 2023 | Percentage Change 2019-2023 |
|---|---|---|---|---|---|---|---|
| | ***Average Total Compensation*** | | | | | | |
| 1 | SullivanCotter Medical Groups | 439 | 452 | 480 | 506 | 533 | 21.4 |
| 2 | Pinnacle Health Group | 370 | 350 | -- | 459 | 525 | 41.8 |
| 3 | Pacific Companies | 467 | 462 | 471 | 482 | 522 | 11.8 |
| 4 | Gallagher | 466 | 446 | 448 | 471 | 512 | 9.8 |
| 5 | SullivanCotter Physicians & Organizations | 421 | 431 | 441 | 483 | 510 | 21.2 |
| 6 | AMGA* | 466 | 454 | 470 | 479 | 508 | 9.2 |
| 7 | ECG Management Consultants | 454 | 438 | 443 | 433 | 499 | 10.0 |
| 8 | Doximity** | -- | 446 | 458 | 463 | 495 | 11.0 |
| 9 | Jackson Physician Search | 474 | 468 | 488 | 495 | 477 | 0.8 |
| 10 | The Medicus Firm** | -- | 413 | -- | 460 | 476 | 15.2 |
| 11 | Medscape | 398 | 378 | 405 | 448 | 472 | 18.6 |
| 12 | AMN / Merritt Hawkins | 399 | 367 | 400 | 450 | 460 | 15.3 |
| 13 | Salary.com | 404 | 418 | 427 | 433 | 436 | 7.9 |
| 14 | MGMA | 472 | 464 | 467 | -- | -- | -- |

Figures sorted in descending order of 2023 total compensation.
*Median total compensation for 2019 to 2022.
**Represents percentage change of reported total compensation between 2020 and 2023.
Survey analytic samples historically range between >200 and >100,000 physicians across multiple specialties.
See slide *"Total Compensation References"* for detailed list of sourcing.

# Publicly Reported Anesthesiology Total Compensation, 2019–2023*

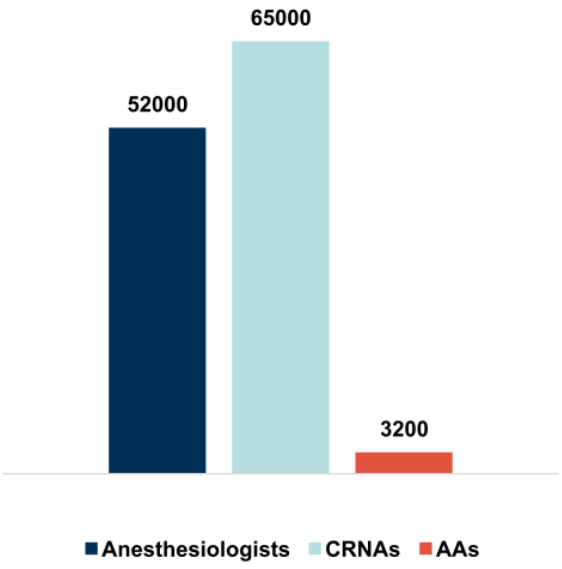



Abbreviated sources: AM=American Medical Group Association (AMGA); AMN=AMN / Merritt Hawkins; DX=Doximity; ECG=ECG Management Consultants; GH=Gallagher; JX=Jackson Physician Search; MC=The Medicus Firm; MG=Medical Group Management Association (MGMA); MS=Medscape; PC=Pacific Companies; PH=Pinnacle Health Group; SC=Salary.com; SM=SullivanCotter-M (medical groups); SP=SullivanCotter-P (broader sample of physicians & organizations). *Represents the calendar year that the survey was open. As an example, if a survey was open from October 2023 to February 2024, the reported average total compensation year is for 2023.

