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Rural Hospitals Are on Life Support.

Hospitals may be rural America's single most important and most endangered institution. Between having to serve some of the sickest and most expensive populations and federal cuts, can small town America save more from closing?

Forkland, Ala., is about as remote and as poor as towns in the United States get. Located on the western edge of Alabama's "black belt"—50 miles south of Tuscaloosa—its 645 residents earn just over $10,000 per capita a year, less than half the state average. The town has just one store—a squat whitewashed building next to city hall—with a smattering of soft drinks, candy bars and potato chips on its otherwise empty shelves. What Forkland does have is kin and community. Get off Highway 43 and the potholed county roads that connect to it, and you'll find that sense of community down the red clay roads winding through the pines that lead to the shacks, single-wides and small homes where generations of family live. When newborns enter this world, they do so at nearby Bryan Whitfield Memorial Hospital.

Forkland is small, poor and overwhelmingly African-American. Next-door Demopolis is larger (population 7,500), wealthier and equally divided between blacks and whites. With two paper mills and a cement factory, Demopolis has a significant industrial economy. It also has another economic driver that supports and supplements local industry: health care. Bryan Whitfield isn't simply a vital provider of medical services for its residents and those in the surrounding areas. It is one of the region's largest employers with about 260 people on its payroll. To put the hospital's impact in context, its budget is more than three times larger than the city and county budget combined.

Like most rural hospitals, Bryan Whitfield is in many ways a creature of government. Built with the help of federal funds under the Hill-Burton Act of 1948, the hospital is organized under Alabama state law as an independent health authority. The city of Demopolis appoints five of the hospital board's nine members and, under the terms of a court settlement, appropriates $125,000 a year to provide indigent care to town residents. Marengo County, in which the hospital is situated, pays an even larger sum—$360,000 a year—under the terms of the same settlement. By far the biggest contributors to the hospital's bottom line, though, are Medicare and Medicaid. Roughly 75 percent of the hospital's $73 million-plus budget comes from those programs, a significantly higher percentage than the average hospital.

In rural Alabama, $73 million is a large number. Even so, Bryan Whitfield's profit margins are razor thin—and recently got thinner. About two years ago, the federal recovery audit program found that the hospital had improperly billed Medicare; the federal government demanded that the hospital repay $1.3 million immediately. That presented hospital administrator Mike Marshall with tough choices. In December, he announced that the board had voted to lay off 40 employees and shut down the hospital's labor and delivery unit, which delivered 231 babies last year, but which did not collect enough revenue to cover its costs. If the labor and delivery unit shuts down, the residents of Demopolis and the areas that surround it, like Forkland, will be forced to drive to Tuscaloosa, Selma or Meridian, Miss., to receive prenatal care and to give birth.

"Some simply won't make it," says Forkland Mayor Derrick Biggs. "You'll have the baby on the way."

Tiffany Ward, one of the two doctors in Demopolis who delivers babies, warns of even more dire consequences. Many pregnant women depend on neighbors or on public transport to get to a doctor's office for a checkup, she points out. With prenatal care and delivery services an hour or more away at best, she says, "babies are going to die."

Unborn babies aren't the only ones at risk. Many residents of Demopolis see the debate about the future of labor and delivery as a proxy for something larger—whether their community will be able to maintain a full-service hospital. Similar debates are playing out in rural communities around the country, engendered by the costs of health care for small populations, by the way the federal Affordable Care Act (ACA) affects hospital financing and by decisions about what mix of services can best serve the health needs of a community that can't afford to have it all.

The stakes are high—and not just in terms of the availability of medical services. "Health care is actually the fastest-growing job in rural America," notes Maggie Elehwany, government affairs and policy vice president of the National Rural Health Association (NRHA). "If the hospital closes, a lot of these towns wither on the vine."

The numbers are startling. Rural America is sicker, poorer, older and more overweight than the country as a whole. That puts financial pressure on the hospitals that serve it.

"They are in more isolated areas, which means they have lower patient volumes overall," says Adam Higman, a vice president with Soyring Consulting, a firm that works with rural hospitals. Lower volume leads to lower staffing levels, which makes it hard to roll out new technology and implement new rules. "You can't get the same utilization out of the equipment," Higman says. "Every case is a higher cost to them than it would be to another facility."

They are also more dependent on Medicaid and Medicare, which tend to reimburse providers at lower levels than private insurance. According to Keith Mueller, who heads a center for rural health policy analysis at the University of Iowa, some 18 percent of rural Americans are Medicaid recipients, compared with 15 percent of urban Americans. Doctors in rural America receive an average of 25 percent of their reimbursements from Medicaid, as compared with 20 percent for nonrural doctors.

