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HEARING TO REVIEW THE STATE OF HEALTH CARE IN RURAL AREAS AND THE ROLE OF FEDERAL PROGRAMS IN ADDRESSING RURAL HEALTH CARE NEEDS

HEARING

BEFORE THE

SUBCOMMITTEE ON SPECIALTY CROPS, RURAL DEVELOPMENT AND FOREIGN AGRICULTURE

OF THE

COMMITTEE ON AGRICULTURE
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

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CONTENTS

	Page
Goodlatte, Hon. Bob, a Representative in Congress from Virginia, opening statement	30
Hayes, Hon. Robin, a Representative in Congress from North Carolina, opening statement	3
McIntyre, Hon. Mike, a Representative in Congress from North Carolina, opening statement	1
Peterson, Hon. Collin C., a Representative in Congress from Minnesota, prepared statement	4
Pomeroy, Hon. Earl, a Representative in Congress from North Dakota, prepared statement	5

WITNESSES

Dorr, Hon. Thomas C., Under Secretary for Rural Development, U.S. Department of Agriculture, Washington, D.C.	9
Prepared statement	10
Morris, Tom, Acting Associate Administrator, Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services, Washington, D.C.	12
Prepared statement	13
Spade, Jeff, Executive Director, North Carolina Rural Health Center; Vice President, North Carolina Hospital Association, Cary, NC	30
Prepared statement	32
Fluharty, Charles W., Founder, President Emeritus, and Director of Policy Programs and Research Professor, Rural Policy Research Institute, Harry S Truman School of Public Affairs, University of Missouri-Columbia, Columbia, MO	38
Prepared statement	39
Myers, M.D., Wayne, Trustee, Maine Health Access Foundation; Past President, National Rural Health Association, Washington, D.C.	93
Prepared statement	94
Rheuban, Dr. Karen, Pediatric Cardiologist, Senior Associate Dean for Continuing Medical Education and Medical Director, Office of Telemedicine, University of Virginia Health System; President-elect, American Telemedicine Association; Member of the Board of Directors, Center for Telemedicine and E-health Law; President, Virginia Telehealth Network, Charlottesville, VA	98
Prepared statement	100

SUBMITTED MATERIAL

Submitted questions	113

HEARING TO REVIEW THE STATE OF HEALTH CARE IN RURAL AREAS AND THE ROLE OF FEDERAL PROGRAMS IN ADDRESSING RURAL HEALTH CARE NEEDS

WEDNESDAY, JULY 23, 2008

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON SPECIALTY CROPS, RURAL DEVELOPMENT AND FOREIGN AGRICULTURE,
COMMITTEE ON AGRICULTURE,
Washington, D.C.

The Subcommittee met, pursuant to call, at 2:30 p.m., in Room 1300, Longworth House Office Building, Hon. Mike McIntyre [Chairman of the Subcommittee] presiding.

Members present: Representatives McIntyre, Cuellar, Salazar, Barrow, Pomeroy, Costa, Smith, Hayes, and Goodlatte (*ex officio*).

Staff present: Aleta Botts, Claiborn Crain, Alejandra Gonzalez-Arias, Tony Jackson, Tyler Jameson, Scott Kuschmider, John Riley, Patricia Barr, Josh Maxwell, and Jamie Weyer.

OPENING STATEMENT OF HON. MIKE McINTYRE, A REPRESENTATIVE IN CONGRESS FROM NORTH CAROLINA

The CHAIRMAN. I will now call this meeting of the Subcommittee on Specialty Crops, Rural Development and Foreign Agriculture of the House Agriculture Committee to order.

Good afternoon, and welcome to the Subcommittee's hearing to review the state of health care in rural areas and the role of Federal programs in addressing rural health care needs. I am pleased to welcome Mr. Thomas Dorr, the Under Secretary for Rural Development; and Mr. Tom Morris, Acting Associate Administrator of the Office of Rural Health Policy for the U.S. Department of Health and Human Services.

Gentlemen, welcome. I look forward to your testimony in just a moment.

As the former Co-Chairman of the Rural Health Care Coalition, a coalition of approximately 178 Members of Congress, both Republican and Democratic, I have long been concerned about whether folks in rural areas have adequate access to quality health care. I continue to serve on the steering committee of the Rural Health Care Coalition, and its organization, I believe, has been one of the most active caucuses, especially on a bipartisan basis, in the United States Congress.

If rural areas are not able to provide health care to their residents, then we have two possible scenarios. First, those rural resi-

dents suffer from inadequate care, or second, those rural residents no longer are rural, they leave and go elsewhere. For those of us who care deeply about the vitality of rural America, neither of these scenarios is acceptable.

Several programs operate at the Federal level to provide assistance to rural health care facilities and their provision of services to rural residents. I know that my home State of North Carolina has directly benefited from the operations of these programs, receiving over $20 million in the past 7 years for rural health care facilities through grants and loans from the USDA Community Facilities Program alone. So we are very grateful for that and the cooperative efforts.

And, again, I commend our State Director, John Cooper, who has done such a wonderful job, a fine Christian gentleman that always knows how to reach out and care for people. I commend him as an example nationwide, Mr. Dorr.

Despite the numerous programs designed to help, we know that gaps remain. The transportation, geographic, and staffing challenges are all too well known by Members of this Committee, and those who live in rural areas. The rural population as a whole tends to be older, tends to be folks of lower incomes, and tends often to have greater health problems than their counterparts in urban and suburban areas.

In fact, nearly ¼ of the U.S. population lives in rural areas, but only about ten percent of physicians live in these areas. That disparity alone says volumes: 25 percent of our population in rural areas, but only ten percent of our physicians.

Another glaring statistic: One-third of all motor vehicle accidents occur in rural areas, but ⅔ of deaths from motor accidents occur on rural roads. While the National Center for Health Statistics recently reported that, nationwide, life expectancy reached a record high of 78.1 years in 2006, an April 2008 study in the *Public Library of Science* journal noted that life expectancy actually is falling for a significant number of American women, mostly living in rural counties in the Deep South, along the Mississippi River, and in the Appalachian Mountain region.

We clearly have more to do on the issue of rural health care. With the limited dollars available for rural health care programs, we have to ensure they are used in ways that do address the challenges. After all, rural citizens are just as much American taxpaying citizens as citizens who live in the big city; and we have to make sure that they are not discriminated against.

We have to make sure there is sufficient coordination to reach America's citizens who may happen to live in the more rural areas. We want to make sure that we are maximizing those efforts, that we are making sure that we are getting the full bang for the buck; and make sure that as we look at these areas that tend to have older populations and tend to have those with greater disparities in terms of types of deaths and other illnesses, that we are not overlooking American citizens, American taxpayers, who also need the attention of the United States Government.

I want to thank all of you for being here today. I encourage the witnesses to use the stated 5 minutes for their testimony. If you can read your testimony in 5 minutes that is fine, but otherwise,

please do not read your testimony if you can't finish it in 5 minutes. Just read the highlights; or better yet, tell us the highlights.

Pursuant to Committee rules, testimony by witnesses, along with questions and answers by any Members of our Subcommittee, will be stopped at 5 minutes. We will, however, gladly accept your written testimony, no matter how long it is, for the record. And that will be a public record, so please do not hesitate to give us all the information you would like in that fashion.

At this time, I would like to recognize the man who is serving *in lieu of* our regular Ranking Member, Mrs. Musgrave, but couldn't be here, our next in order Ranking Member, my fine friend, a great Christian gentleman himself, a great colleague and, in fact, my neighbor who is from the neighboring Congressional district to mine in North Carolina, Mr. Robin Hayes.

Robin?

OPENING STATEMENT OF HON. ROBIN HAYES, A REPRESENTATIVE IN CONGRESS FROM NORTH CAROLINA

Mr. HAYES. Thank you, Mr. Chairman. And you are a great friend. And interestingly, our districts really mirror each other; you could kind of overlay them. We have urban areas on the east and west, but tremendous rural areas in between.

So this is a very relevant hearing. And I may even have to pay your alma mater, who are those folks in Chapel Hill, Carolina Area Health Education Program?

I have to be careful giving him too many compliments on his———

The CHAIRMAN. This is a Duke man.

All right. Go ahead. Thank you.

Mr. HAYES. West Virginia now. All right.

Thank you, Mr. Chairman, for holding today's hearing so we can gain a better understanding of the health care needs of rural America.

Rural Americans face unique challenges in getting quality health care services, most notably the physical and financial strain, particularly given the energy crisis, of traveling long distances. Often the lack of timely access to these services leads to delay, misdiagnosis, preventable diseases, and other issues, some of which you mentioned, like the accident issue in rural areas.

The USDA's many rural development grant and loan programs help to sustain the quality of life in rural communities. These programs build and maintain various health and human services facilities, such as water and wastewater systems; modern telecommunications systems for towns and rural areas, including making certain that emergency and health care services have the latest broadband capability; and in financing essential facilities such as community rooms, libraries, hospitals.

Representing the Eighth District of North Carolina, which is a very rural district, USDA Rural Development and John Cooper have been a tremendous and innovative part of our efforts to improve life in the communities. John Cooper, the State Director and Director of USDA Rural Development in North Carolina, and his staff have served to greatly help increase the quality of health care, and increasing economic development in the Eighth and Seventh

Districts, but also across the state as well. The recently enacted farm bill made several improvements to these current programs.

Changes in the definition of *rural* will help to ensure dollars build hospitals and health care services will go to rural areas with the greatest need. Reauthorization of successful programs, such as distance learning and telemedicine, will continue to provide vital telecommunication infrastructure to health care and emergency services. Reforms to rural broadband programs will create incentives to increase access to affordable, high-speed Internet in rural and underserved areas.

Because of these programs, the knowledge and expertise found in our finest medical facilities are now accessible to physicians, health care professionals, and patients all over the world, but most notably in some of the rural areas of my district. Because of telemedicine services, many of our rural constituents now benefit from the latest in medical knowledge, technology and treatment, while remaining under the care of their hometown health care provider.

Folks living in rural areas should have access to quality health care. And I look forward to today's hearing and the testimony so that we will learn more about the health care needs of rural America; and give my welcome and thanks to our witnesses for being here.

Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Mr. Hayes.

The chair will allow other Members to submit opening statements.

[The prepared statements of Mr. Peterson and Mr. Pomeroy follow:]

PREPARED STATEMENT OF HON. COLLIN C. PETERSON, A REPRESENTATIVE IN CONGRESS FROM MINNESOTA

Thank you, Chairman McIntyre, for calling this hearing and for the leadership you and Ranking Member Musgrave have shown on highlighting the importance of health care delivery in rural areas.

Access to quality, affordable health care is of great concern to all Americans, no matter where they live. The obstacles that Americans can face in obtaining this care, however, are magnified in rural areas—areas that everyone on this Committee represents.

Logistics, distance, and under-investment are significant challenges rural areas face when it comes to health care. On average, rural residents are older and have fewer financial resources than urban and suburban residents. Health care delivery costs are higher in rural areas, and a low supply of medical professionals in the countryside has been a persistent problem.

Distance plays a big role, as well. The distance between home and the nearest health care provider can mean less preventative care, and it can put more strain on emergency personnel and medical facilities when time is critical.

This Committee is limited in what it can do to address rural health care delivery.

USDA operates several rural development programs, in the form of loans and grants, designed to assist less-populated areas in meeting these challenges. The Department of Health and Human Services also operates rural health programs, but unfortunately, the Administration has proposed severe cuts in funding for the kinds of programs that would invest in quality health care for rural America.

And an investment in these kinds of technologies can make a difference in closing the literal gap between a consumer and health care provider. High speed telecommunications and telemedicine, for example, are beginning to play a larger role in rural health care.

The Distance Learning and Telemedicine Program, first authorized in the 1995 Farm Bill, is a popular program that utilizes modern technology to provide additional access to specialists who are not available in many rural communities.

Under Secretary Dorr with USDA's Rural Development Mission is here before the Committee once again and I look forward to hearing not just on the operation within USDA, but the coordination with other agencies with rural health care programs in order to maximize the use of Federal resources in today's budget climate.

I also welcome our panel of witnesses that will provide a ground-level perspective to the problems facing rural medical services and rural health care delivery today.

Thank you again, Mr. McIntyre, for calling this hearing today. I yield back my time.

PREPARED STATEMENT OF HON. EARL POMEROY, A REPRESENTATIVE IN CONGRESS FROM NORTH DAKOTA

I want to thank Chairman Mike McIntyre and the Subcommittee on Specialty Crops, Rural Development and Foreign Agriculture for holding this important hearing today to review the state of health care in rural areas and the role of Federal programs in addressing rural health care needs. As Co-Chair of the Rural Health Care Coalition, I am deeply concerned about access to affordable, quality health care in rural America and this hearing is a good opportunity to get on record the unique rural challenges that folks in my district and across the face.

Rural health care providers and patients living in rural areas face obstacles vastly different that their urban counterparts. Rural health care delivery and access is challenged by numerous impediments including shortages of health care providers, geographic remoteness, low patient volume with disproportionately high Medicare populations, limited access to integrated health systems, and lack of electronic networks to efficiently manage health care delivery.

In fact, only about ten percent of physicians practice in rural America despite the fact that nearly ¼ of the population lives in these areas. Although only ⅓ of all motor vehicle accidents occur in rural areas, ⅔ of the deaths attributed to these accidents occur on rural roads. Rural residents tend to be poorer with average per capita income $7,417 lower than in urban areas. They also tend to have high death rates and poorer health than their urban counterparts.

In addition to these unique socioeconomic characteristics, patients living in rural areas face obstacles to access health care providers who struggle to stay afloat. Approximately 83 percent of North Dakota's counties are federally designated as entire or partial health professional shortage areas. We have two counties without either physicians or medical facilities and 15 counties are served by satellite clinics that are not open every day. Over the last 4 years, four rural ambulance units have stopped operations and since 2000, twenty-six rural pharmacies have closed. In December 2007, a study found that 55 facilities throughout the state were recruiting 185 vacancies including physicians, nurses, physician assistants, nurse practitioners, physical therapy and mental health.

As Co-Chair of the Rural Health Care Coalition, I have fought hard to ensure that our rural providers receive equitable reimbursements under Medicare to help them keep their doors open. As you know, Congress just enacted into law a $3 billion rural health package that maintains and expands our commitment to rural health in the Medicare Modernization Act (MMA). However, these funds are provided for Medicare services only. And as we all know, the majority of the folks living in rural America are not seniors and they need access to rural health care services as well.

That is why the Rural Health Care Coalition has fought hard to maintain the rural health care safety net via Federal funding including grant programs we are discussing today. I would like to submit for the record a letter submitted to the House Labor-Health and Human Services-Education Appropriations Subcommittee by the Rural Health Care Coalition in strong support of robust funding for these important programs in Fiscal Year 2009. Programs supported in this letter include the Rural Hospital Flexibility Program, Small Hospital Improvement Program, Rural Outreach Grants, State Offices of Rural Health and Telemedicine to name a few.

I was disappointed that the Administration's Fiscal Year 2009 budget recommended over $160 million in cuts to these rural safety net programs, which would cost North Dakota $3 million alone. These cuts in my opinion are penny wise—pound foolish. Despite assertions to the contrary, these funds are not duplicative of Medicare rural health care enhancements under the Medicare Modernization Act. MMA was never meant to replace the Health and Human Services rural health grant programs. MMA was about preserving access and helping providers keep their doors open to seniors, the HHS grant programs are meant to improve health care quality and develop innovative systems of care for all rural Americans, young and old. It is my hope that this Congress will avert the President's recommended cuts

and I look forward to working with the new Administration in placing a greater priority on preserving the rural health care safety net.

I look forward to hearing the testimony of my colleagues and distinguished experts to learn more about the roots of these rural health challenges and how the Federal Government can craft common sense policies that can help bring relief to these important populations. I am committed to doing my part to helping reduce disparities in health care and I look forward to working with the Agriculture Committee to advance this important cause.

ATTACHMENT

March 19, 2008

Hon. DAVID OBEY,
Chairman,
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies,
Committee on Appropriations,
U.S. House of Representatives,
Washington, D.C.;

Hon. JAMES WALSH,
Ranking Minority Member,
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies,
Committee on Appropriations,
U.S. House of Representatives,
Washington, D.C.

Dear Mr. Chairman Obey and Ranking Member Walsh:

As Members of the House Rural Health Care Coalition (RHCC) and on behalf of our constituents in rural America, we urge you to support rural health care programs by including funding for them in the FY09 Labor, Health and Human Services, and Education and Related Agencies Appropriations bill. Funding approved by the Committee is critical to the effective delivery of many health programs in rural and underserved communities across the country. We are greatly appreciative of your recommendations last year to restore the rural health care safety net to its 2005 levels, adjusted for inflation. Building on your efforts from last year, we once again ask you to support modest inflationary updates for important rural health care services and giving strong and favorable consideration to the following programs, which are of the highest priority to the RHCC:

Rural Hospital Flexibility Grants

FY 2009 RHCC Request	$39.2 million
FY 2008 Enacted Appropriation	$37.87 million

This funding line supports both the Medicare Rural Hospital Flexibility Grant program and the Small Hospital Improvement Grant program and we urge that the Subcommittee support a modest increase in funding for inflation. The Medicare Rural Hospital Flexibility (FLEX) Grant program is instrumental in guaranteeing access to basic inpatient and outpatient services to residents of rural communities. FLEX program funding can be used to determine if a facility would benefit from conversion to Critical Access Hospital (CAH) status under Medicare. While this funding has helped more than 1,200 facilities convert to CAH status, many of these facilities still have negative operating margins. That is why the FLEX program also supports quality improvement projects and the development of networks of hospitals and other providers such as tertiary care sites or emergency medical service providers to meet the full range of services for Medicare beneficiaries in rural areas.

Under the Small Hospital Improvement program, approximately 1,600 hospitals grants of approximately $9,000 are awarded to purchase computer hardware and software and train staff on computer information systems that are necessary to comply with Federal regulations. Unlike FLEX grants, this program is not solely tied to Critical Access Hospitals but rather to any rural hospital with 50 beds or less. These small grants greatly aid rural facilities in integrating quality improvement strategies and the ongoing implementation of the Prospective Payment System and HIPAA rules that further the need to obtain new technology. According to past reports to Congress, these funds meet critical needs for these small hospitals that would go unmet given their precarious financial situation and lack of operating funds needed to keep pace with constant software and hardware upgrades needed to operate in a complex environment.

Rural Health Outreach and Network Development Grant Program

FY 2009 RHCC Request	$53.9 million
FY 2008 Enacted Appropriation	$48 million

The Rural Health Outreach funding line supports innovative health care delivery systems as well as vertically integrated health care networks in rural areas. Projects funded under this funding line have brought care that would not otherwise have been available to at least two million rural citizens across the country. The grants fund demonstration programs and usually last no more than 3 years. The intent is to provide initial support for innovative ideas in rural communities and then to transition off Federal funding as the projects become self sufficient. Grant programs in this line include: Rural Health Outreach Services Grants, Rural Network Development Grants, Rural Network Planning Grants, and Delta Network Development Grants. Our appropriation request provides for a modest inflationary adjustment.

Office for the Advancement of Telehealth

FY 2009 RHCC Request	$7.1 million
FY 2008 Enacted Appropriation	$6.7 million

This grant program helps increase access to quality care services in underserved and rural communities through the use of advanced telecommunications and information technology. These grants support distance-provided clinical services, and are designed to reduce the isolation of rural providers, foster integrated delivery systems through network development, and test a range of telehealth applications. Given the many challenges facing health care providers and their patients in rural communities, improving the availability of telehealth services is a critical step forward for our rural constituents. We respectfully request that the Subcommittee provide $7.1 million in the FY09 Labor, HHS, and Education appropriations legislation for this important program.

State Offices of Rural Health Grant Program

FY 2009 RHCC Request	$9.2 million
FY 2008 Enacted Appropriation	$7.99 million

This program is a small matching grant program to states to promote the operation of state offices of rural health. Since the initiation of the program in 1991, the number of state offices has increased from 14 to 50. The concept behind the program is to create a state focus for rural health interests, bring technical assistance to rural communities, and help them tap state and national resources available for rural health and economic development. The RHCC requests that the Subcommittee provide adequate funding, including a modest inflationary adjustment, to support the State Offices of Rural Health Grants and enhance the effectiveness of the important programs they oversee.

Rural Health Research Grant Program

FY 2009 RHCC Request	$9.7 million
FY 2008 Enacted Appropriation	$8.5 million

This grant program supports eight academic-based rural health research centers, which study rural health issues, including rural hospitals, health professionals, delivery of mental health services, and functioning of managed care, in rural healthcare delivery systems. This research program is the only one in the Department of Health and Human Services (HHS) that soles examines the rural dimensions of traditional health services research. This research plays an essential role informing the Office of Rural Health Policy staff about key Medicare, Medicaid and workforce issues and their impact on the ability of rural providers to provide essential health care services to rural communities. As Congress continues to modify and reform Medicare, rural communities will rely on the research provided through these centers to adapt to Federal policy changes. The RHCC supports a modest inflationary adjustment to support this important rural health policy research.

National Health Service Corps (NHSC)

FY 2009 RHCC Request	$133.9 million
FY 2008 Enacted Appropriation	$123.5 million

The NHSC plays a critical role in maintaining the health care safety net by placing primary health care providers in our nation's most underserved rural communities. Currently, more than 4,000 NHSC clinicians are providing primary care services to four million Americans. Unfortunately, this represents only 8% of our nation's underserved population. We request this increase in funding to hire additional primary care practitioners, dental practitioners and mental health practitioners are needed to serve the 46 million Americans without adequate health care in their communities. Moreover, President Bush's commitment to expand the number of individuals served by community health centers will require additional health professionals to staff these facilities. We request that the Subcommittee provide $133.9 million for this program which plays a key role in providing clinicians to community health centers.

Area Health Education Centers

FY 2009 RHCC Request	$36.9 million
FY 2008 Enacted Appropriation	$28.18 million

Area Health Education Center funding provides direct financial support to schools for healthcare workforce development and education. AHECs link the resources of university health science centers with local planning, educational and clinical resources. This network of health-related institutions provides multidisciplinary educational services to students, faculty and local practitioners, ultimately improving health care delivery in medically underserved areas. This is an effective program as primary care graduates of this and other Title VII health professions programs are up to ten times more likely to serve minority and disadvantaged populations by practicing in medically underserved communities. We respectfully request your support for a modest inflationary adjustment for these important community resources.

Rural and Community Access to Emergency Devices

FY 2009 RHCC Request	$2.04 million
FY 2008 Enacted Appropriation	$1.46 million

Automated external defibrillators (AEDs) are small, easy-to-use devices that shock a heart back to normal rhythm during cardiac arrest, saving the life of the victim. Access to AEDs for police forces, fire departments, first responders, and community organizations in rural areas is critical to increasing the survival rates of cardiac arrest victims in remote locations. The Rural and Community Access to Emergency Devices program assists in purchasing emergency devices such as AEDs and in training first responders in their use and we urge the Subcommittee to support a modest inflationary adjustment.

The RHCC is grateful for your support in recognizing the need for providing a sound future for the delivery of rural health care. We hope you will continue to support the millions of Americans in rural and underserved areas by acknowledging and considering these funding priorities.

Sincerely,

Hon. EARL POMEROY, *Co-Chair,*
House Rural Health Care Coalition;

Hon. GREG WALDEN, *Co-Chair,*
House Rural Health Care Coalition.

The CHAIRMAN. We appreciate Mr. Salazar being here; and any of the other Members who may come in will be allowed to submit any opening statements for the record, so that we can proceed immediately now and let the witnesses begin their testimony.

Hopefully, we can get through the hearing before we are called to votes. We will ensure there is ample time for questions for each of our Members.

So panel one, we will begin with Mr. Tom Dorr, the Under Secretary, as I said earlier, for USDA Rural Development. And followed immediately by Mr. Tom Morris, the Acting Associate Administrator for the Office of Rural Health Policy.

Mr. Dorr, please begin.

STATEMENT OF HON. THOMAS C. DORR, UNDER SECRETARY FOR RURAL DEVELOPMENT, U.S. DEPARTMENT OF AGRICULTURE, WASHINGTON, D.C.

Mr. DORR. Thank you, Mr. Chairman.

Mr. Chairman, Mr. Hayes, I too must outwardly admit in a very grateful manner that John Cooper is one of our outstanding State Directors; and we are delighted to have him in our camp.

I would like to thank the Members of the Subcommittee for this opportunity to testify on rural health care. This is a high priority for the Administration, for USDA Rural Development and, obviously, for Members of this Subcommittee as well. And I do appreciate, we all do appreciate, the support that Congress continues to provide in this area.

Modern technology has created remarkable new opportunities to improve access to health care in rural communities. We look forward to working with each of you to ensure that these opportunities are realized. We work closely, as well, with our friends at the Department of Health and Human Services, the Indian Health Service, and the Veterans Administration to identify and meet the health care needs of rural communities.

For example, we have developed in conjunction with them a prototype of a rural Critical Access Hospital. This was done with the leadership of the Department of Housing and Urban Development, Department of Health and Human Services and, particularly, the leadership of the Health Resources Service Agency. This model is now available to rural communities as an efficient, cost-effective planning tool.

We are continuing to participate in a Rural Hospital Working Group with HRSA and others in an effort to create a how-to manual for rural communities undertaking the construction of replacement hospitals.

In the private sector, we have developed a close partnership with the National Rural Health Association and with large lenders such as the Farm Credit System, which can handle larger loans than many local banks are able, in many cases, to make. For our own part, we are working to break down the stovepipes and develop synergies across our own program areas.

Rural Development's health-related investments have traditionally been made by our Community Facilities and Distance Learning and Telemedicine Programs. Since 2001, however, we have also invested more than $200 million through the Business and Industry Guaranteed Loan Program, and smaller amounts through the Rural Business Enterprise Grant Program, the Rural Economic Development Loan and Grant Program, and the Renewable Energy and Energy Efficiency Program.

The point here is simply that we are prepared to respond flexibly and to apply all of our tools, as needed. We recognize that projects can be structured differently, approaches may vary, and we intend to work with communities to identify viable solutions.

Finally, we recognize that limited budgets may create a more competitive program environment in the future. The DLT, or the Distance Learning Telemedicine Program, is already competitively awarded. The Community Facilities Program has traditionally had an open loan window in which qualifying projects were funded first come, first served.

We are now examining our options as the market evolves and as it grows. And we look forward to a continuing discussion with the Subcommittee on these and a variety of other matters.

Thank you all very much for this opportunity to be with you, and I look forward to any questions you may have.

[The prepared statement of Mr. Dorr follows:]

PREPARED STATEMENT OF HON. THOMAS C. DORR, UNDER SECRETARY FOR RURAL DEVELOPMENT, U.S. DEPARTMENT OF AGRICULTURE, WASHINGTON, D.C.

Mr. Chairman, Members of the Subcommittee, thank you for this opportunity to discuss the role of USDA Rural Development in improving access to quality health care in rural America.

This is a high priority for the Administration and, I know, for the Members of this Subcommittee as well. We are appreciative of the support that the Congress continues to provide in this area.

At the Federal level, several agencies share responsibility for this effort. We work closely with our colleagues at the Department of Health and Human Services, The Department of Housing and Urban Development, the Indian Health Service, and the Department of Veterans Affairs to identify and meet the heath care needs of rural communities.

As an example of this inter-agency coordination, in cooperation with the Department of Housing and Urban Development and the Department of Health and Human Service's Health Resources and Services Administration (HRSA), we have developed a prototype of a rural Critical Access Hospital, which we have made available to rural communities to aid in the development of efficient, cost-effective hospitals.

We are continuing to participate in a Rural Hospital Working Group with HRSA and others in an effort to create a how-to manual for rural communities undertaking the construction of a replacement hospital.

In addition, in the private sector we have developed a close partnership with the National Rural Health Association (NRHA) and with larger lenders, such as the Farm Credit System, which can handle loans that many local banks are unable to make. We are committed to forming additional partnerships which will enable all parties to strengthen the services we provide to rural America.

While several Federal agencies collaborate to provide rural health care services, our perspectives may sometimes vary. The mission of USDA Rural Development is to increase economic opportunity and improve the quality of life in rural communities. From this perspective, investments in rural health care are a triple play.

First and foremost, we of course recognize the inherent importance of quality health care to rural residents.

In addition, major health care facilities—clinics, hospitals, and a wide variety of specialized care facilities—are intrinsically high-value assets to rural communities. They provide jobs, generate economic activity, support a wide range of ancillary services, and bring to town highly skilled professional people who are likely to make valuable contributions across the entire spectrum of civic life.

