

**RURAL HEALTH CARE IN AMERICA:
CHALLENGES AND OPPORTUNITIES**

HEARING

BEFORE THE

**COMMITTEE ON FINANCE
UNITED STATES SENATE**

ONE HUNDRED FIFTEENTH CONGRESS

SECOND SESSION

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MAY 24, 2018
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RURAL HEALTH CARE IN AMERICA: CHALLENGES AND OPPORTUNITIES

THURSDAY, MAY 24, 2018

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 9:07 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Orrin G. Hatch (chairman of the committee) presiding.

Present: Senators Grassley, Crapo, Roberts, Enzi, Thune, Burr, Portman, Cassidy, Wyden, Cantwell, Carper, Cardin, Brown, Bennet, Casey, Warner, McCaskill, and Whitehouse.

Also present: Republican staff: Jay Khosla, Staff Director. Democratic staff: Joshua Sheinkman, Staff Director.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The hearing will come to order.

I would like to welcome everyone to today's hearing. The topic today is rural health care, which is a critical issue for virtually every member of this committee and so many others.

I have long considered it a special mission to create the same rural payment opportunities that many of our Nation's urban counterparts enjoy. Representing a western State, I understand the challenges our rural hospitals and providers face to deliver high-quality medical care to families in environments with more limited resources.

In the Senate, rural health-care policy boasts a long history of collaboration and cooperation on both sides of the aisle. Take, for example, back in 2003 when we passed the Medicare Modernization Act. The MMA included a comprehensive health-care package tailored specifically with rural communities, hospitals, and providers in mind. The MMA finally put rural providers on a level playing field with their neighbors in larger communities.

The law also put into place common-sense Medicare payment provisions that help isolated and underserved areas of the country provide access to medical care as close to home as possible.

However, while the vast majority of rural health payment policies enacted in the MMA were permanent, some were only temporary. In the years following, these temporary provisions have become known as the Medicare extenders. As many of us know, the problem with extenders is that annual debate over necessary funding often takes priority over developing a more robust, strategic plan for the future.

Although some partisan and bipartisan health-care policies have since altered Medicare payments, many rural and frontier health-care providers still face significant obstacles attempting to successfully participate in Medicare's delivery system reforms and bundled payment arrangements.

And while these changes continue to emphasize new ways to pay providers, Medicare's existing strategies to preserve access to health care in rural areas still rely on special reimbursement programs that either supplement inpatient hospital payment rates or provide cost-based hospital payments.

Now, these special payment structures may work just fine in certain parts of the country. But even with the wide range of special Medicare rural payment programs, some smaller communities are home to hospitals that still find it hard to achieve financial stability. The reasons, as we will learn from the expert witnesses on the panel today, are complex and multifaceted.

For example, when compared to their urban counterparts, on average, the 4 million Medicare beneficiaries living in rural and frontier areas are less affluent, suffer from more chronic conditions, and face higher mortality rates.

To make matters worse, small rural hospitals continue to be more heavily dependent on Medicare inpatient payments as part of their total revenues. At the same time, we are seeing a steady nationwide shift away from inpatient care to providers offering more outpatient services, it seems to me.

Many rural hospitals serve as a central hub of community service and economic development, but some struggle to keep their facilities operating in the black in order to meet local demands for a full range of inpatient, outpatient, and rehabilitation services.

Resolving these issues is no easy task. Clearly, for some communities, Medicare's special rural payment structures may stifle innovations that could pave the way for more sustainable rural health-care delivery systems.

One consistent theme that we will hear from our witnesses today is the need for flexibility. They are not asking Congress for a one-size-fits-all Federal policy. They want the flexibility to design innovative ideas that are tailored to meet the specific needs of the communities they serve. They need the Federal Government to support data-driven State and local innovations that have the promise to achieve results, increasing access to basic medical care, lowering costs, and improving patient outcomes.

But the Federal Government cannot tackle this challenge alone. And while I was pleased to see CMS release its rural health strategy earlier this month, I believe that this administration, led by HHS Secretary Azar, still needs to improve coordination across the agencies within the Department to help prioritize new rural payment models while also reducing regulatory burdens on rural and frontier providers.

State and local officials must be aggressive in their efforts to design transformative policies and programs that meet their unique rural health-care needs.

And the Federal Government really needs to listen. We should listen to what these folks have to say and what some of the solutions really are.

In my view, States should be the breeding ground to test new ideas. However, it is not sustainable for every small town to have a full-service hospital with every type of specialty provider at its disposal. That is why it is so important for rural communities to work together, share resources, and develop networks.

The Federal Government must continue to recognize the important differences between urban and rural health-care service delivery and respond with targeted, fiscally responsible solutions.

By pooling our knowledge, expertise, and financial resources, we can work together to develop targeted payment policies that ensure appropriate access while also protecting Medicare beneficiaries and American taxpayers.

Now, I am looking forward to hearing some of those innovative ideas from our witnesses here today. But before I turn to our ranking member, Senator Wyden, I want to bring one important item to the attention of the committee.

The Medicare Payment Advisory Commission, otherwise known as MedPAC, has submitted a statement for the record, outlining the commission's latest recommendation aimed at ensuring access to emergency services for Medicare beneficiaries living in rural communities.

I encourage all members to review MedPAC's statement, and ask that it be made part of the official hearing record.

[The statement appears in the appendix on p. 45.]

The CHAIRMAN. With that, let me now turn to my partner on this committee, Senator Wyden, for his opening statement.

[The prepared statement of Chairman Hatch appears in the appendix.]

**OPENING STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON**

Senator WYDEN. Thank you very much, Mr. Chairman.

And first, I want to say right out of the gate that I think it is very doable to produce a bipartisan product here. We did that with respect to CHRONIC Care, we did that with respect to 10 years for CHIP. We did it, by the way, in the rural area as related to Medicare extenders, where we were talking about literally life-and-death matters like ambulances.

So I want to make sure that we understand that, on this side, we think it is very doable to come up with a bipartisan product.

Each year, I hold open-to-all town meetings in every rural Oregon county. And there, I meet with many leaders from the health-care field. And they tell me there are a few potential health-care calamities that have them afraid for what is coming down the pike.

First, many in rural communities feel that there is a wrecking ball headed their way because the Trump administration and half of Congress have spent the last 15 months trying to pull out all the stops to make enormous cuts to Medicaid. The President's budget, which, of course, is a public document, indicates that another assault could be coming.

The fact is, Medicaid is a lifeline for rural hospitals and patients. And those who have been on the front lines will tell you—those who have been out there for decades—that if you want to turn rural America into a sacrifice zone where hospitals shut down and

people cannot get the health care they need, the fastest way to do it is by slashing Medicaid.

Second, people in rural areas today feel that their local hospitals are already teetering on the brink of closing their doors. And if the local hospital goes under, that means no more emergency departments available in a crisis.

Now, this is not a far-off, theoretical problem. Decades ago, back when getting routine health care more often meant spending multiple nights in a hospital inpatient bed, rural hospitals were much more secure. They could afford then to maintain the emergency department.

But that service may be on the ropes now because rural hospitals are under such huge financial pressures. Offering a variety of inpatient services and keeping that emergency room open is extraordinarily expensive. And at the same time, more and more Americans are turning to outpatient settings for chronic care, rehab, and routine surgeries.

Since 2010, 83 rural hospitals have closed their doors, and hundreds more are in dire straits.

Bottom line: when you live in a big city, like Portland, Chicago, or Los Angeles, you take it for granted there is always going to be an emergency department nearby. But rural Americans who fear their hospital will be the next to close are left wondering, what is going to happen if their son or daughter breaks a leg in a high school basketball game?

I heard exactly that kind of concern just a couple of weeks ago in rural Oregon. Where would the family go if an older loved one suffered a stroke? Would they get to a hospital in time if dad suffers a heart attack?

Keeping these hospital emergency departments open is a key challenge when it comes to rural health care. In my view, it is step one when you are working to prevent rural America from turning into that sacrifice zone where people cannot get the care they need.

And I will just close with this point. I have already indicated I think we can produce a bipartisan product here. I mean, a country as wealthy as ours—looks like we spent about \$3.5 trillion last year on health care. For that amount of money, you could practically send every family of four in America a check for \$40,000 and say, “Here, get health care.”

It ought to be possible to guarantee that rural Americans are not on the outside looking in.

Thank you, Mr. Chairman. I am looking forward to working with our colleagues and getting that bipartisan product.

The CHAIRMAN. Well, thank you, Senator.

[The prepared statement of Senator Wyden appears in the appendix.]

The CHAIRMAN. Let me just set the record straight. The decline in rural hospitals started long before Medicaid expansion and prior to the Trump administration, of course. Rather than touting Medicaid expansion or blaming Trump, I hope we can set politics aside and evaluate whether Medicare and Medicaid are yielding an appropriate Federal response to States and communities. That is, after all, the purpose of this bipartisan hearing.

We cannot just spend more money on Medicaid and expect to solve every problem. So I look forward to continued discussion with our expert witnesses about what more can be done to ensure Federal dollars are being spent judiciously and wisely to help our rural hospitals and providers. So we need to do that.

Now, I would like to extend a warm welcome to each of our five witnesses today. I want to thank you all for coming.

Today we will briefly introduce each of you in the order you are set to testify. First, we will hear from Dr. George H. Pink, the Humana distinguished professor in the Department of Health Policy and Management at the Gillings School of Global Public Health; deputy director of the North Carolina Rural Health Research Program; and a senior research fellow at the Cecil G. Sheps Center for Health Services Research, all at the University of North Carolina at Chapel Hill.

Prior to receiving his Ph.D. in corporate finance, Dr. Pink spent 10 years in health services management planning and consulting.

Dr. Pink holds a bachelor's degree in marketing from the University of Calgary, a master's degree in health administration from the University of Alberta, and a Ph.D. in corporate finance from the University of Toronto.

Our second witness, Dr. Keith J. Mueller, will be introduced by my good friend and fellow committee member, Senator Grassley.

Senator Grassley, if you would like to, you can proceed right now with your introduction.

Senator GRASSLEY. Okay. Before I do that, since rural hospitals have been brought up, I would like to point out to my colleagues and particularly to Senator Wyden, because he brought it up, I have a bill and it goes by the acronym REACH, that I think about half the Senate is cosponsoring.

And in fact, you may even be a cosponsor of it.

I hope people will look at that, because that is an alternative to the possible closing of some rural hospitals.

It is my privilege to welcome another Iowan, Dr. Keith Mueller. Dr. Mueller is a renowned researcher who is an expert about rural health care. He is the interim dean of the College of Public Health and a professor of health management and policy at the University of Iowa. He directs the RUPRI, which is an acronym for the Center for Rural Health Policy Analysis at the University of Iowa.

Dr. Mueller has published more than 220 scholarly articles and has received national recognition for his rural health-care research.

Welcome, Dr. Mueller.

The CHAIRMAN. Thank you, Senator.

Senator GRASSLEY. Yes.

The CHAIRMAN. Next to speak will be Ms. Konnie Martin. She will be introduced by our friend and colleague, Senator Bennet.

Senator Bennet?

Senator BENNET. Thank you, Mr. Chairman.

And thank you so much for holding this hearing.

Rural communities have long been struggling with the scarcity of health-care providers and facilities. This has exacerbated the challenge of responding to the opioid epidemic, which has hit rural Americans particularly hard.

I am pleased to introduce my fellow Coloradan Konnie Martin, the chief executive officer of San Luis Valley Health, an independent nonprofit health system in Alamosa, CO. Ms. Martin has been working to serve the health-care needs of rural Coloradans in the San Luis Valley for more than 30 years.

Prior to being named CEO in 2013, Ms. Martin served as San Luis Valley Health's chief operating officer. She completed advanced leadership training at the Regional Institute for Health and Environmental Leadership at the University of Colorado, also the health-care executive program at the UCLA Anderson School of Business. She graduated from the University of Arkansas at Monticello.

Ms. Martin also plays a pivotal role in the local community. She is the Adams State University Presidential Search Committee's community liaison and a member of the Alamosa County Economic Development Corporation.

I look forward to hearing Ms. Martin's testimony.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Bennet.

Now, our fourth witness to speak will be Ms. Susan K. Thompson, who is also from Iowa and who will also be introduced by Senator Grassley.

So, Senator Grassley, take it away.

Senator GRASSLEY. Sue, it is my privilege to introduce you to the committee.

She is a senior vice president of integration and optimization for UnityPoint. Sue was also the CEO of UnityPoint Accountable Care, a nurse by training, and she is the first Iowan to be named to the Medicare Payment Advisory Commission—as you said, Mr. Chairman, known as MedPAC for short.

Sue's professional achievements and expertise will speak for themselves. However, I would like to say that a part of her legacy is sitting behind her today, so I am going to talk about her family, who are involved in rural health care as well.

Nate Thompson is Sue's son. Nate is the CEO of Story County Medical Center, a critical access hospital in Nevada, IA.

Ashley Thompson is Sue's daughter-in-law and Nate's wife. Ashley is a government relations specialist for UnityPoint.

Dr. Katelyn Thompson is Sue's daughter. Dr. Thompson is a psychiatrist working with the Berryhill Center for Mental Health, a community mental health center in Fort Dodge, IA.

And Chad Baedke is Sue's son-in-law and Dr. Thompson's husband. Chad is the director of physician billing operations for UnityPoint clinics.

So, Sue, it seems to me like your family is as much involved in rural health care as you are. Welcome to the committee.

The CHAIRMAN. Well, thank you, Senator, for providing that kind introduction.

Our final witness will be Dr. Karen M. Murphy, who will be introduced by our good friend and colleague, Senator Casey.

Senator CASEY. Thank you, Mr. Chairman.

I am privileged to introduce Dr. Murphy. Dr. Murphy is chief innovation officer at Geisinger Health System. I know her from our home town. And she has a long record of service in health care.

She served our State as Pennsylvania's Secretary of Health. She was president and CEO of the Moses Taylor Health Care System, which is just blocks from my home.

Her education is substantial: a doctorate of philosophy and business administration from Temple's Fox School of Business, an M.B.A. from Marywood University—my mother and my daughter and my sisters would want me to mention Marywood—a bachelor of arts from the University of Scranton, and a nursing diploma.

So, whether it is nursing itself, which was her calling, or a real commitment to the reform in the health-care delivery system, in so many ways, Karen has brought a passion and a degree of excellence to these issues that I think is unmatched.

So, Karen, Dr. Murphy, welcome.

The CHAIRMAN. Well, thank you, Senator Casey, for rounding off our introductions.

I would also like to thank the witnesses for being here today. And in particular, I thank them for their testimony and in advance for their patience and their flexibility, as members will be moving in and out of today's hearings because we have other markups going on right now.

I have two or three markups going on right now. Personally, I have to leave to attend a Judiciary Committee markup.

Now, with all of that out of the way, Dr. Pink, we will begin with your opening remarks.

Dr. Pink?

**STATEMENT OF GEORGE H. PINK, Ph.D., DEPUTY DIRECTOR,
NORTH CAROLINA RURAL HEALTH RESEARCH PROGRAM;
SENIOR RESEARCH FELLOW, CECIL G. SHEPS CENTER FOR
HEALTH SERVICES RESEARCH; AND HUMANA DISTINGUISHED
PROFESSOR, GILLINGS SCHOOL OF GLOBAL PUBLIC
HEALTH, UNIVERSITY OF NORTH CAROLINA, CHAPEL
HILL, NC**

Dr. PINK. Chairman Hatch, Ranking Member Wyden, and members of the committee, thank you very much for the opportunity to testify today on behalf of my colleagues at the North Carolina Rural Health Research Program and the Gillings School of Global Public Health at the University of North Carolina at Chapel Hill.

We research problems in health care and rural health-care delivery and are funded primarily by the Federal Office of Rural Health Policy.

I am here to discuss what we know about rural hospital closures. And I will start with an all-too-common story. Coalinga Regional Medical Center in Coalinga, CA is a 24-bed acute care hospital with 200 employees. On May 1st, it announced that after 18 months of losses totaling \$4.5 million, it is insolvent and will close all services in June.

The closure will leave residents in the rural Fresno County city of 17,000 people without an emergency room. The nearest hospital is Adventist Health in Hanford, which is over 40 miles away.

Coalinga will be the second hospital in the San Joaquin Valley to close in the past 6 months. Tulare Regional Medical Center, a 112-bed hospital, closed 6 months ago.

Across the country, 125 rural hospitals have closed since 2005—83 since 2010.

Why is this happening? For many reasons, but long-term unprofitability is an important factor. Years of losing money results in little cash, debt payments that cannot be made, charity care and bad debt that cannot be covered, older facilities, and outdated technology.

Why do they lose money? Small rural hospitals serve patients who are older, sicker, poorer, and more likely to be un- or under-insured. They staff emergency rooms often in communities with small populations and low patient volumes.

Combine this with reimbursement reductions, professional shortages, and many other challenges, and you can see why I prefer being a professor to a rural hospital executive.

What happens after a closure? Some convert to another type of health-care facility, but more than one-half no longer provide any health-care services. They are parking lots, empty buildings, and apartments.

Patients travel an average of 12½ miles more to the next-closest hospital, but many travel 25 miles or more. For the old, poor, and disabled who cannot afford or do not have access to such transportation, these distances can be very real barriers to obtaining needed care.

Who is most affected? We have investigated communities served by rural hospitals at high risk of financial distress, because they may be the next facilities to close. These communities have significantly higher percentages of people who are black, unemployed, lacking a high school education, and who report being obese and having fair-to-poor health. In other words, vulnerable people.

If the hospitals that serve these communities reduce services or ultimately close, already-vulnerable people will be at increased risk.

What can be done? We can try to improve what we have by exploring ways to better target Medicare payments at rural hospitals in greatest need and where closure would have the greatest adverse consequences on the communities.

Preferably, we should develop something new. At meetings around the country, the most common frustration I hear is the lack of a model to replace a distressed or closed hospital. We have acute care, inpatient hospitals with emergency rooms on one end, and we have primary care clinics on the other end. We need something in between.

There is no shortage of innovative ideas. Eight to 10 new rural models have been proposed by various organizations. The profound challenges facing providers that serve rural communities are not going away. We need to step up the pace of innovation, faster evaluation and implementation of new models, and development of the Medicare policies and regulations that will allow and sustain them.

Thank you again for the opportunity to discuss these issues with you today, particularly because, during the past 35 years, some of the most innovative and effective developments in rural health policy have emerged from the Senate Finance Committee.

The CHAIRMAN. Well, thank you so much.

[The prepared statement of Dr. Pink appears in the appendix.]

The CHAIRMAN. We appreciate having you here, and we appreciate your expertise.

Dr. Mueller, we will turn to you now.

STATEMENT OF KEITH J. MUELLER, Ph.D., INTERIM DEAN, COLLEGE OF PUBLIC HEALTH; DIRECTOR, RUPRI CENTER FOR RURAL HEALTH POLICY ANALYSIS; AND GERHARD HARTMAN PROFESSOR OF HEALTH MANAGEMENT AND POLICY, UNIVERSITY OF IOWA, IOWA CITY, IA

Dr. MUELLER. Chairman Hatch, Ranking Member Wyden, members of the Finance Committee, thank you for this opportunity to share my perspectives on key issues in rural health and related policy considerations.

While some things have changed in the 30 years I have been conducting rural health research and policy analysis, the underlying dynamics remain much the same. But we have new tools, both in health-care delivery and through public policy, to help us continue our quest to establish a high-performance health system in rural America.

We have had an interesting ride in policy debates and developments over that time, including weathering the aftermath of creating prospective hospital payment in the 1990s, considering health-care reform in those years, major changes in Medicare payment and benefits, changes through the Patient Protection and Affordable Care Act, and now a renewed and welcome discussion of what we should be doing to best serve the needs of rural residents.

I have benefited from exchanges with this committee and others throughout, starting with a conversation Senator Roberts and I had when I testified as part of the RUPRI Health Panel, which I now chair, to the House Committee on Agriculture in 1993.

We provided analysis of five reform proposals, including the Health Security Act, by assessing their impacts on key rural considerations.

Senator Roberts may remember—and it looks like he does—sharing an appreciation for the straightforward analysis that we provided, which helped give me the confidence to continue bringing forward the best we can offer from policy analysis.

Of course, then-Representative Roberts may not have liked the thumbs-up, thumbs-down table of our conclusions that my local newspaper provided displayed during the hearing.

The RUPRI Health Panel launched in 1992 to bring rural dimensions front and center in policy discussions. We provided analysis during development and implementation of major national policies, including the Balanced Budget Act of 1997, the MMA that Senator Hatch referred to in 2003, and, of course PPACA in 2010.

We provided feedback to this committee and others during policy formation and followed up with analysis of rural impacts of new policies, including calling attention to unintended consequences of the BBA in 1997 before that term was as ubiquitous as it is now.

I have come to appreciate the nexus of what we do in the research community with the concerns and needs of our colleagues developing health-care services.

As president of the National Rural Health Association in 1996, I represented the needs of rural providers in policy discussions.

One of my funded projects in the early 1990s was working with providers in Nebraska and Iowa to develop a template for a provider-sponsored Medicare+Choice plan. Much of my research now involves visits to rural health-care organizations to understand the implications of Medicare and other policies on what they do.

My engagement and that of the RUPRI Center, the RUPRI Health Panel, the Rural Telehealth Research Center based in Iowa, and collaboration with others covers a host of specific topics of interest to this committee, including Medicare Advantage, rural ACOs, rural pharmacy, implications of changes in health-care delivery and organization, delivery system reform initiatives, the evolution of the marketplace in health insurance coverage, and the role of telehealth.

My written testimony includes specific research findings on some of those topics, along with policy considerations.

I would like to share some important questions to consider for the future of the Medicare ACO program.

Are there benefits other than savings related to changes in delivery models that help achieve the triple aim of patient experience, better health, and lower costs?

Should there continue to be different tracks?

Should variations of advance payment, perhaps as grants, continue to be available?

Finally, what is the next iteration of payment reform that builds from the experiences of ACOs? Perhaps global budgeting, which we will hear about later.

I now offer the RUPRI Health Panel's five rural considerations for policies designed to encourage delivery system reform. One, organize rural health systems to create integrated care. Two, build rural system capacity to support integrated care. Three, facilitate rural participation in value-based payments. Four, align Medicare payment and performance assessment policies with Medicaid and commercial payers. And five, develop rural-appropriate payment systems.

In general, policies should be sensitive to the rural practice environment, including population density, distance to providers, and the need for infrastructure investment.

New models can build on the strengths of the rural system, notably primary care.

Thank you for this opportunity, and I look forward to your questions.

The CHAIRMAN. Well, thank you.

[The prepared statement of Dr. Mueller appears in the appendix.]

The CHAIRMAN. We appreciate having your testimony here today.

So we will go to Ms. Martin now at this point.

**STATEMENT OF KONNIE MARTIN, CHIEF EXECUTIVE OFFICER,
SAN LUIS VALLEY HEALTH, ALAMOSA, CO**

Ms. MARTIN. Thank you for the opportunity today to share our health-care story.

I am the CEO of a small health-care system located in the San Luis Valley, which is a rural, agriculture-based community in

southern Colorado. We serve six counties, an area roughly the size of Massachusetts, and are the safety net for our nearly 50,000 residents.

Two of our counties are the poorest in Colorado. Nearly 70 percent of our patients are covered by Medicare or Medicaid, with less than 20 percent having commercial insurance.

With this challenging payer mix, we have a constant struggle to remain financially viable. SLV Health and the rural hospitals around the country are appreciative of this committee's commitment to rural communities, and we are hopeful that meaningful help is on the way.

Our system is comprised of a 49-bed sole community hospital and a 17-bed critical access hospital. We operate five rural health clinics, two of which are provider-based. This past year, we provided 2,500 hospital visits, 58,000 outpatient services, and over 65,000 clinic visits.

We are a level-three trauma center and the only facility that delivers babies, provides surgery, or has any type of specialty care for 120 miles in any direction.

We serve veterans, farm workers, college students, tourists, and our own friends and families. We are a resilient and creative team of health-care providers.

We are the largest employer in our region, with a staff of over 800. Many of them have lived in the community their entire lives, and their families for generations.

As for me, I moved to the valley in 1985, and I began my health-care career in an entry-level IT position, back when the personal computer was new technology, and have worked my way into the current CEO role.

Our staff struggles with the cost of meeting regulatory requirements, which are often different and sometimes conflicting across payers. Our system must report on dozens of measures for the Medicare quality and pay-for-performance programs. However, our private insurers ask us to report yet more, sometimes on the same topic, but using a different definition. This complex and confusing data reporting takes time away from what really matters, which is delivering on our health-care mission.

Recruiting and retaining a qualified workforce is another challenge for rural providers. We have been fortunate to form partnerships with local and State schools that help develop and maintain our workforce. Specifically, we have multiple grow-your-own programs, from paramedic training to hosting medical students, internships, and mentoring those who are pursuing a health-care M.B.A.

We collaborate with the local community health center to host a rural residency training track program. We are set to have the first two physicians complete this training in June of 2019.

We do have our workforce success stories to celebrate as well, with two family medicine physicians in our system who returned to their childhood homes to care for friends and neighbors, and we have a physician who came during college to serve as a volunteer in a local shelter, and today he is a surgeon in our organization.

Rural communities pride themselves on hard work and taking care of their own. However, Federal payment systems and delivery

models must recognize the unique circumstances of providing care in a rural community, and they must be updated to meet the reality and challenges of how health care is delivered today and into the future.

About 10 years ago, the critical access hospital that is part of our system now, approached us for help. Nearing closure and in dire financial condition, we entered into a partnership to provide management services and financial support.

In 2013, this critical access hospital fully merged into the system that is today San Luis Valley Health. This type of arrangement prevented a hospital closure, but such partnerships are not available to many rural hospitals. We see the result, with hospital closures across the country, and today, 12 rural hospitals in Colorado are operating in the red.

Therefore, I am here today to ask for your support and consideration for new financial models that consider our needs, including the creation of a 24/7 rural emergency medical center designation, such as the American Hospital Association has recommended and Senator Grassley has championed.

And I ask you to provide appropriate resources, flexibility, and ongoing dialogue with those of us in rural America who stand ready to innovate, work hard, and meet the current challenges of caring for our friends and neighbors.

In a country as great as ours, where you live should not determine *if* you live.

Thank you.

The CHAIRMAN. Thank you so much.

[The prepared statement of Ms. Martin appears in the appendix.]

The CHAIRMAN. Ms. Thompson, we will turn to you now.

STATEMENT OF SUSAN K. THOMPSON, M.S., B.S.N., R.N., SENIOR VICE PRESIDENT, INTEGRATION AND OPTIMIZATION, UNITYPOINT HEALTH; AND CHIEF EXECUTIVE OFFICER, UNITYPOINT ACCOUNTABLE CARE, WEST DES MOINES, IA

Ms. THOMPSON. Thank you and good morning. Thank you for this great opportunity to address the committee on several of the challenges facing health care in rural America and to offer up some ideas for potential solutions.

Now, I would be remiss if I did not take this opportunity to publicly thank our Senator from Iowa. Senator Grassley has made access to quality health care in rural regions of our country a relentless priority.

Thank you, Senator, for everything you do for Iowa and for our country.

Before assuming my job at the corporate office of UnityPoint Health, I was the CEO of a small health system affiliated with UnityPoint in Fort Dodge, IA. Trinity Regional Medical Center is a 49-bed hospital, including a group of physician clinics and home-care services that over the years have held the designations of a 200-bed PPS hospital, a sole community hospital, a rural health clinic, and most recently, a tweener as it participates in the rural demonstration program.

Trinity has formal management agreements with five critical access hospitals and close referral relationships with sister Unity-

Point metropolitan markets, including Des Moines. But possibly the most unique experience Trinity has participated in to date has been as a Medicare Accountable Care Organization, an ACO.

Classified as a Pioneer ACO, Trinity took responsibility for improving the quality and lowering the total cost of care for approximately 10,000 Medicare beneficiaries attributed to them in this rural northwest Iowa community. They did this successfully and continue to do so as a next-generation ACO.

It is through this work that challenges facing rural health communities, hospitals, and providers have become so palpably clear to us.

The first challenge to highlight is the dichotomy in incentives that exists between those who operate under total-cost-of-care programs, like ACOs, Medicare Advantage plans, and bundled payment programs, and their rural counterparts, who operate under fee-for-service, cost-based reimbursement methods.

While the former looks to keep members healthy and out of the hospital, the latter is rewarded when hospital beds are full of Medicare patients. If the two groups worked in isolation of each other, this might work. But they do not. They are intrinsically woven together.

The beneficiaries attributed to the Trinity Pioneer ACO move in and out of the rural facilities in the region.

When regarding value-based payment models, the rural groups would ask, "Where do we fit in?" And to date, the answer to that question has been, "You do not."

The policy approach has been to exempt them from value-based policy altogether. We submit that this approach is not working and needs to change. Rural health care can fit into value-based payment models.

So you wonder, is UnityPoint Health advocating that cost-based reimbursement be deconstructed? And to that, we answer "no." We are requesting it be renovated.

This brings me to the second challenge I must highlight, and this challenge is the greatest: access to health-care services in rural areas.

Bringing quality care to rural Americans comes at a cost, and the cost is distinct from the actual provision of the medical service. These additional, unique costs relate to the time and the distance from major service centers, lack of comprehensive community services, and health-care workforce dead zones.

We propose that the renovation of health-care delivery in rural areas include a value-based component tied to quality medical outcomes and expenditures and that a separate and distinct payment structure be developed for the portion of cost-based reimbursement that pays for the costs associated with access in rural areas.

While our written testimony goes into greater detail about how such a system could be structured, I offer you some playful dos and just one do not as we design this type of system.

The dos: Do encourage the CMS Innovation Center to develop pilots that test Medicare Advantage programs designed to work in rural markets like Iowa. We see great potential for Medicare Advantage to bring the benefits of population health methods to rural areas.

Do design ACO benchmarks to accommodate for the additional cost of bringing access to rural markets.

And do support bills, like the REACH Act, that allow rural hospitals to transition to new designations designed to meet modern needs.

And do continue to allow telehealth practice to extend the reach of our in-person providers.

And with the utmost respect, just one do not. Do not embrace a policy that allows freestanding ambulatory surgery centers to establish residence in rural markets and cherry-pick patients by procedure, further straining the viability of community hospitals.

I challenge you to find one for-profit, freestanding ASC that has an emergency room.

In closing, health-care entities are the backbone of many of our rural communities. We need our rural health-care delivery systems to be viable. We need them to make the transition to rural health-care access centers we know they can become.

Thank you for this opportunity to share these views.

The CHAIRMAN. Thank you.

[The prepared statement of Ms. Thompson appears in the appendix.]

The CHAIRMAN. Dr. Murphy, we will turn to you. You will be our final witness.

STATEMENT OF KAREN M. MURPHY, Ph.D., R.N., CHIEF INNOVATION OFFICER AND FOUNDING DIRECTOR, GLENN STEELE INSTITUTE OF HEALTH INNOVATION, GEISINGER, DANVILLE, PA

Dr. MURPHY. Chairman Hatch, Ranking Member Wyden, and members of the committee, thank you for inviting me to testify today about rural hospitals.

In addition to my clinical background, which you have already heard, I spent 2 years at CMMI before assuming my role as Secretary of Health, working on the State innovation models initiative.

Today I would like to share the development of an innovative payment and delivery model that was developed when I served as Secretary of Health in Pennsylvania.

I began my tenure as Secretary of Health assessing the status of the health-care delivery systems in Pennsylvania. I was struck by the financial instability of the rural hospitals. In research, I found that the situation in Pennsylvania was being replicated across the country.

Pennsylvania has the third-largest rural population in the United States. Sixty-seven of our 169 hospitals in Pennsylvania are in rural communities. More than 58 percent of those hospitals in rural areas have mounting financial pressure resulting in break-even or negative operating margins.

We began to look for a solution.

After having worked on the Maryland all-payer model while at CMMI and seeing the impressive results, we decided to design a similar model for rural hospitals in Pennsylvania.

We worked collaboratively with CMMI on designing the model. I would also like to acknowledge Senator Casey and his office's support as we designed this model.

The design period was launched in January of 2017. The objective of the model was to provide a path to improving health and health-care delivery in rural communities.

The model changes the way participating hospitals will be reimbursed. The model replaces the current fee-for-service system with a multi-payer global budget based on the hospital's historic net revenue.

Like Maryland, the payment model in Pennsylvania is designed to include all payers. However, it was necessary to develop a new methodology, since Maryland has the authority to establish hospital rates and Pennsylvania does not.

The model moves rural hospitals from focusing inpatient-centric health-care services to a greater focus on outpatient-centric health-care services, with an emphasis on population health and care management.

It replaces the current fee-for-service system, with little emphasis on quality and safety, to a payment model that includes direct incentives to improve quality and safety and eliminate subscale service lines.

Rural hospitals are encouraged to move from traditional models delivered directly on-site to innovative care models that are enabled by technology, such as telehealth, video conferencing, and remote monitoring. The vision is that rural hospitals will invest in care coordination, such as reaching out to patients who frequently use the emergency room services and connecting them with a provider.

It also includes population health and preventative care services, such as chronic disease prevention programs and behavioral health initiatives, including those targeting substance abuse disorder, with the expansion of medical homes to include medication-assisted treatment programs.

Participating hospitals will have the ability to invest in social services that address community issues that lead to detrimental health outcomes.

Based on the global budget, participating hospitals are expected to develop a transformation plan that could outline an innovative approach to improving health and health-care delivery for the communities they serve.

They are encouraged to work with community agencies, such as United Way, area agencies on aging, and drug and alcohol treatment centers, to develop services based on their community needs.

To provide participating hospitals with transformation support, Pennsylvania plans to create a Rural Health Redesign Center.

CMS has entered a cooperative agreement with Pennsylvania to provide up to \$25 million over 5 years to support the Rural Health Redesign Center. This will provide a way to deploy capabilities to support all participating hospitals.

Pennsylvania is planning to engage six hospitals in the initial performance year, gradually expanding to 30 rural hospitals in Pennsylvania.

At Geisinger, we are a participant in the initial phase. Dr. David Feinberg, Geisinger's CEO, has been a staunch supporter of the initiative since its inception, as it builds on our vision for building a

health-care delivery system that focuses on improving health and value-creation for each community we serve.

We are looking forward to working with the State on this very important initiative.

The financial challenges of rural hospitals today are the result of a changing health-care industry. They may not be able to offer the same services that they did in the past, but it is possible that they can be leveraged to improve the health of those residing in rural communities.

Next week, I will be speaking at the Global Budgeting Summit at Johns Hopkins University. Twenty-six States have registered to participate. The Federal Government has the opportunity to engage additional States in the Pennsylvania rural health model. Implementing across diverse States would give us the opportunity to evolve this innovative payment and delivery model.

Thank you for your interest in aiding rural hospitals. I too believe rural communities deserve access to health care, and we must continue to work to identify innovative approaches that are a pathway to that goal.

The CHAIRMAN. Well, thank you so much.

[The prepared statement of Dr. Murphy appears in the appendix.]

The CHAIRMAN. I think this testimony has been very interesting today.

Let me just start with you, Ms. Martin.

In your testimony, you referenced times when your hospital system has been on the verge of financial crisis in the past. How did you leverage resources and streamline service delivery or operation lines to stay financially viable? And can you talk about what you think an appropriate Medicare margin should be for small, non-profit, rural hospitals like yours?

Ms. MARTIN. Thank you, Senator.

I think it is interesting when you talk about margins for rural hospitals. I think any margin would be helpful to so many rural hospitals.

I think for my system, located in the rural part of Colorado, if we can be in a margin area of 3 to 5 percent, we consider that a very successful year.

And so I think different areas have different needs. So much depends on your infrastructure and what you need to replace as far as equipment and facilities go. So I think for our system and from my perspective, that is the margin that we are trying to achieve. But so many times, we are under 1 percent or sometimes in the negative.

I think what we did initially over these past few years is put our two systems of care together, the critical access hospital and our sole community hospital. And we used the economies of scale. You know, we have one CEO for that rural system of care, we have one finance department, we share a lot of services between our two organizations, and that makes it cost-effective to run the different departments.

You know, we have a person who is an expert in laboratory or a person who is expert in imaging, and they help a larger organization when you can divide them across a couple of communities.

The other thing we do is, we are just very frugal. I think in rural America, we are very thoughtful about what we buy. We do not provide services that our community does not need, because we do not have that luxury. We have to match our services to the needs of our community.

We have built our primary care base over these past few years, and that has made a substantial difference with keeping our care close to home. And we have added specialty services that are the highest need for our patients and our community. For instance, we have added oncology services in the past 3 years. We started out with a model where we brought a specialist a day or two a month, and we have built that to where we could have a full-time provider.

I think part of our challenge is, with one single specialist in a rural community, you know, you have to have the connections to have coverage and support for that individual.

So those have been some of our strategies. We are not a lucrative health system at all.

The CHAIRMAN. Well, thank you.

Let me go to you, Dr. Murphy.

First, let me say that there is a lot of excitement around the Pennsylvania rural health model. It clearly holds great promise. And I am personally pleased to see CMS working with States to design innovative rural health-care payment strategies.

Is there any concern under Pennsylvania's new multi-payer global budget payment method that rural hospitals might lose incentives to be efficient in providing health-care services? And secondly, how do you think your State's rural hospitals will figure out ways to lower costs and improve health outcomes if they already know what they are going to get paid for procedures under the global budget?

Dr. MURPHY. Well, thank you, Senator. And I think the challenge—which is why I recommend that CMMI look to expand the test—is to determine if we can successfully transform rural hospitals in a way that is efficient and improves population health as well as health-care delivery services.

There is a monitoring component within the global budget methodology—the model is being evaluated from day one—that will determine the appropriateness of the services and the possibility for unintended consequences to occur. So that is built in within the test of the model.

But I think the goal here—the difference is there is a transformation plan that goes along with the global budget with monitoring metrics throughout the life of the global budget. So the hospital is going to be very tightly monitored as we go through implementing the global budget.

I can assure you that certainly Medicare would be concerned about that, as would all the other commercial payers.

So I believe the model is robust in the way that it will measure for those unintended consequences.

The CHAIRMAN. Well, thank you.

Let me turn to Senator Wyden.

Senator WYDEN. Thank you very much, Mr. Chairman.

I think this has been a terrific panel.

And next week when I have open-to-everybody town meetings in Prineville, Paisley, and Joseph, OR, I am going to remember what you said, Ms. Martin, that where you live should not determine if you live.

And I can just tell you, I looked around the room and practically the whole place got whiplash when you said that, because that really sort of sums up the challenge.

Colleagues, let me give you my sense of where we are in terms of the bipartisan possibilities going forward. We had the Bipartisan Budget Act, we got 5 years additional funding for several important programs for rural communities, extending the Medicare-dependent hospital program, increasing payment for low-volume hospitals, and, as I touched on earlier, the ambulance add-ons. So that at least gives us some measure of predictability for the next 5 years.

But it seems to me we have really got some heavy lifting to do in the next 5 years. I think we understand that this calamity did not arrive on us in 15 minutes; we are not going to solve it in 15 minutes.

So what I would like to do for purposes of going forward in a bipartisan way here under the efforts of colleagues on both sides is, I would like to just go down the row and have each of you give me what would be your top priority for Medicare as it relates to longer-term stability for rural providers and particularly for rural seniors in our country. Because we know that we have a disproportionate number of seniors in rural communities.

So right down the row: top priority for Medicare for this long-term stability that we have a chance to work on, because we have at least a little predictability for the next 5 years.

So just go right down the row.

Dr. PINK. Thank you, Senator. We have talked to people in communities where rural hospitals have closed, and almost always the first thing we hear is the disappearance of the emergency department, the emergency room.

So I would say my top priority is maintaining access to emergency care.

Senator WYDEN. Good.

Dr. Mueller?

Dr. MUELLER. I would say mine would be building that integrated system that I talked about that would include non-hospital-based services, particularly both post-acute care after a hospitalization and care for the elderly with chronic conditions, which was, in part, addressed by the CHRONIC Care Act. And we need to move forward with some of the innovations that are coming out of that.

Senator WYDEN. Good.

Ms. Martin?

Ms. MARTIN. The flexibility to develop a model in each rural community that meets their needs so that they can keep emergency care and can keep services.

Senator WYDEN. That is a very good point. What would be your top priority for flexibility? Because we are all interested in that.

Ms. MARTIN. Right. I think it would be to allow critical access hospitals to develop, to merge into a different model, which would limit their need to have inpatient beds and to be able to be emer-

gency departments and do outpatient care and keep the financials healthy in that model.

Senator WYDEN. Good.

Ms. Thompson?

Ms. THOMPSON. Top priority would be recognition of the difficulty in acquiring and retaining providers to rural communities.

Senator WYDEN. So if you could wave your wand, what would we pursue, because that is enormously important. What would we do by way of provider policy?

Ms. THOMPSON. Rural health care and rural communities create an environment that is unique in this country. The community cares for each other. And I think the opportunities that are before us that have been demonstrated in some of our ACO models create not only an integration of hospitals and physicians, but in all components of health care across the continuum, this kind of an environment that is motivating, that is inspiring, and I think, quite frankly, could create a platform for transforming health care for the country.

Senator WYDEN. Let us do this, because I want to give Dr. Murphy the chance to wrap up this round.

I would like to—and the chairman is always very gracious about this—let us keep the record open for you all to give us as many concrete ideas for getting more providers to rural America, because this is enormously important. And we have tried loans, and we have tried this and that.

And look, we all understand that year after year we are faced with this question of whether there is going to be anybody to keep the lights on. In other words, you have buildings and light, but you have to have people who can run them.

Dr. Murphy, your one priority for Medicare as we kind of use this period where we have 5 years to kind of really push hard for the longer term?

Dr. MURPHY. Expand the test for global budgets to different States.

Senator WYDEN. Very good.

Mr. Chairman, thank you. Only 7 seconds over.

The CHAIRMAN. Okay.

Senator Roberts?

Senator ROBERTS. Thank you, Mr. Chairman. I am very grateful that we are holding this hearing on rural health care in America. It is long overdue that Congress tries to focus on the unique needs, as espoused by all the witnesses, of people in rural areas, the health-care challenges faced by these constituents.

I have the privilege of serving as the co-chair of the Senate Rural Health Care Caucus, along with the ever-enthusiastic and helpful co-chairman, Senator Heidi Heitkamp of North Dakota. We have very similar problems or challenges—we do not have problems, we have challenges.

We have long said that rural residents deserve the same quality health care as their urban counterparts. I think every witness has gone over that. There is no reason why rural communities should be left behind as other areas continue to advance their health-care systems.

Dr. Mueller, thank you so much for reminding everybody that I was here in 1993, as you were. [Laughter.]

And that indicates that this has really been a long-term battle. I can remember clear back when it was not HHS, it was HEW, Secretary Joe Califano.

I think you remember the time that, all of a sudden there was a regulation that came out that said that, before any rural hospital could receive a Medicare reimbursement, three doctors had to review all of the patients that came in and the procedures. And the team of three doctors had to do this every 24 hours. That was ludicrous. I do not know who came up with that.

But then I decided it would be a good thing to be for that, because maybe one of the doctors would stay if in fact they were inspecting the hospital. But it has been a long-term effort.

I want to focus—by the way, we have 86 critical access hospitals in Kansas. And I hope that when we renovate—I think Ms. Thompson said we should renovate, we should not eliminate.

We are on first base or second base, you know, trying to hold on. I do not want to get picked off by all of a sudden saying “no” to the critical access or moving to some other thing without really knowing where we are going.

I want to really concentrate on the workforce situation. And I would like you all to comment on that.

Recruiting, training, and retaining staff are some of the biggest challenges we have. An example in some areas—our physician assistants, our nurse practitioners may be the only primary care providers available.

We have to drive quite a few miles to get to that hospital, like you have in Alamosa, Ms. Martin.

In Wyoming, they have to travel a couple hundred miles maybe to do that.

So let us go down the panel and say—the one thing that I am really interested in is the Federal regulations that come between the provider and the patient. I am talking about the 96-hour rule, I am talking about the face-to-face regulations, things that just do not—it just takes a terrible amount of time and expense.

And if you could really focus on that, what suggestion could you make? And we will start with Dr. Pink.

Dr. PINK. Senator, I would defer that question to my colleagues who have much more expertise on that than I do, if that would be all right.

Senator ROBERTS. That would be fine.

Dr. Mueller?

Dr. MUELLER. Two suggestions. One is looking at Medicare conditions and participation and what is required for supervision. The kind of thing you alluded to from the Califano years still exists today.

And second, whatever we can do to open up even more the use of telehealth services to support the local rural health-care professionals. And we have some of that, as I mentioned earlier, in the CHRONIC Care Act to work with.

Senator ROBERTS. You mentioned telemedicine.

And I am not trying to interrupt, Ms. Martin.

But there were three unique places where telemedicine was to start out. This is back in the 1980s. One was in New Mexico with an Indian reservation, another was an island in Maine, and then the third one was Cimarron, KS between Garden City and Dodge.

And they were selected. We were about to announce that, and then all of a sudden they called up and said, "Do not announce that, we found a doctor." After all that hard work, I was very upset that they had found a doctor. And sure enough, the doctor came.

And they were not like your doctors, the two that came back. Six months, that doctor was gone. And in the meantime, we lost the opportunity for the telemedicine.

Now we have it back, and it is just, you know, very typical.

Now, you have two doctors who came back because they believed in their community and they wanted to live in a community where they could raise their family and all the good things that have been referred to by Ms. Thompson.

But on the Federal regulations side, which one would you pick?

Ms. MARTIN. I think I would pick aligning quality measures so that, as we measure value in rural communities it is with measures that are relevant to who we are and what we provide.

Right now, we report so many different measures to so many different agencies. And they are not meaningful always in moving us ahead with our quality. For instance, some of the things we report on, the volume that we do, is so small that one single fallout appears to make us look like we have a lesser quality than maybe our urban counterparts, and that is just simply not true. So I think that is a very important point.

And then the point with meaningful use. You know, the evolution of meaningful use has certainly improved the use of technology in the health-care industry, but the pace at which the change is happening and the expense that it takes rural facilities to keep up—I worry about those kind of measures really getting between the doctors and their patients.

Senator ROBERTS. Ms. Thompson?

Ms. THOMPSON. Yes, consistent with my concerns around access for providers, I would strongly recommend continuing to expand the use of telemedicine.

Senator ROBERTS. Dr. Murphy?

Dr. MURPHY. I think the two I would give—I think the relaxation of Medicare regulations in terms of allowing rural hospitals to maybe execute more innovative strategies in recruiting physicians. So we have some rules that prohibit that.

And secondly, I think the relaxation or the acceleration of the ability of the Medicare program to waive certain requirements for rural hospitals on their overall management. And CMMI does—

Senator ROBERTS [presiding]. I thank you all for your testimony. Senator Enzi?

Senator ENZI. Thank you. And I appreciate that this hearing is being held, and I appreciate the great talent that we have put together to do it.

I come from the least-populated State in the Nation. Our biggest city is 60,000. And all of our towns are at least 40 miles apart. We only have 19 towns where the population exceeds the elevation.

I have one county that is the size of Delaware. And the city—and you get to be a first-class city when you hit 2,500 people, and they just did—is 2,500 for the whole county. So we just tried to keep a hospital open there, which usually means having a physician assistant. So this is a critical hearing for us.

And I will begin my questions with Ms. Thompson.

The way Medicare pays rural hospitals, including critical access and sole community, like we have in Wyoming, is closely related to inpatient services. As medical providers have started to shift towards providing more and more services on an outpatient basis, is the inpatient metric still the most appropriate measure for hospital costs?

Ms. THOMPSON. I think that is a great point. I am not certain that it is.

You know, when we began our work in the Pioneer ACO, the entire question around utilization of inpatient services was very much at hand, because that is very much what drives the predominance of spend and what calculated the PMPM. And in the contract with the Federal Government in the ACO, we essentially made a promise that we were going to reduce that total cost of care while improving quality to the Medicare beneficiaries.

As a result of a lot of focus, work, and investment in reducing spend, we reduced inpatient utilization, and a lot of these services moved to outpatient. And what I think is more important in terms of the takeaway for this hearing is not that we reduced the spend or that we improved the quality—both quite important and both predominant components of the agreement in terms of the ACO.

What we learned—and what I believe is so important as we rethink policy around rural health care—is how strong and how absolutely woven together a rural community is in commitment to caring for its patients.

And in that lies some secret sauce in terms of how we rethink, not just payment for hospitals or how we think about inpatient or payment for physicians or payment for home care—which is typically how we think about policy development—but rather, how we look at an organized system of care of a defined community, whether it is a rural hospital with six counties they are serving, and create an accountability and motivate a community to want to come together, whether in a global payment model or in some model that gets us out of this siloed way of thinking about how we organize payment structure in rural America.

And in that way of thinking, I believe we will transform not only how we pay for care, but how care is delivered and how we recreate an entirely new health-care system.

That, to me, is the most important thing.

Senator ENZI. I am running out of time.

Ms. THOMPSON. I am sorry.

Senator ENZI. Thank you very much.

For Dr. Murphy: Medicare used to allow States to decide whether to designate hospitals as critical access. I understand we have prohibited State-based designations because of concerns they were overutilized, but we allowed hospitals that had already earned that State-based designation to keep it.

In cases where the critical access designation may have been overutilized, how do hospitals compare to the CMS definition of a critical access hospital?

Dr. MURPHY. So I think the definition of critical access hospitals, Senators, and their impact on whether a hospital is a CA or a non-CA, is probably outdated to even think about. Because the problems suffered by rural hospitals today are really because the health-care industry has changed.

And critical access hospitals, whether they are designated or not, they still have the same—all rural hospitals have the same problem. They have few resources to deliver any type of a substantial inpatient care. They are devoting all their resources to inpatient care for a very small number of patients.

The critical access hospital designation was definitely a plus for hospitals 2 decades ago, but I think what we are faced with today is that any type of assistance to hospitals that exists in a fee-for-service environment, regardless of where it is tied, is going to lead us to the same place, sitting here 2 years from now, if we do not take a look at an innovative payment model.

Senator ENZI. Thank you.

And I have some more questions, and if we have a second round, I will do those. Otherwise, I will submit them.

I appreciate all the expertise that we have here. My time is expired.

Senator ROBERTS. Senator Cassidy?

Senator CASSIDY. Now, folks, I am a physician, and I have worked in a hospital for the uninsured and often interfaced with my colleagues who are in an emergency room at some understaffed critical access hospital, but so understaffed that they frankly had to send all their patients to the hospital where I worked.

And so a lot of what I will say now will reflect that perspective.

Let me first go here. I am interested in the Medicare wage index in which hospitals with a higher cost structure get more. If you will, the more get more.

Now it seems as if under current law, based upon your geographic area, rural hospitals in my State cannot compete with the urban hospital because of Medicare policy, which tells the urban hospital, "We are going to give you more."

And so, obviously, if you are a nurse and you have to decide where to work, you tend to go where you would earn more.

The cost of wages—the current policy does not have a floor or ceiling in place for an adjustment in which the cost of wages is considered when reimbursing providers. And so, as I just said, urban hospitals get more, rural less.

I guess I could ask many of you this question. But, Dr. Pink, does the lack of a ceiling or floor for the Medicare wage index frankly give a perverse incentive for the urban hospitals to keep increasing wages to make it harder for a rural hospital in Louisiana or Iowa or Tennessee to compete and to be able to keep that nurse who lives close to home, home?

Dr. PINK. Senator, we have done some research on the various rural designations that Congress has created, and there are some of these designations where the wage index does play a key role.

For example, in one study we completed last year, we found that many of the sole community hospitals in the country—it is an important payment designation—but they are located in States which have lower wages, and therefore, for the hospitals that are eligible for that designation, in fact there is no advantage to taking it. They take the PPS payment instead of sole community.

So I believe it is an issue. We have not studied it beyond sole community hospitals, however.

Senator CASSIDY. Okay. I will say that Senator Isakson has a bill, which I cosponsor, to put a floor under the Medicare wage index, which we do think would help rural hospitals substantially.

Secondly—and I will stay with you, Dr. Pink—over the last decade, there has been a lot of consolidation in hospital systems.

Just for folks to see, Obamacare passed in about 2009, and that is kind of an inflection point. Whether or not it is causal or just associated, we do not know. But I wanted to show others to see as well.

But subsequent to 2009, we can see that the number of consolidation episodes has increased, about doubling year to year.

Now, we know that that increases cost. There is good data showing that prices at a monopoly hospital are 12-percent higher than those markets with four or more rivals. And I could give more evidence to that.

Dr. Pink, given that these mergers coincided with rural hospital closures—I do not know the answer to this; I am asking you—has consolidation by large hospital systems reduced competition or increased prices and kind of resulted in rural hospital closures?

Dr. PINK. We have not studied urban mergers and acquisitions, Senator. I can say that for many rural hospitals and small communities, merging with a larger health system has been the only option available to them, where they are literally faced with the choice of, do we do nothing or do we affiliate or are we bought by a large system?

Senator CASSIDY. Now, Ms. Thompson raised the issue of these ACOs not being extended to the rural area. But presumably, if an urban hospital consolidated, bought a rural hospital, they would just extend their ACO out to the rural area.

Ms. Thompson, has that not occurred?

Ms. THOMPSON. That has not occurred.

Senator CASSIDY. Now, *pourquoi pas*—as my French teacher would tell me to say—why not?

Ms. THOMPSON. The cost-based reimbursement model that is at place with critical access hospitals simply reduces any opportunity, because they are reimbursed based upon their costs associated with the Medicare patients they are caring for.

Senator CASSIDY. Okay.

Ms. THOMPSON. So they do not have an opportunity to see the shared savings associated in that.

Senator CASSIDY. So we get the consolidation, which may keep the doors open, but none of the extensions, the putative benefits, get extended to others.

Let me move on. I have 9 seconds left and want to fit one more in.

Ms. Martin, we have heard about the rise of freestanding ERs in places like Texas and Colorado. Several of you have mentioned that when these facilities close, frankly, folks' primary complaint is, "I want to have an emergency room nearby."

Proponents argue the facilities are providing increased access to ER care in rural areas where it is not financially feasible to have an entire acute care hospital.

The opponents argue that they are cherry-picking. And although I am told they take anybody who comes and that the physician-owned facility—the fact the physicians owned it is an issue. Currently, the facilities are not reimbursed for Medicare or Medicaid patients.

Ms. Martin, you work in Colorado. They are allowed. If we were to allow these facilities to be reimbursed by Medicare and Medicaid, would this be a good thing for your rural area, increasing access to rural ER care, if you will, or not?

Ms. MARTIN. I do not believe that it would be a good thing in the rural areas. The freestanding EDs that have originated in Colorado are all exclusively in the urban areas. They are not in the rural markets.

And I believe, in a rural market, the idea of an emergency department conversion from a critical access hospital is that you keep care located close to a community where—

Senator CASSIDY. Now, let me stop you for a second. It is impractical if somebody has a head injury that you are going to have a neurosurgeon in a rural hospital, and quite likely you will not have a general surgeon, just because a general surgeon cannot—my wife is a general surgeon; I will use the feminine—she cannot maintain her practice because there is not enough volume and/or your payer mix is so poor.

So I thought the emerging paradigm was, if you stabilize the patient, do as much as you can, but then transport quickly—would that not work in Colorado?

Ms. MARTIN. I guess what I am referring to is the freestanding emergency departments that have been created in the front-range market.

In our rural community and the hospital that I work in, we do have general surgery. And some of the critical access hospitals that neighbor us, they do a lot of stabilization and transferring. That is what we do in the rural facilities.

I think that keeping an emergency department in a rural facility is very positive and something that we need to do collectively. My statement was simply that the freestanding emergency departments that have started on the front range have not—

Senator CASSIDY. You have to wrap it up because I am way over. Okay. I am sorry, I did not mean to interrupt, but I am 2½ minutes over, and my folks have been forbearing. I apologize.

Thank you very much for your answer.

Thank you all.

Senator ROBERTS. Senator Cantwell?

Senator CANTWELL. Thank you, Mr. Chairman.

I thank the witnesses. And I thank both my colleagues for this important hearing.

Obviously, I was not here, Ms. Martin, when you gave your statement, but this statement by you about how where you live should not determine if you live resonates a lot in my State.

The access to health care through the Medicaid expansion was big in rural communities in my State. Writ large, 600,000 people in our State got expanded coverage.

But we have counties like Douglas and Chelan where, again—so the chairman knows where our apple and cherry and pear industry is located—they have seen the uninsured rate drop more than 60 percent thanks to that Medicaid expansion.

So I just wanted to ask about the importance of making sure that we keep that expansion and the importance of not allowing any kind of cap or reduction.

Under this discussion that we had, CBO was saying that the previous proposals on block granting and changing Medicaid might cut as much as a quarter out of Medicaid over the next 2 decades.

So is that problematic, Ms. Martin, for rural areas?

Ms. MARTIN. I think certainly the ACA expansion made a very positive difference in the community where my service area is, and I think in Colorado overall.

We had an uninsured rate of nearly 20 percent, and that has been reduced in my community down to low single digits.

And so the coverage for patients allows patients to get access to care. It has improved the financial bottom line of, certainly our organization.

I spoke earlier that 70 percent of our population is Medicare and Medicaid, so our relationship with government payers is critical to our survival.

Senator CANTWELL. Did you say 70?

Ms. MARTIN. Seventy.

Senator CANTWELL. And ours is up there as well, over 50. I do not know what the latest numbers are. But I do not think people quite understand that that is the challenge we face.

I mean, we love our rural economy, and we love our rural communities. They are a great place for people who are aging to retire and live. And it is more affordable, but that means it is a different mix of the population as it relates to how you build a health-care delivery system. So the Medicaid expansion is so critical to that.

I also wanted to ask about telemedicine, because that is another delivery system that I think—for us, we have this Project ECHO, the University of Washington working with Harborview. You have heard of it, obviously, probably in your State as well, but it has allowed medical professionals from Seattle to consult with people over in the Yakima Basin, some of our clinics, to talk about the decisions for really highly complex patients, for hepatitis C and substance use disorders.

So what do we do about that as it relates to the payment system? Because I do not think fee-for-service is any kind of friend to that cost-saving technology and that cost-saving collaboration that is existing.

Ms. MARTIN. I think in our community, we are modestly beginning the use of telehealth. And part of our challenge is that we do not have the resources for a lot of the startup equipment. And

some of the payment constraints do not allow us to be able to provide the service.

I think one of the best things we could do is to invest in the startup expense, particularly for rural hospitals, and then allow the services to be reimbursed on a fair basis.

We currently do telehealth now in our community for infectious disease, genetic counseling. And we are trying to build that for oncology coverage and for cardiology coverage. And it would actually save the system money.

For instance, when a person goes into our emergency department and we have one cardiologist in the community, when that person is not there, if the condition of the patient warrants, we have to transfer them to another area to be evaluated by a cardiologist. They oftentimes get transferred or evaluated and then they are dismissed from the hospital.

If we could have cardiology services available 24/7, we would save the expense of an air ambulance or a ground transport for a patient with a cardiology problem.

Senator CANTWELL. And there is no reason you cannot with telemedicine, right, with that kind of technology?

Ms. MARTIN. Yes, ma'am, that is true.

Senator CANTWELL. So it is just getting it recognized into the system in some way.

Ms. MARTIN. And paid for.

Senator CANTWELL. Right. Well, that is what I meant—recognized into the system. And that is why the challenge—just a fee-for-service model challenge.

For anybody—well, actually, I do not have any time left—but the doctor shortage issue for rural communities continues. And we just need to fight that.

And so, you know, we have counties in our State that have, like, 4,000 people and no access. So we have got to do better.

Thank you.

Senator ROBERTS. Senator Carper?

Senator CARPER. Thanks so much.

My first question for the witnesses is, how many counties are there in America?

All right; let the record show they have no idea. [Laughter.]

The answer is 3,007. Delaware has three counties, and the southernmost county is called Sussex County. It is the third-largest county in America. We do not have many of them, but we make them big. [Laughter.]

In Sussex County, we raise more chickens than any county in America. Last time I checked, we raise more soybeans than any county in America. I think we raise more lima beans than any county in America. We have more five-star beaches, I think, than any county in America. All in one county: Sussex County.

And we have a lot of rural areas and a lot of people who live in rural areas, despite all of that. We have a lot of people who live along the coast, you know, Rehoboth and Lewes and places like that, Dewey Beach, but the rest of the county is largely agriculture.

And we have some hospitals, rural hospitals. We have community-based outpatient clinics. We have a VA clinic that is actually

quite good. But we still have a lot of people who do not have access to health care because we are just so spread out in a big county.

I want to talk a little bit with all of you, now that we have gotten that out of the way, about costs that flow from tobacco use, costing our—I say our health-care system; it is actually really costing all of us.

And I understand that we are spending in this country about an extra, I want to say, \$200 billion each year because of our addiction to tobacco products. And we are spending, I am told, another \$150 billion to maybe \$200 billion a year because of obesity from one end of the country to the other, including in Sussex County.

But I am told that America's rural communities are still more likely to use tobacco products than other parts of our country. Our rural communities are also more overweight and more obese.

