February 4-6, 2001, Washington, D.C.

Health Resources and Services Administration
Office of Rural Health Policy

Washington, D.C.
February 4-6, 2001

Meeting Summary

The 37th meeting of the National Advisory Committee on Rural Health (NACRH) was held on February 4-6, 2001, at the Washington Court Hotel in Washington, D.C.

Sunday, February 4

Call to Order

Nancy Kassebaum Baker, NACRH Chair

Chairwoman Nancy Kassebaum Baker convened the meeting by welcoming the Advisory Committee members and guests and by outlining the agenda for the next 3 days, which included NACRH participation in two joint sessions with the National Rural Health Association (NRHA). She then introduced Dr. Marcia Brand, the new Director of the Office on Rural Health Policy (ORHP). The following members attended the February meeting: David Berk, H.D. Cannington, Shelly Crow, Dr. Steve Eckstat, Rachel Gonzales-Hanson, Alison Hughes, John Martin, Dr. Keith Mueller, Dr. Tom Nesbitt, Sally Richardson, Dr. Monnieque Singleton, and Dr. Mary Wakefield. A list of current NACRH members follows the meeting summary.

Office of Rural Health Policy Update

Marcia K. Brand, Ph.D., Director of the Office of Rural Health Policy

Dr. Brand provided an update of ORHP's primary focus for fiscal year (FY) 2001. Highlights of her presentation follow:

- Policy development. President Bush and the new Secretary of Health and Human Services (HHS) Tommy G. Thompson, both from rural communities, have expressed interest in working on rural issues. In addition to a new administration, a number of House and Senate committees and caucuses have new chairs. Among changes in the Senate are

- Finance Committee-Chair is Senator Charles Grassley (R) of Iowa, with Senator Max Baucus (D) of Montana as the ranking minority member.
- Senate Rural Health Caucus-Chair is Senator Craig Thomas (R) of Wyoming, with Senator Tom Harkin (D) of Iowa as the ranking minority member.

Changes in the House include

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- Ways and Means Committee-Chair is Congressman Bill Thomas (R) of California, with Congressman Pete Stark (D) of California as the ranking minority member.
- House Rural Health Caucus-Chair is Congressman Mike McIntyre (D) of North Carolina, with Congressman Jerry Moran (R) of Kansas as the ranking minority member.

Dr. Brand reported that these committee leaders have expressed interest in rural issues and have exhibited a strong "spirit of bipartisanship." She hopes that this new bipartisan atmosphere will offer an opportunity to make necessary changes in payment polices to help provide access to health care for residents of rural communities.

- The new administration. As administrative priorities, President Bush has proposed strengthening community health care centers, ensuring that these centers serve rural communities, and providing an additional $3.6 billion to build 1,200 more community health care centers. His proposals have also included "capturing" best practices, creating a clearinghouse so that community health centers (CHCs) have access to data on the most efficient and effective health care operations, and strengthening and revitalizing the National Health Service Corps (NHSC). In addition, President Bush has suggested initiating a 5-year, $500-million grant program called the Healthy Communities Innovation Fund aimed at funding projects and addressing targeted health risks, such as preventing heart disease, childhood and adult diabetes, and childhood obesity.

Other transitions include the following:

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- HHS-Incoming Secretary Thompson spoke by video to an HHS audience and expressed his strong interest in rural health. Other topics that would be of interest to this Advisory Committee included (1) the patient's bill of rights; (2) the importance of creating and fostering faith-based and community initiatives; (3) the possibility of fostering research with the National Institutes of Health; (4) an initiative to increase organ donation, which he hoped to be accomplished in his first 100 days; and (5) the unfairness of excessive Health Care and Financing Administration (HCFA) criticism. Secretary Thompson based this latter topic on the number of new changes produced by the Balanced Budget Act of 1997 (BBA), the Balanced Budget Refinement Act of 1999 (BBRA), and the Benefits Improvement and Protection Act of 2000 (BIPA) and the difficulty of incorporating these changes to meet the current health care challenges without additional resources. He also noted that his wife is a strong proponent of women's health,

particularly rural women's health. Dr. Brand suggested that Mrs. Thompson's interest could possibly create some opportunities for NACRH.

- Health Resources and Services Administration (HRSA)-Although he has strong bipartisan support, it is unclear whether Dr. Earl Fox, Administrator of HRSA, will be asked to remain at the Agency. HRSA has a current budget of $6.2 billion, a reflection of this Congress's confidence in Dr. Fox's leadership.

HRSA will continue to address such issues as mental health, oral health, and border health. Two new crosscutting initiatives for FY 2001 are an initiative involving palliative care, a subject not properly addressed in medical school curriculum, in primary care, or in other settings; and an initiative looking at third-party reimbursement. This latter initiative would involve providing scholarship money to allow front-office administrative management from CHCs to learn about the intricacies of third-party reimbursement. HRSA is currently experiencing a hiring freeze that is not expected to last long.

- ORHP-The Office has a new director, Dr. Brand, and a new acting director, Sahi Rafiullah. It is currently looking to hire five new staff members to provide technical and data-collection support. Dr. Brand commended Tom Morris, policy analyst, and Ms. Rafiullah for fostering and developing ORHP Federal and National health care efforts so effectively.
- Congress's health care agenda. Congress's health care agenda will continue to address Medicare and Medicaid reform. Because of today's strong economy, Medicare could possibly be solvent by 2025. ORHP recognizes the need for Congress to modernize health care (particularly with the advent and use of prescription drugs since 1965). Its primary concern with all new congressional initiatives involving health care will continue to be the equity of and access to rural health care. It is anticipated that the Medicare Payment Advisory Commission (MedPAC) report will be released this June.
- Regulatory agenda. ORHP will continue to monitor regulatory changes through Mr. Morris, with assistance from other staff members. It anticipates the implementation of BIPA, which will create opportunities to write new regulations, and the reintroduction of the health professional shortage areas (HPSA) rule. ORHP will be given the opportunity to comment on both these regulations. The Office has also worked with the University of North Carolina to develop data that support several regulations that are being congressionally updated and that are believed to be important to rural communities. ORHP expects those regulations, as well as BIPA, to be implemented.
- HRSA's FY 2001 appropriations. HRSA's budget this year is the largest ever-$6.2 billion. The Communities and Migrant Health Centers received $168.7 million, a $150 million increase over last year's budget. The Community Access Grant Program (CAP) ($125 million) and State Planning Grant programs ($15 million) received a total budget of $140 million, an impressive sum given the fact that there was no authorization language for these programs last year. State Planning Grants offer a State one-time funding to determine what it would take to provide access to affordable health insurance coverage to every resident in that State. In reference to CAP, Dr. Brand believes that the program will be addressing rural issues and will be reauthorized this year, contrary to rumor. She also noted that 37 percent of these grants are slated for rural, 22 percent for both rural and urban, and 3 percent for tribal.

NHSC will receive a budget of $124.5 million, and the Office for the Advancement of Telehealth, or OAT, will receive a flat funding of $36 million for actual telehealth grants. OAT has become representative of every earmarked project that has technology associated with it.

- ORHP FY 2001 appropriations. Although ORHP has not yet received a final figure, as of January 2001 it has received $97 million in appropriations. The Outreach and Network Grants received a budget of $58.2 million, of which $27.3 million is for earmarked projects, including $6.8 million for a Mississippi Delta Initiative to address community development issues. Other ORHP appropriations include $25 million for Flex Grants, $4 million for State Offices of Rural Health, and $13.4 million for research and policy development, which includes the Denali Commission. This Commission, which will be headed by Dr. Wayne Myers, is similar to the Appalachian Regional Commission in that it will examine health problems in a particular region in Alaska.
- ORHP's legislative agenda. Several programs are up for reauthorization this year, including the State Offices of Rural Health, the Rural Health Outreach Grant, and the Rural Health Network Development Grant. The Rural Hospital Flexibility Grant will be up for reauthorization in about 18 months. Because of the number of reauthorizations, ORHP plans to focus on program promotion. To help with this task, the Office plans to improve its data-collection efforts by hiring an individual with this type of expertise and to concentrate on State-based initiatives.
- ORHP's primary focus. ORHP's primary focus for this year will be on
    - Continuing to work with NACRH.
    - Continuing to work on grant-making activities.
    - Determining the important rural hospital issues that have not yet been captured.

New ORHP initiatives will include

- Looking at Emergency Medical Services (EMS) issues and developing a strategy. Dr. Fox plans to make HRSA home to EMS because of the rural issues involved.
- Determining the rural need for automatic external defibrillators and examining legislation passed at the end of the 106th congressional session to create an authorization for this type of cardiac conversion equipment (there was no appropriation).
- Determining how the Health Insurance Association of America (HIAA) applies to HRSA grantees. Dr. Forrest Calico will work with HIAA as a representative of rural issues.
- Funding a number of activities this year that encompass oral health because of the large number of outreach grants (i.e., one in five) that have been earmarked for dental projects. The Office will also investigate the possibility of primary care providers offering some type of oral care, such as varnish or sealant application, oral screening, or oral care education, particularly for children.
- Working with Texas A&M to conduct an analysis of the Healthy People 2010 document and to determine how the document could be used more effectively in rural communities.
- Focusing on mental health. The Office plans to work with farm families facing difficulties through the "Seeds of Hope" project and with help from NRHA.

Presentation of the Medicare Reform Report

H.D. Cannington, Subcommittee Chair and Chief Financial Officer, Emanuel Medical Center

After receiving thanks from Chairwoman Kassebaum Baker, Mr. Cannington briefly discussed how the Medicare reform report was developed, its format, and the players involved in its production. The Oklahoma site visit played host to the first framework discussion of this report. Discussions on this topic continued during the Kentucky site visit, where talking points were incorporated from two Rural Policy Research Institute (RUPRI) documents. The report, reflecting NACRH sentiments from the two on-site visits, was then drafted. A format was selected that looked at issues relating to four major areas: finance, access, quality, and workforce. These areas were tied together in a separate chapter on equity. The final chapter on reform examines crosscutting themes that emerge from the four major areas of concern and gives the Committee's general consensus on Medicare reform as it relates to rural communities. It was the intention of the report's subcommittee to make sure that different perspectives and different interests were included in the final report.

Mr. Cannington noted that the report has already received favorable comments, and he thanked the members of his subcommittee for their diligence and hard work, as well as others for their meticulous reviews, edits, and data-collecting skills. He specifically thanked Mr. Morris for tying the report together and for being the designated point person on the project.

Advisory Committee Discussion on the Medicare Reform Report and Possible Recommendations

Advisory Committee Members

After complimenting Mr. Cannington and his subcommittee on such a well-written document, NACRH members agreed that after Secretary Thompson has reviewed the report and approved it for distribution, the document should then be shared with congressional staff of relevant committees and other constituency groups in a timely fashion. It was also suggested that the document be abstracted into a briefer version for easier use and handling and that ORHP staff present the final report to members of the Rural Health Caucus of both the House and Senate.

After a discussion on how best to proceed with their review of the most recent version of the Medicare report, the Advisory Committee decided to begin with the Finance Chapter and focus primarily on the Committee Discussion section to establish a consensus on specific recommendations to be included at the end of the chapter. Mr. Cannington explained that the body of the report should reflect the opinions of all Committee members and that the Committee Discussion section found at the end of each chapter should reflect specific recommendations as agreed upon by all the members.

