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AGING IN RURAL AMERICA: PRESERVING SENIORS' ACCESS TO HEALTHCARE

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BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

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CONTENTS

	Page
Opening Statement of Senator Gordon H. Smith	1
Opening Statement of Senator Elizabeth Dole	2
Opening Statement of Senator Ron Wyden	27

PANEL I

Statement of John Hammarlund, Regional Administrator, Region X, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, Seattle, WA	4
Statement of Tom Morris, Acting Associate Administrator, Office of Rural Health, Health Resources and Services Administration, U.S. Department of Health and Human Services, Washington, DC	16

PANEL II

Statement of Margaret Davidson, Board Member, National Association of Area Agencies on Aging, LaGrande, OR	34
Statement of Bill Finerfrock, Executive Director, National Association of Rural Health Clinics, Washington, DC	49
Statement of Scott Ekblad, Director, Oregon Office of Rural Health, Oregon Health and Science University, Portland, OR	60
Statement of Dennis Burke, President and CEO, Good Shepherd Medical Center, Hermiston, OR	69
Statement of Tim Size, Executive Director, Rural Wisconsin Health Cooperative, Sauk City, WI	78

APPENDIX

Prepared Statement of Senator Robert P. Casey, Jr.	99
Testimony of the American Academy of Physician Assistants	100

AGING IN RURAL AMERICA: PRESERVING SENIORS' ACCESS TO HEALTHCARE

THURSDAY, JULY 31, 2008

U.S. SENATE
SPECIAL COMMITTEE ON AGING
Washington, DC.

The committee met, pursuant to notice, at 10:37 a.m. in room SD–106, Dirksen Senate Office Building (Hon. Gordon H. Smith) presiding.

Present: Senators Smith [presiding], Wyden, and Dole.

OPENING STATEMENT OF SENATOR GORDON H. SMITH

Senator SMITH. Good morning, ladies and gentlemen. We thank you all for being here today for this very important hearing as it relates to healthcare for elder Americans who live in rural places.

I particularly want to thank Margaret Davidson, Scott Ekblad, and Dennis Burke for flying across the country from Oregon to be with us today. Each of them has invaluable knowledge to share with us about caring for some of the 60 million Americans living in rural areas of the country.

As each of our witnesses can attest, access to healthcare and support services in rural areas remains a great challenge for our Nation. Today's hearing will examine many of the programs that are vital to our seniors' ability to remain healthy and independent in their rural communities. Along with examining these programs, we will also highlight some of the new and innovative approaches used to increase accessibility to meet rural healthcare needs.

As some of you know, I am from a rural place as well. I am from the community of Pendleton, OR. I personally understand the difficulties that can arise when one lives in a remote region. Large geographic areas, small numbers of patients, and difficulties in recruiting, training, and retaining healthcare providers are just some of the problems that lead to reduced healthcare access.

Often, rural healthcare clinics or small rural hospitals are a community's only resource for healthcare services. Further, individuals living in rural areas disproportionately rely on Medicare, Medicaid, and the State Children's Health Insurance Program for coverage.

In my home State of Oregon, the Critical Access Hospital Network ensures that hospital care is available in small communities. To support these hospitals, I have introduced a bill with my colleague, Senator Wyden, that would give critical access hospitals a layer of flexibility by allowing them to serve patients in times of high need without losing essential Medicare funding. When the flu seasons strikes a community, we should not force our rural hos-

pitals to divert their patients for fear of losing their critical access hospital status.

Further, Oregon is home to over 50 rural health clinics whose sole mission is to provide care for Medicaid and Medicare patients living in rural communities. Several weeks ago, my State's primary care office notified me of a proposed rule that could adversely affect many rural health clinics located in rural places throughout the country.

To that end, Senator Wyden and I introduced legislation that would ensure Federal health programs use consistent standards in determining rural health clinic status. The change will protect these clinics from funding losses.

Additionally, the recent and dramatic increase in gas and food prices has placed a huge burden on local programs that support seniors through the 650 area agencies on aging. These agencies provide vital home-delivered meals, support senior centers, provide in-home help to the daily activities, and support family caregivers. They work to ensure that seniors can live in their homes safely and help alert the community when there is a problem.

I look forward to continuing to work closely with my colleague, Senator Lincoln of Arkansas, to ensure that our senior network has the funding it needs. Every time I return to Oregon, I hear about these issues and how the loss of our county timber payments exacerbates these problems.

Many Oregon counties are economically landlocked by Federal land. Their county budgets heavily rely on Federal timber receipts. As timber harvests dropped and the safety net expired, county funded healthcare programs have been put in peril. I continue to work to extend these payments to prevent entire communities from closing their doors to those in need.

As we discuss the challenges facing rural communities, it is important to keep in mind that by 2030 the number of older adults in the United States will nearly double. This happens to be as 78 million members of the baby boom generation begin turning 65 in the year 2011.

Our help and support systems, especially for those living in rural America, are lagging behind where we should be at this point in time. I hope that today's hearing will shine a light on the unique healthcare needs of those living in rural areas and on the innovative programs that strengthen and buildupon our rural healthcare delivery system.

Again, I thank all of our witnesses for coming today. We proceed with the blessing of Chairman Kohl, who is in a Judiciary Committee markup and will be in and out of this hearing, we expect.

With that, I turn to my colleague, Senator Dole of North Carolina.

OPENING STATEMENT OF SENATOR ELIZABETH DOLE

Senator DOLE. Thank you so much, Senator Smith, for holding this morning's hearing to discuss seniors' access to healthcare and support services in rural America. I would also like to thank today's panelists for joining us.

My home State of North Carolina has so many beautiful and desirable places to live, from our mountains to our coast, and for that

reason, a growing number of people are retiring to all parts of our State, including rural areas. At the same time, millions of North Carolina seniors have spent their entire lives in rural communities, many of whom are poor and medically underserved, with above-average rates of health problems such as cardiovascular disease, diabetes, and obesity. This is a real problem in North Carolina.

Access to high-quality healthcare and services is critical to our senior population, and we must ensure that rural communities have access to quality services. According to Jeff Spade, the Executive Director of the North Carolina Rural Health Center and Vice President of the North Carolina Hospital Association, there are 110 acute care hospitals in the State, 60 of which are rural hospitals serving 2.8 million residents in 61 of our 100 counties. This means that nearly one third of North Carolinians rely on rural healthcare providers.

Mr. Spade, in recent testimony, laid out key issues facing North Carolina rural hospitals. These include, one, financial instability, mostly due to dependence on Government payers and a lack of commercially insured residents; second, the inability to access critically needed investment capital for medical technology; third, the increasing burden of chronic disease and the rising number of uninsured patients; fourth, the withering effects and expenses of substantial and chronic workforce shortages, both physicians and allied health; and fifth, the absolutely vital need for consultation and assistance to continually improve the quality, efficiency, and performance of our rural hospitals and healthcare organizations.

Many of North Carolina's rural residents rely on Medicare for their health coverage. With physicians' practices and hospitals struggling to keep their doors open, thanks in part to the inadequacy of Medicare reimbursements, this contributes to accessibility challenges.

Furthermore, it is very difficult to attract young physicians and other allied healthcare professionals to live and serve in these already medically underserved areas. I am pleased that Congress recently passed, with my strong support, the Medicare Improvements for Patients and Providers Act, which included and extended provisions important for rural hospitals and Medicare providers.

Perhaps most important is that this bill delayed a 10.6 percent cut in Medicare reimbursements to physicians. The proposed payment cuts would have severely limited access to care for seniors, especially in rural communities.

Recently, Congress also acted to extend the moratorium on a CMS regulation that would have narrowed the definition of public hospital. In fact, I think in North Carolina it would have narrowed our hospitals from 45 to 4 in that particular designation.

I was proud to work with a bipartisan coalition of Senators to delay these cuts, which would have cost North Carolina hospitals more than $330 million annually, costs that would have resulted in cuts to services and jobs and further limited healthcare access.

Let me add that with skyrocketing gas and food prices, seniors, particularly those in rural areas, are dealing with greater hardships. In fact, earlier this year, this Committee held a hearing examining the struggles of hunger-stricken seniors and the difficulties that programs like Meals On Wheels face when their volun-

teers, who use their own vehicles, can no longer afford to help deliver a meal.

The ripple effects of high gas and food prices are particularly hard on the Medicare population since many are on fixed incomes. The challenges of ensuring affordable, accessible healthcare to seniors living in rural America are complex and multifaceted, we know. As a Senator from a rural State with a rapidly growing senior population and as a member of the Rural Health Caucus, I very much look forward to hearing from the witnesses today.

Again, thank you, Senator Smith, for this hearing today.

Senator SMITH. Thank you, Senator Dole.

Our first panel will consist of John Hammarlund and Tom Morris. John Hammarlund is the Regional Administrator of Regions V and X for CMS, and he is located in Seattle, WA. He will discuss Medicare and Medicaid reimbursement policies for rural providers intended to improve access for beneficiaries.

Tom Morris is the Acting Associate Administrator of the Office of Rural Health in Health Resources Services Administration, known as HRSA. He will describe HRSA's rural health programs that help meet the needs of rural populations.

So, John, why don't we start with you?

STATEMENT OF JOHN HAMMARLUND, REGIONAL ADMINISTRATOR, REGION X, CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, SEATTLE, WA

Mr. HAMMARLUND. Thank you. Good morning, Senator Smith.

Senator SMITH. You may want to turn on your mike there.

Mr. HAMMARLUND. Thanks a lot. Good morning, Senator Smith. Good morning, Senator Dole, and distinguished members of the Committee.

Thank you so much for the opportunity to testify today regarding the role of CMS in issues impacting seniors in rural America. I am John Hammarlund, Regional Administrator of the Seattle and Chicago offices of CMS. As Senator Smith noted, I am based out of Seattle.

My focus is local outreach and education about CMS programs to our stakeholders in 10 States in the Midwest and Pacific Northwest. I am also the national lead for rural health issues on behalf of all of CMS's regional offices, which offers me an opportunity to coordinate messaging with my other regional colleagues.

Thank you so much for bringing attention to this important topic and to the needs of seniors in rural America. The Medicare program, as you know, provides coverage to approximately 9 million beneficiaries in rural and frontier areas of this country. We are the primary payer of healthcare services in geographically rural areas. We understand and take seriously our obligation to ensure the quality of and access to healthcare in these areas.

As someone who implements our agency's programs at a local level, I can assure you that we strive to ensure that rural beneficiaries are informed about their healthcare choices and the quality of healthcare services available to them. Likewise, we do our best to keep rural providers informed about our policies and help

them understand and comply with them. All of this is to ensure access to quality healthcare.

While Medicare's benefit design and statutory payment systems generally follow a uniform nationwide approach, we recognize the special needs of rural beneficiaries and providers. In early 2008, we formed the Rural Health Council, an internal CMS council designed to more effectively respond to legislation that affects rural beneficiaries and address issues of concern from rural health practitioners.

This new cross-cutting council creates an opportunity, for example, for environmental scanning—information gathered at the local level—to inform our policies and policymaking. CMS regularly exchanges information with national and State rural health associations, the State Offices of Rural Health, and other such organizations to ensure that we understand the environment where rural healthcare providers and beneficiaries are working and living.

We also work quite closely with HRSA's Office of Rural Health Policy, represented here today by my colleague Tom Morris, to ensure that healthcare providers in rural America can function to the best of their ability within the boundaries of our statutory and regulatory frameworks. Clearly, both the Congress and CMS are mindful of the special nature of rural areas. Congress has established and CMS has implemented a number of key rural payment programs and incentives for fee-for-service providers to ensure quality and access.

An example of this is the critical access hospital designation, where certain small hospitals can receive 101 percent of cost as reimbursement for treatment of Medicare beneficiaries. CMS also makes bonus payments to physicians furnishing services in health professional shortage areas, or HPSAs. It is vitally important to rural communities that they can attract and retain physicians, especially primary care doctors, and we hope the HPSA bonuses can have a positive impact.

We also strive to ensure that rural beneficiaries, like all beneficiaries, have choices in health plan coverage. Medicare Advantage enrollment in rural areas has grown significantly. Up until 2006, plan options were concentrated in largely urban areas, and now plans are available in every region of the country, including rural areas, and virtually all beneficiaries have access to at least one Medicare Advantage plan option.

CMS also recognizes the utility and necessity of telehealth in the delivery of certain healthcare services. Since 2001, Medicare has paid for professional consultations, office visits, psychotherapy, and other services delivered via telecommunications systems. We provide a process whereby providers can recommend new services to be included for telemedicine reimbursement to ensure that we maximize the opportunity that this technology provides.

With the passage of the new MIPPA law, more types of health facilities will be added to the list of covered telehealth facilities, such as hospital-based renal dialysis facilities, skilled nursing facilities, and community mental health centers. Telemedicine obviously holds a lot of promise to increase access to care in rural areas, and we look forward to the opportunities to expand its reach.

Finally, Medicare recognizes the unique challenges facing rural ambulance providers. The Medicare fee schedule takes into account these challenges through bonus payments for certain kinds of ambulance trips.

Thank you again for the opportunity to testify today. CMS appreciates the Committee's ongoing interest in this important issue. We believe that by continuing to support the unique needs of healthcare providers in rural areas through the initiatives described today, we will ensure seniors and disabled persons with Medicare will maintain access to quality services.

We are continually considering initiatives to improve access and quality within Medicare, such as value-based purchasing, electronic health records, and e-prescribing, and look forward to continued work with the Committee and our partners represented here today to further strengthen our stewardship of Medicare.

I look forward to any questions you may have.

[The prepared statement of Mr. Hammarlund follows:]

STATEMENT OF

JOHN HAMMARLUND
REGIONAL ADMINISTRATOR,
SEATTLE & CHICAGO REGIONAL OFFICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

"AGING IN RURAL AMERICA: PRESERVING SENIORS' ACCESS TO HEALTH CARE"

BEFORE THE

SENATE SPECIAL COMMITTEE ON AGING

July 31, 2008
Testimony of John Hammarlund
Regional Administrator, Seattle & Chicago Regional Offices
Centers for Medicare & Medicaid Services
On
"Aging in Rural America: Preserving Seniors' Access to Health Care"
Before the
Senate Special Committee on Aging

July 31, 2008

Good morning Chairman Kohl, Senator Smith and distinguished members of the Committee. Thank you for the opportunity to testify today regarding the role of the Centers for Medicare & Medicaid Services (CMS) in issues impacting seniors in rural America. I am John Hammarlund, Regional Administrator for the Chicago and Seattle offices of CMS. In this role, my primary focus is outreach and education about CMS programs to Medicare, Medicaid, and State Children's Health Insurance Program stakeholders in ten states: Alaska, Idaho, Illinois, Indiana, Michigan, Minnesota, Ohio, Oregon, Washington, and Wisconsin. I also am the national lead for rural health issues on behalf of all the CMS regional offices, and help to disseminate and explain CMS policy to rural providers and beneficiaries.

CMS is working to transform itself from a passive payer for services into an active purchaser of higher quality care by linking payment to the value of care provided. This transformation is intended to shift Medicare away from paying for services based solely on volume and to promote higher quality, more efficient health care using techniques such as performance-based financial incentives, public reporting of quality information,

and medication management to encourage improvement in all aspects of quality, including patient safety.

CMS serves beneficiaries and providers in all parts of the nation- urban, suburban, and rural- and we recognize that each geographic area is unique. While fee-for-service Medicare's benefit design and statutory payment systems generally follow a broadly uniform, nationwide approach, we recognize the special needs of rural beneficiaries and strive to address those needs and ensure access. In addition, the Medicare Advantage (MA) program and prescription drug benefit under Part D offer a wide range of benefit options and meaningful choices for beneficiaries throughout the country, including rural areas.

In early 2008, CMS formed the Rural Health Council, an internal working group designed to more effectively respond to legislation that affects rural beneficiaries and address issues of concern from rural health care providers. Through improved internal coordination, this group will facilitate an effective process for working on regulatory and other issues that affect rural health care providers. We also regularly share information with National and State Rural Health Associations, the National Organization for State Offices of Rural Health and other such organizations to ensure we understand the environment where rural health care providers and rural Medicare beneficiaries are living and working.

CMS is committed to working hard to ensure that rural beneficiaries have access to quality providers. We are the primary payer of healthcare services in geographically rural areas. To this extent, we have an obligation in ensuring the quality of and access to healthcare in these areas. In recognition of the special needs for rural areas, Congress has established and CMS has implemented a number of key rural programs with incentives to ensure quality, access, and beneficiary choice such as:

- **Critical Access Hospital (CAH) Designation**: This designation allows hospitals of 25 beds or fewer and that meet certain other conditions to receive 101 percent of cost as reimbursement for treatment of Medicare beneficiaries. This payment approach ensures small hospitals in rural areas will have their costs of caring for beneficiaries covered. In April of 2008, CMS issued guidance that allows CAHs to maintain observation beds that don't count against the 25 bed limit, giving them even greater flexibility. The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) further improved CAH payments by permitting CAHs to receive 101 percent of cost payments for lab services under certain conditions. Additionally, MIPPA offers grants of up to $1 million each ($5 million total) for some Critical Access Hospitals that decide to convert to a Skilled Nursing Facility or Assisted Living facility. This provision was designed to allow better access to long term care options in communities where patients and their families live.
- **Rural Health Clinic (RHC) Designation and Federally Qualified Health Centers (FQHC) Proposed Rule:** Clinics that are certified by Medicare as Rural Health Clinics (RHC) receive cost-based payments, subject to a per-visit limit) for

outpatient physician and certain non-physician services. The new proposed rule issued in June 2008, would implement statutory requirements such as establishing location requirements and exception criteria for RHCs (required by the Balanced Budget Act of 1997); revising the RHC and FQHC payment methodology to comply with the Medicare Prescription Drug Improvement and Modernization Act of 2003; and requiring RHCs to establish a quality assessment and performance improvement (QAPI) program. We have taken this opportunity to propose other programmatic changes that have been requested by the RHCs, such as allowing RHCs to contract with RHC non-physician providers under certain circumstances and allowing one year waivers of the requirement that an RHC have an Nurse Practitioner, Physician Assistant, or Certified Nurse Midwife when efforts to hire one of these practitioners has not been successful. These proposed changes would give RHC providers the support they need to assure that rural beneficiaries get the care they need, and will assure that this program continues to be available to clinics, practitioners, and beneficiaries in rural areas.

- **Sole Community Hospital Designation:** This is a designation for hospitals with 50 beds or fewer that are geographically isolated. These hospitals are paid based on the higher of the Federal inpatient prospective payment rate or a hospital-specific rate. They are eligible for disproportionate share hospital payments, and depending on their location, may be eligible for a higher wage index. They may also be eligible for help with fixed costs if they experience a decline in patients due to circumstances beyond their control.

- **Flu and Pneumonia Vaccine Incentives:** RHCs and FQHCs receive 100 percent of reasonable costs for flu and pneumococcal vaccines and administration. This assures that rural and underserved beneficiaries who get their care in an RHC or FQHC will not have a financial barrier to receiving these vaccines.
- **Health Professional Shortage Area Bonus Payments**: Physicians furnishing Medicare services in an area that has been designated by Health Research Services Administration as a geographic Health Professional Shortage Area (HPSA) receive a 10 percent bonus on those services. This bonus is an important tool in the recruitment and retention of physicians to underserved areas, and is especially crucial in rural areas where the loss of even one physician can have an impact on the community.
- **Telemedicine:** CMS recognizes the utility and the necessity of a telehealth program in the delivery of certain health care services. Since 2001, CMS has paid for professional consultations, office visits, psychotherapy and pharmacologic management delivered via telecommunications systems. With the passage of MIPPA, Medicare telemedicine services can be furnished in more settings, including hospital-based renal dialysis facilities, skilled nursing facilities, and community mental health centers.
- **Medicare Advantage:** MA enrollment in rural areas has grown significantly. Up until 2006, plan options were concentrated in largely urban areas. Now, plans are available in every region of the country, including rural areas, and virtually all beneficiaries have access to at least one MA plan option. Further, in the past 5 years, MA enrollment in rural counties has increased more than 600 percent. The

use of "floor" payment rates has helped to ensure beneficiaries in rural areas have improved access to MA plans, which typically offer additional benefits, for example, reduced cost sharing, reduced Part B or D premiums, and additional covered services such as dental and vision care.

- **Part D:** With a high value placed on beneficiary choice, CMS developed and enhanced an unprecedented network of support to ensure people with Medicare and their loved ones have access to the information they need to select the plan that serves their health care needs best. Rural seniors, like all Medicare beneficiaries, can find information about Part D Plan options at 1-800-MEDICARE, the Plan Finder tool available at Medicare.gov, and through their local State Health Insurance Assistance Program (SHIP). CMS has been working to reach seniors in rural areas, in collaboration with more than 900 partners across the country including SHIPs, local Area Agencies on Aging, pharmacies, membership organizations, and countless other community partners. In the fall 2007 open enrollment campaign and spring 2008 low-income subsidy campaign, radio was used to specially target beneficiaries living in rural areas, where in many cases, print outlets are not available. Additionally, the SHIP funding formula takes into account the challenges associated with conducting outreach in rural areas.
- **FLEX Grants:** The Medicare Rural Hospital Flexibility Program provides grants to states that rural health care providers can use to improve the quality of care facilities provide, and to strengthen health care networks. Funds can be used for services ranging from ambulance transport to the development of small local

hospitals. MIPPA extended the FLEX Grant program through 2010, and will add a new component making mental health services more accessible to rural Iraq War veterans and other rural residents.

- **Demonstration Programs:** CMS has several demonstration programs that benefit rural providers. One is the Frontier Extended Stay Clinic or FESC demo in my corner of the country, up in the Pacific Northwest. This demonstration allows extremely remote clinics to receive payments for critical patients that cannot be immediately transferred to an acute care facility due to weather conditions or other circumstances beyond their control. FESCs are in five remote villages in Alaska and a remote island in Washington State. Additionally, the new MIPPA law provides for a demonstration project that allows eligible entities in up to four states, to explore ways to improve access to, and better integrate acute care, extended care, and other essential health care services to Medicare beneficiaries.
- **Ambulance Services:** Medicare recognizes the unique challenges facing rural ambulance providers and its fee schedule takes into account these challenges in myriad ways. Until the end of this year, for ground ambulance trips that are longer than 50 miles, Medicare allows a 25 percent mileage payment bonus for each mile in excess of 50 miles. Until the end of next year, Medicare allows a 3 percent bonus on payments made for ground ambulance transports where the point of pick-up is in a rural area. Until the end of next year, Medicare will also pay a "super-rural bonus" of 22.6 percent for ground ambulance trips which originate in rural areas with the lowest population densities, and will determine

payment for ground ambulance services based on a blend of national and regional fee schedules for certain census areas where payment determined under the applicable regional fee schedule is greater than the national ground base rate. Finally, the total payment for rural air ambulance services (base rate and mileage) is increased by 50 percent.

