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### Medicaid Expansion Expectations

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# MEDICAID EXPANSION EXPECTATIONS

Deborah R. Farringer\*

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## I. INTRODUCTION

News headlines for nearly three years have focused on how busy, full, and overcrowded hospitals have been during the global COVID-19 pandemic.<sup>1</sup> It seems almost unimaginable that at a time when health care services have proved critical that certain rural communities are experiencing the shuttering of hospital doors. This was the stark reality when Jellico Medical Center shut down in March 2021 in Jellico, Tennessee, a small town on the border of Kentucky in the heart of Appalachia.<sup>2</sup> At the time of its closing, the 54-bed hospital had not admitted a patient since the previous November, providing only emergency outpatient services.<sup>3</sup> The lack of admissions, however, was not indicative of a

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<sup>1</sup> See, e.g., Josh Nathan-Kazis, *Many Hospitals Are Getting Overwhelmed. It's a Crisis That Could Affect Healthcare for Years to Come*, BARRON'S (Jan. 14, 2022, 5:35 PM), <https://www.barrons.com/articles/covid-cases-hospitals-overwhelmed-crisis-51642170882>.

<sup>2</sup> Taylor Sisk, *Rural Tennessee Is Losing More Hospitals Than Anywhere in the Country, but COVID-19 Isn't Fully to Blame*, THE DAILY YONDER (July 27, 2021), <https://dailyyonder.com/rural-tennessee-is-losing-more-hospitals-than-anywhere-in-the-country-but-covid-19-isnt-fully-to-blame/2021/07/27/>.

<sup>3</sup> *Id.*

lack of need for services.<sup>4</sup> The hospital was located in Campbell County, which “ranks 93<sup>rd</sup> worst in health outcomes of Tennessee’s 95 counties and has a poverty rate approximately double that of the nation.”<sup>5</sup> The former operator, Rennova Health, Inc.,<sup>6</sup> had disclosed in certain company filings after closure of the hospital that it owed 49 million dollars and had spent twice as much as it was able to collect from operations of the small hospital.<sup>7</sup> Rennova Health claimed that the building owned by the city had significant deficiencies requiring a large capital investment in order to continue services—an investment that it was calling on the city to make.<sup>8</sup> Despite the Jellico city council’s announcement that another company, Boa Vida Healthcare, was under contract and would be reopening the hospital soon, the doors of the building remain closed for now.<sup>9</sup> Individuals must seek care in neighboring towns and ambulance service is only available from out-of-county providers exacerbating wait and transport times.<sup>10</sup>

The void of hospital services is not unique to Campbell County and the experiences of Jellico, Tennessee reflect similar situations across the country but primarily in the south.<sup>11</sup>

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<sup>4</sup> *Id.*

<sup>5</sup> *Id.*; see also *County Rankings and Roadmaps*, UNIV. OF WIS. POPULATION HEALTH INST., 6 (2021), [https://www.countyhealthrankings.org/sites/default/files/media/document/CHR2021\\_TN.pdf](https://www.countyhealthrankings.org/sites/default/files/media/document/CHR2021_TN.pdf).

<sup>6</sup> *Overview*, RENNOVA HEALTH, <https://www.renovahealth.com/about/overview> (last visited Mar. 7, 2022).

<sup>7</sup> Cole Sullivan, *Jellico Hospital Closed, Operator Leaves Facility Days After City Votes to Cut Ties*, WBIR 10NEWS (Mar. 3, 2021, 7:16 PM), <https://www.wbir.com/article/news/health/jellico-hospital-closed-operator-leaves-facility-days-after-city-votes-to-cut-ties/51-fcbe1327-9fef-4c23-b0ad-51d25a181a91> (explaining that the city of Jellico is the owner of the building and had entered into a contract with Rennova Health to operate the hospital, which is cancelled based on alleged breach of the contract by Rennova Health to provide contracted services).

<sup>8</sup> Blake Stevens, *City Leaders Vote to Terminate Contract with Jellico Medical Center*, ABC WATE (Mar. 3, 2021, 1:30 PM), <https://www.wate.com/news/local-news/city-leaders-vote-to-terminate-contract-with-jellico-medical-center/>.

<sup>9</sup> See Sisk, *supra* note 2; JELICO MEDICAL CENTER, <https://www.jellicomc.com/> (last visited Mar. 7, 2022) (“Jellico Medical Center is currently closed and not accepting patients. Apologies for any inconvenience caused. For information regarding access to medical records, please visit our Contact Page.”).

<sup>10</sup> See Sisk, *supra* note 2.

<sup>11</sup> See U.S. GOV’T ACCOUNTABILITY OFF., GAO-21-93, RURAL HOSPITAL CLOSURES: AFFECTED RESIDENTS HAD REDUCED ACCESS TO HEALTH CARE SERVICES 8 (2020), <https://www.gao.gov/assets/gao-21-93.pdf> [hereinafter “Rural Hospital Report 2020”]. When Jellico Medical Center shut down, the next closest hospital in the state is in LaFollette, which is approximately 25 miles from Jellico. According to a 2020 GAO Report, “residents living in the closed hospitals’ service areas would have to travel substantially farther to access certain health care services. Specifically, . . . the median distance to access of the more common health care services increased by about 20 miles from 2012 to 2018. For example, the median distance to access general inpatient services was 3.4 miles in 2012, compared to 23.9 miles in 2018.” *Id.* at 2.

Twenty-one of Tennessee's ninety-five counties do not have a hospital, making Tennessee the state with the highest rural hospital closure per capita than any other state.<sup>12</sup> While the situation is particularly dire in Tennessee, for almost a decade, the financial stability of hospitals in rural communities has been in peril across the United States.<sup>13</sup> With rising health care costs and declining rural populations, health care administrators, policy analysts, and state and federal legislators have been struggling to identify the right combination of tools and resources that might stave off hospital closures and decreased access to care in rural communities. The global coronavirus pandemic has further accelerated the crises already existing in many rural hospitals and has caused an entirely new set of obstacles for rural communities in trying to ensure access to needed services.<sup>14</sup> Rural hospital fragility poses issues beyond health access. It is well documented that the loss of a hospital and health services in a community impacts the economic viability and sustainability of the community-at-large.<sup>15</sup> According to the American Hospital Association ("AHA"), hospitals support \$2.30 of business activity for every dollar that a hospital spends.<sup>16</sup> Furthermore, because a hospital might be one of the largest employers in a rural community, the influence of a hospital is felt to an even greater extent.<sup>17</sup> Carolyn Bruce, then-CEO of Western Healthcare Alliance in Grand Junction, Colorado, stressed the importance of hospitals to the community in 2018, stating: Decreasing services or closing a hospital stunts

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<sup>12</sup> See Sisk, *supra* note 2.

<sup>13</sup> See generally U.S. GOV'T ACCOUNTABILITY OFF., GAO-18-34, RURAL HOSPITAL CLOSURES: NUMBER AND CHARACTERISTICS OF AFFECTED HOSPITALS AND CONTRIBUTING FACTORS 2 (2018), <https://www.gao.gov/assets/gao-18-634.pdf> [hereinafter, "Rural Hospital Report 2018"].

<sup>14</sup> See Jessie Hellmann, *Rural Reckoning: COVID-19 Highlights Long-Standing Challenges Facing Rural Hospitals. Will It Create Momentum for Change?*, MOD. HEALTHCARE (Oct. 19, 2021, 5:00 AM), <https://www.modernhealthcare.com/providers/rural-reckoning-covid-19-highlights-long-standing-challenges-facing-rural-hospitals-will> (citing various challenges either arising or lingering with rural hospitals including nursing shortages, recruitment issues, uninsured and uncompensated care, vaccine hesitancy, COVID-19 burnout, etc.).

<sup>15</sup> See George M. Holmes, Rebecca T. Slifkin, Randy K. Randolph & Stephanie Poley, *Underserved Populations: The Effect of Rural Hospital Closures on Community Economic Health*, 41(2) HEALTH SERVS. RSCH. 467, 467 (Apr. 2006), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1702512/pdf/hesr041-0467.pdf>; Mark Holmes, *Rural Hospital Closure and Effect on Local Economies*, RURAL HEALTH RSCH. GATEWAY, <https://www.ruralhealthresearch.org/projects/100002523> (last visited Mar. 7, 2022).

<sup>16</sup> *Rural Hospitals: The Beating Heart of a Local Economy*, NAT'L RURAL HEALTH ASS'N (June 18, 2018), <https://www.ruralhealth.us/blogs/ruralhealthvoices/july-2018/rural-hospitals-the-beating-heart-of-a-local-econ> (analyzing the *American Hospital Association's January 2017* report on the economic contributions of hospitals).

<sup>17</sup> *Id.*

growth. Companies are rarely attracted to relocate to a community with little or no health care. Existing businesses may be forced to close or move out of the community. The rest of the community, health-wise and economically, can enter a downward spiral of decline.”<sup>18</sup> Thus, hospital closures create more than a health crisis—the closures can devastate the community at-large.

Although financial stability in rural hospitals has been a relatively long-standing national problem,<sup>19</sup> in the last decade, hospital closures and the incidence of highly distressed hospitals in rural areas have disproportionately impacted certain states.<sup>20</sup> States that have not expanded their Medicaid programs under the Affordable Care Act,<sup>21</sup> which implemented a program to extend additional federal support to cover adults living below 138% of the federal poverty line (referred to herein as “Medicaid Expansion”), are bearing the brunt of this crisis.<sup>22</sup> Since 2010, Tennessee has seen the most hospital closures per capita with 16 closures, including Jellico Medical Center, and Texas leads the country in the number of hospital closures with 21 closures since 2010.<sup>23</sup> Neither state has expanded its Medicaid program and has no pending referendums to do so.<sup>24</sup> In fact, only 12 states have yet to adopt Medicaid Expansion,<sup>25</sup> and eight of those twelve states lead the country in hospital closures.<sup>26</sup> Although the reason for hospital closures is multi-faceted and complex, health policy experts have consistently identified the lack of Medicaid Expansion as a key driver for

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<sup>18</sup> *Id.*

<sup>19</sup> See Rural Hospital Report 2018, *supra* note 13, at 5.

<sup>20</sup> See Taylor Sisk, *As Appalachian Hospitals Disappear, Rural Americans Grapple with Limited Care*, NAT’L GEOGRAPHIC (July 14, 2021), <https://www.nationalgeographic.com/history/article/appalachian-hospitals-are-disappearing>.

<sup>21</sup> Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010).

<sup>22</sup> See Richard C. Lindrooth, Marcelo C. Perrillon, Rose Y. Hardy & Gregory J. Tung, *Understanding The Relationship Between Medicaid Expansions And Hospital Closures*, 37 HEALTH AFFS. no. 1, 111, 116 (2018); Rural Hospital Report 2018, *supra* note 13, at 26 (“A 2018 study found that Medicaid expansion was associated with improved hospital financial performance and substantially lower likelihood of closure, especially in rural markets and counties with large numbers of uninsured adults before Medicaid expansion.”).

<sup>23</sup> *Rural Hospital Closures*, THE CECIL G. SHEPS CTR. FOR HEALTH SERVS. RSCH., UNIV. OF N.C., <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/> (last visited Mar. 8, 2022).

<sup>24</sup> See *Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAM. FOUND. (Jan. 31, 2022), <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/> [hereinafter “Medicaid Expansion Status”].

