SENATE STUDY COMMITTEE ON RURAL HOSPITALS AND RURAL HEALTH

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EXECUTIVE SUMMARY

The Senate Study Committee on Rural Hospitals and Rural Health (Committee) was created by Senate Resolution 841 during the 1998 Session of the Georgia General Assembly. The Committee was charged with conducting a study on the state of rural hospitals and examining the needs of rural communities threatened with losing the crucial element that maintains the health and financial well-being of these communities_their hospitals. Georgia is facing many challenges to its health care delivery system in rural communities throughout the state.

One-hundred and seventeen of the 159 counties in Georgia are considered rural. Problems that have contributed to the present state of rural health in Georgia, include: high infant mortality rates, high rates of heart disease and cancer, large poor and elderly populations, lack of prenatal care, and lack of transportation. Poor health status indicators, coupled with a deteriorating rural health care delivery system have resulted in the present crisis faced today in Georgia's rural communities

Rural hospitals, the economic centers of their communities, are struggling for their survival. A total of 51 rural hospitals have lost money in at least one of the last three years. Twenty-one rural hospitals have lost money *consistently* in the last *three* years. Another 17 have lost money in *two* of the three years, while another 13 more have lost money in *one* of the last three years. Given the vulnerable state of rural hospitals in Georgia, rural communities are in serious jeopardy of losing not only the significant producer of jobs and services to the local population, but also the crucial component of health care delivery in their communities.

Four major obstacles threatening the viability of rural hospitals were identified in the course of the Committee's study.

- **1. Rural hospitals are treating an increasing number of uninsured patients, and cannot afford to continue providing uncompensated care.**

  In Georgia, the estimated population of the uninsured is currently at 18 percent, or 1,319,000 people. Rural hospitals have been losing hundreds of thousands to millions of dollars in uncompensated care, which in turn, is having a major impact on the viability of rural hospitals. The uninsured usually delay medical treatment to the point that they need emergency care, which is the most expensive form of health care. Hospital revenues have been negatively affected by the large and increasing number of uninsured and Medicaid enrolled patients. *The State needs to address the issue of the uninsured.*
- **2. Four years of continued cuts in Medicaid reimbursements have had a serious and detrimental effect on rural hospitals.**

  The reduction of Medicaid reimbursements has been the result of five percent re-directions required in the state Medicaid budget since FY1996. Also, reductions in federal Medicaid and Medicare budgets have left rural hospitals in financially vulnerable conditions given that anywhere from 60 to 95 percent of their revenues come from government-based reimbursement. *The State should examine the result four years of cuts in Medicaid reimbursement rates have had on rural hospitals and propose some type of financial support for hospitals in crisis.*
- **3. Rural communities and their hospitals continue to suffer from the inability to recruit and retain physicians.**

  Rural hospitals are experiencing a severe shortage of physicians, especially primary care physicians. Many students graduate from medical school with huge debts and prefer to go to the hospitals and communities offering them larger

salaries and more benefits. *The State should evaluate and propose incentives to encourage physician recruitment and retention in rural communities.*

- **4. Rural hospitals, facing declining revenues and increasing patient loads, have no money available to use for capital expenditures and re-investment.** Buildings and health care facilities are deteriorating, equipment and information systems are becoming antiquated, and medical technology being used at some rural facilities is considered below the standard of care being offered at urban facilities. In order to stay competitive, rural hospitals must offer the same standard of care. *The State should examine the possibility of using the funding available from the Tobacco Settlement, in part, to assist rural hospitals in infrastructure and capital development.*
- **5. Rural residents of Georgia deserve to live the same quality of life as their urban counterparts, and without a network of viable rural hospitals, the people of rural Georgia will be left without quality health care, or any health care at all. Rural Georgia is entitled to a health care delivery system that is accessible, affordable, and dependable.**

  Without strong, swift policy changes and new funding initiatives, rural Georgia will slip decades behind the rest of the country in health care.

I. INTRODUCTION

A. Charge of the Committee

The Senate Study Committee on Rural Hospitals and Rural Health (Committee) was created by Senate Resolution 841 during the 1998 Session of the Georgia General Assembly. The Committee was charged with conducting a study on the state of rural hospitals and examining the needs of rural communities threatened with losing the crucial economic component that maintains the financial health of these communities_their hospitals. A rural community's ability to attract and bring businesses into communities depends on the presence of a stable, local hospital.

The resolution provided that the Lieutenant Governor appoint the Committee's chairman and members. The Lieutenant Governor appointed Senator Jack Hill as the Chairman. The senators serving on the Committee are as follows: Senator Mike Crotts, Senator Hugh Gillis, Senator Rene' Kemp, Senator Eddie Madden, Senator Harold Ragan, Senator Van Streat, and Senator Nadine Thomas. The legislative staff members assigned to the Committee include: Denese Kurtz, legislative assistant to Senator Jack Hill; Cherine Dabbagh, Senate Research Office; Karen Ewing, Senate Information Office; and Doug Carlyle, Office of Legislative Counsel.

The Committee held five public meetings on the following dates: November 9, 1998, in Atlanta, Georgia; November 20, 1998, in Donalsonville, Georgia; November 30, 1998, in

Springfield, Georgia; December 11, 1998, in Elberton, Georgia; and December 17, 1998 in Atlanta, Georgia.

B. Background: State of Rural Health in Georgia

Georgia is the tenth most populous state in the country, with a population of 7,486,000 people.See footnote 1 [1] Of Georgia's 159 counties, 117 of them are considered rural,

with a total of 2,240,794 (30.8%) of Georgians living in these counties.See footnote 2 [2] Although most of Georgia's 59,000 square miles are rural, the majority of people living in the state live in urban/metropolitan areas.See footnote 3 [3] A "rural area" is defined as any county having a population of less than 35,000 according to the United States decennial census of 1990. Commissioner Tommy Olmstead, Department of Human Resources (DHR), described the problems of rural health as being the same as those faced ten years ago: accessibility, affordability, quality, and range of services.