We strive to be comprehensive source of information to rural health care providers to help them provide the best care they can to their patients. The CMS website www.cms.hhs.gov has an extensive array of information and material for rural providers under the link "Rural Health Center" that can assist providers in delivering care to Medicare beneficiaries in rural areas.

Conclusion

Thank you again for the opportunity to testify today. CMS appreciates the Committee's ongoing interest in this important issue. We believe by continuing to support the unique needs of health care providers in rural areas through the initiatives described above, we will ensure seniors and disabled people with Medicare will maintain access to quality services. We are continually considering initiatives to improve access and quality within Medicare and look forward to continued work with the Committee and our partners represented here today to further strengthen our stewardship of Medicare.

Senator SMITH. Thank you, John.

Tom Morris.

STATEMENT OF TOM MORRIS, ACTING ASSOCIATE ADMINISTRATOR, OFFICE OF RURAL HEALTH, HEALTH RESOURCES AND SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. MORRIS. Mr. Chairman, Senator Dole, members of the Committee, thank you for the opportunity to meet with you today to discuss rural access issues and the challenges individuals face as they age.

We appreciate your interest and support of rural healthcare. I am here today representing the Health Resources and Services Administration, commonly known as HRSA.

HRSA helps the most vulnerable Americans receive quality medical care, regardless of their ability to pay. We work to expand healthcare to millions of uninsured Americans, mothers and children, those with HIV/AIDS, and residents of rural areas.

HRSA to recognize the needs of the elderly population in rural areas and continues to focus and evolve its programs to best meet those needs. We take seriously our obligation to implement enacted legislation. We help train future nurses, doctors, and other clinicians, and we try to place them in the greatest areas of need.

Our efforts stress cost-cutting alliances within the agency and across the department to deliver quality services. The agency also collaborates at the Federal, State, and local level with community-based organizations to seek solutions to rural healthcare problems. My testimony will describe several HRSA activities that touch millions of people in rural America, particularly the elderly.

HRSA's Office of Rural Health Policy (ORHP) is the leading proponent of better healthcare services for the 55 million Americans who live in rural areas. Housed in HRSA, ORHP has a department-wide responsibility to analyze the impact of healthcare policy on rural communities. In that role, we inform and advise the Secretary, and work to ensure that rural considerations are taken into account through the policymaking process.

Some of our efforts include the administration of the Medicare Rural Hospital Flexibility Grant Program, the Rural Healthcare Services Outreach Program, and the State Offices of Rural Health Grant Program. We also fund the Rural Health Research Center Grant Program, which is the only HHS program specifically devoted to rural health services research. We also support the Rural Recruitment and Retention Network, which links providers to rural communities in need.

We collaborate with CMS on a number of levels, as John mentioned, including trying to emphasize the use of the Program of All-inclusive Care for the Elderly (PACE) in rural areas. This program is important because it takes duly eligible Medicare and Medicaid beneficiaries and keeps them out of nursing homes so they can receive their care in a home-based setting.

The Health Center Program is a major component of America's safety net. Due to the efforts of the health centers and the generous support of Congress, we recently completed a Presidential

initiative that created over 1,200 new or expanded health center sites.

Health centers served 16 million patients in 2007, and as part of a renewed focus on high-poverty areas last year, 80 new health center sites serving 300,000 people were created. As you know, poverty is higher in rural areas than it is in urban.

In the past year, rural health centers served 654,000 elderly patients. Today, find that over half of the health centers serve rural populations.

Since its inception in 1970, the National Health Service Corps has placed more than 28,000 health professionals, committed to providing improved access to primary care, oral healthcare, and mental health services in underserved areas. The NHSC is a service program, and its clinicians go wherever the need is great. Approximately 60 percent of NHSC placements are in rural areas.

HRSA also responds to the growing needs of the elderly in rural areas with.

Comprehensive Geriatric Education Grant, which supports nursing personnel by preparing nurses and faculty to care for the elderly.

In an era of high gasoline prices, travel costs have become an even greater barrier to rural patients, especially the elderly. In 2007, HRSA provided 140,000 telehealth visits for 46 different specialty services to patients in rural communities, meaning they did not have to travel to a distant medical center to receive specialized care. We estimate that this has saved 14 million miles in travel or approximately $7 million in travel-related costs.

In conclusion, HRSA takes great pride in the work we do to provide quality healthcare for rural Americans. We thank you for the opportunity to discuss the agency's programs, and we are happy to answer any questions you might have.

[The prepared statement of Mr. Morris follows:]

TESTIMONY OF

TOM MORRIS
ASSOCIATE ADMINISTRATOR
OFFICE OF RURAL HEALTH POLICY
HEALTH RESOURCES AND SERVICES ADMINISTRATION
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

SPECIAL COMMITTEE ON AGING
U.S. SENATE

ON

JULY 31, 2008

Mr. Chairman, Members of the Committee, thank you for the opportunity to meet with you today on behalf of Dr. Elizabeth Duke, Administrator of the Health Resources and Services Administration (HRSA), to discuss rural access issues and challenges individuals face as they age. We appreciate your interest and support of rural health care.

Introduction

The Health Resources and Services Administration (HRSA) helps the most vulnerable Americans receive quality medical care without regard to their ability to pay. HRSA works to expand the health care of millions of Americans: the uninsured, mothers and their children, those with HIV/AIDS, and residents of rural areas. HRSA recognizes the needs of the elderly population in rural areas and continues to evolve and focus its programs to meet their health needs. HRSA takes seriously its obligation to zealously and skillfully implement enacted legislation from the Congress. HRSA helps train future nurses, doctors and other clinicians, and to place these clinicians in areas of the country where health care is scarce. HRSA's efforts stress cross-cutting alliances across its offices and bureaus to bring about quality integrated services. The Agency works and collaborates both within government at Federal, State and local levels, and with community-based organizations to seek solutions to rural health care problems.

My testimony will briefly describe several HRSA activities that touch millions of people in rural America, particularly the elderly. These include Office of Rural Health Policy programs, the Health Center program, the National Health Service Corps, and Geriatric and Telehealth programs.

HRSA's Rural Activities

HRSA's Office of Rural Health Policy (ORHP) is the leading Federal proponent for

better health care services for the 55 million people that live in rural America. Housed in HRSA, ORHP has a department-wide responsibility to analyze the impact of health care policy on rural communities. ORHP informs and advises the Secretary, and works to ensure that rural considerations are taken into account throughout the policy-making process.

I would like to highlight some of ORHP's efforts to improve the health of rural Americans. The Medicare Rural Hospital Flexibility Grant Program (Flex) provides funding to States who in turn award the dollars to rural hospitals. For example, the Flex grants have helped over 1,300 small rural hospitals secure higher payments from the Medicare program under cost-based reimbursement.

Another program, Rural Health Care Services Outreach, works to improve the health status of rural residents by providing a range of services such as health screenings, health education, and provider training. These community-driven projects provide flexibility for addressing health needs specific to rural communities. A majority of these projects fulfill the needs in rural communities as 80 percent of them have continued after Federal funding ended.

The State Office of Rural Health grant program, which funds the 50 States, ensures that there is a focal point for rural health issues. In 2006, the State Offices worked with close to 4,700 rural communities on a variety of activities ranging from quality improvement to assistance with grant writing. In Colorado, for example, funds support quality reviews for over 30 clinical cases from small rural hospitals across the state. Physicians review the cases for appropriate and timely care, helping these hospitals to monitor and improve care if necessary.

ORHP also funds the Rural Research Centers Program, which is the only Federal program entirely dedicated to producing policy-relevant research on health care and population health in rural areas. One research center, for example, analyzed trends in Medicare Advantage

plans for rural beneficiaries. This work helped the Department focus resources on increasing Medicare Advantage enrollment in rural areas. Another research center tracks Medicare pharmacy benefits to help ensure increased access to drug coverage for seniors.

ORHP efforts also include assisting in the enrollment of more than 180 rural hospitals in the 340B Discount Drug program. A change in the law under the Medicare Modernization Act of 2003 allowed qualifying rural hospitals which take care of a large percentage of poor and elderly to qualify for this program. ORHP works extensively with the States to identify eligible hospitals and assist them in the application process for gaining access to low-cost pharmaceuticals.

HRSA's ORHP also supports the Rural Recruitment and Retention Network (3RNet). The 3RNet works to increase the number of providers practicing in rural America by linking rural communities in need of a provider with providers seeking to practice in a rural setting. The 3Rnet consists of 43 States who work together to share information and recruitment strategies. During FY 2007, 3RNet placed 404 physicians and 277 other health professionals such as nurse practitioners, physician assistants and dentists. As a result, the 3Rnet saved rural communities close to $9 million in recruitment costs last year. Over the past four years, 3RNet placed nearly 2,900 clinicians in rural communities.

The Rural Assistance Center (RAC), supported by ORHP, offers rural residents one-stop shopping on health related rural issues. Rural residents can e-mail or call the RAC staff and find out about funding opportunities, successful rural health models or news and statistics on rural communities. In one success story, a 23-county consortia in Pennsylvania used information and assistance from the RAC to help design and monitor a managed care plan for behavioral health.

Over its five-year existence, RAC has worked with more than 5,000 individuals for customized assistance via its 1-800 line.

Finally, ORHP collaborates with CMS to promote the Program of All- Inclusive Care for the Elderly (PACE) in rural areas. The PACE program provides a range of services to help keep Medicare and Medicaid beneficiaries out of nursing homes.

Consolidated Health Centers

The Health Center Program, a major component of America's safety net for the Nation's underserved populations for more than 40 years, is at the forefront of the President's Health Center Expansion Initiative to increase health care access in the Nation's neediest communities. Due to the incredible efforts of the clinicians and staffs of the Health Centers, and the generous support of a bipartisan Congress, the Initiative created over 1,200 new or expanded Health Center sites, serving 16 million patients in 2007— compared with 10 million patients served in 2001. In 2007, as part of a renewed focus on high poverty areas, 80 new Health Center sites served 300,000 people without access to Health Center services in areas of high need.

Health Centers are community-based and patient-directed organizations serving populations with limited access to care. These include low income populations, the uninsured, those with limited English proficiency, migrant and seasonal farmworkers, homeless families, and residents of public housing. Health Centers are open to all—regardless of ability to pay. Moreover, the Health Centers provide comprehensive primary care service on a sliding fee based on the patient's income.

Health Centers improve the health status of underserved populations living in isolated rural communities, where residents often have no where else to go. To meet this need, over half (53 percent) of Health Centers serve rural populations. HRSA funds health center services in

rural areas within a 40 to 60 percent range as required by statute. In 2007, Health Centers served nearly 7.1 million people with 21.4 million patient visits in rural areas. In the last fiscal year, HRSA awarded approximately $836 million to Health Centers serving rural areas. In the past year, rural Health Centers served 654,000 elderly patients (65 and older). Additionally, the Agency recently awarded nearly $5 million in grants to Health Centers in rural areas to spur greater health information technology investments. For example, one rural grantee implemented an electronic health record in 22 Health Center locations, reaching over 50,000 patients.

Peer reviewed literature and major reports document that Health Centers successfully improve access to care, improve patient outcomes for underserved patients, and are cost effective. Clearly, since their inception in the 1960s, Health Centers remain on a quality quest for their rural patients, grounded in the principles of community-oriented primary care.

National Health Service Corps

The National Health Service Corps (NHSC) has the unique distinction of having a book, *The Dance of Legislation*, a television series, *Northern Exposure*, and a movie, *Doc Hollywood*, feature aspects of its story. From its inception in 1970, the NHSC has placed in underserved areas more than 28,000 health professionals committed to providing improved access to primary care, oral, and mental health services.

The NHSC is a service program and its clinicians go wherever the need is great, where others choose not to go. By statute, the Program requires its recruited clinicians to serve targeted areas where they are needed most by linking educational support with a clinical placement (through a scholarship or loan repayment)—to serve patients most in need of primary care services.

From 1993 to 2006, the NHSC provided almost 18,000 total years of dedicated service from its clinicians practicing in rural areas. Approximately 60 percent of the NHSC's placements are in rural areas, continuing a trend throughout its history. Moreover, the most current retention rate of NHSC clinicians in rural areas is approximately 75 percent. To overcome shortages and scarcities in rural areas and to expose students to hands-on primary care rotations, the Agency supports State and community recruitment efforts including retention of their grow-your-own health professionals. Additionally, according to one study, in rural areas, NHSC clinicians are major contributors to local economies, resulting in up to 14,367 jobs, and generating $1.5 billion in economic impact.

For over 35 years, the NHSC has been and continues to be an important contribution to the health care needs of underserved people in rural America.

Geriatric and Telehealth Programs

Geriatric Program

HRSA responds to the growing needs of the elderly in rural areas with its geriatric programs. For instance, the Comprehensive Geriatric Education grant supports nursing personnel by preparing nurses aides, licensed practical nurses, registered nurses, and faculty to care for the elderly. This program also funds the development of curricula and provides continuing education to individuals who provide geriatric care. Americans are living longer, healthier, and more independently than ever before. Health professionals prepared in geriatrics are critical in preventing health problems in the elderly population.

Telehealth Programs

In an era of high gasoline prices, travel costs have become an even greater barrier to rural patients receiving specialty services that are not locally available. The Telehealth Network Grant

Program (TNGP) funds projects that demonstrate the use of telehealth systems in order to improve health care services for medically underserved populations. The TNGP focuses on providing innovative telehealth services to rural areas. From March 2007 through February 2008, nearly 140 thousand telehealth visits for 46 different specialty services were provided to patients in rural communities under this Program. During the same period, the TNGP is estimated to have saved patients over 14 million miles in travel, or otherwise stated, an estimated savings of almost $7 million in travel costs.

Rural areas generally have a greater elderly population than urban areas. With physical access to care the greatest challenge that many elderly rural patients face, HRSA funds telehealth projects to help eliminate this barrier. Some HRSA grantees work on telehealth projects involving home monitoring, chronic disease management, psycho-behavioral management, telestroke, and oncology. These programs are especially crucial for the growing elderly population in rural areas.

In terms of health outcomes, the TNGP examines the impact of remote disease management services on patient outcomes. From September 2006 through February 2008, 33 percent of diabetic patients enrolled in Telehealth diabetes case management programs achieved control over their disease as measured by their hemoglobin A1c levels. This is a significant improvement over the baseline of 10 percent of diabetic patients who are estimated to have had control over the disease.

Under the Telehealth Resource Center grant program, HRSA supports five regional and one national telehealth resource centers to provide technical assistance to rural communities interested in providing or receiving telehealth services. The five regional centers work together to make available technical assistance from the nation's experts on practical approaches to

creating a successful telehealth program, whereas the national center focuses on technical assistance to address the legal and regulatory barriers to sustaining successful programs. For example, the California Telemedicine and eHealth Center Mentor Program created a network of mentors, individuals who have developed successful telehealth programs in California, to serve as role models and advisors to communities that wish to use telehealth technologies to overcome barriers to service.

Conclusion

HRSA takes great pride in the work we do to provide quality health care for rural Americans. Thank you for the opportunity to discuss the agency's rural programs and I am happy to answer any questions you have.

Senator SMITH. Thank you very much, Tom.

We have been joined by my colleague from Oregon, Senator Wyden. We have already done our opening statements, Senator. If you have one, we would be happy to receive it now.

OPENING STATEMENT OF SENATOR RON WYDEN

Senator WYDEN. Mr. Chairman, I apologize for the bad manners. I was prosecuting the Healthy Americans Act cause in the Finance Committee, and I would just make a couple of very quick comments because I know both of you want to go to your questions.

First, I want to commend you, Mr. Chairman, for holding this hearing, and Senator Dole and I have talked also often about healthcare.

I think, for Oregonians, we all remember the account recently about one of our physicians traveling 5 hours recently to Elgin, OR, twice a week to keep the Elgin Family Clinic open. If the clinic closes, Elgin residents—and as we both know, lots of those folks are seniors—would then be driving to La Grande, another big trek for medical care.

So on the November ballot, the mayor and the residents of Elgin are considering creating a health district so that they can, in effect, impose yet another tax on themselves to keep this small clinic open. We both remember that 30 years ago in Condon, that is what they had to do.

It seems to be that we can do better by our folks in rural communities. The three of us are committed to that. Under the Healthy Americans Act, for example, we would make it possible for all those folks in rural communities, tiny communities to be part of larger groups when they purchase their healthcare.

So they would be in a position to get more for their healthcare dollar. They would be protected if they had a pre-existing condition. Because we make changes in the tax code, there is money for low-income folks in these rural areas to get subsidies.

So I am interested in working with both of you on that legislation. Senator Dole knows, she—her husband and I have talked often about these causes, and I think it is very constructive this morning, Mr. Chairman, that you are looking at a number of other issues that are causing great hardships for the rural health clinics. I commend you for your efforts, look forward to working closely with you and Senator Dole on it.

I want to apologize to the Oregon witnesses. I am going to be running in and out because the Finance Committee continues its hearing. But to commend you for this effort, and to have the opportunity to work with both of you is something I appreciate.

Senator SMITH. Thank you very much, Senator Wyden.

John, as you probably know, I am a strong supporter of ensuring critical access hospitals have the ability to serve rural populations. I think you probably know that the designation and its requirements are not perfect. You have got to draw the line somewhere, but I am very concerned with the lack of flexibility in drawing that line.

Dennis Burke is a good friend of mine from Hermiston. At his hospital, Good Shepherd in Hermiston, they have recently had to transfer 17 patients since they became a critical access hospital

due to the daily 25-bed limit rule. That adds up to a cost of about $1,200 per person, per patient to move them around.

That just seems irrational to me, and I wonder if you have a rationale for not allowing a more flexible approach to the bed limit cap so that hospitals can avoid these kinds of expenses and inconveniences to patients?

Mr. HAMMARLUND. Senator Smith, I want to let you know, first, that one of the duties I take very seriously in my role as a regional administrator is to get out of Seattle and to meet with hospital administrators and clinic administrators in rural areas. In fact, every year, I take a van of experts from my office, and we get out into rural areas of Washington and Oregon and Idaho.

In fact, we were in Pendleton just about a year and a half ago, listening to the concerns of administrators such as critical access hospital administrators. I am and I know CMS is very much aware of and understand the issue of the 25-bed limit. At this time, that limit is set by statute.

I understand that you and Senator Wyden have offered a legislative fix to address that issue. At the moment, the administration doesn't have a position on that bill.

Senator SMITH. You are not opposed to Senator Wyden and my bill to add some flexibility to the standard?

Mr. HAMMARLUND. Well, we are always interested in entertaining comments from the Congress, obviously. I understand that our staff had been providing some technical assistance to your staff and Senator Wyden's staff to look at the bill. The administration just simply doesn't have a position at this moment.

But I do understand the pressures on critical access hospitals. As you know, in certain very limited circumstances, such as the flooding that we had recently in the Midwest, the Secretary does, under limited circumstances, have authority to waive that limit.

Senator SMITH. Was it done in the Midwest? Was it waived?

Mr. HAMMARLUND. It was.

Senator SMITH. Well, as Senator Wyden points out the example, of Elgin, OR. Now that refers to a health clinic, but look, I know it is hard to draft rules that fit every circumstance. It is hard to write statutes that do. But I think we desperately need to have more flexibility in this because if you have a rural community, you have a flu outbreak, or you have a flood. You have an earthquake or a volcano going off, it just seems irrational that this is not more flexible.

So, I would certainly plead with CMS to support our bill and support its hasty enactment because it is, literally, life and death to some small communities when they have to shuttle patients around or lose critical access designation.

Mr. HAMMARLUND. Well, I understand, Senator, and I know that CMS staff are very happy to come and work with your staff and Senator Wyden's staff on the bill to provide technical assistance.

Senator SMITH. Now as it relates to proposed changes in rural health clinics rules and regulations, the new rule, as I understand it, would apply this standard—let me see here. You are going to update the shortage area designation every 4 years. Is that correct?

Mr. HAMMARLUND. We actually use the definition of a shortage area as defined by HRSA. But in our particular rule, we require a 3-year look-back time period. That is correct.

Senator SMITH. In the past, you have only applied this to new applicants, but now you are going back and applying it to existing rural communities. Is that correct?

Mr. HAMMARLUND. At its core, the proposed rural health clinic rule requires that all rural health clinics be located in non-urbanized areas and requires that all of them be located in an area that has been designated or certified by the Secretary within the past 3 years as having an insufficient number of needed healthcare practitioners.

So it is our interest to ensure that the rural health clinics that receive a special payment are, indeed, meeting the definition and the policy goal of rural because we want to make sure that the beneficiaries in those rural areas are getting the best care they can and that the rural clinics serving them are doing so appropriately under the law. We want to make sure that we don't risk treating some rural health clinics differently than other rural health clinics.

Senator SMITH. Tom, I understand HRSA has withdrawn a proposed rule on the methodology dictating health professional shortage area designation, and I applaud you for withdrawing that. But I wonder if you can tell me what the HRSA's timeframe is for addressing the shortage designation methodology?

Mr. MORRIS. Yes, sir, Mr. Chairman.

We have got over 600 comments on this rule, and so it is going to take us a while to go through all of those comments and figure out how we might respond to them. Then factor that into writing a new proposed rule that takes into account some of the issues that have been raised.

I don't have a specific timeframe for you because the next few months will just be spent going through those comments. But it is our expectation that eventually we would move to a new proposed rule that I think would use all these comments as technical assistance for us to make sure that we come out with something that balances the needs a little bit better.

Senator SMITH. Well, I appreciate that, and I just note, before I turn the questions over to Senator Dole and then Senator Wyden, you know, our population is aging. We need to get ahead of this curve and not just be reacting to a shortage all the time. We are sure prepared to do our part here in Congress, and we hope that the rules that you all propound will be reflective of that.

