Hearing to Discuss Rural Health Care Disparities Created by Medicare Regulations

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SUBCOMMITTEE ON HEALTH

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Hearing to Discuss Rural Health Care Disparities Created by Medicare Regulations

Tuesday, July 28, 2015
House of Representatives,
Subcommittee on Health,
Committee on Ways and Means,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:06 a.m., in Room 1100, Longworth House Office Building, Hon. Kevin Brady [chairman of the subcommittee] presiding.

Chairman Brady. Good morning. Welcome to today's hearing to discuss rural healthcare disparities created by Medicare regulations. This is an important issue for all, but the challenges facing beneficiaries and providers are especially evident to those of us who represent districts that aren't completely urban.

Our constituents are seeing firsthand the difficulties caused by overregulation and bureaucracy. And it's our rural neighbors who pay the price when it comes to access. Take, for instance, the so-called 96-hour rule. Critical Access Hospitals are a critical piece of rural health infrastructure. Doctors at Critical Access Hospitals have to certify that it is reasonable that an individual be discharged and transferred to a hospital within 96 hours of being admitted to a Critical Access Hospital. That arbitrary cutoff doesn't always match the medical reality for patients seeking treatment at facilities near their homes. I personally heard from St. Joseph's, a Critical Access Hospital in my district, on the problems with the 96-hour rule.

Or consider the rules related to physician supervision: Physician shortages are a reality in many parts of our country. Rules that change the way routine therapeutic services are handled in rural areas or rules that bar physician assistants from providing services, like hospice, disrupt access and the continuity of care for rural beneficiaries.

We can do better. We must do better. We will do better. We should provide relief for all of our hospitals and providers from overly burdensome regulations in bureaucracy. There is no better place to start that process than with our rural hospitals. There is much to be done, and today we are lucky to have here firsthand accounts from providers serving rural communities. First, we have Shannon Sorensen, CEO of Brown County Hospital in the Ainsworth, Nebraska, a constituent of Mr. Smith. Next, we have Tim Joslin, the CEO of Community Regional Medical Centers in Fresno, California, a constituent of Mr. Nunes'. Then we have Carrie Saia, the CEO of Holton Community Hospital, a facility in Congresswoman Jenkins' hometown in Kansas. Finally, we have Dr. Daniel Derksen from the University of Arizona.

We are very happy to have you here today.

This is the latest in a series of hearings held by the Health Subcommittee in the wake of the passage of legislation to fix the way Medicare pays our Nation's physicians. Now, I know we mentioned this in our MedPAC hearing last week, but it stands repeating: We are in the midst a great opportunity to reform how Medicare reimburses hospitals and post-acute-care providers, all critical to saving Medicare for the long term.

I hope today we can make progress in understanding the concerns facing those in rural areas.

And before I recognize the ranking member, Dr. McDermott, for the purpose of an opening statement, I ask unanimous consent that all members' written statements be included in the record.

Without objection, so ordered.

I now recognize Dr. McDermott for his opening statement.

Mr. McDermott. Thank you, Mr. Chairman.

I want to thank the witnesses for coming this morning. I look forward to hearing what you have to say. I believe there is room for us to work together to address how we deliver health care to people who live in rural areas. I also believe that if we are going to have a serious conversation about this topic, we need to get the facts straight. Time and time again, I hear from Republican colleagues about rural hospitals closing down, threatening access to health care for many communities.

I happen to represent an area where we have the WWAMI program, which covers one quarter of the United States' land mass, so I know about rural areas. And as they do with virtually every perceived problem in the healthcare system, my colleagues place the blame for all of it squarely on the Affordable Care Act. There is another side to this story.

One of the major financial strains placed on hospitals is uncompensated care -- has been for years. When patients, many of whom are poor and quite sick, are not covered by insurance and cannot afford to pay out of pocket, hospitals have to pick up the cost. It has been true -- and we have not had the ability in the law yet to say you don't have got to take care of somebody. So if somebody comes in, you have to take care of them. And somebody pays; it is the hospital.

We recognized this problem when we passed the Affordable Care Act. We worked to reduce uncompensated care coverage -- dramatically through an expansion of coverage of Medicaid. This would provide some of the more economically or most economically vulnerable people, many living in rural underserved areas with access to coverage.

However, under Republican leadership, more than 20 States -- 20 States -- refused simply to accept Medicaid expansion, simply because it was part of President Obama's Affordable Care Act. Their decision has left 4.3 million people without insurance, forcing hospitals, many of them which serve rural areas, to pick up the cost. And not coincidentally, 80 percent of the hospitals that have announced recent closures are in States that chose not to expand Medicaid -- 80 percent are in States that didn't expand Medicaid. This is not a problem of Medicare regulations governing rural hospitals, nor is it a problem with the Affordable Care Act. It is a problem with the party that would prefer to sabotage the President's healthcare program for political purposes rather than try to make it work.

So if we want to improve access to rural care and address the issue of rural hospital closures, we have to start by convincing the leadership to do what they should have done in the first place and expand Medicaid. To address the needs of rural communities, we also need to have long-term investments in our professional workforce.

The United States faces a growing shortage of physicians and healthcare providers. That is nurse practitioners, PAs, all the people that provide care in rural ares. And it is predicted to reach in physicians alone by 2025 between 46,000 and 91,000 people short to provide what is necessary. Rural areas are going to have a particular scarcity of physicians. We have tried lots and lots of things in the WWAMI program, but we continue to run into some of the same problems.

Now, we should be skeptical that the solution of the problem lies in gutting Medicare support for graduate medical education in urban areas. There is minimal evidence whatsoever that this will result in more

doctors practicing in rural areas. It will simply exacerbate the nationwide doctor shortage and lower the quality of training. There are better ways to train physicians who serve in rural areas. I encourage my colleagues to look at some alternatives.

The University of Washington has run the WWAMI program, as I mentioned, which trains physicians not only in the cities but out in the rural areas. They are placed out in little bitty places, and they see what it is like. And they learn what is necessary, but also getting them to stay is tough. The program is the finest in primary care and rural in the whole country and has ably served the communities in Washington, Wyoming, Alaska, Montana, Idaho, for more than four decades.

There are some other investments I believe we have to make if we are really going to deal with rural access. We can treat the medical profession like we treat the armed services and provide ROTC-style medical school scholarships to doctors who agree to a tour of service in underserved areas. I call this RDOCS, and I believe it is a smart investment. We don't think there is anything wrong with giving somebody a college education and then keeping him in the Navy or the Army or the Air Force for 5 years. Why don't we do the same thing with medicine? Get somebody to sign a contract upfront: I will take the scholarship, but I will serve 5 years as a result of that. Now, that is the only way you are going to get people out there for a long enough period for them to decide, you know, maybe I want to stay here. That is the real problem.

Moving forward, rather than attacking our existing programs and pitting urban areas against rural areas, as we are going to do with this GME and IME and all the rest of it, I invite my colleagues to consider alternatives that would make a meaningful difference in rural areas.

I yield back the balance of my time.

Chairman Brady. Thank you, Dr. McDermott.

We are really excited to have the witnesses today. We think there is some common ground on areas like this that we can move forward on.

So, Mr. Joslin, you are recognized for 5 minutes.

STATEMENT OF TIM JOSLIN, CEO, COMMUNITY REGIONAL MEDICAL CENTERS, FRESNO, CA

Mr. Joslin. Thank you, Mr. Chairman, Ranking Member McDermott, and members of the subcommittee. My name is Tim Joslin, and I am the chief executive officer of Community Medical Centers, based in Fresno, California. I appreciate the invitation to testify today about rural healthcare disparities and the role of federally funded graduate medical education, known as GME.

Community Medical Centers is the largest healthcare provider in California's agricultural heart, San Joaquin Valley. We are a not-for-profit public-benefit operation operating four hospitals: Community Regional Medical Center in Fresno; Clovis Community Medical Center; Fresno Heart & Surgical Hospital; and Community Behavioral Health Center. Community Medical Centers accounts for one-third of all inpatient discharges in the five-county region.

We run a level 1 trauma center, a burn center, and an ambulatory care center. We are also the largest inpatient provider of Medi-Cal services and uncompensated care in the region. Our downtown Fresno emergency department is one of the busiest in the State with some 114,000 visits a year. We provide all of this with the help of about 300 medical residents and fellows from the UCSF School of Medicine.

Our challenge is unique and daunting. The rural San Joaquin Valley, though rich agriculturally, is very poor economically. Twenty-five percent of residents live in areas of concentrated poverty, making it the fifth poorest area in the country. In Fresno County alone, one-third of all children live at our below the poverty level. About 20 percent of Fresno County residents do not speak English and one-third of adults have not obtained a high school diploma. The entire area's population has significantly higher than average rates of asthma, diabetes, and obesity. Nearly one-third of the population qualifies as obese, for example. The Valley also has a higher than average incidence of chronic lung disease, likely due to is well-documented air quality issues.

