

**Erin Mahn**

**National Rural Health Association**

**1108 K Street NW, 2<sup>nd</sup> Floor, Washington, DC 20005**

**202-639-0550 (Phone)**

**[emahn@NRHArural.org](mailto:emahn@NRHArural.org)**

**Hearing on Expiring Medicare Provider Payment Policies, September 21, 2011**

Thank you for your consideration of the following comments. If you would like additional information, please contact Maggie Elehwany, Vice President of Government Affairs at [melehwany@NRHArural.org](mailto:melehwany@NRHArural.org) or 202-639-0550.

**Testimony of National Rural Health Association  
House Ways and Means Subcommittee on Health  
Hearing on Expiring Medicare Provider Payment Policies  
September 21, 2011**

The National Rural Health Association (NRHA) thanks the House Ways and Means Subcommittee on Health for the opportunity to submit testimony. NRHA is pleased to detail to the committee the importance of several of the expiring Medicare payment policies to rural patients and providers.

NRHA is a nonprofit membership organization with more than 22,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care infrastructure, including rural community hospitals, critical access hospitals, doctors, nurses and individuals. We work to improve rural America's health needs through government advocacy, communications, education and research.

Several of these payment provisions were created by Congress to improve access to care in rural America, and have been successful in meeting that goal. Continuation of these payment provisions is crucial, and NRHA has long sought legislation to make the payments permanent. However, NRHA certainly recognizes the importance of examining these Medicare provider payment policies, many of which expire on or before December 31, 2011. We agree with Chairman Herger that it is important to reexamine the impact of Medicare payment policies to ensure that they continue to improve access to care, especially for rural patients.

Rural Americans, on average, are older, sicker and poorer than their urban counterparts. Rural America needs the extension of these programs to retain physicians and promote rural physician recruitment. Without the extension of these programs, the negative impact on the rural health infrastructure and local economies would be devastating. Medicare beneficiaries should not lose access to local services and care.

This testimony focuses on NRHA's concerns for rural beneficiaries and the need to provide security to the fragile rural health care safety net. Our primary concern is payment equity and access to care in the Medicare system, where rural beneficiaries are most likely to enroll.

The importance of some of the expiring provisions the Subcommittee will be examining include:

**Physician Work GPCI**

Medicare and Medicaid – major components of rural health care – pay rural providers less than their urban counterparts. Rural health care providers operate on a very thin margin and many rural communities have severe medical workforce shortages. Only 10 percent of physicians practice in rural America even though a quarter of the population lives in these areas. Although rural physicians put as much time, skill and intensity into their work as physicians in urban areas, rural physicians are reimbursed at lower rates. In recognition of the challenges rural facilities face in recruiting physicians, the Geographic Practice Cost Index's work geographic index floor was set at 1.0. To recruit and retain physicians, this GPCI payment must be continued. GCPIs adjust payments for geographic differences in the cost of providing services,

including for physician work (or cost-of-living adjustments), practice expenses and medical liability insurances. With rising practice costs, extension of GPCI payments makes rural practice financially viable and allows communities to retain their providers. They also provide incentive for those interested in entering rural medical practice. It is vital that these payments are continued and improved.

### **Direct Billing for Technical Component of Pathology Services**

Since the creation of the Medicare program, independent laboratories have been allowed to bill Medicare directly for certain clinical laboratory services. These independent laboratories allow small and rural hospitals to access high quality services when they do not have the volume or financial resources to support their own state-of-the-art laboratory. Independent laboratories provide pathology services to multiple hospitals, receiving the volume necessary to purchase the most up-to-date equipment and employ skilled laboratory staff. A hospital can utilize any independent laboratory for these services, creating competition among laboratories for delivery services and allowing hospitals to choose the laboratory that best meets their needs. Without this extension, hospitals would have to absorb new costs without a payment increase. This could result in limited access to surgical services for Medicare beneficiaries near their residence. This could result in beneficiaries delaying treatment leading to poorer outcomes and increased costs when complications arise. Congress has recognized the importance of this hospital and independent lab arrangement throughout the years by “grandfathering” independent labs into this program. Under certain circumstances these “grandfathered” facilities are allowed to continue billing Medicare directly for services. An extension would allow independent laboratories to bill Medicare directly for certain clinical laboratory services.

