May 10, 2017 Emailed to Allison Eydt/Teresa Moton

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Verma:

The Texas hospital community, represented in part by the Texas Hospital Association and the Texas Organization of Rural & Community Hospitals, appreciate the opportunity to comment on the Direct Supervision Requirement for Therapeutic Services and our two top concerns in rural health services.

As you know, rural hospitals face a number of challenges. About 165 of Texas' more than 650 hospitals are rural. Maintaining the financial stability that Medicare provides is critically important for rural hospitals' ability to continue providing timely, medically necessary health care to rural Texans. To that end, we support:

- permanently enforcing the moratorium on the Centers for Medicare & Medicaid Services' direct supervision policy for outpatient therapeutic services provided in critical access hospitals and small, rural hospitals;
- permanently enforcing the Medicare Low Volume Adjustment and the Medicare Dependent Hospital supplemental payment provisions; and
- permanently enforcing the special Medicare rural Critical Access Hospital designation program.

Direct Supervision of Hospital Outpatient Therapeutic Services

We recommend making permanent the enforcement moratorium on CMS' direct supervision policy for outpatient therapeutic services provided in CAHs and small, rural hospitals.

- The direct supervision policy that applies to even low risk services can limit clients' access to services and require them to travel to distant locations beyond their means.
- These therapeutic services have always been provided by licensed, skilled professionals under the direction of a physician and with immediate response and assistance from a team of caregivers, including a physician, should an unforeseen event occur.
- Physicians and hospitals maintain the intensified supervision is not medically necessary and imposes an increased financial and staffing burden. These physicians are few in rural communities and are not always on site or immediately available to perform direct supervision in many rural hospitals due to their duties in multiple health delivery settings.
- The 21st Century Cures Act approved by Congress in December 2016 allowed rural hospitals to be paid by Medicare during 2016 for therapy performed without direct

supervision. Direct supervision is not a requirement of the Medicare hospital CoPs and the rules contradict the CoPs for CAHs.

Rural Health Service Delivery Issue # 1-Low Volume Adjustment and Medicare Dependent Hospital Extension/Permanency

We support extending and making permanent the LVA and the MDH supplemental payment provisions in order to help provide financial stability for many rural hospitals.

- LVA, designed to help larger rural hospitals with low patient volumes that do not qualify for other special rural hospital programs such as CAHs, is needed to prevent almost 80 rural Texas hospitals from losing $35 to $40 million a year in Medicare payments and facing closures.
- MDH is needed to prevent an estimated 12 to 15 rural Texas hospitals that are not sufficiently assisted by other rural hospital programs from losing more than $3 million annually.

Rural Health Service Delivery Issue # 2-Extend the No Changes for Critical Access Hospitals

No changes should be made to the special Medicare rural critical access hospital designation program that has helped more than 80 rural Texas hospitals achieve financial stability. Our recommendations include:

- exempting critical access hospitals from the cap on outpatient therapy services;
- removing the 96-hour physician certification requirement as a condition of payment for CAHs; and
- ensuring CAHs are paid at least 101 percent of costs by Medicare and are paid at least the same by Medicare Advantage plans.

Safety-net hospitals are the backbone of rural health and emergency care, but without the increased Medicare payments most of these hospitals could not stay open. Often the only hospital in the community, these 82 small rural hospitals with low volume need protection.

Thank you for your continued support of Texas hospitals and the important work that you do. We look forward to working with you on these issues as well as your ongoing work to reform the nation's health care system. Should you have any questions, please feel free to contact us at rschirmer@tha.org or dpearson@torchnet.org.

Sincerely,

Richard Schirmer, FACHE, FHFMA
Vice President, Health Care Policy Analysis
Texas Hospital Association

David Pearson, FACHE
President/CEO
Texas Organization of Rural & Community Hospitals (TORCH)