



# The Capitol Voice

Newsletter provided as a member service of the  
Texas Organization of Rural & Community Hospitals



## JULY 2011

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8,074 filed last session. 1,502 bills passed compared to 1,726 last session and 24 bills were vetoed compared to 38 last session. The special session saw the passage of seven more bills. If a bill had cost attached to it, it seldom reached a committee hearing.

The overarching attitude was “cuts at all cost”, even though the Legislature heard many tear jerking stories about the implications of serious cuts to health and human services, as well as to public and higher education. Elected reps vowed not to raise taxes and they did not. There will be some fee hikes and some creative accounting put into place, but the bulk of overcoming the initial projected \$27 billion budget shortfall came from cutting spending down to the projected revenue. And, all of this came without any serious effort to fix a permanent budget hitch that Texas faces. Since enacting a business margins tax several years ago – a new tax to offset reductions in local school property taxes – the revenue has never come close to projections. This issue alone gives the state an annual monetary shortfall of \$4 billion. Mix in the bad economy and you have a budget wreck.

## AN EXCEPTIONAL LEGISLATIVE SESSION

### FOR RURAL HOSPITALS DESPITE THE ODDS

The recently concluded regular and special sessions of the 82<sup>nd</sup> Texas Legislature are being labeled by many as the worst in decades primarily because of the budget mess, but it was a good experience for Texas rural hospitals. This edition of Capitol Voice will focus on the great accomplishments by rural hospitals and highlight legislative acts from the sessions that most impact rural hospitals.

The regular session saw the state budget sliced and diced; hundreds...maybe thousands of state employees and public school teachers will be laid off. Medicaid and public education are both underfunded in the next budget cycle by more than \$4 billion each – meaning the first order of business for the next Legislature in the spring of 2013 will be finding money to finish out the budget before they can craft another two year budget.

The 82<sup>nd</sup> session was also one of the most bipartisan sessions in modern Texas history. Long gone are the days of “what is good for Texas” with most votes in the House and Senate cast strictly along party lines. With 101 of the 150 House members being Republican, and many of those elected on the ultra-conservative Tea Party philosophy, most votes cast in the House were 101-49 (plus or minus a few votes). No surprise here. It was also clear that there are fewer and fewer folks in the Legislature with a concern for rural issues.

The session did see fewer bills filed with so much time and focus on the budget. In the regular session 6,304 bills were filed compared to

Even with the worst budget challenge in decades and against the odds, rural hospitals in Texas came out ahead by all measures. Probably the biggest victory for rural hospitals was avoiding some of the drastic cuts in Medicaid payments.

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Inpatient Medicaid services rates to urban hospitals will be cut 8% after September 1, on the heels of a 2% cut a number of months ago. Rural hospitals, however, will avoid this inpatient cut because of the renewal of a provision in the state budget that requires rural hospitals to be paid their cost for Medicaid services rather than standardized Medicaid rates. Not only did rural hospitals dodge the Medicaid cut bullet, but the payment provision was modified to provide that payments made to rural hospitals under the new HMO managed care system cover their cost.

The one downside for rural hospitals is that the 8% Medicaid cut will apply for outpatient payments. The “cost based” provision for rural hospitals has never included outpatient services.

The budget aside, TORCH was also successful at the passage of three separate new laws to help rural hospitals in their daily business. The exemption for reporting certain data was continued despite an effort to end it. And, TORCH spearheaded efforts to stop some bills that would have complicated issues for rural hospitals.

A snapshot of rural hospital victories:

- Cost based reimbursement for inpatient Medicaid for rural hospitals will continue and will also be expanded to include HMO managed care.
- The option of physician employment passed for all CAH, all SCH, and all other hospitals in counties of 50,000 population and less.
- Government owned hospitals (hospital district, hospital authority, county, etc.) may now legally borrow funds short term from a bank. There has not been clear authority to do so.
- Government hospitals are no longer required to register their wellness centers with the state. Many hospitals did not know about this and now it does not matter.
- A proposed requirement for rural hospitals to hold mental patients that are pending a mental commitment hearing was stopped.

This was clearly a session to be on the defense but rural hospitals were also on the offense making their presence known in the halls of the Texas Capitol. Call it sheer luck, good timing, or a highly organized coordinated advocacy effort; this was a session to remember for Texas rural hospitals.

## **THE BUDGET BATTLE**

The Legislative session saw a four and a half month budget rollercoaster ride. Starting out with a \$27 billion gap between projected expenses and projected revenue, lawmakers quickly narrowed the gap by trimming away many of the programs that had been funded with federal stimulus money. From that point, they then made both calculated and seemingly random cuts from the top to the bottom of the budget.

Most universities saw their special line items cut by a fourth. Most state agencies were the subject of deep cuts, although some funding was partially restored toward the end of the budget process. The big ticket items of Medicaid and Public Education were the biggest cuts. Both were intentionally underfunded by \$4 billion. Projections are that both will run out of money six months before the next two year budget cycle ends. Even a step-up in the economy will not bridge the gap in the next budget, leaving the next Legislature with a budget problem when they walk into the door in January of 2013.

