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Statement

of the

American Hospital Association

before the

Subcommittee on Health

of the

Committee on Ways and Means

of the

U.S. House of Representatives

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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 comments regarding actions Congress can take to ensure accessible, affordable health care services are available in rural areas, and to address rural health care disparities created by Medicare regulations. 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 the 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 Additionally, burdensome, duplicative and frequently outdated federal regulations and policies place consistent strain on the ability of rural hospitals to keep their doors open and provide needed health care services.

Hospitals and health systems are transforming care delivery and adapting to a new environment that includes rapid adoption of health information technology (IT), increased pressure on health care spending, a growing abundance of non-traditional and retail health care providers and rising consumerism. While these challenges confront all hospitals and health systems today, the need to maintain a health care presence may be particularly acute among hospitals in rural communities and urban areas. As a result, the AHA is creating a task force to examine ways in which hospitals can help ensure access to health care services in vulnerable rural and urban communities. Rural

payment policy issues are of critical importance to our member hospitals and the communities they serve.

The AHA urges Congress to take action on the issues discussed below to provide relief from harmful federal regulations and policies and protect important programs for America's rural hospitals.

The 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

In December 2014, Congress enacted the bipartisan H.R. 4067, which extended the delay in enforcement of an unreasonable and inflexible direct supervision rule for outpatient therapeutic services at CAHs and other small, rural hospitals throughout calendar year (CY) 2014. However, with the law's expiration on Jan. 1, CMS removed its moratorium on Medicare contractors enforcing its direct supervision policies. 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 direct supervision policy is not only unnecessary, but will result in reduced access to care in CAHs and small rural hospitals with 100 or fewer beds.

The AHA supports bipartisan legislation (H.R. 2878/S. 1461) to extend through CY 2015 the enforcement delay on direct supervision requirements for outpatient therapeutic services provided in CAHs and rural prospective payment system (PPS) hospitals with 100 or fewer beds. In addition, to provide a permanent solution to this short-sighted policy, 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), that would make 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 like all other Medicare contractors.

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 tests 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. 607/H.R. 672), which would extend the program, in its current form, for five years. By extending the demonstration, this legislation would 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 (MDH) program (extended until Oct. 1, 2017);
- Enhanced adjustment for certain low-volume hospitals (extended until Oct. 1, 2017);
- Ambulance add-on payments for ground ambulance services and super-rural areas (extended until Jan. 1, 2018);
- Therapy cap exceptions process until (extended until Jan. 1, 2018); and
- Medicare home health rural add-on (extended until Jan. 1, 2018).

The MACRA 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.

MDH. Program. The network of providers that serve 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 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 expires Oct. 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 MDH program and the enhanced low-volume adjustment payment.

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. More than 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 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 Oct. 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 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 Jan. 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.

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.

Medicare's policies for coverage and payment for telehealth services lag behind other payers due to the program's restrictive statutes and regulations, limiting the geographic and practice settings in which beneficiaries may receive services, as well as the types of services that may be provided via telehealth and the types of technology that may be used.

Through the annual physician fee schedule (PFS) rule, CMS approves new Medicare telehealth services on a case-by-case basis by individual Current Procedural Terminology (CPT) or the Healthcare Common Procedure Coding System (HCPCS) code. In 2015, only 75 individual service codes out of more than 10,000 physician services covered through the Medicare PFS are approved for payment when delivered via telehealth.[i] This number includes seven codes CMS added in the final 2015 PFS rule. Medicare telehealth coverage also is limited with respect to approved technologies. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) provided that Medicare may cover telehealth services furnished only via a real-time video-and-voice telecommunications system. Except in Hawaii and Alaska, Medicare may not pay for telehealth services provided via store-and-forward technologies. And, despite

growing evidence of the benefits of remote monitoring technologies for quality of care and improved outcomes for patients, remote monitoring services are not covered by Medicare.[ii]

As private insurers, Medicare Advantage plans have more flexibility and are beginning to provide telehealth benefits that are not covered under Medicare fee-for-service rules. Although this is a positive step toward additional access to telehealth services for Medicare beneficiaries, it leaves the 70 percent of Medicare beneficiaries utilizing fee-for-service with limited access to these technological advances, unless the current restrictions on geography, practice setting, covered services and approved technologies are lifted. CMS could make progress in expanding telehealth by approving additional telehealth services for Medicare coverage; however, only Congress can lift the geographic and practice setting limitations and approve new technologies. Telehealth is an important component of delivery system reform.

CONCLUSION

The nation's nearly 2,000 rural community hospitals frequently serve as the 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 committee to take action on the aforementioned issues to ensure continued access to health care services in rural communities.

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[i] CY 2015 List of Services Payable under the Medicare Physician Fee Schedule when Furnished via Telehealth. http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.html

[ii] 42 U.S.C. 1395m(m)(1)