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A PRACTICAL POLICY PROPOSAL TO SOLVE THE RURAL HOSPITAL PUZZLE

BRANDON M. HALL*

ABSTRACT

Since the 1980s, waves of rural hospital closures have intermittently plagued the U.S. health care landscape. Although the Affordable Care Act and its expansion of Medicaid have provided a vital lifeline to rural hospitals over the last decade, policy makers have yet to implement a permanent solution powerful enough to stabilize and offset the institutional and populational constraints that have promulgated the widespread hospital closure crisis plaguing rural communities.

This article argues that rural hospitals need to repurpose themselves to better serve the demands of their patient populations in order to survive the unique demographic and economic challenges they face. This article also argues that a new Medicare payment designation status is warranted. This status, known as a "Rural Emergency Hospital," allows rural hospitals to eliminate exorbitant overhead costs of inpatient services and instead utilize their existing infrastructure to provide outpatient services or transfer services for those requiring inpatient care. Rural Emergency Hospital status would further benefit these facilities as it carries a considerably higher reimbursement rate at 110% of cost compared to the current 101% reimbursement rate for Critical Access Hospitals.

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I. INTRODUCTION

Amidst a wave of rural hospital closures in the 1980s, the Federal Office of Rural Health Policy was established in 1987 to advise the Department of Health and Human Services on the effects that federal health care policies have on rural hospitals and access to health care in rural areas.[1] At present, the United States is facing another wave of widespread rural hospital closures.

Rural hospitals across the U.S. are again on the verge of a crisis: four-hundred thirty rural hospitals—or twenty-one percent of all rural hospitals in the U.S.—across forty-three states are at risk of closing unless their financial situations improve.[2] This does not include the 128 rural hospitals in thirty-six states that have closed since 2010.[3] "[A]t-risk rural hospitals represent more than 21,500 staffed beds, 707,000 annual discharges, and about $21.2 billion in total patient revenue."[4] Further, most of these at-risk rural hospitals are the primary, or in some instances, the sole, source of health care in their communities.[5] These at-risk rural hospitals also employ about 150,000 people in their respective communities, meaning the hospital closures often have a detrimental impact to their local economies.[6]

Rural hospitals face geographic isolation and other negatively-impacting factors such as a tendency for rural populations to be older, poorer, and less healthy, and residents in rural communities also often face challenges accessing health care services.[7] Providers are increasingly scarce, and many hospitals in rural areas are struggling to keep their profit margins just high enough to keep their doors open.[8] Further, "[r]ural hospitals tend to have low patient volume, a

1. *See* 42 U.S.C. § 912 (2018). The Federal Office of Rural Health Policy (FORHP) is located in the Health Resources and Services Administration, an agency within HHS. *Federal Office of Rural Health Policy*, HEALTH RESOURCES & SERVS. ADMIN. (Sept. 2018), https://www.hrsa.gov/about/organization/bureaus/orhp/index.html.

2. David Mosley & Daniel DeBehnke, *Rural Hospital Sustainability: New Analysis Shows Worsening Situation for Rural Hospitals, Residents*, NAVIGANT (Feb. 2019), https://guidehouse.com/-/media/www/site/insights/healthcare/2019/navigant-rural-hospital-analysis-22019.pdf%20.

3. *See id. See also 162 Rural Hospital Closures: January 2005 – Present (128 Since 2010)*, U.N.C. CECIL G. SHEPS CTR. FOR HEALTH SERVS. RES., https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/ (last visited May 2, 2020).

4. Jacqueline LaPointe, *21% of Rural Hospitals at High Financial Risk of Closing*, REVCYCLE INTELLIGENCE (Feb. 20, 2019), https://revcycleintelligence.com/news/21-of-rural-hospitals-at-high-financial-risk-of-closing.

5. Jay Bhatt & Priya Bathija, *Ensuring Access to Quality Health Care in Vulnerable Communities*, 93 ACAD. MED. 1271, 1271 (Sept. 2018).

6. *Id. See also Analysis Shows One-in-Five U.S. Rural Hospitals at High Risk of Closing Unless Financial Situation Improves*, NAVIGANT (Feb. 20, 2019), https://www.navigant.com/news/corporate-news/2019/rural-hospitals-analysis.

7. Mosley & DeBehnke, *supra* note 2, at 2. *See* Sidney D. Watson, *Mending the Fabric of Small Town America: Health Reform and Rural Economies*, 113 W. VA. L. REV. 1, 5–6 (2010).

8. Watson, *supra* note 7, at 10; Jane Wishner et al., *A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies,* KAISER FAM. FOUND. 5 (July 7, 2016),

high portion of patients on Medicare and Medicaid, and a high number of uninsured patients," which leads to significant financial challenges.[9]

With the passage of the Affordable Care Act came a requirement for states to expand Medicaid until forced expansion was struck down in *NFIB v. Sebelius*.[10] However, Medicaid expansion has proven to be a solution that has provided a lifeline in those states that have subsequently chosen to expand, and the result has been a slow-down in rural hospital closures.[11] In fact, according to a 2018 Government Accountability Office report, since 2013, fifty-one percent of the U.S.'s rural hospitals have been located in states that have expanded Medicaid, and expansion states are only home to seventeen percent of rural hospital closures.[12] Alternatively, forty-nine percent of all U.S. rural hospitals are located in non-expansion states, and those states have accounted for eighty-three percent of rural hospital closures.[13]

This article argues that in order to stave off closure, remaining rural hospitals should repurpose themselves by restructuring the services provided and the manner in which those services are provided to better accommodate the unique community and economic challenges they face. Part II of this article will give a brief overview of rural hospitals, the challenges they face, and the role of rural hospitals both in providing access to health care and as economic engines for their respective communities.

Part III of this article covers the evolution of the applicable law for rural hospitals. First, this part briefly discusses the impact of the Hill-Burton Act on the rise of rural hospitals. Second, it covers the rise of prospective payment systems and the waves of rural hospital closures. Third, this part shifts to Medicare payment designations and other current trends rural hospitals are using to try to maximize the amounts they are paid. This part will also give an overview of the major Medicare rural hospital designation statuses, beginning with Critical Access Hospitals, the most numerous of the rural hospital designations. This section then provides an outline of rural hospitals designated as Low Volume Hospitals, which are the second most common rural hospital designation. It will then outline Sole Community Hospitals, which are the third most common rural hospital designation. Next, this section discusses Rural Referral Centers, which are the fourth most common rural hospital designation.

https://www.kff.org/report-section/a-look-at-rural-hospital-closures-and-implications-for-access-to-care-three-case-studies-issue-brief.

9. Samantha Scotti, *Tackling Rural Hospital Closures*, 25 NCSL LEGISBRIEF 1 (June 2017), https://www.ncsl.org/portals/1/documents/legisbriefs/2017/lb_2521.pdf.

10. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 588 (2012).

11. U.S. GOV'T ACCOUNTABILITY OFF., GAO-18-634, RURAL HOSPITAL CLOSURES: NUMBER AND CHARACTERISTICS OF AFFECTED HOSPITALS AND CONTRIBUTING FACTORS 26 (2018) [hereinafter GAO-18-634].

12. *Id.* at 27.

13. *Id.*

Finally, this section will outline Medicare Dependent Hospitals, the least prevalent of rural hospital designations.

Part IV of this article will discuss the widespread uptick in rural hospital closures in recent years. This part outlines the key factors that collectively amount to the proximate cause of the rural hospital closures: financial distress. These factors can be subdivided into population and institutional constraints. For the purposes of this article, population constraints mean factors imposed due to the populations in which rural hospitals serve. Institutional constraints refer to payment and other restrictions on the hospitals as institutions.

Part V of this article will highlight and explain the impact that Medicaid expansion has had on slowing rural hospital closures. However, some of these problems transcend Medicaid expansion or non-expansion. As such, this part articulates why the changes proposed in the Rural Emergency Acute Care Hospital (REACH) Act, as introduced, are necessary for the sustainability of rural hospitals across the U.S.

Finally, this article will conclude with a summary of the problems facing hospitals that lead to rural hospital closures and how the proposed solution addresses those looming problems.

II. THE ROLE OF RURAL HOSPITALS

Rural hospitals have a binary role in their respective communities. First, and most apparent, is the role of providing access to care. Second, and arguably just as important, is the considerable economic impact that rural hospitals have on their respective communities. This part will analyze both of these impacts, in turn.

