PRIORITY STATE AND FEDERAL ISSUES FOR TEXAS RURAL HOSPITALS

As of November 2018

STATE ISSUES

MEDICAID UNDERPAYMENTS TO RURAL HOSPITALS

Texas rural hospitals are collectively losing as much as $60 million a year treating Medicaid patients because of an ongoing underpayment issue which is contributing to hospital closures and the growing inability to have a baby delivered in rural Texas. Despite state budget provisions since 1993 requiring that rural hospitals be paid to cover much of their cost to treat Medicaid payments, the state essentially lost control over much of its Medicaid program when it transitioned to managed care private insurance companies. The insurance companies often underpay and deny claims for services. The Texas Health and Human Services Commission (HHSC) maintains it cannot micromanage the insurance companies and has failed to apply the rural hospital payment provision from the state budget into the managed care company contracts. Rural hospitals cannot continue to absorb this underpayment. Besides closures, more rural hospitals are ceasing labor and delivery services because of the dollar losses from the underpayment. Of the 161 rural hospitals, only 66 now provide baby delivery and more are planning to cease those services. ***The Legislature must firmly direct HHSC to correct the underpayment and to assure that rural hospitals are paid full cost to treat Medicaid patients.***

1115 WAIVER

Texas rural hospitals are estimated to lose as much as $200 to $300 million dollars a year starting in 2020 under the 1115 Waiver renewal which began January 2018. Under revised requirements from the Centers for Medicare and Medicaid Services (CMS), starting in 2020 (year three of the new five-year Waiver) the formula for hospital Uncompensated Care (UC) payments shifts from a hospital's total uncompensated care and bad debt to only its true charity care. Because most rural hospital charity care policies are outdated and conservatively low, their charity care totals are artificially reduced and much of the charity care ends up being classified as bad debt. Many rural hospitals have since updated and increased their charity care threshold, but as the calculation starting in 2020 will look back at charity care levels in 2018, many hospitals did not have sufficient time to increase their charity care limits. So, regardless of the amount of money Texas receives under the Waiver for UC payments, hospitals will be capped by their documentable charity care. The new waiver also winds down in 2020 and 2021 the Delivery System Reform Incentive Payment program which will cost rural hospitals an additional $150 million a year. These reductions could be financially devastating for many rural hospitals that report that dollars they receive from the 1115 Waiver and the related DSH program comprise between a fourth and a third of their revenue. ***The Texas Health and Human Services Commission and the Legislature, supported by the Texas Congressional delegation, must find a way to replace a substantial portion those dollars by 2020 or more rural hospital closures are a certainty.***

*(*1115 refers to the section of the Social Security Act which allows states may have special and unique Medicaid related programs)*

PROPERTY TAX CAPS

Tying the hands of locally controlled hospital districts with state-imposed property tax rates caps could ramp up the number of rural hospital closures across the state. Half of Texas' rural hospitals rely upon local property taxes to help cover indigent health care and support hospital operations. It is the only hospital revenue that locally elected hospital boards have control over. The problem for many tax supported rural hospitals is that they are in areas with a low tax base where it could take a notable tax increase to generate sufficient revenue to help keep the hospital open. These hospitals believe the local boards, elected by and answerable to the local voters, are best suited to make the decisions on the appropriate balance between local property tax rates and the needs of the community. ***Legislation capping local tax increases or reducing triggers for a rollback election should exclude smaller hospital districts with limited resources leaving them under current law. An option is to include provisions allowing***

hospital districts to exempt from the roll back tax rate the dollars used to cover uncompensated care which is the result of federal and state mandates or exempt the first $15 million of tax levy from the cap formula.

MENTAL HEALTH SERVICES ACCESS IN RURAL AREAS

Limited or no access to short-term mental health facilities and psychiatric care for much of rural Texas is an ongoing problem. Mental health patients in rural areas often end up in the local hospital emergency room where there is not appropriate staff or facilities to address patient needs, especially for more aggressive or violent patients. The problem is compounded when mental health patients must be held for a mental commitment court hearing (which can take days or weeks) and there are no local or regional inpatient mental health facilities. Despite provisions in Chapters 573 and 574 of the Texas Health and Safety Code directing that mental health patients being held in protective custody or pending a civil court commitment should be in mental health facilities, the reality in rural Texas is these patients are often taken to the local hospital. The dilemma for rural hospitals is that even though they may be ill equipped to deal with the mental health patient and do not have a requirement under state law, the federal EMTALA law (Emergency Medical Treatment and Labor Act) imposes a stabilization and treatment requirement on hospitals for any patient ending up in their emergency room which ultimately means the local hospital must hold the patient until they can be placed in a more appropriate facility, which may take hours or days. Also, as small rural hospitals have limited staff, the time and manpower demand for mental patients takes necessary care away from acutely ill medical and trauma patients. Another point of contention in the current system often occurs between those small rural hospitals and law enforcement. The Health and Safety Code seems to assume that once the patient is transported to a mental health facility, the role of law enforcement is concluded. However, in rural hospitals that are not mental health facilities and do not have secure facilities/staff to manage dangerous and violent patients, the need exists for law enforcement to remain present with the patient which prevents them from returning to their normal duties. ***The Texas Legislature needs to address the continued inability of rural Texas hospitals to timely access mental health beds.***