Besides the underfunding of Medicaid, the budget calls for an 8% cut for inpatient and outpatient hospital services. However, because of the rural hospital payment provisions in the budget (*details in the next story*), rural hospitals will not be subject to the prescribed cuts on the inpatient side. Rural Health Clinics and Federally Qualified Health Centers are also exempt from the Medicaid cuts as their reimbursement rates are controlled by federal law.

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# **Thank you Rural Hospitals!**

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Here is the detail on all Medicaid related provider rate cuts:

	FY 2011	2012-13
Department of Aging and Disability Services		
(1) Community Care Entitlement	0%	0%
(2) Home and Community-based Services (HCS)	-2%	-1%
(3) Other Community Care Waivers	0%	0%
(4) PACE	0%	0%
(5) Nursing Facilities	-3%	0%
(6) Medicare Copay Skilled Nursing Facility	0%	0%
(7) Nursing Facility-related Hospice	-1%	-2%
(8) Intermediate Care Facilities - MR, excluding state centers	-3%	-2%
Health and Human Services Commission		
(1) CHIP Physicians	-2%	0%
(2) CHIP Dental Providers	-2%	0%
(3) Other CHIP Providers	-2%	-8%
(4) Medicaid Physician Services	-2%	0%
(5) Medicaid Hospital Services, excluding under TEFRA	-2%	-8%
(6) Medicaid Dental and Orthodontic Services	-2%	0%
(7) Medicaid Durable Medical Equipment	-2%	-10.5%
(8) Medicaid Laboratory Services, excluding DSHS	-2%	-10.5%
(9) Medicaid Pediatric Private Duty Nursing/Home Health	-2%	0%
(10) Other Medicaid Providers	-2%	-5%

In reviewing the budget, it appears that the greatest impact areas for rural hospitals will be Medicaid outpatient services (8% cut), the dwindling away of the new physician loan repayment program, and a reduction for Texas Tech University Health Sciences Center that has been providing free continuing education services to all Critical Access Hospitals. Texas Tech officials say they will do everything possible to maintain that service despite the cut. The service is partially subsidized by the Texas Department of Rural Affairs. On a related note, Area Health Education Center funding to UTMB (East Texas AHEC Program) was cut substantially, while the West Texas AHEC Program at Texas Tech actually received its full funding request without a cut.

Cuts alone were not enough to make the two year budget work. Payments to local school districts will be subject to a one time delay in order to avoid the payment in one of the two upcoming fiscal years. Payments to school districts are also being reduced leaving local schools scrambling to bridge their gaps, mostly with staff and teacher layoffs. Monies are also being shifted around, such as the unused funds in the state's trauma fund being poured into the general state budget, as well as most of the funds from the new physician loan repayment program. They even robbed the state's gasoline tax of more than \$1 billion.

The one thing the lawmakers did not do was use money from the state's Rainy Day Fund. Supported by oil and gas revenues, and intended to address financial emergencies, there was a hard push to balance the budget with some of the fund. Governor Rick Perry vowed to veto the budget if it used Rainy Day money and there were not enough votes in the full House and Senate to make it happen. But, because of the underfunding of Medicaid and Public Education, use of the

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Rainy Day Fund at the end of the next budget cycle is an almost certainty. While the new budget did not gain any benefit from the Rainy Day Fund, the current budget did. Lawmakers did pull more than \$3 billion from the \$9 billion balance to close out the current budget which was also in the red.

Here is a three budget (6 year) comparison:

Two year budget cycle	State Funds-Discretionary	Total Budget
2012-13	\$80,466,382,345	\$172,345,073,329
2010-11	\$80,614,169,022	\$182,187,966,861
2008-09	\$79,951,538,150	\$167,787,202,202

The discretionary state funds is the only area the legislature has much latitude to make cuts. The remaining dollars in the state budget are dedicated or come from other sources such as the federal government. The reality is that the Legislature only has control over less than half of the total funds making their budgeting process very difficult.

### **COST BASED MEDICAID PAYMENTS CONTINUED AND EXPANDED TO MANAGED CARE**

A major victory was continuation of the requirement that rural hospitals be paid allowable cost for Medicaid inpatient services instead of the standard Medicaid rates. Even better was the success by TORCH at getting the provisions expanded to include managed care HMOs which will soon reach into all of rural Texas. The language was contained as a budget rider for the Texas Health and Human Services Commission and became official with the signing of the budget in mid-June by Governor Rick Perry. (A “rider” is an attached stipulation or rule placed in the budget for a state agency dictating how certain business should be conducted).

As worded for a number of years, paying rural hospitals their cost for inpatient services would only continue for fee-for-service Medicaid and PCCM; and would not apply to the new Medicaid HMO system. TORCH was successful at getting the wording altered so the cost (or near cost) payments will continue in the new HMO system which will roll out into rural Texas over the next year.