A. Rural Hospitals' Role in Providing Access to Health Care

Rural populations face unique health care challenges by and large different from those in urban populations. For example, rural communities tend to have higher populations of elderly citizens, higher rates of uninsured residents, greater instances of chronic diseases, and higher rates of poverty.[14] These rural populations are therefore at an increased risk of loss of access to health care, exacerbation of health disparities, and the loss of health care sector jobs.[15] For example, a 2017 study from the Centers for Disease Control and Prevention highlights that rural Americans are more likely than those in urban communities to die from five causes: cancer, heart disease, chronic lower respiratory disease,

14. Mary Wakefield, *Strengthening Health and Health Care in Rural America*, COMMONWEALTH FUND (Oct. 4, 2018), https://www.commonwealthfund.org/blog/2018/strengthening-health-and-health-care-rural-america.

15. *Hospital Closings Likely to Increase*, HEALTH RESOURCES & SERVS. ADMIN. (Oct. 2017), https://www.hrsa.gov/enews/past-issues/2017/october-19/hospitals-closing-increase.html.

stroke, and accidental injuries.[16] These disproportionate ailments tax the meek rural health landscape.[17]

Further exacerbating problems, rural residents are more likely, on average, to be poorer and less educated.[18] These social factors often lead to poor health care access, neglectful health behaviors, and exposure to unhealthy amounts of stress.[19] In 2014, the rate of suicide was more than fifty percent higher for those living in rural counties than for their urban counterparts.[20] There has also been a recent uptick in deaths of rural working-class whites, driven by so-called "despair deaths."[21] These deaths represent those from suicide, liver disease, and accidental poisonings (including drug overdoses) and are often associated with economic, mental, and familial distress.[22]

Further complicating matters for rural constituents are their attitudinal differences toward health. Rural constituents tend to measure health by a person's ability to work.[23] Because of this attitudinal difference, rural individuals are more likely to delay seeking medical treatment until a condition manifests severely or until multiple conditions accumulate.[24] "This mentality of the underserved exists side-by-side with those who not only have access, but who arguably have too much access, to medical services."[25] That is, those with sufficient insurance have more immediate access to doctors and are frequently encouraged by doctors to overutilize services for repetitive or unnecessary care.[26] Neither underutilization nor overutilization promotes responsible utilization of health care, neither of these two extremes instills confidence in the health care system, and both underutilization and overutilization impose real health and medical costs.[27]

16. Elizabeth Weeks, *The Medicalization of Rural Poverty: Challenges for Access*, 46 J.L. MED. & ETHICS 651, 652 (2018) (citing Press Release, Rural Americans at Higher Risk of Death from Five Leading Causes (Jan. 12, 2017) (on file at https://www.cdc.gov/media/releases/2017/p0112-rural-death-risk.html).

17. *See generally id.*

18. Watson, *supra* note 7, at 5–6.

19. Erika Ziller & Andrew Coburn, *Health Equity Challenges in Rural America*, 43 HUM. RTS. MAG. (2018), https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/the-state-of-healthcare-in-the-united-states/health-equity-challenges-in-rural-america/.

20. *Id.*

21. *Id.*

22. *Id.*

23. Craig Thomas, *Understanding Rural Health Care Needs and Challenges: Why Access Matters to Rural Americans*, 43 HARV. J. ON LEGIS. 253, 257 (2006).

24. *Id.*

25. *Id.*

26. *Id.*

27. *Id.*

Despite arguably facing more prolonged and more pervasive health problems, nearly twenty percent of Americans live in rural areas.[28] These rural Americans depend on rural hospitals as the primary, if not the sole, source of care in their communities.[29] Primary care is greatly lacking in rural areas.[30] "As of November 2018, two-thirds of the nation's 6,941 primary care Health Professional Shortage Areas (HPSAs) were in rural or partially rural areas."[31] Rural shortages are not limited strictly to primary care but "encompass all types of medical professionals: physicians, dentists, pharmacists, registered nurses, and ancillary medical personnel."[32] Due to such shortages, "14% of rural patients must travel more than thirty minutes to receive routine and primary care, while only 10% of urban patients must do so."[33]

Further, long distances to care sites and lack of access to sufficient transportation can pose major barriers to obtaining care. "Having limited access to health care services affects physical, mental and social health status, quality of life and life expectancy. When access to care is not available, it can lead to unmet health needs, a lack of preventive services and preventable, costly hospitalizations."[34] Though costly, rural hospitals can be a lifesaver in these amplified situations.

"Rural hospitals provide access to care close[r] to home."[35] This improved access to health care improves the well-being of the patients and communities they serve by making available local, timely access to care.[36] Having local access thus saves lives and reduces added travel expenses and lost work hours.[37]

B. Rural Hospitals' Economic Role in Their Communities

In addition to the critical role rural hospitals play in their respective communities' access to health care, they also play a vital role in the economic stability of those communities. For instance, rural hospitals bring outside dollars into rural communities through third-party payors, and they help stimulate local hiring and purchasing.[38] A 2016 National Center for Rural Health Works

28. AM. HOSP. ASS'N, RURAL REPORT: CHALLENGES FACING RURAL COMMUNITIES AND THE ROADMAP TO ENSURE LOCAL ACCESS TO HIGH-QUALITY, AFFORDABLE CARE 2 (2019).

29. *Id.*

30. *Id.* at 7.

31. *Id.*

32. Watson, *supra* note 7, at 8.

33. *Id.*

34. EMILY HELLER ET AL., NAT'L CONFERENCE OF STATE LEGISLATURES, IMPROVING ACCESS TO CARE IN RURAL AND UNDERSERVED COMMUNITIES: STATE WORKFORCE STRATEGIES 2 (2017).

35. AM. HOSP. ASS'N, *supra* note 28, at 2.

36. *Id.*

37. *Id.*

38. George M. Holmes et al., *The Effect of Rural Hospital Closures on Community Economic Health*, 41 HEALTH SERVS. RES. 467, 467 (Apr. 2006).

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Economic Impact study found that the average Critical Access Hospital (CAH) generates approximately $1.8 million in taxable revenue within its rural community.[39] Similarly, the average CAH employs 127 employees, which amounts to six million dollars in wages, salaries, and benefits.[40] The annual economic impact of these CAHs amounts to "170 jobs and $7.1 million in wages, salaries, and benefits from overall hospital operations."[41] Similarly, that same study found that "[f]or each $1 million of CAH construction expenditures, there are nine construction employees with annual wages, salaries, and benefit wages of $322,551."[42] The "total annual construction impacts for $1 million of CAH construction are eleven jobs with $403,189 in wages, salaries, and benefits and $100,797 in taxable retail sales impact."[43]

Even among non-CAHs, in some cases, a rural hospital is one of the largest employers in the community. "A 2017 United States Department of Agriculture (USDA) study found that inpatient healthcare facilities were responsible for 1.25 million jobs, or 8.5%, of wage and salary employment in rural communities at their peak in 2011."[44] On average, rural hospitals are responsible for fourteen percent of total employment in their local communities, typically being one of the largest employers in the surrounding area.[45]

Rural hospital closures often cause "health care providers and other hospital employees [to] move away following a closure."[46] While some remain in the community, they must travel further to find employment.[47] The loss of jobs and the potential loss of residents has negative impacts on the tax base in the community, which reduces the available resources for schools and other public services, like public sector jobs outside of the health care field.[48]

III. RURAL HOSPITALS AND THE LAW

In 1946, the Hill-Burton program was established, providing federal funding to construct public and nonprofit hospitals in rural communities.[49] Most rural hospitals were built in the 1950s, with funds then available under the Hill-Burton

39. GERALD A. DOEKSEN ET AL., NAT'L CTR. RURAL HEALTH WORKS, ECONOMIC IMPACT OF A CRITICAL ACCESS HOSPITAL ON A RURAL COMMUNITY 4 (2016).

40. *Id.*

41. *Id.* at 1.

42. *Id.*

43. *Id.*

44. *Community Vitality and Rural Healthcare*, RURAL HEALTH INFO. HUB (Aug. 31, 2018), https://www.ruralhealthinfo.org/topics/community-vitality-and-rural-healthcare.

45. *Rural Hospitals*, RURAL HEALTH INFO. HUB (May 29, 2019), https://www.ruralhealthinfo.org/topics/hospitals.

