

Oct. 5, 2023

House Committee on Ways and Means  
U.S. House of Representatives  
WMAccessRFI@mail.house.gov

## **Request for Information: Improving Access to Health Care in Rural and Underserved Areas**

Dear Chairman Smith and the Honorable Members of the House Committee on Ways and Means:

On behalf of our over 470 member hospitals and health systems, including rural, urban, children's, teaching and specialty hospitals, the Texas Hospital Association (THA) appreciates the opportunity to provide comments about improving access to health care in rural and underserved areas.

Texas has 148 rural hospitals with unique needs and challenges. About 15% of Texas' 30-million-person population is rural, including 586,000 rural Texans without health insurance. Compared with their urban counterparts, rural hospitals serve a larger proportion of older, uninsured and publicly insured patients.

Rural hospitals and health systems are the core of their communities, not only providing integral high-quality patient care but serving as a large local employer. More than ever, rural hospitals are experiencing unprecedented challenges that jeopardize access and services. The aftereffects of the pandemic have resulted in crippling workforce shortages and increasing costs of providing care. Rural hospitals continue to receive underpayment by Medicare and Medicaid, and the growth of Medicare Advantage threatens rural health care access.

Twenty-one rural hospitals in Texas have closed in the last decade – more than any other state – and other rural hospitals have eliminated key service lines, like labor and delivery. In 2022, a [report](#) from Kaufman Hall found 26% of Texas rural hospitals were at risk of closure, compared to 16% in 2020. Today, only about 40% of Texas rural hospitals provide labor and delivery services according to the Texas Organization of Rural and Community Hospitals.

Preventing additional rural hospital closures and protecting rural hospitals' ability to deliver high-quality care is more critical now than ever. THA offers the following comments and suggestions in several key areas to ensure rural hospitals are financially sound and able to meet the needs of their communities.

### **I. Reimbursement and Payment Issues:**

#### ***A. Rural Hospital Programs***

Areas of rural Texas experience a higher percentage of uninsured, Medicaid and Medicare compared to other parts of our great state. To account for this patient population, **THA supports efforts to ensure a Medicare payment system for rural hospitals that, at a minimum, covers the cost of providing that care and believes those payments should be routinely updated to continue to reflect the cost of care.**

**Critical Access Hospital and Sole Community Hospital designations** are, in fact, critical to maintain patient access throughout Texas and should be maintained and available to hospitals that meet the criteria.

**Medicare Dependent Hospitals (MDHs)** are small, rural hospitals where at least 60% of admissions or patient days are from Medicare patients. MDHs receive the inpatient prospective payment system rate plus 75% of the difference between the Inpatient Prospective Payment System rate and their inflation adjusted costs from one of three base years. **THA supports making the MDH program permanent.**

**Low-Volume Adjustment (LVH) Hospitals** are isolated, rural hospitals with a low number of discharges. An LVH hospital receives a payment adjustment increase based on discharge numbers. **THA supports making the LVH program permanent.**

The Consolidated Appropriations Act of 2021 established **Rural Emergency Hospitals (REH)** as a new Medicare provider type. Beginning Jan. 1, 2023, rural hospitals meeting certain criteria have begun applying to convert to REH status, continuing to provide emergency department, outpatient and observation care while generally not providing any acute care inpatient services. Texas has seen a handful of hospitals transition to REH in 2023. The REH designation provided a lifeline to hospitals that were on the brink of closure. THA is grateful for congressional leaders, especially Chairman Jodey Arrington, who recognized the need for, and took steps to create, the REH designation. **THA supports the continuation of the REH designation.**

Additionally, as we enter year two of the program, we encourage an ongoing review of the criteria and identification of potential updates that could ensure continued provision of care in rural communities. Based on feedback from our rural hospitals, potential areas for review include:

- Allowing a hospital to revert back to a Prospective Payment System hospital;
- Allowing an REH to continue participation in the 340B Drug Pricing Program upon conversion;
- REH inclusion in HRSA's National Health Service Corps program so health professionals have access to loan repayment; and,
- Allowance of a labor and delivery option to ensure continued local access to obstetric care.

