

THE CRISIS IN RURAL AMERICA

HEARING
BEFORE A
SUBCOMMITTEE OF THE
COMMITTEE ON APPROPRIATIONS
UNITED STATES SENATE
ONE HUNDRED SIXTH CONGRESS
FIRST SESSION

SPECIAL HEARING

Printed for the use of the Committee on Appropriations



Available via the World Wide Web: <http://www.access.gpo.gov/congress/senate>

U.S. GOVERNMENT PRINTING OFFICE

61-415 cc

WASHINGTON : 2000

For sale by the U.S. Government Printing Office
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THE CRISIS IN RURAL AMERICA

WEDNESDAY, JULY 14, 1999

U.S. SENATE,
SUBCOMMITTEE ON AGRICULTURE, RURAL
DEVELOPMENT, AND RELATED AGENCIES,
COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 10:04 a.m., in room SD-138, Dirksen Senate Office Building, Hon. Thad Cochran (chairman) presiding. Present: Senators Cochran, Gorton, Durbin, and Feinstein.

STATEMENT OF SENATOR THAD COCHRAN

Senator COCHRAN. The subcommittee will please come to order.

Today we are very pleased to convene a hearing to look into the effect of the Balanced Budget Act and the implementation of that act on the financial condition of rural hospitals and how that in turn affects our efforts to develop the economies of the small towns and rural communities throughout the United States.

We all know that rural hospitals can be in some instances the most important economic activity in a small town or a rural community. I think one of our witnesses who will testify today points out that, second only to the local education system, the schools, the local hospitals are the largest employer of workers. So the effect of a rural hospital on the economy of a local area cannot be exaggerated in terms of its impact on the quality of life, first of all, the access to health care that it provides, and also the access to a job and a higher standard of living for the people who live in the area.

So when hospitals are put under a lot of new economic pressures and are forced to close or to make changes that reduce the employment level in that community, it has a very serious economic consequence for the people, not only who work at the hospital or the clinic, but who live in the area.

So our hearing today will look at this problem, which some are saying is a crisis in rural America, and try to determine what, if anything, the Congress should be doing to address this problem and what, if anything, the administration should be doing that it is not doing to deal with this problem.

PREPARED STATEMENT

We are very pleased to have a talented group of witnesses to testify at our hearing today. We are going to be joined later by the distinguished ranking minority member of the committee, Senator Kohl of Wisconsin, and I will put an opening statement in the record in his behalf and call on him when he does arrive.

[The statement follows:]

PREPARED STATEMENT OF SENATOR HERB KOHL

Thank you, Mr. Chairman. Unfortunately, due to a conflict with a Judiciary Committee hearing, I could not be here for the first panel of this hearing. But I look forward to reviewing the first panel's testimony, and I plan to submit several questions for the Record.

I especially want to welcome Anne Klawiter from Southwest Health Center in Platteville, Wisconsin. I know she will provide a clear picture of the critical challenges faced by rural hospitals in Wisconsin and across the nation.

When we passed the Balanced Budget Act of 1997, we intended to achieve a certain level of savings for Medicare. We intended to eliminate wasteful spending. We intended to weed out unscrupulous, fraudulent providers. In short, we intended to save the Medicare program from bankruptcy. We all still support that goal.

However, when we passed the BBA, we never intended to put good, efficient, hard-working health care providers out of business. And we certainly never intended to force rural providers to cut back on needed services or even worse—to force them out of business altogether.

Unfortunately, some of the provisions of the BBA are causing disastrous consequences for rural hospitals. A recent study estimates that, once the BBA is fully implemented, profit margins for small, rural hospitals are expected to fall from 4.2 percent in 1998 to NEGATIVE 5.6 percent in 2002. These reductions will likely force rural hospitals to reduce services—leaving many residents in rural communities without the care they need.

It is time for all of us—both in Congress and the Administration—to take a hard look at the unintended effects of the BBA. And while we cannot and must not go back to the time when Medicare was close to bankruptcy, we do have to make sure that Medicare beneficiaries in rural communities have reliable access to quality health care.

Senator COCHRAN. Our distinguished friend and colleague from the State of Washington, Senator Gorton, a member of the committee, is here as well.

Our lead-off witness is going to be the Senator from Nebraska, Chuck Hagel, whom we appreciate very much being here. At this point I will yield to my friend from Washington for any comments or opening statement he might have. Senator Gorton.

STATEMENT OF SENATOR SLADE GORTON

Senator GORTON. Mr. Chairman, focusing on the impact of the implementation of the Balanced Budget Act of 1997 on rural hospitals and access to care for seniors in rural areas is a vitally important task and one that I am grateful that you have asked this subcommittee to look into. Obviously, that Balanced Budget Act has been one of the amazing successes of American public policy and has had tremendously positive impacts on our economy taken as a whole. But as special provisions are implemented and as the administration develops payment systems, issues its regulations and guidance, I continually hear from providers in my State, and particularly those in rural areas, that the payment reductions and increased paperwork burden are simply untenable.

The administrator at Sunnyside Community Hospital, for example, told me that in his 30 years of experience this is the worst ever for reimbursement cuts. Washington State has one of the most efficient health care systems in the Nation. Hospital inpatient costs are 31 percent in per patient episode costs on average than the national average. Despite these efficiencies, Washington's 92 hospitals, all of which, all except for six, are nonprofit, will bear \$650 million of the payment reductions from the Balanced Budget Act.

Audited data from our State's Department of Health show that in 1997 38 percent of our State's hospitals lost money on operations. This year that figure will be larger. This means that many hospitals will have to cut staffing levels, will lose much of their ability to finance hospital improvements, and may be forced to close some facilities.

But hospitals represent only part of the crisis. Every county in Washington receives an adjusted average cost rate that is below the national average. In 1997 Washington health plans lost a combined \$110 million. Nine of the ten largest plans experienced an operating loss and six of them had net losses even after factoring in investment gains obtained in one of the strongest markets in the history of our Nation.

Those reimbursement rates are even lower in rural areas and are one of the reasons that a number of plans have decided that it was no longer good business to stay in eastern Washington. In fact, low reimbursement rates and the potential for more losses due to implementation of the risk adjustor was one reason that a number of insurance companies across Washington State dropped seniors in rural areas from their health plans. This has meant that in many counties in eastern Washington seniors have no other option than the more expensive fee for service plans.

We know that rural hospitals face unique challenges in the delivery of health care. Typically, rural hospitals serve a higher percentage of Medicare and Medicaid patients than their urban and suburban counterparts. As many as 70 percent of the patients served at Sunnyside are Medicare or Medicaid patients. The administrator for Ferry County Hospital tells me that at least 50 percent of their patients are Medicare recipients and she estimates that they receive 51 cents for every dollar it costs to provide care.

An efficient health care system combined with the challenges of health care in rural markets results in rural health systems that are extremely vulnerable to payment changes and increased bureaucracy that diverts staff time from patient care. Ultimately, it means that we are jeopardizing the quality of care for seniors and other Americans living in rural communities.

I am frustrated by the response from the administration to these challenges. HCFA no doubt has a daunting challenge in front of it as it works to implement the many reforms in BBA 1997. However, it seems that repeatedly the administration has ignored the needs of rural areas.

For example, the proposed beneficiary copay for the outpatient prospective payment system means that outpatient reimbursements to hospitals will be reduced an additional 5.7 percent across the board. Across the board Medicare cuts will only exacerbate the geographic inequities that currently plague the Medicare system and punish the Nation's more efficient providers. There are many other examples that will no doubt be raised in today's hearings.

I hope we will have the opportunity to address the difficulty many rural hospitals have in recruiting and hiring doctors, nurses, and other health care professionals as well. I am proud to represent a State that includes a medical school, the University of Washington, that has an extremely strong program in rural medi-

cine and encourages residents to practice in rural areas throughout Washington, Wyoming, Alaska, Montana, and Idaho.

Preserving access to quality health care in rural areas for seniors and other Americans living in rural areas is a daunting challenge. I am committed to it, as you are, but future reforms must not solely be at the expense of providers and must not punish efficient practices, as is the case in the current system.

I look forward to hearing from our colleague from Nebraska and from the panels.

Senator COCHRAN. Thank you very much, Senator.

Senator Feinstein, a member of our committee, has joined us. Senator, we will recognize you at this minute for any comments or opening statement that you would like to make.

STATEMENT OF SENATOR DIANNE FEINSTEIN

Senator FEINSTEIN. Well, thank you very much, Mr. Chairman. Let me thank you for holding this hearing, because the issue of the rural hospital in California is also a very big issue. We have had since 1996 37 hospital closures and 13 consolidations.

If I may, I would like to submit a list of those hospital closures for the record, because the great bulk of them are really rural hospitals.

Senator COCHRAN. We will make that a part of the record.

Senator FEINSTEIN. This is a map—I do not know if you can see it—put out by the Hospital Conference, that shows the rural hospitals in California. It points out that we have 72 State-defined small and rural hospitals, plus 7 HCFA-defined, non-State-defined rural hospitals, located in non-MSA counties. They serve about 2.6 million rural residents. The non-MSA definition of “rural” benefits only 42 percent of the small and rural hospitals, and they serve about a million residents.

The Office of Rural Health Planning definition of “rural hospitals” expands those to about 62 small and rural hospitals. But there is a real discrepancy there that I think needs to be remedied.

Mr. President, or Mr. Chairman, I just came back from California and I met with a number of doctors and hospital administrators, patients, and others, and I come back to Washington this week with a very deep sense of concern. The California health service system is really stretched to the limit. We are a big State. We have the heaviest penetration of managed care in the Nation, with over 25 million people in some form of managed care.

Doctors tell me that the HMO premiums in California are 40 percent lower than any of the other States, which creates a situation of cost containment. That is the good news. The bad news is that it is pushing the system into self-destruct, in that hospitals are closing, medical practices are going out of business, there is an inability to recruit young doctors, and of course we all know the stories of the absence of patient care.

The Medicaid rates paid to hospitals in our State unfortunately are among the lowest in the country, and that contributes to it. Medicare cuts have exacerbated our hospitals’ difficulty. In California’s rural hospitals, 40 percent of the patients are Medicare and 20 percent are Medicaid. We have an uninsured rate of 22 percent, 6.5 million people, while the national rate is 15 percent. So we are

7 percent above, and that puts a burden of uncompensated care on hospital emergency rooms.

We have 40 percent of the Nation's immigrants. This adds to hospitals' burdens of uncompensated care because most of these immigrants are uninsured.

And California's hospitals now must comply with heightened seismic safety requirements. This is going to cost hospitals \$10 billion by 2008 and \$20 billion by 2030.

Again, we have had 37 hospitals close, most of them rural, 13 consolidations. And the California Health Care Association predicts that 15 percent more of these hospitals will close by the year 2005, and they also predict that our public safety net hospitals will be caught in a major budget squeeze.

As for rural hospitals, the association says that 69 percent of the State's rural hospitals lost money in 1998 and that conversions and consolidations among them could eliminate a 15 percent additional number by 2005.

So no wonder everybody is demoralized and dispirited about health care in California. We see HMO's interfere with medical decisionmaking, focus on cost-cutting at the expense of good health care. So I am very pleased to have this hearing.

PREPARED STATEMENTS

I would like to ask, if you might, that the full text of my remarks and this chart defining rural hospitals in California be placed in the record.

Senator COCHRAN. They will be made a part of the record without objection.

Senator FEINSTEIN. Thank you very much.

Senator COCHRAN. Thank you, Senator. At this time I would also like to enter in the record a statement from Senator Burns.

[The statements follow:]

PREPARED STATEMENT OF SENATOR DIANNE FEINSTEIN

Thank you Mr. Chairman for holding this important hearing today.

I have just returned from California where I met with a number of doctors, hospital administrators, patients and others and I have returned very concerned about the health care system in California. I think it is about to self destruct.

California's health care system is stretched to the limit. We face a number of compelling problems:

- First, we are a big state—33 million people.
- We have the heaviest penetration of managed care in the nation. Over 25 million Californians are in some form of managed care. Managed care has shorter hospital lengths of stay than other types of insurance and managed care plans contract only with certain hospitals. Doctors say that HMO premium rates in California are 40 percent lower than those in other states.
- Medicaid rates paid to hospitals are among the lowest in the country.
- Medicare cuts have exacerbated our hospitals' difficulties. In California's rural hospitals, 40 percent of patients are Medicare and 20 percent are Medicaid.
- We have an uninsured rate of 22 percent, 6.5 million people, while the national rate is 15 percent. That puts a burden of uncompensated care on hospital emergency rooms.
- California has 40 percent of the nation's immigrants. This too adds to hospitals' burdens of uncompensated care because many immigrants are uninsured.
- California's hospitals must comply with seismic safety requirements. This will cost our hospitals \$10 billion by 2008 and \$20 billion by 2030.
- In the last three years, we have had 37 hospitals close and we have had 13 consolidations. The California Health Care Association predicts that up to 15 per-

cent more may close by 2005. They also predict that our public safety-net hospitals will be caught in a major budget squeeze.

—As for rural hospitals, the Association says that 69 percent of the state's rural hospitals lost money in 1998 and that conversions and consolidations among rural hospitals could eliminate up to 15 percent of rural hospitals by 2005.

—Doctors are dispirited and demoralized, as HMOs interfere with medical decision making and focus on cost cutting, at the expense of good health care.

I am very glad we are having this hearing because many of the problems of our rural hospitals are also problems in other areas. In addition, in rural communities, rural hospitals are often the hub of health care services, providing a wide range of services to a broad population.

I believe we, the Congress, must give priority attention to this crisis. I think we should re-examine the cuts of the Balanced Budget Act and their impact on our hospitals.

In my state, the system is headed for meltdown and we must do something.

Today's hearing is a good first start. I look forward to working with my colleagues to make whatever changes are necessary to insure a strong hospital and health care system for our citizens.

CALIFORNIA HOSPITAL CLOSURES FROM 1996–1999

Summary:

Total closures from 1996–1999—37

Total consolidations from 1996–1999—13

1999

Closures

Washington Hospital, Culver City, 2/20/99
 San Bernardino County Medical Center, San Bernardino, 3/29/99
 San Bernardino County Mental Health, San Bernardino, 3/29/99
 Valley Community Hospital, Santa Maria, 3/29/99

No consolidations to date

1998

Closures

Pacifica Hospital Care Center, Huntington Beach, 11/1/98
 North Hollywood Hospital, North Hollywood, 8/31/98
 Capistrano-by-the-Sea Hospital, Dana Point, 6/30/98
 Long Beach Doctors Hospital, Long Beach, 6/25/98
 Pacific Shores Hospital, Oxnard, 5/29/98
 Friendly Hills Regional Medical Center, La Habra, 5/15/98
 South Bay Medical Center, Redondo Beach, 5/31/98
 Del Puerto Hospital, Patterson 4/30/98
 Bloss Memorial District Hospital, Atwater, 3/31/98
 Calexico Hospital, Calexico, 1/15/98

Consolidations

Chico Community Hospital, Chico consolidated with Enloe Medical Center, Cohasset Campus on 6/30/98

Chico Community Rehabilitation Hospital, Chico consolidated with Enloe Rehabilitation Center on 6/30/98

Davies Medical Center, San Francisco consolidated with California Pacific Medical Center, Davies Campus on 7/29/98

1997

Closures

Belmont Hills Hospital, Belmont, 12/30/97
 Newhall Community Hospital, Newhall, 12/29/97
 Woodruff Community Hospital, Long Beach, 11/29/97
 Monterey-Psychiatric Health Facility, Monterey, 5/23/97
 Shriners Hospital, San Francisco, 4/11/97
 Pioneer Hospital, Artesia, 9/4/97
 SHC Speciality Hospital, Westlake Village, 8/1/97
 East Bay Hospital, Richmond, 7/14/97
 Harbor View Medical Center, San Diego, 7/5/97
 Stanislaus Medical Center, Modesto, 11/30/97

Tenet Health Corporation San Diego, San Diego, 12/31/97
Thompson Memorial Medical Center, Burbank, 3/31/97

Consolidations

Memorial Center, Bakersfield consolidated with Bakersfield Memorial on 6/30/97
Encio-Tarzana Medical Center—Tarzana consolidated with Encino Tarzana-Encino on 1/15/97
Specialty Hospital of Southern California—San Gabriel Valley, West Covina consolidated with Specialty Hospital of Southern California on 10/7/97
Siskiyou General Hospital, Yreka consolidated with Fairchild Medical Center, Yreka on 6/30/97

1996

Closures

Westside Hospital, Los Angeles, 12/13/96
Sun Ridge Hospital, Yuba City, 11/5/96
Community Hospital and Sports Medical Center, Perris, 7/10/96
Valley Medical Center of Fresno, Fresno, 10/4/96
Charter Behavioral—Yorba Linda, 4/1/96
Charter Behavioral—Thousand Oaks, 4/1/96
Community Hospital Mental Health Oakcrest, Santa Rosa, 3/26/96
Desert Palms Community Hospital, Palmdale, 3/15/96
Sierra Hospital, Fresno, 2/15/96
Stockton State Hospital, Stockton, 2/2/96
Tustin Medical Center, Tustin closed on 3/30/96 but reopened on 2/23/98 as Vencor-Burbank

Consolidations

Kaiser Foundation Hospital, Martinez, consolidated with Kaiser Foundation Hospital, Walnut Creek on 7/1/96
Sutter Memorial Hospital, Sacramento consolidated with Sutter General Hospital, Sacramento on 4/1/97
Mills Memorial Hospital, San Mateo Consolidated with Peninsula Medical Center on 11/18/96
Specialty Hospital of Southern California, Santa Anna consolidated with Specialty Hospital of Southern California, La Miranda on 11/22/96
Visalia Community Hospital, Visalia consolidated with Kaweah Delta District Hospital on 2/1/96
Bellwood General Hospital, Bellflower consolidated with Orange County Community Hospital, Buena Park on 6/17/96

PREPARED STATEMENT OF SENATOR CONRAD BURNS

Mr. Chairman, thank you for allowing me to speak on behalf of the rural hospitals in Montana today. We are truly in a serious situation with our hospitals in Montana. Many of my constituents have to travel over 100 miles just to visit a hospital or health care center, but that is the least of their problems.

Due to the reduction in Medicare reimbursement as a result of the Balanced Budget Act, we are receiving inadequate payment of the care that our patients require, for both in-patient and ambulatory care services. The Balanced Budget Act was projected to reduce overall Medicare spending by \$116 billion over five years. It appears that these savings could be much greater. The American Hospital Association concluded that the actual savings in hospital spending will be about \$17 billion to \$18 billion more than projected. The underestimates for home health savings have been of a far greater magnitude.

If this shortfall continues, it will result in serious limitations in services available to residents in small agricultural and commercial towns and those who live in the surrounding rural areas. The likely result will be the closure of several hospitals in rural Montana, requiring more patients to travel greater distances to obtain adequate care, including emergency care.

Many of our hospitals in Montana are already scaling back services. Without an increase in Medicare reimbursements patients in Montana are at the crossroads of having to travel upwards of 100–200 miles to receive care for medical conditions as simple as acute appendicitis. Moreover, if rural communities lose their community hospitals, they are likely to experience difficulty in sustaining their commercial base.

As Chairman of the Sub-committee on Telecommunications I have worked very hard on making sure that all people in my state in rural areas have access to hospital care either through tele-medicine or actually visiting a health care facility. For instance, Jordan, MT has not had access to a doctor for many years. Now a Physicians Assistant can live and work in Jordan and have most patients diagnosed by a doctor in Billings. I am very concerned that if something is not done about the Balanced Budget Act that facility in Jordan will not be able to stay open and continue to offer it's services.

Recently, I have heard from senior citizens and nursing home and skilled nursing facility (SNF) operators in my district who are finding it extremely difficult to receive and provide care since the implementation of the SNF prospective payment system (PPS).

Specifically, I have heard concerns in three major areas. First, the new Congressional Budget Office (CBO) estimates show that the cuts to the SNF industry will be \$7.1 billion more that Congress intended. This is having an impact on facilities being able to retain staff and provide services. The excessive cuts could force providers in my district to leave the Medicare program altogether, which will create access problems for seniors needing skilled care services. Congress must work with the Administration to restore funding back into the system.

Second, the new SNF PPS fails to account for medically complex patients needing non-therapy ancillary services, such as prescriptions and respiratory care. We need to take steps to immediately address this flaw in the system. Otherwise, these patients will back up into hospitals, which may not be the most appropriate setting for their care needs, and they will be farther from their communities.

Third, I have concerns regarding the \$1500 cap on outpatient rehabilitation therapy. Already I have heard stories about resident exceeding the cap—and its only July. Congress must take steps to immediately provide relief to those seniors needing therapy. I understand this policy is most harmful to stroke, hip fracture, and Parkinson's disease patients. We must solve this problem.

Mr. Chairman, I urge all members of the Senate to address these problems that pose access and quality risks to patients and seniors in my state. The economic viability of rural Montana depends upon basic health care services being located in the state's smaller commercial centers.

STATEMENT OF SENATOR CHUCK HAGEL, U.S. SENATOR FROM NEBRASKA

Senator COCHRAN. We are happy now to receive the testimony of our good friend and colleague from Nebraska, Senator Chuck Hagel. Senator, you may proceed.

Senator HAGEL. Mr. Chairman, thank you. To my friends and colleagues, Senators Feinstein and Gorton, I appreciate very much an opportunity to address some of the real issues and challenges of our time articulated very clearly by Senators Gorton and Feinstein's comments here in the past few minutes.

