Health Care Reform and Rural Hospitals: Opportunities and Challenges under the Affordable Care Act

A Thesis

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By

Esther Elizabeth Parisian, B.A.
Graduate Program in Rural Sociology

Ohio State University
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Thesis Committee:
Cathy A. Rakowski, Advisor
Joseph F. Donnermeyer
Abstract

Rural hospitals have long faced a set of challenges, due to the unique demographic characteristics of the populations they serve, which sets them apart from their urban and suburban counterparts. On average, rural residents tend to be older, poorer and sicker than urban counterparts, require more care, and are more likely to be uninsured than non rural residents. This means that the higher cost of providing care to this population is more likely to go unpaid and, as a result, many rural hospitals struggle to remain viable financially; providing uncompensated care at such high levels makes it difficult to break even, let alone turn a profit. Because rural hospitals are central to rural communities, in terms of both the important health services they provide and their significant contribution to the local economy, their financial vulnerability is of particular concern to rural residents. Recently, the March 2010 passage of the Affordable Care Act (ACA), a health care reform law which increases access to and lowers the cost of health care for many Americans, has offered renewed hope to rural hospitals. Major rural health organizations have suggested that the ACA may relieve a significant portion of the financial burden faced by rural hospitals by providing a large percentage of the rural uninsured with free or affordable health insurance. However, a critical flaw in this thinking is the assumption of homogeneity among rural hospitals. The ACA, if implemented as planned, will in fact expand health insurance coverage to many previously uninsured Americans, a disproportionate number of whom reside in rural
areas. Nonetheless, the potential benefits of the legislation will be felt differentially by rural hospitals depending upon their size, ownership type, and the demographics of patients served. It is possible that small or isolated rural hospitals and those that serve a disproportionate number of undocumented workers may fail to experience the kind of financial relief predicted for rural hospitals in general.

The objectives of this analysis are to a) assess systematically and critically the expectations/predictions regarding the impact of the ACA; b) evaluate factors that apply specifically to rural hospitals given their current difficulties and the characteristics of the populations they serve; and c) identify factors not considered in the existing policy research that need to be addressed to more accurately predict and control the relative impact of the ACA on rural hospitals.
Dedication

In loving memory of my grandparents, Lowell M. Jones, a rural Ohioan and proud Buckeye, and Anne E. Simonds Jones, a true scholar.
Acknowledgements

I am greatly indebted to Dr. Cathy Rakowski for serving as my advisor and guiding me through the research process. Her personal and professional wisdom have been invaluable to me throughout my graduate career, and I would not have been able to write this thesis without her support. I also thank Dr. Joseph Donnermeyer for serving on my committee and for the enthusiasm and support he offers to all graduate students in the Rural Sociology program. Thanks are also due to Amy Schmidt, whose helpful reminders and infinite knowledge made the administrative side of the process seamless.

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Vita

1981........................................Born, Bowling Green, Ohio
1998........................................Pioneer High School, Ann Arbor, Michigan
2003........................................B.A. International Studies,

The Ohio State University

2009-2011........................................Fellow, The Ohio State University

Graduate Program in Rural Sociology

Fields of Study:

Major Field: Rural Sociology
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List of Abbreviations and Acronyms

ACA—The Patient Protection and Affordable Care Act of 2010
AHA—American Hospital Association
ACO—Accountable Care Organization
CAH—Critical Access Hospital
CBO—Congressional Budget Office
CDC—Centers for Disease Control
CHIP—Children’s Health Insurance Program
CMS—Centers for Medicare and Medicaid Studies
DSH—Disproportionate Share Hospital
EMTALA—Emergency Treatment and Labor Act
HHS—United States Department of Health and Human Services
HIE—Health Insurance Exchange
MCR—Medicare Cost Report
MedPAC—Medicare Payment Advisory Council
NACRHH—National Advisory Committee on Rural Health and Human Services
NCLR—National Council of La Raza
NHIS—National Health Interview Survey
NILC—National Immigration Law Center
NRHA—National Rural Health Association
RUPRI—Rural Policy and Research Institute
SEIU—Service Employees International Union

SHADAC-- State Health Access Data Assistance Center

TORCH—Texas Organization of Rural and Community Hospitals

USDA—United States Department of Agriculture
Introduction

Rural hospitals have long faced a set of challenges, due to the unique demographic characteristics of the populations they serve, which sets them apart from their urban and suburban counterparts. On average, rural residents tend to be older, poorer and sicker than urban counterparts, require more care, and are more likely to be uninsured than non rural residents. This means that the higher cost of providing care to this population is more likely to go unpaid and, as a result, many rural hospitals struggle to remain viable financially; providing uncompensated care at such high levels makes it difficult to break even, let alone turn a profit. Furthermore, smaller patient bases and higher overhead costs render it more difficult for rural hospitals to absorb the costs of treating the uninsured and, as a result, these hospitals are disproportionately burdened by uncompensated care costs in comparison to those located in non rural areas. Because rural hospitals are central to rural communities, in terms of both the important health services they provide and their significant contribution to the local economy, their financial vulnerability is of particular concern to rural residents.

The 1980s and 1990s saw a wave of rural hospital closures, with ten percent of rural hospitals closing during each decade (Bull et al., 2001: 357). Many analysts attribute this high rate of closure to Medicare legislation enacted in the early 1980s, which gave rural hospitals lower effective reimbursement rates; likewise, the 1997 Balanced Budget Act, which attempted to correct for this inequality, has been credited with lowering the rural hospital closure rate. While survival rates for rural hospitals have improved over the last fifteen years, these hospitals remain in a precarious position
financially: in the aggregate, they are unprofitable and more than half of all rural hospitals reported negative profit margins in 2010 (Medicare Cost Report data, 2006-2010). The future of rural hospitals and their ability to continue to provide services to vulnerable populations is decidedly at risk.

Recently, however, the March 2010 passage of the Affordable Care Act (ACA), a health care reform law which increases access to and lowers the cost of health care for many Americans, has offered renewed hope to rural hospitals. Major rural health organizations such as National Rural Health Association (NRHA), Rural Policy and Research Institute (RUPRI) and the American Hospital Association (AHA)’s section on Small and Rural Hospitals have suggested that the ACA may relieve a significant portion of the financial burden faced by rural hospitals by providing a large percentage of the rural uninsured with free or affordable health insurance. However, a critical flaw in this thinking is the assumption of homogeneity among rural hospitals. The ACA, if implemented as planned, will in fact expand health insurance coverage to many previously uninsured Americans, a disproportionate number of whom reside in rural areas. Nonetheless, the potential benefits of the legislation will be felt differentially by rural hospitals depending upon their size, ownership type, and the demographics of patients served. It is possible that small or isolated rural hospitals and those that serve a disproportionate number of undocumented workers may fail to experience the kind of financial relief predicted for rural hospitals in general.

The objectives of the analysis that follows are to a) assess systematically and critically the expectations/predictions regarding the impact of the ACA; b) evaluate factors that apply specifically to rural hospitals given their current difficulties and the
characteristics of the populations they serve; and c) identify factors not considered in the existing policy research that need to be addressed to more accurately predict and control the relative impact of the ACA on rural hospitals.

**Methods**

As a researcher, I am drawn to the topic of health care reform and its impact on rural hospitals for several reasons. For one, I gained extensive knowledge and familiarity with the hospital industry during the several years that I worked professionally as a research analyst for the Service Employees International Union (SEIU), a trade union representing healthcare workers. Much of my professional experience involved analyzing federal policy to determine its impact on hospitals. This contributed to a keen interest in the vulnerability of hospitals to changes in federal policy. Secondly, my sociologic training, including the emphasis on spatial analysis that is a hallmark of rural sociology, has helped me develop a critical lens through which to evaluate health care policy and the strengths and shortcomings of others’ research on health care policy. This critical lens assures attention to the ways in which policy may have differential impacts with respect to race, class, gender, and, in this case, place. Together, my professional experience and academic training prepared me to recognize health care reform and its impacts as a timely social problem and to focus on the impact on rural hospitals as an appropriate sociological research problem for my thesis research.

My analysis is based on extensive document research. Sources included public records, text of legal documents, policy analyses, journal articles, news reports and investigative reporting. Additional details on sources are provided in relevant sections.
below. Critical analysis on my part identified weaknesses in studies that profess to predict the impact of the ACA in general and on rural hospitals in particular. For example, predictions tended to be absolute and alternative scenarios based on variations in measures used were not included. I also identified facile assumptions that greatly influenced analyses by others, including the tendency to treat rural hospitals in the aggregate. And I identified other shortcomings in the literature such as the failure to consider all populations that tend to be under and uninsured, such as undocumented immigrants, and whose health care needs are likely to undermine glowing predictions of an overwhelming reduction in the number of uninsured and, therefore, of uncompensated care borne by certain types of hospitals.

The first section of this manuscript provides an overview of the ACA and how it is likely to impact rural hospitals. When a review of the academic literature revealed very little discussion of the ACA or its potential implications for rural hospitals, it became necessary to rely heavily on an analysis of policy papers and other published materials available through the internet and/or produced by rural health organizations and think tanks. Information from rural health organizations was invaluable. To identify the principal rural health organizations, I utilized Centers for Medicare and Medicaid Services’ (CMS) online Rural Assistance Center, whose mission is to help “rural communities and other rural stakeholders access the full range of available programs, funding, and research that can enable them to provide quality health and human services to rural residents” (Centers for Medicare and Medicaid Services, 2011). Through CMS, I identified fifteen major rural organizations and agencies that were consulted for this article. A full listing and brief description of each can be found in Appendix A.
Additionally, there are nine centers for rural health research funded by CMS’s Office of Rural Health Policy that also were sources of published materials related to the ACA and rural hospitals. Their names and information are included in Appendix B.

For additional hospital-level data, including that related to hospital geography, finances, payer mix, and uncompensated care, I consulted Medicare Cost Reports (MCRs). Hospitals that are certified to accept Medicare reimbursement are required to submit an annual cost report to CMS, which contains provider information such as facility characteristics, utilization data, cost and charges, Medicare settlement data, and financial statement data. CMS makes these data available to the public on its website: [http://www.cms.gov/CostReports/](http://www.cms.gov/CostReports/). Access to the particular dataset utilized for this analysis was provided by the Service Employees International Union (SEIU) District 1199, which maintains MCR data from 2006 to 2010 for all Medicare certified hospitals in the U.S.

The second section of the manuscript attempts to address a notable gap in the literature and official records which concerns the differential impact the legislation may have upon rural hospitals that serve a significant number of undocumented immigrants. For this section, in addition to consulting the academic literature and the literature published by national hospital and rural health organizations listed in Appendices A and B, I also consulted material published by the following Hispanic and immigrant advocacy organizations: Migration Policy Institute, National Immigration Law Center (NILC), National Council of La Raza (NCLR), and Pew Hispanic Research Center. Brief descriptions of the organizations are included in Appendix C.

In order to make sure that I had accessed all possible sources of information and
data on the relevant issues, I conducted a series of telephone and email inquiries between April and June 2011. Among others, I contacted AHA, NRHA and RUPRI I to seek further information as to what kind of work—if any—rural health agencies were performing in relation to the ACA, rural hospitals and undocumented immigrants.

After finding that no adequate data were being recorded on medical treatment and insurance status of undocumented immigrants—not by hospitals or any other source, I decided to consult information on hospital issues for the five states whose rural hospitals would likely treat a disproportionate percentage of undocumented immigrants. Using data from the Pew Hispanic Center, the State Health Access Data Assistance Center (SHADAC), and the Carsey Institute, I was able to determine that Arizona, California, Nevada, Texas and North Carolina are the states with the highest proportion of undocumented immigrants who will likely remain uninsured after the ACA coverage expansion provisions take effect. After selecting these states, I conducted telephone and email inquiries of nine state-based rural health or hospital organizations, in order to determine the level of attention these agencies are paying to the issue of undocumented immigrants and the ACA. Each is included in Appendix D.