Not every rural hospital is struggling. In the energy-rich Mountain West and Great Plains, some rural hospitals enjoy monopoly positions that allow them to earn huge profits. But in areas where the economy is sluggish, as in rural Alabama, hospitals aren't just hurting, they are starting to close. The state has lost six hospitals in the past 18 months, more than in the previous 20 years, according to Don Williamson, the state health officer and acting head of the state's Medicaid agency. Another 22 hospitals are operating in the red. Many are serving areas with high numbers of uninsured patients, a combination that will make it extremely difficult for them to survive.

It's not just Alabama. More than 40 percent of rural hospitals nationwide are operating in the red, according to the NRHA. Even hospitals that are profitable typically operate with narrow profit margins. Many of these facilities are subsidized or owned outright by local or county governments, making what to do about the local hospital one of the most challenging issues faced by local officials. It's a challenge greatly magnified by the controversies surrounding the ACA.

When the reform was signed into law four years ago, the expectation was that virtually all of the nation's 48 million uninsured would gain health insurance, either through subsidized health insurance policies purchased on health exchanges or through expanded state Medicaid programs. In anticipation of this outcome, significant changes were made to the Medicare and Medicaid payments system. Most notably, the ACA requires that the federal government begin making deep cuts in so-

called Disproportionate Share Hospital (DSH) payments to hospitals serving areas with high numbers of Medicaid patients and people without insurance. Other adjustments that have benefited rural hospitals are already being phased out. That might have been tolerable if hospitals were seeing a surge of new customers with health insurance. They are not. The U.S. Supreme Court's summer 2012 ruling on the constitutionality of the ACA gave states the ability to opt out of Medicaid expansion. As of today, only 25 states (and the District of Columbia), have chosen to expand. The result, says Tennessee Hospital Association president Craig Becker, is a slow-motion disaster.

"Between the ACA and other cuts, we are looking at $7.4 billion in cuts over a 10-year period," says Becker. "The cuts"—which begin in earnest in 2016—"are so catastrophic to some of our hospitals, not only rural hospitals but some of our big city hospitals as well, that I don't know how they are going to survive, particularly without a [Medicaid] expansion in place."

The situation poses challenges for state and local government officials. State officials must contend with the politically hot question of expanding Medicaid. Local officials in communities such as Demopolis are looking at committing ever-larger amounts of public funds to the local hospital or risking the loss of valuable services. In the process, they are making life-and-death decisions, both literally and figuratively, for their constituents and their communities.

The debate over the future of Demopolis' labor and delivery unit is many things: a debate about the value of life; about a community's demands and its limits; and about the future of rural medical care, a future embodied by people like Tiffany Ward and her husband Johnny.

Ward is Demopolis' newest physician. At the age of 30, she is also by far its youngest—and the kind of physician smalltown America dreams of. She grew up in a town of 350 people in rural Nebraska. When she decided to become a doctor, she wanted to be a generalist, someone who delivered babies, performed surgery and provided care in a rural area. When she completed her residency, she was recruited to be a doctor in Demopolis. Ward and her husband decided to move, even though it meant that Johnny would have to give up his high-paying job. Three months after arriving in Demopolis, Tiffany read in the local paper that the board had voted to close the labor and delivery unit.

Ward felt betrayed. She felt that she had been clear about her passion for obstetrics, even discussing strategies for increasing the number of kids born at Bryan Whitfield with the hospital board. She and other physicians in the community also worried about the effect a closure would have on patients.

"Transportation is a problem," says Dr. Alex Curtis, who divides his time between private practice and Bryan Whitfield's emergency room. "We have women who live two or three miles from the clinic and can't make it to their visit. We're now going to expect them to drive 50 miles?"

It's a concern that a significant number of Demopolis residents seem to share. On Jan. 30, the city council and county board of commissioners held an unusual joint meeting to explore whether some joint effort to preserve the unit might be possible. Among the ideas discussed was the possibility of enacting a small property tax increase or submitting a larger tax increase to voters as a whole.

It didn't happen. While the city offered $68,000 to keep labor and delivery open for an extra two months, the county board of commissioners balked at the suggestion that the county should make a matching contribution. Nor did county commissioners embrace the idea of raising property taxes.

"How would you like to run [for re-election] on the platform, 'I've raised taxes so we can help people from surrounding counties have babies here?'" asks hospital board member and local businessman Jay Shows, who notes that only 40 percent of the babies born at Bryan Whitfield are Marengo County residents. By a 3-2 vote, the board of commissioners voted the proposal down.

As Bryan Whitfield struggles to shut down unprofitable hospital operations, the town of Thomasville, 45 miles to the south, is doing something very different. It's preparing to open a brand-new hospital in 2016. The primary reason for doing so is economic. Thomasville is trying to supplement its paper and lumber mill economy with steel and pipe fabricators. It's betting that the city's location—100 miles north of the port of Mobile, which is expecting a surge in business after the widening of the Panama Canal is completed—will attract new industry. The documents on Mayor Sheldon Day's desk make it clear where he thinks such investment will come from: A brochure touting Thomasville's attractions is in Chinese.

