

**Statement
of the
American Hospital Association
before the
Committee on Appropriations
Subcommittee on Labor, Health and Human Services, Education and Related Agencies
of the
United States Senate**

“Rural Health”

May 7, 2015

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to submit a statement regarding actions Congress can take to ensure accessible, affordable health care services are available in rural areas. We applaud the subcommittee for holding this hearing.

Approximately 51 million Americans live in rural areas and depend upon the hospital as an important – and often only source of health care in their community. Remote geographic location, small size, limited workforce, physician shortages and often constrained financial resources pose a unique set of challenges for rural hospitals. Additionally, burdensome, duplicative, and often outdated federal regulations and policies present consistent strain on the ability for rural hospitals to keep their doors open and provide needed health care services.

The AHA recommends Congress take action on the issues discussed below to provide relief from harmful federal regulations and policies and protect important programs.

96-HOUR RULE

The Centers for Medicare & Medicaid Services (CMS) has published guidance, in relation to its two-midnight admissions policy that implies that the agency will begin enforcing a condition of payment for critical access hospitals (CAHs) that requires a physician to certify that a beneficiary may reasonably be expected to be discharged or transferred to another hospital within 96 hours



of admission. While CAHs must maintain an annual average length of stay of 96 hours, they 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 resulting financial pressure will severely affect their ability to operate and, therefore, threaten access to care for beneficiaries in rural communities.

The AHA supports the Critical Access Hospital Relief Act (S. 258/H.R. 169), which would remove the 96-hour condition of payment. CAHs would still be required to satisfy the condition of participation requiring a 96-hour annual average length of stay.

DIRECT SUPERVISION

CMS recently removed its moratorium on Medicare contractors enforcing its policies related to its “direct supervision” requirement of outpatient therapeutic services furnished in CAHs and small rural hospitals with 100 or fewer beds. Therefore, for 2015 and beyond, the agency requires a minimum of direct supervision for all outpatient therapeutic services furnished in hospitals and CAHs, unless the service is on the list of services that may be furnished under general supervision or is designated as a nonsurgical extended duration therapeutic service. The AHA is deeply disappointed that CMS did not heed the concerns voiced by CAHs and small rural hospitals that imposing this policy is not only unnecessary, but also will result in reduced access to care.

The AHA supports the Protecting Access to Rural Therapy Services Act (S. 257/H.R. 1611), which, among other things, would adopt a default standard of “general supervision” for these outpatient therapeutic services.

RECOVERY AUDIT CONTRACTORS (RACs)

Overzealous RACs are wasting resources by inundating hospitals with requests for records, requiring specialized staff to handle the heavy workload, and flooding the government appeals process with denials that are overturned more than two-thirds of the time. Rural hospitals are often particularly affected by overly aggressive RAC audits, because they may lack the human and financial resources to respond to ongoing records requests and to appeal perpetually inaccurate claims denials.

The AHA supports bipartisan legislation introduced in the U.S. House of Representatives, the Medicare Audit Improvement Act (H.R. 2156), which makes common-sense, fundamental changes to improve the program’s efficiency and fairness, including changing how RAC contractors are paid. Rather than the current 9-12.5 percent contingency fee RACs receive for each denied claim, the AHA recommends RACS be paid a flat fee, just as all other Medicare contractors.

According to AHA survey data, hospitals appeal 49 percent of their RAC denials and win 72 percent of the time at the third level of appeal, according to the Health and Human Services’ Office of Inspector General. But the appeals process also is heavily backlogged, taking up to

three years for a claim to work its way through the system. Yet hospitals are allowed only one year to rebill any claim.

RURAL COMMUNITY HOSPITAL (RCH) DEMONSTRATION

The Medicare RCH Demonstration Program was established under the Medicare Prescription Drug, Improvement and Modernization Act, and further extended in 2010 under the Affordable Care Act (ACA). The demonstration allows 30 rural community hospitals to test the feasibility of cost-based reimbursement for small rural hospitals that are too large to be CAHs. Currently, 23 hospitals participate in the demonstration.

The AHA supports the bipartisan Rural Community Hospital Demonstration Extension Act (S. 332/H.R. 663), which extends the program, in its current form, for five years. By extending the demonstration for five more years, this legislation will ensure that these hospitals may continue to provide services rural communities need.