TRAUMA FUNDING AND DRIVER RESPONSIBILITY PROGRAM

The Texas Driver Responsibility Program (DRP), which financially penalizes chronically ticketed drivers and persons convicted of DWI, also generates funding for Texas hospital trauma care. The program has drawn criticism the last few Legislative sessions that fees are excessive, especially for lower income drivers. Plus, the program has not been effectively operated with collections running at 40%. Attempts have been made in the last few sessions of the Texas Legislature (and are likely to continue) to abolish the program. Hospitals ***do not*** have an interest in program operations but are concerned about lost revenue should it be abolished. One-half of the penalties collected partially fund hospital trauma care and Medicaid payment increases authorized by the Legislature for safety net and rural hospitals in 2015. Almost $700 million has been distributed to approximately 285 eligible Texas hospitals for trauma enhancement since program inception. Most rural hospitals qualify as a Level IV trauma center and receive approximately $30,000 a year. While not a substantial amount of funding, it is important to a financially struggling hospital. Major Level I trauma centers receive up to $10 million a year. Trauma dollars also go to local EMS systems and the Trauma Regional Advisory Councils. ***Changes or abolishing the Driver Responsibility Program must not reduce trauma funding to hospitals.***

PHYSICIAN EMPLOYMENT LAW FOR RURAL HOSPITALS NEEDS REVISION

When the Texas Legislature authorized in 2011 direct employment of physicians by rural hospitals, the authorization was limited to hospitals in counties of 50,000 population or less and hospitals with a Medicare rural hospital designation. The final version of the bill that passed failed to address what occurs to an employed physician when the county population exceeds the 50,000 mark if the hospital does not have a specific Medicare rural designation. Earlier versions of the bill allowed physicians employed prior to the population hitting the cap to remain as an employed physician. Also, following the passage of the bill in 2011, the Texas Legislature revised the definition of a rural hospital in the Texas Medicaid program to hospitals in a county of 60,000 or less; or with a Medicare rural hospital designation. ***With the 2020 Census in the near future, the Texas Legislature needs to adjust the law to allow for the physicians employed prior to the 50,000-population cap being exceeded to remain an employee of a***

hospital and the cap should be raised to 60,000 population or less to match the Texas Medicaid definition of a rural hospital.

FREESTANDING EMERGENCY ROOMS/URGENT CARE FACILTIES

The proliferation of freestanding emergency rooms and urgent care facilities in Texas continues to have a negative impact on hospitals, especially rural hospitals, by creating a shortage of emergency room physicians. With more than 200 freestanding ER facilities now licensed by the state and hundreds more urgent care clinics (which are parallel to a physician clinic), 1,000+ physicians have been drawn away from existing health care facilities (mostly coming from hospital emergency rooms). For many rural hospitals that regularly use visiting contract physicians to fully cover their emergency centers, the issue is translating into annual physician cost increases of $200,000 to $400,000. This added cost to both urban and rural hospitals will ultimately drive up the cost of health care, impacting taxpayers and insurance premiums. Another growing issue is that most freestanding emergency centers do not contract with insurance companies (out-of-network) meaning that insurance companies and/or patients are forced to pay the higher "billed charges" which can be 5 to 10 times higher than a hospital that is contracted with the insurance company. ***The Legislature needs to continue to direct regulations so that the freestanding ERs serve the general public and not just certain neighborhoods, and incentives should be put into place for future medical students to consider emergency medicine.***