I am here to talk a little bit about the impact of the 1997 Balanced Budget Act on our Nation's rural hospitals. Recent studies indicate that when the BBA is fully implemented access to health care services in rural America, including my State of Nebraska, will be severely threatened. We see those threats currently, again as evidenced by some of the remarks made by Senators Gorton and Feinstein.

I spent over the last few weeks, Mr. Chairman, some time in rural Nebraska visiting some of our hospitals. And not only are the rural hospitals and medical centers in America threatened, but teaching hospitals as well. In most cases rural hospitals, community health centers, and rural health clinics are the only source of primary health care services for hundreds of miles. When they are forced to close their doors, the impact on communities that they once served can be, will be, devastating, not only for the health and physical well-being of its citizens, but also for the community's economic growth and prosperity.

As we all know, without ready access to quality primary health care for workers and their families, these communities will have a difficult time attracting new business, manufacturing, or just keeping their young people in their communities.

The Balanced Budget Act was designed to reduce our Nation's deficit and achieve a balanced budget by the year 2002. Senator Gorton alluded to the fact, and I think we all have some sense of pride and accomplishment in what we did in 1997, that in fact it has worked pretty well. But in order to reach this goal Congress was required to restructure several Federal programs, including Medicare. The changes made to the Medicare program were also necessary in order to ensure its financial solvency through the year 2007.

Unfortunately, most of the savings under Medicare were achieved by reducing payments to providers, by implementing new payment systems and methodologies. Although the BBA was supported—was supposed to reduce Medicare by \$103 billion over 5 years, it is now estimated spending will actually be reduced by over \$220 billion over the 5-year period. This is more than Congress anticipated or intended and its impact on our Nation's rural hospitals will be very significant.

According to a study conducted by the Nebraska Association of Hospitals and Health Systems, Nebraska is now expected to lose more than \$375 million in Medicare payments over the next 5 years. This loss is 45 percent greater than the \$259 million reduction anticipated by the Congressional Budget Office in 1997. Now, that for my State of Nebraska is rather severe. It will have immense consequences for the State of Nebraska.

That is an average of \$75.2 million a year that Nebraska's rural hospitals will lose. This is significant because payment changes in the Medicare program affect rural hospitals far more dramatically, as my colleagues all understand, representing the States that you do, than their urban counterparts, due to their size and lower operating margins. Senator Feinstein again mentioned some of the numbers.

On average, for example, Nebraska's rural hospitals rely on Medicare for approximately 60 to 80 percent of their total income. According to the NAHHS study, the CBO failed to either include or accurately gauge the following factors in their calculations in 1997: First, additional administrative and operating expenses arising from the Health Care Financing Administration's new payment methodology and reporting requirements; two, the cost of purchasing, repairing, and maintaining state of the art medical technology, equipment and facilities.

In May of this year, the HCFA released the methodology it intends to use in calculating Medicare hospital outpatient reimbursement rates. Should these rates go into effect in June 2000, hospitals are expected to lose an additional 5.7 percent or \$850 million a year. Small Nebraska rural hospitals in particular stand to lose an additional 9.2 percent or \$6.2 million additional a year in Medicare payments.

According to HCFA, most hospitals will only experience a 4 percent annual decline in reimbursement levels. But for rural and major teaching hospitals, however, Medicare reimbursement levels

are expected to decline by an average of 17 percent. This reduction comes on the heels of other Medicare cuts, which all together will have a devastating, a devastating impact on rural hospitals in all our States.

The fiscal year 2000 budget resolution contains a sense of the Senate directing Congress to review Medicare reimbursement levels to ensure that seniors have access to skilled nursing, home health, and inpatient and outpatient health services in rural areas. Health care experts both nationally and in the State of Nebraska have confirmed reports that payment levels are indeed beginning to impair access to quality health services.

In fact, the BBA's Medicare reimbursement provisions have already claimed a number of casualties in Nebraska. To date, the Medicare payment reductions under the provision of the BBA 1997 have played a role in the closure of two rural Nebraska hospitals and have driven seven other rural facilities to seek conversion to critical access hospital status. Another 15 rural facilities in Nebraska are now applying to convert to critical access hospital status before the end of the year, which would seriously limit the scope of community health services that they now presently provide.

Hospitals and health plans exist to provide high quality, affordable health care to the communities they serve. But to do so, as we all understand, costs money. Our neighbors, our friends, our family members who are employed by these rural hospitals must be paid. This drastic reduction in Medicare reimbursement rates simply cannot be absorbed by our Nation's rural hospitals in such a short period of time.

In the short term, the BBA must be amended in order to restore Medicare payments to the level Congress intended in 1997. Looking ahead, we need to implement real structural reforms that will increase competition and encourage more providers and health plans to participate and practice in rural areas. This can be accomplished by some of the following:

First, increasing Medicare reimbursement rates for rural hospitals and health clinics by making it easier for them to qualify for special designation.

Second, changing the Medicare managed care reimbursement formula to ensure higher rates for rural and low-paid areas. This will attract more plans, as well as ensure that established plans to continue to remain viable in these rural areas.

Third, require that more representatives from rural America are represented on the Medicare Payment Advisory Committee.

Fourth, encourage physicians and other health providers to practice in rural areas by providing higher Medicare reimbursement rates.

Fifth, expand the rate of services provided under Medicare by telemedicine, in which providers can treat patients from distant locations.

Finally, as a function of size, Mr. Chairman, and dependency on Medicare revenues, changes in Medicare reimbursement can have a disproportionately negative impact, as we all understand, especially on rural hospitals. We must preserve, protect, and ensure the financial solvency of our Nation's rural hospitals by making the entire Medicare program more efficient, while at the same time pro-

viding adequate reimbursement to assure access to care, not only for our Medicare population but all citizens.

PREPARED STATEMENT

Mr. Chairman and my colleagues, I look forward to continuing to work with you, the President, and our other Senate and House colleagues on developing meaningful reforms that will allow rural hospitals to continue to provide their communities with important and accessible affordable quality health care.

Thank you very much, Mr. Chairman.
[The statement follows:]

PREPARED STATEMENT OF SENATOR CHUCK HAGEL

Chairman Cochran, Senator Kohl, distinguished committee members, thank you for inviting me here today to discuss the impact of the 1997 Balanced Budget Act (BBA) on our nation's rural hospitals. To date, only 30 percent of the BBA has been implemented. Nevertheless, recent studies indicate that if the BBA is fully implemented in its current form, access to health care services in rural America, including my state of Nebraska, will be severely threatened.

In most cases, rural hospitals, community health centers, and rural health clinics are the only source of primary health care services for hundreds of miles. When they are forced to close their doors, the impact on the community they once served can be devastating—not only on the health and physical well-being of its citizens—but also for the community's economic growth and prosperity. Without ready access to quality primary health care for workers and their families, these communities will have a difficult time attracting any new businesses or manufacturing, or keeping their young people in the community. In that regard, I commend the committee for its continued leadership in holding this hearing and ensuring access to quality health care services for all rural Americans.

The Balanced Budget Act was designed to reduce our nation's deficit and achieve a balanced budget by 2002. In order to reach this goal, Congress was required to restructure several federal programs, including Medicare. The changes made to the Medicare program were also necessary in order to ensure its financial solvency through 2007. Unfortunately, most of the savings under Medicare were achieved by reducing payments to providers by implementing new payment systems and methodologies.

Although the BBA was supposed to reduce Medicare spending by \$103 billion over five years, it is now estimated spending will actually be reduced by over \$220 billion. This is more than Congress anticipated or intended, and its impact on our nation's rural hospitals will be significant.

According to a study conducted by the Nebraska Association of Hospitals and Health Systems, Nebraska is now expected to lose more than \$375 million in Medicare payments over five years.¹ This loss is 45 percent greater than the \$259 million reduction anticipated by the Congressional Budget Office (CBO) in 1997. That is an average of \$75.2 million a year. This is significant, because payment changes in the Medicare program affect rural hospitals far more dramatically than their urban counterparts, due to their size and lower operating margins. On average, Nebraska's rural hospitals rely on Medicare for approximately 60 percent to 80 percent of their income.

According to the NAHHS study, the CBO failed to either include or accurately gauge the following factors in their calculation:

- Additional administrative and operating expenses arising from the Health Care Financing Administration's new payment methodology and reporting requirements and;
- The cost of purchasing, repairing, and maintaining state-of-the-art medical technology, equipment, and facilities.

In May, the HCFA released the methodology it intends to use in calculating Medicare hospital outpatient reimbursement rates. Should these rates go into effect in June of 2000, hospitals are expected to lose an additional 5.7 percent, or \$850 mil-

¹ Source: *Nebraska Association of Hospitals and Health Systems, April 1999*. The impact was determined using a health industry forecasting model. The calculations compare the payment trends that would be expected under prior law with those estimated under the 1997 BBA.

lion a year. Small Nebraska hospitals, in particular, stand to lose an additional 9.2 percent, or \$6.2 million a year in Medicare payments.²

According to HCFA, most hospitals will only experience a 4 percent annual decline in reimbursement levels. For rural and major teaching hospitals, however, Medicare reimbursement levels are expected to decline by an average of 17 percent. This reduction comes on the heels of other Medicare cuts, which together will have a devastating impact on rural hospitals.

The fiscal year 2000 Budget Resolution contains a Sense of the Senate amendment directing Congress to review Medicare reimbursement levels to ensure that seniors have access to skilled nursing, home health, and inpatient and outpatient hospital services in rural areas. Health care experts, both nationally and in the state of Nebraska, have confirmed reports that payment levels are indeed beginning to impair access to services.

In fact, the BBA's Medicare reimbursement provisions have already claimed a number of casualties in Nebraska. To date, the Medicare payment reductions under the provisions of the BBA have played a role in the closure of two small, rural Nebraska hospitals and have driven seven other rural facilities to seek conversion to "critical access" hospital status. Another fifteen rural facilities are applying to convert to "critical access" hospital status before the end of the year, which would seriously limit the scope of community health services that they presently provide.

Hospitals and health plans exist to provide high quality, affordable health care to the communities they serve, but to do so costs money. Our neighbors, friends and family members, who are employed by these rural hospitals must be paid. This drastic reduction in Medicare reimbursement rates simply cannot be absorbed by our nation's rural hospitals in such a short period of time.

In the short-term, the BBA must be amended in order to restore Medicare payments to the level Congress intended. Looking ahead, we need to implement real structural reforms that will increase competition and encourage more providers and health plans to practice in rural areas. This can be accomplished by:

- Increasing Medicare reimbursement rates for rural hospitals and health clinics by making it easier for them to qualify for special designations.
- Changing the Medicare managed care reimbursement formula to ensure higher rates for rural and other low-paid areas. This will attract more plans, as well as ensure that established plans continue to remain viable.
- Requiring that more representatives from rural America are represented on the Medicare Payment Advisory Commission (MedPAC).
- Encouraging physicians and other health providers to practice in rural areas by providing higher Medicare reimbursement rates.
- Expanding the range of services provided under Medicare by "telemedicine," in which providers can treat patients from distant locations.

As a function of size and dependency on Medicare revenues, changes in Medicare reimbursement can have a disproportionately negative impact on rural hospitals. We must preserve, protect, and ensure the financial solvency of our nation's rural hospitals by making the entire Medicare program more efficient, while at the same time providing adequate reimbursement to assure access to care, not only for our Medicare population, but all citizens of rural America. I look forward to working with the President and our Senate and House colleagues on developing meaningful reforms that will allow rural hospitals to continue to provide their communities with important and accessible, affordable, quality care.

Senator COCHRAN. Senator Hagel, thank you very much for your helpful testimony and the information you gave us as a result of your own personal observations and review of the situation in your State, and the suggestions for specific changes in the law and administration practices that will help improve the situation that rural hospitals are facing. We thank you very, very much.

Senator Gorton, do you have any questions or comments?

Senator GORTON. No. I echo your comments.

Senator COCHRAN. Senator Feinstein.

Senator FEINSTEIN. No question. I was just thinking, you adequately and correctly stated the situation. Hopefully, we will be able to come together across both political parties and remedy it, because I think it is going to alter the delivery system in health

²Source: HCFA Impact File For Proposed Rule On Hospital Outpatients PPS, May 1999.

care in a major way if we cannot keep these hospitals open and running.

Senator COCHRAN. Thank you very much, Senator.

Our next witnesses include—and I will call their names and ask you to please come to the witness table—Dr. Gail Wilensky, who chairs the Medicare Payment Advisory Commission; Dr. Claude Earl Fox, who is Administrator of the Health Resources and Services Administration; and Dr. Robert Berenson, who is Director of the Center for Health Plans and Providers of the Health Care Financing Administration.

We appreciate very much your being available to our committee this morning. We thank you for the written statements which you have submitted to the committee. I have had the opportunity of reading your statements and I congratulate you on the quality of the effort you have put into preparing for the hearing and helping us understand the problem and what some of the options are for dealing with these serious problems.

I am going to ask Dr. Wilensky to open the testimony and to be assured we will include your entire statement in the record as you have submitted it and encourage you to make any summary comments that you think would be helpful to us. Dr. Wilensky.

STATEMENT OF GAIL R. WILENSKY, PH.D., CHAIR, MEDICARE PAYMENT ADVISORY COMMISSION

Dr. WILENSKY. Thank you very much. Mr. Chairman and members of the subcommittee, I am pleased to be here today to speak on behalf of the Medicare Payment Advisory Committee which I chair. As I think you know, I was also the Administrator of the Health Care Financing Administration in the early part of the 1990's.

I would like to use my few minutes to summarize what I think are the most important issues regarding the debate that has started on the fate of rural hospitals and to raise some particular areas that I think are appropriate for your consideration as the Congress considers whether, how, and how much to amend the Balanced Budget Act.

First let me start and summarize what I see as the basic problems that rural hospitals are facing. In general, these are smaller hospitals. They are more Medicare-dependent hospitals, because many of the younger individuals have either moved out entirely or for purposes of their health care go elsewhere. Also, they are more dependent on the outpatient department, and I want to come back to that in particular with regard to some potential remedies.

When the Balanced Budget Act was passed, it looked like rural hospitals in general were doing all right financially. Some, in fact more than is true for hospitals in general, had problems even at the start of the Balanced Budget Act. But in general, it looked like the financial status of rural hospitals was all right, particularly with regard to their total overall margins, that is the difference between their revenues and expenditures.

One of the great problems, one of the great frustrations that we all have felt, is that we do not have good adequate systematic data that tells us what has happened since the introduction of the Balanced Budget Act. I know that you have heard reports. I think it

is helpful for members to go around and to visit in their districts. But those of us who are responsible for making recommendations to the Congress are frustrated by not having good representative information. We are trying to work with some of the trade associations and others involved to see whether there might be a way to have some quicker response so that we can be more helpful in our recommendations.

It does appear that one of the effects that has happened is that, because the Balanced Budget Act affected so many provisions of health care under Medicare, that the combined effect is greater than perhaps was anticipated. In addition, as you have already heard from Senator Hagel, the reduction in spending has also been greater than anticipated, perhaps because of the simultaneous very aggressive actions on the part of the Inspector General in the Department of Justice regarding fraud and abuse and some responses from providers as a result of these activities. But for whatever reasons, as you know, the reduction in spending has been greater than anticipated.

In looking at what is happening for rural hospitals, as a Medicare person I urge you to think about those issues that are properly Medicare's responsibilities, which means if your seniors cannot get access to health care that is a proper Medicare responsibility, and those that may be more in the realm of economic development, which as an economist is something I believe is perfectly appropriate for the Congress to worry about, but I urge you not to necessarily put it on the back of Medicare, a program that is already very fragile.

However, I do think there are areas that you may want to reconsider to the extent that you open up some provisions of the Balanced Budget Act for reconsideration, and let me just mention a few of these.

The first and one that would be very helpful for rural hospitals has to do with the outpatient prospective payment system. As you have already heard, the reduction in spending appears as though it will be about 2 full percentage points greater, 5.7 percent rather than the 3.8 percent that was initially believed to be in the House and Senate bills. In addition, it is scheduled to go in at once in the year 2000. In general, both MedPAC and its predecessor commissions have recommended phased-in introductions of changes so that the Congress can look back and make some adjustments if appropriate and the providers can gradually phase into a new world. So both the amount of the reduction and the fact that it is not being phased in is something that you may want to reconsider.

In addition, both this year and last year MedPAC has recommended that the way we define "disproportionate share" for purposes of Medicare be revised so that the rural hospitals are playing on a level playing field with the urban hospitals. The existing law requires a higher threshold to be reached for rural hospitals, as well as too narrow a definition of what gets counted in terms of the care that is being provided. Both of these changes we think are important and would help the rural hospitals. It is not technically a part of the Balanced Budget Act, however.

Another area, however, that is a part of the Balanced Budget Act has to do with changes in the skilled nursing facility reimburse-

ment. We are concerned, and I know that HCFA is also concerned, that the resources going for the sickest patients, the so-called high-acute patients, may not be great enough to reflect the additional costs that they are bearing, and that is another area, if you are going to put some additional resources back into the system, that we urge you to give serious consideration to.

In addition, you may want to consider whether or not it is appropriate to have ambulance charges included in the prospective payment as long as there is not the same ownership between the skilled nursing facilities and the ambulance company. What I have heard from a number of members of Congress is that that charge can overwhelm the daily reimbursement rate for several days and that if there is not common ownership it is not clear why it ought to be a part of the daily payment, the prospective payment. So if you are going to make changes, that is yet another area that you may want to look at.

Finally, I am going to emphasize the importance of the critical access hospital provisions. When I was at HCFA there was a move to go beyond what had started in Montana as the MAP program to make something that was called the Essential Access and Primary Care Access Programs, and that has now evolved into the critical access hospital designation.

I think it is an important way for hospitals that may not be able to provide all services on a large bed scale to remain very important care facilities on a smaller basis, having important relationships with either rural referral centers or other hospitals that could provide the secondary, tertiary, and quaternary facilities that they may no longer be able to provide.

It is an important aspect. It is one that I urge you to consider in those areas where hospitals may not be able to provide as they have been in the past, but still have both important development and, more importantly, important health care provisions that they can make to the community.

I would be glad to answer any questions that you may have as well. Thank you.

[The statement follows:]

PREPARED STATEMENT OF GAIL R. WILENSKY

Chairman Cochran, Senator Harkin, members of the Subcommittee, I am Gail Wilensky, Chair of the Medicare Payment Advisory Commission (MedPAC). I am pleased to participate in this hearing to examine the problems facing rural hospitals and their impact on rural economic development. My testimony today focuses on what we know about the financial health of rural hospitals, the effects of Medicare's payment policies and other factors on their financial viability, and Medicare's role in ensuring that rural beneficiaries will continue to have access to appropriate care.

As you know, Mr. Chairman, rural hospitals often play a central role in sustaining both the physical and economic health of their local communities. Consequently, perceived threats to their financial vitality raise concerns from several perspectives.

One concern relates to the effects that hospital failures or financial weakness may have on residents' access to care. Aside from their traditional role of providing timely access to emergency care and acute inpatient care, many rural hospitals also have taken responsibility for meeting their communities' needs for primary care and post-acute care services. Most rural hospitals operate outpatient care facilities, including outpatient departments and hospital-owned rural health clinics, and many operate skilled nursing facilities (either a distinct unit or swing-beds), home health agencies, or both. In addition, rural hospitals generally play an essential role in attracting primary care physicians to practice in their communities, and in organizing the pro-

vision of specialty services for patients. Thus, hospital failures could force local residents, including Medicare beneficiaries, to forgo many services or travel further to get them.

Another concern is that declines in rural hospitals' financial health may seriously damage the local economy and its prospects for future development. In many rural communities, a hospital is the single largest employer, directly responsible for a substantial share of residents' earnings and indirectly responsible for an important part of the local tax base. Moreover, the presence of a hospital offering a broad array of services is generally considered critical to attracting new businesses to rural communities. As a result, hospital closures also could adversely affect the economic viability of their communities.

WHAT WE KNOW ABOUT RURAL HOSPITALS' FINANCIAL CONDITION

Much of the recent concern about the financial problems of rural hospitals has been focused on the anticipated effects of Medicare policy changes enacted in the Balanced Budget Act of 1997 (BBA). However, the most recent available data on hospitals' financial condition are from their Medicare cost reports for accounting periods beginning during fiscal year 1997, the last year before the BBA's policies began to have much effect on hospitals' revenues.

These data show that, on average, rural hospitals' inpatient margins under Medicare's inpatient prospective payment system (PPS)—the difference between their Medicare PPS revenues and their corresponding allowable costs as a percentage of their PPS revenues—were at or near historically high levels. The overall average inpatient margin stood at 9.5 percent for rural hospitals, while that for urban hospitals was 17.0 percent. Further, rural hospitals' average total margins—reflecting all revenues and expenses for inpatient care, outpatient care and all other hospital activities, as reported on the Medicare cost reports—also were at an historic high of 6.8 percent, and above that for urban hospitals (6.2 percent).

Rural hospitals' inpatient PPS and total margins generally have been rising (as have those for urban hospitals) since 1991, primarily because they have successfully restrained the growth of their costs. But improvements in financial condition have not occurred uniformly for all rural hospitals. The overall proportion of rural hospitals with negative total margins increased between 1995 and 1997. And many small rural hospitals (those having fewer than 50 beds) appear to be in especially poor financial condition; 35 percent of these hospitals had negative total margins in 1997, up from 29.5 percent in 1995.

Data from the American Hospital Association's (AHA) Annual Survey of Hospitals can be used to examine how well the payments hospitals receive from various payers cover the costs of furnishing care to their patients. The payment to cost ratios for payer groups, such as Medicare, Medicaid, and private payers, relate the payer's payments and costs for all patient care services, generally including inpatient, outpatient, skilled nursing, and home health care. Each payer's costs, however, include all expenses attributed to the payer's patients rather than only Medicare allowable costs. As a result, the Medicare payment to cost ratios from the AHA data are generally lower than similar figures computed from Medicare cost report data.