Compared to urban areas, the death rate for Georgia's rural population is 37 percent higher; the infant mortality rate is 10 percent higher; the child abuse and neglect rate is 47 percent higher, and the teen pregnancy rate is 24 percent higher. Poverty rates for rural counties exceed those in urban counties by 58 percent. Almost 44 percent of Georgia's citizens who reside in households with incomes

below the federal poverty level reside in rural Georgia, and these rural areas have lower educational attainment levels and higher school dropout rates than urban areas of the state.See footnote 4 [4]

Rural residents are much more likely to forego health care because they live in remote locations, requiring long travel time to health care facilities, with some residents even lacking modes of transportation. Higher infant mortality rates are generally the result of mothers in rural counties receiving inadequate prenatal care. Higher illiteracy rates and/or inadequate language skills handicap individuals and families in making solid health care decisions, and hinder the understanding of health education materials disseminated by the health care system. Lower educational levels in rural counties contribute to poverty and lead to individuals working dangerous jobs, usually jobs that do not provide health insurance. Poverty renders people less able to seek care, and thereby contributes to the greater possibility of illness.

Rural hospitals are necessary to provide basic health care services to Georgia's under-served communities. In recently passed legislation, a rural hospital was defined as a health care facility that (1) operates no more than 100 beds, (2) provides 24-hour emergency care as well as a range of services necessary to support the practice of a primary care physician, (3) has at least 40 percent of its patient revenues from Medicare, Medicaid, or any combination thereof, and (4) is located in a county with a population less than 35,000.See footnote 5 [5]

Rural hospitals usually function as the epicenter of their small communities. Rural hospitals are vital to the economic infrastructure because they provide jobs and services to the local population. Rural hospitals often serve as the single largest employers in their communities. A recent study showed that industry developers consider three variables that must exist in order for a rural community to be able to attract new industry: quality education, economic transportation (including rail and air), and a viable and responsive health care system. By ensuring a healthy workforce and adequate health care, businesses will be more likely to consider moving to rural communities.See footnote 6 [6] Given the vulnerable state of rural hospitals currently in Georgia, rural communities are in serious jeopardy of losing not only their most significant employer, but also the crucial component of health care delivery in their communities.See footnote 7 [7]

II. THE PLIGHT OF RURAL HOSPITALS

A. Testimony: Major Problem Areas and What is Needed to Maintain the Viability of Rural Hospitals

1. Uncompensated Care and the Uninsured

A total of 51 rural hospitals have lost money in at least one of the last three years. Twenty-one rural hospitals have lost money *consistently* in the last *three* years. Another 17 have lost money in *two* of the three years, while another 13 more have lost money in *one* of the last three years.See footnote 8 [8] One of the biggest barriers to success has been the losses suffered by hospitals providing uncompensated care to the uninsured. Although Georgia has enjoyed its lowest unemployment rate in years, the estimated population of the uninsured is currently at 18 percent, or 1,319,000 people. The estimated uninsured "vulnerable population" is 17 percent, or 1,248,231 people.

The increase in the uninsured population has been attributed to a marked shift from professional jobs to service jobs. More and more people are working "multiple" and often part-time jobs that usually do not offer insurance. Also, the high cost of insurance benefits have forced employees to drop the costly coverage of their dependents.See footnote 9 [9] The cost per employee for 1998 in an HMO plan was $3,279, with a 6 to 9 percent projected increase in 1999. The cost per employee for 1998 in the most common coverage plan, a preferred provider organization (PPO), is $4,272, with a 5 to 8 percent projected increase for 1999. Employer costs per employee was estimated at $329 per month in a PPO plan.See footnote 10 [10]

In 1994-1995, the "Kaiser Commission on Medicaid and the Uninsured" found that of the 1,021,000 non-elderly uninsured population in Georgia (16%), 184,000 people could be classified as "poor" (less than 100% of poverty), and 356,000 people could be classified as "near-poor" (100- 199% of poverty). One can assume that the rest of the population, approximately 481,000 people, could be classified as "non-poor" (200% or more of poverty).See footnote 11 [11] Of course, these numbers have changed since 1994 to 1995, and will continue to change given the passage of the 1997 welfare reform law, the 1998

passage of PeachCare for Kids, and various changes occurring within the managed care system.

Every hospital administrator that testified during the public hearings attested to their hospitals losing anywhere from hundreds of thousands of dollars to millions in uncompensated care. Dr. William Taylor, Commissioner of the Department of Medical Assistance (DMA), called the problem of the uninsured a "hidden epidemic," and informed the Committee that there were more Georgians uninsured than on Medicaid. *Today*, approximately 1.3 million Georgians are uninsured, and 1.2 million are on Medicaid.See footnote 12 [12] Several administrators and the Georgia Hospital Association (GHA) testified that the problem of the uninsured was one of two factors having a major impact on the viability of rural hospitals. Hospital revenues have been negatively affected by the large and increasing number of uninsured and Medicaid enrolled patients. According to the GHA, the total un-reimbursed cost of bad debt, charity care, and indigent care increased by 44 percent between 1990 and 1997, from $530 million to $764 million.

Studies have shown that two-thirds of the uninsured are working. Those who do not have insurance, usually decide that insurance is to costly, or they may have other spending priorities, viewing health insurance as an unnecessary expenditure. The uninsured usually delay medical treatment to the point that they need emergency care, which is the most expensive form of care. Primary care for the uninsured is taking place in hospital emergency rooms, rather than health clinics or doctors' offices. As rural hospitals work to keep their doors open, the costs of uncompensated care need to be addressed.

Mitchell County Hospital provides a good illustration of the problems facing rural hospitals. Mitchell County Hospital has 33 licensed beds, and

two nursing homes affiliated with the hospital (one with 48 beds, and one with 108 beds, both with waiting lists). The economic impact the hospital has on the community is estimated at $19 million. Check these stats --> Two-hundred and fifty jobs have been created in the hospital system, and 240 jobs have been created elsewhere within the community as a result of the hospital and nursing homes' presence. The hospital experienced losses of $400,000 in 1998, $1.8 million in 1997, and $1 million in 1996. The cost of uncompensated care was $1.2 million for last year, and the hospital received only half of that amount from the Indigent Care Trust Fund (ICTF) in compensation.See footnote 13 [13]

The ICTF has been in operation for seven years. The fund is designed to assist hospitals in defraying uncompensated care costs. The ICTF distributes more than $350 million per year. The ICTF collects money from participating hospitals and state funds, and the sum is matched by federal dollars, which are then sent back to hospitals (in an amount higher than their original contribution). ICTF money helps hospitals cover uncompensated care given to uninsured patients and any Medicaid shortfall. ICTF money is distributed to 88 of the 158 hospitals in the state. However, only 66 hospitals are currently contributing to the fund.