The Affordable Care Act: Background

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act, a set of sweeping changes to the U.S. health care system that represents the most significant expansion of health care access since Medicaid and Medicare were established in the 1960s (Stolberg & Pear, 2010). This law, now usually referred to as the Affordable Care Act or ACA, came about after months of debate in
both the House and Senate, and reflects the three principal goals for health care reform as outlined by the President: expanding access to affordable health insurance for the uninsured, making health insurance more affordable and dependable for those who are already insured, and controlling rising health care costs while simultaneously reducing the federal budget deficit (Stremikis, Davis and Nuzum, 2010: 1-2). The nearly 1,000 pages comprising the ACA contain a comprehensive set of changes to the health care system that apply not only to individuals and employers, but also to health insurance and pharmaceutical companies, the Medicare and Medicaid programs, and state and federal governments. While some provisions of the law were enacted immediately or shortly after its signing by the President, many of the changes are set to take effect in 2014, or will be phased in between 2010 and 2014. Currently, the ACA faces multiple legal challenges as well as legislative attempts to overturn some or all of its provisions, so it is possible that the legislation will not go into effect completely as passed. Unless specified otherwise, analysis of the ACA discussed here is based on the law as signed by the President.

The ACA is organized broadly into ten general topics, or titles. Each title represents a general issue addressed by the legislation; each title is organized into subtitles (e.g., A, B, C) and each subtitle is organized into parts (e.g., 1, 2, 3) and subparts (e.g., A, B, C), each of which contains specific provisions indicated by a four-digit section number. Table 1 provides an outline of each title and a brief description of the provisions it contains. In most cases, the analysis that follows will reference the section number when discussing a specific component of the legislation.
Table 1: Organization of the Affordable Care Act

<table>
<thead>
<tr>
<th>Title</th>
<th>Contains provisions related to:</th>
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<tbody>
<tr>
<td><strong>Title I:</strong> “Quality, Affordable Health Care for All Americans”</td>
<td>Individual and group market reforms, health insurance market reforms, establishment of health insurance exchanges, tax credits for consumers and employers, and individual and employer mandates</td>
</tr>
<tr>
<td><strong>Title II:</strong> “Role of Public Programs”</td>
<td>Medicaid and Children’s Health Insurance Program (CHIP) coverage expansions, reductions to Medicaid Disproportionate Share Hospital (DSH) program</td>
</tr>
<tr>
<td><strong>Title III:</strong> “Improving the Quality and Efficiency of Health Care”</td>
<td>Improvements to Medicare program, value-based purchasing programs</td>
</tr>
<tr>
<td><strong>Title IV:</strong> “Preventing Chronic Disease and Improving Public Health”</td>
<td>Increasing access to preventive health services</td>
</tr>
<tr>
<td><strong>Title V:</strong> “Health Care Workforce”</td>
<td>Education and training initiatives to increase the health care workforce</td>
</tr>
<tr>
<td><strong>Title VI:</strong> “Transparency and Program Integrity”</td>
<td>Transparency provisions related to Medicare, Medicaid, CHIP, physician practices and nursing facilities</td>
</tr>
<tr>
<td><strong>Title VII:</strong> “Improving Access to Innovative Medical Therapies”</td>
<td>Price competition for biologics, approval pathway for biosimilar products</td>
</tr>
<tr>
<td><strong>Title VIII:</strong> “Class Act”</td>
<td>Establishment of national voluntary insurance program for purchasing community living assistance services and support</td>
</tr>
<tr>
<td><strong>Title IX:</strong> “Revenue Provisions”</td>
<td>Revenue offset provisions</td>
</tr>
<tr>
<td><strong>Title X:</strong> “Strengthening Quality, Affordable Health Care for All Americans”</td>
<td>Amendments/additions to titles I-IX</td>
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</table>

Among the many reforms included in the ACA, the law will expand health insurance coverage to more Americans by requiring all U.S. citizens and legal residents—with limited exceptions—to have health insurance, requiring employers with more than fifty employees to provide coverage for their employees, expanding eligibility for Medicaid, and allowing dependent coverage for children up to age 26 on all health insurance policies (Kaiser Family Foundation, 2010). In order to make health insurance
more affordable, the ACA will establish non-profit or publicly run health insurance exchanges, in which consumers may shop for competitive rates on the health insurance products, provide premium subsidies for individuals and families with incomes up to 400% of the Federal Poverty Level, and require insurance companies to provide basic preventive services to infants, children and women without charging a co-pay (Kaiser Family Foundation, 2010). Additionally, the law contains several clauses designed to make health insurance more dependable for consumers by preventing private insurance companies from excluding those with pre-existing conditions, dropping individuals once they become sick, or imposing lifetime limits on coverage. Finally, to achieve the President’s third goal of cost containment, the ACA calls for a number of funding reductions and reimbursement changes to both Medicaid and Medicare, along with measures to address problems of waste, fraud and abuse (Kaiser Family Foundation, 2010).

The Congressional Budget Office (CBO), the nonpartisan federal office that conducts economic and budgetary analysis of congressional legislation, estimates that the changes contained in the ACA could extend insurance coverage to 32 million nonelderly Americans by 2016. As a result, the ACA could lead to provision of health insurance to ninety-five percent of the nation’s uninsured, compared to eighty-two percent who would be covered absent the legislation (Congressional Budget Office, 2011). Furthermore, the CBO projects that, of the twenty-three million nonelderly Americans expected to remain uninsured in 2021, over seven million will be undocumented citizens and more than five million will be eligible for Medicaid but not enrolled in the program (Congressional Budget Office, 2011). Additional analyses of the law by RAND Corporation, a
nonpartisan nonprofit organization that conducts research in support of policy and
decision making, project a decrease in the number of uninsured nonelderly and predict
that those who would remain uninsured after all of the provisions of the ACA have taken
effect will be on average younger and healthier than the current group of uninsured
nonelderly. This would potentially lead to a decrease in the cost of providing care to
those without coverage (RAND, 2010). The Rand analyses also predict that individual
premiums should be two to four percent lower than they would be without the law, and
that the newly insured will face a much smaller risk of high expenditures than they would
under the status quo (RAND, 2010). Additionally, the CBO estimates that the law could
reduce the federal deficit each year of its implementation, with the total deficit reduction
in 2009 estimated to equal $118 billion (Congressional Budget Office, 2010). If the
analyses of the law provided by the nonpartisan CBO, Kaiser Family Foundation, and
RAND are accurate, it appears that the ACA would achieve the President’s three main
objectives—increase access to, lower the cost of, and decrease federal budgetary
obligations attributable to health care in America.

The Situation of Rural Hospitals

According to the American Hospital Association, in 2009 there were nearly 2,000
rural hospitals in the United States, representing approximately forty percent of all U.S.
hospitals (American Hospital Association, 2011b).

Rural hospitals differ from their suburban and urban counterparts in a number of

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1 For the purposes of this analysis, a rural hospital is defined according to the Centers for Medicare and
Medicaid Services (CMS) criteria, which consider any hospital that is not located within a Metropolitan
Statistical Area (a cluster of counties having an urban center with a population of 50,000 or more) to have
rural status (Federal Register Vol. 70 No. 37; OMB Bulletin No. 10-02).
significant ways. Perhaps unsurprisingly, rural hospitals tend to be much smaller than non rural hospitals—the average rural hospital has 50 beds, whereas the average non rural hospital has over 200 beds (Medicare Cost Report, 2006-2010). Almost forty percent of rural hospitals are government-run, typically on the county level (Ricketts and Heaphy, 1999: 104). In this respect, rural hospitals are unique, for, with the exception of VA (Veteran Administration) hospitals, the vast majority of non rural hospitals are not publicly run. About half of rural hospitals are non-profit entities, and less than ten percent of rural hospitals are run by large, for-profit hospital chains (Rural Health Research Center, 2003).

While rural hospitals tend to be smaller and are more likely to be publicly run than non rural hospitals, perhaps the greatest distinction between rural and non rural hospitals lies in the characteristics of the populations they serve. An oft-repeated description of rural populations is that they are older, sicker, poorer, and more likely to be uninsured than the non rural population (Hart, Salsberg, Philips, and Lishner, 2002: 211; Ormond, Zuckerman and Lhila, 2000: 2-3; Reschovsky and Staiti, 2005: 1130; Ricketts, 2000: 639-642). According to the U.S. Bureau of the Census, nearly twenty percent of rural residents are age 65 and older, compared to only 12.6% of non rural residents (U.S. Census Bureau, 2009). In many states, fifty percent or more of those aged sixty-five and older live in rural areas (Bull, Krout, Rathbone-McCuan and Shreffler, 2001: 357).

To rural hospitals, an older patient mix means that a higher percentage of patients are covered by Medicare, the federal health insurance program for individuals ages sixty-five and older. Currently, Medicare reimburses hospitals on average hospitals ninety cents for every dollar spent treating patients (American Hospital Association, 2010);
since payments do not cover the cost of treatment, hospitals lose money by treating Medicare patients. Although about half of all rural hospitals qualify for Medicare reimbursement at 101% of costs (see “Federal Support for Rural Hospitals” below), at best these hospitals can break even or have a slim profit margin from treating Medicare patients, who, because they are older, require more and costlier care (Bull et al., 2001: 357). Therefore, the fact that the elderly are disproportionately represented in rural areas places a significant financial burden upon the hospitals where they seek care, for a high percentage of Medicare patients renders it difficult for hospitals to cover the cost of providing care.

Not only are rural residents older on average than the non-rural population, they are also significantly poorer: U.S. Census Bureau data show that rural residents have lower median incomes than urban residents (U.S. Bureau of the Census, 2009), and other studies have confirmed a higher incidence of poverty in rural America compared to non-rural areas (USDA, 2004). A higher poverty rate not only is linked to poorer health (Adler and Newman, 2002: 60) but also is correlated with higher rates of Medicaid coverage and, indeed, rural residents have higher rates of Medicaid coverage than non-rural areas (RUPRI Health Panel, 2009: 4). Medicaid, the federal health insurance program for the very low income, currently reimburses hospitals at a rate of approximately eighty-nine cents for each dollar of costs (American Hospital Association, 2010), meaning that, like with the Medicare program, hospitals lose money by treating Medicaid patients. Thus, the higher incidence of poverty in rural America among the nonelderly means that rural hospitals must provide more uncompensated care in the form of treating a disproportionate number of Medicaid patients. Figure 1 illustrates the
percentage of the population over age sixty-five and the percentage of the population in 
poverty for rural and non rural populations.

Figure 1: Percent of population over age 65 and in Poverty, 2009—
Rural vs. Non Rural

Source: U.S. Bureau of the Census. “American Community Survey Estimates and 

In addition to being older and poorer on average, rural residents are also more 
likely to report being in poor or fair health than their urban counterparts (Ricketts, 2000: 
640; Ormond et al, 2000: 3) and this disparity persists even after adjusting for the older 
average age of rural populations (National Advisory Committee on Rural Health and 
Human Services, 2008: 8). A recent study suggests that rural residents in general are 
more likely to require hospitalization than urban residents (Reschovsky and Staiti, 2005: 
1134), while National Health Interview Survey (NHIS) data show that most chronic 
conditions are more prevalent in rural areas and Centers for Disease Control (CDC) data 
demonstrate higher rates of obesity and smoking in non-metropolitan counties (National 
Advisory Committee on Rural Health and Human Services, 2008: 9). This poorer than
average health among rural populations translates, again, into more expensive treatment that, coupled with a higher likelihood of being uninsured, low income, or having Medicaid or Medicare coverage, results in rural hospitals providing a disproportionate amount of care at or below cost or even for free. The disproportionate numbers of Medicare, Medicaid and uninsured patients treated by rural hospitals also result in disadvantageous net reimbursement for services; according to the NRHA, in 2009 the average payment per discharge for rural hospitals was $7,432, compared to $10,274 for urban hospitals (National Rural Health Association 2010: 2).

Rural residents are also more likely to be uninsured than their urban counterparts (Ricketts, 2000: 640; Zhang, Mueller and Chen, 2008). Those without health insurance are more likely to defer primary care and are more likely to be hospitalized for preventable conditions (Zhang et al., 2008: 194). Therefore, because uninsured patients tend not to use preventive and primary care services as often as the insured, when their conditions progress to the point where they do seek medical care they are often sicker, and thus more costly to treat, than those with health insurance. Again, this poses a significant financial burden for rural hospitals. Other factors exacerbate the situation. For example, although primary care physicians are at liberty legally to require payment for services from uninsured individuals before providing care, hospital emergency departments are required under the federal Emergency Treatment and Labor Act (EMTALA) to examine and stabilize anyone who presents for care, regardless of the ability to pay for services, and they must admit these patients for treatment if necessary (O’Brien, Collins, Kirsch, Pollock and Slobodkin, 1999: 20). Because the ailments of the uninsured are generally more advanced and therefore costlier to treat by the time the
patient arrives at the emergency room, the disproportionate number of uninsured patients served by rural hospitals adds to higher rates of uncompensated care.

