PRIORITY STATE AND FEDERAL ISSUES FOR TEXAS RURAL HOSPITALS

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FEDERAL ISSUES

STEP-DOWN RURAL HOSPITAL SHOULD BE CREATED

As continued rural hospital closures are a certainty given declining rural population and revenue, coupled with increasing expenses, rural communities need a scaled down hospital option rather than having nothing if their hospital closes. Bills have been filed in Congress during previous sessions with no movement. Congress again needs to consider this. The step-down rural hospital concept is a common sense and viable option for struggling rural hospitals with extreme low inpatient volume. The "hospital" designation is necessary to maintain enhanced payments to offset low volume. Texas hospital consultants believe that several dozen highly vulnerable Texas rural hospitals now in financial harm's way could convert to this and continue to provide their communities limited hospital type services rather than face complete closure in the future. ***Congress must create a step-down rural hospital option to address the closure crisis and give vulnerable rural communities an option for emergency and other care.***

MEDICARE ADVANTAGE ENDANGERING CAHS

The private insurance alternative to regular Medicare known as Medicare Advantage (MA) is creating negative and presumably unintended consequences. As Medicare MA is actually third-party insurance, the MA companies attempt to negotiate lower payment rates in conflict with Critical Access Hospital (CAH) program requirements where regular Medicare pays 101% of the hospital's cost (99% with budget sequestration). Rural hospitals are then torn between accepting a payment that comes as a loss or refusing to treat elderly patients on MA that live in the same community. A second problem is that in the CAH program, Medicare pays a designated hospital the percentage of its overall eligible operating cost that matches the percentage of Medicare patients treated. However, the MA patients do not count toward this calculation and thus reduce the overall Medicare payments to the hospital. The presence of MA patients also reduces the amount of Medicare bad debt that is covered. ***Congress needs to mandate that CMS require MA companies to follow CAH payment rules or CMS should make up the difference with a cost settlement as they do in regular Medicare; and MA payments should be viewed as regular Medicare for purposes of CMS calculating a hospital's Medicare patient days.***

MEDICAID DSH REDUCTIONS

Federal Medicaid Disproportionate Share Hospital (DSH) payments to hospitals are scheduled for reduction in October 2019 through 2025 which will shrink a major funding source for many Texas hospitals. DSH is a program that reimburses hospitals for a portion of their uncompensated care expenses and annually pumps more than $1 billion in federal dollars into Texas Hospitals. Impacted Texas rural hospitals stand to lose $250,000 each on average in the first year of cuts. The Affordable Care Act assumed states would expand Medicaid thus reducing the number of uninsured patients, in turn reducing the need for DSH payments. However, following the Supreme Court ruling making expansion optional in states such as Texas that didn't expand Medicaid, hospitals are seeing a very small increase in the number of insured patients, yet their DSH

payments will soon decline. Congress must halt the DSH cuts and give consideration to legislation to limit reductions in states that did not expand Medicaid. There should be no cost to the federal government as non-Medicaid expansion states would receive continued DSH patients instead of Medicaid expansion payments. (Note – the ACA called for DSH reductions to start in 2014, but Congress on several occasions delayed implementation of scheduled cuts). ***Congress must act to stop the DSH cuts and should consider legislation permanently exempting non-expansion states like Texas from DSH reductions.***

340B DRUG PROGRAM REFORM

With ongoing interest in Congress to reform the 340B drug discount purchase program, rural hospitals must continue to receive the drug cost discounts to partially reduce their losses from treating Medicaid and uninsured patients. Proposed changes in the past have included limiting the hospital drug discount only to uninsured patients or otherwise narrow the program because of the actions of a very few that may have profited from the program. Rural hospitals benefit in two major ways – discounted cost of drugs used by uninsured patients reduces the hospitals loss to treat those patients and profit from discount drugs associated with insured patients also helps to partially offset the hospital's overall uncompensated care. Also, any effort to narrow which patients in a hospital are eligible for 340B discounts could actually drive up cost for Medicare as Critical Access Hospitals (about half of the rural hospitals in Texas) pass their costs back to Medicare to treat Medicare patients - so a higher cost for drugs will mean a higher cost to Medicare. ***Changes in the 340B drug discount program should address documented problems and not use a broad approach which harms rural hospitals.***

