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Chairman Smith, Ranking Member Neal, and members of the Committee on Ways and Means:

Thank you for the opportunity to testify before you on the topic of health care affordability and the challenges sustaining access to high-quality health care, particularly in rural areas of our country. My name is Michael Waldrum and I serve as the chief executive officer for ECU Health, a nonprofit and mission-driven academic health system located in one of the most challenging health care environments in my state, and perhaps our nation.

As a critical care physician and health care administrator, I have dedicated the better part of my life to helping people in need and in places where I can make the greatest impact – whether taking care of some of the most complex patients in the ICU, or as CEO of a rural safety net health system where I am fortunate to have the opportunity to help solve the unique challenges of rural healthcare. I have trained and worked in some of the most prestigious and well-resourced health care organizations in our country delivering care to those fortunate to have access. I have seen the incredible outcomes that access to high-quality medicine can create. But I have also seen the other side – the patients who lack access to even basic health care needs. I have witnessed the damage to communities and hard-working rural citizens when access to care diminishes as resources are concentrated in urban or otherwise growing markets. Their experience is the story of America's rural health care crisis.

The rural health care crisis is not theoretical – it is playing out every day in rural communities across the country at a pace that continues to be hastened by profit-driven industry behavior among for-profit and nonprofit entities alike.

Nowhere in eastern North Carolina is this reality clearer than in Williamston, North Carolina – a rural community abandoned by for-profit health care in 2023, years before the expiration of the lease obligation. Abandonment that occurred so swiftly that nearly three years later there is still evidence of the patient care that was being delivered in the moments before individuals were escorted out and the doors of the hospital were locked. While closure was abrupt, the underlying challenges developed over time. Vulnerable facilities like Martin General Hospital in Williamston, North Carolina are increasingly acquired by large, often cross-market organizations with a promise of investment and stability. But in many cases, those commitments are tied to financial models that prioritize near-term performance over

long-term community sustainability. Rural hospitals operate with low patient volumes, high Medicaid reliance, significant uncompensated care and challenges in recruiting and retaining licensed clinical professionals. Sustaining them requires a hub-and-spoke approach whereby stronger facilities support those that cannot stand alone. However, many corporate structures are not designed to allocate resources in that way, particularly when returns are evaluated at the level of individual facility return-on-investment. As a result, when expected margins are not achieved, capital investment commitments are deferred, services are reduced, and facilities are ultimately moved toward divestiture. In fragile rural communities this dynamic accelerates the loss of essential services as unprofitable and resource-intensive services are eliminated.

Maternity wards across the nation continue to close, disproportionately so in rural areas where birth rates are flat or declining. The provision of maternity care is costly for hospitals of all sizes, but particularly rural facilities with lower volumes. In addition to obstetrician-gynecology specialists, other licensed and specially trained clinicians are necessary: labor and delivery and recovery and postpartum registered nurses, anesthesiologists or certified registered nurse anesthetists, surgical teams, newborn nursery nurses, and sonographers, among others. Even with low delivery volumes, sufficient 24/7 coverage and an operating room must be available to handle unpredictable emergencies, and ongoing competency training and emergency simulation are essential not only for the core obstetric team, but for emergency department staff who may respond to local OB emergencies. This is a high fixed cost model, which is difficult to sustain despite low birth volumes, high Medicaid payor mix, and the challenges of recruiting to rural areas.

The consequences for maternal and infant health outcomes in rural communities are devastating. In eastern North Carolina, the infant death rate is 8.9 per 1,000 live births, which is the second highest in our state, and exceeds the U.S. infant death rate of approximately 5.6 per 1,000 live births. That is why, despite the extraordinary financial costs of maintaining local labor and delivery for volumes that average one delivery per day in some areas, ECU Health has historically been steadfast in maintaining these services for our rural communities. We have done so because we know when those services disappear, our mothers and babies are at higher risk of becoming part of our national maternal and infant mortality statistics.