46. Wishner et al., *supra* note 8, at 9.

47. *Id.*

48. *Id.*

49. *Id.* at 3.

Act.[50] The Hill-Burton Act led to a significant boom in rural hospitals across the country, especially in the South.[51] This coincided with the post-World War II manufacturing boom that spilled into rural communities, bringing larger populations that have since declined.[52]

In the early 1980s, as a result of significant increases in Medicare hospital spending, Congress began requiring use of fixed, predetermined reimbursement rates for hospitals through the prospective payment systems (PPS).[53] The adoption of PPS led to many rural hospitals closing in the 1980s and 1990s.[54] In all, "rural America lost almost 10% of its hospitals in the 1980s and 1990s."[55] "By 1990 Medicare had reduced the growth rate in PPS payments to approximate the growth in hospital costs. Between 1990 and 1993, inpatient margins for Medicare patients—payments minus cost of services divided by patient revenues—were close to zero." Medicare margins grew substantially in 1994, however, reaching a "historic high" of 16.9%.[56] Further complicating matters was the inability of Congress and President Clinton to agree on the federal budget, especially regarding Medicare payments and costs.[57]

The growing concerns over rural health care access led the Centers for Medicare and Medicaid Services (CMS) to implement the Medicare Rural Hospital Flexibility Program of 1997.[58] Further, the Balanced Budget Act of 1997 mandated that PPS payments be lowered, targeting that Medicare margins could be reduced to ten percent by 2002.[59] Unfortunately, the outcome of the Balanced Budget Act was more negative than expected.[60] Instead, "Medicare margins fell to 7.2 percent for urban hospitals and 1.6 percent for rural hospitals in 2002. This negative trend continued, and in 2009, [prior to the passage of the Affordable Care Act,] margins were -2.2 percent for urban hospitals compared to -2.4 percent for rural hospitals."[61]

Fast forward to the present, and those negative margins for rural hospitals are still a critical factor in the viability of these rural hospitals. There are primarily three ways rural hospitals get paid: (1) rural grants, cooperative

50. Watson, *supra* note 7, at 9.

51. Wishner et al., *supra* note 8, at 3.

52. *See* Watson, *supra* note 7, at 10–11.

53. Wishner et al., *supra* note 8, at 3.

54. *Id.*

55. Watson, *supra* note 7, at 9.

56. Stuart H. Altman, *The Lessons of Medicare's Prospective Payment System Show That the Bundled Payment Program Faces Challenges*, 31 HEALTH AFF. 1923, 1927 (2012).

57. *Id.*

58. Wishner et al., *supra* note 8, at 3.

59. Altman, *supra* note 56, at 1927.

60. *Id.*

61. *Id.*

agreements, and contracts; (2) Medicare rural hospital payment designations; and (3) innovative payment and delivery solutions.[62]

A. Rural Grants, Cooperative Agreements, and Contracts

The Federal Office of Rural Health Policy (FORHP) provides funding and technical assistance to rural hospitals.[63] "The largest of these is the Medicare Rural Hospital Flexibility grant program, in which FORHP provides funds to states to support CAHs to stabilize their finances, foster innovative models of care, and support other improvement activities. In 2017, forty-five states received twenty-five million dollars in Flex grants."[64] But while providing critical financial support, FORHP officials noted that due to widespread need, "there is not enough funding to financially assist all Critical Access Hospitals that are at risk of closing."[65]

B. Medicare Payment Designations

CMS administers five Medicare payment designations applicable to rural hospitals.[66] Under these designations, rural or isolated hospitals that meet specified eligibility criteria receive higher cost-based reimbursements for hospital services than otherwise available to hospitals that receive Medicare's standard payment formula.[67] FORHP "defines a rural hospital as one located in a non-metropolitan county or as a hospital within a metropolitan county that is far away from the urban center, as defined by a rural-urban community area code of four or above."[68] "In 2017, about 2,250 general acute care hospitals in the United States were located in areas that met FORHP's definition of rural; these rural hospitals made up 48 percent of hospitals nationwide, and 16 percent of nationwide inpatient beds."[69]

There are several "types" of rural hospitals. "A rural hospital may qualify as a Critical Access Hospital, Sole Community Hospital, or Medicare Dependent Hospital—each of which has different eligibility criteria and payment methodologies."[70] Except for CAHs, other rural hospital types may also qualify as Low Volume Hospitals and Rural Referral Centers, which allows those

62. GAO-18-634, *supra* note 11, at 6.
63. *Id.* at 8.
64. *Id.*
65. *Id.*
66. *Id.* at 7.
67. GAO-18-634, *supra* note 11, at 7–8.
68. *Rural Hospitals and Medicaid Payment Policy*, MACPAC 1, 1 (Aug. 2018), https://www.macpac.gov/wp-content/uploads/2018/08/Rural-Hospitals-and-Medicaid-Payment-Policy.pdf. *But see* GAO-18-634, *supra* note 11, at 4 n.7 ("There are various ways to define a rural area, and no consistent definition is used across government programs.").
69. GAO-18-634, *supra* note 11, at 3.
70. *Id.* at 8.

hospitals to receive additional payments or exemptions.[71] CAHs make up the largest proportion of rural hospitals, representing fifty-six percent of rural hospitals in 2017.[72] These CAHs utilize cost-based reimbursement methods, as opposed to the standard rates under the inpatient prospective payment system.[73] "Due to greater reliance on federal and state payers, low volume, and complexity of services provided, many rural hospitals struggle to remain financially viable under the PPS. As a solution, several payment programs provide consideration for the special circumstances of rural hospitals."[74]

One such designation is as a CAH.[75] A CAH must meet the following eligibility requirements: (1) the hospital must be located in a state with a Medicare rural hospital flexibility requirement; (2) the hospital must be located in an area classified or reclassified as rural; (3) the hospital must be one of: (i) more than thirty-five miles from the nearest hospital, (ii) more than fifteen miles from the nearest hospital if via mountainous or secondary roads, or (iii) prior to 2006, deemed by a state as a necessary provider; (4) the hospital must have fewer than twenty-five acute inpatient beds; or (5) the hospital must meet the conditions of participation, including 24/7 emergency care and average annual acute care length of stay of less than ninety-six hours.[76] "Unlike hospitals paid prospectively using PPS, CAHs are reimbursed based on the hospital's Medicare allowable costs. Each CAH receives payment of 101% of the Medicare share of its allowed costs for outpatient, inpatient, laboratory, therapy services, and post-acute swing bed services."[77] In 2017, there were 1,250 hospitals that were designated as CAHs in the U.S., making it the most prevalent rural hospital designation category.[78]

Another rural hospital designation is as a Low Volume Hospital (LVH).[79] An LVH qualifies for higher reimbursement "if the organization had fewer than 1,600 Medicare Part A discharges during the fiscal year and was located more than 15 road miles from another IPPS hospital."[80] Each LVH receives inpatient

71. *Id.* ("Rural hospitals that do not qualify as a Critical Access Hospital, Sole Community Hospital, or Medicare Dependent Hospital are still eligible for these additional designations. Because the Low Volume Hospital designation is based on the volume of services provided and does not require formal certification, it is more likely than other payment designations to be applied to a hospital one year and not the next.") *Id.* at n.5.

72. *Id.*

73. GAO-18-634, *supra* note 11, at 8.

74. *Rural Hospitals*, *supra* note 45.

75. *See generally* 42 U.S.C. § 1395i-4 (2018); 42 C.F.R. §§ 485.601 (2017).

76. 42 U.S.C. § 1395i-4.

77. *Rural Hospitals*, *supra* note 45.

78. GAO-18-634, *supra* note 11, at 29–30.

79. *See generally* 42 U.S.C. § 1395ww(d)(12); 42 C.F.R. § 412.101.