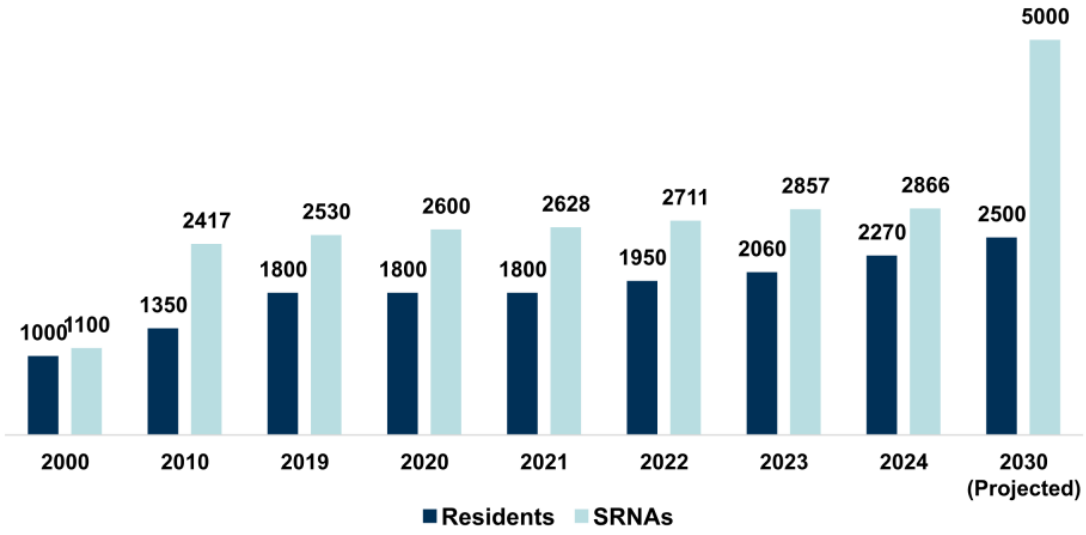
# The Numbers Speak for Themselves

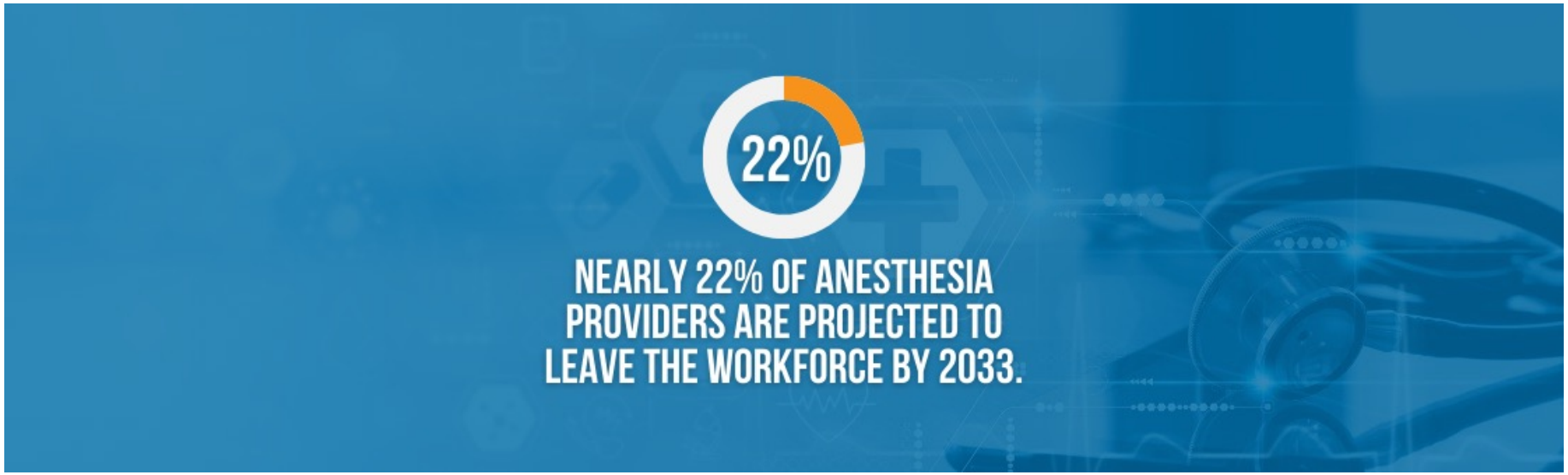
## Defining the anesthesia workforce of the past, present, and future

### Anesthesia Clinician Population (2025)




### Historic and Projected Resident and SRNA Graduates




22%
NEARLY 22% OF ANESTHESIA PROVIDERS ARE PROJECTED TO LEAVE THE WORKFORCE BY 2033.