AHA Medicare payment to cost ratios for 1997 show that urban hospitals' overall Medicare payments exceeded their costs (a ratio of 102.2 percent), but rural hospitals' overall Medicare payments fell below their costs (a ratio of 96.1 percent). In addition, rural hospitals are more dependent on Medicare than are urban hospitals; services furnished to Medicare patients accounted for 47 percent of rural hospitals' total patient care expenses, but only 39 percent of patient care expenses in urban hospitals.

Rural hospitals' Medicare payment to cost ratios generally have been rising since the early 1990s. The most recent data, however, suggest that rural facilities may be facing increased financial pressure from private payers. In the past, hospitals generally have been able to offset payment shortfalls from Medicare, Medicaid, and uncompensated care with extra revenues from private payers. Urban hospitals' payment to cost ratios for private payers have been declining during the 1990s, as private insurers and employers have resisted hospital rate increases. By contrast, rural hospitals' private payer payment to cost ratios generally exhibited little change from their levels in the early 1990s. Preliminary data for 1997, however, suggest that the national average private payer payment to cost ratio for rural hospitals dropped sharply to 134 percent from 139 percent in 1996. It is not clear whether this decline is the beginning of a trend.

POTENTIAL IMPACT OF POLICIES IN THE BBA

Medicare policies enacted in the BBA created the Medicare+Choice program and required the Secretary of Health and Human Services to make major changes in the way many providers are paid under the traditional fee-for-service program. In enacting these policies, the Congress was pursuing several objectives: trying to make a wider array of private health plans available to beneficiaries; improving payment policies for many services furnished under the traditional program; and slowing the growth of program spending.

To restrain spending, the Congress reduced the annual updates applied to the per case payment rates under the hospital inpatient prospective payment system and those applied to the target amounts that limit reimbursements to facilities exempt from the PPS. Further, the Secretary was charged with implementing new prospective payment systems for skilled nursing facility services, hospital outpatient services, home health care, and rehabilitation services. Adopting these new payment systems was intended, at least in part, to stem the extraordinary growth in the volume of, and payments for, these services that has occurred during this decade.

The payment reductions anticipated from any one of these policies probably would have generated relatively little concern. In combination, however, these policy changes may result in a substantial decline in hospitals' Medicare revenues, especially for facilities that provide many of the affected services.

The Health Care Financing Administration (HCFA) began applying reduced updates for PPS hospitals and exempt facilities in fiscal year 1998. It also implemented a PPS for services furnished in skilled nursing facilities in July 1998.

Regarding the skilled nursing facility PPS, MedPAC has raised concerns about the extent to which this system pays adequately for patients who require costly ancillary services. In addition, including costs for ambulance services furnished by an unrelated entity in skilled nursing facilities' per diem payment rates may create inappropriate financial burdens for some providers, especially those located in rural areas where travel distances are greater than average.

In October 1998, HCFA implemented a BBA-mandated interim payment system (IPS), which set temporary limits on home health agencies' costs per visit and on their average costs per beneficiary. HCFA projected that these cost limits would reduce payments to hospital-based home health agencies in rural areas. The expected proportion of these facilities that would be affected and the extent of their payment reductions, however, were substantially smaller than those projected for other groups of urban and rural agencies. A prospective payment system for home health services is scheduled to replace the IPS in October of next year.

HCFA also issued a proposed rule on a new prospective payment system for hospital outpatient services in September 1998, but has delayed implementing this system until the spring of 2000 to avoid year 2000 computer problems. MedPAC has raised concerns about some of the payment system's features and about its disproportionately large projected effects on payments to teaching hospitals and small or low-volume rural facilities.

Two issues seem particularly important to consider before the payment system is implemented. One is whether to phase in the new system. A phase-in period would slow the new system's payment effects, thereby delaying any financial damage it might do.

In addition, a phase-in would permit the Congress to monitor the actual effects on hospitals and identify any problems that need resolution before the new payment system is fully implemented.

A second issue relates to the size of the overall projected reduction in hospitals' Medicare payments for outpatient services. The current estimate of a 5.8 percent drop in hospitals' Medicare outpatient revenues is substantially higher than earlier projections. Moreover, the estimated decline in revenues would expand the already large discrepancy between hospitals' Medicare revenues and costs for outpatient services furnished to program beneficiaries. Consequently, if the Congress is considering ways to reduce the financial impact of the BBA's hospital payment policies, it may be appropriate to focus some of that effort on payments for outpatient care.

Some of the BBA policy changes already have reduced payments to hospitals compared with the amounts Medicare would have paid under prior law, and scheduled reductions for future years will continue to slow payment growth through 2002. Other policy changes that are not yet implemented, such as the outpatient PPS, are expected to reduce many hospitals' Medicare revenues further.

Small rural hospitals and those that furnish a low volume of outpatient care may be particularly vulnerable to the financial impact of the BBA. As noted earlier, such hospitals were more likely to be in poor financial condition before the BBA policies were implemented. In addition, HCFA's analysis of the impact of the outpatient pro-

spective payment system suggested that small and low-volume hospitals would be likely to experience substantially greater payment declines than most other hospital groups. Rural hospitals' actual financial outcomes, however, will depend strongly on the extent to which they are able to continue restraining their cost growth during the next few years.

OTHER FACTORS AFFECTING RURAL HOSPITALS' FINANCIAL VIABILITY

Many rural hospitals have long been facing difficult economic conditions in their local communities. Some areas have experienced both an absolute decline in their resident population and an increase in the proportion of elderly and disabled persons because younger residents have migrated elsewhere to find employment. Hospitals located in these areas are likely to be unusually dependent on Medicare revenues and receive relatively little support from private payers.

Other rural communities have a stable population but high unemployment and poverty rates. Hospitals serving these areas are likely to have a large share of poor patients and a relatively large uncompensated care burden. Medicare makes extra payments to hospitals that serve a disproportionate share (DSH) of poor patients, but the formulas used to determine DSH payments differ between large urban hospitals and smaller ones located in urban and rural areas. For the last two years, MedPAC has recommended that the Congress change the method used to measure the extent of hospitals' service to the poor and apply a single DSH payment formula for all hospitals.

These changes would put rural hospitals on an equal footing with urban ones, regardless of hospital size.

Many remote rural areas, especially in western states, are only thinly populated. Hospitals located in such areas are unlikely to be able to operate at an efficient level of service volume. Consequently, their unit costs for many services may be well above average.

Local conditions also differ among rural areas due to variations in the policies of state governments and private payers. Among states, for example, hospitals' average Medicaid payment to cost ratios in 1997 ranged from a low of 71 percent to a high of 142 percent. Similarly, hospitals' statewide average private payer payment to cost ratios varied from 98 percent to 161 percent.

At a broader level, many if not most rural hospitals have been struggling against two closely related long-term trends. One is the rapid pace of technological change in health care delivery. Rural hospitals often lack the financial resources and the skilled practitioners needed to adopt and efficiently use innovations as they become available. As a result, some health care innovations are not adopted by many rural facilities and others may be adopted much later than in urban hospitals. Partly related to the slower rate of technological innovation in rural hospitals is the willingness of rural residents to bypass rural facilities to obtain more sophisticated services in urban hospitals.

Consequently, many rural hospitals are unable to achieve high enough volume levels to benefit from potential economies of scale, leaving them with relatively high unit costs for some services.

MEDICARE'S ROLE IN ENSURING ACCESS TO CARE FOR RURAL BENEFICIARIES

The Congress has enacted a variety of special provisions under Medicare that were intended to ensure that beneficiaries living in rural areas continue to have access to appropriate care. Many, but not all of these policies are directed at helping rural hospitals, especially small ones, cope with the wide variety of circumstances they face in their local markets. Specific policies apply for:

- sole community hospitals—geographically isolated facilities that are the only readily available source of inpatient care in an area.
- small rural Medicare-dependent hospitals—rural hospitals with fewer than 100 beds and whose Medicare share of days or discharges exceeds 60 percent for the cost reporting period that began during fiscal year 1987, and
- rural referral centers—generally larger rural hospitals that meet criteria regarding number of beds, annual discharge volume, case mix complexity, or proportion of care furnished to patients referred from outside the local area.

The special payment provisions under Medicare's hospital inpatient PPS for sole community hospitals and small rural Medicare-dependent hospitals, raise Medicare's inpatient payment rates for rural facilities facing particular circumstances. Rural referral centers face less stringent criteria under Medicare's geographic reclassification policies.

Referral centers that qualify for reclassification as urban hospitals may receive higher inpatient PPS payments and higher DSH payments.

Other policies exempt rural hospitals temporarily or permanently from requirements or payment policies that apply to most other hospitals. For example, rural hospitals that provide skilled nursing services to beneficiaries under the swing bed program are exempt from the new skilled nursing facility PPS during a three year transition period.

The Congress also has enacted policies intended to help attract physicians and other health professionals to practice in rural areas. One example is the policy enabling communities or rural hospitals located in a Health Professional Shortage Area (HPSA) to establish rural health clinics. Another is the policy of granting bonus payments that raise Medicare payments under the physician fee schedule by 10 percent for physicians practicing in designated HPSAs.

In addition, the Congress has attempted to recognize that the financial distress facing many small rural hospitals primarily reflects the limitations of the local economy. To maintain access to care in rural areas served by small or low-volume hospitals, such facilities are permitted to apply for designation as a critical access hospital (CAH). A CAH must be located more than 35 miles from any other hospital, operate 15 or fewer acute care beds, limit acute care inpatient stays to 96 hours, have formal transfer arrangements with one or more other hospitals, and provide 24-hour emergency care services.

Hospitals that receive CAH designation are exempt from Medicare's inpatient and outpatient prospective payment systems and are reimbursed based on their allowable incurred costs.

The potential benefit of this program is that it may permit many small rural hospitals to continue providing local access to care for community residents while strengthening their financial viability by adjusting their capacity consistent with their communities' resources.

CONCLUSIONS

Although rural hospitals in the aggregate appeared to be experiencing historically high levels of financial performance prior to the enactment of the BBA, the potential combined impact of its provisions has raised much concern about future financial stress. It is too soon to evaluate the extent to which these concerns will be realized. Nevertheless, many small rural hospitals may be especially vulnerable to the payment reductions anticipated from the BBA's policies. Once it is implemented, the outpatient prospective payment system could substantially lower Medicare payments to small rural and low-volume hospitals.

It will be important for the Congress to monitor closely the effects of these policy changes on small rural hospitals because of their importance for access to care. In the longer-term, policies, such as the CAH program, may provide the best means of preserving access by helping rural hospitals to restructure their operations consistent with local economic conditions.

Senator COCHRAN. Thank you, Dr. Wilensky. I think before asking questions of you we will hear from the other two members of this panel. If you will be able to remain, it would be appreciated.

Dr. Fox, you may proceed.

STATEMENT OF CLAUDE EARL FOX, M.D., MPH, ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. FOX. Thank you, Senator Cochran. I would like to thank you and the panel, Senator Feinstein, for both having this hearing and inviting us here.

The agency that I administer is the access agency for the Health and Human Services Department and we house the Office of Rural Health Policy, which is not just the policy office on rural health for us, for the agency, but for the Department. So from an agency standpoint I have an interest.

From a personal standpoint, this issue is also very near and dear to my heart. I was born in a rural hospital, grew up in a rural community. My dad is 84 years old and still gets his care from a rural hospital in Mississippi. So this has a personal note for me as well.

As has already been said, the rural hospitals are often the primary source of health care in the community. We think that they are a critical issue and a critical factor in attracting physicians. We have the National Health Service Corps. We also do health profession shortage area designations, and we think that it is more difficult to recruit physicians when you do not have a hospital in a community.

They are also, if not the largest, usually one of the largest employers in the community. The data show that rural hospitals are responsible for probably some 10 to 15 percent of jobs in rural communities, as a spinoff are responsible for another 5 to 10 percent of other jobs within the community as well.

We also know that, with the aging of the population, ideally rural communities should be a great place for our elderly to live. The cost of living is cheap. It is often much safer than other places. And yet if there is no rural hospital, are we going to be able to attract rural residents to rural communities and keep the ones there that we need? If you were elderly would you want to live in a community with no hospital? If you were in a nursing home or had a family member in a nursing home, would you want to have one in a nursing home in a community that had no hospital? I think you would not.

We also know that hospitals operate on thin operating margins. We have already talked about that. But I would point out that when we talk about rural hospitals we need to draw a distinction. The very small rural hospitals, certainly the ones with under 100 beds, and particularly the ones with under 50 beds, are in particular jeopardy. We know that their numbers are even worse than are stated for all rural hospitals.

We know that a lot of hospitals closed their doors in the late eighties because of changes then. I actually chaired the Alabama Legislative Task Force on Rural Health, and we made a number of recommendations then. We told the hospitals to diversify, go out and do good, get into home health, get into extended care, get into other services, and they did. In fact, we know that now 100 percent of all rural hospitals provide some outpatient services, 60 percent provide home health, 72 percent either have home health or skilled nursing facilities, and 20 percent have all of the above.

So they have diversified. But the low-patient volumes and the fact that the BBA changes now are coming together in all of these areas, I think make them very vulnerable. We know that not only do all these changes come together in an economic way that really hits rural hospitals hard, but also the fact that the percent of Medicare and Medicaid in rural hospitals is often very great.

I looked in Mississippi at a list of 28 rural hospitals that are among the smallest. In most of those hospitals, the combined Medicare and Medicaid admissions are over 70 percent. In my home hospital, Tallahassee General, the combined Medicare and Medicaid admissions are over 75 percent. So there is often very little, if any, private pay for hospitals to shift to. So we have a vulnerability for several reasons.

My agency, HRSA, is the agency that is going to be administering the critical access hospital program. This year, thanks to Congress, we were able to put out \$25 million, some \$800,000 for

each State, that will go through offices of rural health to try to help States look at what they can do to convert hospitals to critical access hospital programs. I think the jury is still out about how many hospitals are going to take advantage of that and what kind of issues we are going to have come up. But we will be, obviously, intimately involved in that.

We are also working with HCFA. We have a team—in fact, it met recently with Nancy Min DeParle—and have for some time and are increasing our interface to work with them on the regulation development in any financing mechanisms that affect rural health. This is a joint agency activity.

Also, finally, we fund a series of things that we think help strengthen rural communities. In addition to our community health centers, migrant health centers, and the National Health Service Corps, we fund rural health outreach grants, rural network development grants, and also we fund rural telehealth. I think one of the testifiers here today from a Mississippi is a recipient of one of our telemedicine grants.

The Department, as you know, is involved in supporting rural hospitals and rural health systems in additional ways.

Let me say finally that I think we do have a problem. I would suggest that we check the blood pressure before the patient goes into shock and not wait and count the death certificates. One of the things that we have to do here is make sure we monitor the situation very carefully. We have a number of grants out now that are going to give us some feedback, the earliest one coming in July, the end of July, that hopefully will tell us what is happening out there, and we look forward to providing that information to you and other members of Congress.

Thank you for having me here today.
[The statement follows:]

PREPARED STATEMENT OF CLAUDE EARL FOX

Senator Cochran, Senator Kohl, members of the Subcommittee—thank you for inviting me to testify today about the current plight of rural hospitals and the impact this might have on our rural economies. This is a topic that is close to my heart. I was born in a rural hospital, grew up in a small rural town and have worked in and with rural communities most of my life. During my time as the State Health Officer in Alabama, I chaired the Alabama Task Force on Rural Hospitals and was part of an important effort there to help champion the critical role these facilities play in their communities.

Rural hospitals are the anchors in our small towns and communities. First, these facilities are the primary source of health care in the community and can help attract the physicians and other health care providers that are often so difficult to find in rural areas. These facilities are often surviving on very thin operating margins and have had to diversify their services to survive. We know that:

- 100 percent of rural hospitals provide outpatient services
- 59 percent of rural hospitals operate home health agencies
- 72 percent of rural hospitals have either a home health agency or a skilled nursing facility or both
- 21 percent of rural hospitals operate an outpatient center, a skilled nursing facility and a home health agency.

This diversification has helped rural hospitals to continue providing needed care to their communities. Unfortunately, given their low volume of patient visits and stays, these facilities are very dependent on each of these services to make ends meet.

But rural hospitals play a much larger role in their local communities than simply providing health care services. They are often among the largest local employers and a bellwether of the economic health of a small town. Research shows that the

health sector provides 10 to 15 percent of the jobs in many rural counties, and that if the secondary benefits of those jobs are included, the health care sector accounts for 15 to 20 percent of all jobs. On an individual employer basis, hospitals are often second only to school systems as the largest employer in rural counties. Studies on industrial and business location also conclude that schools and health services are the most important quality-of-life variables in these decisions. A strong rural hospital can be a solid foundation for a strong small town with a diversified local economy and can serve as a magnet for other economic development. Conversely, a struggling rural hospital or the closure of a small rural hospital can often have the opposite impact on a small town through lost jobs and disincentives for businesses to locate and grow.

When you look at all of these factors together, it's clear to see the importance of maintaining the economic health of our nation's rural hospitals. This is a growing concern in light of the many changes brought about by the Balanced Budget Act of 1997. Consider the following numbers:

- A greater percentage of rural residents are Medicare beneficiaries, compared to urban residents (18 percent vs 15 percent);
- Medicare payments account for 39 percent of rural hospital inpatient revenue and it can reach as high as 80 percent of inpatient revenues for small rural hospitals;
- 50 percent of all patient days in rural hospitals are from Medicare beneficiaries, compared to 37 percent in urban hospitals; and finally,
- Total Medicare payment per beneficiary is nearly \$1,000 less for rural beneficiaries than for urban beneficiaries.

As you can see, changes in Medicare payments from the Balanced Budget Act could have a significant impact on the health care infrastructure of rural towns all across America. My colleague from the Health Care Financing Administration (HCFA) will describe some of these reforms in more detail, but I can assure you, however, that the Department is closely monitoring the impact of these changes. Further, there are a wide range of Federal programs that directly address the unique health care needs of rural hospitals and rural communities. For example:

Starting this year, the Health Resources and Services Administration (HRSA)—through the Office of Rural Health Policy—will administer the new \$25 million Rural Hospital Flexibility program. These grants, which will be given to the individual state offices of rural health, will provide states with up to \$800,000 to support network development and stabilize their small rural hospitals by helping them consider, plan for, and obtain designation as a "Critical Access Hospital." These CAHs can strengthen their outpatient, primary care and emergency services while maintaining a limited inpatient capacity. To help them financially, the Federal government will pay on a cost basis for care delivered to Medicare patients. It is our hope that these new CAHs can become the hub of a revitalized rural health system.

The Office of Rural Health Policy is located in HRSA but has a Department-wide responsibility for advising the Secretary on the impact of Department's policies and regulations on rural communities. This office is working with HCFA and the rest of the Department to seek solutions to health care problems in rural communities by working with other Federal agencies, the states, national associations, foundations and the private sector. They are part of key regulation teams that are implementing the many provisions of the Balanced Budget Act of 1997 and their research centers provide valuable policy relevant rural research. In short, they are rural health advocates inside the beltway. The office also funds several grant programs that can help rural hospitals and other providers.

HRSA also funds Rural Outreach and Network Development programs that help rural communities find innovative ways to stretch and coordinate their scarce health care dollars. There are also a number of other programs that are important supplements to rural hospitals. These programs, such as the Community Health Centers and the National Health Service Corps, help bring services and health care personnel to underserved rural areas. In addition, there also are now more than 3,500 Rural Health Clinics that currently receive cost-based reimbursement from Medicare. Many of these clinics are affiliated with rural hospitals.

HRSA also has been involved in the development of telehealth services for rural areas. This technology has been a real boon for rural hospitals. Through our rural telemedicine network grant program, we have funded the development of telehealth networks that have linked more than 100 rural hospitals with tertiary care centers to bring a wide range of specialized clinical care services to their communities while also increasing the range of education and professional interaction for their providers through distance learning. Last year, we created the Office for the Advancement of Telehealth to continue and expand these efforts.

The Children's Health Insurance Program is another source of help in addressing health care needs for rural communities. This initiative, enacted in the BBA, is helping the states provide coverage to many of the 10 million children in families that work, but are still too poor to afford health insurance. It's our hope that by getting more children covered by health insurance, we can help reduce the amount of charity care that rural hospitals are now providing. That helps improve the bottom line for these hospitals while also getting kids the health care services they need.

Beyond our agency, the Department also has a number of targeted reimbursement programs under Medicare and Medicaid to help rural hospitals. In fact, Medicare already provides special payment support to more than half of all rural hospitals through such designations as the Medicare dependent hospital or sole community hospital designations.

In closing, I think it's important that we continue to monitor the status of rural hospitals as we work our way through the BBA and the other many changes taking place in the health care system. I believe the Department, through its policies and its grant programs, can work to mitigate many of the problems faced by rural hospitals and ensure their long-term viability. I want to thank you, Senator Cochran and Senator Kohl, for the opportunity to be here today, and I will be pleased to answer your questions you may have.

Senator COCHRAN. Thank you, Dr. Fox, for your helpful testimony.

We will now turn to Dr. Robert Berenson, who is Director of the Center for Health Plans and Providers of HCFA, Health Care Financing Administration. You may proceed.

STATEMENT OF ROBERT A. BERENSON, M.D., DIRECTOR, CENTER FOR HEALTH PLANS AND PROVIDERS, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. BERENSON. Thank you, Chairman Cochran and other distinguished subcommittee members. Thank you for inviting us to testify today. We are very grateful for this opportunity to discuss concerns facing rural hospitals and to explore how we might address them in a prompt and fiscally prudent manner.