As part of the ICTF program, hospitals are required to spend 15 percent of the net proceeds on primary care, with the remaining funds going to the uninsured for health care.See footnote 14 [14] Recently, concerns have been raised that ICTF money was not flowing to the hospitals as required, and asked for the ICTF distribution formula to be protected. Administrators and others testifying questioned the state's uses of the money, and the fact that several millions are going to the "big, profitable regional hospitals" who provide indigent care. The administrators concern stemmed from reduced distributions in the last few years, and increased uninsured patient loads. In raising the problem of uncompensated care, hospitals administrators explained that only one-third of the counties are contributing to indigent care, and they suggested that counties share in the cost burdens.

2. Cuts in the Medicaid Reimbursement Rates

During the course of public hearings held throughout the state, the Committee heard testimony that along with the high cost of uncompensated care crippling rural hospitals, the other major factor having a serious impact on the financial viability of rural hospitals is the reduction in Medicaid reimbursement rates experienced these past four years due to the required 5 percent re-directions in the state Medicaid budget. In addition to state budget cuts, the Balanced Budget Act (BBA) passed by Congress in 1997, requires $77 million in Medicaid cuts to Georgia hospitals that participate in the Disproportionate Share Hospital program (also known as the ICTF).See footnote 15 [15]

Georgia's hospitals are also facing a loss of approximately $1 billion dollars in the next few years due to a provision passed in the BBA of 1997 which significantly reduces *Medicare* payments made to providers. Nationwide, hospitals will experience more than $44 billion in cuts between FY 1998 and FY 2002. These facts are crucial in understanding the current financial condition faced by rural hospitals, given that anywhere from 60 to 95 percent of their revenues come from government-based reimbursement.

Another example of a rural hospital in critical condition is Dorminy Medical Center in Fitzgerald, Georgia. Steve Barber, Administrator of Dorminy Medical Center, presented testimony about his 75-bed acute care hospital. According to data from GHA and SHPA, Dorminy's total economic impact on its community in 1996 was $41,670,308. The hospital supports 518 full time jobs, plus the 300 jobs created as a result of the hospital's presence in the community. Dorminy provides a majority of its services to Medicare and Medicaid beneficiaries, 49 percent and 14 percent, respectively, totaling 63 percent of their total business. Mr. Barber stated that neither program pays its share of *costs* required to provide those services. Of the remaining 37 percent of their business, 28 percent was provided to beneficiaries with commercial insurance, and 9 percent to individuals without coverage.

Mr. Barber explained that revenue from private commercial insurance makes up the substantial business of a typical urban hospital, and therefore, profits result. Those with private insurance usually seek health care at urban centers where they perceive the care to

be superior, and thus, private dollars continue to leave rural communities. Rural hospitals are barely surviving since they provide a disproportionate share of health care services to the elderly and poor. Dorminy Medical Center provided $1,108,269 in uncompensated care in 1996. Mr. Barber testified that the due to the BBA of 1997 and state Medicaid budget cuts, Dorminy Medical Center saw a "modest bottom line of $813,107 in 1997 (3.5% of gross charges) disappear to a $438,478 loss in 1998 -- a decrease of $1,251,585 in one year."See footnote 16 [16]

The Georgia Hospital Association (GHA) testified that "in FY 1996, $65 million were cut from hospital inpatient rates. In FY 1997, the hospitals' inflation adjustment was $23 million below costs, plus outpatient payments were cut from 96 percent of Medicaid costs to 90 percent of Medicaid costs. In FY 1998, a Diagnosis Related Groups system that used lower rates was installed, further reducing hospital payments. For FY 1999, full inflation adjustments were not factored into the inpatient rates. [P]roposed cuts by DMA for FY 2000 include significant outpatient cuts of $24 million, [i]ncluding payment cuts of $7.5 million for hospital-based nursing homes."See footnote 17 [17]

GHA testified that thirty of Georgia's nursing homes are affiliated with small, rural hospitals; and that the proposed nursing homes payment reductions will bring substantial harm to these particular hospitals. Hospital- based nursing home administrators participated in the public hearings, and explained that there is a need for a differential in rates between free-standing nursing homes and hospital-based nursing homes because the hospital- based nursing homes are required to accept all patients, even those on ventilators who require more care. The proposal to cut these rates would leave an administrator no choice but to reduce the nursing home staff, which in turn would reduce the quality of care given to their patients.See footnote 18 [18] For a detailed report on the financial future of Georgia's hospitals and the Medicaid program, please refer to Addendum B, entitled "Georgia Medicaid Hospital Funding: Condition Critical," written by the GHA.

3. Physician Recruitment and Retention

According to the Joint Board of Family Practice's report, "Physician Workforce 1996: Toward the Year 2000," there were 13,845 physicians practicing in Georgia in 1996. Sixty-five percent of all physicians practice in the eight counties with a population greater than 150,000, representing 43 percent of the state's population. The report also noted that there exists a shortage of physicians to meet the demands for medical services, quoting the need for an additional 868 medical doctors to serve Georgia by the year 2000.See footnote 19 [19] The shortage, especially, of primary care physicians has led to an increase in non-physician health care providers, or mid-level professionals like physician's assistants, and nurse practitioners. Data has been provided in Addendum C that illustrates the extent of the health care personnel shortage in Georgia.

Dr. Josepe Hobbs, Medical College of Georgia, testified that the problem is one of maldistribution. He explained that it is difficult for hospitals because they are all competing for a finite pool of doctors. Rural hospitals must compete with their urban

counterparts who are offering bigger salaries, and career placement in metropolitan locations. Many students graduate from medical school with huge debts and prefer to go to the hospitals offering them larger salaries and benefits. Rural hospitals are also not recruiting as aggressively as are the health management organizations (HMOs) and urban hospitals.

