



**WRITTEN STATEMENT OF THE
AMERICAN ASSOCIATION FOR HOMECARE**

**SUBMITTED FOR THE
HOUSE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
HEARING ON RURAL HEALTH
JULY 28, 2015**

American Association for Homecare
1707 L St NW, Suite 350
Washington, DC 20036
Phone: 202-372-0107
Fax: 202-835-8306

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The American Association for Homecare (AAHomecare) is pleased to provide its views on the rural health care disparities created by Medicare regulations to the House Ways And Means Subcommittee on Health.

AAHomecare is the national trade association for home medical equipment (HME) providers, manufacturers and other stakeholders in the homecare community. AAHomecare members serve the medical needs of Americans who require home oxygen therapy, mobility assistive technologies (standard and complex wheelchairs), hospital beds, diabetic testing and medical supplies, inhalation drug therapy, home infusion and other home medical products, services and supplies.

Membership reflects a broad cross-section of the homecare community, including providers of all sizes operating approximately 3,000 locations in all 50 states.

AAHomecare strongly recommends that Congress preserve and strengthen access to home medical equipment for the millions of Americans who require medical care in their homes. In particular, we ask that Congress protect access to home medical equipment in rural areas by preventing the use of prices derived from the Medicare competitive bidding program, which has been recognized as flawed by well over 200 economists, computer scientists, statisticians and auction experts from around the world. These rates do not reflect the true cost of business in rural areas, where fewer providers serve larger areas and face higher delivery and associated service and repair costs.

To do so otherwise, would force the closure of many home medical equipment providers in these areas, cost jobs in an economy that cannot afford to lose them, and deprive a growing number of patients, many of whom are seniors or people with disabilities, access to the equipment and services they need to receive medical care in their homes.

Background

Cost Effectiveness of Homecare

HME offers an efficient and cost-effective way to allow patients to receive care they need at home. The need for HME and HME providers will continue to grow to serve the ever-increasing number of older Americans. Homecare represents a small but cost-effective portion of the more than \$2.3 trillion national health expenditures (NHE) in the United States, and approximately 15.5 million Medicare beneficiaries require some type of home medical equipment annually, from bedside commodes for people who have hip replacements to high-tech ventilators for quadriplegics.

Yet, not all products are equal: some require licensed or credentialed clinicians to be on staff or cost \$15,000 just to procure. While past reports from Congress and the Office of Inspector General (OIG) shed light on products they believe to be overpaid, many others are unprofitable for providers to provide even before the bidding program. The high cost of fuel, labor, rent and utilities, and regulatory compliance associated with billing and collections, HIPAA privacy, identity theft, IT security, Sarbanes-Oxley, waste disposal, beneficiary and employee safety, OSHA, DOT and FDA regulations continues to escalate year after year. Anyone who has ever required HME or had a relative who needed it can attest that our service includes much more than just the equipment.

With greater access to quality equipment and services at home, beneficiaries and Medicare will spend less on hospital stays, emergency room visits, and nursing home admissions. Home medical equipment is an important part of the solution to the nation’s healthcare funding crisis. The facts bear this statement out as private health care plans have contracted for our services for decades and reaped the cost-savings along the way. Even the current Administration is trying to develop programs to manage chronically ill Medicare patients in the home through new demonstration projects and the Innovation Center.

One key fact that is sometimes lost in this debate is that HME represents about one percent of annual Medicare spending. So while this program appears to reduce HME expenditures when simply comparing past and current Medicare Part B expenditures, CMS has not examined the cost shifting that occurs as a result of the program as more beneficiaries will be forced to receive care in hospitals, nursing homes, and emergency treatments.

Impact on Rural Areas

The problems with competitive bidding are already well known from the experiences in the original Round 1 and Round 2 areas. Soon, these impacts will be expanded to suppliers and beneficiaries in the small towns and rural areas outside of the original bid areas. These rural home medical equipment providers are in danger of being hit with devastating Medicare cuts that will hurt patient access to HME, close businesses and cost jobs.

On October 31, 2014, the Centers for Medicare & Medicaid Services (CMS) released the final rule on “Medicare Program: End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies,” which establishes the methodology for making national price adjustments to payments for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) paid under fee schedules.

Data used to calculate the fee schedule was based upon information gathered from the DMEPOS competitive bidding programs (CBPs) and phase in special payment rules in a limited number of competitive bidding areas (CBAs) under the CBP for certain, specified DME and enteral nutrition products.

For qualified DME items, the final rule phases in, over 6 months, a new reimbursement rate for non-CBAs. On January 1, 2016, the reimbursement rate for these claims (with dates of service from January 1, 2016 through June 30, 2016) will be based on 50 percent of the un-adjusted fee schedule amount and 50 percent of the adjusted fee schedule amount which will be based on the regional competitive bidding rates.

Starting on July 1, 2016, reimbursement rate will be 100% of the adjusted fee schedule amount which will be based on regional competitive bidding rates. The following are examples of these drastic cuts –

HCPCS Code	Region	Current	1/1/16 rate	7/1/16 rate
E1390 (O2 concentrator)	Mideast	\$178.23	\$134.21 (-25%)	\$90.18 (-49%)
EO470 (BiPAP)	Rocky MT	\$241.85	\$178.50 (-26%)	\$115.14 (-52%)
K0003 (standard wheelchair)	Great Lakes	\$97.98	\$68.78 (-30%)	\$39.58 (-60%)
K0823 (standard PMD)	New England	\$568.89	\$424.22 (-25%)	\$279.55 (-51%)

The application of payment rates, set by CMS’s flawed competitive bidding process, to non-CBAs will disrupt Medicare beneficiaries’ access to the DME items they need. In CBAs, suppliers are forced to accept contracts for

DME items at a lower rate with the knowledge that there will be a limited number of suppliers that can provide service and supplies in that bid area. Suppliers then try to make up for the drastic payment cuts through increased volume of beneficiaries served in that CBA blended with the higher payments from beneficiaries served outside of the CBA. As a result of CMS' final rule, suppliers in non-competitive bid areas will receive the same drastic payment cuts set in CBAs, without exclusive contracts and increase in volume of business or the ability to compensate with higher rates outside of the CBA. The industry also has convincing data that indicates providing DME items in rural areas have a higher cost than in urban areas.

CMS' final rule also limits the bid ceiling for future rounds of competitive bidding to payment rates set by previous rounds of bidding. Currently, bid limits are set by the fee schedule, which allows for adjustments for inflation. CMS has indicated that it plans to continue competitive bidding for DME items far into the future. Decreasing the bid ceiling limit over many years, while medical inflation continues to rise, will set artificially low rates, which will hamper competition. Ever decreasing bid limits will make it impossible to set market prices through an auction process, without negatively impacting beneficiary care. Congress required CMS to save money compared to the (unadjusted) fee schedules, because taken to its logical conclusion, CMS' plan would eventually result in suppliers paying the government to provide items and services.

Conclusion

Rural home medical equipment providers are in danger of being hit with devastating Medicare cuts that will close businesses and cost jobs.

AAHomecare strongly urges the Committee to take action to prevent these drastic cuts and protect access to home medical equipment for seniors and people with disabilities in rural areas.

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The American Association for Homecare represents providers of home medical or durable medical equipment and services who serve the needs of millions of Americans who require prescribed oxygen therapy, wheelchairs, enteral feeding, and other medical equipment, services, and supplies at home. Visit www.aahomecare.org.



August 11, 2015

Representative Kevin Brady
Chairman
Ways and Means Health Subcommittee
1102 Longworth HOB
Washington D.C. 20515

Representative Jim McDermott
Ranking Member
Ways and Means Health Subcommittee
1102 Longworth HOB
Washington D.C. 20515

Dear Chairman Brady and Ranking Member McDermott:

The American Association of Nurse Practitioners (AANP), the largest full service professional organization representing the 205,000 nurse practitioners (NPs) across the country, applauds the committee for taking the time to examine the rural health disparities created by Medicare regulations. AANP would like to lend its support to a number of legislative efforts which the committee could act upon to improve rural residents' access to care by removing barriers to practice which only increase costs and cause delays in care.

Nurse practitioners have been providing primary, acute, and specialty care for half a century, and are rapidly becoming the health care provider of choice for millions of Americans. According to our most recent survey data, more than 900 million visits were made to nurse practitioners in 2012, a number we anticipate will continue to grow in the coming years. Nurse practitioners provide care in nearly every health care setting including clinics, hospitals, emergency rooms, urgent care sites, private physician or nurse practitioner practices (both managed and owned by nurse practitioners), nursing homes, schools, colleges, retail clinics, public health departments, nurse managed clinics and homeless clinics. It is important to remember that in many of these settings nurse practitioners are the lead onsite provider. In addition to diagnosing and treating acute and chronic illnesses, nurse practitioners emphasize health promotion and disease prevention in the care of their patients. Daily practice includes: assessment, ordering, performing, supervising and interpreting diagnostic and laboratory tests, making diagnoses, initiating and managing treatment including prescribing medication (as well as non-pharmacologic treatments), coordination of care, counseling, and educating patients, their families and communities.

Additionally our data shows that the vast majority of nurse practitioners are primary care providers. Eighty-eight percent are educationally prepared to be primary care providers and over seventy-five percent currently practice in primary care settings. Further, over 174,000 nurse practitioners, nearly eighty-five percent of the current nurse practitioner workforce, are treating Medicare beneficiaries. Nurse practitioners are the health care provider for many of the beneficiaries located in rural and underserved areas.

Removing Direct Supervision Requirement for Outpatient Therapeutic Services Furnished in Small Rural Hospitals and Critical Access Hospitals (CAHs)

AANP agrees with all of the witnesses in their support of removing requirements for direct physician/Non-physician provider (NPP) supervision of outpatient therapeutic services furnished in CAHs and small rural hospitals. Removing this arbitrary requirement would allow professionals educated and licensed to provide these vital services to do so without the direct supervision of a physician/NPP. Some of the outpatient therapeutic services impacted by this requirement include drug infusions, blood transfusions, and wound debridement.