80. LaPointe, *supra* note 4. *But see* GAO-18-634, *supra* note 11, at 31 app.I n.g ("Low Volume Hospitals may be within 15 miles of certain types of hospitals excluded from Section 1886(d) of the Social Security Act, such as Critical Access Hospitals.").

payment methodology adjustments of an additional percentage based on the number of Medicare discharges, with a maximum of twenty-five percent for hospitals with less than or equal to 200 discharges.[81] As of 2017, there were 529 LVHs in the U.S., making it the second-most prevalent rural hospital designation type.[82]

A third rural hospital designation is a Sole Community Hospital (SCH).[83] A SCH designation is based on a hospital's geographical proximity to other hospitals.[84] The designation of SCH status requires that the hospital is the only "like hospital" serving its community.[85] A SCH's distance requirements depend on "whether a facility is rural and how inaccessible a region is due to weather, topography, and other factors."[86] For example, the geographic location must meet any one of the following: (1) the hospitals is greater than thirty-five miles from a like hospital; (2) the hospital is located in an area classified or reclassified as rural, twenty-five to thirty-five miles from a like hospital, and less than or equal to twenty-five percent of residents or Medicare beneficiaries who become inpatients in hospitals' service area are admitted to other like hospitals (or admitting criteria would have reasonably been met, but for unavailability of a specialty service, and the hospital has less than fifty beds); (3) the hospital is located in an area classified or reclassified as rural, is fifteen to thirty-five miles from like hospital, and because of topography or weather conditions, like hospital(s) are inaccessible for at least thirty days in two of the last three years; or (4) the hospital is located in an area classified or reclassified as rural, greater than or equal to forty-five minutes travel time to nearest like hospital, because of distance, posted speed limits, and predictable weather conditions.[87] Each SCH receives inpatient payment methodology adjustments based on a higher of (i) standard prospective payments or (ii) a hospital-specific rate based on costs as of 1982, 1987, 1996, or 2006.[88] Further, SCHs may receive an additional payment adjustment if the hospital experiences a five percent or more decline in inpatient volume due to circumstances beyond its control.[89] Finally, SCHs receive approximately a 7.1 percent additional payment for ancillary outpatient

81. 42 C.F.R. § 412.101; *see also* 42 U.S.C. § 1395ww(d)(12) (discussing the temporary percentage increase).

82. GAO-18-634, *supra* note 11, at 29–30.

83. *See generally* 42 U.S.C. § 1395ww(d)(5)(D); 42 C.F.R. § 412.92.

84. *Rural Hospitals*, *supra* note 45.

85. *Id.* "Like hospitals" are those hospitals that furnish short-term, acute care paid under the IPPS, and which are not CAHs. *See* 42 C.F.R. § 412.92(c)(2).

86. *Rural Hospitals*, *supra* note 45.

87. 42 U.S.C. § 1395ww(d)(5)(D); 42 C.F.R. § 412.92.

88. U.S. GOV'T ACCOUNTABILITY OFF., GAO-20-300, INFORMATION ON MEDICARE-DEPENDENT HOSPITALS 31 (2020) [hereinafter GAO-20-300].

89. 42 C.F.R. § 412.92(e).

services.[90] As of 2017, there were 386 SCHs in the U.S., making it the third-most prevalent rural hospital designation.[91]

A fourth designation type is the Rural Referral Center (RRC).[92] RRCs are rural hospitals that receive referrals from surrounding rural acute care hospitals.[93] An acute care hospital qualifies as a RRC for Medicare purposes if the hospital is located in an area classified or reclassified as rural, and if the hospital satisfies any one of the several following qualifying criteria: (1) the hospital has greater than or equal to 275 beds; (2) both (i) greater than or equal to fifty percent of its Medicare patients are referred from other hospitals or physicians, not on staff at the hospital, and (ii) greater than or equal to sixty percent of Medicare patients and Medicare services are provided to those who live greater than twenty-five miles from the hospital; (3) greater than fifty percent of the hospital's Medicare staff are specialists, and the number of discharges and the case-mix exceed certain criteria; or (4) greater than or equal to forty percent of all patients are referred from other hospitals or physicians not on staff at the hospital, and the number of discharges and case mix exceed certain criteria.[94] RRCs receive inpatient payment methodology adjustments in the form of an exemption from a twelve percent cap on Disproportionate Share Hospitals.[95] As of 2017, there were 223 RRCs in the U.S., making it the fourth most prevalent rural hospital designation.[96]

The fifth and final rural hospital designation is the Medicare Dependent Hospital (MDH).[97] MDHs "provide[] enhanced payment[s] to support small rural hospitals with 100 or fewer beds for which Medicare patients make up at least 60% of the hospital's inpatient days or discharges."[98] Notably, "[t]his designation is not available to rural hospitals which are also classified as a SCH."[99] Each MDH receives inpatient payment methodology adjustments based on a higher of (i) standard prospective payment or (ii) the standard payment plus seventy-five percent of the amount by which the standard payment is exceeded

90. Sharita R. Thomas et al., *The Financial Importance of the Sole Community Hospital Payment Designation*, N.C. RURAL HEALTH RES. PROGRAM 1 (2016), https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2016/11/SCH-Financial-Importance-1.pdf.

91. GAO-18-634, *supra* note 11, at 29–30.

92. *See generally* 42 U.S.C. § 1395ww(d)(5)(C)(i) (2018); 42 C.F.R. § 412.96.

93. *Rural Hospitals*, *supra* note 45.

94. *See generally id.*

95. 42 C.F.R. § 412.106; A DSH is "[a] special reimbursement designation under Medicare designed to support hospitals that provide care to a disproportionate number of low-income patients. Although not a rural-specific designation, the DSH designation allows some rural facilities to remain financially viable." *Rural Hospitals*, *supra* note 45.

96. GAO-18-634, *supra* note 11, at 29–30.

97. *See generally* 42 U.S.C. § 1395ww(d)(5)(G); 42 C.F.R. § 412.108.

98. *Rural Hospitals*, *supra* note 45.

99. *Id.*

by the hospital-specific rate based on costs as of 1982, 1987, or 2002.[100] MDHs are also subject to the same additional payment adjustment for decreased volume as SCHs if the MDH experiences a five percent or more decline in inpatient volume due to circumstances beyond its control.[101] As of 2017, there were 146 MDHs in the United States, making MDHs the least prevalent rural hospital designation type.[102]

Overall, the PPS has been successful in lowering Medicare hospital payments by reducing the number of Medicare patients' days of care.[103] However, its impact on overall costs is less clear cut, due to hospitals' receipt of higher payments from most private insurance plans.[104] Despite some success, in the early 1990s, days of care declined for all Medicare patients.[105] Around this time, "the prospective payment system incentives were also combined to reflect the financial pressures imposed by private managed care."[106] Nevertheless, the PPS reduced lengths-of-stay, as evidenced by more significant declines for Medicare patients than for non-Medicare patients.[107] While the days of care were reduced, costs did not follow suit, "suggesting that hospitals adjusted for shorter stays with more intense use and more expensive resources."[108]

C. Innovative Payment and Delivery Solutions

In addition to the Medicare payment designations, one other emerging trend with rural hospitals is a designation (or lack thereof) as a Freestanding Emergency Department (FED).[109] A FED is a state-licensed facility that provides emergency services.[110] A FED is "freestanding," and thus, physically separate from a hospital.[111] A FED provides the same care as a traditional hospital-based emergency department, except for trauma services.[112] In a FED, trauma services are instead offered through patient transfer arrangements made between the FED and an area hospital or hospitals.[113] FEDs operate similarly to urgent care facilities, but differ in that "they are required to be open 24 hours a day, have physicians on-site at all times, provide round-the-clock lab and

100. GAO-20-300, *supra* note 88, at 7.
101. 42 C.F.R. § 412.108(d)(1).
102. GAO-18-634, *supra* note 11, at 29–30.
103. Altman, *supra* note 56, at 1928.
104. *Id.*
105. *Id.*
106. *Id.*
107. *Id.*
108. Altman, *supra* note 56, at 1928.
109. J. DUNC WILLIAMS ET AL., N.C. RURAL RESEARCH PROGRAM, ESTIMATED COSTS OF RURAL FREESTANDING EMERGENCY DEPARTMENTS 1 (2015).
110. *Id.*
111. *Id.*
112. *Id.*
113. *Id.*

imaging services, stock medications not required in urgent-care centers, fulfill specific architectural and equipment requirements, and train staff at a higher level than that required of urgent-care centers. In addition to emergency services, FEDs provide outpatient services such as lab and imaging services."[114]

FEDs can either be hospital-owned or be completely independent from a hospital.[115] Ownership implicates federal regulation, state licensure, and reimbursement.[116] For that reason, the majority of FEDs are hospital-owned and are recognized by CMS as a part of the parent hospital.[117] When a FED falls under a parent hospital, the FED is subject "to the same regulations and billing practices as the parent hospital."[118] Likewise, "hospital-owned FEDs can bill facility fees under the parent hospital's Tax ID."[119] Alternatively, "[i]ndependent FEDs are owned by individuals or organizations other than hospitals and are not recognized by CMS as emergency departments."[120] Accordingly, independent FEDs "are not subject to CMS regulations as emergency departments and are ineligible to receive a CMS facility fee."[121] "Licensing authority for both hospital-owned and independent FEDs falls on the states and varies significantly."[122] Therefore, differences in hospital ownership of a FED can have important implications with regard to CMS and state-specific regulations.

