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TO: House Committee on Ways and Means Subcommittee on Health

FROM: Carrie Saia, CEO

DATE: July 26th, 2015

RE: Challenges Facing Rural Health Care Providers

Mr. Chairman and Members of the Subcommittee,

Thank you for the opportunity to speak to you today. My name is Carrie Saia. I serve as the chief executive officer for Holton Community Hospital in Holton, Kansas. Our hospital is located Jackson County, which encompasses more than 656 square miles northeast Kansas and has a population of approximately 13,500 residents. Our organization, established in 1938, is a 12-bed Critical Access Hospital with three Rural Health Clinics. We employ approximately 140 individuals and operate solely based on income from services provided without revenues generated from mill levies, city or county tax dollars.

I am fortunate and proud to work in a rural community hospital whose employees strive to provide quality and efficient care to the members of their community with whom they live and work. More than 36 percent of all Kansans live in rural areas and depend on the local hospital serving their community. Rural hospitals face a unique set of challenges because of our remote geographic location, small size, scarce workforce, physician shortages, higher percentage of Medicare and Medicaid patients, and constrained financial resources with limited access to capital. These challenges alone would make it difficult for many rural hospitals to survive. However, the increasingly burdensome federal regulations that are being placed on health care providers make it difficult to budget, plan and adequately prepare for the future. I would like to briefly share some of the challenges specifically related to the Medicare policy on direct supervision of outpatient therapeutic services and the 96-hour physician certification requirement.

In 2009, the Centers for Medicare and Medicaid Services issued a new policy for "direct supervision" of outpatient therapeutic services that hospitals and physicians recognized as a burdensome and unnecessary policy change. In essence, the new policy requires that a supervising physician be physically present in the department at all times when Medicare beneficiaries receive outpatient

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therapeutic services. As a result, my organization like many others, has found itself at increased risk for unwarranted enforcement actions. While the Congressional action last year to delay enforcement was applauded by rural hospitals across the nation, there is now an urgency to either permanently fix this unnecessary set of regulations or at very least delay the enforcement until resolution can be met. Congress can provide both immediate and permanent relief from this burdensome regulation by passing legislation. I urge you to consider H.R. 2878, introduced by Representative Lynn Jenkins and David Loebsack. This important legislation would provide immediate relief from the burdensome direct supervision regulation by delaying its enforcement through calendar year 2015 for critical access hospitals and small and rural hospitals.

Holton Community Hospital is staffed similarly to many rural hospitals across the nation. Many have either mid-level providers staffing their hospitals with a physician available for supervision, or a physician readily available (within a 30 minute response time). Staffing a physician on-site as required by the regulations will either result in changing our organization's thin profitable bottom line into a negative bottom line, or restrict the ability to provide services to our beneficiaries within the community.

One example of an outpatient therapy service that is a significant impact to our beneficiaries is the ability to offer intravenous infusions on an outpatient basis. There is a growing need for this service throughout our community, due to a noted increase in patient volume of 22% between fiscal years 2013 and 2015. Not being able to provide this service would result in beneficiaries having to travel outside of their community to receive this treatment, or worse yet the inability of the beneficiary to receive the outpatient service altogether. I strongly encourage this committee to extend the enforcement delay on direct supervision requirements for outpatient therapeutic services provided in CAHs for calendar year 2015. I would also encourage a more permanent fix to provide a solution and support the adoption of a default standard of "general supervision" for these outpatient therapeutic services. Again, I strongly encourage the subcommittee to work to pass H.R. 2878 as well as legislation that would address this problem on a more permanent basis.

A second area of concern is the 96-hour physician certification requirement related to the Medicare condition of participation on the length of stay for critical access hospitals. The current Medicare condition of participation requires critical access hospitals to provide acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient. In contrast, the Medicare condition of payment for critical access hospitals requires a physician to certify that a beneficiary may reasonably be expected to be discharged within 96 hours after admission to the critical access hospital. As a rural hospital administrator, I can say with certainty that the discrepancies between the conditions of participation and conditions of payment have caused confusion and challenges for critical access

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hospitals. This regulation also impedes the ability of the person who knows the needs of the patient best – the physician and other health care providers, and may unnecessarily cause patients to receive care away from their community. Accordingly, I urge Congress to pass the Critical Hospital Relief Act (H.R. 169), introduced by Representatives Adrian Smith, Lynn Jenkins, Todd Young, and David Loebsack. This legislation would remove the Medicare condition of participation that requires a physician to certify that a patient is reasonably expected to be transferred or released within 96 hours. The bill would leave in place the Medicare condition of payment requiring critical access hospitals to maintain an average annual length of stay of 96 hours or less.

On behalf of my organization, and similar rural organizations across the state of Kansas and our nation, it is critically important that our communities are able to access quality health care services. The increasing and unwarranted regulatory burdens that are being placed on health care providers place this access in jeopardy. I would not want to imagine what would happen to patients, similar to a patient just a few days ago in our Emergency Department, who sought treatment after moving heavy equipment at his rural home. He was rapidly identified as having a heart attack, provided stabilization, and transferred the nearest facility with a cath lab. He received successful intervention, and later discharged home. This positive outcome for our beneficiaries and our communities would not be possible without the ability to have access to quality care in a timely fashion. Therefore, steps should be taken to minimize the regulatory burdens that are placed on our rural health care providers and the outcome that affects our communities.

I am honored for the opportunity to submit testimony regarding the action that Congress can take to address rural healthcare disparities created by Medicare regulations. I would be happy to answer questions.