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Texas Health Improvement Network

The Potential for a Rural Community Health System to Improve Health Care Access and Value in Texas

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EXECUTIVE SUMMARY

In 1997, the Texas Legislature adopted SB 1246 to allow for the establishment of a non-profit "statewide rural health care system" that would provide a rural alternative to urban managed care organizations. Steps were taken toward establishing this system in the form of an entity called the Rural Community Health System (RCHS), yet the community-owned health plan envisioned by advocates was never fully operationalized. The revisiting of the RCHS concept and its enabling legislation has been proposed by rural health providers and advocates as a means of increasing options for health care insurance coverage in rural areas and strengthening rural health care in a manner that reflects the needs and context of rural Texas and amplifies the voices of rural providers.

This white paper summarizes findings from a project of the Texas Health Improvement Network (THIN) that considered the potential for an RCHS in the present era. The project investigated the purpose and history of the RCHS and its enabling legislation, reviewed changes in the insurance industry during the past two decades, and assessed the current health insurance landscape in rural Texas, including coverage, options and costs, and factors impacting insurance provision in rural Texas. The project also described relevant elements of the rural health care context, including the health status of rural Texans and provider availability and financial viability. The study team also looked into the activities and experiences of relevant organizations in other states. Investigations were based on interviews and input from a variety of stakeholders within and outside Texas, original analyses of publicly available data, and reports and analyses by others.

This white paper also offers recommendations for a re-envisioned RCHS. As a nonprofit, quasi-governmental, cooperative organization, the RCHS could operate in the space between health insurers and health care providers, to the benefit of both. A fruitful starting focus for the RCHS would be to help enable rural provider participation in value-based payment arrangements. This could include facilitating the development of multi-payer Accountable Care Organizations (ACOs) and Clinically Integrated Networks (CINs). The RCHS could also serve as a backbone/umbrella organization for securing and administering funding from private, state and federal sources, such as the Centers for Medicare & Medicaid Services (CMS), that aim to improve rural health.

The white paper also describes several additional policy changes that could help increase insurance coverage and health care system viability, thus complementing the work of an RCHS. These include aligning insurance rating areas with public health and network adequacy regions and requiring managed care organizations to operate at the public health regional level, rather than at a county level as is currently allowed. This regional realignment is logical from a cost perspective as these rural counties flow patients to the closest urban center for specialty services, and the costs of care in the urban centers drive much of the premium dollars. Also,

alliances between rural providers within a region and their urban counterparts would facilitate the development of rural value-based care arrangements. Distributing the rural counties across all rating areas would more evenly distribute risk posed by less healthy populations in rural areas. Requiring insurers to operate in the surrounding counties within the entire public health/network adequacy/rating area region could stimulate growth in insurance competition in rural counties.

LIST OF ABBREVIATIONS

ACA	Patient Protection and Affordable Care Act
ACO	Accountable Care Organization
ACH	Accountable Communities for Health
AFDC	Aid to Families with Dependent Children
AHC	Accountable Health Communities
APM	Alternative Payment Model
ARCHI	Texas A&M University Rural & Community Health Institute
BCBS	Blue Cross Blue Shield
CCNC	Community Care of North Carolina
CCO	Coordinated Care Organization
CCPN	Community Care Physician Network
CHIP	Children's Health Insurance Program
CIN	Clinically Integrated Network
CMS	Centers for Medicare & Medicaid Services
CO-OP	Consumer Operated and Oriented Plan
DSHS	Texas Department of State Health Services
FPL	Federal Poverty Level
HHS	U.S. Department of Health and Human Services
HHSC	Texas Health and Human Services Commission
HMO	Health Maintenance Organization
MCO	Managed Care Organization
MIPS	Merit-Based Incentive Payment System
MSA	Metropolitan Statistical Area
ORHCC	Office of Rural Health and Community Care
PHR	Public Health Regions
PPO	Preferred Provider Organization
QPP	Quality Payment Program
RAC	Regional Advisory Council
RCHS	Rural Community Health System
RHC	Rural Health Center
RWHC	Rural Wisconsin Health Cooperative
TDI	Texas Department of Insurance
THIN	Texas Health Improvement Network
TMA	Texas Medical Association
VBP	Value-Based Payment

I. INTRODUCTION

A. Project Impetus

In 1997, with a goal "to protect and enhance the rural health care delivery system," the Texas Legislature adopted SB 1246 to allow for the establishment of a "statewide rural health care system" that would provide a rural alternative to urban managed care for Medicaid and potentially other insurance programs [1]. Although steps were taken toward establishing an entity known as a Rural Community Health System (RCHS), the community-owned health plan envisioned by advocates was never fully operationalized.

In the decades since, the need and desire to protect and enhance the rural health care delivery system has only grown more acute. The revisiting of the RCHS concept and its enabling legislation has been proposed by rural health provider advocates as a means of increasing options for health care insurance coverage in rural areas and strengthening rural health care in a manner that reflects the needs and context of rural Texas and amplifies the voices of rural providers.

B. Purpose and Project Scope

The project began with a focus on the potential of an RCHS as a cooperative, community-owned health plan to address barriers to health care coverage and access in rural Texas. The project began with an environmental scan of health insurance coverage options in rural communities and factors contributing to low insurance coverage in rural Texas. As the project progressed, we developed a broader vision for the ways an RCHS could support rural health care systems. This vision became an organizing framework that was used to guide an expanded inquiry into the potential of an RCHS to improve health care access and value in rural Texas. This resulted in recommendations for an RCHS in the present era, as well as recommendations for complementary strategies to improve rural health care access, viability, value, and health outcomes.

C. White Paper Contents

This white paper describes 1) the history of the RCHS and its enabling legislation; 2) the current context for an RCHS, including an assessment of health care coverage and access in rural Texas; and 3) the potential value of an RCHS in the present era. This paper offers a framework describing three inter-related pathways through which an RCHS could lead to improved health care access and value, and provides recommendations for maximizing the potential success and benefits of an RCHS in the present era. The paper also proposes additional policy recommendations to improve rural health care access.

D. Methods and Data Sources

This project utilized a mixed-methods approach, combining a review of academic research, published reports, and legislative documents; original analyses of publicly available data; key informant interviews; and an expert panel and roundtable meeting with stakeholders and advisors, including those who were integral to the original RCHS project and current leaders working to improve rural health in Texas. A list of data sources is provided in Appendix A, and a list of key informants and meeting panelists is provided in Appendix B.

II. CONCEPTUAL FRAMEWORK

Following an initial data gathering and review phase, a framework was developed to illustrate the pathways through which an RCHS could potentially benefit rural health care in the present era (Figure 1). This framework serves as a visual tool for considering how inputs – whether from an RCHS or other source – might generate changes to the benefit of rural health care in a complex system. Each of the three pathways illustrated in the framework is described below.

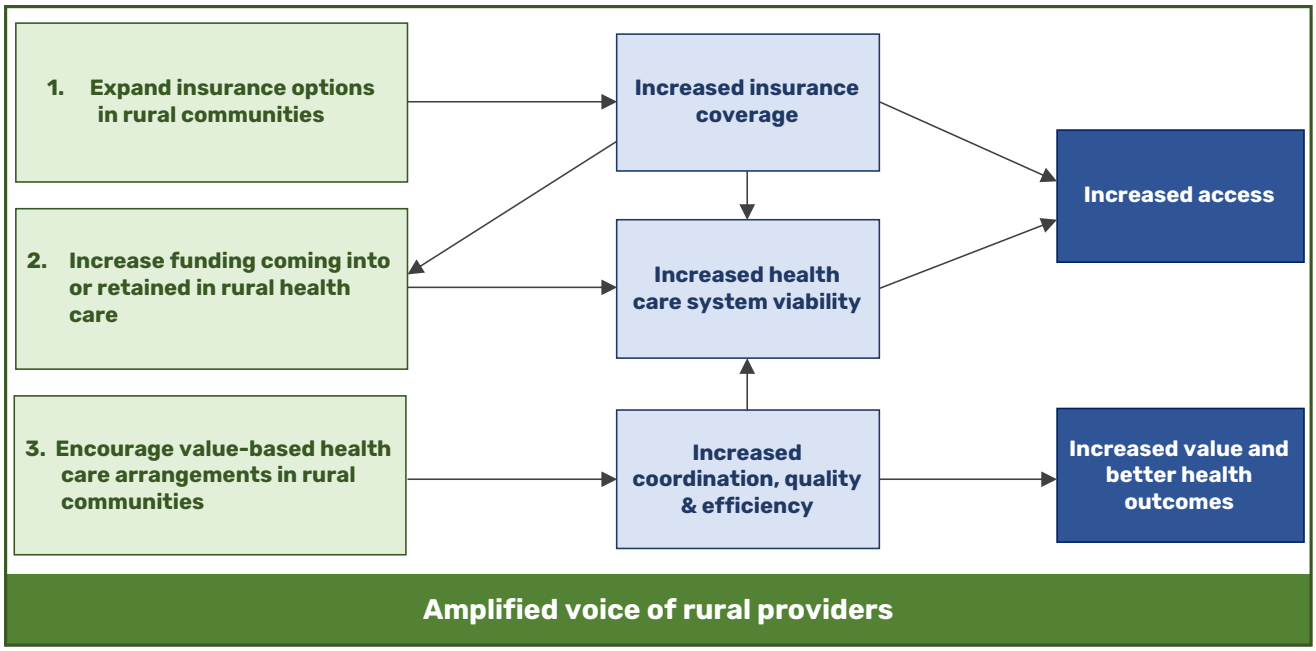

Figure 1: Framework for Considering Potential Pathways for an RCHS to Benefit Rural Communities

Pathway 1: Expanding insurance options for individuals and small employers

The first pathway would involve an expansion of insurance options in rural Texas. Because low-income children and older adults are eligible for public insurance coverage, the individuals most likely to be uninsured are those 19-64 years of age. To increase insurance coverage in rural Texas, an RCHS would need to increase insurance options through the individual and small group markets. To motivate participation by individuals and small-business owners, a new plan would need to be lower cost or provide better benefits than currently existing options. An RCHS could potentially increase funding retained in rural health care by paying providers a higher rate than competitor plans, and/or reinvest unexpended funds into rural health care.

Pathway 2: Increasing funding for rural health care systems

The second pathway would strengthen the viability of rural health care systems by increasing funding available within rural health care systems. An increase in funding would be supported by increased coverage, but could also be achieved by other means, such as increased payments from health plans, improved efficiencies, and grants supporting rural health improvements.

Pathway 3: Supporting a transition to value-based health care

The third potential pathway to rural health care improvement would involve supporting the transition from traditional fee-for-service payment approaches

into value-based and accountable-care models that offer a promise of greater value (better health outcomes for health care dollars) while lowering costs through improved care coordination. This transition is widely seen as the future of health care and health care payments in the U.S., and has been mentioned as critical to the relevance of an RCHS by our project's key informants and advisors. This future requires a new approach to providing care, including increased coordination and collaboration within health care and partnerships with non-clinical care providers to address social determinants of health.