"Currently, there is not a rural-specific federal designation for FEDs located in rural areas."[123] Thus, FEDs operating in rural areas, like other FEDs, are either hospital-owned or independent.[124] Like rural hospitals, rural FEDs face population challenges, including patients "who are sicker, older, and more likely to be uninsured than those in non-rural FEDs. Rural FEDs are also more likely to face challenges maintaining minimum staffing requirements, experience higher fixed costs than non-rural facilities, and have longer transfer times."[125] Accordingly, many of the challenges plaguing rural hospitals parallel the significant barriers to the financial viability of rural FEDs.[126]

To address some of these challenges, the REACH Act, S.1130, re-introduced in May 2017, proposed that CMS create a Medicare designation which recognizes independent, rural FEDs (RFEDs) as a new facility type,

114. WILLIAMS ET AL., *supra* note 109, at 1.
115. *Id.*
116. *Id.*
117. *Id.*
118. *Id.*
119. WILLIAMS ET AL., *supra* note 109, at 1.
120. *Id.*
121. *Id.*
122. *Id.*
123. *Id.* at 2.
124. WILLIAMS ET AL., *supra* note 109, at 2.
125. *Id.*
126. *Id.*

thereby allowing the creation of a facility reimbursement fee.[127] "Further, it proposes enhanced reimbursement for services at 110% of reasonable cost," in contrast to the 101% reimbursed in CAHs.[128]

IV. CONTRIBUTING FACTORS TO THE UPTICK IN RURAL HOSPITAL CLOSURES

While rural hospital closures have been an issue for decades, the recent and drastic uptick is alarming. "[F]rom 2013 through 2017, 64 of the approximately 2400 rural hospitals in the United States closed."[129] There were also eight hospitals that closed and then reopened between 2013 and 2017.[130] Additionally, "[t]he 64 rural hospital closures from 2013 through 2017—approximately 3 percent of all rural hospitals in 2013—exceeded the 49 urban hospital closures during the same time period—approximately 2 percent of all urban hospitals in 2013."[131]

While many factors drive rural hospital closures, the most significant hurdle for rural hospitals' sustainability is insufficient revenue to cover the overhead costs of running and staffing the hospitals.[132] Rural economic conditions and population challenges, including declining population, contribute to rural hospital financial instability.[133]

> Relative to hospitals in urban areas, rural hospital financial margins are typically lower. Challenging rural economic conditions and unfavorable demographics (e.g., aged, poor, uninsured, and underinsured populations) also contribute to hospital financial instability through a poor payer mix. Trends in health insurance and plan design, such as growing use of high deductible health plans and narrow provider networks, can increase a hospital's bad debt and charity care burden.[134]

Shifts in health care delivery, coupled with low patient volumes, hamper rural hospitals' ability to generate sufficient revenue to cover fixed costs, let alone make capital improvements or upgrade facilities.[135] Collectively, these factors often leave rural residents reluctant to utilize their rural hospitals, and they instead choose to travel to more distant health centers with updated facilities and services.[136] This bypassing of the rural hospitals in favor of more urban

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127. *Id. See also* Rural Emergency Acute Care Hospital Act, S. 1130, 115th Cong. § 2 (2017).
128. WILLIAMS ET AL., *supra* note 109, at 2.
129. GAO-18-634, *supra* note 11, at 16.
130. *Id.*
131. *Id.*
132. KEITH J. MUELLER ET AL., AFTER HOSPITAL CLOSURE: PURSUING HIGH PERFORMANCE RURAL HEALTH SYSTEMS WITHOUT INPATIENT CARE 2 (2017).
133. *Id.*
134. *Id.*
135. *Id.*
136. *Id.*

hospitals therefore further exacerbates the financial distress experienced by those local, rural hospitals.[137]

Thus, the current wave of rural hospital closures can be best described as resulting from a combination of both community factors as well as institutional factors.

A. Community Factors

Generally, rural communities tend to have a higher percentage of elderly residents. For example, "[i]n 2014, 18 percent rural counties had a population aged 65 or older, compared with 14 percent in urban counties."[138] Similarly, rural communities have higher percentages of residents with impairments caused by chronic health conditions.[139] For instance, in 2010-2011, eighteen percent of adults living in rural counties experienced limitations caused by chronic health conditions, while this percent dropped to only thirteen in large, central, urban counties.[140] Rural households also tend to have lower median household incomes.[141] For example, "[i]n 2014, the median household income in rural counties was approximately $44,000, compared to $58,000 in urban counties."[142]

Rural populations have also experienced several changes in recent years that have exacerbated these differences. For example, according to research by the USDA, rural areas have suffered from decreasing populations.[143] The first recorded period of rural population decline occurred between 2010 and 2016.[144] Further, rural populations have faced limited employment growth.[145] These two downward spirals, collectively, have led to a tertiary issue: "increased competition for the small volume of rural residents."[146] Because "[r]ural residents may choose to obtain services from other health care providers separate from the local rural hospital," there is an increase in competition for the low volume of rural residents.[147] This increased competition could explain why

137. MUELLER ET AL., *supra* note 132, at 2.

138. GAO-18-634, *supra* note 11, at 4.

139. *Id.*

140. *Id.*

141. *Id.*

142. *Id.*

143. GAO-18-634, *supra* note 11, at 4 ("From 2010 through 2015, the population in rural areas declined, on average, by 0.07 percent per year, while the population in urban areas increased, on average, by 0.9 percent per year.").

144. *Id.* at 24. "Recent population estimates show signs of population recovery in rural area in the United States (2015-2016). Other factors that led to population decline in rural areas include continuous outmigration of young adults, which ages the population, and increased mortality among working-age adults." *Id.*

145. *Id.* at 5.

146. *Id.* at 24.

147. GAO-18-634, *supra* note 11, at 24.

LVHs disproportionately close.[148] That is, hospitals that by definition have a low Medicare volume usually have both lower operating and profit margins than other rural hospitals and as a result are more likely at risk of financial distress.[149]

Finally, rural hospitals' communities face unique geographical challenges. It may seem intuitive, to say the least, to imply that rural communities face geographical constraints based on proximity alone. That's true, but there is another layer built into it: between 2013 and 2017, rural hospitals located in the South accounted for a grossly disproportionate share of the sixty-four closures that occurred.[150]

B. Institutional Factors

> [R]ural hospital closures were generally preceded by and caused by financial distress. In particular, rural hospitals that closed typically had negative margins which made it difficult to cover their fixed costs. For example, one 2016 study found that rural hospitals that closed from 2010 through 2014 had a median operating margin of -7.41 percent in 2009. In contrast, rural hospitals that remained open during the same time period had a median operating margin of 2.00 percent in 2009.[151]

Thus, there is a direct correlation between operating margins and survivability of rural hospitals. Even in those instances where rural hospitals operate on a razor thin margin in the black, that positive balance can be the difference between remaining open and closing.