Finance Chapter

Highlights of this discussion follow:

- It was agreed that the "or" in the sentence (p. 19, 2nd paragraph, 2nd sentence) "Is it solely to provide access to care for beneficiaries or does the program have a responsibility for sustaining the larger health care delivery system?" be changed to "and."
- Because several Advisory Committee members objected to the idea of using the block grant funding formula for Medicare (p. 19, 3rd paragraph, 3rd sentence) because of its implications, Mr. Morris suggested using the words "local control of dollars" instead of "capitation" and "block grant funding formula."
- All agreed to delete the last sentence of paragraph 1, page 19, that reads, "Similarly, Medicare home health payments have helped to cross-subsidize some public health efforts," because it was decided that this was not a true statement given the current transition of the prospective payment system (PPS). The previous sentence that refers to the graduate medical education will remain.
- On the basis of a recommendation by Dr. Mueller, more information on financing Medicare in an equitable manner so that rural areas will receive the same benefits that exist in urban areas (e.g., prescription drugs) will be added to the Finance Chapter. Currently, this information is more pronounced in the Access Chapter.
- Much discussion evolved around the 4th paragraph on page 19 concerning the question about local control of dollars. Chair Kassebaum Baker motioned that the topic be taken up again at Tuesday's meeting to give Committee members time to determine how the paragraph should read.
- Mr. Morris explained that it was the subcommittee's intent that the final report reflect a range of ideas from NACRH members, not necessarily to endorse those ideas, and identify, in the Reform Chapter, specific recommendations about the redesign of Medicare as it relates to rural communities. After a lengthy discussion about how best to structure the report, all agreed to a suggestion by Dr. Mueller that two sections could appear at the end of each chapter that show (1) general ideas discussed by the members and (2) specific recommendations that have full Committee consensus. They also agreed to use the language "the following views were expressed," and not "one Committee member believed."
- All agreed that managed care is not a good option for rural health care delivery because "there just isn't the competition."
- In replying to a query as to why information on reimbursement methodologies is not included in the document, Mr. Morris explained that he did not want to "get down to that level of detail," and furthermore the MedPAC report due out this June specifically looks at methodology and includes practically every benefit under the Medicare program. Ms. Richardson suggested that the Advisory Committee add, possibly at the beginning of the Committee Discussion, that the members agree that "whatever payment methodologies Medicare develops in the future, they ought to have enough flexibility to reflect the real cost of rural community health care. Mr. Morris responded that the Committee should make it clear that it believes that the current Medicare package does not approximate the actual cost involved in providing health care and that the new system would need to increase its reimbursement payments because of the increased cost to provide this care.
- All agreed that the basic benefits package should be available regardless of where the beneficiary is located, and that it would include all of the current benefits as well as access to preventive care and prescription drugs (p. 20, 3rd paragraph).

- Dr. Mueller asked that the last paragraph on page 20 include words to the effect that Medicare cannot resolve problems that are inherent due to the lack of local resources in dispersed populations.
- All agreed with Ms. Gonzales-Hanson's suggestion that the last paragraph of the chapter be moved to the comment section.

Access Chapter

Dr. Nesbitt lead the discussion on access by saying he did not believe that Medicare was ever specifically designed to guarantee geographic access to care, but that the service was more about asset protection and removing financial barriers so people could have a more consistent source of health care. Consequently, he believes that those reviewing the report might be critical if the word "geographic" is placed in front of the word "access," although the word "financial" might work. Dr. Nesbitt asked whether wording could be added to the effect that geographic assess translates into financial barriers. In other words, if one does not have geographic access, then does that not constitute a financial barrier? He also expressed concern similar to that of Dr. Mueller earlier that critics will view the report as trying to expand Medicare way beyond its original intent.

In response to Dr. Nesbitt's statements, several comments followed. Ms. Hughes said that she understood access to mean access to health care, not geographic or financial access and suggested using the wording "access to care in terms of equitable financial reimbursement." Ms. Richardson pointed out that this issue has already been discussed in the Finance Chapter, but in slightly different language, in that Medicare does have the responsibility for ensuring that the local health care delivery system is not put at a disadvantage solely because of geographic location. And if, in fact, this is true, then the Medicare payment system has certain responsibilities to make sure that access is at the local level.

After a brief discussion about the wording of the first sentence in the introduction, all agreed it should be changed to read "The Medicare program was created in 1965 to provide health insurance for elderly Americans," while leaving the rest of the paragraph intact.

Quality Chapter

Several points were brought up during the discussion of the Quality Chapter:

- It was agreed that the wording found at the beginning of the second sentence of the last paragraph on page 32 be changed from "Several Committee members pointed out that…." to "Some would say that…."
- Chairwoman Kassebaum Baker expressed concern that the impact of the third sentence of the same paragraph would be somewhat deluded in its placement after the second sentence. All agreed to separate the two sentences for more emphasis.

- Ms. Hughes suggested that the first sentence in the box on page 32 that reads, "High-quality healthcare in the rural environment need not be a low-technology endeavor" needs tweaking because she felt that in reality one can have high-quality care with low technology as well as with high technology. It was suggested to possibly take out the words "high quality."
- In reference to the first sentence in the second paragraph on page 31 that reads, "There is some sentiment that moving toward a continuous quality improvement (CQI) orientation may serve as a springboard for rural communities to develop and implement quality improvement in rural America that focuses on improving the health status of the population," Ms. Gonzales-Hanson believed that the wording gave the impression that rural areas provide substandard health care and might not be performing CQI. Ms. Richardson recommended turning the sentence into a more positive statement by saying that there is some sentiment for using the current rural efforts of CQI to serve as a springboard for all rural communities to develop and implement quality improvement. All agreed.
- Dr. Wakefield expressed four concerns. First, she proposed including a recommendation related to research on volume outcome that is specific to procedures common in rural areas as opposed to urban areas. She expressed concern that the rural environment is "being tainted a bit" by people too quickly assuming that rural areas cannot or should not perform the same procedures commonly performed in urban areas. Second, Dr. Wakefield suggested including additional wording about Peer Review Organizations (PROs) and their focusing more attention on issues of rural quality of care than they currently do. Third, the Advisory Committee should try to ensure that when the conditions of participation are updated, they include specifications for quality from a rural perspective. As a final point, Ms. Wakefield asked that the report include wording to the effect that patients in both urban facilities or rural facilities ought to have comparable outcomes, all things being equal, even though the type of care might be different. In other words, the quality of care for Medicare beneficiaries in rural hospitals should never be inferior to care for beneficiaries in larger hospitals.
- In continuing with Dr. Wakefield's concern about the quality of care in rural settings, Dr. Mueller directed the Committee to the first paragraph under Committee Discussion on page 31 that discusses the Committee's belief that "Medicare should adopt a flexible approach toward measuring quality that takes into account issues related to volume, population density, and the varying range of services available locally." To this paragraph he suggested possibly adding the words "appropriately accessed outcome," explaining that when examining an outcome, one must put it in the context of what is available in that particular delivery system. Dr. Wakefield added that no matter how the Advisory Committee decides to explain the issue of quality of care, the language must be phrased in a positive way to avoid leaving individuals and organizations with the perception that rural patients receive second-class care.

Workforce Chapter

Mr. Morris began the Advisory Committee discussion on the Workforce Chapter by admitting that he received comments from several Committee members suggesting that the chapter focused too much on physicians. In response to these concerns, he rewrote the introduction paragraph explaining the reasons for this focus.

The Committee discussion that ensued focused primarily on graduate medical education (GME) funding. Dr. Wakefield led off by noting that even though most of GME funds go toward physician workforce and residency training, about $250 million support nonphysician training, such as nursing, an amount that is triple the amount available to support nursing through the HRSA program. Because there is a tremendous amount of activity on Capitol Hill involving nursing-shortage issues, Dr. Wakefield suggested adding language to the chapter indicating that GME funds more than just physician training, that a small portion also funds nursing training. She also mentioned the importance of member agreement on the fact that Medicare does have a role in training a physician workforce through support of residency training, especially in light of MedPAC's statement about Medicare not having a role in workforce training.

In a follow-up statement, Mr. Berk expressed concern about the physician issue in rural areas and the constant struggle with getting medical personnel, such as laboratory and radiology professionals, to work in these areas. A major part of the problem is the lack of available training programs in rural environments, essentially because of the lack of incentives, mechanisms, and any type of reimbursement, especially if the rural facilities are on fixed payment systems.

Mr. Morris acknowledged that it is difficult to determine Medicare's role in addressing this problem and asked for the Advisory Committee's assistance. Mr. Cannington suggested that the issue also be addressed in the Reform Chapter. He also allowed that Medicare has to carefully look at how rural hospitals and rural providers really operate and to make sure the findings are reflected in the payment mechanisms.

Mr. Martin agreed that training money, for the most part, is not going to rural areas at all. One solution would be to require teaching hospitals to take a portion of the GME and demonstrate that the funds would be used in rural areas. If the designated funds were not used in that capacity, the hospitals would lose their funding for the following year.

Chairwoman Kassebaum Baker noted that whether GME should come out of Medicare has been an important topic on the Hill, especially during the debates on health care reform. She pointed out that BBA had taken a step forward on the issue by putting money, although a small amount, into community-based training. It was noted that these funds were really an allowance and that little has been done to implement the provision. Some believed that the issue would be worthwhile to look into.

Ms. Hughes mentioned that some States have adopted policies in which medical students are required to perform rural rotations. Unfortunately, many medical facilities do not always send their students to rural areas of the greatest need. She suggested that some kind of analysis

should be performed at the State policy level to determine how these rural communities are selected for these rotations for both residents and medical students. Ms. Gonzales-Hanson said that she would like to see the universities and the medical institutions share in the cost of training medical students in rural areas.

Dr. Mueller proposed to add a comment in the Committee Discussion section that Medicare's role in workforce distribution is not just workforce training. He also suggested to add some language to the last paragraph under Committee Discussion to the effect that some of the costs in recruiting and retention in training are reimbursable expenses under cost-based reimbursement systems (e.g., critical access and sole-community hospitals) in areas where they exist. Dr. Mueller believes it would also be helpful if these costs could be a reimbursable expense under Medicare.

Furthermore, Dr. Mueller acknowledged that as more training programs, particularly the physician training programs, extend into more communities, issues relating to accreditation of the training program could become a problem. In other words, the payment systems play an important role in any discussion of GME training and the workforce.

Dr. Singleton asked that a recommendation be included that advocated the development and funding of rural training programs and not necessarily wait for academic centers to train more rural residents. He used Hazard, Kentucky, as an example of what can be done in rural communities.

In response to comments about funding of rural training programs, Mr. Morris explained that many of these issues are beyond the scope of this report. But what is within Secretary Thompson's purview are the Title VII/Title VIII programs that include a lot of this type of training, and which currently are not receiving sufficient funding. Therefore, Mr. Morris suggested recommending not only GME reform but also an increase in the funding for and flexibility in Title VII/Title VIII, specifically an increase in start-up funding to help the rural residency programs receive accreditation by the councils.

Ms. Hughes mentioned an earlier NHSC report that systematically found that physicians/spouses who had come from rural areas were much more likely "to be willing to practice in rural communities." On the basis of this finding, Ms. Hughes suggested including in a recommendation that more students from rural areas need to be encouraged to enter a health care profession.

Ms. Richardson followed with an example of how to get health care professionals to work in rural environments. About 10 years ago, West Virginia University, with a Kellogg Foundation

grant and matching State funds, initiated a program that required students in public health professional schools to spend at least 3 months before their residency working and living in a rural community. Evaluations of this program have shown that it has (1) provided a service in these rural areas that otherwise would not be there, (2) engaged a clinical facility in a rural setting, and (3) brought practitioners into rural communities. Program results have also demonstrated a significant retention of providers in West Virginia.

Chairwoman Kassebaum Baker offered a recommendation in regard to physician rotation that would allow temporary replacements for those physicians practicing in rural environments who wish to be relieved for a couple of weeks.

In closing Sunday's meeting, Ms. Kassebaum Baker suggested that the Committee review the Reform Chapter and be prepared to discuss it on Tuesday and to propose some concrete recommendations on Wednesday. Once again, the Committee praised Mr. Morris and his staff on such a well-written document and on the vast amount of work that went into its preparation.

