



**Statement by the Association of American Cancer Institutes for the  
Subcommittee on Health  
Committee on Ways and Means, U.S. House of Representatives hearing on  
Medicare Payment Advisory Commission (MedPAC) Hospital Payment Issues  
July 22, 2015**

The Association of American Cancer Institutes (AACI), representing 95 of the nation's leading academic and free-standing cancer centers, appreciates the opportunity to submit this statement for the record to the subcommittee on the July 22 Medicare Payment Advisory Commission (MedPAC) hearing on hospital payment issues.

Site-neutral policy recommendations have been made recently in regard to hospital outpatient departments and physician offices, with the suggestion to equalize Medicare payments. This recommendation is of concern to our nation's cancer centers. National Cancer Institute-designated cancer centers and academic research institutions are the primary source of new discoveries into cancer's causes, as well as the prevention, diagnosis, and treatment of cancer.

Cancer centers develop and deliver state of the art therapies and provide comprehensive care, from prevention to survivorship, to patients. Our nation's cancer centers are engaged in their communities, providing timely information to healthcare professionals and the general public about cancer prevention and screening measures, conducting research and developing new treatments in their labs, and serving diverse and often underserved and understudied patient populations.

A recent study prepared for the American Hospital Association determined that relative to patients treated in physician offices, cancer patients receiving care in hospital outpatient departments are often more likely to be:

- Minority or underserved patients

- Uninsured, self-pay, charity care or Medicaid patients
- Residing in areas of poverty, with lower household income and lower educational attainment
- Burdened with more severe chronic conditions and comorbidities

Our nation's cancer centers treat some of the sickest and costliest patients through multidisciplinary teams with expertise in specific cancer types. These high-caliber teams are at the forefront of offering specialized therapeutic strategies beyond traditional chemotherapy, including immunotherapies and personalized medicine. Cancer patients require particular treatments in facilities where immediate assistance from nurses and other caregivers can be provided. Compared with physician-based oncology practices, hospital outpatient departments are equipped to serve patients with the potential for high complications, where immediate assistance from appropriate hospital staff can be provided. Such hospitals provide more comprehensive services to treat complex patient needs including social support services, palliative care, on-site pharmacy services, and nutrition assistance. The delivery of care at our nation's cancer centers is unparalleled.

AACI cancer centers face persistent reimbursement challenges and added costs due to state and federal mandates shift an additional burden onto cancer centers. Hospital-based programs assume more responsibilities and fulfill more stringent requirements than do physician offices, including licensing, accreditation, and regulatory requirements. Unlike the physician fee schedule, hospital costs are verified by audited cost report and claims data. Care provided in the hospital outpatient setting is cost-effective, and further reductions to payments could threaten patient access to essential services.

### **Conclusion**

The institutions represented by AACI strongly object to site-neutral reimbursement proposals performed in a budget neutral manner at the expense of cancer centers and other hospital-based programs. The future of cancer care relies on the highly-skilled teams based at our nation's cancer centers. Changes

in Medicare payment rules at the cost of cancer centers could diminish cancer services at our nation's cancer centers and, by extension, the well-being and prospects for recovery of millions of cancer patients.



## AMERICA'S ESSENTIAL HOSPITALS

The Honorable Kevin Brady  
Chair  
Subcommittee on Health  
Committee on Ways and Means  
United States House of Representatives  
Representatives  
Washington, DC 20515

The Honorable Jim McDermott, MD  
Ranking Member  
Subcommittee on Health  
Committee on Ways and Means  
United States House of  
Representatives  
Washington, DC 20515

August 5, 2015

**Statement for the hearing record: Hearing with the Medicare Payment Advisory Commission to discuss hospital payment issues, rural health issues, and beneficiary access to care**

Submitted electronically to: [waysandmeans.submissions@mail.house.gov](mailto:waysandmeans.submissions@mail.house.gov)

Dear Chairman Brady and Rep. McDermott:

On behalf of America's Essential Hospitals and its more than 250 member hospitals and health systems, I thank you for the opportunity to provide our thoughts regarding the July 22, 2015, hearing on Medicare hospital payment issues. Our member hospital systems are united by a commitment to serve all patients, including the most vulnerable, with the best health care possible. Essential hospitals are also primary providers of essential community services that touch all people, including trauma and burn care, disaster response, public health, preventive services, and medical education.

Our comments are on four specific areas: Medicare disproportionate share hospital (DSH) payments, the Hospital Readmissions Reduction Program (HRRP), Medicare indirect medical education (IME) payments, and issues related to Medicare payment for short inpatient stays.

## Medicare DSH

To maintain their financial stability, members of America's Essential Hospitals rely on a patchwork of federal, state, and local support, including Medicare DSH payments. **Because our hospitals on average operate at a loss—an average negative 3.2 percent operating margin in 2013—scaling back any component of that support severely challenges essential hospitals' ability to serve their communities.**

Section 3133 of the Affordable Care Act (ACA) cut Medicare DSH funding by \$22 billion from fiscal years 2014 to 2019. While DSH hospitals continue to receive 25 percent of their Medicare DSH payments as a per-discharge adjustment, the remaining 75 percent is decreased to reflect the change in the national uninsurance rate and distributed based on uncompensated care burden. This change was intended to better incorporate uncompensated care into the Medicare DSH formula to better target support at hospitals with the greatest need. America's Essential Hospitals has long supported this approach and continues to work with the Centers for Medicare & Medicaid Services (CMS) to ensure the targeting is conducted in a fair and accurate manner.

But we are concerned about the sustainability of continued reductions to the aggregate uncompensated care-based DSH payments that are occurring as coverage continues to expand and the national uninsurance rate falls. We urge the committee to evaluate the appropriateness of continuing these Medicare DSH cuts in light of the following points.

The aggregate amount of uncompensated care payments CMS has proposed for fiscal year (FY) 2016—\$6.4 billion—incorporates a nearly 30 percent reduction from FY 2013 levels. This amount will continue to decline with the national uninsurance rate. Hospitals in states that have not expanded Medicaid are not experiencing the drop in uncompensated care that hospitals in expansion states have seen. The cuts have even challenged essential hospitals in expansion states because of continuing high levels of uncompensated care and the vulnerable people they serve.

Further, the CMS's current Medicare DSH methodology relies on an imprecise measure of hospital uncompensated care. Under the methodology, CMS determines a hospital's qualifying uncompensated care burden by estimating the hospital's percentage of the total uncompensated care costs incurred by all DSH hospitals. To date, CMS has concluded that due to shortcomings of the Medicare cost report S-10 worksheet, it must deviate from the common definition of uncompensated care and instead use a proxy to estimate hospital

uncompensated care costs. CMS notes the proxy is an interim measure and proposes to continue to monitor alternative proxies and data sources.

**Given the substantial negative impact of the Medicare DSH cuts on essential hospitals—in both expansion and non-expansion states—and the shortcomings in data needed to accurately calculate uncompensated care, America’s Essential Hospitals would support thoughtfully crafted legislation to stop further aggregate cuts to Medicare DSH.** Since the hearing on July 22, Rep. Kenny Marchant introduced legislation changing the ACA’s Medicare DSH cut policy by directing new funding to hospitals in states that have not expanded Medicaid under the Affordable Care Act. America’s Essential Hospitals is currently analyzing the impact of this legislation and will provide feedback to the committee at a future time.

### **Medicare HRRP**

Section 3025 of the ACA mandated the creation of the Medicare HRRP. The program was designed to give hospitals a financial incentive to reduce avoidable readmissions. While we agree with the general intent of the program, the current readmissions measures do not accurately reflect quality of care because they do not account for patients’ complex social and economic circumstances that exist outside a hospital’s control and drive readmissions. As the Medicare Payment Advisory Commission (MedPAC) noted in its written testimony: “Hospitals’ readmission rates and penalties are positively correlated with their low-income patient share.”

**Because the HRRP fails to adjust for sociodemographic factors that lead to readmissions, many essential hospitals will suffer penalties unrelated to the actual quality of the care they provide.** This reduction in funding will create a vicious cycle, making it even more difficult for hospitals to help patients overcome disadvantages and, in turn, further increasing readmissions. As noted above, most essential hospitals operate on narrow or negative margins and cannot absorb additional funding cuts. HRRP penalties could force some hospitals to make difficult decisions regarding the services they provide, the people they employ, and their reinvestments in the community.

