

Closed, Converted, Merged, and New Hospitals with Medicare Rural Designations: January 2018-November 2022

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Hospital closures, conversions (or downsizes), and mergers, particularly hospitals located in rural areas, can have a significant impact, raising concerns about access to hospital and other health care services in affected communities. Over time, Congress has enacted legislation to increase the Medicare payment rate to qualifying hospitals that have characteristics associated with financial distress from what would otherwise be the Medicare payment rate for inpatient hospital services. Four Medicare hospital designations increase payment rates for inpatient hospital services furnished by certain rural or geographically isolated hospitals. These Medicare rural hospital designations are *critical access hospital (CAH)*, *low-volume hospital (LVH)*, *Medicare dependent hospital (MDH)*, and *sole community hospital (SCH)*.

The reasons for hospital financial distress or closure are complex; however, the literature identifies several key characteristics of hospitals that have closed, are at risk of closing, or are experiencing financial distress that may lead to merging with another hospital or hospital system or downsizing. The Medicare rural hospital designations generally try to address one or more of the following factors associated with financial distress:

- Demographics and health status of the population served by a hospital
- Patient volume or size of a hospital
- Diversity of third-party payers of the patients served by a hospital—a balance of payers that includes the uninsured or self-pay, private insurance, and government coverage, such as Medicare and Medicaid.

This report contains analysis about closed, converted or downsized, merged, and new—both new and existing non-hospital health care facilities that upsized—hospitals for the period January 2018 through November 2022, with a focus on hospitals with Medicare rural designations. Not all rural or geographically isolated hospitals that are eligible to obtain a Medicare rural hospital designation do so. The Congressional Research Service (CRS) determined which hospitals—by Medicare designation, and compared to non-designated small, rural hospitals that are most similar to designated hospitals, and non-designated urban hospitals—were under- or over-represented in each status change category—closed, converted, merged, and new.

CRS's analysis found that of the designated hospitals, only MDHs are over represented in the closed, converted, and merged categories. Specifically, MDHs comprise 3.9% of all hospitals with a status change but comprise 10% of closed, 6.7% of converted and 7% of merged hospitals. Similarly, non-designated hospitals are over represented in the same categories, and in the new status change category. Thus, MDHs and non-designated hospitals tend to be over represented in the closed, converted, and merged status change categories. CRS's analysis cannot determine why MDHs are over represented in these status change categories or whether the differences between MDHs and the other designated hospitals are statistically significant.

Given the results, Congress may examine the effects of particular designations on closures, conversions, and mergers. For example, what, if any, characteristics do MDHs share with non-designated hospitals, or that make MDHs more likely than other designated hospitals to experience a closure, conversion, or merger.

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Introduction

Congress and other stakeholders have an ongoing interest in maintaining access to health care services in rural areas. Of particular focus are rural hospitals, because many rural hospitals are the primary or sole source of access to emergency and other health care services in their communities. The health care access and other effects of rural hospital closures are well documented by the general press and by academic and policy researchers.¹ To this end, Congress has enacted numerous Medicare payment designations over time to assist qualifying rural hospitals through increased payments. These Medicare rural hospital designations are *critical access hospital* (CAH), *low-volume hospital* (LVH), *Medicare dependent hospital* (MDH), and *sole community hospital* (SCH).

Another rural hospital designation—rural emergency hospital (REH)—enacted by the Consolidated Appropriations Act, 2021 (P.L. 116-260) became effective on January 1, 2023. REH information was not available at the time of this analysis thus is not included in this report.² However, REH may have implications for other rural designated hospitals, thus this report addresses potential considerations for Congress. (See “Considerations for Congress.”)

Medicare rural hospital designations provide increased payment amounts for inpatient services furnished by a designated hospital to patients who receive their Medicare coverage through *traditional* Medicare—Medicare Parts A and B. The designations do not necessarily apply to *Medicare Advantage* (Medicare Part C) plan payments to the same hospitals for the same services.³

Medicare payments have been a focus of congressional interest in hospitals because traditional Medicare payments are entirely federally determined.⁴ Other sources of payments to hospitals may come from private health insurers, and other federal non-Medicare public coverage (e.g., Medicaid), or the uninsured. States set Medicaid payment rates, and private insurance plan payment rates are based on negotiations between the plans and the providers (e.g., hospitals) in a specific insurance market.⁵ There is limited financial support to hospitals to defray the cost of the

¹ For example, Katherine E. M. Miller et al., “The Effect of Rural Hospital Closures on Emergency Medical Service Response and Transport Times,” *Health Services Research*, vol. 55, no. 2 (January 27, 2020), pp. 288-300; Sean McCarthy et al., “Impact of Rural Hospital Closures on Health-Care Access,” *Journal of Surgical Research*, vol. 258 (February 2021), pp. 170-178; Emily Baumgaertner, “A Rural Hospital’s Excruciating Choice: \$3.2 Million a Year or Inpatient Care?,” *New York Times*, December 9, 2022; and Brystana G. Kaufman et al., “The Rising Rate of Rural Hospital Closures,” *Journal of Rural Health*, vol. 32, no. 1 (July 14, 2015), pp. 35-43.

² See Section 125 of the Consolidated Appropriations Act, 2021 (P.L. 116-260).

³ Medicare Parts A and B are referred to collectively as *traditional* Medicare. Medicare beneficiaries have the option to receive covered benefits through a private health plan. Under Medicare Advantage (MA, or Part C), Medicare pays private health plans a per-person amount to provide all Medicare covered benefits, with some exceptions. The MA plan then pays providers (e.g., hospitals) based on contracts negotiated between the MA plan and the providers. According to CMS, 43% of Medicare beneficiaries were enrolled in private plans through MA in 2021. For more information on Medicare enrollment by type, see Wafa Tarazi et al., *Medicare Beneficiary Enrollment Trends and Demographic Characteristics*, Office of the Assistant Secretary for Planning and Evaluation, HP-2022-08, March 2, 2022, at <https://aspe.hhs.gov/sites/default/files/documents/f81aafbba0b331c71c6e8bc66512e25d/medicare-beneficiary-enrollment-ib.pdf>. For more information on MA plans, see CRS Report R40425, *Medicare Primer*.

⁴ Medicare rural hospital designations, which provide additional Medicare payment to designated hospitals, do not necessarily apply to other private or public health coverages, such as private insurance or Medicaid. In addition, as noted, the rural hospital designations do not apply to Medicare hospital payments made by MA plans or to MA payments for inpatient hospital services.

⁵ For information on Medicaid hospital payments, see CRS Report R43357, *Medicaid: An Overview*. Commercial insurer payments to hospitals for hospital services are determined largely by the market share and power a hospital has

uninsured patients hospitals treat, and few programs provide general financial assistance for rural hospitals.⁶

Hospital closures, particularly for hospitals located in rural areas, garner congressional and media attention.⁷ The reasons for a hospital closure are complex; however, the literature identifies several key characteristics of hospitals that have closed, are at risk of closing, or are experiencing financial distress. These characteristics include low inpatient volume and a payer mix that includes a small proportion of privately insured patients and a relatively higher proportion of public sources of health care coverage, such as Medicare or Medicaid. (Private insurance payment rates tend to be greater than public payer rates such as Medicare.⁸)

Hospitals qualify for one or more of the Medicare payment designations by virtue of having one or more of these characteristics, and the designations attempt to address some of the characteristics associated with hospitals' financial distress. The designations generally result in higher Medicare payments for services furnished to Medicare beneficiaries in designated hospitals than Medicare typically would pay for the same services furnished in hospitals without these designations, thus providing additional support to potentially financially distressed hospitals.⁹ (See **Appendix A** for an overview of Medicare payment for inpatient hospital services and each of the rural hospital designations.)

in a particular geographic area. Commercial insurer payment amounts are negotiated between the insurer and the hospital or hospital system; in such negotiations, the relative strength of each party's negotiating position influences the outcome. For further information about commercial insurer payments to hospitals, see Chapin White and Christopher M. Whaley, *Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely: Findings from an Employer-Led Transparency Initiative*, RAND Corporation, 2019, at <https://doi.org/10.7249/RR3033>.

⁶ CRS Insight IN12057, *Federal Support for Financially Distressed Hospitals*.

⁷ As an example of congressional attention, see the explanatory statement accompanying the Consolidated Appropriations Act, 2023 (P.L. 117-328), which included language directing the Centers for Medicare & Medicaid Services (CMS) to provide feedback to specified congressional committees about "providing appropriate relief for struggling hospitals in rural and under-served communities." (Explanatory Statement Submitted by Sen. Leahy, Chair of the Senate Committee on Appropriations, Regarding H.R. 2617, Consolidated Appropriations Act, 2023, *Congressional Record*, vol. 168, part 198-Book II [December 20, 2022], p. S8890.) Service line closures also have generated congressional and media attention because, in recent years, hospitals have been closing certain service lines, most notably obstetric care. An evaluation of hospital reduction in services is beyond the scope of this report. For information on declines in obstetric care, see U.S. Government Accountability Office (GAO), *Maternal Health: Availability of Hospital-Based Obstetric Care in Rural Areas*, GAO-23-105515, October 19, 2022, at <https://www.gao.gov/products/gao-23-105515>.

⁸ Chapin White and Christopher M. Whaley, *Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely: Findings from an Employer-Led Transparency Initiative*, RAND Corporation, 2019.

⁹ For purposes of these Medicare rural hospital designations, *rural* means a hospital is located in, or is otherwise treated as being located in, a rural geographic area. *Rural* also may refer to the distance, such as a minimum number of miles, between the designated hospital and another designated or non-designated hospital. *Treated as being located in a rural area* means, for example, a hospital that meets the statutory requirements at 42 U.S.C. §1395ww(d)(8)(E)(ii) or the regulations at 42 C.F.R. §412.64(b)(3).

Selected Research on Rural Hospital Closures

The Government Accountability Office (GAO) has performed analyses that assessed, among other things, the number of rural hospital closures, factors associated with rural hospital closures, and the closures' effect on access to health care services. The research team of the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill (UNC Sheps Center) analyzes and tracks rural hospital closures. In addition, the Medicare Payment Advisory Commission (MedPAC), as a result of congressionally mandated work, assessed Medicare beneficiaries' access to health care services in rural areas and recommended potential modifications to Medicare payment and delivery systems to preserve access to health care services in rural areas.