<sup>25</sup> *Id.*

<sup>26</sup> Sisk, *supra* note 2.

hospital closures and consider future adoption of expansion as an imperative.<sup>27</sup> To that end, there have been several initiatives within the last year to promote and incentivize the remaining twelve states that have not expanded their Medicaid programs to do so.<sup>28</sup> Thus far, no states have opted for expansion based on these incentives—although Medicaid Expansion remains an option.<sup>29</sup> Several other bills have been proposed in Congress to close the so-called “coverage gap,”<sup>30</sup> which range from a federal public option for those in the gap to additional state incentives.<sup>31</sup> What, if any, of these are the right approach, and what might be the impact of each of these initiatives on helping to slow the health care access crisis that is ongoing in rural communities? Are there other factors in these particular states and rural communities that make them exceptionally vulnerable regardless of Medicaid Expansion? Are expectations for the benefits of Medicaid Expansion so high that the hopes for what will be possible for rural hospitals and communities will be unable to be realized? This Article will argue that current federal initiatives attempting to incentivize states to expand Medicaid, while well-intentioned, are politically challenging and unlikely to be successful with the present state leadership. Regardless, the adoption of Medicaid Expansion will remain a key component to maintaining stability in rural health markets and continued federal efforts to narrow the coverage gap should continue.

This Article will explore both current and proposed legal approaches aimed at closing the Medicaid coverage gap to determine whether such efforts

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<sup>27</sup> Nicole Huberfeld, *Rural Health, Universality, and Legislative Targeting*, 13 HARV. L. & POL’Y REV. 241, 250–51 (2018); *See also* Rural Hospital Report 2018, *supra* note 13, at 27.

<sup>28</sup> American Rescue Plan Act of 2021, Pub. L. No. 117-2, 135 Stat. 247 (2021).

<sup>29</sup> It should be noted that at the time that the American Rescue Plan Act was enacted, Missouri and Oklahoma had approved Medicaid Expansion via a ballot initiative, but it had not yet been implemented in either state. Both states were eligible for the incentive payments if they implemented expansion as of July 1, 2021. Oklahoma implemented Medicaid Expansion as of July 1, 2022. Missouri did not start taking applications until October 1, 2021, but pursuant to a court order the applications were retroactive until July 1, 2021. *See* Medicaid Expansion Status, *supra* note 24.

<sup>30</sup> Rachel Garfield, Kendal Orgera & Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, KAISER FAM. FOUND. (Jan. 21, 2021), <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.

<sup>31</sup> *See generally* Meghana Ammula & Robin Rudowitz, *Federal Policy May Temporarily Close the Coverage Gap, but Long-Term Coverage May Fall Back to States*, KAISER FAM. FOUND. (Nov. 4, 2021), <https://www.kff.org/policy-watch/federal-policy-may-temporarily-close-the-coverage-gap-but-long-term-coverage-may-fall-back-to-states/>; John Holahan & Michael Simpson, *Filling the Medicaid Gap With a Public Option*, URB. INST. (July 14, 2021), [https://www.urban.org/research/publication/filling-medicaid-gap-public-option#:~:text=Federal%20spending%20for%20the%20Medicaid,depending%20on%20the%20s%20ubsidy%20schedule; Dave Muoio, Closing Medicaid Gap With a Public Option Would Save Federal Government Billions, Analysis Says, FIERCE HEALTHCARE \(July 15, 2021, 7:30 AM\), https://www.fiercehealthcare.com/payer/closing-medicaid-gap-a-public-option-would-save-federal-government-billions-analysis-says](https://www.urban.org/research/publication/filling-medicaid-gap-public-option#:~:text=Federal%20spending%20for%20the%20Medicaid,depending%20on%20the%20s%20ubsidy%20schedule; Dave Muoio, Closing Medicaid Gap With a Public Option Would Save Federal Government Billions, Analysis Says, FIERCE HEALTHCARE (July 15, 2021, 7:30 AM), https://www.fiercehealthcare.com/payer/closing-medicaid-gap-a-public-option-would-save-federal-government-billions-analysis-says).

will be successful in creating greater financial stability for rural health care providers and the communities they serve. In Part II, it will examine the existing research and literature regarding rural hospital closures since 2010 and how a state's decision to adopt Medicaid Expansion impacts closures and economic stability for the entire community. It will further outline the efforts to incentivize Medicaid Expansion through the American Rescue Plan of 2021,<sup>32</sup> and survey other proposals at federal and state levels aimed at creating greater sustainability for hospital providers in rural markets. In Part III, the Article will compare rural hospitals in expansion states to those in non-expansion states to ascertain whether the expectations for Medicaid Expansion will meet reality. This Part will also analyze the legislative climate in those states that have yet to expand their Medicaid coverage for purposes of understanding the likelihood of success in current efforts. In Part IV, this Article will argue that current incentive-based efforts to close the Medicaid coverage gap in the twelve remaining states that have not yet adopted Medicaid Expansion are unlikely to be successful due to political barriers in those states, both actual and perceived. It will further argue that narrowing or closing the coverage gap nevertheless remains a vital aspect of stabilizing health access and resources in rural communities and that federal efforts to continue to narrow or close that gap should continue. Even if these efforts will not save all hospitals, increasing health access through other forms of providers such as emergency-only services will still require a largely insured population for long-term stability. Part V will then conclude by offering a few suggestions regarding where federal regulators and legislators should focus their efforts to stem the tide of rural hospital closure and instability and further endeavor to suggest ways in which current proposed bills might better target specific issues that will bolster the health care infrastructure of rural communities. This issue needs to be addressed with great urgency to prevent further gaps in the urban-rural health care divide.

## II. BACKGROUND

### A. *The Status of Rural Health*

The challenges of providing access to high quality health care to individuals living in rural communities have been long-standing, vexing federal and state regulators and legislators for years.<sup>33</sup> United States Department of Health and Human Services ("HHS") first established the Federal Office of Rural Health Policy ("FORHP") in 1987 to "advise HHS on the effects that federal health care policies and regulations have on the financial viability of small rural hospitals and access to health care in rural areas."<sup>34</sup> Thus, the federal government, along with various state governments and non-profit organizations

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<sup>32</sup> American Rescue Plan Act of 2021, Pub. L. No. 117-2, 135 Stat. 247 (2021).

<sup>33</sup> See generally Rural Hospital Report 2018, *supra* note 13, at 1.

<sup>34</sup> See *id.*

and associations, have been studying the unique nature and dynamics of rural communities to address and respond to the specific needs and obstacles to health access in rural areas.<sup>35</sup> In a 2018 report, the Government Accountability Office (“GAO”) reported that FORHP had found that 48% of the 2,250 acute care hospitals across the nation are considered to be rural,<sup>36</sup> serving approximately 18% of the United States population.<sup>37</sup> FORHP identified some key characteristics of rural populations that contribute to challenges regarding health care services generally: (1) rural counties contain a higher percentage of elderly residents as compared to urban communities; (2) individuals who experience limitations in their activities due to chronic conditions constitute a higher percentage of the population in rural areas than in urban areas; and (3) individuals living in rural counties earn a lower median household income than their urban counterparts.<sup>38</sup> These challenges are exacerbated by changing dynamics in rural communities, including declining populations in rural areas and slower employment growth.<sup>39</sup>

Declining populations have specifically exacerbated health disparities, as younger, healthier people have left rural areas, leaving behind a population that is, on average, older and has higher injury and smoking rates.<sup>40</sup> The Centers for Disease Control (“CDC”) conducted a series of studies, released in 2017, focused on various health statistics for rural adults, including racial and ethnic health disparities, occupational health risks, illicit drug use and drug overdose

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<sup>35</sup> See, e.g., Jack Hoadley, Karina Wagnerman, Joan Alker, & Mark Holmes, *Medicaid in Small Towns and Rural America: A Lifeline for Children, Families, and Communities*, GEO. UNIV. CTR. FOR CHILD. AND FAM. 9 (June 2017), <https://ccf.georgetown.edu/wp-content/uploads/2017/06/Rural-health-final.pdf>; Wendy Long, Will Cromer, Gabe Roberts, & William Aaron, *FY2018 Budget Presentation*, TENN. DIV. OF HEALTH CARE FIN. & ADMIN. 3 (Nov. 22, 2016), <https://www.tn.gov/content/dam/tn/governoroffice-documents/governoroffice-documents/TennCare.pdf>; *Rural Health Policy*, RURAL HEALTH INFO. HUB, <https://www.ruralhealthinfo.org/topics/rural-health-policy> (last visited Mar. 8, 2022); *The Rural Health Safety Net Under Pressure: Rural Hospital Vulnerability*, THE CHARTIS GROUP (Feb. 2020), [https://www.chartis.com/forum/wp-content/uploads/2020/02/CCRH\\_Vulnerability-Research\\_FINAL-02.14.20.pdf](https://www.chartis.com/forum/wp-content/uploads/2020/02/CCRH_Vulnerability-Research_FINAL-02.14.20.pdf).

<sup>36</sup> See Rural Hospital Report 2018, *supra* note 13, at 3. According to the GAO Report, FORHP “identifies ZIP Codes as rural if they are in: (i) a non-metropolitan county; (ii) a metropolitan county, but with a Rural-Urban Commuting Area code of 4 or higher; or (iii) one of 132 large and sparsely populated census tracts with a Rural-Urban Commuting Area code of 2 or 3.” See Rural Hospital Report 2020, *supra* note 11, at 2 n.3.

<sup>37</sup> Amazingly, these hospitals are located in areas that constitute 84% of the U.S. land area. This means that 82% of the U.S. population lives and receives care in only 16% of the land area of the entire county. See Rural Hospital Report 2018, *supra* note 13, at 3–4. These statistics are unchanged in a subsequent report in 2020. See Rural Hospital Report 2020, *supra* note 11, at 2.

<sup>38</sup> Rural Hospital Report 2018, *supra* note 13, at 4.

<sup>39</sup> *Id.* at 4–5.

<sup>40</sup> According to the CDC, the rural population declined by almost half from 1970 to 2015. U.S. DEPT. OF HEALTH & HUMAN SERV., HEALTH, UNITED STATES, 2016: WITH CHARTBOOK ON LONG-TERM TRENDS IN HEALTH 15 (2017).

deaths, suicide risks, motor vehicle deaths, breast and other cancer incidences, air quality, diabetes self-management programs, mental health disorders, health-related behaviors, and leading causes of death.<sup>41</sup> Among the various reports, it is clear that rural populations experience greater health disparities than their urban counterparts. For example, in 2004 the drug overdose death rates for both urban and rural areas converged, and since 2014 drug overdose deaths in rural areas have eclipsed those in urban areas.<sup>42</sup> By 2015, 17 per 100,000 individuals in non-metropolitan areas were dying of drug overdoses as compared to 16.2 per 100,000 individuals in metropolitan areas.<sup>43</sup> Similarly, suicide rates are higher in rural areas, as opposed to urban communities, with suicide by firearms occurring at nearly double that in metropolitan areas.<sup>44</sup> Moreover, mental health resources are also more scarce in rural areas, and there is a higher percentage of children in rural areas that live in a home with a parent who has a mental, behavioral, and development disorder (“MBDD”) and experience financial disparities at a greater extent than children in urban settings.<sup>45</sup> Whether health disparities in rural populations are a symptom of failing hospitals or the cause is not entirely clear, but the continued closure of hospitals and reduction of access in rural areas will contribute to and intensify health disparities.

