2017 MAJOR STATE ISSUES FOR TEXAS RURAL HOSPITALS

Texas rural hospitals continue to face a financial crisis with 16 hospitals closing in the last four years* – 8% of all rural hospitals in Texas. A driving factor in the closures is payment reductions and underpayments by both Medicare and Medicaid which cost Texas rural hospitals an estimated $120 million a year. The Medicare cuts are denying Texas rural hospitals more than $65 million a year while Medicaid cuts and underpayments hit the hospitals by another $55 million annually. These issues coupled with continued high levels of uninsured, the challenging patient demographics in rural communities, and other factors are expected to result in more closures. Keeping the doors of these rural hospitals open is critical as they are a vital part of the safety net of emergency and other care across Texas. Rural hospitals cover 85% of the state's geography and serve 15% of the state's population. They help keep healthy the workforce that supplies the state's (and much of the nation's) food, fuel, and fiber.

(*Of the 16 closures, three have reopened for the time being and three have been replaced with a freestanding ER or urgent care center)

MEDICAID UNDERPAYMENTS TO RURAL HOSPITALS

Texas rural hospitals are collectively losing as much as $55 to $60 million a year treating Medicaid patients in conflict with decades old Legislative directives that rural hospitals should have their expenses to treat Medicaid patients covered. The reasoning for covering the cost of care is that financially fragile rural hospitals are not capable of absorbing a financial loss from Medicaid beneficiaries, and they are a critical part of the state's safety net of care – often the only hospital for miles that can treat Medicaid and other patients. Given that rural hospitals comprise just over 1% of the Texas Medicaid budget, the enhanced payment rate has little impact on the overall Medicaid budget.

The magnitude of the underpayments to rural hospitals was brought to light in the fall of 2016 with the release of the HCA uncompensated care report commissioned by Texas HHSC as part of the 1115 waiver renewal.

The Medicaid underpayments appear to come in two areas:

1. ***Rural hospitals are being shorted annually by an estimated $45 to $50 million in Medicaid payments mostly from Managed Care Organization underpayments and artificially low rates as calculated by HHSC – a conflict with the 23 year old budget rider directive. HHSC had confirmed the underpayment but has taken no corrective action, maintaining they will need a new directive from the Legislature.***
2. ***An increase in rural hospital outpatient payments authorized by the Legislature in 2015 was not sufficiently appropriated leaving rural hospitals shorted by an estimated $5-$6 million a year below cost, mostly for lab and x-ray services.***

Rural hospitals cannot continue to absorb this underpayment and this will likely contribute to more closures!!

SUPERVISION BY PHARMACISTS IN RURAL HOSPITALS

Texas rural hospitals are opposed to any potential legislation that may arise in the 85th session that would increase the level of supervision required in rural hospital patient pharmacies. Such action would be unnecessary and would drive up the cost of health care. The Texas State Board of Pharmacy has expressed a desire for legislative changes to do away with the long standing two tiered supervision system for in-house hospital patient pharmacies which recognizes the unique operating and staffing challenges in rural hospitals, the continuing pharmacist shortage, and finds a practical balance between those challenges and patient safety. While larger urban hospitals are required to have a pharmacist on duty 24/7 to review the filling of patient medication orders, most rural hospitals operate under a system where a pharmacy tech fills the prescription with a double-check by another health provider in the hospital (often a nurse or the prescribing physician). The supervising pharmacist is not on site every day, but must be in the hospital at least once every seven days to review paperwork and prescription orders retrospectively. The reason for this alternative rural hospital system is that rural hospitals cannot afford 24/7 pharmacist coverage and pharmacists are not readily available in many rural communities – some towns don't even have a single pharmacist. Without this two tiered system, many rural hospitals would not be able to operate a pharmacy and provide prescribed medications to their patients (in effect closing the hospital). And even though the Pharmacy Board suggests the use of video conferencing could come into play easing the demand for onsite pharmacists, teleconference supervision would still add considerable cost to rural hospitals which are already struggling financially (assuming they could even recruit a pharmacist to be on the other end of a video conference review). The Board has also yet to disclose any data or records indicating higher and unacceptable levels of medication errors in Texas rural hospitals.

This proposal will be costly, probably impossible to achieve given the ongoing shortage of pharmacists, will only drive up the cost of health care (including Medicaid, Medicare and private insurance), and is unnecessary.