To make these sobering statistics even worse, the San Joaquin Valley suffers from a doctor shortage. The Valley has 48 primary care physicians per 100,000 residents, well below the minimum recommended level of 6O. If need is the measure, our region of the country should have more physicians per capita, not fewer. Graduate medical education is the key to solving this inequity. Community Medical Centers collaborates with the University of California San Francisco to support the training of graduate medical students. We currently support some 250 medical residents studying in eight areas, including primary care and emergency medicine. And we support 50 fellows studying in 17 medical subspecialties. This GME program is a critical feeder to the region's entire physician population, and we would like to grow the program.

We are constrained, however. Our Medicare funding for GME positions is frozen at 1997 level. Community Medical Centers has expanded the program on its own beyond what Medicare funds by investing well over $400 million over the last 10 years, but considering that Community Medical Centers now shoulders more than $180 million in uncompensated care each year, the ability to expand our GME program on our own is financially limited. This in turn limits our ability to provide our region's residents access to health care now and in the future.

In a region where the need for physicians is perhaps the greatest in the country, we are at a disadvantage under the current Federal system of allocating GME slots, yet our ability to expand access to physicians is highly dependent upon the GME program. As the Institute of Medicine's recent report noted, the location of one's medical school and GME training are predictive of practice location. Our own experience shows this. Close to 30 percent of our trained residents remain in the region to practice medicine. The current GME allocation criteria and caps have led to significant geographic disparities, as noted in a recent health affairs report, and are most acutely felt in our region of California.

For example, our region's population has increased by a third since 1997, yet our federally funded resident physicians have remained at the 1997 level. This contributes to the disparity we see in the ratio of physicians to population. Community Medical Centers supports not only the expansion of GME but, equally critical, better allocation of GME slots to underserved regions within a State. We believe that policy goals of federally funded GME would be better served by a revised allocation system and urge this committee to consider proposals. We believe this will directly lead to more efficient and effective health care in our rural underserved region.

Thank you again for this opportunity.

Chairman Brady. Thank you, Mr. Johnson.

Ms. Sorensen, you are recognized for 5 minutes.

STATEMENT OF SHANNON SORENSEN, CEO, BROWN COUNTY HOSPITAL, AINSWORTH, NEBRASKA

Ms. Sorensen. Good morning, my name is Shannon Sorensen. I am the CEO of Brown County Hospital, a Critical Access Hospital located in north central Nebraska. I would like to thank Chairman Brady, Ranking

Member McDermott, and the members of the House Ways and Means Subcommittee on Health for holding this hearing.

Approximately one in six Americans live in rural areas and depend on the hospital in their communities. We are exactly one of those facilities. Not only does our location, being over 150 miles from the nearest tertiary facility, affect us, our patient mix being over 70 percent Medicare also makes us more reliant on public programs. Changes, such as the 96-hour rule, often have significant and problematic consequences for rural providers.

Due to the great support of our local community, compared to many of my peers, our hospital's financial situation is stable, but we are especially vulnerable to Medicare and Medicaid payment cuts. We are the communities and hospitals that most need your help.

The 96-hour rule is especially burdensome in our day-to-day mission of providing health care in our communities. From the creation of CAH designation, until late 2013, an annual average of 96-hour stays allowed CAH's flexibility within the regulatory framework set up for the designation.

The new policy of strict enforcement of a per-stay 96-hour cap crates an unnecessary red tape. Not only does it potentially limit access to health care by forcing rural beneficiaries to travel farther for treatment, it may deter them from necessary care, inconvenience patients, and add travel costs to Medicare. It impedes rural providers in their ability to care for their patients. Having to focus on regulatory burdens interferes with the best judgment of physicians and other healthcare providers, placing them in a position where our providers are constantly making regulatory decisions to dictate the medical decisions they need to make. The 96-hour condition of payment leaves no room for a needed change in the medical care plan if treatment does not go as anticipated.

It is also important to note that while we must maintain an annual average length of stay of 96 hours, we offer some critical medical services that have standard lengths of stay greater than 96 hours. Enforcing the condition of payment will force us to eliminate these 96-hour-plus services and cause financial pressures that will severely affect our ability to operate. These are important services in our community and allow patients to get needed services and recover around their family and friends.

CAHs in Nebraska and across the country support the Critical Access Hospital Relief Act, which would remove the 96-hour condition of payment. I especially want to thank my Representative, Congressman Smith, for introducing the important legislation. Rural facilities and providers face many challenges without the heavy hand of government. We must be given the flexibility to provide affordable and efficient health care.

Another burdensome regulation is the expansion of mandatory direct physician supervision. We simply do not have the manpower and resources to abide by these arbitrary regulations. Our highly trained licensed personnel are not able to practice at the highest level of their scope with this regulation.

For 2015 and beyond, the agency requires a minimum of direct supervision for all outpatient therapeutic services furnished in our Critical Access Hospital, unless it is on the list of services that may be furnished under general supervision or is designated as nonsurgical extended duration therapeutic service.

We are deeply disappointed that CMS did not heed concerns that this policy will be difficult to implement, will reduce access, and is clinically unnecessary. CAHs and small rural hospitals support the adoption of the default standard of general supervision, consistent definition of direct supervision, and prohibiting enforcement of CMS' retroactive reinterpretation back to 2001.

H.R. 170 delays the unnecessary and burdensome physician supervision regulations and requires CMS to study their impact. We already face many unique challenges, such as providing quality care with more limited resources; satisfying complicated administrative requirements with a smaller staff; complying with

numerous Federal regulations, which limit the discretion of highly trained providers; and now to be located in the building to render these services.

Our community has one full-time primary care physician who is supported by two mid-level providers. With some of the regulatory burdens we face -- such as requiring only a physician to oversee cardiac rehab or only a physician being able to order durable medical equipment, home health, or hospice services -- any time our lone physician is not on our campus, takes vacation, or attends continuing education, significant patient needs have to wait.

Our very capable mid-levels are able to provide the needed services in our emergency room and throughout the hospital. It makes no sense to prevent them from being able to do the same for cardiac rehabilitation, outpatient therapeutic services or other necessary services.

Medicare provides vital funding for many rural payment programs, including Critical Access Hospitals. This subcommittee and Congress has the power to ensure Americans living in rural America who depend on the hospital will have access to appropriate care.

Again, thank you, Congressman Smith, for introducing H.R. 169. We appreciate the subcommittee's interest in the matter and urge it and the Congress to support much needed legislation. Thank you for your time and listening to our impact.

Chairman Brady. Great, thank you.

Ms. Saia, you are recognized for 5 minutes.

STATEMENT OF CARRIE SAIA, CEO, HOLTON COMMUNITY HOSPITAL, HOLTON, KANSAS

Ms. Saia. Good morning, Mr. Chairman, and members of the subcommittee, thank for the opportunity to speak today.

More than 36 percent of all Kansans live in rural areas and depend on the local hospitals serving their community. Rural hospitals face a unique set of challenges because of our remote geographic location, small size, scarce workforce, physician shortages, higher percentage of Medicare and Medicaid patients, and constrained financial resources with limited access to capital.

These challenges alone would make it difficult for many rural hospitals to survive. However, the increasingly burdensome Federal regulations that are being placed on healthcare providers make it difficult to budget, plan, and adequately prepare for the future.

Today, I would briefly like to share some challenges specifically related to the Medicare policy on direct supervision of outpatient therapeutic services and the 96-hour physician certification requirement.

First, I want to highlight the impact of Centers for Medicare and Medicaid policy for direct supervision about patient therapeutic services. This requires that a supervising physician be physically present in a department at all times when Medicare beneficiaries receive these services. This policy places additional unnecessary financial burden on my organization. Holton Community Hospital is staffed similarly to many rural hospitals across the Nation. Many have either a mid-level provider staffing their hospital with a physician available for supervision or a physician readily available within 30 minutes response time.

Staffing a physician onsite, as required by the regulations, will either result in changing our organizations then profitable bottom line into a negative bottom line or restrict the ability for us to be able to provide those services to our beneficiaries in our community.

One example of an outpatient therapy service that is a significant impact to our beneficiaries is the ability to offer intravenous infusions on an outpatient basis. There is a growing need for this service throughout our community. Due to a noted increase in the last couple of fiscal years, 2013 and 2015, this volume grew by over 22 percent. Not being able to provide this in our community and having the beneficiaries travel outside the community to receive this treatment would ultimately result in the beneficiary -- a cost to them as well.

I strongly encourage this committee to extend the enforcement delay on direct supervision requirements for outpatient therapeutic services provided in Critical Access Hospitals for calendar year 2015. I strongly encourage the committee to work to pass H.R. 2878, as well as legislation that would address this problem on a more permanent basis.

A second area I would like to highlight today is the 96-hour physician certification requirement related to the Medicare condition of participation on the length of stay for Critical Access Hospitals. The current Medicare condition of participation requires Critical Access Hospitals to provide acute inpatient care for a period that does not exceed on an annual basis 96 hours per patient.

In contrast, the Medicare condition of payment for Critical Access Hospital requires a physician to certify that a beneficiary may reasonably be expected to be discharged within 96 hours after admission to the hospital. As a rural hospital administrator, I can say with certainty that the discrepancies between the conditions of participation and the conditions of payment have caused nothing but confusion and challenges for Critical Access Hospitals.