AANP would also support the passage of *the Protecting Access to Rural Therapy Services (PARTS) Act (H.R. 1611/S. 257)*. This piece of legislation would not only remove the requirement of direct physician/NPP supervision for outpatient therapeutic services furnished in small rural hospitals and CAHs but would also authorize nurse practitioners to supervise cardiac and pulmonary rehabilitation services. Under current law only a physician may supervise cardiac and pulmonary rehabilitation services even though nurse practitioners are educated and trained to provide these important services that are currently being underutilized due to a lack of access.

Removal of 96 Hour Rule

AANP agrees with removing the current requirement that a physician certify that a beneficiary may reasonably be expected to be discharged or transferred to another hospital within 96 hours of admission. This requirement creates needless additional documentation and busy work that could be spent on other more important activities in the CAH.

Nurse Practitioners & ACOs

During the hearing multiple Members asked for more information regarding the problems that rural ACOs are encountering. One issue of particular significance to nurse practitioners is that under current Medicare law (specifically the Shared Savings Program), nurse practitioners are recognized as ACO professionals but those patients who receive their care solely from a nurse practitioner within an ACO are by statute, ineligible to be counted toward the ACO's Shared Savings. This barrier requires that a patient who currently receives care from a nurse practitioner within an ACO must be seen at least once each year by a physician within that ACO in order to be counted toward the ACO's Shared Savings. This needless requirement makes it harder to establish and maintain ACOs in rural and underserved areas more reliant on nonphysician providers.

AANP asks that the committee pass legislation that ensures patients seen solely by nurse practitioners within an ACO count toward an ACO's shared savings. In the Senate, *the Rural ACO Improvement Act of 2015, S. 1456* has been introduced and would make this change.

Authorize Nurse Practitioners to Certify Patient Eligibility for Medicare Home Health Services

Another barrier to practice which harms patients and is magnified in rural areas is the current Medicare barrier that prevents nurse practitioners from certifying their patient's eligibility for Medicare home health services. While nurse practitioners are currently authorized to perform the face-to-face assessment of their patient's needs prior to ordering home health services, a physician must certify their assessment even though that physician was not involved in the assessment. This specific barrier was

addressed in Shannon Sorensen's, CEO of Brown County Hospital, written testimony as a requirement which decreased access to their patients.

AANP asks that the committee address this burdensome requirement by passing legislation which would allow nurse practitioners who are authorized to perform the face-to-face assessment be authorized to certify that assessment. *The Home Health Care Planning Improvement Act of 2015, H.R. 1342* makes this change and has the bipartisan support of 136 cosponsors including 14 Members of the Ways and Means Committee. Its companion bill in the Senate, *S.578* has 35 cosponsors.

In closing, we look forward to working with the Committee to reduce rural health disparities created by Medicare regulations. AANP is eager to support the committee's efforts to remove barriers to practice which create delays in care and increase in costs while not improving the care provided to patients. We look forward to working with you in the future. Please contact MaryAnne Sapio, Vice President of Federal Government Affairs at msapio@aanp.org for further information.

Sincerely,

A handwritten signature in black ink that reads "David E. Hebert". The signature is written in a cursive style with a long horizontal line extending to the right.

David Hebert
Chief Executive Officer



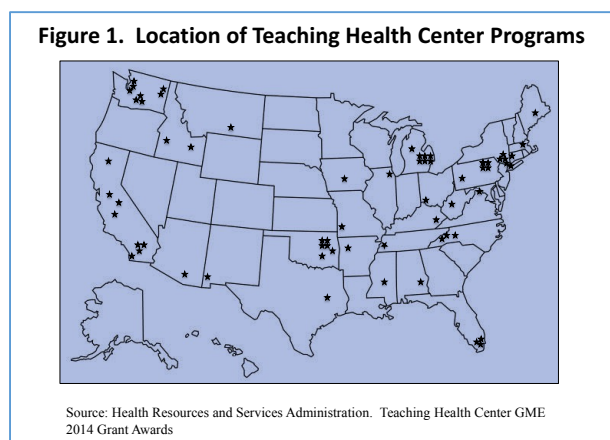
August 11, 2015

The Honorable Kevin Brady
United States House of Representatives
301 Cannon House Office Building
Washington, DC 20515

The Honorable Jim McDermott
United States House of Representatives
1035 Longworth House Office Building
Washington, DC 20515

Dear Chairman Brady and Ranking Member McDermott:

On behalf of the American Association of Teaching Health Centers (AATHC), I am writing in response to the House Committee on Ways & Means Subcommittee on Health hearing held on July 28, 2015 to discuss rural health care disparities created by Medicare regulations.



The AATHC was founded in 2013 to represent the interests of Teaching Health Center Graduate Medical Education (THCGME) programs nationwide – currently comprised of 60 HRSA-supported Teaching Health Centers (THCs) that train 690 resident physicians in rural and urban underserved areas in 27 states and the District of Columbia.

First, we wish to again express our deep gratitude for the continued support shown by Chairman Brady, Ranking Member McDermott,

and the entire Health Subcommittee. We appreciate your good work in drawing attention to the THCGME program, and look forward to our continued partnership.

During the Health Subcommittee's hearing on July 28 discuss rural health care disparities created by Medicare regulations, we were pleased that the Subcommittee highlighted the THCGME program as a possible solution to the primary care shortage that is reaching crisis levels in rural areas of the US. In his testimony, Mr. Daniel Derksen Director of the Arizona Center for Rural Health, called out THCGME specifically as a building block of GME reform. The demonstrated success of the THC model, particularly in rural areas, is indisputable. We are training and producing high-quality primary care doctors for the rural areas that need them most.

Many of these doctors come from the finest medical schools in our country, and the demand for these slots is extremely high. For example, ten programs reported over 11,000 applications from medical students for their 93 residency slots available for the 2014-2015 academic year. Of course, medical students typically apply to multiple residency programs, but the high ratio of applicants to THCGME slots shows that medical students are increasingly interested in THC programs. In the past four years, the number of applicants received by THCGME programs has increased 30 percent.

However, despite the program's overwhelming, documented success, and 2-year extension, THCGME programs nationwide are currently on the brink of collapse and the growth of the program has halted at a time where THCs are just beginning to ramp up to their full complement of residents in order to provide high-quality, accessible, and affordable healthcare in urban and rural areas.

As the result of widespread, bipartisan, bicameral support for the THCGME program, the program was extended for 2 years and \$120 million in H.R. 2, the Sustainable Growth Rate (SGR) "fix" legislation. This additional funding was intended to enable the THCGME program to not only continue training residents and providing care in rural and urban underserved communities, but also lay the foundation for meeting future healthcare workforce needs.

This Republican-led, bipartisan legislative victory demonstrates the widespread impact of the THCGME program and the strong desire of key legislators to see the program not only endure, but also to grow and expand in order to provide well-trained primary care physicians in areas that need them most. Certainly, urgency exists to ensure HRSA implements the funding provided in a way that maintains these programs and continues delivering doctors to communities where they are most needed. Currently, a reduced per resident amount (PRA) is threatening not only the completion of training for many current residents, but also the admission of new residents into training. Without the extension of funding, many of these vital programs are being forced to make the difficult decision to stop accepting residents, or shut down completely.

The traditional method of residency training, funded primarily by CMS under a Medicare formula, is mainly focused on hospital-based training and the profile of physicians trained no longer matches the nation's needs – too few enter primary care and even fewer choose to practice in rural or underserved locations. In contrast, the THC model uses community-based ambulatory health centers, such as nonprofit community health centers and community consortia, to train primary care residents who will practice twenty-first century care in underserved communities both during their training, and after their residencies have been completed.

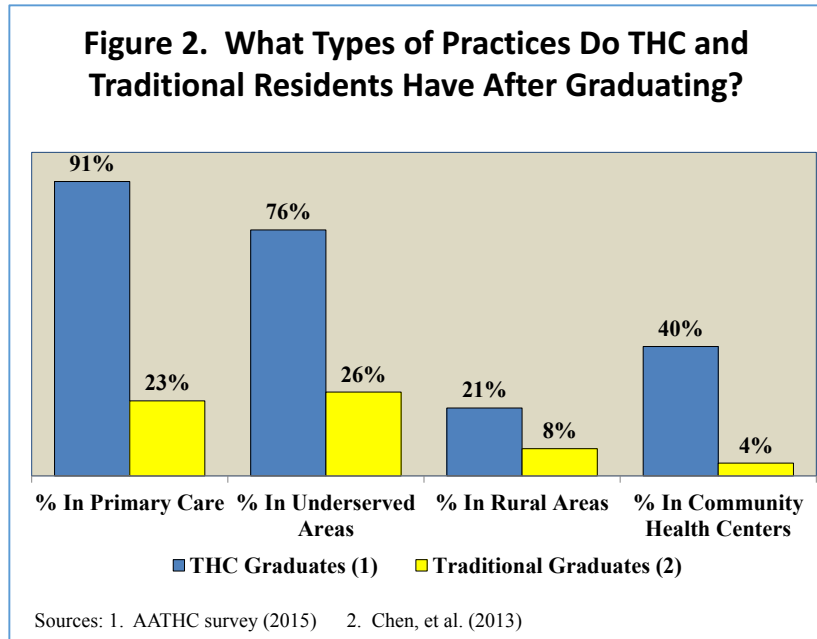
According to the American Academy of Family Physician, by 2025, the United States will require an additional 52,000 primary care physician, and the shortage is being felt most deeply in health professional shortage areas (HPSAs) and medically underserved areas (MUAs). As many as 60 million people living in these areas experience disparities in health care access either because they are uninsured, or because they live in rural, urban, or suburban areas without enough primary care physicians. Additionally, we are reaching a critical time, when the number of medical school graduates will be greater than the number of residency slots. Without a residency medical school, graduates are unable to obtain a medical license.

