BUDGET CUTS TARGET RURAL HEALTH CARE AND HOSPITALS

October 12, 1995

RURAL HOSPITALS ARE ALREADY IN A PRECARIOUS FINANCIAL POSITION:

- **The number of rural hospitals dropped 17%** between 1983 and 1993, while the number of urban hospitals dropped 2%.
- **25% of rural hospitals operate at a loss.**
- **Rural hospitals lose money on Medicare patients;** urban hospitals make a small profit.

RURAL HOSPITALS DEPEND ON MEDICARE AND MEDICAID:

- **Medicare alone accounts for almost 40% of the average rural hospital's net patient revenue.** For some rural hospitals, Medicare accounts for as much as 80%.
- **About 60% of the people discharged from rural hospitals are Medicare or Medicaid beneficiaries** -- 25% higher than the share for urban hospitals.
- **Rural Americans depend more on Medicaid and Medicare because their incomes are 33% lower than the average urban American.** And a 60% higher share of elderly live in poverty in rural areas than in urban areas.

THE REPUBLICAN BUDGET TARGETS RURAL AMERICANS' HEALTH CARE AND RURAL HOSPIT

- **Cuts Medicare for rural Americans by $58 billion -- a 20% cut** in 2002 -- just to pay for a huge tax cut for the wealthy.
- **Cuts will cost the typical rural hospital $5 million** over seven years. This is a huge hit since the typical rural hospital has annual expenses of less than $15 million.
- **Higher out-of-pocket costs and a second class Medicare program for the 9.6 million older and disabled Medicare recipients in rural areas.**
- **Cuts Medicaid for rural Americans by $45 billion, denying coverage for as many as 2.2 million rural Americans,** including:
  - Over 1 million children
  - 230,000 older Americans
  - 350,000 people with disabilities
- **77,000 rural older and disabled Americans could be denied nursing home coverage.**
- **55,000 rural older and disabled Americans could be denied home care benefits.**
- **Cuts will force rural families to choose between nursing home coverage for their parents and education for their children.**

FACTS ON THE IMPACT OF BUDGET CUTS ON RURAL RESIDENTS AND RURAL HOSPITALS

Rural residents and hospitals are uniquely vulnerable to cuts in Medicare and Medicaid. Both are disproportionately dependant on these programs and both typically face significant financial pressures. The Republican budget cuts, as a result, will threaten coverage for many rural residents and pose a unique danger to the many rural hospitals operating on the edge of financial survival.

I. IMPACT OF REPUBLICAN CUTS ON RURAL HOSPITALS

RURAL HOSPITALS REMAIN IN A UNIQUELY PRECARIOUS FINANCIAL POSITION.

- **Rural Hospitals Have Been Closing At A Disproportionate Rate**: The number of rural hospitals in America fell by 17% between 1983 and 1993 (compared to a decrease of 1.9% for urban hospitals). [American Hospital Association, Hospital Statistics, 1994]

- **Rural Hospitals Face Uniquely Severe Financial Pressures**

  - **Higher cost per patient.** The low volume of patients means that many rural hospitals face higher costs per patient than large urban hospitals. [Rural Policy Research Institute (RUPRI), 1995]

  - **Lower Medicare payments.** Making matters worse is the fact that Medicare payments are roughly 20% less per beneficiary in rural areas than in urban ones. [RUPRI, 1995]

  - **Net loss on every beneficiary.** Higher costs and lower payments mean that rural hospitals lose roughly 2% on Medicare patients. Urban hospitals, in contrast, run a slight profit (.6% on Medicare patients). [Prospective Payment Assessment Commission (PPRC), 1995]

  - **Some states may have even larger losses.** According to the *Kansas City Star*, "it is not a question of whether Indiana hospitals will close. It is a question of when . . . . Indiana hospitals already lose about 12 to 14 cents of every dollar they spend on Medicare patients." [*Kansas City Star*, 7/30/95]

- **One out of four Rural Hospitals Operate At A Loss:** *Twenty-five percent* of rural hospitals had a negative total operating margin in 1993. [PPRC, 1995]

RURAL HOSPITALS WILL BE HIT UNUSUALLY HARD BECAUSE THEY SERVE A DISPROPORTIONATE NUMBER OF MEDICARE BENEFICIARIES.

- **The Vast Majority Of Rural Patients Are Medicare Or Medicaid Beneficiaries.** About 60% of the discharges in rural hospitals are Medicare or Medicaid beneficiaries -- 25% higher than the proportion in urban hospitals. [American Hospital Association, Annual Survey of Hospitals, 1993]

- **Medicare Alone Accounts For Almost 40% Of Net Patient Revenue In The Average Rural Hospital.** [Frenzen, 1995] In some rural areas, Medicare represents as much as 80% of revenues.

  - **Rural Indiana:** "On average, Indiana hospitals get about 40 percent to 45 percent of their income from Medicare.... [A]t smaller hospitals in rural Indiana, however, Medicare and...Medicaid can account for 60 to 80 cents of every dollar they collect." [*The Indianapolis Star*, 10/8/95, citing Bob Morr, Vice President of the Indiana Hospital Association]

  - **Rural Minnesota:** Swift County-Benson Hospital, out in the prairie of Benson, Minnesota, gets an overwhelming 85% of its revenue from Medicare and Medicaid. [*Star Tribune*, 10/2/95]

  - **Rural Nebraska:** In a recent article, the *New York Times* profiled a rural hospital in Nebraska -- the Saunders County Health Services -- which "ministers to a population that is largely elderly and exceedingly dependant on Medicare." The *Times* reports that the elderly actually account for 80% of the hospital's revenue. The precarious financial straits of the hospital are typical of many rural centers. Saunders "lost money last year, hopes to break even this year and has been struggling since the mid-1980s." Its manager worries that the new spending controls on Medicare would have a significant impact on his 30-bed hospital. As the Times notes, "the Medicare policies being created in Washington instill anxiety and frustration. " [*New York Times*, 5/21/95]

GIVEN THEIR PRECARIOUS FINANCIAL SITUATION AND THEIR SIGNIFICANT RELIANCE ON MEDICARE AND MEDICAID, PROPOSED BUDGET CUTS WILL LIKELY FORCE THE CLOSING OF MANY RURAL HOSPITALS ACROSS THE NATION.

- **Budget Cuts Will Cost The Typical Rural Hospital $5 Million Over Seven Years**, according to the American Hospital Association. [American Hospital Association, 10/6/95]. To put that figure in context, the typical rural community hospital has total expenses of less than $15 million every year. [American Hospital Association, Annual Survey of Hospitals, 1993]

  - **Example: Nebraska**: The Nebraska Association of Hospitals and Health Systems released a study on September 8, 1995, reporting that the Republican cuts will cost a small rural Nebraska hospital (less than 49 beds) $3.3 million, a mid-size hospital (49-100 beds) $11 million, and a typical larger size rural hospital (100-200 beds) $33 million. [Press Release, 9/8/95]

  - **Cuts ask Hospitals to Provide 19 Months of Free Care**: "The proposed $270 billion reduction in Medicare spending is asking hospitals to provide 19 months of free care to Medicare recipients over the next seven years. . . . Clearly, it's a lose-lose situation, not only for hospitals, but for the public who depend on these hospitals," says Harlan Heald, President of The Nebraska Association of Hospitals and Health System [Press Release, 9/8/95]

- **Recent Press Reports Warn Of Hospital Closings Under Republican Budget Cuts.**

  - The *Kansas City Star* reports: "If Congress cuts Medicare spending by $270 billion, rural health care will be one of its biggest victims, hospital operators, researchers and others predict. Such reductions will force the closing of some rural hospitals, curb such basic services as emergency rooms and community health clinics, and worsen an already serious shortage of doctors and other health care workers." [*Kansas City Star*, 7/30/95]

  - The *Wall Street Journal* reports: "hospitals are closing anyway at a rate of 50 or so each year. But that number could double, or even triple due to stepped-up financial pressures from the government and private payers, analysts say." [*Wall Street Journal*, 10/2/95]

  - The *Billings Gazette*: "In rural areas, the percentage of Medicare [patients] is probably higher so the effect would be more pronounced. Overall, it's going to be devastating." Jim Ahrens, President of the Montana Hospital Association [*Billings Gazette*, 5/29/95]

  - The Fort Lauderdale *Sun-Sentinel* reports that the budget cut "means higher health care premiums, higher deductibles, and more restrictive employer-provided health care plans . . . or an awful lot of rural medical facilities are going to go belly up and a lot of the nation's great teaching hospitals are going to become shells of their former excellence. It's probably both." [*Sun-Sentinel*, 10/3/95]

  - *Baton Rouge Advocate*: "We're facing an enormous crisis in rural hospitals if something is not done about these cuts in Medicare and Medicaid," warned Joe Soileau, chairman of the Louisiana Rural Hospital Coalition. [*Baton Rouge Advocate*, 9/23/95]

  - *Minneapolis Star Tribune*: "The small hospital out on the prairie in Benson, Minnesota has a message for the members of Congress who are trying to shake up the Medicare-Medicaid system: 'If some things don't happen to help us, our life as we know it today will be over in 12 to 18 months,' said John Stidt, Chief Executive Officer of Swift County-Benson Hospital. 'We will have to close our doors.'" [*Star Tribune*, 10/2/95]

  - *Arkansas Democrat-Gazette*: One hospital near Prescott, Arkansas, may soon close its doors. The hospital, according to an administrator, relied on Medicare and Medicaid for 72% of its payments. If it closes, "the nearest hospital will be in Hope, about 15 miles to the southwest." A spokesman for the Arkansas Hospital Association "said that rural hospitals suffer disproportionately because of their heavy reliance on Medicare and Medicaid payments." [*Arkansas Democrat-Gazette*, 7/19/95]

II. Impact Of Health Care Cuts On Rural Residents

MEDICARE CUTS IN RURAL AMERICA WILL AMOUNT TO $58 BILLION OVER SEVEN YEARS, A 20% CUT IN 2002. THESE CUTS WILL SEVERELY DISRUPT THE PROVISION OF MEDICAL SERVICES TO MANY RURAL RESIDENTS.

- **Approximately 9.6 Million Older And Disabled Residents In Rural America Depend On Medicare For Their Health Care.** [Department of Health and Human Services (HHS)]

- **Because Of The Migration Of Young To Urban Centers, A Higher Proportion of Rural Residents Are Older Than Urban Dwellers And Depend Heavily On Medicare.**

  - **Far higher enrollment rates.** The Medicare enrollment rate is 28% higher in rural than in urban areas (16.0% vs. 12.5%), making Medicare a critical source of revenue for the rural health care system. [Frenzen, 1995]

  - **Medicare is particularly vital in farming communities.** 22% of farm operators were 65 or older in 1990, compared to only 3% of the U.S. workforce as a whole. [Council of Economic Advisers]

  - **Example: Nebraska.** In Nebraska, "it is the rural health-care system that is most 'fragile,' as Dr. Mark Horton, the state director of health, put it. Eighteen percent of Nebraska's rural population is over 65; many of the hospitals in rural areas, and many of the primary care physicians there, are exceedingly reliant on the Medicare program." [*Sunday Gazette Mail*, 5/21/95]

- **Rural Communities Are Less Able To Bear The Burden Of Medicare Cuts**, since their residents have less income on average than urban residents and their economies depend more heavily on Medicare payments.

  - **Rural residents have lower incomes**: Rural residents had an average per capita income in 1993 of $16,028, compared to $23,843 for urban residents. [Bureau of Economic Analysis, Regional Economic Information System, 1993.] The incidence of poverty among the non-metropolitan elderly is approximately 60% higher than among metropolitan elderly (16.7% vs. 10.5%). Thus, an across the board increase in premiums will represent a far larger tax in percentage terms on the rural elderly than on the urban elderly. [HHS, RUPRI, 1995]

  - **Rural economies depend more heavily on Medicare payments than urban economies.** Medicare comprises a far greater percentage of total personal income in rural areas than urban areas -- 41% more. [RUPRI, 1995]

  - **"A Financial Shock" to rural America.** "Clearly, a uniform percentage cut in Medicare would give rural America a financial shock," said Glenn Nelson, a researcher for the Rural Policy Research Institute. [*Kansas City Star*, 7/30/95]

MEDICAID SPENDING WILL FALL BY $45 BILLION IN RURAL AMERICA, FORCING MANY TO LOSE CRITICAL HEALTH CARE COVERAGE FOR NEEDED SERVICES.

- **Spending Cuts Could Deny Medicaid Coverage To As Many As 2.2 Million Rural Americans,** according to the Department of Health and Human Services, including:
    - 1 Million Children
    - 230,000 Older Americans
    - 350,000 People With Disabilities

- **As Many As 77,000 Rural Older And Disabled Persons In America Could Be Denied Nursing Home Coverage** in 2002. Most of the 350,000 people living in nursing homes in rural America are covered by Medicaid. Under the Republican Medicaid plan, as many as 77,000 rural nursing home residents (22%) could be denied coverage. [HHS]

- **As Many As 55,000 Rural Older And Disabled Persons In America Could Be Denied Home Care Benefits** in 2002. About 333,000 poor elderly in rural America need home care. Under the Republican Medicaid plan, as many as 55,000 (17%) rural poor elderly who need home care will lose coverage. [HHS]

III. Rural Health Care And Access To Doctors

BECAUSE RURAL DOCTORS RELY DISPROPORTIONATELY ON MEDICARE AND MEDICAID, REPUBLICAN PROPOSALS WILL MEAN THE LOSS OF MUCH NEEDED DOCTORS.

- **Rural Medicare Recipients Could Have Less Choice of their Own Doctor Under Republican Medicare Plans:** Only 44% of physicians in rural areas are members of HMO or PPO plans, compared to 81% for physicians in urban areas. [American Medical Association, 1993].

- **Rural Physicians Rely More on Medicare and Medicaid Than Urban Physicians.**
    - Medicare and Medicaid accounts for 53% of the practice of non-metropolitan primary care physicians, but only 41% of the practice of physicians in large metropolitan areas. [Report of the Council on Medicaid Services, 1995].

- **Republican Budget Cuts Will Make Medical Practice in Rural Communities Less Desirable and Will Cause Medicare Recipients To Lose Needed Doctors.** America's rural Medicare recipients would need 5,084 more primary care physicians to have the same doctor to population ratio as the nation as a whole. [Mueller, 1995]. Yet the American Medical Association has stated that the cuts in Medicare are so severe that they "will unquestionably cause some physicians to leave Medicare." [*New York Times*, October 10, 1995.]

