



Private Equity Descends on Rural Healthcare

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PRIVATE EQUITY

STAKEHOLDER

PROJECT

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Introduction

Rural healthcare in America has hit a crisis point. Millions of Americans living in rural communities do not have access to critical healthcare services.

By most measures, the health of people living in rural areas is significantly worse than in non-rural areas. Compared to urban residents, rural residents generally experience poorer health outcomes and a higher prevalence of chronic conditions.¹ An estimated one in three rural adults lives with a disability, impacting their hearing, vision, cognition, mobility, self-care, or independent living.² Americans in rural areas are more likely to die by suicide.³

These disparities are pronounced for people of color. According to CMS, people of racial and ethnic minorities are “more likely to report not having primary care practitioners, not having accessed healthcare appointments due to cost, and having fair or poor health status. In general, Black, American Indian, and Alaska Native women experience worse maternal health outcomes compared to non-Hispanic White women, and these disparities are compounded by limited access to high quality obstetric care in rural communities.”⁴

Health policy analysts have identified several factors that drive rural health disparities.

Socioeconomic factors are a central cause of the disparities in health quality and access in rural communities. Rural areas experience higher rates of poverty and unemployment as well as uninsurance and underinsurance.⁵

People in rural areas often experience longer travel times to reach their healthcare, where patients often need to drive several hours to reach a healthcare provider. That can mean a day without wages.⁶

Compounding these problems is the erosion of a key pillar of rural health—rural hospitals are closing at a dangerous rate. Since 2010, 140 rural hospitals have shuttered. Nineteen of those closures occurred in 2020 as the COVID-19 pandemic stretched already-thin staffs and hospital operating margins to their limits.⁷ According to a November 2022 study from the Center for Healthcare Quality and Payment Reform, 30% of all rural hospitals are at immediate risk of closing.⁸

Rural healthcare providers are also struggling to adequately staff facilities. While a healthcare staffing crisis becomes increasingly untenable in cities across the US, rural areas account for the most acute staffing shortages, representing a majority of federally designated Health Professional Shortage Areas as of March 2022 including shortages of primary care (66%), dental health (67%), and mental health practitioners (61%).⁹

In this context, it is clear that there is a critical need for investment in rural healthcare. Federal and state agencies have launched initiatives aimed to foster stability in the rural healthcare market and create incentives for increased investment.

Private equity appears to see opportunity to profit from rural healthcare providers. Hospitals, behavioral health providers, air ambulances, doctors' practices, dialysis centers, and urgent care clinics have all seen private equity investment in recent years. Firms have created dedicated rural investment funds and bought up rural healthcare research organizations.¹⁰

While increased investment in rural providers is on its face a positive development, private equity in healthcare carries unique risk. Firms seek high returns, typically looking to double or triple their investment over a relatively short time horizon (4-7 years). This means that companies must find ways to dramatically increase cash flow, which may be particularly challenging in rural healthcare where hospitals are already struggling. Cutting costs at hospitals may mean slashing staffing levels or reducing access to less profitable services, such as obstetrics and pediatric care.¹¹

Other tactics from the private equity playbook may pose risk to rural providers. In sale-leaseback transactions, common among Private-equity-owned hospitals, companies sell their real estate to a third party and lease it back. While these transactions provide a quick way to monetize real estate and generate cash, they can leave hospitals with fewer assets and higher monthly payments.

Similarly, dividend recapitalizations, where a private equity firm directs its portfolio company to take on new debt and use the proceeds to pay the private equity firm a cash payout, can unnecessarily load healthcare providers with debt. While the private equity firm in these situations makes money, the healthcare provider often does not receive proceeds from the loan and still must pay it back, leaving it more vulnerable to market conditions and with fewer resources to support operations as it pays its monthly debt service payments.



This report will examine the extent to which private equity has invested in rural health, the potential financial drivers of significant investment activity in this uniquely distressed part of our health system, and case studies of Private-equity-owned companies in several rural healthcare sectors that highlight some of the risks posed by private equity's incursion into rural healthcare.

Part I examines the scope and impact of private equity investing in rural hospitals by providing data on the current PE owners of rural hospitals and digging into case studies.

Part II expands the scope to private equity buyouts of non-hospital rural healthcare companies, including medical staffing, emergency services, behavioral health, and hospital management and consulting.

Part III analyzes current regulatory framework, policies, and financial incentives that make rural healthcare attractive to private equity investment and propose policy recommendations to ensure rural health providers are protected from private equity profiteering.



Part I: Private Equity in Rural Hospitals

Key Takeaways:

- PESP found that private equity firms own at least 130 rural-serving hospitals.
- 85 of those hospitals benefit from one of the following rural payment designations from CMS: sole community hospital (SCH), Medicare-dependent hospital (MDH), rural referral center (RRC), and critical access hospital (CAH).
- The highest concentration of PE-owned hospitals was in the south. Texas had the most with 17 hospitals.
- A handful of private equity firms dominate the list: Apollo Global Management (LifePoint Health, Scion Health), GoldenTree Asset Management and Davidson Kempner (Quorum Health), and Equity Group Investments (Ardent Health Services).
- **Case Studies:**
 - ◆ Apollo Global Management owns LifePoint Health and ScionHealth, two of the largest nonurban hospital chains.
 - ◆ Lateral Investment Management owned Santa Cruz Valley Regional Hospital in Green Valley, AZ until it closed in 2022, leaving the community without its only hospital. Lateral acquired the hospital in 2018 for \$26 million and sold the hospital's real estate for \$60 million in 2021.
 - ◆ Rural Texas health system Little River Healthcare, owned by Riverside Capital, permanently shuttered in 2018 after filing for bankruptcy earlier that year. The bankruptcy occurred amid investigations surrounding a billing scheme involving lab testing company Little River contracted with, True Health Group (THG), which was owned by Monroe Capital.
 - ◆ Nueterra Capital owned Noble Health, which purchased two struggling hospitals in Missouri. Noble separated the real estate assets from operations, shut down services and furloughed most staff, and sold the operating company for \$2.
 - ◆ Ardent Health Services is a 30-hospital system owned by Equity Group Investments that has in recent years appeared to suffer distress related to high levels of debt, and whose Lovelace Women's Hospital was found in a federal investigation to be racially profiling Native American patients.

Private equity acquisitions of rural healthcare providers are most evident in buyouts of rural hospitals. A 2020 study published in the *Annals of Internal Medicine* found that on average, Private-equity-owned hospitals in the US are more likely to be in low-income, rural areas in the South, and have lower patient experience scores and fewer full-time equivalent employees per occupied bed to non-acquired hospitals.¹²

Private equity’s preference for rural hospitals comes at a moment of acute crisis for many of those facilities. A November 2022 study by the Center for Healthcare Quality and Payment Reform found that 631 rural hospitals—or about 30 percent of all rural hospitals—are at risk of closing in the immediate or near future. More than 200 of those hospitals are at immediate risk of closure. Most of the hospitals at immediate risk for closure are in isolated rural communities, where a closure means that communities served by those hospitals will have to travel long distances for essential care.¹³

Even with substantial financial assistance received during the pandemic, six rural hospitals closed in 2021 and 2022. Three of those were Private-equity-owned: Missouri hospitals Callaway Community Hospital and Audrain Community Hospital, which were owned by Nueterra Capital,¹⁴ and Arizona’s Santa Cruz Valley Regional Hospital, which was owned by Lateral Investment Management.¹⁵

Private Equity Stakeholder Project has counted at least 130 rural hospitals that are currently owned by private equity firms.

A handful of private equity and similar investment firms dominate the list. Apollo Global Management, through its two hospital systems LifePoint Health and ScionHealth,¹⁶ owns 71 rural hospitals. GoldenTree Asset Management and Davidson

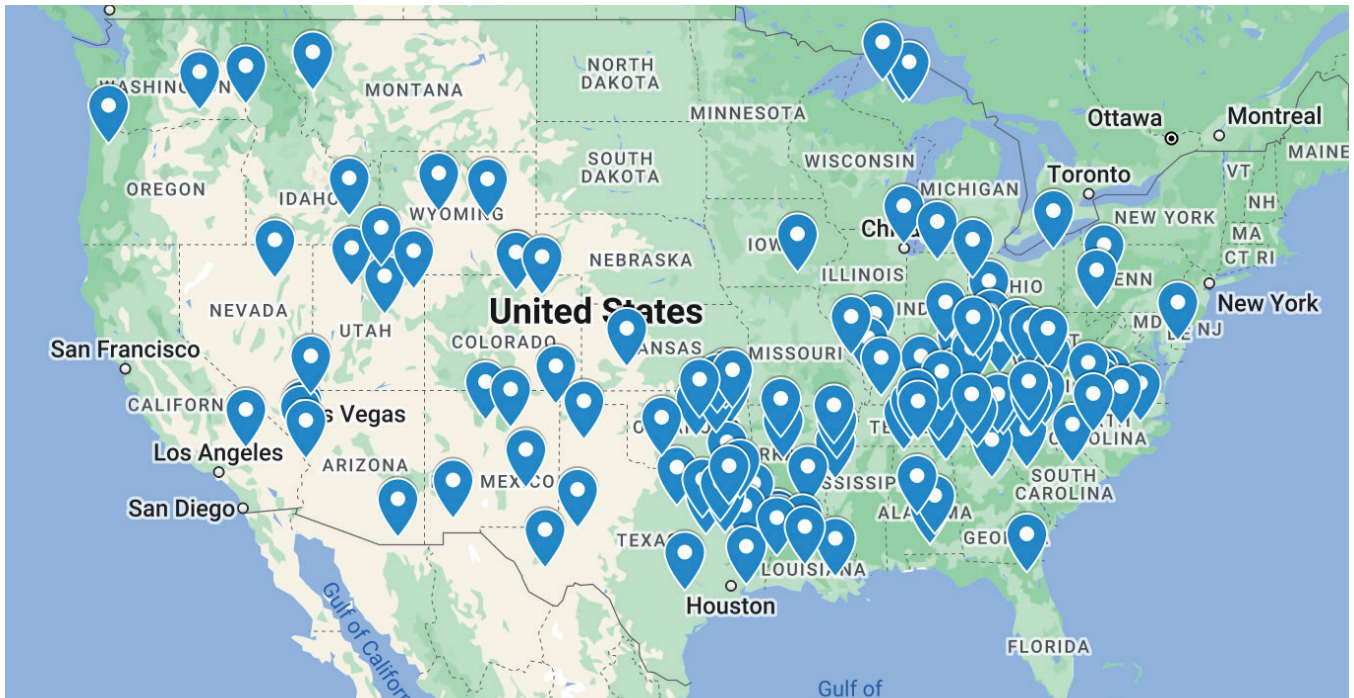
Hospital System	PE Firm	# Rural Hospitals
LifePoint Health	Apollo Global Management	52
ScionHealth	Apollo Global Management	19
Quorum Health	GoldenTree Asset Management, Davidson Kempner	17
Ardent Health Services	Equity Group Investments	15

Kempner own 17 rural hospitals through Quorum Health, which the firms bought after it filed for bankruptcy in 2020.¹⁷ Equity Group Investments, through its hospital system Ardent Health Services,¹⁸ has 15 rural hospitals.

