September 13, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201


Dear Administrator Brooks-LaSure:

The Kansas Hospital Association (KHA) is pleased to offer comments on the provisions of the 2023 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Proposed Rule (Proposed Rule) regarding the Rural Emergency Hospital (REH) Program. Founded in 1910, KHA strives to be the leading advocate and resource for our state's 123 community hospitals, including 82 critical access hospitals (CAHs).

A July 2021 report from the North Carolina Rural Health Research Program applied three measures – negative total margin, low average daily census, and low net patient revenue - to identify those hospitals most likely to consider REH conversion. Of the 68 rural hospitals identified in the report, 16 are in Kansas, more than twice the number in any other state.¹

We are pleased to report that our State Legislature responded quickly to this new opportunity with the introduction of the Rural Emergency Hospital Act to provide for the licensure of REHs in Kansas. This bill was signed into law by the Governor in April 2021.

Communities that have lost their hospitals to closure in the recent past have expressed interest in the REH Model, although the enabling legislation limits the opportunity to hospitals currently in operation. KHA urges CMS to consider options for allowing those recently closed entities to be eligible for the REH model.

The success of the REH Program is critical to preserving access to essential health care services in rural communities. Thus, CMS should do all that it can to eliminate uncertainty from the REH conversion process. Rural hospitals evaluating this opportunity need clarity on how the funding for REH services will work. As we learned through CAH conversion process over twenty years ago, concerns over the unknown often outweigh the potential benefits of moving forward.

¹ The report is available at https://www.ruralhealthresearch.org/alerts/422
Following the publication of the Proposed Rule, KHA convened a work group of rural hospital leaders, including representatives from several communities seriously considering REH conversion. The work group carefully analyzed the REH quality reporting program provisions, fee-for-service reimbursement, monthly facility payment, and enrollment process. The comments developed by this group provide CMS with the perspective of those on the front lines who would be implementing the REH Program in their communities to maintain access to high-quality healthcare services.

I. REH Quality Reporting Program

KHA urges CMS to focus exclusively on identifying the most appropriate measure or measures for the launch of the REH Quality Reporting Program, as opposed to considering measures that may be added as the REH Program matures. Proposed measures should be relevant to the types of care provided at an REH and evaluated using the following criteria: (1) Would a facility converting to an REH have established processes in place to collect the data required for the measure? (2) Is the measured outcome likely to be influenced by factors beyond the REH's control? (3) Does the measure provide data to drive performance improvement initiatives? (4) If the measure pertains to a specific condition or procedure, is it likely the REH will have a sufficient volume of cases to provide meaningful results?

Small rural hospitals often have a single individual responsible for quality reporting, and that individual usually has several different roles. We have seen significant turnover in these positions; it is not uncommon for 20 percent of our members to have a new quality director in any given year. This certainly creates a barrier to consistent and accurate reporting. Given the current staffing challenges, we suggest small set of measures for the launch of the REH program.

KHA agrees with the National Advisory Committee on Rural Health and Human Services' recommendation to include the MBQIP measure for Emergency Department Transfer Communication (EDTC), as it meets each of the criteria. Most Kansas CAHs have established processes to complete required chart abstractions, report results, and develop and implement performance improvement initiatives based on their results. Although these processes are time-consuming, CAHs report the EDTC measure is well-defined and relevant to their operations (i.e., not impacted by factors outside the CAH's control).

In addition, KHA believes that patient experience should be included in the quality measure set. The existing EDCAHPS survey would be a good starting point. Since these surveys are conducted by vendor, the burden placed on staff to collect and report is minimized.

The other measures recommended by the National Advisory Committee have proven less valuable for CAHs, especially given the significant work involved in chart abstraction. The median time to transfer to another facility for acute coronary intervention is impacted by factors beyond the CAH's control, including the availability of ambulance transport and the ability of the other facility to accept the requested transfer. Other measures - including median time from ED arrival to ED departure for discharged patients, door to diagnostic evaluation by qualified medical professional, and left without being seen – often do not provide useful information for performance improvement purposes, given significant variation due to patients' presenting conditions.
KHA also supports including the Hospital Commitment to Health Equity measure in the REH Quality Reporting Program. Organizational commitment to cultural change and leadership accountability are critical first steps toward more equitable care. KHA, however, urges CMS to delay reporting requirements relating to screening for social drivers of health to afford REHs sufficient time to develop streamlined processes to complete and document screenings and report on the measure.