This regulation also impedes the ability of the person who knows the patient best -- the physician and other healthcare providers -- and may unnecessarily cause patients to leave the community from which they live to receive care. I urge Congress to pass the Critical Access Relief Act, H.R. 169, introduced by Representative Adrian Smith, Lynn Jenkins, Todd Young and Dave Loebsack. This legislation would remove the Medicare condition of payment that requires a physician to certify that a patient is reasonably expected to be transferred or released within 96 hours but would leave in place the Medicare condition of participation requiring Critical Access Hospitals to maintain an average annual length of stay of 96 hours or less.

On behalf of my organization and similar rural organizations across the States of our Nation, I want to reinforce that it is critically important that our communities are able to access quality healthcare services. Too often, increasing and unwarranted Federal regulation burdens add additional challenges to providers with already constrained resources. As I highlighted in my written testimony, I have many examples of great outcomes that beneficiaries receive due to the ability to access care in a timely fashion. I am honored to join you today to discuss the action Congress can take to address rural healthcare disparities created by Medicare regulations. I would be happy to answer questions.

Chairman Brady. Thank you.

Mr. Derksen, you are recognized for 5 minutes.

STATEMENT OF DANIEL DERKSEN, DIRECTOR, ARIZONA CENTER FOR RURAL HEALTH, TUCSON, ARIZONA

Dr. Derksen. Chairman Brady, Ranking Member McDermott, and committee members, I really do thank you for your service on this very important issue. But, especially, I want to thank you -- thank you, thank you -- for getting rid of that awful sustained growth rate formula, so we don't have to come back every year and do the doc fix.

I am particularly gratified as a family physician myself in the last 30 years to see a nurse and physician on this committee. I think it is very important when we inform policy that we have Members of Congress that understand what it is like to be in the trenches serving patients.

I want to hit on a couple of issues. I am a family physician. I work in an academic health center. I ran a faculty practice plan, the worst 2 years of my life -- I call it the "thousand points of veto," with 550 faculty members and 450 resident physicians; everyone felt like we could do things a little differently than we were. I think it is particularly important as we look at how professions education is, how do we get a better return on our Federal investment? We are spending $15.5 billion on graduate medical education in this country. Thank you for that investment in higher education. But I think we could get a better return on that investment. I think we need to move from protecting the status quo and holding harmless. Let's hold accountable.

I think we can do better in the $10 billion we are spending in Medicare GME to diversify our investment portfolio to include, for example, teaching health centers, which you also renewed as part of the MACRA legislation to extend teaching health center funding for another 2 years. In comparison, we only spent $230 million over the last 5 years in teaching health centers, which is really to improve the health profession's workforce in rural areas.

Some States, including in New Mexico and Arizona in the Southwest, are experimenting with I think very innovative models in interprofessional teaching health centers, leveraging Medicaid graduate medical education to achieve better outcomes.

You have heard about some of the arcane rules that make it very difficult for rural hospitals and Critical Access Hospitals to maintain and keep their doors open and provide the services that are so important to rural hospitals. I think the two-midnight rule, the 96-hour rule really undermine a physician's judgment. You don't always know, having admitted hundreds of patients in both urban and rural hospitals myself in 30 years of practice, how long it is going to be for someone to be there. I think it is reasonable as a condition of participation to, on average, have 96 hours' admissions for Critical Access Hospital, but it is unreasonable and unfair to make it a condition of payment that if someone exceeds 96 hours in a Critical Access Hospitals that they won't get paid.

As I was getting on the plane in Phoenix, I got a series, a flurry of email messages from one of our rural hospitals, our Critical Access Hospitals, on U.S.-Mexico border. Cochise Regional serves 20,000 individuals in a county that -- its land mass would contain both Delaware and Connecticut. It is a very large area. It is critical. They will close their doors on Friday because Medicare stopped payment to them.

Dr. Derksen. The glacial appeals process will often put a rural hospital under because it takes so long to work through the appeal. We have seen over the last 5 years, 54 rural hospitals close according to the Sheps Center. There is another 283 that are on the verge of closure, at risk of closure, including hospitals in States that you all represent. Fourteen of you represent States that either have hospitals that are closing, especially in Texas, but also in other areas as well.

I think we need to basically streamline that appeal process. We need to make sure that those auditors, such as the RAC auditors, that are paid on a contingency fee, that there is a penalty when they make a mistake and that we don't put our rural hospitals at risk of closure by this glacial process.

The last thing I would say is there are some very good models you can draw on. You heard some last week from Mr. Miller in the MedPAC about how we might better invest our GME dollars. There is certainly some wonderful suggestions in the Institute of Medicine report about how we might do this. But I think there is also some interesting models happening at the State level, but we have to titrate these changes that we are requiring of rural hospitals on quality reporting. We have to make sure that when they report on quality and their payment is tied to it, that they are ready to do that. I think Arizona, for example, through its Medicaid program has a Critical Access Hospital pool and a rural pool that could be modified slightly to

pay them on the basis of value and outcomes. I think these issues would really help us move forward in providing the access in our rural areas, create great jobs in those areas and continue that 24-hour-a-day, 7-day-a-week access to care that is so important in our rural communities. Thank you.

Chairman Brady. Thank you, Dr. Derksen. I agree with you. We need a new path forward on graduate medical education. And I think we need to recognize the changes in indirect medical education, the number of procedures that are occurring, outpatient versus inpatient, making sure we are really getting dollars to those who are providing the education and training for our future doctors.

So, Mr. Joslin, I have a question for you in a second about increasing risks in positions and rural hospitals. But, Ms. Sorensen, Ms. Saia, and Mr. Derksen, Critical Access Hospitals easily meet their annual average 96-hour condition of participation. But asking local doctors to certificate the specific patient's needs won't require a 4-day stay or less is creating we think some real difficulty among our Critical Access Hospitals.

So can you -- for the committee's insight -- can you provide some examples of what services typically fall well under the 96-hour rule and examples of some services that typically are well over the 96-hour limit? Ms. Sorensen?

Ms. Sorensen. Typically, we see a lot of the outpatient -- excuse me, not outpatient, but surgical procedures that would be done in our facility by the qualified providers that we have, maybe a bowel resection, maybe something related to a surgical removal, gallbladder, some of those things that didn't take -- the bowel resection, obviously, always follows typically a 5-day stay. So when we admit on that day, yet we are supposed to precertify for 96 hours. Yet we are capable of doing those, we go through the proper training and competencies and surveys to do those, but for us to send them 150 miles away to get that done and not being able to come back to us is a big impact. Otherwise, we, obviously, have an annual average -- our annual average runs around 70 hours so we see a number of those things that fall underneath that -- the pneumonias, the other types of just acute illness that come in.

The biggest issue becomes if you send in a culture, test the infection, and it comes back something you weren't anticipating; now we need to change the medication, and so we are switching from one antibiotic to another. And now we are up on 96 hours, so what are we going to do? Are we going to go into a swing bed for a short stay because if we go there for a short stay, that is also a red flag? So we create a lot more barriers by having those issues.

Chairman Brady. Great examples.

Ms. Saia.

Ms. Saia. I would just add on, pneumonia is a great example where if it is simple, treatable, and you get the right antibiotic on the right day, that is easily treated within a 5-day stay. But if you have to culture on the second day, sometimes that culture usually take 72 hours to get the results back. There you are at your 5-day window. If you need to wait and see if you need to change the antibiotics to make sure it responds appropriately, you are past the 5-day window. Just another example where usually pneumonia can be treated very easily upon admission. The physician could certify they could be treated and discharged within 5 days, but during those first, 2, 3, days, if they are not responding to treatment and you need to change treatment, then you are past that 5-day window.

Chairman Brady. Makes sense.

Dr. Derksen.

Dr. Derksen. Thank you, Mr. Chairman.

I ran an academic Locum Tenens Program, where we provided practice relief in our rural hospitals and emergency departments across the Southwest. And one of the things we noticed is things, like pneumonia, congestive heart failure, routine urosepsis, people with urinary tract infections that spread to their bloodstream, acute stroke, acute trauma, many times these are things that we could either treat or treat and then move on to a higher level of service in that 3-day timeframe, but you don't always know. A person could come in with a simple, straightforward immunity-acquired pneumonia, and then, because they are dehydrated, they develop acute renal failure. And you may not have the lab results back quick enough to be able to know right at the time that they are going to take another day or two until they are ready to go back home. So those are some examples. Thank you.

Chairman Brady. So the point isn't the average of 96 hours; it is the specificity on every case where the patient may have some different needs that are just evolving as you are treating them.

Auditing, from Ms. Sorensen and Ms. Saia, I have heard mixed feedback regarding how CMS is auditing around the 96-hour COP for Critical Access -- can you describe your experience, if any, with the surveyor who has audited your hospital around the 96-hour rule?

Ms. Sorensen. Chairman Brady, I don't believe we have had any experience with an audit on that as of yet.

Chairman Brady. Well, I am sorry I asked that question for your organization.

Ms. Saia.