The difficulties of operating a rural hospital do not lie solely in their disadvantageous patient mix. Because of their small size, these hospitals face more difficulties in accessing the capital needed for infrastructure improvements, such as modernizing buildings and acquiring new technologies, such as health information technology (IT) and technology used to diagnose and treat patients, such as MRIs and non invasive surgical equipment. In 2004 nearly thirty percent of all rural hospitals were located in physical facilities over forty years old (American Hospital Association, 2011: 7-8). And rural hospitals lag behind their urban counterparts in terms of health IT use and range of services they can provide. Possessing the latest technology is necessary not only for treating patients, but for attracting insured and wealthier patients to the hospital in the first place. Roh and Moon found that, when they can take advantage of other options, rural residents in general are more likely to bypass the local hospital in favor of an urban or suburban hospital when they perceive the latter to offer more high-tech treatments (Roh and Moon, 2005: 388).

In addition to difficulties they confront for modernizing their physical plants, IT and treatment systems, rural hospitals also face barriers in recruiting and retaining staff. Despite the fact that twenty percent of Americans live in rural areas, only nine percent of U.S. physicians practice in rural areas (Agency for Healthcare Research and Quality, 2005: 1). Rural areas also face nursing shortages (Ricketts, 2000), in part because they must compete with urban areas, which offer higher wages for nurses (National Center for Frontier Communities, 2004). According to 2004 data from the Department of Health
and Human Services (HHS), a higher percentage of rural areas are designated as Health Professional Shortage Areas and Medically Underserved Areas than are metropolitan areas (National Advisory Committee on Rural Health and Human Services, 2008: 11-12), indicating that rural areas are disproportionately burdened by health professional shortages. Lack of technology and difficulty in attracting staff, taken together with the primary challenge of providing care that is, on average, costlier and less profitable than that provided by non rural hospitals add to the less favorable position of rural hospitals in the healthcare marketplace in comparison to urban and suburban hospitals.

Rural hospitals often represent the only significant source of health care available to many rural residents. Urban residents may be able to choose between more than one hospital from which to receive care, and are also more likely to have access to health clinics and other health care providers. Rural residents, faced with longer travel distances to health care facilities, have fewer feasible options when it comes to accessing hospital care. Also, because rural areas have fewer outpatient providers—such as physicians and health clinics—rural residents are more likely to depend upon the nearest rural hospital for most or all of their health care.

Rural hospitals are also a vital part of rural economies. Hospitals are often a major employer in rural communities, providing jobs not only for direct hospital staff—e.g. nurses, maintenance, dietary, etc.—but also for health professionals that work in conjunction with the hospital, such as physicians. Moreover, a hospital often attracts other supporting industries, such as hotels and food service. A 1998 study estimated that a rural hospitals closure would lead to the loss of forty-three hospital jobs and eight jobs in other sectors of the economy in the first year alone; over time the total jobs lost
increased by more than fifty percent (McNamara 2009: 4). Another study of hospital closures between 1990-2000 found that the closure of a sole hospital in a rural county led to a four percent decrease in per capita income, and a 1.6% increase in unemployment (McNamara 2009: 4).

According to Moscovice and Stensland, the financial status of a rural hospital depends upon its patient volume, ability to provide care in a cost efficient manner, and reimbursement rates for services provided (2002: 199). Rural hospitals experience relatively higher rates of fixed overhead than do other hospitals, and have difficulties achieving economies of scale (Hart et al., 2002: 211; Heady 2002: 110). Additionally, a 2003 study found that rural hospitals generate less revenue per bed than do urban hospitals, and that, while hospital profitability in the U.S. has improved over time, this improvement has been significantly less dramatic for rural hospitals (Younis 2003: 43-45). More recent data shows that, in 2010, 63.3% of rural hospitals had negative operating margins, compared with 51.5% of urban hospitals (Medicare Cost Report data, 2010). While many hospitals lost money in 2010, perhaps in part to the ongoing economic recession, it is clear that rural hospitals as a group are less likely to be profitable than are urban hospitals.

**Federal Support for Rural Hospitals**

The federal government has recognized the not insignificant burden of providing a disproportionate amount of uncompensated care faced by rural hospitals, and has taken steps to provide additional funding to rural hospitals in recognition of this fact. For example, Centers for Medicare and Medicaid Services (CMS) allows rural hospitals with
25 or fewer beds that are located no more than thirty-five miles away from the nearest hospital to be designated as Critical Access Hospitals (CAHs); these are the rural hospitals that qualify for Medicare reimbursement at 101% of cost (Centers for Medicare and Medicaid Services); currently, 993 rural hospitals qualify as critical access hospitals or slightly more than half of all rural hospitals (Medicare Cost Report data, 2006-2010).

Also, the federal Disproportionate Share Hospital (DSH) program provides additional funds to hospitals that serve a disproportionate number of low-income patients. There are DSH programs for both Medicare and Medicaid. Under Medicare DSH, qualifying hospitals receive a payment adjustment, and under Medicaid DSH, each state is given an allotment of federal funds and a broad discretion as to which hospitals receive this funding. Notably, overall only nine percent of Medicare DSH funds go to rural hospitals and only twenty percent of rural hospitals qualify compared to half of non rural hospitals (Sutton, Stensland, Zhao and Cheng, 2002: 495). With Medicaid DSH, only ten states have chosen to allocate some of these funds to rural hospitals specifically (RUPRI Center for Rural Health Policy Analysis, 2002: 3), and rural hospitals taken together receive far less Medicaid DSH funds than do urban hospitals (National Association of Public Hospitals and Health Systems, 2006: 1). This is in part because urban hospitals tend to treat larger numbers of poor people. However, large urban hospitals may also have more clout when it comes to influencing how a state decides to distribute its pool of DSH funds, and therefore are better able to lobby for increased or special allocations of DSH funding.

The additional funding received by some rural hospitals under the federal CAH and DSH programs should not be taken to suggest that rural hospitals have any sort of
advantage over non rural hospitals. For example, although reimbursement at 101% of cost for CAHs may appear sufficient, private insurance can reimburse at rates up to several times higher than cost. Rather than favoring rural hospitals over urban, then, these measures serve as life-support for remote hospitals, keeping them in operation and existence but in no way rendering them competitive or viable.

The majority of hospitals in the U.S. are located in suburban or urban areas; rural hospitals represent less than half of all U.S. hospitals numerically, and furthermore are responsible for 12% of total hospital revenues and only 11% of all patient days (Medicare Cost Report data, 2006-2010). By most measures, rural hospitals are in the clear minority, and as a result most federal health policy is crafted with non rural hospitals in mind. State Hart et al., “National policy is largely designed to solve urban health care delivery problems, with rural interests left in the backwash to negotiate policy and regulation patches designed to diminish unintended adverse rural consequences” (2002: 212). Analysts have argued that urban bias is present in most of the major federal health programs, including Medicaid (see Hurley, Crawford and Praeger, 2002), Medicare (see Mueller, Shoenman, and Dorosh, 1999; and Ricketts, 2000), and the Medicare and Medicaid DSH programs (see Wynn, Coughlin, Bondarenko, and Bruen, 2002; and Sutton, Stensland, Zhao and Cheng, 2002). Even when federal legislators make special provisions for rural hospitals in order to address any specific issues they face in the aggregate, these provisions tend to be corrective, and have been put in place after the original, urban-oriented legislation has been passed. Urban hospitals are taken as the norm and the variables of rural hospitals are not adequately researched; this is inadequate.
Rural Hospitals and the ACA

Because rural hospitals differ so significantly from their urban and suburban counterparts, there are a number of state and national advocacy organizations which craft, endorse, or lobby for legislative policy in support of rural hospitals. Not surprisingly, these organizations have taken a particular interest in health care reform, as it presents an opportunity for rural hospitals—which serve such a large proportion of the nation’s uninsured—to increase the percentage of insured patients entering their doors, in turn diminishing the amount of uncompensated care these hospitals must provide. Because an increase in the number of Americans with health insurance is believed to have an impact upon not only the bottom line but the very viability of rural hospitals, advocacy organizations such as the American Hospital Association (AHA), the National Rural Health Association (NRHA), and the Rural Policy Research Institute (RUPRI) were strong proponents of health care reform prior to the passage of the ACA, and have subsequently provided some analyses of how the law is expected to impact rural hospitals specifically. Because I could find very little in the academic literature that examines the ACA with respect to rural hospitals, I have drawn heavily from the data produced by policy-oriented organizations regarding how health care reform could impact rural hospitals if implemented as planned.

The ACA is a massive, detailed document of nearly one thousand pages, outlining a comprehensive plan for increasing access to health care, making health care more affordable and reliable, improving quality and lowering costs. The law contains some provisions that are directed toward rural hospitals specifically; however, the main
provisions affecting all hospitals could also have a significant impact upon rural hospitals. Overall, there are three fundamental changes in the ACA that are predicted to have significant impact upon rural hospitals: coverage expansion, changes in reimbursement for federal programs, and new patient care models designed to increase efficiency and lower costs.

*Increasing the Rural Insured*

Perhaps the most significant aspect of the ACA with respect to rural hospitals is its promise to expand health insurance coverage to the uninsured. Most of the coverage expansion elements of the law would go into effect after 2014 and, overall, these changes are expected to have a more significant impact upon rural hospitals than non rural hospitals, based on the fact that rural residents have a higher uninsured rate than non rural residents (American Hospital Association, 2011: 2; RUPRI Health Panel, 2010a: 2). According to a recent analysis of the impact of the ACA by RUPRI, the number of rural residents without health insurance is predicted to decline from the current 8.1 million to 1.9 million, leaving only 4.2 percent of rural Americans uninsured. Considering that some 5.9 percent of urban residents will still remain uninsured after the coverage expansions are enacted, the legislation should have a disproportionate positive impact on rural rates of health insurance coverage (RUPRI Health Panel, 2009: 2-7). Treating a comparatively high percentage of uninsured patients—who, as indicated above, are usually sicker and cost more to treat—is a tremendous burden borne by rural hospitals, and so any decrease in the number of uninsured rural residents is expected to have a favorable impact on the hospitals from which they seek care.
While the ACA should, in the aggregate, provide increased access to insurance for rural residents, this would not be achieved through a single measure, but rather through a number of measures in the bill, including the expansion of eligibility for public programs, the creation of health insurance exchanges, and providing tax credits to small businesses that offer their employees private insurance. As discussed in a previous section, not all insurance programs reimburse hospitals the same amount for services--e.g. Medicaid reimburses only about eighty percent of costs, whereas private insurance can pay up to several times the cost of treating a patient. Because of this disparity in reimbursement, it is important not only to review the overall expected impact of the ACA on rural hospitals, but also to review specific major initiatives included in the legislation to determine how rural hospitals are likely to be affected given the unique characteristics of the rural populations they serve.

The first major change related to coverage expansion contained in the ACA has to do with the expansion of public insurance programs, namely, Medicaid and the Children’s Health Insurance Program (CHIP). According to the law as passed, effective January 1, 2014, all individuals under the age of sixty-five with incomes below 133% of the Federal Poverty Level (FPL) will be eligible for Medicaid (Patient Protection and Affordable Care Act of 2010 § 2001). This will represent an important change in federal policy, not only because it will raise the maximum income requirements to qualify for Medicaid, but also because it will expand Medicaid coverage to all individuals meeting the age and income requirements. Without this change in eligibility, childless adults would continue to find it very difficult to qualify for Medicaid; easing eligibility requirements opens up the possibility of public insurance to these previously excluded
individuals. Furthermore, this section of the bill would eliminate the asset test for Medicaid enrollees. Previously, an asset worth as little as $1,000 could disqualify an otherwise eligible individual from enrolling; the ACA calls for eligibility determinations to be made strictly based upon age and income (Jacobi, Watson and Restuccia, 2011: 69). This is of particular significance to rural populations, who are more likely to own acreage which, under current Medicaid rules, is counted as a disqualifying asset (Mueller, 2010: 17).