In addition to maintaining local labor and delivery, ECU Health's Women's and Children's Service Line is a state and national leader in implementing innovative approaches to solving the maternal health crisis. Through critical federal and state funding, ECU Health is leading the "I Gave Birth" initiative in North Carolina's Perinatal Region VI, for example, to reduce maternal morbidity and mortality. Following implementation, ECU Health Medical Center's postpartum readmissions declined from 2.24 percent in January 2019 to 1.47 percent in June 2022, an early outcome that was directly correlated with program implementation. We partner with providers across our region through perinatal outreach to provide simulation-based training and implementation of standardized approaches like the Levels of Care Assessment Tool. These services and programs remain at risk as rural safety net systems like ECU Health face ongoing payment and policy pressures. Without meaningful changes, sustaining labor and delivery services in rural communities will become increasingly difficult and local access cannot be guaranteed.

The Abandonment of Rural Health Care

My observation is that there are two health care markets in the United States – urban and rural. While federal policy recognizes this in important ways, it often does not fully account for the realities of rural care delivery, leaving gaps that impact access and affordability. Until we correct for this, affordability efforts will not only fall short of desired outcomes but reinforce the flow of limited taxpayer dollars to well-resourced areas and accelerate the decline of markets that need help the most. Rural health care operates under a distinct set of structural realities: higher chronic disease burden, older populations, declining and dispersed populations, and persistent social and economic challenges. These factors drive higher utilization and greater complexity of care, while payment disparities, uncompensated care, and reliance on government payors strain limited resources.

Consolidation is occurring at a rapid pace across the health care industry. But rural consolidation, uniquely, is a survival response. Hospitals and practices consolidate in rural areas to avoid closure. When for-profit operators enter rural markets with a promise of investment and stability, then exit when margins disappoint, they do not leave behind a competitive landscape. They leave behind a community without access to local care. That is what happened in Williamston, North Carolina in August 2023, and that is what is happening across rural America at an accelerating pace.

The disparities between urban and rural health access and outcomes underscore the importance of our nation's safety net health care system. For many Americans, the safety net is not one of many options but rather, it is the primary, trusted source of care. In rural markets, a single provider often exists out of necessity. Low volumes, mostly governmental payor mix, and high fixed costs make it difficult to sustain multiple systems, which is very different from urban markets where consolidation is often driven by competition for market share and increased leverage rather than the preservation of access.

Affordability and access are so inextricably connected in rural America such that they are the same problem. When the only hospital within 60 miles closes, care does not become cheaper – it becomes unavailable. Disruptions in rural care do not disappear because a hospital closes. The care must shift, and the assumption that urban providers can absorb rural demand is not realistic. Many urban systems are already operating at- or near-capacity, and shifting large amounts of additional patients into those settings risks longer wait times, overcrowding, diminished access and higher costs across the board. The failure of rural hospitals and practices is not solely a local issue. It is a national cost driver that this Committee has the tools to address.

Hospitals are 24/7 operations, and health care providers are the only segment of the health care industry delivering direct, hands-on patient care. All hospitals participating in Medicare are required to serve all patients regardless of their ability to pay. This is a critical safeguard. However, approximately 70 percent of ECU Health patient revenue is derived from government payors—Medicare and Medicaid—whose reimbursement rates are set administratively and have historically fallen below the actual cost of delivering care. These rates, and others including commercial reimbursement in rural areas, often does not reflect the realities of rural healthcare, where providers face limited scale, high

fixed infrastructure costs, and labor expenses comparable to or exceeding those in urban markets. Since 2021, ECU Health has provided over $660 million in Community Benefit, and in FY25 alone, the system provided nearly $74 million in charity care as defined by IRS Form 990 Schedule H reporting. This is in addition to numerous programs and services we are providing in our communities every day despite operational losses or through reliance on state and federal grants or the generosity of our philanthropic partners.

Because of our delivery model, systems like ECU Health are far more vulnerable to the impacts of broad and sweeping policy changes and there continues to be fundamental misalignment between how rural health care operates and the payment systems upon which we rely.

