

**Testimony
of the
American Hospital Association
before the
Committee on Small Business
of the
U.S. House of Representatives**

**“The President’s Budget and Medicare:
How Will Small Providers be Impacted?”**

March 18, 2009

Good afternoon Madam Chairwoman. I am Edward Hannon, CEO of McDowell Hospital in Marion, North Carolina, and Chairman of the American Hospital Association (AHA) Small or Rural Hospital Governing Council. I am here on behalf of the AHA’s nearly 5,000 hospitals, health systems, networks and other health care provider members, including almost 1,700 small or rural hospitals.

The McDowell hospital is a 65-bed, rural, not-for-profit hospital, which employs more than 300 people, and is set in the foothills of the Blue Ridge Mountains of western North Carolina, or as we like to say, “where main street meets the mountains.” The hospital provides care to about 2,000 inpatients a year and offers a wide range of health care services to our community, including obstetrical, oncology, emergency and surgical care, as well as various social, family and wellness support services.

THE PRESIDENT’S BUDGET

In the budget outline released last month, President Obama called for reducing the deficit, enacting health reform and retooling our nation’s entitlement programs. We are steadfast in our commitment to health care reform, which ought to start with expanding coverage for all. We commend the President for making health reform a top priority among the many challenges facing our nation.



Furthermore, we support efforts to make health care more affordable, such as focusing on wellness and prevention; better coordinating care; eliminating physician-self referral to hospitals in which they have an ownership interest; utilizing comparative effectiveness research to determine the most effective care; moving toward the adoption of information technology; creating alternative liability systems; and reducing administrative costs.

Given the economic pressures faced by hospitals, which serve as the nation's health care safety net, and given that Medicare already pays hospitals less than the cost of providing services, it is essential to proceed with caution with respect to health care reform, as hospital services for people in need have already been cut at the state and local levels. We are concerned about cuts that affect the work hospitals do for their communities during this economic downturn.

THE UNIQUE CHALLENGES OF RURAL HOSPITALS

Our hospital is like many rural hospitals that dot the landscape of America: We are there to serve our community's needs to the best of our ability, regardless of what those needs might be.

I am pleased to be here this afternoon to testify before this committee on the impact the President's budget outline will have on small or rural hospitals. Specifically, I would like to give you an idea of the unique nature of small or rural hospitals, and, accordingly, how the budget proposals will affect us.

There are three main characteristics of rural hospitals: smaller size and volume, geographic isolation, and the type of population served. Understanding these important issues is critical to understanding how federal health care policy affects rural areas.

SMALLER SIZE MEANS LOWER VOLUME AND LOWER PROVIDER SUPPLY

Current federal policy regarding payment, quality, and safety measures does not adequately account for the differences in the inpatient volume of rural hospitals. As a rule, rural hospitals treat fewer patients, which translates into a substantially smaller "sample size," making interpreting data difficult and, at times, misleading. This small sample size means that the ability to average out or smooth the data is diminished, which tends to give undue weight to aberrant events or circumstantial anomalies.

Lower patient volume also translates into a financial position that is much less predictable, complicating long-range financial forecasting and contingency planning. This makes small and rural hospitals less able to weather financial fluctuations, especially in today's economic environment. For example, our inpatient average daily census routinely fluctuates between 10 and 35 patients; this much variance presents many challenges for us when planning staffing and budgeting.

Rural hospitals also have a difficult time attracting and retaining highly skilled personnel, such as doctors and nurses. One impediment is the lack of commonly available family and social amenities, as well as other conveniences. As a result, many rural patients must travel a relatively long distance for care, a factor that often creates longer intervals between visits or between diagnosing and treating the original or latent conditions.

GEOGRAPHIC ISOLATION

Rural communities are self-contained and far from population centers. Often, the local hospital is far from another population center or health care facility. In my case, the closest hospitals to McDowell are over 30 miles on the other side of the mountain to the west, and about 25 miles to the east. Public transportation is rare and, if it does exist, it is sporadic. For example, in my community, there is no public transportation; the only transportation program that exists is a recently implemented county program that provides transportation for Medicaid patients to their medical appointments. In addition, for many rural communities, inclement weather or other forces of nature can make transportation impossible or, at the very least, hazardous. The inability to rely on safe, consistent transportation for many rural residents means that preventative and post-acute care, pharmaceutical and other services are delayed, or in the extreme, forgone entirely, which can increase the overall cost of care once services are delivered. All of these factors complicate the treatment and care protocols of primary care physicians and again, ultimately, increase the cost of care.

LARGER SHARE OF MEDICARE BENEFICIARIES

America's rural areas have a high proportion of Medicare patients. At my hospital, Medicare accounted for 58% of our discharges in fiscal year 2008. Because we have a high population of Medicare patients, any payment changes or cuts in the program have a disproportionate effect on us. When coupled with our low revenue flow, the problem is compounded because we operate on extremely small margins. We are less able to subsidize losses and to adjust our budget strategy based on our changing patient mix and volume.