Overall, out of pool of the rural uninsured that should be newly covered if and when the ACA goes into effect in its current version, a full twenty-eight percent would be covered under Medicaid expansion, compared with less than twenty-five percent of their urban counterparts (see Table 2) (RUPRI Health Panel, 2009: 7). Certainly, treating more insured persons should have a positive impact upon rural hospitals because of the higher likelihood of cost reimbursement. However, it is important to note that Medicaid reimbursement still will not cover the cost of treatment completely, and if rural hospitals continue to treat a disproportionate number of Medicaid patients, as is projected, then they will remain at a disadvantage with respect to non rural hospitals in terms of revenues (American Hospital Association, 2011:4-5). Given evidence, discussed above, that Medicaid enrollees make more emergency room visits than those with other types of insurance (and also make more avoidable emergency room visits such as visits for conditions that could have been treated in a clinic setting) (Garcia, Bernstein and Bush, 2010: 1), then an increase in Medicaid patients may actually lead to more emergency room visits at greater cost than outpatient visits. While each of the above points are legitimate concerns, nonetheless the consensus among the national rural health policy
organizations consulted for this analysis continues to be that the expansion of Medicaid under the ACA will prove to be a net gain for these hospitals overall due to the fact that uncompensated care has posed such a profound challenge rural hospitals,

CHIP is the other public program through which millions of Americans are projected to become newly insured with implementation of the ACA. If implemented as passed, for four years beginning on October 1, 2015, the federal government will increase funding allotments to states by as much as twenty-three percentage points, up to one hundred percent of the cost of the program (Patient Protection and Affordable Care Act of 2010 § 2101). This projected increase in funding for CHIP could result in over 1.3 million rural children becoming insured through the program (RUPRI Health Panel 2009: 7). Notably, the bill also gives hospitals the authority to make eligibility determinations for both CHIP and Medicaid (Patient Protection and Affordable Care Act of 2010 § 2202); this would be important for rural hospitals whose patients are likely to lack access to information and resources required presently for enrolling in these programs prior to seeking hospital treatment (Mueller 2010: 18).

In addition to expanding Medicaid and CHIP, the proposed ACA also provides for grants for the creation of Health Insurance Exchanges (HIEs), state-run insurance marketplaces where individuals and small businesses can shop for insurance plans (Patient Protection and Affordable Care Act of 2010 § 1311). Intended to promote choice, competition and value in the health insurance market, the ACA would require that HIEs be established in each state by 2014. Initially, only individuals and businesses with fifty or fewer employees will be permitted to purchase plans through HIEs, but by 2019 all businesses would be able to participate (Patient Protection and Affordable Care Act of
2010 § 1311). For their part, HIEs should control premium increases, facilitate comparison between plans for consumers, and administer tax credits to those consumers who qualify (Patient Protection and Affordable Care Act of 2010 § 1311; Davis, Guterman, Collins, Stremikis, Rustgi. and Nuzum, 2010: 9; Jost, 2010: 1). Nearly fifty percent of the now-uninsured rural population (excluding some rural residents as discussed below) is projected to become insured via HIEs, making this provision the most likely source of new insurance for the rural uninsured (RUPRI Health Panel, 2009: 7).

Perhaps the most significant aspect of HIEs with respect to rural residents has to do with the tax credits they would offer to individuals and small businesses. According to Section 1401 of the ACA, individuals with incomes between 133% and 400% of official federal poverty level would be entitled to refundable tax credits to mitigate the cost of purchasing insurance through HIEs (Patient Protection and Affordable Care Act of 2010 § 1401). This measure is designed to provide assistance to low and middle income households who do not qualify for Medicaid under the new law. The RUPRI analysis estimates that over thirty percent of newly uninsured rural residents could use these tax credits to purchase health coverage through HIEs, compared to twenty-five percent of their urban counterparts (see Table 2) (RUPRI Health Panel, 2009: 7). That the rural uninsured would be disproportionately more likely to receive tax credits for use in HIEs should not be surprising, given that the rural population is on average lower income and therefore more likely to qualify for federal assistance of diverse types.

The fact that nearly half of the rural uninsured could become eligible to purchase coverage through HIEs, many at a subsidized rate, would be of great significance to rural hospitals. Treating a patient with some kind of health coverage—be it Medicaid,
Medicare, or private insurance-is always preferable to treating an uninsured patient in terms of a hospital’s ability to recuperate its costs and strive for a sustainable profit margin. But, in general, private insurance is the most favorable of all insurance types, as it is the only one that can be counted on to reimburse at a rate above cost (Reinhardt, 2009). Therefore, rural hospitals should benefit from any increase in the number of patients with private health insurance that may ensue from the ACA.

Not only does the current version of the ACA provide tax credits for individuals to assist in paying premiums, it also calls for tax credits to small businesses to help offset the cost of providing insurance for employees. According to the law, small businesses with no more than twenty-five full-time employees that also have average annual incomes of less than $50,000 will be eligible to receive tax credits equal to either fifty percent of non-elective contributions for premiums or the total amount of contributions the employer would have paid had every employee enrolled, whichever value is the lesser (Patient Protection and Affordable Care Act of 2010 § 1421; Mueller, 2010: 2; 16). Providing assistance to small businesses to offset the costs of providing an employee health insurance plan would expand coverage rates in general. Additionally, this provision is likely to be advantageous to rural residents who, after a decade of declining rates of private insurance coverage, currently lag behind their urban counterparts with respect to access to employer-sponsored insurance (Lenardson, Ziller, Coburn and Anderson, 2009: 2). Given that rural residents are not only more likely to be employed by small firms (Slifkin, 2002: 236) but are also less likely to have access to employer sponsored health insurance (Bailey, 2009:1; Mueller, 2009: 2; Shields, 2009: 1), the impact of the ACA could reduce the disparity in insurance coverage between rural and
non rural workers.

An estimate provided by RUPRI is that over nineteen percent of the newly insured in rural areas could become insured via employer or individual responsibility (i.e., purchasing private insurance outside of an HIE or employer-provided plan; see Table 2), though it is unclear how many of these individuals will access coverage specifically from a tax credit eligible small business (RUPRI Health Panel 2009: 6-7). This ambiguity notwithstanding, RUPRI and NRHA have predicted that tax credits for small businesses will improve the ability of rural residents to access private health insurance (National Rural Health Association, 2010; RUPRI Health Panel, 2010a: 1, 10). This provision should have a favorable impact on the rural hospitals, then, in that it will likely increase the number of patients with favorable insurance policies and decrease the amount of uncompensated care these hospitals provide to uninsured patients.

Table 2. Predicted Health Coverage under the Affordable Care Act, Rural vs. Urban

<table>
<thead>
<tr>
<th></th>
<th>Rural</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of uninsured persons</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before ACA</td>
<td>8,100,000</td>
<td>41,800,000</td>
</tr>
<tr>
<td>After ACA</td>
<td>1,900,000</td>
<td>12,100,000</td>
</tr>
<tr>
<td>Uninsured rate after ACA</td>
<td>4.2%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Proportion of newly insured obtaining coverage through:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIE (adults)</td>
<td>49.8%</td>
<td>51.6%</td>
</tr>
<tr>
<td>With subsidies or tax credits</td>
<td>30.6%</td>
<td>25.4%</td>
</tr>
<tr>
<td>Employer or individual responsibility</td>
<td>19.2%</td>
<td>26.2%</td>
</tr>
<tr>
<td>Medicaid expansion (adults)</td>
<td>28.0%</td>
<td>24.8%</td>
</tr>
<tr>
<td>Children (CHIP)</td>
<td>22.1%</td>
<td>23.6%</td>
</tr>
</tbody>
</table>

The preceding discussion shows that policy analyses predict that HIEs, tax credits to small businesses, and tax credits to employers should increase the number of rural residents with private health insurance which, as noted, is predicted to also both increase revenues and decrease uncompensated care burdens for rural hospitals. However, this scenario assumes that the newly insured will continue to seek services from their local rural hospital, and some evidence suggests caution in making this assumption. As mentioned in an earlier section, studies have shown that rural residents with private insurance are more likely to bypass their local hospital in favor of treatment at larger, urban hospitals (Zimmerman, McAdams and Halpert, 213) and that rural residents without private health insurance are more likely to receive treatment at the local hospital (Escarce and Kapur, 2009: 641). Thus, it is possible that the expected increase in rural residents with private health insurance may not necessarily translate into rural hospitals seeing an increase in patients with this favorable type of insurance and may, in fact, result in urban hospitals experiencing an increase in privately insured patients. Should this occur, the ACA would actually function to direct patients with private insurance away from rural hospitals, placing them at a further disadvantage with respect to urban hospitals. Currently, lack of data makes it difficult to predict how many of the newly insured will bypass rural hospitals once the coverage provisions of the ACA take effect.

Changes to Medicaid DSH

Even if the ACA, if implemented as approved, leads to expected increases in insurance coverage, there are other factors that may interfere with positive impacts on
rural hospitals. The ACA also contains important changes to the federal Medicaid DSH program which could offset some of the gains rural hospitals should see as a result of insurance coverage expansion. In recognition of the fact that all hospitals are expected to experience a decline in uncompensated care as a result of health care reform, the ACA also calls for a series of reductions in DSH funding over the 2014-2020 period, with aggregate reductions in DSH funding to equal $500 million in fiscal year 2014 and $4 billion in 2020 (Mueller, 2010: 19). Since the total federal Medicaid DSH allotment for fiscal year 2009 was $11.3 billion (Centers for Medicare and Medicaid Services, 2011), a $4 billion reduction in 2020 alone represents a significant decrease in funding.

Although for all hospitals in general Medicaid DSH represents twenty-five percent of all subsidies to hospitals for uncompensated care (Vladeck, 2006: 39-40), Medicaid DSH traditionally has not been a major source of revenue for rural hospitals in the aggregate, compared to urban hospitals (RUPRI Health Panel, 2010a: 3). The Medicaid DSH provisions in the ACA assume that decreases in Medicaid DSH allotments will be offset by increased revenues from the newly insured, and yet because Medicaid DSH allotments to rural hospitals vary from state to state—and from facility to facility—not all rural hospitals will be in a position to benefit. For those rural hospitals that depend on Medicaid DSH payments to relieve a significant part of their uncompensated care burden and who do not see a significant increase in the number of newly insured patients, these changes to Medicaid DSH funding levels could have a profoundly negative impact upon their revenues (RUPRI Health Panel, 2010a: 3).

The planned reductions in Medicaid DSH payments beginning in 2014 serve to illustrate the uncertainty that exists regarding how some changes called for in the bill
will play out in practice, an uncertainty not reflected in many of the analyses of the ACA that were consulted. In the case of changes to Medicaid DSH, payment reduction rates are based upon each state’s current level of Medicaid DSH funding, as well as the percentage of uninsured in each state after (and if) the major coverage expansion provisions go into effect in 2014 (Patient Protection and Affordable Care Act of 2010 § 2551). Even conducting a state-by-state analysis of current Medicaid DSH levels, it is difficult to predict what percentage of each state’s population could remain uninsured after 2014. As a result, some analysts have cautioned that the Medicaid DSH program must be monitored closely and adjusted quickly, if needed, to prevent potential negative impacts to rural hospitals (American Hospital Association, 2010: 12-14; RUPRI Health Panel, 2010a: 3). Changes mandated in the ACA will not affect all rural hospitals uniformly, in part given state level differences among others, but also because the net impact of the coverage expansion provisions and changes to Medicaid DSH for each rural hospital will depend on each hospital’s patient mix and current level of DSH funding in 2014 when the initial decreases in funding are set to take effect. While the above analysis suggests that if the ACA is implemented as passed the uncompensated care burden faced by rural hospitals in the aggregate is likely to decline, but not equally across all rural hospitals.

Value-Based Purchasing

The third major provision in the health reform legislation, that of establishing Medicare value-based purchasing models, is decidedly problematic. In an attempt to improve the overall health of the population, improve the experience of care, and lower
the cost of care, the ACA (if implemented as approved) would grant the Department of Health and Human Services (HHS) the authority to develop pay-for-performance demonstration projects under the Medicare reimbursement system, representing a fundamental shift away from an emphasis on patient volume and procedures and toward quality and efficiency of care as the basis for hospitals’ Medicare revenues (Easton, 2010: 587; National Advisory Committee on Rural Health and Human Services, 2011: 19). Specifically, the ACA calls for the establishment of Accountable Care Organizations (ACOs) (Patient Protection and Affordable Care Act of 2010 § 3022) and bundled payment systems (Patient Protection and Affordable Care Act of 2010 § 3023), programs which the Rural Policy Research Institute (RUPRI) describes as “precedent-setting” and which are expected to have a potentially negative impact on rural hospitals (RUPRI Health Panel, 2011: 1).