Foundation Pathway

Underpinning this framework is a foundation of an amplified voice of rural providers and greater rural control, the primary drivers for the initial RCHS-enabling legislation. Any form that an RCHS takes should result in greater rural control, and achieving greater rural control is of value in and of itself. For example, an RCHS may lead to the development of Medicaid plans that are a better fit for rural communities.

III. PROJECT FINDINGS

This section provides a summary of what was learned through interviews and input from a variety of stakeholders within and outside Texas, original analyses of publicly available data, and existing reports and analyses by others. Because the initial vision of the RCHS was for it to be a community-managed health plan, the health insurance coverage landscape in rural Texas is the central focus of the analyses. As the understanding of the potential for the RCHS grew and the framework presented in Section II developed, the scope of the inquiry expanded to include information on value-based care and models in other states.

A. RCHS Legislation and History

1. RCHS-Enabling Legislation

In 1997, the Legislature passed SB 1246, which created a new subchapter in the Insurance Code establishing a statewide rural health care system. Per the legislation, the system would:

- be a nonprofit corporation composed of two or more rural hospital providers and governed by an 18-member board of directors;
- be considered a unit of local government for purposes of tort claims and payments and entering into interlocal cooperation contracts;
- contract with or arrange for local health care providers to deliver health care services to rural enrollees; and
- be awarded at least one Medicaid managed care contract.

The statute specified that the commissioner of insurance would designate one organization to be the system. The statute defined a rural area as any county with a population of 50,000 or less; an area not delineated as an urbanized area by the federal census bureau; or any other area so designated by the commissioner.

The initial statute was amended during the two subsequent legislative sessions to allow more flexibility. In 1999, HB 1194 removed the requirement that health care services be provided on a prepaid basis. In 2001, SB 1394 allowed the system to sponsor as well as provide and arrange for health care services for programs that are not subject to specific regulations governing health plans. Additionally, it removed the requirement that the system's board of directors be appointed by the governor. The bill also allowed the health and human services commissioner to use the system for pilot projects.

The statute allows rural public hospitals and hospital authorities to collectively establish fund sharing and other relationships with urban counterparts, set up shared administrative infrastructure, and accept gifts and grants. The legislation also directs the RCHS to promote healthy communities and individuals by using a public health model that focuses on health promotion, illness prevention, patient self-care education, and incentives that encourage positive health behavior.

See Appendix C for complete summaries of enrolled bills and links to the statutes and related documents available on the Texas Legislature Online website.

2. Motivation and Vision

A key catalyst for the 1997 RCHS-enabling legislation was the growth of managed care in Texas. (See sidebar for information on managed care.) HB 7, passed in 1991, directed the state to establish Medicaid managed care pilot programs. Throughout the 1990s, the Legislature continued to expand Medicaid managed care in urban areas and surrounding counties [2]. The operation of urban-based Medicaid Managed Care Organizations (MCOs) in rural counties sparked concern about the impact of this movement on rural health care delivery. Insufficient reimbursement, network exclusion, and the loss of patients and health care dollars to urban centers as a result of managed care were all seen as threats to the long-term viability of rural health care networks and the economic base of rural communities in Texas [3].

Advocates for SB 1246 were seeking a rural-focused alternative to the urban MCO model. SB 1246 proponents argued that the bill would help managed care competition in rural areas "by helping rural providers participate in an alternative HMO [Health Maintenance Organization] that could match the resources provided by urban, integrated systems" [3]. They envisioned a statewide system that would contract with locally developed networks and individual providers to serve a particular rural area and provide administrative, financial, and technical support to the local networks. As a non-profit organization governed by a community-based board, the RCHS was intended to help ensure that health insurance products were developed in an optimal manner for rural areas and local needs.

While the growth of managed care served as the catalyst for the RCHS legislation, stakeholder interviews point to an underlying motivation: rural providers felt ignored, powerless, and taken advantage of by the large, urban-focused, for-profit insurance companies. Rural providers wanted "to have more control over their destiny" (Sheri Dasco, attorney involved in the original RCHS development). Medicaid managed care was seen as a starting point from which the RCHS could expand into other areas, potentially offering a commercial insurance product or other benefits to rural communities. However, at the heart of the push for the legislation was the desire for rural control. According to Helen Kent Davis, former RCHS board member and current Texas Medical Association (TMA) staff member:

> ***So that was a lot of the motivation...having a community-based model where you have leaders from rural hospitals and physicians on a board with community leaders to help provide accountability and oversight to the entity. That was really important to them that it wasn't an out-of-state entity with no direct connection with the people who actually have to provide the care or the people who were receiving the care.***

Although much has changed since the RCHS-enabling legislation was enacted, this sentiment has persisted and is a primary driver for the re-exploration of the legislation's potential in the current era.

3. RCHS Implementation

Once SB 1246 was passed, the first step to implementation was establishing a board of directors. Establishing the board was challenging and time consuming. This process involved working with the Governor's Office, as half of the board were to be appointees (a requirement removed in a later session). Having physician, hospital, and community leadership on board was critical to achieving the RCHS vision, but it did not ensure the expertise needed to develop a health plan. Eventually, a board was established, and it worked to develop the bylaws and governance structure and establish contracts with rural providers.

In 2003, five years after the legislation was passed, the RCHS submitted its request for a Medicaid contract to the Texas Health and Human Services Commission (HHSC). The Clarendon Insurance Group, which at the time managed the Children's Health Insurance Program (CHIP) in rural Texas counties, was to serve as the third-party administrator for managing eligibility, network development, utilization management and claim payments. However, according to Kay Ghahremani, former HHSC project manager for the RCHS, when the contract with RCHS was submitted for approval to the Centers for Medicaid & Medicare Services (CMS), it was rejected because it was not competitively awarded in accordance with federal procurement requirements. HHSC could not proceed without federal approval, despite the legislatively mandated requirement that the state Medicaid program award a contract to the RCHS once established.

Regardless of the disapproval from CMS, several RCHS advocates felt that HHSC leadership did not see this as a high priority, did not have confidence in the RCHS, and did not want to award the RCHS a Medicaid contract. The inability to secure the Medicaid contract ultimately led to the dissolution of the RCHS board.

Key Elements of RCHS Legislation in the Present Era

Viewing the RCHS-enabling legislation as a potential asset or resource that could be put to use, the following elements established by the legislation were identified that may have value in the present day:

- Existence of the statute provides legitimacy
- Statutory requirement of Medicaid managed care contract award
- Codified into Insurance Code with flexibility compared with other insurers or HMOs
- Exempt from tort claims and able to enter into inter-local agreements

B. Key Changes Impacting the Health Insurance Industry Since 1997

1. Texas Medicaid Managed Care

In the years after the RCHS-enabling legislation was enacted, Medicaid managed care expanded from the urban areas to rural counties adjacent to urban areas, and by 2012 had expanded statewide. Texas Medicaid currently has 13 service areas, three of which are indicated as "rural" (See Appendix D). Each of those rural service areas is served by MCOs that have developed networks in those areas. The MCOs in the rural areas have adjacent urban service areas to aid referrals. By 2017, over 90% of Medicaid enrollees were enrolled in Medicaid MCOs [2].

Of note, in 1985, local providers in the rural West Texas region, working with Texas Tech University, played a major role in organizing a Medicaid MCO, FirstCare Health Plans. After operating for nearly 20 years under the ownership of the Covenant Health System in Lubbock and Hendrick Health System in Abilene, FirstCare was purchased by Baylor Scott & White Health in January 2019 and merged into the Scott & White Health Plan.

2. Affordable Care Act

Major changes have also occurred in the individual and small group health insurance markets, primarily as a result of the 2010 Patient Protection and Affordable Care Act (ACA), which was fully implemented in 2014 [4]. Among its many provisions, the ACA created a new health insurance market for individuals not covered through their employer or a public plan such as Medicare. The impact on the individual insurance market in Texas has been significant. In 2008, individual insurance covered less than 400,000 lives, of which 25,000 were in a state-run high-risk pool for those unable to purchase individual coverage due to pre-existing conditions. In 2020, over 1.6 million Texans were covered by individual plans, and the Texas high risk pool no longer exists, as ACA-compliant plans do not exclude or charge higher rates to those with pre-existing conditions. Approximately 90% of the 1.1 million people in ACA plans receive federal subsidies [5]. The small-employer market has contracted by about 5%

since the ACA, as some employers have moved to providing funds for employees to pick an individual plan and others have stopped offering a health plan due to cost increases. (See Table 2 referenced later in this paper.)

The ACA also includes the "Consumer Operated and Oriented Plan" (CO-OP) program. CO-OPs are private, non-profit, state-licensed health insurance carriers with boards of directors elected by their members. CO-OP profits are reinvested in the plan, rather than paid to shareholders. The hope was that CO-OPs would increase competition and provide a consumer-focused option in the individual and small group markets. However, lack of risk-based capital to cover early-year losses and other issues resulted in their inability to successfully compete. Out of the nearly two dozen CO-OPs started under the ACA, only four were still operational in 2020 [6]. The experiences of the ACA CO-OPs illustrate the challenges of starting a new insurance business, particularly one that is focused on the individual and small group markets.

3. Shift from Fee-For-Service to Value-Based Care and Payments

The past few decades have seen a growing push for new organizational and payment models for health care delivery that emphasize value and health outcomes rather than services and volume. This trend has its roots in the development of managed care in the 1980s. Many new value-based models have developed in recent years, including Accountable Care Organizations (ACOs), Clinically Integrated Networks (CINs), Accountable Health Communities (AHCs) and Accountable Communities for Health (ACHs). (See page 9 for descriptions of each.)

At the federal level, the U.S. Department of Health and Human Services (HHS) has set targets for the use of alternative payment models (APMs) for both Medicare and Medicaid [7]. States have had some flexibility in terms of how these requirements are implemented for Medicaid. In Texas, Medicaid MCOs were required in 2018 to have at least 25% of their medical expenses in a value-based payment (VBP) model, and 10% must be in a risk-based VBP model. These rates increase to 50% and 25%, respectively, in 2021. In addition, 3% of MCO premiums are payable based on meeting certain quality performance metrics (in concert with their contracted providers) [8]. To date, MCOs have generally had no problems meeting these goals and typically implement bonus payments for achieving specific measures [9].

With respect to Medicare, in 2015 CMS created the Quality Payment Program (QPP) through the Medicare Access and CHIP Reauthorization Act. The QPP set up two ways that clinicians can be paid for the provision of Medicare services: the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (APMs). The first is an upside-only model that includes financial incentives for quality, cost, clinical practice improvement and use of electronic health records performance. The latter are delivery and payment models that include risk-sharing and incentivize providers to shift away from being paid for volume and toward being paid for quality [10]. Recognizing that small and rural practices might not have the patient volume, expertise and resources to successfully participate in the QPP, CMS put a three-year transition period in place that set volume thresholds for MIPS eligibility, allowed smaller practices to participate in the QPP via virtual groups (to increase patient volume for reporting purposes) and provided targeted technical assistance [10].

