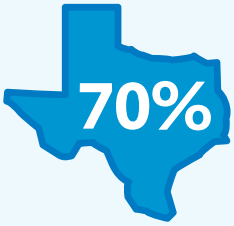
PART 4 in THA's educational series on hospital finance

Rural Hospital Financing



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Of the state's more than 600 hospitals, **ONLY ABOUT 160 ARE IN RURAL AREAS**

STATEWIDE approximately **17% of Texans** have no health insurance but **IN SOME RURAL COUNTIES THAT PROPORTION IS MORE THAN 20% and even 25%**

THE RURAL LANDSCAPE

Much of Texas is rural. Of the state's 254 counties, 70 percent are considered rural. But of the state's more than 600 hospitals, only about 160 are in rural areas.

The challenges of operating a rural hospital in today's health care environment are many. Rural hospitals serve a disproportionately older and lower-income population, making them particularly vulnerable when Medicare and Medicaid reimbursement rates do not cover the costs of services provided, when those rates are cut and when hospital supplemental payments are threatened or are unpredictable.

Rural hospitals also are more exposed to the economic pressures that come from caring for a larger number of patients without health insurance. Statewide, approximately 17 percent of Texans have no health insurance, but in some rural counties that proportion is more than 20 and even 25 percent.

At the same time, rural hospitals often are the only health care provider not just for tens of miles but for hundreds of miles, and their survival is essential for the health and well-being of entire communities.

Texas has experienced more rural hospital closures than any other state, with 19 rural hospitals shuttering their doors since 2013 while a number of other rural hospitals have eliminated key service lines, such as labor and delivery.

Protecting quality health care in rural Texas communities requires not only bolstering Medicare and Medicaid reimbursement, maintaining hospital supplemental payments and reducing the number of uninsured but also **protecting the special financing arrangements that address some of rural hospitals' unique circumstances and challenges.**

This document, the fourth in the Texas Hospital Association's series on hospital financing, examines the special financing arrangements in Medicaid and Medicare that target the unique needs and vulnerabilities of rural hospitals.

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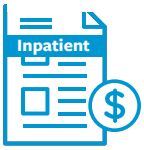
Medicaid

In Texas, Medicaid eligibility is almost entirely limited to federally mandated categories, yet more than 4 million Texans, primarily children and pregnant women, are enrolled in the program. For all hospitals, base Medicaid payments are well below the cost of providing services. For rural hospitals that have disproportionately more lower-income patients, these lower-than-cost payments cause significant financial challenges.

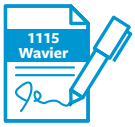
Supplemental payments, such as those that are part of the Medicaid 1115 Transformation Waiver and the disproportionate share hospital payment program, are vital.



Rural Hospital **Medicaid Inpatient Services Reimbursement**

Prior to September 2013 and the implementation of Texas' Medicaid 1115 Transformation Waiver, most hospitals were part of the state's fee-for-service Medicaid system. Under this system, rural hospitals were paid based on cost, and payments covered an estimated 95 to 97 percent of the actual cost of providing services to Medicaid patients. The 1115 waiver authorized the state to implement managed care statewide. Under this capitated model, hospitals contract with managed care organizations, which are responsible for providing care to Medicaid beneficiaries and negotiating payment rates with providers. Currently, approximately 93 percent of Medicaid enrollees are served through managed care organizations. **In fiscal year 2016, Medicaid inpatient and outpatient payments to rural hospitals were estimated to cover approximately 80 percent and 75 percent of costs, respectively. The Texas Health and Human Services Commission estimates $24 million in general revenue is needed to bring rural hospitals' inpatient rates up to cost and $25 million for outpatient rates for 2020-2021.**

The 2014-15 state budget included a rider (Rider 38) that changed rural hospitals' inpatient Medicaid payment from cost-based to a methodology based on a facility-specific, case-mix adjusted standard dollar amount. These amounts are based on 2014 costs and have not been updated since.



Rural Hospital **Uncompensated Care Payments**

In addition to providing authority for statewide implementation of managed care, the 1115 waiver established two pools of supplemental funding: uncompensated care and delivery system reform incentive program payments. **Rural hospitals, or "Rider 38 hospitals," receive preferential treatment in the UC pool. These hospitals receive approximately 80 percent of eligible UC costs.** By contrast, this year, non-rural hospitals receive about 25 percent of their eligible UC costs.

Rider 38 hospitals currently are defined in the UC program rules as, "a hospital located in a county with 60,000 or fewer persons according to the most recent United States Census; a Medicare-designated Rural Referral Center, a Sole Community Hospital, or a Critical Access Hospital." **Currently, 170 Texas hospitals meet the UC definition of rural.**

Two recent events have caused an unanticipated shift in UC funding and required THHSC to consider changes to the UC payment methodology for rural hospitals.

The first is additional hospitals receiving federal designation as Medicare rural referral center (see page 4). Over the last few years, the number of hospitals that have applied for and received the RRC designation has increased. Of the 18 RRCs in Texas, 13 are in a metropolitan statistical area and have more than 101 beds. These are referred to as urban RRCs.

The second event is a March 2018 federal district court ruling causing a statewide change in the way THHSC calculates eligible costs that are reimbursable from the UC pool.

The impact of these two events is that **almost $1.08 billion of the total $3.1 billion UC pool was slated to go rural hospitals in 2018**, a substantial increase over previous years' amounts of $515 million and $434 million (source: Texas Health and Human Services Commission). THHSC estimates that the 13 urban RRCs would receive 18.5 percent of total UC payments while accounting for seven percent of eligible uncompensated care costs.

