



Rural Hospital Environmental **IMPACT** Study



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Texas Organization of Rural &
Community Hospitals (TORCH)
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Foreward

RURAL COUNTIES IN TEXAS ARE FACING A HEALTH CRISIS.

Demographic shifts, aging residents and the shrinking of the middle class are dramatically changing the makeup of rural populations across the state. Many rural residents battle chronic health conditions and engage in high-risk health behaviors. The rural healthcare delivery system faces additional challenges like declining medical reimbursement rates, rising healthcare costs, and closures of rural hospitals. Without changes to strengthen these systems of health in rural communities, the combined forces are taking a toll on the ability of rural populations to maintain good health and access appropriate health services.

Despite having the highest percentage and number of uninsured residents in the nation, the enactment of the Affordable Care Act (ACA) in 2010 made a difference in Texas. The state lowered its uninsured rate from 25% in 2013 to 18% in 2016. Rural counties also made gains, but they continued to have higher uninsured rates than urban areas. Now, uncertainty about the ACA's future and other health reforms leave rural communities wondering what will happen next.

The Episcopal Health Foundation is proud to partner with Texas Organization of Rural & Community Hospitals to bring awareness to the health crisis facing our rural communities. With a population of 10.7 million people, EHF's service area includes the 57 counties of the Episcopal Diocese of Texas located across Central, East and Southeast Texas. Many of those counties are rural counties.

The Rural Hospital Environmental Impact Study was written to inform community members, organizations, and local and state officials of the struggles of rural healthcare facilities and to provide recommendations on how best to advocate, collaborate and innovate for better access to health services in rural areas.

Rural Texas is a great place to live and work. EHF is bringing leaders, communities and sections of the health system together to begin to look for real solutions to the health issues facing rural communities. That's because we believe no matter where you live, ALL Texans deserve access to high-quality, affordable health services.

Elena M. Marks
President and CEO
Episcopal Health Foundation



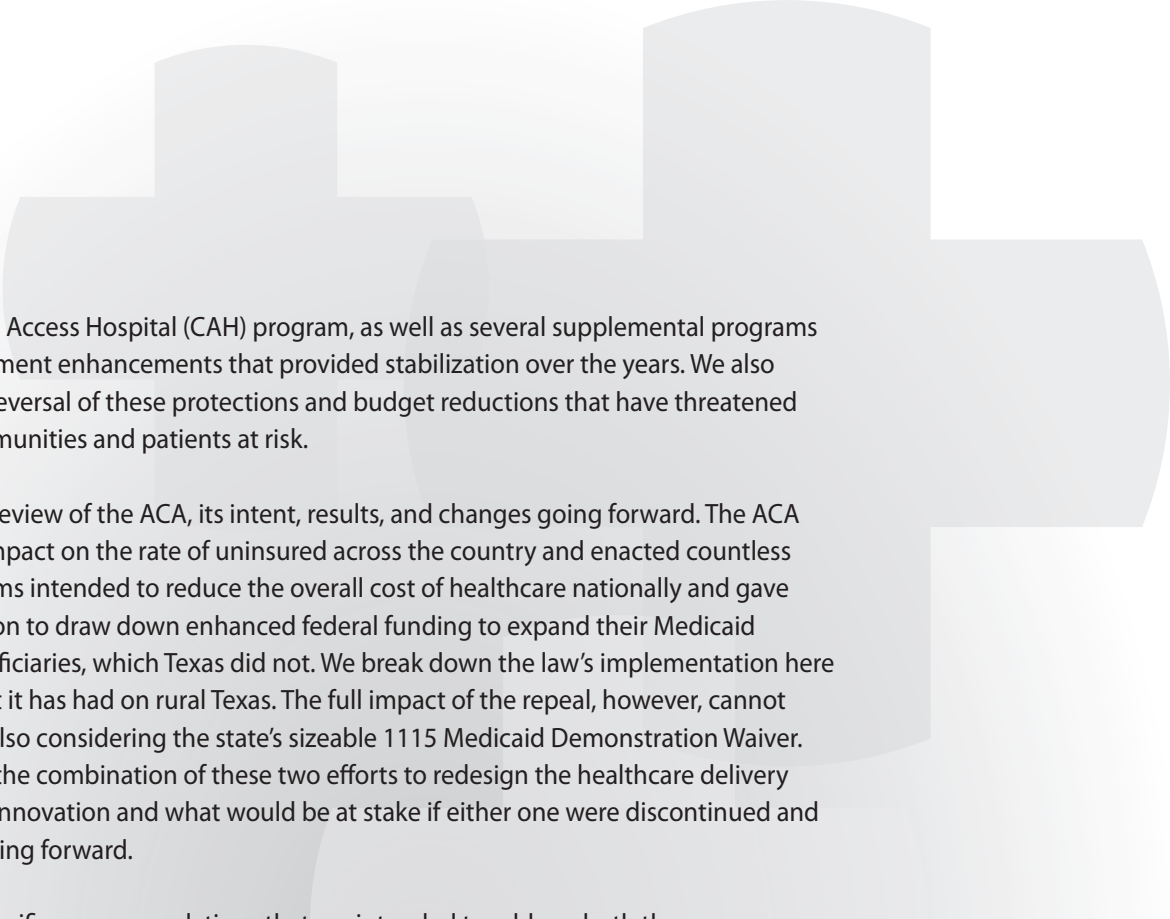
Executive Summary

The impetus for this report, The Rural Hospital Environmental Impact Study, is twofold. First, there is a clear and compelling crisis among rural hospitals in Texas and nationwide. Rural hospitals are closing at an increasing rate. Since 2013, 16 rural hospitals have closed in Texas alone. That is nearly 10% of all rural hospitals in Texas. Second, there is a fierce urgency to consider the implications of the impending repeal of the Affordable Care Act (ACA) by the incoming administration and a Republican-majority Congress and what impact that might have on the U.S. healthcare system and rural hospitals and providers in particular. This landmark legislation was intended to reform and modernize our healthcare system and while the results to date have been mixed, we aim to analyze here how efforts to repeal and replace the ACA will affect rural hospitals either positively or negatively going forward.

The report is organized in four sections: The State of Healthcare, Rural Hospital Closures and Vulnerabilities, the impact of the Affordable Care Act, and Recommendations. Each section is written with rural specifically in mind and every attempt has been made to establish the linkages between past state and federal policies, the current healthcare environment, and possible future changes. While we cannot predict exactly where things are headed, we have done our best to use history as our guide and to recommend changes that we believe will return rural hospitals to a better, more stable financial state. The need is great and the time to act is now. It is imperative, therefore, that this report state in very clear terms how best to assess and respond to the recent decline.

The state of healthcare is ever evolving, but significant change has taken place due to market forces and a major shift in policy that will move the U.S. healthcare delivery system from a traditional fee-for-service (FFS) model to one that is based on value, accountable for outcomes, and consumer focused. In order to explain these changes, this report walks through several key areas of concern for healthcare organizations and providers and how these factors are impacting future strategic considerations. Some of the key drivers of change include: healthcare reform, market dynamics, unsustainable costs, technology and consumerism, changing demographics, and the shift to value-based care and population health management. Each of these forces carries with it new challenges, but they also have the promise of significant progress toward the achievement of the 'Triple Aim' for providers, payers, and consumers.

The Rural Hospital Closures and Vulnerabilities section describes the factors and events that have led rural hospitals to close in the past and again in more recent times. It is also a critical analysis of the operational and financial dynamics that many rural hospitals experience, as well as the policies and legislation that were enacted to stem the tide of closures during the late 1980s and early 1990s. The pressure on these facilities resulted in several positive changes, including the



creation of the Critical Access Hospital (CAH) program, as well as several supplemental programs and rural-specific payment enhancements that provided stabilization over the years. We also discuss the systemic reversal of these protections and budget reductions that have threatened viability and put communities and patients at risk.

The third section is a review of the ACA, its intent, results, and changes going forward. The ACA has had a profound impact on the rate of uninsured across the country and enacted countless initiatives and programs intended to reduce the overall cost of healthcare nationally and gave states the added option to draw down enhanced federal funding to expand their Medicaid program to new beneficiaries, which Texas did not. We break down the law's implementation here in Texas and the effect it has had on rural Texas. The full impact of the repeal, however, cannot be assessed without also considering the state's sizeable 1115 Medicaid Demonstration Waiver. Therefore, we look at the combination of these two efforts to redesign the healthcare delivery system and promote innovation and what would be at stake if either one were discontinued and potential solutions going forward.

Finally, we provide specific recommendations that are intended to address both the environmental factors that are leading some rural hospitals to close, as well as the best possible outcomes and preventative steps that could be undertaken as a part of the ACA repeal process. We believe that a combination of these efforts would in fact ensure the sustainability of rural hospitals here in Texas and across the country. There are likely many more ideas and policies that would improve the operating environment for our remaining rural hospitals, but in an effort to present a manageable solution set, we have limited our recommendations to those with the most substantial chance for improvement. Ultimately, the efficacy of these recommendations depend on the recognition and action of policymakers at the state and federal level.

As the next administration takes office and the 115th Congress works to repeal the health reform law, and as the 85th Texas Legislature convenes to take up the business of our state, it is with a sense of urgency that we present this information with the hope that it advances understanding of the challenges rural providers face, as well as stimulate a dialogue and narrative around how best to advocate, collaborate, share, and innovate to support rural hospitals and our safety net providers.

Rural Texas is a place of great significance, and those who live and work in rural communities deserve the best possible healthcare. The challenges of our time must spur us to action and strengthen our resolve to ensure the vitality of rural Texas, preserve its rich heritage, and honor its roots. In true Texan spirit, we invite opportunities to collaborate meaningfully. Let's work together to strengthen our communities so that we can reap the rewards for all Texans.



Introduction

Healthcare is on the minds of many people — and for good reasons. Following the recent Presidential election, the high-stakes political showdown to dismantle the Affordable Care Act (ACA) is so consuming that it has left the American public and the healthcare industry gripping with deep uncertainties about the fate of the nation's healthcare system.

The transition of power to the Trump Presidency and a Republican-led Congress have reignited a national debate that at its core has been a clash of values, ideas, and realities embodied by this massive law and manifested in lives of people and the livelihood of a \$3 trillion healthcare economy. It, too, is about the powers of the majority and the failure of deep partisanship that has brought us here. While the ACA has been a major catalyst to change, it is easy to forget amidst the current alliteration of “repeal and replace” that, in fact, there is a panoply of other imposing forces working to exert enormous change in healthcare. Though they are interdependent, arguably, some of these forces are enduring and growing in relevance, regardless of what happens to the health reform law.

Like the country as a whole, healthcare is in the midst of unprecedented change. In recent years, rural hospitals have been closing at an ever-increasing rate. Not since the 1980s and 1990s have we seen this level of loss in healthcare. The immediate and downstream impact on the communities is detrimental and far-reaching. Drastic shifts in reimbursement from the Prospective Payment System (PPS), burdensome regulations, and a changing healthcare ecosystem led to a rapid succession of hospital closures and loss of healthcare access in many rural communities. In response, Congress created special payment programs and rural exemptions through the Balanced Budget Act (BBA) of 1997 to help mitigate the further loss of hospitals and to stabilize the industry. With 80 rural hospitals closures across the country since 2010—16 in Texas alone since 2013 — and hundreds more facilities in danger of closing, there is a real need for meaningful interventions again today.



Purpose of Report

To build that case, this report aims to bring into focus the current and future state of healthcare amidst a storm of transformational forces; to calibrate the perception of their impact on healthcare, with an emphasis on rural providers; to reframe questions about the roles and attribution of policies, people, and paradigms for success; and to provide sensible recommendations and solutions for future improvements.

As the new Administration and the 115th U.S. Congress take on the immediate task of repealing and replacing the ACA, and as the 85th Texas Legislature convenes to take up the business of our State, we submit this report as a resource for rural health advocacy and collaboration. We hope to make it easier for policymakers to understand the underlying causes and key environmental factors that are contributing to today's rural hospital crisis, the growing threat of more closures, and loss of healthcare access in rural communities.

The report focuses on four areas:

- (1) **State of Healthcare:** This section provides a brief overview and summary of some major drivers of change impacting healthcare. We synthesize data from a variety of sources on key trends and catalysts, including: healthcare reform, market dynamics, unsustainable costs, technology and consumerism, the shift to value-based care and population health management.
- (2) **Rural Hospital Closures and Vulnerabilities:** This section provides a discussion and analysis of the factors that contribute to the rising trend in rural hospital closures and their impact on their local communities. We catalog recent closures in Texas and vulnerabilities of facilities that are at risk of closing.
- (3) **The Impact of the Affordable Care Act:** This section provides a review of the ACA, its intent, results to date, and changes going forward. As part of this discussion, we also assess the state's sizeable 1115 Medicaid Demonstration Waiver and look at the combination of these two efforts to redesign the healthcare delivery system and promote innovation and what would be at stake if either one were discontinued.
- (4) **Recommendations:** Finally, we submit recommendations around a set of strategic imperatives, policies, competencies, and support required for hospitals and providers to succeed in the healthcare economy of value-based care and integrated delivery. Specific recommendations are tailored towards policy development and advocacy, as well as, grant making, strategic collaboration, and capacity-building considerations.

State of Healthcare: A Brief Overview

The healthcare industry is in flux and in deep transition. Following the results of the recent U.S. election and an untraditional and disruptive incoming presidency of Donald Trump, there is a palpable, growing sense of uncertainty as the country awaits, prepares and predicts the possibilities of the best or worst of times to come.

Whatever the future holds, there is, perhaps, consensus that change is inevitable and accelerating, and the fate of healthcare vis-à-vis the Patient Protection and Affordable Care Act (PPACA or ACA), a legacy of the Obama presidency, may be repealed, replaced, or drastically modified by the incoming President.

Notwithstanding the current political and fiscal climate of the country, healthcare has been undergoing rapid and unprecedented changes in recent years, with a confluence of forces working to affect change in ways that are quite transformational. For this report we highlight some of the key drivers of change, including: healthcare reform, market dynamics, unsustainable trends, technology and consumerism, changing demographics, and the shift to value-based care and population health management (FIGURE 1). Though healthcare is not unaccustomed to change, this time change is unequivocal and profound. The question remains whether any of its past and current experiences will prepare the industry — and the country — for what may lie ahead.

FIGURE 1 – Catalysts for Change



Breaking Developments on the Fight to Repeal the ACA

NOVEMBER 13, 2016



President Trump speaking to Lesley Stahl on CBS' 60 Minutes regarding Obamacare.

JANUARY 3, 2017



The U.S. public is divided almost equally on whether Obamacare should be repealed.
Credit Getty Images

JANUARY 4, 2017



Vice President Mike Pence, second from right, listened as the Senate majority leader, Mitch McConnell, spoke after a Republican luncheon on Wednesday.
Credit Doug Mills/The New York Times

TRUMP: "IT WILL BE REPEALED AND REPLACED"

On November 9th Americans woke up to a new, stunned and unexpected reality — Donald J. Trump is the next president of the United States. Four days later in an interview on CBS' *60 Minutes*, a subdued President spoke to a deeply divided nation that "it [Obamacare] will be repealed and replaced," vowing at the same time to preserve popular provisions of the law, like ensuring that people with preexisting conditions can get insurance and allowing young adults to stay on their parents' health plans.

RESOLUTION INTRODUCED TO REPEAL AND REPLACE THE ACA

On the first day of the 115th Congress, Senate Budget Committee Chairman Mike Enzi (R-WY) introduced a budget resolution that would start the process to unravel large parts of the ACA with a simple majority vote. The resolution instructs four authorizing committees — House Ways and Means, Energy and Commerce, Senate Finance and Health, Education, Labor and Pensions — to achieve at least \$1 billion each in savings in fiscal years (FY) 2017 through 2026 using the budget reconciliation process. The resolution instructs the committees to submit their legislation to their respective Budget Committee by January 27, 2017. The separate bills would then be combined for floor consideration. The budget resolution also includes the establishment of reserve funds for replacing the ACA.

OBAMA MEETS WITH DEMOCRATS AS HEALTHCARE OVERHAUL FIGHTS BEGIN

President Obama met with congressional Democrats on Capitol Hill to discuss ways to defend and preserve his signature healthcare law, as Vice President Mike Pence met with GOP lawmakers to discuss how to dismantle it. These separate strategy sessions came on the second day of the new, GOP-led Congress. In 16 days, Donald Trump replaces Obama in the White House, putting the Republicans' long-time goal of annulling much of the 2010 healthcare overhaul within reach. Republicans' repeal plan includes:

1. The Senate passing a budget resolution the following week that would shield repeal legislation from a Democratic filibuster and allowing House Republican leaders to also approve a version of the budget resolution the same week.
2. The four committees (see above) will assemble legislation intended to eviscerate the health law, but it would likely preserve the most popular provisions such as the prohibition on insurers' denying coverage to people with preexisting conditions. The

legislation would: eliminate the tax penalties imposed on people who go without insurance and on larger employers who do not offer coverage to employees; eliminate the billions of dollars given each year to states that have expanded eligibility for Medicaid; repeal subsidies for private health insurance coverage obtained through the public marketplaces (exchanges); and repeal some of the taxes and fees that help pay for the expansion of coverage under the ACA. Some Republicans have indicated that they may want to use some of that revenue for their as-yet-undetermined plan to replace the healthcare law. There is talk of delaying the effective date of the repeal bill to avoid disrupting coverage and to develop an alternative. It is unclear how long the delay would last, though two to four years are mentioned as possibilities.

3. Within days of taking office, President Trump planned to announce a series of executive actions on healthcare. Details were not provided, but some were likely intended to undo his predecessor's policies and others to stabilize health insurance markets and prevent them from collapsing in a vast sea of uncertainty.
4. Find a replacement. Presently, there is no consensus among Republicans on what that would be.



Senate Minority Leader Chuck Schumer and House Minority Leader Nancy Pelosi on Capitol Hill.
Credit Michael Reynolds/European Pressphoto Agency

TRUMP TAKES TO TWITTER

Trump took on Democrats and healthcare law in a Twitter blitz over the Democrats' efforts to preserve President Obama's healthcare coverage law. He denounced it as a "lie" and a mess from the beginning and called for Republicans and Democrats to work together on a "plan that really works — much less expensive & FAR BETTER!" His latest salvo on social media may also have been his attempt to mount a political defense in a politically toxic showdown to gut the law that has provided healthcare coverage to millions of Americans, as Democratic leaders, Chuck Schumer and Nancy Pelosi, encouraged their colleagues to organize rallies around the country on January 15 to oppose the Republicans' healthcare agenda, warning of catastrophic consequences if the law is repealed.



Senator Tim Kaine of Virginia led the group of Democrats who appealed to Republican leaders to slow down the repeal efforts of the ACA.
Credit Al Drago/The New York Times

THE SPEED OF THE REPUBLICAN REPEAL EFFORT

The Republicans' legislative quick strike to repeal the ACA that would upend much of the American healthcare system has stunned the industry, leaving it in disarray and struggling for a response. The Senate was expected to take the first step by Thursday morning (January 12) to approve parliamentary language in a budget resolution that would fast-track a filibuster-proof repeal bill. House and Senate committees had until January 27 to report out repeal legislation. Already, moderate Senate Democrats appealed to Republicans to slow down the repeal efforts and let lawmakers try to find acceptable, bipartisan changes to make the existing law work better. But for now, Republican leaders were holding firm, as Senator Mitch McConnell, the majority leader, denounced the law, President Obama's signature domestic achievement, as "a lesson to future generations about how not to legislate."

JANUARY 8, 2017

"This scenario does not just move the country back to the situation before the ACA. It moves the country to a situation with higher uninsurance rates than was the case before the ACA's reforms."

The Cost of ACA Repeal, Urban Institute, June 2016

JANUARY 9, 2017



Senator Bob Corker (R-TN), among 5 Senate Republicans who submitted an amendment to the Repeal Bill.

JANUARY 10, 2017



President Barack Obama's farewell address at McCormick Place, Jan. 10, 2017.

Photo by Doug Mills/The New York Times

CONCERNS RISING ON ACA REPEAL WITHOUT A REPLACEMENT

Senate Majority Leader Mitch McConnell is speeding up his time line to have legislation to replace the ACA, but when pressed on a time line, McConnell only said on 'CBS' Face the Nation' that Republicans will be replacing it would happen "very quickly" and refused to provide specifics. In a slight change of tunes, an increasing number of Republican lawmakers and GOP Governors are expressing concerns about the consequences of repealing the ACA without a plan to replace it. According to the Urban Institute's analysis, repealing the ACA without a replacement would cause 30 million people (22.5 million due to loss of subsidies, Medicaid expansion, and the individual requirement to have health insurance, and 7.3 million due to ripple effects of market upheavals) to lose their healthcare, a number that would jump to 59 million by 2019.

GOP SENATORS SEEK TO DELAY START OF ACA REPEAL

Less than a week after Senate Republicans introduced a bill to undo significant parts of the ACA, facing the realities of a complicated health insurance markets, some Republicans are wavering on the speed of repeal, now pushing instead a strategy of crafting a replacement before going ahead with repeal. Five GOP Senators submitted an amendment to the budget resolution that would extend its current January 27th deadline to March 3rd to craft a repeal bill, citing that the President-elect had said that "repeal and replace" should take place simultaneously and recognizing that due diligence is needed on finding a responsible alternative and to ensuring a stable transition to an open healthcare marketplace. Given the slight majority of Republicans in the Senate and the unwillingness of Democrats to help tear down Obama's signature legislative achievement, even a few defections from the Republican Party would cause a repeal bill to fail on a vote. Although the budget reconciliation process is primarily driven by the Senate, House Speaker Paul Ryan said, "It is our goal to bring it all together concurrently."

OBAMA'S FAREWELL SPEECH TO THE NATION

Donald Trump demanded on Tuesday that Congress immediately repeal the ACA and pass another health law quickly. "We have to get to business," Trump told *The New York Times* in a telephone interview. His remarks put Republicans in the nearly impossible position of having only weeks to replace a health law that took nearly two years to pass. That evening, on prime time, President Barack Obama said in his final speech to the nation that, "...I've said and I mean it. If anyone can put together a plan that is demonstrably better than the improvements we've made to our healthcare system, that covers as many people at less cost, I will publicly support it."

JANUARY 11, 2017



Donald Trump in his first press conference as President.

Credit: AP/Evan Vucci

TRUMP'S FIRST PRESS CONFERENCE AS PRESIDENT

In his first wide-ranging news conference as President, Trump told reporters that the healthcare law is collapsing on its own, and instead of waiting, criticizing, and letting the law fail, he would unveil a plan to repeal and replace ACA soon after he takes office and Secretary of Health and Human Services Nominee, Tom Price, is confirmed. "It will be essentially simultaneously," he said. "Probably the same day, could be the same hour." While it is not clear that one comprehensive bill will ultimately emerge from GOP lawmakers, as some senior leaders are already weighing the option of incremental replacement bills, incoming Vice President Pence promised a draft replacement would be available in 30–60 days. On a bright note, no matter what happens to the ACA, Senator Joe Manchin of West Virginia said, "We are going to make sure that we protect our rural hospitals and rural clinics." Manchin emphasized the importance of preserving coverage for patients in rural areas.

SENATE TAKES MAJOR STEP TOWARD REPEALING ACA

In a marathon voting session that started Wednesday evening and extended into early Thursday, the Republican-led Senate voted 51–48 along party lines to approve the budget resolution to clear the first procedural hurdle for repeal of the massive healthcare law that is President Obama's signature achievement. The House of Representatives is expected to take swift action as early as Friday, which will trigger congressional committees to begin crafting a second bill that would dismantle major parts of the ACA.

JANUARY 12, 2017



A bill repealing the ACA signed by U.S. House Speaker Paul Ryan (R-WI) at the U.S. Capitol in Washington.