One large institutional constraint imposed upon rural hospitals is the hospital's respective Medicare rural hospital payment designation.[152] "Medicare Dependent Hospitals (MDHs) – one of three Medicare rural hospital payment designations in which hospitals were eligible to receive a payment rate other than standard Medicare inpatient payment rate – were disproportionately represented among hospital closures."[153] MDHs "represented 9 percent of the [total] rural hospitals in 2013, but accounted for 25 percent of the rural hospital closures from 2013 through 2017."[154]

Another factor that negatively impacts rural hospital institutions is Medicare sequestration.[155] "Rural hospitals are sensitive to cuts to Medicare payments because, on average, Medicare accounted for approximately 46 percent of their

148. *Id.*
149. *Id.*
150. *Id.* at 17–18 (For example, Texas, which is just one southern state, "represented 7 percent of the rural hospitals in 2013, but accounted for 22 percent of the rural hospital closures from 2013-2017.").
151. *Id.* at 23.
152. GAO-18-634, *supra* note 11, at 20.
153. *Id.*
154. *Id.*
155. *Id.*

gross patient revenues."[156] That is, Medicare cuts undermine the long-term viability of rural hospitals. "Under sequestration – [here, meaning] the cancellation of budgetary resources under presidential order … nearly all Medicare's budget authority is subject to a reduction not exceeding two percent, which is implemented through reductions in payment amounts."[157] This can be especially costly to CAHs, which are reimbursed at 101% of costs.[158] Reducing two percent off the costs is the difference between profit and loss.[159] Because these hospitals operate on such razor thin margins, sequestration can be a death order to rural hospitals.[160] This is clearly evidenced by "[a] 2016 study [that] found that Medicare Dependent Hospitals' operating margins decreased each year from 2012 through 2014, which could explain the disproportionate number of closures among the Medicare Dependent Hospital payment designation."[161]

Another factor that can negatively affect rural hospitals is the number of inpatient beds.[162] "Rural hospitals with between 26 and 49 inpatient beds represented 11 percent of the rural hospitals in 2013, but accounted for 23 percent of the rural hospital closures from 2013 through 2017."[163] CAHs, despite having fewer inpatient beds, and despite making up the majority of rural hospitals, are less likely than other rural hospitals to close.[164] And this is true despite the Medicare sequestration reducing 2% off of CAHs' margins, reducing from 101% of cost reimbursement to approximately 99% of costs.[165] Thus, the savings realized by rural CAHs with fewer inpatient beds results in lower overhead costs and is sufficient to overcome the lack of full repayment of costs under the Medicare repayment structure for CAHs.

Finally, one last institutional constraint on rural hospitals is ownership structure.[166] "For-profit rural hospitals represented 11 percent of the rural hospitals in 2013, but accounted for 36 percent of the rural hospital closures from 2013 through 2017."[167] That is, hospitals with for-profit status are less

156. *Id.* at 25 ("Revenue estimate is from the American Hospital Association, which defined rural as non-metropolitan counties. In comparison, Medicare accounted for approximately 43 percent of urban hospitals' gross revenues in 2016.").

157. GAO-18-634, *supra* note 11, at 25. "Under current law, sequestration of direct spending to achieve budgetary goals may be required every year through fiscal year 2027." *Id.* at 25 n.50.

158. *Id.* at 29.

159. *See generally* Letter from Joseph A. Schindler, Vice President of Fin., Minn. Hosp. Assoc., to Andrew M. Slavitt, Acting Adm'r, CMS (June 29, 2016) (discussing the impact on Minnesota hospitals).

160. *Id.*

161. GAO-18-634, *supra* note 11, at 25.

162. *See id.* at 22.

163. *Id.*

164. *Id.* at 22–23.

165. Letter from Joseph A. Schindler to Andrew M. Slavitt, *supra* note 159.

166. *Id.* at 21–22.

167. GAO-18-634, *supra* note 11, at 21.

willing to attempt to endure financial distress and thus, are more likely to close.[168] In fact, "a 2017 study found that for-profit hospitals were more than twice as likely to experience financial distress relative to government-owned and non-profit hospitals."[169] Further, "there is evidence that for-profit hospitals have been more sensitive to changes in profitability."[170] Thus, as profit margins for rural hospitals shrink, or even vanish, for-profit hospital systems are less likely to fight to remain open. This could explain the high number of closures among rural hospitals with for-profit ownership type.[171]

Thus, the cause of the rural hospital closure crisis is a perfect storm of challenging rural demographic and economic trends, leading to difficult and insufficient health care payment and delivery systems, aging facilities, and insurance coverage and reimbursement shortfalls.[172] Collectively, these contributing factors can be summed up as market factors, hospital (institutional) factors, and collectively, financial factors.

V. THE BEST-FIT SOLUTION

To adapt to the unique demographic and economic challenges that they face, rural hospitals need to repurpose themselves to coincide with the demands of their constituencies while also striving to cut costs and preserving their roles as an economic catalyst within their communities. One solution that has played a critical role in the survival of many rural hospitals is Medicaid expansion. With the passage of the Affordable Care Act (ACA) came the initial requirement that states expand Medicaid coverage to individuals who earned up to 133% of the federal poverty level (FPL).[173] The ACA increased federal funding to cover the

168. *Id.*

169. *Id.* at 21–22.

170. *Id.* at 23.

171. *Id.* (noting "that all hospitals must earn sufficient profits to operate, but found that for-profit hospitals were more likely to respond to the level of profitability than the other types of hospitals." That is, while "for-profit hospitals represented 11 percent of the rural hospitals in 2013, but accounted for 36 percent of the rural hospital closures from 2013 through 2017."). *See also* Jill R. Horwitz, *Making Profits and Providing Care: Comparing Nonprofit, For-Profit, and Government Hospitals*, 24 HEALTH AFF. 790, 796 (2005).

172. *Background on Hospital Closures*, NAT'L ORG. ST. OFF. RURAL HEALTH 1, 3, https://nosorh.org/wp-content/uploads/2016/11/Background-on-Hospital-Closures.pdf (last visited Apr. 9, 2020); *see also* Wishner et al., *supra* note 8.

173. The Patient Protection and Affordable Care Act was signed into law on March 23, 2010. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified in scattered sections of 26 U.S.C. and 42 U.S.C.). On March 29, 2010, President Obama also signed the Health Care and Education Reconciliation Act of 2010, which includes a series of amendments to H.R. 3590. Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (codified in scattered sections of 26 U.S.C. and 42 U.S.C). These two laws together are typically referred to as the Health Reform Law, ACA, or the Affordable Care Act. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2018).

states' costs in expanding Medicaid coverage.[174] If a state did not comply with the ACA's new coverage requirements, it would lose not only the federal funding for those requirements, but also all of its federal Medicaid funds.[175] However, in *NFIB v. Sebelius*, the Supreme Court struck down the requirement that states expand Medicaid or lose their Medicaid funding.[176] The Court ruled that such a conditional requirement ran afoul of the Tenth Amendment's anti-commandeering clause, which prohibits the federal government from compelling states to enforce federal laws.[177] The Court upheld the rest of the ACA, ruling that the ACA could encourage states to expand Medicaid, making expansion optional instead of compelling the states to do so.[178] The federal government did so through an enhanced federal match rate.[179]

States that chose not to expand Medicaid coverage under the ACA have higher numbers of uninsured individuals.[180] The correlation goes even further; approximately eighty percent of rural hospital closures since 2014 have occurred in non-expansion states.[181] Additionally, in states that have not expanded Medicaid, there exists a wider Medicaid "coverage gap."[182] That is, in states that have not expanded Medicaid, many adults, including all childless adults, fall into a "coverage gap" by having incomes that exceed eligibility thresholds but that fall below the FPL, which precludes the receipt of ACA Marketplace tax credit assistance, leading to higher uninsured rates.[183] Increased numbers of uninsured patients further exacerbates the financial vulnerability of rural hospitals.[184] Thus, while the percentage of insured individuals is not the sole factor in closures occurring across the U.S., researchers have found an association between Medicaid expansion and improved hospital financial performance, especially in rural areas.[185] For example, "[a] 2018 study found that Medicaid

174. *Id.* § 1396d(y)(1).

175. *Id.* § 1396c.

176. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 585–86 (2012).

177. *Id.* at 647.

178. *Id.* at 588.

179. *See* Robin Rudowitz & MaryBeth Musumeci, *"Partial Medicaid Expansion" with ACA Enhanced Matching Funds: Implications for Financing and Coverage*, KAISER FAM. FOUND. (Feb. 20, 2019), https://www.kff.org/medicaid/issue-brief/partial-medicaid-expansion-with-aca-enhanced-matching-funds-implications-for-financing-and-coverage/.

180. Rachel Garfield et al., *The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid*, KAISER FAM. FOUND. 1, 3 (Mar. 2019), https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.

181. GAO-18-634, *supra* note 11, at 27.

182. Garfield et al., *supra* note 181, at 1.

183. *Id*.

184. Kristin L. Reiter et al., *Uncompensated Care Burden May Mean Financial Vulnerability for Rural Hospitals in States That Did Not Expand Medicaid,* 34 HEALTH AFF. 1721, 1721 (2015).

