Texas Hospital Association

1108 Lavaca Street, Suite 700, Austin, Texas 78701
512/465-1000
www.tha.org

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Via electronic submission to:
HCR_PRU@hhs.texas.gov

COMMENT LETTER

Texas Health and Human Services Commission

Re: Comments on Proposed Rule 23R017 (concerning Limited Services Rural Hospitals)

Dear Sir/Madam:

On behalf of our more than 450 member hospitals and health systems, including rural, urban, children's, teaching and specialty hospitals, and private psychiatric facilities, the Texas Hospital Association is pleased to submit these comments regarding the above-referenced draft rules related to Limited Services Rural Hospitals. Establishing the licensing process for limited services rural hospitals is critical to preserving access to health care in rural communities whose hospitals are under financial stress, and we appreciate this accelerated rulemaking action by HHSC. Preserving these resources in rural communities benefits all Texans by improving health outcomes and maintaining capacity in the health care continuum. Our comments on the proposed rules are set forth below.

Subchapter A, General Provisions

Regarding the waiver process set forth in **§511.3**, we appreciate the flexibility that this section provides and urge HHSC to adopt this rule as proposed.

Subchapter B, Licensing Requirements

Section 511.12(b)(1) provides in part: "HHSC requires an architectural inspection when a qualifying rural hospital that has closed subsequently applies for an LSRH license. HHSC will waive the architectural inspection for a currently operating qualifying rural hospital that applies for an LSRH license." We appreciate the flexibility of waiving the architectural inspection for currently operating facilities and urge HHSC to adopt that language as proposed. We further urge HHSC to consider waiving the requirement for hospitals that have been closed for a short time prior to submitting their licensing application, for example 90 days. The revised language could read:

> HHSC requires an architectural inspection when a qualifying rural hospital that has been closed for longer then 90 days subsequently applies for an LSRH license. HHSC will waive the architectural inspection for a currently operating qualifying rural hospital that applies for an LSRH license, and for a qualifying rural hospital that has been closed for 90 days or less.

Subchapter C, Operational Requirements

Regarding **§511.77(g)(2)**, as we have previously noted in our comments on proposed rules earlier this year, the cumulative penalty structure for pricing transparency violations is not supported by statutory language in Section 327.008, Health & Safety Code.

Subchapter D, Inspections and Investigations

Regarding **§511.111, Integrity of Inspections and Investigations**: this section indicates that a facility "(1) shall not record, listen to, or eavesdrop on any HHSC interview with LSRH staff or patients unless HHSC has granted permission; or (2) shall not record, listen to, or eavesdrop on any internal discussion by or among HHSC staff unless it first informs HHSC staff that it will do so and obtains HHSC's written approval before beginning to record, listen to, or eavesdrop on the discussion."

While we understand and support what appears to be the general spirit and intent of the proposed rule, we are concerned that the wording may foreclose an important and non-controversial learning opportunity for facilities with respect to interviews and conversations that are not intended to be private, and will put facilities in a difficult position if it is not clear that the conversations that are the subject of this subsection are intended to be private. For example, facility personnel are often permitted to sit in on interviews, and often accompany HHSC surveyors as they move through the facility. These noncontroversial activities would be subjected to cumbersome processes in order to avoid a technical violation of the rule as written.

Further, if HHSC staff are conferring together in the presence of facility staff, or in a public area of the facility within earshot of facility staff, but the process for obtaining written permission is not followed, that may be a technical violation of the rule as worded, unless the facility staff first informs HHSC staff that it can hear the conversation and obtains HHSC's written approval.

This language will unnecessarily lead to controversy and unfair secondary citations that could be based on unproveable factual disputes or even misunderstandings, and are not related to an operational requirement. We note that there is no other instance in the Texas Administrative Code that we can find related to "eavesdropping". We urge reconsideration of this potentially controversial language, and recommend that the language in subsection (a) be clarified so that it only applies to intentional surreptitious eavesdropping or recording of conversations that HHSC intends to be private. We suggest subsection (a) be reworded as follows:

(a) In order to preserve the integrity of HHSC's inspection and investigation process, a LSRH:

(1) shall not intentionally record, listen to, or eavesdrop on any HHSC interview with LSRH staff or patients that the LSRH knows HHSC intends to be private as evidenced by HHSC taking reasonable measures to prevent from being overheard; or
(2) shall not intentionally record, listen to, or eavesdrop on any internal discussion by or among HHSC staff conducted solely by and among HHSC staff outside the presence of LSRH staff, and that HHSC takes reasonable measures to prevent from being overheard such as requesting a private room or office or distancing themselves from LSRH staff unless it first informs HHSC staff that it

will do so and obtains HHSC's written approval before beginning to record, listen to, or eavesdrop on the discussion.