Sources: GAO, *Rural Hospital Closures: Number and Characteristics of Affected Hospitals and Contributing Factors*, GAO-18-634, August 2018; GAO, *Rural Hospital Closures: Affected Residents Had Reduced Access to Health Care Services*, GAO-21-93, January 2021; UNC Sheps Center for Health Services Research, "Rural Hospital Closures Since January 2005"; and MedPAC, "Chapter 7: Improving Efficiency and Preserving Access to Emergency Care in Rural Areas," in *Report to Congress: Medicare and the Health Care Delivery System*, June 2016.

Hospital closures receive considerable attention due to the potential service and access impacts for the relevant community. (See text box "Selected Research on Rural Hospital Closures.") Merged hospitals also receive attention, particularly related to the effect a merger may have on health care delivery efficiencies, prices, services, among other effects. Converted hospitals—those that downsize from a full-service inpatient and outpatient hospital to an outpatient-only facility, such as an urgent care center or outpatient clinic—and new hospitals receive less attention.

This report provides a data snapshot of hospitals with a Medicare rural hospital designation that have closed, converted, merged, or that are new—both new health care facilities and existing non-hospital facilities that upsized to a hospital—for the period January 2018–November 2022. Specifically, this report

- identifies the total number of hospitals with each designation;
- provides the number of designated hospitals that have closed, merged, converted, or opened;¹⁰
- compares the number of designated hospitals with the number of non-designated hospitals; and
- notes whether some rural hospital designations are overrepresented in any of the status change categories, particularly closed and converted categories, relative to their numbers overall.

This analysis is intended to inform Congress about aggregate hospital status changes—closed, converted, merged, and new—during the 2018–2022 period with a Medicare rural hospital designation.¹¹ It also complements existing analyses, raises questions and issues that warrant future analyses, and presents considerations for Congress as it deliberates policies for rural hospitals. This report will be updated periodically as new data become available.

The text box immediately below presents key terms used throughout this report, followed by a brief overview of the Medicare rural hospital designations. Next, the report describes key characteristics and factors related to hospital financial distress that the Medicare rural hospital

¹⁰ In the remainder of this report, the four hospital statuses (closed, merged, converted, opened) are referred to collectively as hospital *change status*.

¹¹ This analysis does not include an analysis of facilities operated by federal government entities including those operated by the Departments of Defense or Veterans Affairs. It also does not include facilities operated or funded by the Indian Health Service. In some cases these facilities may be located in rural areas and may affect the patient volume (and therefore financial stability) of the facilities included in this analysis. Available data are not sufficient to determine whether this occurs.

designations are intended to address; trends in hospital closures; and selected policies designed to assist rural hospitals. In addition, the report presents analyses of hospital status changes by Medicare rural hospital designation; this analysis includes a comparison with non-designated rural hospitals that have similar characteristics to designated hospitals, such as size (small, as determined by the number of inpatient beds).

The information in this report is not exhaustive;¹² rather, it provides context for understanding the rural hospital designations and status change data presented later in the report.

Key Terms Used in This Report

Inpatient Prospective Payment System (IPPS): The Medicare payment system for inpatient hospital services consisting of a predetermined, fixed payment rate subject to certain adjustments that is based on the national average cost of furnishing inpatient hospital services to Medicare beneficiaries rather than a hospital's actual cost of furnishing such services to each individual beneficiary served.

Medicare Rural Hospital Designation: For purposes of this report, any of four designations that generally apply to small, rural hospitals—critical access hospital (CAH), low-volume hospital (LVH), Medicare dependent hospital (MDH), and sole community hospital (SCH). These designations permit a qualifying hospital to receive higher Medicare payments than it would otherwise receive absent the designation. In some cases, a hospital can have multiple designations, where applicable (as noted below).

Critical Access Hospital: A hospital that provides low-intensity, short-stay, acute care hospital services in remote geographic areas. This designation allows CAHs to receive cost-based, rather than IPPS, payments from Medicare. CAH is a mutually exclusive designation relative to the other three designations addressed below.

Low-Volume Hospital: A hospital that receives increased IPPS payments to account for the higher incremental costs associated with a low volume of patients. An LVH is not a mutually exclusive designation; an LVH may also have either an MDH or a SCH designation.

Medicare Dependent Hospital: A small, rural hospital serving a high proportion of patients who are Medicare beneficiaries. MDHs receive increased IPPS payments. An MDH cannot also have an SCH designation but can have an LVH designation.

Sole Community Hospital: A hospital that is the sole source of health care in a community. SCHs receive increased IPPS payments. An SCH cannot also have an MDH designation but can have an LVH designation.

Reasonable Cost: The Medicare payment method that generally pays a hospital for the (reasonable) cost of furnishing inpatient hospital services to Medicare beneficiaries. Sometimes also referred to as *cost-based* payment. Reasonable cost is unlike IPPS (defined above), which is a predetermined, fixed payment based on the average cost of furnishing inpatient hospital services to Medicare beneficiaries.

Status Change: For purposes of this report, one of four statuses: closed, converted, merged, or new.

Closed: A hospital that ceased *all* health care services.

Converted: A hospital that no longer provides inpatient services, only outpatient services, such as urgent care, and thus no longer qualifies as a *hospital*. Sometimes also referred to as *downsized* from a hospital to an outpatient-only health care facility.

Merged: A hospital acquired by another hospital or health system.

New: A hospital that opened that did not previously exist as a hospital.

Source: CRS analysis and summary of relevant federal statute, regulations, and nongovernment sources.

¹² For example, the American Hospital Association (AHA) *Hospital Universe Change Report* does not reflect the status change of non-member hospitals. Thus, it is possible for a non-member hospital to be in the universe of hospitals from which AHA has collected data in its annual survey but not be in the change report.

Medicare Rural Hospital Designations

To understand the Medicare rural hospital designations, one must first know how Medicare pays non-designated hospitals. Medicare pays general acute care hospitals—not specialized hospitals, such as psychiatric or rehabilitation hospitals—a predetermined, fixed payment amount, subject to adjustments for factors such as geographic differences in hospital employee wages and patient diagnoses and underlying health conditions. This fixed payment for general acute care inpatient hospital services is the *inpatient prospective payment system* (IPPS).¹³ The IPPS payment amount is set using the average cost of inpatient hospital services furnished to Medicare beneficiaries during the base period September 30, 1982 through August 31, 1983, updated for inflation.¹⁴ In other words, it is the average cost, not the actual cost, of furnishing inpatient hospital services to a specific beneficiary. (Prior to the IPPS, Medicare paid hospitals for inpatient hospital services furnished to Medicare beneficiaries based on *reasonable cost*. See “Prospective Payment Versus Reasonable Cost Payment” textbox for information about prospective payment systems versus cost reimbursement.)

Prospective Payment Versus Reasonable Cost Payment

Prior to Medicare’s inpatient prospective payment system (IPPS), Medicare paid most short-term acute care hospitals *reasonable cost* for inpatient hospital services furnished to Medicare beneficiaries. Reasonable cost meant a hospital would bill Medicare an amount that was unique for each inpatient episode, as long as the episode met Medicare requirements for “reasonable and necessary.” As a result, reasonable cost-based payments varied from hospital to hospital or patient to patient. In contrast, IPPS—like most prospective payment systems—pays a predetermined, fixed payment pegged to the average cost of furnishing inpatient hospital services to a Medicare beneficiary. In addition, the IPPS payment amount is a single payment for a bundle of services furnished by a hospital during an inpatient stay, rather than multiple payments for an itemized list of services, supplies, or pieces of medical equipment used during an inpatient stay.

Concerned about the rapid increase in Medicare spending on hospital services year over year, Congress enacted legislation (Tax Equity and Fiscal Responsibility Act of 1982; P.L. 97-248) that limited the year-to-year increase in Medicare reasonable cost payments for inpatient hospital services. Shortly thereafter, Congress enacted additional legislation (Social Security Amendments of 1983; P.L. 98-21) authorizing the Secretary of Health and Human Services to establish a prospective payment system for short-term acute care hospital inpatient services under Medicare. The resulting IPPS is intended to encourage hospitals to control costs.

IPPS payments to a hospital for inpatient services furnished to beneficiaries, in aggregate, should cover a hospital’s costs. That is, a hospital may not cover its costs on some Medicare patients, may break even on others, and may more than recover its costs on still others. Thus, the goal for hospitals, presumably, is to at least break even or, preferably, to have Medicare payments exceed costs by some margin in aggregate for furnishing inpatient hospital services to Medicare beneficiaries.

Medicare pays three of the four designations addressed in this report using the IPPS method—(1) LVHs, (2) MDHs, and (3) SCHs. Medicare pays an “add-on” amount (i.e., *adjustment*) in the case of LVHs. It also permits MDHs and SCHs to use a baseline cost year different from the IPPS baseline year; in other words, MDHs and SCHs can use baseline costs from 1982, 1987, 1996, or 2006, if doing so would yield a greater Medicare payment than the IPPS baseline costs from 1984.¹⁵ (See **Appendix A** for further details about the payment methodology of these designated hospitals.)

¹³ For a brief overview of the inpatient prospective payment system (IPPS), see MedPAC, Payment Basics, “Hospital Acute Inpatient Services Payment System,” revised October 2022.

¹⁴ 42 C.F.R. §412.71(a)(1). Generally, Medicare used as the IPPS base costs those amounts reflected in the Medicare cost reports of hospitals whose cost-reporting period ended during September 30, 1982 through August 31, 1983.

¹⁵ Health Care Financing Administration, “Medicare Program; Prospective Payments for Medicare Inpatient Hospital

The fourth rural hospital designation, CAH, is not paid using the IPPS method. Rather, CAHs receive Medicare payments based on reasonable cost plus 1%. (Refer to **Appendix A** for further detail about the Medicare payment methodology for CAHs.¹⁶)

Payment enhancements that hospitals receive under these designations apply only to Medicare payments for Medicare beneficiary inpatients.¹⁷ The payment enhancements do not apply to non-Medicare patients who have other health coverage, such as private insurance or Medicaid. The enhancements also do not apply to Medicare beneficiaries who receive their Medicare coverage through a Medicare Advantage (MA, or Medicare Part C) plan.