This hearing provides a timely focus as our monitoring and analyses suggest that some Balanced Budget Act payment reforms may have a disproportionate impact on rural America. Medicare has several policies in place to help rural providers and the BBA includes several new provisions to strengthen rural health care. Indeed, the last available data shows that the average Medicare payment for a rural patient in a hospital is rising relative to an urban patient. So some of these policies may be having some impact.

But rural providers face special challenges and the BBA reforms that have a disproportionate impact on rural hospitals could well create problems for beneficiary access to quality health care, as you have heard from Dr. Fox. This is why the President's Medicare reform plan includes several provisions to help ensure that rural beneficiaries have access to quality health care. It makes it easier for rural hospitals to qualify for higher urban payment rates based on the way the wage index is constructed.

The comment period is still open on the outpatient rule, so we cannot be definitive, but we are certainly looking at the option of providing a transition period to the new outpatient prospective payment system that would permit all hospitals, rural hospitals in particular, a transition period to adjust to the new system. It gives rural hospitals larger rate increases than urban hospitals from the years 2003 to 2009, for the first time identifying a differential pay-

ment rate, and it makes additional administrative adjustments that will increase funding for rural hospitals.

The President's plan also includes \$7.5 billion to smooth the transition to BBA reforms, and that money could well be used to address specific concerns raised at this hearing where beneficiary access to care may be jeopardized in rural areas.

We are working very hard right now to, as Dr. Wilensky suggests, to really get some systematic information about the impacts of the BBA on access to care, to go beyond anecdotes, which are very important in themselves, but need to be put into a larger context. In that regard, we have started a relationship with the National Rural Health Association to evaluate rural access in particular. The association has sent a questionnaire to all its members on the impact of the BBA reforms and they expect to receive responses by the end of the month, which they will share with us.

We are redoubling our efforts to address rural concerns by meeting with rural providers, visiting rural facilities, reviewing the impact of our regulations on rural health care, and conducting more research on rural health care issues. Within HCFA we have established a new internal work group to serve as a focal point for addressing rural concerns so that the providers, the National Rural Health Association, and other associations, HRSA, and other members, other parts of the Federal Government, have a place to work with within HCFA, where we will have people dedicated to trying to understand and work with special rural problems. As Dr. Fox mentioned, we have started a series of endeavors to try to coordinate our activities within the Department.

I had already committed to make a trip to Texas and Oklahoma, before this hearing had been scheduled, to visit rural hospitals at the request of the regional administrator there. I am going to stay through the next panel and maybe extend, based on that, extend the trip to Mississippi or other locations. We are working very hard to try to understand these issues because, again, one of the real difficulties is to try to assess the combined impact of various rational BBA and other policies. Each one may make sense in itself, but one does not understand the sort of combined impact of these policies until you actually go in and visit with the providers and get it from their point of view. So we are going to be working very hard to do that.

That is the end of my oral remarks, and I would be happy to participate in the discussion.

[The statement follows:]

PREPARED STATEMENT OF ROBERT A. BERENSON

Chairman Cochran, Senator Kohl, distinguished Subcommittee members, thank you for inviting us to testify about our efforts to support America's rural health care providers.

This hearing provides a timely focus, as our monitoring and analyses suggest that some Balanced Budget Act (BBA) payment reforms may be having a disproportionate affect on rural Medicare beneficiaries' access to care. The President's Medicare reform plan includes several provisions to help ensure that rural Medicare beneficiaries continue to have access to the quality care they need, and we look forward to working with you to enact these essential reforms.

About one in four Medicare beneficiaries live in rural America, and rural hospitals serve a critical role in areas where the next nearest hospital may be hours away. Yet rural hospitals face special challenges. They have higher per unit costs, difficulty maintaining enough patients to break even, and difficulty recruiting physi-

cians. Medicare has made exceptions and special arrangements to address the unique needs of rural areas and strengthen these vital facilities. Even before the BBA, Medicare provided special payment support to more than half of all rural hospitals.

The BBA includes several new provisions to strengthen the rural health care infrastructure. It provides extra support for small critical access and other rural hospitals, and it authorizes payment for telemedicine to bring urban expertise to rural providers and their patients. As a result, average Medicare payment per rural patient is rising.

However, because other BBA payment reforms may have a disproportionate impact on rural hospitals, and thus on beneficiary access to care, the President's Medicare reform plan includes provisions to:

- make it easier for rural hospitals to qualify for higher urban payment rates;
- help rural hospitals adjust to the new outpatient prospective payment system;
- make additional administrative adjustments that will increase funding for rural hospitals;
- give rural hospitals larger rate increases than they would receive under a straight extension of the BBA from 2003 to 2009; and
- maintain the improvements in managed care payments built into the BBA, which have an indirect effect on hospitals.

The President's Medicare reform plan also sets aside \$7.5 billion over 10 years to fund appropriate and justified modifications that may be necessary to smooth the transition to BBA reforms where beneficiary access to care is being compromised. That money could well be used to address specific concerns raised at this hearing. However, the BBA reforms are critical to strengthening and protecting Medicare. We are proactively monitoring the BBA's impact on beneficiary access to care. And we want to work with Congress, providers and beneficiary groups to determine how to address documented problems in the most carefully targeted and fiscally responsible way.

Most importantly, for rural (and other) health care providers, the President's plan dedicates a portion of the surplus to strengthen Medicare. Combined with reforms, this surplus dedication secures the life of the Medicare Trust Fund for over the next quarter of a century. This averts the need for excessive provider payment reductions that would be inevitable without new financing as the baby Boom generation begins to retire.

The President's plan also helps nearly half of rural Medicare beneficiaries who today do not have any coverage for prescription drugs. Rural beneficiaries have less access to employer-based retiree health insurance because of the job structure in rural areas. Also, three-quarters of rural beneficiaries do not have access to Medicare managed care, which typically offers free drug coverage to beneficiaries living in high-cost areas like Los Angeles or southern Florida—despite the fact that all beneficiaries pay the same premium. This leaves rural beneficiaries at greater risk of not being able to afford medications that are central to their health. The President's plan gives all beneficiaries the option to pay a modest premium for a prescription drug benefit. This benefit will cover half of all prescription drug costs up to \$5,000 when fully phased in, with no deductible—all for a modest premium that will be less than half the price of the average private Medigap policy. As such, it provides an affordable choice for rural beneficiaries with unstable or expensive coverage, and a lifeline for those beneficiaries who simply have no options today.

Even as this plan is being debated, we are redoubling our efforts to actively address the special circumstances of rural beneficiaries. We are meeting with rural providers, visiting rural facilities, reviewing regulations' impact on rural health care, and conducting more research on rural health care issues. And we are participating in a workgroup with the Health Resources and Services Administration's Office of Rural Health Policy to make sure that we stay abreast of rural issues.

BACKGROUND

The BBA includes many provisions to aid rural hospitals and reform Medicare payment systems to promote efficiency and quality. We have implemented all of the provisions that provide assistance to rural facilities. These include:

- allowing very small “critical access” rural hospitals, those with no more than 15 inpatient beds that offer 24 hour emergency care and are located more than a 35 mile drive from any other hospital, to be reimbursed based on what they spend for each patient, rather than on the average expected cost for specific diagnoses that most hospitals are paid;

- reinstating the “Medicare dependent hospital” designation, which provides higher reimbursement for rural facilities with less than 100 beds serving large numbers of Medicare beneficiaries;
- permanently grandfathering special “rural referral center” status for any hospitals designated as such in 1991, which provides higher reimbursement to facilities with 275 or more beds that serve large numbers of beneficiaries living more than 25 miles away from the facility or referred from other hospitals;
- allowing more rural hospitals to obtain special “disproportionate share” payments available to hospitals serving large numbers of low income patients; and
- authorizing payment for telemedicine, in which medical consultations are conducted via phones and computers, for beneficiaries residing in rural areas that have a shortage of health care professionals.

We also have implemented several BBA payment reforms. For example, we have:

- modified inpatient hospital payment rules;
- established a prospective payment system for skilled nursing facilities to encourage facilities to provide care that is both efficient and appropriate;
- refined the physician payment system, as called for in the BBA, to more accurately reflect practice expenses for primary and specialty care physicians;
- implemented the Medicare + Choice program which increases payment rates for rural health plans and allows beneficiaries to be offered options such as provider sponsored organizations and private fee-for-service plans;
- established a National Medicare Competitive Pricing Advisory Commission to design and implement an essential demonstration project using competition to set rates for managed care plans;
- begun implementing an important test of whether market forces can help Medicare and its beneficiaries save money on durable medical equipment; and
- initiated the development of prospective payment systems for home health agencies, outpatient hospital care, and rehabilitation hospitals that will be implemented once the Year 2000 computer challenge has been addressed.

In most cases the BBA prescribes in great detail the changes we are required to make. However, we understand that rural providers may have more difficulty than others in adapting to some of these changes. We are committed to working with rural providers to help them adjust, and to affording maximum flexibility within our limited discretion as we implement BBA reforms.

PRESIDENT’S PROPOSAL

The President’s Medicare reform plan also recognizes rural beneficiaries’ and providers’ special circumstances and the disproportionate impact of BBA payment reforms on rural payments, and includes additional provisions targeted specifically to rural providers.

The President’s plan will make it easier for rural hospitals to receive higher urban payment rates. Right now, rural facilities can obtain urban rates if the wages they pay their employees are at least 108 percent of average wages in their rural area, and at least 84 percent of average wages in a nearby urban area. The President’s plan will adjust those wage thresholds so more rural hospitals can be paid the same as their urban neighbors.

The President’s plan adjusts the BBA’s new outpatient prospective payment system to increase payments to low-volume rural hospitals and other facilities that would otherwise be disproportionately affected by the new system, which we expect to implement next year. An analysis included in our Notice of Proposed Rule Making shows that rural hospitals would be disproportionately affected by the new system.

We are therefore considering a budget-neutral three year transition to the new system that will limit the impact on rural hospitals. We are also delaying implementation of a volume control mechanism on the system that was called for in the BBA, which also will give hospitals extra time and money to adjust. And we may use the same wage index for calculating rates that is used to calculate inpatient prospective payment rates and take into account the effect of hospital rural/urban reclassifications and redesignations.

The President’s plan includes other administrative actions that will help many rural hospitals. It will postpone extension of limits on payment when hospitals transfer patients with specific diagnoses to skilled nursing facility beds, home health agencies, or another hospital or hospital unit. And it will provide relief to home health agencies, including those affiliated with rural hospitals. It extends the time for agencies to repay overpayment without interest from one year to three years. It also postpones the requirement for agencies to obtain surety bonds until

October 1, 2000, and limits the amount of bonds to \$50,000 rather than 15 percent of annual Medicare revenues as was proposed earlier.

The President's plan further acknowledges the special circumstances many rural facilities face by giving rural hospitals larger rate increases than urban hospitals for inpatient care. Specifically, payment rate increases for inpatient rural hospitals would be larger than they would receive under a straight extension of the BBA from 2003 to 2009. The difference in rate increases between rural and urban facilities will decrease by 0.1 percent each year until the same update applies for rural and urban hospitals in 2009. Although this update is less than the full market basket, which would be the update under current law, it is higher than anytime during the BBA (1998 to 2002), and in fact, most years since the prospective payment system has been in operation.

And the President's plan includes \$7.5 billion over 10 years to fund appropriate and justified modifications that may be necessary to smooth the transition to BBA reforms. That money could well be used to address specific access problems, such as those that may be developing in rural areas.

The President called on Congress to work with him to reach a bipartisan consensus on needed reforms this year. Any action we take to smooth the transition to BBA payment reforms must be fiscally prudent and carefully targeted to address areas where there is clear evidence that beneficiary access to quality care is in jeopardy. BBA payment reforms are critical to strengthening and protecting Medicare, and it is clear that they are succeeding in promoting efficiency and extending the life of the Medicare Trust Fund.

MONITORING BENEFICIARY ACCESS

We are therefore actively monitoring the impact of the BBA to ensure that beneficiary access to covered services is not compromised. Our regional offices are gathering information from around the country to help us determine whether specific corrective actions may be necessary. We are gathering data from media reports, beneficiary advocacy groups, providers, Area Agencies on Aging, State Health Insurance Assistance Programs, claims processing contractors, State health officials, and other sources to look for objective information and evidence of the impact of BBA changes on access to quality care.

We are working with the National Rural Health Association to evaluate rural access to care. The Association has sent a questionnaire to all its members on the impact of BBA reforms on rural health services. They are asking for anecdotal descriptions of how services have been affected, and they expect to receive responses by the end of this month.

We also are monitoring Census Bureau data, which allow us to gauge the importance of Medicare in each health service industry, looking at financial trends in revenue sources by major service sectors, and tracking profit margin trends for tax-exempt providers.

We are monitoring the Bureau of Labor Statistics monthly employment statistics for employment trends in different parts of the health care industry. Such data show, for example, that the total number of hours worked by employees of independent home health agencies is at about the same level as in 1996. That provides a more useful indicator of actual home health care usage after the BBA than statistics on the number of agency closures and mergers.

We are being assisted by our colleagues at the HHS Inspector General's office. They have agreed to study the impact of the BBA's \$1500 limits on outpatient rehabilitation therapy. They have also agreed to interview hospital discharge planners as to whether they are having difficulty placing beneficiaries in home health care or skilled nursing facilities. Results of that study should help provide information in addition to surveys done for the General Accounting Office and the Medicare Payment Advisory Commission of home health agencies. And, because home health beneficiaries are among the most vulnerable, we have established a workgroup to develop an ongoing strategy for monitoring beneficiary access and agency closures.

However, it is important to note that the BBA is only one factor contributing to changes in Medicare spending. We have significantly decreased the number of improper payments made by Medicare. And some payments have been slowed during the transition to new payment systems. The BBA also is only one factor contributing to provider challenges in the rapidly evolving health care market place. Efforts to pay right and promote efficiency may mean that Medicare no longer makes up for losses or inefficiencies elsewhere. Our first and foremost concern has always been, and will continue to be, the effect of policy changes on beneficiaries' access to affordable, quality health care.

CONCLUSION

We are all committed to ensuring rural beneficiaries' continued access to quality care, and we are all concerned about the disproportionate impact of BBA reforms on rural health care providers. The President's Medicare reform plan addresses these concerns with specific proposals targeted to assist rural hospitals, and it provides funding to smooth the transition to BBA reforms which could well be used to address problems that may jeopardize rural beneficiaries' access to care. We are very grateful for the opportunity this hearing provides to discuss concerns facing rural hospitals and to explore how we might address them in a prompt and fiscally prudent manner. I thank you again for holding this hearing, and I am happy to answer your questions.

Senator COCHRAN. Thank you very much, Dr. Berenson. We appreciate your willingness to remain here to hear the testimony that is going to be given by those who have the job of helping run the small town hospitals who are the subject of today's hearings.

Dr. Wilensky, in your statement you talk some about the measurement that is used to gauge revenues and the comparison between revenues of hospitals and the costs that are required to deliver those services and what that means in terms of the economic well-being of the hospital. I am told that one study has been done, I think one of the national accounting firms has done it for the health care industry of America, that suggests that for the small rural hospitals the margin, the comparison between revenues and costs, for those hospitals will go from a positive 4.2 percent in fiscal year 1998 to a negative 5.6 percent by fiscal year 2002.

If that is correct, let me ask you what your assessment would be on the impact that that would have on hospitals throughout the country?

Dr. WILENSKY. If it turns out that that projection is correct, it would of course have very major impact on rural hospitals. That is a very significant change in terms of going from overall positive margins to overall negative margins.

There are two points I would like to make in response to that. The first is, even in cases where you have overall on average negative margins, which has happened earlier in the 1990's under Medicare, that does not mean that you do not have a substantial number of hospitals who continue to do financially all right, although it certainly is an area of concern when the average is now negative rather than positive.

The biggest concern with regard to the estimates—and we of course have also seen this report—is that it is not based on new data. It is based, unfortunately, as all of us have our estimates based, on pre-Balanced Budget era numbers. It is using new assumptions. So our real concern is the one that Dr. Berenson has also raised, is that we do not have good, credible, systematic information about what has been happening since the Balanced Budget Act has been introduced.

That is why MedPAC has been working with HCFA to try to see whether we cannot have a sample of hospitals reporting, subject to later audits, so that we can get a good credible early warning data. If it turns out that the assumptions in this report are correct, although we think there is some indication that their 1998 estimates may—or the 1998 assumptions may contain estimates that show greater cost increases than in fact actually occurred, it would in fact be very troubling.

Our recommendation is monitor carefully, but be careful about making expenditures based on projections in 2002.

Senator COCHRAN. There was a similar study that I have been told about for the American Hospital Association, which found that Medicare operating margins for the average rural hospital will fall to a negative 10.42 percent in fiscal year 2002 if the Medicare provisions of the BBA are fully implemented. That is another bit of evidence. It sounds scary.

Dr. WILENSKY. It does sound scary. Again, let me caution you these are new assumptions. They are not new data or information. It is why I think when you consider redoing some parts of the Balanced Budget Act you want to be cautious to change what we think may have already occurred, but I urge you not to undo the whole Balanced Budget Act. We do not know that what has happened in the first year or two will continue to play out this way.

In the 1980's when the DRG's were introduced into your hospitals when Congress changed how Medicare reimbursed hospitals, the first year or two showed substantially greater reductions in spending by hospitals than occurred thereafter. Thereafter the projections were very close to CBO projections. So it is one thing to go in and to make some modest changes that reflect problems we know that already exist. It is something else to do a major redo of the Balanced Budget Act based on what may happen 4 years from now.

Senator COCHRAN. Dr. Fox, you mentioned that some of the advice that the government has been giving to small hospitals has been to diversify, get into other areas, not just traditional hospital activity. Now we are hearing about nursing homes primarily and some other similar health service providers having to shut up shop and go out of business because of the collapse of the entire industry.

I have heard about a company in Kentucky—this is anecdotal, but I just heard about it the other day from one of our Senate colleagues—where this company is going into bankruptcy that had been in the nursing care business. The assumptions are that it is directly related to the changes in Medicare reimbursement.

Of course, all of those residents are elderly and are Medicare eligible. So the assumption is that the system is really in a serious state right now.

So what do we do for those rural hospitals who have been encouraged to diversify in these ways and find themselves now really in dire financial straits?

Dr. FOX. Well, I think the first thing we do, Senator, is we have to make sure we know what is going on. As I mentioned, we have four research grants out there right now, one with the University of Washington, one with the University of Minnesota, one with the University of North Carolina, one with Project Hope, that by this fall will give us some information on what is happening.

The RUPRI, which is the Rural Policy Research Institute, that we also provide funding through, will provide a report on the 31st, I think it is around the 31st or so, 30th or 31st of July. So I think the first thing is to try to make sure that we can monitor the changes as early as possible.

The second, we are working with hospitals on the critical access hospital program and we are doing this through the offices of rural health, and I might just say that that vehicle would not be there if it were not for you. I want to thank you for your support a number of years ago in setting up these offices of rural health, as well as your support of the critical access hospital program.

I think at this point it is kind of dicey to say how this is going to play out. Some of the hospitals have already taken advantage of it, some of them have not. Others are looking at it. I know there is an issue of uncompensated care and how that plays out in hospitals that go to critical access hospital programs. So I think that is the second thing we have got to do, is again continue to work with States and offices of rural health on helping hospitals look at whether or not it is feasible for them to convert.

The third thing I think is that we have to look at other ways of bringing together health care within the community. If I think about my own community, we have a hospital, we have a health department, we have—had a home health agency, private home health agency, I think that actually has gone out of business. Then we have a community health center, other types of health providers.

We need to figure out ways, particularly in rural communities, to pull those together. Can they co-locate? Can we look at the things that we buy as a Federal Government, for instance through the Agency on Aging, Meals on Wheels, nutrition services? Can we encourage States to buy those through small hospitals? Respite care. We know the communities are getting older. What kind of additional services can these hospitals provide?

So I think that what we are looking at, both in the critical access hospital program as well as the administration's proposal on the safety net, the program for the working uninsured, is to try to help bring together the entities that are there so that you have a critical mass and you do not end up with each one kind of working in their own corner and not working synergistically.

So we are working on trying to look at these issues. We also are looking at funding for other kind of health care providers that can come in and work with the rural hospitals, National Health Service Corps being a prime example. About two-thirds of all of our health profession shortage areas are in rural communities, and we only have 2,000 National Health Service Corps that we place out there. We estimate if we eliminated all of our health profession shortage areas we would need 13,000. So we are a long way from what we need to do there.

I think it is the whole issue of monitoring, helping bring the system together, trying to look at best practices—models. We know there are communities that have actually recaptured some of their care that has gone off to other areas; and trying to help them look at strategies to pull that care that is practical for them to keep back in.

It is a whole list of all of the above.

Senator COCHRAN. I appreciate that. I know the hospital flexibility program is something that you have been advocating. Is this a program that will address some of these concerns?

Dr. FOX. Definitely, Senator. I think that the rural hospital flexibility program, the Medicare cost reimbursement. I think that now that many Medicaid programs have the option of whether or not they are going to provide cost-based reimbursement for Medicaid to hospitals, we ought to encourage States to do that.

Again, I come back to the fact that Tallahassee General Hospital has 65 percent Medicare, but they have 10 percent Medicaid, not much else, not much private pay. States have the opportunity to look at what they pay rural hospitals and Medicaid as well as Medicare both—together, they are generally the two major payers for rural communities, and we ought to be honing in on cost reimbursement and encouraging that in both of those realms.