**America’s Essential Hospitals supports legislation drafted by Rep. Jim Renacci: H.R. 1343, Establishing Beneficiary Equity in the Hospital Readmission Program Act.** H.R. 1343 would mitigate the unequal treatment of hospitals in a two-stage approach. First, for fiscal years 2016 and 2017, the bill would require CMS to make a risk adjustment that accounts for both a hospital’s

proportion of inpatients who are full-benefit, dually eligible individuals; and the socioeconomic status of the patients a hospital serves. Second, for fiscal years after 2017, the bill would require CMS to risk adjust the readmission measures based on findings from the Improving Medicare Post-Acute Care Transformation Act of 2014, and also require MedPAC to report on the appropriateness of the program's 30-day threshold for readmissions. America's Essential Hospitals remains open to solutions other than those in H.R. 1343 to limit the negative impact HRRP has on essential hospitals and their vulnerable patients.

### **Medicare IME**

Members of America's Essential Hospitals commit to training the nation's future health care workforce. **In fiscal year 2013, our more than 250 member hospitals trained, on average, 254 physicians per hospital, which is 14 times as many as the average number trained at other U.S. teaching hospitals.**

Graduate medical education (GME) payments cover the direct cost of physician training. Medicare IME payments are designed to cover the indirect higher costs of operating a teaching hospital. The Balanced Budget Act of 1997 capped the number of residency slots for which Medicare can reimburse teaching hospitals. **These caps, based on training levels when Congress passed the 1997 law, are long outdated and have not increased with training needs. Nevertheless, to further their missions and despite financial stress, many essential hospitals train above their Medicare caps.** The funding shortfall for each resident trained beyond a hospital's cap creates additional financial strain on essential hospitals.

**America's Essential Hospitals would support legislation to remedy the ongoing problem presented by an inadequate number of physician residency slots funded by GME, particularly for public and nonprofit teaching hospitals.** Since the hearing on July 22, Chairman Brady introduced legislation that would substantially change the formula by which Medicare distributes funds for IME. America's Essential Hospitals is analyzing the legislation and looks forward to discussing this important issue further with the committee.

### **Medicare Short Stay Policy**

In its FY 2014 inpatient prospective payment rule, CMS first announced the "two-midnight" policy. But in response to concerns raised by providers and

Congress, the agency put in place an enforcement ban on parts of the regulation and has repeatedly extended the ban. Most recently, CMS extended the ban until September 30, 2015, based on a requirement in the Medicare and CHIP Reauthorization Act of 2015. **The repeated extension of the enforcement ban indicates that the agency, hospitals, and other stakeholders are not prepared to implement the two-midnight policy. America's Essential Hospitals supports further extending this ban until appropriate changes to the two-midnight policy are enacted.**

In CMS' Outpatient Prospective Payment System proposed rule, the agency responded to stakeholders' concerns about the impact of the policy on clinicians' judgment by proposing to revise its short stay policy. This proposal would allow for Medicare reimbursement for short inpatient stays in cases where the admitting physician believes the inpatient admission is medically necessary. **We believe that this is a step in the right direction, as ultimately only a physician can decide which setting of care is most appropriate for a patient. This proposed change, in conjunction with measures to limit RACs' ability to overturn admission decisions made by physicians, are important steps in addressing concerns about the impact of the policy on hospitals and their ability to provide an appropriate level of care to patients.**

Since the hearing, Chairman Brady introduced the "Medicare Crosswalk Hospital Code Development Act." America's Essential Hospitals is analyzing the legislation and looks forward to providing feedback to the committee.

Thank you again for the opportunity to comment on these important payment policies. We look forward to providing more feedback regarding recently introduced legislation in several of these areas.

Sincerely,

/s/

Bruce Siegel, MD, MPH  
President and CEO

The logo for the National Association of Chain Drug Stores (NACDS) features the acronym "NACDS" in white, bold, sans-serif capital letters. The text is centered within a dark blue rectangular box that has a thin white horizontal line running through its middle.

NATIONAL ASSOCIATION OF  
CHAIN DRUG STORES

Statement  
Of  
The National Association of Chain Drug Stores

For  
United States House of Representatives  
Committee on Ways and Means  
Subcommittee on Health

Hearing on:  
The Medicare Payment Advisory  
Commission (MedPAC)

July 22, 2015  
10:00 A.M.

B-318 Rayburn House Office Building

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National Association of Chain Drug Stores (NACDS)  
1776 Wilson Blvd., Suite 200  
Arlington, VA 22209  
703-549-3001  
[www.nacds.org](http://www.nacds.org)

The National Association of Chain Drug Stores (NACDS) thanks Chairman Brady, and the members of the Subcommittee on Health for the opportunity to submit the following statement for the record regarding the Medicare Payment Advisory Commission (MedPAC) and the discussion of hospital payment issues, rural health issues, and beneficiary access to care.

NACDS and the chain pharmacy industry are committed to partnering with Congress, HHS, patients, and other healthcare providers to improve the quality and affordability of healthcare services.

NACDS represents traditional drug stores and supermarkets and mass merchants with pharmacies. Chains operate more than 40,000 pharmacies, and NACDS' chain member companies include regional chains, with a minimum of four stores, and national companies. Chains employ more than 3.2 million individuals, including 179,000 pharmacists. They fill over 2.9 billion prescriptions yearly, and help patients use medicines correctly and safely, while offering innovative services that improve patient health and healthcare affordability. NACDS members also include more than 850 supplier partners and over 60 international members representing 22 countries. For more information, visit [www.NACDS.org](http://www.NACDS.org).

The national physician shortage coupled with the continued expansion of health insurance coverage in 2015 will have serious implications for the nation's healthcare system. Access, quality, cost, and efficiency in healthcare are all critical factors – especially to the medically underserved and those living in rural areas. Utilizing pharmacists can help ensure access to requisite healthcare services for these vulnerable populations.

As the face of neighborhood healthcare, community pharmacies and pharmacists provide access to prescription medications and over-the-counter products, as well as cost-effective health services such as immunizations and disease screenings. Retail pharmacies are often the most readily accessible healthcare provider. Nearly all Americans (94%) live within five miles of a community retail pharmacy. Recognition of pharmacists as providers under Medicare Part B would help to provide valuable and convenient pharmacist services to millions of Americans, and most importantly, to those who are already medically underserved or reside in rural areas. Access to these types of services is especially vital for Medicare beneficiaries as nearly two-thirds are suffering from multiple chronic conditions. Through personal interactions with patients, face-to-face consultations, and convenient access to preventive care services, local pharmacists are helping to shape the healthcare delivery system of tomorrow—in partnership with doctors, nurses, and others.

In addition to helping reduce post-acute care issues related to medication non-adherence, retail community pharmacists can provide high quality, cost efficient care and services. However, the lack of pharmacist recognition as a provider by third party payors including Medicare and Medicaid has limited the number and types of services pharmacists can provide, even though fully qualified to do so. For this reason, we support H.R. 592, the “Pharmacy and Medically Underserved Areas Enhancement Act,” which would allow Medicare Part B to utilize pharmacists to their full capability by providing those underserved beneficiaries with services not currently reaching them (subject to state scope of practice laws).

The medically-underserved population includes seniors with cultural or linguistic access barriers, residents of public housing, persons with HIV/AIDS, as well as rural populations and many others. Significant consideration should be given to innovative initiatives within the medically-underserved population to enhance healthcare capacity and strengthen community partnerships to offset provider shortages and the surge in individuals with healthcare coverage. It is especially important that underserved beneficiaries have continued access to a provider for follow up and to ask questions; oftentimes this is the community pharmacist. NACDS urges the adoption of policies and legislation that increase access to much-needed services for underserved Americans, such as H.R. 592. This important legislation would lead not only to reduced overall healthcare costs, but also to increased access to healthcare services and improved healthcare quality for underserved patients, including those in transitions of care.

### **Conclusion**

NACDS thanks the subcommittee for consideration of our comments. We look forward to working with policymakers and stakeholders on looking to find ways to improve care for Medicare patients who are underserved or live in rural areas.



