

**BELLING THE CAT: IMPLEMENTATION OF A PROSPECTIVE
PAYMENT REIMBURSEMENT SYSTEM FOR CRITICAL ACCESS
HOSPITALS, ITS LIKELY SUCCESS, AND POLITICAL
IMPLICATIONS OF THIS POLICY MOVE**

Health care is plagued by inefficient reimbursement policies which encourage expensive financial waste with little incentive to maintain care quality. Though no perfect solution exists, effective remedies may require a hard look at programs so far untouched by policy changes. This article discusses the application of a prospective payment system of reimbursement for critical access hospitals, as well as how this policy change would affect rural health care access, costs, and quality of care. Though some fear prospective payment systems of reimbursement would cripple rural health care, evidence shows it would likely promote more cost-efficient care without diminishing quality or outcomes. Further, there are a number of steps critical access hospitals may take to ensure survival and profitability, and in considering the need for more responsible health care spending, such a change may eventually prove necessary.

I. INTRODUCTION

A notable fable¹ depicts a council of mice congregating secretly to discuss measures they could take to outwit their longstanding enemy—the household cat—which had the frightening propensity of silently sneaking up on the mice, remaining undetected until it had captured its unwary victims. Many potential remedies were discussed; however, one mouse brilliantly ventured that the problem might be solved by using a ribbon to attach a small bell to the cat’s neck, providing warning to the mice when the cat approached. Amid the congregation’s applause upon hearing this plan, an old mouse stood and remarked, “That is all very well, but who is to bell the [c]at?”²

For policymakers, changes in provider reimbursements often echo the old mouse’s concerns—though necessary, no policymaker wishes to be the first to “bell the cat” that might swallow his or her political career. With the federal health care budget soaring at unprecedented levels, policymakers have gradually shifted health care providers from systems of reasonable cost reimbursement (RCR) to a prospective payment system (PPS). These efforts have aimed to curb health care costs and encourage providers to offer more efficient, cost-effective care. However, for financial and political reasons, critical access hospitals (CAHs) have escaped this political migration. Though evidence demonstrates a move would likely be successful in creating a more efficient, cost-effective rural health system, many providers claim a change to PPS would leave America’s most vulnerable rural populations with no access to care.³ This concern is valid. However, this article demonstrates that it is not insurmountable and that the rural health care system, in the long run, would likely benefit from such a change.

This article analyzes the proposal to shift CAHs to PPS reimbursement, as well as the practical and political effects of such a switch on rural health care provision. First, Section II outlines the history of the PPS reimbursement, the CAH exception to this system, and why this exception was created. Section III examines the proposed move of CAHs to PPS reimbursement, the fears and risks accompanying the policy proposal, and how such a switch would affect CAHs based on evidentiary studies. Finally, Section IV discusses the very real challenges of a move to PPS for CAHs and how these should be addressed by policymakers and health care providers to ensure not only survival but also financial viability and enhanced quality of care. Ultimately, this article demonstrates that a switch to PPS would not prove the crippling blow to CAHs

1. Aesop, *Aesop’s Fables, Retold by Joseph Jacobs*, in HARVARD CLASSICS (Charles W. Eliot & Joseph Jacobs eds., 1909), <http://www.bartleby.com/17/1/67.html>.

2. *Id.*

3. Michelle M. Casey et al., *Minimum-Distance Requirements Could Harm High-Performing Critical-Access Hospitals and Rural Communities*, 34 HEALTH AFF. 627, 633 (2015).

as predicted; CAHs would not only survive, but would adapt to provide more cost-effective, quality care.

II. THE HISTORY OF THE CAH SYSTEM AND ITS IMPLEMENTATION

In the battles for policy change, rural health care has historically escaped the brutal fray of budget cuts, enhanced conditions of participation, reimbursement rate reductions, practice regulations, and staffing requirements.⁴ This is particularly true for more vulnerable hospitals such as CAHs, which traditionally maintain thin financial margins,⁵ bear heavier percentages of low-income individuals and sicker populations,⁶ and lack the ability to shift losses to privately covered individuals.⁷ Additionally, rural populations are much less likely to have health insurance.⁸ Though the majority of American hospitals receive PPS reimbursement,⁹ it has long been recognized that rural hospitals provide access to health care for some of America's most vulnerable populations, and thus policy has tended to favor their survival through generous reimbursement policies.¹⁰ To understand how a switch to PPS reimbursement would affect CAHs and their care provision, it is important to provide some background context on CAHs and PPS reimbursement.

A. CAHs and Their Role in Rural Health Care Delivery

CAHs were created as a measure to counteract a series of rural hospital closures, which sparked concerns that legislative action was needed to reduce the financial vulnerability of these hospitals and ultimately to save rural health

4. See, e.g., 42 U.S.C. § 1395x(v)(1)(S)(ii)(III) (2012) (showing that recent across-the-board payment reductions for outpatient hospital services were held inapplicable to community hospitals and critical access hospitals). See also generally Act of Dec. 13, 1977, Pub. L. No. 95-210, 91 Stat. 1485 (Medicare-certified Rural Health Clinics (RHCs)).

5. See NAT'L RURAL HEALTH RESOURCE CTR., CRITICAL ACCESS HOSPITAL 2012 FINANCIAL LEADERSHIP SUMMIT 6 (2012), <https://www.ruralcenter.org/tasc/resources/critical-access-hospital-2012-financial-leadership-summit-summary>. Compare these margins with total aggregate hospital profit margins, which generally remain above four percent. AM. HOSP. ASS'N, TRENDWATCH CHARTBOOK 2016: TRENDS IN HOSPITAL FINANCING tbl. 4.1 (Sept. 1, 2016), <http://www.aha.org/research/reports/tw/chartbook/2016/chapter4.pdf>.

6. Jin Young Choi, *A Portrait of Rural Health in America*, 27 J. RURAL SOC. SCI. 1, 2 (2012).

7. *Id.* at 4.

8. *Id.*

9. See generally 42 C.F.R. §§ 412.20 to .30 (2015).

10. See 42 C.F.R. § 419.20(b)(2) (2015) ("Critical access hospitals (CAHs) are excluded from the hospital outpatient prospective payment system.").

care from collapse.¹¹ In an attempt to salvage the rural health care system, Congress enacted legislation as part of the Balanced Budget Act of 1997 that allowed states to designate certain rural hospitals as CAHs.¹² Under CAH designation, hospitals receive more favorable Medicare reimbursement rates¹³—they are reimbursed at 101% of all reasonable costs¹⁴ “for outpatient, inpatient, laboratory and therapy services, as well as post-acute care in . . . hospital[] swing beds.”¹⁵ Unlike traditional PPS, these costs are not based on the type or number of services provided.¹⁶

Hospitals must meet and maintain compliance with certain legal criteria to gain CAH status.¹⁷ Among these, a hospital must: (1) be a nonprofit or public hospital located in a rural county or more than a thirty-five mile drive (or a fifteen mile mountainous drive) away from another hospital;¹⁸ (2) maintain twenty-four hour emergency care services;¹⁹ (3) have no more than twenty-five acute care inpatient beds, for which each individual stay is not to exceed a period of ninety-six hours (unless exempted or waived);²⁰ and (4) meet staffing

11. *Critical Access Hospitals (CAHs)*, RURAL HEALTH INFO. HUB, <https://www.ruralhealthinfo.org/topics/critical-access-hospitals> (last modified Apr. 8, 2015) [hereinafter RURAL HEALTH].

12. *Id.*

13. *See generally* CTRS. FOR MEDICARE & MEDICAID SERVS., ICN 006400, RURAL HEALTH SERIES: CRITICAL ACCESS HOSPITAL (Feb. 2016).

14. “Reasonable cost,” in part, is defined as follows:

The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs.

42 U.S.C. § 1395x(v)(1)(A) (2012). The Secretary is given the discretion to define “reasonable cost” as well as the “items to be included” under such reasonable costs. *Id.*

15. MEDPAC, CRITICAL ACCESS HOSPITALS PAYMENT SYSTEM I (Oct. 2016).

16. *Id.*

17. Balanced Budget Act of 1977, Pub. L. No. 105-133 § 4201, 111 Stat. 370. *See also* CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 13; *Critical Access Hospitals*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcompliance/cahs.html> (last modified Apr. 9, 2013).

18. 42 C.F.R. § 485.610 (2011) (“Condition of participation: Status and location”).

19. 42 C.F.R. § 485.618 (2016) (“Emergency services”).

20. 42 C.F.R. § 485.620 (“Number of beds and length of stay”).

requirements for hospitals located in rural areas, with certain exceptions,²¹ as well as requirements for Medicare participation.²² The hospital must also currently participate in Medicare.²³

In addition to conditions of participation,²⁴ conditions of payment also apply. These conditions of payment apply differently to inpatient and outpatient services. To receive payment for inpatient services, covered under Medicare Part A, a physician must provide a certification that includes: (1) an order in which the physician reasonably expects the patient to require a stay crossing two midnights, which involves medically necessary inpatient services;²⁵ (2) the reason for inpatient services;²⁶ (3) estimated time the patient will require in the hospital;²⁷ (4) plans for post-hospital care (if necessary);²⁸ and (5) certification that the patient is reasonably expected to be discharged or transferred within ninety-six hours of admission.²⁹

For outpatient services, CAHs may be paid under one of two methods. Under the Standard Payment Method, a CAH receives 101% of reasonable costs for CAH outpatient facility services.³⁰ If the CAH chooses to opt out of the Standard Payment Method, it may choose reimbursement under the Optional Payment Method, which permits reimbursement of reasonable costs

21. 42 C.F.R. § 485.631 (“Staffing and staff responsibilities”).

