# Testimony To the Subcommittee on Specialty Crops, Rural Development and Foreign Agriculture

**Mike McIntyre, (D-NC) Chairman**

Offered July 23, 2008

**By the NC Rural Health Center and the North Carolina Hospital Association**

**Topic: The Critical Role of Rural Hospitals in Meeting the Health and Economic Development Needs of Rural Communities**

Chairman McIntrye and distinguished members of the House of Representatives, I am honored and privileged to be invited to address you today. Representative McIntyre and Representative Hayes, I am especially grateful and appreciative of your active support for rural healthcare and rural hospitals in North Carolina. Your votes in support of the recent legislation to correct and improve the Medicare reimbursement for physicians, along with your continued and patient guidance to establish a moratorium on CMS regulations regarding certified public expenditures in the Medicaid program are immensely valuable to the physicians, hospitals and residents of North Carolina. I also extend my gratitude to the members of this Subcommittee for your vigorous support of rural health development. In my 25 years of experience as a healthcare executive, the House of Representatives has acted as a unified, bipartisan leader in establishing congressional priorities for rural healthcare improvements, significant healthcare legislation and federal budget investments in healthcare. Please be encouraged to continue the tradition of supporting accessibility, affordability and excellence in healthcare for our rural residents and communities.

I am Jeff Spade, the Executive Director of the North Carolina Rural Health Center, a resource and technical assistance center for rural hospitals, healthcare organizations and communities,

based at the North Carolina Hospital Association, located in Raleigh, North Carolina. In addition to directing the NC Rural Health Center, I am a Vice President with the North Carolina Hospital Association, Chairperson of the Governor's Task Force for Healthy Carolinians for the State of North Carolina and faculty with the Institute for Healthcare Improvement based in Boston, MA. I work closely with the Institute for Healthcare Improvement to engage more than 1500 rural hospitals across the nation in the 5 Million Lives Campaign, an initiative to improve hospital quality and patient safety.

Since I am most familiar with rural hospitals and healthcare in North Carolina, my testimony today will briefly describe the key traits of rural North Carolina hospitals, explore the most critical aspects of rural hospitals in relation to the communities they serve, and identify the issues and concepts that are vital to the development of rural hospitals and healthcare in North Carolina.

I have three priority improvements to request of this Subcommittee and Congress. First, restore the rural infrastructure grants that were considered and submitted in the early versions of the FY2008/09 Farm Bill. Second, improve Medicare and Medicaid policies and payment structures to support the continued development of hospital and healthcare services in rural communities. And third, push for federal rural health programs to emphasize and drive greater alignment and collaboration among rural health care organizations and providers.

North Carolina's rural healthcare system was initially organized around the concept of a hospital serving its home county. Passage of the Hospital Survey and Construction Act of 1946, better known as the Hill-Burton Act, began a proliferation of hospital construction in the poor, rural

communities of America, places where no hospital or healthcare would have been possible before. As a consequence many rural communities throughout the country built their own local hospital. For North Carolina, community hospitals were founded in 72 of the state's 100 counties, thus establishing the leadership role that rural hospitals fulfill within their communities, even today.

North Carolina's 61 rural counties, as defined by the Office of Management and Budget, are served by nearly sixty rural hospitals. Rural hospitals are usually smaller than the average North Carolina hospital, with rural hospitals caring for an average daily census of 51 acute care patients in 2007 versus an average of 119 acute patients for all North Carolina hospitals. In 2007, North Carolina rural hospitals cared for 243,383 inpatients, approximately 4.07 million outpatients, an estimated 1.25 million emergency patients and 136,954 patients that received outpatient surgery (see Table 1). The numbers speak for themselves -- millions of visits for urgent and emergent care and hundreds of thousands of hospitalized patients. North Carolina's rural residents depend heavily upon their local hospitals for valuable, timely and necessary inpatient, outpatient, surgical and emergency care services.

