Texas Organization of Rural & Community Hospitals

November 11, 2019

Members of U.S. House of Representatives Committee on Ways and Means
Rural and Underserved Communities Health Task Force

The Texas Organization of Rural & Community Hospitals (TORCH), which represents the 158 rural hospitals across Texas, welcomes this opportunity to submit input to the Rural and Underserved Communities Health Task Force on behalf of the rural hospitals in Texas.

With more rural hospitals than any other state, our comments focus on the current rural hospital closure crisis and our recommendations of how the task force should address the problem. We welcome future opportunity to elaborate on our comments and/or address questions in the RFI.

Texas continues to lead the nation in rural hospital closures with 26 occurring in 22 communities since the beginning of 2010. Of the 22 communities impacted, one hospital closed three times and two hospitals closed twice. Three communities have seen their hospital reopen (mostly with more limited services), 4 have an emergency room and clinic but no inpatient service, 4 have a clinic but no emergency services, and 11 have no hospital, emergency, or clinic services.

Tragically, more closures are anticipated as most rural hospitals now run a negative margin relying upon local taxes, fund reserves, and supplemental payments through the 1115 waiver and other such programs in order to function. Approximately 41% of rural hospitals nationwide faced negative operating margins in 2016 according to a study of more than 2,100 rural hospitals by Chartis Group and iVantage Health Analytics

The driving forces behind the financial challenges of rural hospitals are $50 million a year in Medicare cuts to Texas rural hospitals starting in 2013, a $120 million a year underpayment by Texas Medicaid, increasing cost to operate hospitals, declining rural population, patients bypassing local hospitals and physicians to more urban providers, and high levels of uninsured (16% Texas average – 30% in some rural Texas counties).

While there is no question that the rural hospital challenges are complex with no simple solutions, there are basic services that are critical to a community including immediate trauma or emergency care and outpatient clinic type services. We believe the task force must keep two very important points in mind as you look at alternative models:

1) No one should live more than 30 minutes from an emergency room or their chances of survival after suffering severe trauma greatly diminish in many situations. While most rural hospitals have limited trauma care capabilities, their primary role in the case of severe trauma is to stabilize a patient in a hospital setting and then transfer them to a major trauma center for more advanced

care. This system enhances the chances of survival rather than first responders sending a patient directly from an accident scene on a rural stretch of highway off long distances to a major trauma center without prompt hospital stabilization. We recognize that many rural Texans already live more than 30 minutes from an emergency room. We are not advocating that more emergency rooms be constructed in sparsely populated regions, but that existing trauma infrastructure must be protected and maintained.

2) While there is no hard and fast formula as to a population base sufficient to support continued operations of a rural hospital, especially considering variances and evolutions in the demographics of the population, there is no question that many rural communities can no longer support a full services hospital. However, the location of hospitals should not be solely based on sufficient population. That can bring about too far a distance between hospitals which raise the point address in item 1.

With those points in mind, we offer these thoughts:

- Medicare cuts to rural hospitals across the last six years, brought about mainly through budget sequestration, Affordable Care Act payment penalties, loss of rural hospital PPS outpatient hold harmless adjustment, and reduction of the bad debt allowance (especially for Critical Access hospitals) have financially damaged hospitals – more than a $50 million dollar loss annually for Texas hospitals alone. Those payments must be restored.
- The proliferation of Medicare Advantage (MA) in rural areas is undermining may rural hospital payment methodologies in Medicare. MA companies and the Centers for Medicare and Medicaid Services (CMS) does not consider MA payments (Medicare Part C) as Medicare for purposes of calculating payments to rural hospitals thus reducing annual payment to Texas rural hospitals by an estimated $300,000 to $400,000 a year. This is a substantial dollar amount to a small rural hospital that is already banking a loss. Congress must direct to CMS that Medicare Part C is considered Medicare for purposes of paying rural hospitals.
- The concept of a step-down hospital or rural emergency center is a viable alternative model for delivering basic emergency and other health care in some rural communities. Currently when a rural hospital closes in many rural communities, citizens are left with no access to any level of care. Past sessions of Congress have seen this concept offered allowing an existing rural hospital facing closure to eliminate expensive inpatient services and continue to offer emergency and outpatient care. Such a model is not considered a “hospital” under current law, but the continuance of the “hospital” classification as previously proposed with a step-down model is critical to payments continuing at an elevated hospital rate to help support 24-7 operations but with low volume associated with rural hospitals.
- The use of telemedicine is an important tool to enhance the level of care in a rural hospital and especially under the step-down concept. Many Texas rural hospitals are already successfully using telemedicine to bring advanced trauma care into hospitals, offer remote obstetrical care, electronically bring in neonatologists to assist with premature births and delivery complications,

and expand mental health care. In many cases, however, the reimbursement for these services are very limited and are not sustainable with current reimbursement methodologies. Advances in reimbursement policies and funding to assist rural hospitals with equipment purchases and operations would rapidly expand its use.

The rural hospitals of Texas appreciate the efforts of the Task Force and look forward to playing a role in the process. Please feel free to contact me with questions or for more information.

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