While this shift from the traditional fee-for-service models to value-based models takes a range of forms, it is clear that the transition will continue. Stakeholders interviewed for this project emphasized that to be successful and relevant in the present era, an RCHS must help shepherd rural health care into value-based care arrangements. Providing value-based care in rural areas raises particular challenges not found in urban areas. For example, the specialty and tertiary services needed for seriously ill patients are only provided in urban areas and, therefore, will require collaboration with more urban health care systems [11]. Rather than using an urban-based blueprint in rural communities, a rural-focused approach to ACO development is needed. A revitalization of the RCHS should consider support for the development and operation of rural CINs and ACOs.

THE ONGOING TRANSITION TO VALUE-BASED CARE

The shift from fee-for-service to value-based care has a long history and is continuing to evolve. Managed care seeks to manage the cost and quality of medical services by contracting with a network of providers that provide care for plan members at a reduced cost. By contrast, indemnity health insurance, also known as "fee-for-service," covers a percentage of the costs of care from any medical provider a member chooses. Managed care has its roots in prepaid, membership-based, medical group practices of the early 20th century. Serving populations such as farmers and construction workers, these early managed care practices were designed to address a problem of health care affordability and access for working class individuals, and emphasized preventive care and capitated cost.

The modern managed care movement got kickstarted by the federal 1973 HMO Act, which was spurred by concerns about soaring health care costs and inefficiencies. Since the 1970s, a number of different approaches to organizing, managing, and paying for health care have developed. These include Preferred Provider Organizations (PPOs), ACOs and CINs. ACOs and CINs have been developed to facilitate care coordination across physicians, hospitals and other providers; improve health outcomes; and provide new payment models that pay for quality and provide bonuses for savings, rather than just paying for volume. Propelled by the passage of the ACA, Medicare ACOs are CINs that hold value-based shared savings contracts with CMS for providing care to Medicare beneficiaries [12]. Initially led by Medicare (both traditional and Medicare Advantage plans), ACOs are now starting to move into other insurance segments including Medicaid and commercial lines.

Another growth area in the provision and financing of health care is the development of AHCs. Recognizing that health is influenced by factors other than medical care, these organizations expand on the concept of ACOs to include the provision of non-medical services, such as home remediation for asthma patients or medically tailored meals for diabetic patients. In 2018, CMS funded 30 sites across the country – including three in the major Texas metro areas – to test whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries through screening, referral, and community navigation services will affect health care costs and reduce health care utilization. Oregon's Medicaid program has taken this approach statewide by incorporating non-traditional, community-based organizations into "coordinated care organizations" (CCOs) to address health-impacting social needs.

Similar to the AHC model, but with an expanded focus beyond a particular patient population, ACHs bring together health care, public health, and other cross-sector organizations to plan and implement strategies to improve population health and health equity for residents in a geographic area. ACH models offer opportunities to reduce costs, enhance quality of care, and improve population health. There are over 100 communities implementing ACH-like interventions, all of which have three common features: 1) mechanisms for accountability for health outcomes and cost containment, 2) the ability to share data about health, and 3) financing streams for short-term and longer-term activities [13].

C. Characteristics of the Rural Texas Population

Describing a rural population must begin by establishing a definition of rural. According to the Texas Legislative Council, at least 18 definitions of rural were in use by Texas state agencies in 2018 [14].

SB 1246 defined rural as:

(A) a county with a population of 50,000 or less;

(B) an area that is not delineated as an urbanized area by the federal census bureau; or

(C) any other area designated as rural by rules adopted by the commissioner.

To simplify and facilitate use of county-level data, we used the definition (A) above, and defined rural as counties with populations of less than 50,000. According to population estimates from the Texas Demographic Center, in 1997, 201 of Texas's 254 counties met this definition. In 2020, 186 counties have fewer than 50,000 residents (Figure 2).

The 186 Texas counties with populations of less than 50,000 in 2020 were home to 2.79 million residents, or 9.4% of all Texans. In 1997, 3.07 million lived in the 201

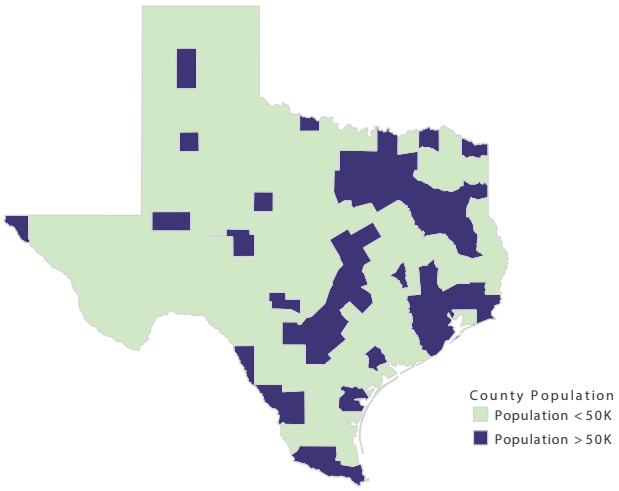

Figure 2: Map of 186 Texas Counties with Populations of Less Than 50,000 in 2020

counties with fewer than 50,000 residents and made up 15.8% of the total Texas population. As in the rest of the country, the rural population is older compared with the general population, with higher percentages of older adults and lower percentages of children and young adults (Figure 3).

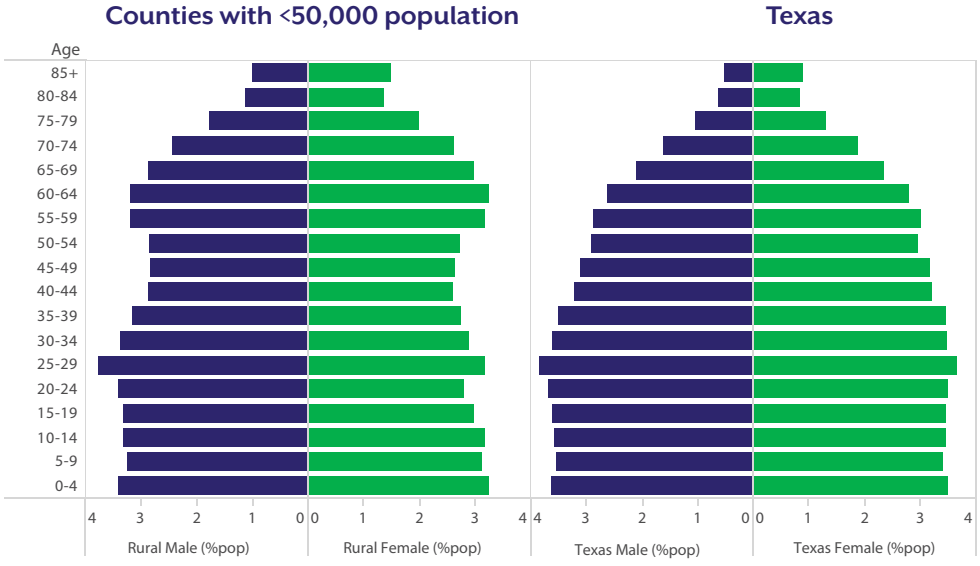

Figure 3. Population Distribution by Age and Sex in 2020: Rural Texas and Texas
Data source: Texas Demographic Center 2020 Population Estimates

In addition to being slightly older than the population of the state as a whole, Texans living in rural counties also experience poorer health than the rest of the state. After adjustment for the geographic differences in age distributions, the overall mortality rate in 2018 was 12% higher in the rural counties compared with Texas overall and higher for four of the five leading causes of death. Notably, the mortality rate for unintentional injuries ("accidents") is 30% higher in rural counties, causing more deaths than stroke. The poorer health of rural populations in Texas is mirrored across the U.S., and the rural-urban health gap has been widening [15].

	Texas Rate	Rural Texas Rate	Rate Difference	% Difference
Heart disease	170.0	199.2	29.2	17.2%
Cancer	142.9	159.6	16.7	11.7%
Chronic lower respiratory diseases	39.7	51.4	11.7	29.5%
Stroke	40.3	40.3	0	0.0%
Unintentional injuries	37.7	49.0	11.3	30.0%
All causes	731.8	819.6	87.8	12.0%

Table 1. Age-Adjusted Mortality Rates per 100,000 Population for Top Five Causes of Death in 2018: Rural Texas Compared with Texas
Data source: National Center for Health Statistics on CDC WONDER database

D. Health Insurance in Rural Texas

1. Insurance Coverage in Texas

Lack of health insurance is a statewide problem. Texas consistently and easily tops lists of states when ranked by the percent uninsured. A 2020 study by the Urban Institute on the characteristics of the uninsured in Texas estimated that 19% of Texans below age 65 were uninsured in 2018, compared with 11% nationally [16]. The study found that a lack of insurance was highest among the lowest income younger adults (19-34), Hispanics, those with less than a high school education, those who were not U.S. citizens, those without a full-time worker in the family, and those without a worker in a large company (defined as one with more than 50 employees). By occupation, those in the construction, arts/entertainment/recreation, and agriculture sectors had the highest uninsured prevalence – at 43%, 42%, and 40% respectively. Geographically, areas with the highest uninsured prevalence were found in parts of major cities, in El Paso, and in south Texas.

The high percentage of uninsured in Texas places a significant burden on individuals and health care systems. Research shows that uninsured individuals are less likely to seek care, especially for preventive services such as annual checkups and screenings. Two in five nonelderly adults without insurance coverage lack a usual source of care. Uninsured nonelderly adults are substantially more likely (30.2%) to have gone without needed care in the past year due to high costs than adults with public insurance (9.5%) and adults with private insurance (5.3%) [17]. For hospitals and providers, uninsured patients lead to uncompensated care. For hospitals, which are required by law not to turn away patients, having patients without the ability to pay for care leads to mounting losses. A high percentage of uninsured people may be a contributing factor to hospital closures, particularly in rural communities [18].

2. Health Insurance Coverage in Rural Counties

An analysis of data from the U.S. Census American Community Survey showed modest differences between the urban and rural counties for those aged 19-64 in insurance coverage rates and sources of coverage. Because children and those over the age of 65 have public insurance options, the vast majority of uninsured people are between 19 and 64 years old. The proportion of uninsured in counties with populations of 50,000 or greater and those in counties with

fewer than 50,000 were nearly identical (17.4% vs. 17.5%, respectively). However, among those aged 19-64, 23.4% and 25.6% of urban and rural residents, respectively, were uninsured. Within the younger age group of 19- to 34-year-olds, 28.7% and 32.7% of urban and rural residents, respectively, were uninsured.

A closer look suggests a complex relationship between insurance status and geography, and shows that some rural counties are particularly hard hit by the problem of the uninsured. Within rural counties, the median county-level percentage of uninsured was 16.7%, but it ranges 27 percentage points, from 4.7% to 31.7% (See Figure 4).