Monday, February 5

Chairwoman Kassebaum Baker opened the meeting by outlining the day's agenda. She agreed to inform Secretary Thompson of NACRH's expertise in providing recommendations on rural health issues and to ask him about his thoughts on supporting rural health care efforts. It was suggested that the Secretary meet with Advisory Committee members in the near future. Ms. Kassebaum Baker then turned the floor over to Dan Hawkins and Bill Finerfrock for their presentation on CHCs and rural health clinics (RHCs).

Community Health Centers and Rural Health Clinics

Dan Hawkins, Vice President, National Association of Community Health Centers, and Bill Finerfrock, Director, National Association of Rural Health Clinics

Mr. Hawkins and Mr. Finerfrock presented a comparison of Federally qualified health centers (FQHC) and RHCs. FQHCs include all the Federally funded CHCs, as well as a number of other organizations that do not get Federal support but are recognized for purposes of Medicare and Medicaid as special providers of care to medically underserved communities and populations. Unlike FQHCs, RHCs do not receive any Federal funding but get special payments from Medicare and Medicaid to help support them in their work with underserved rural communities.

Mr. Hawkin's Presentation

Mr. Hawkins started the presentation by first giving a brief history of health centers and then describing their accomplishments, characteristics, requirements, and current challenges.

The history of health centers goes back to the turn of the 20th century with the incredibly pressing needs of urban immigrants and low-income populations. The hospitals at that time were the core of health care and in-patient care, and the dispensaries they set up quickly became specialty care clinics focusing on teaching and medical education instead of concentrating on providing primary care access, even in urban communities. Through the middle part of the 20th century, organized medicine ensured that health care delivery, both in urban and rural communities, was the under the distinct purview of the private sector and that government programs, even government-assisted programs, were not to compete with them. During this time, public health services were limited to preventive, well-child, and prenatal care and did not include acute care or care for the chronically ill.

Health centers developed out of the civil rights and war-on-poverty movements in the 1960s. They were founded to meet not only the medical needs but also other pressing social needs that affected the health care of low-income and minority populations, both in rural and urban areas. These centers evolved into a unique public and private partnership with resources that were needed to cover the cost of care for those who could not afford payment. They provided health care to community-owned and community-operated organizations to help meet the local health needs of the community. Today, health centers serve nearly 12 million Americans, including 1 out of 9 uninsured persons (4.9 million), 1 out of 8 Medicaid recipients (4.1 million), 1 out of 10 rural Americans (6.2 million), and 8 million people of color (African American, Latino, Native American, and Asian/Pacific Islander).

Mr. Hawkins noted that last year the Institute of Medicine (IOM) issued a report, The Health Care Safety Net: Intact but Endangered, that discussed a number of factors that were undermining attempts to provide health care to individuals because of who they were and where they lived. This information led to the report's identification of two types of safety nets: (1) a broad safety net (the charity care net) that includes most of the private medical community, community hospitals, and those facilities that provide pro bono care; and (2) a core safety net that struggles to make health care available and affordable to all community members. Mr. Hawkins then identified four basic characteristics that all safety net providers must fundamentally meet to be eligible to receive funding as a CHC or to be designated as an FQHC:

- Located in high-need communities, including medically underserved areas (MUAs) and HPSAs;
- Capable of providing comprehensive health and related services;
- Open to all residents, regardless of ability to pay, with charges prospectively, not retrospectively, set according to income and ability to pay; and

- Community-owned and operated, with all resources targeted on meeting local needs.

Mr. Hawkins then showed how FQHCs and RHCs identify with those four characteristics. In the case of RHCs: (1) all are located in underserved or high-need areas; (2) many provide comprehensive services or at least more than basic medical care; (3) many are open to everyone, with affordable fees; and (4) a large number are community-directed, nonprofit institutions. In the case of FQHCs: (1) most receive resources from the Federal Government, specifically to make health care affordable to those individuals with inadequate or no health insurance; (2) they are located in both urban and rural areas; (3) all offer comprehensive services with affordable fees and are open to everyone; and (4) all are community-directed institutions.

In return for receiving Federal grants, health centers are held to certain accountability measures. In addition to the requirement of providing more than basic care and of offering a prospectively set fee system based on family income, FQHCs must also offer

- Evening and weekend hours to ensure that medical care is accessible to working families who cannot afford to take time off during the day,
- After-hours coverage systems for patients,
- Hospital referral/admitting relationships so that patients may be admitted to a hospital for in-patient and specialty care,
- Quality assurance systems that are evaluated regularly,
- Annual agencywide independent financial audits and performance reviews, and
- Linguistic and cultural appropriateness standards.

FQHCs, RHCs, and private physicians all play a part in the health care safety net by treating the uninsured, the publicly insured (Medicare and Medicaid), and the privately insured. Almost 70 percent of the RHC patient population, on average, are either publicly insured or uninsured, whereas the figure is about 85 percent for FQHCs. These statistics are significantly different from the average for private physicians or physicians in private practice according to data from the National Center for Health Statistics.

FQHCs, both urban and rural, and RHCs face a number of common challenges today. In fact these challenges affect all parts of the health care system, but none more so than the safety net as it tries to respond to the continual needs of rural communities. Current challenges faced by FQHCs and RHCs include the following:

- Health centers and RHCs continue to feel the effects of welfare reform, with millions of eligible persons facing enormous enrollment barriers.
- As a result of the expansion of managed care in both urban and rural areas, providers who previously provided uncompensated care cannot afford to continue. This situation has put increasingly greater pressure on the safety net.
- Medicaid and Medicare revenues remain an uncertainty.

In conclusion, Mr. Hawkins emphasized that it is absolutely imperative that NACRH and other such councils do everything possible to advocate for and ensure the safe guarding of providers in terms of third-party payment programs like Medicare and Medicaid, and that these programs continue to pay their fair share so that those individuals who remain uninsured can secure health care.

Mr. Finerfrock's Presentation

Mr. Finerfrock began his presentation on the history and role of RHCs by defining rural as "any community under 50,000 or any contiguous communities whose combined populations do not exceed 50,000." RHCs must be located in an MUA or an HPSA within that type of community. State Governors have the authority to designate an area as underserved for the purpose of establishing a RHC.

RHCs started in 1977 as a result of initiatives that were trying to improve access to health care. In the early 1960s, physician assistants (PAs), nurse practitioners (NPs), and the nurse midwifery professions emerged in rural areas of West Virginia and the Appalachia region to provide the necessary health care to the underserved. Unfortunately, the lack of Medicare and Medicaid coverage was a major impediment to their utilization. As a result, legislation was introduced in Congress in the early 1970s to provide for Medicare and Medicaid reimbursements of PAs and NPs primarily. Out of this legislation, State initiatives to allow these practitioners to practice in rural underserved areas were combined with a provision to provide these medical professionals with a reimbursement mechanism through RHCs to support them in their practice. Since that time, the RHC program has become a permanent fixture in rural areas.

RHCs receive cost-based reimbursement, with an imposed cap of $61.85 per visit. By comparison, the rural FQHC cap is $82 per visit. Since the inception of the RHC program in 1977 and up until 1986, Congress had always set the cap, with periodic adjustments. Beginning in 1986, the cap began to be adjusted for inflation. The cap for the FQHC program was established in 1994 using a resource-based relative value scale system (RBRVS) of payment. This payment methodology placed a greater value on primary care services relative to the old system and thus resulted in a much higher cap for the rural FQHCs than for the RHCs. Mr. Finerfrock noted that the only benefits difference between FQHCs and RHCs is that FQHCs are authorized to provide preventive services and that this difference is clearly not enough to account for $20 more per FQHC visit. He believes that the cap difference creates a strong incentive for qualified RHCs to convert to FQHCs, as well as creates a need to reexamine the cap for the RHC program so as to make it more relevant to the current value of services.

The majority of RHCs are for-profit organizations and have a variety of tax structures under which they operate. A clinic is typically owned by a physician who operates it as a private practice that has an RHC designation. Some are also owned by NPs or PAs. Clinics are required to have a PA, an NP, or midwife delivery care available to patients at least 50 percent of the time that they are in operation. FQHCs, on the other hand, are not required to include these professionals as part of their medical team.

The amount of commercial practice exposure for RHCs is comparable to that of FQHCs, although the mix of the publicly insured and uninsured is significantly different. RHCs do not have the number of uninsured that FQHCs have, although they have a high Medicaid population. Thirty percent of RHC patients have Medicaid, and about 27 percent are on Medicare. These figures are higher than those found for FQHCs, primarily because rural areas typically have a higher percentage of individuals over 65 years of age.

Committee Discussion

In response to questions about the distribution of CHCs and RHCs in rural areas across the country and the proportion of rural versus urban populations that are served, Mr. Hawkins explained that out of 3,400 FQHC facilities in operation today, almost 2,000 are located in rural areas. About 53 percent of the 12 million people served by FQHCs are rural residents (about 6.2 million people). In 1998, statistics showed that 136 counties out of almost 3,000 had an NHSC, a CHC, and an RHC placement, and 152 counties had both an RHC and an FQHC. About 814 counties had only an RHC. As an aside, Mr. Hawkins reminded the Panel that there are more than 40 million people today who do not have a regular source of primary care-no RHCs, CHCs, FQHCs, or private doctors-other than the emergency room.

In reply to a concern about the lack of health care facilities and the lack of access to some of the governmental programs in low-volume frontier communities, Mr. Hawkins pointed out that sometimes productivity standards, gross indicators, and the difficulty in generating the volume and targeting the necessary resources in these areas prove to be impediments or barriers to securing Federal grant funds. In addition, the National Association of Community Health Centers has contended that the factors developed by the Bureau of Primary Health Care to identify high-need areas are "insufficiently attentive" and insensitive to rural communities. On a positive note, over the past 3 years, Congress has appropriated a significant chunk of new resources that is earmarked for the development of new service capacity and for new service delivery sites in communities that do not currently have a health center. Most of the funded sites are in rural areas.

Dr. Eckstat explained that the biggest problem he has faced in delivering care at his free clinic is the lack of funds, primarily because the law prohibits asking for Medicare/Medicaid funds to cover some of the costs. He asked how that gap could be bridged. In addressing this concern, Mr. Hawkins explained that there are a number of ways to bring free clinics into the family of safety net providers for public programs such as Medicare and Medicaid. As an example, he referred to his slide on the four basic characteristics of safety net providers and showed that with a little creativity and flexibility how free clinics could become eligible to receive additional health care funding:

- A provision in the Public Health Service Act allows State Governors to designate or request the designation of an area that does not meet all the criteria in the MUA/HRSA statutes as having special health needs and therefore is eligible to be considered a safety net provider. To date, not a single Governor's request has been turned down.
- Although safety net providers are required to provide comprehensive health and related services, the statutes do not specify that every service has to be delivered directly by the health facility. The provider is allowed to have affiliation agreements in which services are contracted out if they cannot be provided in-house.
- On the issue of charges, a free clinic may set up a charge system for its patients that meets the requirements of Section 330 of the Community Health Center Law and then waive the charge. If some patients have third-party coverage, the clinic should then charge everyone the same rate but forgive those charges for the uninsured. As a free clinic, Medicare/Medicare must pay the charge-based rate.
- A safety net provider must be community-owned and operated. In order to have a patient-majority policy board, a free clinic must set up a structure that meets the requirements of Section 330 of the Community Health Center Law.

Mr. Hawkins noted that consideration should be given to the amount of care being provided to uninsured and underinsured individuals that is not occurring through some formal government program. Some specific issues that should be addressed include the following:

- Medicare deductibles are waived for beneficiaries when they receive services from an FQHC. The Medicare law needs to be examined to see if that type of benefit can be extended to other types of providers.
- The problem of insured patients having to pay high deductibles needs to be examined. Many individuals cannot afford group rates and therefore pay extremely high deductibles for their insurance coverage.
- It has been shown that the uninsured tend to access the primary care delivery system less, which in turn affects inpatient services.
- There is a considerable amount of uncompensated care being delivered today by providers who are not participating in a health care program. The examination of possibly extending the safety net beyond programs like RHCs and FQHCs should be considered.