THA and the Texas Organization of Rural and Community Hospitals will continue to work with Chairman Arrington to address oversights or unintended consequences of the new REH program

and ensure rural hospitals can meet the needs of their communities within the confines of the designation.

### *B. Site-Neutral Payment Policies*

**As Congress continues to explore reforms in Medicare, THA remains steadfastly opposed to policies that provide reimbursement regardless of location.** Site-neutral payments will reduce access to critical health care services, especially in rural and other underserved communities. Hospital outpatient departments (HOPDs) treat more patients from medically underserved populations who tend to be sicker and more complex to care for than Medicare patients treated in independent physician offices and ambulatory surgical centers. HOPDs also are held to more rigorous licensing, accreditation and regulatory requirements than other patient care settings. They are required to fully integrate their operations into those of the main hospital, ensuring that patients receive hospital-level care in these outpatient settings. Additionally, cuts in HOPD payments will further undermine a fragile rural delivery care system in areas where rural providers already struggle to receive payments that cover the cost of care.

### *C. The 340B Drug Pricing Program*

The 340B Drug Pricing Program helps hospitals serving vulnerable populations stretch scarce resources. As you know, section 340B of the Public Health Service Act requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to health care organizations that care for many uninsured and low-income patients. Hospitals, including those in rural areas, use 340B savings to provide free care for uninsured patients, free vaccines, mental health services, and medication management and community health programs. **THA opposes any efforts to undermine the 340B Program and harm the patients and communities it serves.**

## II. Medicare Advantage:

The rapid growth of Medicare Advantage (MA) threatens Texas' health care safety net. For rural hospitals, MA causes financial instability on an already-fragile provider community. While MA aims to curtail costs of the program broadly, studies have shown in some cases it impedes patients' access to medically necessary care and threatens the stability of the hospital safety net. **Ongoing concerns voiced by patients, providers and policymakers – including reports by the [Government Accountability Office](#) and the [U.S. Office of Inspector General](#) about the harmful impact of MA – warrant Congressional oversight and action.**

MA plans reimburse hospitals at a lower rate and offer benefits and cost-sharing arrangements for beneficiaries that are significantly different from traditional Medicare. The rapid growth in enrollment exacerbates reimbursement issues. According to [KFF](#), 55% of Medicare beneficiaries in Texas are enrolled in MA. In some rural areas of our state, that percentage is now as high as 73%.

MA plans' payment rates are based on a negotiated contract and do not consider federal payment policies designed to help vulnerable hospitals ensure access to care. These plans do not provide cost-based reimbursement, nor are they recognized as Medicare for federal cost report purposes.

This is detrimental to Texas' 85 critical access hospitals that receive cost-based reimbursement in traditional Medicare. Low MA rates undermine the federal payment policies designed to ensure adequate reimbursement for rural critical access hospitals.

For some rural hospitals, the difference in reimbursement between traditional Medicare and MA has resulted in an annual loss of several hundred thousand dollars. For hospitals with very thin operating margins, a shift of this magnitude can negatively impact patient care and a hospital's ability to stay open for business.

In addition to payment issues, our members describe MA plans as inflexible and difficult. Requests for appropriate diagnostic services and advanced imaging (e.g., MRIs and CTs) in medically appropriate situations are routinely denied because a more conservative treatment was not first tried. MA plans often do not authorize medically justified admissions to acute and/or swing bed services, or retrospectively deny authorization after preauthorization was secured and care was already provided. Furthermore, patients are treated in hospital emergency departments around the clock, but MA authorizations typically cannot be obtained in the evenings or on weekends. An MA patient needing admission on a weekend must be admitted before preauthorization can be requested on Monday morning, with no assurance the MA plan will authorize or pay for the admission. When plans deny an initial authorization request, hospitals must often restart a new authorization request, further delaying care while the hospital determines what services an MA plan is willing to approve.

Some MA plans may also be motivated to keep patients in hospitals for longer than necessary because the plan is reimbursing acute care at a flat rate. Plans delay or attempt to avoid discharging the patient to the next site of care, which would require separate reimbursement. The hospital is obligated to care for the patient in an acute setting until a transfer is approved, even if the inpatient payment amount is exhausted. The result is that too many patients are being denied timely access to medically necessary skilled nursing, rehabilitation or other care due to the practice of withholding post-acute transfer to boost plan profits. Hospital acute care beds stay occupied with patients who no longer meet inpatient criteria and are awaiting transfer, making those beds unavailable for other patients with acute care needs.