The demographics of rural North Carolina are similar to many rural states. The population of North Carolina's 61 rural counties is estimated at 2.8 million residents, nearly a third of North Carolina's total population of 8.8 million. It is estimated that more than 412,000 Medicare beneficiaries and 627,000 Medicaid recipients reside in rural North Carolina, respectively accounting for 15% and 23% of the rural population. The challenges facing North Carolina's rural counties are proportional, that is North Carolina's rural population has higher s proportions

or percentages, when compared to the state averages, of elderly, low income residents and those in poverty, minority residents, immigrants and uninsured residents, as well as higher rates of unemployment, chronic disease, health-related mortality, avoidable hospitalizations and the underlying determinants of health, such obesity, poor nutritional status, lack of exercise and physical activity and lower rates of educational attainment. In summary, the difficulties of providing healthcare in rural North Carolina are multiplied by the challenges of our rural demography.

North Carolina was blessed to be the home state of an innovator and leader in rural healthcare, Jim Bernstein. I was fortunate to be a colleague and protégé of Jim's. In 1975, at a time when very few health leaders understood the merits of rural health integration, Jim Bernstein emphasized the importance of integrated rural health networks in meeting the needs of rural residents. In 1986 Jim Bernstein brought his concepts into practice in developing the prototype rural hospital network in Scotland Neck, North Carolina. In 1990 Jim was able to share his ideas regarding rural hospitals and health networks before a Subcommittee of the House Ways and Means Committee of the U.S. House of Representatives. As a result, the rural hospital network as envisioned and created by Jim Bernstein became the national model for the Small Rural Hospital Flexibility Program, which evolved into the Critical Access Hospital (CAH) program. In the early 1990s, Our Community Hospital in Scotland Neck became one of the first Critical Access Hospitals in the country.

North Carolina's version of a *network*, as defined by Jim Bernstein, is a patient-focused system of care consisting of private and public organizations that provide an array of medical and social

services to the community. A successful rural network should include the local rural hospital, along with its tertiary care referral center, in a highly-integrated collaborative supported by community-based organizations such as public health, primary care, dental care, emergency medical services, social services, transportation, mental healthcare and long term care. The composition of a rural health network varies by community, but in communities across North Carolina rural health networks consistently deliver efficient, effective and coordinated quality health services to rural North Carolina residents.

Jim Bernstein's innovative design for successful rural hospital and health networks can be summarized in four basic concepts:

- To build community systems of care that assure access to healthcare services focused on meeting the health needs of rural residents.
- To provide the planning, implementation and operational support required by rural hospital networks to achieve higher levels of integration while continuing to meet patient needs.
- To integrate national and local initiatives that complement state priorities and programs in order to improve the access, quality and cost-effectiveness of patient care for Medicaid, low-income and uninsured patients.
- To focus on patients, not the provider, as the key integral in rural health network development**.**

The vision that Jim Bernstein established and fostered for rural hospitals and networks in the early 1970s is even more important today -- a model that has gained wide acceptance nationally.

What are the critical aspects of rural hospitals in relation to the communities they serve? First, rural hospitals are central to the healthcare and social service networks that under gird every rural county and community. The healthcare "quilt" of a rural community is comprised of a broad spectrum of healthcare organizations, community agencies and services, government-sponsored health services and providers, and a vast array of human service organizations that provide invaluable health related benefits to the residents of rural communities. In North Carolina, rural hospitals touch every component of this community support system, from public health departments and Medicaid, to Healthy Carolinians projects, community health centers and free clinics. In addition to their healthcare mission, rural hospitals offer to the community knowledgeable health professionals, leadership, badly needed resources and space for community activities and organizations, in-kind support and the basis for collaboration and coordination. The rural hospital is an invaluable resource and lifeline that ensures the viability of rural communities and their associated healthcare networks.

Another crucial aspect of rural hospitals is their role as catalysts for the development of local access points for healthcare. Both primary care and specialty care physicians are dependent upon the local hospital for a range of health services, from outpatient and emergency care to complex inpatient care. Many rural communities would lack access to even basic healthcare services without the support of their local, rural hospital. Today, rural hospitals are highly involved in the recruitment and retention of critical healthcare providers such as physicians and nurses. More than half of North Carolina's rural counties are designated by the federal government as whole or partial healthcare professional shortage areas (HPSA). Since many rural North Carolina counties are considered HPSAs, the contribution of rural hospitals as the regional anchor for trained

health professionals is paramount. More than 3,727 physicians practice in rural North Carolina counties. Many physician practices would not be viable without the ability to diagnose, treat and care for patients at a local hospital. Furthermore, over 19,800 registered nurses, 6,192 licensed practical nurses and 1,931 pharmacists practice in rural North Carolina. The healthcare services provided by these valuable, highly skilled health professionals are directly tied to the services anchored by rural hospitals.

