May 26, 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 by the Texas Hospital Association and the Texas Organization of Rural & Community Hospitals, appreciated the opportunity to participate in the May 16 listening session on rural health service delivery issues. We commend your attention to rural health care and soliciting provider input.

Our priorities for rural health care in Texas include protecting providers from undue regulation like the outpatient supervision rule, but also continuing and making permanent rural-specific Medicare payment policies and continuing the Medicaid 1115 Transformation Waiver.

Rural hospitals are in a vulnerable position. In the last four and half years, there have been 16 Texas rural hospital closures-13 permanent and 3 temporary closures. These rural hospital closures, the most of any state, leaves residents without access to emergency and inpatient hospital care. They also have unique needs and challenges. They cover 85 percent of Texas geography and provide access to routine and emergency health care for 15 percent of our state's population. Compared with their urban counterparts, they serve a larger proportion of older, uninsured and publicly insured patients and, as such, are particularly vulnerable to any cuts to Medicare and Medicaid.

The Medicare inpatient prospective payment system disadvantages rural hospitals for two reasons:

1) Because a high proportion of rural hospital revenue comes from the Medicare program, discrepancies between Medicare costs and payments have a significant effect on overall financial status.
2) Rural hospitals have a smaller proportion of privately insured patients to make up for any shortfalls in Medicare payments.

As a result, Texas hospitals depend on several rural-specific Medicare payment policies to be able to provide essential care.

1. **Low-Volume Program**-The Low-Volume Program helps rural hospitals that may not serve a high volume of patients. Although Medicare seeks to pay efficient providers their costs of furnishing services, certain factors beyond the provider's control can affect the costs of furnishing services. Patient volume is one such factor and is particularly relevant in small and

isolated communities where providers frequently cannot achieve the economies of scale possible for their larger counterparts.

In Texas, approximately 80 hospitals currently receive the low-volume payment adjustment. For all of our low-volume hospitals, these additional payments are the difference between a hospital keeping its doors open or closing. These payments are essential for the continued financial viability of these hospitals.

The low-volume adjustment, continued by the Affordable Care Act, better accounts for the relationship between cost and volume, helps level the playing field for low-volume providers, and sustains and improves access to care in rural areas. This improved low-volume adjustment expires Sept. 30, 2017, and rural hospitals depend on its continuation. We support extending and making permanent the LVH supplemental payment provisions.

2. **Medicare-Dependent Hospitals-**The MDH Program provides special reimbursement to hospitals that serve a high volume of Medicare patients. Medicare Dependent Hospital designation helps rural hospitals that otherwise would struggle to maintain financial stability under Medicare's fee schedule because of their small size and large share of Medicare beneficiaries who make up their patient base. These payments allow MDHs greater financial stability and help them more effectively serve their communities. Approximately 15 Texas are classified as a Medicare Dependent Hospital.

   Although the program has existed since 1990, MACRA reauthorized it through FY 2017. It expires Sept. 30, 2017. We support extending and making permanent the MDH supplemental payment provisions.

3. **Critical Access Hospitals**-Congress created this designation in response to a string of hospital closures in the 1980s and early 1990s. The intent is to provide extra support to hospitals in more remote areas to improve their financial health and continue offering services in their communities. Hospitals designated as critical access hospitals receive cost-based Medicare reimbursement and much needed freedom from certain staffing and regulatory requirements intended to address their status as a low-volume facility.

   In Texas, 82 hospitals are classified as Critical Access Hospitals. Often the only hospital in the community, these 82 small rural hospitals with low patient volume need protection. No changes should be made to this special Medicare rural critical access hospital designation.

4. **Telehealth**- As Texas is a very large state, rural Texas hospitals view telehealth innovations as a virtual tool that will effectively shrink the geography our patients face and help our at-risk communities. Telehealth is a vital tool for rural health care providers and patients for reducing costs, improving access to care and promoting better care outcomes.

   During the current Texas legislative session, the Texas legislature approved SB 1107, which removes existing clinical practice barriers for licensed telemedicine providers. The governor is expected to sign the legislation. If it becomes law, the bill would amend the definition of "telemedicine" and "telehealth," remove the requirements for a telepresenter, and authorize the medical, nursing, and pharmacy boards to develop regulations enforcing the statute.

   Childress Regional Medical Center (TX.) has been using telemedicine to connect their isolated community to specialty services like NICU, psychiatry, and pain management. The hospital also sees downstream opportunities to connect even smaller communities and schools to local primary

care providers. John Henderson, CEO, Childress Hospital would welcome the opportunity to discuss the opportunities they have realized using telemedicine and how they have improved patient care services using telemedicine. Mr. Henderson can be contacted at 940/937-9178 or jmh@childresshospital.com.

We urge you to expand Medicare's coverage and payment for telehealth services, adopt a more flexible approach adding new telehealth services to Medicare, and include telehealth waivers in all new care models.

5. **340B Program**-For more than 20 years, the 340B Drug Pricing Program has provided financial relief to certain safety-net hospitals from high prescription drug costs and broadened access to care for vulnerable populations. Rural referral centers and critical access hospitals benefit from this program.

   The 340B program is critical for Childress Regional Medical Center, for example, to be able to provide dialysis and chemotherapy to local residents. A copy of their AHA 340B case example is attached.

   We support continuing the 340B program so it can fulfill its intent of helping hospitals stretch limited resources to expand and improve access to comprehensive health care services to low-income patients. We oppose efforts to scale back or significantly reduce the benefits of the 340B program. In addition, we support expanding the program to cover inpatient services.

Finally, we support extension of the Medicaid 1115 Transformation Waiver. Expeditious resolution of the state's request to extend the waiver through September 2019 is essential for all Texas hospitals, but particularly rural hospitals that have very thin operating margins. Hospitals are beginning their budget planning processes for next year and need to know if they can count on continued waiver funds. Failure to extend the waiver could seriously impact the delivery of health care throughout the state and result in the closure of rural hospitals and service reductions in urban areas.

This waiver has done more than provide a financial lifeline to Texas Medicaid providers-it has helped foster critically important innovation that is rapidly improving the delivery system in tangible ways. This process must be allowed to continue.

Thank you again for your careful attention to these matters. 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 free to contact us at rschirmer@tha.org, dpearson@torchnet.org, or jmh@childresshospital.com.

Sincerely,

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John Henderson
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