When considering the types of services and providers that are available in rural areas, the Governmental Accountability Office (“GAO”) issued a report in 2020 comparing services in counties without hospital closures to counties with hospital closures.<sup>46</sup> Without comment as to the cause or effect of provider financial instability, the GAO noted that counties without hospital closures had a greater percentage of service offerings at their hospital.<sup>47</sup> Most notably, counties without closures had a great percentage of hospital-based outpatient

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<sup>41</sup> See *Morbidity and Mortality Weekly Report (MMWR): MMRW Rural Health Series*, CTR. FOR DISEASE CONTROL & PREVENTION, [https://www.cdc.gov/mmwr/rural\\_health\\_series.html](https://www.cdc.gov/mmwr/rural_health_series.html) (last visited Mar. 8, 2022).

<sup>42</sup> Karin A. Mack, Christopher M. Jones & Michael F. Ballesteros, *Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas—United States*, CTR. FOR DISEASE CONTROL & PREVENTION (Oct. 20, 2017), [https://www.cdc.gov/mmwr/volumes/66/ss/ss6619a1.htm?s\\_cid=ss6619a1\\_w](https://www.cdc.gov/mmwr/volumes/66/ss/ss6619a1.htm?s_cid=ss6619a1_w).

<sup>43</sup> *Id.*

<sup>44</sup> Asha Z. Ivey-Stephenson, Alex E. Crosby, Shane P.D. Jack, Tadesse Haileyesus, et al., *Suicide Trends Among and Within Urbanization Levels by Sex, Race/Ethnicity, Age Group, and Mechanism of Death—United States, 2001–2015*, CTR. FOR DISEASE CONTROL & PREVENTION (Oct. 6, 2017), <https://www.cdc.gov/mmwr/volumes/66/ss/ss6618a1.htm>.

<sup>45</sup> Lara R. Robinson, Joseph R. Holbrook, Rebecca H. Bitsko, Sophie A. Hartwig, et al., *Differences in Health Care, Family, and Community Factors Associated with Mental, Behavioral, and Development Disorders Among Children Aged 2–8 Years in Rural and Urban Areas—United States, 2011–2012*, CTR. FOR DISEASE CONTROL & PREVENTION (Mar. 17, 2017), <https://www.cdc.gov/mmwr/volumes/66/ss/ss6608a1.htm>.

<sup>46</sup> Rural Hospital Report 2020, *supra* note 11, at 12–13.

<sup>47</sup> *Id.*

services available.<sup>48</sup> For example, in 2017, in counties with hospital closures, only 34.9% of the hospitals offered hospital-based outpatient care centers whereas 65.8% of hospitals in counties without closures had these services.<sup>49</sup> Similarly, only 36.5% of hospitals in counties with closures offered outpatient surgery in 2017, whereas 72.7% of the hospitals in counties without closures provided that same service that year.<sup>50</sup> These same findings were true for other outpatient services such as a free-standing outpatient care centers, urgent care centers, and pain management services; in all instances, the counties without closures offered a greater percentage of these services.<sup>51</sup> It is difficult to glean causation from these statistics. Did patients stop seeking care at hospitals in counties with closures due to quality or other concerns, thus reducing and limiting the services these distressed hospitals were able to provide? Or, did the hospitals in counties with closures start reducing or limiting services to save money or reduce expense, which in turn drove patients to seek care in counties without closures where hospital services are more robust? The GAO noted:

The reductions in these hospitals from 2012 to 2017 may have affected residents' utilization of health care services. For example, HHS data show that from 2012 to 2017, the median rate of hospital outpatient visits per 1,000 Medicare FFS beneficiaries declined among those in services areas with rural hospital closures, but increased among those in service areas without closures.<sup>52</sup>

It is not clear from this statement whether the hospitals had made conscious decisions to reduce or limit services or whether it was driven by already declining patient volumes. Regardless, the information makes clear that the availability and accessibility of robust care involving a variety of inpatient and outpatient services are critical to support ongoing access and services.

Additionally, there has been a dramatic shift in the last 20 years to outpatient services away from inpatient services, and outpatient services on average tend to wield higher margins than inpatient services.<sup>53</sup> Medicaid

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<sup>48</sup> *Id.*

<sup>49</sup> *Id.* at 12.

<sup>50</sup> *Id.*

<sup>51</sup> *Id.* at 13.

<sup>52</sup> *Id.*

<sup>53</sup> Pooja Kumar & Ramya Parthasarathy, *Walking Out of the Hospital: The Continued Rise of Ambulatory Care and How to Take Advantage of It*, MCKINSEY & CO. (Sept. 18, 2020), <https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/walking-out-of-the-hospital-the-continued-rise-of-ambulatory-care-and-how-to-take-advantage-of-it>; *see also*, *A Primer on Interpreting Hospital Margins*, THE CECIL G. SHEPS CTR FOR HEALTH SERVS. RSCH., UNIV. OF N.C. (July 2003), <https://www.shepscenter.unc.edu/wp-content/uploads/2014/10/Primer.pdf> (noting a shift that took place after 1999 due to a revision in the applicable regulations that reduced or eliminated the incentive that hospitals had to “maximize

Expansion with its provision of increased funding for indigent patients—even if Medicaid pays only pennies on the dollar—has to be a factor as to viability, given that the West and the South offer approximately the same amount of outpatient services on average (67% and 66%, respectively) and the Northeast has a substantially lower percentage (58%),<sup>54</sup> and yet the number of hospital closures in 2010 is just six hospitals in the West and eight hospitals in the Northeast, as compared to 72 hospitals in the South.<sup>55</sup> Consistent with reports regarding the financial viability of Jellico Medical Center before its closing, the GAO noted that rural hospitals that ultimately closed were financially distressed in the years leading up to the closure.<sup>56</sup> The median margins for rural hospitals were already in decline in the two years prior to the hospital's closure.<sup>57</sup> When looking at currently distressed hospitals, The North Carolina Rural Hospital Research Project has found large increases in the percentage of rural hospitals in the South that are already financially distressed, consistent with the increased number of hospital closures in this region relative to other regions in the U.S.<sup>58</sup>

While rural populations tend to be more racially and ethnically homogenous than urban areas, it should be noted that Hispanics are the fastest growing segment of the rural population, currently accounting for approximately 8.6% of the rural population.<sup>59</sup> This is important to note when considering existing health disparities, as studies have shown that there is a disproportionate impact of a lack of Medicaid Expansion on individuals who are African American and Hispanic because these populations have a higher percentage of individuals who are living in poverty.<sup>60</sup> For example, African Americans constitute 20% of the Medicaid population, but represent only 13.4% of the total

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reimbursement by allocating more overhead costs to outpatient areas. Thus, artificially low outpatient margins are built into the new payment system.”)

<sup>54</sup> See *A Primer on Interpreting Hospital Margins*, *supra* note 53.

<sup>55</sup> Rural Hospital Report 2020, *supra* note 11, at 8.

<sup>56</sup> *Id.* at 20; see also Sullivan, *supra* note 7.

<sup>57</sup> See Rural Hospital Report 2020, *supra* note 11 (noting a 3.3% decline in margin in the 2 years prior and then to 13.8% decline in the margin in the year prior to the closure).

<sup>58</sup> *Id.* at 14; Rural Hospital Closures, *supra* note 23.

<sup>59</sup> *Racial and Ethnic Minorities Made up About 22 Percent of the Rural Population in 2018, Compared to 43 Percent in Urban Areas*, ECON. RSCH. SERV., U.S. DEP'T OF AGRIC. (Oct. 13, 2020), <https://www.ers.usda.gov/data-products/chart-gallery/gallery/chart-detail/?chartId=99538#:~:text=In%202018%2C%20Whites%20accounted%20for,19.8%20percent%20of%20urban%20areas>.

<sup>60</sup> See Renee M. Landers, *Buffering Against Vicissitude: The Role of Social Insurance in the COVID-19 Pandemic and in Maintaining Economic Stability*, 49 GA. J. OF INT'L & COMPAR. L. 505, 518 (2021) (citing Jesse Cross-Call & Matt Broadus, *States That Have Expanded Medicaid Are Better Positioned to Address COVID-19 and Recession*, CTR. ON BUDGET & POL'Y PRIORITIES (July 14, 2020), <https://www.cbpp.org/research/health/states-that-have-expanded-medicaid-are-better-positioned-to-address-covid-19-and>).

population in the U.S.<sup>61</sup> Similarly, 29.3% of Medicaid recipients are Hispanic, but individuals who identify as Hispanic or Latino make up only 18.5% of the national population.<sup>62</sup> Granted, as of right now many of these individuals dwell in more urban areas, but this highlights another challenge that is presented as some of the demographics shift and when considering the individual impact of the Medicaid program more holistically.

*B. Medicaid Expansion and Hospital Closure Risk*

While certain gaps in health care services have existed in rural and urban communities for some time, the differences began to widen rather significantly when Medicaid Expansion was first made available to the states as part of the ACA.<sup>63</sup> Prior to the COVID-19 public health emergency, of a total Medicaid population of 75.2 million individuals, approximately 15.3 million individuals were enrolled in Medicaid Expansion.<sup>64</sup> In addition, about 4.3 million people in the twelve non-Expansion states would have been eligible for Medicaid Expansion, if their states had expanded.<sup>65</sup> This means that nearly 20 million individuals, the majority of whom were uninsured or underinsured prior to the ACA, would now have state Medicaid insurance. Approximately 2.2 million of the four million living in non-expansion states fall into what is referred to as the “coverage gap,” which is the population of individuals who earn greater than the maximum income eligible for their state’s Medicaid coverage, but less than the minimum required to be eligible for subsidies and credits on the insurance exchange.<sup>66</sup> The remaining 1.8 million individuals earn enough to qualify for subsidies and credits to purchase private insurance on a health insurance exchange, but would qualify for Medicaid (presumably at a lower cost to the individual) if the state had adopted Medicaid Expansion.<sup>67</sup> More than one-third of those in the “coverage gap” live in Texas and approximately 40% reside in the states of Florida, Georgia, and North Carolina.<sup>68</sup> As a corollary, Texas leads the country in the number of hospital closures, and North Carolina and Georgia are

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<sup>61</sup> See *Distribution of the Nonelderly with Medicaid by Race/Ethnicity*, KAISER FAM. FOUND. (2019), <https://www.kff.org/medicaid/state-indicator/medicaid-distribution-nonelderly-by-raceethnicity/>; *Quick Facts*, U.S. CENSUS (July 1, 2021), <https://www.census.gov/quickfacts/fact/table/US>.

<sup>62</sup> *Id.*

<sup>63</sup> See 42 U.S.C.A. § 1396d(y)(2)(A) (West 2022).

<sup>64</sup> See Garfield et al., *supra* note 30.

<sup>65</sup> *Id.*

<sup>66</sup> *Id.* The current minimum income for eligibility for subsidies and credits on the health insurance exchanges is 100% of the federal poverty level.

