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1. Executive Summary

The Health and Human Services Commission (HHSC) submits the Rural Hospital Services Strategic Plan Progress Report in accordance with Title 4 Texas Government Code Section 531.201. Per Section 531.201, HHSC must provide updates on the strategies and operational milestones outlined in the Rural Hospital Services Strategic Plan Progress Report published in November 2020. This second update outlines key activities undertaken to support the plan's strategies. Due by November 1 of each even-numbered year, future reports will continue to describe the activities undertaken to support the strategies identified herein. The update provides measures taken by HHSC to identify key strategies to further the goal of ensuring access to hospital services. In the past year, strategies focused on the following established goals:

1. Ensure Medicaid reimbursements are adequate and appropriate;
2. Increase access to established revenue opportunities to maximize reimbursement for hospitals; and
3. Identify challenges hospitals experience in providing services to persons covered by Medicare and other payers.

The Texas Legislature continues to provide meaningful financial support for rural hospitals through increased appropriations targeted to increase Medicaid reimbursement rates. The 87th Texas Legislature appropriated approximately $61 million in all funds, allowing HHSC to increase reimbursement for outpatient services. In addition, on March 25, 2022, the Centers for Medicare & Medicaid Services (CMS) approved two directed payment programs that rural hospitals may choose to participate in if eligible: the Comprehensive Hospital Increase Reimbursement Program (CHIRP) and the Rural Access to Primary and Preventive Services (RAPPS) for the program period covering September 1, 2021 to August 31, 2022. CMS then approved CHIRP and RAPPS for a second year on August 1, 2022, for the program period covering September 1, 2022 to August 31, 2023.

While HHSC administers the Texas Medicaid program, the challenges facing rural hospitals are not exclusively related to Medicaid reimbursement. Therefore, a successful plan must consider the impact of each payer.

For all three strategies, this second progress report outlines specific operational milestones accomplished or underway to maintain access to rural hospitals. The operational plans each have target implementation dates. Finally, the updated

report describes the efforts of HHSC since the initial report to strategically improve the relations and education for rural hospitals related to the Medicaid program.

2. Introduction and Background

Texas Government Code Section 531.201 requires HHSC to submit an update by November 1 of each even-numbered year on the agency's efforts to support the strategic plan. The strategic plan was created to ensure Texans residing in rural areas have access to hospital services. The 86th Texas Legislature appropriated funds to increase rates for inpatient services and create a $500 add-on payment for labor and delivery services. Senate Bill (S.B.) 1621 and S.B. 170, 86th Legislature, Regular Session, 2019, directed HHSC to implement improved reimbursement methods and establish a directed payment program, such as a minimum fee schedule, to ensure Medicaid reimbursements are adequate and appropriate. The best available census data indicates that approximately 10.3 percent of Texans reside in rural areas (Rural Health Information Hub, 2021).

For persons living in a rural area, access to hospital services, particularly in an emergency, can be the difference between life and death. With rural hospital closures occurring nationally and in Texas, affected communities now find themselves without access to hospital services unless they travel long distances.