While a portion of inappropriate denials are reversed after appeal, many Texas hospitals cannot keep up with the administrative burden of chasing prior authorizations and recovering payments that should not have been denied in the first place. Some Texas rural hospitals report employing staff whose sole job is to pursue authorizations and payments from MA plans for care that is routinely authorized under traditional Medicare. Rural hospitals in precarious financial positions would be much better off redirecting financial resources spent to resolve avoidable MA preauthorizations and denials in service of other activities that further their patient care missions.

**THA recommends Congress continue to direct CMS and support CMS' efforts to address prior authorization concerns raised by GAO and OIG reports and experienced by Texas hospitals:**

- Support new CMS rules that require plans to comply with national coverage determinations, local coverage determinations, and general coverage and benefit conditions, including in traditional Medicare. CMS also finalized rules that limit when MA plans may use internal coverage criteria and required that such criteria be based in widely accepted treatment guidelines available to CMS, enrollees and providers.
- Draft standards to ensure preauthorizations are timely, flexible in emergencies and potentially life-threatening circumstances, and available overnight and on weekends. Require or incentivize plans to implement electronic preauthorization with “real-time” decisions for routinely requested care. For non-routine requests, CMS could consider the following automatic authorization triggers to ensure timely determinations:
  - If a plan cannot provide a decision on an inpatient authorization within 24 hours, the inpatient stay should be automatically approved.
  - Post-acute authorizations should be approved within 48 hours, with no penalty to hospital or post-acute providers if transfer occurs after the 48-hour period.
  - Observation should not require pre-authorization.
- Collect and publish data to show denial rates of prior authorization requests and payment for common procedures under each MA plan as compared to traditional Medicare. Make this information available to providers and consumers shopping for MA plans.
- Standardize the complaint process for hospitals and other providers with grievances regarding the preauthorization practices of MA plans. CMS should have transparency into all complaints, actively monitor complaints industry-wide, and formalize a role for the agency to intervene in complaints that are repeated, severe or taking excessive time to resolve.
- Develop and enforce a tiered penalty structure for MA plans that consistently fail to authorize medically necessary care for beneficiaries. First-line actions may include written notices and corrective action plans, escalating through financial and administrative penalties up to and including termination of an MA organizational contract.

These steps ought to be least burdensome on MA plans already delivering medically appropriate care management consistent with Medicare guidelines, while introducing accountability for MA plans with inappropriate patterns of denials and delays that lead to poor patient outcomes. If implemented and enforced, these actions will keep hospital administrative costs reasonable and allow more resources to flow toward patient care. We also note the similarities between the above recommendations and certain proposals in the Improving Seniors’ Timely Access to Care bill, which THA has endorsed and will continue to support. THA and the Texas Organization of Rural and Community Hospitals have also been working closely with Rep. Lloyd Doggett and Chairman Jodey Arrington on proposals to ensure oversight of MA plans and protection of rural hospitals that treat MA enrollees.

### III. Innovative Models and Technology:

#### A. *Telehealth*

The rapid expansion of telehealth services throughout the pandemic demonstrated the benefits that expanded coverage provided to patients, particularly in underserved rural areas. **THA supports the permanent expansion of telehealth waivers and flexibilities that were extended through 2024, including those related to originating and geographic site restrictions, audio-only telehealth in specific settings, the inclusion of additional providers in the list of qualifying providers, and delay of the in-person requirement for behavioral telehealth.**

#### *B. Acute Hospital Care at Home*

Congress has extended the Acute Hospital Care at Home program through the end of 2024. Texas hospitals, including in rural settings, have embraced this model and are innovating care delivery. **THA supports a permanent extension of this program, which provides hospitals the regulatory flexibility to treat eligible patients in their own home.**

CMS' requirements ensure that the program is only used for patients who can safely be cared for in the home setting. Patients are only eligible for the program if they initiate treatment at the emergency department or an inpatient setting of a hospital. Facilities must have appropriate screening protocols in place before patients may receive care at home. Registered nurses must evaluate and monitor patients daily, either remotely or in person. In addition, registered nurses or mobile integrated health paramedics must visit the patient twice in person each day. Data is showing that this program results in fewer readmissions and returns to the emergency department, higher patient outcomes and satisfaction, lower use of skilled nursing facility care following discharge, and increases flexibility to a hospital's capacity.

