

**IMPLICATIONS OF THE BALANCED
BUDGET ACT ON RURAL HOSPITALS**

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

SPECIAL HEARING
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IMPLICATIONS OF THE BALANCED BUDGET ACT ON RURAL HOSPITALS

TUESDAY, JULY 11, 2000

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

The subcommittee met at 10:48 a.m., in room SD-138, Dirksen Senate Office Building, Hon. Thad Cochran (chairman) presiding.
Present: Senators Cochran and Burns.

OPENING STATEMENT OF SENATOR THAD COCHRAN

Senator COCHRAN. The subcommittee will please come to order. Today we are convening this hearing to consider the economic plight of rural hospitals and their communities. We will consider the effects of Federal policies on the financial well-being of providers and how that affects efforts to develop the economies of small towns and rural communities. Hospitals are major economic contributors to their communities and many hospitals serve a large portion of Medicare and Medicaid patients with very few, if any, private pay patients to offset deficiencies caused by lower Medicare reimbursements.

Experts from HCFA and MedPAC will address reimbursement issues and other witnesses will discuss such problems as a lack of capital to improve and expand facilities and a lack of ability to recruit and retain key personnel. While these are problems of all hospitals, rural hospitals seem to be disproportionately affected. We will hear from hospital administrators from my State of Mississippi about the roles that their hospitals play in their communities.

Our first witness we invited to testify is Senator Charles Grassley of Iowa. As you know, we have a vote taking place on the floor of the Senate right now and we will hear from him as soon as he arrives at the hearing. He has been a leader on rural Medicare issues in the Senate Finance Committee.

We also have a panel of witnesses that includes: Dr. Robert Berenson, Director of the Center for Health Plans and Providers of the Health Care Financing Administration, who testified at a hearing we had last year on this subject and who visited facilities in Mississippi last summer; Dr. Mary Wakefield, who is Director of the Center for Health Policy at George Mason University and is a member of the Medicare Payment Advisory Commission; Thomas Scully, President of the Federation of American Health Systems,

who represents for-profit hospital systems and is a former senior official with OMB in the Bush Administration.

We also have a panel of hospital administrators, including Mr. Jimmy Blessitt, the Administrator of South Sunflower County Hospital in Indianola, Mississippi, and Mr. Philip Grady, who is the Chief Executive Officer of King's Daughters Hospital in Brookhaven, Mississippi.

We are pleased to welcome our good friend, my colleague from Iowa, the distinguished Senator Charles Grassley, who as I pointed out earlier has been a leader in this area and is a member of the Finance Committee, which has important jurisdiction in this area.

Senator Burns, do you have any opening comments?

STATEMENT OF SENATOR CONRAD BURNS

Senator BURNS. Thank you, Mr. Chairman. I do, and I will submit my statement, but there is a couple of points that I want to make. I want to thank you for holding this hearing. It is a timely hearing and I think most of us coming back now off of the Fourth of July break spent most of the time on the road. I know I did, and of course if you are up for re-election that is where you are.

I met with a lot of folks in rural areas, and of course the whole State of Montana is considered rural, and then we have got some that is considered frontier, and they face unusual challenges, as you know.

Not for profit health care facilities are the backbone of my State's health care delivery system. Since the beginning their mission has been to meet the health care needs and improve the health of folks in their communities. While their mission remains the same, the environment under which they have been operating has been changing at a rapid and inconsistent pace, a pace that has negatively impacted those facilities.

As Montana faces unique challenges, Montana's 56 counties, 45 are classified as frontier counties. All 40 counties are classified as primary care health professional shortage areas. For the past 3 years, Montana hospitals have lost money serving patients. They are forced to make it up in other areas, by managing other services such as physicians' clinics and durable medical equipment businesses, and through investments.

While the larger hospitals survived this way, it is increasingly difficult for rurals to do so. Our county-owned rural facilities, about 15 in Montana, in an effort to survive and keep their doors open to many of their residents in need, have increasingly been forced to turn to tax subsidies in the form of mill levies and direct subsidies from the county as a matter of last resort.

This bad problem looks like it is only going to get worse, folks. Already, this year I have heard that many Montana hospitals are far worse than they were just a year ago. I would like to provide you with a quick snapshot of some hospitals' financial condition. It shows all but one facility losing money so far this year. In the case of St. Patrick's Hospital, which is considered an urban facility, it has gone from a \$12 million profit in 1997 to a \$4 million loss May 31 of this year of 2000.

The Community Hospital of Anaconda is opening at a loss, as the Clarkford Valley Hospital in Plains and St. Joseph's Hospital in

Polson, just to name a few. This is a disturbing trend, placing rural America in real jeopardy as far as health care delivery systems are concerned.

I am glad to see Senator Grassley here. I serve with him on the Aging Committee and he has long been the champion of rural health and considered one of the experts on rural health. I look forward to listening to his testimony and also working with him on—he has introduced a bill which is the Geographic Adjustment Fairness Act of 2000, of which I would like to be a co-sponsor.

It would provide an opportunity to correct the unfair geographic inequity in traditional fee for service Medicare payments. The changes are set forth in the good Senator's bill and they should not be difficult for HCFA to implement because hospitals already submit annual cost reports which list their labor and non-labor costs. I think it is a step in the right direction.

So, Mr. Chairman, I appreciate the opportunity. As you know, we have I think some 13 or 14 counties with no doctors. We rely on physician's assistants, PA's. So we face a challenge that is not any different than any other State, really, in some of their rural areas. But we have a thing called distance to deal with because—you have heard me say it before—I come from a State where there is a lot of dirt between lightbulbs. But those people deserve the best health care that we can provide for them.

I thank the Senator and I look forward to Senator Grassley's testimony.

Senator COCHRAN. Thank you very much, Senator Burns.

ADDITIONAL SUBMITTED STATEMENTS

The subcommittee has received statements from Senators Kohl, Durbin and Feinstein which they have asked be placed in the record.

[The statements follow:]

PREPARED STATEMENT OF SENATOR HERB KOHL

Thank you, Mr. Chairman. I am glad you have called this hearing to draw Congress' attention to the plight of hospitals in rural communities, and the disastrous impact of a weakened health care system on rural development.

Some may question why the issue of health care is being explored by a Subcommittee which focuses on agriculture and rural development. But these issues are inextricably linked. The success of rural America depends upon the ability to sustain a viable, attractive health care system. A strong health system attracts employers and economic growth to rural areas, and hospitals serve as the center of that system. The lack of a strong health care infrastructure not only jeopardizes the health and well-being of Americans living in rural and agricultural-based communities; it also jeopardizes the growth and viability of rural America.

As our witnesses are well aware, health care in rural America is in trouble. The Balanced Budget Act of 1997 was 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.

However, as we all know, the BBA reforms have resulted in far deeper cuts to Medicare providers than Congress originally intended. These cuts are causing hardships in many areas of our nation, but they are particularly devastating for rural areas, where hospitals and other providers are more reliant on Medicare payments.

I am deeply concerned about these unintended effects. 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 or eliminate needed services—or even worse, to jeopardize access to care for rural sen-

iors. Congress must act immediately to ensure that Medicare beneficiaries in rural areas have access to the health care services to which they are entitled and deserve.

Congress took several important first steps toward addressing Medicare payment problems last year when we passed the Balanced Budget Refinement Act of 1999. The President recently called on Congress to provide an additional \$40 billion over ten years to restore Medicare cuts to hospitals, home health agencies, and nursing homes—including \$1 billion for rural providers. In the remaining days of this session, Congress must take action to ensure that rural Medicare beneficiaries have access to the care they deserve.

However, in addition to the restoration of BBA cuts, I believe Congress must take an even larger step to bring common sense and equity to the Medicare program. Current Medicare formulas penalize seniors in Wisconsin and other areas of the country by paying less per beneficiary than in other States. While the national average Medicare payment was \$5,538 per senior in 1998, the payment per Wisconsin senior was much less—only \$4,237. By contrast, the average payment per senior in Florida was \$6,563; in Texas, it was \$6,737; and in Louisiana, it was \$7,252. Do seniors and health care providers in these States deserve more than those in Wisconsin?

Unfortunately, this inequity is even worse in rural areas. In 1997, the average Medicare payment for urban areas of Wisconsin was \$4,354—still much less than the national average of \$5,416. But the payment in rural Wisconsin was even less—only \$3,786. This disparity is causing real harm in rural Wisconsin, with many providers barely able to stay afloat, and fewer options and benefits for Wisconsin's elderly patients.

After all, we can talk about numbers, but the real travesty here is that this payment disparity has a direct effect on seniors' access to care. Most seniors in Florida have coverage for prescription drugs, eyeglasses, and preventive benefits, but too many seniors in Wisconsin do not. Providers in Wisconsin are struggling to make ends meet and continue providing the highest quality care. And Medicare+Choice plans have been leaving Wisconsin altogether or cutting benefits—resulting in interruptions in benefits and confusion and frustration among seniors. In other words, even though Wisconsin seniors pay the same Medicare payroll taxes and the same Medicare Part B premiums, they do not enjoy the same benefits. This is simply unacceptable.

I have cosponsored legislation, S. 2610, the Medicare Fairness in Reimbursement Act of 2000, to address this fundamental inequity. This bill would ensure that no State receives less than 95 percent of the national average Medicare per-beneficiary payment, and no State receives more than 105 percent of the national average payment. It also requires the Secretary of Health and Human Services to revise the hospital wage index formula so that it more accurately reflects the actual costs hospitals incur. These two key changes will help equalize Medicare payments—and seniors' benefits—for Wisconsin, including rural areas.

I am fully aware that passing this legislation will not be easy. Because the bill is budget neutral, any increase in payments to Wisconsin and other disadvantaged States will result in lower payments to other States. But this is an issue of fairness—of making sure that our nation's elderly have access to the health care they need and deserve, regardless of where they live. We must address this issue as part of any comprehensive Medicare reform bill considered in Congress.

Again, Mr. Chairman, I want to thank you for shedding light on the important issue of rural health care. I know that the experiences and suggestions made by today's witnesses can lead to real BBA relief and ensure that Medicare reimburses rural providers more appropriately. I share your hope that Congress will act to address these issues quickly and comprehensively, so that health care in rural America remains vital and strong.

PREPARED STATEMENT OF SENATOR RICHARD J. DURBIN

Mr. Chairman, in Illinois, 13 percent, or 11 of all rural hospitals have closed in the last 14 years, leaving 23 counties with no hospital. This hearing is very important to my state and I thank you for taking the time to discuss these critical health access issues during the busy appropriations season.

Financing rural hospitals is not simply a budget issue. It is also about providing access to health services for Americans.

A recent study by the University of Illinois at Urbana-Champaign found that poor people in rural areas are more likely to lack health insurance than any other group of Illinoisans. Low income adults in rural Illinois are 24 percent less likely to be insured than their big city counterparts.

In fact, the study found that poor rural adults with jobs are 20 percent less likely to have health coverage than unemployed people. Rural residents are generally poorer, older and less insured than their urban or suburban counterparts.

Rural areas report higher rates of chronic disease and infant mortality. Injuries related to the use of farm machinery and rural occupational hazards associated with mining and forestry and fishing are unique problems for rural health care systems. Trauma mortality, especially for motor vehicle accidents and gun-related injuries is disproportionately higher in rural areas.

The fact is, in rural America, hospitals are serving as a safety net. Despite rapid health systems changes, for many rural communities it is the hospital that has served as the focus of health care delivery in the community and it is the hospital that remains the most prominent institution around which the delivery of health care is organized.

The majority of rural hospitals are government owned or non profit. They also are more dependent on Medicare than are urban providers.

Of the total 38.1 million Medicare beneficiaries in 1997, over 9.7 million (25.7 percent) resided in non-metropolitan counties. Medicare paid 35 billion in reimbursements for rural beneficiaries in 1995 (22 percent of the total).

It is also true that a higher proportion of the non-metropolitan population is enrolled in Medicaid, 15.9 percent compared to 12.5 percent in 1996. Many of our states have low reimbursement rates for Medicaid, often more than 15 percent lower than Medicare. This puts an even greater strain on rural hospitals.

As a result, we all know that rural hospitals have been disproportionately affected by the cuts included in the Balanced Budget Act of 1997 (BBA).

In 1998 rural hospital inpatient margins dropped by more than 4 percentage points to 5.2 percent. This contrasts with urban hospitals whose inpatient margins which fell 2.3 percent to 15.8 percent. The Illinois Hospitals and Health Systems estimates that Illinois rural hospitals will lose over \$271 million between fiscal year 1998 and fiscal year 2002 due to the BBA.

Last year, I introduced the health care preservation act of 1999 which included important provisions to protect rural hospitals.

The bill provided stop-loss protections to prevent rural hospitals from losing money in the Medicare outpatient payment system.

It allowed increased flexibility for the creation of critical access hospitals.

It establishes a prospective payment system specifically for rural health centers and it creates a new fee schedule for ambulance services in rural areas.

Many of these provisions have since been enacted, but clearly more needs to be done.

I will soon be introducing a new bad debt relief act that provides assistance to hospitals when they treat the near poor.

I look forward to working with both hospitals, seniors groups and disability organizations to make sure that the Medicare payment system preserves seniors and the disabled's access to quality health care for all, including those who live in rural America today.

PREPARED STATEMENT OF SENATOR DIANNE FEINSTEIN

Thank you Senator Cochran for holding this hearing today on the crisis in health care in rural America. Rural hospitals play a key role in their communities. They are often the sole provider of health care because these communities, unlike their urban counterparts, do not have large networks of clinics, physician groups, skilled nursing care facilities or other providers of care. They often provide the full range of services.

In California, rural hospitals provide primary and acute services to 2.6 million people. The average size of a rural hospital in California is 37 acute-care beds. A June 2000 report by the California Healthcare Association found the following:

“The financial status of rural hospitals in California does not look encouraging. Last year, these hospitals averaged a 2.2 percent patient operating margin. . . . Seventy-four percent of the rural hospitals lost money on operations in 1999. . . . Over the last three years, approximately 20 percent of the rural hospitals have either closed or entered into bankruptcy . . . three rural hospitals are in the planning stages of filing for bankruptcy and two hospitals have recently come out of bankruptcy.”

Mr. Chairman, this conclusion is not just disturbing. It is alarming.

And it is doubly alarming because it is a symptom of a sick system in my State as a whole. Let me share with you some headlines from newspapers around my state:

“Walnut Creek Hospital Closing at End of Month”
 “Scripps Plans to Shut Down Its Hospital in El Cajon”
 “Hospitals Closing Its Doors”
 “ER Crisis Threatens California”
 “Giant Medical Group Is Back in Crisis Mode”
 “UCSF Predicts Big Drop in Medical Center’s Losses”
 “State’s Blood Banks Find Medicare Cuts Run Deep”
 “Searching for Doctors; Low Rates Deter Specialists from Treating California’s Poor”

Quite frankly, Mr. Chairman, the entire health care system in my state is coming unraveled. Resources are stretched to the limit, patients are not getting the services they need, and doctors are leaving the state. During the past year, I have met with a number of doctors, hospital administrators, and patients who say that California’s health care system is on the verge of self-destruction.

Several factors are to blame for California’s faltering health care system:

(1) *California’s uninsured population has exploded.*—Over 7 million Californians currently do not have health insurance. That’s more than 24 percent percent of California’s population, compared to a national uninsured rate of 18 percent. And more than 50,000 Californians join the ranks of the uninsured monthly, totaling more than 600,000 each year.

(2) *Hospitals, nursing homes, home health agencies, emergency departments, and physician groups are closing their doors.*—Thirty-eight California hospitals have shut down since 1996, and up to 15 percent more may close by 2005.

As for rural hospitals, 69 percent of California’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.

Approximately 167 (12 percent) of the 1,376 nursing home facilities have filed for bankruptcy in 1999 and 2000, according to the American Health Care Association.

Over 300 home health agencies in California have closed within the last two years, leaving some areas of the State without access to a home health care provider.

California’s emergency rooms are also strained to the breaking point as 19 state-wide have closed since 1997 despite an increase in the number of uninsured requiring care.

Today, 64 percent of California hospitals are losing money.

For rural California hospitals, because 40 percent of patients receive Medicare and 20 percent receive Medicaid, 69 percent lost money in 1998, according to the California Health Care Association.

(3) *California spends less on Medicaid beneficiaries than virtually all other states.*—California ranks 48th nationwide in Medicaid spending per beneficiary and we rank last among the ten most populous States.

(4) *Californians are much more likely to be enrolled in a managed care plan and managed care payment rates are low.*—Today, 53 percent of all insured Californians are enrolled in an HMO compared to 28 percent nationwide. We have the heaviest penetration of managed care in the nation. Over 25 million Californians are in some form of managed care. Doctors say that HMO premium rates in California are 40 percent lower than those in other states.

(5) *California’s hospitals must comply with seismic safety requirements.*—This requirement will cost California hospitals \$10 billion by 2008 and \$20 billion by 2030.

As a result of these difficult dynamics and limited resources, many California hospitals and other health care providers have been forced to limit hours of operation and discontinue services. The burden to provide care is put on those that have remained open, and many of these facilities are now facing financial problems of their own.

I am very glad we are having this hearing because many of the problems of California’s rural hospitals are replicated and exacerbated across the state.

I believe that Congress must give priority attention to the health care crisis. We should revisit the cuts of the Balanced Budget Act and their impact on all providers. If Congress does not act this year, California will have an even more serious health care crisis on its hands.

The bottom line is that restoring Medicare and Medicaid cuts must be of the highest priority. If it is not, the health of people throughout California and the nation will be placed in serious jeopardy.

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 all our citizens.

STATEMENT OF SENATOR CHARLES GRASSLEY, U.S. SENATOR FROM IOWA

Senator COCHRAN. Senator Grassley, we welcome you to the hearing. You may proceed.

Senator GRASSLEY. First of all, Senator Burns, thank you very much for offering to co-sponsor right now. Senator Cochran had already done that and I thank Senator Cochran for his help in this area of one of the pieces of legislation that I am going to speak about.

First of all, Senator Cochran, thank you very much for holding a hearing on the financial health of our rural hospitals, because the word "Development" being in your subcommittee's jurisdiction, "Rural Development" specifically, obviously could—the health delivery system in rural America, it is very important for that rural development.

Many rural areas are struggling economically and have a hard time retaining population. It is difficult to attract major employers when you have no hospital because a hospital is the basis for other health care facilities. So this is not just about preserving hospitals, it is about preserving rural America as a viable place to live.

The Iowa Hospital Association has reported to me that over 60 percent of our State's rural hospitals lost money on patient care last year. I am sure that the numbers that have been given by both of you imply that it is similar or even worse in your States. So it is not an isolated problem, but a widespread one.

With negative operating margins, how many of those hospitals are going to hold on? We had one close already this year in my State. In many cases, they are county hospitals, requiring ever-increasing local tax subsidy. But raising taxes, of course, is working against economic development as well because it scares off potential employers. It is not a sustainable situation not to have a viable health system and expect economic development to happen.

There are many reasons for this problem, but I would like to focus on one that we are in a position to do something about. That is inadequate Medicare payments to low-cost hospitals. Rural areas tend to have older populations, so rural hospitals rely on Medicare more than most. The sad fact is that Medicare has never treated rural hospitals well and the situation is now worse than ever before.

We are probably all familiar with Medicare Plus Choice payment battles. That is Medicare people joining managed care plans. We fought those battles 3 years ago and we made some progress in those areas. But very few rural seniors are in such private plans.

So the legislation we focus on today and we have introduced focuses on the inequity in the fee for service payments to rural areas. Now, on a per capita basis rural Medicare beneficiaries receive many fewer services than those in urban and suburban areas. Much of this is due to differences in medical practice from one part of the country to the other. We in rural America simply do not go to the doctor as much as those in places like here in Washington, D.C.

I wish there were some sort of magic wand that we could wave to correct this with just one situation, one approach. But that is not because Medicare fee for service is an entitlement program. What we can do is identify the unfair aspects of the current payment system one by one and try to fix them. We can identify those things that are easy to identify other than the different methods of practicing medicine, which it is difficult to do when you are dealing with an entitlement.

Now, one such flaw is this hospital wage index, which is meant to adjust payments to reflect local labor costs. But one of the many problems with the wage index is that it is applied to a larger share of rural hospital costs than it ought to be. My proposed fix is a bill that you both are now co-sponsoring, and I introduced it just before the recess and already you were on by that time, Senator Cochran, so thank you.

The bill simply says that Medicare will apply the wage index adjustment which lowers payments to hospitals in low-cost rural areas—so we want to apply it to the wage index adjustment—only to an individual hospital's actual labor costs, not to the national average. It is a very simple reform, and who can really argue with a change that makes the system more accurate?