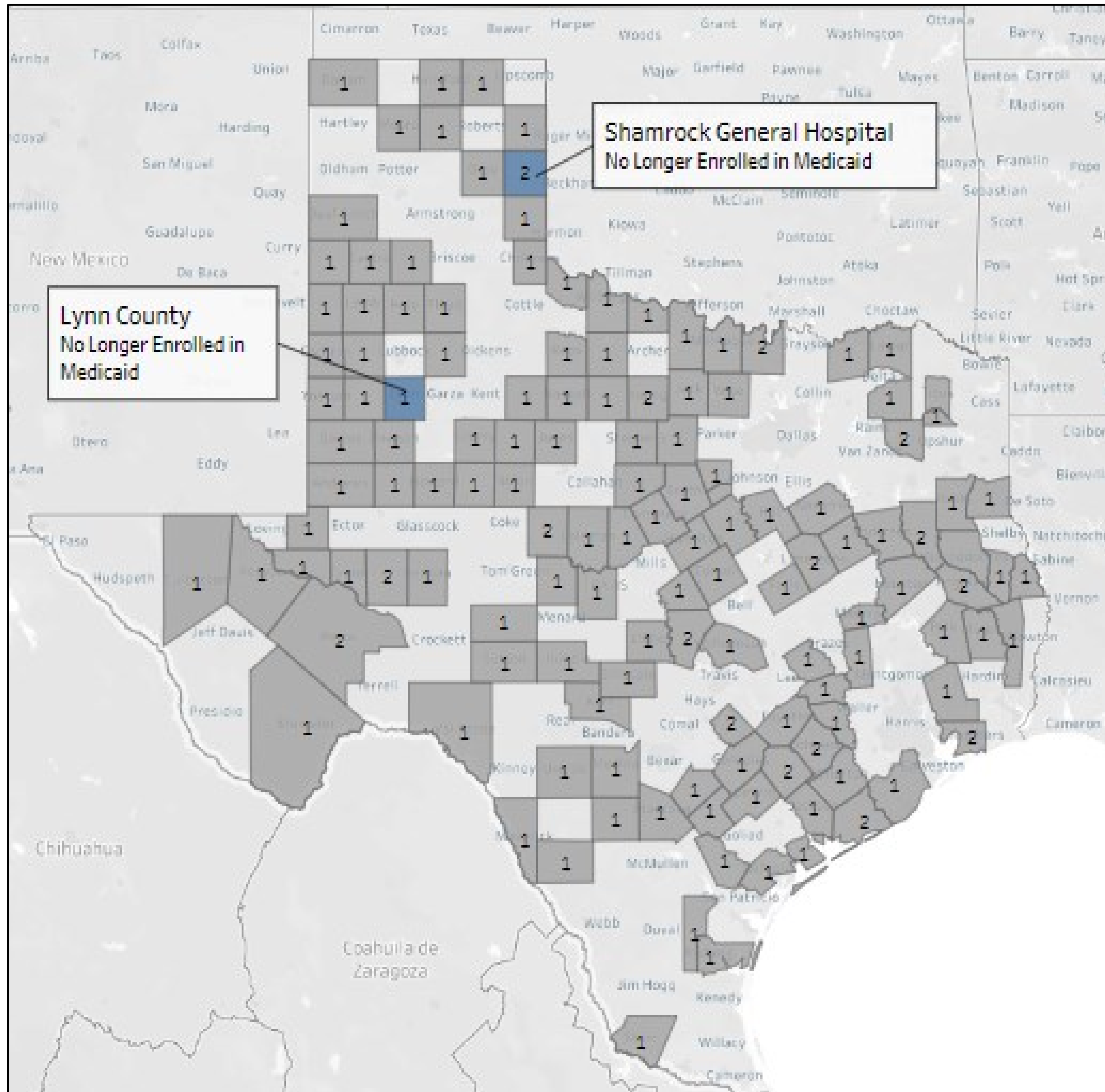
There are various definitions of what constitutes an area and hospital as rural. Many definitions rely on population-based information within defined geographic boundaries that may or may not align with a political jurisdiction (Economic Research Service, 2019). For the purposes of this update, HHSC used the definition of a rural hospital from the 2022-2023 General Appropriations Act,S.B. 1, 87th Legislature, Regular Session, 2021, (Article II, HHSC), which defines rural hospitals as:

1. Hospitals located in a county with 60,000 or fewer persons according to the 2010 U.S. Census; or
2. A hospital designated by Medicare as a Critical Access Hospital (CAH), a Sole Community Hospital (SCH), or a Rural Referral Center (RRC) that is not located in a Metropolitan Statistical Area (MSA); or
3. A hospital that has 100 or fewer beds is designated by Medicare as a CAH, a SCH, or a RRC and is located in an MSA.

