

Rural Hospital Closure Rates Higher in Non-Medicaid Expansion States

Since the passage of the *Patient Protection and Affordable Care Act* (ACA) in March of 2010,¹ the number of rural hospitals closing per year has significantly increased, from three (3) rural hospitals closing in 2010 to seventeen (17) rural hospitals closing in 2015, out of a total of 2,258 rural hospitals in the U.S. in 2015.² This alarming trend in the increased closure rate of rural hospitals has continued into 2016, with eleven (11) rural hospitals closing from January to May of 2016.³ Of the total number of rural hospital closings since 2010, approximately 85% of the closings occurred in states that have not, or had yet to, expand the Medicaid programs in their state.⁴ This *Health Capital Topics* article will present an overview of the recent increase in the number of rural hospital closures in the U.S., as well as, explore the causes behind this growing problem, including the potential correlation between rural hospital closures and the lack of Medicaid program expansion.

In recent years, the financial viability of rural hospitals has become a growing problem for the U.S. healthcare delivery system. According to a recent report from the Cecil G. Sheps Center for Health Services Research at the University of North Carolina, since 2010, 75 rural hospitals have closed across the U.S.⁵, with the yearly number of closures increasing at a *Compounded Annual Growth Rate* (CAGR) of approximately 47.33% from the period of 2010 through 2015.⁶ Additionally, a significant number of rural hospitals have been identified as currently facing a *high risk* of closing, based on a consideration of the financial performance of the hospital, as well as its organizational and market characteristics.⁷ Many rural hospitals identified as having a high risk of closing in 2015 are located in the Southeastern and South Central regions of the U.S., most notably:

- (1) Texas (17 rural hospitals at risk of closing);
- (2) Oklahoma (17 rural hospitals at risk of closing);
- (3) Tennessee (14 rural hospitals at risk of closing);
- (4) Arkansas (13 rural hospitals at risk of closing);
- (5) Georgia (13 rural hospitals at risk of closing);
- (6) Alabama (13 rural hospitals at risk of closing);
- and,
- (7) Kentucky (10 rural hospitals at risk of closing).⁸

Numerous factors may be contributing to the recent increase in rural hospital closures. Most prominent among these potential causes is the correlation between rural hospital closures and state actions regarding Medicaid expansion. Under the ACA, states were originally required to expand Medicaid coverage to all adults with incomes up to 133 percent of the *federal poverty level* (FPL) by January 1, 2014.⁹ However, this provision was modified by the June 28, 2012, U.S. Supreme Court decision in *National Federation of Independent Business v. Sebelius*, the landmark decision that invalidated the mandatory expansion of state Medicaid programs.¹⁰ Despite the ACA's provisions regarding Medicaid expansion becoming effective in 2014, under the Court's ruling, states have the option of whether or not to participate.¹¹ State decisions regarding this expansion may be resulting in the unintended consequence of adding further stress to rural hospitals, which, in the face of the rising prevalence of high-deductible health plans and potential cuts to Medicaid disproportionate share hospital payments,¹² rural hospital operators have viewed Medicaid expansion as potentially resulting in a "*positive net financial impact*" for rural hospitals.¹³ Of the total number of rural hospital closings since 2010, approximately 85% of the closings occurred in states that have not, or had yet to, expand the Medicaid programs in their state.¹⁴ Further, many of the states with the highest number of rural hospitals at risk of closure are located in states that have yet to expand the Medicaid programs, excluding Arkansas and Kentucky, both of which expanded the Medicaid programs in their states in 2013.¹⁵

Another factor that may be forcing financially struggling rural hospitals to close stems from litigation surrounding the ACA's *Cost Sharing Reduction* (CSR) provision. Section 1402 of the ACA indicates that "[i]n the case of an eligible insured enrolled in a qualified health plan—(1) the Secretary shall notify the issuer of the plan of such eligibility; and (2) the issuer shall reduce the cost-sharing under the plan..."¹⁶ Section 1402 requires ACA qualified health plan insurers "to reduce deductibles, coinsurance, copayments, and similar charges for eligible insured individuals enrolled in their plans."¹⁷ The ACA refers to these reductions as CSRs, and in order to qualify for them, an individual must be enrolled in a qualified health plan and have a household income that is between 100 and 400 percent of the FPL.¹⁸ CSRs are a vital component of the