II. Fee-for-Service Reimbursement for REH Services

The authorizing statute defines REH services as "(i) Emergency department services and observation care [and] (ii) At the election of the rural emergency hospital, with respect to services furnished on an outpatient basis, other medical and health services as specified by the Secretary through rulemaking." CMS, however, proposes a more restrictive definition, limiting REH services to those services for which PPS hospitals are reimbursed under OPPS.

However, there are several services within the statutory definition of REH services for which PPS hospitals are reimbursed on other fee schedules, including laboratory services, outpatient therapy services, mammography, and services furnished by opioid use treatment providers. Rather than defining these services as non-REH services to be reimbursed at their respective fee schedule rates, CMS' regulations should remain consistent with the statutory language, including these services within the definition of REH services. Consistent with congressional intent, CMS should provide a 5% add-on to the respective fee schedule payments for these services.

For example, Section 1833(t)(1)(B)(iv) of the Social Security Act excludes from the outpatient prospective payment systems for hospital outpatient services those therapy services reimbursed under a fee schedule established under Section 1834(k). Under that section, CMS is directed to pay for outpatient therapy services under the fee schedule established under Section 1848, i.e., the Medicare Physician Fee Schedule. Section 1848 affords CMS broad authority in maintaining the Medicare Physician Fee Schedule. Nothing in that statute would prohibit CMS from revising the relevant regulations in 42 CRF Part 414 to provide a 5% add-on for therapy services furnished in an REH.

More robust payment policies will not only encourage more CAHs and rural hospitals to convert rather than close but to offer more necessary services after conversion. REHs should receive the extra 5% payment when they determine that their communities need additional services, like outpatient therapy and opioid use treatment, that are not reimbursed under OPPS.

KHA also requests that Medicare Geographic Classification Review Board (MGCRB) reclassification be allowed for the REH wage index and the rural floor. REHs should be allowed to apply for reclassification by the MGCRB to reclassify to a higher wage area and receive a higher payment rate.

Finally, KHA fully supports CMS' proposal regarding payment for services furnished in an off-campus outpatient department of an REH. KHA agrees that the statutory language reflects Congressional intent that REH payments should not vary based on the location of the department where the service is provided.
III. Monthly Facility Payment

KHA has carefully reviewed the document CMS released with the Proposed Rule detailing each step in the formula to calculate the monthly facility payment. However, CMS has not published its computation, i.e., the dollar amount assigned to each step in the calculation. The only definite dollar amounts CMS has made available are the total amount of Medicare spending for CAHs in CY 2019 ("Actual Spending"), $12.08 billion, and the total projected amount of Medicare spending for CAHs if paid prospectively in CY 2019 ("Projected Spending"). In the latter case, two different amounts are listed in the Proposed Rule: $7.68 billion (87 Fed. Reg. 44786) and $7.03 billion (ld. at 44780).

KHA urges CMS to publish its computation of Actual Spending and Projected Spending to allow stakeholders to review and validate the calculation of the monthly facility amount. As discussed below, many questions remain about whether CMS considered all relevant factors, especially given the two different amounts listed for Projected Spending. However, given the importance of the monthly facility payment to those considering REH conversion, there should be no lingering questions regarding its validity.

**Method II billing.** Regarding the formula used to calculate Actual Spending, it appears CMS did not include payments for professional services to those CAHs that elected Method II billing. These CAHs received 115% of the applicable Medicare Physician Fee Schedule rate (multiplied by 110% for services furnished in a health professional shortage area) for services provided by physicians and non-physician practitioners who re-assigned their billing rights to the CAH. By failing to include these payments, CMS under-counted Actual Spending, thus reducing the amount of the monthly facility payment.

**Ambulance Payments.** It does not appear that CMS did not account for the enhanced reimbursement received by those CAHs that operate the only ambulance services within 30 miles of their facilities. Therefore, CMS should include in Actual Spending the difference between the cost-based reimbursement these CAHs received and the ambulance fee schedule rates these CAHs would have otherwise received. Using this approach, CMS would not need to include ambulance payments in Projected Spending.