1115 WAIVER CHANGES

Texas rural hospitals are estimated to lose as much as $200 to $300 million dollars a year starting in 2020 under the 1115 Waiver as the Centers for Medicare and Medicaid Services is requiring Texas to change its method of calculating uncompensated care. The waiver also winds down in 2020 and 2021 the Delivery System Reform Incentive Payment program which will cost rural hospitals an additional $150 million a year. These reductions could be financially devastating for many rural hospitals that report that dollars they receive from the 1115 Waiver and the related DSH program comprise between a fourth and a third of their revenue. ***The Texas Health and Human Services Commission supported by the Texas Congressional delegation, must find a way to replace a substantial portion of the lost dollars by 2020 or more rural hospital closures are a certainty.***

WAVE OF MEDICARE CUTS NEEDS TO BE REVERSED

A major contributing factor to 10% of Texas' rural hospitals closing in the last six years and the financial weakening of many more rural hospitals is Medicare payment cutbacks, the Affordable Care Act penalties, and government mandates. The estimated collective loss from this for Texas' remaining 158 rural hospitals is estimated at more than $50 million a year.

2% Sequestration	*$22,000,000*	*(all 158 hospitals)*
Value Based quality penalty	*$15,000,000*	*(79 hospitals)*
Loss of Outpatient Hold Harmless	*$10,000,000*	*(51 hospitals)*
Readmission Penalty	*$3,000,000*	*(49 hospitals)*
Bad debt allowance reduction	*$2,000,000*	*(all 158 hospitals)*
Hospital Acquired Conditions penalty	*$800,000*	*(8 hospitals)*

Besides these cuts, hospitals have recently absorbed the cost of some or all of mandates such as the ICD-10 medical coding system and Electronic Medical Records. The situation is further aggravated with an estimated $100 million plus underpayment by the Texas Medicaid system. ***Congress must restore Medicare cuts to rural hospitals.***

CAH 96 HOUR STAY RULE

Federal law requires patients in a Critical Access Hospital (CAH) be discharged on an <u>*annual patient average*</u> within 96 hours or be transferred to a larger hospital. The law also requires a physician must certify that each <u>*individual*</u> patient will be released or transferred within 96 hours. A conflict occurs when an individual patient stay exceeds the 96-hour limit but complies with the annual average. The end result is that CAHs may be denied payment for patient stays exceeding the 96-hour limit (even though they may fall within the 96-hour annual average requirement) which hospitals argue was never the intent of Congress. Medicare also incurs additional expense if a patient is not ready for discharge at the end of 96 hours and must be transferred to another hospital. Congress should eliminate both rules. ***S.586 and HR 1041 eliminate the doctor certification.***

CMS PRIMARLY ENGAGED DEFINITION COULD BE PROBLEMATIC

A few very low volume rural hospitals may be in conflict with a new definition of a "hospital" issued by the Centers for Medicare and Medicaid Services (CMS). Section 1861(e)(1) of the Social Security Act governing Medicare has, for many years, defined a "hospital" as an institution that '"is ***primarily engaged*** in providing, by or under the supervision of physicians, to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons…", however CMS tightened that law in the fall of 2017 by adding an internal agency definition that to be "***primarily engaged as a hospital"*** there must be two inpatients at the time of the hospital survey and average daily census and average length of stay data will be two primary factors utilized to determine whether a hospital is "***primarily engaged***" in providing inpatient services. CMS exempted Critical Access Hospitals from this rule as the law creating CAHs doesn't have the primarily engaged language. But, the new rule does apply to rural Prospective Payment System (PPS) hospitals – which is almost half of the rural hospitals in Texas. A conflict comes about as many small rural hospitals are seeing a downward inpatient census trend for reasons including a CMS push to shorten hospital stays and deem more inpatient stays as outpatient – such as the two-midnight rule. The new two inpatients rule appears to be a response to the rise in urban based "micro" hospitals and specialty care hospitals who have few inpatients but are afforded higher hospital payments. There is also a legal question as to CMS's authority to adopt such a definition without going through the public rule making process.

MAINTAIN CRITICAL ACCESS HOSPITAL PROGRAM

The special Medicare rural Critical Access Hospital (CAH) designation program, created by the Balance Budget Act of 1997 has financially stabilized 85 Texas rural hospitals over the years and recognizes their unique and challenging operating dynamics. No changes should be made in this program although potential changes have been discussed in recent years by Congress and CMS. These safety-net hospitals are the backbone of rural health and emergency care. Without increased Medicare payments (101% of allowable cost rather than standardized Medicare rates – 99% under sequestration) most of these hospitals could not stay open. These are small rural hospitals with low volume, but the only hospital for miles. Past proposals that would damage the CAHs include:

-Recommendation by the HHS OIG (Aug 2013) that grandfathered mileage separation waivers be eliminated. If enacted, 60 of the 83 CAHs in Texas would lose status and possibly close. Many states like Texas previously relied upon mileage waivers to grant CAH status when hospitals were not far enough apart. This is important for Texas as the original 35-mile separation requirement discriminated against Texas where many rural hospitals are 20 to 30 miles apart.