According to Day, in the past seven years Thomasville has attracted $700 million in investments that Day says will create 1,500 new jobs. However, these are not low-risk jobs. Injuries are common and employers want treatment for injured workers to be readily available. "We recruited industries here with the understanding that a new hospital would be built," Day says.

Thomasville had a small, 49-bed private hospital—until its parent company went bankrupt three years ago. Now the city is partnering with a group of investors to build a facility that will be three times larger than the old one. The new hospital, however, will have only 29 beds. Instead of inpatient hospital beds, the new facility will have a large emergency room and spaces that can be used for more profitable undertakings, such as outpatient care.

"That's where the business is today, whether you like Obamacare or not," says Day. "At the end of the day, Obamacare is designed to keep people out of the hospital, which means outpatient services are what will be easier to get paid for."

The old hospital had a labor and delivery unit. The new hospital will not.

Back in Demopolis, hospital administrator Mike Marshall isn't surprised. "I came here from the for-profit sector," he says. "I told board members, 'If you want me to make this profitable, I can make it extremely profitable, but there are things you will lose as a result of that.'" The challenge, says Marshall, is finding the right balance. Ultimately, he says, "it's a community hospital, and we are trying to do everything we can to serve the needs of the community."

Marshall's actions in Demopolis—and Thomasville's plans for the future—illustrate something important. At the national and state level, debates about Medicaid expansion and the impact of health-care reform on hospitals tend to portray outcomes in binary terms: Hospitals stay open or they close. Sometimes that is exactly what happens. After all, rural hospitals in states such as Alabama and Georgia, which did not expand their Medicaid program, are already beginning to fail—and more failures are a virtual certainty in other states that refuse to expand Medicaid coverage.

What is more common, however, is that the mix of services rural hospitals offer will change. Instead of offering a full range of services, hospitals will focus on revenue opportunities. Rather than operating as stand-alone facilities, hospitals will join in the hospital industry's movement toward greater consolidation. Profitable rural hospitals, for instance, might join a for-profit chain, bringing the community the fiscal relief of a major new taxpayer but also a loss of control over what services will be available in the community. Other rural hospitals will affiliate with a larger institution that can offer technical assistance with the latest technological and quality initiatives as well as access to capital. This could bring real benefits, but it also creates the risk that facilities that once offered a full range of services become little more than glorified emergency rooms. That's better than nothing but worse than what many communities have now—hospitals that serve their communities as their communities want to be served.

In the end, the decision about what direction health services go will be made by elected officials. To get a new hospital, Thomasville passed a half-cent sales tax increase. Mayor Day estimates that it will raise at least half a million dollars a year for the new facility. Some in Demopolis hope for something similar, among them Dan England, the sole Republican on the Marengo County board of supervisors.

“It may surprise people, me being a Republican and all, but I think the hospital is kind of like the fire department,” England says. “We don’t expect the fire department to fund itself. There has to be public support.”

But that doesn’t mean that England is wholly enthusiastic about providing it. He’d prefer that the city of Demopolis step up.

Hospital administrator Mike Marshall and the majority of his board believe they are fighting for the community too. A positive cash flow isn’t about greed. It’s about maintaining the ability to recruit doctors, invest in equipment and undertake capital improvements. In short, it’s about maintaining the hospital’s viability.

“Look at the needs of the community,” says Marshall, noting that the number of deliveries has been declining for years. The hospital, in short, is allocating $1.4 million a year to serve 145 residents. “Every year at budget time we talk about it,” he says. “It has become such a drain that it is harming our ability as a hospital to be viable as a whole.”

As for the idea that babies will die if labor and delivery closes, Marshall and his board don’t buy it. “It will be a hardship on our citizens,” says board member Shows. But “it is not the end of the world. And if they come in at 2 in the morning, we will deliver the baby.”

As for Tiffany Ward, she has made her position clear: If the labor and delivery room closes, she’s leaving. “We fell in love with this city,” she says. Still, she says, “I don’t want to waste a skill I went to school for 11 years for, either.”

Demopolis Mayor Mike Grayson admits that, from a business perspective, keeping labor and delivery open doesn’t make sense. But, he adds quickly, “I have yet to hear a good alternative.”

What does seem clear is this. The decisions to come will only get more difficult—and not just in Demopolis. As Don Williamson, Alabama’s health officer, points out, in rural areas there are not enough physicians, there is poor access to specialty physicians plus some of the more lucrative revenue-generating procedures are not available. “Keeping a rural hospital in play,” Williamson says, “is a difficult, difficult thing.”

BY JOHN BUNTIN | APRIL 2014