It is an example of a proposal that came to us from the grassroots. We had rural hospital administrators examining their payments to figure out why they were so low-cost in rural areas compared to urban. They identified this flaw in the formula in Medicare.

There are other proposals for wage index reforms that differ from mine and I am open to these. The main thing is that we get something done and get it done this year.

Now, there are some other changes that we need to make to preserve rural hospitals. I would list some of these from Senate bills 980, 2505, and 2537. We need to update the Medicare dependent hospital program and make it permanent, because since I first was involved in that program I think we had to re-authorize it now three times and sometimes it lapses and so sometimes that money is not available for rural hospitals.

This program, as you know, benefits hospitals that are over 60 percent dependent on Medicare, but only if they met that level by the statistics that existed in 1988. Now, this is an example, Mr. Chairman, of how outdated the Medicare program is when these formulas are applied to something in rural America. Opposition in the House prevented us from fixing this last year, so we will have to try again.

Now, one hospital in my State that did not make the 60 percent limit in 1988 has 90 percent Medicare patients today. That is how far behind we are on this.

We need to restore additionally to rural hospitals a full market basket increase in inpatient care. We need to accept MedPAC's recommendations and, finally, equalize the urban and rural standards for receiving disproportionate share funds. We need to change Medicare payment rules so that rural hospitals can begin to take advantage of telehealth technology.

These are all examples of the hard work of addressing the rural flaws in the Medicare fee for service system. It is not easy and it

is surely not glamorous. Politically, it is always an uphill battle to help rural America, but it has to be done.

It now seems likely that the Finance Committee will consider Medicare provider payment issues again this year. Last year rural health care did not do as well in conference as it should have. As far as I am concerned, this year rural hospitals should be in the front of the line. I look forward to fighting for them, and thank you for holding this hearing and helping to build momentum for that fight that we all share.

Senator COCHRAN. Thank you very much, Senator Grassley. I think your testimony is very important for us here in the Senate at this time. You point out the possibility of attention to this from the Finance Committee. That would be certainly welcome. We know that we have got to work hard to bring to the attention of those who are in key policy positions of the opportunities that they have to modify some of these indexes and formulas without Congressional action if that is possible.

We appreciate your leadership which is very strong and steady, and we thank you very much for being here to lead off this hearing.

Senator GRASSLEY. Thank you.

Senator COCHRAN. Senator Burns.

Senator BURNS. I have no questions. I just appreciate what he is doing. I watched his leadership in the Aging Committee and it has been exemplary.

Senator COCHRAN. Thank you very much, Senator Grassley.

Our panel of witnesses from HCFA and MedPAC, as I have already indicated, are here and if they will come forward we will hear their testimony at this time. Dr. Robert Berenson is Director of the Center for Health Plans and Providers of the Health Care Financing Administration. Dr. Mary Wakefield is Director of the Center for Health Policy at George Mason University and a member of the MedPAC, Medicare Payment Advisory Commission. Thomas Scully is President of the Federation of American Health Systems, representing for-profit hospital systems.

We thank you all for attending our hearing and for being available to us with information and suggestions about how we can deal with this problem that we have identified this morning.

Let us begin with Dr. Berenson. We appreciate your attendance. 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 very much, Chairman Cochran and Senator Burns. Thank you for inviting me to be here today to discuss our efforts to support hospitals in America's rural areas. We understand that rural providers face unique challenges in serving the medical needs of their beneficiaries and helping them is a high priority for the administration.

In fact, just recently the President recognized the challenges rural hospitals face when he included \$1 billion in additional funding over 10 years specifically for rural hospitals in his mid-session budget review. This proposal would further assist rural facilities by increasing Medicare payments to all hospitals by \$10 billion over

10 years. This money would be used for policies to improve the sustainability of rural hospitals similar to those in the bipartisan Health Care Access and Rural Equity Act of 2000, introduced by Senator Conrad and co-sponsored by you, Chairman Cochran, Senator Harkin, and others in the Senate and House of Representatives. We look forward to working with you to secure this essential funding.

As you know, Chairman Cochran, I have personally visited facilities in Mississippi last, I guess, September. Prior to that I visited hospitals in East Texas and southern Oklahoma to better understand their situation. I learned firsthand of the importance of the hospital to the health and economic well-being of their communities, and indeed I saw that the rural hospital was necessary for providing basic emergency medical services and basic primary care services that otherwise would have been lacking to those communities.

Rural hospitals tend to be smaller, have difficulty attracting and keeping health care professionals, and they are more dependent on Medicare patients than urban hospitals. About one in four Medicare beneficiaries live in rural America and rural providers serve a critical role in areas where the next nearest provider may be hours away. Yet many of these rural providers have higher average costs than their more urban counterparts and face difficulty maintaining enough patients to break even.

Medicare has made exceptions and special arrangements to address the needs of rural America and strengthen providers in these areas. For example, we have several special designations and enhanced payment systems for specific types of rural providers. These include critical access hospitals, sole community hospitals, Medicare dependent hospitals, and rural referral centers. These designations enable qualifying facilities to be paid higher rates for their Medicare services.

The Balanced Budget Act also included several provisions to help rural providers. In addition to creating the critical access hospital program, it allowed more rural hospitals to obtain special disproportionate share hospital payments that are available to hospitals serving large numbers of low income patients and it authorized payments for telemedicine and it included payment reforms for several providers that directly impact rural hospitals.

In addition, Congress and the administration worked together last year to enact the Balanced Budget Refinement Act, which further enhanced these special payments for rural providers, investing over \$1 billion over 5 years to help rural providers.

We have also taken administrative steps to help rural hospitals. For example, we have made it easier for rural hospitals whose payments are now based on lower rural area average wages to be reclassified and receive payments based on higher average wages in nearby urban areas. And importantly, we last year established the rural health initiative within our agency to increase and coordinate attention to rural issues. Already, that work group has been working with the Office of Rural Health in HRSA and has been meeting with organizations representing rural health interests, and I think we have an increased awareness of rural health issues within the Health Care Financing Administration.

This initiative includes senior staff and a specially designated rural point person in each of our ten regional offices to respond to rural provider inquiries and concerns, and we are proceeding with demonstration projects to expand telemedicine in Medicare. We are all committed to ensuring rural beneficiaries continued access to quality care and we want to work with Congress to make additional adjustments that may be necessary to ensure that rural providers can continue to provide beneficiaries with access to the high quality care they deserve.

I thank you for this opportunity to discuss our efforts to help rural providers and beneficiaries, and I would be happy to participate in the discussion. I guess I provided written testimony for the record. Thank you very much.

Senator COCHRAN. Thank you, Dr. Berenson. Your written testimony will be included in the transcript of the hearing in full. Thank you.

[The statement follows:]

PREPARED STATEMENT OF ROBERT A. BERENSON

Chairman Cochran, Senator Kohl, thank you for inviting me to be here today to discuss our efforts to support hospitals in America's rural areas. We understand that rural providers face unique challenges in serving the medical needs of their beneficiaries, and helping them is a high priority for us.

Rural hospitals tend to be smaller, have difficulty attracting and keeping health care professionals, and they are more dependent on Medicare patients. About one in four Medicare beneficiaries live in rural America, and rural providers serve a critical role in areas where the next nearest provider may be hours away. Yet many of these rural providers have higher average costs than their more urban counterparts and face difficulty maintaining enough patients to break even. As you know, Chairman Cochran, I have visited some of these facilities in Mississippi and other States to better understand their situation.

Medicare has made exceptions and special arrangements to address the needs of rural America and strengthen providers in these areas. The Balanced Budget Act included several provisions to help rural providers. The Balanced Budget Refinement Act provided further assistance, investing about \$1 billion over 5 years to help rural providers.

Most recently, the President recognized the challenges rural hospitals face when he included \$1 billion in additional funding over 10 years specifically for rural hospitals in his Midsession Review budget. This proposal would further assist rural facilities by increasing Medicare payment to all hospitals by \$10 billion over 10 years.

In addition, we have taken administrative steps to help rural hospitals. And we have established a Rural Health Initiative within our agency to increase and coordinate attention to rural issues. This initiative includes senior staff and a specially designated rural point person in each of our 10 regional offices to respond to rural provider inquiries and concerns. I have attached a list of these 10 point people and their contact information. And we are proceeding with demonstration projects to expand telemedicine services in Medicare.

We will continue to closely monitor how laws and regulations governing our programs affect rural beneficiaries and providers. And we want to work with Congress to make any additional adjustments that may be necessary to ensure that rural providers can continue to provide beneficiaries with access to the high quality care they deserve.

MEDICARE'S SPECIAL RURAL DESIGNATIONS

Medicare has long recognized the special needs of rural providers, and includes several special designations and enhanced payment systems for specific types of rural providers. These include:

Critical Access Hospitals.—These facilities have no more than 15 inpatient beds, offer 24 hour emergency care, and are located more than a 35 mile drive from any other hospital. They are reimbursed based on what they spend for each patient, rather than on the average expected cost for specific diagnoses that most hospitals are paid.

Sole Community Hospitals.—These facilities serve as the sole source of inpatient care in a community, either because they are geographically isolated, or because severe weather conditions or local topography prevents travel to another hospital. They can be paid higher rates based on their own previous costs.

Medicare Dependent Hospitals.—These facilities have fewer than 100 beds, do not serve as a Sole Community Hospital, and Medicare patients accounted for at least 60 percent of inpatient days or discharges during 1987. They also can be paid higher rates based on their own previous costs.

Rural Referral Centers.—These facilities have 275 or more beds, serve beneficiaries living more than 25 miles away or referred by other hospitals, or have specialist as more than half of staff physicians. They receive higher pay to assist in caring for low income patients and can more easily qualify for higher payments based on nearby urban wage rates.

BALANCED BUDGET ACT

The Balanced Budget Act of 1997 created the Critical Access Hospital program, and built upon other special provisions for rural providers. It:

- reinstated the Medicare Dependent Hospital designation, which had expired in 1994;
- permanently grandfathered rural referral centers;
- allowed more rural hospitals to obtain special disproportionate share hospital payments that are available to hospitals serving large numbers of low income patients; and
- authorized 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.

The BBA also included payment reforms for several providers that directly impact rural hospitals. For example, it modified inpatient hospital payment rules. It also mandated development and implementation of prospective payment systems for skilled nursing facilities, home health agencies, outpatient hospital care, and rehabilitation hospitals to encourage facilities to provide care that is both efficient and appropriate.

BALANCED BUDGET REFINEMENT ACT

Working together, Congress and the Administration last year enacted the Balanced Budget Refinement Act (BBRA), which further enhanced these special payments for rural providers. It included several provisions to assist Critical Access Hospitals, such as:

- applying the 96-hour length of stay limit on an average annual basis;
- permitting for-profit hospitals to qualify for Critical Access Hospital designation;
- removing constraints on length of stay in “swing beds” in hospitals with a total of 50 to 100 beds that serve both acute care and skilled nursing patients;
- allowing hospitals that closed or downsized since 1989 to be Critical Access Hospitals;
- permitting Critical Access Hospitals to streamline their billing processes by combining physician and hospital charges; and
- eliminating beneficiary coinsurance for clinical laboratory tests furnished by a Critical Access Hospital.

For Sole Community Hospitals, the BBRA included a higher pay increase, fully adjusted for inflation, for fiscal year 2001. And it extended the Medicare Dependent Hospital program for 5 years. For other rural hospitals, the BBRA holds them harmless for 4 years during the transition to the new prospective payment system for hospital outpatient care, and provides separate, budget-neutral payments for high-cost patients and certain drugs, devices, and biologicals for all hospitals, which will especially help hospitals that would otherwise have had to spread these costs across a small case load.

To promote physician services, the BBRA raised the cap on medical residents by 30 percent in rural areas. It also included incentives to encourage urban physician education programs to establish separate training programs in rural areas.

For skilled nursing facilities that are part of many rural hospitals, the BBRA provided an immediate increase in payment for high-cost patients. It created special payments to facilities that treat a high proportion of AIDS patients, and excluded certain expensive items and services from consolidated billing requirements, such as ambulance services for dialysis, prostheses, and chemotherapy. Importantly, the BBRA provided an across-the-board increase of 4 percent for fiscal year 2001 and fiscal year 2002 for skilled nursing facilities, and gave them options in how their

rates are calculated. It also placed a two-year moratorium on physical and occupational therapy caps in the BBA, which appeared to be presenting particular problems for patients in these facilities.

For home health agencies that also are part of many rural hospitals, the BBRA delayed a scheduled 15 percent pay cut until after the first year the new home health prospective payment system is in place. It also provided an immediate adjustment to per beneficiary limits for certain agencies, gave extra pay to help cover the costs associated with the OASIS quality survey system, and excluded durable medical equipment from consolidated billing under the prospective payment system. Once the prospective payment system is in place, payments will be tailored specifically to the condition and needs of the patients and there will be no per visit or per beneficiary limits. A case-mix adjusted payment will be made for each 60-day episode of care, the limit on the number payment episodes will be removed, and agencies will receive extra pay for more costly cases.

PRESIDENT'S MIDSESSION BUDGET

The President's Midsession Budget proposal includes a reserve for specific provisions to help rural hospitals, which total \$500 million over five years and \$1 billion over 10 years. This money would be used for policies to improve the sustainability of rural hospitals, similar to those in the bipartisan "Health Care Access and Rural Equality Act of 2000 (H-CARE)", introduced by Senator Conrad and cosponsored by you, Chairman Cochran, Senator Harkin, and others in the Senate and House of Representatives. H-CARE, for example, would:

- provide payment increases that are fully adjusted for inflation to all rural hospitals with 100 beds or less;
- make the Medicare Dependent Hospital program permanent and make it easier for hospitals to qualify by letting them use any of the three most recent audited cost reporting periods rather than their 1987 cost reporting period as mandated under current law;
- pay Critical Access Hospitals for clinical diagnostic services based on reasonable costs and without the beneficiary copayment;
- extend payment flexibilities for Sole Community Hospitals; and
- provide grants for upgrading data systems.

We also would consider improving equity for rural hospitals in the Medicare disproportionate share hospital (DSH) formula, which provides additional funding for facilities that serve large numbers of low income patients.

In addition, the Midsession Budget proposal would provide assistance for all hospitals totaling \$10 billion over 10 years, as well as \$2 billion over 10 years for skilled nursing facilities and \$3 billion over 10 years for home health agencies. All of these provisions will result in increased payments to rural hospitals and other rural providers. Including the reserve for rural hospital policies, the proposal includes a reserve fund of \$21 billion over 10 years for developing future policies.

ADMINISTRATIVE ACTIONS

We have taken a number of administrative steps to further assist rural providers. For example, we have made it easier for rural hospitals, whose payments are now based on lower, rural area average wages, to be reclassified and receive payments based on higher average wages in nearby urban areas. This allows them to apply for all the special rural designations described above and the higher payments these designations confer.

We are helping rural hospitals adjust to the new outpatient prospective payment system by using the same wage index for determining a facility's outpatient rates that is used to calculate inpatient rates. We are postponing for two years expansion of the BBA "transfer policy," which limits hospital payments when patients with certain diagnoses are discharged early to a post-acute care setting, and considering whether further postponement is warranted. We also are working with colleagues at the General Accounting Office and Medicare Payment Advisory Commission to review the impact and appropriateness of the wage index that is used to factor local health care wages into Medicare payment rates and generally results in lower payments to rural hospitals than to their urban counterparts.

For skilled nursing facilities, we are using our administrative flexibility to refine, in a budget neutral way, the manner in which we classify medical conditions for purposes of payment that more accurately reflects the full range of costs incurred on behalf of sicker patients. The refinements should increase payments for patients with complex medical conditions.

For home health agencies, we are providing financial relief by extending the time frame for repaying overpayments resulting from the Interim payment system from

one year to three, with the first year interest-free. We are postponing the requirement for home health agencies to obtain surety bonds until October 1, 2000. And we have eliminated a "sequential billing" requirement that had been problematic for some agencies, including some in rural areas.

RURAL WORKGROUP

In an effort to redouble our efforts to more clearly understand and actively address the special circumstances of rural providers and beneficiaries, we last year launched a new Rural Health Initiative. We are meeting with rural providers, visiting rural facilities, reviewing the impact of our regulations on rural health care providers, and conducting more research on rural health care issues. We are participating in regularly scheduled meetings with the Health Resources and Services Administration's Office of Rural Health Policy to make sure that we stay abreast of emerging rural issues. And we are working directly with the National Rural Health Association to evaluate rural access to care and the impact of recent policy changes.

Our goal is to engage in more dialogue with rural providers and ensure that we are considering all possible ways of making sure rural beneficiaries get the care they need. We are looking at best practices and areas where research and demonstration projects are warranted. We want to hear from those who are providing services to rural beneficiaries about what steps we can take to ensure they get the care they need.

We have put together a team for this rural initiative that includes senior staff in our Central and Regional Offices and dedicated personnel around the country. The work group is co-chaired by Linda Ruiz in our Seattle regional office and Tom Hoyer in our central office headquarters in Baltimore. Each of our ten regional offices now has a rural issues point person that you and your rural provider constituents can call directly to raise and discuss issues, ideas, and concerns. A list of these contacts and their respective States is attached to my testimony. We are confident that this initiative will ensure that Medicare policies are attuned to the needs of rural health providers and beneficiaries.

TELEMEDICINE

We are proceeding with projects to evaluate Medicare coverage for telemedicine. We recently completed a comprehensive, \$230,000 technology assessment of telemedicine, in conjunction with the Agency for Healthcare Research and Quality, under contract with the Oregon Health Sciences University. This study involved an assessment of the clinical and scientific literature dealing with the cost-effectiveness of telemedicine, specifically looking into the areas of "store and forward" technologies, patient self-testing and monitoring, and potential telemedicine applications for non-surgical medical services. We will examine the results of this study to determine if there is a need to expand telemedicine beyond the current payment regulations.

We are also testing expanded coverage for telemedicine. On February 28, 2000, we awarded a \$28 million cooperative agreement to Columbia University for the Informatics, Telemedicine, and Education Demonstration Project, as required by the BBA. This randomized, controlled study will explore how teleconsultations between physicians in New York City and rural, upstate New York affect diabetic patient care and program costs.

CONCLUSION

We are all committed to ensuring rural beneficiaries' continued access to quality care, and we are all concerned about the disproportionate impact that policy changes can have on rural health care providers. The Balanced Budget Act, the Balanced Budget Refinement Act, and the administrative actions we have taken address these concerns with specific provisions targeted to assist rural providers. Our Rural Health Initiative and our consultation with the SBA will help us to take any additional steps that may be appropriate.

We are very grateful for this opportunity to discuss our efforts to help rural providers and beneficiaries, and to explore further actions we might take to address their concerns in a prompt and fiscally prudent manner.

MEDICARE REGIONAL RURAL REPRESENTATIVES

REGION I: Boston.—Jeanette Clinkenbeard, 617-565-1257; Serving: Maine, New Hampshire, Vermont, Massachusetts, Connecticut, and Rhode Island.

REGION II: New York.—Elizabeth Romani, 212-264-3958; Serving: New York, New Jersey, Puerto Rico, and the Virgin Islands.

REGION III: Philadelphia.—Joe Hopko, 215-861-4192; Serving: Pennsylvania, Maryland, Delaware, West Virginia, and Virginia.

REGION IV: Atlanta.—Catherine Cartwright, 404-562-7465; Serving: Kentucky, North Carolina, South Carolina, Tennessee, Mississippi, Alabama, Georgia, and Florida.

REGION V: Chicago.—Gregory Chesmore, 312-353-1487; Serving: Minnesota, Wisconsin, Michigan, Illinois, Indiana, and Ohio.

REGION VI: Dallas.—Becky Peal-Sconce, 214-767-6444; Serving: New Mexico, Oklahoma, Arkansas, Louisiana, and Texas.

REGION VII: Kansas City.—Robert Epps, 816-426-5783; Serving: Nebraska, Iowa, Kansas, and Missouri.

REGION VIII: Denver.—Penny Finnegan, 303-844-7117; Serving: Montana, North Dakota, South Dakota, Wyoming, Utah, and Colorado.

REGION IX: San Francisco.—Sharon Yee, 415-744-2935; Serving: California, Nevada, Arizona, Hawaii, Guam, and American Samoa.

REGION X: Seattle.—Jim Underhill, 206-615-2350; Serving: Washington, Oregon, Idaho, and Alaska.

**HEALTH CARE FINANCING ADMINISTRATION
REGIONAL OFFICE BOUNDARIES**



Senator COCHRAN. Dr. Mary Wakefield, welcome. You may proceed.