Dr. Hobbs also stated that part of the problem is medical students not getting exposure to rural communities early on in their education, and therefore, they are not familiar with the rural patient base.See footnote 20 [20] The students participating in "loan forgiveness programs" work in rural communities for the 2-3 years required in the program, and then leave to work in larger urban hospitals offering more money. Another problem is that most of their patient base are Medicaid and Medicare recipients and/or the uninsured, and physicians desire a mixed client base. If 70 percent of their patients are Medicaid/Medicare recipients, and funding in both programs continue to be cut, doctors feel they are not making enough money to want to stay in rural communities.

Physician recruitment and retention programs like the "loan forgiveness program," the "J-1 Visa Waiver Program," and various scholarship and loan payment programs have helped rural communities, but are not doing enough to solve the problem as expressed by hospital administrators. Administrators asked for more funding of the grant and loan forgiveness programs, as well as more slots for the J-1 Visa program. The J-1 Visa is an educational visa provided to foreign medical students who come to the United States to further their medical training. Foreign physicians who wish to train or obtain a medical education in the United States must obtain a J-1 immigration status in order to stay in the United States. The law requires the physician to be placed in a Health Professional Shortage Area.See footnote 21 [21] A few of the administrators who testified in the public hearings requested that more slots or waivers be provided to allow more foreign doctors to serve in rural communities.

Hospital administrators testified that financial incentives were the best tool to recruit physicians and keep them in their communities. Terry Stratton, CEO of Appling Healthcare System, testified that the greatest threat to the hospital's viability is the inability of the hospital to recruit and retain physicians. Mr. Stratton recommended that lawmakers can help rural hospitals by paying an "enhanced reimbursement" for physicians who live and practice in rural areas. Physicians need financial incentives to remain in rural communities longer than the three years required by loan forgiveness programs or J-1 Visa programs.

Some communities are trying the "home grown" approach, identifying and assisting students in their early years. Students interested in medicine and science are targeted in the hopes of developing loyalty and interest in the local community so that upon completion of their medical training, they may come back to serve their communities. The Medical College of Georgia (MCG) has expanded its curriculum to include a "rural component," by providing residency programs within a rural network, providing opportunities with private group practices in rural areas in conjunction with small, rural hospitals, and forming partnerships with local hospitals and community health centers to

train students while in school. MCG has also tried to promote rural communities in its medical fairs.See footnote 22 [22]

4. Infrastructure Problems and Antiquated Equipment

Continued reductions in Medicaid and Medicare funding, coupled with increasing patient volumes, have resulted in rural hospitals facing declining revenues in the last few years. Therefore, money that used to be available for capital expenditures and re-investment is no longer there. Buildings and health care facilities are deteriorating, equipment and information systems are becoming antiquated, and medical technology being used at some rural facilities has been considered below the standard of care currently being offered at urban facilities. Several hospital administrators expressed the need for capital in order to upgrade and modernize equipment, and provide for infrastructure improvements. Rural hospitals have been left with a difficult choice in needing to cut costs without compromising quality.

In order for rural hospitals to stay competitive they must offer the same standard of care. Administrators indicated that part of the problem in recruiting and retaining physicians is that they cannot offer them the resources, like state-of-the-art equipment and modern facilities, that they need to do their jobs. New technology like telemedicine has been a way to provide speciality care to remote communities, but money is necessary to keep up with these new technological advances.

The telemedicine system allows a doctor at a "speciality referral hospital" the ability to examine a patient at a rural facility using an "interactive voice and video telecommunication system integrated with biomedical diagnostic instrumentation." This system is credited with saving over $68,000 in Medicaid transportation costs and out-of-pocket expenses paid by patients. Telemedicine has been in operation since 1991, when it was introduced in Georgia. There are currently 30 sites in operation, with 50 additional sites planned.See footnote 23 [23] Telemedicine has played an important role in providing health care to rural communities. Rural hospitals need modern facilities and up-dated technology to remain competitive in the health care marketplace.

5. Certificate of Need

Hospital administrators were split on the *certificate of need* (CON) issue. A CON is a document issued by the State Health Planning Agency (SHPA) that authorizes the building or development of certain health care projects. A CON application must show that the health care project is necessary to meet community needs. A CON is required before a health care facility can: (1) proceed with a construction or renovation project or any other capital expenditure exceeding $1,035,096; (2) purchase or lease major medical equipment costing more than $575,054; (3) offer a health care service which was not provided on a regular basis during the previous 12- month period; or (4) add new beds.See footnote 24 [24]

Most of the administrators who testified found CON to be an obstacle to providing a

continuum of care for the elderly and disabled. Administrators wish for their doctors to treat patients in a continuum, so that patients may move from acute care--to home health--to nursing care within one system.See footnote 25 [25] Steve Barber, Dorminy Medical Center, suggested an exemption be written into law for rural hospitals. However, Ron Guilliard, Mitchell County Hospital, asked for the CON laws to remain intact because without them their small hospital would have to compete with others in obstetrical services, which he explained brings in much of their revenues.

6. House Bill 600

A matter raised by several administrators was *House Bill 600*, a law passed by the 1997 General Assembly. Several addressed House Bill 600 as a threat to the viability of their hospitals. House Bill 600 provides for certain requirements to be met in the sale or lease of nonprofit hospitals to any entity, for-profit or non-profit. A summary of some of the requirements in the law are as follows: (1) hospitals must provide notice to the Attorney General at least 90 days before the proposed transaction, and must send in a non-refundable fee of $50,000; (2) hospitals must provide detailed information involving the sale or lease to the Attorney General, including an expert's economic and financial analysis of the impact, a report on the sale or lease, and all related documents; (3) financial disclosure must be made of all of the nonprofit hospitals' board members which states any interest they or a family member may have in the transaction; (4) notice by publication from the Attorney General's office must be made of the proposed sale within 10 days after receipt of the notice, and (5) within 60 days of the public notice, the Attorney General's office must conduct a public hearing; and further, (6) within 30 days after the public hearing, the Attorney General is required to publish a report of the hearing and disclosure by the interested parties.