The burden of these structural realities is compounded when profit-driven agendas enter rural markets. For-profit healthcare, specifically, is structured to drive profits, often targeting markets with advantageous payor mix and growth opportunity, but proximal to markets with safety net providers who carry a disproportionate share of the uncompensated care burden. They benefit from revenues generated through government sources while also enjoying commercial offsets for losses. In 2025, the largest health care provider in the country, with more than 200 hospitals across at least 20 states and the United Kingdom, reported total revenues of $75.6 billion, yet has a Medicaid payor mix of only between 10 and 12 percent of revenue, while enjoying a commercial mix of approximately 50 percent. By comparison, ECU Health's Medicaid mix in FY25 was 20.3 percent, which is among the highest across peer organizations, and a commercial mix of 24 percent, which is among the lowest among peer organizations. Further, the nature of for-profit health care ensures that profits are returned to shareholders living far from the communities served, while organizations like ECU Health are returning limited resources, much of which accrue through government programs and subsidies, directly back into our communities. To be clear, nonprofit designation is not necessarily a safeguard against profit-driven behavior, as some nonprofit health systems exhibit financial and operational behaviors that closely mirror those of for-profit entities. Also, this profit-driven behavior is not exclusive to hospitals – it exists across the entire health care delivery system – insurers, drug manufacturers and pharmacy benefit managers, durable medical equipment suppliers and post-acute care providers.

This is not an indictment of urban or for-profit health care. Rather, it is about the need to design policies that make rural health care delivery viable for all types of providers – nonprofit and for-profit alike. That means aligning incentives so that limited taxpayer resources flow to, not away from, areas with the greatest need, and ensuring a level playing field that sustains access to care. If we get that right, rural health care becomes a more attractive environment for productive investment and participation, enabling all providers to serve fairer shares of high public payer mix and uncompensated care while preserving local access.

ECU Health and Health Care Delivery in Rural Eastern North Carolina

ECU Health serves a vast 29 county region of approximately 1.4 million people with a mission to improve the health and well-being of eastern North Carolina. Importantly though, our work as a mission-driven

organization extends far beyond clinical care delivery. We are deeply committed to the advancement of local medical education, and the creation of a healthcare ecosystem that allows local business and community-based organizations to thrive in support of more prosperous rural communities.

We are the largest employer in our region, which is approximately the size of Maryland, and the majority of our communities are among the most economically distressed in the state of North Carolina. The health care affordability crisis is exacerbated in our region due to a high concentration of chronic disease burden, an aging population, widespread poverty, significant social vulnerability and great distance between healthcare facilities while traveling on aged and limited infrastructure and without public transportation. If eastern North Carolina were its own state, it would rank among the sickest and poorest in the nation. In our rural region, people with Type 2 diabetes – a preventable and reversible condition – are twice as likely to die as the rest of our state and the country, making our Diabetes Self-Management Education & Support program and healthy food initiatives, for example, critically important. These factors and others drive increased utilization and higher acuity of care, often in our most resource-intensive settings – 24/7 emergency rooms and inpatient facilities – rather than physician practices.

We serve a vastly underserved region: all 29 of our counties are Health Professional Shortage Areas (HPSAs) for primary care and mental health, and 25 counties are dental HPSAs. Across our region, provider supply is severely limited, with averages of just 3.73 primary care physicians, 9.42 physicians, 3.65 physician assistants, and 7.65 nurse practitioners per 10,000 people. This shortage is especially pronounced given 27 counties in our 29-county service area are considered rural where recruitment challenges and limited infrastructure further constrain access to care. In stark contrast, U.S. metro areas, on average, have significantly higher provider availability per 10,000 people: 8 primary care physicians, 32 physicians, 6 physician assistants, and 13 nurse practitioners – highlighting a substantial disparity in access between rural and urban areas.

ECU Health has grown over time from one small county-owned hospital to a nine-hospital regionally integrated academic health system with more than 1,200 providers across more than 120 locations. This growth has occurred primarily through consolidation, born from the need to preserve local access rather than in pursuit of greater network size and profits.

