Introduction

Rural hospitals are a vital part of the U.S. healthcare sector and provide strong economic impacts. These healthcare facilities, which have an average of 25 inpatient beds, differ from urban hospitals in several ways. Many rural hospitals serve as the first point of care, sending patients to larger hospitals with more staff and medical equipment for specialized treatment. Due to their larger size and budgets, urban hospitals can offer a more comprehensive array of services. However, many rural hospitals perform just as well as urban hospitals and, in some cases, even outperform them.

At the time of the 2010 Census, rural areas accounted for 97 percent of the nation’s land and 19 percent of the U.S. population, approximately 60 million Americans. Approximately 2,200 of the nation’s 4,663 acute care hospitals are in rural areas. According to the Rural Health Information Hub, the healthcare sector comprises roughly 14 percent of total employment in rural areas. A mid-size rural hospital with 26 to 50 beds has an average of 185 employees and spends $11.8 million on annual wages, salaries, and benefits. A larger rural hospital with 51 to 100 beds has an average of 287 employees and spends $19.9 million on employee pay.

Each year, as part of the Hospital Value-Based Purchasing Program, the U.S. Centers for Medicare and Medicaid Services (CMS) calculates a Total Performance Score (TPS) for all Medicare-participating hospitals. Scores are calculated based on four criteria: clinical outcomes; safety; person and community engagement; and efficiency and cost reduction. In fiscal year 2020, the average TPS for rural hospitals was higher than the national average.

Although poverty is a national issue, it is more prevalent in the South, particularly in rural areas. In 2018, the rural poverty rate was 16.1 percent, compared to 12.6 percent in urban areas. Nearly 85 percent of rural, persistent poverty counties—where 20 percent or more of the population has lived in poverty in the previous 30 years—are in Southern states. Furthermore, the per capita income of rural residents in the South is $21,935, lower than the national average by $9,242.

Due to these rates, rural hospitals are more likely to serve low-income patients on Medicare and Medicaid than their urban counterparts. Medicare and Medicaid regularly reimburse hospitals less than the actual cost of healthcare services, making them a losing venture for many hospitals. On average, CMS reimburses hospitals 87 cents for...
every dollar they spend on care for Medicare and Medicaid patients. In 2017, Medicare and Medicaid reimbursements accounted for 56 percent of rural hospital revenue.\(^1\) Rural hospitals also serve fewer patients than urban hospitals. From 2012 to 2013, rural hospitals had an average of seven inpatients receiving care daily, while urban hospitals had 102.\(^1\)

Furthermore, rural residents tend to be older than the average American. From 2012 to 2016, 17.5 percent of rural residents were 65 or older, compared to 13.8 percent in urban areas. The percentage of rural senior citizens has increased steadily in the past 40 years. In 1980, seniors comprised 10.9 percent of rural residents, compared to 11.4 percent of urban residents.\(^1\)

Rural hospitals have struggled financially for years. As displayed in Figure 1, 180 U.S. rural hospitals have closed since January 2005, with most closures in the South.\(^1\) The reasons behind these closures include decreasing rural populations, changing federal healthcare regulations, and geographic isolation. A February 2019 report from Navigant, a Chicago-based consulting firm, found that 21 percent of U.S. rural hospitals were at high risk of closing unless their finances improve.\(^1\) For more on these issues, please see the November 2019 SLC Regional Resource, Rural Hospitals: Here Today, Gone Tomorrow.

**COVID-19 and Rural Hospitals**

When COVID-19 emerged in the United States, many hospitals were forced—either by necessity or by law—to cancel elective procedures, a significant revenue source for healthcare providers.\(^1\) According to an October 2020 analysis by law firm McGuire Woods, nearly every state issued stay-at-home orders, elective procedure guidance, or both in the first wave of the pandemic, as seen in Figure 2. Examples of guidance include executive orders to delay all elective procedures until a specified date or delay elective procedures when a specified hospital capacity level was reached. After the first wave of COVID-19 cases subsided, states

---

**Figure 1** U.S. Rural Hospital Closures, 2005-present

![Figure 1](https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/)

began to lift these orders. At the time of this writing, no states are prohibiting elective procedures, and only four states have stay-at-home advisories: California, Kentucky, New Mexico, and Wisconsin. In these states, residents are advised but not required to stay home.16,17

In response to the pandemic, CMS temporarily suspended specific federal rules to expand access to healthcare. As a result of these changes, doctors could remotely care for patients at rural hospitals, even across state lines, via phone, radio, or online communication. Additionally, CMS waived federal personnel qualifications for clinical nurse specialists, nurse practitioners, and physician assistants, allowing them to work at rural hospitals if they met state licensure requirements.18