According to the state fiscal year 2022 Medicaid data, rural hospitals were paid approximately 87 percent of their cost for inpatient services and 86 percent for general outpatient services. HHSC previously implemented reporting requirements for Medicaid managed care organizations (MCOs) to monitor the timeliness of

payments to rural hospitals and identify improvements in encounter data (Health and Human Services Commission, 2019).

Figure 1. The following map shows currently enrolled Texas Medicaid rural hospitals by county.



3. Strategies

HHSC is required by S.B. 1621 to report on progress toward implementing the strategic plan. This report updates operational milestones toward reducing rural hospital closures and details activities undertaken to support the strategies within the plan.

Table 1. Strategy 1 – Ensure Medicaid reimbursements are adequate and appropriate.

Operational Goal	Anticipated Impact	Implementation Deadline	Status
Realignment of hospital rates to reflect current costs	Increase appropriate hospital reimbursement according to their hospital-specific costs	New rates effective September 1, 2021	Ongoing

S.B. 170, 86th Legislature required HHSC to develop rates that more closely align with rural hospitals' cost of providing Medicaid services. Rural hospital rates were realigned to the current cost, effective September 1, 2021. The next realignment of rural hospital standard dollar amount (SDA) rates will take effect on September 1, 2023, unless otherwise directed by the 88th Legislature.

HHSC reimburses outpatient hospital services under the reimbursement methodology in the Outpatient Hospital Reimbursement, Title 1 Texas Administrative Code (TAC) Section 355.8061. The rule states that HHSC will reimburse for outpatient hospital services based on a percentage of allowable charges and an outpatient interim rate. The 2022-2023 General Appropriations Act, S.B. 1, 87th Legislature, Regular Session, 2021 (Article II, Rider 8(f)), appropriated approximately a $61 million increase yearly in Medicaid outpatient hospital reimbursement beginning in state fiscal years 2022 and 2023.

HHSC allocated $61 million yearly to increase outpatient reimbursement rates for rural hospitals. The rate increase included the following changes effective September 1, 2021:

1. Removed the September 1, 2013 cap applied to the hospital specific outpatient ratio of cost to charge (RCC);
2. Applied up to a 16 percent increase to the uncapped RCC for each rural hospital;

3. Eliminated the recoupment of funds due to cost report settlement calculation but continued the policy of no payouts due to cost settlement established on September 1, 2013;
4. Reduced from 65 to 55 percent of cost allowed for outpatient emergency department services to accommodate the increase in RCC and keep the payments below 65 percent of the cost;
5. Increased clinical diagnostic laboratory services provided by rural hospitals to 137 percent for the Medicare clinical lab fee schedule rate; and
6. Increased diagnostic radiology services to 126 percent of the Medicare Outpatient Prospective Payment System fee schedule.

Table 2. Strategy 2 – Increase access to established revenue opportunities to maximize reimbursement for hospitals.

Operational Goal	Anticipated Impact	Implementation Deadline	Status
Work with cross-agency staff to identify federal grant opportunities for rural hospitals and healthcare providers	Increased communication from Texas state agencies regarding established funding opportunities	September 1, 2021	Ongoing

HHSC staff continue to work with cross-agency staff to identify federal grant opportunities for rural hospitals and health care providers. HHSC anticipates that similar cross-agency approaches will be used as new grant opportunities are made available. In August 2020, CMS announced a new funding opportunity called the Community Health Access and Rural Transformation (CHART) (CMS, 2020). This voluntary payment model is designed to meet rural communities' needs. The CHART Model is designed to test whether aligned financial incentives, increased operational flexibility, and robust technical support promote rural healthcare providers to implement effective healthcare delivery on a broad scale. The model aims to increase financial stability for rural providers, remove regulatory burdens by providing waivers, and enhance beneficiaries' access to healthcare services. HHSC convened a cross-agency group with the Texas Organization of Rural and Community Hospitals (TORCH) and agencies to coordinate applications statewide, including the Texas Department of Agriculture, Texas Department of State Health Services, and HHSC.