Table 1 contains the number of hospitals with and without a Medicare rural hospital designation—CAH, LVH, MDH, and SCH—for the period January 2018–November 2022.¹⁸

Table 1. Annual Number and Percentage of Short-Term Acute Care Hospitals and Applicable Medicare Rural Designations
(January 2018–November 2022)

Hospitals and Applicable Medicare Rural Designation	2018 ^a	2019 ^a	2020 ^a	2021 ^a	2022 ^a (Through November)
Critical Access Hospital (CAH) ^b	1,356	1,352	1,350	1,349	1,343
Low-Volume Hospital (LVH)	2 ^c	608	621	621	615
Medicare Dependent Hospital (MDH)	0 ^d	156	169	170	180
Sole Community Hospital (SCH)	448	446	451	454	460
Non-Designated (IPPS) Hospitals	2,626	2,371	2,280	2,138	2,076

Source: Congressional Research Service (CRS) analysis of Medicare Impact File data and Flex Monitoring Team (an academic consortium funded by the Federal Office of Rural Health Policy) for the relevant years.

Notes: IPPS = Inpatient prospective payment system. This table does not contain totals because LVH is not a mutually exclusive Medicare rural hospital designation; some hospitals that are either MDH or SCH are also LVH. Thus, summing each column would result in duplicate counts. The time frame (beginning with 2018) in this table reflects CRS's access to American Hospital Association (AHA) hospital status change data, which are the basis for the analysis in the remainder of this report; the time frame does not reflect when the Medicare rural hospital designations were enacted. See "Medicare Rural Hospital Designations" and **Appendix A** for more details about each designation.

- a. The SCH, MDH, and LVH data use fiscal years, and the CAH data are by calendar year. In any year noted in this table, there are approximately 3,300 IPPS hospitals, including LVHs, MDHs, and SCHs, and non-designated hospitals, in addition to approximately 1,350 CAHs.

Services; Final Rule," 49 *Federal Register* 233, January 3, 1984, p. 327.

¹⁶ For a graphical summary of the Medicare eligibility criteria and payment methodology of critical access hospitals (CAHs), low-volume hospitals (LVHs), Medicare dependent hospitals (MDHs), and sole community hospitals (SCHs), and, see CRS Infographic IG10023, *Medicare Payment for Rural or Geographically Isolated Hospitals, 2021*.

¹⁷ In addition, independent of these Medicare rural hospital designations, Medicare pays a portion of qualifying hospitals' uncompensated care costs and some of the costs associated with serving a disproportionate amount of low-income patients.

¹⁸ To calculate the average number of MDHs and LVHs for the period, CRS excluded FY2018 because of the unusually low number of MDHs and LVHs due to expiration of the MDH program and the enhanced eligibility criteria for LVHs. Congress later temporarily extended and modified eligibility for both MDH and LVH designations. In addition, IPPS hospitals, including rural designation IPPS hospitals LVH, MDH, and SCH use fiscal years; the CAH data are by calendar year.

- b. Facilities operated by the Indian Health Service or operated by Indian Tribes or Tribal Organizations using Indian Health Service funds may be designated as critical access hospitals and receive Medicare reimbursement using CAH methodology for the IHS beneficiaries who are enrolled in Medicare and receive Medicare covered services. These CAHs are not included in the data in this table because IHS facilities are beyond the scope of this report. For information on IHS CAHs, see Indian Health Service, “Critical Access Hospitals,” Critical Access Hospitals, Fact Sheets (ihs.gov).
- c. The modified, temporary eligibility criteria for the LVH designation expired at the end of FY2017; Congress later extended the modified, temporary eligibility criteria multiple times, most recently through September 30, 2024.
- d. The MDH designation is a temporary program that briefly expired at the end of FY2017; Congress later extended the program multiple times, most recently through September 30, 2024.

Key Characteristics Addressed by Medicare Rural Hospital Designations

Rural hospitals, whether paid under IPPS or reasonable cost, share certain characteristics that may make it more challenging to maintain financial stability. Factors that are often associated with the financial condition of a hospital include the

- demographics and health status of the population served by a hospital;
- patient volume or size of a hospital; or
- diversity of third-party payers of the patients served by a hospital—a balance of payers that includes self-pay for the uninsured, private insurance, and government-sponsored coverage such as Medicare or Medicaid.¹⁹

These factors are not mutually exclusive and are often interrelated. In addition, these factors are the primary basis for the Medicare rural hospital designations addressed in this report. The sections below briefly address each of these factors individually.

Demographics and Population Health Status

The demographics and health status of the rural population may affect the costs of care in rural areas. The population in rural areas tends to have higher rates of certain chronic conditions and health risk factors relative to urban areas that may make it costlier to deliver care in rural areas. The rural population is on average older and sicker than the population residing in urban areas.²⁰ For example, rural areas have higher rates of risk factors for mortality (e.g., smoking) and certain chronic diseases (e.g., obesity) than urban areas.²¹ Rural areas also have higher age-adjusted rates of certain conditions, such as heart disease, lung cancer, and stroke, than urban areas. In addition, the rural population is on average older than the urban population; specifically, nearly one out of every five people living in a rural area is over the age of 65 (18%), versus 14% of the population

¹⁹ Medicare pays a portion of qualifying hospitals’ uncompensated care costs and some of the costs associated with serving a disproportionate amount of low-income patients (i.e., Medicaid or Medicare Supplemental Security Income). These payments do not make a hospital “whole”; they only compensate for a portion of a hospital’s uncompensated care and disproportionate share costs. See CRS In Focus IF10918, *Hospital Charity Care and Related Reporting Requirements Under Medicare and the Internal Revenue Code*, for an overview of uncompensated care and federal tax-exempt status.

²⁰ Centers for Disease Control and Prevention, “Rural Americans Are Dying More Frequently from Preventable Causes Than Their Urban Counterparts,” press release, November 7, 2019, at <https://www.cdc.gov/media/releases/2019/p1107rural-americans.html>.

²¹ Ibid.

in urban areas.²² As a result, because Medicare eligibility begins at the age of 65, a higher proportion of the rural population than the urban population is Medicare eligible. Poverty rates are also higher in rural areas (16.1% of rural residents live below the poverty line, in contrast to 12.6% of people who reside in metropolitan areas).²³ In addition, unemployment rates are higher in rural areas than in urban areas.²⁴

The health status of patients in rural areas may be a source of financial distress for hospitals. Although Medicare adjusts hospital payments to account for clinical diagnoses, comorbidities, and certain patient characteristics, these payment adjustments apply only to Medicare beneficiaries. Medicare's payment adjustments that account for these patient characteristics may not apply to patients in the same hospitals who are covered by other insurance, such as Medicaid, or who are uninsured. In addition, for the more than 3,000 hospitals paid under Medicare IPPS, the goal is to provide services at or below the average cost set under Medicare for as many beneficiaries as possible. If a hospital cannot accomplish that goal for any number of reasons—including patient volume, inefficiency, and unpredictable cost increases (e.g., staffing)—the hospital may experience financial distress.

Patient Volume and Hospital Size

A hospital, by long-standing Medicare definition, must maintain inpatient services and the staffing appropriate to provide these services.²⁵ As such, there are fixed costs to maintain a hospital that must be offset by revenue obtained from patient care. Given the fixed payment rate structures under most private health insurance and government-sponsored health coverage, higher patient volume makes it more likely a hospital will offset financial losses on some patients with gains on others under a particular insurance coverage type.²⁶ In other words, higher patient volume may mitigate large financial losses on a smaller but more expensive subset of insured patients or patients who are uninsured. Smaller hospitals or those with relatively low patient volume may not be able to make up financial losses on some patients with gains on others. Thus, rural hospitals, especially if they are small or have low patient volume, may have difficulty covering their fixed costs because they cannot spread those costs across more patients, or may not be able to offset the cost of a few relatively expensive patients.²⁷ In general, according to a 2021 report by the Medicaid and CHIP Payment Access Commission, “rural hospitals face financial pressures due to the low occupancy rates, high levels of uncompensated care, competition from

²² Anna Nicholson, Rapporteur, Roundtable on Population Health Improvement: Board on Population Health and Public Health Practice; Health and Medicine Division, National Academies of Sciences, Engineering and Medicine, *Population Health in Rural America in 2020: Proceedings of a Workshop*, (Washington, DC: National Academies Press, 2021), p. 6.

²³ Ibid., p. 10.

²⁴ Ibid., p. 10.

²⁵ However, this definition of hospital changed with the enactment the REH designation, which became effective January 1, 2023. REHs are *not required* to furnish inpatient care, *must* provide emergency care, and *may* provide other outpatient services.

²⁶ The kinds of services hospitals provide (or do not provide) are determined by many factors, including Medicare conditions of participation, community need, staffing, and profitability. This report does not address hospital decisions about which services not to furnish (e.g., pediatric or obstetrics services). For further reading about how hospitals choose which lines of services to provide, see, for example, Katy B. Kozhimannil et al., “Rural Hospital Administrators’ Beliefs About Safety, Financial Viability, and Community Need for Offering Obstetric Care,” *JAMA Health Forum*, vol. 3, no. 3 (March 25, 2022) at doi: 10.1001/jamahealthforum.2022.0204; or Advisory Board, “Why So Many Hospitals Are Cutting Back on Services,” September 6, 2022.

²⁷ Ibid.

other hospitals, and weak local economies.”²⁸ These factors make rural hospitals less profitable and more likely to close than urban hospitals.²⁹

Payer Mix

Payer mix refers to the range of payment sources for health care services furnished—in this case, inpatient hospital services. Payment sources include third-party payers such as employer-sponsored insurance, or government coverage such as Medicare or Medicaid, or self-pay or uninsured persons. As noted above, the payer mix is an important factor for hospital finances and high rates of uninsured or publicly insured populations may contribute to hospital financial stress. The economic circumstances of the rural population (e.g., unemployment and poverty rates; see “Demographics and Population Health Status”) affect the health insurance coverage of rural residents, who are more likely to be uninsured than are residents of urban areas.³⁰ In addition, Medicaid covers a larger share of the rural population than the urban population.³¹ These relatively higher rates of publicly insured or uninsured populations may be financially challenging for rural hospitals.