## Anesthesiologist Workforce Demographics:

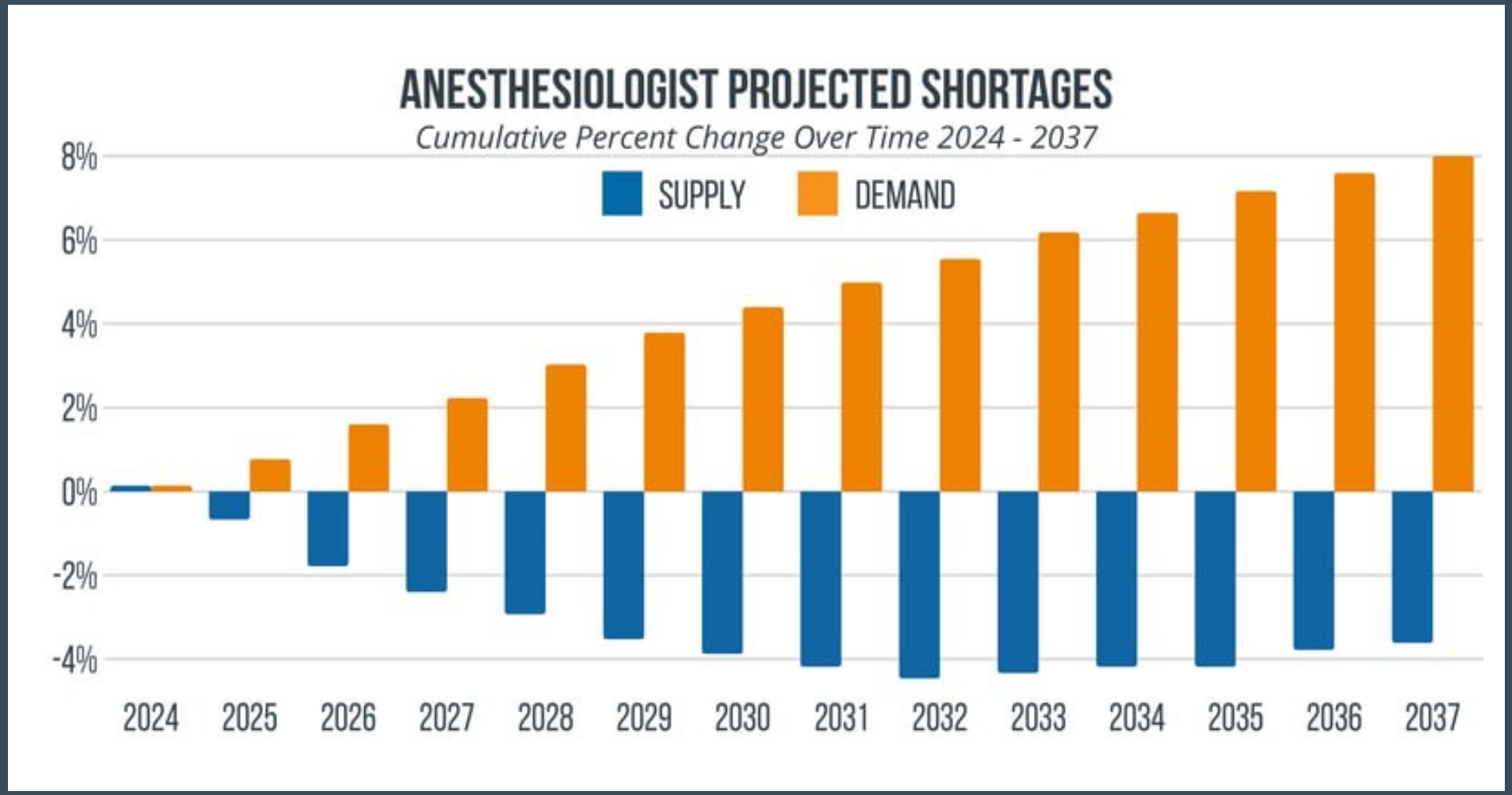

THE AVERAGE AGE OF ANESTHESIOLOGISTS WAS 52.6 YEARS IN 2020.


45% OF ANESTHESIOLOGISTS WERE OLDER THAN 55 YEARS OLD IN 2020 .