While it is too early for a full assessment of the THC program, preliminary analyses demonstrate positive and promising results and signal that this innovative model of graduate medical education should continue to be developed and meet its full potential.

During their residency training, THC residents practice in the approved primary care specialties of Family Medicine, General Internal Medicine, Obstetrics and Gynecology, Pediatrics, Psychiatry and General Dentistry. These residency practices are located in underserved communities,

expanding access to health care and decreasing health disparities. *A fundamental question is: Do they continue to fill these roles after they complete their residencies?* In July 2014, AATHC conducted a survey after the 2014 academic year to determine where THC graduates ended up after graduating from the THCGME program.

Figure 2 compares the post-residency choices of THC and general Graduate Medical Education (GME) residents. These signal the extent to which, on a longer term basis, THC's newly-minted



physicians help address national needs – particularly by providing ambulatory primary care in underserved areas.

The results of AATHC's survey prove that the THC model is working.

- 91 percent of THC graduates remain in primary care practice, compared to about 23 percent of traditional GME graduates.

- More than three times as many THC graduates (76 percent) went on to practice in

underserved communities, compared to 26 percent of the traditional graduates.

- Twice as many THC graduates (21 percent) go on to practice in rural areas, compared to 8 percent of traditional graduates.
- About nine times as many decided to practice at nonprofit community health centers (40 percent) as regular medical graduates (4 percent).
- Most (61 percent) of the THC graduates continue to practice in the state where they conducted their residencies. For example, in Texas, a state with a particularly serious primary care physician shortage, 80 percent of those residents who trained in Texas stayed in Texas.

In addition to an increase in demand among institutions and medical students, there is widespread support for this program among Members of Congress, local communities, and key health care stakeholder organizations.

Since traditional CMS-funded residency training continues to produce an inordinate proportion of specialists under their fixed cap at the expense of primary care, the THC model is arguably the single most promising alternative to traditional CMS-funded residency training. In the 2015-2016

academic year, the program will support over 750 residency slots, provide more than 750,000 primary care visits in underserved rural and urban communities, and, perhaps, most significantly to the American tax payer, guarantee that every dollar spent is used exclusively for primary care training.

The uncertainty of future federal funding remains a serious inhibitor to the long-term success of the Teaching Health Center model – the most reliable training model for primary care physicians in underserved rural and urban locations. If the H.R. 2 funding is not front-loaded in the current 2015-2016 academic year to ensure the \$150,000 PRA is maintained, it will continue to have a negative impact on the rural communities that the THCGME program serves. It is imperative we secure funding immediately to permanently fund the THCGME program, allowing it to reach its full potential and produce physicians to train and serve in rural areas.

On behalf of the AATHC, thank you for your continued support of this vital program. We look forward to hearing from you, and continuing to work together to ensure the long-term success of the THCGME program.

Sincerely,

Stephen McKernan, DO
Executive Committee, American Association of Teaching Health Centers
Program Director, Conroe Family Medicine Residency Program
CEO, Lone Star Family Health Center

**TESTIMONY OF
AMERICA'S CRITICAL ACCESS HOSPITAL COALITION
HOUSE WAYS AND MEANS COMMITTEE
SUBCOMMITTEE ON HEALTH
JULY 28, 2015**

Chairman Brady, Ranking Member McDermott, and distinguished Committee members, thank you for holding the Rural Health Hearing to discuss rural health care disparities created by Medicare regulations. America's Critical Access Hospital Coalition works with over 150 CAHs across the country to bring together healthcare leaders to discuss innovative, sustainable practices and plan for the future of healthcare in rural America. We would like to offer our testimony on the disparities in rural care, most specifically on the issue of allowable costs for Critical Access Hospitals (CAHs).

CAHs play an integral role in most States serving the health care needs of rural communities – delivering inpatient and outpatient services, as well as 24-hour emergency care. CAHs make it possible for individuals living with complex medical needs to remain in their communities without travelling long distances to receive the care they require. Currently, CAHs are reimbursed for 101% of reasonable costs to ensure they are able to maintain high quality care in communities with low patient volume and high proportions of Medicare and Medicaid patients. However, as we will describe in detail below, most in fact receive anywhere from 75 to 95 percent of the costs associated with Medicare and Medicaid Patients.

One of the challenges our members consistently face is the lack of continuity in how allowable costs are interpreted by Medicare Audit Contractors (MACs). The lack of clarity is particularly burdensome for systems that have CAHs located in different regions, and thus reviewed by different MACs, or when a new MAC begins reviewing the CAH. Currently, regulations are interpreted differently in each region with regards to allowable cost for CAHs – what may be allowed in one area is not allowed in another. Additionally, when a new MAC takes over a region, CAHs may suddenly be informed that a cost that was covered for years will not be moving forward. A uniform, nation-wide definition of allowable costs is needed to create consistency across the country.

Our members have identified several examples of the most common discrepancies they encounter:

Emergency Room Physician Availability Cost: Some auditors have disallowed emergency room physician availability costs over a disagreement with the submitted time study methodology or an absence of a written allocation agreement. In addition, certain MACs do not follow Provider Reimbursement Manual guidance to calculate allowable costs.

Certified Registered Nurse Anesthetist: Several CAHs have recently experienced certain auditors disallowing CRNA standby time, while different auditors always

allowed the expense. This is a huge expense for CAHs, and the limit may result in an end of OB coverage for districts, which are often an hour from another hospital.

Provider Fees/Taxes: For years, Provider taxes have been imposed by states on health care services such as a tax on inpatient hospital services or nursing facility beds. CMS has given MACs the authority to evaluate each state's provider taxes on an individual basis to determine if they are allowable. In recent years, some MACs determined that either all or part of this reimbursement is not allowed, this has resulted in several CAHs receiving notices that the recent audit has found that they were overpaid for this cost, in some cases very large sums from up to six years prior.

Thank you for providing us with the opportunity to express our concerns with the Ways and Means Committee. We are committed to the communities we serve, and we hope to continue this discussion with you and your staff to ensure that CAHs are able to maintain their services and guarantee high quality care to beneficiaries living in rural communities.



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
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

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

August 6, 2015

Congressman Kevin Brady
Chairman
House Ways & Means Subcommittee on
Health
1102 Longworth House Office Building
Washington, DC 20515

Congressman Jim McDermott
Ranking Member
House Ways & Means Subcommittee on
Health
1106 Longworth House Office Building
Washington, DC 20515

RE: Statement for the Record of the Subcommittee Hearing on Rural Health Care Disparities Created by Medicare Regulation

Dear Chairman Brady and Ranking Member McDermott:

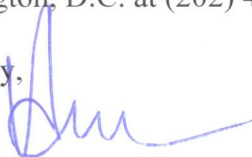
On behalf of the Kaweah Delta Health Care District, we are pleased to offer this statement for the record of your recent hearing. We believe our location, catchment area, and our newly Accreditation Council for Graduate Medical Education (ACGME) accredited GME program, provide us with a unique perspective on rural health.

As you may already be aware, Kaweah Delta is located in Visalia, California, in the heart of the largely rural and agricultural Central Valley. We serve a population of over half a million people that spans 41 zip codes surrounding our main hospital campus. Although our main campus is located within the city limits of Visalia, over fifty percent of the population we serve resides in rural areas of Tulare County. As a result, our medical team focuses on a unique group of both rural and urban patient needs at all times of the year. We are currently designated as a Level 3 trauma center and are evaluating a move to upgrade our trauma capabilities to an ACS Level 2 trauma center, which will bring many additional patients from around the Central Valley region of California.

While our GME program is just beginning, we have made several observations during our implementation that we would like to bring to the Committee's attention. Since our accreditation in 2011, we have established a Family Medicine program, an Emergency Medicine program, and a Psychiatry Residency program. We are also beginning our first class for the Transitional Year program and our General Surgery program.

Below you will find our observations on rural health and GME. If you would like additional clarification or comment on any of these responses, please contact me at (559) 624-2330 or Imann@kdhcd.org. You may also contact Lynn Jacquez who is our representative in Washington, D.C. at (202) 465-3000 or ljacquez@cj-lake.com.

Sincerely,



Edward Hirsch, MD
VP, Chief Medical Officer

1) The U.S. has an abundance of medical school graduates but not enough residency positions.

Because 50% of residency graduates (who are usually in the time of their lives to get married, have children and settle down) stay within 50 miles of where they completed their residency training, it is important to locate the training where the patients need them.

2) Rural medicine should be synonymous with a wider scope of practice. In essence, it is the opposite of a specialist.

What is considered a specialist's procedure in Chicago (ie vasectomy) is well within the scope of a primary care physician in Visalia, California. The current model, designed around tertiary care training, breeds this narrower subspecialist mentality and reduces access to care. One does not need a urologist to perform a vasectomy but one will if the Family Medicine physician is not properly trained. Family Medicine as a specialty gets weaker because of this movement of specialized training in tertiary care centers.

3) In order to achieve any semblance of adequate reimbursement for patient services, Kaweah essentially must partner with the local Federally Qualified Health Center (FQHC).

The clinic is located next to the hospital and although the catchment area of the hospital is rural, the zipcode of the clinic is not. There is a new Health Resources and Services Administration (HRSA) waiver process that would allow for reimbursement through the FQHC that we think may help. However, pairing with a local FQHC does not always achieve the same goals and objectives or ACGME requirements as the residency program and is a contractual nightmare and an issue with which institutions across the country struggle.

4) There are few federal resources available for developing a new GME program. Most grants have statutes stipulating prior ACGME accreditation is already awarded.

The current system forces institutions like ours to incur significant startup costs for programs. Kaweah believes that the current system tends to benefit existing GME programs at the expense of new ones. Therefore, we would support the creation of a GME transformation fund that would be specifically dedicated to developing and evaluating innovative GME programs.