This unique set of demographic and public policy circumstances exerts considerable negative financial pressure on America's rural hospitals and, for many, threatens their long-term financial sustainability. This in turn threatens the health and welfare of rural America.

THE BUDGET'S IMPACT ON SMALL/RURAL HOSPITALS

Now that I have provided this background, I would like to outline how these issues intersect with several of the proposals in the administration's budget outline.

As I said, we may be considered small hospitals, but the impact rural facilities have on our communities is large. Rural hospitals are partners and providers of first, second and last resort in countless small towns, villages and reservations all over our country. The geographic realities, isolation and large coverage area means that we are THE medical center for, in some cases, hundreds of miles. There simply is no other option. We see it all, treat it all, and must stand ready to handle a wide range of medical and public health situations, whether caused by man or nature. These unique circumstances require stable and predictable financial resources and manpower, both of which, as I outlined earlier, tend to be in short supply. It is for these reasons that small or rural hospitals have been early and ardent proponents of reforming our health care system.

Now, Madam Chairwoman, I would like to take a moment to share our views about the readmissions, bundling and pay-for-performance proposals in the President's budget outline.

READMISSIONS

The President's budget outline contains a provision to reduce payments to hospitals with high numbers of patients readmitted within 30 days. The proposal is projected to save \$8.43 billion over 10 years. Determining preventable readmissions is a complex undertaking and must be thoroughly analyzed before policies can be adopted. The use of readmission rates is concerning because it does not fully account for all the circumstances involved in a readmission. The use of a readmission rate would seem to be an arbitrary judgment that all readmissions are preventable. That is not the case. While some readmissions are clearly under the control of the hospital, most are the result of a complex series of conversations, circumstances and medical decisions that involve hospitals, physicians and other providers who manage patients' care, as well as patients and their families.

Let me give you an example of the factors that come into play when a rural hospital readmits a patient. An elderly patient was admitted for a small bowel obstruction. Her surgery was successful and her physician recommended a skilled-nursing facility (SNF) for post-acute care. However, as is very common in small, rural areas, she is fiercely independent and refused to go to the SNF. As a result, her condition worsened, and she had to be readmitted. We persisted in working with her and she eventually did agree to skilled care, but only after two more admissions for the same diagnosis.

Further, some readmissions are planned and appropriate patient care – such as for repeated chemotherapy treatments or reconstructive surgery following trauma. Any provision that does not recognize these legitimate reasons for readmission may become an obstacle to patient care and safety.

BUNDLING

The President's budget outline contains a provision to bundle payments for hospital and post-acute care, which is projected to save \$17.84 billion over 10 years. In our view, we welcome any option that decreases the cost of care and increases patient quality, but any changes should be the result of careful, thoughtful research. The need for studied evaluation of existing demonstration projects in this arena, phasing-in implementation gradually and providing the appropriate tools and infrastructure for coordinating care and managing risk must be integral to any new plan. Our members recognize that payment systems are fragmented and paying providers based on volume is not a strategy for an efficiently run, coordinated health care system. Some of our members are organized in ways that would facilitate bundling payments, but many are not, and they need the tools to be able to operate in this manner.

As it appears in the President's budget outline, bundling of hospital and post-acute payments is problematic. We believe that there are other bundling methodologies that could improve care coordination and promote efficiency.

As a rural hospital CEO, bundling raises many questions. For example, many of the pilot projects that have explored the effectiveness of bundling have focused on care that is not commonly given at rural hospitals, such as for coronary artery bypass graft surgery. Would bundling of payments be effective and feasible for the care that rural hospitals commonly do

provide, such as chest pain and chronic obstructive pulmonary disease? Understanding the care process, the unique obstacles rural health care faces and the needs of rural patients will be crucial if we are to shape a fair and coherent payment bundling system.

We have serious concerns about the underlying assumptions of bundling on small and rural hospitals. Most bundling proposals posit that if hospitals control the payment bundle, they will select the most appropriate, effective post-acute care provider. The underlying assumption of bundling is that a hospital will have the option to choose the highest-quality and lowest-cost provider. However, there is often little, if any, choice in rural areas due to low provider supply; there is also less capacity, and wait times for post-acute care can be long.

For example, we have three home health agencies in our county, which is a high number for a rural area. The largest agency has a very limited number of physical therapists. As a result, there is often a two-week delay in patients being able to access these services, and in some cases, the agencies will decline referrals because they are at capacity.

Travel times, distances and other common rural circumstances have a profound effect on the frequency and ability of the patient to obtain post-acute care and therefore impact the efficacy of care. As an example, one of our elderly patients was admitted with a hip fracture and needed post-acute home health care. However, her living conditions were not conducive to healing, as her home was unhygienic. Unfortunately, this is not an uncommon situation. Predictably, her condition worsened and she was readmitted for other complications that were unrelated to the quality of care she received in the hospital.

How will these limitations affect the feasibility and advisability of implementing bundling in rural areas? Right now we simply do not know. Therefore, more study and analysis must occur before we embark on bundled payment arrangements in rural areas.