August 5, 2015

The Honorable Paul Ryan, Chairman  
House Ways and Means Committee  
1102 Longworth House Office Building  
Washington, DC 20515

The Honorable Sandy Levin, Ranking Member  
House Ways and Means Committee  
1106 Longworth House Office Building  
Washington, DC 20515

Dear Chairman Ryan and Ranking Member Levin:

The National Rural Accountable Care Organization is organizing rural providers across the country under the Medicare Shared Savings Program (MSSP) to redesign their delivery systems to provide better care at a lower cost. We currently operate 6 Accountable Care Organizations (ACOs) with 30 rural health systems covering 9 states. Supported by the ACO Investment Model (AIM) opportunity, we will be submitting applications on behalf of an *additional* 149 rural health systems in 32 states to form 26 Medicare ACOs in 2016. These 179 rural health systems support approximately 500,000 Medicare Fee-For-Service beneficiaries with a total annual spend of more than \$5 billion. In addition, our non-profit, the National Rural Accountable Care Consortium, is in discussions with the Center for Medicare and Medicaid Innovation (CMMI) to set up care coordination and quality improvement and reporting programs for an additional 300 rural health systems that are not yet ready for Advanced Payment Models under the Transformation of Clinical Practice Initiative (TCPI). When you combine the two programs listed above, we will be supporting more than 20% of the 1,971 rural community health systems identified by the American Hospital Association to achieve the three-part aim, with achievable goals of improving quality by 20% and reducing cost by 10%. If successful, we will reduce Medicare spending for rural beneficiaries by \$500 million per year, and simultaneously strengthen the financial viability of rural health systems.

First, we would like to recognize the extraordinary support and commitment for rural healthcare reform from individuals at the Department of Health and Human Services and the Medicare Payment Advisory Commission (MedPAC). We are actively engaged with them in developing a better future and a better healthcare and payment system for rural beneficiaries. We deeply appreciate the time and attention they are paying to rural health.

As you consider policy and alternative payment models and options for rural America, we ask you to consider the following:

1. Provide positive incentives for rural clinicians to participate in Medicare ambulatory quality reporting programs, such as the Physician Quality Reporting System (PQRS), targeting improvement in quality and access for rural beneficiaries.
2. Remove negative incentives for rural beneficiaries to use their rural health system to improve quality and enable rural Patient Centered Medical Homes (PCMH), which reduces costs to the Medicare Trust Fund.
3. Provide positive incentives for Rural Health Clinics (RHCs) to provide the Initial Preventive Physical Exams, Annual Wellness Visits, Transition of Care Management and Chronic Care Management Services to improve quality while lowering costs.
4. Provide positive incentives for rural Emergency Departments (EDs) and Emergency Medical Services to act as an integral member of the rural primary care team, including payment for provision of primary care visits when preferred by the beneficiary, in addition to allowing them to bill for the Initial Preventive Physical Exams, Annual Wellness Visits, Transition of Care Management and Chronic Care Management Services and for collaboration with rural Care Coordinators.
5. Revise the spending calculations used in the MSSP for Critical Access Hospitals (CAHs), RHCs, and Federally Qualified Health Centers (FQHCs) to improve accuracy and exclude special payments.
6. Support the Rural ACO Improvement Act of 2015, which appropriately attributes patients to the Nurse Practitioners and Physician's Assistants who are the primary care providers for many rural beneficiaries.
7. Support the REACH Act to preserve local access to emergency, short stay, skilled nursing, outpatient and primary care in communities that are too small to continue to support an acute care hospital.

**Provide positive incentives for rural clinicians to participate in Medicare ambulatory quality reporting programs, such as the PQRS, to improve quality and access for rural beneficiaries.** In order to achieve the Secretary's goal of tying some portion of 90% of provider payments to cost and quality, rural clinicians will need to be included. While ACOs are currently reporting quality scores above 70%, we find rural providers are averaging slightly below 60% when they enter the program, indicating a potential gap in quality. We are deeply concerned about how lower quality scores of patients coming from rural primary care providers will affect their ability to access care from urban specialists whose income will be adjusted downward for low quality patients under the Medicare Access and CHIP Reauthorization Act (MACRA). We find the PQRS and ACO measures that we currently report to be appropriate and achievable for rural providers, and focus their energy on implementing process improvements and evidence-based medicine practices that are proven to improve outcomes, lower cost and enhance patient satisfaction. We applaud CMS for proposing that rural providers begin

reporting HCPCS codes on their bills in 2016 to enable value-based payments, and the potential participation in PQRS. We support the implementation of voluntary enrollment of RHCs and FQHCs in PQRS, with no penalties for lower performance, similar to solo practice physicians, but with the potential to earn incentive increases in the rates that reward quality performance.

**Remove negative incentives for rural beneficiaries to use their rural health system to improve quality, enable Medical Homes and reduce costs to the Medicare Trust Fund.** RHCs and CAHs are reimbursed based on cost, and cost per beneficiary is calculated based on total cost divided by number of beneficiaries. Rural providers have high fixed costs, therefore, decreases in volume do not result in proportional decreases in costs and conversely increases in volume result in decreases in per beneficiary cost.

To illustrate that point, if CAH discharges are 75% Medicare, the CAH's allowable costs are \$5,000,000, and there are 1000 patient days, Medicare pays the CAH  $75\% \times \$5,000,000 \times 101\% = \$3,787,500$  or **\$3,786 per patient day**. If the CAH doubled its average daily census from 3 to 6, and the incremental cost was only 15%, Medicare would pay the CAH \$4,355,625, or **\$2,178 per patient day**. Conversely, if the number of patient days decreases to 500, and the incremental cost drops 15%, the average cost per patient day would increase to **\$6,438.75 per patient day**. The same is true for outpatient services, which account for almost 75% of CAH revenue.

Working against the obvious benefit of maximizing *local* appropriate utilization of the cost-reimbursed healthcare system, current policy has substantial penalties for beneficiaries who use their local rural provider. Beneficiaries are required to pay 20% of charges for outpatient and ambulatory services, which frequently exceeds the amount of out-of-pocket costs for similar Prospective Payment System (PPS) facilities. MedPAC has reported that beneficiaries pay an equivalent of 50% coinsurance for CAH outpatient services, as compared to the PPS rate. To date, much of this has not been transparent to beneficiaries due to the high prevalence of Supplemental Insurance and general opacity of healthcare pricing. As we move toward more pricing transparency, consumerism and limitations of copay and deductible waivers under MACRA, we anticipate that more beneficiaries will choose lower cost facilities when feasible to reduce out-of-pocket expenses. As a result, we expect rural market share to decrease, and as a result, rural per beneficiary spending to increase. As rural volumes decrease, per beneficiary costs will increase, which will drive more patients out of the system. Policies that encourage rural patients to utilize their local health system, such as capping all copays and deductibles at the corresponding PPS rate to create parity, and waiving copays and deductibles for rural primary care services as seen in FQHCs, will go far to reduce the cost of rural Medicare beneficiaries to the Medicare Trust Fund, improve access and strengthen the financial viability of the rural health systems.

**Provide positive incentives for RHCs to provide the Initial Preventive Physical Exams, Annual Wellness Visits, Transition of Care Management and Chronic Care Management Services to improve quality and lower costs.** Annual Wellness Visits and Initial Preventive Physical Exams are critical for keeping seniors healthy and avoiding costly complications by facilitating early intervention, yet our claims data indicates that 40% of our rural health systems are **not** currently performing annual

wellness visits. Only 11.6% of our beneficiaries have received these visits this year, with 71.5% of those patients seen in fee-for-service clinics. Fee-for-service clinics can invest additional resources to frequently accomplish these visits while the patients have presented for other issues, and can bill separately to pay for the cost. RHCs and FQHCs cannot bill for the visit in addition to the All Inclusive Rate, so if they do this work at all they do it at their own expense with no compensation to invest in resources to get the work done. Attempts to get rural patients to come into the clinic solely for the Annual Wellness Visit have been largely unsuccessful.

CMS has proposed the ability for RHCs to bill for Chronic Care Management in addition to the All Inclusive Rate in the 2016 Physician Fee Schedule, which we strongly support. We propose that this exception is also extended to Annual Wellness Visits and Initial Preventive Physical Exams.