#### IV. Workforce Challenges and Needs:

While health care workforce shortages existed long before COVID-19, the pandemic acutely impacted the people who provide care inside the walls of hospitals – from burnout and fatigue to leaving the profession altogether. The pandemic exacerbated the situation, and Texas hospitals continue to be in an unsustainable workforce crisis that threatens hospitals' ability to care for patients.

In late 2022, a THA survey showed that 64% of Texas hospitals reduced services due to workforce vacancies. To maintain services that were not reduced, hospitals turned to contract agencies and pay increases. Texas data from 2022 showed that hospital labor expenses were 20.9% higher than pre-pandemic levels. This is \$18.1 billion higher than in 2019, due to both higher staffing and contract labor expenses. Addressing these workforce shortage issues are critical to ensure continued access to care. These issues are even more acute in rural care settings. Targeted programs that help address workforce shortages in rural communities should be supported and expanded.

- **Graduate Medical Education.** We urge Congress to pass additional legislation to increase the number of Medicare-funded residency slots, which would expand training opportunities in rural settings and help address health professional shortages.

- **Conrad State 30 Program.** We urge Congress to pass legislation to make permanent the Conrad State 30 J-1 visa waiver program and expand the state allocation of physicians.
- **Loan Repayment Programs.** We urge Congress to pass legislation to provide incentives for clinicians to practice in rural Health Professional Shortage Areas. We support expanding the National Health Service Corps and the National Nurse Corps, which incentivize health care graduates to provide health care services in underserved areas.
- **Boost Nursing Education.** We urge Congress to support nursing education and provide resources to boost student and faculty populations.
- **Health Care Workers Protection.** We urge Congress to enact federal protections for health care workers against violence and intimidation, and to provide hospital grant funding for violence prevention training programs and coordination with state and local law enforcement. Specifically in this Congress, THA supports passage of the bipartisan Safety from Violence for Healthcare Employees (SAVE) Act.

## V. Additional Issues for Consideration

### A. *Maternal Health*

Maternal health is a top priority for THA and its rural members. **We urge Congress to continue to fund programs that improve maternal and obstetric care in rural areas, including supporting the maternal workforce, promoting best practices and educating health care professionals.**

### B. *Behavioral Health*

Implementing policies to better integrate and coordinate behavioral health services will improve care in rural communities. **We urge Congress to:**

- **fully fund authorized programs to treat substance use disorders**, including expanding access to medication assisted treatment;
- **implement policies to better integrate and coordinate behavioral health services with physical health services;**
- enact measures to ensure vigorous enforcement of mental health and substance use disorder **parity laws;**
- **permanently extend flexibilities under telehealth services** granted during the COVID-19 public health emergency; and,
- increase access to care in underserved communities by investing in **supports for virtual care and specialized workforces.**

**We further urge Congress to revisit and eliminate the “institutions for mental diseases” (IMD) exclusion,** an outdated and discriminatory policy that prohibits Medicaid coverage of inpatient mental health services for most adults younger than 65 years of age and puts pressure on the entire behavioral health continuum in all communities by denying access to care to the individuals most in need of those services.

THA appreciates the opportunity to provide feedback to the committee and your dedication to identifying and addressing issues critical to rural patients and providers. Texas has a proud rural heritage and looks forward to working with our congressional delegation and the committee to ensure continued and strong access to care for Texans in every community. For questions and follow-up, please don't hesitate to contact me at 512-465-1000.

Sincerely,

A handwritten signature in black ink that reads "Jennifer Banda". The signature is written in a cursive, flowing style.

Jennifer Banda, J.D.  
Senior Vice President  
Advocacy and Public Policy  
Texas Hospital Association