TEXAS RURAL HOSPITALS
AND
THE 1115 WAIVER

Presentation to the
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on
Health and Human Services

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RURAL HOSPITAL BACKGROUND

- There are 164 rural hospitals in Texas
- Rural hospitals are closing in near record numbers across the United States and Texas primarily because of Medicare and Medicaid payment cuts.
- 15 Texas rural hospitals have closed* since the beginning of 2013 (last 3 ½ years) – this is 8% of the rural hospitals in Texas.
- Several more are in financial distress, bankruptcy, and on the brink of closure.
- The upswing in Texas closures started in early 2013, primarily attributable to Medicare and Medicaid payment cuts to rural hospitals totaling almost $100 million a year in Texas which began in 2011-12.
- The closure rate in Texas has slowed with only 2 closures in the last year.
- The closure slowdown is partially attributable to the increase in Medicaid outpatient payments to rural hospitals authorized by the Texas Legislature in 2015 and the inflow of dollars from the 1115 waiver.
- 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.
    - 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 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%).

*(*Ceasing inpatient services is considered a hospital closure. Of the 15 closures in the last 3½ years, 2 have reopened for now, 5 continue to operate only an ER, and one new rural hospital was constructed)*

IMPACT OF THE 1115 WAIVER ON RURAL HOSPITALS

- The Waiver has helped many rural hospitals keep their doors open.
- It has allowed rural hospitals as a whole to keep supplemental payments that would have been lost with the ending of the Texas Upper Payment Limit system when Texas converted its Medicaid program to a private insurance, managed care program.
- Supplemental payments from the Waiver and related Disproportionate Share (DSH) program help urban hospitals provide services – in rural hospitals they make the difference in whether the hospital stays open.
- Many rural hospitals report that between 25 and 33% of their income now comes from one or both of these programs.
- The waiver is allowing some rural hospitals to participate in new and innovative health programs that they would not otherwise have been able to participant in
- The waiver has strengthened communications, patient care coordination and collaboration between many rural hospitals and with the larger medical centers in their region

ESTIMATED 1115 PAYMENTS TO RURAL HOSPITALS*

YEAR	DSRIP		UC	
	ALL PAYMENTS	RURAL HOSP	ALL PAYMENTS	RURAL HOSP
DY4	2,279,000,000	122,840,000	3,179,670,000	313,580,000
DY3	2,358,760,000	140,170,000	3,353,730,000	236,160,000
DY2	1,930,350,000	114,060,000	3,900,470,000	204,340,000
DY1	480,634,000	27,880,000		

*Payments include local match funds. Net to most hospitals will be approximately 56% of total.

*Payments may not align with program year because of payment delays.

*Payments to rural hospitals are estimated from HHSC waiver payments ledger. HHSC records do not total rural hospitals separately.

*Rural hospital definition from Medicaid.

RURAL HOSPITAL SUCCESS STORIES FROM THE WAIVER

- 87 rural hospital projects associated with primary care
- 20 (approximately) rural hospital projects associated with telemedicine
- 20 rural hospital projects associated with specialty care

Here are some examples of how some Texas rural hospitals have carried out DSRIP projects:

CHILDRESS REGIONAL MEDICAL CENTER *(Childress)* - NAIP Telemedicine

- A middle of the night flight transfer for a 6 day old infant with severe kidney problems was avoided with the use of a telemedicine consult to Children's Medical Center in Dallas. It was followed-up with a scheduled urgent visit to the specialist several days later.
- A 10 year old was taken to Dallas several days away for dialysis under the supervision of a pediatric nephrologist. Childress Regional could provide dialysis but is without the specialist. With telemedicine, the dialysis now takes place in the child's home town. The child is back in school, and the father is back at work instead of being a full time driver.

HEART OF TEXAS MEMORIAL (Brady) – Healthy Eating Education

- Students at risk of childhood obesity are educated about health eating with the Coordinated Approach to Child Health (CATCH) program to students in the schools. This includes the growing of healthy vegetables that are served in the cafeteria.

ELECTRA MEMORIAL HOSPITAL (Electra) – Increased access with primary care clinics.

- This included the opening of a new clinic in Iowa Park, Texas were there was no primary care and expanded hours at the clinic in Electra. Coordination with the United Regional Health Care System in Wichita Falls allowed for access to some specialty care in the clinics. A specially care coordination program was put in place for rural providers to provide testing prior to their specialist visit in order to avoid duplication of services and speed specialist office visit time.

OLNEY HAMILTON HOSPITAL (Olney) – Increased primary care access

- Opened a rural health clinic in Archer City to provide additional primary care access and opened a Wellness Center in Olney that includes access to Health Coaches – the Center is open to the public

NORTH TEXAS MEDICAL CENTER (Gainesville) - Increased primary and behavioral care

- Opened a new behavioral health clinic offering evening and weekend hours and expanded primary care access with additional hours and on-site providers

NACOGDOCHES MEMORIAL HOSPITAL (Nacogdoches) – Patient self-health management project

- Implemented an evidence-based self-management program to improve primary and preventative care to the Medicaid and underserved populations

HOPKINS COUNTY HOSPITAL (Sulphur Springs) – Reduction of congestive heart failure effects

- Developed and implemented standardized clinical protocols and evidence based care delivery model to improve care transitions focusing on the congestive heart failure patients

EAST TEXAS MEDICAL CENTER (Carthage) – Primary care access project

- Increased access to healthcare through extended clinic hours on nights and weekends, recruited a family practice physician and a physician assistant, and added support staff.

FRIO REGIONAL HOSPITAL (Pearsall) – Cardiac telemedicine

- Implemented telemedicine to provide patient consultations by a cardiologist for inpatient, outpatient and emergent situations

STARR COUNTY MEMORIAL HOSPITAL (Rio Grande City) – Enhanced prenatal care

- Obtained family practice physician with an OB background to provide services in the Rural Health Clinic as well as complete rounds at SCMH and integrate diabetes education in a group setting and optional one-on-one for diabetic, pregnant women, in an effort to promote a healthy pregnancy and decrease complications.

NONE OF THESE RURAL DSRIP PROGRAMS WOULD HAVE OCCURRED IF NOT FOR THE 1115 WAIVER DSRIP FUNDING!

ISSUES TO BE CONSIDERED FOR RURAL HOSPITALS IN RENEWAL

- The overall allocation in the first waiver period only provided approximately 6% of the funds to rural providers. 15% of the population lives in rural Texas. While rural patients might benefit from some of the urban programs, the preventive and primary care is largely delivered locally.
- The distribution of dollars to the Regional Health Partnerships seemed to us to be weighted to certain regions because of the presence of extremely large public hospitals pulling dollars – in effect – from smaller regions not dominated by a very large public hospital
- The rules and distribution formulas were a moving target and very cumbersome and complicated – especially for rural hospitals that do not have staff or resources to figure this all out. We hope that will simplify. Many rural hospitals were forced to hire staff or consultants to weave through the administrative a nightmare which took funds away from patient services.
- Realistic and reasonable minimum funding amounts for projects - Some rural hospitals did not receive significant funds to carry out meaningful projects - some netting out less than 15,000 a year. We do commend HHSC for addressing that issue and establishing a minimum program level of $250,000 a year for the next year.
- Uncompensated Care must remain a prominent part of the waiver, at least for rural hospitals
- Rural hospitals want to be part of the health transformation with DSRIP projects but need operational dollars to stay open.
- We ask and hope that HHSC will be aggressive in waiver negotiations to secure a separate rural hospital pool which continues uncompensated care dollars for our rural hospitals in the next full five year wavier window – without it, we may not be here.