**Provide positive incentives for rural EDs and Emergency Medical Services to act as an integral member of the rural primary care team, including payment for provision of primary care visits when preferred by the beneficiary, in addition to allowing them to bill for the Initial Preventive Physical Exams, Annual Wellness Visits, Transition of Care Management and Chronic Care Management Services and for collaboration with rural Care Coordinators.** The rural ED is an integral part of the rural primary care system. We average 20-24% more ED visits than Medicare Fee-For-Service. Approximately 50% of them are level one visits, which are likely non-emergent primary care. Not coincidentally, we average 59-64% of the hospital admission rate from the ED. Many rural beneficiaries cannot get to the ED during clinic hours, and after-hours care or advice is rarely available. Rural emergency rooms are accessible 24/7, have little or no waiting times, are well-staffed and operated, and thanks to Supplemental Insurance are usually at no cost to the beneficiary. In other words, convenient, high-quality, and low-cost or free – a consumer’s dream.

Rural Emergency Medical Services are also often under-utilized with fixed costs and can play a very important role in providing efficient home visits for chronically ill and frail Medicare beneficiaries when partnered with the rural community health system.

We support a re-evaluation of how these providers can be compensated for better integration into the rural primary care system, in addition to considerations of how we can utilize their excess capacity to provide more access to important primary care services. In some situations, the rural ED may be the best home for a community-based care coordination service. Many rural communities only have enough Medicare beneficiaries that require Chronic Care Management to be supported by a single care coordinator. Many of the patients that need this service are frequent users of the ED, making the rural ED a desirable location for this service.

**Revise the spending calculations used in the MSSP for CAHs, RHCs, and FQHCs.** In order to move rural providers into Advanced Payment Models, payment calculations must be transparent and predictable. The MSSP does not appropriately account for the ongoing adjustments of the payment rates for CAHs, which account for about 1/3 of rural Medicare Spending. CMS also protects certain payments from the cost calculation, such as indirect medical education and disproportionate share

hospital payments, because these additional payments are supporting important programs for Medicare. The same considerations should be made for payments to rural hospitals, clinics and FQHCs, which are also important programs for Medicare.

**Support the Rural ACO Improvement Act of 2015 to correctly attribute patients to the Nurse Practitioners and Physician's Assistants who are the primary care providers for many rural beneficiaries.** The Rural ACO Improvement Act, recently introduced by Senators Cantwell and Thune, with a companion bill from Congressman Welch and Black, corrects an anomaly of the Affordable Care Act that does not recognize non-physician primary care providers for the majority of attribution under the MSSP. As a result, attribution in rural health systems served by Physicians and Advanced Practice Nurses and Physician's Assistants is generally 1/3 lower than attribution for Physician-only ACOs. Recent changes to the methodology in MSSP attribution will improve attribution somewhat, but still require that the patient see a Physician in the ACO at least once per year. Our beneficiaries are confused by requirements to see a Physician in addition to their designated non-physician primary care provider.

**Support the REACH Act to preserve local access to emergency, short stay, skilled nursing, outpatient and primary care in communities that are too small to continue to support an acute care hospital.** The REACH Act, recently introduced by Senator Grassley, provides an important alternative to the closure of rural hospitals that provide services for populations too small to support an Acute Care Hospital. We commend Senator Grassley and the National Rural Health Association for the development of this model.

We thank the Committee for its outstanding support of rural health and rural beneficiaries, and look forward to continued dialogue on how to deliver better care at a lower cost in rural America.

Sincerely,

*Lynn Barr*

Lynn Barr, MPH  
Chief Transformation Officer  
National Rural ACO  
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**ORGANIZATIONS REPRESENTED BY THIS LETTER**

	<b>FACILITY NAME</b>	<b>ADDRESS</b>	<b>CITY, STATE, ZIP</b>
1	<b>Caverna Memorial Hospital</b>	1501 South Dixie Street	Horse Cave, KY 42127
2	<b>The James B. Haggin Memorial Hospital</b>	464 Linden Avenue	Harrodsburg, KY 40330
3	<b>Monroe County Medical Center</b>	529 Capp Harlan Road	Tompkinsville, KY 42167
4	<b>Breckinridge Health</b>	1011 Old Highway 60	Hardinsburg, KY 40143
5	<b>Livingston Hospital and Healthcare Services, Inc.</b>	131 Hospital Dr	Salem, KY 42078
6	<b>Ohio County Hospital</b>	1211 Old Main Street	Hartford, KY 42320
7	<b>Carroll County Memorial Hospital</b>	309 Eleventh Street	Carrollton, KY 41008
8	<b>Twin Lakes Regional Medical Center</b>	910 Wallace Ave.	Leitchfield, KY 42754
9	<b>Rhea Medical Center</b>	9400 Rhea County Hwy	Dayton, TN 37321
10	<b>Southeast Colorado Hospital District.</b>	373 E. Tenth Ave	Springfield, CO 81073
11	<b>Spanish Peaks Regional Health Center &amp; Spanish Peaks Veterans Community Living Center</b>	23500 US Hwy. 160	Walsenburg, CO 81089
12	<b>Prowers Medical Center</b>	401 Kendall Drive	Lamar, CO 81062
13	<b>Yuma District Hospital &amp; Clinics</b>	1000 West 8th Avenue	Yuma, CO 80759
14	<b>Mt. San Rafael Hospital</b>	410 Benedicta Avenue	Trinidad, CO 81082
15	<b>Arkansas Valley Regional Medical Center</b>	1100 Carson	La Junta, CO 81050
16	<b>Colorado West Healthcare System</b>	2021 North 12th Street	Grand Junction, CO 81501
17	<b>Colorado Canyons Hospital &amp; Medical Center - Family Health West - Lower Valley Hospital Assoc.,</b>	300 W. Ottley	Fruita, CO 81521
18	<b>LeFlore County Hospital Authority dba Eastern Oklahoma Medical Center</b>	PO Box 1148	Poteau, OK 74953
19	<b>Wagoner Community Hospital</b>	1200 West Cherokee	Wagoner, OK 74467
20	<b>Wilson County Hospital dba Wilson Medical Center</b>	2600 Ottawa Road P.O. Box 360	Neodesha, KS 66757
21	<b>Belmond Community Hospital; dba Iowa Specialty Hospital - Belmond</b>	403 1st St. SE	Belmond, IA 50421
22	<b>Iowa Specialty Hospital - Clarion</b>	1316 S. Main St.	Clarion, IA 50525
23	<b>Sioux Center Health</b>	1101 9th St. SE	Sioux Center, IA 51250
24	<b>Cass County Health System</b>	1501 E 10th St.	Atlantic, IA 50022
25	<b>Virginia Gay Hospital</b>	502 N. 9th Ave.	Vinton, IA 52349
26	<b>Greater Regional Medical Center</b>	1700 West Townline Street	Creston, IA 50801
27	<b>Fort Madison Community Hospital</b>	5445 Avenue O	Fort Madison, IA 52627
28	<b>Fairfield Memorial Hospital</b>	303 N.W. 11th Street	Fairfield, IL 62837
29	<b>ProHealth, Inc. DBA Pekin Memorial Hospital</b>	600 S. 13th Street	Pekin, IL 61554
30	<b>St. Margaret's Hospital</b>	600 East First Street	Spring Valley, IL 61362
31	<b>Graham Health System</b>	210 West Walnut	Canton, IL 61520
32	<b>Morris Hospital &amp; Healthcare Centers</b>	150 West High Street	Morris, IL 60450

