

## Introduction

With decreasing rural populations and changing federal regulations, many rural hospitals have struggled to maintain financial viability in recent years. In 2017, 6,210 total hospitals operated in the United States;<sup>1</sup> 2,250, of these are rural hospitals. Nationally, 113 rural hospitals have closed since January 2010.<sup>2</sup> Furthermore, the rate of rural hospital closures from 2013 to 2017 was twice as high as the rate of the previous five years.<sup>3</sup> In January 2010, SLC member states had approximately 831 rural hospitals. Since then, 81 rural hospitals (9.7 percent) in the South have closed.

Rural hospitals provide strong economic returns to rural areas. In some cases, the rural healthcare sector comprises as much as 20 percent of a community's employment and income. According to the National Rural Health Association (NRHA), a Washington, D.C.-based nonprofit professional association and one of the major proponents for the improvement of rural healthcare, the average Critical Access Hospital<sup>†</sup> creates 170 jobs and generates \$7.1 million in annual salaries and benefits, often being one of the top employers in a rural area. The closing of a rural hospital has a ripple effect on the community, impacting

local businesses that supply materials to the hospital and eliminating the income of former hospital employees.<sup>4</sup> A 2019 report conducted by researchers at the University of Washington found that when a rural hospital closes, mortality rates increase by 6 percent in the surrounding area.<sup>5</sup>

Highlighting the precarious condition of rural hospitals, in February 2019, Navigant, a Chicago-based consulting firm, released their Rural Hospital Sustainability report, which found that 21 percent of rural hospitals in the United States are at high risk of closing unless their finances improve. The authors rated a rural hospital's financial risk by examining their total operating margin, number of days with cash on hand and debt-to-capitalization ratio. Thirty-four states had five or more rural hospitals at high financial risk, including 13 of the 15 SLC member states. In the South, 27.8 percent of rural hospitals are at high financial risk, as depicted in Table 1.

The Navigant report cites a 2006 report from Health Services Research, an academic journal on healthcare based in Chicago, which found that when a rural hospital closes, per capita income decreases 4 percent and unemployment rises 1.6 percent. Of the Southern states, fiscal challenges for rural hospitals were the greatest in Alabama, with 21 hospitals—50 percent of the state's total—at high financial risk, followed by Mississippi with 48.4 percent, and Georgia with 41.3 percent.<sup>6</sup>

<sup>\*</sup> According to the U.S. Government Accountability Office, 31 rural hospitals closed from 2008 to 2012, 64 rural hospitals closed from 2013 to 2017.

<sup>†</sup> Appendix 1 provides information on rural hospital classifications.

Table 1		Southern States with Rural Hospitals at High Financial Risk	
State	Total Rural Hospitals	Rated at High Financial Risk	Percentage at High Financial Risk
Alabama	42	21	50.0%
Arkansas	49	18	36.7%
Florida	23	8	34.8%
Georgia	63	26	41.3%
Kentucky	65	16	24.6%
Louisiana	50	10	20.0%
Mississippi	64	31	48.4%
Missouri	61	14	23.0%
North Carolina	47	6	12.8%
Oklahoma	58	17	29.3%
South Carolina	15	4	26.7%
Tennessee	37	7	18.9%
Texas	127	12	9.4%
Virginia	22	1	4.5%
West Virginia	27	10	37.0%
<b>Total</b>	<b>750</b>	<b>201</b>	<b>27.8%</b>

Source: David Mosley and Daniel DeBehnke, M.D., “Rural Hospital Sustainability: New Analysis Shows Worsening Situation for Rural Hospitals, Residents,” February 2019, Navigant, <https://www.navigant.com/-/media/www/site/insights/healthcare/2019/navigant-rural-hospital-analysis-22019.pdf>, accessed April 25, 2019.

This *SLC Regional Resource* examines the unique circumstances facing rural hospitals and communities today, including healthcare regulations and recent federal actions aimed at directing greater financial support toward rural healthcare providers, followed by a review of legislation adopted in the 15 SLC member states addressing rural health, rural hospitals and their challenges. Throughout, the term “rural hospital” refers to a healthcare facility—including for profit or nonprofit facilities, and public or private facilities—providing medical services to rural Americans, as defined by the U.S. Census Bureau, unless otherwise noted. The “Defining Rural” section (page 3) contains more information regarding rural versus urban delineations.

## How Did We Get Here?

Approximately 62 million Americans, nearly one-fifth of the total population, live in rural areas.<sup>7,8</sup> While the national population has grown 13 percent since 2000, many rural areas are experiencing population declines. Nationally, half of all rural counties had fewer residents in 2018 than in 2000.<sup>9</sup> These population losses are one of several factors, including higher poverty rates in rural areas, geographic isolation and changes to federal healthcare policy, contributing to the closure of rural hospitals.

In recent years, many rural hospitals have struggled to stay in operation, as illustrated in Figure 2. If this trend continues, some experts project that additional rural hospitals will be forced to close, with disastrous consequences. These closures may lead to a feedback loop: when a rural hospital closes, the former hospital employees leave the area to find work, more rural hospitals close as there are fewer rural patients and the cycle continues.

The patient payment methods at a rural hospital often differ from an urban hospital. According to a 2019 American Hospital Association (AHA) report, rural hospitals are more likely to serve Medicare and Medicaid patients than urban hospitals.

Both Medicare and Medicaid regularly reimburse hospitals less than the hospital spends to provide care; on average, hospitals are reimbursed 87 cents for every dollar they spend on care for Medicare and Medicaid patients. In 2017, Medicare and Medicaid reimbursements provided 56 percent of rural hospital revenue.<sup>10</sup> Such a disproportionate share of Medicare and Medicaid patients can affect a hospital’s financial solvency. Rural hospitals also serve fewer patients than urban hospitals. From 2012 to 2013, rural hospitals had an average of seven inpatients receiving care daily, while urban hospitals had an average of 102.<sup>11</sup> Further complicating matters, federal spending decreases implemented in 2013 still are in effect.