Credit REUTERS/Jonathan Ernst

HOUSE VOTES TO BEGIN ACA REPEAL

Despite growing concerns among lawmakers of both parties, the U.S. House of Representatives voted 227–198 to pass a measure that started the process of dismantling the ACA. No Democrats supported the initiative. Nine Republicans voted against the measure. This vote instructs committees to draft a repeal legislation by January 27 to deliver on the Republicans' long-time effort to scrap the law.



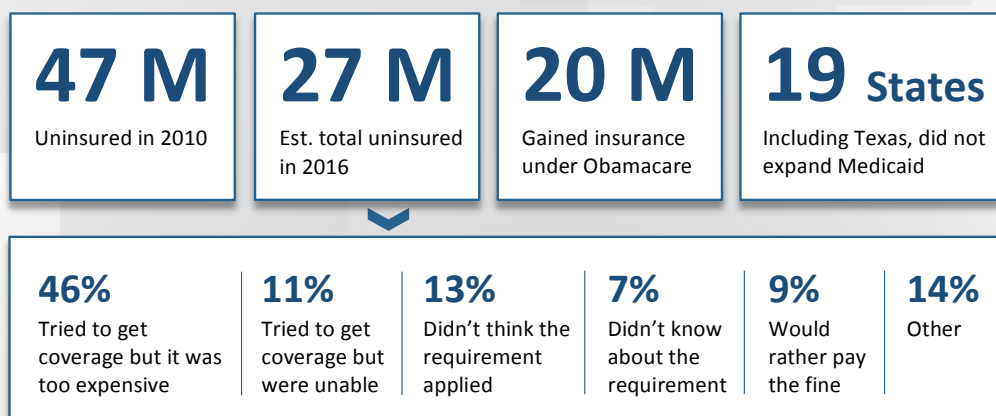
HEALTHCARE REFORM

Since its passage in 2010, the merits of the Affordable Care Act (ACA) have been vigorously contested on many fronts. This debate is now reanimated in light of the Trump administration and a Republican-majority control of the U.S. House and Senate. From the halls of Congress to the Governor's mansions, state legislatures and the courts, to boardrooms of corporations and bedsides at hospitals and clinics, to diners and dinner tables in homes across the country, healthcare is on the minds of many people as they debate with renewed vigor the tenets of this sweeping federal law, a law signed by a Democrat president without a single Republican vote in Congress. While repealing and replacing the ACA was Trump's number one promise on the campaign trail and reassurance since his election, the big questions remain: Will it be repealed with a replacement or without a replacement? Can the law in its current form be delayed until a substitute is negotiated? Repealing ACA will have important consequences and the consequences are highly complicated and risky.

Certainly, the politics, failures, successes, and future of the ACA is beyond the scope of this paper, but for present purpose, we focus on how the passage of this landmark legislation — from health insurance coverage expansion, tax reforms, and cost-sharing subsidies; to market interventions, system modernization, expansion of public programs, changes to provider payments, and technology reforms — has been a defining force critically reshaping the American healthcare system. In its effort to expand coverage, control healthcare costs, improve care delivery, and finance it all, this comprehensive reform legislation has implemented and set in motion a multitude of provisions and programs that have effectively thrust healthcare into a new paradigm of government-mandated coverage and investment on value, innovation, accountability and outcomes. Central to this vision is a strategic focus on wellness, preventive services, primary care, and clinical integration in the pursuit of the “Triple Aim” (improving patient experience of care, including quality and satisfaction; improving the health of populations; and, reducing the per capita cost of healthcare).

Perhaps, among its most important and contentious provisions are the requirements for individuals (all U.S. citizens and legal residents) to have qualifying health coverage and the requirements for employers (those with up to 50 or more full-time employees) to offer coverage. Coverage expansion was designed to be accomplished through federal financial incentives or subsidies to states for Medicaid expansion (though Texas opted not to expand Medicaid). Originally, the Congressional Budget Office (CBO) estimated that the ACA will provide coverage to 33 million people by 2022, with an estimated cost of \$1.34 trillion over ten years.¹ In 2016 alone, it was expected to cost a total of \$110 billion. The law created new marketplace exchanges that proved to be volatile, and despite rising costs in premiums and weeks away from inauguration of Trump and a Republican-controlled Congress committed to dismantling the ACA, enrollment

FIGURE 2 – Status of ACA Coverage, 2016




Graphic adapted from Bloomberg article, Oct. 2016 (<https://www.bloomberg.com/graphics/2016-obamacare/>)

surged. Today, it is reported that some 20 million Americans have coverage as a result of the ACA (FIGURE 2) and the revised projection by the CBO and the Joint Committee on Taxation (JCT) showed that the federal subsidies, taxes, and penalties associated with health insurance coverage for people under age 65 will result in a net subsidy from the federal government of \$660 billion in 2016.²

MARKET DYNAMICS

In large part as a result of ACA implementation, the healthcare industry is in deep transition and experimentation in response to changes that are occurring in the market. Increasingly, strategic positioning within the healthcare market is driven by consolidation, mergers and acquisitions, and management and operational affiliations, particularly as disruptive forces like health reform, changes in the payment system, value-based contracting, consumer-directed healthcare, and technology continue to gain momentum. In fact, 2015 was a record-breaking year in healthcare mergers and acquisitions³, reaching \$546 billion in announced deal value — a 2.5 times increase over the previous decade's average annual value.⁴ Among the top five largest insurers (by market share) in the country, mega-merger deals are underway to leverage scale to position for competitive advantage, which if they pass regulatory scrutiny, three major players will dominate the insurance market by 2017. Moreover, as part the aggressive strategic positioning, a group of some of the largest healthcare systems and insurers in the United States are committing to a significant percentage (75%) of their payments to be tied to value-based contracts.⁵

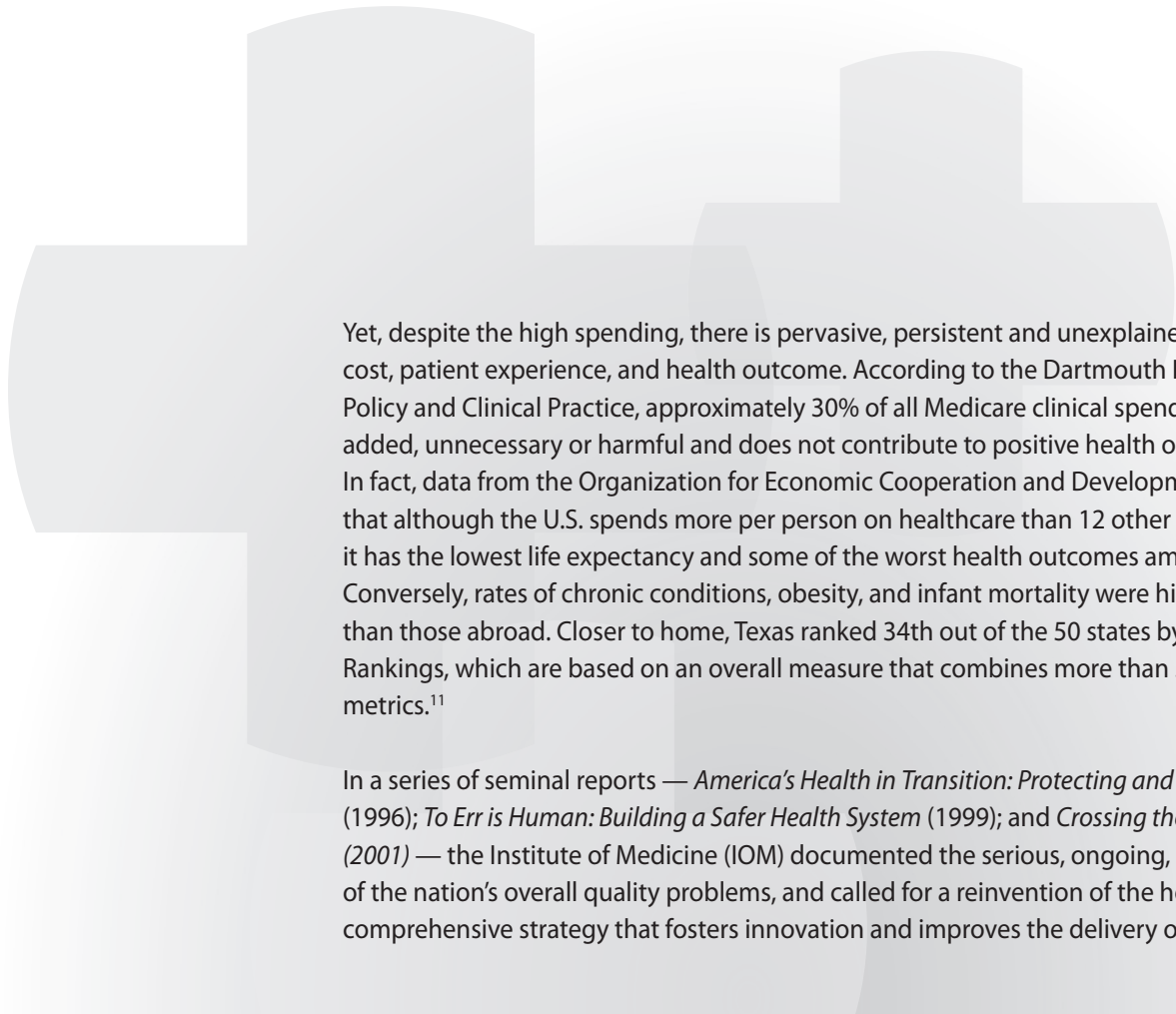


But there is more at stake than just leverage and size, as payers seek to diversify revenue streams from new products, optimization of health IT and powerful data analytics. And, there are more players involved in this land grab frenzy than just the traditional payers and provider organizations. Post-healthcare reform, market strategies involving vertical integration, diversification and the emergence healthcare conglomerates are fast blurring — if not erasing and reconfiguring — the lines among industry sectors to disrupt and innovate markets and to reimagine business models that capitalize on and distinguish areas of expertise in response to healthcare’s “brave new world” of accountability, risks and rewards for managing the total cost and total outcome of care at the population level.

Consolidations in healthcare are expected to continue at record pace. Narrow networks, tiered networks and accountable care arrangements will likely expand to include pharmaceuticals, life sciences, social services and others as organizations and providers look for growth, alignment and integration to provide services along the continuum of care to populations. There will be a proliferation of new care models, disruptor’s and innovators, and there certainly will be winners and losers. New imperatives demand new strategies and new competencies. It remains to be seen if this trend in mergers and acquisition will be a harbinger of a model of the future where big is going to be better, and if so, for whom and in what way? Can small survive? What will be the future of rural community providers?

UNSUSTAINABLE COSTS

Among the many catalysts driving change in healthcare, perhaps the biggest and most fundamental force is the need to manage the growing cost of healthcare spending. Arguably, at the root of much of the pressure for systematic change and system modernization is a recognition that healthcare spending in the U.S. is unsustainable at its current pace and projection. In 2015, federal government spending on healthcare grew 5.8% to \$3.2 trillion and accounted for 17.8% of Gross Domestic Product (GDP). This increase is due largely to ACA implementation and Medicaid expansion, along with the surge in the cost of biologic specialty drugs.⁶ Medicare spending grew 5.5% to \$618.7 billion (the fastest rate since 2009) and accounted for 20% of total health expenditures, while Medicaid spending increased by 18.4%, totaling \$495.8 billion.⁷ Private health insurance spending grew 7.2% to \$1,072 billion in 2015 and accounted for 33% of total national health expenditure. The ACA market place subsidies, together with Medicare, Medicaid and the Children’s Health Insurance Program (CHIP), accounted for 24% of the federal budget, or roughly \$836 billion.⁸ Physician and clinical services expenditures grew 6.3% to \$634.9 billion in 2015. According to the CBO and the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary, health spending growth is expected to continue at an average rate of 5.7% for 2017 through 2019, and 6.0% for 2020 through 2025. As a result, the health share of GDP is expected to rise to 20.1% by 2025 and 31% by 2035. Absent drastic change, this growth is unsustainable.



Yet, despite the high spending, there is pervasive, persistent and unexplained variations in quality, cost, patient experience, and health outcome. According to the Dartmouth Institute for Health Policy and Clinical Practice, approximately 30% of all Medicare clinical spending is non-value added, unnecessary or harmful and does not contribute to positive health outcomes⁹ (FIGURE 3). In fact, data from the Organization for Economic Cooperation and Development (OECD) showed that although the U.S. spends more per person on healthcare than 12 other high-income nations, it has the lowest life expectancy and some of the worst health outcomes among this group.¹⁰ Conversely, rates of chronic conditions, obesity, and infant mortality were higher in the U.S. than those abroad. Closer to home, Texas ranked 34th out of the 50 states by America's Health Rankings, which are based on an overall measure that combines more than 30 health-related metrics.¹¹

In a series of seminal reports — *America's Health in Transition: Protecting and Improving Quality* (1996); *To Err is Human: Building a Safer Health System* (1999); and *Crossing the Quality Chasm* (2001) — the Institute of Medicine (IOM) documented the serious, ongoing, and pervasive nature of the nation's overall quality problems, and called for a reinvention of the health system and a comprehensive strategy that fosters innovation and improves the delivery of care. Furthering

FIGURE 3 – The Cost of Non-Value Added Healthcare Spending

30%

Excess Medicare Spending

According to the Dartmouth Institute for Health Policy and Clinical Practice, 30 percent of all Medicare clinical care spending is unnecessary or harmful and could be avoided without worsening health outcomes.

\$690 billion

Waste in Health Care

A September 2012 Institute of Medicine report estimated that \$690 billion was wasted in US health care annually, not including fraud.


\$389 billion

Waste Because of Administrative Complexity

Administrative complexity, such as unnecessary forms and paperwork, added up to \$389 billion in wasteful spending in 2011.

“Although there is general agreement about the types and level of waste in the US health care system, there are significant challenges involved in reducing it.”

Health Affairs: Health Policy Brief, December 13, 2012

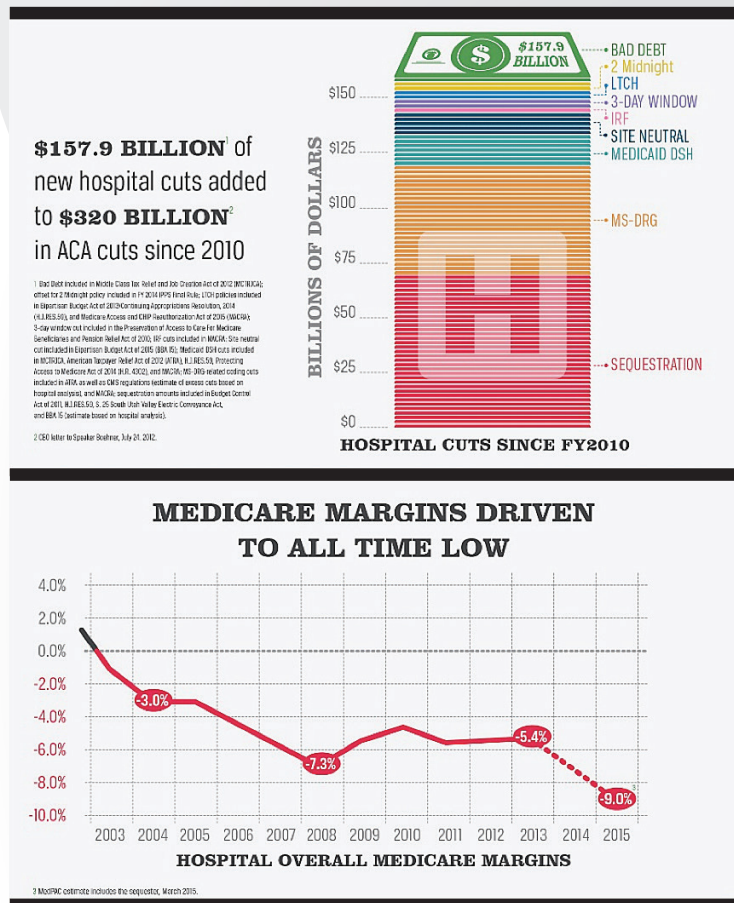


measurement and informed purchasing, the IOM's report *Leadership by Example: Coordinating Government Roles in Improving Health Care Quality* in 2002 encourages the federal government to take full advantage of its influential position as purchaser, regulator, and provider of healthcare services to determine quality for the healthcare sector. The framework for that vision has propelled a portfolio of demonstration projects over the years and in many of today's value-based programs and system modernization policies. As the country attempts to manage the rapid rising cost of healthcare, and transition away from the current fee-for-service system that rewards volume to a value-based purchasing system that rewards accountability, risk-sharing, outcomes, and innovation, the industry will experience some of its most challenging days to come.

In addition to the pressure to control rising healthcare costs, there is a convergence of other costly trends that have contributed significant financial strain to hospitals and healthcare providers over the years. Some of these include:

- **Payment cuts and rising costs:** Over the years hospital payments continue to decline amidst rising costs. According to the Federation of American Hospitals (FAH), \$158.1 billion of new hospital cuts have been added to the \$320 billion in ACA cuts since 2010 (FIGURE 4).¹² In 2013, hospitals were underpaid by \$51 billion; this includes \$37.9 billion from Medicare and \$13.2 billion from Medicaid.¹³ For Medicare, hospitals received payment of only 88 cents for every dollar spent by hospitals caring for Medicare beneficiaries, and for Medicaid, only 90 cents for every dollar spent by hospitals caring for Medicaid patients. In fact, data from a recent report by the Texas Health and Human Services Commission (HHSC) on the evaluation of uncompensated care and Medicaid payments in Texas hospitals showed that, in 2014, Texas hospitals were paid only 66.7 cents for every dollar spent for care to Medicaid patients. Further, the FY2017 pro forma showed that even if the state expanded Medicaid and covered the entire eligible uninsured population, Texas hospitals could still incur \$8.2 billion annually in unreimbursed Medicaid and uninsured costs.¹⁴
- **Declining margin:** In tandem with payment cuts, hospitals have also faced deep negative Medicare operating margins, which plummeted to a record low of -9.0% in 2015. In a four-year period from 2009Q4 to 2013Q4, a quarter of all U.S. hospitals had negative margins.¹⁵ In our own work with Texas Critical Access Hospitals (CAH) using Medicare cost report data compiled by the Flex Monitoring Team, we found that 41% of Texas CAHs had a negative total margin in 2013, with the worse at -23.1%.¹⁶ On top of this, more than a fifth (21.9%) of CAHs in the states are operating with a dangerously thin cushion of less than 10 days available cash-on-hand, which severely hampers their ability to respond effectively to change and new regulations, or to invest in strategic capabilities and services to meet the healthcare needs of their communities.

FIGURE 4 – Cuts in Hospital Payment



Federation of American Hospitals, 2014

In 2013, 43.6% of Texas CAHs had negative operating margins. Operating margins reflect the overall performance of hospitals. Those with better performance or a positive bottom line often cite their financial dependence on a number of key non-operating income, including:

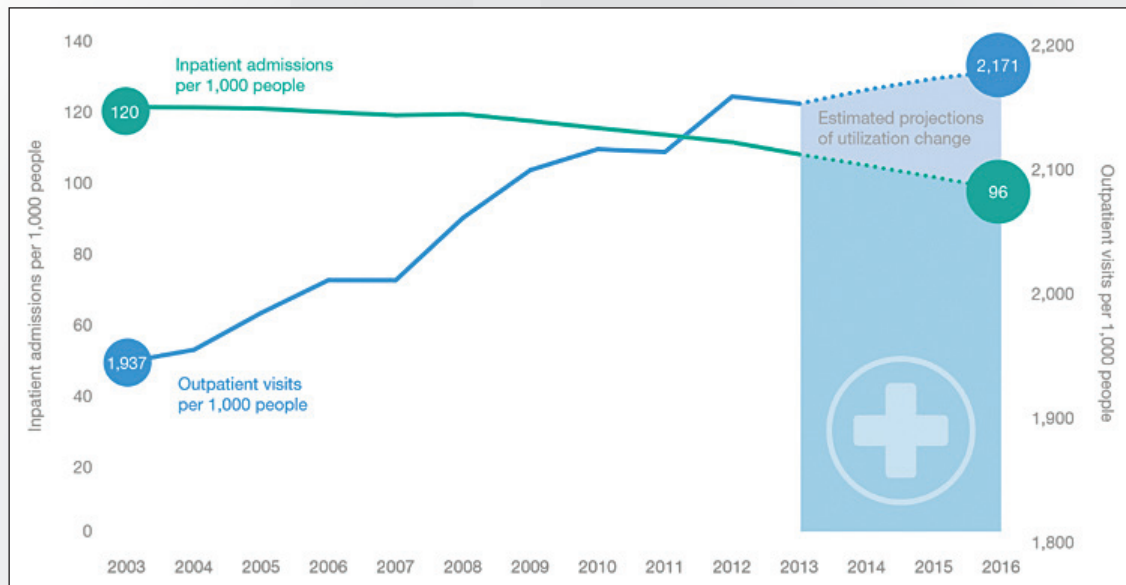
- Tax support;
- Outpatient and ancillary services, such as laboratory, radiology, CT scan, and wound care;
- Supplemental programs, like the 1115 Texas Medicaid Transformation Waiver Program, particularly through the Delivery System Reform Incentive Payment (DSRIP) income-based projects and the uncompensated care (UC) funding;
- Disproportionate Share Hospital (DSH) payment; and
- Other special programs, like as 340B Drug Discount Program, and on a more limited basis, the Nursing Home Upper Payment Limit (UPL).

Decline in hospital margins has been occurring for decades. For a 30-year period between 1981 through 2011, hospital days have declined 33%.¹⁷ Coincident with this decline in use, 15% of hospitals closed. According to the American Hospital Association (AHA), 37% of available bed-days are unused at any

given time.¹⁸ On the clinic side, spending on physician office visits has fallen 17% over the past 10 years while expenditures have increased 19%. On top of this, over the years (and especially since ACA implementation), there has been a steady decline in hospital inpatient utilization and a rapid increase in outpatient utilization and clinic settings (FIGURE 5), which has motivated high levels of physician consolidations, mergers and acquisitions, and management affiliations. While a necessary strategy for many, cumulatively this has led to a loss of autonomy and independence for many rural hospitals and systems.

