In the Shadows of Reform – The translation of Rural Health and the reality of the ACA in Rural Tennessee

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The Medicaid Expansion Problem

The Patient Protection and Affordable Care Act

In 2010 President Barack Obama signed into law the Patient Protection and Affordable Care Act (ACA), opening the flood gates to a myriad of regulations, reforms, and initiatives all aimed to fundamentally change the deliverance and experience of health care in the United States. In rural America, the nuances of the ACA not only exist as an enigma to many individuals living in the region who are direct recipients of the law's many provisions, but also the success or failures of the law in these regions remain largely unexplored and unknown, holding severe consequences for lawmakers. A recent example of this failure is exemplified in the Tennessee General Assembly decision not to expand Medicaid, and a discussion of these circumstances provides a place to begin to understand the nature of the problem.

The ACA ostensibly seeks to expand health coverage to nearly every American as well as to decrease the cost of health insurance for the average American. The law originally sought to accomplish these goals by A) forcing individuals, who do not receive coverage from their employer or through a government program to obtain health coverage through the “individual mandate” (The ACA accommodated for this influx of individuals by establishing exchanges where individual health insurance could be purchased and providing subsides to such individuals purchasing insurance on these exchanges) and B) increasing the amount of individuals receiving insurance through a government program through the expansion of Medicaid.

However, the objectives of the law and the law itself became fundamentally altered in 2012 when the Supreme Court of the United States in the landmark case National Federation of Independent Business vs. Sebelius held that although the individual mandate is a legitimate use
of congress’s power as founded in the taxing power of the constitution, the provision providing for the compelled expansion of Medicaid in all states could not stand. Following the decision, states were left to decide whether or not they would choose to voluntarily expand Medicaid.

Tennessee’s Actions towards the Expansion of Medicaid

During the first week in February 2015, the Tennessee Senate Committee on Health and Welfare voted 7 – 2 to oppose the expansion of Medicaid, striking down SJR0001 ‘Insure Tennessee.’

The provision to expand Medicaid provides that the federal government will cover the expansion initially in full until 2016 and then scale back funding to 90% of the cost of expansion gradually by 2020. The ‘Insure Tennessee’ Plan, the governor’s proposed plan for Medicaid expansion, is unique in this respect as Hospitals and Providers across the states voluntarily agreed to pay higher taxes in order make up the reduction in federal funds.1 The logic behind these organizations voluntarily paying increased taxes to cover the state's share of the bill in a shared state-federal program, is to ensure the increase in Medicaid funds by the federal government at a marginal cost to these organizations.

The Effects on Rural Health

In order to provide funding for the expansion of Medicaid, the ACA directs funding away from disproportionate-share hospital payments (DSH), payments to hospitals serving a disproportionate share of uninsured patients, under the logic that these formally uninsured individuals would receive coverage through the expansion in Medicaid, leaving hospitals with fewer patients paying little or none of their cost of care. However, Tennessee has chosen not to

1 Provider taxes are to cover up to 6%. Hospitals are looking to cover 4.52%
expand Medicaid and will nonetheless simultaneously receive fewer federal dollars in disproportionate-share payments than before to cover these poor, uninsured Tennesseans.

According to a statement from the Tennessee Justice Center released before the General Assembly’s decision, 28 hospitals are now at risk of closing with the potential to leave 21 rural counties in Tennessee without a hospital. These are hospitals that had previously relied heavily on DSH payments, and are now forced to continue to provide care to communities with minimal other accessible forms of care on tighter budgets.

The Problem

Rural populations in the United States are affected both uniquely and acutely by Health Care reform. Given this particular reality characterizing the relationship between health care reform and rural health, the importance of a substantive understanding of rural health is imperative for the future of health reform. However, often this reality of health in the rural south is eclipsed in the greater political conversations regarding health reform. My project, *In the Shadows of Reform – The translation of Rural Health and the reality of the ACA in Rural Tennesseee*, sought to ask then, how (if at all) is health and life, as lived in rural Tennessee, conceptualized and subsequently translated into a particular vocabulary that is able then to enter into a greater political conversation regarding the status and progression of health reform? This paper will seek to survey this problem and this project focusing in particular on the Tennessee General Assembly and two rural Hospitals: The Cumberland River Hospital in Clay County, TN and the Rhea Medical Center in Rhea County, TN.