THE REPUBLICAN BUDGET TARGETS RURAL AMERICA AND HITS IT HARD

October 11, 1995

THE REPUBLICAN BUDGET TARGETS RURAL MEDICARE BENEFICIARIES AND HOSPITALS:

- **Cuts Medicare for rural Americans by $58 billion -- a 20% cut** in 2002 -- just to pay for a huge tax cut for the wealthy:

- **Higher out-of-pocket costs and a second class Medicare** program for the 9.6 million older and disabled Americans in rural areas.

- **Many rural hospitals will be forced to close** -- sometimes the only hospital for miles, leaving rural Americans with nowhere to turn for the health care they need.

THE REPUBLICAN BUDGET TARGETS RURAL MEDICAID:

- **Eliminates coverage for as many as 2.2 million rural Americans including:**
  - Over 1 million children
  - 230,000 older Americans
  - 350,000 people with disabilities

- **77,000 rural older and disabled Americans could be denied nursing home coverage.**

- **55,000 rural older and disabled Americans could be denied home care benefits.**

- **Cuts will force rural families to choose between nursing home coverage for their parents and education for their children.**

THE REPUBLICAN BUDGET TARGETS FARMERS:

- **25% bite out of farm programs** -- jeopardizing the rural way of life in America.

- **Cuts come right out of the pockets of farmers** -- net farm income for target price crops and soybeans is expected to decline by $9 billion over seven years.

THE REPUBLICAN BUDGET RAISES TAXES ON RURAL WORKING FAMILIES:

- **Raises taxes on 4 million rural working families by an average of $352.**

THE REPUBLICAN BUDGET TARGETS RURAL EDUCATION:

- **Cuts will deny 113,000 rural children basic and advanced skills education** -- at a time when many small-town and rural schools are already having trouble making ends meet.

IMPACT OF REPUBLICAN BUDGET CUTS ON RURAL AMERICA

October 11, 1995

HEALTH CARE IN RURAL AMERICA

The Republican MEDICARE Cuts Will Force 9.6 Million Older And Disabled Americans In Rural America To Pay Higher Premiums and Higher Deductibles For A Weakened Second Class Medicare Program.

Medicare Spending For People In Rural Areas Of America Will Be Cut By $58 billion Over Seven Years -- A 20% Percent Cut In 2002 Alone.

- **The Republican Cuts Will Increase The Severe Financial Pressure On Rural Hospitals In America And Force Some Rural Hospitals To Close.** Today, rural hospitals lose money on Medicare patients while urban hospitals make a small profit. Medicare accounts for almost 40% of net patient revenue in the average rural hospital, and as much as 80% in some rural hospitals.

- **According to the American Hospital Association, under the Republican cuts, the typical rural hospital will lose $5 million in Medicare funding over seven years.**

- **Rural Medicare Recipients Would Lose Much-Needed Doctors.** America's rural Medicare recipients would need 5,084 more primary care physicians to have the same doctor to population ratio as the nation as a whole. Yet the American Medical Association has stated that the cuts in Medicare are so severe that they "will unquestionably cause some physicians to leave Medicare." [*New York Times*, October 10, 1995.]

The Republican MEDICAID Cuts Will Further Hurt Rural Hospitals And Eliminate Coverage For Millions Of Rural Americans.

- **Rural Hospitals Will Suffer Additional Revenue Losses From The $45 Billion Republican Medicaid Cuts.** In addition to the average of $5 million rural hospitals will lose from Medicare cuts, rural hospitals will also face revenue shortages due to the severe Republican Medicaid cut.

- **As Many As 2.2 Million Rural Americans Will Be Denied Medicaid Coverage, Including:**
  - 1 Million Children
  - 230,000 Older Americans
  - 350,000 People With Disabilities

- **Over 77,000 Rural Older And Disabled Persons In America Could Be Denied Nursing Home Coverage** in 2002. Most of the 350,000 people living in nursing homes in rural America are covered by Medicaid. Under the Republican Medicaid plan, approximately 77,000 rural nursing home residents (22%) could be denied coverage.

- **Over 55,000 Rural Older And Disabled Persons In America Could Be Denied Home Care Benefits** in 2002. Most of the 365,600 poor elderly in rural America who need home care are covered by Medicaid. Under the Republican Medicaid plan, approximately 55,000 (17%) rural poor elderly who need home care will lose coverage.

FARMING IN RURAL AMERICA

The Republican Budget Slashes Farm Spending By 25% over seven years. Farm spending in America will be reduced by $13 billion -- drastically reducing support for commodity programs.

The Republican Budget Will Reduce Farm Income Nationwide. As a result of the Republican cuts, net farm income for target price crops and soybeans is expected to decline by $9 billion over seven years -- a 4% reduction in earnings.

TAXES ON WORKING FAMILIES IN RURAL AMERICA

The Republican Budget Raises Taxes On 4 Million Working Families In Rural America By An Average Of $352 in 2002. Republican cuts to the Earned Income Tax Credit will impose a $59.2 million tax increase on working families and their children in rural America.

EDUCATION IN RURAL AMERICA

The Republican Education Cuts Will Deny 113,000 Children Basic And Advanced Skills In Rural America in 1996. Title I funds in rural areas will be cut by $113 million -- more than 17% -- denying crucial assistance at a time when many small-town and rural schools are already having trouble making ends meet.

PUBLIC HEALTH AND THE ENVIRONMENT IN RURAL AMERICA

The Republican Budget Will Reduce The Amount Of Money That States Can Spend To Keep Water Clean In Small Communities And Rural Areas By 20% Compared To The President's Balanced Budget. These cuts will derail initiatives that are working to fight water pollution and protect public health.

The Republican Budget Proposal Will Stop Or Slow The Clean-up Of At Least 115 Toxic Waste Sites In Rural America. Nationwide, the Republican Budget reduces spending on toxic waste cleanups by 36% -- or $560 million -- below the President's balanced budget. These cuts will restrict or stop clean-ups of sites nationwide that pose a threat to public health and the environment.

TRANSPORTATION IN RURAL AMERICA

The Republican Budget Will Cut Transportation Grants For Rural Areas By 20%. Republican proposals cut $57.4 million for rural transportation in America. These funds are essential for giving residents access to medical services, supermarkets and grocery stores, and job training.

NUTRITION IN RURAL AMERICA

Republican Cuts Will Slash Up To 15% From Food Assistance To Rural America. Republican budget cuts will fall particularly hard on the rural poor, cutting as much as $11 billion in food assistance from rural areas over seven years.

Republican Nutrition Cuts Will Eliminate Jobs In America. These cuts will reduce farm prices and incomes, and result in the loss of as many as 328,900 jobs nationwide -- including up to 57,800 rural jobs.

HOUSING IN RURAL AMERICA

The Republican Housing Cuts Will Reduce Spending On Public Housing Capital In Rural America 46% Below The President's Request in 1996. Cuts to public housing capital assistance in rural areas will total $460 million in 1996, severely hindering efforts by rural housing agencies to rehabilitate run down public housing projects and provide much needed security and anti-crime programs.

The Republican Budget Will Cut 40% From Assistance To Homeless Persons in Rural Areas in 1996. The Republican plan will cut $108 million in homeless assistance to rural areas. The reduction will mean 4.9 million fewer nights of shelter for America's rural homeless.

SPECIAL

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503-0001

LRM NO: 5533

FILE NO: 2795

9/10/96

LEGISLATIVE REFERRAL MEMORANDUM

Total Page(s): 8

TO: Legislative Liaison Officer - See Distribution below:

FROM: Janet FORSGREN Janet Forsgren (for) Assistant Director for Legislative Reference

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SUBJECT: HHS Proposed Testimony RE: HR3753, The Rural Health Improvement Act of 1996

DEADLINE: 11:00 a.m. Wednesday, September 11,1996

In accordance with OMB Circular A-19, OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President.

Please advise us if this item will affect direct spending or receipts for purposes of the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.

COMMENTS: Hearing is before the House Committee on Ways and Means on Thursday, September 12th. Jeff Human, from PHS' Office of Rural Health Policy, is the witness.

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RESPONSE TO LEGISLATIVE REFERRAL MEMORANDUM

LRM NO: **5533**

FILE NO: **2795**

If your response to this request for views is short (e.g., concur/no comment), we prefer that you respond by e-mail or by faxing us this response sheet.
If the response is short and you prefer to call, please call the branch-wide line shown below (NOT the analyst's line) to leave a message with a legislative assistant.
You may also respond by:
(1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); or
(2) sending us a memo or letter
Please include the LRM number shown above, and the subject shown below.

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_____ (Telephone)

SUBJECT: HHS Proposed Testimony RE: HR3753, The Rural Health Improvement Act of 1996

The following is the response of our agency to your request for views on the above-captioned subject:

_____ Concur

_____ No Objection

_____ No Comment

_____ See proposed edits on pages _____

_____ Other: _____

_____ FAX RETURN of ____ pages, attached to this response sheet

DRAFT TESTIMONY
COMMITTEE ON WAYS AND MEANS
SEPTEMBER 12, 1996
JEFFREY HUMAN

Good morning.

Mr. Chairman, I am pleased to be here to be a part of an important hearing on the availability of health care in rural communities. This is a significant problem that has plagued the Nation for many years. We are appreciative of the support the House Ways and Means Committee has provided through the years in addressing rural health care concerns.

There are two major components of the unique problems rural Americans face in getting health care. First, there is a shortage of physicians and other health care professionals in rural areas. Second, rural hospitals have been closing at a disproportionate rate for the past 15 years.

With respect to physicians shortages; on a per capita basis there are almost twice as many primary care physicians practicing in urban areas as there are in rural areas. When we consider all physicians, not just those practicing primary care, there are well over twice as many physicians - on a per capita basis - practicing in urban areas.

If we look at the problem on a county basis, about 1400 of the nation's 2100 rural counties are classified as Health Professions Shortage Areas, because of a shortage of primary care physicians. For the most part these are the more remote counties, those that are farthest away from the Nation's cities. Most of the counties on the Great Plains, for example, are shortage areas and more than 100 have no physicians at all.

More than 2000 physicians would be needed to correct this problem, nationwide. There are also documented shortages of nurses, psychiatrists, dentists, social workers, psychologists and other health professionals in rural areas.

The other problem is the viability of rural hospitals. In 1980 there were over 2800 rural hospitals serving small communities across the Nation. In 1996 there are abut 2,260, a reduction of more than 550 rural hospitals; a loss of 20% of the nation's rural hospitals. The rate of closure has slowed during the past five years but 25% of the remaining 2260 rural hospitals have negative operating margins - that is they are losing money and are at risk of closure.

More than a few urban hospitals also have closed during this period, but the consequences of the closure of a rural hospital are almost always more difficult for local people than the consequences of the closure of an urban hospital. Those of us who live in the DC area have many hospital choices. Hospitals that close in rural areas may leave local people with no choice, or a very long distance to travel.

Before we talk about solutions to these problems we should put them into a broader context. In 1900 over 60% of the nation's population lived in rural areas. Today that figure is under 25% and falling. It is not only the hospitals that are closing but also the schools, grocery stores, farms, and manufacturing plants. There are not only shortages of health professionals, but of professionals of all stripes.

And any strategy to improve health care in rural America will benefit rural viability as well. Towns without physicians usually cannot attract employers, or even hold the employers they already have. Rural hospitals are typically the second or third biggest employer in a town. When the rural hospital closes, the local physicians, typically, also leave. And the prognosis for the economic viability of the community darkens considerably and immediately. The availability of health care in America's smaller communities, and the economic viability of those communities are inexorably entwined.

There is also a close relationship between rural poverty, uninsurance, and health care. In 1994, 16.3% of rural people were below the poverty level, compared to 14.9% of urban people. This is approximately 8 1/2 million rural people. About 17% of all rural Americans are uninsured.

As we look at the problem of accessability to health care in this country's more remote areas we can count many federal initiatives that assist rural people. We must, however, resist the temptation to define rural health as a federal problem that requires a federal solution. It is a national problem that cannot be solved without the involvement of the States, the local governments and the private sector. What we do in government at any level, or in foundations or associations, merely compliments and helps fill in the gaps for the thousands of dedicated physicians and other health professionals who serve rural areas, despite lower compensation. They need and deserve our support.

Through the years the Congress has passed a number of acts designed to assist rural populations to get the health care they need and to support the health professionals who serve them. Some of these public laws fall under the jurisdiction of this committee. Let me just mention some of these. Ms. Kathy Buto of the Health Care Financing Administration, the next witness, will discuss some of these programs in more detail:

- The Medicare Resource Based Relative Value Fee System (or RBRVS) pays primary care physicians more than used to be the case. These are the physicians rural areas depend on most.
- Primary care physicians in rural areas that are classified as underserved receive a 10% bonus for each encounter under Medicare.
- Medicare certified Rural Health Clinics receive cost based reimbursement in shortage areas for the physicians, nurse practitioners and physician assistants they employ.

- Several special reimbursement programs for rural hospitals have helped many survive that might otherwise have perished. These include the Swing Bed Program which allows rural hospitals to use some beds for long term care when necessary, and the Sole Community Hospital reimbursement program, which pays higher Medicare rates to many of the most isolated and remote hospitals. Rural Healthcare Transition Grants also are under the jurisdiction of this committee. These grants help rural hospitals re-examine their roles in the community, change their service mix, or offer new services as necessary.

- The office I direct, the Office of Rural Health Policy, is authorized under section 711 of the Social Security Act, even though we are located administratively in the Health Resources and Services Administration (HRSA), so we also fall under this committee's jurisdiction. While we administer some programs, which I will describe, our principal roles are to serve as a voice for rural health in the federal establishment, and to develop information and policy alternatives that help rural America.

Most of the rural health programs under this committee's jurisdiction are reimbursement programs under Title XVIII. A number of other HRSA programs, including some we administer, compliment these reimbursement programs with direct assistance to rural communities in need. Among these are:

- Community and Migrant Health Centers in rural areas. Over 3.7 million Americans in 1,100 of the poorest communities in this country receive their day to day primary care from these private medical clinics. Federal support from HRSA allows the clinics to offer discounted fees to the poor and near poor who are the bulk of the centers patients. A reimbursement program under this Committee's jurisdiction known as Federally Qualified Health Centers (FQHC) helps these centers receive cost based reimbursement for Medicare and Medicaid patients.

- The National Health Service Corps. Under the Corps' scholarship program physicians receive their medical education at government expense and pay the country back by serving in the communities that experience the greatest difficulty recruiting physicians. The Corps also repays the educational loans of other young physicians at up to $20,000 per year in return for service in underserved areas. Currently about 1,300 of the 2,200 physicians and other health professionals in Corps service are in rural areas. Three quarters of a million people receive their care from Corps' practices as well as many more in community and migrant health centers served by Corps professionals.

- Area Health Education Centers in 36 states link medical schools and teaching hospitals with rural communities and help them recruit physicians as well as provide continuing medical education to those who already are there. More than one and a half million health professionals have received AHEC sponsored training, most of them in rural areas.