And I would just ask, what tools—here is my second question of the day—what tools, what resources, what delivery system reforms could we be using to reduce the disparity in rural communities when it comes to tobacco use and obesity?

And I want to start with Dr. Murphy.

Dr. MURPHY. Thank you, Senator.

Senator CARPER. I was told you are really good on this question.

Dr. MURPHY. Oh, thank you. What we have talked about earlier was a new way to pay for rural health—I do not even say rural hospitals—but a new way to reimburse rural hospitals. And it is a multi-payer global budget system that allows hospitals to focus on the problems that you just talked about. And instead of investing in subscale services, invest in tobacco cessation programs, invest in substance use disorder treatments, investment in the health status outcomes that we are looking for to end this disparity, or to gradually decrease this disparity, between rural health outcomes and those of their urban counterparts.

So that is the beauty of this model. It allows for the investment in care coordination. It allows communities to really take those chronic disease problems and reallocate the dollars that they were receiving from subclinical care services that they had to provide because that was the only way they got paid. It now allows them to address this population's health more.

Senator CARPER. Let me ask the other four witnesses. If any of you agree with what she has just said, would you raise your right hand?

All right. Do any of you have something you would like to add to what Dr. Murphy said?

Ms. Martin?

Ms. MARTIN. I would just like to add that an investment in primary care providers—because I think that is the relationship that impacts patients' behaviors—impacts patients' ongoing quality of life.

And so, in so many communities, it is the importance of the primary care provider that impacts these behaviors.

Senator CARPER. Does anybody else want to add to it?

Yes, please.

Dr. MUELLER. I would add to that the investment in public health infrastructure. And you can come at that in two ways: one, encouraging collaboration between the health-care sector, the clin-

ical sector, and the public health sector, which the ACO model does; and two, direct investment into public health agencies.

Senator CARPER. All right. One last quick question. What are your recommendations for how we can increase the supply of mental health workers and improve access to mental health treatment in rural and underserved areas?

And we will start all the way on my left, please.

Dr. Pink?

Dr. PINK. Again, I would defer to my colleagues. I have no expertise in that area.

Senator CARPER. All right; thank you.

Dr. MUELLER. One comment would be to integrate our support for behavioral and mental health services with primary care.

Senator CARPER. Okay; thank you.

Ms. Martin?

Ms. MARTIN. I think it is investing in the education and programs where, as community hospitals, we can educate and train a workforce of our own. We have an extreme shortage in the number of qualified professionals in that area.

Senator CARPER. Thank you.

Ms. Thompson?

Ms. THOMPSON. Yes. I believe it is to further study the integrated health home model that is at play with our Medicaid population. And I think there is a great deal to learn there and a great deal of excitement to create in young folks if we can get into high schools and educate and motivate them about the opportunities in mental health.

Senator CARPER. Okay.

Dr. Murphy, do you want to add anything to this?

Dr. MURPHY. I would just say leveraging the technology so that we can access, rural areas can access the more urban centers.

Senator CARPER. All right. Where have you all come from? Tell me where you are from.

Dr. Murphy, where are you from?

Dr. MURPHY. I am the chief innovation officer at Geisinger.

Senator CARPER. Oh, good. I have been there before. You guys do good work.

Yes?

Ms. THOMPSON. UnityPoint Health in Des Moines, IA.

Senator CARPER. Okay, yes.

Ms. MARTIN. San Luis Valley Health, Alamosa, CO.

Dr. MUELLER. University of Iowa.

Dr. PINK. University of North Carolina at Chapel Hill.

Senator CARPER. Okay. Well, you have come from—some of you have come from a long ways. We thank you, and we thank you for the work you do. It is really important for our country and for the people of our country. Thank you so much.

Senator ROBERTS. Senator Portman?

Senator PORTMAN. Thank you, Chairman Roberts.

And thanks to the panel. I was here earlier to hear your testimony. I really appreciate it, some of the insights about the special challenges we face in the rural areas.

I come from Ohio. We have a lot of big urban hospitals, and we have a lot of small rural hospitals. Sadly, some of them are closing down or consolidating.

And I will tell you, in my State, one of the issues that is particularly difficult to deal with in our rural areas is the opioid epidemic. And I would think if you did a per-capita analysis of the opioid epidemic in my State, you would probably find that in the rural areas the problem is even more acute than it is in some of our suburban and urban areas, although it is in every ZIP code. But the difference is really not so much the per-capita impact, but the services that are provided.

And one of the issues, as you know, is that we have more and more children who are being born with neonatal abstinence syndrome, meaning they really have to be taken through withdrawal themselves.

We have some great programs, taking moms who are addicted, weaning them off of their addiction and helping to ensure that these babies are born without the neonatal abstinence syndrome. But it is overwhelming us, our neonatal units. I am sure the same is true with you.

One of the things I am hearing about from our children's hospitals is that sometimes they can take care of the babies shortly after their birth, but then these babies go home, and there is not the ability to continue to monitor, particularly in our rural areas.

And so I guess what I am asking you today is—and I know, Dr. Murphy, you mentioned the opioid epidemic earlier. I think you were the one who talked about that.

But to the hospital CEOs, maybe you could help me a little on this. What services do your hospitals offer to support the longer-term recovery needs of these growing number of children who have this neonatal abstinence syndrome, and for their moms and their families?

And in particular, if you work with kids with NAS, how do you work to ensure that the families receive the support that they need?

Ms. MARTIN. In our community, we have certainly seen an increase in this issue. Just last year, about 11 percent of the babies that we delivered had this syndrome that you speak of.

And we have done a lot of training with our staff to have them have the skillset to help the babies, you know, for the first few weeks of life. And we sometimes keep them for that period of time.

When they move out into the homes—and oftentimes, unfortunately, they are going into foster homes because, if the mother was a user, unfortunately, they are placed in foster families. And so we have pediatricians who try to work with these families. And we have a grassroots community organization that involves the schools, early childhood development, some of our primary care providers. And together, we are trying to sort of leverage and learn about resources.

It is a challenge, because there is just not a lot of information about that. We hear from our school teachers, particularly of elementary schools, that they do not feel equipped to deal with the challenges that some of these young children bring to the classroom.

And so I think just additional resources around education and training, so that our workforce would know better how to help these children, would make a huge difference.

Senator PORTMAN. Yes.

Any others?

Dr. MURPHY. Senator, at Geisinger, we are just beginning to develop a program for moms who have substance abuse and their children subsequently born with neonatal abstinence syndrome.

So the vision for the program is that we would intervene when the mother begins medication-assisted treatment prenatally. And then we would, what we say is, wrap our arms around the mother and the baby with services such as behavioral health services, addiction medicine, counseling, pediatric services, and other social services that would enhance the likelihood of the mom staying in recovery after the baby is born.

So the idea behind it is that we would test. We would offer these services for a period of up to 2 years and evaluate the model and determine what interventions really helped that mom stay in recovery and go on to live a productive life.

Senator PORTMAN. Well, thank you.

And we did pass legislation here called the Comprehensive Addiction and Recovery Act, which has a separate title for pregnant moms, postpartum moms, and these kids with NAS.

Since that time, we passed a budget which increased the funding for that. So for those few who are not aware of that, apply for it. We are looking for good pilot programs around the country.

But I think Ms. Martin is right; Dr. Murphy is right. If we can, spend some money up front to avoid some of the longer-term problems and figure out what works.

You mentioned information and the right kind of therapies to be able to help these babies as well as their moms take advantage of this moment.

Many of these moms are facing their addiction because of their pregnancy. In other words, they do not want their kids to be born with this syndrome, so they are willing to go into treatment and, maybe previously, they were not.

And I think Dr. Murphy is right. How do you then, once the baby is born, keep them—usually it is a Suboxone treatment that is a weaning off of the opioid. How do you then keep them in that treatment program and longer-term recovery and use that family relationship to help kindle some better prospects for longer-term recovery?

So anyway, we look forward to working with you all on that. And I think in the rural hospitals, again, the rural setting, we have a particular challenge.

And I appreciate your being here today and look forward to following up.

I have another question on the Stark Law, but I will offer that as a question for the record. Senator Bennet and I have some legislation I want to get your views on. Thank you.

Senator ROBERTS. Well, thank you, Senator.

Coop, you are up next. [Laughter.]

Senator THUNE. Thank you, Mr. Chairman. It must be “High Noon.”

Thank you for holding this hearing.

We have, in my home State of South Dakota, lots of challenges in accessing health-care services in rural areas. And we have providers who work diligently coming up with creative solutions, but there are still barriers and complications that they face on a daily basis. Part of it has to do with traveling long distance and having limited transportation options. They are big hurdles for people to overcome.

And attracting providers, of course, to rural areas is another challenge that we face. Too often, we lose South Dakotans if they attend school and train in other States.

And we have a unique issue in South Dakota as well with our tribal communities, making sure that they have access to quality health-care services, due to the pervasive problems that Indian Health Service facilities throughout the Great Plains region continue to have.

So I look forward to working with my colleagues on this committee in trying to advance solutions that will address many of these challenges.

Dr. Mueller, in your written testimony, you mention that RUPRI Center has completed multiple studies on how telehealth can serve as a tool to expand access to care in rural settings. And I could not agree more.

I understand that you have a current project that is looking at Avera Health's eCARE initiatives in South Dakota, which range from emergency department, e-ICU, e-pharmacy, e-behavioral health, and more.

I have seen some of this technology first-hand. I know they are working hard to innovate.

I should say for this committee's benefit, could you discuss what you have learned so far about Avera's model and how it has helped increase access in our State of South Dakota?

Dr. MUELLER. Well, thank you, Senator Thune, for the question. I will focus primarily on what we have learned about the use of telehealth in the emergency rooms, because that has impressed us the most.

What that has done, especially since—I mentioned earlier, the CMS condition of participation was changed a number of years ago to allow meeting the necessity for an on-call physician through the use of telehealth. And that has made a tremendous difference across South Dakota and other facilities that Avera supports, because you can have an advanced-practice primary care provider, not a physician, in the ER who can quickly access a board-certified physician.

But more important even than that is the finding that the use of that kind of telehealth actually helps in recruitment and retention of primary care providers. And this goes to a broader point that the more we can do to support the professional activity of those health-care professionals in the local environment, the greater the likelihood they will come there—because that is how they want to practice, with the support of board-certified physicians—and the greater the likelihood they will stay, because they are getting that kind of consultative support.

The other quick example is in the case of pharmaceutical services. Inside the hospital in particular, which is how the e-health suite from Avera reaches out, you can meet the requirements for review of medication as it is being prescribed in a hospital much more efficiently and effectively through the use of telehealth.

Senator THUNE. We have, perhaps as you know, put forward multiple policies that were signed into law this year that will reduce barriers to the use of technology in Medicare and promote telehealth in Medicare Advantage, in Accountable Care Organizations, and other areas, including in treating stroke patients. And these are significant advancements.

But I am wondering if there are other areas where technology can transform delivery of care in rural States. I mean, what should we be looking for in terms of technology opportunities in Medicare and Medicaid from your perspective?

And, Ms. Thompson, if you would care to comment on that as well.

We are making some headway, but what else should we be doing?

Dr. MUELLER. I think we should try to learn as rapidly as we can—you mentioned the use of telehealth in ACOs and Medicare Advantage plans—so that we can transfer that knowledge into the basic Medicare system and affect reimbursement policy, as was mentioned earlier this morning as one of the barriers to the expansion of telehealth.

Senator THUNE. Ms. Thompson?

Ms. THOMPSON. And I would simply add I think there is a great opportunity to attract the new generation of physician providers, or providers in general, to rural health. These young people have grown up with technology, it is very familiar to them, and, frankly, it gives them a lifestyle that is something that is very attractive and I think would help us answer the needs of recruiting to the rural areas.

Senator THUNE. Good.

Mr. Chairman, I have another question I can submit for the record having to do with the EHRs and how that impacts service delivery in rural areas as well. But I see my time is expired, so I will submit that for the record.

Thank you.

Senator ROBERTS. We thank you, Senator.

Senator Warner?

Senator WARNER. Thank you, Senator Roberts.

One of the issues that—and I think, Ms. Martin, it was raised in your testimony—I am increasingly seeing is kind of isolated areas where there may be, you know, two competing hospital systems, and they leave an isolated island in between where the two systems' catchment area comes. And you may have rural communities with a single doc. And in my State, in the county of King George, the doc has been practicing 35 years, done a great job, and is about to leave, and because it falls in between two competing health-care systems, nobody has wanted to take this region. And should he retire—and frankly, his system is being sold—we have a community that could frankly go without any kind of coverage at all.

This problem of isolated areas where there is not a larger system to provide the back-office coverage, even if the rural area has relatively high affluence—this one particular community, King George, has relatively high affluence—you know, how are we going to get at that? How do we—are there any systemic things we can do, whether it would be a slight increase in terms of Medicaid reimbursements or other reimbursements, to make these islands more attractive on a longer-term basis?

Ms. MARTIN. I think we do not—I do not—experience that quite as much in my region of Colorado, because geographically we are defined by a mountain range. And so certainly, anything within our valley, we are covering and taking care of.

We see that a little more in the eastern plains of Colorado, where you will have a community that, with the retirement of a physician or the closure of a hospital, you have a gap in coverage.

And I really hope that the State-wide leadership can make a difference in that in pushing people there.

I do think that the age of physicians going and starting practices on their own, if it has not come to an end, it is slowly coming to an end. And I think it is going to take working with existing rural health-care systems so that they have the financial means to do a startup and a practice.

I think loan repayment for physicians makes a difference with that. And I think certainly Medicaid reimbursement makes a difference with that in rural communities. Because when you have 70 percent Medicare or Medicaid, like you do in my community, you cannot make a private-model business work.

Senator WARNER. But this notion of an individual doc going has to have some kind of back-office operation to support him or her. And do you have other ideas?

I know back in the 1990s, the Robert Wood Johnson Foundation had a huge kind of focus on this issue of underserved communities and GP practices opening up. But as you said, the ability to open up a practice on your own right now without some additional support from an overall system is really hard.

Is there any way—has anyone thought about beyond what the government could do in terms of reimbursement levels or loan forgiveness, you know, incentives to health-care systems to make sure you do not leave these isolated islands not having coverage?

Ms. MARTIN. I guess my thought on that would be that I think rural systems do really look at that geography and make a difference.

The idea of even the J-1 Visa programs, things that will help small hospitals like ourselves be able to get providers that will go to these communities through long-term incentives, that is what comes to mind for me.

I think the idea of a critical access hospital or a rural hospital like the one we have in Alamosa being able to get paid under a different reimbursement model in those communities gives you the resources to take on those communities that do not have providers.

I think it is a real challenge. And I wish I had a better answer.

Senator WARNER. Yes.

Does anybody else want to add on to this? I do think the notion of a higher reimbursement level—but then, do you create almost an

incentive for some systems to kind of drop providers so that they could then qualify for an increased reimbursement?

It is a real conundrum. I mean, I would be happy to hear from anybody else on the panel. This will be my only question.

Well, I think this is not—when you have the hospital systems that want to make a profit and are not willing to stretch for these isolated islands, and with the retirement of many docs and the inability for a new doc to go into these communities, it is a real problem, a real issue. They cannot set it up on their own. We have to find a way to crack this code.

Thank you, Mr. Chairman.

Senator ROBERTS. Senator Cardin?

Senator CARDIN. Thank you, Mr. Chairman.

I thank the panel.

I first want to just concur with the comments of several of my colleagues on telemedicine and particularly for rural health care. I think it is really an area where we can do much better.

I am proud to join some of my colleagues on legislation that would allow for Medicare reimbursement for telemedicine broader than it is today.

But I want to talk about what we do in Maryland. We are the only State in the country that has an all-payer rate structure for hospital reimbursement. And we went to the next plateau a couple of years ago, and just approved this month, the final aspects of this demonstration that allows our hospitals basically to be judged on the overall reduction of the growth rate of health-care costs rather than just the hospital element of it.

So we have an all-payer rate structure in our hospitals, but coordinated with reducing the overall costs of that patient's health care beyond the hospital care. So there are incentives to keep people healthy.

And by way of example, the Western Maryland Regional Medical Center, which is in a rural part of our State, offers care coordinators, navigators, and local practices to use its telemonitoring for blood glucose, blood pressure, and weight, and works on the social needs of the patients. And that can be incorporated into the all-payer rate structure, which means all of the third-party payers are helping to reimburse for that, because you cannot get discounts in Maryland hospitals.

So it works to allow rural areas to have full access to the continuum of services.

So my point is, this model—and this is now being implemented in our State—how do we take this type of a model into the rest of the country that is still in the stovepipe-type reimbursements that, to me, work against rural America? How do we take the model of what we are doing in Maryland and use this to develop more access to care and reduce the growth rate of health-care costs in rural America?

Dr. MURPHY. Senator, thank you for that question. So I had the opportunity when I worked at CMMI to work on the Maryland model and can share your enthusiasm with the model.

And in Pennsylvania, there is actually a Pennsylvania Health rural initiative that is looking to do exactly what you just articulated, so taking the Maryland model in a State that is not an all-

payer rate-setting State and developing a different methodology, but similar in the way that it includes all payers and has also the metrics of total cost of care involved in the model, but really using it in the way Maryland did for the Total Patient Revenue hospitals back in 2010, but with 8 more years of knowledge on how we transform and how we focus on population health.

So we concur that it is a great model. I had previously testified that in your State next week the Johns Hopkins University School of Public Health is conducting a summit for States to attend on global budgeting. And it is my understanding that we have over 26 States that are interested in pursuing this.

Senator CARDIN. Yes?

Ms. MARTIN. I would just say that in Colorado we are beginning to explore this model as well. We are very much in the beginning stages of it. But the conversations around global budgets and ways to keep our community healthy and control cost are at the forefront of our mind too.

Senator CARDIN. Ms. Thompson?

Ms. THOMPSON. And I just simply want to applaud the recognition that the current payment structures, the current payment systems for rural America, while all well-intentioned and all designed at a certain point in time to help save rural health care, at this point in time are now setting rural health care back and not being able to move into population health and the alternative payment models and MACRA.

And I just want to applaud the work.

Senator CARDIN. Well, thank you. And my concern is that I think the payment structure does not allow for this to occur, so you really have to find very creative ways in order to do it. And we should be looking at some mechanisms that allow you to use a reimbursement structure modification that brings down the overall cost of health care in your community so that the hospitals are not the driving force for utilization, rather that they are part of the overall coordinated and integrated care.

Thank you, Mr. Chairman.

Senator ROBERTS. Senator McCaskill?

Senator MCCASKILL. Thank you very much, Mr. Chairman.

I for the record want to thank the chairman and ranking member. They actually moved up the hearing this morning because we anticipated that a number of us would be in the NDAA markup. We did so well in the NDAA yesterday, we finished it last night, but I still appreciate the consideration.

I want to talk a little bit this morning—well first, I want to just say for the record this is a crisis in our country, the costs of health care in rural communities, and we are doing nothing in the U.S. Congress to address it at this moment.

We know that premiums on the exchanges are going up because of various things that have occurred. And I think I can get everybody to agree that when we have more uninsured and underinsured, we have more rural hospitals in stress, and insurance premiums go up for those of us who buy it. Correct? Correct?

All five witnesses agree.

So every time the uninsured number goes up, it costs everybody who is paying, including taxpayers and including everyone who

buys insurance. So the idea of keeping the uninsured number down is all about saving money in the health-care system and making everyone responsible for their own health-care bills.

So it is just ironic to me that we are going to go back to the bad old days where uninsured numbers are climbing, and we are doing nothing right now to address it.

And there are a lot of bills out there that would help. So I am hoping that Leader McConnell will see fit to allow some of the bipartisan bills that have been negotiated to the floor so we can actually provide some relief.

My issue I want to talk about—there was a really good State audit done in my State by the auditor, Nicole Galloway, about a rural hospital. And what was discovered was there was a small rural hospital that transferred operational ownership through a lease agreement in November of 2016, and all of a sudden there was this giant increase in laboratory billings.

And what happened is the vast majority of these billings were for lab activity for individuals who were not even patients of that hospital. Billings began immediately after the management agreement, despite the fact the hospital in Unionville, MO had not even begun processing tests.

The Hospital Partners, which is the company that took over this small rural hospital, also placed on the hospital payroll 33 out-of-state phlebotomists to perform laboratory services throughout the country. It appears that Hospital Partners reduced Putnam to a shell organization for purposes of lab billing.

This morning, I am directing a letter to the Inspector General at HHS to investigate this. Evidently, this same group was involved in the northern district of Georgia, sued on a pass-through billing scheme at Chestatee Regional Hospital.

The Missouri audit findings note that a large private insurance company has identified up to \$4.3 million in payments for fraudulent claims to Putnam in recent months.

So my question to all of you who are researching rural hospitals and who are working in rural systems is, is this a trend? Are these companies coming around and buying up these hospitals to front for shady billings on lab work? Have you seen this anywhere else?

No, you have not? Okay.

Well, this letter is going to HHS today. And I think there is some—in all likelihood, I am betting there is some criminal activity somewhere. And I think that maybe there should be some kind of cap on payments to labs outside of the State, particularly if the billings are coming from a rural hospital.

I know you all have talked about the lack of doctors in rural communities. I had the University Hospital in Columbia, MO say they were taking in more rural patients than they should. Rural patients were bypassing their local hospitals and going to the University Hospital, mainly because that is where their doctors were.

Can any of you address—maybe, Ms. Martin, you can address the real problem, especially that we have with OB/GYNs being able to be in rural areas, and any ideas you might have of how we can incentivize doctors to stay in these rural communities, go to these rural communities and stay in these rural communities.

Ms. MARTIN. I think the workforce issues are very much challenges in rural areas. I think we spoke today about the loan repayment programs, the Conrad 30 J-1 Visa programs; I think they are very important to rural communities.

But I also think it is about easing some of the regulatory burden on physicians who work in small areas, because they just want to be physicians; they want to take care of patients. And when they can work to the top of their license and to the top of their skill, they are more satisfied in a rural community.

And I think that we talked about telehealth a bit today. When physicians know that they can be covered when they are off and they are out or they do not feel the burden of a 24/7 responsibility, I think that is a more satisfying opportunity for them as well.

We know with OB/GYNs we are very fortunate in the community that I am in that we have three OB/GYNs who work there. And we work a lot with nurse midwives to do first-line coverage for call, for regular deliveries, to give them a little bit of relief so that their call time and their quality of life balances, is different maybe than what they would experience without those.

And so it is the use and the complement of those advanced-practice nurses that help to keep the OBs in our community.

Senator MCCASKILL. Thank you.

Thank you, Mr. Chairman.

Senator ROBERTS. Senator Brown?

Senator BROWN. Thank you, Mr. Chairman.

My State of Ohio struggles with some of the highest rates of infant mortality and maternal mortality in the country. Shamefully, it is partly because we have under-invested in public health for decades. It is more complicated than that.

Between 2008 and 2014, 400 women died from pregnancy-related causes in Ohio, and in 2016 more than a thousand babies died before their first birthday. Obviously, these losses, these tragedies, were not felt equally across all communities. African-American communities in our cities suffered disproportionately to the greatest extent.

We also know that, in terms of maternal and infant mortality, places like Appalachia, Ohio and other small towns generally a little more affluent than Appalachia, dealt with this.

This hearing is about rural hospitals and rural health care, so I will stick to that. I am concerned, though, that—not in a conspiracy sort of way—this committee has done nothing that I can see on infant mortality generally when the problems are equally acute, maybe even more so, in urban areas, among low-income people of color especially.

There is a national Republican effort, troubling, that Governors are—work requirements seem to be the new far-right-wing rage in this country: work requirements for food stamp beneficiaries, even if they are getting treatment from opioids and even if they are, you know, incapable of working. They are also now looking to do work requirements for Medicaid. And they are doing it in a way that will absolve more rural white communities' high unemployment from these work requirements, but will have these work requirements on inner-city families, increasingly because they are really smart

and they have figured out how to do it legally, apparently, but immorally, if I could say that.

But because this hearing is about rural health, I will stick to a question about that—a couple of questions.

Dr. Murphy, if I could start with you, what do we do? And partly taking off on Senator McCaskill's question, what do we do to support rural communities in improving outcomes for moms and babies?

Ms. Martin said something about that. I would like to hear your thoughts, and particularly about maintaining access to obstetric services.

Dr. MURPHY. I think we have to be realistic with the maintaining of obstetrical services in rural communities.

I think Ms. Martin gave an example where there is adequate coverage, three physicians there who, in case of an emergency, could certainly cover for one another.

It is a very high intensity. An OB/GYN has a very high-intensity schedule, so you really need the numbers that Ms. Martin talked about to be able to effectively and safely render obstetrical care.

So I think in areas where they are fortunate enough to be able to have the physician services on-site in a safe and a high-quality manner, I think then we should do that.

I think we should work through other providers, such as nurse midwives, certified nurse practitioners, physician's assistants, to be able perhaps to offer some of the obstetrical care in the rural community when it is not possible to deliver there, so a mom does not have to drive 35 miles for her monthly appointment.

But I think it is a very difficult service to staff in rural communities unless you have the number of physicians that Ms. Martin talked about.

Senator BROWN. Thank you.

A few weeks ago, I hosted a conference in our office, and Rob worked with us to host a conference for CEOs from Ohio's smaller hospitals. We have some of the best hospitals in the country in Ohio. But rural hospitals are not often part of the conversation, and they rarely come to Washington. And so we hosted a number of them.

One of the questions that came up, of course, was the challenge faced when attracting and retaining a strong workforce.

So I am sorry I have been in another hearing today, but from Ms. Martin's comments and Dr. Murphy's comments, I appreciate that.

I would like to, before I yield back, Mr. Chairman—and I wanted to thank, too, Senator Wyden, who has been helpful on this Medicaid work requirement, and, as you know, we are working on some things together. I wanted to thank him.

But I want to just close with this.

And just a comment, Senator Roberts.

I want to thank Senators Grassley and Casey for their work on a bipartisan bill we introduced together, Senate bill 109, that would allow pharmacists to bill Medicare for services they are trained to provide in underserved areas. I understand pharmacists are not perhaps the greatest need in every case, but they obviously are central to a lot of this too. They can work then with rural hospitals to help improve access to basic health-care services like im-

munizations and chronic disease management in their communities.

About a dozen members of this committee, if I could just name them—Thune, Scott, Roberts, Stabenow, Cardin, Nelson, Bennet, Enzi, and Cantwell—are also cosponsors of this legislation.

And I am hopeful that—I know the chairman is not here—I am hopeful that Chairman Hatch and Ranking Member Wyden will commit to working with Senator Grassley and me on this bill and other creative initiatives to help all of you deal with the challenges you have in workforce retention.

So thank you all so much.

Thanks, Senator Roberts.

Senator ROBERTS. Senator Wyden?

Senator WYDEN. Thank you very much.

And before he leaves, I just want to tell Senator Brown I am anxious to work with him on the agenda he has outlined. Because as usual, he is going to bat for folks who do not have clout and do not have power, and I want to thank him for his comments.

So we have been at it for almost 2½ hours.

You all have been terrific.

But what I am struck by is, I do not think we have mentioned over the course of 2½ hours what is really the backbone of rural health care, literally from sea to shining sea, and that is rural health clinics.

And I am heading home. We have 83 of them in my home State.

And I know, Ms. Martin, you have a significant number of them.

Dr. Mueller, you have expertise on this.

In my home State, from Curry County to Enterprise, these rural clinics are literally the backbone of health care. And they are where seniors go and people go for preventive screenings and primary care services and everything that helps them to stay healthy and out of the hospital.

So what I would like to do, since we are getting ready to wrap up, is go right down the row again, since we have this little window here to try to look at what is important going forward—I do not think it gets much more important than these rural health clinics.

So why don't we start with you, Dr. Mueller?

Everybody, one item on your wish list for the rural health clinics going forward.

Dr. Mueller?

Dr. MUELLER. Optimizing the use of the non-physician professionals through State policy, scope of practice, and Federal policy on conditions of participation and supervision requirements.

Senator WYDEN. I missed your colleague Dr. Pink. And maybe I just need to wear my glasses.

Dr. Pink?

Dr. PINK. The suggestion made by Dr. Mueller, I would strongly endorse.

Senator WYDEN. Okay.

Ms. Martin?

Ms. MARTIN. The issue with colocation and comingling rules that prevent the true integration of the health-care provider.

Senator WYDEN. I think that is so important. And you know, Chairman Roberts is one of the co-chairs of this really important

Rural Health Caucus, along with our colleague Senator Heitkamp, who talks to me about this constantly. Hardly a week goes by when she does not bring it up.

I would just say, Mr. Chairman, this whole question of the comingling rules that Ms. Martin is talking about, this just looks like a bureaucratic la-la land to me, trying to sort all this stuff out. So I am going to talk with Chairman Roberts about it.

Yes, ma'am?

Ms. THOMPSON. Strengthening the support to these advanced registered nurse practitioners and P.A.s and extenders that many times are working in very isolated areas, to give them the support, the education, the retraining, and the access to consultation.

Senator WYDEN. Giving them a bigger role.

Ms. THOMPSON. Absolutely.

Senator WYDEN. I have to tell you—and we had it in our Healthy Americans Act, our bipartisan bill with eight Democrats and eight Republicans—you ought to be able to practice at the top of your license and particularly in these rural areas.

So, Mr. Chairman, that is another one. I mean, why you would not let people practice up at the top of their license in a rural area—I mean, that is just common sense. That has nothing to do with Democrats and Republicans.

Well, you all have been terrific. You know, we have been at it for close to 2½ hours.

And I think, to me, without rural health care, you cannot sustain rural life. This is not rocket science. There are a couple of pieces to the puzzle that are a part of this.

We are trying, for example, to expand broadband. And one of the striking aspects about this is, I think we started a revolution in Medicare with our CHRONIC Care bill, because what we are doing is moving from acute care, which back when I was director of the Gray Panthers, was the program. You broke your ankle—that is not Medicare anymore. Today, Medicare is cancer, diabetes, heart disease, strokes, that kind of thing.

So we had a terrific group of members, led by Senator Schatz and Senator Wicker, come and make the case for telemedicine. It is really, really important in rural areas. But what we have seen in central Oregon and the like is that if they do not have broadband, they cannot tap all the opportunities for telemedicine.

So there are a lot of pieces to this puzzle. But you have given us a lot of suggestions.

I want also to say I am especially looking forward to the suggestions for the record with respect to how to get more providers in rural health care, because you can have the facilities, but if you do not have the providers, that is that.

So, Mr. Chairman, I think it has been a really good, really important hearing. People know I have very, very strong feelings, which I will not express again, which will please the chairman, about how damaging these Medicaid cuts would be.

We can get a bipartisan package here—this is doable—a bipartisan product in a crucial kind of area.

I am looking forward to working with all of you and with Chairman Hatch and all of my colleagues on both sides of the aisle.

There was not a bad question in the house today. So we have a lot of work to do.

I look forward to working with you, Senator Roberts.

Senator ROBERTS. Thank you, Senator Wyden.

And thank you all for your attendance and your participation today.

This was in fact an important and very helpful conversation. All of us look forward to working with each of you in a bipartisan way, both sides of the aisle, as we continue to work on a path forward to improve our rural health care for all of us who are privileged to represent rural and small-town America.

Dr. Mueller, let us see, it was 1993 that you testified before me, I guess. And now here it is 2018. So I look forward to hearing from you in 2033, when I hope we have these things settled. [Laughter.]

I ask any member who wishes to submit questions for the record to do so by the close of business on Friday, June 8th.

With that, this hearing is adjourned. Thank you so much.

[Whereupon, at 11:20 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HON. ORRIN G. HATCH,
A U.S. SENATOR FROM UTAH

WASHINGTON—Senate Finance Committee Chairman Orrin Hatch (R-Utah) today delivered the following opening statement at a hearing to examine the challenges and discuss ways to improve health care in rural America.

The topic today is rural health care, which is a critical issue for virtually every member of this committee.

I have long considered it a special mission to create the same rural payment opportunities that many of our Nation's urban counterparts enjoy. Representing a western State, I understand the challenges our rural hospitals and providers face to deliver high-quality medical care to families in environments with more limited resources.

In the Senate, rural health-care policy boasts a long history of collaboration and cooperation on both sides of the aisle.

Take, for example, back in 2003 when we passed the Medicare Modernization Act. The MMA included a comprehensive healthcare package tailored specifically with rural communities, hospitals, and providers in mind.

The MMA finally put rural providers on a level playing field with their neighbors in larger communities.

The law also put into place common-sense Medicare payment provisions that help isolated and underserved areas of the country provide access to medical care as close to home as possible.

However, while the vast majority of rural health payment policies enacted in the MMA were permanent, some were only temporary. In the years following, those temporary provisions have become known as the Medicare extenders. As many of us know, the problem with extenders is that annual debate over necessary funding often takes priority over developing a more robust strategic plan for the future.

Although some partisan and bipartisan health-care policies have since altered Medicare payments, many rural and frontier health-care providers still face significant obstacles attempting to successfully participate in Medicare's delivery system reforms and bundled payment arrangements.

While these changes continue to emphasize new ways to pay providers, Medicare's existing strategies to preserve access to healthcare in rural areas still rely on special reimbursement programs that either supplement inpatient hospital payment rates or provide cost-based hospital payments. Now, these special payment structures may work just fine in certain parts of the country.

But even with a wide range of special Medicare rural payment programs, some smaller communities are home to hospitals that still find it hard to achieve financial stability. The reasons, as we will learn from the expert witness panel with us here today, are complex and multifaceted.

For example, when compared to their urban counterparts, on average, the 4 million Medicare beneficiaries living in rural and frontier areas are less affluent, suffer from more chronic conditions, and face higher mortality rates.

To make matters worse, small, rural hospitals continue to be more heavily dependent on Medicare inpatient payments as part of their total revenues. At the same time, we are seeing a steady, nationwide shift away from inpatient care to providers offering more outpatient services.

Many rural hospitals serve as a central hub of community service and economic development, but some struggle to keep their facilities operating in the black in order to meet local demands for a full range of inpatient, outpatient, and rehabilitation services.

Resolving these issues is no easy task.

Clearly, for some communities, Medicare's special rural payment structures may stifle innovations that could pave the way for more sustainable rural health-care delivery systems.

One consistent theme that we will hear from our witnesses today is the need for flexibility.

They are not asking Congress for a one-size-fits-all Federal policy.

They want the flexibility to design innovative ideas that are tailored to meet the specific needs of the communities they serve.

They need the Federal Government to support data-driven State and local innovations that have the promise to achieve results—increasing access to basic medical care, lowering costs, and improving patient outcomes.

But the Federal Government cannot tackle this challenge alone.

While I was pleased to see CMS release its rural health strategy earlier this month, I believe that this administration, led by HHS Secretary Azar, still needs to improve coordination across all agencies within the Department to help prioritize new rural payment models while also reducing regulatory burdens on rural and frontier providers.

State and local officials must be aggressive in their efforts to design transformative policies and programs that meet their unique rural health-care needs.

And the Federal Government should listen.

In my view, States should be the breeding ground to test new ideas.

However, it is not sustainable for every small town to have a full-service hospital with every type of specialty provider at its disposal.

That is why it is so important for rural communities to work together, share resources, and develop networks.

The Federal Government must continue to recognize the important differences between urban and rural health-care service delivery and respond with targeted, fiscally responsible solutions.

By pooling our knowledge, expertise, and financial resources, we can work together to develop targeted payment policies that ensure appropriate access while also protecting Medicare beneficiaries and American taxpayers.

I am looking forward to hearing some of those innovative ideas from our witnesses today.

But before I turn to Ranking Member Wyden, I want to bring one important item to the attention of the committee.

The Medicare Payment Advisory Commission—otherwise known as MedPAC—has submitted a statement for the record outlining the commission's latest recommendation aimed at ensuring access to emergency department services for Medicare beneficiaries living in rural communities.

I encourage all members to review MedPAC's statement and ask that it be made part of the official hearing record.

**Ensuring Access to Emergency Services for
Medicare Beneficiaries in Rural Communities**

May 24, 2018

Statement of James E. Mathews, Ph.D., Executive Director,
Medicare Payment Advisory Commission

The Medicare Payment Advisory Commission (MedPAC) is a small congressional support agency established by the Balanced Budget Act of 1997 (Pub. L. 105-33) to provide independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to achieve a Medicare program that ensures beneficiary access to high-quality, well-coordinated care; pays health care providers and health plans fairly, rewarding efficiency and quality; and spends taxpayer dollars responsibly. The Commission would like to thank Chairman Hatch and Ranking Member Wyden for the opportunity to submit a statement for the record today.

The Commission has a long history of developing Medicare payment policies to improve access to care, quality of care, and efficiency of care delivery in rural areas. The Commission conducted broad-based reviews of Medicare payment policy in rural areas in our June 2001 and June 2012 reports to the Congress. More recently, the Commission has evaluated causes of rural hospital closures and voted unanimously on a recommendation for a new, voluntary payment option for rural hospitals that would preserve access to emergency services in isolated rural areas. (The recommendation will appear in our forthcoming June 2018 report to the Congress.)

To help ensure beneficiary access to hospital care in rural communities, over time the Medicare program has implemented several adjustments that increase payments to rural hospitals. Many of Medicare's special payments to rural hospitals are linked to inpatient status and are based on hospitals' costs. Despite these special payments, hospital closures have increased in rural areas as populations have declined. The volume of inpatient services provided in small rural hospitals has declined even more rapidly. Though beneficiaries in rural areas where hospitals have closed may be able to receive planned, nonemergent inpatient care from other hospitals, the Commission is concerned that these closures may leave beneficiaries without access to timely emergency care. Given changes in demographics and in the way that care is delivered, Medicare payment policies must change as well. As we outline below, we have recommended a new, voluntary model of payment that will allow stand-alone emergency departments to operate in rural areas that cannot support an inpatient hospital.

Evaluating Access to Care in Rural Areas

Each year, the Commission assesses Medicare beneficiaries' access to health care services. To conduct that assessment, we survey beneficiaries, interview beneficiaries in focus groups, and analyze Medicare data on beneficiaries' use of services. We frequently examine variation in Medicare spending and use of health care services in rural areas across the country, and we visit rural areas with different demographic and practice pattern characteristics. In general, we find that beneficiaries in rural areas use similar levels of hospital services as beneficiaries in urban areas (Medicare Payment Advisory Commission 2017, Medicare Payment Advisory Commission 2012). More broadly, beneficiaries in rural and urban areas also report similar levels of satisfaction with their access to routine care, even though some rural beneficiaries have to travel outside their area to obtain care. (On average, rural beneficiaries travel farther for routine care and obtain about 30 percent of their routine care in urban areas (Medicare Payment Advisory Commission 2012).)

However, while, on average, rural and urban beneficiaries use similar levels of health care services and express comparable satisfaction with their care, there are beneficiaries in some rural communities who may have difficulty accessing emergency care. When a hospital that serves an isolated community closes, even though beneficiaries may be able to travel and receive their nonemergent, planned hospital care in other locations, the Commission is concerned that beneficiaries may not be able to access emergency care in a timely fashion.

The recent increase in small rural hospital closures has underlined the Commission's concern. Fifty-one rural hospitals closed between 2013 and 2017 (Young

2018).¹ Among those closures were 22 critical access hospitals. While 28 of the hospitals that closed were located less than 20 miles from the nearest hospital (suggesting that there may have been excess capacity in these markets and that beneficiaries have alternative sources of hospital care), 21 of the closed hospitals were located between 20 miles and 35 miles from the nearest hospital, and 2 were over 35 miles from the next nearest hospital.

Medicare's Special Payments to Rural Hospitals Are Not Targeted to Preserve Access to Emergency Services

In addition to evaluating beneficiary access to care, the Commission also examines the adequacy of Medicare payments to providers. In general, our analyses have found that the adequacy of fee-for-service (FFS) payments to rural hospitals does not differ systematically or significantly from the adequacy of urban hospitals' payments. However, the financial performance of rural hospitals varies, and some of the smallest rural hospitals have had the most financial trouble, potentially creating problems for beneficiary access to hospital care.

To support beneficiary access to hospital care, over time the Medicare program has implemented several adjustments that increase hospital payments. For example:

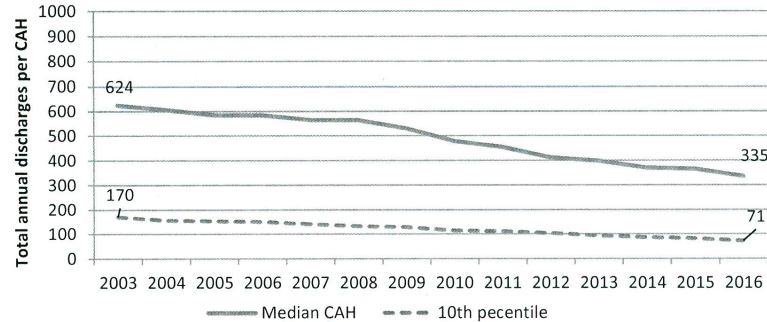
- **Sole community hospital (SCH)**—SCHs are hospitals that are at least 35 miles from the nearest hospital that is paid under Medicare's inpatient prospective payment system (IPPS). More than 300 hospitals are eligible for this program. Payments to SCHs for inpatient services are based on the SCH's historical costs, updated for inflation. This program increased payments to participating hospitals by about \$1 billion in 2015, relative to the IPPS rates that would have otherwise applied.
- **Medicare-dependent hospital (MDH)**—MDHs are hospitals with high shares of Medicare patients (60 percent of days or discharges). About 150 hospitals are eligible. In this program, hospitals receive an increase to their inpatient payments that is based 75 percent on the MDH's costs and 25 percent on IPPS rates. Medicare payments to MDHs were about \$100 million higher in 2015 than they would have been under the IPPS.
- **Critical access hospital (CAH)**—CAHs are small rural hospitals with 25 or fewer acute care beds. About 1,300 hospitals are designated as CAHs. Each is paid 101 percent of its Medicare costs for inpatient, outpatient, and laboratory services, as well as post-acute skilled nursing care in the hospital's swing beds (acute care beds that can be used for post-acute nursing care). New CAHs must be 35 miles from other hospitals, but many older CAHs were exempted from the distance requirement. The program increased payments to CAHs by about \$1 billion in 2015 relative to IPPS rates; because of the way beneficiary coinsurance is calculated for CAH services, the program also increased beneficiary cost sharing by about \$1 billion.

In some communities, these special payment policies have not preserved access to high-quality, efficient care for two reasons: (1) these special payments require hospitals to maintain inpatient status, and (2) these special payments are linked to hospitals' costs.

The dilemma is that, for many rural communities, an expensive inpatient delivery model may not be a financially viable option but, to receive these special payments from Medicare, a hospital must maintain its inpatient status and all of the associated costs (*e.g.*, complying with certain staffing and facility requirements). This dilemma has become more acute because the volume of inpatient admissions in rural hospitals has continued to decline.

For example, in 2016, the median number of inpatient admissions (all payers) at CAHs reached fewer than one per day (Figure 1). (In that same year, about 10 percent of CAHs had fewer than two admissions per week.) Declining inpatient volume has important consequences for a rural hospital's financial viability. As the number of admissions falls, the hospital has fewer inpatients over whom to spread its fixed costs. Thus, the cost per admission increases, undermining the efficient delivery of care. In addition, Medicare's special payments to rural hospitals are linked to inpatient volume, so a hospital's special payments fall as volume declines. The drop in inpatient volume has thus contributed to hospital closures.

¹ We generally define *rural* as all areas outside of metropolitan statistical areas (MSAs). This definition of rural includes micropolitan areas. Others have a broader definition of rural areas that includes some small towns within MSAs.

Figure 1. Declining inpatient use of critical access hospitals, 2003 to 2016

Source: MedPAC analysis of hospital cost report data from CMS.

While the use of inpatient services in these hospitals has fallen, in some communities the hospitals may still be needed as a source of emergency care. However, under current policy, isolated communities that want an emergency department (ED) must maintain a hospital with inpatient capacity, even if the hospital does not admit enough patients to be financially viable. This requirement can result in some hospitals offering services (*e.g.*, post-acute services, MRI services) to increase their volume, even though the hospital may not be a relatively efficient provider of that care.

The second reason why Medicare's special payments are poorly targeted to maintain access to care is that payment is based on a hospitals' costs. Thus, these policies provide little incentive for hospitals to manage their costs, resulting in higher spending for the Medicare program and for beneficiaries. In addition, cost-based payment is poorly targeted because it focuses subsidies on a hospitals' historical costs, rather than the access needs of beneficiaries in isolated communities. The challenge for Medicare is to develop payment policies that ensure access to efficient emergency care in rural communities where it is not financially viable to support a costly inpatient facility, while also protecting the taxpayer and beneficiary dollars used to finance the program.

The Commission's Recommendation for a New Payment Option for Rural Communities to Maintain Access to Emergency Services

In our June 2012 report to the Congress, the Commission set out three principles for designing special payments to preserve access to care in rural areas:

- ***Payments should be targeted toward low-volume isolated providers—that is, providers that have low patient volume and are at a distance from other providers.***
- ***The magnitude of special rural payment adjustments should be empirically justified. That is, the payments should increase to the extent that factors beyond the providers' control increase their costs.***
- ***Rural payment adjustments should be designed in ways that encourage cost control on the part of providers.***

With these principles in mind, the Commission has recommended a new approach for Medicare payment that would give communities options in choosing how best to maintain access to needed emergency care. Importantly, this approach would better target Medicare's subsidies and would not require a significant increase in federal spending. As an alternative to maintaining a costly inpatient-centered hospital, the Commission recommends a new, voluntary payment model that would allow Medicare to pay for emergency services at stand-alone EDs in isolated rural areas (more than 35 miles from another ED). The rural facility would have an ED that is open 24 hours a day and seven days a week, but it would not provide acute inpatient care. The facility could retain other services such as ambulance services and outpatient clinics. We refer to the combination of the stand-alone ED and its affiliated outpatient services as an outpatient-only hospital. Isolated rural full-service hospitals that choose to convert to outpatient-only hospitals would receive the same

standard Medicare outpatient prospective payment rates for ED visits as a full-service hospital. (While the Commission's work has focused on the conversion of existing inpatient-centered facilities to this new model of care, new outpatient-only hospitals could also participate in the program to provide access to needed emergency services in communities that do not currently have access.)

In addition, to help cover facilities' fixed costs, Medicare would make a set annual payment that would be the same across all outpatient-only hospitals. Unlike the current cost-based special payments, hospitals with higher cost structures would not receive a higher payment. In addition, the fixed payment would be the same regardless of ED volume, so as not to encourage unnecessary ED use.

If an inpatient hospital chooses to convert to an outpatient-only hospital, we expect that the financing and delivery of care would change as follows:

- Isolated rural hospitals choosing to forgo acute inpatient services would qualify to receive an annual fixed payment from Medicare. The hospital would have discretion on how to use that fixed payment, enabling the hospital to support the costs of operating an ED, so that beneficiaries in that community would maintain access to emergency services. Medicare would pay for emergency services in the outpatient-only hospital under the outpatient PPS.
- Shifting from CAH cost-based rates for outpatient services to outpatient PPS rates would lower beneficiary cost sharing dramatically. The Commission estimates that Medicare beneficiaries could see their coinsurance fall by 70 percent or more. This is because beneficiaries' coinsurance at CAHs is set at 20 percent of charges, which is often close to the full payment amount that Medicare would otherwise make under the outpatient PPS (Medicare Payment Advisory Commission 2016, Medicare Payment Advisory Commission 2011).
- Beneficiary access to scheduled, nonemergent inpatient services would be preserved as patients would be redirected to neighboring hospitals.
- Eliminating services that can be more efficiently delivered in centralized regional facilities (*e.g.*, MRI services) would substantially lower costs relative to existing models.
- Some hospitals might choose to convert their inpatient beds to skilled nursing facility (SNF) beds. SNF PPS rates would be applied to the SNF services provided under the existing eligibility rules.
- Any existing outpatient clinics would continue to operate unaffected by the change in the hospital's status.

The Commission's Recommendation to the Congress

The Congress should:

- **Allow isolated rural stand-alone emergency departments (more than 35 miles from another emergency department) to bill standard outpatient prospective payment system facility fees, and**
- **Provide such emergency departments with annual payments to assist with fixed costs.**

This new voluntary payment option would give rural providers greater flexibility to maintain needed access to emergency services in communities that cannot support a full-service hospital. Hospitals would retain the option to convert back to their prior status. Medicare beneficiaries would benefit from local access to emergency services and reduced coinsurance.

The payment option would also preserve access to needed emergency services without a significant increase in Medicare spending. The policy would target existing Medicare payments and replace the cost-based programs that have not preserved access to high-quality, efficient care in some isolated rural communities.

Note: This recommendation will appear in the forthcoming June 2018 report to the Congress.

Outpatient-Only Hospitals Could Switch Back to Prior Status

In determining whether or not to participate in the rural outpatient-only hospital model, existing hospital boards would have to decide whether they are willing to discontinue providing inpatient services and convert to outpatient-only hospitals to best meet the needs of their communities. Discontinuing inpatient services would be a difficult decision for rural communities that have long been served by hospitals that focused on inpatient care. To reduce the communities' perceived risk of losing a full-service inpatient hospital, Medicare could allow all small rural hospitals that convert to outpatient-only hospitals the option of converting back to their prior status in the future if the community determines that such a change is necessary. While we expect this option of converting back to prior status would be rarely used, allowing this option should make it easier for hospital boards to make the initial decision to convert to an outpatient-only hospital.

An outpatient-only hospital would also have the option of aligning with its area's larger hospital system to support some functions at the outpatient-only hospital. For example, the larger hospital system could help with peer review of physicians, purchasing supplies, and billing for services. Under this option, the new outpatient-only hospital could work cooperatively with other healthcare providers to ensure continuity of care across settings.

It is not clear how many providers would choose to convert from an IPPS hospital or CAH status to an outpatient-only hospital under this policy. The decision would in part be determined by the size of the fixed payment and how the program was targeted. The fixed-payment model we discuss is targeted to isolated providers only; *isolated* could be defined as a certain driving distance from other EDs. We use the 35-mile criterion because under current Medicare regulations, EDs can bill Medicare for emergency services if they are affiliated with a hospital that is within 35 miles. Thus, communities within 35 miles of another hospital already have an existing payment method that would support an ED to ensure access to emergency care. In addition, the 35-mile criterion is the limit currently used in the SCH and CAH programs.

Summary

Maintaining emergency access in rural areas is challenging because of declining populations in many rural areas, coupled with a payment system that is tied to an expensive inpatient delivery model and hospitals' costs. Creating a voluntary payment model to support outpatient-only hospitals in isolated rural communities will help those areas maintain the capacity to provide emergency services, ensuring beneficiary access to necessary services. The Commission's recommendation would provide an annual fixed payment to support the costs of operating an ED and would allow qualified outpatient-only hospitals to receive outpatient PPS payment rates. This policy would also reduce cost sharing for rural beneficiaries dramatically.

The Commission has long recognized the unique challenges with access to care facing rural Medicare beneficiaries and has continuously supported the development of targeted payment policies to ensure appropriate access while protecting the taxpayers and beneficiaries whose dollars finance the program. The Commission looks forward to continuing to be a resource for the Committee as it develops its policies to achieve the goal of ensuring access to efficient, high-quality care for rural beneficiaries.

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PREPARED STATEMENT OF KONNIE MARTIN,
CHIEF EXECUTIVE OFFICER, SAN LUIS VALLEY HEALTH

Thank you for the opportunity today to share our healthcare story. I am the CEO of a small health care system located in the San Luis Valley, which is a rural, agricultural-based community in southern Colorado. We serve 6 counties, an area roughly the size of Massachusetts, and are the safety net for our nearly 50,000 community members. Two of our counties are the poorest in Colorado; nearly 70 percent of our patients are covered by Medicare or Medicaid, with less than 20 percent having commercial insurance. With this challenging payer mix, we constantly struggle to remain financially viable. SLVH and rural hospitals around the country are appreciative of this committee's commitment to rural communities, and we are hopeful that meaningful help is on the way.

Our system is comprised of a 49-bed sole community hospital and a 17-bed Critical Access Hospital. We operate 5 rural health clinics -2 of which are provider-based. This past year we provided 2,500 hospital visits, 58K outpatient services, and over 65K clinic visits. We are a Level III trauma center and the only facility that delivers babies, provides surgery or any type of specialty care for 120 miles in any direction. We serve veterans, farm workers, college students, tourists and our own friends and family. We are a resilient and creative team of health care providers.

We are the largest employer in our region and employ over 800 staff. Many of them have lived in our community their entire lives—and their families for generations. As for me, I moved to the Valley in 1985, and began my health care career in an entry-level IT position—back when the personal computer was new technology—and have worked my way into my current CEO role.

Our staff struggles with the costs of meeting regulatory requirements, which are often different—and sometimes conflicting across payers. Our system must report on dozens of measures for the Medicare quality and pay-for-performance programs. However, our private insurers ask us to report yet more—some on the very same topic, but using different definitions. This complex and confusing data reporting takes time away from what really matters—delivering on our health care mission.

Recruiting and retaining a qualified workforce is another major challenge for rural providers. We have been fortunate to form partnerships with local and State schools that help develop and maintain our workforce. Specifically, we have multiple “grow your own” programs—from paramedic training, hosting medical students, internships, and mentoring those pursuing a healthcare MBA. We collaborate with the local community health center to host a Rural Residency Training Track Program. We are set to have the first 2 physicians complete their training in June 2019.

We have our own work force success story to celebrate with two family medicine physicians who returned to their childhood homes to care for their friends and neighbors. And, we have a physician who came during college to serve as a volunteer at a local shelter, and today he's a surgeon in our organization.

Rural communities pride themselves on hard work and taking care of their own. However, Federal payment systems and delivery models must recognize the unique circumstances of providing care in rural communities, and must be updated to meet the realities and challenges of how health care is delivered today and in the future. About 10 years ago, the critical access hospital that is part of our system approached us for help. Nearing closure and in dire financial condition, we entered into a partnership to provide management services and financial support. Then, in 2013, this CAH fully merged into the system that is today, SLV Health. This type of arrangement prevented a hospital closure, but such partnerships are not available to many rural hospitals. And we see the result with 83 rural hospitals closing since 2010 and 12 CAHs in CO currently are operating in the red today.

Therefore, I am here today to ask for your support and consideration for new financial models that consider our needs, including the creation of a 24/7 rural emergency medical center designation, such as the AHA has recommended, and that Sen. Grassley has championed. And I ask you to provide appropriate resources, flexibility, and ongoing dialogue with those of us in rural America who stand ready to innovate, work hard, and meet the current challenges of caring for our friends and neighbors. In a country as great as ours, where you live should not determine if you live.

Again, thank you for having me here today.

Thank you for the opportunity today to share our health care story. I am the CEO of San Luis Valley Health (SLVH), a small health care system located in the San

Luis Valley, which is a rural, agricultural-based community in southern Colorado. We serve six counties, an area roughly the size of Massachusetts; and are the safety net for our nearly 50,000 community members. Two of our counties are the poorest in Colorado. Nearly 70 percent of our patients are covered by Medicare or Medicaid, and less than 20 percent have commercial insurance. With this challenging payer mix, we constantly struggle to remain financially viable. SLVH and rural hospitals around the country appreciate this committee's commitment to rural communities, and we are hopeful that meaningful help is on the way.

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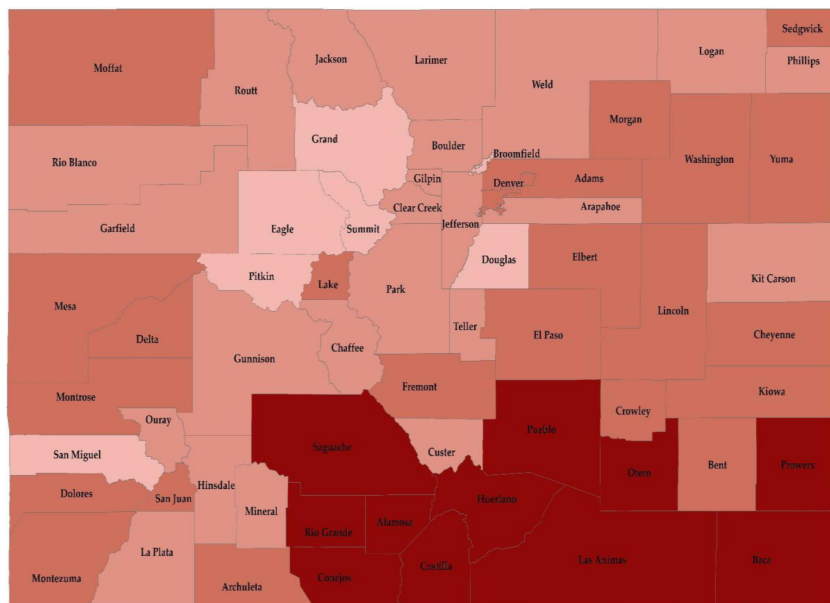
Rural Hospitals are facing significant challenges across the country with 83 rural hospitals closing since 2010. Currently 12 CAHs in Colorado are operating in the red. Regulatory burden, limited resources, challenging payer and patient mix, and geographic isolation are among the key hardships facing rural hospitals. For example, our staff struggles with the costs of meeting regulatory requirements, which are often different—and sometimes in conflict across payers. We must report on dozens of measures for the Medicare quality and pay-for-performance programs. However, our private insurers ask us to report on yet more measures—some on the very same topic, but using different definitions. This complex and confusing data reporting takes time away from what really matters—delivering on our health care mission.

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OVERVIEW OF HEALTH CARE IN RURAL COLORADO

- Nearly 750,000 people live in Colorado's 47 rural counties.
- CAHs and Rural Health Clinics (RHC) were established to provide access to care in rural communities. Rural Colorado has older, sicker, poorer patients than its urban counterparts. CAHs and RHCs do not have a high-volume patient population to provide care without cost-based reimbursement.
- In Colorado's rural counties 30 percent–60 percent of patients are on Medicaid and Medicare, and some facilities see upwards of 70 percent Medicare and Medicaid patients (78 percent in Costilla County, 68 percent in Huerfano, 54 percent in Delta County—see dark red counties below, data is from County Health Rankings, geocoded by Colorado Rural Health Center, the State Office of Rural Health as of May 2016).

Colorado: Medicaid Enrollment by County

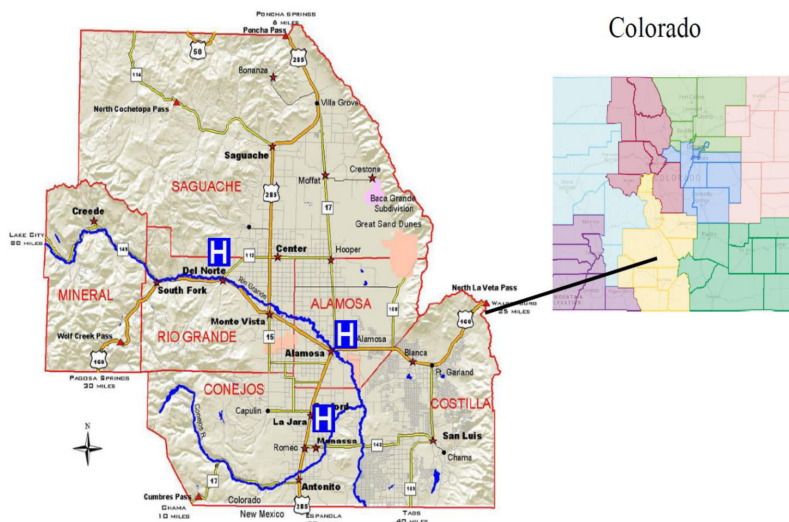


OVERVIEW OF SAN LUIS VALLEY HEALTH SYSTEM

SLVH is an essential health care system with roots tracing back to the 1920s when a group of concerned Lutherans accepted the responsibility of management and operation of Alamosa Community Hospital. The organization's mission, "To be a premier, fully-integrated rural health care system providing exceptional, patient-centered services to the San Luis Valley," directs its partnerships between patients, families, and health care providers and the strategies that drive current organizational priorities and program services.

SLVH is a non-profit, 501(c)(3), that provides various forms of health care services to nearly 50,000 residents who make up the total population. SLVH Regional Medical Center (RMC) offers the only nearby Level III Trauma Center that offers 24/7 access to orthopedic and general surgeons. SLVH RMC also offers the only labor and delivery unit within 120 miles, which means that patients do not have to travel over a mountain pass to deliver their newborns. SLVH Conejos County Hospital (CCH) Emergency Department (ED) uniquely serves residents in two of the State's poorest counties, Conejos and Costilla, and northern New Mexico. Rio Grande Hospital distinctly serves the west end of the SLV. Three counties in the SLV region do not have a hospital.