22. Balanced Budget Act of 1997, Pub. L. 105-33, 111 Stat. 370 (1997) (*codified as amended* at 42 U.S.C. 1395i-4 (2010)); 42 C.F.R. § 485.601-647.

23. 42 C.F.R. § 485.635 (“Condition of participation: Provision of services”); 42 C.F.R. § 485.612 (“Condition of Participation: Compliance with Hospital Requirements at the Time of Application”). *See also* CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 13.

24. In addition to the above-mentioned conditions of participation, other conditions of participation also apply. *See* 42 C.F.R. § 485.627 (dealing with the organizational structure and government of the CAH); 42 C.F.R. § 485.616 (noting the necessity of agreements with at least one other hospital in the case that the CAH is part of a rural health network); 42 C.F.R. § 485.641 (describing quality assurance review); 42 C.F.R. § 485.638 (providing standards for maintaining clinical records); 42 C.F.R. § 485.639 (listing requirements regarding surgical safety); 42 C.F.R. § 485.643 (providing requirements regarding tissue procurement protocols); 42 C.F.R. § 485.645 (noting special requirements for CAHs providing long-term care services); and 42 C.F.R. § 485.647 (describing special requirements for CAHs providing psychiatric and rehabilitation units). However, these conditions of participation are either requirements generally applied to hospitals (both CAH and non-CAH), or are not applied to all CAHs. *See, e.g.*, 42 C.F.R. §§ 485.639, 485.643, 485.645, 485.647.

25. *Fact Sheet: Two-Midnight Rule*, CTRS. FOR MEDICARE & MEDICAID SERVS. (July 1, 2015), <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-07-01-2.html>.

26. 42 C.F.R. § 424.13(a)(1) (2015).

27. *Id.* § 424.13(a)(2).

28. *Id.* § 424.13(a)(3).

29. 42 C.F.R. § 424.15(a) (2015). *See also* CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 13, at 3.

30. 42 U.S.C. § 1395m(g)(1) (2015).

of facility services plus 115% for professional services if the physician or practitioner has reassigned his or her billing rights to the CAH.³¹

CAHs may also be reimbursed for ambulance transportation if the CAH is the sole provider or supplier of ambulance transports located within a thirty-five mile drive of the CAH and, if there is no other provider or supplier of ambulance supports within a thirty-five mile drive, the CAH owns and operates an entity furnishing ambulance transports that is more than a thirty-five mile drive from the CAH if that ambulance provider is the closest provider to the CAH.³²

Currently, there are 1,332 certified CAHs throughout the United States,³³ mostly concentrated in northern, rural states.³⁴ Since the implementation of the Rural Hospital Flexibility Program, CAHs have fared with notable success, though they have generally maintained thinner margins than normally experienced by urban hospitals.³⁵ Rural hospitals also face more challenges than their urban counterparts.³⁶ Twenty-three percent of the population,³⁷ or about 60,000,000 individuals,³⁸ live in rural areas, and rural residents tend to be older,³⁹ with more health problems,⁴⁰ and lower incomes.⁴¹ Rural residents

31. *Id.* § 1395m(g)(2).

32. *Id.* § 1395m(l)(8). *See also* CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 13, at 4.

33. RURAL HEALTH, *supra* note 11.

34. GOV'T ACCOUNTABILITY OFFICE, MEDICARE: LEGISLATIVE MODIFICATIONS HAVE RESULTED IN PAYMENT ADJUSTMENTS FOR MOST HOSPITALS 24–26 (Apr. 2013) (noting that CAHs are predominantly located in the central states; in 2012, North Dakota and Montana had the largest percentage of hospitals designated as CAHs at eighty-four and seventy-nine percent, respectively).

35. THE NAT'L ADVISORY COMM. ON RURAL HEALTH, A TARGETED LOOK AT THE RURAL HEALTH CARE SAFETY NET 9–10, 19 (Apr. 2002), (explaining that rural hospitals are less able to balance financial losses by shifting costs to third-party payers, largely due to the significant number of uninsured patients rural hospitals typically cover).

36. AM. HOSP. ASS'N, *supra* note 5, at 1.

37. *Id.* at 2.

38. H.R. 3225, 116th Cong. (2015).

39. Currently, rural America is home to more than fifty-nine million people. Choi, *supra* note 6, at 1. Of these individuals, a disproportionate number are elderly. *See* M.K. Miller et al., *Rural Populations and Their Health*, in RURAL HEALTH SERVICES: A MANAGEMENT PERSPECTIVE 3, 9–10 (Joyce E. Beaulieu & David E. Berry eds., 1994). “More than seventeen percent of rural individuals are sixty-five or older, versus thirteen percent of the total United States population.” Choi, *supra* note 6.

40. Choi, *supra* note 6 (noting that rural areas experience significantly greater health care needs than the general United States population, as rural residents tend to have much poorer health than urban residents. Chronic health conditions such as diabetes and cardiovascular disease are much more common, as well as obesity, mental illness, and disability). *See also* *The Affordable Care Act – What It Means for Rural America*, HHS.GOV (Sep. 30, 2013), <http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/what-aca-means-for-rural-america/index.html>.

are also more likely to be uninsured⁴² or to receive coverage under Medicare and Medicaid.⁴³ Because nearly sixty percent of gross revenues to rural hospitals come from Medicare and Medicaid, CAHs are also particularly sensitive to policy changes, especially regarding reimbursement rates.⁴⁴ Persistent physician shortages in rural areas only emphasize financial strains.⁴⁵ “Seventy-seven percent of rural counties . . . are designated as primary care health professional shortage areas while [nine] percent [of rural counties] have no physicians at all.”⁴⁶ However, the CAH system has mitigated some of the unique struggles faced by rural providers.

Though the CAH program has afforded many benefits to rural health systems in light of the unique challenges they face, the rising costs of rural health care, as well as the lack of incentives for providing cost-effective care under RCR, have raised persistent doubts about the CAH program’s effectiveness. These benefits and detriments are highlighted next.

1. The Benefits of CAHs in Rural Health Care Provision

The CAH system has undeniably benefited struggling rural hospitals. The most prominent benefit is financial. Not only has the 101% reimbursement rate

41. High uninsurance rates are exacerbated by the lower income levels typically found in rural areas; the average per capita rural income is \$28,781 versus the \$40,570 found in urban areas. *See Choi, supra* note 6. Rural counties also comprise eighty-one percent of counties designated as suffering persistent child poverty, and one-fourth of the nonelderly rural population has a family income below poverty level. *Id.*

42. AM. HOSP. ASS’N, *supra* note 5, at 2. *See also* Jon M. Bailey, *The Top 10 Rural Issues for Health Care Reform*, CTR. FOR RURAL AFF., Mar. 2009, at 1, 1 (individuals are less insured and thus more dependent on the insurance market); Jennifer Lenardson et al., *Health Insurance Profile Indicates Need to Expand Coverage in Rural Areas*, in RURAL HEALTH RES. & POL’Y CTRS., CHALLENGES FOR IMPROVING HEALTH CARE ACCESS IN RURAL AMERICA 11, 11 (2009-2010) (the rate of uninsured is as high as twenty-three percent, compared to the nineteen percent rate found in urban areas; these rates have not changed since 1997).

43. Choi, *supra* note 6, at 4.

44. AM. HOSP. ASS’N, *supra* note 5, at 4.

45. RURAL HEALTH IN THE UNITED STATES vii (Thomas C. Ricketts, III ed., 1999) (showing that even though rural Americans comprise twenty percent of the nation’s population, only nine percent of physicians practice in rural areas. Additionally, rural patients tend to utilize physicians less frequently and consequently tend to have longer rates of hospital stays). Rural areas also face difficulties in attracting medical staff; physicians and other health professionals are retained at historically low rates. *See* Senator Craig Thomas, *Understanding Rural Health Care Needs & Challenges: Why Access Matters to Rural Americans*, 43 HARV. J. ON LEGIS. 253, 257 (2006). Hospital vacancies for registered nurses, radiology technicians, and pharmacists are all greater than ten percent. *Id.* Moreover, one in seven hospitals face severe nursing shortages; more than twenty percent of nursing positions have not been filled. *Id.* One of the reasons for this difficulty in attracting medical staff is the isolation inherent in rural areas; this has been somewhat mitigated through the construction of rural health networks. *Id.*

46. H.R. 3225, 116th Cong. (2015).

afforded the ability to provide care in areas otherwise inaccessible to hospitals, higher reimbursement rates for telehealth services at CAHs have allowed even more extensive access to care for isolated and elderly rural residents.⁴⁷ Furthermore, CAHs receive reimbursement for 101% of the costs of training full-time equivalent residents in approved residency training programs at the CAH, which has allowed smaller hospitals to recruit and train vital health care professionals.⁴⁸ Similarly, pass-through exemptions allow for CAHs to be paid at RCR rates for certified registered nurse anesthetist services, which give CAHs funds needed to attract these vital professionals to practice in designated health professional shortage areas (HPSAs).⁴⁹ In certified HPSAs, physicians may receive a ten percent bonus payment for outpatient professional services furnished to a Medicare patient.⁵⁰ Finally, CAHs may receive generous grants of up to \$50,000 from the Secretary of the Department of Health and Human Services⁵¹ for planning and implementing rural health care plans,⁵² establishing or expanding rural emergency health services,⁵³ or technologically upgrading various hospital systems.⁵⁴ These financial benefits have provided enormous aid to smaller, geographically isolated hospitals.⁵⁵

Furthermore, CAHs have successfully invested these financial benefits back into their communities⁵⁶ by contributing significantly to local economic sustainability. For example, one city in Kentucky demonstrated the pronounced success of the CAH system by examining the difference in impact on the local community both before and after the conversion of local hospitals to CAH status.⁵⁷ Investments poured into funding local CAHs, which ultimately exhibited successful rates of return between 1.20 and 1.55 times for total local industry output, 1.23 to 1.64 times for employment levels, and 1.12 to 1.48 times for income levels.⁵⁸ Accordingly, the rate of return on an investment in

47. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 13, at 6 (noting that Medicare is to reimburse designated providers for eighty percent of the costs of telehealth services utilized). *See also generally* DEP'T OF HEALTH & HUMAN SERVS., TELEHEALTH SERVICES 2 (2015).

48. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 13, at 2.

49. *Id.* at 7. *See also* CTRS. FOR MEDICARE & MEDICAID SERVS., CMS MANUAL SYSTEM: PUB 100-04 MEDICARE CLAIMS PROCESSING: TRANSMITTAL 2719 (2013).

50. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 13, at 2.

51. 42 U.S.C. § 1395i-4(g)(3)(D) (2016).

52. *Id.* § 1395i-4(g)(1).

53. *Id.* § 1395i-4(g)(2).

54. *Id.* § 1395i-4(g)(3).

55. ILL. CRITICAL ACCESS HOSP. NETWORK, THE ECONOMIC IMPACT OF THE CRITICAL ACCESS HOSPITAL PROGRAM ON ILLINOIS COMMUNITIES 9 (2006).

56. *See* Lucia Ona & Alison Davis, *Economic Impact of the Critical Access Hospital Program on Kentucky's Communities*, 27 J. RURAL HEALTH 21, 22–23 (2011).

57. *Id.* at 25.

58. *Id.*

converting hospitals to CAHs greatly exceeded its costs.⁵⁹ These benefits extended statewide, as the new CAH system created approximately 6,410 jobs, along with \$668.9 million in revenues.⁶⁰

Finally, in the face of physician shortages in rural areas, CAH status makes higher levels of staffing in rural hospitals more affordable, thus helping to alleviate physician shortages and to allow for more patients to access medical care than customarily available in rural areas.⁶¹ CAHs also demonstrate a level of care at least as good as other rural hospitals, with high ratings for quality of care, culture of safety, and work environment, and their nursing staff tend to have more experience than other rural hospitals.⁶²

However, even in consideration of the benefits, a number of detriments to CAH policy remain. Not only is the CAH program cost ineffective, but also it may have parted from its original purpose in a way that will be self-defeating if no policy changes are made.

2. The Detriments of CAH Designation

The detriments brought about by the CAH designation, like the benefits, are significant. History has shown that RCR promotes more inefficient behavior and less responsibility in cost management by providers.⁶³ Furthermore, the CAH program as enacted today no longer corresponds with the original intentions of the program originally designed by Congress, exacerbating the problems of inefficiency and cost management.

RCR has played a large role in promoting higher levels of inefficiency and less responsibility in managing costs. When determining reimbursement mechanisms for health care providers, Congress “believed that payment mechanisms should (1) increase efficiency, (2) preserve financial viability of efficient providers, (3) support access to high-quality care, and (4) make

59. *See id.*

60. *Id.*

61. ILL. CRITICAL ACCESS HOSP. NETWORK, *supra* note 55, at 19. *See also and compare* 42 C.F.R. § 485.604 (2014) (adding clinical nurse specialists as qualified staff to perform clinical services at CAHs under the law), *with* Personnel Qualifications, 77 Fed. Reg. 29060 (May 16, 2012) (to be codified at 42 C.F.R. § 485.604) (noting that the Conditions of Participation for CAHs were revised to allow clinical nurse specialists to practice at CAHs).

62. Marianne Baernholdt et al., *A Comparison of Quality of Care in Critical Access Hospitals and Other Rural Hospitals*, 14 ONLINE J. RURAL NURSING AND HEALTH CARE 3, 15, 19, 21 (2014), <http://rnojournals.binghamton.edu/index.php/RNO/article/view/328>.

63. Justin Cristian Nedelea & James Matthew Fannin, *Impact of Conversion to Critical Access Hospital Status on Hospital Efficiency*, 47 SOCIO-ECON. PLAN. SCI. 258, 264 (2013). *See also* Michael D. Rosko & Ryan L. Mutter, *Inefficiency Differences Between Critical Access Hospitals and Prospectively Paid Rural Hospitals*, 35 J. HEALTH POL., POL'Y & L. 95, 118 (2010) (noting that CAHs tend toward inefficiency because they do not suffer the same financial losses for high costs that are faced by non-CAHs under PPS reimbursement; when costs increase, CAHs are simply paid more).

equitable payments.”⁶⁴ Congress felt PPS did not encourage hospitals to meet the second and third criteria, and it endeavored to structure the CAH payment system to promote efficiency and quality care.⁶⁵ However, the implementation of CAHs may have worked against the best of intentions. Once hospitals converted to CAH status, they tended to become less efficient in managing costs and allocating resources.⁶⁶ For some hospitals, cost inefficiency increased as much as 21.85%.⁶⁷

Such inefficiencies drive up per-visit health care costs. For example, when given the choice of two comparable treatments, the cost-efficient doctor will choose the less costly of the two if the treatments are expected to have similar outcomes.⁶⁸ However, in a cost-inefficient system, doctors will have no incentive to choose the less costly method and will often choose the more expensive of the two—a tendency that is exaggerated when the costs are fully

64. Rosko & Mutter, *supra* note 63, at 119.

65. *Id.*

66. Nedelea & Fannin, *supra* note 63, at 259 (showing that here, technical efficiency reflected “the relationship between inputs used (i.e., capital and labor) and outputs produced (i.e., outpatient visits, inpatient days, surgeries, etc.). Allocative efficiency reflect[ed] the ability of a hospital to produce a given level of outputs using the optimal combination of inputs (i.e., cost-minimizing), given input prices. A hospital [was considered] (overall) cost efficient when it [was] both technically and allocatively efficient . . . indicat[ing] the extent to which the hospital minimize[d] the cost of producing a specific level of outputs, given input prices.”). *See also* Rosko & Mutter, *supra* note 63. The authors took into consideration that this inefficiency could have been “a reflection of more cost-inefficient hospitals choosing to convert to CAH status.” However, this inefficiency held even when the studied CAHs were compared to their pre-CAH performance. *Id.* Furthermore, these comparisons still showed an increase in inefficiency over time as CAHs participated in cost-based reimbursement. *See id.* Conversely, it is significant to note that there was a negative, i.e., inverse relationship, between PPS reimbursement and efficiency, suggesting that non-CAH hospitals participating in PPS reimbursement were incentivized financially to achieve higher levels of cost efficiency. *Id.* *See also* Shrinivas Gautam et al., *Measuring the Performance of Critical Access Hospitals in Missouri Using Data Envelopment Analysis*, 29 J. RURAL HEALTH 150, 156 (2013). Finally, it must be noted that inefficiency is an amorphous concept and difficult to both define and measure. *See* ACADEMY HEALTH, EFFICIENCY IN HEALTH CARE: WHAT DOES IT MEAN? HOW IS IT MEASURED? HOW CAN IT BE USED FOR VALUE-BASED PURCHASING? 2–3 (2006).

67. Rosko & Mutter, *supra* note 63, at 115 (stating that hospitals that had participated in the CAH program for one year had a mean cost inefficiency of 13.33%, which increased each year until the seventh year—when the maximum recorded inefficiency was 21.85%—and then declined slightly to a mean of 20.24%).

68. GARY ROBBINS ET AL., NAT’L COMM. PHARMACISTS ASS’N, NCPA POL’Y REP. NO. 182, INEFFICIENCIES IN THE HEALTH CARE SYSTEM: WHAT CAN WE DO? 1 (April 1994). Such inefficiencies arise, in part, because of our dependence on third parties to pay the medical bill, which encourages overuse, as well as the fact that third-party reimbursement may provide less coverage for lower-cost treatment options, distorting prices in a way that make the costlier option appear more affordable to the patient. *Id.* at 1–3.

covered, as in an RCR system.⁶⁹ In such systems, doctors have no incentive to consider the additional cost of using a more expensive product or of utilizing expensive inpatient hospital stays rather than outpatient facilities, raising health care costs both for the patient and the third-party payer.⁷⁰ Consequently, cost-based reimbursement has served as a driver for escalating health care costs,⁷¹ and history shows that the CAH program has not been a valuable program in terms of promoting cost-efficiency.⁷² Competition among CAHs only exacerbates these inefficiencies,⁷³ and with the high level of competition⁷⁴ currently facing CAHs, there may be more room for efficiency improvement than presently indicated by CAHs' thin financial margins.⁷⁵

In addition to the unnecessarily costly practices exhibited by CAHs, these hospitals may have also drifted from their original design to the point where many CAH-designated hospitals no longer fulfill their purpose as intended. The CAH certification program was originally created to ensure that vulnerable rural beneficiaries could obtain access to health care services.⁷⁶ To ensure that it fulfilled this purpose and did not extend beyond the services required by these vulnerable populations, the thirty-five mile rule was created,

69. *Id.* at 1.

70. *Id.* at 4.

71. Julie Barnes, *Moving Away from Fee-for-Service*, ATLANTIC (May 7, 2012), <http://www.theatlantic.com/health/archive/2012/05/moving-away-from-fee-for-service/256755/>.