Ms. Saia. I am sorry you asked that, too. We have not been audited with regards to the 96 hour. I did before, in preparing for the testimony, went back and looked through 10 years of our submissions of where did our annual average end up for that year in regards to the length of stay, and the max that ever our average was, was 4 days, around 72 hours, so we have not been audited.

Chairman Brady. Oh, I am sure you will be on someone's list now.

Again, really sorry about that.

Chairman Brady. Mr. Joslin, last week, the committee heard testimony from Mark Miller, the executive director of MedPAC. He testified that increasing residency positions for hospitals in rural areas doesn't necessarily translate into those residents staying in rural areas. My experience has been, in Texas and our district, has been the opposite. Your thoughts, other than increasing the number of slots, what would you recommend to us to do to incentivize physicians trained in rural areas to stay there and practice medicine because it is so critical for communities like ours and certainly those on the subcommittee.

Mr. Joslin. Yeah, absolutely, it is such a critical issue because underserved areas are so difficult to recruit physicians to in the first place. Obviously, the economics play a major role in that. And so you have to have other ways to get physicians there. I am not familiar with the testimony of the MedPAC individual.

Although, my experience has been different. My experience has been when you do provide training and additional training in those areas, a large percentage of those residents do stay. If you look at us, for example, over the last 40 years, we have trained 3,000 residents, and a 1,000 of them have stayed in the Valley. They don't just stay in Fresno; they stay in these outlying rural areas. We serve a 15,000 square mile radius, a large geographic area. And a lot of that is underserved and rural, and that is where the physicians are staying. Over the last 4 years alone, we have had 120 of those residents stay and practice in these rural areas.

So I would argue that training does pay if it ends relative to the physicians staying in these areas. At least our statistics show that at least 30 percent of the physicians that we train do stay in these areas. So I think

that is critical. I do think there are other things and creative ideas that are being suggested and how we can provide specific training in these rural areas that also supplements the GME, slots that are currently available. It is not just funding additional slots, but certainly looking at the way those slots are allocated within States, which is a huge problem for us. In California, for example, if you look at California, relative to the Central Valley, it is very skewed because the Central Valley is the poorest area. As I mentioned earlier, it is about the fifth poorest area in the country, but when you factor in Los Angeles and San Francisco, the numbers are very skewed. And so you have to also then start looking within States and looking at underserved areas within States. And our area is a perfect example. In central California, we have 48 primary care physicians per 100,000 residents. In San Francisco Bay area, they have 85, and so, obviously, there is not the same dire need in the San Francisco Bay area, and I am not minimizing their issues by any means. I am simply saying that when you look at how you are provided slots, I mean, there are two issues associated with that. Certainly there is the number of slots you provide, but certainly just as important is how you allocate those slots. And really the whole intent of this program is to help get physicians in underserved areas. There has to be a key component of that. Our slots have been captive since 1997, and that issue needs to be respectfully revisited so that these underserved areas like ours can do something because if we don't, they are going to continue to do what they are doing today, which is just showing up in the emergency room.

Chairman Brady. Thank you, Mr. Joslin.

And, Dr. McDermott, you are recognized.

Mr. McDermott. Ms. Saia, you testified before the -- you reported in a Topeka news report saying, quote: "If Medicaid would expand, it would be over a $300,000 impact of Holton Hospital, where some years that is the difference of us being a profitable hospital or not." Would you tell us how expanding Medicaid would make it better in your State?

Ms. Saia. How -- could you ask the question again?

Mr. McDermott. What percentage of your patients come in with no insurance, no anything? I mean, what I am trying to get at, Governors who made a decision not to do Medicaid expansion leave you hanging out to dry in the rural areas, with people coming in who are sick and you can't turn them away. Tell me about the problem of your hospital.

Ms. Saia. So expanding Medicaid in different pockets and different service areas, the emergency department is where our largest volume of uncompensated care is given, and that percentage is right around 20 percent, which is smaller than a lot of other facilities, but that 20 percent is directly written off as uncompensated care.

Mr. McDermott. How much money is 20 percent?

Ms. Saia. Twenty percent of our emergency department volumes? I would have to submit written testimony back to you. If could you get back to you --

Mr. McDermott. I would appreciate that.

Mr. McDermott. Ms. Sorensen, you said before the Nebraska legislature a reduction in uncompensated care and cost shifting, better work health, and fewer bankruptcies, less ACA penalties for business owners, a shift of some of the States direct cost to Medicaid would generate billions of dollars in Federal money. Tell me what does not being in Medicaid in Nebraska does for you?

Ms. Sorensen. For us, it is really the economic impact that we have. So in our small rural community, we are 70 percent Medicare and what percentage of that then are also Medicaid, even just in the impact of we recently had our local nursing home close within our community, which was about 70 percent Medicaid as well as. So when we have that high level of care, that high continuum of care needed within that age and that population, that is the impact that we see, so now those aren't even in our community.

We don't have a real high percentage of Medicaid in our community. We run about 10 percent Medicaid, 8 percent self-pay in there, but really it just becomes more, as he mentioned, showing up and the access to the care. So now we are not getting in and doing the preventative screening. We are not doing the wellness pieces. We are just showing up in the ER for nonemergent cases, where the highest cost of care is given.

Mr. McDermott. When you have a stroke patient in your area, do you have a lab to test whether they should be given an infusion of medication to dissolve the clot?

Ms. Sorensen. We do laboratory testing and CT scan at the point of arrival. Of course, with our distance, we are typically arranging for that transfer as soon as possible. And then, in Nebraska, we are utilizing some of the stroke cares that they are doing through the University of Nebraska Medical Center and pushing into all of our facilities on the most timely amount of care. And so we do stock the medications, but it also depends on we have to make sure they are stable before they go on that lengthy of a transfer.

Mr. McDermott. And do you use helicopters, or do you use just ambulances?

Ms. Sorensen. Both. It depends. We have seen more air transfers out this year. It is as much as it was last year, already at this point halfway through the year. Some of that has been due to acuity. Some of that has also been due to time issues. So but, yeah, we have about 65 transfers that go out a year. And last year we only had about 14 that went by air, and we are already at 14 so far this year.

Mr. McDermott. And if I understood your answer to Mr. Brady's question, neither of you have been audited so you are not exceeding or you have not come up on the radar screen at Medicare headquarters overextending your 96 hours. Is that right? Is that what you are telling me?

Ms. Sorensen. Yes. I would say we have not been audited specifically for the 96-hour per stay. Of course, for all of our fiscal years, as Ms. Saia mentioned too, our average annual is well under the 96. So I don't think that would probably be something --

Mr. McDermott. Why is it a problem? Everybody says it is a big problem; we have to got to get rid of this 96-hour rule. But you never -- you don't exceed it in your average, and so I am trying to understand, give me some examples of patients, you know, where it became a problem.

Ms. Sorensen. Absolutely. The biggest issue is going to be, of course, the annual average falls in okay, but if we had a patient that had a surgical procedure --

Mr. McDermott. Surgical procedure done there at your hospital?

Ms. Sorensen. Yes, like a bowel resection or something, so they will be admitted into that acute status, but we already know ahead of time, they will probably be there for 5 days, just to get things back up and going and medically stable and everything, get them back to eating normal. And so with the per-stay condition of payment, that has been said to be enforced, that is where if we are certifying or precertifying they are going to be there less than 96 hours but really we anticipate them to be longer, we are not going to get paid for that stay.

The same thing happens -- and maybe Ms. Saia wants to comment to that -- in an pneumonia case, where we will admit on day one, doesn't seem to be responding to it, get the culture, something comes back. It

comes back unexpected and we need to change medication. So now, even if we did precertify we reasonably expect them to be there less than 96 hours, now we are already at 90 hours; we need to change the medications. Are we running that risk? We are not even going to get paid for that entire episode.

Mr. McDermott. Mr. Chairman, I realize you have given me a little extra time here. I would like to submit the CMS rules on the 96-hour rule for the record. The rule explains that CHAs still get paid after 96 hours if the patient still needs care. Nobody is denied care. Nobody is denying payment apparently. So I would like to submit that for the record.

Chairman Brady. Without objection.

[The information follows: The Honorable Jim McDermott]

Chairman Brady. And, clearly, we appreciate the witnesses being here today. Usually witnesses come because there is a problem, especially when it deals with treatments for patients in real life. Today's hearing is about drawing some of those insights out, see how we can address them.

Mr. Johnson, you are recognized.

Mr. Johnson. Thank you, Mr. Chairman.

Thank you all for testifying today, and I appreciate you for being here. My district in Texas is right outside of Dallas and fairly suburban, but no mistake, I still understand the importance of our rural and critical access hospitals. You drive just one or two counties away, and you are going to find rural hospitals, and rural hospitals cover about 85 percent of the Texas geography.

Medicare has long had the so-called 96-hour rule, and some of you covered that in their testimony, but for years, CMS has enforced that rule based on the average patient's stay. But now CMS has changed their enforcement to require doctors to certify for each and every patient that they do not expect the patient to be there more than 96 hours.

Changing from an average of 96 to requiring certification for each patient doesn't at first sound like a big deal, but as you know and we have been talking about it, the implications are significant.