The list does not include hospitals that were formerly owned by private equity, though it is worth noting that a substantial number of rural-serving hospitals have at various times been owned by private

equity firms. For example, Steward Healthcare, which owns at least seven hospitals serving rural communities, was owned by Cerberus Capital Management until spring 2020.¹⁹ HCA, one of the largest health systems in the US with at least 27 hospitals serving rural patients, was owned by Bain Capital between 2006 and 2011.²⁰

Map of Private-equity-owned Rural Hospitals



[Click here for an interactive map.](#)

Of states that had the highest number of PE-owned hospitals Texas has the most, with 17 facilities. Kentucky and North Carolina follow with 12 private-equity-owned facilities. Consistent with previous studies, PESP found that the South generally has the highest concentration of private equity-owned rural hospitals.

85 of the 130 rural hospitals currently owned by private equity firms benefit from one of the following rural payment designations from CMS: sole community hospital (SCH), Medicare-dependent hospital (MDH), rural referral center (RRC), and critical access hospital (CAH).

State	# PE-owned rural hospitals
TX	17
KY	12
NC	12
OK	9
TN	8
LA	7
AL	5
NM	5





Payment Model	# of PE-owned hospitals
Critical Access Hospital	20
Medicare Dependent Hospital	14
Rural Referral Center	17
Sole Community Hospital	24
Sole Community Hospital/ Rural Referral Center	10
Total	85

These payment designations broadly aim to support rural hospitals through a variety of beneficial payment provisions. For example, Medicare pays CAHs for the same services as other acute care hospitals, but payments are based on each CAH's costs and the share of those costs that are allocated to Medicare patients. Cost based reimbursement provides significant financial advantage to CAHs by allowing them to get paid at 101% of costs on all of their hospital Medicare

business.²¹ Similarly, SCHs are paid on the higher of the Inpatient Prospective Payment System (IPPS) rate or a base year federal rate, and MDHs are reimbursed by the Outpatient Prospective Payment System (OPPS) and have a special payment for inpatient services.²²

Methodology

We used a combination of Center for Medicare and Medicaid Services' (CMS) list of hospitals that register with Medicare and data from the Cecil G. Sheps Center for Health Services Research on rural hospitals in the US.

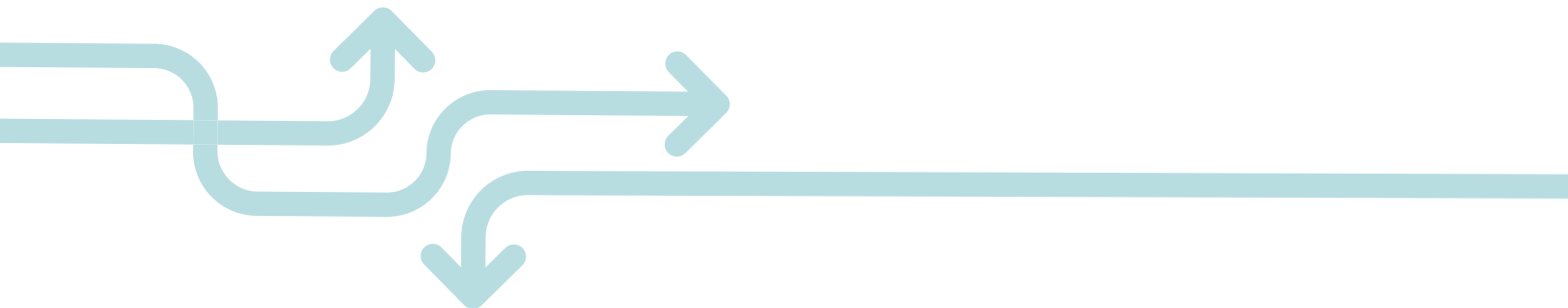
Our list includes acute care hospitals (Critical Access, Cancer, Indian Health Service, Medicare-Dependent, Rural Referral Center, Sole Community, and Prospective Payment System Hospitals), and specialty hospitals (long-term acute care, children's rehabilitation, psychiatric, and religious hospitals).

We calculated rurality based the following factors:

- Rural status based on the definition used by the Federal Office of Rural Health Policy (FORHP) and the hospitals' payment designation with CMS (provided by the Sheps Center).
- CMS rural payment designations: sole community hospital (SCH), Medicare-dependent hospital (MDH), rural referral center (RRC), and critical access hospital (CAH).

We identified hospitals that are Private-equity-owned through a combination of news searches and the data provider Pitchbook, which tracks private equity firms and deals. It is likely that there are rural hospitals that we did not identify—private equity firms are generally not required to disclose acquisitions, so many deals are not publicly disclosed.

Additionally, we did not include in our tally non-profit or publicly owned hospitals that are operated by Private-equity-owned companies (such as QHR Healthcare, a hospital management company owned by Grant Avenue Capital that we discuss in Part II of this report). Many of these management relationships are not publicly disclosed, so it is difficult to know the extent to which private equity firms manage public and non-profit facilities.



Case Studies

LifePoint Health & Scion Health—Apollo Global Management

Two of the largest health systems serving rural communities are LifePoint Health and ScionHealth, which are both owned by private equity firm Apollo Global Management.

The two companies are the result of a series of hospital acquisitions by Apollo, which in 2018 bought LifePoint and merged it with another hospital chain, RegionalCare Hospital Partners.²³ Then in December 2021 LifePoint acquired large acute care hospital chain Kindred Healthcare. As part of the transaction, LifePoint shifted some of the acquired facilities and some of its existing hospitals into a new company called ScionHealth, which is also controlled by Apollo.²⁴

To support the acquisition of the Kindred hospitals, LifePoint made a \$350 million preferred equity contribution to ScionHealth, in addition to ScionHealth raising \$550 million in debt.²⁵

Following the Kindred acquisition and spinoff of ScionHealth, LifePoint has around 65 community hospitals, 30 behavioral health and rehab hospitals and an additional 15 in the works, 170 outpatient and post-acute facilities and 50,000 employees.²⁶ ScionHealth consists of 79 hospital campuses in 25 states, including Kindred's 61 long-term acute care hospitals and 18 of LifePoint's community hospitals and associated health systems.²⁷

With LifePoint and Scion together, Apollo owns over 140 hospitals and 170 outpatient and post-acute facilities. However, this number could increase substantially; both LifePoint and Scion are growing quickly. For example, in May 2022 Scion announced that it was acquiring Texas-based Cornerstone Healthcare Group,²⁸ which operates 17 specialty hospitals, 8 senior living facilities, a behavioral health hospital in six states across the South.²⁹ In August 2022, LifePoint announced that it is acquiring psychiatric hospital chain Springstone,³⁰ which operates 18 behavioral health hospitals and 35 outpatient locations in nine states primarily in the South and Southwest.³¹

See PESP's September 2021 report: [Private Equity Firms Reap Payouts After Hospital Chain Received \\$1.6 Billion in CARES Act Support](#)

In April 2021 Apollo sold LifePoint from one of its private equity funds (Apollo Investment Fund VIII) to another fund managed by Apollo (Apollo Investment Fund IX), making a \$1.6 billion profit from the transaction. This transaction likely generated hundreds of millions of dollars in carried interest for the private equity firm and its executives.³²

Apollo has also profited off LifePoint by selling the real estate for some of its hospitals and leasing it back. In November 2019 LifePoint sold the real estate assets for 10 of its acute care hospitals in Pennsylvania, Iowa, Wyoming, Texas, Oklahoma, and Kansas to healthcare REIT Medical Properties Trust (MPT) for \$700 million.³³ Those hospitals now pay rent on the property they previously owned. Such sale-leaseback transactions have garnered scrutiny for effectively diverting cash that could be invested in hospital operations into rent payments and leaving hospital systems with fewer assets.

Hospitals Sold in 2019 Sale—Leaseback

Facility	Location
Conemaugh Memorial Medical Center	Pennsylvania
Conemaugh Meyersdale Medical Center	Pennsylvania
Conemaugh Miners Medical Center	Pennsylvania
Conemaugh Nason Medical Center	Pennsylvania
Ottumwa Regional Health Center	Iowa
Palestine Regional Medical Center	Texas
Sage West Health Care –Lander Campus	Wyoming
Sage West Health Care–Rivelon Campus	Wyoming
Southwestern Medical Center (including the Southwestern Behavioral Health Center)	Oklahoma
Western Plains Medical Complex	Kansas

Despite being owned by Apollo—which has \$515 billion assets under management—through a fund which at the time had more than \$2 billion available to support its investments,³⁴ LifePoint collected a staggering \$1.6 billion in CARES Act grants and loans.³⁵

Aided by the federal support, LifePoint generated \$1.14 billion in EBITDA and \$304 million in net income in 2020 despite the pandemic. LifePoint ended 2020 with

over \$2.6 billion in cash, despite receiving CARES Act money intended to be invested in operations that year.³⁶ Moody's reported that LifePoint still had \$1.8 billion in cash on its balance sheet as of September 30, 2021.³⁷

Despite the pandemic and the federal relief aid, LifePoint cut operating costs substantially in 2020, slashing salary and benefit costs by \$166 million versus the prior year. LifePoint cut supply costs by \$54 million in 2020 versus the prior year.³⁸ LifePoint also cut the charity care it provided by 21% (\$7.3 million) in 2020.³⁹

Quality issues & service closures

Notwithstanding LifePoint's profitability, press reports and regulatory investigations describe operating challenges that pose a threat to quality care and access to medical services at LifePoint hospitals around the country.

Wilson Medical Center—Wilson County, NC

LifePoint's Wilson Medical Center faced regulatory scrutiny in summer 2022, including a threat by the Centers for Medicare & Medicaid Services (CMS) to revoke its Medicare payments and an investigation by the state's attorney general. Wilson is the only hospital in Wilson County, located about an hour east of Raleigh.