SLVH also includes a physician service practice that provides primary and specialty services, behavioral health, and other ancillary services—three of its five clinics are designated as RHCs and two are designated as provider based. SLVH partners and collaborates with each SLV hospital, all local clinical providers and nursing staff, in addition to other relevant community partners such as behavioral health, law enforcement, health and human services, to ensure that resources are maximized and not duplicated in a manner that benefits optimal patient outcomes. The true beneficiaries of this level of care are all the residents who have access to a reliable health care system that provides quality health care services to all patients, regardless of where they live or ability to pay. A geographic illustration of the SLV region and SLVH hospital designations are provided below:



COMMUNITY AND GEOGRAPHY

The SLV is the largest and highest valley in North America, surrounded by three mountain ranges that effectively isolate the Valley from the rest of Colorado. The region spans 8,194 square miles and is comprised of six counties covering Alamosa, Conejos, Costilla, Mineral, Rio Grande and Saguache Counties. According to the 2017 U.S. Census Bureau Population Estimates Program, the total population is 47,204, with rich diversity represented by a sizeable Hispanic population (41 percent compared to 21 percent statewide) as well as a significant population of indigent and migrant farm workers. Close to one third of the population (28 percent) speaks a language other than English at home, compared to a rate of 17 percent in Colorado (U.S. Census Bureau, American Community Survey (ACS) and Puerto Rico Community Survey (PRCS), 5-year Estimates).

Three of our six counties are designated rural and three are frontier. Frontier areas are sparsely populated rural areas, which are isolated from population centers and services and are defined as counties having a population density of six or fewer people per square mile. This definition does not take into account other factors that may isolate a community such as challenges in accessing public transportation, affordable housing, health and human services, and other social support. Of the six counties in the region, two are among the five poorest counties in Colorado. 22 percent of the population lives below poverty level (compared to 11 percent for Colorado), and (in 2016 dollars) median household income levels of \$35,897 fell short of the State's comparable \$62,520 (U.S. Census Bureau, ACS and PRCS, 5-Year Estimates). Economic, cultural and other social determinants of health exacerbate geographic and other challenges of providing health care services. The number of persons in the SLV without health insurance, under age 65 years averages 12.5 percent, compared to the State average of 8.6 percent (U.S. Census Bureau, QuickFacts). Seventy-one percent of patients served at SLVH in 2017 were enrolled in Medicare and/or Medicaid. In fiscal year 2016–17 SLVH provided \$1,126,323 in charity care, not including \$1,758,532 in bad debt. Importantly SLVH provides services to all patients regardless of their ability to pay.

Social determinants of health, the geographic expanse of the SLV region, inadequate reimbursements, regulatory burden and other factors pose public health challenges for residents and the health care system. Coordinating health care services across the continuum of care is mired with complications rooted in these factors as well as information gaps occurring at the point of service and siloed information systems. Additionally, there are significant costs associated with maintaining and updating aging facilities (dating back to the 1920s (RMC) and 1960s (CCH)) and outdated equipment, which are not factored into reimbursement. Through all of this, SLVH perseveres in its goal of providing health care services that meet the needs

of its community while also meeting the standards of care in line with Colorado's other health care providers, hospitals, and designated trauma centers.

ALIGNING SERVICES WITH COMMUNITY NEEDS

SLVH and rural hospitals around the country constantly work to match the services they provide to the needs of their communities. Every three years, SLVH conducts a community health needs assessment involving community stakeholders and patient feedback. The primary need identified during the 2016 survey was addressing substance abuse and mental health. This aligned with an analysis commissioned by the Colorado Office of Behavioral Health regarding substance use disorder services that documents gaps and needs that are significant and varied, and underlines that nearly every population (in Colorado) is underserved. These needs correlate directly with current demographics that indicate residents in the SLV report a higher incidence of poor mental health days compared to State and national rates. (Robert Wood Johnson Foundation, 2017 County Health Rankings and Roadmaps). Ranking data also shows SLV counties have fewer mental health provider ratios (except for Alamosa County).

In addition, just as in the rest of the Nation, an increasing number of residents in the SLV are experiencing opioid dependence, abuse or misuse, and/or addiction, and many are turning to heroin and other cheap alternatives. These disorders are often associated with chronic physical illnesses such as heart disease and diabetes, and when one is out of control, it affects the other. These disorders also increase the risk of physical injury and death through accidents, violence, and suicide. Overall, only about half of those affected receive treatment according to the National Institute of Mental Health.

SLVH has provided Behavioral Health (BH) services in its busiest primary care clinic since 2011, and has increased BH staffing throughout primary care clinics, including the use of Care Coordinators, who help connect and engage patients in their own self-management beyond clinic exam rooms. Currently all SLVH primary care clinics provide Screening Brief Intervention Referral and Treatment (SBIRT), Drug Abuse Screening Tests (DAST), Pain Management Agreements, prescription drug monitoring, referral to medication assisted treatment, social supports and care coordination for patients who are at risk or are already abusing substances. Other ancillary supports include physical therapy and chiropractic treatment. BH staff participate in the development of integrated BH treatment plans and follow up on emergency room and hospital admissions in order to positively impact clinical outcomes, patient-provider satisfaction, and cost of care. SLVH EDs are implementing clinical guidelines for alternatives to opioids to help address the opioid epidemic and prevent future misuse. (Please see the attached SLVH Opioid Puzzle.)

COMMITMENT TO QUALITY AND SAFETY

SLVH is dedicated to providing high quality care to our patients, and participates in many quality measurement and improvement efforts. While we are proud of our performance, many of the current measures and methods of publicly reporting our quality data do not fully reflect the quality care our patients receive in our facilities. SLVH provides safe and high quality clinical services and demonstrates superior outcomes by assessing performance with objective and relevant measures, however not all mandated measures are applicable or reflective of true patient care services.

SLVH's Quality and Safety Plan is a collaborative effort with SLVH's Quality and Safety Department, Risk Management, all clinical services, and the medical staff. All departments of the organization develop annual goals to address and support improvement of the care, treatment, service, efficiency, and safety of outcomes that align with the organization's overall mission.

The Quality and Safety Department utilizes many resources to identify areas of improvement for SLVH, such as: Event Reporting System, HAC, Culture of Safety Survey, Core Measures, HCAHPS/CGCAHPS, MACRA/MIPS, HQIP, MBQIP, QualityNet, etc. The chart on the following page helps illustrate the number of regulatory agencies to which SLVH reports, as well as the number of initiatives and metrics on which we report. It also provides a crosswalk of the number of metrics reported to multiple agencies. As this chart clearly illustrates, the staff time required for data input, the time required for manual abstraction, and other administrative resources needed to fulfill the reporting requirements render these metrics and methods of reporting antiquated and ineffective.

Targeted regulatory reform is needed to allow rural hospitals to report meaningful, accurate quality measures aligned with the services provided and that account

for the challenges of measuring in the rural environment, including low patient volumes, the wide variation in service mix and socioeconomic factors. Rural hospitals want to be recognized for the quality of care we are providing, however we need the right measures and methods for reporting. (Please see the Metric Crosswalk on the following page.)

Metric Crosswalk

	Required Reporting Metrics													
	NHSN	MIPS	HQIP	HIIN	CPC +	eCCM	I-Care	WSM	IQR	OQR	Hos Compare	Readmission Penalty	MBQIP	VBP
7-day Readmissions								x						
All-Cause Readmissions		x	x	x				x			x	x		x
AMI Measures										x		x	x	
Breast Ca Screening		x			x									
Cataract Surgery		x								x	x			
CAUTI	x			x					x		x			x
C-diff	x			x					x		x			x
CLABSI	x			x					x		x			x
Closing the referral Loop		x			x									
Colon Follow-up		x								x	x			x
Colonoscopy Return		x								x	x			
Colorectal Screening		x			x									x
CP										x		x	x	
C-Section Rate		x	x											
CT MRI		x									x			
Culture of Safety			x	x										
Diabetic -A1C		x			x									
Diabetic Eye Exam		x			x									
ED Throughput						x				x		x	x	x
EDTC													x	
Employee FLU	x									x				
Falls, Risk Assessment		x			x									
HCHAPS			x				x	x			x			x
HF D/C							x							
High BP		x			x									

(AMI – Acute Myocardial Infarction; CAUTI – Catheter Associated Urinary Tract Infection; CLABSI – Central Line Associated Blood Stream Infection; CP – Chest Pain; EDTC – Emergency Department Transfer Communication; HF D/C – Heart Failure Discharge Communication)

Rural hospitals face the same complex reporting and regulatory requirements as larger urban facilities, but with fewer available technology supports and financial and staff resources. As mentioned above, data submitted through registries and vendors requires hours of manual abstraction. One-size-fits-all metrics are not an accurate way to measure clinical care, nor do they add value to health delivery processes in rural areas. Oftentimes the metrics do not apply to low-volume service lines or match the needs of the community identified in the health needs assessment. For example, SLVH maintains an average daily census of less than one in its Intensive Care Unit (ICU), but is still required to report specific ICU measures, such as infections from catheters and central lines. Although the organization has been fortunate to report no central line infections in several years, SLVH is still required to use a registry to identify all eligible patients and to abstract data from their charts into a national reporting system. There is no applicability, and this information does not provide a meaningful comparison against similar organizations. These metrics are based upon volume standards much larger than SLVH.

Another example, in the last year: SLVH had one catheter associated urinary tract infection in its ICU, but because patient days are so low, the overall rate of infections looks disproportionately high. This causes confusion and frustration among caregivers and instills a lack of confidence in our patients seeking safe and reliable care. These metrics also impact SLVH's CMS star rating and potentially reimbursement through programs like Value Based Purchasing.

SLVH remains completely committed to providing safe and effective health care and to being accountable for the delivery of quality health care services through established metrics. However, rural providers need the flexibility to report data on measures which reflect its services and patient population. An example of a meaningful quality improvement metric is the reduction of early elective deliveries. SLVH RMC serves as the only hospital in the SLV that delivers babies. A few years ago,

staff recognized an uptick in early elective deliveries. Providers and nurses developed a process improvement plan and over the course of 18 months reduced early elective deliveries from 10 percent to 0 percent. This is great example of a quality metric that was meaningful, relevant and resulted in safer and more affordable patient care. Each rural hospital has their own unique story about their patient population and needs the flexibility to identify priorities based upon data, patient population and community health needs assessment data to identify a menu of reporting metrics. Rural providers also need to be benchmarked against similar peers so that the ratings are more meaningful and add context.

MEANINGFUL USE AND ELECTRONIC HEALTH RECORDS

Meaningful Use (MU) reporting is another area that deserves careful consideration. SLVH implemented its Electronic Health Record (EHR) in 2013, and 2018 will be the sixth year of reporting. We initially participated in the program because of the opportunity it held for improving patient care and shared investment in the adoption and use of EHRs. For example, the incentive potential was meaningful as both RMC and CCH Hospitals are dual eligible, which means incentives were possible under both Medicare and Medicaid. However, the incentive funds were not enough to address the ongoing costs of the program, including updating and maintaining the technology. Currently, SLVH attests to Medicare MU because reporting is required to avoid payment penalties. We no longer report to Medicaid MU.

MU criteria is constantly changing, which presents challenges for any provider, but especially rural providers. SLVH's EHR vendors struggle to provide adequate updates to our system to pull the required information. Each time there is a criteria change, an EHR update is required and SLVH must invest more time, resources and funding in order to meet MU requirements or face a penalty. Furthermore, pulling reports from Practice Partner (outpatient EHR) for eligible clinicians is time consuming. And not all meaningful use measures are relevant to SLVH, particularly at CCH where patient volume results in a low denominator for the calculation. The only electronic clinical quality data SLVH submits for CCH are ED throughput and VTE measures.

Additionally, the EHR has presented unintended challenges for clinicians, who now must report in the MACRA system. Physician attention is too often focused on clicking certain fields in the EHR instead of focused on the patient. Several measures hold the physician accountable for actions outside of the physician's control—such as the Patient Portal and Secure Messaging.

FLEXIBILITY AND ALTERNATIVE PAYMENT MODELS FOR CRITICAL ACCESS HOSPITALS AND SMALL RURAL HOSPITALS

About 10 years ago, Conejos County Hospital (CCH), the critical access hospital that is now part of our system, approached us for help. Nearing closure and in dire financial condition, we entered into a partnership to provide management services and financial support. Then, in 2013, this CAH fully merged into the system that is today SLVH. This type of arrangement prevented a hospital closure, however it is important to note that such partnerships are not available to many rural hospitals.

The frontier county CCH serves is home to 8,200 people in an agricultural dependent area, larger in square miles than the State of Rhode Island. The poverty rate for Conejos County is just above 22 percent, and the payer mix of CCH is 80 percent Medicare and Medicaid. Cost based reimbursement has allowed the hospital to reduce its financial vulnerability and maintain access to essential services in a vulnerable area of the State. This reimbursement model has also provided flexibility in staffing and services, access to Flex Program resources and grants, and the inclusion of capital improvement costs in allowable expenses. By maintaining a modest, but positive margin, CCH has been able to make improvements in its existing facility, replace vital patient care equipment, and meet regulatory requirements. SLVH CCH has also been able to recruit health care professionals to an underserved area. Again, these partnerships are not available to all struggling CAHs who are facing decisions about reducing or eliminating services or even closing.

Because of our partnership, SLVH has been able to streamline CCH and RMC services and costs to ensure the highest quality of services and efficiencies, with an eye toward providing services within CCH that meet the community's unique needs. With its aging population, the needs for diagnostic services, therapy, past-acute rehabilitation (swing beds), and 24-hour emergency services have emerged as the community's most pressing needs. The number and type of inpatient services offered at

CCH have declined over the last ten years. This dramatic decrease in market share for inpatient services is illustrated in the chart below, which highlights the decline in inpatient services and rise in demand for ED patients, swing, observation, and other outpatient services.

Year Reported	2014	2016	2017
Inpatient Market Share	37.1%	23.8%	15.4%
Outpatient Market Share	37.5%	48.1%	49.3%

As rural health care facilities continue to adapt to the changing needs of our patient population, we need the tools and flexibility necessary to innovate and respond. Alternative payment models, such as a 24/7 rural emergency department designation would provide an option for certain small rural hospitals struggling to maintain access to care in their communities. The creation of a 24/7 rural emergency medical center designation, has been recommended by the American Hospital Association (AHA) Task Force on Ensuring Access in Vulnerable Communities. Senators Chuck Grassley and Amy Klobuchar have introduced bipartisan legislation in the Senate to establish such a designation under the Medicare Program. Similar bipartisan legislation has also been introduced in the House by Representatives Lynn Jenkins and Ron Kind.

WORKFORCE CHALLENGES

Recruiting and retaining a qualified workforce is another major challenge for rural providers. SLVH has been fortunate to be able to develop partnerships with local and State schools to help develop and maintain our workforce. Specifically, we have multiple “grow your own” programs—from environmental systems maintenance programs through technical school education to nurse professional programs through our local junior college and Adams State University. We partner with medical schools, advance practitioner training programs, physical therapy and pharmacy schools, and many others. We use innovative strategies to educate and train those who desire to work and live in a rural community. This partnership provides meaningful employment opportunities while serving our community’s healthcare needs.

SLVH collaborates with the local community health center to host a Rural Training Track Residency Program. We are set to have our first two physicians complete their education in June 2019. We have around 100 physicians in our community; only two of those are in private practice: the other 98 are employed. We are at the forefront of provider-hospital integration driven by the financial necessity of collaborating.

Federal programs currently exist to help make it easier for physicians to practice in rural areas. It would be helpful for Congress increase the number of Medicare-funded residency positions and extend the Conrad State 30 J-1 visa waiver program.

CONCLUSION

Rural hospitals and communities pride ourselves on hard work and taking care of our own. However, Federal payment systems and delivery models must recognize the unique circumstances of providing care in rural areas, and be updated to meet the realities and challenges of how health care is delivered today and in the future.

SLVH’s two hospitals are the anchors of the health care infrastructure in our region. However, the fixed costs of providing care in rural communities is an ongoing challenge. We must maintain and update our facilities, and medical equipment and hire, train and retain highly skilled staff. Additionally, regulatory burden, geographic isolation, low patient volumes, limited resources and a challenging payer and patient mix are also hardships we deal with every day. Some recommendations to address these challenges are listed below.

- Support models allowing for adjustments in what defines a CAH, including the creation of a 24/7 rural emergency medical center designation, such as the AHA has recommended.
- Reduce the number of metrics, streamline metrics across regulatory agencies, and establish clear definitions of the metrics required.

- Change the regulations to allow true integration of care. Clarify the unnecessarily burdensome regulations around co-location, removing those that serve as barriers to integrating care in rural communities. Co-location saves the system resources and allows rural facilities to offer a broader range of services in a cost effective manner.
- Support flexible models for telehealth: In order to help deal with the severe workforce shortages allow rural facilities to be an originating site for telehealth. Remove barriers so that rural facilities may fully utilize telehealth services.
- Support existing Federal programs to help make it easier for physicians to practice in rural areas: increase the number of Medicare-funded residency positions and extend the Conrad State 30 J-1 visa waiver program.

I thank this committee for the opportunity to speak today and appreciate your commitment to deliver meaningful reforms and resources that will help us in rural communities meet the current challenges of caring for our friends and neighbors. In a country as great as ours, where you live should not determine if you live.

QUESTIONS SUBMITTED FOR THE RECORD TO KONNIE MARTIN

QUESTIONS SUBMITTED BY HON. ORRIN G. HATCH

Question. I was very intrigued by your comments about designing rural quality measures. My understanding is that the National Quality Forum is expected to issue a final report in August that identifies a core set of relevant rural measures. While I know that rural hospitals and providers want to show how high quality their services are, they often cannot report on the same types of measures as urban facilities. In fact, some rural stakeholders have told me that the NQF measure set is actually more focused on process measures than on outcomes measures, which could increase rural hospital and provider reporting burdens. Do you have any specific suggestions on how Congress could most effectively implement value based reimbursement for Critical Access Hospitals?

Answer. Rural hospitals value quality and safety. I believe most have programs and processes in place that demonstrate the quality of services they provide. We should be measured and evaluated on services we provide consistently and in a high enough volume to provide a true picture of the outcome. Some options for consideration include: (a) urging NQF to allocate measure development dollars towards filling gaps in rural measurement—for example, rather than evaluating existing measures to determine if any could be applied to rural providers, NQF should seek to address measurement gaps (*e.g.*, access, assessing when to transfer patients, etc.); and (b) requesting that CMMI test a voluntary demonstration of a Value Based Purchasing (VBP)-like approach for CAHs.

Currently, rural providers are not wholly unaffected by VBP. The MACRA's MIPS program, for example, has no statutory exclusion for rural providers. Rather, it has a low-volume threshold that CMS can choose to alter to include more/fewer clinicians. It is reasonable to expect that as CMS lowers the low-volume threshold, more providers (including method II CAHs with clinicians who have reassigned their billing rights to the hospital) will participate in these programs.

Question. Because not every rural town can support a full-service hospital, rural researchers, rural stakeholders, and non-partisan public policy think tanks—such as the Bipartisan Policy Center—have called on Congress to give States and communities more flexibility to design locally driven health care solutions. One idea is to allow small, rural hospitals to transform into rural emergency centers. Do you think this is a good approach? What types of services, in general, do you think a rural emergency center should offer?

Answer. Yes. I do support the establishment of a rural emergency medical center designation under the Medicare Program, and believe that it is right approach for keeping medical care in rural communities. In addition, I agree with your statement that not every rural town can, nor should, have a full-service hospital. Protecting emergency type services in strategic geographic locations aids our healthcare system in meeting the needs of rural residents. This designation would give communities an important tool to maintain access to certain services while improving financial viability and predictability. It unencumbers rural facilities from the mandate to maintain inpatient services in order to receive special Medicare designation status.

These facilities should offer essential health care services such as emergency and outpatient services, along with additional services that meet a community's specific needs. Additional services could include post-acute, diagnostic, primary care, hospice/respite care, etc. Regarding payment, I encourage Congress to consider a fixed facility payment plus the outpatient rate for services. This approach aligns with MedPAC's recent recommendation and is supported by the American Hospital Association. Such a payment structure would provide needed predictability by accounting for some of the high fixed costs of operating a facility and unique challenges of providing services in rural communities.

QUESTIONS SUBMITTED BY HON. MICHAEL B. ENZI

Question. Critical Access Hospitals can have up to 25 beds, but the smaller ones in Wyoming often have only between two and ten of those beds occupied on an average day. It is difficult to staff a 25 bed hospital that only has two beds full. What can rural hospitals do to maintain and improve efficiency when they face this kind of patient volume?

Answer. Facilities in remote geographic locations with low inpatient volume face significant challenges. I believe communities should have flexibility to determine the health care services that best meet their needs. For example, these low volume hospitals should have the option to transition to a rural emergency medical center and select outpatient services most needed by residents.

Additionally, reimbursement rates for outpatient services should be increased. Currently, outpatient services are reimbursed at significantly lower rates than inpatient services, making it more difficult for providers to maintain access. The way reimbursement is currently structured, many rural hospitals have no choice but to focus on inpatient care over expanding services that might better align with the needs of their community.

I am also an advocate for partnerships and affiliations when possible. Our health-care system has both a PPS hospital and a CAH. This partnership allows multiple opportunities for staff to learn from one another and have the experience and volumes that keep us competent and ready to care for our community.

Finally, ending the Medicare sequestration cuts, which reduce payments by 2 percent, would significantly help CAHs, including those with very low patient volumes.

Question. There has been a lot of focus on Critical Access Hospitals, and rightfully so, but how is patient care delivered and reimbursed in hospitals that are close to meeting the CAH designation but not quite there, like Campbell County Health in my hometown of Gillette?

Answer. I truly understand your point and the dilemma you reference. Our health-care system has two hospitals; one is a PPS, Sole Community Provider facility and the other a CAH. I recognize firsthand the benefits and the shortcomings of both designations.

Hospitals that are too large to qualify for CAH status are often too small to benefit from economies of scale. In cases where sustaining inpatient care is problematic, I support options such as the establishment of a rural emergency center designation. While it is not a solution for every community, it could offer an option for increased financial stability while maintaining access to essential services.

For rural hospitals that would not meet the CAH criterion of 25 beds or less, but remain geographically isolated, a Sole Community Hospital designation can be beneficial. SCHs are eligible to receive higher payments in order to maintain care access in their remote location.

I also know that the Rural Community Hospital (RCH) Demonstration has been a lifeline for some hospitals by allowing cost-based reimbursement under Medicare for certain rural hospitals with 26–50 beds. This and other alternative payment models should be available for communities. Finally, improved reimbursement for outpatient services and the elimination of Medicare sequestration would help address the challenges faced by this category of hospitals, which is too large to qualify for CAH status, but too small to benefit from economy of scale.

QUESTIONS SUBMITTED BY HON. JOHN THUNE

Question. Ms. Martin, in your written testimony, you discuss meaningful use and electronic health records as a challenge to rural providers. Several members on the committee and I have long advocated for ensuring that electronic health records do not cause undue compliance burdens on providers. It's why we introduced the EHR Regulatory Relief Act last year. CMS has since the proposed what seem to be positive changes to meaningful use through the 2019 IPPS rule, including a new scoring methodology that may help address some of our concerns about the current all or nothing approach to meaningful use. Have you had the opportunity to review these changes to the program? Are they a good start, or what areas would you focus on?

Answer. Changes to the Promoting Interoperability Program included in the IPPS Proposed Rule would offer much needed flexibility and improvements; however, more is needed. Positive changes include the proposed scoring methodology, which would eliminate required thresholds and permit hospitals to get credit for building performance in some areas while earning additional points in areas of strong performance. Other flexibility and improvements include the allowance of a 90-day reporting period for 2019 and 2020; the reporting of four electronic clinical quality measures for one quarter; and the removal of an objective that hold hospitals and CAHs responsible for the actions of others.

However, the Proposed Rule still requires hospitals to use 2015 Edition Certified EHR technology. Instead, balance is needed between the positive move toward patient apps connecting to provider EHRs and the real and developing risks that this approach raises for systems security and the confidentiality of health information. Hospitals like mine will take measures to secure systems, however, how this will be evaluated when the rules against information blocking are enforced is an area where greater clarity is needed.

The IPPS Proposed Rule provided important flexibilities and changes to the Promoting Interoperability Program, however, it does not address critical challenges hospitals have in successfully meeting its goals. In the IPPS proposed rule, most of the points are available for health information exchange among providers and provider to patient. Providers that cannot meet one of the performance requirements are able to receive an exclusion but they must make up the points through additional health information exchange. Unfortunately, CMS offers limited options for exchange. For example, providers that use a Health Information Exchange cannot receive credit for using the HIE to support health information exchange. This type of barrier to successfully meeting the program goals should be addressed.

Your legislation is necessary because it would remove the "all-or-nothing" approach to meeting the requirements of the program. Providers must report something for every objective and every measure in the program in order to successfully meet program requirements.

QUESTION SUBMITTED BY HON. ROB PORTMAN
AND HON. MICHAEL F. BENNET

Question. We have previously introduced legislation to encourage providers to participate in alternative payment models and facilitate care coordination, including the Medicare PLUS Act (S. 2498 in the 114th Congress) and the Medicare Care Coordination Improvement Act (S. 2051 in the 115th Congress). When we consider coordinating care for patients in rural settings, what administrative burdens do you face? What can Congress do to ensure that value-based care is effective in rural areas?

Answer. As a rural facility leader, I have very little experience with these type of ACOs and care coordination activities for the Medicare population. I do not feel I can adequately answer your question.

QUESTIONS SUBMITTED BY HON. RON WYDEN

RURAL WORKFORCE

Question. As discussed during the hearing, the shortage of primary and specialty care providers is a critical issue facing rural communities across the country. In Oregon, 25.9 percent of residents live in a health professional shortage area. Difficulty recruiting and retaining physicians and other members of the care team can result

in longer patient wait times and reduced access to care for those living in rural communities.

What concrete policy ideas would you suggest this committee pursue to help attract more providers to rural America?

Answer. The following are policy ideas that could assist in rural workforce issues: (a) increase the number of GME slots by passing the Resident Physician Shortage Reduction Act of 2017 (S. 1301/H.R. 2267); (b) pass the Conrad State 30 and Physician Access Reauthorization Act (S. 898/H.R. 2141), to provide regulatory relief to international physicians using J-1 visas who practice in rural and underserved areas; (c) ensure the financial stability of rural hospitals through the establishment of new and alternative payment models, adequate reimbursement (*e.g.*, increased reimbursement for outpatient services, ending Medicare sequestration; telehealth coverage and reimbursement); and (d) partnerships? local education?

RURAL BENEFICIARY HEALTH NEEDS

Question. Rural communities tend to be older, sicker, and lower income compared to their urban counterparts. When rural hospitals are forced to close their doors, Medicare beneficiaries living in the surrounding areas often have limited health care options. The prevalence of multiple chronic conditions among those living in rural areas heightens the need to ensure all Medicare beneficiaries have access to high quality care—regardless of where they live.

In your view, where should this committee focus its efforts to ensure that Medicare beneficiaries living in rural areas (especially those with multiple chronic conditions) have access to high quality care?

Answer. This most important resource for supporting rural Medicare beneficiaries is to keep the healthcare providers financially viable and the care close to home: (a) ensure adequate coverage and reimbursement rates for care provided in rural hospitals (including telehealth services and remote patient monitoring technology); (b) protect crucial designations and payment programs that support rural providers such as the CAI-I and Sole Community Hospital designations, and the Medicare Dependent Hospital, low-volume adjustment, and ambulance add-on programs; (c) provide flexibility through alternative payment models such as the establishment of a rural emergency medical center designation; and (d) invest in broadband connectivity.

Question. What Medicare policy changes would be most impactful in the short term and long term?

Answer. (a) Improved reimbursement rates for outpatient services; (b) coverage and reimbursement of telehealth services; (c) establishment of alternative payment models and additional demonstration programs; and (d) end Medicare sequestration cuts.

TELEHEALTH

Question. Building on the proven success of telehealth in the rural setting, Congress passed the CHRONIC Care Act earlier this year, which expanded access to telehealth in Medicare to allow individuals receiving dialysis services at home to do their monthly check ups with their doctors via telehealth, to ensure individuals who may be having a stroke receive the right treatment at the right time, to allow Medicare Advantage plans to include additional telehealth services, and to give certain ACOs more flexibility to provide telehealth services.

In your view, what, if any, Medicare payment barriers to adoption and utilization of telehealth services remain in the rural setting today?

Answer. I know I join other rural providers in applauding the work of the Senate Finance Committee and others in Congress for passing the CHRONIC Care Act and including additional funds in the FY 2019 omnibus appropriations bill for the adoption of telehealth. These new policies have given telehealth a much needed boost. Yet barriers to increased adoption and utilization of telehealth remain.

Reimbursement for telehealth services is not always equal to care provided in person. The costs associated with providing telehealth services include the acquisition of expensive equipment, training and operation costs, and maintenance. Rural hospitals often serve as originating sites for telehealth (where patients physically go to receive a service). However, even in cases where originating sites are eligible to bill Medicare for a telehealth facility fee, the reimbursement rates are marginal compared to the overall costs.

Increased investment is needed to expand broadband. According to the FCC, 34 million Americans lack access to broadband—many in rural locations. Broadband is necessary to provide telehealth and other modern health-care services. For example, electronic health records, health information sharing for coordinated care, and remote-monitoring technologies all require broadband connections. In addition, these technologies can help improve access to specialty services for patients in rural communities, such as oncology and mental health and addiction services.

Question. To the extent that barriers remain, what Medicare policy changes would you suggest the committee consider to address them?

Answer. I would suggest the following: (a) increase coverage of services and equal reimbursement for services provided through telehealth arrangements and those provided in person, and help account for the costs of acquiring, operating and maintaining equipment; (b) expand technologies that may be used, including remote patient monitoring; and (c) expand access to broadband.

QUESTION SUBMITTED FOR THE RECORD BY HON. DEBBIE STABENOW
AND HON. BENJAMIN L. CARDIN

DENTAL CARE

Question. Lack of oral health care is a significant public health problem in the United States. Significant health professional shortages and lack of access to dentistry impacts rural and underserved communities disproportionately. We know that our seniors are negatively impacted by the lack of a dental benefit in Medicare. We also know that children, families and people with disabilities who rely on Medicaid and CHIP, programs which offer coverage for pediatric dental care and sometimes care for adults, often struggle to find providers to see them. Nowhere is the need for comprehensive dental coverage and access to providers more profound than in our rural and underserved communities. We have an opportunity to address the needs of our rural and underserved communities by improving our health care system by incorporating dental care more holistically through better coverage in Medicare, Medicaid and CHIP, utilizing telemedicine, and assessing provider and workforce gaps that can and should be filled in these communities. Ms. Martin, what is the most important thing that we, as the Senate Finance Committee, can do to improve dental care and coverage for people living in rural and underserved communities?

Answer. As a hospital system, dental care is beyond our scope of care. However, having spent my career in a rural community and had some experience in a federally qualified health center, I believe that the single biggest contribution we could make to improve dental health for our community is to provide benefits for Medicare recipients. Most in rural communities are living on small fixed income, and it is difficult or maybe impossible, for them to afford the dental care needed. Dental health plays a major role in overall health, and having coverage for care is the answer for overall improved health.

QUESTIONS SUBMITTED BY HON. DEBBIE STABENOW

MATERNITY COVERAGE

Question. We've heard from families and health-care providers in Michigan who are concerned about access to maternity coverage in rural areas. Close to 500,000 women give birth each year in rural hospitals and often face additional barriers and complications. For example, women in rural areas report higher rates of obesity, deaths from heart disease, and child-birth related hemorrhages. In addition, more than half of women in rural areas must travel at least half an hour to receive obstetric care, which can lead to decreased screening and an increase in birth related incidents.

Since 2004, a large number of rural obstetric units have closed, and only increased the distances that mothers must travel in order to receive maternity and delivery care. Unfortunately, the percent of rural counties in the United States without hospital obstetric units increased by about 50 percent during the past decade.

Do you have experience with loss of obstetric care for women within your respective fields?

Answer. We continue to provide obstetric care for the women in our community and see it as an essential community service. We are over 120 miles away from the next nearest facility that provides this service. Without this care, our community would wither away. I cannot fathom how a rural community can maintain its workforce and families without the support of obstetric care. We have a strong commitment to obstetric care and desire to maintain the services.

Having said that, obstetric care loses money. We have over 90 percent of our deliveries paid by Medicaid, which at this point only covers about 80 percent of the cost of care. The only method by which we can keep this service is to cost shift onto those services that provide margin.

We currently employ 3 OB/GYN physicians and 2 nurse mid-wife providers. This compliment of professionals are able to find the right work/life balance and maintain skills to support our community. We trained our nurse midwife team through a "grow your own" program by providing resources for education and employing them through the training process. They are strongly committed to this community and our organization in this partnership.

Question. What steps should be taken to ensure that the proper range of maternal care services are being offered through innovative rural health models?

Answer. As Congress considers new and alternative payment models for rural providers, it should ensure that the Medicare and Medicaid Programs adequately reimburse them so that they are financially stable and able to maintain services in vulnerable communities. These services need to be reimbursed at a level that at least covers the cost of providing care. There are essential health services that should be maintained in all communities, whether rural or urban, including prenatal care, emergency services and transportation to higher acuity facilities as needed. And take actions that expand scope of practice Jaws and allow non-physicians to practice at the top of their license and adequate funding for training programs for nurses and other allied professionals would help address workforce challenges.

QUESTIONS SUBMITTED BY HON. BENJAMIN L. CARDIN

TELEMEDICINE

Question. Although many may think of Maryland as an urban hub with its DC suburbs and large cities, there are parts of my State, both on the Eastern Shore and on the western side of the State, that are either very rural or medically underserved. My constituents who live in these parts of the State, must often drive long distances to get the health care they need. One way to increase access to quality health services to rural and underserved communities, is by offering treatment through telehealth technology. Ms. Martin, how do you see the role of telehealth continuing to grow in health-care delivery, and how can it be better utilized to increase care for Medicare beneficiaries?

Answer. I believe the role of telehealth will continue to increase in the healthcare delivery system. Rural communities need expanded access to broadband. Telehealth services can only be as strong as the network on which they are delivered. Coverage of service and reimbursement rates should be improved (e.g., adequate reimbursement for originating sites and payment parity with in person services). The high cost of acquiring telehealth equipment can be a barrier for rural hospitals. Grant programs could assist in these upfront costs for certain providers.

CHRONIC KIDNEY DISEASE AND MEDIGAP

Question. For many Medicare beneficiaries living with kidney failure, particularly those living in rural or underserved areas, accessing affordable care for their complex and chronic condition is a constant financial challenge. Over 92,000 dialysis patients live in States with no access to Medigap. This often leaves them unable to afford Medicare Part B's 20 percent cost sharing, which for a patient with kidney failure can often amount to tens of thousands of dollars of out-of-pocket costs each year. Ms. Martin, have you had challenges with Medicare beneficiaries who don't have access to Medigap coverage getting the care they need? For example, Medicare beneficiaries or patients with ESRD under 65?

Could you speak to the challenges Medicare beneficiaries face when they don't have access to Medigap plans and the benefits for Medicare beneficiaries who do have access to Medigap plans?

Answer. I am sorry. I have no experience with Medigap plans and am unable to answer this.

QUESTIONS SUBMITTED BY HON. ROBERT P. CASEY, JR.

Question. In your written testimony, you recommend that increased support for flexible models for telehealth can help address some of the challenges facing rural health-care providers. You stated that it would be helpful to “remove barriers so that rural facilities may fully utilize telehealth services.” Could you discuss specific changes that could be made to help increase the use and availability of telehealth services?

Answer. Currently, Medicare does not reimburse telehealth services the same as in-person services, nor does it treat all sites of services the same for providing telehealth services. The professional providing the service (located at the distant site), is paid under the Medicare fee schedule; however, the facility where the patient is located (originating site) is paid a small “originating” fee of about \$30. While the Medicare statute does not specify which facilities may serve as distant site, CMS has excluded rural health clinics and federally qualified health centers. Reduced reimbursement rates fail to account for the fixed costs of operating an originating site, as well as acquisition and maintenance costs for equipment.

There are many examples of services where telehealth could bring needed specialty care to a rural community. For our organization, we have one oncologist in our community. When this provider is out of the office, on vacation, or ill, there is no one to provide consultation and coverage when cancer patients are receiving infusion or chemotherapy treatments. The use of telehealth care would allow patients to continue their care plans and our community to have 24/7 coverage without that burden being placed on a solo provider.

Some options to consider are: (a) in order to increase the use and availability of telehealth services, Medicare should provide payment parity and cover all but an excluded list of services; (b) Medicare should expand the types of technology that it allows, including use of remote patient monitoring; (c) in many rural areas, access to broadband can also prevent adoption of telehealth services; and (d) another specific change is allowing specialists in remote sites to provide on-call, evening and weekend services for a rural specialist. This use of telehealth services will not only maintain or improve access to certain specialty care (e.g., oncology; behavioral health), but will help hospitals recruit and retain providers.

PREPARED STATEMENT OF KEITH J. MUELLER, PH.D., INTERIM DEAN, COLLEGE OF PUBLIC HEALTH; DIRECTOR, RUPRI CENTER FOR RURAL HEALTH POLICY ANALYSIS; AND GERHARD HARTMAN PROFESSOR OF HEALTH MANAGEMENT AND POLICY, UNIVERSITY OF IOWA

Chairman Hatch, Ranking Member Wyden, members of the Finance Committee, thank you for this opportunity to share my perspectives on key issues in rural health and related policy considerations. While some things have changed in the 30 years I have been conducting rural health research and policy analysis, the underlying rural dynamics remain much the same. But we have some new tools, both in health care delivery and through public policy, to help us continue our quest to establish and sustain a high performance rural health system.

We have had an interesting ride in policy debates and developments, including weathering the aftermath of converting hospital payment to PPS, considering health reform in the early 1990s, major changes in Medicare payment and benefits, changes through the Patient Protection and Affordable Care Act, and now a renewed (and welcome) discussion of what we should be doing to best serve the needs of rural residents. I have benefited from exchanges with this committee and others throughout, starting with a conversation Senator Roberts and I had when I testified, as part of the RUPRI Health Panel (which I have chaired for 20 years), to the House Committee on Agriculture in 1993. We provided analysis of five health reform proposals, including the Health Security Act by assessing their impacts on key rural considerations. Senator Roberts may remember sharing his appreciation for the straightforward analysis, which helped give me the confidence to continue bringing forward the best we can offer from policy analysis to help you continue to improve policies. Of course the then Representative Roberts may not have liked the “thumbs

up, thumbs down” table of our conclusions in my local newspaper, displayed during the hearing.

The RUPRI Health Panel launched in 1992 to bring the rural dimension front and center in policy discussions. We provided analysis during development and implementation of major national policies including the Balanced Budget Act of 1997, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and of course PPACA in 2010. We provided feedback to this committee and others during policy formation, and followed up with analysis of potential rural impacts of new policies, including calling attention to “unintended consequences” of the BBA of 1997 before that term was as ubiquitous as it is now.

I have come to appreciate the nexus of what we in the research community contribute to your efforts, and the concerns/needs of our colleagues delivering health-care services. As President of the National Rural Health Association in 1996 I represented the interests of rural providers in policy discussions. One of my funded projects in the late 1990s was to work with rural providers in Nebraska and Iowa to develop the template for a provider-sponsored Medicare+Choice plan. Much of my research involves site visits to rural health care organizations to understand the implications of Medicare and other policies on what they are able to do in their communities.

My personal engagement and that of the RUPRI Center, the RUPRI Health Panel, the Rural Telehealth Research Center (based in Iowa), and collaborations with others covers a host specific topics of interest to this committee. They include Medicare Advantage, rural ACOs, access to rural pharmacy services, rural implications of changes in health care delivery and organization, delivery system reform initiatives in Medicare and Medicaid payment, the evolution of the marketplace in health insurance coverage, and the role of telehealth. My written testimony includes specific research findings on some of those topics, along with policy considerations.

I would like to share some important questions to consider for the future of the Medicare ACO program. Are there benefits other than savings, related to changes in delivery models, that help achieve the triple aim of improved patient experience, better health, and lower costs? Should there continue to be different tracks? Should variations of advanced payment (perhaps as grants) continue to be available? Finally, what is the next iteration of payment reform that builds from the experiences of ACOs—perhaps global budgeting?

I now offer the RUPRI Health Panel’s five rural specific considerations for policies designed to encourage delivery system reform: (1) organize rural health systems to create integrated care; (2) build rural system capacity to support integrated care; (3) facilitate rural participation in value-based payments; (4) align Medicare payment and performance assessment policies with Medicaid and commercial payers; and (5) develop rural-appropriate payment systems.

In general, payment policies should be sensitive to the rural practice environment, including population density, distances to providers, and need for infrastructure investment. New models can build on the strengths of the rural system, notably primary care.

Rural health care organizations may need access to investment capital they are unable to generate on their own as they participate in new, better ways of organizing services. We should test ideas and programs specific to rural circumstances, as is underway in Pennsylvania. Payment policies and alternative sources of financial support should recognize the importance of access to services in places wherein patient revenue will not be sufficient to cover all costs.

Thank you for this opportunity, and I look forward to your questions.

Chairman Hatch, Ranking Member Wyden, and other members of the Finance Committee, thank you for this opportunity to share work of the Rural Policy Research Institute (RUPRI) Center for Rural Health Policy Analysis and the RUPRI Health Panel, as well as other published research and reports. I will focus on three areas of particular relevance, rural experience with Medicare’s accountable care organizations, or ACOs; payment policies driving changes in delivery systems; and use of telehealth. I will conclude with general observations about future directions in rural health policy.

BACKGROUND

While some things have changed in the 30 years I have been conducting rural health research and policy analysis, the underlying rural dynamics remain much the same. But we have some new tools, both in health care delivery and through public policy, to help us continue our quest to establish and sustain a high performance rural health system.

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My personal engagement and that of the RUPRI Center, the RUPRI Health Panel, the Rural Telehealth Research Center (based in Iowa), and collaborations with others covers a host specific topics of interest to this committee. They include Medicare Advantage, rural ACOs, access to rural pharmacy services, rural implications of changes in health care delivery and organization, delivery system reform initiatives in Medicare and Medicaid payment, the evolution of the marketplace in health insurance coverage, and the role of telehealth.

MEDICARE ACOS (SHARED SAVINGS PLANS AND DEMONSTRATIONS)

Rural presence in ACO activities has grown dramatically, as of the end of 2016 in 22 percent of rural counties at least 30 percent of Medicare beneficiaries were attributed to ACOs. Also by the end of 2016 there were nearly 40 percent of rural (non-metropolitan) counties with at least 3 ACOs with attributed beneficiaries, up from 17 percent in 2014.¹ As of the end of 2017 at least one Medicare ACO was operating in 60 percent of rural counties.² Maps showing the spread of rural ACOs based on attributed lives for each year 2014–2016, and a map showing presence of ACOs based on where there are participating providers, are in an attachment. Factors accounting for the increased rural participation include:

- Demonstration programs making advanced payments available to invest in information systems and other start-up costs;
- National firms supporting multiple ACOs (aggregators that centralize functions such as data analytics);
- Rural health care organizations already engaged in care management and perhaps even performance based contracting;
- Network development among rural health care organizations (HCOs); and
- Spread of urban-based systems into rural regions.

What have we learned from the early adopters of the ACO model in rural areas? We know that experience matters, both prior experience in network development and care management, and experience gained as a result of functioning as an ACO. Approaches to developing ACOs vary considerably, from a single regional system like the Billings Clinic and affiliates in Montana, to rural networks like the Illinois Critical Access Hospital Network, to affiliations of geographically disperse HCOs under a national organization such as CaravanHealth, to spread of urban-based ACOs. We also know that there is not a “typical ACO model,” that in rural areas in particular we are seeing different strategies for building aggregations of HCOs to reach the critical mass in attributed beneficiaries necessary to generate savings from affecting the care-seeking behavior of historically high users of expensive services.

Tables 1–3 display characteristics of 525 Medicare Shared Savings Plans (MSSP) and Next-Gen ACOs, based on the RUPRI data about where there are providers participating in those ACOs. We classify ACOs based on the counties in which they have providers, so “100 percent nonmetro” means that all counties of the ACO with participating providers are designated nonmetropolitan; “70%–99%” is again based

¹A. Clinton MacKinney, F. Ullrich, and K. Mueller (2018), “Medicare Accountable Care Organization Growth in Rural America, 2014–2016.” RUPRI Center Data Report Brief No. 2018–1. March, www.public-health.uiowa.edu/rupri/.

²Document in development; based on RUPRI Center for Rural Health Policy Analysis data set that plots location of health care providers included in ACOs.

on the percent of all counties in which the ACO has participating providers. As we should expect, a majority of ACOs are in metropolitan or mostly metropolitan areas. However, as of 2017 there were 53 ACOs operating exclusively or mostly in non-metropolitan counties, and nearly all of the AIM ACOs, as intended, serve non-metropolitan counties. Table 3 demonstrates the strong preference of rural-based ACOs for the Track 1 model, but nearly 14 percent of those in the categories of mostly nonmetropolitan and mixed are participating in Track 3 or Next Generation ACOs. Table 4 uses these same categories of ACOs on a nonmetropolitan—metropolitan scale to display other characteristics of interest. Notably, rural ACOs are more likely to be non-profit and less likely to be independent hospitals. We have much to learn about the interaction of ACO development and sustainability of rural health infrastructure, an ongoing project of the RUPRI Center for Rural Health Policy Analysis.

Table 1: Medicare ACOs by Metropolitan/Nonmetropolitan County Presence, as of January 2017

Metro/Nonmetro	Description	Count	Percentage
Nonmetro	100% nonmetro counties	8	1.5%
Mostly nonmetro	70%–99% nonmetro counties	45	8.7%
Mixed	30%–69% nonmetro counties	144	27.7%
Mostly metro	1%–29% nonmetro counties	112	21.5%
Metro	0% nonmetro counties	211	40.6%

Source: RUPRI Center for Rural Health Policy Analysis database on ACO provider locations.

Table 2: Medicare ACO Participation in AIM, by Metropolitan/Nonmetropolitan County Presence, as of January 2017

Metro/Nonmetro	Description	AIM Participation	
		Count	Percentage
Nonmetro	100% nonmetro counties	6	75.0%
Mostly nonmetro	70%–99% nonmetro counties	16	35.6%
Mixed	30%–69% nonmetro counties	16	11.1%
Mostly metro	1%–29% nonmetro counties	2	1.8%
Metro	0% nonmetro counties	5	2.4%

Source: RUPRI Center for Rural Health Policy Analysis database on ACO provider locations; and CMS “ACO Investment Model” data (<https://innovation.cms.gov/initiatives/ACO-Investment-Model/>, accessed April 14, 2018).

Table 3: Medicare ACO Model Participation, by Metropolitan/Nonmetropolitan County Presence, as of January 2017

Metro/Nonmetro	Description	Track 1		Track 2		Track 3		Next Gen	
		Ct	Pct	Ct	Pct	Ct	Pct	Ct	Pct
Nonmetro	100% nonmetro counties	8	100%	0	0%	0	0%	0	0%
Mostly nonmetro	70%–99% nonmetro counties	42	93.3%	0	0%	1	2.2%	2	4.4%
Mixed	30%–69% nonmetro counties	124	86.1%	0	0%	9	6.3%	11	7.6%

Table 3: Medicare ACO Model Participation, by Metropolitan/Nonmetropolitan County Presence, as of January 2017—Continued

Metro/ Nonmetro	Description	Track 1		Track 2		Track 3		Next Gen	
		Ct	Pct	Ct	Pct	Ct	Pct	Ct	Pct
Mostly metro	1%–29% nonmetro counties	95	84.8%	2	1.8%	5	4.5%	10	8.9%
Metro	0% nonmetro counties	172	81.5%	3	1.4%	14	6.6%	22	10.4%

Source: RUPRI Center for Rural Health Policy Analysis database on ACO provider locations.

Table 4: Medicare ACO Characteristics

Characteristic	Nonmetro		Mostly nonmetro		Mixed		Mostly Metro		Metropol		Total	
	Ct	Pct	Ct	Pct	Ct	Pct	Ct	Pct	Ct	Pct	Ct	Pct
ACO "For Profit" Status												
For-profit	0	--	0	0%	18	45.0%	15	32.6%	25	54.3%	58	41.1%
Not-for-profit	0	--	9	100%	22	55.0%	31	67.4%	21	45.7%	83	58.9%
ACO Taxonomy type												
Expanded Physician Group	0	--	5	26.3%	22	25.3%	23	26.1%	30	20.8%	80	23.7%
Full-Spectrum	0	--	1	5.3%	17	19.5%	15	17.1%	16	11.1%	49	14.5%
Hospital Alliance	0	--	2	10.5%	11	12.6%	13	14.8%	13	9.0%	39	11.5%
Independent Hospital	0	--	4	21.1%	8	9.2%	10	11.4%	11	7.6%	33	9.8%
Indep. Physician Group	0	--	4	21.1%	14	16.1%	15	17.1%	48	33.3%	81	24.0%
Physician Group Alliance	0	--	3	15.8%	15	17.2%	12	13.6%	26	18.1%	56	16.6%
Sponsoring Entity Type												
Hospital system	1	16.7%	14	36.8%	52	44.1%	52	53.1%	59	34.3%	178	41.2%
Physician group	1	16.7%	8	21.1%	38	32.2%	37	37.8%	85	49.4%	169	39.1%
Other	4	66.7%	16	42.1%	28	23.7%	9	9.2%	28	16.3%	85	19.7%
Provider Type												
Hospital system	2	33.3%	7	18.9%	27	22.1%	28	28.3%	31	17.6%	95	21.6%
Physician group	3	50.0%	15	40.5%	50	41.0%	32	32.3%	83	47.2%	183	41.6%
Both	1	16.7%	15	40.5%	45	36.9%	39	39.4%	62	35.2%	162	36.8%

Source: RUPRI Center for Rural Health Policy Analysis database on ACO provider locations; and Levitt Partners Torch Insight Database (<https://torchinsight.com/>, 2018).

Metropolitan/Non-Metro categories:

- Nonmetro: 100% nonmetro counties
- Mostly nonmetro: 70%–99% nonmetro counties
- Mixed: 30%–69% nonmetro counties
- Mostly metro: 1%–29% nonmetro counties
- Metro: 0% nonmetro counties

ACO Taxonomy Type (Leavitt Partners' classification)—A categorization of ACOs based on organizational structure, ownership, and patient care focus:

- Expanded Physician Group: ACOs who directly provide outpatient services, but will contract with other providers to offer hospital or subspecialty services.

- Full Spectrum Integrated: ACOs who provide all aspects of healthcare to their patients. ACOs in this classification are often dominated by a large integrated delivery network.
- Hospital Alliance: ACOs who have multiple owners with at least one of those owners directly providing inpatient services.
- Independent Hospital: ACOs who have a single owner and directly provides inpatient services, but do not provide subspecialty care. Outpatient services could also be directly provided by this type of ACO if the owner is an integrated health system.
- Independent Physician Group: ACOs who have a single physician group owner and do not contract with other providers to offer additional services.
- Physician Group Alliance: ACOs who may have multiple physician group owners—often including multi-specialty groups—but do not contract with other providers to offer additional services.

Provider Type—The type of provider organizations that are participating in an ACO. Options include: “Hospital System,” “Physician Group,” and “Both.” For the purpose of this field “Hospital System” refers to any organization that owns and operates a hospital. The “Both” option is appropriate when there is a single organization, such as an integrated delivery network, that includes both a hospital system and a physician group as well as when there are separate hospital system and physician group organizations participating in the ACO.

There have been two recent “pushes” of the ACO model in rural places. First, the ACO Investment Model (AIM) has provided start-up capital to qualifying organizations, and the criteria are weighted in favor of small (by beneficiary count) rural ACOs. Second, regional and national organizations are providing administrative support, and in some instances training in care management, to geographically disperse provider organizations. Several Management Service Organizations serve at least 15 ACOs, including ones in nonmetropolitan areas:

- Aledade (16 total ACOs, 10 nonmetro/mostly nonmetro/mixed).
- CaravanHealth (22 total ACOs, 21 nonmetro/mostly nonmetro/mixed).
- Collaborative Health Systems (19 total ACOs, 6 nonmetro/mostly nonmetro/mixed).
- Imperium Health (15 total ACOs, 7 nonmetro/mostly nonmetro/mixed).

While there is debate regarding the aggregate impact of ACOs on Medicare spending, our research and that of others find improvements in the quality measures used in the program. Rural ACOs, for example perform well (better than urban counterparts) on care management/patient safety and preventive health domains. Expenditure savings vary; a 2017 OIG report found net reduction in spending across all ACOs, but concentrated in less than half of them. Eight of the 11 rural ACOs in the Advanced Payment Model, an early demonstration prior to the current AIM demonstration, generated savings. Analysis of 2016 final reports showed that 56 percent of MSSP ACOs saved Medicare expenditures, with 31 percent receiving share savings bonuses.³

We are at a critical point in time in learning from the experiences of early entrants into the Medicare ACO program. Some important questions should be addressed. Is the policy goal solely to continuously show lower expenditures versus a target influenced by the ACO’s own previous success and the regional market? Are there benefits to this payment model related to changes in delivery models, including greater likelihood of achieving the triple aim of improved patient experience, better health, and lower costs? Should policy continuously accommodate different cost savings expectations, given variability in circumstances across all participating ACOs? Should variations of advanced payment (perhaps as grants) continue to be available? Finally, what is the next iteration of payment reform that builds from the experiences of ACOs—perhaps global budgeting?

PAYMENT POLICIES AND DELIVERY SYSTEM REFORM

The ACO program is generating a great deal of attention, but it is but only one approach to payment reform designed to motivate changes in the delivery system (delivery system reform or DSR). We should expect more payment reform initiatives going forward, including implement of physician payment reform. As we do so the RUPRI Panel encourages attention to five rural specific considerations:

1. Organize rural health systems to create integrated care.
2. Build rural system capacity to support integrated care.
3. Facilitate rural participation in value-based payments.
4. Align Medicare payment and performance assessment policies with Medicaid and commercial payers.
5. Develop rural-appropriate payment systems.

In discussing each of those considerations, the Panel provides specific suggestions in our Policy Paper, which can be downloaded from the Panel’s website: http://www.rupri.org/wp-content/uploads/FORHP-comments-km-DSR-PANEL-DOCUMENT_PRD_Review_112315.clean-4_sn-3.pdf.

³R. Saunders, D. Mulestein, and M. McClellan (2017), “Medicare Accountable Care Organization Results for 2016: Seeing Improvement, Transformation Takes Time.” *Health Affairs Blog*. November 21. 10.1377/hblog20171120.211043.

In general, payment policies should be sensitive to the rural practice environment, including population density, distances to providers, infrastructure investment including information technology and data analytics capabilities, and opportunities to develop models that actually take advantage of smaller scale and integrating all local services with those provided at some distance. One example of that sensitivity is to be aware of differences in readiness to change. For example, our analysis of 2015 data from physician compare shows that among categories of urban, rural, and “mixed” physician practice locations, rural practices were least likely to report quality measures (58.5 percent) and use electronic records (17.7 percent). These data indicate a need for a modified timeline to implement payment reform, and/or a rationale to provide additional technical assistance and access to capital.

TELEHEALTH

Appropriate use of telehealth, the third area of focus in my testimony, could facilitate taking full advantage of the strengths of the rural model, focused on direct patient engagement from a primary care base. Studies completed by the RUPRI Center (www.ruprihealth.org) and underway by the National Center for Rural Telehealth Research (www.ruraltelehealth.org), show that telehealth can be a tool that reinforces and augments care provided by primary care providers (PCPs) in rural settings. Access to specialist services included in the continuum of care initiated by PCPs is enhanced when the specialist is brought to the rural site through telehealth. Further, virtual office visits and home monitoring provide the specialist with information needed to manage chronic conditions.

In our research focused on use of telehealth in hospital facilities we found that tele-emergency care enhanced local access by having board-certified emergency doctors available on call. This was instrumental in recruiting and retaining primary care physicians who knew they had the support of those board certified physicians who see many cases of what in a rural setting are infrequent occurrences. We also found reported improvements in quality of care, greater ability to focus on patient needs, and improved community support of the local hospital. Use of telehealth services is expected to increase, especially given provisions in the Chronic Care Act section of the Bipartisan Balanced Budget Act. As that happens there are ongoing policy considerations. First, fee-for-service payment policies need to be in place allowing payment for services delivered through telehealth. As payment evolves away from fee-for-service telehealth should be supported as a means to the achieving the triple aim. Second, support is needed for ongoing research indicating when telehealth services add value to health care delivery.

CONCLUDING OBSERVATIONS

I now offer general observations based on the past several years of RUPRI Health Panel work in policy analysis and using our framework of a high performance rural health delivery system. We are in a time of transformation in health care, both in what is possible in delivery and how we pay for services. In this time of health care transformation, we should provide support to rural providers who because of the scale of their organizations cannot adapt as rapidly as the system may change. Rural HCOs may need access to investment capital they are unable to generate on their own as they participate in new, better ways of organizing services. Many rural HCOs want to participate in delivery system reform and new payment methodologies, but we should test ideas and programs specific to rural circumstances, as is underway in Pennsylvania. Payment policies and alternative sources of financial support should recognize the importance of access to services in places wherein patient revenue will not be sufficient to cover all costs.

I offer these observations about how to approach changes to policies affecting rural health delivery:

- We should think in terms of total cost of care, not the prices of individual services or single encounters.
- New approaches to delivering services and payment policies should be coordinated across payers.
- Individual and population health are affected by circumstances and policies beyond the immediate purview of health policies; that interaction should be considered in a rural context.

Finally, I offer other resources as the committee considers policy improvements serving rural America. I realize that much attention focuses on the closure of rural hospitals and the struggles those remaining open incur to meet financial needs. Discussions about future action include thinking through alternative models for rural communities. Abrupt closure of the local hospital should not be an option because

there will be residents who lose access to essential services as a result. The RUPRI Health Panel has completed work to summarize and compare alternative models for rural communities, accessible from our website: <http://www.rupri.org/wp-content/uploads/Alternatives-for-Developing-the-High-Performance-Rural-Health-System-FIN....pdf>. But the issues facing rural communities are much more encompassing than the focus on hospitals, and communities fortunate to have a viable, robust hospital delivery system still confront questions about how to transform to a value-based system. In addition to our work on Medicare payment reform, the Health Panel published a document describing challenges and opportunities for rural health systems in Medicare payment and delivery system reform: <http://www.rupri.org/wp-content/uploads/RUPRI-Health-Panel-Medicaid-and-Delivery-System-Reform-June-2016.pdf>. Finally, the RUPRI Health Panel is committed to helping providers and policy makers learn of options that advance us toward a high performance rural health system. We established a framework for defining that end objective in documents released in 2011, with a follow up document in 2014 suggesting a specific strategy: <http://www.rupri.org/wp-content/uploads/2014/11/Advancing-the-Transition-Health-Panel-Brief.pdf>.

More recently, the Health Panel completed a comprehensive assessment of progress of health system transformation, including impacts on rural health delivery and outcomes for rural populations. We included an assessment of remaining gaps and how policies across seven topical areas could address them. The areas are Medicare, Medicaid and CHIP, Insurance Coverage and Affordability, Quality, Healthcare Finance and System Transformation, Workforce, and Population Health. The document (Taking Stock: Policy Opportunities for Advancing Rural Health) can be accessed as a single download, or by the chapters just enumerated: <http://www.rupri.org/areas-of-work/health-policy/#paneldochealth>.⁴ The RUPRI Center for Rural Health Policy Analysis, as referenced earlier in this testimony, publishes research briefs and papers, as well as scholarly journal articles, on a number of topics. Those topics include Medicare Advantage, health insurance markets, rural pharmacies, rural ACOs, and physician payment. The Center's website is www.ruprihealth.org.⁵

QUESTIONS SUBMITTED FOR THE RECORD TO KEITH J. MUELLER, PH.D.

QUESTION SUBMITTED BY HON. ORRIN G. HATCH

Question. Given your extensive research into rural delivery system reforms, can you talk in more detail about why rural providers are not robustly participating in new value based payment models? What specific legislative changes do you think Congress and the administration should consider to help rural and frontier communities tailor advanced payment models that meet their unique circumstances?

MEETING REQUIREMENTS FOR NUMBERS OF PERSONS SERVED

Answer. Issue: New payment models that share financial risk, or that are part of demonstration programs to be evaluated, can require large minimum populations to assure fiscal viability. Examples include the ACO program minimum of 5,000

⁴The work of the RUPRI Health Panel has been supported by the following sources:

- The U.S. Department of Agriculture (special grant to RUPRI from which Panel support was provided in its early years).
- The Federal Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services (ongoing cooperative agreement).
- The Robert Wood Johnson Foundation (work in 2009–2010).
- The Agency for Healthcare Research and Quality (1990s).
- The Leona M. and Harry B. Helmsley Charitable Trust (current grant).

The information, conclusions and opinions expressed in this testimony are those of the author and no endorsement by any of the funders is intended or should be inferred.

⁵The work of the RUPRI Center for Rural Health Policy Analysis has been supported by the following sources:

- The Federal Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services (ongoing cooperative agreement to the Center, funding the project Rural Health Value, evaluation work).
- The Leona M and Harry B. Helmsley Charitable Trust (supporting evaluation of telehealth).
- The Robert Wood Johnson Foundation (work related to health reform in 2009).
- Office of Rural Health, Veterans' Health Administration.

The information, conclusions and opinions expressed in this testimony are those of the author and no endorsement by any of the funders is intended or should be inferred.