Senator Dole.

Senator DOLE. Thank you.

Mr. Hammarlund, rural hospitals, of course, are very dependent on Medicare and Medicaid reimbursement to stay operational, and some rural hospitals in my State depend on the Federal Government for up to 70 percent of their revenue. Rural hospitals also have a significant uncompensated care burden. As a result of this burden, the average North Carolina rural hospital received 2.2 percent less revenue than it actually costs to provide their valuable services.

This dire financial situation is simply not sustainable, of course, in the long run. In fact, two of our North Carolina rural hospitals

closed their doors recently, and two have declared bankruptcy. Well, I can't speak for the rest of the country, but I assume there are similar problems happening across America.

Would you review any recommendations regarding what policies could be put in place to ensure that hospitals serving high numbers of Medicare patients don't have to close their doors?

Mr. HAMMARLUND. Well, thank you very much, Senator Dole, for that question.

We certainly want to protect the access to care of the beneficiaries in rural and frontier America like we do throughout the country. CMS is ever vigilant in trying to understand the nature of challenges of the providers such as the ones you have in your State.

I know, from the perspective of somebody who works in a regional office, we are on the phone an awful lot talking to the constituents in your State and others, trying to help them cope, if you will, with the environmental challenges, the economic challenges, as well as to understand our laws and to comply with them.

Medicare does have in place, thanks to Congress, a variety of special payment mechanisms for certain rural providers, and those are in place, of course, because we recognize the special needs of the rural communities. We recognize the special economic challenges of rural providers, and so we have designations such as critical access hospitals or Medicare-dependent hospitals or sole community hospitals or rural referral centers. These are all programs designed specifically for rural areas to help keep them functioning within the law.

We always, of course, are interested in entertaining other proposals that the Congress might have, and of course, I can always assure you that we will do the very best to deal with specific problems that we might have in your State by talking to providers and understanding their concerns.

I don't have any new proposals today, but I am very much aware that the Congress and our agency does pay special attention to the needs of rural providers through these special payment mechanisms.

Senator DOLE. Could you tell me a little bit about a new concept that is being promoted called the medical home, which has shown, I think, early signs of success in North Carolina? The recently passed Medicare bill included increased funding for the medical home demonstration program, and I would be very interested in hearing how you see that working into existing programs.

Mr. HAMMARLUND. Thank you, Senator.

I will confess to you I don't know an awful lot about the current demonstration. I am aware of its existence, and I know that some of my other colleagues in other parts of the country are supporting that more directly than I am out in Region X.

I do think that it holds a lot of promise, and I am glad to know that the MIPPA law expanded its reach. We have not yet done all of the analysis of the new MIPPA law and its impacts, so I can't really speak to how it may change the demonstration program. I would be happy to get you a detailed answer to your question about the medical home demonstration for the record and for your information.

[Information submitted by Mr. Hammarlund:]

CMS is currently designing the Medical Home Demonstration. The demonstration was mandated by Section 204 of the Tax Relief and Health Care Act of 2006 (TRHCA) in up to eight states to provide targeted, accessible, continuous and coordinated family centered care to Medicare beneficiaries who are deemed to be high need (that is, with multiple chronic or prolonged illnesses that require medical monitoring, advising or treatment).

The recently enacted Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) increased the funding available to conduct the medical home demonstration to $100 million in excess of the amount that we would otherwise have had available to spend under TRHCA. The TRHCA did not specify a dollar amount for the demonstration, but did provide language that presumed savings would accrue and be shared with medical home practices. We read the MIPPA language to permit us to spend up to $100 million in excess of project savings, that is, the demonstration can go $100 million over budget neutrality.

MIPPA also gave the Secretary discretion to expand the duration and scope of the demonstration, if the Secretary determines that the expansion would improve the quality of patient care or reduce Medicare spending. Site selection will be followed by a solicitation of practices to participate in the demonstration. We expect to announce site selection in December.

Senator DOLE. Great. Thank you.

Mr. Morris, like many other States, North Carolina is facing that growing shortage of physicians in rural places, and this includes general surgeons as well as primary care physicians. I am concerned about what this will mean for access to care. Are Title VII and Title VIII program funding enough to address the workforce shortage, and how can we help get more trained professionals into rural areas?

Mr. MORRIS. Yes, ma'am. The Title VII, Title VIII, in particular the nursing education—basic nursing education practice grants we think are an important tool in addressing workforce shortages. Also the National Service Corps, where more than half of the placements go into rural areas, and they can be both primary care, and that would be in family medicine, internal medicine. We think that is probably our most effective tool at addressing long-standing workforce challenges.

In addition to those programs, I mentioned briefly in my testimony the Rural Recruitment and Retention Network is a network of 46 States, rural recruitment and retention specialists at the State level who work together to link providers who are looking to practice in a rural area with rural areas that are trying to recruit a provider.

Over the last 4 years, that service has placed 2,900 clinicians into rural areas. If you consider that it costs about $20,000 to recruit a physician, that has generated, I think, a substantial savings for the rural communities that use this.

In addition, Congress, about a year and a half ago, expanded the Conrad 20 program to the Conrad 30 program, which allows J1 visa physicians to practice in underserved areas, and the great majority of these folks end up in rural areas.

So, I think those are the tools we have available to address the workforce challenges.

Senator DOLE. Great. Thank you very much.

Thank you, Mr. Chairman.

Senator WYDEN. Mr. Chairman, thank you, and I share many of the concerns you and Senator Dole have brought up.

I would say to Senator Dole, I think you are very much onto a key issue in terms of the medical home. In fact, one of the policies we advocate in the Healthy Americans Act we call the "health home" so that you can, in effect, get more practitioners—and they are especially important in rural areas—like the nurses and physician assistants into the coordination of care. That seems to have been well received by both doctors and nurses and PAs. But I share your view that it is an extraordinarily important part of the healthcare future.

Question for you, Mr. Hammarlund. I understand that you all are civil servants, and some of these judgments we are asking about are largely political kinds of questions. I share Senator Smith's view about the critical access hospitals and getting the flexibility. We want to work with you until we can get that right. But it is an urgently, urgently, urgently needed piece of legislation.

I think that what you are hearing from us is that, to some extent, if you don't get rural healthcare right, you turn rural communities into sacrifice zones. They can't survive without healthcare. On our watch, the three of us are just saying that is unacceptable. So that is what is behind it, and let us expedite the process of negotiating the critical access hospitals legislation that we have been talking about, S. 1595.

One technical question that I wanted to ask you, Mr. Hammarlund, something I think you can do something about, and that is that with respect to the processes you use for calculating reasonable cost, what our providers tell us is that you are always light-years behind their real costs. For example, it seems that the Oregon Office of Rural Health indicates that for the average cost of a Medicare visit in Oregon, it is $105, about $106, and your reimbursement rate is capped at just over $70.

So, essentially, these hard-hit communities are falling behind every single time a rural resident walks in the doors, and we just can't stand by and let that go unaddressed. So what is being done specifically at your level to keep the Medicare payments in line with the realities of what these rural health clinics have to spend in terms of caring—giving high-quality care to a rural resident?

Mr. HAMMARLUND. Thanks for that question, Senator Wyden.

I may ask that I will provide a more expert and detailed explanation for the record that would be more helpful to you. But let me take a crack at it.

As you know, reasonable costs are one mechanism by which Medicare can reimburse providers. In fact, in the olden days, we were reimbursing most providers by reasonable costs. But in the case of many provider categories now, we now pay a prospective payment rate rather than reasonable costs.

So there are a few providers still that are paid under a reasonable cost basis. You are absolutely right, they are based on historical costs, which we then attempt to trend forward to bring them to a currency that would be allowed for appropriate coverage of cost for the providers. So that is to say, payments are built on a historical cost base that is trended forward to try to keep up with current costs.

I imagine you are correct in that providers will tell us that reasonable cost-based payments aren't quite as current as need be,

and that is certainly something that I am happy to take back to the agency's experts and policymakers to see what we could possibly do.

Senator WYDEN. First of all, this is the agency's language. This is not something that we have concocted because we have got a handful of problems. Because if we were somehow seeing a more modern system that met the needs of these clinics, we wouldn't be asking any questions. But in the June 27th proposed rule, the rule that you all have been talking about, the agency uses the term "reasonable cost." That is the agency's characterization of what is going on.

What Senator Smith and I find when we go home, these clinics are getting clobbered every time they have a visit because they are not keeping up. So why don't you get back to us for the record? Can you do that within 10 days?

Mr. HAMMARLUND. Be happy to.

Senator WYDEN. OK. So get back to us within 10 days with respect to, first, how reasonable costs are being calculated, and then I would like to know how you would address this shortfall and particularly whether you can address it administratively? Because this goes right to the heart of how rural clinics keep their doors open. Can't keep the doors open if they get shellacked in terms of meeting their expenses every time somebody comes in the door.

Mr. HAMMARLUND. I understand.

Senator WYDEN. OK. Mr. Chairman, thank you.

Senator SMITH. Thank you, Senator Wyden.

I want to clarify one of the problems that we have in these rural clinics. As I understand it, when it comes to recertifying, CMS operates on a 4-year timetable and HRSA operates on a 3-year timetable. What we need to do is have you on the same timetable, and that is what our bill does. Is there any reason you all wouldn't support that?

Mr. HAMMARLUND. Well, I will start with an answer, Senator. We have those different time periods because of different statutory frameworks, and my understanding is that you and Senator Wyden do have a bill moving forward and that we have staff who have been providing some technical assistance to your staff on that bill.

At the moment, my understanding is that the administration has not taken a position on that legislation.

Senator SMITH. Well, we hope to pass it in an expedited way, and we look forward to your support of it because I think that is very important to be on the same page between your agencies.

Do you have any further questions?

Well, thank you very much. We appreciate you very much, John and Tom, for your time here and your service to our country.

Mr. HAMMARLUND. Thank you, Mr. Chairman.

Senator SMITH. We will now call up our second panel. It consists of Margaret Davidson. Ms. Davidson is a board member for the National Association of Area Agencies on Aging, as well as the Executive Director of Community Connections of Northeast Oregon in La Grande, OR. She will discuss the important assistance that the Older Americans Act programs and agencies on aging provide to seniors living in rural areas to help them remain in their homes. Welcome, Margaret.

We will also hear from Mr. Bill Finerfrock. Did I pronounce that right, Bill? All right. He is the Executive Director for the National Association of Rural Health Clinics. He will discuss services that rural clinics provide to individuals living in rural parts of the country. He will also discuss challenges encountered by the States and providers when they develop creative healthcare delivery models in rural areas.

Mr. Scott Ekblad will follow him. Mr. Ekblad is the Director of the Oregon Office of Rural Health at the Oregon Health and Science University. He will discuss the role of the State Offices of Rural Health and their work to increase the availability of healthcare professionals and quality of care to rural residents.

Mr. Dennis Burke is the President and CEO of Good Shepherd Medical Center in Hermiston, OR, my neighbor. He will discuss the role of critical access hospitals in rural areas.

Finally, Mr. Tim Size. Mr. Size is the Executive Director of Rural Wisconsin Health Cooperative. He will discuss how healthcare reform must include rural perspective and address future healthcare workforce needs.

Thank you, all. Margaret, why don't we start with you?

STATEMENT OF MARGARET DAVIDSON, BOARD MEMBER, NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING, LA GRANDE, OR

Ms. DAVIDSON. Thank you, Senator Smith. It is an honor to be here.

My name is Margaret Davidson, and as you said, I am the Director of Community Connection of Northeast Oregon in La Grande, OR, and I serve as a board member of the National Association of Area Agencies on Aging, N4A.

Thank you for inviting me. It is, like I said, an honor to be here representing N4A and the 650 area agencies on aging and 240 Title VI Native American aging programs that have successfully delivered aging services across the country for the last 30 years, serving more than 8 million older adults with Older Americans Act funding.

My organization is a private nonprofit corporation that was formed in 1969, and in addition to being an AAA, we are also a community action program. We have 13,000 seniors in my rural area, spread across the vast area of 13,000 square miles. As you know, this is a mountainous area, and winter travel conditions persist from November through April.

Much has been written about the aging demographics that our country faces, but not as well known is what the rural areas face. In my area, the younger generations leave our areas to go to college and find family wage jobs while the boomers and others move in for the quality of life. As a result, the 23 percent senior citizens in my area generally have less income. In fact, the poverty rate for seniors in my area is 38 percent higher than the State average.

I can relate to the issues around rural health clinics. One of my staff people is the mayor of Elgin and has been very involved in addressing the health clinic issue in the city of Elgin that Senator Wyden mentioned. So she is very involved in that.

I think the best way to articulate the challenges that rural area agencies face is to tell you about a typical client. Our Mrs. Jones, she is 77, widow of a World War II veteran who worked the family farm and at the local mill.

She never worked outside the home, but she was a community volunteer with the PTA, the church bazaar, and just an integral member of the community. She lives on $900 a month of Social Security. While she can do most things for herself, she knows that taking care of her yard and her house is getting to be too much for her. While she is proud and doesn't want to ask for help, she knows that the time is coming.

As her budget gets tighter, costs continue to escalate. She is being pinched more and more. Last year, she heated only two rooms of her home, and still the energy bills were too much for her. She often has to choose between food and medicine when it comes to stretching her monthly budget, and it is not uncommon for her to eat cold cereal for both breakfast and lunch.

This is where the area agencies on aging come in offering information and assistance and direct services to their clients like Mrs. Jones. I believe that we are the best-kept secrets across the country. Many people know that senior meals are our flagship programs, but what we really do is lend a knowledgeable ear and provide support and find solutions to the common and not-so-common problems that we each will face as we age. As my grandmother liked to say, we find a way or make one.

Through our meals program and transportation, we continue to stretch the dollars further and further. Costs are escalating. Our meals costs alone—cost to prepare the meals has increased 18 percent in the last year. Fuel surcharges from our food distributors have doubled.

As Senator Dole said, our Meals On Wheels volunteer drivers are, for the first time, asking for a gas subsidy, and we have had to increase the suggested donation at our meal site for the first time in 3 years just to help forestall any service cutbacks. Our transportation fuel costs have increased by 25 percent over the last 6 months.

So I am very supportive of the action that we see Congress taking in the supplemental appropriations bills. We would encourage you to add supplemental funding for the area agencies to address the food and energy costs that we are facing and our clients are facing through the Older Americans Act and LIHEAP program. Also would encourage you to fulfill the promise made last year in the 2006 Older Americans Act reauthorization by actually funding those enhanced community-based care provisions.

Also, the importance of the surface transportation bill cannot be overstated and encourage that to be fully funded again.

Thank you.

[The prepared statement of Ms. Davidson follows:]

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TESTIMONY OF

Margaret Davidson

Board Member, Region 10
National Association of Area Agencies on Aging (n4a)

AND

Executive Director
Community Connection of Northeast Oregon, Inc.
La Grande, Oregon

BEFORE THE

U.S. Senate Special Committee on Aging

"Aging in Rural America:
Preserving Seniors' Access to Health Care"

July 31, 2008, 10:30 a.m.
106 Dirksen Senate Office Building
Washington, DC

Good morning, Chairman Kohl, Ranking Member Smith and other distinguished members of the Committee, my name is Margaret Davidson. I am the Executive Director of the Community Connection of Northeast Oregon, Inc. in La Grande, Oregon, and I serve as a Board Member of the National Association of Area Agencies on Aging (n4a).

n4a represents our nation's 650 Area Agencies on Aging, or AAAs as they are known, and 240 Title VI Native American Aging Programs that serve older adults and caregivers around the country. As the local component of the Aging Network, Area Agencies on Aging and Title VI aging programs have successfully delivered aging services in every community across the country for over 30 years, and provide assistance to over 8 million older Americans annually.

Community Connection is a private, non-profit that was formed in 1969, and in addition to being an Area Agency on Aging, is also a Community Action Program. Our agency covers 13,000 square miles across four rural counties of Northeast Oregon, which is mountainous and experiences winter travel conditions from November through April. There are 13,000 seniors in our area accounting for 23 percent of the total population of the region.

I want to thank the Committee for inviting me here today to testify on behalf of n4a on the issue of aging in rural America, and preserving seniors' ability to access health care and social services that will allow them "age in place."

Growth of the Aging Population in Rural Areas

The aging demographics our nation faces as a whole are well documented. The population 65 and older will increase from 35 million in 2000 to 40 million in 2010 (a 15 percent increase) and then to 55 million in 2020 (a 36 percent increase for that decade). By 2030, there will be about 71.5 million older adults age 65 and older, almost twice their number in 2005, or 20 percent of the total U.S. population.

However, the particular pressures that rural areas of the country face are less well known and yet deserve significant attention. The 65 and older population represents 15 percent of total non-metro population compared to 12 percent for the country as a whole.

The rural aging population will accelerate at a significant rate over the next several years. The USDA Economic Research Service reports that growth rates from aging-in-place alone (i.e., not new elders moving to an area) will triple among the non-metro older population, from 6 percent this decade to 18 percent in the next decade. These growth rates in the rural aging population are complicated by the fact that rural seniors generally have less income, lower educational attainment, and a higher dependence on Social Security income than their non-rural counterparts. In addition, it is generally more expensive to deliver services in rural areas due to fewer service providers per capita and higher per capita costs in sparsely populated and remote areas of the country.

Population shifts due to the out migration of young adults and the in migration of retirees and the Baby Boomers are also clearly having an impact on the complexion of the aging population in rural areas. While these trends vary by location in how pronounced they are, the aging-in-place population in rural areas generally has access to fewer health care services, which are in turn more costly. These disadvantages are difficult to address in rural areas currently experiencing declining workforce populations and worsening local economies.

An Average Client: Mrs. Jones

Perhaps the best way to articulate the challenges agencies like mine in rural areas face in serving older adults is with a real life example. Let me introduce you to Mrs. Jones, a very typical 77-year-old, widow of a World War II veteran who worked the family farm and at the local mill. Mrs. Jones never worked outside the home, but instead she spent her years raising her family, volunteering with the PTA and at the church bazaar, and

sharing flowers from her garden. Mr. Jones passed away ten years ago, and their children are grown and do not live nearby. Her monthly income is $900 from Social Security. She is in fairly good health for her age and manages her hypertension and Diabetes with medication, and she can do most things for herself.

Yet, taking care of the big yard and house that she raised her family in is getting to be too much. She won't drive after dark anymore or during the winter months. The eight miles to town and half mile to the nearest neighbor make for lonely days for Mrs. Jones.

Rapidly rising costs for gas, home heating fuel and food have squeezed Mrs. Jones and her already tight budget. Last winter, she only heated two rooms of her home and she still couldn't afford it. With gas so expensive, Mrs. Jones's fixed income can not cover both the gas and insurance. As the cost of food keeps going up, along with medicine and co-pays, she is often torn between paying for food or medicine. She often eats cereal for breakfast and lunch.

Mrs. Jones is proud and doesn't like to ask for help, but she knows she is starting to need some support. She wants to stay in the community where she spent her entire life and where her friends and neighbors live. All Mrs. Jones asks for is to be safe, warm, and able to live independently for as long as possible. Mrs. Jones' situation is not unlike many older adults living in rural areas as they seek to age in place.

Overview of Aging Programs in the Community

Established under the Older Americans Act (OAA) in 1973, Area Agencies on Aging offer a host of options to help older adults stay in their homes and communities for as long as possible. While our mission is to ensure that individuals can age-in-place where they want to — at home and in the community — this system also reduces long-term care costs to taxpayers by providing alternatives to more expensive institutional care.

The OAA also helps fund Native American Aging Programs, known as "Title VI," to meet the unique needs of older American Indians, Alaska Natives, and Native Hawaiians.

Following leadership at the federal level from the U.S. Administration on Aging and the state level from the State Units on Aging, AAAs leverage public and private funds to help older adults remain active and contributing members of their communities as long as they can. They do this by offering a wide range of services that fall into five broad categories: information and access services, community-based services, in-home services, housing and elder rights. Some AAAs provide direct services and some contract with local providers, but they all customize what they offer to reflect local needs and resources.

For example, older adults and their caregivers turn to their local AAAs:

- to arrange for Meals on Wheels home deliveries or attend congregate meals;
- to learn about and access other home and community-based supports that are available locally;
- to access to home health and other in-home services;
- to secure transportation to doctor's appointments and other essential trips;
- to get help in a fraud or elder abuse situation;
- to provide legal assistance;
- to get information and counseling to enroll in Medicare Part D and other public health benefits; or
- to access needed information and support for caregivers of the elderly.

Community Connection's annual allocation through the Older Americans Act is approximately $420,000. We use these funds to leverage twenty times more in resources through multiple funding sources for a total annual budget of $8.5 million.

Community Connection Is Not Unlike Many Rural Aging Programs

Community Connection is a direct service provider and our comprehensive services can meet many of an average client like Mrs. Jones' needs. We can provide nutrition

services (both home-delivered and congregate meals), transportation, and advocacy and service coordination. Our agency operates 13 meal sites in the four counties we cover – two serve five days a week, one serves four days a week, two serve three days a week, and the others serve once a week. In fiscal year 2008, we have served 124,000 total meals from these sites, including home-delivered meals. This year, the cost to prepare, serve and deliver each meal has increased 18 percent compared to last year – from $4.60 per meal up to $5.41. In addition, the fuel surcharge from our food distributor has doubled from about $4.00 to $8.00 per food order. Many volunteers for Meals On Wheels are, for the first time, asking for a fuel subsidy. In short, increases in staff, food costs and transportation have nutrition programs stretched to very limit. For the first time in three years, we have increased the suggested donation at our meal sites to postpone service cutbacks, but anticipate that this will only delay the inevitable this year. Our advisory council is working to do more fundraising to minimize the impact on seniors.

We provide nearly 19,000 units of information, outreach, and counseling assistance annually to seniors and their families on issues ranging from caregiver support, advocacy and service coordination with hospitals, home health care, mental health services, and other in-home services. Our agency plays a significant role in assisting seniors with their transportation needs, home energy assistance through the Low-Income Home Energy Assistance Program (LIHEAP), and with Medicare counseling as we are a local State Health Insurance Assistance Program (SHIP).