- **Rising costs:** Amidst declining reimbursement, the average cost per inpatient day has been rising. An analysis of Medicare cost report data for Texas CAHs showed that 34.2% have Medicare acute inpatient cost exceeding \$3,000 per day, with the three highest reaching

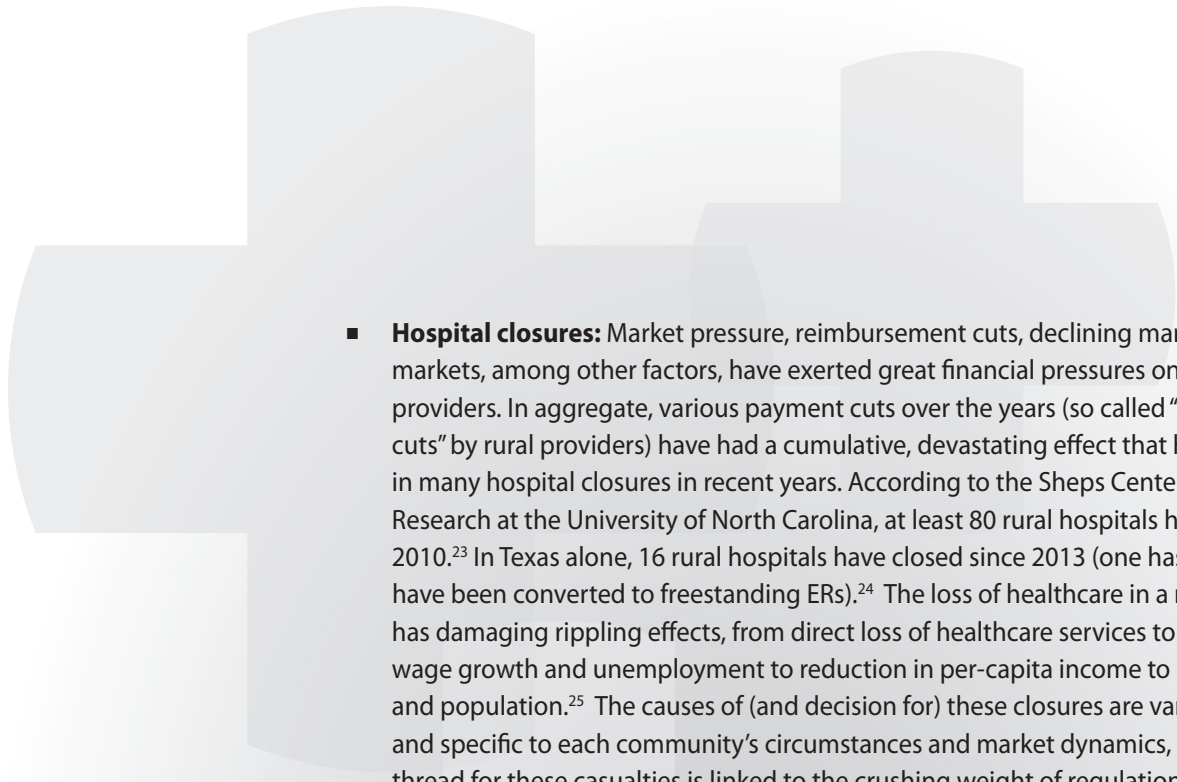
FIGURE 5 – Inpatient Volume Care on a Rapid Decline: Changes in Hospital Inpatient and Outpatient Utilization



Source: American Hospital Association (AHA) Chartbook: Trends Affecting Hospital and Health Systems, 2013, and PwC's Health Research Institute analysis

\$17,383 per day. Hospitals have also had to endure other rising costs, including: growing labor and supply costs, soaring insurance premiums, and surging prescription drug prices. Despite mounting uncertainties and risks in the current healthcare ecosystem, PwC's Health Research Institute predicts 2017 to be "a year of equilibrium for medical costs," citing that forces that increase health costs are being tempered by a strong demand for value in the New Health Economy.¹⁹ Part of this rationale, however, depends on healthcare organization's ability to increase access to affordable, consumer-friendly, and convenient services while still decreasing unit cost — a feat that has proved very challenging for most providers.

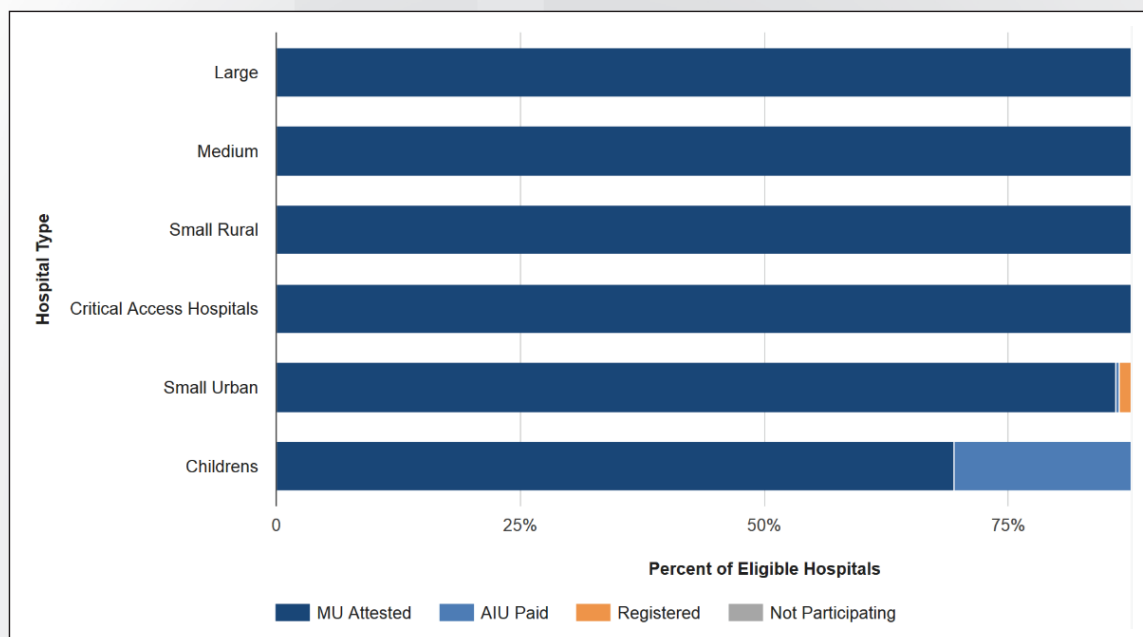
- **Uncompensated care:** Amidst declining payments and rising costs, Texas acute care hospitals continue to bear a disproportional amount of uncompensated care. According to a report by the Department of State Health Services' (DSHS) Center for Health Statistics on the utilization and financial trend of Texas hospitals, of the \$6.09 billion of uncompensated care provided by public hospitals in 2011, 87.3% of them are born by hospital districts.²⁰ In 2015, uncompensated care pool payments accounts for 54.9% of aggregate net income of all revenue for Texas hospitals.²¹ Texas currently has the highest uninsured residents at 19.1%, compared to a national average of 11.1%.²² With expected cuts in Medicaid DSH payments in 2018 (unless it is reversed as a function of the ACA repeal process), many hospital operators and health policy experts are advocating for the state Legislature to pass Medicaid expansion and raise the base Medicaid rate.

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- **Hospital closures:** Market pressure, reimbursement cuts, declining margins, shrinking markets, among other factors, have exerted great financial pressures on many hospitals and providers. In aggregate, various payment cuts over the years (so called “deaths by a thousand cuts” by rural providers) have had a cumulative, devastating effect that has resulted literally in many hospital closures in recent years. According to the Sheps Center for Health Services Research at the University of North Carolina, at least 80 rural hospitals have closed since 2010.²³ In Texas alone, 16 rural hospitals have closed since 2013 (one has reopened and five have been converted to freestanding ERs).²⁴ The loss of healthcare in a rural community has damaging rippling effects, from direct loss of healthcare services to adverse impact on wage growth and unemployment to reduction in per-capita income to loss of skilled labor and population.²⁵ The causes of (and decision for) these closures are varied, complicated and specific to each community’s circumstances and market dynamics, but often a common thread for these casualties is linked to the crushing weight of regulations and payment cuts compounded by the ACA.

HEALTH INFORMATION TECHNOLOGY AND THE RISE OF CONSUMERISM

Within the last decade, healthcare has been greatly disrupted by health information technology (HIT). As part of the economic stimulus bill, the Health Information for Economic and Clinical Health (HITECH) Act of 2009 thrust healthcare into the adoption of HIT. The government invested \$19.2 billion to provide incentive payments to eligible professionals and hospitals to adopt, implement, upgrade or demonstrate meaningful use of certified electronic health record technology (CEHRT).²⁶ In 2015, the Office of the National Coordinator (ONC) reported that 96% of all non-federal acute care hospitals had possessed certified health IT (94% of small rural and small urban hospitals, 96% of CAHs, 97% of medium hospitals, and 98% of large hospitals had certified health IT)²⁷ and 95% had demonstrated meaningful use of CEHRT through participation in the CMS HER Incentive Programs (FIGURE 6). The rate of EHR adoption and meaningful use demonstration was slower with physicians. In 2015, 78% of office-based physicians had adopted a certified EHR²⁸ and 56% have demonstrated meaningful use.²⁹ Among physicians using EHRs, 46% reported participating in a delivery system reform program (such as pay-for-performance, patient-centered medical home and accountable care organization).³⁰

FIGURE 6 – Hospital Progress to Meaningful Use, by Size, Type, and Rural/Urban Location, 2016




Source: Office of the National Coordinator. Health IT analysis of data from the Medicare and Medicaid EHR Incentive Programs

Rapid advancements in technologies, both within and beyond the health sector, will continue to shape and transform the industry in ways that defy our imagination and challenge the way we view, deliver, finance and consume care. As healthcare continues to leverage technology to provide the best care possible to patients and populations in the new digital age, it is confronted with new challenges and uncertainties. But, with disruption comes an era, too, of unprecedented opportunities and promise through innovation. The future of healthcare — indeed, to great extent, the current state of healthcare is — and will be dramatically impacted and reinvented by forces like:

- Health information exchange (HIE) and interoperability:** Technology is embedded deeply in virtually all aspects of the care delivery system. The ability to exchange and transmit information in support of improved care delivery for individual patients and populations requires the harmonization of technical standards and development of policies for information assurance and data governance. Many of today's IT applications are designed to operate in a highly dynamic (real-time or near real-time) environment. Yet, much of the technology in the market is proprietary. The technical challenges associated with linking, transporting, and transforming disparate, unstructured data across an extremely diverse and highly fragmented delivery system can be complex and costly.

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- **Mobility:** The proliferation of mobile devices through the Internet of Things (IoT) has heralded an era of mobility and unconstrained connectivity, enabling consumers to access their personal health records and information online, virtually anytime, anywhere.
 - **Internet of Things (IoT):** Patients and providers both stand to benefit from IoT playing a bigger presence in healthcare. With everything connected to everything, health IT innovation is moving “patient-centric” care to a level where it is truly about the consumers and their total experience of care. The pervasiveness of big data, rich media and social platforms are pushing health IT to enhance ambient user experience and immersive environments as integral aspects of the care process.
 - **Big data and the intelligence enterprise:** With big data, analytics, and predictive modeling tools, the healthcare industry is increasingly becoming a precision business, where quality, competitive advantage, and market strength is highly dependent on the strategic use of business intelligence and data analytics to combat economic inefficiencies, augment or reconfigure the labor force, increase specialization, and improve quality of care and patient experience. The availability of data has also enabled consumers to engage more actively in their care process.
 - **Telemedicine:** Among the promises of the digital revolution is the application of telemedicine as a strategy and solution to increasing access to healthcare, particularly in rural, remote areas. Continuing advances in technology and applications in telemedicine hold the promise of addressing a number of issues, including specialist referral services, patient consultations involving the remote examination of medical data, remote patient monitoring, continuing medical education, and consumer medical and health education, among others. Broader use of telemedicine, however, depends largely on access to broadband connectivity, payment policies, infrastructure funding, community adoption, provider collaboration, and scope of work policies (within and across state lines).
 - **Data security:** This is arguably the most unsettling time in history for healthcare providers and technology professionals. Both healthcare and the health IT landscape are evolving at an astounding rate. The financial and economic security of a healthcare organization (and that of the industry as a whole) depends on the reliability of its critical infrastructure. With increased access points and new channels come the need for proper information assurance and data governance and security. Yet, like France’s famed Maginot line, today’s defenses are inadequate and failing, as the number of users and methods used to access cyberspace have grown exponentially. Cyberattacks are becoming alarmingly more frequent, diverse, distributed, sophisticated and fast-evolving. Today, cybersecurity is among biggest



challenges and threat to the industry. According to the Ponemon Institute's most recent report, nearly 90% of healthcare organizations had a data breach in the past two years, with the average cost of a data breach estimated to be more than \$2.2 million for healthcare organizations and more than \$1 million for business associates (BAs).³¹ While data breaches in healthcare remain consistently high in terms of volume, frequency, impact and cost, the study also found that the majority of healthcare organizations still do not have sufficient security budget to curtail or minimize data breach incidents.³²

- **mHealth and consumerism:** The digital revolution in healthcare is already here as digital connectivity and interaction have become mainstream in healthcare as in every other aspect of life. According to Statista, the overall number of mobile phones is expected to grow to 4.77 billion in 2017.³³ In the U.S. wireless penetration is estimated at 110 mobile phone subscriptions per 100 population³⁴ and estimates place mobile phone ownership by American adults approaching 80%^{35, 36} and Millennials (ages 18-34 and the largest segment of the workforce) at 92%.³⁷ Firmly entrenched as an integral, mainstream part of modern life, digital communication is not a trend and digital healthcare is not just merely convenience; rather, it is a necessity. Aided by the ubiquity of mobile devices, advances in cloud computing and the proliferation of digital services (e.g., software- and technology-enabled services) — wearable tech and health apps and accessories, consumerism is profoundly changing the way care is provided, assessed and consumed. With an “app for that” available, no longer is healthcare local, confined by geography or to traditional brick-and-mortar providers. According to 2015 and 2016 Salesforce surveys, 72% of U.S. adult Internet users look for health information online, 66% of Generation X members said they would be open to virtual care as an alternative to office visits, 73% of Millennials are interested in interacting with their doctors using mobile devices, and 63% of Millennials are interested in sharing health information with their doctors through wearable devices.³⁸

Indeed, the digital revolution has thrust healthcare into a new era, where the traditional notions of supply and demand, brick-and-mortar settings of care, and patient-doctor relationships are being reinvented in a new cultural phenomenon and a new norm driven by convenience, immediacy, choice, value attribution, and overall quality of experience. This is the new consumer-centered, consumer-driven digital economy of the 21st century. This is the great inflection point in modern medicine.



CHANGING DEMOGRAPHICS

Another major force driving change in healthcare is the shift in demographics. As the country's population gets older and more diverse, the ever-evolving composition of its people — changes in population size, age, race and ethnicity — will have profound impact on the healthcare delivery system and those in its care. In recent years (and, especially since the passage of the ACA), the healthcare industry has seen enormous change and disruption. Among the most important challenges ahead is how the system will evolve to meet the growing needs and demands of its various populations. Some of these challenges include:

- **Baby Boomers:** Baby Boomers (people born between 1946 and 1964) comprise approximately 28% of the U.S. population, or 76.4 million people.³⁹ Each day, some 11,000 Baby Boomers are aging into Medicare,⁴⁰ and by 2029, one in five Americans will be Medicare eligible, but the number of those able to pay into Medicare will drop to 57%.⁴¹ A study conducted by *Jama Internal Medicine* showed that the Baby Boomer generation may have a higher life-expectancy than previous generations, but have a higher incidence of chronic disease, disability, and poor lifestyle choices.⁴² These findings strengthen the prediction that the industry as a whole will face major financial strain as this cohort begins to retire and need chronic care management and long-term care services.
- **Millennials:** Millennials (population ages 18 to 34 as of 2015) now number 75.4 million, surpassing the 74.9 million Baby Boomers.⁴³ As the largest generation in the U.S., their growing purchasing power will be a major and growing influence in the healthcare market and may signal a tipping point for the industry. Raised in the trappings of the digital age, Millennials (also sometimes referred to as the “instant gratification” generation) are often accustomed to having all of the spoils of the Internet literally at their fingertips. So, as consumers of healthcare, they place a high value on convenience and speed of access and adopt a more holistic perspective of fitness and preventive health — a premium that has placed a culture of well-being and engagement at the center of healthcare. Known also as the “Young Invincibles,” Millennials do not want to see the doctor in person, and unlike older generations, they often avoid and only see primary care doctors as a last resort. As many as 34% prefer retail clinics and 24% prefer acute care clinics,⁴⁴ and three out of four prefer to interact with their physicians through mobile devices. Generally, they do not participate in the insurance markets and remain the uncovered segment of the population, thus, not contributing equally to risk-sharing. Collectively, the mindsets, influencers and habits of Millennials do not align with traditional models of healthcare delivery, so the healthcare industry must necessarily adapt to be successful in the future.

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- **Middle class:** Another important dynamic within the demographics of healthcare is the decrease in the American middle class. The Pew Research Center reports that after more than four decades serving as the nation's economic majority, there were 120.8 million adults in middle-income households in 2015, compared with 121.3 million in lower- and upper-income households combined.⁴⁵ In general, as healthcare services continue to consume a great proportion of consumer spending, cost sensitivity has become an important attribution of overall patient satisfaction. Medical cost trends are still outpacing both economic inflation and income growth.⁴⁶ No longer the majority and falling behind financially, the middle class is bearing a growing burden of the rising costs for healthcare services and health insurance premiums. The Henry J. Kaiser Foundation report, based on the 2015 employer benefits survey, found that the average deductible for all covered workers in 2015 is \$1,077, up 67% from 2010 and 255% from 2006.⁴⁷ Moreover, the economic security of middle-class families is weakened further as employers scale back wage increases and increase employee's cost sharing in response to higher healthcare costs. Rising costs have resulted in a demand for price transparency, billing clarity, cost comparison tools, and more quality reporting mandates. According to a 2015 Trends in Healthcare Payment Annual Report, 91% of patients said it was important to know their financial responsibility prior to a provider visit.⁴⁸
 - **Chronic diseases and health risk behaviors:** Chronic diseases and conditions — such as heart disease, stroke, cancer, type 2 diabetes, obesity, and arthritis — are among the most common and preventable of all health problems. Yet, the prevalence of chronic disease impacts 133 million people, or 45% of the U.S. population,⁴⁹ and is projected to grow to an estimated 157 million by 2020, with 81 million having multiple conditions.⁵⁰ Seven of the top 10 causes of death were chronic diseases, with heart disease and cancer, together, accounting for nearly 48% of all deaths.⁵¹ In 2011, two-thirds of Medicare beneficiaries had three or more chronic conditions.⁵² While among the most common and preventable of health problems, chronic medical conditions and the health risk behaviors that cause them account for 86% of all healthcare spending was for people with one or more chronic medical conditions.⁵³ Patients with multiple co-morbidities are high utilizers of healthcare resources. These “super-utilizers” (individuals whose complex physical, behavioral and social needs are not well met through the current fragmented healthcare system and who are typically admitted five or more times a year) have been the intense focus of many of today's complex care management programs and innovative population health initiatives aimed at reducing hospital utilization, readmission and cost. Trends in payment policies and accountable care models suggest that the future of healthcare is about wellness, preventive services, primary care, and clinical integration.

Together, demographic shifts, aging populations, the middle class dynamics, chronic medical conditions and health risk behaviors combine to intensify pressures on the healthcare delivery system to manage cost and employ population health management strategies to optimize care coordination and care transitions as these are the greatest opportunities for improvement.

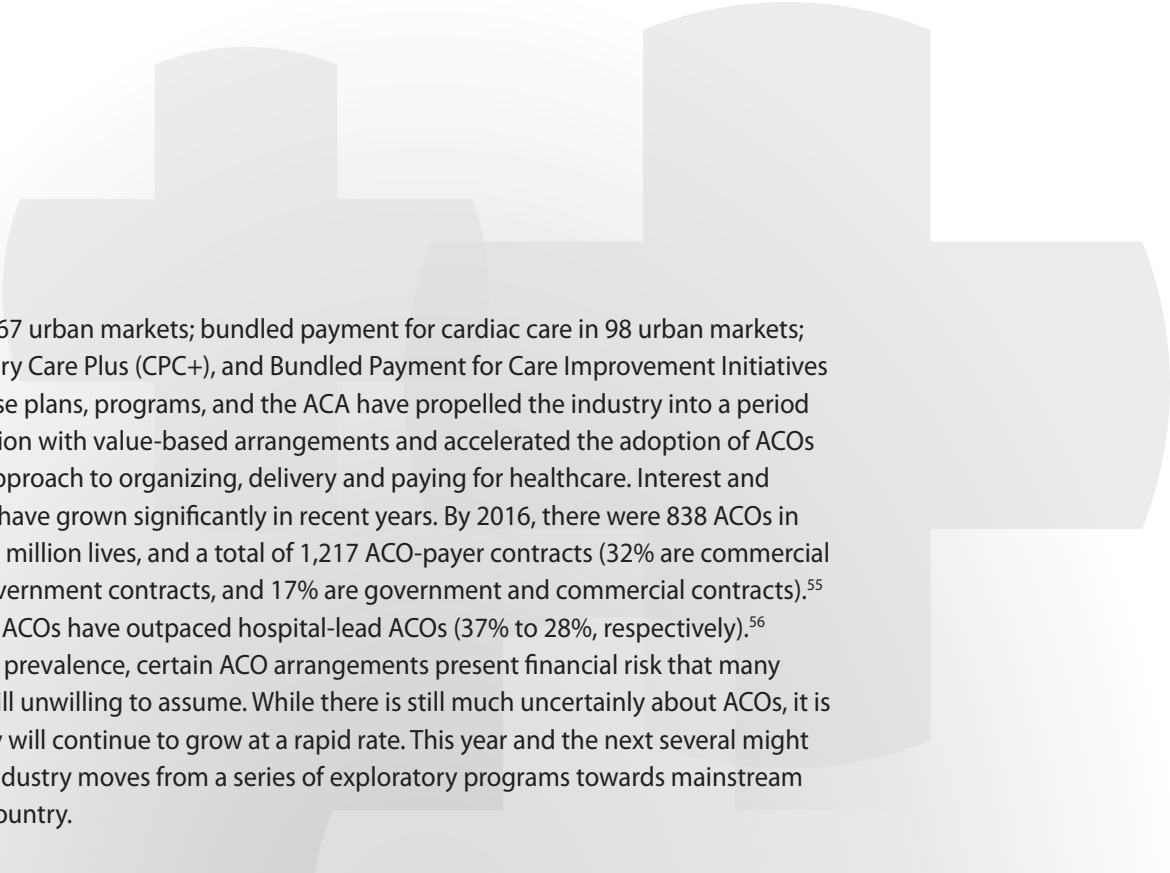


VALUE-BASED CARE

Several important provisions of the ACA served as catalysts to reform the U.S. healthcare delivery system and payment policies. Those provisions focus on three broad areas: testing new, innovative delivery models and spreading successful ones; encouraging the shift away from the high-cost, consumption-production model based on volume to one based on a value and outcome of care; and developing resources for system-wide improvement. Building on existing reform models in both the private and public sectors, these provisions directly target how healthcare is organized, delivered, and financed. Through the ACA, population health management and accountable care organization (ACO) emerged as new models for delivering healthcare.

Fundamentally, the promise of the ACO model is attractive and simple: alignment and aggregation of providers into larger and more capable, integrated, and coordinated organizations and networks to care for and manage the health of populations across care settings — and in doing so, will result in better care at reduced costs. In reality, achieving value-based care is more complex, as it requires concurrent transformations on multiple levels: business model transformation where new, strategic competencies are employed; care delivery model transformation where providers are aligned and clinically integrated; and cultural transformation where consumers are engaged, compliant, and leading healthy lifestyles.

In the early years following ACA implementation, the Medicare ACO roll out was gradual due to a number of factors, such as costs, complexity, unfamiliarity, risks, and regulatory requirements associated with this model. In particular, participation of rural hospitals and providers was difficult, limited, even impractical, for many rural communities that cannot meet the population attribution threshold requirement of the program. In recent years, however, there has been a rapid increase in the prevalence of ACOs as a result of program improvements and specific provisions designed to increase rural participation. Additionally, in a historic announcement in January 2015, Health and Human Services (HHS) Secretary Sylvia Burwell set explicit goals and time line for shifting 85% of all traditional (fee-for-service) Medicare payments to quality or value by 2016 and 90% by 2018 through programs such as the Hospital Value-Based Purchasing and the Hospital Readmissions Reduction Programs. Concurrently, it plans to tie 30% of traditional, or fee-for-service (FFS), Medicare payment to quality or value through alternative payment models, such as ACOs or bundled payment arrangements, by the end of 2016 and increasing to 50% by the end of 2018.⁵⁴ HHS further asserted that it will work with private payers, including health plans in the health insurance marketplace, Medicare Advantage (MA) plans, and state Medicaid programs to move in the same direction toward value-based payments. Since then, the government has released a series of alternative payment programs, including: Medicare Shared Savings Program [MSSP, with multiple tracks; Next Generation ACO (NGACO)]; Comprehensive Care for Joint



Replacement (CJR) in 67 urban markets; bundled payment for cardiac care in 98 urban markets; Comprehensive Primary Care Plus (CPC+), and Bundled Payment for Care Improvement Initiatives (BPCI). As a result, these plans, programs, and the ACA have propelled the industry into a period of deep experimentation with value-based arrangements and accelerated the adoption of ACOs as a new, prevailing approach to organizing, delivery and paying for healthcare. Interest and participation in ACOs have grown significantly in recent years. By 2016, there were 838 ACOs in the U.S., covering 28.3 million lives, and a total of 1,217 ACO-payer contracts (32% are commercial contracts, 51% are government contracts, and 17% are government and commercial contracts).⁵⁵ To date, physician-led ACOs have outpaced hospital-lead ACOs (37% to 28%, respectively).⁵⁶ Despite their growing prevalence, certain ACO arrangements present financial risk that many providers today are still unwilling to assume. While there is still much uncertainty about ACOs, it is likely certain that they will continue to grow at a rapid rate. This year and the next several might prove pivotal as the industry moves from a series of exploratory programs towards mainstream adoption across the country.