185. Richard C. Lindrooth et al., *Understanding the Relationship Between Medicaid Expansions and Hospital Closures*, 37 HEALTH AFF. 111, 117 (2018).

expansion was associated with improved hospital financial performance and substantially lower likelihood of closure, especially in rural markets and counties with large numbers of uninsured adults before Medicaid expansion."[186] Another study from 2017 "found that from 2008-2009 and 2014-2015 the drop in uninsured rates corresponded with states' decisions to expand Medicaid" as permitted under the ACA.[187] "The increase in Medicaid coverage and decline in uninsured were both largest in the small towns and rural areas" of states that chose to expand Medicaid.[188] Further still, "from 2013 through 2017, rural hospitals in states that had expanded Medicaid as of April 2018 were less likely to close compared with rural hospitals in states that had not expanded Medicaid."[189]

Of the states that have opted not to expand Medicaid, most have two common factors: (1) they are located in the South; and (2) they are controlled by Republican governors and/or legislatures.[190] Even in states that have expanded Medicaid, however, expansion is neither a viable cure-all solution nor a sustainable long-term strategy.[191] Rural hospital closures have still occurred, just at a significantly less rate by proportion.[192] One could reasonably argue that due to the complex and expensive structures of rural hospitals, solving the closures crisis requires a federal solution and not a state-by-state attempt to fix. Thus, in addition to Medicaid expansion, further federal solutions are necessary.

A. The Rural Emergency Acute Hospital Act

The missing pieces to solving the rural hospital closure puzzle are the structural and institutional changes introduced in the bipartisan REACH Act. The REACH Act proposed creating a new Rural Emergency Hospital (REH)

186. GAO-18-634, *supra* note 11, at 26 ("This same study reported that rural hospitals experienced better total margins, operating margins, and Medicaid and uninsured margins because of Medicaid expansion.").

187. *Id.*

188. *Id.* (finding that "the rate of uninsured adults in rural and small-town counties fell by 11 percent in states that expanded Medicaid on or before January 1, 2014, but only 6 percent in states that did not expand Medicaid. In contrast, during the same time period the rate of uninsured adults in urban areas fell by 9 percent in states that expanded Medicaid on or before January 1, 2014."). *See* J. Hoadley et al., *Medicaid in Small Towns and Rural America: A Lifeline for Children, Families, and Communities*, GEO. U. CTR. FOR CHILD. & FAMS., U.N.C. N.C. RURAL HEALTH RES. PROGRAM 1, 9 (2017), https://ccf.georgetown.edu/wp-content/uploads/2017/06/Rural-health-final.pdf.

189. GAO-18-634, *supra* note 11, at 26.

190. *See* RURAL FORWARD, A TOUGH ROW TO HOE: HOW REPUBLICAN POLICIES ARE LEAVING RURAL HEALTH CARE IN THE DUST 6 (2018), https://www.protectourcare.org/wp-content/uploads/2018/06/A-Tough-Row-to-Hoe-How-Republican-Policies-Are-Leaving-Rural-Health-Care-in-the-Dust.pdf.

191. *See* Wishner et al., *supra* note 8, at 9.

192. GAO-18-634, *supra* note 11, at 26.

classification under Medicare by allowing a hospital to have a freestanding emergency room and provide outpatient services.[193] Such a classification would eliminate the requirement that rural hospitals provide inpatient beds.[194] The reduction in the high overhead costs associated with operating those inpatient beds can be redirected toward higher operating margins.[195] The REH designation seeks to address "the difficulty that CAHs may have in achieving [inpatient] occupancy rates high enough to keep . . . the hospitals themselves open."[196] "REHs would provide only 24/7 emergency care, observation care, and outpatient services."[197] Transfer services by ambulance would also be available to transport patients who need a higher level of care or need to be admitted as inpatients once the patients are stabilized at the REH.[198] "REHs would not operate any acute-care inpatient beds themselves."[199] "CAHs and other small rural hospitals [with 50 beds or fewer] that meet these [eligibility] criteria" could receive the designation.[200] The Act would not impose any new mandates on these rural hospitals.[201] Instead, the Act would re-emphasize the need to maintain and comply with some current protocols, such as the ability to safely transfer a patient, if necessary, in exchange for eliminating inpatient services.[202] The underlying logic for this new designation is that these rural hospitals are more likely to be financially viable without the high overhead costs of maintaining inpatient beds.[203] The hospitals' resources could instead be directed at treating, stabilizing, and/or transporting patients to larger or higher-level trauma medical centers, while the rural hospitals would continue to be reimbursed at the higher Medicare reimbursement rates.[204]

The changes introduced in the bipartisan REACH Act would allow for rural hospitals to make a number of decisions to try to maintain solvency. First, the newly-created REH designation under the Medicare program would "allow facilities in rural areas to provide emergency medical services without having to maintain inpatient beds."[205] That is, with passage of the REACH Act, in addition

193. *See* Rural Emergency Acute Care Hospital Act, S. 1130, 115th Cong. § 1–3 (2017).

194. *Id.* § 2(11)–(12).

195. *Id.*

196. Wishner et al., *supra* note 8, at 11.

197. *Id.*

198. *Id.*

199. *Id.*

200. *Id.*

201. *Grassley, Klobuchar, Gardner Introduce Legislation to Help Rural Hospitals Stay Open, Focus on Emergency Room Care, Outpatient Services*, CHUCK GRASSLEY (May 16, 2017), https://www.grassley.senate.gov/news/news-releases/grassley-klobuchar-gardner-introduce-legislation-help-rural-hospitals-stay-open.

202. *Id.*

203. Wishner et al., *supra* note 8, at 11.

204. *Id.*

205. Rural Emergency Acute Care Hospital Act, S. 1130, 115th Cong. § 2(11) (2017).

to providing emergency care, REHs could "convert the space previously used for inpatient services to provide other medical services including, but not limited to, observation care, skilled nursing facility care, infusion services, hemodialysis, home health, hospice, nursing home care, population health, and telemedicine services."[206]

A rural hospital can qualify as a REH if it satisfies six requirements.[207] First, as of December 31, 2016, the hospital must be or have been a CAH or was a hospital with no more than fifty beds and located in a rural area as defined under the Social Security Act.[208] Under the REACH Act, there is also a five-year lookback clause for hospitals that were designated as a CAH or had fewer than fifty beds, but which ceased operations no more than five years prior to the December 31, 2016 date. Second, the hospital cannot provide twenty-four-hour emergency medical care and observation care that exceeds an annual per patient average of twenty-four hours or more than one midnight; third, the hospital cannot provide any inpatient acute care beds and has protocols in place for the timely transfer of patients who require acute care inpatient services; fourth, the hospital elects to be designated as a REH; fifth, the hospital must receive approval from the state it operates in to operate as a REH in accordance with Section 1834(v)(3)(A) of the Social Security Act; and sixth, the hospital must be certified by the Secretary under Section 1834(v)(3)(B) of the Social Security Act.[209] Similarly, the term "rural emergency hospital outpatient services" means "medical and other health services furnished by a rural emergency hospital on an outpatient basis, but does not prohibit a rural emergency hospital from providing extended care services."[210]

The REH designation would also get its own PPS payment rate.[211] The changes introduced in the REACH Act amend Section 1834 of the Social Security Act,[212] changing the amount of payment for REH outpatient services to be equal to 110% of the reasonable costs of providing such services.[213] This is important and generous, especially considering the aforementioned razor thin margins of profitability by which most rural hospitals run, exacerbated by the also aforementioned Medicare sequestration cuts. Accordingly, versus designation as a CAH, which would receive cost-based reimbursements of 99% of its costs (101% minus 2% sequestration) and would thereby be in the negative, under the REH status, as proposed in the REACH Act, the hospital would

206. *Id.* § 2(12).
207. *Id.* § 3.
208. *Id.* § 3(a)(1)(B).
209. *Id.*
210. S. 1130, § 2(11).
211. *Id.*
212. *Id.* § 3(a)(2)(B).
213. *Id.*

receive cost-based reimbursements of 108% (110% minus 2% sequestration), which should thereby allow for profit margins to stay in the positive.[214]

The REACH Act outlines the steps to obtain REH status. First, state approval to operate as a REH is required;[215] the hospital will not be paid or reimbursed unless certified as a REH.[216] Under the changes introduced by the REACH Act, rural hospitals would also be eligible to both waive the distance requirement for replacement CAHs and have the option to re-designate as a CAH if so desired.[217] Additionally, states have the option of waiving the distance requirement with respect to another facility located in the state that is seeking designation as a CAH.[218] Likewise, a REH that was previously designated as a CAH under this paragraph may elect to be re-designated as a CAH at any time, subject to such conditions as the Secretary may establish.[219]

Thus, the changes introduced in the REACH Act would provide rural hospitals that previously had fewer than fifty inpatient beds flexible alternatives to try to stave off closure by allowing for a new designation and a favorable new payment scheme.