In June 2022, regulators found enough deficiencies at LifePoint's Wilson Medical Center in North Carolina that CMS threatened to terminate its Medicare contract.⁴⁰

A compliance survey by state regulators found that the deficiencies warranted an "immediate jeopardy" designation for the hospital. According to CMS, immediate jeopardy represents a situation in which a hospital has "placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment or death."⁴¹

The investigation highlighted three incidents that occurred in early 2022—one patient died after a fall and sedation at the facility; another patient died shortly after his heart monitor was disconnected; and a suicidal patient locked himself in a bathroom in the hospital's emergency room lobby and threatened to overdose on medication that regulators say the hospital should have confiscated.⁴²

The hospital submitted its corrective action plan to CMS that satisfied state inspectors, and the immediate jeopardy status was removed.⁴³ However, CMS officials reinstated the immediate jeopardy status again in November 2022, which remains as of the time this writing.⁴⁴

However, a few weeks later, the North Carolina Department of Justice began pursuing a separate investigation of Wilson. Assistant Attorney General Llogan Walters wrote to LifePoint that the state's DOJ is "extremely concerned about patients' ability to access quality healthcare" at Wilson, noting a decrease in available beds for inpatient care and allegations of chronic understaffing, a decrease in the treatment of low-income patients and the effective denial of care for patients who cannot pay for essential treatment.⁴⁵

Denying care for patients in need of emergency treatment who do not have the ability to pay would violate the Emergency Medical Treatment and Labor Act (EMTALA). Federal regulators are reportedly reviewing an ongoing investigation into possible EMTALA violations at Wilson.⁴⁶

Central Carolina Hospital—Lee County, NC

In July, the U.S. Department of Labor's Wage and Hour Division ordered LifePoint to pay \$97,209 in back wages after finding overtime pay violations for EMS workers at LifePoint-Central Carolina Hospital. The investigation found that the hospital used timekeeping software that deducted workers' pay meant for breaks they did not get.⁴⁷

SageWest Health—Riverton, WY

In 2020 the Wall Street Journal reported on how in Wyoming LifePoint chipped away at staffing and services at its hospital in working-class Riverton until most services were transferred to another LifePoint hospital in Lander, 30 miles away.⁴⁸

Riverton residents reported that the consolidation severely reduced access to medical services, pointing out that the transfer led to increased utilization of air ambulances, from 155 in 2014 to 937 in 2019.⁴⁹

According to WSJ, Wyoming’s Department of Health urged LifePoint to ensure adequate staffing after several alleged safety incidents involving unsupervised patients and inspection reports for the hospital found sanitation issues, including unsanitary surgical tools.⁵⁰

Conemaugh Nason Medical Center—Roaring Spring, PA

LifePoint’s Conemaugh Nason Medical Center announced it would end scheduled obstetrics deliveries beginning October 9, 2022. In an email to employees announcing the discontinuance, Conemaugh Nason’s CEO Tim Harclerode told employees that because deliveries had declined over the past several years, the limited demand for the services combined with “operational challenges” have made it difficult for Nason to effectively provide obstetric services. Additionally, Conemaugh Nason’s OB/GYN stopped accepting new patients in August 2022 and closed October 2022, along with the hospital’s pediatric clinics. However, a new fourth operating room is expected to open.⁵¹

Santa Cruz Valley Regional Hospital—Lateral Investment Management

Santa Cruz Valley Regional Hospital, a general acute care hospital in Green Valley, AZ owned by private equity firm Lateral Investment Management, closed its doors in June 2022, leaving the rural community without its only hospital.⁵² The hospital’s 315 employees all lost their jobs.⁵³

The seven-year-old hospital opened in May 2015 and struggled financially from the beginning, filing for Chapter 11 bankruptcy in 2017.⁵⁴ California-based Lateral Investment Management bought the hospital out of bankruptcy in February 2018 for \$26 million. Since then, conditions at the hospital have been volatile.

Over the last few years, workers and patients had raised the alarm about declining conditions at the hospital. [Green Valley News reported in 2019](#) that while hospital management made assurances that the hospital was financially stable, workers reported that the hospital lost vendors due to chronically late payments and was consistently without basic medical supplies, including, at times, surgical needles,

bed pans, needles to draw blood, lab tubes, oxygen sensors and bed pads. Three people said they quit because they feared they would lose their licenses because of the unsafe staffing levels and the potential for bad patient outcomes, and patients with life-threatening conditions were being admitted to the hospital despite the lack of qualified medical professionals on-site.⁵⁵

According to the hospital's management, the COVID-19 pandemic was a primary reason for the hospitals' financial woes. CEO Stephen Harris cited crushing debt related to Medicare advance loans as the primary reason for the closure, made worse by onerous payments to nursing staffing agencies.⁵⁶

However, SCVRH collected millions of dollars in pandemic relief funds, including \$5.9 million in federal paycheck protection program money, \$5.4 million from the state's COVID-19 Crisis Contingency and Safety Net Fund, and \$6.4 million in advanced Medicare payments.⁵⁷

Former SCVRH workers are now questioning why the hospital closed even after receiving so much relief aid. Hosanna Hembree, a former nurse at SCVRH, told the Arizona Daily Star: "The COVID money the hospital received that should have gone back to equipment and funding and staff, but we did not see any of that money."⁵⁸

When the hospital shuttered in late June, hospital representatives said that workers would receive pay and health insurance through August 20 and compensation for up to 80 hours of unused vacation pay. However, former workers claim that they have not been paid what they were promised.⁵⁹

In 2021 Lateral sold the hospital's real estate in a sale-leaseback transaction to Broadstone Net Lease, a real estate investment trust (REIT), for \$60 million.⁶⁰

Further details about the hospital's finances are unavailable, though community members and former workers are also calling for a forensic investigation into the company.

Lateral Investment Management is a new private equity fund, founded in 2014. SCVRH appears to be its first and only foray into healthcare investing; its portfolio is primarily comprised of manufacturing and technology companies.⁶¹



Little River Healthcare—True Health Group, The Riverside Company, Monroe Capital

Little River Healthcare, a rural health system in Texas, permanently shuttered in 2018 after filing for bankruptcy earlier that year, citing an inability to pay its bills. The bankruptcy occurred amid investigations surrounding a billing scheme involving a lab testing company Little River contracted with, True Health Group (THG). THG filed for bankruptcy the following year. Both companies were owned by private equity firms at the time of their bankruptcies.

Little River’s hospitals reportedly had unusually high lab charges in the years leading up to its bankruptcy. According to Modern Healthcare, in 2016 its flagship critical access hospital billed \$372 million for outpatient labs—86% of its total bills that year.⁶²

Little River shuttered all its facilities permanently in December 2018 after filing for bankruptcy several months before.⁶³ At the time of the closure, Little River operated the only acute-care hospitals in Rockdale and Cameron, Texas. It had 600 employees.⁶⁴

THG filed for chapter 11 bankruptcy in 2019 after CMS suspended Medicare payments to the company.⁶⁵ In the bankruptcy proceedings, lawyers for the U.S. Department of Health and Human Services claimed that True Health was trying to use chapter 11 unfairly to thwart the government’s pursuit of fraud.⁶⁶

True Health had been operating under a partial suspension from Medicare dollars dating back to 2017 that was related to a whistleblower suit. In 2019 CMS fully suspended Medicare payments to True Health citing “recent credible allegations of fraud.”⁶⁷

True Health served about 335,000 patients per year at the time of the bankruptcy, 65,000 of them Medicare beneficiaries. Those patients accounted for about 30% of True Health’s revenue.⁶⁸

In 2022 the US Department of Justice filed a complaint against THG for Medicare fraud. The [government alleges](#) that laboratory executives and employees of True Health Diagnostics conspired with Little River Healthcare to pay physicians to refer patients to hospitals for laboratory testing.⁶⁹

Private Equity Ownership

Both Little River Healthcare and True Health Group were owned by private equity firms.

Private equity firm Riverside Company acquired a stake in THG in January 2017.⁷⁰

In April 2015 Monroe Capital provided a \$36.8 million senior credit facility to Little River Healthcare, recapitalizing the company.⁷¹ In 2017 Monroe invested again, increasing its total equity ownership in the company to 18%.⁷²

Monroe Capital also owned a stake in THG alongside Riverside Co. In 2017 Monroe provided a \$125 million credit facility that included “recapitalization and minority investment” at the same time as the Riverside investment.⁷³

Monroe continued to report profits on its loans to Little River even after it went bankrupt and liquidated. In 2017, Monroe listed the value of its investment in Little River (aka Rockdale Blackhawk LLC) as \$21.742 million. In 2019, after the bankruptcy, the value was listed as \$29.538 million.⁷⁴

Noble Health—Nueterra Capital

In June 2022, Kaiser Health News (KHN) [released a damning investigation](#) of private equity-backed Noble Health, a startup company that purchased two struggling hospitals in Missouri: Audrain Community Hospital and Callaway Community Hospital. Noble was backed by Nueterra Capital, a venture capital and private equity firm.⁷⁵

Employees reported to KHN that Noble’s owners were not paying for supplies and drugs needed to properly care for patients.⁷⁶ In a separate [article](#), KHN reported that in one of the hospitals, “state inspectors determined that conditions in the hospital endangered patients.”⁷⁷

According to KHN, “Noble acquired the hospitals after charming local leaders desperate to save beloved local institutions. And federal regulators did nothing to block or thoroughly vet the acquisition, despite red flags.” A local attorney quote in the article claims Noble was the only bidder for Audrain.⁷⁸

KHN’s report indicates that “Noble kept hospital operations and real estate assets separate,” in line with the common private equity tactic of asset-stripping struggling hospitals of their real estate. The CEO of Nueterra Capital, Jeremy Tasset, told KHN that “we are a minority investor in the real estate and have nothing to do with the operations of the hospitals.”⁷⁹ It is unknown at the time of publication if the real estate has been sold to a REIT.

After closing services at both hospitals in and furloughing most of the staff, Noble sold them for only \$2 alongside a stock transfer to Texas-based Platinum Neighbors in April 2022. Platinum assumed all liabilities, which one individual interviewed by KHN estimates to be between \$45 and \$50 million dollars.⁸⁰

Since acquiring the hospitals, Platinum has terminated all remaining staff. The hospitals remain closed, and Platinum has made repeated requests to the state of Missouri to extend the deadline to reopen them.⁸¹

KHN's extensive reporting on Noble Health and the fate of the hospitals they acquired and then closed can be accessed [here](#) and [here](#).