In addition to these requirements, if a hospital violates any provision of the law, its license may be revoked or suspended. The statute also imposes a penalty of $50,000 on each of the board members and CEOs of both parties for violation of any of the disclosure provisions in the law, and any violation will null and void the disposition or acquisition of the asset.See footnote 26 [26]

This law affects small rural hospitals disproportionately because it hinders the process of forming partnerships when these hospitals need to do

so in order to gain the funding for needed capital expenditures. This law is also an important consideration in leasing arrangements. A hospital representative testified that his rural hospital was in a vulnerable financial state, and consequently, was in danger of closure because it had to meet the requirements of House Bill 600 when it had to extend its lease. Small, rural hospitals usually do not have the resources to meet the requirements of the legislation. The process is lengthy, and costs thousands of dollars. Rural hospital representatives testified that the law was too cumbersome and complex, and asked for the law to be amended to make compliance easier, and the process more concise.

Proposals were made as to how to change the law, among them were the following: (1) change the lease rollover provisions; (2) amend the penalty section of the law that imposes a $50,000 fine, and instead put hospitals behind the "corporate veil" where they must be personally liable; (3) change the loss of licensure provision, seen by rural hospitals as a draconian measure; and (4) amend the requirements to impose an "expedited summary review," at least for the smaller, rural hospitals. See footnote 27 [27]

7. Non-Emergency Transportation

Another obstacle in the rural health care delivery system is access to care. Long distances to the health care provider and lack of transportation prevent numerous rural residents from receiving the proper care. The issue of the current *non-emergency transport system* was raised in the public hearings. Non-emergency transportation is important especially for long- term care residents and children with special needs. Complaints were raised about the new system because of its inability to transport patients with tracheotomies, dialysis equipment, or those on oxygen to receive treatment. The old system was better in that the patients had health care professionals transporting them, not just drivers; the vans were equipped with the proper medical equipment; and because transportation was handled locally, patients were given a more local "touch." See footnote 28 [28]

B. Success Stories

Rural communities in Georgia struggling to maintain their local health care delivery system have made efforts to address their vulnerable conditions. The examples provided illustrate how rural communities, with valuable assistance, have managed to hold on to their local health care systems, while confronting their need to address their long term viability. The programs or "stories" described below are considered "successes" in that they attempt to tackle this serious problem with a community-based approach, limited resources, and goal-oriented solutions.

1. The Community Decision-Making Program (CDM)

The CDM program was established in 1992 with the original mission to help rural communities work together, through grassroots efforts, to complete a community health needs assessment and identify common goals for creating a healthier community. The program's philosophy is based on the belief that communities can benefit from accepting greater ownership and responsibility for improving their own health status. A major objective of

the CDM program is to help communities better understand and plan for the future of their health systems. The program's focus has expanded and evolved to include creating sustainable community partnerships. Developing relations between community leaders and health care providers encourages the sharing of resources, avoiding of duplication, and it finds new and better ways to keep health care dollars in the communities. The CDM program offers technical support and guidance to establish the foundation of these partnerships.

The CDM process involves several steps which include: the completion of a community-wide health needs assessment; the identification of economic, social, environmental and healthcare system factors that influence a community's health status; and the development of short and long term goals for achieving a healthier community. The program has had a significant impact in 25 communities, and its success seems to be based on collaboration among the various "players," and citizens taking "ownership" of their community's health status. Last year, the CDM program joined with the Georgia Health Policy Center to establish its "Networks for Rural Health" program which will use community development principles along with healthcare system development principles to help rural health systems maintain their viability.See footnote 29 [29]

2. "Networks for Rural Health"

The "Networks for Rural Health" initiative was created to analyze and assess the state of rural community health care systems. The Department of Medical Assistance commissioned the Georgia Health Policy Center to develop a plan, entitled the "Safety Net Program," to help prepare rural communities for the negative financial impact that will occur as private and public money for healthcare continues to shrink. The program calls for a team to design a program of technical assistance to assist each rural health care system. The program contains a four-phase approach: (1) local leaders organize and agree to work together to achieve common goals; (2) needed information to form a community profile is gathered to guide the decision- making; (3) project staff and community leaders make decisions regarding the structure of the future local health care system; and (4) technical assistance is provided as the plan is implemented.

The Safety Net Program is supported by state agencies, various organizations, community leaders and volunteers who have agreed to work together through a process of community organization, self-assessment, decision-making and implementation. The program will run until October of 1999. The objective is to stabilize ten rural community health systems by ensuring that each health system offers clinically relevant services, is financially viable over the long-run, provides access to services reasonable for that community, and forms appropriate regional partnerships. The communities currently participating in this program are Miller, Lanier, Emanuel, Jefferson, Dooly, and Clinch.See footnote 30 [30]

3. Partnership Arrangements

Some struggling rural hospitals have managed to keep their doors

open by establishing partnership arrangements with larger regional medical centers. The Hospital Authority in Baxley/Appling County joining with St. Joseph's/Candler Health System (SJ/CHS) is one example of a successful union created to keep a community hospital in its county. These two institutions, in competition with one another, decided to come together and work jointly for their community by offering better, more efficient services, while improving the quality of care.

First in 1996, St. Joseph's Hospital and Candler Hospital joined together in an effort to reduce excess capacity and eliminate the duplication of services in the health care market by realigning services to specific hospitals to take advantage of each one's strength (i.e. aligning Candler's strength in primary care and obstetrics, with St. Joseph's strength in tertiary services like Cardiology, Orthopaedics, and Neurology). By joining together, consolidating all administrative functions, and increasing their purchasing power, St. Joseph's/Candler was able to remove $14 million of costs from the health system the first year. In February 1998, St. Joseph's/Candler Health System (SJ/CHS) took its lessons to Appling County and reached an agreement with the Hospital Authority.See footnote 31 [31] SJ/CHS would manage the hospital for Appling, but would receive no management fee, and the Hospital Authority would retain its ownership and control of the hospital.