A September 2020 analysis by NPR found that roughly one-fifth of the first 100,000 deaths caused by COVID-19 occurred in places outside of large metro areas—proportionate to the percentage of the rural population. However, of the second 100,000

---

**COVID-19 Pandemic**

The World Health Organization (WHO) identified the first cases of coronavirus disease 2019 (COVID-19) in Wuhan, China, on January 9, 2020. On January 21, 2020, the Centers for Disease Control and Prevention (CDC) confirmed the first U.S. case of COVID-19 in the state of Washington. The administration declared COVID-19 a public health emergency on February 3, 2020. By March 11, the WHO declared COVID-19 a pandemic; two days later, the administration called COVID-19 a national emergency.1

As of this writing, approximately 156 million cases of COVID-19 have been reported worldwide, including 32 million cases in the United States. Approximately 3.2 million people worldwide, including 577,041 Americans, have died from the coronavirus pandemic.ii

---


deaths, nearly half occurred outside of large metro areas. The most significant increase occurred in small towns and rural areas.\textsuperscript{19} According to a March 2021 report from the RUPRI Center for Rural Health Policy Analysis, COVID-19 cases and deaths have been disproportionately higher in rural areas.\textsuperscript{20}

From September to November 2020, the highest rate of new infections was in entirely rural counties; the lowest new infection rate was in major metro areas, as seen in Figure 3. Potential reasons for this include rural Americans needing to travel greater distances to receive care and being older, more likely to lack insurance, and more likely to have other health issues.\textsuperscript{21}

The distribution of COVID-19 vaccines has also been a challenge for rural hospitals, as the Pfizer-BioNTech and Moderna vaccines must be stored at extremely low temperatures. While in storage, the Pfizer vaccine must be kept between -112 and -76 degrees Fahrenheit; the Moderna vaccine must be stored between -58 and 5 degrees Fahrenheit.\textsuperscript{22} Many small rural hospitals lack freezers that can store the vaccines at the necessary temperatures.\textsuperscript{23}

Like any organization, hospitals aim to maintain a positive operating margin—bring in more revenue than expenses—to remain solvent. Before the pandemic, approximately 25 percent of U.S. hospitals had negative operating margins. In early 2021, roughly half of U.S. hospitals had negative margins. Earlier this year, consulting firm KaufmanHall analyzed historical data to predict potential hospital revenue for 2021. Under an optimistic scenario, KaufmanHall projects that all hospitals could face a $53 billion total revenue loss in 2021, and 39 percent of hospitals will have a negative margin. This model assumed a quick vaccine rollout and a sustained decrease in COVID-19 cases. Under a pessimistic scenario, hospitals could lose $122 billion in revenue for the year, and half of all hospitals will continue to operate in the red. In the pessimistic model, the vaccine rollout is slow, and COVID-19 case numbers remain steady. Both models exclude potential government intervention.\textsuperscript{24,25}
Defining Rural

Rural hospitals provide healthcare to residents in less populated areas of the United States. However, determining what qualifies as a rural hospital or rural resident can be difficult due to variances in the criteria used by different federal entities. The federal Office of Management and Budget (OMB) classifies urban counties based on core-based statistical areas (CBSAs). A metropolitan area contains a core urban area of 50,000 or more residents, and a micropolitan area has an urban core of 10,000 to 50,000 residents. Under the OMB criteria, any resident of a metropolitan or micropolitan CBSA is an urban resident; anyone not in a metropolitan or micropolitan CBSA is a rural resident.

The U.S. Census Bureau defines rural as “any population, housing, or territory not in an urban area.” Urban areas fall into two groups: “urbanized areas” with a population of 50,000 or more; and “urban clusters” with at least 2,500 and less than 50,000 residents. The Census Bureau recently announced a national population estimate based on the 2020 Census; however, new data regarding the rural and urban divisions of the U.S. population is not yet available.