In an answer to a question about collaboration between the RHC program and governmental programs, Mr. Finerfrock admitted that the RHC program is in "dire" need of more collaboration with governmental agencies. In other words, there has to be better communication and

collaboration between the entity that pays for health care and the agency that is responsible for access and health professionals. As an attempt in this direction, the RHCs have begun talks with NHSC about the placement of PAs, NPs, and nurse midwives in rural environments. The RHC program is currently working on establishing better collaborative relationships with HRSA and HCFA.

Mr. Hawkins then mentioned two other types of entities that qualify as FQHCs: the Indian Health Clinics (IHCs) and the Tribally Operated Health Clinics (TOHCs). About 40 IHCs exist throughout the United States, but only half offer direct services; the rest are coordinators of health care. IHCs offer the only off-reservation care that is authorized under the Indian Health Care Improvement Act. On the other hand, there are more than 300 TOHCs around the country, and all are located on reservations. Only a handful of those centers have sought FQHC identification, which would allow them a higher rate of reimbursement, possibly because the State would have to share in the cost of reimbursement.

In replying to a query about the availability of GME and health professional training in rural areas, Mr. Hawkins noted that HCFA, especially Medicare, only focuses on institutional based training for physicians. Furthermore, no CHC has yet received reimbursement under Medicare for GME, even for direct costs, despite the fact that one-half of all health centers participate in health professional education and graduate medical physician training.

Dr. Singleton asked whether health centers and RHCs were collaboratively addressing the uninsured issue in rural America. Mr. Hawkins admitted that dialog between these two entities has not always been positive and collaborative, but that the chartered Bureau of Primary Health Care and the State Primary Care Associations are bringing them together in States where they exist. In a follow-up question, Ms. Hughes asked whether regulatory limitations exist that discourage mergers of clinics and hospitals in the same rural communities. Or is it a territorial issue? Mr. Hawkins responded that the friction that exists between physicians and hospitals, which involves both control and territory, is extremely difficult to overcome. He also mentioned that there are laws prohibiting partnerships and joint ventures between hospitals/group practices and health centers. One collaborative arrangement that proved successful was the financial pressure that diagnostic-related groups (DRGs) were placing on rural hospitals to shift some of their costs out of the inpatient environment and into an outpatient setting. This situation created an incentive for hospitals to establish RHCs as a way of delivering health care more economically to the community.

Discussion on the Reform Chapter of the NACRH Medicare Reform Report

Committee Members

The Advisory Committee members discussed a number of concerns about the Reform Chapter and agreed to many additions to the text and changes in language. The discussion and the changes are reflected as follows:

- Page 41, 3rd paragraph-Replace the 4th sentence with "Rural hospitals under 100 beds were allowed to remain in an essentially cost-based system until January 1, 2004. There are also concerns by some rural providers that there are larger problems with the new outpatient PPS in terms of charges that are no longer allowed."
- In response to Dr. Singleton's question whether any studies exist that look at the difference in the length of stay in rural hospitals as compared with their urban counterparts, Mr. Morris said such data do exist, but they only mention that the length of stay in rural facilities is longer than it is in urban facilities, not specific reasons why. Mr. Morris agreed to include information on lengths of stay, including examples of extenuating circumstances that keep lengths of stay longer, in the report after he and his staff determine the appropriate place in which to put it.
- Chairwoman Kassebaum Baker suggested taking out the 2nd paragraph on page 42 and replacing it with "The Committee urges policymakers to examine the components of the current Medicare system to gain a better understanding of the current rule."
- Page 42, 3rd paragraph, 2nd sentence-The Committee discussed whether the words "not" or "more" belonged in the sentence "They must also create a new policy framework that assures that rural beneficiaries are not treated more equitably than under current rules and regulations." Final consensus was to rewrite the sentence.
- Include in the report more information about MedPAC's studying the failures of the current Medicare system, as well as language encouraging MedPAC action.
- Under Medicare Reform Proposals, page 42, 1st paragraph-Add "and prevention services" at the end of the last sentence.
- To capture some of the issues that were presented in the discussion about FQHCs and RHCs and how regulatory burdens make it difficult to get providers to work together, add the following sentence somewhere in the chapter: "The Committee strongly encourages ways to support collaborative efforts and to ensure that regulatory burdens do not discourage this." As an aside, Chairwoman Kassebaum Baker suggested that the Committee might want to focus on some of the initiatives brought up during Mr. Hawkin's and Mr. Finerfrock's presentations as future topics of discussion. Ms. Crow suggested also focusing on problems of accessing Medicare for Indian Nations
- Page 43, 1st paragraph-Add the words "and how it pay for services" at the end of the first sentence.
- Ms. Richardson noted that the Reform Chapter contains no discussion about managed care in rural areas. This chapter should include information not only about rural areas not having access but also about the danger of the inequity created between what is available to urban beneficiaries and what is available to their rural counterparts. Mr. Morris said that information about managed care does appear in the chapter but that it should be moved closer to the beginning.
- Page 43, 2nd paragraph under the Committee's Consensus, 3rd sentence-In referring to the sentence "Not every rural hospital needs an MRI or a large surgical unit," several points were made. It was suggested to include more language about shared services, such as the use of MRIs, that could be provided in rural areas. In other words, expand the concept of proximate access. Dr. Nesbitt mentioned that there was no need to

replicate the services of other hospitals but that shared or coordinated services could address this concern.

- Page 43, 2nd paragraph under the Committee's Consensus, 1st sentence-Remove the word "more" from the words "more equitably." Also replace the words "proximate access to the core services" in the last sentence with "appropriate access to the continuum of services."
- Dr. Mueller expressed the extreme importance of the sentence "The new funding mechanism would be based on new measures of cost that are not tied solely to past expenditures" found on page 43, 3rd paragraph under the Committee's Consensus. The words "it is critical that" could be added to the beginning of the sentence to indicate that importance. He also suggested an additional sentence that reads, "Past expenditures do not reflect costs incurred because of changing labor markets, new treatment modalities, and capital investments (including new information systems required for regulatory compliance)." Dr. Wakefield proposed capturing Dr. Mueller's concern about basing future payments on historical expenditures in a recommendation placed in the Financial Chapter.
- Page 43, 5th paragraph under the Committee's Consensus-Eliminate the first part of the first sentence that reads, "While the Committee expresses no formal support or opposition to any of the current reform proposals now being debated…" and possibly substitute the wording, "We asked policymakers…."
- Page 43, 5th paragraph under the Committee's Consensus-It was suggested to use the word "expenses" for "it" in the last sentence, but the Committee decided to delete the sentence instead because it does not follow in thought with the rest of the paragraph.
- Page 44, last paragraph, 1st sentence-Replace the first word "if" with "as." Also, take out "policymakers would be well served" and replace with "beneficiaries would be well served."
- Ms. Richardson proposed replacing "policymakers and advisors" with "beneficiaries" throughout the report.
- Page 44, last paragraph, 2nd sentence-Change the wording of the sentence to read "The Committee believes providers need to be adequately reimbursed for care." Add the sentence, "The Committee believes that rural providers need to be adequately reimbursed for care and that rural beneficiaries should have access to the same appropriate continuum of services at the same out-of-pocket cost as urban beneficiaries."
- A table of contents should be added.
- Page 44, last paragraph, last sentence-Replace the word "cost-effective" with "less expensive (to the health plan)."

Planning Session for the June and September On-site Visits

Tom Nesbitt, M.D., Assistant Dean, Regional Outreach and Telehealth
John Martin, Professor, University of Maine at Fort Kent

Chairwoman Kassebaum Baker opened the afternoon session by noting that the topics of discussion would be NACRH's proposed site visits to California in June, to Maine in September, and to Arizona in June 2002. She reminded the Committee that these visits must have a particular focus or theme so expenditures can be justified. Dr. Brand added that it would be helpful to focus on environmental issues. Dr. Eckstat asked that the Advisory Committee focus

more on innovative solutions to some of the insurmountable rural health problems in the United States, such as those solutions initiated by the University of Kentucky in Hazard.

June 2-5 On-Site Meeting

Dr. Nesbitt first outlined a tentative itinerary for the members' visit to California. He suggested that the members fly into Sacramento on Sunday, June 2; spend the night; visit migrant clinics and rural hospitals located in the Sierras; and then drive to North Lake Tahoe on Monday, using this location as a base. Members would fly home Wednesday from either the Sacramento airport or out of Reno, Nevada.

He then suggested a number of issues on which the Committee could focus:

- Construction of hospital facilities-This issue is considered important in California because of recently passed legislation requiring all hospitals to develop new plans for replacing facilities that do not meet seismic standards regardless of where they are located. This issue is causing a panic among a number of rural hospitals that fear they might have to close. One innovative solution to this problem, which is shared by a group of 23 rural hospitals, is to develop a single plan for replacing the facilities. This initiative calls for sharing the cost of moving the paperwork through State bureaucracies and sharing all engineering costs. The Advisory Committee could discuss how these kinds of efforts might be encouraged and facilitated.
- Migrant health issues-Dr. Nesbitt suggested inviting State officials to the on-site meeting to discuss border health issues that are a major concern in California.
- Visit hospitals in the North Lake Tahoe area-The Panel could visit the Tahoe Forest Hospital, a small hospital currently in the planning stage, and the Sierra Valley District Hospital, a small hospital that has just declared bankruptcy and is in the process of trying to save the facility.
- Across-State-line issues-An example of this type of issue involves a rural population that lives on the east slope of the Sierras and is covered under the State Medicaid program-MediCAL. These individuals must travel 10 or 15 miles into Nevada for medical care but are having difficulty receiving these services because of the across-State-line issues.
- Agricultural health-related issues-The Committee could discuss the studies that the Agricultural Safety Center at the University of California at Davis are conducting on occupational health issues related to rural migrant workers.
- The Kings Beach Community Clinic-This clinic, located in the North Lake Tahoe area, provides health care to local hotel and food service workers who receive minimal salaries.
- Spanish-speaking migrant clinics-In a response to Dr. Singleton's reference to the problems faced by the Asian population in California in dealing with a different culture and language, Dr. Nesbitt suggested visiting a migrant clinic that serves both a Spanish-speaking clientele and a large Southeast Asian clientele. He agreed that providing adequate interpreting services and patient education materials to these populations is an important issue.
- Telemedicine networks in California-The Advisory Committee could look at the Northern Sierra Rural Health Network made up of a number of hospitals and clinics in the Northern Sierra that are using telecommunication technology to share medical services. These hospitals and clinics have also received some Internet tools from the University of

California at Davis. Because California has one of the largest and most extensive telemedicine networks in the country, providing 30 different specialties, Dr. Nesbitt will try to arrange for some demonstrations.

Chairwoman Kassebaum Baker introduced Fred Johnson, Executive Director of the California Rural Health Policy Council, who corroborated Dr. Nesbitt's preliminary agenda for NACRH's on-site visit to California. He also mentioned that he worked closely with the Nevada State Office of Rural Health and that they could possibly contribute to discussions about "across-border" issues.

September 8-11 On-Site Meeting

Mr. Martin agreed to host the September on-site visit to Maine. He briefly outlined a preliminary itinerary and a number of issues that the Committee members could focus on during their stay. He suggested that the members first fly to Bangor, Maine, drive to Washington County, stay overnight at Campobello Island right across the border in Canada, and then go by bus to northern Maine to visit several health centers.