72. I. Cristian Nedelea and J. Matthew Fannin, *Analyzing Cost Efficiency of Critical Access Hospitals*, 35 J.P. MODELING 183, 193 (2013). *See also* Asa B. Wilson et al., *Financial Performance Monitoring of the Technical Efficiency of Critical Access Hospitals: A Data Envelopment Analysis and Logistic Regression Modeling Approach*, 57 J. HEALTHCARE MGMT. 200, 206 (2012) (noting that only eighteen of 183 studied CAHs were operating efficiently). *See also generally* Rosko & Mutter, *supra* note 63 (concluding that inefficiency increased as length of participation in the CAH program continued).

73. *See* Rosko & Mutter, *supra* note 63, at 95, 114 (noting that price-based competition tends to lower cost inefficiency). Though this is true for most health care organizations, which under the Affordable Care Act rely on cost-efficiency to sustain profit margins, RCR tends to increase inefficiency in CAHs by minimizing the incentives to reduce costs that comes with price competition. *See* I. Cristian Nedelea et al., Selected Paper Presentation at the S. Agric. Econ. Ass'n Annual Meeting: Cost Efficiency of Critical Access Hospitals 3 (2010). When cost is not an issue, hospitals tend to engage in service-based competition rather than price-based competition; such hospitals in more competitive settings employ costlier capital and equipment, incurring higher costs. *Id.* at 16–17. CAH competition, due to the receipt of cost-based reimbursement, mimics service-based competition rather than the more cost-efficient price-based competition. *Id.*

74. *See generally* DEP'T OF HEALTH & HUMAN SERVS., OFFICE OF INSPECTOR GEN., MOST CRITICAL ACCESS HOSPITALS WOULD NOT MEET THE LOCATION REQUIREMENTS IF REQUIRED TO RE-ENROLL IN MEDICARE (Aug. 2013) (concluding that a great number of CAHs would not meet the distance requirement if required to re-enroll, and therefore, face high levels of competition with nearby CAHs).

75. Wilson et al., *supra* note 72, at 209–10.

76. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 74, at 1.

requiring that each CAH be located not less than thirty-five miles from the nearest hospital.⁷⁷ However, from 1997 until 2006, Congress permitted a waiver of this distance requirement for hospitals deemed medically necessary to local populations.⁷⁸ This waiver of the rule led to an explosion of CAHs,⁷⁹ creating competition detrimental to CAH functioning. Today, CAHs represent approximately twenty-five percent of acute care hospitals in the United States.⁸⁰ This competition has led to financial struggles as CAHs have struggled to maintain sufficient patient flow and adequate payer mix⁸¹ to cover their costs. Furthermore, the large number of CAHs has led to a rural health care environment more focused on competition to bring in sufficient patients rather than the provision of care intended—a wasteful focus when cost-efficiency has become the presumption in federal reimbursement policies.

Such cost inefficiencies and the failure to adhere to the original purpose of the CAH designation have led Congress to reconsider PPS reimbursement as an option for CAHs.⁸² These considerations have been heightened by unsustainable rises in health care costs, as well as requests for budget cuts for Medicare reimbursement programs.⁸³ The predominant fear of switching CAHs to a prospective payment method of reimbursement is that the CAHs would not survive this switch, leaving the most vulnerable populations in America with no access to health care.⁸⁴ This next section explores the benefits and challenges of switching to a PPS for CAHs, as well as the difficulties that would arise politically should such a system be proposed and the potential solutions for addressing these difficulties.

77. *Id.*

78. *Id.* at 3.

79. *Id.*

80. RURAL POL'Y RESEARCH INST. HEALTH PANEL, CTRS. FOR MEDICARE & MEDICAID SERVS. VALUE-BASED PURCHASING PROGRAM AND CRITICAL ACCESS HOSPITALS 2 (Jan. 2009).

81. *See generally* GA. STATE OFFICE OF RURAL HEALTH, CRITICAL ACCESS HOSPITAL FINANCIAL ANALYSES – 2009 3 (June 2010). This situation exemplifies the struggles CAHs face when located too close to commercial health care organizations; here, the commercial organizations tend to attract privately insured patients, while the remainder of the population—usually containing a higher proportion of uninsured—tends to utilize CAH services. *Id.*

82. *See* CONGRESSIONAL BUDGET OFFICE, REDUCING THE DEFICIT: SPENDING AND REVENUE OPTIONS 53 (Mar. 2011) [hereinafter REDUCING THE DEFICIT]. *See also generally* NAT'L HEALTH ADVISORY COMM. ON RURAL HEALTH AND HUMAN SERVS., IMPLICATIONS OF PROPOSED CHANGES TO RURAL HOSPITAL PAYMENT DESIGNATIONS (Dec. 2012) [hereinafter NAT'L HEALTH ADVISORY COMM.].

83. AHA SECTION FOR SMALL OR RURAL HOSPS., CAH UPDATE 1–3 (2015).

84. NAT'L HEALTH ADVISORY COMM., *supra* note 82, at 2; REDUCING THE DEFICIT, *supra* note 82.

III. A BRIEF HISTORY OF PPS REIMBURSEMENT, THE CAH EXEMPTION, AND THE OVER-DEPENDENCY OF CAHS ON RCR

CAHs were created as an exception to traditional PPS reimbursement in order to provide rural services to more vulnerable, isolated rural populations. However, as a result of the cost inefficiency and counterproductive competitive practices, Congress has begun to reconsider CAH reimbursement for the majority of existing CAHs.⁸⁵ In addition to a switch to PPS reimbursement, policy recommendations have included implementing a modified value-based purchasing system among CAHs as an incentive to improve performance,⁸⁶ lifting exemptions previously given that waived the thirty-five mile distance requirement for certain rural hospitals,⁸⁷ and changing CAHs from RCR to a PPS method of reimbursement.⁸⁸

Though the exceptional treatment of CAHs under the law has permitted health care access to extend throughout rural America, as demonstrated in Section II, the CAH system has presented a number of detriments as well.⁸⁹ Not only have CAHs become overly dependent on RCR rates, leading to cost and resource allocation inefficiencies, but their operations have also drifted from their original purpose as designed by Congress—to provide hospital access to rural populations who would not otherwise have access to health care. These detriments have led Congress to reconsider reimbursement methods for CAHs.

PPS reimbursement compensates providers for expenses at predetermined, fixed amounts.⁹⁰ Payment rates are based on the classification system of that service, such as diagnosis-related groups for inpatient hospital services or case-mix groups for inpatient rehabilitation hospitals.⁹¹

85. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 74, at 7.

86. RURAL POL'Y RESEARCH INST. HEALTH PANEL, *supra* note 80, at 2–3, 7; NAT'L ADVISORY COMM. ON RURAL HEALTH & HUMAN SERVS., VALUE-BASED PURCHASING DEMONSTRATIONS FOR CRITICAL ACCESS AND SMALL PPS HOSPITALS 1 (Sept. 2011) [hereinafter VALUE-BASED PURCHASING].

87. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 74, at 2; Joe Carlson, *Proposal to Strip Critical-Access Status from Two-Thirds of Those Hospitals Called a Death Knell for Many*, MODERN HEALTHCARE 2 (Aug. 17, 2013), <http://www.modernhealthcare.com/article/20130817/MAGAZINE/308179942>.

88. CONGRESSIONAL BUDGET OFFICE, *supra* note 82.

89. *See generally* AM. HOSP. ASS'N, TRENDWATCH: THE OPPORTUNITIES AND CHALLENGES FOR RURAL HOSPITALS IN AN ERA OF HEALTH REFORM (Apr. 2011).

90. *Prospective Payment Systems – General Information*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/medicare/medicare-fee-for-service-payment/prospmedi carefeesvcptgen/index.html> (last visited Jan. 15, 2017).

91. *Id.* *See also Medicare Prospective Payment Systems*, AM. SPEECH-LANGUAGE-HEARING ASS'N, http://www.asha.org/practice/reimbursement/medicare/pps_sum.htm (last visited Jan. 15, 2017).

PPS reimbursement applies to the majority of health care providers, with certain exceptions.⁹² Separate PPSs are used for different types of hospitals, such as acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities.⁹³ Among other goals,⁹⁴ PPS aims to encourage effective, efficient care without overutilization of services by incentivizing managers to control the spending inefficiencies produced by unnecessary tests and treatment.⁹⁵ Variations in PPS reimbursement rates per hospital type attempt to reflect actual variations in the costs of care between hospitals and services by reimbursing for factors considered beyond the hospital's control and not related to the hospital's level of efficiency, leaving health care organizations freer to strive for more efficient standards where improvement is possible.⁹⁶ Additionally, payment rate adjustments are available for variances in labor expenses, costly outlier services, and rural areas where hospitals may experience more financial stress.⁹⁷ These adjustments have been used to help smaller, more isolated hospitals.⁹⁸ Payment rates, which are set by the Department of Health and

92. See Act of Dec. 13, 1977, Pub. L. No. 95-210, 91 Stat. 1485 (showing that Medicare-certified rural health clinics are excluded from PPS); see also 42 C.F.R. § 419.2 (2010) (noting services excluded from PPS); 42 C.F.R. § 412.23 (2011) (listing classifications of hospitals excluded from PPS, including certain psychiatric hospitals, rehabilitation hospitals, children's hospitals, long-term care hospitals, cancer hospitals, and hospitals specially excluded—all of which must meet specific requirements to apply for and maintain exclusion from PPS reimbursement).