To help rural communities overcome challenges and build on previous successes, HHSC applied for the CHART Model Community Transformation Track with support from 14 rural hospitals. CMS notified HHSC on September 10, 2021, that it was

awarded CHART Model funding as the Lead Organization. The estimated project period is October 1, 2021 through December 31, 2028.

As the Lead Organization, HHSC is responsible for driving the redesign of the healthcare delivery system by recruiting Participant Hospitals and Aligned Payers, convening and engaging the CHART Model Advisory Council, and leading the development and implementation of a Transformation Plan.

As of June 2022, HHSC has recruited (with the help of community partners like TORCH) 55 rural Texas hospitals for potential participation in the CHART Model. To participate in Performance Period 1 (calendar year 2023), hospitals must sign participation agreements with CMS by November 1, 2022. To support hospitals in their decision-making about CHART Model participation, HHSC is:

- Hosting information webinars and question-and-answer opportunities with CMS staff,
- Sending multiple notices and emails to stakeholders,
- Reviewing aspects of the model in detail with stakeholders,
- Providing one-on-one meetings with hospital officials, and
- Regularly posting new information and materials to the HHSC website.

HHSC facilitated two CHART Model Advisory Council meetings in 2022 and will continue to do so quarterly for the remainder of the project. HHSC submitted its draft of the Transformation Plan to CMS on May 18, 2022, and provided the CHART Model Advisory Council members a copy for review and signature. HHSC submitted its final Transformation Plan to CMS on July 15, 2022 with CMS approval. The approved model is available on the HHSC CHART Model website. HHSC will work with stakeholders to update the Transformation Plan at least annually.

Table 3. Strategy 3 – Identify challenges hospitals experience in providing services to persons covered by Medicare and other payers.

Operational Goal	Anticipated Impact	Implementation Deadline	Status
Analyze federal rules and regulations to identify barriers to rural hospital services	Provide information to determine if any federal flexibility can be sought to support Texas hospitals	September 1, 2021	Ongoing

Operational Goal	Anticipated Impact	Implementation Deadline	Status
Analyze state regulatory requirements to determine if cost reductions can be achieved	To be determined (TBD)	September 1, 2021	Ongoing

Federal rules: Congress created a new type of Medicare provider called the Rural Emergency Hospital (REH) in response to the loss of emergency services in rural areas due to hospital closures designated by the Consolidated Appropriations Act of 2021, effective January 2023. CMS stated the new designation would allow a CAH or small rural hospital with no more than 50 beds to convert to an REH. The REH will be a rural hospital that does not provide inpatient care but will provide 24-hour emergency services. By creating the REH, Congress has established the first new rural provider type since the CAH was created in 1997. The proposed rule would establish conditions that REHs must meet to participate in the Medicare and Medicaid programs. CMS included these requirements to ensure that REHs furnish high-quality care. The proposed rule also includes changes to the conditions CAHs would have to meet to participate in the Medicare and Medicaid programs. CMS will develop proposed payment and enrollment policies for REHs under separate rulemaking.

In Texas, S.B. 1621, 86th Legislature, Regular Session, 2019, requires HHSC to issue licenses for rural hospitals to act as limited-services rural hospitals. HHSC’s Regulatory Services Division estimates the need for five FTEs at a cost of $493,367 all funds annually to implement the REH program. HHSC does not have the ability to estimate the number of hospitals that will choose to seek licensure as an REH, but it is estimated that 106 hospitals are eligible under the statutory and federal criteria. Creation of the designation will require rulemaking and other steps which are estimated to take approximately 12 months.

Once the licensure type is established, HHSC’s Medicaid and CHIP Services Division estimates that it will take approximately three to six months to add the REH designation in the state's provider enrollment and claims payment Medicaid Management Information System (MMIS) at the cost of around $600,000 in all funds. Because of the MMIS transition, it is not likely the work could start before September 1, 2023. Once included in MMIS, Medicaid MCOs will need a further 90 days for their systems changes.