The lack of a balanced payer mix, which includes both private insurance and public program (e.g., Medicare coverage), is associated with hospital closures and financial distress. The North Carolina Rural Health Research Program built a model to examine financial distress at rural hospitals to predict hospitals most at risk of closing. The model characterized a hospital’s profitability, taking into account numerous factors, including the hospital’s cash on hand and share of Medicare discharges. It found that a hospital’s share of Medicare-covered patients is predictive of financial distress, as is the poverty rate of the population the hospital serves.³² Similarly, greater uninsured rates are associated with hospital closures and financial distress. Regarding private insurance, one estimate found that payment rates from private insurance are 50% *higher* than hospital costs.³³ Rural areas, due to their comparatively higher rates of uninsured residents and residents with government-sponsored insurance, have smaller proportions of commercially insured residents than urban areas. These trends make rural hospitals more likely to experience financial distress, especially given the differences between private insurance, Medicare, and Medicaid payment rates. Specifically, a RAND study of medical claims data from 4,000 hospitals in all states between 2018 and 2020 found that on average private insurance payment rates were 224% higher than Medicare payments though they found variation across states, with prices ranging from 175% higher than Medicare prices to 310% higher than Medicare prices.³⁴

²⁸ Medicaid and CHIP Payment Access Commission (MACPAC), *Medicaid and Rural Health*, Issue Brief, April 2021, p. 3, at <https://www.macpac.gov/wp-content/uploads/2021/04/Medicaid-and-Rural-Health.pdf>.

²⁹ Ibid.

³⁰ U.S. Census Bureau, “Rates of Uninsured Fall in Rural Counties, Remain Higher Than Urban Counties,” press release, April 9, 2019, at <https://www.census.gov/library/stories/2019/04/health-insurance-rural-america.html>.

³¹ Julia Foutz, Samantha Artiga, and Rachel Garfield, *The Role of Medicaid in Rural America*, Kaiser Family Foundation, Issue Brief, April 2017, at <https://files.kff.org/attachment/Issue-Brief-The-Role-of-Medicaid-in-Rural-America>.

³² Brystana Kaufman, George Pink, and Mark Holmes, *Prediction of Financial Distress Among Rural Hospitals*, NC Rural Health Research Program, Findings Brief, January 2016, at <https://www.shepscenter.unc.edu/wp-content/uploads/2016/01/2015Prediction-of-Distress.pdf>.

³³ Testimony of Medicare Payment Advisory Commission (MedPAC) Executive Director Mark E. Miller, in U.S. Congress, House Committee on Ways and Means, 114th Cong., 1st sess., July 22, 2015.

³⁴ Christopher M. Whaley et al., *Prices Paid to Hospitals by Private Health Plans Findings from Round 4 of an*

Trends and Characteristics of Rural Hospitals

The Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill (UNC Sheps Center), which monitors rural hospital closures throughout the continental United States, found that 193 rural hospitals have closed since 2005 (as of the date of this report's publication). Of these, 100 completely *closed*, meaning they no longer provide any health care services, and 89 *converted*, meaning they no longer provide inpatient care but provide some type of health services (e.g., outpatient urgent care).³⁵ Additionally, 4 hospitals converted to REH, the newest Medicare hospital payment designation. Of the 193 closures or conversions, 150 occurred since 2010, including 37 between 2020 and 2023.

The CAH designation, established in the 1980s,³⁶ is credited with slowing the rate of closures in the late 1990s and early 2000s. However, rural hospitals continued to close and the rates began to grow again during the 2008-2009 recession.³⁷

It is not yet clear how the Coronavirus Disease 2019 (COVID-19) pandemic emergency period will affect hospital closures going forward.³⁸ Data from 2020 show that 19 hospitals closed, a similar number to the 18 hospitals that closed in 2019. In contrast, in 2021, only two rural hospitals closed; 2022 saw another seven closures. The relatively low numbers in 2021 and 2022 may be due to the availability of COVID-19 funding for rural facilities through both the Provider Relief Fund and the American Rescue Plan Act during those years.³⁹ At the time of this report's publication, no additional COVID-19 funding for rural providers is available.

Some experts suggest that rural hospitals remain vulnerable to closures despite the lower closure numbers in 2021 and 2022, as approximately 40% are operating in deficit status.⁴⁰ As such, 2023 and thereafter *may* bring closure numbers similar to those of 2019 and 2020.

The UNC Sheps Center and others have examined trends among closures. Researchers have found that (1) closures are most common in the South, where poverty rates are higher and people are less likely to be insured than in other parts of the country;⁴¹ and (2) most hospitals (both rural and urban) that close do so because of financial problems, but rural hospitals are more likely than urban hospitals to be unprofitable.⁴² Other research identified similar trends and noted that closed

Employer-Led Transparency Initiative, RAND Corporation, July 2022, p. 13.

³⁵ Cecil G. Sheps Center for Health Services Research, "Rural Hospital Closures," at <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>.

³⁶ Brystana G. Kaufman, "The Rising Rate of Hospital Closures," *Journal of Rural Health*, vol. 32, no. 2016 (2015), pp. 35-43.

³⁷ *Ibid.*, see "Frequently Asked Questions."

³⁸ A public health emergency was initially declared effective January 31, 2020 and is set to end on May 11, 2023. The public health emergency made additional funding and flexibilities available to hospitals. For more information, see HHS, Administration for Strategic Preparedness and Response, "Declarations of Public Health Emergency," at <https://aspr.hhs.gov/legal/PHE/Pages/default.aspx> and "Fact Sheet: COVID-19 Public Health Emergency Transition Roadmap," at <https://www.hhs.gov/about/news/2023/02/09/fact-sheet-covid-19-public-health-emergency-transition-roadmap.html>.

³⁹ CRS Report R46897, *The Provider Relief Fund: Frequently Asked Questions*.

⁴⁰ The Chartis Group, "Pandemic Increases Pressure on Rural Hospitals and Communities," National Rural Health Association Rural Health Policy Institute Conference, Washington, DC, February 2022.

⁴¹ For example, the Sheps Center data show more than five closures in each of the following states Alabama, Florida, Georgia, and more than 10 closures in North Carolina and Tennessee. Overall, Texas had the highest number of closures (27).

⁴² Brystana G. Kaufman, George Pink, and Mark Holmes, "Predictions of Financial Distress Among Rural Hospitals,"

hospitals were likely to be a greater distance from the nearest hospitals, were more likely to serve non-White populations, and had lower utilization than hospitals that did not close.⁴³

Researchers also have examined differences between hospitals that closed and those that converted to another type of provider such as an urgent care center that no longer furnishes inpatient services. Hospitals that closed (which the UNC Sheps Center termed *abandoned*) were more likely to serve populations with higher poverty rates, be further away from the nearest hospitals, and have lower profitability and liquidity prior to having closed than hospitals that converted.⁴⁴

Selected Policies to Maintain Health Care Services in Rural Areas

In addition to the four Medicare rural hospital designations addressed in this report, the Centers for Medicare & Medicaid Services (CMS) tests payment models designed to provide increased payment across different payers to rural hospitals to increase financial stability. For example, beginning in 2019, the CMS Innovation Center is testing a new model for rural hospitals in Pennsylvania. This demonstration uses a global budget model in which hospitals receive a set payment amount in advance for inpatient and outpatient care. This model is intended to provide hospitals financial stability through predictable, steady income (rather than income that fluctuates based on patient volume) and incentives to coordinate care and invest in preventive care.⁴⁵

To respond to the COVID-19 pandemic, CMS permitted some hospitals to provide and receive reimbursement for services rendered beyond the four walls of the hospital, termed *Hospital Without Walls*.⁴⁶ Though not exclusively rural, this flexibility allows hospitals to expand the number of beds and patients they serve without adding physical infrastructure; as such, it could provide additional revenue for rural hospitals.

The Medicare program has other incentives available to outpatient providers in rural areas, including bonus payments to physicians who practice in geographic health professional shortage areas. In addition, facilities with the Medicare designation of *rural health clinic* receive payments that are generally considered higher than payments in other outpatient settings.⁴⁷ Similar to rural health clinics, but not exclusively rural, Medicare designates certain outpatient facilities in health professional shortage areas as *federally qualified health centers*; this designation enables the

NC Rural Health Research Program, Findings Brief, January 2016, 2015, at <https://www.shepscenter.unc.edu/wp-content/uploads/2016/01/2015Prediction-of-Distress.pdf>.

⁴³ Shawnda Schroeder, “Effects of Rural Hospital Closures,” Rural Health Research Gateway, December 2017; Brystana G. Kaufman, “The Rising Rate of Hospital Closures,” *Journal of Rural Health*, vol. 32, no. 2016 (2015), pp. 35-43.

⁴⁴ Shawnda Schroeder, “Effects of Rural Hospital Closures,” Rural Health Research Gateway, December 2017.

⁴⁵ CMS, “Pennsylvania Rural Health Model,” at <https://innovation.cms.gov/innovation-models/pa-rural-health-model>.

⁴⁶ CMS, “CMS Announces Comprehensive Strategy to Enhance Hospital Capacity amid COVID-19 Surge,” press release, November 25, 2020, at <https://www.cms.gov/newsroom/press-releases/cms-announces-comprehensive-strategy-enhance-hospital-capacity-amid-covid-19-surge>.

⁴⁷ See CMS, Medicare Learning Network, “Health Professional Shortage Area Physician Bonus Payment Program,” February 2021, at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HPSAfctst.pdf>; and CMS, Medicare Learning Network, “Rural Health Clinic,” January 2022, at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/RuralHlthClinfctst.pdf>.

facilities to receive payments that are generally considered higher than payments in other outpatient settings.⁴⁸

Beyond Medicare payments, the federal government has programs to assist rural hospitals. In general, existing programs generally take one or more of the following approaches:

- Maintain hospital-level services in rural areas through technical assistance to improve hospital operations and quality or payment policies
- Increase services available through telehealth
- Encourage cooperation among rural providers to minimize duplication of services in an attempt to maintain access to care when low patient volume may not be sufficient to support multiple providers
- Maintain access to non-hospital-level health care services in rural areas (i.e., converting hospitals into outpatient-only urgent and other outpatient services)

The HHS Federal Office of Rural Health Policy (FORHP) supports programs that demonstrate each of these policy approaches. Through its rural hospital programs, FORHP provides technical assistance to rural hospitals and funding for activities such as quality improvement and targeted support for vulnerable rural hospitals.⁴⁹ FORHP also supports rural community programs, including programs that provide grants to coordinate care in rural areas and establish rural health networks.⁵⁰ In addition, FORHP provides funds to health care providers (including but not exclusive to hospitals) to increase their capacity to provide services via telehealth; these funds support broadband services and encourage the provision of specific health services, such as behavioral health, through telehealth.⁵¹ Outside of HHS, the U.S. Department of Agriculture (USDA) also provides financial support in the form of loans and grants to rural facilities, including rural hospitals, through its Community Facilities Program. In addition, USDA received one-time funding through the American Rescue Plan Act of 2021 (P.L. 117-2) to provide emergency funding to rural providers, including hospitals.⁵²

Policy approaches also have included efforts to preserve access to health care in rural areas by moving away from inpatient care models. For example, in 2020, Congress enacted a new Medicare payment model designed to preserve emergency care in rural areas. This model, unlike current Medicare rural hospital designations, does not require that the facility primarily focus on inpatient care. The new payment model, which creates a new Medicare provider type called a *rural emergency hospital* (REH), became effective January 1, 2023.