Senator COCHRAN. Dr. Berenson, I can remember one time when we were trying to do something about the disparity between reimbursement rates for rural hospitals as compared with those in urban areas. There were some categories that there was some flexibility on. I think legislatively we made some adjustments that benefited those community hospitals that served a broad geographical area and really had more physicians and health care professionals working there than some of the city hospitals did, and their costs were the same and in some cases even higher than the city costs.

Is it unfair to continue to reimburse rural hospitals at a lower rate for the services they provide than we provide to the urban centers? Should we not make the reimbursement rates the same?

Dr. BERENSON. Well, approximately 50 percent or so of rural hospitals are in separate categories that in fact do get either cost-based reimbursement or some additional reimbursement. I think you are referring to rural referral centers, which are major catchment hospitals for a geographic area. A significant part of reimbursement has to do with the wage index. We make it easier for them to reclassify as urban in their reimbursement, in their designation of wage index.

We are looking to extend that going forward. We need to have a rationale for paying differentially, but the BBA did some of that and we are looking to see if we can extend that administratively for a number of more hospitals, mostly through this mechanism of the wage index.

Senator COCHRAN. You mentioned the President's proposal to increase funding and to provide some new ideas. Are there any specific changes in the BBA that have been submitted by the administration or assumptions made that legislation will be changed in any specific way to deal with these problems?

Dr. BERENSON. The President's proposal basically says he wants to work with the Congress. He has identified \$7.5 billion to smooth out the BBA, identify areas that might need some additional funding, where things went perhaps a little too far.

We are also looking to see what we can do administratively. Dr. Wilensky mentioned and you brought up the issue of hospitals getting into other areas. There seems to be a problem of underestimating the acuity of skilled nursing facility beneficiaries, those who may be receiving ventilator care or something like that. We now have a contract out to help us readjust our case mix index so that we could revisit that issue and provide additional payment to high acuity nursing homes.

So there is sort of a combination. The President has basically committed to funding availability and wants to work with the Congress to really identify the most important areas that need some attention.

Senator COCHRAN. I do not want to start an argument, but you heard Dr. Wilensky's suggestions for some specific changes to the BBA. I made some notes. There were four specific ones as I understand it: The outpatient prospective payment system, phasing in the changes rather than making an abrupt change; skilled nursing facility reimbursement payments are not keeping pace with costs in that area; ambulance charges could be included, for example, in those reimbursements and critical access hospital provisions. That is an important way for some hospitals to remain a part of the health care system.

What is your reaction to those proposals?

Dr. BERENSON. Well, as I said earlier, the first two I think we have talked about together and I think we are quite sympathetic to a transition in outpatient, a phase-in of outpatient. Again, we are currently in a comment period; comments are coming in, so I cannot definitively tell you where we would be at this point, but we think there is likely to be merit in that suggestion.

As I just said, on the skilled nursing facility, we think there is a problem with high acuity patients and are looking at how we might adjust the case mix to deal with that. In terms of critical access hospitals, there is actually a lot of work that we are doing with HRSA to identify the universe of hospitals that would be eligible. Earl knows a lot more about it than I do—in the area of the States' requirement to develop a plan. We would certainly be open and eager for a number of hospitals to qualify as critical access hospitals.

I cannot comment specifically on the ambulance one, but we will look at that.

Senator COCHRAN. Thank you.

Senator Feinstein.

Senator FEINSTEIN. Thank you very much, Mr. Chairman. I feel very similarly to you, except perhaps maybe even more strongly, because I think we are on our way to a major disaster.

Senator COCHRAN. We call it a crisis in the title of the hearing.

Senator FEINSTEIN. Well, I would certainly agree with that. I would certainly agree in California.

If I understand correctly, the BBA of 1997 cut payments to all hospitals treating Medicare patients by \$32.9 billion over 5 years. That is huge by anybody's calculation. There are differing views here, but if there were an effort to restore—you mentioned the President has put out there \$7.5 billion—in each of your professional judgments, to prevent what is happening now, which is the tremendous stress on teaching hospitals, the closure of hospitals urban and rural all across the board, how much would have to be restored?

Dr. WILENSKY. I do not know the answer. I think that, as I understand, the \$7.5 billion that was raised, it was raised over 10 years. That strikes me as a little smaller than what I had assumed Congress might consider in terms of replacing some of the unex-

pected savings that occurred with regard to the Balanced Budget Act.

When you look at the projections of how much more savings will occur than was initially projected by the Congressional Budget Office, I urge you to think about it in terms of two pieces: The first, which is what has already occurred, and my understanding is that we are talking roughly about \$20 or \$22 billion already of more savings than was thought to occur; and that the additional number that we heard referenced earlier is what may happen in the future.

You will have to decide where the additional funds will come from, as you well know. But I urge you to be a little more cautious about trying to put money back in for savings that may be greater than you or the Congressional Budget Office thought would occur when they have not actually occurred. Our ability to correctly project exactly what spending will be in any year is a little shaky and, while I think there is good justification for putting back some money in the outpatient, I think the outpatient hospital has better justification than putting money back into the inpatient portion as of what we see now, although I would certainly urge additional reductions not be made until we know what we are doing more.

So I think the \$7.5 billion is an aggregate number over 10 years, if that is the correct number as I recall it. It seemed a little less overall putting back in. But I would be careful about not thinking about the very large numbers of extra savings that had been reported earlier in this hearing.

Senator FEINSTEIN. Thank you, doctor.

Dr. Berenson.

Dr. BERENSON. If I could comment—

Senator FEINSTEIN. I am asking for your best professional judgment now, not necessarily the position of the administration.

Dr. BERENSON. Oh, I understand, but that is somewhat difficult.

I would just point out that the hospital inpatient margins pre-BBA, using data pre-BBA, were really at an unprecedented level, and their ability to control costs has developed such that costs actually have not gone up for 4 or 5 years in a row. So that was the sort of predicate, I think, on taking significant savings from the hospital industry.

We have heard, just as you have now, from hospitals of different categories—teaching hospitals, rural hospitals, public hospitals—that the world is very different now, 18 months later. We are working very hard to try to understand that.

But there is this at least basis for believing that at least inpatient revenue, inpatient margins, were quite healthy. So I would I guess share a little bit the concern of Dr. Wilensky that we really identify the problems and maybe target a response, rather than come to a conclusion that we went too far overall.

Some of the greater savings that are attributable to the BBA are actually attributable to general economic conditions. Inflation was not as high, so the baseline did not go up as much. Some of the different spending is because of our success actually in protecting against waste, fraud and abuse, where spending was lower than had been expected. So it's complex.

We do not want to sit and be idle. We are working very hard to understand what has changed since that last data was published.

We are working with MedPAC to try to quickly figure out how we can get updated information to get a much more current snapshot of what hospital margins are.

We actually did have some concerns about the studies that the chairman referred to, about some of the methodology, and are not convinced that their predictions are as accurate or are accurate. But we are very concerned and clearly are working in this area.

Senator FEINSTEIN. But if we take too long, another 15 percent of my State's hospitals are due to close. If we take too long, there will not be anything left. And you know, you now have two major teaching hospitals, the University of California and Stanford, in huge trouble, Mount Zion Hospital in San Francisco in huge trouble. So it is happening in a major, in a mega way.

So you have no number to propose?

Dr. BERENSON. No, we do not. We again do not—there are a number of areas that have been identified—the teaching hospitals, rural hospitals, the sub-acute nursing homes. The therapy caps have been identified as an issue in the BBA, the implementation of outpatient PPS. And rather than the administration proposing specific fixes at this time, we actually want to work with the Congress to identify where relief is needed.

Senator FEINSTEIN. Dr. Fox.

Dr. FOX. Senator, as a pediatrician I am not sure you want my professional judgment is on this issue. Let me say we are working with HCFA. We actually have offered our rural health research centers to HCFA for their use in answering some of these questions.

I do not know that we have a number. We have not run the figures, and I would be strictly pulling it out of the dark if I were to give you a number today. But I would point out that the study that Leuwen did on the same issue, they estimated the negative hospital margins for rural hospitals by 2002, 2003, being minus 7 percent. So they are all somewhat in that same neighborhood.

But again, we look forward to working with HCFA and making our resources available, our research sources available, to help answer some of these questions and provide the information back to them and to you.

Senator FEINSTEIN. Thank you very much.

Thanks, Mr. Chairman. Thank you.

Senator COCHRAN. Thank you.

Senator Durbin.

STATEMENT OF SENATOR RICHARD J. DURBIN

Senator DURBIN. Thank you very much, Mr. Chairman.

I apologize to the panel. I was on the floor in a debate involving the Patient's Bill of Rights. I think that might be relevant to this discussion to some extent, but I will not get into it.

When it comes to rural hospitals in my State of Illinois, I think people are surprised to learn that an otherwise healthy national economy and an otherwise bustling economy in our State tends to conceal the fact that in rural Illinois things are not very good. Commodity prices have been plummeting and farmers are struggling, and as they struggle a lot of businesses fold, unable to sell them the equipment and other things necessary for their farm.

These businesses close down and towns dry up, which puts a burden on the rural hospitals that, frankly, is aggravated by this economic situation across the country. There may be some exceptions, but for the most part I think Illinois mirrors what is happening across the country.

It is very obvious as we take a look at the Balanced Budget Act that we went too far. We were trying to do everything we could to bring the budget into balance and it appears that we decided to put a number on a page and then say, well what policy changes do we have to make to reach that number. I think we were insensitive to the fact that many of these policy changes would be devastating to individuals and families and to rural hospitals. That is the reason we are here today.

I would have to say by way of preface here that I am troubled by Washington's response to this crisis, both in the White House and in Capitol Hill. I have heard from the President's personal staff about their plans to rescue some of these extraordinary cuts in Medicare and their impact on rural hospitals and many inner city hospitals, I might add, as well. I think they are pitifully inadequate. They are just not responsive to the size of the problem.

When you come to Capitol Hill, you kind of enter into fantasyland, because we happen to believe that, despite the crisis which has been described here, we can have with a straight face a press conference today and announce a one trillion dollar tax cut. It is as if we are not sensitive to the fact that many of the things that we have done are causing great havoc in the quality of life across America.

I am for a tax cut once we have met our obligations, and our first obligation clearly is to Social Security and the Medicare, and we have not addressed it. We have not addressed it, neither in the budget resolution nor in the negotiations to date.

Dr. Berenson notes in his testimony the administration's commitment to dedicating a portion of the surplus to Medicare. This is a one-way conversation so far. I hope that it becomes a bipartisan conversation, where we say that in order to deal with this problem in the long haul we cannot talk about trillion dollar tax cuts before we talk about putting Medicare on a sound footing, or by the time we get around to talking about tax cuts there will not be many rural hospitals left.

I guess the bottom line question which I have to each of you is this. What have you seen in the changes in populations, in the medical facilities serving rural areas, evidencing these cutbacks in Medicare? Have we seen any kind of decline in those populations in nursing homes or in hospitals? Basically, the question is what kind of service cutbacks have we seen as a result of the Balanced Budget Amendment changes that can demonstrate that in fact we are no longer in an area of cutting back on the profitability of hospitals in rural areas, but frankly at a point where we may be threatening their existence?

Dr. Wilensky.

Dr. WILENSKY. I do not think we have such information. I think it is important that we continue to monitor. There are some provisions that I think we can look at and say may not make sense in retrospect. Dr. Berenson referenced the \$1,500 rehabilitation cap

that exists irrespective of the patient's condition; the fact that in the outpatient prospective payment the amount that is going to be reduced is greater than what the House and Senate bills had anticipated and will be introduced in full force rather than phased in.

To the best of my knowledge, there is not information either with regard to skilled nursing facilities or home care or hospital care that documents access problems. MedPAC, at your instructions, at Congress' instructions, monitors this very closely. We are concerned. We think, as Mrs. Feinstein suggested, there are some areas where you ought not to wait until you have documentable problems, that there are problems in the policies per se that suggest rethinking them even before we have information.

But to the best of my knowledge, we do not have documentable indications of access problems for seniors to date. But we are concerned, all of us here.

Senator DURBIN. Dr. Berenson.

Dr. BERENSON. I agree with that. What we are doing specifically with our colleagues at the Inspector General's Office in HHS is actually go out to discharge planners at hospitals, who are the people who actually have to find nursing homes or home health agencies, and specifically do a survey of randomly selected hospitals. And I have asked whether we can oversample rural facilities and we will try to do that also.

Senator DURBIN. What is the time frame on that?

Dr. BERENSON. Within the next couple of months. It is an urgent study that is going on right now. They are in a position to do it quickly and so we have asked them to do that.

Our focus is really on beneficiary access. We are concerned about providers' health and well-being, but our primary concern is access for beneficiaries. We are doing a series of things, but that is one that I think might be most promising. We think at this moment, between the GAO study and MedPAC's study on home health care, that we have not documented access problems to home health care.

There have been closures, but we now have about the same number of home health agencies today that we had in 1996. There was just a huge increase and now it is back to essentially where it was. We have not found, nor have the other agencies problems there.

The IG is specifically looking at access to nursing homes, access to therapy caps—I mean, access to physical and occupational therapy and whether those caps have had impact, and it is a technique that we will use to try to understand other issues as well.

Senator DURBIN. I cannot remember where I read it, but I read recently that there was a decline in the population of nursing homes in our country. Do you recall reading anything along those lines, or am I wrong?

Dr. WILENSKY. I do not know. I do not recall reading that?

Senator DURBIN. Dr. Fox, do you have any comments?

Dr. FOX. Senator, I would agree with Dr. Wilensky, that I think it is a little early to know. I mentioned earlier we have several research grants that are looking at this. I will give you an example of one instance that I know for sure where we have had an impact. When I was Commissioner of Health in Alabama, we ran a large home health program. We had about 800,000 nursing visits a year.

In the last 12 months that agency has had to lay off 600 people who are primarily providing home health care in rural areas.

If we extrapolate that—and again, I commented in my statement that many hospitals run home health programs, and they are low volume, which is a problem to begin with, and you talk about a situation where you have that kind of effect with a huge agency that can adjust and can shift, the effect on rural hospitals I think is going to be dramatic, and I think we need to make sure we know it early.

Senator DURBIN. Thank you.

Thank you, Mr. Chairman.

Senator COCHRAN. Thank you, Senator Durbin.

Thank you all for being here today and for your testimony.

We have another panel now we will invite to come forward. It includes: Douglas Higginbotham, who is Executive Director of the South Central Regional Medical Center in Laurel, Mississippi; Anne Klawiter, who is Chief Executive Officer of the Southwest Health Center in Platteville, Wisconsin; Deborah Griffin, Administrator of the Humphreys County Memorial Hospital in Belzoni, Mississippi; and Roland E. King, who is the former Chief Actuary of the Health Care Financing Administration.

We welcome each of you to the hearing and thank you for preparing testimony for us. We appreciate your submitting statements. We will include those statements in full as a part of the hearing record and encourage you to make any summary comments from those statements that you think will be helpful to the committee.

I am going to start by calling on Douglas Higginbotham from Laurel, Mississippi, to tell us about the situation in his town of Laurel. He is Executive Director of a regional medical center there. Mr. Higginbotham.

**STATEMENT OF G. DOUGLAS HIGGINBOTHAM, EXECUTIVE DIRECTOR,
SOUTH CENTRAL REGIONAL MEDICAL CENTER, LAUREL, MISSISSIPPI**

Mr. HIGGINBOTHAM. Mr. Chairman, Senators, staff members, and guests of the committee: My name is Doug Higginbotham. I am the Executive Director of South Central Regional Medical Center in Laurel—

Senator COCHRAN. Would you pull the mike just a little closer so we will not have any trouble hearing.

Mr. HIGGINBOTHAM. Can you hear me now?

Senator COCHRAN. Yes.

Mr. HIGGINBOTHAM. All right. I am the Executive Director of South Central Regional Medical Center in Laurel, Mississippi. It is my honor to appear before you today to present testimony on the effect of the passage of the Balanced Budget Act of 1997 on Mississippi's rural hospitals.

I will begin with a brief overview of our hospital and our hospital's role in our community. Laurel is a small community in Jones County, which is located in southeast Mississippi. In the past we were designated as a rural referral center and we are a little larger than many rural facilities.

Our services include general surgery, ophthalmology, obstetrics and gynecology, cardiology, emergency services, including the oper-

ation of an ambulance service. We have a full range of radiology services, including CAT scan, MRI, and interventional procedures. We operate a nursing home, a home health agency, hospice program, geriatric mental health program, a skilled nursing facility, a rural health clinic, and until recently an inpatient alcohol and chemical dependency unit.

We are the only hospital for a 30-mile radius and we serve a four-county area. Last year we provided services to 47,000 emergency room patients, 22,000 outpatients, and delivered more than 1,000 babies, and admitted over 9,000 patients.

It is important in this debate to get an idea where we get our operating revenue and how that money is used. We get 55 percent of our revenue from treating Medicare patients, 12 percent from treating Medicaid patients. We get an additional 25 percent of our revenue from various commercial and governmental sources. Of our revenue, 8 percent is attributable to bad debt or charity care.

Salaries and benefits make up 50 percent of our expenses. We spent 22 percent of our revenue on medical supplies, 6 percent on professional fees. Of our expenses, 22 percent represent maintenance and utilities, debt service, provision for bad debt, depreciation and amortization. We are left with a net income of about 3.5 cents on the dollar. These funds are reinvested in equipment, renovation, and building programs.

Even though our facility is larger than most rural facilities, we still face the same threats that the other rural facilities throughout Mississippi and really throughout the country face. Like every other facility, we face declining reimbursement, an increasing load of charity and bad debt care, cost pressure from labor shortages and regulatory changes, enormous difficulty in recruiting and retaining physicians, and difficulty in gaining access to capital for reinvestment in our facilities and equipment.

Before discussing these threats, I think it is important you understand the importance of our rural hospital to our community. A rural hospital is not just another hospital. South Central is typical of many of these rural facilities. We are the only hospital for a large geographic area and provide the backbone of health care delivery in our area. We are the ones that recruit physicians, nurses, nurse practitioners, therapists, both physical and occupational, and other health care professionals.

We are the ones who provide vital services like emergency rooms, ambulances, home health, and clinics. Rural communities like Laurel do not have public transportation such as buses, taxis, subways, or rail. Patients often have no choice but to use our emergency rooms as their point of access for care. We are based in a town of 18,000 people. Yet we provided emergency room treatment to 47,000 patients last year. We are the primary source of medical care for a sizable portion of our population.

South Central is not the only health care—not only the health care safety net of southeast Mississippi. It also contributes significantly to the area's economic well-being. We are one of the region's largest employers and one of the only employers of highly skilled workers. Our employees are actively involved in civic, social, and religious organizations in towns in which they are located. We are frequently large supporters of economic development. Our own eco-

conomic development cites access to health care as a key factor in attracting business to locate in our area. Our employees are leaders in the community as well as a resource to others.

For a long time we played a vital role in rural areas. Now for the first time in my memory, it is being seriously threatened, our survivability.

One threat is declining reimbursement. As a rule, rural hospitals serve a greater proportion of Medicare cases than other hospitals. Small changes in reimbursement rates can have a devastating effect on these hospitals. Under the current BBA language, we will suffer an approximately \$18 million loss of anticipated revenue over a 5-year period. Because of the BBA and other regulations, we have seen a 50 percent reduction in the volume of our home health services and a 50 percent reduction in hospice services. We have had a 55 percent reduction in the skilled nursing home—skilled nursing facility reimbursement, and that is forcing us to seriously evaluate the viability of that facility.

We may—others have done it—we may have to soon eliminate skilled nursing services in our area of Mississippi.

Prior to BBA, we were paid what amounted to an average per diem of about \$600 in our skilled nursing facility. Today we are paid an average of \$255. This \$255 is supposed to provide all the necessary care to a patient. In short, we are to provide room, board, medicine, supplies, nursing staff, physical and occupational therapist, and all other services for the cost of a hotel room in Washington, DC.

Along with the cuts we have already absorbed, we and other rural providers face proposed changes in the definition of hospital-based services that threaten to eliminate our rural health clinic. Changes in home health regulations and proposed changes in reimbursement severely threaten the viability of home health agencies and hospice services.

While these services may evaporate, the needs of our patients do not. We are morally and legally responsible to our patients to provide care, but our alternatives are quickly disappearing.

When you cut reimbursement, the cost of providing care to these patients is shifted to us. These are costs we cannot continue to absorb. We will not compromise on quality, but we may be soon forced to limit the level and type of services that we are able to provide to our patients.

Staff availability is a second major threat. It is not only a financial concern, but it is a quality concern. Hospitals, just like any other business, are faced with decisions about the allocation of resources. We have to pick and choose how we spend our money, whether it is on property, plant, and equipment, how much we spend on maintenance, how much on staffing, and how much on professional services.

We have cut to the bone the area of professional services. This summer we reduced staff on paper by reducing the number of hours our staff is required to work. This allowed us to avoid layoffs. We reduced retirement benefits, increased insurance deductibles, and delayed all raises by 2 months. Eventually we gave raises, but it was essential for us to do that to remain minimally competitive in salaries.

The reductions still resulted in staff, mostly nursing staff, leaving to go to large cities to seek employment. New Orleans is about 2½ hours away. A nurse can go work one weekend in New Orleans and make more money there than we can afford to pay in a week. As a result, we faced a nursing shortage this winter when the patient volumes increased.