- Rural Interdisciplinary Training Grants train students to work effectively in multi-disciplinary teams that enhance the capability of every member of the team to help the patient. More than 55% of the 1,700 students who have participated in this program now practice in rural areas. This program thus serves as a recruitment program for rural areas.

- My office supports several important rural programs including the Rural Information Center Health Service (RICHS), in collaboration with USDA. By dialing 1-800-633-7701 rural communities can get information on such diverse topics as how to recruit a doctor or how to build a community water and sewer system. RICHS operates a World Wide Web Site that is hyperlinked to many rural health programs throughout the country. RICHS also publishes monographs and bibliographies on topics of concern to rural leaders and health providers.

- We fund grants to communities for Rural Health Outreach projects to help each community develop unique solutions to its particular problems. Thus we fund an Alaska tribal consortium that brings itinerant physician services to two remote villages, an elementary school district in Arizona that brings preventive and primary care to school children in eleven school districts and a hospital in Iowa that is providing training to nurses, paramedics and emergency medical technicians. We currently fund about 150 projects in 48 states and three territories.

  Under outreach rules the projects must be directed locally, the money must be spent locally, and the patients served must be local people. A consortium of three or more local organizations need to coordinate the services provided. Thus our grants help local community groups work together to build self sufficiency and economic viability while improving health care.

  One of the key criteria by which we evaluate the Outreach Grant applications is the ability of the applicant to maintain the health care services funded by the grant after the federal support is completed. Results to date indicate that more than 70 percent of our grantees have been able to continue their projects after the federal grant has ended, often through third party payments, local tax support, community contributions, or a combination of these and other strategies.

- We also provide grants for rural health research centers. These Centers are exploring many important issues: how market driven reform is affecting rural areas; barriers to the formation of rural networks and rural-based managed care organizations; policy options for increasing the number of health professionals in rural areas; and how to provide rural people with access to mental health services.

- Our office administers the Rural Telemedicine Grant Program, which is designed to create the information base necessary for a systematic evaluation of rural Telemedicine. We currently fund 12 projects in 11 states, all of which also are facilitating the development of rural health networks. In addition, the office also funds an additional 18 Telehealth/Telemedicine projects under its Outreach Grant Program. Most projects also involve distance education. In addition, the Office also has just completed the first comprehensive survey of rural Telemedicine. A report describing the survey findings will be available by early October. Later this month, we will be entering into a cooperative agreement with the Telemedicine Research Center in Portland, Oregon, to create an ongoing system for evaluating Telemedicine. Development of the system will be coordinated with other federal agencies sponsoring Telemedicine demonstrations, including the Health Care Financing Administration.

  Finally, my Deputy Director chairs the Joint Working Group on Telemedicine, an interagency committee under the Vice President. Federal agency representatives meet twice a month to coordinate various Telemedicine programs of the Executive Branch to ensure the best use of Federal dollars. The working group will be providing an update to Congress in January which describes all of its activities to date, including development of a joint evaluation strategy for Federal Telemedicine program. The report will also include findings from current Federal projects and a discussion of strategies for overcoming the barriers to the cost-effective use of Telemedicine, such as cross-state licensure barriers and reimbursement. A group sponsored information base on federally funded Telemedicine projects will be available on the World Wide Web in late Fall.

- The Office helps to shape Departmental programs and policies on rural health care by reviewing regulations and legislative proposals that affect rural health care providers and rural populations. For example, we review Medicaid waiver applications from the states and provide HCFA with comments on the potential effects of state plans for bringing Medicaid managed care to rural areas.

- The Office also staffs the Secretary's National Advisory Committee on Rural Health. Over the past six years the Committee has produced a wide array of recommendations on rural health care financing issues and ways to improve access to health care in rural communities. Some of the recommendations have been of interest to Congressional Committees involved with rural health care issues.

- We help the 50 States each fund Rural Health Offices much like our own and work with them to develop joint programs such as a 44 state project to facilitate and coordinate the recruitment and retention of physicians, using an 800 toll free number and the existing staffs of the participating states.

  State office efforts have led to the placement of over 1,000 physicians in rural practices in recent years. All state offices serve as information clearinghouses for their state, coordinate state based rural health activities, and help local communities find financing for their activities.

I haven't discussed the various block grant programs out of HRSA, SAMSHA, and CDC because its difficult to disaggregate the various rural programs given the wide array of state programs.

It should be noted that the reimbursement programs and the grant programs compliment each other. The reimbursement programs create a general eligibility for groups of institutions and populations, and the grant programs provide resources to specific high need areas or populations.

Mr. Chairman, there are other rural health problems that are pervasive, such as emergency medical systems shortages, mental health shortages and occupational health problems. There are also other federal programs I have not had time to describe and thousands of state local and private efforts that help. These however are most of the federal programs that are most important to rural areas. Thank you for allowing us to introduce them to you and the committee.

TO: Carolyn
FROM: Jen
RE: Rural Health

I've attached some fact sheets and talking points on rural health care. I wrote the first page when the President did a rural hospital conference call. You can use all the facts but not the information about the Republican budget. HHS sent over the rest.

Marilyn Yager pointed out that in the part of Iowa that the President is visiting there is small rural hospital about every ten miles, and they all depend on Medicare and Medicaid revenues. You might want to mention that the Medicare portion of President's balanced budget proposal includes a number of investments in rural health care, including telemedicine grants, rural health outreach grants and rural referral centers. It also authorizes direct payments for physician assistants, nurse practitioners and clinical nurse specialists in rural areas.

I'm expecting more from HHS so I'll send it over whenever I get it. Feel free to call with any questions.

GENERAL FACTS ABOUT RURAL HOSPITALS AND RURAL HEALTH CARE

RURAL HOSPITALS ARE ALREADY IN A PRECARIOUS FINANCIAL POSITION.

- **The number of rural hospitals in America dropped 17%** between 1983 and 1993, while the number of urban hospitals dropped 2%.

- **One in four rural hospitals operate at a loss:** *Twenty five percent* of rural hospitals had a negative total operating margin in 1992.

- **Rural hospitals already lose money on Medicare patients.** Rural hospitals lose roughly 2% on Medicare patients. Urban hospitals, in contrast, run a slight profit (.6% on Medicare patients).

RURAL HOSPITALS DEPEND ON MEDICARE AND MEDICAID

- **Medicare alone accounts for almost 40% of net patient revenue in the average rural hospital.** In some rural areas, Medicare represents as much as 80% of revenues.

- **The majority of rural patients are Medicare or Medicaid beneficiaries**. About 60% of the discharges in rural hospitals are Medicare or Medicaid beneficiaries -- 25% higher than the proportion in urban hospitals.

- **Rural Americans depend more on Medicaid and Medicare because they have lower incomes**. Rural residents had an average per capital income in 1993 of $16,028, compared to $23,843 for urban residents. The incidence of poverty among the non-metropolitan elderly is approximately 60% higher than among metropolitan elderly. Thus, an across the board increase in premiums will represent a far larger tax in percentage terms on the rural elderly than on the urban elderly.

REPUBLICAN BUDGET BUDGET TARGETS RURAL AMERICANS' HEALTH CARE AND RURAL HOSPITALS

- **Cuts Medicare for rural Americans by $58 billion -- a 20% cut** in 2002. This will mean higher out-of-pocket costs for the 9.6 million older and disabled Americans on Medicare in rural areas.

- **Budget cuts will cost the typical rural hospital $5 million over seven years**, according to the American Hospital Association. To put that figure in context, the typical rural community hospital has total expenses of less than $15 million every year.

- **Cuts Medicaid for rural Americans by $45 billion, denying coverage to as many as 2.2 million rural Americans, including over one million children.**

- **As many as 77,000 rural older and disabled Americans could be denied nursing home coverage.**

- **As many as 55,000 rural and disabled Americans could be denied home care benefits.**

October, 1995

Contact: HHS Press Office
(202) 690-6343

Rural Hospitals and Medicare and Medicaid

Medicare

- There are approximately 2,500 hospitals in the U.S. that are located in rural communities.
- An estimated 24 percent of rural hospitals had a negative operating margin in 1992.
- Medicare accounted for almost 40 percent of rural hospitals' annual revenue in 1993. For many rural hospitals, Medicare accounts as much as 80 percent or more of annual revenue.
  - Significant reductions in Medicare revenues could cause many distressed rural hospitals to close or to turn to local taxpayers to increase already substantial local subsidies.
- The rural health infrastructure is fragile and highly sensitive to even small changes in payment policies.
  - Because of their low patient volume, many rural hospitals have very high per-case costs.
  - Many rural hospitals have disproportionately high bad debts and an eroding privately insured patient population.
  - Rural hospitals have limited ability to downsize because of the need to maintain staffing and services to meet accreditation and clinical standards.
- The market penetration of health maintenance organizations (HMOs) in private insurance and in Medicare is lower in rural areas.

Medicaid

- Medicaid accounted for an average of about 20 percent of rural hospitals' annual revenue in 1992, representing a fiscal safety net for these communities.
- Rural communities often have a disproportionate concentration of elderly, disabled, and low-income families.

Talking Points
Donna E. Shalala
Secretary of Health and Human Services
on
Health Reform and Rural America

March 18, 1994

I Problems Facing Rural Americans

- More than 8 million rural Americans have no health insurance, including 18 percent of all farm families.
- More than 400,000 rural Americans live in a county that does not have a single doctor.
  - 34 million rural Americans live in rural areas with an undersupply of physicians.
- The majority of rural Americans who do have insurance often must obtain it on their own.
  - Only 25 percent of the cost of such self-insurance is tax-exempt compared to 100 percent for employer-provided coverage.
- A higher percentage of rural Americans are elderly and rural areas have much higher rates of serious accidents.
- Physicians and other health care professionals find few incentives to practice in rural areas.
  - The average age of rural doctors is rising.
- Rural Americans often must travel a long distance to get to available services.
  - Public transportation is frequently unavailable;
  - More than half of low-income rural Americans don't own a car;
  - Nearly 60 percent of rural elderly do not have a driver's license.

II Benefits of the Health Security Act

- All Americans will have private coverage that cannot be taken away.

Talking Points for the President April 18, 1995

Accomplishments in Rural Health

The Administration has empowered America's rural communities to reconfigure and rebuild their health care services in the last several years. We have developed a cooperative partnership with states, leveraged many new initiatives with federal dollars, and helped create the setting for networking and technical assistance across communities.

- In the Health Security Act, I proposed that all Americans, including all who live in rural areas, have access to health insurance that could never be taken away. In Title II of that Act, a number of initiatives would build medical care capability in rural areas, including tax incentives for physicians who move to rural areas that are now very much underserved. I remain committed to health reform that will work in rural areas.

- I also proposed to reform graduate medical education to produce more of the primary care physicians who are the backbone of rural medicine. Under my proposal, 55% of all residency positions would have gone to those training for careers in family medicine, general internal medicine, general pediatrics, and obstetrics/gynecology.

- During the past two years, Medicare reimbursement to rural hospitals has been increased to eliminate the urban/rural distinction that was once as high as 25%. Now the Medicare "standardized amount" payments to rural hospitals are equal to those of urban hospitals.

- We have also fostered the development of more rural health care clinics. Medicare-certified rural health clinics have proliferated during the past two years, increasing from fewer than 800 to more than 2,000. More than a third of the 2000 clinics are hospital based. These clinics use nurse practitioners, physician assistants and nurse midwives in support of physicians. As a result, Medicare provides cost-based reimbursement to help support the clinics. The increase in the number of clinics is a direct result of their promotion by the Department of Health and Human Services.

- Federal funding for programs that most help rural areas, such as community health centers, migrant health centers, and the National Health Service Corps, have been greatly increased during the past two years. These programs provide primary medical care to nearly 3 million rural Americans in some of the poorest communities in this country.

- With Federal encouragement and some matching funds, we have seen the number of rural health offices at the state level increase from 26 in 1992 to all fifty states today. These state offices are very active partners with their rural communities, their state, and with the federal government in designing new strategies to solve rural health problems.

Medicare and Medicaid Rural Issues and Initiatives

- The Rural Health Care Transition Grant Program was established in 1987 to provide grants to small rural hospitals for strategic planning and service enhancement. Hospitals must be non-Federal, not-for-profit, short-term general acute care, located in rural area and have fewer than 100 beds. Grants are not to exceed $50,000 a year, for up to 3 years. In FY 1993, 179 new grants were awarded. In 1994, 129 new grants were awarded for a total grant program of $20.4 million. In 1995, 65 new grants were awarded for a total grant program of $16.6 million.

- The Rural Health Clinic Services Act was passed in December of 1977. This authorized Medicare and Medicaid payment to qualified rural health clinics for "physician services" whether provided by a physician, physician assistant or nurse practitioner. Since 1993, 1554 clinics were established bringing the total to about 2527 clinics. This represents a growth rate of 25% in 1992 and 46% in 1993 and 1994.

- The FY 1994 HCFA appropriation for research, demonstration, and evaluation activities included $7.25 million over the budget request with $5 million of this increase intended for rural telemedicine grants. Five awards were made in July 1994.

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- **Budget cuts will cost the typical rural hospital $5 million over seven years**, according to the American Hospital Association. To put that figure in context, the typical rural community hospital has total expenses of less than $15 million every year.

- **Cuts Medicaid for rural Americans by $45 billion, denying coverage to as many as 2.2 million rural Americans, including over one million children.**

- **As many as 77,000 rural older and disabled Americans could be denied nursing home coverage.**

- **As many as 55,000 rural and disabled Americans could be denied home care benefits.**

American Hospital Association Analysis of the Effect of the Senate Finance Medicare Proposal on Typical Hospitals

Loss of Medicare revenue for the typical hospital in each group, cumulative for 1996 - 2002:

Overall:	$17 million
Urban:	$25 million
Rural:	$5 million
50 beds:	$3 million
150 beds:	$12 million
250+ beds:	$26 million
300+ beds:	$60 million
Teaching:	$45 million

Relayed by phone from C. Dyer; 10/6/95

THE WHITE HOUSE

WASHINGTON

October 11, 1995

RURAL HOSPITAL CONFERENCE CALL

DATE:	**October 12, 1995**
TIME:	**11:45 a.m. to 12:30 p.m.**
LOCATION:	**Roosevelt Room**
FROM:	**Marilyn Yager/Jennifer Klein**

I. PURPOSE

To highlight the impact of the Republican Medicare and Medicaid cuts on rural hospitals and their communities through a discussion with six rural hospital administrators.

II. BACKGROUND

Both the House and Senate Reconciliation bills cut $270 billion from Medicare and at least $182 billion from Medicaid.