Medicare beneficiaries and the Accountable Health Communities demonstration minimum of 53,000 Medicaid enrollees. Rural healthcare organizations would not typically meet those thresholds, necessitating time to form, or participate in, larger system arrangements (*e.g.*, national ACOs, regional AHCs). Some rural providers may assume the requirement cannot be met and not pursue the payment model.

Resolution: New programs could allow time, either through a prolonged period to enter a program that has cycle, or through multiple cycles, for providers to develop the relationships needed to create aggregations of participating beneficiaries/enrollees. Another approach would be to allow experimentation with smaller numbers of participants, adjusting some of the particular model's parameters accordingly (*e.g.*, calculations of shared financial risk and reward). This approach, for example, is built into the ACO program, albeit with the minimum remaining at 5,000 enrollees. New payment programs could be designed to explicitly allow for new aggregations of providers to participate, as the case for small physician practices forming virtual groups in the Merit-based Incentive Payment System (MIPS).

LIMITED CAPACITY IN RURAL HEALTH-CARE ORGANIZATIONS TO CHANGE TO NEW PAYMENT DESIGNS

Issue: Value-based payment models require expensive and sophisticated retooling of provider infrastructure and operations. Large urban systems have the resources to do so, and to weather short-term losses. Rural providers do not have the resources, nor the financial reserves, to rapidly or dramatically change.

Resolution: One recommendation is to help build rural system capacity, to build integrated care systems that are responsive to new payment models. Several specific approaches could be used (first three are taken from the RUPRI Health Panel November 2015 brief, Medicare value-based Payment Reform, www.rupri.org/areas-of-work/health-policy/#paneldochealth):

- Provide low-cost capital to rural providers demonstrating need for such assistance;
- Provide technical assistance for transitions to value-based care;
- Support development and implementation of population health data management platforms and skills; and
- Build in up-front payment in long term programs, such as the ACO Investment Model which attracted rural participants to that program.

A general approach is for payers, including Medicare, to provide (internally or through contracted entities) direct assistance in early phases of implementing new payment designs, as CMS is doing in the Quality Payment Program. Since the challenges facing small rural health-care organizations are both financial capacity (funding for investment and start-up costs) and analytical capacity to adjust to new reporting requirements and payment formulae, there are opportunities for modest investments in grants and loans to generate substantial return through system transformation in rural places. Specifically, programs in CMS and HRSA could be used to provide direct technical assistance and support development of tools and strategies rural providers could use to adopt new payment models.

SPECIFICS OF PAYMENT MODEL DESIGN

Issue: Fundamentally payment models need not be different for rural and urban providers; payment based on value would be seeking the same results in any practice environment. However, as recognized in the preceding comments, the starting points for implementing improved payment systems based on value rather than volume are not the same. There need to be considerations of rural circumstances in design and implementation of new systems, including accounting for transitioning out of payment systems designed for rural circumstances (*e.g.*, cost-based payment and volume adjustments) and adjusting for patient mix (including low volume).

Resolution: These considerations are taken from the RUPRI Health Panel's January 2018 paper, "Taking Stock: Policy Opportunities for Advancing Rural Health."

- Payment policies to rural providers under tightly defined criteria could include adjustments for higher per person or per episode fixed costs associated with maintaining local access when patient volumes are not sufficient to generate necessary revenue streams supporting all fixed costs.
- Value-based payment presumes integrated health-care delivery systems taking full advantage of patient information (including population health data). Rural providers will need to develop new capacities to participate in those

systems, making rural investments in broadband and technical workforce development essential.

- Alternative payment delivery models could be tested in rural communities using demonstration and pilot programs. These could be based on existing demonstrations, such as AHCs, but modified to take full advantage of rural community circumstances (*e.g.*, primary care-based delivery system, limited number of community-based service entities) and encourage new developments (*e.g.*, linking to regional providers).

QUESTION SUBMITTED BY HON. ROB PORTMAN
AND HON. MICHAEL F. BENNET

Question. We have previously introduced legislation to encourage providers to participate in alternative payment models and facilitate care coordination, including the Medicare PLUS Act (S. 2498 in the 114th Congress) and the Medicare Care Coordination Improvement Act (S. 2051 in the 115th Congress). When we consider coordinating care for patients in rural settings, what administrative burdens do you face? What can Congress do to ensure that value-based care is effective in rural areas?

ADMINISTRATIVE BURDENS

Answer. A major burden I hear of often from rural providers is one of reporting multiple measures to multiple payers to meet requirements for full payment. The RUPRI Health Panel recommended in its November 2015 Policy Brief “Medicare Value-Based Payment Reform” that Medicare payment and performance assessment policies be aligned with Medicaid and commercial payers. Initiatives such as the all-payer global budget demonstrations in Pennsylvania and Maryland are consistent with that recommendation. Measurement development led by the National Quality Forum, supported by Federal agencies and commercial payers, is also helpful. Any further payment reform development, legislative and regulatory, should maintain the focus on streamlining reporting requirements across payers. A second burden is that of transaction costs associated with developing relationships to support coordinated care. Particularly for small rural provider in cost-based payment systems, time spent to build new relationships is time not reimbursed. Either modest investments in the initial set-up costs (through something similar to the AIM program in the ACO arena) or making them “allowable costs” would be helpful.

DEPLOYING ADDITIONAL RESOURCES

Care coordination requires coordinating professionals, processes, and relationships. If the professionals to provide care coordination are not present in a rural area, it is challenging for rural health systems to hire and develop them *de novo*. And if the care coordination professionals are not present, the requisite processes and relationships to make care coordination successful are not present either. Therefore, this health-care worker needs to be considered when developing workforce policies and incentives to create positions and recruit persons to rural areas. Other investments will also be helpful to the spread of care coordination in rural settings: new population health and financial risk management technology and infrastructure, a primary-care focused health care workforce supported by new professionals (*e.g.*, community paramedics and community health workers), EHRs that are designed to be interoperable and serve improved patient care (and community health), and data provided by all payers (including CMS) that directly assists providers to improve care and community health. Public policy can directly accelerate the adoption of these value-laden inputs.

QUESTIONS SUBMITTED BY HON. RON WYDEN

RURAL WORKFORCE

Question. As discussed during the hearing, the shortage of primary and specialty care providers is a critical issue facing rural communities across the country. In Oregon, 25.9 percent of residents live in a health professional shortage area. Difficulty recruiting and retaining physicians and other members of the care team can result in longer patient wait times and reduced access to care for those living in rural communities.

What concrete policy ideas would you suggest this committee pursue to help attract more providers to rural America?

PROVIDER RECRUITMENT

Answer. We know from research literature the factors that optimize the likelihood that healthcare professionals will choose rural communities as practice sites—their own community roots, training in rural areas, completing residencies in rural areas, desires based on culture and lifestyle of both the healthcare professional and significant other, attraction (or lack thereof) of the practice environment, and income expectations (intentionally mentioned last). Given those research findings, the following policy ideas warrant pursuit (most originate in the RUPRI Health Panel's *Taking Stock* document, which includes supporting narrative):

- Decentralize training programs into rural environments through improvements in CMS GME funding.
- Target GME funding toward rural health care needs, including primary care in addition to alignment with other national health priorities.
- Target Federal funding of non-GME training programs to national health priorities.
- (Not from *Taking Stock*) Support “pipeline programs” that are comprehensive approaches to recruiting rural students into the health professions (broadly defined) and extend through all of their training, including rural training tracks and rural residency training.
- (Not from *Taking Stock*) Support connectivity between rural practices and regional (urban-based) services through investments in interoperable health information systems and telemedicine.

PROVIDER RETENTION

Retaining providers that are in rural communities is the other side of the same coin that included recruiting them. Elements in a successful retention strategy include:

- Payment policies that create comparability across locations.
- Payment policies that support non-physicians and patient support providers, needed in a person-centered health home in rural communities (from *Taking Stock*).
- Opportunities for rural health-care professionals to participate in new payment models such as Comprehensive Primary Care Initiatives (including CPC+), MIPs, and advanced alternative payment models.

RURAL BENEFICIARY HEALTH NEEDS

Question. Rural communities tend to be older, sicker, and lower income compared to their urban counterparts. When rural hospitals are forced to close their doors, Medicare beneficiaries living in the surrounding areas often have limited health care options. The prevalence of multiple chronic conditions among those living in rural areas heightens the need to ensure all Medicare beneficiaries have access to high quality care—regardless of where they live.

In your view, where should this committee focus its efforts to ensure that Medicare beneficiaries living in rural areas (especially those with multiple chronic conditions) have access to high quality care?

What Medicare policy changes would be most impactful in the short term and long term?

ENGAGING RURAL HEALTH AND HUMAN SERVICES PROVIDERS

Answer. Many of the improvements in assuring high quality are linked to changes in payment (value-based payment designs), encouraging new methods of organizing services (patient-centered medical homes, accountable health communities), and spreading innovation in clinical practice and population health (including healthy lifestyle programs). *A critical rural consideration is to be sure that innovations are designed and implemented in ways that include rural provider and rural community organization participation.* Policy specifics to follow this principle include:

- Instituting evaluation/assessment processes that adjust for the small volume of rural providers (e.g., statistically “borrowing” power by aggregating over time or across geographies);
- Allowing sufficient time for rural providers and organizations to transition from current practices and payment models to new ones;
- Providing technical assistance to small scale organizations (provider and community-based);

- Taking steps to incorporate new payment adjustments such as chronic care management fees into existing payment design, as has been done for RHCs and FQHCs; and
- Changes in payment that both advance quality and generate savings should be sensitive to rural circumstances (*e.g.*, extremely low and sometimes negative margins) that require time and assistance to mollify.

EXTENDING SERVICES TO RURAL BENEFICIARIES

Making the highest quality care accessible to rural beneficiaries means ensuring access to affordable integrated services in total care plans—subspecialty care coordinated with all needs and special circumstances. This requires communications flow, including medical records, and access to consultants, across distance (not the urban model of a multispecialty group or accessing additional providers in close proximity). Additionally, rural beneficiaries benefit from integration across clinical providers and community-based organizations focused on quality of life for beneficiaries. Specific policy considerations include (from RUPRI Health Panel documents response from Keith Mueller, Ph.D. (University of Iowa, RUPRI), page 5, including *Advancing the Transition to a High Performance Rural Health System, Care Coordination in Rural Communities*, and the *Taking Stock* document referenced earlier):

- Using the leverage of grant and demonstration programs to facilitate joint governance structures across community-based organizations and health care organizations, such as models in Minnesota focused on rewards for addressing total cost of care;
- Supporting new technology, including systems that achieve interoperability of clinical and health records across organizations;
- Providing stable long-term funding supporting locally-appropriate public health prevention programs; and
- Incentivizing integrating preventive and clinical services.

TELEHEALTH

Question. Building on the proven success of telehealth in the rural setting, Congress passed the CHRONIC Care Act earlier this year, which expanded access to telehealth in Medicare to allow individuals receiving dialysis services at home to do their monthly check-ins with their doctors via telehealth, to ensure individuals who may be having a stroke receive the right treatment at the right time, to allow Medicare Advantage plans to include additional telehealth services, and to give certain ACOs more flexibility to provide telehealth services.

In your view, what, if any, Medicare payment barriers to adoption and utilization of telehealth services remain in the rural setting today?

Answer. First, when telehealth requires participation of multiple (usually two) providers, both need to receive payment. A barrier to that occurring can be a calculation of budget neutrality that does not account for increased value which would include patient engagement. Second, When Medicare payment is very low but the administrative burden to collect is high, we may not see telehealth utilization in the claims data because providers are opting not to file.

Question. To the extent that barriers remain, what Medicare policy changes would you suggest the committee consider to address them?

Answer. Rather than policy change, policy makers may consider research regarding the use of telehealth in global payment and capitated systems; *e.g.*, CMS's Maryland demonstration and large closed HMOs. These payment systems obviate the overuse risk in telehealth and may elucidate appropriate uses.

RURAL ACOS

Question. Aligning a fragmented delivery system can be particularly challenging in rural areas, where there is often a shortage of health care professionals, limited financial capital available, and a patient population composed of older and sicker patients. Although several rural Accountable Care Organizations (ACOs) have records of success, many rural providers still find the prospect of joining an ACO daunting. Creating opportunities for rural providers to participate in value-based payment models, such as ACOs, is critical to transitioning to a health care system that rewards value instead of simply volume of services provided.

What characteristics have allowed some rural ACOs to succeed?

Are there certain “lessons learned” from these success stories that may be helpful to rural providers interested in participating in a rural ACO?

CHARACTERISTICS OF SUCCESSFUL RURAL ACOS

Answer. The RUPRI Center for Rural Health Policy Analysis has been studying the creation and operations of rural Medicare ACOs since the program began. Much of the historical information about the presence of ACOs in rural places was in my written testimony. Rural experiences are variations on the themes emerging from studies of all Medicare ACOs (which tend to have an urban bias because of the disproportionate presence in urban areas, at least until the AIM program and national aggregators helped boost rural participation in recent years). Our current study of high performing rural ACOs (defined using quality scores and shared savings results) is finding these seven characteristics to be important:

- Prior experience with multi-organizational collaborations; especially important for rural ACOs with independent hospital and physician practice participation;
- Prior experience with the specific organizations in the ACO;
- Strategic managerial and clinical leadership;
- Shared governance structure; providers from multiple sites on the governing board;
- Engagement in care coordination for targeted patients (based on diagnosis);
- Improvement in continuum of care, including adding non-acute services and partnering with local social service agencies and pharmacies; and
- Use of advanced analytics and access to the requisite data.

LESSONS LEARNED AND IMPLICATIONS FOR ACO ACTION AND PUBLIC POLICY

For rural providers considering participating in ACOs, they should map out a strategic plan/approach that generates the characteristics listed above, either by drawing on their own history or by setting a long enough time line to develop them. They can consider affiliations with other providers, either within a rural region (such as the aggregation of Critical Access Hospitals in an Illinois ACO), with a regional system (such as UnityPoint in the Midwest), or working with a national aggregator such as Caravan Health. All are examples of achieving the scale needed to support some of the factors of success, particularly data collection and analytics, care coordination scaled to achieve savings, and managing care across the entire continuum to improve quality and lower total expenditures. General considerations for the Medicare Shared Savings Program include:

- Thus far, only about 25% of ACOs have received shared savings. And the cost to establish and ACO is significant. Thus, a rural provider requires financial reserves and progressive leadership to establish an ACO. At least for now, the purpose of forming or joining an ACO is not to realize profit, but to obtain data for more informed managerial decisions and gain experience in population health and financial risk management.
- The CMMI AIM program has been successful in expanding the program. Developing the “next AIM program” might encourage additional rural provider participation in ACOs.
- ACOs should be considered an iterative step toward value-based payment (ACOs are still built on a fee-for-service platform). ACOs are “training wheels” for bundled payment, primary care capitation, global payment, or other systems not yet designed.

TRANSITION FROM VOLUME TO VALUE

Question. The passage of the bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was a milestone in Congress’s efforts to repeal the flawed SOR and move our health-care system from one that rewards volume to one that rewards value. In many cases, however, rural providers report that participating in value-based payment models is a significant challenge for them, particularly when it comes to taking on financial risk for patient health outcomes and population health. In order to successfully transition our health care system to one that rewards value, it is critical to ensure there are meaningful opportunities for rural providers to participate in a value-based payment system.

What barriers exist today that discourage rural providers from participating in value-based payment models?

What, if any, Medicare policy changes would help ensure that rural providers and communities are not left behind in the transition to value-based payment?

BARRIERS

Answer. While there are hurdles to participate in several of the models being tested, at least some rural providers are engaged in nearly all of them. The Rural Health Value project provides a catalog of the programs that includes, for each of them, identification of rural participation, *Catalog of Value-Based Initiatives for Rural Providers*. General hurdles facing rural providers are described as follows:

- Except for ACOs, demonstrations readily appropriate for rural providers have been limited. Understandably, researchers desire high volumes to test change. But more creativity is needed to consolidate demonstration data so multiple rural provider systems can participate in demonstrations and gain experience in value-based payment models.
- Locally, rural providers are discouraged from participating in value-based payment models because limited operating margins and reserves cannot allow financial risk; that is, the cost of infrastructure development and operational change and the risk of revenue loss in a new model. Large health systems have the infrastructure and resources to affect change and tolerate short-term losses. Not so with many rural providers, as manifest by recent rural hospital closures.

More specifically, the hurdles are illustrated by the challenges facing physicians wanting to participate in the Merit-Based Incentive Payment System (MIPS). They must first understand intricacies of a highly complex system. Since most cannot hope to do so on their own, they either incur an additional expense for outside consultants, or take the time to work with one of the CMS regional technical assistance providers. Second they will need to be sure their reporting systems create the data required to calculate payment. Third, they will want to incorporate appropriate changes in their practices, yet another investment of time (which is time lost to reimbursable services) and perhaps direct cost.

POLICY CHANGES

I start this response with a recognition that CMS has taken an important step to improve rural participation in developing and publishing its *Rural Health Strategy* that includes five objectives: “(1) apply a rural lens to CMS programs and policies; (2) improve access to care through provider engagement and support; (3) advance telehealth and telemedicine; (4) empower patients in rural communities to make decisions about their health care; and (5) leverage partnerships to achieve the goals of the DCMS Rural Health Strategy” (<http://go.cms.gov/ruralhealth>). Providing ruralspecific technical assistance in programs such as CPC+ and MIPS are actions underway that will be helpful. There are also specific actions that would be helpful:

- Rural-specific value-based payment demonstrations;
- Extended transition from volume-based to value-based payment;
- Finite transition to allow proper future planning;
- Rural-appropriate performance measures;
- Revamped medical education system that prioritizes primary care; and
- Mandatory EHR compatibility.

QUESTION SUBMITTED BY HON. DEBBIE STABENOW
AND HON. BENJAMIN L. CARDIN

DENTAL CARE

Question. Lack of oral health care is a significant public health problem in the United States. Significant health professional shortages and lack of access to dentistry impacts rural and underserved communities disproportionately. We know that our seniors are negatively impacted by the lack of a dental benefit in Medicare. We also know that children, families and people with disabilities who rely on Medicaid and CHIP, programs which offer coverage for pediatric dental care and sometimes care for adults, often struggle to find providers to see them. Nowhere is the need for comprehensive dental coverage and access to providers more profound than in our rural and underserved communities. We have an opportunity to address the needs of our rural and underserved communities by improving our health care system by incorporating dental care more holistically through better coverage in Medicare, Medicaid and CHIP, utilizing telemedicine, and assessing provider and workforce gaps that can and should be filled in these communities. Dr. Mueller, what

is the most important thing that we, as the Senate Finance Committee, can do to improve dental care and coverage for people living in rural and underserved communities?

Answer. Given the preponderance of Medicare coverage through the traditional program in rural (as compared to higher MA enrollment in urban areas), include routine dental care as a traditional Medicare benefit. For beneficiaries receiving dental coverage as a result of dual eligibility, assuring that benefit continues unless until this is a traditional Medicare benefit is an important policy consideration.

QUESTION SUBMITTED BY HON. DEBBIE STABENOW

MATERNITY COVERAGE

Question. We've heard from families and health-care providers in Michigan who are concerned about access to maternity coverage in rural areas. Close to 500,000 women give birth each year in rural hospitals and often face additional barriers and complications. For example, women in rural areas report higher rates of obesity, deaths from heart disease, and child-birth related hemorrhages. In addition, more than half of women in rural areas must travel at least half an hour to receive obstetric care, which can lead to decreased screening and an increase in birth-related incidents.

Since 2004, a large number of rural obstetric units have closed, and only increased the distances that mothers must travel in order to receive maternity and delivery care. Unfortunately, the percent of rural counties in the United States without hospital obstetric units increased by about 50% during the past decade.

Do you have experience with loss of obstetric care for women within your respective fields?

What steps should be taken to ensure that the proper range of maternal care services are being offered through innovative rural health models?

Answer. I do not have direct experience with loss of obstetric care, given my role as a health policy analyst in a College of Public Health. Colleagues at the University of Minnesota Rural Health Research Center have completed and published a national study of access to hospital-based obstetric services that is gloomy at best (see their article in the *Journal of the American Medical Association*: <https://jamanetwork.com/journals/jama/fullarticle/2674780>). They followed that with an op-ed column in the *Washington Post* (https://www.washingtonpost.com/opinions/rural-americas-disappearing-maternity-care/2017/11/08/11a664d6-97e6-11e7-b569-3360011663b4_story.html?utm_term=.003094e99c6f) that offered these policy suggestions:

- Designate maternity-care shortage areas; and
- Expand workforce programs to include maternity services.

QUESTION SUBMITTED BY HON. BENJAMIN L. CARDIN

DENTAL CARE

Question. In your work you encourage the integration of the delivery system to better focus on preventing and managing chronic conditions. This approach requires us to effectively utilize midlevel providers, like physician assistants and nurse practitioners. As I'm sure you know, there is substantial evidence showing that oral health is a critical component of overall health and poor oral health can have significant health consequences and lead to chronic conditions. There has been some movement around the country to integrate oral and medical health care to improve health outcomes. How would midlevel health and dental providers be most effectively used in an integrated delivery system?

Answer. *General response:* As in medical care, dental care is best provided by a team of professionals, each operating at the "top" of his or her license, training, and experience—all interdependent, not independent. Government payers should pay dental providers at appropriate rates, but should consider expanding the role of mid-level dental providers to care for routine prevention (*e.g.*, exam, cleaning, and varnish) and treatment (fillings and uncomplicated extractions). Dental care proximate to primary care (as in many FQHCs) serves patients well.

Specific cases: I recommend two documents that contain data regarding integrating mid-level dental practitioners in health teams. One is from the Kaiser Family Foundation and includes definitions of mid-level providers and case studies of their contributions: <https://www.wkcf.org/-/media/pdfs/dental-therapy/mid-level-dental-providers.pdf?>. The other is an early evaluation (2014) of the Minnesota legislation creating a new classification, dental therapist, which found improved access to dental services for rural residents: <http://www.health.state.mn.us/divs/orhpc/workforce/dt/dtlegisrpt.pdf>.

PREPARED STATEMENT OF KAREN M. MURPHY, PH.D., R.N., CHIEF INNOVATION OFFICER AND FOUNDING DIRECTOR, GLENN STEELE INSTITUTE OF HEALTH INNOVATION, GEISINGER

Chairman Hatch, Ranking Member Wyden, and members of the committee, thank you for inviting me to testify today about rural hospitals. To provide context for my perspective, I would like to share my background. I started my career as a registered nurse in a community hospital in northeastern Pennsylvania. I held various positions at the hospital, ultimately serving as the president and chief executive officer. Following my time at the hospital I spent 2 years at the Center for Medicare and Medicaid Innovation where I led the State Innovation Models Initiative. I then served for 2½ years in Governor Tom Wolf’s cabinet as Secretary of Health. In 2017, I joined Geisinger as chief innovation officer and founding director of the Steele Institute for Health Innovation. It was during my time with the State that I led the Pennsylvania Rural Health Initiative. Today, I’d like to share the development and evolution of this innovative payment and delivery model for rural hospitals.

I began my tenure as Secretary of Health assessing the status of the health care delivery systems in Pennsylvania. I was struck by the financial instability of the rural hospitals. An overwhelming majority of the 67 rural hospitals were not in a position to weather any financial challenge and had not invested in their facilities for many years. I found from my research that rural hospitals in other states faced the same challenges at those in Pennsylvania.

Today, rural hospitals provide essential health care services for 57 million people across the country, but achieving financial stability is difficult for most hospitals.¹ The reasons for the instability are multifaceted. Nationally, the number of inpatient admissions is declining, a trend that is also prevalent in rural hospitals. Rural hospitals also lack the financial and human resources to offer complex, highly specialized inpatient care that is required for most admissions today. In addition, reimbursement for rural hospitals remains predominantly fee for service, with public payers contributing a sizable percentage of the hospitals’ revenue. The combination of declining inpatient admissions, resulting in decreased reimbursement, and a payer mix that yields a lower price per service has greatly contributed to the current crisis in rural hospitals.

The most recent statistics indicate that over the past 7 years, 83 of 2,244 rural hospitals in the United States have closed.² One analysis suggests that without intervention, an estimated 673 rural hospitals in the United States may also close over the next 5 years.³ Individuals residing in rural communities tend to have poorer health outcomes compared with residents of urban areas. For example, opioid overdose deaths and the incidence of obesity, cancer, and cardiovascular disease are also more predominant in rural communities.⁴

Historically, Federal and State governments have made unsuccessful attempts to stabilize rural hospitals by providing additional payments. Because the subsidies

¹ Gugliotta G. “Rural hospitals, beset by financial problems struggle to survive.” *Washington Post*. https://www.washingtonpost.com/national/health-science/rural-hospitals-beset-by-financial-problems-struggle-to-survive/2015/03/15/d81af3ac-c9b2-11e4-b2a1-bed1aaa2816_story.html. Published March 15, 2015.

² The Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. “83 Rural hospital closures: January 2010–present.” <http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures>.

³ “More than 200 rural hospitals are close to closure, iVantage study claims.” *Healthcare Finance*. <http://www.healthcarefinancenews.com/news/more-200-rural-hospitals-are-close-closure-ivantage-study-claims>. Published February 16, 2016. Accessed December 16, 2017.

⁴ Garcia M, Faul M, Massetti G, et al. “Reducing potentially excess deaths from the five leading causes of death in the rural United States.” *MMWR Surveillance Summ*. 2017;66(2):1–7.

were largely based on fee-for-service and inpatient admissions, they provided little benefit.

After having worked on the Maryland All-Payer Model while at CMMI and seeing the impressive results, we decided to design a similar model for rural hospitals in Pennsylvania.

Pennsylvania has the third largest rural population in the United States,⁵ and 67 of 169 hospitals are in rural communities. More than 58 percent of the hospitals have mounting financial pressures resulting in break even or negative operating margins.⁶

We worked collaboratively with CMMI on designing the model. The design period was launched in January of 2017. The objectives of the model are to provide a path to improving health and health care delivery in rural communities. Rural health transformation promotes transition to higher quality, integrated, and value-based care. The model changes the way participating hospitals will be reimbursed by replacing the current fee-for-service system with a multi-payer global budget based on hospitals' historic net revenue. Like Maryland, the payment model in Pennsylvania is designed to include Medicare, Medicaid, and commercial payers. However, it was necessary to develop a new methodology since Maryland has the authority to establish hospital rates. Pennsylvania does not.

The model moves rural hospitals from focusing on inpatient-centric reactive health-care services to a greater focus on outpatient-centric health-care services, with an emphasis on population health and care management. It replaces the current fee-for-service system with little emphasis on quality and safety to a payment model that includes direct incentives to improve quality and safety and eliminate sub-scale service lines.

Rural hospitals are encouraged to move from traditional care delivery model rendered directly by onsite health care providers to innovative care delivery models enabled by technologies such as tele-health, video conferencing, remote monitoring, and diagnostic scanning. The vision is that rural hospitals will invest in care coordination such as reaching out to patients who frequently use emergency services and connecting them with a primary care provider or guiding patients after hospital discharge to make sure they follow up with a physician. It also includes population health and preventative care services such as chronic disease prevention programs and behavioral health initiatives, including those targeting drug abuse and addiction, and the expansion of medical health homes to include medication-assisted treatment programs. Participating hospitals will have the ability to invest in social services that address community issues that lead to detrimental health outcomes—such as parenting classes and connections to social services for eligible benefits such as WIC. The model will be evaluated measuring improvements of health status and health care delivery in the participating rural communities.

Based on the global budget, participating hospitals are expected to develop a transformation plan that could outline an innovative approach to improving health and health care delivery. The hospitals are encouraged to work with community agencies, including United Way, Area Agencies on Aging, and drug and alcohol treatment centers, to develop services based on their communities' needs. To provide participating hospitals with transformation support, Pennsylvania plans to create a Rural Health Redesign Center (RHRC). CMS has entered a cooperative agreement to provide Pennsylvania up to \$25 million over 5 years to support the RHRC. The RHRC will provide a way to deploy capabilities to support all participating hospitals.

Pennsylvania is planning to engage six hospitals in the initial performance year, gradually expanding participation to include 30 rural hospitals across the State by the third performance year. At Geisinger, we are a participant in the initial phase. Dr. David Feinberg, Geisinger CEO, has been a staunch supporter of the initiative since its inception. The model builds on Geisinger's vision for building a health care delivery system that focuses on improving health and value creation for each community we serve. We are looking forward to working with the State on this important initiative.

⁵ U.S. Census Bureau. 2010 Census urban and rural classification and urban area criteria. <https://www.census.gov/geo/reference/ua/urban-rural-2010.html>.

⁶ Pennsylvania Health Care Cost Containment Council. "Financial analysis 2016: general acute care hospitals: an annual report on the financial health of Pennsylvania hospitals." http://www.phc4.org/reports/fin/16/docs/fin2016report_volumeone.pdf. Published April 2017.

The financial challenges of rural hospitals today are the result of a changing health care industry. Even though rural hospitals may not offer the same services as they did in the past, it is possible that they can be leveraged to improve the health of those residing in rural communities. This model, if it achieves better quality and lower costs, could potentially be scaled as a model for the Nation for rural health-care delivery.

Next week, I will be speaking at a Global Budgeting Summit at Johns Hopkins University. Twenty States have registered to participate. The Federal Government has the opportunity to engage additional States in the Pennsylvania Rural Health Model. Implementing the model across diverse States gives the opportunity for it to evolve. Adding additional resources to the Rural Health Redesign Center would bring efficiency and an ability to disseminate best practices in rural health transformation across the United States.

Thank you for your interest in aiding rural hospitals. Rural communities deserve access to health care. We must continue to identify innovative approaches that offer a pathway to that goal.

Chairman Hatch, Ranking member Wyden, and members of the committee, thank you for inviting me to testify today about rural hospitals. To provide context for my perspective, I would like to share my background. I started my career as a registered nurse in the Intensive Care Unit in a community hospital in northeastern Pennsylvania. I held various positions at the hospital, ultimately serving as the president and chief executive officer. Following my time at the hospital I spent 2 years at the Center for Medicare and Medicaid Innovation (CMMI) where I led the State Innovation Models Initiative. I then served for 2½ years in Governor Tom Wolf's cabinet as Secretary of Health, before joining Geisinger as chief innovation officer and founding director of the Steele Institute for Health Innovation. It was during my time with the State that I led the Pennsylvania Rural Health Initiative. Today, I'd like to share the development and evolution of this innovative payment and delivery model for rural hospitals.

As a cabinet member, I recognized that I had limited time in my role and wanted to be impactful. I began my tenure assessing the status of the health care delivery systems in Pennsylvania. I learned that, for the most part, hospitals in Philadelphia and Pittsburgh were doing well and did not need my help. However, I was struck by the financial instability of the vast majority of 67 rural hospitals. Their number of days cash-on-hand was very low, and their facilities' age-of-plant was well above benchmarks. This meant that the hospitals had little ability to weather any financial challenge and had not adequately invested in facilities for many years.

As I began to research rural hospitals in other states, I found that the challenges faced by rural hospitals across the country mirrored those in Pennsylvania.

Today, rural hospitals provide essential health care services for 57 million people across the country. However, the ability to achieve financial stability is difficult for most hospitals.¹ The reasons for the instability are multifaceted. Nationally, inpatient admissions are declining, a trend that is also prevalent in rural hospitals. Rural hospitals also lack the financial and human resources to offer complex, highly specialized inpatient care required for most admissions today. In addition, reimbursement for rural hospitals remains predominantly fee-for-service, with public payers contributing a sizable percentage of the hospitals' revenue. The combination of declining inpatient admissions resulting in decreased reimbursement and a payer mix that yields a lower price per service has been a large contributor to the current crisis in rural hospitals.

Over the past 7 years, 83 of 2,244 rural hospitals in the United States have closed.² One analysis suggests that without intervention, an estimated 673 rural

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²The Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. "83 Rural hospital closures: January 2010–present." <http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures>.

hospitals in the United States may also close over the next 5 years.³ Preserving health care in rural communities is imperative people living in rural communities tend to have poorer health outcomes compared with residents of urban areas. For example, opioid overdose deaths and the incidence of obesity, cancer, and cardiovascular disease are also more predominant in rural communities.⁴ Given the financial pressure under their current fee-for-service reimbursement structure, rural hospitals are frequently unable to address the health of their communities. Economic instability is also more prevalent in rural communities. Poverty rates are higher. Hospitals are frequently the largest employer affecting the entire economy in the rural community.

While at CMMI I had the opportunity to work on the Maryland All-Payer Model. With this model, hospitals are reimbursed by a global budget based. The hospitals are accountable for the total cost and quality of care. Maryland began global budgeting for rural hospitals in 2010 with great success. Maryland extended the model to include all hospitals in January 2014 and has yielded positive results over the past 4 years. That provided the foundation of the Pennsylvania Rural Health Initiative.

Pennsylvania has the third largest rural population in the United States,⁵ and 67 of 169 hospitals are in rural communities. More than 58 percent of the hospitals have mounting financial pressures resulting in break even or negative operating margins.⁶ Pennsylvania recognized the health and socioeconomic imperative involving rural communities. We estimated that over 27,000 people were employed by rural hospitals.

We began the work on the Pennsylvania initiative in the spring of 2015 and presented the initial concept to CMMI in the fall of 2015. We worked collaboratively with CMMI on refining the model. The design period was launched in January of 2017. The objectives of the model are to provide a path to improving health and health care delivery in rural communities. The model changes the way participating hospitals will be reimbursed by replacing the current fee-for-service system with a multi-payer global budget based on hospitals' historic net revenue. Like Maryland, the payment model in Pennsylvania is designed to include Medicare, Medicaid, and commercial payers. However, it was necessary to develop a new methodology since Maryland has the authority to establish hospital rates. Pennsylvania does not.

The model provides that the hospital budget will be prospectively calculated, and each month the hospital will be paid $\frac{1}{12}$ of the total budget amount. This approach is expected to provide rural hospitals with a predictable revenue stream. Most importantly, it could support the transformation of delivering health care services. The global budget is intended to incentivize rural hospitals to retain the established revenue base, regardless of hospital use. To achieve this, payers are expected to invest in the health of the population residing in rural communities. Annual adjustments are planned to account for changes in market share for the commercial payers.

Based on the global budget, participating hospitals are expected to develop a transformation plan that could outline an innovative approach to improving health and health-care delivery. The hospitals are encouraged to work with community agencies, including United Way, Area Agencies on Aging, and drug and alcohol treatment centers, to develop services based on the communities' needs. Hospitals may choose to reconfigure or eliminate substandard or underused inpatient service lines and invest in community-facing interventions. Expanded care coordination, growth in behavioral health services with an emphasis on the opioid crisis, and increased access to preventive services, such as colonoscopy and mammography, are examples of strategies that rural hospitals can execute to improve community health.

To support participating hospitals' transformation, Pennsylvania plans to create a Rural Health Redesign Center (RHRC). CMS has entered a cooperative agreement to provide Pennsylvania up to \$25 million over 5 years to support the RHRC. The

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RHRC will provide a way to deploy scaled capabilities to support all participating hospitals. The RHRC will perform the following key functions throughout the performance period of the model:

- **Model Oversight:** Provide oversight, approve Global Budgets and transformation plans. Advise on and approve changes to operational and payment mechanisms, and approve reasonable exceptions to agreed-upon payment algorithms and rules through an approved procedure.
- **Global Budget Administration:** Run algorithms for the defined payment model logic to determine Global Budget amounts, adjustments, and payer proportions.
- **Data Analytics:** Analyze and report to support model-specific goals. Provide stakeholders with regular reports to inform decision-making. Securely collect and store data from payers and providers. Clean data for performance reporting and budget calculation.
- **Technical Assistance:** Provide strategic and operational technical assistance to support care delivery transformation. Convene hospitals to share best practices. Change management.
- **Quality Assurance:** Provide an annual assessment of compliance with transformation plan and Global Budget targets. Recommend corrective action plans where needed. Contract with an independent outcome evaluation group to provide board and CEO with rigorous evaluation of model's progress against population health, quality of care, and cost targets. Engage stakeholders through an advisory panel for input on program policy and outcomes.

In addition, Pennsylvania has established savings goals for Medicare. Over the next 5 years, participating rural hospitals are expected to implement strategies that could save an estimated minimum of \$35 million to Medicare over the life of the model. The plan stipulates that in the first 2 years, rural hospitals retain 100 percent of the realized savings. In the third year, the hospitals will retain 75 percent of the savings. In subsequent years, the payers and hospitals are expected to share an equal portion of the savings. Pennsylvania has also agreed to demonstrate improvement in access to health services, quality of care, and population health outcomes.

Pennsylvania is planning to engage six hospitals in the initial performance year, gradually expanding participation to include 30 rural hospitals across the State by the third performance year.

However, this initiative has clear challenges. While Maryland has experienced success using global budgets, as previously pointed out, a notable distinction is that Maryland is using its regulatory authority to establish inpatient hospital rates for all payers. Demonstrating success using multi-payer global payments in a non-rate setting State will be tested in the Pennsylvania model. In addition, the size of the State and the large number of commercial and Medicaid-managed care organizations will pose challenges. Also, the goal of the program is to stabilize the financial status of rural hospitals but at the same time reduce the cost to payers. Reconciling these two goals will be a challenge.

The lessons learned in developing this model could assist other states in this journey. The model requires strong support from the governor, State and Federal legislators. In Pennsylvania, Governor Wolf was engaged early in the process and identified the model as one of his priorities. In Pennsylvania, the model engaged several State agencies in addition to the Department of Health. The Department of Agriculture, Department of Human Services and the Insurance Department all contributed to the work. The support of the Governor was critical in achieving an effective collaboration across State agencies.

States may require enabling legislation to execute the model. In Pennsylvania, State legislators were briefed early in the development of the model. The Department also engaged Senator Casey's office and the U.S. Secretary of Agriculture, Tom Vilsak, throughout the design of the initiative.

This model is complex, requiring sophisticated data analytics and technical assistance. State agencies ordinarily do not have those internal resources or capabilities, and will require consultants with expertise in payment models and health-care transformation to support the work.

Pennsylvania also worked with experts in Maryland in the design. The former Secretary of Health, Dr. Josh Sharfstein, and the Executive Director of the HRSC

in Maryland, Donna Kinzer, were tremendous resources to Pennsylvania. Maryland's vast experience can be helpful in other states in designing global budgets.

The Pennsylvania Hospital Association was extremely helpful in supporting the model. They assisted the State in engaging hospital CEOs early in the process and throughout the design process. States will be required to collaborate with their State hospital association.

Engage rural hospitals early in the process is also essential. This model requires that each participating hospital have a CEO and Board of Directors with a vision and commitment for transformation. Hospitals need adequate time to develop effective transformation plans. The transition from fee-for-service reimbursement to a global budget requires a completely new paradigm moving from volume to value.

At Geisinger, we are a participant in the initial six hospitals. Dr. David Feinberg, Geisinger CEO, has been a staunch supporter of the initiative since its inception. The model builds on Geisinger's vision for building a health-care delivery system that focuses on improving health and value creation for each community we serve. We are looking forward to working with the State on this important initiative.

CMS and Pennsylvania have demonstrated a strong interest in stabilizing health care in rural communities. Previous attempts to stabilize rural hospital by Federal and State governments providing additional payments have been unsuccessful. These subsidies were largely based on fee-for-service and inpatient admissions, and therefore, provided little benefit.

The financial challenges of rural hospitals today are the result of a changing health care industry. Even though rural hospitals may not offer the same services as the past, it is possible they can be leveraged to improve the health of those residing in rural communities. This model, if it achieves better quality and lower costs, could potentially be scaled as a model for the Nation for rural health-care delivery.

Next week, I will be speaking at a Global Budgeting Summit at Johns Hopkins University. Twenty States have registered to participate. The Federal Government has the opportunity to engage additional States in the Pennsylvania Rural Health Model. Implementing the test across diverse States gives the opportunity for the model to evolve. Additional resources to the Rural Health Redesign Center would bring efficiency and an ability to disseminate best practices in rural health transformation across the United States.

Thank you for your interest in aiding rural hospitals. Rural communities deserve access to health care. We must continue to identify innovative approaches that offer a pathway to that goal.

QUESTIONS SUBMITTED FOR THE RECORD TO KAREN M. MURPHY, PH.D., R.N.

QUESTIONS SUBMITTED BY HON. ORRIN G. HATCH

Question. During the hearing I asked you if there is any concern, under Pennsylvania's new multi-payer global budget model, that rural hospitals might lose incentives to be efficient in providing health care services. Specifically, I asked if you think participating rural hospitals will figure out ways to lower costs and improve health outcomes if they already know what they will get paid for procedures under the global budget. You responded that this behavioral assumption has been accounted for as a monitoring component within the model's methodology. Additionally, you mentioned a transformational plan that is in place to monitor metrics on a number of the model's assumptions and impacts. Can you tell me a little bit more about the transformational plan that you mentioned? What is it, how does it work, and how will CMS, State officials, participating hospitals and providers use it to analyze data and make adjustments as the model is implemented?

Answer. Rural hospitals are expected to develop a transformation plan that outlines an innovative approach to improving health and health care delivery. The hospitals will be encouraged to work with community agencies to develop services based on the communities needs. Hospitals may choose to reconfigure or eliminate substandard or underused inpatient service lines and invest in community-facing interventions. Expanded care coordination, growth in behavioral health services with an emphasis on the opioid crisis, and increased access to preventive services, such as colonoscopy and mammography, are examples of strategies that rural hospitals can execute to improve community health.

To provide participating hospitals with transformation support, Pennsylvania plans to create a Rural Health Redesign Center (RHRC). CMS has entered a cooperative agreement to provide Pennsylvania up to \$25 million over 5 years to support the RHRC. The RHRC is expected to provide technical assistance to rural hospitals including review and approval of the hospitals' global budgets and transformation plans, as well as data collection, analytics, and practice transformation support.

Transformation plans will be approved by CMS and the RHRC prior to implementation. The RHRC will monitor the model performance and make adjustments as necessary.

Question. There is a lot of excitement around the Pennsylvania Rural Health Model. It clearly holds great promise. I am pleased to see CMS working with States to design innovative rural health care payment strategies. Can you explain what exactly happens if the rural hospitals participating in the Pennsylvania Rural Health Model have costs greater than their global budget allows? Is this also accounted for as part of the transformation plan?

To clarify, the payment model is based on historical net revenue. Theoretically the hospital's cost structure should be accounted for as a part of the transformation plan. There could be a scenario where a hospital recognized more volume than projected resulting in higher cost. In that case the global budget for the following year would be adjusted accordingly.

QUESTION SUBMITTED BY HON. MICHAEL B. ENZI

Question. Medicare's Sole Community Hospital designation is important to many Wyoming hospitals, but to qualify, a potential sole community hospital must be located 35 miles away from the nearest hospital in most cases, with the exclusion of Critical Access Hospitals. How does excluding Critical Access Hospitals from the geographic limit affect how the sole community hospital designation is targeted?

Answer. I defer to Ms. Thompson.

QUESTION SUBMITTED BY HON. ROB PORTMAN
AND HON. MICHAEL F. BENNET

Question. We have previously introduced legislation to encourage providers to participate in alternative payment models and facilitate care coordination, including the Medicare PLUS Act (S. 2498 in the 114th Congress) and the Medicare Care Coordination Improvement Act (S. 2051 in the 115th Congress). When we consider coordinating care for patients in rural settings, what administrative burdens do you face? What can Congress do to ensure that value-based care is effective in rural areas?

Answer. Heretofore it has been difficult for hospitals in rural settings to participate in alternative payment models. Most of the innovative payment models to date require large numbers of providers and patients. Rural hospitals tend to have fewer providers on their medical staff. In addition, rural hospitals tend to have relatively small administrative staff as compared to their urban counterparts. Innovative payment models require infrastructure to design, implement and test. The best approach to expand value based care in rural communities is to continue exploring several different options for rural hospitals transformation with the understanding that rural hospitals will require more financial support and technical assistance as compared to urban providers.

QUESTIONS SUBMITTED BY HON. RON WYDEN
PENNSYLVANIA RURAL HEALTH MODEL

Question. The Pennsylvania Rural Health Model is an exciting new model that will test whether the predictability of a global budget will allow rural hospitals to invest more in quality and focus on preventive care.

As Pennsylvania's Secretary of Health, what issues did you identify as unique to rural areas that informed the design of the global payer model?

Answer. There were several influencing factors that prompted Pennsylvania to design the global payer model. We noted that a large number of rural hospitals were financially challenged. It was apparent that reasons causing the financial instability were not going to change and threatened the survivability of rural hospitals across the State. They included:

- The number of inpatient admissions is declining nationally, a trend that is also prevalent in rural hospitals;
- Rural hospitals frequently lack the financial and human resources to offer complex, highly specialized inpatient care that is required for most admissions today;
- Reimbursement for rural hospitals remains predominantly fee-for-service with public payers contributing a sizable percentage of the hospitals' revenue; and
- The combination of declining inpatient admissions resulting in decreased reimbursement and a payer mix that yields a lower price per service is exacerbating an already unstable business model.

Question. When considering other global payer models, such as Maryland's, what aspects needed modification to accommodate the specific needs of rural hospitals and allow them to focus on quality and prevention?

Answer. While Maryland has experienced success using global budgets, a notable distinction was that the State is a rate setting State that can use its regulatory authority to establish inpatient and outpatient rates for all hospitals. Pennsylvania does not have the same regulatory authority so it was required to develop a new methodology for the payment model. The model is based on each hospital's historical net revenue.

Question. How did you ensure the structure of the global payer model addressed the unique financial and operational needs of rural hospitals in Pennsylvania?

Answer. During the design process, we worked with rural hospital CEOs, the Hospital Association of Pennsylvania, as well as rural health associations to be certain we were addressing the unique needs of rural hospitals.

RURAL WORKFORCE

Question. As discussed during the hearing, the shortage of primary and specialty care providers is a critical issue facing rural communities across the country. In Oregon, 25.9 percent of residents live in a health professional shortage area. Difficulty recruiting and retaining physicians and other members of the care team can result in longer patient wait times and reduced access to care for those living in rural communities.

What concrete policy ideas would you suggest this committee pursue to help attract more providers to rural America?

Answer. It is necessary to approach recruitment to rural communities differently. It will be very difficult to fulfill the physician and health-care workforce using traditional strategies. When I was in Pennsylvania I considered developing a "Rural Health Workforce." The design would be to offer loan repayment and salary for short term service in rural communities, such as two-week service blocks. The community would provide housing for the physicians rotating in the community. My thoughts were to leverage providers in the large academic medical centers to recruit primary care and advanced nurse practitioners. It would require many providers and strong care coordination. The model has the potential to increase access to needed providers in rural communities.

RURAL BENEFICIARY HEALTH NEEDS

Question. Rural communities tend to be older, sicker, and lower income compared to their urban counterparts. When rural hospitals are forced to close their doors, Medicare beneficiaries living in the surrounding areas often have limited health-care options. The prevalence of multiple chronic conditions among those living in rural areas heightens the need to ensure all Medicare beneficiaries have access to high quality care—regardless of where they live.

In your view, where should this committee focus its efforts to ensure that Medicare beneficiaries living in rural areas (especially those with multiple chronic conditions) have access to high quality care?

Answer. I think the focus should be on developing innovative payment and delivery models that meet the needs of rural communities. Also, investments in technology such as virtual care to larger urban centers is important.

Question. What Medicare policy changes would be most impactful in the short term and long term?

Answer. CMS should change supplemental payments for rural hospitals away from those that are inpatient centric to a more population health based payment.

QUESTION SUBMITTED BY HON. DEBBIE STABENOW
AND HON. BENJAMIN L. CARDIN

DENTAL CARE

Question. Lack of oral health care is a significant public health problem in the United States. Significant health professional shortages and lack of access to dentistry impacts rural and underserved communities disproportionately. We know that our seniors are negatively impacted by the lack of a dental benefit in Medicare. We also know that children, families and people with disabilities who rely on Medicaid and CHIP, programs which offer coverage for pediatric dental care and sometimes care for adults, often struggle to find providers to see them. Nowhere is the need for comprehensive dental coverage and access to providers more profound than in our rural and underserved communities. We have an opportunity to address the needs of our rural and underserved communities by improving our health care system by incorporating dental care more holistically through better coverage in Medicare, Medicaid and CHIP, utilizing telemedicine, and assessing provider and workforce gaps that can and should be filled in these communities. Ms. Thompson, Ms. Martin, Ms. Murphy, Mr. Pink, and Dr. Mueller, what is the most important thing that we, as the Senate Finance Committee, can do to improve dental care and coverage for people living in rural and underserved communities?

Answer. As previously described, I think we should approach recruitment to rural communities differently. It will be very difficult to fulfill the physician and health-care workforce using traditional strategies. When I was in Pennsylvania I considered developing a "Rural Health Workforce." The design would be to offer loan repayment and salary for short term service in rural communities. The community would provide housing for the physicians rotating in the community. My thoughts were to leverage the large academic medical centers to recruit primary care and advanced nurse practitioners. It would require a large number of providers and strong care coordination. This approach has the potential to also work in dental care.

QUESTION SUBMITTED BY HON. DEBBIE STABENOW

MATERNITY COVERAGE

Question. We've heard from families and health care providers in Michigan who are concerned about access to maternity coverage in rural areas. Close to 500,000 women give birth each year in rural hospitals and often face additional barriers and complications. For example, women in rural areas report higher rates of obesity, deaths from heart disease, and child-birth related hemorrhages. In addition, more than half of women in rural areas must travel at least half an hour to receive obstetric care, which can lead to decreased screening and an increase in birth related incidents.

Since 2004, a large number of rural obstetric units have closed, and only increased the distances that mothers must travel in order to receive maternity and delivery care. Unfortunately, the percent of rural counties in the United States without hospital obstetric units increased by about 50 percent during the past decade.

Do you have experience with loss of obstetric care for women within your respective fields?

Answer. I do not.

Question. What steps should be taken to ensure that the proper range of maternal care services is being offered through innovative rural health models?

Answer. Studies have demonstrated that quality outcomes in obstetrical services are improved when they are performed in centers that perform a large number of deliveries. In other words, the higher the volume the better the outcomes. Rural birthing centers tend to perform a lower number of deliveries. While I do not believe that all rural hospitals should have obstetrical services, I do think that utilizing vir-

tual care for prenatal visits, lessening the need for women to travel while receiving high quality care from urban centers.

QUESTIONS SUBMITTED BY HON. BENJAMIN L. CARDIN

TELEMEDICINE

Question. Although many may think of Maryland as an urban hub with its DC suburbs and large cities, there are parts of my State, both on the Eastern Shore and on the western side of the State, that are either very rural or medically underserved. My constituents who live in these parts of the State, must often drive long distances to get the health care they need. One way to increase access to quality health services to rural and underserved communities, is by offering treatment through telehealth technology. Ms. Murphy, how do you see the role of telehealth continuing to grow in health-care delivery, and how can it be better utilized to increase care for Medicare beneficiaries?

Answer. I see virtual care such as telemedicine and remote monitoring as enabling strategies to improve access to care for those residing in rural communities.

CHRONIC KIDNEY DISEASE AND MEDIGAP

Question. For many Medicare beneficiaries living with kidney failure, particularly those living in rural or underserved areas, accessing affordable care for their complex and chronic condition is a constant financial challenge. Over 92,000 dialysis patients live in states with no access to Medigap. This often leaves them unable to afford Medicare Part B's 20 percent cost sharing, which for a patient with kidney failure can often amount to tens of thousands of dollars of out-of-pocket costs each year. Ms. Murphy, have you had challenges with Medicare beneficiaries who don't have access to Medigap coverage getting the care they need? For example Medicare beneficiaries or patients with ESRD under 65?

Answer. I have not had experience in this area.

Question. Could you speak to the challenges Medicare beneficiaries face when they don't have access to Medigap plans and the benefits for Medicare beneficiaries who do have access to Medigap plans?

Answer. Studies have demonstrated that seniors with Medigap policies have higher utilization rates as compared to those that do not have Medigap policies. Given the high cost of health care it is fair to assume that Medicare beneficiaries without Medigap coverage would be less likely to access health-care services.

QUESTIONS SUBMITTED BY HON. ROBERT P. CASEY, JR.

Question. In your written testimony, you discuss the innovation of the Pennsylvania Rural Health Model and the ways in which this model can support the transformation of the health care service delivery. Could you expand on the ways Pennsylvania incorporated new or existing telehealth services into this new model of care and payment?

Answer. As we designed the model we envisioned that hospitals in rural communities could leverage telehealth to improve access to health care. Rural hospitals were encouraged to collaborate with larger urban hospitals to provide the services lacking in their respective communities.

Question. In your written testimony you stated that "the challenges faced by rural hospitals across the country mirrored those in Pennsylvania." Could you expand on your thoughts about the viability of using the Pennsylvania Rural Health Model as the basis for an initiative that other States may use to develop a global budget model that is specific to their State?

Answer. Numerous States have expressed interest in the Pennsylvania Rural Health Initiative. It would be beneficial to expand the initiative to include other States. A larger sample size would allow for the opportunity to refine and improve the model to meet the needs of rural hospitals. In addition, there would be lessons learned that potentially could lead to using global budgets more broadly.

What are ways the Federal Government can be involved in and be supportive of successfully developing and implementing these innovative models?

CMMI has the expertise and infrastructure to test innovative payment and delivery models. Continued support of CMMI will be crucial in expanding value-based payment models.

PREPARED STATEMENT OF GEORGE H. PINK, PH.D., DEPUTY DIRECTOR, NORTH CAROLINA RURAL HEALTH RESEARCH PROGRAM; SENIOR RESEARCH FELLOW, CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH; AND HUMANA DISTINGUISHED PROFESSOR, GILLINGS SCHOOL OF GLOBAL PUBLIC HEALTH, UNIVERSITY OF NORTH CAROLINA

Chairman Hatch, Ranking Member Wyden, and members of the committee, thank you for the opportunity to testify today on behalf of my colleagues at the North Carolina Rural Health Research Program and the Gillings School of Global Public Health at The University of North Carolina at Chapel Hill. We research problems in rural health care delivery and are funded primarily by the Federal Office of Rural Health Policy.

I am here to discuss what we know about rural hospital closures, and I will start with an all too common story. Coalinga Regional Medical Center in Coalinga, CA is a 24-bed acute care hospital with 200 employees. On May 1st, it announced that after 18 months of losses totaling \$4.5 million, it is insolvent and will close all services in June. The closure will leave residents in the rural Fresno County city of 17 thousand people without an emergency room. The nearest hospital is Adventist Health in Hanford, which is over 40 miles away. Coalinga will be the second hospital in the San Joaquin Valley to close in the past 6 months. Tulare Regional Medical Center, a 112-bed hospital, closed 6 months ago. Across the country, 125 rural hospitals have closed since 2005, 83 since 2010.

Why is this happening? Long-term unprofitability is an important factor. Years of losing money results in little cash, debt payments that can't be made, charity care and bad debt that can't be covered, older facilities, and outdated technology.

Why do they lose money? Small rural hospitals serve patients who are older, sicker, poorer, and more likely to be un- or under-insured. They staff emergency rooms, often in communities with small populations and low patient volumes. Combine this with reimbursement reductions, professional shortages, and many other challenges—you can see why I prefer being a professor to a rural hospital executive.

What happens after a closure? Some convert to another type of health care facility, but more than one half no longer provide any health care services—they are now parking lots, apartments, or empty buildings. Patients travel an average of 12.5 miles to the next closest hospital, but many travel 25 miles or more. For the old, poor, and disabled who cannot afford or do not have access to reliable transportation, these distances can be very real barriers to obtaining needed care.

Who is most affected? We have investigated communities served by rural hospitals at high risk of financial distress because they may be the next facilities to close. These communities have significantly higher percentages of people who are black, unemployed, lacking a high school education, and who report being obese and having fair to poor health; in other words, vulnerable people. If the hospitals that serve these communities reduce services or ultimately close, already vulnerable people will be at increased risk.

What can be done? We can try to improve what we have by exploring ways to better target Medicare payments at rural hospitals in greatest need and where closure would have the greatest adverse consequences on the communities.

Preferably, we should develop something new. At meetings around the country, the most common frustration I hear is the lack of a model to replace a distressed or closed hospital. We have acute care hospitals with emergency rooms at one end and primary care clinics at the other end, but we need something in-between. There is no shortage of innovative ideas—eight to ten new rural models have been proposed by various organizations. The profound challenges facing providers that serve rural communities are not going away: we need to step up the pace of innovation—faster evaluation and implementation of new models, and development of the Medicare policies and regulations that will *allow* and *sustain* them.

Thank you again for the opportunity to discuss these issues with you today, particularly because during the past 35 years, some of the most innovative and effective developments in rural health policy have emerged from the Finance Committee.

PREPARED STATEMENT OF GEORGE H. PINK, PH.D., DEPUTY DIRECTOR, NORTH CAROLINA RURAL HEALTH RESEARCH PROGRAM; SENIOR RESEARCH FELLOW, CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH; AND HUMANA DISTINGUISHED PROFESSOR, GILLINGS SCHOOL OF GLOBAL PUBLIC HEALTH; AND G. MARK HOLMES, DIRECTOR, NORTH CAROLINA RURAL HEALTH RESEARCH PROGRAM; DIRECTOR, CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH; AND PROFESSOR, GILLINGS SCHOOL OF GLOBAL PUBLIC HEALTH, UNIVERSITY OF NORTH CAROLINA

Chairman Hatch, Ranking Member Wyden, and members of the committee, thank you for the opportunity to testify today on behalf of my colleagues at the North Carolina Rural Health Research Program (NC RHRP) and the Gillings School of Global Public Health about our research into financial distress and closure of rural hospitals.

The NC RHRP at the Cecil G. Sheps Center for Health Services Research is built upon a 44-year history of rural health research at The University of North Carolina at Chapel Hill and draws on the experience of a wide variety of scholars and researchers, analysts, managers, and health service providers associated with the Center. NC RHRP studies problems in rural health care delivery through basic research, policy-relevant analyses, geographic and graphical presentation of data, and the dissemination of information to organizations and individuals who can use the information for policy or administrative purposes to address complex social issues affecting rural populations. We are funded primarily by the Federal Office of Rural Health Policy (FORHP) in the Health Resources and Services Administration.

Our testimony summarizes our research on rural hospital closures and the financial distress of rural hospitals. To explain, we will focus on the following four categories: rural hospital closures between 2005–18, causes of financial distress and closure, characteristics of communities served by hospitals at high-risk of financial distress, and potential strategies that might be considered.

RURAL HOSPITAL CLOSURES BETWEEN 2005–18

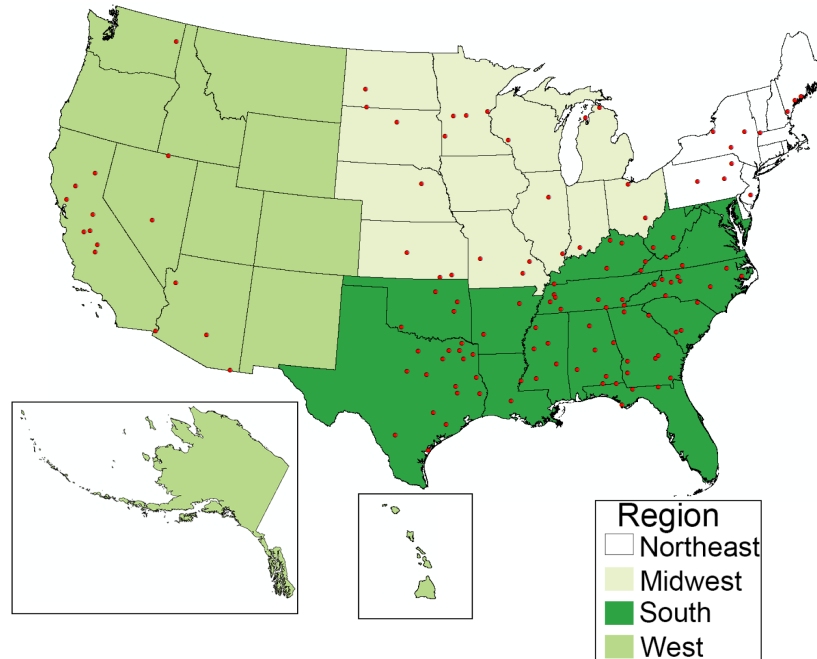
We define *rural hospital closures* as rural hospitals (including all Critical Access Hospitals) that close their inpatient service or move their services fifteen or more miles away from the current location. The definition is important because of the variation in circumstances that might be considered open or closed.

Rural hospital closures are sometimes difficult to identify because they may close and re-open, be part of a merger, a move, a disaster, etc. For example, they may close temporarily due to hurricane damage or they may close their emergency department, but keep inpatient care open. Our primary method of discovering closed hospitals is through media outlets. Applying this definition helps us keep an accurate and defensible count as not every hospital administrator sees their situation as a closure.

Figure 1 shows that since January 2005, 125 rural hospitals have closed (83 since January 2010).¹ These closures increased annually until 2016, but have started to slow.

¹“Rural Hospital Closures.” 2014; <http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>.