Health care professionals do not just flock to rural communities like Laurel, Mississippi. They are very difficult to recruit and very difficult to retain. With the projections for Medicare cuts in our facilities, we are concerned about being able to make adjustments in salaries next year. In addition to nursing shortages, we have been faced with shortages in registered records administrators, respiratory technicians, medical laboratory technicians, physical therapists, radiology technicians, and other specialized staff. The care provided at a hospital is only as good as its staff. Shortages can and do threaten quality.

Even more critical to rural hospital survivability is the availability of physicians. A significant portion of my time is spent trying to recruit and retain physicians. Physicians have numerous options available to them when they come out of school. Most do not include rural communities as their number one preference. In recruiting, you consider the spouse and their interests in skills, which may not match your community's resources.

Without physicians, a hospital cannot exist. We have heard much about physician oversupply in our country. However, I am here to tell you we do not have an oversupply of physicians in rural America.

A final significant threat is the availability of capital. Many rural facilities like ours were built under the Hill-Burton program in the late 1940's and early 1950's and have not been significantly updated since that period. Changes in technology and the resulting structural demands on buildings to house new equipment and to meet changing needs of patients and physicians are always present.

Again, our case is typical. We have limited borrowing capacity and do not have access to capital markets. This means that we have to update our facility through our net income or reserves. Reduced reimbursement makes this task far more difficult and ultimately will threaten our ability to survive. If you cannot update your facility and medical equipment, you cannot recruit physicians and you cannot provide the services that the community deserves.

Mr. Chairman, this is my first brush with anything remotely like a Senate hearing and I know I have probably not said all that should be said. I have provided a brief view of rural hospitals and some of the threats they face. We are not perfect, but we have worked hard to improve our efficiency. I believe strongly that rural hospitals are an essential part of providing health care resources to all citizens in the country.

To allow rural hospitals to fail reduces or in some cases will effectively eliminate access to health care for those who choose to live in rural areas. With the closure of a rural facility, not only do the residents of the community lose access to health care, they also lose a key component in their ability to grow in the future.

I had the opportunity to visit Washington in January and was impressed with the seriousness with which individuals I met took their responsibility to their constituents. I know many issues occupy your time, but I encourage you to talk to your constituents, to nurses, nurse aides, therapists, and physicians, and to elderly members of your family. Ask them where they would go for health care if their local hospital closed or eliminated key services such as the emergency room. Ask your local business leaders if they can recruit staff to their businesses if they have no access to health care.

I do not claim to be an expert on anything, but I am a person who has some experience in rural health care, and I am concerned about the future of our rural hospitals.

PREPARED STATEMENT

Thank you for this opportunity to address the committee and for your patience and consideration of this important issue.

[The statement follows:]

PREPARED STATEMENT OF G. DOUGLAS HIGGINBOTHAM

Mr. Chairman, senators, staff members and guests of the committee, my name is Doug Higginbotham. I am the Executive Director of South Central Regional Medical Center, in Laurel, Mississippi.

It is my honor to appear before you today to present testimony on the effect of the passage of the Balanced Budget Act of 1997 on Mississippi's rural hospitals.

I will begin with a brief overview of our hospital's role in our community.

Laurel is a small community in Jones County, which is located in southeast Mississippi. In the past were designated a Rural Referral Center and are a little larger than many rural facilities. Our services include: general surgery, ophthalmology, obstetrics and gynecology, cardiology, emergency services including the operation of an ambulance service, and a full range of radiology services including CAT scan, MRI and interventional procedures.

We operate a nursing home, a home health agency, hospice program, geriatric mental health program, skilled nursing facility, a rural health clinic, and until recently, an inpatient alcohol and chemical dependency unit.

We are the only hospital for a 30-mile radius and serve a four county area. Last year we provided services to 47,000 emergency room patients, 22,000 outpatients, delivered more than 1,000 babies and admitted over 9,000 patients.

It is important in this debate to get an idea of where we get our operating revenue and how that money is used.

We get fifty-five percent of our revenue from treating Medicare patients and twelve percent of our revenue from treating Medicaid patients. An additional twenty five percent of our revenue comes from various commercial and governmental sources. Eight percent is charity care and bad debt.

Salaries and benefits make up fifty percent of our expenses. We spend twenty-two percent of our revenue on medical supplies, six percent on professional fees, and twenty two of our expenses represent percent on maintenance and utilities, debt service, provisions for bad debt, depreciation and amortization.

We are left with a net income was about 3.5 cents on the dollar. These funds are reinvested in equipment, renovation, and building programs.

Even though our facility is larger than most rural facilities, we still face the same threats as other rural facilities throughout Mississippi. Like every other facility in our area we face declining reimbursement, an increasing load of charity and bad debt, cost pressure from labor shortages and regulatory changes, enormous difficulty in recruiting and retaining physicians, and difficulty in gaining access to capital for investment in our facilities.

Before discussing the threats, it is important to understand the importance of our rural hospital to our community. A rural hospital is not just another hospital. South Central Regional Medical Center is typical of many of these rural facilities.

We are the only hospital for a large geographic area and provide the backbone of health care delivery in our area. We are the ones that recruit the physicians, nurses, nurse practitioners, therapists and other health care professionals.

We are the ones who provide vital services like emergency rooms, ambulances, home health and clinics.

Rural communities, like Laurel, do not have public transportation such as buses, taxi, subways, or rail. Patients often have no choice but to use our emergency rooms as their point of access for care. We are based in a town of 18,000 people, yet provided emergency room treatment to 47,000 patients last year. We are the primary source of medical care for a sizable portion of our population.

South Central is not only the health care safety net of southeast Mississippi, it also contributes significantly to the areas economic well being.

We are one of the region's largest employers and one of the only employers of highly skilled workers. Our employees are actively involved in civic, social, and religious organizations in the towns in which they are located. We are frequently large supporters of economic development. Our own Economic Development Authority cites access to health care as a key factor in attracting business to locate in our area. Our employees are leaders in the community as well as a resource to others.

For a long time, hospitals have played a vital role in rural areas. Now, for the first time in my memory that role is being seriously threatened.

One threat is declining reimbursement.

As a rule, rural hospitals serve a greater proportion, as a percentage of revenue, of Medicare patients than other hospitals. Small changes in Medicare reimbursement can have a devastating effect on these hospitals. Under the current BBA language we will suffer an \$18.0 million loss of anticipated revenue over a five-year period. Because of the BBA, and other regulations we have seen a 50 percent volume reduction in our home health services and a 50 percent reduction in hospice services. A 55 percent reduction in skilled nursing reimbursement is forcing us to seriously evaluate the viability of our skilled nursing facility. We may have to soon eliminate skilled nursing services in our area of Mississippi.

Prior to BBA we were paid what amounted to an average per diem of \$600, today we are paid an average of \$255. This is for all of the care we are expected to provide to a patient. In short, we are to provide room, board, medicine, supplies, nursing staff, physical and occupational therapist, and all other services for the cost of a hotel room in Washington D.C.

Along with the cuts we have already absorbed, we, along with other rural providers, face proposed changes in the definition of hospital based services that threaten to eliminate our rural health clinic. Changes in the home health regulations and proposed changes in reimbursement severely threaten the viability of home health agencies and hospice services. While these services may evaporate, the needs of our patients will not. We are morally and legally responsible to our patients to provide care, but our alternatives are quickly disappearing. When you cut reimbursement the cost of providing care to these patients is shifted to us. These are costs we cannot continue to absorb. We will not compromise on quality, but we may soon be forced to limit the level and type of services we are able to provide our patients.

Staff availability is a second major threat. It is not only a financial concern, it is a quality concern. Hospitals, like businesses are faced with decisions about the allocation of resources. We have to pick and choose how much to spend on property plant and equipment, how much on maintenance, how much on staffing and how much on professional services.

We have cut to the bone in the area of professional services. This summer we reduced staff on paper by reducing the number of hours our staff is required to work. This allowed us to avoid layoffs. We reduced retirement benefits, increase insurance deductibles, and delayed all raises by two months. The raises eventually given were essential to put us in a position to be minimally competitive in salaries.

The reductions still resulted in staff, mostly nursing staff, leaving to go to large cities to seek employment. New Orleans is about two and one half-hours away. A nurse can work one weekend in New Orleans and make more money there than we can afford to pay in one week. As a result we faced a nursing shortage this winter when the patient volumes increased. Health care professionals do not just flock to rural communities like Laurel, MS. They are very difficult to recruit and difficult to retain.

With the projections for Medicare cuts in our facility, we are very concerned about being able to make any adjustments in salaries next year. In addition to nursing shortages, we have been faced with shortages in Registered Records Administrators, Respiratory Technicians, Medical Laboratory Technicians, Physical Therapists, Radiological Technicians and other specialized staff. The care provided at the hospital is only as good as its staff. Shortages can and do threaten quality.

Even more critical to rural hospital survival is the availability of physicians. A significant portion of my time is spent trying to recruit and retain existing physicians. Physicians have numerous options available to them when they come out of

school—most do not include rural communities as their number one preference. In recruiting you consider the spouse and their interests and skills which may not match your community's resources. Without physicians a hospital cannot exist. We have heard much about physician oversupply in our country, I'm here to tell you that we don't have an oversupply of doctors in rural America.

A final significant threat is availability of capital. Many rural facilities, like ours were built under the Hill-Burton program in the late 1940's and early 1950's and have not been significantly updated since that period. Changes in technology and the resulting structural demands on buildings to house new equipment, and to meet changing needs of patients and physicians are always present.

Again, our case is typical. We have limited borrowing capacity and do not have access to capital markets. This means we have to update our facility through our net income or reserves. Reduced reimbursement makes this task far more difficult and ultimately will threaten our ability to survive. If you cannot update your facility and medical equipment, you cannot recruit physicians and you cannot provide the services that the community deserves.

Mr. Chairman, this is my first brush with anything remotely like a Senate hearing, and I know I have probably not said all that should be said. I have provided a very brief view of rural hospitals, and some of the threats they face. We are not perfect, but we have worked hard to improve our efficiency. I believe strongly that rural community hospitals are an essential part of providing health resources to all citizens in the country. To allow rural hospitals to fail reduces, or in some cases will effectively eliminate, access to health care for those who chose to live in rural areas. With the closure of a rural facility, not only do the residents of the community lose access to health care, they also lose a key component in their ability to grow in the future.

I had the opportunity to visit Washington in January and was impressed with the seriousness in which the individuals I met take their responsibility to their constituents. I know a great many resources occupy your time, but I encourage you to talk to your constituents, to nurses, nurse aides, therapist, and physicians and to elderly members of your family. Ask them where would they go for healthcare if their local hospital closed or eliminated key services such as the emergency room. Ask your local business leaders if they can recruit staff to their business if they have no access to healthcare.

I don't claim to be an expert in anything, but I am a person that has some experience in rural health care, and I am concerned about the future of our rural hospitals.

Thank you for this opportunity to address this committee and for your patience and consideration of this important issue.

Senator COCHRAN. Thank you, Mr. Higginbotham, for your excellent statement. It is very helpful to the hearing that we are having today.

Ms. Klawiter, we appreciate your coming down from Wisconsin. You may proceed.

**STATEMENT OF ANNE KLAWITER, CHIEF EXECUTIVE OFFICER,
SOUTHWEST HEALTH CENTER, PLATTEVILLE, WISCONSIN**

Ms. KLAWITER. Mr. Chairman, members of the committee, I am Anne Klawiter, Chief Executive Officer of Southwest Health in Platteville, Wisconsin. I am here today on behalf of the Federation of American Health Systems and its nearly 1,700 privately owned and managed hospitals nationwide.

Thank you for this opportunity to present to the committee our views on the impact of the Balanced Budget Act of 1997 and in particular the impact of those policies as they affect rural America.

Southwest Health Center is a nonprofit health care organization located on three campuses in three communities. We operate a 35-bed acute care hospital, a 10-bed psychiatric facility for geriatric patients, a 94-bed skilled nursing facility, and a 16-bed community-based residential facility. These services as well as many outpatient services are typical of rural providers, who often are the sole source of primary health care in their communities.

We employ 299 health care professionals dedicated to delivering quality patient care. Our center relies on Medicare for 69 percent of its gross inpatient revenues.

The Balanced Budget Act offers many challenges for all of us. Myself and my colleagues as providers and you as Senators are faced with the tough decisions on how to best allocate our health care dollars. I personally am not afraid of challenge nor of change. Over the past 15 years we have eliminated 85 acute care beds and consolidated hospital programs and services from three separate organizations encompassing three separate communities into one location.

However, I have some grave concerns regarding the opportunity or the lack thereof for rural health providers to continue to offer quality patient care and services in light of the reimbursement changes. In fact, due in large part to the cuts from the Balanced Budget Act, Southwest Health Center's operating margin for current programs will decline over a 2-year period of 92 percent.

The transfer provision of the Balanced Budget Act is creating serious problems, especially for rural hospitals that typically care for a large percentage of Medicare patients. The transfer provision penalizes hospitals with shorter than national average lengths of stay and undercuts the basic principle and objective of the prospective payment system for inpatient care. Therefore, the provision unnecessarily and unreasonably penalizes hospitals for effective and efficient treatment and for moving post-acute care patients into the most appropriate setting to receive needed services to maintain their quality of life.

The transfer provision is reportedly having a greater negative financial impact on hospitals than was originally estimated. I urge the Congress to act to repeal the transfer policy.

Another area of significant concern is the proposed Medicare outpatient prospective payment system. The basics of the new payment system will reimburse hospitals for Medicare outpatient services according to ambulatory payment classifications, or APC's, at established rates which would be similar to inpatient DRG's. The Health Care Financing Administration has estimated that APC's will hit rural hospitals particularly hard, in part because rural hospitals are handicapped by lower volume and have greater difficulty spreading losses to other areas.

In short, small rural hospitals with lower volumes are at a disadvantage. As a result, we may be forced to eliminate services that are unlikely to be provided elsewhere in the community, thus creating a potential access problem.

To give you an example of the real world impact of BBA policies, when the elimination of the so-called formula-driven overpayment went into effect our hospital lost \$60,000 in one year. This \$60,000 is equal to 18 percent of our entire operating margin. In addition, I understand that if HCFA's proposed outpatient rule remains unchanged, hospitals will be asked to shoulder an additional \$900 million a year, a cut through a formula design that alters its budget neutrality intention.

There were 77 Senators, including the majority of this committee, who sent a letter to HCFA asking that the Department re-

flect Congressional intent in its final rule and ensure that this additional hit to hospitals is not implemented.

All hospitals are concerned with the fact that under the BBA the hospital market basket index, which is a proxy for hospital inflation or the cost of goods and services used, does not keep pace with inflation. Congress has the power to do many things, but it cannot control inflation. This is important because some 70 percent of our operating costs are labor-related. Particularly in rural areas, where labor markets are very tight and it is especially difficult to attract and retain adequately trained health professionals, Medicare payment updates must do a better job of recognizing the increasing costs of quality care.

As noted previously, Southwest Health Center also operates a skilled nursing facility. Changes in the way nursing home care is reimbursed has created a significant administrative burden. The new prospective payment system for nursing home care and consolidated billing requirements have forced us to add at least one administrative employee just to administer the regulations. In fact, overload and ambiguity in Medicare regulations are an extreme burden for all health care facilities.

Recently I had the privilege to participate in a study which was commissioned by the Wisconsin Department of Commerce and the Wisconsin Health and Education Facilities Authority. The study evaluated the importance of the health care sector on the overall economic well-being of Grant County, where Southwest Health Center resides. It found, first of all, every job lost in the health care industry causes a job to be lost in another local industry. Second, every dollar of revenue that was generated by the health care industry generated an additional \$1.30 of revenue in other industries in Grant County.

Rural communities are often interwoven in this way. When there are changes to health care delivery, they must certainly impact the quality and the quantity of services available to local residents. As this study underscores, these changes have serious economic implications for other industries in the county as well.

Members of the committee, you should also know that rural Wisconsin already receives 33 percent less per Medicare beneficiary than the national average. With the costs of advances in such important areas as technology and drugs, it is imperative that hospitals have the financial ability to keep current with state of the art medicine.

What to do? What do all of these changes mean for Southwest Health Center's ability to deliver quality patient care and contribute to the overall financial well-being of Grant County? With many BBA cuts yet to be implemented, coupled with the ever-increasing salary and supply expenses, it seems highly unlikely that Southwest Health Center will be able to sustain delivering quality patient care. The impact of Medicare reimbursement is far-reaching and deserves careful consideration.

PREPARED STATEMENT

Thank you for the opportunity to share my experiences with you. I look forward to working with you to rebuild some of the Balanced Budget Act's damage for hospitals across the United States.

[The statement follows:]

PREPARED STATEMENT OF ANNE KLAWITER

Mr. Chairman, I am Anne Klawiter, Chief Executive Officer of Southwest Health Center in Platteville, Wisconsin. I am here today on behalf of the Federation of American Health Systems and its nearly 1,700 privately-owned and managed hospitals nationwide. Thank you for this opportunity to present to the Committee our views on the impact of the Balanced Budget Act of 1997, and in particular the devastating impact of these policies on rural America.

Southwest Health Center is a nonprofit health care organization located on three campuses, in three communities. We operate a 35-bed acute care hospital, 10-bed psychiatric facility for geriatric services, a 94-bed long-term care facility, and a 16-bed community based residential facility. These services, as well as many outpatient services, are typical of rural providers who often are the sole source of primary healthcare in their communities. We employ 299 healthcare professionals dedicated to delivering quality patient care.

I am told that recent federal analyses estimates that the Balanced Budget Act (BBA) of 1997 saved more than double its intended savings goal. This means that on top of implementing the most extensive reforms to the program since its inception, the BBA has asked providers to shoulder more than twice the reimbursement reductions voted on by Congress. I am sure I don't have to tell you that these kinds of cuts have serious consequences. I work in the real world of rural health care delivery, and I can testify that this major piece of legislation is resulting in significant changes for caregivers, and the patients we serve.

I urge the Committee to seriously evaluate the consequences of the Balanced Budget Act and to protect the interest and the security of your rural constituents.

Several respected research organizations have analyzed the impact of the BBA on hospitals, most recently the HCIA has published independent findings that reflect what I know to be happening in my state and in other rural regions of our country.

—Hospitals Medicare margins have declined to .1 percent in 1999¹

—Once the BBA is fully implemented, the medical hospital margin is expected to fall to negative .28 percent²

—Medicare outpatient margins are negative 17 percent today, and declining to 28 percent by 2002. Note that this is BEFORE the additional 5.7 percent unanticipated reduction in the new draft Outpatient PPS regulation that has been circulated by the Health Care Financing Administration. I commend Senator Cochran for taking a leadership role in raising this issue with his colleagues and HCFA.

—Small, rural hospital margins are expected to fall a startling 233 percent over five years.³

SOUTHWEST MEDICAL CENTER'S STORY

At Southwest Health Center, we rely on Medicare for 69 percent of our gross inpatient revenue. This is a change from a few short years ago when Medicare made up 57 percent of our inpatient mix. However, as the population ages, and the nation's demographics shift to urban and suburban America, this kind of dependence on Medicare payment will continue, particularly in rural communities.

In addition, nearly 52 percent of our total hospital revenue comes from providing outpatient services. Many people do not recognize that hospitals are already losing money by providing outpatient services. The BBA significantly reduced already inadequate outpatient payments. The viability of providing continued outpatient care clearly becomes an issue when this kind of reduction is implemented. How long can we continue to operate these necessary services in the red?

To give you an example of a real-world impact of the BBA, recently I presented the corporate annual budget to the Board of Trustees. Along with the operational budget, the Board needed to consider capital expenditures. I presented a list capturing over \$3 million dollars of requests for well-justified and necessary capital improvements. Due to expected revenue and cash flow expectations, almost half of the requests needed were denied. What does that mean for Southwest Health Center? It means that development of needed community healthcare programs have been denied, air handling equipment will not be replaced, sidewalks will not be repaired, and most importantly some patient care and safety items will be delayed. Many re-

¹ 1999 HCIA "The BBA and a Guide to Hospital Performance."

² 1999 HCIA "The BBA and a Guide to Hospital Performance."

³ 1999 HCIA "The BBA and a Guide to Hospital Performance."

quests simply could not be denied, as they were essential to direct patient care. As a consequence, with this additional spending to maintain patient quality, my hospital will be forced to expend more for capital improvements that our operating cash flow can support. Where does the money come from in the future to satisfy growth and development of services and ensure quality patient care?

RURAL SNAPSHOT

It is important to understand that rural hospitals depend much more heavily on Medicare payments than do their urban counterparts. Consider the following:

- Medicare is the most important source of payment for rural hospital patients, comprising 47.2 percent of total payments versus 39.1 percent in urban areas.⁴
- In addition, rural residents are typically older, poorer and sicker than non-rural populations.
- Total margins for small, rural hospitals will fall from 4.2 percent in 1998 to NEGATIVE 5.6 percent in 2002, largely due to the BBA⁵
- Capital access tends to favor large institutions, yet rural capital needs for equipment replacement, technology and programs remain high.
- Rural hospitals have less flexibility to reduce fixed and variable costs.

Given this snapshot, it should be clear that rural hospitals such as Southwest Health Center are more vulnerable to Medicare payment reforms and reductions.

THE BBA WENT TOO FAR—WHAT SHOULD CONGRESS FIX?

America's hospitals have given above and beyond the call of duty to the important goal of balancing our federal budget. It is now time to examine closely the impact of many of the unintended consequences of the BBA. Our nation's hospitals, and the patients and communities we serve need some relief from these drastic payment reductions.