INNOVATION DESPITE LIMITED RESOURCES: WE ARE DOING MORE WITH LESS

Much of our success can be attributed to our hub and spoke model, whereby our community hospitals are supported in large part by the clinical capabilities, infrastructure, and financial strength of our academic tertiary medical center, a model that allows us to extend specialized care and other limited resources across a large and rural region. But delivering care across a geographically dispersed, low-density population area requires more – not fewer – resources. The American College of Cardiology, for example, advises that about 13 cardiologists per 100,000 population is necessary to improve cardiovascular disease related outcomes. In rural regions like ours, we often must meet or exceed those benchmarks simply to ensure reasonable *local* access, because centralizing services would require

patients to travel significant distances. To bridge this gap, we are advancing new care models – expanding the use of advanced practice providers and leveraging telemedicine – to bring care closer to patients while maintaining quality and access.

Just as solving the affordability crisis cannot be untangled from the issues of rural health care access, affordability also demands that we address our nation's persistent health care workforce needs. ECU Health Medical Center in Greenville, North Carolina serves as the academic teaching hospital for Brody School of Medicine at East Carolina University, which ranks among the top medical schools in the nation for graduating family medicine, internal medicine, pediatrics, and OB-GYN physicians, and ranks in the top 10 percent of U.S. medical schools for graduating physicians who practice in our state, practice primary care, and practice in underserved areas. Among the Class of 2025 students, 52 percent will enter primary care residencies, 42 percent of which will stay in North Carolina, and 20 percent were matched at ECU Health Medical Center for residency. We are also proud that Brody School of Medicine prioritizes reducing medical student debt, recognizing that education costs are a significant barrier to recruiting and retaining a rural workforce. We must support rural medical education *in and for* rural communities not only through Graduate Medical Education (GME) funding that is protected for rural providers, but also through workforce development grants, tax policies, loan forgiveness/repayment and payment models that reflect the difficulty of maintaining sustainable practices, coverage models, and specialty care access in rural communities. At ECU Health, we are leading this work, developing innovative models like our Rural Family Medicine Residency Program and a two-year Family Medicine-Obstetrics Fellowship to support unique rural workforce needs. At present, ECU Health is training 440 residents and fellows—165 residents over our direct graduate medical education (DGME) funded cap, and 209 residents over our indirect medical education (IME) funded cap. Medicare-supported GME is an important and unique public-private partnership between teaching hospitals and the Medicare program that supports our nation's ability to meet care demand for Medicare beneficiaries. Teaching hospitals like ECU Health Medical Center are committed to partnering with the federal government to train the next generation of the physician workforce, which is currently and projected to suffer from significant shortages. For rural communities, this is not just a national workforce issue. It is an access issue and an economic vitality issue. We know that when physicians train in rural areas they are more likely to remain in the community to practice. Without intentional investment in rural training through GME, shortages will persist and access gaps will widen in communities that need care the most.

We are aligning our efforts and partnering locally to solve access and medical education and training needs through unique models like our Primary Care Learning Center, which is a partnership between ECU Health, Brody School of Medicine, the City of Greenville, NC and our generous philanthropic partners. This model – an example of a scalable, collaborative solution – serves as a local training site for growing medical school, physician assistant, and nurse practitioner programs while addressing a dire need for comprehensive primary care and access to social support in a community with high rates of social vulnerability, transportation barriers, and high volumes of low-acuity or otherwise avoidable ED visits. This model is also proposed to include pharmacy services in our quest to address the rising rate of pharmacy deserts in rural communities.