We offer dial-a-ride and door-to-door transportation services for older adults and persons with disabilities, and medical transportation up to 250 miles in one direction. For these transportation services, we utilize both volunteer and paid drivers and reimburse for mileage at the current IRS rate of 58.5 cents a mile. In fiscal year 2008, we have provided a total of 105,040 rides funded through Federal Transit Administration (FTA) formula grants and state funds. While we have been able to increase the total rides provided by 9 percent compared to fiscal year 2007 by taking advantage of multiple funding sources, our fuel costs have increased by 25 percent over the last six months compared to July through December 2007 ($1.24 vs. 99 cents per ride).

As a Community Action Program, we administer LIHEAP, which is critical to older adults like Mrs. Jones in Northeast Oregon who are struggling with increasing energy costs for both heating and cooling. The typical retiree on Social Security makes just under $13,000 a year. One fill up of a 275 gallon tank of oil can cost $1,300. If that retiree needs six tanks of oil this winter, she will spend 60 percent of her income to heat her home. In fiscal year 2008, our agency assisted 868 older adult households or 41 percent of the 2,100 households we provided with assistance. However, due to the jump in energy prices affecting the broader low-income population and the resulting increase in crisis payments, we have seen a 12 percent drop in the number of older adults that we have been able to assist through LIHEAP during the last two years, despite the 18 percent increase in funding.

We also provide health insurance counseling services as part of our Oregon's State Health Insurance Assistance Program, known as SHIBA. During fiscal year 2008, we have provided one-on-one counseling and enrollment assistance to 150 beneficiaries, spending on average 45 minutes per counseling session. We rely heavily on volunteers to provide the information and counseling assistance and often the counselors who volunteer their time and experience are seniors themselves. These services have also been limited because of rising fuel costs this year, which has caused our agency to cut back on the amount of outreach efforts we have been able to undertake in the community.

Challenges Faced by Rural Aging Programs

Distances and isolation are major factors for many rural seniors. Many of the communities in our planning and service area are 20 miles or more from the nearest focal point for services, which increases the cost of services. Mileage from one end of my service area to another is 215 miles, with two-thirds of it only accessible through two-lane roads. And I know some of my AAA and Title VI aging program colleagues cover distances even greater. The impact of travel costs and the staff time consumed by

transportation to and from a client's home has a direct connection to the amount of services a rural agency can provide.

Adequate funding is also an issue for rural area agencies. For example, in fiscal year 2008 there was roughly a $17 million funding increase combined for the home-delivered and congregate meals programs at the federal level. Oregon receives 1 percent of the federal allocation for these programs or $170,000; Community Connection receives 2.1 percent of Oregon's share, which translates into $3,400 or about 26 cents for each of the 13,000 seniors in Northeast Oregon. When distributed across my four counties, the additional funding means $850 more for each county or a total of 160 additional meals in that entire fiscal year. This translates into **four** older adults receiving a meal three times a week for 12 months.

While this funding is much appreciated, it is far less than what is needed after years of static funding and no inflation adjustments. For many seniors, our home-delivered meals drivers are the only people they see all day. In those outlying communities, meals are provided just one day per week. Consequently, many older adults withdraw and become depressed and develop physical and mental health issues. The interaction they receive at senior centers and with outreach staff that visit their home helps to minimize or prevent such conditions.

Community Connection is typical of many rural area agencies. Many provide multiple types of services, but if not they are very well connected to complementary service providers that enable them to readily respond to clients' needs. Whether a client has the ability to pay for some or all services and supports, our experience shows that clients and their families lack the ability to navigate, broker, and arrange the array of programs, differing eligibility requirements, and fee structures to effectively access the services they need. This is where we come in offering information, referral, case management services, and direct services to older adults like Mrs. Jones.

Capacity of Local Aging Programs in Rural Areas

Based on the 2007 Aging Network Survey of all AAAs and Title VI aging programs, 49.5 percent of AAAs report serving rural areas and a total of 86.5 percent of AAAs report they served locations that included some rural areas. By comparison, 50 percent of AAAs in Oregon report serving rural areas, and a total of 92.9 percent reported they served locations including some rural areas. Based on preliminary findings, the number of Title VI aging programs that serve rural communities is even more pronounced: 20.3 percent report they serve mostly remote or frontier areas, 1.2 percent report serving a mix of rural and remote or frontier areas, 65.7 report serving mostly rural areas, and a total of 98.2 percent report serving locations including some rural areas.

Half of AAAs have a budget of $3.8 million or less and half serve 3,020 or fewer clients. Comparatively, half of Title VI aging programs have a budget of $141,119 or less and half serve 150 or fewer clients. AAAs have an average staff size of 39 full-time employees and 20 part-time employees, while Title VI aging programs have an average staff size of 3.9 full-time employees and 3.2 part-time employees. Currently, AAAs and Title VI aging programs depend on Older Americans Act funding to varied degrees. With AAA budgets on average comprised of 41.9 percent OAA funding and Title VI Aging Program budgets comprised of 73.3 percent OAA funding on average. However, when asked about fiscal constraints, barriers and challenges, over 90 percent of AAAs and 95 percent of Title VI aging programs report increasing expenses limit what they can do.

n4a "Seniors Stranded" Survey Highlights Economic Pressures

A national survey of AAAs and Title VI aging programs on rising fuel, food, and other costs recently conducted by n4a in June, revealed that if aging programs continue to face escalating costs while funding remain static, millions of older adults will suffer serious consequences in 2009. According to the survey, over half of AAAs (56 percent) and Title VI aging programs (59 percent) have already been forced to cut back on services and 90 percent of AAAs and 100 percent of Title VI aging programs will be forced to make more cuts in 2009 due to rising operating costs. More than half of

agencies report an increase in the number of seniors forced to wait for service including transportation to medical appointments, home-delivered meals, respite care, homemaker services, and homecare. Other key findings include:

Economic impact on operating costs spikes: 86 percent of AAAs and 94 percent of Title VI aging programs report that operating costs have increased for the array of programs their agency offers seniors since the beginning of calendar year 2008;

Fuel costs directly impact volunteer services: Over 73 percent of agencies reported it is more difficult to retain volunteers and over 74 percent said it is more difficult to recruit volunteers; and

Fuel costs directly affect services: 53 percent of AAAs and Title VI aging programs have had to either somewhat or significantly decrease the number of weekly scheduled trips their agency can provide to older adults.

Opportunities and Challenges Ahead for the Aging Services Network

Even before the first Baby Boomers turned 60 years old in 2006, national spending for long-term care, especially under Medicaid and Medicare, was placing significant strain on federal and state resources. Although, times are now hard with agencies making the most out of limited funding resources to serve a growing number of clients despite ever increasing costs, the future holds both opportunities and challenges for the Aging Services Network. We are poised nationally and at the local level to better serve the Mrs. Jones' and their families in rural communities.

Congress recognized this potential when it enacted new provisions expanding the Network's role in providing long-term care services and supports during the Older Americans Act reauthorization in 2006. It is now time for Congress to fulfill that promise by providing the resources needed to implement these consumer-centered and cost-effective solutions. These provisions empower the Aging Services Network to

implement strategies encompassing person-centered access to information, evidence-based disease prevention and health promotion activities, and enhance nursing home diversion services.

Each of these strategies have been tested through the U.S. Administration on Aging in cooperation with State Units on Aging and AAAs, and have proven to reduce the need for more expensive institutional care and prevent "spend down" to Medicaid for people of all ages with disabilities. n4a and the National Association of State Units on Aging (NASUA) have released a proposal to fully implement these provisions that has the potential to reach over 40 million Americans and reduce federal Medicaid and Medicare costs by an estimated $2.7 billion over the first five years, resulting in a net savings to the federal government of over $300 million. As the proposal is fully implemented over ten years the net federal savings are expected to reach over $1.4 billion.

Policy Recommendations

With this in mind, n4a recommends the following policy recommendations to better serve rural older adults like Mrs. Jones.

1) Provide emergency funding for Older Americans Act programs in the next supplemental appropriations bill. This funding should be targeted to assist area agencies with the rising costs of fuel and food during the remainder of this calendar year, in particular, home-delivered and congregate meals programs and Title III B which provides very flexible funding to states and local agencies that they can use to provide a wide range of needed supportive services to older Americans. Title III B dollars, for example, support senior transportation programs, case management services, housing assistance, in-home services for frail elderly, and emergency/disaster response efforts targeted to older adults.

2) Expand on funding available under the Low-Income Home Energy Assistance Program in anticipation of record high home heating bills this winter. We fully

support increasing funding for LIHEAP to the program's authorized level of $5.1 billion under the Energy Policy Act of 2005. While Congress has indicated some willingness to increase LIHEAP funding as part of a supplemental appropriations bill, we urge you to also consider raising income and asset guidelines under LIHEAP, and increasing the fuel allotment per household to match the increase in fuel cost inflation expected this winter. We also encourage you to expand on crisis payments for the 60 and older population and homebound older adults.

3) Enhance home and community-based services for older adults who live in rural areas and around the country. Congress should act on the provisions under the 2006 Older Americans Act reauthorization by funding them to expand on the Aging Services Network's role in providing long-term care services and supports. These provisions will streamline access to home and community-based services and supports, empower consumers to stay active and healthy through disease prevention and health promotion services, and enhance the organizational capacity of the Aging Services Network to provide enhanced home and community-based long-term care systems.

4) Increase mobility options for rural seniors in the next surface transportation reauthorization bill (SAFETEA-LU). In the upcoming reauthorization, we urge Congress to further invest in senior transportation needs by enhancing funding for the FTA's Section 5310 Elderly and Disabled Formula Grant Program, which helps non-profit transportation providers meet the needs of the elderly and persons with disabilities, the Section 5311 Rural Formula Grant Program and Section 5317 New Freedom Program. This additional investment will allow area agencies and other non-profit providers to maintain their existing vehicles and replace and enhance their aging fleets, in order to increase capacity to meet the growing demand for services.

In light of rising fuel prices that often prevent vehicles from being fully utilized, it is increasingly important that current restrictions on the Section 5310 program be relaxed to allow transportation programs greater flexibility to use funds where they are most needed. Congress must also provide greater incentives to help aging programs recruit

and retain the volunteer drivers that they depend upon so much, but who are struggling due to high fuel costs.

5) Ensure that there is an adequate supply of safe, affordable, accessible, and energy efficient housing for older adults. The majority of rural housing is old stock and there is currently limited assistance for repairs and home modifications to make housing more accessible for seniors and support aging in place for the majority of older adults who want to stay in their own homes. This aging housing stock is not energy-efficient and, consequently, leads to higher home heating bills. We encourage Congress to continue at least level funding for the Community Development Block Grant program and support an increase in funding for the Section 202 Elderly Housing Program to reach the estimated ten seniors who are waiting for each Section 202 unit that becomes available. We also urge Congress to pass S. 2736, The Section 202 Supportive Housing for the Elderly Act of 2008, introduced by Chairman Kohl, to simplify and streamline the development and preservation of affordable, supportive, senior housing to increase participation by non-profit developers, private lenders, investors and state and local funding agencies.

Thank you, Chairman Kohl and Ranking Member Smith, for the opportunity to testify before you today to call attention to the needs of rural seniors and the aging programs they depend upon as they seek to age in place. I would be pleased to answer any questions you may have.

Senator SMITH. Thank you, Margaret.

I think your testimony just points out how difficult a place we find these vital programs to seniors. I mean, the funding has been stagnant for a decade now, but your costs and the population you serve and the miles you cover have not been diminishing. We are doing everything we can to move these programs to higher levels of funding so that you can accommodate these terrible increases that all Americans are facing, but particularly vulnerable seniors in rural places bear the brunt of this.

So thank you for being here.

Ms. DAVIDSON. I appreciate that. I appreciate being here.

Senator SMITH. Bill, take it over.

STATEMENT OF BILL FINERFROCK, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS, WASHINGTON, DC

Mr. FINERFROCK. Thank you, Senator.

Senator SMITH. Hit your mike, too.

Mr. FINERFROCK. Sorry. On behalf of the National Association of Rural Health Clinics and the more than 3,000 federally certified rural health clinics in the United States, I want to thank you for the opportunity to talk with you today.

The Rural Health Clinic Program is one of the largest and oldest programs to try and improve access to healthcare, primary healthcare in rural underserved areas. It was established in 1977 by an act of Congress and provides enhanced payments to practices that get certified as RHCs through a cost-based reimbursement methodology and mandates the utilization of physician assistants and nurse practitioners in the delivery of care.

It has been a very successful program, but we have a number of challenges that confront us. As far back as the mid 1970's, we recognized that traditional fee-for-service payments weren't adequate to sustain rural providers. You have heard from a number of folks, the previous witnesses indicating, and as you know, Medicare and Medicaid payments are considerably more significant in rural communities than they are at other locations. So, having adequate payments from those programs is critical to the survival of those clinics.

But it is not even often enough. I think a good example, and you have heard it referenced here today, is Gilliam County, OR. Back in 1980, they had had a succession of providers through the National Health Service Corps, none of whom were able to stay in the community, and they decided upon the idea of establishing a rural health clinic and staffing it with two physician assistants because one of the problems that you have in rural communities is the burnout factor, where providers are there 24 hours a day, 7 days a week and simply cannot sustain that level of work.

So, they created the rural health clinic, staffed it with two PAs. But they determined that there wasn't sufficient revenue, and they came up with a very creative idea, which was referenced during Senator Wyden's comments about Elgin. They created a tax district where, in essence, similar to a property tax—well, it is a property tax that they levy on themselves. But instead of going to schools, the more traditional concept, it goes to support healthcare.

This past year, that property tax covered 22 percent of the budget for the Gilliam County medical center. That meant that the Medicare and Medicaid payments fell that far short that they, in essence, had to tax themselves in order to generate sufficient revenue. But it has worked. I am pleased to be able to tell you that that clinic, the PAs and physician who started that clinic in 1980, David Jones and Dennis Bruneau and Dr. Carlson, are still working with that clinic 30 years later.

So something that went through a succession of changes is a successful model, but it can't continue to work. You made reference before to reasonable cost. Their average cost per visit in that clinic is $89 a visit, but they only get paid $75.63 by Medicare. If Medicare were to pay adequately for that clinic, the community wouldn't have to subsidize it to the extent that they do. But because Medicare doesn't pay, they at least have that tax subsidy. But that is just not right. It can't continue.

Senator SMITH. Bill, does Medicare Advantage play into this at all? Is it helping?

Mr. FINERFROCK. I don't know whether Medicare Advantage was in that particular part of Oregon. It was interesting. We did see a number of Medicare Advantage plans that were actually paying rural health clinics more than what Medicare was paying them. They came in and said we will pay you 101—in one case, we will pay you 105 percent of what Medicare paid you. Now part of that was because they were getting paid more by Medicare as an incentive to go into those markets.

One of the ironic issues with regard to Medicare Advantage is it is great to put the plans out there, but if you don't have providers who can deliver the care, what is the good to have the card that says I have a card that gives me access to all these great benefits if I don't have a provider who can deliver it?

Senator SMITH. That is a point I am sure many here recognize. I just simply emphasize that Senator Wyden has authored the Healthy Americans Act, and I am a co-sponsor of that. We are just looking for every way that we can to get people insured.

I am not sure there is a perfect plan out there, but we want all Americans to have healthcare. But there is another side to that coin, and that is simply if everybody has a healthcare policy, but there are no providers—

Mr. FINERFROCK. That is right.

Senator SMITH [continuing]. We have got a problem.

Mr. FINERFROCK. That is right.

Senator SMITH. We have a problem.

Mr. FINERFROCK. I have a piece of paper that is worthless. I have a card that looks great, but I don't have anybody. I don't have a hospital. I don't have a clinic. I don't have a provider. So you are not doing me any good.

Senator SMITH. Exactly right.

Mr. FINERFROCK. What we are saying is we need to focus as much attention on ensuring that there is a provider in that community to make that card valuable as we have on making sure that they have the card. That is where we have fallen short.

Our frustration on a provider side is that there has not been a recognition—I know, with all due respect to the previous panel,

there was discussion about Medicare does this or Medicare—very often a critical access hospital was not created by CMS. It was created by Congress.

Senator SMITH. Right.

Mr. FINERFROCK. The Rural Health Clinic Program was created by Congress. The health professional shortage area payments were created by Congress because the agency itself does nothing proactively to try and recognize its own problems. It takes an act of Congress to do it.

States have historically come up—they are considered the incubator of great ideas out there. They come up with creative and innovative ways of trying to deliver healthcare in their States and in their communities. But yet we get to the Federal level, and the Federal Government says, well, we are not going to pay for that.

Senator SMITH. So they are killing good ideas.

Mr. FINERFROCK. I think that that is—they are not killing it. They are dying by neglect. Now because every time somebody comes up with a new idea, they have to come to Congress. The flip side of that, and this is the irony, and you mentioned before the rural health clinics role, in this proposed rule, they proposed a dramatic change in the way they want to calculate rural health clinic payments.

Now the statute for rural health clinics and how those are to be calculated is the same today as it was in 1977 when it was passed by Congress. We have been getting paid the same way for the last 30 years. But now in this proposed rule, they say, "well, we are going to make a technical change in the way that we are going to pay rural health clinics" and, "oh, by the way, it is going to reduce the amount that you get paid," but this is the way we now interpret the law.

Well, if they can interpret the law after 30 years of doing it one way, essentially overturn 30 years of interpretation and you go and you ask them, "well, we have got this problem with the critical access hospitals" and their response is, "oh, well, you have to change the law."

Senator SMITH. We are going to change it, give them something else to do.

Mr. FINERFROCK. But why is it that they have the ability to do a technical correction to change the payment methodology that they have done for one way, but when we bring other problems to the attention that for whatever reason they choose they don't want to deal with it? Oh, you have to go and change the law.

To me, they have the same flexibility to address your problem if they feel that they can change our payment methodology after 30 years.

Senator SMITH. I couldn't agree more, and I am sure you all recognize that part of the value of having congressional hearings and having these good civil servants come here is to put light and heat on them and let them know we are watching them. Frankly, we are moving. We are going to change some things here because this is not working for rural Oregon. So, your presence here is valuable, and it is part of our strategy—

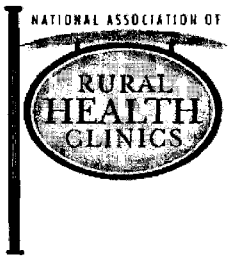
Mr. FINERFROCK. Well, I want to thank you for all of your work, both on this proposed rule, the health professional shortage area

proposed rule, Senator Wyden's work on both of those issues. You have been really excellent advocates, and we appreciate it.

We want to go forward to address these problems. We want to work with the Congress. We want to work with CMS to try and get these. In my office, I have—it has been there for many years, and it says—I cut it out of a newspaper, and it says, "Worry about the patients." That has got to be our daily reminder.

This isn't about rural health clinics. It is not about critical access hospitals as institutions. It is about people, and those institutions provide healthcare. They make it available in those communities. To the extent that we make it harder for critical access hospitals, rural health clinics, rural physicians to provide care, it is the beneficiaries who ultimately lose.

[The prepared statement of Mr. Finerfrock follows:]



Testimony of

Bill Finerfrock

Executive Director

National Association of Rural Health Clinics

Before

Senate Aging Committee

"Growing Old in Rural America"

July 31, 2008

Mr. Chairman and members of the Aging Committee. On behalf of the National Association of Rural Health Clinics, I want to thank you for this opportunity to talk with you about the challenges facing rural providers in meeting the healthcare needs of rural underserved communities.

The Rural Health Clinic (RHC) program is the oldest and largest federal program aimed at improving access to healthcare in rural underserved communities. There are more than 3,000 federally certified RHCs and many have been providing quality, cost-effective healthcare in rural underserved areas for 30 years.

To be certified as an RHC, a clinic must:

* be located in a non-urbanized area;
* be located in an area designated as a health professional shortage area (HPSA), medically underserved area (MUA), or governor-designated shortage area;
* be engaged primarily in providing outpatient primary medical care;
* employ at least one nurse practitioner (NP), physician assistant (PA), or certified nurse midwife (CNM) at least 50 percent of the time that the clinic is open; and,
* receive medical direction from a physician who periodically reviews the services provided by the NPs, PAs and/or CNMs and is on-site and available to provide care at least one day every two weeks.

When the RHC program was created in 1977, it was viewed as an experiment by many at the federal level. The payment methodology – cost-based reimbursement rather than fee-for-service reimbursement for both Medicare and Medicaid - and staffing requirements (mandatory use of PAs or NPs) were and continue to be unique.

Congress, as far back as the mid-1970s, recognized that the traditional fee-for-service payment methodology was inadequate to support and sustain a traditional medical practice in rural medically vulnerable communities. For this reason, RHCs were authorized to be paid using capped, cost-based payment principles and payment would be an all-inclusive payment. This has

proven to be an attractive and successful incentive for providers to locate in rural underserved areas.

But even the special payment methods can't solve all problems.

Gilliam County, Oregon is a good example.

Gilliam County has a population of roughly 2,000 people. It is what many might describe as "frontier" and it is geographically larger than some states. The Gilliam County Medical Center, a federally certified Rural Health Clinic in Condon, Oregon, is the principle provider of primary health care for most County residents.

The medical center was established in 1980 by two physician assistants, David Jones, PA-C and Dennis Bruneau, PA-C and a physician, Dr. Bruce Carlson. Prior to the creation of this clinic, there was a revolving door of physicians through the community. The National Health Service Corps (NHSC) would place a physician in the community but as soon as the physician's NHSC obligation was fulfilled, the physician would leave. As state and county officials looked at this situation, it was clear that part of the reason the community could not retain their physicians was the burn-out factor so common in rural America.

It was determined that the community required at least two primary care providers who could share call and responsibility and as a result, the RHC program would be well-suited for this community because of the clinics planned reliance on PAs as the primary source of healthcare. But even with the higher reimbursement available through the RHC program, it was apparent that there would be insufficient revenue to sustain the clinic over time. Working with community leaders, the idea of creating the Gilliam County Healthcare tax district was brought to the voters of southern Gilliam County. The idea is similar to property taxes used to support the local school system, but instead, the healthcare tax district would levy a property tax to support primary healthcare. The voters of Gilliam County approved this unique subsidy.