Specifically:

Repeat the Balanced Budget Agreement's Transfer Policy

This policy cuts hospital payments for patients who are discharged to post-acute settings such as rehabilitation centers, nursing homes, or their home where they receive home health care. The transfer policy is inconsistent with the goals of the prospective payment system, and it turns its back on advances in patient care. One of the key advances of this decade with regard to patient care is the ability of hospitals to be responsive to each patient's medical needs and treat those needs in the most appropriate care setting. Clearly, it is in patients' interest to move them to less intensive care settings when appropriate.

In addition, the transfer policy creates an administrative nightmare for hospitals. Hospitals are now required to keep track of what happens after a patient is discharged to another setting. An illustration: A patient is discharged with no plan for further treatment. Several days later the patient's physician decides that they should begin receiving home care, but does not notify the hospital. The hospital is now at financial and legal risk. The original payment must now be adjusted to reflect the per diem methodology rather than payment based on the DRG. This creates a near impossible situation for hospitals by requiring them to track patients post discharge and requiring hospitals to constantly go back and readjust charges.

Outpatient PPS

Outpatient payment policy has been flawed for many years. The BBA included outpatient savings totaling \$7.2 billion through a number of outpatient related provisions, including the elimination of the so-called "formula-driven overpayment." While these BBA payment reductions clearly have serious financial implications for hospitals, hospitals accepted those cuts in good faith, as a painful but necessary step toward a more rational prospective payment system.

However, the Health Care Financing Administration has proposed in its implementing rule, a change to the PPS formula that would alter its original budget neutrality concept. The result: HCFA estimates that its interpretation of the statutory language will cost hospitals an additional \$900 million per year or \$4.5 billion over five years—this is an unexpected, and additional cut to an already vulnerable patient care arena. For rural hospitals this proposal is estimated to be even greater—an additional 7.4 percent cut.

As mentioned earlier in my testimony, outpatient margins have been estimated to fall to a negative 28 percent by 2002, even without this additional cut. Adding

⁴ 1999 Tiber Group "New Rules, New Roles for Rural Healthcare Providers."

⁵ 1999 HCIA "The BBA and a Guide to Hospital Performance."

this unanticipated reduction would push hospital reimbursement for outpatient services even further into the red. This is bad for hospitals and worse for patients.

Hospitals and outside legal experts believe that HFCA is not required to follow its current narrow reading of the language of the statute. We believe it has the flexibility to adopt a rule reflecting Congress' clear intent, and we encourage HCFA to revisit its interpretation. A recent letter signed by 77 Senators, many of whom sit on this subcommittee, seeks to clarify Congress' intent. We hope that HCFA will listen to the vast majority of sitting Senators and not impose this additional cut on hospitals.

Medicare Bad Debt

Under federal law, hospitals, as part of their contract with communities and patients, treat all patients, regardless of their ability to pay. Until the enactment of BBA, hospitals were fully reimbursed for Medicare-based bad debt, once a hospital could show they exercised due diligence to collect the unpaid bill from the patient. BBA cut that reimbursement to 55 percent.

As you know, there is a hefty \$768 deductible charged to Medicare beneficiaries for inpatient hospitalizations as part of the Medicare program. Almost 80 percent of seniors are covered by Medigap insurance, which helps defray the costs of the deductibles and copays. About 10 percent of seniors are poor enough to qualify for Medicaid, which covers these costs. The remaining 10 percent of Medicare recipients—the near poor—often cannot and do not pay their Medicare hospital deductible. It is this population that accounts for the bulk of Medicare bad debt, many of whom live in rural communities. The bottom line is these patients do not have the money to pay, no matter how much time and resources a hospital expends in attempting to collect the money.

This is a government program—hospitals that care for near-poor seniors should not be financially disadvantaged for serving these deserving patients. Full Medicare reimbursement for bad debt is essential to the survival of many hospitals, particularly those with a high percentage of near poor Medicare patients. Without this reimbursement, areas with a high concentration of elderly poor patients, such as many rural areas, could be faced with reduced access to services.

This funding is critical to the financial health of hospitals that provide quality care across this nation to low income seniors. Unfortunately, things seem to be moving in the wrong direction. Just before the July 4th recess, the Senate Finance Committee voted to fund a veterans' bill with a further cut to bad debt. While I certainly understand the notion of helping veterans, hospitals should not be hit again. This action sent chills down the spines of hospital administrators across this country.

MEDICARE REFORM

The Federation has long been a supporter of comprehensive Medicare Reform. We submitted detailed recommendations nearly a year ago to the Medicare Commission led by Senator Breaux and Congressman Thomas. It is certainly time to give seniors the same choices of plans that we all have in the private sector. However, we are concerned that each of the current Medicare Reform packages has included cuts for providers to pay for policy changes. As the effects of the BBA should surely indicate, wholesale change in this provider cut approach is badly needed.

For instance, the Clinton Medicare Reform plan, released just last week, contained an additional \$39 billion in Medicare cuts. In most cases the plan extends cuts contained in BBA for an additional seven years, until 2009. Clearly, the Administration doesn't realize the impact these cuts have had on hospitals. Hospitals are reeling under what we have been faced with in BBA—seeing no light at the end of the tunnel will send a very unfortunate signal to hospitals across this county—that Washington just doesn't get it.

The Administration did include a modicum of recognition for the circumstances many health care providers face—nursing homes, home health and hospitals. The plan does include a "quality assurance fund" of \$7.5 billion over 10 years to assist with provider circumstances where substantial quality or access problems could be demonstrated. While we are grateful for this recognition, the cuts, just over the course of the BBA, through 2002, are now expected to be \$206 billion, double the level voted on by the Senate in 1997. \$7.5 billion will not go far among all providers hit by the BBA.

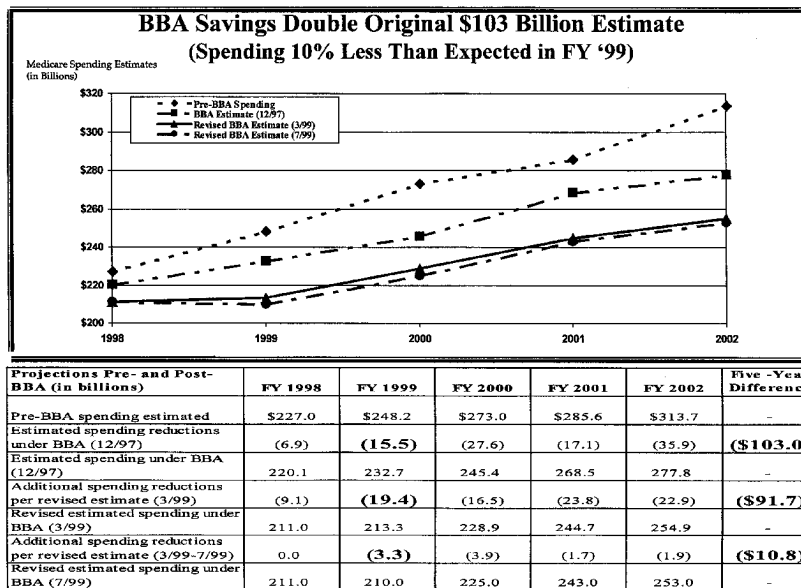
As I mentioned in my earlier testimony, one of the priorities for the industry has been repeal of the ill-advised transfer policy that was enacted as part of the BBA. The Secretary of HHS was given the authority under the BBA to expand transfer policy beyond the 10 DRGs it applies to, to all DRGs. The President's Medicare plan would delay this expansion to 2002; not much comfort for hospitals that strongly

believe that the policy itself should be repealed. The message many hospitals are hearing is that we will only make the cuts worse later!

CONCLUSION

The central question that the Administration and Congressional leaders must answer is "How can we hope to ensure a sound future for Medicare if we are dangerously eroding the financial solvency of the nation's health care institutions?" The Balanced Budget Agreement of 1997 has caused real pain for our nation's hospitals and the communities they serve. The Congress is right to examine the repercussions of payment reductions that in the real world have translated into double their original intent. Members of the Committee, I run a hospital in rural America and I am here to tell you that we need your help in meeting our shared goal of continuing to provide the best quality health care in a fiscally prudent environment.

Thank you for the opportunity to share my slice of America with you this morning. We look forward to working with you to rebuild some of the BBA's damage to hospitals across the U.S.



Sources: CBO, "The Economic and Budget Outlook: An Update", July 1, 1999; CBO, "An Analysis of the President's Budgetary Proposals for FY 2000: A Preliminary Report", March 3, 1999; CBO, "Budgetary Implications of the Balanced Budget Act of 1997", December 1997.

Senator COCHRAN. Thank you, Ms. Klawiter, for your helpful statement.

Our next witness is Ms. Deborah Griffin, who is Administrator of the Humphreys County Memorial Hospital in Belzoni, Mississippi. Thank you very much for being here. You may proceed.

STATEMENT OF DEBRA L. GRIFFIN, ADMINISTRATOR, HUMPHREYS COUNTY MEMORIAL HOSPITAL, BELZONI, MISSISSIPPI

Mr. GRIFFIN. Mr. Chairman, Senator Durbin, staff members and guests of the committee, I am Debra Griffin, Administrator of Humphreys County Memorial Hospital, a 28-bed small rural acute care hospital located in Belzoni, Mississippi. It is called the heart of the Mississippi Delta. It is my honor to appear before you today to present testimony on the effects of the passage of the Balanced Budget Act on rural hospitals in Mississippi.

The Mississippi Delta is impoverished and underserved. Humphreys County, with a predominantly rural population and agricultural base, is characterized by high rates of poverty and unemployment and low levels of educational attainment. Two-thirds of the children born each year are born to single or teen mothers and the majority of the children live in households with incomes below the poverty level. All available data indicate poor health outcomes.

Humphreys County Memorial Hospital is a member of the Delta Rural Health Network. The Delta Rural Health Network is a network of 10 small rural hospitals that share a common vision, to improve the delivery of health care and financially strengthen each rural hospital. All of the participating network hospitals are at risk both financially and strategically. As stand-alone facilities, we are the true small rural hospitals.

All of the network hospitals' percentage of total discharge paid by Medicare-Medicaid and charity bad debt services are above the national averages. Such losses and allowances for Medicare and Medicaid cannot be recouped from our extremely small private pay and insurance sector.

Small rural hospitals have a large disproportionate share of Medicare and Medicaid patients. Conversely, we have a smaller private pay population. If a hospital is 70 percent Medicare and Medicaid and you have a 10 percent cut in reimbursement, that translates to a 7 percent reduction in total revenue. Small rural hospitals do not have the ability to increase revenues by increasing charges. This partly explains why initiatives such as the Balanced Budget Act are having such a devastating effect on our small hospitals.

With the committee's indulgence, please allow me to outline four examples of the financial impact on small rural hospitals in Mississippi. South Panola Community Hospital in Batesville, Mississippi, is losing \$1.4 million net for the period fiscal year 1998 to 2002. King's Daughters Hospital in Yazoo, Mississippi, is losing \$2.6 million net for the same period. Montfort Jones Memorial Hospital in Kosciusko, Mississippi, is losing \$2 million for the same period. And Humphreys County Memorial Hospital is losing \$8.1 million net for the same period.

These amounts might not seem alarming to you in itself. However, when you are a provider of health care services in a county without a strong economic tax base and when patient needs and vendors' costs are increasing, these numbers become a recipe for devastation.

In this situation, your options are limited. You can reduce or eliminate services, triage patients and only treat the true emergency or acute, postpone capital purchases and, if you are lucky, building projects, or simply close the county's most valuable asset.

True small rural hospitals need special legislation and policy consideration from decisionmakers regarding Medicare reimbursement. Just because we live in rural Mississippi does not mean that we should not enjoy the same benefits and access to health care as other Americans. The ever-changing rules for Medicare and Medicaid are overwhelming to our small facilities. Small and rural hospitals do not have the administrative staff to implement such changes at such rapid rates.

Members of our network believe that HCFA should be required to do pilot projects at truly rural small primary care hospitals before they implement complete system changes. In addition, it should be noted that many of our facilities are Hill-Burton hospitals and have aged. The Hill-Burton program provides funding to build these rural hospitals, but made no provisions for capital to renovate and update them. With no access to capital, our aging buildings have become dinosaurs and, along with the Balanced Budget Act, our ability to provide adequate health care is limited.

It is good, sound, economic policy to invest in rural health care. A healthy hospital can assist in making a community healthy and financially stronger.

I am not a native Delta, I am a transplant. I love where I work and I love the people that I work with, and I also feel like the song "Cheers," the comedy, that says "Wouldn't you like to go to a place where everybody knows your name and they're glad that you came." That is how I feel about Belzoni and Humphreys County.

PREPARED STATEMENT

I think that, instead of listening to the policy wonkers about the numbers and the percentages of operating margins and looking closely and studying the situation, that there are real issues that are really affecting rural people. Our hospital is a necessary entity to our community, and we are good stewards of the dollars that come in and we appreciate it. But we do need special consideration. [The statement follows:]

PREPARED STATEMENT OF DEBRA L. GRIFFIN

Mr. Chairman, Senator, Staff members and guests of the committee, I am Debra L. Griffin, Administrator of Humphreys County Memorial Hospital, a 28 bed small rural acute care Hospital located in Belzoni, Mississippi in the heart of the Mississippi Delta. It is my honor to appear before you today to present testimony on the effect of the passage of the Balanced Budget Act of 1997 on rural hospitals in Mississippi.

The Mississippi Delta is the most impoverished and under served region in the United States. Humphreys County, with a predominantly rural population and agricultural base is characterized by high rates of poverty and unemployment and low levels of educational attainment. Two thirds of the children born each year are born to single or teen mothers, and the majority of the children live in households with incomes below the poverty level. All available data indicate poor health outcomes.

Humphreys County Memorial Hospital is a member of the Delta Rural Health Network. The Delta Rural Health Network is a network of ten small, rural hospitals that share a common vision to improve the delivery of healthcare and financially strengthen each hospital.

All of the participating network hospitals are at risk both financially and strategically. As "stand alone" facilities, we are the true small rural hospitals.

All of the network hospital's percentages of total discharges paid by Medicare, Medicaid and Charity Bad Debt services are above national averages. Such losses and the allowances from Medicare and Medicaid cannot be recouped from our extremely small private pay and insurance sector.

Small rural hospitals have a large disproportionate share of Medicare and Medicaid patients; conversely, we have smaller private pay population.

If a hospital is seventy percent Medicare and Medicaid and you have a 10 percent cut in reimbursement, that translates to a seven-percent reduction in total revenue. If a hospital is forty percent Medicare and Medicaid, a cut of 10 percent is only a 4 percent reduction in total revenue. A hospital with a patient population of 70 percent Medicare/Medicaid (this is probably average for our facilities) will have only 5 percent to 10 percent paying patients, with the remaining being charity or bad debt. In the situation described above our hospitals would face a reduction of \$7.00 per \$100.00 of revenue. With only 10 percent paying patients you must increase the

charges that brought in the \$100.00 in revenue by \$70.00 to regain a net revenue of \$100.00, as only 1 in 10 patients actually pay the increase—an increase of charges of \$1.00 will only produce 10 cents in payments.

Small rural hospitals do not have the ability to increase revenue by increasing charges. This partly explains why initiatives such as the Balanced Budget Act are having such a devastating effect on the small rural hospitals.

With the committee's indulgence, please allow me to outline four examples of the financial impact of the Balanced Budget Act of 1997.

—South Panola Community Hospital in Batesville, Mississippi is losing 1.4 million net dollars for the period of fiscal year 1998 to 2002

—King's Daughters Hospital in Yazoo City, Mississippi is losing 2.6 million net dollars for the period of fiscal year 1998 to 2002

—Montfort Jones Memorial Hospital in Kosciusko, Mississippi is losing 2 million net dollars for the period of fiscal year 1998 to 2002 and,

—Humphreys County Memorial Hospital is losing 8.1 million net dollars for the period of fiscal year 1998 to 2002

These amounts might not seem alarming to you in itself, however, when you are a provider of health care service in a county without a strong economic tax base, and when patient needs and vendor costs are increasing, these numbers become a recipe for devastation.

In this situation, your options become limited. You can reduce or eliminate services, triage patients and only treat true acute and emergencies, postpone capital purchases and if you're lucky building programs, or simply close the county's most valuable asset.

True small rural hospitals need special legislation and policy consideration from decision makers regarding Medicare reimbursements. Just because we live in rural Mississippi, it does not mean that we should not enjoy the same benefits and access to health care as other Americans.

The ever-changing rules from Medicare and Medicaid are overwhelming to our small facilities. Small and rural hospitals do not have the administrative staff to implement changes at such rapid rates.

Members of our network believe HCFA should be required to do pilot projects at truly small rural primary care hospitals before issuing rules that require complete system changes.

In addition, it should be noted that many of our facilities are Hill Burton hospitals and have aged. The Hill Burton program provided funding to build these rural hospitals but made no provision for capital to renovate and update them. With no access to capital, our aging buildings have become dinosaurs and along with the Balanced Budget Act, our ability to provide adequate health care is limited.

It is good sound economic policy to invest in rural healthcare—a healthy hospital can assist in making a community healthy and financially stronger.

Senator COCHRAN. Thank you very much, Ms. Griffin, for this information. We appreciate your being here.

Mr. King, thank you for being a part of this panel. You may proceed with your testimony now.

**STATEMENT OF ROLAND E. "GUY" KING, CONSULTING ACTUARY,
FORMER CHIEF ACTUARY, HEALTH CARE FINANCING ADMINISTRATION**

Mr. KING. Thank you, Mr. Chairman.

Senator COCHRAN. Would you pull the microphone close to you so we can hear you.

Mr. KING. Certainly.

Thank you, Mr. Chairman. I am a self-employed consulting actuary and I was the Chief Actuary of the Health Care Financing Administration from 1978 to 1994.

The previous three witnesses have put a human face on the impact of the BBA. Let me give you a few of the numbers that are behind that human face. I recently participated in a study together with Ernst & Young and HCIA, a study that you referred to previously in this hearing, in which we studied the effect of the Balanced Budget Act on hospitals in general. Now, our purpose was

not to dispute MedPAC's fine work. Our purpose was to supplement and extend MedPAC's work, and by and large what we did was consistent with what MedPAC has done.

We felt that previously too much attention had been focused on inpatient hospital margins alone, and the reason that we felt that way is because the hospital industry has diversified, and as they have diversified into areas such as outpatient, skilled nursing facility, and home health agency services, it has allowed them to spread their fixed costs over these additional services in an accounting sense. That makes the inpatient hospital margin look artificially high. That is partially what is responsible for the reason why inpatient margins look so healthy up to now.

Our study, as I said, wanted to present a more complete picture and we felt that we could do that by using more current cost report data than was used in the latest MedPAC study, projecting total Medicare margins, not just inpatient but total Medicare margins, and also assessing the impact of the BBA by modeling the effect of the BBA on actual hospital cost reports.

Even though rural hospitals were not the primary focus of our study, using small hospitals with 99 beds or less, which these are predominantly rural hospitals, we found that the small hospitals are hardest hit by the BBA. Their margins are significantly decreased, from 4.2 percent in fiscal year 1998 to negative 5.6 percent in fiscal year 2002. We felt that when hospitals—we also noted in our report that when hospitals begin taking the aggressive actions that are necessary to survive under the BBA, such as cutting services, reducing wages, and laying off employees, access to care will be more likely to suffer in rural areas.

Because of the time constraints, let me summarize for you the key findings of our analyses. First, total hospital margins are expected to decline from 4.3 percent in fiscal year 1997 to only .1 percent in fiscal year 1999. Total hospital margins are projected to decline 48 percent in just 5 years, from 6.9 percent in fiscal year 1998 to 3.6 percent in fiscal year 2002. Of course, I already mentioned that total hospital margins for small rural hospitals are expected to fall from 4.2 percent in fiscal year 1998 to 5.6 percent in 2002.

I have mentioned that our findings are essentially consistent with the projections of MedPAC as far as MedPAC goes. It is just that we went a little further.

Hospital outpatient margins, as has been mentioned previously in this hearing, are already negative 17 percent in fiscal year 1998, and they are projected to get substantially worse, dropping to negative 27.8 percent by 2002. The BBA has traditionally—has significantly reduced outpatient payments, payments that were already inadequate.

Our analysis modeled the impact of the formula-driven overpayments, FDO or "Fido," but it did not model the impact of the prospective payment system on outpatient services. But we note that PPS would reduce margins another 3.8 percent according to HCFA's impact analysis.

The BBA's transfer policy reduces hospital inpatient payments by approximately two and a half times more than the original estimates. I think one thing that has come up is that the impact of

the BBA underestimated and this is actual evidence that that problem occurred.

The magnitude of these reductions in margins on Medicare payments should be considered in light of two other significant outcomes that are largely to the BBA. First, we note that CBO projected Medicare spending would be \$191.5 billion lower than was anticipated when the BBA was enacted. CBO's estimate of Medicare spending reductions at the time of enactment was \$103 billion, so I think, although we do not know exactly how much of this reduction in expenditures is due to underestimates at the BBA and how much is due just to a change in baseline, I think that suggests that there was some underestimation of the BBA effects.

The other point is that the BBA cuts have shaken confidence in the health care industry and have led to numerous downgrades in bond ratings for community hospitals. Once again, I would suspect that rural hospitals were especially hard hit and that their access to capital, already tougher than a community hospital in an urban area, is going to be even worse.

PREPARED STATEMENT

That concludes my formal testimony. I will be happy to answer any questions.

[The statement follows:]

PREPARED STATEMENT OF GUY KING

Mr. Chairman, my name is Guy King. I am a self-employed Consulting Actuary. I was the Chief Actuary for the Health Care Financing Administration from 1978 to 1994.