HHSC’s Chief Financial Officer Division estimates that steps necessary to establish reimbursement rates for REHs could occur concurrently with the establishment of

the REH in MMIS. However, a modification to the definition of rural hospitals (discussed in future strategies) may be necessary to include the new designation as rural for purposes of Medicaid reimbursement.

As a result, while federal rules may be adopted in January 2023, it is unlikely that Texas will be prepared to operationalize the addition of the new designation for at least 18 months following the receipt of the full-time equivalents and funding needed for implementation.

State rules: HHSC has determined that there are not currently any modifications to state rules that can be made to reduce costs of compliance for rural hospitals.

4. Future Strategies

Over the next two years, HHSC will continue collaboration efforts with the rural hospital community, related hospital associations, and other state agencies to provide continued consideration of potential difficulties that impact rural hospitals.

New Goals

HHSC believes additional operational goals fall under the umbrella of the three original strategies.

Table 4. Future Strategy 1 – Review inpatient rural hospital rates.

Operational Goal	Anticipated Impact	Implementation Deadline	Status
Standard Dollar Amount (SDA) realignment	Rates better reflect the cost of service provided by rural hospitals	September 1, 2023	Ongoing and every 2 years

HHSC will realign the base SDAs for inpatient rural hospital services every two years. The realignment will use the most recent cost and claim information. HHSC will publish new rates for public comment for a proposed effective date of September 1, 2023. The comment period allows for a thorough review of public comments as some hospitals may see an increase or decrease as the realignment is completed. Analysis of this ongoing strategy will involve engagement between HHSC and stakeholders such as TORCH and the Rural Hospital Advisory Committee (RHAC).

Table 5.Future Strategy 2 – Analysis of 2020 Census data for rural hospital definition.

Operational Goal	Anticipated Impact	Implementation Deadline	Status
Update the TAC rule to reflect the usage of the latest 2020 Census data	Using the latest data will affect one hospital in the state	TBD based on stakeholder engagement	TBD

HHSC reviewed the rural hospital definition of the TAC rule using 2020 U.S Census data and analyzed the potential impact of:

1. Maintaining the current rural hospital definition; or
2. Changing the definition to reflect the latest Census data.

In looking at the two options, HHSC analyzed the number of rural hospitals in Texas and the potential impact on rates for rural hospitals. HHSC's analysis focused on this portion of the definition: "located in a county with 60,000 or fewer persons according to the 2010 U.S. Census." The current TAC Inpatient Hospital Reimbursement Rule Section 355.8052 states the following criteria for a rural hospital:

> (32) Rural hospital--A hospital enrolled as a Medicaid provider that:
>
> (A) is located in a county with 60,000 or fewer persons, according to the 2010 U.S. Census;
>
> (B) is designated by Medicare as a Critical Access Hospital (CAH), a Sole Community Hospital (SCH), or a Rural Referral Center (RRC) that is not located in a Metropolitan Statistical Area (MSA), as defined by the U.S. Office of Management and Budget; or
>
> (C) meets all of the following:
>
> (i) has 100 or fewer beds;
>
> (ii) is designated by Medicare as a CAH, a SCH, or a RRC; and
>
> (iii) is located in an MSA.

HHSC determined that updating the definition to utilize 2020 Census data would affect Lake Granbury Medical Center in Granbury, Texas. Due to the population growth of Hood County from 51,182 to 61,182, Lake Granbury would no longer qualify as a rural hospital. If their designation changed from rural to urban, their inpatient SDA rate would decrease by 62 percent, and their outpatient reimbursement would decrease by approximately 45 percent.

However, HHSC analyzed the impact on current non-rural hospitals if the population limit of the definition increased to 65,000. No hospitals in the non-rural list would become rural if HHSC expanded the population limit to 65,000. This change would

require an amendment to the definition used in the General Appropriations Act as well as Section 355.8052, Texas Administrative Code.

