THA Priorities

Legislative and Regulatory Actions to Support the Financial and Workforce Stability of Hospitals and Ensure Quality Care to Patients Across Tennessee.

Extend Tennessee's Partial Medicaid DSH Payments

For over four decades the Medicaid statute has required a disproportionate share hospital (DSH) payment to hospitals treating large numbers of low-income patients. This helps to offset hospitals' uncompensated care costs and improve access for Medicaid and uninsured patients.

Tennessee is at a unique disadvantage as the only state without a permanent Medicaid DSH allotment.

Since 2004, with strong, bipartisan support from our congressional delegation, Tennessee has received several temporary partial Medicaid DSH payments through various legislative vehicles. In 2015, our delegation worked to secure a 10-year extension of Tennessee's partial DSH payment of $53.1 million for each fiscal year but this extension will expire in 2025. We appreciate the engagement we have already seen from our delegation on this issue and look forward to our continued efforts to secure a permanent extension of these critical Medicaid DSH payments.

Fix the Flawed Area Wage Index

Enact a Permanent Legislative Fix:
The *Save Rural Hospitals Act* (S.803) was reintroduced in the Senate by Senator Blackburn and will soon be reintroduced in the House. The bill would establish a permanent Medicare area wage index floor of 0.85 which would benefit the majority of Tennessee hospitals. Currently 73 percent of Tennessee hospitals are below the floor the bill would establish. We are grateful for the strong support from our delegation on the *Save Rural Hospitals Act* and ask for your continued support to pass the bill this Congress.

Continuation of Critical Regulatory Relief:
In 2019, the Center for Medicare and Medicaid Services (CMS) established a four-year lower-quartile adjustment where hospitals in the lowest reimbursement areas (the bottom 25%) received a wage index increase. This is a critical lifeline for Tennessee hospitals, providing more than $100 million in reimbursement relief between FY2020-2022.

THA is pleased CMS recently indicated in their IPPS proposed rule that they intend on continuing the low wage index hospital policy through FY2024. We are grateful for the strong support over the last two years from our delegation in letters to CMS urging this decision.

Financial Stability and Payer Challenges

Oppose Site-Neutral Payment Approach Which Ignores Patient Needs

Medicare patients who receive care in a hospital outpatient department (HOPD) are more likely to come from medically underserved populations and be sicker and more complex to treat than patients treated in independent physician offices (IPO) and ambulatory surgical centers (ASC).

Proposals under discussion by policymakers to compensate hospitals the same amount as IPOs and ASCs for Medicare services– often referred to as "site-neutral" payment policies – fail to reflect important differences in the patients, clinical expertise, and numerous state and federal requirements which hospitals must comply with compared to other providers.

Unlike other providers, hospitals maintain standby capacity for natural and man-made disasters, public health emergencies, other unexpected traumatic events, and the delivery of 24/7 emergency care to all who come through their doors, regardless of a person's ability to pay or insurance status. Reducing all payments to the lowest established payment creates an unlevel playing field for hospitals and places patient needs and access at risk.

Prior Authorization and Medicare Advantage

The Medicare Advantage (MA) prior authorization system needs meaningful reform, improved oversight, and transparency to ensure patients have appropriate and timely access to care. We are encouraged by CMS' recent final rule which increases oversight of MA plans and seeks to better align MA coverage with traditional Medicare. THA believes this is a strong first step and we ask for your support for additional oversight and enforcement.

Last Congress, the House passed the *Improving Seniors' Timely Access to Care Act* with overwhelming support. The bill aims to streamline MA prior authorizations and address unnecessary delays and denials of patient care. We ask for your continued support for the bill when reintroduced.

Post-Acute Discharge Delays

Due to prior authorization delays/denials and workforce shortages, many post-acute patients remain in acute hospital beds for days and sometimes weeks. Health insurers rarely pay for those additional days of inpatient care, forcing hospitals to absorb those costs. These delays not only create additional costs and resources to patient care, but also threaten patient recovery and contribute to staff burnout.

Establishing a temporary hospital per diem payment to offset the financial burden of post-acute patients awaiting discharge would help to mitigate these costs, ease capacity issues, and align the financial incentives of health plans to provide patients with the appropriate level of care.

