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Chairman Blunt, Ranking Member Murray and Members of the Subcommittee, thank you for the opportunity to discuss current challenges facing rural health care providers. According to the Sheps Center at the University of North Carolina, 50 rural hospitals have closed since January 2010. My two hospitals, Citizens Memorial Hospital in Bolivar, Missouri (CMH), and Lake Regional Health System in Osage Beach, Missouri (Lake Regional), are striving not to be included in that statistic. A hospital closure means not just the loss of access to health care for a community. As a rural hospital is frequently the largest employer in the community, its closure represents an economic blow as well. The long-term impact is also significant, as businesses are reluctant to locate in a community without a hospital.

Legislation in recent years requires hospitals to improve quality and patient satisfaction, while receiving less Medicare reimbursement. While all hospitals feel the impact of cuts in Medicare reimbursement, rural hospitals are particularly susceptible to these cuts. Before describing several key challenges rural hospitals face that make them more vulnerable to Medicare cuts, I want to talk about what's working in rural health care.

Rural hospitals provide quality care close to home. And, in many cases Medicare spends less on this care in rural hospitals than in urban hospitals. Looking at the most recent data CMS reports on Medicare Spending per Beneficiary, CMH has a ratio of 0.93, while Lake Regional has a ratio of 0.92. Both of these ratios are well below the national average, meaning Medicare spends less on care initiated at these hospitals than at the average hospital. CMH is also exploring the possibility of joining an accountable care organization (ACO) under the CMS ACO Investment Model recently announced. This program offers funds to assist with the large investment required to start an ACO.

Rural hospitals provide personalized care, and focus on the patient's needs. Both CMH and Lake Regional have certified our primary care clinics as patient centered

medical homes, which focus on the patient's health, offering care coordination, education, and assistance with self-management of chronic conditions. CMH is participating in the Missouri Medicaid medical home program, with over 1,100 Medicaid patients receiving assistance in managing their chronic health conditions. We have seen measurable improvements in health status since we began offering this program.

Rural hospitals try to find solutions. Sac-Osage Hospital in Osceola, Missouri, 35 miles north of Bolivar, closed on November 1, 2014, due to declining patient volumes and lack of financial resources. Rather than leaving that community without local health care, CMH took over the operations of the ambulance service, primary care clinic, and retail pharmacy, the only pharmacy in Osceola, and operates an outpatient rehabilitation clinic. Our primary care clinic includes walk-in clinic services 12 hours per day, 7 days per week. While the loss of jobs, inpatient beds, and a 24-hour emergency department are all significant, we are trying to find the most feasible solution to make sure healthcare is available to the residents of Osceola and the surrounding area.