Population health is evolving quickly under the ACA. It has been touted that the success of value-based care as a clinical, cultural, and economic goal in the U.S. rests on the back of the ACA. Now, with healthcare reform facing imminent repeal without yet a clear replacement, the \$3 trillion healthcare industry which has invested an enormous amount of resources into this grand value-based experiment is left bracing for a new tsunami of uncertainties to come. Will the outcome-based healthcare economy suffer the same fate as the ACA? How will value-based contracting in the private sector fare in a potentially destabilizing insurance market if a responsible alternative is not, or cannot, be offered timely? The Democrats passed the ACA without a single Republican vote. Does it matter that this time around if the Republicans pass their version without bipartisan support? And, what if the appetite for repeal is no longer priority among the populous? It remains to be seen how early forays into population health and the future economic health and well-being of its citizens will be impacted by the politics of healthcare. The high-stakes political showdown has already begun in earnest in the 115th Congress.



A TIME OF CHALLENGE AND OPPORTUNITY

Not so unlike the country as a whole, the healthcare industry today is in unfamiliar times, anxious for what the days and years ahead will bring with the new administration — certain that change is unequivocal and personal. It is clear that no one factor alone determines the stability of the U.S. healthcare delivery system; rather, a constellation of interrelated factors — legislative, regulatory, market, financial, environmental, community, demographics, workforce, technology — combine to create each community's unique situation and conditions for viability. Yet, nearly all of the greatest challenges facing healthcare, particularly for rural providers, relate directly or indirectly to funding and have a profound impact on the overall financial stability of providers. While financial barriers in healthcare are many, and the industry has had to cope with continuous change for years, this time, a confluence of forces are working to affect healthcare in ways that are quite unprecedented and untested. Once, hospitals were the central hub of healthcare in the community, especially in small towns. With the rapid outmigration to outpatient settings of care and the accelerating emergence of primary care as a result of an aging population needing intensive chronic care management, it is increasingly evident that the relevance of hospitals are waning, and will likely continue to the point where the future hospital will look very different than it does today. For some, this trend is a harbinger of an existential crisis to some. Once, it was perhaps an immutable truth that, like politics, all care is local. In today's digital, highly mobile society, that is no longer the case. Once, the financial health of a provider organization was largely a function of market size, patient served, and tests performed. Now, in the new value-based economy, revenue centers are becoming cost centers as providers are held accountable for the total cost of care of populations, and leadership, collaboration, innovation, strategic agility, and business intelligence are quintessential. Indeed, healthcare — like our nation — is in the midst of great change and transition. It is a challenging time, but it is also a time infused with reasons and opportunities for optimism, hope, innovation, and progress.



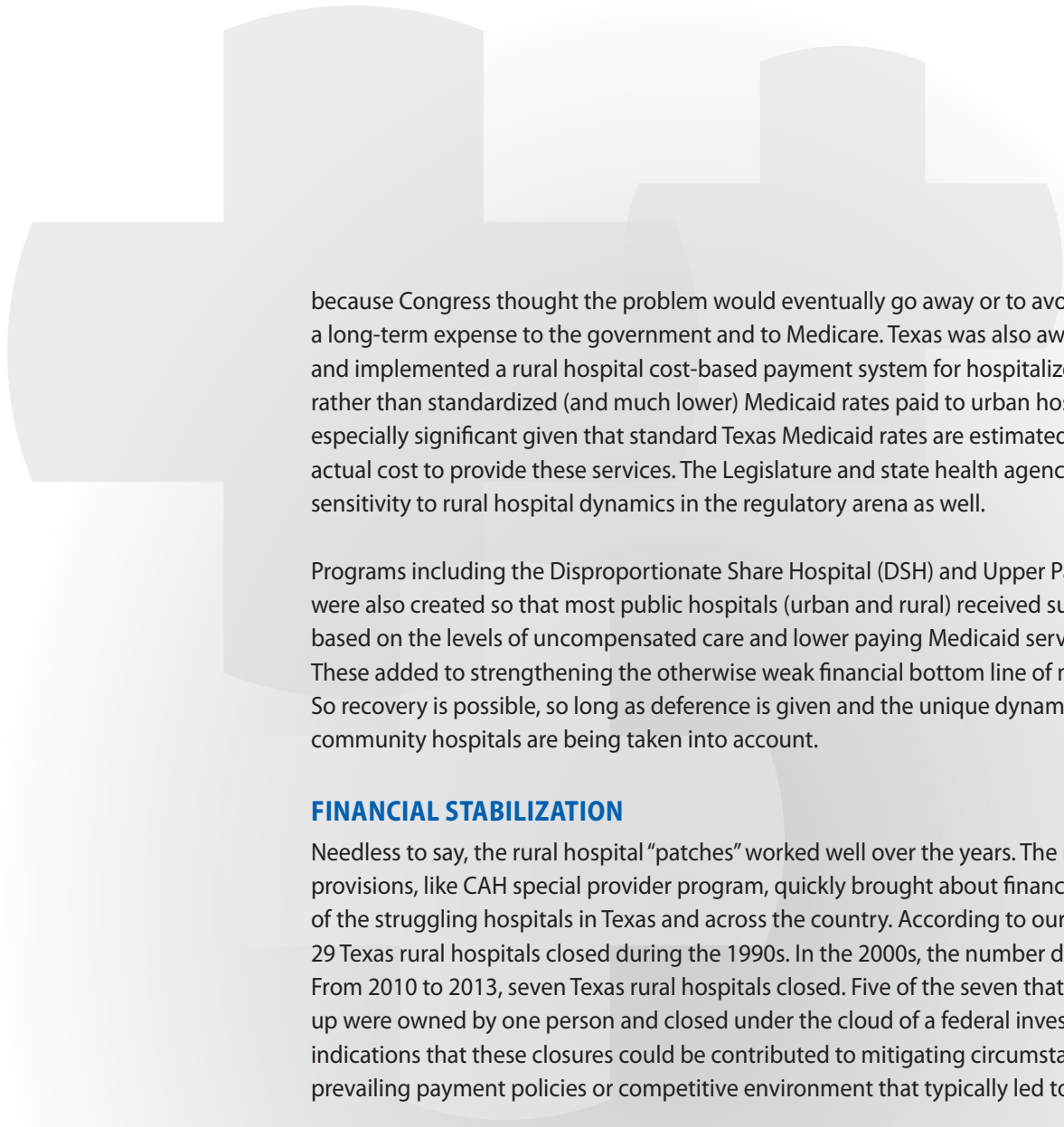
Rural Hospital Closures and Vulnerabilities

BACKGROUND

This section aims to put the state of healthcare in context with regard to the past challenges and current environmental factors and how they, in aggregate, have contributed to the closure of many rural hospitals across the country and in Texas in recent years.

Rural hospital closures are not uncommon and this is not the first time we have experienced notable loss of access to healthcare, particularly in rural communities. In the 1980s, following the mandated fixed reimbursement rates of the Prospective Payment System (PPS), burdensome regulations, financial difficulties, harsh economic conditions and competition from other hospitals, 10% of rural hospitals in the U.S. closed.¹ According to the American Hospital Association (AHA), 206 rural hospitals closed between 1980 and 1988.² During this period, physicians reported government reimbursement policies as the most important reasons for hospital closures.³ The driving force behind so many of the closures then was that Medicare placed all hospitals (urban and rural) under a “one size fits all” standardized payment system under the belief that services and payment rates should be standardized. The problem, however, is that the initial PPS rates were based on high-volume, very large urban hospitals, and did not take into account the unique operating factors of rural hospitals and the demographics of rural America. Since rural hospitals see a higher percentage of Medicare patients than their urban counterparts, the PPS system hit rural hospitals the hardest. Consequently, a great many closed.

While some regard the closure phenomenon in rural areas as a natural market response to decreased utilization of inpatient facilities, other observers are alarmed at the rapid succession of closures that persisted through the 1990s. In response, Congress ultimately passed the Balanced Budget Act (BBA) of 1997, which included special payment programs, rural exemptions and payment adjustments and add-ons to help mitigate the further loss of rural hospitals. Some core programs that were created through the BBA included the Critical Access Hospital (CAH) program. At the federal level, Congress made some of the special rural hospital programs permanent while others were given temporary or short-term life spans. Many short-term fixes were done



because Congress thought the problem would eventually go away or to avoid the appearance of a long-term expense to the government and to Medicare. Texas was also aware of the situation and implemented a rural hospital cost-based payment system for hospitalized Medicaid patients rather than standardized (and much lower) Medicaid rates paid to urban hospitals. This was especially significant given that standard Texas Medicaid rates are estimated to pay just half of the actual cost to provide these services. The Legislature and state health agencies have expressed sensitivity to rural hospital dynamics in the regulatory arena as well.

Programs including the Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL) were also created so that most public hospitals (urban and rural) received supplemental funding based on the levels of uncompensated care and lower paying Medicaid services they provide. These added to strengthening the otherwise weak financial bottom line of many rural hospitals. So recovery is possible, so long as deference is given and the unique dynamics of rural and community hospitals are being taken into account.

FINANCIAL STABILIZATION

Needless to say, the rural hospital “patches” worked well over the years. The rural hospital provisions, like CAH special provider program, quickly brought about financial stability to many of the struggling hospitals in Texas and across the country. According to our own records, only 29 Texas rural hospitals closed during the 1990s. In the 2000s, the number dropped to nine. From 2010 to 2013, seven Texas rural hospitals closed. Five of the seven that were boarded up were owned by one person and closed under the cloud of a federal investigation. There were indications that these closures could be contributed to mitigating circumstances and not to the prevailing payment policies or competitive environment that typically led to other closures.

Without question, rural hospital leaders and others credit the stabilization of rural healthcare to the many special federal and state provisions. It seems that history, however, has a way of repeating itself.



RE-EMERGENCE OF RURAL HOSPITAL CLOSURES

In recent years, an alarming number of rural hospitals have closed their doors. Since 2010, 80 rural hospitals have closed. In Texas alone, 16 have closed since 2013. Another 673 facilities across the U.S. have been identified as vulnerable to closure by iVantage Health Analytics in its *2016 Rural Relevance: Vulnerability to Value Study*.⁴ While rural hospitals have closed for a variety of reasons over the years, not since the 1980s and early 1990s has the industry witnessed such consistent high rate of hospitals closing. The situation in the 1980s looks eerily familiar when compared to today: there was no single factor or event which caused hospitals to close, but rather, a set of interrelated conditions relating to hospital financing — including declining revenues due to fewer admissions and lowered utilizations of inpatient services, lowered reimbursement, and growing burden of uncompensated care — that led to diminished hospital viability.

Over the years a number of special provisions created to protect rural facilities and providers have since been allowed to expire, while others have been adversely adjusted, and the rest under constant scrutiny and suspicion from ongoing federal efforts to control cost. The underlying agenda appears to be the relentless effort to cut from the federal and state budgets. But the consequences of fiscal conservatism come at the expense of rural communities. In Texas many rural and community hospitals are reporting low or negative margins. Others continue to depend heavily on non-operating income, such as tax subsidies and special supplemental programs like the 1115 Medicaid Waivers, to stay afloat, fearing that it is only a matter of time before they too become insolvent and are forced to shut their doors. Without meaningful interventions soon, more rural facilities will bite the dust as Congress, CMS, and policymakers continue to tinker with ‘budget dust’ in misplaced efforts to save inconsequential amounts of money in the system.

The situation is exacerbated by the fact that there are few members of the U.S. Congress and the Texas Legislature who are in office who understand or have an appreciation for the dilemma that rural hospitals faced in their fight to survive. Consequently, a diminished rural representation in Congress over the years has continued to hurt rural populations. As the population growth in Texas (and much of the country) is in urban and suburban areas, state legislative and congressional district lines are being drawn in a manner that create even more urban elected officials and less in rural areas. Those urban elected officials often question why rural hospitals are getting special treatment or why they should not be subjected to free market forces. There is a fallacy in their thinking.



RURAL IS NOT SMALL URBAN

In reality, rural hospitals are not like urban facilities, and rural is not a small version of urban. They are very different, and many of them are unique and inherent in the rurality and remoteness of their geography. They operate under a totally different set of dynamics and dependencies often characterized by low volume and low average daily census (ADC). According to the Medicare Payment Advisory Commission (MedPAC), in 2013, rural hospitals with fewer than 100 beds had an occupancy rate of only 37%, compared to a 63% occupancy rate for urban facilities. Generally, rural hospitals serve disproportionately older, poorer, sicker, and more vulnerable patient populations. Despite its small size and smaller patient base, a rural hospital must still maintain a broad range of essential health services for its community. Fewer patients over which to spread fixed expenses (hence, higher cost per case) and smaller sizes often translate into a vulnerable financial position that is much less predictable. Moreover, as often the hub of care in their communities, rural hospitals provide essential inpatient, emergency, ambulatory, and certain specialty services to meet the needs of local residents, even when some of these services are a loss leader and are at odds with financial performance targets. Even with the ACA in place, rural hospitals also often deal with much higher levels of uninsured and underinsured patients who have fewer resources to cover their own healthcare expenditures. Together, their small size, low patient mix, increased uncompensated care, growing bad debt, and dependence of public programs and payments from Medicare and Medicaid make small rural hospitals less able to weather financial fluctuations and growing pressures from regulatory and market forces.



HOSPITAL PAYMENT CUTS

Besides the loss of some special payment provisions and the endangering of others, rural hospitals have also been forced to endure across-the-board cuts to all hospitals. Those include the two percent Medicare payment reduction under Federal Budget Sequestration, a 10% Texas Medicaid outpatient payment reduction in 2011, a 40% payment reduction for non-urgent use of the emergency room by a Medicaid recipient, among others.

Insurance companies and managed care providers are also moving to reduce payments to hospitals. With the awareness that they have long picked up some of the cost for the lower paying government healthcare systems and for uncompensated care, they are pushing back trying to cut payment rates and by placing more restraints on services. While rural hospitals have no obligation to contract with private insurance companies, they know that the failure to do so will leave some of their community residents without accessible healthcare.

Besides funding cuts, all hospitals have endured a series of unfunded and underfunded mandates, such as the expensive requirement of conversion to electronic health records and the ICD-10 coding system. And of course, there are numerous regulations and requirements that lead to added expense for all hospitals on a nearly constant basis, most recently a change in the way that hospitals must dispose of fetal remains and at much greater expense.

Also brought into the financial mix over the last few years are various penalty provisions under the ACA, which are costing all hospitals. Ramped up audit efforts where even legitimate medical services are being challenged over certain billing codes resulting in hospitals often refunding Medicare for legitimate services they provided. The Medicare Recovery Audit Contractor (RAC) program costs many rural hospitals \$150,000 to \$250,000 a year alone.

While the financial dynamics of every rural hospital are different and are driven by a myriad of factors (like local tax support or none), more and more rural hospitals are reporting a narrower bottom line, and many have negative operating margins. Rural hospitals can cut costs and regularly lay off employees, but with such a small workforce to begin with, such actions can prove self-defeating and often end up exacerbating the situation.



IMPLICATIONS OF HOSPITAL CLOSURES

Rural communities depend on its healthcare infrastructure, where the hospital is often the hub of care, as a critical source of the area's economic and social fabric. The closure of a rural hospital, therefore, has devastating and rippling effects on a rural community, as it jeopardizes a community's direct access to essential medical services and undermines the area's economic viability. The immediate impact is often the loss of 75 to 150 jobs, on average. Frequently serving as one of the region's largest employers, the closing of a local hospital results in the loss and exodus of many high-paying, high-skilled jobs. As a result, the community has a very difficult time attracting and retaining skilled workers and businesses. The outmigration of skilled labor and decrease in wages and economic activities are detrimental to the town as it faces a series of challenges that ultimately threaten its survival. There have been numerous studies on the direct economic impact of a hospital closure. For example, a 1990 study simulated the effect of a hospital closure in rural Oklahoma and estimated that over a 5-year period approximately 78 jobs, \$1.7 million in income, \$452,100 in retail sales, and \$9,100 in sales tax revenue would be lost because of the closure. It is a given that any community that loses a hospital will fight an uphill battle when trying to recruit a new business to town. A reinvestment in the local health system is often the smartest move a community can make.

Apart from the economic impact and loss of qualified healthcare professionals, is the reality that the residents must now travel much greater distances for hospital-related care. The loss of emergency care can sometimes contribute to unfortunate situations such as occurred when the hospital in Center, Texas, closed in 2013. On August 12, 2013, an 18-month-old toddler choked on a grape and died. The parents rushed the child to the hospital in Center, TX only to find it closed. The local ambulance was unavailable. They were out of town transporting another patient to the nearest hospital. By the time law enforcement could assist in getting the child to the next nearest emergency room, it was too late. Stories like these are bound to repeat themselves eventually in every community that no longer has a hospital with local emergency room services.



RURAL-URBAN INTERDEPENDENCIES: THIS IS EVERYBODY'S CONCERN

From a statewide policy perspective, everyone should be concerned over rural hospital closures. Texans are very mobile and traverse the state frequently, traveling through its vast rural areas. Accidents and emergencies happen and the worst seldom near home. A hospital within miles of any accident site is the key to keeping a trauma victim alive. Once the 'Golden Hour' has passed, the odds of saving a trauma victim's life drop precipitously.

And then there is the economic welfare of the state. Described as the source of much of the "food, fiber and fuel" much of the state's sustenance and resources come from rural Texas. It is critical for a healthy workforce to be in place to produce products for consumption and export.

FUTURE PLAN AND PATHWAY FOR SUCCESS

As we think about how hospital closures are challenging the delivery of healthcare in rural Texas, it is hard not imagine what some communities might be like today, if only their hospitals had survived. Herein lies the challenge for all of us. How can we take our knowledge of the past and use it to improve our chances going forward? How can we maintain the protections that have been put in place to help sustain rural hospitals and also adjust to meet the needs of a reformed healthcare system? We cannot do it one hospital or one rural community at a time. We must adopt meaningful policies that take into account the uniqueness and dynamics of rural areas and populations, pass legislation that serve to advance the health and welfare of its people — not just cut costs — and reestablish adequate funding that protects and preserves existing rural facilities, and by extension a vital part and fabric of American life.

In times of great change — perhaps, especially so — true innovations and new opportunities will often emerge. Right now, there are rural hospitals in Texas that are succeeding, but not enough of them, and many are struggling. Their ability to thrive amidst great change is evident that success is very possible and testimony to the value of versatility, innovation, and leadership. Add to resiliency, optimism, grit, and collaborative spirit, these are, in fact, the defining characteristics that distinguish rural communities and lay lasting claim to its appeal. Rural hospitals have always existed precisely to serve the healthcare needs in their communities. It is incumbent upon us all to work with our elected officials and policymakers to ensure that every effort is being made to see that rural hospitals and safety net providers succeed. We point to the list of recommendations found at the end of this report for the reasons and means by which to do so.

The Impact of the Affordable Care Act

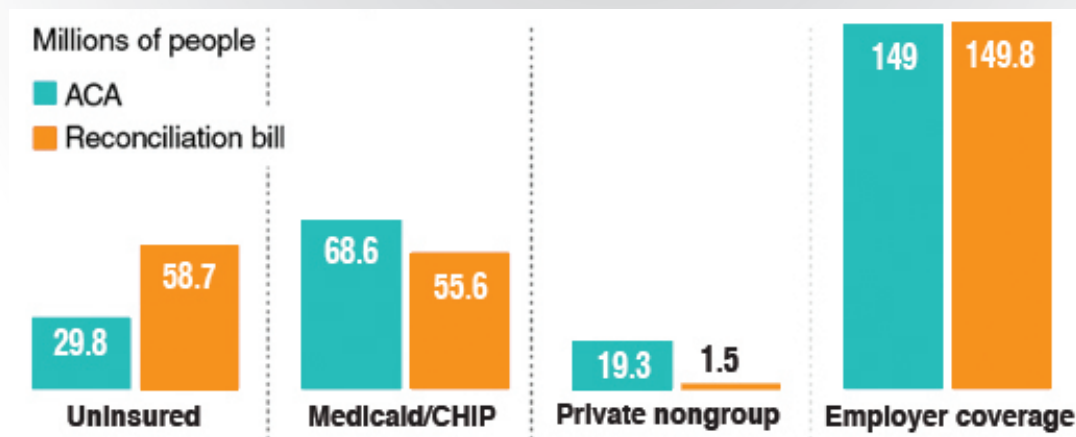
INTRODUCTION

The Affordable Care Act (ACA) was the largest, most comprehensive, effort to reform the U.S. healthcare delivery system in several decades. Its implementation has drastically changed the landscape for all health providers, including rural hospitals. In light of current efforts to repeal the ACA as one of the earliest actions that will be taken by both the incoming Trump Administration and the Republican-majority Congress, it is prudent to consider a balanced, objective perspective of the benefits and burden this law has had on rural hospitals and the industry to date, and what a repeal and a replacement — whatever that may be — might mean for individuals and the healthcare economy as a whole.

While there are early indications that a ‘replacement’ (or a rebrand) is being developed, it is unclear what aspects of the law will undergo wholesale change versus incremental adjustments or budget amendments. It is also clear that a repeal without a replacement will have important consequences (FIGURE 7). According to Modern Healthcare, “Both parties have powerful political reasons to avoid disrupting healthcare for the 30 million Americans who obtained coverage through the new individual marketplaces or state Medicaid expansions,”¹ so perhaps that will mean that a smooth transition is in the offering. (Note: most sources cite 20 million Americans have received coverage through the ACA).

FIGURE 7 – Potential Impact of ACA Repeal without a Replacement

Here’s how unwinding the ACA through the budget reconciliation process without a substitute for the individual mandate could affect coverage for non-elderly Americans in 2019:



NOTE: Analysis based on the budget reconciliation bill passed by Congress and vetoed by President Barack Obama in 2016. Source: Urban Institute

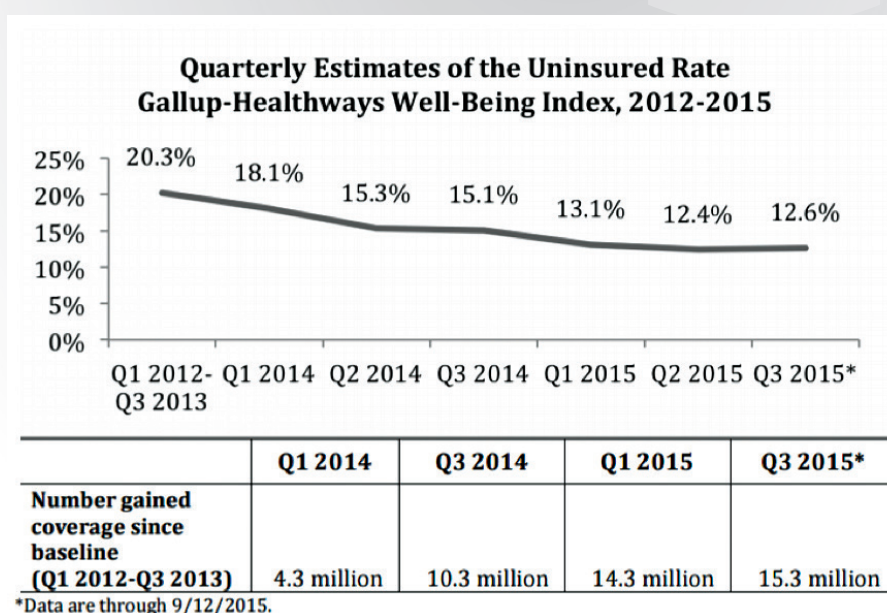
However, one other thing is also clear. While some states have taken full advantage of the ACA's opportunities to reduce the uninsured population and increase coverage through Medicaid expansion, in Texas the effect of any changes will be fairly muted, given state leadership's decision to implement as little of the original law and those corresponding benefits as possible. That does not mean that significant changes to the law would not be felt here. With rural hospitals in such a fine balance financially, it would take very little disruption to cause great harm to any at-risk facilities.