ACA's goal to provide affordable health insurance and healthcare to low and moderate-income individuals.¹⁹ In order to achieve affordable healthcare, the ACA requires insurers to reduce cost sharing for those below 250 percent of the FPL.²⁰ However, on May 12, 2016, the federal district court for the District of Columbia ruled that Congress has not explicitly appropriated money for insurers to be reimbursed for the incurred costs in reducing cost sharing for individuals with incomes below 250 percent of the FPL.²¹ If CSR payments stopped, insurers would still be legally required to reduce cost sharing without reimbursement, costing insurers a projected \$7 billion in 2016 and \$130 billion over the next ten years.²² Consequently, insurers may terminate certain marketplace coverage as a result of this extra cost burden,²³ which could have a disproportionate effect on rural hospitals, given that the overall rate of poverty is higher in rural areas than in urban areas.²⁴

Among the negative aspects of rural hospital closures, patients are often forced to travel greater distances to receive care that they once received at their local hospital. As a result, patients often rely on surrounding counties' ambulance services to get to and from hospitals.²⁵ For example, in Newton, Mississippi, when its local hospital closed in December 2015, turnaround times for ambulance services increased threefold, from 20 minutes to 60 minutes.²⁶ This additional travel requirement may complicate patient care in acute incidents that require immediate medical attention.²⁷

Policymakers have attempted to solve the problem of increased rural hospital closures, with limited effect. In July 2015, U.S. Representatives Sam Graves [R-MO] and Dave Loebsack [D-IA] introduced the "Save Rural Hospitals Act," which seeks to improve the viability of rural hospitals through various Medicare and Medicaid reforms, including permanently increasing Medicare payment rates for ground ambulance services in rural areas, as well as, eliminating rural Medicare and Medicaid disproportionate share hospital payment reductions.²⁸ However, since August 2015, the bill has remained assigned to the Subcommittee on Health within the U.S. House of Representatives' Committee on Energy and Commerce, which may delay, or prevent, overall passage of the bill.²⁹

Given the potential revenue that may be gained by rural hospitals through patients who have increased access to Medicaid coverage, and in light of the continued growth in the rate of rural hospital closures, it may be prudent for policymakers exploring how to improve and stabilize the environment for the viability of rural hospitals to consider the role that Medicaid expansion (in accordance with the ACA) may contribute toward the financial security of rural hospitals.

1 "Patient Protection and Affordable Care Act" Pub. L. No. 111-148, 124 Stat. 119 (March 23, 2010).
 2 "Rural Hospital Closures: Closures from January 2010-Present" North Carolina Rural Health Research Program, The Cecil G. Sheps Center for Health Services Research, May 26, 2016,

<http://www.shepscenter.unc.edu/programs-projects/rural-health/> (Accessed 06/10/2016); "Rural Hospitals" Email by Julie Perry, Research Associate, NC Rural Health Research Program, Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill, to Kenneth J. Farris, Esq., Associate, Health Capital Consultants, June 20, 2016 (noting a total number of 2,258 rural short-term general and critical access hospitals open as of January 1, 2016). This article, as well as the underlying sources, defines a "rural hospital" as "any short-term, general acute, non-federal hospital that is a. not located in a metropolitan county OR b. is located in a RUCA type 4 or higher OR c. is a Critical Access Hospital."