Ardent Health Services—Equity Group Investments

Ardent Health Services is a Tennessee-based hospital system with 30 hospitals in Texas, Oklahoma, Idaho, Kansas, New Mexico, and New Jersey.⁸² It is owned by private equity firm Equity Group Investments (EGI).⁸³

A federal investigation in 2020 found that Ardent-owned Lovelace Women's Hospital in Albuquerque violated patients' rights by singling out pregnant Native American women for COVID-19 testing and separating them from their newborns without adequate consent until test results became available.⁸⁴

New Mexico In Depth and ProPublica reported that the hospital had targeted Native American mothers for COVID-19 testing based on their tribal-area ZIP codes. According to ProPublica, "The practice, while meant to stop the spread of COVID-19, was described by clinicians and health care ethicists as racial profiling."⁸⁵

The hospital did not admit to any wrongdoing but reported that the practice has been halted.⁸⁶

According to CMS, "Black, American Indian, and Alaska Native women experience worse maternal health outcomes compared to non-Hispanic White women, and these disparities are compounded by limited access to high quality obstetric care in rural communities."⁸⁷

EGI acquired Ardent in 2015 from healthcare REIT Ventas, which had just acquired Ardent from private equity firm Welsh, Carson, Anderson & Stowe for \$1.75 billion. Ventas immediately separated Ardent's hospital operations from its real estate by selling its hospital operations to EGI for \$475 million while retaining the real estate. EGI entered into a long-term master lease with Ventas with an initial base rent of \$100 million and Ventas retained 9.9 percent interest in hospital operations.⁸⁸

Ardent filed to go public in 2018 but later scrapped the plan. According to its 2018 IPO registration filings, Ardent had substantial liabilities, at more than \$2 billion as of December 31, 2018, and just \$60 million in cash, suggesting liquidity risk.⁸⁹



Steward Healthcare—Cerberus Capital Management

Steward Healthcare was owned by private equity firm Cerberus Capital Management from November 2010 until May 2020.⁹⁰ Steward owns dozens of hospitals in nine states, including at least seven hospitals that serve rural communities in Arizona, Arkansas, Florida, Pennsylvania, and Texas.⁹¹

Cerberus' exit from Steward made headlines after it quadrupled its investment in the company through a series of complicated transactions that stripped some of its hospitals of their real estate. For example, in 2016 Steward sold the real estate for five of its hospitals to the REIT Medical Properties Trust (MPT) for \$600 million and leased them back. Steward said the deal helped it pay down debt, but \$484 million of the proceeds from the deal went to Cerberus and its investors.⁹²

One of the hospitals whose real estate was sold was Easton Hospital in Easton, PA, a safety net hospital that also serves as a rural referral center (RRC). As a result of the 2017 real estate sale, the Easton hospital was forced to pay millions of dollars in annual rent on property it previously owned.⁹³

Then at the onset of the COVID-19 pandemic, Steward threatened to close the hospital unless the state of Pennsylvania gave it a \$40 million bailout to remain open. The state ultimately provided \$8 million to keep Easton open through April 30 due to fears about not having enough capacity to deal with the expected COVID-19 surge.⁹⁴ The following month, Cerberus offloaded its stake in Steward to a group of physicians and walked away with \$800 million profit from its investment.⁹⁵ Steward sold Easton Hospital to a non-profit in July 2020.⁹⁶



PART II: Private Equity Looks to Other Rural Health Services

Key Points:

- Private equity investment in rural healthcare extends far beyond hospitals:
 - ◆ Emergency care & transport: Envision Healthcare, owned by KKR, is a physician staffing firm with a large rural footprint. Envision is one of two companies that have been drivers of the surprise medical billing problem in the U.S. Two private equity firms, American Securities and KKR, control nearly two-thirds of the national market for air ambulances, which poses a unique threat to rural healthcare. Private-equity-owned air ambulances have been found to receive higher payments, generate larger and more frequent surprise bills.
 - ◆ Medical staffing: Rural hospitals around the country are battling pronounced shortages of critical medical staff, including physicians and nurses. Private equity firms are actively acquiring medical staffing firms, particularly during the pandemic. 2021 was a record year for private equity M&A of medical staffing companies.
 - ◆ Behavioral health: Private equity has recently been active in addiction treatment, for which there has been increased demand in rural areas. Several of the largest and fastest-growing Private-equity-owned behavioral health providers have a significant presence in rural areas.
 - ◆ Hospital management & consulting
 - ◆ Case study: QHR Healthcare
- [Click here](#) to view a list of Private-equity-owned rural healthcare companies

From creating dedicated investment funds targeting rural health to buying up and merging smaller rural health providers into industry giants, private equity firms are making significant inroads into rural health investing through a variety of strategies.

The American Investment Council, the primary lobbying group for the private equity industry, published a report in March 2021 touting private equity's role in increasing health access in rural communities. AIC writes: "Usually under the radar, PE firms have been leading the charge on rural health care expansion."⁹⁷

Indeed, private equity investment in rural healthcare extends far beyond hospitals. Firms have actively bought or created investment platforms focused on rural urgent care (e.g., Xpress Wellness Urgent Care—LatticeWork Capital Management⁹⁸) physicians' groups (e.g., Rural Physicians Group—Sorenson Capital, Leavitt Equity Partners⁹⁹), dental care (e.g., Spark Dental Management—Rock Mountain Capital¹⁰⁰), renal care (e.g., Sanderling Renal Services—Pharos Capital Group¹⁰¹) and others.

Some private equity firms have set their sights on rural healthcare investing through dedicated investment vehicles. For example, in December 2020 Revelstoke Capital Partners raised \$111 million for a fund dedicated solely to rural healthcare investment, Revelstoke Single Asset Fund II L.P.¹⁰² Pharos Capital Group, a healthcare-focused private equity firm, touts having invested over \$180 million specifically into rural markets.¹⁰³

In 2019 the Audax Group acquired The Chartis Center for Rural Health (aka the Chartis Group), a consulting firm focused on rural healthcare investing, from another private equity firm, RLH Equity Partners.¹⁰⁴ In addition to conducting rural health research and consulting, Chartis bills itself as a "leading advisor to healthcare-focused private equity (PE) firms and investor-backed platforms. From inception to exit, our dedicated PE Advisory Practice is purpose-built to help you uncover and realize untapped value in healthcare services and technology investments."¹⁰⁵

Part I of this report focused on private equity-owned rural hospitals. Part II of this report will examine several other key areas of rural healthcare that have seen significant investment by private equity firms: emergency care, medical staffing, behavioral health, and hospital management and consulting services. At the end of this section we also provide a list of private-owned-companies that specialize in rural health, which we hope will provide a roadmap for future study.

Emergency Care

Emergency Department Staffing

Emergency medicine is attractive to third party physician staffing groups because “it is episodic care requiring minimal follow-up and is well compensated in the US clinical reimbursement system,” according to a 2021 research study on healthcare outsourcing.¹⁰⁶ The same study claims that two thirds of emergency departments “use some form of outsourcing.”¹⁰⁷

Envision Healthcare (owned by private equity firm KKR since 2018) is one of the largest physician staffing firms in the U.S. and has a considerable rural footprint. As of 2019, Envision had 100 emergency medicine hospital contracts in its rural hospital division, with average annual emergency encounters at each hospital approximately 10,250.¹⁰⁸

Envision Healthcare is one of two private equity-backed companies (the other being TeamHealth, owned by Blackstone) that have played a prominent role in America’s surprise medical billing problem. Surprise medical billing occurs when a patient goes to a hospital that is in-network with their insurance plan, but receives treatment from out-of-network providers.¹⁰⁹

In 2017, a group of Yale researchers found that when Envision “enters into a new contract to manage a hospital’s ED services, they immediately exit networks, bill as out-of-network providers, and seek to collect their charges (which they also raise by 96% relative to the charges billed by the prior physician group in that hospital).”¹¹⁰

When KKR acquired Envision in 2018, the company was already under scrutiny for its surprise billing practices that left patients with unaffordable medical bills.¹¹¹ After legislation was introduced to help protect patients from surprise billing in 2019, Envision and TeamHealth funded a dark money campaign to stymie the legislation. By April 2020, they had spent over \$57 million on this campaign to preserve their ability to impose surprise medical bills.¹¹²

Emergency health care is characterized by inelastic demand, meaning that when prices change demand remains the same.¹¹³ That is because people cannot plan for a health emergency and price shop ahead of choosing a provider. In many rural communities there are even fewer options for emergency care, and therefore the emergency department where one ends up may have a great deal of leverage to charge higher than average prices.

KKR’s investments in emergency staffing groups, as well as in emergency transport (both ground and air ambulances, as explored in the next section) suggest a business strategy that leverages the inelastic demand of emergency care to generate outsized profits.

In a 2019 op-ed about solving the surprise medical billing issue, Judy Baker, a professor of healthcare administration at NYU, explained that “Surprise billing has a particularly debilitating impact on the most vulnerable, hard-to-reach patient populations, including those living in rural parts of our country.”¹¹⁴ One study published in 2020 in JAMA found that nearly a third of rural adults had issues paying their medical bills.¹¹⁵

Emergency Transport

Private equity firms dominate the air ambulance industry, which poses a unique threat to rural healthcare. Air ambulances fill a critical gap in healthcare delivery in rural areas, particularly in areas that lack advanced-care facilities like trauma centers. As of 2018 a quarter of Americans, or 85 million people, were estimated to be unable to access healthcare in less than an hour of travel time without an air ambulance.¹¹⁶

Air ambulances are lightly regulated and highly profitable, making the industry an attractive target for private investment. Until 2002, air ambulances were primarily owned by hospitals. This changed when Medicare created a national fee schedule for the industry which substantially increased the Medicare reimbursement for helicopter ambulances, particularly in rural areas.¹¹⁷ The increase in potential revenue resulted in an explosion of investment in the industry and led to an oversupply of air ambulances; between 2002 and 2008 the number of air ambulances more than doubled. Then, in the five-year period from 2012 to 2017, providers established more than a hundred new helicopter bases. Utilization and demand for air ambulances did not increase at a comparable rate, so providers began to drive up prices per patient to recoup the high fixed costs of operating air ambulances.¹¹⁸

Two private equity firms, American Securities and KKR, controlled nearly two-thirds of the national market for air ambulances as of 2017.¹¹⁹ American Securities acquired Air Methods in 2017¹²⁰ and KKR acquired Air Medical Resource Group in 2015.¹²¹