Ms. Sorensen and Ms. Saia, could you discuss how this change to the 96-hour rule has impacted your hospitals, both from a financial and operational standpoint? And could you also address in what circumstances a patient might have to be at the hospital for more than 96 hours? And what happens if a patient is admitted for more than 96 hours? One at a time go ahead.

Ms. Sorensen.

Ms. Sorensen. I would just comment to the example I gave a little bit earlier relative to pneumonia and a change in medications. A surgical procedure where there was a bowel resection or organ removal, biopsy excision, those types of things that may alter that. Also just the usual if treatment doesn't go as planned and a medical care plan needs to be adjusted or modified to improve patient status.

Mr. Johnson. Go ahead, Ms. Saia.

Ms. Saia. As previously mentioned, the regulation is confusing and conflicting from the condition of participation. So to be able to abide by the regulation as it stands, the physician must certify that they do not believe the patient is going to stay longer than 96 hours. So if -- and my understanding and I may be corrected -- but my understanding is that the payment would not occur after 96 hours, and therefore, we

would need to ship the person from our facility to a larger facility that could care for that patient, that is taking -- would impact the patient as well as where they are getting their care. So it would move their community -- their loved ones to another facility if we are unable -- are those buzzings me, I am sorry -- if we are not able to care for that patient past that 96 hours, and you just never know. You don't have a crystal ball that tells you the answers as a provider upon admission what is going to change during that course of stay. So, with the 96-hour, the understanding and trying to enforce that and abide by that, the understanding is that they need to be transferred if their care needs longer than 96 hours.

Mr. Johnson. Were you all geared up to do that? I mean, you don't have an ambulance on standby just to take somebody to another hospital, do you?

Ms. Saia. No.

Mr. Johnson. I didn't think so. And I think that is crazy to even think about, don't you? But do you get paid if they are over 96 hours?

Ms. Saia. Do we get paid? Well, so far, the enforcement of that has been delayed, so we are not upheld to that current standard right now.

Mr. Johnson. Okay.

Ms. Saia. We are just upheld to the condition to participation, not of payment.

Mr. Johnson. But they are pushing you to do that.

Ms. Saia. Pushing and we with like you to push for the delay to continue and look at a more permanent fix. If we are not able to delay that, could we at least look at a permanent fix for that?

Mr. Johnson. Thank you very much.

Thank you, Mr. Chairman.

Chairman Brady. Thank you.

Mr. Thompson, you are recognized.

Mr. Thompson. Thank you, Mr. Chairman.

And thank you to all the witnesses for coming. It has been good testimony. And I know you guys -- I represented a rural area for most of the time I spent both in the State legislature and in Congress, so I know some of the challenges you have. And my wife is a healthcare provider in a rural hospital in my current district. And so I know very firsthand how challenging it can be. So thank you for helping us understand the problems and trying to figure out some solutions to the challenges that you face.

I am a big supporter of telemedicine and telemonitoring. I have had a number of pieces of legislation that has helped advance this. Mrs. Black and I have legislation in this Congress to help move that forward again. And I think it is a way we can address a lot of the problems that we face. So I would like to know how your hospitals are using -- if they are using, and if so, how they are using both telehealth and remote patient monitoring?

Start with Mr. Joslin. You don't have to do a thesis.

Mr. Joslin. Okay, thank you. We are a safety net hospital, and we work with the rural hospitals closely. In fact, we receive about 600 transfers a month from outlying hospitals. However, we do use telemedicine quite a bit as well. We do it through the University of California, San Francisco, and with their specialists as well. But we have been using telemedicine for the last several years as a key component of the care that we are providing to help rural hospitals in outlying areas and physicians and clinics as well, to extend that to as many providers as possible. Because with what is going on in health care, the need for population health, how we look at redesigning the system, it is not just hospital to hospital, hospitals to physicians, but there are a lot of other types of providers, and telemedicine is a critical component of that piece as well.

Ms. Sorensen. I would agree we are a big proponent of telehealth. We use tele-emergency, so we have board-certified emergency docs in our emergency room at the push of a button 24/7. We also have remote pharmacists that oversee 100 percent of our inpatient medications. Teleradiologists, as well as just the one-on-one patient visits, many of them are used for oncology with an occasional orthopaedic followup. Psychology of course.

The biggest barrier that we have in telehealth is getting the physicians themselves into a scheduling routine and access to the electronic devices so that they either can do it right from their desk or an examine room in their clinic. And then, of course, reimbursement issues that come into the challenge as well. They are often not willing to see the patient via telehealth because of the reimbursement and payment issues. So, therefore, our patients drive 2-1/2 hours for that 10-minute visit that could have been done via telehealth.

Ms. Saia. We are currently not using telehealth services, but supportive of that. We are currently looking at meeting the needs of our community in regards to mental health and exploring opportunities with a couple of different companies for telesite coverage.

Mr. Thompson. So you see it as something you can use or maybe should be using as something that can bring some relief.

Ms. Saia. Yes.

Dr. Derksen. In Arizona, we were able to get legislation through for payment parity, so that insurers would be paying for telehealth services. We use it for teleradiology and places that can't afford to --

Mr. Thompson. The non face-to-face reimbursement.

Dr. Derksen. Exactly. So it has been very important, but it is also important to strike that balance between making those services available in rural communities, but making sure that, through licensing, credentialing, and privileging, that we assure the high quality of services that are available onsite. We don't have these kind of folks coming in from other places that undermine the fiscal viability of a place because someone else is kind of taking those services out of that community.

Mr. Thompson. A couple of you kind of alluded to some things, but are there any things specifically that would help you do more or better telehealth? Are there any roadblocks that Medicare reimbursements provide, or is there anything that Congress can do to help you better perform telehealth services?

Ms. Sorensen. I would like to be able to provide written testimony with some more information because I need to look into that. But I know that just at a conference that I attended last week looking at that face-to-face reimbursement rate and what can actually be billed via that, there is a lot more opportunities available via telehealth, but right now we need to get that face-to-face reimbursement rate equal in telehealth.

Ms. Saia. If possible, I would like to provide some additional testimony as well. We have looked at the tele-emergency coverage, and just the cost upfront I am told the cost of the salary of one FTE of a

nurse. That is a little bit -- when I was originally told that, that is probably less than what our current salary makes -- it was closer to around $80,000. And just being able to come up with that, making sure that we have got the adequate room in our emergency department is also a concern as well, so I would provide more written testimony on that.

Mr. Thompson. Thank you. I would invite to you get that written testimony, and I would be very interested in seeing it.

I don't know if the committee wants it, Mr, Chairman, but I sure would like to get it in my office.

Mr. Thompson. Thank you very much.

Chairman Brady. Mr. Smith, you are recognized.

Mr. Smith. Thank you, Mr. Chairman.

And certainly thank you to our panelists here today, our witnesses. I most admire your abilities and willingness to be on the frontlines of health care that are, I am sure, difficult. I don't pretend to think that the answers are here in Congress or even that there would be a bunch of answers in just increasing funding for some broken mechanisms in health care. I think that these arbitrary regulations that have come about, whether it is the 96-hour rule, whether it is the physician supervision, to keep those in place and just expand Medicaid, as some would suggest a solution would entail, I think we owe our providers a better policy than that out of Washington, D.C., that really entrusts our providers.

And, certainly, Shannon, thank you for being here, for traveling from very rural Nebraska to share your expertise, your insight. We know that Brown County Hospital is the only hospital in the county, hence the name. But the county has a land mass larger than the entire State of Rhode Island, and it happens to be next door to Cherry County, that is larger than the State of Connecticut, and it, too, only has one hospital.

So just to try to identify what the issues are here, we know the Critical Access Hospital designation I think is an effective component of our policy. But we ought not assume that every Critical Access Hospital has the same level of care or the same skills that are within that facility or the same community profile. And we need some flexibility.

That is why I have introduced the 96-hour rule, as well as the physician supervision bill that would push back there. These are arbitrary. I have a hard time even figuring out how they came about or why they came about. That story has not been told. But I do know that the 96-hour bill is a very bipartisan solution, with some 70 cosponsors, very bipartisan like I said. And these concerns are across America and I would say even in more urban areas too. Just the impact seems to be felt more at the rural level.

Now, there were some questions about audits. I mean, certainly I assume you have been audited but just not for 96-hour, right, I see strong nods in agreement, yes. So the RAC auditors, that was mentioned as well; that needs to be addressed. I am glad that telemedicine was brought up. I think that telehealth probably even adds to the need to address this 96-hour rule that is arbitrarily out there.

Do you want to elaborate a little bit on the audits that do take place, Ms. Sorensen or Ms. Saia?

Ms. Sorensen. Absolutely. We have had audits for claims, overall episodes of care, what would be considered RAC. Our RAC activity has not been real high. But we definitely have had audits. And these are very laborious. They are intensive in terms of submitting a number of additional supporting documentation and often for claims that we feel were unnecessarily audited or reviewed to look at in more detail. In all of them -- and we have even gone to the level of having to appeal at the administrative law

judge level. And the times that we have done that, we have been successful in appealing those but have not gone without much effort, time, and resources that has been needed to do that.