The outlook is worse for rural hospitals. According to KaufmanHall’s projections, in an optimistic scenario, by the end of 2021, rural hospitals may have operating margins 10 percent lower than before the COVID-19 pandemic. Under a pessimistic scenario, rural hospitals may have operating margins 80 percent lower than pre-COVID. The rural models include $10 billion in federal aid allocated to rural hospitals under the 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act.26

Federal Response

In March and April 2020, Congress passed three COVID-19 relief bills: the $8.3 billion Coronavirus Preparedness and Response Supplemental Appropriations Act; the $192 billion Families First Coronavirus Response Act; and the $2.2 trillion Coronavirus Aid, Relief, and Economic Security (CARES) Act. These bills aimed to limit the damage of the COVID-19 pandemic through financial assistance to individuals, businesses, and governments.27 This first round of federal legislation included measures such as the Paycheck Protection Program, which provided forgivable loans to companies and organizations, including hospitals. Additionally, the CARES Act contained several measures that supported healthcare providers, including:

» $100 billion in funding to the Public Health and Social Services Emergency Fund to compensate healthcare providers for unreimbursed expenses related to COVID-19, including lost revenues caused by a break in non-COVID-19 care;
» expansion of the types of hospitals eligible for Medicare accelerated payments;
» additional 20 percent to the Medicare hospital reimbursement rate for patients with COVID-19;
» pausing of the lower Medicare “sequestration” rates from May 1, 2020, to December 31, 2020;
» $200 billion allocation to the Federal Communications Commission for a COVID-19 Telehealth Program;
» simpler methods for rural health clinics and federally qualified health centers to provide telehealth treatment to patients;\(^\text{28}\)
» $10 billion in funding for hospitals in COVID-19 high impact areas, such as New York and California, and $10 billion in funding for rural health clinics and hospitals;\(^\text{29}\) and
» $29 million allocated annually for fiscal years 2021 through 2025 for grant programs administered by the Health Resources and Services Administration (HRSA) promoting the expansion of telehealth services, with at least half of the funds allocated to projects in rural areas.\(^\text{30}\)

In March 2021, Congress passed the American Rescue Plan (ARP), which contained a third round of economic impact payments. The $1.9 trillion bill also included:

» $1.9 trillion bill also included:

» $174 billion for vaccine distribution, COVID-19 testing, contact tracing, and other health measures;
» extension of the Paycheck Protection Program and unemployment benefits;
» $350 billion state and local government fiscal recovery fund—which includes a $10 billion Coronavirus Capital Projects Fund for capital projects related to the pandemic;
» temporary expansion of subsidies to purchase health insurance through the federal marketplace; and
» $8.5 billion to reimburse rural healthcare providers for expenses and lost revenues associated with the COVID-19 pandemic.\(^\text{31,32,33}\)

State Actions
Since the emergence of COVID-19, Southern states have taken numerous measures in response to the pandemic. A summary of all state-level COVID-19 legislation is beyond the scope of this report. Instead, what follows is a summary of important state-level legislation related to rural hospitals and rural healthcare enacted since January 2020. As the pandemic is still ongoing and states are still responding, this summary is not exhaustive. The information below is current as of April 30, 2021.

### Alabama
Alabama’s fiscal year 2021 budget bill appropriated $2 million to the Office of Primary Care and Rural Health to give annual payments to licensed physicians or nurse practitioners who agree to practice in a medically underserved rural area. Payments up to $50,000 each year can be awarded for a maximum of three years. Additionally, the bill appropriated $2.7 million for the Family Practice Rural Health Board, which distributes the funds to rural health programs and scholarships in the state.\(^\text{34}\)

Passed in May 2020, House Bill 236 expanded a tax credit offered to physicians who practice in rural areas of the state to include certified registered practitioners and anesthetists. Qualifying healthcare providers receive a $5,000 tax credit for practicing in a small or rural community.\(^\text{35}\)

In April 2021, the Legislature appropriated $1.25 million for the Rural Hospitals Resource Center at the University of Alabama at Birmingham,\(^\text{36}\) created by legislation enacted in 2018. The Center, which plans to begin operations in 2021, will provide technical assistance and support to rural hospitals in the state.\(^\text{37}\)

### Arkansas
The Legislature passed Senate Bill 410 in April 2021 to replace Arkansas Works—the state’s Medicaid Section 1115 demonstration project—with the Arkansas Health and Opportunity for Me (ARHOME) program. The new program will continue to offer health insurance to low-income residents and include physical and mental health treatment. It will also address rural Arkansans’ health-related social needs through hospital-based community bridge organizations and work to strengthen the finances of critical access hospitals and other rural hospitals. The legislation defines a
“small rural hospital” as one with 50 or fewer staffed beds, located in a rural area, and enrolled as an Arkansas Medicaid provider.38

**Georgia**

Georgia’s fiscal year 2021 appropriations bill, House Bill 793 (2020), directed federal CARES Act funds to the relevant state programs ($4.8 million for the Small Rural Hospital Improvement Program and $95,455 for the Area Health Education Centers Program) and increased the available funds for the Rural Hospital Stabilization Grants program from $3 million to $15 million. The Rural Hospital Stabilization Committee, created in 2014 by then-Governor Nathan Deal, is responsible for administering these grants.39