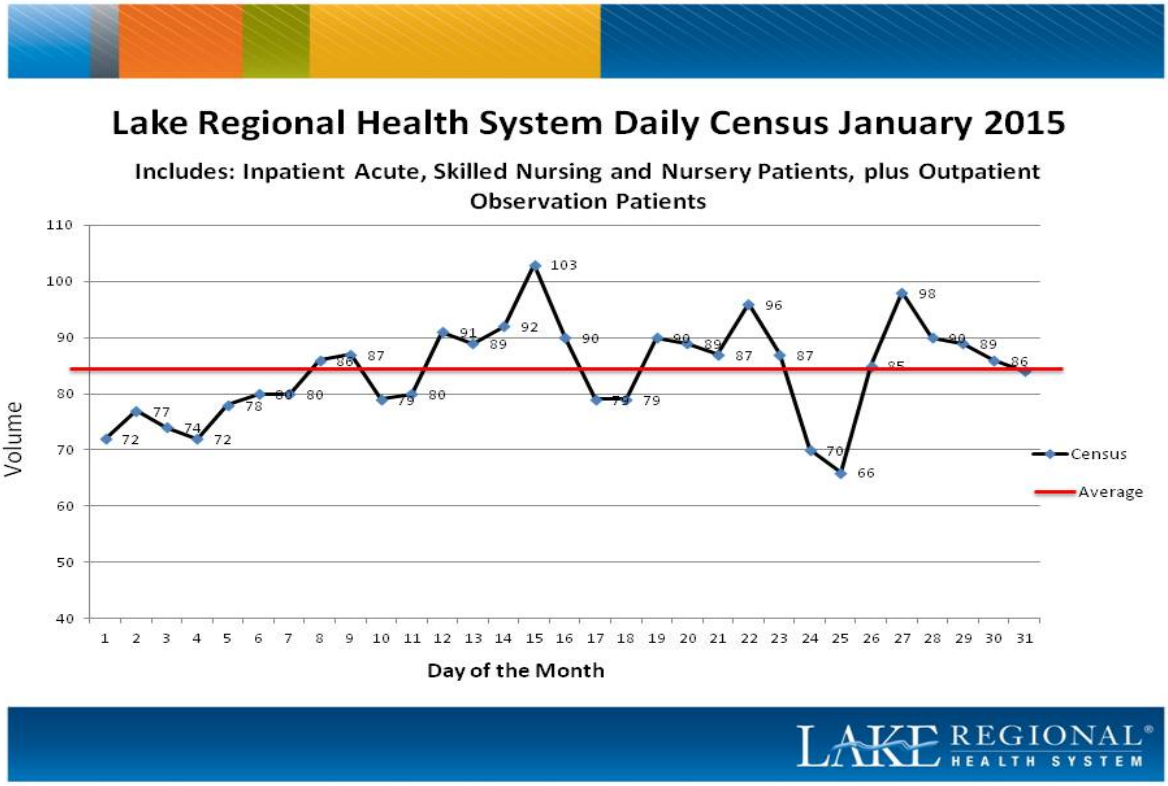
But rural hospitals do face many challenges. The four challenges I would like to highlight regarding rural hospitals are patient volumes, Medicare utilization, the cumulative impact of Medicare reimbursement cuts and the increasingly complex regulatory environment in which we operate.

Patient Volumes

Medicare's prospective payment systems generally rely on averages in setting rates applicable to hospitals, with special adjustments for different classifications of hospitals. Rural hospitals are generally smaller than urban hospitals and have lower patient volumes. This creates challenges as we spread fixed costs over lower volumes, trying to keep costs reasonably in line with PPS payment rates. We also have to manage our workforce on a day to day basis as patient volumes fluctuate.

Looking at the past 12 months of data, CMH's lowest average daily census was in July 2014, with an average of 26 patients. Our highest average census occurred in February 2015, with an average of 34 patients, 31% higher than the July average. Likewise, Lake Regional had an average daily census of only 39 patients in May 2014, increasing by 49% to an average daily census of 58 patients in January 2015. To put this in more perspective, the following graph shows Lake Regional's daily census for January 2015, including traditional inpatients plus skilled nursing, nursery and

outpatient observation patients using inpatient beds. The graph shows the month started with a census of 72, peaked on January 15th with a census of 103 patients and hit a low of 66 patients on January 25th. The census rebounded rapidly to a census of 98 patients two days later and we ended the month with 86 patients.



The significant volume fluctuations shown in this graph make it extremely difficult to manage our workforce. When possible, we try to manage staffing levels based on the daily census, but if we reduce staff hours too often, we risk employee dissatisfaction. We experience patient care staff leaving the area to work at urban facilities with more stable work hours and patient volumes, and frequently higher pay rates.

Medicare Utilization

Rural hospitals generally have significantly higher Medicare utilization than urban hospitals. The American Hospital Association provided the table on the next page, showing Medicare and Medicaid discharges for urban hospitals compared to several subsets of rural hospitals.