Figure 1: Rural Hospital Closures between 2005-18



Rural hospitals are often the largest or second largest employer in their communities, so the closure of the only hospital in the county can have significant negative economic effects on a rural community.² After the closure of inpatient services, alternative health care delivery models offer the potential to retain local access to some health care services as well as soften the economic impact of closure on the community. Of the 125 closed hospitals, some have converted to outpatient/primary care clinics (18.1%), urgent or emergency care (21.7%), or skilled nursing facilities (6%), but more than half either converted to non-health care use (54.2%), such as condominiums, or were abandoned.

Most closures and “abandoned” rural hospitals are in the South (60%), where poverty rates are higher and people are generally less healthy and less likely to have health insurance (private or public).³ Southern States have also been less likely to expand Medicaid. Ten out of 18 States that have not expanded Medicaid are southern States.^{4,5} It is difficult to accurately determine whether it is the expansion decision per se that has led to higher closure rates, or whether States that have not expanded Medicaid have other factors leading to higher closure rates; this is an important question on which many researchers are currently working.

Figure 2 shows that patients in affected communities are probably traveling at least 5 to 30 miles to access inpatient care (12.5 miles on average); however, 43% of the closed hospitals are more than 15 miles to the nearest hospital, and 15% are

² <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1702512/>.

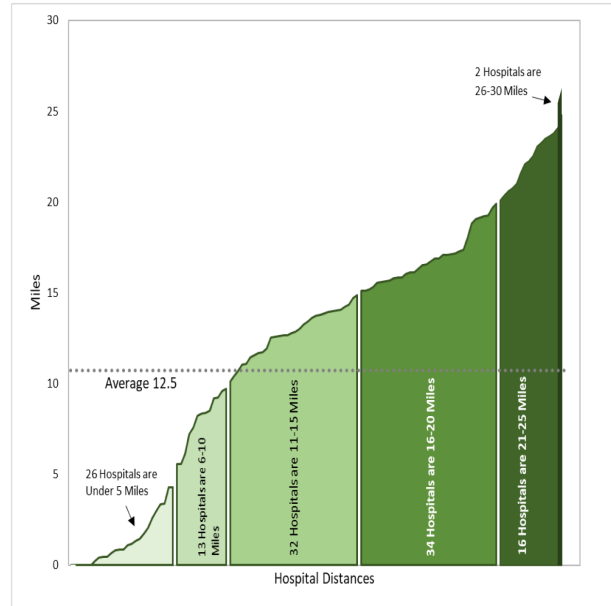
³ Garfield R, Damico A. “The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid.” Kaiser Family Foundation. November 1, 2017. <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.

⁴ “Current Status of State Medicaid Expansion Decisions.” Kaiser Family Foundation. <https://www.kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/>.

⁵ Rural Health Information Hub. “Rural Health Disparities: What regions of the country experience high levels of rural health disparities?” November 14, 2017. <https://www.ruralhealthinfo.org/topics/rural-health-disparities>.

more than 20 miles.⁶ The additional travel burden is of concern because residents of rural communities are less likely to have reliable transportation (due to age, health conditions, and income) than urban residents.⁷

Figure 2: Range of distance from closed hospital to next closest hospital



CAUSES OF FINANCIAL DISTRESS AND CLOSURE

The causes of financial distress and closure of rural hospitals are numerous and complex. We have developed a model to predict financial distress among rural hospitals. After exploring a large number of potential causes, we found that four types of factors predict financial distress: (1) financial performance and profitability; (2) proportion of Medicare and Medicaid in the payer mix; (3) hospital ownership and size, and (4) characteristics of the market served by the hospital, including competition, economic condition, and market size.

Among these factors, profitability is particularly important. Nationally, urban hospitals were twice as profitable as rural hospitals in 2016: the U.S. median profit margin for urban hospitals was 5.51% which was more than double the margins for Critical Access Hospitals (2.56%) and other types of rural hospitals (2.01%). There was also substantial geographic variation in profitability: among census regions, Critical Access Hospitals in the South and other types of rural hospitals in the Northeast were less profitable than hospitals in other regions.

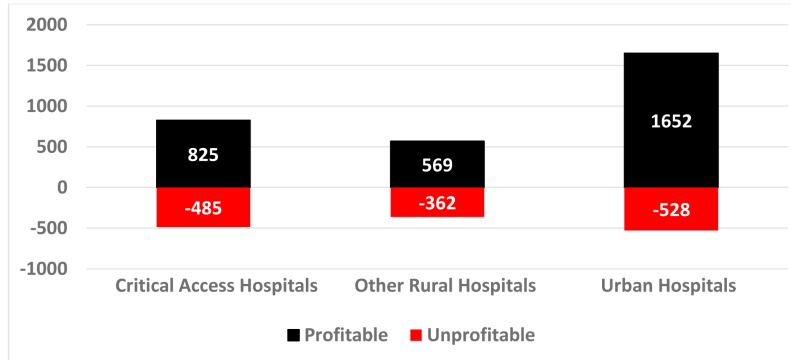
Figure 3 shows that, in 2016, 31 percent of all acute care hospitals (1,375/4,471) were unprofitable, and the majority of unprofitable hospitals were rural: 847 unprofitable rural hospitals versus 528 unprofitable urban hospitals.⁸

⁶Clawar M, Thompson K, Pink G. "Range Matters: Rural Averages Can Conceal Important Information." (January 2018). NC Rural Health Research and Policy Analysis Program. UNC-Chapel Hill. <http://www.shepscenter.unc.edu/download/15861/>.

⁷"Rural Health Snapshot 2017." (May 2017). NC Rural Health Research and Policy Analysis Program. UNC-Chapel Hill. <http://www.shepscenter.unc.edu/download/14853/>.

⁸GH Pink, K Thompson, HA Howard, GM Holmes. "Geographic Variation in the 2016 Profitability of Urban and Rural Hospitals." NC Rural Health Research Program Findings Brief. March 2018.

Figure 3. Number of Profitable and Unprofitable Hospitals in 2016*



*Note: *Other Rural Hospitals* are Medicare Dependent Hospitals, Sole Community Hospitals, and rural PPS hospitals (as well as not CAHs and not urban)

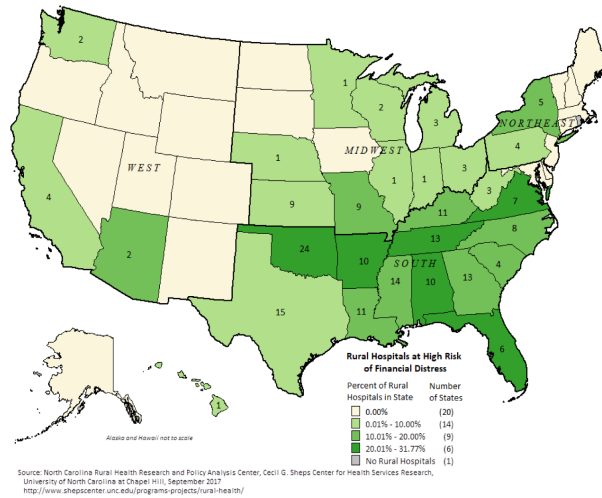
There was also substantial geographic variation in the number of unprofitable hospitals: among census regions, the greatest number of unprofitable hospitals were “other rural hospitals” in the South, urban hospitals in the South, and Critical Access Hospitals in the Midwest. There are many reasons for geographic variation in the profitability of urban and rural hospitals: for example, compared to urban hospitals, rural hospitals serve older, poorer, and sicker communities where higher percentages of patients are covered through public insurance programs, if they are covered at all. Most rural hospitals are located in the South, the region with the highest rates of poverty, and in the Midwest, the region with the lowest rates of poverty. Regardless of the reasons, unprofitable hospitals are at greater risk of closing and warrant elevated concern by policy makers and those concerned with access to hospital care by rural residents.

CHARACTERISTICS OF COMMUNITIES SERVED BY HOSPITALS AT HIGH RISK OF FINANCIAL DISTRESS

We used profitability and the other three factors to develop a model to predict financial distress of rural hospitals.⁹ Among 2,177 rural hospitals in 2015, 9 percent (197 hospitals) were classified at high risk of financial distress and 16 percent (339 hospitals) at medium-high risk. Most high-risk hospitals are located in the South: States with the largest percentages of rural hospitals at high risk were Oklahoma (31%, n=24), Tennessee (25%, n=13), Florida (25%, n=6), Virginia (24%, n=7), and Alabama (23%, n=10).

⁹GM Holmes, BG Kaufman, GH Pink. “Predicting Financial Distress in Rural Hospitals.” *Journal of Rural Health* 33 (2017) 239–249.

Figure 4. Rural hospitals at high risk of financial distress in 2017



One finding of particular concern was a racial disparity among communities served by hospitals at high-risk of financial distress compared to those served by hospitals not at high risk. Communities served by rural hospitals at high risk of financial distress had a significantly higher percentage of non-Hispanic black residents (16% vs. 7%), while those served by rural hospitals not at high risk had a higher percentage of non-Hispanic white residents (84% vs. 75%). Communities served by rural hospitals at high risk of financial distress had a significantly higher percentage of residents who did not graduate high school and who were unemployed. Finally, communities served by rural hospitals at high risk of financial distress had a significantly higher percentage of residents who reported having fair to poor health, who were obese, who smoked, and who had increased years of potential of life lost (premature mortality).

Hospitals at high risk of financial distress serve a more vulnerable population than those not at high risk. Because hospitals at high risk of financial distress are more likely to close or curtail services, these vulnerable populations are at increased risk of reduced access to hospital services, exacerbation of health disparities, and loss of hospital and other types of local employment.

POTENTIAL STRATEGIES TO ADDRESS FINANCIAL DISTRESS AND CLOSURE OF RURAL HOSPITALS

Given the factors above and the fact that during the past 35 years some of the most innovative and effective developments in rural health policy have emerged from the Finance Committee, we hope the committee will consider our two suggested approaches to address financial distress and closures.

1. *Improve what exists—Assess whether Medicare payment designations could be better targeted.* Over the past 25 years, Congress has created special payment classifications and adjustments to assist rural hospitals, including Critical Access Hospital, Sole Community Hospital (SCH), Medicare Dependent Hospital, Rural Referral Center, Medicare Disproportionate Share Hospital and low-volume hospital adjustment. These programs are important to many rural hospitals; however, some of them might be refined to better target rural hospitals at high risk of financial distress. For example, the SCH program provides payment enhancements to safety-net hospitals that are often the only source of such services for many rural communities. In our initial study we found that there would be significant financial consequences to hospitals if the SCH program did not exist. However, we also found that the hospitals that benefited

the least from the SCH program were in the South,¹⁰ the region with the greatest prevalence of rural hospitals at high risk of financial distress and closures.¹¹ In our subsequent study, we found that hospitals that benefited from the SCH program were: (1) located in markets with greater total population, lower unemployment and poverty rates, and higher high school graduation rates; (2) located in counties with lower percentages of people who are obese, have fair/poor self-rated health, and have no health insurance, as well as a lower number of potential years of life lost, and; (3) more profitable (higher total and operating margins), larger (greater net patient revenue), more efficient (higher occupancy rate), and employed more FTE staff per bed.¹² These findings raise the question of whether the SCH program could be better targeted by reassessing eligibility criteria, conditions of participation, or the payment method. This could be done for other Medicare hospital payment classifications and other types of providers, such as ambulances and home health.

2. *Develop something new—Select some models for demonstration and accelerate evaluation of current demonstration projects.* The Centers for Medicare and Medicaid Services' Innovation Center has several rural demonstration projects, including the Rural Community Hospital Demonstration, the Frontier Community Health Integration Project and the Pennsylvania Rural Health Model. The Medicare Payment Advisory Commission has proposed a 24/7 emergency department model and a clinic and ambulance model for communities that may have insufficient inpatient volume.¹³ The American Hospital Association Task Force on Ensuring Access in Vulnerable Communities Emerging Strategies to Ensure Access to Health Care Service identified several rural models.¹⁴ The National Rural Health Association has proposed the Community Outpatient Hospital as a model to ensure emergency access to care for rural patients.¹⁵ The Kansas Hospital Association is promoting "Primary Health Centers" to shift small rural hospitals away from a focus on admissions to more outpatient and transitional services.¹⁶ The Oregon Rural Health Reform Initiative is an effort to sustain rural hospitals financially by transitioning them away from a cost-based reimbursement model.¹⁷ Thus there is no shortage of innovative ideas that could lead to demonstration projects and proposed models that may hold the ultimate solutions for enhancing access to care in rural communities. The profound challenges facing providers that serve rural communities are getting worse: we believe that innovation needs to be accelerated—testing of new models, simpler approval processes, faster evaluation and implementation, and development of new Medicare payment methods, Conditions of Participation, and regulations that will allow and sustain new models of rural care and Medicaid as foundational elements of demonstration models.

CONCLUSION

In conclusion: (1) Rural hospital closures are likely to continue and will probably occur more frequently in disadvantaged communities; (2) the causes of financial distress and closure are complex and the number of rural hospitals at high risk of financial distress is growing; and (3) assessment of whether Medicare payment designations could be better targeted and acceleration of innovation and testing of more new models are recommended strategies.

Many communities across the United States are concerned about the ability of their hospitals to continue providing health care to their residents. Rural hospitals at high risk of financial distress and closure are not well positioned to meet the

¹⁰ SCHs in the South would be less affected by cessation of the SCH program because more are already paid at the IPPS rate (because their hospital-specific rates are lower than the Federal IPPS rate).

¹¹ SR Thomas, R Randolph, GM Holmes, GH Pink. "The Financial Importance of the Sole Community Hospital Payment Designation." NC Rural Health Research Program Findings Brief. November 2016.

¹² SR Thomas, GM Holmes, GH Pink. "Differences in Community Characteristics of Sole Community Hospitals." NC Rural Health Research Program Findings Brief. November 2017.

¹³ "Improving Efficiency and Preserving Access to Emergency Care in Rural Areas." Chapter 7 in *Report to Congress: Medicare and the Health Delivery System*. Medicare Payment Advisory Commission. June 2016.

¹⁴ <https://www.aha.org/system/files/content/16/ensuring-access-taskforce-exec-summary.pdf>.

¹⁵ <https://www.ruralhealthweb.org/advocate/save-rural-hospitals>.

¹⁶ Kansas Hospital Association Rural Health Visioning Technical Advisory Group. March 2015. "Sustaining Rural Health Care in Kansas: The Development of Alternative Models." Topeka, Kansas. Kansas Hospital Association.

¹⁷ <http://www.oregon.gov/oha/pages/rhri.aspx>.

challenges of the new realities in the health care delivery system. Major payment reform and industry restructuring will put pressures on hospitals of all types, but especially on financially weak organizations. Thus, it will be critical to assess carefully how these changes are affecting rural hospitals, the care they deliver, the populations they serve, as well as how existing and potential policies might impact hospitals.

QUESTIONS SUBMITTED FOR THE RECORD TO GEORGE H. PINK, PH.D.

QUESTIONS SUBMITTED BY HON. ORRIN G. HATCH

Question. Since Critical Access Hospitals are reimbursed on a cost basis, which covers their expenses to provide services to Medicare beneficiaries, do you believe that some of these facilities' reimbursement challenges stem from the lack of commercial reimbursement? Can you explain in more detail why only certain Critical Access Hospitals are financially distressed and losing money?

Answer. Yes, most Critical Access Hospitals (and other rural hospitals as well) have payer mixes with a lower percentage of commercial insurance and a higher percentage of Medicare, Medicaid, and uncompensated care (bad debt and charity care) in comparison with urban hospitals. One study found:

	Rural Hospitals	Urban Hospitals
Medicare	52%	41%
Medicaid	15%	18%
Commercial	24%	31%
Selfpay and other	9%	10%

Source: M Hall and MF Owings, "Changing Patterns in Hospitalization and Inpatient Surgery of Rural and Urban Residents," National Center for Health Statistics, 2015 National Conference on Health Statistics.

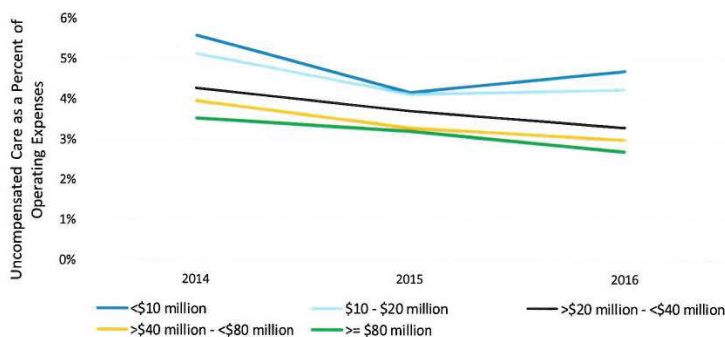
Although CAHs were originally reimbursed 101 percent of costs for Medicare beneficiaries, many continue to struggle under the 2-percent reduction imposed by sequestration (101 percent minus 2-percent sequester for actual value of 99 percent of cost). Cost-based reimbursement is a buffer against volume decline or cost increases, but it doesn't provide profit to cover high fixed costs that are not covered by rates paid by non-Medicare payers.

A particular payer mix challenge that we have investigated is uncompensated care. In a recent study, we found that between 2014–16, the median uncompensated care as a percent of operating expense was highest for smaller hospitals. Specifically, it was highest for hospitals with less than \$10 million in net patient revenue and next highest for hospitals with \$10–\$20 million in net patient revenue, almost all of which are CAHs. Furthermore, between 2015 and 2016, uncompensated care increased for hospitals with less than \$20 million in net patient revenue and decreased for hospitals with more than \$20 million in net patient revenue.

Higher levels of uncompensated care reduce profitability and increase the risk of financial distress among CAHs and other rural hospitals.

The causes of financial distress of CAHs and other rural hospitals are numerous and complex. We have developed a model to predict financial distress among rural hospitals. After exploring a large number of potential causes, we found that four types of factors predict financial distress: (1) financial performance and profitability; (2) proportion of Medicare and Medicaid in the payer mix; (3) hospital ownership and size, and; (4) characteristics of the market served by the hospital, including competition, economic condition, and market size (see GM Holmes, BG Kaufman, and GH Pink, "Predicting Financial Distress in Rural Hospitals," *Journal of Rural Health* 33 (2017) 239–249).

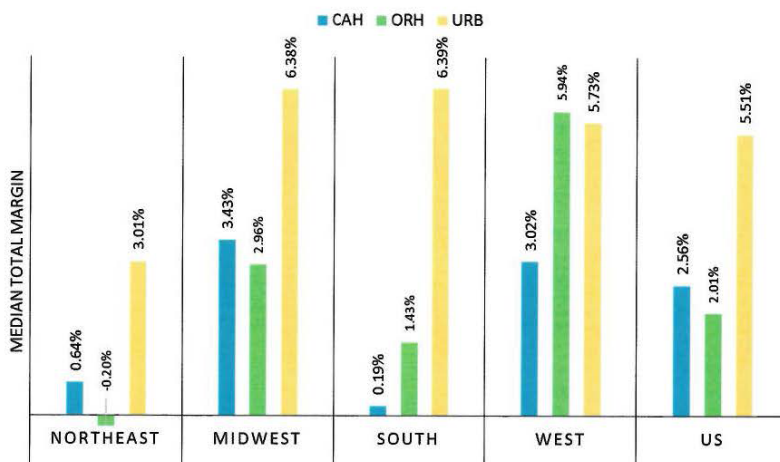
Median Uncompensated Care as a Percent of Operating Expense by Hospital Type (2014-2016)



Source: KG Garcia, K Thompson, HA Howard, and GH Pink. *Geographic Variation in Uncompensated Care between Rural and Urban Hospitals, NC Rural Health Research Program Findings Brief, June 2018.*

Among these factors, profitability is particularly important. Nationally, urban hospitals were twice as profitable as rural hospitals in 2016: the U.S. median profit margin for urban hospitals was 5.51 percent, which was more than double the margins for Critical Access Hospitals (2.56 percent) and other types of rural hospitals (2.01 percent).

2016 Median Total Margins for Critical Access Hospitals (CAH), Other Rural Hospitals (ORH), and Urban Hospitals (URB) by Census Region



Source: GH Pink, K Thompson, HA Howard, and GM Holmes. *Geographic Variation in the 2016 Profitability of Urban and Rural Hospitals. NC Rural Health Research Program Findings Brief, March 2018.*

There are many reasons why CAHs and other rural hospitals are more unprofitable than urban hospitals. Low patient volumes, workforce shortages, and lack of access to capital are pervasive. Rural hospitals serve older, poorer, and sicker communities where higher percentages of patients are covered through public insurance programs, if they are covered at all. Regardless of the reasons, unprofitable hospitals are at greater risk of closing and warrant elevated concern by policy makers and those concerned with access to hospital care for rural residents.

Question. According to your testimony, small rural hospitals that are paid under Medicare's traditional inpatient payment system also face financial stress. What would be an appropriate Medicare margin for these rural hospitals to make?

Answer. This is a difficult question to answer. In its March 2018 *Report to the Congress*, MedPAC reported that, in 2016, rural IPPS hospitals (excluding CAHs) had a -7.4 percent overall Medicare margin, which was 2.4 percentage points higher than the -9.8 percent margin for urban hospitals. Some of this difference could be accounted for by Medicare disproportionate hospital (DSH) payments: the adjustment formula is capped for <500-bed rural hospitals but there is no cap for >100-bed urban hospitals. MedPAC concludes that, "While Medicare payments do not cover the full costs (fixed and variable) of the average hospital, they are approximately 8 percent higher than the marginal cost of adding additional Medicare patients. Therefore, hospitals with excess capacity have an incentive to serve more Medicare patients." Although most rural hospitals have excess capacity and want to serve more Medicare patients, this is a challenge in communities with stable or declining numbers, and high proportions of Medicare beneficiaries who are poor, disabled, and without access to transportation. Nevertheless, some would say that -7.4 percent is an appropriate Medicare margin for rural IPPS hospitals.

In contrast, recent articles in the practitioner literature claim that declining Medicare margins are resulting in layoffs and reductions in services, particularly in rural markets where there hasn't been an influx of new employers offering commercial coverage (Dickson V, "Slumping Medicare margins put hospitals on precarious cliff," *Modern Healthcare*, November 25, 2017). Another article claims that unless hospitals contain losses from treating Medicare patients, their financial futures are in jeopardy (Goldsmith J and Bajner R, "5 Ways U.S. Hospitals Can Handle Financial Losses From Medicare Patients," *Harvard Business Review*, November 15, 2017). This would suggest that current Medicare margins for rural IPPS hospitals are too low.

So what is an appropriate Medicare margin? At the risk of sounding like an economist, on the one hand, it can be argued that Medicare should cover its own costs in which case 0 percent is an appropriate Medicare margin. On the other hand, it could be argued that cost shifting is appropriate and desirable, and the Medicare Trust Fund cannot afford to absorb price increases that would result in an average Medicare margin of 0 percent. One thing is certain, if the gap between Medicare rates and commercial rates continues to grow, this will be a problem. As MedPAC states, "the disparity in incentive to see Medicare patients and commercially insured patients will have to be addressed . . . or eventually the difference between commercial rates and Medicare rates will grow so large that some hospitals will have an incentive to focus primarily on patients with commercial insurance" (March 2018 *Report to the Congress*, page 117).

QUESTIONS SUBMITTED BY HON. MICHAEL B. ENZI

Question. There has been a lot of focus on Critical Access Hospitals, and rightfully so, but how is patient care delivered and reimbursed in hospitals that are close to meeting the CAH designation but not quite there, like Campbell County Health in my hometown of Gillette?

Answer. Over the past 25 years, Congress has created special payment classifications and adjustments to assist rural hospitals, including Critical Access Hospital, Sole Community Hospital (SCH), Medicare Dependent Hospital, Rural Referral Center, Medicare Disproportionate Share Hospital and low-volume hospital adjustment. (A good summary of these designations can be found at <https://www.ruralhealthinfo.org/topics/hospitals#designations>.)

Campbell County Health includes Campbell County Memorial Hospital, a 90-bed acute care hospital that is designated a Sole Community Hospital (SCH). Congress created the SCH program to support small rural hospitals for which "by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals, is the sole source of inpatient hospital services reasonably available in a geographic area to Medicare beneficiaries." A hospital qualifies as a SCH by meeting the following criteria:

- (1) It is located at least 35 miles from a similar hospital; or
- (2) It is between 25 and 35 miles from a similar hospital, and meets one of the following criteria: (a) no more than 25 percent of its total inpatients or 25 percent of Medicare inpatients admitted are also admitted to similar hospitals

- within a 35-mile radius; or (b) it has fewer than 50 acute care beds and would admit at least 75 percent of inpatients from the service area were it not for patients requiring specialized care that the hospital does not offer; or
- (3) It is between 15 and 25 miles from other similar hospitals that are inaccessible for at least 30 days in each of two out of three years due to topography or weather; or
- (4) Travel time to the nearest hospital is at least 45 minutes because of distance, posted speed limits, or predictable weather.

A SCH is often the only source of hospital care for isolated rural residents. As such, Medicare SCH classification helps to keep these institutions financially viable through certain payment enhancements and protections to the hospital. For inpatient services, Sole Community Hospitals receive the higher of payments under (1) the Inpatient Prospective Payment System (IPPS) or (2) an updated hospital-specific rate (HSR), which are payments based on their costs in a base year (1982, 1987, 1996, or 2006) updated to the current year and adjusted for changes in their case mix. Since 2006, SCHs also receive an additional adjustment set at 7.1 percent above the Outpatient Prospective Payment System (OPPS) rate for outpatient services. Additionally, SCHs can qualify for adjustments due to decreases in inpatient volume and participation in the Hospital Value-Based Purchasing Program, Hospital Readmissions Reduction Program, and Hospital-Acquired Condition program.

Senator Enzi may find the following comparative information for Campbell County Memorial Hospital and other hospitals in Wyoming to be of interest.

**Comparison of Campbell County Memorial Hospital to all Wyoming Hospitals
Medicare Cost Reports Ending in 2016**

	Campbell County Value	Critical Ac- cess Hos- pitals in WY Median	Other Rural Hospitals in WY Me- dian	Urban Hos- pitals in WY Median
Profitability				
Operating margin	-7.4%	-3.0%	5.1%	2.8%
Total margin	3.7%	0.4%	8.9%	2.8%
Cash flow margin	2.7%	1.8%	12.4%	6.8%
Return on equity	2.8%	1.5%	6.8%	1.1%
Liquidity				
Current ratio	1.9	3.5	2.9	2.6
Days cash on hand	202	81	118	238
Days in gross accounts receivable	45	57	49	56
Days in net accounts receivable	85	55	62	59
Capital structure				
Equity financing	73%	68%	89%	82%
Debt service coverage	4.7	7.4	6.5	2.4
Long-term debt to capitalization	21%	18%	6%	13%
Revenue				
Medicare inpatient payer mix	35%	71%	42%	51%
Medicare outpatient payer mix	17%	41%	26%	30%
Outpatient revenue to total revenue	74%	67%	66%	39%
Patient deductions	48%	31%	48%	60%
Medicare outpatient cost to charge	0.40	0.57	0.40	0.26
Cost				
Average age of plant	N/A	9.9	9.5	8.2
FTEs per adjusted bed	12.1	11.4	8.4	6.5
Average salary per FTE	\$58,364	\$63,123	\$67,422	\$79,072
Salaries to net patient revenue	40.6%	55.5%	38.8%	37.2%
Uncompensated care to total operating expense	6.4%	7.3%	5.8%	6.9%
Utilization				
Acute average daily census	19	3	17	91
Number of hospital cost reports		16	7	3

For further information about Sole Community Hospitals, we have recently produced two findings briefs:

S Thomas, K Thompson, and GH Pink, "The Community Experience of Sole Community Hospitals," NC Rural Health Research Program Findings Brief, June 2017.

S Thomas, K Thompson, and GH Pink, "The Financial Experience of Sole Community Hospitals," NC Rural Health Research Program Findings Brief, November 2016.

QUESTIONS SUBMITTED BY HON. RON WYDEN

RURAL WORKFORCE

Question. As discussed during the hearing, the shortage of primary and specialty care providers is a critical issue facing rural communities across the country. In Oregon, 25.9 percent of residents live in a health professional shortage area. Difficulty recruiting and retaining physicians and other members of the care team can result in longer patient wait times and reduced access to care for those living in rural communities.

What concrete policy ideas would you suggest this committee pursue to help attract more providers to rural America?

Answer. Despite considerable evidence that health professionals trained in rural sites are more likely to practice in rural communities, health workforce training remains concentrated in urban settings. The Federal Government spends \$14.5 billion annually on graduate medical education (GME), but only about 1 percent goes to rural settings (GAO 2018). Federal GME investments were set by the Balanced Budget Act of 1997 and are not targeted toward specialties, health-care settings and geographic regions of the country facing shortages (Mullan et al 2013; Fraher et al 2017). The National Academy of Medicine (NAM) has made numerous recommendations that could be enacted by Congress including: 1. modernizing Federal GME payments to reward performance, ensure accountability, and incentivize innovation; 2. creating a GME Policy Council in the Office of the Secretary in DHHS and a GME Center within CMS; and 3. using a portion of existing GME funds to develop and evaluate innovative GME programs, determine and validate appropriate GME performance measures, pilot alternative GME payment methods, and award new Medicare-funded GME training positions in priority disciplines and geographic areas.

While Medicare spending makes up 71 percent of Federal GME funds, Congress funds the Teaching Health Center (THC) Program at about \$76 million annually. Evaluations have shown that physicians who complete THC residencies are more likely to work in underserved communities (Bazemore et al. 2015; Talib et al. 2018). The THC program could be expanded and funded on a permanent basis, rather than having to rely on an annual appropriation from Congress. Congress could also expand programs like the Rural Training Tracks (RTT). Current regulations require new RTTs to be affiliated with an urban program that has never had Medicare-supported residents. While Congress can't change this regulation, it could create and expand funding for a similar program that does not have this stipulation but does require additional training slots to be placed in rural areas.

Federally qualified health centers (FQHCs), rural health centers (RHCs) and Critical Access Hospitals (CAHs) where rural training often occurs, are often financially fragile. Adding students to these sites places even greater strains on the organizations. CAHs are considered non-hospital providers under Medicare funding which means that any time a resident spends in a CAH results in a loss of Medicare funding for the parent residency program. One solution would be to classify CAHs similarly to RHCs and FQHCs so that resident time spent in those facilities would not result in a loss of Medicare funding for the parent training program. Congress could also provide supplemental funding to CAHs, FQHCs and RHCs that provide residency training to incent more sites to take on trainees.

In contrast to the \$14.5 billion spent annually on GME for physicians, the Federal Government spends very little on clinical training for Nurse Practitioners (NPs) and other advanced practice nurse practitioners (APRNs). Yet NPs play an increasingly important role in meeting the primary care needs of rural communities. In 2016, Nurse Practitioners (NPs) constituted 25.2 percent of providers in rural practices, up from 17.6 percent in 2008 (Barnes et al. 2018). A recent evaluation of a CMS demonstration project funding Graduate Nurse Education (GNE) for AP RNs increased the number of NPs available to deliver primary care in community-based

settings and primary care (Aiken et al 2018). Funding/or the GNE program could be increased and targeted toward rural hospitals, rural health clinics, and FQHCs.

For a handout summarizing research on redesigning GME to better meet population health needs, follow this link: <http://www.shepscenter.unc.edu/workforce-product/research-on-redesigning-graduate-medical-education-to-better-meet-population-health-needs/>. This handout was also shared with the House Committee on Veterans Affairs in June 2018.

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RURAL BENEFICIARY HEALTH NEEDS

Question. Rural communities tend to be older, sicker, and lower income compared to their urban counterparts. When rural hospitals are forced to close their doors, Medicare beneficiaries living in the surrounding areas often have limited health care options. The prevalence of multiple chronic conditions among those living in rural areas heightens the need to ensure all Medicare beneficiaries have access to high quality care—regardless of where they live.

In your view, where should this committee focus its efforts to ensure that Medicare beneficiaries living in rural areas (especially those with multiple chronic conditions) have access to high quality care?

Answer. The Finance Committee took important steps toward addressing chronic disease management with the passage of last year’s CHRONIC legislation that created new and important flexibility within the Medicare Advantage program. An open question is whether the benefits from the CHRONIC legislation could be expanded to rural Medicare FFS beneficiaries who have multiple chronic conditions. For example, it might be possible to pay providers a per member per month fee for care given to FFS Medicare beneficiaries with multiple chronic diseases. This might give small and rural practices more freedom to focus on the unique needs of this population in a non-risk bearing payment environment. This could also be done in a budget neutral manner for small practices in geographic isolated areas to limit the costs and focus on areas of greatest need.

Recommendation: Investigate the feasibility of paying providers a per member per month fee for care given to FFS Medicare beneficiaries with multiple chronic diseases.

Question. What Medicare policy changes would be most impactful in the short term and long term?

Answer. In the short run, the committee could better target Medicare payments at rural hospitals in greatest need—and where closure would have the greatest adverse consequences on the communities. Among rural hospitals types, PPS hospitals with 26–50 beds (known as “tweener” hospitals because they are too large to quality

for CAH status but still relatively small hospitals) and Medicare Dependent Hospitals have the lowest profitability compared to other hospitals. Most of these hospitals are located in more rural areas with a higher percentage of elderly (SR Thomas, GM Holmes, GH Pink, 2012–14, “Profitability of Urban and Rural Hospitals by Medicare Payment Classification,” NC Rural Health Research Program Findings Brief March 2016).

In the longer run, we believe that the best solution is to develop and implement new models of rural health care. There is no shortage of innovative ideas that could lead to demonstration projects and proposed models that may hold the ultimate solutions for enhancing access to care in rural communities. We believe that the future of rural health care is new and innovative health-care delivery and payment models that allow for low patient volumes, recognize fixed costs of maintaining access to emergency care, use rural relevant quality measures, and are flexible enough to meet the specific needs of local rural residents. The profound challenges facing providers that serve rural communities are not going away.

Recommendation: Step up the pace of innovation—faster evaluation and implementation of new models, and development of the Medicare policies and regulations that will allow and sustain them.

QUESTIONS SUBMITTED BY HON. DEBBIE STABENOW

RURAL ACCESS TO MENTAL HEALTH CARE

Question. Many areas of the United States have little or no access to psychiatrists to meet the demand for mental health and opioid treatment services. Recent studies show that 60 percent of all counties in this Nation—including fully 80 percent of rural counties—do not have a single psychiatrist to treat residents with mental illnesses. Based upon HRSA Mental Health Professional Shortage Area data, just 590 psychiatrists serve more than 27 million Americans—most of whom live in rural areas.

In your testimony, you discussed the role of telemedicine in expanding access to health care in rural parts of the country.

Do you think these technologies can be employed to enhance the delivery of mental health and substance abuse treatment services as well?

Answer. Telehealth, particularly in mental health, has great potential. Although the volume is growing, it is a very small part of Medicare service volume: “The use of telehealth services under the PFS has grown rapidly in recent years, but remains low. In 2016, 108,000 beneficiaries (0.3 percent of FFS beneficiaries) accounted for over 300,000 telehealth visits totaling \$27 million. These services were most commonly used for basic physician office and mental health services. Use was concentrated among a small group of clinicians and beneficiaries” (MedPAC, March 2018, *Report to the Congress*, page xxvii).

The use of telehealth for mental health and substance abuse treatment could expand if: (1) financial incentives were aligned with this objective—a distant specialist is paid a professional fee for telehealth services by FFS Medicare, but a small rural hospital or clinic receives a \$25 facility fee that frequently does not cover its cost, and rural providers offer the services because it benefits their patients and keeps care local, but they do this in the absence of a financial incentive; and (2) the distinction between originating sites and distant sites was eliminated, which would allow Rural Health Clinics and FQHCs to provide as well as receive telehealth services.

Recommendation: Assess the adequacy of the facility fee paid to rural hospitals and clinics for telehealth services, and consider elimination of originating versus distant sites.

Question. Senator Barrasso and I introduced the Seniors Mental Health Access Improvement Act, S. 1879, which would add licensed mental health counselors and marriage and family therapists to the Medicare program.

While telehealth offers great potential, is there more we can do to take advantage of mental health professionals already on the ground in rural America?

Answer. Access to licensed mental health counselors and marriage and family therapists by Medicare beneficiaries continues to be an important issue in rural health. Forty years ago, Rural Health Clinics were the first test sites for the use

of nurse practitioners and physician assistants. RHCs could serve the same role for licensed mental health counselors and marriage and family therapists. RHCs would provide a well-defined and limited setting to assess the impact and to determine whether these providers should be added to the list of eligible Medicare providers.

Recommendation: Consider testing the impact of increased access to mental health counselors and marriage and family therapists in Rural Health Clinics.

The WWAMI Rural Health Research Center is a leader in this area of research. Recent publications related to your questions include:

Andrilla CHA, Coulthard C, Larson EH, Patterson DG, Garberson LA, “Geographic Variation in the Supply of Selected Behavioral Health Providers,” *American Journal of Preventive Medicine* Volume 54, Issue 6, Supplement 3, pages S199–S207.

Andrilla CHA, Garberson LA, Patterson DG, Larson EH, “The supply and distribution of the behavioral health workforce in America: A State-level analysis,” Seattle, WA: WWAMI Rural Health Research Center, University of Washington, July 10, 2017.

Andrilla CHA, Coulthard C, Larson EH, “Changes in the supply of physicians with a DEA DATA Waiver to prescribe buprenorphine for opioid use disorder,” Seattle, WA: WWAMI Rural Health Research Center, University of Washington Data Brief #J62, May 1, 2017.

MATERNITY COVERAGE

Question. We’ve heard from families and health-care providers in Michigan who are concerned about access to maternity coverage in rural areas. Close to 500,000 women give birth each year in rural hospitals and often face additional barriers and complications. For example, women in rural areas report higher rates of obesity, deaths from heart disease, and childbirth-related hemorrhages. In addition, more than half of women in rural areas must travel at least half an hour to receive obstetric care, which can lead to decreased screening and an increase in birth related incidents.

Since 2004, a large number of rural obstetric units have closed, and only increased the distances that mothers must travel in order to receive maternity and delivery care. Unfortunately, the percent of rural counties in the United States without hospital obstetric units increased by about 50 percent during the past decade.

Do you have experience with loss of obstetric care for women within your respective fields?

Answer. Loss of obstetrics services has been a prominent issue in North Carolina. Blue Ridge Regional Hospital in Spruce Pine closed its labor and delivery unit on September 30th. Angel Medical Center in Franklin shut down its maternity ward in July 2017. For residents in these mountain communities, the next closest hospital with a maternity ward is 20 or more miles away. In the summer, the drive is 30 minutes but the roads through the mountains during labor pose a major concern during winter. The peaks in this region are the highest in the eastern United States (C Pearson and F Taylor, “Mountain maternity wards closing, WNC women’s lives on the line,” Carolina Public Press, September 25, 2017).

Question. What steps should be taken to ensure that the proper range of maternal care services are being offered through innovative rural health models?

Answer. A frequently reported reason for closure of obstetrics by a rural hospital is insufficient volume for a financially viable service. In rural areas with more than one hospital, the aggregate obstetrics volume may be financially viable if it is centralized in one facility. Incentives could be provided by states to develop regional networks of obstetrical care, perhaps through existing or new Medicaid waiver authority. Networks could include hospitals and other providers that focus on prenatal care, coordinated case management, and high-risk pregnancies and deliveries. Tele-fetal monitoring could provide backup specialty coverage and support for some networks. In comparison to a single facility, a regional network of obstetrical care could have more success in recruitment and retention of OB–GYN physicians and nurses and in bearing the high liability costs for rural family practice physicians (for example, Federally Qualified Health Centers provide liability to their providers through the Federal Tort Claims Act or FTCA).

Recommendation: Explore the feasibility of regional networks of obstetrical care.

The University of Minnesota Rural Health Research Center is a leader in this area of research. Recent publications related to your questions include:

<http://rhrc.umn.edu/2018/03/association-between-loss-of-hospital-based-obstetric-services-and-birth-outcomes-in-rural-counties-in-the-united-states/>.

<http://rhrc.umn.edu/2017/09/access-to-obstetric-services-in-rural-counties-still-declining-with-9-percent-losing-services-2004-14/>.

<http://rhrc.umn.edu/2017/04/state-variability-in-access-to-hospital-based-obstetric-services-in-rural-u-s-counties/>.

<http://rhrc.umn.edu/2017/04/closure-of-hospital-ob-services/>.

QUESTION SUBMITTED BY HON. DEBBIE STABENOW
AND HON. BENJAMIN L. CARDIN

DENTAL CARE

Question. Lack of oral health care is a significant public health problem in the United States. Significant health professional shortages and lack of access to dentistry impacts rural and underserved communities disproportionately. We know that our seniors are negatively impacted by the lack of a dental benefit in Medicare. We also know that children, families and people with disabilities who rely on Medicaid and CHIP, programs which offer coverage for pediatric dental care and sometimes care for adults, often struggle to find providers to see them. Nowhere is the need for comprehensive dental coverage and access to providers more profound than in our rural and underserved communities. We have an opportunity to address the needs of our rural and underserved communities by improving our health care system by incorporating dental care more holistically through better coverage in Medicare, Medicaid and CHIP, utilizing telemedicine, and assessing provider and workforce gaps that can and should be filled in these communities. Dr. Pink, what is the most important thing that we, as the Senate Finance Committee, can do to improve dental care and coverage for people living in rural and underserved communities?

Answer. The Senators' question very effectively summarizes the challenges rural and underserved communities face as they seek to improve their population's oral health. The inclusion of dental benefits in Medicare and creating incentives for all States to expand Medicaid dental coverage for adults would have the potential for making the greatest impact on the oral health of rural communities, which have higher rates of poverty and relatively larger numbers of the elderly. Additionally, providing reimbursement through public benefit programs (Medicare, Medicaid and CHIP) to a diverse, interdisciplinary work force, practicing at the top of their scope of practice in a patient-centered model, would help to address workforce shortages and improve quality and oral health outcomes.

PREPARED STATEMENT OF SUSAN K. THOMPSON, M.S., B.S.N., R.N., SENIOR VICE PRESIDENT, INTEGRATION AND OPTIMIZATION, UNITYPOINT HEALTH; AND CHIEF EXECUTIVE OFFICER, UNITYPOINT ACCOUNTABLE CARE

Chairman Hatch, Ranking Member Wyden, and honorable members of the committee, on behalf of UnityPoint Health and UnityPoint Accountable Care, thank you for the opportunity to submit written testimony as a supplement to the oral testimony provided on May 24, 2018 at the "Rural Health Care in America: Challenges and Opportunities" hearing. By way of background, I am pleased to submit the following comments to further illustrate health-care challenges experienced in rural Iowa, along with greater detail regarding potential solutions highlighted in my oral testimony.

BACKGROUND

UNITYPOINT HEALTH

UnityPoint Health® is one of the Nation's most integrated health systems. Through relationships with more than 280 physician clinics 280 physician clinics, 38 hospitals in metropolitan and rural communities and home care services throughout its 9 regions, UnityPoint Health provides care throughout Iowa, western Illinois and southern Wisconsin.

UnityPoint Health entities employ more than 30,000 physicians, providers, clinicians and staff. Each year, through more than 5.4 million patient visits, UnityPoint Health, UnityPoint Clinic and UnityPoint at Home provide a full range of coordinated care to patients and families. With projected annual revenues of \$4.08 billion, UnityPoint Health is the Nation's 13th largest nonprofit health system and the fourth largest nondenominational health system in America.

UNITYPOINT ACCOUNTABLE CARE

Iowa Health Accountable Care, L.C., doing business as UnityPoint Accountable Care, L.C., is an Iowa limited liability company that brings together a diverse group of health-care providers, including hospitals, physicians, and home health entities. As part of UnityPoint Health, UnityPoint Accountable Care is one of the largest Accountable Care Organizations (ACO) in the Nation, with a growing network including 47 hospitals and more than 7,750 Iowa, Illinois, Wisconsin and Missouri physicians and providers and more than 85 skilled nursing facilities. In 2017, UnityPoint Accountable Care provider networks provided care for more than 200,000 lives in governmental and commercial insurance value-based arrangements. UnityPoint Accountable Care is one of the largest participants in the Centers for Medicare and Medicaid Services' (CMS) Next Generation ACO Model and is a leader in industry transformation.

In my oral testimony before the committee, I referenced the experiences of UnityPoint Health-Trinity Regional Medical Center (TRMC) in Fort Dodge, IA, and those of the five Critical Access Hospitals (CAH) it partners with in the UnityPoint Health-Fort Dodge region—both in regard to designations under rural payment rules and TRMC's participation as the Trinity Pioneer ACO—are responsible for the total cost of care of attributed Medicare beneficiaries.

UNITYPOINT HEALTH—FORT DODGE (TRINITY HEALTH SYSTEMS)

Trinity Health Systems, also known as the UnityPoint Health—Fort Dodge region, covers an eight-county area in North Central Iowa with a population of approximately 137,000. The region includes 27 primary and specialty care clinics, home care services, a Community Mental Health Center and its flagship hospital, TRMC. In addition, the region includes partnerships with five “affiliate” CAHs.

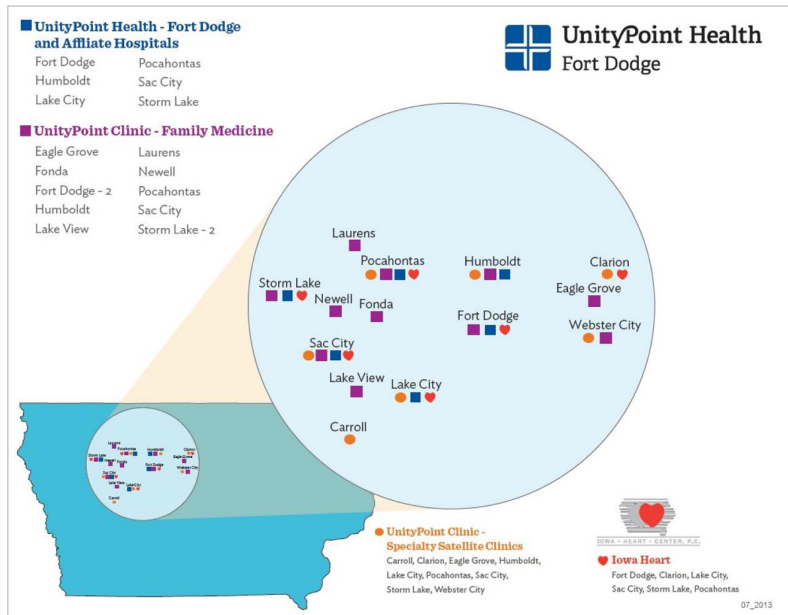


Figure 1: Map of the UnityPoint Health - Fort Dodge region and related entities and services.

UNITYPOINT HEALTH—TRINITY REGIONAL MEDICAL CENTER

TRMC, located in Fort Dodge, IA, is a licensed, non-profit hospital. In addition, TRMC is a safety-net hospital, designated by the CMS as a sole community hospital and a rural referral center. Most recently, TRMC converted from a Prospective Payment System (PPS) hospital to a “tweener” status hospital by reducing its inpatient beds to below 50. This conversion allowed TRMC to become eligible to participate in the CMS Rural Demonstration Program for the year 2018.¹

TRMC employs over 1,000 health-care professionals, technicians, and individuals with a medical staff of approximately 90 providers. In 2016, TRMC served 3,460 patients, with 51.9 percent having Medicare as a primary payor.

CRITICAL ACCESS HOSPITAL PARTNERS

As referenced above, TRMC provides management services to five CAHs in its eight-county service area. These hospitals include Buena Vista Regional Medical Center (Storm Lake, IA); Humboldt County Memorial Hospital (Humboldt, IA); Loring Hospital (Sac City, IA); Pocahontas Community Hospital (Pocahontas, IA); and Stewart Memorial Community Hospital (Lake City, IA). With a common electronic health record (EHR) platform shared between these entities, the CAHs serve as important extensions of the region’s care continuum.

TRINITY PIONEER ACO

In 2011, several health-care entities, including TRMC and Trimark Physicians Group (now part of UnityPoint Clinic, the primary and specialty care arm of UnityPoint Health), came together to create the Trinity Pioneer ACO. Originally 1 of 32 planned organizations using the Center for Medicare and Medicaid Innovation Center’s (CMS Innovation Center) Pioneer ACO Model, its success took it to the final stages, positioning it as one of the final 19 Pioneer ACOs. **It is important to note that the five CAHs referenced in the previous section provide care to some of the Medicare beneficiaries attributed to the Trinity Pioneer ACO; however, the hospitals themselves were not participating entities in the ACO.**

Despite the small size of TRMC, the hospital and its region have been an early adopter of value-based service delivery. As a CMS Pioneer ACO Model participant, TRMC wholeheartedly embraced delivery system reform efforts to move from service volume to population value. This entails a shift in investment away from inpatient care towards preventive and primary care with an emphasis on greater access to care in outpatient settings. The Trinity Pioneer ACO was able to produce two years of savings under the model while demonstrating strong performance in quality and patient experience,^{2,3} all of which earned national recognition from the U.S. Department of Health and Human Services (HHS), including an onsite visit from then HHS Secretary Sylvia Burwell, who commented that, “I’m here today to visit one of the great models of people accelerating change that the rest of the Nation needs to do.”⁴

Due in part to its success in the Pioneer ACO Model, the Trinity Pioneer ACO has since migrated to the CMS Innovation Center’s Next Generation ACO Model under UnityPoint Accountable Care. Participation in this model makes many of the UnityPoint Health—Fort Dodge region’s physicians and providers eligible for Advanced Alternative Payment Model (AAPM) status under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

THE DICHOTOMY CREATED BY OPPOSITE INCENTIVES FOR PROVIDERS IN RURAL MARKETS IS A CHALLENGE

It is through this work that the challenges facing rural communities, hospitals and providers have become so palpably clear to us. While the success of the Trinity Pioneer ACO came by meeting quality metrics and lowering the total cost of care, its CAH partners were then and are still operating under a cost-based reimbursement model. The CAH designation is designed to reduce the financial vulnerability

¹Centers for Medicare and Medicaid Services. (2017, April 17). Rural Community Hospital Demonstration [Press release]. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-04-17.html>.

²Pioneer ACO Model Performance Year 3 (2014) Quality and Financial Results. <https://innovation.cms.gov/Files/x/pioneeraco-fncl-py3.pdf>.

³Evaluation of CMMI Accountable Care Organization Initiatives: Pioneer ACO Evaluation Findings From Performance Years One and Two.” March 10, 2015. (2015, March 10). <https://innovation.cms.gov/Files/reports/PioneerACOEvalRpt2.pdf>

⁴“Burwell Touts UnityPoint Health ACO” (2016, July 15). *The Messenger*. <http://www.messengernews.net/news/local-news/2016/07/burwell-touts-unitypoint-health-aco/>

of rural hospitals and improve access to care by keeping services in rural communities. To accomplish this goal, CAHs receive certain benefits, such as cost-based reimbursement for Medicare services. Through this model, CMS reimburses CAHs for their “allowable” costs; that is, costs that CMS deems core to the business of operating a hospital.⁵ This cost-based reimbursement model creates a different and often contradictory incentive to that which is in place under value-based models, including the Pioneer ACO and Next Generation ACO Models, among others.

This dichotomy that exists between those who operate under total cost of care programs like ACOs, Medicare Advantage (MA) plans and bundled payments, and their rural CAH counterparts, who operate under a cost-based reimbursement model is not optimal. The population health movement, and more generally the movement to managed care in both the Medicare and Medicaid programs, and further encouraged by the construct of MACRA have left rural providers behind. Policy must be adjusted to encourage our rural partners to engage more deeply in value-based models, of which are outlined in the sections below.

ACCESS TO HEALTH-CARE SERVICES CONTINUES TO BE A
SIGNIFICANT CHALLENGE FOR RURAL COMMUNITIES

The second challenge highlighted in my oral testimony is the most daunting: access to health-care services in rural areas. Bringing quality care to rural Americans comes at a cost. The cost is distinct from the actual provision of the medical service. These additional, unique costs relate to the time and distance from major service centers, lack of comprehensive community services, and health-care workforce dead zones.

POTENTIAL SOLUTIONS FOR THE CHALLENGES IDENTIFIED

I. REDESIGN RURAL REIMBURSEMENT IN A MANNER WHICH DIVIDES
THE MEDICAL SPEND FROM THE COST OF PROVIDING ACCESS

We propose payment for health-care delivery services in rural areas include a value-based component tied to quality medical outcomes and expenditures, and that a separate and distinct payment structure is developed for the portion of cost-based reimbursement that pays for the costs associated with access in rural areas.

In Iowa, 82 of our 117 hospitals are identified as CAH.⁶ Given the geographic density of these rural health-care entities, there is potential to develop and implement a new rural health-care delivery model that evaluates a cluster of hospitals in a defined geographic area of the State (for example, CAHs in a 30-mile area or a defined number of counties) that focus on select areas of care. Or, if these hospitals, in order to retain their cost-based structure, develop local integrated delivery systems that would then be aligned to an AAPM. These local delivery systems would be required to include either a minimum percentage or a defined number of aligned lives of the AAPM. As part of the local integrated delivery system, the CAHs would be required to offer a defined set of services, such as extended hours for primary care and mental health services (either face-to-face or through telehealth), 24/7 emergency department care and immediate connections to community-based social services that can address the needs of patients such as transportation, housing or food insecurity, among others. If these minimum criteria are met, the participating CAHs in the local integrated delivery system would keep their cost-based reimbursement. If CAHs unable to demonstrate success in the model, policy for modifying the cost-based reimbursement might be considered.

Policy Recommendations:

1. Design ACO benchmarks to accommodate for the additional cost of bringing access to rural markets.
2. Access to care payments should be left out of ACO benchmark calculations.
3. While access to care payments between rural and urban centers need to differ, rural providers need to be held to the same quality of care standards as urban providers for areas within their scope of expertise.

⁵ Critical Access Hospitals Payment System. (2017, October). http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_17_cah_final09a311adfa9c665e80adff00009edf9c.pdf?sfvrsn=0.

⁶ Rural Health for Iowa Introduction—Rural Health Information Hub. <https://www.ruralhealthinfo.org/states/iowa>.

II. CREATE RURAL DESIGNATIONS THAT ARE MEANINGFUL
TO MODERN DAY RURAL AMERICA

Policy Recommendation: Congress should create new designations for Rural Emergency Rooms and Rural Access Centers. Specifically:

- **Rural hospitals should be redefined in to specified categories based on average daily census.** An example categorization could define the hospitals as: (1) Small Rural (average daily census of five or fewer patients); (2) Rural (average daily census of six to 25 patients); and (3) “Tweener” (average daily census of 26 to 49 patients).
 - **“Small Rural” hospitals** would receive cost-based reimbursement for outpatient services in exchange for discontinuing acute inpatient services while maintaining 24/7 emergency department services.
 - **“Rural” hospitals** would continue to receive cost-based reimbursement if they are participating in an ACO, MA plan, or other value-based model that includes a component of downside risk.
 - **“Tweener” hospitals** would receive “permanent,” ongoing cost-based reimbursement for inpatient services if they are participating in an ACO, MA plan, or other value-based model that includes downside risk. In turn, these tweener hospitals should become a rural health “aggregator,” serving as a convener by which the populations served by the tweener and local “Small Rural” and “Rural” hospitals patient populations could form a rural ACO or other value-based arrangement.

Support bills like the Rural Emergency Acute Care Hospital (REACH) Act⁷ that allow rural hospitals to transition to new designations designed to meet modern needs. The Act would allow CAHs and PPS hospitals with 50 or fewer beds to convert to Rural Emergency Hospitals and continue providing necessary emergency and observation services. Rural Emergency Hospitals would receive enhanced reimbursement rates of 110 percent of reasonable costs, and enhanced reimbursement for the transportation of patients to acute care hospitals in neighboring communities.

III. ADJUST THE MEDICARE ADVANTAGE PROGRAM TO TIE RURAL
HEALTH REGIONS INTO POPULATION HEALTH RESOURCES

Policy Recommendation: Encourage the CMS Innovation Center to develop pilots that test MA programs designed to work in rural markets like Iowa. We see great potential for MA to bring the benefits of population health methods to rural areas.

An MA/ACO Hybrid Model could leverage the successes of and lessons learned from high-performing, two-sided risk Medicare ACOs to shift from volume-based payments to a model designed to promote the delivery of higher quality care to rural Medicare beneficiaries. The underlying shared savings model for ACOs is not sustainable and ACO reimbursement still relies on a Fee-For-Service foundation. Although the MA Model has been increasing its national market penetration, regional market penetration varies significantly and rural States have been slow adopters due in part to stringent network adequacy rules and Medigap plans that perpetuate Traditional Medicare.

Models submitted to the CMS Innovation Center that facilitate rural enrollment into MA Organizations (with integrated provider partners) and give regulatory flexibility to integrate clinically-nuanced ACO approaches into their benefit design, should be tested. It may be upon the chassis of MA plans that rural markets have the ability to tap into additional workforce, population health resource and connection to specialty care.

IV. FULLY UTILIZE TELEHEALTH AS AN EXTENDER OF IN-PERSON VISITS

Policy Recommendation: Congress has recently dramatically increased the telehealth services that are available through the Medicare program. We are appreciative of this movement, and encourage Congress to continue the loosening of restrictions surrounding when telehealth services are covered by the program.

⁷Rural Emergency Acute Care Act, S. 1130, 115th Cong. (2017–2018). <https://www.congress.gov/bills/115th-congress/senate-bill/1130/text?q=%7B%22search%22%3A%5B%22%5C%22Rural+Emergency+Acute+Care+Hospital+Act%5C%22%22%5D%7D&r=1>.

V. FREESTANDING AMBULATORY SURGERY CENTERS
ARE THREATENING RURAL HEALTH CARE

Medicare covers surgical procedures provided in freestanding or hospital-operated ambulatory surgical centers (ASC). ASCs are distinct facilities that furnish ambulatory surgery; the most common procedures in 2015 were cataract removal with lens insertion, upper gastrointestinal endoscopy, colonoscopy, and nerve procedures. According to preliminary estimates from the CMS, Medicare payments to ASCs were \$4.4 billion in 2016, including both program spending and beneficiary cost sharing.

With recent reports that routine surgeries performed outside of hospitals in ASCs have led to 260 deaths since 2013, continued concerns about the lack of connection between ASCs and hospitals exist. As part of a national study on ASCs, Kaiser Health News and *USA Today* found that, while Medicare requires ASCs to have processes in place with local hospitals in the event that emergencies arise, the geographic location between a rural ASC and the nearest hospital can have fatal impact on patients in need of emergent post-surgical care provided in the rural ASC setting.⁸

In January 2008, Medicare began paying for facility services provided in ASCs—such as nursing, recovery care, anesthetics, drugs, and other supplies—using a new payment system that is primarily linked to the Hospital Outpatient Prospective Payment System (OPPS). Under the OPPS, Medicare pays for the related physician services—surgery and anesthesia—under the physician fee schedule. Like the OPPS, the ASC payment system sets payments for procedures using a set of relative weights, a conversion factor (or base payment amount), and adjustments for geographic differences in input prices. Beneficiaries are responsible for paying 20 percent of the ASC payment rate.

Policy Recommendation: Prohibit freestanding ASCs from establishing residence in rural markets.

IN CLOSING

Health-care entities are the backbone of our many of our rural communities. They care for their residents from birth to death and should remain the resource for health-care emergencies, connection to a broader array of health-care services, and wellness epicenters. We need our rural health-care delivery systems to be viable and we need them to make the transition to the rural health access centers we know they can become.

Thank you for the opportunity to share these views.

QUESTIONS SUBMITTED FOR THE RECORD TO SUSAN K. THOMPSON, M.S., B.S.N., R.N.

QUESTIONS SUBMITTED BY HON. ORRIN G. HATCH

Question. As one of a very small number of Next Generation ACO participants located in a rural market, how have you been successful in getting your attributed Medicare patients to stay within your ACO network? Because UnityPoint seems to be an outlier success story in this regard, can you please talk a little bit more about how your organization has been able to thrive in an advanced ACO program while other rural providers struggle to participate even in the non-risk bearing Track One payment structure?

Answer. A key to maintaining attribution was learned from our participation in the Center for Medicare and Medicaid Innovation Center's (CMS Innovation Center) Pioneer ACO Model-beneficiaries will stay where they have a reliable and personal relationship with their primary care provider. **We attribute our success in large part to creating a provider culture.** To drive and support their patients within a network or system of organized care, providers must understand the role of the ACO and find value (*e.g.*, access, communication, consistency) for their patients. Our Trinity Pioneer ACO intensively outreached to providers for a year ahead of ACO participation.

⁸Jewett, C., Alesia, M., and *USA Today* Network. (2018, April 24). "As Surgery Centers Boom, Patients Are Paying With Their Lives." <https://khn.org/news/medicare-certified-surgery-centers-are-expanding-but-deaths-question-safety/> <https://khn.org/news/medicare-certified-surgery-centers-are-expanding-but-deaths-question-safety/>.

Yet even with this success in provider outreach, **beneficiary “stickiness” is a continuing challenge as our attributed beneficiaries still receive greater than 40 percent of their care from providers outside our ACO. This margin is due to unlimited beneficiary choice within the Medicare program.** As structured, there is little incentive for beneficiaries to consider cost or quality when selecting a provider. While the Next Generation ACO is testing benefit enhancements, such as discounted co-pays, to encourage beneficiaries to stay within the ACO for services, these efforts are still being tested but do not appear to completely address this challenge.