Our analysis of these cuts indicates that:

- Medicare spending in rural areas will be cut by $58 billion over seven years -- a 20% cut in 2002 alone. The Medicare cuts will force 9.6 million people on Medicare in rural America to pay higher premiums and deductibles.

- Medicaid spending in rural areas will be cut by $45 billion over seven years. As many as 2.2 million rural Americans will be denied Medicaid coverage, including over one million children.

According to the American Hospital Association, the typical rural hospital will lose $5 million in Medicare funding alone over seven years.

III. PARTICIPANTS

Secretary Donna Shalala

Rural hospital administrators (listed in speaking order)

1. Don Sipes, CEO, St. Lukes Northland Hospital, Smithville, MO
2. H.D. Cannington, Administrator, Jay Hospital, Jay, FL
3. John Kelly, Administrator, Soldiers and Sailors Memorial Hospital, Penn Yan, NY
4. Margo Arnold, CEO, West Side District Hospital, Taft, CA
5. Peter Hofstetter, CEO, Northwestern Medical Center, St. Albans, VT
6. Todd Linden, President/CEO, Grinnell Regional Medical Center, Grinnell, IA

Background information on each hospital administrator and the focus of their remarks is attached.

IV. SEQUENCE OF EVENTS

- You will open the conference call with a brief statement.
- You will ask Secretary Shalala to make brief statement.
- You will call on each of the Administrators to make brief comments. Each participants is prepared (in under 2 minutes) to highlight the particular impact of the proposed Republican Medicare and Medicaid cuts to their hospital and community.
- You will have the opportunity to ask follow-up questions and make additional comments.

V. MEDIA

Open press with regional satellites and audio to each locality. Each hospital has arranged for local media to join them for additional events and discussion following the conference call.

VI. REMARKS

Talking points are attached.

Background on Hospital Administrators
(Listed in Speaking Order Along with Topic)

1. **Don Sipes, CEO, St. Luke's Northland Hospital, Smithville, MO**

BACKGROUND: In addition to Don Sipe's position as CEO of Northland Hospital, he serves as rural advisor to the St. Luke's Health System in Missouri. St. Luke's Northland Hospital is a two-campus health care facility north of Kansas City, MO. In an effort to survive, these two hospitals integrated their services this past year, with one campus providing acute medical-surgical care and the comprehensive outpatient services and the other campus providing long term care, rehabilitation, mental health, and home health services.

Seventy percent of Northland Hospital's patients are Medicare and Medicaid beneficiaries. As the largest employer in Smithville, a community with a population of 2,500, the hospital's 125 employees provide a critical economic anchor.

FOCUS OF COMMENTS: **Overview of importance of Medicare and Medicaid to rural hospitals.** Don will highlight the fact that, since most rural hospitals in Missouri have approximately 60 to 80 percent Medicare patient mix, surviving in today's costly and aggressive health care marketplace is already difficult. Their Medicare admissions continue to rise every year. With several Missouri rural hospitals closing in the past several years, Northland Hospital is surviving only because they were able to integrate two facilities while they were still able to raise the capital to do so. He is also concerned about the effects of managed care on the elderly, most of whom do not yet have access to managed care in rural areas even if they wanted to choose managed care.

2. **H.D. ("HD") Cannington, Administrator, Jay Hospital, Jay, FL**

BACKGROUND: In 1979, Jay Hospital faced financial disaster and the inability to keep their physician staff. The community asked Baptist Health System to help them stay open and during the intervening years the hospital has taken many of the steps other rural hospitals have had to take to keep health services available to their small community: they added long term care services, home health, and provide a mobile clinic to deliver the essential primary and preventive care services needed by their community.

FOCUS OF COMMENTS: Impact on local community if hospital is forced to close. With a Medicare/Medicaid patient mix of 73 percent, "HD" Cannington believes his 55 bed hospital would close under the current Congressional proposals. "HD" believes the GOP cuts would be devastating for Jay Hospital (110 employees) and an economic disaster for the town of Jay (population 600). Losing the hospital, its physicians, and in turn the primary care and emergency services they provide would result in sicker people seeking care at greater distances. Ultimately, Medicare and Medicaid would pay more for the care the beneficiaries finally receive.

3. **John Kelly, Administrator, Soldiers and Sailors Memorial Hospital, Penn Yan, NY**

BACKGROUND: The Soldiers and Sailors Memorial Hospital is rural, non-profit hospital in the finger lakes region of New York. The Hospital has 217 beds, which include acute care, long-term care, and psychiatric care. They operate numerous rural health clinics throughout the county. Their Medicare/Medicaid patient mix is 75 percent.

FOCUS OF COMMENTS: Importance of Medicaid and the impact of these cuts -- especially Medicaid cuts -- on vulnerable rural populations. Jon Kelly's comments will site several specific ways the devastating Medicare and Medicaid cuts will hurt their rural community. Because Penn Yan is one of the poorest counties in the state, he will also comment on Medicaid and its critical role meeting the healthcare needs of rural Americans.

4. **Margo Arnold, CEO, West Side District Hospital, Taft, CA**

BACKGROUND: West Side District Hospital employs 160 people in a town of 5,900 people. As a high Medicare/Medicaid hospital (78 percent) they have struggled in recent years to make ends meet on providing acute care, and they have switched many beds into skilled nursing care to help cover their costs. The community is largely dependent on the oil industry and is long past the boom times of the 1970s.

FOCUS OF COMMENTS: Rural hospitals and long-term care for the elderly. Margo believes that the proposed Medicare and Medicaid cuts would close her facility, and with the next closest hospital an hour away, she believes lives would be lost. This 84 bed hospital recently converted 63 of their beds to long term care to help underwrite the acute care services of the facility. However, the Republican proposals would have a double effect on a their facility because the cuts are deep in both acute care and skilled nursing care.

5. **Peter Hofstetter, CEO, Northwestern Medical Center, St. Albans, VT**

BACKGROUND: Northwestern Medical Center is a 70 bed community hospital with a 58 percent Medicare/Medicaid patient mix. The hospital serves an immediate community of 7,300 people but, as the only hospital in Franklin and Grand Isle County, it serves a larger patient population of approximately 40,000 people. In the state of Vermont, they rank 14th highest out of 15 hospitals for bad debt write offs. Serving some of the lowest income areas of the state, Northwestern has sought innovative ways to expand access and primary care into every little hamlet up to the Canadian border. They have often benefited from the National Health Service Corps program, but these young physicians often leave after the term of their service.

FOCUS OF COMMENTS: Difficulties of attracting and retaining hospital personnel. Peter plans to focus his comments on how the Medicare/Medicaid GOP cuts will further exacerbate their struggle to attract and retain physicians. To expand primary care access in the Northern Vermont, Northwest Medical Center has been setting up clinics in five small towns to be staffed by nurse practitioners and physician assistants, with hospital staff physicians spending several days a week in these rural clinics. They believe that by improving people's access to primary care, lives as well as dollars are saved. However, they already cut corners to find the money to attract and pay physicians and nurse practitioners for their facility and further Medicare and Medicaid cuts are likely to close down their rural clinics altogether.

6. **Todd Linden, President/CEO, Grinnell Regional Medical Center, Grinnell, IA**

BACKGROUND: Grinnell Regional Medical Center is an 81 bed hospital in a town of 8,900 people. Todd Linden was recently sited by Modern Healthcare magazine as one of the nation's "Up and Comers" in the hospital industry and is widely known for his advocacy on behalf of rural hospitals. He currently serves as Chair of the Iowa Telemedicine Advisory Council and is actively seeking ways to help rural hospitals become more efficient with fewer resources.

FOCUS OF COMMENTS: Rural hospitals as "total community health provider." Grinnell Regional Medical Center is very dependent on Medicare (over 50 percent) as are many hospitals in Iowa. Todd will comment on their efforts over the past decade to become more efficient, eliminate waste, and develop better use of their space (very few hospitals fit the 1980s stereotype of hospitals with empty beds) by expanding into home health care, hospice, skilled nursing swing beds. Therefore, further cuts in Medicare leave them very few options other than eliminating services that are needed in their community. Because they are the "total health provider" in their community, they will be hit by large Medicare cuts in many different practice areas (home health, skilled nursing care, acute care, etc).

PRESIDENT WILLIAM J. CLINTON
TALKING POINTS FOR CONFERENCE CALL
WITH RURAL HOSPITAL ADMINISTRATORS

THE ROOSEVELT ROOM, THE WHITE HOUSE
OCTOBER 12, 1995

- I'm glad that you all are joining me today on this conference call to discuss the importance of continuing our investment in health care in rural America.

- As you know, we are involved in a serious national debate about how to balance the federal budget.

- I want to balance the budget, and I have a proposal to do it. I have said for a long time that we need to balance the budget to lift the burden of debt off of our children and to strengthen our economy.

- But we need to do it in a way that reflects the values that we have always held dear in this country. Values like giving every American the opportunity to make the most of his or her own life, strengthening our families, and respecting the duty we all owe to each other. This budget debate is not just about programs and dollars; it's about providing for our children's futures and honoring our parents.

- My balanced budget plan reflects America's values. It secures the Medicare Trust Fund, while strengthening -- not gutting -- our Medicare program. It calls for reasonable, moderate reforms in Medicaid, while keeping our guarantee to children and older and disabled Americans. It addresses the budget deficit, while responding to the education deficit by continuing our national commitment to education and training. And it targets a tax cut to middle class, working families.

- In my judgment, the budget that the Republicans in Congress have offered violates those values. It will decimate the Medicare and Medicaid programs -- by taking twice the level of Medicare cuts I have proposed and more than three times the level of Medicaid cuts. It will force American families to choose between educating their children and making sure their parents have the health care they need.

- These cuts will be particularly devastating to rural communities and families because Medicare and Medicaid are the backbone of the health care system in rural areas.

    - As you well know, hospitals in rural areas struggle every day to make ends meet and are already closing at more rapid rates than hospitals in cities. And you depend more on Medicare and Medicaid payments than urban hospitals.

- When you look at the situation out there and the level of these cuts, it's easy to see what the Republican budget will mean for health care in rural America. Imagine what it will mean for your local hospital -- that is there not only for families in emergencies, but also for families with a child who needs to be immunized, or a mother or father who needs long-term care.

- I grew up in a community where we depended on the local community hospital for just about everything, and I can only imagine what drastic cuts like these would have meant for that hospital. And I can only imagine what it would have meant for my town if that hospital had been forced to close.

- I'd like to call on Secretary Shalala to say a few words.

- I would now like to hear from you about your hospitals and what the budget cuts will mean to your hospitals and communities.

1. Don Sipes, CEO, St. Luke's Northland Hospital, Smithville, MO
   Topic: Overview on importance of Medicare and Medicaid to rural hospitals

2. H.D. Cannington, Administrator, Jay Hospital, Jay, FL
   Topic: Impact on community if hospital closed

3. John Kelly, Administrator, Soldiers and Sailors Memorial Hospital, Penn Yan, NY
   Topic: Importance of Medicaid and impact of Medicaid cuts

4. Margo Arnold, CEO, West Side District Hospital, Taft, CA
   Topic: Rural hospitals and long-term care for the elderly

5. Peter Hofstetter, CEO, Northwestern Medical Center, St. Albans, VT
   Topic: How cuts will exacerbate struggle to attract and retain physicians

6. Todd Linden, President/CEO, Grinnell Regional Medical Center, Grinnell, IA
   Topic: Rural hospitals as "total providers" (i.e., providers of all types of health care)

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- **The number of rural hospitals in America dropped 17%** between 1983 and 1993, while the number of urban hospitals dropped 2%.

- **One in four rural hospitals operate at a loss:** *Twenty five percent* of rural hospitals had a negative total operating margin in 1992.

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- **As many as 55,000 rural and disabled Americans could be denied home care benefits.**

BUDGET CUTS TARGET RURAL HEALTH CARE AND HOSPITALS

October 12, 1995

RURAL HOSPITALS ARE ALREADY IN A PRECARIOUS FINANCIAL POSITION:

- **The number of rural hospitals dropped 17%** between 1983 and 1993, while the number of urban hospitals dropped 2%.
- **25% of rural hospitals operate at a loss.**
- **Rural hospitals lose money on Medicare patients;** urban hospitals make a small profit.

RURAL HOSPITALS DEPEND ON MEDICARE AND MEDICAID:

- **Medicare alone accounts for almost 40% of the average rural hospital's net patient revenue.** For some rural hospitals, Medicare accounts for as much as 80%.
- **About 60% of the people discharged from rural hospitals are Medicare or Medicaid beneficiaries** -- 25% higher than the share for urban hospitals.
- **Rural Americans depend more on Medicaid and Medicare because their incomes are 33% lower than the average urban American.** And a 60% higher share of elderly live in poverty in rural areas than in urban areas.

THE REPUBLICAN BUDGET TARGETS RURAL AMERICANS' HEALTH CARE AND RURAL HOSPITALS:

- **Cuts Medicare for rural Americans by $58 billion -- a 20% cut** in 2002 -- just to pay for a huge tax cut for the wealthy.
- **Cuts will cost the typical rural hospital $5 million** over seven years. This is a huge hit since the typical rural hospital has annual expenses of less than $15 million.
- **Higher out-of-pocket costs and a second class Medicare program for the 9.6 million older and disabled Medicare recipients in rural areas.**
- **Cuts Medicaid for rural Americans by $45 billion, denying coverage for as many as 2.2 million rural Americans**, including:
  - Over 1 million children
  - 230,000 older Americans
  - 350,000 people with disabilities
- **77,000 rural older and disabled Americans could be denied nursing home coverage.**
- **55,000 rural older and disabled Americans could be denied home care benefits.**
- **Cuts will force rural families to choose between nursing home coverage for their parents and education for their children.**

THE WHITE HOUSE

WASHINGTON

October 12, 1995

MEMORANDUM FOR THE BUDGET WORKING GROUP

FROM: JASON GOLDBERG

SUBJECT: Rural Impact Documents

Attached are two documents for your use and circulation:

- Talking points and background on the impact of the Republican cuts on Rural America
- Talking points and background on the impact of the Republican cuts on rural health care and hospitals.

Please contact me if your office needs more copies of the comprehensive rural state-by-state book (456-7256).

cc: Erskine Bowles
Gene Sperling

THE REPUBLICAN BUDGET TARGETS RURAL AMERICA AND HITS IT HARD

October 11, 1995

THE REPUBLICAN BUDGET TARGETS RURAL MEDICARE BENEFICIARIES AND HOSPITALS:

- **Cuts Medicare for rural Americans by $58 billion -- a 20% cut** in 2002 -- just to pay for a huge tax cut for the wealthy:
- **Higher out-of-pocket costs and a second class Medicare** program for the 9.6 million older and disabled Americans in rural areas.
- **Many rural hospitals will be forced to close** -- sometimes the only hospital for miles, leaving rural Americans with nowhere to turn for the health care they need.