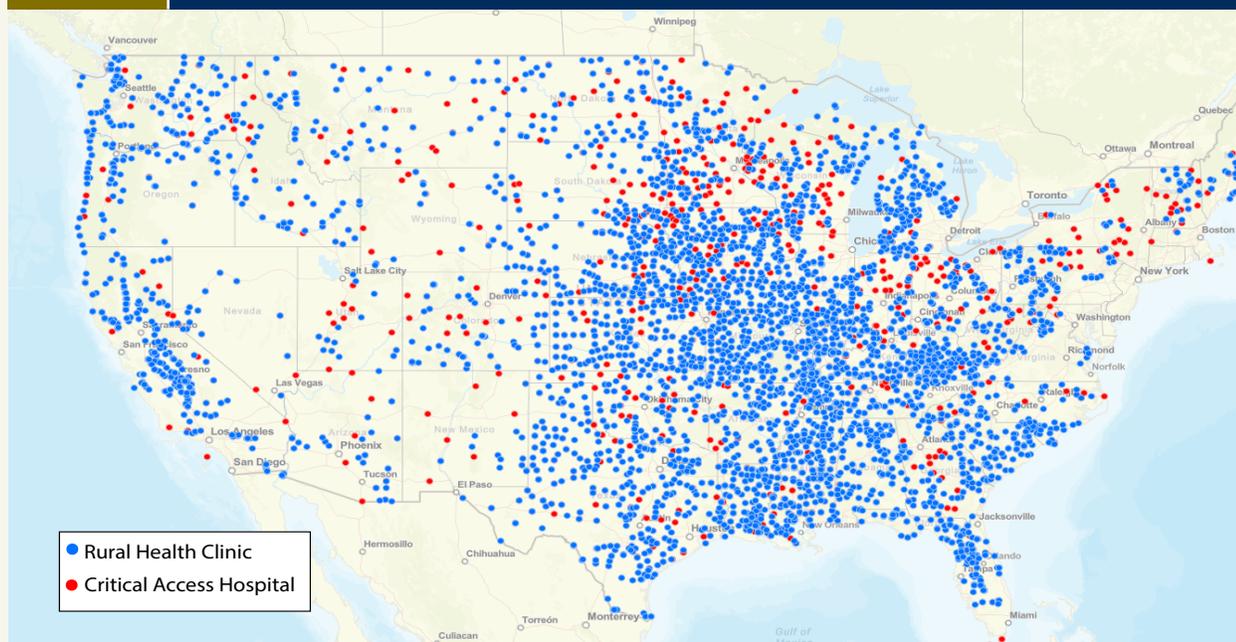
## Defining Rural

Rural hospitals provide much needed healthcare to residents in less populous areas of the United States. However, determining what qualifies as a rural hospital or rural resident can be difficult, due to variances in the criteria used by different organizations. The federal Office of Management and Budget (OMB) classifies urban counties based on core-based statistical areas (CBSAs).<sup>\*</sup> Some federal programs classify counties outside CBSAs as rural. In addition, the Census Bureau has their own criteria, but does not actually define rural.<sup>†</sup> The Federal Office of Rural Health Policy (FORHP) employs aspects of both definitions when delineating between urban and rural areas. However, the Centers for Medicare and Medicaid Services (CMS) does not have a universal classification system for all rural hospitals and, instead, identifies six types, each with distinct characteristics and geographical requirements.<sup>‡</sup> Figure 1 displays two types of rural hospitals: rural health clinics and critical access hospitals.<sup>§</sup>

The majority of completely rural counties (counties with fewer than 2,500 residents) are located in the western United States. However, the majority of rural residents live in the South. In 2010, the South had 27 million rural residents; compared to 8 million in the Northeast, 16 million in the Midwest and 7 million in the West.<sup>¶1,122</sup>

Source: "HRSA Map Tool," Health Resources and Services Administration, <https://data.hrsa.gov/maps/map-tool/>, accessed October 17, 2019.

**Figure 1 Rural Health Clinics and Critical Access Hospitals in the United States 2019**



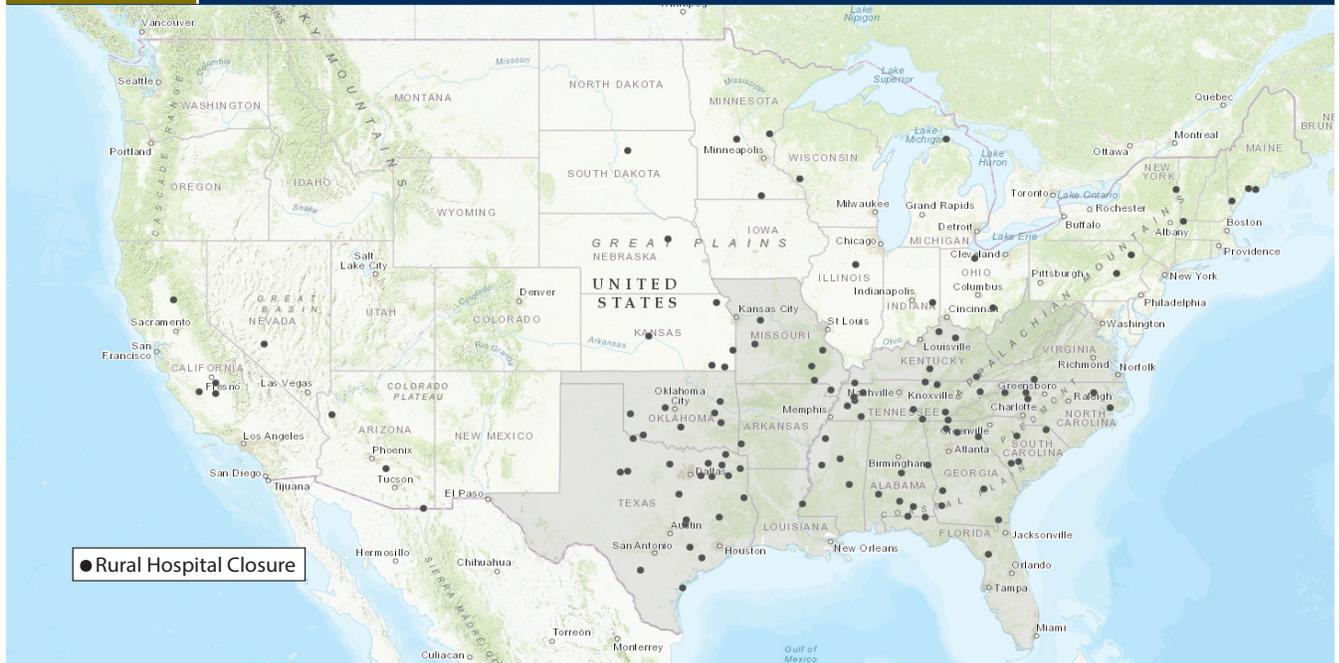
<sup>\*</sup> Under the OMB criteria, any resident of a metropolitan or micropolitan CBSA is an urban resident. A metropolitan area contains a core urban area of 50,000 or more residents, and a micropolitan area contains an urban core of 10,000 to 50,000 residents.

<sup>†</sup> Under the Census Bureau, urban areas and urban clusters are defined, all other areas are rural. Urbanized areas contain 50,000 or more residents. Urban clusters have more between 2,500 and 50,000 residents.

<sup>‡</sup> For a more detailed discussion of the varying definitions for rural and urban areas, see SLC's April 2019 Policy Analysis, "Federal Legislation on Rural Hospitals," available at <https://www.slcatlanta.org/research/index.php?pub=587>.

<sup>§</sup> Rural hospital classifications under Medicare. Appendix 1 provides more information on rural hospital classifications.

<sup>¶</sup> This analysis uses U.S. Census Bureau regional divisions. Under this system, the Southern states are Alabama, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia. The SLC region includes Missouri, but not Delaware or Maryland.

**Figure 2****Rural Hospital Closures in the United States January 2010 – August 2019**

Source: “113 Rural Hospital Closures: January 2010 – Present,” University of North Carolina’s Sheps Center for Health Services Research, <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>, accessed August 23, 2019.

To curtail deficit spending, the Budget Control Act of 2011 required mandatory budget reductions for all federal agencies and departments, often referred to as “sequestration.” Starting April 1, 2013, the legislation required a 2 percent reduction in all Medicare reimbursement payments.<sup>12</sup>

Although poverty is a national issue, nearly 85 percent of rural, persistent poverty counties\* are in the South.<sup>13</sup> According to the NRHA, the per capita income of rural residents, \$21,935, is \$9,242 lower than the national average. Per the U.S. Census Bureau, national per capita income from 2013 to 2017 was \$31,177.<sup>14</sup> Similarly, a September 2019 report by the U.S. Census Bureau noted that, in 2018, the South had the highest poverty rate and, from 2017 to 2018, was the only region without a decrease in the poverty rate.<sup>†</sup> In 2018, the poverty rate in the South was 13.6

\* A county in which 20 percent or more of its population has lived in poverty in the previous 30 years.

† This report uses U.S. Census Bureau regional divisions. See the “Defining Rural” section (page 3) for a list of states.

percent, compared to 10.3 percent in the Northeast, 10.4 percent in the Midwest and 11.2 percent in the West.<sup>15</sup> The 2019 median income in the South was \$57,299, compared to \$70,113 in the Northeast, \$64,069 in the Midwest and \$69,520 in the West.<sup>16</sup>

Higher rates of poverty and lower incomes of rural Americans often lead to a multitude of additional challenges, such as lower rates of health insurance; poorer health; higher use of the Supplemental Nutrition Assistance Program; greater transportation challenges when visiting a healthcare provider; higher use of tobacco; higher rates of diabetes; and lack of access to broadband internet. In addition, the majority of vehicle accident-related deaths occur in rural areas, and most rural Americans must travel twice as far as urban residents to reach the nearest hospital.<sup>17</sup> These factors all pose particular health-related and technological challenges for rural hospitals which are not experienced to the same degree by urban residents.