A 2021 white paper from the USC-Brookings Schaeffer Initiative for Health Policy found that private equity-owned air ambulances receive higher payments:

“We find that allowed amounts for helicopter air ambulance transports from providers owned by private equity or publicly-traded parent companies are significantly more expensive than rides carried out by other providers, with standardized allowed amounts (including both in-and out-of-network rides) averaging \$32,051 (5.6 times what Medicare would have paid) in the years 2016–2017...This amount was nearly 60% higher than the standardized average allowed amount for rides provided by hospitals, nonprofits, and independent companies of \$20,146, which was still 3.5 times what Medicare would have paid.”¹²²



The Brookings report also found that Private-equity-owned air ambulance companies are substantially less likely to be in-network (with 89% of their transports from 2014-2017 out-of-network) and, as a result, have a higher prevalence of surprise medical bills. The authors estimate that 55% of all helicopter transports delivered by private equity and publicly-traded carriers had the potential to result in a balance bill in 2017, compared with 29% of transports from hospital, nonprofit, and independently-owned providers.¹²³

Surprise medical bills by Private-equity-owned air ambulance companies are also significantly more expensive. Between 2014 and 2017 the size of surprise bills by private equity or publicly-traded companies providers grew more than 50%, reaching an average of \$26,507 in 2017.¹²⁴

Travel Nursing

Historically, rural hospitals around the country have battled shortages of critical medical staff, including physicians and nurses.¹²⁵ In fact, rural areas accounted for a majority of federally designated Health Professional Shortage Areas as of March 2022, which include shortages of primary care (66%), dental health (67%), and mental health practitioners (61%).¹²⁶ However, rural health staffing issues have become amplified during the COVID-19 pandemic,¹²⁷ with some hospitals experiencing staffing shortages so severe that they are making the difficult decisions to close units that may be essential to a rural community, such as labor and delivery.¹²⁸

Travel nursing has become particularly lucrative for both staffing companies and nurses. Heightened demand for nursing staff around the nation as well as the federal covid relief monies that could be used to subsidize the increasing cost of labor at hospitals has made it possible for travel nurse agencies to charge unprecedented rates to hospitals for the temporary nurses they supply.¹²⁹ Michael Topchik, of healthcare research and advisory firm the Chartis Center for Rural Health, told Fierce Healthcare in August 2022 that “It’s an arms race a rural hospital cannot win. They just don’t have the competitive clout.”¹³⁰

Since the pandemic began, some travel nurses have been able to make double to triple the money that staff nurses are making. For nurses in critical care, they can make even more.¹³¹ As such, nurses in rural hospitals, who “on average make \$4,000 less each year than their urban counterparts,”¹³² have a major financial incentive to take up travel nursing. According to a recent survey by the Chartis Center, 48% of nurse staff departures from rural hospitals are due to “financially lucrative opportunities at nurse staffing agencies.”¹³³

A positive feedback loop arises for rural hospitals due to the increased demand and higher pay for travel nurses: 1) permanent nursing staff are incentivized to leave their roles for traveler positions and 2) hospitals then need to rely on expensive travel and temporary labor contracts to fill the gaps, which is unsustainable in the long run for under-resourced rural hospitals. In July 2022, Becker's Hospital Review reported that "Memorial Hospital of Carbon County in Rawlins, Wyo., ended labor and delivery services June 15 [2022] amid staffing shortages. The hospital was spending \$100,000 a week on travel nurses after losing five nurses in the labor and delivery department. Eliminating labor and delivery services will help the hospital alleviate financial pressure, a spokesperson told Wyoming Public Radio."¹³⁴

While hospitals (rural and urban, alike) have struggled with staffing issues during the pandemic, private equity firms have seen opportunity in the surge in travel nursing demand.¹³⁵ 2021 was a record year for private equity acquisitions in medical staffing, with private equity firms acquiring and sometimes consolidating medical staffing agencies of various types.¹³⁶ Two of the largest¹³⁷ healthcare staffing companies are Private-equity-owned: CHG (Leonard Green & Partners, Ares Management) and Medical Solutions (Centerbridge Partners, CDPQ, Beecken Petty O'Keefe & Company).¹³⁸

For rural hospitals that already face chronic staffing shortages, the increased cost of temporary healthcare labor that can be traced to travel nurse and other medical staffing agency rate hikes can be financially devastating. As of this writing, some Members of Congress have called for an investigation into travel nurse agencies over inflated pricing, although the Biden administration has not confirmed if an investigation is occurring.¹³⁹

In June 2022, Senator Kevin Cramer (R-ND) also introduced the Travel Nursing Transparency Study Act bill which would compel a government investigation, if passed. The bill specifically calls for an investigation into private equity investment in travel nursing and its impacts on profits.¹⁴⁰

Behavioral Health

Private equity firms have been actively buying up behavioral health companies ranging from mental health to addiction treatment in recent years, capitalizing on increasing demand, expanded coverage, and a fragmented market. In 2021 the number of behavioral health acquisitions jumped more than 35% to 153 versus the previous year, and of those, 123 involved private-equity firms. In the first quarter of 2022, private equity firms were responsible for 30 of 41 total behavioral health acquisitions.¹⁴¹

However, private equity firms have a troubling track record in investing in behavioral health where cost-cutting tactics at such as reducing staff, relying on unlicensed staff, and failing to maintain facilities have been shown to create harmful outcomes

for patients.¹⁴² See our reports on private equity in behavioral health: [The Kids Are Not Alright: How Private Equity Profits Off of Behavioral Health Services for Vulnerable and At-Risk Youth](#) (February 2022); [Understaffed, Unlicensed, and Untrained: Behavioral Health Under Private Equity](#) (September 2020).

There is a pronounced need for behavioral health services in rural areas. From 1999 through 2019, drug overdose deaths in rural counties increased from 4.0 per 100,000 to 19.6 per 100,000. In 2019, drug overdose death rates in rural counties were higher than urban rates in five states, including California, Connecticut, North Carolina, Vermont, and Virginia.¹⁴³ In 2017, half of rural U.S. residents and 74 percent of farmers and farm workers said they had been directly impacted by opioid abuse.¹⁴⁴



A survey published in 2022 found that 52% of rural adults were experiencing more stress and mental health challenges than a year earlier and are seeking mental health care due to increased stress.¹⁴⁵ One 2022 literature review found suicide rates in rural areas were higher than urban areas. Possible explanations offered by the researchers included social isolation, easier access to lethal means, stigmatization towards people with mental health problems, and reduced supply of mental health services.¹⁴⁶

While rates for mental illness and most psychiatric disorders are similar between rural and urban areas,¹⁴⁷ adults living in rural areas receive mental health treatment less frequently than those residing in urban areas.¹⁴⁸ One study, based on 2015 data, found 65% of rural counties lacked a psychiatrist (compared to 27% of urban counties), 47% of rural counties lacked a psychologist (19% for urban counties), and 81% lacked a psychiatric nurse practitioner (42% for urban counties).¹⁴⁹ A study published in 2021 found that the median driving time to the nearest opioid treatment provider was 61 minutes in rural areas compared to 12 minutes in urban areas.¹⁵⁰ Additionally, more than 60% of designated mental health provider shortage areas are in rural areas.¹⁵¹

The mental and behavioral healthcare industry is highly fragmented and lacks scale, making the area attractive for private equity consolidation.¹⁵² Other factors that may drive investment include the increased demand for behavioral health during the pandemic, reduced stigma around mental health treatment, and strengthened commitment from employers to support employee mental health.¹⁵³ There is growing interest from payers around clinical outcome data and cost savings data, which can increase understanding around returns on investments. Additionally, recent regulations have allowed providers higher reimbursement for telehealth services.¹⁵⁴

Some of the largest behavioral healthcare and addiction treatment networks serving rural areas are owned by private equity firms.

For example, Behavioral Health Group (BHG) is among the largest networks of opioid treatment and recovery centers in the US¹⁵⁵ and has been owned by a series of private equity firms since it was created as a platform company by VantageCap Partners in 2006.¹⁵⁶ It was acquired in 2011 by private equity firms Frontenac and the Cambria Group, which then sold the company in 2018 to The Vistria Group, another private equity firm. At the time, BHG had more than 50 treatment centers in twelve states.¹⁵⁷ The company grew substantially over the following years, adding 36 locations in 2021, and had 117 locations in twenty-four states at the beginning of 2022.¹⁵⁸

Colonial has been owned by private equity firm Warwick Capital Group since at least 2001.¹⁵⁹ The company has rebranded as New Season, and as of 2022 operates more than 80 addiction treatment centers in 20 states.¹⁶⁰ The acquisition illustrates the challenge PE firms have had in identifying high-quality, ethical addiction treatment providers.¹⁶¹

In 2015 Colonial shut down a treatment center in Duluth after the state revoked its license. The location's license was revoked in 2012 due to dozens of violations but remained open for three additional years during the appeals process. The clinic had been the only methadone provider in the area until a new clinic was opened that year.¹⁶²

Concerns about Warwick-owned Colonial/New Season go back at least a decade. In 2013, a Colonial facility in Alabama agreed to pay a \$95,000 penalty to the U.S. Department of Justice for numerous record-keeping violations related to its inventory of controlled substances.¹⁶³ That same year, reports analyzed in a local investigative reporting article indicated that a Minnesota methadone clinic run by Colonial had caseloads two to three times higher than what were allowed under state regulations.¹⁶⁴

In that New Hampshire, health officials and health inspector records from 2014 show that Colonial loaded clinics with high patient numbers, raised methadone doses above federal recommendations, and continued dosing clients who tested positive for other drugs.¹⁶⁵ Another facility north of Wilmington, NC was also cited by the state Department of Health and Human Services in 2017 for improper training and hiring procedure, failure to provide adequate counseling to patients, as well as structural and maintenance issues.¹⁶⁶

In addition to Vistria-owned BHG and Warwick-owned New Season, other private equity firms are cashing in on behavioral health companies with rural footprints.

BayMark, which brands itself “the largest specialty healthcare organization in North America addressing the opioid crisis”,¹⁶⁷ is owned by private equity firms Webster Capital Partners¹⁶⁸ and BPEA Private Equity.¹⁶⁹ In early 2022, BayMark acquired Kaden Health, an online addiction treatment platform offering treatment for opioid use disorder. The acquisition is reportedly part of a plan to expand BayMark’s reach to more rural areas where it is hard for patients to access treatment in facilities.¹⁷⁰

Additionally, Apollo Global Management-owned rural hospital chains LifePoint Health and ScionHealth (profiled in Part I) are substantially expanding their presence in behavioral health.