THE REPUBLICAN BUDGET TARGETS RURAL MEDICAID:

- **Eliminates coverage for as many as 2.2 million rural Americans including:**
  - Over 1 million children
  - 230,000 older Americans
  - 350,000 people with disabilities
- **77,000 rural older and disabled Americans could be denied nursing home coverage.**
- **55,000 rural older and disabled Americans could be denied home care benefits.**
- **Cuts will force rural families to choose between nursing home coverage for their parents and education for their children.**

THE REPUBLICAN BUDGET TARGETS FARMERS:

- **25% bite out of farm programs** -- jeopardizing the rural way of life in America.
- **Cuts come right out of the pockets of farmers** -- net farm income for target price crops and soybeans is expected to decline by $9 billion over seven years.

THE REPUBLICAN BUDGET RAISES TAXES ON RURAL WORKING FAMILIES:

- **Raises taxes on 4 million rural working families by an average of $352.**

THE REPUBLICAN BUDGET TARGETS RURAL EDUCATION:

- **Cuts will deny 113,000 rural children basic and advanced skills education** -- at a time when many small-town and rural schools are already having trouble making ends meet.

IMPACT OF REPUBLICAN BUDGET CUTS ON RURAL AMERICA

October 11, 1995

HEALTH CARE IN RURAL AMERICA

The Republican MEDICARE Cuts Will Force 9.6 Million Older And Disabled Americans In Rural America To Pay Higher Premiums and Higher Deductibles For A Weakened Second Class Medicare Program.

Medicare Spending For People In Rural Areas Of America Will Be Cut By $58 billion Over Seven Years -- A 20% Percent Cut In 2002 Alone.

- **The Republican Cuts Will Increase The Severe Financial Pressure On Rural Hospitals In America And Force Some Rural Hospitals To Close.** Today, rural hospitals lose money on Medicare patients while urban hospitals make a small profit. Medicare accounts for almost 40% of net patient revenue in the average rural hospital, and as much as 80% in some rural hospitals.

- **According to the American Hospital Association, under the Republican cuts, the typical rural hospital will lose $5 million in Medicare funding over seven years.**

- **Rural Medicare Recipients Would Lose Much-Needed Doctors.** America's rural Medicare recipients would need 5,084 more primary care physicians to have the same doctor to population ratio as the nation as a whole. Yet the American Medical Association has stated that the cuts in Medicare are so severe that they "will unquestionably cause some physicians to leave Medicare." [*New York Times*, October 10, 1995.]

The Republican MEDICAID Cuts Will Further Hurt Rural Hospitals And Eliminate Coverage For Millions Of Rural Americans.

- **Rural Hospitals Will Suffer Additional Revenue Losses From The $45 Billion Republican Medicaid Cuts.** In addition to the average of $5 million rural hospitals will lose from Medicare cuts, rural hospitals will also face revenue shortages due to the severe Republican Medicaid cut.

- **As Many As 2.2 Million Rural Americans Will Be Denied Medicaid Coverage, Including:**

    - 1 Million Children
    - 230,000 Older Americans
    - 350,000 People With Disabilities

- **Over 77,000 Rural Older And Disabled Persons In America Could Be Denied Nursing Home Coverage** in 2002. Most of the 350,000 people living in nursing homes in rural America are covered by Medicaid. Under the Republican Medicaid plan, approximately 77,000 rural nursing home residents (22%) could be denied coverage.

- **Over 55,000 Rural Older And Disabled Persons In America Could Be Denied Home Care Benefits** in 2002. Most of the 365,600 poor elderly in rural America who need home care are covered by Medicaid. Under the Republican Medicaid plan, approximately 55,000 (17%) rural poor elderly who need home care will lose coverage.

FARMING IN RURAL AMERICA

The Republican Budget Slashes Farm Spending By 25% over seven years. Farm spending in America will be reduced by $13 billion -- drastically reducing support for commodity programs.

The Republican Budget Will Reduce Farm Income Nationwide. As a result of the Republican cuts, net farm income for target price crops and soybeans is expected to decline by $9 billion over seven years -- a 4% reduction in earnings.

TAXES ON WORKING FAMILIES IN RURAL AMERICA

The Republican Budget Raises Taxes On 4 Million Working Families In Rural America By An Average Of $352 in 2002. Republican cuts to the Earned Income Tax Credit will impose a $59.2 million tax increase on working families and their children in rural America.

EDUCATION IN RURAL AMERICA

The Republican Education Cuts Will Deny 113,000 Children Basic And Advanced Skills In Rural America in 1996. Title I funds in rural areas will be cut by $113 million -- more than 17% -- denying crucial assistance at a time when many small-town and rural schools are already having trouble making ends meet.

PUBLIC HEALTH AND THE ENVIRONMENT IN RURAL AMERICA

The Republican Budget Will Reduce The Amount Of Money That States Can Spend To Keep Water Clean In Small Communities And Rural Areas By 20% Compared To The President's Balanced Budget. These cuts will derail initiatives that are working to fight water pollution and protect public health.

The Republican Budget Proposal Will Stop Or Slow The Clean-up Of At Least 115 Toxic Waste Sites In Rural America. Nationwide, the Republican Budget reduces spending on toxic waste cleanups by 36% -- or $560 million -- below the President's balanced budget. These cuts will restrict or stop clean-ups of sites nationwide that pose a threat to public health and the environment.

TRANSPORTATION IN RURAL AMERICA

The Republican Budget Will Cut Transportation Grants For Rural Areas By 20%. Republican proposals cut $57.4 million for rural transportation in America. These funds are essential for giving residents access to medical services, supermarkets and grocery stores, and job training.

NUTRITION IN RURAL AMERICA

Republican Cuts Will Slash Up To 15% From Food Assistance To Rural America. Republican budget cuts will fall particularly hard on the rural poor, cutting as much as $11 billion in food assistance from rural areas over seven years.

Republican Nutrition Cuts Will Eliminate Jobs In America. These cuts will reduce farm prices and incomes, and result in the loss of as many as 328,900 jobs nationwide -- including up to 57,800 rural jobs.

HOUSING IN RURAL AMERICA

The Republican Housing Cuts Will Reduce Spending On Public Housing Capital In Rural America 46% Below The President's Request in 1996. Cuts to public housing capital assistance in rural areas will total $460 million in 1996, severely hindering efforts by rural housing agencies to rehabilitate run down public housing projects and provide much needed security and anti-crime programs.

The Republican Budget Will Cut 40% From Assistance To Homeless Persons in Rural Areas in 1996. The Republican plan will cut $108 million in homeless assistance to rural areas. The reduction will mean 4.9 million fewer nights of shelter for America's rural homeless.

BUDGET CUTS TARGET RURAL HEALTH CARE AND HOSPITALS

October 12, 1995

RURAL HOSPITALS ARE ALREADY IN A PRECARIOUS FINANCIAL POSITION:

- **The number of rural hospitals dropped 17%** between 1983 and 1993, while the number of urban hospitals dropped 2%.
- **25% of rural hospitals operate at a loss.**
- **Rural hospitals lose money on Medicare patients;** urban hospitals make a small profit.

RURAL HOSPITALS DEPEND ON MEDICARE AND MEDICAID:

- **Medicare alone accounts for almost 40% of the average rural hospital's net patient revenue.** For some rural hospitals, Medicare accounts for as much as 80%.
- **About 60% of the people discharged from rural hospitals are Medicare or Medicaid beneficiaries** -- 25% higher than the share for urban hospitals.
- **Rural Americans depend more on Medicaid and Medicare because their incomes are 33% lower than the average urban American.** And a 60% higher share of elderly live in poverty in rural areas than in urban areas.

THE REPUBLICAN BUDGET TARGETS RURAL AMERICANS' HEALTH CARE AND RURAL HOSPITALS

- **Cuts Medicare for rural Americans by $58 billion -- a 20% cut** in 2002 -- just to pay for a huge tax cut for the wealthy.
- **Cuts will cost the typical rural hospital $5 million** over seven years. This is a huge hit since the typical rural hospital has annual expenses of less than $15 million.
- **Higher out-of-pocket costs and a second class Medicare program for the 9.6 million older and disabled Medicare recipients in rural areas.**
- **Cuts Medicaid for rural Americans by $45 billion, denying coverage for as many as 2.2 million rural Americans**, including:
  - Over 1 million children
  - 230,000 older Americans
  - 350,000 people with disabilities
- **77,000 rural older and disabled Americans could be denied nursing home coverage.**
- **55,000 rural older and disabled Americans could be denied home care benefits.**
- **Cuts will force rural families to choose between nursing home coverage for their parents and education for their children**

FACTS ON THE IMPACT OF BUDGET CUTS ON RURAL RESIDENTS AND RURAL HOSPITALS

Rural residents and hospitals are uniquely vulnerable to cuts in Medicare and Medicaid. Both are disproportionately dependant on these programs and both typically face significant financial pressures. The Republican budget cuts, as a result, will threaten coverage for many rural residents and pose a unique danger to the many rural hospitals operating on the edge of financial survival.

I. IMPACT OF REPUBLICAN CUTS ON RURAL HOSPITALS

RURAL HOSPITALS REMAIN IN A UNIQUELY PRECARIOUS FINANCIAL POSITION.

- **Rural Hospitals Have Been Closing At A Disproportionate Rate**: The number of rural hospitals in America fell by 17% between 1983 and 1993 (compared to a decrease of 1.9% for urban hospitals). [American Hospital Association, Hospital Statistics, 1994]

- **Rural Hospitals Face Uniquely Severe Financial Pressures**

  - **Higher cost per patient.** The low volume of patients means that many rural hospitals face higher costs per patient than large urban hospitals. [Rural Policy Research Institute (RUPRI), 1995]

  - **Lower Medicare payments.** Making matters worse is the fact that Medicare payments are roughly 20% less per beneficiary in rural areas than in urban ones. [RUPRI, 1995]

  - **Net loss on every beneficiary.** Higher costs and lower payments mean that rural hospitals lose roughly 2% on Medicare patients. Urban hospitals, in contrast, run a slight profit (.6% on Medicare patients). [Prospective Payment Assessment Commission (PPRC), 1995]

  - **Some states may have even larger losses.** According to the *Kansas City Star*, "it is not a question of whether Indiana hospitals will close. It is a question of when . . . . Indiana hospitals already lose about 12 to 14 cents of every dollar they spend on Medicare patients." [*Kansas City Star*, 7/30/95]

- **One out of four Rural Hospitals Operate At A Loss:** *Twenty-five percent* of rural hospitals had a negative total operating margin in 1993. [PPRC, 1995]

RURAL HOSPITALS WILL BE HIT UNUSUALLY HARD BECAUSE THEY SERVE A DISPROPORTIONATE NUMBER OF MEDICARE BENEFICIARIES.

- **The Vast Majority Of Rural Patients Are Medicare Or Medicaid Beneficiaries.** About 60% of the discharges in rural hospitals are Medicare or Medicaid beneficiaries -- 25% higher than the proportion in urban hospitals. [American Hospital Association, Annual Survey of Hospitals, 1993]

- **Medicare Alone Accounts For Almost 40% Of Net Patient Revenue In The Average Rural Hospital.** [Frenzen, 1995] In some rural areas, Medicare represents as much as 80% of revenues.

  - **Rural Indiana:** "On average, Indiana hospitals get about 40 percent to 45 percent of their income from Medicare.... [A]t smaller hospitals in rural Indiana, however, Medicare and...Medicaid can account for 60 to 80 cents of every dollar they collect." [*The Indianapolis Star*, 10/8/95, citing Bob Morr, Vice President of the Indiana Hospital Association]

  - **Rural Minnesota**: Swift County-Benson Hospital, out in the prairie of Benson, Minnesota, gets an overwhelming 85% of its revenue from Medicare and Medicaid. [*Star Tribune*, 10/2/95]

  - **Rural Nebraska:** In a recent article, the *New York Times* profiled a rural hospital in Nebraska -- the Saunders County Health Services -- which "ministers to a population that is largely elderly and exceedingly dependant on Medicare." The *Times* reports that the elderly actually account for 80% of the hospital's revenue. The precarious financial straits of the hospital are typical of many rural centers. Saunders "lost money last year, hopes to break even this year and has been struggling since the mid-1980s." Its manager worries that the new spending controls on Medicare would have a significant impact on his 30-bed hospital. As the Times notes, "the Medicare policies being created in Washington instill anxiety and frustration. " [*New York Times*, 5/21/95]

GIVEN THEIR PRECARIOUS FINANCIAL SITUATION AND THEIR SIGNIFICANT RELIANCE ON MEDICARE AND MEDICAID, PROPOSED BUDGET CUTS WILL LIKELY FORCE THE CLOSING OF MANY RURAL HOSPITALS ACROSS THE NATION.

- **Budget Cuts Will Cost The Typical Rural Hospital $5 Million Over Seven Years**, according to the American Hospital Association. [American Hospital Association, 10/6/95]. To put that figure in context, the typical rural community hospital has total expenses of less than $15 million every year. [American Hospital Association, Annual Survey of Hospitals, 1993]

  - **Example: Nebraska**: The Nebraska Association of Hospitals and Health Systems released a study on September 8, 1995, reporting that the Republican cuts will cost a small rural Nebraska hospital (less than 49 beds) $3.3 million, a mid-size hospital (49-100 beds) $11 million, and a typical larger size rural hospital (100-200 beds) $33 million. [Press Release, 9/8/95]

  - **Cuts ask Hospitals to Provide 19 Months of Free Care**: "The proposed $270 billion reduction in Medicare spending is asking hospitals to provide 19 months of free care to Medicare recipients over the next seven years. . . . Clearly, it's a lose-lose situation, not only for hospitals, but for the public who depend on these hospitals," says Harlan Heald, President of The Nebraska Association of Hospitals and Health System [Press Release, 9/8/95]

- **Recent Press Reports Warn Of Hospital Closings Under Republican Budget Cuts.**

  - The *Kansas City Star* reports: "If Congress cuts Medicare spending by $270 billion, rural health care will be one of its biggest victims, hospital operators, researchers and others predict. Such reductions will force the closing of some rural hospitals, curb such basic services as emergency rooms and community health clinics, and worsen an already serious shortage of doctors and other health care workers." [*Kansas City Star*, 7/30/95]

  - The *Wall Street Journal* reports: "hospitals are closing anyway at a rate of 50 or so each year. But that number could double, or even triple due to stepped-up financial pressures from the government and private payers, analysts say." [*Wall Street Journal*, 10/2/95]

  - The *Billings Gazette*: "In rural areas, the percentage of Medicare [patients] is probably higher so the effect would be more pronounced. Overall, it's going to be devastating." Jim Ahrens, President of the Montana Hospital Association [*Billings Gazette*, 5/29/95]

  - The Fort Lauderdale *Sun-Sentinel* reports that the budget cut "means higher health care premiums, higher deductibles, and more restrictive employer-provided health care plans . . . or an awful lot of rural medical facilities are going to go belly up and a lot of the nation's great teaching hospitals are going to become shells of their former excellence. It's probably both." [*Sun-Sentinel*, 10/3/95]

  - *Baton Rouge Advocate*: "We're facing an enormous crisis in rural hospitals if something is not done about these cuts in Medicare and Medicaid," warned Joe Soileau, chairman of the Louisiana Rural Hospital Coalition. [*Baton Rouge Advocate*, 9/23/95]

  - *Minneapolis Star Tribune*: "The small hospital out on the prairie in Benson, Minnesota has a message for the members of Congress who are trying to shake up the Medicare-Medicaid system: 'If some things don't happen to help us, our life as we know it today will be over in 12 to 18 months,' said John Stidt, Chief Executive Officer of Swift County-Benson Hospital. 'We will have to close our doors.'" [*Star Tribune*, 10/2/95]

  - *Arkansas Democrat-Gazette*: One hospital near Prescott, Arkansas, may soon close its doors. The hospital, according to an administrator, relied on Medicare and Medicaid for 72% of its payments. If it closes, "the nearest hospital will be in Hope, about 15 miles to the southwest." A spokesman for the Arkansas Hospital Association "said that rural hospitals suffer disproportionately because of their heavy reliance on Medicare and Medicaid payments." [*Arkansas Democrat-Gazette*, 7/19/95]

II. Impact Of Health Care Cuts On Rural Residents

MEDICARE CUTS IN RURAL AMERICA WILL AMOUNT TO $58 BILLION OVER SEVEN YEARS, A 20% CUT IN 2002. THESE CUTS WILL SEVERELY DISRUPT THE PROVISION OF MEDICAL SERVICES TO MANY RURAL RESIDENTS.