FY13 Medicare and Medicaid Discharges by Hospital Type

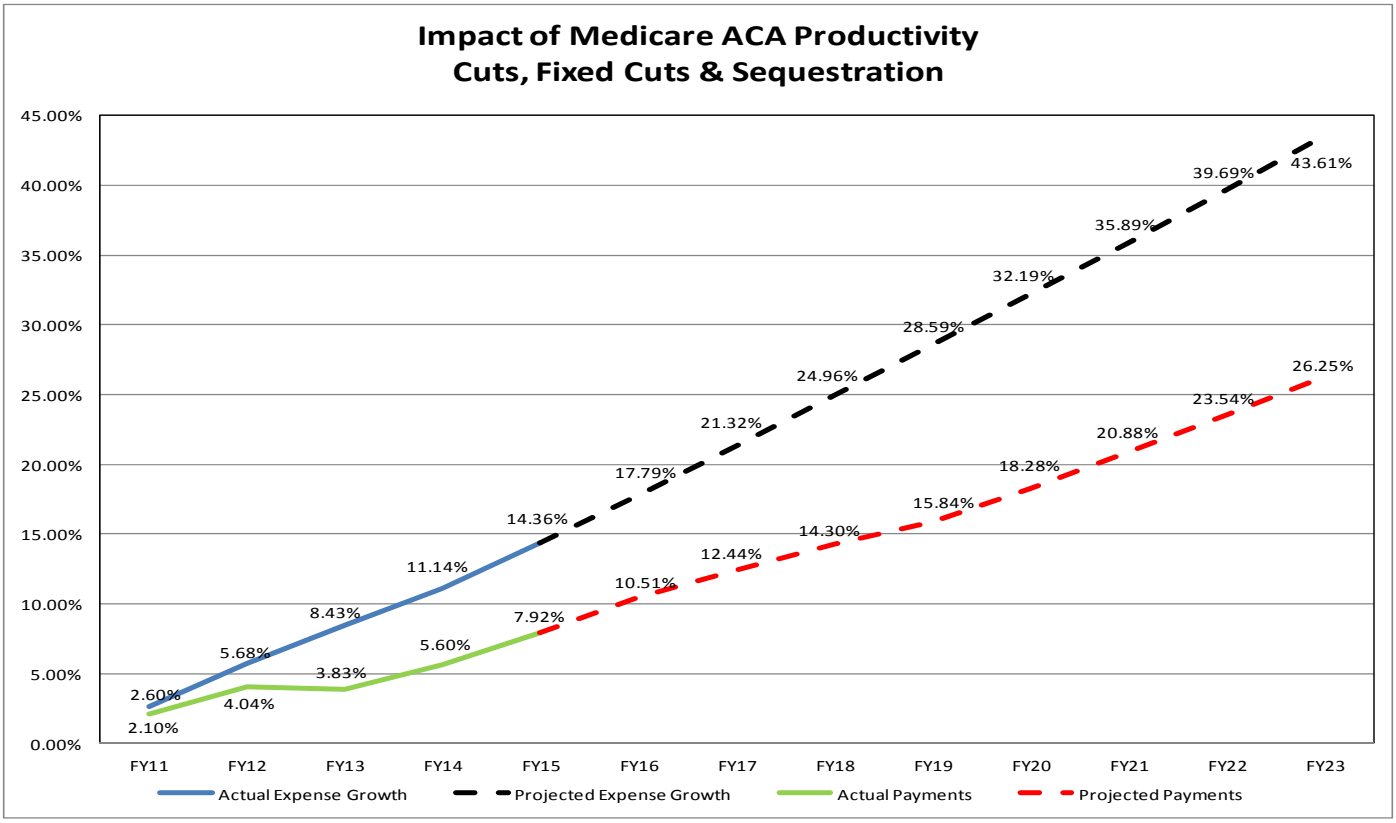
	Number of Hospitals	Medicare Discharges	Medicare Discharge Percent	Medicaid Discharges	Medicaid Discharge Percent	Total Discharges
All Hospitals	4,683	9,583,416	31.5%	3,872,807	12.7%	30,425,687
Urban	2,565	8,035,725	30.0%	3,354,041	12.5%	26,786,587
All Rural	2,118	1,547,691	42.5%	518,766	14.3%	3,639,100
CAH	1,202	298,666	49.4%	64,825	10.7%	604,217
MDH	192	171,974	48.5%	50,784	14.3%	354,279
SCH	377	533,742	41.4%	182,658	14.2%	1,289,173
Other Rural	347	543,309	39.0%	220,499	15.8%	1,391,431

Source: FY2013 Medicare cost report data from CMS HCRIS file, 1st quarter 2015 update. Note the 'CAH' category includes rural CAHs only – urban CAHs are in the urban category. The 'Other Rural' category includes only rural hospitals with no special payment status (i.e., non-SCH, non-MDH, non-CAH).