-Recommendation by HHS OIG that "swing beds" in CAHs should be paid lower nursing facility rates. A CAH is allowed to keep a patient bound for a skilled nursing facility short term until they can be placed in such a facility and be paid hospital rates rather than the nursing home rates. The reasoning is that skilled nursing beds are not readily available in a small rural community. However, even though patient status may have changed, hospital cost is still higher and the hospital should be paid their full rate (March 2015)

-Ongoing budget recommendations that CAH payments be lowered from 101% of allowable cost (99% with sequestration) to 100% of allowable cost (98% with sequestration). It is important to note that because CMS regularly disallows payments on some services or reduces the amount allowable, many CAHs actually receive about 80-90% of their cost on Medicare patients (Feb 2016)

HR 2990 (Green/Thompson) – removes mileage separation for critical access hospitals if a state designates the hospital as a CAH, which was allowed under the original CAH program and later removed.

BAD DEBT REDUCTION

Congress has reduced the amount of Medicare bad debt they are willing to cover in recent years increasing losses for and reducing Medicare payments to hospitals, especially rural hospitals. Bad debt is when a

Medicare beneficiary fails to pay their copay and deductible. The current amount of bad debt covered is 65% of a hospital's Medicare bad debt. Proposals regularly arise calling for a reduction to 25%. Prior to 2012, Medicare would reimburse 70% of the bad debt for most hospitals and 100% for Critical Access Hospitals. The situation is further exacerbated by the increasing shift by many Medicare beneficiaries to Medicare Advantage (MA), where the private MA plans are not obligated to cover MA bad debt, even though it is an alternative to regular Medicare. ***The bad debt reductions need to be reversed.***

RURAL HEALTH CLINIC REVISIONS NEEDED

Several revisions are needed in the Centers for Medicare and Medicaid Services (CMS) rules for Rural Health Clinics (RHC) so they may better serve rural areas. A major change needed is a broadening of the list of mental health providers allowed to deliver services. Currently, CMS only allows reimbursable services to be provided by a physician, a nurse practitioner, a physician assistant, a certified nurse midwife, a clinical psychologist, or a clinical social worker. Missing from the list is a licensed professional counselor (LPC) which has very similar training and education requirements to a clinical social worker. LPCs are often the only mental health related professional available in many rural Texas communities. As the demand for mental health care services explodes in rural areas, many RHCs are without psychiatrists, psychologists, and clinical social workers. And only with an LPC for which they cannot be paid. Another growing challenge for RHCs is they can receive telemedicine services to patients in an RHC, but cannot be paid for delivering telemedicine services to an off-site location. RHCs are the bedrock of primary care in rural areas across the country numbering more than 4,500. Texas has more than 300 RHCs, most owned and operate by rural hospitals to keep primary care patients away from more expensive emergency rooms. ***Congress should mandate these two revisions to RHC rules.***

THERAPY SUPERVISION RULE FOR RURAL HOSPITALS PERMANENTLY ADDRESSED

Rural hospitals need Congress to permanently halt unreasonable efforts by the Centers for Medicare and Medicaid Services (CMS) to increase the level of direct on-site physician supervision over certain therapeutic services in Critical Access Hospitals (CAH) and other small/rural hospitals less than 100 beds. Physicians and hospitals maintain the intensified supervision is not medically necessary and imposes an increased financial and staffing burden. Physicians are not always on site in many rural hospitals and not immediately available to perform direct supervision. Hospital staff is more than capable of performing much of the therapy under physician orders. CMS is currently not enforcing the rule because of push back from hospitals and congressional questions but this could change at any time as this is discretionary with CMS. Congress reinforced that physician oversight is not necessary for cases through the end of 2017 but needs to permanently clarify in law that the therapy supervision is not necessary. (***S.895 addresses this).***

FEDERAL BILLS OF INTEREST

S.586 (Roberts/Tester) – Removes CAH 96-hour patient stay physician certification requirement

S.895 (Thune/Stabenow) - permanently extends moratorium on CMS enforcing requirement of direct supervision of outpatient therapy in a rural hospital

S.948 (Klobuchar/Collins) – Extends the J1 visa program allowing foreign doctors to remain in the U.S. without having to return home for two years provided they practice in an underserved area for three years. Would increase the state allocations from 30 to 35 physicians per year and provide flexibility to further expand the number of waivers in states where the demand exceeds the limit.