5) The existence of Kaweah's GME program has already helped the hospital to recruit and retain highly vested, systems-based focused physicians.

These physicians practice here because they want to train residents. Doctors that would otherwise wish to practice in other areas of the Country where reimbursement rates are higher, are attracted to the opportunity to teach residents. As a result, access to care is improved even before one resident graduates from a program. However, it is well known that physicians who train residents at academic centers do not get reimbursed as well as those who work in the private sector. This lower reimbursement, coupled with Kaweah's additional rural status recruitment challenge essentially mandates stronger financial support of the education efforts of physicians than the tertiary care centers in order to keep reimbursement within fair market value and to meet the health care needs of our patients.

6) Kaweah is fortunate to control a few rural health clinics (RHCs) in the area. In our efforts to build GME and potentially begin internal medicine, neurology and OB/Gyn residency programs, we will need to recruit many specialists to the area (ie – endocrinology, gynecology/oncology).

These subspecialties are highly needed for our patient population. It would be doubly beneficial if we could add these specialists, who will work clinically with residents at the RHCs, to the hospital's call panel to provide access to care in the specialty. In making this change, a hospital could maximally support the specialists required for creating a residency program in the RHC while adding to the call coverage capabilities of the institution. We are aware that RHC services must be primarily primary care. It would be beneficial to create programs that support the location of specialists in the RHCs and to reward the coordination of the delivery of specialty care with the local FQHC rather than foster competition between the RHCs and the FQHC over primary care.

In order to satisfy their specialty needs, the FQHC is then forced to scrounge (often times unsuccessfully) for sparsely available specialty referrals in faraway locations (Bakersfield and Fresno) rather than in their own backyard at Kaweah. Eventually the patient who never gets the referral, or who needs to wait months and months for the referral, becomes so ill that they visit our Emergency Department because they had nowhere else to turn.



Written Testimony of

Steve R. Ommen, MD
Medical Director, Mayo Clinic Center for Connected Care

How to Improve Rural Health Care Disparities through Changes in Federal Telehealth Policy

Submitted to:
House Ways and Means Subcommittee on Health
Hearing on Rural Health Care Disparities Created by Medicare Regulations

The Honorable Kevin Brady, Chairman
The Honorable Jim McDermott, Ranking Member

July 28, 2015

Mayo Clinic Contacts:

Kathleen Harrington
Chair, Division of Government Relations
200 First Street, SW
Rochester, MN 55905
(507) 266-4812
(507) 538-4583 (fax)
harrington.kathleen2@mayo.edu

Jennifer Mallard
Director, Federal Government Relations
1455 Pennsylvania Ave., NW, Suite 400
Washington, DC 20004
(202) 327-5424
(507) 538-4583 (fax)
mallard.jennifer@mayo.edu

Thank you for the opportunity to share our recommendations with respect to improving rural health care disparities created by Medicare regulations. While there are many issues impacting rural health care disparities, I am writing to specifically address how the advancement of telehealth through changes in federal policy can expand the reach of medicine and knowledge, save health care costs and, most importantly, improve outcomes and reduce health disparities for patients located in rural communities.

As part of the largest integrated, not-for-profit medical group practice in the world, Mayo Clinic physicians see great potential to improve health and health outcomes for people in rural communities through greater use of telehealth services. In addition, because our physicians see patients from all 50 states each year, Mayo is acutely aware of the barriers that exist at both the federal and state levels that inhibit the delivery of medical services through “connected care,” our term for the spectrum of telehealth platforms. Indeed, I write in my capacity as the Medical

Director of Mayo Clinic's Center for Connected Care. Mayo uses connected care in many aspects of our practice from saving lives with our telestroke program, to enabling video consultations in skilled nursing facilities, to monitoring intensive care patients at rural facilities and across state borders, to sharing our knowledge with physicians across the country through eConsults and our AskMayoExpert program. In all of these situations, we have observed that connected care improves access, service and affordability for our patients.

Below are five policy priorities that will help advance the delivery of telehealth and work to reduce health disparities in all parts of the country, and most critically in our rural communities.

1. Promote telehealth delivery to improve access to critical care in rural areas

Mayo's initiative in telestroke diagnosis has shown great promise in improving patient outcomes and reducing health care costs. Researchers have found that using telehealth to deliver stroke care, also known as telestroke, not only improves patient outcomes, but is cost-effective for health care payers.

In telestroke care, the use of a secure, high definition telestroke monitor allows a patient presenting with symptoms of a stroke to be examined in real time by a neurology specialist from a remote location. The neurologist consults via computer with the emergency room physician at the patient's site, which like most rural hospitals, may not have neurology specialists. Mayo provides telestroke care by acting as a single source of specialized care – a hub – to connect a network of multiple hospitals – spokes. Many of these "spokes" are Critical Access Hospital sites that do not have the patient volumes or the financial resources to offer 24-hour access to specialized critical care.

A Mayo study estimated that compared with no network, a modeled telestroke system consisting of a single hub and seven spoke hospitals may result in the appropriate use of more clot-busting drugs, more catheter-based interventional procedures and other stroke therapies, with more stroke patients discharged home independently. Despite upfront and maintenance expenses, the entire network of hospitals realizes a greater total cost savings.

When comparing a rurally located patient receiving routine stroke care at a community hospital, a patient treated in the context of a telestroke network incurred \$1,436 fewer costs. The improvement in outcomes is associated with reduced resource use (such as inpatient rehabilitation, nursing homes, and caregiver time). Mayo Clinic Telestroke maintains hubs in Arizona, Florida, and Minnesota, and serves more than 20 health care institutions in seven states. We estimate that in Arizona alone telestroke services have saved more than 70 quality years of human life and \$5 million societal dollars since 2008. The Mayo study showed that expansion of telestroke networks across the country can improve patient-related outcomes and quality while saving overall costs, including Medicare and Medicaid funds.

Enhanced critical care remote monitoring is another example of an innovative delivery system that would improve outcomes and save health care costs if diffused more broadly. To illustrate, ICU (intensive care unit) patients in Eau Claire and La Crosse, Wisconsin, are monitored 24 hours a day, seven days a week by critical care specialists located in Rochester, Minnesota, utilizing Mayo connected care systems. Through constant surveillance, and by providing the care

teams with timely patient information, E-ICUs have been associated with a 55 percent reduction in ICU mortality and a 40 percent reduction in clinical complications.

We encourage Congress to direct the Centers for Medicare & Medicaid Services (CMS) to take advantage of this innovative care delivery by exploring alternative payment methods to more widely expand adoption of these uses of telehealth. We would be happy to provide greater detail on both the telestroke and E-ICU initiatives to the committee.

2. Lift geographic and originating site restrictions

The advantages of connected care services are not only applicable when the patient is distant or in a very remote location, but also because they can be in touch more often with more appropriate, logistically simpler methodologies than the traditional face-to-face encounter. The CMS requirement that telehealth consults be confined to authorized originating sites, such as hospitals and clinics, prevents home bound residents from receiving quality home monitoring. While travel time and distance can be important factors, there are many patients in both urban and rural settings whose limited mobility makes it equally problematic to travel from home to a clinic. A patient may live in a rural area; however, the closest originating site may be in the hospital located in the nearest small city with a population of 50,000, making the visit ineligible for telehealth coverage. Medicare telehealth restrictions do not recognize the advances in technology, cost savings and patient demand for remote health care delivery –especially in our rural communities.

While CMS recently expanded coverage slightly to include rural census tracts within a Metropolitan Statistical Area (MSA), we encourage Congress to direct CMS to remove all geographic and originating site limitations, and follow the lead taken by most state Medicaid programs, which have lifted these arbitrary geographic and originating site restrictions enabling Medicare patients to receive connected care services regardless of location.

3. Expand coverage for store-and-forward or asynchronous communications

The use of secure, asynchronous (also referred to as store-and-forward) exchange of medical information effectively and economically uses telehealth technology to improve patient access and quality of care. In our outpatient clinic settings, we use this technology with our eConsults program, both within the Mayo system and with outside health organizations. This enables compliant provider-to-provider exchange of clinical information to allow subspecialty consultations to help guide diagnosis and management of more complex cases through a review of the patient's medical record, imaging studies and laboratory tests without the patient having to schedule an appointment time or go to a specific location. This saves time and the cost of scheduling visits, and improves access for other patients that require face-to-face encounters by freeing up capacity where a face-to-face visit was not warranted. Additionally, for some patients, this maximizes the care they can receive in their rural primary health care market and increases patient access to expert consultation that otherwise may be foregone if they were unable to afford additional time away or experience travel barriers to more distant facilities. Not only does this help alleviate the physician shortage in rural areas, it also saves the regional providers the costs and salary of hiring dedicated sub-specialists.

4. Expand coverage for patient home monitoring

A recent Mayo randomized study, published in *Telemedicine and E-Health*, of more than 200 patients who received either additional home telehealth monitoring or the usual medical care, found that those receiving care via telemedicine had less variability in cost of care, lower decedents-to-survivors cost ratio, and lower total 30-day readmission cost than patients receiving traditional medical care.¹

5. Collaborate through medical licensure compacts

The patchwork of state-by-state medical licensing rules presents a costly and time-consuming administrative barrier to connected care services expansion both within health systems that span state lines, as well as with providers in other health systems. Presently, in order to provide medical advice via telehealth services, providers must be licensed in the state where the patient resides. While a national licensure system has been part of the widespread policy debate, the adoption of the state-by-state Medical Licensure Compact (currently adopted by 11 states) promises to be a significant improvement. In rural communities on or near state borders, a provider in a neighboring state may be more proximate to a patient than the nearest provider of the same type in their home state.