Finally, access to quality health care is clearly an important condition for many business and institutional site decisions. In this respect, quality health care is essentially an infrastructure issue like transportation, adequate electric capacity, water and wastewater treatment capacity, and broadband access. Communities that lack these attributes may be effectively redlined for many types of developmental opportunities. It is therefore an important part of our mission to help ensure that these gaps are filled.

In considering Rural Development's role in this area, it is important to note that we are community-driven. We administer over 40 programs which we are prepared to use flexibly to solve problems identified by rural communities themselves. Since 2001, we have worked hard to build synergies among programs, break down stovepiping, and encourage both our own staff and our partners in the communities we serve to work across traditional program boundaries.

Traditionally the bulk of USDA Rural Development's investment in rural health care has been provided through the Community Facilities Program, and in dollar terms this continues to be the case.

Since 2001, we have supported investments of more than $1.75 billion in Community Facilities to help rural communities develop or improve more than 1,000 health care facilities. Of this total, 144 facilities were hospitals while 262 were health clinics. Other health care investments in this period included assisted living facilities, nursing homes, vocational and medical rehabilitation centers, and mental health centers.

The Community Facilities Program, however, does not stand alone. In the health care sector, from FY 2001 through FY 2007, no fewer than six separate Rural Development programs have invested or supported investments in a total of over $2.2 billion in more than 1,800 health care-related projects:

	Projects	Funding
• Community Facilities		
Loans	795	$1,152,420,669
Guaranteed Loans	284	648,953,654
Grants	363	32,950,541
• Distance Learning and Telemedicine/Medical		
100% Grants	245	80,789,842
Loans and loan combos	17	78,409,821
• Business and Industry Guaranteed Loans	82	202,897,348
• Rural Business Enterprise Grants	28	3,553,287
• Rural Economic Dev. Loans and Grants	27	10,929,833
• Renewable Energy Guaranteed Loans And Grants	5	59,386

During the same period, our Community Facilities Program also supported investments of over $831 million in 5,201 fire, rescue, and public safety projects. Many of these, including rescue and ambulance services, communications facilities, storm warning systems, and fire equipment, directly support the public health mission.

Looking forward, demand for these programs is growing and we expect that this will continue. Anticipating this demand, the Administration proposed in its 2007 Farm Bill submission $85 million in mandatory funding to support an additional $1.6 billion in guaranteed loans and $5 million in grants to support the reconstruction and rehabilitation of Rural Critical Access Hospitals.

Although Congress did not choose to fund this initiative, we will continue to invest in rural health care as funds are available. We also anticipate that growing demand coupled with new technologies and a stringent budget environment are likely to drive changes in program delivery.

The Distance Learning and Telemedicine program is already in high demand. It is administered as a nationally competitive program with scoring based on (a) the rural nature of the service area; (b) economic need; (c) leveraging, through matching funds; (d) project location in USDA Enterprise Zones; (e) the need for services and benefits; (f) innovativeness; and (g) cost effectiveness. In 2008, we anticipate making approximately $24 million in grants and $28 million in loans and combos.

Health care investments through the Community Facilities Program, in contrast, have historically been community and demand driven. And we continue to fund rural health care infrastructure through this program as the current resources allow.

In closing, let me express again my thanks for the support of this Subcommittee for rural health care. These investments are critical to rural residents and to the long-term health of rural communities. We look forward to working with you to ensure that these needs are met.

The CHAIRMAN. Thank you so much for that very prompt and excellent summary. We look forward to our questioning time.

In the meantime, Administrator Morris, if you would proceed.

STATEMENT OF TOM MORRIS, ACTING ASSOCIATE ADMINISTRATOR, OFFICE OF RURAL HEALTH POLICY, HEALTH RESOURCES AND SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, D.C.

Mr. MORRIS. Mr. Chairman, Members of the Subcommittee, thank you for the opportunity to meet with you today to discuss the health care needs of rural populations in this country. I am here today representing the Health Resources and Services Administration, known as HRSA.

HRSA focuses on the most vulnerable Americans and makes sure they receive health care. HRSA works to expand the health care of millions of Americans—the uninsured, mothers and their children, those with HIV/AIDS, and residents of rural areas.

HRSA takes very seriously its obligation to implement enacted legislation. We help train future nurses, doctors, and other clinicians and place these clinicians in the areas of greatest need. Our efforts stress cross-cutting alliances within the agency to deliver quality services. We also work with governments at the Federal, state, and local levels, and with community-based organizations to seek solutions to rural health care problems.

My testimony will describe HRSA's activities in rural America and our collaboration with other partners, such as the USDA.

HRSA's Office of Rural Health Policy is the leading Federal proponent for better health care services for the 55 million people that live in rural America. Housed in HRSA, ORHP has a department-wide responsibility to analyze the impact of health care policy on rural communities. ORHP informs and advises the Secretary of HHS, and works to ensure that rural considerations are taken into account in the policymaking process.

Some of our efforts at ORHP include the Medicare Rural Hospital Flexibility Grant Program, Rural Health Care Services Outreach grants, and the State Offices of Rural Health. We also help support the Rural Recruitment and Retention Network, which links providers to rural communities in need.

The Community Health Center Program is a major component of America's health care safety net, and due to the efforts of the health centers and the generous support of the Congress, we recently completed a Presidential initiative that created over 1,200 new or expanded health centers in this country. They served 16 million patients in 2007, and as part of a renewed focus on high-poverty areas in the last year, we awarded 80 new health center sites that serve 300,000 people in areas of highest need. Today, more than half of the health centers, 53 percent, serve rural populations.

The National Service Corps is another program, and has placed more than 28,000 health professionals committed to providing improved access to primary care, oral health care, and mental health services in underserved areas. This is a service program, and the clinicians go wherever the area is of greatest need. Approximately 60 percent of NHSC's placements are in rural areas.

In an era of high gasoline prices, travel costs have become an even greater barrier to residents of rural areas. In 2007, HRSA provided funding for 140,000 telehealth visits in 46 different spe-

cialty areas to patients in rural communities. We estimate that this has saved patients over 14 million miles in travel, or almost $7 million in travel-related costs.

The geographic isolation of rural communities poses significant challenges in ensuring that all mothers and children have access to routine preventive care, acute care, and specialty care. To meet this challenge, HRSA funds the Healthy Start Program and the Maternal and Child Health Services Block Grant Program to states.

HRSA works with sister agencies in HHS and other Federal departments as we seek solutions to rural health care problems. We collaborated with the U.S. Department of Agriculture on the capital projects that Mr. Dorr already mentioned. We are also seeking to work with them in the coming year with their Economic Research Service to seek to create a definition of *frontier*. We are also working to make sure that the health centers provide WIC services, Women, Infant, and Children's services, in the health care setting, and we will serve as an *ex officio* member of the recently formed Rural Advisory Committee for the Department of Veterans Affairs.

In conclusion, we take great pride in the work we do to provide quality health care for rural Americans. I thank you for the opportunity to testify, and I am happy to answer any questions.

[The prepared statement of Mr. Morris follows:]

PREPARED STATEMENT OF TOM MORRIS, ACTING ASSOCIATE ADMINISTRATOR, OFFICE OF RURAL HEALTH POLICY, HEALTH RESOURCES AND SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, D.C.

Mr. Chairman, Members of the Subcommittee, thank you for the opportunity to meet with you today on behalf of Dr. Elizabeth Duke, Administrator of the Health Resources and Services Administration (HRSA), to discuss rural access issues as they affect the nation and what is being done to meet the health care needs of the rural and highly rural populations in this country. We appreciate your interest and support of rural health care and access to care for people residing in rural areas.

Introduction

The Health Resources and Services Administration (HRSA) helps the most vulnerable Americans receive quality medical care without regard to their ability to pay. HRSA works to expand the health care of millions of Americans: the uninsured, mothers and their children, those with HIV/AIDS, and residents of rural areas. HRSA takes seriously its obligation to zealously and skillfully implement enacted legislation from the Congress. HRSA helps train future nurses, doctors and other clinicians, and to place these clinicians in areas of the country where health care is scarce. HRSA's efforts stress cross-cutting alliances across its offices and bureaus to bring about quality integrated services. The Agency works and collaborates both within government at Federal, state and local levels, and with community-based organizations to seek solutions to rural health care problems.

My testimony will briefly describe several HRSA activities that touch millions of people in rural America. These include Office of Rural Health Policy programs, the Health Center program, the National Health Service Corps, Telehealth, and Maternal and Child Health programs. I will also briefly describe our collaboration with our partners in other agencies, including the U.S. Department of Agriculture who is testifying alongside of me today.

RSA's Rural Activities

Office of Rural Health Policy

HRSA's Office of Rural Health Policy (ORHP) is the leading Federal proponent for better health care services for the 55 million people that live in rural America. Housed in HRSA, ORHP has a department-wide responsibility to analyze the impact of health care policy on rural communities. ORHP informs and advises the Secretary, and works to ensure that rural considerations are taken into account throughout the policy-making process.

I would like to highlight six of ORHP's efforts to improve the health of rural Americans. The Medicare Rural Hospital Flexibility Grant Program (FLEX) provides funding to states who in turn award the dollars to rural hospitals. For example, the FLEX grants has helped over 1,200 small rural hospitals secure higher payments from the Medicare program under cost-based reimbursement.

Another program, Rural Health Care Services Outreach, worked to improve the health status of rural resident by providing a range of services such as health screenings, health education, and provider training. These community-driven projects provided flexibility for addressing health needs specific to rural communities. A majority of these projects fulfilled the needs in rural communities as 80 percent of them have continued after Federal funding ended.

The State Office of Rural Health grant program, which funds the 50 states, ensures that there is a focal point for rural health issues. In 2006, the State Offices worked with close to 4,700 rural communities on a variety of activities ranging from quality improvement to assistance with grant writing. In Colorado, for example, funds support quality reviews for over 30 clinical cases from small rural hospitals across the state. Physicians review the cases for appropriate and timely care, helping these hospitals to monitor and improve care if necessary.

ORHP efforts also include assisting in the enrollment of more than 180 rural hospitals in the 340B Discount Drug program. A change in the law under the Medicare Modernization Act of 2003 allowed qualifying rural hospitals which take care of a large percentage of poor and elderly to qualify for this program. ORHP works extensively with the states to identify eligible hospitals and assist them in the application process for gaining access to low-cost pharmaceuticals.

HRSA's ORHP also supports the Rural Recruitment and Retention Network (3RNet). The 3RNet works to increase the number of providers practicing in rural America by linking rural communities in need of a provider with providers seeking to practice in a rural setting. The 3Rnet consists of 43 states who work together to share information and recruitment strategies. During FY 2007, 3RNet placed 404 physicians and 277 other health professionals such as nurse practitioners, physician assistants and dentists. As a result, the 3Rnet saved rural communities close to $9 million in recruitment costs last year. Over the past 4 years, 3RNet placed nearly 2,900 clinicians in rural communities.

Finally, the Rural Assistance Center (RAC), supported by ORHP, offers rural residents one-stop shopping on health related rural issues. Rural residents can e-mail or call the RAC staff and find out about funding opportunities, successful rural health models or news and statistics on rural communities. In one success story, a 23-county consortia in Pennsylvania used information and assistance from the RAC to help design and monitor a managed care plan for behavioral health. Over its 5 year existence, RAC has worked with more than 5,000 individuals for customized assistance via its 1–800 line.

Consolidated Health Centers

The Health Center Program, a major component of America's safety net for the nation's underserved populations for more than 40 years, is at the forefront of the President's Health Center Expansion Initiative to increase health care access in the nation's most needy communities. Due to the incredible efforts of the clinicians and staffs of the Health Centers, and the generous support of a bipartisan Congress, the Initiative created over 1,200 new or expanded Health Center sites, serving 16 million patients in 2007C compared with ten million patients served in 2001. In 2007, as part of a renewed focus on high poverty areas, 80 new Health Center sites serving 300,000 people without access to Health Center services in areas of high need.

Health Centers are community-based and patient-directed organizations serving populations with limited access to care. These include low income populations, the uninsured, those with limited English proficiency, migrant and seasonal farmworkers, homeless families, and residents of public housing. Health Centers are open to all regardless of ability to pay. Moreover, the Health Centers provide comprehensive primary care service on a sliding fee based on the patient's income.

Health Centers improve the health status of underserved populations living in isolated rural communities, where residents often have no where else to go. To meet this need, over half (53 percent) of Health Centers serve rural populations. HRSA funds health center services in rural areas within a 40 to 60 percent range as required by statute. For example, in 2006, in rural areas, Health Centers served over 6.6 million people with 20.5 million patient visits. In the last fiscal year, HRSA awarded approximately $836 million to Health Centers serving rural areas. Additionally, the Agency recently awarded nearly $5 million in grants to Health Centers in rural areas to spur greater health information technology investments. For exam-

ple, one rural grantee implemented an electronic health record in 22 Health Center locations, reaching over 50,000 patients.

Peer reviewed literature and major reports document that Health Centers successfully improve access to care, improve patient outcomes for underserved patients, and are cost effective. Clearly, since their inception in the 1960s, Health Centers remain on a quality quest for their rural patients, grounded in the principles of community-oriented primary care.

National Health Service Corps

The National Health Service Corps (NHSC) has the unique distinction of having a book, *The Dance of Legislation*, a television series, *Northern Exposure,* and a movie, *Doc Hollywood*, feature aspects of its story. From its inception in 1970, the NHSC has placed in underserved areas more than 28,000 health professionals committed to providing improved access to primary care, oral, and mental health services.

The NHSC is a service program and its clinicians go wherever the need is great, where others choose not to go. By statute, the Program requires its recruited clinicians to serve targeted areas where they are needed most by linking educational support with a clinical placement (through a scholarship or loan repayment) to serve patients most in need of primary care services.

From 1993 to 2006, the NHSC provided almost 18,000 total years of dedicated service from its clinicians practicing in rural areas. Approximately 60 percent of the NHSC's placements are in rural areas, continuing a trend throughout its history. Moreover, the most current retention rate of NHSC clinicians in rural areas is approximately 75 percent. To overcome shortages and scarcities in rural areas and to expose students to hands-on primary care rotations, the Agency supports state and community recruitment efforts including retention of their grow-your-own health professionals. Additionally, according to one study, in rural areas, NHSC clinicians are major contributors to local economies, resulting in up to 14,367 jobs, and generating $1.5 billion in economic impact.

For over 35 years, the NHSC has been and continues to be an important contribution to the health care needs of underserved people in rural America.

Telehealth

In an era of high gasoline prices, travel costs have become an even greater barrier to rural patients receiving specialty services that are not locally available. The Telehealth Network Grant Program (TNGP) funds projects that demonstrate the use of telehealth systems in order to improve health care services for medically underserved populations. The TNGP focuses on providing innovative telehealth services to rural areas. From March 2007 through February 2008, nearly 140 thousand telehealth visits for 46 different specialty services were provided to patients in rural communities under this Program. During the same period, the TNGP is estimated to have saved patients over 14 million miles in travel, or otherwise stated, an estimated savings of almost $7 million in travel costs.

In terms of health outcomes, the TNGP examines the impact of remote disease management services on patient outcomes. From September 2006 through February 2008, 33 percent of diabetic patients enrolled in Telehealth diabetes case management programs achieved control over their disease as measured by their hemoglobin A1c levels. This is a significant improvement over the baseline of ten percent of diabetic patients who are estimated to have had control over the disease.

Under the Telehealth Resource Center grant program, HRSA supports five regional and one national telehealth resource centers to provide technical assistance to rural communities interested in providing or receiving telehealth services. The five regional centers work together to make available technical assistance from the nation's experts on practical approaches to creating a successful telehealth program, whereas the national center focuses on technical assistance to address the legal and regulatory barriers to sustaining successful programs. For example, the California Telemedicine and eHealth Center Mentor Program created a network of mentors, individuals who have developed successful telehealth programs in California, to serve as role models and advisors to communities that wish to use telehealth technologies to overcome barriers to service.

Maternal and Child Health

The geographic isolation of rural communities poses significant challenges in assuring that all mothers and children have access to routine preventive care, and acute medical and specialty care. To meet this challenge, HRSA funds programs to improve maternal and child health through the Healthy Start Program and the Maternal and Child Health Services Title V Block Grant to states. Healthy Start works to eliminate or reduce racial/ethnic disparities in birth outcomes in high-risk com-

munities. For example, North Carolina's Healthy Start Program serves fourteen rural counties. The minority infant mortality rate in these counties was 2½ times higher that the state's rate. A recent evaluation indicates this year that there has been close to a 14 percent reduction in racial disparity for early entry into prenatal care, 12.9 percent reduction in the racial disparity for neonatal mortality, and a 10.8 percent reduction in overall infant mortality.

The Maternal and Child Health Services State Block Grant Program helps improve the health care of many rural mothers and children. States prioritize the use funds to address a multitude of maternal and child health needs within the state. Among other things, states work to reduce the rate of child deaths by motor vehicle accidents, decrease the number of child suicide deaths, and lessen the rate of birth for teenagers. Several rural states focus on reducing child injuries caused by motor vehicle crashes. In South Dakota, for example, the state's efforts have reduced the rate of deaths to children caused by motor vehicle crashes from 11.1 in 2002 to 7.1 in 2006.

Collaboration With Partners

HRSA works with its sister agencies in HHS and other Federal departments to seek solutions to rural health care problems. We collaborate with the U.S. Department of Agriculture (USDA) and the Department of Housing and Urban Development to assist small rural hospitals in accessing capital for building projects through programs funded by these two Departments. HRSA has also worked with USDA to revise and define a frontier definition, and to increase the number of health center grantees providing Women, Infant and Children (WIC) services such as supplemental foods and nutrition education. Today 95 percent of health centers provide such services. In addition, we will serve as an *ex officio* member of the Department of Veteran's Affairs Rural Advisory Committee, which advises the Secretary on health issues affecting veterans living in rural areas.

Conclusion

HRSA takes great pride in the work we do to provide quality health care for rural Americans. Thank you for the opportunity to discuss the agency's rural programs and I am happy to answer any questions you have.

The CHAIRMAN. Thank you.

Thank you, gentlemen. And you two have been the first witnesses we have ever had that have done a very succinct job in less than the time offered. So thank you for showing it can be done and done with great respect. That allows us even more time for discussion and questions as we may need it, and we thank you for that respect.

The chair would like to remind Members that they will be recognized for questioning in order of seniority for Members who were here at the start of the hearing, according to Committee rules. After that, Members will be recognized in order of arrival. And I appreciate the Members understanding and following this procedure.

But I would also like to welcome Mr. Costa. Although not a Member of this Subcommittee, is a Member of the larger Agriculture Committee, and he has joined us today. And I have consulted with the Ranking Member, and we are pleased to welcome him and let him join us, as appropriate, during times of questions as well.

And we are also pleased to be joined by Mr. Barrow of this Subcommittee, who is joining us just in time for the questions. So we are glad to have you, Mr. Barrow.

Secretary Dorr, can you discuss the role of financing from local banks in the Farm Credit System in particular, that you mentioned in your testimony, and the excellent job it has done for the construction or renovation of health care facilities in rural America?

Mr. DORR. Well, certainly.

Traditionally, our programs have emphasized the direct loan component. Over the years, however, we have recognized that limited resources and, in fact, the ability to more effectively engage local communities is likely to develop a stronger relationship and a stronger commitment to the success of the programs, long term. As a result, we have been for the last few years going toward more effective guaranteed loan programs.

An example of this is a project in St. James, Minnesota, which was initiated a couple of years ago. In that particular case, they had a hospital that was built in 1957. It needed to be rehabilitated and, in fact, replaced, which they did. It was a $22 million project, I believe about $17 million of it was a guaranteed loan, and $4 million or thereabouts was a direct loan. That guaranteed loan component was one in which our Rural Development Office was struggling to find someone to originate that loan. Ultimately, Arborone, I believe a North Carolina-based farm credit investment group, got involved in it and provided the origination of the loan, and we were able to provide the guarantee.

What this really demonstrates is that we are working with a more and more diverse group of banks, investors, and other financial entities to address this emerging rebuilding of the infrastructure of rural America. Because of the history of the way we have financed things in rural America over the last several decades, this has been a bit of a new challenge.

We are delighted to find that there are organizations like Farm Credit. There are some banks that are also now beginning to get involved and they are actually able to utilize our loan guarantee in a very low-cost way to step in and provide the necessary buildout for this. In this particular case, we were able to mitigate about 250 basis points or 2½ interest off the prime rate. That probably would have been an added cost that may have prohibited the local community from embarking on this project. If you amortize that, say, on a $15 million loan, just on an average basis, that amounts to $350,000, $360,000 a year.

So we are looking for these kinds of partners, Farm Credit through their investment groups. I understand this particular project evolved out of the Investments in Rural America Initiative that was started under Chairman Nancy Pellett at the Farm Credit Administration. We found this as being a very attractive project and program for us to work with. So we think it has been very good.

The CHAIRMAN. Thank you, sir.

Administrator Morris, as part of the Administration's assessment of rural health programs, we know your office sets goals both to reduce health disparities and to strengthen public health infrastructure and health care delivery systems.

Would you give us your honest assessment of the progress that you have been able to achieve on those goals, both in the short term and in the long term?

Mr. MORRIS. Yes, Mr. Chairman. In terms of health disparities, certainly rural America has its share of them. And there is a very regional tilt to it, with areas in the Southeast facing some severe challenges.

Our Rural Health Care Outreach Services Grant Program, the beauty of the program is, it is noncategorical, which means the community can decide what the focus should be. And what we find is that most of the applicants of this program tend to focus on trying to improve health through health fairs, and adapt them to what the local need is.

In order to track this, we have begun a performance measurement system that will allow them to report on their progress on disease indicators, access to primary care, and things like that. We are hopeful that through the creation of this we will be able to report quantifiable results that show direct community health status improvement for where we make those investments.

The CHAIRMAN. All right. Thank you, sir. Thank you very much.

I will proceed and let Mr. Hayes be recognized to see if he has any questions at this time.

Mr. HAYES. Thank you, Mr. Chairman.

Mr. Dorr, what analysis has USDA done to compare the impacts of various projects that you funded in rural communities, and the examples of successes. Hopefully, no failures, but if so, what are some of those?

Mr. DORR. We have begun to attempt this. I will try to respect the time and abbreviate this.

As I have indicated to this Committee in the past, it was very difficult when I first became the Under Secretary to ascertain what the impact was of the variety of loans and grants and loan guarantees we were making. In other words, what kind of an impact in terms of new jobs, gross domestic product, tax revenues, those sorts of things were being created with an investment that we made, whether it was a grant or whether it was a direct loan—which obviously has a higher credit score—or whether it was a loan guarantee?

We embarked several years ago to try to ascertain how to do that in our B&I Program, in our Business and Industry portfolio. This evolved into something we called SEBAS, the Socio-Economic Benefits Assessment System. And what that system does in our B&I portfolio, using economically valid databases and appropriate models, is to scrub and determine how many gross new jobs we have created; it reduces them to net FTEs.

That is, if you invest money someplace, and it provides the same service and eliminates a job over there, you can't technically call a job here a net new job. This system scrubs a lot of that out of the system. And, it ultimately generates a number that identifies how much additional new gross domestic product that investment creates. You then are able, for example, to divide that by the number of jobs. You get a salary per job or a quality of job indicator.

The interesting thing is that in addition to giving us that data, it also is going to be a tool that ultimately will help us analyze whether an application or an investment is really a good one. So, in preparation for coming up here, I had our folks pull the SEBAS numbers for B&I loans. We don't do SEBAS yet in Community Facilities, but we are looking at how to implement that technology there.

We have done a number of loan guarantees in the B&I portfolio that are directly related to health care. For example, in the area

of continuing care retirement, in a period from 2001 through to date, we have made 26 B&I loans. It required a total of $3.45 million in budget. These investments generated $7.5 million in GDP annually, and they created 272 net new jobs.

Now, here is the interesting thing: The total tax revenue generated at the state and the local level annually will pay off that budget requirement in 15 years and will have created an additional job that is worth about $29,000.

What we also found out was that of those 26 loans, nine of them actually created no new jobs. That is a significant finding. This is a tool that allows us to determine whether or not it is a good investment. We are able to find out, for example, that our investments in hospitals create jobs with about $45,000 annual salaries. You can repay the budget authority off in about 2½ or 3 years. This varies by category of investment.

This is a tool that, in the long term, will offer a lot of potential. It will enable us to provide you with the kind of information necessary for you to make better decisions as you write statutes and decide what you are interested in funding. And I think, as an Administration, we can likewise do the same.

I am sorry for the lengthy answer, but it was a bit involved.

Mr. HAYES. Mr. Morris, quickly, how do you assess the effectiveness of the programs operated by your office in helping rural areas meet challenges associated with providing health care?

Mr. MORRIS. Yes, Mr. Hayes, we have moved in HRSA towards developing quality indicators for all of our programs, some of which are common across programs, whether it is Maternal and Child Health or Community health centers or even grant programs in our office.

What we are trying to do with that is be able to measure where our dollars have actually resulted in an improvement in terms of various conditions, whether it is diabetes, cardiovascular health, things such as that. And what we hope to do is wrap that in an overall agency performance assessment that will enable us to see what is working and what is not. And that can factor into how we write our guidance for our grants in the coming year, stressing continuous quality improvement as we can.

Mr. HAYES. Thank you, sir.

Mr. Chairman, I yield back.

The CHAIRMAN. Thank you very much.

Mr. Salazar.

Mr. SALAZAR. Thank you, Mr. Chairman.

And thank you Under Secretary Dorr and Mr. Morris for being here with us today.

As you know, I represent the western and southern part of Colorado, one of the largest districts in the country, very sparsely populated, and we have great disparities in how we are able to afford health care to many of our constituents. The biggest problem that we have is retaining doctors in rural communities.

But let me just ask you a question about what some of the health care administrators have told us. They say that financing buildings through the Community Facilities Program requires more red tape than it does through financing it through other institutions. Have

you looked at ways to cut down and to make things—simplify the procedures, Mr. Dorr?

Mr. DORR. I believe we have. We are doing so on a continuing basis.

We are cognizant of the limitations in many of these rural areas in terms of the expertise to deal with these programs. We are attempting vigorously to cross-train our field staffs so they are more capable of working with the customers at their locations to figure out how to submit applications, and to ascertainment whether or not these sorts of applications really will work.

I just talked about SEBAS. If we are able to ultimately implement that system it should begin to quantify the kinds of services we provide in the context of what really makes sense for those areas.

For example, we know from our colleagues' databases is that no one should be more than 35 minutes—I believe is the number—from an emergency trauma center in the event of an accident. There are a number of those sorts of measures that we are trying to incorporate into how we analyze applications, how we provide guidance and assistance and, more importantly, how we begin to leverage our loan guarantee programs with outside lenders. And it is going to take time, but we are making progress, and a number of these performance indicators will make it less complicated to get where we need to get.

Mr. SALAZAR. Thank you.

And, Mr. Morris, like I said before, one of the biggest problems that we have in our community is trying to retain doctors in rural areas. Do you have any ideas as to how we might enhance programs to solicit doctors to come and stay in rural communities?

Mr. MORRIS. Yes, sir, Mr. Salazar.

Well, I think that over the years one of the most successful programs we have had has been National Service Corps both through its scholarships and its loans. And we find that now we are leaning more towards the loan repayment as an effective tool.

We place these folks based on where they score in terms of a Health Professional Shortage Area score. And so, that way we make sure they are going to the area of greatest need.

So, what we found is that more than 50 percent of them go to rural areas. We are seeing a great need in rural areas, and so the National Service Corps has committed a lot of resources to that also.

Two other things we have done to try to help is we support the Rural Recruitment and Retention Network. This is 45 states working together, usually with a state point of contact who does recruitment and retention for the state. And over the last 4 years the 3RNet, as we call it, has placed 2,900 clinicians in rural areas; and that is mostly physicians, but some dentists, physician assistants, and nurses. They do about roughly 4,000 a year.

They do a lot of site development where they do a lot of work ahead of time trying to make sure that the community is the right fit for the clinician.

I think "grow your own" programs tend to be very popular, where you identify somebody who enjoys the rural lifestyle, who appre-

ciates it, and is more likely to stay. And that is the sort of retention issue that I think is important.

To help support this, we have also asked each of our State Offices of Rural Health—there are 50, one in each of the 50 states—to identify a point of contact for rural recruitment and retention issues so that there will be one person they can call in each state to do this. And I will say that in your State of Colorado we have one of our strongest State Offices of Rural Health; they have really done a great job with the resources they have over the years of recruitment and retention, sir.

Mr. SALAZAR. Thank you.

And could you, Mr. Morris, give me a list of the different programs, retention programs that you have? If you would provide my staff with that, I would certainly appreciate that very much.

Mr. MORRIS. I would be happy to do that for the record.

Mr. SALAZAR. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you very much.

