



Statement of
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Before the
Committee on Ways and Means
Subcommittee on Health
U.S. House of Representatives
Rural Health Care Disparities Created by Medicare Regulations & Payment
July 28, 2015 at 10:00 A.M. in 1100 Longworth House Office Building

Chairman Brady, Ranking Member McDermott, distinguished Committee members – my name is Dan Derksen. I am the director of the Center for Rural Health at the University of Arizona College of Public Health. I am honored to provide expert testimony on rural health and disparities created by Medicare regulations. I have over 30 years experience working as a family physician and faculty member at two public land grant universities.

Today I am not representing the University or any other entity. I draw on my three decades of experience - as a family physician practicing in underserved sites where most of my patients were on Medicare or Medicaid, or were uninsured; as a faculty member creating training programs and preparing health professions students to practice in rural communities; as director of an academic faculty practice plan; as a director working for a Governor to establish a state-based health insurance marketplace; and as at health policy fellow working for a U.S. Senator researching and drafting legislation to improve the supply and distribution of the health workforce to rural areas.

You have heard the rural health challenges: fewer health providers, poorer health outcomes, higher rates of poverty and uninsured. Medicare regulations, cuts and threats to Medicare payment – such as disproportionate share hospital (DSH) payment, graduate medical education (GME) payment and arcane regulatory burdens including the Two Midnight Rule, 96-hour Rule, and onerous and costly reporting and auditing requirements - do not improve health outcomes. These catalyze the closure of



an alarming number of our nation's rural hospitals (54 since 2010)¹, and push many more to the brink of fiscal extermination (283 rural hospitals at risk of closure)². To bring this message home to the Members of this Health Subcommittee, that translates to 10 Members representing states with rural hospital closures since 2010 (CA, GA, KS, NE, TN, TX, WI) and 14 Members from states with rural hospitals at risk of closure (CA, FL, GA, IL, KS, NE, TN, TX, WA, WI).^{1,2}

Medicaid (+12.3 million³) and the Marketplace (+8.7 million receiving advance premium tax credits⁴) covered many more Americans in 2014-15, intensifying demand for health services especially in rural counties where 77% are federally designated primary care Health Professions Shortage Areas⁵. Expanded coverage has improved hospital fiscal margins over the last 18 months. To assure ready access to high quality, cost efficient health care, private physicians and health providers, Critical Access Hospitals, Rural Hospitals, Rural Health Clinics, Federally Qualified Health Centers, and health professions education and training programs play crucial roles.

The real challenge is to move beyond the comfortable “hold harmless” to the “hold accountable” approaches that yield a better return on our public investment, that measurably improve health outcomes, and use formulas that anyone can understand.

I will discuss innovative approaches and provide specific examples, of how some communities are improving access to high quality, cost efficient rural health care; moving the health professions training pipeline closer to areas of high need; creating jobs and spurring economic growth in rural communities; while assuring the health and wellness of rural populations.

(1) *Graduate Medical Education (GME) – Yielding a Better Return On Our Public Investment -*
Our nation spends \$15.5 billion per year⁶, \$10 billion by Medicare for direct and indirect

¹ Rural Hospital Closures: January 2010 – Present. Sheps Center for Health Services Research. Accessed 7/26/15 at:

² Topchik M: Vulnerability to Value 2015. iVantage Health Analytics. Accessed 7/26/15 at: <http://info.ivantagehealth.com/rural-relevance-2015-study-request-0>

³ Medicaid & CHIP: April 2015 Enrollment Report June 23, 2015. Accessed 7/16/15 at: <http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/april-2015-enrollment-report.pdf>

⁴ Marketplace Enrollees. Kaiser Family Foundation. Accessed 7/26/15 at: <http://kff.org/health-reform/state-indicator/marketplace-enrollees-eligible-for-financial-assistance-as-a-share-of-subsidy-eligible-population/>