In August 2022, LifePoint announced it will acquire psychiatric hospital chain Springstone.¹⁷¹ Springstone operates 18 behavioral health hospitals and 35 outpatient locations in nine states: Arizona, Colorado, Indiana, Kansas, North Carolina, Ohio, Oklahoma, Texas, and Washington.¹⁷² Springstone is currently owned by healthcare REIT Medical Properties Trust (MPT), which will continue to own and lease the real estate to the hospitals.¹⁷³ MPT had acquired Springstone from private equity firm Welsh, Carson, Anderson, & Stowe (WCAS) in June 2021 and separated out the real estate from the operating business.¹⁷⁴ WCAS created Springstone in 2010 as a single newly constructed psychiatric hospital and has constructed each new facility since.¹⁷⁵

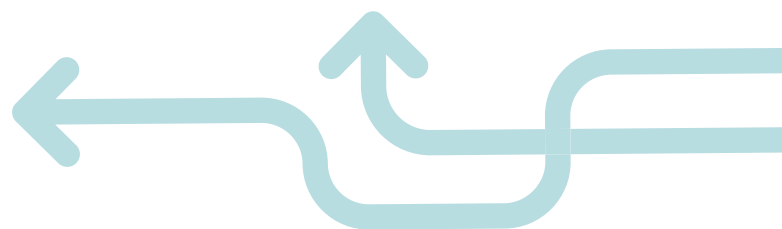
The acquisition is a significant expansion of LifePoint’s behavioral health services, which currently includes 30 behavioral health units in various community hospitals and three inpatient behavioral health facilities in Texas and Washington.¹⁷⁶

Looking Ahead in Rural Behavioral Health

Though there is a pronounced need for increased investment in behavioral health services in rural areas, it should not come at the cost of care. Private equity has a track record of cost-cutting that has led to understaffing, untenable caseloads for clinicians, and failing to adequately train staff or maintain facilities. The industry’s growing interest in behavioral health, including in rural behavioral health, merits scrutiny.

Hospital Management Companies

Hospital management and consulting companies can provide an avenue for private equity firms to harvest profits from nonprofit and public healthcare providers. QHR Health, owned by private equity firm Grant Avenue Capital since 2021, focuses on independent and rural hospitals.¹⁷⁷



Case study: QHR Health

QHR Health is a hospital management and consulting company that markets itself specifically to community and rural hospitals.¹⁷⁸ On its [website](#), QHR calls itself the “largest hospital management firm in the U.S.” and says that its hospital management and advisory services have served 700 clients with an average client tenure of 21 years. It currently has hospital management clients across 33 states,¹⁷⁹ and 105 multi-year hospital clients across 40 states, overall.¹⁸⁰ Its other services include:

- revenue cycle management (i.e. bill collection) through its company, [ResolutionRCM](#)
- its \$1.1 billion purchasing network through its company, [PLUS](#)
- marketing (which QHR calls “patient outreach”)¹⁸¹
- IT services and consulting¹⁸²

Private equity firm Grant Avenue Capital acquired QHR Health from Quorum Health Corporation in June 2021.¹⁸³ Many of the clients QHR is working with now are clients it had before the acquisition.

The case studies involving QHR’s management of rural hospitals around the country discussed below raise questions about the relationship between for-profit hospital management companies with their nonprofit clients, and how private equity ownership may impact these relationships further.

Montrose Regional Health—Montrose, CO

In Montrose, Colorado, QHR had a 30-year relationship with the local hospital, Montrose Regional Health.¹⁸⁴ In tax year 2020, the [hospital paid QHR \\$913,561](#) for a hospital management contract, which included management fees and the cost of a CEO and CFO to whom QHR paid salaries.

In 2020, the hospital ended the relationship and hired a nonprofit hospital management company.¹⁸⁵ QHR has since partnered with a venture capital firm, Colorado Outdoors, LLC, to construct an ambulatory surgery center in the community that is slated to open in 2023.¹⁸⁶ [Velocity Surgical Management](#), one of QHR’s subsidiaries, will manage the center.¹⁸⁷ This center will be in direct competition with Montrose Regional Health, which is also opening an ambulatory care center. While the CEO of QHR, Dr. Dwayne Gunter, maintains that their outpatient center will not be a threat to the local hospital and may even help prevent a “larger entity from coming to set up an inpatient care facility,” the Montrose Regional Health board does not share that view. The board president, Kjersten Davis, told the Montrose Daily Press in March 2022 that “having a duplicate service in the same town threatens everyone’s ability to offer health care at the cheapest price.”¹⁸⁸ According to Davis, competition is not always a good thing in a “certain size market,” because if volumes are too low, then the providers “tend to raise prices.”¹⁸⁹

The hospital's CEO, Jeff Mengenhause, published an editorial in the Montrose Daily Press less than a month later. He wrote:

"We have a different point of view on how the medical clinic being proposed by the national firm QHR in the Colorado Outdoors area will affect Montrose Regional Health and your care providers. Since QHR is a for-profit entity, they need to generate revenue to support their national shareholders. Are they going to accept every patient regardless of their ability to pay? Are they going to be here to support the local events, give back through a health fair, support your children's sports' team? What is their motive for coming to Montrose?... QHR can choose to offer only the services that receive the highest reimbursement and gather those patients to make a profit, while we need all of the services to properly care for our communities."¹⁹⁰

Both the hospital's and QHR's ambulatory surgery centers are in the construction phases, with QHR's expected to open first.¹⁹¹

QHR's decision to remain in a rural community after the local hospital ended its contract with the firm, and to then go on and compete with the hospital despite QHR's considerable financial advantage as a large, national company backed by private equity deserves further scrutiny.

Springfield Hospital—Springfield, VT

In Springfield Vermont, QHR entered into a management contract in 2018 with the local hospital.¹⁹² QHR continued to collect management and contract fees even as the hospital cut services and filed for bankruptcy in June 2019.¹⁹³

During that year, the hospital paid \$845,536 to QHR for management services, which includes compensation for a CEO and CFO. In its 2020 990 form, the hospital claims it was not aware of the amount of compensation paid to the CEO and other executives by QHR.¹⁹⁴

A local newspaper reported in 2020 that QHR was costing the hospital over \$100,000 per month even as the hospital had filed for bankruptcy.¹⁹⁵

Under QHR's leadership from 2019–2021, Springfield Hospital closed its Childbirth center and reduced the workforce.¹⁹⁶ Despite these cuts and a state bailout, Springfield Hospital is still experiencing financial woes.¹⁹⁷ QHR continued to [advertise Springfield Hospital as a success story on its website at the time of publication](#).¹⁹⁸

Profiting from nonprofits

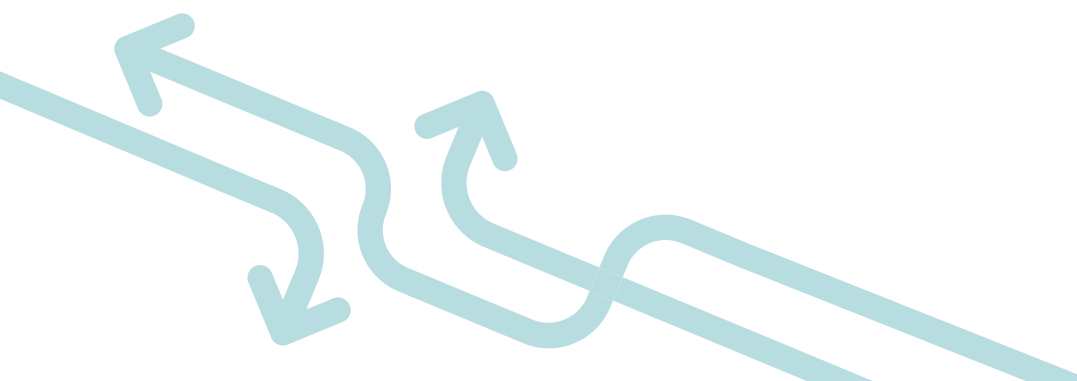
Struggling rural hospitals often decide it is necessary to bring in consultants and management groups to help achieve financial solvency. Healthcare administration is often mired with excessive bureaucracy and regulatory complexity, and so many hospitals can and do benefit greatly from hiring experts to help.



However, achieving financial solvency is not always in alignment with community needs. Oftentimes it involves layoffs, closing lines of service that do not produce revenue but are important nonetheless (e.g. labor and delivery), and adding lines of services that are profitable but not necessarily a community need (like sleep study services).

QHR has subsidiary companies and additional services that many of its clients end up contracting with or paying for. Through these services, QHR can offer economies of scale¹⁹⁹ Yet, as a hospital management company, it is not subject to the same legal or regulatory antitrust scrutiny as a hospital chain.

The fact that a for-profit (and now private equity-owned) hospital management company has a business model that relies on extraction of revenues from nonprofit, oftentimes struggling critical access and rural hospitals, is cause for concern and warrants further scrutiny.



Private-equity-owned Rural Health Companies

The following is a list of companies currently owned by private equity firms that either explicitly operate rural-oriented healthcare companies or have substantial operations in rural areas. Most have multiple locations across multiple states and regions. Because private equity firms largely operate in the shadows with few reporting requirements, even in healthcare investments, it is not possible to know the extent to which private equity firms have bought up rural health providers—this list provides a sampling of companies, but the complete list is likely far greater.