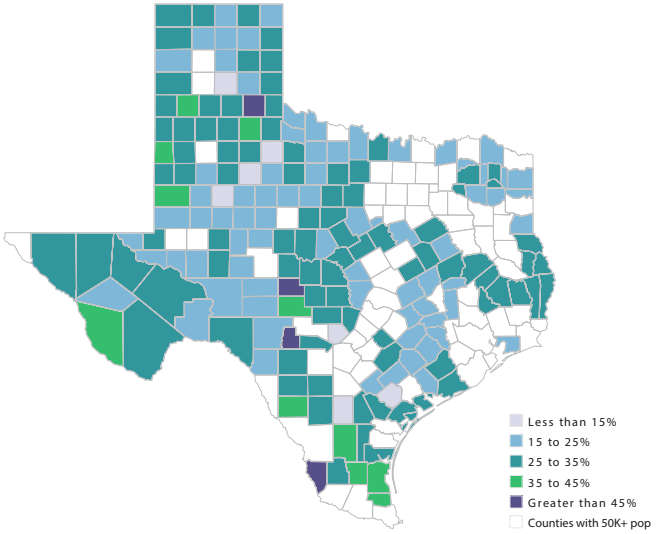

Figure 4. Percentage of 19- to 64-year-olds Uninsured in Counties with Less Than 50,000 Population in 2018
Data source: U.S. Census Bureau; 2018 American Community Survey 5-Year Estimates, Table B27010

Variation in the source of insurance coverage was also found. Among those aged 19-64, those living in rural counties were less likely to be covered by employer-based insurance and slightly more likely to be covered through public insurance or an individual plan through the ACA Marketplace (Figure 5).

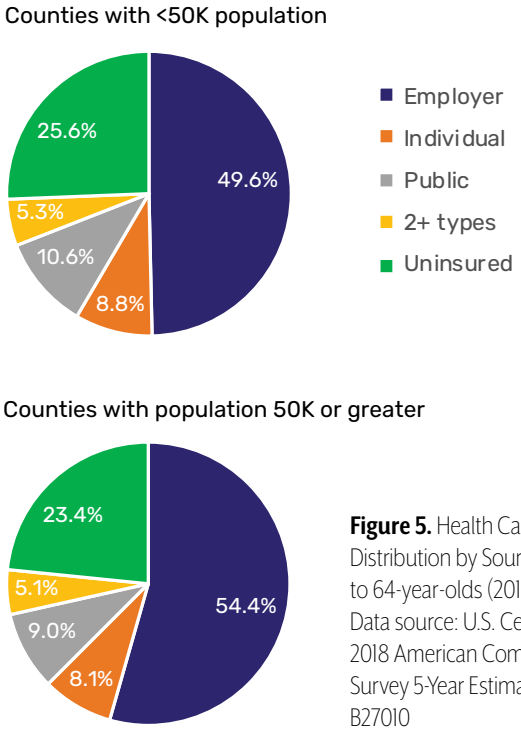

Figure 5. Health Care Coverage Distribution by Source Among 19- to 64-year-olds (2014- 2018)
Data source: U.S. Census Bureau; 2018 American Community Survey 5-Year Estimates, Table B27010

3. Health Insurance Options in Rural Texas Counties

Our analysis found that fewer insurance options are available in rural counties. In the small-employer market, which is critical in rural areas due to fewer large employers, health insurance options are very limited. As shown in Table 2, Blue Cross Blue Shield (BCBS) is essentially the only small group option in rural Texas, with approximately 80% market share. The primary competitor to BCBS in the small group rural market is the Scott & White Health Plan, which operates in central Texas and in the Amarillo area. In the Medicare Advantage market, there were at least five options in all rural counties in 2019, while there were at least 20 in each of the urban counties [19]. In the individual ACA Marketplace, 78 rural counties had only one insurance option (BCBS) in 2020, and most other rural counties had only two options. However, in 2021 the number of counties with only one option will drop to 37, suggesting that the ACA Marketplace is expanding (Figure 6) [20].

Statewide:

Year	Blue Cross	United	Humana	BS&W	Others	Total	Carriers
2015	553,337	140,996	113,426	36,282	26,693	870,734	16
2016	580,839	138,221	110,627	39,729	18,074	887,490	15
2017	555,354	138,515	122,707	42,021	19,742	878,339	13
2018	605,597	108,550	98,448	32,767	8,864	854,226	9
2019	653,509	81,475	71,980	21,091	927	828,982	8
Marketshare (2019)	79%	10%	9%	3%	0%		

Rural Areas*:

Year	Blue Cross	United	Humana	BS&W	Others	Total
2015	160,116	27,510	25,118	34,221	13,899	260,864
2016	162,970	28,636	25,058	36,687	11,724	265,075
2017	153,393	33,250	26,887	36,002	10,905	260,437
2018	173,822	26,581	24,719	28,003	2,685	255,810
2019	189,291	20,153	17,849	18,421	651	246,365
Marketshare (2019)	77%	8%	7%	7%	0%	

Table 2. Small Employer Covered Lives in Texas 2015-2019

*These data are not available at the county level, but are available at the 3-digit Geo-ZIP level, which in rural areas cover multiple counties. If more than half of the counties covered by a 3-digit Geo-ZIP code had a population <50,000, that Geo-ZIP was classified as rural for this analysis. This results in a higher percentage of statewide enrollment classified as rural than in other analyses.
Source: Insurers' Annual Small Employer Health Benefit Plan Reports (Form LAHR 335) to Texas Department of Insurance

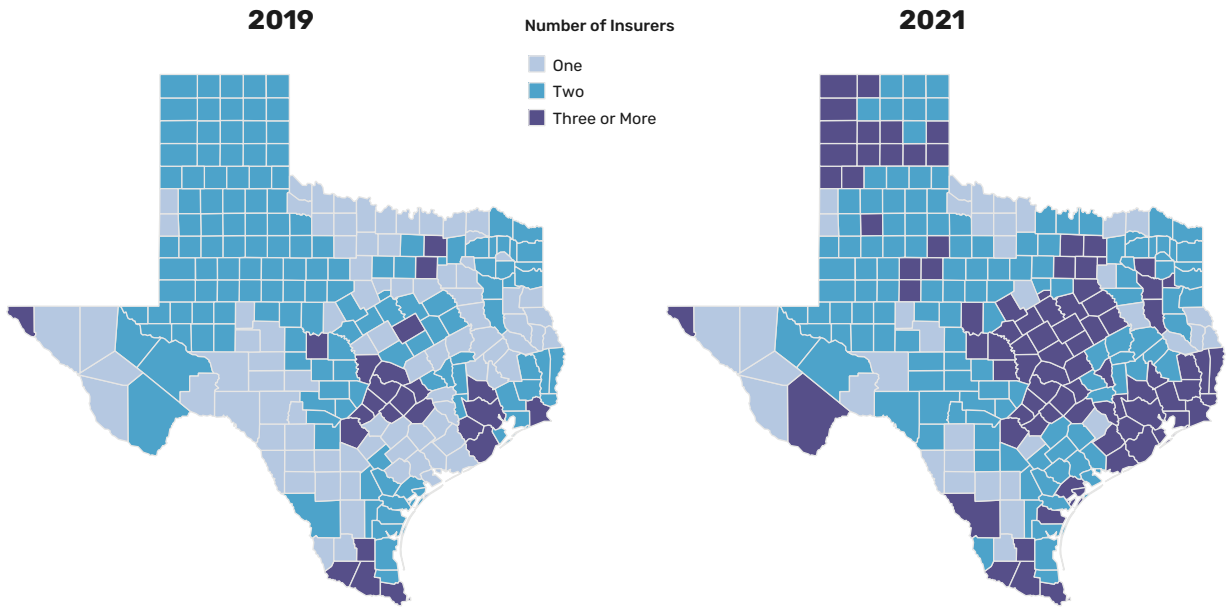

Figure 6. Insurer Participation on the ACA Marketplaces 2019 to 2021
Source: Kaiser Family Foundation analysis of data from Healthcare.gov and a review of state rate filings, available at: https://www.kff.org/private-insurance/issue-brief/insurer-participation-on-the-aca-marketplaces-2014-2021/

For those covered by Medicaid or CHIP, the number of available MCO options is similar across the state. Since 2011, Medicaid has provided managed care options in all rural counties, divided among three rural regions in West, Northeast and Central Texas. Many rural counties proximate to metropolitan areas are included in an urban region. (See Appendix D for Texas Medicaid managed care service area map and MCO options.) In all Medicaid regions, three or more MCOs are available for children and pregnant women (the primary populations enrolled in Medicaid or CHIP in Texas) [21].

4. Health Insurance Costs in Rural Texas

Despite fewer insurance carriers in rural Texas, our analysis of insurance premiums did not reveal pricing (insurance premiums) to be higher in rural Texas. We reviewed rates in the 26 rating regions used by the Texas Department of Insurance (TDI) and the CMS for rate-setting for individual and small group insurers [22]. The 26 regions are shown in Figure 7. Note that each of the 25 metropolitan statistical areas (MSAs) of Texas is its own rating region, and all other rural counties are rating region 26, required to have the same premium rates whether north, south, east or west in rural Texas. As Figure 8 shows, the premium rates in rural Texas appear to be in the middle of the pack compared with other parts of the state. This is true both in individual insurance and the "capitation" rates paid to MCOs in Medicaid (Figure 9).

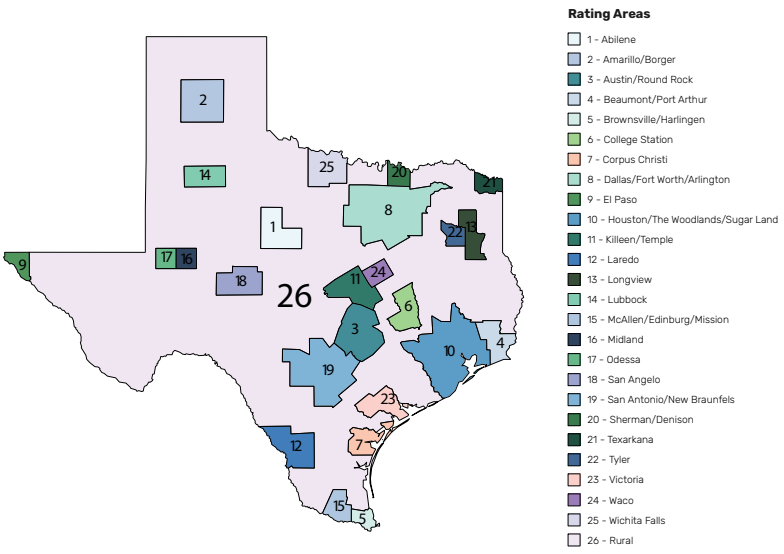

Figure 7. Texas Department of Insurance/CMS Rating Areas for Individual and Small Group Plans

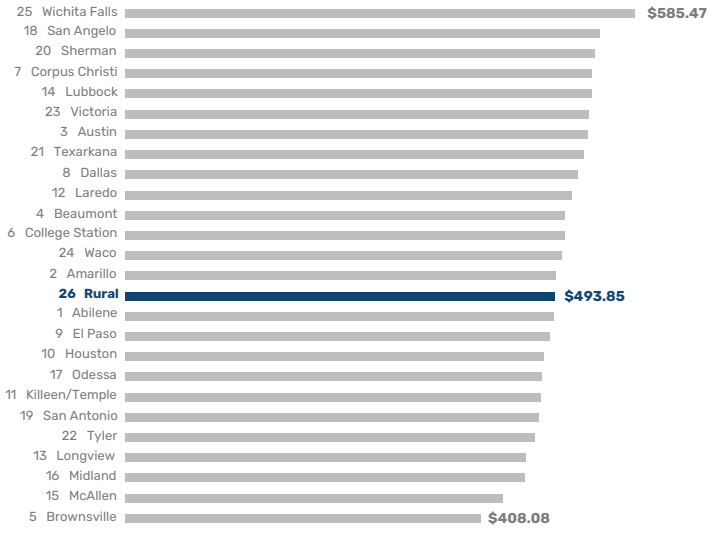

Figure 8. Premiums by Rating Area for Blue Cross Blue Shield Blue Advantage Silver HMO 205 Plan