B. How the Passage of the REACH Act Would Help Stave off Rural Hospital Closures

To assess how and why the changes introduced by the REACH Act are such a good solution for the rural hospital closure crisis, it is important to remember the three main root causes: market factors, hospital (institutional) factors, and accumulatively, financial factors.

> In 2012-2013, rural hospitals had an average of 50 beds and [had] a median of 25 beds. They had an average daily census of 7 patients and 321 employees, and they were 10 years old on average. Compared to urban hospitals, rural hospitals are more likely to be located in counties with an elderly and poor population.[220]

REHs would eliminate the burdensome costs associated with staffing and facilitating the excess, unfilled beds.[221] Under the REACH Act, hospitals are required to eliminate inpatient beds to be certified as a REH.[222] This would help eliminate costs, allowing the hospitals to remain solvent.

The changes introduced in the REACH Act also encourage utilizing former inpatient space to increase access to more outpatient services that are especially

214. *Critical Access Hospital (CAHs) Introduction*, RURAL HOSP. INFO. HUB (Dec. 27, 2019), https://www.ruralhealthinfo.org/topics/critical-access-hospitals.

215. S. 1130, § 3.

216. *Id.*

217. *Id.*

218. *Id.*

219. *Id.*

220. Wishner et al., *supra* note 8, at 3.

221. *See generally* S. 1130, § 2.

222. *Id.* § 3.

necessary for rural populations. Because rural populations tend to be older, sicker, and poorer, maintaining providers in the community is crucial to their continuity of care. Expanding access to those necessary outpatient services and properly monitoring and managing symptoms in a timely manner, without unnecessarily burdening the hospital with inpatient beds and staff, allows REHs to target treatment based on their respective communities' needs. This retooling of a rural hospital's roles is exactly what rural hospitals need in order to survive.

The changes introduced in the REACH Act would also have profound impacts on the local community markets. "[T]he typical rural hospital creates over 140 jobs and generates $6,800,000 in compensation while serving an average population of 14,600."[223] Thus, rural hospital closures have a profound twofold adverse effect on rural communities: the negative impact on the local economy and the loss of timely access to emergency medical care.[224] Further, "[t]he percentage of trauma deaths occurring in rural areas could continue to increase as more rural hospitals close, further limiting access to emergency services and requiring patients to travel longer distances to receive emergency medical care."[225] The changes introduced in the REACH Act are intended to preserve a substantial bulk of the jobs within the hospital, and clearly, any jobs saved amount to more than if the hospitals close. This is a major economic boost to these rural communities because it attracts families to move to the community, increases tax and spending revenue for the community, and directly pays the salaries of many local constituents.[226] The REH status also allows for the life-saving and emergency care necessary in rural communities. Thus, the preservation of these roles within rural communities is crucial to the stability of these local community markets.

The changes introduced in the REACH Act also rectify many of the institutional challenges that rural hospitals are currently facing. For example, the Act takes the logic of CAHs—that being that the fewer the beds, the better reasoning for cost-based reimbursement—and amplifies that logic with the creation of REHs. CAHs get 101% cost-based reimbursement, which, after Medicare sequestration, amounts to 99%.[227] Under the changes introduced in the REACH Act, if hospitals make the effort to eliminate the overhead costs of inpatient beds and staff, those hospitals are reimbursed at 108% after sequestration.[228] This comes opposed to the Act enforcing traditional IPPS reimbursements, which likely would be neither as lucrative nor as predictable.

223. *Id.* § 2(5).
224. *Id.* § 2(4).
225. *Id.* § 2(10).
226. *Community Vitality and Rural Healthcare*, *supra* note 44.
227. Letter from Joseph A. Schindler to Andrew M. Slavitt, *supra* note 159.
228. S. 1130, §§ 2(10), 3(a)(2)(B).

The REACH Act also takes the work-around guesswork currently faced by FEDs out of the equation by creating a new substitute Medicare payment designation. That designation, the REH, eliminates the question of whether or not a hospital without inpatient beds can even be reimbursed by Medicare, or how they must code to remain in compliance. Instead, under the Act, the REH designation option triggers the cost-based reimbursement for all qualified REHs.[229]

The Act also works into its repayment scheme a protective barrier to minimize the impact of Medicare sequestration. As noted above, the annual two percent reduction in Medicare repayments, without the REH designation, has proven to be a matter of life or death for rural hospitals.[230] That is, without the REH status, the best rural hospitals of any designation status can do currently is ninety-nine percent of costs reimbursed. Given that the average rural hospital operating margin is two percent, the protection against sequestration provided by REH status is crucial to year-to-year, long-term fiscal survivability.[231]

Likewise, from a fiscal standpoint, passage of the changes introduced in the REACH Act makes sense. Collectively, the Act gives rural hospitals options to retool themselves to maximize the amount of money they can be reimbursed and earn. While the REACH Act cannot force states to expand Medicaid, it can have a profound impact in both states that have and states that have not expanded Medicaid by creating profit margins for rural hospitals so they can afford to provide uncompensated care. Especially in those states that have not expanded Medicaid, this means the ability to provide and absorb (and, under REH status, be reimbursed for) the costs of some uncompensated care, which is known to be a costly imposition to rural hospitals. Similarly, and again, the Act builds in a safety net for reimbursements of up to a net of 108% of reasonable costs.[232] The Act also protects communities' jobs, tax revenue, and infrastructure, often where there is little else.[233] This preservation and boost would allow rural hospitals to repurpose themselves in sustainable way for the first time in nearly seventy years, which is paramount.[234] The changes introduced in the REACH Act would also be mutually beneficial to both for-profit and not-for-profit ownership types, so long as the cost reimbursements at the Act's reimbursement rate sufficiently satisfy the for-profit-owners' profit standards. However, for-profit entities are generally less likely to be community-oriented than not-for-profits, and therefore, if for-profit entities close, such closures should be less heavily scrutinized, especially in areas of market saturation.

229. *Community Vitality and Rural Healthcare*, *supra* note 44.

230. *See generally* Letter from Joseph A. Schindler to Andrew M. Slavitt, *supra* note 159.

231. *See generally id.* (explaining why CAH reimbursement cannot be reduced any more than it already has been).

232. *See generally* S. 1130, § 3.

233. *See generally Community Vitality and Rural Healthcare*, *supra* note 44.

234. *See* Watson, *supra* note 7, at 9.

While the REACH Act faces significant federal and state legislative and regulatory hurdles, its passage is necessary.[235] Currently, there are no "[f]ederal or [s]tate designations for many integrated (private) or partial (ED only) service models."[236] Because the designation does not currently exist, there are no payment methodologies that currently allow for reimbursement.[237] In order to expand rural hospitals' ability to receive payment from CMS, Congress likely needs to define new provider categories and designations that fit the REHs.[238] Likewise, states will likely need to develop new licensure categories and certification processes.[239]

VI. CONCLUSION

The recent wave of rural hospital closures is likely to continue without federal action that would permit states to allow and incentivize rural hospitals to repurpose themselves to better respond to local economic challenges and institutional challenges that are inherent in the outdated rural hospital models. While Medicaid expansion has proven to be a lifeline in states that have opted to expand, Medicaid expansion alone is incapable of completely solving the puzzle, and it is a non-sustainable attempt at solving a bigger policy crisis. Therefore, Congress should pass the REACH Act. Doing so would allow for an opt-in to a new Medicare payment designation to FEDs, maximizing the hospitals' cost-based reimbursement rates, maintaining and expanding outpatient services, and ensuring some level of fiscal integrity. More importantly, passage of the REACH Act would preserve rural communities' access to both health care and to jobs by keeping a majority of the non-inpatient jobs intact at these hospitals. The changes introduced in the REACH Act, collectively, amount to the missing puzzle piece that would allow rural hospitals to repurpose themselves in a cost-efficient way, ensuring that they can more effectively provide care to their communities, despite the unique community and institutional factors these hospitals face.

235. Wishner et al., *supra* note 8, at 17.
236. *Id.*
237. *Id.*
238. *Id.*
239. *Id.*

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