



Physicians Caring for Texans



Oct. 16, 2020

The Honorable Senfronia Thompson, Chair  
House Committee on Public Health  
*Submitted via email to [publichealth@house.texas.gov](mailto:publichealth@house.texas.gov)*

***RE: Interim Charge 1 – Rural Health***

Dear Chair Thompson and Committee Members:

On behalf of the Texas Medical Association (TMA) and the Texas Academy of Family Physicians (TAFP), which together represent more than 53,000 Texas physicians and medical students, thank you for the opportunity to provide feedback on the House Public Health Committee's Interim Charge 1 related to rural health.

Prior to the arrival of COVID-19, Texas' rural health system faced unprecedented financial and demographic pressures. The pandemic has only amplified them. As such, rural physicians are eager to see the state continue its efforts to ensure rural patients can access the quality care they need to lead successful, healthy lives.

In the past decade, 27 rural hospitals have closed in Texas.<sup>1</sup> More remain financially tenuous. Additionally, many Texans continue to leave rural communities for urban and suburban locales, leaving behind a population that is older, sicker, and more expensive to care for.

Rural physicians and hospitals have a symbiotic relationship, each in need of the other to ensure not only that patients receive timely, quality health care close to home but also the viability of their businesses. Without local physicians, rural hospitals cannot serve their local communities. Likewise, rural physicians need a local facility capable of providing care not suited to a physician's office, including surgical, emergency, and maternity care. After a rural hospital closes, death rates in surrounding communities increase nearly 6%, and that's without a pandemic.<sup>2</sup>

Like any business, Texas hospitals have closed because costs outweigh revenue. Rural Texans are generally more expensive patients because they experience higher rates of obesity, tobacco use, and chronic disease; report fair to poor health; and/or have a greater number of potential years of life lost.<sup>3</sup> High rates of uninsured saddle rural hospitals with uncompensated care costs and often insurmountable

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<sup>1</sup> Ayla Ellison, Rural hospital closures hit record high in 2019 — here's why, *Becker's Hospital Review*, Becker's Healthcare, Dec. 5, 2019.

<sup>2</sup> Sarah Jane Tribble, Prognosis for Rural Hospitals Worsens With Pandemic, Kaiser Health News., Aug. 26, 2020. <https://khn.org/news/rural-hospital-closures-worsen-with-pandemic/>.

<sup>3</sup> Sharita R. Thomas, MPP; George H. Pink, PhD; Kristin Reiter, PhD, Characteristics of Communities Served by Rural Hospitals Predicted to be at High Risk of Financial Distress in 2019, The North Carolina Rural Health Research Program, The Cecil G. Sheps Center for Health Services Research, April 2019.

debt. Additionally, Medicaid comprises a substantial portion of rural hospital revenue, a program whose appropriations are determined by the state legislature.

The Texas Medicaid 1115 Transformation Waiver provides rural hospitals supplemental payments to help offset uncompensated care costs. However, the waiver does not cover all uncompensated care and will expire in two years. Without a renewal, the loss of supplemental dollars will further threaten rural hospitals and patients' access to care. (Please see TMA and specialty society comments on Interim Charge 2 regarding the 1115 Transformation Waiver).

In 2019, lawmakers took several important steps to fortify the state's rural health system. Senate Bill 170 reaffirmed the legislature's intent to pay hospitals for the cost of care. This bill and the subsequent Health and Human Services Commission budget brought the state closer to closing its funding gap. House Bill 1, the state budget bill for the 2020-21 biennium, allocated \$41 million (general revenue)/\$106 million (all funds) to stabilize rural hospitals' fiscal health, including new monies to help rural hospitals maintain labor and delivery services. These dollars most certainly have helped.

However, even with these payment adjustments, Texas Medicaid pays physicians and rural hospitals less than the cost of care by \$120 million each year.<sup>4</sup> In FY 22-23, a prospective payment system should be implemented that may help close this gap.

Senate Bill 1621 outlined a plan for step-down rural hospitals. Such facilities can provide emergency, clinical, or obstetric care in communities that lose their rural hospital. Increased flexibilities in hospital definitions would allow alternative facilities to thrive in areas that may not need hospitals with many inpatient beds, given population concentrations in rural areas and improving technology increasing outpatient procedure availability. Step-down hospitals can save lives by giving physicians a facility to stabilize trauma patients, deliver babies, or provide preventive care. The committee should continue to explore increased regulatory flexibilities that would allow for this innovative option.

As noted above, the COVID-19 pandemic has worsened circumstances for rural health care. Patients are afraid to enter care facilities and physician practices, decreasing patient volumes and revenue even further. In rural areas, high costs of care, increasing rates of the uninsured, and payment shortfalls are a recipe for operating in the red.

According to a recent report published by Texas A&M University Bush School of Government & Public Service, "hospitals in states with Medicaid expansions have had stronger financial performance particularly in rural markets where a large fraction of the population was uninsured. About 11% of uninsured Texans have incomes at or below 138% of federal poverty. ... If Texas extended Medicaid coverage, an estimated 162,700 residents of rural counties would be eligible, and a projected 121,600 would enroll, bringing \$689,650,000 to their local economies (approximately 13% of the total)."

**For Texans to have access to quality health care, improving Medicaid payment rates for physicians and hospitals as well as taking meaningful steps to reduce the rate of uninsured will be essential to stopping the bleed of revenue from our rural hospitals and physician practices.**

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<sup>4</sup> Texas Health and Human Services Commission, Evaluation of Rural Hospital Funding Initiatives, August 2019, <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/evaluation-rural-hospital-initiatives-aug-2019.pdf>.

We recommend the following initiatives to ensure the continued viability of rural hospitals and health systems and to ensure patients have access to local, high-quality care:

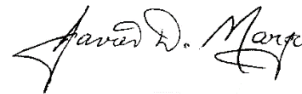
- Redouble Texas' efforts to make comprehensive, affordable health insurance available to all.
- Ensure physicians and hospitals are paid the cost of care they provide.
- Support step-down hospital formation by expanding the bed capacity and service requirements used to qualify a hospital for Medicaid and Medicare payments.
- Encourage physicians to practice in rural areas by replenishing funding for the State Physician Education Loan Repayment Program and Rural Resident Physician Grant Program.
- Prevent budget cuts that would further drive rural hospitals to closure, particularly given the need for local care during the COVID-19 pandemic.

Again, thank you for the opportunity to provide feedback on Interim Charge 1 related to rural health. If you have any questions, please do not hesitate to contact any of the following Texas Medical Association staff at TMA's main number, (512) 370-1300, or by email: Dan Finch, vice president, Advocacy, at [dan.finch@texmed.org](mailto:dan.finch@texmed.org); Helen Kent Davis, associate vice president, Governmental Affairs, at [helen.davis@texmed.org](mailto:helen.davis@texmed.org); or Sophie Jerwick, health policy analyst, Governmental Affairs, at [sophie.jerwick@texmed.org](mailto:sophie.jerwick@texmed.org).

Sincerely,



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