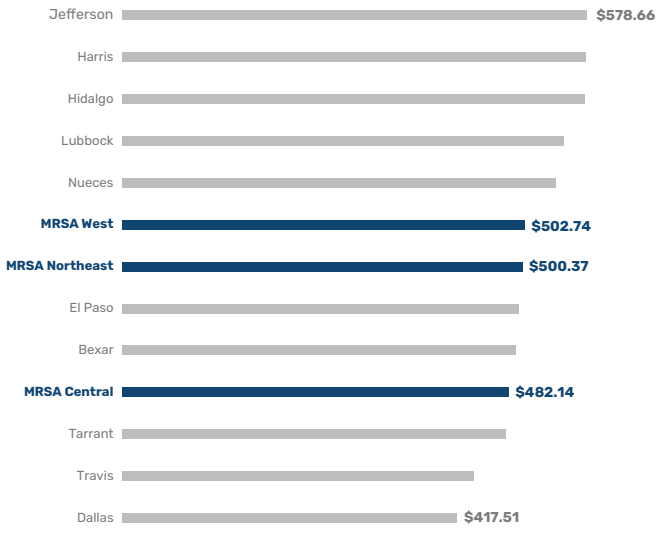

Figure 9. Medicaid Managed Care Capitations by Service Area TANF Adults (SFY 2021)

5. Challenges of Providing Health Insurance in Rural Communities

Insurance companies interested in operating in rural areas face a specific set of challenges. Rural communities lack the economies of scale found in urban areas. Rural populations are much smaller and more widely distributed across a geographic region than urban populations. This presents challenges for insurers trying to minimize risk, as they are unable to form a big enough risk pool to absorb high-cost members [23]. In addition, rural populations often have greater health challenges than those in urban areas, which can lead to higher health care costs and more high-cost members [24].

A related challenge for insurers is the low numbers of providers in rural areas, which makes it challenging to create provider networks and limits insurers' negotiating power for lower prices [23]. Fewer health plans and providers in rural areas mute competition by creating "bilateral monopolies," with both health plans and providers having limited negotiating power [25]. Furthermore, where insurers do enter rural marketplaces, the smaller numbers of covered individuals result in higher per-member administrative costs for insurers to operate these networks [23]. These barriers prevent insurers from entering rural marketplaces in the first place.

6. Summary

A slightly higher percentage of rural Texans are uninsured compared with urban Texans, a smaller percentage are covered by employer-sponsored plans, and a slightly higher percentage are covered through public or individual plans. Compared with urban counties, rural counties generally have fewer options in insurance providers, but options are increasing for rural residents who purchase insurance as individuals through the ACA Marketplace. Despite fewer options, insurance premiums do not appear to be higher in rural counties. Insurers face several challenges to providing insurance in rural areas, including smaller risk pools, poorer health of residents, and fewer providers with which to contract.

E. Health Care Availability and Viability

By many measures, health care availability and viability in rural Texas is worse than in urban areas, and this gap has only widened in the two decades since the passage of SB 1246. In the 1960s, Texas had 300 rural hospitals [26]. Currently, only 158 rural hospitals exist in Texas, with 26 closing since 2010. This represents approximately 20% of rural hospital closures nationally. Reportedly, 60% of Texas' remaining rural hospitals are at risk of closing [27]. A host of factors are at play including lower utilization of inpatient services, lowered Medicaid and Medicare reimbursement, and growing levels of uncompensated care [26, 28]. A Texas HHSC evaluation of rural hospital funding initiatives found that the state Medicaid reimbursement levels were set at 53% of costs incurred by rural hospitals to provide outpatient care and 83% of in-patient care [29].

The issue of rural hospital viability is complex, and not all closures result in decreased health care access. The Texas A&M University Rural & Community Health Institute (ARCHI) has produced two reports that provide nuanced analyses of the challenges facing rural hospitals and a menu of potential solutions to allow communities to retain needed access [30, 31]. However, rural hospitals overall are under tremendous financial strain, and without an increase in funding either coming into or retained in rural health care, rural hospitals will continue to close, and rural access to health care will continue to shrink. Rural hospitals will continue to be challenged, and many rural hospitals will evolve to be emergency centers, with short-term observation beds, and transfers to large metropolitan hospitals for most major (and expensive) specialty services will continue.

Rural communities also face challenges in terms of the availability and viability of rural health care providers. In rural areas, the number of primary care providers per capita has decreased during the past several decades, and that trend is predicted to continue [32]. Currently, 32 counties in Texas have no primary care providers (Figure 10). The economic effects of the COVID-19 pandemic may accelerate the downward trend in rural provider access. A May 2020 survey by the Texas Medical Association suggests that the economic

impact of the COVID-19 pandemic on individual physicians has been significant. Two-thirds of respondents reported that patient volumes were decreased by more than 50%, and 63% of respondents reported practice revenues had fallen by more than 50%. In order to alleviate cash flow concerns, 63% of rural providers reported reducing physician compensation and/or benefits, while 25% applied for other forms of financial assistance, and 22% reported laying off or furloughing staff . These findings are mirrored by findings from the ongoing COVID-19 Primary Care surveys carried out by The Larry A. Green Center. In the December 2020 survey, 30% of respondents reported being paid for less than half of their work in the spring of 2020, and 52% said that reimbursement levels had worsened since that time . While these economic effects are not unique to rural providers, the consequences may be greater, as shortages were already in place before the pandemic. There will always be a need for primary care providers in person in small towns in rural Texas. This need may increasingly be met through federally subsidized Rural Health Centers (RHCs), nurse practitioners or other licensed professionals rather than physicians.

F. Rural Provider Participation in Value-Based Care

As detailed previously in Section B.3, pressure from the federal and state governments is moving providers away from fee-for-service reimbursement and toward VBP models that reward providers financially for achieving certain quality goals and/or achieving certain cost savings. Doing so is most feasible when providers have a sufficient volume of patients to dampen the effects of small numbers of "extreme" values, have data management systems in place to facilitate reporting, and can systematically coordinate care for patients who are living with chronic conditions. This section details what is known about rural provider participation in risk-sharing value-based care arrangements with Medicare and commercial insurers. (Data are not publicly available for Texas Medicaid.)

Across the state, providers have a long way to go to get to true risk-sharing value-based care, but interestingly, for Medicare at least, rural providers during 2018 were more likely than urban providers to participate in the QPP's risk sharing model (36.7% vs. 31.4% of non-rural providers). This is possibly due to rural providers having a larger number of Medicare beneficiaries per physician than non-rural practices (145.9 vs. 119.1) [36]. While rural clinicians were more likely to receive waivers for all performance categories than were non-rural clinicians (2.1% vs. 0.01%) and have lower overall scores than non-rural clinicians (mean 79.6 vs. mean 80.8), it is not clear that these differences were practically significant.

No data are publicly available for Medicaid and commercial insurer VBP arrangements with individual providers or providers by geography. However, in communication with BCBS, one of the largest providers of individual and small group commercial insurance in the state (and by far the insurer with the greatest reach into rural areas), they have 27 primary-care-driven ACOs representing about 1.3 million members in Texas. Not surprisingly, a greater share of those members lives in urban than rural areas. However, they do have arrangements with primary-care-driven ACOs in 40 of the 186 Texas counties with fewer than 50,000 residents. In addition, they reported having pay for performance and other value-based arrangements with specialists and hospitals across the state (email communication with Shara McClure, 1/15/2021).

MODELS FROM OTHER STATES

As part of our inquiry process, we interviewed leaders of organizations working to improve rural health and the financial sustainability of rural providers. Some of the work in other states could be useful to those in Texas.

1. Mountain Health CO-OP

In Montana, Mountain Health CO-OP is one of the few surviving co-ops established under the ACA. Mountain Health CO-OP operates as a prominent insurer in rural counties, offering ACA Marketplace plans. However, Mountain Health has not expanded to Medicaid or Medicare at this time. As a result of long distances between providers and few large urban markets for specialty services, Mountain Health focuses on building relationships with primary care providers, RHCs, and a few critical access hospitals. Through discussion with Mountain Health CO-OP's CEO, Richard Miltenberger, we learned that the insurer's major challenge is maintaining the rural voice in its now multistate health plan (including Idaho and Wyoming). According to Mountain Health executives, there are no silver bullets, but they are surviving with generally only BCBS as a competitor.

2. Community Care of North Carolina

North Carolina is well recognized for its rich history of successfully collaborating with rural communities to develop health care infrastructure that serves local needs [37]. These efforts, which date back to the 1960s, historically prioritized the development of primary care infrastructure. In the early 1980s, with an eye to improving physician participation in Medicaid, the North Carolina Foundation for Advanced Health Programs, the Division of Medical Assistance, and the Office of Rural Health and Community Care (ORHCC) piloted a patient medical home initiative with support from the Kate B. Reynolds Charitable Trust. The success of this initiative led to its expansion throughout the state, with ultimately 70% of women and children in the Aid to Families with Dependent Children (AFDC) population covered. Community Care of North Carolina (CCNC), formally established in 1998, was a logical outgrowth of these efforts.

Unlike earlier efforts, CCNC was designed with the dual goals of improving quality and lowering costs. In addition, the focus expanded to the aged, blind and elderly Medicaid population, which entailed the need to develop systems for identifying and coordinating the care of patients with complex conditions (i.e., chronic disease with multiple morbidities). Key elements of the new model included the formation of local physician networks to cooperatively plan for meeting member care needs, population management tools, case management and clinical support, and the provision of data analytics and reporting services [37]. Initially, CCNC was run by the State of North Carolina. However, according to an interview with Torlen Wade (the head of the ORHCC and early leader of CCNC), the decision was made to attain independent 501(c)(3) status when North Carolina transitioned to contracting with five MCOs for Medicaid in 2010-2011. In addition, in order to facilitate contracting with the MCOs through state Medicaid contracts, the original 14 physician networks have been consolidated into one statewide network. The group also now has a Medicare Advantage contract.

Services CCNC provides today to member physicians (and their patients) include: (1) assistance with MCO contracting, (2) care coordination, (3) pharmacy services, (4) data analytics, (5) group purchasing, and (6) a venue for learning and innovation. A staff recruitment program is under development that will benefit rural practices. Other current initiatives include working with the state to get a state health plan contract as well as with commercial plans to develop contracts to serve the individual and small group markets.

Mr. Wade identified the following factors that have been key to the organization's success:

- A foundation of trust-based relationships built on several decades of collaborative work
- Involvement and support of state government from the beginning that provided both financial resources and credibility
- Having a foundation (the North Carolina Foundation for Advanced Health Programs) that could get money from a variety of other entities (i.e. other foundations and pharmaceutical companies)
- Starting small, which allowed the efforts to fly under the radar. "We didn't have to air our dirty laundry or be evaluated too early."
- Initial focus on the AFDC population allowed the group to select health targets that allowed them to demonstrate success and savings early (i.e., focused first on asthma). Over the years multiple external organizations have evaluated the organization's return on investment and have found significant savings. (Filmore 2014, Steiner 2008).