Mr. Smith. Ms. Saia?

Ms. Saia. We have been involved with a variety of different audits, the compensated care issue you mentioned previously. But our RAC audits have not, we have not had a lot of activity. There have been a very few small claims. But the time involved with reviewing those, making sure that claims were correctly submitted is very time-consuming. We have not been successful in two of them, in overturning the audit results. But, again, the activity has not been extremely high in regards to that.

Mr. Smith. Okay. Thank you. And I do want to certainly emphasize the diversity of Critical Access Hospitals. As Ms. Sorensen said, there is one doctor for the entire hospital, the entire community, the county. Now, some Critical Access Hospitals would have 10, 15 docs, maybe, offering a different level of services. So 96 hours of care could mean different things in different communities. And I would hope that we can get our policies to reflect that.

Thank you, again, to our witnesses.

Thank you, Mr. Chairman. I yield back.

Chairman Brady. Thank you.

Mr. Davis, you are recognized.

Mr. Davis. Thank you very much, Mr. Chairman.

And I want to thank all of our witnesses.

You know, I was thinking, I grew up in rural America. Although I represent a large urban population, I have always had a great deal of affinity and, hopefully, some understanding of rural America's needs as it relates to health care. In my family, we often discuss the fact that we believe that my mother may have died prematurely because she had to travel more than 150 miles to get to a regional medical center where she could get dialysis treatment.

I am a big fan of regional medical centers like the ones, Mr. Joslin, that you come from and represent. But I also recognize that in training, we need to train the best physicians that we possibly can, not only in principles and concepts of medicine, but also there has to be enough opportunity for the individuals to experience disease entities enough times to, I mean, I always like physicians personally that I feel have seen a lot of patients like me and that, in the process of doing so, probably has a better understanding of whatever it is that I am there for.

In terms of finding a solution to obviously a very difficult problem, I mean, we look at reimbursement, and I think that reimbursement rates that are different based upon the complexity of small numbers of people that an entity might be able to see is something to consider. Obviously, telemedicine, as it continues to advance, and other types of incentives, how do you feel that these incentives can be tweaked enough or couched enough to really make a serious impact on the ability to recruit physicians and other medical personnel for the rural areas that are having the difficulties we are discussing?

Mr. Joslin, perhaps we could start with you.

Mr. Joslin. It is a great question. I think there is two parts to that question. There is the question of how you tweak the system, but I think you have to start out with the fundamental realization that the system is

flawed because the system is just not -- it doesn't produce enough. And we touched on it earlier. We touched on the number of slots, and we touched on how these slots are allocated. And then trying to provide some type of incentive for physicians to want to go and train in these areas, whether it is financial incentive for educational purposes or however you structure something, but the shear magnitude of the issue is just the lack of enough slots in these underserved areas that there is really no effective way to move the pieces around until we solve that fundamental problem. And I think we have to be creative to do both because obviously there is not unlimited resources. We don't have the ability to just keep adding. We have a deficit issue we need to tackle. And so we need to deal with those types of creative things. And I think those kinds of answers are going to come in the bigger answer of how we are going to effectively redefine this healthcare system, to develop a marriage or partnership between those regional medical centers you referred to, safety net facilities, and those rural facilities, and partner with all the other, not only physicians but other healthcare providers that are out there providing these types of resources, there is going to ultimately have to be a different type of system developed so that we can really reallocate resources within a very limited system itself.

Mr. Davis. Ms. Sorensen?

Ms. Sorensen. I think one of the most beneficial incentives that we have had really, for example, the meaningful use incentive, that pushed a lot of facilities into getting to the medical records so that we can get where we need to go. We are a long ways from getting where we need to go. But there was at least the jump into that. For us, from the telehealth perspective, for example, our e-Emergency that we have, so we have that board-certified ED doc at the push of a button in our ER 24/7. And it was a huge recruitment tool for us. We have recently recruited a family practice physician that will join us next year. And much of that is the comfort of knowing there is somebody there to support them. They are not practicing completely independent.

So much of what Mr. McDermott mentioned earlier in terms of maybe incentivizing with loans or some type of an arrangement, in the State of Nebraska, we are looking at trying to help with student loans and contracts early on for recruitment purposes and incentivizing them for the services to our communities.

Ms. Saia. I don't know that I have anything additional to add in regards to incentives for recruiting. What has worked in our facility is being a rural area, where, upon graduation, there is a loan forgiveness for coming to our area. And that has worked for two of our doctors, one of our doctors, and three of our midlevels for reimbursement for staying in the area. What we have tried to do, though, is just have a great community and a great facility to work in where they want to stay after those 2 years. And that has been successful for us.

Dr. Derksen. I would just like to say that I don't know about the MedPAC testimony that was provided last week related, but our evidence in New Mexico and Arizona is that when you train health professionals in rural areas, they are much more likely to go. In fact, when we decentralized our family medicine training and our dental residency training to include rural experiences, we doubled or tripled the rate of retention of practitioners going into practice there. It works for nurse practitioners. It works for dentists. It works for physicians. It works for allied health professionals. I think the evidence is incontrovertible. We have to invest in that health professions training infrastructure to move the health professions training pipeline closer to the areas of need.

Mr. Davis. Thank you, Mr. Chairman.

Chairman Brady. Thank you, Mr. Davis.

Mr. Davis. I Thank you for the indulgence.

Chairman Brady. My pleasure.

Ms. Jenkins, you are recognized.

Ms. Jenkins. Thank you, Mr. Chairman.

And thank you to the panel for being here today. A special thanks to Ms. Saia. We both hail from the great community of Holton, Kansas. I am sorry Senator Roberts isn't here. We could all join in the Holton fighting wildcat song. We appreciate the good work that you do, running our hospital, Critical Access Hospital. The community is only about a little over 3,000 folks. And so the hospital is key to the success of our community.

And there are few issues that I hear more about at home than ensuring access to quality, accessible, rural health care. And I believe this hearing is a very important step forward in addressing the problems that providers and patients face in rural America.

Carrie, in your written testimony, you speak about the damaging effects that CMS' direct supervision requirement for outpatient therapy services would have on hospitals like Holton Community Hospital. And you mentioned your support for H.R. 2878, the legislation that I have introduced on that matter. One example that you gave of a routine outpatient therapy service is intravenous infusion. Drawing on your nursing background, can you briefly describe what kind of patient might need an infusion and the process involved for the attending medical professional?

Ms. Saia. I would be happy to. There is a wide variety of examples. The one that comes to mind is a patient that is suffering from rheumatoid arthritis. They need an outpatient infusion for their medical condition. So they have been seen by their primary doctor. They have been referred to a specialist that comes to our facility and orders a medication. That infusion is usually one time a week for the course of 6 to 8 weeks. And they would come in and need that infusion given intravenously. Another example could be blood component therapy or chemotherapy drugs are also different examples in regards to that.

Ms. Jenkins. Okay, perfect. Thank you. Could you also describe the added burden that direct supervision puts on physicians and ways in which other hospital services suffer because of it?

Ms. Saia. With direct supervision, the regulation speaks to requiring a physician being readily or immediately available. So if that physician is involved with -- Thursdays, we have stress tests in our facility. And a physician has to be physically present and cannot do anything else. So for that physician then to not be able to meet the requirement for direct supervision, if a patient is getting that infusion on that day, that would mean two doctors then would be tied up, one doing stress tests, one doing the outpatient infusion. And then what would suffer would be the care of just normal care in our primary clinics because we have two providers, two doctors tied up doing those two services.

Ms. Jenkins. I see.

Ms. Saia. If that makes sense.

Ms. Jenkins. It does. Before CMS announced that it was going to enforce the direct supervision rule, were nonphysician providers at Holton Hospital able to administer outpatient therapy services effectively without direct supervision?

Ms. Saia. They were. We have five different midlevels. They are all trained in advanced trauma life support, advanced cardio, CPR, advanced life support, trauma courses. They provide coverage for our emergency department. But, yet, with this regulation, they are not able to provide coverage for a person on an outpatient basis receiving an infusion.

Ms. Jenkins. Okay. Thank you.

I want to touch on another topic. Ms. Saia probably knows that Holton Community Hospital provides hospice services for folks who are very ill and likely near the end of their life. In fact, my own father spent his final days under the care of the hospice at Holton Community Hospital. And we find that patients are at their most vulnerable at that stage. And I worry that folks in rural areas may be limited by the fact that Medicare's list of authorized hospice providers is not as inclusive as it should be. And this could lead to gaps in access to those who may need hospice but are unable to get it.

And I have introduced legislation, along with Mr. Thompson here on our subcommittee of California, which would recognize physician assistants as attending physicians to serve hospice patients. And I am just curious, maybe Ms. Sorensen and Ms. Saia, do you think that this legislation would help? And I am getting gavelled down. Maybe if you could --

Chairman Brady. Yes, briefly would be great.