93. *Id.*

94. See OFFICE OF INSPECTOR GEN., OFFICE OF EVALUATION & INSPECTIONS, MEDICARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM: HOW DRG RATES ARE CALCULATED AND UPDATED 3 (2001) (noting that in creating the PPS for hospital systems, Congress had four goals: "(1) To ensure fair compensation for services rendered and not compromise access to hospital services, particularly for the more seriously ill; (2) To ensure that the process for updating payment rates would account for new medical technology, inflation, and other factors that affect the cost of providing care; (3) To monitor the quality of hospital services for Medicare beneficiaries; and (4) To provide a mechanism through which beneficiaries and hospitals could resolve problems with their treatment"). These goals were intended to transform the way hospitals thought about care delivery, because under the PPS system, the amount hospitals charged for reimbursement no longer mattered; payments were capped. *Id.*

95. AM. SPEECH-LANGUAGE-HEARING ASS'N, *supra* note 91.

96. CONGRESSIONAL BUDGET OFFICE, RURAL HOSPITALS AND MEDICARE'S PROSPECTIVE PAYMENT SYSTEM 11 (Dec. 1991).

97. DEP'T OF HEALTH AND HUMAN SERVS., HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM 5 (Jan. 2016) [hereinafter PROSPECTIVE PAYMENT SYSTEM]. Note also that different pay structures may be used for rural hospitals to ensure financial viability. Two examples of this are the sole community hospital and the Medicare-dependent hospital, which receive PPS reimbursement for all services except inpatient care. MEDPAC, *supra* note 15, at 4. Additionally, PPS rates for these hospitals are based on historical costs trended forward. *Id.*

98. PROSPECTIVE PAYMENT SYSTEM, *supra* note 97.

Human Services and are disclosed to the health care organization at the beginning of the fiscal year,⁹⁹ cover expenses for defined periods of time, such as per diem, per stay, or sixty-day episodes.¹⁰⁰

Congress enacted PPS reimbursement in 1983 as a response to soaring health care costs under the existing Medicare system, which, at that time, reimbursed hospitals on a generous retrospective cost basis.¹⁰¹ This system paid hospitals based on what the hospitals spent; however, the cost of care began to outpace inflation rates, and the full reimbursements under the existing retrospective payment system did little to incentivize efficiency or savings.¹⁰² After enacting interim changes, Congress legislated the PPS under the Social Security Act of 1983.

Though the PPS reduced reimbursement rates for the majority of health care providers, certain hospitals could apply for exemptions from the system based on economic and perceived societal needs, receiving RCR rates for provided services instead of the traditional PPS reimbursement.¹⁰³ Hospitals exempt from PPS initially included a number of short-stay hospitals, psychiatric hospitals and units, rehabilitation hospitals and units, alcohol-drug hospitals and units, long-term care hospitals, and children's hospitals.¹⁰⁴ After a rash of hospitals in rural areas began to close their doors in the 1980s and 1990s,¹⁰⁵ this exception was extended to create a new designation of hospitals—CAHs.

However, since the establishment of CAHs, RCR has proven a detriment to the system, and CAHs have become overly dependent on the high levels of reimbursement. This over-dependency has led to increased cost inefficiency and resource allocation, ultimately leading Congress to reconsider reimbursement rates for CAHs to counteract these tendencies.

IV. THE POLICY BATTLE: WOULD PPS REIMBURSEMENT OF CAHS DEVASTATE RURAL HEALTH CARE?

Changes in reimbursement rates are never easy political moves, and switching CAHs to PPS reimbursement would likely present a struggle. This same political battle was exemplified in the original switch to a PPS in 1983 and will be discussed next, along with the ramifications of the 1983 switch, and how CAHs would likely fare under the proposed PPS today.

99. OFFICE OF INSPECTOR GEN., *supra* note 94.

100. *Id.*

101. Stuart Guterman & Allen Dobson, *Impact of the Medicare Prospective Payment System for Hospitals*, 7 HEALTH CARE FIN. REV. 97, 97 (1986).

102. *Id.*

103. *See generally* 42 C.F.R. § 412.23 (2011).

104. Guterman & Dobson, *supra* note 101, at 100.

105. RURAL HEALTH, *supra* note 11.

A. *The Challenges of Switching to PPS Reimbursement*

PPS reimbursement applies to most providers today, though it was not always this way. Originally, the vast majority of hospitals were reimbursed on a full or reasonable cost basis.¹⁰⁶ Rising health care costs eventually led to reconsideration of such generous methods of reimbursement, and the first hospitals were moved to the PPS in 1983.¹⁰⁷ These switches embroiled Congress and the health care system in a political tug-of-war for funding. On one side of the rope, Congress gestured towards ballooning health care costs and dug in its heels, refusing to spend more funds in ways it already felt were being wastefully used and hoping that payment reductions would incentivize more efficient use of hospital resources.¹⁰⁸ On the other side, skeptical health care providers feared that an unviable balance would be struck, with too little reimbursement provided for services, and an over-abundance of faith in hospitals' ability to compensate.¹⁰⁹ Congress ultimately prevailed, and the aftermath revealed a previously unfound ingenuity among health care providers towards more efficient, quality health care services, as well as a decrease in overall health care spending.¹¹⁰ The reduction in funding encouraged ultimately better, more cost-effective care,¹¹¹ and health care survived. Since this initial political skirmish, the majority of health care providers have been moved to PPS by Congress, with exceptions to this reimbursement system still carved out for hospital systems deemed particularly vulnerable, most notably, the majority of rural health care systems.¹¹² Now, with most health care systems faring well on PPS reimbursement, even these traditional exemptions are no longer secure as Congress continues to eye the growing health care budget.

The challenges of switching CAHs from RCR to PPS reimbursement are multi-faceted and are addressed here in two parts: first, the financial implications on the CAH system of a reduction in reimbursement rates and, second, how potential closures of CAHs might affect rural health outcomes.

106. Barnes, *supra* note 71.

107. 42 U.S.C. § 1395WW (2006).

108. Robert F. Coulam & Gary L. Gaumer, *Medicare's Prospective Payment System: A Critical Appraisal*, (Supp. 1991) HEALTH CARE FIN. REV. 45, 45. *See also generally* Guterman & Dobson, *supra* note 101.

109. Coulam & Gaumer, *supra* note 108.

110. *Id.* at 48.

111. *Id.*

112. *See* 42 C.F.R. § 412.96 (2016).

1. The Financial Implications of Reductions in Reimbursement Rates on CAHs

Financial difficulties have long plagued rural hospitals. Though CAHs represent over sixty percent of rural hospitals, the variation in financial status between CAHs is significant.¹¹³ Due to their small size and generally remote location, CAH performance is particularly sensitive to changes in patient revenue.¹¹⁴

For example, there is some evidence that rural hospitals are less able to cost-shift to private parties than urban hospitals.¹¹⁵ Many believe that compensation for government cutbacks occurs in the form of cost-shifting towards private payers.¹¹⁶ However, studies have shown that cost markups do not vary significantly with financial pressures—at least, not enough to offset costs generally.¹¹⁷ Rather, evidence shows that hospitals tend to take measures to reduce costs rather than cover their costs through markups.¹¹⁸ These actions include reducing personnel (resulting in smaller, more highly-skilled staff),¹¹⁹ postponing pay increases, and limiting charity care.¹²⁰ Evidence demonstrated initially successful results from cost-containment efforts in reducing length of stay; however, mixed results were demonstrated regarding increases in efficiency per patient stay.¹²¹

In considering a switch to PPS reimbursement, it must also be noted that PPS reimbursement rates are designed to reflect variations in costs among hospitals resulting from factors beyond the hospital's control and unrelated to efficiency; thus, CAHs would receive higher rates of reimbursement under a PPS than other hospitals might.¹²² The cost-related factors for which a CAH may receive additional reimbursement include types of medical conditions treated and local labor costs,¹²³ as well as location, market forces, and costs of

113. George H. Pink et al., *Variations in Financial Performance Among Peer Groups of Critical Access Hospitals*, 23 J. RURAL HEALTH 299, 299 (2007).

114. *Id.* at 304.

115. AM. HOSP. ASS'N, *supra* note 89, at 4–5.

116. Jack Hadley & Judith Feder, *Hospital Cost Shifting and Care for the Uninsured*, 4 HEALTH AFF. 67, 68 (1985). However, it must be noted that the evidence for cost-shifting is mixed; it is likely more research is necessary in this area before firm conclusions may be drawn. See Tamara Hayford & Lyle Nelson, *CBO's Analysis of Financial Pressures Facing Hospitals Identifies Need for Additional Research on Hospitals' Productivity and Responses*, CONGRESSIONAL BUDGET OFFICE (Sept. 8, 2016), <https://www.cbo.gov/publication/51920>.

117. Hadley & Feder, *supra* note 116.

118. *Id.* at 68–69.

119. Eileen Appelbaum & Cherlyn Skromme Granrose, *Hospital Employment Under Revised Medicare Payment Schedules*, 8 MONTHLY LAB. REV. 37, 44 (1986).

120. Hadley & Feder, *supra* note 116, at 75. See also Hayford & Nelson, *supra* note 116.

121. K. Davis et al., *Is Cost Containment Working?*, 4 HEALTH AFF. 81, 87 (1985).

122. CONGRESSIONAL BUDGET OFFICE, *supra* note 96, at 11, 13.

123. *Id.* at 9.

providing health care.¹²⁴ Moreover, rural hospitals are paid additional coverage for historical cost differences with unknown causes.¹²⁵ Because of the unique financial difficulties and health care costs faced by CAHs in comparison with urban and non-CAH rural hospitals, CAHs would likely receive a higher PPS reimbursement rate than currently is provided to other hospitals.