Private-equity-owned Rural Healthcare Companies

Company	Type	PE Firms	Date Acquired	# of Locations	States
Air Methods	Air ambulances	American Securities	Apr-17	N/A	N/A
Altius Healthcare Management	Dental	Bridges Fund Management	Feb-21	30	TX
Angel MedFlight	Air ambulances	Vistria Group, WP Global Partners	Jun-14	N/A	N/A
Ardent Health Services	Health system	Equity Group Investments	Aug-15	36	OK, TX, NJ, NM, KS, ID
Azalea Health	Health tech	LLR Partners	Apr-21	N/A	N/A
Barnet Dulaney Perkins, Southwestern Eye Center	Eye care	H.I.G. Capital	Apr-17	40	AZ
ClearSky Health	Rehab hospitals	Blue Wolf Capital Partners, Leavitt Equity Partners and Peloton Equity	Apr-19	16	AZ, NM, TX, , MO, LA, FL, MI, OH
Code 3 Emergency Partners	FSED, urgent care	Morgan Stanley Credit Partners	Oct-17	N/A	N/A
Community Care Partners (SouthStar Urgent Care)	Urgent care	Shore Capital Partners	Oct-17	70	OR, WA, MT, CO, WY, LA, TX
Community Dental Partners	Dental	Boathouse Capital	Aug-15	70	TX, IN, GA

Company	Type	PE Firms	Date Acquired	# of Locations	States
Concentra	Urgent care	Welsh, Carson, Anderson & Stowe, Select Medical	Mar-15	520	AR, AK, AZ, CA, CO, CT, DE, FL, GA HI, IA, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, NC, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, TN, TX, UT, VA, VT, WA, WI
Critical Health Connection	Medical staffing	Apogee Equity Partners	May-18	N/A	N/A
Emerus Hospital Partners	Micro-hospitals	Welsh, Carson, Anderson & Stowe	Sep-15	39	TX, OK, NV, WA, PA, WI, WV
Ernest Health	Rehab hospitals	One Equity Partners	Oct-18	32	AZ, CA, CO, ID, IN, MT, NM, OH, SC, TX, UT, WY
Fast Pace Health Urgent Care	Urgent care	Revelstoke Capital Partners		200	TN, KY, LA, MS, IN, AL
FastMed Urgent Care	Urgent care	Abry Partners and BlueMountain Capital	May-15	200	AZ, CA, NC, TX, FL
Guardian Flight (Air Medical Resource Group)	Air ambulances	KKR	Apr-15	N/A	N/A
inReach Health (fka Rural Partners in Medicine)	Medical staffing	Latticework Capital Management	Jul-18	N/A	N/A
Legacy Hospice Holdings	Hospice	Prairie Capital	Dec-19	21	AL, AR, LA, MS, MO, OK, TN
LifePoint Health	Health system	Apollo Global Management	Nov-18	265	AL, AZ, AR, IN, IA, KY, MI, MT, NV, NM, NC, OR, PA, TN, TX, UT, VA, WA, WV
MainStreet Family Care	Rural and pediatric healthcare centers	Trinity Hunt Partners	Sep-20	38	AL, FL, GA, NC

Company	Type	PE Firms	Date Acquired	# of Locations	States
Med First Primary & Urgent Care	Health clinics, urgent care	Sverica Capital Management and Cadiz Capital	Aug-16	21	NC, SC
QHR Health	Hospital management	Grant Avenue Capital, Nashville Capital Network, and Brentwood Capital Partners	May-21	N/A	N/A
Quorum Health	Health system	GoldenTree Asset Management, Davidson Kempner	May-20	21	AL, AR, CA, GA, IL, KY, NM, NV, NC, OR, TX, UT, WY
Renal Care 360°	Renal care	Pharos Capital Group	Sep-22	6	TN, GA, SC
Rural Physicians Group	Medical staffing	Sorenson Capital, Leavitt Equity Partners	Apr-15	N/A	N/A
Sanderling Renal Services	Renal care	Pharos Capital Group	May-22	15	CA, TN, CO, UT, NV, OK
ScionHealth	Health system	Apollo Global Management	Dec-21	158	CA, WA, NV, ID, WY, CO, NM, TX, OK, MO, IL, WI, IN, OH, KY, TN, WV, NC, SC, GA, AL, FL, MS
SGA Dental Partners	Dental	Thurston Group	Mar-22	60	AL, GA, LA, MS
Spark Dental Management	Dental	Rock Mountain Capital	Apr-21	70	PA, TN, GA, VA, NJ, DE, IN
Thema Health Services	Hospice	Pharos Capital Group	Oct-21	N/A	AZ
ValueHealth	Surgical centers	Nueterra Capital, BC Partners, Ares Management		N/A	31 states
Vantage Outsourcing	Staffing, ophthalmology	Pharos Capital Group	Oct-21	N/A	N/A
Xpress Wellness Urgent Care	Urgent care	Latticework Capital Management and BPEA Private Equity	Jul-18	43	OK, KS



PART III: Safeguarding Rural Health from Private Equity

Key Points:

- There are a number of factors that may contribute to private equity's interest in rural healthcare, including opportunities to profit from real estate sales, management and consulting partnerships that allow firms to reap substantial profits from nonprofit hospitals, regulatory flexibilities specific to rural health providers, and rural payment models and hospital designations that have the potential to be lucrative if exploited.
- Based on the current landscape of rural health and private equity's incursion into rural healthcare, we propose the following policy recommendations:
 - ◆ Increase oversight over changes in ownership
 - ◆ Place limits on sale-leaseback transactions
 - ◆ Place limits on dividend recapitalizations and extraction of fees for services not provided
 - ◆ Increase accountability for participation in certain CMS payment programs
 - ◆ Increase antitrust scrutiny
 - ◆ Expand programs that incentivize clinicians to live and work in rural areas
 - ◆ Congress should pass the Travel Nursing Agency Transparency Study Act, or similar legislation, to compel a government investigation into potential anti-competitive practices among travel nurse agencies
 - ◆ Halt programs that provide incentives and loopholes to game Medicare
 - ◆ Fund research that examines the impacts of outsourcing of services at rural nonprofit and public hospitals
 - ◆ Hold private equity firms accountable for Medicare/Medicaid fraud by portfolio companies
 - ◆ Increase oversight of hospital management companies
 - ◆ Increase public investment in rural health

Why Might Private Equity Invest in Rural Health?

Given the severe financial distress faced by many rural health providers, private equity's investing in the space may seem imprudent. However, there are a variety of strategic reasons to invest in rural health companies.

Academic research and political analyses in recent years have highlighted how rural Americans have historically been left behind by federal policymakers in an increasingly globalized economy. Consequently, the language of investing in rural America has become a bipartisan rallying cry and rhetorical tool for politicians to court the rural electorate. This rhetoric has also been leveraged by private equity and other well-capitalized groups²⁰⁰ who see profit opportunities in the bipartisan interest in rural healthcare, as well as an opportunity to deflect attention from negative impacts that private equity investment has had on cost of, quality of, and access to care.

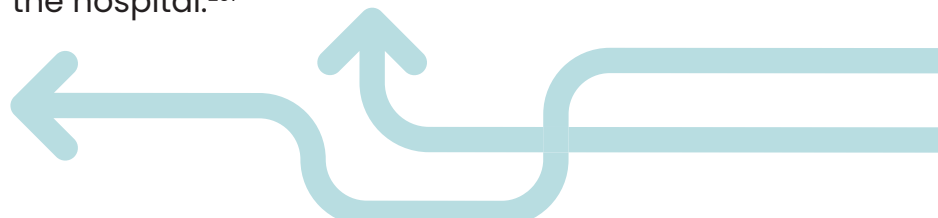
In Part III we examine the current policy and regulatory landscape impacting rural healthcare, including financial incentives for private equity investment. We then provide policy recommendations to ensure that private equity cannot exploit rural health providers at the cost of quality of care.

Struggling rural hospitals create opportunity for profit

The lack of sufficient public funding for some struggling rural hospitals creates a pressing need for capital from other sources. Many rural hospitals, with their finances in the red, must contend with closing the hospital or declaring bankruptcy if unable to find a willing buyer or source of capital to keep it afloat.

Rural hospitals on the verge of closure and/or bankruptcy may be more likely to accept offers from buyers they may otherwise have never taken if it means being able to keep the hospital open for the surrounding community. Regulators may also apply less scrutiny to such transactions if failing to approve a deal would result in the imminent closure of a hospital. Therefore, private equity firms looking to buy failing hospitals may have the leverage to get a price and terms for the deal that they would not be able to obtain otherwise—even private equity firms with little or no healthcare experience.

Part I explored a number of case studies involving private equity acquisitions of rural hospitals that illustrate the ways private equity firms have generated returns from struggling hospitals. A common strategy they have used involves asset stripping hospital real estate by selling it to a real estate investment trust (REIT) which then leases it back to the hospital. Dubbed a “sale-leaseback” transaction, this tactic can generate a quick return on investment for the firm while often contributing to financial distress of the hospital.²⁰¹



Outsourcing provides an avenue for private equity and other for-profit interests to make a buck from nonprofit and public rural hospitals

Private equity firms do not need to buy out rural hospitals in order to make profits in rural health: their portfolio companies can enter into lucrative contracts with nonprofit and public rural hospitals, allowing them to ultimately benefit from payment models, grants, and hospital designations that for-profit hospitals cannot access.

Outsourcing both nonclinical and clinical services has become increasingly common for healthcare providers in recent years. A group of researchers who examined this trend found that outsourcing clinical services, specifically those of radiology, emergency medicine, laboratory services, and environmental services, runs high risks of deteriorating quality of care for patients.²⁰² The researchers warn that outsourcing, in general, can produce cost savings in the short term, but that there are often “hidden (sometimes ballooning) costs” that often make outsourcing an unreliable strategy to save money in the longer term.²⁰³

Part II provided examples of the downsides to outsourcing rural health to private equity-owned hospital management companies, emergency physician groups, air ambulances, and more.

Regulatory flexibilities and opportunities

Stark law flexibilities

The Stark Law, officially known as the Physician Self-Referral Law, is a federal statute that “prohibits physicians from referring patients to receive ‘designated health services [DHS]’ payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies.”²⁰⁴ Designated health services include radiology, physical therapy, clinical laboratory services, and more.²⁰⁵

The Rural Provider Exception permits entities located in rural areas that “furnish substantially all (not less than 75 percent) of its DHS to residents located in rural areas” an exception under Stark Law.²⁰⁶ This exception may be attractive to investors in rural health who might otherwise be hindered by strict referral laws.

LifePoint Health, for example, includes “nonurban hospitals across 30 states and regional physician practices, outpatient centers and post-acute care providers;”²⁰⁷ based on the locations of these entities and who they serve, it is possible that some physicians in this megasystem and their investors may benefit from the Rural Provider Exception.

Some hospitals, as well as the American Hospital Association, have lobbied for even greater flexibilities and potential changes to the Stark Law and other anti-kickback and anti-fraud laws, arguing these laws may be negatively impacting rural health and hinder the transition to value-based care payment models.

In 2020, CMS issued a new rule aimed to “modernize and clarify the regulations that interpret the [Stark Law].”²⁰⁸ Nicknaming it the “Patients over Paperwork” initiative, the CMS website argues it will reduce “the unnecessary regulatory burdens on physicians.”²⁰⁹

One law firm noted this rule change (along with changes to the Anti-Kickback Statute) “may increase flexibility for private equity firms exploring opportunities in the healthcare space as well as private equity-backed healthcare platforms as they consider transactions, investment/alignment opportunities, patient engagement approaches and other business opportunities.”²¹⁰

CMS Designations

Rural hospitals and providers may also be attractive to investors, including those in hospital management companies, because of Medicare payment models and/or hospital designations that take into account factors such as rurality, volume, and number of Medicare patients served. These designations have major implications for how much hospitals receive from government payers (e.g. Medicare, Medicaid) for services.