ECU Health is transforming the care delivery system to shift more care to lower-cost settings and implementing new care models based on community need. The closure of Martin General Hospital is only one example of hospital failures in our market. ECU Health has itself, in its history, closed a rural hospital. Pungo District Hospital – later Vidant Pungo Hospital – was built in 1949 and acquired by ECU Health in 2011 when local management was unable to ensure solvency. The decision to close a rural hospital is never easy and has lasting repercussions for rural communities. However, instead of abandoning Belhaven, North Carolina when the local hospital was found to be beyond repair, ECU Health developed a modern multispecialty clinic, inclusive of a helipad, to ensure the local community maintained access to care. Located in a community of just over 1,400 people, ECU Health Multispecialty Clinic-Belhaven has been a successful model offering local family medicine and primary care, immediate and walk-in care, behavioral health, heart and vascular care, and therapy and rehabilitation – services informed by our community health needs assessment and careful evaluation of patient utilization data. The multispecialty clinic is not financially solvent on its own, but through integration into the ECU Health regional system of care, we are able to proudly continue serving the community, despite the loss of hospital-based services. Similarly, despite projected losses, we are partnering in Martin County, North Carolina to consider models that would re-establish essential health care services for a community left without local access to care, including assessing the viability of the Rural Emergency Hospital designation Congress established through the Consolidated Appropriations Act of 2021.

Unfortunately, where one lives in America is still a great predictor of health outcomes. Innovation and adaptability are critical to closing care gaps despite the complex structural realities of rural health. We have invested in targeted virtual care models like tele-ICU and tele-specialty care to extend the reach of our providers into our rural communities. The North Carolina Statewide Telepsychiatry Program (NC-STeP), established in 2013, is a nationally recognized program in the Center for Telepsychiatry and e-Behavioral Health at Brody School of Medicine at ECU that extends the reach of limited psychiatric professionals into rural and underserved regions to solve persistent ED boarding challenges, reduce avoidable psychiatric hospitalizations, and improve equitable access to behavioral health services. Since 2013, the program has resulted in more than 67,500 ED psychiatric assessments, prevented 11,802 hospitalizations, and generated $63.7 million in cost savings through a funding partnership between ECU, state government and in some cases, philanthropic organizations. The program has successfully expanded over time to meet the rising demand for pediatric behavioral health and university student mental health access. ECU Health also partners with NC-STeP through the Maternal Outreach Through Telehealth for Rural Sites (MOTHeRS Project) to integrate mental health and maternal-fetal medicine to improve outcomes among high-risk mothers in rural areas.

At ECU Health, innovative technologies are becoming part of how we drive efficiency, deploy new care models and expand access across the continuum from direct-to-patient ambulatory visits, remote patient monitoring, inpatient care and specialty consultation, and critical care support. Each program is deliberate, governed, and measured, and together they are designed to ensure that every patient in our system has access to the same quality of care available at our academic medical center, regardless of where they live. For example, eastern North Carolina carries a disproportionate burden of hypertension and congestive heart failure—two leading drivers of preventable hospitalization, emergency utilization,

and cardiovascular mortality in our region. Remote Patient Monitoring allows for continuous blood pressure monitoring for our high-risk hypertensive patients and can capture the early warning signals – weight and fluid changes and other signs of decompensation – that indicate intervention is needed among our congestive heart failure patients. Eastern North Carolina is often considered the 'buckle of the stroke belt' due to higher-than-average rates of stroke and stroke mortality, and in stroke, minutes matter. We have deployed a highly successful tele-stroke program across all hospitals in our region, leveraging provider-to-provider telehealth in our EDs to connect regional providers with neurologists in our hub for guided treatment and transfer decisions to optimize the intervention window for our patients. Our medical center is the region's only Joint Commission Certified Comprehensive Stroke Center, and all our community hospitals are now recognized as either Primary Stroke Centers or Acute Stroke Ready Hospitals by the Joint Commission. Over the past two years, median door-to-needle times have trended toward national best-practice targets and more than 90% of stroke patients were consistently receiving thrombolytic therapy within the recommended 60-minute window. We are keeping more stroke patients in our community hospitals who previously would have required transfer to our academic medical center – the costliest model of care for our patients.