An interview or conversation for which facility staff are permitted either by words or actions to be present shall not constitute a violation of this rule.

Regarding **§511.113(h)**, which provides that an LSRH shall permit HHSC access to interview members of the governing body, personnel, and patients, including the opportunity to request a written statement, we have two concerns with this language, as follows:

(1) Members of the governing body are likely community members who are not involved (nor should they be) in the day-to-day operations of the LSRH. For that reason, members of the governing body should not be subjected to interrogations by surveyors and doing so is likely going to dissuade community members from serving on these boards, depriving LSRHs of much-needed leadership.

(2) The language related to requesting a written statement is ripe for controversy and sets up the potential of a secondary enforcement action to the extent a written statement cannot be provided or when the HHSC is not satisfied with the content of the statement. This applies to LSRH personnel and governing body members. Moreover, the language is not mandatory - and we doubt that HHSC has the statutory authority to compel written statements by rule - but will undoubtedly set up an adversarial situation if an individual or facility declines to provide the requested statement.

We urge HHSC to remove the reference to governing body, and to remove the language related to requesting a written statement.

Subchapter E, Enforcement

Regarding §511.121, we urge HHSC to review subsection (c), grounds for license denial. Some of the listed reasons appear to be overly broad, as noted below. While these broad categories of conduct could involve circumstances where HHSC would be justified in denying a license, minor regulatory infractions or other instances of these categories that have no bearing on the fitness of the LSRH to operate the facility would not. We have the specific concerns regarding the grounds for license denial enumerated in subsection (c):

(B) [F]ederal Medicare or state Medicaid sanctions or penalties: While we assume that enforcement discretion will be utilized, this category is very broad. It is not uncommon for health care providers navigating the extremely complex billing and reimbursement structure of the Medicare program to make unintentional billing errors that result in sanctions. In these cases the provider often repays any amounts owed and any penalties associated with the errors and is free to continue participating in Medicare going forward without limitations or stipulations. Other regulatory infractions and violations of the Medicare conditions of participation can result in citations, and often, the infractions are minor and the "sanctions" or "penalties" quite inconsequential. These circumstances do not justify denying an LSRH license. Termination of the Medicare provider agreement is specified as a ground for revoking a license. We urge HHSC to remove this language as a ground for license denial or mirror the language related to termination found in the revocation section.

(C) [U]nsatisfied federal or state tax liens: Our concern with this language is that the provider may not have had the opportunity to fully dispute a lien and the license could be denied for an unresolved lien for which a dispute is pending. We request the language revised to:

> (C) federal or state tax liens that are unsatisfied after all avenues of dispute have been exhausted;

(D) [U]nsatisfied final judgments: This category is overly broad and we believe misplaced. Civil judgments can be taken for many reasons having no bearing on the fitness to operate a LSRH, e.g., minor contractual disputes with vendors, and even a "final judgment" could still be on appeal and technically "unsatisfied." We urge HHSC to remove the category or specify the specific types of judgments that could result in denial and to account for final judgments that may be on appeal.

(F) [U]nresolved federal Medicare or state Medicaid audit exceptions: Again, we believe this is overly broad in that it contains no threshold amount in controversy and fails to account for audit exceptions that are in the process of being disputed. We urge HHSC to revise this to read:

> (F) federal Medicare or state Medicaid audit exceptions that are unresolved after all avenues of dispute are exhausted.

We appreciate your consideration of these comments. Should you have any questions or need additional information, please do not hesitate to contact me at 512/465-1577 or swohleb@tha.org.

Respectfully submitted,

Stephen G. Wohleb
Senior Vice President and General Counsel
Texas Hospital Association