As discussed in Part I, 85 of the 130 rural hospitals currently owned by private equity firms benefit from one of the following rural payment designations from CMS: sole community hospital (SCH), Medicare-dependent hospital (MDH), rural referral center (RRC), and critical access hospital (CAH). These designations give hospitals payment provisions that provide significant financial advantage.

On its website, private-equity-owned QHR Health (Grant Avenue Capital) advertises how it helped Jennie Stuart Health, a nonprofit hospital in Hopkinsville, Kentucky, increase its revenue by \$4.4 million over three years after helping it secure a rural health designation as well as a Medicare Sole Community Hospital Designation.²¹¹

The American Hospital Association (AHA) and Federation of American Hospitals (FAH) recently lobbied legislators to renew two hospital designations they argued are critical for the financial solvency of rural hospitals, that were both set to expire in September 2022: Medicare-dependent Hospital (MDH) and Low-Volume Hospital (LVH) designations.²¹² On September 30, 2022, Congress voted to renew these programs.²¹³

Under the direction of the Trump administration, CMS introduced a pilot payment model in 2020 for rural hospitals, called CHART (Community Health Access and Rural Transformation).²¹⁴ The Biden administration has continued this pilot program, which aims to help rural hospitals achieve financial stability, partly through “operational and regulatory flexibility.”²¹⁵ Within the original CHART model were two tracks: Community Transformation Track and the Accountable Care Organization (ACO) Transformation Track. However, the Biden administration removed the ACO track, given the fact that there are “broader efforts underway” in regard to ACOs,²¹⁶ discussed in a later section of this report.

The Biden administration has also launched a new rural provider designation slated to go into effect January 1, 2023: the rural emergency hospital (REH). According to the press release, this new designation “will provide an opportunity for small rural hospitals and CAHs to right-size their service footprint and avoid potential closure so they can continue to provide essential services for their communities.”²¹⁷ Under the REH designation, there will be an adjusted Medicare payment model and current rural hospitals, including Critical Access Hospitals, can choose to convert to this new type.²¹⁸ Functionally, the REH designation allows hospitals to offer outpatient



services while retaining status as a hospital and operating on a Medicare payment model that is more favorable than if they were to transition fully to outpatient services.²¹⁹

This new designation has the potential to keep some hospitals open that otherwise would close due to financial issues. It remains to be seen if

some Critical Access Hospitals and other hospitals offering inpatient care will be incentivized to reduce their services and convert to the REH designation to increase their revenues, even if such a change is not needed to remain financially solvent. In light of growing private equity investment in rural hospitals and in companies that provide consulting services to rural hospitals, it is important to remain vigilant of any profit-motivated conversions that could impact access to care in rural America.

Policy Recommendations

The crisis in rural healthcare extends far beyond private equity. However, the incursion of private equity investment in rural health both exploits and exacerbates weaknesses in the healthcare system.

The following policy recommendations are meant to address the extractive practices that private equity firms and similar Wall Street investors employ that can be harmful to health providers, more generally, but can particularly impact rural health providers.

Increase oversight over changes in ownership

States can require for-profit healthcare facilities to give notice to state regulators before entering an agreement or undertaking a transaction involving an asset sale or disposition, or change in control in management or governance. Non-profit healthcare facilities converting to for-profit status through acquisition must do the

same. The regulatory authority can reject, approve, or approve the transactions with conditions after review and public hearing.

Conditions on hospital owners may include:

- capital commitments
- commitments to keep the health provider or certain essential services open for a set number of years
- notification requirements for changes to services provided
- limits on the sale of real estate
- limits on leverage used to finance an acquisition
- protections for workers related to mass layoffs.

Place limits on sale-leaseback transactions

Sale-leaseback transactions are a common tactic of private equity firms to monetize a hospital's real estate assets and generate quick cash, which is commonly used to provide a payout to the investors. In a sale-leaseback transaction, a private equity firm that controls a hospital system has the hospitals sell their real estate and lease it back from the new owner. This essentially replaces mortgage payments with lease payments and strips hospitals of a valuable asset.

States can increase transparency and prevent extortionate sale-leaseback transactions by requiring health systems to provide notice of real-estate splits, and provide essential information to and receive approval from state regulators such as a health department or attorney general for such transactions.

Place limits on dividend recapitalizations and extraction of fees for services not provided

Dividend recapitalizations are transactions by which private equity firms load debt onto companies they own to give themselves cash payouts. In a dividend recapitalization transaction, a company will take on new debt and then use the proceeds of the loan to provide a special dividend to its private equity owners.

The tactic has been widely criticized by both supporters and skeptics of the private equity model for needlessly saddling companies with debt to extract capital without making substantive operating improvements. This puts those companies at risk for restructuring, bankruptcy, or cost cutting to make up the interest payments and pay off debt. Private equity firms have executed record numbers of dividend recapitalizations in recent years, including at healthcare companies.²²⁰

States should prohibit healthcare from paying dividends to owners/investors for two years following a leveraged buyout. After that, dividends may only be paid as a percentage of overall profit, and may not be funded by taking on additional debt.

Investor owners may not charge arbitrary fees to healthcare companies, such as management fees for services not provided.



Increase accountability for participation in certain CMS payment programs

Hospitals seeking designation as critical access hospitals (CAH), rural emergency hospitals (REH), rural referral centers (RRC) or other classifications that can access rural payment models through CMS must be subject to disclosures and limits on extractive financial policies referenced above that divert money away from care.

Enforcing laws related to the corporate practice of medicine

Private equity firms are barred from directly owning physician practices in most states by “corporate practice of medicine” (CPOM) prohibitions. These laws prohibit non-licensed individuals or unauthorized entities from practicing medicine, or owning, investing in, or controlling professional medical practices.

Private equity firms are able to circumvent these laws by creating or buying physician management companies (PPM) that affiliate with a physician-owned medical groups. These physician practice management companies typically manage the business administration of medical practices, including insurance contracting and billing.²²¹

States should place limits on what PPMs can do in order to preserve the intent of bans on the corporate practice of medicine. This could include prohibiting fee-splitting arrangements, where a PPM takes a percentage of the practice’s revenue in exchange for running the business. Medical decisions should be made by clinicians using their best clinical judgement, without being influenced by a management company’s shared interest in potential profits.

Increase antitrust scrutiny

Because private equity rollups and mergers typically fall under the radar of antitrust regulation,²²² the Federal Trade Commission (FTC) and the Department of Justice (DoJ) should scrutinize healthcare deals involving private equity firm owners even if individual deals do not meet the typical threshold to trigger FTC review.

Medical staffing/travel nursing

Congress should expand programs that incentivize clinicians to live and work in rural areas. This would reduce the need to rely on contingent labor which is often more expensive and leaves many rural residents without the benefit of long-term patient-provider relationships.

Congress should pass the [Travel Nursing Agency Transparency Study Act](#), or similar legislation, to compel a government investigation into potential anti-competitive practices among travel nurse agencies, as well as the potential impacts of private equity ownership of travel nurse agencies on prices and profits. Based on the results of such an investigation, Congress should pass legislation that protects health systems from unsustainable labor costs while ensuring bedside nurses are paid fairly, regardless of who their employer is.

Halt programs that provide incentives and loopholes to game Medicare

Halt initiatives like the ACO REACH program that incentivize providers to game Medicare for overpayment by over-diagnosing and upcoding, and lead to further privatization of Medicare.

Hold private equity firms accountable for Medicare/Medicaid fraud

The DOJ should pursue action against private equity firms whose portfolio companies, including rural healthcare providers, are found to commit Medicare or Medicaid fraud. There is [substantial overlap](#) between the risks associated with private equity ownership of healthcare companies and the activities targeted by the False Claims Act (FCA), the federal law that establishes liability for companies that defraud governmental programs such as Medicare and Medicaid.

For example, in an effort to dramatically increase revenue to meet return targets, private equity owned healthcare companies may reduce staffing or fill beds without adequate staffing ratios; rely on under-licensed or unlicensed staff to reduce labor costs; and pressure or incentivize physicians to provide unnecessary and potentially costly services.²²³

Fund research that examines the impacts of outsourcing of services at rural nonprofit and public hospitals

Federal and state agencies should fund research to examine the extent to which outsourcing either clinical services, nonclinical services, or both has impacted the financial solvency of rural hospitals, as well as the quality of patient care offered.

Increase oversight of hospital management companies

Hospital management companies should be required to disclose their contracts with nonprofit and public hospitals to state and federal governments. Employees of hospital management companies who are appointed as executives at nonprofit and public hospitals should be barred from leadership positions at more than one hospital at any given time, as well as barred from doing simultaneous consulting work at other locations.

Increase public investment in rural health

The lack of direct public investment into rural hospitals creates openings for for-profit companies, including those that are private-equity-owned, to invest in rural health. As the case studies in this report have illustrated, private investment—while often needed in the short term to keep certain hospitals open—can often be extractive and fail to strengthen rural health systems in the long term.

Currently, many policies aimed at preserving access to healthcare in rural areas involve adding to an already complex regulatory landscape of various payment models and hospital designations that can be gamed by for-profit interests, or that prioritize achieving financial solvency of individual hospitals above community access to critical services, such as emergency departments, labor and delivery, and more. Hundreds of rural hospitals are at risk of closure or at risk of shuttering essential services, despite current policy solutions in place aimed at supporting rural health.



Time and time again, aspects of our healthcare system defy the market-based assumptions that underly so many health policies. Rural healthcare, especially, can be harmed by market-based solutions, because rural healthcare is often inherently unprofitable. Sometimes a sole provider may be the only option for patients in a particular area—not because of a “monopoly” in the traditional sense but because of population density and community need. Therefore, payment models based on value or volume may not work to keep many rural hospitals solvent.

Instead, the federal government should invest directly into rural hospitals to ensure that they can offer all the essential healthcare services a community needs, regardless of whether these services produce revenue. These hospitals should not have to remain financially self-sufficient, but rather have direct subsidies to support important services for the community.

Direct public investment must come with guidelines and strict accountability measures, and limit extractive practices from for-profit interests, such as private equity firms, private insurers, physician staffing groups, medical staffing agencies, and vendors. With proper measures in place, public investment in rural health has the potential to preserve and even expand access to healthcare, including life-saving care.

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