****TESTIMONY IS EMBARGOED UNTIL START OF THE HEARING: 10 AM, JULY 28, 2015****

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AT 10:00 AM TUESDAY JULY 28, 2015***

Testimony of Shannon Sorensen, Chief Executive Officer
Brown County Hospital, Ainsworth, Nebraska on behalf of
Brown County Hospital and the Nebraska Hospital Association
House Committee on Ways and Means
Subcommittee on Health

July 28, 2015

Good morning, my name is Shannon Sorensen. I am the CEO of Brown County Hospital, a critical access hospital (CAH) located in north central Nebraska. I would like to thank Chairman Brady, Ranking Member McDermott, and the members of the House Ways and Means Subcommittee on Health for holding this hearing.

Approximately one in every six Americans lives in rural areas and depends on the hospital in their communities. Remote location, small size, limited workforce, physician shortages and often strained financial situations pose unique challenges for rural hospitals. Not only does our location, being over 150 miles from the nearest tertiary facility affect us, our patient mix being over 70% Medicare also makes us more reliant on public programs. Changes such as the "96 Hour Rule" often have significant and problematic consequences for rural providers.

Due to the great support of our local community, compared to many of my peers, our hospital's financial situation is stable, but we are particularly vulnerable to Medicare and Medicaid payment cuts. Furthermore, many of my colleagues are struggling. Currently 38% of CAHs have a negative operating margin. CAHs make up nearly 30% of acute care hospitals, but receive less than 5% of total Medicare payments to hospitals. CMS actually spends 2.5% less on rural beneficiaries than it does on urban beneficiaries. Unfortunately, the hospitals and communities in dire straits are too absorbed in their struggles to keep their doors open to reach out to their members of Congress or to come and testify like I am doing today. We are the communities and hospitals that most need your help.

96 Hour Rule. Recent CMS guidance, in relation to its two-midnight admissions policy, implies that the agency will begin enforcing a condition of payment for 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. If the provider cannot certify this, the hospital either must transfer the patient or face non-reimbursement. This requirement adds one more unnecessary burden on our rural facility, others like it and the Medicare beneficiaries who already must travel long distances for treatment. From the creation of the CAH designation until

late 2013 an annual average of 96 hour stays allowed CAHs flexibility within the regulatory framework set up for the designation. The new policy of strict enforcement of a per stay 96 hour cap creates unnecessary red-tape. Not only does it potentially limit access to health care by forcing rural beneficiaries to travel even farther for treatment, it may deter many from seeking necessary care, inconvenience patients and add travel costs to Medicare. This enforcement eliminates important flexibility to allow general surgical services well suited for our high quality local providers to be able to perform needed and necessary procedures. It also impedes rural providers in their ability to care for their patients. Having to focus on regulatory burdens interferes with the best judgment of physicians and other health care providers, placing them in a position where highly qualified local providers cannot provide care for their patients.

It is also important to note, that 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 those "96 hour plus" services and cause financial pressures that will severely affect our ability to operate. Ultimately, access to care for beneficiaries in rural communities will diminish.

CAHs in Nebraska and across the country support the Critical Access Hospital Relief Act (H.R. 169/S. 258), which would remove the 96 hour condition of payment. I am especially pleased to thank my representative, Congressman Smith, for introducing this important legislation. Rural facilities and providers face many challenges without the heavy hand of government. We must be given the flexibility to provide affordable and efficient health care.

Physician Supervision. Another burdensome regulation is the expansion of mandatory direct physician supervision. Physician supervision rules require a physician's presence and direct supervision over nearly all routine procedures administered in hospitals. While physician supervision requirements are less of a challenge for large hospitals, they can be very problematic in areas with few doctors. CAHs simply do not have the manpower and resources to abide by these arbitrary regulations. Nor does this regulation allow all of our licensed personnel to perform within the highest level of their scope of practice.

The Centers for Medicare and Medicaid Services (CMS) previously delayed enforcement of physician supervision for CAHs as did Congress through 2014. 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.