The ACA mandates that an ACO-Medicare shared savings program be enacted by January 1, 2012, and makes this payment system a permanent option under Medicare (Patient Protection and Affordable Care Act of 2010 § 3022). According to CMS, an ACO may be defined as “an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it” (Center for Medicare and Medicaid Services, 2010:1). In this case, “health care providers” may be understood to refer to hospitals, physicians, and other providers, such as outpatient physical therapy or nursing care. Providers within an ACO are expected to work together to create the best health outcomes at the lowest cost, and those ACOs that achieve lower per capita Medicare expenditures than the prior three year average will be entitled to
share in a percentage of the savings (Stowell and Puiia, 2011:21).

In some respects, the call for ACOs in the health reform legislation serves as an opportunity for rural hospitals to not only increase quality and efficiency, but also to form partnerships and collaborate with other providers. Some analysts argue that rural hospitals, almost all of which operate under tight budgets and slim margins, are already accustomed to providing care at a low cost (Barr, 2011: 28; MacKinney, Mueller and McBride, 2011: 134). The American Hospital Association suggests that rural hospitals that are presently integrated—such as those whose geographic isolation and limited resources have led them to form rural health networks or to merge with larger health systems that include non rural hospitals—may be well positioned to create ACOs (American Hospital Association, 2011: 12-13). Despite these possible advantages, however, the emphasis on ACOs in the health reform legislation presents a series of challenges to rural hospitals.

The principal concern with ACOs relates to the main eligibility requirement for participation—ACOs must serve a minimum of five thousand Medicare patients in order to be eligible. For many rural hospitals, low patient volumes will make it difficult or impossible to qualify under the guidelines established by the ACA; this is particularly true for CAHs, which are designated as such in part because they serve relatively few patients (American Hospital Association, 2011: 13; Stowell and Puiia, 2011: 22). Although the law does mandate the establishment of a three-year demonstration program for CAHs (Critical Access Hospitals) in order to test the feasibility of ACOs for these rural hospitals (Patient Protection and Affordable Care Act of 2010 § 3001), the ACO model is nonetheless best suited for large delivery systems, which concentrate in non
rural areas (NACRHHS, 2011: 21).\(^2\) Considering that, on average, more than fifteen percent of rural hospital patients are Medicare beneficiaries, for a rural hospital to reach the required five thousand Medicare patients, its total service area must be over 33,000 in population, which is prohibitively large for many rural providers (MacKinney et al., 2011: 134).

In addition to many rural hospitals facing the prospect of not having enough Medicare patients to participate in the ACO program, the extreme financial strain faced by rural hospitals currently also will make it difficult for rural hospitals to establish ACOs in the first place. ACOs, as a new type of payment system, require hospitals to create linkages and partnerships with other providers in order to qualify for participation. To do so requires a significant amount of planning and coordination, representing an additional cost burden not easily absorbed by rural hospitals, particularly the most remote rural hospitals that are unlikely to have already-established working relationships with other health care entities (MacKinney et al., 2011: 133-134). Some estimates place the cost of forming an ACO at a prohibitively high $1 to $1.5 million (Barr, 2011: 28).

While the ACA would provide grants of up to $50,000 to help rural hospitals establish ACOs, the manner in which the program is to be administered could provide each hospital with as little as $8,000, increasing the burden of start-up costs for rural ACOs on hospitals (National Advisory Committee on Rural Health and Human Services, 2011: 24). Moreover, those rural hospitals that do acquire the funds necessary to create an ACO could still face difficulty in attracting the additional administrative workforce.

\(^2\) CAHs, which account for fifty percent of all rural hospitals, may experience disproportionate difficulties in establishing ACOs. CAHs are among the smallest and most geographically isolated of all hospitals, and therefore they will have less capital to devote to creating an ACO and will have to create more linkages with other providers in order to reach a patient volume that will sustain an ACO.
needed to administer the program (Easton, 2010: 588), and would remain disadvantaged by lack of technology. Thus it appears that the potential for generating additional revenue through the ACO payment system is likely to favor non-rural hospitals, whose more robust operating margins would make it more feasible to cover start up costs and access networks.

Rural hospitals that do manage to establish ACOs may find it difficult to gain financially from participating in this new program. Historically, rural providers have employed cost efficiency measures out of necessity, and as a result they have little room for additional savings. As the National Advisory Committee on Rural Health and Human Services notes (2011),

Although the payment reform outlined in the ACA holds promise to bring costs down while also improving the quality of health care, many rural providers are burdened by reimbursement rates that make it difficult for them to provide services currently, and these providers do not see how improvements can be made by seeking further reductions (25).

Because ACOs are rewarded based in part upon the percent decrease in costs they are able to demonstrate, rural hospitals, many of which have already lowered costs as much as possible, may be disproportionately prevented from reaping the benefits of this program (RUPRI Health Panel, 2010b: 4-5).

The other value-based purchasing initiative contained in the ACA calls for a five year pilot program on payment bundling for the treatment of both Medicare and Medicaid patients scheduled to begin on January 1, 2013 (Patient Protection and Affordable Care Act of 2010 § 3001), provided that the current lawsuits challenging the legislation do not
delay its implementation. Payment bundling is a cost and quality improvement measure that seeks to “bundle” payments to all providers involved in a patient’s episode of care—including hospitals, physicians, skilled nursing facilities and home health care agencies, as applicable—into a single comprehensive payment intended to cover all services (American Hospital Association, 2011:12). Under the current Medicaid and Medicare reimbursement systems, health care providers are paid under a fee-for-service model, which creates an incentive to increase the volume of care provided to each patient; payment bundling represents an attempt to correct this incentive by rewarding quality of care and by spreading the financial risk associated with providing care evenly between those paying for treatment (i.e., Medicare and Medicaid) and the hospitals that provide it (National Advisory Council on Rural Health and Human Services, 2011: 20). Those hospitals that meet the quality criteria established by the program each year would be eligible to receive a bonus payment—an incentive for hospitals to participate in this model of payment (American Hospital Association, 2010: 13).

Policy analysts predict that payment bundling, like ACOs, will favor non rural hospitals. NACRHHS warns that payment bundling as described in the ACA appears to apply primarily to complex cases, which are found disproportionately in urban hospitals. Thus the ACO mandate could serve to siphon those patients in need of more complex treatment toward urban hospitals, resulting in a decrease in patient volume for rural hospitals (NACRHHS, 2011). Should this diversion of patients away from rural hospitals occur, rural hospitals’ finances could suffer due to the fact that patients treated by an ACO are covered by Medicare and many rural hospitals are dependent upon Medicare reimbursement to help offset other expenses, such as uncompensated care. While the
ACA would require that the Government Accountability Office perform a review of the pilot program that considers the barriers faced by small rural hospitals in meeting payment bundling requirements, the report is not due until July 1, 2017 (Patient Protection and Affordable Care Act of 2010 § 3001). As a result, in the intervening five years between commencement and review of the program, rural hospitals would remain at risk of both losing out on increased payments and also losing patient volume.

Clearly, a large portion of the ACA is concerned with improving quality and lowering costs, and the two value based purchasing initiatives contained in the legislation—ACOs and payment bundling—represent an attempt to reward those hospitals that achieve these goals. However, since these incentives have an urban bias, rural hospitals are expected to face significant barriers in both implementing and benefiting financially from ACOs and payment bundling mechanisms. Thus, while the expanded coverage that could result from the ACA may have a disproportionate impact on rural hospitals, value based purchasing models will grant a distinct advantage to non rural hospitals and may place rural hospitals at a disadvantage in the healthcare marketplace going forward.

Other Issues to Consider

Although coverage expansion, reduction in Medicaid DSH, and value-based payment programs appear to be the three principal changes in the ACA that could have profound impact on rural hospitals, there are other measures contained in the legislation which, though not as fundamental to rural hospitals overall, are still worth noting. The legislation includes specific allotments for certain rural hospitals, allocating $300 million
in Medicare payment bonuses over ten years to low volume hospitals, and $200 million over two years for hospitals located in the lowest quartile for Medicare spending, categories in which rural hospitals are sure to be overrepresented (Jarousse, 2011: 23). This could offset some of the negative impacts of the value-based purchasing provisions of the ACA. However, rural hospitals with low Medicare volume may be more likely to provide a high percentage of uncompensated care, so these payment bonuses may prove to have only a small impact on hospital finances as a whole. Also, the legislation contains a number of provisions for granting a significant amount of funding for the expansion of the rural health care workforce, including rural physician training and loan programs, increased funding to the National Health Service Corps, and a redistribution of residency slots to give preference to states with health professional shortages (Bailey, 2010: 1-2). While rural hospitals would not receive this funding directly, an increase in the pool of health care workers, physicians in particular, who are able to serve in rural communities may assist rural hospitals in serving the increased patient volumes that organizations such as the AHA and RUPRI have predicted will occur after coverage expansion goes into effect.3 However, most of the rural provisions related to health care workforce expansion are currently unfunded because they are dependent on the annual Congressional appropriations process (Bailey 210: 5-6). Although increased funding for certain rural hospitals treating low volumes of Medicare patients and for rural health workforce programs are encouraging, they are expected to have a less direct impact upon

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3 Should the coverage expansion provisions in the ACA in fact lead to rural hospitals seeing increased patient volume due to larger numbers of rural insured, an expanded rural health care workforce could help rural hospitals meet this new demand. Absent this funding for health care professionals targeted to rural areas, rural hospitals could risk not having sufficient personnel to treat increased numbers of patients.
the viability of rural hospitals than are the three principal changes outlined in the previous sections.

**Undocumented Immigrants: Missing from ACA Analysis**

According to the above analysis, the health care reform bill is generally predicted to provide a net gain for rural hospitals though analysts differ on the degree of gain and the circumstances and factors that would support or interfere with the desired direction of change. Some analysts highlight that the legislation also presents challenges to rural hospitals, such as reduced Medicaid DSH funding, and is likely to place them at a disadvantage vis-à-vis urban hospitals in taking part in AOCs and payment bundling. Overall, however, the expanded access to health insurance provided in the ACA could be significant to many rural hospitals in terms of their financial health and their continued viability in the increasingly competitive health care market or may inadvertently lead to reduced capacity to compete for some. While rural areas face many of the same challenges, such as older, poorer and sicker populations on the whole, there is great diversity among rural areas in terms of one important variable ignored in analyses and calculations of impact of the ACA on rural hospitals. Many rural hospitals serve a large population of undocumented immigrants. This is not an insignificant fact. The ACA as approved specifically excludes undocumented immigrants from coverage expansion provisions. Given this, those rural hospitals serving a higher proportion of undocumented immigrant patients are less likely to experience predicted positive impacts of the ACA than those whose patient base is comprised of primarily U.S. citizens.

In September 2009, President Obama discussed this issue in a speech outlining his
proposal for health care reform (Galarneau, 2011: 422). The legislation he signed six months later explicitly excludes undocumented immigrants from the individual mandate to carry health insurance and explicitly makes all undocumented immigrants ineligible for virtually all federal coverage (National Immigration Law Center, 2010). The exclusion of undocumented immigrants from Medicare, Medicaid and CHIP does not represent a change of course in federal policy—undocumented immigrants historically have been banned from taking part in these programs (Castel, Timbie, Sendersky et al., 2003; Hirota, Garcia, Silber et al., 2006: 84; Okie, 2007: 528). Thus, the ACA reinforces the status quo with respect to undocumented immigrants and public health insurance, and yet the fact that coverage expansion does not apply to this group may nonetheless have a significant impact upon selected rural hospitals.

In addition to continuing to prevent undocumented immigrants from accessing federal programs, the ACA also takes the surprising step of banning this group from purchasing health coverage from HIEs (National Immigration Law Center, 2010). If and when most provisions of the ACA go into effect in 2014, the only health coverage options for undocumented immigrants will be to obtain employer-sponsored insurance, or to purchase private insurance outside of HIEs. Relatively few undocumented immigrants will be in a position financially to take advantage of these options and health care reform may result in many undocumented immigrants losing their existing coverage. Galarneau states that, despite its official title of the Patient Protection and Affordable Care Act, health care reform legislation neither protects undocumented immigrants, nor makes their care more affordable (Galarneau, 2010: 424).