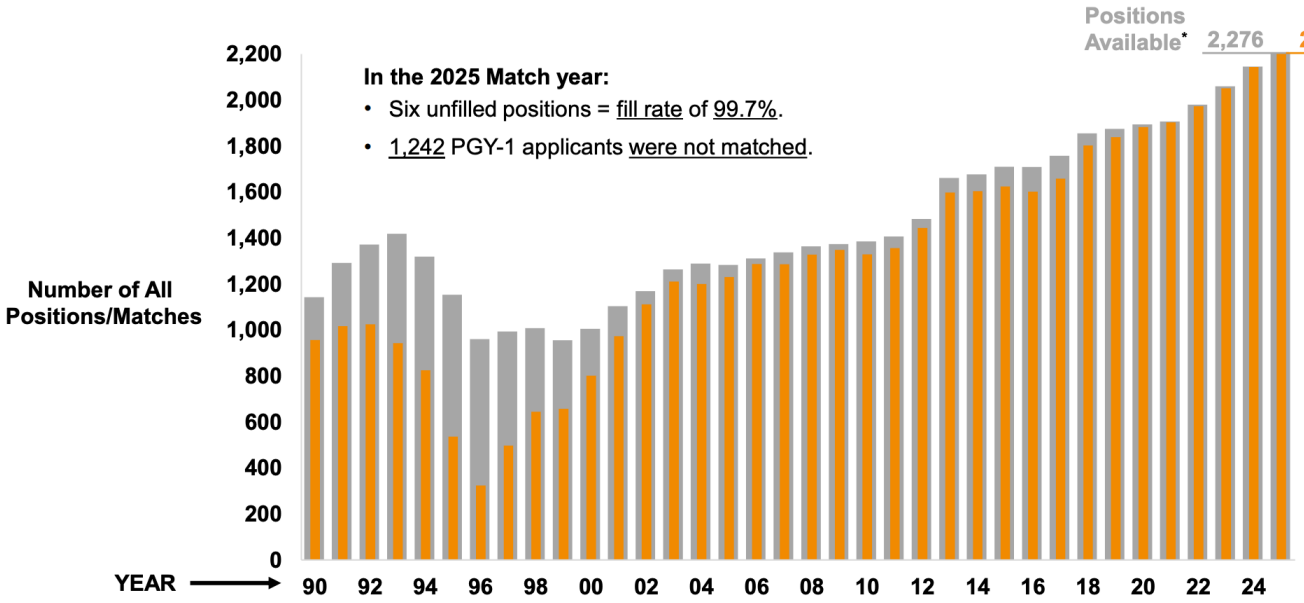
## CRNA Workforce Demographics:


THE AVERAGE AGE OF CRNAs IS 47.5 YEARS OLD.


12% OF CRNAs REPORTED PLANNING TO RETIRE BY 2027.


ANESTHESIOLOGIST PROJECTED SHORTAGES
Cumulative Percent Change Over Time 2024 - 2037
SUPPLY
DEMAND
8%
6%
4%
2%
0%
-2%
-4%
2024
2025
2026
2027
2028
2029
2030
2031
2032
2033
2034
2035
2036
2037

# Anesthesiology Positions Available Compared to Total Anesthesiology Candidates Matched*, 1990–2025

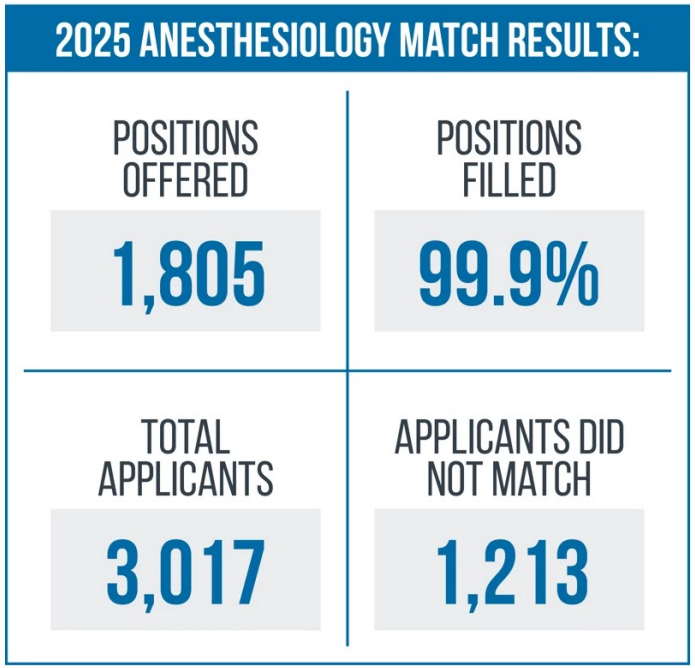



| 2025 Match Year | Available Positions # | Available Positions % |
|---|---|---|
| PGY-1 | 1,813 | 79.7 |
| CA-1 | 311 | 13.6 |
| Physician (R) | 152 | 6.7 |
| **TOTAL** | **2,276** | **100.0** |

Source: 36 years of reports (1990 to 2024): National Resident Matching Program, Results and Data: Main Residency Match®. National Resident Matching Program, Washington, D.C.
2025 data: Advanced Data Tables: 2025 Main Residency Match®. National Resident Matching Program, Washington, D.C.
Represents NRMP specialty programs in: Anesthesiology, Emergency Medicine (EM)-Anesthesiology, Medicine-Anesthesiology and Pediatrics-Anesthesiology.
*PGY-1 plus CA-1, and from 2014-2025, includes Physician (R) programs. See "Definitions" slide for candidate description.
Note, a small portion of applicants can match into PGY-1 and CA-1 positions in tandem. You may access further reading on positions and the Match here.