### **Extension of Improved Payments for Low-volume Hospitals**

Federal regulations have established various payment formulations within Medicare to help Sole Community Hospitals (SCHs), Medicare Dependent Hospitals (MDHs) and low-volume hospitals remain viable. These hospitals, located in rural areas, are more vulnerable to the limitations of the Inpatient Prospective Payment System. The current inpatient payment rates do not account for the fact that most rural facilities do not or cannot operate on the same economies of scale as a large, urban hospital. This important provision helps low-volume rural hospitals that cannot make ends meet under the PPS system, but do not want to convert to or do not qualify for Critical Access Hospital status.

### **Mental Health Add-On Payment**

Workforce shortages also create inaccessibility for mental health care in rural areas. A vast majority of rural areas are designated as mental health professional shortage areas and most rural counties do not have a psychiatrist or psychologist. Marriage and family therapists or licensed professional counselors are often the only mental health professionals in remote rural and frontier areas. The expiration of the mental health provider reimbursement will cause an even larger shortage in mental health services. These payments are crucial for ensuring access to mental health services.

### **Ambulance Add-ons**

Distance and geographic barriers play a major role in access to health care in rural America. For many rural areas, emergency medical services are often the front-line providers, required to respond to both emergency and non-emergency events. Often composed of volunteer

providers, rural ambulance services have found it difficult to keep their doors open due to inadequate Medicare payments and inappropriate payment denials by Medicare claims processors. To help alleviate this burden and ensure ambulance services in rural America, the bonus payment for ground and air ambulance trips was created to build a stronger, more financially viable rural emergency network. Without the extension of this program, rural Americans will not have their needs of rural emergency medical services met. Expiration will jeopardize the level of care that ambulance services can deliver and increase the time it takes to respond to patients.

### **Outpatient hold harmless provision**

Small rural hospitals (100 beds or fewer) receive Medicare payments so that they are held harmless from the effects of the outpatient prospective payment system. Eligible hospitals will receive a partial and declining hold harmless payment until the end of CY2009. In CY 2006, hospitals received 95 percent of any difference between their PPS payment and payments under the previous system, 90 percent in CY 2007, and 85 percent in CY 2008 and CY 2009. Since 2009, this provision has been extended on multiple occasions. We urge the committee to do so again.

### **Conclusion**

These programs protect the rural health care safety net and provide critical access to health care for rural Americans. Rural physicians and hospitals generate billions of dollars for the local economy. Studies at the National Center for Rural Health Works at Oklahoma State University have found that one fulltime rural primary care physician generates about \$1.5 million in revenue, and creates or helps create 23 jobs. Rural health care systems make huge economic contributions to their communities. Reducing rates for rural providers will force many facilities to offer reduced services or even close their doors, further reducing access to care for rural Americans. Rural hospital closures also devastate local economies. In the past, a closed hospital has meant as much as a 20 percent loss of revenue in the local rural economy, 4 percent per capita drop in income, and a 2 percent increase in the local unemployment rate.

Medicare Provider Payment Policies are critical to the ability of our rural health care safety net and the ability for our health care providers to continue to provide quality care to rural Americans. The development of permanent policies that address these issues is vital to the ongoing success and viability of the rural health care safety net. In the past, members of Congress have looked to the bi-partisan Rural Hospital and Provider Equity Act (R-HoPE) to address these issues in the long-term and provide rural providers with the certainty they need. We encourage the committee to look to that legislation (S. 1157, 111<sup>th</sup> Congress) as a guide for addressing all these issues in the long-term.

NRHA looks forward to continuing working with members of the Subcommittee and Congress. We thank Chairman Herger and the Subcommittee for the opportunity to provide testimony.