STATEMENT OF MARY WAKEFIELD, RN, Ph.D., PROFESSOR AND DIRECTOR, CENTER FOR HEALTH POLICY RESEARCH AND ETHICS, GEORGE MASON UNIVERSITY

Dr. WAKEFIELD. Thank you. Good morning, Chairman Cochran and Senator Burns. I am Mary Wakefield, the Director of the Center for Health Policy Research and Ethics at George Mason University, and I want to personally thank you for holding a hearing on rural health care again this year and I am pleased to participate in it.

I do want to say that, while I serve as a Commissioner, I have the privilege of serving as a Commissioner, on the Medicare Payment Advisory Commission, as well as some other rural-oriented committees, I am not here today representing MedPAC's views, though I will be incorporating some of their data in my testimony.

This morning I want to address two topics: first, the relevance of health care to rural economic development; and second, the fi-

nancial health of rural hospitals. You know, there is an old expression that says if you have your health you have everything, and if you lose your health you lose everything. On a larger scale, I think that statement is really true. Communities that have good access to health care can survive and grow, but communities that lose local health care and good access to services lose their ability to prosper.

Health care service is a key to economic survival. It is as much a cornerstone of a local economy as schools are and businesses are. Health care service is not only an essential service, it is an economic engine that generates hundreds of thousands of dollars in additional revenues for local areas.

The economic statistics offered today come from a substantial body of national research and indicate that health care provides 10 to 15 percent of the jobs in many rural counties. When the secondary benefits of those jobs are included, health care accounts for 15 to 20 percent of all jobs. Also, when industry and business consider a new location, schools and health services are the most important quality of life factors that influence their choices about where to locate. In addition, a strong health care system also attracts retirees.

The economic impact of individual practitioners, health care practitioners, is also important to consider. One Oklahoma study of a small community revealed that if a single physician were to move away or retire a total of 8.4 jobs would be lost within the local economy as a result of that departure.

Unfortunately, a lot of health care spending takes place outside of rural communities. For example, an average rural county of 22,000 residents generates about \$73 million annually in health expenditures, but only about \$35 million are spent locally. The money that rural citizens pay out for health insurance premiums and Medicare taxes does not return to the local community in the form of payment for services at nearly the same rate as it flowed out of the community.

The movement of both services and dollars out of rural communities impacts both rural residents and the economy of their communities. Some of this loss is unavoidable and is in fact appropriate when there is a need for highly specialized health care services. But a significant portion could stay in rural areas if the health care system were organized and supported to encourage local utilization.

When considering rural economies, why should we be especially concerned with rural hospitals? I think because in rural areas they are a linchpin for the development of local and regional health care services. There is little service redundancy in rural areas, especially in small towns. In contrast, many metropolitan areas are flush with services: multiple hospitals, multiple nursing homes, home health agencies, and ambulance companies and the like. But in rural towns there are fewer providers in most service categories and gaping holes in some types of service.

The rural health care system is also highly interdependent. A rural town's only hospital very likely has the only outpatient surgery unit, the only ambulance service, and the only home health agency. The importance of rural hospitals as coordinators of serv-

ices for their communities can be seen in these statistics: In 1996, approximately two-thirds of rural hospitals provided home health services and one-third provided nursing home care. Twenty-one percent of rural hospitals in 1996 provided both.

While not every hamlet can afford a hospital, rural communities minimally need a hospital within a reasonable distance to anchor their local primary care, to support emergency services, and to stabilize the ill and injured. Rural hospitals have been able to keep going thanks to a patchwork of special fixes and protective policies enacted by Congress in the last decade. For example, the critical access hospital program was established under the BBA as a national model to support small rural facilities that could provide brief care or stabilize a patient before transferring them elsewhere. Critical access hospitals constitute an option that is welcomed by many rural communities, and as of June of this year Medicare has already certified 170 critical access hospitals. Another 191 hospitals are considering making that conversion to critical access hospital status.

Even with these kinds of programs, however, many rural hospitals remain threatened. While hundreds of rural hospitals closed in the first decade of prospective payment system implementation, eliminating in some cases excess capacity, much more care needs to be exercised now if we are to avoid significantly compromising access to rural health services.

We are again poised to make sweeping changes to their financial health, though, through efforts to balance the budget and control Medicare costs. I think that Congress should carefully assess broad Medicare reform proposals for their impact specifically on rural health care systems and also look carefully at the effects of the new prospective payment systems on access to services for rural Medicare beneficiaries.

The Balanced Budget Act introduced new prospective payment systems for outpatient care, skilled nursing facilities, home health, and ambulance services. These new payment systems will have a compound impact on rural hospitals and the rural health infrastructure. In fact, 72 percent of all rural hospitals will come under two of the new Medicare prospective payment system payment policies and 21 percent will be affected by at least three of them. The payment systems will also have a substantial effect because rural hospitals are more dependent on Medicare reimbursement than their urban hospital counterparts. In fact, Medicare patient expenses in 1998 accounted for an average of 47 percent of rural hospitals' patient care expenses, compared to 36 percent of urban hospitals.

Mr. Chairman, today we have some data by which to measure the impact of the BBA so far on categories of rural hospitals. Based on recently available data for 1998, the first year that BBA policies began to take effect, the picture is not particularly reassuring. There is a decline in Medicare margins for inpatient care and rural hospitals' revenues on average have decreased more than urban hospitals.

Rural hospitals' margins in 1998 were down, with a 4.3 percent decline in just 1 year. In 1997 the average Medicare inpatient mar-

gin of rural hospitals had been half as large as urban hospitals. One year later it was only a third of the urban hospital margin.

The poor facility profile of rural hospitals under Medicare is also reflected in the percent with negative Medicare inpatient margins. The lowest Medicare inpatient margins reported by the Medicare Payment Advisory Commission for any hospital groups are for two somewhat overlapping categories, both in rural areas: one, very small rural hospitals with fewer than 50 beds; and secondly, government-owned rural hospitals. In 1998, for example, the very small, those with under 50 beds, had an inpatient margin of 2.6 percent.

In 1998 the overall Medicare margin for rural hospitals was 6.4 percent under their costs, down further from their 3.9 percent loss in 1997. This downward turn in 1998 for rural hospitals in Medicare revenues is especially worrisome because it reflects just the leading edge of changes due to the BBA. The worst may well still be to come with the extension of prospective payment over more forms of services, and that is especially important because over the past several years rural hospitals have diversified their services, enabling them to meet a wider range of health care needs for rural communities, but potentially without adequate revenues from these services.

Yet, the new prospective payment systems may be imposed without correcting in the process some fundamental problems in the Medicare formulas. I would like to focus just a couple of comments on these problems because I think they now represent an important opportunity for Congress to put rural health care on a more level playing field with the rest of the Nation. There are three areas that offer an opportunity and addressing those areas could go a long way toward protecting rural health care access.

First there is the long-recognized bias toward urban hospitals in the payment that Medicare makes to hospitals shouldering a disproportionate share of low-income patients. These are known as DSH, or disproportionate share payments. Second, Medicare reimbursement formulas do not recognize or compensate small, low-volume rural hospitals for the higher per unit costs they incur in providing care. Third, Medicare's geographic wage adjustment, which is supposed to account for differences in urban and rural labor rates and to which Senator Grassley spoke, is flawed and it under-compensates many rural hospitals.

First a comment about DSH payments. Under the present complex allocation formulas, hospitals with the same proportion of low-income patients can have very different payment adjustments. Current policy particularly favors urban areas. As a consequence of this inequity, more than 95 percent of all DSH payments go to urban hospitals. How much money are we talking about? In 1998, total Medicare DSH payments added up to 6 percent of Medicare's total inpatient PPS payment, which was \$75.6 billion. That is \$4.5 billion, and urban facilities received through DSH about 95 percent of it.

The Medicare Payment Advisory Commission has recommended redressing this situation by treating all hospitals more equitably. That Commission proposes that payments should be made according to each hospital's share of low income costs.

The second issue that relates to the unique circumstances of rural health care systems is also important, and that is the problem of fixed overhead costs coupled with low patient volume. Medicare's prospective payment policy was designed to promote efficiency and eliminate waste. The decision to pay all providers the same base price for the same procedure, irrespective of all hospitals, size of all hospital size, was deliberate. This prospective payment for a procedure was based upon the average cost per care incurred by a presumably efficiently operated hospital.

I would like to suggest to the committee that this design feature certainly was sensible policy for urban providers, but not for all rural providers, for whom major economies of scale are simply not achievable. Basically, the one size fits all approach ignores the population distinctions between rural and urban populations and their order of magnitude. Since many rural towns have few or only one provider for particular services, it is critical that these regions—it is critical in these regions to take into account the relationship between a provider's volume and unit costs.

An X-ray machine and a minimum staff are required, for example, for a radiology lab, whether it takes 5 X-rays a day or 50 X-rays a day. These fixed costs in low-volume facilities result in high cost per unit of service, and almost all services have fixed costs associated with them. A good example of this unique problem with high fixed costs and low volume is rural ambulance service.

Mr. Chairman, I believe it is time for the Congress to consider including low-volume adjustment for small isolated rural providers for the prospective payment systems. I am also attaching to my testimony today a paper by Dr. Graham Atkinson which offers a fuller discussion of policy approaches to accomplish this.

The last problem I will just mention in need of a policy solution is, as Senator Grassley has already described, dealing with Medicare's geographic area wage index. Currently the hospital wage index used to adjust Medicare inpatient payments for geographic variation in labor costs generally undercompensates rural hospitals and potentially overcompensates urban hospitals. While the index should rightly reflect area labor costs that are beyond a hospital's control, it should not reflect a rich occupational mix that reflects from a hospital's desire to enhance its staffing.

But in fact, the current index is calculated on averages in actual payrolls rather than the relative differences in wage scales. This rural inequity has unfairly depressed many rural hospitals' payments, inpatient payments, for close to 2 decades. As far back as 1988 and at least four times since then, the Prospective Payment Advisory Commission expressed concern over the inappropriate treatment of occupational mix within the area wage index. So we have known and this problem has been recognized for a number of years.

In addition, the crudely drawn definition of hospital labor market areas is also a problem, based on the metropolitan statistical area-non-metro statistical area dichotomy and on arbitrary boundaries of States. Thanks to Congressional action to alleviate large wage index differences near labor market borders, some hospitals today can apply for reclassification to an adjacent area. However, both

HCFA and ProPAC before MedPAC analysts have said that this has not solved the problem.

As we move further into the post-BBA era, it will become important to monitor Medicare reform's effect on the entire rural health care system. That is to say, the highly interdependent nature of rural health care providers makes it important to have the latest financial information on the combined impact of all recent and future Medicare policies, including the new prospective payment systems.

Mr. Chairman, our Nation's population has shifted largely from rural to urban areas in just three generations. But even so, rural Americans today number 61 million people. Consequently, we need to ensure that our national policies do not defeat rural economies nor compromise rural beneficiaries' access to quality health care services. Special Medicare payments to rural providers should not be considered add-ons. Medicare payments per enrollee are already 18 percent less per rural beneficiary than per urban beneficiary even with the modest programs focusing on rural needs.

There is a legitimate cost of sustaining health care services in rural areas and there is a tremendous return on investment when we realize the economic impact of the health care sector.

Finally and fortunately, Federally supported research linking rural economic impact with rural hospitals and rural health care delivery is research that is not gathering dust on university shelves. Through an important new national initiative, for example, rural communities are now looking at their own economic profiles. Today there is a project under way in 15 States called Operation Rural Health Care Works, in which local data is collected to demonstrate the multiplier effect of locally spent health care dollars on service and employment for individual communities.

That is a joint project supported by USDA's Cooperative Extension, the Health Resources and Services Administration, and the Minnesota-based Rural Policy Research Institute. This and other research endeavors on rural health care systems and their relationship to rural economies will help to illuminate challenges and policy opportunities for sustaining health care and strengthening communities for millions of rural Americans.

Thank you for your attention, and I would be happy to try to answer any questions.

[The statement follows:]

PREPARED STATEMENT OF MARY WAKEFIELD

Chairman Cochran, Senator Harkin, members of the Subcommittee, I am Mary Wakefield, director of the Center for Health Policy, Research and Ethics at George Mason University. I want to thank you for holding a hearing on rural health care again this year and I am pleased to participate in it. This morning I will address two major topics in my testimony: First, the relevance of health care to rural economic development, and second, the financial health of rural hospitals.

There is an old expression that says, "If you have your health, you have everything. If you lose your health, you lose everything." On a larger scale, it is also true. Communities that have good access to health care can survive and grow. But communities that lose local health care and good access to services, lose their ability to prosper. Health care service is a key to economic survival. It is as much a cornerstone of the local economy as schools and business. Health care service is not only an essential service, it is an economic engine that generates hundreds of thousands of dollars in additional revenue for local areas. Every health care dollar spent locally recycles through that local economy one and a half times.

RURAL ECONOMIC DEVELOPMENT

The economic statistics offered today come from a substantial body of national research developed over the last decade, much of it pioneered out of Oklahoma State University, and the Universities of Nebraska and Kentucky—and supported by the Agency for Healthcare Research and Quality and the USDA. Health care provides 10 to 15 percent of the jobs in many rural counties. When the secondary benefits of those jobs are included, health care accounts for 15 to 20 percent of all jobs. Also, when industry and business consider location, schools and health services are the most important quality-of-life factors influencing their choices. In addition, a strong health care system also attracts retirees.

The economic impact of individual practitioners is also important to consider. One Oklahoma study of a small community revealed that if a single physician were to move away or retire, a total of 8.4 jobs would be lost within the local economy as a result of that departure.

One study of the economic impact of National Health Service Corps physicians on rural communities found that each generates more than five jobs and over \$233,000 in income to the local economy. In addition to the fact that the Corps provides essential access to health services for communities in need of practitioners, this is another good reason to reauthorize this program.

Unfortunately, too much health care spending takes place outside of rural communities. For example, an average rural county of 22,000 residents generates \$73 million annually in health expenditures, but only about \$35 million is spent locally. The money that rural citizens pay out for health insurance premiums and Medicare taxes does not return to the local community in the form of payment for services at nearly the same rate it flowed out of the community.

The movement of both services and dollars out of rural communities impacts both rural residents and the economy of their communities. Some of this loss is unavoidable where there is a need for highly specialized services. But a significant portion could stay in rural areas if the health system were organized to encourage local utilization. The trend in the health care industry is to move care and related expenditures from high-cost acute care settings back to the home sites of patients and providers. The lower intensity, lower cost of care of the sort that predominates in rural communities can be advantageous in an era of cost containment.

Small communities can provide a broad array of primary, preventive, wellness, home health, and residential care. Larger rural communities of 40,000 to 50,000 can provide a wide range of fairly sophisticated services. But delivering affordable, cost-effective care requires knowing the real needs of the community.

RURAL HOSPITALS AND RURAL HEALTH SERVICES

When considering rural economies, why should we be especially concerned with rural hospitals?—Because in rural areas, they are a lynchpin for the development of local and regional health care services. There is little service redundancy in rural areas, especially in small towns. In contrast, metropolitan areas are flush with services—multiple hospitals, nursing homes, home health agencies, and ambulance companies, not to mention freestanding surgical centers, freestanding radiology centers, freestanding clinical laboratories, ambulatory care clinics and the like. But in rural towns, there are fewer providers in most service categories and gaping holes in some types of service, like obstetrics and kidney dialysis.

The rural system is also highly inter-dependent. A rural town's only hospital very likely has the only outpatient surgery unit, the only radiology unit and the only clinical laboratory. Its outpatient clinic may be the only primary care practice in town, and it may have the only ambulance service and the only home health agency. The importance of rural hospitals as coordinators of services for their communities can be seen in these statistics: In 1996, approximately two-thirds of rural hospitals provided home health services and one-third provided nursing home care in a nursing home facility. Twenty-one percent of rural hospitals in 1996 provided both.

While not every hamlet can afford a hospital, rural communities minimally need a hospital within reasonable distance to anchor their local primary care, support emergency services, and stabilize the ill and the injured.

Rural hospitals have been able to keep going, thanks to a patchwork of special "fixes" and protective policies enacted by Congress in the last decade. For example, some rural hospitals can apply for payment reclassification to a higher urban wage area rate. Some are exempted from the inpatient PPS by virtue of their classification as sole community hospitals, or status as Medicare-dependent, or their willingness to become limited service hospitals with a restricted average patient length of stay. This latter group, known as the Critical Access Hospital, was established

under the BBA as a national model to support small rural facilities that could provide brief care or stabilize a patient before transferring them elsewhere.

Critical Access Hospitals constitute an option that is welcomed by many rural communities. The cost-based Medicare reimbursement for inpatient and outpatient Part A services and the more flexible staffing requirements under Medicare are important contributions to the viability of facilities that are essential providers in their localities. As of June of this year, Medicare has already certified 170 critical access hospitals. Another 191 hospitals are considering making the conversion to CAH status. This program, implemented with direct state-level involvement and federal grants to states for supporting technical assistance, will encourage the best use of rural resources and foster a stable service infrastructure.

The federal Office of Rural Health Policy, which administers the program, also provides regional workshops and a national technical assistance resource center to help states and rural communities assess their best options. A vision of the program is to foster service networks that might include area physicians, health departments, and ambulance companies, in addition to hospitals. The development effort is also designed to involve the community in understanding the economic role of local health care.

Even with these programs, however, many rural hospitals remain threatened. While hundreds of rural hospitals closed in the first decade of PPS implementation—eliminating some excess capacity—much more care needs to be exercised now if we are to avoid significantly compromising access to rural health care services. We are again poised to make sweeping changes to their financial health through our efforts to balance the budget and control Medicare costs. I believe the Congress should carefully assess the impact of broad Medicare reform proposals for their impact on rural health care systems, and look carefully at the effects of the new prospective payment systems on access to services for rural Medicare beneficiaries.

While there are many good reasons to proceed with cost controls introduced by the Balanced Budget Act of 1997, we should realize that poorly drawn formulas of reimbursement through Medicare—the nation's largest public insurer—will have a complex and reverberating impact on both rural health and the rural economic picture.

The BBA introduces four new prospective payment systems: one for outpatient care, another for skilled nursing—already being phased in, another for home health, and yet another for ambulance services. These new payment systems will have a compound impact on rural hospitals and the rural health infrastructure. Seventy-two percent of all rural hospitals will come under two of the new Medicare PPS payment policies and 21 percent will be affected by at least three of them. They will also have a substantial effect because rural hospitals are more dependent on Medicare reimbursement than urban hospitals. Medicare patient expenses in 1998 accounted for 47 percent of their total patient care expenses, compared to 36 percent of urban hospitals'.

A year ago at this time there was great concern that the BBA, with its new Medicare prospective payment mandates and its reductions in inpatient care payments, was creating a financial crisis for rural hospitals and other rural providers. While there were a lot of assumptions at that time, there were no post-BBA data on which to base any corrections in our course of action.

Nevertheless, given the severity of projections for the impact on rural hospital outpatient revenues using 1997 data, Congress agreed to a temporary hold-harmless provision for them in the Balanced Budget Refinement Act of 1999. This provision (through year 2003) is not insignificant to rural Americans: It protects rural hospitals of up to one hundred beds. That's 1,785 hospitals—or fully 82 percent of all rural hospitals.

Mr. Chairman, today we have some data by which to measure the impact of the BBA so far on rural hospitals. The February Medicare cost reports are in and analyzed and the Medicare Payment Advisory Commission has issued its June Report. For the first time, this report not only compares rural hospitals with urban hospitals but it looks at rural hospitals on a number of dimensions that include five major subgroups: The report provides some data on very small hospitals of under 50 beds, those with 50–100 beds, and those hospitals operating under special programs—namely rural referral centers, sole community, and small Medicare-dependent facilities. These breakouts give policy makers a much more detailed picture of the condition of rural hospitals and make it possible to track and target—when necessary—new policies and programs to those groups most in need.

What do the data tell us for 1998—the first year BBA policies began to have an effect on hospital revenues? The picture is not reassuring. There is a decline in Medicare margins for inpatient care, and rural hospitals' revenues on average have decreased more than urban hospitals'. While urban hospitals' overall average mar-

gin was 15.8 percent in 1998—a decrease for them of 2.3 percent—rural hospitals' margins were down to 5.2 percent with a 4.3 percent decline in just one year.

In 1997, the average Medicare inpatient margin of rural hospitals had been half as large as urban hospitals'—9.5 percent compared to 18.1 percent. One year later it was only a third of the urban hospital margin. The poorer financial profile of rural hospitals under Medicare is also reflected in the percent with negative Medicare inpatient margins. Thirty-nine percent of all rural hospitals had negative inpatient margins compared with about half that proportion of urban hospitals at 20.6 percent.