**Kentucky**

House Bill 387, codified in April 2020, created the Rural Hospital Operations and Facilities Revolving Loan Fund to support struggling rural hospitals. The Kentucky Cabinet for Economic Development determines the terms and conditions of each loan; monitors the performance of the recipient hospital; and issues a report on the status of all loans to the Interim Joint Committee on Appropriations and Revenue each year by October 1.40 House Bill 556 (2021) appropriated $20 million in fiscal year 2022 to the Rural Hospital Operations and Facilities Revolving Loan Fund, which had not received funding before this legislation.41

**Mississippi**

In June 2020, the Legislature passed a bill to establish the Mississippi Center for Rural Health Innovation within the Department of Health’s Office of Rural Health. The Center aims to provide services and resources to rural hospitals, including expert analysis, training opportunities, and investment in expanding telehealth in the state. The legislation does not identify funding for the Center, as the bill drafters expected funding to come from the CARES Act and similar federal legislation.42

House Bill 1782 (2020) appropriated $1 million to rural hospitals to offset costs incurred from providing COVID-19 related care and allocated $1 million to reimburse hospitals that had more than 25 COVID-19 patients hospitalized as of June 21, 2020, but did not receive a rural provider payment from the U.S. Department of Health and Human Services. The legislation also apportioned $1.8 million to the Mississippi Rural Physicians Scholarship Program to provide funds for medical school students to serve rural areas of the state.43

Senate Bill 2799 (2021) instructed the state’s Medicaid division to recognize federally qualified health centers, rural health clinics, and community mental health centers as both originating and distant site providers for telehealth reimbursement, allowing them to offer telehealth treatment to Medicaid patients.44

**Missouri**

Missouri’s fiscal year 2021 budget bill, House Bill 2010 (2020), established a pilot grant program to support hospitals in counties with fewer than 60,000 residents or municipalities with fewer than 25,000 residents. The legislation appropriated $35 million for these grants, capped the maximum award amount for individual grants at $3.5 million, and specified that grants should be used for expenditures related to testing for COVID-19; facilities and equipment; environmental disinfection and personal protective equipment; and services and patient care innovations.45

**North Carolina**

The 2020 COVID-19 Recovery Act, House Bill 1043 (2020), codified several measures related to the pandemic. The legislation appropriated $50 million to the Department of Health and Human Services (DHHS) to provide funds for rural and underserved communities impacted by the COVID-19 pandemic and $20 million to DHHS to provide funds to support local health departments, rural health providers, the state Laboratory of Public Health, and behavioral health and crisis services. The legislation allocated $1.8 million to Old North State Medical Society, Inc., a nonprofit health organization, to be used in rural areas and African American communities for outreach, health education, and COVID-19 testing. The measure also appropriated $65 million to establish the COVID-19 Rural Hospitals Relief Fund to provide grants to Critical Access Hospitals located in
a Tier 1 county or a Tier 2 county with a population of less than 150,000 to offset costs incurred from providing COVID-19 related care.  

**Oklahoma**

The Physician Manpower Training Commission (PMTC) was established in 1975 to enhance medical care in rural and underserved areas of the state through incentive programs, such as the Intern-Resident Cost-Sharing Program, Physician Placement Program, Nursing Student Assistance Program, and other primary care training programs. In May 2020, the Legislature specified that 75 percent of the state’s funding to the PMTC must be used to train primary healthcare and family practice physicians to serve in rural and medically underserved areas of the state. The legislation also modified the process for filling vacancies on the Commission. In fiscal year 2021, the Legislature appropriated $6,546,877 to the PMTC.

**Tennessee**

House Bill 776 (2021) specified that the state shall distribute federal CARES Act funds between the Tennessee Business Relief Program, the Coronavirus Agricultural and Forestry Business Fund, the Hospital Staffing Assistance Program, the Emergency Medical Services Assistance Program, and the Tennessee Small and Rural Hospital Readiness Grant program. The Small and Rural Hospital Readiness Grant was established in April 2020 to support hospitals facing extreme financial pressure due to the COVID-19 pandemic. The following month Governor Bill Lee announced the distribution of $10 million in grants to qualifying applicants. Twenty-nine hospitals in the state have received grants ranging from $136,545 to $500,000.

**Virginia**

The state’s fiscal year 2022 budget bill codified several actions related to rural healthcare and the COVID-19 pandemic. Notable measures include an appropriation of $380,000 for a pilot program to improve rural healthcare access through the expanded use of nurse practitioners and telehealth services and $300,000 to the Office of Rural Health to continue implementing its Five-Year Action Plan to improve healthcare access in medically underserved areas. The legislation also exempts federally qualified health centers and rural health centers from an increase to the Medicare telehealth originating site facility fee imposed on other Medicare facilities in the state.