Furthermore, the consequences of losing healthcare coverage can be life-altering for individuals and families. Tom Daschle, the former Democratic Senate majority leader who helped craft the ACA, contends that healthcare re-reform "has the potential to swamp any presidential administration because of its complexity and the extraordinary emotional context of people's lives and health."² That complexity underscores the need for rural health advocates to place special emphasis on efforts to track the government's actions and progress on this issue.

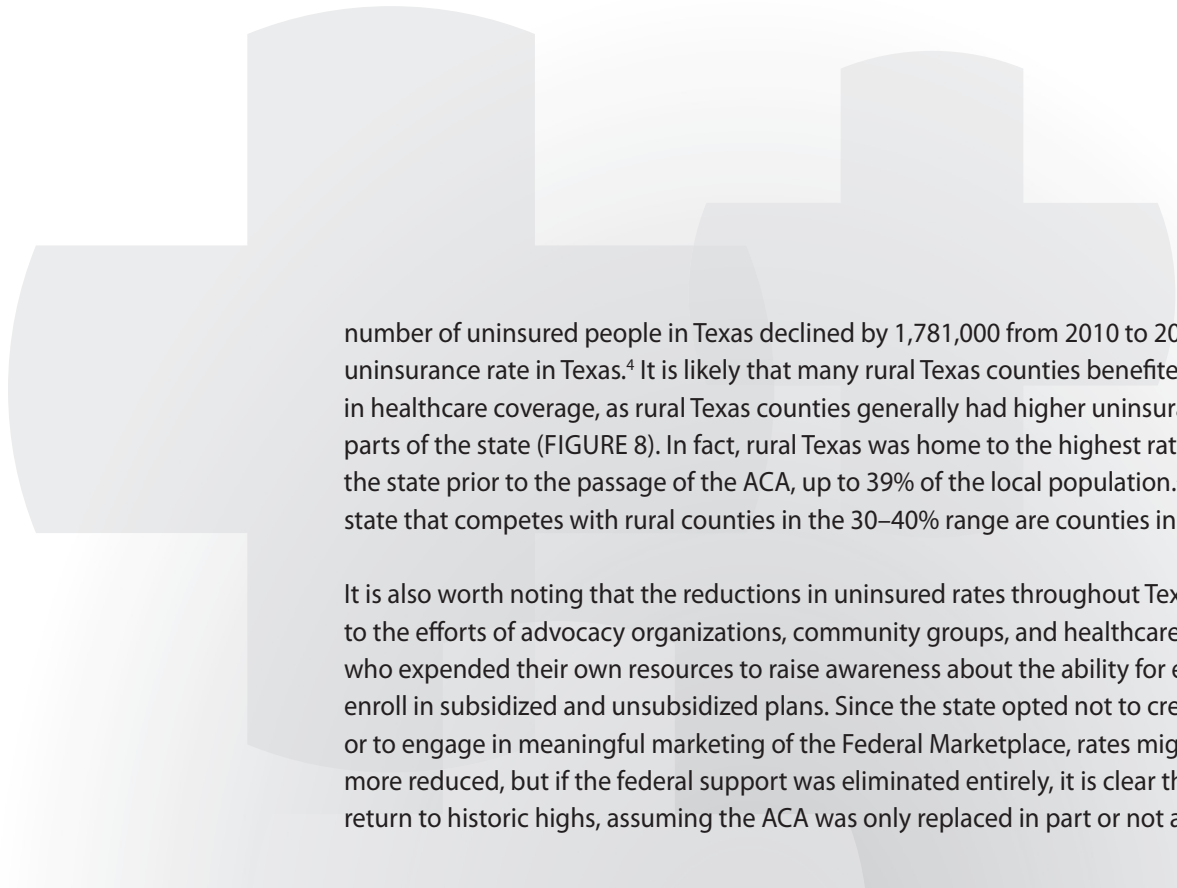
FEDERAL MARKETPLACE UPTAKE IN RURAL TEXAS

At significant risk in the current political environment are the gains that Texas has been able to make in reducing its uninsured population, even without the benefit of added covered lives under the ACA's Medicaid expansion provision. From the Open Enrollment period that ended in February 2016, Texas has approximately 1,092,650 with effectuated coverage through the Federal marketplace, which was nearly 13% higher than it had been a year earlier³ (FIGURE 8). The

FIGURE 8 – Gain in Coverage and Decline of Uninsured Rates



Source: US Census Bureau's Small Area Health Insurance Estimates (SAHIE) Program. County health rankings, 2016 Online Access: <http://www.countyhealthrankings.org/app/texas/2016/measure/factors/85/map>



number of uninsured people in Texas declined by 1,781,000 from 2010 to 2015, a 28% drop in the uninsurance rate in Texas.⁴ It is likely that many rural Texas counties benefited from the expansion in healthcare coverage, as rural Texas counties generally had higher uninsurance rates than other parts of the state (FIGURE 8). In fact, rural Texas was home to the highest rates of uninsured in the state prior to the passage of the ACA, up to 39% of the local population.⁵ The only area of the state that competes with rural counties in the 30–40% range are counties in the border region.

It is also worth noting that the reductions in uninsured rates throughout Texas are due primarily to the efforts of advocacy organizations, community groups, and healthcare providers themselves who expended their own resources to raise awareness about the ability for eligible individuals to enroll in subsidized and unsubsidized plans. Since the state opted not to create a State Exchange or to engage in meaningful marketing of the Federal Marketplace, rates might have been even more reduced, but if the federal support was eliminated entirely, it is clear that rates would rapidly return to historic highs, assuming the ACA was only replaced in part or not at all.

Comparative Analysis of Uninsurance Rate and ACA Enrollment

In this section, we analyzed the currently available data for uninsurance and enrollment throughout the ACA's lifespan and to illustrate the impact of coverage under the ACA not only on rural and urban areas in Texas, but also with a specific emphasis on the Episcopal Health Foundation's (EHF) 57-county service area. This information illustrates the degree to which providers and residents in the EHF area are benefiting from the healthcare law, and to help advocacy efforts to prioritize resources and strategies to ensure and to advance improvements for this important region of the state.

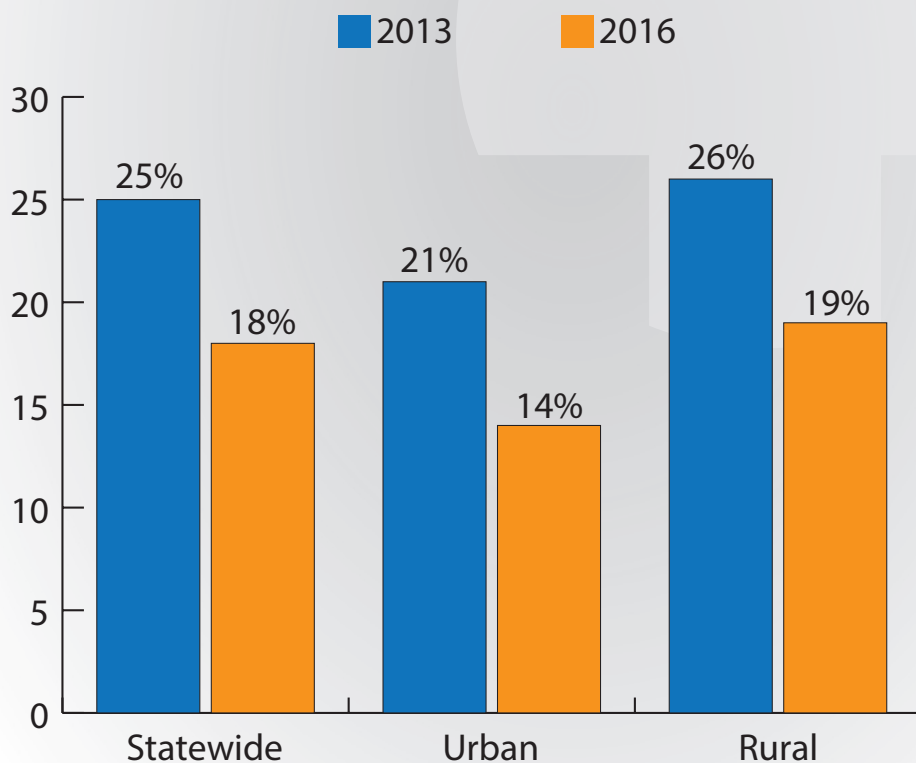
This new analysis of data that has been published by CMS, Enroll America and EHF itself, is particularly enlightening and it shows that the ACA has succeeded in reducing the uninsured rate in Texas as a whole and in rural counties, even without the benefit of Medicaid expansion. While the uninsurance rate in Texas has fallen from 2013 through 2016, the overall rate of enrollment in rural areas of Texas is small by comparison. However, the expanded coverage for rural residents is not an insignificant number, and thus we feel that a full repeal of the ACA without an acceptable replacement would abruptly reverse the important progress made — if not, worsen matters — and leave a sizeable rural population lacking the much-needed health coverage that would adversely impact the health status of rural Texans. Without the 1115 Waiver to pick up the slack, the vulnerability of our rural facilities will also increase.

In, 2016 the total number of Plan Selections was 1,306,208 covered individuals with healthcare coverage through the ACA.⁶ The Effectuated Marketplace Enrollment as of March 2016 was 1,092,650⁷ and over 84% of Marketplace Enrollees have received a subsidy or some form of financial assistance. Compare that to the 4,730,940 Medicaid and CHIP enrollees as of August 2016,⁸ which has increased 7% since the first Open Enrollment Period (OEP1). The national uninsured rate has dropped to 8% from 16% among 18–64 year olds since 2013.

UNINSURED RATE

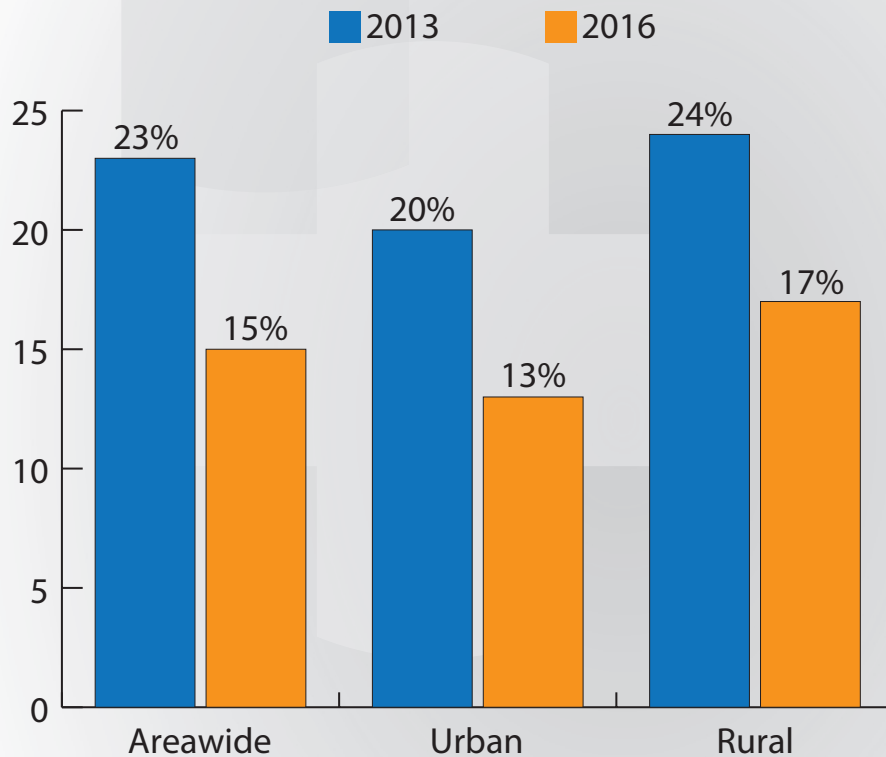
According to EHF, the Texas uninsured rate in 2013 was at 25% and it has decreased 7 percentage points to 18% in 2016. Rural county uninsured rates tend to be far higher than urban, even as high as 30% or more of the local population, but this data shows that overall the rate for rural areas went from 26% to 19% over the same period (FIGURE 9).

FIGURE 9 – Texas Uninsured Rate from 2013-2016



Within the 57 counties that EHF serves, the uninsured rates for rural areas are higher than the urban areas by nearly 5% after four years of ACA enrollment (FIGURE 10). The good news is that when comparing the two, the EHF service area has performed slightly better than the state as a whole on reducing the rate of uninsured in both rural and urban counties.

FIGURE 10 – EHF Uninsured Rate 2013-2016



ACA ENROLLMENT

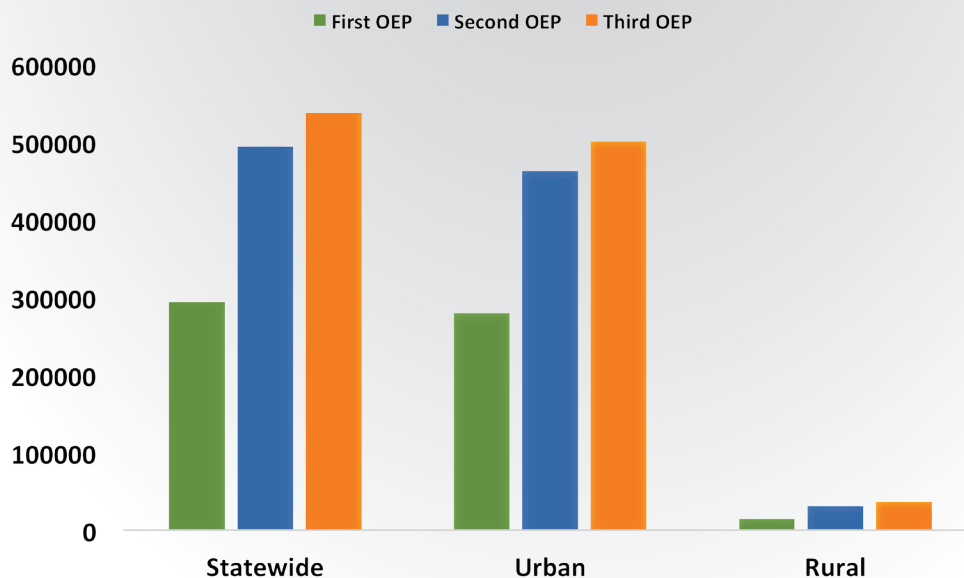
In terms of the pure numbers of ACA Enrollees, there is an even wider gap between rural and urban participation. Although part of that may be accounted for through differentials in population density between rural and urban, it is clear that the ACA has not taken root well enough to offset the higher rate of uninsured rural Texans (FIGURE 11).

FIGURE 11 – Texas Enrollment 2013-2016



Again, the EHF service area has a high percentage of the state's ACA Enrollment, but rural areas remain far behind in terms of total ACA Enrollees for the period between 2013 and 2016 (FIGURE 12).

FIGURE 12 – EHF Enrollment 2013-2016



UNINSURED RATE BY DEMOGRAPHIC

The last set of figures represents the uninsured rate comparison between the rural and urban counties within the EHF Service Area by race, gender and age. In all cases the rates are significantly higher in rural counties. This suggests that if there is an ongoing opportunity to provide health coverage in the future, additional emphasis and support must be placed on outreach and enrollment in rural areas.

FIGURE 13 – Uninsured Rate By Race

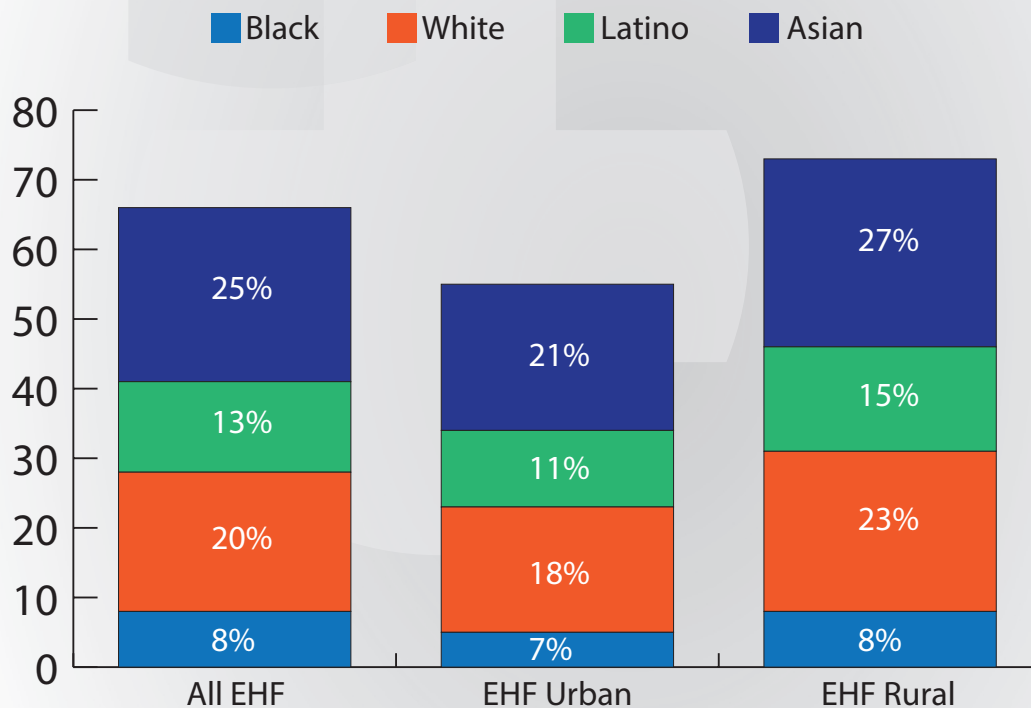


FIGURE 14 – Uninsured Rate By Gender

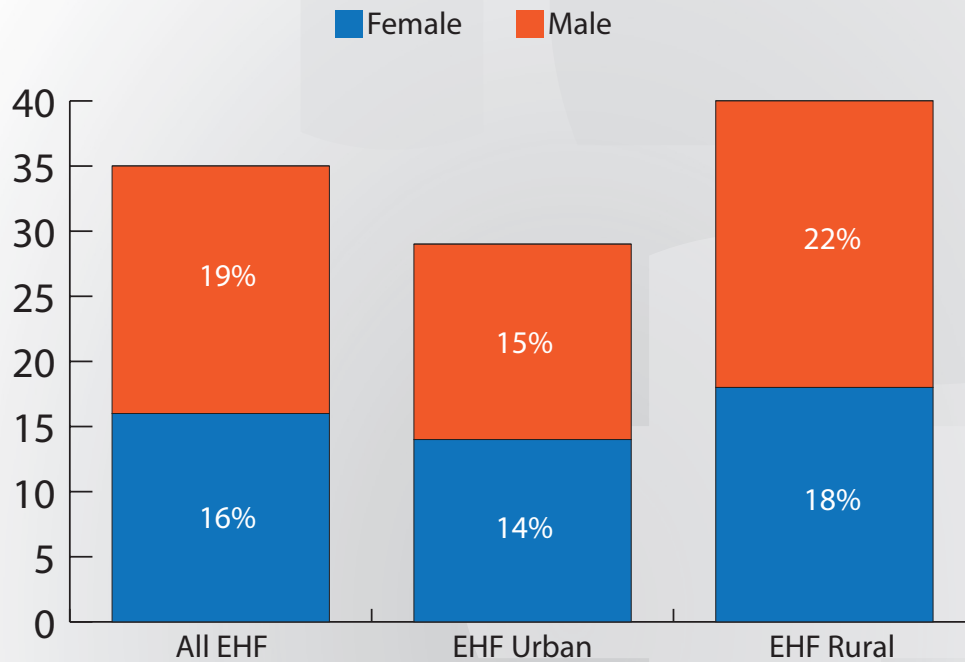
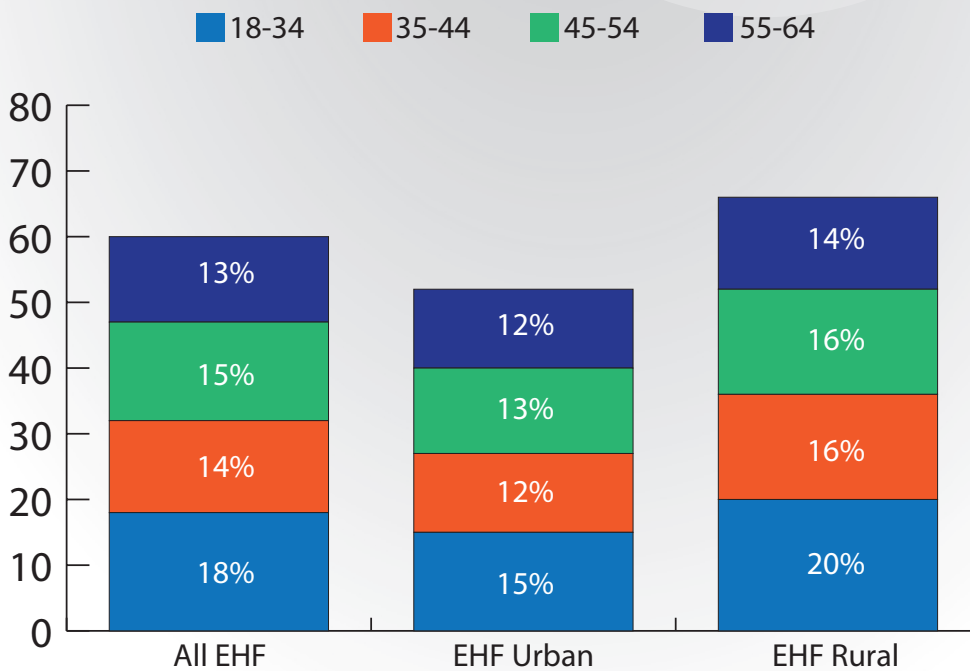
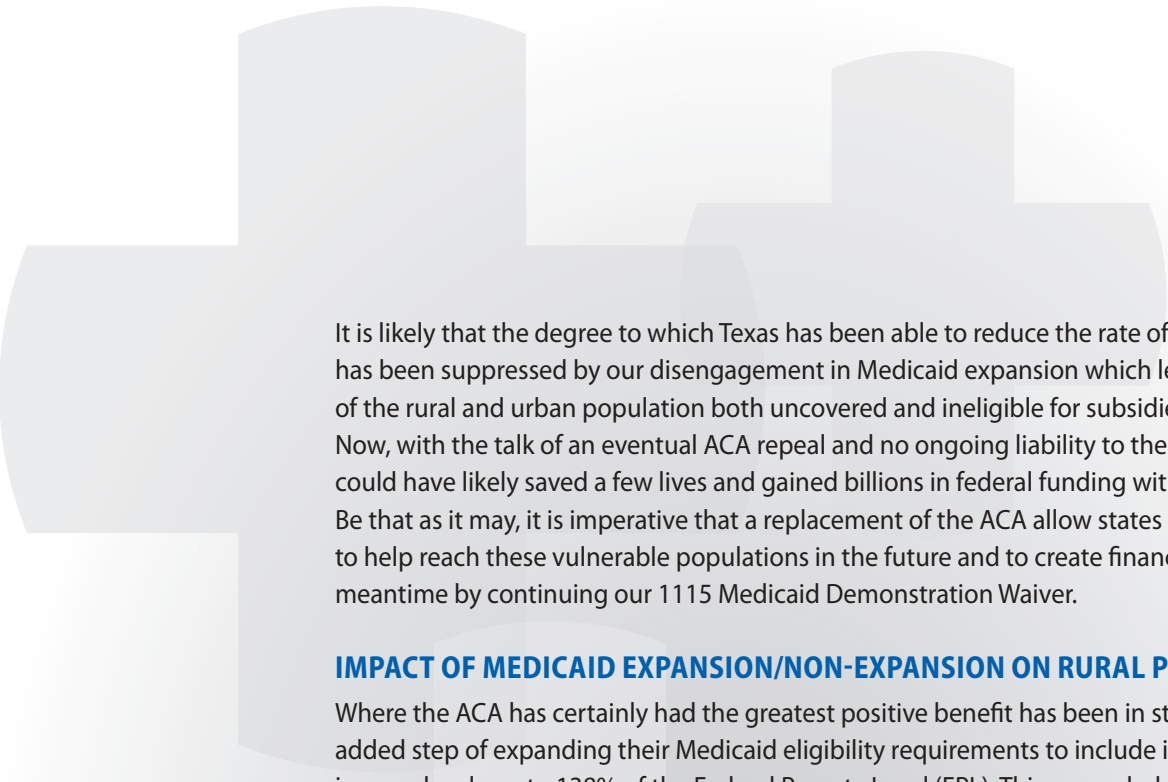