The lowest Medicare inpatient margins reported by MedPAC for any hospital groups are for two, somewhat overlapping categories: very small rural hospitals with fewer than 50 beds and government-owned rural hospitals. In 1998, the "very smalls" had a margin of 2.6 percent and rural government-owned hospitals had a margin of 1.8 percent. Within these two categories, the bottom 10 percent had negative margins starting as low as minus 26 percent. It's hard for any business to survive long with these kinds of margins.

Another reading on the BBA's impact to date is available in the form of Medicare payment-to-cost ratios reported by the American Hospital Association's annual survey. This survey takes into account all expenses attributable to the patient, not just Medicare's allowable costs. In 1998, the overall Medicare payment for rural hospitals was 6.4 percent less than their costs—down further from their 3.9 percent loss in 1997. Compare this to urban hospitals whose overall Medicare payments exceeded their costs by 1.9 percent in 1998.

This downward turn in 1998 for rural hospitals and Medicare revenues is especially worrisome because it reflects just the leading edge of changes due under the BBA. The worst may well be yet to come with the extension of prospective payment over more forms of service. Over the past several years, rural hospitals have diversified their services, enabling them to meet a wider range of health care needs for rural communities. But without adequate revenues from these services—outpatient care, nursing home care, home health and ambulance services, it can be difficult to keep the doors open.

Yet none of the new prospective payment systems contains any special payment adjustments for rural hospitals. Worse, they may be imposed without correcting some fundamental problems in the calculus of the Medicare formulas. I would like to focus on those problems because they now represent an important opportunity for Congress to put rural health care on a more level playing field with the rest of the nation.

POLICY OPPORTUNITIES

There are three areas that offer an opportunity to correct Medicare payment inequities. These are flaws, omissions, or inequities in the program's payments that can be corrected at little cost to the Medicare fund. Addressing them could go a long way toward protecting rural health care access. Left unchanged, and replicated in the forthcoming PPS formulas, these flaws will compromise rural health services—eliminating them in some instances, and adversely impacting rural economies in the process.

First, there is the long-recognized bias toward urban hospitals in the payments that Medicare makes to hospitals shouldering a disproportionate share of low-income patients. These are known as DSH, or Disproportionate Share Payments. Second, Medicare reimbursement formulas do not recognize or compensate small, low-volume rural hospitals for the higher per-unit cost they incur in providing care. Third, Medicare's geographic wage adjustment, which is supposed to account for differences in urban and rural labor rates, is flawed and under-compensates many rural hospitals.

DISPROPORTIONATE SHARE (DSH) PAYMENTS

Let me begin with the DSH payments. Under the present complex allocation formulas, hospitals with the same proportion of low-income patients can have very different payment adjustments. Current policy particularly favors urban areas. Almost half of urban hospitals receive DSH payments compared with only about a fifth of rural facilities. Also, urban facilities receive payments that are steeply graduated by hospital size.

As a consequence of this inequity, more than 95 percent of all DSH payments go to urban hospitals. How much money are we talking about? In 1998, total Medicare DSH payments added up to six percent of Medicare's total inpatient PPS payment, which was \$75.6 billion. That's \$4.5 billion—and urban facilities received 95 percent of it.

The Medicare Payment Advisory Commission has made a recommendation every year since 1998 to redress this situation by treating all hospitals equally. The commission proposes that payments should be made according to each hospital's share of low-income patient costs. What would this change mean for rural hospitals as a group? It would increase the total of Medicare's inpatient PPS payment to them by 6.5 percent. It would decrease the total inpatient payment to urban hospitals by only one percent.

ABSENCE OF LOW-VOLUME ADJUSTMENT

Let me now turn to the second issue that relates to the unique circumstances rural health care systems face: That is the problem of fixed overhead costs coupled with low patient-volume. Medicare's prospective payment policy was designed to promote efficiency and eliminate waste. The decision to pay all providers the same base price for the same procedure, irrespective of hospital size, was deliberate. The prospective payment for a procedure was based on the average cost per case incurred by a presumably efficiently operated hospital. Also, it was not unreasonable to assume that a uniform price would be an incentive for smaller providers to merge and achieve economies of scale that could result in lower costs and higher margins.

I would like to suggest to the committee that this design feature was sensible policy for urban providers, but not, certainly, for all rural providers—for whom major economies of scale are simply not achievable. In terms of low volume and fixed overhead, there are good lessons government programs can learn from the private sector. For example, even as we attempt to draw large managed care plans into rural areas to serve Medicare beneficiaries, the private sector is telling us that the market dynamics are difficult; and given payment rates, they cannot afford to do business in low-volume, low-density places.

Basically, the "one-size fits all" approach to Medicare payment policy ignores the population distinctions between rural and urban populations and their order of magnitude: Urban hospitals serve populations in the tens and hundreds of thousands. Forty percent have 200 or more beds and 75 percent have a hundred or more beds. Rural hospitals serve populations numbered in the hundreds and the thousands. Eighty-two percent have fewer than one hundred beds.

Since many rural towns have few or only one provider for particular services, it is critical in these regions to take into account the relationship between a provider's volume and the unit costs. An X-ray machine and a minimal staff are required for a radiology lab, whether it takes five X-rays a day or 50. These fixed costs in low volume facilities result in high costs per unit of service. And almost all services have fixed costs associated with them—costs that can't be eliminated through attempts to improve efficiency.

Rural Ambulance Service

A good example of the unique problems with high fixed costs and low volume is rural ambulance service. The availability of ambulance service is one of the top priorities for developing viable health systems in rural communities. Medicare payment must be adequate to sustain such a critical service. HCFA will soon publish a proposed rule on the Medicare ambulance fee schedule that was developed through a negotiated rulemaking committee. This schedule recognizes the need to adjust rates to compensate for the higher costs per transport where population density is low, although there is a methodological obstacle of not having a scale of rurality for making graduated payments. The proposal for a 50 percent add-on to the mileage rate on the first 17 miles is a temporary proxy for the higher cost of low-volume suppliers and the negotiated rule-making committee urged development of a method that could address low-volume payment as soon as possible. This will be extremely important to the new Critical Access Hospitals and the effort to integrate them with rural ambulance service.

Mr. Chairman, I believe that it is time for the Congress to consider including a low volume adjustment for small, isolated rural providers for all of the prospective payment systems: the new systems as well as inpatient PPS. Such an adjustment would be possible to design using available data. Most importantly it would be inexpensive—in the range, according to one estimate, of only \$500 to \$1,500 for every million dollars in Medicare inpatient payments. This is because total Medicare payments to small rural providers are a tiny proportion of total Medicare payments. In 1996 the Prospective Payment Advisory Commission estimated that rural hospitals of under 50 beds received only two percent of Medicare inpatient PPS operating payments and those of 50–99 beds received only four percent.

I am attaching to my testimony today a paper by Dr. Graham Atkinson, which offers a fuller discussion of policy approaches to accomplish this.

MEDICARE GEOGRAPHIC AREA WAGE ADJUSTERS

The last problem in need of a policy solution has to do with the Medicare Geographic Area Wage Index. Currently, the hospital wage index used to adjust Medicare inpatient payments for geographic variations in labor costs generally undercompensates rural hospitals and overcompensates urban hospitals. While the index should rightly reflect area labor costs that are beyond a hospital's control, it should not reflect a rich occupational mix that results from a hospital's desire to enhance its staffing. But in fact, the current index is calculated on averages in actual payrolls rather than the relative differences in wage scales.

The rural inequity in the wage index has unfairly depressed rural hospitals' inpatient payments for close to two decades. Now it is to be used in the new prospective payment systems rather than just the one for which it was designed. The rural underpayment built into the current inpatient system is about to be extended to a much larger proportion of Medicare payments to rural hospitals, not to mention freestanding rural nursing homes and home health agencies. Mr. Chairman, there is a new urgency to the need for Congress to address the rural inequity in the Medicare area wage index.

As far back as 1988 and at least four times since then, the Prospective Payment Advisory Commission expressed concern over the inappropriate treatment of occupational mix in the wage index.

Since then, MedPAC has recommended improving the crudely drawn definition of hospital labor market areas, which is based on the MSA, non-MSA dichotomy and on the arbitrary boundaries of states. In fact, rural labor markets are treated as statewide and ending at the state line. This ignores legitimate variations in the labor market across a state's rural areas, as well as the reality that labor market areas often include parts of two or more states. The result is that neighboring hospitals on opposite sides of the state boundary are often compensated very differently for the same procedure. For example, a North Dakota rural hospital across the border from a neighboring hospital in Minnesota will be paid eight percent less by Medicare for all its Medicare cases: It will get only \$3,515 from Medicare for a simple pneumonia and pleurisy case, compared to the \$3,821 paid to the Minnesota hospital.

Thanks to Congressional action to alleviate large wage index differences near labor market borders, some hospitals today can apply for reclassification to an adjacent area. However, both HCFA and ProPAC analysts have said this has not solved the problem. ProPAC specifically recommended a more accurate delineation of labor market areas.

An enormous problem now on the horizon is the fact that this flawed hospital inpatient wage index is inappropriate to apply to skilled nursing facilities and home health agencies as they move to prospective payment. The mix of employees and the wages paid by these providers differ substantially from those of hospitals. Yet HCFA is using—the inpatient wage index for these providers.

By way of example, when the state of Wisconsin recently used its own nursing home wage data to calculate an appropriate wage index for rural Wisconsin, the result was a much higher index than the hospital-based one proposed by HCFA in the May 2000 Federal Register notice. Rural Wisconsin's was 98 percent of Milwaukee's wage index, not 93 percent as calculated by HCFA using the hospital index. Lest this seem too trivial, let me add that the state calculated it would mean a six or seven million-dollar difference a year in reimbursements for rural Wisconsin nursing homes. Mr. Chairman, the wage index is certainly not an easy topic to tackle, but it is a crucial one for rural areas, and I will leave your staff with a policy brief on the topic by Anthony Wellever just published in conjunction with the Rural Policy Research Institute.

MONITORING THE WHOLE SYSTEM

As we move further into the post-BBA era, it will be important to monitor reform's effect on the whole rural health care system. That's to say, the highly interdependent nature of rural health care providers makes it important to have the latest financial information on the combined impact of all recent and future Medicare policies, including the new prospective payment systems.

Studies which look only at how many home health agencies have closed, for example, will miss the point in rural areas: If a rural hospital operates the only home health agency, it is more likely to keep that service open to ensure patients have access to post-hospital care—even though home health may very well move from a profit center to a loss center for the hospital. A more valid measure of home health access would be to look at operating margins for hospitals with hospital-based home health agencies before and after the new interim payment system was imposed.

SEEING THE ECONOMIC STAKES

Mr. Chairman, our nation's population has shifted from largely rural to urban in just three generations. Even so, rural Americans today number 61 million people—exceeding the population of France and many other European nations combined. Consequently, we need to ensure that our national policies do not defeat rural economics, or compromise rural beneficiaries' access to quality health care services. Special Medicare payments to rural providers should not be considered add-ons. Medicare payments per enrollee are already 18 percent less per rural beneficiary than per urban beneficiary—even with the modest programs focusing on rural needs. There is a legitimate cost of sustaining health care services in rural areas. And there is a tremendous return on investment, when we realize the economic impact of the health care sector.

Fortunately, federally supported research on this subject is not gathering dust on university shelves. Through an important new national initiative, for example, rural communities are looking at their own economic profiles. Today there is a project underway in fifteen states called "Operation Rural Health Works," in which local data is collected to demonstrate the multiplier effect of locally spent health care dollars on services and employment for individual communities. It's a joint project supported by USDA's Cooperative Extension, the Health Resources and Services Administration, and the Minnesota-based Rural Policy Research Institute. This and other research endeavors on rural health care systems and their relationship to rural economies will help to illuminate challenges and policy opportunities for sustaining health care and strengthening communities for millions of rural Americans.

Mr. Chairman, thank you for your attention. I would be happy to answer any questions.

Senator COCHRAN. Thank you, Dr. Wakefield, for your helpful analysis of the situation. It is very illuminating for our committee and I appreciate very much your efforts to put together such a helpful statement.

Mr. Thomas Scully, President of the Federation of American Health Systems, welcome.

STATEMENT OF THOMAS A. SCULLY, PRESIDENT AND CHIEF EXECUTIVE OFFICER, FEDERATION OF AMERICAN HEALTH SYSTEMS

Mr. SCULLY. Mr. Chairman, thank you.

Senator COCHRAN. Thank you for being here.

Mr. SCULLY. I talk almost as fast as Mary does. Two Yankees in a row; maybe the next Mississippi panel will balance that out.

Senator COCHRAN. We are exhausted, or we will be, listening so hard.

Mr. SCULLY. Well, I will try to keep it slow.

I am the President of the Federation, which has 1,700 member owned and managed hospitals, 28, as you know, in Mississippi. We actually have 12 that we manage in Montana. Across the country, about 400 of those 1,700 hospitals are rural, so we have a significant problem, obviously, with rural hospitals.

I am going to shift gears a little bit from what Mary and Dr. Berenson talked about. I am going to take a little more of a budget angle. As you mentioned, I spent 4 years on the White House staff in OMB doing health care budgeting in the prior administration, so I have a little bit of background on that.

The problem really here I think is that there is really no precedent for what has happened in 1997 BBA numbers-wise. When you look at the numbers, I think they are pretty stunning. There is no precedent in the Medicare program or in the history of the Federal budget for what has happened in the last 2 or 3 years in the Medicare program.

All across the board hospitals, urban and rural, have been hammered by the BBA, but I think it has been unquestionably much

tougher for rurals. If you look just at this year, fiscal year 2000, Medicare spending this year will be \$29 billion or 12 percent less than it was supposed to be when the BBA passed two and a half years ago. That was after the cuts, after the BBA cuts, \$29 billion less.

The original \$103 billion savings target of the BBA is now conservatively estimated to have saved about \$250 billion. So while it is wonderful for the surplus and wonderful for the deficit, it has had a huge impact on the Medicare program. The rural share just this year of those cuts is \$7 billion, so rural health care spending on Medicare is \$7 billion less than it was supposed to be when the bill was passed two and a half years ago.

I would respectfully suggest that if your 302(b) allocations on the committee were cut by \$7 billion this year, there would be a big problem in the Appropriations Committee and a big problem in the Senate. But because this happened in an extremely complex entitlement program, Medicare, even though that money is flowing to the same communities, most people do not really have a grip for what has happened policywise and there has been far less attention on it.

Medicare spending in total, which a lot of people do not realize, actually fell last year by 1 percent, negative 1 percent real growth, and Part A spending in the trust fund, which is mainly hospitals and also nursing homes, fell by 4.4 percent. That has never happened in the history of Medicare.

Medicare hospital spending—and I have an attached chart, attachment D in my testimony—Medicare hospital spending in 1999 was 2 percent less, \$3 billion lower almost, in 1999 than it was in 1996. So if you look back 3 years later, with 1 percent a year beneficiary growth and roughly 2.5 to 3 percent a year inflation, in 1999 absolute Medicare hospital spending was a couple billion dollars less than it was in 1996. There is nothing in the history of any Federal entitlement program that I am aware of that is remotely like that, and certainly not in the Medicare program.

What is the rural impact of that? Well, one-third of rural hospitals are now operating in the red and, whether you look at the MedPAC, the Commission that Mary serves on, or HCFA's data, the Urban Institute has a rather detailed study on rural health care out, or the HCA-Ernst and Young study that was put out this spring, no matter what data you put out, and I have attachments on each of those, I think you will find that the overwhelming evidence of all the recent studies is that rural hospitals and rural health care have been hit far harder than anybody else, although I think all hospitals have been hit hard.

Well, why do hospitals get hit hardest in rural areas? I will just try to use one example, Mississippi, to give you an example of what has happened. There is a hospital in Bolivar, as I am sure you all know, Bolivar County, Mississippi, Cleveland, Mississippi, the home of Delta State. It has a 70-bed hospital that has about \$30 million a year in revenue. For many years it was a very successful hospital, had generally about a \$500,000 surplus on \$30 million of revenue. Forty-five percent of its patients are Medicare patients, 30 percent Medicaid, 15 percent, which is very low, private insurance, and 10 percent indigent care, who just cannot pay.

As a direct result of the BBA, that \$500,000 a year surplus on average through the nineties was turned into a \$2 million a year loss, and that is a county-owned hospital. What was the reason for that? Medicaid pays \$200 a day less than costs. Medicaid in almost every State, including Mississippi, is generally the worst payer by far. Medicare is usually the second worst.

Second, even though that is the only hospital in the county, it cannot get sole community provider payments because technically there is one very small psychiatric hospital also in the county, quite a far distance away. But due to the Medicare rules they cannot become a sole community provider, so they could not get extra payment due to that. There is obviously, with 15 percent private pay, no private sector to shift the cost to when you have extremely low Medicaid patient payments and extremely low Medicare patients—payments, excuse me.

So they really had nowhere to go. So the county really had no choice, but they sold the hospital about 2 months ago, as I am sure you know, to Providence Health Care, one of my members that owns 19 rural hospitals around the country and manages 58. Now, what has had to happen? Providence has invested, committed to invest, \$10 million over the next few years in that hospital and they have paid off the hospital's debt. But there is no question, and the community knows this, that they are going to have to cut \$2 to \$3 million in costs per year.

Now, that is a small town with the hospital probably next to Delta State as the biggest employer, and that means significant cuts in staffing and significant changes in the hospital, in a hospital that has done a great job for many years for that community. So obviously they are going to be a terrific impact on that small community.

When you look at it, what are the reasons? Lower Medicaid payments by far is the biggest reason. Low Medicaid payments, and in rural areas very little private sector-based to shift any costs to. So what is the remedy? We think a very good start is obviously, we call it, the Grassley-Cochran-Conrad-Baucus-Daschle—I could throw in a few others—bill. But obviously, the bill that you have introduced is a very good start.

I do not think you can solve all the problems of rural health care this year, but that bill provides a full market basket update, which I think is appropriate for all hospitals. If you look at the last 3 years, due to the BBA all hospitals had a freeze in their base payments, which are DRG's, in 1998. They had market basket, which is our CPI minus 1.8 percent, for the last 2 years. Those cuts, which are the biggest in the hospital program, so it saved probably close to three times what they are supposed to save in 1997. And I think it is hard for me to argue with the rural-urban that a hospital should not get a full inflation update in the coming years.

The Medicare-dependent hospital program is a very helpful program to a lot of rural hospitals, but unfortunately you cannot qualify for it unless you were in the program in 1986. Dr. Berenson mentioned that the administration is looking at changing that. That would be helpful.

Another thing in your bill is the capital loan program that would be very helpful to put in for small hospitals. Finally, and I am very

happy to see the administration actually support it this morning, adjustments to the Medicare disproportionate share program, which I think probably would have the biggest single impact to a lot of rural hospitals, is to allow rural hospitals more flexible rules to get into the Medicare disproportionate share program.

Now, I have a lot of big urban hospitals, too, and I would argue it would not be—hopefully, that would be done with new money, because I think it would be very dangerous. No hospital I know are doing particularly well. So I think opening up the DSH program to new providers would be a terrific idea, but hopefully would not be done at the expense of the hospitals that already provide a lot of indigent care.

What is the process this year? The President reversed some of the budget suggestions early in this year. Obviously, hospitals were happy with that. He proposed a \$21 billion BBA restoration package about 2 weeks ago, which we are very supportive of. That included a full market basket inflation. We think that is a great start, with a lot of the rural provisions from your bill in it.

We hope—the Democratic leadership in the House and the Senate have supported it. We have seen very positive signs certainly in the House, a little bit in the Senate. And we hope very strongly that, with your support, there will be some kind of a BBA restoration package. I think when you look at the numbers, you find the BBA overshot its target by \$29 or \$30 billion this year, and the most I know of anybody talking about putting back in is probably \$2 billion this year. And it has overshot its target by \$200 billion over 5 years and we are talking about in the President's package \$21 billion. So you are basically talking about putting back in at the very most 10 percent of what was inadvertently taken out.

I think that is a pretty modest restoration package. So we very much appreciate your support, Mr. Chairman, and the support of the committee in having these hearings, and we have tried to work with you closely and we would love to work with you in the future to do whatever we can to help push forward a rural health package and a rural Medicare package.

[The statement follows:]

PREPARED STATEMENT OF THOMAS A. SCULLY

Mr. Chairman, My name is Tom Scully, and I am the President and CEO of the Federation of American Health Systems. The Federation represents nearly 1,700 privately owned and managed community hospitals across the United States. Our member hospitals are heavily concentrated in the Southern and Western United States. In Mississippi, we have 28 member hospitals, mostly in rural areas, serving a very diverse and very low-income population. In total, we represent more than 400 rural hospitals, in almost every state of the Union. As I am sure you will hear from almost all of the witnesses today, the last few years have not been pleasant—or easy—for anyone involved in rural healthcare.

