Financing Rural Health Care

Isaac D. Buck

University of Tennessee College of Law

Follow this and additional works at: https://researchrepository.wvu.edu/wvlr

Part of the Health Law and Policy Commons

Recommended Citation

This Article is brought to you for free and open access by the WVU College of Law at The Research Repository @ WVU. It has been accepted for inclusion in West Virginia Law Review by an authorized editor of The Research Repository @ WVU. For more information, please contact beau.smith@mail.wvu.edu.
I. INTRODUCTION

The rural health care crisis—as it relates to hospital access—is a financial crisis. Put most simply, rural hospitals are closing because they are not adequately funded. Hospital closures are a symptom of public and private spending policy, and their solutions seem largely political—a question of societal responsibilities and values.

To be sure, however, the lack of adequate rural hospital financing is caused by phenomena more complex than just the simplistic failure to pay. The crisis is also caused by the rising costs of medical care, the unpredictable nature of medical needs, the payer mix in rural areas, and the outmoded fee-for-service reimbursement structure, which is characterized by instability for rural providers. But, from the hospital’s bottom line, it is dollars and cents: when patient loads are down and uncompensated care is up, rural hospitals become especially financially precarious.

Indeed, more than 130 rural hospitals have closed since 2010, and no state has been more impacted on a per capita basis than my home state of Tennessee, with the Appalachian region being dramatically impacted. Solving
the rural access problem requires solving its tricky financing challenges. On that front, the federal government has announced new initiatives and has furthered preexisting efforts to protect rural hospitals through improving payer mixes and providing more stable funding.

For example, through actions taken by the Centers for Medicare and Medicaid Services (CMS), like the Community Health Access and Rural Transformation Model (CHART), the federal government is seeking to inject regulatory flexibility and utilize innovative financial arrangements in an effort to address access-related rural health disparities. In addition to CHART, CMS has also begun the Pennsylvania Rural Health Model, which seeks to examine whether global capitated budgets can improve quality of care, lower the cost of care, and address rural health disparities. Finally, Congress has created a new provider type, Rural Emergency Hospitals (REHs), which, in 2023, also will seek to provide additional funding and funding streams to rural hospitals.

Many of these projects are in their infancies, and they all have laudable aims and goals. These new efforts, along with new strategies to incentivize Medicaid expansion in holdout states, seem to illustrate a continuation of public payer-based policy solutions, reliant on the major health care programs of Medicare and Medicaid, to solve the crisis. These interventions seek to provide more funds to rural hospitals in an effort to stave off more closures. They are limited policy solutions from a federal agency, and, as a result, they may be slow to solve the problem. Importantly, whether they will work remains an open question.

This article will summarize these current efforts that seek to solve rural hospital-based health care. First, it will document effects of the hospital closure crisis in rural America by examining the impact of these closures on citizens' physical health and local economies. Next, it will place a variety of policy solutions, such as Medicaid expansion under the Patient Protection and Affordable Care Act of 2010 (ACA), the CHART Program, the Pennsylvania Rural Healthcare Model, and the Rural Emergency Hospitals provider type, in a larger context of rural health care issues in 21st century America. Finally, in its conclusion, this article will take account of the current state of rural hospital-based health care in light of these policy developments.

II. THE CRISIS OF RURAL HOSPITAL CLOSURES

As of 2022, dozens of rural hospitals in the United States have reached a breaking point. According to the Cecil G. Sheps Center at the University of North Carolina, 97 rural hospitals have closed completely since 2005, and 83 rural hospitals have closed some portion of their services. Of those 181 total closures, 138 have occurred since 2010. Nine hospitals closed in 2020 alone—the highest total of any recent year.

Rural hospitals that have survived to this point are often in a financially precarious position. In 2019, before the pandemic further scrambled hospital finances, a number of rural hospitals were already on the financial brink and more than 40% were operating at a negative margin. And now in the last two years, hospitals have had to withstand a historic pandemic, pushing many "over the cliff." Indeed, the pandemic has applied unprecedented pressure to rural hospitals, furthering two exacerbating trends: (1) patients have avoided hospitals due to COVID-19, and (2) those patients who have come to the hospital in need of care have required more complex and expensive treatment.

When a rural hospital closes, the impacts are dramatic. This section will analyze both (1) the negative impact on the physical health of rural citizens

---

6 Id.
7 Id.
8 Sarah Jane Tribble, Prognosis for Rural Hospitals Worsens With Pandemic, KAISER HEALTH NEWS (Aug. 26, 2020), https://khn.org/news/rural-hospital-closures-worsen-with-pandemic/ ("Nearly 80% of Alabama’s rural hospitals began the year with negative balance sheets and about eight days’ worth of cash on hand. Before the pandemic hit this year, hundreds of rural hospitals ‘were just trying to keep their doors open.’").
12 Tribble, supra note 8.
themselves, and (2) the economic health of the rural community following rural hospital closures.