Pew Hispanic Research Center estimates that there are now 11.2 million
undocumented immigrants in the United States (Passel and Cohn, 2011: 1), over one million of whom live in rural areas (State Health Access Data Assistance Center, 2010: 19). Sixty percent of all undocumented immigrants are uninsured (Sanchez, Sanchez-Youngman, Murphy, Godin, Santos, and Burciaga Valdez, 2011: 685-686). As a group, undocumented immigrants comprise twenty percent of the uninsured population in the U.S. (Hirota et al., 2006: 82; National Immigration Law Center, 2009: 1). Given the high percentage of uninsured in this cohort, it is reasonable to question why the ACA explicitly denies coverage to anyone who is not a legal U.S. resident. According to Senator Max Baucus, chair of the Senate Finance Committee and principal author of the Senate health reform bill (which would later become the ACA), the issue of covering undocumented immigrants was “too politically explosive” and likely to “sidetrack” the passage of the bill (Galarneau, 2011: 423). Extending health coverage—particularly publicly funded coverage—to undocumented immigrants is indeed a politically charged issue, due at least in part to the perception held by its opponents that undocumented immigrants place an undue strain upon public services, and that granting public benefits to undocumented immigrants encourages more individuals to enter the U.S. illegally. Although both of these claims have been demonstrated to be untrue (National Immigration Law Center, 2009: 1), it appears that the drafters of the legislation made the decision to forgo the inclusion of undocumented immigrants in the ACA because of the political risk the issue carries (Galarneau 2011: 423).

*Rural Hospitals and Undocumented Immigrants*

In order to evaluate how denying coverage to undocumented immigrants may
impact certain rural hospitals, it is important to understand how this group currently interacts with the health care system. As noted above, undocumented immigrants are nearly twice as likely as legal immigrants and U.S. citizens to be uninsured (State Health Access Data Assistance Center, 2010: 19). However, because most undocumented immigrants come to the U.S. to work and earn money, they are on average younger and more likely to report good health than the average legal resident (Jensen, 2006: 26; Okie, 2007: 525). Furthermore, 83% of undocumented immigrants belong to a working family, and as a whole undocumented immigrants are estimated to have an employment level equal to that of documented residents (Kaiser Commission on Medicaid and the Uninsured, 2008: 1-2). A common perception is that undocumented immigrants, due to lack of health insurance, place an inordinate strain on hospital emergency rooms. In reality, undocumented immigrants are much less likely to utilize health services than legal residents—in fact, only 1.5% of all public medical expenditures go toward care for undocumented immigrants (National Immigration Law Center, 2009: 1; Okie, 2009: 526). In dollar amounts, expenditures for legal residents more than double those for undocumented immigrants (Kaiser Commission on Medicaid and the Uninsured, 2008: 1). Furthermore, while hospitals are not required to report data related to how many undocumented patients they treat on Medicare cost reports, studies of communities with high rates of emergency room visits find they are likely to have lower undocumented immigrant populations, and vice versa (Kaiser Commission on Medicaid and the Uninsured, 2008: 1; National Immigration Law Center, 2009: 1).

This weak relationship between undocumented immigrants and use of the U.S. health system may be attributed in part to their overwhelming lack of health insurance
coverage. However, it may also stem from an unwillingness to deal with health care providers, either due to language barriers or apprehension of being reported due to undocumented status (Castel et al., 2003; Diaz-Perez, Farley and Cabanis, 2004: 259; Harari, Davis and Heisler, 2008: 1355-1360). Despite the fact that undocumented immigrants currently pose a relatively smaller burden to the health care system than do legal residents, some analysts predict that this is likely to change once the coverage expansion provisions contained in the ACA go into effect. As more Americans gain access to health insurance through Medicaid and HIEs, undocumented immigrants—who, as a group, are denied participation in these programs—are likely to comprise a larger portion of the nation’s remaining uninsured. As a result, rural hospitals located in areas with significant undocumented populations could come under pressure to continue to treat a disproportionate number of uninsured patients relative to other hospitals, a variable not considered in earlier predictions of benefits and challenges rural hospitals face following implementation of the ACA in its current version.

While the exclusion of undocumented immigrants from health care reform certainly will impact these immigrants, it also will likely have profound significance for those hospitals that serve them. Considering the relatively small but significant presence of undocumented immigrants in rural America, the fact that they disproportionately lack health insurance, and their very pointed exclusion from the major coverage expansion provisions in the ACA, it stands to reason that those organizations that represent the interests of rural hospitals would have produced some sort of analysis of this specific issue. However, my review of the policy literature and repeated efforts to locate data through the organizations consulted strongly suggest that the exclusion of undocumented
immigrants from coverage expansion has not been addressed sufficiently by national rural health policy organizations. A spokesperson for RUPRI stated that the issue of undocumented immigrants has not emerged in any of the discussions RUPRI has engaged in regarding implementation of the ACA and rural hospitals (information provided by phone, June 2011).

My search for literature produced by the state-based rural health and hospital organizations listed in Appendix D returned no direct analysis of the ACA with respect to undocumented immigrants. A spokesperson for TORCH stated that, although the organization has continuously requested that the issue of undocumented immigrants be addressed on a national level so as to ease the uncompensated care burden they place on Texas hospitals, TORCH members consider the ACA to promote the status quo, in that it will neither increase nor decrease the amount of uncompensated care attributed to undocumented immigrants for rural hospitals4 (information provided by phone, June 2011). The remaining eight organizations I contacted consistently reported that the issue of undocumented immigrants lacking health coverage under the ACA was not one that they had addressed directly (based upon emails and phone calls placed to state-level rural health and hospital organizations between April and June, 2011; see Appendix D).

Although state-based rural health and hospital agencies have yet to analyze how the ACA will impact rural providers in high undocumented immigrant areas, immigrant and Hispanic advocacy groups have begun to address the issue of the ACA and its exclusion of undocumented immigrants from health coverage expansion. The literature published by these organizations, together with the analysis of rural hospitals provided in

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4 As a previous section notes, some undocumented immigrants are expected to lose insurance coverage due to the ACA, suggesting that perhaps TORCH members did not have access to these figures before making the claim that the ACA does nothing to change the insurance status of undocumented immigrants.
previous section of this analysis, provide insights into how the ACA may impact hospitals that serve large undocumented populations.

By refusing to allow income-qualifying undocumented immigrants to enroll in Medicaid under the expanded eligibility guidelines, the ACA denies coverage to an estimated 3.7 million undocumented immigrants who otherwise would qualify for the program if they were legal residents (State Health Data Assistance Center, 2011: 21). Because undocumented immigrants have always been exempt from accessing Medicaid benefits, this provision of the law does not result in a net loss of coverage for this group, but rather a failure to realize a net gain in coverage, which, as has been predicted, legal residents and U.S. citizens are certain to experience. Hospitals in areas with undocumented immigrants likely will be left to treat a larger number of uninsured patients after health reform goes into effect than will those hospitals with fewer undocumented patients. Therefore, excluding undocumented immigrants from Medicaid under the ACA will not produce a change in the number of uninsured, undocumented immigrants a rural or an urban hospital treats. For all the reasons cited above that handicap rural hospitals financially and in terms of cost recovery and the differential way in which the ACA is expected to impact rural versus urban hospitals, rural hospitals are likely to disadvantaged relative to urban hospitals following implementation of the current version of the ACA.

Although undocumented immigrants are excluded from taking part in Medicaid under the ACA, the legislation does permit U.S. born children of undocumented immigrants to enroll in both Medicaid and CHIP (National Immigration Law Center, 2010). This too does not represent a change from the status quo, as legally residing
children of undocumented immigrants have historically been eligible for both programs (Galarneau, 2001: 424; Hirota, et al., 2006: 84). However, confusion about the law, inability to obtain proof of income from employers due to anti-immigration legislation in some states, and/or fear of deportation could prevent some undocumented immigrants from enrolling their children in the public programs for which they are eligible (Abascal 2010: 2; National Council of La Raza, 2010: 2). Because the ACA would empower hospitals to make eligibility determinations (discussed above), they will be able to do so for these children. In this respect, the ACA may potentially decrease the amount of uncompensated care provided by rural hospitals to the children of undocumented immigrants, not only because more of these children could qualify under the proposed expanded income guidelines, but because hospitals would be permitted to take a more active role in ensuring that children of undocumented immigrants enroll in Medicaid or CHIP if they meet the income requirements.

Not only will undocumented immigrants remain ineligible for public health coverage under the ACA, the law also bans this population from participating in HIEs (National Immigration Law Center, 2010). According to the current version of the ACA, undocumented immigrants do not qualify to receive tax credits for purchasing insurance on the state-based exchanges and, furthermore, they are not allowed to use HIEs to purchase health insurance for themselves or any other undocumented immigrant (although they are permitted to purchase insurance for legally residing children on the exchange) (National Immigration Law Center, 2010). This means that even undocumented immigrants willing to use their own funds to pay full price for health coverage offered on the HIE would be prohibited from doing so. As with the Medicaid
expansion provision, the exclusion of undocumented immigrants from HIEs will do nothing to increase the insurance coverage rate of this group, and hospitals that treat large numbers of undocumented immigrants will not experience the same level of relief in terms of uncompensated care as those that treat smaller numbers of undocumented patients.

By preventing undocumented immigrants from participating in HIEs, the ACA also risks increasing the uninsured rate amongst this population. Notably, while the majority of undocumented immigrants are uninsured, an estimated forty percent currently have health coverage (National Immigration Law Center, 2010). Because undocumented immigrants cannot access coverage under Medicaid or Medicare, those with health insurance will have purchased coverage either from an employer-sponsored plan or through the private market. The ACA’s proposed requirements for HIEs state that all participating plans must meet reasonable premium guidelines, and as a result those plans that are not offered via HIE are expected to be significantly more expensive for consumers (Kuznia, 2010). National Council of La Raza (NCLR), a national Hispanic civil rights and advocacy organization, predicts that HIEs may have the effect of draining private insurance risk pools of almost everyone except undocumented immigrants (Kuznia, 2010). Should this occur, those undocumented immigrants with this type of health insurance could see their premiums become unaffordable. Thus, HIEs represent one aspect of health care reform that, instead of maintaining the status quo in terms of the number of uninsured undocumented, could result in a significant increase in the portion of undocumented immigrants without coverage.
Although severely restrictive in terms of expanding coverage to undocumented immigrants, the ACA does permit undocumented immigrants to purchase employer-sponsored coverage. As mentioned above, the ACA mandates that employers with at least fifty full time employees either provide health insurance for employees or pay a penalty (Patient Protection and Affordable Care Act of 2010 § 1513). Therefore, it is possible that some undocumented immigrants working for larger employers may gain access to employer-sponsored coverage—provided that they are paid legally. As the Social Security Administration estimates, seventy-five percent of all undocumented workers pay payroll taxes (Porter, 2005), suggesting that, legal or not, they are on the books as employees and therefore eligible to access employer-sponsored coverage. However, undocumented immigrants are disproportionately likely to work for small businesses that are exempt from providing employer-sponsored coverage (Abascal 2010: 2). The Migration Policy Institute estimates that forty-six percent of undocumented immigrants work at small firms that do not provide insurance (Capps, Rosenblum and Fix, 2009: 5).