CHONICALLY SLOW PRISON HEALTH PAYMENTS

Twenty-two (22) Texas rural hospitals contract with Texas Tech or UTMB to provide inmate health care in a number of Texas prison units. This is a mutually advantageous arrangement producing addition funded patients for struggling rural hospitals and saving money for the Texas Department of Criminal Justice as inmate transports with guards (usually on overtime) are shortened because of a near-by hospital under contract; rather than transporting inmates to prison hospitals in Lubbock and Galveston. In recent years, however, the contract approval process for many of the hospitals has become lengthy on the state side resulting in the impacted hospitals receiving partial payments historically into the 9th and 10th months of a 12-month contract. The hospitals have eventually received full payment but the delay creates a cash flow challenge. The issue is that a budget rider (TDCJ 46, D,2) requires that contracts for payment rates above Medicare, which most of the hospitals require, must be additionally approved by the Legislative Budget Board (LBB). That is where the process has sat on hold for months in recent years. ***The Legislature should remove the LBB from the contract approval process or require them to approve the contracts within 30 days of receipt from TDCJ.***

TELEMEDICINE COORDINATION

The increasing use of telemedicine in Texas is revealing challenges in coordination. As new telemedicine projects launch it is difficult to identify medical facilities already utilizing telemedicine (hospitals, providers, universities) and what equipment may already be in use. Much of the equipment in use is proprietary in nature and does not interface with other networks and equipment. Some rural hospitals are using multiple telemedicine platforms having two or three different units which connect to two or three different remote locations, and in many cases, the connections are on different dedicated broadband circuits. The lack of interconnectivity and operability and the redundancy in connectivity, will inevitably add to the cost of telemedicine and could limit its growth. The Texas Statewide Health Coordinating Board identified the potential of this problem as far back as 2002 when in its report on telemedicine it recommended that "an agency or body should be designated that can serve as the authority and recognized expert on TMTH (telemedicine/telehealth) information for current and future TMTH providers, grantees and policymakers. This entity should produce a Texas unified TMTH state plan, which would serve as a point of coordination for all TMTH projects within the state." ***The Texas Legislature should act on the TSHCB recommendation to catalog telemedicine efforts in Texas as well as establish operating platform standards including interoperability.***

FEDERAL ISSUES

STEP-DOWN RURAL HOSPITAL CLASSFICIATION SHOULD BE CREATED

As continued rural hospital closures are a certainty given declining rural population and revenue coupled with increasing expenses, rural communities need a scaled down hospital option rather than having nothing if their hospital closes. Several bills have been proposed in Congress to create the option but have had little traction. The best model proposed has been HR 5678 from the 115th Congress:

-HR 5678 (Rural Emergency Medical Center Act of 2018 - Jenkins/Kind) would allow any Critical Access Hospital or other rural hospital of 50 beds or less to convert to a 24-hour emergency room and outpatient clinic but patients could be held for observation for up to 24 hours (no traditional inpatient). After the observation period, patients would need to be discharged or transferred to a full-scale hospital depending on their status. The bill would also apply to any Critical Access Hospital or rural hospital of 50 beds or less that closed in the five-year period before the enactment date of the bill. The Critical Access Hospital designation not only entitles the facility to higher payments for hospital services, but those payments would cover the cost of the facility operations attributable to Medicare patients including a portion of the facility downtime with no patients which helps make this a financially viable model. This is the key to making this work and no extra cost is anticipated for Medicare.

The step-down rural hospital concept is a common sense and viable option for struggling rural hospitals with extreme low inpatient volume. Texas hospital consultants believe that several dozen Texas rural hospitals now in financial harm's way could convert to this and continue to provide their communities limited hospital type services rather than face complete closure in the future. ***Congress must create a step-down rural hospital to address the closure crisis and gives rural communities an option that are about to lose their hospital.***

WAVE OF MEDICARE CUTS NEEDS TO BE REVERSED

A major contributing factor to 10% of Texas' rural hospitals closing in the last five years and the financial weakening of many more rural hospitals is Medicare payment cutbacks, the Affordable Care Act penalties, and government mandates. The estimated collective loss from this for Texas' remaining 161 rural hospitals is estimated at almost $53 million a year.

2% Sequestration	*$22,000,000*	*(all 161 hospitals)*
Value Based quality penalty	*$15,000,000*	*(80 hospitals)*
Loss of Outpatient Hold Harmless	*$10,000,000*	*(52 hospitals)*
Readmission Penalty	*$3,000,000*	*(50 hospitals)*
Bad debt allowance reduction	*$2,000,000*	*(all 161 hospitals)*
Hospital Acquired Conditions penalty	*$800,000*	*(9 hospitals)*