Mr. Costa.

Mr. COSTA. Thank you very much.

Mr. Morris, we are all obviously concerned about the new rulemaking that is coming out and its definitions and impact on our rural areas throughout the country. In my district, I have some significant health challenges. It is a rural area, but we have urban populations nearby, like Fresno—and Hanford is now over 50,000—and Bakersfield. Yet we are three of the number one ag counties in the nation, based on gross receipts, have large populations of uninsured or underinsured; and health clinics are obviously very important.

Critical access to hospitals through health care is also overused, *i.e.,* emergency rooms. And so I understand funding is limited, but in your regulation process, I believe we are going to exclude more and more of these rural health facilities.

Here is my question: Under your rules to address capacity, does the capacity to handle the patient caseload which, in my district, I have 14 facilities that may lose their rural designation because of your rulemaking. If they close, clearly the caseload is going to enlarge the responsibility of other facilities for these rural patients.

Again, many of them are uninsured or underinsured. So the primary care facilities sometimes do exist within 25 miles under your rulemaking, but that doesn't mean they are easy to access. These are working poor people that at $4+ for a gallon of gasoline, it is very difficult.

So what does this mean? I mean, this does a disservice not only to the clinics, but it further impacts the hospitals. Do you have a response?

Mr. MORRIS. Yes, sir, Mr. Costa.

Are you referring to the recently published proposed rule on Health Professional Shortage Area Designation?

Mr. COSTA. Right. Right.

Mr. MORRIS. The comment period just closed on that, and we are in the process of looking through all the comments to decide what our next steps are.

I would be happy to get back to you for the record, or have our legislative staff follow up about what we think our next steps are going to be. I don't know myself.

Mr. COSTA. The irony, of course, all politics is local in part. But in Kings County I have a community with right around 50,000, another community that is 15 miles away, 10 miles away, with 30,000 people. For the purpose of qualifying under Federal formulae, they have combined their geographical formula population, which now no longer makes them, by definition, *rural*.

CMS is really complicating and making it more difficult to provide access. How about the issue of areas where they are principally served by farm workers? Do these Rural Health Programs that provide the access, are there other programs based on patients served that would be made available, not just the location of the facility? And do you provide waivers for these centers?

Mr. MORRIS. I think for migrant farm workers—the program that has been the most effective over the years has been the Migrant Health Center Program, because they built on a track record and have served those folks. That is not determined by either rural or urban status. It is defined mostly by where the population is.

I think the set of Migrant Health Centers are best equipped to do that.

And with the President's expansion, we put Community Health Centers, 1,200 new sites, in places they hadn't been before. So that safety net of Community Health Centers is much broader than it used to be.

And can I ask one question about the definition of *rural* that you raised?

Mr. COSTA. Right.

Mr. MORRIS. For our programs in the Office of Rural Health Policy, we try to use a broader definition of *rural* that we developed in partnership with USDA. So we look at nonmetro counties, but then we also look at the metro counties, which are the areas you are referring to, and we identify the rural Census tracts within those, so they are eligible for our grants.

Mr. COSTA. So if 51 percent of the patients come from a nonurban area, would they qualify? Is a waiver possible? Can the number be lowered to 25 percent?

Mr. MORRIS. I think that is referring to a regulation of the Community Health Center Program. I will have to get back to you for the record.

Mr. COSTA. It is. And in terms of timeline, I have been told it is different than what you just told us—my time is almost up—that the new rule was proposed 2 weeks ago, but August 26th is the deadline for the first comment period, and CMS has 90 days to respond to the comments.

And if the clinic can't meet the requirements, they can't get an exemption. And it can be decertified in 180 days.

Mr. MORRIS. Okay.

Mr. COSTA. I mean, I am told that this could impact, in California, 14 sites—or I mean eight areas in California by this new rule.

Mr. MORRIS. There are several regulations pending right now, and a lot of them focus on the same populations as the Rural

Health Clinic regulation that is out for comment right now, which has a process in it in which clinics may be decertified if they are no longer in a rural area, or if they are not in an updated shortage area.

And then there was the Health Professional Shortage Area redefinition that just closed.

I think we can follow up with you and get some clarification on all those issues.

Mr. COSTA. I would appreciate that. My time has expired.

Mr. Chairman, I want to thank you for holding this very important and timely hearing for our rural areas throughout the country.

And I would like to add whatever support to you and the Subcommittee, if you want to put together a letter in terms of questioning this whole rulemaking process, because, if the impacts can happen in rural California, they happen all over rural America, and this health care for the under- and uninsured is critical.

The CHAIRMAN. Absolutely. Thank you. Thank you Mr. Costa, for joining us today. And thank you for your kind words.

Mr. Barrow.

Mr. BARROW. Thank you, Mr. Chairman. I want to talk Critical Access Hospital funding for a minute.

This is something I learned about in two different ways. One is a result of my serving on both this Committee and the Energy and Commerce Committee, which has jurisdiction over HHS for some purposes. And also I learned about it on my last rural hospital listening tour last year.

Critical Access Hospitals, as best I understand it, we basically make a deal with rural hospitals. We say, "Look, you give up your dream, your ambition, your struggle to try and be a full-service hospital, we will make you, in a feeder system, sort of a primary clinic for a larger hospital to be designated elsewhere, and we will reimburse you on a completely different rate.

Since most of your patients are Medicare patients, we will reimburse you on something different than your traditional Medicare. We will do sort of a cost-plus type basis, kind of keep you afloat. You lower your mission, you lower your sights to be something different than what you have been in the past, and we will reimburse you on a basis to make it possible for you all to keep on doing it." That is the deal in a nutshell.

I found out last year that CMS is telling Medicare C—is telling hospitals, Critical Access Hospitals that have accepted this deal that their Medicare C patients aren't Medicare patients for purposes of this reimbursement formula agreement that has been in place from the very get-go. Of course we hadn't had any Medicare C patients to speak of until Medicare D came along.

And then, all of a sudden, when folks had to go to Medicare D to get the drugs they couldn't get anyplace else, they were bamboozled, hornswoggled, pushed, shoved, or tricked into buying Medicare C coverage. So all of a sudden you have a whole bunch of people showing up at hospitals, and they have Medicare C coverage, when they have always had traditional, and they didn't even know they were buying C.

Nobody in their right mind would buy a C policy in exchange for Medicare A and B, but that is where we are finding increasing per-

centages of our rural constituents who have bought into it without realizing it.

Now they show up at the Critical Access Hospitals, and the Critical Access Hospitals are saying, "Wait a minute, this person isn't a Medicare A, not a Medicare B, they are Medicare C. So we don't reimburse you for these folks at cost-plus basis; we treat them as if they aren't a part of the system at all."

I can't think of anything more stupid. Under Medicare A and B, the government is paying an insurance company to administer and manage the government's risk. Under Medicare C, we are using tax dollars to pay an insurance company to assume the government's risk. In both cases, the government is paying for both of them out of Medicare funds; the taxpayer is footing the bill either way. But the administrations at these hospitals are being told, "Wait a minute, you folks, an increasing percentage of these folks simply aren't covered by the original deal."

Now my question to you all is in three parts. Are you aware of this? If not, why not? If so, what are you doing about it to try and persuade your counterparts at CMS that what they are doing is, they are killing rural hospitals while Medicare C is eating people alive with this bait-and-switch deal we have going on, on a massive scale.

I will let either one or both of you gentlemen try your hand at answering these questions. Are you aware of it? If not, why not? And if so, what are you doing about it?

Mr. MORRIS. Mr. Barrow, I am not aware of the full extent of that, but I do know that Part C plans are paid differently than Part A and B. But we meet quarterly with CMS and go over there and talk to them about rural health issues.

And I will definitely take your concerns back.

Mr. BARROW. Will you commit to me that you will undertake to advocate with these folks that as far as the hospitals are concerned, their Medicare C patients should be treated exactly the same for reimbursement purposes as Medicare A and B patients should be? After all, the same taxpayers are footing the same bill.

How about you, Mr. Dorr? Are you aware of this? Can you shed some light on this?

Mr. DORR. I can offer no insight.

Mr. BARROW. Will you undertake to advocate that so far as the hospitals are concerned, Medicare C folks should be treated exactly the same way as Medicare A and B folks?

The hospitals aren't selling the policies, the constituents are exactly the same, and the person who is underwriting the cost of this government financed benefit is precisely the same.

Do you see the sense of this?

Mr. DORR. I will do what I can to look into the issue and get information back to you. But I am not familiar with this issue.

Mr. BARROW. Then I would ask you, please, to become familiar with it, and let's see what we can do to fix it.

Thank you very much. I yield the balance of my time.

The CHAIRMAN. Thank you.

Along those lines, normal Committee rules would be to ask for your response to come within 10 calendar days. Can you gentlemen

comply with that, as per Mr. Barrow's request? I would like an answer.

Mr. DORR. Certainly.

Mr. MORRIS. Yes, sir.

Mr. DORR. We will certainly try.

The CHAIRMAN. Okay. All right. Thank you.

Thank you, Mr. Barrow. Mr. Smith has consented.

Mr. Pomeroy, you may proceed.

Mr. POMEROY. Thank you, Mr. Chairman. I have a statement I would like to add to the record.

The CHAIRMAN. Your statement will be allowed. We announced earlier, any statements you would like to enter we will be glad to receive.

Mr. POMEROY. Thank you very much.

The CHAIRMAN. Yes, sir.

Mr. POMEROY. I want to thank you for having this hearing, Mr. Chairman. Like the hearing you had on hunger last week, I think that you are showing the kind of leadership that is fleshing out the real potential of this Subcommittee. As a Member of the Subcommittee, I appreciate it.

The CHAIRMAN. Thank you.

Mr. POMEROY. To attest to this statement, I have a letter that we sent to the Appropriations Committee regarding the funding of a number of programs that were discontinued in the President's budget, specifically the funding of Rural Hospital Flexibility Grants, Rural Health Outreach and Network Development Grants, and the Office for the Advancement of Telehealth. Basically, these and other programs mentioned in the attached letter that I will add to the record reflect investments in rural health infrastructure.

[The document referred to is located on p. 6.]

Mr. POMEROY. Mr. Morris, you are pretty new on the job, as I understand it; is that correct?

Mr. MORRIS. I am sorry?

Mr. POMEROY. How long have you been in your position at CMS?

Mr. MORRIS. I have been with the government for 12 years, the Office of Rural Health Policy for 10 of those, and in this job officially as of Monday.

Mr. POMEROY. Well, in fact, some of your prior experience at one point was as an intern with Senator Kent Conrad of North Dakota; is that correct?

Mr. MORRIS. Yes, sir.

Mr. POMEROY. Great. Anyone with an internship in one of the North Dakota offices has a good grounding for a start. I will not, therefore, hold you in any way responsible for the cuts that we are trying to restore.

But it does seem to me important, especially in light of some of the funding issues that you are talking about—grant funding for a hospital improvement project here, grant funding for something there—that this is part of some kind of plan, there is some strategic evaluation of rural infrastructure that is funded and advanced as part of these investments that we are making. And I would like you to reflect on how that takes place through CMS in a rural outreach area like North Dakota.

Mr. MORRIS. Thank you, Mr. Pomeroy.

I think that one of our primary focuses right now is on the quality side, especially as it relates to rural hospitals, because of the move towards public reporting, which is the right thing to do for folks. But the challenge is that rural hospitals sometimes have less staff, and therefore, developing the capacity to actually publicly report to show how they are doing it can be a bit of a challenge.

We have been working with CMS extensively to try to make sure that the measures that are in place, are reflective of the types of services that are delivered in rural hospitals. And some of the data we have seen so far shows that, like for pneumonia cases in Critical Access Hospitals, they do as well or better than their urban and suburban counterparts. Other cases, where they transfer out, is probably not as appropriate a measure for them.

As we expand public reporting to the outpatient side and we add things like transfer, we are going to have a much fuller picture of how rural hospitals perform from a quality standpoint. I think that dovetails nicely with what the Institute of Medicine has been pushing folks since the release of their report, *To Err Is Human.* That has been one of the primary areas we have been focusing on as of late.

Mr. POMEROY. I look forward to continuing to work with you, now in your new position, on this whole HRSA grant rural health infrastructure issue. I think it is critically important to strategically advancing the system in a rational way. I appreciate what you have told me about quality reporting.

Mr. MORRIS. Yes.

Mr. POMEROY. Mr. Secretary, nice to see you again. I want to ask you about, in my opinion, a very curious decision made by the Administration in the funding of its human nutrition labs under ARS. You have recommended the closure of the only rural nutrition lab focused on obesity research, and that would be the human nutrition lab in Grand Forks, North Dakota.

Now, I like the ARS folks. I have worked hard to support their budget to the fullest extent that I can. I think they made a really bad judgment call in trying to take down capacity for what has become a national epidemic and, arguably, a national epidemic particularly problematic in rural areas with Native populations, like the areas served by the human nutrition lab in Grand Forks.

Do you have any response to that?

Mr. DORR. I really don't. It is not in my area. I was not involved in that decision. And I will certainly share your concerns with those who are. I suspect they have already heard them, but I will reiterate that they have come up again.

And aside from that, I don't really think I can offer any insight into that decision.

Mr. POMEROY. I saw the Secretary at lunch today, and like Mr. Morris, the Secretary had an early, very positive grounding as a North Dakotan for his responsibilities.

Mr. DORR. I am well aware of that on a daily basis.

Mr. POMEROY. I know my time has elapsed.

Do you attempt to break down the stovepiping that occurs? You know, we ask him to do some stuff on rural; and you, rural; and other people, rural. How do you try and coordinate all this?

Mr. DORR. I would just simply say on behalf of our organization that we have made a very definitive attempt to break down stovepipes.

As I indicated in my early testimony, perhaps my oral statement before you were here, we have worked together to develop a prototype on Critical Access Care Hospitals in order to minimize costs and duplication and increase efficiencies and, yet, enhance the ability to have flexible space and flexible use of these facilities.

There are a number of other areas as well. We are working with the Indian Health Services and the Veterans Administration.

I would be the last to suggest that we are doing everything perfectly in that area, but it is an area that we need to aggressively pursue. And I have encouraged our shop to do so in any one of a number of areas, including this.

Mr. POMEROY. Good.

Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Sure. Thank you, Mr. Pomeroy.

Mr. Smith?

Mr. SMITH. Thank you, Mr. Chairman.

My question—well, first let me say, Mr. Dorr, that I appreciate the communication with my district. And your representative, Mr. Blehm, in Nebraska does a fabulous job.

Mr. Morris, I do have a question pertaining to policy. It is interesting, the feedback that I hear from, say, a rural physician *versus* an urban physician as it relates to midlevel practitioners, advanced practice nursing, and otherwise. There seems to be a little more open-mindedness in rural areas, and that a physician sees a physician assistant as an enhancement to the practice rather than a threat; and I find it quite refreshing, actually.

But could you elaborate perhaps on any policies that you think—Federal policies that could be enhanced or changed to offer better health care, perhaps—meaning access through maybe some expanded scopes of practice?

Mr. MORRIS. Thank you, Mr. Smith.

I think that one reason for that open-mindedness stems from one of the longest-standing rural programs that has been on the books, and that is the Rural Health Clinic Act, which was established in 1977. And for 20 years it was the only way that physician assistants and nurse practitioners could practice in almost an autonomous way. It wasn't until 1997 that, under Medicare, they were given the right to bill directly.

And so, as a result, there are 3,400 rural health clinics around the country—that infrastructure has shown that these folks can play a very important role in being a source of primary care in rural communities. I think the RHC program is really to be saluted for that.

I have no comment on the state scopes of practice. That is an issue that is determined at the state level. But, what we have seen in the literature and other things is that you can get primary care from a nurse practitioner or a PA, as well as a physician; and it can be good, high-quality care.

Mr. SMITH. Okay. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Cuellar.

Mr. CUELLAR. Thank you, Mr. Chairman.

First of all, I appreciate what you all are doing to provide health care in the rural areas. One of the questions I have is, I wish we could find a place where we could look at all the different programs. Because I know, for example, Mr. Secretary, you all have a list of programs; and I appreciate that.

And same thing for HHS, Mr. Morris.

But is there a way that you could have them coordinated, where we could look at the list? Is there a way that you have all done that together already that we could, say, for this type of category from both the agencies, we have this available? Or even from the working group, if you have the other agencies, could you put that together?

And I would like to get a copy so that way we are not going to find everything under USDA, find everything under HHS and the other members of your working group. How fast—or do you have that already? How fast could you get that over to us?

Mr. MORRIS. I think we have a good start on it. And it is through the Rural Assistance Center (RAC) which is in North Dakota. And this was created just over 5 years ago with the express intent of being one-stop shopping for all things rural.

And so, you can go to that. There is a reference librarian. You can call up. They will do information searches for you. They try to share information across the Federal Government about funding opportunities for rural, not just within the Federal Government, but at foundation level, things like that. And so we found that the RAC is a good way do that.

But one thing we could do is make sure that USDA is aware of it, and that we have all their programs, and that we are reflective fully of their rural investment, too. We can commit to doing that.

Mr. CUELLAR. Okay.

So how fast could you—both of you all get that over to us?

Mr. MORRIS. I can send you information on the RAC within a day or 2. And we will have some conversations about getting them to take a look at the RAC website and make sure it is representative of what their programs do.

Mr. CUELLAR. Yes. Because I am a big believer, Mr. Secretary, in a one-stop center. And if we have a hard time looking for it, you can imagine the person in a rural area trying to find that.

So if you all can put it into plain English and simplify it for us, this would be a great tool to provide to the rural areas. So, Mr. Secretary, if you all could get together on that.

Mr. DORR. You are speaking to the choir. And I can assure you that I will have our staff work with these folks to make sure that there are appropriate links made as quickly as we can make them. And we will get that feedback to you.

Mr. CUELLAR. Who would be one contact person we could have? Linda or—I am sorry, could we have—because we have different agencies, I want to make sure that if somebody contacts me, both of you haven't talked already.

Mr. DORR. Certainly. I just suggest you call my office, and we will make sure we have somebody to contact, to deal with this issue, when I get back. I am not sure who it exactly would be

today. I would want to talk to the Administrator, and I am sure he will appoint someone within his staff to do it.

Mr. CUELLAR. Okay. I appreciate it.

The other point I want to go into is, it was in your testimony, about the distance learning and the telemedicine. I am a big believer in that.

In my areas—I have rural areas in south Texas, I have Colonials. As you know, they are basically Third World conditions, and the long-distance learning and the telemedicine is a good, effective way of using the dollars.

Could you again, when that individual comes in—Mr. Secretary and Mr. Morris—if you could, get us everything that is available on long-distance learning and telemedicine to us. Again, not only to me, but for the Committee, because I think this would be a great tool for our constituent work, which is important to us.

I have no further questions, Mr. McIntyre. I just want to say thank you very much.

I was with the Secretary Schafer in Colombia on the trade agreement, and I really appreciate it. We had a good visit. And I appreciate the work that you all have been doing.

Mr. DORR. Well, thank you very much.

Mr. CUELLAR. Thank you, Mr. Morris.

The CHAIRMAN. Thank you. And I agree with Mr. Cuellar, if you could get us all that information on telemedicine and how that relates to health care in rural areas that would be helpful to us, given that that, in essence, is what we are here for today, talking about the delivery of rural health care and how we can tie that in, especially to our great medical universities and research centers as they relate to our particular states. Where the telemedicine would best be served in each state in terms of what you all have seen according to your surveys and information, that would be most helpful.

Let me say, as a native of Robeson County in North Carolina, my home county, which is also the largest, but yet the poorest of all 100 counties in North Carolina, we know how important rural health care is. In fact, our county had the first public health department in the entire United States.

So we invite you to come down sometime, and we would love for you to come see the long history, in fact, the longest history of any public rural health department in the nation down in my native Robeson County. And we hope to have you come join us sometime, each of you gentlemen, in the future.

And with that, I want to thank you for being with us today. We will conclude this panel in the interests of time, but may God bless you. Thank you for your good work, and please continue it.

We will ask our next panel to proceed to the table as I introduce you. Now the second panel will begin.

We would like to invite to the table Mr. Jeff Spade, Vice President of the North Carolina Hospital Association, and also Executive Director of the North Carolina Rural Health Center in Cary, North Carolina, which is in the Research Triangle Park area; Mr. Charles W. Fluharty, President Emeritus and Director of Policy Programs of the Rural Policy Research Institute; Dr. Wayne Myers, Trustee for the Maine Health Access Foundation, on behalf of the National

Rural Health Association; and Dr. Karen Rheuban, Professor of Pediatrics and Medical Director for the Office of Telemedicine with the University of Virginia Health System.

If would you each take your seat, we will proceed immediately with testimony.

While we are welcoming you to the table, I would also like to recognize—we are thrilled to have the Ranking Member of the entire Committee on Agriculture for the U.S. House, whose portrait is right behind you, but look in front of you and the man is really here, Bob Goodlatte, a great friend, former Chairman of the full Committee.

And, Mr. Goodlatte, prior to starting this panel if you have any statement for the record we would welcome it.

OPENING STATEMENT OF HON. BOB GOODLATTE, A REPRESENTATIVE IN CONGRESS FROM VIRGINIA

Mr. GOODLATTE. Thank you, Mr. Chairman. I really appreciate your holding this hearing, and I am looking forward to hearing what all of our panelists have to say.

But I particularly want to welcome Dr. Karen Rheuban, who is a good friend and has been a great help to me and my constituents by helping to spread telemedicine to some of the most remote places and some of the most unlikely places, to help people in all different walks of life receive excellent health care and excellent advice from one of the finest university hospitals in the country, the University of Virginia.

So, Dr. Rheuban, welcome; and to all the panelists welcome. I am always interested in opportunities to mix my two great loves, technology and agriculture. So that is what we are doing here today.

The CHAIRMAN. Amen. Thank you, sir. And thank you again for being with us.

All right. I am pleased to introduce our first presenter starting off with the panel, from Cary, North Carolina, which is just outside of Raleigh. Jeff Spade is the Executive Director of the North Carolina Rural Health Center, a resource center supported by the North Carolina Hospital Association, whose mission is to provide and assist rural health providers in addressing local and regional health needs, and to foster innovation and improvements in rural health care delivery.

Mr. Spade, please begin.

STATEMENT OF JEFF SPADE, EXECUTIVE DIRECTOR, NORTH CAROLINA RURAL HEALTH CENTER; VICE PRESIDENT, NORTH CAROLINA HOSPITAL ASSOCIATION, CARY, NC

Mr. SPADE. Thank you, Chairman McIntyre and distinguished Members of this panel, Subcommittee in the House of Representatives. I am honored to be able to address you today. I appreciate the opportunity.

And especially Chairman McIntyre and Representative Hayes, who was here earlier, I am grateful for the work that you do on behalf of rural hospitals and North Carolina hospitals. Both of you have been very supportive.

And I really extend my gratitude to the Members of the Subcommittee for their vigorous support of rural health development.

I am the Executive Director of the Rural Health Center, as the Chairman mentioned, which is a resource in technical assistance there for rural hospitals, rural health organizations, communities in North Carolina. I am based at the Hospital Association in North Carolina, but I work at the front line of rural communities every day to help rural hospitals, rural health organizations and rural health leaders in addressing the needs of their residents.

As a matter of fact, I also have done some work on the Institute for Health Care Improvement campaign to improve care for five million lives. And, in that capacity, I have worked with hospitals in Colorado, Texas, Nebraska and Georgia as well. So, other members of this panel, I have been in your states and worked with the Critical Access Hospitals and rural hospitals there.

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

I have three priority improvements, requests of this Subcommittee and of Congress. First, I would like you to consider reconstituting the rural infrastructure grants and loans that were considered and introduced in the earlier versions of the farm bill. Second, we definitely need to improve Medicare and Medicaid policies and payment structures to support and accelerate the continuing development of hospital and health care services in rural communities. And, third, provide more incentives for Federal rural health programs to emphasize and promote alignment and collaboration amongst rural health care organization providers. Very similar to the alignment you are talking about at the Federal level, this needs to happen at the community level too.

In North Carolina, we have 61 rural counties served by 60 rural hospitals. We have 21 Critical Access Hospitals. I have had the opportunity to bring all of those 21 Critical Access Hospitals into existence. About ⅓ of our rural hospitals are Critical Access Hospitals, but in the country, more than half, almost 60 percent, of rural hospitals are Critical Access Hospitals. This is a very high number.

In North Carolina, rural hospitals cared for 243,000 inpatients, four million outpatients, 1.25 million emergency patients, 137,000 patients that receive outpatient surgery. So there is no doubt about the numbers for rural health care—millions of visits for urgent and emergent care and health care for hundreds of thousands of hospitalized and surgical patients. And in North Carolina, of our 61 rural counties, that is 2.8 million residents, a third of our total population. There are over 400,000 Medicare beneficiaries and 600,000 Medicaid beneficiaries residing in North Carolina.

A crucial aspect of rural hospitals is the role as catalyst for development of local access points for health care. Both primary and specialty physicians are very dependent upon our hospitals. And in North Carolina, 3,700 physicians practice in rural North Carolina. Many of these physicians' practices would not even be viable without the ability to diagnose, treat and care for patients at their local hospital.

But I do really want to focus on fiscal integrity and viability for our rural hospitals. They are highly dependent on Medicare and Medicaid reimbursement for sources of revenue, which counts for 63 percent of our hospital revenues in rural areas. This dependence presents very serious difficulties because government payers only reimburse hospitals at the financial break-even point or less.

And our rural hospitals also have an uninsured burden. In our case it is about nine percent. So you add that together, and the average rural North Carolina hospital receives two percent or more less in revenues than it costs to provide care for its patients.

The North Carolina Hospital Association has extensively studied the issue of financial viability and learned that the most financially vulnerable hospitals are those with the highest rates of Medicare, Medicaid and uninsured utilization. And in our case, 55 percent of our rural hospitals fall into this most vulnerable category simply because of serving government patients and the uninsured, while only 12 percent of our urban hospitals are similarly burdened.

But do not forget that we have this great economic catalyst in our communities in rural hospitals: $4.2 billion in economic output in North Carolina from rural hospitals, $1.8 billion in salaries and benefits, and employment of 42,200 rural hospital employees. In 75 percent of our rural counties, the hospital is amongst the top five largest employers in the county.

In summary, the major challenges facing rural hospitals are substantial: financial instability, ability to access critical investment for capital, increasing burden of chronic disease, and a rising number of uninsured. And we also need to continually improve the quality, efficiency and performance of our rural hospitals and health care organizations.

I can speak more to these issues as we move into our discussion. I appreciate this opportunity to address this Subcommittee. And I look forward to working with you further, as you look at how to increase the viability of rural health care across the United States.

Thank you very much, Chairman McIntyre, Members of the House of Representatives.

[The prepared statement of Mr. Spade follows:]

PREPARED STATEMENT OF JEFF SPADE, EXECUTIVE DIRECTOR, NORTH CAROLINA RURAL HEALTH CENTER; VICE PRESIDENT, NORTH CAROLINA HOSPITAL ASSOCIATION, CARY, NC

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

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

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

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

I have three priority improvements to request of this Subcommittee and Congress. First, restore the rural infrastructure grants that were considered and submitted in the early versions of the FY 2008/09 Farm Bill. Second, improve Medicare and Medicaid policies and payment structures to support the continued development of hospital and healthcare services in rural communities. And third, push for Federal rural health programs to emphasize and drive greater alignment and collaboration among rural health care organizations and providers.

North Carolina's rural healthcare system was initially organized around the concept of a hospital serving its home county. Passage of the Hospital Survey and Construction Act of 1946, better known as the Hill-Burton Act, began a proliferation of hospital construction in the poor, rural communities of America, places where no hospital or healthcare would have been possible before. As a consequence many rural communities throughout the country built their own local hospital. For North Carolina, community hospitals were founded in 72 of the state's 100 counties, thus establishing the leadership role that rural hospitals fulfill within their communities, even today.

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

The demographics of rural North Carolina are similar to many rural states. The population of North Carolina's 61 rural counties is estimated at 2.8 million residents, nearly a third of North Carolina's total population of 8.8 million. It is estimated that more than 412,000 Medicare beneficiaries and 627,000 Medicaid recipients reside in rural North Carolina, respectively accounting for 15% and 23% of the rural population. The challenges facing North Carolina's rural counties are proportional, that is North Carolina's rural population has higher s proportions or percentages, when compared to the state averages, of elderly, low income residents and those in poverty, minority residents, immigrants and uninsured residents, as well as higher rates of unemployment, chronic disease, health-related mortality, avoidable hospitalizations and the underlying determinants of health, such obesity, poor nutritional status, lack of exercise and physical activity and lower rates of educational attainment. In summary, the difficulties of providing healthcare in rural North Carolina are multiplied by the challenges of our rural demography.