PAY-FOR-PERFORMANCE

The President's budget outline contains a provision to link a portion of inpatient hospital payments to performance on specific quality measures, which is projected to save \$12.09 billion over 10 years. Providing incentives for improving quality through pay-for-performance or value-based purchasing are areas worthy of consideration. Hospitals, more than any other provider type, have a history of linking quality measurement and improvement to payments. However, we are concerned about the proposal in the budget for value-based purchasing that would cut payments up-front, since we believe overall savings can be achieved by improved care leading to fewer medical visits.

The goal of incentive approaches should be to improve performance. The use of payment to change incentives in today's health care system should reward providers for demonstrating excellence in improving quality and patient safety and providing effective care. Using these approaches as cost-cutting measures is of particular concern for rural hospitals because of our low volume. Again, this low volume could lead to rural hospitals having fewer resources and lower margins, which makes these potential payment cuts even more devastating.

In addition, we have many questions about how pay-for-performance will be implemented in rural areas. Specifically, some hospitals may have limited data available for certain measures because of their low volume – they may not often deliver the services that feed into the measures being used. For these hospitals, their data may not be statistically stable or sufficiently indicative of their real performance to enable meaningful participation in a pay-for-performance program, i.e. one patient could have a disproportionate effect on the score of a certain measure. A way to address low volume situations must be included in any pay-for-performance proposal.

Along these same lines, current proposals use a standard set of measures, which may involve procedures not performed at all small or rural hospitals, and hospitals cannot report on procedures they do not do. We are concerned about whether and how these limitations will be taken into account when crafting pay-for-performance policy – if they are not adequately considered, it will put small and rural hospitals at a distinct disadvantage. The concept of rewarding performance excellence holds merit and I believe that rural hospitals offer high quality care. However, we are concerned that some of the approaches used will result in payment penalties, inequities and other serious consequences – intended and unintended – for hospitals and the communities they serve, particularly those in rural areas.

Finally, there are several provisions in the President’s budget outline that we strongly support: inclusion of permanent reform for the Medicare physician fee schedule; strengthening the health professions workforce; and a ban on physician self-referral.

MEDICARE PHYSICIAN FEE SCHEDULE FIX

We strongly support the President’s proposal to permanently reform the Medicare physician fee schedule. Medicare has been slated to cut physician payments by a significant amount for many years. Although the cuts have been prevented each year, the repeated threat puts physicians in a very difficult position and many physician practices will not be able to remain viable under Medicare if the cuts go through. Rural areas have a very tough time recruiting physicians because of our low volume and geographic isolation. And when coupled with our high proportion of Medicare patients, these repeated difficulties with Medicare physician payment make recruiting infinitely more difficult.

For example, we have been able to successfully recruit seven physicians in the past year. However, we have only been able to do so by agreeing to employ them at the hospital, which places an enormous risk, burden and cost on us, as we must guarantee their salary, provide benefits and assume billing responsibility. Unless employed by the hospital, these physicians felt that their payments would not be steady and reliable enough to ensure that they would be able to maintain a viable practice. This is both because of the low, and often unpredictable, volumes in rural areas, as well as the sustained threat of cuts to Medicare payments.

Permanently reforming the Medicare physician fee schedule will substantially aid our ability to recruit and retain physicians.

STRENGTHENING THE HEALTH PROFESSIONS WORKFORCE

The President’s budget outline invests \$330 million to address the shortage of health care providers in medically underserved areas, many of which are rural. For many of the same

reasons we support reforming the physician fee schedule, we also support this proposal. As I outlined above, rural areas often have a very difficult time attracting and retaining health care providers.

For example, after 17 years, our two obstetricians left the hospital, citing poor quality of life, including the fact that one or the other was required to be on call at all times, as well as the constant decline in reimbursement rates. While we eventually recruited new physicians, for several months we were forced to pay a hefty price to employ temporary physicians. Their services are at a premium and the commuting cost to our hospital was extraordinary. When we did find physicians who agreed to practice in our community, it was only as an employee of the hospital. The business model for private practice did not make sense. This need to employ our doctors is a large burden and puts the hospital at risk – if the physician does not receive sufficient reimbursement to cover his or her salary, the hospital covers the difference. In this case, we are bearing a loss, as obstetrical services are not appropriately reimbursed.

BAN ON PHYSICIAN SELF-REFERRAL

We strongly support the President's inclusion in his budget outline of a ban on physician self-referral to hospitals in which they have an ownership interest. We look forward to working with the administration and Congress to achieve this goal.

CONCLUSION

Madam Chairwoman, hospitals are more alike than different. No matter where we are, no matter the size of our institution or community, we exist to heal and to help anyone who needs us. This is the rich heritage of America's hospitals.

However, as I have explained today, there are unique concerns that apply to rural hospitals. Any budget proposal must recognize how health care is delivered in rural America. I ask that you and your colleagues ensure that we embrace a federal policy that understands and enhances our ability to provide the care our rural communities expect and every patient deserves.

Thank you for your time today.