I am pleased to tell you that nearly 30 years later, the Gilliam County Medical Center continues to exist and is still staffed by physician assistants David Jones and Dennis Bruneau and their supervising physician, Dr. Bruce Carlson. The clinic sees all patients regardless of their ability to pay. Last year, nearly 15% of the patients seen by the medical center were uninsured. This is considerably higher than the percentage of uninsured seen by the typical primary care medical practice in the U.S. This past year, the revenue generated by property taxes constituted 22% of the clinic's budget. Were it not for the combination of revenues generated by being a rural health clinic and the revenue from the tax district, the clinic would likely have closed many years ago.

The Gilliam County medical center story is only one of dozens of creative and innovative solutions to providing quality, affordable healthcare in rural America. Chairman Kohl, similar examples exist in Wisconsin that I will talk about shortly.

But we are in serious danger of losing many of the creative solutions that have been developed at a community level and, more importantly, federal policies are stifling the creation of the next Gilliam County medical center. Just recently, the Centers for Medicare and Medicaid services issued proposed changes in the RHC rules and regulations that if adopted as published, would, we believe, devastate the health care infrastructure of rural America. This CMS proposal comes on the heels of another, equally damaging proposal put forward by the Health Resources and Services Administration to change how we determine if areas are underserved.

I want to acknowledge the efforts of many of the Senators on this Committee – particularly those of Senator Smith – to force HRSA to address some of the unique problems with the shortage area rule. Like many others, I was pleased that HRSA announced last week that rather than moving ahead with what clearly became a very controversial proposal, they decided to go back to the drawing board. Without your help and support, this never would have happened.

But we still must deal with the RHC proposed rule. Again, I want to acknowledge the efforts of two members of this Committee, Senator Wyden and Senator Smith for taking a leadership role in helping the rural community get more information on the impact of this proposed rule, an

extension of the public comment period and, for introducing legislation to try to address the inconsistency between the HRSA review timetable for shortage area designations and the CMS standard that RHCs can only be located in shortage areas that have been updated within the past 3 years.

It has often been said that states are the incubators for the development of new ideas. I believe this is true. Unfortunately, federal policies are often killing these new ideas before they have a chance to take root and grow. Or, they support innovation in the early stages, only to penalize communities later on when they are successful.

In the typical rural underserved community, payments from Medicare and Medicaid can often represent 50 – 60 percent of a clinic's revenues. According to a survey of Rural Health Clinics conducted by the University of Southern Maine, over 30% of the patients coming into the typical RHC have their healthcare paid for by Medicare and on average 25% are covered by Medicaid. In addition, nearly 15% of the typical RHC patients have no insurance. This means that only 25 - 30% of the typical RHC patients are covered by commercial insurance. I would like to note that the typical RHC sees far more Medicare and Medicaid patients – as a percentage of patients – than ANY other provider of primary care services – including Federally Qualified Health Centers.

What this tells us is that rural providers, such as RHCs, are heavily dependent upon adequate Medicare and Medicaid payments to support the availability of healthcare in these communities. Unlike practices in Milwaukee or Portland where low Medicare or Medicaid payments can be offset by revenues from commercial insurers, rural providers don't have this luxury. And, unlike practices located in more urbanized areas, rural providers typically see all patients, regardless of their ability to pay – even when there is no federal support for them to do so. In rural America it would be considered a breach of faith for a provider to turn patients away.

Another innovation we have seen in the past 15 years, is the development of networks of Rural Health Clinics. These are networks that link several RHCs either independently or through a hospital network.

One of the early physician groups that got involved with the RHC program was the Miles Bluff Clinic. Through a network that includes two Rural Health Clinics and specialty physicians, the Miles Bluff Clinic has been serving the communities in central Juneau County since 1980.

Unfortunately, network arrangements such as the Miles Bluff Clinic are threatened by their own success. If the RHC proposed rules recently released by CMS are adopted as proposed, the Miles Bluff clinic will be forced to close some of its outreach facilities. The added cost associated with the reduced payments proposed by CMS will severely hamper the ability of the Miles Bluff clinic and other RHCs to continue to survive financially.

I want to encourage the Committee to appreciate and support the on-going innovative efforts at the state level to meet the challenge of bringing quality healthcare to rural populations.

Despite years of effort, we still have a mentality in some government agencies that there is only one way – the urban way – to deliver healthcare. I thought we had overcome these biases with the widespread acceptance of physician assistants and nurse practitioners, but I continue to see attitudes and policies that fail to recognize the lead the states are taking in creating new health professionals to meet the workforce needs of their communities. The efforts to develop the next "PA" or the next "NP" are often stifled because of what was done originally with PAs and NPs, the Medicare program says – we won't pay for healthcare provided by this state licensed health professional unless you get the Medicare law changed to recognize this new health professional. This not only affects individual providers, but innovative facilities as well. The Critical Access Hospital program is another example.

In addition to failing to adopt innovative delivery strategies developed at the state level, we fail to adequately keep pace with the need to make positive changes in the programs already on the books. Here are some other issues that need to be addressed:

1. Raise the RHC per visit Cap

2. Consider more carefully possible changes in the methodology used to determine health professional shortage areas.
3. Concerns about proposed changes in RHC rules and regulations
4. The need to foster greater opportunities for collaboration between RHCs, CAHs, small rural hospitals and Federally Qualified Health Centers.
5. Ensuring the ability of rural providers to offer new and expanded services approved by Congress but because of different payment policies, make it difficult for rural providers to make these services available. Services such as diabetes education.

The Rural Health Clinic program has a long and proud history of helping to meet the healthcare needs of individuals living in rural underserved areas. The RHC program isn't the answer for every rural community, but it is the answer for many. I must tell you that I am very worried about the future of this program. The policies we see coming out of CMS have a decidedly anti-rural tone. Whether this is intentional or simply sins of omission we cannot tell.

Rural America is not just another special interest group. Rural seniors deserve to have access to high quality, affordable healthcare. We can do this but Medicare needs to be a partner in this effort.

Senator SMITH. Thank you very much, Bill.

Mr. FINERFROCK. Thank you.

Senator SMITH. Scott, take it away.

STATEMENT OF SCOTT EKBLAD, DIRECTOR, OREGON OFFICE OF RURAL HEALTH, OREGON HEALTH AND SCIENCE UNIVERSITY, PORTLAND, OR

Mr. EKBALD. Thank you very much.

For the record, my name is Scott Ekblad. I am the Director of the Oregon Office of Rural Health, and I really appreciate being invited to talk here today.

Senator SMITH. Thanks for coming.

Mr. EKBALD. I am going to start by talking about the State Offices of Rural Health. As Tom Morris from the Office of Rural Health Policy stated, it is a nationwide program. Some may wonder why there is a need for something as specific as an Office of Rural Health. The answer is really simple. Rural people are generally older, sicker, poorer, more likely to be under or uninsured than their urban counterparts.

Healthcare services are relatively few and far between for rural people, and many are accessible only in distant urban communities. There are far fewer physicians in rural communities, and most of them are overwhelmed. In Oregon, there is a physician for every 327 urban dwellers, and 1 for every 819 rural Oregonians.

Rural physicians, clinics, and hospitals must survive financially with small population bases in an environment in which too many of their patients can't pay for their healthcare and when Government programs such as Medicare pay less than the cost of delivering a service. That is why there are State Offices of Rural Health. We help rural providers stay in business and meet the needs of their patients.

There is a State Office of Rural Health in each of the 50 States. Most are located within State government. About a dozen are located at universities, like the one in Oregon, and there are even a few private, nonprofit Offices of Rural Health.

But we all share certain core functions, and one is a State clearinghouse for information about rural health. Another is to coordinate the activities in the State that relate to rural healthcare. A third is to facilitate participation of rural healthcare entities in Federal, State, and local programs, assist in the recruitment and retention of healthcare professionals, and strengthen State, local, and Federal partnerships. Those are all fairly broad mandates, but we are very creative in doing in each State what is needed.

Oregon's Office of Rural Health was created by State statute in 1979 and actually pre-dated the national program. So the Oregon Office of Rural Health is one of the oldest in the country. We were part of the State government until 1989, when it was relocated to Oregon Health and Science University.

The synergy that results from being located at a health science university—the State's only school of medicine, its only school of dentistry, as well as a nursing school and a pharmacy school—helps us accomplish our mission, which is to improve the quality and availability of healthcare for rural Oregonians.

The Oregon Office of Rural Health is involved in many activities to achieve our mission, including preparation of rural healthcare workforce, advocacy for rural providers, and access to oral and mental health services. But I will focus today on the services we provide that are of particular benefit to Oregon's rural seniors.

The first program I want to talk about is the Medicare Rural Hospital Flexibility Program. The Flex Program ensures the viability of small rural hospitals by ensuring cost-based Medicare reimbursement for those that qualify to become CAHs. In Oregon, the State legislature also guarantees cost-based reimbursement for Medicaid services.

Dennis Burke, the CEO of one of the finest rural hospitals in Oregon, will speak to you about the role of a CAH in a rural community. But I want to talk a little bit about what the office does with the Flex Program. The Flex Program does much more than enable enhanced reimbursement.

It also grants funds to each participating State to provide technical assistance and other services to these hospitals and the communities in which they operate.

These activities help rural hospitals match services to the needs of their communities, and I want to give a few examples of what the State of Oregon has done with their annual State Flex grant. For example, we provide monthly Webcast seminars on topics such as preventing surgical infections, effective provider recruitment and retention strategies, and updates on CMS regulations.

We provide innovation grants to communities to foster appropriate solutions for local problems. We provide training for local emergency medical technicians, the hospitals that they refer to, and the community clinicians to facilitate a collaborative high-quality system of care from pickup by the ambulance to transfer to the hospital.

Senator SMITH. Scott, can I ask you on this, the whole approach of innovation, is telemedicine a piece of that? Are you familiar with what the VA is doing in terms of telemedicine and—

Mr. EKBALD. I am familiar with it. Frankly, I think that in Oregon at least, telemedicine has really not quite hit its stride as far as applicability to rural communities. The State of Oregon or an entity within Oregon, the Oregon Healthcare Network received $20 million in funds from the FCC, and it is called "the Last Mile" funds. That is to lay the cable, literally, to the very most remote clinics and hospitals.

So, once that is in place, I think that we will be able to utilize telemedicine quite a bit more. The problem still exists—

Senator SMITH. Is it going to be one of our answers, or what other problems are related to telemedicine?

Mr. EKBALD. Well, there are a few more steps before I would call it a solution, and one of them is accessing the capital that would be required to utilize telemedicine. There needs to be a hub where services are provided. So far, that doesn't really exist in one central location.

Senator SMITH. Would that be healthcare clinics?

Mr. EKBALD. Well, and the healthcare clinics also need to purchase the equipment that is necessary, but I think that it could really be tremendously helpful in providing services that are just

never going to be cost effective to deliver in a very small community.

Senator SMITH. As you think of innovation and how to keep rural Oregon connected, I think watching what the VA has been doing is just groundbreaking and very impressive. The quality of care may not be the same as if you are sitting in the doctor's office, but I have watched it, and it is pretty darned good. It is better than not having it.

Mr. EKBALD. I also understand that it is particularly useful for younger folks. The younger people are the more comfortable interacting in that medium.

Senator SMITH. Yes, I guess that rules me out.

Mr. EKBALD. You and me both, Senator. [Laughter.]

Oregon began its State Flex Program in 2000, and we had lost roughly 10 hospitals in the preceding decade due to financial difficulties. I am happy to say that since the advent of the Flex Program, we have not lost one single rural hospital. So that alone is a testament to the value of the program.

Senator SMITH. How important is Medicare Advantage, in your view, to rural health?

Mr. EKBALD. Well, I am not familiar with any examples, such as Mr. Finerfrock stated, of a Medicare Advantage program coming in and offering more than what they would—the clinic would ordinarily get. So the examples I hear about are ones where the Medicare Advantage plans, and we do have a fairly large penetration of Medicare Advantage plans in rural Oregon, are really putting hospitals in particular in a bind because of the payment.

I want to talk also a little bit about rural health outreach and network development grants. They are very important. These are grants that go directly to the communities. They don't come to the State Office of Rural Health, but I did want to mention a couple examples.

There is one entity in southern Oregon that has received an outreach grant in order to integrate behavioral healthcare with primary healthcare. A lot of primary care visits, they come to the family practices, for example, and really what they have is an underlying mental health or behavioral health issue.

This one rural health outreach grant enabled this organization to place a behaviorist in a primary care practice so that when the primary care physician identifies an underlying behavioral health problem, they can call the behaviorist and consult with the patient right on the spot. There is no losing people by having them come back for another visit. So that is one example of how an outreach grant has been used.

In closing, I want to talk a bit about provider incentives. The State Office of Rural Health in Oregon is also proud to implement State-based incentive programs for providers, such as the State income tax credit program for all rural physicians and other providers in our State. We also have a malpractice subsidy program in Oregon for rural providers that is implemented by our office.

Also tax credits for volunteer EMTs—

Senator SMITH. Scott, tell me about the malpractice piece. Do you help them be able to access and afford insurance?

Mr. EKBALD. We literally help them pay their premiums.

Senator SMITH. You pay their premiums.

Mr. EKBALD. As I am sure you know, malpractice premiums in Oregon are particularly high, and we were at risk of losing literally all obstetrical services in rural Oregon.

Senator SMITH. When the cap was taken off—did they explode then?

Mr. EKBALD. Actually, they were quite high before that, and now the situation is even worse.

Senator SMITH. But because of the program, your physicians are able to get insurance because you help them pay for it?

Mr. EKBALD. Yes. Yes, that is true. However, it is a finite pot of money, so to speak. It is not a funding stream, and so we are due to run out of those funds sometime in 2010 or 2011. So we are working with the legislature to see how we might be able to continue that program.

Senator SMITH. Very good.

Mr. EKBALD. So, in closing, please allow me to thank you and your colleagues for inviting us here today and for your support of House Resolution 6331. The provisions that were mentioned earlier are very important to Oregon and to many other States.

I hope that we can also count on your support for the funding that comes along with the Labor-HHS-Education bill because even though, for example, the Flex Program was reauthorized under H.R. 6331, the funding comes through Labor-HHS-Education bill. For the reasons that I have just mentioned, they are so important to our State.

So thank you very much.

[The prepared statement of Mr. Ekblad follows:]

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United States Senate
Special Committee on Aging
Testimony of Scott Ekblad, Director
Oregon Office of Rural Health
July 31, 2008

State Offices of Rural Health

Some may wonder why there is a need for something as specific as an Office of *Rural* Health. The answer is simple: rural people are generally older, sicker, poorer and more likely to be under- or uninsured than their urban counterparts. Health care services are relatively few and far between for rural people, and many are accessible only in distant urban communities. There are far fewer physicians in rural communities, and most of them are overwhelmed. In Oregon, there is a physician for every 327 urban dwellers, compared to one for every 819 rural Oregonians.

Rural physicians, clinics and hospitals must survive financially with small population bases, in an environment in which too many of their patients can't pay for their health care, and when government programs such as Medicare pay less than the cost of delivering a service. That is why there are state Offices of Rural Health - we help rural providers stay in business, and meet the needs of their patients.

There is a state Office of Rural Health in each of the 50 states. Most are located within state government; a dozen or so, like Oregon's, are located at health sciences Universities. There are also a few private, non-profit Offices of Rural Health.

All state Offices of Rural Health share certain core functions. They are:

1. Establish and maintain within the state a clearinghouse for collecting and disseminating information on rural health care issues;
2. Coordinate the activities carried out in the state that relate to rural health care;
3. Facilitate participation of rural health care entities in federal, state, and nongovernmental health care programs;
4. Assist in the recruitment and retention of health professionals in rural areas; and
5. Participate in strengthening state, local and federal partnerships in rural health.

Oregon's Office of Rural Health, created by state statute in 1979, is one of the oldest in the country. We were part of state government until 1989, when it was relocated to Oregon Health & Science University. The synergy that results from being located at the state's only schools of medicine and dentistry, as well as a school of nursing and pharmacy, helps us accomplish our mission, which is to *improve the quality and availability of health care for rural Oregonians.*

The Oregon Office of Rural Health is involved in many activities to achieve our mission, including preparation of a rural health care workforce, advocacy for rural providers, and access to oral and mental health services, but I will focus today on the services we provide that are of particular benefit to Oregon's rural seniors.

Medicare Rural Hospital Flexibility ("Flex") Program

The "Flex Program" ensures the viability of small, rural hospitals by assuring cost-based Medicare reimbursement for those that qualify to become Critical Access Hospitals (CAH). In Oregon, the state legislature guarantees cost-based reimbursement for Medicaid services, as well. Dennis Burke, CEO of one of the finest rural hospitals in Oregon, will speak to you about the role of a CAH in a rural community. The Flex Program does much more than enable enhanced reimbursement for CAHs. It also grants funds to each participating state to provide technical assistance and other services to hospitals that help them improve the quality and scope of services to their communities. These activities help rural hospitals match services to the needs of their communities, and retain the market share needed to remain financially viable.

Examples of Flex Program activities in Oregon include:

- Monthly webcast seminars on topics such as preventing surgical infections, effective provider recruitment and retention strategies, and updates on CMS regulations.
- Creation of a state rural health plan to serve as a "roadmap" for quality improvement in health care in rural Oregon.
- Innovation grants made to communities to foster appropriate solutions for unique health care challenges.
- Training for local emergency medical service agencies, the local hospital and community clinicians to facilitate collaborative, high quality care for patients from first contact through transfer to inpatient care.
- Coordination of Community Health Improvement Partnerships (CHIPs), which are year-long community assessment and decision-making processes that engage the entire community to identify and meet their health care needs.

- Creation and support of the Oregon Rural Healthcare Quality Network, a collaborative of 20 rural hospitals that works together to develop and implement quality improvement programs that work in small, rural settings.
- Ongoing, open exchange of best practices in the areas of pneumonia, AMI transfer, heart failure and other CMS Core Measures.
- Facilitate learning and decision-making among CAHs regarding electronic health records (EHR) and other health information technology (HIT) applications.
- Development of a recruitment and retention tool kit for rural EMS volunteers.
- Foster network development among hospitals, rural health clinics, federally qualified health centers, and other providers of health and social services in order to provide more comprehensive care to rural residents.
- Support distance learning and on-site training of incumbent hospital workers to become nurses.

Oregon began its state Flex program in 2000. We had lost roughly ten rural hospitals in the preceding decade due to financial failure. I am happy to report that not one rural Oregon hospital has been forced to close since the advent of the Flex program. Not only does it ensure adequate reimbursement for the care provided to Medicare beneficiaries, it provides the technical assistance and other forms of support necessary to help rural hospitals meet the evolving needs of its community.

Federally Certified Rural Health Clinics

Mr. Finerfrock has already discussed the vital role played by Rural Health Clinics (RHCs) in a rural community, but I wanted to touch on how the Oregon Office of Rural Health uses its resources to support them.

We have two field staff who spend the bulk of their time on the road, providing on-site technical assistance to Oregon's 53 Rural Health Clinics. Our staff are available to conduct practice assessments and advise clinic staff on how to effectively and efficiently operate their businesses while providing care to as many patients as possible. We teach them appropriate coding and billing practices. Many of these clinics are community-supported, and our staff helps boards of directors and clinic staff generate the revenue needed to keep their doors open. Many have formed health districts to generate tax revenue to subsidize the clinics. Others must pursue grants and community fundraising activities to offset their costs. Some are lucky enough to draw from a large enough patient population that patient revenue alone is enough to stay solvent. Our staff also serves as a liaison with regulatory agencies to ensure that Rural Health Clinics stay informed of what is required of them to retain their federal certification as Rural Health Clinics.

Our office recently secured foundation funding to conduct an in-depth analysis of Oregon's RHCs, and I offer the resulting report as a resource to you. It can be found on our web site, at www.ohsu.edu/oregonruralhealth.

Rural Health Outreach and Network Development Grants

These two grant programs are available directly to rural communities and, in my opinion, the reason they are so successful and valuable is that they are intended to encourage local people to develop local solutions to their own health care dilemmas.

Many patients present to their primary care providers with ailments that, upon evaluation, are due to underlying mental or behavioral health problems. Anecdotal reports from some rural Oregon physicians indicate that as many as 50% of their patients are suffering from a mental or behavioral health condition such as stress, depression or drug/alcohol abuse. A drug and alcohol treatment organization in one rural Oregon community received a Rural Health Outreach grant to integrate a behavioral therapist into a local primary care practice. The physician sees the patient, completes his/her assessment and, when appropriate, connects the patient with a behavioral health specialist during the same visit. In addition, the patient may be more likely to agree to subsequent visits with the behaviorist because they are conducted at a primary care facility, rather than at an addictions treatment center.

Earlier I mentioned the Oregon Rural Healthcare Quality Network (ORHQN), the collaboration of rural hospitals working together to improve quality of care. Oregon's Flex Program facilitated their creation, but the network also benefited greatly from receipt of a Network Development grant. The support they received for organizational development, strategic planning and program development is responsible in large part for their ongoing success. One of the outcomes of that grant is the development of a peer review network. Critical Access Hospitals are required to obtain external peer review of a sampling of their physicians' charts. Many CAHs found this requirement to be cost-prohibitive ($200 - $1000+ per chart) and, in many cases, not true *peer* review, as the only services available to them utilize urban physicians. ORHQN put together the training and infrastructure required to create a peer review network using physician reviewers in participating hospitals. The Office of Rural Health acts as the hub, receiving the charts to be reviewed and randomly assigning them to physician reviewers in other rural hospitals within the network. As a result, the review is done by actual peers, and the cost to the hospitals is $35, roughly the cost of postage.

Provider Incentives

The Oregon Office of Rural Health is proud to administer state-sponsored incentive programs such as a state income tax credit program for rural providers, a malpractice subsidy program for rural physicians and nurse practitioners, tax credit programs for rural volunteer emergency medical technicians (EMTs) and physicians who see TRICARE patients. Our office also helps to administer state loan repayment programs for physicians, nurses, physician assistants, dentists and pharmacists who practice in underserved rural areas.

We are currently collaborating with our state Area Health Education Center to develop a training program within the OHSU School of Medicine to support and prepare medical students specifically for rural practice. We are also working together to create a non-profit locum tenens (temporary staffing) service to fill in for rural providers who need to leave their practices for continuing education, vacation, or in a situation where a provider leaves the community and a successor has not yet been recruited.