More recently, CCNC has developed the Community Care Physician Network (CCPN), a CIN of over 3,000 independent primary care doctors statewide. The CCPN is a separate entity and is managed by a board of physicians. According to Mr. Wade, the establishment of this CIN has been critical for acquiring new managed care contracts.

3. Oregon Coordinated Care Organizations

In Oregon, the Medicaid agency has migrated its managed care program to regional CCOs. A CCO is a network of all types of health care providers (physical health care, addictions and mental health care and dental care providers) who work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid). CCOs focus on prevention and helping people manage chronic conditions such as diabetes. This helps reduce unnecessary emergency room visits and gives people support to be healthy. CCOs are organized as a regional nonprofit with local boards, who contract with the state. Traditional large insurers often support the CCOs with back-office operations on a contract basis, but the strategic decision making on local needs is focused on the local entity. For example, Moda Health, the largest health insurer in Oregon, helps to manage the rural Eastern Oregon Coordinate Care Organization. Moda is looking at Texas as a potential state for expansion of the CCO concept in rural areas.

4. Pennsylvania Rural Health Model

Another relevant model being tested by CMS is the Pennsylvania Rural Health Model. The intent is to test whether the predictable nature of global budgets will allow rural hospitals to invest in quality and preventive care in ways that meet local community needs and improve hospital financial viability [38]. CMS plans to provide up to $25 million to help the state implement the model. The state's Department of Health has established a Rural Health Redesign Office, an independent entity, to provide technical assistance to participant hospitals, aggregate and analyze data, compile and submit reports, set global budgets, approve transformation plans and conduct quality assurance [38]. A unique aspect of this endeavor is the involvement not just of Medicare, but also Medicaid and commercial insurers.

5. Rural Wisconsin Health Cooperative

The Rural Wisconsin Health Cooperative (RWHC) has been providing affordable and effective services to health care organizations since 1979. RWHC owns and operates 43 rural acute, general medical-surgical hospitals. The cooperative's emphasis on developing a collaborative network among both freestanding and system-affiliated rural hospitals distinguishes it from alternative approaches. RWHC offers a variety of programs and services to its members as well as to other clients across the nation. RWHC started as a co-op insurer that also provided technical and administration support to rural health care organizations, but sold the health insurance operation to BCBS and now focuses on developing and managing a variety of products and services such as workforce development, coding consultation, legal services, payer contract consulting, and development of a network for payer-provider contracting. Tim Size, RWHC's executive director, has been a nationally known expert in rural health for more than 30 years.

IV. IMPLICATIONS AND RECOMMENDATIONS

A. A New Vision for an RCHS in the Present Era

A contemporary RCHS could embark on the originally envisioned path and develop as an insurance cooperative. To expand insurance options (framework pathway 1), the RCHS would need to offer a plan or plans through the individual and small group ACA Marketplace. To increase coverage, the RCHS plan would need to entice uninsured individuals to purchase insurance, or small businesses to begin offering coverage to their employees. An RCHS Medicaid MCO plan could benefit the community if it were able to increase funding retained in rural health care, by either paying providers more or investing more in the health care system than other Medicaid MCOs (framework pathway 2). An RCHS plan could also benefit the community by operating more efficiently and generating more value than other MCOs currently operating in the rural communities. However, the challenges of providing insurance in rural communities, plus the significant change in the insurance landscape and coverage options since the legislation was enacted in 1997, together suggest that a new, cooperative insurance plan for rural Texas probably would not be the most fruitful incarnation of an RCHS in the present era.

An alternative vision for a contemporary RCHS would be as a cooperative, membership-based organization operating in the space between providers and payers, to the benefit of both. The need for technical expertise to assist with the development of collaborative relationships, formal organization, technology design, data analysis and grant-writing has never been greater. The formation of provider networks (in whatever form they take) that meet the needs of rural residents would also make it easier for insurers to enter these areas. An entity particularly focused on helping rural providers transition to value-based care will result in more efficient, higher-quality care and more financially viable rural health care systems. The current statute enabling an RCHS is written broadly enough to support such an entity without amendment.

Organizationally, this newly reconstituted RCHS would still be incorporated as a non-profit, likely a 501(c)4 under the Internal Revenue Code. Bylaws and other organizational issues would not change from the original plan, however, the new RCHS would likely file with TDI as third-party administrator, rather than an HMO or health insurer. The RCHS could still maintain the exemption for the Tort Claim Act and be allowed to enter into inter-local agreements. The CINs operating downstream from the RCHS would be separately incorporated non-profits (likely 501(a) organizations of physicians).

Such an organization could:

- Provide support for the development of rural ACOs and CINs. This would include:
  - Data support, including data aggregation and population health analytics
  - Assistance in contract negotiations with insurers for value-based arrangements
  - Utilization management, care management and other quality improvement programs needed for value-based contracts
  - Sharing best practices in clinically integrated care across providers
- Provide support for the development of rural Accountable Health Communities and Accountable Communities for Health
- Offer additional shared administrative, legal, technical, and financial services based on demand
- Seek and serve as a backbone/umbrella organization for funding from private, state, and federal sources (e.g., the Centers for Medicaid & Medicare Services)
- Provide a platform for innovation and experimentation to create what works for rural Texas

Value-based payment models are becoming ever more prevalent, abetted by federal efforts to shift health care reimbursement away from expensive fee-for-service, which rewards volume over value, to payment strategies that reward outcomes while at the same time disincentivizing unnecessary, low-impact care. Many stakeholders interviewed noted that in general, rural providers are not currently structured to be able to successfully participate in risk-sharing arrangements due to having too small a volume of patients. The solution is for rural providers to create networks that will increase volume, reduce fluctuation in outcomes, and increase the likelihood of meeting performance goals.

Unfortunately, rural providers are often at a disadvantage relative to their urban counterparts when it comes to developing the relationships and formal structures needed to participate in value-based care arrangements because they frequently lack (1) experience and expertise in developing these relationships, (2) the financial cushion needed to invest in the technical infrastructure needed to capture data on performance, and (3) the technical capacity to analyze the data, implement quality improvement efforts and seek funding to support these efforts. However, several organizations in other states have addressed these shortcomings and expanded the provision of value-based care into rural areas in ways that are financially sustainable. (See the "Models from Other States" section for examples.)

Due to the size of our state and the diversity of its populations, the rural context in Texas – as a number of stakeholders have stated – is varied. However, rural residents tend to value their independence and to put a high value on trusted relationships. Rather than attempt to create one statewide solution that meets all needs, an RCHS can work in partnership with communities to design solutions that work for each.

B. Complementary strategies to increase rural health care access and value

An RCHS that supports a successful and fruitful transition to value-based care in rural Texas, provides other valued services that help to increase the health care system viability, and amplifies the voice of rural providers will help address some of the key issues facing rural health care systems. However, an RCHS alone is by no means the complete answer to ensuring access to quality care in rural Texas communities. Through our investigation of the potential for RCHS to benefit rural

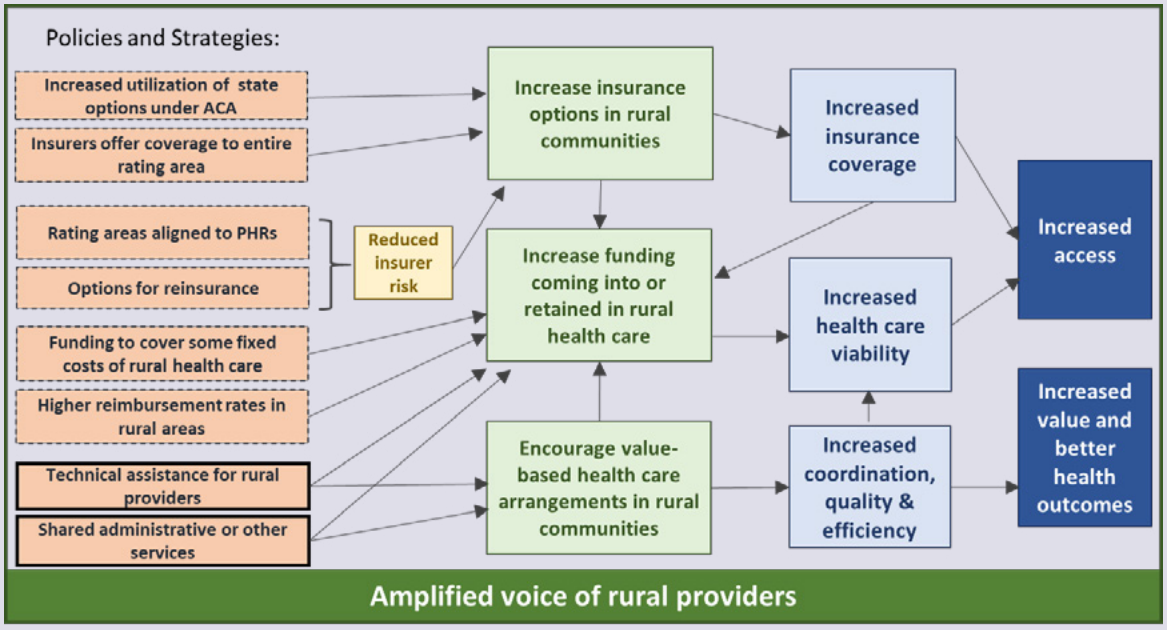

Figure 11: Potential Policies and Strategies to Increase Rural Health Care Access and Value
Note: The solid borders on the orange boxes indicate recommended strategies for an RCHS in the present era.

Texans, we identified a set of complementary strategies that have the potential to help drive improvement in rural health care and make an RCHS more successful. These strategies were incorporated into the initial conceptual framework presented in Section II. The resulting expanded framework is shown in Figure 11. These complementary strategies are described below.

1. Align insurance rating areas with Texas Public Health Regions

Myriad regional divisions have developed over the years to serve different purposes, and with varying degrees of intentionality. Aligning regions that relate to health insurance, health care networks, and public health could help to facilitate regional alignment across sectors that impact health and facilitate easier entry into rural health insurance marketplaces (and thus increase competition). In 2011, the Texas Department of Insurance (TDI) made a decision to align new network adequacy regions for PPOs with the existing Texas Department of State Health Services' (DSHS) Public Health Regions (PHRs) (see Figure 12). This smart approach should be expanded to other regionalization approaches to increase the number of insurers and more competitive processes in rural areas.

Specifically, TDI could create insurance rating areas that nest within the PHR/TDI network adequacy regions. As shown in Figure 13, the existing 25 MSA rating areas fall cleanly into the 11 PHRs. Some of the 25 rating areas could be consolidated (e.g., Midland/Odessa), and in others where there are variations in costs within very large urban areas (DFW and Houston), the rating areas could be split. The existing rural rating area 26 would be eliminated, and rural counties within the PHRs would become part of the regional rating areas. One potential example of such a realignment, with rating areas nested within PHR regions, is given in Figure 14.