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

Hospital in Scotland Neck became one of the first Critical Access Hospitals in the country.

North Carolina's version of a *network,* as defined by Jim Bernstein, is a patient-focused system of care consisting of private and public organizations that provide an array of medical and social services to the community. A successful rural network should include the local rural hospital, along with its tertiary care referral center, in a highly-integrated collaborative supported by community-based organizations such as public health, primary care, dental care, emergency medical services, social services, transportation, mental healthcare and long term care. The composition of a rural health network varies by community, but in communities across North Carolina rural health networks consistently deliver efficient, effective and coordinated quality health services to rural North Carolina residents.

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

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

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

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

Another crucial aspect of rural hospitals is their role as catalysts for the development of local access points for healthcare. Both primary care and specialty care physicians are dependent upon the local hospital for a range of health services, from outpatient and emergency care to complex inpatient care. Many rural communities would lack access to even basic healthcare services without the support of their local, rural hospital. Today, rural hospitals are highly involved in the recruitment and retention of critical healthcare providers such as physicians and nurses. More than half of North Carolina's rural counties are designated by the Federal Government as whole or partial healthcare professional shortage areas (HPSA). Since many rural North Carolina counties are considered HPSAs, the contribution of rural hospitals as the regional anchor for trained health professionals is paramount. More than 3,727 physicians practice in rural North Carolina counties. Many physician practices would not be viable without the ability to diagnose, treat and care for patients at a local hospital. Furthermore, over 19,800 registered nurses, 6,192 licensed practical nurses and 1,931 pharmacists practice in rural North Carolina. The healthcare services provided by these valuable, highly skilled health professionals are directly tied to the services anchored by rural hospitals.

A summary of rural hospital traits and characteristics would not be complete without mentioning that fiscal integrity and vulnerability are a constant concern for North Carolina's rural hospitals. As I highlighted earlier, by virtue of their location, rural hospitals serve proportionately more elderly, more poor, more uninsured and more disadvantaged patients than their urban counterparts. As a consequence, rural hospitals are highly dependent upon Medicare and Medicaid reimbursement for sources of revenue (63% of rural hospital revenues); some rural North Carolina hos-

pitals depend upon government payers for more than 70% of their revenues. This dependence presents serious difficulties because government payers only reimburse hospitals at the financial break-even point, or *less*. In addition, government payment sources can be unpredictable due to Federal and state budget constraints, leading to budget freezes, or even worse, budget cuts. Rural hospitals also have a substantial uncompensated care burden (8.8% of gross charges in 2007). As a result, in 2007 the average rural North Carolina hospital received 2.2% less revenue than it actually cost to provide patient care services—a situation that is untenable in the long run. The precarious fiscal situation of rural hospitals led to two North Carolina hospitals closing their doors and two other rural hospitals to declare bankruptcy.

Rural hospital financing of Critical Access Hospitals is worthy of special mention. A CAH is a small, rural hospital with 25 acute beds or less. North Carolina has 21 CAHs, soon to be 22 CAHs, ⅓ of North Carolina's rural hospitals. Nationally more than 60% of rural hospitals are officially designated as Critical Access Hospitals. The CAH program is designed to help small, rural hospitals manage the detrimental impact of fixed-payment government reimbursements upon their hospital finances. In North Carolina, CAHs are reimbursed their inpatient and outpatient costs for providing services to Medicare and Medicaid beneficiaries. The CAH program has had a stabilizing effect on small, rural hospital finances. However, CAH reimbursement does not address the fiscal burdens of caring for uninsured patients, nor does it provide an adequate level of reimbursement for investments in renovations and upgrades to buildings, capital equipment and medical technology, or to establish new health services. As a consequence, the financial picture for North Carolina's CAHs has improved but many small, rural hospitals, including CAHs, still face the perils of substantial operational losses and fiscal vulnerability.

Looking beyond healthcare and into the realm of economic development, rural hospitals are vital to the economic health of the community. Rural economic development and the viability and sustainability of rural hospitals are closely linked. Employers in rural communities frequently cite the availability of local healthcare services as a determining factor in business development. Less well known, however, is the contribution of rural hospitals to the economic vitality of rural communities. For the purpose of economic investment, North Carolina categorizes all counties into three economic development tiers. The economically challenged counties are in Tier 1 and Tier 2, with the economically advantaged counties in Tier 3. Of the forty-one counties in the most economically disadvantaged category (Tier 1), thirty-three of the counties are rural. Furthermore, these thirty-three economically disadvantaged rural counties are served by 28 rural hospitals. The importance of rural hospitals as an economic engine is best understood by examining some revealing statistics from 2003 (see *Table 2*). North Carolina's rural hospitals accounted for an estimated $4.21 billion in economic output and $1.79 billion in salaries and benefits paid to an estimated 48,219 rural hospital-related employees in 2003. Overall, rural health in North Carolina generated an estimated $11.6 billion in economic output and $4.9 billion in salaries and benefits paid to an estimated 165,029 rural workers in healthcare-related businesses. In 75% of North Carolina's rural counties, the hospital is among the top five leading employers in the county. The evidence is simple and straightforward; rural hospitals contribute billions of dollars in local and regional economic value and bring tens of thousands of jobs to rural North Carolina economies and communities year after year.

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

In summary, the major challenges facing our rural hospitals are substantial: financial instability, mostly due to dependence on government payers and a lack of commercially insured residents; the inability to access critically needed investment capital for medical technology, health information systems and electronic medical records, for facility renovations and replacements and the development of medical and clinical services; the increasing burden of chronic disease and the rising numbers of uninsured; the withering effects and expense of substantial and chronic workforce shortages (both physician and allied health); and the absolutely vital need for consultation and assistance to continually improve the quality, efficiency and performance of our rural hospitals and healthcare organizations.

I congratulate the House Agriculture Committee and confirm that the USDA rural health and development programs are meeting a definite need, however more support and funding are required to stabilize and improve our rural healthcare systems. The rural hospital loan programs initially supported in this year's Farm bill were

a step in the right direction—to offer a package of grants and low-cost loans for advanced medical technology, for quality and patient safety upgrades and for investments in small rural hospital facilities and renovations. At a minimum, please restore the health information technology and infrastructure grants as initially introduced in the farm bill.

A second priority for North Carolina rural hospitals is directly related to Medicare and Medicaid policy and payment, since these payment programs are absolutely vital to the continued existence of rural hospitals. These issues for Medicare and Medicaid include a fair and equitable payment structure by CMS for rural hospitals; continued maintenance and support of the certified public expenditure program to fund state Medicaid services to low income rural residents; giving rural hospitals and CAHs strong opportunities for success in the new pay-for-performance system; and protecting and improving the Critical Access Hospital program by increasing CAH reimbursement to 103% of cost, expanding the bed size for eligible CAHs to 50 beds or less, and allowing CAHs to participate in the Federal 340B drug program.

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

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

TABLE 1
Averages for North Carolina Hospitals
2007

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

Source: NCHA Data Initiative, FY 2007 survey

Economic Benefit of Rural
North Carolina Hospitals & Healthcare
2003

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

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

The CHAIRMAN. Thank you, Mr. Spade.

Mr. Fluharty?

STATEMENT OF CHARLES W. FLUHARTY, FOUNDER, PRESIDENT EMERITUS, AND DIRECTOR OF POLICY PROGRAMS AND RESEARCH PROFESSOR, RURAL POLICY RESEARCH INSTITUTE, HARRY S TRUMAN SCHOOL OF PUBLIC AFFAIRS, UNIVERSITY OF MISSOURI-COLUMBIA, COLUMBIA, MO

Mr. FLUHARTY. Thank you, Mr. Chairman. It is an honor to be with you again. And I would ask my full statement be placed in the record.

The CHAIRMAN. Yes, sir.

Mr. FLUHARTY. I would just like to make a few comments. I want to commend you for talking about rural development. As everyone on the Committee knows, it is the first or second most critical economic sector in every rural community. And I really commend you for starting to think about that framework within this Rural Development Committee. I thank you for that. It is critical.

Just several observations, as the hour is late.

This USDA RD interaction with HHS is emergent, but it is a really stellar example of what future rural policy for our Federal system needs to look like.

When I was in front of this Committee last year in March, when you were looking at the RD title, I laid out two or three things that we in RUPRI feel are essential if we are going to move to a globally competitive rural development policy. Two of those were thinking about greater attention to diverse regional actions and, second, thinking about how various Federal, state and local departments work together.

We in the RUPRI rural health panel, which, as you know, has worked with the caucus for 15 years, have been honored to think about this with the Congress over time. And so I just would like to offer some thoughts about how this Committee might move forward on this agenda you are clearly leading.

A couple of things have to happen, it seems to us. The first is the Committee needs to think more about viewing Federal expenditures as an investment. And the *quid pro quo* for that investment needs to be stronger attention to return on investment and some sense of longer-term benefits. Second, thinking about how we drive synergy in those investments so that the whole is greater than the sum of the parts in the Federal Government.

Now, this emergent USDA–HHS interaction is really exciting. It is an example of what we think could move forward. I just would encourage you to continue that, because it is complementarity that we are seeking.

As you know, HHS has small grants programs, technical assistance, balanced scorecard, the outreach grants. But USDA RD has a huge capital investment opportunity, and linking those two in a rational way is a truly unique opportunity to move forward.

The question you have to ask, how can we do this better and how can we do it more? And what can this Committee do to support the other committees of jurisdiction?

I just offer one possibility from our perspective, and that is a lot stronger evaluative framework that improves the scope of the USDA rural health policy investments.

We are probably unique in this regard in RUPRI. Two programs were mentioned here earlier: SEBAS, the evaluative program at USDA, and the Rural Access Center at North Dakota. We are honored to be strong partners in both of those. So we have a unique orientation as to how these two Committees might work better together. So just a couple of suggestions for the Committee, if I could.

First of all, if you look at greater FLEX program authority, which may come on the other side, and we think about Critical Access Hospitals maybe being able to convert to assisted living, skilled nursing—you combine that with the fact that Medicare in 2011 is going to have a mandatory e-prescribing. So when you think about the infrastructure grants USDA is publicly able to make, including public reporting, we should be thinking about RD investments in infrastructure as much as bricks and mortar.

And there are really three issues in the continuum of care: time, appropriateness of care, and where it occurs. And ORHP is looking at all that. And I really think that if we think a bit more about population health and appropriateness in terms of investment, this Committee could really help a great deal in building the linkage with ORHP.

Just in closing, I want to applaud you again for this. I do believe if we think about a regional rural innovation system, the health care sector, the sector that you are talking to, has gone far further than any other sector in building that integration. But USDA RD has an absolutely unique ability to build the information infrastructure systems that are going to be essential for wiser economic choices in the future. And I commend you for starting to think about that, Mr. Chairman.

Thank you.

[The prepared statement of Mr. Fluharty follows:]

PREPARED STATEMENT OF CHARLES W. FLUHARTY, FOUNDER, PRESIDENT EMERITUS, AND DIRECTOR OF POLICY PROGRAMS AND RESEARCH PROFESSOR, RURAL POLICY RESEARCH INSTITUTE, HARRY S TRUMAN SCHOOL OF PUBLIC AFFAIRS, UNIVERSITY OF MISSOURI-COLUMBIA, COLUMBIA, MO

Chairman McIntyre, Ranking Member Musgrave, and Members of the Subcommittee, it is an honor to appear before you again. I applaud your leadership in assuring that the rural development concerns addressed under the purview of this Subcommittee include attention to rural health care. As you know, quality health care that is equitable, affordable, and accessible is one of the most critical components in the continuing viability of our nation's rural regions.

I am Charles W. Fluharty, Director of Policy Programs for the Rural Policy Research Institute, and a Research Professor in the Harry S Truman School of Public Affairs at the University of Missouri-Columbia. RUPRI is a multi-state, interdisciplinary policy research consortium jointly sponsored by Iowa State University, the University of Missouri, and the University of Nebraska.

RUPRI conducts research and facilitates dialogue designed to assist policy makers in understanding the rural impacts of public policies. Continual service is currently provided to Congressional Members and staff, Executive Branch agencies, state legislators and executive agencies, county and municipal officials, community and farm groups, and rural researchers. Collaborative research relationships also exist with numerous institutions, organizations and individual scientists worldwide. Since RUPRI's founding in 1990, over 250 scholars representing 16 different disciplines in 100 universities, all U.S. states and 25 other nations have participated in RUPRI projects, which address the full range of policy and program dynamics affecting

rural people and places. Collaborations with the OECD, the EU, the German Marshall Fund, the Inter-American Institute for Cooperation on Agriculture, the International Rural Network and other international organizations are framing RUPRI's comparative rural policy foci.

As this Committee begins consideration of the future design of USDA organizational structure and program delivery, it is important to note that we also anticipate a renewed discussion of more systemic change in health policy in the next session of Congress. I would hope that this Committee and USDA Rural Development will also engage those discussions, as you represent a very critical building block in sustaining a viable rural health system.

The Rural Policy Research Institute established the RUPRI Rural Health Panel in 1993 to provide science-based, objective policy analysis to Federal policy makers. While panel members are drawn from a variety of academic disciplines and bring varied experiences to the analytic enterprise, panel documents reflect the consensus judgment of all panelists.

This panel, comprised of many of our nation's leading rural health researchers, has advocated since its inception that Federal, state, and local public sector decision makers create innovative investment approaches which unite multiple funding streams to ensure local sustainability. For this to be accomplished, two major shifts must occur. First, we must consider public sector expenditures to be investments, designed to force local grant and loan recipients to demonstrate long-term benefit. Second, this process must also create synergy across investment streams, so that the whole of these investments is greater than the sum of their parts. Today, in most developed nations, these principles are driving rural regional innovation approaches, across all public sector policy and program design.

In discussing this global rethinking before this Subcommittee last spring, during your consideration of the farm bill rural title, I offered the following rationale for such an approach:

> *". . . The promise of such a Regional Rural Innovation Policy is premised upon the following realities:*
>
> *1. National competitiveness is increasingly determined by the summative impact of diverse regional actions, capturing asset-based competitive advantage.*
>
> *2. Support for such an approach will require a substantive rethinking of core missions across Federal departments, state agencies, and regional and local governments, and a commitment to leadership renaissance within these institutions and organizations.*
>
> *3. Funding support for these place-based policies are WTO greenbox compliant, non-trade distorting funding opportunities for the Federal Government.*
>
> *4. Finally, such a commitment improves the potential for Congressional Agriculture Committees to retain existing funding baselines, and for these Committees to retain statutory responsibility for rural development policy . . ."*

Nothing has changed since to alter my perspective. In fact, most OECD nations are now moving to align policies and programs with this new rural paradigm.

We all recognize the importance and challenge of rural health care delivery, but this paradigm offers a very specific framework for how this Committee might approach its work in this regard, to ensure the emerging cooperation between USDA Rural Development and HHS/Office of Rural Health Policy is supported and enhanced. Other panelists will no doubt speak to other specifics within the health sector. I would like to limit my comments to the very real opportunities which exist to better align and target USDA investments in rural health care, to complement and expand HHS/ORHP programs and facilitate even greater inter-agency alignment.

We are pleased these efforts are already underway, and commend the leadership of both agencies for these innovative developments. In this regard, we are perhaps uniquely positioned to comment, since RUPRI receives significant policy research support from both agencies, and works across the entire Federal portfolio to assist decision-support in both rural development and rural health care delivery and finance.

We were very encouraged by the possibility for expanded RD rural health program support within the rural development title of the new farm bill, and were very disappointed that these new mandatory commitments were not included in the final legislation. However, as these programs were under consideration by the Senate Committee on Agriculture, Nutrition, and Forestry, our rural health panel was asked to assist USDA RD Community Facilities program staff in exploring a new grant and/or loan framework which could be utilized in implementing this expanded

authority, should it be enacted into law. While this outcome did not materialize, recommendations of our panel could also be applied to existing RD rural health programs, and could inform future approaches which better integrate USDA RD and HHS/ORHP investments.

I have summarized our recommendations below, and included the full working document developed by our panel for USDA RD at the conclusion of this testimony. Any major policy shift should ensure that core health services are available locally, that they are integrated into services outside the local area, and that this is done in a manner consistent with science-based evidence, to ensure results which both improve the quality of life for residents and better health quality integration, across rural geography. USDA investments in rural health care have implications beyond the bricks and mortar of individual facilities; they are part of a mosaic readying the rural areas of our nation to be fully advantaged by systemic improvements in health care delivery and finance.

Specifically, future USDA Rural Development investments in rural health care should be framed around these considerations:

I. *Access to Affordable Care.* USDA loan and loan guarantee programs sustain the presence of hospitals in rural areas, enabling rural residents to receive essential hospital services locally.

II. *Value of Health Care.* As in urban areas, health care value must be measured in relationship to health care costs. USDA Rural Development programs should use this goal as one criterion in assessing applications for loans and loan guarantees. These return-on-investment considerations ensure that program investments are assessing economic realities, while helping to create the infrastructure needed to advance the more ambitious goal of system improvement.

III. *Choice Considerations Apply to Both Providers and Treatment Options.* The effective exercise of choice assumes information is available to compare alternatives. USDA RD facility investments are assisting in the development of these information systems. Significant additional work should be done in this area.

IV. *Capacity Must Exist in Systems of Care.* Beyond affordability, we must ensure that systems of care exist to address the rural health needs of a region. One critical element to assure this outcome is adequate consideration of rural interests in any resource allocation within the sector. USDA, as a long-standing spokesperson for rural interests, advances this goal by collaborating with other agencies, especially HHS, to use its investments in combination with rural program spending within those agencies.

V. *High Quality Health Care is Delivered Through Coordinated Care.* In the enclosed document, the RUPRI Health Panel recommends that USDA consider targeted investments (through a priority-setting scheme) in rural institutions with ties to larger geographic systems of care (formal or informal). USDA investments could create incentives to leverage interest in building information systems and relationships necessary to better coordinate patient care across providers not practicing in the same large groups or even the same localities. This is one of the most promising potentialities within a USDA/HHS collaboration, and should be specifically pursued in an interagency agreement.

VI. *A Redesigned System Elevates the Health of Populations.* Public health services are essential in all local areas, including rural regions. USDA programs supporting local infrastructure can and should require applicants to demonstrate linkages to local public health agencies. Examples can include sharing information to help identify local health issues (*e.g.,* hospital admissions for asthma in children), programs the loan or loan guarantee institutions support (*e.g.,* special wellness programs using hospital facilities and hospital-employed nutrition and health counselors), and organizational participation in regional efforts designed to improve the health of the public (*e.g.,* comprehensive community-based programs targeting important goals, such as obesity reduction).

These recommendations are more fully addressed within the following document. I hope they are helpful to this Subcommittee, and I thank you, again, Mr. Chairman and Members of the Subcommittee, for the opportunity to testify before you today. Your continuing leadership in crafting a twenty-first century rural policy is critical, and we look forward to working with you in the future. I'll be pleased to answer any questions you have.

ATTACHMENT 1

RUPRI Health Panel
Keith J. Mueller, Ph.D., Chair
www.rupri.org/ruralhealth • (402) 559-5260 • kmueller@unmc.edu

March 2008

Implementing A New USDA Rural Development Program Targeting Small Rural Hospitals and Their Communities

Recommendations of the RUPRI Health Panel: Andrew F. Coburn, A. Clinton MacKinney, Timothy D. McBride, Keith J. Mueller, Rebecca T. Slifkin, and Mary K. Wakefield

The RUPRI Health Panel was asked to offer recommendations for implementing a new USDA Rural Development program, included in the Senate Farm Bill proposal, should it be enacted into law. The goal of this program is to strengthen rural health care delivery systems, to provide necessary health care services to rural residents in a cost-effective manner. We believe this goal is best accomplished through a comprehensive, coordinated approach that fosters community-based efforts to promote health and wellness, in addition to innovative programming designed to improve quality of services. These recommendations can also be used to inform other programs already managed by the USDA, such as the Community Facilities Program.

Eligibility

- Small rural hospitals that are capable of repaying loans

Criteria to Assess Proposals

Context

The Panel recognizes that the USDA must assess the financial feasibility of the proposed projects for which loans would be made. We recommend that the criteria and process for this assessment allow for flexibility to offer loans to some rural hospitals that might be excluded from commercial markets, because of considerations related to their business environment and management, even though their current financial condition may be solid. This is especially true for hospitals that have a compelling need for investment to secure their future, because they are the sole provider of acute care health services for a large geographic area or for populations that traditionally lack access to the health system (e.g., the uninsured, ethnic and racial minorities).

Some portion of available funds should be explicitly dedicated to supporting those hospitals excluded from commercial markets that can provide evidence of ability to repay loans, based on reasonable assumptions of how the capital investment will improve financial performance (e.g., increase market share or improve efficiency). To help the USDA with these determinations, we recommend consulting with rural health services research centers funded by the Office of Rural Health Policy that have analyzed the financial condition of Critical Access Hospitals.

Program Goal and Related Criteria

The Panel believes that beyond assisting individual hospitals with their capital needs, this loan program also can help strengthen rural health care delivery systems and thereby assure the sustainability of necessary and cost-effective health care services to rural residents. To this end, we suggest priority for loan assistance be given to hospitals that propose capital projects which:

1. Meet a documented need for health service improvement or new services in the hospital's service area,
2. Promote the involvement of other health care providers that serve the same population, in an integrated approach to service delivery,
3. Coordinate with other USDA-funded activity in the region evident in the state strategic plan as submitted by USDA Rural Development state directors, such as loans and loan guarantees for community facilities and possible linkages with the Extension Service, where the latter has health-related activity relevant to the applicant's population,
4. Coordinate with other federal- and state-supported projects to improve rural health care delivery infrastructure,
5. Have a strategy to sustain any service(s) initiated with these funds.

Elements of a Proposal

In order to judge applications based on the above criteria, the Panel suggests that the funding announcement request the following information, both current data and projections for the next five years:

1. A demonstration of a need for health service improvement or new services through capital investment that is responsive to quantifiable community need by:
   - Demonstrating the need for services or service improvement based on available demographic data and a community assessment,
   - Identifying any population groups (such as the elderly, recent migrant groups, low income, disabled, etc.) whose special needs would be met by the capital investment,
   - Incorporating population health data,
   - Identifying other community assets that can be used to help meet needs, including those of the hospital,
   - Demonstrating how local sectors can work together to meet the needs of particular populations, e.g., meeting the needs of the elderly with a coordinated approach that links housing with health care.

2. A description of the involvement and commitment of other health care service providers where appropriate, as evidenced by:
   - Identifying the hospital market area for the capital improvement-supported services, including an assessment of whether the applicant is the primary source of the services (e.g., more than 70% of the market share) or whether there is market area overlap with other small rural hospitals,

- Demonstrating collaboration with other small rural hospitals (through specific signed agreements) where there is overlap in hospital market areas,
- Including memoranda of understanding with any providers involved in providing local services to the population(s) being targeted with this intervention, including private physicians, long-term care facilities, home health agencies, emergency medical service providers, assisted living, special health services (e.g., for those needing assistance with activities of daily living),
- Identifying linkages to services provided to target populations by providers located outside the rural community,
- Including services other than acute care in plans to meet community need, such as assisted living, independent living, and community-based social services,
- Explaining how the investment would improve the coordination of health care services in the community, including improvement in coordination of care across the continuum of care (for example, with providers who are outside the immediate service area but provide important services that are locally unavailable).

3. A description of how the project would coordinate with other USDA-supported entities, as evidenced by:
   - Presenting an inventory of relevant USDA projects in the region obtained from the USDA Rural Development state director and other state and local offices participating in USDA programs,
   - Including an analysis of potential interaction with those projects.

4. A description of how the project would coordinate with other federal- and state-supported projects focused on rural health care delivery, including:
   - Coordinating with programs monitored by the state office of rural health,
   - Coordinating with any programs sponsored by the Federal Office of Rural Health Policy,
   - Coordinating with any projects supported by other federal agencies, such as telehealth projects.

5. A demonstration of the sustainability of changes induced by the capital project. Elements to be included in this section depend on the type of project proposed, but might include the following:
   - Ability to meet operating expenses of new or improved facilities and/or services,
   - Evidence of a replacement plan, where appropriate,
   - Ability to secure necessary technical support, whether through direct hiring of staff or through contracts,
   - For HIT proposals, evidence of a business plan that (1) projects the impact on revenue or changes in efficiency, both in the implementation phase and over the long term; (2) describes practice improvements to encourage continued use; and (3) identifies methods for continuous technical support of the system,
   - Incorporation of expected changes in population and demographics (including growth or decline in numbers of residents) in a plan for sustainability,
   - Evidence of a proposed action plan.

Evaluation

The Panel recommends that USDA require each application to include an evaluation plan. This evaluation should assess how well the funded project has strengthened the rural health care delivery system and improved the quality and efficiency of health care services provided to rural residents. Furthermore, when evaluating return on investment, USDA should evaluate not only financial parameters (loan repayment), but also quality, access, and service parameters. Potential parameters for evaluation include:

- Service line expansion and/or new service line development,
- Health care delivery efficiency,
- Health care quality and patient safety,
- Access to health care services,
- Collaboration activity,
- Impact across the care continuum,
- Completion of goals identified in the original application.

RUPRI Health Panel

Andrew F. Coburn, Ph.D., is a professor of Health Policy and Management, directs the Institute for Health Policy in the Muskie School of Public Service at the University of Southern Maine, and is a senior investigator in the Maine Rural Health Research Center.

A. Clinton MacKinney, M.D., M.S., is a board-certified family physician delivering emergency medicine services in rural Minnesota; a senior consultant for Stroudwater Associates, a rural hospital consulting firm; and a contract researcher for the RUPRI Center for Rural Health Policy Analysis at the University of Nebraska Medical Center.

Timothy D. McBride, Ph.D., is a professor of Health Management and Policy in the School of Public Health at St. Louis University.

Keith J. Mueller, Ph.D., is the Rural Health Panel chair, associate dean of the College of Public Health at the University of Nebraska Medical Center, a professor of Health Services Research and Administration, and director of both the Nebraska Center for Rural Health Research and the RUPRI Center for Rural Health Policy Analysis.

Rebecca T. Slifkin, Ph.D., is director of the North Carolina Rural Health Research and Policy Analysis Center, director of the Program on Health Care Economics and Finance at the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, and a research associate professor in the Department of Social Medicine in the University of North Carolina Medical School.

Mary K. Wakefield, Ph.D., R.N., is a professor, director of the Center for Rural Health at the University of North Dakota, and deputy director of the Upper Midwest Rural Health Research Center.

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ATTACHMENT 2

MRP Rural Community & Economic Convergence Meeting

Minnesota Rural Partners, Inc.

Back to our pioneer roots: Entrepreneurship as a rural development framing strategy

Minnesota Rural Partners, Inc.
2002-2003 Proposed Workplan
and Rural Development Strategy

Minnesota Rural Partners, Inc.

Why you are here

- Follow-up to VEN press conference & Vital Economy presentation July 10
- Rural Development policy in flux, chance to brainstorm -- we are partners in rural development
- Background and update
  - *Setting the stage*
  - *MRP, Inc. overview*
  - *Framework, strategy and goals for state rural development*
  - *Projects – business, education and community together*
- Scrutiny and feedback
- Sharing ideas, activities update
- Moving forward together for rural development
  - *Follow-up actions, meetings, communication*

Minnesota Rural Partners, Inc.

Who we are

- MRP - State Rural Development Council since 1995
  - *Approx 40 nationwide – federal state partnership – limited funds from feds*
  - *Connector for rural development*
- MRP, Inc. - Non-profit organization since 1998
  - *Raise operations and program funds*
  - *Support work of partnership*
  - *Create and implement projects*

Minnesota Rural Partners, Inc.

Our Vision & Initiatives

Recognized as one of the most effective rural development councils in the country Minnesota Rural Partners (MRP) is in a unique position to impact rural initiatives. Over the past seven years MRP has built substantive networks and programs around key rural issues in Minnesota and regionally. MRP has the extensive and specialized experience, resources and know-how to bridge the gap between rural policy, practice and reality on local, state and national levels. MRP's current agenda makes vital connections for rural development through five major issue areas.

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Guiding Agenda for MRP

- **Closing the Digital Divide**
  Create the environment and infrastructure that creates functionally and technically literate rural communities and residents.
- **Energizing Rural Entrepreneurs**
  Energize civic, social and business entrepreneurs through policy change, education and training, and connections to resources.
- **Building the New Agriculture**
  Support for rural growers by facilitating strong statewide rural/urban connections to increase return on agricultural effort through value-added opportunity.
- **Boosting Human Capital**
  Tightly coordinated education and enterprise networks to lift rural skill levels and provide economic opportunities that will attract and retain rural workers.
- **Sustaining the Rural Environment**
  Enhance the quality of life in rural areas without threatening the physical environment; a challenge for current rural residents and policy makers.