3 *Ibid.*
 4 *Ibid.*; "Where the States Stand on Medicaid Expansion" The Advisory Board, May 26, 2016, <https://www.advisory.com/dailybriefing/resources/primers/medicaidmap> (Accessed 06/09/2016).
 Author utilized North Carolina Rural Health Research Program's (NCRHP) Report "75 Rural Hospital Closures: January 2010 - Present" to determine that 85% of hospitals closed in states that have not, or had yet to, expand the Medicaid programs in their state. Author looked at the total number of rural hospitals that closed (75) and determined which ones occurred in states that had not expanded Medicaid by cross referencing the NCRHP report with the article "Where the states stand on Medicaid Expansion" and found that number to be 55 hospitals of the total 75 (approximately 73%). To get a more accurate representation of the potential link, author also cross referenced report with article to ascertain which states had rural hospitals that closed before the state had expanded Medicaid and found this number to be 9 of the remaining 20 hospitals. This percentage (12%) was then added to the approximate 73% to achieve the 85% cited in the article.
 5 North Carolina Rural Health Research Program, May 26, 2016.
 6 *Ibid.*
 The author calculated the compound annual growth rate (CAGR) for the periods shown in order to illustrate the annual growth of rural hospital closure. CAGR was calculated using the following formula: $CAGR = [(New\ Metric/Old\ Metric)^{(1/Years\ Elapsed)}] - 1$.
 7 "Geographic Variation in Risk of Financial Distress Among Rural Hospitals" By Brystana Kaufman et al., North Carolina Rural Health Research Program, The Cecil G. Sheps Center for Health Services Research, January 2016, <http://www.shepscenter.unc.edu/programs-projects/rural-health/projects/north-carolina-rural-health-research-and-policy-analysis-center/publications/> (Accessed 06/02/2016).
 8 *Ibid.*
 9 Pub. L. No. 111-148, § 2001, 124 Stat. 119, 271 (March 23, 2010).
 10 "National Federation of Independent Businesses v. Kathleen Sebelius" 132 S.Ct. 2566 (2012).
 11 *Ibid.*
 12 Kaufman, et al., January 2016, p. 8.
 13 Kaufman, et al., January 2016, p. 4-5.
 14 North Carolina Rural Health Research Program, May 26, 2016; The Advisory Board, May 26, 2016.
 Author utilized North Carolina Rural Health Research Program's (NCRHP) Report "75 Rural Hospital Closures: January 2010 - Present" to determine that 85% of hospitals closed in states that have not, or had yet to, expand the Medicaid programs in their state. Author looked at the total number of rural hospitals that closed (75) and determined which ones occurred in states that had not expanded Medicaid by cross referencing the NCRHP report with the article "Where the states stand on Medicaid Expansion" and found that number to be 55 hospitals of the total 75 (approximately 73%). To get a more accurate representation of the potential link, author also cross referenced report with article to ascertain which states had rural hospitals that closed before the state had expanded Medicaid and found this number to be 9 of the remaining 20 hospitals. This percentage (12%) was then added to the approximate 73% to achieve the 85% cited in the article.
 15 The Advisory Board, May 26, 2016.

- 16 “Patient Protection and Affordable Care Act” Pub. L. No. 111-148, § 1402(a), 124 Stat. 119, 220-21, (March 23, 2010).
- 17 “United States House of Representatives v. Burwell” Case No. 14-1967 (D.D.C, May 12, 2016), Opinion, p. 6.
- 18 “Reduced cost-sharing for individuals enrolling in qualified health plans” 42 U.S.C. § 18071(b)(2) (January 3, 2012).
- 19 “Judge Rules Against Administration in Cost-Sharing Reduction Payment Case” Health Affairs Blog, May 12, 2016, <http://healthaffairs.org/blog/2016/05/12/judge-blocks-reimbursement-of-insurers-for-aca-cost-sharing-reduction-payments/> (Accessed 05/27/2016).
- 20 *Ibid.*
- 21 No. 14-1967, p. 2.
- 22 Health Affairs Blog, May 12, 2016.
- 23 *Ibid.*
- 24 “Geography of Poverty” United States Department of Agriculture, December 17, 2015, <http://www.ers.usda.gov/topics/rural-economy-population/rural-poverty-well-being/geography-of-poverty.aspx> (Accessed 6/10/2016).
- 25 “Rural Hospital Keep Closing. What can be Done?” By Meg Bryant, HealthcareDive, March 22, 2016, <http://www.healthcaredive.com/news/rural-hospitals-keep-closing-what-can-be-done/416038/> (Accessed 05/27/2016).
- 26 *Ibid.*
- 27 “The Relationship Between Distance to Hospital and Patient Mortality in Emergencies: An Observational Study” By Jon Nicholl, et al., Emergency Medicine Journal, Vol. 24, No. 9 (2007), p. 667.
- 28 “Save Rural Hospital Act” H.R. 3225, 114th Cong. (July 27, 2015).
- 29 “H.R. 3225 – Save Rural Hospitals Act: All Actions” August 5, 2015, <https://www.congress.gov/bill/114th-congress/house-bill/3225/all-actions?overview=closed> (Accessed 6/10/2016).




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