There were some “roller coaster” moments during the session about the rural hospital payment requirement. During budget hearings, questions were raised by some urban representatives as to “why rural hospitals get special treatment” and there was even discussion to remove it from the budget. There was also some “grumbling” from urban legislators and hospitals toward the end of the session that rural hospitals were not “taking the pain” of other hospitals. These comments were a result of the fact that all other hospitals will be taking the 8% cut for inpatient Medicaid which follows the 2% cut from months ago.

Rural hospitals also owe some thanks to Tom Suehs, Executive Commissioner of the Texas Health and Human Services Commission. Suehs was supportive of rural hospitals continuing to be paid cost, even in the managed care rollout. TORCH constantly reminded all parties that the total payments to rural hospitals comprise only 1.4% of the Medicaid budget.

Here is the wording in the budget as approved by the Governor:

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***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)***

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***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.***

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A couple of notes about this budget language:

- It is not clear yet how HHSC will make payments to rural hospitals in the HMO system under the new Standard Daily Amount cost averaging system they want to transition to. Presumably, HMOs will pay the hospital their SDA rate with no negotiations. (Note - Medicaid is shifting to statewide or regional SDAs for payments to other hospitals – the rural hospital SDA is different as it is a hospital specific SDA based on some cost averaging - details of the new system are still being developed and TORCH is in regular communication with Texas Health and Human Services on this issue).
- The cost based payments will continue for three categories of hospitals: 1) all hospitals in counties of 50,000 population and less, 2) all Sole Community Hospitals and Rural Referral Centers that are located in a non-MSA, and, 3) all Critical Access Hospitals.
- Non-CAH and non-SCH hospitals in the population only category will be based on the 2000 Census - not the 2010 Census. This is a great victory for TORCH and means several hospitals that were about to be excluded because of population growth will remain included. Also, a few hospitals previously excluded from cost based reimbursement because of incorporation into HMO pilot projects or exceeding the 50K population since 2000 should now be able to return to the cost-based payment system.

## **RECORD LEGISLATION PASSED AND A HUGE POLICY SHIFT SPURRED BY TORCH**

TORCH certainly had a stellar session successfully shepherding through three bills that change the laws to help rural hospitals.

The biggest “win” and policy shift was the passage of a law (Senate Bill 894) to allow rural hospitals to directly employ physicians. While not all rural hospitals are interested in pursuing employment of doctors, the long standing prohibition was a recruitment barrier for some rural hospitals. The six plus year battle to get the law changed culminated with the unanimous passage of a bill in both the House and Senate which was signed into law on May 12 by Governor Rick Perry. The law went into effect immediately rather than the traditional September 1 start date following a legislative session.

As hospitals begin to take the road to physician employment, they are urged to become very familiar with the contents of the new law. The bill language can be found on the State Legislature’s website at <http://www.capitol.state.tx.us/tlodocs/82R/billtext/html/SB00894F.htm>.

TORCH has also learned that some physicians expressing an interest in employment are now raising some of the same points raised by the Texas Medical Association during the bill debate which are not included in the final bill. Any requirements beyond what is written in the new law are not a legal obligation of hospitals, but could certainly be subject to business negotiations between a hospital and physician. Over the next few months, TORCH will disseminate information on the best approach for hospitals to engage physicians in an employee role.

The new law allows the option of direct hire of physicians by all Critical Access Hospitals, all Sole Community Hospitals, and all other hospitals in a county of 50,000 population and less (according to the most recent census). TORCH extends its thanks to Senator Robert Duncan and State Representative Garnet Coleman for sponsoring the bill.

Certainly not as high profile as physician employment, TORCH quietly maneuvered two other bills through the session that will assist some rural hospitals with their daily operations.

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Senate Bill 335 removes the requirement to register with the state a government owned hospital wellness center as a health spa. The new exemption applies only to government owned hospitals (non-profit hospitals are already exempt and the bill did not address for-profit hospitals). Most hospitals falling under this requirement were not aware of the existing law and were technically in violation for failing to register. The registration law even holds criminal penalties and theoretically a government owned hospital could have been prosecuted for failure to register. The TORCH bill corrects the problem by removing the requirement for government hospitals. An important note is that for-profit hospitals with a wellness center are still potentially required to register. Their omission from the law change was unintentional but occurred as a result of the way the bill was written. TORCH will most likely seek to expand the exemption next session to the for-profit hospitals. The new law goes into effect September 1<sup>st</sup>. Kudos to State Senator Troy Fraser and State Representative Craig Eiland for sponsoring the bill.

Another important TORCH bill that passed is Senate Bill 494 which will allow government owned hospitals to borrow funds from a bank. State law has never authorized direct borrowing of funds from a bank by a government owned hospital (although some hospitals have engaged in such borrowing unaware it was not authorized). Public hospitals will now be allowed to borrow short term funds from a bank for such purposes as bridging payroll, purchasing equipment and even for UPL match. Many thanks to State Representative Tom Craddick and State Senator Troy Fraser for authoring the bill. The new bank borrow authorization law is effective on September 1<sup>st</sup>.