A summary of rural hospital traits and characteristics would not be complete without mentioning that fiscal integrity and vulnerability are a constant concern for North Carolina's rural hospitals. As I highlighted earlier, by virtue of their location, rural hospitals serve proportionately more elderly, more poor, more uninsured and more disadvantaged patients than their urban counterparts. As a consequence, rural hospitals are highly dependent upon Medicare and Medicaid reimbursement for sources of revenue (63% of rural hospital revenues); some rural North Carolina hospitals depend upon government payers for more than 70% of their revenues. This dependence presents serious difficulties because government payers only reimburse hospitals at the financial break-even point, or less. In addition, government payment sources can be unpredictable due to federal and state budget constraints, leading to budget freezes, or even worse, budget cuts. Rural hospitals also have a substantial uncompensated care burden (8.8% of gross charges in 2007). As a result, in 2007 the average rural North Carolina hospital received 2.2% less revenue than it actually cost to provide patient care services -- a situation that is untenable in the long run. The precarious fiscal situation of rural hospitals led to two North Carolina hospitals closing their doors and two other rural hospitals to declare bankruptcy.

Rural hospital financing of Critical Access Hospitals is worthy of special mention. A CAH is a small, rural hospital with 25 acute beds or less. North Carolina has 21 CAHs, soon to be 22 CAHs, one third of North Carolina's rural hospitals. Nationally more than 60% of rural hospitals are officially designated as Critical Access Hospitals. The CAH program is designed to help small, rural hospitals manage the detrimental impact of fixed-payment government reimbursements upon their hospital finances. In North Carolina, CAHs are reimbursed their inpatient and outpatient costs for providing services to Medicare and Medicaid beneficiaries. The CAH program has had a stabilizing effect on small, rural hospital finances. However, CAH reimbursement does not address the fiscal burdens of caring for uninsured patients, nor does it provide an adequate level of reimbursement for investments in renovations and upgrades to buildings, capital equipment and medical technology, or to establish new health services. As a consequence, the financial picture for North Carolina's CAHs has improved but many small, rural hospitals, including CAHs, still face the perils of substantial operational losses and fiscal vulnerability.

Looking beyond healthcare and into the realm of economic development, rural hospitals are vital to the economic health of the community. Rural economic development and the viability and sustainability of rural hospitals are closely linked. Employers in rural communities frequently cite the availability of local healthcare services as a determining factor in business development. Less well known, however, is the contribution of rural hospitals to the economic vitality of rural communities. For the purpose of economic investment, North Carolina categorizes all counties into three economic development tiers. The economically challenged counties are in Tier 1 and Tier 2, with the economically advantaged counties in Tier 3. Of the forty-one counties in the

most economically disadvantaged category (Tier 1), thirty-three of the counties are rural. Furthermore, these thirty-three economically disadvantaged rural counties are served by 28 rural hospitals. The importance of rural hospitals as an economic engine is best understood by examining some revealing statistics from 2003 (see Table 2). North Carolina's rural hospitals accounted for an estimated $4.21 billion in economic output and $1.79 billion in salaries and benefits paid to an estimated 48,219 rural hospital-related employees in 2003. Overall, rural health in North Carolina generated an estimated $11.6 billion in economic output and $4.9 billion in salaries and benefits paid to an estimated 165,029 rural workers in healthcare-related businesses. In 75% of North Carolina's rural counties, the hospital is among the top five leading employers in the county. The evidence is simple and straightforward; rural hospitals contribute billions of dollars in local and regional economic value and bring tens of thousands of jobs to rural North Carolina economies and communities year after year.

Rural North Carolina hospitals are a treasure to be valued, nurtured, understood and embraced. Rural hospitals and health networks are vital components of the rural communities they serve. Attention must be given to the value of preserving, enhancing and investing in rural hospitals and rural health networks in order to ensure that effective, quality healthcare services remain consistently available and accessible for North Carolina's rural residents and communities.

