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Testimony of the National Rural Health Association (NRHA)
Concerning HRSA's Programs Impacting Rural Health
Submitted for the Record to the U.S. House of Representatives
Subcommittee on Health Committee on Energy and Commerce
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The National Rural Health Association (NRHA) is pleased to provide the U.S. House of Representatives Committee on Energy and Commerce, Subcommittee on Health with a statement for the record on rural provisions that have a significant impact on the health of rural Americans and should be extended.

NRHA is a national nonprofit membership organization with a diverse collection of 21,000 individuals and organizations that 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 research, communications, and education.

NRHA unequivocally supports a group of rural health provisions that assist rural communities in maintaining and building a strong health care delivery system into the future. Most importantly, these programs help increase the capacity of the rural health care delivery system and true safety net providers. Without these provisions, many rural health facilities will be forced to reduce services and staff, or close. The expiration of other extenders, such as outpatient transitional outpatient payments, or OPPS "hold harmless" payments, has already caused some Sole Community Hospitals to reduce staff and services.

Rural doctors, hospitals, and EMS providers across the nation will experience dramatic Medicare reductions if these programs are allowed to expire, putting Medicare beneficiaries' access to critical primary, emergency and hospital care in severe jeopardy. NRHA asks that the Medicare Dependent Hospital (MDH) designation, Low-Volume Hospital (LVH) adjustment, the current rural and "super-rural" ambulance payments, and the rural work floor in the Geographic Practice Cost Index (GPCI) be extended.

The MDH designation is designed to help rural hospitals that struggle to maintain financial stability under Medicare's fee schedule because of their small size and the large share of Medicare beneficiaries who make up their patient base. MDH's financial margins would degrade considerably without the designation's accompanying payment methodology.

Similarly, the LVH adjustment is designed to help isolated facilities that treat a very low number of beneficiaries. Congress created this program to help rural hospitals offset the higher incremental costs of providing care for seniors. The adjuster assists hospitals with certain fixed costs and other operating costs that low-volume hospitals struggle to meet because of a lack of economies of scale.

Equitable Medicare payments to rural hospitals keep hospital doors open and protect rural patients, the tax payer and rural communities. Rural care is quality primary care and is reimbursed at lower rates than specialty care which is most likely the care received in a non-rural setting. Eliminating rural hospital services or closing rural hospital doors only shifts Medicare costs to more expensive care. The loss of the MDH and LVH programs means rural hospitals will lose millions of dollars.

Cuts to rural hospitals hurt rural economies. A closed rural hospital can mean as much as a 20 percent loss of revenue in the local economy, 4 percent per capita drop in income, and a 2 percent increase in the local unemployment rate. Even if a hospital doesn't close, reduced services compromise local access to care and job loss in the community.

Another critical program is the current rural ambulance payments which help sustain isolated rural EMS providers who have long transport distances that are not adequately paid for under the current reimbursement structure. These payments sustain incredibly important rural first responders and must be extended.

Lastly, the program designed to deliver payment equity to rural physicians and other providers paid under the physician fee schedule, commonly known as the "GPCI Work Floor," should also be extended. This limits the geographic payment reductions that Medicare is allowed to make to providers based on their practice location. The continuation of this policy is necessary to combat the provider shortage crisis in rural America.

The above provisions are congressionally established rural payment programs that are cost-effective and targeted that help maintain access to care for millions of rural patients and financial stability for thousands of rural providers across the country. While these programs are critical to the stability of the rural health care delivery system, they also provide exceptional value to the taxpayer. Recent data shows that the federal government spends 3.7% less per rural Medicare beneficiary than they do on urban beneficiaries.

The National Rural Health Association appreciates the opportunity to provide our recommendations to the Subcommittee. These programs are critical to the rural health delivery system and help maintain access to high quality care in rural communities. We greatly appreciate the support of the Subcommittee and look forward to working with Members of the Subcommittee to continue making these important investments in rural health.