Still, even though evidence suggests that the CAH system could support a switch to PPS in the long-term, it is likely that a switch to a PPS would lead some CAHs to close in the short-term.¹²⁶ Accordingly, the effects of potential CAH closures on rural health care systems is addressed next.

2. The Effects of Potential CAH Closures on Rural Health Care

Proposals to switch CAHs to PPS reimbursement have raised a number of fears about potential hospital closures and maintaining access to care for rural populations. Though a switch to PPS reimbursement for CAHs would lead to the closure of some CAHs,¹²⁷ evidence suggests both that such closures would not, in fact, reduce access to quality health care for America's most vulnerable rural populations¹²⁸ and that a reduction in competition and the conversion from a RCR system to prospective payment would ultimately enhance efficiency and incentivize cost savings and without reducing quality of care.¹²⁹

First, a closure of some CAHs would not likely lead to a reduction in quality of care because not all CAHs may, in fact, be necessary for adequate care provision in rural areas.¹³⁰ Initially, it was required that all CAHs be located no less than thirty-five miles from the nearest hospital or no less than fifteen miles in areas with mountainous terrain.¹³¹ However, from 1997 to 2005, states could waive this requirement for hospitals designated as "necessary" health service providers.¹³² Following 2006, hospitals again had to meet the distance requirements; however, exemptions were given for those hospitals constructed during the 1997-2005 waiver period.¹³³ Because of these

124. NAT'L RURAL HEALTH RES. CTR., CRITICAL ACCESS HOSPITAL FINANCE 101 MANUAL 8 (2012).

125. CONGRESSIONAL BUDGET OFFICE, *supra* note 96, at 13.

126. Michelle M. Casey et al., *Minimum-Distance Requirements Could Harm High-Performing Critical-Access Hospitals And Rural Communities*, 34 HEALTH AFF. 627, 631-32 (2015).

127. *Id.* at 632-33.

128. Rosko & Mutter, *supra* note 63, at 122.

129. *Id.*

130. J. Matthew Fannin & I. Cristian Nedelea, *Performance of the Critical Access Hospital Program: Lessons Learned for Future Rural Hospital Effectiveness in a Changing Health Policy Landscape*, 28 CHOICES 1, 1 (2013).

131. Casey et al., *supra* note 126, at 627.

132. *Id.*

133. *Id.*

exemptions granted, the number of CAHs exploded during the initial years.¹³⁴ Many of these “necessary provider” hospitals were constructed within the thirty-five mile proximity requirements. Currently, two-thirds of CAHs are within the thirty-five mile requirement and would not meet the requirements to retain critical access certification if required to re-enroll in Medicare.¹³⁵ Of the 846 CAHs that would not meet the distance requirement, 306 were located within fifteen miles of the nearest hospital.¹³⁶ Of these, 235 were between ten and fourteen miles of the nearest hospital, while the other seventy-one were less than ten miles from the nearest hospital.¹³⁷

The close proximity of such a large number of CAHs has spurred competition between CAH hospitals, increasing financial struggles.¹³⁸ In light of this, a reassessment of CAH criteria resulting in a switch to a PPS would not necessarily endanger rural health care. The Centers for Medicare and Medicaid Services (CMS) has already begun to consider whether to reassess the certification of these CAH hospitals—an act projected to save Medicare and its beneficiaries \$449 million, even if only hospitals less than fifteen miles from each other were considered for reevaluation.¹³⁹ Implementation of PPS reimbursement for these CAHs (or, as discussed by CMS, stripping these hospitals completely of CAH status) would lead to short-term high rates of closure due to a reduction in profit margins.¹⁴⁰ However, these closures would occur primarily as a result of the underlying competition, exposed by a change in reimbursement rates.¹⁴¹

A switch to PPS reimbursement, even just for the hospitals specifically addressed by CMS, would draw CAHs back into the boundaries of their original purpose as designed by Congress. Originally, the thirty-five mile distance requirement was calculated to balance the health care access of isolated rural populations with efficient federal budgeting: Congress desired to bring hospitals into areas that were considered financially unviable. However, to add more hospitals would introduce competition among providers in already

134. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 74, at 3–4.

135. *Id.* at 12. “Overall, 849 of the 1,329 CAHs (64 percent) would not meet the location requirements if required to re-enroll in Medicare. The vast majority of these CAHs would not meet the distance requirement, and only three of these CAHs would not meet the rural requirement. Of the 846 CAHs that would not meet the distance requirement . . . 306 were located a drive of 15 or fewer miles from their nearest hospitals or other CAHs. Of these CAHs, 235 were between 10-14 miles from their nearest hospitals or other CAHs. The other 71 CAHs were less than a 10-mile drive from their nearest hospitals or other CAHs.” *Id.*

136. *Id.*

137. *Id.*

138. GA. STATE OFFICE OF RURAL HEALTH, *supra* note 81.

139. See DEP’T OF HEALTH AND HUMAN SERVS., *supra* note 74, at 16.

140. Casey et al., *supra* note 126, at 633.

141. CONGRESSIONAL BUDGET OFFICE, *supra* note 96, at 7–8.

sparsely populated areas and would reduce budgetary efficiency, while fewer hospitals would result in a lack of access to care.¹⁴² The thirty-five mile distance requirement was a compromise between the two. Nevertheless, hospitals took advantage of the system and began to request waivers of the distance requirement so they could still obtain CAH status.¹⁴³ This CAH waiver was in effect until January 1, 2006 and allowed for CAHs to build at distances as close as ten miles from one another.¹⁴⁴ As a result, nearly two-thirds of CAHs today would not meet the thirty-five mile distance requirement.

These findings are important. The close proximity of CAHs in sparsely-populated areas has led to fierce competition in an effort to maintain open doors,¹⁴⁵ which has led hospitals to spend money inefficiently or promote more costly procedures to their patients in an attempt to attract patients from the sparse surrounding populations.¹⁴⁶ These sorts of competitive practices tend to raise the cost of health care, both for the patient and for the third-party payers.¹⁴⁷

Because CAHs in close proximity compete for the same small groups of patients, hospital closures resulting from competitive proximity between hospitals would not notably affect access to needed health care services.¹⁴⁸ One study examined forty-one rural hospitals that closed in 1989 and found that twenty-six were located twenty miles or less from another hospital, and only three were located thirty or more miles from another hospital.¹⁴⁹ Though the closures may have reduced some access to physicians and emergency

142. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 74, at 19.

143. *See* Casey et al., *supra* note 126, at 627.

144. Memorandum from Dep't of Health & Human Servs. to State Survey Agency Dirs., Critical Access Hospitals (CAHs): Distance from Other Providers and Relocation of CAHs with a Necessary Provider Designation (Sept. 7, 2007), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter07-35.pdf>.

145. George M. Holmes et al., *The Effect of Rural Hospital Closures on Community Economic Health*, 41 HEALTH SERV. RES. 467, 482–83 (2006).

146. *See* Rosko & Mutter, *supra* note 63, at 114.

147. *Id.* at 97. Rosko and Mutter note:

Medicare payments to CAHs rose at an annualized growth rate of 9.5 percent from 1998 to 2003, compared to a 3.3 percent growth rate for similar hospitals that did not convert to CAH status and were paid prospectively. As a result, Medicare paid approximately \$850,000 more per CAH in 2003 than it would have if payment had increased at the rate of nonconverting, comparison hospitals. MedPAC estimates that the difference was nearly \$1 million per hospital in 2006. This amounts in total to a projected \$1.3 billion in Medicare payments above what would have been made under prospective payment.

Id. (internal citation omitted). These increases in reimbursements were ultimately due to rising costs of care. *Id.* at 98.

148. CONGRESSIONAL BUDGET OFFICE, *supra* note 96, at 8.

149. *Id.*

services, the study concluded that the closings did not affect overall care because alternative hospitals remained available to receive patients.¹⁵⁰

Further, even a high rate of closures would not likely change health care outcomes for these populations.¹⁵¹ During the original shifts to PPS reimbursement among some rural hospitals, which had originally received RCR,¹⁵² a string of rural hospitals began to close their doors for good.¹⁵³ Yet, health outcomes and access to care remained largely unaffected by this new policy due to the fact that a majority of the hospital closures occurred as a result of surreptitiously fierce competition.¹⁵⁴ This longstanding competition had been quietly cloaked by generous reimbursement policies that, once pulled back, revealed the underlying wasteful expenditures churned out by hospitals to attract the same scarce populations.¹⁵⁵

B. *The Benefits of a Switch to a PPS for CAHs*

A switch to PPS reimbursement would likely encourage higher quality care and increased cost efficiency. As aptly stated by the National Rural Health Association, “[f]orm follows finance: regardless of the type system, providers will conform to ‘how the money flows’. Innovative models of care delivery and providers will be an outcome associated with changes in reimbursement practices.”¹⁵⁶ Studies of the effects on previous hospitals of a switch from cost-based reimbursement to a PPS support this conclusion. In the first year of PPS implementation in 1983, PPS-participating hospitals were able to significantly decrease the length of patient stays,¹⁵⁷ an indicator often consulted as a measure of efficiency. Whereas the largest previous drop in length of stay had only been four percent, in 1984, length of stay dropped by nine percent.¹⁵⁸ With the implementation of the PPS, hospitals experienced significantly lower occupation rates, with an average occupation rate of 67.7% (down from 73.7%).¹⁵⁹ With repeated demonstrations of decreases in patient length of stay

150. *Id.*

151. *Id.*

152. *Id.*

153. CONGRESSIONAL BUDGET OFFICE, *supra* note 96, at 7.

154. *Id.*

155. *Id.*

156. NAT’L RURAL HEALTH ASS’N, POLICY BRIEF: THE FUTURE OF RURAL HEALTH 1, 8 (Feb. 2013).

157. Guterman & Dobson, *supra* note 101. *See also* Yi-Wen Tsai et al., *The Effect of Changing Reimbursement Policies on Quality of In-Patient Care, From Fee-for-Service to Prospective Payment*, 17 INT’L J. QUALITY HEALTH CARE 421, 423 (2005); Peter J. Huckfeldt et al., *Effects of Medicare Payment Reform: Evidence from the Home Health Interim and Prospective Payment Systems*, 34 J. HEALTH ECON. 1, 2 (2014).