Conclusion

As advances in technology and consumer demand for telehealth options grow, government policies must keep pace with these technological and societal changes. This is important because we have seen firsthand at Mayo Clinic that telehealth provides great benefits, including greater convenience for patients and their families, safer care, better outcomes, fewer redundancies, and ultimately higher quality and cost savings for patients, providers and payers, including the Medicare and Medicaid programs. Moreover, government policies should ensure patient access to telehealth by encouraging physician-to-physician consultations and physician-to-patient services that are integrated into various care settings (clinics, hospitals, nursing homes, home health agencies, etc.). A patient's health care needs are not defined by where they live or where they receive health care; thus, telehealth solutions enable patients and providers access to clinical expertise and care alongside the local and regional health care organization, offering wider sub-specialty care, convenience and fewer costs for the patient and his/her family. In the end, Mayo Clinic believes this will help address some of our disparities in the provision of health care services.

Thank you for the opportunity to address how advancing telehealth services through changes in federal health policy can improve health care disparities in our rural communities. If you have any additional questions or would like to have more information, please reach out to Kathleen Harrington at 507-266-4812 or harrington.kathleen2@mayo.edu or Jennifer Mallard at 202-621-1850 or mallard.jennifer@mayo.edu.

¹ Upatising Benjavan, Wood Douglas L., Kremers Walter K., Christ Sharon L., Yih Yuehwern, Hanson Gregory J., and Takahashi Paul Y.. *Telemedicine and e-Health*. January 2015, 21(1): 3-8. Doi:10.1089/tmj.2014.0021.

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:
Rural Health Care Disparities Created by
Medicare Regulations

July 28, 2015
10:00 A.M.

1100 Longworth House Office Building

National Association of Chain Drug Stores (NACDS)
1776 Wilson Blvd., Suite 200
Arlington, VA 22209
703-549-3001
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 rural health care disparities created by Medicare regulations. NACDS and the chain pharmacy industry are committed to partnering with Congress, HHS, patients, and other health care providers to improve the quality and affordability of health care 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 health care 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.

The national physician shortage coupled with the continued expansion of health insurance coverage will have serious implications for the nation's health care system. Access, quality, cost, and efficiency in health care are all critical factors – especially to the medically underserved and those living in rural areas. Currently, the Medicare statute does not recognize pharmacists as a provider in the Medicare program. By recognizing and utilizing pharmacists, Medicare can fill the health care gaps currently experienced in the rural setting and help ensure access to requisite health care services for this vulnerable population.

As the face of neighborhood health care, 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 health care 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 health care delivery system of tomorrow—in partnership with doctors, nurses, and others.

Retail community pharmacists provide high quality, cost efficient care and services. However, the lack of pharmacist recognition as a provider in Medicare 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 medically-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 health care capacity and strengthen community partnerships to offset provider shortages and the surge in individuals with health care 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 health care costs, but also to increased access to health care services and improved health care quality for underserved patients, including those living in a rural setting.

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.

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

Elehwany@nrharural.org
(202) 639-0550
1025 Vermont St. NW, Suite 1100
Washington, DC 20005

Testimony of the National Rural Health Association (NRHA)
Concerning Access to Rural Health Care
*Submitted for the Record to the House Committee on Ways and Means
Subcommittee on Health – July 28, 2015*

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.

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 make sure 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. 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.

These 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. Without these programs, 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-five 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.

If Congress allows these 283 rural hospitals on the brink to close, then 700,000 patients

would lose direct access to care. Already 640 counties across the country are without quick access to an acute-care hospital. Seventy-seven percent of the nation's 2,041 rural counties are Health Professional Shortage Areas. 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.

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.

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 to consider the impact of access to care for rural Americans when necessary safety net providers close. Fifty five rural hospitals have already closed, and 283 are on the brink of closure. NRHA is calling on members of Congress to stabilize the rural hospital closures. 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. NRHA understands the need for an innovation model for rural hospitals who continue to struggle, while ensuring access to emergency care and outpatient care that meets the needs of their unique rural communities.

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 legislation

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 of the Rural Hospital Coalition

House Committee on Ways and Means
Subcommittee on Health

“Rural Health Care”

July 28, 2015

Submitted by Nancy Taylor
On Behalf of the Rural Hospital Coalition
202.331.3133

Statement of the Rural Hospital Coalition

House Committee on Ways and Means
Subcommittee on Health

“Rural Health Care”

July 28, 2015

“Rural hospitals face huge challenges; nearly 50 of them have closed in the last four years, according to the North Carolina Rural Health Research Program. But the many successful hospitals, beyond providing an array of jobs from the bottom to the top of the economic ladder, also stimulate local spending and help attract new businesses that offer a stable of insured patients.”

– *New York Times*, April 29, 2015¹

The Rural Hospital Coalition would like to thank Chairman Kevin Brady (R-TX), Ranking Member Jim McDermott (D-WA), and other Members of the Health Subcommittee for holding a hearing on Medicare issues associated with rural health care.

The Rural Hospital Coalition represents nearly one-fifth of all rural hospitals in America, with nearly 200 facilities located across more than thirty states. Our hospitals are major economic drivers in rural communities, providing jobs, economic development and the health care needed to keep rural Americans thriving. In many rural communities, hospitals serve as one of, if not *the*, largest employers. Rural hospitals can account for a full 20% of the economic activity that a rural community sees in a year. A rural hospital is often a vital element in attracting outside investment and new employers to a rural community.

Rural hospitals frequently serve as the sole provider of health care for their community. They care for individuals who, on average, earn significantly less than those in urban areas and are more likely to live at or below the Federal poverty level. Rural Americans are more likely to have comprised overall health² and are less likely to have private health insurance or prescription drug coverage. As a result, rural hospitals provide higher rates of uncompensated care than metropolitan facilities³. These hospitals also see a greater share of patients on Medicaid than urban facilities⁴ – a program that has historically paid less for hospital services than the actual costs associated with providing care.⁵ And while Medicare payments to rural hospitals are also

¹ Searcey, Dionne. “Hospitals provide a pulse in struggling rural towns,” *New York Times*, April 29, 2015.

² National Rural Health Association, What's Different about Rural Health Care?, <http://www.ruralhealthweb.org/go/left/about-rural-health/what-s-different-about-rural-health-care>, Accessed December 26, 2013.

³ *Id.*

⁴ Rural Assistance Center, What are some challenges that rural hospitals face?, <http://www.raconline.org/topics/hospitals/faqs>, Accessed January 3, 2014.

⁵ American Hospital Association, *Underpayment by Medicare and Medicaid: Fact Sheet*, December 2010, <http://www.aha.org/content/00-10/10medunderpayment.pdf>.

proportionally less than those paid to urban hospitals for the same services, Congress has initiated payment policies that help offset these and other challenges faced by rural hospitals – such as lower patient volumes and the recruitment and retention of physicians and other health care providers⁶.

The rural payment policies created by Congress have been critical to the preservation of health care services to rural Americans. This is why the Rural Hospital Coalition applauds Congress for extending several Medicare payment programs in the recent Medicare Access and CHIP Reauthorization Act.⁷ We especially thank Congress for extending the improved payment for low-volume hospitals and the Medicare Dependent Hospital (“MDH”) programs through October 1, 2017.

Going forward, we urge Congress to strengthen these policies and make them permanent. Our hospitals need the certainty that comes with permanent Medicare payment supports. Together, the CBO estimates that these two programs will cost just \$600 million per year in 2016 and 2017. This year, these programs will amount to approximately 0.04% of net Medicare outlays. But while their financial impact is miniscule relative to total Medicare spending, these policies provide a much-needed lifeline to rural hospitals and the communities they serve.

Improved Payment for Low-Volume Hospitals

The improved payment for low-volume hospitals applies a percentage add-on for each Medicare discharge from a hospital that is located 15 road miles or more from another hospital⁸, and has less than 1,600 Medicare discharges during a fiscal year. This provision affords qualifying hospitals an enhanced payment to account for the higher incremental costs associated with a low volume of discharges, as compared to the lower incremental costs incurred per patient at higher volume hospitals. The enhanced payment is not provided after a one-time qualification, but requires that a hospital provide sufficient evidence to demonstrate that it continually meets the discharges and distance requirements, ensuring that hospitals which do not consistently qualify for the payment are not unjustly enriched by a one-time qualifying discharge rate or distance measurement.

Medicare Dependent Hospital Program

The MDH program dates back to 1987, and was "intended to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges."⁹ Congress applied this designation to rural hospitals with 100 beds or fewer, not classified as an SCH, and having at least 60% of inpatient days or discharges covered by Medicare. As noted by the Medicare Payment Advisory Commission ("MedPAC"), a greater dependence on Medicare makes such hospitals more financially vulnerable to the prospective payment system ("PPS"). The MDH designation mitigates this financial risk, providing an enhanced payment to account for reduced payments under PPS. Additionally, the MDH designation provides small rural hospitals assurance that if its caseload falls by more than 5 percent due to circumstances beyond

⁶ Id.

⁷ P.L. 114-10

⁸ This applies only to “subsection (d) hospitals” - Not including psychiatric hospitals, rehabilitation hospitals, children’s hospitals, hospitals with average inpatient lengths of stay greater than 25 days, or cancer centers.

⁹ MedPAC, *Summary of Medicare’s special payment provisions for rural providers and criteria for qualification*, June 2001, at 142.

its control, the MDH will receive such payments as necessary to cover fixed operating costs. This designation allows many rural hospitals to keep their doors open.

In addition to the two programs discussed above, the Rural Hospital Coalition also applauds Congress for extending ambulance add-on payments through January 1, 2018. Rural hospitals depend on ambulance providers, who must deal with the challenges posed by lower patient volumes and longer travel distances that are part of the nature of rural health care. Recognizing the increased costs faced by rural ambulance providers, Congress created an add-on for rural ambulance services in the Medicare Prescription Drug, Improvement, and Modernization Act. Today, the add-on amounts to 3 percent and helps ensure that rural Americans have access to emergency health services when needed.