As originally written, the Affordable Care Act of 2010 (ACA) required states to expand Medicaid to

all Americans with incomes up to 133 percent of the federal poverty guideline (FPG).<sup>‡</sup> The ACA also provided tax credits to Americans with incomes from 100 percent to 400 percent of the FPG to purchase health insurance policies through federal and state marketplaces. The ACA does not provide private health insurance tax credits to Americans below 100 percent of FPG, as the expectation was that these individuals would be covered by Medicaid expansion.<sup>18,19</sup>

In a 2012 decision, the U.S. Supreme Court ruled that the federal government could not require states to expand Medicaid. As a result, Medicaid expansion became optional, and nearly 2.5 million uninsured Americans fell into a coverage gap, with incomes too high to qualify for Medicaid, but too low to receive marketplace tax credits. Of these 2.5 million Americans in the coverage gap, 92 percent reside in the South.<sup>20</sup>

As of September 2019, 36 states have expanded Medicaid. A 2019 analysis by the Pew Charitable Trust found that rural hospitals in states that did not expand Medicaid are in greater danger of closing. Ten of the 14 states that did not expand Medicaid are SLC member states. In the 14 non-expansion states, the average income limit to qualify for Medicaid is 43 percent of the FPG, approximately \$9,159 for a family of three.

## Uncompensated Care

Lacking a primary care provider, many uninsured Americans go without care or turn to hospital emergency rooms. Under the Emergency Medical Treatment and Labor Act of 1986, Medicare-participating hospitals are required to provide emergency services to all patients, regardless of their ability to pay.

According to the AHA, community hospitals<sup>§</sup> have administered nearly \$620 billion worth of uncompensated care since 2000, as displayed in table 2.<sup>21</sup> A provision in the ACA revised the Medicare Disproportionate

<sup>‡</sup> \$17,374 for a family of three in 2010 and \$21,300 in 2019

<sup>§</sup> Community hospitals are all nonfederal, short-term general, and other special hospitals.

Table 2		Annual Uncompensated Care Cost at Community Hospitals
Year	Community Hospitals	Uncompensated Care Cost
2000	5,012	\$21.6 billion
2001	4,986	\$21.5 billion
2002	5,020	\$22.4 billion
2003	5,018	\$24.9 billion
2004	5,104	\$27.0 billion
2005	5,374	\$29.3 billion
2006	5,350	\$31.6 billion
2007	5,322	\$34.4 billion
2008	5,396	\$36.8 billion
2009	5,362	\$39.5 billion
2010	5,371	\$39.8 billion
2011	5,376	\$41.6 billion
2012	5,367	\$46.3 billion
2013	5,359	\$46.8 billion
2014	5,308	\$43.2 billion
2015	5,280	\$36.1 billion
2016	5,267	\$38.4 billion
2017	5,262	\$38.4 billion
<b>Total</b>		<b>\$619.6 billion</b>

Source: "Uncompensated Hospital Care Cost Fact Sheet," January 2019, American Hospital Association, <https://www.aha.org/system/files/2019-01/uncompensated-care-fact-sheet-jan-2019.pdf>, accessed August 9, 2019.

Share Hospital (DSH)<sup>¶</sup> reimbursement rate and provided for an additional payment to cover a hospital's uncompensated care. Since fiscal year 2014, DSHs have received 25 percent of the Medicare reimbursement rate they received under the previous system. The remaining 75 percent is provided to hospitals to offset the cost of uncompensated care. Although

<sup>¶</sup> Created by the Consolidated Omnibus Budget Reconciliation Act of 1985, Disproportionate Share Hospitals (DSH) receive payments from CMS to offset the costs of providing care to uninsured patients. These hospitals, which are not limited to rural areas, serve significantly greater numbers of low-income patients.

annual uncompensated care at community hospitals has decreased since implementation of the ACA, it continues to pose another financial challenge for rural hospitals.<sup>22</sup>

## Rural Hospitals: Paths to Recovery

Governments have initiated various actions to support rural hospitals in recent years. This section details legislation, policies and programs implemented at the federal and state levels to strengthen rural hospitals.

### Federal Programs, Policies and Legislation

The federal government has made myriad efforts to bolster rural hospitals. This section highlights loans and grants, federal Medicare reimbursement rates and pending legislation specific to rural hospitals and communities.

### Health Professional Shortage Areas

Many rural areas lack sufficient medical service providers to adequately serve the population. In urban areas, there are 53.3 primary care physicians (PCPs) for every 100,000 residents; rural areas have 39.8 PCPs for every 100,000 residents.<sup>23</sup>

To address this discrepancy, the U.S. Department of Health and Human Services (HHS) created the Health Professional Shortage Area (HPSA) designation to offer incentives for providers to work in underserved areas.<sup>24</sup> Criteria considered for the HPSA designation include the population-to-provider ratio; percentage of population below the federal poverty level; and travel time to the nearest source of care. The formulation varies depending on type of service provided: primary care, dental or mental health.<sup>25</sup> Nationally, HHS has identified 4,118 HPSAs in rural areas, compared with 1,960 HPSAs in urban areas.<sup>26</sup>

The National Health Service Corps (NHSC) Loan Repayment Program encourages healthcare providers to serve in HPSAs.<sup>27</sup> The NHSC is a subdivision of the U.S. Department of Health and Human Services Health Resources and Services Administration, Bureau of Clinician Recruitment and Service. Founded in 1972, the NHSC awards scholarships and provides loan repayment options to qualifying

## Acronyms

**ACA:** Affordable Care Act of 2010

**AHA:** American Hospital Association

**CAH:** Critical Access Hospital

**CBSA:** Core-Based Statistical Area

**CMS:** Centers for Medicare and Medicaid Services

**DSH:** Disproportionate Share Hospital

**FORHP:** Federal Office of Rural Health Policy

**FPG:** Federal Poverty Guidelines

**HHS:** Department of Health and Human Services

**HPSA:** Health Professional Shortage Area

**REACH Act:** Rural Emergency Acute Care Hospital Act

**RRC:** Rural Referral Center

**SCH:** Sole Community Hospital

**SORH:** State Office of Rural Health

**SRHA:** Save Rural Hospitals Act

physicians who practice at any of the more than 5,000 NHSC-approved locations in underserved communities.<sup>28,29</sup>

### Medicare Area Wage Index

Hospitals may receive different Medicare reimbursement rates for the same procedure due to the Medicare area wage index, which provides Medicare reimbursement based on the average wage paid to hospital employees and cost of living in the service area. A current rule prohibits urban wage indexes from being lower than rural wage indexes.<sup>30</sup> A 2018 report by the HHS Office of the Inspector General found that the current wage index rules contributed to \$140.5 million in reimbursement overpayments to urban and rural hospitals between 2014 and 2017 and recommended changes to the system.<sup>31</sup>

In April 2019, CMS proposed a new rule that would alter the wage index to increase reimbursement rates to rural hospitals and decrease reimbursement rates to

## Glossary

**Medicare:** a federal health insurance program for individuals age 65 or older or for those under age 65 with certain disabilities.

**Medicaid:** a state and federal health insurance program for low-income individuals.

**Inpatient:** a patient who stays overnight in a hospital while receiving treatment.

**Outpatient:** a patient who receives medical treatment, but does not stay overnight in a hospital.

**Rural hospital:** a healthcare facility—including for profit or nonprofit facilities, and public or private facilities—providing medical services to rural Americans, as defined by the U.S. Census Bureau.

**Micro-hospital:** an inpatient facility with fewer beds and services than a traditional hospital.

**Managed care program:** a healthcare delivery system under which an insurer works with a contractor to deliver care. Some state Medicaid agencies work with a managed care organization to provide Medicaid services.