## Anesthesiologist Training Insights:

Anesthesiology residency positions have increased by approximately 24% since 2021, according to the National Resident Matching Program (NRMP). Yet, current growth rates fall short of meeting projected workforce requirements and the expanding volume of anesthesia cases.



## CRNA Training Insights:

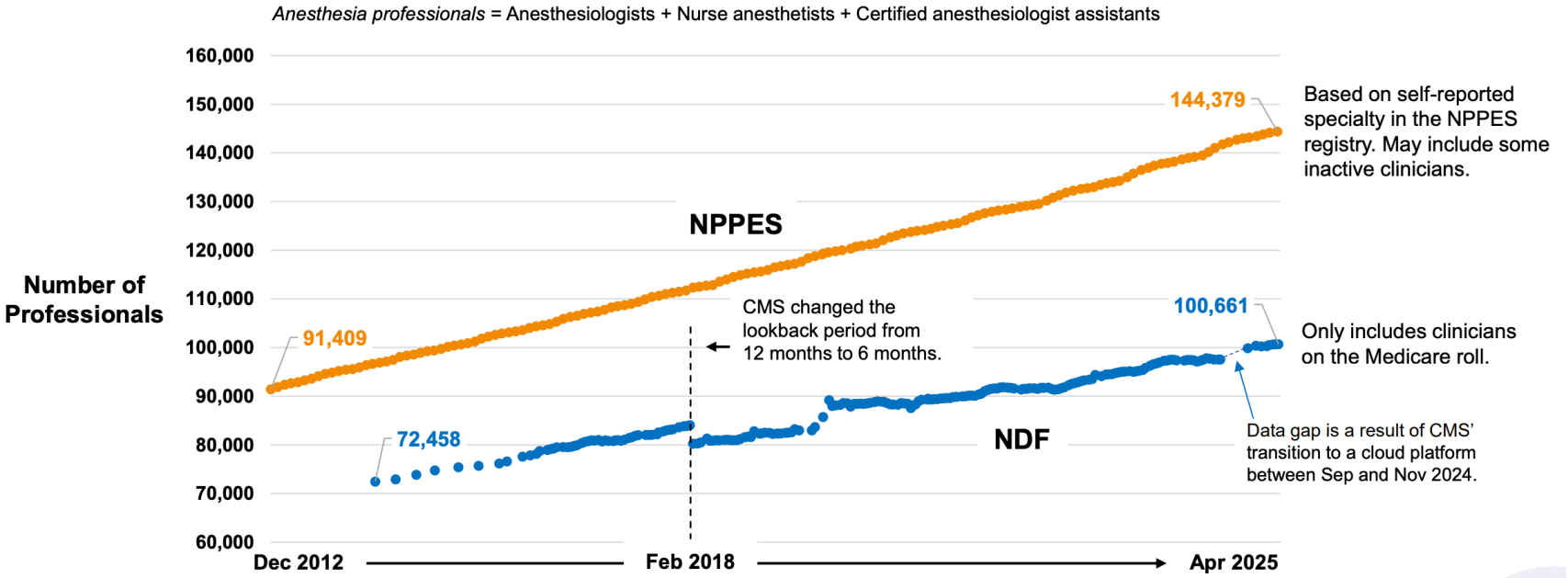
Although 2,400 CRNAs graduate annually, according to the AANA, training capacity remains insufficient to meet rising patient demand and address the growing anesthesia workforce shortage.


CRNA TRAINING IS HIGHLY COMPETITIVE, WITH AN **AVERAGE ACCEPTANCE RATE OF 24%**.

THERE ARE **142 ACCREDITED NURSE ANESTHESIA PROGRAMS** THROUGHOUT THE U.S.