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2This number should be read in reference to a total of 54 counties in TN, designated as rural (38.8% of rural counties). http://www.tnjustice.org/wp-content/uploads/2013/02/Medicaid-Expansion-is-a-Lifeline-for-Tennessee%E2%80%99s-Rural-Hospitals-FINAL-unbranded-2-6-13.pdf
Tennessee lawmakers approached the passage and gradual implementation of the ACA with much skepticism and doubt. The now Lieutenant Governor and Speaker of the Senate (ex officio), Ron Ramsey, referred to the ACA as unconstitutional and ‘a disaster for Tennesseans.’ Although the exact motivations for such opposition is outside of the scope of this paper and are perhaps unknown to anyone but the members themselves, the ACA occupied in a state of general resistance in the minds of most members. The first official action taken by the General Assembly in response to the ACA occurred on February 7, 2011 just short of a year following the signing of the ACA into law, when Rep. Glen Cassada introduced HB 328. The bill (and its senate equivalent SB 815) required the Commissioner of the Department of Health (DOH) to report on the implementation, costs, benefits, and burdens to the State regarding specific elements of the ‘federal Patient Protection and Affordable Care Act’ and the ‘Health Care and Education Reconciliation Act’ to the House Health and Human Resources Committee and Senate General Welfare, Health and Human Resources Committee ‘on or before January 31, 2012.’ At first glance this piece of legislation appears rather innocent, an example of a state legislature seeking to perform its own due diligence on tracking the effects of a piece of legislation with a direct impact on the state. However, the legislation assumes a rather curious character when one begins to explore the ‘specific elements’ the legislation targeted. The text of HB 328 mentions specifically that the commissioner will address the following:

(1) The authorization of grant awards by states to providers who treat a high percentage of medically underserved populations or who are located in health

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3 https://www.memphisdailynews.com/editorial/ArticleEmail.aspx?id=48771
professions shortage areas under § 10501(k) of P.L. 111-148;

(2) The effects of budgetary expansions of the Community Health Center Fund under § 10503 of P.L. 111-148;

(3) The availability of grants to implement the Elder Justice Act under § 6703 of P.L. 111-148; and

(4) The interaction of Community Living Assistance Services and Supports Program under title VIII of P.L. 111-148 with the program of home and community-based services available under Tennessee Code Annotated, Title 71, Chapter 5, Part 14.

Curiously, in a state where the majority of counties are designated as ‘rural,’ the term is completely absent in the vocabulary of the General Assembly. However, a criticism based on the absence of a single word would not truly represent a fair critique of the bill, i.e. simply because the term ‘rural’ is not present in the bill’s text does not equate with the notion being absent in functionality. Yet, this deeper contention exposes a much starker realization concerning the notion of rural at the early stages of the ACA in the minds of Tennessee’s lawmakers. Section one does indeed mention ‘health professional shortage areas,’ a phrase that both legally and logically refers to rural areas. However, the text specifically limits the commissioner’s charge to testify in regards to ‘grant awards by states.’ These ‘grant awards’ as qualified by the rest of the bill’s text could only really be referring to the aforementioned Disproportionate-Share Payments (DSH) that are reduced under the ACA, to be replaced by an increase in Medicaid benefits. In essence then, the bill would have limited the conversation regarding rural health to the problem of potential closures, yet would eclipse the correlate solution included within the legislation. Thus, the bill did not simply ignore the problem of ‘rural health’ but rather immediately articulated the notion as political fodder. The bill died on the house floor, caught in the

4 http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/primarycarehpsaoverview.html
crosshairs of the amendment process, yet orients the General Assembly’s position as understanding the ‘rural’ as a mere political tool.

*King v. Burwell: A change to modus operandi?*

As the ACA further began to gain traction, a major problem arose nationally under the law’s language, cumulating in the case *King v. Burwell*. A key part of the Affordable Care Act was to provide subsidies to individuals who were then required to purchase health insurance under the individual mandate and more specifically through health exchanges set-up by either individual states or the federal government. The case centered on the interpretation of a key phrase in the law, that is that subsides for insurance coverage will be provided for plans purchased from an “Exchange established by the State under Section 1311.” The IRS interpreted this phrase to mean “Exchange established by a State under Section 1311, or an Exchange established by the Federal government under Section 1321.” The correct interpretation of this phrase is important because it is in Section 1401 of the ACA, where the clause is found that determines who is eligible to receive subsidies to pay for their insurance. As the case began to unfold, in Tennessee Sen. Kesley introduced SB0072 (later introduced in the House as HB0061), a bill that prohibited the state from establishing an exchange. Again the bill omits any reference to ‘rural’ health, choosing rather to berate the IRS.