Telemedicine

We urge Congress to support innovations that will permit greater use of telehealth in the vast rural and frontier areas we serve. The innovations occurring in the private marketplace should be permitted under Medicare. Medicare policies are limiting our ability to expand the use of these programs and urge Congress to pass legislation that permits physicians to use state-of-the-art technology to care and treat patients.

Conclusion

We hope that this testimony provides insight into the impact that these Medicare payment policies have on sustaining health care delivery in rural America. The attached chart outlines the five active Medicare payment policies that bolster rural hospitals, as well as the seven payment policies that have expired in recent years – a loss that is still felt by rural providers.

Thank you and we look forward to working with all Members on these important issues.



Medicare Payment Policies

As providers of health care in America's rural communities, we have a special understanding of the adverse impact failure to pass these extenders would have on beneficiaries and the providers on which they depend. Below is a list of provisions that have been addressed by Congress in the past.

Active Policies

- **Extension of improved payments for low-volume hospitals** - Applies a percentage add-on for each Medicare discharge from a hospital more than 15 road miles from another like-kind hospital¹⁰ that has fewer than 1,600 Medicare discharges during the fiscal year. The estimated cost is approximately \$400 million per year in 2016 and 2017.
 - *Expires: October 1, 2017.*
- **Extension of Medicare Dependent Hospital Program** - Extends the designation to rural hospitals with fewer than 100 beds, not classified as an SCH and having at least 60% of inpatient days or discharges covered by Medicare. The estimated cost is approximately \$200 million per year in 2016 and 2017.
 - *Expires: October 1, 2017.*
- **Extension of ambulance add-ons** - Implements a bonus payment for ground and air ambulance services in rural and other areas. The estimated cost is approximately \$100 million per year in 2016 and 2017.
 - *Expires: January 1, 2018.*
- **Extension of exceptions process for Medicare therapy caps** - Extended the process allowing exceptions to limitations on medically necessary therapy. The estimated cost is approximately \$800 million and \$600 million per year in 2016 and 2017 respectively.
 - *Expires: January 1, 2018.*
- **Extension of the work geographic index floor under the Medicare physician fee schedule** - Applies a floor on geographic adjustments to the work portion of the fee schedule, with the effect of increasing practitioner fees in rural areas. The estimated cost is approximately \$400 million per year in 2016 and 2017.
 - *Expires: January 1, 2018.*

¹⁰ This applies only to "subsection (d) hospitals" - Not including psychiatric hospitals, rehabilitation hospitals, children's hospitals, hospitals with average inpatient lengths of stay greater than 25 days, or cancer centers.

Expired Policies

- **Extension of outpatient hold harmless provision** - Extends the outpatient hold harmless provision for those rural hospitals and Sole Community Hospitals (“SCHs”) with 100 or fewer beds. The estimated cost is approximately \$200 million over ten years for a one year extension.
 - *Expired: December 31, 2012 for rural hospitals and SCHs with no more than 100 beds. It expired March 1, 2013 for SCHs with more than 100 beds.*
- **Hospital wage index improvement** - Extends reclassifications under Section 508 of the Medicare Modernization Act (P.L 108-173).
 - *Expired: March 31, 2012.*
- **Extension of payment for the technical component of certain physician pathology services** -- Allows independent laboratories to bill Medicare directly for certain clinical laboratory services.
 - *Expired: June 30, 2012.*
- **Extension of certain payment rules for long-term care hospital services and of moratorium on the establishment of certain hospitals and facilities** - Extended Sections 114(c) and (d) of the Medicare, Medicaid and SCHIP Extension Act of 2007.
 - *Expired: June 30, 2012.*
- **Extension of physician fee schedule mental health add-on** - Increased the payment rate for psychiatric services delivered by physicians, clinical psychologists and clinical social workers by 5 percent.
 - *Expired: February 29, 2012.*
- **Extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas** - Reinstated the policy included in the Medicare Modernization Act of 2003 (P.L. 108-173) that provides reasonable cost reimbursement for laboratory services provided by certain small rural hospitals.
 - *Expired: June 30, 2012.*
- **Extension of Community Health Integration Models** - Removed the cap on the number of eligible counties in a State. .
 - *Expired: September 30, 2012.*



July 27, 2015

Honorable Kevin Brady
Chairman, Health Subcommittee
House Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20515

Honorable Jim McDermott
Ranking Member, Health Subcommittee
House Ways and Means Committee
1106 Longworth House Office Building
Washington, DC 20515

Dear Chairman Brady and Ranking Member McDermott:

On behalf of America's Critical Access Hospital Coalition, I respectfully submit to you written testimony for the hearing on July 28, 2015, to discuss rural health care disparities created by Medicare regulations. America's Critical Access Hospital Coalition is comprised of more than 150 CAHs across the country that brings together healthcare leaders to develop innovative, sustainable practices and plan for the future of healthcare in rural America.

Thank you for providing the Coalition the opportunity to express several of its concerns. We look forward to working with you.

Sincerely,

Paul Lee
Senior Partner and Founder
Strategic Health Care

cc: House Ways and Means Committee, Subcommittee on Health Members

July 2015



Testimony for Submission

Before the

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

Hearing Entitled

“Rural Health Care Disparities Created by Medicare Regulations”

July 28, 2015

Chairman Brady and members of the Subcommittee, thank you for holding this important hearing on rural health and for the opportunity to submit written testimony for the record.

Background

Teladoc was founded in 2002 with the goal of improving and broadening access to health care professionals while enhancing quality and decreasing costs. The company is the first and largest company providing primary care telehealth consultations in the United States. Teladoc's physicians serve over 11 million members and it is anticipated that they will conduct more than five hundred thousand unique visits this year. Teladoc provides 24/7/365 access to affordable, high quality medical care via interactive audio and audio-visual technology. Teladoc deploys its network of over 1100 board-certified physicians and behavioral health professionals to address simple non-emergent medical conditions.

Industry experts, payers and most importantly, individual consumers have embraced Teladoc as a convenient, affordable way for patients to access healthcare services. Our services are available to individuals primarily through their employer- or association-sponsored health benefit plans. Our clients include health plans, large and small employers, hospital systems, unions, and state health plans.

All of the doctors in Teladoc's network are U.S. board-certified family practitioners, emergency room physicians, pediatricians and internists who use electronic health records to diagnose, treat, and write prescriptions when necessary. Our quality process meets National Committee for Quality Assurance (NCQA) standards. Teladoc physicians provide care while adhering to our set of 110 proprietary, evidence-based clinical practice guidelines for the treatment of common uncomplicated medical conditions using audio video or interactive audio with asynchronous store and forward technology.

Telehealth is safe. 100% of the time, patients using Teladoc's physician network must provide a complete medical health record through the telehealth platform, often times supported by the medical history provided by the patient's health plan. The physician must review the data before the real time visit

is arranged. In the practice of traditional cross coverage, the covering physician may not have access to the patient's Electronic Medical Record (EMR). The standards and quality of care for patients treated through telehealth is at least equal to and sometimes greater than that of an in-person encounter.

Telehealth saves the system money. A Teladoc visit is just 30% of the cost of a traditional primary care physician visit, 25% of an urgent care visit and only 2.5% of an emergency room visit. The cost savings to patients, employers, Medicare and Medicaid is substantial. As an additional benefit, there is a significant reduction of unnecessary emergency room visits, improving access for true medical emergencies.

Telehealth is responsible for curbing health care costs and increasing positive patient outcomes and satisfaction within the health care system. New data released by the University of Rochester Medical Center found that telehealth eliminated nearly one in five emergency room visits¹.

A study released in February 2015 by Veracity Healthcare Analytics found that the use of Teladoc's services among beneficiaries of one of the nation's largest employers was associated with a significant reduction in per member per month spending, in part as a result of reduced office visits, emergency room visits and hospitalizations². A separate analysis prepared for Teladoc by Red Quill Consulting³ found that the average cost of a telehealth visit is substantially lower than a visit for in-person acute care and that, even in Medicare where telehealth visits are reimbursed at the same rate as in-person care, the Medicare program would achieve significant savings by offering telehealth services more

¹ Orr, Leslie, "Is Telemedicine a Viable Alternative to Ambulance Ride and ER Visit?," June 11, 2015.

² Choudhry, N., Milstein, A., Gagne, J., "Impact of Teladoc Use on Average per Beneficiary Per Month Resource Utilization and Health Spending," Veracity Healthcare Analytics, February 2015.

³ Yamamoto, Dale H., "Assessment of the Feasibility and Cost of Replacing In-Person Care with Acute Care Telehealth Services," December 2014.

broadly. That same analysis found that even a modest amount of increased utilization – because of the introduction of telehealth services – would not offset these Medicare savings⁴.

Telehealth provides more options for patients to access care. The use of telehealth is particularly important to rural areas – approximately half of Teladoc’s patients reside in rural areas. Moreover, telehealth is an effective way to provide timely access to those who travel frequently or who may not have the flexibility to access a physician’s office during regular business hours. It is a health care service for which there is growing consumer demand.

Telehealth provides routine medical care. Interactive audio using asynchronous store and forward technology and audio-video medical consults conducted by experienced primary care physicians appropriately address routine, acute, non-emergent, non-recurrent medical conditions with marketplace receptivity for its merits in addressing minor issues. In researching possible methods for nurse telephone, triage for interventions, some large health plans have identified nearly 5000 clinical scenarios and 320 symptoms from which an intake nurse can choose. After further questions, approximately 15 ultimate scenarios may arise from any one symptom. Experience has determined that there are about 550 clinical scenarios as candidates for telehealth consultations; 120 of these scenarios may be appropriate for physician intervention instead of or in addition to a nurse.⁵ Some examples include:

- Respiratory Infections
- Gastroenteritis
- Sinusitis
- Bronchitis
- Urinary Tract Infections
- Pharyngitis
- Seasonal Allergies

⁴ Yamamoto, Dale H., “Assessment of the Feasibility and Cost of Replacing In-Person Care with Acute Care Telehealth Services,” December 2014.