Thank You

Please allow me the opportunity to thank you and your colleagues in both the Senate and the House of Representatives for passing H.R. 6331, the Medicare Improvements for Providers and Patients Act of 2008. The Medicare provisions in this act are vital to the survival of rural providers. I would like to mention two specifically - reauthorization of the Flex Program and suspension of a 10.6% cut in Medicare payments to rural physicians. If Medicare physician payments are cut, I can guarantee you that it would result in a dramatic reduction in access to care for Medicare beneficiaries. Similarly, if the Flex program is discontinued, the viability of many rural hospitals would be in jeopardy. Thank you for your support on that bill, and I hope we can count on your support for continued essential rural health funding contained in the Labor-HHS-Education bill. That is the source of funding for the federal Office of Rural Health Policy, for State Offices of Rural Health, for the Medicare Rural Hospital Flexibility Program, for Rural Outreach and Network Development grant programs, and for Area Health Education Centers. All have suffered budget cuts in recent years and they are in desperate need of your increased support. The minimal investment these programs represent yields concrete healthcare options for rural seniors and all rural Americans.

Thank you for the opportunity to speak with you today, and I'd be happy to answer any questions you may have.

Senator SMITH. Thank you very much, Scott.

Dennis, my friend, tell us about critical access.

STATEMENT OF DENNIS BURKE, PRESIDENT AND CEO, GOOD SHEPHERD MEDICAL CENTER, HERMISTON, OR

Mr. BURKE. Senator Smith, it is nice to be here. My name is Dennis Burke.

You are very familiar with our community, but for those in the room who aren't, I will just go over a little bit of details about us. I am President of Good Shepherd Healthcare System in Hermiston, OR, where I have had the pleasure of serving for the past 20 years.

Hermiston is a rural community with approximately 17,000 residents located in north-central Oregon near the Columbia River. We enjoy a mild desert climate and have a lot of recreational opportunities. Good Shepherd Healthcare System serves a population of about 50,000, and part of our mission is to improve access to healthcare services.

We offer a broad array of general medical, surgical, and obstetrical services. We have a busy 24–7 emergency room that is designated as a Level 3 trauma center. Our emergency room also serves as a major primary care safety net for the region. We provide home health and hospice care and a transportation service to assist people in getting to their medical appointments, which, by the way, is highly utilized by seniors.

Our community has seen a significant growth in the number of seniors targeting Hermiston and the vicinity for retirement. In fact, the city of Hermiston now actively promotes Hermiston as a designation retirement community. We appreciate the supportive programs that have come through our Government that have strengthened America's smallest hospitals that serve its most vulnerable communities. The Critical Access Hospital Program is a prime example of this support.

Following Good Shepherd Healthcare System's enrollment in the critical access program 2½ years ago, I am pleased to say that Good Shepherd Healthcare System is now on solid financial footing, following several years of financial losses.

While much is good, there are opportunities for improving healthcare and access in rural America, and I would like to focus on our two top priorities in Hermiston. Recruitment and retention of professional and technical personnel is our biggest challenge. Unless there are system changes, this problem is only projected to get worse.

In our experience, like that of many rural communities, our shortages are not for a lack of applicants. We have many interested and qualified students that cannot get into healthcare programs due to a lack of capacity within the educational system. Our local community college has three qualified applicants for every available position in their nursing program. We rely heavily on the college for quality nurses.

Several years ago, we formed a partnership with our sister hospital in Pendleton to fund an additional instructor position. This has provided an additional six to seven new nursing graduates per year, which has been very favorable for both our facilities.

As scarcity of professionals has increased, market pressures have pushed their compensation higher, making it difficult for colleges to offer the competitive salaries necessary to entice qualified professionals back into teaching. Much more needs to be done across our country to increase access and availability for qualified students who wish to pursue healthcare careers.

Second, I would like to speak to the Critical Access Hospital Program 25-bed cap. Good Shepherd Healthcare System runs an average census of approximately 17 patients per day. But that census has varied this past year from a low of 10 to a truncated high of 25, the point at which in order to be compliant we must transfer patients to other hospitals.

Good Shepherd Healthcare System's large obstetrical program compounds the problem. Over the past year, our OB daily census has ranged from 0 to 11 patients. Obstetrical patients count toward the critical access hospital 25-bed cap. This means that beds available for other acute care patients in our community can vary from the full 25 beds down to 14, depending on the daily OB census.

While OB services generally have little to do with Medicare patients, they certainly have an impact on our seniors' access to care depending on the luck of the draw when they present for acute care services. Not only is a transfer due to the 25-bed limitation disruptive and inconvenient for patients and their families, it also involves a degree of unnecessary risk to the patient and adds significantly to the cost of care.

We doubt that any of the transfers that we have made have resulted in significant cost savings at another facility, especially when considering the additional $1,200, at minimum, of expenses that the transport adds.

I want to thank you, Senator Smith and Senator Wyden, for your understanding of the problem that the 25-bed cap has caused and your collective efforts in developing the Critical Access Hospital Flexibility Act. This bill provides for use of an annual average daily census rather than a cap as a determinant for critical access hospital eligibility. Use of an annual average census standard would free critical access hospitals from the difficult choice of transferring patients and risking goodwill or keeping the patient and risking essential reimbursement.

We believe this would be a far better delimiter, and we encourage the Subcommittee to support this legislation. This modification of the critical access program will strengthen America's smallest hospitals and enable them to fulfill their mission, enhancing access in their communities, which we are prepared to do.

I appreciate the opportunity to be here and would be open to questions.

[The prepared statement of Mr. Burke follows:]

Statement of

Dennis E. Burke, MHA
President, Good Shepherd Health Care System
Hermiston, Oregon

before

Senate Special Committee on Aging

July 31, 2008

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Written Testimony of Dennis E. Burke, President
Good Shepherd Health Care System
Hermiston, Oregon
July 31, 2008

Chairman Kohl, Ranking Member Smith, and distinguished members of the committee: Thank you for the opportunity to provide testimony on behalf of our hospital and community. I hope my testimony is representative of many smaller hospitals in America and contributes to improving healthcare for all Americans living in rural communities, including our senior populations.

My name is Dennis Burke. I am the president of Good Shepherd Health Care System in Hermiston, Oregon, where I have had the pleasure of serving for the past 20 years. I am also the current finance section chair of the Small and Rural Hospital Committee of the Oregon Association of Hospitals. This committee focuses on financial issues of Oregon's smaller hospitals.

Hermiston is a rural community located in north central Oregon, near the Columbia River and the Washington state border. We enjoy a mild desert climate and have a strong, diverse economy. While Hermiston itself has approximately 17,000 residents, Good Shepherd Health Care System serves an area population of about 50,000.

Surrounding hospitals range in distance from 30 miles east to Pendleton to over 100 miles west to The Dalles. The closest tertiary referral hospital is Kadlec Medical Center, 40 miles to the north in Richland, Washington.

Part of the mission of Good Shepherd Health Care system is to improve community access to healthcare services. In doing so, we have attempted to offer as broad a spectrum of ancillary and acute medical services as we can competently provide in a financially feasible manner. Good Shepherd Health Care System is accredited by the Joint Commission and offers general medical, OB/GYN, pediatric, critical care and surgical services. We have a busy 24/7 Emergency Room that is designated as a Level 3 trauma center. Our emergency room also serves as a major primary care safety net for our region. Our health care system also provides home health and hospice care, a retail pharmacy and a transportation service. We also offer or sponsor approximately 600 health education programs per year, focusing on improving and maintaining the health of our community.

Our community has seen a significant growth in the number of seniors targeting Hermiston and the vicinity for retirement. In fact, the city of Hermiston and our Chamber of Commerce actively promote Hermiston as a destination retirement community. We now have six assisted living facilities and very active area community senior center programs. From my 20-year vantage point, service availability and access to care has greatly improved in Hermiston and our surrounding communities.

I would like to take this opportunity to express my appreciation to you, our government leaders and to CMS for the supportive programs and grants that have strengthened America's smallest hospitals that serve its most vulnerable communities.

The Critical Access Hospital program is a prime example of this support. Prior to the Critical Access Hospital (CAH) program, Good Shepherd Health Care System suffered financial losses for several straight years. Following our enrollment in the CAH program 2 ½ years ago, Good Shepherd Health Care System is now on solid financial footing.

This improvement in financial position has allowed us to keep our technology reasonably current, enhance our facilities to meet our current needs, and to compete more successfully for scarce professional and technical talent.

We also appreciate the Rural Hospital Medicare Flexibility Program grants that have been provided to assist rural hospitals in improving quality, safety and education. We are a very supportive member of the Oregon Rural Health Quality Network. This consortium of rural hospitals, combined with the State Office of Rural Health and other quality stakeholders, was formed to help Oregon's smallest hospitals work in a collaborative environment to improve health care for all our citizens. The FLEX grants have been instrumental in providing resources to assist the network in achieving its goals. The Oregon Rural Health Quality Network has become a very effective forum assisting Oregon's rural hospitals in measuring their quality performance and developing best practices.

OPPORTUNITIES FOR IMPROVEMENT

While much is good, there are opportunities for improving healthcare in rural America. I would like to focus on our two top opportunities in Hermiston.

1. **Recruitment and retention of professional and technical personnel is our foremost day-to-day challenge.** There is no question that shortages of key health care professionals and technical personnel exist, and unless there are system changes, this problem is only projected to get worse. In our experience, it's not for a lack of applicants. There are many interested and qualified students that cannot get into healthcare programs due to a lack of capacity within the education system.

Our local college - Blue Mountain Community College in Pendleton - has three qualified applicants for every available position in their nursing program. We work closely with Blue Mountain Community College as a clinical site and rely heavily on them for qualified nurses. Several years ago, Good Shepherd Health Care System and St. Anthony Hospital in Pendleton partnered with Blue Mountain Community College to help fund an additional faculty position to increase the enrollment size of the nursing program. This has provided an additional 6-7 nursing graduates per year, which has been very favorable for our hospitals and communities.

We are excited about our partnership with the new medical school in Yakima, Washington. The Pacific Northwest University of Health Sciences will enroll its first class of medical students this September. In two years, we will begin participating as a site for their clinical rotations. Part of the mission of this new medical school is to focus on local, qualified applicants who hopefully will have a high penchant for returning to their local communities. We, as well as many other rural communities in our region, look forward to an increase in the number of local students who will be able to achieve their healthcare dreams and hopefully return to their local communities.

While these programs are a positive step, they are but a small contribution toward solving the health care professional shortage problem. Much more needs to be done across our country to increase access and availability for qualified students who wish to pursue health care careers.

2. Secondly, **I would like to speak to the Critical Access Hospital Program 25-bed cap.** Good Shepherd Health Care System runs an average census of approximately 17 patients per day. But that census has varied this past year from a low of 10 to a truncated high of 25, the point at which, in order to be compliant, we must transfer patients to other

hospitals—patients that we could otherwise care for within the community. While we have been successful in minimizing the number of transfers through careful utilization review and discharge planning, transfers are becoming more frequent as our population continues to grow. Good Shepherd Health Care System's large obstetrics program compounds the problem. Many CAHs do not provide OB services; therefore, all of their beds are available to the community for other medical and surgical services. Good Shepherd Health Care System performs approximately 600 deliveries per year—about twice the average number of annual deliveries for a hospital of our size. This is due to a younger workforce population and a significant migrant population in our service area. Our obstetrical census varies widely. Over the past year, our OB daily census has ranged from 0 to 11 patients. OB patients count toward the CAH 25-bed cap. This means that beds available for other acute patients vary from 25 beds down to 14, depending on the daily OB census. While OB services generally have little to do with Medicare patients, they certainly have an impact on our seniors' access to care depending on "the luck of the draw" when they present for acute services.

Since our inception as a Critical Access Hospital, we have had 17 transfers due to the 25-bed limitation. In addition to being disruptive and inconvenient for the patient and the patient's family, a transfer involves a high degree of unnecessary risk to the patient and adds significantly to the cost of care. GSHCS and our community have been fortunate in that I do not have examples to share of patients encountering acute problems while in transport. Other CAHs have not been so lucky. But, we believe that none of the transfers that we have made resulted in a significant cost savings at another facility, especially when coupled with the cost of transporting the patient—a minimum of $1,200—to our closest receiving facility.

We strongly feel that increased flexibilty would greatly benefit all CAH communities, placing access on an equal footing in those communities that choose to maintain local OB services.

I want to thank our Oregon Senators Smith and Wyden for their understanding of the problems that the 25-bed cap has caused and their collective efforts in developing the Critical Access Hospital Flexibility Act. This bill provides for use of an annual average daily census as a determinant for Critical Access Hospital eligibility. We believe this would be a far better delimiter. We encourage this committee to support the intent of this legislation: allowing critical access hospitals to discontinue our current counter-intuitive approach of transferring patients when our facilities have the ability to provide the service. This modification will strengthen America's smallest hospitals, and enable them to fulfill their missions in serving their communities as they are prepared to do.

I appreciate the opportunity to present this testimony before you today and certainly would be willing now or at any time to take questions on the views I have expressed or on other questions pertaining to small and rural hospitals. Thank you.

Senator SMITH. Well, thank you, Dennis.

Look, I guess I wouldn't be in this business if I wasn't an optimist. But we really do need to get this changed, and we do have a good bill that will force the change. I am very hopeful that we will get this done sooner than later because I do understand, in a very personal way, why you have to have that flexibility or else a lot of rural hospitals just simply won't be there when people need them.

Mr. BURKE. That is right.

Senator SMITH. Tim Size, thank you for being here from Wisconsin.

STATEMENT OF TIM SIZE, EXECUTIVE DIRECTOR, RURAL WISCONSIN HEALTH COOPERATIVE, SAUK CITY, WI

Mr. SIZE. Good morning, sir. It is a pleasure.

I am Tim Size. I am Executive Director of the Rural Wisconsin Health Coop. A little background, the coop is a collaborative of 34 rural hospitals. Twenty-eight are critical access, so six are PPS.

Before I get into my prepared remarks, I would really like to support what Dennis just said. It is exactly what we are seeing in Wisconsin. I actually got a call from one of the hospitals last winter. "What am I supposed to do? I have 25 people in-house, and I have a mother coming to the hospital ready to deliver?"

I mean, basically, we are forced to go out of compliance or do very inappropriate patient care.

Senator SMITH. What do you do, Tim? Do you shove them off to a clinic somewhere?

Mr. SIZE. I think in that situation, we just—you do the right thing for the patient.

Senator SMITH. Yes.

Mr. SIZE. We also had a flu epidemic in some of our communities last—exactly what you were talking about was exactly the problem. Earlier, under the current law, somehow our regional offices were able to be flexible. But then we got the word this year pretty much if it is not like on international TV—it is a flood—don't expect any relief. So I am very, very thankful for the bill that you have introduced.

Senator SMITH. Well, hopefully, it doesn't take another flood to get it passed.

Mr. SIZE. The flood is all right because it is on TV, and so then we get the waiver. It is flu that is not as obvious.

Anyway, I would like to get to my prepared remarks. I would like to address three issues today that I believe, as well as the hospitals with whom I work, must have significantly greater attention here in the Nation's capital, but also back in our States.

We need to make health workforce a priority. I think a number—it is a thread through a lot of us who have spoken this morning. We need to see that Medicare Advantage plans are held accountable, and my written testimony goes into some detail. But I will just highlight a bit in a second. We also need to invest in healthy communities.

I actually testified in this room, I think, about 20 years ago to the same committee, and I can tell you today, being a baby boomer

and about 62, I guess, I am taking it a lot more personally than I did 20 years ago.

Senator SMITH. Yes.

Mr. SIZE. So I am hoping you attend to some of these issues.

Both nationally and in Wisconsin, rural health's many successes are a testament to the endurance and creativity of rural communities. Federal initiatives, whether they be formal reform or informal, need to build on this strength and not weaken it.

Regarding workforce, the soon-to-explode retirement of baby boomers will lead to a critical shortage of workers. Our current approach to growing the next generation of doctors, nurses, pharmacists, et cetera, is in critical disarray, and I don't use that description lightly. I think you can think about Keystone Cops. We don't know where we need to go, and we don't know how to get there.

I think Dennis mentioned some really important points about the pipeline, and that is a major problem. It is not the only problem.

Many rural communities already face staff shortages. We are actually even beginning to hear our urban colleagues having problems. But I can assure you, and this is a quote from one of my board members at our last strategic planning session, that when it starts raining in the suburbs, you can expect a tsunami in rural communities. We get the mal-distribution on top of the supply problems, and the supply problems are coming.

The Association of Academic Health Centers has just released, I think last week, "Out of Order, Out of Time: The State of the Nation's Health Workforce," which focuses attention on the critical need for a new collaborative, coordinated national health workforce planning initiative. They draw three critically important conclusions, all of which I strongly agree with, and it is what we are seeing in Wisconsin.

A broader, more integrated national strategic vision than our historic approach to health workforce policymaking and planning is needed if complex and urgent health workforce issues are to be addressed effectively.

Two, a new mechanism is needed to serve the currently unfilled integrative role that existing health workforce policymaking and planning processes are not designed and are ill equipped to serve.

Three, it is critically important to act immediately to develop and implement an integrated comprehensive national health workforce policy before intensifying health workforce needs outpace available resources, putting U.S. seniors and the rest of the country at substantial risk.

Regarding Medicare Advantage, MA plans are gaining rural market share. We are now at actually 23 percent in rural Wisconsin, which is the State-wide average. The potential consequences to rural health are significant and potentially quite negative.

I would like to digress for a second and say that I am kind of agnostic. I am not here to talk for Medicare Advantage or against it, but to talk about current implementation.

In a 2007 report to the Department of Health and Human Services Secretary, his National Advisory Committee on Rural Health noted that rural America cannot wait to see what MA does or doesn't do. Potential problems need to be identified and resolved

before the MA program becomes entrenched and less readily adjusted. If not, the negative impact on the rural healthcare infrastructure could take a generation to rebuild.

Medicare beneficiaries should not be required to lose access to local services to obtain the promise of increased benefits. The National Rural Health Association has made numerous specific recommendations about how CMS should enhance the accountability required of Medicare Advantage plans, and I have detailed them in my written testimony.

Rural health provides care to small communities at some distance from large urban hospitals and clinics. We do so even as patients are attracted out of our communities or forced out of town. For example, the 25-bed cap.

Laws have long been required that insurers respect the right of people to receive healthcare locally when they are enrolled in closed network plans. These laws will continue to be stretched and tested. Protecting access to local care for Medicare Advantage must be a high priority.

Regarding health communities, the American Hospital Association is definitely on target when they call for America's hospitals to get serious about individual and community wellness. In their agenda, "Health for Life: Better Health, Better Healthcare," the AHA says without change, America's healthcare capabilities and finances will be overwhelmed.

As a society, we must provide access to education and preventive care, help all reach their highest potential for health, and reverse the trend of avoidable illness. As individuals, we must achieve healthier lifestyles, take responsibility for our health behaviors and choices, and each one of us must take action.

Reform is about people getting the care they need at a cost our country can afford. Equally important, reform must help individuals and communities to become healthier, to not need as much healthcare. If the growing need for care is not reduced, costs will explode, whatever the form of reform or adjustments we make.

Unlike Lake Wobegon, two out of three counties in rural Wisconsin are less healthy than average. But it is no surprise. We predict them to be so. They are less healthy not because of poor rural healthcare. It is due to too much smoking, too much drinking, and in my case, too much eating. It is due to too little exercise, too little education, too few jobs, and too low income.

Reform without the bigger picture will fail. At the very least, healthcare reform must lay down a roadmap to make our seniors and communities as healthy as we know they can be.

Thank you.

[The prepared statement of Mr. Size follows:]

U.S. Senate Special Committee on Aging
A Hearing on "Growing Old in Rural America" July 31st, 2008

Testimony: "Assuring Healthcare 'Reform' Doesn't Bypass Rural America"

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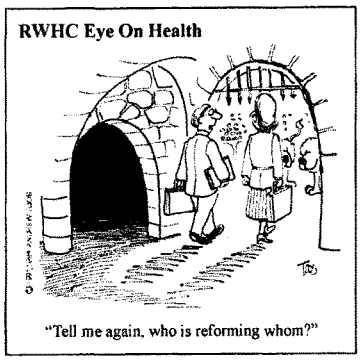
A portion of these comments been previously distributed through the Rural Wisconsin Health Cooperative's monthly Newsletter, "Eye on Health".

I. Introduction: Much of the Healthcare "Reform" Debate Misses Critical Rural Issues

Rural health is at risk with healthcare reform. It is at risk without it. Rural does not drive this train, but we have a voice that must be heard.

Healthcare in America is neither equitable nor can it continue to work as we have known it. We must continue to make it better. Whether the reform is in small pieces over time or all at once like the birth of Medicare, every approach includes tradeoffs. Different ways, including doing nothing, will affect key interests and goals differently. These goals help and compete with each other, whether they address cost, the uninsured, quality, fairness, benefits, choice or making communities healthy.



"Tell me again, who is reforming whom?"

Those of us who care about rural health have the same diversity of opinion about healthcare reform as the whole country does. But we must find common ground on those issues that hit hard our rural communities, whether or not they are on anyone's reform agenda. I would like to address three such issues today that must have significantly greater attention in Washington DC and in each of our states:

√ Make the Health Workforce a Priority
√ Hold Medicare Advantage Plans Accountable
√ Invest in Healthy Communities

For each of these three issues, this testimony will discuss the issue from a national perspective and then, as an example, note how it is currently playing out in Wisconsin.

Both nationally and in Wisconsin, rural health's many successes are a testament to the endurance and creativity of rural communities. Reform needs to build on that strength, not weaken it.

II. Make Health Workforce a Priority

The National Perspective–The Association of Academic Health Centers issued on July 17th *"Out of Order, Out of Time: The State of the Nation's Health Workforce* which "focuses attention on the critical need for a new, collaborative, coordinated, national health workforce planning initiative. The report's seven chapters include more than 40 findings that document what is 'out of order' with respect to the nation's health workforce, as well as the looming social and economic forces that leave no time for further delay before the problems get dramatically worse."

The report draws several broad conclusions from the detailed findings including:

- "A broader, more integrated national strategic vision than our historic approach to health workforce policymaking and planning is needed if complex and urgent health workforce issues are to be addressed effectively.

- A new mechanism is needed to serve the currently unfilled integrative role that existing health workforce policymaking and planning processes are not designed, and are ill-equipped, to serve.