As a nonprofit health care organization, we are not only required to conduct a Community Health Needs Assessment (CHNA) every three years, but we take seriously our obligation to ensure our actions are aligned with community need. In 2023, ECU Health launched a Health Hub initiative, which is a strategic effort to bridge gaps in community need with the resources of the health system to meet patients where they are. The Health Hubs, which are located in 'access deserts' or areas of high vulnerability, are deployed in partnership with trusted community organizations like churches and businesses and serve as opportunities to provide access to virtual primary care, health education, and navigation. Hubs are equipped with computers and webcams, vital sign monitors like blood pressure cuffs, pulse oximeters, and thermometers, which support virtual visits for patients without access to technology or broadband at home. In addition to Health Hubs, we partner with community-based organizations to bring vital health screenings to our communities, and pair this outreach with access to healthy food boxes in partnership with local farmers. This is critical community-based outreach that is funded through health system operations and grant funding, but many of these services and programs are not eligible for Medicare and Medicaid reimbursement. Our work extends deep into our communities to solve for the non-clinical drivers of health outcomes, which make up 80 percent of the factors that contribute to health outcomes.

These efforts and others demonstrate how we are implementing scalable, coordinated community networks and programs in rural areas to improve access to care, address health disparities, and integrate health and social services to drive improved health outcomes and reduce costs.

I am honored for the opportunity to share with you the story of ECU Health and our region. We have made significant progress but have much work to do. It is my hope that this testimony shines a light on our unique experience of delivering care to a vast rural region. It is also my hope that this testimony highlights the implications for rural communities and health systems when policies and programs are

not developed through the reality of the two-market system, urban and rural, within which health care operates in the United States.

SOLUTIONS

As we look ahead, I encourage Congress to consider federal health care policy through the lens of the complex structural realities of rural health care delivery and avoid one-size-fits-all approaches that do not account for the amplified effects in rural areas as compared to urban areas. We want to partner with Congress in solving these complex challenges. We are already doing the work in eastern North Carolina to find practical, innovative ways to restore and sustain access to care. But we cannot do it alone. Sustainable rural health care requires strong federal partnership, thoughtful policy, and targeted investment. Below are examples of solutions to consider:

- Pause/delay implementation of planned cuts to State Directed Payments to allow more time to thoroughly study the impacts on truly rural health systems.
- Define rurality for healthcare in a way that acknowledges the structural realities of rural health care operations.
- Funding and support for rural GME to address rural workforce shortages.
- Additional direct funding to providers through the Rural Health Transformation Program for hospital infrastructure modernization projects for rural hospitals operating in original Hill-Burton facilities; expansion of infrastructure funding to modernize ambulatory facilities in rural areas.
- Avoid implementation of new policies in ways that risk destabilizing rural access; policies should be phased and tested in markets better positioned to absorb change.
- Standardization of community benefit, charity care, and bad debt reporting with the goal being transparency and comparability across all hospitals, for-profit and nonprofit.
- Extension of rural classifications and enhanced payment such as the Rural Health Clinic model to rural ambulatory settings in a way that supports rural ambulatory care delivery while also streamlining billing and lower out of pocket costs for patients.
- Enhanced reimbursement for rural community hospital outpatient care and safeguards or carve-outs for rural community hospitals in the implementation of site neutral payment policies.
- Improved coordination with states to ensure Medicaid alignment for new federal provider models. For example, the Rural Emergency Hospital designation which was established under the Consolidated Appropriations Act of 2021, is reimbursed under a hospital-based framework in Medicare. However, states are not required to adopt a comparable approach in Medicaid leaving the model vulnerable to clinic-based reimbursement under state Medicaid plans. This is not financially sustainable for areas with high Medicaid payor mix, particularly given the requirement to maintain 24/7 operations, licensed clinical staff, and advanced diagnostic capabilities to treat emergency conditions.

- Solving administrative barriers that prevent timely access to care and hospital payment, such as prior authorization and denials.
- Centers for Medicare and Medicaid Innovation models that contemplate the structural realities of rural health care delivery; meaningful design in partnership with rural health systems to encourage wider rural health system participation; longer-term stability and relevancy of models.

If we get this right, we can protect access, improve outcomes, and ensure that the 66 million Americans across our nation's rural communities are not left behind simply because of where they live.

Thank you for the opportunity to offer testimony on the critical topic of health care affordability and offer our rural experience.