Since much of my testimony is budget related, I might add that from 1989 to 1993 I served as the Associate Director of the Office of Management & Budget, and as a Deputy Assistant to President Bush. Among other responsibilities, I was responsible for the budget and policy oversight of Medicare, Medicaid and other federal health programs.

THE PROBLEM: THE 1997 BBA

All hospitals, urban and rural, have been hammered by the Balanced Budget Act of 1997 (BBA), which has had a far greater impact than anyone could have imagined when it passed 2½ years ago. Just this year, fiscal year 2000, Medicare spending will be more than \$29 billion less than intended when the BBA passed (see At-

tachment “A”). This is an unintended 12 percent cut in the program. The rural share of this unplanned plunge in program spending is about \$7 billion this year (see Attachment “B”). You can’t pull nearly \$30 billion a year out of the health system—and nearly \$7 billion out of rural communities—and not see a BIG impact. It wasn’t intended, but the results are impossible to miss (see Attachment “C”).

I would respectfully suggest that if the Subcommittee’s 302(b) allocation for rural programs were cut by \$7 billion this year, there would be chaos in the Appropriations Committee and the Senate. This is the magnitude of the cut in rural health spending. But it has occurred in a very complex entitlement program, where the impact of policy changes on each community can be difficult to ascertain. So, the legislative focus on the problem has also been somewhat blurred.

Last November, the Balanced Budget Refinement Act (BBRA), a.k.a. the BBA ‘add back’ bill, restored \$1 billion in program spending for fiscal year 2000, and \$15.8 billion over 5 years. We were, and are, very grateful for Congress’ thoughtful bipartisan response. However, between November 1999 and January 2000 Medicare spending estimates fell by \$8 billion for fiscal year 2000 alone, and by \$73 billion over 5 years, wiping out—many times over—the intended impact of the restoration package.

Making matters worse, when the Congressional Budget Office’s (CBO) “Mid-Session” estimates are released later this month, Medicare spending estimates are expected to fall an additional \$45–\$85 billion from fiscal year 2001–05. The result is an astounding, and totally unprecedented, reduction in projected spending of well over \$100 billion in just eight months.

Medicare BBA savings could exceed the intended \$103 billion (1998–2002) by as much as \$200 billion. Over \$125 billion of this unexpected windfall is forever “gone” to deficit reduction and the surplus. Both Houses of Congress have considered Medicare ‘lock box’ proposals that would ensure that any future unexpected savings would be reserved for Medicare. This would be an enormous positive step in strengthening the program.

Medicare spending, in total, fell 1.0 percent last year, and Part A of Medicare (the Hospital Insurance Trust Fund) fell by 4.4 percent. For comparison, total hospital-based Medicare revenues were almost 2 percent lower in fiscal year 1999 than they were in fiscal year 1996! (see Attachment “D”). It is impossible to find any major federal program that has felt this type of squeeze particularly with the Medicare population growing at greater than 1 percent a year, and inflation at 2–3 percent per annum.

THE RURAL IMPACT

Almost one-third of ALL hospitals will operate in the red this year the highest number ever. No matter where you look, whether it is government reports or independent studies, hospital margins are sharply lower. An equally clear point, in virtually every study, is that rural hospitals have been hit the hardest. The evidence is overwhelming:

- The Medicare Payment Advisory Commission found that “rural hospitals have lower inpatient margins. From 1992–97 the gap widened . . . and rural hospitals were also disproportionately affected by the BBA”. (June 2000 Report)
- The Health Care Financing Administration (HCFA) in its recently released Hospital Prospective Payment System (PPS) Rule for fiscal year 2001, stated that, “rural hospitals continue to struggle financially approximately one-third of rural hospitals continue to experience negative Medicare margins.” The rule further states that “because rural hospitals’ financial performance has consistently remained below that of urban hospitals, we now believe that rural hospitals merit special dispensation . . .”
- The Urban Institute, in a March 2000 study, Supporting the Rural Health Care Safety Net, found that “unless rural circumstances are taken explicitly into account, not only in the design of programs for rural areas, but in policy changes in Medicare and Medicaid, the unintended consequences for rural areas can be severe. The importance of such changes can be seen most clearly in the toll that the Balanced Budget Act changes have taken on rural hospitals . . . For communities whose systems are struggling, the result may be the collapse of the local system.”
- An HCIA/Ernst & Young study found that margins for rural hospitals (<100 beds) in 2000 averaged .69 percent, while larger hospitals (>100 beds) averaged 4.27 percent. (see Attachment “E”). This study also found that “hospitals with less than 100 beds are hardest hit by the BBA: their margins significantly decrease from positive 4.2 percent in fiscal year 1998 to negative 5.6 percent in fiscal year 2002, a drop of 233 percent.”

WHY DO RURAL HOSPITALS GET HIT HARDEST?

They have a higher Medicare inpatient population (about 63 percent on average) than the average hospital, and Medicare pays substantially less than private payers (about 98 percent of costs vs. 119 percent of costs). With a limited private insurance sector to shift costs to, there is nowhere for rural facilities to go.

Rural hospitals generally have very high Medicaid populations and Medicaid is almost always the worst payer.

Doctors, nurses and even “coders,” i.e. those who code Medicare payments, are extremely hard to recruit to rural areas. And while payments for hospitals are “adjusted” to reflect local wages, rural wages are usually extremely low. Therefore, the cost of recruiting medical staff, and the proportion that these costs represent of a rural facility’s costs, are often higher.

Finally, regulatory burdens are also more costly. The expense of inspections, compliance programs, and all other regulatory costs are roughly the same for a 60-bed hospital in the country as they are for a 400-bed hospital in an urban setting. But, they are a far greater percentage of the rural facility’s expenses.

ONE MISSISSIPPI EXAMPLE

The experience of one Mississippi hospital is a microcosm of rural America. Bolivar County Hospital, a 70-bed hospital in Cleveland, Mississippi, had operated successfully for years in this small town, home to Delta State University. It had operated on approximately \$30 million a year in revenues, showing an annual profit—or surplus—of about \$500,000. Its patient base was, and is, about 45 percent Medicare, 30 percent Medicaid, 15 percent private insurance and 10 percent indigent care (i.e. ‘bad debt’).

As a direct result of the BBA, Bolivar County went from a \$500,000 a year profit to a \$2 million per year loss. What happened?

- Medicaid pays \$589 per day a certain loss of over \$200 per day per patient;
- Even though it is the only significant hospital in the county, due to arcane Medicare rules, it couldn’t qualify for Sole Community Provider status because there is another very small (mostly psychiatric care) hospital in the county; and
- Finally, as noted earlier, like most other rural facilities, there is no private base for Bolivar County to shift the cost. Therefore, the loss of Medicare and Medicaid revenues from the BBA could not be made up elsewhere.

So, the community was in a fiscal hole, with no way out and no warning. As a result, this May the county sold the hospital to Province Healthcare, a Federation member that owns 19 rural hospitals and manages 58 other non-profit hospitals. Province has agreed to pay off the hospital’s debt, and invest \$10 million over the next few years in Bolivar County Hospital. But this transition will be painful. Province hopes to cut \$2–\$3 million in expenses, partially by improving contracts and cutting supply costs through its larger system. Still, there will also be staff layoffs there was simply no other way out. The community understands this, but still, they won’t like it—what community would?

Keep in mind, Bolivar County was in a relatively healthy situation. And hundreds of other rural hospitals aren’t on such solid footing, and without Congressional action, might soon be in similar straits. This is the reality of the BBA in rural communities. The numbers don’t lie and absent some relief, it will only get worse.

THE BEST REMEDY: S. 2735—THE GRASSLEY/COCHRAN/CONRAD/BAUCUS/DASCHLE BILL

The long-term problems of rural health care can’t be solved this year. But the Health Care Access & Rural Equity Act of 2000 (H.R. 2735) is a solid start. The key components are:

- A full market basket (MB) update, which is the hospital equivalent of the Consumer Price Index (CPI). This full inflation update should be done for ALL hospitals—on both inpatient and outpatient payments. The inflation adjustment policy from the BBA for the last three years has been: a freeze (fiscal year 1998); MB–1.8 (fiscal year 1999) and MB–1.8 (fiscal year 2000). The cumulative impact has been devastating, and the policy has already saved far, far more than was intended in 1997.
- An update in the rules for the Medicare Dependent Hospital (MDH) program, which now only includes hospitals that were eligible in 1986. Basing the qualification on more recent data would help hundreds of rural hospitals receive marginally higher but certainly helpful—additional payments for the patients they serve; and

—The capital loan program, which would provide greatly needed assistance in raising capital for rural hospitals. Few of my members would utilize this program, but it could be very helpful to many struggling rural facilities.

Finally, we would suggest adding a policy, not included in the bill:

—Adjusting the Medicare Disproportionate Share Hospital (DSH) eligibility to allow for greater equity between rural and urban hospitals. This would aid hospitals that care for very poor seniors. However, any change must NOT be made at the expense of urban hospitals that are already in the program. Still, many rural hospitals serve huge numbers of poor seniors (as in Mississippi), but they receive little or no DSH payments because the qualifications are so much higher for rural hospitals (generally 45 percent of indigent patients vs. 15 percent in urban areas). This policy alone would have an enormous impact in poor rural areas.

THE PROCESS FOR RURAL RELIEF

In addition to S. 2735, another much needed addition would be a fuller BBA restoration package. The President recently offered such a proposal, totaling more than \$21 billion in relief over the next five years. The package included a full inflation adjustment for inpatient payments for fiscal year 2001, and implied that it would also include the Grassley/Cochran/Conrad/Baucus/Daschle bill. But, it only specified \$10 billion of the \$21 billion in new spending, leaving much to “future discussions with the Congress”. The Federation believes that this is a good start to what we hope will be a serious, bipartisan and bi-cameral BBA restoration discussion.

The Democratic Leadership of the House and Senate has endorsed the President’s package, and the House Republican Leadership has indicated that they also intend to address BBA relief over the next few months. We certainly hope that this hearing will encourage Senators, on a bipartisan basis, to place BBA restoration on the “must do” list for the Senate before Congress adjourns. The nation’s 39 million seniors, who depend on America’s hospitals to meet their daily healthcare needs, desperately need this attention.

Mr. Chairman, thank you again for inviting the Federation to testify. I look forward to answering any questions that you may have for me.

Senator COCHRAN. Tom Scully, we thank you for your insight and your helpful observations about what we can do and what the administration can do to help alleviate this very serious problem. I am fascinated by the prospects that we are arriving at a consensus for some change legislatively and I hope administratively as well. I hope this hearing will help serve the purpose to generate some more interest and enthusiasm for moving quickly to deal with these problems.

In connection with the suggestions, Dr. Berenson made a couple of observations of things that could be helpful. I would hope that we would see some specific administrative changes and not just suggestions for Congressional action. Is there a list or do you have some items that you could tell us that the administration is expected to do on its own, that does not require Congressional action, that would help alleviate some of the problems that are confronting rural hospitals?

Dr. BERENSON. Most of the benefits really come out of legislation. We have on our own, however, for example, in the implementation of the outpatient hospital regulation provided clarity that critical access hospitals do not have to meet the requirements of the new, more complicated line item billing procedures or reporting. We actually had worked with the Congress last year to make sure that as we implement outpatient that rural hospitals are protected for over 3 years in terms of the financial hit that would happen to them.

We have in a number of instances tried to make it easier for rural hospitals to reclassify into urban areas for purposes of getting the urban wage index and work through something called the Gold-

smith modification that permits a rural-like area within a large urban county to be able to also get additional wage index payments.

So we have in a number of instances within our discretion tried to accommodate some of the immediate needs of rural hospitals, but many of the fixes I think really do require statutory change.

Senator COCHRAN. One of the suggestions that we have heard from some hospitals is that it would be helpful to receive full and timely payments under Medicare. Is this something that the administration plans to implement, this so-called OPPS payment contingency plan?

Dr. BERENSON. Yes. That refers to the current transition that we are now making to the outpatient payment system, which will for all hospitals require significant changes. We have actually postponed the effective day for implementation of the outpatient prospective payment system from July 1 to August 1 because we understood that neither HCFA systems were fully ready and that we needed to give hospitals somewhat more time to become ready.

As part of that, we have committed to payments. If in fact we are not able to get the system up on time and be able to process claims on time, we will be making payments for this adjustment period and have committed to doing that.

Senator COCHRAN. One suggestion included in Senator Grassley's testimony dealt with the wage index, and also Dr. Wakefield mentioned that it assumes that rural areas pay less for health care professionals and other expenses in doing business. Does HCFA plan to re-evaluate the wage index policy for reimbursement purposes?

Dr. BERENSON. Well, we on an ongoing basis may determine—the Office of the Actuary actually determines—what the percentage that is attributable to the wage index. The suggestion of having it be based on the hospital's own cost report gives us some concern about operational issues. This would certainly complicate the calculation for over 6,000 hospitals, their ability to project what their payment would be to be dependent on what could be for small hospitals year to year fluctuations.

At the same time, if in fact—we are prepared to look at whether there is a systematically different percentage of wage index that applies to rural hospitals as opposed to urban hospitals and if that can be demonstrated perhaps could work with the Congress to develop a system that does not create sort of operational problems, but has a different percentage that would apply to rural hospitals. We will be happy to work with the committee to try to understand that.

Senator COCHRAN. Dr. Wakefield, you mentioned also this wage index problem and I wonder if it is your view that this should be something that is undertaken through legislative action by Congress working with the administration to develop a plan that we could agree on and then put it in place that way. Is that your suggestion?

Dr. WAKEFIELD. It would be. It is in fact, and I think Senator Grassley and his colleagues are to be commended for starting to tackle this really complicated formula that by all accounts disadvantages rural hospitals.

There are some additional areas that one might look at from the Congress beyond the focus of his bill, and he himself mentioned that his bill addresses one facet of the area wage index problem, but that there are others. For example, currently there is a 4-year gap between the time when data are collected on which that wage index is calculated and the year to which that wage index is applied. So for example, the wage index for fiscal year 2000 is based on data that were collected in fiscal year 1996. So that would be one additional area to look at.

Second, defining labor market areas, a big problem. All rural areas within a State now are assigned to the same labor market for calculating the rural area wage index. These labor market definitions really do not adequately reflect the variation in relative labor costs among hospitals. You can have two hospitals across a State border and they may be in the same labor market, but they are assigned to different indexes. And you can have a single State-wide labor market that may be too large in many States to recognize differences in the amounts that are paid for labor.

So that is another area. Effective occupational mix is a third. Also, I would say to be really mindful that, with the introduction of prospective payment systems now for other services—home health, skilled nursing facilities, et cetera—the wage index that is applied to those services is also going to impact rural hospitals to the extent that rural hospitals provide not only inpatient care, but also home health, skilled care, et cetera.

Senator COCHRAN. What would you view as the most pressing inequity between rural and urban hospital reimbursement that should be addressed by this Congress, if you had to pick the highest priority?

Dr. WAKEFIELD. Boy, pressing is tough, because they are all such high priorities. But one that I think could be done with relative ease and, frankly, with your good staff I bet they could put the formula together pretty quickly, that would be a change in DSH. We have already got some parameters for how that should change, and not even going as far as MedPAC has proposed, but just applying more broadly to rural hospitals DSH formula as it currently exists would be a relatively easy fix. That could be put together with the help of some analysts, some of the Federal Office of Rural Health Policy staff, I think very quickly.

Senator COCHRAN. This is the disproportionate share payment?

Dr. WAKEFIELD. Yes, thank you. Sorry for using the acronym.

Senator COCHRAN. That is all right. There might be somebody here who does not know what that meant.

But the current policy favors the urban areas, is what you said in your testimony?

Dr. WAKEFIELD. Absolutely, in a very significant way. And that could be fixed with relative ease.

Senator COCHRAN. Well, by fixing it are we going to hurt the urban hospitals? We do not want to do that.

Dr. WAKEFIELD. Well, you are going to have to do what Tom asked for, actually. That is to take it out—

Senator COCHRAN. Say that again yourself, then, Tom?

Mr. SCULLY. Well, I said that it is about a \$4.5 to \$5 billion pot, and a lot of it by definition you are going to have to treat a lot of

low-income people to get into the program. Now, I think it is very unfair to rural hospitals. For example, if you had a small rural hospital in Mississippi with say 90 beds, you would have to have 45 percent of your patient population be either Medicaid, which is low income, or SSI, to be eligible as a general rule, whereas in an urban area it would be 15 percent.

So if you are in Clarksdale or Bolivar or someplace like that, it is very difficult to qualify. Now, it is relatively cheap to just expand the program for rurals because there are not that many and the costs are relatively low to expand the DSH program. But my own personal view is that if you did it at the expense of large urban hospitals that are, in fact, taking care of a lot of poor people in urban areas, that would be a mistake, and I also think it would be—you know, they are highly dependent on it and they are not doing particularly well, either.

Just to switch back to wage index, to be honest, you have a similar problem there. The wage index also, I believe, is largely—and these sound technical, but it is \$4.5 billion for DSH, the wage index, is the single biggest factor in \$90 billion worth of payments a year. It is the single biggest factor for every hospital in the country.

When you look at the wage index, it used to be far more unfair until 2 years ago, when the AHA convened a group of State hospital association people and myself and we spent 5 months helping HCFA hammer out a new wage index. It used to be more heavily weighted toward the Northeast and big cities and it is now a little bit better. But the idea that I think you can get a wage index adjustment that hurts the hospitals that are already hurting in big cities to shift a finite pot, I think you have the same problem with the wage index. If you are going to fix it for rural areas, there probably has to be an addition of new money and not taking it out of Philadelphia and Cleveland and New York, because I think that is difficult to do.

The good news is when you are trying to fix rural problems they are significantly less expensive to fix as a budget matter than they are when you are trying to fix urban problems.

Senator COCHRAN. I know, for example, in our State the University of Mississippi Medical Center has a high percentage of indigent care and that would be a shame if we ended up taking money away from that center, for example.

Mr. SCULLY. Yes, clearly I am sure you would not want to do that.

Senator COCHRAN. Let me ask you one other thing, and that is you mentioned this sole provider benefit, that if you were the only hospital in a county like Bolivar, can you get a waiver in case of a situation like that? Where there is a hospital but it is a specialty hospital and may not have been contemplated that it would be the kind of hospital that was intended in the legislation? Can the administration grant a waiver?

Mr. SCULLY. They can, but it is tough and it is on a case by case basis. I think that is someplace they could help. I mean, we have the situation in Bolivar where I think there is a 10-bed, maybe 12-bed hospital with a few psych beds that happens to be in the same

county, so Bolivar cannot get sole community provider status even though they really are the only acute care provider in that county.

I have another situation in Alice, Texas, just to give you an example, where the only hospital in that county, someone opened a small, 20-bed hospital in the same county, so they just lost their sole community provider status, which is about \$3 million a year to that hospital. It took it from being in the black to being in the red in a day.

HCFA is flexible and in that case we are still working on it. But that is one place I think where HCFA can be significantly helpful.

Senator COCHRAN. Dr. Berenson, did you write that down?

Dr. BERENSON. I did. I am looking actually at our eligibility criteria and we have tried to contemplate lots of exceptions. The definition of the sole community hospital is that it is located more than 35 miles from another, is located between 25 and 35 miles from another and it serves at least 75 percent of inpatients in its service area or has less than 50 beds. Then there is weather and then there is other things, and I cannot imagine that we cannot find a way to help that situation out.

Senator COCHRAN. The weather is hot down there. Does that count?

Dr. BERENSON. There you go.

Mr. SCULLY. We can get a building at Delta State named for that.

Dr. BERENSON. It actually says "where the weather makes it inaccessible for at least 30 days in each of 2 out of 3 years." I mean, we have attempted to try to be flexible with how we apply this, but obviously as sort of a Federal program we try to be consistent and have criteria that could be applied broadly.

I would also like to just, if I could have the opportunity, just make one comment on picking up a point actually that both Mary and Tom made about occupational mix, but then the difficulty of making a change. ProPAC before MedPAC had identified this issue, as Mary said, of occupational mix which potentially is an explanation for why urban hospitals have higher wage index, because they have a more significant burden of illness, the kinds of diseases that come through, and so they need a higher occupational mix.

The logic would be that by factoring out occupation in trying to determine wages for comparable professional staff you would find a differential. When HCFA and the hospital industry has looked at it, it has not been clear and there has been concern about new reporting burdens, and I think there is also a concern by the urban hospitals about what happens to them if, in fact, they found such a change.