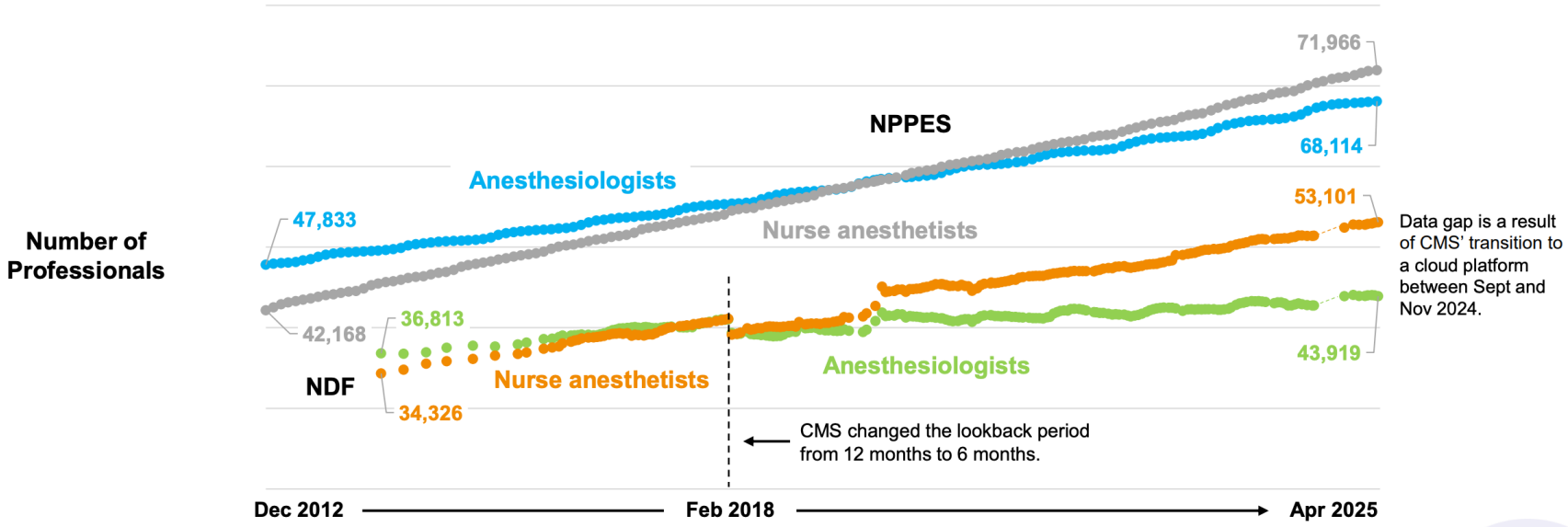

NURSE ANESTHESIA PROGRAMS RANGE FROM **36 TO 51 MONTHS**.

# How Many Anesthesia Professionals Are There?




Source: NPPES/NPI Datasets, 12/15/2012–04/13/2025 and CMS Provider Data: Doctors and Clinicians, National Downloadable File (NDF). Updated 04/18/2025. Available at https://data.cms.gov/provider-data/dataset/mj5m-pzi6 Referred as the CMS Physician Compare National Downloadable File prior to May 2021.

# How Many Anesthesiologists and Nurse Anesthetists Are There?




Source: NPPES/NPI Datasets, 12/15/2012–04/13/2025 and CMS Provider Data: Doctors and Clinicians, National Downloadable File (NDF). Updated 04/18/2025. Available at https://data.cms.gov/provider-data/dataset/mj5m-pzi6 Referred as the CMS Physician Compare National Downloadable File prior to May 2021.

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# Nurse Anesthetists Less Anesthesiologists Billing Medicare, Feb 2018–Apr 2025