- It is critically important to act immediately to develop and implement an integrated, comprehensive national health workforce policy before intensifying health workforce needs outpace available resources, putting the U.S. at risk of losing its status as the global health care leader."

The report recommends that all public and private stakeholders work together to:

- "Make the U.S. health workforce a priority domestic policy issue;

- Begin addressing national health workforce issues immediately to avert crises in national workforce capacity and infrastructure;

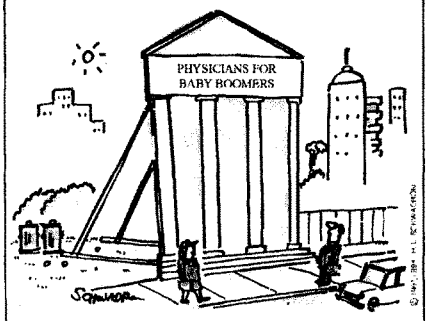
- Develop an integrated, comprehensive national health workforce policy that recognizes and compensates for the inherent weaknesses and vulnerabilities of current decentralized multi-stakeholder decision-making; and

- Create a national health workforce planning body that engages diverse federal, state, public and private stakeholders with a mission to:
  - Articulate a national workforce agenda;
  - Promote harmonization in public and private standards, requirements and prevailing practices across jurisdictions;
  - Address access to the health professions and the ability of educational institutions to respond to economic, social, and environmental factors that impact the workforce; and
  - Identify and address unintended adverse interactions among public and private policies, standards, and requirements."

A similar call to action entitled "For the Healthcare Work Force, a Critical Prognosis" by Daniel W. Rahn and Steven A. Wartman was published in *The Chronicle of Higher Education on November 1st, 2007:*

"The United States faces a looming shortage of many types of healthcare professionals, including nurses, physicians, dentists, pharmacists, and allied-health and public-health workers. The results will be felt acutely within the next 10 years."

RWHC Eye On Health



"Looks solid to me."

"The final crucial factor precipitating the healthcare-work-force crisis is a lack of comprehensive work-force planning on the parts of academe, government, and the healthcare professions. We need strategic direction instead of the current piecemeal approach at the national and state levels; both federal and state policy making has tended to respond to immediate crises or issues related to one particular profession or constituency. Commissions and task forces abound, yet many reports gather dust on shelves; the infrastructure for putting good ideas or new policies into effect is at best uneven."

"The healthcare shortage we face is serious. Some experts may argue that there is no cause for alarm, because work-force shortages are cyclical, market-driven, and easily ameliorated. But that perspective is not valid today. The work-force shortfall in healthcare cannot be resolved in the marketplace alone. It is time for organized action, not only within colleges, but also at our nation's highest levels."

At the Same Time, Rural Faces Uncertainty about Health Professional Service Area (HPSA) Eligibility

On another front, the Department of Health & Human Service's (DHSS) proposal to "reform" the designation of health professional shortage areas will further penalize states with insufficient workforce data. [DHHS has just announced plans to revise their originally proposed new Rule and will re-issue as a new Notice of Proposed Rule-Making with a new Comment period.] According to the State of Wisconsin's May 27th comment on the earlier proposed new rule for Health Professional Shortage Area designations, the economic burden on states for data reporting for HPSA designations is not reduced but substantially increased:

- "Although the Health Resources & Services Administration (HRSA) will be able to make some of the federally-collected population and high-need indicator data available to states, the national provider datasets are not current or detailed enough for HPSA designations."

- "When Wisconsin conducted testing of the new HPSA Rule using the national physician data and mid-level state professional association data, the vast majority of current HPSAs do not qualify for a new Tier-1 geographic HPSA and consequently could lose access to critical federal resources."

- "The majority of states (83%) currently do not have the detailed mid-level data needed for this new HPSA Rule (24 out of 29 states in a recent survey of state primary care offices). And all responding states indicate they already have to do additional data collection and/or cleaning to get the detailed physician data needed for HPSAs (31 out of 31 states)."

- "State primary care offices have not received any significant increase in their federal grants in more than 15 years to support their HPSA data collection and analysis. It is very labor intensive to collect the detailed provider Full Time Equivalent (FTE) and patient population data that are needed for HPSA designations."

- "Even the HRSA Shortage Designation Branch acknowledged that the AMA physician data and national mid-level provider data used for federal testing of the new HPSA Rule are not very accurate or up to date."

Examples from Wisconsin–It is important to note that Wisconsin's Department of Workforce Development has given needed visibility to the overall problem of health workforce shortages; it has generated reports based on currently available data and helped identify and is promoting needed best practices such as the voluntary "no-lifting" program. I would also like to acknowledge examples of important work such as the Wisconsin Hospital Association's "Who Will Care For Our Patients" (on the growing shortage and maldistribution of physicians) and various regional retirement and departure surveys directed at health sector employers and employees.

How are we failing?

Even with such efforts, Wisconsin's very own "inconvenient truth" is that we do not have a system to produce ongoing, labor market specific information that would allow us to make knowledgeable projections about healthcare workforce shortages. In turn, such a system would allow us to better target the needed investments in our post secondary educational and vocational systems.

Due to limited resources and instances where collaboration needs to be substantially enhanced, our current approach to healthcare workforce planning falls far short because as regards to job vacancies, we don't know where we are or where we are going.

Regarding the strategic investments and changes that need to be made in and by Wisconsin's universities, colleges and schools, we are playing a high stakes game of "blind man's bluff." Do we have the right number of nursing schools? Are we producing the right number of ADN and BSN graduates? Are we graduating enough physicians in the needed disciplines who are prepared to work in all of Wisconsin, not just selected communities? Isn't a second school of dentistry long over due, explicitly designed to address our states chronic shortage of dentists accessible to the uninsured? Can we change the share of our pharmacy graduates going into rural practice from 6 percent to something closer to a replacement rate of 30 percent?

The problem is that we have a fair amount of data but not much information upon which to make knowledgeable workforce development decisions in or for either public or private sectors. We tend to know how many people are employed in various occupations but not whether they work full time or part-time or for multiple employers nor how many vacancies currently exist or are projected to exist.

What can we do?

The Federal Health Resources and Services Administration has a Workforce Shortage Forecasting tool but its estimates for future shortages in Wisconsin are based on relatively small sample sizes and to date have been mostly limited to Nursing. We need to better understand the HRSA model, the "simplifying" assumptions it makes and the data inputs it needs to produce usable outputs.

Regardless of what predictive model we end up using, its outputs will only be as good as the inputs; and good inputs require more collaboration than we have yet seen. Critically important data we need but currently do not have access to includes, but is not limited to (a) number of first time licenses by year, (b) number of license renewals (c) age of each license holder, and (d) for new licenses: the degree granting school and year the degree was awarded. In Wisconsin, we need to either mandate survey participation as part of the health professions licensure process or make it hard to avoid.

The professional licensing process in North Carolina and Minnesota is an integral part of the state's workforce planning process; we can and must do as well in Wisconsin.

We must also find a way for employers and academic institutions to join government in this work. Various claims of "it's not my responsibility" or we have a "proprietary interest in 'our' data" is crippling our ability to appropriately plan for our collective future workforce needs. We must develop mechanisms that aggregate survey data from regional and other efforts.

Once we have the data to mathematically project estimates of shortages and perhaps in some instances, surpluses, we need to have an organized infrastructure to turn the data into information and knowledgeable estimates that can inform our investments in education, training and other interventions. While we need to start with mathematical projections, by themselves they are not useful. We need to add what we know may or could be happening to impact relevant policy that wasn't otherwise incorporated into the model's assumptions. We must look beyond statewide numbers to regional data analysis so we can understand and address how shortages vary around the state, with a particular focus on traditionally underserved communities, rural and central city.

We need to get real about resources. It would be helpful to know what the best practices are in other states regarding projecting specific healthcare workforce shortages; and what resources they allocate for the process. We are already behind in addressing in preparing for the future as Wisconsin (a) is a "graying state," with a larger proportion of its residents in or close to an age that typically brings a much higher need for medical care, (b) we already are facing significant shortage and misdistributions and (c) the lead time to make strategic changes in our healthcare education and training infrastructure is limited.

Wisconsin needs more caregivers at the same time workforce participation is declining. It was fun to play blind man's bluff as a kid but not now, given the high stakes of baby boomers retiring out of providing care and entering a stage of life where they will increasingly need it.

Due to limited resources and instances where collaboration needs to be substantially improved, our current approach to healthcare workforce planning falls far short because as regards to job vacancies, we don't know where we are or where we are going. Our future patients requires us to do better.

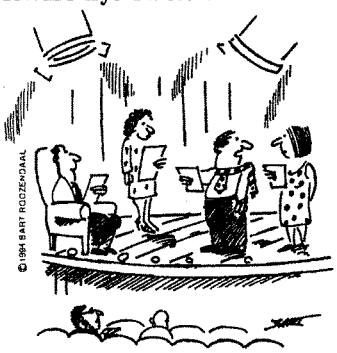
III. Hold Medicare Advantage Plans Accountable

The National Perspective–The following is from the National Rural Health Association's April, 2007 Policy Brief entitled, "Medicare Advantage for Rural America?"

"The enactment of the Medicare Prescription Drug Improvement and Modernization Act of 2003 fundamentally changes Medicare in ways not yet understood by either the public or providers. Medicare Advantage (MA) is intended to fulfill the goals of (1) substantially increasing the number of Medicare beneficiaries enrolled in private health insurance, based on the premise believed by many policy mak-

ers that competition among these private health plans and between these plans and the traditional fee-for-service Medicare program will reduce federal spending; and (2) creating opportunities for beneficiaries to enroll in richer benefit packages than available through traditional Medicare (sometimes with tradeoffs regarding choice of providers and drug formularies, and oftentimes at a higher cost than the cost of care under traditional Medicare fee-for-service). Policy makers may also believe, at least implicitly, that private health plans can be held accountable for healthy outcomes for enrollees, as measured against benchmarks established by the National Committee for Quality Assurance."

RWHC Eye On Health



"Tell me again how we act like we care about their quaint local ways."

"The focus of this Policy Brief is to address MA implementation issues relevant to rural communities. It assumes that the federal policy of 'privatizing' Medicare to create a competitive structure to cut costs will continue. It is left to others to argue the probability of MA taking permanent root in rural America, in a way its predecessor, Medicare+Choice, did not. What we do know is that if MA plans gain rural market share, the potential consequences to rural health is significant, and potentially quite negative."

"Rural America cannot wait to see what MA does or doesn't do. Potential problems need to be identified and resolved before the MA program becomes entrenched and less readily adjusted. MA must be implemented in a manner that is sensitive to the needs of rural communities. If not, the negative impact on the rural healthcare infrastructure could take a generation to rebuild. Medicare beneficiaries should not be required to lose access to local services to obtain the promise of increased benefits. NRHA made the following recommendations:

1. "The Congress should pass legislation that ensures Critical Access Hospitals and Rural Health Clinics are paid by MA organizations an amount equivalent to or no less than they would be paid by traditional Medicare."

2. "The Centers for Medicare & Medicaid Services (CMS) must engage with rural health experts regarding how best to determine and enforce rural community access standards consistent with individual communities' historic/present patterns of care. CMS must also engage with rural citizens about these standards by developing more user- friendly web sites, train more call center workers who understand the 'older learner' and/or their (mature) children or friends who have questions."

3. "CMS must take action to ensure that beneficiaries are given the information and support to allow them to make well-informed decisions, particularly for rural beneficiaries who typically have less experience with managed care."

4. "CMS Regional Offices must regain their role as an access point by providers in their regions for definitive MA information and an ombudsman for dispute resolution with plans."

5. "CMS needs to continue providing county or equivalent specific plan enrollment data and in a timely manner (quarterly over time)."

6. "A web site is needed for providers to verify beneficiaries' current plan enrollments."

7. "The approval process of MA plans and amendments needs to be transparent, including web-based access to the details of the approved applications."

8. "Payments to MA plans should not rely on a payment mechanism that rewards regions with high utilization at the expense of regions with lower utilization."

9. "Administration of PFFS plan payments to non-contracted providers needs to be improved. Situations where intermediaries artificially keep interim rates low as well as not including the Certified Registered Nurse Anesthetist pass-through and bad debt in interim rates, need to be addressed."

10. "The Federal Office of Rural Health Policy should be given expanded authority to provide technical assistance and outreach on ways rural providers can collaborate in the review of MA contracts."

11. "Congress should increase funding for local organizations serving the elderly to provide increased technical assistance to beneficiaries enrolling in MA plans."

12. "State insurance commissioners' offices should be encouraged to act as state level ombudsmen for rural beneficiaries enrolled with MA plans."

"Medicare Advantage is still unfolding, with its full effect yet to be seen. If the privatization of Medicare in rural America is only partially accomplished, the rural health landscape will be significantly transformed. It is imperative that (1) rural beneficiaries are ensured appropriate access to local care, (2) rural beneficiaries have access to and receive the benefits equivalent to those able to be offered by MA in urban communities, (3) payment rates are high enough to sustain a viable rural health system, and that (4) the relationship among beneficiaries, providers, plans and, CMS be well integrated."

Examples from Wisconsin–According to figures released by CMS for March of this year, almost 200,000 of Wisconsin's 850,000 Medicare beneficiaries are enrolled in Medicare Advantage (MA) plans. The comparable enrollment for 2007 was 150,000. This represents an increase of over 30% from 2007 with nearly 1 in 4 of Wisconsin beneficiaries now enrolled in Medicare Advantage. While slightly higher than the national average, what is most noteworthy in Wisconsin is that Medicare Advantage market penetration is on average as high in rural counties as urban.

With the exception of the Regional PPO Plan, plans are approved and marketed by county. This means that within a given county, market penetration may vary significantly from what the statewide average indicates. As indicated below, county level market shares in Wisconsin range from 8% to 56%.

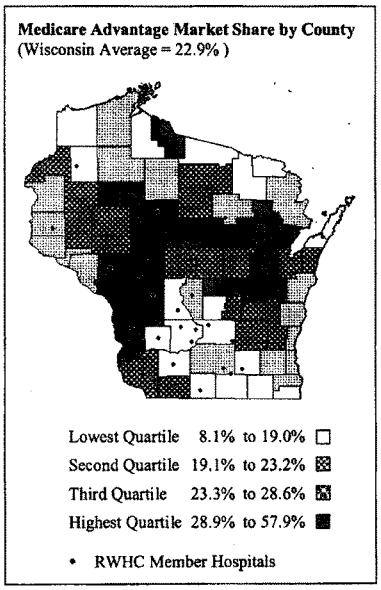
Since the Private Fee for Service (PFFS) plans comprise such a large segment of enrollment in replacement plans by Medicare beneficiaries in Wisconsin, it is important to understand how

Wisconsin Medicare Advantage Plan Enrollment

WI Plans by Type	Enrollment
Private Fee for Service (PFFS)	118,234
Local HMO/POS Plans	52,992
Local PPO Plans	12,902
1876 Cost Plans	11,540
Regional PPO Plans	997
National PACE Plans	728
Total	197,393

Source: Centers Medicare & Medicaid Service for enrollment as of March, 2008

these plans operate. A Medicare PFFS plan is a Medicare Advantage health plan offered by a private insurance company under contract to the Medicare program. Medicare pays a set amount of money every month to the PFFS organization to arrange for healthcare coverage for Medicare beneficiaries who have enrolled in the Medicare PFFS plan.



Enrollees in a Medicare PFFS plan can obtain plan covered healthcare services from any eligible provider in the U.S. who is willing to furnish services to a PFFS enrollee. Given the recent passage of Medicare Improvements for Patients and Providers Act (MIPPA), how this legislation will be applied is not yet fully understood but the following is still expected to be a fair general description of how PFFS are working in rural markets.

Medicare PFFS plans are not required to contract with any Providers. Providers become aware that beneficiary participates in a Medicare PFFS plan when the beneficiary presents their enrollment card. A provider is a deemed provider and must follow a PFFS plan's terms and conditions of participation if the following conditions are met: a) in advance of furnishing services the provider knows that a patient is enrolled in a PFFS plan and b) the provider either possesses or has access to the plan's terms and conditions of participation.

It is important to note that a provider is not required to furnish healthcare services to enrollees of a Medicare PFFS plan. However, when a provider chooses to furnish services to a PFFS enrollee and the deeming conditions have been met, the provider is automatically a deemed provider (for that enrollee) and must follow the PFFS plan's terms and conditions of participation.

The terms and conditions of participation establish the rules that providers must follow if they choose to furnish services to an enrollee of a PFFS plan.

A PFFS organization is required to make its terms and conditions of participation reasonably available to providers from whom its enrollees seek healthcare services. This generally means that the organization offering the PFFS plan will post its terms and conditions on a web site and make them available upon written or phoned request.

Given the ease with which hospitals will be "deemed" to be contracting providers, it is important that hospitals understand the basics concerning how Medicare PFFS plans operate and take steps to identify the specific Medicare PFFS plans that will be operating in their area (and their specific terms and conditions of participation).

Providers can decide to contract with a particular Medicare PFFS plan, either directly or by deeming, and make such decision known to admissions staff. Hospitals are not obligated to serve Medicare beneficiaries enrolled in PFFS plans, except in emergency situations governed by EMTALA. It may be a

difficult decision for providers to deny services to a Medicare beneficiary who participates in a Medicare PFFS plan.

A Medicare PFFS plan must establish uniform payment rates for all contracted providers (those with written contracts and those deemed to be contracted providers). The Medicare PFFS plan must pay both contracted and "deemed" contracted providers the fee-for-service amount specified by the plan in the terms and conditions of payment for the particular service minus any applicable enrollee cost-sharing.

If a Medicare PFFS plan has an insufficient number of contracted hospital providers to furnish the services covered under the Medicare PFFS plan, it must pay all hospital providers (contracting, deemed and non-contracting) at least what they would have been paid under original Medicare and may not vary beneficiary cost sharing.

In Wisconsin, we see Medicare beneficiaries not knowing they are MA enrollees or finding that insurers can dictate their care. We've also witnessed providers entrapped in endlessly malfunctioning insurer bureaucracies. And these are results that have occurred before these insurers gain enough market share to flip their "open" networks to closed ones.

The Centers for Medicare and Medicaid Services (CMS) should be required to (1) mandate complete disclosure of benefits before enrollment, (2) hold all MA plans accountable for their actions with beneficiaries and providers by establishing a set of publicly reported minimum performance standards, and (3) establish clear pathways for beneficiaries and providers to register complaints and to correct problems.

As regards to the Private Fee-For-Service variant of MA most common in rural Wisconsin, CMS should also require them to (1) offer cost-based providers the choice of a cost settlement or their interim rate plus a fixed percentage, (2) participate in quality of care reporting comparable to local health plans and providers, and (3) protect the beneficiary's right to access local services such as swing beds as they are needed.

Wisconsin Insurance Commissioner Sean Dilweg hit the nail on the head when he testified last May before the Subcommittee on Health of the House Committee on Ways and Means. "We need the ability to hold companies responsible for the acts of their agents in Medicare Advantage as we currently have for all other insurance products... consumers should be able to go directly to their state insurance departments to resolve problems, rather than having to call CMS who seems to have neither the manpower nor the expertise to deal with many of these types of complaints."

MIPPA now requires that PFFS plans in counties with several plan choices must create provider networks, PFFS plans in rural areas without other plan options can continue to operate as they do today. This change makes the role of "community access standards" more critical than ever to rural Medicare beneficiaries and providers.

The PFFS plan may have discretion in setting payment rates for contracted and deemed contracted providers. A Medicare PFFS plan can establish payment rates that are less than traditional Medicare for designated types of providers if the plan demonstrates to CMS that it has a sufficient number of providers of each such type under written contract to meet Medicare access standards. CMS assesses the sufficiency of a PFFS plan's contracted network on the same basis as network sufficiency for a coordinated care plan.

The Central Role of the Robust Enforcement by CMS of "Community Access Standards"

The following is from The 2007 "Report to the Secretary: Rural Health and Human Service Issues" from the National Advisory Committee on Rural Health and Human Services, January 2007:

"The MA program statutes and regulations require that CMS ensure that plan enrollees have reasonable access to covered services, and CMS has emphasized its commitment to providing that access. How CMS and MA plans interpret what is "reasonable" access by beneficiaries to local health care is critically important to rural beneficiaries and providers as well as to the acceptance of MA plans in rural communities. The past operational policy of CMS has supported using community access standards when making network adequacy determinations. As made explicit in the CMS Medicare Managed Care Manual: "Plans must...ensure that services are geographically accessible and consistent with local community patterns of care." This policy did not change with the advent of MA, but the Committee has not been able to determine how or whether CMS is enforcing this provision with PFFS plans."

"If beneficiaries enrolled in an MA plan are not well informed about their rights to access care locally, they are less likely to exercise that right. If CMS does not diligently monitor and enforce plan compliance, plans will have significantly less incentive to contract with a region's rural providers, undermining the rural health infrastructure in that region's communities. As long as the current uncertainty and lack of transparency regarding access and network adequacy persist, rural beneficiaries and the providers that serve them will be less likely to consider MA plans a viable alternative to traditional Medicare."

"The Committee is further concerned that lax enforcement of network adequacy will discourage MA plans from contracting with rural providers. Due to their low patient volumes, the fixed costs of operation are high for many rural providers. As a result, rural providers may require payment rates above those offered in urban areas in order to remain in business. Also, there are generally few providers in rural areas. Without the ability to guarantee increased volume in return for lower payment, it can be difficult for plans to negotiate low rates if rural providers are necessary for the plan to meet network adequacy requirements. The Committee believes that this is what contributed to M+C being a largely urban-specific model. If health plans are allowed weak networks of providers in rural areas, plans might steer rural beneficiaries away from their established health care providers. This could force some to commute a greater distance to new providers, in the process disrupting the web of provider linkages that have traditionally treated those beneficiaries and other rural residents."

IV. Invest in Healthy Communities

The National Perspective–The American Hospital Association (AHA) is definitely on target when they call for America's hospitals to get serious about individual and community wellness. They have been circulating a "framework for reform" that puts a significant emphasis on healthy communities. *"Health for Life, Better Health, Better Healthcare"*—a set of goals and an agenda for creating better, safer, more affordable care and a healthier America. While it is described as a "work in progress," the AHA's recognition and advocacy for hospitals to go well beyond a traditional medical role is much needed.