Mr. Martin then mentioned several issues or topics that the Committee might find interesting to discuss:

- Migrant workers-While in Washington County, one of the poorest counties in the country, the Panel could visit with the blueberry pickers, who are both Native American and Mexican, to look at how medical care is provided to these populations.
- Health care centers-Members could visit a health center and a rural hospital located in an area whose population is predominantly of French Acadian and French Canadian heritage. Mr. Martin noted that the health centers in this area must employ bilingual receptionists and professionals, a necessity especially with the older population. The rural hospital in this area (than 50 beds) is in the process of establishing a psychiatric unit for children.
- Telemedicine-Members could be briefed on a telemedicine operation currently being implemented at the Lubeck health center in Washington County.
- Prescription drugs-Mr. Martin just received approval on January 19 that allows drugs to be acquired at the Medicaid rate for individuals at 300 percent of the poverty level. With this new waiver, 90 percent of all Maine citizens are now covered by some form of a drug reimbursement plan. Mr. Martin suggested looking into this new waiver, as well as into the many problems facing emergency medical services today.
- Medical training program for physicians-The Eastern Maine Medical Center, full-service medical and trauma facility serving central and northern Maine, has partnered with Dartmouth College to operate a medical training program to train physicians to work in rural areas.
- Telecommunication/teleconferencing-The University of Maine at Fort Kent, together with the local hospital, has equipped the first floor of the hospital with a new nursing program and with a state-of-the-art telecommunication/teleconferencing facility that will be used jointly by Eastern Maine Medical Center and the University faculty.

June 2002 On-Site Meeting

Ms. Hughes explained that health care issues in northern Arizona are notably different from those found in southern Arizona. She first discussed possible issues of interest associated with southern Arizona and then outlined a few areas of interest related to the northern part of the State.

Many of the health care concerns found in southern Arizona encompass border issues, specifically the Yuma border, in regard to migrant workers. Upon hire, migrant workers are usually offered two alternative insurance policies. One option offers health care coverage in Mexico with no co-pay. The other option offers coverage on the U.S. side of the border but requires a co-pay. As expected, most migrants elect the non-co-pay insurance policy, so consequently they receive medical attention in Mexico. Problems occur when migrant workers require emergency treatment and are taken to Yuma Regional Hospital where they have no insurance coverage. In such cases, the hospital has to absorb the costs. State legislators are currently looking into the matter.

The high steel wall that is currently being built at the Nogales and Douglas border to separate the United States and Mexico is causing great concern in the area. Apart from the symbolism, the wall is also causing a strain on the local hospital because of the influx of patients with broken limbs due to scaling the wall. With the hospital in Douglas facing closure, the possible shortage of emergency services in this area is a critical problem. Ms. Hughes acknowledged that she is working with two groups, a local group and an Iowa profit-making group, in trying to secure a critical access designation for the hospital.

Furthermore, if NACRH decides to visit the Nogales area, Ms. Hughes proposed setting up a meeting with the chairperson of the new Border Health Commission created by President Clinton so as to learn more about other rural health and environmental concerns in the border areas.

Another issue worthy of discussion involves the raw sewage that is currently being driven down from the mountains and polluting local water supplies, which is causing health problems such as lupus and cancer along the border. Another environmental concern in this area is the problem of air pollution caused by noxious emissions discharged by NAFTA (North American Free Trade Agreement) convoys traveling between the United States and Mexico (the NAFTA corridor). Substance abuse and mental health are also major problematic issues.

The Panel could also travel to northern Arizona, where the terrain and climate are different than in the southern border region, and look at health care issues facing the Navajo Nation. Another

possible focus could be the 638 issue, the Self-determination Act, which continues to be a concern for the Navajo Nation, particularly for the Helo River Tribe.

Future Topics of Discussion

Advisory Committee Members

Chairwoman Kassebaum Baker asked the Panel members whether they wanted to continue to identify with one large yearlong project, as it did with Medicare reform, or to use its budge for a number of smaller products. After much consideration, the Panel decided to concentrate on a rural health safety net initiative as their primary focus. This initiative could also include other topics such as

- Questions and comments pertaining to the Medicare report.
- The plight of the uninsured and underinsured in rural communities, possibly linking it to the changing demographics in rural areas.
- The inadequacies of mental health services in rural America, the lack of insurance and resources for residents with mental health problems, and the lack of well-trained professionals in the mental health field.
- EMS concerns, oral health issues, and rural implications of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).
- The whole concept of the administrative infrastructure of rural health, specifically what the important issues are and what barriers these issues create for rural health providers.
- Different ways to deal with FQHCs, RHCs, and CHCs. This topic would cover both the uninsured and the administrative infrastructure as it relates to Medicare and Medicaid. It is also an important concern because HPSA designations are going to be an issue this year and could have a detrimental impact on FQHCs, RHCs, and CHCs.
- The solicitation of responses to the MedPAC report and to other types of initiatives, such as prescription drugs.
- The faith-based initiatives that are being proposed. Dr. Singleton mentioned that he did not believe that rural African American churches "had the capacity or resources to work with the governmental structure."

Mr. Morris suggested that the Advisory Committee stay with issues that are under the purview of Secretary Thompson, such as the collaboration of block grants with Medicaid payments and how resources could be focused most effectively in rural communities. Chairwoman Kassebaum Baker suggested waiting until June to decide on the focal issues. Also, by that time, the Committee might have received some feedback from its reform proposal for possible discussion.

Report on the NRHA Policy Board Meeting

Marcia K. Brand, Ph.D., Director of the Office of Rural Health Policy
Keith J. Mueller, Ph.D., Professor and Director, Nebraska Center for Rural Health Research and the RUPRI Center for Rural Health Policy Analysis

Dr. Brand and Dr. Mueller discussed some of the highlights of their attendance at NRHA Policy Board meeting this morning. The Policy Board opened the session by honoring Dr. Fox and Dr. Myers for their dedication and contributions to rural health. Dr. Brand then presented an update of ORHP's primary focus for FY 2001, which was similar to the one she presented to NACRH members Sunday afternoon. Dr. Mueller later talked about the legislative and regulatory landscape and Medicare reform with the aid of a slide presentation.

Dr. Brand and Dr. Mueller both fielded several questions about (1) the reauthorization of the outreach and network grant programs and how they serve rural communities and (2) CHC reauthorization and how advocates could get CHC funds to serve rural communities more effectively. Other topics discussed during the Policy Board meeting included the following:

- The importance of collaborating with other rural health groups.
- The development of a better definition of the word "rurality" so that the term can be applied to all rural health reports without confusion as to its meaning.
- A discussion lead by Senator Baucus about the mood of bipartisanship that appears to be currently pervading Washington, D.C. Senator Baucus also mentioned his weekly meetings with Senator Grassley to discuss Finance Committee issues regarding health care reform and his long-standing interest in keeping rural issues in the forefront. He also discussed (1) the importance of considering changes made to Medicare in the general context of what is going to happen around financing altogether; (2) developing some type of prescription drug program that provides access and equity; and (3) looking at administrative reform in terms of problems in rural communities where "paperwork impairs patient work," more specifically, what rural health groups could do to ease the administrative burden on hospitals.

Tuesday, February 6

Chairwoman Kassebaum Baker opened Tuesday's session by asking the Panel how it would like to proceed in formulating recommendations for the Medicare report. After a lengthy discussion, the Advisory Committee decided to develop specific consensus recommendations for each chapter on the basis of its discussion today as well as on Sunday. Mr. Morris agreed to apply the necessary "wordsmithing" to the suggested recommendations and then e-mail the final product to each member for approval. The Committee began with the Finance Chapter.

Finance Chapter

Highlights of the discussion on the Finance Chapter follow:

- There should be some guarantee that rural communities have enough capacity or stream of dollars to deliver the benefits package to their residents. The redesign of Medicare should include giving local communities the flexibility to meet health care needs at the local level within the framework of national policy.
- However, as Medicare is reformed, all of the payment streams need to merge into a single capitated payment (e.g., Medicare+Choice). To whatever extent this is handled for rural communities, all those payment streams need to be going directly to locally based health plans and not filtered through State and regional governments. One participant was concerned that locations such as the frontier regions and extremely rural areas cannot support locally based health plans. As it is, some local health plans are barely surviving, and failure could result in a plan's reliance on safety net providers for financial support.
- Dr. Mueller suggested the need to calculate a per beneficiary or area dollar amount instead of calculating dollars for doctors, hospitals, and so forth, and to distribute this amount to locally based health plans. It would then be up to the rural communities to determine how to use the funds.
- Dr. Wakefield remarked that the fragmentation that currently exists in the payment policy also fragmentizes patient care and payments for this care. She suggested more flexibility in payment policies and more community involvement.
- Reimbursement payment streams are not consistent in the way they are configured in terms of paying for inpatient versus outpatient types of services.
- Dr. Eckstat proposed that the Advisory Committee endorse a plan or a demonstration model that works in rural communities, such as the models identified at the Oklahoma and Kentucky visits. The Panel might also want to examine these models' methodologies and how they solve the issue of handling two payment streams.
- In regard to examining different model methodologies, Dr. Nesbitt suggested looking at the Managed Risk Medical Insurance Board of California, the California Children's Health Insurance Program (CHIP), and CALPHERS, one of the biggest retirement systems in the world.
- Dr. Mueller asked whether a recommendation could be developed that ensures that the dollars that are supporting the health care delivery system are spent in a way that is consistent with community planning and development efforts.
- Ms. Gonzales-Hanson asked that more information about the methodology for primary care versus subspecialty care be included in the report. Mr. Morris and his staff agreed to strengthen the primary care focus in both the Finance and Access Chapters after they receive written input from Ms. Gonzales-Hanson.
- Mr. Martin pointed out that the high cost involved in transferring hospital patients to long-term care facilities is a burden on the health care delivery system. The primary factor that affects cost in this case is the considerable distances patients must be transported from hospitals to nursing homes.
- All agreed that a consensus on administrative burden should be placed in the Reform Chapter.

From this discussion, the Committee extracted a number of specific recommendations that could be presented in the final report.

- Payment systems should consider volume, geographic, cultural, and economic factors and should not base cost on previous expenditures. It does not make sense to base new models on old models because of the constant technology and demographic changes in the rural health care delivery system

- Payments for low-volume providers in rural areas should be increased.
- The reliance on managed care to guarantee equity is problematic.
- Current benefits should include preventive care and prescription drugs.
- The payment policy across all service delivery providers should consider low-volume circumstances, such as ambulance care and home health care, and not just relate costs to inpatient hospital care. The Committee also acknowledged that because of the current changes taking place in the health care delivery system, other solutions need to be found to meet these needs. It was recommended that example solutions could be displayed in a text box at the end of the chapter.
- Equity in payments should be guaranteed for both rural and urban Medicare beneficiaries, as well as equity in access to services.

Access Chapter

Ms. Richardson explained that during yesterday's roundtable discussions with participants of the NRHA Policy Institute, it was brought up that options for long-term care are gravely needed, especially in rural areas where the solution is so often institutional care and not home- and community-based service care. She noted that Medicare actually pays for some services in long-term care, such as skilled nursing care. But, as a result of BBA, Medicare has cut its payments to home health agencies, thereby driving a lot of them out of business. Mr. Morris agreed to capture more on the lack of options for long-term care, as well as palliative care, in this chapter.

Ms. Hughes asked to include information about the problem of rural hospitals having to "dump" their long-term care wings because reimbursement does not equal the cost of patient care. She noted that two skilled nursing homes in rural Arizona have discarded a number of patients in the past 6 months. Language about this problem and examples from rural areas in Arizona could possibly be placed in a text box.

As a last comment to this discussion on the Access Chapter, Dr. Nesbitt asked that the chapter emphasize that a complete continuum of quality care be available. Although this kind of care may be more expensive to provide, it could result in future cost avoidance.

Quality Chapter

The Advisory Committee agreed on the following recommendations for the Quality Chapter:

- Medicare should ensure full access to the complete continuum of quality of care for rural residents.
- Medicare should adopt a flexible approach toward measuring quality that takes into account issues related to volume, population density, and the varying range of services available locally.
- Rural hospitals should be measured by what they do, not by what they do not do.

- Links should be developed between training programs and rural communities to ensure that more training occurs outside academic medical centers.
- Incentives should be created in Medicare GME payments to support rural educators with a track record of placing providers in locations where their services are required most.
- Technology can play a key role in helping rural communities improve their quality of care.
- Process and structure for quality may be different for rural areas.
- It is important to engage the community in ongoing dialog about health quality issues.
- Local involvement is required to enable communities to design and implement their own health care services and systems.