**Certificate of need:** a certificate required in some states to demonstrate that a new healthcare facility is needed. Qualifying criteria vary by state.

urban hospitals. After a public comment period, CMS limited the wage index decrease for urban hospitals to 5 percent or less of their current amount. The new rule became effective on October 1, 2019 and will remain in effect for at least four years. Rural hospitals anticipate increased revenue as a result of the change, which may help to ameliorate current financial conditions and reduce or delay rural hospital closures.<sup>32</sup>

### Federal Office of Rural Health Policy

Established in 1987, the Federal Office of Rural Health Policy (FORHP) advises the HHS secretary on rural healthcare issues including access to quality healthcare, viability of rural hospitals and the effect of HHS policies on rural healthcare.<sup>33</sup> In addition to its advisory role, FORHP provides aid to rural healthcare providers through grants, research and technical assistance. The following sections provide details on FORHP grants for rural hospitals and communities.

#### Rural Health Network Development Grant Program

The Rural Health Network Development Grant Program awards funding to support integrated healthcare networks. Networks must consist of at least three healthcare providers owned by separate organizations; multiple providers owned by the same organization are

not eligible. Each healthcare provider must sign a memorandum or agreement with the other participating providers. The goals of the program are to:

- » Improve the quality of essential healthcare services;
- » Increase efficiency and expand access; and
- » Strengthen the rural healthcare system.

It is expected that FORHP will award up to \$13.8 million in grants to as many as 46 healthcare networks through this program.<sup>34,35</sup>

#### Delta States Rural Development Network Grant Program

The Delta States Rural Development Network Grant Program differs from the Rural Health Network Development Grant Program in two ways. First, the grant is available only for the eight Delta states (Alabama, Arkansas, Illinois, Kentucky, Louisiana, Mississippi, Missouri, and Tennessee). Second, applicants are strongly encouraged to propose a program addressing no more than two of the following health-related issues: diabetes, cardiovascular disease, obesity, acute ischemic stroke, or HIV/AIDS.<sup>36</sup>

### Small Rural Hospital Improvement Grant Program

The Small Rural Hospital Improvement Grant Program helps rural hospitals meet the costs of implementing data system requirements for Medicare by providing hardware, software and training. To qualify, hospitals must be in a rural area and have fewer than 50 beds. The FORHP has allocated \$18.7 million for the 2019 program and anticipates awarding grants to as many as 47 qualifying hospitals.<sup>37,38</sup>

### Small Rural Hospitals Transition Project

Established in 2014, the Small Rural Hospital Transition Project supports rural hospitals through on-site technical assistance, including trainings and consultation. The project's goal is to help rural hospitals transition from a fee-for-service and volume-based payment system to a data- and quality-driven system. Qualifying hospitals must be in federally designated persistent poverty counties, in a rural area and have fewer than 50 beds. Each year, up to nine hospitals are selected to participate. Since its inception, the project has aided 34 rural hospitals. These hospitals experienced:

- » 17 percent increase of net patient revenue;
- » Doubling of net income; and
- » Increases of 10 percentage points in their results on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.<sup>39</sup>

The HCAHPS survey is designed by two agencies within HHS: CMS and the Agency for Healthcare Research and Quality. It is the first national, standardized, publicly reported survey on patients' healthcare satisfaction. The survey includes 27 questions on a patient's healthcare experience and is administered to a random sample of adult patients within six weeks of their discharge.<sup>40</sup>

### State Offices of Rural Health Coordination and Development Program

The State Offices of Rural Health Coordination and Development Program is designed to improve the capacities of the 50 State Offices of Rural Health (SORHs) by increasing opportunities for collaboration

and assisting in the coordination of rural healthcare. Grant funding is available to enhance leadership development and promote collaboration among SORHs.<sup>41</sup>

### Pending Federal Legislation

#### Rural Emergency Acute Care Hospital (REACH) Act

To address the issues facing rural hospitals, U.S. Senator Charles Grassley of Iowa sponsored the Rural Emergency Acute Care Hospital (REACH) Act in June 2015 and May 2017. On both occasions, the bill was read twice and referred to the Senate Finance Committee, then chaired by Senator Orrin Hatch of Utah, with no further action taken. In 2018, Senator Hatch retired from the U.S. Senate and Senator Grassley became chair of the Finance Committee. Supporters of rural hospitals are optimistic that Senator Grassley will re-introduce the bill.<sup>42,43</sup>

In 2017, the REACH Act was sponsored by Senator Charles Grassley and had four co-sponsors, Senator Cory Gardner of Colorado, Senator Amy Klobuchar of Minnesota, Senator Susan Collins of Maine and Senator Angus King of Maine. The bill has been supported by the AHA, calling it "an important first step toward ensuring access to healthcare services in some rural communities."<sup>44,45</sup>

The primary goal of the REACH Act is to create a new Rural Emergency Hospital (REH) classification under Medicare to prevent rural hospitals from losing Medicare funding and potentially closing. These REHs would maintain an emergency room and outpatient services—and still would be eligible to participate in Medicare—but would not be required to provide inpatient services. To provide care to patients with severe injuries or illnesses, REHs would need protocols in place to transport patients to hospitals that provide inpatient treatment. Under the proposed legislation, the Medicare reimbursement rate would be 110 percent of reasonable costs (including transportation services), compared with the current 101 percent reimbursement rate for Critical Access Hospitals (CAHs). If the bill is enacted, the CAH classification still would be available and hospitals

would not be required to convert to the REH classification. Additionally, CAH hospitals that convert to REH could revert to the CAH classification, should conditions change.<sup>46</sup>

The REACH Act also allows REHs to add the emergency medicine specialty\* to the list of specialty professions under the National Health Service Corps (NHSC). To encourage new doctors to work in rural areas, the legislation would permit Medicare reimbursement for hospitals with approved residency programs for interns and residents who perform emergency department rotations in REHs.<sup>47</sup>

### Save Rural Hospitals Act

The National Rural Health Association has supported the REACH Act, but prefers the Save Rural Hospitals Act (SRHA), sponsored by Representative Dave Loebsack of Iowa and Representative Sam Graves of Missouri.<sup>48</sup> Like the REACH Act, the SRHA was introduced in the 114th Congress (2015-2016) and the 115th Congress (2017-2018), but did not advance out of committee.<sup>49</sup>

The SRHA would eliminate the aforementioned Medicare sequestration cuts;<sup>50</sup> extend payment levels for Low-Volume Adjustment Hospitals and Medicare Dependent Hospitals (see Appendix 1); delay penalties for rural hospitals that have yet to become electronic health record users; make increased Medicare payments for ambulance services in rural areas permanent; and establish a program for rural hospitals meeting specific criteria to receive higher payments for qualified outpatient services. Additionally, the SRHA would create a new Medicare hospital designation, the Community Outpatient Hospital (COH), which would not be required to provide inpatient services. Critical Access Hospitals

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\* Emergency medicine focuses on the immediate decision-making and action necessary to prevent death or further harm in the pre-hospital setting and emergency department. Source: "American Board of Emergency Medicine," American Board of Medical Specialties, <https://www.abms.org/member-boards/contact-an-abms-member-board/american-board-of-emergency-medicine/>.

and rural hospitals with 50 acute care beds or less would be eligible to become COHs, with reimbursement rates at 105 percent of reasonable cost.<sup>51</sup>

### Status

As of October 2019, neither the REACH Act nor the SRHA have been re-introduced in the 116th Congress (2019-2020).

### State Programs, Policies and Legislation

This section details statewide rural healthcare-related legislation passed in the previous five years and other state rural healthcare-related information, as of October 1, 2019. The first year of expansion is listed for the five Southern states that expanded Medicaid under the ACA. Table 3 displays rural healthcare statistics for the 15 Southern states. Data on state population, percentage of population uninsured, Medicaid expansion status and number of rural hospital closures is derived from the University of North Carolina's Sheps Center for Health Services Research, Navigant, U.S. Census Bureau, Rural Health Information Hub and Kaiser Family Foundation.<sup>52,53,54,55,56</sup>

### Alabama

Six rural hospital have closed in the state since 2010. The state currently has 42 rural hospitals, half of which are at high financial risk of closing, according to Navigant's 2019 Rural Hospital Sustainability report. In 2018, 10 percent of the state's population lacked health insurance and 23.3 percent lived in rural areas.