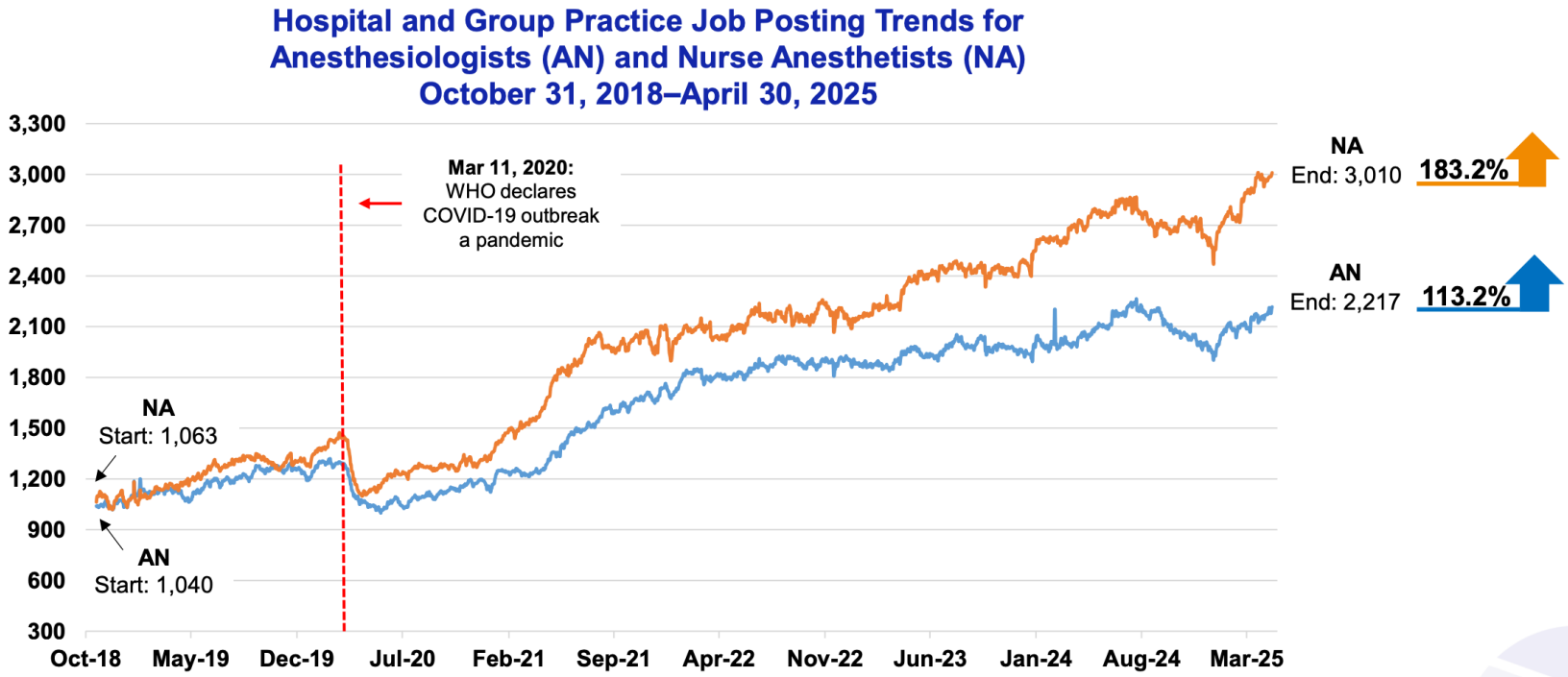

In the past six months, **20.9%** (9,182) more nurse anesthetists than anesthesiologists billed Medicare.

Based on primary ***or*** secondary specialty of "anesthesiology" and primary specialty of "certified registered nurse anesthetist."

Anesthesia professionals billing Medicare in the previous six months.

Source: CMS Provider Data: Doctors and Clinicians, National Downloadable File (NDF). Updated 04/18/2025.
Available at https://data.cms.gov/provider-data/dataset/mj5m-pzi6 Referred as the CMS Physician Compare National Downloadable File prior to May 2021.

# GasWork Job Postings: Hospital and Group Practice, Oct 2018–Apr 2025




Source: www.GasWork.com, an anesthesia employment resource, October 31, 2018–April 30, 2025.

# Financial Strain: The Impact of Limited Anesthesia Access

The OR is one of the more challenging sectors within a health system to keep adequately staffed and optimally utilized. Healthcare leaders continue to face challenges in the recruitment and retention of surgeons, anesthesia providers, and OR staff.

SURGICAL SERVICES MAKE UP ROUGHLY **60% OF A FACILITY'S REVENUE**.