A. The Impact of Rural Hospital Closures on Physical Health

Hospital closures have an undeniable impact on citizens’ physical health. Indeed, rural hospital closures have “life-or-death” implications on citizens. For those who need care immediately, when a hospital closes, citizens in a rural area in need of care are required to travel long distances to seek it, causing delays in access that can result in needless deaths and long-term negative health consequences. Overall, the loss of a hospital for a rural community has a real and grim effect: a recent study that examined 92 rural hospital closings in California found that the rural hospital closures led to an increased mortality rate of nearly 9% in those areas.

Beyond the effect of increasing mortality in rural areas, a rural hospital closure has a general impact on the health of a rural community by limiting access to vital health care. As many as 25% of individuals living in rural counties have reported having access problems in seeking care. And about 25%


14 See Amy Goldstein, In the Tennessee Delta, a Poor Community Loses Its Hospital—and Sense of Security, WASH. POST (Apr. 11, 2017), https://www.washingtonpost.com/national/health-science/in-the-tennessee-delta-a-poor-community-loses-its-hospital—and-sense-of-security/2017/04/10/6c550492-1941-11e7-855e-4824bbb5d748_story.html (“In his office in the small city hall adjacent to the fire department, he has a letter from a woman whose 8-year-old nephew was playing in the family driveway on a late winter morning last year when their Dodge sedan rolled backward, pinning him under a tire. Without a hospital in town, she explained, ‘needless to say he did not make it.’”).

15 See, e.g., Scanlan & Weinstein, supra note 9 (noting that, following a hospital closure in Jamestown, Tennessee, the nearest hospital is either 45 minutes or 60 minutes away).


of those respondents said the hospital or clinic was “too far or difficult to get to.”\textsuperscript{20} This particularly impacts the elderly and low-income citizens.\textsuperscript{21}

Consequently, rural hospital closures lead to a reduction of emergency care,\textsuperscript{22} obstetric care,\textsuperscript{23} and even specialty care.\textsuperscript{24} Of particular importance is the loss of specialty treatment for mental health and substance use disorder treatment.\textsuperscript{25} A recent Government Accountability Office (GAO) study found that in areas that lost their rural hospital, individuals needing alcohol or drug abuse treatment had to travel a median of 44.6 miles to receive treatment—up from a median of 5.5 miles before the closure.\textsuperscript{26} Similarly, the distance for citizens from a coronary care unit increased from 4.5 miles to 35.1 miles.\textsuperscript{27} This has a real impact on health, as distance from care is associated with higher mortality rates.\textsuperscript{28}

And finally, a rural hospital's loss of obstetric services—from 2004 to 2014, 179 rural hospitals lost these services—has been significantly associated with an increasing the number of preterm births.\textsuperscript{29} Now, more than half of rural counties lack hospital-based obstetric services.\textsuperscript{30} Indeed, “worsening access has

\textsuperscript{20} Id.

\textsuperscript{21} Jane Wishner, Patricia Solleveld, Robin Rudowitz, Julia Paradise et al., \textit{A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies}, KAISER FAM. FOUND. (July 2016), https://files.kff.org/attachment/issue-brief-a-look-at-rural-hospital-closures-and-implications-for-access-to-care (“Elderly and low-income individuals were more likely than others to face transportation challenges following the closures, and were thus more likely to delay or forgo needed care.”).

\textsuperscript{22} Id.

\textsuperscript{23} See Katy Kozhimannil, Peiyin Hung, Carrie Henning-Smith, Michelle M. Casey et al., \textit{Association Between Loss of Hospital-Based Obstetric Services and Birth Outcomes in Rural Counties in the United States}, 319 JAMA 1239 (Mar. 27, 2018).

\textsuperscript{24} Wishner et al., supra note 21, at 8.

In many cases, specialists who had visited the local hospital on a regular basis to provide outpatient visits were no longer available to see patients locally after the hospital closed. With the closure, local residents also lost their access point for referrals to subspecialists. Several respondents commented that many people now forgo lab work and diagnostic imaging rather than travel to another community for the services.

\textsuperscript{25} Id. ("Unmet need for mental health and substance use disorder treatment, a significant issue before the hospital closures, has also intensified.").


\textsuperscript{27} Id.


\textsuperscript{29} See Kozhimannil et al., supra note 23.

\textsuperscript{30} See Frakt, supra note 28.
contributed to increases in maternal mortality and morbidities among rural residents, particularly Black women."  

Further, these closures result in a decrease in care received: when two rural counties in Georgia saw hospitals close, visits to emergency rooms anywhere fell by 35%. In short, when hospitals are not available or accessible, people are simply unable to access vital health care. They simply go without it.