The board members set the following goals: to control costs for patients and purchasers of health care; to retain the unique identity of the Appling Healthcare System; to create an effective vehicle for collaborating with physicians and other healthcare providers; and to create "economies of scale." The relationship will provide greater access to tertiary and specialty services of St. Joseph's/Candler, Mayo Clinic Jacksonville, Nemours Children's Hospital, and Emory University through an established network. Before this arrangement, patients would have to leave Appling to receive these important services. Other benefits include rotating radiology and other patient care staff through St. Joseph's Hospital and Candler Hospital so that these staffs may improve their skills and gain more experience. Also, the use of auditing and accounting experts from these hospitals at Appling will improve charge coding and other administrative functions. Appling Hospital still continues to lose money; however, through its partnership arrangement, Appling Hospital has been able to keep its doors open to its community.See footnote 32 [32]

C. Working Toward Solutions

1. Essential Rural Health Care Provider Access Act

During the 1998 legislative session, the Georgia General Assembly passed the Essential Rural Health Care Provider Access Act (ERHPA) to encourage the existence and availability of certain health care providers in rural areas of the state. The law requires insurance companies to consider small, rural hospitals as part of a network plan. This law was passed in reaction to a problem faced by many small rural health care providers. Managed care companies were not allowing the small rural hospitals to participate in, or join their networks, leaving rural hospitals with few private dollars, and large numbers of Medicare/Medicaid and indigent patients. This, in turn, contributed to rural hospitals' fragile financial states.

The legislation gives small rural hospitals, defined as those with fewer than 100 beds with at least a 40 percent Medicare/Medicaid patient mix, in a county with a population of less than 35,000, an opportunity to negotiate contracts with managed care companies. If the hospital is denied access to the network, the managed care company must submit an explanation of the denial in writing, and provide an opportunity to cure. Steve Finley, Chastatee Regional Hospital, explained that the problem in his community has stemmed

from the large number of HMO-covered residents living in the county who must travel to Atlanta for their health care, instead of use the local hospital.

Although Mr. Finley supports the law, he asked that the law be amended to put enforcement mechanisms in place, and to attach penalties to the law because managed care companies are not responding to their hospital's request for negotiations.See footnote 33 [33] Other hospital administrators testified that ERHPA has not been an issue in their counties, and supported the legislation's attempt to provide greater access to health care services in rural Georgia. Based on the provisions of the legislation and the present oversight responsibility of the Insurance Commissioner, the Committee urges the Insurance Commissioner to promulgate the necessary rules and/or regulations needed to enforce this law.

2. Critical Access Hospital Program

A federal grant program was created called the "Medicare Rural Hospital Flexibility Program" as part of the Balanced Budget Act of 1997 to assist states in addressing rural health problems. Grants will be awarded to states for establishing and implementing rural health plans, developing community health networks, designating facilities as critical access hospitals, and integrating rural emergency medical services with other components of the health care delivery system. In the 1999 omnibus spending bill, $25 million was appropriated to fund these grants.

A critical access hospital (CAH) is a limited-service facility, with less than 15 beds, that offers primary and emergency care to patients, and receives Medicare cost-based reimbursement. CAHs are a viable alternative for small rural communities who wish to provide some acute care services locally while ensuring access to primary care and 24 hour emergency medical services. The State Health Planning Agency (SHPA) submitted its rural health plan to the federal agency, and has been approved for the program. To date, only one hospital has expressed interest in making the conversion. Rural hospitals are hesitant to make the conversion because once it is done, the procedure cannot be reversed. This program is considered a "life preserver" to keep at-risk hospitals afloat. The CAH program is a way to keep a facility that is about to close its doors in the community. See Addendum D for detailed information on the CAH program.

3. Rural Health Systems Program

The "Rural Health Systems Program" is a proposal to help save rural health care providers that are experiencing critical financial hardships. The program will provide for a one-time community grant expenditure with the purpose of strengthening the quality and access to health care services in rural areas. This grant will be a one-time award made available to grantees in rural communities who are facing a potential crisis or break-down of essential health care services in their delivery system. The grant can be

used for the following purposes: infrastructure development, strategic planning, operational uses, and non-traditional uses.

In exchange for the money, the state would require that rural communities provide access to appropriate health care services and devise cost-effective and efficient health systems to meet local health care needs. The program requires applicants to submit a "Community Health Survival Plan" so that communities will be able to sustain themselves after the funding from the grant is expended. The program encourages strategic planning and community collaboration. Although the decision is not final, the request for the grant money will be placed in the general budget. The recommendation will be made for the Department of Human Resources to administer the grants, and for the SHPA to be responsible for reviewing applications.

4. Rural Development Grant from the U.S. Department of Agriculture

The U.S. Department of Agriculture (USDA) has created the "Rural Economic Development Grant" programs to assist rural communities with the financial and technical assistance needed to improve the quality of life in rural America, and help individuals and businesses compete in the global marketplace. The programs offer interest-free loans, loan guarantees and various grants to be used for building and improving community facilities and infrastructure with the purpose to create and maintain employment, and improve the economic viability in rural areas. The Rural Development programs would assist rural hospitals in their need for capital improvements. A hospital may apply for these grants if it has non-profit status, and is in a community with a population of 50,000 or less. Howard Franklin, from the USDA, encouraged Georgia to make use of these programs to help rural hospitals stay in their communities.See footnote 34 [34]

5. Southern Rural Access Grant and the Office of Rural Health

The Office of Rural Health (ORH) was created in 1998, as an independent division within the Department of Human Resources (DHR). The ORH was established to improve access to health care in under-served rural areas, to provide a continuum of services between the Division of Public Health and private providers, and to assist communities in identifying and addressing their health care needs. The goal of the ORH is to provide a system of health care services that is affordable and accessible to Georgia's rural residents. The ORH was involved in submission of a grant proposal, called the "Southern Rural Access Grant," for funding to improve rural access to primary care services.

The Southern Rural Access Grant, a private grant from the Robert Wood Johnson Foundation, is intended to build the leadership and institutional skills needed to improve access to basic care in under-served rural communities. The application was submitted, and Georgia has been chosen as one of the "Southern Rural Access Sites." Georgia will be receiving approximately $350,000 to fund long-range policy development for rural under-served areas. The grant will fund the "Rural Enrichment and Access Program," starting March 1, 1999. The money will be used in Georgia for network and leadership development, and for activities involving the recruitment and retention of primary care providers. The program will be housed in the Mercer School of Medicine, but will be

administered by the ORH. The ORH also plans to establish a health care revolving loan fund.

The $350,000 in funding will be available for the first 15 months, and subsequently, the ORH plans to apply for the grant every 15 months for the next three years.