These cutbacks and penalties are a contributing factor in the closure of 19 inpatient rural hospitals in Texas since early 2013 (4 have reopened for now and 3 continue to operate only their ER). Hospitals recently absorbed the cost of some or all of mandates such as the ICD-10 medical coding system and Electronic Medical Records, which has created a whole new unfunded mandate issue for hospitals now dealing with EMR software updates and cybersecurity. The situation is further aggravated with an estimated $60 million plus underpayment by the Texas Medicaid system. ***Congress must restore Medicare cuts to rural hospitals.***

MEDICARE ADVANTAGE ENDANGERING CAHS

The private insurance alternative to regular Medicare known as Medicare Advantage (MA) is creating negative and presumably unintended consequences for some rural hospitals. Because Medicare MA is actually third-party insurance, the MA companies attempt to negotiate low payment rates to all rural hospitals in conflict with Critical Access Hospital (CAH) program requirements where regular Medicare is directed to pay 101% of the hospital's cost (99% with budget sequestration) rather than standard or negotiated rates. Most MA companies refuse to pay the full rate to CAHs, so hospitals are then torn between accepting a payment that comes as a loss or refusing to treat elderly patients on MA that live in the same small rural community. A second problem is that in the CAH program, Medicare pays a designated hospital the percentage of its overall eligible operating cost that matches the percentage of Medicare patients treated at the hospital. However, the MA patients do not count toward this

calculation and thus reduce the overall Medicare. The presence of MA patients also reduces the amount of Medicare bad debt that is covered. ***Congress needs to mandate that CMS require MA companies to follow the same rules as standard Medicare for Critical Access Hospitals and MA payments should be viewed as regular Medicare for purposes of CMS calculating a hospital's Medicare patient volume.***

340B DRUG PROGRAM REFORM

As interest grows in Congress to reform the 340B drug discount purchase program, rural hospitals must continue to receive the drug cost discounts to partially reduce their loss from treating uninsured patients. There are a number of proposals to limit the discount only to uninsured patients or otherwise narrow the program because of the actions of a very few that may have profited from the program. Rural hospitals benefit in two major ways – discounted cost of drugs used by uninsured patients reduces the hospitals loss to treat that patients and profit from discount drugs associated with insured patients also helps to partially offset the hospital's overall uncompensated care. Also, any effort to narrow which patients in a hospital are eligible for 340B discounts could actually drive up cost for Medicare as Critical Access Hospitals (about half of the rural hospitals in Texas) pass their costs back to Medicare to treat Medicare patients - so a higher cost for drugs will mean a higher cost to Medicare. ***Congress should focus changes in the 340B drug discount program to address documentable problems any and not use a broad approach which will harm rural hospitals.***

(Section 340B of the Public Health Service Act requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to health care organizations that care for uninsured and low-income patients. The concept was to enhance hospital profits on those drugs to help offset other uncompensated care.)

NEW CMS "HOSPITAL" DEFINTION COULD CLOSE SOME RURAL HOSPITALS

A few very low volume rural hospitals may clash with a new definition of a "hospital" recently issued by the Centers for Medicare and Medicaid Services (CMS). Section 1861(e)(1) of the Social Security Act governing Medicare has, for many years, defined a "hospital" as an institution that '"is ***primarily engaged*** in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons…", however CMS tightened that law in the fall of 2017 by adding an internal agency definition that to be "***primarily engaged as a hospital"*** there must be two inpatients at the time of the hospital survey and average daily census and average length of stay data will be two primary factors utilized to determine whether a hospital is "***primarily engaged***" in providing inpatient services. CMS exempted Critical Access Hospitals from this rule as the law creating CAHs doesn't have the primarily engaged language. But, the new rule does apply to rural Prospective Payment System (PPS) hospitals – which is half of the rural hospitals in Texas. A conflict comes about as many small rural hospitals are seeing a downward census trend for reasons including a CMS push to shorten hospital stays and deem more inpatient stays as outpatient – such as the two-midnight rule. The new two inpatients rule appears to be a response to the rise in urban based "micro" hospitals and specialty care hospitals who have few inpatients but are afforded higher hospital payments. There is a legal question being raised as to the authority that CMS has to internally adopted such a definition without going through the public rule making process.

NO CHANGES FOR CRITICAL ACCESS HOSPITALS

The special Medicare rural Critical Access Hospital (CAH) designation has financially stabilized 83 Texas rural hospitals over the years and recognizes their unique and challenging operating dynamics. No changes should be made in this program although potential changes have been discussed in recent years by Congress and CMS. These safety-net hospitals are the backbone of rural health and emergency care. Without increased Medicare payments (101% of allowable cost rather than standardized Medicare rates – 99% under sequestration) most of these hospitals could not stay open. These are small rural hospitals with low volume, but the only hospital for miles. Attacks on CAHs include:

-Recommendation by the HHS OIG (Aug 2013) that past mileage separation waivers be eliminated and CAH status pulled from any CAH closer than 35 miles (15 via secondary roads) to another hospital. If enacted, 60 of the 83 CAHs in Texas would lose status and possibly close. Many states like Texas previously relied upon mileage waivers to grant CAH status when hospitals were not far enough apart. This is important for Texas as the original 35-mile separation requirement discriminated against Texas where many rural hospitals are 20 to 30 miles apart.