Regarding the formula used to calculate Projected Spending, it appears CMS failed to properly apply several payment rules, resulting in an overestimation of PPS payments. These apparent errors result in a proposed monthly facility payment less than the amount authorized by statute.

**72-hour rule.** It appears CMS failed to adjust payments to account for the fact CAHs are not subject to the 72-hour rule. Unlike PPS hospitals, CAHs receive full payment for any outpatient diagnostic or other medical services performed within 72 hours before hospital admission. To calculate estimated PPS payments, therefore, CMS would need to exclude any service for which a CAH received payment within the 72-hour window, as a PPS hospital would not have received any compensation for those services.

**Hospital IQR.** In the explanation of the DRG payment calculation, it appears CMS assumed all CAHs would have met all Hospital Inpatient Quality Reporting Program requirements and thus would not have been subject to the reduction in the applicable annual payment rate update. Given CAHs were not subject to similar quality

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reporting requirements in 2019, it would be appropriate to assume all CAHs would not have been subject to this payment reduction.

**Promoting Interoperability.** It appears CMS did not consider the reduction in the applicable annual payment rate update associated with the Promoting Interoperability program. In this case, CMS should reduce the projected DRG payments for inpatient admissions at those CAHs subject to the negative adjustment under this project (i.e., received 100% instead of 101% of costs).

**Transfer fraction.** To calculate DRG payments, CMS compared the "covered days of stay to the Geometric Mean Length of Stay of the DRG code, per the post-acute care transfer adjustment policy." Presumably, CMS reduced the amount of DRG payment if the length of stay was less than the geometric mean and the patient was transferred to another facility, hospice care, or home with home health services. Due to the 96-hour limit on inpatient stays, CAHs frequently transfer patients to their swing beds. Because the post-acute care transfer adjustment policy does not apply to swing bed transfers, CMS should confirm it did not reduce the DRG payment if the beneficiary was transferred to a swing bed. Also, CMS should confirm the transfer fraction was applied only for those DRGs to which the post-acute transfer adjustment policy applies. Neither of these matters is addressed explicitly in the Proposed Rule or the document published by CMS with the Proposed Rule.

**Low volume payment adjustment.** Regarding the low volume payment adjustment, CMS reasoned that "[s]ince CAHs must be located either more than 35-miles from the nearest hospital (or more than 15 miles in areas with mountainous terrain or with only secondary roads), they meet criterion 1 for low volume adjustment," i.e., the hospital is more than 15 road miles from another subsection (d) hospital. CMS, therefore, applied the low-volume adjustment in calculating the projected DRG payments for all CAHs with fewer than the minimum number of discharges.

A significant number of CAHs are located within 15 miles of another hospital. In its 2013 report, *Most Critical Access Hospitals Would Not Meet the Location Requirements if Required to Re-Enroll in Medicare,* the Office of Inspector General found that "306 [CAHs] were located a drive of 15 or fewer miles from their nearest hospitals or other CAHs." Although criterion 1 refers to the distance to another subsection (d) hospital, CAHs are treated the same as subsection (d) hospitals for this analysis. Thus the low-volume adjustment should not apply to CAHs within 15 miles of another provider, regardless of whether that facility is presently a CAH or subsection (d) hospital. Using the methodology specified in the OIG report, CMS should identify those CAHs that do not meet criterion 1 and reverse the low volume adjustment applied to any of those CAHs' projected DRG payments.

**DSH/UCP add-on payments.** The method CMS proposes to use to project the amount of DSH/UCP add-on payments CAHs would have received if paid prospectively raises concerns. Although CAH cost reports include the data elements used to calculate these payments, CMS does not propose using cost report data due to undefined "data availability and validity concerns." Instead, CMS proposes to project these payments by assigning to each CAH the low-income percentage and uncompensated care cost percentage of the nearest rural PPS hospital based on "the premise that DSH/UCP are determined by the demographics the hospitals serve." Hospitals are free to establish their own financial assistance policies and charge structures that directly impact uncompensated care. This brings into question the use of hospital proximity as a representative proxy. Absent

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3 Available at [https://oig.hhs.gov/oei/reports/oei-05-12-00080.pdf](https://oig.hhs.gov/oei/reports/oei-05-12-00080.pdf)
a reliable method to make projections, CMS should exclude DSH/UCP add-on payments from Projected Spending, as it proposes to do with hospital value-based purchasing program payments.