**West Virginia**

The fiscal year 2021 state budget, Senate Bill 150 (2020), appropriated $2.6 million to the Division of Human Services to support rural hospitals with less than 150 beds; and approximately $1 million to rural health outreach programs at public universities. The fiscal year 2022 state budget, House Bill 2022 (2021), made identical appropriations.

**Paths Forward**

The COVID-19 pandemic has exposed weaknesses in the rural healthcare system and highlighted the critical role that rural hospitals play. Federal COVID-19 relief bills have aided rural hospitals but are only a temporary solution. As the pandemic subsides, policymakers may wish to explore more permanent solutions.

As initially written, the Affordable Care Act of 2010 (ACA) required states to expand Medicaid to all Americans with incomes up to 133 percent of the federal poverty guideline (FPG). The Supreme Court overturned this requirement. The ACA also provided tax credits to Americans with incomes from 100 percent to 400 percent of the FPG to purchase health insurance policies through federal and state marketplaces. The ACA does not provide private health insurance tax credits to Americans below 100 percent of FPG, as the bill’s drafters expected these individuals to be covered by Medicaid expansion. As of May 2021, 38 states and the District of Columbia have expanded Medicaid. Of the 12 states that have not expanded Medicaid, eight are in the SLC region, as seen in Figure 4.

According to a 2018 study published in the academic journal Health Affairs, the frequency of rural hospital...
closures in non-Medicaid expansion states increased rapidly after 2014, the first year that Medicaid expansion was available.\(^5\) To expand the reach of Medicaid, the federal government has been willing to issue Section 1115 waivers, which allow states to create their own Medicaid qualifying criteria and rules. Section 1115 of the Social Security Act allows the secretary of Health and Human Services to approve pilot projects that promote the objectives of Medicaid. All programs must be budget-neutral to the federal government.\(^6\)

As of October 2020, CMS has approved 57 Medicaid Section 1115 waivers for 44 states. Examples of waivers include requiring recipients to work to qualify for Medicaid, requiring recipients to pay monthly premiums, and requiring tobacco users to pay a monthly surcharge.\(^6\) All 15 SLC member states have Medicaid waivers approved or currently pending approval by CMS. In February 2021, the administration notified states with waivers allowing Medicaid work requirements that CMS will be withdrawing these waivers as they do not promote Medicaid program objectives.\(^6\)

Other paths forward for states include creating task forces to understand their states’ rural healthcare needs, working with colleges and universities to incentivize medical students to practice in rural areas, and selecting rural hospitals to receive planning assistance from successful hospitals. For more on these issues, please see the November 2019 SLC Regional Resource, Rural Hospitals: Here Today, Gone Tomorrow.

Rural hospitals were on a complex trajectory before the COVID-19 pandemic, which has exacerbated existing problems. Moving forward, state legislators will need to determine whether assisting rural hospitals is in the public interest. Without state or federal intervention, one can expect the closure trend to continue.


26. Ibid.
36. Alabama House Bill 189 (2021)
42. Mississippi House Bill 94 (2020).
43. Mississippi House Bill 1782 (2020).
44. Mississippi Senate Bill 2799 (2021).
48. Oklahoma Senate Bill 1276 (2020).
49. Oklahoma Senate Bill 1922 (2020).
54. West Virginia Senate Bill 150 (2020).
This report was prepared by Nick Bowman, policy analyst and committee liaison of the Agriculture & Rural Development Committee of the Southern Legislative Conference, chaired by Senator Casey Murdock of Oklahoma. This report reflects the policy research made available to appointed and elected state officials by the Southern Office of The Council of State Governments (CSG South).

Opened in 1959 as the final regional office of CSG, the mission of the Southern Office is to promote and strengthen intergovernmental cooperation among its 15 member states, predominantly through the programs and services provided by its Southern Legislative Conference (SLC). Legislative leadership, members and staff depend on CSG South to identify and analyze solutions for the most prevalent and unique state government policy issues facing Southern states. Member outreach in state capitols, leadership development and staff exchange programs, workshops, domestic and international delegations, study tours, and policy fly-ins by the Southern Office support state policymakers and legislative staff in their work to build a stronger region.

Established in 1947, the SLC is a member-driven organization and serves as the premier public policy forum for Southern state legislatures. The SLC Annual Meeting and a broad array of similarly well-established and successful programs—focusing on both existing and emerging state government innovations and solutions—provide policymakers diverse opportunities to interact with policy experts and share their knowledge with colleagues.