-Recommendation by HHS OIG that "swing beds" in CAHs should be paid lower nursing facility rates. A CAH is allowed to keep a patient bound for a skilled nursing facility short term until they can be placed in such a facility and be paid hospital rates rather than the nursing home rates. The reasoning is that

skilled nursing beds are not readily available in a small rural community. However, even though patient status may have changed, hospital cost is still higher and the hospital should be paid their full rate (March 2015)

-Ongoing budget recommendations that CAH payments be lowered from 101% of allowable cost (99% with sequestration) to 100% of allowable cost (98% with sequestration). It is important to note that because CMS regularly disallows payments on some services or reduces the amount allowable, many CAHs actually receive about 80-90% of their cost on Medicare patients (Feb 2016)

THERAPY SUPERVISION RULE FOR RURAL HOSPITALS PERMANENTLY ADDRESSED

Rural hospitals need Congress to permanently halt unreasonable efforts by the Centers for Medicare and Medicaid Services (CMS) to increase the level of direct on-site physician supervision over certain therapeutic services in Critical Access Hospitals (CAH) and other small/rural hospitals less than 100 beds. Physicians and hospitals maintain the intensified supervision is not medically necessary and imposes an increased financial and staffing burden. Physicians are not always on site in many rural hospitals and not immediately available to perform direct supervision. Hospital staff is more than capable of performing much of the therapy under physician orders. CMS is currently not enforcing the rule because of push back from hospitals and congressional questions but this could change at any time as this is discretionary with CMS. Congress has reinforced that physician oversight is not necessary for cases through the end of 2017 but needs to permanently clarify in law that the therapy supervision is not necessary.

BAD DEBT REDUCTION

Congress has reduced the amount of Medicare bad debt they are willing to cover in recent years increasing losses for hospitals, especially rural hospitals. Bad debt is when a Medicare beneficiary fails to pay their copay and deductible. The current amount of bad debt covered is 65% of a hospital's Medicare bad debt. Proposals regularly arise calling for a reduction to 25%. Prior to 2012, Medicare would reimburse 70% of the bad debt for most hospitals and 100% for Critical Access Hospitals. The situation is further exacerbated by the increasing shift by many Medicare beneficiaries to Medicare Advantage (MA), where the private MA plans are not obligated to cover MA bad debt, even though it is an alternative to regular Medicare.

CAH 96 HOUR STAY RULE

Federal law requires that patients in a Critical Access Hospital (CAH) must be released on an *annual patient average* within 96 hours or be transferred to a larger hospital. At the same time, the law also requires a physician must certify that each *individual* patient will be released or transferred within 96 hours. A conflict occurs when an individual patient stay exceeds the 96-hour limit but complies with the annual average. The end result is that CAHs may be denied payment for patient stays exceeding the 96-hour limit (even though they may fall within the 96-hour annual average requirement) which hospitals argue was never the intent of Congress. Medicare also incurs additional expense if a patient is not ready for discharge at the end of 96 hours and must be transferred to another hospital. Congress should eliminate both rules.

TWO MIDNIGHT RULE

The CMS "two-midnight" rule was a hot button issue for all hospitals for several years, but has subsided with adjustments made by CMS in 2016 appearing to back away from enforcement due to opposition from the hospital industry and concerns expressed by some members of Congress. Hospitals, however, remain concerned that CMS could try to resurrect the rule at some point in the future. The "two-midnight" rule was an attempt by CMS in 2013 to better define what constitutes an "inpatient" versus an "outpatient" hospital stay. The difference has a significant impact on the amount a hospital is paid by Medicare. Most patients and hospitals may believe an admission and spending the night is an "inpatient" stay, but that is not always the case according to CMS. Under the proposed rule, an overnight hospital stay spanning less than two midnights would have been presumed to be outpatient and the hospital would have been paid lower outpatient rates. The rule also presumed any stay of more than two midnights to be inpatient. Hospitals were concerned the rule was confusing to patients, was arbitrary, and would override medical judgment. CMS claims they will now look at cases on an individual basis.