When an emergency does occur, patients, now reliant on hospitals farther away, have longer ambulance rides to the hospital. Anecdotally, patients ask to be treated by the arriving ambulance instead of being transported, with many refusing to be taken to the hospital dozens of miles away, knowing they will have to pay to get themselves home after hospital treatment. 

Accordingly, with hundreds of miles to cover, ambulances have been forced into the role of emergency rooms. Crews “have been stepping up their protocols” and now can “insert chest tubes, start intravenous antibiotics and intubate patients to help keep airways open.” In short, ambulances in rural areas “have become their first line of health care.” But some counties—in addition to lacking a hospital and physician—do not even have ambulances.

31 Martha Hostetter & Sarah Klein, Restoring Access to Maternity Care in Rural America, COMMONWEALTH FUND (Sept. 30, 2021), https://www.commonwealthfund.org/publications/2021/sep/restoring-access-maternity-care-rural-america (noting that “more than half of rural counties in the U.S. were considered maternity care deserts”).


33 Id.

34 See Hospital Closures in Rural Communities Lead to Longer Ambulance Drives, UNIV. OF N.C. GILLINGS SCH. OF GLOB. PUB. HEALTH (Feb. 4, 2020), https://sph.unc.edu/sph-news/hospital-closures-in-rural-communities-lead-to-longer-ambulance-drives/ (noting that a study found that the transport times increased 2.6 minutes in the year of a hospital closure and increased by 4.7 minutes in the subsequent year compared to the year prior to closure).

35 See Goldstein, supra note 14.

36 See Randall Rice, Opinion, Epidemic of Rural Hospital Closures Endangers Tennesseans, TENNESSEAN (Mar. 29, 2021), https://www.tennessean.com/story/opinion/2021/03/29/epidemic-rural-hospital-closures-endangers-tennesseans/7052687002/ (“Ambulance services are seriously stretched as they try to respond to emergencies that now demand extra hours in transit.”).

37 See Goldstein, supra note 14.

38 See Scanlan & Weinstein, supra note 9.

39 See Andy Miller, Rural Communities Left Hurting Without a Hospital, Ambulance or Doctors Nearby, ATLANTA JOURNAL-CONST. (Dec. 31, 2021), https://www.ajc.com/life/health/rural-communities-left-hurting-without-a-hospital-ambulance-or-doctors-nearby/R4HYR2QNMRF7PXTXVPP5O3UKE/ (documenting the reality of Echols County, Georgia, which “could be called a health care desert”).
B. The Impact of Rural Hospital Closures on Economic Health

Rural hospital closures also have an undeniable impact on the overall economic health of a community. Rural communities have a more difficult time recruiting other businesses and families to a community following the loss of a hospital. A recent case study found that respondents noted "that the impact of the hospital closure on the local economy was more significant than its impact on access to care." Further, the jobs within the hospital-supporting industries, "including food and laundry services and construction" that operate to provide support to the hospital, can evaporate following the closure of a rural hospital.

Unsurprisingly, hospital closures lead to physicians leaving rural communities. Even talk of a struggling hospital can lead to quicker "outmigration" of physicians, further precipitating its closure. Indeed, physician recruitment and retention are vital to the success of a hospital—"recruiting and retaining doctors is so pressing that hospital officials even try to become social matchmakers," by suggesting various social outlets based on the physician's interests. The National Health Service Corps (NHSC), which is "designed to deploy physicians, mental health professionals, dentists, and nurse practitioners to nonprofit clinics in health care shortage areas for two years, in exchange for education scholarships or loan repayment," may fill an important gap.

40 See George M. Holmes, Rebecca T. Slifkin, Randy K. Randolph & Stephanie Poley, The Effect of Rural Hospital Closures on Community Economic Health, J. RURAL HEALTH (2006) (finding that the "closure of the sole hospital in the community reduces per-capita income by $703 or 4 percent and increases the unemployment by 1.6 percentage points").

41 See Hospital Closures Can Have a Profound Impact on the Local Economy, W. VA. PUB. BROAD. (Sept. 10, 2019), https://www.wvpublic.org/news/2019-09-10/hospital-closures-can-have-a-profound-impact-on-the-local-economy (raising the point that young families will not be relocating into areas without access to health care).

42 See Holmes et al., supra note 40 at 9.

43 See Frakt, supra note 28.

44 See Hayley Drew Germack, Ryan Kandrack & Grant R. Martsolf, When Rural Hospitals Close, the Physician Workforce Goes, 38 HEALTH AFFAIRS 2086 (Dec. 2019) ("the closure of a rural hospital is associated with average annual reductions of 9.2 percent in the supply of physicians, 8.3 percent in the supply of primary care physicians, and 4.8 percent in the supply of obstetrician-gynecologists"); see also Bolin et al., supra note 10 (noting that the closure of a hospital results in the loss of "professionals, including doctors, nurses and pharmacists, and fewer students in local schools").