<sup>67</sup> *Id.*

<sup>68</sup> *Id.* (noting that, of those individuals in the Coverage Gap, 19% are from Florida, 12% are from Georgia, and 10% are from North Carolina).

tied for fourth-most, with six hospital closures each since 2013.<sup>69</sup> In contrast, there are only two states outside the south that had four or more closures since 2013: Kansas, which has had four closures, and Missouri, which has had six closures.<sup>70</sup> Notably, Kansas has not adopted Medicaid Expansion and Missouri adopted Medicaid Expansion via state ballot measure, which became effective as of July 2021.<sup>71</sup>

The possibility of Medicaid availability for up to 20 million people for whom it was not previously available is impactful. With a more elderly and less wealthy population in rural areas, it is not surprising that “rural hospitals are more reliant on public payers and have lower operating margins.”<sup>72</sup> From when Medicaid Expansion was first made optional, studies showed a correlation between Medicaid Expansion and increased stability for rural markets: “[S]tudies have shown that, on average, Medicaid revenues and Medicaid-covered hospital discharges have increased more, and charity care (care for which no payment is expected) and bad debt (unrecoverable debt) have decreased more, in states that have expanded Medicaid than in those that have not.”<sup>73</sup>

The Chartis Group undertook an extensive study into the various factors that impact hospital closures in a state and identified nine indicators as having a significant impact.<sup>74</sup> The report listed the following significant indicators: average age of plan, case mix index, government control status, percentage capital efficiency, percentage change total revenue, percentage occupancy, percentage outpatient revenue, system affiliation, and state-level Medicaid Expansion.<sup>75</sup> Medicaid Expansion status was one of the highest impacts overall, finding that “being located in a Medicaid expansion state decreases the likelihood of closure by 62 percent on average.”<sup>76</sup> In fact, Medicaid Expansion status was second only to Government Control Status, which was shown to decrease the likelihood of closure by 70% on average.<sup>77</sup> The report then used this information to chart and anticipate the vulnerability of rural hospitals going forward.<sup>78</sup> Not

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<sup>69</sup> See Rural Hospital Closure Report 2020, *supra* note 11, at 8. Tennessee comes in second with 12 hospital closures since 2013 followed by Oklahoma in third with seven hospital closures.

<sup>70</sup> *Id.*

<sup>71</sup> Medicaid Expansion Status, *supra* note 24.

<sup>72</sup> See Brystana G. Kaufman, *Medicaid Expansion Affects Rural and Urban Hospitals Differently*, 35 HEALTH AFFS., no. 9 1665, 1665 (Sep. 2016), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.0357>.

<sup>73</sup> *Id.*

<sup>74</sup> *The Rural Health Safety Net Under Pressure*, *supra* note 35, at 3.

<sup>75</sup> *Id.*

<sup>76</sup> *Id.* at 4.

<sup>77</sup> *Id.* at 8. Government Control Status is presumed in the report as “[h]aving—or securing—government control status opens doors to additional funding and access to resources.” Government control would be when the hospital has some sort of status that enables government funding, including being operated by a county, city, or municipality, or by the federal government.

<sup>78</sup> *Id.* at 6.

unlike statistics regarding hospital closures that have taken place thus far since 2010, the report identified that states located in the southwest and lower Great Plains are the most vulnerable for additional closures, identifying an additional 36 hospitals in Texas and 19 in Kansas.<sup>79</sup> Tennessee has only 48 rural hospitals total, but 25 of those are considered “vulnerable” and 15 are considered “most vulnerable.”<sup>80</sup> This constitutes 52% of the state’s hospitals being considered as vulnerable.<sup>81</sup> Texas was a close second with 51% of its hospitals considered to be vulnerable (of a total rural hospital count of 152), and Missouri, Mississippi, North Carolina, Alabama, South Carolina, Kansas, and Wyoming all have 30% or more of their hospitals considered vulnerable.<sup>82</sup> At the time the report was issued, none of the states in this list had adopted Medicaid Expansion.<sup>83</sup>

Unsurprisingly, failure to adopt Medicaid Expansion, which impacts hospital financial stability, has also led to a decline in access to care in non-expansion states. Several studies have concluded that Medicaid Expansion is “associated with great improvements in access to care in rural areas, including increased HIV diagnosis and access to mental health care.”<sup>84</sup> Further, other studies have also indicated that rural hospitals that were located in states that have expanded their Medicaid programs lead to “substantial improvements in financial performance.”<sup>85</sup> Thus, it is not simply that lack of Medicaid expansion exacerbates existing challenges, but that Medicaid Expansion bolsters and supports hospitals that might otherwise be financially weak.

Despite the available evidence for state legislators and governors regarding the benefits of Medicaid Expansion for rural hospitals and thus in turn the benefits for the economy of the community overall, adoption of expansion in remaining states has been significantly slowed since its first opportunity for adoption in 2014. By the end of 2015, 28 states had adopted Medicaid Expansion.<sup>86</sup> Another two states adopted expansion in 2016, and the remaining nine states expanded their Medicaid programs within the last two to three years, the majority of which did it by statewide ballot, thereby bypassing their governor

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<sup>79</sup> *Id.*

<sup>80</sup> *Id.* at 7.

<sup>81</sup> *Id.*

<sup>82</sup> *Id.*

<sup>83</sup> Missouri later expanded its Medicaid program through state ballot, which was effective as of July 1, 2021. *See* Medicaid Expansion Status, *supra* note 24.

<sup>84</sup> Madeline Guth & Meghana Ammula, *Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021*, KAISER FAM. FOUND. (May 6, 2021), <https://www.kff.org/report-section/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021-report/>.

<sup>85</sup> *Id.*

<sup>86</sup> *Id.*

and/or legislature.<sup>87</sup> Some of those states that expanded based on ballot initiatives had to fight in court to implement Medicaid Expansion when legislatures or governors actively fought against implementation.<sup>88</sup>

### C. Current Legislative Efforts

With the benefits of Medicaid Expansion in mind and the goal of full implementation of the ACA as envisioned, the U.S. Congress sought to reinvigorate the push for states to implement Medicaid Expansion. In 2021, Congress enacted The American Rescue Plan Act of 2021 (“ARPA”).<sup>89</sup> In general, the ARPA is intended as a stimulus bill to build on some of the aid and measures set forth in the two previous stimulus plans: the Coronavirus Aid, Relief, and Economic Security Act (“CARES Act”)<sup>90</sup> and the Consolidate Appropriations Act.<sup>91</sup> Like the other two stimulus plans before it, the bulk of the provisions under the ARPA are intended to infuse cash into the hands of individuals and businesses impacted by measures adopted for health and safety reasons under the COVID-19 public health emergency.<sup>92</sup> As such, the primary provisions of the ARPA focus on providing or supplementing individual income, including the provision of \$1,400 personal checks, an increase to the Child Tax Credit, Earned-Income Tax Credit, and Child and Dependent Care Tax Credit, an extension of unemployment insurance, monetary support for small businesses, and a reduction in health insurance premiums and provision of 100% COBRA subsidy.<sup>93</sup> Importantly, there are several provisions under the ARPA that impact

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<sup>87</sup> *Id.* Idaho, Maine, Missouri, Nebraska, Oklahoma, and Utah all approved Medicaid Expansion through a ballot initiative when their state governors and/or state legislatures either refused to act or actively worked against expansion.

<sup>88</sup> *See, e.g., Maine Governor Sued After Refusing to Implement Medicaid Expansion That Voters OK'd Months Ago*, KAISER HEALTH NEWS (May 1, 2018) (“Maine Gov. Paul LePage (R) says he won’t expand the program until state lawmakers find a way to fund it under his conditions, despite voters’ approval of a ballot initiative with nearly 60 percent support.”).

<sup>89</sup> American Rescue Plan Act of 2021, Pub. L. No. 117-2, 135 Stat. 247 (2021).

<sup>90</sup> CARES Act, Pub. L. No. 116-136, 134 Stat. 281 (2020).

<sup>91</sup> Consolidated Appropriations Act, Pub. L. No. 116-260, 134 Stat. 1182 (2021).

<sup>92</sup> *See American Rescue Plan: President Biden’s Plan to Provide Direct Relief to Americans, Contain COVID-19, and Rescue the Economy*, THE WHITE HOUSE, <https://www.whitehouse.gov/american-rescue-plan/> (last visited Mar. 8, 2022) (“The American Rescue Plan is delivering direct relief to the American people, rescuing the American economy, and starting to beat the virus.”).

<sup>93</sup> *Id.* COBRA refers to a federal program that “provides workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events.” *Continuation of Health Coverage*, U.S. DEP’T OF LAB., <https://www.dol.gov/general/topic/health-plans/cobra> (last visited Mar. 8, 2022). This law was originally enacted in the 1990s to prevent situations in which a person who leaves one job for whatever reason and then also loses access to health insurance because the insurance was provided

Medicaid specifically. First, to encourage the twelve states that have not expanded their Medicaid program,<sup>94</sup> the law provides an additional 5% increase to the state's traditional federal matching rate for Medicaid beneficiaries, which is in addition to the 90% federal matching funds already available under the ACA.<sup>95</sup> By way of background, under the traditional Medicaid program, states receive on average approximately two-thirds matching funds from the federal government to support a state's Medicaid population.<sup>96</sup> That is, the federal government pays approximately two-thirds of the cost of Medicaid and the states pay approximately one-third of the cost. When the ACA was enacted, the federal matching funds remained unchanged for the traditional Medicaid population.<sup>97</sup> The ACA added a new category of Medicaid eligibility: individuals who did not qualify for traditional Medicaid but earned less than 138%<sup>98</sup> of the Federal Poverty Level.<sup>99</sup> For this new so-called expansion population, the federal government provided matching funds far more than the typical two-thirds matching available under the traditional Medicaid program.<sup>100</sup> In fact, in fiscal years 2014, 2015, and 2016, the federal government provided 100% federal

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through an employer. It also was intended to avoid a situation in which the individual was without coverage for a time, thereby potentially exposing that person to the possibility that a future employer could deny the individual for pre-existing conditions.

<sup>94</sup> It also applied to Oklahoma and Missouri, which were both in the process of implementing Medicaid Expansion in 2021 pursuant to state ballot. See MaryBeth Musumeci, *Medicaid Provisions in the American Rescue Plan*, KAISER FAM. FOUND. (Mar. 18, 2021), <https://www.kff.org/medicaid/issue-brief/medicaid-provisions-in-the-american-rescue-plan-act/>.

<sup>95</sup> 42 U.S.C.A. § 1396a(e) (West 2022).

<sup>96</sup> “Under the formula, the federal share (FMAP) varies by state from a floor of 50 percent to a high of 78 percent for FY 2022[.]. States may receive higher FMAPs for certain services or populations. In 2019, the federal government paid 64 percent of total Medicaid costs with the states paying 36 percent.” Robin Rudowitz, Elizabeth Williams, Elizabeth Hinon & Rachel Garfield, *Medicaid Financing: The Basics*, KAISER FAM. FOUND. (May 7, 2021), <https://www.kff.org/report-section/medicaid-financing-the-basics-issue-brief/#:~:text=The%20ACA%20provided%20100%20percent,to%2090%20percent%20by%202020.&text=In%20general%2C%20costs%20incurred%20by,at%20a%2050%20percent%20rate.>

<sup>97</sup> See 42 U.S.C.A. § 1396d(y)(2)(A) (identifying the “Newly Eligible Mandatory Individuals”).

<sup>98</sup> *Id.* § 18051(e)(1)(B) (West 2022). Note that the language of the ACA describes the newly eligible as those with an income of less than 133% of the federal poverty level; however, there is a 5% income disregard, thus the actual amount that is permitted is income less than 138% of the federal poverty level. See *id.* § 1396a(e)(14)(i).