The Board of Pharmacy pushed for the elimination the two tiered supervision system in 2009 with the Texas Legislature siding with rural hospitals and passing HB 1924 in the 81st session. It set out in statute that the two tiered system was acceptable without compromising patient safety. In fact, the Pharmacy Board has never produced any data that medication errors in rural hospitals that could harm patients are more prevalent than in urban hospitals with more intense pharmacist supervision)

RENEWAL OF THE 1115 WAIVER

Texas has requested of the Centers for Medicare and Medicaid Services (CMS) a 21 month extension to its 1115 waiver program (a second extension to the original five year waiver). Approval by CMS is critical to Texas as this special supplemental Medicaid payment program allows hospitals and other providers to access funds to offset some of their losses from treating the uninsured and to provide new and innovative services that enhance access and quality. While Texas will be seeking another full five year waiver with changes from the original program, the state now needs to extend the first waiver until October 1, 2019 in order to have a clearer picture of the new direction of CMS and federal health programs. Hospitals support this request. The 1115 waiver provides more than $3 billion in federal dollars annually to Texas hospitals and other providers; and helps keep the doors open at many rural hospitals. For some rural hospitals, supplemental funds comprise as much as a third of their revenue.

(Note – 1115 refers to the section of the Social Security Act allowing states to operate special and unique Medicaid programs with permission from the federal government. The current Texas 1115 waiver is a successor program to the Upper Payment Limit program which funded supplemental payments to hospitals).

FREESTANDING EMERGENCY ROOMS

The proliferation of freestanding emergency rooms is beginning to have a negative impact on hospitals, especially rural hospitals, by creating a shortage of emergency room physicians. With more than 200 facilities now licensed by the state and dozens of pending applications for a license, the freestanding facilities require 1,000+ physicians (most 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 and more per hospital. 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 are forced to pay the higher "billed charges" for their customers which can be 5 to 10 times higher than what they would pay a hospital that is contracted with the insurance company. In the case of a non-emergency, patients can be left with paying the excessive charges. Examples range from a business with a self-funded insurance plan paying $31,000 for an employee experiencing chest pains that sought treatment in a freestanding emergency center to a person with a sinus infection having to pay $1,700 for treatment.

TEXAS PROMPT PAY LAW

Texas rural hospitals are opposed to any efforts to dilute or weaken the Texas Prompt Pay law. Texas requires health insurance companies to timely pay hospitals and physicians, or face stiff penalties. The law has worked with insurance companies readily admitting that they timely pay 99.7% of their claims, a vast improvement from when the law first passed in 1999. Rural hospitals, concerned with cash flow in their struggling financial environment, believe that the law works well and should not be changed. Hospitals do concede that an updating of the law may be in order by modifying the penalty structure to one based on negotiated rates with insurance companies, as opposed to the current system were the penalty is tied to a provider's "billed charges". However, should the penalty structure be changed, penalties must remain high to assure compliance from multi-billion dollar insurance companies.

TRAUMA FUNDING AND DRIVER RESPONSIBILITY PROGRAM

The Texas Driver Responsibility Program, a system which financially penalizes chronically ticketed drivers and those with a DWI conviction, has drawn criticism the last few Legislative sessions that fines and fees are excessive, especially for drivers with lower income, and that it has not been effectively operated with collections running at 40%. The program is expected to face strong efforts in the 85th Legislative session to dismantle it. Hospitals do not have an interest in the operations of the program but are concerned because the half of the fines and penalties it derives are the source of some of their trauma funding. Eenacted in 2003, one half of the collections go into the state's general operating fund and one half go to trauma care. Almost $700 million has been distributed to approximately 285 eligible Texas hospitals since program inception. Most rural hospitals which qualify as a Level IV trauma center receive approximately $28,000 a year. While not a substantial amount of funding, it is still very 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. The same funding source is also used for trauma add on payments and rural hospital enhanced Medicaid payments approved in 2015. Should the program be abolished, an alternative funding source must be identified by the Legislature to continue trauma care at current levels.

REDUCING THE HIGH LEVEL OF UNINSURED

Texas hospitals continue to deal with high levels of uninsured even with a reduction under the Affordable Care Act – Texas dropping from 25% uninsured statewide to around 17% (compared to 10% nationwide and still the highest in the country). Some rural counties, however, continue to have uninsured rates near or above 30% - Presidio 34%, Starr 34%, Hudspeth 32%, Culberson 29%, Reeves 28%, Foard 27%, Val Verde 27%, Castro 26%, Collingsworth 24%. The challenge for hospitals is that federal law (Emergency Medical Treatment and Labor Act) requires Medicare-participating hospitals that offer emergency services to provide a screening exam and stabilization for persons claiming to have an emergency, regardless of ability to pay. So, for uninsured patients much of the cost is born by hospitals and local property taxpayers. If the Texas Legislature continues to elect not to expand Medicaid under the Affordable Care Act, an alternative system such as a block grant or other must be found to increase the number of Texans with health plan coverage and lessen the financial burden on local taxpayers and hospitals.