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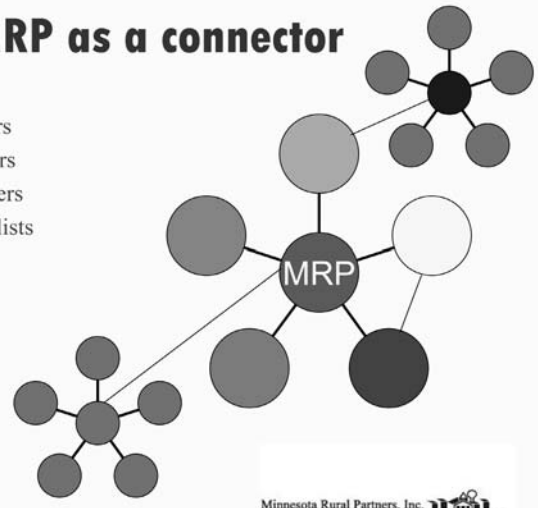
MRP as a connector

- Central connectors
- Boundary spanners
- Information brokers
- Peripheral specialists



Harvard Business Review,
June 2002

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MRP active projects

- Virtual Entrepreneurial Network
- Rural Policy Forum
- Efoliomn
- Rural Summit
- Federal rural development monitoring

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MRP workplan goals

- Help Rural Minnesota:
  - *re-engage ingenuity*
  - *optimize 21st century tools and opportunities to build and sustain healthy community*
  - *stay ahead of the pack.*

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Minnesota Rural Development Strategy

- Use community and economic entrepreneurship as the rural development framing strategy – be enterprising in our attitude and actions
  - *Build on the convergence of business and education tools available through 21st century technology*
  - *Re-invigorate and recognize Minnesota ingenuity to inspire widespread entrepreneurial leadership for the rural economy and community spirit*
  - *Recognize and reinforce the unique role of very small businesses and their advantages using the tools of our age*
  - *Create localized and statewide entrepreneurial business climate and entrepreneurial community culture*

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Define Entrepreneur

- Entrepreneur – a person who organizes and manages a business undertaking, assuming the risk for the sake of the profit, and in this project, for the sake of strengthening rural communities, too.
- Enterprise: 1. An undertaking. 2. A bold, hard, dangerous, or important undertaking…3. Willingness to venture on such undertakings; readiness to take risks or try something untried; energy and initiative.

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Why should we care? current situation in rural America

- RUPRI – the case for a rural policy "tipping point"
  - *The Farm Bill process and outcome*
  - *A growing understanding of the true rural economy*
    - 0.39% of US population engaged in farming as primary occupation
    - Only 1.78% of the *US rural population* is engaged in farming as primary occupation
  - *The new Census and its implications*
  - *Redistricting & the next two electoral cycles*

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Why should we care?
We must reverse the decline.

- We have had the ability but not the will
- We have had the opportunities and the means and squandered them
- We have fragmented efforts; it's time to pull together behind a united front before the opportunities close for good
- We must invent and implement our vision for this century, based on our ingenuity and the tools available to us

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Opportunities are everywhere

- Conditions are ripe for entrepreneurial renaissance in the small and emerging business – Owen Study, Vanderbilt, 2000
  - *Technology empowerment*
  - *Democratization of capital*
  - *Flowering of diversity*

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Opportunities are everywhere thanks to convergence

- Lexus and the Olive Tree – Thomas Friedman 2000
  - *Convergence of the Lexus(technology/markets) and the Olive Tree (relationships, traditions/culture)*
    - Change in how we communicate – democratization of technology – computing, miniaturization, compression, digitization
    - Change in how we invest - democratization of finance
    - Change in how we look at the world – democratization of information
    - Democratization of decisionmaking

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Opportunities are everywhere thanks to convergence

- Lowered barriers of entry to create a business – still tough, but you can do it overnight thanks to technology
- But we haven't created a viable organizing system to support this opportunity, especially for rural – a superstory framework based on a new set of criteria
  - *Super empowered individuals*
  - *States*
  - *Super Markets*

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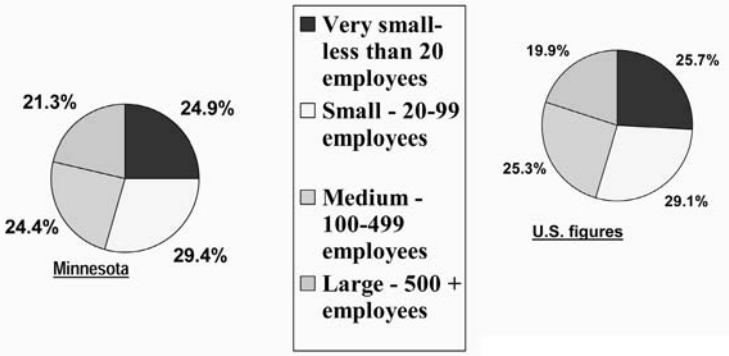
Distribution of MN Employment by Business Size, 1995 - Compared to U.S.



MN Department of Trade & Economic Development, Compare Minnesota report, 2001

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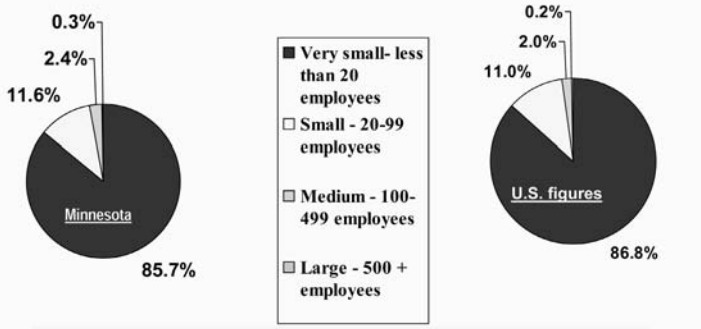
Distribution of MN Establishments by Business Size, 1995 - Compared to U.S.



This is the opportunity…….strengthening small business and thereby strengthening community

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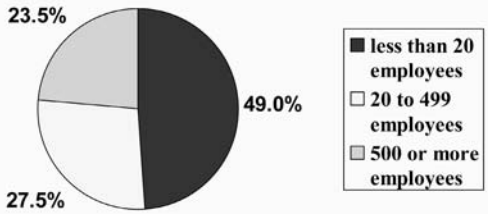
Share of Net New Jobs by Employment Size of Firm 1990-1995



Small businesses have historically been the generators of the bulk of the new jobs in the U.S. economy.

U.S. Small Business Administration, *The Third Millennium: Small Business & Entrepreneurship in the 21st Century, 2000*

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Why Entrepreneurs and Entrepreneurial Communities?

- America is beginning to falter because of declining investments in innovation - *Michael Porter, The Competitive Advantage of Nations*
- Without the right culture there is no economic improvement, no constant striving for comparative advantage - *Davis Landes, The Wealth and Poverty of Nations*
- Which rural areas were winners? The winners formed clusters -- *Mark Drabenstott, Finding Rural Success: The New Rural Economic Landscape*

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Review of development literature

- Communities and firms without competitive advantage will not prosper -- they lapse into decline or subsistence
- Those that prosper constantly invest in creating new competitive advantage, rather than protecting old advantage
- Risk-taking entrepreneurs are key to seeking new competitive advantage
- Economic improvement and growth are not enough to sustain communities - social & human capital, too

-Karl Stauber, Northwest Area Foundation - "Why Invest in Rural America - And How? A Critical Public Policy Question for the 21st Century"

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Attributes of Successful, Entrepreneurial Communities

- community controversy is accepted
- schools have a major focus on academics, not sports
- local people have combined enough financial resources to support joint risk taking
- people are willing to invest financial surplus in local private enterprises
- people tax themselves to support local infrastructure
- community is defined broadly and inclusive -- rather than competition among smaller units
- adequate local social capital to direct resources, particularly information, to the community
- leadership is dispersed and flexible

-Cornelia and Jan Flora, Iowa State University, Ames, Iowa

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Eight Critical Community Factors

- recruitment and entrepreneurship
- manufacturing and services
- progressive firms
- ongoing local economic development efforts
- pro-growth attitude
- finances and infrastructure
- local leadership
- support from outside the community

-*A Brighter Future for Rural America* - DeWitt John, Sandra Batie, Kim Norris

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Lead, follow, help, or get out of the way

- MRP, Inc. is using entrepreneurship as a rural development framing strategy/organizing system. This is the superstory Friedman talks about
- We are proposing a *State Rural Development Strategy* centered on entrepreneurship
- Outcomes: an entrepreneurial business climate and enterprising community culture (public, private, non-profit – attitude & action)

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How? Look to the wisdom and the tools MN Rural Entrepreneurship Academy Report 2000

- Capital
  - *Inventory, assessment, analysis, promotion of opportunities by biz stage – Vital Capital Portal*
- Technical Assistance & Physical Infrastructure
  - *Bizpathways – organizing tool for service providers, biz dev acceleration for entrepreneurs – take the mystery out, at the same time encourage use of broadband by raising awareness of its applications (ex. VEN and efoliomn)*
- Education
  - *Efoliomn to take control of your education (lifelong learning) and career (workforce) accomplishments and goals*
- Community Culture
  - *Rural Policy Forum --- Organizing principles for communities based on re-engagement with entrepreneurship as a guiding American strategy – Vital Economy framework*
  - *Public, private, civic and social entrepreneurial leadership*
  - *Physical design strategies to encourage community entrepreneurship*

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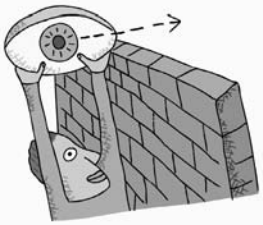
Obstacles are those frightful things you see when you take your eyes off the goal.

- Henry Ford



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MN Rural Entrepreneurship Academy - October, 2000

We define "entrepreneur" as "an individual who has created economic value by starting a small business venture." Of course, these small ventures may grow over time; and we see the distinction between "entrepreneur" and "small business owner" as defined in Minnesota as increasingly moot.

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Academy Findings

- Capital
- Technical Assistance
- Physical Infrastructure
- Culture & Education

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Capital & Technical Assistance

- Help financing business
- Match business with communities
- Public/private partnerships
- Economic/demographic/industry information
- Access to business services

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Physical Infrastructure

- Access to High Speed Internet
- Telecommunications services comparable to urban
- Technology to support community infrastructure
- Reduce cost of technology

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Entrepreneurial Culture & Education

- "Culture change" - lack of support for entrepreneurial spirit
- Isolation from peer group
- Need access to professional infrastructure, advisors
- Education to meet high-tech demands

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Tools for the Entrepreneurial Strategy

- Capital
  - *Vital Economy Capital*
- Technical Assistance & Infrastructure
  - *VEN & bizpathways.org*
- Lifelong Learning and Workforce Development
  - *efoliomn*
- Community Culture
  - *Rural Policy Forum & Vital Economy process*

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Capital - change in how we invest - democratization of finance -

- Need:
  - *demystify capital access process*
- Action:
  - *inventory & promote available sources via online portal; build and promote structures for community members to invest in their own communities/businesses*
- Responsibility:
  - *Applicable state agencies, banking community, other funders, business resource providers, economic & community development organizations*

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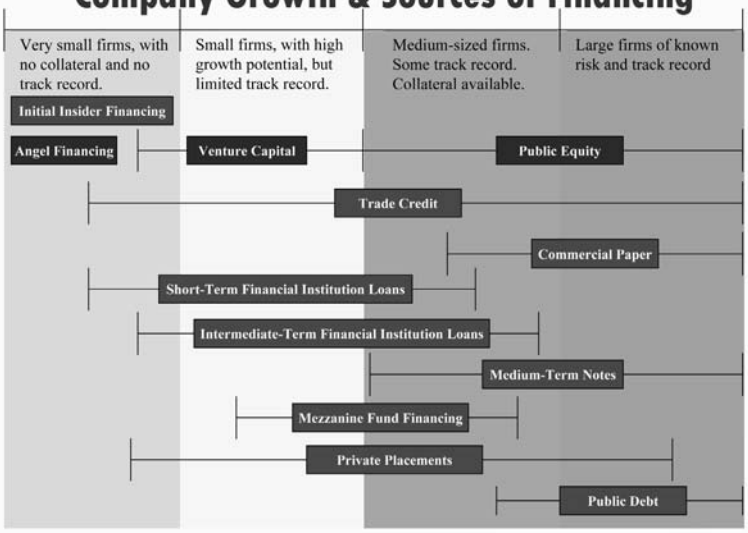
Company Growth & Sources of Financing



Financing Your ViTAL Economy Plan

Why Vi Finance ?

- Create a launch pad for accelerated growth
- Offer business a seamless financing system
- Build the capacity to retain growing firms
- Create a collaborative financing community
- Reduce risk & increase investment leverage
- Access national resources for local gain
- Develop local capacity to sustain growth
- Break down the finance wall that inhibits growth

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Technical Assistance & Infrastructure
- change in how we communicate -

democratization of technology
computing, miniaturization, compression, digitization

- Need:
  - *–Organize and target resources for businesses and communities using knowledge management tools and enterprise portals*
- Action:
  - *–Stock bizpathways shelves with existing resources, tools, events; promote availability at workforce, business and community entry points – Secy of State's office, workforce centers, etc.*
- Responsibility:
  - *–MRP, Inc. , state agencies and local business resource providers*

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"Starting and growing a business anywhere is fraught with well-documented perils. These are compounded in rural America."

-Brian Dobson, President, Corporation for Enterprise Development (as quoted in the 2001 Annual Report, Center for the Study of Rural America, Kansas City Federal Reserve Bank)

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Virtual Entrepreneurial Network (VEN)

MINNESOTA RURAL PARTNERS

OUR PARTNERS

Agiliti

MINNESOTA Trade & Economic Development

VeZone

NORTHERN TIER High Technology Corridor

Community Technology Advisors

EWING MARION KAUFFMAN FOUNDATION

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What is the Virtual Entrepreneurial Network?

Caution: Under Construction

- It is an online information system (bizpathways.org) and community organizing framework (Entrepreneurial Community Clusters).
- It is designed to help people, existing resources, and communities connect more effectively to support entrepreneurship at local, regional and state levels.

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VEN Project Components

- bizpathways.org: a website with advanced technology tools to assess users and match them with appropriate, existing business resources
- Entrepreneurial Community Clusters: hands-on organizing to help communities understand and develop an entrepreneurial culture

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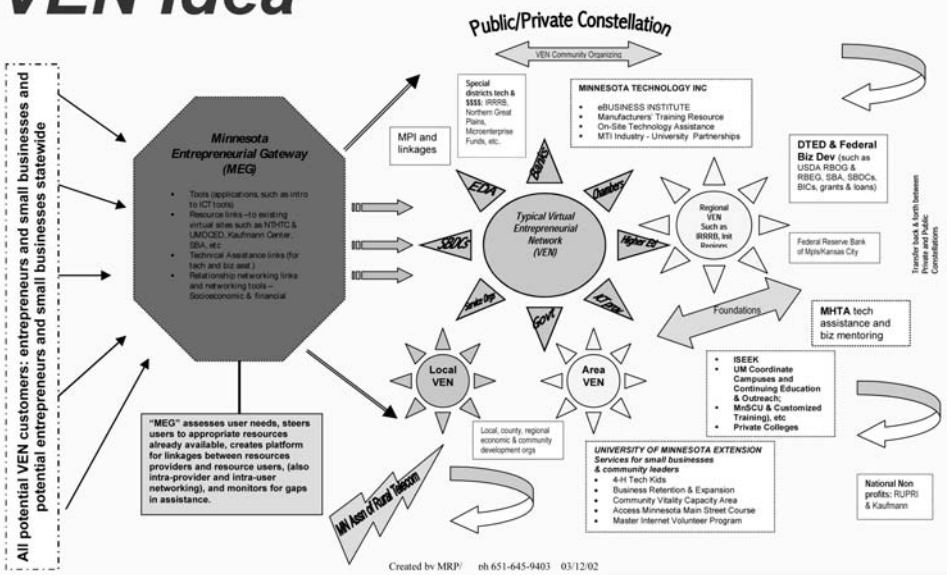
VEN Idea



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VEN FIRST STAGE - Gateway

Minnesota Entrepreneurial Gateway (MEG)

- Tools (applications, such as intro to ICT tools)
- Resource links –to existing virtual sites such as NTHTC & UMDCED, Kaufmann Center, SBA, etc
- Technical Assistance links (for tech and biz asst.)
- Relationship networking links and networking tools – Socioeconomic & financial

COMPONENTS:

- Welcome and instructions
- User registration
- Structured query to send back relevant info to user
- Assessment tools – ISEEK, SBA, UM-Cont Ed
- Financial tools, incl AMEX microenterprise loan application
- Email listserv registration
- Entrepreneurial/Small biz development checklist for individuals and communities
- Tech assistance links
- Help links for site
- Reference tools
- Community building tools
- Web based Portfolio starting point
- Partner and TOP information (required language by TOP)

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Gateway concept becomes

bizpathways

VIRTUAL ENTREPRENEURIAL NETWORK

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Public/Private Constellation becomes

•organized to help ***geographic community*** understand and develop an entrepreneurial culture.

• may organize ***communities of interest*** without regard for geographic proximity to accomplish business-to-business networking and form strategic alliances across sectors

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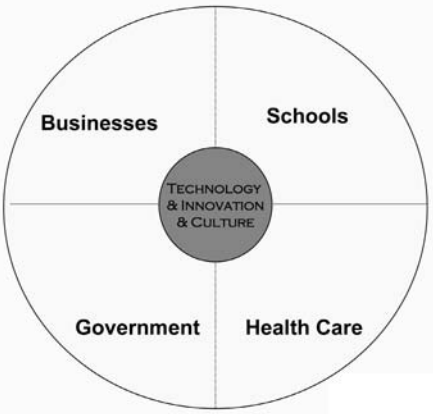
The Small Business Economy

Entrepreneurial Community Clusters Model



(MRP, Inc., copyright 2002)

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Implications for community leaders & resource providers

- aggregate data we collect can help inform future planning of bizpathways services, state agency resource allocation, etc.
- focus resources where the data indicates need and interest are in greatest demand.
- spot trends in business development at local, regional, and state levels and plan for these trends accordingly.

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Implications for research

- How people use the tool bizpathways - access and exploit info in new and productive ways (NSF)
- Demo how modern ICT can fundamentally change the way in which topical material is represented and delivered to diverse communities of users (NSF)
- Tie into Humphrey Institute knowledge cluster study (USDA FRA)

www.bizpathways.org

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Lifelong Learning & Workforce Development

- Change in how we look at the world -

democratization of information

•Need:

–Self-organize education and work histories. Be more entrepreneurial in how we engage in education and training and in how we present ourselves as students, community members, educators, employers, and workers

•Action:

–Promote use of efoliomn as individual and community portfolio tool from k thru lifelong

•Responsibility:

–K-12, higher ed, state agencies, local business & community resource providers

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WWW.EFOLIOMN.COM - Short History

- Project was part of a grant received by the Minnesota State Colleges and Universities system (MnSCU) through the federal Department of Education.
- Work efforts kicked-off in the Summer of 2001.
- Three work groups (plus a design team) were involved in the specifications - student, worker, and educator
- MnSCU partnership with Avenet, Dept of Economic Security, MRP, Inc. and others states

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Some definitions first….

- Portfolio: Information an individual maintains about themselves to support a particular goal.
- Electronic portfolio (e-portfolio): A portfolio that is stored in an electronic format (floppy, CD-ROM, LAN)
- Web-based e-portfolio: An e-portfolio that uses the web to store and display information. What we call in Minnesota an "efolio".

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Portfolios - a strong legacy

- Portfolios have been used for years as part of the teaching and learning experience.
- Their value to an individual and an organization has been well documented.
- Examples…..

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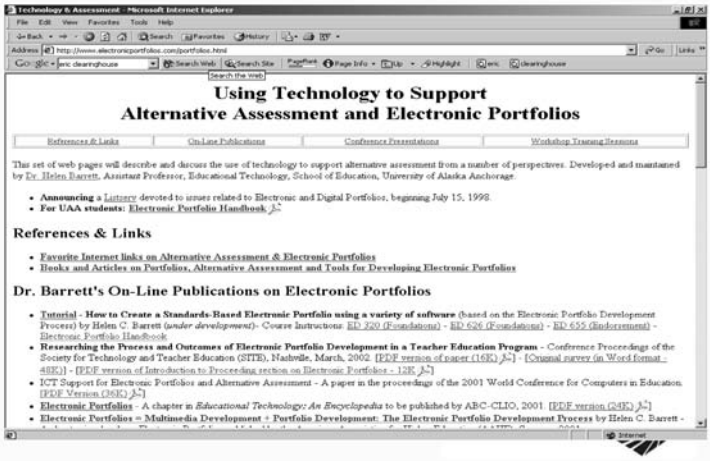
Research...

More research from Dr. Barrett



A University of MN effort

CMA is part of the portfolio legacy

- CMA - Career Management Account was an effort sponsored by the Department of Labor as part of the America's Career Kit effort.
- The CMA was an Internet-based safety deposit box where individuals can collect store, organize and manage all of their lifelong learning and career development information including third party validated documents such as transcripts, assessments, certificates and licenses.

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Looking at the CMA...

CMA - Caught in the transition

November 27, 2001 E- Mail message to the CMA Team

As you all know, on October 22nd, the NetBoard approved funding to continue the CMA pilot for 18 months. Last week, however, the Assistant Secretary for Employment and Training decided to discontinue the project. This is obviously very disappointing news, especially for our partners and those of us who have worked so hard and believe so strongly in this project

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Key project assumptions

- Technology literacy
  - *Need to accommodate users of various skill sets - from basic word processing skills up to HTML coding*
- Customizable
  - *One size can not fit all*
- Types of information
  - *Text and multi-media documents*

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Assumptions continue

- Security
  - *Three levels of security - public, restricted and private.*
- Web-based
  - *"Nothing but net". Access through IE or Netscape.*
- Administrative tools
  - *Limiting site size, turning off sites, etc.*

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What makes Minnesota's effort unique

- Scope
  - *Minnesota residents and students (enrolled at Minnesota institutions) are eligible*
- Deployment
  - *Effort is completely web-based*
- Flexibility
  - *Customizable to meet the needs of workers, students and educators*

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Uniqueness

- Availability/cost
  - *Free for a lifetime (target)*
- "Pedagogical" independence
  - *OWNED by the individual*

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Four key areas

- Minnesota project
- National pilot project
- Funding/grant opportunities
- MnSCU/Avenet - public-private agreement

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Minnesota project

- Completed beta testing. Results were positive and identified some enhancement areas.
- Pilot testing began the week of June 10th.
- Full operations began August 1, 2002. (Right now on target).

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National pilot project

- MnSCU amended its contract with Avenet to provide efolio sites for up to 5,000 users. Some limited additional funding is available for enhancements (some ideas from beta testers).
- Runs through June 30, 2003

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Finding funding/grant opportunities

- MRP is working on a communication strategy/plan
- MRP has already started looking for grant and funding opportunities
- Chance to partner with other states/ organizations

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How does it work - simple as 1, 2, 3

- Step 1 - Get to www.efoliomn.com
- Step 2 - Go through the sign-up process
  - *Overview of the tool*
  - *Provide your name, age (under 18 issue)*
  - *Agree to code of conduct/terms of use (accountability placed on owner of site)*
- Step 3 - Sign-in to your site
  - *Receive an email notification with your site URL (www.paulwasko.efoliomn.com) along with your password and userid*

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Community Culture
- balance between Lexus & the Olive Tree -
democratization of decisionmaking

•Need:

– community engagement tool, updated community economic development organizing framework (nothing from state since industrial park era Star City)

•Action:

– expand e-commerce ready community framing now in use by DTED to become Vital Economy framework; use Rural Policy Forum as localized tool for discussion and decisionmaking

•Responsibility:

–All

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Rural & Community Policy Challenges

- Rural interests are fragmented and busy
- Lack of public space for rural policy discussion
- Lack of mechanism for archiving rural policy dialogue
- Conversation needs to extend beyond critical agricultural concerns

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"pol·i·cy" *by definition*

1 a : prudence or wisdom in the management of affairs
b : management or procedure based primarily on material interest

2 a : a definite course or method of action selected from among alternatives and in light of given conditions to guide and determine present and future decisions
b : a high-level overall plan embracing the general goals and acceptable procedures especially of a governmental body

Source: Merriam-Webster Collegiate Online Dictionary
http://www.m-w.com/cgi-bin/dictionary

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New Rural Realities

- Rural is more than agriculture
- Rural economy is uneven
- Pockets of persistent poverty remain
- Rural population shifts
- Relationship with federal, state and local revenue streams

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Goals

- Advance the conversation
- Generate a grassroots consensus
- Provide road map of issues and priorities
- Offer data to support policymakers at all levels

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Rural Policy Forum Convenings

- The Times – They are A-Changing, Working Partnerships for Viable Communities, July 2001 / Duluth MN USA - Joint International Summit on Community & Rural Development

- Rural Idaho: Challenged to Change, November 2001, Caldwell, ID

- Marketplace of Ideas, January 2002, Grand Forks, ND

- Minnesota Rural Summit – Linking Healthcare and Economic Development, June 2002, Duluth, MN

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The Process

- MRP works with a committee to:
  - *Identify Issues*
  - *Formulate Questions*
  - *Conduct Outreach*
  - *Design Survey Questions*
- Each convening is customized to provide a link to the geographic place or event theme

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Issue Identification

- Conversation varies slightly across events and places, yet the main issue is "Why invest in rural America?"
- Conversation is sparked by questions about:
  - *Public policy*
  - *Service gaps and barriers*
  - *Successful strategies*
  - *Needed resources*
  - *Priorities and opportunities*

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Outreach and Conversation

- Outreach conducted to potential participants through a variety of media
- Utilize existing networks/databases to reach the target market
- Conversation is conducted online prior to an event
- Conversation is managed daily to cultivate a comprehensive grassroots response

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Event Survey and Management

- The online conversation influences the event survey
- The event survey is launched online just prior to the event and remains open for a short time after the event
- Cyber Café fully staffed by experienced technical assistants
- Incentives and encouragement are provided throughout event to maximize participation
- Preliminary results will be made available at event closure

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Follow-up

- Minnesota Rural Partners compiles the Survey results and creates formal reports
- The event and place specific results are made available in electronic formats to all audiences
- Results are integrated into the broader national rural policy forum

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Online Discussions

- Run over a one-month period prior to the event
- 8-10 Questions
- Excellent participation
- Articulate and colorful responses
- Complete text available at www.ruralpolicyforum.org

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Formula for a ViTAL Economy

The Eight Elements of a ViTAL Economy

- ENVISION the future together.
- PINPOINT the measurable results of your success.
- STRATEGIZE a collaborative course of action.
- POSITION your communications to capture broad-based community and regional support.
- MOBILIZE your resources & put your plan into action.
- AMPLIFY the ability of your customer-facing resources to protect existing markets and grow new ones.
- FINANCE your initiative with a powerful and scalable investment strategy.
- INGRAIN what you have learned to sustain your success.

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Challenges of the New Economy

- Global competition is intensifying.
- Knowledge sectors are driving growth.
- To compete businesses must become continuous innovators.
- Innovative businesses learn to specialize.
- A fertile environment for innovation is key.

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Sustainable Economic Growth

- Knowledge and Innovation are the **foundation** of sustainable economic growth that changes the way we live, work, learn, and govern.
- Connectivity, Collaboration, Changed Spending and Breakthrough Financing are the **fuel** of sustainable economic growth in a ViTAL Economy.

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A ViTAL Economy

A global town square which enhances quality of life and provides local, regional, and, global access to the resources and relationships that are needed to compete in a 21st century marketplace *anytime and anywhere* !

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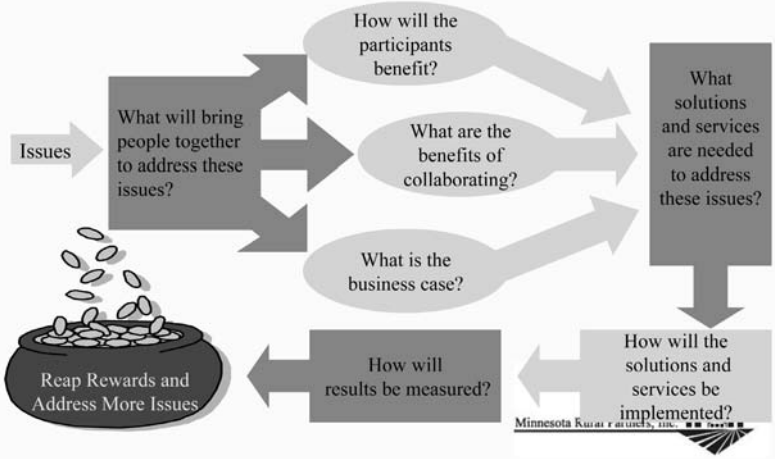
Value Linkage Process



The Reason for Action

A changing economy impacts the way we
live, work, learn, govern and connect.