### **TORCH BILLS THAT RAN OUT OF TIME**

In every Legislative session there is a traffic jam of bills near the end of session and the clock just runs out. Two of the TORCH legislative agenda bills fell prey to that traffic congestion. The bill to create a rural hospital replacement fund got as far as on the agenda for a full House vote, but a midnight deadline hit in the House when it was only 20 bills away from a vote.

The bill that would require HMOs to give rural hospitals a chance to provide ancillary services was voted favorably out of the House Insurance Committee but the meter ran out before it could be scheduled for a full House vote. This is the fate of hundreds of bills in every session and TORCH will probably pursue the filing of these bills again in the next Texas legislative session.

### **BAD LEGISLATION FOR RURAL HOSPITALS AVERTED**

Several bills which could have been detrimental for some rural hospitals were headed off by TORCH. Senate Bill 44 could have required hospitals to detain mental patients pending a court hearing, when no mental health facility is available. The primary intention of the bill was to remove jails as authorized holding facilities for mental patients, defaulting the holding facility of last resort to hospitals. TORCH interceded and was successful at getting hospitals removed from the bill as a mental patient detention facility. Time ran out and the bill ultimately died at the end of the session before reaching the House for a vote.

SB1500 was a bill that would allow residents of the Hamlin County Hospital District (Jones County near Abilene) to seek an election to de-annex from the hospital district and from paying taxes to the district. The bill was a local bill only applying to that specific hospital district, but TORCH was concerned over the precedent it could set – especially in these “tea party” times where more and more taxpayers are irate over taxes. TORCH worked to slow the bill down and it died at the end of session.

### **MEDICAID REFORM – AGAIN**

A product of the special session was Senate Bill 7, which was a cross section of several bills that died in the regular session and promises Medicaid reform. In fact, the bill contains language from various bills that died over the last two Legislative sessions. Numbering 215 legal pages (yes, legal size pages...not letter size pages) the bill covers a hodge-

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podge of subjects that promises to deliver almost \$500 million in savings to the Texas Medicaid system. In fact, budget writers used that claim of savings as part of the creative accounting to balance the budget.

Provisions range from a number of pay-for-performance initiatives designed to improve quality and patient safety while reducing costs in Medicaid and CHIP, to the establishment of the regulatory framework for health care collaboratives. The bill contains an authorization for Texas to join an interstate Medicaid compact and requires Texas hospitals to develop policies on immunizations for staff and contractors who have contact with patients.

Inserted as an amendment to the original bill was language that prohibits public hospitals from receiving state funding (Medicaid) if they pay for or perform abortions. Time will tell how this is all interpreted and enforced but it does contain several exceptions, including abortions needed to save the life or long-term health of the mother or for cases involving a severe fetal abnormality, defined as "a life-threatening physical condition that in reasonable medical judgment, regardless of provision of life-saving medical treatment, is incompatible with life outside the womb."

The bill also extends the rural hospital data reporting exemption for a few years, as outlined in a later story.

As a wise hospital CEO once stated "the devil is in the Medicaid rules". The full impact of this bill cannot be fully assessed until the Texas Health and Human Services Commission develops the details and proposed rules.

### **DATA REPORTING EXCEPTION FOR RURAL HOSPITALS EXTENDED**

The data reporting exemption for rural hospitals was slated to end this September pursuant to legislation filed during the session, but will continue at least through 2014 with language weaved into SB 7, the Medicaid reform bill. Going into the regular session, the TORCH board and advocacy committee charted a legislative position where TORCH would no longer fight for an exemption to the data reporting requirement for Texas hospitals, especially in view of the public's growing demand for transparency in health care and the general movement toward a performance or data based payment system. However, ending the exemption in September 2011 is too soon for many rural hospitals that are struggling with federal electronic health records mandates and are hard pressed to find vendors to incorporate data reporting into systems at a reasonable cost. Consequently, when the proposal was put on the table to end the data reporting exemption for rural hospitals, TORCH was successful at getting the data reporting exception extended until September 2014.

### **NEWBORN HEARING TESTING EXTENDED TO RURAL HOSPITALS**

Another long standing exemption for rural hospitals was removed during the regular session with the concurrence of TORCH. Starting September 1<sup>st</sup>, rural hospitals that deliver a baby will be required to provide newborn hearing tests and submit the results to the state. For a number of years, rural hospitals have been exempt from the testing requirement due to the low volume of births and the cost associated with testing equipment. The perceived impact of the change is minimal as many rural hospitals do not provide obstetric services, while most rural hospitals that do deliver babies are already voluntarily performing newborn hearing tests.

A special note on this topic is there has been some recent confusion on when hospitals are obligated to report the test results. The vendor hired by the Texas Department of State Health Services to receive and process the test results, known as Oz, was insisting that some rural hospitals report within a matter of days after the test is performed. Part of the TORCH support of bringing rural hospitals under the reporting umbrella was based on the understanding that rural hospitals often cannot report immediately, as direct patient care takes first priority from some secondary paperwork because of limited staff. TORCH has confirmed that the state requires the reporting of newborn hearing tests by the 15<sup>th</sup> of the month following the month the infant is born. In other words, hospitals have between 15 and 45 days to report, depending on when the baby was born. If any hospitals are told otherwise by the vendor, please contact TORCH immediately.