- **Approximately 9.6 Million Older And Disabled Residents In Rural America Depend On Medicare For Their Health Care.** [Department of Health and Human Services (HHS)]

- **Because Of The Migration Of Young To Urban Centers, A Higher Proportion of Rural Residents Are Older Than Urban Dwellers And Depend Heavily On Medicare.**

  - **Far higher enrollment rates.** The Medicare enrollment rate is 28% higher in rural than in urban areas (16.0% vs. 12.5%), making Medicare a critical source of revenue for the rural health care system. [Frenzen, 1995]

  - **Medicare is particularly vital in farming communities.** 22% of farm operators were 65 or older in 1990, compared to only 3% of the U.S. workforce as a whole. [Council of Economic Advisers]

  - **Example: Nebraska.** In Nebraska, "it is the rural health-care system that is most 'fragile,' as Dr. Mark Horton, the state director of health, put it. Eighteen percent of Nebraska's rural population is over 65; many of the hospitals in rural areas, and many of the primary care physicians there, are exceedingly reliant on the Medicare program." [*Sunday Gazette Mail*, 5/21/95]

- **Rural Communities Are Less Able To Bear The Burden Of Medicare Cuts**, since their residents have less income on average than urban residents and their economies depend more heavily on Medicare payments.

  - **Rural residents have lower incomes**: Rural residents had an average per capita income in 1993 of $16,028, compared to $23,843 for urban residents. [Bureau of Economic Analysis, Regional Economic Information System, 1993.] The incidence of poverty among the non-metropolitan elderly is approximately 60% higher than among metropolitan elderly (16.7% vs. 10.5%). Thus, an across the board increase in premiums will represent a far larger tax in percentage terms on the rural elderly than on the urban elderly. [HHS, RUPRI, 1995]

  - **Rural economies depend more heavily on Medicare payments than urban economies.** Medicare comprises a far greater percentage of total personal income in rural areas than urban areas -- 41% more. [RUPRI, 1995]

  - **"A Financial Shock" to rural America.** "Clearly, a uniform percentage cut in Medicare would give rural America a financial shock," said Glenn Nelson, a researcher for the Rural Policy Research Institute. [*Kansas City Star*, 7/30/95]

MEDICAID SPENDING WILL FALL BY $45 BILLION IN RURAL AMERICA, FORCING MANY TO LOSE CRITICAL HEALTH CARE COVERAGE FOR NEEDED SERVICES.

- **Spending Cuts Could Deny Medicaid Coverage To As Many As 2.2 Million Rural Americans**, according to the Department of Health and Human Services, including:
    - 1 Million Children
    - 230,000 Older Americans
    - 350,000 People With Disabilities

- **As Many As 77,000 Rural Older And Disabled Persons In America Could Be Denied Nursing Home Coverage** in 2002. Most of the 350,000 people living in nursing homes in rural America are covered by Medicaid. Under the Republican Medicaid plan, as many as 77,000 rural nursing home residents (22%) could be denied coverage. [HHS]

- **As Many As 55,000 Rural Older And Disabled Persons In America Could Be Denied Home Care Benefits** in 2002. About 333,000 poor elderly in rural America need home care. Under the Republican Medicaid plan, as many as 55,000 (17%) rural poor elderly who need home care will lose coverage. [HHS]

III. Rural Health Care And Access To Doctors

BECAUSE RURAL DOCTORS RELY DISPROPORTIONATELY ON MEDICARE AND MEDICAID, REPUBLICAN PROPOSALS WILL MEAN THE LOSS OF MUCH NEEDED DOCTORS.

- **Rural Medicare Recipients Could Have Less Choice of their Own Doctor Under Republican Medicare Plans:** Only 44% of physicians in rural areas are members of HMO or PPO plans, compared to 81% for physicians in urban areas. [American Medical Association, 1993].

- **Rural Physicians Rely More on Medicare and Medicaid Than Urban Physicians.**
    - Medicare and Medicaid accounts for 53% of the practice of non-metropolitan primary care physicians, but only 41% of the practice of physicians in large metropolitan areas. [Report of the Council on Medicaid Services, 1995].

- **Republican Budget Cuts Will Make Medical Practice in Rural Communities Less Desirable and Will Cause Medicare Recipients To Lose Needed Doctors.** America's rural Medicare recipients would need 5,084 more primary care physicians to have the same doctor to population ratio as the nation as a whole. [Mueller, 1995]. Yet the American Medical Association has stated that the cuts in Medicare are so severe that they "will unquestionably cause some physicians to leave Medicare." [*New York Times*, October 10, 1995.]

Is this figure - $15 million - comparable to the $5 million loss?

Profile of Rural Community Hospitals

	Mean
Beds set up & staffed	93
FTE employees	265
Total Expense (millions)	$14.7
Total Discharges	2133
Medicare Discharges (as a percent of total)	44.0%
Medicaid Discharges (as a percent of total)	15.8%

Figures are based on data from 2,525 U.S. rural community hospitals on AHA's 1993 Annual Survey of Hospitals

SENATE FINANCE COMMITTEE MEDICARE PROPOSAL
PROJECTION OF LOST MEDICARE REVENUE
FOR TYPICAL HOSPITALS

Reflects seven-year cumulative losses (1996-2002) per hospital

HOSPITAL TYPE	ESTIMATED MEDICARE REVENUE LOSS PER HOSPITAL (7-YR CUMULATIVE LOSS 1996-2002)
Typical Hospital	$17 million
Typical Urban Hospital	$25 million
Typical Rural Hospital	$5 million
Typical 50-Bed Hospital	$3 million
Typical 150-Bed Hospital	$12 million
Typical 250-Bed Hospital	$26 million
Typical 450 Bed Hospital	$60 million
Typical Teaching Hospital	$45 million

Source: American Hospital Association 10/6/95

PRESIDENT WILLIAM J. CLINTON
TALKING POINTS FOR CONFERENCE CALL
WITH RURAL HOSPITAL ADMINISTRATORS

THE ROOSEVELT ROOM, THE WHITE HOUSE
OCTOBER 12, 1995

- I'm glad that you all are joining me today on this conference call to discuss the importance of continuing our investment in health care in rural America.

- As you know, we are involved in a serious national debate about how to balance the federal budget.

- I want to balance the budget, and I have a proposal to do it. I have said for a long time that we need to balance the budget to lift the burden of debt off of our children and to strengthen our economy.

- But we need to do it in a way that reflects the values that we have always held dear in this country. Values like giving every American the opportunity to make the most of his or her own life, strengthening our families, and respecting the duty we all owe to each other. This budget debate is not just about programs and dollars; it's about providing for our children's futures and honoring our parents.

- My balanced budget plan reflects America's values. It secures the Medicare Trust Fund, while strengthening -- not gutting -- our Medicare program. It calls for reasonable, moderate reforms in Medicaid, while keeping our guarantee to children and older and disabled Americans. It addresses the budget deficit, while responding to the education deficit by continuing our national commitment to education and training. And it targets a tax cut to middle class, working families.

- In my judgment, the budget that the Republicans in Congress have offered violates those values. It will decimate the Medicare and Medicaid programs -- by taking twice the level of Medicare cuts I have proposed and more than three times the level of Medicaid cuts. It will force American families to choose between educating their children and making sure their parents have the health care they need.

- These cuts will be particularly devastating to rural communities and families because Medicare and Medicaid are the backbone of the health care system in rural areas.

    - As you well know, hospitals in rural areas struggle every day to make ends meet and are already closing at more rapid rates than hospitals in cities. And you depend more on Medicare and Medicaid payments than urban hospitals.

- When you look at the situation out there and the level of these cuts, it's easy to see what the Republican budget will mean for health care in rural America. Imagine what it will mean for your local hospital -- that is there not only for families in emergencies, but also for families with a child who needs to be immunized, or a mother or father who needs long-term care.

- I grew up in a community where we depended on the local community hospital for just about everything, and I can only imagine what drastic cuts like these would have meant for that hospital. And I can only imagine what it would have meant for my town if that hospital had been forced to close.

- I'd like to call on Secretary Shalala to say a few words.

- I would now like to hear from you about your hospitals and what the budget cuts will mean to your hospitals and communities.

1. Don Sipes, CEO, St. Luke's Northland Hospital, Smithville, MO
   Topic: Overview on importance of Medicare and Medicaid to rural hospitals

2. H.D. Cannington, Administrator, Jay Hospital, Jay, FL
   Topic: Impact on community if hospital closed

3. John Kelly, Administrator, Soldiers and Sailors Memorial Hospital, Penn Yan, NY
   Topic: Importance of Medicaid and impact of Medicaid cuts

4. Margo Arnold, CEO, West Side District Hospital, Taft, CA
   Topic: Rural hospitals and long-term care for the elderly

5. Peter Hofstetter, CEO, Northwestern Medical Center, St. Albans, VT
   Topic: How cuts will exacerbate struggle to attract and retain physicians

6. Todd Linden, President/CEO, Grinnell Regional Medical Center, Grinnell, IA
   Topic: Rural hospitals as "total providers" (i.e., providers of all types of health care)

HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

October, 1995

Contact: HHS Press Office
(202) 690-6343

Rural Hospitals and Medicare and Medicaid

Medicare

- There are approximately 2,500 hospitals in the U.S. that are located in rural communities.
- An estimated 24 percent of rural hospitals had a negative operating margin in 1992.
- Medicare accounted for an average of 36 percent of rural hospitals' annual revenue in 1993. For many rural hospitals, Medicare accounts for 50 percent or more of annual revenue.
  - Significant reductions in Medicare revenues could cause many distressed rural hospitals to close or to turn to local taxpayers to increase already substantial local subsidies.
- The rural health infrastructure is fragile and highly sensitive to even small changes in payment policies.
  - Because of their low patient volume, many rural hospitals have very high per-case costs.
  - Many rural hospitals have disproportionately high bad debts and an eroding privately insured patient population.
  - Rural hospitals have limited ability to downsize because of the need to maintain staffing and services to meet accreditation and clinical standards.
- The market penetration of health maintenance organizations (HMOs) in private insurance and in Medicare is lower in rural areas.

Medicaid

- Medicaid accounted for an average of about 20 percent of rural hospitals' annual revenue in 1992, representing a fiscal safety net for these communities.
- Rural communities often have a disproportionate concentration of elderly, disabled, and low-income families.

Effect of Proposed Medicare and Medicaid Cuts on Rural Hospitals

Medicare

- Republican-proposed reductions in Medicare payment would have a major impact on rural hospitals. There are about 2500 rural hospitals in the US.
  - Given the precarious financial position of many rural hospitals (24 percent of whom had negative total operating margins in 1992), reductions in Medicare payments would have major impacts.
  - Significant reductions in Medicare revenues could cause many distressed rural hospitals to close or to turn to local taxpayers to raise what are already substantial local subsidies.
- Health care spending in general, and Medicare expenditures in particular, represent a large proportion of income in rural economies.
  - For rural hospitals, Medicare inpatient payments account for approximately 33 percent of revenue.
  - While Medicare payments to small rural hospitals (under 100 beds) represent only 6 percent of all Medicare PPS payments, they represent 50 percent or more of revenue for many rural hospitals.
- In most cases, the rural health infrastructure is fragile and highly sensitive to even small changes in payment and other policies.
  - Many rural hospitals face significant financial problems resulting from low volume and correspondingly high per case costs, high bad debt, and an eroding privately insured population to which higher costs can be shifted.
  - Although many rural hospitals have chronically low patient volume due to their limited population base, they have limited ability to downsize because of the need to maintain staffing and services to meet accreditation and clinical standards.
- There are significant obstacles in many rural areas to the success of market-based approaches to Medicare reform:
  - Limited provider supply and chronic health care capacity problems are likely to inhibit the development of multiple, competitive health plans in many areas.

- The market penetration of both Medicare HMOs and commercial HMOs is lower in rural than in urban areas.

Medicaid

- Medicaid is a safety net for many rural hospitals.
- Contrary to public opinion, Medicaid recipients are not concentrated only in inner cities. Rural elderly, disabled, and low-income families also rely on Medicaid.
- Republicans have proposed to end Medicaid and replace it with block grants to states.
  - Block grants will not keep pace with expected growth in the need for state medical assistance spending.
  - States will be under pressure to lower provider payment rates.
  - Block grants reduce Federal requirements and allow greater state flexibility in determining who qualifies for Medicaid, what services they receive from providers, and how much providers are paid for those services.

Summary

- Given the importance of Medicare and Medicaid funding to rural hospitals, and the general limitations in rural service delivery networks, the Republican proposals to cut Medicare and Medicaid create major fiscal problems that may very well result in reduced service or access.