6. Federally Qualified Community Health Centers

Federally funded community health centers (CHCs) provide comprehensive primary medical care and preventative health services for Georgia's medically under-served population. Services are provided to community residents regardless of their ability to pay. Patients are offered a reduced sliding fee schedule based on a person's income and family size. Those who can afford to pay for care are expected to do so, but no one is ever refused care. CHCs accept Medicare/Medicaid patients, as well as those with private insurance coverage. Because of limited resources, CHCs work in partnership with other health care providers, hospitals, and health departments to coordinate services. In 1997, Georgia's CHCs served over 175,000 people, 79,000 of those individuals were uninsured, and 52,000 were covered by Medicaid.

The Georgia Association for Primary Health Care (GAPHC) conducted a study of the federal funding levels for this program and found that the funding in Georgia is one half of the average federal funding received in three of Georgia's neighboring states: Alabama, Mississippi, and South Carolina. Georgia received $21.7 million in grant awards in 1997, whereas the other states received approximately $43 million on average. Georgia has not received its maximum allotment due to a lack of coordination between state agencies and advocates in applying for this federal funding. For communities with no access to primary care services, CHCs are a viable option in addressing the problem of access to health care.

7. PeachCare for Kids

The PeachCare for Kids program, passed in 1998 by the Georgia General Assembly, provides health insurance to children who are ineligible for Medicaid, but whose families cannot afford private insurance. Congress created this program as part of the Balanced Budget Act of 1997, in which block grants are provided to states enabling them to tailor the children's health insurance program to the state's needs by giving them flexibility in deciding how and on whom to spend the money. Approximately $40 billion will be guaranteed to states over the next ten years in federal matching funds.

First year funding for PeachCare in Georgia will total $72 million, $20 million of it in state funds. In Georgia, 380,000 children lack health insurance, and about 168,000 of those children should be eligible for PeachCare. Benefits offered in the program include preventive care, dental care, eyeglasses, prescription drugs, and emergency and hospital services. PeachCare will not require a co-payment for service, but will charge a premium of $7.50 per month per child, or $15 per month for two or more children. For children under the age of 6, no premium will be charged. Eligibility for the program will be for

children 0-18 years old, in families earning up to 200 percent of the federal poverty level ($32,900 for a family of four). The Department of Medical Assistance (DMA) will be administering the program.

8. Medicaid Initiatives

Dr. William Taylor, Commissioner of the DMA, discussed new initiatives at the DMA meant to improve the health status of Medicaid recipients. The Nurse Call System will offer a 24-hour nurse care services

and advice line. In addition, DMA wishes to increase the reimbursement rates for mid-level professionals who are providing primary care in medically under-served areas. Both programs are geared toward addressing health access issues that are currently harming rural residents. Telemedicine services are also being reimbursed, and Dr. Taylor views this area with a potential for growth. Dr. Taylor stated that the health problems facing rural communities are those attached to "risk behavior," like deaths from motor vehicles, poor prenatal care, lack of access to primary care, and higher death rates from preventable diseases (i.e. those associated with tobacco use or substance abuse). To address these problems, more attention is being focused on preventative care both at the DMA and the DHR.

III. CONCLUSION

A. Summary of Barriers to Providing Quality Health Care in Rural Georgia

Georgia is facing many challenges to its health care delivery system in rural communities throughout the state. Several problematic health status indicators disproportionately affect rural Georgia, including: high infant mortality rates, high rates of heart disease and cancer, large poor and elderly populations, lack of prenatal care, and lack of transportation. All of these problems have contributed to the present state of rural health.

Rural hospitals are desperately trying to make ends meet while trying to provide quality care to local residents. In some communities, hospitals cannot even afford to pay their staff. Doctors are leaving rural communities because the salaries offered to them are well-below the standard of pay offered in urban centers, and because no money is available to invest in infrastructure and technology, therefore, making it difficult for doctors to do their jobs without the proper resources. Buildings and health care facilities are deteriorating, equipment and information systems are antiquated, and most of the medical technology available in rural hospitals are below the standard being offered at urban facilities.

Rural hospitals, the economic centers of their communities, are struggling for their survival. Three major obstacles threatening the viability of rural hospitals were identified in the course of the Committee's study. *First*, rural hospitals are treating an increasing number of uninsured patients, and cannot afford to continue providing uncompensated care. *Second*, four years of continued cuts in Medicaid reimbursements have had a

serious and detrimental effect on rural hospitals. *Third*, rural communities and their hospitals continue to suffer from the inability to recruit and retain physicians. Rural hospital administrators outlined several problems facing their hospitals during the course of the Committee's meetings; however, the three obstacles mentioned above stand as the major barriers to their success and in most cases, their existence.

Communities cannot remain economically viable with substandard health care. Rural hospitals not only provide health care to their local residents, but they are vital to the economic infrastructure because they provide jobs and services to the local population. Rural residents of Georgia deserve to live the same quality of life as their urban counterparts, and without a network of viable rural hospitals, the people of rural Georgia will be left without quality health care, or any health care at all. Rural Georgia is entitled to a health care delivery system that is accessible, affordable, and dependable. Without strong, swift policy changes and new funding initiatives, rural Georgia will slip decades behind the rest of the country in health care.

B. Committee Recommendations

The Committee makes the following recommendations:

*** The State needs to address the issue of the uninsured.** There needs to be a conscious effort made by policy makers to address the issue of the "working uninsured." For small business employers, high insurance costs have forced them to make tough decisions: absorb the higher costs, pass them on to the employees, or not offer any health benefits at all. The uninsured population will continue to increase as small business owners continue to face this dilemma. Possible consideration should be given to creating a "PeachCare for Working Families" to provide health insurance for working adults who are currently uninsured, and cannot afford health insurance coverage.

* **The State should examine the result four years of continued cuts in Medicaid reimbursement rates have had on rural hospitals and propose some type of financial support for hospitals in crisis.**

* **The State should consider the legislation entitled, "Rural Health Systems Program," to be introduced in the 1999 legislative session.** This one-time community grant will be awarded to rural health care providers who are threatened with potentially losing essential health care services in their delivery system.

* **The State should examine the possibility of using the funding available from the Tobacco Settlement, in part, to assist rural hospitals struggling for survival.** The Committee recommends setting up a grant program or trust fund that may be used to assist rural hospitals, in particular, making money available for infrastructure and capital development.