45 Wishner et al., supra note 21 ("In Independence, Kansas, providers began to leave Mercy Hospital even before it closed when talk of closure ‘was in the air,’ hastening the deterioration of the already struggling hospital.").

46 See The Struggle to Hire, supra note 19.

47 Corey Meador, In Rural Areas With Health Care Shortages, These Doctors Are Answering the Call, PBS (Apr. 9, 2021), https://www.pbs.org/newshour/health/rural-areas-health-care-shortages-these-doctors-are-answering-the-call.
Recruitment of new physicians is difficult when there is a lack of personal connection to, or history with, the rural area doing the recruiting.\(^48\) Additionally, while recruiting a family physician to a rural area is a positive thing for primary care, access to specialty services—like mental health care or care for autism—often remains a substantial challenge in rural communities.\(^49\)

Those providers who do populate rural hospitals and clinics face difficult challenges. First, doctors are often unfamiliar with their patients or their family histories due to high turnover.\(^50\) Second, rural physicians have a wide scope of practice when compared to other providers,\(^51\) and are often asked to provide specialty services. In addition to seeing patients in a number of different settings (including home visits and nursing home visits), rural family physicians have been found to be more likely to provide “obstetrical deliveries, newborn care, pediatric care, occupational medicine, palliative care, and mental health care” as compared to urban family physicians.\(^52\)

Finally, rural hospital closures also have a negative psychic impact on a rural community. Citizens in rural areas that have lost their hospitals have mourned their loss\(^53\) as a “source of pride” in their community.\(^54\) Following a closure, citizens are justifiably scared and worried about the future.\(^55\) Hospital closures can communicate a deep lack of care and attention from policymakers.
and can contribute to the feeling that rural America has been abandoned and forgotten.\textsuperscript{56}

III. PROMINENT POLICY SOLUTIONS

Policymakers in Washington have sought policy solutions to the rural health care crisis in an effort to stabilize funding to rural hospitals. The most prominent, of course, is the voluntary\textsuperscript{57} Medicaid expansion under the ACA.\textsuperscript{58} The number of states that have not expanded their Medicaid programs has shrunk since the passage of the ACA, and the Biden administration has examined ways in which it can successfully push states to expand their programs.

Other efforts by CMS—such as the CHART Program, the Pennsylvania Rural Health Model, and the new Rural Emergency Hospitals provider type—seek to find new ways to improve rural hospital financing by making reimbursement more stable and by changing hospital incentives. All of these efforts are summarized below.

A. Medicaid Expansion Under the ACA

Upon coming into office, the Biden administration has prioritized strengthening and building on the structure of the ACA. Even while many in his party proposed more dramatic health policy reforms during the 2020 presidential primary, President Biden has sought to make the private market reforms in the ACA more durable and has pushed Medicaid expansion to improve health care finance and access.\textsuperscript{59} In other words, instead of a new reform structure, the old ACA battles continue—often featuring a push-pull between the federal government and the states—with major impacts on rural health care.

In that vein, currently, 38 states and the District of Columbia have expanded or are expanding their Medicaid programs under the ACA.\textsuperscript{60} Missouri and Oklahoma are the newest states to decide to expand their programs following


\textsuperscript{57} The Medicaid expansion was originally a mandatory component piece of the ACA but was made voluntary by the Supreme Court in 2012 when it determined that it was unduly coercive. See NFIB v. Sebelius, 567 U.S. 519 (2012). As a result, a growing number of states have decided to expand their programs since its passage.

\textsuperscript{58} See Patient Protection and Affordable Care Act, Pub. L. No. 111-148.

\textsuperscript{59} See Zack Buck, \textit{Biden’s Early Focus: Durable and Attainable Private Insurance}, BILL OF HEALTH (May 13, 2021), https://blog.petrieflom.law.harvard.edu/2021/05/13/biden-private-health-insurance/ (arguing that the private reforms may make global systemic reform less likely).


2020 voter initiatives in both states.\textsuperscript{61} South Dakota, a potential 39th state to implement the ACA’s Medicaid expansion, will vote on the expansion during its upcoming November 2022 elections.\textsuperscript{62}

The 12 states that have not expanded their Medicaid programs are primarily located in the Southeast.\textsuperscript{63} These states’ decisions not to expand currently leave two million people within a “coverage gap,” with no access to health insurance.\textsuperscript{64} Further, these states are losing billions of dollars in federal funding—and these losses are particularly painful for hospitals in those states with high amounts of uncompensated care.\textsuperscript{65}

In 2021, the American Rescue Plan (ARP)\textsuperscript{66} assisted in closing this “coverage gap” by making some receiving unemployment insurance eligible for marketplace subsidies. Indeed, the ARP allowed these individuals to go out on the ACA’s health care exchanges to purchase health insurance with the assistance of subsidies.\textsuperscript{67} But this change was made only for the calendar year 2021.\textsuperscript{68}