EXTENDERS

The AHA applauds Congress for passing the Medicare Access and Chip Reauthorization Act of 2015 (MACRA), which temporarily extended several important programs for rural hospitals, including the:

- Medicare-Dependent Hospital program (extended until October 1, 2017);
- Enhanced adjustment for certain low-volume hospitals (extended until October 1, 2017);
- Ambulance add-on payments for ground ambulance services and super-rural areas (extended until January 1, 2018);
- Therapy cap exceptions process until (extended until January 1, 2018); and
- Medicare home health rural add-on until January 1, 2018.

The MACRA, which is now current law, provided short-term certainty for several important programs; however, more needs to be done. AHA-supported, bipartisan, bicameral legislation has been introduced this Congress to make each of these extensions permanent.

Medicare-Dependent Hospital (MDH) Program

The network of providers that serves rural Americans is fragile and more dependent on Medicare revenue because of the high percentage of Medicare beneficiaries who live in rural areas. Additionally, rural residents on average tend to be older, have lower incomes and suffer from higher rates of chronic illness than their urban counterparts. This greater dependence on Medicare may make certain rural hospitals more financially vulnerable to prospective payment.

To reduce this risk and support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges, Congress established the MDH program in 1987. The approximately 200 MDHs are paid for inpatient services the sum of their prospective payment system (PPS) rate plus three-quarters of the amount by which their cost per discharge exceeds the PPS rate. These payments allow MDHs greater financial stability and leave them better able to serve their communities. The MDH program will expire on October 1, 2017

The AHA strongly encourages Congress to pass the Rural Hospital Access Act (S. 332/H.R. 663), bipartisan legislation to permanently extend the enhanced low-volume adjustment payment and the MDH program.

Low-Volume Adjustment

The ACA improved the then low-volume adjustment for fiscal years (FY) 2011 and 2012. For these years, a low-volume hospital was defined as one that was more than 15 road miles (rather than 35 miles) from another comparable hospital and had up to 1,600 Medicare discharges (rather than 800 total discharges). An add-on payment was given to qualifying hospitals, ranging from 25 percent for hospitals with fewer than 200 Medicare discharges to no adjustment for hospitals with more than 1,600 Medicare discharges.

This enhanced low-volume adjustment was extended by Congress in several subsequent years. Over 500 hospitals received the low-volume adjustment in FY 2013.

Medicare seeks to pay efficient providers their costs of furnishing services. However, certain factors beyond providers' control can affect these costs. Patient volume is one such factor and is particularly relevant in small and isolated communities where providers frequently cannot achieve the economies of scale possible for their larger counterparts. Although a low-volume adjustment had existed in the inpatient PPS prior to FY 2011, CMS had defined the eligibility criteria so narrowly that only two to three hospitals qualified each year.

The improved low-volume adjustment in the ACA better accounts for the relationship between cost and volume, helps level the playing field for low-volume providers, and sustains and improves access to care in rural areas. This program expires October 1, 2017.

The AHA strongly encourages Congress to pass the Rural Hospital Access Act (S. 332/H.R. 663), bipartisan legislation to permanently extend the enhanced low-volume adjustment payment and the MDH program.

Ambulance Add-On Payments

Small patient volumes and long distances put tremendous financial strain on ambulance providers in rural areas. To help alleviate this situation and ensure access to ambulances for patients in rural areas, the Medicare Prescription Drug, Improvement, and Modernization Act increased payments by 2 percent for rural ground ambulance services and included a super rural payment for counties are in the lowest 25 percent in population density. Congress, in the Medicare Improvements for Patients and Providers Act (MIPPA), raised this adjustment to 3 percent for rural ambulance providers. Most recently, Congress extended these adjustments until January 1, 2018.

Congress appropriately decided that these additional rural payments were necessary and important because rural ambulance providers incur higher per-trip costs because of longer travel distances and fewer transports of patients. These provisions ensure that ambulance services are more appropriately reimbursed and that beneficiaries in rural and super rural areas will have access to emergency transport services.

The AHA supports the bipartisan Medicare Ambulance Access, Fraud Prevention and Reform Act (S. 377/H.R. 745), which would permanently extend the ambulance add-on payment adjustment.