This analysis of the various ways in which the ACA might impact the health insurance coverage rates of undocumented immigrants underscores two issues. First, there is a substantial lack of data with respect to undocumented immigrants. Although estimates of the number of undocumented immigrants that currently reside in the United States may vary in reliability, scarcity of data related to what types of firms employ them and offer health insurance is an important problem. Furthermore, it is difficult to predict which firms will opt to provide coverage for employees and which will choose to pay a penalty once the employer responsibility provisions of the ACA go into effect.
Therefore, it is impossible to determine with accuracy whether the ACA would represent a net gain or net loss in terms of health coverage for undocumented immigrants. The several scenarios outlined above point to the various ways in which the legislation may impact undocumented immigrants, but whether or not they materialize depends on where undocumented immigrants live, which hospitals they use, and future changes in anti-immigration legislation. This uncertainty is reflected in conflicting information provided by spokespersons from rural organizations. For example, AHA, NRHA, RUPRI and TORCH conclude that the ACA represents no diversion from the status quo in terms of Medicaid coverage for undocumented immigrants. NILC and NCLR project that HIE rules will result in many undocumented immigrants losing private insurance coverage. Neither considers how the two assessments may relate to each other. The second significant issue that arises from the discussion of the ACA and undocumented immigrants is the fact that this group is excluded so specifically from health care reform. While legislators may have made the pragmatic decision to exclude undocumented immigrants from accessing public funds, either via Medicaid and CHIP or through tax credits in order to assure the passage of health care reform, it is not clear why the law also prohibits undocumented immigrants from spending their own money to pay full price for insurance coverage on the HIE. In fact, given that undocumented immigrants tend to be younger and healthier and would likely utilize fewer health services than U.S. citizens, it would stand to reason that insurance companies would consider this group to be a favorable addition to the risk pool. Similarly, from the perspective of a hospital, an undocumented immigrant with health insurance purchased on the HIE would be a much
more favorable patient than one without any insurance at all in terms of reimbursement for care provided.

In addition to the economic arguments in favor of including undocumented immigrants in health care reform (see also American Nurses Association, 2010; Galarneau, 2011; National Immigration Law Center, 2009; Service Employees International Union), some analysts have raised concerns about the public health implications of excluding this group (see Galarneau, 2011: 426) as well as the issue of access to health care as a human right (American Nurses Association, 2010: 1). Despite these arguments for inclusion, the ACA continues unchanged at this time. Nonetheless, I consider it important to emphasize the fact that health care reform legislation, intended to improve access to insurance coverage and treatment, singles out one group in particular as ineligible to participate in coverage expansion programs and that this in turn, according to the general consensus, is likely to have negative consequences for rural hospitals.

**Conclusion**

The 2010 signing of the Affordable Care Act by President Obama marked the passage of what is widely regarded as the most important social legislation in decades. In recognition of the magnitude and the timeliness of this legislation, I developed and fulfilled the following three objectives for this thesis: a) to assess systematically and critically the expectations and predictions regarding the impact of the ACA; b) to evaluate factors that apply specifically to rural hospitals given their current difficulties and the characteristics of the populations they serve; and c) to identify factors not
considered in the existing policy research that need to be addressed to more accurately predict and control the relative impact of the ACA on rural hospitals. During research, I critically evaluated and synthesized the major findings of rural health organizations regarding the ACA. Both my professional knowledge of the hospital industry and methodological training were very useful in this process. I was able to examine critically the current projections as to how the ACA might impact rural hospitals and identify missing variables and several different scenarios that might modify the projections in the reports consulted. In particular, this thesis has focused on the unique characteristics of different types of rural hospitals and their patients to evaluate the ways in which rural hospitals might respond to the ACA that go beyond, and at times defy, officially-sanctioned predictions.

The findings in policy analyses and reports on the potential impacts of the ACA discussed in this thesis were constrained by common shortcomings and gaps that I identified during my analysis of these documents. Among the most important shortcomings were: untested assumptions and missing variables in the projections related the impact of the ACA on rural rates of health insurance coverage; the assumption that rural hospitals can be treated as a homogenous group; failure to situate rural hospitals within the U.S. healthcare marketplace; and failure to control for current levels of Medicaid DSH funding and impact of the health care needs and constraints of undocumented immigrants.

During my analysis of the literature produced by rural health organizations and research centers, it became clear that these organizations were not making context-specific analyses; rather, they considered “rural hospitals” in the aggregate when
estimating the various impacts of the ACA. For example, the publications produced by
RUPRI rely on sophisticated statistical models to predict how many uninsured rural
residents “will gain” health insurance should the coverage expansion provisions take
effect as passed in 2014. RUPRI concludes that this increase in the rural insured will be
positive for rural providers and, in doing so, appears to assume that the rural newly
insured will be evenly distributed among the two thousand rural hospitals in the U.S.
Because, as discussed in an earlier section, rural communities and the hospitals that serve
them are not a homogenous group, the ACA will undoubtedly impact hospitals
differently based on variables such as ownership type (e.g., public, nonprofit, for profit),
patient mix, and present level of integration with other hospitals.

An important gap that I identified is a lack of attention to the situation of rural
hospitals in the context of the larger healthcare marketplace. For example, many of the
organizations listed in Appendices A and B reviewed the impact of the ACA on rural
hospitals without consideration of the fact that some rural hospitals must compete with
suburban and urban hospitals to attract funding and patients; when they do so, they tend
to be on the losing end of such competition. It also is possible that, while a certain
provision of the ACA may be posited in policy analyses to have a positive impact on
rural hospitals in the aggregate, it could have an even more pronounced positive impact
on non rural hospitals, reinforcing existing disparities between the two types. My
analysis situated rural hospitals within a larger health care marketplace in an effort to
clarify how certain sections of the ACA might affect the long-term viability and
sustainability of some rural hospitals relative to their non rural counterparts.
One important omission in the literature has to do with rural hospitals and Medicaid DSH. When discussing the planned reductions in Medicaid DSH funding contained in the ACA, the policy organizations consulted for this project concluded uniformly that Medicaid DSH has not been a significant source of revenue for rural hospitals and, therefore, they expect changes to the program to have minimal impact on these hospitals. While rural hospitals certainly receive less Medicaid DSH than non rural hospitals in the aggregate, there are certain states (such as Ohio and Louisiana) that distribute significant portions of their Medicaid DSH pool to rural hospitals specifically. Rural hospitals in these states are likely to feel the impact of decreased funding, particularly in cases where the increase in insured patients is not sufficient to make up for a loss in Medicaid DSH revenue.

In this thesis, I also pay attention to a significant aspect of the health care law that none of the rural health organizations that I consulted addressed—the fact that undocumented immigrants are excluded specifically from nearly all of the major coverage expansion provisions of the ACA. Because ninety percent of undocumented immigrants are estimated to reside in non rural areas, it may be tempting to assume that undocumented immigrants remaining largely uninsured is perhaps more of a concern to urban hospitals than rural ones. However, when a hospital’s capacity for treating the uninsured is taken into account, it is clear that the significant pool of uninsured undocumented workers that the ACA is predicted to leave behind will likely pose a disproportionate burden to rural hospitals. A 2005 study by the Center for Studying Health System Change found that communities with well-developed capacity for treating the uninsured are typically those that are traditional destinations for immigrants, i.e.
urban areas. In general, rural areas do not have this kind of capacity to absorb the health care needs of this population (Staiti, Hurley and Katz, 2006: 1-3). Thus, leaving out undocumented immigrants from health care reform may impact rural hospitals more acutely than their urban counterparts, based upon their limited resources to share the costs of treating the uninsured with other providers.

It seems incomprehensible that nearly two million rural residents who will remain uninsured despite health care reform are ignored in policy analyses. I conclude, then, that the ACA, if implemented as passed, would essentially create a group of individuals who, regardless of their age, income or employment, will never be eligible to participate in Medicaid, Medicare, and HIEs. This thesis takes this group into account and provides important insights into the potential impact of uninsured undocumented immigrants on rural hospitals in the context of health care reform and how their exclusion potentially weakens certain provisions of the ACA, such as the financial gains intended through HIEs.

Policy Recommendations

The ACA calls for sweeping changes to the U.S. healthcare system, which present both challenges and opportunities to rural hospitals. Table 3 illustrates the sections of the ACA that this thesis concludes are likely to have the most significant impact upon rural hospitals as a whole and the nature of this impact (positive, negative, or mixed). My analysis suggests that the ACA contains some provisions that have the potential to support the financial stability and viability of rural hospitals, as well as other provisions
that, if not corrected, are likely to contribute to increased strain on the resources of these hospitals either in an absolute sense and/or relative to the situation of non rural hospitals.

The most significant opportunity for rural hospitals that could result from implementation of the ACA and that is supported by most policy analyses that I assessed is an expected increase in the percentage of the population that could become newly insured. Large numbers of the existing rural uninsured are expected to benefit from coverage expansion provisions of the law that could go into effect in 2014. As discussed above, these include changes to Medicaid eligibility, the creation of HIEs, and tax credits to individuals and small businesses to subsidize the cost of purchasing insurance. If the ACA is able to extend health coverage to more than three-fourths of the rural population currently without insurance—as the RUPRI analysis predicts—then this would decrease substantially the uncompensated care burdens of most rural hospitals. Of course, this predicted outcome relies on a slew of assumptions built into policy analyses that ignore variability factors such as patient choice of hospitals. Nonetheless, bringing health insurance to more than 75% of the rural population could result in an increase in the number of paying patients using rural hospitals.

As for the most significant challenge to rural hospitals posed by the ACA, my critical assessment of policy predictions and reports concludes that establishing ACOs could be the most difficult task should the ACA be implemented as passed. Due to their small size, relative isolation and generally poor finances, rural hospitals are likely to be burdened disproportionately by an inability to reach the required number of Medicare patients to participate, create necessary connections with other hospitals, and cover the administrative and legal costs associated with establishing and running an ACO. While
the ACO payment system mandate appears to hold great promise for larger urban hospitals and hospital networks, I conclude that, unless the ACO model proposed is modified to account more fully for differences among hospitals, it is likely that large numbers of rural hospitals—particularly the smallest ones—will be excluded from taking part in this program at all, compounding their comparative disadvantage.

Table 3. Summary of Major ACA Provisions and Their Impact on Rural Hospitals

<table>
<thead>
<tr>
<th>ACA Provision (Section Number)</th>
<th>Impact on Rural Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides grants to states to establish HIEs (1311)</td>
<td>Mixed</td>
</tr>
<tr>
<td>Provides tax credits to individuals with incomes up to 400% of the Federal Poverty Level to assist with purchasing health insurance through the HIE (1401)</td>
<td>Positive</td>
</tr>
<tr>
<td>Excludes undocumented immigrants from participating in HIEs (1411)</td>
<td>Negative</td>
</tr>
<tr>
<td>Makes tax credits available to small businesses with no more than 25 employees to help subsidize the cost of providing insurance (1421)</td>
<td>Positive</td>
</tr>
<tr>
<td>Increases Medicaid coverage to all individuals under age 65 at or below 133% of the Federal Poverty Level (2001)</td>
<td>Positive</td>
</tr>
<tr>
<td>Increases the match for CHIP enrollees by 23 percentage points, up to 100%. (2101)</td>
<td>Positive</td>
</tr>
<tr>
<td>Allows hospitals to make a presumptive eligibility determination for Medicaid eligible populations (2202)</td>
<td>Positive</td>
</tr>
<tr>
<td>Reduces Medicaid DSH payments to hospitals (2551)</td>
<td>Negative</td>
</tr>
<tr>
<td>Establishes a pilot Medicare value-based purchasing program for Critical Access Hospitals (3001)</td>
<td>Positive</td>
</tr>
<tr>
<td>Establishes Accountable Care Organization (ACO) model of payment for Medicare (3022)</td>
<td>Negative</td>
</tr>
<tr>
<td>Establishes pilot program for Medicare bundled payments (3023)</td>
<td>Negative</td>
</tr>
</tbody>
</table>

Clearly, the ACA is neither uniformly positive nor negative for rural hospitals; this may reflect a lack of engagement with rural health stakeholders during the crafting of
this legislation. Were the needs of rural residents and hospitals taken into account during the policy making process, perhaps the ACA would address the special situation of rural hospitals more carefully. Considering this, rural health providers need to lobby for more attention to rural issues in federal legislation. Most of the provisions in the ACA that will have the greatest impact upon rural hospitals have yet to take effect, and there are numerous court challenges to specific mandates, so there is time to amend the legislation to create a more even playing field for rural hospitals. The following reviews the most important and feasible policy recommendations intended to mitigate the negative impacts of this legislation on rural hospitals.

In order to ensure that rural residents are able to access the coverage expansion provisions of the ACA, RUPRI suggests that outreach for Medicaid, tax credits and HIEs must be monitored carefully. Specifically, RUPRI recommends that information about expanded Medicaid eligibility reach the rural poor and that small businesses be made aware of tax credits available (RUPRI Health Panel, 2010: 10). I suggest that CMS and HHS develop communications strategies targeted to rural residents and small businesses, respectively, to meet these objectives. RUPRI also recommends that states, which are responsible for establishing HIEs, conduct outreach to rural populations in particular, as well as review plans offered to make certain that there are sufficient affordable choices for rural residents (RUPRI Health Panel, 2011: 10).