Perhaps even more importantly, however, the ARP also added additional incentives for non-expanding states, bumping federal funding for Medicaid expansion from 90% to 95% for two years following the implementation of

\begin{footnotesize}
\begin{enumerate}
\item See Phil Galewitz, \textit{South Dakota Voters to Decide Medicaid Expansion}, KAISER FAM. FOUND. (Jan. 6, 2022), https://khn.org/news/article/south-dakota-medicaid-expansion-ballot-initiative/ (Due to an anticipated summer ballot initiative proposed by South Dakota’s GOP leaders, the measure will be required to garner 60% of the vote in order to be enacted). See also id.
\item See Status of State Medicaid Expansion Decisions: Interactive Map, supra note 60 (Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina, Tennessee, and Texas are eight of the 12 states that have yet to expand under the ACA).
\item See Selena Simmons-Duffin, \textit{12 Holdout States Haven’t Expanded Medicaid, Leaving 2 Million People in Limbo}, NPR (July 1, 2021), https://www.npr.org/sections/health-shots/2021/07/01/1011502538/12-holdout-states-havent-expanded-medicaid-leaving-2-million-people-in-limbo (The two million “don’t qualify for Medicaid in their state, and make too little money to be eligible for subsidized health plans on the Affordable Care Act insurance exchanges”).
\item President Biden’s White House was quick to highlight all the ways the American Rescue Plan and Build Back Better agenda were to assist rural America and rural health care. See \textit{Fact Sheet: Biden Administration Takes Steps to Address COVID-19 in Rural America and Build Rural Health Back Better}, THE WHITE HOUSE (Aug. 13, 2021), https://www.whitehouse.gov/briefing-room/statements-releases/2021/08/13/fact-sheet-biden-administration-takes-steps-to-address-covid-19-in-rural-america-and-build-rural-health-back-better/.
\item See id.
\end{enumerate}
\end{footnotesize}
expansion. 69 This halved the amount of financial responsibilities that the non-expanding states would have to take on with Medicaid expansion and caused at least one state to look carefully at the new incentives it would receive with expansion. 70 But by the end of 2021, none of the 12 states had made any notable moves toward expansion. 71

President Biden’s proposed Build Back Better Act (BBBA), which had passed the House of Representatives but stalled in the Senate, would have closed this “coverage gap” from 2022 to 2025 by allowing those falling in the gap to qualify for a premium tax credit that would completely cover the health care insurance premium. 72 Further, BBBA would limit the cost sharing obligation by the beneficiary to just 1% of health care expenses. 73 According to a Congressional Budget Office (CBO) estimate, this would have covered an additional 1.7 million Americans. 74

Still, without the passage of the stalled BBBA, 75 these individuals—more than two million in total, 60% of whom are people of color 76 —continue to exist in the coverage gap. These two million look back to the states who continue to resist Medicaid expansion while BBBA remains stalled in the Senate. 77

---


71 See Status of State Medicaid Expansion Decisions: Interactive Map, supra note 60.


76 Cox et al., supra note 72.

77 See Lisa Lerer & Emily Cochrane, Frustrated Democrats Call for Reset Ahead of Midterm Elections, N.Y. TIMES (Jan. 14, 2022), https://www.nytimes.com/2022/01/14/us/politics/democratic-midterms.html (“Meanwhile, Mr. Biden’s top domestic priority—a sprawling $2.2 trillion spending, climate and tax policy plan—remains stalled, not just because of Republicans, but also opposition form a centrist Democrat.”).
It is vital to understand how Medicaid expansion decisions impact rural hospital closures. Although it is not a panacea, there is clearly a correlation between the states that did not expand their Medicaid programs under the ACA and those experiencing the most rural hospital closures, with studies showing that states that expanded their Medicaid programs under the ACA were less likely to experience rural hospital closures. The three states with the most rural hospital closures—Texas, Tennessee, and North Carolina—are all non-expansion states.

Further, another analysis concluded the

... expansion’s effects on margins were strongest for small hospitals, for-profit and non-federal-government operated hospitals, and hospitals located in non-metropolitan areas. A third study found larger expansion-related improvements in operating margins for public (compared to nonprofit or for-profit) hospitals and rural (compared to non-rural) hospitals.

According to the Kaiser Family Foundation, analyses that examined coverage changes between rural and urban areas found “that Medicaid expansion has had a particularly large impact on Medicaid coverage or uninsured rates in rural areas.” The insurance status of citizens in a given area has a major impact on the fiscal health of the hospital in the area; indeed, when hospitals have a greater amount of uncompensated care, they are more financially vulnerable.