*** The State should evaluate and propose incentives to encourage physician recruitment and retention to rural communities.** Meaningful assistance should be

provided in securing and keeping physicians, especially primary care providers, in rural communities.

*** The State should encourage participation in the Critical Access Program by rural hospitals struggling to keep their doors open.**

*** The State should provide strict enforcement mechanisms for the Essential Rural Health Provider Access Act to ensure that HMO's do not exclude rural health care providers from participating in their networks.**

This report was adopted by members of the Senate Study Committee on Rural Hospitals and Rural Health in January 1999.

Respectfully submitted,

_____ _____

The Honorable Jack Hill, Chairman The Honorable Mike D. Crotts
Senator, 4th District Senator, 17th District

_____ _____

The Honorable Hugh Gillis The Honorable Rene' D. Kemp
Senator, 20 District Senator, 3rd District

_____ _____

The Honorable Eddie Madden The Honorable Harold J. Ragan
Senator, 47th District Senator, 11th District

_____ _____

The Honorable Van Streat The Honorable Nadine Thomas
Senator, 19th District Senator, 10th District -->

Footnote: 1 [1] "Access to Primary Health Care: Tracking the States," 1998 Health Policy Tracking Service, page 108.

Footnote: 2 [2] 1998 Data from the Office of Planning and Budget, SHPA Rural Health Care Report, page 15.

Footnote: 3 [3] "Access to Primary Health Care: Tracking the States," 1998 Health Policy Tracking Service, page 108.

Footnote: 4 [4] "Rural Health in Georgia," Summary prepared by the State Office of Rural Health and Primary Care, 1997.

Footnote: 5 [5] See O.C.G.A. Section 33-20B-2.

Footnote: 6 [6] Testimony by Steve Barber, Administrator, Dorminy Medical Center, on November 20, 1998, Senate Study Committee on Rural Hospitals and Rural Health.

Footnote: 7 [7] "Rural Health in Georgia," Summary prepared by the State Office of Rural Health and Primary Care, 1997.

Footnote: 8 [8] Refer to Addendum A, entitled "Hospitals At Risk," Jimmy Lewis, HomeTown Health.

Footnote: 9 [9] "Access to Primary Care: Tracking the States," Health Policy Tracking Service, 1998, page 108-109.

Footnote: 10 [10] Hewitt Associates, KPMG Peat Marwick, "National Coalition on Health Care."

Footnote: 11 [11] 1994-1995 Statistics from the Kaiser Family Foundation, "Kaiser Commission on Medicaid and the Uninsured.."

Footnote: 12 [12] Testimony of Dr. William Taylor, Commissioner of Department of Medical Assistance on November 9, 1998, Senate Study Committee on Rural Hospitals and Rural Health.

Footnote: 13 [13] Testimony of Ron Guilliard, Administrator, Mitchell County Hospital, on November 20, 1998, Senate Study Committee on Rural Hospitals and Rural Health.

Footnote: 14 [14] Article, "Hospitals, State Strike Deal on Indigent Care," Atlanta Journal-Constitution, December 26, 1998, page H2.

Footnote: 15 [15] GHA Report entitled, "Georgia Medicaid Hospital Funding:Condition Critical," page 5.

Footnote: 16 [16] Testimony by Steve Barber, Administrator, Dorminy Medical Center, on November 20, 1998, Senate Study Committee on Rural Hospitals and Rural Health.

Footnote: 17 [17] Testimony by Glenn Pearson, Executive Vice President, GHA on November 9, 1998, Senate Study Committee on Rural Hospitals and Rural Health.

Footnote: 18 [18] Testimony by Jerry Wise, Ty Cobb Health Care System, on December 11, 1998, Senate Study Committee on Rural Hospitals and Rural Health.

Footnote: 19 [19] Id., page 25.

Footnote: 20 [20] Testimony by Dr. Josepe Hobbs, Medical College of Georgia, on December 11, 1998, for the Senate Study Committee on Rural Hospitals and Rural Health.

Footnote: 21 [21] SHPA's Rural Health Care Plan, page 27.

Footnote: 22 [22] Testimony by Dr. Hobbs, Medical College of Georgia, on December 11, 1998, for the Senate Study Committee on Rural Hospitals and Rural Health.

Footnote: 23 [23] SHPA Rural Health Plan, page 23.

Footnote: 24 [24] Ga. Comp. R. & Regs. Chapter 272-2-(19), "Certificate of Need."

Footnote: 25 [25] Testimony by Jimmy Lewis, HomeTown Health on November 20, 1998, Senate Study Committee on Rural Hospitals and Rural Health.

Footnote: 26 [26] See O.C.G.A. Section 31-7-70 to 31-7-96.

Footnote: 27 [27] Testimony by Mr. Michael Green, General Counsel, Ty Cobb Health System, on December 11, 1998, Senate Study Committee on Rural Hospitals and Rural Health.

Footnote: 28 [28] Testimony by Tom Brown, Ty Cobb Health System, on December 11, 1998, Senate Study Committee on Rural Hospitals and Rural Health.

Footnote: 29 [29] Testimony by Jeff Hill, Georgia Hospital Association, on November 30, 1998, Senate Study Committee on Rural Hospitals and Rural Health.

Footnote: 30 [30] Testimony by Dr. Karen Minyard and Dr. Jim Ledbetter, Georgia Health Policy Center, on November 9, 1998, and December 17, 1998, Senate Study Committee on Rural Hospitals and Rural Health.

Footnote: 31 [31] Testimony of J. Hunter Hurst, St. Joseph's/Candler Health System, on December 17, 1998, Senate Study Committee on Rural Hospitals and Rural Health.

Footnote: 32 [32] Testimony of Terry Stratton, Appling Healthcare System, on December 17, 1998, Senate Study Committee on Rural Hospitals and Rural Health.

Footnote: 33 [33] Testimony by Steve Finley, Chastatee Regional Hospital, on December 11, 1998, Senate Study Committee on Rural Hospitals and Rural Health.

Footnote: 34 [34] Testimony by Howard Franklin, U.S.D.A., on December 11, 1998, Senate Study Committee on Rural Hospitals and Rural Health.