In March 2018, the Legislature passed Senate Bill 351, creating the Alabama Rural Hospital Resource Center to operate under the University of Alabama at Birmingham (UAB) Health System. The Center will provide expert guidance to public and nonprofit rural hospitals on matters including logistics, strategic planning and insurance reporting.<sup>57</sup> Senator Greg Reed, sponsor of the bill, told the Tuscaloosa News that as many as 32 hospitals in the state could receive assistance from the Rural Hospital Resource Center.<sup>58</sup>

In April 2018, the Department of Public Health declared that 62 of the state's 67 counties lacked

sufficient primary care physicians and qualified as HPSAs. In response, Blue Cross Blue Shield of Alabama donated \$3.6 million to UAB to establish a scholarship program to train 60 primary care physicians over five years. To qualify, scholarship recipients are required to practice in an HPSA for a minimum of three years after completion of a medical residency.<sup>59</sup>

In May 2019, the Legislature passed House Resolution 240 supporting CMS' aforementioned rule change to adjust the Medicare area wage index. The rule change had not been finalized when the resolution was passed.<sup>60</sup>

Table 3		SLC State Rural Healthcare Statistics				
State	State Population (2018)	Rural Population (2018)	Percentage of Population in Rural Areas (2018)	Percentage of Population Uninsured (2018)	Medicaid Expansion Status	Rural Hospitals Closures Since January 2010
Alabama	4,887,871	1,138,858	23.3%	10.0%	No	6
Arkansas	3,013,825	1,130,051	37.5%	8.2%	Yes, 2014	1
Florida	21,299,325	716,213	3.4%	13.0%	No	2
Georgia	10,519,475	1,794,520	17.1%	13.7%	No	7
Kentucky	4,468,402	1,829,922	40.9%	5.6%	Yes, 2014	4
Louisiana	4,659,978	749,722	16.1%	8.0%	Yes, 2016	0
Mississippi	2,986,530	1,595,263	53.4%	12.1%	No	5
Missouri	6,126,452	1,540,870	25.2%	9.4%	No	6
North Carolina	10,383,620	2,215,596	21.3%	10.7%	No	5
Oklahoma	3,943,079	1,335,480	33.9%	14.2%	No	7
South Carolina	5,084,127	744,386	14.6%	10.5%	No	4
Tennessee	6,770,010	1,515,869	22.4%	10.1%	No	12
Texas	28,701,845	3,073,050	10.7%	17.7%	No	20
Virginia	8,517,685	1,037,819	12.2%	8.8%	Yes, 2019	2
West Virginia	1,805,832	688,724	38.1%	6.4%	Yes, 2014	0
<b>Total</b>	<b>118,083,929</b>	<b>18,890,747</b>	<b>24.7%</b>	<b>10.6%</b>	<b>5 States</b>	<b>81</b>

Sources: "113 Rural Hospital Closures: January 2010 - Present," University of North Carolina's Sheps Center for Health Services Research, <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>, accessed August 23, 2019.

David Mosley and Daniel DeBehnke, M.D., "Rural Hospital Sustainability: New Analysis Shows Worsening Situation for Rural Hospitals, Residents," February 2019, Navigant, <https://www.navigant.com/-/media/www/site/insights/healthcare/2019/navigant-rural-hospital-analysis-22019.pdf>, accessed April 25, 2019.

Edward Berchick, Jessica Barnett and Rachel Upton, "Health Insurance Coverage in the United States: 2018," September 2019, United States Census Bureau, <https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf>, accessed September 12, 2019.

"State Guides," Rural Health Information Hub, U.S. Department of Health and Human Services, <https://www.ruralhealthinfo.org/states>, accessed August 23, 2019.

"Status of State Action on the Medicaid Expansion Decision," August 1, 2019, Kaiser Family Foundation, <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>, accessed September 12, 2019.

## Arkansas

Since 2010, one rural hospital has closed in the state. The state has 49 rural hospitals, with 18 (36.7 percent) at high financial risk of closing. In 2018, 8.2 percent of Arkansans lacked health insurance and 37.5 percent lived in rural areas. Arkansas expanded Medicaid under the ACA in 2014, the first year that expansion was available.

Senate Bill 155 (2019) revises state law regarding the Rural Health Services Revolving Fund, codified in 1991, which provides matching funds on a one-to-one basis, up to a maximum of \$200,000, to applicants seeking to stabilize or expand rural healthcare. The new legislation clarifies that funds may be transferred from the General Improvement Fund, established to allocate surplus general revenues for capital improvement projects, or its successor fund or fund accounts, including the Development and Enhancement Fund, which replaced the General Improvement Fund in 2019.<sup>61,62</sup>

Passed in April 2019, House Bill 1841 creates the Osteopathic\* Rural Medical Practice Student Loan and Scholarship and establishes a board to administer the scholarship and identify medically underserved areas. The legislation, which became effective on July 1, 2019, also specifies application criteria to qualify for the scholarship. The maximum amount of each loan is \$16,500 per academic year or equal to the reasonable and necessary costs as determined by the Osteopathic Rural Medical Practice Student Loan and Scholarship Board.<sup>63</sup> The new loan and scholarship program is in addition to the state's Rural Medical Practice Student Loan and Scholarship Board, established in 1949.<sup>64</sup>

## Florida

Two rural hospital have closed since 2010. Eight of Florida's 23 rural hospitals (34.8 percent) are at high financial risk of closing. In 2018, 13 percent of the population was without health insurance. The state has the lowest per capita rural population of any Southern

state, with only 3.4 percent of the state's 21 million residents living in rural areas.

Senate Bill 2514 (2017) broadens the definition of a "rural hospital" to include Sole Community Hospitals (see Appendix 1), regardless of the number of licensed beds. Prior to the bill's passage, only Sole Community Hospitals with up to 175 licensed beds qualified as rural hospitals.<sup>65</sup>

The fiscal year 2020 budget—Senate Bill 2500 (2019)—revises the Agency for Health Care Administration's rural hospital outpatient service provider reimbursement rate to 1.5622 times the value of the service provided. This new reimbursement rate becomes effective at the start of each fiscal year. The budget also appropriates the following amounts for Disproportionate Share Hospitals: \$6.5 million from the General Revenue Fund; \$90.4 million from the Grants and Donations Trust Fund; and \$230.1 million from the Medical Care Trust Fund.<sup>66</sup> The Legislature appropriated similar amounts in 2016, 2017, and 2018.<sup>67,68,69</sup>

## Georgia

Seven rural hospital have closed since 2010. The state has 63 rural hospitals, with 26 at high financial risk of closing (41.3 percent). In 2018, 13.7 percent of Georgia residents did not have health insurance and 17.1 percent of Georgians lived in rural areas. Georgia has not expanded Medicaid, but currently is exploring options for a Medicaid expansion waiver.<sup>70</sup>

In April 2014, then-Governor Nathan Deal created the Rural Hospital Stabilization Committee to study issues pertaining to rural healthcare, increase communication between rural hospitals and state government and expand access to rural healthcare. The committee issued a 2015 report that included the following recommendations:

- » Adopt a "hub and spoke" model of healthcare delivery, in which a central hospital ("hub") provides emergency and primary care services, and refers patients to smaller specialty hospitals ("spoke") that

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\* Osteopathic medicine focuses on the interrelations of all systems in the body. Osteopathic doctors practice in all areas of medicine.

are part of the same organization, when necessary, similar to the “rural emergency hospital” classification proposed in the REACH Act;

- » Create a pilot program for the “hub and spoke” model, expanding the use of new and existing technology, such as Wi-Fi and telemedicine equipped ambulances, school health clinics, public health departments and physicians; and
- » Maintain existing certificate of need laws to protect existing rural hospital infrastructure.<sup>71</sup>