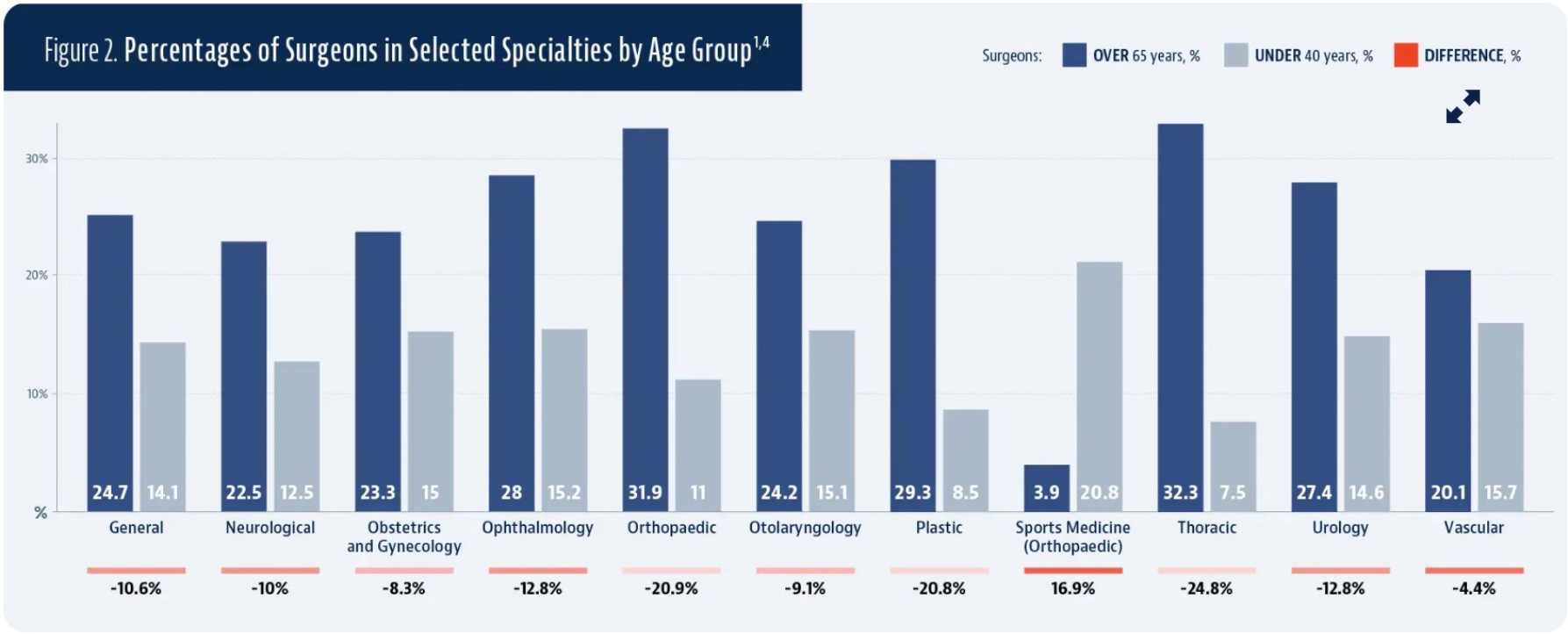
FILLING A PERMANENT ANESTHESIOLOGIST POSITION TAKES **APPROXIMATELY 120 DAYS**.

# Future Workforce of Physicians and Surgeons

**More Physician and surgeon shortages**

- AAMC projects a physician shortage up to **86,000 by 2036**
- Surgeon shortfall projected **~10,100 to 19,900 by 2036**

## Figure 2. Percentages of Surgeons in Selected Specialties by Age Group[1,4]



# The Future: Technology

AI + telehealth as force multipliers, not replacements!

- AI will help bridge Specialist the gap though better imaging and specialist decision support.
- AI will help with burnout and increase efficiency through better documentation support (estimated to allow physicians to reclaim 1-2 hours of increased patient face to face time daily).
- Strengthen financial viability through better RCM functions.
- Ideally, AI will help to decrease reliance on ”symptom” treatment through earlier recognition of underlying disease processes.

# Legislative Needs

- **Stabilize rural hospital financing**
  - Protect predictable revenue streams and create targeted stabilization funding for the most at-risk sites.
  - Tie to: outcomes, margins, closures, access miles.
- **Invest in workforce pipelines that actually land in rural**
  - Clinical rotations, rural training tracks, preceptor incentives, and housing support.
- **Protect anesthesia coverage as critical infrastructure**
  - Treat anesthesia staffing like ED coverage: if it fails, surgery, endoscopy and OB fail.
- **Support rural maternity care**
  - If <half of rural hospitals still deliver babies, you're already in "maternity care desert" territory.
- **Make RHTP dollars operationally usable**
  - Encourage programs that reduce premium contract labor reliance, build sustainable staffing and invest in technology for the future .

# Summary

- Rural Hospitals and Rural Healthcare are critical for communities and the patients they serve
- Financial stressors are not completely going away
- Workforce shortages may worsen before they improve, especially for surgical services
- Investments are being made, capital budgets need to be investments in the future and not just band aids for today's problems
- California is uniquely positioned:
  - scale, innovation capacity, and visibility
  - but also rural fragility and geography

  “California can be the canary in the coal mine, or the model other states follow.”

# Thank you!

- Questions, Comments, Concerns?