S.1037(Barrasso/T. Smith) - modernize provisions relating to rural health clinics including allowing RHC to be a telemedicine distant site, increases payment rate, allows "contract" providers rather than recruitment to be "employed", addresses outdated regulations.

HR 1041 (A. Smith/Sewell) - Removes CAH 96-hour patient stay physician certification requirement

HR 2666 (Cleaver/J. Smith) - requires the CMS to pay on a reasonable-cost basis for anesthesia services furnished by an anesthesiologist in a rural hospital in the same manner as payment is provided under current law for services furnished in a rural hospital by a certified registered nurse anesthetist.

HR 2788 (A. Smith/McMorris Rodgers) - modernize provisions relating to rural health clinics including allowing RHC to be a telemedicine distant site, increases payment rate, allows "contract" providers rather than requirement to be "employed", addresses outdated regulations.
HR 2990 (Green/Thompson) – removes mileage separation for critical access hospitals if a state designates the hospital as a CAH, similar to what was allowed under the original CAH program and later removed.
HR 3672 (Brindisi/Reed) – provides relief for small rural hospitals from inaccurate instructions provided by certain Medicare administrative contractors. Sole Community Hospitals and Medicare Dependent Hospitals can move in and out of qualifying for supplemental payments and this bill was reduces some of the kneejerk negative financial impact.
HR 3431 (Axne/A. Smith) - extension of the enforcement instruction on supervision requirements for outpatient therapeutic services in critical access and small rural hospitals through 2021.

STATE ISSUES

MEDICAID UNDERPAYMENT TO RURAL HOSPITALS

Texas rural hospitals are collectively losing more than $100 million a year treating Medicaid patients because of an ongoing underpayment issue which is contributing to hospital closures and the growing inability to have a baby delivered in rural Texas. The Legislature did respond in the 86th session to the payment crisis with just over $50 million a year in additional payment dollars for rural hospitals, but it falls well short of the estimated $170 million a year underpayment. The continuing underpayment is despite a 1993 promise from the Legislature to rural hospitals that they would be paid full cost to treat Medicaid patients. Over time the state strayed from the commitment and lost control over much of its Medicaid program when it transitioned to managed care private insurance companies. The insurance companies often underpay and deny claims for services. Rural hospitals cannot continue to absorb this underpayment. Besides closures, more rural hospitals are ceasing services such as labor and delivery services because of the dollar losses from the underpayment. Of the 158 rural hospitals, only 66 now provide baby delivery and more are planning to cease those services. ***SB 170 from the 86th session upped the payments to rural hospitals and mandates in state law full cost payments starting in September 2021. The 87th session must provide the full required appropriations.***

1115 WAIVER CUTS

Texas rural hospitals are estimated to lose as much as $200 to $300 million dollars a year starting in 2020 under the 1115 Waiver renewal which began January 2018. Under revised requirements from the Centers for Medicare and Medicaid Services (CMS), starting in 2020 (year three of the new five-year Waiver) the formula for hospital Uncompensated Care (UC) payments shifts from a hospital's total uncompensated care and bad debt to only its charity care as defined by hospital policy. Because most rural hospital charity care policies are outdated and conservatively low, their charity care totals are artificially reduced and much of the charity care ends up being classified as bad debt. Many rural hospitals have since updated and increased their charity care threshold, but as the calculation starting in 2020 will look back at charity care levels in 2018, many hospitals did not have sufficient time to increase their charity care limits. So, regardless of the amount of money Texas receives under the Waiver for UC payments, hospitals will be capped by their documentable past charity care. The new waiver also winds down in 2020 and 2021 the Delivery System Reform Incentive Payment program which will cost rural hospitals an additional $150 million a year. These reductions could be financially devastating for many rural hospitals that report that dollars they receive from the 1115 Waiver and the related DSH program comprise between a fourth and a third of their revenue. ***The Texas Health and Human Services Commission and the Legislature, supported by the Texas Congressional delegation, must find a way to replace a substantial portion those dollars by 2020 or more rural hospital closures are a certainty.***
*(*1115 refers to the section of the Social Security Act which allows states may have special and unique Medicaid related programs)*