## WHATEVER HAPPENED TO TDRA?

Just when it appeared that the Texas Department of Rural Affairs (TDRA) survived a political tug-of-war during the regular session to remain a standalone state agency, a last minute bill addition in the special session moved TDRA into the Texas Department of Agriculture. In his State-of-the-State address early in the session, Governor Perry stated he wanted the agency merged with the Texas Department of Agriculture. Privately he threatened to veto the agency from the state budget if it were not moved. Bills were filed to move the agency, but they died in the crush of bills at the end of the session. Then came days of worry about whether Perry would veto the appropriations for TDRA, but he did not.

So, when it appeared TDRA had somehow dodged a bullet, the special session surprise emerged. When the conference committee was meeting to develop the final version of Senate Bill 2 – a bill in the special session to help make the new state budget work with money swaps, etc. – language came from “left field” to move TDRA. SB 2 was then approved in the final days of the special session, so TDRA will become a division of the Texas Department of Agriculture (TDA) on September 1. It appears TDRA will remain relatively intact within TDA with the exception of the block grant disaster funds program which was transferred over to the Texas General Land Office.

Somewhat of a secondary blow for TDRA is the fact the state portion of their budget was radically trimmed from \$6 million annually to \$4 million.

TORCH has maintained ongoing dialogue with Agriculture officials since the discussions began earlier in the session about this possible merger. Ag officials have maintained all along that they want to keep TDRA programs as they have been and will place a priority on the rural health component. TORCH will continue the discussions.

## PHYSICIAN LOAN REPAYMENT PROGRAM ZAPPED BUT NOT DEAD

The new physician loan repayment program created two years ago by the Texas Legislature was a victim of the budget crunch. Most of the smokeless tobacco funded tax money that runs the program was robbed away into other areas of the budget. But, the Legislature did leave \$5.6 million in the program for the next two year budget cycle. The program has been operational for one year. Carryover funds from current budget cycle plus the limited new funds may be enough money to carry the first round of doctors in the program through their second and third years. There would be no money for a fourth year unless the Legislature pumps money back in next session and no money for new doctors beyond the first round of approximately 150.

While disappointing, the news of some continuation is much better than the total elimination of the program which was first proposed by the Legislature. The program originally promised loan repayments of up to \$160,000 across four years on outstanding loans for physicians working in a rural or underserved area. Funding was derived from changing the tax structure for smokeless tobacco.

*Please feel free to call the committee members anytime. Their numbers are listed in the membership directory.*

### 2011 TORCH Advocacy Committee

John Henderson, Childress - TORCH Board Chair  
 Jack Endres, Comm Chairman, Jacksonville      Jim Buckner, Uvalde  
 Robbie Dewberry, Colorado City      Ernest Flores, Carrizo Springs  
 Steve Gularte, Weimer      Jerry Jasper, Hondo  
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 Robert Pascasio, Anahuac      Jan Reed, Electra  
 John Simms, Brenham  
 Kevin Reed, Austin - Ex-Officio  
 Don McBeath, Lubbock - Director of Advocacy and Communications