Dr. Singleton suggested including more information on palliative care in the chapter's discussion of CQI, as well as mentioning its importance in the Access Chapter. He agreed to submit a statement and a recommendation on this issue to Mr. Morris for review.

Dr. Wakefield asked the Advisory Committee to include a recommendation that says that the Medicare program should use the tools at its disposal (e.g., PROs) to target the special needs of rural health care delivery systems. She asked whether PROs are paying adequate attention to those unique circumstances with which rural health providers have had to deal (e.g., lack of personnel) to ensure high-quality care in rural health care facilities. In response, Dr. Mueller said that an effort exists within the PRO associations to address some of these concerns. He suggested including a text box that elaborates on current PRO activities.

Workforce Chapter

Several recommendations agreed upon by the Panel included the following:

- It ought to be emphasized that BBA allows non-hospital providers, such as FQHCs, RHCs, and Medicare+Choice organizations, to receive funding for direct costs of training residents.
- Medicare GME policy should require placing residents in rural areas. In other words, the onus should be put on medical schools by tying their payments to the placement of practitioners in rural areas.
- A transition period should be required for moving GME training away from medical schools and teaching hospitals and into rural areas.

HCFA Update

Tom Hoyer, HCFA Rural Liaison

Mr. Hoyer, a senior staff member at HCFA who studies rural issues in regard to policy and regulation development, provided the NACRH members with an overview of the historical role of rural issues in HCFA policy making. Since the early 1980s, he has been involved in a number of important legislative issues that include hospice in 1982, hospital prospective payment in 1983,

nursing home reform in 1987, essential access community hospitals and rural primary care hospitals in 1989, and skilled nursing facility (SNF) and home health prospective payment in 1998 and 2000. This year Mr. Hoyer will address the rehabilitation hospital prospective payment.

HCFA policy is strictly controlled by the limits of the law. Although it is believed that the latitude HCFA has in making and implementing policies related to its benefits is fairly broad, it is in fact fairly narrow and will become narrower in the future. There are a number of reasons for this. First, congressional flexibility has been constrained. Second, ever since the implementation of the budget reconciliation process, increasingly detailed statutes have constrained the beginning and end of expenditures. Third, the need for effective Congressional Budget Office scoring limits flexibility, details, and statutes. Fourth, the demands of both urban and rural constituencies are more detailed because the law today is more detailed. As a result, HCFA receives very precise changes in very detailed laws, thus making flexibility difficult. On a positive note, Congress has begun to act more promptly on issues than historically was the case. Examples of this expediency are the enactments of BBA, BBRA, and BIPA 2000.

When BBA was first enacted, many of its provisions had a negative impact on rural areas, especially those areas where rural hospitals were essentially rural health care systems that included SNFs, home health agencies, and RHCs, to name a few. The impact of the multiple savings provisions was catastrophic. As a result, BBRA was enacted to provide a number of appropriate changes and structural improvements to BBA. All these adjustments were made in "real time."

Before BBA, BBRA, and BIPA could be enacted, Congress and HCFA required reports from MedPAC and the General Accounting Office (GAO) on such topics as wage index calculations and the process of providing care in the rural areas so that changes to the benefits could be planned and managed more efficiently. Today, reconciliation acts include many more rural provisions than previously included.

Next, Mr. Hoyer reported on HCFA's continuing relationships with other rural health organizations. The Agency is continuing its regular meetings with ORHP staff in Baltimore, Maryland, to discuss policy and implementation issues. HCFA's association with the NRHA remains very helpful, and Jerry Hill of the Rural Health Resource Center continues to serve as an intermediary in bringing rural concerns and issues from the field to HCFA's attention.

Changes to recently enacted legislation are going to require HCFA's best efforts in terms of policy making and systems design. The Agency is already developing the occupational "mix" and the data-collection instruments for uncompensated health care that are necessary for the

refinement of the wage index and for disproportionate share hospital (DSH) calculations. Much time and effort is needed to design the instruments and collect the data.

In developing a PPS for rehabilitation hospitals, Mr. Hoyer was able to demonstrate, by using collected data, that a demonstrable and measurable difference between rural and urban rehabilitation hospitals really exists. On the basis of this information, HCFA proposed a 15 percent payment differential for rural rehabilitation hospitals to reflect differences in volume and case mix. As a final comment, Mr. Hoyer emphasized that all legislation, statutes, and programs endorsed or implemented by HCFA are limited by the data collected and by the law.

Discussion

Before fielding questions from Panel members and in response to expressions of appreciation from the Panel, Mr. Hoyer acknowledged with gratitude "the civility with which the rural health world has treated HCFA" and the exceptional patience shown, especially with the cost-to-charge ratios for outpatients and with HCFA's need to compute hospital-specific ones. He also noted that the Agency's implementation report on changes to BIPA indicates that these changes will be made expeditiously through cost-report adjustments and systems changes. He hopes to have the troublesome lab coinsurance problem fixed by the July 1st systems release date.

In the discussion that followed Mr. Hoyer's remarks, a number of points were raised:

- Dr. Wakefield asked whether there were any issues concerning the comparable and equitable application of the provisions of the Medicare program for rural beneficiaries that are still outstanding or that need modifying. Mr. Hoyer explained, in fairly broad terms, that issues such as these need a substantive amount of data to effect policy making and that more data still need to be collected to make a change. He noted two other contentious issues, somewhat similar to the equity issues, that are problematic from a Medicare standpoint:
    - DSH payments-Although these payments are a necessity for many providers, the underlining conceptual basis for computing them is not data driven. It is hoped that the data collected on uncompensated care will help HCFA make these payments more realistic.
    - Wage index-Because the wage index is HCFA's only measure of price differentials from area to area, it has become an overburdened tool, which has resulted in some problems. Oftentimes, data are very hard to obtain, and some hospitals have difficulty reporting data accurately.

Mr. Hoyer strongly believes that the use of effective data will force people to be equitable but admits that data collection is not the only answer to problem solving. For example, the recent GAO study that looks at different adjustments in the Medicare statute for rural providers (e.g., sole community, Medicare dependent) points out that more comprehensive political solutions are needed to solve equity issues.

- When asked about the issue of local and/or State involvement in the reimbursement system, Mr. Hoyer said that he had noticed during his years of involvement with Medicare that Medicaid payment plans were somewhat insensitive to rural issues. Medicare is considered a national program, and therefore, national solutions are needed to solve policy problems.
- A question was raised about how to put different funding streams together in a more coordinated way and through whom to channel them. Mr. Hoyer mentioned the Program of All-Inclusive Care for the Elderly (PACE) as a good model for how Medicare and Medicaid funds can be channeled through a local organization. PACE is a home- and community-care program whose services are capitated to an organization adhering to Federal regulations but certified and monitored by the State. The program is supported by a capitated premium to which both the Federal and State Governments contribute. The end result is a local organization that is fully responsible for the beneficiaries and is funded by both Medicare and Medicaid. This model will be implemented on a national basis in the next couple of years, and if successful, could be a strong paradigm for successful managed care.
- In regard to a concern about the lack of qualified individuals handling Medicare/Medicaid billing in rural areas, Mr. Hoyer responded that this is a problem HCFA is very much involved in and that its Center for Health Plans and Providers, whose sole purpose is provider education, is currently looking into the issue. In addition, HCFA's web site discusses a number of consumer concerns, such as how to properly fill out the HCFA 1500 form.
- A question about the status of a joint HHS, HCFA, and Indian Health Service (IHS) plan benefiting American Indian tribes, prompted the following answer. HCFA developed a demonstration project proposal several years ago that would have basically placed about 76 million additional dollars into Indian health. That money and Medicare's current contribution would be capitated. The project also proposed that IHS, in consultation with the tribes, design a broader service package.

Since the project's inception, BIPA provisions authorized IHS facilities and freestanding clinics to implement additional physician and practitioner services that did not exist before. This authorization created an additional $50 million in revenue streams to IHS providers under Medicare rules. Instructions for implementing the provision have been drafted and will be taken up by the new administration, but the $76-million contribution has been cut to $26 million. Mr. Hoyer believes it might be better to just expand the benefits, as previously done, and work with IHS to expand the infrastructure of Indian facilities than to proceed with the demonstration proposal.

- Mr. Cannington expressed concern about the low hourly rates designated for administrative positions in small rural hospitals as compared to those rates received by employees in larger urban facilities. The average hourly rates in smaller hospitals do not account for what is actually paid for per volume of service. What is happening is that an inflated average hourly rate is applied to a per unit of service with no volume adjustment.

Mr. Hoyer admitted that the wage index is not perfect and that it is currently under review. He suggested that better data collection or possibly stratifying it by, for example, management and other occupational mixes, might help. Another challenge to providing a more effective wage

index is the difficulty rural hospitals will have, as data-collection technology becomes more sophisticated, in producing more complex wage-index calculations. This year, HCFA will be soliciting comments on the impact of its first attempt at implementing a specific wage index for a SNF.

- Dr. Mueller requested an explanation about why there is an apparent need to calculate a new payment formula or system every time a change in legislation occurs. As an example, he noted that when Congress claimed that critical access hospitals' (CAHs') swing beds would not be subject to prospective payment changes under skilled nursing care, HCFA's response was to develop a new payment formula to pay CAHs for skilled nursing care. Using this case, Dr. Mueller expressed confusion as to why Congress did not revert to the old payment system when it decided not to use the new system of prospective payment.

After explaining that the previous system for paying for swing beds was not a cost-based system under Medicare/Medicaid but a cost-proxy system, Mr. Hoyer admitted that it did not occur to HCFA to immediately revert to the old payment system.

- Dr. Wakefield asked if there were specific ways to redirect resources within GME to encourage the placement of providers in rural areas, as well as to ensure their retention. She also inquired about prioritizing some of the GME payments into residency training for geriatricians and geriatric NPs.

In reply, Mr. Hoyer gave a brief statutory history of the development of GMEs. GMEs and a number of other payment provisions in Medicare were initially intended to be short-term substitutes that would last as long as it would take the community or State hospitals to come up with the money themselves for those needed functions. Because that obviously never happened, these provisions have become difficult to change. He believes that a long-term solution would include having that kind of funding come directly from HRSA instead and be targeted toward real needs identified by some method other than Medicare.

- Chairwoman Kassebaum Baker asked Mr. Hoyer how he sees Medicare evolving over the next 5 years, especially in term of affordability. Mr. Hoyer believes that if the program were to continue to follow a pathway of incremental change, as it has historically, then it would likely be viable and affordable in the future. With an increase in data collection on patients and cost per patient, with continuing information from the DRG system, and with more adjustments in the payment systems, Medicare will eventually evolve into the type of program that beneficiaries really need.
- Dr. Singleton inquired about an increased emphasis on prevention services and screenings for beneficiaries as Medicare reform progresses. Mr. Hoyer stated that prevention costs a provider more than it is worth. In a managed care setting with open enrollment periods every year, it is difficult for an HMO to provide preventive services to an individual for 1 year, only to have that patient change to a less-expensive HMO the following year. One advantage to having payment systems driven by patient status is that the patient's health and needs become increasingly more important, both from a quality of insurance standpoint and from a payment standpoint.

- Ms. Hughes suggested that the PACE projects be used as an example of a demonstration model in the NACRH Medicare report. Mr. Hoyer offered that the PACE projects have not yet been converted into Medicare/Medicaid providers but that this will happen when the projects are replicated on a large scale. Only after standards are developed and implemented can PACE be judged a success or failure.
- In an answer to a query about PACE being able to fit into a rural environment, Mr. Hoyer explained that it is a possibility, although large geographic areas could be problematic because of patient transportation needs. According to Dr. Mueller, there are no rural-based PACE projects at the moment because of the transportation and spatial limitations. Mr. Hoyer noted that the model does not have to be disease specific and that the only requirements for PACE support are one's eligibility for nursing home placement and one's ability to live at home with PACE assistance.