This regional realignment is logical from a cost perspective as these rural counties flow patients to the closest MSA for specialty services, and the costs of care in those MSAs drive much of the premium dollars. Also, alliances between rural providers within a region and their MSA counterparts would facilitate the creation of rural or regional ACOs. It also makes intuitive sense to organize rating areas around the urban centers where hospitals and specialty care providers are likely to be based. Finally, distributing the rural counties across all rating areas would more evenly distribute risk posed by less healthy populations in rural areas.

In addition to a TDI rating area alignment with the PHR and network adequacy regions, Medicaid regions could also be aligned with PHR/TDI network regions. This alignment would allow providers and provider organizations such as ACOs to operate consistently for Medicaid, the ACA, and the small employer markets, giving them more opportunities to scale to sufficient size to be viable (See Figure 15). Additionally, the 22 Regional Advisory Councils (RACs) responsible for coordinating trauma and other emergency services within the 11 Public Health Regions could be utilized to facilitate other regional collaboration in slightly smaller geographic areas, such as evolution of the Regional Health Partnerships under recent 1115 waivers for Medicaid funding, and other activities.

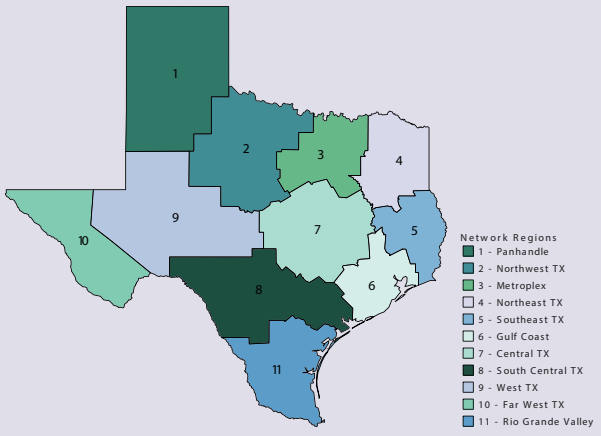

Figure 12. Texas DSHS Public Health Regions and TDI Network Adequacy Regions

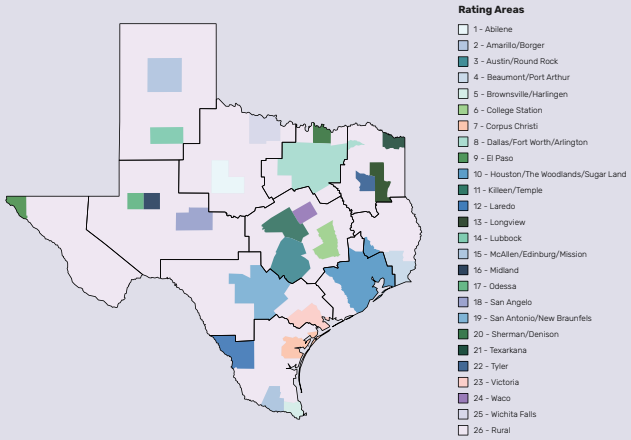

Figure 13. TDI Rating Areas and Public Health /Network Adequacy Regions

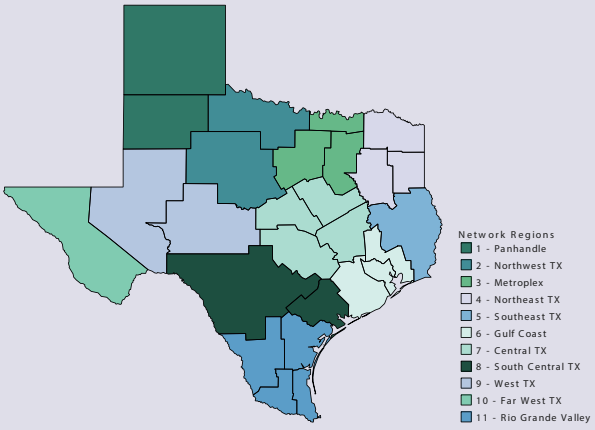

Figure 14. Example of Proposed Rating Areas aligned with Public Health/ Network Adequacy Regions

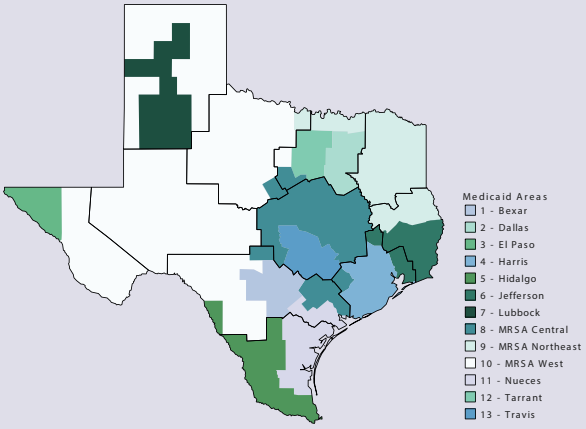

Figure 15. Medicaid Service Areas and Public Health/Network Adequacy Regions

Returning to the topic of an RCHS, these regional realignments would support the work of the RCHS in developing rural value-based care arrangements. Figure 16 illustrates one possible RCHS structure (based on rating areas organized around PHRs). In this illustration, the RCHS operates between multiple health insurers and MCOs and providers, supporting a CIN of rural and other providers within each of the PHRs to create new value-based arrangements. One CIN may act as a Medicare ACO, as part of the network for one or more Medicare Advantage plans, commercial health plans, and Medicaid managed care plans, thus creating the scale needed across multiple MCOs to succeed in value-based contracts. Not all PHRs may have an RCHS-supported CIN, and one CIN may span two or more regions, but coupled with the earlier recommendation that managed care organizations should operate throughout an entire PHR, the PHR-based CIN supports both the community health and the needs of the MCOs.

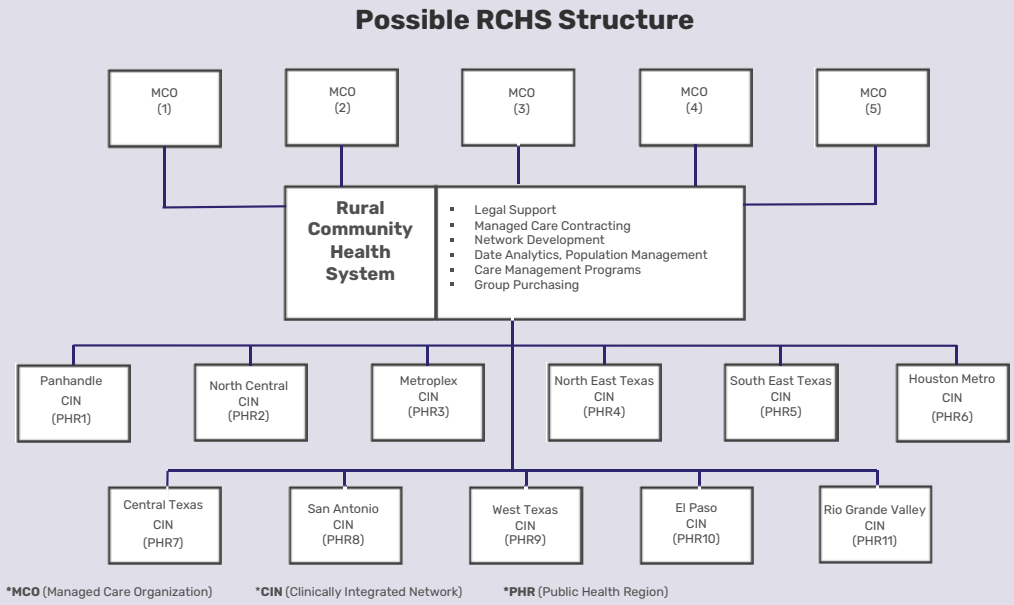

Figure 16. Example of a potential RCHS Structure

2. Require insurance carriers to operate in the entire rating area

To further improve competition and regional alignment, we recommend TDI require HMOs and PPOs to operate at the PHR-aligned rating area level rather than at a county level as now allowed. Currently, insurers can choose to operate only in urban counties. Requiring insurers to operate in the surrounding counties within the entire PHR/rating area region could stimulate growth in insurance competition in rural counties.

While this recommendation poses potential benefits to rural counties in terms of increased number of insurance plans available to rural providers and residents, there is a possibility that requiring a new insurer to operate in a broader rating area may inhibit new entrants into Texas. However, this policy would only require a new entrant to cover the most adjacent surrounding counties (10 or fewer) and should not pose a huge additional burden on new entrants. Further, if there is an inhibiting force, it would only affect the number of insurers in urban areas, as new entrants are drawn by the larger urban markets. The tradeoff for potential benefit to rural counties in terms of increased options and competition would be worth any potential impact on competition in urban counties and could help address the current geographic disparities in health insurance options between rural and urban counties.

3. Increase Utilization of State Options Under the ACA

The ACA passed in 2010 included several provisions aimed at ensuring all citizens had access to affordable insurance coverage. The new American Rescue Plan passed in March 2021 increased the financial incentives for states to expand participation in the ACA. Much could be done by legislation and/or TDI rule-making to expand coverage via the state flexibility provisions of the ACA. The following is a list of some options, available to the state, that could increase the number of Texans, including rural Texans, who have access to affordable health insurance.

a. Increase the number of people who are eligible for coverage under Medicaid

The ACA gave states the option to provide Medicaid coverage to all individuals and families living below 133% of the federal poverty level (FPL). In much of the U.S., Medicaid has become a critical source for health coverage for rural populations in states that enacted this provision, largely due to the inability of small employers to afford to offer coverage [23]. Studies show that increased coverage through Medicaid expansion has had positive effects on access to care, utilization of care, and health care affordability [39]. A recent report by researchers at the Texas A&M University Bush School of Government estimates that if Texas joined

the 38 other states that expanded Medicaid (Figure 17) [40], over 1.2 million additional Texans would become eligible for health care coverage, including 132,000 rural county residents. Additionally, of the $5.4 billion in estimated annual federal funding, over $500 million would be allocated to rural counties [41]. Texas could also draw down ACA funds with a 90/10 federal match via an 1115 waiver-based coverage expansion, allowing additional flexibility not available in a traditional Medicaid expansion in a uniquely Texan coverage plan for low-income Texans who are not eligible for other ACA subsidies.

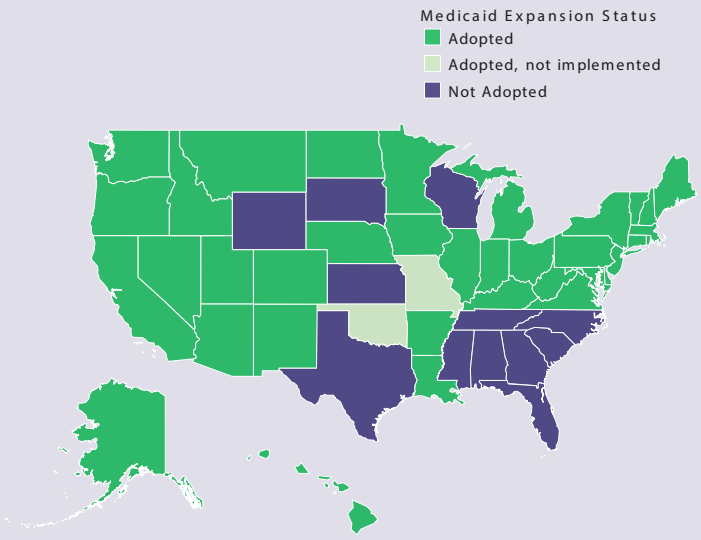

Figure 17. Status of State Medicaid Expansion Decisions
SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated February 4, 2021. https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

b. Encourage greater enrollment in subsidized ACA-compliant "Marketplace" plans.