We can't run a 21st century business, community or government
on 20th century rules.

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What will our legacy be?

" Insanity is when you keep
doing the same thing over and over again,
each time hoping for different results."

W. Edwards Deming

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Living in 19th century towns while we try to envision the 21st century

- In the 1870s in Nebraska, Burlington Railroad expanded west laying out towns every eight miles and naming them in alphabetical order: Crete, Dorchester, Exeter, Fairmont, Grafton, Harvard…….
- How should we "lay out" towns today to encourage entrepreneurial action and attitude now and in the future?

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Federal/Regional Opportunities

- Northern Great Plains Rural Development Authority
- Farm Bill – Rural Development Title
- What's Happening in Your World?

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Scrutiny & Feedback
Idea & Activities Sharing
Action steps

2003 Summit on Public & Private Entrepreneurship

Mankato – Aug 3-5, 2003

Minnesota Rural Partners, Inc.

Contact information

Jane Leonard
Acting Director, Minnesota Rural Partners
Phone: 651-645-9403
Email: jleonard@minnesotaruralpartners.org
www.minnesotaruralpartners.org

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The CHAIRMAN. Thank you. Thank you very much.

Dr. Myers?

STATEMENT OF WAYNE MYERS, M.D., TRUSTEE, MAINE HEALTH ACCESS FOUNDATION; PAST PRESIDENT, NATIONAL RURAL HEALTH ASSOCIATION, WASHINGTON, D.C.

Dr. MYERS. Chairman McIntyre and distinguished Members of the Committee, thank you very much for this opportunity.

My name is Wayne Myers. I am a past President of the National Rural Health Association and Trustee of the Maine Health Access Foundation. National Rural Health Association is a national nonprofit organization, probably 18,000 members, whose mission is to improve the health of rural Americans.

The quality of health care is critical to the physical, mental, and even economic health of rural communities. Often, the rural health facility is the center post supporting both the health and the economy of the community. If local health care disappears, as much as 20 percent of the local economy goes with it.

Over the past decade, as the nation lost manufacturing jobs, it has gained health care jobs. In fact, even though rural manufacturing jobs declined at twice the rate of urban manufacturing, health care has filled a lot of that void. Health care and education are now the largest rural employers and added the most to the rural economy across the nation in 2007. These jobs provide skilled employment, abundant employment due to recirculation of dollars paid into the community, and help retain families in the rural community.

My State of Maine has 15 Critical Access Hospitals, 50 federally qualified health center sites and 39 rural health clinics. Each is vital to rural patients and the rural economy. Our Maine Department of Labor estimates that statewide, 30 percent, nearly a third, of all new jobs until 2014 will be health care jobs.

The ancillary or secondary spending impact of all that is very significant. A typical rural hospital has a multimillion-dollar payroll, and a lot of that money is re-spent in the community, generating local jobs and revenue.

But there is a lot of difficulties. Disparities between rural and urban persist. In 2005, the average health care wage in Maine's rural counties was $26,800, nearly $10,000 less than health care job salaries in urban counties.

Rural facilities face significant challenges: budget constraints, recruitment and retention of health care personnel, access to capital. Rural populations, as you mentioned in your opening statement, Mr. Chairman, are older and poorer. Therefore, rural facilities are terribly reliant on reimbursement rates of Medicare and Medicaid, which do not cover the cost of the care that is provided, and those programs are continually threatened by cuts.

Due to these concerns, NRHA recommends stronger Federal investment in and partnership with rural America. Capital investment in rural facilities helps retain and recruit physicians and improves patient safety and quality.

USDA, through its Community Facilities Loan and Grant Program, has an impressive record of rural lending. This program has

helped to create some vibrant rural communities by ensuring that essential structures receive the capital that they need. Under Secretary Dorr has made, I believe, a personal commitment to Critical Access Hospitals as an important component of that program, and we sincerely thank him for his commitment.

Mr. Chairman, NRHA does strongly support these programs, but we do need improvements. First of all, more Federal dollars are needed to replace all those rural hospitals that were built during the 1960s and the 1970s. NRHA was disappointed to see Title VI funding levels reduced in the farm bill.

The lending process for USDA loans is complex. A facility must convincingly demonstrate that private financing is really not available, and that can be a long and discouraging process. The loan amount is typically insufficient to fund a project, and facilities truly in need of the program may fail to qualify due to rigid lending standards. So NRHA strongly supports increasing the lending program, easing the red tape and cost of applying, and improving outreach to facilities that provide quality care, yet fall short of the stringent USDA lending criteria.

On a slightly different topic: RUPRI has come forth with a recommendation for a new capital lending program from USDA, and we strongly support that. NRHA applauds the Committee for including language in the 2008 Farm Bill and we regret that that didn't make it.

We would strongly support any continuing efforts to strengthen health information technology in rural areas—terribly important, yet more difficult to implement than in other communities.

So, Mr. Chairman, in conclusion, thank you for all that you do for rural America. I and NRHA look forward to working with you.

[The prepared statement of Dr. Myers follows:]

PREPARED STATEMENT OF WAYNE MYERS, M.D., TRUSTEE, MAINE HEALTH ACCESS FOUNDATION; PAST PRESIDENT, NATIONAL RURAL HEALTH ASSOCIATION, WASHINGTON, D.C.

Chairman McIntyre, thank you for this opportunity to testify. I am Wayne Myers, M.D., Trustee of Maine Health Access Foundation and I am a Past-President of the National Rural Health Association (NRHA). Thank you for this opportunity to speak on behalf of the NRHA at this important hearing. I am pleased to tell you why quality health care in rural America is critical to both the community's citizens and the community's economy. I will also discuss the impact of Federal programs with a specific focus on USDA health programs.

The NRHA is a national nonprofit, non partisan, membership organization with approximately 18,000 members that provides leadership on rural health issues. The Association's mission is to improve the health of rural Americans and to provide leadership on rural health issues through advocacy, communications, education and research. The NRHA membership consists of a diverse collection of individuals and organizations, all of whom share the common bond of an interest in rural health.

Health Care in Rural America is a Vital Component of the Economy

Health care is critical to the physical and mental well-being of the citizens of a community. In rural America, health care is also critical to the economic well-being of the community.

As factories and plants across the nation close due to outsourcing, many parts of rural America's economy are in flux. A vital health care system is often one of the few bright spots in the local economy.

Over the last decade, cities and towns across the nation lost manufacturing jobs, but gained heath care jobs. Last year the manufacturing industry lost 310,000 jobs and the health care industry gained 363,000 jobs. Rural manufacturing jobs declined at double the rate of urban manufacturing jobs. In fact, health care and education

are the largest rural employers and added the most jobs to the rural economy in 2007. According to Health Resources and Services Administration (HRSA), health care services are consistently a top employer in rural America and if local health care should disappear, as much as 20 percent of a local economy could go with it. In brief, health care services provide skilled employment, abundant ancillary employment, and help retain young families and the elderly (who rely on quality health care) in the community.

My State of Maine is similar to the rest of America. Healthcare looms large in Maine's present day economy and in 2005 accounted for 15% of all rural jobs. The Maine Department of Labor forecasts that, statewide, 30% of all new jobs from now until 2014 will be health care jobs.

Between 1998 and 2007, the Bangor metropolitan area (population 150,000) lost about 3,700 jobs in manufacturing, but gained 3,500 jobs in health care. For many, the hospital is replacing the mill as the passport to the middle class. The shift to medicine is evident throughout Bangor. The local community college's most popular courses are no longer welding and pipe fitting; they are nursing and medical radiology. In 1990, 16% of the jobs in the Bangor area were in manufacturing, while 12% were in health care. In 2007, 6% of the jobs were in manufacturing and 20% were in health care.

In rural Maine, health facilities are the communities' lifeline, both literally and figuratively. Maine has 15 Critical Access Hospitals, 50 Federally Qualified Health Center sites and 39 Rural Health Clinics. Each of these facilities is vital to the betterment of the rural patients and the rural economy. Despite this, the disparities between rural and urban persist. Rural areas have a larger share of lower-paying health care jobs such as nursing assistants and personal care attendants. In 2005, the average health care wage in Maine's rural counties was $26,841 a year, $10,000 less than in the urban counties. Statewide the average wage for all jobs was $32,393.

The Wall Street Journal recently outlined this concern with a feature on a 51 year paper mill worker in Millinocket, Maine who was told he would be laid off his job of 28 years. The mill worker quit his job, took classes at the local community college and became a certified surgical technologist. Today he makes $16 an hour, $5 less than what he made at the paper mill.

Health Care's Influence on Other Sectors of the Rural Economy

The ancillary economic impact of health care in rural America is significant. A typical rural hospital may employ 20 percent of the local workforce and possess a multimillion dollar payroll. Much of the money paid to health sector employees is then spent in the community, which generates additional local jobs and revenue.

Additionally, health care employers and employees are important purchasers of goods and services, supporting many local business establishments. The employees who in work in health care, such as hospital and nursing home workers, physicians, dentists and pharmacists, are important sources of income in the community, supporting services such as housing and construction, retail establishments, restaurants and other local services. The hospitals and other health care institutions are also important purchasers of local inputs such as food, laundry services, waste management and other resources.

An often-overlooked aspect of the health care system in economic development is its importance to communities' efforts to attract and recruit firms. Rural leaders across the nation are becoming increasingly aware that the presence of quality health care is a vital component of numerous economic development strategies. From a survey of community leaders, almost 90% indicated that health care is important to the local economy. Manufacturers and high tech industries are unlikely to locate in an area that does not have adequate access to health care. Health care is also a key factor in attracting and retaining retirees.

The Challenges of Rural Health Care

Despite the growth of health care in rural America and its importance to the rural economy, many geographic and demographic challenges jeopardize its viability. Rural health systems are often facing severe budgetary restraints. Some rural facilities are on the verge of closing. In other cases, health care services are being cut. Recruitment and retention of physicians and other providers are often extremely difficult and expensive. Access to capital for facility improvements can be severely limited. Rural populations are older and poorer than urban. Younger, more prosperous rural citizens are more likely to seek care in larger, regional urban centers while relying on local rural resources for emergency care. Therefore, rural healthcare facilities are heavily reliant on the reimbursement rates of Medicare and Medicaid, which do not adequately cover the cost of care and are continually threatened by

cuts. Indigent care burdens are increasing due to rising unemployment and a flagging economy, while states are struggling to meet their Medicaid budgets.

Recommendations: Federal Investment and Partnership Vital to Rural Health and Economic Development

A. Grants and Loans for Capital Improvements

Health care will only be an important economic component if rural facilities can maintain quality structures and equipment. A large portion of rural hospitals were built using funding provided through the Federal Hill-Burton Act, in force from 1946 through 1975. Unfortunately, many quality rural facilities continue to operate in obsolete and deteriorating buildings, or operate with sub-standard equipment, because of the difficulty in accessing capital. This does not have to continue.

According to a 2005 Rural Hospital Replacement Study conducted by Stroudwater Associates and Red Capital Group, investment in rural facilities:

- Helps physicians and staff recruitment and retention;
- Reduces facility expenses (due to improved efficiencies);
- Improves patient safety;
- Improves quality of care and continuity of care; and
- Increases patients use and utilization.

The USDA has a long history of bolstering the rural economy and its influence on rural health care has been both direct and indirect. The vehicle for much of the USDA efforts has been the farm bill, which generates about $100 billion in Federal spending each year.

Rural Development Programs in the farm bill provide some amount of grant funding for hospital and clinic construction, and leverage much more through loan guarantees and interest rate subsidies. They help fund construction of a range of related facilities, including wellness centers, emergency medical services (EMS), and long-term care centers. The NRHA strongly supports these programs yet believes improvements can and should be implemented.

1. **Current Loan Guarantee Programs Must be Improved.** From our members who have utilized or attempted to utilize USDA loan programs, the concerns are consistent:

- The process is long and complex.
- The process often proves not cost-effective because of the costly application requirements.
- Inter-creditor loan agreements are cumbersome.
- The program is often limited to Critical Access Hospitals. Other rural health facilities are excluded.
- The loan amount is typically insufficient to fund the entire project.
- The process precludes facilities that are in true need of the program from qualifying for the program.

The NRHA often hears complaints from Critical Access Hospitals, who are in dire need of capital improvements or equipment improvements, which failed to meet the strict criteria of USDA guaranteed loan programs. The USDA's stringent lending criteria deserve credit for the low default rate of these loans. The NRHA commends a low default rate; however, the NRHA also strongly supports greater outreach to the facilities in true need.

The USDA guaranteed lending programs' mission is to improve economic development. That mission is best achieved if the USDA reaches facilities with significant needs. Since 1977, under the Community Reinvestment Act (CRA), Federal law has required private lending institutions to offer credit throughout their entire market area. The purpose of the CRA is to provide credit to underserved populations and small businesses that may not have previously had access to such credit. USDA Federal lending programs should have a similar mission. The NRHA strongly believes that this type of Federal outreach is the most effective way to improve quality health care and improve local economies.

2. **Implement New Loan Program Per Recommendations of RUPRI.**

In March 2008, the Rural Policy Research Institute (RUPRI) documented recommendations for implementing a new USDA Rural Development Program that strengthens rural health care delivery systems. RUPRI was established in 1990 to address a concern of Members of the Senate Agriculture Committee that no objective non-government source of external data, information, and analysis, re-

garding the rural community was available for policy decision makers. NRHA finds RUPRI's recommendations for expansion of the USDA lending program to be sound and prudent. Attached to this testimony are RUPRI's complete recommendations.*

3. **Grants for Capital Improvements are Needed.**

The NRHA applauds this Committee for including language in the 2008 Farm Bill that would have made grant monies available to a wide range of rural facilities and to improve health care quality and patient safety. We regret that this section was not included in the final farm bill.

4. **Increase Investment in Information Technology**

Health Information Technology (IT) is particularly important for rural people, yet difficult to secure. Rural people typically get their primary health care in their home communities, but travel to larger centers for specialty services. The dangers and inefficiencies related to moving paper and film record are great, as are the difficulties of having access to these records where and when they are needed across the region.

Therefore, the importance of a usable and interoperable health IT infrastructure and equipment in rural America is critical to patient safety, quality and facility sustainability. Additionally, technology can increase access to care, provide remote diagnostic services, and provide education and training for health care workers who otherwise have limited access to professional colleagues and continuing education. Development funds through the farm bill and other programs have been used to establish telemedicine and support broadband construction for rural communities. Such funding must continue and expand.

In it's 2004 report, *Quality through Collaboration: The Future of Rural Health Care,* the Institute of Medicine (IOM) stated that the acceleration of health knowledge is "pivotal" to patient safety and quality health care improvement in rural America. The report calls for a stronger health care quality improvement support structure to assist rural health systems and professions, and recognizes the importance of "investing in an information and communications technology infrastructure."

Health IT in rural America faces challenges far more significant than their urban counterparts. Both the 2004 IOM and Medicare Payment Advisory Commission (MedPAC) highlight problems with health IT in rural communities because of the relative scarcity of professional, technical and financial resources and interoperability issues which arise among numerous small independent health agencies.

Of these concerns, finance is the overriding challenge. Rural health facilities are small businesses who struggle to keep their doors open and meet their mission of providing care to their community. Investment in health IT or continued operation of the equipment is prohibitively expensive. (Often in rural areas, there is only a single telecommunications service provider—which limits competition and increases costs.)

Additionally, rural hospitals often depend on the Critical Access Hospital designations and the Universal Services Funds to maintain operations and access technology. This tenuous existence, however, doesn't allow for any financial cushion in invest in technology. Current payment rates are insufficient to cover the costs associated with overcoming challenges of acquiring hardware and software, implementing community-based communications networks and obtaining training and ongoing support.

Investment in health IT can drive the expansion of telecommunication technologies to rural communities. Other rural businesses have similar investment and infrastructure issues. Successful projects driven by health providers such as hospitals, community health centers, or training facilities have demonstrated how the entire community can benefit when it is "wired." NRHA strongly supports provisions in the farm bill to expand broadband services in rural areas and hopes that more can be done.

Health Insurance Coverage in Rural America

While health insurance is outside the scope of this Committee and this summit, I would be remiss to not mention this important issue and help highlight how difficult and complex rural economic development can be. On this issue, rural America lags behind its urban counterparts and has disproportionately higher rates of the uninsured and underinsured. This is true of both adults and children.

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*The document referred to is located on p. 42.

As already highlighted, a healthy workforce is vital to having a vibrant economy. Without insurance coverage of the local populace, most people cannot afford routine health checkups and must rely on more expensive emergency care. This is both more costly for the community and leads to poorer health outcomes. In addition, health insurance coverage can help provide the monies necessary to keep health providers in rural communities driving further economic development.

For the future of our rural communities, we cannot continue to see increasing rates of uninsured adults and children. Nationwide, the trend has been decreasing employer sponsored health coverage. This trend has been more acute in our rural communities that tend to have smaller-sized businesses and more small business owners that cannot afford to insure their own family. We must find ways to provide insurance coverage.

Already, rural citizens disproportionately rely more on Medicare, Medicaid and the State's Children Health Insurance Program (SCHIP) than their urban counterparts. However, in providing this coverage, we must be cognizant that health insurance does not equal health care. Federal insurance programs such as the ones mentioned have a responsibility to make sure that our rural citizens can access care in their own communities and that the care they receive is of high quality. Without it, rural America may lack a productive workforce in the future.

Congress has attempted to pass meaningful SCHIP legislation only to have it vetoed. This program has been a significant source of health coverage for rural children. If additional SCHIP legislation is debated in this Congress, the NRHA asks that considerable improvements in health insurance coverage and outreach for children in rural communities be included. For those that care about the future of rural America, the reauthorization and expansion of SCHIP is of the utmost importance.

Conclusion

Health care is a vital segment of the rural economy. Quality health care in rural America not only provides for the health of the community, but creates jobs, infuses capital into the local economy, attracts businesses and encourages families and seniors to maintain residency within the community. Federal, state, and local partnerships must be formed to protect this critical yet fragile component of the local economy. Grants and loans must be accessible for both capital improvements and IT infrastructure and development. Insurance programs such as SCHIP, Medicare and Medicaid must take into account their responsibility in providing health insurance for rural beneficiaries and in making sure those same people can access their care in their community. And finally, the USDA must continue to establish policies that help rural health care flourish—for both the sake of the health of rural Americans and for the economy of rural America.

The CHAIRMAN. Thank you. And thank you for the work you all do with the National Rural Health Association, which I know our rural health care coalition has worked very closely with through the years.

Dr. Karen Rheuban?

STATEMENT OF DR. KAREN RHEUBAN, PEDIATRIC CARDIOLOGIST, SENIOR ASSOCIATE DEAN FOR CONTINUING MEDICAL EDUCATION AND MEDICAL DIRECTOR, OFFICE OF TELEMEDICINE, UNIVERSITY OF VIRGINIA HEALTH SYSTEM; PRESIDENT-ELECT, AMERICAN TELEMEDICINE ASSOCIATION; MEMBER OF THE BOARD OF DIRECTORS, CENTER FOR TELEMEDICINE AND E-HEALTH LAW; PRESIDENT, VIRGINIA TELEHEALTH NETWORK, CHARLOTTESVILLE, VA

Dr. RHEUBAN. Chairman McIntyre, Mr. Goodlatte and Members of the Subcommittee, thank you for the opportunity to testify today.

I serve as Professor of Pediatrics, Senior Associate Dean for CME, and Medical Director of the UVA telemedical program, and I am President-elect of the American Telemedicine Association.

Although all Americans face challenges in access, quality and cost of care, disparities attributable to a host of factors disproportionately impact the health of our rural citizens. Over and over

again, I have seen the challenges faced by my own pediatric cardiology patients and countless others needing specialty care not locally available. The Institute of Medicine cites core health care services as being considerably less accessible in many rural communities. Access to specialty care presents an even greater challenge. When one considers the cost of overnight stays, lost time from work, and the increasingly high cost of fuel, travel for health care imposes great burdens on our rural families.

Tomorrow I will join more than 200 UVA volunteers to participate in the Remote Area Medical Clinic held at the Virginia-Kentucky Fair Grounds, where more than 3,000 patients will receive free medical, dental and vision care, and cancer screenings. Patients arrive at all hours of the night to stand in line to obtain a ticket for entry to the clinic and then wait uncomplainingly, often in the hot sun, to receive health care provided in barns and in tents. For many participants, this is the only time they will see a physician or dentist.

And since I am limited to only a few moments and since a picture is worth a thousand words, this is a photograph from one of our more recent Remote Area Medical Clinic expositions.

For many decades, the University of Virginia has tried to address the challenges of access for our rural patients. We staff subspeciality outreach clinics in communities remote from our medical center.

In 1995, with Federal and state grant support, we established our telemedicine program. We serve as the hub of a 60 site network in the Commonwealth of rural clinics, federally qualified health centers, community hospitals, Critical Access Hospitals, schools, prisons and health department sites. To date, we have facilitated more than 12,500 patient encounters in more than 30 different medical and surgical subspecialties that are provided on a scheduled basis or emergently using interactive videoconferencing.

We also offer store-and-forward services, such as screenings for diabetic retinopathy, interpretation of cardiac ultrasound for critically ill newborns, and mobile digital mammography to screen for breast cancer. We have saved lives, supported timely interventions, and spared patients and their families needless travel and extensive transfer.

We offer distance learning for health professionals. Telehealth spans the entire spectrum of health care and across the continuum, from prematurity to geriatric care. Cardiology, dermatology, ophthalmology, neurology, mental health and critical care are but a few of the many applications of telehealth.

With the aging of our population and greater numbers of patients with chronic illness, home telehealth offers an effective mechanism to provide for early intervention, with improved outcomes and reduced hospitalization.

Federal investment is critical to the development of telehealth networks across the nation. Sound Federal and state policies are required for the integration of telehealth into mainstream health care. Rural Virginians have benefited greatly from telehealth grants from the USDA and other Federal agencies. We applaud the Rural Utility Service for its definition of *rural* with regards to eligibility for telehealth grants.

Despite a favorable revision of the Medicare telehealth rules following passage of BIPA 2000, the Benefits Improvement and Protection Act, many critical telehealth-facilitated services remain ineligible for Medicare reimbursement based on the location and/or type of consult origination site. CMS has interpreted the statute narrowly, and as a result, the opportunity to serve rural Americans in need has been limited.

CMS recently reported that total Medicare expenditures for telehealth in the past 6 years were less than $5 million, far below the level of several hundred million dollars that Congress anticipated. Practitioners eligible for reimbursement for in-person services delivered in the home should be reimbursed for similar services through telehealth. Store-and-forward services are only available in Alaska and Hawaii. Many Medicaid programs still do not reimburse telehealth-facilitated care, and yet Medicaid funds the high cost of long-distance patient transportation and the serious consequences of delays and access to health care.

Rural grants will be of much less value without reasonable Medicare and Medicaid reimbursement policies. Federal investment in our rural broadband infrastructure remains crucial to expanding and sustaining telehealth programs and health information exchange nationwide. The rural health care support mechanism of the Universal Service Fund is still fraught with statutory limitations that pose barriers to many programs. Finally, there are enormous opportunities to help patients with chronic illnesses, such as congestive heart failure, through programs that provide remote monitoring support.

In conclusion, through robust investments in telehealth and expanded favorable Federal policy, Congress has the opportunity to greatly enhance access to quality health care services that improve the health of our rural Americans.

Thank you. I would be happy to respond to any questions.

[The prepared statement of Dr. follows:]

PREPARED STATEMENT OF DR. KAREN RHEUBAN, PEDIATRIC CARDIOLOGIST, SENIOR ASSOCIATE DEAN FOR CONTINUING MEDICAL EDUCATION AND MEDICAL DIRECTOR, OFFICE OF TELEMEDICINE, UNIVERSITY OF VIRGINIA HEALTH SYSTEM; PRESIDENT-ELECT, AMERICAN TELEMEDICINE ASSOCIATION; MEMBER OF THE BOARD OF DIRECTORS, CENTER FOR TELEMEDICINE AND E-HEALTH LAW; PRESIDENT, VIRGINIA TELEHEALTH NETWORK, CHARLOTTESVILLE, VA

Chairman McIntyre, distinguished Members of the Subcommittee, my name is Dr. Karen Rheuban. I am a Pediatric Cardiologist, and also serve as Senior Associate Dean for Continuing Medical Education and Medical Director of the Office of Telemedicine at the University of Virginia Health System in Charlottesville. I am also the President-elect of the American Telemedicine Association, a member of the Board of Directors of the Center for Telemedicine and E-health Law, and President of the Virginia Telehealth Network.

It is an honor and a privilege to provide testimony that will address:

(a) the status of rural healthcare, and in particular, data regarding healthcare in rural Appalachian Virginia

(b) the role of telemedicine in the delivery of healthcare and educational services to rural Americans,

(c) the enormous benefits of Federal programs that support the development and deployment of telehealth technologies and networks, and

(d) opportunities to further expand innovation in telemedicine and e-health so as to enhance the quality of life of all Americans.

A. The status of rural healthcare

Rural patients face challenges of access to quality healthcare. Twenty percent of our U.S. population resides in heterogenous rural communities which vary in character from towns adjacent to suburban areas to remote and/or frontier communities with extremely low population densities. Although all Americans face challenges in access, quality and cost of care, disparities attributable to a host of factors disproportionately impact the health of our rural populations.

The Institute of Medicine, in its report, "The Future of Rural Healthcare", cites "core health care services" of primary care, emergency medical services, long term care, mental health and substance abuse services, oral health and other services as being considerably less accessible in rural communities.[1] Access to specialty care presents an even greater challenge. The implications of a lack of timely access to quality healthcare are well known, and include delayed diagnoses of preventable or treatable illnesses and a higher cost of care, when and if such care is received.

Rural patients tend to be older, and participate in adverse health behaviors (smoking, lack of fitness, obesity) which leads to chronic diseases at rates higher than their urban counterparts. The challenges of a less robust infrastructure in support of economic development, lower educational levels of achievement, high rates of uninsured status, and the financial burdens of travel for healthcare all contribute to the health disparities of rural citizens. As an example, although nationally we have increased access to screening mammography over the last decade, due to the impact of distance, limited income, and uninsured status, women residing in rural areas are screened for breast cancer at significantly lower rates than women residing in urban areas, particularly if travel more than twenty miles for screening is required.[2–3]

It has been forecast that our nation faces a shortage of physician providers, in the range of 85,000 to 200,000 physicians by 2020.[4–5] Lack of access in rural areas is exacerbated by the limited numbers of specialists who practice in rural communities and the limited resources generally available in those communities. Attracting health professionals to rural communities remains a daunting task; retaining those health professionals is equally difficult. Rural healthcare providers tend to work longer hours, see more patients, lack cross coverage opportunities and experience a greater sense of isolation than their urban counterparts. Rural health professionals have been slower to adopt electronic medical records in their practices.

To craft a strategy for improving the health of patients residing in the most rural and underserved regions of the Commonwealth of Virginia, in collaboration with Virginia Department of Health, the University of Virginia recently conducted an analysis of the health status, the health workforce and relevant economic indicators impacting the citizens of the Coalfields regions of western Appalachian Virginia.[6] These rural regions of Virginia are: (1) economically depressed, (2) medically underserved, and (3) geographically isolated. The findings of that report showed that:

- 20% of the residents of the region live below the poverty level as compared to 10.2% for Virginia.
- Only 62% of the region's population has completed high school and 11% completed college compared with 82% and 30% respectively for Virginia.
- Per-capita income levels in the region are a little more than half of the levels of state for 2000.
- The numbers of unemployed and those not in the work force is twice that of the rest of the Commonwealth.
- 19% of adults in the region do not have health insurance coverage.
- The death rate from cardiovascular disease is 1.7 times higher than that of the Commonwealth of Virginia.
- The death rate from solid tumors is 1.4 times greater than that of the state.

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[1] *Quality Through Collaboration, The Future of Rural Health,* Institute of Medicine, National Academies Press, 2004.

[2] Peek, M.A., *Disparities in Screening Mammography: Current Status, Interventions, and Implications,* J. GEN. INTERN. MED. 2004 February; 19(2): 184–194.

[3] Brustrum, J.E., *Going the Distance: How Far Will Women Travel to Undergo Free Mammography?* MILITARY MEDICINE, 2001, 166 (4), 347–349.