Suppose CMS goes forward with using proximity as a proxy. In that case, KHA believes only the smallest rural PPS hospitals (1 to 50 available beds) with actual geographic location assignment in a rural area (as opposed to those hospitals classified as rural for payment purposes) should be identified for this purpose as they are most comparable to CAHs. Also, the PPS hospital should be in the same state as the CAH, given the impact of state policies on rates of uncompensated care.

**IME add-on payments.** CMS's proposed use of proximity as a proxy to project IME add-on payments raises concern. Unlike DHS/UCP, IME add-on payments are not determined by the demographics the hospitals serve. Instead, IME add-on payments reimburse teaching hospitals for their higher patient costs; hospitals without residency training programs do not receive these payments.

Each CAH's cost report (specifically, Worksheet S3, line 27, column 9) indicates whether the CAH maintained a residency training program. No add-on payments should be included for any CAH that did not have such a program in 2019. If CMS uses proximity as a proxy to calculate IME payments for a CAH with a residency training program, the same hospital identified using the abovementioned method should be used. If that hospital did not receive IME add-on payments in 2019, no add-on payment should be included for that CAH.

**Amount of Projected Spending.** Regarding the final calculation of the monthly facility payment (i.e., (Actual Spending minus Projected Spending) divided by the number of CAHs in 2019), KHA asks CMS to address the inconsistency in the reported amount of Projected Spending. As noted above, this amount is reported as $7.68 billion (87 Fed. Reg. 44786) and $7.03 billion (Id. at 44780). CMS uses the former number in calculating the monthly facility payment. However, if the latter number is used, the annual payment rate is increased by $472,298. For a provider considering REH conversion, this higher rate may be the deciding factor in moving forward. And again, this highlights the need for CMS to make the detailed computation of the monthly facility payment available.

**Number of CAHs in 2019.** KHA urges CMS to make an adjustment for those CAHs that closed in 2019. For example, Oswego Community Hospital in Oswego, Kansas, closed on February 14, 2019. Horton Community Hospital in Horton, Kansas, closed on March 12, 2019. Rather than counting each of these hospitals as 1.0 for purposes of the final calculation, CMS should count these hospitals as 0.12 and 0.2, respectively. CMS should make the same adjustment for the other four CAHs that closed in 2019. Although the monthly facility payment amount would not change significantly, this adjustment acknowledges the impact hospital closures have had on rural communities.

**IV. Other Payment-Related Issues**

**A. SNF Payments**

KHA urges CMS to establish a transition period for those rural hospitals and CAHs with swing bed programs that must convert those programs to SNF distinct part units as part of REH conversion. For example, SNFs were afforded more than a year to prepare for the Patient Driven Payment Model (PDPM) transition, including developing and implementing new processes and completing staff training relating to assessments and
collecting and submitting data. Similarly, CMS should afford an REH for at least 18 months to transition to PDPM, continuing reimbursement at the prior swing bed rates for the transition period.

KHA also asks CMS to study the impact of eliminating swing bed reimbursement for rural hospitals and CAHs that convert to REHs on the availability of post-acute services in rural communities. If these facilities discontinue post-acute services due to inadequate SNF payments, CMS should be prepared to advocate for supplemental payments to protect rural beneficiaries.

B. Ambulance Payments

Kansas rural hospital leaders considering REH conversion are deeply concerned that the communities they serve will lose access to essential inpatient services. Today, residents must leave their community to receive tertiary or quaternary care. However, transportation issues plague these residents, as Medicare coverage for ambulance services is limited. With an REH, residents would have to travel outside their community to receive any acute care level (without the opportunity to receive acute hospital care at home). Unless transportation issues associated with patient transfers are addressed, rural residents will face serious inequities in access to acute care services. Consideration to all types of ambulance services (land and air) should be given and how Medicare coverage can support these services.

CMS proposes to amend 42 CFR 410.40(d) regarding origin and destination requirements to include REHs. In addition to these proposed changes, CMS should add two new subsections to the regulation:

1. Add a new subsection addressing coverage for facility-to-facility transfers for emergency services: "From a hospital, CAH, or REH to a hospital or CAH for emergency services not available at the hospital, CAH, or REH to which the patient came."