FIGURE 15 – Uninsured Rates By Age





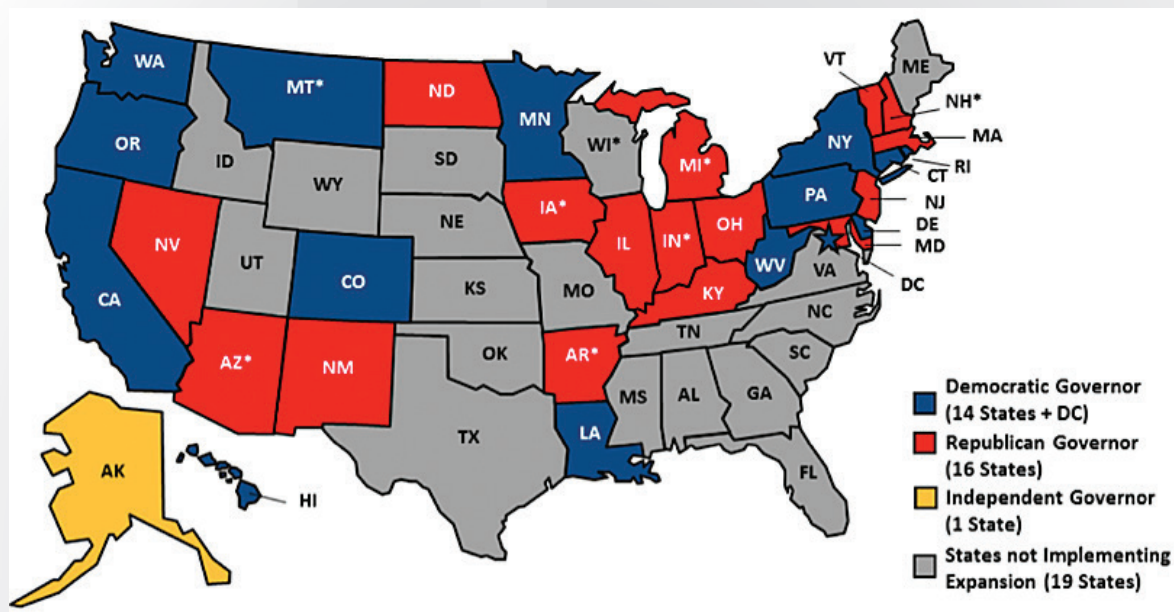
It is likely that the degree to which Texas has been able to reduce the rate of uninsurance overall has been suppressed by our disengagement in Medicaid expansion which left a sizeable portion of the rural and urban population both uncovered and ineligible for subsidies under the ACA. Now, with the talk of an eventual ACA repeal and no ongoing liability to the state as a result, we could have likely saved a few lives and gained billions in federal funding with no obligations. Be that as it may, it is imperative that a replacement of the ACA allow states like Texas an avenue to help reach these vulnerable populations in the future and to create financial stability in the meantime by continuing our 1115 Medicaid Demonstration Waiver.

IMPACT OF MEDICAID EXPANSION/NON-EXPANSION ON RURAL PROVIDERS

Where the ACA has certainly had the greatest positive benefit has been in states that took the added step of expanding their Medicaid eligibility requirements to include individuals with income levels up to 138% of the Federal Poverty Level (FPL). This expanded demographic, which is comprised primarily of working-class, childless adults, is a significant subset of the uninsured population and a major contributor to driving coverage rates up in many areas of the country other than the Deep South, which is also where the majority of rural hospital closures have taken place.⁹

A study published in the journal *Health Affairs* titled, *Medicaid Expansion Affects Rural And Urban Hospitals Differently*, found in states with expanded Medicaid, rural hospitals saw a greater increase in Medicaid revenue than did urban hospitals.¹⁰ Rural hospitals typically serve a lower income group which tends toward Medicaid eligibility. Thus, Medicaid expansion allowed these states to benefit financially from the ACA to a far greater degree than did non-expansion states. The authors also found that “For both types of hospitals [rural and urban]...Medicaid expansion was associated with increases in Medicaid-covered discharges, [but that], the increases in Medicaid revenue were greater among rural hospitals than urban hospitals.”¹¹ The hospitals in the nineteen states, including Texas, which opted out of Medicaid expansion (FIGURE 16), therefore, were unable to reap these same benefits, including Texas. Kaiser Health concludes, “All hospitals generally fared better under the larger Medicaid program, but there’s more at stake for rural hospitals when the state expands coverage.”¹² Indeed, there is much more to lose for those in states that did not.

FIGURE 16 – Medicaid Expansion and Non-Expansion States

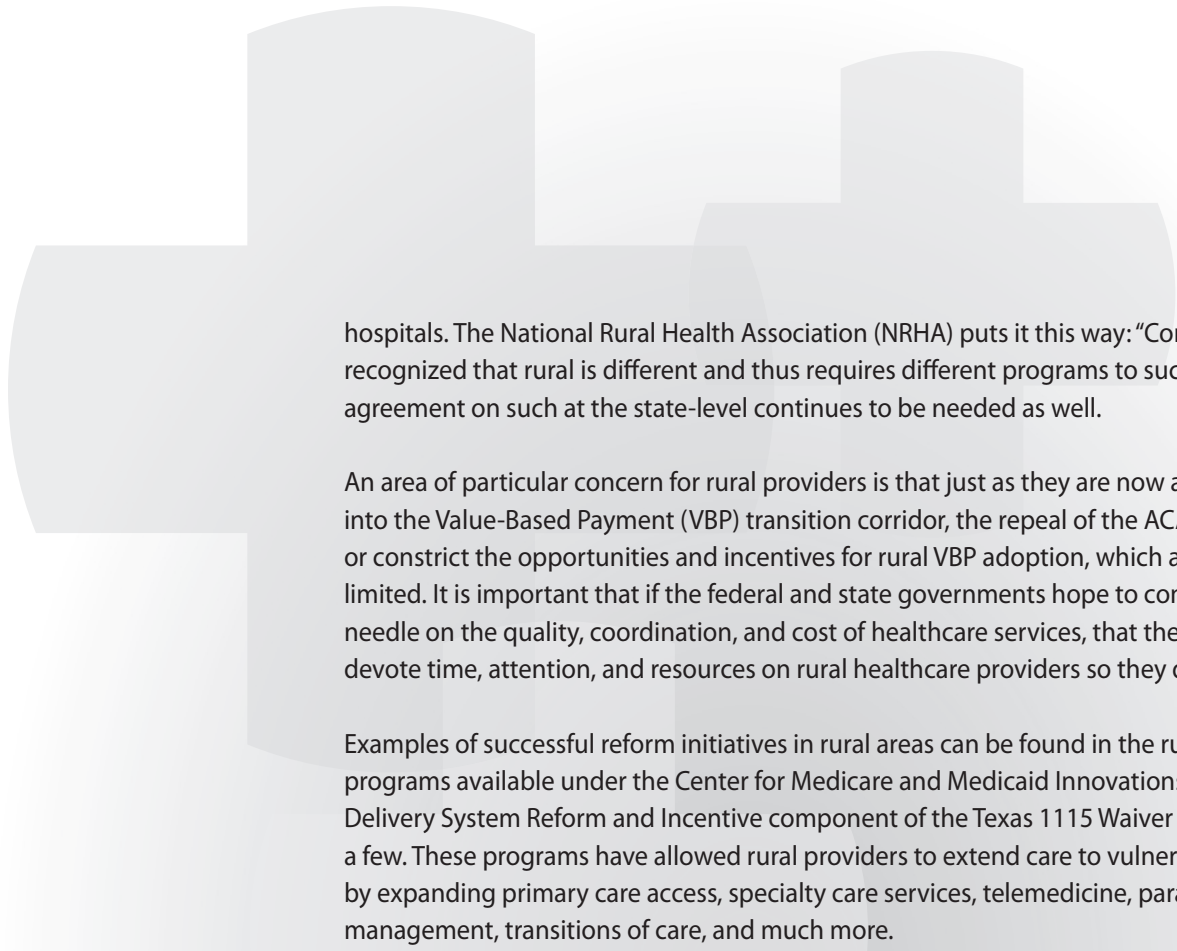


Source: Henry J. Kaiser Foundation. Online access: <https://kaiserfamilyfoundation.files.wordpress.com/2016/12/8943-figure-1.png>

While there is much more to lose for those in states that did not expand coverage, including Texas, there is little solace in the hope of Medicaid expansion now with a Republican President and Republican-majority committed to scrap the law. The situation today in rural Texas is one where this opportunity loss only adds to the financial uncertainty that is being felt by hospitals across the southern U.S. Add to that, mounting uncompensated care costs, reductions in available IGT to support critical supplemental payment programs, especially Texas' multi-billion dollar 1115 Medicaid Demonstration Waiver that is currently under negotiation, combine to make a recipe for disaster and indicates a critical need for ongoing advocacy and resources to support the rural health safety net.

MARKET REFORMS AND MODERNIZATION

Both the ACA and the Texas 1115 Waiver have helped usher in a new era of delivery system transformation and a period of sustained and systemic healthcare reform efforts. These changes at the federal and state level have had a profoundly positive impact on rural healthcare as well, because for once they brought with them the funding and resources to support the hospitals' efforts, rather than heavy-handed, one-size-fits-all regulations, audits, fees, and penalties. The carrot approach and increased flexibility are imperative when attempting to engage rural



hospitals. The National Rural Health Association (NRHA) puts it this way: “Congress has long recognized that rural is different and thus requires different programs to succeed.” General agreement on such at the state-level continues to be needed as well.

An area of particular concern for rural providers is that just as they are now attempting to merge into the Value-Based Payment (VBP) transition corridor, the repeal of the ACA could also eliminate or constrict the opportunities and incentives for rural VBP adoption, which are already somewhat limited. It is important that if the federal and state governments hope to continue moving the needle on the quality, coordination, and cost of healthcare services, that they also continue to devote time, attention, and resources on rural healthcare providers so they do not get left behind.

Examples of successful reform initiatives in rural areas can be found in the rurally-focused programs available under the Center for Medicare and Medicaid Innovations (CMMI) and the Delivery System Reform and Incentive component of the Texas 1115 Waiver program, just to name a few. These programs have allowed rural providers to extend care to vulnerable populations by expanding primary care access, specialty care services, telemedicine, paramedicine, care management, transitions of care, and much more.

Again, we cannot afford to let political motivations undermine legitimate efforts on the part of rural hospitals and other providers to improve the access to and availability of much-needed, locally-available healthcare services. Each time a rural hospital closes, it creates another hole in an already fragile safety net. Texas already has about a quarter of its geography without the benefit of local acute care services and that area has increased dramatically since 2010, after many years of relative stability. The only way to prevent further loss of essential access to care in rural areas is to commit to protecting rural hospitals, clinics, and providers while these existing reforms and the ACA replacement take shape.

THE OVERALL THREAT TO HOSPITALS

To summarize, the greatest threats to the hospital industry based on the discussion about repealing the ACA are two-fold. First: the shock to the system that would be created by suddenly dumping 20 million previously covered individuals back on our healthcare system, seeking services through ERs, or delaying assistance with treatable conditions would be costly and have potentially deadly consequences at best. Congress and the Trump Administration must carefully consider the implications of not providing an adequate replacement for what now amounts to enough covered lives to roughly equal to the population of Florida or the sixteen smallest states combined.

Second, it is difficult to expect any hospital to budget or plan under the threat of such major changes. The strategic partnerships that many hospitals have forged over the past few years could become irrelevant or at the very least may require renegotiation to be workable again in version

2.0 of the ACA. The insurance industry will also be going through a similar period of readjustment, vis-à-vis their involvement in state and federal exchanges, risk-sharing arrangements and provider contracts.

A recent article in Modern Healthcare also points out that, “Repealing the expansion would cost states billions of dollars, creating budget strains” and “force states to slash eligibility, benefits and payment rates to providers.”¹³ This would have a traumatic effect in a state like Texas where budget deficits have become fairly routine and provider payments are already well below the cost of caring for Medicaid beneficiaries.

For that matter, even if Texas had acquiesced and fully implemented every aspect of the ACA, we would still be left with a sizeable financial and access to coverage burden totaling:

- \$8.7 billion in annual uncompensated care costs;
- \$4 billion in uncompensated care after federal supplemental payments; and
- 4.6 million uninsured individuals.

While this is far from a comprehensive list of the challenges that hospitals would face, it outlines several of the most troubling concerns that would result from rash action on the ACA without an appropriate backup plan.

SPECIFIC THREATS FACING RURAL HOSPITALS

In addition to all of the possible threats above, there are some additional benefits that would be lost opportunities for rural providers if the ACA were to be repealed. Clearly, no other policy or program has moved the needle so far or so fast on helping to reduce the indigent and uncompensated care burden on rural providers than the ACA. Even if that benefit is unevenly distributed and brought with it other challenges such as narrow networks, high deductibles and unexpected premium increases, it is the only factor that has improved for otherwise struggling rural hospitals. It gave rural residents an avenue to be able to purchase much-needed health insurance.

The ACA also ushered in a few supplemental payment extensions, such as the Medicare Dependent Hospital and Low Volume Hospital programs, which now comprise one of the few remaining available supplemental payments that many rural hospitals qualify for. Of course, the ACA also required that there be reductions in Disproportionate Share Hospital programs as the rate of coverage increased over time. It is our sincere hope that any repeal will also include this provision, which would amount to double-jeopardy if it continued after ACA coverage came to an end.

The ACA also brought with it increases in funding to address the rural health workforce shortage. New investments in programs like National Health Service Corps (NHSC) that are designed to train and incentivize health professionals to choose a rural practice location. Upstream from this, there were ACA dollars dedicated to medical schools and other training sites to help increase the number of students and residents that would ultimately decide to train in primary care, an enduring need for both rural and urban underserved areas.

Again, there are threats that go well beyond the loss of health insurance coverage and though Texas is among the nineteen states that failed to expand Medicaid during the last five years, it is the potential upheaval caused by a short-sighted repeal process that strikes fear into the hearts of most healthcare professionals. With rural hospitals closing at an ever increasing rate and 673 at similar risk nationwide according to NRHA, even greater risks include:

- 11.7 million patients without direct access to care;
- 640 counties across the country without quick access to an acute-care hospital;
- 77 percent of the nation's 2,041 rural counties are health professional shortage areas;
- More than 40% of rural patients have to travel 20-plus miles to receive specialty care, compared to 3 percent of metropolitan patients; and
- 60% of trauma deaths occur in rural America, even though only 20% of Americans live in rural areas.

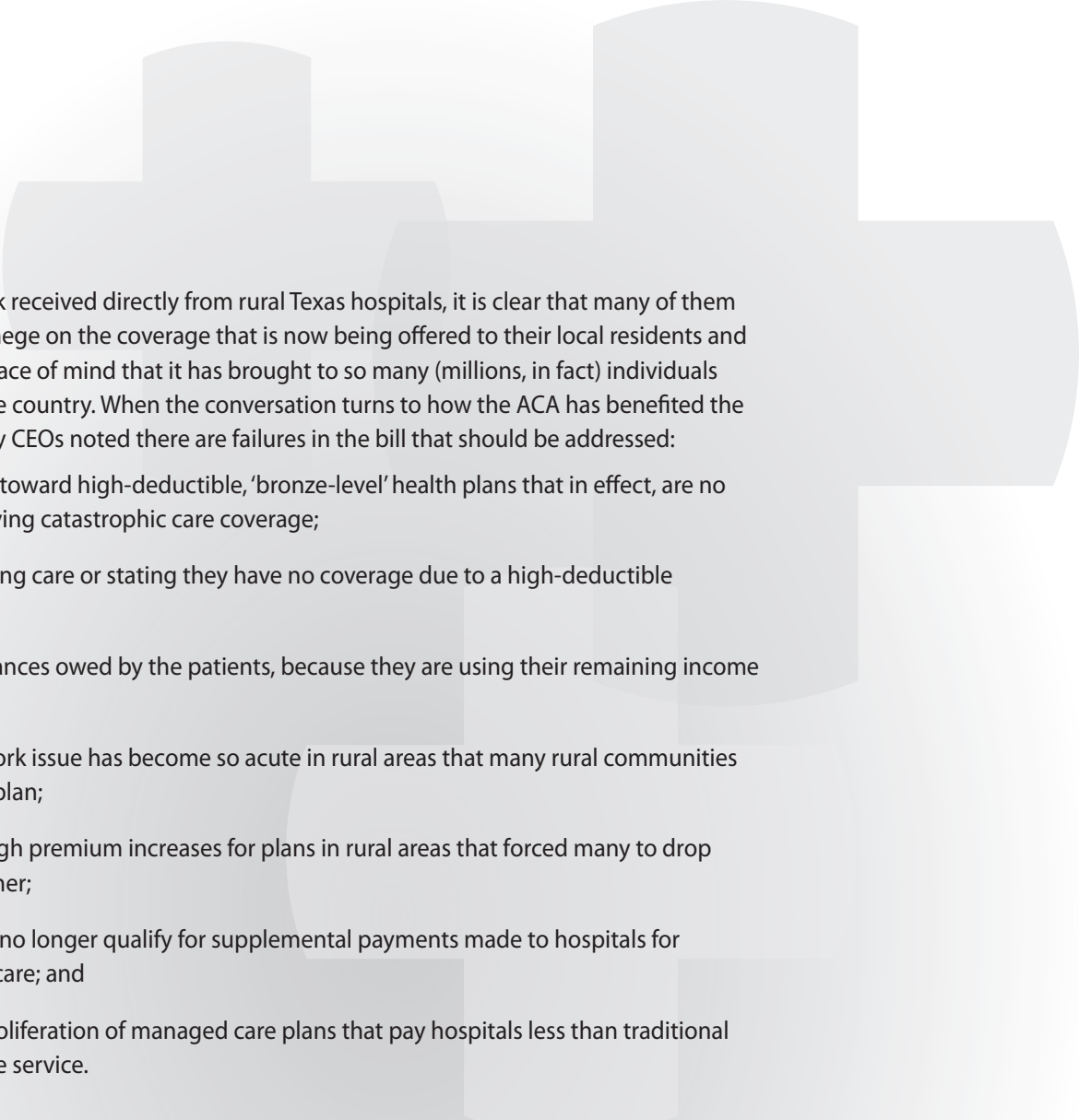
If the total elimination of either the ACA or 1115 Waiver or both comes to pass, we will experience widespread closure of rural hospitals statewide. The only possible opportunity that most hospitals would have at saving themselves from that sort of reduction in funding would depend on the local property owners to tax themselves in order to save their hospital.



The City of Anson (pictured left) was able to pass such a tax increase, but many communities are unable to overcome the opposition. Furthermore, the available property tax base in most rural areas would never be near enough to make up the difference, meaning if the community ultimately supported such a venture, the math simply does not work.

THE SOLUTIONS DEPEND ON YOUR PERSPECTIVE

We describe above the primary policy arguments about rural hospital closures and the predictions about how the ACA might impact rural hospitals from a research and an industry perspective. However, when our member hospitals are queried about the potential loss of ACA coverage and the impact such a change might have on rural facilities operationally and financially, the responses tend to be quite a mixed bag.



According to feedback received directly from rural Texas hospitals, it is clear that many of them do feel it wrong to renege on the coverage that is now being offered to their local residents and the corresponding peace of mind that it has brought to so many (millions, in fact) individuals and families across the country. When the conversation turns to how the ACA has benefited the hospital directly, many CEOs noted there are failures in the bill that should be addressed:

- The massive shift toward high-deductible, ‘bronze-level’ health plans that in effect, are no different than having catastrophic care coverage;
- Patients not seeking care or stating they have no coverage due to a high-deductible obligation;
- Large unpaid balances owed by the patients, because they are using their remaining income to pay premiums;
- The narrow network issue has become so acute in rural areas that many rural communities are down to one plan;
- The alarmingly high premium increases for plans in rural areas that forced many to drop coverage altogether;
- ‘Insured’ patients no longer qualify for supplemental payments made to hospitals for uncompensated care; and
- The continued proliferation of managed care plans that pay hospitals less than traditional plans for the same service.

Again, it is not that no harm will befall rural hospitals if the ACA were to be repealed without a replacement, but many of our members have noted that they are struggling to keep up under the current law and since coverage does not equal access, Congress should definitely take this opportunity to repair or rebase the payments and policies for rural providers during the repeal process and hopefully, before more facilities are forced to close.

With so many concerns to try to mitigate, the only possible solution for rural hospitals is to advocate for our elected officials in Washington, D.C. and Austin to successfully navigate the reimplementation of both these extremely vital health system finance mechanisms. Without one or the other, the odds are that the list of closed facilities here in Texas and across the country will rise unabated.



Recommendations

ACA REPEAL AND REPLACEMENT

Regardless of the political mandate that Republican leaders feel they may have to eliminate the ACA and send a message to the voters who supported them, this is not the time to act first and think later. There are ways to deliberately amend the current legislation or to at least take the time necessary to address the replacement in a way that minimizes the disruptions to patients, providers, payers, the healthcare system and industry as a whole. We would certainly recommend that on behalf of the rural hospitals across the great State of Texas, that proper due diligence is given to the repeal and replacement process, and that lawmakers, policymakers, industry professionals, practitioners and consumers alike will collaborate and give it the time, thought, attention and inclusiveness it deserves as a landmark piece of legislation that has changed our entire healthcare system and brought never-before seen increases in health coverage to some 20 million Americans. If the creation (recreation) of the nation's healthcare vision, legislation and framework continues to be a partisan effort, then the people will continue to litigate it.

Recommendation: Advocate for a deliberate, inclusive, and concurrent ACA repeal and replacement process.

1115 MEDICAID DEMONSTRATION WAIVER

Arguably, of greater and more immediate importance to many Texas hospitals than even the ACA is the need for a successful renegotiation and implementation of the state's 1115 Medicaid Demonstration Waiver. The \$30 billion in funding over five years to support system-wide reform and healthcare delivery innovations has been keeping our state Medicaid program from collapsing. According to a report called 'Rocks in the Water: The Unseen Cost of Losing Federal Support for Uncompensated Care,' the potential loss of the 1115 Waiver would cost Texas hospitals \$465 million in DSRIP, \$900 million in UC, and \$175 million in Medicaid DSH funding in 2018 alone.¹ These funds are critical to the sustainability of our state Medicaid program and the viability of most, if not all rural providers.

Recommendation: Ensure the successful renegotiation of the 1115 Medicaid Demonstration Waiver and address the unintended consequences on rural providers.