“It’s a good bill and I would like to see it passed.”

– Angie Allen Director of Rural Health for the Tennessee Department of Health

The two pieces of legislation described in the previous section in addition to the committee votes on ‘Insure Tennessee’ represent three of the major actions taken on behalf of the General Assembly vis-à-vis the Affordable Care Act. Although such measures do not comprise the entire
spectrum of action taken on the matter, they do form a representative sample. Provided such is the case, these actions demonstrate a clear failure of the General Assembly to articulate an understanding of the ‘rural’ in reference to health reform. Despite calls for either chamber to bring the Governor’s “Insure Tennessee” plan to a floor vote, both the Senate and the House have resisted. Given that only a handful of members ever formally placed votes on the measure, when I inquired for comments on the matter I received either no reponse or was declined by every member I contacted.

In light of this fact, I turned my attention to the ‘demand’ side of the problem. I visited two hospitals at risk of closing, The Cumberland River Hospital in Clay County, TN and the Rhea Medical Center in Rhea County, TN, meeting with both administrators and staff multiple times throughout the summer of 2015 to discuss the needs of their respective communits and to discuss the role of health reform in advancing or hindering such objectives. Emerging throughout the course of these conversations was a rather nubulous construct of ‘the rural’ alongside unique and pressing needs for reform.

*Rhea County Medical Center*

Rhea Medical Center is located on US-27 only three miles from downtown Dayton, TN, a city made famous by the notorious ‘Scopes Trial’ of 1925. The city itself sits nearly halfway between Chattanooga, TN and Knoxville, TN, but is positioned far enough west as to be far off from Interstate-75, the link between the two larger cities. The city was home to a mere 7,395 people in 2014, with nearly a tenth of such number being comprised of college students attending the local Bryan College, named after the notorious Williams Jennings Bryan. The hospital facility itself appears as a rather, impressive structure, built in 1957 as a public corporation with the

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expectation that the center would serve the city of Dayton and the surrounding rural areas by providing an emergency room and surgical center, as well as a variety of inpatient services. The hospital is a Critical Access Hospital, a special designation afforded to certain rural hospitals by the Centers for Medicare & Medicaid Services (CMS), that allows them to be reimbursed at a higher rate than most hospitals.

The hospital, channeling some rather odd nature of Dayton, has failed to rise to prominence. I sat down with Kenneth Croom, the current Chief Executive Officer of the hospital to talk about the hospital in detail. He explained to me that “Chattanooga is just over those hills” referencing the view that had comprised my one and half hour drive along US-27 through Tennessee’s meandering mountains. “[For] Anything major that's where they [citizens of the town] go, Chattanooga or Nashville.” There was a curious cadence in his voice as to the way he came to express that for most major operations, local residents would rather drive to Chattanooga than opt to have the procedure ‘here at home.’ Mr. Croom explained that most of those procedures could be performed at the center, but noted that most of the physicians’ primary offices are in Chattanooga and patients ‘don’t really seem to have a problem driving down there.’ That said, Mr Croom was quick to point out the growth the hospital had experienced over the last few years, specifically the near 60% increase in surgical procedures over the past few years thanks to a new partnership with an area surgeon who works in Chattanooga.

The hospital felt empty. Perhaps by virtue of its large size being occupied by only a few active units or perhaps because of its once high promise now a stark reminder of the state. I talked to Mr. Crooms at length in regards to the challenges his hospital was facing, and quickly transitioned into a conversation on Medicaid expansion. He noted that, although he had some political reserve, he had indeed talked to his Senator about the matter, stating that “it’s always
good to be able to bill, and medicaid expansion would do that, and I think he knows that.” When I asked Mr. Crooms about how much he kept up with the legislation, he replied “Very little, I just simply don’t have the time.”

Rhea Medical Center is located in Senate District 12 and is represented by Senator Ken Yager. Senator Yager does not serve on the Committee on Health and Welfare and has never placed a vote on Insure Tennessee, nor gone on the record regarding the matter. Mr. Croom, under certainly less political pressure, lacked the time to play the political game needed. Rather his priority at the end of the day is to keep the doors of the hospital open. Aware of the ramifications Insure Tennessee would have in terms of providing a payor base, it still “would not change anything overnight.” Mr. Crooms is right. At the time we spoke, his top priority was evolving the surgical practice to a full-time operation.