In terms of our success, program features that have been helpful include prospective attribution, sheer cohort size and ACO composition. Simply knowing the beneficiaries that an ACO is accountable for in advance within the Pioneer ACO Model and Next Generation ACO programs has enabled us to target interventions to improve the health of those with specific needs. We have been able to deploy predictive analytics and decision support tools to identify individuals with high and rising risks and effectively manage care. Retrospective attribution, common in most Medicare Shared Savings Program (MSSP) contracts, is subject to beneficiary churn on a quarterly basis¹ and creates a moving target for population health initiatives. By combining our Medicare ACO programs, we were able to spread downside risk across a large cohort of attributed lives. Without sufficient size,² rural providers are exposed to uncertain financial risk—as the number of attributed lives grows, the random variation in financial results increasingly stabilizes. Our providers were also more willing to participate because tertiary hospitals were ACO Participants, providing an anchor for services and infrastructure and a large-scale partner to share in risk. **For operational features that contributed to our success, we would refer you to the response to Senator Wyden in regards to “Rural ACOs.”**

We agree that many rural providers struggle to make the leap to value. **Current AAPM model design has not targeted rural providers, and current models have uncertain advantages, require infrastructure investments, and have changing participation rules.** Even though UnityPoint Health is a seasoned early adopter, when we look to the future, it is uncertain—the Next Generation ACO is a CMS Innovation Center demonstration and will eventually sunset. **In exploring options for our rural health-care network, a preferred solution seems to blend ACO provider-driven programming with the payment stability of Medicare Advantage (MA).** This blended ACO–MA model also appears to address many of the barriers to AAPMs for rural providers with the added benefit that it removes the Federal Government from health-care administration.

Question. Can you ever perceive of a time in the future where ACOs located and operating in rural and frontier parts of the country will be able to take on two-sided risk?

Answer. We believe this is possible with the right model and appropriate size. The current shared savings model is predicated on an urban design, and rural providers are not measured on par with their urban counterparts for the same amount of clinical and care management effort. **While traditional ACOs in their current form may not provide appropriate vehicles for rural providers with limited scale, provider-sponsored Medicare Advantage plans with broad geographic reach could provide a more viable model.** In addition, rural reimbursement is often different than urban reimbursement and needs to be considered in model design to ensure financial incentives are appropriately aligned on the journey to value.

QUESTIONS SUBMITTED BY HON. MICHAEL B. ENZI

Question. In your testimony, you proposed a “separate and distinct payment structure [be] developed for the portion of cost-based reimbursement that pays for the

¹Under the UnityPoint Accountable Care MSSP program, our churn rate was as high as 25 percent per quarter. It was common for a patient attributed in Q1, to lose attribution in Q2 and then to be attributed back in Q3.

²The roughly 400 ACOs with fewer than 20,000 lives routinely experience savings and losses of 10 percent to 20 percent simply due to statistical variation in health-care spending. Barr, L, Loengard, A., Hastings, L., and Gronniger, T. “Payment Reform in Transition-Scaling ACOs for Success,” *Health Affairs Blog*, May 11, 2018. Accessed at <https://www.healthaffairs.org/doi/10.1377/hblog20180507.812014/full/>.

costs associated with access in rural areas.” Please provide a copy of this proposal or specific outline that explains your views on what costs are associated with access in rural areas, how such costs should be reimbursed, and what criteria rural hospitals should have to meet in order to participate in such a payment system.

Answer. Ultimately, there needs to be a balance between incentivizing rural providers to reduce the overall cost of care, investing in healthcare resources needed to improve quality in extreme rural areas and providing satisfactory access to Medicare beneficiaries in rural geographies. This concept of a separate “cost of access” has been percolating since our participation in the Pioneer ACO Model to address regional population health initiatives involving a multi-county service area that encompassed a sole community hospital and five Critical Access Hospitals (CAHs). At issue was that approximately 65% of Medicare beneficiaries attributed to the Trinity Pioneer ACO lived in communities served by cost-based CAHs. **The rewards for cost-based reimbursement were, and still are, firmly rooted in inpatient versus ambulatory and community-based costs.** While the ACO or other regional delivery system could lower utilization/cost of care in an individual CAH, its interim rates under the cost-reimbursement structure simply readjusted the following year to correct for the lower volume, and subsequently Medicare reimbursed more on a “per day” basis. Over time, CAHs always received their costs. In addition, the CAH reimbursement created a disincentive for other cost-saving measures; for instance, many transitional services fall outside allowable CAH reimbursement calculations. The CAH reimbursement structure was, and is, generally at odds with value-based care. **By separating the “cost of access” from the “cost of care,” reimbursement incentives and high-value care can be aligned in rural areas.**

The “cost of care” concept is the equivalent of traditional medical care and could be reimbursed through Medicare Fee-For-Service rate schedules. Like all healthcare facilities, small/rural hospitals should be held accountable for reducing the cost of care while maintaining quality standards. A value-based payment program could be implemented for cost of care services with the potential to be rewarded through a shared savings or other quality program. “Cost of access” refers to services that maintain/improve access for beneficiaries in rural areas that are proven to lower the total cost of care. These items should be encouraged. Examples of access costs include care coordination teams, palliative care, telehealth, homecare, hospice, eVisits, and urgent care clinics. These cost items could be reimbursed using an incremental rate founded on cost-based reimbursement and proposed adjustments could be made via cost reports or similar mechanisms. We acknowledge that actuarial modeling would need to occur to offer greater formula/adjustment details.

As envisioned, an add-on earned for rural access could be applied to any value-based program. It would **allow rural providers and facilities to participate in value-based programs for their “cost of care” component while still receiving proportional cost-based reimbursement to promote “cost of access” infrastructure.**

Question. Medicare’s Sole Community Hospital designation is important to many Wyoming hospitals, but to qualify, a potential sole community hospital must be located 35 miles away from the nearest hospital in most cases, with the exclusion of Critical Access Hospitals. How does excluding Critical Access Hospitals from the geographic limit affect how the sole community hospital designation is targeted?

Answer. The Sole Community Hospital (SCH) designation and its reimbursement structure bolster the fragile margins of these hospitals. In comparison to SCHs, CAHs are not “like hospitals” and offer markedly different services per their Conditions of Participation. In Iowa, there are seven SCHs, including two associated with UnityPoint Health. If the SCH 35-mile geographic limit were revised to include CAHs, this change would effectively remove all Iowa hospitals from receiving a SCH designation. Instead of a change in mileage criteria, **Congress must create incentives that encourage regional care coordination, access and delivery to strengthen the collective ability of health-care providers and facilities to meet the needs of their rural communities.**

QUESTION SUBMITTED BY HON. RON PORTMAN
AND HON. MICHAEL F. BENNET

Question. We have previously introduced legislation to encourage providers to participate in alternative payment models and facilitate care coordination, including

the Medicare PLUS Act (S. 2498 in the 114th Congress) and the Medicare Care Coordination Improvement Act (S. 2051 in the 115th Congress). When we consider coordinating care for patients in rural settings, what administrative burdens do you face? What can Congress do to ensure that value-based care is effective in rural areas?

Answer. Thank you for introducing these pieces of legislation. UnityPoint Health has previously suggested Stark Law exceptions and Anti-Kickback Statute safe harbor provisions for providers participating in value-based payment network arrangements. As Advanced Alternative Payment Models (AAPMs) are developed, each requires a separate analysis and raises individual compliance concerns. For an industry that is generally risk adverse, this creates further hesitation to innovate and move from volume to value payments. **To promote further adoption of risk-bearing models, Stark Law exceptions and/or Anti-Kickback Statute safe harbor provisions would be an appreciated first step.** In addition, UnityPoint Health has also suggested that Medicare Advantage models be accepted as an AAPM under the Quality Payment Program. **Participation in MA models should be considered under the Medicare-only participation threshold without the need for a separate determination under the All-Payer participation threshold.** With participation thresholds set to increase in both 2019 and 2021, the ability to count MA models towards both revenue and patient count thresholds without the paperwork submissions required under the All-Payer Determination would encourage continued movement to value.

In addition, the present payment structure for health-care delivery services in rural areas does not incentivize the movement from volume to value. We would suggest **a redesign of rural reimbursement in a manner which divides the medical spend from the cost of providing access.** A value-based component could then be tied to quality medical outcomes and expenditures, and a separate and distinct payment structure could be developed for the portion of cost-based reimbursement that pays for the costs associated with access in rural areas.

QUESTIONS SUBMITTED BY HON. RON WYDEN

RURAL WORKFORCE

Question. As discussed during the hearing, the shortage of primary and specialty care providers is a critical issue facing rural communities across the country. In Oregon, 25.9 percent of residents live in a health professional shortage area. Difficulty recruiting and retaining physicians and other members of the care team can result in longer patient wait times and reduced access to care for those living in rural communities.

What concrete policy ideas would you suggest this committee pursue to help attract more providers to rural America?

Answer. We would suggest this committee **strengthen rural training programs, permit top of licensure practice, and expand telehealth** as tool to reduce provider isolation.

While rewarding, rural practice is not a lifestyle that fits all, and missteps in recruitment efforts are costly and disruptive to patient continuity of care. **This committee should focus efforts on targeting students/employees that have a heightened affinity to rural practice.** My experience in rural Iowa has mirrored studies that show that physicians who grow up in rural areas are more likely to pursue careers there and further that medical students who graduate from rural residency programs are more likely to practice in rural areas as opposed to those who graduate from urban programs. **Expansion of rural residency programs, Area Health Education Centers in rural areas, or other training programs located in rural settings would enhance recruitment and retention in rural locales generally. Academic institutions in rural areas or with targeted outreach to rural students should likewise be incentivized.**

Aside from physicians, shortages exist for other health-care professionals. As detailed in the response to Senators Stabenow and Cardin's question on dental care, workforce strategies should encompass a comprehensive look at health care as a whole. One example is **nursing, another profession with shortages that would benefit from targeted rural residency programs.** As an integrated health system, UnityPoint Health has nursing vacancies in acute care settings (covering all departments), ambulatory settings and home health environments. A residency that

offered rotations in various care settings, not just hospital departments, would enable nurses to test different settings prior to making a career decision.

Provider shortages can be combated and rural recruitment assisted by allowing providers and healthcare professionals to practice at top of license. There are a number of Federal law and regulations which supersede State licensure requirements. For example, Iowa, in addition to several other States, allows for independent practice by an Advanced Registered Nurse Practitioner (ARNP). Iowa hospitals, particularly CAHs and those located in rural areas, have increasingly turned to advanced practice providers for an onsite presence in providing services in Emergency Departments. The Emergency Medical Treatment and Active Labor Act (EMTALA) permits emergency care to be provided by advanced practice providers within the scope of the license as determined by the States; however, the EMTALA statute and corresponding regulations supersede State licensure with respect to certifying patient transfers. In particular, EMTALA requires consultation between an ARNP and a doctor of medicine or osteopathy to certify the transfer of a patient. This consultation requirement must occur in every case regardless of ARNP knowledge and experience. This requirement does not allow independent practice, imposes an undue delay in providing care, and has financial implications for hospitals that are already operating on tight margins. **We request that EMTALA be revised to allow certification of patient transfers to follow State scope of practice laws.**

Recruitment in rural areas is challenged by geographic silos and the perception that a provider is alone. **We would recommend the acceleration of more robust investment opportunities in support of an advanced telehealth infrastructure.** Telehealth can be a powerful tool to create a provider support community for consults and educational opportunities.

RURAL BENEFICIARY HEALTH NEEDS

Question. Rural communities tend to be older, sicker, and lower income compared to their urban counterparts. When rural hospitals are forced to close their doors, Medicare beneficiaries living in the surrounding areas often have limited health-care options. The prevalence of multiple chronic conditions among those living in rural areas heightens the need to ensure all Medicare beneficiaries have access to high-quality care—regardless of where they live.

In your view, where should this committee focus its efforts to ensure that Medicare beneficiaries living in rural areas (especially those with multiple chronic conditions) have access to high quality care?

Answer. We agree that rural residents have a higher prevalence of multiple chronic conditions. To address this, **we encourage this committee to focus its efforts on enabling rural residents to age in place.** Strategies that can improve quality of life for our seniors are palliative care, leveraging community resources, use of telemedicine, and quality post-acute alternatives. Please note that these supports all fall within the suggested reimbursement category of “cost of access” for rural facilities as described in our response to Senator Enzi.

Palliative care—Palliative care is intended to increase the ability of seriously ill patients to remain within their homes for as long as they are comfortable. Palliative care is provided by an interdisciplinary team (specialized physicians, nurses, social workers and others, such as chaplains) and the team treats pain and other symptoms; provides time intensive communication; supports complex medical decision making; ensures practical, spiritual and psychological support; and co-manages care across settings. While UnityPoint Health has demonstrated that this team-based care reduces costs,³ **Medicare reimbursement structures provide limited support.**

Community resources—Many health issues are the result of or exacerbated by other life circumstances. Care coordination is often a challenge borne out of social determinants of health—lack of transportation, limited food and pharmacy options,

³At UnityPoint Health, we conducted a longitudinal study to estimate the financial impact of palliative care consults and subsequent enrollment in the palliative care programs. Administrative accounting and claim files were reviewed for 1,973 patients consulted between October of 2011 and September of 2012. We analyzed the use and cost of hospital service 6 months prior to the palliative care consult and 6 months following the consult, for these same patients as they were continuously monitored. It was found that there were 1,401 less Emergency Department visits and hospitalizations (a 54-percent decrease). This amounted to \$4,312,458 savings in associated variable direct cost in this acute setting (a 47-percent decrease).

reduced funds for medication, and low health literacy. Health-care professionals must leverage its community agencies as appropriate to provide wrap-around services, including public health, Area Agencies on Aging, community action agencies, food pantries, schools, social service agencies, mental health agencies, skilled nursing facilities, faith-based organizations, and United Way agencies. As an example, the “Stepping On” falls prevention programming is a recent collaboration with Area Agency on Aging in Fort Dodge, IA. As part of this effort, our ACO clinics offer falls assessments to retain older residents within their homes. Although the resources and relative capacity of community partners will vary among regions, when they are available, they should be leveraged. **The care coordination function is vital and should be reimbursed and expanded by Medicare.**

Telemedicine—Although addressed in other responses, telemedicine is a tool that allows patients to remain in place—whether at a skilled nursing facility and receiving a palliative care consult via a tablet, whether at home with equipment to monitor a pace maker rhythm, whether at the Emergency Department receiving a neurology consult, whether at the community mental health center receiving a psychiatry visit, or at home with a home health aide sending an image to a wound care specialist. **These services bring care to the patient, and reimbursement policy should remove geographic and originating site restrictions.**

Skilled Nursing Facility support—Our Medicare ACO has participated in the SNF 3-day rule waiver. Beneficiaries, if medically appropriate, may receive skilled nursing care and/or rehabilitative services at SNFs without prior hospitalization or a 3-day inpatient admission. This waiver requires that participating SNFs meet and maintain quality standards and has resulted in heightened SNF collaboration. SNFs participate in group shared learning meetings, develop shared population health policies/goals for items such as avoidable readmissions or Emergency Department visits, and collect data and monitor progress. On an individual basis, outreach and training is provided to SNF staff to increase/maintain competency. Outreach and tools have included Adaptive Design (rapid cycle improvement), SBAR (order and communication processes), INTERACT HI tools (care pathways), and IPOST (advanced care conversations). **This benefit enhancement has resulted in cost avoidance,⁴ and these waivers should continue to be available to providers engaged in value-based arrangements.**

Question. What Medicare policy changes would be most impactful in the short term and long term?

Answer. **In the short term, this committee should consider enhancing claims data that are available to providers who engage in population health initiatives.**

For AAPM Participants, **a more robust system should be instituted to share Medicare claims data** for attributed patients. This should include an option to receive both raw claims-level data and claims summary data. In addition, we would encourage HIPAA flexibility to facilitate improved service delivery:

- Access to substance abuse records by treating providers.
- Permit sharing of patient medical information between managed care plans and associated providers.
- Permit sharing of patient medical information within a clinically integrated care setting. HIPAA currently restricts the sharing of a patient’s medical information for “health-care operations.”

On a larger scale, we support the **development of all-payer claims databases** that would collect information from all private and public payers to promote transparency and increase the quality of health care provided to the patients we serve. In this effort, we would encourage Congress and CMS to take a lead role in creating data standardization and governance rules for these databases with input and feedback from stakeholders. As a multistate health-care organization, we cannot overstate the importance of having a single standard across States, instead of complying with one-off solutions in each State. When treating complex patients, comprehensive information on disease incidence, treatment costs and health outcomes is essential to inform and evaluate population health initiatives, but it is not readily available.

In the long term, we encourage this committee to address drug pricing to reduce the total cost of care. The spiraling costs of price of prescription drugs needs to be

⁴Trinity Pioneer ACO reduced average SNF length of stay by almost a week.

addressed by Congress to curtail Medicare spending. We are encouraged by the recent Request for Information from Health and Human Services on drug pricing, and would comment that for many rural residents drug costs compete with meeting other daily needs.

TELEHEALTH

Question. Building on the proven success of telehealth in the rural setting, Congress passed the CHRONIC Care Act earlier this year, which expanded access to telehealth in Medicare to allow individuals receiving dialysis services at home to do their monthly check-ins with their doctors via telehealth, to ensure individuals who may be having a stroke receive the right treatment at the right time, to allow Medicare Advantage plans to include additional telehealth services, and to give certain ACOs more flexibility to provide telehealth services.

In your view, what, if any, Medicare payment barriers to adoption and utilization of telehealth services remain in the rural setting today?

Answer. Medicare payment is definitely a barrier to telehealth adoption and utilization not only in rural areas but generally. **The first barrier relates to policy generally and the fear of over-utilization of telehealth services for unnecessary services.** This fear persists despite lack of supporting evidence to demonstrate overutilization. Due to this fear, telehealth law has been plagued by burdensome documentation requirements, provider and site of care limitations, and eligible service restrictions. **We would suggest that Congress empower two-sided risk AAPMs to fully test telehealth by permitting reimbursement for these services without provider or site of service restrictions.** Two-sided risk AAPMs would have no incentive to overutilize telehealth and presumably develop appropriate and innovative use studies that promote high value (reducing cost while maintaining quality).

The rural geographic limitation is in itself a barrier to wider adoption in rural areas. Organizations and providers frequently focus resources and efforts required to start a new telehealth service (*e.g.*, technology, training and implementation of an electronic medical record setup) in areas with greater numbers of patients. While it would seem that urban areas would be ripe for telehealth, Medicare's rural reimbursement policy has excluded the nearly eighty percent of Medicare beneficiaries that live in a Metropolitan Statistical Area. As a result, the market is dissuaded from implementing telehealth solutions generally due to relatively small percentage of the population eligible for reimbursement. **If the rural geographic restriction were eliminated, it is likely that more health-care organizations, providers and specialists would adopt and provide telehealth services, thus increasing the availability of services to rural areas from the larger pool of providers delivering services.**

Question. To the extent that barriers remain, what Medicare policy changes would you suggest the committee consider to address them?

Answer. **State licensure is a significant barrier to telehealth delivery. Similar to the recent Department of Veteran's Administration rule, we would request that licensed health-care providers be authorized to treat beneficiaries through telehealth irrespective of the State, or of the location in a State, of the health-care provider or the beneficiary.** This would not expand the scope of practice for health-care providers beyond what is statutorily defined in the laws and practice acts of the health-care provider's State of licensure, including and restrictions regarding the provider's authority to prescribe and administer controlled substances. We would call out the VA's rationale that "Just as it is critical to ensure there are qualified health-care providers onsite at all VA medical facilities, VA must ensure that all beneficiaries, specifically including beneficiaries in remote, rural, or medically underserved areas, have the greatest possible access to mental health care, specialty care, and general clinical care."⁵ The same need applies to rural residents universally, regardless of veteran status.

Additionally, we would **recommend that arrangements for two-sided risk AAPMs be provided operational flexibility.** For instance, UnityPoint Accountable Care is currently participating in the Next Generation ACO and, through a benefit enhancement, has the ability to receive reimbursement for services provided

⁵"Authority of Health Care Providers to Practice Telehealth," Federal Register, Vol. 83, No. 92, Friday, May 11, 2018, <https://www.federalregister.gov/documents/2018/05/11/2018-10114/authority-of-health-care-providers-to-practice-telehealth>.

through telehealth in urban areas and to patients in their homes. While the telehealth benefit enhancement has allowed additional case uses, it is limited to providers on our Next Generation ACO “Preferred Provider” list. Since telehealth leverages providers from multiple geographic areas and sometimes other States, many of the providers delivering care through telehealth belong to a different ACO and therefore we are unable to leverage these telehealth services. Additionally, it is administratively burdensome to match the provider and beneficiary before the visit (to confirm coverage) and then confirming the visit occurred as scheduled. Utilization of the telehealth benefit enhancement would increase and enable a better demonstration of its potential by lifting requirements for a preferred provider list and matching of providers to beneficiaries.

RURAL ACOS

Question. Aligning a fragmented delivery system can be particularly challenging in rural areas, where there is often a shortage of health care professionals, limited financial capital available, and a patient population composed of older and sicker patients. Although several rural Accountable Care Organizations (ACOs) have records of success, many rural providers still find the prospect of joining an ACO daunting. Creating opportunities for rural providers to participate in value-based payment models, such as ACOs, is critical to transitioning to a health care system that rewards value instead of simply volume of services provided.

What characteristics have allowed some rural ACOs to succeed?

Answer. The ACO model was initially established as a provider-driven solution to bridge the fragmented delivery system. We would like to take this opportunity to share characteristics from our Trinity Pioneer ACO, the most rural of the Pioneer Participants, which enabled our success and allowed us to achieve two years of savings over the course of our three-year contract.

- **Hub medical practice with a strong relationship with a local hospital.** In our case, the medical practice had a strong primary care presence, although the practice was multi-specialty. The relationship between the ambulatory and acute care settings does not have to be an ownership relationship, but location proximity is important. Some of our clinics are actually co-located on the hospital site.
- **Structure for providers.** This references the existence of a broader physician community. The governance and committee structure facilitated provider engagement in the ACO model and monitored progress and areas of opportunity.
- **Responsibility for all aspects of care.** There was engagement in all settings of care across the continuum—inpatient, outpatient, home health, behavioral health and skilled nursing facilities. Silos of care were broken down to provide holistic services.
- **Services coming to patients,** unless medically indicated. For an elderly population with multiple chronic conditions, services were largely provided locally when possible. For the most part, transportation was not a barrier, as specialty care and tests were mainly provided at the medical hub and hospital.
- **Well-defined tertiary hospital in the ACO with “skin in the game.”** Since inpatient care is often the most expensive service, hospitals that do not share an accountable role can easily negate otherwise high-value care through longer lengths of stay and/or additional tests. For the Trinity Pioneer ACO, Trinity Regional Medical Center served as the program Participant with primary responsibility for shared losses and savings. This hospital is a sole community hospital and rural referral center and has management arrangements with five area CAHs within an eight-county service area.
- **Palliative care.** This type of care is focused on providing patients with relief from the symptoms, pain and stress of a serious illness—whatever the diagnosis—and can be provided in conjunction with curative treatment. Overall, this service prioritizes patient goals of care and quality of life issues and resulted in reduced emergency department visits, readmission rates and lengths of stay. The Trinity Regional Medical Center was an early adopter of this service line and its role was greatly expanded under the ACO.
- **Post-acute care.** In recognition of the frequent transitions of care to Skilled Nursing Facilities (SNFs) and the ACO’s 3-day waiver, the Trinity Pioneer

ACO established a post-acute preferred provider network. The network provided a forum for shared learning and to disseminate training to augment the confidence and skill level of SNF staff in caring for medically needy patients. Participating SNFs were able to maintain or increase quality scores, and communications with acute care and ambulatory providers were enhanced.

- **Community consortiums.** To keep patients in the community and address social determinants of health, public health and social services agencies were leveraged. For instance, the public health agency provided certain vaccinations and performed environmental assessments for bed bug infestations.

Question. Are there certain “lessons learned” from these success stories that may be helpful to rural providers interested in participating in a rural ACO?

Answer. While the attributes of our very small rural ACO are listed above, the lessons learned relate to our providers and their support team who operationalized our accountable care experiment.

- **Outreach, outreach, and more outreach**—Get out well in advance of planned participation and build expectations for the work ahead. Rural providers want to know what is in it for the patient. While there will be learning along the way, start the dialogue early. Since providers and the supporting team will be on the front lines, they will be the best advocates for the work. The more preparation time, the better the comfort level with the work; however, once launched outreach and communication must be ongoing and frequent. It is important to keep the team apprised of progress as well as opportunities for improvement.
- **Provider incentives need to be meaningful**—Rural providers do not have the patient volume to permit anything other than going all in. Incentive packages need to be straightforward and coupled with quality performance. If done correctly, these incentives will serve as the platform to have purposeful conversations about the anticipated work and outcomes. Shared savings distribution should recognize individual contribution at specific levels. To make the amount meaningful, the Trinity Pioneer ACO banked all Medicare incentive program monies into one pot for distribution in the following year.
- **Electronic Health Record (EHR) use**—If a common EHR platform is not used, there must be a plan for sharing medical records in real time. While an EHR investment is an expense, it assists with timely care and drives population health initiatives.

TRANSITION FROM VOLUME TO VALUE

Question. The passage of the bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was a milestone in Congress’s efforts to repeal the flawed SGR and move our health care system from one that rewards volume to one that rewards value. In many cases, however, rural providers report that participating in value-based payment models is a significant challenge for them, particularly when it comes to taking on financial risk for patient health outcomes and population health. In order to successfully transition our health care system to one that rewards value, it is critical to ensure there are meaningful opportunities for rural providers to participate in a value-based payment system.

What barriers exist today that discourage rural providers from participating in value-based payment models?

Answer. As mentioned in my oral and written testimony, **the present reimbursement structure does not encourage rural provider participation.** It is a hard sell to convince rural hospitals to forego the security of cost-based reimbursement or a cost report adjustment to accept a value-based arrangement. **To engage rural America’s tailored opportunities in the value space are needed.** While UnltyPoint Health has hospitals that are participating in the Rural Community Hospital Demonstration program and we are encouraged by the Pennsylvania Rural Health Model, these models are too few and the development of more rural options should be accelerated. Suggestions for models are provided in response to the question below.

For rural practitioners, **CMS has expanded the exemption of rural low-volume providers from Merit-based Incentive Payment System (MIPS) participation, even on a reporting-only basis. This expansion excuses rural providers from transitioning to Rural Health Care in America: Challenges**

and Opportunities value. Then should providers desire to participate, current AAPM models are poor fits and providers often lack EHR and analytic sophistication. Specifically, current AAPM models are subject to uncertain and even arbitrary financial results when attributed populations are small. This is compounded by the absence of an overall hierarchy of AAPMs, making it unclear how these programs overlap or interact. For instance, beneficiary attribution to episodic care models should not trump attribution to overall population health initiatives (like ACOs), which jeopardize already relatively small attributed populations. In addition, rural providers often do not have the financial up-front resources to make investments in needed population health infrastructure for quality reporting, data sharing and analysis.

Question. What, if any, Medicare policy changes would help ensure that rural providers and communities are not left behind in the transition to value-based payment?

Answer. Prior to suggesting policy for specific reimbursement structures or incentives that could be explored to promote access and value in rural areas, we would encourage Congress to use a wide lens. This country cannot continue to promote siloed and isolated care. Rather, **we would urge Congress to promote regional health-care solutions and incentives for larger collaboratives of health-care providers to work collectively and become accountable for regional communities.** While sufficient population bases are necessary to deliver value-based care consistently and in a sustainable manner, it is most important to assure that care is delivered safely.

Among areas to explore for rural models, we would suggest:

- **Rural ACO model** with different benchmarks for a smaller pool of attributed lives as well as differentiated risk—medical costs versus access costs.
- **Re-designation of rural hospitals into specified categories based on average daily census.** For instance:
 - “*Small Rural*” hospitals (average daily census of five or fewer patients) would receive cost-based reimbursement for outpatient services in exchange for discontinuing acute inpatient services while maintaining 24/7 emergency department services.
 - “*Rural*” hospitals (average daily census of six to 25 patients) would continue to receive cost-based reimbursement if they are participating in an ACO, MA plan or other value-based model that includes a component of downside risk.
 - “*Tweener*” hospitals (average daily census of 26 to 49 patients) would receive “permanent,” ongoing cost-based reimbursement for inpatient services if they are participating in an ACO, MA plan or other value-based model that includes downside risk. In turn, these tweener hospitals should become a rural health “aggregator,” serving as a convener by which the populations served by the tweener and local “Small Rural” and “Rural” hospitals patient populations could form a rural ACO or other value-based arrangement.
- **Rural Emergency Departments/Centers:** Support bills like the Rural Emergency Acute Care Hospital (REACH) Act⁶ that allow rural hospitals to transition to new designations designed to meet modern needs.
- **Critical Access Hospital Excess Capacity Demonstration:** Allow a pilot to relax the 96-hour rule or other Condition of Participation barriers to test innovative service delivery models. For instance, using CAH beds as psychiatric beds in mental health HPSA areas.

For rural providers, **Congress could consider tax incentives as a channel to address current participation barriers amongst providers and reward those physicians whom have already transitioned to AAPM models.** Incentives could take form as tax-free retained earnings, retained by the physician practices, which could exclusively be utilized as infrastructure development and risk reserve offsets to assist in the transition to an AAPM model. Distributed incentive earnings should not be considered as a loan and should not require physicians to match funds.

⁶Rural Emergency Acute Care Act, S. 1130, 115th Cong. (2017–2018). <https://www.congress.gov/bills/115th-congress/senate-bill/1130/text?g%7B%22search%22%3A%5B%22%5C%22Rural+Emergency+Acute+Care+Hospital+Act%5D%22%22SD%7D&r=1>.

QUESTIONS SUBMITTED BY HON. DEBBIE STABENOW
AND HON. BENJAMIN L. CARDIN

DENTAL CARE

Question. Lack of oral health care is a significant public health problem in the United States. Significant health professional shortages and lack of access to dentistry impacts rural and underserved communities disproportionately. We know that our seniors are negatively impacted by the lack of a dental benefit in Medicare. We also know that children, families and people with disabilities who rely on Medicaid and CHIP, programs which offer coverage for pediatric dental care and sometimes care for adults, often struggle to find providers to see them. Nowhere is the need for comprehensive dental coverage and access to providers more profound than in our rural and underserved communities. We have an opportunity to address the needs of our rural and underserved communities by improving our health-care system by incorporating dental care more holistically through better coverage in Medicare, Medicaid, and CHIP, utilizing telemedicine, and assessing provider and workforce gaps that can and should be filled in these communities. What is the most important thing that we, as the Senate Finance Committee, can do to improve dental care and coverage for people living in rural and underserved communities?

Answer. As mentioned during my comments and responses to committee members, **we believe that Congress has opportunities to support integrated care models and innovative programs that offer patients access to physical, behavioral, and social health care.** Specific to improvement of dental care and coverage for our fellow Americans living in rural and underserved communities, **integrating oral health care into primary care is the first priority.** This integration increases access to and use of dental services to reduce disparities in rural and underserved areas by:

- Building on relationships between providers and patients;
- Allowing for direct or warm hand-offs between medical and dental providers;
- Reducing barriers to care such as transportation, time off work, childcare, etc.; and
- Enabling care coordination especially for patients with chronic issues.

In Iowa, our **Federally Qualified Health Centers (Community Health Centers) are an example of how this integration can be developed and offered to rural and underserved patients.** To ensure these programs continue to be sustainable and successful in providing affordable and high-quality services, health centers and other providers need stable funding and resources so they can continue to serve this unique patient population, recruit talented providers and expand services where appropriate. In particular, incentivizing integrated programs promotes whole person health and results in the greatest return on Federal investments.

As a complement to this effort, improving dental care and coverage for people living in rural and underserved communities should include **incentives and funding to develop innovative workforce pilot projects.** These projects should have the flexibility to utilize more economical dental workforce strategies within medical, dental and public health settings. Examples could include Community Health Workers with oral health training, expanded function dental assistants and dental hygienists, opportunities for additional mid-level dental professionals such as dental therapists to be licensed in States and serve as an additional provider option, and the use of tele-dentistry to increase the reach of the limited number of dentists. Further, programs such as the National Health Service Corps could assist in allowing dental students to take jobs in rural and underserved areas which may be cost prohibitive due to their student loans. These or other pilot programs aimed at workforce solutions for dental provider shortages can only improve access issues.

QUESTIONS SUBMITTED BY HON. DEBBIE STABENOW

MATERNITY COVERAGE

Question. We've heard from families and health-care providers in Michigan who are concerned about access to maternity coverage in rural areas. Close to 500,000 women give birth each year in rural hospitals and often face additional barriers and complications. For example, women in rural areas report higher rates of obesity, deaths from heart disease, and childbirth related hemorrhages. In addition, more

than half of women in rural areas must travel at least half an hour to receive obstetric care, which can lead to decreased screening and an increase in birth related incidents.

Since 2004, a large number of rural obstetric units have closed, and only increased the distances that mothers must travel in order to receive maternity and delivery care. Unfortunately, the percent of rural counties in the United States without hospital obstetric units increased by about 50% during the past decade.

Do you have experience with loss of obstetric care for women within your respective fields?

Answer. Of the 118 hospitals in Iowa, 35 percent (43) do *not* offer obstetric care. For rural Iowans served by Critical Access Hospitals, 50 percent (41 of 82) do *not* provide obstetric care. Three obstetric unit closures have occurred in the last 5 years, with the most recent involving a hospital with less than 30 births annually and 27 miles from the nearest hospital with obstetric services.

Question. What steps should be taken to ensure that the proper range of maternal care services are being offered through innovative rural health models?

Answer. **While this question targets maternity care, it is representative of the larger policy issue facing rural America—how to safely right size service delivery.** Maternity care, as a specialty area, illustrates the need for rural models to address the cost of access—*i.e.*, time and distance from major service centers, lack of comprehensive community services, and healthcare workforce dead zones. Innovative models must carefully define service areas with these access characteristics in mind and promote service delivery flexibility to allow providers to practice at top of licensure, use centers of excellence models when appropriate, and capitalize on technology to overcome distance barriers. **For maternity, a special emphasis should include prenatal care and outreach and leverage child and maternal health funding.**

In terms of the larger picture, rural service delivery needs a regional emphasis with weight concentrated on the front end of the story (*i.e.*, preventive services). A regional emphasis does not mean common healthcare ownership; instead, providers must be connected to a healthcare facility/facilities with enough volume to provide safe and quality care. These strong linkages are imperative to respond in an emergency to an acute event or over time to manage a chronic disease. As a country, we cannot support an OB specialist, cardiologist, neurologist, or pulmonologist at each hospital, nor can advanced practice professionals fill every gap. **We would encourage Congress to incentivize collaborative relationships in rural areas to uphold Medicare's duty to provide quality services regardless of location.**

QUESTIONS SUBMITTED BY HON. BENJAMIN L. CARDIN

TELEMEDICINE

Question. Although many may think of Maryland as an urban hub with its DC suburbs and large cities, there are parts of my State, both on the Eastern Shore and on the western side of the State, that are either very rural or medically underserved. My constituents who live in these parts of the State, must often drive long distances to get the health care they need. One way to increase access to quality health services to rural and underserved communities, is by offering treatment through telehealth technology. How do you see the role of telehealth continuing to grow in healthcare delivery, and how can it be better utilized to increase care for Medicare beneficiaries?

Answer. **Telehealth offers an important tool to increase access to health care.** The use of telehealth continues to increase as a means to enhance access to and improve quality of care in the most cost-effective setting.⁷ Telehealth technologies are quickly evolving and becoming increasingly patient-focused in terms of attempting to provide access to care in a location of the patient's preference. To support telehealth, laws should be flexible to accommodate new and emerging tech-

⁷ In 2001, the Congressional Budget Office estimated it would cost the Medicare program \$150 million to cover telehealth services for the first 5 years (\$30 million a year). Fifteen years later, total payments (2011–2016) still have not cracked that \$150-million forecast, and annual spend has not hit \$30 million. Lactman, Nathaniel, "Medicare Payments for Telehealth Increased 28% in 2016: What You Should Know," *National Law Review*, August 28, 2017.

nologies and reduce administrative burden to enable rural facilities to shift costs to infrastructure investment to best serve the needs of rural and underserved patients. In particular, **we would recommend that two-sided AAPMs and MA plans should be provided with regulatory flexibility to encourage telehealth and its role in high value service delivery.**

In general, **the case use for telehealth has been restrained by Medicare payment policy.** It is difficult in some areas to determine its efficacy because it has not been widely used. The following are options that Congress could consider to better serve Medicare beneficiaries through telehealth:

- **Remove licensure barriers.** As stated in the response to Senator Wyden, this would enable licensed health care providers to be authorized to treat beneficiaries through telehealth irrespective of the State, or of the location in a State, of the health-care provider or the beneficiary.
- **Remove geographic restrictions.** This would allow telehealth to be provided in locations regardless of rural or HPSA status. This is currently allowed in the Next Generation ACO benefit enhancement and is scheduled to be expanded to other ACOs in 2020.⁸ This policy should encompass all AAPMs as an incentive to take risk; however, it could be expanded further.
- **Expand coverage.** Explore a broader approach to telehealth coverage beyond the “replicate and repeat” of the Medicare Fee-For-Service reimbursement schedule.
- **Define “clinically appropriate.”** MA plans will soon be allowed to offer additional, clinically appropriate telehealth benefits in their annual bid amounts. We encourage Congress and CMS to clarify that clinically appropriate should reflect the full scope of practice as determined by State licensing boards and should not be restricted by CMS.
- **Authorize additional coverage areas.** This would entail revising Social Security Act section 1834(m) to allow Medicare telehealth services for:
 - “Store-and-forward” services such as wound management and diabetic retinopathy;
 - Provider services otherwise covered by Medicare, such as physical therapy, occupational therapy, and speech-language-hearing services; and
 - Already covered health procedures rendered by a telehealth method.
- **Expand “originating site” to include a beneficiary’s residence.** Unlike Medicare, many healthcare systems and commercial insurance providers have adopted and cover direct-to-consumer telehealth services. Medicare’s noncoverage shifts the cost burden to the beneficiary for self-pay, instead of a co-pay, and potentially delays care due to scheduling and travel. This is another item that is available to certain Medicare ACOs, but should be considered for expansion to all AAPMs and perhaps beyond.

CHRONIC KIDNEY DISEASE AND MEDIGAP

Question. For many Medicare beneficiaries living with kidney failure, particularly those living in rural or underserved areas, accessing affordable care for their complex and chronic condition is a constant financial challenge. Over 92,000 dialysis patients live in States with no access to Medigap. This often leaves them unable to afford Medicare Part B’s 20-percent cost sharing, which for a patient with kidney failure can often amount to tens of thousands of dollars of out-of-pocket costs each year. Have you had challenges with Medicare beneficiaries who don’t have access to Medigap coverage getting the care they need? For example Medicare beneficiaries or patients with ESRD under 65?

Answer. Iowa does not require Medigap policies for people under 65 and eligible for Medicare because of a disability or End-Stage Renal Disease (ESRD). We would agree that when beneficiaries, particularly those with chronic illnesses, are uninsured or underinsured, financial pressures exist. **It appears that this question is larger than Medigap coverage and may demand alternative models for addressing these chronic conditions, such as the CMS Innovation Center’s Comprehensive ESRD Care (CEC) Model.**

⁸Balanced Budget Act of 2018.

Question. Could you speak to the challenges Medicare beneficiaries face when they don't have access to Medigap plans and the benefits for Medicare beneficiaries who do have access to Medigap plans?

Answer. We lack the specifics to appropriately respond, as there are upwards of 11 different standard benefit packages for Medigap with varying cost sharing levels.

IN CLOSING

Thank you for permitting us to share our thoughts as this committee considers the future of rural health care. We are passionate about our work in rural health care and its impact on the well-being of our residents and the vitality of our communities. We welcome and look forward to continuing this dialogue in the future and extend an offer to this committee to come see us in action.

PREPARED STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON

Every year I hold open-to-all town hall meetings in every rural Oregon county, and I meet with a lot of leaders from the rural health care community. There are a few potential health-care calamities that have them afraid for what's coming down the pike.

First, people in rural communities feel like there's a wrecking ball headed their way because the Trump administration and half of Congress have spent the last 15 months desperately trying to make huge cuts to Medicaid. Now there are rumblings that another assault may be coming. The fact is, Medicaid is a lifeline for rural hospitals and patients. The experts will tell you that if you wanted to turn rural America into sacrifice zones where hospitals shut down and people cannot get the health care they need, the quickest way to do it is by slashing Medicaid.

Second, people in rural areas today feel like their local hospitals are already teetering on the brink of closing their doors. And if the local hospital goes under, that means no more emergency department open in a crisis.

This isn't a far-off, theoretical problem. Decades ago, back when getting routine health care more often meant spending multiple nights in a hospital inpatient bed, rural hospitals were much more secure. They could afford to maintain the emergency department. But that service may be on the ropes, because rural hospitals today are under huge financial pressure. Offering a variety of inpatient services and keeping that emergency room open is enormously expensive, and at the same time, more and more Americans are turning to outpatient settings for chronic care, rehab and routine surgeries. Since 2010, 83 rural hospitals have closed services, and hundreds more are in dire straits.

Bottom line, when you live in a big city like Portland, Chicago, or Los Angeles, you take it for granted that there's always going to be an emergency department nearby. But rural Americans who fear their hospital will be the next to close are left wondering where they'd turn if their son or daughter breaks a leg in a high school basketball game. Where would they go if an older loved one suffers a stroke? Would they get to a hospital in time if dad suffers a heart attack?

Keeping these hospital emergency departments open is a key challenge when it comes to rural health care. In my view, it's step one when you're working to prevent rural America from turning into that sacrifice zone where people can't get the care they need. In a country as wealthy as this one, where we spend \$3.5 trillion a year on health care, it absolutely must be possible to guarantee rural Americans aren't on the outside looking in.

COMMUNICATIONS

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The American Ambulance Association (AAA) is pleased that the Senate Finance Committee is holding a hearing entitled "Rural Health Care in America: Challenges and Opportunities." The AAA represents ambulance services of all types and sizes and from all areas of the United States, including ambulance services in the most rural areas of the country.

Founded in 1979, the AAA's Mission is to promote health care policies that ensure excellence in the ambulance services industry. The AAA represents ambulance services across the United States that participate in serving more than 75 percent of the U.S. population with emergency and nonemergency care and medical transportation services. The Association views prehospital care not only as a public service, but also as an essential part of the total public health care system.

Ambulance services are the front line and initial access point of our local and national health care and emergency response systems. Ambulance services provide crucial medical emergency response to patients when they need it most. They also assist beneficiaries who require skilled medical transportation and services in certain non-emergency situations. In addition the vast majority of ambulance services are small business. 54 percent of ambulance services provide 250 or fewer Medicare transports each year.

Ambulance services located in rural and super-rural areas face many of the same challenges that other providers and suppliers are trying to address. For example, while the Congress continues to extend the rural and super-rural add-ons, these amounts do not make ambulances whole; the Medicare rates still do not cover the cost of providing services in rural areas, as the GAO has noted in two different studies. In addition, CMS changed the ZIP code designations for several rural and super-rural areas that has resulted in some clearly rural areas, such as Siequoia National Forest, being deemed "urban." A ZIP code being designated as rural has a significant impact on reimbursement under the Medicare ambulance fee schedule. Transports that originate in a rural ZIP code receive an additional 1 percent increase to the base and mileage rates, but more importantly a 50 percent increase in the mileage rates for miles 1 to 17. This can mean as much as an 8 percent increase in reimbursement for providers who serve rural areas.

In addition, ambulance services find it difficult to maintain the skilled workforce necessary to provide high quality services. Given the low Medicare rates, EMTs and paramedics can often earn more at fast food restaurants than by providing life-saving and life-sustaining care as part of an ambulance team.

The low-density population in rural areas also presents serious challenges. Economies of scale possible in more densely population areas are not achievable in rural areas, especially when ambulances are required to transport patients to highly skilled facilities in far-away urban areas that can be hours away from their locations.

Moreover, rural ambulance services often find themselves as the safety net for citizens and only available health care provider in communities in which the hospital has closed ore or other health care providers have left or limited their hours. This safety net is being strained.

However, despite these challenges, there is hope—ambulance services can help rural communities maintain access to health care services. Ambulance services can and do provide highly specialized and skilled care that 20 years ago was only available in hospital emergency departments. In addition, Medicare demonstration projects have shown that ambulance services can provide important community health care services, including services such as care management, pharmacological interventions, airway management, and vaccinations, as well as patient safety checks and education.

MedPAC recognized in its 2016 *Report to the Congress* Chapter on “Improving efficiency and preserving access to emergency care in rural areas” that “communities that cannot support a 24/7 ED . . . may have to rely on an ambulance service to stabilize and transfer patients.”¹ In some instances, an ambulance service may work with a primary care practice. Some communities are already testing these models, such as the Kansas Hospital Association efforts in rural areas of the State.

Other models, such as community paramedicine, offer additional avenues through which ambulance can assist in addressing the rural health care crisis. Results from the Centers for Medicare and Medicaid Innovation have shown that ambulance services are able to improve patient outcomes and reduce overall Medicare spending when allowed to provide innovative models of care. In the analysis of this pilot, Regional Emergency Management Services Authority (REMSA) through its community paramedicine showed statistically significant reductions in inpatient admissions. While REMSA’s sample size was small, REMSA’s data show that it saved during the four-year grant period \$1.8 million in program savings by avoiding 1,509 emergency department visits.

To enable ambulance services to fill the gaps in these communities, the Congress should:

1. Stabilize the Medicare ambulance fee schedule by making the add-ons permanent and taking into consideration 132 rural census tracts when determining how ZIP codes are designated as rural and super-rural.
2. Consider other funding mechanisms, such as MedPAC’s recommendation for federal subsidies, to incentivize ambulance services in underserved areas to remain when other providers have closed their doors.
3. Allow ambulance services to be defined as “providers” under Medicare and reimburse them for the care provided, even if a patient does not require transport to a designated facility.
4. Eliminate unnecessary and overly-burdensome regulatory requirements by:
 - a. Eliminating the requirement for the Physician Certificate Statement when a beneficiary is transported between hospitals or by Specialty Care Transport, which duplicates other paperwork requirements;
 - b. Requiring ambulance providers to update the 8558 Ambulance Enrollment Form no more than once a year, rather than any time a vehicle is added to, or removed from, the service;
 - c. Eliminating the requirement that patients sign ambulance claims when other documentation establishing that the beneficiary received the service is available; and
 - d. Requiring the Secretary to take into account inaccuracies in Social Security records or other official death records before revoking billing authority for ambulance services.

As the Committee considers ways to address the rural health care crisis in America, the AAA encourages Members to find ways not only to stabilize the economics of ambulance services to ensure access to these critically important health care services in rural American, but also to incentivize these services so that they remain in the communities. The AAA appreciates the Committee’s attention to this important issue and offers our assistance in working with you to develop, pass, and implement appropriate policies that make sure that rural ambulance services can overcome the challenges they face, as well as to eliminate statutory and regulatory barriers that make it difficult for ambulance services to develop innovative care delivery models to meet the needs of patients and to address the unique situations rural communities face.

¹MedPAC, “Improving efficiency and preserving access to emergency care in rural areas,” Ch. 7, *Report to the Congress* (June 2016).

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Introduction

The American Clinical Laboratory Association (ACLA) appreciates the opportunity to provide this statement for the record for the May 24, 2018 hearing entitled, “Rural Health Care in America: Challenges and Opportunities.”

ACLA is a not-for-profit association representing the nation’s leading clinical and anatomic pathology laboratories, including national, regional, specialty, ESRD, hospital and nursing home laboratories. The clinical laboratory industry employs nearly 277,000 people directly and generates over 115,000 additional jobs in supplier industries. Clinical laboratories are at the forefront of personalized medicine, driving diagnostic innovation and contributing more than \$100 billion to the nation’s economy.

Flawed Implementation of PAMA Section 216

Congress passed the Protecting Access to Medicare Act (PAMA) in 2014. Section 216 of PAMA dramatically changed how laboratories are reimbursed for providing clinical laboratory services to Medicare beneficiaries, moving from a static fee schedule to determining payments based on commercial payments to the broad spectrum of laboratory providers.

Congress directed the Centers for Medicare & Medicaid Services (CMS) to collect private payor payment rates and associated volumes (“applicable information”) from independent laboratories, hospital laboratories, and physician office laboratories (“applicable laboratories”), and to calculate a weighted median for each test on the Clinical Laboratory Fee Schedule (CLFS) to determine a Medicare payment rate for each test.

However, CMS deliberately disregarded Congress’ instructions by gathering rate and volume information from less than one percent of laboratories nationwide. This blatant omission ignores the fundamentals of a market-based system. By ignoring the data from more than 99 percent of the nation’s laboratories, CMS’ actions will have a chilling effect on patient care and delivery system reforms moving forward. Furthermore, per CMS’ own analysis, only 36 rural laboratories in the entire United States reported data.¹ That is less than 2 percent of the total number of laboratories, although 23 percent of Medicare beneficiaries live in rural areas.²

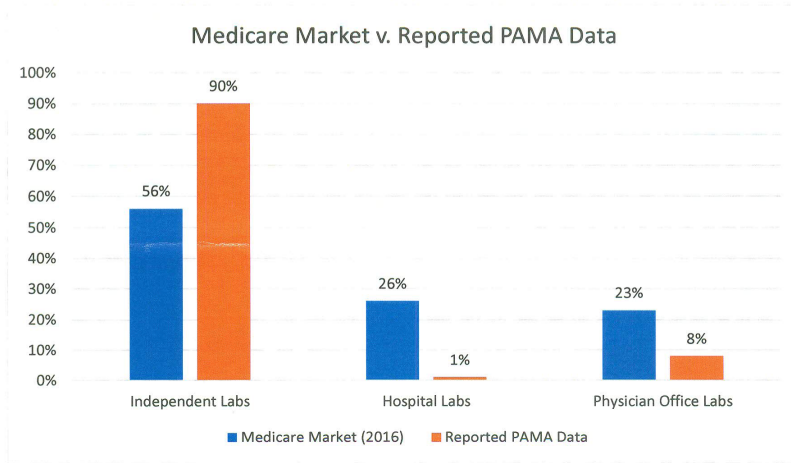
Additionally, as shown below, the volume of applicable information CMS received from independent laboratories, physician office laboratories, and hospital laboratories is far out of proportion to their respective shares of CLFS volume.^{3,4}

¹Summary of Data Reporting for the Medicare Clinical Laboratory Fee Schedule Private Payor Rate-Based System (“Summary”), available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/CY2018-CLFS-Payment-System-Summary-Data.pdf>.

²“Health Care Spending and the Medicare Program,” MedPAC, available at http://www.medpac.gov/docs/default-source/data-book/jun17_databookentirereport_sec.pdf.

³Summary of Data Reporting for the Medicare Clinical Laboratory Fee Schedule Private Payor Rate-Based System (“Summary”), available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/CY2018-CLFS-Payment-System-Summary-Data.pdf>.

⁴“Medicare Payments for Clinical Diagnostic Laboratory Tests in 2016: Year 3 of Baseline Data,” available at <https://oiq.hhs.gov/oei/reports/oei-09-17-00140.pdf>.

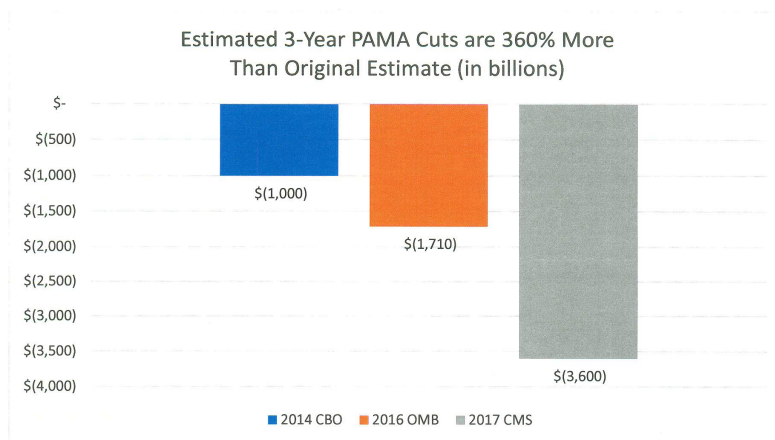


Clearly, independent laboratories submitted a far larger proportion of applicable information than their share of CLFS volume. Hospital laboratories and physician office laboratories submitted significantly less applicable information by volume than their share of CLFS volume. Simply put, the preliminary rates cannot be characterized as “market-based” when the data does not reflect the market.

PAMA Payment Amounts Not Market-Based

The flawed data reporting requirements established by CMS have resulted in Medicare payment rates that are not market-based. The Medicare payment rate cuts could be unsustainable for many laboratories furnishing services to Medicare beneficiaries and threaten access to laboratory services in some areas, particularly in rural and underserved communities. The cuts go far beyond what Congress and the Office of Management and Budget (OMB) anticipated, calling into question CMS’ approach to implementing the law.

The below chart includes the increasing estimates of the PAMA cuts. The Congressional Budget Office (CBO) estimated the initial three-year transition to a market-based system at \$1 billion. CMS now estimates the cuts at \$3.6 billion, an increase of 360 percent.



Under PAMA Sec. 216, nine of the top 10 laboratory tests (by CLFS spending) will be cut by more than 30 percent when fully phased-in. Moreover, 18 of the top 25 lab tests (by CLFS spending) will be cut by more than 30 percent, and another three of the top 25 tests will be cut by between 20 and 30 percent. For example:

- Comprehensive metabolic panel will be cut by 37 percent (41.6 million tests performed in 2016).
- Complete blood count will be cut by 35 percent (42 million tests performed in 2016).
- Vitamin D test will be cut by 35 percent (9 million tests performed in 2016).
- Glycosylated hemoglobin Ale test will be cut by 36 percent (19.3 million tests performed in 2016).
- Thyroid stimulating hormone test will be cut by 35 percent (21.5 million tests performed in 2016).

Collectively, laboratories performed more than 133 million of the foregoing five tests for Medicare beneficiaries in 2016. The top 25 tests by CLFS spending represented fully 63 percent of all Medicare payments for lab tests in 2016, or \$4.3 billion.⁵ But the deep cuts are in no way limited to the highest volume test codes. The majority of test codes will be cut by more than 10 percent when they are fully phased-in.⁶

Cuts of this magnitude could be unsustainable for many laboratories serving beneficiaries in rural areas, physician office labs in many locations, and nursing homes, and they could threaten beneficiary access to even basic laboratory testing. The costs of providing laboratory testing to Medicare beneficiaries in these areas is higher than in urban areas. It is likely that the cost could exceed the return for some routine tests, meaning some rural labs may shutter and some physician offices no longer will offer routine lab testing to their patients to inform treatment and enable diagnosis at the time of a patient's visit. It is unlikely other laboratories will rush in to fill the void once these laboratories stop operating.

This misguided approach to PAMA implementation will directly harm millions of beneficiaries, and beneficiaries in rural areas will be most severely impacted. Over the next three years, ACLA has estimated that laboratories in an urban area like Washington, DC will experience a 15 percent cut, while some laboratories in rural areas, for instance rural hospital laboratories, will experience a 28.5 percent cut.⁷ By drastically cutting rates, particularly for the top-25 most performed lab tests, CMS is severely affecting beneficiaries managing diabetes, heart disease, liver disease, kidney disease, prostate and colon cancers, anemia, infections, opioid dependency and countless other common diseases and conditions. Reducing access to clinical lab service will ultimately drive up the cost of care for beneficiaries and taxpayers and result in delays in care as well as adverse outcomes.

The harm from these cuts only increases for beneficiaries who are frail or reside in medically underserved communities, such as rural areas. These communities and patients rely on a shrinking number of smaller, local laboratories: laboratories that will face the brunt of these cuts. These cuts will force laboratories serving the most vulnerable and homebound to either shut down operations, reduce services, eliminate tests, or lay off employees. Ultimately, patients will have fewer options to receive the lab test services that will keep them healthy and out of the hospital, particularly patients who are less mobile or would have to travel unreasonable distances to receive laboratory services.

Cuts to Medicaid Payments for Labs Further Threaten Rural Patient Access

In addition to the direct cuts to Medicare laboratory rates, we have seen additional cuts in state Medicaid reimbursement rates. More than one-third of all states have pegged their Medicaid rates for laboratory services to the Medicare CLFS. Those state that base their Medicaid reimbursement on then-current Medicare CLFS rates experienced a cut in Medicaid reimbursement, in addition to Medicare reimbursement, as the new PAMA rates went into effect on January 1, 2018. Since the new

⁵“Medicare Payments for Lab Tests in 2016: Year 3 of Baseline Data” (OEI-09-17-00140) at 3.

⁶Summary at 6. CMS itself said that “about 58 percent of HCPCS codes will receive a phased-in payment reduction in CYs 2018, 2019, and 2020, rather than a full private payor rate-based payment amount in CY 2018 because the total payment decrease” will exceed 10 percent.

⁷CMS Final 2018 Clinical Lab Fee Schedule Rates, 2016 100% Outpatient Standard Analytic File, 2016 Physician/Supplier Procedure Summary File.

CLFS rates went into effect, some states have reduced Medicaid reimbursement for laboratory services even further, beyond the already deep PAMA cuts. The application of an even lower percentage of Medicare rates by state Medicaid programs imposes even greater reductions than anticipated for Medicaid beneficiaries particularly in rural and areas where there are relatively few providers. These Medicaid cuts, in addition to the Medicare cuts, may leave providers no choice but to discontinue laboratory services for Medicaid patients as the rates will be less than what they cost to provide the services.

Conclusion

ACLA thanks the Committee for consideration of our comments. We look forward to working with the Senate Finance Committee and stakeholders on advancing legislation to address the flawed implementation of Section 216 of the Protecting Access to Medicare Act, protecting access to laboratory services for Medicare beneficiaries.

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On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners—including more than 270,000 affiliated physicians, 2 million nurses and other caregivers—and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to provide input regarding action Congress can take to maintain access to health care in rural communities.

Nearly 60 million Americans live in rural areas and depend on their hospital as an important—and often only—source of care in their communities. Rural hospitals face multiple instabilities due to the unique circumstances of providing care in rural areas, including remote geographic location, low-patient volumes, workforce shortages, and a population that is often older and sicker and more dependent upon federal programs, such as Medicare and Medicaid, which reimburse below the cost of care.

During the 1990s, Congress created the critical access hospital (CAH) program and other special payment programs to help address the financial distress facing many rural providers, as well as an increase in the number of rural hospital closures.

Over time, as health care delivery has shifted from volume to value, and as more services are provided in the outpatient setting, many of these special rural programs have become outdated and fail to provide the intended financial stability. Over this same period, federal payment changes and the cost of meeting increasing regulatory requirements (*e.g.*, Medicare’s 96-hour rule and “direct supervision” policy, Meaningful Use, etc.) have further exacerbated the financial instability of many rural providers. According to the North Carolina Rural Health Research Program, 83 rural hospitals have closed since 2010 due to “likely multiple contributing factors, including failure to recover from the recession, population demographic trends, market trends, decreased demand for inpatient services, and new models of care.”

Recognizing these challenges and the need for new integrated and comprehensive health care delivery and payment strategies, the AHA Board of Trustees created in 2015 the Task Force on Ensuring Access in Vulnerable Communities. The following year, the task force issued a report outlining nine emerging strategies that can help preserve access to health care services in vulnerable communities. These strategies will not apply to or work for every community, and each community has the option to choose one or more that are compatible with its needs. The AHA is pleased to include those recommendations in this statement, along with additional policy recommendations from the AHA Rural Advocacy Agenda and the 2018 AHA Advocacy Agenda.

Our statement provides an overview of the unique circumstances and challenges facing rural communities and hospitals, as well as recommendations for action. We appreciate the opportunity to submit this statement for the record.

UNIQUE CIRCUMSTANCES AND CHALLENGES FACING RURAL COMMUNITIES AND HOSPITALS

DECLINING POPULATION, INABILITY TO ATTRACT NEW BUSINESSES AND BUSINESS CLOSURES

Rural communities are challenged by declining populations because population growth from natural change (births minus deaths) is no longer sufficient to counter migration losses when they occur. According to the U.S. Department of Agriculture (USDA), from April 2010 to July 2012, the estimated population of non-metro counties as a whole fell by close to 44,000 people.¹ Although this may seem like a small decline, the USDA indicates that it is a sizeable downward shift from the 1.3 percent growth these counties experienced during 2004–2006.² From July 2012 to July 2013, the population in non-metro areas continued this three-year downward trend.³ Such declines may have a ripple effect, leading to other negative impacts, such as business closures. They may change the health or needs of the community, which may in turn affect the viability of certain businesses. When businesses close or a community is unable to attract new businesses, it becomes more difficult for it to retain existing health care services and recruit new providers. As a result, these communities tend to have fewer active doctors and specialists, and face difficulties in accessing care, which can complicate early detection and regular treatment of chronic illnesses.