⁴⁸ CMS, Medicare Learning Network, “Federally Qualified Health Center,” October 2022, at <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/fqhcfactsheet.pdf>.

⁴⁹ Health Resources and Services Administration (HRSA), Federal Office of Rural Health Policy (FORHP), “Rural Hospital Programs,” at <https://www.hrsa.gov/rural-health/rural-hospitals>. The President’s Budget for the FORHP included a new \$10 million funding stream to provide targeted technical assistance to rural hospitals at risk of closure and included a proposed \$20 million pilot program for rural hospitals that would provide start-up capital funding to enhance existing or add new service lines. For more information see HRSA, “Health Resources and Services Administration, FY2024: Justification of Estimates for Appropriations Committees,” at <https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2024.pdf>, pp. 377-382.

⁵⁰ HRSA, FORHP, “Rural Community Programs,” at <https://www.hrsa.gov/rural-health/community/index.html>.

⁵¹ HRSA, FORHP, “Office of Advancement of Telehealth,” at <https://www.hrsa.gov/rural-health/telehealth>.

⁵² U.S. Department of Agriculture, “Community Facilities Programs,” at <https://www.rd.usda.gov/programs-services/community-facilities>; and CRS Report R46834, *American Rescue Plan Act of 2021 (P.L. 117-2): Public Health, Medical Supply Chain, Health Services, and Related Provisions*.

The REH model grew out of congressionally mandated analysis published in 2016 by the Medicare Payment Advisory Commission (MedPAC) in which it presented various policy options for preserving access to emergency health care services in rural areas.⁵³ Hospital emergency services are considered outpatient services; some of these outpatient services result in an inpatient stay. Medicare rural hospital designations are targeted to hospitals and inpatient services. To that end, MedPAC noted that Congress could consider options to provide Medicare payment and support for emergency departments or urgent care clinics with ambulance service—both focusing on maintaining emergency services without inpatient capacity.⁵⁴ To assist hospitals with conversion to REH, in FY2022, the FORHP received an appropriation of \$5 million to provide technical assistance to support public nonprofit hospitals that seek to convert to REHs.⁵⁵

Hospital Status Change

Table 2 contains information about closed, converted, merged, and new hospitals by Medicare rural designation—CAH, LVH, MDH, and SCH. Medicare rural hospital designations are by definition hospitals that are small (based on number of beds) or have low inpatient volume. To put the designated hospitals in context, where possible, **Table 2** compares designated hospitals with similar non-designated small (≤ 100 beds) rural hospitals and with all other non-designated hospitals.

One hundred ninety-eight unique hospitals had a status change—closed, converted, merged, or new—during the period January 2018–November 2022. Of those, 61 hospitals had at least one Medicare rural designation and 137 did not. Of the hospitals with a Medicare rural designation, 24 were CAHs, 26 LVHs, 16 MDHs, and 6 SCHs.⁵⁶ Of the 137 non-designated hospitals that had a status change, 12 were small (≤ 100 beds) rural hospitals and 125 were other non-designated hospitals. The sections below following the table provide additional detail about each of the status changes.

Table 2. Unique Number and Percentage of Medicare Rural Hospitals by Designation and Status Change

(January 1, 2018–November 30, 2022)

Hospital Designation	Closed (% of Closed)	Converted (% of Converted)	Merged (% of Merged)	New (% of New)
All Hospitals^a	110	15	57	16
Critical Access Hospitals (CAH)	19 (17%)	2 (13%)	2 (4%)	1 (6%)
Low-Volume Hospitals (LVH)	18 (16%)	2 (13%)	6 (11%)	0

⁵³ Medicare Payment Advisory Commission (MedPAC), *June 2016 Report To The Congress: Medicare And The Health Care Delivery System*, June 2016, Chapter 7, pp. 201–225.

⁵⁴ Ibid. See pp. 218–221.

⁵⁵ Rep. Nancy Pelosi, “Division H–Department of Labor, Health and Human Services, and Education, and Related Agencies, Appropriations Act, 2022,” Text of the House Amendment to the Senate Amendment to the Text, *Congressional Record*, daily edition, vol. 168, part 42–Book II (March 9, 2022), p. H1534.

⁵⁶ A hospital can have more than one Medicare rural designation; therefore, the sum of these hospitals will not equal 47.

Hospital Designation	Closed (% of Closed)	Converted (% of Converted)	Merged (% of Merged)	New (% of New)
Medicare Dependent Hospitals (MDH)	11 (10%)	1 (7%)	4 (7%)	0
Sole Community Hospitals (SCH)	6 (5%)	0	0	0
All Non-designated Hospitals^b	65 (59%)	10 (67%)	47 (82%)	15 (94%)
IPPS Small (≤ 100 beds) Rural Hospitals	9 (8%)	1 (7%)	2 (4%)	0
All Other IPPS Hospitals	56 (51%)	9 (60%)	45 (79%)	15 (94%)

Source: CRS analysis of Medicare Impact File data, FLEX Monitoring Team, and AHA DataQuery™.

Notes: IPPS = Inpatient prospective payment system. One closed hospital was removed from the data because it was identified as a CAH, LVH, and MDH; a CAH is not permitted to also hold either an LVH or an MDH designation. Thus, CRS determined this was an error in the source data set(s).

- The “All Hospitals” row contains the total, unduplicated number of hospitals for each change status. These totals are used as the denominator for the percent values in all remaining rows of the table. Because hospitals can have more than one designation, the sum of the percent values in each column will not add to 100.
- “Non-designated Hospitals” category included for comparison with rural designated hospitals.

Almost seven times as many hospitals closed as opened (i.e., new hospitals) between January 1, 2018, and November 30, 2022—110 versus 16. This disparity resulted in a net loss of 94 ($110 - 16 = 94$) health care facilities.⁵⁷ However, the loss or gain of a hospital did not necessarily affect the same geographic areas. The sections below describe the number and percentage of hospitals in each of the status change categories—closed, converted, merged, or new.

Closed

The hospital status change that garners the greatest attention is a closure. Fifty-six percent (56%) of status changes between January 1, 2018, and November 30, 2022, were closures.⁵⁸ During this period, 110 hospitals closed—45 rural designated hospitals (41% of closed hospitals) and 65 non-designated hospitals (59% of closed hospitals). Of the rural designated hospitals, 19 were CAHs (17% of all closed hospitals), 18 were LVHs (16% of all closed hospitals), 11 were MDHs (10% of all closed hospitals), and 6 were SCHs (5% of all closed hospitals). Of the 65 non-designated hospitals, 9 were small (≤ 100 beds) rural hospitals (8% of all closed hospitals) and 56 were other non-designated hospitals (51% of all closed hospitals).

Converted

Of the 15 hospitals that converted between January 1, 2018, and November 30, 2022, 5 (33% of all converted hospitals) were rural designated hospitals and 10 (67% of all converted hospitals)

⁵⁷ For purposes of this report, a *merged* or *converted* hospital is not counted as a loss, because the facility still provides health care services.

⁵⁸ For purposes of this report, *closed* means a hospital that ceased all health care operations—inpatient and outpatient services—and does not include hospitals that changed from one Medicare rural hospital designation to another (e.g., an IPPS hospital changing to an IPPS with an SCH designation, or a CAH switching back to being an IPPS hospital).

were non-designated. Of designated hospitals that converted, two (13%) were CAHs, two (13%) were LVHs, and one (7%) was an MDH; no SCHs converted. All but one of the non-designated converted hospitals were in the “Other IPPS Hospitals” group.

Merged

Of the 57 hospitals that merged between January 1, 2018, and November 30, 2022, 10 (18%) were rural designated and 47 (82%) were non-designated. Of the rural designated hospitals, two (4% of all merged hospitals) were CAHs, six (11%) were LVH, and four (7%) were MDH; no SCHs merged. Of the non-designated merged hospitals, 2 (4%) were small rural hospitals and 45 (79%) were other non-designated hospitals.

New

Of the 16 hospitals that opened between January 1, 2018, and November 30, 2022, 1 (6%) was a rural designated hospital and 15 (94%) were non-designated. The only new rural designated hospital was a CAH. All 15 of the new non-designated hospitals were in the “Other IPPS Hospitals” category; none of the non-designated hospitals was a small, rural hospital.

Differences in Status Change by Medicare Rural Hospital Designation

Certain hospitals are represented in each of the status change categories to a greater or lesser extent than their shares overall. **Figure 1** illustrates this information. For example, MDHs represent 3.9% of all hospitals but represent a higher percentage of closed, converted, and merged facilities relative to their proportion of all hospitals—10.0%, 6.7%, and 7.0%, respectively. Only SCHs and CAHs represent a smaller proportion of closed hospitals than each represents among all hospitals—SCHs are 10.3% of all hospitals but only 5.5% of closed hospitals, and CAHs represent 28.3% of all hospitals but only 17.3% of closed hospitals.