158. Guterman & Dobson, *supra* note 101, at 103–04.

159. *Id.* at 104.

as well as admissions,¹⁶⁰ it is likely that CAHs would experience these same efficiency savings under PPS reimbursement.

Additionally, PPS is intended to encourage collaboration,¹⁶¹ and reimbursement changes have been shown to facilitate improvement discussions within organizations, as well as to align these organizations to provide more patient-centered and proactive care, to leverage provider expertise to deliver more efficient care, and to improve the overall quality of care.¹⁶² These incentives are furthered by the current focus on programs such as value-based purchasing, which seeks to tie reimbursement funds to the quality of care produced by hospitals.¹⁶³ Thus, a switch to PPS reimbursement would likely encourage greater collaboration and systemization among rural hospitals, facilitating financial viability and quality patient care.

Finally, PPS has been shown to better hospital processes, including clinical documentation processes.¹⁶⁴ One Dallas hospital began to find smarter ways to utilize the hospital's electronic health records (EHR) to run patient reports; they also redesigned EHR templates to try to improve the quality of patient treatment information captured in notes and to improve note-taking efficiency by physicians.¹⁶⁵ These endeavors, inspired by a switch to PPS reimbursement, encouraged successful changes to improve hospital process flow. Likewise, financial pressures under a PPS could incentivize CAHs to improve process flows and record-keeping procedures.

In light of the benefits presented by a potential switch to PPS reimbursement, policymakers and providers must note that RCR is not necessarily the only, or the best, remedy to prevent CAH closure or to maintain access to rural health care.¹⁶⁶ Under the current CAH system, RCR has served as only one method to provide a safety net for vulnerable hospitals. Evidence

160. See Tsai et al., *supra* note 157; see also Huckfeldt et al., *supra* note 157, at 17.

161. Press Release, Dep't of Health & Human Servs., CMS Announces Sites for a Demonstration to Encourage Greater Collaboration and Improve Quality Using Bundled Hospital Payment (Jan. 7, 2009), <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2009-Press-releases-items/2009-01-07.html>.

162. Eduardo Lacson, Jr. & Raymond M. Hakim, *The 2011 ESRD Prospective Payment System: Perspectives From Fresenius Medical Care, a Large Dialysis Organization*, 57 AM. J. KIDNEY DISEASE, 547, 547–48 (2011).

163. *Linking Quality to Payment*, MEDICARE.GOV, <https://www.medicare.gov/hospitalcompare/linking-quality-to-payment.html> (last visited August 7, 2016).

164. Joseph Goedert, *New Payment System Compels Better Clinical Documentation*, HEALTH DATA MGMT. (Oct. 29, 2013, 9:54 AM) <http://www.healthdatamanagement.com/news/new-payment-system-compels-better-clinical-documentation>.

165. *Id.*

166. See Rosko & Mutter, *supra* note 63, at 199 (noting that even if hospitals benefit financially through the CAH program, at the end of the day, they must operate profitably in order to survive, suggesting that other considerations such as effective financial management remain imperative).

supports that it is not the best, or even the better, option to provide financial relief for struggling rural hospitals.¹⁶⁷ A cost-benefit analysis taking into account the current inefficiencies of CAHs, as well as the benefits demonstrated by hospitals currently operating under PPS, points to PPS as a viable long-term solution for rural health care providers. Thus, political actors and stakeholders must not grasp too firmly at a familiar system that presents some benefits but, ultimately, may not be the better answer to rural health care provision. Though CAHs would likely face interim struggles during a switch to PPS reimbursement, they would ultimately overcome these challenges to survive long-term, and such changes would likely inspire more efficient, cost-effective, quality care.

IV. RESPONDING TO THE CHALLENGES OF MOVING CAHs TO PPS REIMBURSEMENT

Though evidence supports that CAHs would likely survive the interim difficulties they would face with a switch to PPS reimbursement, there are several actions that CAHs may take to help ensure their financial viability.

The first actions to ensure the survival of rural hospitals deemed most critical would likely occur in the realm of policy. These policy solutions include a modified PPS reimbursement rate, legal redefinitions (and stricter enforcement) of distance requirements, easing of certain regulatory burdens, and state modification of laws governing health practitioners' scope of practice.

In response to a shift to PPS reimbursement, a modified reimbursement rate might assist in ensuring CAH survival. Regardless of potential benefits of a shift to PPS reimbursement, the fact remains that rural hospitals are less able to shift costs to private payers to account for cuts in reimbursement rates, as the majority of their patients tend to be publicly insured.¹⁶⁸ This characteristic sets them apart from their urban counterparts, who are better able to shift costs when under financial strain. A tailored PPS reimbursement rate, where CAHs receive more compensation than is currently provided upon meeting certain criteria, though not to the extent of RCR, would help to ease strain due to cost-shifting inabilities.¹⁶⁹ Such modified reimbursement rates might avert potential financial hardship while also encouraging efficiency and cost-savings. This modified reimbursement rate might come in the form of a version of value-based purchasing, which could provide the additional benefit of incentivizing quality and cost-efficiency—qualities historically difficult to promote under

167. *Id.*

168. Shannon Muchmore, *Legislation Languishes as Rural Hospitals Struggle*, MOD. HEALTHCARE (Oct. 3, 2015), <http://www.modernhealthcare.com/article/20151003/MAGAZINE/310039980>.

169. *See generally* REDUCING THE DEFICIT, *supra* note 82.

traditional Medicare reimbursement.¹⁷⁰ However, value-based purchasing methods would need to be adapted for the rural communities, as historically it has been difficult to translate these methods from urban providers to their rural market counterparts.¹⁷¹

Second, legally redefining distance requirements for CAHs might alleviate the tension in some areas straining to provide care to more isolated rural residents. Though the thirty-five mile standard was originally established to provide a balance between access to care and unnecessary competition, some counties have still struggled to maintain accessible care for their communities under these requirements.¹⁷² In 2007, a bill was introduced in Congress to reduce the thirty-five mile requirement for CAHs to thirty miles; however, this bill was referred to the Subcommittee on Health after a few days and has not been brought up since.¹⁷³ It is not likely to be addressed any time soon. However, this is one action that might be taken to enhance financial viability by “strik[ing] a [better] balance between convenient access to . . . care and unnecessary competition.”¹⁷⁴

Furthermore, financial solutions may still be available for CAHs who switch to PPS reimbursement. First, instead of simply shifting CAHs from one system of payment (RCR) to another (PPS), Congress could restructure CAHs to reflect the payment systems for sole community hospitals (SCHs) or Medicare-dependent hospitals (MDHs). These hospitals receive cost-based payments only for inpatient services and receive modified PPS reimbursements that are based on historical costs trended forward.¹⁷⁵ This encourages cost-savings, as reimbursements do not increase when costs increase.¹⁷⁶ Furthermore, the conditions of participation for SCHs and MDHs are similar to those already required of CAHs,¹⁷⁷ facilitating a potential restructuring of CAHs to reflect one of these two systems.

Another solution might come through the easing and restructuring of regulatory burdens on CAH operations and staffing. In 2012, Congress attempted to ease regulatory burdens on CAHs, thus permitting them to devote

170. VALUE-BASED PURCHASING, *supra* note 86.

171. NAT'L RURAL HEALTH ASS'N, *supra* note 156, at 3–4.

172. *Change in Mileage Requirement for Hospitals Could Assist Rural Areas*, DEMOPOLIS TIMES (May 30, 2007), <http://www.demopolistimes.com/2007/05/30/change-in-mileage-requirement-for-hospitals-could-assist-rural-areas/>.

173. *See* H.R. 2322, 110th Cong. (2007).

174. DEMOPOLIS TIMES, *supra* note 172.

175. MEDPAC, *supra* note 15, at 2.

176. *Id.*

177. *Id.* at 1–3.

resources to providing care to vulnerable populations.¹⁷⁸ These provisions included increased flexibility in meeting conditions of participation for special reimbursement rates: for example, by broadening the concept of “medical staff” to allow smaller hospitals to include other practitioners as staff in accordance with state law;¹⁷⁹ permitting podiatrists to participate in medical staff leadership;¹⁸⁰ permitting self-administration of certain medications;¹⁸¹ and eliminating requirements that CAHs furnish diagnostic, therapeutic, laboratory, radiology, and emergency procedures directly by CAH staff.¹⁸² This rule reduced the total regulatory burden experienced by CAHs and similar hospitals by nearly five billion dollars over the next five years, with the greatest potential cost savings stemming from changes to the conditions of participation.¹⁸³ These savings would likely permit greater flexibility in policy changes, alleviating some concerns about shortfalls in revenue. However, additional modifications could be made. For example, easing of federal licensure and certification processes might reduce operation costs and barriers to care.¹⁸⁴ Under licensure and certification requirements, there is little room for rural hospitals to invest in innovative approaches to care, creating high health care costs for rural hospitals even though rural health care remains less expensive per beneficiary.¹⁸⁵ Additionally, regulations could be restructured to support a more patient-centered focus appropriate to clusters of rural communities, allowing for prioritization of services tailored to community needs, rather than the current provider-centered focus that predominates.¹⁸⁶ Regulatory incentives, perhaps financial, to establish rural health care networks may also provide a vital component to ensuring CAH survival.¹⁸⁷

178. Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation, 77 Fed. Reg. 95, 29034 (May 16, 2012) (to be codified at 42 C.F.R. §§ 482, 485).