For 2015 and beyond, the agency requires a minimum of direct supervision for all outpatient therapeutic services furnished in small rural 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. CAHs and small rural hospitals are deeply disappointed that CMS did not heed their concerns that this policy will be difficult to implement, will reduce access and is clinically unnecessary. CAHs and small rural hospitals support:

- Adoption of a default standard of "general supervision" for outpatient therapeutic services, supplemented with a reasonable exceptions process with provider input to identify those specific procedures that require direct supervision;
- Assurance that, for CAHs, the definition of "direct supervision" is consistent with the CAH conditions of participation that allow a physician or non-physician practitioner to present within 30 minutes of being called; and
- Prohibiting enforcement of CMS's retroactive reinterpretation that the "direct supervision" requirements applied to services furnished since Jan. 1, 2001.

H.R. 170 delays the unnecessary and burdensome physician supervision regulations and requires CMS to study their impact. CAHs already face many unique challenges such as providing quality care with more limited resources, satisfying complicated administrative requirements with a smaller staff, complying with numerous federal regulations which limit the discretion of highly trained providers that provide lifesaving services to some of our most elderly rural populations.

Our community has one full-time primary care physician who is supported by two mid-level providers. With some of the regulatory burdens we face such as requiring only a physician to oversee cardiac rehab, or only a physician being able to order durable medical equipment, home health or hospice services, anytime our lone physician is not on our campus, significant patient needs have to wait. Our very capable mid-levels are able to provide the needed services in our emergency room and throughout the hospital. It makes no sense to prevent them from being able to do the same for cardiac rehabilitation outpatient therapeutic services.

Electronic Health Records (EHRs) and Meaningful Use. CAHS and small rural hospitals continue to be concerned about the impact of the EHR incentive program on CAHs and small rural providers. Specifically, this program should close, not widen, the existing digital divide. Yet, CMS data indicates that CAHs, in particular, have found it more challenging to meet meaningful use requirements than their urban counterparts, partly due to limited vendor choice and capacity. While the impact of the incentive has been a positive experience for us, we are struggling with an older population which has less access to computers; consequently making it difficult to meet Meaningful Use requirements for the patient portal.

Two-Midnight/Patient Status. Whether a patient is admitted to a hospital as an inpatient or treated under outpatient observation status has implications for Medicare payment and Medicare beneficiary coverage. Traditionally, the decision to admit a patient as an inpatient has been up to the judgment of the treating physician, with oversight from the hospital and input from the patient. CMS recovery audit contractors (RACs) and Medicare administrative contractors (MACs) have repeatedly second guessed physician judgment, declaring that some patients who were admitted should not have been. This has, in turn, created ambiguity over who decides what constitutes an appropriate admission and what the criteria are for making such a determination.

In an effort to clarify that ambiguity, CMS addressed the issue of patient status in the FY 2014 inpatient PPS final rule and finalized its "two-midnight" policy whereby the agency will generally consider hospital admissions spanning two midnights as appropriate for payment under

the inpatient PPS. In contrast, hospital stays of less than two midnights will generally be considered outpatient cases, regardless of clinical severity. Unfortunately, that effort added more pressure to an already stressed financial situation for most CAHs. In addition, it creates more expenses for our Medicare beneficiaries who are already on fixed incomes.

Recovery Audit Contractors (RACs). The RAC program needs to be reformed to realign the financial incentives that drive RACs to inappropriately deny claims. Payment structure for RACs should be changed from the current 9-12.5 percent commission on every denied claim to a retainer that does not incent them to deny claims. To ensure auditing accuracy, RACs should be assessed financial penalties for poor performance. The one-year timely filing limit to rebill outpatient (Part B) claims should be eliminated, which would allow hospitals to request outpatient payment for certain denied inpatient claims. RACs should only be able to consider the medical information that is available when a patient is seen by his or her physician when determining whether an inpatient stay was necessary. Our staff spend many laborious hours submitting appeals with additional supporting documentation to defend claims that were clearly appropriate and necessary.

Conclusion. Medicare provides vital funding for many rural payment programs including the critical access hospital (CAH), sole community hospital (SCH), Medicare-dependent hospital (MDH) and rural referral center (RRC) programs. This subcommittee and Congress has the power to ensure that Americans living in rural areas who depend on the hospital in their communities will have access to the appropriate care they need by removing the heavy hand of government. Again, I want to thank Congressman Smith for introducing H.R. 169. We appreciate the Subcommittee's interest in this matter and urge it and Congress to support this much needed legislation. Thank you for your time and listening to our impact.