⁵ Gingrich, Newt; Boxer, Richard MD; Brooks, Byron MD; Telephone Medical Consults Answer the Call for Accessible, Affordable and Convenient Healthcare; Center for Health Transformation, Washington, DC; 2008

- Prescription refills as appropriate for the short-term, excluding controlled

Government Program Barriers

In recent years, the use of telehealth entered the mainstream of health care delivery for primary care. Commercial payers, employers and consumers have embraced telehealth as a convenient, efficient, and cost-effective way to provide primary care services. Unfortunately, government programs such as Medicare have been slow to embrace telehealth services. In fact, government rules and regulations pose significant barriers that prevent Medicare and Medicaid beneficiaries, veterans and others from accessing telehealth services.

Medicare beneficiaries have had much more limited access to telehealth services because federal telehealth policies are out of date. Reimbursement is only available for a limited range of Medicare Part B services. Reimbursement also is available only when live video is substituting for an in-person visit, and does not extend to asynchronous store and forward technology except in a limited number of federal telehealth demonstration projects. Moreover, telehealth is covered in Medicare only when originating in a limited setting when a site is operating in a health professional shortage area, a demonstration program in Alaska and Hawaii, or a country outside a metropolitan statistical area.

Recommendations for Removing Barriers

We strongly believe that acute care telehealth services should be billable under the Healthcare Common Procedure Coding System where such services would have been reimbursed as medically necessary care in an in-office setting or other physical setting under Medicare. We also believe that barriers to telehealth services should be removed so that Medicare beneficiaries with chronic conditions can have expanded access to remote monitoring services, especially if they are part of a care network within a Medicare Advantage plan setting, Accountable Care Organization, Patient-Centered Medical Home or other form of coordinated system within the program.

Specifically, Teladoc would recommend that the Committee consider the following changes to the Medicare program:

- 1) revise Medicare policy so that physicians need not be required to be physically present for telehealth services to be reimbursed under Medicare;
- 2) allow reimbursement under Medicare for telehealth services without requiring that such services originate from a statutorily or regulatorily defined specific site of care; and
- 3) waive Medicare origination site fees for providers of telehealth services.

These changes would go a long way to expanding access to care, helping reduce Medicare costs, and improving services for beneficiaries with chronic conditions.

Providing more broad-based access to Medicare beneficiaries not only would create a better patient experience for seniors, but would reduce emergency room visits and prevent getting non-emergency care in more expensive care settings. As Baby Boomers continue to enter the Medicare system, they will already be accustomed to utilizing technology for their care delivery and management. Some examples of how Teladoc can alleviate cost pressures and enhance quality in the Medicare program include decreasing emergency room visits for non-emergent care, improved access to medical care by removing the disparities in access between rural and urban area and decreased costs for both the program and the patients.

For seniors with transportation or mobility challenges, the ability to access the healthcare system from home will allow this group to maintain their independence and to seek medical help without the inconvenience of arranging travel. Currently, without access to Teladoc, seniors are forced to wait for availability with their physician and physician's offices are backlogged with these visits limiting their

ability to see additional patients and make up cost deficiencies with volume. From a safety and continuity of care perspective, complications that might arise from delayed access to a physician, exacerbate the issue and are another factor that increase costs and decrease quality of life for seniors.

Conclusion

Teladoc would welcome the opportunity to meet with the members of the Committee to further discuss telehealth, our company and our policy recommendations. We appreciate the Subcommittee's focus on issues related to rural health and look forward to working with you in the future.



Statement of the
Wisconsin Hospital Association
before the
Committee on Ways and Means of the
U.S. House of Representatives
“Rural Health Disparities Created by Medicare Regulations”
Tuesday, July 28, 2015

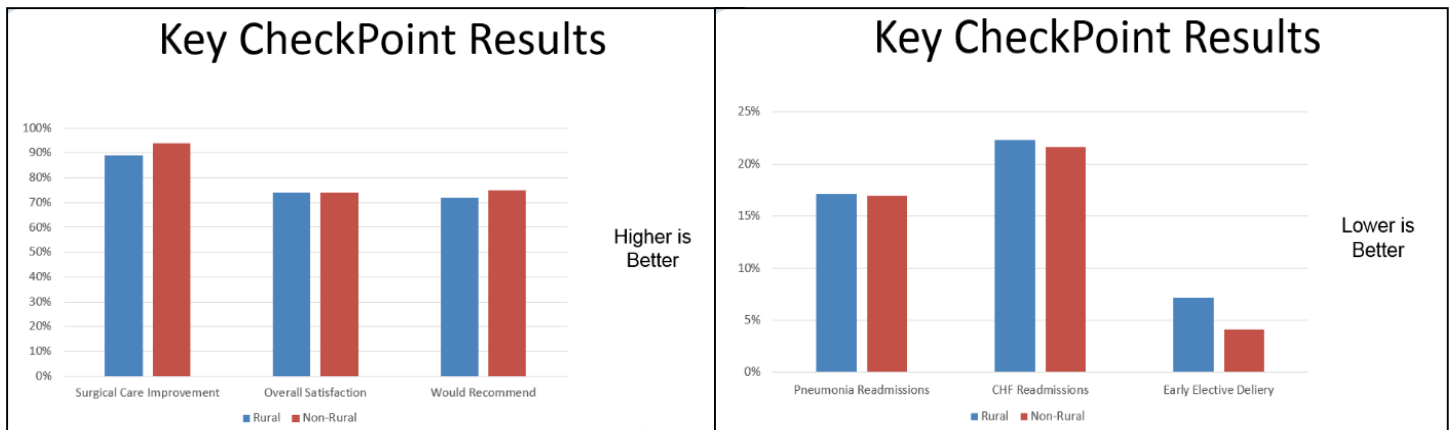
On behalf of our more than 140 member hospitals and health systems, including many small and rural hospitals, the Wisconsin Hospital Association (WHA) appreciates the opportunity to provide comments on rural health disparities created by Medicare regulations.

By way of background, Wisconsin hospitals and health systems are nationally known as innovators and deliverers of high “value” care – high quality, cost efficient care. Wisconsin’s rural prospective payment system (PPS) and Critical Access Hospitals are equally committed as their larger suburban and urban counterparts to providing high value care. In fact, Wisconsin was ranked the second most highly-rated state in the country based on the quality of its health care according to the federal Agency for Healthcare Research and Quality (AHRQ). Wisconsin had the second best overall health care quality measure score among all 50 states based on more than 200 measures that AHRQ used to evaluate health care performance. The rankings are posted here: <http://nhqrnet.ahrq.gov/inhqrdr/state/select>. Results like these have been confirmed by others including the Dartmouth Atlas, Kaiser Family Foundation and The Commonwealth Fund and equate to benefits for both the Medicare program and Medicare beneficiaries.

Proactive Commitment To Quality, Value

A few examples of the proactive work of Wisconsin hospitals are CheckPoint, PricePoint and Wisconsin’s Partners for Patients initiatives. These are projects in which virtually all Wisconsin hospitals, including rural PPS and Critical Access Hospitals, participate.

- Wisconsin's CheckPoint: First Voluntary Quality Public Reporting Site in Nation** – health care quality work in Wisconsin is grounded in measurement and transparency. WHA launched CheckPoint (www.WiCheckPoint.org) in 2004, the first voluntary hospital quality public reporting site in the nation. For over a decade, CheckPoint has promoted health care transparency by collecting and reporting information to help consumers make informed decisions about their hospital care. The mission of CheckPoint is to develop consumer-focused initiatives that provide reliable, valid measures of health care in Wisconsin to aid the selection of quality health care and quality improvement activities within the hospital field. Virtually every hospital in Wisconsin participates in CheckPoint, including reporting on over 50 outcome (eg: readmissions, infections, mortality), process and satisfaction (HCAPS) measures. Unlike quality reporting efforts in other states and even at the national level, **Wisconsin's CAHs participate in CheckPoint. Below are several examples of rural and urban outcomes on CheckPoint measures.**



- Wisconsin Partners for Patients** – the vast majority of Wisconsin hospitals participated through WHA's "hospital engagement network" (HEN) in this national initiative. This means Wisconsin's hospitals are working collaboratively to address key quality and patient safety issues, including reducing readmissions, preventing hospital-associated infections, decreasing adverse events and reducing the number of babies delivered before 39 weeks. Our hospitals, including rural PPS and CAHs, had the following outcomes between 2011-2014 from their work:
 - 98% of Wisconsin CAHs participated in these collaborative initiatives
 - 20% reduction of readmissions
 - 40% reduction of patient harm
 - Wisconsin health system cost savings for Medicare program totaled **\$87,094,000**
 - Potential patient harm reduced for **9,304 Wisconsin patients**

Access information on these impressive efforts at: <http://www.wha.org/quality.aspx>

- Wisconsin's PricePoint** – PricePoint is Wisconsin's price transparency website supported by the work of the WHA Information Center (WHAIC). WHAIC is dedicated

to collecting and disseminating complete, accurate and timely data about charges and services provided by Wisconsin hospitals and ambulatory surgery centers. WHAIC has been collecting and reporting data since 2003. An updated, more consumer-friendly version of the website was recently launched. All of Wisconsin hospitals participate in PricePoint, another testament to their proactive efforts to providing meaningful information to the public. Access the website at <http://www.wipricepoint.org>

We believe these are several examples of our hospitals' commitment to increasing value to patients, employers and payers, including Medicare. Wisconsin's rural PPS and CAHs are just as dedicated to these efforts as any other facility.