So it is not as if we have not looked at it in the past. There has really been on consensus for change in this area. Maybe, Tom, you have a little history as well. It would seem like that would have explained some of this difference, but at least as I understand it, not having been there at the time, it really did not hold up as a valid differentiator or, alternatively, the burden of reporting was just too much for what the difference that turned up.

But having said that, we are quite interested in looking at wage index issues. GAO and MedPAC specifically are now looking at wage index issues and we are certainly willing to work with them.

It is complicated in a context where some group of hospitals will be winners and others will be losers, and so it is a complicated area. But as Tom says, it makes up such a large percentage of the payment that is made that it deserves another look at this point.

Senator COCHRAN. You mentioned, Tom, about making greater equity, allowing greater equity between urban and rural hospitals. What adjustment specifically would you suggest?

Mr. SCULLY. Well, there are a number, I think. As I said, the wage index certainly could be further adjusted. I would strongly urge you to do it in a way that is not budget-neutral, because I think when you create losers you create even bigger problems in the hospital sector. But I think the biggest one is probably Medicare disproportionate share and the disproportionate share program is clearly—there are about seven different categories and I would not hope to torture you with all the details of how it works.

But generically, it is very difficult for a rural hospital. To get 45 percent of your hospital population, if you have under 100 hospital beds, which most rural hospitals do, 45 percent of your hospital population as either Medicaid or SSI is very, very tough. I think there may be two or three in Mississippi that meet that criteria. But it is difficult. And if you have over 100 beds, it becomes far easier. If you have over 250 beds, it becomes still far easier. And I am not sure that makes a lot of sense in a low income, rural State like a Mississippi or Arkansas. A lot of those hospitals that are struggling to stay open would be significantly enhanced by getting access to the Medicare disproportionate share pool. I think that by far in my opinion would have the single biggest impact, if you changed the DSH rules for most hospitals.

Senator COCHRAN. That would have to be done by legislation?

Mr. SCULLY. I believe that has to be done by legislation. HCFA does not have the discretion to do that.

Senator COCHRAN. Well, your testimony has been very helpful. I appreciate the time you have all put into preparation for the hearing in a concise way, even though you did talk fast, really fast. I think we have got the gist of it anyway, and a lot of specifics in the record, and I appreciate that very much. You have been very helpful. Thank you.

Mr. SCULLY. Thank you very much.

Senator COCHRAN. Our other witnesses include administrators from hospitals in my State. I introduced Mr. Blessitt and Mr. Grady during my opening statement. To remind everyone, Mr. Jimmy Blessitt is the Administrator of South Sunflower County Hospital in Indianola, Mississippi, which is a 69-bed facility located in the Mississippi Delta area; and Mr. Phillip Grady, who is Chief Executive Officer of King's Daughters Hospital in Brookhaven, Mississippi. That is a 122-bed facility which serves as a regional—serves a regional health care role.

We appreciate very much your attendance at our hearing and we will ask Mr. Jimmy Blessitt to proceed first.

STATEMENT OF JIMMY BLESSITT, ADMINISTRATOR, SOUTH SUNFLOWER COUNTY HOSPITAL, INDIANOLA, MISSISSIPPI

Mr. BLESSITT. Thank you, Senator Cochran. After listening to the presentations that have been given, I feel like wanting to change

what I have to say. But I do want to thank you for allowing the opportunity for me to come and give testimony today concerning the crisis facing the small rural hospitals and its impact on rural development, particularly in my emphasis in the low-income communities.

This crisis has been building for some time due to certain inequities in the Medicare and Medicaid reimbursement system and they are being compounded severely now by the provisions of the Balanced Budget Act of 1997. I know I am preaching to the choir, but agriculture is an important part of any civilization and it is necessary for it. American agriculture, its economic value is tremendous as far as export and the balance of trade. The food and fiber of American agriculture, the raw products of timber and mining, cannot be done in New York City and it cannot be done in Washington, D.C., and it cannot be done in San Francisco. Somebody has got to live and work in rural America if we are going to maintain the Nation that we have.

While our rural population is accustomed to a lack of diversity in cultural and social opportunities, it does require certain fundamental support services through economic development and government support. One of these services which directly impacts economic development is adequate health care. In rural impoverished communities all across this country, the hospital is not only the local basic center for primary care, it is also usually one of the largest employers, with the most highly trained and highest paid employees in the community.

When one of these hospitals closes, it is not only devastating to the provision of health care, it is devastating to the local economy. The closure of a hospital also precludes further economic development. Businesses will not locate in a community without adequate health care, physicians will not practice in a community without a hospital. They cannot afford the sophisticated lab, X-ray equipment and whatever to practice modern medicine in a small private clinic. If you do not have a local hospital, you lose your physicians, as Senator Burns was demonstrating the problem in Montana due to that very reason.

One factor that I think sometimes in economic development terms we tend to overlook is the impact of the payment for medical services at the local level. As most hospital care is paid for by third party payers, these funds that come to a local community for the payment of health care should be viewed as new money. They are new money coming into the community.

Even at a small facility such as South Sunflower County Hospital, that approximates \$10 million a year of new dollars coming into Indianola, Mississippi. Regardless of the multiplier you use to evaluate the value of new dollars in a community, \$10 million has a dramatic effect on a small community in rural Mississippi serving an impoverished population. It is a dramatic amount.

Obviously, not all hospitals currently open should remain so. Some hospital closures necessitated by demographic changes and other factors are inevitable and appropriate. But to force the closure of an otherwise viable community hospital due to an inequitable payment system is to economically doom the community it serves.

I think Mr. Jim Clayton in a letter that I think he sent a copy to you, Senator, he has branches of his bank in nine communities in Mississippi, very active in economic development; he summed it up best in that letter when he stated: "We are doing all we can to promote the area and develop the economy, but without adequate health care we do not have a chance to survive." I think that is very true in a lot of our rural communities. If we lose our hospitals, we are going to lose a lot of those communities.

I am going to talk about my hospital just a little bit, Senator. It is South Sunflower County Hospital. It is a 69-bed acute care facility with 150 employees located in the center of the Delta. As in many low-income communities in Mississippi, Medicare and Medicaid account for 76 percent of our gross revenue. Our charity and bad debt is 18 percent. That leaves us 6 percent of gross revenues available from commercial insurance sources.

It does not take a lot of calculating to realize that there is no room there. Our bad debt and charity is three times our commercial. So you can see the importance of Medicare and Medicaid in our operation.

While we share—support the efforts for relief for all rural hospitals, including Senate bill 2018 and 2735, for the inpatient restoration as well as the measures to prevent further reduction in the State Medicaid disproportionate share program, which is Senate 2299 and 2203, especially important is those bills to Mississippi. The Medicare disproportionate share payment system is critically important to the State of Mississippi and other really low-income States.

While I have not had the opportunity to read Senator Grassley's proposal, it sounds good and I think we appreciate you signing onto that and we would support anything to address the wage index issue. At the same time, Senator, as you know, our hospital is part of a coalition of 48 other small primary care hospitals in Mississippi which constitutes 50 percent of the hospitals in the State. They feel like more of the story needs to be told.

There are several factors which contribute to rural hospitals' ability to remain viable in the face of continued reimbursement inequities and reductions. These include income of the population served. We have got to have some methodology of recognizing the importance of that. And also whether it is a primary care hospital or whether it provides specialty services. That changes the world as far as providing hospital services.

When a hospital is small and rural, serving a low-income population by providing acute care, there are no resources to counteract the slow continuous ratcheting down of the reimbursement necessary for survival. Last year our 150 employees—and this is 150 employees, is what we have—we admitted and cared for 2,700 inpatients, delivered 400 babies, performed 400 major surgical procedures and 800 minor procedures, carried out 45,000 lab tests, 10,000 X-rays, 1,500 ambulance trips, and saw over 12,000 patients in the emergency room.

In hospitals like ours there is no middle management personnel to cut, no extra nurses, no extra lab technicians. We are providing the basic 24-hour acute care services with the barest of staffs already. We are at the bare minimum.

If you will look at those numbers I just called out and compare them to most rural hospitals, you will think, well, how can you do that? But that is true in a lot of your primary care hospitals in Mississippi.

If reimbursement is reduced for emergency care, emergency room care, how do you lay off a half of the only nurse you have got working? How do you cut those costs under the new prospective payment system for outpatient services?

Also, the small acute care, primary care hospitals do not have the ability to any patient volume. We are already serving the needs, the primary care needs of our communities. We do not have a big enough patient base to attract specialists to provide specialty care. So our market is as big as our market is going to be. We are doing all we can do.

Two additional items I would like to stress is, number one, is that the closure of a primary care hospital in a rural setting is loss of the most economic health care available to that population and also to third party payers. A pneumonia treated at South Sunflower County Hospital is going to cost the payer, by Medicare's own figures, a great deal less than the same pneumonia treated at a medical center in Jackson. Costs are higher at specialty hospitals and they are distributed through all patients.

To force the closure of these primary care hospitals is really a bad deal for Medicare. If you take all those patients treated in these little hospitals and put them in urban settings, Medicare is going to be paying more, because they just pay us by the disease anyway.

The second something that I feel is grievous and does not get any attention, I do not think, is the way the Medicare methodology works, it inadvertently makes the poorest elderly citizens in the United States pay the highest portion of their out of pocket expense. Not only—this affects the hospital and its ability to collect these additional revenues, but it just really negatively impacts the very population who is already struggling to obtain health care. As we shall see, the effects of the BBA then penalizes the hospitals that are providing the care to the poor populations.

I was going to skip the next part, Senator, but due to the testimony I want to briefly go through a little bit about how the payment system works. We have had a lot of testimony about how complicated this system is and fixes to it. On the basic level it is not really complicated. I can calculate it for 55 rural hospitals in Mississippi with me and my secretary, so it is not that hard to figure out what is going on and how it hurts you.

Basically, as far as rural Mississippi it is pretty simple. HCFA comes up with a dollar amount that is the nationwide dollar average to treat a patient in a rural setting, \$3,888.46. They then say: Nationwide average, 71 percent of a hospital's cost is labor. So they multiply it by 71 percent and come up with a dollar figure, multiply it by your wage index, add the other 29 percent.

On the surface, sounds fairly reasonable. That is then multiplied by the relative wage index. I do not know whether you have a copy of any of the information or not, but the trouble is how all these things are done. You ask what can HCFA do. Dr. Berenson said

that they are continually looking at the relative weights of the DRG's and making those adjustments.

I would like to point out that between 1998 and 1999, those 2 years, which 1999 is the nearest figures we have, there was adjustments made to the relative weight scale. It seems to be perpetually taking the weight away from the primary care diagnosis and putting them on the specialty diagnosis. This cost the 55 primary care hospitals in Mississippi \$48.68 per admission loss between 1998 and 1999. At my hospital that is well over \$40,000, purely on HCFA's changing how much they calculate it takes to treat a pneumonia versus heart surgery. That is an ongoing thing and it is something that you do not recognize in the payment system. It is a hidden thing, but it is a very real cut to primary care hospitals.

We have talked a lot about the wage index and relooking at it. I am not sure what happens with the wage index. It must be when they make the calculations they pull it back to budget neutrality or something.

For 2000, as of October 1 this year, rural Mississippi's wage index fell from .7327 to .7306. In other words, by HCFA's calculations wages dropped in rural Mississippi; increased in the Jackson area, increased everywhere else, but they went down in rural Mississippi. Now, we know that wages in rural Mississippi did not take a dive this year. They went up just like anywhere else. But that adjustment increased the discrepancy between rural Mississippi and Jackson area hospitals. Of course, I am not saying they are paid too low, and they are paid well below Memphis and well below New Orleans.

But in 1999 we were paid \$269 less than the Jackson hospitals. This year it is up to \$311 less than Jackson for the year 2000.

There is something wrong with those calculations, Senator. You cannot recruit, retain employees, health care professionals, get them to come to communities like Indianola, Mississippi, these young college graduates, for less than they could go to Memphis or Jackson or Tupelo. We know that is not correct. That is just not the way it really works. There is not that substantial degree in differences.

In the information you have, I pulled from HCFA's public use files their wage indexes of some hospitals in Jackson, Memphis, and rural Mississippi. You can look at those and see that—I will just call out one, Saint Dominic's in Jackson; by HCFA's own record, hourly rate is \$15.71 an hour. Mine is \$16.36 an hour. Just a few hospitals scattered across rural Mississippi: Hazlehurst, \$16.51; Centerville, \$16.75; Houston, Mississippi, \$17.30; Meadville, \$17.41; Emory, Mississippi, \$17.89.

But we are paid \$311 less because our wages are less. It is not a realistic thing. The wage index does far more damage than its application to the wage factor, though, Senator. A big part when I was talking about the formula, it is 71 percent labor as applied to the \$3,800. The 29 percent is non-labor, the cost of supplies and goods and services. That is the same supplies, not different ones. The weight of the DRG for each diagnosis pays for the difference in the cost of treating pneumonia versus a heart attack, that type thing, and the more expensive supplies required. Capital, the

equipment to do the bigger procedures, is paid through a separate capital payment. So this is for the same supplies.

Theoretically, this year for 2000 there is a \$20 difference between Memphis area and rural Mississippi. However—and this is part of what Senator Grassley was talking about. He was really talking about it on the labor side. But if you look at the effect of the calculation on the non-labor side, the problem is HCFA says that, of the national average, 71 percent of rural Mississippi's labor cost, 71 percent of that amount is our rural labor cost.

That is not true. The average of all Mississippi hospitals is slightly over 50 percent. In the primary care rural hospitals it is about 45 percent. So if you think about how the multiplication then works, if you take 71 percent and say, okay, this is your cost, then apply the wage factor to it, then add it back to your supply cost, what is the net difference?

In material I have submitted, you will see that the difference if you used, actually used our 45 percent, which is what is the real labor cost in rural Mississippi, slightly over 50 for all of Mississippi. And if it is that hard to calculate, we will get up a group and calculate it nationwide. It is not undoable.

But that difference, when you run those together and add it back, costs the 55 primary care hospitals in Mississippi \$277.42 per admission decrease in their allowance for the cost of their supplies. If you total those, just those three things—and we have not gotten to the BBA yet. This is non-BBA issues. With the rural hospitals in Mississippi, average case mix for this year being .9461 and our prospective payment rate being \$3,100, that will give us a payment of \$2,900, a little over \$2,900. Those three items I just called out to you add up to \$637. That is 21 percent of our payments. Those cuts are 21 percent of the payments that a rural primary care hospital in Mississippi would receive.

Those reasons, coupled with the DSH problems, is why the rural, the really rural primary care hospitals serving these really poor populations, are not going to survive. Many of them are going to close. As you are aware, we have identified about 396 of these across the country that serve a really poor population that have these effects and that are true primary care hospitals that offer no specialty care.

That is a factor that is tremendously important and is not recognized. When you start providing specialty care and get the higher paying DRG's, it is a different world than when you only provide primary care.

As far as the BBA, of course, we need the inpatient update, but I think an item in Mississippi, in rural Mississippi, the beneficiary has to pay 26.6 percent of the cost of their hospital care out of pocket. These are the poorest Medicare beneficiaries in the United States. They are having to pay the highest proportion of their hospital care out of their pocket. That average in New York is 8 percent. A Medicare beneficiary in rural Mississippi pays 26 percent of the cost of the care; one in New York pays 8. Of course, it varies on the type of hospital you are attending. Iowa is about 15 percent, which is about like Saint Dominic's in Jackson.

But the BBA is disallowing 50 percent or 45 percent of any Medicare deductibles that is uncollectible, that becomes bad debt. So in

Mississippi, in rural Mississippi, BBA is going to cut 12 percent on all those patients, and we have the highest portion of patients that are below poverty level of any State in the Union. So the way the situation is working, you know, you have the poorest beneficiaries in the Nation have to pay the highest percentage of their hospital care and the lowest paid hospitals in America have to collect the highest percent of their revenues from those poorest people, and now the BBA is going to disallow 12 percent of our revenues because we are serving a poor population, is how the system, how the mechanism really works if you sit down and run the numbers out.

I know I am running over and I am going to stop.

Senator COCHRAN. That is all right. We have not got anything to do that is any more important than this.

Mr. BLESSITT. One thing I would—well, two things I would like to touch on, one in my notes on the outpatient PPS. I think the issue you were trying to raise, which is a very real issue: HCFA is only going to pay 85 percent. Congress directed HCFA to hold the smaller hospitals harmless, reimburse them their costs on the old basis if it was less than the PPS.

How they are implementing that is they are saying: Okay, we will pay 85 percent of it until cost report settlement. So bottom line, if you are a rural primary care hospital, although Congress has said hold us harmless, HCFA is going to hold 15 percent for 18 months. That very thing will get some small hospitals. There are small hospitals out here that cannot take a 15 percent cash flow cut in their outpatient payments for 18 months. They will be gone before those payments are made, which is I think HCFA is not carrying out the intent of Congress on that particular issue.

I think HCFA could take a chance and go on and pay 100 percent. If it is a couple dollars over, they can pull it out of a payment register later on.

The billing regulatory requirements are a problem, but the critical access hospital situation, Senator, is exactly the same type situation with the wage index with these other calculations. You know, the trouble with the wage index on your payment system is it works to your disadvantage if your wage index is below one, like Mississippi is .73, because you are getting reduced on 70 percent of your base amount when it is only really 45 percent. So you are taking this big—you are getting reduced on theoretically 71 percent of your costs when in fact it is only 45 percent.

If your wage index gets above one, as it is in more affluent areas, whatever, the multiplication runs the other way. It is not a geometrically smooth payment system according to a change in the wage index. If you are average, if your wage index is one, which HCFA says is the average across the Nation, it does not make any difference. It does not make any difference how those calculations between the base amount and 71 percent works. If you are below that, it geometrically hurts you more. If you are above one, it geometrically helps you, because you will get say a 10-percent increase on 71 percent of your cost when, in fact, it is only 60 percent of your costs.

So those are the things in the system that hurt and geometrically work against you depending on where you are within the scale of rich to poor. The critical access to a great extent works the same

way. If you do not have around 25 percent commercial pay basis, you cannot—you can convert to critical access, but you can get ready to close your doors. You will go broke. Critical access works well again in a community that has a good commercial pace and pretty good shape anyway. In rural Mississippi, there is one hospital that I know of—that is at Forest, Mississippi—that has the base, the commercial base, to convert and take advantage of critical access.

There is a world of hospitals that would love to, Belzoni, Water Valley, on and on and on, that would love to be able to convert and be critical access and be cost-based reimbursed. But the way your payment runs out as a critical access hospital unless you have above 25 percent commercial pay, you are financially ruined if you try to do it. As I say, Lackey is the only one in the State that I know of that is seriously considering doing it, because it just will not work.

Senator, I appreciate the time. I would like to conclude by again asking you and maybe your committee to consider the legislation that has been presented from the Coalition on Essential Service Hospitals. We really feel like that these 396 hospitals that serve these poorest counties across the Nation that are truly primary care hospitals, they are the bottom of the barrel. Some Senators I have heard say, and Congressmen, they would support relief if they could identify which hospitals really need it. These hospitals really need it. But I would like to have consideration of bringing this before the Senate.

We would be glad to work with you, any of the administrators of the 48 hospitals in Mississippi that meet this definition. I appreciate the opportunity to present the story of the small hospital. Thank you, Senator.

[The statement follows:]

PREPARED STATEMENT OF H.J. (JIMMY) BLESSITT

Mr. Chairman, members of the Committee: I am Jimmy Blessitt, Administrator of South Sunflower County Hospital in Indianola, Mississippi. I want to thank you for the opportunity to testify before you today on the crisis facing small rural hospitals and its impact on rural development, particularly in low-income communities. This crisis has in fact been building for some time due to certain inequities in the Medicare and Medicaid reimbursement system, which are now being compounded by the Balanced Budget Act of 1997.

Where to begin is problematic. We could start with World Peace being impossible as long as hungry populations exist, or with the concept that a stable and adequate food supply is one of the fundamental roles of Government and is key to the development of any nation. We could start with the tremendous production capabilities of American Agriculture, its economic value in export dollars and its role in maintaining our balance of trade. Whatever our individual "big picture" concept may be, I feel we can all agree that you cannot produce the food and fiber of American Agriculture, nor the raw materials of the mining or timber industries, in New York City, or in Chicago, or in Dallas, or in San Francisco; somebody must live and work in Rural America.

While our rural population is accustomed to a lack of diversity in local cultural and social opportunities, it does require fundamental support services provided through economic development and Government support. One of these essential services, and one which also directly impacts economic development, is adequate health care.