MENTAL HEALTH

Limited or no access to short-term mental health facilities for much of rural Texas and the reality that the mental health system in many rural areas does not mirror the mental health provisions of the Texas Health and Safety Code are ongoing problems for many rural hospitals.

Mental health patients in rural areas often end up in the local hospital emergency room where there is not appropriate staff and 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, federal law (Emergency Medical Treatment and Labor Act - EMTALA) 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.

To address these lingering problems, rural communities need more immediate access to mental health beds with reasonable proximity to their communities so that mental health patients can be assessed and treated by the most appropriate mental health providers, patients pending an assessment and a court hearing can be safely held in a medically appropriate manner to protect themselves and others, and law enforcement can return to regular duties in a more timely fashion. Any Legislation which alters the fragile and underfunded mental health system must take into account the problems it may create in rural Texas.

Under Texas Health and Safety Code Chapter 573, the detaining officer must believe that the person poses a substantial risk of serious harm to themselves or others, meaning they would need to be held in a secure environment and with trained personnel that can provide appropriate level of security and restraint, which is not available in most rural hospitals resulting in the need for law enforcement to stay with the patient.

PROPERTY TAX CAPS

Rural hospitals finding themselves in a financially vulnerable status are concerned about efforts to remove local control from elected boards by limiting local taxing authority. SB2 would lower the current trigger for allowing a tax rollback election from the current 8% revenue increase to 4%, as well as making an election automatic if a taxing entity sets a rate with more than a 4% increase. The problem for many tax supported rural hospitals is that they are in areas with a low tax base where it could take a substantial 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 without changes in state law.

TDCJ INMATE HEALTH CARE PAYMENT DELAYS

More than 20 rural hospitals (and a number of urban hospitals) provide care for Texas Department of Corrections inmates. The arrangement is beneficial to the state and to the hospitals, providing extra revenue for struggling rural hospitals and saving Texas taxpayers money when TDCJ doesn't have to transport inmates long distances for care. Unfortunately, these hospitals have been faced with payment delays from the state in recent years. TDCJ and its health contractors (Texas Tech University Health Sciences Center and UTMB Galveston) must seek authorization from the Legislative Budget Board (LBB) to pay hospitals at rates above Medicare (TDCJ Budget Rider 47, D, 2), and many of the rural hospitals must have the higher rates to offset the impact that inmates have on hospital operations and other patients. The last two years, hospitals did not see higher rates approved until 8 plus months into the contract year although the contracts were timely negotiate. Hospitals did receive interim payments at Medicare rates with a retrospective adjustment once contracts were approved. However, the delay created a cash flow crunch for hospitals and reflects poorly on the State. The LBB needs to approve the contracts in a timelier manner.

NURSING HOME MPAP

The nursing home Minimum Payment Amount Program (MPAP), commonly referred to as "nursing home UPL", effectively died on September 1, 2016 leaving many Texas rural hospitals and nursing homes in a bind when the Centers for Medicare and Medicaid Services (CMS) failed to continue the program for Texas, thus cutting off $350 million a year in federal funding to improve care, quality, and services in public owned nursing homes. A replacement program known as the Quality Incentive Payment Program (QIPP) is expected to begin in the fall of 2017, but that leaves participating hospitals and nursing homes with a one year gap in funding. The Texas Health and Human Services Commission has been encouraged by participating hospitals to push CMS for a "bridge" extension of MPAP to cover the period between the two programs. MPAP works similarly to the 1115 waiver in that local government funds from districts and counties are matched with federal Medicaid dollars and the proceeds go to nursing homes controlled by the hospitals. Currently, an estimated 45 Texas rural hospitals (district and county owned) as well as several urban hospital districts participate in the program. A renewal of the program and funding for the full one year gap is critical to improving the quality of care in the nursing homes and providing an additional limited revenue source for financially ailing rural hospitals.

*Updated 2-27-17 - This document is regularly updated and is subject to changes.

For more information:
Don McBeath, Director of Government Relations
Texas Organization of Rural & Community Hospitals (TORCH)
P.O. Box 203878, Austin, TX 78720
don.mcbeath@torchnet.org mobile 806-543-1992