The General Assembly appropriated \$3 million in the fiscal year 2016 budget for the first phase of the Rural Hospital Stabilization Program, a result of the committee’s work, featuring four rural hospitals. Participating hospitals used the funding for improvements including: better Wi-Fi connection, improved internet technology, newer medical equipment and expansion of telemedicine. Participating hospitals reported a \$9.2 million increase in net revenue; a 58 percent decrease in encounters by high emergency department utilizers; and an increase of \$496,343 in charges from their top 25 high inpatient care utilizers.\* The second and third phases of the program, with new hospitals, started in 2017 and 2018, respectively.<sup>72,73</sup>

In 2017, the General Assembly passed the Rural Hospital Organization Assistance Act (Senate Bill 14), which authorizes the Department of Community Health to provide grants to ailing rural hospitals. The legislation specifies necessary criteria for grant qualification, including that hospitals must provide inpatient hospital services at a facility located in a rural county or be a Critical Access Hospital; participate in Medicaid and Medicare; and provide healthcare services to indigent patients. The maximum amount granted to any hospital is \$4 million per calendar year, and grant funds may be used for infrastructure planning, strategic planning, nontraditional healthcare delivery systems and/or the provision of 24-hour emergency room services.<sup>74</sup>

House Bill 769 (2017) allows for the creation of micro-hospitals, defined as facilities in a rural county

\* Comparing calendar year 2014 to 2016.

that provide two to seven inpatient beds and around-the-clock emergency services. The legislation allows hospitals in the state to purchase closed healthcare facilities or ones scheduled to close and operate them as micro-hospitals. Additionally, the legislation requires the creation of a Rural Health Innovation Center; mandates legal, fiduciary and grant management training for rural hospital executives and board members; and makes contributions of up to \$5,000 to rural hospital organizations 100 percent tax deductible—previously 90 percent of the contribution was deductible.<sup>75</sup> The Rural Health Innovation Center began operations in 2019 at the Mercer University School of Medicine.<sup>76</sup>

A provision in House Bill 321 (2019) encourages charitable donations to rural hospital organizations by requiring the Department of Community Health to create an operations manual that identifies rural hospitals in the state, ranked in order of financial need. The legislation further requires the department to post this manual and all charitable contributions to rural hospitals on their website.<sup>77†</sup>

## Kentucky

Since January 2010, four rural hospitals have closed. Sixteen of Kentucky’s 65 rural hospitals are at high financial risk of closing (24.6 percent), according to Navigant’s 2019 Rural Hospital Sustainability report. In 2018, 5.6 percent of the population was uninsured, the lowest uninsured rate in the South, and 40.9 percent of Kentuckians lived in rural areas, the second highest rate in the South. Kentucky expanded Medicaid in 2014.

House Bill 303 (2016) required that, until June 30, 2018, an acute care hospital seeking to become a Critical Access Hospital must be receiving funding for a feasibility study from the Office of Rural Health, or file a request for such funding.<sup>78</sup> House Bill 200 (2018) moved the expiration date of the CAH feasibility study requirement to June 30, 2020.<sup>79</sup>

† More information on this manual is available online: <https://dch.georgia.gov/rural-hospital-tax-credit>

In 2018, the General Assembly passed House Bill 444, exempting certain categories of outpatient service providers from the requirement to obtain a certificate of need before opening a facility; making a substantial change in a facility's bed capacity; acquiring major medical equipment; and making a substantial change in a project. Providers exempted by the legislation include rural health clinics; primary care centers; special health clinics, unless the clinic provides pain management services; and ambulatory care clinics treating minor illnesses and injuries.<sup>80</sup>

## Louisiana

Louisiana is one of two Southern states with no rural hospital closures since 2010. Ten of the state's 50 rural hospitals (20 percent) are at high financial risk of closing. In 2018, 8 percent of Louisianans lacked health insurance and 16.1 percent resided in rural areas. The state expanded Medicaid in 2016.

House Bill 326 (2018) updates and clarifies state statutes pertaining to the Health Trust Fund, as well as other sections.<sup>81</sup> The Health Trust Fund, created by the Legislature in 2001 to support healthcare in the state, provides funding to primary care clinics in rural hospitals and other facilities. The Legislature appropriates money to the Health Trust Fund using interest from the Medicaid Trust Fund, intergovernmental transfers, monies contributed by local governments to obtain federal matching funds and proceeds from the Deepwater Horizon Economic Damages Collection Fund.<sup>82</sup> Upon the recommendation of the Dedicated Fund Review Subcommittee, formed in 2018 to study the Legislature's use of dedicated funds that cannot be annually adjusted, the Health Trust Fund will be eliminated effective July 1, 2020. Going forward, funds still will be allocated for health-related purposes, but the level of funding will not be mandated by state law.<sup>83,84</sup>

To guard against future rural hospital closures, Senate Bill 36 (2019) prohibits healthcare providers from opening new freestanding emergency rooms<sup>‡</sup> within

<sup>‡</sup> Freestanding emergency rooms are not connected to a hospital and are not urgent care centers.

the primary service area of a rural hospital.<sup>85</sup> Some freestanding emergency rooms only offer the most profitable services, potentially decreasing revenue for rural hospitals.<sup>86</sup>

Senate Bill 59 (2019) aims to attract more health-care providers to rural areas in the state by allowing the Small Town Health Professional Tax Credit, established in 2017, to be available to rural physician assistants and optometrists. The credit provides a non-refundable tax credit without carryforward<sup>§</sup> equal to the lesser of the tax due or \$3,600. Previously, only physicians and primary care nurse practitioners were eligible for the credit. To qualify, healthcare providers must establish and maintain a primary office located in a rural Health Professional Shortage Area and accept Medicaid and Medicare payments.<sup>87</sup>

## Mississippi

Five rural hospital closures have occurred since 2010. Thirty-one of the state's 64 rural hospitals (48.4 percent) are at high financial risk of closing. In 2018, 12.1 percent of Mississippians did not have health insurance. The state has the largest per capita rural population of any Southern state, with 53.4 percent of residents living in rural areas.

Passed in 2016, Senate Bill 2297 allows for the operation of freestanding emergency rooms, provided the facility operates 24 hours a day, is not located on a hospital campus and is located at least 15 miles from the nearest rural hospital-based emergency room. The legislation also instructs the State Department of Health to adopt and enforce rules, regulations and standards for these freestanding emergency rooms.<sup>88</sup>

Senate Bill 2836 (2018) allows the state Division of Medicaid (DOM) to grant rural hospitals with 50 or fewer beds the option to receive reimbursements for outpatient hospital services under a new, fee-for-service reimbursement system. These hospitals are reimbursed at 101 percent of the Medicare reimbursement rate

<sup>§</sup> Carryforward allows an unused tax credit to be carried forward to subsequent years.

for their outpatient hospital services, instead of the previous ambulatory payment classification\* method set by DOM.<sup>89,90,91</sup>

A provision in House Bill 1650 (2019) instructs the DOM to develop a new payment system to reimburse rural hospitals with 50 or fewer beds that would result in increased payments for outpatient services. The DOM must submit their proposed system to the Legislature by December 31, 2019.<sup>92</sup>

## Missouri

Since 2010, six rural hospitals have closed, and 14 of the state's 61 operating rural hospitals (23 percent) are at high financial risk of closing. In 2018, 9.4 percent of Missourians did not have health insurance and 25.2 percent of residents lived in rural areas.

Senate Bill 275 (2019) establishes a Joint Task Force on Radiologic Technologist Licensure—a 15-member task force comprised of two Senators, two House members and 11 health professionals—and charges it with formulating recommendations to improve radiologic licensing standards in the state. The task force must develop a plan to address the need for licensed radiologic technologists in rural areas. One member of the task force will be appointed by the Missouri Association of Rural Health Clinics.<sup>93</sup>

Also passed in 2019, Senate Bill 514 updates state law addressing collaborative practice agreements, which allow physician assistants to perform certain tasks traditionally performed by a physician. The legislation allows physician assistants to prescribe and administer up to a five-day supply of Schedule III, IV and V controlled substances<sup>†</sup> and hydrocodone without a refill. Additionally, the legislation states that further restrictions will not be imposed on collaborative practice agreements in a rural health clinic, other than those specified by federal law.<sup>94</sup>

\* An ambulatory payment classification system is how government agencies pay hospitals for services performed under Medicare or Medicaid.