In addition, future definitions of rural hospitals may need to be amended to include the REH designation so that Medicaid reimbursement for hospitals achieving that designation may be able to be considered rural for purposes of Medicaid reimbursement.

Figure 2. The following map shows the hospital affected by updating the rural hospital definition.

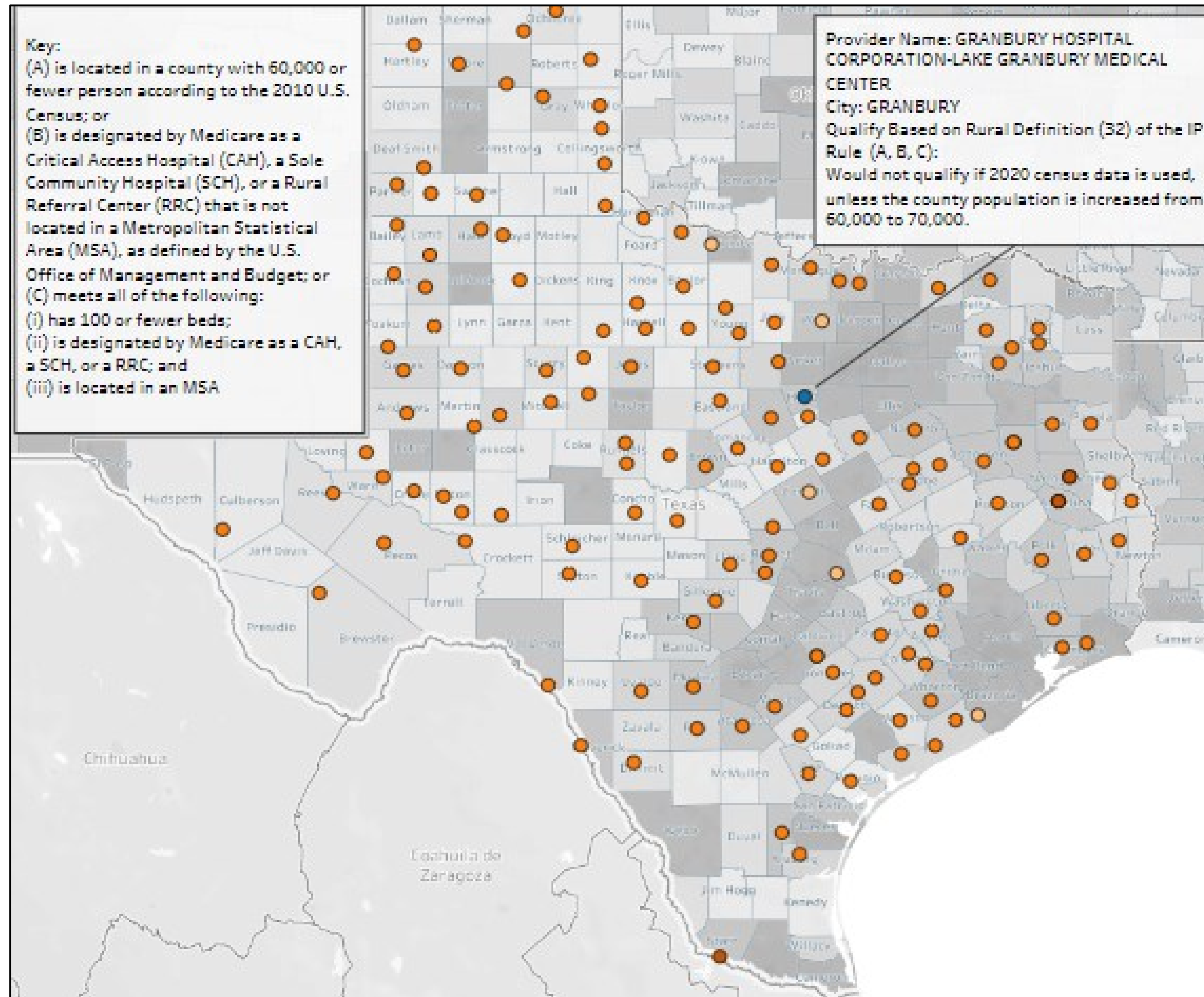


Table 6. Future Strategy 3: – Utilize Appropriations, when available, to Stabilize Rural Hospitals in the Least Administratively-Burdensome Manner