PROJECTION FOR MEDICARE REVENUES 1996-2002 UNDER THE SENATE FINANCE RECONCILIATION PROPOSAL (in thousands of dollars)

HOSPITAL	FISCAL YEAR	CURRENT LAW REVENUES (IN $1000s)	PROPOSED PAYMENT CUTS (IN $1000s)	ESTIMATED REVENUE DECREASE (IN $1000s)
St. Luke's Northland, Smithville Mo	FY2002	5,559	4,694	-865
	Total 1996-2002	31,778	26,552	-7,000
Jay Hospital, Jay, FL	FY2002	3,347	2,872	-475
	Total 1996-2002	20,208	18,477	-1,731
Soldiers and Sailors Memorial, Penn Yan, NY **	FY2002	No Data	No Data	No Data
	Total 1996-2002	41,300	--	-8,000
West Side District Hospital, Taft, CA	FY2002	1,728	1,464	-265
	Total 1996-2002	9,976	8,996	-980
Northwest-ern Med. Center, St. Albans, VT	FY2002	9,321	7,921	-1,400
	Total 1996-2002	54,584	49,282	-5,302
Grinnell Regional Medical Center	FY2002	No Data	No Data	No Data

Data by AHA. **NY Data by HANYS

DRAFT

RURAL RESIDENTS & HEALTH CARE SYSTEMS

GENERAL FACTS:

Population

- Elderly are a higher and growing proportion of rural residents because of the general aging of the population and the outmigration of young people to urban areas for employment. (RUPRI, 1995)

- Job growth in rural areas is projected to be half that of urban areas. (RUPRI, 1995) This emphasizes the important of health care jobs to rural areas.

- Rural residents are, on average, poorer than urban residents. (RUPRI, 1995) Avg. per capita income, 1993:

Rural:	$16,046
Urban:	$23,843

- Rural residents rely more on transfer payments than do urban residents. (RUPRI, 1995) This means that they rely more on the government and will feel a greater impact of the reduction in government spending.

- Medicaid is particularly important since rural workers are less likely to get health insurance through their employers. (Frenzen, 1995) Percent of workers receiving health insurance on the job:

Rural workers:	50%
Urban workers:	55%

This difference reflects the higher levels of employment in small firms in rural areas, which are not as likely to offer coverage due to the higher administrative costs and worse negotiating positions. Small firms in rural areas also are more likely to face higher premiums due to the prevalence of hazardous or season jobs.

Health Care Systems:

Hospitals:

- In 1992, there were approximately 2,285 rural hospitals (44% of total), relative to about 3.000 urban hospitals. (Office of Rural Health Policy, 1995)

- Rural hospitals are closing at a greater rate than urban hospitals (Office of Rural Health Policy, 1995):

		1992		
Rural hospital closures: 1980-92:	367	2881	1995 –	2906 → understated urban
Urban hospital closures: 1980-92:	479	2518		2893 rural

particularly higher in 1980s

Take Culp 301-443-6894

- Rural hospital admissions are declining at a rapid rate; between 1982 and 1992, the change in admissions was (Office of Rural Health Policy, 1995):

Rural hospitals:	40% decline
Urban hospitals:	7.8% decline
US:	14.6% decline.

- Over half of discharges in rural hospitals are Medicare or Medicaid beneficiaries relative to less than half of urban hospitals' discharges. (Office of Rural Health Policy, 1995) Percent of discharges paid by:

	Medicare	Medicaid	Combined
Rural	44 %	15 %	59.5% of discharges
Urban	36 %	12 %	47.7% of discharges

October 10; 8:00am

AHA Hospital Statistics 1993-1994

8.8% Total

1988-92 ↓ 1.1% urban comm. hosp.

plunged ↓ 17.2% rural " "

1991-92

urban ↑ 2.9%

rural ↓ 5.6%

Physicians:

- Provider shortages are persistent in rural areas. (Mueller, 1995)

  5,085 more primary care physicians would need to be added to rural areas to achieve the standard physician-to-population ratio of 1 to 3,500.

  The reductions in funding for provider education could exacerbate the problem.

- Significantly fewer physicians in rural areas have contracts with managed care organizations. (AMA, 1993) Percent of physicians with contracts with:

	HMO	PPO
Rural:	7%	37%
Large Urban:	22%	59%

MEDICARE:

Beneficiaries:

- Coverage is proportionally higher in rural areas (Frenzen, 1995):

  Rural beneficiaries as a percent of rural residents: 16.0%
  Urban beneficiaries as a percent of urban residents: 12.5%

- Rural Medicare beneficiaries have lower income on average than urban beneficiaries, meaning that they will be disproportionately affected by premium and deductible increases:

  Rural average income (1992): $19,517
  Urban average income (1992): $24,300

  [NOTE: We'll try to get these updated for at lease 1993]

- Payments per rural resident are less than Medicare payments per urban resident:

  Medicare payments per rural beneficiary: $3,191
  Medicare payments per urban beneficiary: $3,937
  Percent difference: rural is nearly 20% lower (RUPRI, 1995)

  Since Medicare pays nearly 20% less per beneficiary in rural areas, there is little room for additional efficiencies -- the cuts will mean fewer services or reduced access.

- Part of the reason for the lower payments per beneficiary results from the concentration of specialists in urban areas.

  Although about 25% of beneficiaries reside in rural areas, only 20% of Medicare payments go to rural areas. (Frenzen, 1995)

- Rural economies rely more on Medicare revenue. (RUPRI, 1995) Ratio of Medicare payments to total personal income:

  Rural: 3.31
  Urban: 2.34
  Difference: rural is 41% higher than urban ratio

Hospitals:

- Rural hospitals rely more on Medicare than do urban hospitals:

Medicare accounts for almost 40% of net revenue in rural hospitals.

Average percent of net patient revenue from Medicare for nonmetropolitan community hospitals (1993) (Frenzen, 1995):

Non-metropolitan hospitals:	38.8%
Metropolitan hospitals:	33.5%

- In rural hospitals, Medicare beneficiaries are a much higher proportion of discharges. (Office of Rural Health Policy, 1995)

Rural hospital Medicare discharges as percent of total:	44.4%
Urban hospital Medicare discharges as percent of total:	35.7%

Physicians:

- Rural physicians rely more on Medicare than do urban physicians:

Average percent of practice revenue from Medicare for primary care physicians (1994) (Report of the Council on Medicaid Services, 1995):

Non-metropolitan practices:	36.9%
Large metropolitan area practices:	31.6%

MEDICAID:

Beneficiaries:

- Medicaid covers relatively more rural residents, mostly because of higher poverty rates in rural areas (Frenzen, 1995):

Rural Medicaid beneficiaries:	12.0%
Urban Medicaid beneficiaries:	11.1%

Although the Medicaid beneficiaries as a percent of the general population is higher in rural areas, the percent of poor people covered by Medicaid in rural areas is actually lower in rural areas. The lower coverage of poor people in rural areas reflects the more restrictive eligibility standards in predominantly rural states.

- Medicaid coverage has been growing faster in rural areas than in urban areas. (see attached chart)

Hospitals:

- In rural hospitals, Medicaid beneficiaries are a much higher proportion of discharges. (Office of Rural Health Policy, 1995)

Rural hospital Medicaid discharges as percent of total:	15%
Urban hospital Medicaid discharges as percent of total:	12%

Physicians:

- Rural physicians rely more on Medicaid than do urban physicians:

Average percent of practice revenue from Medicaid for primary care physicians (1994) (Report of the Council on Medicaid Services, 1995):

Non-metropolitan practices:	16%
Large metropolitan area practices:	9%
All metropolitan practices:	10.5%

Additional data available:

- Number / percent of hospital discharges by state by rural / urban
- Number / percent of rural hospitals by state
- Number / percent or rural community health centers by state
- Number / percent of rural Medicare HMO enrollees by state
- Physician payment rates by state (not sure if we have rural urban)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH RESOURCES AND SERVICES ADMINISTRATION

FEDERAL OFFICE OF RURAL HEALTH POLICY

TO: Jennifer Kline

NO. OF PAGES 3
(including this page)

FAX: 202-456-7431

FROM: Jeff Human
OFFICE OF RURAL HEALTH POLICY
5600 FISHERS LANE, ROOM 9-05
ROCKVILLE, MD 20857

PHONE: (301)443-0835
FAX: (301)443-2803*

MESSAGE: Here are the talking points I mentioned in my voice mail message. Note particularly the third and forth ones. Regards.

Jen- These came here, so [redacted] I am sending them your way.

Sarah

Talking Points for the President April 18, 1995

Accomplishments in Rural Health

The Administration has empowered America's rural communities to reconfigure and rebuild their health care services in the last several years. We have developed a cooperative partnership with states, leveraged many new initiatives with federal dollars, and helped create the setting for networking and technical assistance across communities.

- In the Health Security Act, I proposed that all Americans, including all who live in rural areas, have access to health insurance that could never be taken away. In Title II of that Act, a number of initiatives would build medical care capability in rural areas, including tax incentives for physicians who move to rural areas that are now very much underserved. I remain committed to health reform that will work in rural areas.

- I also proposed to reform graduate medical education to produce more of the primary care physicians who are the backbone of rural medicine. Under my proposal, 55% of all residency positions would have gone to those training for careers in family medicine, general internal medicine, general pediatrics, and obstetrics/gynecology.

- During the past two years, Medicare reimbursement to rural hospitals has been increased to eliminate the urban/rural distinction that was once as high as 25%. Now the Medicare "standardized amount" payments to rural hospitals are equal to those of urban hospitals.

- We have also fostered the development of more rural health care clinics. Medicare-certified rural health clinics have proliferated during the past two years, increasing from fewer than 800 to more than 2,000. More than a third of the 2000 clinics are hospital based. These clinics use nurse practitioners, physician assistants and nurse midwives in support of physicians. As a result, Medicare provides cost-based reimbursement to help support the clinics. The increase in the number of clinics is a direct result of their promotion by the Department of Health and Human Services.

- Federal funding for programs that most help rural areas, such as community health centers, migrant health centers, and the National Health Service Corps, have been greatly increased during the past two years. These programs provide primary medical care to nearly 3 million rural Americans in some of the poorest communities in this country.

- With Federal encouragement and some matching funds, we have seen the number of rural health offices at the state level increase from 26 in 1992 to all fifty states today. These state offices are very active partners with their rural communities, their state, and with the federal government in designing new strategies to solve rural health problems.

Jen

RURAL HOSPITAL CONFERENCE CALL WITH THE PRESIDENT ON THURSDAY, OCTOBER 12 FROM 11:30 AM TO 12:30 PM. Eastern Standard Time:

Participants

1). Peter Hofstetter, President
Northwest Medical Center
St. Albans, VT
802/524-5911 or 524-1041
Fax:802/524-1238
Press contact: Jonathon Billings
802/524-1044
(media market: Plattsburgh,NY/Burlington,VT)

2). John Kelly, President
Soldiers and Sailors Memorial Hospital
Penn Yan, NY
315/536-4431 ext. 276 or 178 (H:315/536-7930)
Fax:315/536-0414
Press Contact: Harold Gray
315/536-4431, ext. 326
(media market: Rochester, NY)

3). Don Sipes, President/CEO
St. Lukes Northland Medical Center
Smithland, MO
816/532-7765 (Vickey Norton)
Fax:816/532-7136
Press contact: John Miller
816/532-7171 (pager 292-1567)
(Kansas City,MO media market)

4). Neal Whipkey, CEO
Glade Hospital
Bell Glade, FL
407/996-6081 or 7506
Press Contact: Curt Thompson
407/996-6571, Ext. 445
(Miami media market)

5). Margo Arnold, CEO
West Side District Hospital
Taft, CA
805/763-4211, ext. 227
Fax: 805/763-5641
Press Contact; Christine Beyer
805/763-4211, ext. 226
(Bakersfield media market)

6). Todd Linden, President
Grinnell Regional Medical Center
Grinnell, IA
515/236-2300
Fax: 515/236-4048
Press contact: Chris Nolte
515/236-8637
(Des Moines and Cedar Rapids media markets)

Jen

Profile of Rural Community Hospitals

	Mean
Beds set up & staffed	93
FTE employees	265
Total Expense (millions)	$14.7
Total Discharges	2133
Medicare Discharges (as a percent of total)	44.0%
Medicaid Discharges (as a percent of total)	15.8%

Figures are based on data from 2,525 U.S. rural community hospitals on AHA's 1999 Annual Survey of Hospitals

SENATE FINANCE COMMITTEE MEDICARE PROPOSAL
PROJECTION OF LOST MEDICARE REVENUE
FOR TYPICAL HOSPITALS

Reflects seven-year cumulative losses (1996-2002) per hospital

HOSPITAL TYPE	ESTIMATED MEDICARE REVENUE LOSS PER HOSPITAL (7-YR CUMULATIVE LOSS 1996-2002)
Typical Hospital	$17 million
Typical Urban Hospital	$25 million
Typical Rural Hospital	$5 million
Typical 50-Bed Hospital	$3 million
Typical 150-Bed Hospital	$12 million
Typical 250-Bed Hospital	$26 million
Typical 450 Bed Hospital	$60 million
Typical Teaching Hospital	$45 million

Source: American Hospital Association 10/6/95

SOLDIERS & SAILORS
MEMORIAL HOSPITAL

THE HOMESTEAD
DUNDEE MEDICAL CENTER
418 North Main Street
Penn Yan, New York 14527-1085
315 536 4431

SOLDIERS & SAILORS MEMORIAL HOSPITAL

FAX TRANSMITTAL SHEET

TO: Marilyn Yaeger

FROM: Sheila McMichael

DATE: 10/6/95

Number of Pages (including title sheet): ~~15~~ 14

If you did not successfully receive any of these pages, contact (315) 536-4431, Extension: 177.

Enclosed are materials from John Kelly as discussed.

October, 1995

SOLDIERS & SAILORS MEMORIAL HOSPITAL
418 North Main Street
Penn Yan, New York 14527
(315) 536-4431

Since 1924, Soldiers & Sailors, a rural, not-for-profit, community hospital, has served residents and visitors in Yates County. Located in the central Finger Lakes region, one hour south of Rochester, the Hospital has experienced significant expansion of services, facilities and staff during the 1990's. The enclosed brochure (1992) does not list several projects completed since its publication.

- 217 beds: 49 medical-surgical, 4 intensive care, 12 psychiatric, 152 long term care
- 39 patient services
- 37 medical staff members
- 550 full and part-time staff (401 Full Time Equivalent positions)
- $20.1 million FY 1995 Operating Budget

Recent Facilities

February 1994	$ 6 million addition to existing long term care facilities: 72 beds, including 30 for multiply impaired residents; adult day health care for 10 participants; 2 respite beds
Spring 1996	Completion of a $1.5 million outpatient mental health center to house existing clinic and continuing treatment day programs

The Finger Lakes Rural Residency In Family Medicine

This innovative program was established in 1994 to train physicians to work in underserved rural communities. Soldiers & Sailors is a primary training site for inpatient medical services for six residents in partnership with the Rushville Health Center, Rushville, New York.