**ORGANIZATIONS REPRESENTED BY THIS LETTER**

	<b>FACILITY NAME</b>	<b>ADDRESS</b>	<b>CITY, STATE, ZIP</b>
33	<b>Margaret Mary Health</b>	321 Mitchell Avenue	Batesville, IN 47006
34	<b>Henry County Memorial Hospital</b>	1000 N. 16th Street	New Castle, IN 47362
35	<b>Hancock Regional Hospital</b>	801 North State Street	Greenfield, IN 46140
36	<b>Hendricks County Hospital</b>	1000 East Main Street	Danville, IN 46122
37	<b>Johnson Memorial Hospital.</b>	1125 W Jefferson Street	Franklin, IN 46131
38	<b>Witham Memorial Hospital</b>	2605 N Lebanon St.	Lebanon, IN 46052
39	<b>Reid Hospital &amp; Health Care Services, Inc.</b>	1100 Reid Parkway	Richmond, IN 47374
40	<b>Sullivan County Community Hospital</b>	P.O. Box 10 2200 North Section Street	Sullivan, IN 47882
41	<b>Jay County Hospital</b>	500 W Vitaw Street	Portland, IN 47371
42	<b>Perry County Memorial Hospital</b>	8885 SR237	Tell City, IN 47586
43	<b>Decatur County Memorial Hospital</b>	720 N. Lincoln St.	Greensburg, IN 47240
44	<b>King's Daughters Health</b>	PO Box 447	Madison, IN 47250
45	<b>Daviess Community Hospital.</b>	1314 E. Walnut Street	Washington, IN 47501
46	<b>Fayette Regional Health System</b>	1941 Virginia Street	Connersville, IN 47331
47	<b>Pulaski Memorial Hospital</b>	616 East 13th Street	Winamac, IN 46996
48	<b>Marlette Regional Hospital</b>	2770 Main Street	Marlette, MI 48453-0307
49	<b>McKenzie Health System</b>	120 Delaware Street	Sandusky, MI 49471
50	<b>Scheurer Hospital</b>	170 N. Caseville Road	Pigeon, MI 48755-9781
51	<b>Alcona Citizens for health, Inc.</b>	177 N. Barlow Rd.	Lincoln, MI 48742
52	<b>Cedar Hill Medical Dickinson County Healthcare System</b>	1721 S. Stephenson Ave.	Iron Mountain, MI 49801
53	<b>Hills &amp; Dales General Hospital</b>	4675 Hill Street	Cass City, MI 48726
54	<b>Hayes Green Beach Memorial Hospital</b>	321 East Harris Street	Charlotte, MI 48813
55	<b>Helen Newberry Joy Hospital &amp; Healthcare Center</b>	502 West Harrie Street	Newberry, MI 49868
56	<b>Schoolcraft Memorial Hospital</b>	7870 W. US Highway 2	Manistique, MI 49854
57	<b>Sheridan Community Hospital</b>	301 North Main Street	Sheridan, MI 48884
58	<b>Hillsdale Community Health Center</b>	168 S. Howell	Hillsdale, MI 49242
59	<b>Charlotte Family &amp; Urgent Care Center</b>	616 Meijer Drive	Charlotte, MI 58813
60	<b>Community Health Center of Branch County</b>	274 E. Chicago Street	Coldwater, MI 49036
61	<b>Sturgis Hospital</b>	916 Myrtle Avenue	Sturgis, MI 49091
62	<b>South Haven Health System</b>	955 South Bailey Avenue	South Haven, MI 49090
63	<b>Allegan General Hospital</b>	555 Linn Street	Allegan, MI 49010
64	<b>Three Rivers Health</b>	701 South Health Parkway	Three Rivers, MI 49093
65	<b>Indian Stream Health Center</b>	141 Corliss Lane	Colebrook, NH 03576
66	<b>Cottage Hospital</b>	90 Swiftwater Road	Woodsville, NH 03785
67	<b>Weeks Medical Center</b>	173 Middle Street	Lancaster, NH 03584
68	<b>Ammonoosuc Community Health Services, Inc.</b>	25 Mount Eustis Road	Littleton, NH 03561
69	<b>Littleton Regional Healthcare</b>	600 Saint Johnsbury Road	Littleton, NH 03561
70	<b>Androscoggin Valley Hospital.</b>	59 Page Hill Rd	Berlin, NH 03570

**ORGANIZATIONS REPRESENTED BY THIS LETTER**

	<b>FACILITY NAME</b>	<b>ADDRESS</b>	<b>CITY, STATE, ZIP</b>
71	<b>Upper Connecticut Valley Hospital Association, Inc.</b>	181 Corliss Lane	Colebrook, NH 03576
72	<b>Monadnock Community Hospital</b>	452 Old Street Road	Peterborough, NH 03458
73	<b>Van Wert County Hospital</b>	1250 South Washington St.	Van Wert, OH 45891
74	<b>The Bellevue Hospital</b>	1400 West Main Street	Bellevue, OH 44811
75	<b>Knox Community Hospital</b>	1330 Coshocton Ave.	Mount Vernon, OH 43050
76	<b>Fisher Titus Medical Center</b>	272 Benedict Avenue	Norwalk, OH 44857
77	<b>Berger Health System</b>	600 North Pickaway Street	Circleville, OH 43113
78	<b>Davis Medical Center</b>	PO Box 1484	Elkins, WV 26241
79	<b>Broaddus Hospital</b>	#1 Healthcare Drive	Philippi, WV 26416
80	<b>Grant Memorial Hospital</b>	PO Box 1019	Petersburg, WV 26847
81	<b>Stonewall Jackson Memorial Hospital</b>	230 Hospital Plaza	Weston, WV 26452
82	<b>Perry County Memorial Hospital</b>	434 N. West Street	Perryville, MO 63775
83	<b>Nevada Regional medical Center</b>	800 S. Ash	Nevada, MO 64771
84	<b>Missouri Delta Medical Center</b>	1008 North Main	Sikeston, MO 63801
85	<b>Seminole Hospital District</b>	209 NW 8th Street	Seminole, TX 79360
86	<b>Cuero Community Hospital</b>	2550 N. Esplanade	Cuero, TX 77954
87	<b>Graham Hospital District</b>	1301 Montgomery Road	Graham, TX 76450
88	<b>Gonzales Healthcare Systems</b>	P.O. Box 587	Gonzales, TX 78629
89	<b>Hill Country Memorial</b>	1020 South State Highway 16	Fredericksburg, TX 78624
90	<b>El Campo Memorial Hospital</b>	303 Sandy Corner Road,	El Campo, TX 77437
91	<b>Brazosport Regional Physician Services Organization</b>	100 Medical Drive	Lake Jackson, TX 77566
92	<b>Chambers County Public Hospital District #1 d.b.a. Chambers Health</b>	P.O. Box 398	Anahuac, Texas 77514-0398
93	<b>Chambers County Public Hospital District #1 d.b.a. Chambers Health</b>	P.O. Box 398	Anahuac, Texas 77514-0398
94	<b>Coryell Memorial Healthcare System</b>	1507 W Main	Gatesville, TX
95	<b>Matagorda Regional Medical Center.</b>	104 7th St	Bay City, TX 77414
96	<b>Connally Memorial Medical Center</b>	499 10th St.	Floresville, TX 78114
97	<b>Northern Hospital of Surry County</b>	830 Rockford Street	Mount Airy, NC 27030
98	<b>Hugh Chatham Memorial Hospital</b>	180 Parkwood Drive	Elkin, NC 28621
99	<b>Edisto Regional Health Services Organization</b>	3000 St. Matthews Road	Orangeburg, SC 29118
100	<b>Miller County Hospital.</b>	209 N. Cuthbert St	Colquitt, GA 39837
101	<b>Chatuge Regional Hospital.</b>	110 S. Main St	Hiawassee, GA 30546
102	<b>Effingham Health System.</b>	459 Highway 119 S	Springfield, GA 31329
103	<b>Appling Healthcare System</b>	163 East Tollison Street	Baxley, GA 31513
104	<b>Northwest Medical Partners, P.A.</b>	280 N. Pointe Boulevard	Mount Airy, NC 27030
105	<b>Union General Hospital</b>	35 Hospital Rd	Blairsville, GA 30512
106	<b>North Mississippi Medical Clinics, Inc. (North Mississippi Medical Center-Hamilton)</b>	1150 S. Green St., Suite 1A	Tupelo, MS 38804
107	<b>North Mississippi Medical Clinics, Inc. (North Mississippi Medical Center-Eupora)</b>	1150 S. Green St., Suite 1A	Tupelo, MS 38804