[4] Cooper, R.A., *Weighing the evidence for expanding physician supply,* ANN. INTERN. MED. 2004: 141:705–714.

[5] Blumenthal D. *New steam from an old cauldron: the physician supply debate,* N. ENGL. J. MED.: 2004:350:1780–1787.

[6] Cattell Gordon, D., "Healthy Appalachia", Report to the Southwest Virginia Health Facilities Authority, May 2008.

- The probability of dying of chronic lung disease in this area is twice the probability of dying of the same cause elsewhere in Virginia.
- The mortality rate in the region from diabetes is nearly twice the mortality rate of the state.

Although University of Virginia physicians regularly staff specialty outreach clinics in many rural regions of the Commonwealth, the ongoing need for locally provided specialty services is very great. When one considers the cost of overnight stays, lost time from work, the increasingly high cost of fuel and other automotive expenses, travel for healthcare imposes great burdens on our rural families.

Tomorrow, I will join two hundred of my University of Virginia Health System colleagues to participate in the Remote Area Medical (RAM) Clinic held at the Virginia-Kentucky Fairgrounds, a 6 hour drive from Charlottesville. At that annual weekend event, more than 3000 patients from Appalachian Virginia and surrounding states receive free medical care, dental care, vision care, patient education and cancer screenings. Patients arrive at all hours of the night to stand in line to obtain a ticket for entry to the clinic, and then wait uncomplainingly, often in the hot sun, to receive services. At that clinic, healthcare is provided in barns and in tents (see photograph, below).

Photograph: Remote Area Medical Clinic (courtesy St. Mary's Health Wagon).

Rural Americans experience disproportionate disparities in healthcare as compared to their urban counterparts.

B. The role of telehealth in the delivery of services to rural Americans:

Telehealth can reduce many of the barriers of access to locally unavailable healthcare services. The societal integration of advanced technologies into everyday venues has profound implications for the development, support and delivery of a new paradigm of healthcare services in the digital era. The powerful tools of health information technologies are critical to the transition from a culture in which health related services are primarily delivered in a balkanized model on an episodic basis to an integrated systems approach focused on disease prevention, enhanced wellness, chronic disease management, decision support, quality, ease of access and patient safety. Through the incorporation of such tools and technologies, clinicians will be able to satisfactorily manage the exponentially expanding volumes of medical information, research and decision support analytic tools.

The incorporation of telehealth technologies into integrated systems of healthcare offers tools with great potential to address the challenges of access, specialty shortages, and changing patient needs in *both* the rural and urban setting. Clinical services delivered via telehealth technologies span the entire spectrum of healthcare, and across the continuum from prematurity to geriatric care, with evidence based applicability to more than 50 clinical specialties and subspecialties. Cardiology, dermatology, ophthalmology, neurology, high risk obstetrics, pulmonary medicine, mental health, pathology, radiology, critical care, and home telehealth, are but a few of the many applications in general use, and for which a number of specialty societies have developed telehealth standards.[7–11] These services can be provided in live-

[7] Williams, J.M. *et al., Emergency medical care in rural America,* ANN. EMER. MED. 2001: 38(3):323–327.

[8] Burgiss, S.G. *et al., Telemedicine for dermatology care in rural patients,* TELEMED. JOURNAL 1997; 3 227–33.

interactive modes and some, asynchronously, using store and forward applications. Examples of the latter include the acquisition of digital retinal images of patients with diabetes by a trained nurse. These images can be sent for review by a retinal specialist to identify patients at risk for diabetic retinopathy, the number one cause of blindness in working adults. Digital images can be integrated into the patient's electronic medical record to follow changes over time. In these and so many other applications, telehealth supports the goals of the Federal Healthy People 2010 initiative, and is aligned with the President's 2004 Executive Order to "advance the development, adoption, and implementation of health care information technology standards nationally through collaboration among public and private interests".[12]

The aging of our population has already created increased demand for specialty healthcare services to address both acute and chronic disease in the elderly. Such a demand, in the face of anticipated provider shortages, requires a fundamental shift from the model of physician centered care to one focused on patient centered care using interdisciplinary teams, evidence based medicine, the use of informatics in decision support and telehealth technologies where specialty care services are either not locally available or for other consultative needs. As an example, nationally, only 2% of eligible (ischemic) stroke victims receive brain saving thrombolytic therapies, primarily because this treatment must be administered within 3 hours from the onset of an ischemic stroke under the direction of a trained neurologist. The use of telehealth technologies offers immediate access to stroke neurology and neurointensive care with improved outcomes, and an increase in the delivery of thrombolytic therapies to as many as 80% of eligible stroke patients.[13–15]

With the aging of the population and greater numbers of patients with chronic illness, home telehealth, home monitoring tools and biosensor devices offer an effective mechanism to improve health, and provide early intervention where appropriate. The evidence has demonstrated improved outcomes and reduced hospitalizations for patients with congestive heart failure, diabetes, and other chronic diseases through the use of home monitoring and home telehealth technologies.[16–17]

Telehealth technologies should be viewed as integral to rural development. Data from some telehealth providers have indicated that more than 85% of patients seen via telehealth technologies remain within their community healthcare environment, resulting in a reduction in unnecessary transfers, less hospital lost revenue, as might occur with patient transfers, and enhanced economic viability of the community hospital. A viable community healthcare environment and workforce ultimately provides incentives for the relocation of industry, thereby enhancing community economic development. The benefits of shared utilization of bandwidth for other applications in rural communities cannot be overstated.

In an effort to address the significant rural-urban disparities in the Commonwealth of Virginia, we established the University of Virginia Telemedicine program in 1995, specifically to enhance access to specialty healthcare services and health related education for distantly located patients and health professionals using broadband telecommunications technologies. With Federal and state support, we have created and serve as the hub of a 60 site network of community hospitals, Critical Access Hospitals, a veteran's hospital, veteran's clinics, federally qualified community health centers, rural clinics, prisons, schools and state health department clinics located primarily in rural communities in western, southwestern, central and eastern Virginia.

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[9] Chiang, Michael, Lu Wang; Mihai Busuioc; Yunling E. Du *et al., Telemedical Retinopathy of Prematurity: Diagnosis, Accuracy, Reliability, and Image Quality Arch Ophthalmol, 2007*: 125 1531–1538.

[10] Flowers, C.W. *et al., Teleophthalmology: rationale, current issues, future directions,* TELEMED. J., 1997: 3(1): 43–52.

[11] Breslow, M.J., *Effect of a multiple site intensive care unit telemedicine program on clinical and economic outcomes: An alternative paradigm for intensivist staffing,* CRIT. CARE. MED. 2004 32(1): 31–38.

[12] George W. Bush, Executive Order, *Incentives for the Use of Health Information Technology and Establishing the Position of the National Health Information Technology Coordinator,* April 27, 2004.

[13] Schwamm, L.E. *et al., Virtual telestroke support for the emergency department evaluation of acute stroke*, ACAD. EMER. MED. 2004: 11(11) 1193–1197.

[14] Vespa, P., *Intensive care unit robotic telepresence facilitates rapid physician response to unstable patients and decreased cost in neurointensive care,* SURG. NEUROL., 2007 (67) 331–337.

[15] Fessler, R., Michigan Stoke Network, An 18 month update, 3rd Annual Remote Presence Clinical Innovations Forum, Santa Barbars, CA, July 18, 2008.

[16] Field M.J. and Grigsby, J. *Telemedicine and remote patient monitoring,* JAMA 2002:288(4):423–425.

[17] Noel, H.C., *Home telehealth reduces healthcare costs,* TELEMEDICINE J. AND E. HEALTH, 2004, 10(2): 170–183.

To date, we have facilitated more than 12,500 patient encounters linking remotely located patients and our University of Virginia health professionals representing more than 30 different medical and surgical subspecialties. These services are provided on a scheduled basis or emergently, as needed, at any time, day or night. We offer store and forward services such as screenings for diabetic retinopathy or breast and cervical cancer. We have provided more than fifty thousand radiographic interpretations through our teleradiology program. We provide live interactive consultations using traditional models of video-teleconferencing and critical care applications, such as acute stroke evaluation and treatment, using traditional videoconferencing and robotic "remote presence" technologies connecting emergency physicians with stroke neurologists. We have saved lives, supported timely interventions, and spared patients and their caregivers unnecessary travel and expensive transfer when feasible.

At the Remote Area Medical Clinic in Wise, in addition to on-site clinical services, we offer telemedicine facilitated subspecialty consultations and mobile digital mammography services transmitted over broadband linkages for immediate interpretation by our radiologists.

Through our telehealth network, we have broadcast thousands of hours of health professional, student and patient education programs otherwise not locally available. We offer access to cancer clinical trials for patients and collaborative tumor boards for health professionals serving those patients.

C. The enormous benefits of Federal programs that support the development and deployment of telehealth technologies and networks (such as the USDA Rural Utilities Service Distance Learning and Telemedicine Grant Program).

Federal funding has been critical to the development and deployment of telehealth technologies and networks across the nation. The University of Virginia Telemedicine network has benefited greatly from USDA funding through the Rural Utilities Service Distance Learning and Telemedicine (DLT) Grant Program and through the USDA Community Facilities Program. We have expanded services to more than a dozen healthcare facilities with USDA grants and recently have launched a major rural cancer outreach initiative with a 2007 grant from the USDA DLT program.

Since the inception of the program in 1993, hundreds of RUS grants have been awarded to telemedicine projects similar to our own. This funding has been critical to the development of rural telemedicine networks nationwide. The USDA Rural Broadband Grant and Loan Program has supported the deployment of communications infrastructure which underpins successful telemedicine, E-health applications and health information exchange.

We have also received critical funding from other Federal agencies including the Health Resources Services Administration (HRSA), the Department of Commerce, the Federal Communications Commission (FCC), the Dept. of Housing and Urban Development, and the Appalachian Regional Commission.

We applaud the Rural Utilities Service for its process of identification of rurality re eligibility for the DLT program. These USDA definitions are simple and practical and are very much aligned with community gaps in specialty health professional services. Ironically, these definitions include communities otherwise deemed ineligible for other Federal telehealth-related services—such as reimbursement under Medicare or communications discounts in the FCC Rural Healthcare Support Mechanism of the Universal Service Fund. These issues will be addressed below but raise the concern that the long-term sustainability of telemedicine projects established through this program and other Federal telehealth programs may be at risk.

We urge Congress to support greater levels of funding for USDA and other Federal programs that expand telehealth initiatives, and to facilitate policies that more broadly integrate telehealth into mainstream healthcare.

D. The role of Congress in fostering greater deployment of telehealth technologies:

The telehealth community is indebted to Congress for its commitment to foster an environment that enhances access to healthcare for all Americans, regardless of rural or urban location.

Notwithstanding an initial climate of non-reimbursement from third party payers, high telecommunications costs, limited deployment of broadband services in many rural communities, high equipment costs, restrictive state licensure regulations and a general skepticism of the ability to provide quality care via such technologies, we and other telehealth providers have persevered in our efforts to offer our rural patients access to the same quality healthcare and educational services enjoyed by our urban citizens.

Such programs have only been realized with the help of the Congress for the funding of telemedicine demonstration projects in all 50 states, in fostering a climate of competition in the telecommunications sector, in mandating reimbursement through the Medicare programs and as feasible, by encouraging states to do the same through their Medicaid programs.

Despite a favorable revision of Medicare telehealth rules brought about by the Medicare Benefits Improvement and Protection Act of 2000 (BIPA), many critical telehealth facilitated services are still considered ineligible for Medicare reimbursement based on the location and the type of consult origination site. Indeed, Medicare expenditures for telehealth in the 6 years that followed BIPA were reported by the Center for Medicare and Medicaid Services (CMS) as less than $5 million.

We applaud Congress for the passage of the very recent Medicare legislation that expands the eligible consult origination sites. Still there are many appropriate and worthy clinical sites from which telehealth consultative services are not reimbursed, such as non-hospital based dialysis facilities. Medicare will only reimburse telehealth services that originate in rural locations, based on a definition of rural far less inclusive than that of the USDA or even the FCC. Consults cannot be reimbursed by Medicare if that originating site is not located in a designated health professional shortage area, or a federally designated county wide metropolitan statistical area (MSA).

Store and forward services are ineligible for Medicare reimbursement other than services provided in Alaska and Hawaii. Home telehealth technologies provide well documented improvements in health status, and should be reimbursable as a part of a comprehensive care program designed to reduce improve clinical outcomes and lower healthcare costs. Practitioners eligible for Medicare for in-person services delivered in the home should be reimbursed for similar services provided using telehealth technologies.

We strongly commend Congress for the passage of the Telecommunications Act of 1996, and its effect in bringing about a reduction in the cost of communications services and an increase in the deployment of broadband connectivity to our rural communities. In 1995, the monthly ongoing cost of a T1 connection from Charlottesville to Wise, Virginia was $5,800 per month. In 2008, with Universal Service Fund discounts, that same service now costs $200/month. And yet, the Rural Healthcare Support Mechanism, as mandated in the Telecommunications Act, still remains significantly underutilized, in part because statutory barriers prevent the program from achieving the goals envisioned by Congress. Many communities designated as rural by USDA standards do not qualify for Universal Service Fund support by virtue of uncoordinated agency definitions of rurality.

The time limited Rural Healthcare Pilot Program, launched in November 2007, holds promise to expand the deployment of broadband services for purposes of telemedicine and e-health, however, this program is also fraught with limitations that pose barriers to its success. As an example, neither administrative costs of managing the project nor programmatic evaluation are eligible for support in the Rural Healthcare Pilot Program.

Any effort to coordinate and facilitate greater utilization and cost-effective deployment of telemedicine initiatives will ultimately enhance the sustainability of rural telemedicine programs and by inference, the health of our rural citizens. Without coordination across all the agencies, we are at risk of engendering obsolescence in the Federal Government's considerable investment in telemedicine programs.

Conclusion:

In conclusion, by

a. Increasing Federal funding for quality demonstration projects and grant programs,

b. Further reducing both statutory and regulatory barriers to telehealth in Medicare,

c. Aligning Federal agency definitions of rural with *specialty* healthcare shortages, and in particular, using as a model, the definitions of rural applied by the USDA Distance Learning and Telemedicine Grant Program,

d. Encouraging the use of (and reimbursement for) store and forward telemedicine, and home telehealth, and

e. Further improving the Rural Healthcare Support Mechanism,

Congress has an opportunity by to improve access to locally unavailable quality healthcare services that reduce rural—urban disparities and improve the health of all Americans.

Thank you for this opportunity to offer testimony before the Committee today. I would be happy to respond to any questions.

The CHAIRMAN. Thank you.

Thanks to each of you and for speaking right to the point.

I want to invite Mr. Goodlatte, if he has any questions.

Mr. GOODLATTE. Well, thank you, Mr. Chairman. I do, indeed.

You are right, a picture is worth a thousand words. And you mentioned that clinic. Do you have any means of providing follow-up care to all those people when they come in and wait in line like that and get some initial advice? Is there a way to follow up?

Dr. RHEUBAN. Absolutely. What we try to do is refer patients to a medical home in their community. So we refer patients to their federally qualified health centers and rural clinics.

And since we make every effort to register every patient that we see as a UVA patient, they have an electronic medical record, and we can provide telehealth-facilitated follow-up care for those patients when they go to the community health centers and hospitals that are connected back to UVA.

Mr. GOODLATTE. I imagine you find people of every kind of circumstance—some people who have minor problems, some people who have very major problems, some people have health insurance, some people who don't, some people who are under Medicaid. Tell me about how you sort through all that.

Dr. RHEUBAN. We actually see everyone, every comer; it doesn't matter what their health insurance status is. And then, again, when they go to the community health centers, that is where the sliding scale applies for them. And we provide free care during those clinics.

We bring a mobile digital mammography van. We do cancer screenings. We do sigmoidoscopies for patients who unfortunately have to be prepped using porta-potties at that clinic. It is a very dire situation, but we are there to serve. And no patient is ever turned away.

Mr. GOODLATTE. So, do you have a whole array of people back at UVA or other hospitals that are waiting to take a look at them, as they are trying to do their other jobs back at the hospital at the same time?

Dr. RHEUBAN. We do provide follow-up at UVA, and———

Mr. GOODLATTE. No, I mean during the———

Dr. RHEUBAN. Oh, we do telemedicine, yes, sir. We provide telehealth encounters in this clinic, but we bring a host of subspecialists with us to participate in that clinic. And the Virginia Dental Association brings 60 dental chairs and provides dental care, as well, from VCU dentists.

So we do do telehealth for what we don't have onsite, but we bring a lot of specialists as well.

Mr. GOODLATTE. What would you say is the biggest challenge that you face in providing more telemedicine, telehealth services?

Dr. RHEUBAN. The largest challenge that we face, quite frankly, is the lack of reimbursement. We do not turn away any patient. We see everyone via telehealth. I think telehealth would exponentially increase nationwide if consultant physicians would be able to be paid for the services we provide. And there are provisions through Medicare, but as I articulated, it is not nearly enough.

Mr. GOODLATTE. And has this continued to grow exponentially, or is it leveling off? Where would you say it is?

Dr. RHEUBAN. Telehealth is continuing to grow. And, certainly, we are very grateful for the infrastructure grants that we get from HRSA, from USDA. But it would be very important to orchestrate policies across the various agencies so that we can further facilitate the use of telehealth, such as the *rural* definition, such as reimbursement, such as the cost of telecommunications services.

Mr. GOODLATTE. Other than the cost, maybe that is the biggest problem with the broadband programs, but are there things that need to be retooled with regard to broadband programs to do a better job in enhancing what you can do with telemedicine?

Dr. RHEUBAN. We are very grateful for the rural health care support mechanism. And if you polled all the telehealth providers around the country, each one of them would say, without that discount program, our programs would go away. It would still be unaffordable. We still have many areas in the Commonwealth of Virginia where there is no competition, and so we rely on that program.

That being said, there are statutory barriers in that program that could be improved by Congress, if and when you are willing to relook at the Telecommunications Act, so that we can serve more individuals through telehealth.

Mr. GOODLATTE. Good.

Dr. Myers, do you believe that health information technology legislation that has been drafted in other committees—it is not our jurisdiction—accommodates the concerns specific to rural areas?

Dr. MYERS. I am sorry to say that I don't believe that I am comparatively well enough versed in the materials in those. We can certainly work on that and get you a report in a very few days. But I would hesitate to answer off the top of my head.

Mr. GOODLATTE. Sure. I have been in that situation myself when a question comes right out of left field.

Anybody else have any thoughts on that subject?

Mr. FLUHARTY. Just quickly, I would say overwhelmingly the reimbursement challenge is the issue. I think that is something that could be statutorily addressed. It is the overwhelming challenge.

Mr. GOODLATTE. Very good.

Mr. Chairman, thank you very much. I think my time has just about expired.

And I want to thank all of our panelists.

The CHAIRMAN. Thank you, Mr. Goodlatte. Good to have you with us.

Mr. Pomeroy?

Mr. POMEROY. I just observed the Ranking Member may not have had well-formulated answers to off-the-wall questions, but it never stopped him from trying to———

[Laughter.]

Mr. GOODLATTE. Never.

Mr. POMEROY. Thank you, panel. This is a very interesting panel.

Extraordinary, Dr. Rheuban, I represent very rural areas in North Dakota. But you are dealing with some issues that are new to my understanding of rural health care in that region of the country.

One of the things we are talking about in the context of health reform is information technology as a means to improve our collective understanding of what works, what doesn't work in medicine. It seems to me we have been very slow on the uptake on moving to more data-based medicine in this country. It was a topic that was often discussed when I was an insurance commissioner, and I haven't been an insurance commissioner since 1992. So we have really been slow at getting moving here.

But it is going to take some considerable infrastructure investment. And we are worrying about rural practices that are going to have a harder time costing this out because they don't see as many patients.

I am wondering, Mr. Fluharty, if you have looked at this area.

Dr. Myers, you might want to comment on what it is going to take to have the rural sector fully participating in health IT in ways that aren't financially punishing to our practitioners.

Mr. FLUHARTY. I would also just like to commend UVA. It is a phenomenal program. I think it also points to the unbelievable need that exists in our current institutional challenge.

Congressman, while you are here, I would just simply say for the Congressman that asked before, the Rural Access Center at North Dakota has indeed everything online that was asked for, Mr. Chairman. And our colleague, Mary Wakefield, who is a constituent of the Congressman's, heads that center. And in response to that question, that is an example of how technology is starting to move in the field.

Let me simply say the Senate language that would have looked at, within the Agriculture Committee, infrastructure for IT development, quality control and information systems as a potential infrastructure grant to USDA under the Agriculture Committee, we felt was very good legislation.

The challenge is going to be in the small grants program at HHS, securing sufficient capital to move that infrastructure design into the field at a scalable level. And that is going to be one of the challenges, who will step up with the infrastructure commitment? Is it Federal, is it state, is it the private sector?

And, when we move to the quality considerations that is going to drive CMS and we look at e-prescription, we have a huge disconnect, Congressman, in the capacity of all our rural providers. And I am sure the rest of the panel would like to comment on that.

Mr. POMEROY. Dr. Myers?

Dr. MYERS. I think I would add that the different silos in information technology and telecommunicated health care are converging, in a way, and yet we still operate in some patterns that were set up way back in the 1970s and 1980s. And by that I mean that imaging; all your X-rays are now digitized the same as an electronic medical record. And the way you abstract those for quality studies are all in the same medium now. But we tend to think of those in different boxes.

I personally believe that we could use help resolving the interoperability issues so that different small shops work for each other. If you are running a half-billion-dollar enterprise, you can figure out those interoperability problems. But if you are a little place out in the country, you really can't.

So I see technical assistance—and that is not to undervalue the Office of Telemedicine Coordination. I have the title wrong, and I am sorry. But the technical assistance issues and coordination issues are very important. And for a success story, we could look at Denmark and Scandinavia for putting all these things together.

Mr. POMEROY. Final point: I want to thank you, Dr. Myers, by the way, an aside, for your work on behalf of the National Rural Health Association, Co-Chair of the Rural Health Care Alliance. I think it has gotten a lot accomplished for rural medicine, and we appreciate your work, sir.

Dr. MYERS. Thank you.

Mr. POMEROY. This is to Mr. Fluharty.

As you look at rural health policy, we are always talking about, gosh, you have to pay us more, you have to pay us more, you have to pay us more fairly, this differential doesn't cut it. Those are standard rural arguments relative to Medicare reimbursements.

More recently, I have become intrigued with the notion of advancing the argument that we ought to pay for systems that are achieving better results at lower cost. And we have tried to learn from the financial—we should reverse financial incentives that drive care to costly inefficient places even at the expense of quality. Where we pay more and get less, by way of quality outcome, than systems that you are more likely to see in rural America that are primary care medicine-based and achieve better value, better outcome, lower cost.

Is there anything within your body of work and the substantial research capacity within your organization that can help us flesh out some of this?

Mr. FLUHARTY. Congressman, you know the work probably already, given all of your service on the caucus. But there is a body of work, and we would be glad to forward some things. I would make two or three comments.

The research is very, very clear that there are a set of quality indicators in which our rural practitioners are advantaging patients *vis-à-vis* urban areas. Our overall concern is the development of innovation systems of care that think about return on investment but use population health as an indicator. And you have named it essentially, Congressman.

I will simply say in our next SEBAS work with RUPRI—and we are building that system for USDA—looking at community facilities, we are trying to indigenize, essentially, population care dynamics with a return on investment that talks about new quality of care systems. If we can do that, it is going to advantage the Agriculture Committee because there are many ways in which a rural presentation of a problem is resolved at a lower cost and a higher quality outcome. We just don't have those numbers yet. It is difficult. But we clearly need to move to those systems.

When we do that, what Dr. Myers raises is the real question. If we think about continuum of care, we are going to have to have some jurisdiction say, it may be linked to a system outside of our county, and how do we build that? And many states are already doing that. UVA is but one example. North Carolina is doing great work.

But if this Committee would stay on that from a viability standpoint within USDA, we might move the SEBAS facility assessment to beginning to make those investments so that the indicators are more than just economic return on investment.

Mr. POMEROY. I know my time has expired. I think that would be very, very helpful.

Thank you, Mr. Chairman.

The CHAIRMAN. Yes, that sure would be. Thank you. Thanks very much.

All right. Mr. Spade, you had mentioned that Congress can improve collaboration by creating incentives for rural health providers to work together with their rural communities. Can you just list for us what types of incentives you are talking about to make sure that collaboration happens?

Mr. SPADE. Sure. For instance, the alignment of quality of care incentives between physicians and hospitals would be a great example, where physicians are now moving into an incentive-based system, pay for performance, if you will, and hospitals as well. Right now those are not aligned. You know, physicians have different ways that they are receiving reimbursement for their hospitalized patients *versus* the hospitals. The hospitals are going to be incentivized on quality performance. The physician working that needs to also be in alignment.

Outpatient settings, as well: If you think about, let's say, evidence-based practice in diabetes or asthma care, those need to be aligned with federally qualified health clinics, community health centers, migrant health centers, as well as the private practice of medicine, Medicaid programs for instance. So that is one example.

Another example would be in the FQHC and community health clinic program where more funding is being put into creating those. But, in North Carolina, we have had to work quite a bit to try to engage across the health care settings to bring community health clinics and FQHCs into the local health care environment, to be a part of working with a hospital, as part of working with private physicians.

So those types of things are key. For instance, in that program, you could incentivize it in their grant program, make it a much stronger incentive piece. Make it very clear what collaboration is in those organizations.

So there is a ton of opportunity. Also, you had the—this is a great question that Representative Pomeroy asked. Community care of North Carolina is an award-winning program that is using Medicaid to bring together physicians, hospitals and public health to operate a health care system, an integrated health care system, based on quality and preventing disease for Medicaid clients and uninsured residents of North Carolina.

The cool thing about that program and the reason it is award-winning is it saved $230 million over a 2 year period of time. It drove incentives together where we improved the care, saved money for the government program, and had increases of health status of the clients being served.

Those are the kind of opportunities we need to find, where we are saying, across the health care spectrum, we are working together—public health, federally funded health centers, private

medicine plans, health care plans that are also engaged in this work and activity. And that is the kind of alignment we need to see.

The CHAIRMAN. Thank you very much.

Dr. Myers, you mentioned that current loan program guarantees for rural health care facilities are a burdensome process. What specific changes would you recommend to make sure that the costly application requirements in these cumbersome requirements would not be put on the applicant?

Dr. MYERS. I would say, starting out, that I don't think anybody in the field would undervalue the work that Under Secretary Dorr has put into doing his best, given the terrain he was dealt, to make that process work better.

One of the real problems just is sheer duration, and part of the duration goes into proving that you are not really able to get private money. And so you have to accumulate three, four, five failures before you can go forward with access to the USDA money.

It might be possible to devise an annually negotiated formula that would specify eligibility rather than going through a repetitive failure process to qualify for some of that loan money.

People that have worked with this far more than I may have other suggestions, but that would be one for starters.

The CHAIRMAN. If you could, please follow up with how you would suggest doing that. Because I know with the network you have in the National Rural Health Care Association and since you are here on behalf of that association, would you go back to their staff and ask them specifically to make a recommendation?

Because if it is a burdensome process, we do want to make specific changes or make suggestions for those changes. And we would welcome, with the great respect that the National Rural Health Association has, we would welcome your input. And if you could do that, that would be most helpful.

Dr. MYERS. Absolutely.

The CHAIRMAN. I know we are going to be going into votes momentarily. I want to thank all of you for your attendance today at this important hearing.

Under the rules of the Committee, the record of today's hearing will remain open for 10 additional calendar days to receive additional material and supplementary written responses, as we have specifically asked of witnesses today.

We would ask you to please submit those within 10 calendar days from today.

This hearing of the Subcommittee on Specialty Crops, Rural Development and Foreign Agriculture is now adjourned.

I want to thank you all for your attendance and support. May God bless you in the very important work you are doing to help rural citizens in America. Thank you very much.

The meeting is adjourned.

[Whereupon, at 4:10 p.m., the Subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

SUBMITTED QUESTIONS

Responses from Hon. Thomas C. Dorr, Under Secretary for Rural Development, U.S. Department of Agriculture

Question Submitted by Hon. John Barrow, a Representative in Congress from Georgia

Question. Please provide a response to the concerns expressed regarding Medicare C payment disparity. I recognize that this is not your jurisdiction, but Mr. Dorr indicated that he would get back to him on this.

Answer. The scope of the concern raised at the hearing is not within USDA's jurisdiction. We respectfully defer to HHS to answer this question.

Question Submitted by Hon. Henry Cuellar, a Representative in Congress from Texas

Question. Please provide list of the different rural health care programs for all agencies within the Working Group and plan for creating a "one-stop shop"/web link, along with information on what is available on distance learning/telemedicine. Same request made to HHS.