From AHA: "Without change, America's healthcare capabilities and finances will be overwhelmed. As a society we must: provide access to education and preventive care, help all reach their highest potential for health and reverse the trend of avoidable illness. As individuals we must achieve healthier lifestyles, take responsibility for our health behaviors and choices and each one of us must take action...

Chronic illness is on the rise, half of Americans have one or more chronic illnesses; 80% of spending is linked to chronic illness, much of this is avoidable; obesity has doubled; diabetes is on the rise... Not all illness is preventable. But good primary care, health education and a healthy lifestyle are essential to improving health. Costs for health coverage and healthcare can be controlled as health improves."

Real reform must address universal access to healthcare and yes, the cost of healthcare. But equally important, it must focus on what individuals and communities can do to become significantly more healthy and less dependent on what will always be very expensive medical interventions. To do less is not reform, but a collective self-deception we can't afford.

Rural has a unique opportunity to help lead the country in this regard. The following is from "It Takes a Community, Rural hospitals may have an edge in improving population health" by Jessica Zigmond in *Modern Healthcare*, 6/12/06:

"As the federal government pushes the healthcare industry to adopt pay-for-performance, rural hospitals could have an advantage over their urban counterparts in one area: working collaboratively to improve the overall health of their community populations. 'Pay-for-performance is a payer-driven initiative," says Tim Size, executive director of the Rural Wisconsin Health Cooperative, Sauk City. 'We're in a reactive mode, and haven't had anything to react to yet,' he says of rural hospitals."

"Terry Hill, executive director of the Rural Health Resource Center in Duluth, Minn., says one of his organization's goals is to educate rural hospitals on this issue. 'There is no question that this is where the federal government is going,' Hill says. 'What we're trying to tell rural hospitals is you have to develop capacity to measure your information and get ready for pay-for-performance.' "

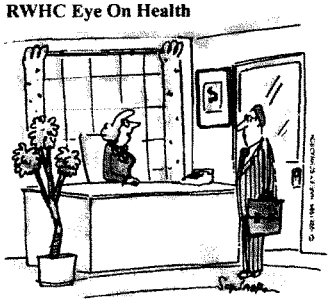
"As rural hospitals learn more about traditional pay-for-performance initiatives, they might consider a concept that was introduced in the spring 2006 edition of the *Journal of Rural Health* and discussed at the National Rural Health Association conference in Reno, Nev., in May. Rural hospitals, with their well-established communitywide relationships, could lead efforts to involve other community players such as local businesses, clinicians, schools and employers in improving a population's overall health."

"The article emphasized that 'the issue is not whether or not rural hospitals should be in charge, but whether or not rural hospitals have a collaborative leadership role to play.' David Kindig, one of the article's three authors, says factors besides healthcare are needed to keep a community healthy."

" 'Ten years ago, most people were still in the mode of thinking that healthcare is the most important determinant,' says Kindig, who serves as professor emeritus of population health sciences at the University of Wisconsin School of Medicine and Public Health. 'The social factors, like education, income and individual behaviors could be right up there with medical care in terms of their impact on health outcomes.' "

"Kindig acknowledges that 'the jury is still out' on how well this concept will work, especially given that connect-

RWHC Eye On Health



"Sure we can just keep dousing fires, or we can find the kid with the matches."

ing different sectors in the community is not an easy task. 'You really need people talking to each other from the school board, the community board, and the county board on maximizing the balance of the portfolio across these sectors for population health improvement.' "

"Hilda Heady, executive director of the West Virginia Rural Health Education Partnerships-Area Health Education Centers, says it is possible for rural hospitals to work with other members in the community to improve a population's health. The purpose of Heady's group is to help retain West Virginia-trained health science graduates in underserved rural West Virginia by creating partnerships with the community, higher education, providers and government."

" 'Rural communities are very accustomed to having to collaborate with limited resources,' Heady says. If applicable, rural hospitals should link with the higher education institutions in their states, Heady says. In West Virginia, medical students in state-supported schools are required to complete three months of their training in any discipline in a rural community. 'When you look at resource-limited communities, you don't have the luxury of thinking in silos,' Heady says. 'You have to collaborate to survive.' "

"Size, who served on the Institute of Medicine's Committee on the Future of Rural Health, worked on a report that culled the six quality aims the IOM introduced in its publication *Crossing the Quality Chasm* in March 2001. Those aims—safety, effectiveness, patient-centered care, timeliness, efficiency and equity—can also be applied when trying to improve rural health, where the entire community is seen as the patient (consequently, the committee changed 'patient-centered' to 'community-centered'). Size says community leaders in business, faith organizations, public education and local government can work collaboratively to improve the overall health of a community."

"Size, Kindig and third author, Clint MacKinney, outlined steps for rural hospitals to start promoting population health awareness and to establish collaborative efforts, such as adding board members with interests or expertise in population health measurement and improvement, including public health professionals, educators and economic development experts. Hospitals can also devote a periodic board meeting or a portion of every meeting to review available population health indicators, and create a 'population health' subcommittee of the hospital board to explore opportunities for hospital partnerships with other community organizations."

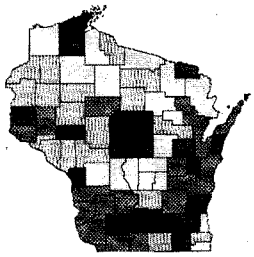
" 'Health status is overwhelmingly not a function of healthcare but of (individual) behaviors and socioeconomic conditions,' Size says. Bruce Behringer, assistant vice president for the division of health sciences at East Tennessee State University, Johnson City, supports the idea, says hospitals have both an economic interest and social responsibility in a community. 'If in fact a hospital in a rural community—which is typically the largest employer—can take the benefit from being funded by tax dollars, there should be some sense of relationship between what happens in the quality of that hospital and the community,' Behringer says."

Examples from Wisconsin–Each summer, the University of Wisconsin Population Health Institute reports on "Wisconsin County Health Rankings." This county by county comparison of health is unique in the view it gives us of our state—it is intended "to summarize the current state of health and distribution of key factors that determine health." Like any report of this type, there are limitations and the reader is left with as many questions as answers. Which is the point—the report isn't intended to be the last word, but to begin long overdue local community conversations.

What struck me this year is that the report has two halves, that must be seen as complementary. Not made explicit, but easy enough to calculate is the following: three-quarters of Wisconsin's urban coun-

ties have health outcomes that are better than average while only one-third of rural counties can say the same. At first glance, not a rural health success story. But before rural Wisconsin healthcare providers get defensive, lets look at the rest of the story.

Rural Wisconsin Expected To Have Lower Than Average Health & It Does



Worst Quartile (white) Second Quartile (red)
Third Quartile (redder) Best Quartile (reddest)

Calculated from the 2007 *"Wisconsin County Health Rankings,"* University of Wisconsin Population Health Institute

In addition to calculating "health status" the report also shows a ranking of key factors that are thought to determine health status in each county. The ranking is based on the University's best guess of the relative weight or importance of four key factors: 10% for healthcare, 40% for health behaviors, 40% for socio-economic factors, and 10% for the physical environment. When you look at these rankings, three-quarters of Wisconsin's urban counties have health "determinants" that are better than average while only one-third of rural counties do. If you follow the math, there is a simple bottom line; rural counties are predicted to have worse health status and they do. Because individual behaviors like smoking and exercising matter, as do education, jobs and income—the cumulative effect can be, quite literally, deadly.

Does this let rural healthcare providers off the hook? I don't think so. It just means we have a large hook with plenty of room for company. Some "healthcare reform" advocates figure if everyone has health insurance and healthcare providers can be properly "controlled," problem solved! As one prominent state supporter of single payer healthcare once asked me, "what am I supposed to do, campaign door to door and tell folks to 'drop the donut.' " No, but we need to get real. Healthcare reform isn't health reform. What we care about is our health and the health of our family, friends and neighbors. It is the lack of community health that drives costs that we increasingly can no longer afford.

V. Summary

Rural health provides care to smaller communities at some distance from larger urban hospitals and clinics. We do so even as patients are attracted or forced out of town. We struggle with the power of huge public and private healthcare insurers. Federal "anti-trust" laws were written to protect communities against powerful monopolies. Now they seem to help for-profit giants over communities by limiting our ability to cooperate with each other.

Laws have long required insurers to respect the right of people to receive healthcare locally. These laws will continue to be stretched and tested. Congress is likely to continue its experiment to offer Medicare through for-profit insurers known as Medicare Advantage plans or Medicare HMOs. Protecting access to local care must be a high rural priority.

The soon to explode retirement of baby boomers will lead to a critical shortage of workers. Our current approach to growing the next generation of doctors, nurses, pharmacists and therapists makes Katrina look well handled. Think Keystone Cops. We don't know where we need to go or how to get there but

we look sincere and very busy. Many rural communities already face staff shortages. But when it starts raining in the suburbs, expect a tsunami "outstate."

Reform is about people getting the care they need at a cost our country can afford. Equally important, reform must help individuals and communities to become healthier, to not need as much healthcare. If the growing need for care is not reduced, costs will explode, whatever the reform.

Unlike Lake Wobegon, two out of every three counties in rural Wisconsin are less healthy than average. This is not because of poor rural healthcare. It is due to too much smoking, drinking and eating. It is due to too little exercise, education, jobs and income. Reform without the bigger picture will fail.

And at the very least, healthcare reform must lay down a road map to make our seniors and communities as healthy as we know they can be.

In summary, healthcare reform must address factors unique to the rural context and achieve the following:

√ Make the Health Workforce a Priority
√ Hold Medicare Advantage Plans Accountable
√ Invest in Healthy Communities

Thanks.

Senator SMITH. That is excellent, Tim.

Many of you have talked about the shortage of providers, and I just wonder—why we don't have more people in medical school and nursing training? I know so many young people with superior grades can't get into these programs. What is holding them back, Tim? Is the cost of medical education just so high that—

Mr. SIZE. I am not an expert on workplace education. We have worked a lot with our educational institutions on that very issue. There are multiple problems.

One is to produce graduates is not the same thing as producing graduates that are sensitive and able and interested in working in rural America. So there is a burden that I think academia needs to take on to focus more on their responsibility to produce graduates that will work in a variety of settings.

My sense that we, over the last few years, have not anticipated the baby boomers and what that will do in terms of massive numbers of people exiting the health workforce as well as large new numbers of patients coming into our systems. So, in fact, we have kind of been holding our own on average, continuing to bump along with mal-distribution problems in rural America.

However, now—and it is something I am really scared about—part of the problem is we are not real good planning 5, 10 years down. We need to be forecasting today what doctors, nurses, pharmacists, physical therapists, nurse practitioners we need 10 years from today. Because if we don't get them in school today and next year, we will have the shortage in 10 years.

Maybe that gets messed around a little bit with J1 and all that stuff, but we have a responsibility, I think, to grow our own. Right now, the focus in our State is basically just to get our arms around the description of what current problems we have and what we are forecasting those problems to be like once the real baby boomer bulge starts to work its magic.

That is one of the big problems with the proposed HPSA rule. It assumes a level of data that is simply not there. So we have a lot of work. We have got to take it a lot more seriously. I have no involvement with the Association of Academic Medical Centers, I just came across their report last week when it was released. It is thinking like that that we have to pay attention to.

I know the Chronicle of Higher Education last winter also had a major report on exactly the same issue. We are really, really behind in our planning.

Senator SMITH. Scott, you are located at OHSU. I know you may not have any responsibility for this area, but do you know whether the medical school, the dental school, and the nursing school are doing more to increase enrollment? They have sure got a lot of applicants.

Mr. EKBALD. We are trying very hard to increase the pool of candidates, but we are really quite restricted physically with the location of Oregon Health and Science University.

Senator SMITH. That is why we built that cable car there.

Mr. EKBALD. As soon as we get the new building at the bottom of the cable car, we will be in good shape.

But I just want to echo what Tim said, it is not just production of providers. It is distribution, and most of the problems in dis-

tribution to rural areas has to do with economic challenges. I mean, primary care is the backbone of a rural healthcare system. Yet they are the very lowest paid of all the physician specialties.

There has got to be more incentives for people to choose a primary care specialty and then to choose a rural practice. The research clearly shows that people will end up practicing in close proximity to where they were trained. Well, if we can't train them in rural areas, we can't expect them to go there.

You can't spend 8 years training in, you know, Portland is a fairly small city, let alone New York or Boston. So don't expect them to move to a rural area. It is really unrealistic. So—

Senator SMITH. Any other thoughts? Closing comments?

Yes, Bill?

Mr. FINERFROCK. There is a few years ago, there was a movie out called "A Field of Dreams," and one of the seminal lines in that was, "If you build it, they will come." Well, I think what Scott just touched on is the corollary in healthcare, which is, "If you pay them, they will come." Part of the problem that we have with rural providers is that what we pay rural providers to deliver care in rural communities is dramatically less than what we would pay them to provide the same care. So if one looks at it from an economic standpoint strictly, then your reaction is I will go provide, I will live in suburban Portland. I will have access to more urban environment, potentially different school opportunities and options than I would have in a rural community.

We have to overcome those payment disincentives in order to get the providers to go out there. It is not the only thing, but it is a key part of it.

Senator SMITH. Tim, you had a—

Mr. SIZE. Yes, I agree with Bill on the economic incentives. But I would also like to get in the record something I think Wisconsin is doing right and is a model for other States. We have created a rural medical school inside our medical school called the Wisconsin Academy of Rural Medicine. We are now beginning our third year. When that is fully up and going, that will be 25 rural-focused medical students per year.

We are basically building on a strategy of recruiting young people from rural communities, who have a particularly community and primary care orientation. Then—the first and second year is in Madison. But the third and fourth year are with academic partners around the State. In fact, they are having a medical school experience in rural areas with rural mentors, and they have been chosen for a higher probability of going back to rural.

Senator SMITH. Do you know whether, either Wisconsin or Oregon, they have incentives in terms of admission if they commit to go to rural?

Mr. SIZE. We have—that was a very interesting question. I mean, the University of Wisconsin is a very prestigious medical school, and sometimes I think some members of the admissions committee, it is all about the so-called "best and brightest," but very narrowly defined with MCATs and the grade point averages.

We are saying, look, the research is really clear. Once you get a certain point of smartness, to be a good doctor, it is as much about relationship—

Senator SMITH. Exactly. I just know a lot of kids in northeastern Oregon who wanted to go to medical school, but they were not admitted. Had there been any preferences given to the actual need in society would that have benefited them? They are smart enough. My heavens.

Mr. SIZE. Well, we created the slots. Basically, we have 25 slots that are being held for rural, and they are plenty smart enough to meet and do the work. So, we stopped looking at the grades, stopped looking at MCAT, and look at other attributes.

Senator SMITH. Any other final comments? Yes, Dennis?

Mr. BURKE. I just wanted to mention, along that same vein, that we have the first medical school opening in about 60 years in Yakima, WA. The Pacific Northwest is the most under medical school to population area of any place in the country. The new Pacific Northwest University of Health Sciences, which focuses on students from rural areas with the idea of returning them to the rural areas, they are taking their first class of 30 medical students this September.

Good Shepherd Healthcare System is signed up as a clinical rotation site. Two years after intense academics, we will be looking forward to having them on our campus.

Senator SMITH. There you go.

Mr. BURKE. That is a very exciting concept and program.

Senator SMITH. Well, listen, I thank you all so very much. Your testimonies added, I think, greatly to the Senate record, and you have helped us to turn up some light and heat on the parties that be. So our time is well spent this morning because you have come this long way to help us, and thank you.

We are adjourned.

[Whereupon, at 12:06 p.m., the hearing was adjourned.]

APPENDIX

PREPARED STATEMENT OF SENATOR ROBERT P. CASEY, JR.

Senator Smith, thank you for bringing us together today to discuss the important issue of health care for our older citizens who live in rural areas. This is an issue that too often gets ignored, and I appreciate your drawing our attention to it.

Rural health care is an important issue that deserves consistent attention, especially with respect to our older citizens who do not always have the means or ability to travel the many miles that are often necessary to get the health care they need. Many older citizens also live on fixed incomes and the high gas prices of recent months underscores this issue.

In Pennsylvania, 48 or our 67 counties are classified as rural. We also have the second highest number of residents over the age of 65 in the country. We must carefully examine whether or not we are meeting the current health care needs of our older citizens who live in rural areas, and also continue to be innovative and farsighted in designing new ways to help these individuals, especially as the baby boom generation retires and enters this demographic.

Access to providers continues to be a challenge in rural areas. In 2007, only 12 percent of primary care physicians in Pennsylvania practiced in rural areas. This translates into approximately one physician per 1300 residents. In urban areas, the ratio is approximately one physician per 650 residents. We must continue to work to increase the number of health care practitioners in rural areas, and examine how we can utilize nurse practitioners, certified nurse midwives and other health care providers to meet the needs of older citizens in rural areas.

Providers in rural areas face their own set of challenges. As I mentioned before, they have proportionately greater numbers of patient load and often have fewer resources to care for those patients. Furthermore, rural providers tend to see more patients covered under Medicare and Medicaid.

The Medicare Improvements for Patients and Providers Act which became law earlier this month included several provisions for rural health care. Telehealth services were expanded, FLEX grants were extended and payments for sole community hospitals and critical access hospitals were improved. These were important changes, but there is more work to do.

I would like to thank Senator Smith again for organizing this important hearing. I look forward to hearing the testimony of the witnesses and working with my colleagues to find solutions to the challenges of health care for our older citizens who live in rural areas.

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TESTIMONY OF

THE AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS

SUBMITTED TO THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

REGARDING PRESERVING RURAL SENIORS' ACCESS TO HEALTH CARE

August 8, 2008

On behalf of the nearly 70,000 clinically practicing physician assistants in the United States, the American Academy of Physician Assistants appreciates the opportunity to submit comments for the record on the role of physician assistants in providing and preserving health care for seniors in rural Americans.

Physician Assistant Practice

Physician assistants (PAs) are licensed health care professionals educated to practice medicine with the supervision of physicians. In all states, physicians may delegate to PAs those medical duties that are allowed by law and are within the physician's scope of practice and the PA's training and experience. All states, the District of Columbia, and Guam authorize physicians to delegate prescriptive privileges to the PAs they supervise. PAs are located in almost all health care settings and medical and surgical specialties. In 2007, an estimated 245 million patient visits were made to PAs and approximately 303 million medications were prescribed or recommended by PAs.

PAs in Rural Communities

PAs extend the ability of physicians to provide medical services and provide quality, cost effective medical care in communities across the country, delivering needed health care services in settings such as rural health clinics, community health centers, private practices, and public hospitals. Many PAs practice in areas with large Medicare populations, where they have been credited with improving access to quality, cost-effective health care for vulnerable Medicare patients. Fifteen percent of all PAs practice in rural areas where they may be the only full-time providers of care (state laws stipulate the conditions for remote supervision by a physician).

Physician assistants have a long history of serving the underserved. Since the rise of the profession in the early 1970s, physician assistants have played a key role in providing needed health care services for medically underserved populations, such as frontier and border communities, small rural towns, and at-risk groups such as the elderly. The 1977 Rural Health Clinic Services Act increased and improved the delivery of health care to rural physician shortage areas by assuring Medicare (and Medicaid) reimbursement to certified clinics staffed by physician assistants working with physician supervision. In rural communities across the country, PAs are often the only health care professionals for some distance; as a result, PAs form a special connection with their communities and with the patients they serve – patients who utilize and rely upon their PA as their medical home.

Access and Continuity of Care Challenges for Rural Seniors

The Centers for Medicare and Medicaid Services holds that the 1997 Balanced Budget Act's Medicare provisions regarding coverage of services provided by PAs does not apply to home health care, hospice care, or skilled nursing facility (SNF) care. As a result, Medicare beneficiaries who use a PA as their medical home and who have critical, chronic, or end-of-life care needs, are not able to have these important medical needs met. The problem affects Medicare beneficiaries throughout the United States, but it is especially acute in rural and other medically underserved communities where a PA is often the only primary care provider and has established relationships with Medicare patients that span a decade or more.

By definition, PAs work as part of a physician-PA team; that is the hallmark of the profession. Because direct on-site supervision is not generally required by state law, PAs are able to extend their supervising physician's reach beyond the immediate community. Currently under Medicare, PAs must obtain the supervising physician's signature on orders for hospice, home health, or SNF care. However, physicians aren't always available to sign the forms, especially in remote communities if the physician is a great distance away or on travel, or in clinics staffed by PAs who by themselves provide the night and weekend care. Therefore, PAs who are otherwise able to provide full-spectrum care to patients as delegated by their supervising physician must ask patients to wait – sometimes days or weeks – because of paperwork requirements. For these Medicare patients, these delays can often mean decreased time at home with loved ones when little time remains, and places an unconscionable burden on patients and families to find alternative care outside of their medical home at a time when they are the most vulnerable.

The inability of PAs to certify and provide hospice, home health, or SNF care disrupts continuity of care and decreases the availability of care, especially in medically underserved communities, at a time when the Medicare patient most needs efficient and timely attention.

PAs have shared with us many examples of delays in health care for Medicare patients caused by the inability of PAs to order home health, hospice and SNF, or to provide the hospice benefit. In one such example, a Georgia grandmother was turned away from a skilled nursing facility when it was discovered that a PA had signed the form. The grandmother was sent home where she suffered a fall and was subsequently hospitalized.

In yet another, PAs at critical access hospitals in Nebraska and other states report difficulty with discharge planning. By law, critical access hospitals must have a PA or nurse practitioner on site fifty percent of the time. However, because Medicare will not accept the hospitals' skilled nursing facilities orders that have been signed by a PA, many Medicare patients end up spending more time than necessary in a costly hospital bed while the problem is sorted out.

America's seniors who utilize a PA for their medical home, especially those in rural areas, deserve the same access to care and continuity of care that their fellow seniors in non-rural areas receive.

Recommendations

The American Academy of Physician Assistants and the nearly 70,000 clinically practicing physician assistants across the country take great pride in the role PAs have played in increasing access to care to some of the country's most geographically isolated or otherwise medically underserved communities. As cost-effective, high-quality, and critically needed health care providers, America's physician assistants appreciate the Committee's interest in looking for ways to increase and improve medical care for seniors, and look forward to being a continued part of the health care solution in future reform efforts. Thank you.

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