† Schedule III, IV and V controlled substances serve medical purposes and have a potential for abuse. Examples of these drugs include Xanax, Ambien and Ketamine.

## North Carolina

Five rural hospitals have closed since 2010. Six of the state's 47 rural hospitals (12.8 percent) are at high financial risk of closing. In 2018, 10.7 percent of residents lacked health insurance and 21.3 percent lived in rural areas.

A provision of the 2017-2019 biennial budget, Senate Bill 257 (2017), directs the Office of Rural Health to merge the state's Physician Loan Repayment Program, Psychiatric Loan Repayment Program and the Loan Repayment Initiative into one program for doctors practicing in state hospitals, rural areas and medically underserved communities. The bill also allocates funds for the Office of Rural Health: \$7.5 million in funding for fiscal year 2018 and fiscal year 2019, with up to \$6.9 million allocated each year to award grants.<sup>95</sup>

House Bill 998 (2017) directs the Department of Health and Human Services to study and make recommendations regarding incentives for medical education in the state's rural areas and how to assist rural hospitals with receiving CMS's teaching hospital designation. The legislation also advises the Office of Rural Health to collaborate with the University of North Carolina's Sheps Center for Health Services Research to identify rural areas lacking sufficient dental services and to address these shortages through the use of loan repayment funds.<sup>96</sup>

A provision in the Heroin and Opioid Prevention and Enforcement Act, Senate Bill 616 (2018), updates the guidelines for a statewide telepsychiatry program administered by the Office of Rural Health. Under the new law, providers may offer psychiatric care to patients in need of mental health or substance abuse care at an approved site, including public health departments, rural health centers, federally qualified and school-based health centers, free clinics and other hospitals.<sup>97</sup>

## Oklahoma

Seven rural hospitals have closed since 2010. Seventeen of the state's 58 rural hospitals (29.3 percent) are at high financial risk of closing. In 2018, 14.2 percent of Oklahomans lacked health insurance and 33.9 percent lived in rural areas.

To maximize federal matching funds, Senate Bill 1044 (2019) directs the Oklahoma Health Care Authority (OHCA) to increase payments to hospital-based rural healthcare clinics. The legislation also directs the OHCA to revise the state's Disproportionate Share Hospital criteria and redirect any additional funds to qualifying rural hospitals.<sup>98</sup>

According to the Oklahoma Hospital Association, the OHCA has not been following federal and state regulations regarding payments to hospital-based rural health clinics or utilizing its entire federal DSH funding. The OHCA estimates that the Legislature will need to appropriate an additional \$3 million to increase payments to hospital-based rural healthcare clinics. The Oklahoma Hospital Association argues that allocating an additional \$8.6 million in state funding to DSHs would generate an added \$22.8 million in federal matching funds.<sup>99</sup>

### South Carolina

Since 2010, South Carolina has experienced four rural hospital closures. Four of the state's 15 rural hospitals (26.7 percent) are at high financial risk of closing. In 2018, 10.5 percent of residents were uninsured and nearly 15 percent lived in rural areas.

Since 2013, the General Assembly has allocated annual funds to the Department of Health and Human Services (DHHS) to support rural hospitals under the Rural Hospital DSH Payment program. To qualify, hospitals must be designated as rural by the state and participate in a Healthy Outcomes Plan, collaborating with DHHS to improve the coordination of care for uninsured patients and providing monthly reports tracking their progress. Under the plan, hospitals that qualified prior to October 1, 2014, may receive up to 100 percent of uncompensated care costs and, from that date forward, up to 90 percent of uncompensated costs.<sup>100,101,102</sup> As of October 1, 2016, hospitals located in a persistent poverty county are eligible for the Rural Hospital DSH Payment program, which reimburses up to 80 percent of uncompensated care costs.<sup>103</sup>

The fiscal year 2020 budget, House Bill 4000 (2019), appropriates \$7.5 million to DHHS for the agency's

Rural Health Initiative, created to support rural health-care in the state. The bill instructs DHHS to partner with other state agencies and universities to better meet the needs of medically underserved communities in the state. At least \$1 million of the funds must be provided to the University of South Carolina School of Medicine's Center for Excellence to support rural medical education and up to \$500,000 will be used to award grants related to rural healthcare.<sup>104</sup>

### Tennessee

Twelve rural hospitals have closed since 2010. Seven of the state's 37 rural hospitals are at high financial risk of closing (18.9 percent). In 2018, 10.1 percent of residents did not have health insurance and 22.4 percent lived in rural areas.

The Tennessee Rural Hospital Transformation Act of 2018, introduced as House Bill 2326, aims to help rural hospitals restructure through the Rural Hospital Transformation Program, administered by the Department of Economic and Community Development. The program's 21-member advisory committee – comprising staff members of key state agencies and three health-based nonprofit organizations – will select hospitals to receive technical and planning assistance from contractors with rural health-care experience and expertise. The General Assembly has appropriated \$1 million in annual funds for the program, which will terminate in 2021.<sup>105</sup> In the initial year, Navigant, the Chicago-based consulting firm that produced the 2019 Rural Hospital Sustainability report, will help selected hospitals create a “transformation plan” to preserve healthcare services in their area.<sup>106</sup> The state hopes to assist a minimum of 10 hospitals in the first two years of the program.<sup>107</sup>

### Texas

Since 2010, 20 rural hospitals have closed. Twelve of the state's 127 rural hospitals (9.4 percent) are at high financial risk of closing. In 2018, 17.7 percent of Texans lacked health insurance, the highest uninsured rate in the South, and 10.7 percent lived in rural areas.

The state's 2019-2021 biennial budget, House Bill 1 (2019), makes the following appropriations for rural

hospitals: \$60 million to maintain Medicaid outpatient reimbursement rates; \$90.4 million to increase inpatient rates at rural hospitals; and \$16 million to provide a \$500 Medicaid add-on payment for labor and delivery services provided by rural hospitals.<sup>108</sup>

Senate Bill 170 (2019) directs the executive commissioner of the Health and Human Services Commission (HHSC) to adopt a prospective reimbursement methodology that ensures rural hospitals participating in Medicaid are reimbursed on an individual basis for Medicaid services. This methodology must use a hospital's most recent cost information, and new reimbursement rates must be calculated biannually.<sup>109</sup>

Also passed in 2019, Senate Bill 1621 requires the HHSC to develop a strategic plan ensuring that rural residents will have access to hospital services and submit it to the Legislative Budget Board by January 1, 2020. The plan must propose at least one of the following reforms: enhanced cost reimbursement methodology and supplemental payment program for rural hospitals participating in the Medicaid Managed Care Program; rate enhancement program for rural hospitals; reduction of punitive actions that require reimbursement for Medicaid payments made to a rural provider; reduction of regulatory-related costs for rural hospitals; or the creation of a minimum fee schedule for payments by a managed care organization to rural hospitals. After the first report, the HHSC must submit a report detailing updates to the strategic plan and its implementation every even-numbered year. The legislation also establishes an advisory committee on rural hospitals – comprising interested individuals appointed by the executive commissioner of the HHSC – and instructs the HHSC to collaborate with the Office of Rural Affairs to maximize federal grant funding for rural hospitals.<sup>110</sup>

## Virginia

Two rural hospitals have closed since 2010. One of Virginia's 22 rural hospitals is at high financial risk of closing (4.5 percent), the lowest financial risk rate of any Southern state. In 2018, 8.8 percent of Virginians did not have health insurance and 12.2 percent resided

in rural areas. The commonwealth expanded Medicaid, effective January 1, 2019.