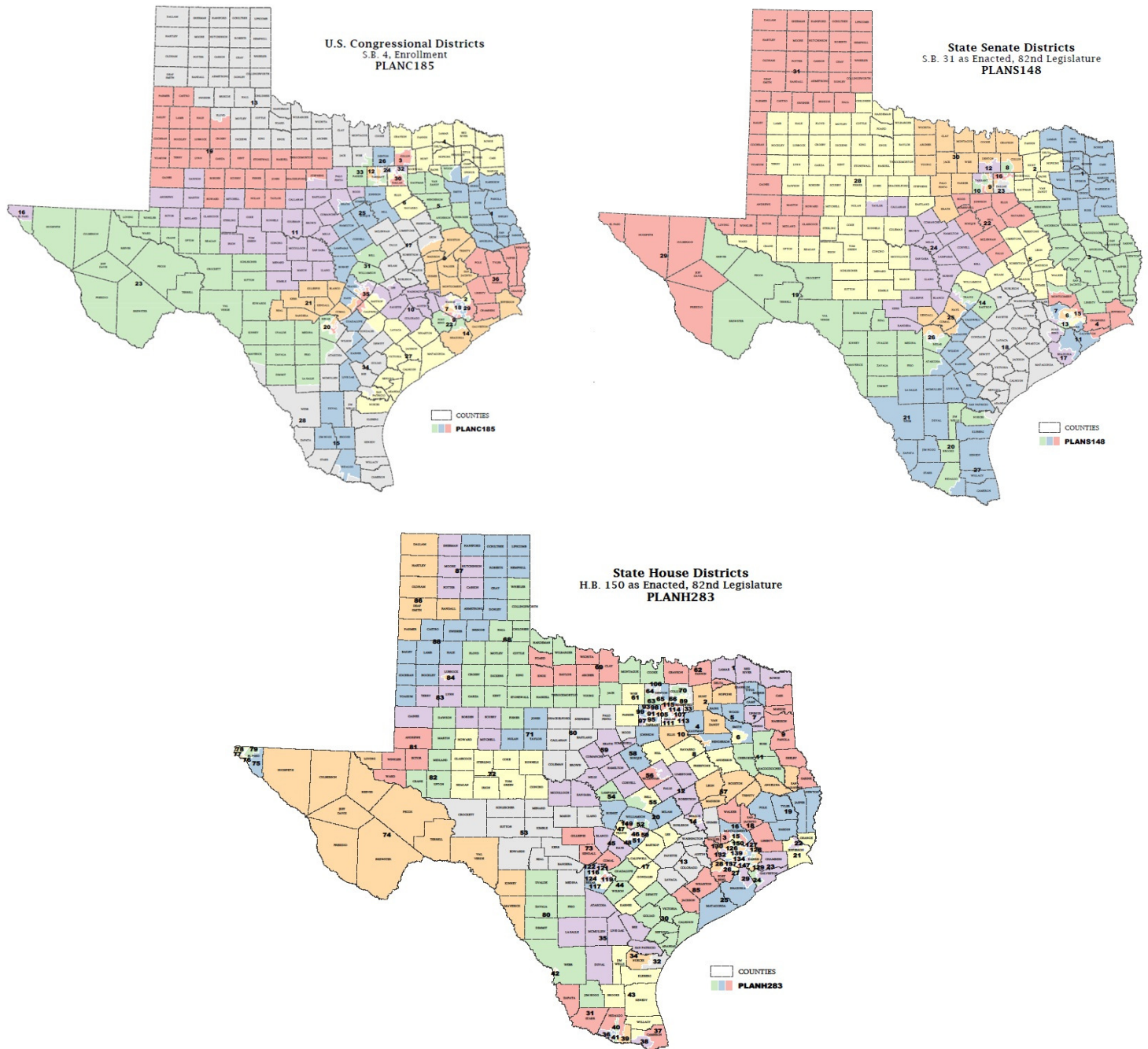
## REDISTRICTING

The redistricting maps came out about as good as anyone could expect for rural Texas. The Legislature was faced with shrinking many urban districts and expanding the size of most rural districts to balance population for the 150 state House and 31 Senate districts. With explosive population growth in urban areas and in the valley, rural Texas was sure to lose. Fortunately, only one House district was lost in the upper Panhandle and most of the other rural House and Senate districts just grew in size.

Congressional districts remained fairly stable other than some party line drawing in some of the urban areas. It certainly helped that Texas gained four congressional seats – now at 36 – taking the pressure off the possibility of eliminating some of the rural districts.

While the Legislature voted on the new lines for State Reps, Senators, and members of Congress, there is sure to be litigation and a close eyeballing by the U.S. Justice Department. Some changes to the boundaries could occur as a result of litigation, but the rural areas will probably remain intact.

These maps reflect the proposed new districts.



## **BROADBAND DISCOUNTS CONTINUED FOR RURAL PUBLIC AND NON-PROFIT HOSPITALS**

The long standing discounts on broadband T1 and other network circuits for public and non-profit hospitals was continued by the Texas Legislature during the session with the passage of SB 773. State mandated discounts from major telecommunications companies were set to expire on January 1, 2012, but will now be extended until January 2016. The one concession to the phone industry is the maximum rate that can be charged was raised from no more than 105% of the service's long run incremental cost to not more than 110% of that cost. The Texas law is intended to reduce the cost of broadband circuits in rural areas to the average urban cost. It applies to public and non-profit hospitals, education institutions, libraries, and community health centers.

## **MEDICAID AND THE MANAGED CARE ROLLOUT**

Efforts to convert the entire Texas Medicaid system to an HMO type managed care plan are still alive and well. The shift is not a product of the recent Legislative session but rather something that was initiated more than 15 years ago. Prompted by the Legislature, and reaffirmed in every Legislative session since, Texas has been converting portions of the Medicaid system – mostly in urban areas – to full or partial HMO plans. Known as STAR and STAR+Plus, the state is purchasing private HMO insurance plans for Medicaid recipients. Until now, most of rural Texas has remained under the traditional fee-for-service or PCCM systems. And, some rural hospitals tied into nearby urban HMOs were not required to take lower negotiated payment rates and could still cost settle their Medicaid payments.

The final phase of implementation is into rural Texas and the next step is around the corner, despite an ongoing debate as to whether this plan will save money – especially in rural areas. Proponents argue it will curtail unnecessary utilization and direct Medicaid recipients to healthier lifestyles. There is little question that under the HMO system, the Legislature can better project Medicaid costs as HMO premiums are locked for a year or two at a time. Under the fee-for-service system, projecting utilization has been difficult and thus budgeting a big question mark.

Efforts to convert the remaining rural areas to the HMO system were ramped up earlier this year and the plan is for all of Texas to be covered by one HMO plan or another by the spring of 2012.