For comparison, **Figure 1** includes two additional categories of hospitals (“IPPS, Other Non-designated” and “IPPS Small, Rural”); both comprise hospitals that do not have a Medicare rural designation. The “IPPS Small, Rural” hospitals are somewhat comparable to the designated hospitals based on certain characteristics, such as being located in a rural area and having a limited number of acute inpatient beds.⁵⁹ The “IPPS, Other Non-designated” category contains non-designated hospitals that are not small and rural.⁶⁰

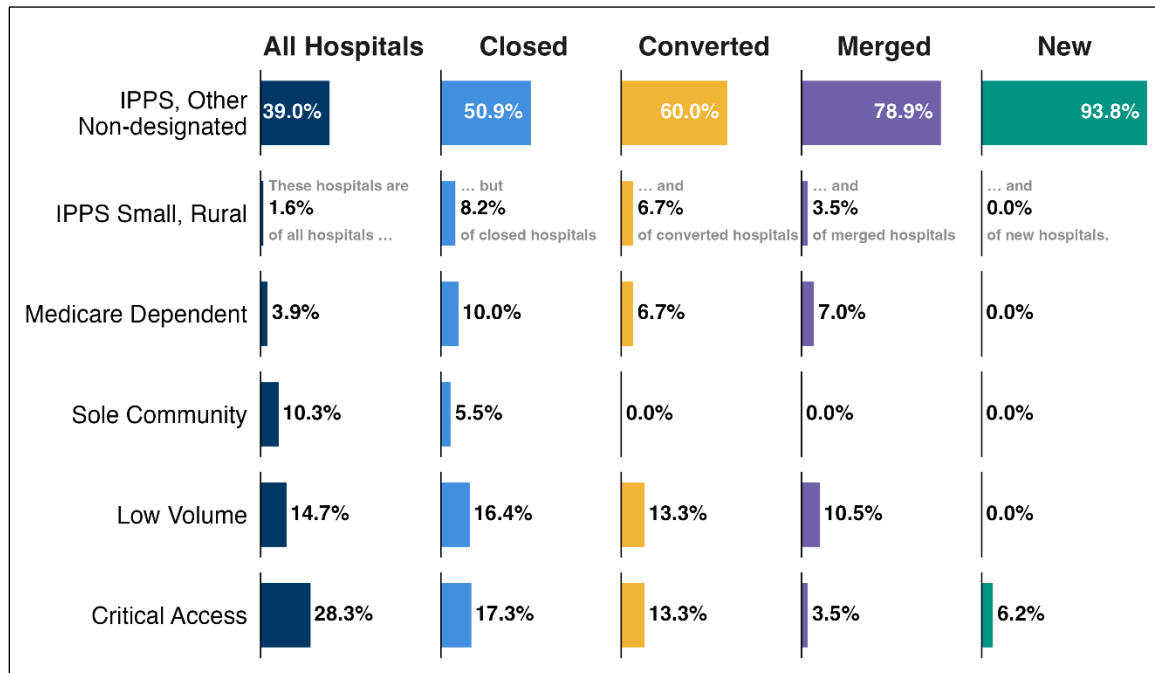
Like most of the Medicare rural designated hospitals, hospitals in both of the non-designated categories have greater representation in the status change categories than their numbers overall (with the exception of new hospitals defined as “IPPS Small, Rural”). Specifically, “IPPS Small, Rural” hospitals represent 1.6% of all hospitals but 8.2% of closed, 6.7% of converted, 3.5% of merged, and 0.0% of new hospitals. “IPPS, Other Non-designated” hospitals represent 39.0% of all hospitals but 50.9% of closed, 60.0% of converted, 78.9% of merged, and 93.8% of new hospitals.

⁵⁹ For purposes of this report, the comparison category “IPPS Small, Rural” contains hospitals that are located in a rural area, as defined by Medicare, and have 100 or fewer inpatient beds.

⁶⁰ Using the threshold of 100 or fewer inpatient beds to define a hospital as *small*, the “IPPS, Other Non-Designated” category could contain hospitals that are small and urban, large and urban, or large and rural.

These data do not allow us to determine with a high level of confidence why differences exist or whether the differences are significant, but it is worth noting that there are differences. For example, of the Medicare rural designated hospitals, MDHs are overrepresented in the closed category, given that they comprise a relatively small proportion of all acute care hospitals. CRS is unable to determine the reason for this overrepresentation. MDH is the only Medicare rural hospital designation that expires *in its entirety* after September 30, 2024, unless Congress enacts legislation to extend it.⁶¹ Whether or how the temporary nature of this designation affects the financial condition of these hospitals is unclear and may be worth further research.

Figure 1. Percentage of Medicare Rural Designation Hospitals with a Status Change Relative to All Hospitals with a Status Change
(January 2018–November 2022)



Source: CRS analysis of Medicare Impact File data, FLEX Monitoring Team, and AHA DataQuery™.

Notes: IPPS = Inpatient prospective payment system. The information contained in this figure does not imply causation or correlation. Rather, it is the proportion of hospitals that have a specific change status relative to all hospitals (column headers), by Medicare rural hospital designation or type of hospital—IPPS small rural, IPPS other non-designated as comparison (row headers). This figure does not contain totals because low-volume hospital is not a mutually exclusive Medicare designation; some hospitals that are either Medicare dependent hospitals or sole community hospitals also hold the low-volume hospital designation. However, hospitals cannot be both Medicare dependent hospitals and sole community hospitals. Thus, summing each column would result in duplicate counts.

Considerations for Congress

As Congress debates policy options for rural hospitals and access to health care services in rural areas, below is a list of *select* considerations.

⁶¹ Additionally, the LVH's current eligibility criteria and payment methodology will expire after September 30, 2024, if Congress does not enact legislation to extend them. The LVH designation does not expire—only the existing eligibility criteria and payment methodology. SCH and CAH are permanent designations.

- Congress may continue to monitor the effects of the COVID-19 pandemic public health emergency on rural hospital closures, conversions, and mergers. Few rural hospital closures occurred in 2021 and 2022, which may be associated with the availability of federal funding to support these providers during the height of the COVID-19 public health emergency. Congress may wish to monitor whether rural hospital closures remain at 2021-2022 levels or return to or exceed 2020 levels (19 closures) to determine the need for policy intervention.⁶²
- The COVID-19 pandemic increased the use of telehealth and expanded payment for telehealth services under federal programs. Recent payment changes enacted in the Consolidated Appropriations Act, 2023 (P.L. 117-328), will continue the expanded Medicare reimbursement for telehealth. Telehealth's full effects on access to care and its spillover effects on brick and mortar providers are not yet known. Congress may consider monitoring how telehealth affects rural hospital finances.
- The REH model became effective January 1, 2023. Congress may consider analyses of the REH designation's effect on rural hospitals to determine whether to modify aspects of REH or the Medicare rural hospital designations addressed in this report.
- Congress may examine the effects of particular designations on closures or other status changes, as noted in this report. This report found that MDH and LVH comprised a greater percentage of closures relative to their respective proportion of all hospitals. Congress may consider exploring the factors that underlie these trends. For example, the MDH designation is temporary, though Congress has enacted legislation to temporarily extend the designation multiple times since its enactment. The LVH designation's current eligibility criteria and payment adjustment also are temporary, and Congress has enacted legislation to temporarily extend the current eligibility criteria and payment adjustment.⁶³ The temporary nature of these designations may make them unpredictable and therefore less attractive to hospitals as they explore ways to stabilize their finances. Congress may explore the role Medicare rural hospital designations have on the rural hospitals that may qualify for these designations and whether temporary designations are less effective than permanent designations at preventing closures or conversions.
- The Medicare rural hospital designations provide enhanced payment only for Medicare beneficiaries served by designated hospitals. Hospitals may not receive similar enhanced reimbursement under other third-party payers—public or private. Thus, Medicare payment enhancements to hospitals for Medicare patients may not address financial distress due to payments for patients covered under Medicaid, private insurance, or those who are uninsured.

⁶² A public health emergency was initially declared effective January 31, 2020 and is set to end on May 11, 2023. The public health emergency made additional funding and flexibilities available to hospitals. For more information, see HHS, Administration for Strategic Preparedness and Response, "Declarations of Public Health Emergency," at <https://aspr.hhs.gov/legal/PHE/Pages/default.aspx> and "Fact Sheet: COVID-19 Public Health Emergency Transition Roadmap," at <https://www.hhs.gov/about/news/2023/02/09/fact-sheet-covid-19-public-health-emergency-transition-roadmap.html>.

⁶³ For a legislative history of the LVH and MDH designations, see CRS congressional distribution memorandum, *Legislative History of Medicare Rural Hospital Payment Designations: Low-Volume Hospital, Medicare Dependent Hospital, and Sole Community Hospital*, available to congressional clients upon request.

- In addition to Medicare rural hospital designation, the FORHP and USDA have programs that can be used to support rural hospitals. Congress may seek to evaluate the interactions of these programs to identify potential duplication and gaps.
- Although this report focuses on status changes among Medicare designated hospitals, this analysis found that both designated and undesignated hospitals closed, converted, and merged between January 2018 and November 2022. Congress may examine the effects of closures, conversions, and mergers on access to health care in general, including any similarities and differences between designated and undesignated hospitals that are also financially distressed or at risk of closing.
- This analysis does not address federal government-operated hospitals such as Veterans Affairs and those operated or funded by the Indian Health Service. It is unclear how, or whether, the presence of these federal facilities may affect the financial viability of the rural hospitals that are the basis of this analysis. In areas with patients using federal facilities, patient volume at non-federal rural hospitals may be affected, thereby potentially negatively affecting their finances. Whether or not this occurs is beyond the scope of this report's analysis; however, the interaction between federal facilities and rural hospital closures may be an area to consider for Congressional oversight and investigation.
- Congress may explore whether there is a need for general financial support for certain hospitals and health care services outside of the Medicare hospital IPPS. Medicare is not a grant or general financial support program; rather, Medicare is primarily a health insurance program that pays hospitals (and other providers) for services furnished to Medicare beneficiaries. As noted earlier, the REH designation is the first hospital designation whose payment is a hybrid prospective payment system and annual lump sum payment. The lump sum is intended to cover an REH's fixed costs that otherwise may not be covered under a pure PPS.