TELEMEDICINE COORDINATION

The increasing use of telemedicine in Texas is revealing challenges in coordination. As new telemedicine projects launch it is difficult to identify medical facilities already utilizing telemedicine (hospitals, providers,

universities) and equipment already in use. Much of the equipment in use is proprietary and does not interface with other networks and equipment. Some rural hospitals are using multiple telemedicine platforms having two or three different units which connect to two or three different remote locations, and in many cases, the connections are on different dedicated broadband circuits. The lack of interconnectivity and interoperability as wells as redundancy in connectivity, will inevitably add to the cost of telemedicine and could limit its growth. The Texas Statewide Health Coordinating Board identified the potential of this problem in 2002 when it recommended that "an agency or body should be designated that can serve as the authority and recognized expert on TMTH (telemedicine/telehealth) information for current and future TMTH providers, grantees and policymakers. This entity should produce a Texas unified TMTH state plan, which would serve as a point of coordination for all TMTH projects within the state." ***The Legislature should act on the TSHCB recommendation to catalog telemedicine efforts and establish operating platform standards including interoperability.***

MENTAL HEALTH SERVICES ACCESS IN RURAL AREAS

Limited or no access to short-term mental health facilities and psychiatric care for much of rural Texas is an ongoing problem. Mental health patients in rural areas often end up in the local hospital emergency room where there is not appropriate staff or facilities to address patient needs, especially for more aggressive or violent patients. The problem is compounded when mental health patients must be held for a mental commitment court hearing (which can take days or weeks) and there are no local or regional inpatient mental health facilities. Despite provisions in Chapters 573 and 574 of the Texas Health and Safety Code directing that mental health patients being held in protective custody or pending a civil court commitment should be in mental health facilities, the reality in rural Texas is these patients are often taken to the local hospital. The dilemma for rural hospitals is that even though they may be ill equipped to deal with the mental health patient and do not have a requirement under state law, the federal EMTALA law (Emergency Medical Treatment and Labor Act) imposes a stabilization and treatment requirement on hospitals for any patient ending up in their emergency room which ultimately means the local hospital must hold the patient until they can be placed in a more appropriate facility, which may take hours or days. Also, as small rural hospitals have limited staff, the time and manpower demand for mental patients takes necessary care away from acutely ill medical and trauma patients. Another point of contention in the current system often occurs between those small rural hospitals and law enforcement. The Health and Safety Code seems to assume that once the patient is transported to a mental health facility, the role of law enforcement is concluded. However, in rural hospitals that are not mental health facilities and do not have secure facilities/staff to manage dangerous and violent patients, the need exists for law enforcement to remain present with the patient which prevents them from returning to their normal duties. ***The Texas Legislature needs to address the continued inability of rural Texas hospitals to timely access mental health beds.***

PHYSICIAN EMPLOYMENT LAW FOR RURAL HOSPITALS NEEDS UPDATING

When the Texas Legislature authorized in 2011 direct employment of physicians by rural hospitals, the authorization was limited to hospitals in counties of 50,000 population or less and hospitals with a Medicare rural hospital designation. The law fails to address what occurs to an employed physician when the county population exceeds 50,000 if the hospital does not have a specific Medicare rural designation. Following the passage of the bill in 2011, the Texas Legislature revised the definition of a rural hospital in the Texas Medicaid program to hospitals in a county of 60,000 or less; or with a Medicare rural hospital designation. ***With the 2020 Census in the near future, the Texas Legislature needs to adjust the law to allow for the physicians direct employed prior to the census to remain direct employed if their county's population exceeds 50,000. The population cap should also be raised to 60,000 to match the definition of a rural hospital under Medicaid.***

FREESTANDING EMERGENCY ROOMS/URGENT CARE FACILTIES

The proliferation of freestanding emergency rooms and urgent care facilities in Texas continues to have a negative impact on hospitals, especially rural hospitals, by creating a shortage of emergency room physicians. With more than 200 freestanding ER facilities now licensed by the state and hundreds more urgent care clinics (which are parallel to a physician clinic), 1,000+ physicians have been drawn away from existing health care facilities (mostly coming from hospital emergency rooms). For many rural hospitals that regularly use visiting contract physicians to fully cover their emergency centers, the issue is translating into annual physician cost increases of $200,000 to $400,000. This added cost to both urban and rural hospitals will ultimately drive up the cost of health care, impacting taxpayers and insurance premiums. Another growing issue is that most freestanding emergency centers do not contract with insurance companies (out-of-network) meaning that insurance companies and/or patients are forced to pay the higher "billed charges" which can be 5 to 10 times higher than a hospital that is contracted with the insurance company. ***The Legislature needs to continue to direct regulations so that the freestanding ERs serve the general public and not just certain neighborhoods, and incentives should be put into place for future medical students to consider emergency medicine.***

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