---

78 See Wishner et al., supra note 21 (“Medicaid expansion alone cannot overcome the financial challenges facing rural hospitals.”).


82 Id.

83 See Kristin L. Reiter, Marissa Noles & George H. Pink, Uncompensated Care Burden May Mean Financial Vulnerability for Rural Hospitals in States that Did Not Expand Medicaid, 34 HEALTH AFFS. (Oct. 2015), https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1340 (“We found that the decision of many states to not expand Medicaid could widen rural-urban coverage disparities and, in turn, threaten the financial viability of many rural hospitals . . . . Proposed cost cutting under health reform, combined with the lack of Medicaid expansion in some states, may pose a serious threat to financially vulnerable providers.”).
And hospitals in expansion states saved an estimated $6.2 billion in uncompensated care.\textsuperscript{84}

The relationship between Medicaid expansion and the financial vitality of rural hospitals cannot be overstated. Indeed, for a rural hospital that maintains an emergency room and treats all patients regardless of their ability to pay,\textsuperscript{85} the amount of uncompensated and undercompensated care that the hospital administers—that is, the amount of uninsured individuals who come to the hospital in need of care but who cannot afford the full cost of their care—becomes a vitally important consideration for the hospital’s finances. When hospitals lose money treating the patients they treat, their financial health deteriorates. In states with higher insured rates, hospitals have to worry less about the effects of uncompensated and undercompensated care.

\textbf{B. The Community Health Access and Rural Transformation (CHART) Program}

In addition to attempted legislative fixes to improve the finances of rural hospitals, and following an executive order by former President Donald Trump,\textsuperscript{86} CMS launched innovative models in an effort to change health care delivery systems and bolster rural hospitals’ financing.\textsuperscript{87} The first, the CHART program, implemented by the CMS Innovation Center, has provided funding to four different lead organizations in Alabama, South Dakota, Texas, and Washington.\textsuperscript{88} Each are to “use the award funds to develop and implement a health care redesign strategy for their defined community over the course of the

\textsuperscript{84} See David Dranove, Craig Garthwaite & Christopher Ody, \textit{The Impact of the ACA’s Medicaid Expansion on Hospitals’ Uncompensated Care Burden and the Potential Effects of Repeal}, \textit{The Commonwealth Fund} (May 3, 2017), https://www.commonwealthfund.org/publications/issue-briefs/2017/may/impact-acas-medicaid-expansion-hospitals-uncompensated-care (“Overall, these estimates suggest that Medicaid expansion cut every dollar that a hospital spent on uncompensated care by 41 cents between 2013 and 2015. If the 19 nonexpansion states were to expand Medicaid, uncompensated care in those states would fall from 6.1 percent of operating costs to an estimated 3.6 percent.”); Frakt, \textit{supra} note 28.


\textsuperscript{86} See Denise Burke & Nina Wall, \textit{CMS Announces Initiative to Transform Rural Health}, \textit{Waller} (Aug. 13, 2020), https://www.wallerlaw.com/news-insights/3736/CMS-announces-initiative-to-transform-rural-health (noting the Aug. 3, 2020, executive order that “required that a rural health action plan be launched to (1) build sustainable models for rural communities; (2) focus on preventing disease and mortality; (3) leverage innovation and technology, and (4) increase access to care”).

\textsuperscript{87} See CHART Model, supra note 1.

\textsuperscript{88} \textit{Id.}
model,” which allows them to represent and apply them to their own respective rural communities.\textsuperscript{89}

These lead entities—which are the University of Alabama Birmingham, the state of South Dakota Department of Social Services, Texas Health and Human Commissions, and the Washington State Healthcare Authority—are to “drive a redesign” by working with community partners to coordinate and manage the initiative.\textsuperscript{90} For its part, the lead organizations and the community hospitals will “receive upfront cooperative agreement funding, financial flexibilities through a predictable capitated payment amount for participant hospitals in a community, and operational and regulatory flexibilities.”\textsuperscript{91}

The hope is that the “stability and predictability” that the capitated, prospective payments bring will make transformation easier—a transformation that seeks to increase access for rural patients, improve quality of care and outcomes, and make finances more sustainable for rural doctors and hospitals.\textsuperscript{92} This model, which relies on specific payment methodology to determine the capitated payment amounts, replaces the fee-for-service model, which can be unpredictable, rewards volume, and leads to financial precarity during periods of volume declines.\textsuperscript{93} Quality will also be rewarded,\textsuperscript{94} and payments will be checked during the middle of the year and adjusted annually to “account for changing populations served.”\textsuperscript{95}