Public Health Update

Anjum Hajat and Michael Meit, the National Association of County and City Health Officials

Mr. Meit prefaced his presentation on public health in the rural community by thanking NACRH members for the use of their report titled Stabilizing the Rural Public Health Infrastructure. This study is the genesis of the National Association of County and City Health Officials' (NACCHO) current rural health project. The premise of the project states that unless a strong public health infrastructure capable of monitoring disease, accessing community needs, and focusing on prevention is in place, it will be difficult to focus on what is going to really improve health on a broader perspective. According to the NACRH report and the data collected for the NACCHO rural health project, it is apparent that the rural public health infrastructure and the public health infrastructure in general are very strained.

An example of the kinds of problems rural health departments are facing today can be seen in the outburst of the West Nile virus that is rapidly moving down the East Coast, causing a strain on many local health departments. A number of these departments have had to cease their normal functions so as to address this emerging disease, underscoring the need for a strong public health infrastructure. The challenge is in finding ways to fund this infrastructure and to ensure that the staff is well trained and available.

Mr. Meit then provided a summary of NACCHO and the rural health project:

- Overview of NACCHO. NACCHO works with a variety of local public health agencies, including city, county, and regional health districts nationwide. There are about 3,000 local public health agencies throughout the country. About 1,000 of them are active members in NACCHO. About 60 percent of these facilities are in urban locations and about 40 percent are in rural areas.
- Mission of NACCHO. As the national voice of local public health, NACCHO promotes national policy, develops resources and programs, and supports the development of

effective local public health practices and systems that protect and improve the health of communities.

- Essential public health services. Essential services of a local public health department include the following
  - Monitoring health status to identify community problems
  - Diagnosing and investigating health problems and health hazards in communities
  - Developing policies and plans that support individual community health efforts
  - Enforcing laws and regulations that protect health
  - Ensuring a competent public health workforce
  - Researching innovative solutions to health problems
  - Educating the public and mobilizing partnerships
  - Linking people to needed personal health services
- Direct service provision. Local health departments appear to be moving away from providing direct services, whereas rural communities are still providing them.
- NACCHO project areas. NACCHO works closely with community health initiatives, including primary care, maternal and child health, tobacco control, HIV/AIDS, and a hepatitis project. In the environmental health field, NACCHO is working on a food safety project, a Superfund project, and a Brownfields redevelopment project that is reusing former industrial sites and redeveloping inner-city communities. NACCHO also has a strong research and development division, which houses a National Electronic Disease Surveillance System, and is involved in a bioterrorism initiative. Its community health assessment projects try to ensure that local health departments conduct thorough community health assessments to identify community needs and public health issues.
- Rural health project overview. The rural health project, funded by ORPH, has two primary goals. The first goal is to enhance NACCHO's database and analysis activities to better address the needs of local rural health departments. Once database enhancement is completed, the second goal is to disseminate the final report to these rural health departments, to other local health departments, and to NACCHO partners.
- Database enhancements. NACCHO maintains several data sets on local public health infrastructure, including its National Profile of Local Public Health Departments. This document takes a comprehensive look at local health departments around the country in terms of the kinds of services they provide, workforce issues, and training of local health officials. NACCHO will use these data sets to identify the operational and programmatic differences between rural and nonrural health departments.

Following Mr. Meit's presentation, Ms. Hajat provided an overview of the type of data collected by NACCHO's infrastructure survey sponsored by RWJ. She organized her presentation according to the six major issues that were highlighted in the ORHP infrastructure report. She began by providing a methodological background of how the data were collected from November 1999 to April 2000.

- Survey methods. The infrastructure survey was a weighted and stratified sample survey that reflected a consensus of a large number of health departments (63 percent response rate). The type of data collected included workforce issues, services and programs provided by the health departments, types of partnerships, and community assessments.
- Methods: linking data. One of the first steps in conducting the survey was to link each local public health department in the country to the county or counties in which they serve. The 1999 Area Resource File, which contains necessary FIPS codes (unique

identifiers for each county in the nation) and Office of Management and Budget metro (urban) and nonmetro (rural) designations, was then linked to the NACCHO data.

- Caveats for county-based metro and nonmetro designations. The county-based definition system for rural and urban did not necessarily capture their true nature. In the future, these types of surveys will look at smaller units beyond the county level. The metro/nonmetro classification did not capture the local health departments that had both an urban and rural area within one county.
- Percentage of metro and nonmetro local public health departments. Figures show that there are more nonmetro (59 percent) than metro (41 percent) health departments in the United States.
- Leadership. In surveying the academic degrees of agency executives and whether they have public health training, it was found that about 50 percent of metro health department executives have public health training, while only 30 percent of rural health department executives have some public health background.
- Workforce preparedness. Data showed a wide discrepancy between the number of full-time employees (FTE) in metro health departments and in nonmetro health departments. Types of employment for both metro and nonmetro were broken down by percentage into such occupations as public health nurse, environmental scientist, and public health social worker to indicate where staff is lacking.

Several reasons were identified for the lack of staff in both metro and nonmetro health departments. They included an insufficient budget (the primary reason), inadequate pay and benefits, unattractive geographic location, and program expansion. Data also showed that 80 percent of metro health departments had continuing education budgets compared to 70 percent for nonmetro.

- Direct services provided by local public health departments. The nonmetro or rural health departments were found to provide more direct services such as school clinics, diabetes and other chronic disease screening, the WIC (women, infant, and children) program, home health care, and maternal health care than did their metro counterparts.
- Population-based services provided by local public health departments. From the collected data, the researchers determined the percentage of the types of services provided by public health departments. Some of these services include childhood and other types of immunization, STD (sexually transmitted disease) and other communicable disease testing, and tobacco prevention programs.
- Inspection and environmental health services provided by local public health departments. Of the services examined, such as sewage, food safety, and health facility inspection, all were provided more by metro health departments than by nonmetro health departments.
- Impact of managed care. Although relatively little data were collected for the question on partnering with managed care organizations and HMOs, it was concluded that metro health departments are partnering more than nonmetro health departments with the managed care sector-55 to 45 percent, respectively. About 20 percent of the nonmetro departments indicated that this question was not applicable to them.
- Telecommunications. The data indicated that the ratio of the number of information technology (IT) staff people employed by urban and rural public health departments was 5 to 1. This ratio shows that the IT capacity of rural public health departments is somewhat limited. Not only are they limited in the number of IT personnel, but they also

lack the actual physical hardware. When asked whether IT staff was a top priority, 5 percent of metro and 1 percent of nonmetro said it was.

- Funding: expenditures. Data found that the mean or average expenditure for metro health departments was $9 million annually as compared with $1 million for nonmetro health departments. The median was $1 million for metro and $500,000 for nonmetro.
- Funding: source of the budget. Metro health departments receive almost 60 percent of their funding from local governments, whereas nonmetro health departments receive about 35 percent from local governments and about the same amount from State governments. Nonmetro departments receive a much larger chunk of funds from service reimbursements that include Medicare, Medicaid, insurance, and direct patient fees.
- Future directions. Researchers for this project will
    - Continue to analyze future data by metro/nonmetro designation.
    - Disseminate information via several research briefs and through a report on the state of rural local public health.
    - Conduct focus groups to ascertain qualitative data not captured in surveys.
    - Ultimately, transform data into infrastructure improvements to the benefit of rural communities.

Discussion

In the discussion that followed the public health presentation, the following questions and issues were raised:

- In response to a question on whether public health departments today provide pregnancy prevention programs and mental health services, Mr. Meit assured the Advisory Committee that public health departments are still heavily involved with family planning issues. Mental health services, on the other hand, especially services at the local level, are usually carved out of public health services. In other words, they are two separate parallel systems. Local public health agencies usually work very closely with their community mental health agencies to ensure that all needs are addressed. Mr. Meit also noted that the survey for NAACHOs rural health project specifically provided survey recipients with a range of services to which to respond.
- In answer to a question about the extent to which public health departments are dependent on reimbursable services, Mr. Meit pointed out that about 20 percent of public health department funds are from service reimbursement.
- Ms. Hughes asked two questions related to the bioterrorism initiative, whose purpose is to strengthen the public health infrastructure of the nation. First, she asked whether this initiative has had in fact any impact at all on strengthening the infrastructure, and second, whether any public health departments receiving money for the initiative have been collaborating with the military.

In response, Mr. Meit stated that the money allotted to the bioterrorism initiative is being filtered down to the larger communities first so very little money has yet reached the smaller rural communities. The larger communities are making good use of these funds to build infrastructure, particularly in technical capacities, such as computer software and hardware. These communities also are collaborating with the military and local police forces to strengthen the infrastructure for preparedness. Mr. Meit also mentioned that the same disease surveillance

system that identifies a bioterrorist event can also identify an emerging virus or disease, such as West Nile virus.

- Mr. Cannington inquired how rural communities, which many times do not have the volume to justify a fully staffed public health department, can develop partnerships or relationships to help meet their health care needs. In reply, Mr. Meit affirmed that it is the responsibility of Federal and State agencies and national associations to encourage their memberships and their grantees to work together to ensure an infrastructure that can provide both individual and population-based services. NACCRO has highlighted and hopes to replicate a number of models, such as the one in Boulder, Colorado, that have been successful in this respect. Many health departments are also partnering with schools.

Mr. Cannington expressed concern about the idea of "regionalizing" services, because it could lead to patients having to drive long distances to receive care from county public health departments. He offered that some FTEs could be shared but that preventive services and other services should be provided in local communities. Mr. Meit agreed but noted that all health departments do not necessarily have to have the same infrastructure.

- As a follow-on question, Mr. Berk asked whether there is a drive to start centralizing services. Although NACCHO and local health departments are making some progress, Mr. Meit admitted that categorical funding is a significant barrier to its implementation. Categorical funding is grant money that is applied to specific service areas. Very few sources of funding, other than in the maternal and child health block grant, are flexible.

Chairwoman Kassebaum Baker thanked the guest presenters and noted that far too often public health is not given the attention that it deserves in this country. Public health has not been recognized professionally with salaries that are concomitant to enhancing its reputation. She then suggested that the Advisory Committee follow up on some of the discussion topics, such as health assessment and "regionalization," in future discussions.

The Uninsured: Key Issues Affecting Rural Health

Judy Waxman, Director of Government Affairs, Families USA
Dean Rosen, Senior Vice President of Policy and General Counsel, the Health Insurance Association of America
David Metz, Senior Vice President for Retirement, Safety and Insurance, the National Rural Electric Cooperative Legislative Counsel

Ms. Waxman's Presentation

Ms. Waxman, leading authority on managed care issues, Medicaid/Medicare, and patient protection, provided an overview of the uninsured population in the United States from the perspective of the lower income person. She also discussed her proposal cosponsored by

Families USA, the Health Insurance Association of America (HIAA), and the American Hospital Association that presents several solutions to the problem of the uninsured.

There are about 44.3 million uninsured people in the United States according to 1998 statistics. This figure covers about 18.4 percent of the under-65 population. About 30 percent of people will be uncovered for at least 1 month over a 3-year period. The average period of noncoverage is about 5 months. These figures show that a large percentage of people are in and out of coverage.

There are a number of reasons why people lose coverage. Some of these include a change in employment status; a move to another state or community; a change in family status, such as marriage, divorce, and family additions; and a change in health risk status, such as pregnancy or illness.

Most of the uninsured are families that have at least one full-time worker (about 74 percent or about three-fourths of all households). Only 16 percent of nonworkers and 10 percent of part-time workers are uninsured.

Lower wage workers are less likely to be offered health benefits. If a worker is earning $15 or more an hour, then he or she has a 93 percent chance of being offered coverage. Only 43 percent of employees earning $7 or less per hour are offered health benefits by their employer. Even in today's relatively good labor market, this continuing problem of low-wage workers not being offered coverage still exists. Another problem surfaces in the high cost of insurance coverage incurred by the employee. Workers who earns more than $15 an hour pay about $84 in coverage, whereas workers who receive less than $7 per hour about pay $130 in coverage.