In rural, impoverished, communities all across this country, the local hospital is not only the center of basic primary acute care, it is often one of the largest employers with the most highly trained and highest paid employees in the community. When one of these hospitals closes, it is not only devastating to the provision of local

health care, it is devastating to the local economy. The closure of a local hospital also precludes further economic development; business will not locate in a community without adequate health care; Physicians will not go into practice in a community without a hospital. When a hospital closes, physicians generally leave; a hospital not only provides a place for them to admit and treat patients, it provides the sophisticated ancillary services, such as radiology and lab, that are too costly to maintain in a small private clinic.

Another factor to be considered in this crisis is the direct economic impact of the payment for hospital services at the local level. As most hospital care is paid for by third party payors outside the local community, these payments are in fact "new dollars" to the local economy. Even at a small facility such as South Sunflower County Hospital, these new dollars can approximate \$10,000,000 per year. Regardless of the multiplier one uses to evaluate the effect of new dollars on a local economy, \$10,000,000 has a dramatic influence in any small rural, perhaps impoverished, community.

Obviously, not every hospital currently open should remain so; some hospital closures necessitated by demographic changes or other factors are inevitable and appropriate. But to force the closure of an otherwise viable community hospital due to an inequitable payment system is to economically doom the community it serves. I think Mr. James Clayton, President and CEO of Planters Bank and Trust, which has branches in nine Mississippi communities, and who is very active in economic development activities, summed up the situation very well in a recent letter regarding the rural Banking industry wherein he stated, "We're doing all we can to promote the area and develop the economy, but without adequate health care, we don't have a chance to survive."

South Sunflower County Hospital is a 69-bed acute care rural facility, with 150 employees located in the center of the Mississippi Delta. As in many low-income communities, Medicare and Medicaid account for 76 percent of our gross inpatient revenues, charity (and bad debt) will account for another 18 percent, leaving us 6 percent of gross revenues available from commercial sources. We share problems common to many rural facilities and support efforts at relief for all rural hospitals. This includes restoration of inpatient payment reductions (S2018) and legislation to prevent further reductions in the state Medicaid disproportionate-share hospital payments (S2299/2308). The latter is especially critical to Mississippi hospitals. And, while I have not had the opportunity to read Senator Grassley's proposed legislation regarding the Wage Index, I fully support any effort to reform this area of the payment system.

At the same time, South Sunflower County Hospital is also a member of a Coalition that includes 48 rural Mississippi hospitals (50 percent of the hospitals in Mississippi) that feel there is more to the story which needs to be told. Not all rural hospitals are the same, nor do they face the same problems. There are several factors which contribute to a rural hospital's ability to remain viable in the face of continued reimbursement inequities and reductions: the income of the population it serves, the size of the facility, and whether the hospital is a provider of Primary Care or Specialty Care (though frequently the size of the hospital also determines the focus of care).

When a hospital is small and rural, serving a low-income population by providing basic primary acute care, there are no resources available to counteract the slow, continuous ratcheting down of the reimbursement necessary for survival. Last year our 150 employees admitted and cared for 2,700 inpatients, delivered 400 babies, performed over 400 major surgeries and 800 minor procedures, carried out 45,000 lab tests and 10,000 x-rays, made nearly 1,500 ambulance trips, and saw over 12,000 patients in the Emergency Room. In hospitals like ours, there are no middle management personnel to cut, no extra nurses or overabundant lab technicians to lay off, in fact they are usually providing the basic 24 hour acute care services required by their communities with the barest of staffs already. If reimbursement is reduced for emergency room care, how do you lay off one-half of the only nurse that is working the ER at night? And, the primary care hospital cannot generate new revenue by increasing the volume of patients; they are already treating the primary care needs of the surrounding population.

Lastly, two other important issues are often overlooked in considering the overall economic impact of closing a rural hospital: the first is that closure of the primary care hospital in the rural setting is loss of the most economic healthcare available to that population and to the third party payors. A pneumonia treated at South Sunflower County Hospital is going to cost the payor, by Medicare's own figures, a great deal less than the same pneumonia treated at a medical center in Jackson; costs are simply higher at the specialty hospitals, and those costs are distributed throughout all patient types.

The second issue is that current reimbursement methodologies inadvertently result in the poorest of our elderly citizens paying the highest proportion of “out of pocket” expenses. Not only does this equate to an inability of the hospital to collect those additional revenues, it negatively impacts the very population who is already struggling to obtain health care. As we shall see, the B.B.A. provisions unfairly penalize the rural primary care hospitals that serve this population.

The following pages present a brief overview of the current reimbursement methodology, and the very specific ways in which it inadvertently continues to ratchet down the reimbursement to small rural providers, even before the effects of the B.B.A. are considered. While this information is tedious, a knowledge of these issues is necessary to understand why we are on the verge of a wave of small rural hospital closures.

INPATIENT PPS DIAGNOSTIC RELATED GROUPS

The base DRG amount is what Medicare will pay nearly all Hospitals for the inpatient care of a patient with a specific diseases or conditions.

In theory, it should take into account the complexity of an average case of standard medical practice, and arrive at the average cost of treating a group of those patients.

While differences may seem slight when each element is looked at individually, they lead to tremendous changes in reimbursement to the individual hospitals.

Calculation of the DRG payment is critically important. It has 2 parts, the relative weight and hospital-specific PPS rate.

The Relative Weight of the disease or condition is supposed to indicate its complexity or intensity of service, reflecting the kinds of supplies needed for the condition, and how difficult it is to treat. Relative Weights are based on an average of 1. Some Relative Weights are above 1, and some are below 1.

—This Relative Weight is ____

—Multiplied by ____

—The Hospital-Specific PPS Rate ____

The Hospital-Specific PPS Rate is a dollar amount calculated for each hospital. It has 2 parts, but each part is arrived at based on HCFA's estimation of the average cost to treat an inpatient in an “Urban” area (\$3,951.03) or in all “Other” areas (\$3,888.46). The two parts are:

The Federal Labor Amount (71 percent of HCFA's estimate of the average cost of treating a patient—\$2,809.18 in “Urban” and \$2,764.70 in “Other” areas) adjusted by (multiplied) a Local Wage Index for different groups of hospitals. Plus:

The Federal Non-Labor Amount (HCFA's estimate of the average cost of treating a patient minus the Federal Labor Amount—\$1,141.85 in “Urban” and \$1,123.76 in “Other” areas). This is to cover the cost of supplies, goods and services.

The PPS rate is then adjusted by (multiplied) a Market Basket Updating Factor (This is the BBA effect on the DRG). (Any Disproportionate Share payment is then added to the base PPS amount)

THE EFFECT OF THE RELATIVE WEIGHT CALCULATION ON THE PRIMARY CARE RURAL HOSPITAL

HCFA seems to be systematically reducing the relative weights of the DRG's commonly seen in the Primary Care Rural Hospital. The following are some of the most frequently treated DRG's at 55 primary care rural Mississippi Hospitals, showing the change in the relative weights from 1988 to 1999. These are reflective of the typical rural primary care hospital. The “dollar loss” is calculated from the base PPS rate for rural Mississippi of \$3,001.36 during 1998.

DRG	Description	1998 Relative weight	1999 Relative weight	Dollar loss per admission
127	Heart failure & shock	1.0199	1.0131	\$21.22
089	Simple Pneumonia > 17cc	1.1006	1.0838	52.43
088	C.O.P.D. ....	.9705	.9530	54.61
140	Angina Pectoris .....	.5993	.5957	11.23
296	Nutritional & Metabolic .....	.8657	.9497	49.93
294	Diabetes age > 35 .....	.7546	.7478	21.22
320	Kidney & Urinary Inf. > 17 .....	.8787	.8665	38.07

Most of the remaining DRG's that the small primary care hospital treats are spread out over a wide variety of generally low paying medical diagnoses, with only 2 or 3 treated per year.

The Average Case Mix Index fell from an average of .9617 in 1998 to .9461 for 1999 for these 55 Mississippi Hospitals. With an average DRG payment of \$3,001.36 in 1998, this represents a cut in revenue of \$48.68 per discharge. (It is estimated to be approximately \$50.00 for 2000)

With this large of a sample it is statistically possible to state that the decreases in the Relative Weights for the DRG's treated by primary care hospitals is the cause of this loss in revenue.

Remember, the Relative Weight system is based on an average of 1; therefore whatever was taken away from the Weights in the above DRG's was added to the Weights of other DRG's in the system. (HCFA makes the nonsensical argument that nothing really changed because the average is still 1)

There are increases in some high paying DRG's (Craniotomy, Spinal Procedures, Extracranial Vascular Procedures, Other Nervous system procedures, E.N.T. and mouth Malignancy, Cardiac Valve procedures, Major Cardiovascular Procedures, Major Joint & Limb procedures, Hip and Femur procedures, Major Male Pelvic procedures, etc.).

However, these conditions are not treated by the primary care rural hospital.

This reduction in reimbursement for rural hospitals is not part of the BBA reductions.

THE EFFECT OF THE HOSPITAL-SPECIFIC PPS RATE CALCULATION ON THE PRIMARY CARE RURAL HOSPITAL

Part 1. The Federal Labor Amount

The Federal Labor Amount for most of Mississippi for 1999 was \$2,739.36. Desoto County and Tupelo were paid at the Memphis Urban rate of \$2,809.18. For 2000 the rural rate was increased to \$2,764.70 (71.1 percent of \$3,888.46).

This Federal Labor Amount is multiplied by a Wage index figure to arrive at a hospital's labor portion of the DRG. The 1999 Wage Index figure for rural Mississippi was .7327; for the Jackson area it was .8310.

As of October 1st, the 2000 rate for rural Mississippi fell to .7306, while the Jackson rate increased to .8387.

The effect is rural Mississippi hospitals are paid an average of \$311.62 per discharge less than Jackson area hospitals, (\$269.13 in 1999) and much less than the Memphis area and Tupelo hospitals based on their Labor Cost. This implies a determination by HCFA of a higher hourly wage paid in these areas. However, in looking at HCFAs hospital specific hourly rates (available in HCFA Public Use Files) for the following rural hospitals in various areas of the State, the following is noted:

Hospital	Town	Average hourly rate
Gilmore Memorial	Amory	\$17.89
Franklin County Hospital	Meadville	17.41
Trace Regional Hospital	Houston	17.30
Field Memorial	Centreville	16.75
Hardy Wilson Memorial	Hazlehurst	16.51
South Sunflower County	Indianona	16.36
The following Hospitals are paid at the higher Jackson rate:		
St. Dominic Memorial	Jackson	15.71
Central Miss. Med. Center	Jackson	16.93
Madison General	Canton	13.62
The following are paid at the higher Urban Memphis rate:		
North MS Medical	Tupelo	17.12
Baptist Hospital Desoto	Southaven	17.12

THE REALITY OF HOSPITAL WAGES IN RURAL MISSISSIPPI

You can not recruit and retain hospital staff in Rural Mississippi for substantially less than the urban areas. Rural hospitals often have longer tenure staff that have earned pay increases over time. In an effort to survive, many rural hospitals have used Exempt Units to cover the cost of core staff which lowers the hospital hourly rate, but this is being cut also. Rural hospitals must retain a core staff and do not

have the ability to adjust staff by patient load. Again, this reduction for rural Mississippi hospitals is in addition to the reductions of the BBA.

Part 2. The Federal Non-Labor Amount

The 2000 Federal Non-Labor Amount for most of Mississippi is \$1,123.76 (\$3,888.46-\$2,764.70). The Memphis Urban Rate is \$1,141.85.

The non-labor amount is supposed to reflect what hospitals pay for the same supplies, goods, and services. It does not reflect the different types of supplies, goods, or services required for specialty care; that cost is reflected in the Relative Weights of the more complicated DRG's. The more expensive equipment is reflected in an additional payment for capital cost.

Superficially HCFA's formula implies a small rural hospital in Mississippi has the purchasing power to buy similar medical supplies for \$20.00 less per patient than Baptist Memphis or Charity in New Orleans, after paying the additional transportation cost; this is nonsensical.

The same supplies and drugs are used to treat DRG 089 (Simple Pneumonia) whether in Indianola, Memphis, or New Orleans.

However, the reduction in payment to rural providers is actually far more than the obvious \$20.00. This is due to the averaging system used by HCFA. In the formula they use an average of 71 percent of total cost as the labor cost. This would not be an accurate assumption in a small rural hospital serving a high poverty population. The average labor cost for all hospitals in the state of Mississippi is only slightly above 50 percent of their total cost, with the average in the 55 small rural hospitals in the poorest counties being about 45 percent. Using HCFA's rural average of \$3,888.46, the following demonstrates the effect the current method compared to using the actual percentage of labor cost (available to HCFA on our yearly Cost Reports)

Federal Labor Amount Calculation

Calculation using Current Average:	
Average Rural Cost	\$3,888.46
71.1 percent average	×.711
Fed. Labor Amount	2,764.70
Calculation using Actual Labor percentage:	
Average Rural Cost	3,888.46
45 percent actual	×.45
Fed. Labor Amount	1,749.81
(The Hospital Specific PPS labor amount would decrease by \$1,014)	

Federal Non-Labor Amount Calculation

Calculation using Current Average:	
Average Rural Cost	\$3,888.46
Less labor amount	-2,764.70
Non-labor amount	1,123.76
Calculation using Actual Labor percentage:	
Average Rural Cost	3,898.46
Less labor amount	-1,749.81
Non-labor amount	2,138.65
(The Hospital Specific PPS non-labor amount is increased by \$1,014)	

When these figures are applied to the computation of the PPS rate of the small rural hospital in an impoverished area the effect is seen.

Hospital Specific Rate using current method:	
Fed. Labor Amount	\$2,764.70
MS Rural Wage Index	×.73306
Adjusted Labor Cost	2,019.89
Add Non-Labor Cost	1,123.76
Total PPS Amount	3,143.65
Hospital Specific Rate Using actual percentages:	
Fed. Labor Amount	1,749.81

MS Rural Wage Index	×.73306
Adjusted Labor Cost	1,282.72
Add Non-Labor Cost	2,138.65
<hr/>	
Total PPS Amount	3,421.07

The use of the 71 percent average labor cost by HCFA causes small rural hospitals in low income are to loose \$277.42 per patient on the cost of their medical supplies. As can be seen, this loss is attributable to the wage index in two ways in that it affects the labor to total cost ratio as well as the adjusted labor cost of an individual hospital. This causes any change in the wage index not to geometrically adjust a hospitals payments in relation to the national base amounts. The current methodology works to the advantage of the 50 percent of the hospitals in affluent communities, with a wage index above 1.0000 (a wage index of 1.0000 is the point at which the 71 percent averages have no effect). They receive percentage increases on 71 percent of the base amount, even though their labor cost may only be 60 percent of their actual cost. We have a "poor gets poorer and rich get richer" situation as it relates to actual revenue to cover operating cost.

Total effect of relative weight, wage index, and PPS calculation.—With an Average Case Mix Index of .9461 and a Total Federal PPS rate of \$3,143.65, small rural Mississippi hospitals will be paid an average of \$2,974.20 per discharge in fiscal year 2000.

When the dollar affect of the Relative Weight recalculation (\$48.68), the Wage Index discrepancy (\$311.62), and the Non-Labor Amount of the PPS calculation (\$277.42) are added together the small rural primary care hospital in Mississippi is facing a shortfall of \$637.72 per discharge.

This is over 21 percent of their average payment. (For South Sunflower County Hospital this represented \$542,062 in 1999) In addition:

MedPAC's March 2000 Report to the Congress essentially reiterated it's report for the last two years regarding the Medicare DSH adjustments. Excerpts include:

"In particular, current policy favors hospitals located in urban areas; almost half of urban hospitals receive DSH payments, compared with only about one-fifth of rural facilities.

"The Commission believes the objective of protecting Medicare patients' access to hospital services is best met by concentrating DSH payments on Medicare cases in the hospitals with the largest low-income patient shares."

The small primary hospitals in rural America serving a low income population can not survive unless immediate action is taken to rectify this situation. This is the basis of the request of the Coalition of Essential Service Hospitals for a 20 percent DSH payment adjustment.

THE EFFECTS OF THE BALANCED BUDGET ACT OF 1997

Part of the inequity in the BBA adjustments is that, by most reliable estimates—Urban reimbursement is Reduced by about 6 percent while Rural reimbursement is Reduced by about 14 percent.

However, small rural primary care hospitals serving a low income population face additional cuts not recognized in this average.

A factor negatively impacting the hospital serving the low-income Medicare population is the Deductible and Coinsurance system. Patients in impoverished rural areas are going to be paying a higher percentage of the cost of their hospital care. The average Medicare discharge DRG at the 55 Mississippi Hospitals in this category is \$2,952.68; the Medicare Deductible is \$786.00; the impoverished Medicare population of these Counties are expected to pay nearly 26.6 percent of the cost of their hospital bill. A Medicare Beneficiary in Iowa pays 15 percent (about the same as St. Dominic Jackson), those in Pennsylvania pay 11 percent, and in New York they would pay 8.5 percent.

And when those beneficiaries cannot pay their deductibles, the BBA will disallow 45 percent (\$353.70 per admission) from the reimbursement in rural Mississippi, or 12 percent of the total reimbursement per discharge at these small rural Hospitals. The Hospital in Iowa will lose only 6.9 percent (about the same as St. Dominic), in Pennsylvania, 5 percent, and in New York, 3.9 percent. And this is only considering each patient; the small rural hospital in an impoverished area is going to be treating a higher percentage of Medicare patients who cannot pay their deductible than hospitals in less rural and less disadvantaged areas, disproportionately burdening the small rural provider serving a poor population.

The current Medicare reimbursement system requires the poorest beneficiaries in America to pay the largest percentage of their hospital care; and the lowest paid hospitals in America to collect the largest percentage of their cost from the poorest people.

Now the BBA is making the largest percentage cuts in reimbursement for Medicare Bad Debt to the lowest paid hospitals, which are located in impoverished areas with no commercial payor base to make up the shortfall.

Some BBA cuts impact the Small Rural Primary Care Hospitals serving a low income population far more dramatically than other facilities.

OUT-PATIENT PPS

The out-patient PPS system (APG's) came into being to address the rising cost of out-patient services. Most of the growth in out-patient payments came as a result of speciality procedures that were historically done on an in-patient basis being shifted to out-patient procedures as a result of the restrictions placed on in-patient reimbursement. This had little to do with the small primary care hospitals as they do not perform the high cost speciality procedures. However, the OP-PPS system does not address just the speciality outpatient procedures, it includes basic Evaluation and Management codes of the primary care Emergency Room.

This will be devastating to the small rural hospital. It is estimated to cut out-patient reimbursement by 17 percent for rural hospitals. This is again an "average". In any given Emergency Room the actual cut in reimbursement when going from Cost Based reimbursement to an "average payment, adjusted for labor cost, per unit of service" will be the 17 percent reduction only if you have the "average number of visits and the average wage index". The per unit cost of a low volume Emergency Room will always be higher than a large busy Emergency Room. The small rural hospital that only has one nurse in the Emergency Room, with laboratory and X-Ray staff on call at night, does not have the ability to cut its cost.

While Congress has adopted legislation to "hold harmless" rural hospitals of less than 100 beds for several years, we are still faced with the cost of immediately implementing the systems to bill under the new system. Also HCFA has decided to hold 15 percent of any "hold harmless" payment for the 18 months required to file and settle a cost report. As far as cash flow is concerned, small hospitals will see at least a 15 percent reduction in payment even if they can correctly code under the new system (and most small hospitals will not be able to).

CAPITAL RELATED COSTS

Added to this situation is the BBA reduction in allowable Capital Related Costs. Small Hospitals in impoverished rural areas have little hope of raising capital from local bond issues or community sources; they will be unable to maintain their facilities or update their equipment or technology.

BILLING AND REGULATORY REQUIREMENTS

The small rural hospital must have the computer systems and administrative personnel to function within the billing and regulatory guidelines of the Medicare program. This is a far greater percent of operating revenue than in the larger hospitals. In many rural facilities there are many charges for services to Medicare beneficiaries that are simply not filed, as the system has become so complicated, time consuming, constantly changing, and legally threatening that our small administrative staffs, with multiple other duties, can not develop and implement systems to comply with these regulations.

Finally, your staff has previously been provided with proposed legislation that is specifically directed at approximately 396 small rural primary care hospitals serving a very low income population across the United States. I understand some Members of Congress would support relief for hospitals that really needed help, but did not know how to identify them. While other rural hospitals may need relief also, I can assure you that virtually all of these facilities are truly at the bottom of the barrel.