Participation for hospitals is limited to acute care hospitals and critical access hospitals (CAHs) that also meet Medicare payment qualifications.\textsuperscript{96} It is also a long-term project; as of 2021, performance periods are set for January of 2023 through December of 2028.\textsuperscript{97} Interestingly, state Medicaid agencies (SMAs) are required to participate in the model by making sure that a percentage

\begin{footnotesize}
\begin{itemize}
  \item [89] Id.
  \item [90] Id.
  \item [91] Id.
  \item [93] Id. at 15.
  \item [94] Id. at 18.
  \item [95] Id. at 30.
  \item [96] Id. at 12 (noting that the hospital must either be located in the Community and receive “at least 20 percent of its eligible Medicare fee-for-service revenue from services provided to residents of the Community,” or that the entity “provides services to residents of the Community that in aggregate account for at least 20 percent of the eligible Medicare fee-for-service expenditures of the Community”).
  \item [97] Id. at 9.
\end{itemize}
\end{footnotesize}
The regulatory flexibility seeks to ease the burden on rural providers and entities. Specifically, this would “waive certain Medicare hospital conditions of participation to allow a rural outpatient department and emergency room to be paid as if they were classified as a hospital,” as well as “allow[ing] participant hospitals to waive cost-sharing for certain Part B services, provide transportation support, and gift cards for chronic disease management.” It also allows rural providers to expand telehealth.

Relatedly, CMS is also operating an “ACO Transformation Track” as part of the CHART Model. As part of this program, CMS will select as many as 20 rural-focused accountable care organizations (ACOs) to receive advanced payments through the Medicare Shared Savings Program (M SSP). The ACOs will receive the upfront payment as well as a prospective per beneficiary per month payment for up to two years. This program is focused on assisting rural providers by providing more stable and predictable financial arrangements, similar to other successful ACO models.

Again, the goal of this new model is to give rural providers a source of stable funding while incentivizing them to try to move more of their reimbursement model away from fee-for-service and toward value-based reimbursement. It is designed to give rural providers “a helping hand” to better coordinate care and invest in value-based models. This is because rural

---

100 Id.
101 See CHART Model, supra note 1.
102 Id.
103 Id.
106 Id. (quoting the CEO of the National Association of ACOs as saying that the ACO Transformation Track will “offer[] resource-deprived rural providers a helping hand to invest in the tools needed to build accountable care models, including health IT, data analytics, and care managers”).
providers have been slower to move to value-based payments. 107 Through this program and through the appointment of lead entities, the funding model "can be customized to each community's specific needs." 108 Nonetheless, because the performance years have not yet begun, the success and outcome of the model are unknown.

C. The Pennsylvania Rural Health Model

The CMS Innovation Center has also established the Pennsylvania Rural Health Model (the "Pennsylvania Model"), which has many of the same designs and goals as the CHART model but is a few years ahead of CHART. 109 This is the third state-specific model (following all-payer models in Maryland and Vermont), but the first with a specific rural focus. 110 In the Pennsylvania Model, CMS and other payers pay participating rural hospitals on a capitated, global basis—an amount, like CHART, is set in advance. 111 The Pennsylvania Model covers inpatient and hospital-based outpatient services. 112

In short, the Pennsylvania Model "tests whether the predictable nature of global budgets will enable participating rural hospitals to invest in quality and preventive care, and to tailor their services to better meet the needs of their local communities," and is available to rural Pennsylvania's critical access hospitals (CAHs) and acute care hospitals. 113 Like the CHART Model, the goal is to "help transform the care that rural hospitals provide and to improve the quality of care for as many rural Pennsylvanians as possible." 114

Within the Pennsylvania Model, the state sets a prospective all-payer global budget (which, by year two of the Model, accounts for 90% of each hospital's global budget) and the participating hospitals must design a Rural Hospital Transformation Plan, which is to be approved by Pennsylvania and

---


109 See Pennsylvania Rural Health Model, supra note 2.

110 Id.

111 Id.

112 Id.

113 Id.

114 Id.
The state seeks to meet three targets, including participation targets, financial targets, and population health, access, and quality targets. Under the Model, Pennsylvania can tie financial incentives to performance on three metrics: (1) increasing access to primary and specialty care, (2) reducing rural health disparities through improved chronic disease management and preventive screenings, and (3) decreasing deaths from substance use disorder and improving access to treatment for opioid abuse. Pennsylvania will also save $35 million in Medicare hospital savings throughout the lifespan of the Model.

Interestingly, the report noted that "reconciling the two goals of the Model—stabilizing the financial status of the rural hospitals and reducing the cost to payers will be a significant challenge." Other findings included that participation was slower than anticipated, and that the financial viability of some of the hospitals "worsened during the baseline period" (prior to the start of the Model), and that "most participating hospitals reported that their financial status was central to their decision to participate."

The report also found that upfront capital was vital to build financial transformation plans—indeed, "hospitals struggled to dedicate staff and resources to implement their hospital transformation plans and operationalize care delivery transformation." The Model, according to the report authors, may bolster short-term funding stability, but long-term stability is still a struggle, especially for independent hospitals. "Significant cost savings seem unlikely," but, nonetheless, the stable payments in the Model "eliminated variability in Medicare reimbursement and ensured a predictable revenue stream for hospitals."