Ms. Saia. I think it is being very futuristic and very supportive of trying to keep the hospice patient in their local community to receive that, important services, at a very critical time instead of having them leave their local community to receive it elsewhere. We are fortunate to have a medical physician right now available for that. But looking at the future and knowing the shortages, not only hospice, home health, DME, those type of services really could be supported with this legislation.

Ms. Jenkins. Thank you, Mr. Chairman.

Chairman Brady. Thank you. No one ever calls my legislation futuristic and visionary, so congratulations.

Mr. Pascrell, you are recognized for 5 minutes.

Mr. Pascrell. Thank you, Mr. Chairman.

And I want to thank the panel for being so forthright. I want to remind the panel, as well as the members of the committee, Mr. Chairman, that on June 22, when we had our last hearing, Dr. Mark Miller was with us from MedPAC, gave us a report. And in that report, 80 percent of rural hospitals that have completely closed their doors are located in States that have not expanded Medicaid, et cetera, et cetera, et cetera. You know, we need to take the time to read the stuff that gets to us, Mr. Chairman. That is my point. Because I think many times, as Mr. Joslin says, you have got to get to the fundamental problems and ones that we do not want to address.

So I agree that access to health care in rural areas is an awesome issue. It is worthy of the committee's focus. I come from North Jersey where the closest rural area is more than a stone's throw. But I ran point on rural hospitals in South Jersey. I am very proud of that record. Every day our New Jersey hospitals face challenges associated with serving urban populations. Medicare beneficiaries and other patients living in urban areas need access to quality health care, to provide economic opportunity, ensure community vitality, just like residents living in rural areas. I want everybody to be healthy. And I assert that access to care cannot only be measured by how long it takes you to drive to the nearest hospital or the nearest clinic, isolation from transportation services in urban areas can be just as prevalent and is, in reports that I have seen, as in rural. In my home town of Paterson, New Jersey, which is the third largest city in New Jersey, local hospitals care for a population where 29.1 percent of the residents are living below the Federal poverty level -- that is a problem -- where the medium household income is $32,707 -- that is a big problem -- and 62.5 percent of the households speak a language other than English. These issues, along with a number of others, like patient mix, a reduction in the disproportionate share of hospital payments, which we had in New Jersey, pose very real challenges for urban hospitals.

But despite these challenges, urban New Jersey hospitals cannot receive any of the add-on payments that rural hospitals are eligible for. If we are going to look at this, let's look it across the board. The State of

New Jersey does not have any hospitals with Critical Access Hospital, Medicare Dependent Hospital, or Sole Community Hospital designations.

Mr. Joslin, in your testimony, you painted a good picture of what your hospital's patient population looks like. Despite the fact that your hospital is located in a rural area, it is actually very similar to the patient population at St. Joseph's Hospital in urban Paterson, New Jersey. I compared it. You mentioned high rates of poverty, low education levels, and limited English. Can you discuss some of the challenges associated with this patient population?

Mr. Joslin. Certainly. And your example is absolutely perfect. When you are looking at urban hospitals, their safety net providers in economically challenged areas, it is tremendously difficult to provide all those services that you need. In our area, a third of the adults don't graduate high school, a third. You know, a third of the children in our area are living at or below the poverty level. Twenty percent of the population doesn't speak English. We are in a huge metropolitan area, relatively speaking, Fresno County and the outlying areas. And there are tremendous challenges.

So we have in common what these rural hospitals have in common, thin operating margins. And we live on the edge financially because there is not a lot of excess in the system of what we deal with, same thing that you are dealing with in your area. So we have to be very efficient. We have to cooperate with others. We have to take an integrated delivery approach to this so that if there are issues with transportation, for example, we can't just admit a patient to the hospital, discharge them, and say, "Okay, now go your way because there are all these resources out there for you." We have to help provide all those additional resources, transportation, getting them to and from, skilled nursing facilities, home care, hospice, all these things we have to help facilitate as well. Because the challenge is -- and we had $180 million last year in uncompensated health care, similar probably to what your hospitals have.

Mr. Pascrell. Yes. Mr. Chairman, just one more statement before I yield.

Chairman Brady. Quickly please.

Mr. Pascrell. We want to be fair to everybody. I want to be fair to everybody. What I want folks to know, I am never going to vote for any help for rural hospitals unless, instead of going into the pocket we already have and, therefore, those hospitals suffering, we need to expand the pocket. We need to expand Medicaid. And that is really at the bottom of many of the problems -- you talked about getting to the fundamental problems. That is what I think we need to do.

Thank you, Mr. Chairman.

Chairman Brady. Thank you, Mr. Pascrell.

I would point out, I think hospitals are struggling with the $700 billion of cuts to Medicare, many of which landed on our community and rural hospitals. And they have been feeling damaged for quite some time. Today's hearing, I understand the point of Medicaid expansion, but the point today was really about listening to specific challenges they face and some proposed bills, bipartisan bills, we hope can help eliminate some of those concerns.

So, Mrs. Black, you are recognized.

Mrs. Black. Thank you, Mr. Chairman.

Thank the panel for being here.

Mr. Chairman, I would like to ask unanimous consent to submit a letter from the Equal Pay for Equal Care Coalition on behalf of the Tennessee Hospital Association concerning the hospital area wage index for the record.

Chairman Brady. Without objection.

[The information follows: The Honorable Diane Black Submission]

Mrs. Black. Thank you, Mr. Chairman.

Mr. Derksen, I appreciate your testimony on the acute financial pressures that rural hospitals face because of onerous Medicare regulations and cuts in reimbursement. As you point out in your testimony, for hospitals and rural States, like Tennessee, the risk of closure is real. I represent, about 50 percent of my district is rural, so we have a lot of those hospitals that are sitting in that situation.

But I would like to bring up another challenge that is adversely impacting Tennessee hospitals, which is the Medicare hospital wage index. This issue hasn't received as much attention as those that have been identified in your testimony. But I believe that it will be receiving more and more attention in the near future as it negatively impacts these hospitals and potentially will mean closure for them as well, unless that reimbursement is changed. And although the area wage index is intended to ensure that Medicare hospital payments reflect the geographic differences in wages, many, including myself, believe that the system is broken.

In fact, we had an exchange last week with MedPAC's executive director, Mark Miller, in which he agreed that the area wage index is neither accurate nor fair, and it needs to be repealed. So the area wage index is having an adverse impact on hospitals in Tennessee and other hospitals in rural areas. Thus, this letter that I am going to be submitting, which has a whole coalition of hospitals that are represented, mostly rural areas, all over the country. These hospitals have seen the area wage index levels rapidly decreasing over the years, while the levels for a handful of the others have been increasing. So I know this is going to be a difficult topic because some have seen significant increases, while others have seen significant decreases.

And would you talk about repealing this wage index and replacing it with a more accurate and fair system that would help to relieve some of those financial pressures specifically on those rural hospitals that are in this situation?

Dr. Derksen. Mr. Chairman, Representative Black, thank you for bringing up this issue. This is a crucially important issue in some parts of our country, including the area I work in in Tennessee obviously. I think we do need to bring some rationality to this. I think we need to bring some fairness. And I certainly appreciate your leadership on this issue. But there are complicated issues that need to be ironed out. And I admire the courage to bring this forward. Because whenever there is winners and losers, the stakes and the fights get pretty intense.

But I think the issue is there shouldn't be winners and losers where large swaths of the United States, where 20 percent of our population lives, are basically forced to accept these very low payments. I don't think it is just with the Medicare area wage index. I think there are some issues related to graduate medical education payments that are very, very low. When I was in New Mexico, we had the lowest per-resident amount. Why in the world, you know, is Connecticut or New York hospitals being paid nine times per capita what Texas is being paid for Medicare GME? I think the work that you have done in a bipartisan manner in this committee is exactly the kind of leadership we need. And I think that the types of things that you have proposed and have been talking about are, it is time for us to address these issues and to make this a much more rational policy. Thank you.

Mrs. Black. You are welcome.

One other issue, and I know I am not going to have enough time to really ferret this out, but I would like for the panelists, if they have an opportunity, to respond back in a written form about being able to use ACOs in rural areas.

My colleague, Mr. Thompson, did hit on something that we are working on together on the telehealth, but also what are the barriers for using the Accountable Care Organizations where we could have more coordinated care? I know that we are seeing those maybe be successful in the bigger urban areas. But I would like to hear from you about where you believe that the barriers might be in also using ACOs, where we could actually have those alternative payment models and be able to coordinate the care. So if you could just let me know or let the panel know what is hampering those efforts, we would really appreciate hearing from you. So that would be another area we might be able to help our rurals in.

Thank you, Mr. Chairman. I yield back.

Chairman Brady. Great. Thank you.

Mr. Kind, you are recognized.

Mr. Kind. Thank you, Mr. Chairman. Thanks for holding this hearing.

I want to thank the witnesses for your testimony, your patience today. And just to follow up on that last point, I am glad Mrs. Black raised this issue, it was actually a question I was going to ask you in regards to challenges you face with ACOs, the implementation in rural areas. I hail from the State of ACOs. My healthcare providers throughout Wisconsin have been practicing a more integrated, coordinated, patient-centered healthcare delivery system for quite some time. What I am hearing from my Critical Access Hospitals, a lot of rural providers, is that there are some unique challenges that they face with the ACO model, medical homes, that more coordinated care. So anything you can provide our committee to provide some insights because I have been reaching out to my providers back home on this as well.