2. Add a new subsection addressing coverage for hospital-to-SNF transfers: "For a beneficiary who qualifies for SNF or swing bed services following an inpatient stay, from a hospital or CAH to a hospital, CAH, or SNF in the beneficiary's home community for SNF or swing bed services."

These clarifications regarding coverage for ambulance services to align with the REH Program are necessary to ensure appropriate transportation is available to and from communities served by REHs. In Kansas, we have experienced these issues first-hand. Since 2015, the hospitals in Independence and Fort Scott, Kansas – each serving a community of approximately 10,000 - have closed. Presently, each community is served by an emergency department operated by a hospital in a neighboring town. These hospital leaders – who would be happy to discuss their experiences directly with CMS officials - report numerous challenges in arranging transportation to an acute care facility and back to the patient's home community. In many cases, overly strict interpretations of the Medicare coverage rules have resulted in beneficiaries being charged thousands of dollars to access acute care services previously available in their local community. Again, regarding health equity, CMS must eliminate this barrier to rural beneficiaries receiving appropriate care.

In Kansas, EMS services are provided at a local level. Many parts of our state still rely on a volunteer staffing model and have minimal vehicles/equipment. If an ambulance service is located in a county with a REH, it will likely need additional staff and equipment to meet the increased demand in services. Consideration should be given to an additional annual payment to those ambulance services to ensure safe and timely patient transfers.
C. Rural Health Clinic Status

KHA asks CMS to state explicitly in the REH payment regulations that a provider-based rural health clinic (RHC) that was reimbursed at non-capped rates before the rural hospital or CAH's conversion to an REH will continue to be reimbursed at those rates rather than the national statutory payment limit. This is consistent with the statutory language; specifically, 42 USC 1395x(kk)(6)(B), which states an REH "is considered a hospital with less than 50 beds for purposes of the exception to the payment limit for rural health clinics under section 1833(f)." Again, this higher reimbursement is necessary to maintain access to services in communities with higher per-visit costs. The potential loss of such revenue may make it impossible for some hospitals or CAHs to pursue REH conversion.

D. Bad Debt Reimbursement

CMS should clarify whether an REH will be eligible for bad debt reimbursement under 42 CFR 413.89. KHA asks CMS to apply the current bad debt policy of a 35% reduction to REHs, especially because CAHs that convert to REHs should benefit from consistency in anticipated payments. CMS should also make bad debt payments to REHs on a biweekly basis, as they are for PPS hospitals.

E. Participation in the 340B Program

The statute authorizing the 340B Drug Pricing Program, 42 USC 256b, identifies the types of entities eligible for the program, including certain CAHs and PPS hospitals. In authorizing the REH Program, Congress did not expressly amend this provision to reference REHs. Still, Congress did not specifically state a rural hospital or CAH that undergoes REH conversion must give up 340B participation. KHA encourages CMS to amend 42 CFR 10.3 to clarify that "covered entity" includes any REH that qualified as a covered entity and participated in the program before its conversion.

Rural Kansas hospital leaders have raised concerns over whether to convert without 340B eligibility. The option to continue participation in 340B would likely increase the number of rural hospitals and CAHs considering converting to an REH. Suppose CMS should conclude it lacks the authority to permit REHs to participate. In that case, KHA encourages the agency to work alongside Congress to ensure that a statutory change is made to include REHs as covered entities.

Additionally, KHA thanks CMS for proposing to reinstate the average sales price (ASP) plus 6% payment rate for 340B drugs in the final rule in light of the Supreme Court decision in American Hospital Association v. Becerra, 596 U.S. ___ (2022).

F. Method II Billing

Under 42 USC 1395m(g)(2)(B), a CAH may elect Method II billing, receiving 115% of the Medicare Physician Fee Schedule amount for professional services furnished in its facility. Again, Congress did not amend this statutory provision to make specific reference to REHs, but Congress did not expressly state a CAH that undergoes REH conversion must give up Method II billing. And again, KHA urges CMS to revise its implementing regulation, 42 CFR 413.70(b)(3), to clarify that a CAH that converts to an REH may maintain its election of Method II billing.