POOR ECONOMY, HIGH UNEMPLOYMENT AND LIMITED ECONOMIC RESOURCES

The presence of a poor economy typically leads to high levels of unemployment and a limited amount of economic resources. These factors are linked to poor health outcomes. For example, poverty may result in individuals purchasing processed food instead of fresh produce, which over time could lead to hypertension, obesity and diabetes. This also may affect individuals' mental health and result in other health conditions, such as high blood pressure, high cholesterol, diabetes and obesity.⁴ Rural and inner city areas more often show the effects of a poor economy. For example, overall, rural areas have seen moderate growth in employment, but certain areas face losses in jobs (including much of the South, Appalachia, Northwest and the Mountain West).⁵

AGING POPULATION

America's rural areas have a high proportion of Medicare patients, which means changes and cuts to federal reimbursement programs have a disproportionate effect on rural providers. U.S. Census data indicate that close to 18 percent of rural counties' total population is aged 65 or older.⁶ This is in contrast to the general average of 14.3 percent in large metropolitan statistical areas (MSAs) and 14.8 percent in other MSAs.⁷ Given that older individuals are more likely to have one or more chronic diseases, these communities may face poorer health outcomes. This challenge can be exacerbated if access to health care services in the community is already limited.

LOWER VOLUME AND LOWER PROVIDER SUPPLY

Rural hospitals' low-patient volumes make it difficult for these organizations to manage the high fixed costs associated with operating a hospital. This in turn makes them particularly vulnerable to policy and market changes, and to Medicare and Medicaid payment cuts. Many rural hospitals operate with modest balance sheets and have more difficulty than larger organizations accessing capital to invest in modern equipment or renovating or "right-sizing" aging facilities.

¹United States Department of Agriculture Economic Research Service. "Rural America at a Glance, 2013 Edition." Last accessed 1/19/16 at: http://www.ers.usda.gov/media/1216457/eb-24_single-pages.pdf.

²*Id.*

³United States Department of Agriculture Economic Research Service. "Rural America at a Glance, 2014 Edition." Last accessed 1/19/16 at: <http://www.ers.usda.gov/media/1697681/eb26.pdf>.

⁴Think Progress. "Four Ways That Poverty Hurts Americans' Long-Term Health." Last accessed 10/24/16 at: <http://thinkprogress.org/health/2013/07/30/2381471/four-ways-poverty-impacts-americans-health/>.

⁵United States Department of Agriculture Economic Research Service. "Rural America at a Glance, 2014 Edition." Last accessed 1/19/16 at: <http://www.ers.usda.gov/media/1697681/eb26.pdf>.

⁶U.S. Census Bureau. "2009–2013 American Community Survey 5-Year Estimates." Note: Urban/Rural status is assigned to counties based on FY 2015 CBSA designations.

⁷*Id.* Note: Large MSAs have a population of 1 million or more; other MSAs have a population of less than 1 million.

Rural hospitals also have a difficult time attracting and retaining highly skilled personnel, such as doctors and nurses.

GEOGRAPHIC ISOLATION

Rural communities are often self-contained and located away from population centers and other health care facilities. Public transportation is rare and, if it does exist, it is sporadic. In addition, for many rural communities, inclement weather or other forces of nature can make transportation impossible or, at the very least, hazardous. Challenges with transportation for many rural residents means that preventive and post-acute care, pharmaceutical and other services are delayed, or, forgone entirely, which can increase the overall cost of care once services are delivered.

LACK OF ACCESS TO PRIMARY CARE SERVICES

High-quality primary care involves health care providers offering a range of medical care (preventive, diagnostic, palliative, therapeutic, behavioral, curative, counseling and rehabilitative) in a manner that is accessible, comprehensive and coordinated.⁸ A meaningful and sustained relationship between patients and their primary care health care providers can lead to greater patient trust in the provider, good patient-provider communication, and the increased likelihood that patients will receive, and comply with, appropriate care.⁹ Unfortunately, access to primary care services is unavailable for many Americans. Today, nearly 20 percent of Americans live in areas with an insufficient number of primary care physicians. These health professional shortage areas for primary care face clear recruitment and retention issues and have less than one physician for every 3,500 residents.¹⁰ They also tend to be more common in remote rural towns. Lack of access makes it difficult for millions of Americans to access preventive health care services, leaving them and their communities susceptible to fragmented, episodic care and poorer health outcomes.

The AHA's Task Force on Ensuring Access in Vulnerable Communities identified additional challenges facing rural communities in its report. In addition, the task force identified the essential health care services that should be provided in all communities, including emergency services, primary care services, transportation and a robust referral structure.

RECOMMENDATIONS

ALTERNATIVE PAYMENT MODELS

Rural Emergency Medical Center Designation. The AHA's Task Force on Ensuring Access in Vulnerable Communities considered a number of integrated, comprehensive strategies to reform health care delivery and payment. The ultimate goal was to provide vulnerable communities and the hospitals that serve them with the tools necessary to determine the essential services they should strive to maintain locally, and the delivery system options that will allow them to do so.

One such option is the 24/7 Emergency Medical Center (EMC) model. The EMC would allow existing facilities to meet a community's need for emergency and outpatient services, without having to provide inpatient acute care services. EMCs would provide emergency services (24 hours a day, 365 days a year) as well as transportation services. They also would provide outpatient services and post-acute care services, depending on a community's needs.

The AHA urges Congress to consider the Rural Emergency Acute Care Hospital (REACH) Act (S. 1130), which would establish a 24/7 rural emergency medical designation under the Medicare program to allow small rural hospitals to continue providing necessary emergency and observation services (at enhanced reimbursement rates), but cease inpatient services.

Additionally, the AHA strongly supports the Rural Emergency Medical Center (REMC) Act (H.R. 5678), which would allow exiting CAHs and those with 50 or fewer beds to convert to a new designation (REMC) under the Medicare program. REMCs would provide 24/7 emergency services and the type of services a hospital provides on an outpatient basis to Medicare beneficiaries, including observation, diagnostic and telehealth services. REMCs also could provide

⁸American Medical Association. "Health and Ethics Policies of the AMA House of Delegates." Last accessed 10/24/16 at: <http://www.ama-assn.org/ad-com/pol/find/Health-Ethics.pdf>.

⁹Office of Disease Prevention and Health Promotion. "Healthy People 2020 Access to Health Care." Last accessed 10/24/16 at: <http://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services>.

¹⁰Health Resources and Services Administration Data Warehouse. Last accessed 10/24/16 at: <http://datawarehouse.hrsa.gov/Topics/ShortageAreas.aspx>.

post-acute care in a separately licensed skilled nursing facility unit. Payment for REMCs would be a fixed facility fee and the outpatient prospective payment system (OPPS) rate for services. REMCs would be required to provide transportation services to higher acuity facilities as needed. (The Medicare Payment Advisory Commission recently expressed support for isolated, rural stand-alone emergency departments that would bill at the OPPS rate and provide annual payments that would assist with fixed costs.)

Rural Community Hospital Demonstration Program. Special hospital designations and demonstration programs have the potential to enable rural hospitals to maintain access to critical health care services. The Rural Community Hospital (RCH) Demonstration is a program Congress created in the Medicare Modernization Act of 2003, extended and expanded in the Patient Protection and Affordable Care Act, and extended again in the 2016 as part of the 21st Century Cures Act. The RCH program allows hospitals with 26- 50 beds to test the feasibility of cost-based reimbursement. These hospitals are too large to qualify for the CAH program, but too small to benefit from economies of scale. **The AHA urges Congress to expand the RCH program and make it permanent.**

In addition to the EMC model and RCH Demonstration program, the AHA recommends the establishment of additional alternative payment models, including global budgets, a frontier health strategy and urgent care centers. These are discussed in detail in the attached report.

WORKFORCE

Recruiting and retaining health professionals in rural areas remains challenging and expensive. Telehealth offers a promising solution to some of the challenges related to physician shortages in rural areas and limited access to certain services including behavioral health and addiction treatment. However, coverage and payment for telehealth services must be expanded in order to better address the issue (see additional information below regarding improving access to telehealth). Additionally, Congress should expand existing programs that make it easier for physicians to practice in rural areas and expand scope of practice laws to allow nurses and other allied professionals to practice at the top of their license.

The AHA urges Congress to pass the Conrad State 30 and Physician Access Act (S. 898/H.R. 2141) to extend and expand the Conrad State 30 J-1 visa waiver program, which allows physicians holding J-1 visas to stay in the U.S. without having to return home if they agree to practice in a federally designated underserved area for three years; and the Resident Physician Shortage Reduction Act (S. 1301/H.R. 2267) to increase the number of Medicare-funded residency positions.

REIMBURSEMENT

Medicare reimburses hospitals below the cost of care for the services they provide and does not account for the high fixed costs associated with operating a hospital. Medicare sequestration cuts of 2 percent of reimbursement have further destabilized many small, rural hospitals. The AHA urges Congress to end Medicare sequestration and ensure providers are appropriately reimbursed for the care they provide.

REGULATORY RELIEF

A recent AHA report on the regulatory burden faced by hospitals indicates that the burden is substantial and unsustainable. Hospital and health systems spend nearly \$39 billion a year solely on administrative activities related to regulatory compliance from four federal agencies, such as quality reporting, Medicare conditions of participation, and audits of various kinds.

Meeting regulatory requirements requires an investment of both staff and resources, which can be more challenging for rural providers who must meet many or all of the same requirements as other hospitals. Federal regulation is largely intended to ensure that health care patients receive safe, high-quality care. In recent years, however, clinical staff find themselves devoting more time to regulatory compliance, taking them away from patient care. An overall reduction in regulatory burden would enable providers to focus on patients, not paperwork, and reinvest resources in innovative approaches to improve care, improve health, and reduce costs.

Additionally, certain federal regulations are unnecessary; do not positively impact patient care; and have the potential to limit access to services. Some examples are provided below.

Direct Supervision. The Centers for Medicare and Medicaid Services' (CMS) "direct supervision" rule requires that CAHs and hospitals with 100 or fewer beds provide

outpatient therapeutic services under the “direct supervision” of a physician. These services have always been provided by licensed, skilled professionals under the overall supervision of a physician and with the assurance of rapid assistance from a team of caregivers, including a physician. While hospitals recognize the need for “direct supervision” for certain outpatient services that pose a high risk or are very complex, the agency’s policy generally applies to even the lowest risk services. **The AHA urges Congress to pass the Rural Hospital Regulatory Relief Act (S. 243/H.R. 741) to make permanent the enforcement moratorium on CMS’s “direct supervision” policy for outpatient therapeutic services provided in CAHs and small, rural hospitals.**

Ninety-six-hour Physician Certification. Medicare currently requires physicians to certify that patients admitted to a CAH will be discharged or transferred to another hospital within 96 hours in order for the CAH to receive payment under Medicare Part A. While CAHs must maintain an annual average length of stay of 96 hours, they may offer some critical medical services that have standard lengths of stay greater than 96 hours. Enforcing the condition of payment will force CAHs to eliminate these “96-hour-plus” services. **The AHA urges Congress to pass the Critical Access Hospital Relief Act (H.R. 5507) to remove permanently the 96-hour physician certification requirement as a condition of payment for CAHs, thus recognizing that this condition of payment could stand in the way of promoting essential, and often lifesaving, health care services to rural America.** These hospitals would still be required to satisfy the condition of participation requiring a 96-hour annual average length of stay.

Electronic Health Records (EHRs) and Interoperability. America’s hospitals are strongly committed to the adoption of EHRs, and the transition to an EHR-enabled health system is well underway. We are pleased that CMS proposed some significant changes to the newly renamed Promoting Interoperability program to increase flexibility in 2019. This includes moving to a performance-based scoring system and removing several measures that unfairly hold hospitals accountable for the actions of others. In addition, the agency proposes a 90-day reporting period in 2019 and 2020. Unfortunately, CMS proposes to require the use of the 2015 Edition certified EHR in 2019 and to retain the requirement to connect “apps” to a hospital’s system without the ability to vet them for security. **The AHA urges Congress to pass the EHR Regulatory Relief Act (S. 2059), which would eliminate the “all or nothing” approach, establish a 90-day reporting period, and expand hardship exemptions.**

Co-location. Hospitals in rural communities often create arrangements with other hospitals or providers of care in order to offer a broader range of medical services and better meet the needs of patients. For example, a rural hospital may lease space once a month to medical specialists from out of town, such as a cardiologist, behavioral health professional or oncologist. These kinds of arrangements can improve access to care and care coordination, while also increasing convenience for patients.

However, in 2015, a CMS presentation created concern among hospitals that long-standing co-location arrangements would be declared “non-compliant with CMS’s rules.” Since then, hospitals have heard mixed messages related to co-location. Hospital staffs have spent significant amounts of time trying to ascertain the rules and determine how to sustain the most effective patient care for their community while considering whether re-construction would be required in some circumstances. Out of an abundance of concern and in the absence of clear direction, some hospitals have begun to unwind their co-location or shared service arrangements. Unfortunately, these changes can result in patients having difficulty accessing needed care.

If CMS does not clearly and appropriately define how hospitals can share space, services and staff with other providers in rural areas, Congress should statutorily define such arrangements in order to protect access to specialists in rural communities.

Stark and Anti-Kickback. Hospitals and other providers are adapting to the changing health care landscape and new value-based models of care by eliminating silos and replacing them with a continuum of care to improve the quality of care delivered, the health of their communities and overall affordability. Standing in the way of their success is an outdated regulatory system predicated on enforcing laws no longer compatible with the new realities of health care delivery. Chief among these outdated barriers are portions of the Anti-kickback Statute, the Ethics in Patient Referral Act (also known as the “Stark Law”) and certain civil monetary penalties. These laws make it difficult for providers to enter into clinical integration agreements that would allow them to collaborate to improve care in ways envisioned by

new care models. Providers also need additional opportunities and support to participate in new models of care, especially in rural areas where there may be limited funds available for the significant infrastructure investments that many of the existing models require.

The AHA urges Congress to create a safe harbor under the Anti-kickback Statute to protect clinical integration arrangements so that physicians and hospitals can collaborate to improve care, and eliminate compensation from the Stark Law to return its focus to governing ownership arrangements.

EXPAND ACCESS TO TELEHEALTH SERVICES

Telehealth is changing health care delivery. Through videoconferencing, remote monitoring, electronic consultations and wireless communications, telehealth expands patient access to care while improving patient outcomes and satisfaction.

Telehealth offers a wide-range of benefits, such as:

- Immediate, around-the-clock access to physicians, specialists, and other health care providers that otherwise would not be available in many communities;
- The ability to perform remote monitoring without requiring patients to leave their homes;
- Less expensive and more convenient care options for patients; and
- Improved care outcomes.

Medicare Coverage of Services. Coverage for telehealth services by public and private payers varies significantly and whether payers cover and adequately reimburse providers for telehealth services is a complex and evolving issue. However, without adequate reimbursement and revenue streams, providers may face obstacles to investing in these technologies. This may be especially detrimental to hospitals that serve vulnerable rural and urban communities—where the need for these services may be the greatest. For Medicare specifically, more comprehensive coverage and payment policies for telehealth services that increase patient access to services in more convenient and efficient ways would likely be necessary to make these strategies work for vulnerable communities. This would include elimination of geographic and setting location requirements and expansion of the types of covered services.

As the use of telehealth has grown in recent years, well over half of U.S. hospitals connect with patients and consulting practitioners at a distance through the use of video and other technology. However, there are several barriers to wide use of telehealth, including statutory restrictions on how Medicare covers and pays for telehealth. While the AHA was pleased that the Bipartisan Budget Act (BiBA) of 2018 expanded Medicare coverage for telestroke and provided waivers in some alternative payment models, more fundamental change is needed. In addition, many hospitals and health systems find that the infrastructure costs for telehealth are significant. Establishing telehealth capacity requires expensive videoconferencing equipment, adequate and reliable connectivity to other providers, and staff training, among other things. The fiscal year (FY) 2018 omnibus appropriations bill included more than \$50 million for rural telehealth programs, but greater support is needed.

The AHA urges Congress to further expand telehealth capacity by establishing a grant program to fund telehealth start-up costs. Congress also should remove Medicare's limitations on telehealth by:

- Eliminating geographic and setting requirements so patients outside of rural areas can benefit from telehealth;
- Expanding the types of technology that can be used, including remote monitoring;
- Covering all services that are safe to provide, rather than a small list of approved services; and
- Including telehealth in new payment models.

Access to Broadband. Adequate broadband infrastructure is necessary to improve access to telehealth services and facilitate health care operations, such as widespread use of EHRs and imaging tools. Many innovative approaches to care delivery require a strong telecommunications infrastructure. However, according to the Federal Communications Commission (FCC), 34 million Americans still lack access to adequate broadband. Lack of affordable, adequate broadband infrastructure impedes routine health care operations, such as widespread use of EHRs and imaging tools, and lim-

its the ability to use telehealth in both rural and urban areas. Congress took steps to address this challenge in the FY 2018 omnibus appropriations bill, which included \$600 million to the Department of Agriculture for a new pilot program offering grants and loans for broadband projects in rural areas with insufficient broadband. The FCC also has a Rural Health Care Program, which supports broadband adoption for non-profit rural health care providers. Unfortunately, the \$400 million annual cap has been unchanged for over 20 years, and was exceeded in both 2016 and 2017, leading to significant cuts for rural health care providers that have limited budgets. These cuts not only affect the ability of these rural health care providers to maintain strong broadband connections but also could force tough decisions affecting funding for essential health care services. In a February 2nd letter, we asked the FCC to restore this funding and supported an FCC proposal to adjust the funding cap annually for inflation, including a “catch up” increase for FY 2017 to account for inflation since the program began. We also urged the Commission to assess future demand for broadband-enabled health care services to set a more accurate cap.

The AHA appreciates Congress’s focus in this area and urges continued support for funding to help improve rural broadband access for health care providers.

CONCLUSION

The AHA applauds this Committee’s focus on issues facing rural hospitals and the patients and communities they serve. The AHA looks forward to working with you and the Congress to take meaningful action to ensure access to health care services in vulnerable communities and to support rural hospitals and the patients they serve.

See also:

AHA Task Force on Ensuring Access in Vulnerable Communities Report
 AHA Rural Advocacy Agenda
 AHA 2018 Advocacy Agenda

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Established in 1980, the Association of Air Medical Services (AAMS) is an international, non-profit 501(c)(6) trade association headquartered in the Washington, DC area that represents and advocates on behalf of our membership to enhance their ability to deliver quality, safe, and effective medical care and medical transportation for every patient in-need. AAMS is a dedicated team, committed to representing and advocating for the air medical and the critical care ground transport industry and supporting our members who proudly serve their communities throughout the United States and around the world.

AAMS, on behalf of the 257 AAMS members representing over 95% of the air medical operations in the United States, submits the following statement to the Senate Finance Committee.

Air Medical Services

The use of air medical services has become an essential component of the rural health care system. Air medical critical care transport saves lives and reduces the cost of health care. It does so by minimizing the time the critically injured and ill spend out of a hospital, by bringing more medical capabilities to the patient than are normally provided by ground emergency medical services, and by helping get the patient to the right care quickly. Helicopter emergency medical services (HEMS) and fixed wing aircraft are flying emergency intensive care units deployed at a moment’s notice to patients whose lives depend on rapid care and transport. While air medical services may appear to be expensive on a single-case basis compared with ground ambulance service, examining the benefits behind the cost on an individual and a system-wide basis shows that it is cost-effective. This is especially true in rural America, where patients are simultaneously at greater risk of severe injury and farther from definitive care.

Emergency air medical transport services are:

- Required to respond to all requests for emergency transport without knowledge or regard to the patient's ability to pay.
- Available 24 hours a day, 7 days a week, 365 days a year, for response to emergency requests, with some states requiring a minimum response time.
- Are always requested by medical professionals (physicians or first responders). They do not self-dispatch and have no control over their volume.

Air Medical's Critical Role in Rural Health Care

Air medical services provide a valuable medical resource that can transport patients and medical staff long distances, as well as carry medical equipment and medical supplies directly to the scene of the onset of an illness or injury. The air medical industry dramatically improves access to Level 1 and 2 trauma centers for over 120 million Americans who would not be able to receive emergent care in a timely manner otherwise. Over 90% of air medical flights are for treating trauma, cardiac, and stroke—all conditions that are dependent on rapid treatment at advanced medical facilities for the best outcome possible.

In rural and frontier areas, HEMS and fixed wing aircraft play a particularly important role. For example, when the nearest ground ambulance is farther, by travel-time, from the scene of injury than the nearest HEMS, the air medical service may be the primary ambulance for critically ill and injured patients in that area. Similarly, when the nearest advanced life support (ALS)-capable medical facility is farther, by travel-time, from the scene of the injury than a HEMS or a fixed wing provider, the air medical service may be the primary ALS provider for critically ill or injured patients in that area.

The air medical service can transport specialized medical staff (surgical, emergency medicine, respiratory therapy, pediatric, neonatal, obstetric, and specialized nursing staff) to assist with a local mass casualty event or to augment the rural/frontier hospital's staff in stabilizing patients needing special care before transport.

Increased need for these services, combined with the highly trained staff, medical equipment, aviation and patient safety improvements, and overhead costs, have increased operating costs significantly since the Centers for Medicare and Medicaid Services (CMS) established the air medical services fee schedule.

Study on Air Medical Costs

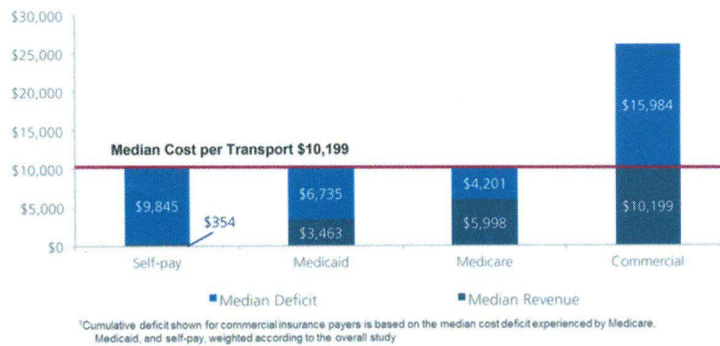
Current Medicare rates were never based on the cost of providing the service and must be updated to reflect modern-day costs. AAMS engaged an independent research firm, Xcenda LLC, to explore the cost of providing emergency air medical transport using common Medicare cost reporting methods. The purpose of the study was to provide unbiased data to CMS, the Government Accountability Office (GAO), and members of Congress regarding the actual costs of providing emergency air medical services. The study was designed to represent the entire industry, not just one business model or type, and to be as inclusive as possible across the air medical community. AAMS strongly believes this study provides an actual cost baseline for transport providers regardless of business model.

Key findings from this groundbreaking study include:

- While the study shows the break-even cost of an emergent transport is estimated to be \$10,199, it is important to understand that CMS, as a government payer, does NOT include the costs of uncompensated care generated by transporting un-insured and under-insured patients and by patients covered by under-paying government programs like Medicaid, Indian Health, TRICARE, and others.
- When those costs (the accumulated deficit from transporting un-insured, under-insured, and under paying government programs, weighted according to the percentage of patients they cover) are accounted for, the break-even cost of an emergent transport is estimated to be over \$26,000.
- Those break-even costs do NOT include any operating income to ensure air medical services are able to continue to operate. Every business must be financially viable to sustain its operations. A modest positive change in net assets (non-profit companies) or a modest margin (for-profit companies) enable air medical programs to invest in their people (medical licensing, certifications, etc.), new equipment (aircraft, medical equipment, etc.), safety improvements (night vision systems, flight data monitors, etc.), training (flight simulators, medical training, etc.), and other systemic improvements to ensure they provide

the finest, patient-centered emergent care possible, 24/7/365, for every patient-in-need.

Figure 4. Cost Deficit Illustration Experienced by Providers, Based on Reported Payer Mix¹



Shortfall in Reimbursements for Air Medical Services

The air medical transport industry is faced with consistent reductions in reimbursement payments for the emergency medical services provided to patients in need. Despite the regularly increasing costs of providing these emergency services, Medicare reimbursement has remained stagnant and many state Medicaid programs cover little or no reimbursement for these emergency transports. On average, 40% to 50% of the patients transported are covered by Medicare, an additional 20% to 30% are covered by Medicaid, and 10% are uninsured. This means that only 2 or 3 out of ten patients are commercially insured—an average that worsens in rural America—and while the cost of providing the transport is relatively the same for the majority of patients, the amount reimbursed for that cost can vary widely from patient to patient. Those costs must be recouped from somewhere, or the service cannot survive in that location; this raises the price for all patients, in the hopes of preserving the service and the access to healthcare it provides.

Commercial insurers play a very large role in the ability of air medical services to survive. If they refuse payment, delay payment, or question the medical necessity of a service that can only respond when requested by a physician or trained first-responder, air medical services are unable to provide ongoing critical healthcare access. Worse, varying state insurance laws allow insurance companies in some states to arbitrarily limit payments to air medical transport providers, leaving patients responsible for covering the remainder of their bill. Patients are left in the middle and often used as leverage to lower insurers' payment responsibilities.

While insurers must be held accountable and patients protected from being used as leverage, the root cause of the problem can be addressed by reforming Medicare and providing transparency through mandatory cost reporting.

The "Ensuring Access to Air Ambulance Services Act of 2017" (S. 2121)

Congress can protect access to definitive care for the most critically ill and injured patients by supporting the Ensuring Access to Air Ambulance Services Act of 2017 (S. 2121), introduced last November by Senators Heller (R-NV) and Bennet (D-CO). This legislation would establish mandatory cost and quality reporting requirements on air medical operators and update the Medicare fee schedule for air medical services. The bill was designed and drafted to provide a long-term solution to the shortfall in Medicare reimbursements which is already leading to base closures and the curtailment of air medical operations across the country.

This legislation helps ensure:

- **Transparency:** Cost and quality reporting measures will provide transparency to the public on the high cost of providing air medical transport, especially in rural areas.

- **Efficiency:** Increased transparency on costs and quality will drive a more efficient system, rewarding those who can perform higher quality services at a lower cost.
- **Quality:** Value based purchasing program rewards high performing air medical transport services and incentivizes increased quality in healthcare transportation across the air medical community.
- **Access:** Most importantly, the bill helps ensure that the largest single payer of air medical transports—Medicare—funds those transports at or near the cost of that service. This provides for the stability of existing services and the access they provide to healthcare.

We urge the Senate Finance Committee to report S. 2121 to the full Senate, as it will address the chronic shortfall in Medicare reimbursements and support the continued provision of this life-saving service across the country and especially in rural areas.

Conclusion

We thank the Senate Finance Committee for this important opportunity to provide the views of the air medical community on these critical issues, and are happy to provide further information upon request.

CENTERSTONE
44 Vantage Way, Suite 400
Nashville, TN 37228

June 7, 2018

U.S. Senate
Committee on Finance
Dirksen Senate Office Building
Washington, DC 20510-6200

RE: Statement for the record pertaining to May 24, 2018 full committee hearing entitled “Rural Health in America: Challenges and Opportunities”

Dear Chairman Hatch and Ranking Member Wyden:

We applaud you for your commitment to examining ways to offer rural Americans better care in their communities. Centerstone shares that goal. Below, we share some information about our services, and share our recommendations for improving the quality and timeliness of care for individuals living in rural parts of the country.

About Centerstone

Centerstone is a multi-state not-for-profit provider of evidence-based behavioral health services. In operation for over 63 years, we service nearly 180,000 lives across Florida, Illinois Indiana, Kentucky, and Tennessee in both inpatient and outpatient settings. In Florida, Centerstone has facilities in Manatee and Sarasota counties. In Illinois, Centerstone has facilities in 4 counties, with one considered a rural county by the Health Resources and Services Administration (HRSA)^{1, 2} and 2 experiencing population declines. Illinoisans come to our facilities from at least 54 other counties across the state, most of which are rural. In Indiana, 10 of the 18 counties with Centerstone facilities are considered rural by the HRSA, with 9 counties experiencing population declines.³ In Kentucky, we serve 7 counties.⁴ In Tennessee, 17 of the 30 counties we serve are defined as rural by the HRSA, with 3 experiencing population declines.⁵

¹ <https://www.hrsa.gov/sites/default/files/ruralhealth/resources/forhpeligibleareas.pdf>.

² Centerstone has facilities in the following Illinois counties: Franklin,* Jackson, Madison, and Williamson. Those designated by an asterisk(*) are considered rural counties by the HRSA.

³ Centerstone has facilities in the following Indiana counties: Bartholomew, Brown, Decatur,* Delaware, Fayette,* Henry,* Jackson,* Jefferson,* Jennings,* Johnson, Lawrence,* Monroe, Morgan, Owen, Randolph,* Rush,* Scott, Wayne.* Those designated by an asterisk(*) are considered rural counties by the HRSA.

⁴ Centerstone has facilities in the following Kentucky counties: Bullitt, Henry, Jefferson, Oldham, Shelby, Spencer, Trimble.

⁵ Centerstone serves the following counties in Tennessee via outpatient clinics, school-based therapy, or mobile crisis services: Bedford*, Bradley, Cheatham, Coffee,* Davidson, Dickson, Franklin,* Giles,* Hamilton, Hickman, Houston,* Humphreys,* Lawrence,* Lewis,* Lincoln,* Marshall,* Maury, McMinn,* Montgomery, Moore,* Perry,* Polk, Putnam,* Robertson, Ruther-

Continued

Through our specialized military services, we also serve veterans, service members, and their families across the United States. Finally, our Centerstone Research Institute (CRI) is tasked with developing clinical innovations based upon the very best science that aims to close the 17-year science-to-service gap. With decades of on-the-ground experience, supported by outcomes research generated by CRI, we are able to identify the most significant barriers to offering timely and safe care to individuals.

“How do we get more providers to rural America?”

➤ Take steps to support the behavioral healthcare workforce

Senator Roberts noted that “recruiting, training, and retaining staff are some of the greatest challenges we have.” We agree. According to a 2018 State of Workforce Management Survey, the top priority for behavioral health not-for-profit providers is recruiting and retaining top talent, with the primary challenges being (a) an inability to offer competitive pay and benefits, and (b) a lack of qualified applicants. Thus, Centerstone supports the use of financial incentives to start to close the critical behavioral healthcare workforce gap.

The **Substance Use Disorder Workforce Loan Repayment Act of 2018 (H.R. 5102/S. 2524)** would function to directly alleviate the supply problem because it would provide a loan-repayment incentive to individuals choosing to practice in workforce shortage areas. The bill would authorize the HRSA to pay up to \$250,000 of an individual’s program loan obligations for those who complete a period of service in an SUD treatment job in a mental health professional shortage area or in a county particularly badly impacted by the opioid epidemic. Specifically, the bill will offer student loan repayment of up to \$250,000 for participants who agree to work as a SUD treatment professional in areas most in need of their services. The program will be available to a wide range of direct care providers, including physicians, registered nurses, social workers, and other behavioral health professionals. Loan repayment would be for individuals pursuing a “SUD treatment job” in an area defined as a Mental Health Professional Shortage Area (MHPSA), as designated under section 332, or a county (or a municipality, if not contained within any county) where the mean drug overdose death rate per 100,000 people over the past 3 years for which official data is available from the State, is higher than the most recent available national average overdose death rate per 100,000 people, as reported by the Centers for Disease Control and Prevention. Persons would need to work full time for 6 years to receive the full \$250,000 in loan forgiveness.

The **Opioid Crisis Response Act of 2018 (S. 2680)** includes very similar language in **Section 412**, but struck a critical provision of H.R. 5102/S. 2524, which extends applicability of the loan repayment beyond the boundaries of just Health Professional Shortage Areas (HPSAs) to also include areas hardest hit by the opioid crisis (as explained above). H.R. 5102/S. 2524 would function to more effectively alleviate workforce shortages in areas that have the most need, many of which are rural areas. Additionally, by providing loan repayment year by year and not considering leaving early a breach of contract, H.R. 5102/S. 2524 avoids deterring participants who might be hesitant to sign up for a longer commitment. By providing up to \$250,000 in loan forgiveness, there will be a significant incentive for participants to stay in the program once they join. Finally, more types of providers are eligible to participate in loan forgiveness through H.R. 5102/S. 2524 than through the S. 2680 language. H.R. 5102/S. 2524 provides a broad list of providers that would be eligible for the program, and allows the Secretary to add professions as needed. Thus, we ask that you **consider the benefits of the H.R. 5102/S. 2524 language in recruiting and retaining providers in the hardest hit areas nationwide, which will not only help bring providers to rural areas, but should also help them stay in those areas long-term.**

➤ Enable professionals to work at the top of their licensure

We know that there are more than 30 million people living in rural communities in which no treatment options of any kind exist today—let alone comprehensive, evidence-based ones.⁶ By the year 2025, workforce projections estimate that there will be a workforce shortage in the fields of substance abuse and mental health treatment of approximately 250,000 providers across all disciplines.⁷ In 2013, all

ford, Stewart,* Sumner, Wayne,* White,* Wilson. Those designated by an asterisk (*) are considered rural counties by the HRSA.

⁶National Rural Health Association.

⁷https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf.

nine types of behavioral health practitioners had shortages. Currently, six provider types have estimated shortages of more than 10,000 FTEs, including psychiatrists, clinical and counseling psychologists, substance abuse and behavioral disorder counselors, mental health and substance abuse social workers, and mental health counselors.⁸ With immense gaps in treatment access and fatal opioid-related overdoses at an all-time high,⁹ it is imperative that we take steps to address from multiple angles.

Licensed marriage and family therapists (LMFTs) and licensed mental health counselors (LMHCs) hold licensures on par with licensed clinical social workers (LCSWs), yet their exclusion under Medicare is somewhat arbitrary. (Please see attached document entitled: “Medicare Standards for Licensed Mental Health Counselors, Licensed Clinical Social Workers, and Licensed Marriage and Family Therapists.”) As a result of this workforce gap, providers face significant barriers when recruiting within the limited allowable provider types, particularly in rural areas. This shortage in eligible workers also results in wait times that can be 4 times higher amongst Medicare patients, as opposed to under Medicaid, which permits for reimbursement of LMHC and LMFT services in some of our sites. The **Mental Health Access Improvement Act of 2017 (H.R. 3032/S. 1879)** would allow LMFT and LMHC services to be reimbursed by Medicare. **This bill would enable faster access to care for Medicare and some commercial patients, as well as optimize our current workforce to operate at the top of its licensure.**

> Urge CMS to issue swift guidance to all Medicare Managed Care entities on ways to streamline the credentialing process so as to improve credentialing in high need areas

Access to specialty addiction care is alarmingly low in rural areas. In a meaningful step forward, the American Board of Medical Specialties (ABMS) is now recognizing Addiction Medicine as a specialty. Despite this recognition, however, it has been our experience in Florida, Kentucky, Illinois, and Indiana that if a physician, certified in addiction medicine by the American Board Certification of Addiction Medicine (ABAM), is *not a psychiatrist*, then that physician will either (a) be denied in the credentialing process, or (b) the payer will not reimburse for their services, regardless of credentialing approval. With some of the hardest hit areas facing the most significant workforce shortages, these credentialing and reimbursement barriers are not only undue red-tape, but are also endangering patients by denying them access to professional care. Below, we provide two examples of such scenarios:

- One of our Medicare Managed Care entities has stated they would accept Addiction Medicine Doctors on their panel as long as they were listed with the American Board of Medical Specialties (ABMS). As noted above, ABMS is now recognizing Addiction Medicine as a specialty. However, with the documentation “transition” still in progress, ABAM certified physicians are still not listed with ABMS. Thus, even though a physician may be certified, we are not able to credential them with the managed Medicare entity if they are not listed with ABMS.
- A separate managed Medicare entity will credential ABAM certified addiction specialists, who are not psychiatrists, but have stated they will not reimburse Centerstone for any medication management services rendered. In this case, the payer/insurance company claimed that the addiction specialist is not categorized under the correct taxonomy code, and noted that in order to be eligible for reimbursement, the addiction specialist would need to be categorized under taxonomy code 2084A0401X, which requires a physician to be a psychiatrist. Thus, even though this entity will credential ABAM certified physicians (who are not psychiatrists), they will not reimburse for their services.

Therefore, Congress should urge CMS to issue swift guidance to all Medicare Managed Care entities, stating that board certified addiction specialists in good standing with appropriate medical boards shall be credentialed within 30 days of submitting an application, and be reimbursed for their services.

“How do we get our deployment models to catch up to the new and emerging needs of our population?”

> Encourage the use of telehealth services

⁸ <https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/behavioral-health2013-2025.pdf>.

⁹ <https://www.cdc.gov/vitalsigns/opioid-overdoses/>.

Encouraging the use of telehealth services can go a long way towards treating rural populations. Telehealth has a dual purpose of both connecting patients to life-saving care that may have previously been beyond their physical reach, and also of reducing the effects of a behavioral health workforce shortage. Moreover, aging researchers have found that, “isolated seniors had a 59 percent greater risk of mental and physical decline than their more social counterparts.”¹⁰ Telehealth can help seniors get the care they need while continuing to live in communities that are important to them.¹¹ As such, telehealth may play an instrumental role in providing a layer of connectivity for some seniors, or minimally reducing the burden for care takers so they are better equipped to provide on-going care.

Lawmakers should fully optimize the value of our behavioral health workforce by affording them a wider latitude to treat SUD patients in hard-to-reach areas via telemedicine.¹² The Ryan Haight Act makes it illegal for a practitioner to issue a prescription for a controlled substance via telemedicine without having first conducted at least one in-person medical evaluation of the patient. There are currently three FDA-approved medications for the treatment of opioid use disorder: naltrexone, methadone, and buprenorphine.¹³ These medications are recognized by the National Institute of Drug Abuse,¹⁴ American Society of Addiction Medicine,¹⁵ and the Substance Abuse and Mental Health Services Administration¹⁶ as essential tools in responding to the opioid epidemic. Under current law, non-SAMHSA practitioners who wish to prescribe Suboxone (brand name for buprenorphine) to a patient they are treating via telemedicine would need to first perform an in-person evaluation, had they not already done so. Following this regulatory mandate for buprenorphine prescribing, however, may be overly burdensome in many circumstances, and may prevent many patients from receiving life-saving treatment. Thus, we believe that **licensed community mental health and addiction providers, who follow nationally recognized models of treatment, should gain access to a special registration process so that they may register with the DEA to prescribe substances now commonly embraced in MAT practice, without a prior in-person patient/provider encounter.** To bring about this end, we support the **Special Registration for Telemedicine Clarification Act of 2018 (H.R. 5483)**, which calls for the promulgation of interim final regulations on the topic of special registration for health care providers to prescribe controlled substances via telemedicine without the initial in-person contact. **Section 401 of the Opioid Crisis Response Act of 2018 (S. 2680)** would do the same.

We know that telehealth can bridge the gap of distance and stigma by allowing beneficiaries to receive care when and where they need it.¹⁷ A Medicare provider can only be reimbursed for telehealth services if the patient is located at a specified “originating site”—a restriction that clearly limits the purpose and benefits of telehealth. The **Access to Telehealth Services for Opioid Use Disorders Act (H.R. 5603)** would authorize the Secretary to, through rulemaking, waive originating site and geographic restrictions for the delivery of telehealth to Part A beneficiaries with a substance use disorder (SUD) diagnosis, or to a beneficiary with a SUD and serious mental illness (SMI) diagnosis effective January 1, 2020. By essentially waiving the “originating site” restriction for certain Medicare patients, this bill will expand the number of providers that are able to treat the elderly in their own homes, and will significantly improve access to addiction treatment services to these patients.

¹⁰ <https://www.agingcare.com/articles/loneliness-in-the-elderly-151549.htm>.

¹¹ https://www.aarp.org/content/dam/aarp/ppi/2018/05/using-telehealth-to-improve-home-based-care-for-older-adults-and-family-caregivers.pdf?utm_source=Telehealth+Enthusiasts&utm_campaign=e0e7_a09bcc-EMAIL_CAMPAIGN_2018_06_01_09_59&utm_medium=email&utm_term=0_ae00b0e89a-e0e7a09bcc-353221013.

¹² <https://homehealthcarenews.com/2018/05/cms-launches-rural-health-strategy-with-telehealth-aims/>.

¹³ Dr. McCance-Katz, oral testimony, November 13, 2017, <http://www.aei.org/events/the-opioid-crisis-what-can-congress-do-a-conversation-with-house-committee-on-energy-and-commerce-chairman-greg-walden-r-or/>.

¹⁴ <https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/overview>.

¹⁵ [https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24#search=medication assisted treatment](https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24#search=medication%20assisted%20treatment).

¹⁶ <https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat>.

¹⁷ <https://www.healthitnow.org/press-releases/2018/5/29/blog-honor-mental-health-month-by-re-dedicating-commitment-to-technology-enabled-treatment-and-support>.

➤ Encourage the use of peer support services

Peer support services are currently accepted as evidence-based practices by both CMS and SAMHSA. Research indicates that use of peer supports leads to significant decreases in substance use, symptom improvement, and better management of patients' own conditions.¹⁸ Connecting with a peer support specialist also helps individuals feel less alone in their challenges and has also been positively linked with addressing social isolation for older adults.¹⁹ These outcomes are largely achieved by a sense of trust and by the non-judgmental attitude peers exhibit towards patients. These services are currently reimbursable under most state Medicaid programs. Therefore, **Centerstone recommends that Congress fully optimize the value of our behavioral health workforce by recognizing certified peer supports within the Medicare program.**

➤ Enable providers to access full patient records

The Confidentiality of Substance Use Disorder Patient Records rule—42 CFR Part 2—is a stringent rule that prevents providers from systematically treating OUD/SUD patients in reliance on complete and accurate patient histories. In moving towards more robust integrated care models where every member of a patient's treatment team needs to understand a patient's full medical/SUD history, Part 2 stands as a hindrance to whole-person, safe care. Part 2 has never been applied universally: only federally assisted alcohol and drug abuse programs providing SUD diagnosis or treatment are subject to the stringent Confidentiality of Substance Use Disorder Patient Records rule—42 CFR Part 2.^{20,21} Part 2 prevents these federally funded providers from accessing a patient's full substance use history without the patient's prior written consent. In contrast, non-federally assisted providers throughout the country are governed only by HIPAA. Today, SUD is the only condition not governed by HIPAA. Failure to update Part 2 has weakened our Nation's ability to tackle our addiction problems. Stigmatized conditions like mental health disorders and AIDS are governed under HIPAA—care for both of those conditions are improving.

The bipartisan **Opioid Prevention and Patient Safety Act (OPPS Act) (H.R. 5795/S. 1850)** would function to align Part 2 with HIPAA's consent requirements for the purposes of treatment, payment, and healthcare operations (TPO), which would allow for the appropriate sharing of SUD records, among covered entities, to ensure persons with OUD and other SUDs receive the integrated care they need. The bill further clarifies that SUD records may not be used as evidence in any criminal proceedings, may not be used for any purposes in federal agency proceedings, may not be used for law enforcement purposes at any agency level, and may not be used to apply for a warrant, except where a patient has provided consent, or when a court order has been issued. Penalties for violations are those outlined in the Public Health Service Act. Discrimination is prohibited in treatment, housing, employment, and courthouse settings. No recipient of federal funds may discriminate against affected individuals. HITECH Notification of Breach provisions apply to the same extent as they apply to all other breaches of protected health information. (For a visual representation of Part 2 intricacies, please see attached document entitled: "Congress Considers Medical Privacy Overhaul to Combat the Opioid Epidemic.")

We at Centerstone aim to do everything we can to evaluate what is most appropriate for each individual on a case-by-case basis in order to provide the highest quality, individually-tailored care. Without a full understanding of the challenges an individual is facing, however, the care of even the best-intentioned providers will fall short of the care they could offer if they understood the whole person. Therefore, **we strongly urge lawmakers to pass legislation that would align 42 CFR Part 2 with HIPAA for the purposes of treatment, payment, and health care operations.**

"How can we promote higher quality care?"

➤ Incent reimbursement models that promote integrated, whole-personcare, as opposed to fragmented care

¹⁸ <https://www.ncbi.nlm.nih.gov/pubmed/26882891>.

¹⁹ <http://clri-ltc.ca/2018/04/the-power-of-peer-support/>.

²⁰ <https://www.samhsa.gov/sites/default/files/faqs-applying-confidentiality-regulations-to-hie.pdf>.

²¹ <http://www.jhconnect.org/wp-content/uploads/2013/09/42-CFR-Part-2-final.pdf>.

Currently, in many of our states, Medicare and HMOs do not reimburse for more than one service per day. In other words, if a patient has a doctor's visit and a group therapy session on the same day, only one service will be reimbursed. This means that patients with co-occurring physical and behavioral health conditions who may need a medical evaluation followed by an individual therapy session will typically be required to make multiple appointments for these services on separate days so that providers do not incur a financial loss. This not only creates tremendous inefficiencies in the cost of delivering high quality, integrated care, but also makes treatment more burdensome for patients. Multiple appointments can be impossible for some patients to keep due to school and work schedules, family responsibilities, or transportation challenges (as in the case of many rural citizens).

It is important that Congress incent reimbursement models that promote integrated, whole person care, such as Certified Community Behavioral Health Clinics or Health Homes. These care models are designed to be the antithesis to disjointed care. Through Centerstone's implementation of grant funded patient centered health homes designed for consumers with co-occurring and complex conditions, where patients receive the appropriate care as the need arises, we have experienced a lower health care spend per capita in comparison to non-integrated care models. More importantly, 84% of our patients with high blood pressure saw lower readings after 12 months; recipients reported a 56% improvement in anxiety levels; 53% showed improvement in general health. Additionally, we saw a significant reduction in emergency room utilization. Through this model, we have been able to provide contiguous care to consumers who had previously only experienced fragmented, expensive care. Our participants awarded this model a 98% approval rating. We continue to capture cost savings through integrated health home pilots. Therefore, we recommend that Congress prioritize legislation that will help break down barriers for same day billing for behavioral health providers in Medicare and, more generally, incent reimbursement models that promote integrated, whole-person care such as Certified Community Behavioral Health Clinics as identified in the **Excellence in Mental Health and Addiction Treatment Expansion Act (H.R. 3931/S. 1905)**.

> Amend the appeals process so that reimbursement practices follow federal parity laws

When a claim is denied, an appeal may be filed. Appeals are supposed to take up to 30 days, but may take longer. A successful appeal typically involves multiple phone calls with the managed care entity and our treatment team, including with one of our treating psychiatrists or addiction specialists, followed by a submission of the client record. With most of our facilities facing workforce shortages, dealing with the appeals process uses valuable provider time, which would be better utilized serving patients.

Thus, we recommend that federal parity laws be strictly enforced so as to guard against undue claims denials. Currently, many states lack appropriate systems for tracking prior authorizations and denials between coverage types (medical vs. behavioral health benefits). Because states often lack the infrastructure to track parity, the full extent of parity violations is unknown. Thus, even though there is industry-wide consensus that the federal parity law goes systematically unenforced, robust evidence detailing the extent of medical/behavioral health discrepancies is currently missing. We suspect if the parity law was fully and faithfully implemented, we would see a steep reduction in administrative burden.

We appreciate the opportunity to submit comments for the record on the topic of improving the quality of care for rural Americans. Kindly let us know if you have any questions or comments, or wish to discuss any of these items further. We look forward to collaborating with you in the future.

Sincerely,

Lauren McGrath, MSSW
Vice President of National Policy, Centerstone

Monica Nemec, JD, MPP
Director of National Policy, Centerstone

**Medicare Standards for Licensed Mental Health Counselors, Licensed Clinical Social Workers,
and Licensed Marriage and Family Therapists**

Social Security Act § 1861(hh)(l) sets out the education, experience, and licensure requirements for mental health professionals' participation in Medicare. Clinical social workers are recognized as Medicare providers, but mental health counselors and marriage and family therapists are not. The text below is taken directly from Social Security Act § 1861(hh)(1) for social workers and the legislation adding mental health counselors and marriage and family therapists to the law.

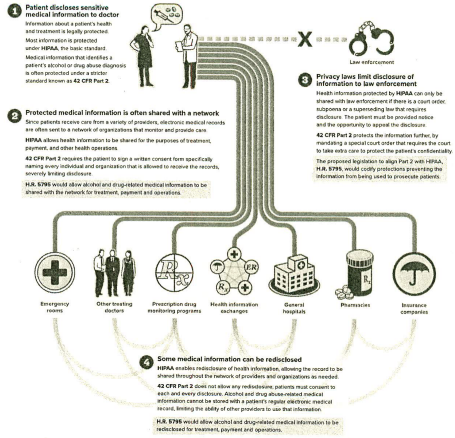
	Licensed Clinical Social Worker	Licensed Mental Health Counselor	Licensed Marriage and Family Therapist
Current Medicare Provider:	Yes	No	No
Education:	Possesses a master's or doctoral degree in social work	Possesses a master's or doctoral degree in mental health counseling or a related field	Possesses a master's or doctoral degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law
Experience:	Two years of post-graduate supervised clinical social work experience	Two years of post-graduate supervised mental health counselor practice	Two years of post-graduate clinical supervised experience in marriage and family therapy
Licensure Requirement:	Licensed or certified to practice as a clinical social worker by the State in which the services are performed	Licensed or certified as a mental health counselor within the State of practice	Licensed or certified as a marriage and family therapist within the State of practice
State Licensed Providers:	193,000	144,500	62,300

May 29, 2018

Congress Considers Medical Privacy Overhaul to Combat the Opioid Epidemic

To protect individuals who seek medical treatment for alcohol and substance abuse problems, existing law strictly limits the sharing of alcohol and drug-related medical information under a statute known as 42 CFR Part 2. Lawmakers are worried that these legal protections are too cumbersome and have hampered the medical community's response to the opioid overdose epidemic. To integrate alcohol and drug-related treatment with the rest of the medical system, House lawmakers have proposed legislation, H.R. 5795, that would sign 42 CFR Part 2 with HIPAA — a more generally applicable law governing medical information sharing — for the purposes of treatment, payment and other operations. This would be an important change. HIPAA typically assumes that patients want their medical information shared with a network of providers, unless the patient says otherwise, whereas 42 CFR Part 2 assumes that patients do not want information shared without explicit consent.

How legally protected medical information flows through a health care network



Comparison of the major features of HIPAA and 42 CFR Part 2

	HIPAA	42 CFR Part 2
General purpose	<ul style="list-style-type: none"> HIPAA establishes the minimum requirements for the protection of individuals' protected health information. 	<ul style="list-style-type: none"> Part 2 creates stricter protections for medical records pertaining to alcohol and substance abuse, so that patients seeking treatment are not discouraged by potential legal and personal consequences.
Individuals have the right to access their records.	<ul style="list-style-type: none"> Individuals have the right to access their records. 	<ul style="list-style-type: none"> Programs have discretion to decide whether patients can view or obtain their records, unless state law says otherwise.
Entities governed	<ul style="list-style-type: none"> Applies to all health providers, health plans, clearing houses and any business associates that transmit any health information electronically. 	<ul style="list-style-type: none"> Applies to any federally assisted program that provides alcohol or drug abuse diagnosis, treatment, or referral for treatment. A program is "federally assisted" if: <ul style="list-style-type: none"> It is federally authorized, licensed, certified or regulated. It receives any federal funding for any purpose. It receives a grant of an interest status or an allotment of tax deductions for contributions by the IRS.
Authorization for treatment and payment	<ul style="list-style-type: none"> Medical records governed by HIPAA can be disclosed without the patient's permission for treatment and payment purposes. Information shared with outside entities could be redisclosed to other parties for those purposes. 	<ul style="list-style-type: none"> Individuals must authorize any disclosure with a written form that specifically names the persons or organizations that the records are being shared with. Information can not be redisclosed without specific authorization from the individual, except in the case of medical emergencies where the patient's life is clearly in danger.
Enforcement	<ul style="list-style-type: none"> Violators face civil fines enforced by the HHS Office for Civil Rights and state attorneys general. Further criminal penalties can be assessed on a case-by-case basis, especially if disclosure is treated under false pretenses or with malicious intent. 	<ul style="list-style-type: none"> Violators are identified by the Substance Abuse and Mental Health Services Administration, and referred to the Justice Department for criminal charges.
Courts and law enforcement	<ul style="list-style-type: none"> Records can be shared without the individual's authorization in response to a court order or subpoena. The individual must be given notice and the opportunity to object to the disclosure with a protection order. 	<ul style="list-style-type: none"> Records can not be disclosed without a special court order subject to additional confidentiality requirements under Part 2. A subpoena is not sufficient for disclosure; only a special court order under Part 2 rules can compel disclosure.
Public health reporting	<ul style="list-style-type: none"> As needed, information can be shared with public health authorities such as state and local health departments, HSA, CDC and the Occupational Safety and Health Administration. 	<ul style="list-style-type: none"> Part 2 severely restricts the ability to share protected information with public health authorities. Any information that is shared must be stripped of information that could be used to identify a patient with an alcohol or substance abuse diagnosis.

Note: The graphic does not constitute legal advice.

Sources: International Association of Privacy Professionals; Substance Abuse and Mental Health Services Administration; National Association for Addiction Professionals; By Robert Delaney, FOLIOXO Pro Desktop

MEDICARE DEPENDENT RURAL HOSPITAL COALITION
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Statement for the Record

On behalf of the Medicare Dependent Rural Hospital Coalition, thank you for holding the May 24, 2018 hearing entitled, "Rural Health Care in America: Challenges and Opportunities." As discussed at the hearing, there are a number of challenges to providing high-quality health care in rural communities. The Coalition is pleased

to submit testimony for the record highlighting some of these challenges and offering collaborative solutions to ensure access to health care in rural areas is maintained and improved.

Created in 2011, the Medicare Dependent Rural Hospital (MDH) Coalition is an informal coalition of affected and concerned hospitals from around the country who wish to see the MDH program extended and enhanced. According to a recent U.S. Department of Health and Human Services (HHS) report, rural America is older than the urban population (18.2 percent of rural individuals are 65 and over, compared to 13.7 percent in the U.S. population overall).¹ This statistic demonstrates the importance of the Medicare program—and to sustaining the rural health care infrastructure—to rural communities nationwide. The MDH Coalition is committed to ensuring that lawmakers and policymakers in Washington, DC understand just how critical this program is to the rural population.

About MDHs

The Medicare-Dependent, Small Rural Hospital program was established by Congress in 1990 with the intent of supporting small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. To qualify as a MDH, a hospital must be: (1) located in a rural area, (2) have no more than 100 beds, and (3) demonstrate that Medicare patients constitute at least 60 percent of its inpatient days or discharges.

Because they primarily serve Medicare beneficiaries, MDHs rely heavily on Medicare payment to sustain hospital operations. As such, Congress acknowledged the importance of Medicare reimbursement to MDHs and established special payment provisions to buttress these hospitals. Congress recognized that if these hospitals were not financially viable and failed, Medicare beneficiaries would lose an important point of access to hospital services. Today, more than 150 hospitals nationwide have MDH status.

Challenges Facing MDHs

When examining rural health challenges, the Coalition believes it is important to address unique challenges facing MDHs that may impact the quality of, and access to, essential health care services. Some of these issues are described below.

Older and Aging Patient Population: MDHs serve a disproportionate number of Medicare beneficiaries. In 2018, the most recent year for which Medicare cost report data is available, Medicare patients (excluding Medicare Advantage patients) accounted for 54 percent of MDH patient days, significantly more than the 42 percent average at other rural hospitals, as well as the 34 percent average at urban hospitals.² Medicaid enrollees also account for a substantial percentage of hospital discharges at MDHs, although empirical data is not available to quantify that.

Congress has recognized that MDHs are vitally important to the Medicare program, as evidenced by the number of Medicare patients they serve. If an MDH fails, Medicare beneficiaries lose access to an important source of hospital services. As a result, Congress has repeatedly extended the MDH designation since the program's beginning. Most recently, the Balanced Budget Act of 2018 extended the MDH program for five years, until October 1, 2022.

Narrow Operating Margins: In its March 2018 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) found that rural IPPS hospitals (excluding Critical Access Hospitals (CAHs)) had a negative 7.4 percent overall Medicare margin.³

Because of the high percentage of Medicare (and Medicaid) patients, MDHs lack the ability to offset costs through non-governmental payer patients. Whereas larger rural and urban facilities can shift costs to make up for negative Medicare margins, MDH do not have that same flexibility.

While MedPAC examines Medicare margins by hospital type each year, it does not examine Medicare margins by specially designated Medicare hospital type. A Government Accountability Office report was included in the Bipartisan Budget Act of

¹“Rural Hospital Participation and Performance in Value-based Purchasing and Other Delivery System Reform Initiatives,” Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Issue Brief, October 19, 2016.

²Centers for Medicare and Medicaid Services, FY 2018 IPPS Impact File, September 29, 2017.

³“Hospital inpatient and outpatient services: Assessing payment adequacy and updating payments,” MedPAC, March 2018, http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch3_sec.pdf?sfvrsn=0.

2018 that would report data on Medicare margins for MDHs. However, this report is not due to Congress until early-to-mid 2020.

If Congress is evaluating the ongoing need for the MDH program, it should direct MedPAC to include hospital margin data on hospitals with special designations under Medicare, including MDHs.

Recommendations for Congressional Action

Overall, MDHs treat an older, rural patient population with limited financial resources. This makes these rural providers dependent on accurate and appropriate payment policies. To ensure MDHs are able to continue to provide high-quality health care to rural communities, there are six policy changes the Coalition recommends.

Recommendation One—340B Eligibility for MDHs: The 340B program has been critical in expanding access to lifesaving prescription drugs to low-income patients in communities across the country. Congress created the 340B program with the mission of enabling its covered entities “to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.” The program has been essential to helping hospitals and other health care providers ensure that their patients get access to affordable medications and quality health care.

Under the 340B program—which is administered by the Health Resources and Services Administration (“HRSA”)—certain covered entities may purchase outpatient drugs from manufacturers at discounted prices, provided they comply with certain program requirements. Congress designated certain provider types as covered entities because they each fulfill a special role in serving low-income, special-needs, and otherwise vulnerable populations. In 2010, Congress extended 340B program eligibility by making it easier for freestanding cancer hospitals, CAHs, Rural Referral Centers (RRCs) and Sole Community Hospitals (SCHs) to participate as well.

Many 340B participating hospitals—particularly rural safety net facilities—are indispensable to their communities, and the discounts they receive through the 340B program play an essential role in allowing these facilities to provide care to otherwise underserved communities.

Under this change, freestanding cancer hospitals and CAHs are eligible by virtue of their status. RRCs and SCHs are not automatically eligible, but Congress made it easier for them to qualify by lowering the DSH threshold to eight percent for these facilities. Currently, MDHs are the only specially recognized Medicare provider type not eligible for 340B based on status or through a lowered threshold. Given Congress has recognized the unique role all of these rural providers play in providing care to rural communities, *the eight percent threshold qualifying level should be extended to MDHs.*

Recommendation Two—Extend 340B Exception to MDHs: Congress should examine the impact of the Center for Medicare & Medicaid Services (CMS) drug payment policy implemented via the CY2018 OPSS rulemaking, but in the meantime take steps to prevent further harm to rural providers. As the Committee is aware, beginning in 2018, CMS instituted a policy change reducing the amount Medicare pays hospitals for drugs covered under Part B of the program when those drugs are purchased through the 340B program. Specifically, CMS reduced payment from Average Sales Price (ASP) plus six percent to ASP minus 22.5 percent. While CMS excepted rural SCHs from the payment adjustment, MDHs are subject to the adjustment. CMS cited hospital operating margins, closure rates of rural hospitals, low-volume, and existing special payment designations among reasons for excepting rural SCHs, but not other rural safety net providers.

MDHs also play a vital role in the rural health care infrastructure, and exhibit some of the very same characteristics CMS used to justify excepting SCHs from the cuts. *Congress should except MDHs from the payment cuts in the OPSS as well.*

Recommendation Three—Update and Align MDH Payment Rate: As the Committee knows, the primary benefit of MDH status is eligibility for payments based on hospital-specific payment rates. Under Medicare’s Inpatient Prospective Payment System (IPPS), hospitals with MDH status receive payments based on the federal rate or hospital-specific rate, whichever is greater. If the hospital-specific rate is greater, the MDH is paid the federal rate plus 75 percent of the difference between the hospital-specific rate and federal rate.

There are two updates to the MDH payment Congress should consider. First, an MDH’s hospital specific rate is based on the hospital’s costs in 1982, 1987 or 2002.

We propose that Congress add a more current cost year—e.g., 2016 or 2017—for purposes of determining the target amount.

Second, MDHs should be afforded the same payment benefits as SCHs. As mentioned above, if the hospital-specific rate is greater, MDHs are paid 75 percent of the difference between the hospital-specific rate and the federal rate. SCH payments use the same formula, but receive 100 percent of the difference. MDHs and SCHs both serve as safety net providers for rural communities. Additionally, like SCHs, MDHs play a vital role in caring for patients facing more complex and chronic health issues, but MDHs lack the ability to cross-subsidize with additional private payer payments. Congress should consider closing the gap in the payment rate between MDHs and SCHs by increasing the payment rate difference to 100 percent for MDHs.