S&S

SOLDIERS & SAILORS
MEMORIAL HOSPITAL

418 North Main Street
Penn Yan, New York 14527
315-536-4431

- THE HOMESTEAD
  ... Long Term Care
  536-4431
- DAISY MARQUIS JONES FAMILY HEALTH CENTER
  ... Outpatient Primary Care
  536-7409
- DUNDEE FAMILY HEALTH CENTER
  ... Outpatient Primary Care
  34 Millard Street
  Dundee, New York 14837
  607-243-7881
- OUTPATIENT MENTAL HEALTH CLINIC
  ...
  165 Main Street
  Penn Yan, New York 14527
  536-4461
- OUTPATIENT MENTAL HEALTH CONTINUING TREATMENT PROGRAM
  ...
  98 West Lake Road
  Penn Yan, New York 14527
  536-7417

"...Soldiers and Sailors is increasingly recognized as a rural hospital that is working toward continued growth, rather than simply hoping for it ... we are reshaping the Hospital for the 1990s and beyond to address a changing healthcare environment..."

John Kelly
S&S Administrator

An Introduction To Your Community Hospital ...

Since 1924, when Soldiers and Sailors opened, your community hospital has provided quality care to area residents and visitors to Yates County. Soldiers and Sailors was named to honor and memorialize individuals from our area who served in World War I, and the Hospital has proudly become one of our community's most important resources and its largest employer.

This publication is an introduction to our services, our staff and facilities and our plans for further expansion. Our commitment to providing accessible, affordable quality care involves our acceptance of a leadership role in identifying the healthcare needs of our region and working with local and regional agencies, and resource personnel, to address those needs.

Quality care requires excellence in staffing, equipment and facilities to support a diversity of hospital-based services and outreach programs. Soldiers and Sailors has, historically, attracted an outstanding medical staff, which is ably supported by highly qualified nursing, technical and support staffs.

Because we serve a rural area that has a population base of approximately 21,000, which is augmented by a sizeable number of summer residents, Soldiers and Sailors is cognizant of its role in providing services to those who have been underserved within the traditional healthcare system. The development of outpatient primary care services, located at the Hospital (Daisy Marquis Jones Family Health Center) and in nearby Dundee (Dundee Family Health Center), and the integration of inpatient and outpatient mental health services into our services program are examples of meeting such needs.

Community-based healthcare is an essential component of the quality of life available in our rural area. Soldiers and Sailors is appreciative for the strong support we have received throughout our decades of service to Yates County. The partnership between community and the Hospital has been an essential ingredient in our expansion of services, facilities and staffing.

Our directors, staff and I invite you to become better acquainted with Soldiers and Sailors, and we look forward to serving you.

John Kelly
Administrator

PATIENT SERVICES

Ambulatory Surgery
Anesthesiology
Audiology
Cardiology*
Clinical Laboratory
Coronary Care
Dentistry*
Diagnostic Imaging
- Angiography
- CT Scanning
- Echocardiography
- Fluoroscopy
- Interventional Radiology
- Mammography
- Ultrasound
- X-Ray

EKG
Emergency Medicine
Family Medicine
General Surgery
Gynecology
Inpatient Psychiatric Unit
Intensive Care Unit
Internal Medicine
Long Term Care
Neurosurgery*
Occupational Therapy
Ophthalmology
Orthopedic Surgery
Outpatient Mental Health
Pathology
Pharmacy
Physical Therapy
Podiatry
Respiratory Therapy
Social Work
Speech-Language Pathology
Sports Medicine
Urology*

*Consulting Basis

FACILITIES

Beds	
Acute Nursing	49
Intensive Care	4
Long-Term Care	80
Psychiatric	12

. The original facilities of Soldiers and Sailors opened in 1924. Since then, expansion occurred in the 1950s and 1960s. The Medical Arts Building was added in 1973, and The Homestead in 1984. A $4 million building project, completed in 1991, involved renovation of every patient service area in the Hospital, including construction of a new emergency medicine department, entrance-lobby and registration-admission area.

A new intensive care unit; laboratory-phlebotomy area; an expanded physical therapy department; inpatient psychiatric unit; new radiologic equipment, including a CT Scan unit, and patient waiting areas were included in the recent project.

The modern facilities of Soldiers and Sailors afford accessibility and adequate working space for professional, technical and support staff.

Located on the the northern edge of Penn Yan, a village of 6,000, Soldiers and Sailors serves area residents and a large number of seasonal residents who have vacation homes along Keuka, Seneca, Waneta and Lamoka lakes.

A $6 million expansion of the long-term care facility, The Homestead, will be completed in early 1994. 72 additional beds and an adult day healthcare area will be included in this new venture.

PROFESSIONAL STAFF
January, 1993

NURSING PERSONNEL: 175

Acute Medical-Surgical, Emergency Department, Operating Room, Nursing Administration, Intensive Care Unit

	Full Time	*Part Time*	*PRN/ Casual*	*Per Diem*	*Totals*
RN	32	11	1	16	60
Graduate Nurse	3	1			4
LPN	16	1		1	18
Graduate Practical Nurse		1			1
Nursing Assistant	2	4			6
OR Aide	1				1
	54	18	1	17	90

Long Term Care

	Full Time	*Part Time*	*Casual*	*Per Diem*	*Totals*
R.N.	4	4	1	3	12
L.P.N.	8	4	1		13
Nursing Assistant	18	14	1		43
Restorative Aide		1			1
	30	33	3	3	69

Inpatient Psychiatric Unit

	Full Time	*Part Time*	*Casual*	*Per Diem*	*Totals*
R.N.	4	4			8
Graduate Nurse					
L.P.N.	1	1			2
	5	5			10

Outpatient Mental Health & Outpatient Primary Care

	Full Time	*Part Time*	*Casual*	*Per Diem*	*Totals*
Pediatric Nurse Practitioner	1				1
R.N.	2	1			3
L.P.N.	2				2
	5	1			6

Number of Full-time Equivalent Positions: 303
Total Number of Employees: 388
1992 Salary Budget: $6,330,935
1992 Employee Benefits Budget: $1,315,443

MEDICAL STAFF: 28

Senior
Ted D. Barnett, M.D.
Michael J. Boquard, M.D.
J. Mark Costenbader, M.D.
William H. Dean, M.D.
Timothy J. Dennen, M.D.
Eleanor H. DeWitt, M.D.
Mary D. Driesch, M.D.
Steven Lasser, M.D.
Norman W. Lindenmuth, M.D.
Robert W. McLaughlin, M.D.
Karen E. Mead, M.D.
Stephen Payne, M.D.
James Sakr, M.D.
Paul A. Shapiro, M.D.
Charles L. Stackhouse, M.D.
William F. Ware, M.D.
William P. Welbourne, M.D.
Laurence Wildrick, M.D.

Associate
Frank O. Bonnarens, M.D.
Jan Kohl, M.D.
Stewart Lipson, M.D.

Emergency Medicine
Olusola Akindele, M.D.
Lauren E. Costello, M.D.
William Craig-Kuhn, M.D.
Frances Mifsud, M.D.
William Remington, M.D.
Ravi Singh, M.D.
John K. Sullivan, M.D.

During the past three years Soldiers and Sailors has:

- Completed a $4 million construction-renovation project
- Added a 12-bed psychiatric unit
- Assumed management of outpatient mental health services
- Opened the Daisy Marquis Jones Family Health Center
- Invested $1.3 million in radiology equipment, including a new CT Scan Unit
- Added services and a full-time physician at The Dundee Family Health Center
- Increased staffing to 388, 30% growth; S&S is the largest employer in Yates County
- Expanded surgical services
- Begun a $6 million expansion of The Homestead, involving 72 additional long term care beds, services for the multiply impaired, adult day healthcare and respite beds

LOCATION

Penn Yan, the county seat of Yates County, is located in the heart of the Finger Lakes region of central upstate New York. Situated at the northern end of Keuka Lake, Penn Yan, a village of 6,000, is approximately 50 miles southeast of Rochester. Within an hour's drive are Elmira, Ithaca, Corning, while Syracuse is 1 1/2 hours by car.

A rural area, Yates County is characterized by its natural resources and beauty, agricultural and tourism industries, wineries and small town environment. Its serene hills and lakes afford bountiful opportunities for recreational activities.

Extensive information regarding Yates County and the Finger Lakes region is available from:

The Finger Lakes Association
309 Lake Street
Penn Yan, New York 14527
(315) 536-7488

Penn Yan Area Chamber of Commerce
104 Lake Street
Penn Yan, New York 14527
(315) 536-3111

SOLDIERS AND SAILORS MEMORIAL HOSPITAL
PENN YAN, NY 14527

MEDICAID PROPORTION BY SERVICE
BUDGET 1995

LONG-TERM CARE	74%
PRIMARY CARE CLINICS	43%
MENTAL HEATLH	
Inpatient	43%
Clinic	16%
Continuing Treatment	43%
ACUTE INPATIENT	3%
OVERALL	**35%**

MEDICARE PROPORTION
BUDGET 1995

OVERALL	**30%**

John D. Kelly

Career Highlights

Chief Executive Officer, Soldiers & Sailors Memorial Hospital

- Developed high quality programs in Medical Care, Emergency Services, Long Term Care, Inpatient Psychiatry, Outpatient Psychiatry, Primary Care
- Completed 3 major building projects, totaling $13 million
  - Complete renovation of acute care hospital: 1990
  - New 80 bed long term care facility: 1984
  - New 72 bed long term care addition: 1994
- Quadrupled revenue base from $5.0 million to $20.0 million
- Increased Long Term Care capacity from 24 to 152 beds and Adult Day Health Care Program
- Developed Primary Care to provide access for entire community in one of poorest counties in New York State
- Developed first and only inpatient psychiatry unit in County
- Completed 12 years in reimbursement experiment, including global budget program for inpatient acute care. This program was rural equivalent to Rochester, New York experiment
- Participated in several grant projects funded by National Institute of Health, Health Care Financing Administration, New York State Department of Health
- One of only, if not only, hospitals in area not to have been in enforcement action by New York State Department of Health
- Developed one of first long term care units for multiply-impaired
- Community activities included coordinating village inclusion in first coordinated watershed arrangement program in the Finger Lakes Region
- Doubled employment base for institution and community
- Connected institution to newly formed Rural Residency in family medicine of the University of Rochester

- Active in Multi-institutional planning and other activities of 4 county hospital consortium

- All achievements occurred in one of the most difficult hospital environments in the United States; a federally designated rural hospital in the most regulated state. During the same period 4 similarly sized or larger hospitals in same area closed or converted operations.

JOHN D. KELLY

Home Address:
447A East Lake Road
Penn Yan, New York 14527
(315) 536-7930

Business Address:
Soldiers & Sailors Memorial Hospital
418 North Main Street
Penn Yan, New York 14527
(315) 536-4431

WORK EXPERIENCE:

PRESIDENT, SOLDIERS & SAILORS MEMORIAL HOSPITAL OF YATES COUNTY, PENN YAN, NEW YORK, 1994-Present.

CHIEF EXECUTIVE OFFICER, 1982-1994

Developed and manage $20 million rural health organization which includes acute care hospital, long term care facility, satellite ambulatory care facility, hospital-based primary care practice, in and out patient mental health services, foundation and active role in development of Family Medicine educational consortium within a unique hospital multi-institutional environment which includes reimbursement demonstration with Global Budget, joint planning activities and shared service development. Successful in improving financial position of facility including break even performance over 11 year period despite constraints of New York health care environment and Federal reimbursement penalties.

Area activities have included: serving for 3 years as chairman of the administrators' committee of FLAHC, a six member hospital consortium which developed and administered the only rural health reimbursement demonstration in the Nation and joint planning and development of an allocated CT service; membership on statewide HANYS Health Services Committee; membership on the Board of Rochester Regional Hospital Association; membership on group of community leaders to deal with common administrative problems and broad community issues; membership on Human Resources Committee of Yates County Planning Board; membership on School Board Task Force to analyze area business perspective on educational needs; membership in Keuka Lake Watershed Task Force to develop inter-community approach to watershed protection.

John D. Kelly

ASSISTANT ADMINISTRATOR, CHENANGO MEMORIAL HOSPITAL AND ADMINISTRATOR, SKILLED NURSING FACILITY, CHENANGO MEMORIAL HOSPITAL, NORWICH, NEW YORK, 1977-1982

Managed Professional Services Division as Assistant Administrator, for acute hospital, with active Out Patient Department. Managed Skilled Nursing Facility. General staff responsibilities for hospital included Certificate of Need projects, creation of a satellite laboratory for another hospital, renovation and expansion of Skilled Nursing Facility.

FINANCIAL MANAGER, CAPTAIN, UNITED STATES AIR FORCE, WRIGHT-PATTERSON AIR FORCE BASE, OHIO, 1972-1975

Managed $82 Million Research, Development and Production funds for acquisition of air transportable 4,500 man Air Force Base, including Modular Air Transportable Hospital.

BASE BUDGET OFFICER, LIEUTENANT, UNITED STATES AIR FORCE, JOHNSTON ATOLL AIR FORCE BASE, THE PACIFIC, 1971-1972

Managed $7.8 million operating and maintenance budget for Atomic Energy Commission. Pacific Nuclear Testing Site. Facilities included a 2 physician remote site hospital.

EDUCATION:

CORNELL UNIVERSITY, GRADUATE SCHOOL OF BUSINESS AND PUBLIC ADMINISTRATION, SLOAN PROGRAM IN HOSPITAL AND HEALTH SERVICES ADMINISTRATION, ITHACA, NEW YORK, 1975-1977

Masters Degree (M.P.S.-H.H.S.A.). Courses included Managerial and Cost Accounting, Hospital Financial Management, Planning Analysis, Hospital Operations Management, Hospital Corporate Planning, Hospital Labor Relations and Personnel Administration.

John D. Kelly

ST. ELIZABETH MEDICAL CENTER, DAYTON, OHIO, SUMMER 1976

Administrative residency in 552 bed acute care hospital, affiliated with medical school through Family Practice residency program.

WRIGHT STATE UNIVERSITY, DAYTON, OHIO, 1972-1974

Part-time graduate and undergraduate courses in Calculus, Demography, Population Analysis and Economics.

GROVE CITY COLLEGE, GROVE CITY, PENNSYLVANIA, 1966-1970

Arts Baccalaureate Degree in English Literature.

LICENSES: Nursing Home Administrator, New York State.

October 6, 1995

To: Marilyn Yaeger

From: John Kelly

Listed below are the names and address of my children:

Ewen McDowell Kelly

Zachary DeVilliers Miner

447A East Lake Road
Penn Yan NY 14527