MEDICAID REIMBURSEMENT

Texas rural hospitals are collectively losing as much as \$30-35 million a year (or more) treating Medicaid patients, which is in stark conflict with decades old legislative directives that rural hospitals should have their expenses to treat Medicaid patients covered in whole. The reasoning for covering the cost of care for rural hospitals is that financially fragile rural hospitals are not capable of absorbing a financial loss from their Medicaid beneficiaries, and they are also a critical part of the state's healthcare safety net.

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 and therefore, must be readdressed. A recent report on UC costs revealed the underpayments appear to be in two areas. First, funds appropriated for higher outpatient payments in 2015 were set at \$6 million a year (\$2.5M state GR) below the cost estimated by HHSC and those additional funds need to be added. Second, rural hospitals appear to be shorted annually \$25–30M per year (all funds) for Medicaid inpatient services despite the 23-year old budget rider directive (SEE APPENDIX C). HHSC is currently verifying the true amount of the shortfall, but we estimate it to be approximately \$14.5 million in additional state GR funds.

From a federal perspective, Medicaid is also an important policy issue, especially with recent talk of Block Grants as a potential funding mechanism. Any Medicaid reform must include a Rural Impact Study that identifies anticipated impacts on rural areas and contain specific proposals for mitigation of any disproportionate negative impact on rural beneficiaries, health care providers, or health care delivery systems.

In implementing Medicaid reform, including approving state plans and waivers, the federal government must not abdicate its moral, legal, and financial responsibilities to rural, Medicaid-eligible populations and to support the development of sustainable rural health systems and rely on the results of targeted research that further documents and defines rural-specific potential impacts of any reform proposals.

Recommendation: Maintain and ensure appropriate Medicaid reimbursement for rural hospitals and safety net providers by rebasing the Medicaid rate and adjusting to rising costs.

MARKET REFORM INITIATIVES

TORCH, like its national advocacy partner, National Rural Health Association (NRHA), supports policies that will also increase plan availability and competition in rural markets, create more affordable plans, and lower-deductibles for rural patient populations and increase access to local rural providers. The massive shift toward high-deductible health plans has created a new cost shift to hospitals who are getting stuck with more and more unpaid patient balances. Patients may even delay care or avoid care all together, even though they are now insured and large premium increases are making the situation even worse. And since newly insured patients no longer qualify for uncompensated care, the hospital is losing on the front end and the back end. Changes must be made, if the ACA is ever to become truly beneficial.

Recommendation: Support rural relevant policies that promote and ensure plan availability, affordability and equity.

FEDERAL BUDGET RESTORATION

In addition to the recommendations stated above, two of the biggest threats to rural hospitals in the year ahead are indifference and inaction on the need to fund rural hospitals differently. We simply must address the revenue shortfall that has been created over time as a result of budget reductions at the state and federal level. They are a major contributing factor to 8% of Texas' rural hospitals closing in the last four years (SEE APPENDIX A). The collective annual loss from federal payment cuts to Texas' remaining 161 rural hospitals is estimated at almost \$55 million.

2% Sequestration	\$22,000,000	(all 162 hospitals)
Value-based Quality Penalty	\$15,000,000	(83 hospitals)
Loss of Outpatient Hold Harmless	\$10,500,000	(52 hospitals)
Readmission Penalty	\$3,000,000	(52 hospitals)
Bad Debt Allowance Reduction	\$2,400,000	(all 162 hospitals)
Hospital Acquired Infections penalty	\$870,000	(10 hospitals)

These cutbacks and penalties are a significant contributing factor in the closure of 16 inpatient rural hospitals in Texas since early 2013 (SEE APPENDIX D). Hospitals are also faced with unfunded mandates, the loss of incentives meant to cover Electronic Health Record conversion costs and rising expenses related to staffing, pharmaceuticals, cybersecurity, advanced diagnostic equipment and more. Unless Congress and our state legislature readopts a proactive and progressive approach to rural hospital payment policy and reimbursement, then rural hospitals and communities are destined to become an endangered species.

Recommendation: Eliminate any future payment reductions and restore essential payments to rural hospitals.



PROTECTIONS FOR RURAL HOSPITALS

It is clear that no one factor alone determines the stability of the U.S. healthcare delivery system or the financial viability of its many providers; rather, a combination of interrelated factors and dynamics create unique situations and conditions for optimum viability. Nearly all of the greatest challenges facing healthcare, particularly for rural providers, however, relate directly or indirectly to funding and payment policies and have a profound impact on the overall financial stability of providers.

These challenges include the need to protect any and all payment provisions that help rural hospitals to control costs, like the 340b Drug Program, or to eliminate revenue shortfalls, like cost recovery methodologies in Medicaid and Medicare. We must therefore promote state and federal legislation that addresses these two objectives at the same time and soon. While hospitals and hospital organizations work to advocate for changes that would help provide stabilization, many of their peers are dying on the vine.

Burdensome regulation and unfunded mandates that impose a certain, often urban, standard with little evidence to show marked improvement in the quality of care or healthcare outcomes must also be curtailed or at least controlled. Frankly put, we are now in an age where cost-containment efforts and continuous overregulation are overwhelming the ability for low-volume, rural providers to keep pace and it is putting at risk their overall ability to continue to meet the basic health needs of the communities they serve.

At some point we must recognize that some changes in reimbursement and one-size-fits-all policy priorities should be implemented on a sliding scale, so that we can more appropriately address and promote improvement in rural areas, but without capsizing small hospitals and leaving communities bare.

Recommendation: Implement needed legislative and regulatory changes that would allow rural and community hospitals to better meet healthcare needs without compromising operational viability.



POPULATION HEALTH MANAGEMENT

Population health is fast evolving under the ACA, and despite the uncertain future of the healthcare law (what will be repealed, what will survive, and what will be replaced), the shift from the current payment system based on volume and fee-for-service (FFS) to value-based care, health outcomes and accountability will persist. In the long run, this paradigm shift in the attribution of value will have greater lasting effect and will transform the system to be more efficient and responsive to consumer needs and the needs of populations.

Recommendation: Develop a statewide rural accountable care, clinically integrated, and collaborative network and service delivery platform that aggregates and aligns rural hospitals and other providers to prepare for and respond to the shift to value-based healthcare.

CAPACITY DEVELOPMENT FOR RURAL COMMUNITIES

Despite the plethora of challenges facing rural Texas communities and the rural healthcare infrastructure, rural has always been known for its resiliency, creativeness, and perseverance. There are, without a doubt, centers of excellence and hubs of innovation through rural communities. It is imperative that we seek to foster meaningful collaborations with community organizations and leverage established formal and informal networks and influencers to leverage expertise and resources to develop local capacities among rural communities.

Recommendation: Support the development of targeted local capacity building by providing incubator challenge funding to stimulate community-driven initiatives that demonstrate innovation in healthcare delivery improvement; that integrates expand the use of social networks to support a culture of wellness, preventive services and essential primary care; and that activates consumers and patients to engage in their process of care and well-being.

IMPERATIVE OF STRATEGIC COLLABORATION

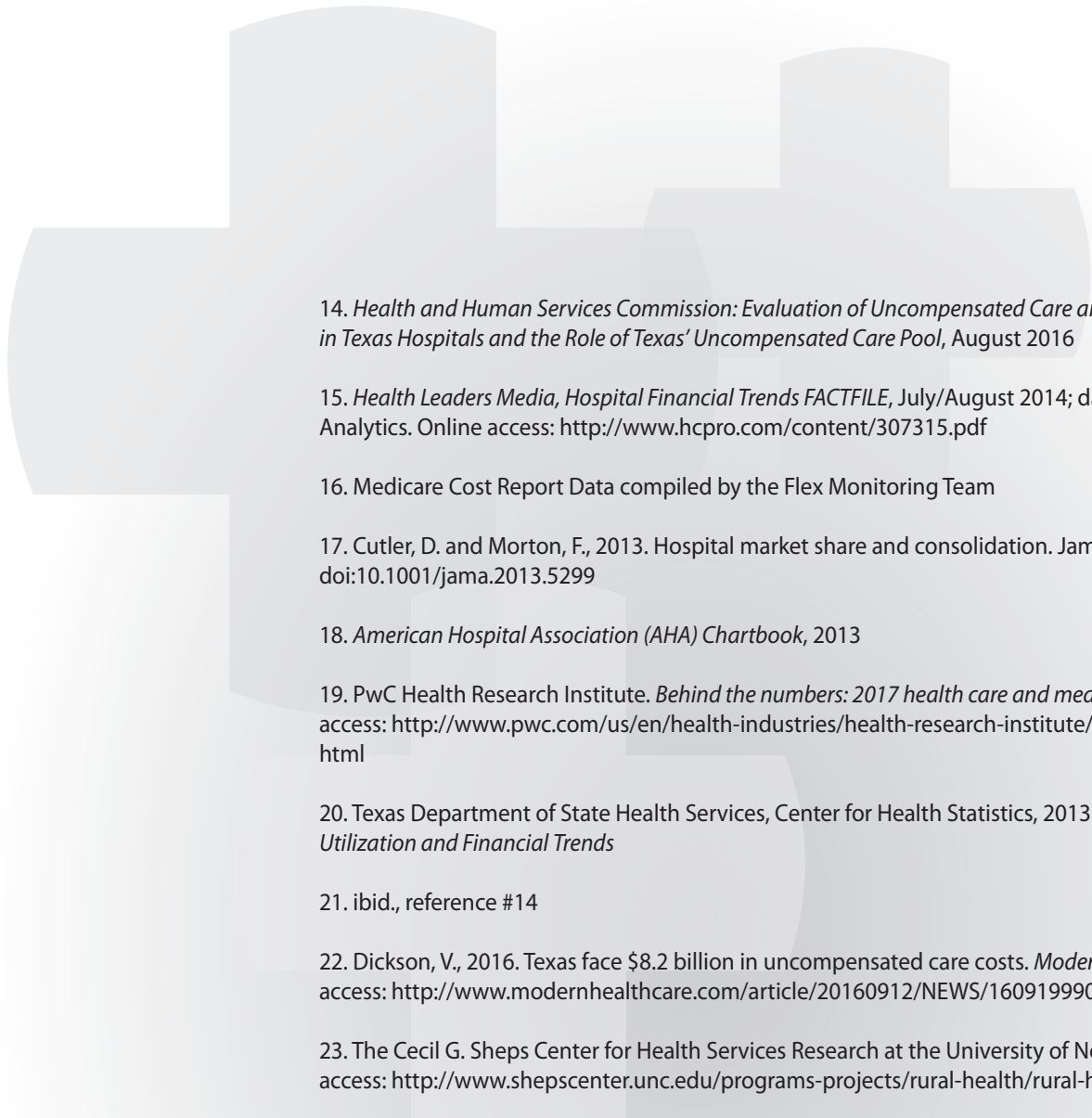
The challenges in healthcare are great and multitudinous. But, perhaps unlike many states in the country, Texas is fortunate to have an extensive network of organizations and people focusing on rural healthcare, many of whom share similar vision for a healthier, more vibrant, and highly sustainable rural healthcare system.

Recommendation: Foster strategic collaborations among aggregators (organizations and influencers) who effectively advocate for, naturally represent, and have the trusted relationships with rural constituents to maximize opportunities for efficient use of resources towards systemic and sustained improvements.

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Appendices & Sources

- Appendix A Rural Hospital Closures by the Numbers
- Appendix B Rural Hospital Closures 1995–2016
- Appendix C Hospital Medicaid Payment History

Appendix A

RURAL HOSPITAL CLOSURES BY THE NUMBERS

1980-85	166
1986-87	24
1988	10
1989	11
1990	10
1991	5
1992	5
1993	0
1994	0
1995	3
1996	2
1997	1
1998	1
1999	2
2000	2
2001	3
2002	1
2003	0
2004	0
2005	1
2006	1
2007	2
2008	1
2009	0
2010	1
2011	0
2012	1
2013	4
2014	6
2015	4
2016	3

These numbers for Texas rural hospital closures are estimated numbers compiled by the Texas Organization of Rural & Community Hospitals (TORCH) from records with the Texas Department of State Health Services, the State Office of Rural Health, TORCH, and newspaper and media accounts.

The Texas Department of State Health Services licenses hospitals and is the official depository for licensing and closure records, however, some hospital closures in the past have apparently not been reported to DSHS. Also, because DSHS actually tracks license cancellations, a reissue to a new owner can be mistakenly viewed as a closure even though a hospital never ceased operations.

Some of these closures are of the same hospital on more than one occasion where a hospital closed, reopened, and then closed again.

Some closures may have occurred in one year and reported in the next.

Some closed hospitals reopened later.

Updated 12-7-16

Appendix B

RURAL HOSPITAL CLOSURES 1995-2016

1965

Spur Memorial Hospital, Spur, TX; 20 beds; Dickens County

1980-1985

(Records found in the State Office of Rural Health indicate 166 closures between 1980 and 1985, although no detailed list has been found other than the two listed in 1985. It is unknown if this number might contain non-rural hospitals.)

1985

Mercy Hospital, Slaton, TX; Lubbock County
Richards Hospital, Paducah, TX; Cottle County

1986

(Records found in the State Office of Rural Health indicate 24 closures in 1986 and 1987, although no detailed list has been found other than the hospital identified in 1987)

1987

Hico Hospital, Hico, TX
(Records found in the State Office of Rural Health indicate 24 closures in 1986 and 1987, although no detailed list has been found other than this hospital)

1988

(Records found in the State Office of Rural Health indicate 10 closures in 1988, although no detailed list has been found)

1989

Sterling City, TX
Mauritz Hospital, Ganado, TX
South Plains Hospital Clinic, Amherst, TX
Hall-Bennett Memorial, Big Spring, TX
Archer County Hospital, Archer City, TX
San Saba Hospital, San Saba, TX
Menard Hospital, Menard, TX
Newton County Memorial, Newton, TX
Leon Memorial, Buffalo, TX
(Records found in the State Office of Rural Health indicate 11 closures in 1989, however 2 have not been identified.)

1990

(Records found in the State Office of Rural Health indicate 10 closures in 1990, although no detailed list has been found)

1991

9/91

Rollins Brook, Lampasas (reopened shortly after with new owner)
(Records found in the State Office of Rural Health indicate 5 closures in 1991 although no detailed list has been found other than this one hospital.)

1992

8/92

Medical Center, Gladewater, TX
(Records found in the State Office of Rural Health indicate 5 closures in 1992 although no detailed list has been found other than this one hospital.)

1993

6/93

Lee Memorial, Giddings, 32 beds

1994

(No closures identified)

1995

8/95

Goliad County Hospital, Goliad; general/county; 24 beds; Goliad County

8/95

Gilmer Medical Center, Gilmer; general/church; 46 beds; Upshur County

10/95

Brooks County Hospital, Falfurrias; general/county; 31 beds; Brooks County

1996

7/96

Crockett County Hospital, Ozona; general govt-county; 20 beds; Crockett County

10/96

Garza Memorial Hospital, Post; general govt-county; 26 beds; rural; Garza County

1997

3/97

Shackelford County Hospital District, Albany; general/hospital district; 24 beds

1998

10/98

Palo Duro Hospital; Canyon; general hospital district; 49 beds; Randall County.

1999

5/99

Silsbee Doctors Hospital, Silsbee; General/Corporation, 69 Beds; Hardin County

6/99

East Texas Medical Center – Rusk

2000

2/00

Medical Center of Winnie, Winnie; General/Corporation, 49 beds; Chambers

4/00

Baylor Medical Center at Ellis County, Ennis; General/Non-profit

2001

5/01

Hillcrest Medical, West, TX, 49 beds

8/01

East Texas Medical Center Gilmer

10/01

Hi-Plains Hospital, Hale Center; General, 41 beds; Hale County

2002

8/02

Hall County Hospital; 1800 N Boykin, Memphis, TX 79245

2003-2004

(No closures identified)

2005

7/05

DeLeon Hospital, DeLeon, TX

2006

8/06

Living Hope New Boston Medical Center, New Boston; 63 beds,

2007

1/07

Barix Clinics of Texas, Wylie, TX

1/07

Renaissance Hospital Terrell North Campus, Terrell, TX

2008

1/08

Dolly Vinsant Memorial, San Benito, TX

2009

(No closures identified)

2010

11/10

Bastrop (later replaced with freestanding ER)

2011

(No closures identified)

2012

8/12

Weimer (reopen in Aug 2015)

2013

2/13

Renaissance – Terrell

7/13

Shelby Regional – Center (later replaced with freestanding ER)

8/13

Cozby-Germany – Grand Saline (reopened 4-15 as Texas General)

8/13

Central Texas Hospital – Cameron (reopened 11-14 as Little River Healthcare)

2014

4/14

Lake Whitney Medical – Whitney

4/14

Good Shepard – Linden

8/14

Cleveland Regional – Cleveland

12/14

ETMC – Gilmer

12/14

ETMC – Mount Vernon

12/14

ETMC - Clarksville

2015

1/15

North Texas Regional – Bridgeport (acquired by nearby Wise Health in 2013, closed inpatient services Jan 2015, but continues with an urgent care center - not a full ER)

4/15

Hunt Regional – Commerce (inpatient hospital closed services but continues as a freestanding ER and outpatient facility)

11/15

Bowie Memorial Hospital – Bowie, 44 beds

2016

5/16	Gulf Coast Regional Medical Center, Wharton, 159 beds (ER and outpatient services continued, ER closed in Nov 16)
10/16	Nix Community, Dilley, 18 beds
11/16	Weimar Medical Center, Weimar, 38 beds (the hospital was called on 11/28/16 and the person answering the phone stated they are not closed but have temporarily suspended operations).

***Footnotes:**

A hospital ceasing inpatient services is considered to be closed. Some hospitals in recent years have closed inpatient services but continue to operate as a so called “free standing” emergency or urgent care center and may also offer outpatient services, but they are no longer considered a hospital.

There is no known single listing of rural hospitals closures. This closure list is compiled by the Texas Organization of Rural & Community Hospitals (TORCH) from records with the Texas Department of State Health Services, the State Office of Rural Health, TORCH, newspaper and media accounts, and personal knowledge of persons with experience in Texas rural hospitals.

The Texas Department of State Health Services licenses hospitals and is the official depository for licensing and closure records, however, some hospital closures in the past have apparently not been reported to DSHS. Records on some of the older closures are not locatable. DSHS records showing the cancellation of a license are often construed as a closing when the license may have been reissued because of owner change and there was no closing.

Some of these closures are of the same hospital on more than one occasion where a hospital closed, reopened, and then closed again.

Some of the hospitals on this list may not be considered “rural” under current definitions as the county may have been brought into a MSA, etc.

Some closures may have occurred in one year and reported in the next.

This list is regularly updated as historic information on closures is located.

Updated 12-6-16

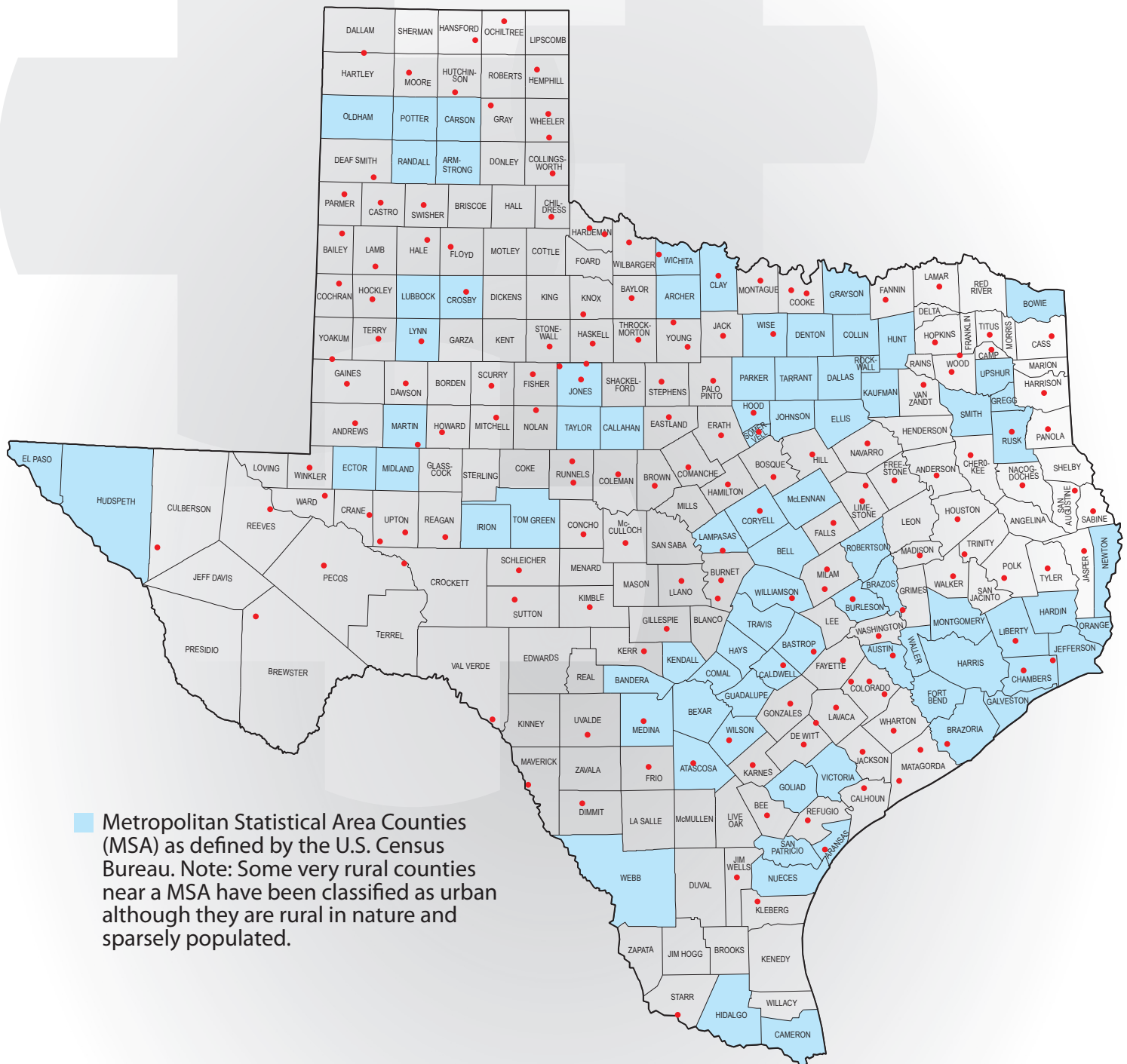
Appendix C

TEXAS RURAL HOSPITAL MEDICAID PAYMENT HISTORY

WHAT IS A RURAL HOSPITAL?

- It depends on whose definition of rural you use!
- Generally considered to be a hospital located in a rural area or one that serves a high percentage of rural residents.
- The federal government and Texas have dozens of definitions of rural depending on which program, agency, etc.
- The Texas Legislative Council in 2014 identified 48 definitions of rural in Texas laws and codes.
- **Medicaid** (Texas) definition of a rural hospital – *Hospital with a Critical Access Hospital (CAH), Sole Community Hospital (SCH), Rural Referral Center (RRC) designation from Medicare, or any other hospital in a county of 60,000 and less (according to the 2010 census)* – (this definition has changed over the years).
- **Medicare** definition of a rural hospital – *Hospital in a non-Metropolitan Statistical Area or in a rural census tract of a MSA, a hospital designated by state law or regulation as rural, or an urban hospital that would meet all requirements of a RRC or a SCH if it was located in a rural area.*
- **TORCH** association definition - *Hospital with a CAH, SCH, RRC designation from Medicare or any other hospital in a county of 75,000 and less.*
- Under the Medicaid definition, Texas has 159 rural hospitals.
- Under TORCH definition, Texas has 164 rural hospitals.

TEXAS MAP OF RURAL HOSPITALS



Rural hospital defined by Medicare as Critical Access Hospital, Sole Community Hospital, Rural Referral Center, hospital in a non-MSA, or other designation as rural/defined by Texas Medicaid as CAH, SCH, RRC, or in county of 60,000 population or less.