About 1.3 million Texans are currently covered by individual ACA policies that include federal subsidies. However, a 2019 study by the Kaiser Family Foundation estimated that 37% (nearly 2 million) additional uninsured Texans are eligible for ACA subsidies that are available to families earning less than 400% of FPL (about $50,000 for an individual, $100,000 for a family of 4) [42]. Outreach activities can increase awareness of options and benefits, reduce confusion about eligibility, and ultimately decrease the number of uninsured Texans. Such outreach efforts could be specifically focused in the rural counties that have been identified as having the highest prevalence of uninsured adults.

c. Make use of the ACA 1332 waiver option

The ACA allows states to help lower the cost of ACA-compliant health plans via a reinsurance program. Fourteen states have already enacted 1332 waiver reinsurance programs, primarily through an "invisible" reinsurance pool that reimburses insurers for the cost of specific high-cost claims, allowing rates to be set 5%-15% lower than without the reinsurance in place. TDI is currently studying options for such a 1332 waiver to create a reinsurance option in Texas [43].

d. Create a State-Based Exchange under the ACA

Under the ACA, states can create their own exchanges with modifications to plan designs, premium rates, and subsidies that could be used to make insurance more affordable and be used as an avenue for increased marketing and advertising of ACA-compliant health plans (no pre-existing conditions exclusions, broad list of covered services, etc.). A state-based exchange, as implemented by several other states (e.g., Pennsylvania) would probably be able to operate at lower costs than the federally facilitated marketplace Healthcare.gov, and the savings could be passed to consumers or used to fund the state share of the reinsurance noted above. A state-based exchange would also be better positioned to encourage enrollment of the many people eligible for subsidies not currently enrolled (as noted in b) above.) It could also be a more active purchaser and negotiator with insurers than Healthcare.gov.

V. POTENTIAL NEXT STEPS

A re-envisioned RCHS is a real possibility as an organization that supports rural providers' voices and financial viability by facilitating network development, contracting and successful implementation of value-based contracts. As such, we would suggest the following next steps:

1. Widely distribute this report to appropriate stakeholders, policymakers, and the media.
2. Work with the Texas Governor's Office, TDI and HHSC to solicit their support and input for a contemporary RCHS organization.
3. Identify regions with local champions and strong interest in working with the new RCHS.
4. Seek funding through a state appropriation and/or philanthropic sources to reconstitute a board, hire leadership staff, and engage in other start-up activities.
5. Work with regional stakeholders to develop details of the operation, goals and focus.
6. Provide additional details to TDI, HHSC and appropriate legislative committees regarding complementary recommendations in this report.

A present-day RCHS, utilizing the existing statutes that authorize its establishment, can operate to the benefit of providers and insurance plans by facilitating the transition to value-based care and the entry of health insurance companies into rural communities. In doing so, the RCHS can help strengthen the financial viability of rural providers, increase access to insurance options, and improve rural health care value and outcomes.

Acknowledgements

This project received financial support from the Episcopal Health Foundation, the Texas Association of Family Physicians, the Texas Organization of Rural and Community Hospitals, the Texas Medical Association, and the Texas Hospital Association. In-kind support provided by the University of Houston College of Medicine.

The following advisors provided critical guidance and insights throughout the course of this project:

- Nora Belcher, Texas eHealth Alliance
- Nancy Dickey MD, Texas A&M Rural and Community Health Institute (ARCHI)
- Kay Ghahremani, Texas Association of Community Health Plans
- Mike Morris PhD, The University of Texas at Tyler
- William Sage MD JD, UT Austin Dell Medical School

About the Texas Health Improvement Network

The Texas Health Improvement Network (THIN) is a multi-institutional, multi-sector initiative established by the Texas Legislature in 2015 to address urgent health care challenges and improve the health care system in this state. THIN is administered by The University of Texas System, through the Office of Health Affairs, Population Health. For more information, please visit: https://utsystem.edu/texas-health-improvement-network

Suggested Citation:

Nehme E, Janda K, J Meier, K Wilson, Lakey D. 2021. The Potential for a Rural Community Health System to Improve Rural Health Care Access and Value. Austin, TX: Texas Health Improvement Network/UT System Population Health.

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APPENDICES

A. Quantitative Data Sources

Source	Analysis
Texas Demographic Center https://www.demographics.texas.gov/	Population estimates and age distributions
National Center for Health Statistics on CDC WONDER database	Age-adjusted mortality rates for top five causes of death
U.S. Census Bureau; American Community Survey, 2018 American Community Survey 5-Year Estimates, Table B27010	Insurance coverage status Insurance coverage by source
Kaiser Family Foundation analysis of data from Healthcare.gov and a review of state rate filings https://www.kff.org/private-insurance/issue-brief/insurer-participation-on-the-aca-marketplaces-2014-2021/	Individual plan options (ACA market-place participation)
Kaiser Family Foundation analysis of CMS MA Landscape Source file, released October of each year https://www.kff.org/medicare/state-indicator/plans/	Medicare advantage plan options
Texas Department of State Health Services https://dshs.texas.gov/chs/hprc/tables/2019/PC19.aspx	Ratio of people per primary care provider
Center for Medicare & Medicaid Services https://data.healthcare.gov/dataset/QHP-Landscape-PY2020-Individual-Medical-Zip-File/kxp2-7zyr/	Insurance premiums in the 26 rating regions used by Texas Department of Insurance (TDI) and CMS for rate-setting for individual and small group insurers
Insurers' Annual Small Employer Health Benefit Plan Reports (Form LAHR 335) to Texas Department of Insurance (obtained by request)	Small employer covered lives in Texas 2015-2019

B. Key Informants and Roundtable Meeting Panelists

The following individuals participated in interviews for this project:

- Tom Banning, Executive Director, Texas Association of Family Physicians
- Shannon Calhoun, Aledade
- Sherri Dasco, RCHS legal counsel
- Helen Kent Davis, former RCHS board member and current Associate Vice President, Governmental Affairs, Texas Medical Association
- Trenton Engledow, Director, Texas State Office of Rural Health
- Kay Ghahremani, former HHSC project manager for the RCHS, current Executive Director, Texas Association of Community Health Plans
- John Henderson, former RCHS board member and current Executive Director, Texas Organization of Rural and Community Hospitals
- Pati McCandless, VP State Health Policy and Shara McClure, Divisional Senior VP Health Care Delivery, Health Care Service Corporation (Blue Cross Blue Shield)
- Richard Miltenberger, Executive Director, Mountain Healthcare Coop
- Nick Soman, Chief Executive Officer, Decent
- Torlin Wade, current head of the ORHCC and early leader of CCNC
- Michael Wilson, Chief Executive Officer, Healthcare Highways

The following individuals served as panelists for the December 15, 2020, expert panel and roundtable meeting:

- Garth Vaz MD, Alliance Medicare ACO
- Shannon Calhoun, Aledade
- Tom Mueller MD, Texas Academy of Family Physicians
- Trenton Engledow, Texas Office of Rural Health
- Lucia Williams MD, TMA Rural Health Committee

C. RCHS-Enabling Legislation

1. SB 1246 - 75th Regular Session (1997)

Senate Bill 1246 amends the Insurance Code to establish a statewide rural health care system to arrange for or provide health care services on a prepaid basis to enrollees who reside in rural areas. The commissioner of insurance is required to designate as the system one organization that meets the requirements imposed by the Texas Health Maintenance Organization Act, and the system is required to be a nonprofit corporation composed of a combination of two or more rural hospital providers. The system is required to arrange for local health care provider networks that are composed of not more than 19 counties to deliver services to enrollees residing in the rural areas served by the system participants. If local providers are unable to provide services, the system is authorized to contract with health care practitioners who are not local providers. To the extent consistent with federal law, the state is required to award to the system at least one Medicaid managed care contract to provide services to beneficiaries in the rural areas served by the providers participating in the system. The system is required to meet established standards for providing care to Medicaid beneficiaries, and the Medicaid contracting agency is required to reimburse the system at the state-defined capitation rate for each service area in which the system operates.

The act takes effect September 1, 1997, except that the insurance commissioner is required to adopt rules to implement the program by January 1, 1998, and the statewide rural health care system is required to begin offering services by March 1, 1998, unless the system determines that it is not prepared to fulfill its obligations by that date.

Available at: https://capitol.texas.gov/BillLookup/Text.aspx?LegSess=75R&Bill=SB1246

2. HB 1194 - 76th Regular Session (1999)

Enrolled Bill Summary:
House Bill 1194 amends the Statewide Rural Health Care System Act to require the commissioner of insurance, when designating rural areas, to consider any area that is delineated as an urbanized area by the federal census bureau and: (1) is contiguous with and not more than 10 miles away from a rural area; (2) is sparsely populated compared to areas within a 10-mile radius that are delineated as urbanized areas by the bureau; (3) has not increased in population in any single calendar year in the seven years before the commissioner makes the designation; and (4) in which emergency or primary care services are limited or unavailable and would be made materially more accessible by allowing access to care in a contiguous area that is eligible to participate in the system.

House Bill 1194 also modifies that act to establish that the system arrange for or provide health care services generally and not necessarily on a prepaid basis. If the system arranges for or provides a health service on a prepaid basis, it must obtain a certificate of authority under, and meet the requirements of, the Texas Health Maintenance Organization Act, with certain exceptions allowed by commissioner rule. The act also eliminates the requirement that the board appoint an advisory committee but allows the board to do so.

Available at: https://capitol.texas.gov/BillLookup/BillSummary.aspx?LegSess=76R&Bill=HB1194

3. SB 1394 - 77th Regular Session (2001)

Senate Bill 1394 amends the Insurance Code to allow the statewide rural health care system to sponsor as well as provide and arrange for health care services for programs in rural areas that are not subject either to certain laws requiring coverage or the offer of coverage by a particular health care provider or to certain uninsured or indigent care initiatives. The bill requires 12 of the system's board of directors to be appointed in accordance with its bylaws rather than by the governor. The bill adds that the board may contract for management and support services as well as for administrative services. The bill allows the commissioner of health and human services to use the system for a voluntary pilot or demonstration program that evaluates the use of an insured model for beneficiaries of a medical

assistance program in a rural area not included in an existing Medicaid managed care pilot program and that incorporates prevention and disease management principles or study of the use of promotoras. Senate Bill 1394 modifies the goals of the system to include an emphasis on disease management as a significant attribute of a successful health care organization.

Available at: https://capitol.texas.gov/BillLookup/BillSummary.aspx?LegSess=77R&Bill=SB139

D. Texas Managed Care Service Areas