As a result of this unanticipated shift in funding, THHSC decided to split into two the last UC payment for fiscal year 2018 while it considers making additional changes to the UC payment methodology to narrow the criteria for rural hospitals that receive preferential treatment:

2018

- **The first proposed change is limiting urban RRCs' UC payments.** Under this proposal, urban RRCs would receive 54 percent of eligible UC costs in fiscal year 2018 (rather than the current 80 percent) and would not be considered a rural hospital eligible for preferential treatment in the UC program in fiscal year 2019. As of this writing, a final decision has not been made.

2019

- **The second proposed change is to allow rural hospitals to receive up to 100 percent of their eligible UC costs associated with uninsured patients beginning in fiscal year 2020**. This change would coincide with the new UC payment methodology for all hospitals required under the terms and conditions of the new Medicaid 1115 Transformation Waiver approved in late 2017. Rules are expected to be adopted by January 2019.

Rural Hospital **Outpatient Services Reimbursement**

With a scarcity of community-based physicians in rural areas, rural hospitals fill a need for outpatient care in their communities by operating primary and specialty care clinics. Medicaid reimbursement for these services, which is primarily based on a fee schedule, is below cost. Since 2016, rural hospitals receive increased Medicaid reimbursement for outpatient services. **For the 2018 – 2019 biennium, Texas lawmakers appropriated $25 million in general revenue ($58.3 million all funds) for this rural payment increase.**

Medicare

Some rural hospitals receive increased Medicare reimbursement for inpatient services for elderly patients, although which hospitals qualify depends on the particular funding program and how it defines "rural."

Medicare defines a rural hospital as, a "hospital in a non-Metropolitan Statistical Area or in a rural census tract of an MSA; a hospital designated by state law or regulation as rural; or an urban hospital that would meet all requirements of a rural referral center or a sole community hospital if it was located in a rural area." There is no enhanced or increased Medicare payment for meeting this definition. However, enhanced Medicare reimbursement for hospitalized, elderly rural residents is available through several federal programs for different categories of rural hospitals, including critical access hospitals, sole community hospitals, low-volume hospitals and Medicare-dependent hospitals. **Changes to the definitions of qualifying hospitals under these various programs can cause rural hospitals to experience major revenue losses.**

THA's educational series on hospital finance includes:

Part I: Medicaid's Role in Hospital Financing
Part II: Local Provider Participation Funds in Texas
Part III: Value-Based Payment Models
Part IV: Rural Hospital Finance
Part V: Local Property Tax Revenue Feeds Most of Hospitals' Supplemental Payments
Part VI: Hospital Payment Sources

Critical Access Hospitals

Approximately 85 rural Texas hospitals have federal designation as a critical access hospital, meaning they meet all of the below criteria:

- Have 25 or fewer acute care inpatient beds.
- Are located more than 35 miles from another hospital.
- Maintain an annual average length of stay of 96 hours or less for acute care patients.
- Provide 24/7 emergency care services.

These are vulnerable rural hospitals that operate under particularly challenging market and financial circumstances. In 2013, more than 40 percent of Texas CAHs had negative operating margins. To help protect these hospitals, since 1997, **Medicare reimburses CAHs at 101 percent of costs**, although they are subject to the across-the-board 2 percent reduction in Medicare rates due to sequestration.

Sole Community Hospitals

Approximately 43 Texas hospitals are federally designated as a sole community hospital – a classification that entitles them to higher Medicare payment. SCHs meet one of the below criteria:

- The hospital is located at least 35 miles from other like hospitals.
  OR
- The hospital is rural, located between 25 and 35 miles from other like hospitals, and meets one of these criteria:
  - No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital or, if larger, within its service area.
    OR
  - The hospital has fewer than 50 beds and would meet the 25 percent criterion above if not for the fact that some beneficiaries or residents were forced to seek specialized care outside of the service area due to the unavailability of necessary specialty services at the hospital.
- The hospital is rural and located between 15 and 25 miles from other like hospitals but because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each of two out of three years.
  OR
- The hospital is rural and because of distance, posted speed limits and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.

Medicare-Dependent Hospitals

Twelve Texas hospitals are categorized as Medicare-dependent and receive a higher Medicare reimbursement rate. These are hospitals with at least 60 percent of their inpatient days or discharges attributable to Medicare beneficiaries. They also must be located in a rural area, have 100 or fewer beds and not be classified as a sole community hospital.

Low-Volume Hospitals

Currently, 65 Texas hospitals have federal designation as a low-volume hospital, which entitles them to an add-on Medicare payment of up to 25 percent for each Medicare discharge. Low-volume hospitals are defined as those more than 15 road miles from the nearest hospital and with fewer than 3,800 total discharges. The add-on payment is administered on a sliding scale with hospitals having fewer Medicare discharges receiving larger payments.

Medicare Rural Referral Centers

Although no increased Medicare reimbursement is associated with meeting the federal definition of a rural referral center, the definition is used in other programs for increased payment, including the 340B drug discount program, Medicare disproportionate share hospital program payments and, notably, Texas Medicaid as described earlier.

The Medicare RRC program was established to support high-volume rural hospitals. Hospitals meet the definition generally by meeting criteria governing bed size, discharge, volume of referrals or staff size. Eighteen Texas hospitals are designated as Medicare RRCs.