The table shows urban hospitals average only 30% Medicare utilization, while rural hospitals average 42.5% Medicare utilization. Every classification of rural hospitals averages significantly higher Medicare utilization than urban hospitals. In fact, rural hospitals average higher Medicaid utilization as well. During this same time period, CMH had 38.7% Medicare utilization while Lake Regional had 47.0% Medicare utilization. The challenge of such high Medicare utilization is that cuts to the Medicare program represent a higher percent of our budget. And, because of the high Medicare utilization, we have less commercial and managed care volume available to subsidize the Medicare losses.

Cumulative Impact of Medicare Reimbursement Cuts

Lower overall volumes and higher Medicare utilization make it particularly difficult for PPS hospitals to adjust to the ongoing and increasing Medicare cuts. The largest ongoing cuts affecting PPS hospitals are the productivity and fixed cuts under the Affordable Care Act, as well as the 2% sequestration cut that started April 1, 2013. The graph on the next page compares actual and projected growth in costs and payments for PPS hospitals from FY2011 through FY2023. The top line shows actual and projected growth in costs using CMS projected market-basket inflation factors. The bottom line shows these market-basket inflation factors, reduced by required productivity and fixed cuts under the ACA, and sequestration cuts under the Budget Control Act, and thus represents the expected growth in Medicare payments over this same time period.



The widening gap between the lines demonstrates the increasing pressure PPS hospitals will feel to reduce expenses, or increase charges to other third parties, to make up for the escalating Medicare cuts. The gap grows annually, and is expected to exceed 17% by 2023. The cumulative impact of these cuts over this 13-year period is estimated to total approximately $43 million for CMH and approximately $78 million for Lake Regional.

Note that the cuts reflected in the graph represent only a portion of the cuts PPS hospitals are experiencing or soon will experience under the ACA and other legislation. Other cuts or funding lapses not measured in the graph include the following:

- Effective for fiscal years beginning on or after 10/1/12, Medicare bad debts are reimbursed at 65% of the actual bad debt
- Effective 1/1/13, Medicare outpatient hold harmless reimbursement for rural hospitals was allowed to expire
- Effective 10/1/13, cuts in Medicare disproportionate share payments began
- Effective 10/1/13, CMS implemented a 0.2% Medicare cut because they felt the 2-midnight rule would result in more inpatient admissions, although it hasn't

- Effective 1/1/14, sole community hospitals experienced a significant reduction in TRICARE payments for inpatient services
- Effective 10/1/14, a 1% Medicare cut for the lowest quartile of PPS hospitals with high rates of hospital-acquired conditions
- Effective 10/1/17, cuts in Medicaid disproportionate share payments will begin which will total $43 billion by 2025
- Effective 10/1/17, the Medicare-dependent hospital and low-volume hospital payment provisions recently extended in HR 2 will be at risk of expiring

Beyond all of these legislative and regulatory cuts and funding lapses, PPS hospitals are also experiencing the end of the cash flow cycle under the electronic health records meaningful use program. The meaningful use program generated $6 to $8 million in funding for PPS hospitals the size of CMH and Lake Regional, funds that were vital to reimburse us for the heavy investments made on meaningful use technology. However, those funds helped mask the impact of the ACA and other cuts that took effect during the past few years and now that meaningful use funds are diminishing, the full impact of other cuts is being felt. And, hospitals that do not maintain their status as meaningful users risk incurring penalties under the meaningful use program.

Finally, the recovery audit contractor (RAC) program has consumed extensive hospital resources to manage those requests in recent years and appeal the excessive denials issued by the RACs. Although activity has diminished while CMS works on the new round of RAC contracts, hospitals continue to deal with a huge backlog of RAC appeals. Lake Regional currently has over 500 claims in the RAC appeals pipeline, with approximately $3.5 million in reimbursement tied up in this process. There are a number of other similar programs operated by Medicare, Medicaid and other payers. At CMH, for example, we have experienced 17 denials by Humana's Medicare HMO plan where the admission was preauthorized, but subsequently denied several months after the patient was discharged.