To address the barriers rural hospitals face to creating and participating in ACOs, MacKinney et al. recommend that states and/or the federal government provide technical assistance to rural hospitals to facilitate the development of legal structures necessary to support partnerships between providers and payers (MacKinney et al., 2011: 136). Policy
makers should also consider developing mentoring programs in which existing ACOs are paired with potential or newly formed ACOs to learn how successful models function (MacKinney et al., 2011: 136; Mueller 2011: 18). In terms of payment bundling, it is important to recognize that some measures of quality and efficiency may be more appropriate for rural hospitals than others; according to the AHA, CMS should review these criteria to ensure that they account for the unique characteristics of rural hospitals (American Hospital Association, 2011: 13).

Certain provisions of the ACA may be strengthened by increased rural representation in decision making bodies. HIEs will be mandated to have a governance structure (e.g., Board of Directors) that is responsible for determining which plans it will offer. RUPRI recommends that HIE governance include representation of rural issues, to increase the likelihood that HIEs offer insurance plans that are relevant and affordable to rural residents (RUPRI Health Panel, 2011: 10). More broadly, NRHA recommends that rural representation on the Medicare Payment Advisory Commission (MedPAC), the independent Congressional agency that advises Congress on Medicare payment rates, be proportional to rural representation among Medicare beneficiaries (National Rural Health Association, 2011: 2). Specifically, I suggest that the ACA be amended to mandate that twenty-six percent of MedPAC appointments represent rural areas, to reflect the proportion of Medicare beneficiaries residing in rural areas.

Furthermore, I recommend that the ACA be amended to allow undocumented immigrants specifically to purchase health insurance through HIEs. This would benefit all HIE consumers, who should see their costs decrease from the addition of this group to the risk pool (Immigration Policy Center, 2009). I also endorse allowing undocumented
immigrants to take part in Medicaid and Medicare. The American Nurses Association notes that allowing this group access to public health programs may pose additional costs to the federal government, yet the fiscal and public health risks of not providing basic health coverage to undocumented immigrants may prove costlier over time (American Nurses Association, 2010: 8). While perhaps not presently feasible politically on a federal level, the ACA could be amended to allow states to determine whether or not to extend Medicaid benefits to undocumented immigrants meeting eligibility requirements.  

Rural hospitals are disproportionately dependent upon Medicaid and Medicare, and as a result, they are particularly sensitive to any changes in health policy at the federal level. For this reason, the ACA must be monitored closely as it is implemented, so that any potential disadvantageous impacts upon rural hospitals may be noted and corrected at an early stage (RUPRI Health Panel, 2010a: 48). In addition to rural hospitals and rural health organizations monitoring the impacts of the ACA, I propose that HHS develop a formal monitoring system for rural hospitals specifically that includes performing data analysis at regular intervals to identify emerging trends and disparities.

**Recommendations for Future Research**

Going forward, there are several opportunities for further research that could enhance and verify thesis findings and that can help overcome shortcomings in predictions and improve the reliability of analyses produced by diverse organizations and

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5 State governments presently have limited discretion in determining the parameters of Medicaid eligibility for undocumented immigrants for their own populations. For example, some states allow undocumented pregnant women to enroll in Medicaid for the duration of their pregnancy (State Health Access Data Assistance Center, 2011: 8).
scholars. For example, currently data collection with respect to hospitals and undocumented immigrants is scarce and there are no publicly available data sets where researchers can access this information. An important move for researchers could be to develop a pilot program in which a sample of hospitals collect and report the number of undocumented immigrants they treat and the type of insurance, if any, they have. The data collected could then be analyzed along with hospital financial data in order to gain a better understanding of how uninsured undocumented immigrants are likely to impact the profitability of a hospital.

Similarly, I recommend that Medicare require hospitals to collect data on the number of undocumented immigrants they treat and the type of insurance coverage they have. These data should be included on Medicare cost reports. This could be very useful to hospitals, state hospital associations, rural health organizations, and immigrant advocacy groups in the policy making process. If Medicare were to collect such data, it could also be used to determine which hospitals, if and when the ACA is implemented, are left treating large numbers of uninsured undocumented immigrants. Based on this information, HHS could develop a subsidy program, modeled perhaps after the Medicaid DSH program, for hospitals whose uncompensated care burdens are attributable to disproportionate numbers of uninsured undocumented patients.

Qualitative data also are needed to better interpret trends identified in statistical analyses and to reveal variables not yet understood or included in such analyses. For example, the impact of undocumented immigrants on rural hospitals can be explored through in-depth interviews conducted at a sample of rural hospitals. Interview participants could include hospital administrators, physicians, nurses, and emergency
room personnel. These interviews could provide valuable information as to the impact of undocumented immigrants on the viability of rural hospitals. Information collected by these proposed methods would be useful not only to rural health organizations, which could then make more accurate predictions of how the ACA will affect rural hospitals financially, but also to Hispanic and immigrant advocacy organizations, which could use it to support their arguments for inclusion of undocumented immigrants in health care reform.

As the above analysis suggests, there is also a great need for more context-specific analysis of the impact of the ACA on rural hospitals. As a next step, rural health organizations should begin to analyze the law with respect to certain types of rural hospitals. Specifically, the organizations listed in Appendices A and B should create separate analyses of how the ACA will likely impact rural hospitals based on ownership type, size (as measured by bed size), payer mix, and level of integration with other hospitals (i.e., part of a larger health care system vs. independently operated). Furthermore, there is an opportunity for state-based rural health organizations, such as those listed in Appendix D, to analyze the state level impacts of the ACA on rural hospitals. These organizations need state level data to predict how many newly insured the ACA is likely to produce among the state’s rural uninsured, and to synthesize this prediction with an analysis of likely changes to state level Medicaid DSH disbursements to determine the financial impact of the ACA on rural hospitals within the state.

Finally, there is a distinct need for greater sharing of research among rural health organizations, academic journals, and other groups interested in examining the impacts of health care reform on certain populations. These stakeholders should organize focus
groups and small policy conferences in order to create the context-specific analyses of the ACA that are currently absent from published reports and journal articles. This would not only contribute to the body of research related to health care reform, but would also support evidence-based policymaking going forward.

In the rural U.S., hospitals play a central role, both in terms of providing necessary health services for isolated and vulnerable populations, and also with respect to the economic well being of the communities in which they are located. Their viability is critical to rural life. The ACA, if it extends coverage to a large proportion of the rural uninsured (as intended), may bring some relief to rural hospitals currently burdened by high volumes of uninsured patients. Other aspects of the legislation, however, are likely to pose significant challenges to rural hospitals. Rural hospitals, health organizations, policy organizations and lobby groups lack adequate information on the likely mixed impact the ACA will have on rural hospitals. This thesis emphasizes the absolute necessity to correct methodological shortcomings in impact and policy analyses, as well as the patent urban bias in the law. Maintaining a critical eye on policy analysis related to the ACA, as well as the monitoring, evaluation and revising of this legislation, will help to ensure that health care reform sheds its predominantly urban orientation and will acknowledge the unique situation of diverse types of rural hospitals and the rural residents they serve.
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Appendix A

The following is a list and brief description of the national rural health organizations that I consulted in my research:

- American Hospital Association Section for Small or Rural Hospitals—represents the interests of small and rural hospitals

- National Rural Health Association (NRHA)—comprised of individuals and organizations devoted to improving rural health. Works to promote information, communication, education, research and advocacy related to rural health.

- Office of Rural Health Policy (ORHP)—part of the Health Resources and Services Administration, U.S. Department of Health and Human Services (HHS). Focuses on matters affecting rural hospitals and health care; also maintains a national information clearinghouse.

- Rural Policy Research Institute (RUPRI)—conducts policy-oriented research to highlight the rural impacts of public policies and programs.

- Agency for Healthcare Research and Quality (AHRQ) -- conducts research focusing on health care outcomes, quality, cost, use, and access. Research is oriented toward health care decision makers.

- American College of Small or Rural Healthcare (ACSRH)--part of the American Academy of Medical Administrators (AAMA); an interest group that focuses on small or rural healthcare providers.

- Center for Rural Affairs (CRA)—a Nebraska-based foundation that focuses upon small businesses, family farms and ranches, and rural communities in the U.S.

- Centers for Medicare and Medicaid Services (CMS)
Operates the Medicare and Medicaid programs; part of the U.S. Department of Health and Human Services.

- Health Resources and Services Administration (HRSA)
  Works to improve and expand health care access and quality; part of the U.S. Department of Health & Human Services.

- Kaiser Family Foundation
  A nonprofit, private foundation that conducts health care research and policy analysis.

- National Advisory Committee on Rural Health and Human Services (NACRHHS)
  A 21-member panel composed of nationally recognized citizen rural health experts; provides recommendations on rural issues to the Secretary of the Department of Health and Human Services.

- U.S. Department of Agriculture (USDA)
  Provides grants aimed at promoting rural economic development; conducts research related to rural communities.

- U.S. Department of Health and Human Services (HHS)
  Serves as the U.S. government's principal agency for issues related to the health of the U.S. population and needed human services.
Appendix B

The following is a list and brief description of the nine federally funded rural health research centers I consulted in my research:

- Maine Rural Health Research Center
  Focuses on rural health care financing and system reform, rural long term care, and rural mental health.

- North Carolina Rural Health Research and Policy Analysis Center (Cecil G. Sheps Center)
  Focuses on rural hospitals and healthcare delivery organizations and access.

- RUPRI Center for Rural Health Policy Analysis
  Focuses on rural health care financing, rural systems building, and meeting the health care needs of special rural populations.

- South Carolina Rural Health Research Center
  Focuses on inequities in health status within the rural U.S.

- Upper Midwest Rural Health Research Center
  Focuses on quality of rural health care and other rural health issues. A collaboration between the University of Minnesota Rural Health Research Center and the University of North Dakota Center for Rural Health.

- West Virginia Rural Health Research Center
  Focuses on environmental health in rural populations and other topics.

- WWAMI Rural Health Research Center
  Focuses on training and supply of rural health care providers, rural women and
children, and access to care for vulnerable and minority rural populations. Based in the Department of Family Medicine at the University of Washington School of Medicine.
Appendix C

The following is a list and brief description of the Hispanic and Immigrant advocacy organizations I consulted in researching this topic:

- **National Council of La Raza (NCLR)**
  
The largest national Hispanic civil rights and advocacy organization in the U.S.
  
  A nonprofit organization focusing on applied research, policy and advocacy.

- **National Immigration Law Center (NILC)**
  
  A national organization focusing on defending and advancing the rights of low-income immigrants and immigrant families.

- **Migration Policy Institute**
  
  A nonprofit, nonpartisan think tank focusing on the movement of people worldwide; conducts research at the local, national and international level.

- **PEW Hispanic Center**
  
  A nonpartisan research organization focusing on Hispanics and Latinos in the U.S.; does not take a position on policy matters.
Appendix D

The following is a list and brief description of the state-level rural health and hospital organizations I consulted in researching this topic:

- **Arizona Rural Health Office**
  Promotes the health of rural and medically underserved individuals, families, and communities through service, education, and research.

- **Arizona Rural Health Association, Inc.**
  Advocates on behalf of the health needs of rural Arizonans at national, state and local levels.

- **California State Rural Health Association**
  A nonprofit, nonpartisan, grassroots organization that works to improve the health of rural Californians, focusing on health care quality and accessibility.

- **California State Office of Rural Health**
  Focuses on increasing rural access to health care; links small rural communities with state and federal resources.

- **Nevada State Office of Rural Health**
  Provides technical assistance activities to rural communities; a division of the Center for Education and Health Services Outreach at the University of Nevada School of Medicine.

- **North Carolina Office of Rural Health and Community Care**
  Provides technical assistance to small hospitals and community health centers and recruits health care providers to work in rural and medically underserved communities; provides grants for community health centers.
- **Texas Department of Rural Affairs**
  Plans, coordinates and advocates within the state of Texas to ensure continued access to rural health care services.

- **Texas Rural Health Association**
  Works to improve the health of rural Texans through advocacy, communication, and education.

- **Texas Organization of Rural and Community Hospitals (TORCH)**
  Advocates and conducts research on behalf of rural and community hospitals in Texas.