<sup>99</sup> The “Federal Poverty Level” is a term established under Section 673(2) of the Omnibus Budget Reconciliation Act of 1991 (“OBRA”) for the purpose of directing the Secretary of Health and Human Services to establish poverty thresholds, established based on the Consumer Price Index for All Urban Consumers to determine eligibility for Medicaid and other federal health care programs. HHS determines income thresholds each year based on family size. See Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 673(2), 95 Stat. 357, 512 (1981). For example, the Federal Poverty Level for a family of four for the year 2022 is an annual income of \$27,750. 138% of that figure is \$37,295.

<sup>100</sup> 42 U.S.C.A. § 1396d(y)(1)(A).

matching.<sup>101</sup> Funds were then slowly reduced over time from 95% federal matching for 2017, 94% federal matching for 2018, 93% federal matching for 2019, and finally 90% federal matching for 2020 and beyond.<sup>102</sup> Because of this new incentive under the ARPA, states that elect to expand their Medicaid programs at this point are eligible for 95% federal matching for up to two years after initial expansion, rather than the previous maximum of 90%.<sup>103</sup> The intention behind the two-year increase is to offset the expense that states incur by adding the expansion category under their programs.<sup>104</sup>

In addition to the expansion incentives, the ARPA provides states with the option to extend Medicaid coverage for post-partum women from its current 60 days to up to one year.<sup>105</sup> This option is available beginning on April 1, 2022, and continues for five years.<sup>106</sup> Women who are eligible under this benefit qualify for full benefits, not just coverage of pregnancy-related benefits.<sup>107</sup>

Importantly for rural populations, the ARPA provides funding of \$8.5 billion for the fiscal year 2021 to be paid to rural providers who provide services to Medicaid, CHIP, and Medicare beneficiaries.<sup>108</sup> The intention is to reimburse rural health care providers “for health care related expenses and lost revenues that are attributable to COVID-19.”<sup>109</sup> Providers are required to submit an application to the Secretary of HHS setting forth the need of the provider for the payment, which documentation includes: statement justifying the provider’s need along with documentation showing expenses and lost revenues attributable to COVID-19; tax identification number of the provider; any assurances as may be required by HHS and any ongoing reports as may be required to ensure compliance with applicable regulations; and any other information that the Secretary deems necessary or appropriate.<sup>110</sup> To be eligible, a provider or supplier must be enrolled in either the Medicare program or the state’s Medicaid and/or CHIP programs; provide diagnoses, testing, or care for individuals with possible or actual cases of COVID-19; and be a rural provider or supplier.<sup>111</sup> This

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<sup>101</sup> *Id.*

<sup>102</sup> *Id.*

<sup>103</sup> *Id.* § 1396d(ii).

<sup>104</sup> *See* Musumeci, *supra* note 94.

<sup>105</sup> 42 U.S.C.A. § 1396a(e)(4).

<sup>106</sup> *Id.*

<sup>107</sup> *Id.*; *see also* Musumeci, *supra* note 94.

<sup>108</sup> *See* 42 U.S.C.A. § 1320b-26(a).

<sup>109</sup> *Id.*

<sup>110</sup> *Id.* § 1320b-26(b).

<sup>111</sup> *Id.* § 1320b-26(e). To be considered a “rural” provider or supplier, the provider or supplier must meet the following definition: “(A) a provider or supplier located in a rural area (as defined in Section 1395ww(d)(2)(D) of this title); or [] provider treated as located in a rural area pursuant to Section 1395ww(d)(8)(E) of this title; (B) a provider or supplier located in any other area that serves rural patients [including] a metropolitan statistical area with a population of less than 500,000 . . .; (C) a rural health clinic . . .; (D) a provider or supplier that furnishes home health,

report is a temporary measure to address current financial exigencies and vulnerabilities caused by the COVID-19 pandemic and thus will be a good lifeline for some hospital providers, but not a long-term fix to more complicated and long-standing financial stability that might be caused by lack of Medicaid Expansion.

A bill circulating through Congress known as the Build Back Better Act proposes a structure that would bypass the states altogether and offer Medicaid Expansion to the identified population through a federal program.<sup>112</sup> The bill in its current form contains a provision in which individuals who fall into the coverage gap would be able to receive subsidies to purchase insurance on the federal health insurance exchange, commonly known as *healthcare.gov*.<sup>113</sup> As proposed in the bill, the Secretary of HHS would establish a so-called “Federal Medicaid Program” no later than January 1, 2025, that would enable individuals living in non-expansion states, referred to in the bill as “coverage gap States,” to purchase insurance on the federal exchange with subsidies from the federal government.<sup>114</sup> This will primarily be implemented through contracts with third-party Medicaid managed care organizations and third-party administrators.<sup>115</sup> The current bill still provides some incentive for states to adopt Medicaid Expansion on their own, as opposed to waiting for this federal option, as states that have expanded their Medicaid population will be eligible for 93% federal matching through as opposed to the current rate of 90% federal matching.<sup>116</sup> This provision is likely more so to secure states that have already expanded their Medicaid programs to keep those programs intact as opposed to trying to incentivize the states that have yet to expand. One key challenge is that the funding for this program is only contemplated in the bill as extending through 2025, likely due to the cost of the bill overall and competing interests in funding various infrastructure projects.<sup>117</sup>

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hospice, or long-term services and supports in an individual’s home located in a rural area . . . ; or any other rural provider or supplier . . . “ 42 U.S.C.A. § 1320b-26(e)(5) (West 2022).

<sup>112</sup> Build Back Better Act, H.R. 5376, 117th Cong. (2021). It should be clarified that technically the “coverage gap” is those individuals who earn below 100% of the Federal Poverty Level because those individuals are not eligible for Medicaid in non-expansion states, but are also not eligible for any subsidies or credits on the health insurance exchanges. In contrast, individuals who earn above 100% of the Federal Poverty Level, but less than 138% of the Federal Poverty Level are currently eligible for subsidies and credits on the health insurance exchanges, but would otherwise be eligible for Medicaid. Many individuals in this latter category are unable to afford insurance even with the subsidies and credits. See Katie Keith, *House Passes Build Back Better Act*, HEALTH AFFS. (Nov. 23, 2021), <https://www.healthaffairs.org/doi/10.1377/forefront.20211123.122022>.

<sup>113</sup> H.R. 5376, § 30701.

<sup>114</sup> *Id.* § 30701(a).

<sup>115</sup> *Id.* § 30701(b).

<sup>116</sup> *Id.*

<sup>117</sup> Brett Kelman, *Tennessee GOP Can’t Stop Biden’s Medicaid Expansion ‘Workaround’ Plan*, THE TENNESSEAN (Nov. 16, 2021).

There are several concerns that have been raised about these provisions, beyond generalized concerns raised regarding the costs of the bill overall.<sup>118</sup> First, while there is funding in the bill for outreach efforts to explain this option to individuals, it could nevertheless be confusing for the consumer. Despite the moniker of Federal Medicaid Expansion, individuals who sign up for a third-party insurance product on the insurance exchange and would not be made part of the state's Medicaid program.<sup>119</sup> Further, the coverage under a commercial plan will be different than Medicaid coverage and may end up being more costly for the individual despite the subsidies.<sup>120</sup> According to Kaiser Family Foundation,

While some states require nominal co-payments for certain services, Marketplace coverage under the Build Back Better Act will likely require higher cost sharing for some enrollees than what they would have paid in Medicaid. (While plans with cost sharing subsidies have very low deductibles and copays for most services, coinsurance might apply for key costly services, such as hospitalization, emergency room care, or specialty drugs).<sup>121</sup>

Kaiser Family Foundation also points out that Medicaid in many states applies retroactive coverage for up to three months prior to the application date, but commercial insurance plans purchased on the insurance marketplace are all prospective and would only cover care from the first day of the month following plan selection—typically.<sup>122</sup> One additional consideration relates to the available network for marketplace plans as compared to Medicaid plans. Health insurance products offered on the exchange tend to provide narrower networks on average, which might limit the available providers who may be accessible from these plans as compared to being enrolled in the state's Medicaid program.<sup>123</sup>

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<sup>118</sup> See Press Release, Joe Manchin, Senator, Manchin Statement on Build Back Better Act, (Dec. 19, 2021), <https://www.manchin.senate.gov/newsroom/press-releases/manchin-statement-on-build-back-better-act>.

<sup>119</sup> See Kelman, *supra* note 117.

<sup>120</sup> Cynthia Cox, Jennifer Tolbert, Robin Rudowitz & Karen Pollitz, *Build Back Better Would Change the Ways Low-Income People Get Health Insurance*, KAISER FAM. FOUND. (Dec. 14, 2021), <https://www.kff.org/health-reform/issue-brief/build-back-better-would-change-the-ways-low-income-people-get-health-insurance/#:~:text=If%20passed%2C%20the%20Build%20Back,through%20a%20non%2Dexpansion%20pathway>.

<sup>121</sup> *Id.*

<sup>122</sup> *Id.*

<sup>123</sup> *Id.*; see also Deborah R. Farringer, *Everything Old Is New Again: Will Narrow Networks Succeed Where HMOs Failed?*, 34 QUINNIPIAC L. REV. 299, 303 (2016). It should be noted that network adequacy within traditional Medicaid programs and Medicaid managed care plans have been criticized as providing fewer than necessary providers who are willing to provide services to Medicaid patients. Therefore, while this is a risk, network adequacy remains

Regardless of the benefits or potential negative impacts of the bill, at this point there is no guarantee that the Build Back Better Plan will pass in its current form. Thus, it is possible that the Medicaid Expansion proposals set forth in the bill currently are not ultimately enacted. The proposed language, however, provides some insight into the lack of confidence many have regarding the likelihood that non-expansion states accept any incentives from the ARPA or hope that the coverage gap will be closed through state action.

### III. REACTION TO EXISTING INCENTIVES AND PRESSURES

#### A. Political Landscape

Since the publication of *National Federation of Independent Business v. Sebelius* in 2012,<sup>124</sup> the efforts to implement the intentions of the ACA have been challenging. Once the Supreme Court had established that states were no longer required by law to expand their Medicaid programs to low-income individuals who are not otherwise categorically eligible, the issue of whether to expand a state's Medicaid program became divide—not universally but in large part—down party-lines politically.<sup>125</sup> In fact, when Medicaid Expansion became effective in January 2014, 25 states adopted Medicaid Expansion, with another three adopting it by January 2015.<sup>126</sup> Of these 28 states, ten had Republican governors: New Jersey, Ohio, New Mexico, Nevada, North Dakota, Michigan, Iowa, Arizona, Pennsylvania, and Indiana.<sup>127</sup> Even in those states, not all of the efforts to expand were without controversy. For example, John Kasich's efforts in Ohio were ultimately successful through the authority of a special legislative panel, which Kasich formed because the Ohio legislature had opposed Medicaid Expansion and refused to go along with Kasich's efforts to expand.<sup>128</sup> This was only after the Ohio Supreme Court determined the authority of the special legislative panel to take such action was valid.<sup>129</sup> Six of the states did not accept the Medicaid Expansion program as set forth under the ACA, but instead agreed to extended coverage to the expansion population as part of other programs or

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problematic under Medicaid plans in general as well. *See, e.g., Armstrong v. Exceptional Child Care Ctr., Inc.*, 575 U.S. 320 (2015).