- Expansion of STAR/STAR+PLUS to contiguous rural counties: Sept. 1, 2011
- Covert to STAR+PLUS (Lubbock and El Paso): March 1, 2012
- Managed Care Expansion to Hidalgo Service Area: March 1, 2012 (Hidalgo, Cameron, Maverick)
- Remaining PCCM counties converted to Capitated Managed Care: March 1, 2012

The good news for rural hospitals is that with wording changes secured by TORCH in the Medicaid payment requirements to rural hospitals, qualifying hospitals that fall under the new HMO managed care should still receive payments near their cost for the services.

There is the slight possibility that some remote rural counties may be delayed falling under the HMO plans if insurance companies fail to bid on those counties. Presumably, if that situation occurs, those counties would remain under the PCCM or fee-for-service.

More details in the managed care rollout can be found at: <http://www.hhsc.state.tx.us/medicaid/MMC-Proposals.shtml>.

## **UPL CHANGES APPEAR TO BE ON THE HORIZON TIED TO HMO CONVERSION**

Major changes to the Texas Upper Payment Limit (UPL) program may soon occur, driven by the shift of Medicaid in Texas to a totally HMO managed care system. Texas will soon be seeking a waiver from the federal government through the Centers for Medicare and Medicaid Services (CMS) to allow UPL payments to hospitals to continue under the managed care system. The reason for the change is that CMS does not traditionally take into account Medicaid payments made to hospitals through HMOs. They view such payments as private insurance as the state is purchasing private insurance for Medicaid recipients and hospitals no longer receive direct Medicaid payments from the state.

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Reduced direct Medicaid payments could lead to a reduction in UPL payments. Texas will propose to CMS that they continue to give consideration to HMO payments as if they were direct Medicaid payments.

The hitch to the new proposed system, however, is that the Texas Health and Human Services Commission (HHSC) wants to use this as a vehicle to make some changes in the Texas UPL program. The biggest change would be how the funds are distributed to hospitals. Rather than the historic formulas, HHSC is proposing to create two pools of dollars, one for uncompensated care and one for incentives.

In conversations with the hospital industry thus far on the planned changes, HHSC states their goals for the incentive pot of money are:

- To implement system improvements and improve quality.
- To pilot initiatives consistent with waiver goals.
- Payments to be based on hospitals meeting defined measures and outcomes, or reporting on qualifying pilots and initiatives.
- Payments would not be considered patient service revenue; and do not count against any Medicaid or DSH limits.

TORCH has regularly voiced the position that UPL payments should remain as they currently are and that UPL payments are “reimbursement” for funds the hospital has already expended on Medicaid and uncompensated patients. At this point, it appears HHSC is determined and will prevail with implementing some type of incentive based system. This approach is consistent with ongoing directives from the Legislature and with the approach CMS is moving to with Medicare. TORCH will remain in conversation with HHSC and monitor the process.

## **FEDERAL THIS, THAT, AND THE OTHER**

While the focus has been mostly on the state Legislative session recently, there are a number of important federal issues looming for Texas rural hospitals. TORCH was in Washington in June talking about a number of concerns.

- **FEDERAL BUDGET** - the federal budget battle is shaping up to be one on a similar path as Texas. Without a majority sentiment in Congress to increase the federal debt ceiling, cuts in the federal budget are now more certain than ever. And, huge targets for cuts are Medicare and Medicaid – especially because they are such large ticket items. A clearer picture on the federal budget will appear over the next few months. Speculation is to look first for cuts in Medicaid match from the feds. This would obviously further aggravate Texas’ Medicaid problems. There is also growing talk of block grants of Medicaid funds to states without voluminous rules. While this is of interest to states such as Texas who want less federal rules, the block grants would most likely also come with substantial dollar amount cuts. One health care consulting firm in Washington, DC has predicted Texas alone could see as much as a 30% cut in federal match with the block grant scenario. This could be devastating for the Texas Medicaid system which is already expected to see its federal match drop soon from the current 70% during the stimulus period to 58% later this year.

Over the months ahead as the federal budget is developing, TORCH will be communicating with our Texas members in Congress about the importance of maintaining the rural health infrastructure. For example, a recent report from the Congressional Budget Office cited elimination of the Critical Access Hospital program as a way to save money.

From the recent TORCH visit to Washington, it is very clear that new or expanded programs are not an option and a budget victory for rural health would be maintaining current programs and funding.

- **PHYSICIAN SIGNATURE RULE TO BE REVERSED** - CMS recently announced they plan to drop a new rule which required that lab and other tests ordered by a physician or other provider must have the provider’s actual signature on the requisition. This applied to physicians or qualified non-physician practitioners (clinical

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nurse specialists, clinical psychologists, clinical social workers, nurse-midwives, nurse practitioners, and physician assistants).

CMS implemented the rule the first of the year and then turned around placing the new rule on hold following complaints and some Congressional pressure. The first step to rescinding the rule is publishing notice in the Federal Register which occurred on July 1 and taking comments through August 29. Information is available at <http://www.gpo.gov/fdsys/pkg/FR-2011-06-30/html/2011-16366.htm>.

The official rule change will be several months away but in the meantime, CMS will keep on hold the current rule which requires the signature.