Clearly, that is the direction that the Affordable Care Act is trying to drive the healthcare system, to more coordination, more integration in healthcare delivery services. But there are unique challenges that we recognize in rural areas. And that needs to be addressed as well.

Let me shift and address a topic that hasn't been addressed yet today. Maybe you might provide some insights. Clearly, there has been increased consolidation in the healthcare industry in recent years. We are seeing more consolidation, with the bigger providers coming into rural areas, buying up hospitals and clinics. We are also seeing a huge amount of consolidation with health insurance companies right now. Obviously Cigna and Aetna are the latest in the news right now. But I wanted to get anyone's reaction on the panel today and these trends that we are seeing, the impact it could have on rural healthcare providers, both the access and the quality issues, if you would like to share with us today.

Dr. Derksen.

Dr. Derksen. Mr. Chairman, Representative Kind, I think where integration and consolidation results in quicker access to health care, to high-quality health care, or it reduces the rate of cost growth, or it improves health outcomes, and those are measurable health outcomes, I am all for it.

When integration and consolidation means fewer choices for providers, for patients, and it increases the costs, I think we ought to look at those types of issues. And that is where I am kind of worried. In States where there is robust competition, for example, in the health insurance marketplace, such as Arizona, we have at least seven insurers offering 70 different plans in our 13 rural counties. That is a lot of competition. As a result, our premiums went down for silver plans 10 percent. I think the marketplace can work, but it requires robust competition. I have noticed in other States with only one or two insurers, that

those rates go up. And there is these kind of endless requests for increases in premiums. So I think there is some advantage to bring it together. I think rural communities and our community hospitals are looking to partner in ways through telemedicine, telepsychiatry, through teleradiology, and other mechanisms. We ought to encourage that. But let's keep the end in sight here. We want high-quality care. We want ready access. And we want to control cost growth. And if those three criteria are met, then that should be kind of our litmus test to me.

Mr. Kind. Mr. Joslin?

Mr. Joslin. I think fundamentally the system is fragmented and broken. And I think you are seeing consolidations not for business purposes but for patient care purposes. And I think the only way we are going to fix this healthcare system is to partner together and develop new models that are much more effective in treating patients. If you do the same thing over and over and over again, obviously, you are not going to get different results. We have to get creative and look to doing things differently. So what I look forward to sharing with you in the coming months are a pilot that we are doing, for example, where we, in a large urban area, are partnering with a large provider in the rural area to develop an integrated network with access to care, I absolutely agree with you, access to care, the primary driver in this, to make sure there is a system there for everybody, regardless of resources, that is available close to where those patients are, and provides the different level of resources they need. But it has to be this new level of partnership if the mission is correct. And the mission has to be accessed to high-quality, affordable health care. And so you are going to see lots of these models pop up. Some will be good. Some won't be so good. But we need to learn from all of them and continue to work towards developing a better model.

Mr. Kind. I would agree with both of those things.

Mr. Chairman, this might be another topic ripe for a future hearing, as there are large forces taking place in the healthcare field and consolidation, both on the provider and the insurance side. And we are going to have to provide more oversight.

And, finally, on the training aspect, Mr. Joslin, you talk about the importance of training in rural areas. I know, in Wisconsin -- this might be true in your areas too -- we are really making a concerted effort to try to recruit in rural areas before even training because we have found if we can get them from the rural community, from the quality of life they grew up in, it is easier to direct them back into those communities to serve in the healthcare function.

So if you have got some unique programs that you have been working on as far as recruitment, we would be interested in hearing about that so we can take that to capacity.

Thank you, Mr. Chairman.

Chairman Brady. Thank you, Mr. Kind.

Mrs. Noem, you are recognized.

Mrs. Noem. Thank you, Mr. Chairman.

And thank you for allowing me to take part in this hearing. I am not a normal member of the Health Subcommittee. But I represent South Dakota. And I have the entire State. So there is not much in South Dakota that isn't rural and doesn't face a lot of the challenges that you all have been discussing today.

And I am glad that Mr. Kind touched on that because that was something I was going to point out that Mr. Derksen talked about earlier, was the fact that when you train physicians and caregivers in rural areas, they tend to come back. We have a very difficult problem with recruiting physicians to some of our

communities in South Dakota. But we have noticed that if we have the training in those communities, if we have residencies available, that that makes a world of difference.

So I want to thank you for discussing that today and putting that in the record because it is important to make sure that we have the kind of access to care that we need. And we have that by making sure there are physicians in the area. And I have visited many, many of the rural hospitals in South Dakota. I have seen the necessary care that they provide to our population and the people that live in my home and the patient population that they serve. In fact, a lot of my rural hospitals feel that many times they are treating patients that may be sicker, that may be older. We have a very -- our population is much older than I think, on average, than some other States. And they feel like they have more challenges because of that than some of their urban hospital counterparts. And they outlined a number of the challenges that they face.

And Congress and the administration have agreed that access to care is limited in these areas and communities. And people have to travel farther to get the kind of checkups and emergency services they need. And this can significantly increase the cost of health care and impact outcomes in emergencies when time is critical. In fact, research shows that rural residents travel twice as far to the closest emergency room than urban populations do. Rural communities face demographic challenges both with the Medicare population and the community population at large. You have discussed many of these issues today. And as a result of all of these challenges, a lot of our rural hospitals are operating at a financial loss. So what concerns me is how we will keep access to care in these parts of the country. And there are many things that Congress can do, and there are many proposals and bills that are filed. I would like to know from each of you what your biggest challenge is at keeping that access to care in those rural communities and a suggestion of what Congress, it may be a payment system, it may be a reimbursement formula, it may be different policies or regulations that cost you so much money in complying with them rather than delivering care to patients. What is your biggest challenge that Congress could immediately address that would be a relief to our rural community hospitals?

We will start with Mr. Derksen.

Dr. Derksen. Mr. Chairman, Representative Noem, thank you for bringing up these issues. I think it is very important. I spent a lot of years trying to figure out ways to get health professionals trained and ready to practice in rural areas. And I mentioned one of them. I think the thing before us now pragmatically that we could invest in is graduate medical education. And maybe the leverage point there, as we expand Medicaid in at least 30 of the States so far, is to use Medicaid graduate medical education where States have far more flexibility, through State plan amendments and such, of supporting a rural health professions infrastructure.

But the second thing has been mentioned several times, there is no greater thing that a Governor can do is to reduce the uncompensated care. If you just shift uncompensated care cost to someone else, that is a hidden tax, every bit as important as any other kind of tax you might levy. And in Arizona, we are the very last State to do Medicaid. You know, that was passed in 1965 as part of an amendment to the Social Security Act. We didn't get around to it for 17 years in Arizona until 1982. But we did expand Medicaid to 100 percent of the federal poverty level. We were an early expansion State. But we had to freeze that. 200,000 people got forced off of Medicaid during the Great Recession a couple years ago. And what happened is the uncompensated care costs for our hospitals doubled and tripled and have put many to the brink of fiscal extinction. Governor Brewer, not to be confused with a progressive, you know, Democratic Governor, very conservative, somehow she restored that coverage back to 100 percent. And while she was at it, being very unpopular with her conservative colleagues, expanded it to 138 percent. That single factor of getting people health coverage, a payment source, has brought -- in 2013, half of our Critical Access Hospitals had negative margins. Now they are just barely above the positive margin, but they are in positive. Getting people coverage is there. Every State does it different.

In Arizona, we do it as the Arizona healthcare cost containment system. But it is a way to go about assuring accountability. Every State is going to have to sort through how best to cover their

uninsured. And I think that factor alone is probably the most important for our rural hospitals and our rural providers.

Mrs. Noem. But not necessarily something that Congress can do.

Dr. Derksen. Pardon me?

Mrs. Noem. Not necessarily something that Congress can make a decision on today.

Dr. Derksen. I think any time you are looking at Medicare and Medicaid coverage, you can't really separate them easily. But the types of policies that you are doing here, the types of payment issues -- the hospital, I mentioned that we will close on Friday because Medicare has frozen payment, well, Medicaid can't pay them in our State either. So a lot of these issues go hand in hand. Thank you.

Mrs. Noem. Mr. Chairman, I realized I am out of time. If the rest of the panelists wouldn't mind submitting to me your recommendations on what you believe are the biggest challenges to maintaining access to care in rural communities, I would certainly appreciate that.

Mrs. Noem. With that, I yield back.

Chairman Brady. Thank you. I would like to thank today's witnesses for their testimony today. And I appreciate your continued assistance getting answers to the questions that were asked by the committee. As a reminder, any member who may wish to submit a question for the record will have 14 days to do so. If they do, I would ask the panel to respond in writing in a timely manner.

Again, we are looking for common ground in how we address these rural healthcare disparities. Today's hearing was helpful.

With that, the committee is adjourned.

[Whereupon, at 11:45 a.m., the subcommittee was adjourned.]

Public Submissions For The Record