⁵ WWAMI Rural Health Research Center. Accessed 7/26/15 at:

http://depts.washington.edu/uwrhrc/uploads/Rural_Primary_Care_PB_2009.pdf

⁶ GME That Meets the Nation's Health Needs. Institute of Medicine. Accessed 7/26/15 at:

<http://iom.nationalacademies.org/Reports/2014/Graduate-Medical-Education-That-Meets-the-Nations-Health-Needs.aspx>



GME, and almost \$4 billion in the 42 states using Medicaid funds⁷ to support GME to train physicians in residencies after completing undergraduate education in medical allopathic and osteopathic schools. As more are covered, demand for health care increases, especially in rural areas. Rural training programs have demonstrated success training health professionals that practice in the high need primary care specialties in the areas they are most needed.

To complement the outstanding education in urban academic health centers, Teaching Health Centers (THCs) intend to move the primary care training pipeline closer to areas of need. THCs are now in: AL, AK, AZ, CA, CT, ID, IL, IA, KY, ME, MA, MI, MO, MT, NM, NY, NC, OK, PA, TX, WA, WV. Some are testing new THC models, to include nurse practitioners and other health providers in community-based teams to assure the nation's rural communities have the health workforce they need, such as in New Mexico, leveraging Medicaid GME to invest in the health professions training pipeline⁸.

MedPAC testified recently that Medicare pays hospitals more than \$3.5 billion above their empirically justified costs for indirect GME (IME) hospital payment⁹. I have worked in academic health centers for 30 years, and have researched and drafted federal and state legislative interventions. Based on those experiences, my suggestions are to:

- a) Diversify Medicare and Medicaid GME investments to include Teaching Health Centers, to reform the structure and financing of primary care GME¹⁰.
- b) Invest Medicare current GME dollars more strategically – there are many approaches such as those suggested by MedPAC and the IOM^{6,9}.
- c) Address the wide variation in Medicare GME payment between states¹¹. Why should New York receive nine times more Medicare GME funding per capita than Texas (NY =

⁷ Teaching Health Centers. Health Affairs Blog. Accessed 7/26/15 at: <http://healthaffairs.org/blog/2014/10/17/teaching-health-centers-an-attainable-near-term-pathway-to-expand-graduate-medical-education/>

⁸ HB 310: Creation of Primary Care Residency Slots through FQHC THC Program. Accessed 7/22/15: <http://www.nmlegis.gov/Sessions/14%20regular/bills/house/HB0310.PDF>

⁹ MedPAC Committee on Ways and Means testimony of 7/22/15 at: [http://www.medpac.gov/documents/congressional-testimony/testimony-hospital-policy-issues-\(ways-and-means\).pdf?sfvrsn=0](http://www.medpac.gov/documents/congressional-testimony/testimony-hospital-policy-issues-(ways-and-means).pdf?sfvrsn=0)

¹⁰ Proposal for reform of the structure and financing of primary care GME. *Fam Med*. 2013. Accessed 7/26/15 at: <http://www.ncbi.nlm.nih.gov/pubmed/23463428>

¹¹ Mullan F: Geography of GME. Accessed 7/26/15 at: <http://content.healthaffairs.org/content/32/11/1914.abstract>