179. *Id.*

180. *Id.*

181. *Id.*

182. *Id.* at 29035.

183. 77 Fed. Reg. at 29035. (“The rule will reduce the total regulatory burden for hospitals and CAHs by nearly \$940 million initially and by almost \$5 billion over the next five years. Changes to the following CoPs accounted for the greatest potential savings in the final rule: § 482.22, Medical staff (\$330 million); § 482.23, Nursing services (\$110 million); § 482.24, Medical record services (\$170 million); and § 482.54, Outpatient services (\$300 million).”).

184. NAT’L RURAL HEALTH ASS’N, *supra* note 156, at 3.

185. *Id.*

186. *Id.* at 6.

187. *Id.* at 8.

Moreover, CAHs have demonstrated success in garnering additional revenue by diversifying medical procedures offered.¹⁸⁸ This diversification may be necessary to offset shrinking patient visits and revenues.¹⁸⁹ CAHs have already begun to diversify their revenue streams to bring in additional patient groups and to better adapt to local community needs.¹⁹⁰ Local collaborative partnerships with larger hospitals have provided further opportunity for revenue stream diversification.¹⁹¹ This will become even more important as health care reform progresses, particularly in states that have expanded Medicaid programs and patient demand rises that may strain limited resources.¹⁹² Currently, CAHs most often offer services such as primary group practices, long-term care facilities, and specialty facilities such as orthopedic units, general surgical units, and oncology.¹⁹³ Still, concerns such as financial risk, lack of specialists available to work full-time in more isolated areas, and competition between entities have made revenue stream diversification more difficult.¹⁹⁴ These concerns have been somewhat mitigated by strategic partnerships; for example, in some cases, a third party such as a county will own the facilities, which are operated day-to-day by the CAHs.¹⁹⁵ Such partnerships have allowed for the addition of services such as dental offices, community health centers, mental health practices, emergency medical services, and retail pharmacies, where it is in the interest of the CAH to offer such services.¹⁹⁶

In correspondence with procedure diversification, CAHs could improve their financial situation by following the national shift¹⁹⁷ to a focus on preventive and primary care, rather than tertiary care. As noted by the National Rural Health Association:

The broad goal of rural health advocates should be to improve the health of rural people. There is recognition that good health is determined by more than just access to acute health services. Prevention, health improvement strategies, and social determinants of health are profoundly important. Without

188. GA. STATE OFFICE OF RURAL HEALTH, *supra* note 81, at 2. Though diversification efforts have been unique for each hospital, they have included components such as swing beds, rural health clinics, and skilled nursing facilities. *Id.*

189. *Id.*

190. Melissa Henriksen et al., *Illinois Critical Access Hospital Program: Learning from the Past, Building the Future*, ILL. CRITICAL ACCESS HOSP. NETWORK, Jan. 2015, at 1, 8.

191. *Id.* at 8–9.

192. See AM. HOSP. ASS'N, *supra* note 89, at 1.

193. Henriksen et al., *supra* note 190, at 8–9.

194. *Id.* at 9.

195. *Id.*

196. *Id.* at 8.

197. See Regina M. Benjamin, *The National Prevention Strategy: Shifting the Nation's Health-Care System*, 126 PUB. HEALTH REP. 774, 774–75 (2011).

recognizing that the population segments are diverse and without addressing those conditions that drive disparities, realistic expectations and strategies for long-term improvement in health cannot be sufficiently defined, let alone achieved. Health related costs cannot be managed, let alone minimized.¹⁹⁸

With health care reform and the subsequent redesigning of health care delivery models, preventive care as a tool to promote population health and reduce health care costs is becoming more important.¹⁹⁹ The ideal rural health care system—one that would maximize health care resources while minimizing costs—would promote and allow increased access to prevention and screening services that would prevent or delay the onset of the chronic diseases that so heavily burden rural communities.²⁰⁰

Finally, shrewd cost-cutting and efficiency implementation processes may ease budget tensions in shifting to a PPS method of reimbursement. Health care administrators tend to launch into cost-cutting measures that seem intuitive but are, in reality, counterproductive, ultimately leading to higher costs and lower-quality care.²⁰¹ Often, thin financial margins in health care organizations are a consequence not of insufficient reimbursement, but instead “are the result of mismatched capacity, fragmented delivery, suboptimal outcomes, and inefficient use of highly skilled clinical and technical staff.”²⁰² Ultimately, avoiding these common mistakes requires active collaboration in cost-measurement and management not just between administrators and suppliers, but also between administrators and clinicians.²⁰³ It may also require a realistic recognition that not all services currently provided to rural populations are necessary. The National Rural Health Association addresses this issue directly, asserting:

198. NAT'L RURAL HEALTH ASS'N, *supra* note 156.

199. RURAL POL'Y RES. INST. & ROBERT WOOD JOHNSON FNDN., *THE HIGH PERFORMANCE RURAL HEALTH CARE SYSTEM OF THE FUTURE* 3 (Sept. 2011).

200. *Id.*

201. Robert S. Kaplan & Derek A. Haas, *How Not to Cut Health Care Costs*, HARV. BUS. REV., Nov. 2014, at 117, 118–22 (noting that the five most common mistakes that health care administrators make when cutting costs are (1) cutting back on support staff which can immediately lower costs, but can also be “shortsighted” by lowering clinicians’ productivity and significantly increasing the costs of administrative tasks and patient treatments; (2) underinvestment in space and equipment, which tends to shift costs by creating longer wait times and lower volumes of patients treated and, consequently, lower revenues; (3) focusing too narrowly on the negotiating prices of supplies while failing to control potentially wasteful utilization of these supplies; (4) limiting office visits to specific fixed time periods, such as fifteen or thirty minutes, which ultimately promoted longer inpatient stays and higher rehabilitation costs, and (5) failing to benchmark and standardize costs and clinical and administrative processes, which can result in costs for similar services that vary between hospitals by more than five hundred percent).

202. *Id.* at 122.

203. *Id.*

It is easy to say that rural residents should have ready access to all of the identified services and referral linkages to more specialized providers and facilities. However, in many cases neither the local capacity nor the referral resources and linkages are adequate. To state that all identified resources should just ‘be there’ is overly simplistic. This does not mean that we should lower our sights. It does mean that in rural areas, priority should be given to putting in place the identified building blocks and securing the resources necessary for their sustainability.²⁰⁴

In an area of limited resources, it is vital to recognize these limitations when creating policy. Recognition of these limitations will ultimately aid in providing more cost-effective use of available resources and may play a key role in ensuring the survival of needed rural health care services.

Each of these solutions provides a viable option to offset potential costs incurred by switching from RCR for CAHs to a PPS method of reimbursement. Still, the most daunting challenge to address would be a political one. The ramifications of switching CAHs to PPS reimbursement are positive in the long-term. However, in light of the short-term financial difficulties that will ensue, the question remains: who is to bell the cat?

Aesop’s witty fable aptly shows that even the better ideas often propose an unconsidered but daunting challenge.²⁰⁵ Though, in reality, a switch to PPS reimbursement would likely benefit rural health care long-term, the painful short-term consequences make such a move a great idea in theory, but practically undesirable to enact. The challenges intimated by PPS reimbursement, though not impossible to overcome, bring with them the equally intimidating challenge as to who will dare face the opposition of many provider, patient, and physician groups to enact what might certainly be seen as an uncertain, if not devastating, remedy. Cuts to health care spending are notoriously difficult to implement and even more so for populations perceived as vulnerable, which are generally exempted from such cuts.²⁰⁶

Providers will initially feel the blade of health care reimbursement cuts and will likely struggle under the pressure to provide quality services more cost-efficiently—a prospect that has left policymakers and patients fearing they will be left without access to care. This fear of cutting health care funds is deeply interwoven with the perception that vulnerable populations will be left destitute and unviable. Unless and until these unsavory but exaggerated perceptions are addressed honestly by providers and fully confronted by

204. NAT’L RURAL HEALTH ASS’N, *supra* note 156, at 9.

205. *See id.* at 4.

206. *See* Social Security Act of 1977, Pub. L. No. 95-210, 91 Stat. 1485 (Dec. 13, 1977) (to be codified at 42 U.S.C. 1395k); 42 U.S.C. § 1395x(v)(1)(S)(ii)(III) (2012). *See also generally* ECONOMIC REPORT OF THE PRESIDENT, REDUCING COSTS AND IMPROVING THE QUALITY OF HEALTH CARE (2013).

policymakers with the benefits of a switch demonstrated as fully as feasibly possible prior to implementation, such a conversion may be long in coming.

V. CONCLUSION

There is not, and there will never be, a perfect remedy for the United States health care system; there are only better alternatives. Furthermore, with soaring health care costs, there remains a dire and growing need for greater responsibility in government management of taxpayer dollars to control spending and for hospitals to be held accountable to responsible spending. Ultimately, a switch to PPS for CAHs would not prove the crippling blow predicted. Not only would CAHs survive, but a PPS would also encourage more cost-efficient, quality care. However, it is not so easy to “bell the cat.” In considering a move to PPS reimbursement for CAHs, American policymakers must fully confront and address both the risks and fears involved in this policy move if America is to move forward with such a system.

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