TELEHEALTH

Telehealth increasingly is vital to our health care delivery system, enabling health care providers to connect with patients and consulting practitioners across vast distances. Hospitals are embracing the use of telehealth technologies because they offer benefits such as virtual consultations with distant specialists, the ability to perform high-tech monitoring without requiring patients to leave their homes, and less expensive and more convenient care options for patients. According to AHA survey data, in 2013, 52 percent of hospitals used telehealth and another 10 percent were beginning the process of implementing telehealth services.ⁱ

Approximately 20 percent of Americans live in rural areas where many do not have easy access to primary care or specialist services. The availability of telehealth services to these areas facilitates greater access to care by eliminating the need to travel long distances to see a qualified health care provider. Telehealth also can fill gaps in subspecialist care. Telepharmacy is another way to offer patients the convenience of remote drug therapy monitoring, authorizing for prescriptions, patient counseling and monitoring patients' compliance with prescriptions. With a nationwide shortage of psychiatrists, telepsychiatry can assist patients in need of behavioral health services who may otherwise have to drive hours to see mental health providers. Telepsychiatry services allow psychiatrists to speak to and evaluate patients in need of mental health services through videoconferencing.

Rural and critical access hospitals are often in need of critical care clinicians to diagnose, manage, stabilize and make transfer decisions concerning their most complex patients. Tele-ICU programs can help hospitals supplement clinician staffing of their ICU beds. In addition to improving access, patients are increasingly expecting levels of convenience in health care similar to what is available in the retail and banking sectors.ⁱⁱ Telehealth, regardless of geographic location, can foster a patient's ability to connect with a primary care physician or health system on a more flexible basis and often without an in-person visit. Patients are able to receive services at a distance by using secure online video services or through secure email, often with the added benefit of reducing travel to health care facilities. The AHA urges to committee to provide funding to expand these types of telehealth opportunities.

FUNDING FOR RURAL PROGRAMS

As the committee deliberates on funding for programs within the Departments of Labor, Health and Human Services (HHS), Education and Related Agencies for FY 2016, the AHA urges you to consider the potential effect your committee's decisions will have on rural hospitals' ability to meet the many challenges facing them – such as workforce shortages, maintaining emergency readiness, coordinating care for the chronically ill and facilitating information technology to improve safety and quality of care.

While we recognize the fiscal constraints imposed upon the committee, we ask you to give strong and favorable funding consideration to the following rural health care programs, which have proven successful in improving access to quality health care. They have served to greatly improve the health of our citizens and we ask that you make funding these programs a priority in your FY 2016 appropriations measure

- **Health Professions Programs.** An adequate, diverse and well-distributed supply of health care professionals, including allied health care workers, is indispensable to our nation's health care infrastructure. Health professions programs help address problems associated with maintaining primary care providers in rural areas. These programs also support recruitment of individuals into allied health professions. Our nation must maintain a vibrant workforce in the educational pipeline. Without decisive intervention, workforce shortages threaten hospitals' ability to care for patients and communities.
- **National Health Service Corps (NHSC).** The NHSC awards scholarships to health professions students and assists graduates of health professions programs with loan repayment in return for an obligation to provide health care services in underserved rural and urban areas. **The AHA supports maintaining investments in the NHSC.**
- **Rural Health Programs**
Rural Health Programs, such as the Medicare Rural Hospital Flexibility Grant Program, Rural Health Outreach and Network Development, State Offices of Rural Health, Rural Telehealth, Rural Policy Development, and other health care programs are vital to ensuring that needed services remain available in America's rural communities. The president's FY 2016 budget proposes to cut rural health programs by \$20 million to rural programs. **The AHA urges the subcommittee to reject efforts to cut funding below current levels for these programs.**

CONCLUSION

The nation's nearly 2,000 rural community hospitals frequently serve as an anchor for their region's health-related services, providing the structural and financial backbone for physician practice groups, health clinics and post-acute and long-term care services. In addition, these hospitals often provide essential, related services such as social work and other types of community outreach. Rural hospitals face additional challenges due to their often remote geographic location, small size, limited workforce and constrained financial resources.

The AHA urges the subcommittee to take action on the aforementioned issues to ensure access to health care services in rural communities.

ⁱ AHA Annual Survey, Health Information Technology Supplement (2013).

ⁱⁱ PricewaterhouseCoopers Health Research Institute. New Health Economy (April 2014).