Appendix A. Medicare Rural Hospital Designations

Medicare pays for most hospital inpatient services furnished in short-term acute care hospitals under the inpatient prospective payment system (IPPS);⁶⁴ IPPS has been in effect since October 1, 1986.⁶⁵ The IPPS payment is a predetermined, fixed amount that is set administratively by the Centers for Medicare & Medicaid Services (CMS) for a Medicare beneficiary who is discharged from the hospital. All IPPS payments are subject to adjustments related to (1) the cost of hospital labor in the geographic area where a hospital is located relative to the national cost of labor and (2) the patient's diagnoses, comorbidities, and complications. Some IPPS payments are subject to further adjustments—for example, the cost of a medical residency program or serving a disproportionate share of low-income and uninsured patients. The payment covers most services, supplies, and room and board costs from the time the hospital admits the patient through discharge. The payment also covers pre-admission-related services such as diagnostic tests performed within three days prior to and including the day of admission. Hospitals may not bill separately for items and services that Medicare pays for under the fixed IPPS payment.⁶⁶

Certain hospitals are exempt from the IPPS and are paid under different prospective payment system models or on a reasonable cost basis.⁶⁷ For example, the following hospital types (or such units or wards within an IPPS hospital) are paid under their respective Medicare payment methodologies (i.e., not IPPS): (1) inpatient rehabilitation facilities, (2) long-term care hospitals, (3) psychiatric facilities, (4) children's hospitals, and (5) cancer hospitals.⁶⁸

Medicare's IPPS payment is intended to cover the *average* cost of providing inpatient services to a Medicare beneficiary, with applicable adjustments as noted above. It is intended to provide an incentive for hospitals to deliver inpatient services to Medicare beneficiaries efficiently—ideally for the hospital, the IPPS payment is greater than its costs. However, if a hospital's costs of furnishing inpatient services to Medicare beneficiaries consistently exceed the Medicare IPPS fixed payment amount, the hospital may experience financial distress. Additionally, if a hospital has low patient volume or a disproportionate share of Medicare beneficiaries (relative to patients who have commercial insurance, for example)—characteristics that are associated with hospital financial distress—IPPS may not work financially for such a hospital.⁶⁹

⁶⁴ As distinguished from, for example, long-term care hospitals, psychiatric hospitals, or rehabilitation hospitals or from services provided to Medicare beneficiaries in such a unit or ward of an IPPS hospital. These non-IPPS hospitals or units within an IPPS hospital are paid under different prospective payment system methodologies from IPPS.

⁶⁵ Social Security Amendments of 1983 (SSA 1983; P.L. 98-21), §601. SSA 1983 established a transition period from October 1, 1983, through September 30, 1985, during which Medicare paid hospitals for inpatient services using a blend of cost-based payment rates and the new IPPS rate.

⁶⁶ Physician services provided during a hospital inpatient stay are paid separately by Medicare. For example, if an inpatient stay required anesthesiology, the anesthesiologist's fee would be paid separately from the hospital's IPPS payment under the Medicare physician fee schedule.

⁶⁷ The *reasonable cost* payment method involves paying an amount that is not fixed or predetermined by the Centers for Medicare & Medicaid Services (CMS), such as is done under the IPPS. Prior to the IPPS, Medicare paid for inpatient hospital services based on reasonable cost, subject to certain limits on costs.

⁶⁸ Additionally, other hospitals that are exempt from the IPPS and are reimbursed by Medicare under different methods include hospitals in Maryland, hospitals in U.S. territories (with the exception of Puerto Rico), and hospitals of the Indian Health Service. Children's hospitals focus on patients from birth to the age of 18 and may serve few Medicare beneficiaries, because Medicare eligibility is generally for those over the age of 65 or who are disabled (although some disabled patients may be children).

⁶⁹ Private insurer payments to hospitals for hospital services are largely determined on the market share and power a hospital has in a particular geographic area. Commercial insurer payment amounts are negotiated between the insurer

For qualifying rural or low-volume hospitals for which IPPS does not work financially, Medicare has numerous payment designations that permit such hospitals to receive a modified IPPS payment amount or an add-on payment for each Medicare beneficiary the hospital serves. These designations include critical access hospital (CAH), low-volume hospital (LVH), Medicare dependent hospital (MDH), and sole community hospital (SCH), which are described below.

Critical Access Hospitals

Critical access hospitals were established by the Balanced Budget Act of 1997 (P.L. 105-33) to maintain access to hospital care in rural areas and are paid by Medicare outside of the IPPS. CAHs are modeled on a medical assistance facility (MAF) demonstration conducted in Montana to test alternative payment models for hospital care. MAFs focused on low-intensity, short-stay, acute care hospital services in remote geographic areas. As such, MAFs provided a maximum of 96 hours of inpatient care; patients with serious illnesses or injuries were stabilized at an MAF and transported to a full-service hospital. The MAF demonstration expired and was replaced with the Medicare Rural Hospital Flexibility Program and the establishment of a new Medicare hospital designation, CAH. Facilities that were MAF participants were grandfathered as CAHs.

Unlike IPPS hospitals, Medicare pays CAHs at 101% of the CAH's reasonable costs for most hospital inpatient, outpatient, laboratory, therapy, and post-acute services in swing beds.⁷⁰

To become a CAH, a hospital must meet *all five* of the following criteria:

1. Be located in a rural county⁷¹
2. Be located more than a 35 mile drive from another CAH or IPPS hospital,⁷² or meet *one* of the following criteria:
 - Be located more than a 15 mile drive in mountainous terrain or where only secondary roads are available
 - Be certified as a CAH prior to January 1, 2006, based on state designation as a "necessary provider"⁷³
3. Provide 24/7 emergency services
4. Have 25 or fewer inpatient beds
5. Have an annual average length of stay of 96 hours or less

The CAH designation is mutually exclusive of any of the other Medicare rural designations addressed in this report.

and hospital; in such negotiations, the relative strength of each party's negotiating position influences the outcome. For further information about commercial insurer payments to hospitals, see Chapin White and Christopher M. Whaley, *Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely: Findings from an Employer-Led Transparency Initiative*, RAND Corporation, 2019, at <https://doi.org/10.7249/RR3033>.

⁷⁰ A *swing bed* refers to a bed that can be used for either acute (hospital) or skilled (such as skilled nursing or rehabilitation) levels of care.

⁷¹ *Rural* is defined, for purposes of qualifying as a critical access hospital, as a geographic area that is outside of a metropolitan statistical area or New England County Metropolitan Area, as defined by the Office of Management and Budget, or that meets other regulatory requirements at 42 C.F.R. §412.64(b). Certain hospitals that are not located in rural areas may be considered rural if the hospital reclassifies as rural for purposes of the Medicare IPPS wage index adjustment under an urban-to-rural reclassification. See 42 U.S.C. §1395ww(d)(8)(E) and 42 C.F.R. §412.103.

⁷² Indian Health Service hospitals do not count as "another CAH or IPPS hospital" for purposes of qualifying as critical access hospital (CAH) based on the driving distance between hospitals.

⁷³ 42 U.S.C. §1395i-4(c)(2)(B)(i)(II).

Low-Volume Hospital Adjustment

Under Medicare, qualifying hospitals receive an adjustment to some of their IPPS per discharge payments to account for the higher incremental costs associated with a low volume of discharges. LVH was enacted by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173).

LVHs receive up to a 25% increase in their per discharge Medicare IPPS payment for a limited number of discharges. The Secretary of Health and Human Services determines the appropriate percentage increase per discharge by hospital, up to the 25% ceiling. LVHs with fewer discharges receive a larger payment adjustment. The adjustment declines in a continuous linear manner—from a maximum 25% adjustment per Medicare discharge for discharges 1-500, with a reduced per discharge LVH adjustment for every additional Medicare discharge up to 3,800 discharges.

Currently, to receive the LVH designation a hospital must meet *both* of the following criteria:

1. Have less than 3,800 total discharges
2. Be more than 15 road miles from another IPPS hospital

After September 30, 2024, if Congress does not act to extend or otherwise modify the current eligibility criteria and payment adjustment, the LVH criteria will revert to less than 800 *total* (Medicare and non-Medicare) discharges and being located more than 25 road miles from another IPPS hospital.⁷⁴ Also, under the statutory criteria, although hospitals may have as many as 800 total discharges to qualify for LVH, CMS previously established through rulemaking that only hospitals with fewer than 200 total discharges and that meet the aforementioned distance requirement qualify for LVH.⁷⁵

The LVH designation is not mutually exclusive; a hospital may have LVH and either MDH or SCH, in addition. (An SCH may not also be an MDH, and an MDH may not also be an SCH. As noted above, a CAH is mutually exclusive; a CAH cannot also be designated an SCH, MDH, or LVH.)

Medicare Dependent Hospitals

The Medicare dependent small, rural hospital designation provides for IPPS payment adjustments to assist certain hospitals that serve a high proportion of patients who are Medicare beneficiaries. MDH is a temporary designation, originally enacted by the Omnibus Reconciliation Act of 1989 (P.L. 101-239) and authorized for Medicare cost reporting periods April 1, 1990, through March 31, 1993. Congress has extended and modified the MDH designation multiple times since then. MDH is set to expire after September 30, 2024, if Congress does not extend the program or make it permanent.⁷⁶

⁷⁴ 42 U.S.C. §1395ww(d)(12). The current eligibility criteria and the payment adjustment were most recently extended by the Consolidated Appropriations Act, 2023 (P.L. 117-328), Title IV, Subtitle A, §4101. For a legislative history of the Medicare dependent hospital (MDH) designation, see CRS congressional distribution memorandum, *Legislative History of Medicare Rural Hospital Payment Designations: Low-Volume Hospital, Medicare Dependent Hospital, and Sole Community Hospital*, available to congressional clients upon request.

⁷⁵ 42 C.F.R. §412.101.

⁷⁶ The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) established the MDH designation as a temporary program. Congress has not made MDH permanent but has temporarily extended it multiple times. The MDH designation was most recently extended in the Consolidated Appropriations Act, 2023 (P.L. 117-328), Title IV, Subtitle A, §4102. For a legislative history of MDH, see CRS congressional distribution memorandum, *Legislative History of*

Currently, Medicare pays an MDH the IPPS base payment rate plus 75% of the difference between the IPPS base rate and the hospital's hospital-specific rate, constructed from either FY1982, FY1987, or FY2002 costs, whichever yields the greater payment.⁷⁷ In addition, Medicare adjusts the MDH payment to fully compensate for fixed costs that exceed a hospital's IPPS payment when inpatient volume declines by more than 5% in a given year.

To qualify as an MDH, a hospital must meet *all four* of the following criteria:

1. Be located in a rural area⁷⁸
2. Have no more than 100 beds
3. Not be designated a SCH
4. Have at least 60% of its inpatient days attributed to Medicare beneficiaries (for two of the three most recently audited cost reporting periods)⁷⁹

Sole Community Hospitals

The SCH designation was established in 1972, predating the hospital IPPS, to recognize hospitals that were the sole source of health care in a community.⁸⁰ The Social Security Amendments of 1972 (P.L. 92-603), Section 223, established limitations on Medicare's reasonable cost reimbursement; hospitals designated as SCHs were allowed to exceed those limits.⁸¹ The limit on cost increases, and therefore Medicare payment increases in a pre-IPPS environment, was thought to disadvantage some rural or geographically isolated hospitals.