Rhea Medical Center serves as a curious example of a rural Tennessee Hospital operating in the shadow of health reform. The notion that medicaid expansion, while understood, could save the hospital was still functionally a completely foreign concept. Dayton, TN has always been a city that sought to be put on the map. Medicaid expansion would not present a clear avenue to growth, rather it was a slight change to a policy that was not at the forefront of the administration’s mind.

*The Cumberland River Hospital*

The Cumberland River Hospital is located on the southern side of Celina, TN (pronounced CeLINEa), a town of 1,485 people in north-central Tennessee, some five miles from the Kentucky-Tennessee border. When I visited in the summer of 2015, the hospital was in the
process of becoming (and just recently became in September 2015) certified by CMS as a
Critical Access Hospital (CAH), an accomplishment they were proud to boast.

I made multiple visits to the Celina community, speaking extensively with the Hospital
Administrator and others involved in the delivery of health care in the region. Each time I sat
down to talk with the administrator, she would always begin by inquiring as to how I drove in.
Asked once there is nothing odd, I guess, about this question, but I found it curious how despite
my answer never changing, “From the west on 52” I would say, she would continue to ask the
question.

My conversations with the administrator centered on the immediate needs of the hospital. In
exchange for talking to me about the status of health reform, I volunteered in assisting her in
reading and drafting the hospital’s Community Health Needs Assessment (CHNA), a document
required by the ACA to be submitted every three years by non-profit hospitals in order to retain
their non-profit status.

When I turned the conversation to the issue of Medicaid expansion, she could not recognize the
program, Insure Tennessee, by name, but was familiar with many of the provisions. I asked her
what she thought of Medicaid expansion and instantly she came to endorse the idea, but quickly
dismissed the possibility of the program becoming law, commenting “that the Governor just does
not want to get it done.” On April 14, 2014 Governor Haslam signed HB 0937, preventing the
Governor from expanding Medicaid under the ACA without the express consent of the General
Assembly.6 As in the previous examples in this paper, the term ‘rural’ is not present within the
legislation. Although one could argue the Governor played a role here in limiting the likelihood
of expanding Medicaid, the fate of Insure Tennessee, the Governor’s own program, it should be

noted, lies with the General Assembly, not with the Governor. Multiple times, however, the hospital administrator blamed the governor for ‘not doing anything.’

This attribution of failure to the governor I found to be rather curious, and should not be dismissed. The administrator understood the value of expanding medicaid being familiar with the particulars of reform. The Hospital had just been certified as a CAH, and she knew the possibilities expansion held. Yet she knew very little regarding the political process to make such reform a reality, despite admitting having gone to Nashville to speak in favor of the measure.

The state was failing her, and she as did the other administrator didn’t have the time to know why. On my last trip to Celina, I asked her why she would always asked me how I came. She replied, “You come the right way from the West, you see what this community is about.” There is one road driving into Celina, Route 52. From the west, the route is a 2-line country road winding its way through the hills of Tennessee. From the East, Route 52 is a highway, ‘Livingston Highway’ as it is named on Google maps. “You see that highway [referring to Route 52 eastbound] ruined us. It was supposed to open the way for new business to come-in, It didn’t. It opened up the way to leave. People used to shop downtown, now they don’t. They go to Walmart now. Same with health care, they (the ambulances) can leave, so they do.”

**Out From the Shadows**

This paper, and my entire project, began with a problem: despite the impact the ACA would have on rural health, the notion of ‘rural’ is absent from the debate. This problem poses fundamental questions as to the state of the current political process as able to sufficiently represent a populous. Reflecting on my experience with these two hospitals has shown that this problem extends much further than a question of representation. The ‘state,’ both as an articulation of the state apparatus and the state of Tennessee have found themselves in the middle of being in two
different worlds entirely. Just as the notion of rural is absent in the state process of health reform, is the state largely absent from the rural as someone capable of reform.

Epilogue – (04.29.16)

Following immense political pressure from Tennesseans across the state, Speaker of the House Beth Harwell in early April 2016 formed a ‘health care task force’ to generate a counter proposal to the governor’s plan, Insure Tennessee. On Monday April 25th 2016 the task force convened for the first time. No senators or democrats were present on the first day, yet this composition changed for day two. Although the plan presented to and by the task force had extensive ‘circuit breaker’ provisions that would terminate, should costs get out of hand, the plan closely resembles Insure Tennessee. Darin Gordon, the director of TennCare (the state’s current Medicaid program) presented to the task force the necessary requirements for the state to draw down federal funds.