Operational Goal	Anticipated Impact	Implementation Deadline	Status
Analyze options to utilize additional appropriations, when available, to stabilize rural hospitals	TBD	TBD	TBD

The Texas Legislature appropriated $75 million in grant funding pursuant to S.B. 8, Section 12, 87th Legislature, 3rd Called Session, 2021, for rural hospitals. The grant funding was intended to support rural hospitals that had been impacted by COVID-19. In the 2020 version of the rural hospital strategic plan, HHSC identified that the federal Provider Relief Funds distributed to rural hospitals indicated a potentially interesting opportunity to study the stabilizing impact of grants or funding unrelated to utilization could have for rural hospitals.

With the appropriation of the one-time grant funding from S.B. 8, HHSC was able to issue two tiers of grants for rural hospitals. Under Tier 1, all rural hospitals were eligible for a direct grant award of $250,000. These funds were able to be distributed more quickly because the process was not competitive, and providers received a specific amount. Under Tier 2, rural hospitals were eligible for up to $1,000,000 but were required to apply under a competitive Request for Application process.

Through the course of administration of the two grants tiers, HHSC has determined that the administrative burden to HHSC and to rural providers of a competitive process may have delayed payments and increased the administrative burden to the extent that the stabilizing impact of the funding was not as effective as it might otherwise have been. As a result, if there are future appropriations for grants for rural hospitals, HHSC recommends analyzing options to utilize those appropriations to stabilize rural hospitals in the least burdensome manner possible. Options that could be considered would be:

1. utilizing funds as the non-federal share of supplemental or directed-payment programs like CHIRP, RAPPS, Disproportionate Share Hospital, or Uncompensated Care;

3. administering grants as an open-enrollment, non-competitive procurement; or

4. issuing direct grant awards with no associated reporting requirements.

5. Conclusion

S.B. 1621 requires HHSC to provide an update to the implementation of the strategic plan by November 1 in each even-numbered year. HHSC provides this progress report in accordance with these guidelines. This report includes status updates related to the strategies identified in the January 2020 Rural Hospital Services Strategic Plan. Future reports may include new strategies to maintain hospital services in rural communities as they are identified.

HHSC continues collaboration efforts with the rural hospital community, related hospital associations, and other state agencies to provide continued consideration of potential difficulties impacting rural hospitals.

For this report update, HHSC engaged rural hospital stakeholders such as RHAC and TORCH for their feedback on the content of this report. RHAC was established as part of a strategy from the previous strategic plan to gather feedback from the public to inform future reports and plans.

Finally, HHSC plans to include initiatives and requirements from CMS creating opportunities or barriers for rural hospital services in future reports. With Medicare as the major payor in many rural hospitals, it is important to ensure that any Texas-led solutions consider federal rules and regulations. HHSC continues to build upon current efforts to increase rural hospital reimbursement while monitoring the status of rural reimbursement enhancements.

List of Acronyms

Acronym	Full Name
CAH	Critical Access Hospital
CHART	Community Health Access and Rural Transformation
CHIRP	Comprehensive Hospital Increase Reimbursement Program
CMS	Centers for Medicaid and Medicaid Services
HHSC	Health and Human Services Commission
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
MSA	Metropolitan Statistical Area
RAPPS	Rural Access to Primary and Preventive Services
RCC	Ratio of Cost to Charge
REH	Rural Emergency Hospital
RHAC	Rural Hospital Advisory Committee
RRC	Rural Referral Center
S.B.	Senate Bill
SDA	Standard Dollar Amount
SCH	Sole Community Hospital
TAC	Texas Administrative Code
TBD	To Be Determined
TORCH	Texas Organization of Rural and Community Hospitals

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