Map prepared by the Texas Organization of Rural & Community Hospitals
October, 2016

RURAL HOSPITAL CRISIS

- 15 Texas rural hospitals have closed* since the beginning of 2013 (last 3 ½ years).
- Several more are in financial distress, bankruptcy, and on the brink of closure.
- 7 Texas rural hospitals closed in the decade 2003-2012.
- 14 Texas rural hospitals closed in the decade 1993-2002.
- Deaths have been directly and indirectly attributed to hospital closures in Texas over the past few years because of added time and distance to get to trauma care in communities where a hospital closed.
- Upswing in Texas closures starting in early 2013 primarily attributed to Medicare and Medicaid payment cuts to rural hospitals totaling almost \$100 million a year starting in 2011-12.
- Texas cuts in Medicaid outpatient starting in FY2012 totaled an estimated \$32-35 million a year for rural hospitals (as estimated by those hospitals).
- Rural hospital Medicaid cuts were substantially restored in the FY16-17 state budget with \$58 million for the biennium (all funds) for higher Medicaid outpatient rates (\$25 million general revenue for the biennium).
- The higher Medicaid outpatient payments are having a positive impact on the safety-net rural hospitals appearing to slow the closure rate in Texas with only one closure thus far in 2016.
- Texas rural hospitals continue to be shorted about \$65+ million a year because of Medicare cuts that Congress has not yet addressed, and \$4-6 million a year still short in Medicaid (lab, x-ray, ER, rates lagging behind cost).

**(Ceasing inpatient services is considered a hospital closure. Of the 15 closures in the last 3 ½ years, 2 have reopened for now, 5 continue to operate only an ER, and one new rural hospital was constructed).*

CRITICAL OPERATING DYNAMICS FOR TEXAS RURAL HOSPITALS

- Rural hospitals operate very differently from urban hospitals.
- They experience wide swings in patient volume (2 patients on one day, 15 patients the next day, and back down to 2) versus urban hospitals which are usually consistently full.
- The staff to patient ratio can be higher on certain days in rural hospitals because of patient volume variations which can make the cost for staff higher than in an urban hospital.
- Rural hospitals do not provide more profitable services such as advanced cardiac care and orthopedic care.
- Rural hospitals do provide services which tend to be less profitable or often come at a financial loss to the hospital – OB (Medicaid), caring for the elderly, and running an emergency room 24-7 which is required by state rules.
- Rural hospitals do not experience an economy of scale or purchasing power because of their low volume.
- Rural hospitals tend to care for older and poorer patients which results in higher percentages of Medicare and Medicaid, as opposed to urban hospitals which tend to treat a higher percentage of insured patients.
- Rural hospitals deal with higher levels of uninsured patients – Texas now averages around 17% uninsured but many rural counties are much higher - (Presidio 34%, Starr 34%, Hudspeth 32%, Culberson 29%, Reeves 28%, Foard 27%, Val Verde 27%, Castro 26%, Collingsworth 24%).
- Rural hospitals fall under the Emergency Medical Treatment and Labor Act (EMTALA) which requires Medicare-participating hospitals that offer emergency services to provide a medical screening examination and stabilization for any person claiming to have an emergency, regardless of ability to pay.

FEDERAL HISTORY ON RURAL HOSPITAL REIMBURSEMENT

- Congress enacted a number of Medicare special rural hospital payment programs starting in 1997 to address a spike in rural hospital closures across the country spurred by earlier efforts by Medicare to standardize all hospital payments. Medicare changes in the early 1980s lead to approximately 200 Texas hospitals closing (mostly rural) – more than 1,000 closed nationally.
- The Balanced Budget Act (1997) was the first step with creation of the Critical Access Hospital (CAH) program which set aside a group of small rural hospitals for payments based on cost rather than standardized Medicare rates. The CAH program intent was to maintain access to care by keeping small rural hospitals open as a safety net for emergency and other care when they were the only hospital in town.
- Texas currently has 80 CAHs.
- Over the years since 1997, Congress has created a number of other “nitch” payment programs for rural hospitals not qualifying as a CAH.
- The Medicare rural hospital programs helped financially stabilize many rural hospitals greatly reducing the number of closures until the 2011 cuts.

TEXAS HISTORY ON RURAL HOSPITAL REIMBURSEMENT

- Texas has recognized for 22 years that rural hospitals operate differently and need to be under a separate payment methodology.
- Texas adopted its’ Medicaid special rural and small hospital approach starting in FY94 after the national closure epidemic of the 80s and on the heels of special Medicare programs for rural hospitals.
- The Texas policy on rural hospital payments has been prescribed through a rider in the budget.
- Rider language has changed many times over the years and is now probably the most restrictive in its history.
- The rider historically addressed inpatient Medicaid payments to rural hospitals but now only mentions outpatient.

(See attachment with session by session history of rural hospital riders)

POLICY CONSIDERATIONS WITH THE RURAL HOSPITAL BUDGET RIDER

- Rural hospitals need all payors to remit a fair reimbursement for services or they will not be able to keep their door open.
- Rural hospitals tend to treat a higher percentage of Medicaid patients than urban hospitals and are disproportionately impacted when rates are cut.
- Rural hospitals have less alternative areas to shift losses from patient care to (such as third party payors).
- Rural hospitals create a safety net for Medicaid beneficiaries and other patients as they are often the provider of last resort in communities.
- Loss of rural hospitals further exacerbates challenges associated with network adequacy in Medicaid. Additional closures will deny access to care and further create gaps in network adequacy for rural Medicaid recipients; plus could contribute to more deaths from trauma in rural areas.
- A “one size fits all” does not work in the Medicaid payment system for hospitals.

84TH SESSION CHANGES TO RURAL HOSPITAL RIDER

- The provision relating to inpatient Medicaid payments to rural hospitals (a budget rider since 1994) was removed by the LBB – our understanding of the reason is that the same language existed in Texas Administrative Code rules for HHSC and the language in the budget was considered redundant.
- Rural hospitals disagree with this removal (even though HHSC has stated they do not intend to make changes) and believe the inpatient language (and well as the current outpatient rider) is needed in the state budget to clearly demonstrate the desire of the Legislature that rural hospitals not be forced to provide Medicaid services at a loss.
- New rider language was added to address outpatient payments to rural hospitals (outpatient was not included in previous budget riders).
- The new rider language also directed that rural hospitals be paid no more than 65% of their cost when a Medicaid recipient visits the emergency room with a non-urgent need.
- While this policy seeks to reduce non-emergent visits to the ER, given EMTALA and the lack of other non-urgent facilities in many rural communities, not paying hospitals in full pushes a financial burden onto local hospitals and taxpayers.

WHAT DOES THE CURRENT RIDER STATE?

ALL HHSC AGENCIES Sec. 58. Payments to Rural Hospital Providers.

a. Out of funds appropriated above to the Department of State Health Services (DSHS), \$10,000,000 in each fiscal year out of the General Revenue-Dedicated Designated Trauma Facility and EMS Account No. 5111 is allocated for the purpose of DSHS entering into an interagency contract with the Health and Human Services Commission (HHSC) to provide for eligible expenses in the Medicaid program.

b. Out of funds appropriated to HHSC, the commission shall expend \$2,000,000 in General Revenue Funds, \$10,000,000 in Interagency Contracts, and \$28,043,936 in All Funds in fiscal year 2016 and \$3,000,000 in General Revenue Funds, \$10,000,000 in Interagency Contracts, and \$30,030,030 in All Funds in fiscal year 2017 to provide an add-on payment for rural hospitals. Rural hospitals are defined as hospitals located in a county with 60,000 or fewer persons according to the 2010 U.S. Census, and Medicare-designated Rural Referral Centers (RRC), Sole Community Hospitals (SCH), and Critical Access Hospitals (CAH).

c. Increases may include a combination of increases in or add-ons to any or all of the following: general outpatient reimbursement rates; outpatient emergency department services that do not qualify as emergency visits; the outpatient hospital imaging services fee schedule; and the outpatient clinical laboratory services fee schedule. The total amount of increases or add-ons may not exceed the amounts identified in section (b). No reimbursement rate may exceed 100% of cost. Outpatient emergency department services that do not qualify as emergency visits may not exceed 65% of cost.

HOW DID HHSC IMPLEMENT THE NEW OUTPATIENT RIDER AND CONTINUE THE INPATIENT POLICY

1) **Medicaid inpatient** payment rates for rural hospitals are derived from a base line rate set for each individual rural hospital that is determined from each hospital's actual average cost to provide Medicaid services (less any cost that HHSC may disallow) with actual payments for each Medicaid patient adjusted up or down from that base rate depending on the intensity and type of service provided. The base rate calculation is known as the Standard Dollar Amount (SDA). This is not a true cost reimbursement for each patient but it does allow for a substantial amount of each hospital's specific patient cost to be recovered. The baseline SDA calculation also includes a maximum and minimum cap based on an averaging of all rural hospitals cost to provide the service. A shortfall in this system is that each rural hospital SDA currently being used in the payment calculation was determined with 2010 data, so even with small yearly inflation adjustments granted by HHSC, most rural hospitals report that Medicaid payments lag behind their true cost.

2) **Medicaid outpatient** payment rates for rural hospitals are based on a determination of each individual hospital's collective Medicaid patient billed charges compared each hospital's collective actual costs for those patients (less expenses disallowed by HHSC). HHSC and the Medicaid MCOs are billed full retail charges by the hospital where they then apply each hospital's billed charges to cost ratio, and pay the reduced amount. In theory, this results in an actual payment that is close to the hospital's cost to provide the services, keyed from the full retail bill sent by the hospital. There are no inflation adjustments for the outpatient system and the charges to cost ratio currently used was set using 2010 hospital cost data meaning payments are lagging behind actual cost for many rural hospitals. Under this system, if HHSC later determines that the hospital was paid more than their actual cost, the hospital must refund the difference to HHSC or the MCOs. However, if it is later determined that the payment to the hospital fell short of the hospital's cost, there is no additional payment to the hospital who then takes the loss. *Because of insufficient funds being appropriated in 2015 to fully cover the cost of outpatient services in rural hospitals, HHSC does not pay near full cost in the areas of lab services and x-ray. Also, provisions in the budget rider caps payment to rural hospitals for non-urgent emergency use by a Medicaid recipient at 65% of the hospitals allowable cost.*

Note – this is a broad high level summary and is subject to clarification or specifics by HHSC

KEY FACTS ABOUT RURAL HOSPITAL MEDICAID PAYMENTS

- Medicaid payments to rural hospitals for FY14 comprised only 1.1% of Medicaid cost (not including supplemental payments such as 1115 waiver, DSH, and MPAP which are not part of the state budget).
- While most rural hospitals have a significant portion of their cost to provide care for Medicaid patients covered under this system, it still falls short of their cost.
- The manner that payment rates are calculated including the use of 2010 cost data results in payments below cost.
- Payments are based on allowable cost, with some cost items commonly disallowed – such as having a high ratio of non-patient to patient space in the hospital, marketing expenses, etc.
- The near cost payments to rural hospitals does not give those hospitals a “blank check” or disincentive to reduce expenses – audits, disallowed cost, and other scrutiny by Medicare, insurance companies, and others motivates rural hospitals to reduce cost anywhere they can without curtailing quality.

HOW DO RURAL HOSPITALS FIT INTO THE TEXAS MEDICAID SYSTEM?

Texas Medicaid and Supplemental Payments for Health Services - FY14 (Info from HHSC presentation to House Appropriations, Art II subcommittee on April 6, 2016)

Texas Medicaid Services		% of Medicaid
Long Term Services and Supports	\$ 6.3 billion	26%
Physician & Professional	\$ 5.9 billion	24%
Hospital Inpatient	\$ 3.7 billion	15%
Hospital & Clinic Out Patient	\$ 2.9 billion	12%
Prescription Drugs	\$ 2.8 billion	11%
Medicare Parts A, B, & D	\$ 1.5 billion	6%
Dental	\$ 1.0 billion	4%
Supplemental Delivery Payments for Births	\$ 0.5 billion	2%
Medical Transportation	\$150 million	1%
TOTAL	\$24.8 billion	

Supplemental Payments for Health Services*		% Supplemental
Uncompensated Care and DSRIP (1115)	\$ 7.6 billion*	82%
Disproportionate Share Hospital	\$ 1.7 billion	18%
(*Includes match dollars of approximately 41% from local governments and hospital districts)		
(*the \$7.6 billion total appears to include payments made during the 12 month period for a period of longer than 12 months as the Federal cap for Texas is \$6.2 billion a year)		
TOTAL	\$9.3 billion	

Hospital Payment Detail Extracted From Numbers Above Not Including Supplemental Payments (Info provided separately by HHSC not included in April 6, 2016 presentation)

Hospital Inpatient Detail		% Inpatient
Urban	\$2,159,526,288	57.5%
Children	\$1,282,819,645	34.2%
Rural*	\$173,257,557	4.6%
Psychiatric	\$113,599,622	3.0%
Out of State	\$26,009,778	0.7%
Total	\$3,755,212,888	

Hospital Outpatient Detail (does not include non-hospital clinic outpatient)		% Hosp Outpatient
Urban	\$950,013,005	62.3%
Children	\$457,287,310	30.0%
Rural*	\$103,333,604	6.8%
Out of State	\$8,183,343	0.5%
Psychiatric	\$6,227,504	0.4%
Total	\$1,525,044,766	

RURAL HOSPITAL INPATIENT/OUTPATIENT PAYMENTS TOTAL \$274M AND COMPRISE 1.1% OF TEXAS DIRECT (NON-SUPPLEMENTAL) MEDICAID EXPENDITURES of \$24.8 BILLION*

(*Rural hospital as defined in Texas Medicaid program is a CAH, SCH, RRC, or any other hospital in a county of 60,000 population or less. Rural hospital totals do not include approximately \$29 million in additional dollars annually in outpatient payments authorized to rural hospitals in 2015)

RECOMMENDATIONS FOR THE 85TH SESSION ON RURAL HOSPITAL PAYMENTS

- Clearly establish in the rider(s) that Legislative intent is for rural hospitals to not lose money treating Medicaid patients (have their reasonable cost fully covered).
- Restore the inpatient rural hospital rider to the budget and maintain the current outpatient rider to emphasize legislative intent that rural hospitals should not suffer a loss from Medicaid inpatient and outpatient.
- Fully appropriate for full allowable cost recovery in both inpatient and outpatient (including ER) – an estimated additional \$4-6 million needed for the next biennium*.
- Direct HHSC to simplify and merge the current rural hospital inpatient and outpatient payment methodologies into a single payment system.
- Direct HHSC to adjust the base rates for rural hospitals using more current individual hospital cost data (rebase), understanding that an annual rebasing is labor intensive and costly, but an adjustment is due now and should be made every 3 to 4 years.

****This is an estimate. More specific numbers would have to be calculated by HHSC***

RURAL AND SMALL HOSPITAL PAYMENT RIDERS SINCE INCEPTION IN 1994

2016-17 ALL HHSC AGENCIES Sec. 58. Payments to Rural Hospital Providers.

- a. Out of funds appropriated above to the Department of State Health Services (DSHS), \$10,000,000 in each fiscal year out of the General Revenue-Dedicated Designated Trauma Facility and EMS Account No. 5111 is allocated for the purpose of DSHS entering into an interagency contract with the Health and Human Services Commission (HHSC) to provide for eligible expenses in the Medicaid program.
- b. Out of funds appropriated to HHSC, the commission shall expend \$2,000,000 in General Revenue Funds, \$10,000,000 in Interagency Contracts, and \$28,043,936 in All Funds in fiscal year 2016 and \$3,000,000 in General Revenue Funds, \$10,000,000 in Interagency Contracts, and \$30,030,030 in All Funds in fiscal year 2017 to provide an add-on payment for rural hospitals. Rural hospitals are defined as hospitals located in a county with 60,000 or fewer persons according to the 2010 U.S. Census, and Medicare-designated Rural Referral Centers (RRC), Sole Community Hospitals (SCH), and Critical Access Hospitals (CAH).
- c. Increases may include a combination of increases in or add-ons to any or all of the following: general outpatient reimbursement rates; outpatient emergency department services that do not qualify as emergency visits; the outpatient hospital imaging services fee schedule; and the outpatient clinical laboratory services fee schedule. The total amount of increases or add-ons may not exceed the amounts identified in section (b). No reimbursement rate may exceed 100% of cost. Outpatient emergency department services that do not qualify as emergency visits may not exceed 65% of cost.

(Note – previous rider language related to rural hospital inpatient payments was removed by LBB during 2016-17 budget development based on the language also existing in HHSC rules)

2014-15 HHSC 38. Payments to Rural Hospital Providers.

It is the intent of the Legislature that out of funds appropriated above in Goal B, Medicaid, the Health and Human Services Commission (HHSC) shall rebase rural hospital rates as follows:

- a. These provisions shall apply to hospitals located in a county with 60,000 or fewer persons to the 2010 U.S. Census, and Medicare-designated Rural Referral Centers (RRC), Sole Community Hospitals (SCH), and Critical Access Hospitals (CAH).
- b. Inpatient:
 - (1) Hospitals defined above shall be reimbursed based on a facility-specific prospective full cost standard dollar amount (SDA) based on their historical costs limited by a floor and a ceiling. The ceiling should be equal to approximately two standard deviations above the full-cost SDA for providers with more than 50 claims; the floor should be equal to approximately 1.5 standard deviations below that same average.
 - (2) In calculating the facility specific prospective full cost SDA, the rates will be trended forward by the CMS Market Basket inflation factor to adjust for inflation.
 - (3) It is the intent of the Legislature that for patients enrolled in managed care including but not limited to health maintenance organizations (HMO), inpatient services provided at hospitals meeting the above criteria shall be reimbursed based on the above considerations and rates, in order to maintain access to care.
- c. Outpatient: In order to ensure that access to emergency and outpatient services remain in rural parts of Texas, it is the intent of the Legislature that when HHSC changes its outpatient reimbursement methodology to an Enhanced Ambulatory Patient Groups or similar methodology, HHSC shall promulgate a separate or modified payment level for the above defined providers.
- d. The commission may consider a phase down schedule for a hospital which met the definition of "rural hospital" in the preceding biennium, but does not meet the definition provided in paragraph a. above.

2012-13 HHSC 40. Payments to Hospital Providers.

Until the Health and Human Services Commission (HHSC) implements a new inpatient reimbursement system for Fee-for-Service (FFS) and Primary Care Case Management (PCCM) or managed care, including but not limited to health maintenance organizations (HMO) inpatient services, hospitals that meet one of the following criteria: 1) located in a county with 50,000 or fewer persons according to the U.S. Census, or 2) is a Medicare-designated Rural Referral Center (RRC) or Sole Community Hospital (SCH), that is not located in a metropolitan statistical area (MSA) as defined by the U.S. Office of Management and Budget, or 3) is a Medicare-designated Critical Access Hospital (CAH), shall be reimbursed based on the cost-reimbursement methodology authorized by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) using the most recent data. Hospitals that meet the above criteria, based on the 2000 decennial census, will be eligible for TEFRA reimbursement without the imposition of the TEFRA cap for patients enrolled in FFS and PCCM. For patients enrolled in managed care other than PCCM, including but not limited to health maintenance organizations (HMO), inpatient services provided at hospitals meeting the above criteria will be reimbursed at the Medicaid reimbursement calculated using each hospital's most recent FFS rebased full cost Standard Dollar Amount for the biennium.

2010-11 HHSC 43. Payments to Hospital Providers.

Until the Health and Human Services Commission implements a new reimbursement system for Fee-for-Service (FFS) and Primary Care Case Management (PCCM) inpatient services, hospitals that meet one of the following criteria: 1) located in a county with 50,000 or fewer persons, or 2) is a Medicare-designated Rural Referral Center (RRC) or Sole Community Hospital (SCH), that are not located in a metropolitan statistical area (MSA) as defined by the U.S. Office of Management and Budget, or 3) is a Medicare-designated Critical Access Hospital (CAH), shall be reimbursed the greater of the prospective payment system rate or a cost-reimbursement methodology authorized by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) using the most recent data. Hospitals reimbursed under TEFRA cost principles shall be paid without the imposition of the TEFRA cap. Hospitals that meet the criteria as of September 1, 2009, retain this reimbursement for FFS and PCCM inpatient services.

2008-09 HHSC 52. Payments to Hospital Providers.

Until the Health and Human Services Commission implements a new reimbursement system for Fee-for-Service (FFS) and Primary Care Case Management (PCCM) inpatient services, hospitals that meet one of the following criteria: 1) located in a county with 50,000 or fewer persons, or 2) is a Medicare-designated Rural Referral Center (RRC) or Sole Community Hospital (SCH), that are not located in a metropolitan statistical area (MSA) as defined by the U.S. Office of Management and Budget, or 3) is a Medicare-designated Critical Access Hospital (CAH), shall be reimbursed the greater of the prospective payment system rate or a cost-reimbursement methodology authorized by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) using the most recent data. Hospitals reimbursed under TEFRA cost principles shall be paid without the imposition of the TEFRA cap. Hospitals that meet the criteria as of September 1, 2007, retain this reimbursement for FFS and PCCM inpatient services.

2006-07 18. Payment of Hospital Providers.

At the hospital's option, all payments from funds appropriated for acute care services made to hospitals (1) with more than 100 licensed beds, located in a county that is not a metropolitan statistical area (MSA) as defined by the U.S. Office of Management and Budget, and designated by Medicare as Sole Community Hospital (SCH) or Rural Referral Center (RRC), or (2) with 100 or fewer licensed beds may be reimbursed under a cost-reimbursement methodology authorized by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) using the most current available cost figures. Hospitals reimbursed under TEFRA cost principles shall be paid without the imposition of the TEFRA cap. Hospitals that meet this criteria as of September 1, 2005, retain this reimbursement methodology in fee-for-service and managed care models. At initial cost settlement of the hospital's fiscal year, the Health and Human Services Commission shall determine the amount of reimbursement the hospital would have been paid under TEFRA cost principles, and if the amount of reimbursement under the TEFRA principles is greater than the amount of reimbursement received by the hospital under the prospective payment system, the Health and Human Services Commission shall reimburse the hospital the difference. These payments shall be made out of the funds appropriated above for acute care hospital services.

2004-05 24. Payment of Hospital Providers.

At the hospital's option, all payments from funds appropriated for acute care services made to hospitals (1) with more than 100 licensed beds, located in a county that is not a metropolitan statistical area (MSA) as defined by the U.S. Office of Management and Budget, and designated by Medicare as Sole Community Hospital (SCH) or Rural Referral Center (RRC), or (2) with 100 or fewer licensed beds may be reimbursed under a cost-reimbursement methodology authorized by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) using the most current available cost figures. Hospitals reimbursed under TEFRA cost principles shall be paid without the imposition of the TEFRA cap. At initial cost settlement of the hospital's fiscal year, the Health and Human Services Commission shall determine the amount of reimbursement the hospital would have been paid under TEFRA cost principles, and if the amount of reimbursement under the TEFRA principles is greater than the amount of reimbursement received by the hospital under the prospective payment system, the Health and Human Services Commission shall reimburse the hospital the difference. These payments shall be made out of the funds appropriated above for acute care hospital services.

1994-2003 Payments to Hospital Providers.

At the hospital's option, all payments from funds appropriated for Acute Care Services made to hospital with 100 or fewer licensed beds may be reimbursed under a cost-reimbursement methodology authorized by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), using the most current available cost figures. Hospital reimbursed under TEFRA cost principles shall be paid without the imposition of the TEFRA cap. At the initial cost settlement of the hospital's fiscal year, the Department of Health shall determine the amount of reimbursement the hospital would have been paid under TEFRA cost principles, and if the amount of reimbursement under TEFRA cost principles is greater than the amount of reimbursement received by the hospital under the Prospective System, the Department of Health shall reimburse the hospital the difference.