Preserve the Ban on Physician-owned Hospitals

Congress should protect access to care by preserving the existing ban on the growth and expansion of physician-owned hospitals, which cherry-pick patients and provide less uncompensated and emergency care than community hospitals.

Surprise Billing Reforms to Ensure the Law is Implemented as Intended

Urge CMS to reverse the 600 percent fee increase to file a No Surprises Act (NSA) Independent Dispute Resolution (IDR) claim. CMS announced an amendment to its 2023 IDR fee guidance on Dec. 23, raising the $50 fee it set in October to $350. The 600 percent administrative fee increase essentially makes the IDR process cost prohibitive and unworkable for many claims since the difference in the payment may be less than the fee.

Providers are also struggling to get payers to adhere to the NSA. Some payers are not issuing timely payments, others are refusing to pay claims once the IDR has reached a decision, and other payers are not providing the level of detail about the qualifying payment amount (QPA). In addition to decreasing the fees, more insurer oversight is necessary to ensure payments are made timely and in accordance with the NSA.

Mental & Behavioral Health

Eliminate the Medicare 190-day Lifetime Limit for Inpatient Psychiatric Hospital Care
Medicare beneficiaries are currently limited to just 190 days of inpatient psychiatric hospital care in their lifetime. No other Medicare specialty inpatient hospital service has this type of arbitrary cap on benefits. The 190-day lifetime limit is problematic for patients being treated in psychiatric hospitals as they may easily exceed the 190 days if they have a chronic mental illness.

Eliminating this cap will expand patient choice, increase access to essential treatment for the most seriously ill, and help to improve continuity of care.

Repeal the Medicaid IMD Exclusion
The Medicaid Institutions for Mental Diseases (IMD) exclusion prevents adult Medicaid beneficiaries (ages 21-64) from accessing short-term, acute behavioral healthcare in psychiatric hospitals and other residential treatment facilities with more than 16 beds. Eliminating the IMD exclusion would give states flexibility to contract with cost-effective, efficient, and high-quality treatment programs, which would help lower costs and increase access.

Protect the 340B Drug Pricing Program

The 340B Drug Pricing Program requires drug companies to sell outpatient drugs to certain not-for-profit hospitals, health centers, and specialty clinics ("covered entities") at discounted rates. Savings from these discounted rates allow hospitals and their affiliated clinics and pharmacies to provide comprehensive services to the nation's most vulnerable patients, while mitigating the losses they experience due to chronic underpayments from public payers like Medicaid.

Efforts led by the pharmaceutical industry and others seek to roll back its benefits. Further cuts to 340B Program benefits would have significant adverse consequences for the vulnerable communities served by 340B-eligible hospitals, especially in Tennessee's rural and underserved areas. The 340B Program should be protected and expanded to every hospital that meets the eligibility requirements, regardless of ownership status.

Support Legislation to Increase Needed Healthcare Workforce in Tennessee

Rural America Health Corps Act (S. 940/H.R.1711)
Sponsored by Senator Blackburn in the Senate and Reps. David Kustoff and Diana Harshbarger in the House, the bill provides incentives for clinicians to practice and plant roots in rural areas and will help increase the supply of healthcare professionals at a critical time for our nation's healthcare workforce.

Rural Physician Workforce Production Act (H.R. 834/S.230)
Bipartisan legislation, sponsored by Rep. Harshbarger, improves Medicare reimbursements and enhances the current structure of the Medicare-funded graduate medical education (GME) program to bring more medical residents and doctors to rural areas.

Conrad State 30 and Physician Access Reauthorization Act (S.665)
Cosponsor bipartisan legislation to extend for three years the Conrad State 30 program. The program would allow international doctors to remain in the U.S. upon completing their residency under the condition they practice in areas experiencing doctor shortages. Rural areas across Tennessee lack the healthcare workforce needed to provide quality and timely care. This legislation will allow American-trained doctors to help fill those gaps.

Restoring America's Healthcare Workforce and Readiness Act (S.862)
Support the reauthorization of the National Health Service Corps, National Nurse Corps, and Title VII and VIII which address nursing and primary care clinical training and development programs. All of these programs are set to expire on Sept. 30.