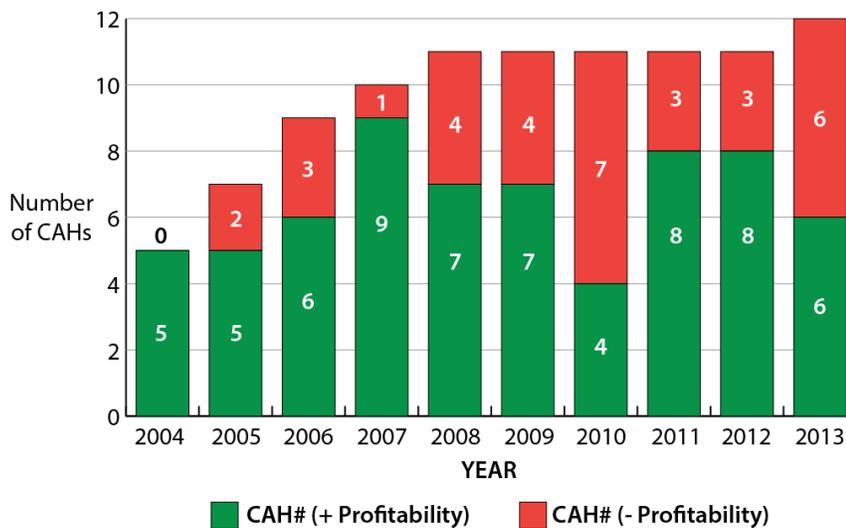


\$103.63 per person, TX = 11.51)? Why should Connecticut receive \$155,135 average Medicare payments, and others get half of that (TX \$65,500; CA \$87,121; GA \$86,448)?

- d) Let states innovate – use Medicaid GME, or a portion of current (e.g., IME) Medicare or new GME funding, to test and disseminate the interprofessional, community-based Teaching Health Centers needed to serve rural populations.

(2) Rural providers and hospitals struggle to maintain positive fiscal margins, and keep their doors open to serve their patients and communities. Small Medicare payment, regulatory or reporting changes can push them over the brink. Figure 1 illustrates 12 Arizona Critical Access Hospital fiscal margins – half are negative. Diminishing Disproportionate Share Hospital (DSH) payments, fanatical Recovery Audit Contractors (RAC) with fiscal incentives (contingency fees) to deny payment without balancing penalties to extinguish inappropriate and unjustified denials also contribute to the hostile environment that threatens rural hospital survival. The tiered, glacial RAC denial appeal process requires a tenacity and commitment that many rural hospitals cannot sustain.

Figure 1: Arizona CAHs' Profitability Summary
2004-2013



Source – Arizona Dept. of Health Services: Hospital Cost Reports (2004-2013)



(3) Ease the Medicare rural hospital and physician regulatory burdens:

- a) Eliminate the 96 Hour Rule as a condition of payment for Critical Access Hospitals (CAHs). As a family physician that has admitted hundreds of patients over the years in urban and in rural areas, it can be very difficult to determine which patients will require longer hospitalizations. CAHs can satisfy conditions of participation requiring an annual average of 96 hours length of stay.
- b) Modify the Two-Midnight Rule – this complicated rule has almost everyone unhappy, but especially Medicare patients, who may be forced to pay more for services that are ruled outpatient. A prudent path forward would be for Congress to extend the partial enforcement delay of the two-midnight policy until March 30, 2016.
- c) Align quality and satisfaction reporting for Medicaid and Medicare for rural hospitals and physicians. Critical Access Hospitals, community health centers, rural health clinics and physician practices have limited personnel, and high turnover of “C-suite” personnel – Chief Executive Officer, Chief Nursing Officer, Chief Medical Officer, Chief Financial Officer – making it difficult for hospitals and clinics to report metrics required for payment such as those reported on Hospital Compare for larger hospitals, Medicare Beneficiary Quality Improvement Project (MBQIP), and patient satisfaction in HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems). Increasingly, rural hospital and physician payments are tied to quality reporting and value based outcomes. Rural hospitals, physicians and health providers need training and support to help them prepare for value based payment changes, such as those in the 815-page proposed rule released in July by the Centers for Medicare and Medicaid Services relating to the Physician Fee Schedule. An intermediate step to value based payment – creating voluntary quality pools, based on the model of the rural and critical access pool Medicaid payments in the Arizona Health Care Cost Containment System (AHCCCS).

The simplest gauge of quality is whether we meet health needs. We must leverage our public Medicare dollars to reinvent health professions education and meet our nation’s health needs.

Chairman Brady, Ranking Member McDermott, distinguished Members of the Committee - thank you for the opportunity to provide expert testimony.