Currently, Medicare may pay SCHs using an IPPS base payment rate that is constructed from a different cost reporting year than other IPPS hospitals. SCHs receive a base payment rate that is either the IPPS base rate or an SCH's hospital-specific rate constructed from its FY1982, FY1987, FY1996, or FY2006 costs, whichever yields the greater IPPS payment.⁸² In addition, Medicare adjusts payment to SCHs for costs that exceed the hospitals' IPPS reimbursement when inpatient volume declines by more than 5% in a given year. Further, SCHs receive a 7.1% increase to their Medicare hospital outpatient reimbursements.⁸³

Medicare Rural Hospital Payment Designations: Low-Volume Hospital, Medicare Dependent Hospital, and Sole Community Hospital, available to congressional clients upon request.

⁷⁷ A hospital's unique base rate is trended forward.

⁷⁸ See footnote 71 for the definition of *rural*. Similar to the sole community hospital (SCH) designation, if the geographic area where the MDH is located changes to urban due to a population shift, the MDH loses its designation. See 42 C.F.R. §412.108(b).

⁷⁹ 42 U.S.C. §1395ww(d)(5)(G).

⁸⁰ Hospital IPPS was enacted by the Social Security Act Amendments of 1983 (P.L. 98-21).

⁸¹ See Marc P. Freiman and Jerry Cromwell, "Reimbursement of Sole Community Hospitals Under Medicare's Prospective Payment System," *Health Care Financing Review*, vol. 9, no. 2 (winter 1987), p. 39, at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4192868/>.

⁸² 42 C.F.R. §412.92(d).

⁸³ CMS, *Hospital Outpatient Prospective Payment System*, January 2023, at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html#Hospital>.

Generally, a hospital is eligible for the SCH designation if it meets *one of the following four* criteria:

1. Be located more than 35 miles from another IPPS hospital
2. Be rural (i.e., not located in an urban area as defined by OMB), be located between 25 and 35 miles from another hospital, *and* meet *one* of the following:⁸⁴
 - Be the exclusive hospital provider in the area based on certain criteria related to the minimum proportion of residents or Medicare beneficiaries in the geographic area who become inpatients at that hospital
 - Have fewer than 50 beds and would have met the aforementioned requirement but for the fact that the hospital lacked the specialty care services needed by some residents or beneficiaries
3. Be rural and located between 15 and 25 miles from another hospital but inaccessible for at least 30 days in each of two out of three years due to local topography or periods of prolonged severe weather conditions
4. Be rural and at least 45 minutes from the nearest hospital due to distance, posted speed limits, and predicted weather conditions⁸⁵

⁸⁴ See footnote 71 for the definition of *rural*. If the basis for a hospital's SCH designation is that it is located in a rural area, and the area becomes urban due to a population changes, as determined by the Office of Management and Budget, the SCH must either meet the SCH "greater than 35 miles" from a like hospital criterion or lose the SCH designation. See 42 C.F.R. §412.92(b)(3)(ii)(D).

⁸⁵ 42 U.S.C. §1395ww(d)(5)(D)(iii).

Appendix B. Data, Methodology, and Limitations

To determine the closed, converted, merged, and new hospitals, the Congressional Research Service (CRS) used the American Hospital Association (AHA) dataset *AHA Hospital Universe Change Report*.⁸⁶ The report lists hospitals added or deleted from AHA DataQuery™ universe of hospitals each month based on changes reported to the AHA membership department.⁸⁷ The status change may be a result of a hospital opening, closing, merging, or no longer meeting the AHA definition of a hospital. AHA defines a hospital as follows:

Community hospitals are defined as all nonfederal, short-term general, and other special hospitals. Other special hospitals include obstetrics and gynecology; eye, ear, nose, and throat; long term acute-care; rehabilitation; orthopedic; and other individually described specialty services. Community hospitals include academic medical centers or other teaching hospitals if they are nonfederal short-term hospitals. Excluded are hospitals not accessible to the general public, such as prison hospitals or college infirmaries.

Other hospitals include nonfederal long-term care hospitals and hospital units within an institution such as a prison hospital or school infirmary. Long-term care hospitals may be defined by different methods; here they include other hospitals with an average length of stay of 30 or more days.⁸⁸

The basis of analysis for this report are hospitals with certain Medicare rural designations—Medicare dependent hospital (MDH), low-volume hospital (LVH), sole community hospital (SCH)—that also had a status change in the *AHA Hospital Universe Change Report*.⁸⁹

CRS performed a data match between the *AHA Hospital Universe Change Report* and multiple years of the Medicare IPPS Impact File.⁹⁰ This involved an intermediate step of matching the *AHA Universe Change Report* and the AHA Universe of U.S. Hospitals data to obtain the Medicare ID. Once the AHA change report hospitals had a Medicare ID, CRS matched the AHA change report dataset to the Medicare IPPS Impact File. For hospitals with the critical access designation that also had a status change, CRS used the variable identifying these types of hospitals in the AHA Universe of U.S. Hospitals.

The universe of status change hospitals was extracted from the *AHA Hospital Universe Change Report* data from January 1, 2018, through November 30, 2022. AHA compiles change report data by the 15th of each month for the previous month's data.

⁸⁶ AHA Hospital Universe Change Report is a dataset that contains hospitals that have been added or deleted from the American Hospital Association's (AHA) AHA DataQuery™ universe of hospitals database. It contains the reason for the addition or deletion; the reason for the addition or deletion is noted as resulting from a hospital opening, closing, merging, or downsizing from a hospital to another type of health care facility.

⁸⁷ The American Hospital Association (AHA) *Hospital Universe Change Report* does not reflect the status change of non-member hospitals. Thus, it is possible for a non-member hospital to be in the universe of hospitals from which AHA has collected data in its annual survey but not be in the change report.

⁸⁸ AHA, "Fast Facts on U.S. Hospitals, 2021," at <https://www.aha.org/statistics/fast-facts-us-hospitals>.

⁸⁹ This analysis does not include federal government-operated hospitals such as Departments of Defense, Veterans Affairs, and those operated or funded by the Indian Health Service.

⁹⁰ CRS used multiple years in the matching process to ensure hospitals that may have been in one year's file but not in another year's file were not erroneously excluded from the analysis. CRS used fiscal year 2016 through 2022 Medicare Inpatient Prospective Payment System (IPPS) Impact File data. CMS publishes the Impact File annually; it contains information about short-term acute care hospitals, most of which are paid by Medicare under the IPPS. For each hospital, it contains information such as name, number of beds, average daily census, ownership type, and eligibility for certain IPPS payment adjustments such as Medicare Disproportionate Share Hospital (DSH).

A separate analysis was required to identify the *total* number of hospitals with a certain rural designation that were operational at some point between 2018 and 2022. This number would include hospitals with and without a status change.⁹¹ CRS used the 2018-2022 Medicare IPPS Impact Files and the 2018-2022 Flex Monitoring Team files of CAHs for this analysis.⁹² The 2018-2022 Medicare IPPS Impact Files were appended together, and then the unique hospitals over this period were identified using their Medicare IDs. CRS identified the total number of hospitals with the MDH and SCH rural designations using the Medicare IPPS Impact File variable that identifies the type of rural designation of each hospital. CRS used this same variable to isolate non-designated hospitals in the Medicare IPPS Impact File (labeled “inpatient prospective payment system” or “IPPS” hospitals). Then, CRS used the variable that identifies the number of beds in a hospital to determine if the hospital was *small* or *large*.⁹³ CRS used the Urban or Rural Designation for the Standardized Payment Amount (URSPA) variable to identify whether a hospital is urban or rural.⁹⁴ These variables together comprise the “IPPS, Other Non-designated” and “IPPS Small, Rural” categories. CRS used a separate variable from the Medicare IPPS Impact File to identify hospitals that have the LVH designation.⁹⁵

The total number of CAHs that were operational between 2018 and 2022 was determined using the FLEX Monitoring Team CAH files. For this analysis, CRS appended the quarterly CAH files between 2018 and 2022 and then identified each unique CAH, using a combination of the hospital name, ZIP code, and state.

This analysis and the nature of the multiple data sources make it difficult to identify causation or correlation. Thus, CRS can identify differences between the types of hospitals by change status but cannot determine why these differences exist and whether the differences are significant. For example, CRS cannot determine whether the differences are due to the characteristics that are unique to a particular rural designation, be it volume-based (e.g., LVH) or a higher proportion of Medicare patients (e.g., MDH). CRS also cannot determine whether these differences relate to the unique structure of Medicare payments of each of the designations. In addition, CRS cannot determine from this analysis how effective any of the Medicare rural hospital designations are in, for example, preventing or delaying a closure or a conversion.

This analysis covers the time period that includes the Coronavirus Disease 2019 (COVID-19) public health emergency (PHE) declared on January 31, 2020, which is still in effect as of the publication date of this report.⁹⁶ In response to the PHE, Congress created two programs—the Provider Relief Fund and the American Rescue Plan Rural Distribution—that provided supplemental funding to rural hospitals; these programs may have prevented or delayed a status

⁹¹ Specifically, these numbers were used to determine the percentages in the “All Hospitals” column of **Figure 1**.

⁹² The FLEX Monitoring Team is an academic consortium funded by the Federal Office of Rural Health Policy. It compiles critical access hospital data and publishes analyses.

⁹³ This report defines a *small* hospital as one with less than 100 beds.

⁹⁴ There is no standard definition of rural or urban across federal programs. For purposes of Medicare payments to hospitals, a hospital is *urban* when it is located in (or reclassifies into) a metropolitan statistical area (MSA) and *rural* when it is located in (or reclassifies into) a non-MSA. For further information about geographic adjustments to the IPPS payment, referred to as the wage index adjustment, see CRS Report R46702, *Medicare Hospital Payments: Adjusting for Variation in Geographic Area Wages*.

⁹⁵ In both the status change analysis and the analysis of the overall number of designated hospitals, it is possible for a hospital to be designated as a low-volume hospital and either a Medicare dependent hospital or a sole community hospital. One designation was not chosen over another (i.e., recoding a low-volume hospital as a Medicare dependent hospital) to show the true number of hospitals with a certain designation.

⁹⁶ CRS Report R46809, *Federal Emergency and Major Disaster Declarations for the COVID-19 Pandemic*.

change. This time period may be anomalous. Whether this proves to be true will be examined in future CRS analyses.⁹⁷

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⁹⁷ CRS Report R46897, *The Provider Relief Fund: Frequently Asked Questions*.