I recently participated in a study, with Ernst & Young, LLP and HCIA, Inc., of the effect of the 1997 Balanced Budget Act (BBA) on the financial condition of the hospital industry. The purpose of this study is to supplement the efforts of Congress, MedPAC, and others attempting to assess the financial status of hospitals.

Previously, attention has been focused on inpatient hospital margins. In today's environment, focusing exclusively on inpatient margins would be misleading. One factor that may have contributed to the increasing inpatient margins pre-BBA is the effect expanded service lines have had on the allocation of fixed costs. Many hospitals have diversified into other service lines, including expanded outpatient, skilled nursing facility (SNF), and home health agency (HHA) services. When these services are added or expanded, fixed costs are spread over not only inpatient care, but the other service lines as well. Spreading fixed costs over all service lines improves the inpatient margin, even when the overall margin is unaffected or getting worse. Stated another way, with revenue held constant, a hospital's inpatient margin improves simply because a smaller amount of fixed costs are allocated to inpatient services.

This study is intended to produce a more complete and current picture of the industry's financial health and Medicare's contribution to hospitals' financial status by:

- 1. Projecting hospital Medicare inpatient margins using more current cost report data;
- 2. Projecting total Medicare margins, including margins for all service lines—e.g., outpatient, SNF, and HHA—not just inpatient acute care; and
- 3. Assessing the impact of the BBA on total hospital margins through modeling of actual hospital cost report data.

Congressional decisions that could ultimately determine the financial fate of community hospitals across the country should be made with a thorough understanding of hospitals' financial health.

Rural hospitals are not the primary focus of the study. However, when the results are stratified by bed size, the total margins for small hospitals with 99 beds or less, which are predominantly rural, are hardest hit by changes under the BBA. Their margins significantly decrease from 4.2 percent in fiscal year 1998 to negative 5.6 percent in fiscal year 2002. It is also noted that when hospitals begin taking the

aggressive actions necessary to survive the impact of these revenue reductions, such as cutting services, reducing wages, and laying off employees, access to care will be more likely to suffer in rural areas.

Key findings of these analyses are highlighted below.

Toad hospital Medicare margins are expected to decline from 4.3 percent in fiscal year 1997 to only 0.1 percent in fiscal year 1999. These margins are projected to remain below 3 percent through fiscal year 2002, the duration of the Balanced Budget Act (BBA) payment reduction provisions.

Total hospital margins are projected to decline 48 percent in just five years, from 6.9 percent in fiscal year 1998 to 3.6 percent in fiscal year 2002. While total hospital margins for all hospitals would have decreased even if the BBA had not been enacted, these margins are significantly smaller under the BBA and decrease at a much faster rate during the five-year period.

Total hospital margins for small, rural hospitals are expected to fall from 4.2 percent in fiscal year 1998 to negative 5.6 percent by fiscal year 2002.

Findings on hospital Medicare inpatient margins are consistent with MedPAC. While these findings—which revealed that hospital Medicare inpatient margins decreased from 16.9 percent in fiscal year 1997 to 16.5 percent in fiscal year 1998—are consistent with those of the Medicare Payment Advisory Commission (MedPAC), they represent only a portion of the overall fiscal picture for hospitals.

Hospital outpatient margins are already negative 17 percent in fiscal year 1998, and are projected to get substantially worse, dropping to negative 27.8 percent by fiscal year 2002. The BBA has significantly reduced outpatient payments, payments that were already inadequate. This analysis modeled the impact of the elimination of the formula-driven overpayment (FDO), but not the impact of the outpatient prospective payment system (PPS). The PPS would reduce margins another 3.8 percent, according to HCFA's impact analysis that was published in a September 1998 proposed rule. As outpatient revenues continue to increase as a portion of total hospital revenues, the impact of these negative margins will be even more injurious to hospitals.

The BBA's transfer payment policy reduces hospital inpatient payments by approximately two and a halftimes more than original estimates. The transfer policy reduced inpatient payments between \$500 and \$800 million in fiscal year 1999, and by approximately \$3 billion between fiscal years 1998 and 2002. The Congressional Budget Office (CBO) had estimated a \$1.3 billion five-year budget impact when the BBA was enacted in 1997.

The magnitude of these reductions in margins and Medicare payments must be considered in light of two other significant outcomes attributable largely to the BBA:

The CBO projects Medicare spending will be \$191.5 billion lower than was anticipated when the BBA was enacted. Recent CBO spending estimates for Medicare project total spending to be \$191.5 billion less than original estimates for fiscal years 1998 through 2002. CBO's estimate of Medicare spending reductions at the time of BBA enactment was \$103 billion.

BBA cuts have shaken confidence in the health care industry and have led to numerous downgrades in bond ratings for community hospitals. Many analysts are attributing much of the precipitous drop in health care bond ratings to the impact of the BBA. Lowered bond ratings ultimately impair a hospital's ability to access capital to finance technological and facility improvements which, in turn, negatively affect patient access to, and quality of, care.

I will be pleased to try to answer any questions you may have.

Senator COCHRAN. Thank you very much for your giving us this information and giving us the benefit of your study and review of the financial condition of rural hospitals, and particularly the impact that changes made under the Balanced Budget Act have caused.

It appears from what you tell me that rural hospitals have been affected disproportionately by the unintended consequences of the Balanced Budget Act. Is that an accurate assessment?

Mr. KING. Yes, that is what it appears to be.

Senator COCHRAN. We have an indication, and I think you referred to it in your statement, that the Congressional Budget Office anticipated that there would be less spending under the Medicare program as a result of the Balanced Budget Act, but their esti-

mates were not nearly consistent with what the facts have turned out to be. Is that what you are telling us?

Mr. KING. Well, we know that the change in spending projections is \$191 billion lower than what it was under the BBA. The CBO's estimate of savings under the BBA was \$103 billion. I think, although there have been things mentioned earlier in this hearing about what could be the causes of that change in projections—inflation being lower than projected, the fraud, abuse, and waste efforts—but I think there is also evidence that CBO underestimated the impact of the BBA, particularly, as Gail Wilensky mentioned, particularly when the combined impact of all the provisions of the BBA is taken into account.

Senator COCHRAN. Well, since the savings have been much greater, whether they are due to the Balanced Budget Act and the implementation of that act or not, do you think this justifies the Congress and the administration getting together and trying to rectify the impact that those reduced spending levels have had on the financial condition of health care providers throughout the country?

Mr. KING. Yes, I think even the administration has acknowledged that if the BBA went too far, that there is a need to put money back into the system where the BBA went further than intended.

Senator COCHRAN. Let me go now to the witnesses who talked about the practical consequences on their own hospitals and medical centers that they operate. Ms. Griffin talks about the Mississippi Delta and in particular the Humphreys County Hospital there and the network that you are a part of. Let me ask you this. I am told that there are six hospitals in Mississippi that will be closed by the end of the year or soon thereafter unless some changes are made in this Balanced Budget Act or some of the other Federal programs that provide reimbursements to hospitals.

Are there any hospitals in your network that you know of that are a part of this group that are likely to be closed?

Ms. GRIFFIN. Senator, there are 10 hospitals in our network and there are two that are in weakened states, and there are others like myself that could be there if some relief does not come to fruition.

The Delta Rural Health Network was organized because small rural hospitals wanted to try to control their own future. Peter Drucker says the best way to predict your future is to create it. HRSA under Dr. Fox gave us a network grant and we have had wonderful synergy in working together in trying to share our successes and talk through some of our failures or problems.

I cannot speak to other hospitals and their specific financial state. I do know that, because my hospital is so small and we do provide other services and needs to the community, but our county is not able to subsidize us in any form. The services that we provide, we are either going to get the money from Medicare or the insurance payers or from no one, and we could be at risk if we do not have relief.

I specifically want to talk with Brad afterwards about some concerns for our hospital or hospitals our size that I would like to see take place.

Senator COCHRAN. You read off a list of hospitals and towns where they are located. Batesville is one that I remember.

Ms. GRIFFIN. South Panola.

Senator COCHRAN. South Panola.

Ms. GRIFFIN. South Panola Hospital in Batesville, Mississippi; Yazoo City—excuse me, King's Daughters Hospital in Yazoo City, Mississippi, and Montfort General Memorial in Kosciusko. These hospitals are also part of our network.

Senator COCHRAN. Those are hospitals where you can document or they have documented losses as compared to last year's revenues?

Ms. GRIFFIN. Yes, sir.

Senator COCHRAN. These are dropoffs because of reimbursements from Federal programs?

Ms. GRIFFIN. Most definitely, and I have provided the support documentation to Mr. Pruitt.

Senator COCHRAN. Well, we certainly do want to work with you and get your ideas for specific changes. Do you have any that you can mention to me at this point that you think would be helpful? There were some that were suggested by others. What are some of the proposals that you think have merit?

Ms. GRIFFIN. Well, I think the critical access hospital designation, I think they call it the Medicaid Rural Flexibility Act. I think the pilot was done in Kansas, Montana, and Colorado, and the final product that came out probably was good for those hospitals. In Mississippi, and more specifically in the Mississippi Delta, we looked at that critical access designation and thought this would be good for us.

But we are 80 percent Medicare-Medicaid and about 2 to 5 percent private pay, and that is probably being very generous, and the balance is indigent. There is no way if you convert can you have that indigent care population taken care of. We can get our Medicaid-Medicaid costs reimbursed, but then we have got this big gap, which makes the problem really worse.

The other issue is that a couple of years ago a piece of legislation provided for small hospitals like myself to open distinct part PPS geriatric psych units. The thought behind that from the policy-makers was that these units could be paid at cost because these acute elderly patients hit the emergency room and the acute side of the hospital not so much all the time because they have real acute care illnesses, but they have some mental illnesses or they have some social illness where they mixed up their medicines or they did not get their scrips.

The psych unit was put in place the help these patients deal with onset of depression and issues such as that. So we opened the psych unit and we really saw a lot of decrease in our acute care admissions because we were really trying to make this program work and service these patients well. But a year or two after we got this unit open, we saw our inpatient admissions decrease by 150 actual admissions. Then a year later, then HCFA comes and changes how they reimburse that unit. So not only do we suffer on that side of the reimbursement, losing money from that unit, but from the acute care, because we were playing the game like we

thought we needed to play it. So really, by being efficient we were punished.

Senator COCHRAN. Is there any plan to make any other changes? You heard Dr. Fox, for example, talking about bringing together in the community at one site, maybe at the hospital site, some of the senior citizen benefit programs and other activities in the community to try to make more efficient the delivery of services, including health care services, to the people who live in the area.

Has anything like that been tried or considered in Belzoni?

Ms. GRIFFIN. We have an old building and about 8 months ago I presented to the board of trustees and the board of supervisors a concept of a one-stop shop for health care in Humphreys County, and we did a rendering of a multiplex with a hospital, health department, human services, and mental health. Everybody was interested, but we had no way to get capital for that building, and then once we got capital to what margin could we repay that money back?

But I think that that would be a more efficient use of resources in our county, because there are some duplications in those services. And in the rural you have transportation issues, so if someone is coming to get their economic assistance or coming to get their vaccinations they are already on the campus, so they can see the doctor and then they will get their care earlier and they will not have to be in the emergency room.

Senator COCHRAN. Is there a WIC program center, clinic, or other facility there in Belzoni?

Ms. GRIFFIN. Yes, sir, there is a WIC distribution center.

Senator COCHRAN. And it is not a part of the center where you are, though?

Ms. GRIFFIN. No, sir. Everything in our community—I hate to say this—is very fragmented. We are in different locations and different operations and, like everything else, there is turf issues.

Senator COCHRAN. Well, we appreciate so much your being here and discussing these issues with us. We are going to work with you and others similarly situated to try to improve this situation and try to keep these hospitals open and providing services to the extent that it is possible to do so.

Ms. GRIFFIN. Thank you. I want to add that I appreciate your effort and concern in the issues that face us regarding the effect of the Balanced Budget Act. We appreciate that.

Senator COCHRAN. Well, thank you very much.

Ms. Klawiter, you talked about in Wisconsin that there have been some new requirements imposed on medical centers and hospitals under the Balanced Budget Act. The Health Care Financing Administration was required to do some of these. Others I think they had the flexibility to make decisions. But there is one example that I am told is the outcome and assessment information set, called OASIS. Are you familiar with that? Have you ever heard of that? It is for home health agencies.

Ms. Klawiter. I have heard of it. Home health agencies, absolutely.

Senator COCHRAN. Right.

Ms. Klawiter. Southwest Health Center actually is a good example of working cooperatively with two surrounding communities

to offer home health services. We knew that we needed for efficiencies and for quality of care to be delivered to the residents that live within our county, and actually two surrounding counties are served as well, that we cooperate and we work together on our efforts. We are seeing dramatic changes in the home health delivery of services.

The staff—there is one facility who actually holds the license, if you will, and then there are two other hospitals that also have what are called branch offices. In Platteville, we have noticed that there is over a 50 percent decline in personnel available for that unit, simply because of reimbursement.

If I had my physicians here with me, they would love to be able to expound on that because we have recently had several meetings on how on earth are we going to be able to take good care of the elderly and others that live in the community and need these services.

Senator COCHRAN. Are the services being curtailed or reduced, or just unavailable, because of requirements under the new regulations?

Ms. KLAWITER. Well, I think one of the things that has happened is that the amount of visits that someone is eligible to receive has been dramatically changed. So that has been cut.

I would like to believe that we are working extremely hard in terms of offering quality and maybe trying to put just as much into every one of those visits as you can. The point is you sometimes get to an irreducible minimum and you now have done everything that you can from an efficient standpoint, a cost effective standpoint, and there is nowhere else to go. I feel like that is where we are headed and where we actually are, but it appears as though things are going to get even worse.

Senator COCHRAN. You heard Ms. Griffin talk about the hospitals and how much money they had lost really compared with previous years under these new requirements. Have you had similar experiences in Wisconsin?

Ms. KLAWITER. Actually, the Wisconsin Hospital Association has just conducted a study for us and it indicates that Southwest Health Center will lose \$1.25 million between now and 2002 just with the projected cuts. That is extremely significant when you take a facility of our size and trying to cover the area.

Senator COCHRAN. Have you been able to identify any specific changes in the Federal requirements or Federal law, including the Balanced Budget Act, that could be made that would be helpful to you and to the facility that you represent here today?

Ms. KLAWITER. To name a few, probably I would certainly look for some changes with the transfer policy.

Senator COCHRAN. Tell us about that. What is that transfer policy and what effect has that had? What does that mean?

Ms. KLAWITER. What has been happening, the government ended up expanding, if you will, the definition for transfer. Before the facility—if we transferred out a patient to a tertiary care facility, for instance, you would be paid a per diem rate for the number of days that someone was into the facility. Now they have expanded that definition to say that a transfer means indeed that patient may be

sent to a skilled nursing facility, that patient may be sent to their own home and receive home health services.

Now that is going to greatly reduce and put us back onto a per diem rate, even though we are being penalized, in my opinion, for having given that patient good, efficient, and cost effective care, now returning them to a more adequate setting to be able to take care of their extended needs and to preserve quality of life.

I guess I thought that that was one of the things that hopefully was at the heart of what we were trying to do.

Senator COCHRAN. Mr. Higginbotham, you have heard all of the witnesses testify today. One comment was made by our actuary here about the change in bond rating. Because of the Medicare reimbursement changes, you are no longer rated as a good enough credit risk for some rating agencies to get a high rating that would attract bond buyers.

Have you to your knowledge known of any medical centers in our State or has yours had its bond rating changed as a result of these new regulations and laws?

Mr. HIGGINBOTHAM. I cannot address other hospitals. I can tell you what has happened with our facility. We issued some bonds to refinance some back in 1997, so we got our own credit at that point. Thus far we have been able to maintain our credit rating. But what has happened to us is our debt capacity is gone. We do not have the ability to go out and get additional or issue additional bonds. That means we have to go to local banks to meet our capital needs.

What is happening to us is, since we do not have debt capacity and our margins are starting to shrink a little bit, just like any other creditor, a bank looks and says, well, am I going to be able to be repaid for the money I have lent to you? And if you start seeing your margins go from 4 percent to 1 percent to a negative, the banks are not going to be too inclined to want to loan to you.

You have got to understand for the capital needs, when you say access to capital, we talk sometimes about buildings. Those are essential. You have got to have roofs and that kind of thing to keep your equipment dry. But some examples of things that we need capital for: Just earlier this year we had one of our vendors, GE, tell us that they are no longer going to provide service or anything for a particular piece of equipment that we have. So we are faced with we have got to replace that piece of equipment. That is a \$40,000 investment there.

Just 2 weeks ago we were told by one of our vendors that they will no longer produce a particular piece of equipment in nuclear medicine. By the time we are all said and done, we are probably looking at \$120,000 to replace that piece of equipment.

These little things come up, and that is just to stay current. We are not even trying to get ahead. And if you cannot provide those services—access to capital eventually ties in to recruiting physicians, it ties into getting staff, it ties into the margins, it ties into the whole thing. You have got to have the equipment and facility there for the people to have confidence to come to your facility, for physicians to want to come and practice in your community.

As far as bond ratings, I can't say we've had any impact yet. But I can tell you as far as access to capital, we are getting stretched.

Senator COCHRAN. Do you know of any changes that you have made that are directly related to the provisions of the Balanced Budget Act or the implementation regulations that have been issued by the Health Care Finance Administration?

Mr. HIGGINBOTHAM. We have reduced, our volume is reduced in home health. We cut about 50 percent of our work force there. We had around 90 employees in our home health. We are down to about 50, right around 50 right now.

Our skilled nursing facility, we have seen a decrease in the number of patients out there. We have, as I told you in my testimony, we have not made a decision what to do with it at this point. Those patients still need care, and we are not sure whether we should maintain them in the building. If we maintain them in the building we get absolutely nothing for them. If we can move them to a skilled nursing facility, at least we get something.

The other thing that we are seeing is hospice, hospice has taken about a 50 percent hit, and we have reduced our staff there about 11, I believe it is. Last year also, during the summer, as I mentioned—and it is not entirely Balanced Budget Act—part of it was volume, but part of it was our concern about some of the cuts that were coming. We were able to, through hours reductions and reassignment of responsibilities, reduce our staff by about 86 employees.

Senator COCHRAN. If you could pick out two or three changes that you could make in the regulations or the reimbursement rates, what would you emphasize as the most important for Congress and the administration to try to accomplish, that would help your center?

Mr. HIGGINBOTHAM. Help your senator. Well—

Senator COCHRAN. Your medical center, not your Senator.

Mr. HIGGINBOTHAM. I am trying to help the Senator right now.

Obviously, the transfer provision, that is a huge impact on our skilled nursing facility. I think you need to understand that these patients that go to the skilled nursing facilities in rural communities, we do not necessarily have a plethora of nursing homes or support services available for some of these patients. So they are too sick to go home. They need something, kind of an intermediate care, and they meet the qualifications for a skilled nursing facility.

If you do not have that skilled nursing facility, you still do not have anywhere to send that patient yet. So you maintain them in the hospital at a much higher cost, and that hurts you in the long run.

So the transfer provision is a large one. I have just got to come back, and I do not know all the mechanisms that are in this, but when I look at the Balanced Budget Act, and I heard some of this today, I think they originally said an impact of \$103 billion. It is going to be now anywhere from—

Senator COCHRAN. 191 or more.

Mr. HIGGINBOTHAM. Yes, as high as 220.

Senator COCHRAN. Right.

Mr. HIGGINBOTHAM. And I found it fascinating that they are willing to give us back \$7 billion over 10 years. They are willing to take \$200 billion over 5 years, but give us back \$7 billion over 10.

I think you just need to look at the overall level of reimbursement. I can give you examples. Cataract surgery, if you do that in our facility the physician gets paid more than the hospital does. I do not even remember. I think our reimbursement is about \$330, \$350 or something like that. Just the lens alone that goes into the key is right around \$200, \$170 to \$200 for us. Then we have got to cover all the medications, all the nursing staff, or time, everything, with the rest of that. There is no way. We lose money on cataract surgery.

So how long can we continue to do these type things? It is a need in our community. We have an elderly community. A large percentage of our population is over 65.

I guess what I am getting to is more money in the system as a whole, to continue to provide access to the things that our people need.

Senator COCHRAN. If you were entitled to the same kind of level of reimbursement as the New Orleans hospitals—you mentioned people who would be able to go down and work just for the weekend and make as much as they would make at your hospital or your medical center working a whole week—would that help solve a lot of problems, too?

Mr. HIGGINBOTHAM. It would certainly make my life a lot easier, yes, sir, it would.

Senator COCHRAN. Well, I frankly think that is one area where we can really concentrate some effort and attention. I think the small towns and rural communities have been discriminated against long enough on the reimbursement rates. You try to recruit a physician or any other health care professional, you are competing against the salaries and the other things that are really so much more generous in the larger cities than they are in the small towns and rural communities. You just cannot continue to attract people to come work there or live there, and that is sad.

That ties into rural development. We are talking about the economic well-being of these communities. They are going to continue to have a harder and harder time just surviving.

So I think we have got a crisis on our hands and this Congress has got to get serious and get moving, and so has this administration. We have got to start working together. There is a big debate in the Senate right now on health care, but this is an area of health care concern to me that is just as important as what we are debating on the floor of the Senate today, maybe even more important, to be honest about it. We need to concentrate our efforts here, too.

Your being here and your talking about your experiences and your knowledge of the problem has been very helpful to our committee's understanding of it. We will continue to work to identify the ways that we can be helpful to you and to the people who live in our small towns and rural communities in this country.

CONCLUSION OF HEARING

Thank you very much. The hearing is recessed.

[Whereupon, at 12:13 p.m., Wednesday, July 14, the hearing was concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]

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