**ORGANIZATIONS REPRESENTED BY THIS LETTER**

	<b>FACILITY NAME</b>	<b>ADDRESS</b>	<b>CITY, STATE, ZIP</b>
108	<b>North Mississippi Medical Clinics, Inc. (North Mississippi Medical Center-Pontotoc)</b>	1150 S. Green St., Suite 1A	Tupelo, MS 38804
109	<b>Anderson Regional Medical Center - South Campus</b>	1102 Constitution Ave.	Meridian, MS 39301
110	<b>King's Daughters Medical Center</b>	427 Highway 51N	Brookhaven, MS 39602
111	<b>North Mississippi Medical Clinics, Inc.</b>	1150 S. Green St., Suite 1A	Tupelo, MS 38804
112	<b>Hattiesburg Clinic</b>	415 South 28th Avenue	Hattiesburg, MS 39401
113	<b>Fishermen's Hospital, Inc.</b>	3301 Overseas Highway	Marathon, FL 33050
114	<b>Doctors Memorial Hospital</b>	2600 Hospital Drive	Bonifay, FL 32425
115	<b>Bailey Family Practices</b>	101 E. Wisconsin Ave	Bonifay, FL 32425
116	<b>Hendry Regional Medical Center</b>	524 W. Sagamore Avenue	Clewiston, FL 33440
117	<b>Northwest Florida Community Hospital</b>	1360 Brickyard Rd PO Box 889	Chipley, FL 32428
118	<b>Jackson Hospital</b>	4250 Hospital Drive	Marianna, FL 32446
119	<b>Medlink Management Services, Inc.</b>	850 East Main Street	Lake Butler, FL 32054
120	<b>Calhoun Liberty Hospital</b>	20370 NE Burns Avenue	Blountstown, FL 32424
121	<b>Memorial Medical Center</b>	216 Sunset Place	Neillsville, WI 54456
122	<b>Jersey Shore Hospital</b>	1020 Thompson Street	Jersey Shore, PA 17740
123	<b>Ridgecrest Regional Hospital</b>	1081 N. China Lake Blvd.	Ridgecrest, CA 93555
124	<b>Truckee Tahoe Medical Group</b>	10956 Donner Pass Rd. #110	Truckee, CA 96161
125	<b>Mammoth Hospital</b>	PO Box 660	Mammoth Lakes, CA 93546
126	<b>Barton Health</b>	2170 South Avenue	South Lake Tahoe, CA 96150
127	<b>Southern Inyo Healthcare District</b>	P.O. Box 1009	Lone Pine, CA
128	<b>Inland Behavioral and Health Services, Inc.</b>	1963 North E. Street	San Bernardino, CA 92405
129	<b>Roosevelt General Hospital</b>	42121 Hwy 70, PO Box 868	Portales, NM 88130
130	<b>Cibola General Hospital</b>	1016 E. Roosevelt Ave	Grants, NM 87020
131	<b>Artesia General Hospital</b>	702 N. 13th Street	Artesia, NM 88210
132	<b>Nor-Lea Hospital District</b>	1600 North Main	Lovington, NM 88260
133	<b>Rehoboth McKinley Christian Health Care Services</b>	1901 Red Rock Drive	Gallup, NM 87301
134	<b>Miners' Colfax Medical Center</b>	203 Hospital Drive	Raton, NM 87740
135	<b>Mason General Hospital &amp; Family of Clinics</b>	PO Box 1668	Shelton, WA 98584
136	<b>Summit Pacific Medical Center</b>	600 E. Main Street	Elma, WA 98541
137	<b>Lower Umpqua Hospital District</b>	600 Ranch Road	Reedsport, OR 97467
138	<b>PeaceHealth Peace Harbor Hospital</b>	400 9th Street	Florence, OR 97439
139	<b>Cottage Grove Community Medical Center</b>	1515 Village Drive	Cottage Grove, OR 97424
140	<b>Newport Hospital &amp; Health Services</b>	714 West Pine Street	Newport, WA 99156
141	<b>Clallam County Public Hospital District #1</b>	530 Bogachiel Way	Forks, WA 98331
142	<b>Klickitat Valley Health</b>	310 S. Roosevelt	Goldendale, WA 98620

**ORGANIZATIONS REPRESENTED BY THIS LETTER**

	<b>FACILITY NAME</b>	<b>ADDRESS</b>	<b>CITY, STATE, ZIP</b>
143	<b>Coulee Medical Center</b>	411 Portways Road	Grand Coulee, WA 99133
144	<b>Tri-State Memorial Hospital &amp; Medical Campus,</b>	1221 Highland Ave	Clarkston, WA 99403
145	<b>Jefferson Healthcare</b>	834 Sheridan	Port Townsend, WA 98368
146	<b>Ferry County Hospital District #1</b>	36 N. Klondike Road	Republic, WA 99166
147	<b>Columbia County Health System</b>	2012 S. 3rd Street	Dayton, WA 99328
148	<b>Sunnyside Community Hospital &amp; Clinics</b>	P.O. Box 719	Sunnyside, WA 98944
149	<b>Central Montana Medical Center</b>	408 Wendell Avenue	Lewistown, MT 59457
150	<b>Sidney Health Center</b>	216 14th Avenue SW	Sidney, MT 59270
151	<b>St. Luke Community Hospital</b>	107 6th Ave SW	Ronan, MT 59864
152	<b>Public Hospital District for Beaverhead County dba Barrett Hospital and Health Care Organization</b>	600 MT Highway 91 South	Dillon, MT 59725
153	<b>Marcus Daly Memorial Hospital</b>	1200 Westwood Drive	Hamilton, MT 59840
154	<b>Clark Fork Valley Hospital &amp; Family Medicine Network</b>	P.O. Box 768	Plains, MT 59859
155	<b>Community Hospital of Anaconda</b>	401 West Pennsylvania	Anaconda, MT 59711
156	<b>Steele Memorial Medical Center</b>	203 South Daisy Street	Salmon, ID 83467
157	<b>North Valley Hospital</b>	1600 Hospital Way	Whitefish, MT 59937
158	<b>Clearwater Valley Hospital.</b>	301 Cedar Street	Orofino, ID 83544
159	<b>St. Mary's Hospital</b>	701 Lewiston St. PO Box 137	Cottonwood, ID 83522
160	<b>Gritman Medical Center</b>	700 S. Main	Moscow, ID 83843
161	<b>Moscow Family Medicine</b>	623 South Main Street	Moscow, ID 83843
162	<b>West Park Hospital District</b>	707 Sheridan Avenue	Cody, WY 82414
163	<b>Memorial Hospital of Carbon County</b>	2221 West Elm St PO Box 460	Rawlins, WY 82301
164	<b>Lake Region Healthcare.</b>	712 S. Cascade Street	Fergus Falls, MN 56537
165	<b>Memorial Community Health Inc.</b>	1423 7th Street	Aurora, NE 68818
166	<b>Winona Health Services</b>	855 Mankato Ave	Winona, MN 55987
167	<b>Madison Lutheran Home</b>	900 2nd Avenue	Madison, MN 56256
168	<b>Heart of America Medical Center</b>	800 S. Main Avenue	Rugby, ND 58368
169	<b>Sakakawea Medical Center</b>	510 8th Ave NE	Hazen, ND 58545
170	<b>McKenzie County Healthcare Systems, Inc.</b>	516 North Main	Watford City, ND 58854
171	<b>Southwest Healthcare Services</b>	802 2nd Street NW	Bowman, ND 58623
172	<b>First Care Health Center</b>	115 Vivian Street PO Box I	Park River, ND 58270
173	<b>UND Center for Family Medicine</b>	701 East Rosser Avenue	Bismarck, ND 58501

Contact: Maggie Elehwany  
Vice President  
Government Affairs and Policy  
National Rural Health Association

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1025 Vermont St. NW, Suite 1100  
Washington, DC 20005

Testimony of the National Rural Health Association (NRHA)  
Concerning Access to Rural Health Care and MedPAC's report  
*Submitted for the Record to the House Committee on Ways and Means  
Subcommittee on Health*

The National Rural Health Association (NRHA) is pleased to provide the House Ways and Means Subcommittee on Health a statement regarding the significance of rural health care to patients and providers.

NRHA is a national nonprofit membership organization with a diverse collection of 21,000 individuals and organizations who share a common interest in rural health. The association's mission is to improve the health of rural Americans and to provide leadership on rural health issues through advocacy, communications, education and research.