Increasingly Complex Regulatory Environment

Those not involved in day-to-day hospital operations may assume a PPS hospital learns to operate under a prospective payment system and ongoing operations are not that difficult. The reality is that a PPS hospital must learn multiple payment systems to ensure accurate payment for services to Medicare patients. There may also be significant variations in payment systems for Medicare managed care plans, state Medicaid plans, Medicaid managed care plans and other payers. For example, CMH

must maintain medical records and learn the billing requirements to ensure compliance with the following Medicare prospective payment systems and fee schedules:

- Inpatient acute care PPS
- Inpatient psychiatric PPS
- Inpatient skilled nursing PPS
- Outpatient PPS
- Home health PPS
- Hospice PPS
- Physician fee schedule
- Outpatient rehabilitation fee schedule
- Outpatient laboratory fee schedule, for tests not bundled under outpatient PPS
- Ambulance fee schedule
- Durable medical equipment fee schedule
- Pharmacy fee schedule

The value-based purchasing and other quality programs under the ACA and other legislation have increased the need for hospitals to maintain data on various patient indicators and ensure prompt reporting of the data. In fact, CMH has two full-time nurses spending substantially all of their time on quality reporting data collection and verification. Likewise, CMS changes billing and documentation requirements on a regular basis, making it essential hospitals monitor such developments to ensure we remain in compliance, and ensure we don't miss out on vital reimbursement for the services we render. A well-known example of such changes is the 2-midnight rule CMS implemented on October 1, 2013. CMS has also been implementing significant changes in the outpatient PPS as well, in particular bundling many laboratory tests into the PPS rate. These are just two examples of the ongoing changes in payment systems we must educate our staff about and ensure we implement compliantly.

Beyond the payment systems themselves, a new coding system takes effect October 1, 2015. While we understand the reason for the change to ICD-10, and have been training extensively for the change, this is one more significant change in our operations that must be implemented, with scarce funds available for the implementation.

Both of my hospitals were early adopters of electronic health records and have achieved Stage 2 status. However, with the funding drying up and the requirements continuing to advance, this has also become an administrative burden to keep up with the changes CMS implements.

The complex regulatory environment also affects our physicians. While recruiting physicians to rural areas is a longstanding problem, the complex environment of implementing electronic health records, ICD-10 and various quality reporting programs means most physicians are unwilling to practice in rural areas unless a hospital is willing to manage their practice and ensure income stability. In urban areas, independent physicians can join larger clinics with the expertise to manage these complex issues outside of a hospital. In rural areas, these large clinics do not exist, with the hospital taking on the role of managing clinic operations on behalf of most physicians.

The Future for Rural PPS Hospitals

With 50 hospitals closing since January 2010, Congress must act to prevent a further erosion in the availability of hospital services in rural America. We appreciate Congressional actions to protect the funding we receive. For example, HR 2, the Medicare Access and CHIP Reauthorization Act of 2015, eliminates the annual threat of a significant reduction in the Medicare physician fee schedule. The legislation also provides a 30-month extension in the Medicare low-volume and Medicare-dependent hospital programs, and extends several other rural programs. Finally, the legislation includes an additional 6-month delay preventing post-payment patient status reviews under the 2-midnight program. We greatly appreciate the support Congress has shown for these rural programs, as well as the delay in the 2-midnight patient status reviews.

For rural PPS hospitals to continue to survive, we need Congress to continue to support these rural reimbursement programs, in fact, making them permanent. Likewise, rural hospitals should be exempted from sequestration and any future cuts to Medicare programs. We also need continued support for programs such as the 340B drug discount program, a lifeline for hospitals such as CMH, which also saves money for the state of Missouri and the federal government.

Finally, grant funding or funding similar to meaningful use funds should be made available to rural hospitals to assist with the transition to ICD-10 and the larger transition of rural hospitals into future care delivery and payment models. This could include expansion and extension of programs such as the CMS ACO Investment Model mentioned previously, and federal funding for Medicare and Medicaid medical home programs.

Thank you for the opportunity to present this testimony today and I look forward to answering any questions you may have.