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Chairman Hatch, Ranking Member Wyden, members of Finance Committee, thank you for this opportunity to share my perspectives on key issues in rural health and related policy considerations. While some things have changed in the 30 years I have been conducting rural health research and policy analysis, the underlying rural dynamics remain much the same. But we have some new tools, both in health care delivery and through public policy, to help us continue our quest to establish and sustain a high performance rural health system.

We have had an interesting ride in policy debates and developments, including weathering the aftermath of converting hospital payment to PPS, considering health reform in the early 1990s, major changes in Medicare payment and benefits, changes through the Patient Protection and Affordable Care Act, and now a renewed (and welcome) discussion of what we should be doing to best serve the needs of rural residents. I have benefitted from exchanges with this committee and others throughout, starting with a conversation Senator Roberts and I had when I testified, as part of the RUPRI Health Panel (which I have chaired for 20 years), to the House Committee on Agriculture in 1993. We provided analysis of five health reform proposals, including the Health Security Act by assessing their impacts on key rural considerations. Senator Roberts may remember sharing his appreciation for the straightforward analysis, which helped give me the confidence to continue bringing forward the best we can offer from policy analysis to help you continue to improve policies. Of course the then Representative Roberts may not have liked the “thumbs up, thumbs down” table of our conclusions in my local newspaper, displayed during the hearing.

 The RUPRI Health Panel launched in 1992 to bring the rural dimension front and center in policy discussions. We provided analysis during development and implementation of major national policies including the Balanced Budget Act of 1997, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and of course PPACA in 2010. We provided feedback to this committee and others during policy formation, and followed up with analysis of potential rural impacts of new policies, including calling attention to “unintended consequences” of the BBA of 1997 before that term was as ubiquitous as it is now.

 I have come to appreciate the nexus of what we in the research community contribute to your efforts, and the concerns/needs of our colleagues delivering healthcare services. As President of the National Rural Health Association in 1996 I represented the interests of rural providers in policy discussions. One of my funded projects in the late 1990s was to work with rural providers in Nebraska and Iowa to develop the template for a provider-sponsored Medicare+Choice plan. Much of my research involves site visits to rural health care organizations to understand the implications of Medicare and other policies on what they are able to do in their communities. My personal engagement and that of the RUPRI Center, the RUPRI Health Panel, the Rural Telehealth Research Center (based in Iowa), and collaborations with others covers a host specific topics of interest to this Committee. They include Medicare Advantage, rural ACOs, access to rural pharmacy services, rural implications of changes in health care delivery and organization, delivery system reform initiatives in Medicare and Medicaid payment, the evolution of the marketplace in health insurance coverage, and the role of telehealth. My written testimony includes specific research findings on some of those topics, along with policy considerations.

 I would like to share some important questions to consider for the future of the Medicare ACO program. Are there benefits other than savings, related to changes in delivery models, that help achieve the triple aim of improved patient experience, better health, and lower costs? Should there continue to be different tracks? Should variations of advanced payment (perhaps as grants) continue to be available? Finally, what is the next iteration of payment reform that builds from the experiences of ACOs – perhaps global budgeting?

 I now offer the RUPRI Health Panel’s five rural specific considerations for policies designed to encourage delivery system reform:

1. Organize rural health systems to create integrated care.
2. Build rural system capacity to support integrated care.
3. Facilitate rural participation in value-based payments.
4. Align Medicare payment and performance assessment policies with Medicaid and commercial payers.
5. Develop rural-appropriate payment systems.

In general, payment policies should be sensitive to the rural practice environment, including population density, distances to providers, and need for infrastructure investment. New models can build on the strengths of the rural system, notably primary care.

Rural health care organizations may need access to investment capital they are unable to generate on their own as they participate in new, better ways of organizing services. We should test ideas and programs specific to rural circumstances, as is underway in Pennsylvania. Payment policies and alternative sources of financial support should recognize the importance of access to services in places wherein patient revenue will not be sufficient to cover all costs.

 Thank you for this opportunity and I look forward to your questions.