<sup>124</sup> *Nat'l Fed. of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012).

<sup>125</sup> Andrew Prokop, *The Battle over Medicaid Expansion in 2013 and 2014 Explained*, VOX (May 12, 2015, 3:46 PM), <https://www.vox.com/2015/1/27/18088994/medicaid-expansion-explained>.

<sup>126</sup> *See* Medicaid Expansion Status, *supra* note 24.

<sup>127</sup> *See* Prokop, *supra* note 125.

<sup>128</sup> *Id.*; *see* Catherine Candisky, *Ohio Supreme Court Upholds Kasich's Expansion of Medicaid*, COLUMBUS DISPATCH (Dec. 21, 2013, 10:07 AM), <https://www.dispatch.com/story/lifestyle/health-fitness/2013/12/20/ohio-supreme-court-upholds-kasich/23464827007/>.

<sup>129</sup> *See* Candisky, *supra* note 128.

mechanisms via the Section 1115 waiver program.<sup>130</sup> Many of those states that elected waivers did so in order to add other restrictions or limitations on the Medicaid programs such as work requirements or the expansion population having access only to third-party insurance.<sup>131</sup>

After the initial adoption, Medicaid Expansion became a particularly challenging endeavor among certain Republican leaders for a few reasons. First, many Republicans still firmly believed that, either through legislative efforts or ongoing legal challenges in the courts, the ACA would ultimately be repealed.<sup>132</sup> If the ACA were repealed and state Medicaid programs had already added this new expansion population to the rolls, then the federal money would no longer be available and states would have to decide whether to remove all of those newly added individuals or fund the new population itself.<sup>133</sup> Moreover, other critics simply felt Medicaid was already a poorly run and failing program prior to expansion, and adding new individuals to the program will do little to improve health access and outcomes for this particular population.<sup>134</sup>

Since the initial wave of expansion adoption, the remaining states have been slow to act, with only 11 additional states expanding their Medicaid programs after January 1, 2015.<sup>135</sup> Moreover, all but two states that have expanded Medicaid have done so without support from either the governor, the legislature, or both.<sup>136</sup> Between 2015 and 2016, three of the four states that expanded did so pursuant to executive authority only—without action from the legislature.<sup>137</sup> Following a hiatus of any expansions in 2017 and 2018, six additional states have implemented Medicaid Expansion since 2019 and all but one did so via state-wide ballot.<sup>138</sup> Thus, more recent actions bypassed governors and legislatures altogether.

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<sup>130</sup> See Medicaid Expansion Status, *supra* note 24.

<sup>131</sup> *Id.* (noting that Arizona, Arkansas, Indiana, Iowa, Michigan, Montana, and Utah all adopted expansion via Section 1115 waivers “to operate their Medicaid expansion programs in ways not otherwise allowed under federal law. In some states, these included previously-approved Section 1115 work requirements that have since been withdrawn by CMS under the Biden Administration.”).

<sup>132</sup> See Prokop, *supra* note 125.

<sup>133</sup> *Id.*

<sup>134</sup> See *id.* (“Medicaid’s very cheapness means that it has to reimburse doctors at lower rates, and as a result, it’s sometimes difficult to find a doctor who accepts Medicaid.”).

<sup>135</sup> See Medicaid Expansion Status, *supra* note 24.

<sup>136</sup> Erin Brantley & Sara Rosenbaum, *Ballot Initiatives Have Brought Medicaid Eligibility to Many but Cannot Solve the Coverage Gap*, HEALTH AFFS. (Jun. 23, 2021), <https://www.healthaffairs.org/doi/10.1377/forefront.20210617.992286/full/#:~:text=Since%202014%2C%20only%20two%20states,was%20signed%20by%20the%20governor> (noting that only Virginia and Montana have adopted Medicaid Expansion following a bill passed by the legislature and then signed by the governor).

<sup>137</sup> *Id.*

<sup>138</sup> *Id.*

While these ballot initiatives have been relatively successful,<sup>139</sup> more recent efforts in some of the 12 states that have yet to expand have been met with greater obstacles. Florida and South Dakota have ongoing efforts to expand via a statewide ballot, but no action has yet been taken.<sup>140</sup> Of the remaining states, none have the ability currently to introduce a voter-driven ballot initiative process.<sup>141</sup> Mississippi's struggles were laid bare in a very recent case, invalidating the ballot initiative process.<sup>142</sup> Unrelated to Medicaid Expansion, Mississippi's Supreme Court issued a ruling on May 14, 2021, invalidating a medical marijuana proposal because the process for enabling such a proposal is "outdated and unworkable."<sup>143</sup> In order to pass any other initiatives, the entire process would need to be reorganized through the state legislature.<sup>144</sup>

Even if the ballot initiatives pass in the three states in which ballot initiatives are possible—Florida, South Dakota, and Wyoming—it would still only provide coverage for approximately one-quarter of the individuals currently in the coverage gap.<sup>145</sup> Texas, with an anticipated 1,665,000 individuals who could be added under expansion, constitutes 30% of the total potential expansion population.<sup>146</sup> Moreover, there is no possibility of a voter-led initiative and no indication from Governor Abbott that he will be undertaking expansion any time soon.<sup>147</sup> The Texas legislature did propose a bill in April 2021 that would

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<sup>139</sup> The ballot initiatives have not been without some controversy. For example, then-Governor LePage in Maine refused to implement expansion after the ballot passed unless the legislature agreed to certain demands. After six months of inaction, 80,000 low-income Maine adults who were supposed to qualify for the benefits sued the Maine Department of Health and Human Services. See Rachana Pradhan, *Maine Governor Sued for Defying Medicaid Expansion Ballot Measure*, POLITICO (Apr. 30, 2018, 1:32 PM), <https://www.politico.com/story/2018/04/30/lepage-sued-medicaid-expansion-ballot-measure-559952>. The issue was ultimately resolved when a new governor was elected, and she proceeded to implement expansion as of her first day in office. See Medicaid Expansion Status, *supra* note 24.

<sup>140</sup> See Brantley & Rosenbaum, *supra* note 136. Note that an initiative to put Medicaid Expansion on the 2020 ballot in Florida has been delayed and is now slated for the 2022 ballot. See Medicaid Expansion Status, *supra* note 24.

<sup>141</sup> See Brantley & Rosenbaum, *supra* note 136.

<sup>142</sup> Emily Wagster Pettus, *Mississippi Official Won't Challenge Court on Initiatives*, AP NEWS (May 27, 2021), <https://apnews.com/article/donald-trump-mississippi-health-courts-government-and-politics-25cdf4e75c41fe64a91709592f39b9c6>.

<sup>143</sup> *Id.*

<sup>144</sup> See Brantley & Rosenbaum, *supra* note 136.

<sup>145</sup> *Id.*

<sup>146</sup> *Id.* Other estimates state that an anticipated 1,748,000 individuals would be covered if the state estimated expansion. See Louise Norris, *Texas and the ACA's Medicaid Expansion*, HEALTHINSURANCE.ORG (Dec. 2, 2021), <https://www.healthinsurance.org/medicaid/texas/>.

<sup>147</sup> See Brantley & Rosenbaum, *supra* note 136; Karen Brooks Harper, *Texas House Votes Down Budget Amendment Aimed at Giving Health Coverage to More Uninsured Texans*, TEXAS TRIBUNE (Apr. 22, 2021, 4:40 PM), <https://www.texastribune.org/2021/04/22/texas-house-medicaid-expansion-uninsured/>.

implement expansion, but it failed to pass.<sup>148</sup> Texas has an upcoming governor's election, and the economic impact that Medicaid Expansion could have had if previously been adopted and could have in the future has been a particular topic of certain campaigns.<sup>149</sup> Similarly, there are also upcoming gubernatorial races in Georgia,<sup>150</sup> Alabama, Florida, Kansas, South Carolina, South Dakota, Tennessee, Wisconsin, and Wyoming.<sup>151</sup> While a change in leadership could shift the balance of power in a certain state, this is not a given. Kansas has a Democratic governor who has again included Medicaid Expansion in her proposed budget for 2022, but efforts to expand Medicaid through legislation were unsuccessful during the 2021 legislative session and a similar effort to include it in the budget was likewise rejected for the 2022 fiscal year.<sup>152</sup>

According to one study, the probability of Medicaid Expansion becomes increasingly difficult with greater Republican control. The study notes that "between 2013 and 2020 every state with unified Democratic control... expanded Medicaid when given the opportunity. In contrast, states with divided control had a 35% chance of expanding, while Republican-controlled states had an 8% chance."<sup>153</sup> While the authors concede that party-affiliation is not the singular factor in Medicaid Expansion decisions, it does seem to contribute to the obstacles. This seems to have played out in the 2021 legislative cycle. All twelve of the non-expansion states in the year 2021 had Republican-controlled legislatures<sup>154</sup> and all states other than Kansas and North Carolina had a Republican governor.<sup>155</sup> Despite some comments by legislators and even some bills that made it to a vote, none of the states adopted Medicaid Expansion during the 2021 session.

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<sup>148</sup> Harper, *supra* note 147.

<sup>149</sup> Nusaiba Mizan, *Fact-Check: Did Texas Turn Down \$100 Billion When Republicans Rejected Medicaid Expansion?*, AUSTIN AMERICAN-STATESMAN (Jan. 9, 2022, 10:00 AM), <https://www.statesman.com/story/news/politics/politifact/2022/01/09/texas-turned-down-100-billion-when-decided-not-expand-medicaid/8858664002/>.

<sup>150</sup> Sam Gringlas, *Georgia Voters Will Decide the Next Governor and the State's Status with Medicaid*, NPR (Jan. 24, 2022, 5:05 AM), <https://www.npr.org/2022/01/24/1075264815/ga-voters-will-decide-the-states-next-governor-and-whether-to-expand-medicaid>.

<sup>151</sup> *Gubernatorial Elections, 2022*, BALLOTPEDIA, [https://ballotpedia.org/Gubernatorial\\_elections\\_2022](https://ballotpedia.org/Gubernatorial_elections_2022) (last visited Mar. 8, 2022).

<sup>152</sup> See Medicaid Expansion Status, *supra* note 24.

<sup>153</sup> Patrick N. O'Mahen & Laura A. Petersen, *Will the American Rescue Plan Overcome Opposition to Medicaid Expansion?*, 36 J. GEN. INTERNAL MED. 3550, 3550 (Aug. 11, 2021), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8356545/>. The authors note that the obstacles are not merely political, but ideological.

<sup>154</sup> *Election Results, 2021: Party Control of State Legislatures*, BALLOTPEDIA, [https://ballotpedia.org/Election\\_results\\_2021:\\_Party\\_control\\_of\\_state\\_legislatures](https://ballotpedia.org/Election_results_2021:_Party_control_of_state_legislatures) (last visited Mar. 8, 2022).

<sup>155</sup> *Partisan Composition of Governors*, BALLOTPEDIA, [https://ballotpedia.org/Partisan\\_composition\\_of\\_governors](https://ballotpedia.org/Partisan_composition_of_governors) (last visited Mar. 8, 2022).