Medicare Policies and Their Impact on Rural Care

Despite our state's aggressive commitment to improving quality and value, Medicare policies can and do pose roadblocks to maintaining access to care in rural communities. WHA respectfully recommends addressing the following key CMS policies:

- **Harmonize Conflicting “96 Hour” Rules For CAHs** – In sub-regulatory guidance stemming from the two midnights policy in the FY 2014 PPS final rule, CMS stated that, as a condition of payment, physicians at critical access hospitals (CAHs) must certify that a beneficiary may reasonably be expected to be discharged or transferred within 96 hours after admission to the CAH. If a physician cannot certify the reasonable expectation that a Medicare beneficiary will be discharged or transferred within 96 hours, then Medicare Part A payment is inappropriate. This guidance appears to have brought to the foreground an apparent conflict in two 96 hour rules. WHA believes the differing 96 hour rules stem from the 1999 Balanced Budget Refinement Act (BBRA), which made important improvements to the CAH program, including establishing the 96 hour annual average for patients in order to participate in the Medicare program. However, the BBRA does not appear to have appropriately cross-referenced the corollary payment statute as well and left 96 hour limit (*not* an annual average) under its Conditions of Payment.

Unless these two 96 hours are harmonized, access to care that should be delivered locally will be denied for numerous Medicare patients in rural America, forcing care further away to non-local facilities. This policy creates a barrier to care that legitimately can be provided in rural hospitals. It also places an arbitrary time-based barrier in the physician-patient relationship. It does so by requiring a physician at a CAH to certify that each Medicare patient will be discharged or transferred within the 96 hour window. Situation where this CMS policy could increase rural disparities for care include: managing chronic diseases, pneumonia, other respiratory issues and certain procedures. The patients may be forced to travel longer distance to a hospital outside of their community or they may choose not to seek care at all. **WHA and our rural, Critical Access Hospitals strongly support harmonizing these 96 hour rules, as contained in HR 169, the Critical Access Hospital Act, currently pending in the U.S. House Ways & Means Committee.**

- **Allow For More Flexibility In “Direct Supervision” Rules** – Beginning in 2009, CMS introduced the concept of “direct supervision” with some commentary in Open Door Forums. That commentary stated the physician must be “physically present” in the outpatient therapy department. While the requirement was referred to a “clarification,” it was actually a fairly drastic change in policy without clinical rationale or evidence that quality of care or patient safety had been compromised in hospital outpatient departments. Further, the policy contradicted Medicare Conditions of Participation for CAHs. As a result, hospitals found themselves at increased risk for unwarranted enforcement actions for care they are qualified and capable of providing. Although CMS has implemented some smaller modifications to this policy, it is in force at the current time.

WHA believes the change was unwarranted and will be particularly problematic for rural hospitals’ ability to provide Medicare beneficiaries with access to certain outpatient therapeutic services. WHA also believes it is important to raise the point that rather than traveling to other hospitals for their care, many rural Medicare beneficiaries may choose instead to *not* seek care if that care is not locally accessible. As we are certain the Committee is aware, delayed care causes more medical issues for patients, less preventative care and higher costs to the Medicare program. **For these reasons, WHA supports bipartisan legislation – HR 1611, The Protecting Access to Rural Therapy Services (PARTS) Act – currently pending in the U.S. House Ways & Means Committee.**

- **Two Midnight Policy/Recovery Audit Contractors** – The onset of the Recovery Audit Contractor (RAC) program several years ago has had a variety of unintended consequences, one of which revolves around inpatient versus observation stays. This issue is the direct result of the RAC focus on denying Medicare payment for shorter inpatient stays because the RAC deems, post-fact, that care should have been provided in the outpatient setting (regardless of the fact care was medically necessary). A corollary CMS policy effective throughout much of the existence of the RAC program has been to essentially deny hospitals the ability to rebill (Medicare Part B) for these medically necessary services (note: this is the subject of pending litigation.) The ensuing confusion over RAC denials has resulted in some uptick in the number of patients put into what is known as “observation status.” Unfortunately, the solution CMS put forth in its FY 2014 Inpatient Prospective Payment System Rule to this issue, over objections from the hospital field, was a multi-part policy known as the “two midnight” rule.

Under the original two midnight policy, a time-based benchmark for inpatient admissions was created. The benchmark indicates physicians (or other qualified individuals) should admit a patient if he/she expects care to span at least two midnights. Second, it set forth criteria for physician orders, certification and documentation that must be included in the medical record in support of medical necessity and that inpatient admission was appropriate. Third, the policy provided a general presumption for external review contractors (like the RACs) that care spanning more two midnights should be presumed appropriate for inpatient admissions and Part A payment criteria are met. At the time the two midnight policy was released by CMS, the hospital field, including rural and CAHs,

expressed concerns that the policy was placing an arbitrary, time-based criteria into the physician-patient relationship. Fortunately, Congress understood the depth of problems this CMS policy created and legislatively delayed *enforcement* (ie: RAC recoupment efforts) of it through September 30, 2015. Unfortunately, Congress did not stop or adjust the policy itself, which is still in effect.

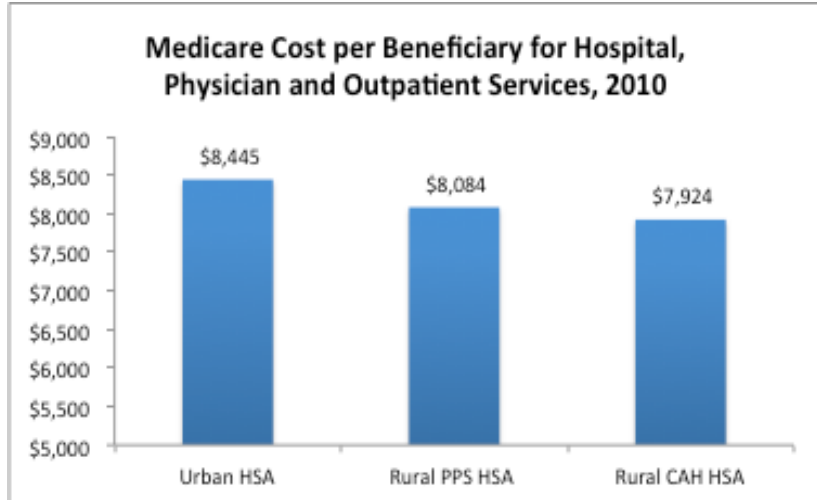
Due to the policy's problems, MedPAC recently recommended the policy's repeal. CMS has yet to do so. Instead, in its proposed CY 2016 OPPI rule, CMS would adjust its policy for stays spanning less than two midnights. In these instances, inpatient payment would be appropriate on a "case by case basis" based on the medical judgment of the admitting physician. CMS also proposes removing Recovery Auditors and Medicare Administrative Contractors from the first line medical review for these shorter stays and has initial reviews of stays less than two midnights done by Quality Improvement Organizations (QIO). CMS is proposing no changes to the two midnight policy for stays spanning longer than two midnights.

Overall, WHA believes CMS' proposed modifications as discussed above are valuable, but still do not address the underlying problems that created this situation—overzealous RACs. The two midnight policy was just one downstream impact caused by the Recovery Audit program, but there are others. WHA believes CMS needs to do more to fix the problems with this program and, therefore, supports legislation – the Medicare Audit Improvement Act (HR 2156) pending in the House Ways & Means Committee – that would do so.

Finally, WHA wants to reiterate the unique circumstances of rural PPS and Critical Access Hospitals in states like ours. These facilities are the rural health care infrastructure in Wisconsin and across the nation and WHA continues to strongly support the Critical Access Hospital program designation as well as key Medicare policies for rural PPS hospitals known as "Medicare Dependent Hospitals" and "Low Volume" hospitals. As CMS and Congress look at Medicare program policy, WHA asks it to keep the following in mind with respect to small, rural hospitals:

- Congress created the **Critical Access Hospital designation in 1997** as hundreds of small hospitals closed due to their inability to financially survive under Medicare's prospective payment system. Due to their small size and fluctuating patient mix, CAHs needed more stability in payments in order to survive. **The alternative payment model used by Medicare for CAHs has allowed stability and access to care for some 60 million rural residents who are scattered over 90 percent of the nation's landmass.**

- States with CAHs are providing cost-effective care for Medicare. For example, Medicare spending in Wisconsin is lower for rural than urban \$6,424 (rural) \$6,706 (urban) (source: iVantage). Further, other sources confirm that rural PPS and CAHs provide cost efficient care, as seen in these two charts.



Source: Dartmouth Atlas of Healthcare, 2010 Medicare reimbursements per enrollee.

Total Medicare (Part A & Part B) Reimbursements per Enrollee

	Reimbursement/Enrollee	Commonwealth Fund Rank	# CAHs
Hawaii	\$5,311	1	9
Iowa	\$6,572	7	82
Montana	\$6,340	5	48
New York	\$9,564	51	13

Source: <http://www.rwhc.com/Portals/0/papers/CAH%20Values%20Final%202013.pdf>

- Rural populations tend to be older, sicker and poorer than individuals in urban areas. In fact, the Department of Health and Human Services states, “rural areas have higher rates of poverty, chronic disease, and un-insurance, and millions of rural Americans have limited access to a primary care provider.” While 20 percent of the population lives in rural America, only nine percent of physicians practice in rural areas. Seventy-seven percent of the 2,050 rural counties in the U.S. are primary care HPSAs. More than 50 percent of rural patients have to travel 60 miles or more to receive specialty care. (source: NRHA). Additional flexibility for rural Graduate Medical Education opportunities is also an area where CMS policy could be improved.

In closing, Wisconsin hospitals have a strong and long-standing commitment to collaboration and the pursuit of high value care—high quality, cost efficient care. This pursuit is shared by all of Wisconsin’s facilities, regardless of size. WHA and our hospitals stand at the ready to assist Congress and CMS in developing approaches that continue moving Medicare further along the health care value continuum while still recognizing the unique roles rural PPS and Critical Access Hospitals play throughout our state and much of the country.