- **HEALTH CARE REFORM** - Federal health care reform remains alive and well despite efforts to stop it. The new Republican dominated U.S. House of Representatives is determined to derail it, but efforts thus far have gone nowhere. Steps from the House to dismantle or change the health reform plan are unlikely to get out of the Senate. There have also been some efforts to curtail funding to some aspects of health care reform and it will take time to see if that reaches any degree of success, especially in view of the pending budget debate.

2010 was the first year for implementation with 26 major components operationalized. Highlights of the 2010 provisions include some major insurance reform, the new federal tax on indoor tanning, and extending insurance coverage for dependent children until they reach age 26. The only major hospital related provision was one directing non-profit hospitals to conduct community needs assessments and develop a financial assistance policy, with a tax of \$50,000 per year for failure to meet these requirements.

The second wave of health care reform components is being enacted in 2011. One issue that will impact hospitals is a prohibition of federal payments to states for Medicaid services related to certain hospital-acquired infections. CMS adopted final rules in June and the states will soon follow with their actual Medicaid rules to implement the new federal requirement. Another 2011 piece requires pharmaceutical manufacturers to provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap beginning in 2011 and begins phasing-in federal subsidies for generic prescriptions filled in the Medicare Part D coverage gap.

An excellent year by year breakdown of the phases of federal health reform is provided by the Kaiser Foundation on their website at <http://healthreform.kff.org/Timeline.aspx>.

## **TORCH HOT FEDERAL ISSUES**

As we shift our focus back on Washington, here are the hot federal issues that are bubbling up for Texas rural hospitals:

- The current rural health infrastructure, programs, and funding must be maintained.
- The Critical Access Hospital and Sole Community Hospital designations and funding are critical for Texas.
- Many Texas rural hospitals will need more time to comply with “meaningful use” for electronic health records.
- Medicaid match dollars for Texas from the federal government must be maintained at current or higher levels.
- Uncompensated care for undocumented aliens continues to be a major problem in Texas and federal dollars should be restored to offset some of that cost.
- Rural Health Clinics need to be put in parity with FQHCs.

**This issue of Capitol Voice has been emailed to all members.  
You will now receive all TORCH newsletters electronically.**

**LATE BREAKING NEWS**

As of the publishing of this Capitol Voice edition, discussions are underway in Washington regarding the debt ceiling and related cuts in the federal budget. While details of budget cut plans are few and far between, there is apparently one plan that calls for \$16 billion in cuts across ten years in a category labeled as “Reform Rural Hospital Programs”. No other details are provided as to what that means, but a safe bet is the plan would involve cuts to or elimination of the Critical Access Hospital and Sole Community Hospital reimbursement systems.

**TORCH continues to urge all hospitals to make calls to Senators Cornyn and Hutchison as well as to their Congressman expressing concern over this proposal. Hospitals should also engage other community leaders to make similar calls.**

**NOTES FROM THE FIELD****Comments from TORCH Advocacy Director Don McBeath**

*It was indeed a stellar session for rural hospitals. It was a session where mere survival and holding on was a win for most folks. Rural hospitals did that, plus made some serious strides in protecting themselves from certain Medicaid cuts under managed care and getting a few laws changed to help them do business. Many associations address the legislative session in a defensive manner...protecting their members from bad things. TORCH was certainly on the defense but also on the offense. Not all associations can claim that get laws changed to help their members, but TORCH did that too.*

*I continue to appreciate the opportunity to be a part of the TORCH team. Much of my excitement is knowing I am part of an advocacy team comprised of more than 150 hospitals. You can pay me to walk the halls of the Capitol and talk your story, but the “rubber meets the road” when offices in the Capitol get telephone call after call from the hospitals in their district. I cannot thank our advocacy committee and member hospitals enough for the countless calls, letters, and emails you fired off. When member hospitals engage, things get done.*

*One of the highlights of the session for me was when I emailed out to our hospitals asking that calls be made on an issue. Hours later, I was in a Senate office when a staff member looked at me and said “I hope you are having your hospitals call other offices at the volume we are receiving calls. We get it!” I grinned and said “hospitals are calling you? Must be important and I hope you are listening.”*

*I recognize it is hard to break away from your busy day and make a phone call or two. But you did, and it worked. Thanks for helping make this a good session for Texas rural hospitals.*

**2011 CALENDAR****TEXAS ASSOCIATION OF  
RURAL HEALTH CLINICS**

July 27, 28, & 29, 2011  
Omni Hotel Downtown  
Austin, Texas

**RURAL HOSPITAL INFORMATION  
TECHNOLOGY CONFERENCE &  
TRADESHOW**

November 2-3, 2011  
Omni Downtown Dallas  
Dallas, Texas

**TORCH Leadership & Management  
Institute Conference & Retreat**

September 7-8, 2011  
Hyatt Regency Hill Country Resort  
& Spa  
San Antonio, Texas

**TORCH ANNUAL CONFERENCE  
& TRADESHOW**

APRIL 11-13, 2012  
Omni Downtown Dallas  
Dallas, Texas