*B. Impact of Medicaid Expansion*

In addition to the incentives proposed in the ARPA, other organizations have studied Medicaid Expansion to try and lay out the economic case for states' leadership. For example, The Commonwealth Fund, published an Issue Brief in May 2021 explaining the economic and employment effects of expansion based on the ARPA.<sup>156</sup> The Commonwealth Fund concluded the following:

Expanding Medicaid would increase federal revenue to the 14 states by \$49 billion in 2022; state matching costs would be \$5 billion. More than 1 million jobs would be created nationwide, with largest gains in Texas (298,000), Florida (134,700), North Carolina (83,000), and Georgia (64,300). Collectively, the 14 states would expand their economies by \$350 billion from 2022 to 2025. While state governments would bear some additional costs, the American Rescue Plan's bonus incentives plus additional tax revenues would exceed state matching costs.<sup>157</sup>

The proposed costs and savings are based on all states implementing Medicaid Expansion as of January 1, 2022, which did not occur for any of the twelve remaining states.<sup>158</sup> The brief outlines what it refers to as the "Multiplier Effect" to show the impact that Medicaid Expansion has on states through the increased federal Medicaid revenues.<sup>159</sup> Specifically, the report notes that federal revenues to states for Medicaid Expansion passes through to providers (hospitals, clinics, pharmacies, etc.), their staff, vendors (landlords, suppliers, etc.), and retailers.<sup>160</sup> All of those entities and individuals then pass along those revenues to state and local municipalities through tax payments.<sup>161</sup> Thus, the money paid by the federal government for Medicaid Expansion does not support only the beneficiaries who have the benefit of Medicaid coverage, but the economic position of the state and its health system overall.

Research has shown that uncompensated care—care that hospitals provide but for which they are unable to collect payment—is disproportionate in

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<sup>156</sup> Leighton Ku & Erin Brantley, *The Economic and Employment Effects of Medicaid Expansion Under the American Rescue Plan*, THE COMMONWEALTH FUND (May 20, 2021), <https://www.commonwealthfund.org/publications/issue-briefs/2021/may/economic-employment-effects-medicaid-expansion-under-arp#:~:text=The%20American%20Rescue%20Plan%20Act,family%20of%20three%20in%202021>.

<sup>157</sup> *Id.* It should be noted that the authors included Missouri and Oklahoma, which had not implemented Medicaid Expansion at the time of publication. Both states have since implemented Medicaid Expansion.

<sup>158</sup> *Id.*

<sup>159</sup> *Id.*

<sup>160</sup> *Id.*

<sup>161</sup> *Id.*

expansion states as compared to non-expansion states.<sup>162</sup> Research published in 2021 compared hospitals in Louisiana to hospitals in non-expansion states.<sup>163</sup> Louisiana is a good comparison to the other non-expansion states, as it resembles in many respects those states in terms of its location, per-capita income, and pre-ACA uninsured rate for its adult population.<sup>164</sup> Overall, uncompensated care accounts for only 3% of hospital operating expenses in expansion states and is 7% in non-expansion states.<sup>165</sup> In comparing Louisiana hospitals before and after expansion, Medicaid Expansion resulted in a “33% reduction in the share of total operating expense attributable to uncompensated care costs for general medical and surgical hospitals in Louisiana in the first three years after expansion.”<sup>166</sup> The impact was especially pronounced in rural areas, finding that rural hospitals noticed a 55% decrease in uncompensated care costs as a percentage of operating expenses.<sup>167</sup> This coincided with a drop in the state’s uninsured for non-elderly adults, which was reduced from 18.3% to 11.8% by 2018.<sup>168</sup> The hope is that similar gains could be achieved in the remaining non-expansion states given the similarities between Louisiana and many of the remaining non-expansion states.<sup>169</sup>

Similarly, emergency access has been significantly reduced in non-expansion states.<sup>170</sup> Studies compared population access to all hospitals and concluded that there was an increase in populations in non-expansion states without emergency access to an acute care hospital as compared to states that had expanded their Medicaid program.<sup>171</sup> In quantifying their results, this amounted to a projected population of 421,000 individuals and 48,000 lower-income individuals who experienced a loss of emergency access in states that did not expand Medicaid.<sup>172</sup> This is compounded by a reduction in the number of

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<sup>162</sup> See Gideon Lukens, *Medicaid Expansion Cuts Hospitals’ Uncompensated Care Costs*, CTR. ON BUDGET & POL’Y PRIORITIES (Apr. 20, 2021), <https://www.cbpp.org/blog/medicaid-expansion-cuts-hospitals-uncompensated-care-costs>.

<sup>163</sup> *Id.*

<sup>164</sup> *Id.*

<sup>165</sup> *Id.*

<sup>166</sup> Kevin Callison, Brigham Walker, Charles Stocker, Jeral Self, et al., *Medicaid Expansion Reduced Uncompensated Care Costs at Louisiana Hospitals; May Be a Model for Other States*, 40 HEALTH AFFS. no. 3, 1 (2021).

<sup>167</sup> See Lukens, *supra* note 162.

<sup>168</sup> See Callison, *supra* note 165.

<sup>169</sup> See Lukens, *supra* note 162.

<sup>170</sup> See David J. Wallace et al., *Association Between State Medicaid Expansion and Emergency Access to Acute Care Hospitals in the United States*, JAMA NETWORK OPEN (Nov. 16, 2020), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2772995>.

<sup>171</sup> *Id.*

<sup>172</sup> *Id.*

safety net hospitals disproportionately located in non-expansion states.<sup>173</sup> All of this resulted in a “projected population impact of not expanding Medicaid [as] a loss of emergency access to the nearest safety-net hospital for 2.2 million total persons and 364,000 low-income persons for 2017 for states that did not expand Medicaid.”<sup>174</sup>

As more time passes since the date upon which Medicaid Expansion was first implemented by states, more and more evidence has emerged showing the advantages of expansion for the individual residents of a state, for rural communities in general, and for the financial viability of rural hospitals. Although the business case for Medicaid Expansion appears clear, the adoption of Medicaid Expansion has seemingly ground to a halt and it is not obvious whether those incentives and motivating factors will be sufficient.

#### IV. ARGUMENT

Jacy Warrell, Director of Rural Health Association of Tennessee, recently stated: “I’m optimistic that rural communities have the potential to solve this problem. I think what needs to happen is for policymakers and administrators to really listen to the needs of the community and become partners in solving these issues. I think the answers are there.”<sup>175</sup> What are those answers and is there reason to believe that policymakers and administrators are in fact listening to the needs of rural communities? This is really the question that many are struggling to solve, as the solutions for rural health access remain somewhat divided. The health crisis that is currently taking place in rural America is happening across the country and will require a thoughtful approach to reverse current trends. Health disparities between our urban and rural communities have been widening, creating a deepening divide that impacts outcomes and long-term health and threatens the economic viability of rural communities. With both hope and despair, it has become clear over the past seven to eight years that Medicaid and the availability of Medicaid in rural communities can help stem the tide of hospital closures and hospital financial instability. There is hope because Medicaid Expansion under the ACA has given some states at least one additional tool to curb hospital closures and bolster fiscal support for struggling hospitals. Likewise, there is despair as it seems like some state leaders are reticent to use the support that Medicaid Expansion could bring. This hesitancy could further exacerbate regional disparities and make access even more challenging for certain individuals in our communities.

Certainly, Medicaid Expansion cannot be thought of as the singular savior or a quick-fix solution that will change the trajectory overnight. Rural

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<sup>173</sup> *Id.* (noting that the “majority of safety-net closures occurred in non-expansion states (37 of 73 closures [51%]), with an additional 11 closures occurring in later-expanding states prior to their changes in Medicaid eligibility (cumulative of 48 of 73 closures [65%]).”).

<sup>174</sup> *Id.*

<sup>175</sup> *See Sisk, supra* note 20.

hospitals are still struggling to stay afloat throughout the country, despite Medicaid Expansion, due to changing dynamics of care delivery, staffing and resources challenges exacerbated by the COVID-19 pandemic,<sup>176</sup> and lack of financial resources to upgrade and renovate ailing and aging facilities.<sup>177</sup> It is well-documented, however, that hospitals in expansion states have fared better at staving off hospital closures.<sup>178</sup> Thus, despite what might be considered an uphill battle, it is vital that Medicaid Expansion or something in a similar form that provides insurance coverage for uninsured and underinsured individuals in rural communities continue to be pursued.

This begs the question: will current efforts to encourage or incentivize states to adopt Medicaid Expansion be successful? If not, will current alternative strategies be more successful, and will these alternatives be able to produce similar gains? Based on the actions of the twelve non-expansion states, it seems unlikely that the incentives proposed in the ARPA are likely to result in widespread adoption of Medicaid Expansion for the remaining states. This is true for three reasons. First, the ARPA was enacted in March 2021 and since that date, there has been little momentum or response to the incentives offered under the ARPA other than from advocates for Medicaid Expansion.<sup>179</sup> The Texas legislature did put a proposal for expansion up for a vote, which is more of a reaction than has taken place in some other states.<sup>180</sup> That said, it did not pass. Other state legislatures have merely stated that they will “look into it” without taking any meaningful action at this point.<sup>181</sup>

One state that may be the exception is South Dakota; there, the Secretary of State in January 2022 validated a constitutional amendment that would

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<sup>176</sup> See Jessie Hellman, *Rural Reckoning: COVID-19 Highlights Long-Standing Challenges Facing Rural Hospitals. Will it Create Momentum for Change?*, MOD. HEALTHCARE (Oct. 19, 2021), <https://www.modernhealthcare.com/providers/rural-reckoning-covid-19-highlights-long-standing-challenges-facing-rural-hospitals-will>; see also Sarah Kliff, Jessica Silver-Greenberg & Nicholas Kulish, *Closed Hospitals Leave Rural Patients ‘Stranded’ as Coronavirus Spreads*, N.Y. TIMES (Apr. 26, 2020), <https://www.nytimes.com/2020/04/26/us/hospital-closures-west-virginia-ohio.html> (describing closures in West Virginia and Ohio, both states that expanded Medicaid, but where rural communities are continuing to struggle).

<sup>177</sup> See Sisk, *supra* note 20 (noting problems in Appalachia that impact Virginia, West Virginia, Kentucky, North Carolina, and Tennessee, with only Tennessee and North Carolina being states that have not adopted Medicaid Expansion).

<sup>178</sup> See Lukens, *supra* note 162; Ku & Brantley, *supra* note 156; Wallace et al., *supra* note 170.

<sup>179</sup> See Ku & Brantley, *supra* note 156; see also Hannah Katch, Anna Bailey & Judith Solomon, *American Rescue Plan Act Strengthens Medicaid, Better Equips States to Combat the Pandemic*, CTR. ON BUDGET & POL’Y PRIORITIES (Mar. 22, 2021), <https://www.cbpp.org/research/health/american-rescue-plan-act-strengthens-medicaid-better-equips-states-to-combat-the>.

<sup>180</sup> See Norris, *supra* note 146.