In summary, the major challenges facing our rural hospitals are substantial: financial instability, mostly due to dependence on government payers and a lack of commercially insured residents; the inability to access critically needed investment capital for medical technology, health information systems and electronic medical records, for facility renovations and replacements

and the development of medical and clinical services; the increasing burden of chronic disease and the rising numbers of uninsured; the withering effects and expense of substantial and chronic workforce shortages (both physician and allied health); and the absolutely vital need for consultation and assistance to continually improve the quality, efficiency and performance of our rural hospitals and healthcare organizations.

I congratulate the House Agriculture Committee and confirm that the USDA rural health and development programs are meeting a definite need, however more support and funding are required to stabilize and improve our rural healthcare systems. The rural hospital loan programs initially supported in this year's Farm bill were a step in the right direction -- to offer a package of grants and low-cost loans for advanced medical technology, for quality and patient safety upgrades and for investments in small rural hospital facilities and renovations. At a minimum, please restore the health information technology and infrastructure grants as initially introduced in the Farm Bill.

A second priority for North Carolina rural hospitals is directly related to Medicare and Medicaid policy and payment, since these payment programs are absolutely vital to the continued existence of rural hospitals. These issues for Medicare and Medicaid include a fair and equitable payment structure by CMS for rural hospitals; continued maintenance and support of the certified public expenditure program to fund state Medicaid services to low income rural residents; giving rural hospitals and CAHs strong opportunities for success in the new pay-for-performance system; and protecting and improving the Critical Access Hospital program by increasing CAH reimbursement to 103% of cost, expanding the bed size for eligible CAHs to 50 beds or less, and

allowing CAHs to participate in the federal 340B drug program.

A third priority for rural North Carolina hospitals is the need for federal rural health programs to increase collaboration and alignment among rural health providers and their communities. For instance, Congress and CMS can act to improve the alignment between quality incentive programs for rural physicians and hospitals. In addition, federal grant programs should emphasize and require greater community-level collaboration among Federally Qualified Health Clinics, Community Health Centers, migrant health centers, rural health clinics, rural hospitals and other rural health programs funded by federal grants and loans. The substantial issues and challenges of providing quality healthcare services in rural communities can only be solved by high levels of cooperation and collaboration among the critical healthcare providers in our rural communities. Congress can improve collaboration by creating incentives for rural health providers to work together, and with, their rural communities to design healthcare solutions that are more integrated and more responsive to rural health needs.

In closing, I appreciate this opportunity to address this Subcommittee and the members of the House of Representatives. In light of the renewed debate on comprehensive health reform and the likelihood that Congress and the White House may, in the near future, take important steps towards a health care marketplace that provides greater access, higher quality and better value for rural residents and patients, the NC Rural Health Center and NCHA look forward to working with Congress and the Subcommittee as the federal health reform agenda develops and evolves.

## *TABLE 1*
## *Averages for North Carolina Hospitals*
## *2007*

| | *Average Rural NC Hospital* | *Annual Totals for Rural NC Hospitals* | *Average NC Hospital* |
|---|---|---|---|
| Average Daily Census (Acute) | 51 | NA | 119 |
| Annual Discharges | 4,868 | 243,383 | 9,334 |
| Annual Outpatient Visits | 82,968 | 4.065 million | 159,082 |
| Annual Outpatient Surgeries | 2,739 | 136,954 | 5,087 |
| Annual Emergency Visits | 25,088 | 1.25 million | 35,930 |
| Total Employees | 649 | 29,856 | 1,385 |
| Percent Net Revenue from Medicare/Medicaid | 63% | NA | 58% |
| Patient Operating Margin | -2.2% | NA | 0.4% |
| Percent Outpatient Revenue | 59% | NA | 54% |
| Uncompensated Care as a Percent of Gross Revenue | 8.8% | NA | 8.2% |
| Average Age of Plant | 10.2 years | NA | 9.7 years |
| Total Community Benefit | $7.2 million | $18.0 million | $357 million |

***Source: NCHA Data Initiative, FY 2007 survey***

## *Economic Benefit of Rural North Carolina Hospitals & Healthcare 2003*

| | ***Total Economic Impact NC Rural Hospitals*** | ***Total Economic Impact NC Rural Health*** |
|---|---|---|
| Economic Output | $4.21 billion | $11.6 billion |
| Labor Income | $1.79 billion | $4.9 billion |
| Employment | 48,219 | 165,029 |

***Source:*** ***IMPLAN 2003, NC Office of Research, Demonstrations & Rural Health Development***