Answer. The USDA Rural Development Telecommunications Program manages the Distance Learning and Telemedicine Program (*http://www.usda.gov/rus/telecom/dlt/dlt.htm*). The American Telemedicine Association has a link to the USDA Distance Learning and Telemedicine Program on its website (*http://www.americantelemed.org/news/links.htm*). The Federal Communications Commission also links to the USDA site (*http://www.fcc.gov/cgb/rural/* and *http://wireless.fcc.gov/outreach/index.htm?job=broadband_home*). We have coordinated with the Dept. of HHS on their Health Information Technology initiative and with the FCC on their telehealth pilot program. The *www.grants.gov* website provides information on grant programs available from Federal agencies, and there is a search capability.

USDA Rural Development welcomes any further suggestions concerning websites.

Question Submitted by Hon. Mike McIntyre, a Representative in Congress from North Carolina

Question. How telemedicine would best be accomplished in states, using medical universities and research centers.

Answer. The Telecommunications Program's Distance Learning and Telemedicine (DLT) loan and grant programs provide funding for telemedicine projects throughout rural America. We do not believe that there is one "best" model for deploying telemedicine services. Flexibility, innovation, and the ability to adapt delivery mechanisms to local circumstances are important considerations. As technology advances, we are prepared to explore new options.

Many medical universities and research centers have participated in the telemedicine program. Participation may evolve over time as institutions gain experience with the program and identify new opportunities for deployment.

DLT grantees have included for-profit and nonprofit organizations, universities, private hospitals, clinics, *etc.* Program staff interacts with telemedicine industry associations and organizations to stay current on best practices and approaches. Information on grant projects is available on the Rural Development website, with project descriptions and contacts. Headquarters and field staff provide information and support to prospective applicants, including how to apply workshops. Outreach activities are conducted at the national, state and local level.

Responses from Tom Morris, Acting Associate Administrator, Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services

Question Submitted by Hon. John T. Salazar, a Representative in Congress From Colorado

Question. A list of the different programs, including retention programs, HHS has directed toward rural areas.

Answer. Below is a list of HHS rural and retention programs:

- **Health Center Program**—Health Centers are community-based and patient-directed organizations serving populations with limited access to care. Health Centers are open to all regardless of ability to pay. Moreover, the Health Centers provide comprehensive primary care service on a sliding fee based on the patient's income. Health Centers improve the health status of underserved populations living in isolated rural communities, where residents often have no where else to go. To meet this need, over half (53 percent) of Health Centers serve rural populations. (HRSA)

- **National Health Service Corps (NHSC)**—The NHSC Scholarship Program awards scholarships to health professions students committed to a career in primary care and service in underserved communities of greatest need. Awards are targeted to individuals who demonstrate characteristics that are significantly related to a probable success in a career of service to the underserved. The NHSC Loan Repayment Program offers fully trained primary care clinicians the opportunity to receive assistance to pay off qualifying educational loans in exchange for service in a HPSA of greatest need. Both NHSC scholars and loan repayers are equally ready to serve. This service commitment is for a minimum of 2 years in an underserved community. (HRSA)
- **Nursing Education Loan Repayment Program (NELRP)**—This is a competitive program that repays 60 percent of the qualifying loan balance of participating registered nurses in exchange for 2 years of service at a critical shortage facility. Participants may be eligible to work a third year and receive an additional 25 percent of the qualifying loan balance. (HRSA)
- **Nursing Scholarship Program (NSP or "Nursing Scholarship")**—This is a competitive program for individuals attending schools of nursing. The scholarship consists of payment for tuition, fees, other reasonable educational costs, and a monthly support stipend. In return, the students agree to provide a minimum of 2 years of full-time clinical service (or an equivalent part-time commitment, as approved by the NSP) at a health care facility with a critical shortage of nurses. (HRSA)
- **National Rural Recruitment and Retention Network (3RNet)**—This network links together rural health care provider recruitment experts in 45 states. The 3RNet links providers in search of rural practice opportunities with rural communities in need of practitioners. More information on the 3RNet is available at *http://www.3rnet.org.* (HRSA)
- **Capacity Building to Develop Standard Electronic Client Information Data System** (*http://www.raconline.org/funding/funding_details.php?funding_id=1754*)—Funding to organizations funded under Part A–D of the Ryan White HIV/AIDS Treatment and Modernization Act of 2006 to promote the development of standard electronic client information data. (HRSA)
- **Community Economic Development Program Operational Projects** (*http://www.raconline.org/funding/funding_details.php?funding_id=516*)—Grants to provide technical and financial assistance for community economic development activities designed to address the economic needs of low-income individuals and families through the creation of employment and business opportunities. (ACF)
- **Empowering Older People to Take More Control of Their Health Through Evidence-Based Prevention Programs: A Public/Private Collaboration** (*http://www.raconline.org/funding/funding_details.php?funding_id=1267*)—These grants are designed to mobilize the aging, public health and nonprofit networks at the state and local level to accelerate the translation of HHS funded research into practice. (AoA)
- **Faculty Loan Repayment Program (FLRP)** (*http://www.raconline.org/funding/funding_details.php?funding_id=314*)—A loan repayment program for individuals from disadvantaged backgrounds who serve as faculty at eligible health professions schools for a minimum of 2 years. (HRSA)
- **Office of Child Support Enforcement Special Improvement Project (SIP) Grants** (*http://www.raconline.org/funding/funding_details.php?funding_id=325*)—Funding for special improvement projects which further the national child support mission, vision, and goals. (ACF)
- **Projects of National Significance: Family Support 360 for Military Families** (*http://www.raconline.org/funding/funding_details.php?funding_id=1896*)—Grants to plan and implement up to three Family Support 360 Centers for military families of children with developmental disabilities. (ACF)
- **Rescue & Restore Victims of Human Trafficking Regional Program** (*http://www.raconline.org/funding/funding_details.php?funding_id=1681*)—Grants to continue and expand the efforts through regional grantees who will serve as the focal point for an intensification of local outreach to and identification of victims of severe forms of trafficking in persons. (ACF)
- **Take Action: Healthy People, Places, and Practices in Communities Project** (*http://www.raconline.org/funding/fund-*

ing__details.php?funding__id=1452)—Funding to evaluate activities in local communities across the HHS regions that support and promote healthy lifestyles. (OPHS)

- **Delta Health Initiative Cooperative Agreement** (*http://www.raconline.org/funding/funding__details.php?funding__id=1183*)—This Cooperative Agreement Program is to provide funding to an alliance to address longstanding unmet rural health needs (access to health care, health education, research, job training and capital improvements) of the Mississippi Delta. (HRSA)
- **FLEX Critical Access Hospital Health Information Technology Network Implementation Grants (CAHHITN)** (*http://www.raconline.org/funding/funding__details.php?funding__id=1610*)—Funding for up to 15 grantees to support the development of one (1) Flex CAH–HIT Network pilot programs in each state that is awarded a grant. Only current Flex Grantees may apply. (HRSA)
- **In Community Spirit—Prevention of HIV/AIDS for Native/American Indian and Alaska Native Women Living in Rural and Frontier Indian Country Program** (*http://www.raconline.org/funding/funding__details.php?funding__id=1190*)—To support collaborative efforts to provide accurate prevention education to Native/American Indian and Alaska Native (AI/AN) women living in rural and frontier Indian Country. (OWH)
- **Medicare Rural Hospital Flexibility Program** (*http://www.raconline.org/funding/funding__details.php?funding__id=1609*)—Grants to improve and sustain access to appropriate healthcare services of high quality in rural America by supporting conversion of small rural hospitals to critical access status, helping develop rural health care networks, and strengthening rural EMS. (HRSA)
- **Medicare Rural Hospital Flexibility Program Evaluation-Cooperative Agreement** (*http://www.raconline.org/funding/funding__details.php?funding__id=1864*)—The evaluation project will continue to assess the effectiveness of implementing the grant program in states and in rural communities and to provide recommendations for increasing the impact of the program to improve healthcare in rural America. (HRSA)
- **One-Year Rural Health Research Grant Program** (*http://www.raconline.org/funding/funding__details.php?funding__id=679*)—Grants to conduct and disseminate policy-relevant research on issues of national significance in the area of rural health services. (HRSA)
- **Targeted Rural Health Research Grant (TRHR)**—This grant provides funding for policy-oriented research projects which address critical issues facing rural communities in their quest to secure affordable, high quality health services. (HRSA)
- **Rural Health Care Services Outreach Grant Program** (*http://www.raconline.org/funding/funding__details.php?funding__id=60*)—The emphasis of this grant program is on health care service delivery through creative strategies requiring the grantee to form a consortium with at least two additional partners. (HRSA)
- **Rural Health Network Development Grant Program (RHND)** (*http://www.raconline.org/funding/funding__details.php?funding__id=61*)—This grant program is designed to support organizations that wish to further ongoing collaborative relationships among health care organizations to integrate systems of care administratively, clinically, financially, and technologically. (HRSA)
- **Rural Health Network Development Planning Grant Program (RHNPGP)** (*http://www.raconline.org/funding/funding__details.php?funding__id=218*)—This Rural Health Network Development Planning Grant Program supports 1 year of planning to develop integrated health care networks in rural areas. (HRSA)
- **Rural Health Research Center—Cooperative Agreement Program** (*http://www.raconline.org/funding/funding__details.php?funding__id=361*)—Grant awards for Rural Health Research Centers. (HRSA)
- **Rural Policy Analysis Cooperative Agreement** (*http://www.raconline.org/funding/funding__details.php?funding__id=1572*)—Grant to support research and analysis into key policy issues affecting rural communities. (HRSA)
- **Small Rural Hospital Improvement Grant Program (SHIP)** (*http://www.raconline.org/funding/funding__details.php?funding__id=64*)—This program provides funding to small rural hospitals to help them do any or all of the following: pay for costs related to the implementation of PPS, comply with

provisions of HIPAA and reduce medical errors and support quality improvement. (HRSA)

- **State Rural Health Coordination and Development Cooperative Agreement** (*http://www.raconline.org/funding/funding_details.php?funding_id=947*)—Grants to build and sustain rural health infrastructure in states. (HRSA)
- **Targeted Rural Health Research Grant Program** (*http://www.raconline.org/funding/funding_details.php?funding_id=1824*)—Grants for Rural Health Research studies on a selected number of topics. (HRSA)
- **Research on Emergency Medical Services for Children** (*http://www.raconline.org/funding/funding_details.php?funding_id=831*)—Grants to improve the quality and quantity of research related to emergency medical services for children (EMSC). (HHS)
- **Frontier Extended Stay Clinic Program (FESC)**—Cooperative agreement demonstration program to examine the effectiveness and appropriateness of a new type of provider, the FESC, in providing health care services in certain remote clinic sites. The FESC is designed to address the needs of patients who are unable to be transferred to an acute care facility because of adverse weather conditions, or who need monitoring and observation for a limited period of time. (HRSA)
- **State Offices of Rural Health Grant Program (SORH)**—Grants to strengthen rural health care delivery systems by creating a focal point for rural health within each state. (HRSA)
- **Delta States Rural Development Network Grant Program (Delta)**—The purpose of this grant program is to fund organizations located in eight Delta States (Alabama, Illinois, Kentucky, Louisiana, Mississippi, Missouri, and Tennessee) which address unmet local health care needs and prevalent health disparities through the development of new and innovative project activities in rural Delta communities. (HRSA)
- **Rural Access to Emergency Devices (RAED)**—This grant program provides funding to rural community partnerships to purchase automated external defibrillators (AEDs) that have been approved, or cleared for marketing by the FDA; and provide defibrillator and basic life support training in AED usage through the American Heart Association, the American Red Cross, or other nationally-recognized training courses. (HRSA)
- **Small Health Care Provider Quality Improvement Grant Program (Rural Quality)**—This grant program supports rural public, rural nonprofit, or other providers of healthcare services, such as Critical Access Hospitals or rural health clinics. The purpose of the program is to improve patient care and chronic disease outcomes by assisting rural primary care providers with the implementation of quality improvement strategies, with a focus in quality improvement for chronic disease management. (HRSA)
- **Radiation Exposure Screening and Education Program (RESEP)**—RESEP supports healthcare organizations to improve the knowledge base and health status of persons adversely affected by the mining, milling, or transporting of uranium and the testing of nuclear weapons for the nation's weapons arsenal. (HRSA)
- **Black Lung Clinics Program (BLCP)**—This program seeks out and provides miners (active or inactive) with the intention of minimizing the effects of respiratory impairment or improving the health status of miners or coal miners exposed to coal dust as a result of employment and to increase coordination with other services and benefits programs to meet the health-related needs of this population. (HRSA)
- **Program of All-Inclusive Care for the Elderly (PACE)**—The PACE program provides a range of services to help certain Medicare and Medicaid beneficiaries who meet their state's standards for nursing home care to continue living safely at home rather than be institutionalized. (CMS)
- **Telehealth Network Grant Program (TNGP)**—Grant program that provides grants to health care networks to develop and evaluate the use of Telehealth technologies to improve access to underserved communities. The TNGP focuses on providing innovative telehealth services to rural areas. From March 2007 through February 2008, nearly 140 thousand telehealth visits for 46 different specialty services were provided to patients in rural communities under this Program. (HRSA)

- **Telehealth Resource Center Grant Program**—HRSA supports five regional and one national telehealth resource centers to provide technical assistance to rural communities interested in providing or receiving telehealth services. The five regional centers work together to make available technical assistance from the nation's experts on practical approaches to creating a successful telehealth program, whereas the national center focuses on technical assistance to address the legal and regulatory barriers to sustaining successful programs. (HRSA)

Question Submitted by Hon. Jim Costa, a Representative in Congress from California

Question. Information on rulemaking status and effects on rural areas.

Answer. HRSA received many substantive comments on the February 29, 2008 Proposed Rule on the Designation of Medically Underserved Population and Health Professional Shortage Areas and will consider these comments.

Question Submitted by Hon. John Barrow, a Representative in Congress from Georgia

Question. A response to the concerns expressed regarding Medicare C payment disparity.

Answer. We understand that in 2006 and 2007 there were complaints from Critical Access Hospitals (CAH) that Medicare Advantage (MA) plans were not making timely payments and were requesting certain documentation in order to receive payment. Most of these complaints were related to payments from non-network private fee-for-service (PFFS) plans. The Centers for Medicare & Medicaid Services (CMS) has provided instructions to contracted MA plans on making appropriate payments to contracted and non-contracted CAHs.

MA comprises a number of different health plan options, from traditional managed care HMOs to PFFS options that provide a wide range of providers. In PFFS plans that use "deeming" to obtain services for their beneficiaries at providers with whom the plan has no contract, the plan is required to pay the CAHs based on standard Medicare FFS rules—in other words, 101% of their costs—just as FFS does—even if they are used by the PFFS plan's members on a non-emergent basis. CAHs that choose to contract with an MA plan to become part of its network are reimbursed at the rate that was agreed upon between the CAH and the MA plan. Since there is no Federal guarantee of supplemental payments to CAHs, CAHs that contract with any type of MA plan must negotiate the most advantageous rate to the best of their ability. CMS is prohibited from interfering in the contracting process between MA plans and providers.

We also understand there have been complaints that MA plans are not cost settling with CAHs, in order to be paid like Medicare. Although CAHs may cost settle with their Fiscal Intermediary (FI) for FFS claims, MA plans are not required to cost settle. FIs work directly with CAHs during the course of the CAH's fiscal year to set estimated (a.k.a. "interim") payment rates amounts based on their costs; therefore, in order to pay the interim rate to the CAH, MA plans may ask a billing CAH to submit a copy of their most recent interim rate letter from their FI. The interim rate is sufficient compensation for cost-reimbursed providers. Sometimes the CAH "wins" when the cost settlement is downward, sometimes the MA plan "wins" when the cost settlement is upwards. Interim rates may change one or more times during the year, therefore, it is important plans are aware of the correct rate, since they must reimburse the CAH for the rate that is in effect at the time of service.

Question Submitted by Hon. Henry Cuellar, a Representative in Congress from Texas

Question. A list of the different rural health care programs for all agencies within the Working Group and plan for creating a "one-stop shop"/web link, along with information on what is available on distance learning/telemedicine.

Answer. A list of HHS programs is provided above (Rep. Salazar list). HRSA does not maintain a list of rural programs across the Federal Government. However, HRSA funds the Rural Assistance Center (RAC) which offers rural residents one-stop shopping on health-related rural issues. The RAC collects information about rural health funding opportunities from across the Federal agencies. The link to the website is *www.raconline.org.*

Question Submitted by Hon. Mike McIntyre, a Representative in Congress from North Carolina

Question. How telemedicine would best be accomplished in states, using medical universities and research centers.

Answer. University medical centers play a critical role in developing telemedicine programs throughout the country, usually acting as the pioneers in establishing telemedicine networks and documenting the contribution of these networks to im-

proving access to care. However, the role of the universities differs dramatically from state-to-state.

The University of California, Davis is a prominent example of a university and state that invest heavily in telemedicine. UC Davis launched one of the earliest programs in 1992, focusing on fetal monitoring in rural communities. Over the years, UC Davis created the Telemedicine Learning Center, providing educational programs for health professionals, administrators, and technologies on how to develop a sustainable telemedicine program. It is a key provider of telemedicine services to rural communities within the state. In 1996, California was the first state to pass a law that required providers to be reimbursed for delivering services via telemedicine and in 2006, the legislature allocated $200 million for designing, building and equipping facilities in the University of California system that enhance medical education, with an emphasis on telemedicine.

Universities not only play key roles in service provision and educating/advocating for telemedicine, they are often the nexus in statewide initiatives to obtain funding. For example, in both Virginia and Arkansas, universities were pivotal players in obtaining significant funds to support the development of pilot programs under the FCC's Rural Pilot program to improve the telecommunications infrastructure for telehealth services in rural areas.

Response from Wayne Myers, M.D., Trustee, Maine Health Access Foundation; Past President, National Rural Health Association

Question Submitted by Hon. Bob Goodlatte, a Representative in Congress from Virginia

Question. How would health information technology legislation that has been drafted in other committees accommodate concerns specific to rural areas?

Answer. Representative Goodlatte, thank you for your leadership on issues addressing the high-tech needs of America.

The main concern of rural health providers is their financial ability to both purchase and then maintain health information technology systems. In most of the HIT bills that have been introduced, Congress has sought to address these concerns in one of two ways—incentive payments as a percentage of the Medicare payment or competitive grant programs to purchase equipment. Rural providers need more.

Rural facilities have less volume than their urban counterparts. Most of the purchase cost of HIT equipment has a single fixed cost. No matter how many patients a provider sees, such equipment is still going to cost approximately the same basic amount both to purchase and maintain. So while incentive payments may seem to help defer some of the maintenance costs or seem to reward facilities that use the technology the most, the neediest rural facilities will not ever be able to use these payments to make such purchases.

Alternatively, grant programs have the promise of providing the upfront cost of purchasing HIT equipment. Unfortunately, the grant programs proposed in a number of Congressional HIT bills do not carve out rural providers with a separate pot of money or help to weigh rural providers appropriately. Our experience with competitive grants is that it is the largest providers that have the staffing needed to compete for such monies. And, even if rural providers end up receiving these grants, there is not follow up funding to help them operate these systems. Often ongoing maintenance costs exceed the purchase cost within a very short time frame.

Obviously, some combination of the two with a rural emphasis would be helpful to increase HIT utilization in rural America.

One last thing that I would note, Congress has introduced a variety of different programs over the years that have been housed in a number of Federal agencies—the Department of Agriculture, Department of Health and Human Services, Federal Communications Commission—we would strongly recommend using a single lead agency to advance these potential initiatives, such as the Office of the National Coordinator for Health Information Technology. Doing so makes it much easier for rural providers to access the adequate assistance than dealing with a variety of Federal agencies.

Response from National Rural Health Association by Charles A. Wells, Jr., President, Healthcare Financial Advisers, Inc.

Question Submitted by Hon. Mike McIntyre, a Representative in Congress from North Carolina

Question. What changes would you recommend to make sure that application requirements for loan guarantee programs are less burdensome and costly for the applicant?

Answer. The following comments about the suitability of the USDA loan programs for rural hospitals are based on my 30 years of experience working as a financial and strategic adviser in this market. During that time, I have assisted several clients in pursuing USDA financing, although none of these transactions have occurred in the last 3 years.

As an aside I've had relatively good experience with USDA on smaller nursing home financings, as these projects are typically much smaller and significantly less complex.

Background

Prior to 2003/2004 there was very limited access to capital for rural hospitals (Critical Access Hospitals in particular). Accordingly, the USDA and HUD programs were in the forefront of options under consideration. Then the "conventional" tax exempt bond markets (sold primarily to institutional investors such as bond funds, banks, and insurance companies) and the underwriting firms who sell to those sources warmed up to the cost reimbursement elements of Critical Access Hospitals, and the situation improved dramatically. The period from 2004–August 2007 was the best time in my working lifetime (1970–2002) for rural hospitals to access capital through conventional, non-governmental sources. From my vantage point, during this period, the governmental programs were non-competitive.

When USDA and HUD were the only games in town, the deficiencies in their offerings were tolerated, but now the market has changed. However, the last 12 months have been very tumultuous in the tax exempt markets for rural hospitals, and USDA and HUD could once again become relevant.

When I first encounter a new client situation with a rural hospital (critical access or otherwise), I do a fairly quick assessment of their financial history and prospects to determine where they might access capital under the most favorable terms. For the past 4–5 years, the only clients I would recommend pursuing USDA or HUD would be those that I am absolutely certain would be turned down by the conventional markets.

The following summarizes some of the reasons for this viewpoint:

Direct Loan Program

Loan Size Limitations/Inter-creditor agreement complexities

To my knowledge, the largest USDA direct loan ever made to a hospital was $7 million (for a CAH in Iron County, MO). Most USDA direct loans are in the range of $2–$4 million. Most major replacement projects for Critical Access Hospitals will require funding in excess of $20 million. This means that the USDA Direct loan must be married with another debt instrument. At the conversational level, the USDA people will say "no problem, we're happy to do a loan on a parity basis with another lender(s)." However, it has been my experience that this can be a troublesome once the USDA attorneys become involved, resulting in USDA seeking a preferred position. This is an enormously important "detail." Whatever savings might occur with the lower rate on $5 million of a USDA direct loan will be offset by increases in the costs of the remaining $15+ million.

Prevailing Wage

If a hospital accepts governmental money, it will subject the entire project to "prevailing wage" (which I believe is part of the Davis-Bacon Act). For example, in a recent rural Illinois project this meant that unskilled laborers were making $41/hr to push a broom on the construction site. This can add 3%–7% to overall construction costs. This can also upset the local labor market significantly.

Time Required for the Application Process

Almost all decisions on the direct loan program are made in August–September (the end of the government's fiscal year is 9/30). One typically submits an application in June seeking preliminary approval in August with final approval in either September or October. For applications not funded through the state allocation, the next step is to access the "pooling" process to see if there are unused funds from other states. This could delay acceptance until October/November or rejection at that time. In order to file this application, you will need an "examined" forecast *versus* the "compiled" forecast. This typically increases the hospital's cost by $25,000–$50,000.

Hospital projects that don't fit the government's calendar are at a disadvantage and are faced with the decision to either slow down their efforts or seek other, more flexible sources of capital.

The most cumbersome part of the application process is that the construction drawings must be substantially complete so USDA architects can review the plans. The practical implications of this are that the hospital must spend several hundreds of thousands of dollars in architectural fees without having any assurance that their

project will be funded. In contrast, in the commercial market the underwriters give reasonable assurances about the viability of the financing much earlier in the process (after the "schematic" design is complete) and before the hospital then undertakes the major expense of completing "detailed design" and "construction drawings." In addition I know several, capable hospital architects who have been through this, and find that the USDA architectural review is very cumbersome and can result in many expensive, unnecessary changes.

There is also a requirement to receive a letter from a lender saying "we won't lend money on this deal." In theory, the USDA programs are supposed to be for the deals conventional lenders will pass on.

Based on personal, and painful experience with clients in the pre 2003 era, there is a distinct possibility that you can go through this expensive, time-consuming process and receive a rejection. On a $20 million project, assuming 10% inflation, wasting 6 months chasing USDA can erode a hospital's borrowing power by $1 million.

USDA Loan Guarantee Program

If turned down in the direct loan program, USDA will often promote their "loan guarantee" program which shares all of the undesirable qualities of the Direct program, but with added disincentive of high, taxable interest rates (usually over 7.5% and usually variable).

The loan guarantee program is even more cumbersome than the direct. This application process involves finding a bank willing to make the loan with the guarantee. It is also worth noting that the USDA guarantee doesn't take effect until the project is completed and the hospital is certified for occupancy. The lender then has to bear the full risk of the construction phase of the loan, thus increasing the cost of capital.

Additional Borrowing Covenants

One of the worst aspects of a USDA loan relates to covenants. Conventional bonds have "additional borrowing" covenants that specify "you meet these financial criteria, then you can issue additional debt on a parity basis with the current bonds." The USDA covenant says "you can issue additional debt with our permission." This can be a very perilous trap and forces the hospital to either refinance, or go through an entire re-application process, with a significant chance of getting "no" for an answer.

State Differences

USDA is organized by districts within states. It has been my experience that some states have staff that understand rural hospitals, such as Missouri, and some states that don't.

Questions for the USDA Representative

During the past few months I have had conversations with the USDA representatives in Kansas and Iowa who are responsible for promoting the "Loan Guarantee" program in their states. I asked each the following questions:

> How many such deals have been done in your state? Answer: "None".
>
> What interest rates might my clients expect through this program? Answer: "Don't know."
>
> Can you get me a list of rates/banks from any transactions from other states? Answer: "I don't have access to that information."
>
> What banks have the most experience in working with USDA on this program? Answer: "I don't know."
>
> What is your underwriting criteria? And if my client meets that criteria what is the probability of getting approval? Answer: "I don't know."

I can assure you that those promoting other financing options for rural hospitals are better informed about their offerings.

Recommendations

As of today rural hospitals that are reasonably strong have several non governmental options in accessing capital and have little reason to consider USDA. Weaker hospitals could benefit from an improved USDA offering. I would, however, be gravely concerned if improvements in the USDA program were such that the result was the diminution of the private capital markets from this market. Then we would be back to the pre 2003 era.

Here's a quick list of some suggested changes USDA might consider to improve their offerings:

Process:

—Establish reasonable underwriting standards to give applicants a reasonable idea whether their application will be accepted before undertaking a lengthy process. For those meeting the criteria provide a written approval subject to certain conditions. *As a practical matter those of us who live and breath rural hospitals can undertake this analysis in a matter of hours from readily available data. Much of the information required on the USDA application is of no value in assessing the creditworthiness of the loan.*

—Eliminate the requirement to have detailed construction drawings before approving a loan.

—Eliminate the requirement for USDA architects to review the plans. *Every project will be reviewed by the state's architect, the state fire marshal, and Medicare certifying authorities. The USDA architect's review adds little value and in some cases reduces value.*

—Accept a compiled forecast vs. examined.

—Change loan covenants to make them more competitive with conventional tax exempt bonds, specifically pertaining to the topic "additional borrowing" on a parity basis.

—In the case of the direct loan program revise USDA thinking about parity "Inter-creditor" agreements on a parity basis. *There are many excellent examples of how this can be accomplished by borrowing from the private markets. There is no need to reinvent this "wheel".*

—Allow hospitals to use "guaranteed maximum price" contracts with construction managers. Currently USDA requires that all construction be done on a "hard bid" basis. The advantage of GMPs is that it speeds up the process.

Loan guarantee program:

—Expand the guarantee to cover the construction period. *Banks typically view construction loans as distinct from permanent financing, with major differences in the credit analysis. Many banks consider the construction period to be much higher than the post construction period and they price their capital accordingly. In contrast, tax exempt revenue bonds issue combine the two components. For the USDA program to be successful they need to act more like the conventional tax exempt markets.*

The greatest improvement that could be made to the loan guarantee would be to allow the loans to be tax exempt, but I am also aware of the complex dynamics associated with a change of this nature. A change of this nature could have an adverse affect on other sources of capital for the rural hospitals.

Summary

I grew up in a small town, have worked with several hundred rural hospitals, and have traveled many blue highways. I am a passionate believer in the value of rural hospitals to their communities, and I would welcome the chance to assist in anything that would increase their access to capital under favorable terms. I am also quite aware of the unintended consequences that can result from good intentions. I would be guardedly optimistic about the potential for good to occur from significant revisions in the way USDA approaches the rural hospital market. I hope these thoughts are helpful. I'd be happy to discuss this topic further at any time.

CHUCK WELLS.

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