<sup>181</sup> See Kelman, *supra* note 117. The Tennessee legislature’s comments about “looking into it” seem hollow based on the fact that the legislature has met for a special session three times since the enactment of the ARPA to pass new bills but has never brought up or addressed in any way Medicaid Expansion.

approve Medicaid Expansion appearing on the November 2022 ballot.<sup>182</sup> If it passes, the bill will require South Dakota to implement Medicaid Expansion effective as of July 1, 2023.<sup>183</sup> There is also some movement to gather signatures for a state statute to expand Medicaid that would appear on the 2022 ballot.<sup>184</sup> Both of these efforts, however, are promoted by citizen action committees and not through the legislature or the governor.<sup>185</sup> The Governors of North Carolina and Kansas have both attempted to include Medicaid Expansion in their state budgets, but the legislatures have not yet acquiesced.<sup>186</sup> For the remainder of states, state leaders have mostly stayed silent or continued to tout their opposition. Perhaps it is like a game of chicken with each of the states waiting for the other states to act first. Regardless, despite initial hope that the incentives would drive the remaining states to finally adopt expansion, the incentives do not appear powerful enough at this point to convince state leadership to close the coverage gap.

Second, most of the remaining states have a difficult path to expansion based on an examination of historical processes. The biggest adoption of Medicaid Expansion took place as of its ACA effective date—January 1, 2014.<sup>187</sup> While there were a few states that implemented Medicaid Expansion relatively easily after January 1, 2014, most of the remaining states adopted Medicaid Expansion without support of either the governor, the legislature, or both in the case of ballot initiatives.<sup>188</sup> In the meantime, several states—primarily those states that were openly opposed to Medicaid Expansion—created legal barriers to expansion with the goal of ensuring that tactics adopted in other states were not adopted in their state. For example, then-Tennessee governor Bill Haslam had expressed support for Medicaid Expansion and engaged in discussions to implement expansion through negotiation of a Medicaid Section 1115 Waiver.<sup>189</sup> The legislature then passed a bill preventing the governor from being able to expand the Medicaid population without express approval from the legislature, thereby ensuring that the governor could not undertake Medicaid Expansion

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<sup>182</sup> See Medicaid Expansion Status, *supra* note 24.

<sup>183</sup> *Id.* It is not clear whether the incentive funding would still be available at this point. Under the ARPA, the funding is effective for a period of two years beginning July 1, 2021. It is possible that these efforts will be despite additional incentives.

<sup>184</sup> *Id.*

<sup>185</sup> See Phil Galewitz, *South Dakota Voters to Decide Medicaid Expansion*, KAISER HEALTH NEWS (Jan. 6, 2022), <https://khn.org/news/article/south-dakota-medicaid-expansion-ballot-initiative/> (noting that Governor Kristi Noem “strongly opposes Medicaid expansion”).

<sup>186</sup> See Medicaid Expansion Status, *supra* note 24.

<sup>187</sup> See *id.*

<sup>188</sup> See *id.*

<sup>189</sup> See Reid Wilson, *After Months of Debate, Tennessee Medicaid Expansion Dies a Quick Death*, WASH. POST (Feb. 5, 2015), <https://www.washingtonpost.com/blogs/govbeat/wp/2015/02/05/after-months-of-debate-tennessee-medicaid-expansion-dies-a-quick-death/>.

without legislative support.<sup>190</sup> As noted above, after the Supreme Court decisions invalidating Mississippi's balloting process, there are only a few states that even have the capability to allow a decision on Medicaid Expansion to be made by the voters. Nearly all the most recent expansions have been pursuant to a voter-led ballot process and not through the governor or legislature. For the remaining 12 states, the path for expansion without major leadership change has been so narrowed that expansion appears unlikely.

Lastly, there seems to be a level of entrenchment in current state leadership that indicates that incentives alone will not be enough. As mentioned throughout this Article, there have been numerous studies and research conducted to establish both a business case and a health care case for why Medicaid Expansion is not only beneficial for a state's citizenry, but also for the state itself. Although there is some upfront cost to establish the infrastructure and an increase in overall expense due to the increase in the Medicaid population more generally, the federal matching money that is invested back into the state through its hospitals, providers, residents, businesses, etc. should offset this expense relatively quickly. The savings and benefits of Medicaid Expansion to financial health overall have been long touted and should be well-known to state leadership at this juncture. Following the recent U.S. Supreme Court case of *California v. Texas*, upholding the ACA for yet another time, total repeal of the ACA, now over a decade old, appears less likely.<sup>191</sup> Given all this, states do not appear poised to react to incentives alone, as there have been inducements and enticements to states for some time and the remaining states have long ago forgone any such "carrots."

In considering a solution, then, when incentives fail the most obvious next step is some sort of deterrent or impediment, usually in the form of reduced funding. For example, could states that refuse to expand Medicaid have their federal matching for their standard Medicaid program reduced by the 10% the federal government would have to pay to offer coverage to the expansion population through the federal government? The likely reason that this approach has not been used thus far is due to the holding of *National Federation of Independent Business v. Sebelius* ("NFIB").<sup>192</sup> Under *NFIB*, the Court held that the federal government could not condition the federal matching for traditional Medicaid on states' expansion of their Medicaid programs to include low-income adults who were not otherwise eligible.<sup>193</sup> Thus, it was coercive to require states to expand Medicaid; such expansion would have to be optional.<sup>194</sup> This holding becomes especially problematic for Congress and HHS in considering what types of actions it might take to encourage adoption of expansion. Incentives are the

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<sup>190</sup> *Id.*

<sup>191</sup> *See California v. Texas*, 141 S. Ct. 2104 (2021).

<sup>192</sup> *See Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012).

<sup>193</sup> *Id.* at 585–87.

<sup>194</sup> *Id.* at 585.

safest avenue because it is clear from the case that offering increased incentives to states to expand is in no way coercive. If, however, the tactic is flipped and penalties are imposed that act as a punishment to effectively hold back money from one program to incentivize participation in the other program, this could land Congress right back in the same position as *NFIB*. Thus, it becomes increasingly difficult for Congress to fashion a way to encourage that states to act without requiring them to do so.

The proposed plan in the Build Back Better Act is presumably designed with this pitfall in mind; that is, the law bypasses non-expansion states altogether and instead offers a federal option to those in the coverage gap, enabling them to purchase insurance with no premiums.<sup>195</sup> The drafters recognize the potential flaw in this plan, however. There is a risk that if there is a federal option for those individuals in the coverage gap, states that have expanded will lack any incentive to continue to fund their 10% portion. Rather, states may drop their Medicaid Expansion population and let those individuals purchase insurance on the insurance marketplace covered at 100% by the federal government. To ameliorate this risk, the current version of the bill provides an incentive to states that have already expanded to maintain their expansion population by offering them additional matching funds—an increase from 90% federal matching to 93% matching.<sup>196</sup> The funding is also only guaranteed for four years, which further limits the time that a state could be assured that funding for individuals in the coverage gap. This methodology is a result of the challenge that Congress faces in trying to maintain Medicaid Expansion as originally contemplated under the ACA while acknowledging the reality that closing the coverage gap will likely require the federal government to step in.

Given these challenges, what might be the best approach to close the coverage gap without sacrificing or cratering the success of the other states operating Medicaid Expansion? The incentives proposed in the ARPA are a good option considering the limitations set forth in *NFIB*, but the last few months have proven that the political landscape and existing leadership make widespread adoption unlikely, at least in the immediate future. Proposals like the Build Back Better Act face the political realities more head on, but risk upending the structure that seems to be working successfully by expanding existing Medicaid programs in individual states. Further, any solution that contemplates offering a federal option through commercial insurance purchased on the insurance marketplace must be recognized as a different product altogether. Although many states operate their Medicaid programs through third-party managed care organizations, those managed care organizations are controlled by the federal laws and regulations that dictate the way Medicaid is administered.<sup>197</sup> In contrast,

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<sup>195</sup> Build Back Better Act, H.R. 5376, 117th Cong. (2021).

<sup>196</sup> *See id.*

<sup>197</sup> Elizabeth Hinton & Lina Stolyar, *10 Things to Know About Medicaid Managed Care*, KAISER FAMILY FOUND. (Feb. 23, 2022), <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/>.

the commercial insurers that offer insurance on the marketplace are subject to the rules of qualified health plans on the health insurance exchange. These rules do not contain the same controls and considerations that have been incorporated in the Medicaid program because Medicaid is dealing uniquely with a low-income population that likely cannot meet many of the cost sharing obligations that might be common in standard insurance products. Thus, offering a federal option through the insurance marketplace might help reduce the coverage gap by providing insurance access, but it may not achieve the same successes and benefits of Medicaid Expansion as originally envisioned.

Nevertheless, it is critical that Congress and HHS continue to push efforts to ensure insurance access for the millions of individuals who are currently in the coverage gap. It is clear based on the observations of many over the last decade that ensuring some sort of payor coverage, whether it is Medicaid or commercial insurance, can provide much needed financial support and stability for rural health care providers. Bolstering rural health care providers and safeguarding health care access not only improves health outcomes for vulnerable rural populations but creates a positive economic impact for the communities at large. Thus, despite the challenges of the ARPA incentives and some of the drawbacks of proposals in the Build Back Better Act, continued efforts to close the coverage gap need to continue. Although current incentives do not seem poised to prompt the remaining twelve states to adopt Medicaid Expansion soon, leadership changes could create a different result, or some states may be able to successfully undertake voter-led initiatives. Incentives do appear to be the safest way to avoid legal challenges that might arise with more aggressive tactics, such as penalties or reductions to other aspects of federal funding. While current efforts face many obstacles towards achieving the goals of the ACA as envisioned, for places like Jellico, Tennessee, and rural Texas, it is imperative for rural communities that these efforts continue.

## V. CONCLUSION

If current projections are correct, the recent hospital closures in Texas, Tennessee, Georgia, North Carolina, and other non-expansion states are likely to continue on their current trajectory without interventions to reduce hospital vulnerability.<sup>198</sup> Studies and research over the last decade have made clear that while Medicaid Expansion is not the singular solution, it does provide financial support for rural hospitals and rural communities by association. The Commonwealth Fund has noted:

States that expand Medicaid also realize economic benefits beyond increased federal funds. For example, a Commonwealth Fund-supported study found that as a result of new economic activity associated with Medicaid Expansion in Michigan,

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<sup>198</sup> *The Rural Health Safety Net Under Pressure*, *supra* note 35.

including the creation of 30,000 new jobs mostly outside the health sector, state tax revenues are projected to increase \$148 million to \$153 million a year from FY2019 to FY2021.<sup>199</sup>

By some estimates, the projected number of individuals who would be able to enroll in Medicaid if all twelve of the remaining states adopted Medicaid Expansion is 5,731,000.<sup>200</sup> Thus, the potential impact of Medicaid Expansion on the lives of millions of individuals and the communities in which they live is substantial. It is for that reason that the continued efforts to realize the benefits of Medicaid Expansion should continue, despite current challenges and obstacles. Recent tactics such as increased financial incentives may not be sufficient under current leadership, but it is critical for rural America that such efforts continue. For individuals like Andrea Hass in Jellico, continuing these efforts and trying to stave off more hospital closures can be a matter of life or death. When asked whether she thinks that Jellico Medical Center will reopen, she said, "I'm hopin'."<sup>201</sup>

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<sup>199</sup> Susan L. Hayes, Akeiisa Coleman, Sara R. Collins & Rachel Nuzum, *The Fiscal Case for Medicaid Expansion*, THE COMMONWEALTH FUND (Feb. 15, 2019), <https://www.commonwealthfund.org/blog/2019/fiscal-case-medicaid-expansion>.

<sup>200</sup> See Brantley & Rosenbaum, *supra* note 136.

<sup>201</sup> Sisk, *supra* note 20.