Access to quality, affordable health care is essential for the 62 million Americans living in rural and remote communities. Rural Americans are more likely to be older, sicker and poorer than their urban counterparts. Specifically, they are more likely to suffer with a chronic disease that requires monitoring and follow up care, making convenient, local access to care necessary to ensuring patient compliance with the services that are necessary to reduce the overall cost of care and improve the patients' outcomes and quality of life. Yet, many rural Americans live in areas with limited health care resources, restricting their available options for care, including primary care.

NRHA strongly disagrees with the Medicare Payment Advisory Commission's (MedPAC) assumption that there is no difference in access between urban and rural beneficiaries and the findings that access to care for rural patients is no longer a concern. Access to health care is an increasing concern for rural beneficiaries, exacerbated by the increasing crisis of rural hospital closures. Access in rural America is impeded by not only geography, but also by decreasing reimbursements, physician shortages, and excessive regulatory burdens.

The Administration and Congress have agreed that access still remains a concern. Testimony from the Office of Rural Health Policy to the Senate Appropriations Committee in May 2015 stated, "Individuals in rural communities have to travel farther for regular check-ups and emergency services, which can significantly increase the cost of medical treatment and impact outcomes in emergencies when time is critical."

Rural Medicare beneficiaries face a number of challenges when trying to access health care close to home. Seventy-seven percent of rural counties in the U.S. are Primary Care Health Professional Shortage Areas while nine percent have no physicians at all. Rural seniors are forced to travel significant distances for care, especially specialty services. In an emergency, rural American travel twice as far as their urban counterparts to receive care. As a result, while 20 percent of Americans live in rural areas, 60 percent of trauma deaths occur in rural America.

Rural programs and designations, from the Physician Work Geographic Practice Cost Index to Critical Access Hospitals, are essential to increasing the capacity of the rural health care delivery system to ensure access for rural senior and ensure these rural safety net providers can fulfill that mission. NRHA urges the Committee to continue its strong support of these important programs.

### **Rural Payment Provider Policies**

Congress has created several rural health payment provisions to improve access to care in rural America. While these programs have been largely successful in maintaining access, continuation of these payments and rural health extenders is crucial. To provide these rural providers with certainty and the ability to engage in longer term planning, NRHA has long sought legislation to make the rural extenders permanent. But even with the existing program, the problem of access still remains. Rural Healthy People 2010 highlighted access as the greatest challenge in rural health. Unfortunately, even with the existing rural health programs, it remains the number one problem in the updated Rural Health People 2020. More must be done to ensure rural Americans have access to the health care resources necessary to allow them to lead healthy lives.

Rural health care delivery is challenging. Workforce shortages, older and poorer patient populations, geographic barriers, low patient volumes and high uninsured and under-insured populations are just a few of the barriers. Rural physicians and hospitals work around many of these barriers to provide high quality personalized care to their communities. Congress has address some of the payment related barriers by creating specific payment structures for certain rural providers to better address the unique patient populations and structural challenges faced by these small rural practices.

Medicare and Medicaid – major components of rural health care – pay rural providers less than their urban counterparts. Medicare spends 2.5 percent less on rural beneficiaries than it does on urban beneficiaries. Critical Access Hospitals (CAHs) make up nearly 30 percent of acute care hospitals, but receive less than 5 percent of total Medicare payments to hospitals. Rural health care providers operate on very thin margins and many rural communities have severe medical workforce shortages. Yet, rural physicians, who put as much time, skill and intensity into their work as their urban counterparts, are reimbursed at lower rates.

Congressionally established rural payment programs for hospitals and providers are not ‘bonus’ or ‘special’ payments, but rather alternative, cost-effective and targeted payment formulas that maintain access to care for millions of rural patients and financial stability for thousands of rural providers across the country.

NRHA is concerned that MedPAC does not take into account temporary payments when looking into the financial stability of providers, including rural hospitals. The March MedPAC report indicates the 2013 overall Medicare margins for rural hospitals (excluding CAHs) was 0.2 percent. In discussing this margin, the report concedes this is largely a result of Health technology payments that are declining from 2013 to 2016, meaning these payments are not going to be a part of the margin for hospitals for very much longer. NRHA believes MedPAC should take into account the temporary, and targeted, nature of these payments in making

determinations on payment adequacy. These payments are targeted for the purchase of expensive health IT products that add substantial costs to a hospital and were never intended to be used to justify actual reimbursement costs calibrated to sufficient cover the cost of care and ensure the availability of future care.

Additionally MedPAC shows that rural hospital all-payer margins are substantially lower than for urban hospitals. Over 40 percent of rural hospitals are operating with negative margins. Yet, MedPAC does not seem to take into account the temporary nature of incentive payments, such as HIT, when considering important rural add on payments.

Without access to care in local communities, rural patients would be forced to travel further for more expensive care. Or worse, these rural Americans would forego essential care because they could not reach the necessary medical providers, resulting in poorer health, a lower quality of life, and more expensive care later. The existing rural payments help, but rural access remains a critical problem with potential life and death consequences for rural Americans.

### **Hospital Closure Crisis**

Rural health care challenges are well known – from accessing health care services to recruiting and retaining health professionals. Rural communities depend on safety net providers such as Critical Access Hospitals, Community Health Centers, Rural Health Clinics and Federally Qualified Health Centers.

But these important rural access points are facing a closure crisis. Fifty-six rural hospitals have closed since 2010; 283 more are on the brink of closure. Since the start of 2013, more rural hospitals have closed than in the previous 10 years—combined. These closures are a part of a larger trend according to the Cecil G. Sheps Center for Health Services Research at the University of North Carolina, and their numbers show the rate is escalating. Continued cuts in hospital reimbursements have taken their toll, forcing far too many closures and leaving many of our nation’s most vulnerable populations without timely access to care.

The March 2015 MedPAC report stated that the rural hospitals were a proportionate share of the overall hospital closures at 44 percent. Unfortunately, in rural America these closures are a part of a larger trend according to the Cecil G. Sheps Center for Health Services Research at the University of North Carolina, 56 rural hospitals have closed since 2010, and their numbers show the rate is escalating. Additionally, comparing rural and urban closure percentages fails misses the real problem of hospital closures. When a rural hospital closes, the additional distance to care is significantly greater than an urban closure. Additionally, the closure of a hospital often results in the loss of other health care in the community, increasing the distance to receiving non-hospital based care.

An iVantage study shows at the financial situation of the remaining rural hospitals and found that an additional 283 rural hospitals are on the brink of closure. Before these closures, Research shows that a rural resident is already traveling twice as far to get to emergency care. According to the March 2015 report the closed hospitals are an average of 21 miles to the next nearest hospital, yet the report does not specifically address the issue of access to care in rural

America. Already, more than 40 percent of rural patients have to travel 20 or more miles to receive specialty care, compared to 3 percent of metropolitan patients. Rural hospitals provide excellent care to rural Americans, and without these rural hospitals, more patients lose access points to care. When a patient has a heart attack, 21 additional miles of travel makes a difference in patient outcomes. Without access to local emergency care, a patient is more likely to experience loss of function and future impairment, resulting in reduced quality of life and increased Medicare expenditures.

A rural hospital closing doesn't just hurt patients; it hurts the rural economy as well. In rural America, the hospital is often one of the largest employers in the community. Health care in rural areas can represent up to 20 percent of the community's employment and income. The average CAH creates 195 jobs and generates \$8.4 million in payroll annually. If a rural provider is forced to close their door the community erodes. If we allow the 283 rural hospitals that are on the brink to close: 36,000 direct rural health care jobs will be lost; 50,000 rural community jobs will be lost; and rural economies would take a \$10.6 billion loss. When a rural hospital closes, leaving a community without local access to health care, the community quickly begins to die.

Unfortunately, we have seen the impact of hospital closures before. From 1990 to 1999, 208 rural hospitals closed and rural Americans lost access to health care. These hospitals struggled to maintain financial stability under the urban-centric Medicare Prospective Payment System because of their small size and unpredictable patient mix. Congress enacted the Medicare Rural Hospital Flexibility Program as part of the Balance Budget Act (BBA) of 1997, creating the Critical Access Hospital (CAH) designation. This designation was designed to prevent hospital closures by allowing CMS payments to more accurately reflect the realities of providing care in rural America. The CAH payment structure allows for more flexible staffing options relative to community need, simplifying billing procedures and creating incentives to develop local integrated health delivery systems, including acute, primary, emergency and long-term care.