G. Population Health

Kansas hospitals have an interest in engaging in activities that address population health and social determinants of health but find the lack of adequate reimbursement for these activities to be a barrier. Additional resources will be needed if this is to be a focus of a rural emergency hospital.
H. Accelerated Payments

CMS should make every effort to avoid cash flow issues during the conversion process. Several Kansas CAHs experienced significant financial challenges during the early days of the CAH conversion process due to delayed payments from Medicare and other payers. In addition to working directly with the MACs, CMS should afford newly converted REHs the opportunity to request and receive accelerated payments while in the conversion process.

I. FLEX/SHIP Participation

Unfortunately, the enabling legislation does not include conforming amendments to include references to rural emergency hospitals in the provision establishing the Medicare rural hospital flexibility program, 42 USC 1395i-4(g)(1). However, this oversight should not limit the agency’s authority to promulgate regulations permitting REH participation in the FLEX Program’s activities. In like manner, KHA would urge CMS to promulgate regulations to allow REH participation in the Small Hospital Improvement Program.

J. Other Payers

To ensure rural residents do not face inequities in access to acute care services, CMS should direct or encourage other payers to either eliminate or expedite prior authorizations for REH transfers to other hospitals for inpatient care.

Medicare Advantage. The statute authorizing the REH Program and the proposed regulations are silent on Medicare Advantage payments for REHs. At present, MA plans pay cost-based rates to CAHs. If the plans pay REHs under OPPS with no upward adjustment or at a negotiated rate less than cost, the conversion will cause revenue loss, which may impact the REH Program's long-term viability. CMS should require MA plans to pay REHs with the same payment methodology as under traditional Medicare. CMS should also address the REH Program's impact on network adequacy requirements for MA plans.

State Medicaid Programs. Presumably, each state’s Medicaid program will determine how it will reimburse CAHs. KHA requests that CMS issue guidance to state Medicaid directors regarding the REH Program, including guidance regarding the impact of the REH Program on network adequacy requirements for Medicaid managed care organizations. To the extent a state plan amendment would be required to establish REH reimbursement for a state Medicaid program, KHA urges CMS to create a streamlined process for submitting, reviewing, and approving such amendments to avoid unnecessary administrative burden and delay.

Marketplace Plans. Finally, to eliminate any future issues, KHA encourages CMS to publish guidance clarifying that REH services are included in the essential health benefits all marketplace plans must cover.

K. Sequestration

KHA is concerned about Medicare sequestration and the impending Pay-As-You-Go (PAYGO) sequester. Medicare sequestration is currently in effect and reduces Medicare payments by 2%. Additional PAYGO reductions are set to go into effect on January 1, 2023, absent congressional action to further delay the implementation. KHA believes that because REHs are a new provider type and did not exist when Medicare sequestration began that they should be exempt from these payment cuts. Sequestration should not apply to either the OPPS rate plus 5% or the additional facility payments.
V. Enrollment

KHA fully supports CMS' proposal to streamline the REH conversion process. Because Kansas was one of the two states that participated in the EACH/RPCH program, several Kansas hospitals were among the first to convert to CAH status. Lessons learned from that conversion process should inform the REH conversion process. CMS should issue detailed guidance to and provide in-depth training to its Medicare Administrative Contractors (MACs) regarding the conversion process, including enrollment and claims processing and resolution of outstanding matters (e.g., filing and settlement of cost reports for pre-conversion periods). Second, CMS should identify a specific group of individuals available to assist hospitals and CAHs with any issues arising with the MACs relating to REH conversion.

KHA urges CMS to publish the completed chapter for the State Operations Manual concerning the REH Program at the same time it publishes final regulations for the program. This will eliminate any ambiguity regarding program operations, thus providing hospital leaders with critical information in deciding whether to pursue conversion to an REH. CMS also should require training for those surveyors who will evaluate a facility’s compliance with REH Program requirements to reduce the risk of confusion and misinterpretation of those requirements.

The authorizing statute requires a CAH or hospital applying for conversion to submit a detailed transition plan that lists the services the REH will retain, modify, add, and discontinue and a list of intended outpatient services. Therefore, CMS should provide detail regarding the form and process for plan submission and approval.

KHA thanks CMS for the opportunity to submit these comments and its continued work to support access to affordable, high-quality health care services in rural communities.

Sincerely,

Chad Austin
President & CEO
Kansas Hospital Association