The state's 2018-2020 biennial budget – House Bill 5002A (2018) – appropriates \$190,000 in fiscal year 2019 and another \$190,000 in fiscal year 2020 for a pilot program to expand healthcare into more rural areas using nurse practitioners and telemedicine. The legislation also instructs the health commissioner to continue implementation of the state's five-year rural health plan and appropriates \$150,000 for fiscal year 2019 and another \$150,000 for fiscal year 2020 as the state match for the Federal Office of Rural Health Policy Grant.<sup>111</sup>

The state's most recent five-year rural health plan, adopted October 2013, provided several recommendations and objectives for the most pertinent stakeholders, including:

- » Rural residents should encourage policymakers to consider rural health in their long-term and short-term planning;
- » Healthcare providers should work to increase the number of providers in rural areas; and
- » Rural localities should organize to target high priority health concerns and try to make improvements related to these concerns.<sup>112</sup>

In August 2019, the State Office of Rural Health received funding to draft a new rural health plan and aims to have one completed by August 2020.<sup>113</sup>

## West Virginia

West Virginia is one of two Southern states with no rural hospital closures since 2010. Ten of the state's 27 rural hospitals (37 percent) are at high financial risk of closing. In 2018, 6.4 percent of residents lacked health insurance and 38.1 lived in rural areas. The state expanded Medicaid in 2014, the first year that expansion was available.

Senate Bill 593 (2019) updates state law to permit a Critical Access Hospital to become a Community Outpatient Medical Center if it has been designated as

a CAH for at least one year. A community outpatient medical center must provide 24-hour emergency care and observation care services; treat all patients regardless of insurance status; and have transfer protocols for patients who require a higher level of care. Unlike a CAH, Community Outpatient Medical Centers would not be required to maintain a certain number of inpatient beds.<sup>114</sup>

The fiscal year 2020 budget, House Bill 2020 (2019), appropriated \$2.6 million to support rural hospitals with fewer than 150 beds and \$1.3 million to various rural health programs administered by the state's public universities and Higher Education Policy Commission. The Legislature appropriated similar amounts to these institutions in 2016, 2017 and 2018.<sup>115,116,117,118</sup>

## Conclusion

Since January 2010, 113 rural hospitals, out of 2,250, across the United States have closed, constituting 5 percent. Remarkably, 81 of those 113 closures (71.7 percent) are in the SLC region. The closure of 81 rural hospitals in the Southern region represents 9.7 percent of the approximately 831 rural hospitals operating in 2010. This *SLC Regional Resource* has examined a number of factors contributing to the recent increase in closures, including rural demographics, higher rates of poverty, uncompensated care and changes to federal healthcare laws. This list of causes is not exhaustive.

According to a 2018 study published in the academic journal *Health Affairs*, the frequency of rural hospital closures in non-Medicaid expansion states increased rapidly after 2014, the first year that Medicaid expansion was available.<sup>119</sup>

The federal government has demonstrated a willingness to issue Medicaid waivers, which allow states to create their own Medicaid qualifying criteria and rules. As of September 2019, CMS has approved 49 Medicaid waivers for 40 states; 13 waivers have been approved in 10 SLC member states.<sup>120</sup> In the South, approved state demonstrations focus on five key areas of Medicaid/Children's Health Insurance Program (CHIP) services and coverage:

- » Expanding care for family planning services for individuals who currently are ineligible for Medicaid or CHIP;
- » Providing care for individuals with long-term disabilities who currently are ineligible for Medicaid or CHIP;
- » Implementing community engagement requirements as a condition of Medicaid eligibility;
- » Establishing funding for substance use disorder treatment and broader behavioral health initiatives; and
- » Expanding Medicaid managed care, which provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between Medicaid agencies and managed care organizations.<sup>121</sup>

The adjustment to the Medicare Area Wage Index by CMS, which became effective October 1, 2019, will increase reimbursement rates for rural hospitals. While the higher rates will assist rural hospitals in addressing their financial challenges in the immediate term, it is unlikely that the issues rural hospitals are facing will be resolved completely. As reviewed in this *SLC Regional Resource*, state legislatures in the South have adopted several policies to augment the federal support for rural areas and improve the delivery of, and access to, rural healthcare, including:

- » Creating task forces to understand the rural healthcare needs in their states;
- » Working with colleges and universities to incentivize medical students to practice in rural areas;
- » Selecting rural hospitals to receive technical and planning assistance;
- » Revising reimbursement rates to rural hospitals; and
- » Creating new hospital classifications.

Given the disproportionate share of rural residents in the SLC region, policymakers will need to address this issue for many years to come. While most SLC state legislatures have begun to remediate this situation, legislation already passed may only prove to be a stop-gap measure. As the cost of healthcare continues to rise, coupled with an aging rural population, policymakers may find themselves back at the drawing board before too long.

Appendix 1	Medicare Designations for Rural Hospitals
Designation	Eligibility Criteria
Sole Community Hospital (SCH)	<p>More than 35 miles from other similar hospitals (excluding CAHs) or serves a rural area as defined by the U.S. Census Bureau and one of the following:</p> <ul style="list-style-type: none"> <li>• Between 25 and 35 miles from other similar hospitals and serves as main hospital in the vicinity</li> <li>• Between 15 and 25 miles from other similar hospitals, but other hospitals are difficult to access</li> <li>• Nearest similar hospital is at least 45 minutes away</li> </ul>
Rural Referral Center (RRC)	<p>Serves a rural area as defined by the U.S. Census Bureau plus one of the following:</p> <ul style="list-style-type: none"> <li>• 275 acute care inpatient beds or more</li> <li>• Majority of Medicare patients referred by outside providers and majority of Medicare patients live more than 25 miles away</li> <li>• High case mix and high discharge volume and one of the following: mostly specialty practitioners, most inpatients live 25 miles away, many patients referred by outside providers</li> </ul>
Medicare Dependent Hospital (MDH)	<ul style="list-style-type: none"> <li>• Serves a rural area as defined by the U.S. Census Bureau</li> <li>• Not a SCH</li> <li>• 100 beds or fewer</li> <li>• At least 60 percent of inpatient days or discharges are Medicare Part A beneficiaries</li> </ul>
Critical Access Hospital (CAH)	<ul style="list-style-type: none"> <li>• Serves a rural area as defined by the U.S. Census Bureau</li> <li>• More than 35 miles from nearest hospital or CAH or more than a 15-mile drive from another hospital in an area with challenging road conditions or designated by state as “necessary provider” before 2006</li> <li>• 25 acute care inpatient beds or fewer</li> <li>• 24-hour emergency services</li> <li>• Annual average length of patient stay of 96 hours or less for acute care patients</li> </ul>
Low-Volume Adjustment Hospital	<p>Pilot program; expired in 2017, extended through 2022 with new criteria beginning in 2019:</p> <ul style="list-style-type: none"> <li>• Fewer than 3,800 total discharges in fiscal year</li> <li>• Located more than 15 road miles from the nearest subsection (d) hospital</li> </ul>
Rural Community Hospital	<p>Pilot program; extended in 2016 for five years (30 participating hospitals):</p> <ul style="list-style-type: none"> <li>• Serves a rural area as defined by the U.S. Census Bureau</li> <li>• Fewer than 51 acute care inpatient beds</li> <li>• 24-hour emergency services</li> <li>• Not designated/eligible to be CAH</li> </ul>
Rural Health Clinic	<p>Serves a rural area as defined by the U.S. Census Bureau; and is located in an area currently designated or certified by the Health Resources and Services Administration within the previous four years as one of these types of areas:</p> <ul style="list-style-type: none"> <li>• Primary Care Geographic Health Professional Shortage Area (HPSA)</li> <li>• Primary Care Population-Group HPSA</li> <li>• Medically Underserved Area</li> <li>• Governor-designated and Secretary-certified shortage area</li> </ul>

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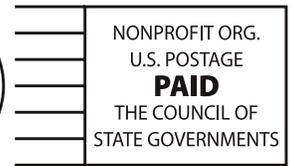
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