Congress created unique payment structures for certain rural providers to enable them to keep their doors open and to allow them to continue to serve their communities by providing access to high quality health care.

Rural Hospitals provide cost-effective primary care. It is 2.5 percent less expensive to provide identical Medicare services in a rural setting than in an urban or suburban setting. This focus on primary care, as opposed to specialty care, saves Medicare \$1.5 billion per year. Quality performance measurements in rural areas are on par if not superior to urban facilities.

NRHA asks members of the Committee and MedPAC to consider the impact of access to care for rural Americans when necessary safety net providers close. NRHA is calling on members of Congress to stabilize the rural health closures.

## **Regulatory Relief Needed**

NRHA calls on regulatory relief to help the Medicare beneficiaries in rural America. The elimination of the CAH 96 Hour Condition of Payment, the rebase of supervision requirements for outpatient therapy services at CAHs and rural PPS facilities, and modification to the 2-Midnight Rule and RAC audit and appeals process would help relieve burdens placed unfairly on these small, rural hospitals and providers.

NRHA calls for the elimination of the 96 hour Condition of Payment requirement that physicians at CAHs certify, at the time of admission that a Medicare patient will not be at the facility for more than 96 hours. From the creation of the CAH designation until late 2013 an annual average of 96 hour stays allowed CAHs flexibility within the regulatory framework set up for the designation. The new policy of strict enforcement of a per stay 96 hour cap creates unnecessary red-tape and barriers for CAHs throughout rural America; and eliminates important flexibility to allow general surgical services well suited for these high quality local providers.

The 96-hour rule is counter to the clear congressional intent to provide CAHs greater flexibility, evident in the 1999 modification of the 96 hour condition of participation from a hard 96 hour cap to a flexible annual average. The sudden imposition of the condition of payment is unnecessary and limits access to health care in rural areas and disallows rural providers to focus on caring for their patients. This regulation interferes with the best judgment of physicians and other health care providers, placing them in a position where high quality and qualified local providers cannot provide care for their patients. As a result, patients have had to seek care far from home. Additionally, since it is 2.5 percent less expensive to provide identical Medicare services in a rural setting than in an urban or suburban setting, such a transfer results in greater Medicare expenditures. Removing the 96-hour rule condition of payment would allow for rural patients to receive the care they need in their local communities.

## **The Solution is Legislative**

Twenty percent of Americans live on the 90 percent of America that is rural. For these Americans local access to care is essential, but there are substantial barriers and challenges involved in providing this care.

The rural payment programs created by Congress address just some of these challenges and help 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 full-time 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 and transferring patients to more expensive urban providers. 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 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 towards bipartisan rural legislation to address issues in the long-term and provide rural providers with the certainty they need. We encourage the committee to look at the Save Rural Hospitals Act, introduced by Reps. Sam Graves (R-MO) and Dave Loebsack (D-IA) as a guide for addressing all these issues in the long-term.

The National Rural Health Association appreciates the opportunity to provide our recommendations to the Subcommittee. These programs are critical to the rural health delivery system and help maintain access to high quality care in rural communities. We greatly appreciate the support of the Subcommittee and look forward to working with Members of the Subcommittee to continue making these important investments in rural health.

**Statement for the Record of**  
**John Kastanis, President and C.E.O.**  
**Temple University Hospital**  
**House Committee on Ways & Means, Subcommittee on Health**  
**Hearing on Hospital Payment Issues, Rural Health Issues,**  
**and Beneficiary Access to Care**  
**Wednesday, July 22<sup>nd</sup>, 2015**

On behalf of Temple University Hospital (TUH), I appreciate this opportunity to provide testimony for the record in follow up to the Committee's hearing Medicare payment issues. My testimony pertains to the issue of Medicare DSH payments and the need to mitigate the scheduled reductions in these payments.

**The Challenge in Serving High-Need Safety Net Populations on Limited Medicare Reimbursement**

The cuts in Medicare DSH payments mandated by the Patient Protection and Affordable Care Act (PPACA) are highly problematic for an institution such as TUH that serves a very high percentage of patients who are low income, minority, afflicted by behavioral health issues, and dually eligible for Medicare and Medicaid. In addition, we have a payer mix heavily skewed toward public programs with very little commercial insurance to help absorb costs.

Specifically, about 84% of TUH inpatients are covered by government programs, including 33% by Medicare and 51% by Medicaid. Patients that are dually eligible for Medicare and Medicaid comprise 23% of our inpatients who are covered by Medicare according to most current CMS data, placing TUH as #1 among Pennsylvania academic medical centers, in the 95th percentile among all acute care hospitals nationwide. Furthermore, about 42% of our inpatients include a behavioral health diagnosis.

Extensive research correlates a patient profile such as ours with higher costs of care. Despite this, we serve this challenging population in a highly efficient manner -- our wage and case mix adjusted discharge costs are in the lowest quartile of all Academic Medical Center hospitals as is our ratio of Full Time Equivalents (FTE) per occupied bed.<sup>1</sup> Notwithstanding this efficient delivery system, Medicare reimbursements fall well below actual cost. In fiscal year 2013, our case mix adjusted average cost for Medicare Fee-For-Service inpatients was \$12,022 but our case mix adjusted Medicare reimbursement for this population was \$9,805 (*including* both DSH and DME), well short of cost (81.5%).

In sum, Temple University Hospital serves a high-risk, high-cost public payer population in an efficient manner and with virtually no ability to have costs absorbed by commercial payers. Our Medicare reimbursement – even before the imposition of PPACA DSH cuts – does not cover the cost of that care and we are simply not able to absorb additional Medicare cuts. We are certainly not the only safety net institution facing this type of challenge, but we are quite certainly the type of institution for which Medicare DSH payments were originally intended.

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<sup>1</sup> Association of American Medical Colleges (AAMC) quarterly Operations and Financial Performance data,

## *The Need to Mitigate Pending Reductions in Medicare DSH Payments*

To date, the Centers for Medicare and Medicaid Services (CMS) have partially mitigated the impact of PPACA's Medicare DSH cuts in their regulatory implementation of the program – they have used their authority to employ “proxy” data that measures the sum of an institution's Inpatient Medicaid Days and Inpatient Medicare SSI days for purposes of allocating reductions to the 75% of prior Medicare DSH funding that is subject to cuts under PPACA. But as these cuts grow in size over the coming years, this ability of CMS to mitigate the impact for some providers will diminish. And they are in any event unlikely to permanently utilize the proxy data approach.

A basic problem with the Medicare DSH cuts mandated in PPACA is that they applied an analysis by the Medicare Payment Advisory Commission (MedPAC) in a “broad brush” manner. In 2007, MedPAC analyzed the overall relationship between the DSH formula and Medicare costs per case and concluded that -- looking at *all* Medicare DSH hospitals -- about three-quarters of the DSH payments were not “empirically justified” (that is, they could not be correlated to higher costs per case). Leaving aside questions regarding the veracity of MedPAC's analysis, this overall correlation did not consider the much higher correlation seen in studies focused on only large urban hospitals -- let alone urban hospitals such as TUH with disproportionately high-risk caseloads.

Highly impacted institutions such as TUH struggle to overcome negative Medicare margins related to an extraordinarily disproportionate share of diverse, low-income, medically complex patients with a high incidence of behavioral health problems that complicate underlying medical issues. Medicare DSH payments are crucial to our ability to mitigate inadequate reimbursements under the Medicare Inpatient Prospective Payment System. Given our very low share of patients covered by commercial insurers, we are not able to shift costs to the private marketplace. Thus any additional cuts to Medicare DSH will challenge our ability to care for these unique patient populations and ultimately our ability to serve as a major point of access for Pennsylvania's most vulnerable citizens. We simply cannot absorb additional cuts to the Medicare DSH program and urge Congress to place a moratorium on these slated reductions.

We appreciate your consideration of these views.