The second annual report, expected in 2022, is anticipated to have more information on target performances, and a "descriptive assessment of financial performance, spending and utilization, and access and quality of care outcomes..."
during the performance period."125 By the start of performance year three, in 2021, 18 hospitals across Pennsylvania were participating,126 with many located in the western part of the state.127

D. Rural Emergency Hospitals (REHs)

Rural Emergency Hospitals (REHs), a new provider type that was borne out of the "growing concern that closures of rural hospitals and Critical Access Hospitals (CAHs) are leading to a lack of services for people living in rural areas," will be recognized starting in 2023.128 Because REHs are a brand-new hospital reimbursement category and it remains very early in the regulatory process, rulemaking will continue through the year.129 REHs will be made up of facilities that are either converts from CAHs or are rural hospitals with less than 50 beds and do not provide acute care inpatient services.130 REHs will be "required to furnish emergency department services and observation care and may provide other outpatient medical and health services as specified by the Secretary through rulemaking."131 Nonetheless, REHs will seek to address the rural hospital closure crisis, and CMS is currently seeking feedback on services, quality measures, and payment provisions.132

IV. CONCLUSION: WHERE THIS LEAVES RURAL HOSPITALS

Even though the number of rural hospital closures dropped in 2021, that may have been due to additional funding through federal intervention in response to the COVID-19 public health emergency.133 Federal subsidies have seemed to

---

125 Id. at 84.
126 See Pennsylvania Rural Health Model, supra note 118.
128 See CY 2022 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule (CMS-1753-P), supra note 3.
129 Id.
130 Id.
132 Id.
forestall COVID-19’s worst financial impacts. But what happens when the public health emergency comes to an end?

Through pushing Medicaid expansion, the CHART Model, the Pennsylvania Model, and the new REH provider type, the federal government—mainly through the executive branch—seems intent on trying to find an answer to rural hospital closures. Whether it is bolstering the payer mix by increasing the insurance rate in rural areas through Medicaid expansion, or simply giving hospitals more breathing room to attempt to move to more value-based care through its innovation models, what seems to be a solution to the hospital crisis is simple: additional funding. And what may ultimately solve the rural health care crisis—and particularly, the hospital closure crisis—demands new and creative applications to fully understand the causes of financial precarity for hospitals.

In this way, the rural hospital crisis resembles a question of political will and focus. And, viewed in that light, the solution to the rural health care crisis may have been expected to come through the legislature—either through Congress or various state legislatures. Indeed, perhaps state intervention could guarantee more durable rights to health care access in rural areas. But the likelihood of a legislative fix to these issues seems unlikely, and the federal government, largely through its executive branch, is using its levers to try to address the crisis.

Consequently, the federal policy solutions seem to be focused on public payer-based interventions—levers the federal government has readily available to it. These solutions, reliant on funding streams already in place, seek to “supercharge” the funding mechanisms through public insurance programs in hopes that those programs lead to funding stability for rural hospitals. Indeed, if one puts faith in the executive branch’s actions under President Biden, these goals are admirable, and the policy solutions seem appropriately targeted. Payment pilot programs produce important results and can contribute to policymakers’ understandings about what works and what does not work in an effort to solve the crisis.

But devising solutions in this space have not been easy. And these solutions have limitations. They are likely still be years from producing a satisfying answer to the rural health care crisis. Additionally, they seem somewhat convoluted, in that administrative, technocratic solutions that are being sought may seem opaque to the average citizen.

Indeed, in the interim, rural hospitals—particularly in non-expansion states—are likely to continue to struggle financially. Without any major, holistic reform for rural hospitals, and without any major and more direct legislative

federal government’s share of health spending increased by 36%. In a twist, that growth was driven not so much by care devoted to patients, but by federal subsidies to keep hospitals and medical providers solvent; funding to develop and deploy COVID-19 tests, vaccines, treatments and countermeasures; and assistance to state Medicaid programs facing a potential wave of uninsured people in a public health crisis.”).
effort to secure access to health care services for individual citizens in rural areas, the immediate future is likely to feature many of the same challenges as have been seen during the last decade. In short, it is likely that hospitals in rural areas will continue to face financial instability and precarity.

With the Biden administration pushing states to expand Medicaid, and encouraging—through CMS—different delivery models, there does not seem to be a rural-health-securing paradigm change in the offing in the immediate future. Thus, once the temporary supplemental pandemic funding comes to an end, it is likely that the same tensions and challenges that caused the rural hospital closure crisis will continue to constrain hospital finances, with ongoing negative effects. And rural citizens, unfortunately and tragically, will continue to face the brunt of those consequences.