Mr. Chairman, I realize the reluctance of many in Congress to enter into a serious political debate in which there will be divisiveness between the Urban and Rural Delegations. I also realize there are problems faced by a Member of Congress in supporting legislation for a one segment of an industry in his/her home state. It is somewhat similar to why our Trade Associations (such as The American Hospital Association and many State Hospital Associations) will not support legislation for a particular segment or group of hospitals. The best they will do is not oppose legislation as long as it is "New Money" and not a reallocation of existing funds. As demonstrated above there has been a continual reallocation of funds away from the rural primary care hospital unfortunate enough to serve a low income population.

Unless someone in Congress interested in the Quality of Life in rural America will address the special issues of the approximately 396 primary care rural hospitals serving a very low income population we are going to see many of these facilities close in the very near future. I would like for you and this Committee to consider being the vehicle to bring this issue, so important to many areas of rural America, to the attention of the United States Senate.

My colleagues from our 48 Mississippi hospitals and I (as well as many from other states) would be very interested in working with you and your Committee to incorporate our special issues into any existing or new proposals for relief for rural hospitals.

Thank you for this opportunity to present the small rural primary care hospital story. It is one that has been seldom heard.

Senator COCHRAN. Thank you very much. I thought your testimony was very persuasive and compelling in every respect, and I appreciate your coming up here and giving us this information and making it clear so even a Senator can understand it. We appreciate it.

Mr. Grady, we are glad you are here from Brookhaven and we invite you to proceed now.

STATEMENT OF PHILLIP L. GRADY, ADMINISTRATOR, KING'S DAUGHTERS HOSPITAL, BROOKHAVEN, MISSISSIPPI

Mr. GRADY. Thank you. I would like to summarize my prepared statement that I ask be included in the record.

Senator COCHRAN. It will be included.

Mr. GRADY. I am honored to testify today on how the 1997 Balanced Budget Act and other Medicare regulations are affecting Mississippi's rural hospitals and specifically King's Daughters Medical Center.

King's Daughters Medical Center is a 122-bed facility serving five counties in southwest Mississippi. Due to our rural location, we are not only the primary source of access to essential health care services in our region, but we also contribute significantly to the area's economic well-being as well. But that role of the rural hospital in the economy is being seriously threatened. The BBA and other Medicare statutes and regulations are jeopardizing the ability of rural providers like King's Daughters Medical Center to ensure that high quality health care will be there when our community needs it, and with it the community's ability to recruit and retain industry.

For the first time in 10 years, we sustained an operating loss of \$350,000 in fiscal year 1999 that was directly attributable to the impact of the BBA. It is estimated that the BBA will reduce Medicare payments to King's Daughters Medical Center by \$9.9 million through 2002. Last year's Balanced Budget Refinement Act will restore only about \$60,000 of that amount to our facility. The result of these BBA cuts is diminished access to care.

For example, we have seen a 30-percent reduction in sub-acute patient days due to BBA-mandated changes. This past year, an 80 year old Medicare beneficiary was admitted to the sub-acute unit following hip surgery for continued therapy and treatment of a minor pressure ulcer. Once physical therapy rehabilitation was complete, the patient no longer met Medicare's continued stay criteria, despite the pressure ulcer, requiring us to discharge the beneficiary. Because her family was unable to care for her, she was readmitted 2 weeks later with a more extensive pressure ulcer. Had

we been allowed to keep the patient in the sub-acute unit, we could have prevented her re-admission and saved the Medicare program thousands of dollars.

BBA cuts also forced us to curtail service at our rural health care clinic, again diminishing access to care. Despite a clear need for the facility, the BBA payment cuts made it impossible for us to continue operating this facility. We transferred ownership in January to Franklin County Hospital of the rural health care clinic because they could be reimbursed on a cost basis versus the way that we were being reimbursed.

While our reimbursement has been dramatically reduced under the BBA, our costs have not decreased and in many cases continue to increase. Health care services cannot be provided without varied and competent professionals. The BBA cuts have impacted our ability in some instances to provide competitive salaries for our employees. In the past year, we have lost 21 highly trained professionals as a result. This further drives up our payroll costs as we then have to incur the expense of recruiting and training replacements, diverting resources that would otherwise go to patient care.

Another issue of concern, as addressed by Senator Grassley, Dr. Wakefield, and Jimmy, is the wage index component of the Medicare reimbursement system. As it is currently structured, urban hospitals have more money to pay higher wages when it is often, in fact, necessary to pay a premium in rural markets to obtain the necessary clinical skills to meet patient needs.

Mr. Chairman, I am very concerned about our ability to make adjustments in salary in the next year. This is critical as we face shortages of professionals in such areas as critical care nursing, ultrasoundography, and coders, among others. Staff shortages not only impact access to service, but also our ability to contribute to Brookhaven and Lincoln County's local economy.

Availability of capital for the purchase of new equipment and re-investment in our facilities is key to our health care mission. Access to capital markets has diminished as a result of the BBA due to lenders' concerns over the fiscal health of the health care industry. Moody's Investors Service in March noted that downgrades for bond ratings for hospitals last year exceeded upgrades at a rate of five to one. This translates to increased cost of financing needed improvements in health care facilities.

Rural hospitals will soon be in a crisis mode if we cannot update our facilities and equipment. We are now less than 20 days from implementation of the outpatient prospective payment system. While HCFA took one and a half years to develop the final regulations, health care organizations have had only 120 days to make the necessary costly system and billing changes to comply. We estimate that our initial expenses to comply will exceed \$50,000 and that will be in order for us to receive an estimated \$398,000 less than cost to provide these services to Medicare beneficiaries.

Upon expiration of the transitional corridor on January 1, 2002, our loss for providing these services will increase to \$772,000 annually. I am not confident at this point that HCFA and the fiscal intermediaries will be ready to administer this new payment methodology beginning August 1, 2000. Dr. Berenson referenced contingency payment plans, but these are not adequate for hospitals to

continue with their sustained operations if HCFA is not ready to proceed at that point. Nevertheless, hospitals are expected to be fully compliant with their billing or face the threat of false claims.

The burden of increasing regulations continues to require hospitals to shift much-needed patient care resources to administrative functions. Additionally, we are already beginning to see a slowdown in payments under the existing Medicare program as HCFA makes changes in their systems.

Mr. Chairman, the following specific action is needed: First, Congress should restore a full market basket update for fiscal year 2001 and 2002. S. 2018, the American Hospital Preservation Act, has been introduced to address this issue. Hospital update amounts must keep pace with the cost of delivering care.

Second, Congress should pass legislation providing relief on wage index inequities and the arbitrary way that the wage index is used to calculate payments. Senator Grassley, as he discussed earlier, introduced S. 2828, the Geographic Adjustments Fairness Act, which will help King's Daughters Medical Center meet the rising costs of attracting highly qualified health care professionals. Senator Cochran, I appreciate your co-sponsorship of this legislation along with that of Senator Burns.

Third, the reduction in Medicare bad debt payments to 55 percent must be repealed for those States where over 10.5 percent of their over-65 population is in poverty. As you are well aware, Mississippi's level is 19.5 percent. Mississippi hospitals should not be penalized for serving lower income Medicare beneficiaries. Implementation of outpatient PPS, as Jimmy discussed a few minutes ago, will further compound this problem, as the majority of outpatient payments will remain the responsibility of the Medicare beneficiary.

Fourth, delay implementation of the outpatient prospective payment system. Also, extend the definition of hospitals that qualify for the hold harmless provision to rural hospitals with an average daily census less than 100, such as King's Daughters Medical Center, versus a definition that focuses on licensed beds, as the BBA legislation does. Our size facility often does not qualify for the special Medicare designations that Dr. Berenson discussed earlier. It is unreasonable to expect hospitals to provide mandated services at less than the cost to provide these services.

Finally, rural hospitals need help in maintaining a viable post-acute care network, as we are often the only providers left furnishing home health, ambulance, and nursing care services due to the drastic payment reductions imposed by the BBA.

My colleagues and I look forward to working with you to rebuild some of the damage made by the BBA's cuts to both our hospitals in rural Mississippi and rural America and to our economies. Thank you for providing me with the opportunity to share our experiences with you.

[The statement follows:]

PREPARED STATEMENT PHILLIP L. GRADY

Mr. Chairman, members of the committee, I am Phillip Grady, CEO of King's Daughters Medical Center in Brookhaven, Mississippi. I am honored to present testimony before you today on the effects of the passage of the Balanced Budget Act of 1997 (BBA) and the impact of other Medicare regulations on Mississippi's rural

hospitals, specifically, King's Daughters Medical Center and their local communities.

To set the stage, I will briefly describe our facility. King's Daughters Medical Center is a 122-bed, acute-care hospital located in Brookhaven, a community of 11,500 in Lincoln County. We serve five counties in southwest Mississippi. In Fiscal 1999, we provided services to over 16,000 emergency room patients, 29,000 outpatients, delivered 590 babies and admitted more than 3,800 patients.

Typical of rural providers, our sources of revenue are heavily weighted to governmental payors, with Medicare comprising 50.2 percent of our gross inpatient revenues and Medicaid comprising 10.5 percent. From an expense standpoint, hospitals are very labor, supply and capital intensive. Salary, wages, and benefits account for 44 percent of our expenses. Patient supplies, including pharmaceutical expenses, account for 17.3 percent. King's Daughters, due to our rural location, is not only the primary source of medical care for a sizable portion of southwest Mississippi, but also contributes significantly to the area's economic well-being. With 511 employees, we are one of the region's largest employers. Our employees are among the most highly educated and involved members of our local community. For example, one of our employees not only is a full-time therapist, but also has started two local businesses and is president of a parent organization in the public schools.

The presence of a strong, viable medical community is key to economic development, along with strong schools, churches and recreational activities. It is impossible to successfully recruit business and industry without these elements. But the rural hospital's role in the economy is being seriously threatened. The BBA and other Medicare statutes and regulations are jeopardizing the ability of rural providers, like King's Daughters Medical Center, to ensure that high-quality healthcare will be there when our community needs it and, with it, the community's ability to recruit and retain industry. The closure or limitation of a rural healthcare facility would destroy the community's ability to grow in the future.

For King's Daughters, the provision of quality healthcare is the key element of our mission. For the first time in 10 years, we sustained an operating loss of \$350,000 in fiscal 1999 that was directly attributable to the impact of the BBA. These losses will be exacerbated due to increased regulatory requirements hampering our ability to generate a positive operating margin.

The five-year projected impact of the BBA on King's Daughters is \$9.9 million. While every little bit helps, the estimated relief of the BBRA for our facility is only \$60,000 per year. This significant impact on financial operations has not only been seen at our facility but also in other rural locations in Mississippi and through out the country.

It is important that I share some specific examples of how the BBA has impacted King's Daughters, hampering not only our ability to offer high quality of services, but, in fact, reducing access to care.

We offer one of the only hospital-based subacute facilities in our region of the state. Most providers have already eliminated this service due to the BBA, two providers in southwest Mississippi alone. We have seen our reimbursement decline from an average of \$460 per day to \$217. Bear in mind this is an all-inclusive rate for all the care provided including pharmaceuticals. We have seen a 30 percent reduction in our patient days, thus making this unit less accessible to patients.

This past year, for example, an 80 year-old Medicare beneficiary was admitted to the subacute unit following hip surgery for continued therapy and treatment of a minor pressure ulcer. Once physical therapy rehabilitation was complete, the patient no longer met Medicare's continued-stay criteria, despite the pressure ulcer, requiring us to discharge the beneficiary. Because the patient's family was unable to care for the beneficiary, she was readmitted two weeks later with a more extensive pressure ulcer. Had we been allowed to keep the patient in the subacute unit, we could have prevented her readmission and saved the Medicare program thousands of dollars. As this example demonstrates, there is a need for this skilled nursing facility and the positive impact it has had on our patients. But, without further relief, I am concerned about our ability to continue its operation.

The number of home health patients we served decreased 50 percent since January 1998, due to BBA-mandated changes in covered services such as venipuncture for stable diagnosis like insulin dependent diabetics. We operate a home health branch in affiliation with Lawrence County Hospital, a 64-bed facility located in Monticello. Lawrence County's five year BBA impact has been estimated by the Lewin Group to be \$7 million. While I am deeply concerned about our ability to shoulder our BBA impact, I am even more concerned about the viability of smaller rural facilities like Lawrence County, which depend on programs such as home health agencies for survival.

The BBA also changed the payment methodology for hospital-based rural health clinics from a reasonable cost methodology to a per-visit payment cap. This change significantly impacted our rural health care clinic resulting in a \$289,000 loss in fiscal 1999. To combat this loss, we dramatically reduced staffing and clinic hours resulting in a 50 percent reduction of services. As you are aware, services provided in rural clinics particularly benefit patients with limited financial resources. Our efforts to reduce costs to a point where we did not have to subsidize this service failed.

However, there are not only financial considerations, but human factors as well. This clinic serves as the primary care provider for over 700 Medicaid patients that would have no other provider if the clinic closed. Additionally, the clinic is the only outpatient source in our region for epogen and procrit shots, expensive and critical injections to increase red blood cell counts in dialysis and cancer patients. The 20 patients served per week would not be able to afford the \$300 per injection that they need twice a week without the clinic. In an effort to keep from closing this facility completely and wanting to see the needs of these patients served, King's Daughters transferred ownership of the clinic on January 1st to Franklin County Hospital, a 41-bed facility that is still reimbursed on a cost basis. We would rather give up being the provider of this service than see it eliminated for our patients.

While our reimbursement has been dramatically reduced under the BBA, our costs have not decreased and, in many cases, continue to increase. Healthcare services cannot be provided without varied and competent professionals. The BBA cuts have impacted our ability in some instances to provide competitive salaries for our employees. In the past year, we lost 21 highly trained professionals as a result. This further drives up our payroll cost, as we then have to incur the expense of recruiting and training replacements.

Recently, the Medicare Payment Advisory Commission (MedPAC), Congress' advisor on Medicare payment issues, agreed that more needs to be done to help hospitals deal with the magnitude of the BBA's cuts. The commission recommended that Congress increase the inpatient prospective payment system update by between 3.5 percent and 4 percent—more than twice what is in current law.

According to independent estimates, the BBA reduced Medicare payments to hospitals by more than \$70 billion over five years—about \$20 billion more than anticipated at the time the law was enacted. MedPAC recognized the rising labor, drug and technology costs faced by hospital's as they struggle with the BBA's impact. While Congress last year passed the Balanced Budget Refinement Act to take some of the sting out of those cuts, the legislation increased Medicare payments to hospitals by only 1 percent which equates to only an estimated \$59 million over 5 years to Mississippi hospitals. A drop in the bucket compared to the nearly \$1 billion removed from the healthcare system in Mississippi through the BBA. This amount does not include the impact on the Mississippi economy.

Availability of capital for the purchase of new equipment and reinvestment in our facility is key to our healthcare mission. Access to capital markets has diminished as a result of the BBA due to lenders' concerns over the fiscal health of the healthcare industry. Moody's Investors Service in March noted that downgrades in bond ratings for hospitals last year "exceeded upgrades at a rate of 5 to 1." This increases the cost of financing needed improvements in health care facilities. Of last year's BBRA, Moody said the "relief will not make a material difference to the majority of hospitals and by itself will not ensure the financial stabilization necessary to avoid credit deterioration." With reduced borrowing ability in the capital markets and with small to negative operating margins, rural hospitals will be hard-pressed to survive if they cannot update their facilities and equipment.

Another issue of concern is the wage index component of the Medicare reimbursement system. It arbitrarily favors urban hospitals over rural hospitals. The base rate on which all hospital payments are calculated is adjusted by a wage index. The wage index variation between urban and rural hospitals is the primary reason Medicare reimbursement is lower to rural hospitals. The net result is urban hospitals have more money to pay higher wage rates when in fact it is often necessary to pay a premium in rural markets to obtain the necessary clinical skills to meet patient needs.

I am very concerned about our ability to make adjustments in salaries in the next year. This is critical as we face shortages of professionals in such areas as critical care nursing, ultrasonography, and coders among others. Staff shortages impact not only access to service, but also impact quality of care and buying power in the local economy.

In addition to the wage index issue, we are gravely concerned about the implementation of the outpatient prospective payment system. HCFA has less than 20 days to implement the system. While the agency took one and a half years to develop the final regulations, healthcare organizations have had only 120 days to

make the necessary, costly system and billing changes to comply. We estimate our initial expenses to comply will exceed \$50,000 and that will be in order for us to receive an estimated \$398,000 less than cost for providing outpatient services to Medicare beneficiaries. Upon expiration of the transitional corridor on January 1, 2002, our loss for providing these services will increase to \$772,000 annually.

After a meeting with HCFA officials, it is clear HCFA was and continues to be on a steep learning curve for this system change. My peers and I are not confident that HCFA and the fiscal intermediaries will be ready to administer this new payment methodology by August 1, 2000. Nevertheless, hospitals are expected to be fully compliant with their billing or face the threat of false claims. The burden of increasing regulations continues to require hospitals to shift much needed patient care resources to administrative functions.

Mr. Chairman, the following specific action is needed:

First, Congress should restore a full market-basket update for fiscal year 2001 and 2002. S.2018, the American Hospital Preservation Act, have been introduced to address this issue. Hospital update amounts must keep pace with the costs of delivering care. A study by Ernst & Young and HCIA-Sachs found that Medicare hospital spending has been flat while hospital costs plus beneficiary growth rate are approximately 4.5 percent per year.

Second, Congress should pass legislation providing relief on wage index inequities and the arbitrary way the wage index is used to calculate payments. Senator Grassley introduced S.2828, the Geographic Adjustment Fairness Act, which will help King's Daughters Medical Center meet the rising cost of attracting highly qualified healthcare professionals. Senator Cochran, I appreciate your co-sponsorship of this legislation.

Third, the reduction in Medicare bad debt payments to 55 percent must be repealed for those states with over 10.5 percent of their over 65 population in poverty. Mississippi's level is 19.5 percent—Mississippi hospitals should not be penalized for serving lower income Medicare beneficiaries. Implementation of outpatient PPS will further compound this problem, as the majority of outpatient payments will remain the responsibility of the beneficiary.

Fourth, delay implementation of the outpatient PPS system. Also, extend the definition of hospitals that qualify for the hold harmless provision to rural hospitals with an average daily census less than 100 such as King's Daughters Medical Center. It is unreasonable to expect hospitals to provide mandated services at less than the cost to provide those services.

Finally, rural hospitals need help in maintaining a viable post-acute care network since they are often the only providers left furnishing home health, ambulance and nursing care services due to the drastic payment reductions imposed by the BBA.

Mr. Chairman, you and your fellow members on this committee are faced with tough decisions on how to best allocate healthcare dollars just as hospital administrators and hospital boards are faced with difficult decisions about the allocation of resources. I encourage each of you to visit the hospitals in your states to see first hand the impact of Medicare reform legislation on the healthcare delivery system. When you do, it will becoming increasingly clear that, despite some Medicare payment relief provided to hospitals last year by Congress, the cost of caring continues to rise—to the point where further relief this year from the BBA's cuts, its associated regulations, and Medicare system inequities such as the wage index is essential.

My colleagues and I look forward to working with you to rebuild some of the BBA's damage to both hospitals and their local economies across the United States.

Thank you for providing me with the opportunity to share King's Daughters experiences with you.

Senator COCHRAN. Thank you very much, Mr. Grady. I think the facts that you both have made available to us are very alarming and I think the Congress has got to get serious and get on the ball to get this legislation that you have identified that will be very helpful considered and passed and to the President before this session of the Congress ends. We are going to see a lot of closures throughout our State and other States as well unless that happens. I think it is just as clear as can be from what you tell us and what we have heard from those who are experts in this issue area.

So I am very grateful to you for letting us have the benefit of your time and your effort to be here and to understand fully what

the implications of these Federal policies are for the people who live in the small towns and rural communities of our Nation.

We spend a lot of time and effort here designing policies to encourage investment, to encourage enterprise in small towns and rural communities. That is part of our mission as a committee that has jurisdiction over rural development initiatives. To see this Federal program now on the other hand working as a disincentive for those same kinds of activities just flies in the face of reason. So I am hopeful that our committee can serve as a catalyst for moving the Congress to act quickly and help alleviate some of these serious problems that you are facing.

CONCLUSION OF HEARING

I commend you for hanging in there and doing as well as you have done under these extraordinarily difficult circumstances in the situation that you find yourself in. So I want you to know we are on your side. We are going to do everything we can to be helpful, not just to you but to the people who depend upon the hospitals and the health providers to continue to provide them with the health care that they absolutely have to have if they are to stay in these small towns and rural communities.

Thank you very much. This concludes our hearing.

[Whereupon, at 12:27 p.m., Tuesday, July 11, the hearing was concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]