Recommendation Four—Make MDH Designation Permanent: Because MDHs serve a disproportionate number of Medicare beneficiaries, MDHs rely on Medicare payments for delivering patient care to these beneficiaries and their broader communities. MDH status and the associated payment protections are critical to the continued viability of these facilities.

The Bipartisan Budget Act of 2018 extended the MDH program for 5 years. While the Coalition appreciates this extension, providing short-term extensions is not a long-term solution. As such, we support the Rural Hospital Access Act (S. 872), which would make the MDH program permanent, and *urge Congress to make the MDH program permanent.*

Further, as the program gets closer to lapsing, the cost for renewal will increase. If Congress considers this change well in advance of the next expiration in 2022, it would be less costly to the government and taxpayers. It also would provide MDHs more financial stability, the ability to plan effectively and continue to provide high-quality care. Congress should pass this legislation.

Recommendation Six—Extend 7.1 Percent OPSS Payment Adjustment to MDHs: Under current CMS policy, Medicare payments to rural SCHs for outpatient services are increased by 7.1 percent. CMS makes this adjustment because it found, pursuant to a study required by Congress, that, compared to urban hospitals, SCHs have substantially higher costs, and need a payment adjustment to be comparably treated under the outpatient PPS. CMS was not directed to include MDHs in this study, and has not examined this issue on its own. Congress should direct CMS to study the difference in costs by ambulatory payment classification (APC) between MDHs and hospitals in urban areas and make adjustments based on the findings.

Conclusion

As the Committee continues its examination of rural health challenges, we urge thoughtful attention and consideration be given to MDHs. As described above, these hospitals play essential roles in providing high-quality health care to rural communities and Medicare beneficiaries. We are available for questions, further comments, and additional information. Please feel free to reach out to Eric Zimmerman (ezimmerman@mcdermottplus.com) or Rachel Stauffer (rstauffer@mcdermottplus.com).

NATIONAL ASSOCIATION OF CHAIN DRUG STORES (NACDS)

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Introduction

The National Association of Chain Drug Stores (NACDS) thanks Chairman Hatch, Ranking Member Wyden, and members of the Committee on Finance for holding the hearing on “Rural Health Care in America: Challenges and Opportunities.”

NACDS and the chain pharmacy industry are committed to partnering with Congress, HHS, patients, and other healthcare providers to improve the quality, access, and affordability of health care services in underserved parts of the country, particularly in rural America. NACDS represents traditional drug stores, supermarkets and mass merchants with pharmacies. Chains operate over 40,000 pharmacies, and NACDS’ nearly 100 chain member companies include regional chains, with a minimum of four stores, and national companies. Chains employ nearly 3 million individuals, including 152,000 pharmacists. They fill over 3 billion prescriptions yearly, and help patients use medicines correctly and safely, while offering innovative serv-

ices that improve patient health and healthcare affordability. NACDS members also include more than 900 supplier partners and over 70 international members representing 20 countries. Please visit www.NACDS.org.

As the face of neighborhood health care, chain pharmacies and pharmacists work on a daily basis to provide the best possible care and the greatest value to their patients with respect to access to critical medications and pharmacy services. We help to assure that patients are able to access their medications and take them properly. NACDS believes retail pharmacists can play a vital role in improving access to affordable, quality health care in rural areas of the country. As this Committee examines the challenges and opportunities related to rural health care in America we offer the following for your consideration.

Pharmacist Provider Status

As the U.S. healthcare system continues to evolve, a prevailing issue will be the adequacy of access to affordable, quality healthcare. The national physician shortage coupled with the evolution of health insurance coverage will have serious implications for the nation's healthcare system. Access, quality, cost, and efficiency in healthcare are all critical factors—especially to the medically underserved and those in rural areas. Significant consideration should be given to policies and initiatives that enhance health care capacity and strengthen community partnerships to offset provider shortages in communities with medically underserved populations.

Pharmacists play an increasingly important role in the delivery of services, including key roles in new models of care beyond the traditional fee-for-service structure. In addition to medication adherence services such as medication therapy management (MTM), pharmacists are capable of providing many other cost-saving services, subject to state scope of practice laws. Examples include access to health tests, helping to manage chronic conditions such as diabetes and heart disease, and expanded immunization services. However, the lack of pharmacist recognition as a provider by third-party payors, including Medicare and Medicaid, limits the number and types of services pharmacists can provide, even though they are fully qualified to do so. Retail pharmacies are often the most readily accessible healthcare provider. Research shows that nearly all Americans (89 percent) live within five miles of a retail pharmacy. Such access is vital in reaching the medically underserved.

NACDS encourages your support for S. 109, the Pharmacy and Medically Underserved Areas Enhancement Act, which will allow Medicare Part B to utilize pharmacists to their full capability by providing underserved beneficiaries with services, subject to state scope of practice laws, not currently reaching them. This important legislation would lead not only to reduced overall healthcare costs, but also to increased access to healthcare services and management of medications.

Combating the Opioid Crisis

Not only can pharmacists play a vital role in ensuring access to care for those who reside in rural areas, but pharmacists can also play an important role in helping combat the opioid crisis. As such, NACDS supports the expansion of community-based services, such as enhanced roles for retail community pharmacists in identifying and treating those with opioid addiction, as well as community-based programs in which retail community pharmacists educate consumers on the dangers of opioid abuse and addiction.

This can be accomplished by recognizing the value pharmacists play as a member of the healthcare team and utilizing them at the top of their training in fighting the opioid crisis. For example, pharmacists could play a greater role in:

- Providing greater access to community-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) activities. SBIRT is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs and includes a referral to treatment for those in need. Pharmacists are currently recognized as providers of this service in at least one state Medicaid program.
- Providing essential screenings and immunizations related to Hepatitis B, Hepatitis C, HIV, Tuberculosis (TB), and depression to improve the population health of communities. For example, one community pharmacy has partnered with a State health department to provide HIV screening/testing in their pharmacies. The pharmacy can provide these services at a lower cost, and patients find the pharmacies to be less stigmatizing locations than other places to receive screenings.

- Increasing access to Naloxone, a medication designed to rapidly reverse opioid overdose. Several states have recognized the importance of ensuring quick access to this life-saving medication and have employed various approaches to make it easier for pharmacists to provide naloxone to patients, such as:
 - Establishing authority for pharmacists to “furnish” naloxone without a prescription;
 - Allowing pharmacists to dispense naloxone in accordance with a written statewide protocol; and
 - Employing the use of standing orders and/or collaborative practice agreements between prescribing practitioners and pharmacists.
- Assisting physicians with opioid treatment program, which provide medication-assisted treatment (MAT) for people diagnosed with an opioid-use disorder. CMS recently recognized the importance of MAT in its proposed FY 2019 Call Letter, when it stated “. . . it is imperative to also ensure that Medicare beneficiaries have appropriate access to medication-assisted treatment (MAT).”
- Increased use of pharmacogenomic testing to determine the right pain medication and dosing. By performing pharmacogenetic testing, personalized medicine allows patients to be prescribed with the right drug to be administered for adequate pain control—to avoid experiencing dose-dependent side effects or lack of drug efficacy. A pain medication may alleviate pain for one patient and provide no relief for another. Pharmacogenetic testing can help alleviate this problem.

Conclusion

NACDS thanks the Committee for your consideration of our comments. We look forward to working with policymakers and stakeholders on improving rural healthcare through pharmacist services in Medicare Part B.

NATIONAL RURAL HEALTH ASSOCIATION (NRHA)

The National Rural Health Association (NRHA) is pleased to provide the Senate Finance Committee with testimony on the reforms necessary to ensure the economic prosperity and healthy future of rural America. As we watch our rural communities face the gravest health care crisis in decades, we want to thank the Committee for holding a hearing devoted to the opportunities and challenges facing rural health care. Please know that we look forward to continuing this dialogue in the coming months.

NRHA is a national nonprofit membership organization with a diverse collection of 21,000 individuals and organizations who share a common interest in rural health. The association’s mission is to improve the health of rural Americans and to provide leadership on rural health issues through advocacy, communications, education and research. As such, we recognize the important role that health care serves in the economic development of rural communities across the country. The economic needs of rural America are vastly different than those faced by counterparts in other geographic and population settings. So too are the health care challenges, and opportunities, for rural health care providers.

Access to Quality Care Is Paramount

Access to quality, affordable health care is essential for the 62 million Americans living in rural and remote communities. Rural Americans are more likely to be older, sicker and poorer than their urban counterparts. Disparities both between urban and rural communities, and within rural communities along lines of race, income, and age, continue to widen. Further, access in rural America is impeded by not only geography, but also by decreasing reimbursements, physician shortages, and excessive regulatory burdens.

This is exacerbated by the increasing crisis of rural hospital closures. Eighty-three rural hospitals have closed since 2010, and two more will close later this month. 10,000 rural jobs have been lost as a result and 1.2 million rural patients have lost access to local community care. Even more concerning is that 673 rural hospitals are at risk of closure, meaning that without Congressional action, 1 in 3 rural hospitals are financially vulnerable.

Medical deserts are appearing across rural America, leaving many of our nation’s most vulnerable populations without timely access to care. Seventy-seven percent of rural counties in the United States are Primary Care Health Professional Shortage

Areas while nine percent have no physicians at all. Rural seniors are forced to travel significant distances for care, especially specialty services. In an emergency, rural Americans travel twice as far as their urban counterparts to receive care. As a result, while 20 percent of Americans live in rural areas, 60 percent of trauma deaths occur in rural America.

In Rural America, One Size Cannot Fit All

In rural America, health care is a pillar of the community. It helps to create and foster a sustainable and livable environment for rural Americans, and without health care, without a hospital, a rural community will crumble. As John Henderson, CEO of Childress Regional Hospital in Texas explains, “Hospitals, schools, churches. It’s the three-legged stool. If one of those falls down, you don’t have a town.”

A hospital is essential to a community, providing jobs and fostering economic growth with a healthy workforce and a source of care in case of an emergency. As the landscape of rural America and the face of health care throughout our nation change we need to adapt our ideas about care provision. Examining the diverse needs of communities requires us to create policy that can address a wide array of challenges to help a diverse group of providers.

Growing Health Disparities in Rural Communities

The health disparities between rural populations and their urban counterparts are pronounced and growing rapidly. 18% of rural populations are living below the poverty threshold, compared to less than 16% in urban areas (HRSA Health Equity Report 2017), and health outcomes and income are inextricably linked. According to the Center for Disease Control’s (CDC) Morbidity and Mortality Weekly Report (MMWR), rural populations are significantly more likely to report poor or fair health outcomes. Additionally, rural communities have significantly higher rates of suicide, substance use disorder, heart disease, cancer, chronic respiratory disease, and unintentional injury; and these conditions are more likely to result in unnecessary deaths because of lack of treatment or lack of access to appropriate care.

If you are a member of a minority group in rural America, these disparities are even more pronounced. A recent study in the *Journal of Rural Health* underscored the alarming extent of these challenges. Using data from the National Center for Health Statistics, and adjusting for age, the researchers found that rural whites have 102 more deaths per 100,000 members of the population than their urban counterparts. Rural blacks have 115 more deaths per 100,000 than their urban counterparts. The number of excess rural deaths from 1986 to 2012 was 694,000 for whites and 53,000 for blacks.

These disparities are visible even at birth. Maternity care shortages plague rural communities, and the most vulnerable communities are the most likely to be without obstetrics. Rural counties with higher percentages of African American women were more than 10 times as likely as rural counties with higher percentages of white women to have never had hospital-based obstetric services and more than 4 times as likely to have lost obstetric services between 2004- 2014, when more than 200 rural maternity wards closed their doors.

As Health Disparities Worsen, So Does the Rural Hospital Closure Crisis

Between 2017 and 2018, the number of rural hospitals operating at a loss rose from 40 to 44%. As stated earlier, 83 rural hospital have closed since 2010 and 673 rural hospitals are currently at financial risk. Three more rural hospitals announced in May that they will soon close their doors.

Rural hospitals are closing for a myriad of reasons, including lower patient volumes in certain rural communities. However, the most significant reason of increased financial risk is the cumulative reduction in reimbursement rates in Medicare, Medicaid and private insurers. Rural hospitals serve more Medicare patients (46% rural vs. 40.9% urban), thus across-the-board Medicare cuts do not have across the board impacts. According to MedPAC Average Medicare margins are negative, and under current law they are expected to decline in 2016 has led to 7% gains in median profit margins for urban providers while rural providers have experienced a median loss of 6%. Since 2013 many hospitals have seen Medicare reduce the share of beneficiaries’ unpaid debt it covers for out-of-pocket costs; the rate-dropped from 70% to 65%. This cut was even deeper for Critical-Access Hospitals, which went from having 100% of that debt covered down to 65%.

Continued changes to bad debt, sequestration, and Medicare reimbursement cuts have put more and more hospitals at risk. As more rural hospitals close, the number

of rural communities at risk grows. Most rural closures occurred in states that did not expand Medicaid, and with reductions in the Disproportionate Share Hospital (DSH) payments that helped hospitals cover bad debts incurred by serving high rates of uninsured people, these hospitals could not survive.

But full closure of a hospital is not the only concern. Across the country, hospitals are losing their obstetrics units—between 2004 and 2014 more than 200 rural hospitals stopped providing labor and delivery services. The most vulnerable are placed at greater risk: rural counties with higher percentages of African American women were more than 10 times as likely as rural counties with higher percentages of white women to have never had hospital-based obstetric services and more than 4 times as likely to have lost obstetric services between 2004–2014.

As access to care in rural communities disappears, we need the support of Congress now more than ever to stop the flood of hospital closures and create an environment in which innovation can thrive.

Economic Impact of Rural Providers

Rural health care providers are not only critically important for the health of rural Americans, the providers are critically important for the economic health of rural communities.

Much of rural America was left behind in the economic recovery. According to the United States Department of Agriculture (USDA), rural counties were losing 200,000 jobs per year and the rural unemployment rate stood at nearly 10 percent during the Great Recession. Since then, the economic recovery that has positively changed the face of many other communities has not come to rural America. In fact, 95% of the jobs that have returned since the end of the Great Recession have been to urban, not rural areas.

While many industries in rural America have been shrinking for a wide variety of reasons, health care is an industry with the potential to reverse declining employment. As factory and farming jobs decline, the local rural hospital often becomes the hub of the local business community—not only offering critical life-saving services, but also representing as much as 20 percent of the rural economy.

Simply put, hospitals provide a large number of jobs. The economic well-being of rural American towns depends on a healthy rural economy, which is anchored by the local rural hospital and local providers. The average Critical Access Hospital (CAH) creates 195 jobs and generates \$8.4 million in payroll annually. Rural hospitals are often the largest or second-largest employer in a rural community (along with the school system). In addition, even a single rural primary care physician can generate 23 jobs and more than \$1 million in annual wages, salaries and benefits.

Because hospitals provide so many jobs, it follows that their closure has a devastating effect on employment. If we allow the 673 additional vulnerable rural hospitals to shut their doors, 99,000 direct health care jobs and another 137,000 community jobs will vanish.

A critical component of maintaining economic stability in rural communities is ensuring that rural hospitals and other health care providers are able to remain in their communities. Protecting rural hospitals from closure is an immediate step that can be taken to prevent significant job loss in rural communities.

Workforce Shortages Continue to Plague Rural America

Workforce challenges also exist in rural America. The rural health landscape, with its uneven distribution and shortage of health care professionals, is faced with significant problems in recruiting and retaining a trained health care workforce. This is compounded by the disparity in federal reimbursement for rural providers, which if addressed, would not only improve the recruitment and retention of rural physicians, but would also stabilize the rural economy.

Currently, 77 percent of the 2,050 rural counties in the United States are designated as primary care Health Professional Shortage Areas. The Association of American Medical Colleges projects a shortage of 124,000 full-time physicians by 2025. The Council on Graduate Medical Education projects a shortage of 85,000 physicians in 2020, which is approximately 10% of today's physician workforce. However, the most severe workforce shortages are seen among mental and behavioral health professionals, oral health providers, and obstetrics and gynecology specialists.

Providers are more likely to practice in a rural setting if they have a rural background, participate in a rural training program (RTT Technical Assistance Program) and have a desire to serve rural community needs. The RTT Technical Assistance

Program identified that residents training in rural training track residency programs were about twice as likely to practice in rural areas following graduation than family medicine graduates overall. Investments in rural distributed medical education are supported by such programs as Area Health Education Centers (AHEC), and supported by organizations such as the RTT Collaborative, a not-for-profit sustainable result of the RTT Technical Assistance Program.

Distributed medical education campuses across rural states and rural America then become the platform for workforce initiatives that develop infrastructure to support quality healthcare delivery and produce economic value. Graduate medical education regulatory reform that allows for common sense investment specifically allowing for education of physicians in rural hospitals is one example of how to address rural economic development and workforce shortages in one action, while improving quality and delivering cost-saving healthcare.

Rural Provider Challenges—Geographic Diversity Effects Operating Margins

We see geographic diversity in hospital operating margins, provider shortages, hospital closures, and other aspects of rural health care provision. All rural hospitals struggle because of multiple payment cuts that have caused Medicare margins that are currently below the cost of providing care according to MedPAC. While opportunities to innovate can keep the cost of providing care down, NRHA supports reimbursement rates that ensure rural providers have the resources necessary to provide vital care for their communities. Keeping rural PPS hospitals and Critical Access Hospitals (CAHs) open when possible provides cost-effective primary care delivery as well as economic stability in rural communities across the nation. For communities that no longer need a full service rural hospital, new models can allow them to right size their hospital to meet the needs of the community.

While all rural communities have commonalities, each possesses needs specific to the demographics of the area and its location. The needs of a small town on the plains of Nebraska are different than a frontier community in Wyoming or a remote Appalachian community in West Virginia. While the Midwest has seen changes that impact their rural hospitals, southern communities with high poverty and racial disparities have been particularly hard hit by the closure crisis. While some policy changes can help every one of these rural areas, different policy solutions may be necessary to address the wide range of rural providers.

Breaking Down Regional Variance

A 2016 report from the Sheps Center at the University of North Carolina studied the total margin of rural and urban hospitals by geographic census area. The total margin metric, as explained by the researchers, “measures the control of expenses relative to revenues, and expresses the profit a hospital makes as a proportion of revenue. For example, a 5 percent margin means that a hospital makes five cents of profit on every dollar of revenue.” Medicare Dependent Hospitals, Sole Community Hospitals, and rural PPS hospitals (denoted in the study as “ORH”) in the Midwest had a total margin of 2.96% in the Midwest compared to only 1.43% in the South. Midwest CAHs had a total margin of 3.43% compared to just 0.19% in the South.

This difference may be in part due to the differences in the populations that the two areas serve. The majority of rural hospitals are located in the South, the region with the highest rates of poverty. The second largest region is the Midwest, the region with the lowest rates of poverty. Southern rural hospitals are more likely to serve increasingly vulnerable populations—those with higher rates of poverty, more racial minorities, and increasingly remote communities.

According to the United States Department of Agriculture (USDA) Economic Research Service (ERS) “the non-metro/metro poverty rate gap for the South has historically been the largest.” From 2012–2016, the South had a non-metro poverty rate of 21.3%—higher than the Midwest and Northeast and nearly 6 percentage points higher than in the South’s metro areas. During this period, 42.6% of the nation’s non-metro population lived in non-metro Southern areas and 51.1% of the nation’s non-metro poor lived in the South. More simply, “non-metro counties with a high incidence of poverty are mainly concentrated in the South.” Within the Southern region, those areas with the most severe poverty are found in the Mississippi Delta and Appalachia, as well as on Native American lands.

The USDA ERS also found more health care industry jobs in the Midwest, which considering the role that a rural hospital has in creating community-based jobs, may be a factor in considering poverty rates. Between 2001 and 2015, rural counties with

the most inpatient healthcare facility jobs per resident were concentrated in the Upper Midwest and Northern Great Plains. Regions with fewer inpatient healthcare jobs per resident included the West, the Southern Great Plains, and the South.

Developing Policy to Address National Needs

NRHA believes a multifaceted approach is necessary to address the struggles of rural health care providers. This is why we have continuously supported legislation such as H.R. 2957, the Save Rural Hospitals Act. Passage of this bill will provide immediate relief to rural hospitals by stopping the onslaught of reimbursement cuts that have hit rural hospitals. Without increasing reimbursement rates, it will stabilize payments and stop rural hospital closures. It will also create a new health care delivery model with the critical flexibility to be adjusted as necessary to fit the varied needs in rural communities. That being said, we believe that any legislation passed should include three pieces and accomplish two goals: stabilization and innovation.

The first prong is ensuring rural providers' reimbursement rates are sufficient to allow them to keep their doors open and provide critical community care.

The second prong is supporting measures that reduce the cost of providing care including regulatory relief efforts that reduce costs without negatively impacting patient care.

And the third prong is bolstering new models that allow communities to retain necessary access to local care including a local emergency room while right sizing their facilities to flexibly meet the needs of the specific community.

Together, these policies can all begin to bring rural health care into the 21st Century and ensure its successful future. We look forward to working with the Senate Finance Committee moving forward to develop legislation that will support innovation and increase opportunities for care in rural America.

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May 24, 2018

Senate Finance Committee Testimony

Good morning, Mr. Chairman:

Greetings from the great State of Georgia and its governor, Governor Deal. Thank you for the opportunity to share perspectives and dilemmas for the rural hospital community, as seen in Georgia and many other states with rural hospitals.

I, Jimmy Lewis, Founder and CEO of HomeTown Health and rural health advocate for over 70 hospitals throughout the Southeast, have personally studied and worked in rural hospitals for over 20 years after serving many years in various fortune 500 companies. The dilemma of rural hospitals in the United States is very threatening to the rural way of life and patient care for as many as 20% of Americans who live in rural America. I would like to share critical information about rural hospitals using four different perspectives to speak from.

These perspectives include:

- I. Rural Hospital Reimbursement.
- II. Rural Hospital Patient Access.
- III. Georgia's Rural Hospital Stabilization Committee Program, created by Governor Nathan Deal.
- IV. Rural Hospitals as Economic Development Engines.

I. Rural Hospital Reimbursement

The Georgia Medicaid Program is highly underfunded due to a budget adjustment dating back to 1999. At that time, the Medicaid payment rates were cut by 15% to about 85% of cost. In the nearly twenty years following, cuts have never been restored; resulting in Georgia Medicaid being underpaid by \$4 billion. This has occurred where Medicaid has grown substantially due to increased Medicaid eligible patients; which, in turn, means the financial losses to hospitals have increased as the total Medicaid population has increased. More Medicaid covered lives with con-

tinuing losses has critically damaged the Medicaid Program. The product of this scenario has put the Georgia Medicaid Program among the lowest payers in the nation.

While all of this has occurred, the complexity of the rural hospital claims payment systems has accelerated. Currently, typical hospital business offices are required to administer more than 40 insurance payment platforms. This complexity translates directly into the loss of cash flow. Claims payment is damaged through denials of insurance payments, resulting from inability to understand and apply rules in over 40 insurance platforms. Many hospitals have less than 10 days of cash on hand; and, for a \$10–15 million annual revenue hospital, this is extremely difficult to manage.

As a further problem in reimbursement, Critical Access Hospitals, which were designed to pay 101% of cost to keep these smaller hospitals operationally viable, have found that for the smaller hospital (typically under \$10 million annual net revenue), the hospital cost report, which is the final measure of performance for rural hospitals, runs into a cost-to-charge efficiency penalty—that forces CMS to make claw-backs for unintended overpayments. Over time, as the rural hospital tries to manage its cost to make payroll, those efforts are negated by these claw-backs that are often as much as \$600,000 annually.

Solution Options: One major solution-seeker has been the Georgia Governor’s Rural Hospital Stabilization Committee Program announced in 2014. This program has been funded for the purpose of having 22 rural hospitals within a “hub and spoke” program to seek and develop solutions to improve financial sustainability. This program’s success has contributed to keeping many rural hospitals from closing.

II. Rural Hospital Patient Access

Georgia has closed eight rural hospitals in the last 5 years and is the third worst state for closure during that time. Many hospitals have eliminated services, including more than 10 rural hospitals dropping OB services. With a typical rural hospital covering 10,000 to 15,000 population and with eight rural hospitals having closed, that equates to health care access having been jeopardized or transplanted for 120,000 rural Georgians, as well as another 150,000 of the population impacted from the loss of baby deliveries when OB services were eliminated. This is basically creating a third world nation type of health care in the rural parts of Georgia.

Solution options: Three major solution options have been developed that include, but are not limited to, the following:

1. Georgia has developed a Tax Credit Program: This allows private citizens and corporate citizens to donate directly into hospital operations with 100% state tax credit for donation to the hospital to offset losses, thus keeping the hospital open along with services like OB.
2. Due to the shortage of primary care physicians (estimated to be 1,600 physicians short in Georgia), rural health care access is being helped incrementally through leveraging telemedicine. Growth in telemedicine usage can come additionally with CMS funding for telemedicine consults. With more than 150 providers having over 650 end points, Georgia has faced this physician shortage head-on by conducting thousands of telemedicine consults annually, using state of the art remote diagnostic and monitoring technology.
3. County governments raising money to support local hospitals through local referendums and tax millage carve-outs from county budgets dedicated to rural hospitals. This occurred about 10-12 times in Georgia in 2017, thus keeping those rural hospitals from potentially closing due to financial distress. This is a direct cost shift to the local citizens for health care.

III. Governor Deal’s Rural Hospital Stabilization Committee Program

Governor Deal has budgeted \$12 million over the last four years to fund research and pilot development for rural health care through best practices. Best practices can be replicated throughout the rural hospital community to prevent rural hospital closure. To date, approximately 18 hospitals have been researched through the Georgia State Office of Rural Health. Four additional hospitals are in pilots, for a total of 22 hospitals studied for process improvement through this program. Process improvements include, but are not limited to: community paramedicine, telemedicine, mental health outreach, denial management and continuous education.

IV. Rural Hospitals as Economic Development Engines

Rural hospitals serve as one of the top three employers in a rural community and offer among the highest salary rates available in those areas. Rural hospitals that

close in Georgia typically employ 80–120 citizens. Hospital closures in rural communities are comparable to funerals, impacting the local community and those that are able to remain living there after the rural hospital closure. Keeping a rural hospital open is a direct investment in economic development. This means preserving the economic viability of health care for the 20% of Georgia rural citizenry, as well as the local tax base that keeps industry retained or added.

As a means to preserve the rural economy, the Georgia Legislature has recently passed and the Governor has signed a major piece of legislation to:

1. Facilitate the 100% tax credit to rural hospitals for donors.
2. Create Hospital Board Training to ensure that properly educated decisions are made by hospital boards.
3. Create a Rural Health Care Innovation Center in an academic setting to further explore best practices that can be shared to save rural hospitals and communities.
4. Offer certain incentives to physicians locating to rural Georgia.
5. Enhance use of remote pharmacists to offset pharmacist shortages.

The primary barriers rural health care continues to face, in spite of the innovative initiatives described above, include:

1. The lack of skilled health care personnel at all levels. This includes physicians, nurse practitioners, physician assistants, nurses, pharmacists, and educated business office personnel, just to name a few. As the unemployment rate has dropped nationally and in Georgia, the unintended consequence has been the migration of rural skilled personnel to large urban centers, leaving rural communities underserved.
2. Telemedicine is an ideal source for solution, however the payment structure to support telemedicine has not kept pace with the technological advances. Telemedicine is the key to redistributing the mal-apportioned skill sets, especially physician specialists, but must have enhanced reimbursement to succeed.
3. Entitlement expansion for Medicaid has out-paced the ability to raise payment rates for core Medicaid services, resulting in physicians dropping out of Medicaid.
4. The inability for a rural county to absorb the cost-shift for federally funded Medicaid through locally funded health care referendums. County governments cannot afford to pay for the expected health care services created by entitlements.
5. EMTALA, the federal law that requires providers who accept Medicaid to take all comers no matter their ability to pay. It is not uncommon for a rural hospital to absorb over \$3 million annually in indigent, self-pay, and charity care. There is no practical way rural hospitals can afford this cash loss. Furthermore, there is inconsistency in federal programs that require EMTALA. For example, Federally Qualified Health Centers (FQHCs) do not have to abide by EMTALA, thus putting the rural hospital at a serious payment disadvantage. Additionally, mental health units called Community Service Boards (CSBs), which are mental health hospitals, do not have to abide by EMTALA Law.

In summary, rural hospitals serve 20% of the population of the United States. Rural health care is complex and underfunded but critically important to keep rural Georgians from living in third world type conditions. Georgia has invested in process improvements to save rural hospitals but continues to suffer from near insurmountable barriers. Any help that can be afforded by Congress in budget allocation and/or regulation improvement to cut overhead will be appreciated by the citizens of Georgia. Thank you for your time, consideration, and the opportunity to present these findings.

Respectfully Submitted,

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POINT OF CARE TESTING ASSOCIATION (POCTA)
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Statement for the Record

On behalf of the Point of Care Testing Association (POCTA), thank you for holding the May 24, 2018 hearing entitled “Rural Health Care in America: Challenges and Opportunities.” POCTA appreciates the Committee’s attention to the very unique challenges faced by healthcare providers in rural settings and supports the mission to ensure that individuals living in rural communities have access to essential health care services.

POCTA comprises manufacturers of in vitro diagnostic test systems ordered and furnished directly in patient care settings to allow for effective and efficient incorporation of diagnostic test results into patient care decision making. Point-of-care (POC) testing is performed in physician office laboratories (POLs), emergency departments, hospital clinics, and at the bedside during inpatient stays. POC testing is critical to providing real-time diagnostic answers to healthcare questions that aid in the diagnosis and treatment of a wide variety of medical conditions from the chronic to the acute.

POC testing plays a substantial role in rural and underserved areas. Because POC tests are performed in the healthcare setting, providers can rapidly diagnose and begin treatment without the need to wait days or weeks for a test result. For providers and facilities that do not have comprehensive in-house testing facilities, POC tests can improve the time from test to result, in turn optimizing a provider’s decision making ability.

Rural areas may be particularly susceptible to population health issues including heart disease, diabetes, obesity and certain cancers, particularly if they have diminished access to testing. With the ability to immediately identify disease and begin appropriate treatment, providers minimize the risk of losing patients to follow up and improve their ability to treat and prevent the spread of disease throughout their community.

While it is important that the Committee continue to examine ways to address closures of rural hospitals, it is equally important to ensure that physicians, and other types of safety-net providers, are able to continue to provide the care that rural Americans need. As these hospitals close, the ability of rural communities to get the care and the testing they need becomes increasingly difficult and the role of the physician office becomes even more critical.

Recently, the Centers for Medicare and Medicaid Services (CMS) implemented the most wide ranging reforms to the Medicare Clinical Laboratory Fee Schedule (CLFS) since it was created in the early 1980s. These reforms, included in the Protecting Access to Medicare Act of 2014 (PAMA), aimed to modernize the way that Medicare determines payment rates for diagnostic tests, including POC tests.

PAMA requires CMS to collect commercial insurer payment data from labs and use those commercial payer rates to set payment rates under the Medicare CLFS. The payment rates calculated under the PAMA based CLFS apply to all diagnostic tests, irrespective of the type of test (chemistry or molecular); place of service (physician office, reference lab, etc.); or whether provided in rural, suburban or urban settings.

POCTA remains concerned that, because the CMS data collection process under PAMA was skewed toward large reference labs, data collected are not representative of the overall lab marketplace—especially the marketplace for POL tests. In fact, only 1,100 POLs reported data to CMS. This represents less than one percent of the estimated 120,000 POLs.¹

POCTA members develop novel *in vitro* diagnostic technologies that are typically billed under the same billing codes as tests for the same analytes performed by large reference laboratories. However, the cost structures and value of tests are significantly different in the point-of-care setting (physician offices, emergency departments, at the hospital bedside, and at nursing facilities) compared with the reference laboratory setting. Each setting plays an important role in the U.S. healthcare system, but they each operate in different marketplaces, have vastly dif-

¹ Report: “Labs Within a U.S. Physician’s Office a 1.5 Billion-Dollar Market,” *PRNewswire*: January 14, 2015.

ferent cost experiences and have different arrays of private payor rates for tests billed under the same codes.

Establishing rates for POL tests based upon data reported by large reference laboratories will not represent the marketplace of private payor rates for tests that are performed in large part in the POL setting, and as a result, the Medicare payment rates may not cover the cost of furnishing POC tests in non-reference lab settings.

While we acknowledge the need for Medicare to be able to act swiftly in the face of changing testing technology, and to be fiduciaries of the Medicare program by not overpaying for lab tests, we are concerned that these payment reductions (some as high as 50 percent or more when new rates are fully phased in) will compromise the ability of physician office labs and other common POC testing sites to make such POC testing available, and that these consequences may be particularly felt in rural communities where access already is so fragile. While payment decreases are limited to 10 percent each year between now and 2020 and then 15 percent per year through 2023, reductions of the magnitude that some tests will experience can only have a negative impact on providers' willingness and ability to continue to provide care.

POCTA's members supported the enactment of PAMA as an opportunity to modernize the CLFS. At the same time, shortly after enactment, and throughout the comment process when it became clear that CMS's data collection scheme would underrepresent POLs, POCTA's members raised concerns about the potential negative effects of PAMA on payment for clinical diagnostic tests furnished at the point-of-care in particular, tests performed in the POL setting.

We are concerned that the impact of these cuts may be amplified in rural healthcare settings because of the fragility of the rural health care safety net and rural providers' heightened sensitivity to costs in excess of payment. Our data show that a significant number of tests are provided by providers in rural settings. The following table demonstrates the magnitude of these payment rate changes on 20 of the test codes that are frequently performed at the point of care, and for which there is significant volume reported by providers in rural areas. For the 20 codes included on this table, we show:

1. "*Rural Utilization*"; that is, the number of units of each code billed to Medicare in 2016 from a physician's office enrolled with Medicare in a rural ZIP code;
2. "*Fully Implemented Medicare Rate*"; that is, the actual weighted median of private payer rates submitted to Medicare without application of payment rate reduction guardrails; and
3. "*Decrease from 2017 Medicare Rates*"; that is, the total percentage decrease (or increase) from 2017 payment rates to the fully reduced rate without application of payment rate reduction guardrails (these may reflect rates after 2022 if the next round of PAMA data collection, reporting and rate setting—which commence next year—are unchanged from current policies).

This table shows that virtually all of these 20 test codes will experience substantial decreases in payment rates resulting from the recent changes to CLFS payments made based on the PAMA reforms. These decreases range from modest (less than one-half of one percent) to significant (exceeding 38 percent).

**POCTA
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CPT Code	Descriptor	Rural Utilization (Units)	Fully Implemented Medicare Rate ²	Decrease From 2017 Medicare Rate
85610	Prothrombin time	1,470,140	\$4.29	-20.4%
80053	Comprehensive metabolic panel	1,366,150	\$9.08	-37.3%
80061	Lipid panel	1,063,578	\$11.23	-38.2%
83036	Glycosylated hemoglobin test	1,050,858	\$8.50	-36.2%

POCTA—Continued
POINT OF CARE TESTING ASSOCIATION

CPT Code	Descriptor	Rural Utilization (Units)	Fully Implemented Medicare Rate ²	Decrease From 2017 Medicare Rate
81003	Urinalysis auto w/o scope	687,968	\$2.18	-29.2%
80048	Metabolic panel total ca	633,338	\$8.06	-30.5%
81002	Urinalysis nonautomated without microscopy	504,801	\$3.48	-0.6%
81001	Urinalysis automated with microscopy	483,827	\$2.82	-35.2%
82962	Glucose blood test	285,610	\$3.28	+2.2%
81000	Urinalysis by dipstick or tablet	241,186	\$4.02	-7.6%
82570	Assay of urine creatinine	226,732	\$4.62	-34.9%
82947	Assay glucose blood quant	166,020	\$3.68	-31.7%
82043	Microalbumin, urine quantitative	122,878	\$4.85	-38.8%
82044	Microalbumin, urine semiquantitative (reagent strip assay)	104,476	\$6.23	-0.8%
84550	Assay of blood/uric acid	78,234	\$4.02	-35.2%
82565	Assay of creatinine	77,822	\$4.89	-30.4%
87804	Influenza assay w/optic	74,342	\$16.55	+0.7%
84460	Transferase, alanine amino (alt) (sgpt)	64,991	\$4.71	-35.2%
87880	Strep a assay w/optic	59,772	\$16.53	+0.5%
82550	Assay of creatine kinase (CK) (CPK); total	59,400	\$5.80	-35.1%

Table 1: Rural Test Codes; Payment Changes.

²The rate shown reflects the fully implemented payment change. Payment decreases in 2018, 2019, and 2020 are limited to 10 percent of the previous year's payment; payment decreases in 2021, 2022, and 2023 are limited to 15 percent of the previous year's payment rate.

Note: Data was sourced from CMS PAMA Rate Setting File and from CMS Physician/Supplier Procedure Summary File; 2016.

As the Committee is aware, the overall number of providers in rural communities is lower than that of urban and suburban areas. To the extent that new CLFS payment rates make it financially infeasible for physicians to offer these tests in rural areas, millions of beneficiaries could find it difficult to access point of care testing, and that could have negative public health implications for rural communities.

Two tests among the top 20 highlight this concern. Medicare reimbursements will decrease more than 38 percent for HCPCS Code 80061 (lipid panel), and more than 30 percent for HCPCS code 80048 (basic metabolic panel [calcium total]). The lipid panel test is an important diagnostic to manage patients at risk for heart disease. The metabolic panel test is used to evaluate and follow up on patients with diabetes, on diuretics, with kidney disease, or with severe diarrhea or vomiting. In both instances, there is substantial clinical benefit, in fact need, for physicians to obtain immediate results in the office, at the bedside, or in an emergency department to rapidly understand and respond to a patient's condition. The alternative is that the physician sends specimens to a reference lab, and waits multiple days (maybe a week in some rural areas), to obtain results. That wait time between clinical visit and action can significantly compromise patient health management, compromise patient health, and increase health care costs.

As the Committee considers ways to protect access to high-quality care for rural communities, we encourage you to consider the implications of the changes made to Medicare's CLFS on rural healthcare providers and access to care in rural areas, and to carefully consider how Congress can support and encourage access to POC testing in rural areas.

Please contact Eric Zimmerman at ezimmerman@mcdermottplus.com if you have any questions or wish to discuss this further.

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Statement for the Record

On behalf of the Rural Referral Center/Sole Community Hospital Coalition (the "Coalition"), thank you for holding the May 24, 2018, hearing entitled, "Rural Health Care in America: Challenges and Opportunities." As discussed at the hearing, there are a number of challenges to providing high-quality health care in rural communities. The Coalition is pleased to submit testimony for the record highlighting some of these challenges and offering collaborative solutions to ensure access to health care in rural areas is maintained and improved.

Formed in 1986, the Coalition is comprised of hospitals designated as Rural Referral Centers ("RRCs") and Sole Community Hospitals ("SCHs") under the Medicare Program. Member hospitals of the Coalition share the common goal of ensuring that federal hospital payment policies recognize the unique and important role of these hospitals in providing access to quality care in their communities.

Rural Referral Centers and Sole Community Hospitals

The RRC program was established by Congress to support high-volume rural hospitals that treat a large number of complicated cases and function as regional referral centers. Generally, to be classified as an RRC, a hospital has to be physically located outside a Metropolitan Statistical Area (indicating an urban area) and either have at least 275 beds or meet certain case-mix or discharge criteria.

The SCH program was created to maintain access to needed health services for Medicare beneficiaries in isolated communities. The SCH program ensures the viability of hospitals that are geographically isolated and thus play a critical role in providing access to care. Hospitals qualify for SCH status by demonstrating that because of distance or geographic boundaries between hospitals they are the sole source of hospital services available in a wide geographic area. There are a variety of ways in which hospitals can qualify for SCH status, but the majority qualify by being more than 35 miles from another provider.

RRCs and SCHs provide rural populations with local access to a wide range of health care services. In so doing, RRCs and SCHs localize care, minimize the need for referrals and travel to urban areas, and provide services at costs lower than would be incurred in urban areas. These hospitals also commonly establish satellite sites and outreach clinics to provide primary and emergency care services to surrounding underserved communities, a function which is becoming increasingly important as economic factors force many small rural hospitals to close.

RRCs and SCHs are also vital to their local economies. These hospitals typically are significant employers, generating considerable cash outflow into the area economy and boosting the area tax base. There are 395 hospitals in 45 states with RRC status and 448 hospitals in 47 states with SCH status; 131 of these hospitals have both RRC and SCH status.¹

For these and other reasons, Congress has long appreciated the special role of RRCs and SCHs in the rural health care community and the need to afford these hospitals special recognition and protections to ensure their continued viability and role in the rural health care network.

¹ Centers for Medicare and Medicaid Services, FY 2018 FR and CN Impact File, September 29, 2017.

Challenges Facing RRCs and SCHs

When examining rural health challenges, given the important role these hospitals play in their communities, it is important to address the challenges facing RRCs and SCHs that may impact the quality of, and access to, essential health care services.

Sole Source of Care: First, many of the RRCs and SCHs are, by definition, the sole source of care within and around a rural community. Many patients that live in rural communities depend on these facilities for a full complement of health care services, from primary care to inpatient sophisticated treatment. The closures of rural hospitals remains an on-going trend, causing access problems for residents of rural communities. When an RRC or SCH closes, the consequences for the community may be more grave than otherwise.

- Since January 2005, 125 rural hospitals have closed (83 since January 2010). Of the 125 closed hospitals, more than half either converted to non-health care use (54.2 percent) or were abandoned.²
- Patients in affected communities are traveling further to access inpatient care: 43 percent of the closed hospitals are more than 15 miles to the next nearest hospital, and 15 percent are more than 20 miles.³
- Approximately 673 rural hospitals are vulnerable to close, representing more than one third of the rural hospitals in the U.S. and impacting up to 11.7 million rural patients.⁴
- The pace of closures is accelerating. From March 2013 to March 2016, 43 rural hospitals closed. . . . While 27 of the closures were less than 20 miles from the nearest hospital, 13 were 20 to 30 miles from the nearest hospital and three were over 30 miles from the nearest hospital.⁵

Unique Patient Populations: Second, providers in rural areas treat more challenging patient populations. Individuals who live in rural areas have higher rates of chronic or life-threatening diseases, such as diabetes and coronary heart disease.⁶ Additionally, rural residents are more likely to face significant mental health issues including substance abuse and seasonal affective disorder.⁷ RRCs and SCHs tend to face even more complex patients than other rural hospitals. For instance, the average Medicare case mix index for RRCs and SCHs is 1.62 and 1.39, respectively, compared to 1.26 for all other rural hospitals.⁸ The Medicare case mix index of RRCs more closely resembles that of urban hospitals (1.62), demonstrating that RRCs are fulfilling the congressional intent of localizing sophisticated care in rural areas.⁹

Financial Challenges: Third, and finally, rural health care providers are increasingly confronting extremely difficult financial circumstances. Rural hospitals (including RRCs and SCHs) tend to have negative or very small operating margins, in contrast to their urban counterparts, making them financially vulnerable. Additional Medicare reimbursement reductions impose further financial strain and compromise their ability to serve rural communities.

- Rural hospitals tend to have lower operating margins due to lower volumes, a predominately public payer mix, and higher levels of uninsured patients.¹⁰
- Nationally, urban hospitals were twice as profitable as rural hospitals in 2016: the U.S. median profit margin for urban hospitals was 5.51 percent which was

²“Rural Hospital Closures.” 2014, <http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospitalclosures/>.

³Clawar, M, Thompson, K, and Pink, G. “Range Matters: Rural Averages Can Conceal Important Information” (January 2018). NC Rural Health Research and Policy Analysis Program. UNC-Chapel Hill, <http://www.shepscenter.unc.edu/download/15861/>.

⁴“2016 Rural Relevance: Vulnerability to Value Study.” iVantage Analytics, February 2016.

⁵*Report to the Congress: Medicare and the Health Care Delivery System*. Medicare Payment Advisory Commission, June 2016, page 208.

⁶O’Connor, A, and Wellenius, G (2012, April 24). “Rural-urban disparities in the prevalence of diabetes and coronary heart disease.” *The Royal Society for Public Health*, 126(10), 813–820, doi:10.1016/j.puhe.2012.05.029.

⁷“Health Status and Behaviors,” Stanford Medicine, eCampus Rural Health.

⁸Centers for Medicare and Medicaid Services. FY 2018 IPPS Impact File, September 29, 2017.

⁹*Id.*

¹⁰“Rural Hospital Participation and Performance in Value-based Purchasing and Other Delivery System Reform Initiatives,” Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Issue Brief, October 19, 2016.

more than double the margins for Critical Access Hospitals (2.56 percent) and other types of rural hospitals (2.01 percent).¹¹

- Rural hospitals on average treat a higher percentage of Medicare patients (as measured by Medicare days) than their urban counterparts, 46 percent for rural hospitals compared to 34 percent for urban hospitals.¹² RRCs and SCHs, not surprisingly, tend to play an equally significant role in the Medicare program, having on average 43 percent and 45 percent, respectively, of their inpatient days accounted for by Medicare beneficiaries.

While this negatively impacts patient care, it also significantly impacts local economies that often depend on rural hospitals as a large employer in their communities.

These hospitals also often do not have the same flexibility as other hospitals to discontinue lower margin or unprofitable services, like mental health services. As mission driven organizations, and the only source of hospital services for their community, these hospitals often will continue to offer services, even at great financial loss, because there are no other providers offering those services.

These hospitals also are struggling with dwindling federal support. Congress and the Centers for Medicare and Medicaid Services (CMS) have discontinued some of the benefits that these hospitals originally enjoyed.

Historically, RRC status carried with it several important financial benefits, including a higher standardized amount payment rate than ordinary rural hospitals. Today, RRCs receive special treatment under geographic reclassification and the Medicare disproportionate share hospital (DSH) program. With respect to geographic reclassification, hospitals with RRC status are exempt from proximity and certain other requirements. With respect to DSH, RRCs are not subject to the 12 percent payment adjustment cap that applies to certain other rural hospitals. RRCs are also eligible to participate in the 340B program at a lower DSH threshold.

SCHs are reimbursed by Medicare for operating costs associated with inpatient services provided to program beneficiaries on the greater of the federal payment rate applicable to the hospital (*i.e.*, the payment that the hospital would otherwise receive under the inpatient service prospective payment system (“PPS”)) or a cost-based payment, which is determined based on the hospital’s costs in a base year: 1982, 1987, 1996 or 2006 trended forward, whichever is highest, but these cost years have not been updated in more than a decade.

A hospital with SCH status also is eligible for an upwards payment adjustment for any cost reporting period during which the hospital experiences a more than 5 percent decrease in its total inpatient discharges as compared to its immediately preceding cost reporting period due to experiences beyond its control. The adjustment is determined based on a variety of considerations, but can be as high as the difference between the hospital’s operating costs and the federal payment rate applicable to the hospital for the year in question.

Additionally, SCHs are eligible for “special access” rules for purposes of Medicare geographic reclassification, which means that a hospital with SCH status applying for reclassification does not have to be within 35 miles of the area to which it seeks reclassification, and may apply to the nearest Metropolitan Statistical Areas (MSAs).

Hospitals with SCH status receive a 7.1 percent adjustment to Outpatient Prospective Payment System. SCHs used to receive transitional payments under the OPPTS, but Congress allowed that program to lapse in 2013.

Recommendations for Congressional Action

Overall, RRCs and SCHs treat patient populations with the most chronic and costly health issues with limited financial resources. This makes these rural providers especially dependent on accurate and appropriate payment policies. To ensure RRCs and SCHs are able to continue to provide high-quality health care to rural communities, there are five policy changes the Coalition recommends.

Recommendation One—Examine Impact of CMS’s OPPTS Drug Payment Policy: First, Congress should examine the impact of the CMS drug payment policy implemented via the CY2018 OPPTS rulemaking, but in the meantime take steps to

¹¹ Pink, GH, Thompson, K, and Holmes, GM. Testimony, Senate Finance Committee, May 24, 2018.

¹² Centers for Medicare and Medicaid Services. FY 2018 FR and CN Impact File, September 29, 2017.

prevent further harm to rural providers. As the Committee is aware, beginning in 2018, CMS instituted a policy change reducing the amount Medicare pays hospitals for drugs covered under Part B of the program when those drugs are purchased through the 340B program. Specifically, CMS reduced payment from Average Sales Price (ASP) plus 6 percent to ASP minus 22.5 percent. Fortunately, CMS excepted from this payment adjustment *rural* SCHs. Urban SCHs and RRCs, however, are subject to the adjustment. CMS cited hospital operating margins, closure rates of rural hospitals, low-volume, and existing special payment designations among reasons for excepting rural SCHs, but not other rural safety net providers. Urban SCHs and RRCs share many of these same characteristics, and also should be protected while CMS examines the impact. The idea of implementing a significant policy change, and then examining the harm is potentially reckless given the known fragility of these providers.

The OPSS rule established policies that do not appropriately support these communities and address these issues. *Congress should make the SCH exception in the OPSS permanent.* SCHs play a vital role in the rural health care infrastructure. By definition, these hospitals are the sole source of hospital services for a large area (they are either many miles away, separated by geographic barriers, or a minimum driving distance). If an SCH fails, a community is left without access to inpatient hospital services, and residents must travel great distances to access this care. CMS recognized these challenges in the May 8, 2018, release of its “Rural Health Strategy,” where issues such as the unique economies of providing health care in rural America were highlighted.¹³ The uncertainty provided under the current policy—*i.e.*, not knowing if CMS will extend the policy—inhibits investment in services in rural communities, and further strains the rural health care safety net.

Congress also should examine extending the exception to urban SCHs. CMS uses MSAs to delineate between urban and rural areas. MSA is a crude tool, at best, for characterizing urban and rural areas. Given that MSAs uses counties as building blocks, many “urban” areas are as rural as the most isolated frontier area. In fact, to be an *urban* SCH, a hospital has to be even further (35 miles) from another hospital to qualify. Currently, there are 78 urban SCHs in 38 states.¹⁴ Using MSAs to identify urban and rural areas is particularly problematic in the western United States where there are many very large counties that comprise MSAs (see, for example, San Bernardino County in California and Pima County in Arizona). There are instances where an SCH is designated urban by CMS, but is actually a considerable distance from the nearest urbanized area. For example, Verde Valley Medical Center is located in Prescott, AZ and is considered an urban SCH. However, the closest urbanized area with more than 40,000 people is Flagstaff, AZ, which is nearly 100 miles away.¹⁵

Using this approach, CMS fails to recognize MSAs are not an appropriate means to determine rural and urban SCHs. Further, it does not take account for the fact that urban and rural SCHs serve very similar patient populations, face the same financial challenges as described above, and both play an essential role as safety net providers in rural communities. While there are a relatively small number of urban SCHs, they should be afforded the same benefits of their rural counterparts.

Similarly, *Congress should examine extending the exception to RRCs.* RRCs, like SCHs, play an important role in the rural healthcare safety net, and exhibit many of the same vulnerabilities as SCHs. Congress sought to buttress RRCs in the 340B program the same as SCHs, by lowering the eligibility bar for both provider types.

Recommendation Two—Close the Orphan Drug Loophole: In 2010, Congress extended 340B Program eligibility by making it easier for freestanding cancer hospitals, Critical Access Hospitals (CAHs), RRCs, and SCHs to participate. Under this change, freestanding cancer hospitals and CAHs are eligible by virtue of their status as these providers. RRCs and SCHs are not automatically eligible, but Congress made it easier for them to qualify by lowering the DSH threshold for these facilities.

¹³“Rural Health Strategy.” Rural Health Council. Centers for Medicare and Medicaid Services, May 8, 2018, <https://www.cms.gov/About-CMS/Agency-information/OMH/Downloads/Rural-Strategy-2018.pdf>.

¹⁴Centers for Medicare and Medicaid Services. FY 2018 IPPS Impact File, September 29, 2017.

¹⁵“Metropolitan and Micropolitan Statistical Areas of the United States and Puerto Rico.” U.S. Census Bureau, July 2015, https://www2.census.gov/geo/maps/metroarea/us_wall/Jul2015/cbsa_us_0715.pdf.

According to 2018 HRSA data, approximately 100 RRCs or SCHs participating under the lower DSH threshold are participating in the 340B Program.

However, at the same time that Congress made it easier for these facilities to participate in the 340B Program, it also sought to ensure the program's discounts would not stifle investment in and development of drugs for rare diseases or conditions. Specifically, Congress included a provision that exempted from the 340B discount requirements any "drug designated by the Secretary under section 360bb of title 21 for a rare disease or condition" when purchased by one of the expansion entities. This provision effectively exempts any drug with orphan drug designation.

Many commonly used drugs have orphan designation for one or more indications, even though the drug also is approved for more common indications too. Indeed, a January 2017 study by Kaiser Health News (KHN) found that about one third of orphan approvals made by the FDA since the orphan drug program was enacted in 1983 have been either for mass market drugs repurposed for an orphan designation, or for drugs that received multiple orphan designations.¹⁶ The FDA's orphan drug program provides a number of incentives—such as market exclusivity and tax credits—to encourage development of drug therapies for rare diseases or conditions, but each of these orphan drug incentives applies only when the drug is used to treat the rare disease or condition, and not when used for other indications.

In 2011, HRSA published a proposed rule that sought to define the orphan drug exclusion established under the 2010 law by proposing that orphan drugs would be exempt from 340B discount requirements only when used for the rare condition or disease for which that drug received orphan designation. In 2013, HRSA published a final rule that largely adhered to the proposed rule's interpretation of the orphan drug exclusion.

Shortly after HRSA promulgated its final rule, the pharmaceutical industry—which had been urging HRSA to interpret the exception as applying to any drug with orphan designation, regardless of the clinical condition for which the drug was prescribed—sued the agency seeking to enjoin implementation of the final rule; the federal district court issued an opinion siding with the pharmaceutical industry. In 2014, HRSA responded by reissuing its notice as an interpretive rulemaking, which essentially announces the agency's interpretation of the statute, but does not include regulations enforcing it. The pharmaceutical industry responded with a new lawsuit challenging the interpretive rule; again the same court sided with the pharmaceutical manufacturers and invalidated the interpretive rule.

Since the court decisions, many pharmaceutical companies are restricting access to 340B Program discounts on drugs with orphan designations, thereby undermining the benefits of the program for RRCs, SCHs, CAHs and freestanding cancer hospitals. Many such hospitals report significant increases in drug spending since the court decision and are not realizing the full benefit of the 340B Program.

Congress established the orphan drug program to encourage development of drugs for the diagnosis and/or treatment of rare diseases or conditions, and the 340B orphan drug exclusion is, in effect, yet another incentive to promote investment these drugs. However, Congress could not have intended to extend this benefit to a drug use for which there is a substantial and lucrative market. Recent data shows that eight of the 10 best-selling drugs in the U.S. in 2015 were drugs with orphan designation.¹⁷ Further, spending on these drugs accounted for 55 percent of all Medicare Part B drugs.¹⁸

The Coalition urges the Committee to review and consider the Closing Loopholes for Orphan Drugs Act (H.R. 2889). This bill seeks to clarify the orphan drug exclusion by amending the exemption to limit the carve-out only to those uses for which the drug received orphan status. This important, bipartisan piece of legislation will ensure that RRCs and SCHs (as well as CAHs and cancer hospitals) benefit from the 340B Program to the extent that Congress intended, allowing these facilities to con-

¹⁶ "Drugmakers Manipulate Orphan Drug Rules to Create Prized Monopolies." *Kaiser Health News*, January 17, 2017, http://khn.org/news/drugmakers-manipulate-orphan-drug-rules-to-create-prized-monopolies/?utm_campaign=KHN%3A+Daily+Health+Policy+Report&utm_source=hs_email&utm_medium=email&utm_content=40780219&hsenc=p2ANqtz-Iz5qtlLkNBVUJN3TerDq15vXUOZzQR0hDe9_cERt1nPfP_T44hddg2bb5zflA&ZB00isTyHt_xt4PcGhjl7UwJ0u&_hsm_i=40780219.

¹⁷ Orphan Drug List Governing April 1 to June 30, 2018, <https://www.hrsa.gov/opa/program-requirements/orphan-drug-exclusion/index.html>.

¹⁸ 2015 Total Part B Drug Spending from MedPAC June 2017 Data Book (Chart 10-1), http://www.medpac.gov/docs/default-source/data-book/jun17_databookentirereport_sec.pdf?sfvrsn=0.

tinue to provide rural communities with local access to important health care services.

Recommendation Three—Extend and Codify the 7.1 Percent Payment Adjustment: Under current CMS policy, Medicare payments to rural SCHs for outpatient services are increased by 7.1 percent. CMS makes this adjustment because it found, pursuant to a study required by Congress, that, compared to urban hospitals, rural SCHs have substantially higher costs, and need a payment adjustment to be comparably treated under the outpatient PPS. Because Congress directed CMS to study only rural hospitals, the adjustment applies only to rural SCHs.

For the same reasons articulated above, *Congress should extend this adjustment to urban SCHs.* Urban and rural SCHs serve very similar patient populations, face the same financial challenges, and both play an essential role as safety net providers in rural communities. There is no policy basis to differentiate between urban and rural SCHs for purposes of this policy.

Recommendation Four—Update Hospital Specific Rate Base Year: SCHs are reimbursed by Medicare for operating costs associated with inpatient services provided to program beneficiaries on the greater of the federal payment rate applicable to the hospital (*i.e.*, the payment that the hospital would otherwise receive under the inpatient PPS) or a cost-based payment, which is determined by adding together the federal payment rate applicable to the hospital and the amount that the federal payment rate is exceeded by a hospital-specific rate (based on the hospital's costs in fiscal year 1982, 1987, 1996 or 2006 trended forward, whichever is higher). A hospital that qualifies for SCH status will continue to be reimbursed under the PPS for as long as reimbursement under the PPS is more than reimbursement on a cost-basis; the hospital will be paid on a cost-basis if cost-based reimbursement is greater than reimbursement under the PPS.

We propose that Congress add a more current cost year—e.g., 2016 or 2017—for purposes of determining the target amount. Congress last required an update nearly a decade ago (see, section 122 of Public Law 110-275, the Medicare Improvement for Patients and Providers Act of 2008), and it is time for this program to reflect more current cost experience.

Recommendation Five—Examine Why Annual MS-DRG Adjustments Disadvantage RRCs and SCHs, and Require an Appropriate Adjustment to Compensate: CMS inpatient payment policy has been systematically disadvantaging RRCs and SCHs vis-a-vis their urban counterparts. According to CMS's own Impact Analysis of Proposed Changes (Table 1, 83 Fed. Reg. 20,603 *et seq.*), rural hospitals are disproportionately disadvantaged by the budget neutrality adjustments CMS uses when implementing and reconciling MS-DRG changes from year-to-year. For FY 2019, CMS estimates that this adjustment will be neutral for urban hospitals, but cause a 0.3 percentage point payment reduction for rural hospitals. The impact for certain categories of rural hospitals is even greater, including 0.4 percentage point for SCHs. As if this isn't troubling enough, as the table below reveals, this has been a consistent trend in recent years, serving to perpetuate the gap between urban and rural hospitals and further threatening the gap between urban and rural providers.

Congress should require CMS to examine and report on this phenomenon, and make an adjustment, if deemed appropriate, to restore these hospitals to a level playing field.

**Weights and DRG Changes With Application of Recalibration Budget Neutrality Values
Comparison Between Urban and Rural Hospitals From 2014 to 2018¹⁹**

Year	Urban	Rural	RRC	SCH	MDH	SCH and RRC	MDH and RRC	Data Source
2014	0	-0.4	-0.1	-0.6	-0.7	-0.3	-0.5	IPPS 2014 Final Rule
2015	0	-0.2	0	-0.2	-0.3	-0.3	-0.3	IPPS 2015 Final Rule Correction Notice
2016	0	-0.2	-0.1	-0.3	-0.3	-0.3	-0.3	IPPS 2016 Final Rule Correction

**Weights and DRG Changes With Application of Recalibration Budget Neutrality Values
Comparison Between Urban and Rural Hospitals From 2014 to 2018**¹⁹—Continued

Year	Urban	Rural	RRC	SCH	MDH	SCH and RRC	MDH and RRC	Data Source
2017	0	-0.4	-0.1	-0.3	-0.6	-0.3	-0.6	IPPS 2017 Final Rule Correction
2018	0	0.1	0.1	-0.2		-0.1		IPPS 2018 Final Rule Correction
2019	0	-0.3	0	-0.4	-0.5	-0.2	-0.5	IPPS 2019 Proposed Rule
Total	0	-1.4	-0.2	-2.0	-2.4	-1.5	-2.2	

¹⁹ Federal Register Vol. 83, No. 88, Monday, May 7, 2018, Proposed Rules.

Conclusion

As the Committee continues to examine rural health challenges, we urge thoughtful attention and consideration be given to RRCs and SCHs. As described above, these hospitals play essential roles in providing high -quality health care to rural communities. We are available for questions, further comments, and additional information. Please feel free to reach out to Eric Zimmerman (ezimmerman@mcdermottplus.com) or Rachel Stauffer (rstauffer@mcdermottplus.com).