It was found that in 32 States a parent cannot receive Medicaid when he or she works full time at minimum wage ($5.15 an hour). The eligibility levels are so low in these States that a full-time worker may not get offered any insurance coverage at all. Medicaid is not an option if an employee does not qualify on the basis of salary.

Most States will cover children up to 200 percent of the Federal poverty level (FPL). The median eligibility level for parents, however, is 61 percent of FPL, whereas for nonparent adults, it is 0 percent. A number of people tend to postpone or forego needed care if they do not have insurance.

To help solve some of the problems faced by the uninsured, Ms. Waxman suggested building on programs that have been proven to work-Medicaid and CHIP. Some of the positive factors attributed to these programs include

- Coverage of 41 million people
- Viewed as a "good program" by 94 percent of parents of enrolled children (Medicaid)
- Shown recent significant growth in children's coverage (more than 3 million children have enrolled)
- Some of the challenges of Medicare and CHIP include
- Drastic coverage loss in recent years associated with welfare reform
- Limited or no eligibility for working parents earning minimum wage in many States
- Limited or no eligibility for childless adults of any income in most States

To help alleviate some of these problems with the uninsured, Ms. Waxman proposed the following:

- Ensure that Medicaid is available for people with incomes up to 133 percent of FPL.
- Ensure that CHIP is available for people with incomes between 134 percent and 200 percent of FPL.
- Devise an employer tax credit to help the working poor get coverage.
- Build on the current public programs and systems and support the current employer system to go along with these programs.

Mr. Rosen's Presentation

Like Ms. Waxman, Mr. Rosen presented statistical material on the problem of the uninsured but with a focus on a proposed employer tax credit to help low-wage employees get insurance coverage. He noted that the insured usually include those persons who tend to flit in and out of coverage, are chronically uninsured for long periods of time, or simply cannot afford coverage. Families USA and HIAA used these issues as a starting point in developing their uninsured proposal to help make a difference in the number of uninsured. Mr. Rosen elaborated on the proposal's key factors later in his presentation.

Mr. Rosen first presented a number of graphs illustrating the increase in the uninsured and why poor Americans are more likely to be uninsured. From 1998 to 1999, the number of uninsured declined slightly by a little over a million. Despite that decline, if the rate of inflation on health care continues, the uninsured population will increase. It is predicted that at the end of the next 10 years, the current figure of 42.1 million uninsured Americans will increase to 55 million, or more than 1 in 6 adults under the age of 65. This number could go as high as 61 million if this country experiences a combination of inflation and recession during the next couple of years.

Mr. Rosen explained that in the early to mid-1990s, this country experienced a steep decline in employer health insurance premiums with the widespread adoption of managed care. But from 1998 to 2000, premium costs and underlining health care costs (national health expenditure) began to rise. This year, on average, employee premiums are expected to grow by about 11 or 12 percent. Consequently, as costs go up, the number of people without coverage increases.

Low-income employees are more likely to be uninsured than higher income employees. About 54 percent of those persons without coverage are below 200 percent of poverty. For their proposal, Families USA and HIAA focused on those individuals who could not afford coverage on their own because of gaps in the public or private system.

The HIAA and Families USA uninsured proposal offered several recommendations in addressing the uninsured problem: expanding the Medicare and CHIP components and developing an employer tax credit. Because Ms. Waxman's presentation covered the first two recommendations, Mr. Rosen provided more information about the tax credit. He began by discussing some of the issues involved in the private employment-based insurance system. This system, either through unions or through work, provides more than 172 million Americans with private coverage.

In addition to the growth of public coverage (Medicare and CHIP) between 1998 and 1999, one of the reasons why the uninsured declined during this period was because employment-based coverage had also grown. The percentage of firms offering coverage today is increasing, probably due to the good economy, the tight labor market, and the need for firms to remain competitive.

There is tremendous strength in the employment-based system because of the availability of employee subsidies and the affordability of coverage made possible by group administration of insurance. HIAA and Families USA used this system to find a way to help low-income people to receive more money. Their proposed tax credit basically gives employers a one-to-one credit if they pick up all or part of the premiums paid by their employees. This proposal hopes to encourage employers to pick up more of the coverage cost, thereby making premiums more affordable, especially to those low-wage workers who had previously refused to accept coverage when offered.

Mr. Metz's Presentation

Chairwoman Kassebaum Baker prefaced Mr. Metz's presentation by noting that rural electric co-ops are an important entity in rural communities and have participated in many issues involving the uninsured. Association members are key employers in rural America, so consequently they are a vital part of the health insurance coverage.

Mr. Metz provided NACRH members with some additional information on issues of the uninsured and access to care. He pointed out that the HIAA and Families USA proposal represents a positive development in expanding existing programs and also in drawing on the

public- and private-based insurance system. "These are steps in the right direction, and they will certainly make a difference in the number of uninsured."

He also pointed out that the demand for health services is not likely to decrease and that the capacity to diagnose and treat disease as it expands may outstrip the desire to pay for it. The consequence is that certain segments of the population might not receive the benefits of these emerging advances in medical science and technology.

Mr. Metz explained that the National Rural Electric Cooperative Association (NRECA) represents a community approach to dealing with health care issues. It currently provides medical insurance for about 125,000 beneficiaries nationwide. NRECA is not involved with managed care but does perform contract work with provider network aggregators such as PPOs.

Mr. Metz pointed a number of things that the NRECA insured want and do not want from their health care coverage:

- They do want their choices limited.
- They do not like to be told where to get their health care.
- They do not like any interference with their relationships with their health care provider.
- They want NRECA to pay bill charges or some other expenditure cap.
- They do not want to pay too much for health insurance. They want first-dollar coverage, with no out-of-pocket expenses for medical and prescription drugs.
- They want coverage to include the latest advances in medical science and technology.

As recommendations are proposed to expand the coverage of health care costs for the uninsured, such as those proposed by Ms. Waxman and Mr. Rosen, a number of issues should be considered that have particular significance in rural areas. These issues include the following:

- Putting more money into paying for health care services, whether it is from private or public sources, will not by itself expand the availability of proximate access to these services, but it will certainly increase the cost of the insurance. It may also encourage expansion and duplication of unnecessary facilities and services.
- Expanding coverage will not by itself improve the health status of local populations, health outcomes, or the underlying social, economic, and demographic issues of rural communities.
- Expanding coverage will not change the behavior of the local populations or of the 20 to 25 percent of the people nationally who do not use health care services because they do not believe it is necessary.
- Putting more money into the system to pay for care for the 20 percent of the population that accounts for about 80 percent of the health care expenditures is not necessarily going to achieve the desired objectives.

Mr. Metz then listed a number of ways that payers can help expand access to insurance coverage:

- Encourage rural communities to organize and focus on local health care issues.
- Encourage them to make public health and health care a priority.
- Support rural communities in the development of new and innovative approaches to finding ways to reduce or eliminate environmental hazards and in educating adults and children about prevention and self-care and in the use of the health care system.
- Provide recruitment efforts and shared services and encourage affiliation with other organizations and communities
- Arrange to transport patients and residents to other communities as necessary.
- Build on the established private and public systems.
- Eliminate obstacles to collaboration among community providers and encourage cooperation and innovation
- Encourage providers to locate and remain in rural communities.
- Experiment with creative reimbursement policies to encourage providers and community residents to organize alternative approaches to providing or arranging for health care services.
- Develop approaches to managing the health care of the insured population through patient education and outreach programs for disease and case management.
- Provide for mental health services for alcoholism and drug abuse and for certain basic primary care services.

Discussion

In the discussion that followed the presentation of the HIAA-Families USA uninsured proposal, a number of issues were raised:

- Ms. Waxman reiterated some of the themes that Mr. Metz discussed during his presentation. She emphasized that health care coverage cannot necessarily solve every problem facing rural environments today, but that it can make a difference in what services are accessible to the beneficiary.
- Several Committee members had comments and questions about the HIAA and Families USA proposal that recommended Medicaid for families with incomes up to 133 percent of FPL. Mr. Martin asked if that part of the proposal were mandated today, what percentage of people would be covered at that level and what would be the cost to the Federal budget. Mr. Rosin replied that about one-half of those people below 200 percent of poverty (about 23 million people) would be eligible for coverage at a considerable cost to the Federal Government. He noted that the cost to expand Medicaid is the most expensive part of the proposal because it will affect the largest number of people. It is expected that those States required to pick up their share of Medicaid will show some kind of resistance and that this resistance may discourage local and State participation.
- Mr. Martin also asked whether any individual State analyses have been conducted on the cost and/or the impact of implementing an employment-based system. Mr. Rosin acknowledged that no analyzes have been conducted on those issues yet, but it is a possibility.
- Several Panel members were interested in whether the proposal under discussion was really mandating that Medicaid pay for all people with incomes up to 133 percent of FPL and whether this would cause a serious reaction from the States. Ms. Waxman

explained that it was a mandate and that the figure of 133 percent was used because "that is the floor now in Medicaid for children under 6 years of age." She also noted that States were generally unhappy with the mandate because of the costs involved, even though the Federal Government would be required to pick up a portion of the cost.

Mr. Rosin added that the proposed Medicare mandate would in some ways follow the current law in that States are encouraged through incentives to provide financial support. The proposal hopes that States will be required to provide an enhanced match of funds beyond what Medicaid now provides. If this becomes a requirement, State Governors will be unhappy because they will lose their flexibility in whether to participate in Medicaid or not.

- In answer to a query about charges to the payer, Mr. Metz responded that all charges are passed onto the customer. Electric co-ops traditionally provide rich benefits, with the employer paying the largest share of the cost of the programs. But now there is an increase in cost shifting to the employee. In other words, employers are asking their employees to make larger contributions to company programs usually by raising deductibles. Customers are also concerned that payers might accept discounts on health care payments, which could result in health care providers leaving certain communities because they cannot afford to continue to live there.
- Ms. Hughes talked about an inititative on Arizona's last November election ballot that involved health care for the uninsured. The initiative, which passed by 70 percent of the vote, will add 384,000 families to the State Medicaid program. Ms. Hughes asked whether other States were conducting similar ballot initiatives, and if so, how would this affect payer strategy. In reply, Ms. Waxman confirmed that other States, many with use of their tobacco money, are expanding their Medicare programs to include parents of almost any income level. Families USA is now working with advocates and legislators in about 10 States that are contemplating this initiative.
- Mr. Rosin offered some thoughts on the growth of the uninsured and the high cost of health care. The growth of the uninsured will not abate without help from the Federal Government, but this will take a lot of money because the high cost of health care is forever increasing. Statistics prove that people who fall under 200 percent of poverty are having great difficulty affording the basic costs of care. The HIAA and Families USA proposal, which recommends expanding Medicare and building on the employment-based system, is a first step forward in solving this problem.
- In responding to a concern about whether this proposal would address the health needs of migrant workers, Ms. Waxman said that this issue would have to be addressed and added to the proposal at a later date. She also noted that unfortunately Medicaid and other State programs do not always benefit that group. Dr. Nesbitt added that California's Access to Infant and Mothers Program (AIM) provides coverage up to 350 percent of FPL and uses a sliding scale for the percentage of coverage required from the beneficiary (usually about 2 percent of income). California still faces tremendous problems with large numbers of farm workers migrating in and out of the State. Health needs for this group are usually handled in traditional ways such as the using the services of migrant clinics.

Dr. Nesbitt asked whether the State of California could subsidize the expansion of the Healthy Families Program under CHIP through the proposal's mandate. Ms. Waxman offered that many

States, including California, are now combining tobacco money and CHIP money to cover health care for parents.

- Dr. Wakefield expressed concern about the underinsured, specifically those individuals who, because of high co-payments, underutilize primary care services. Also included in this group are the self-insured who sustain steep out-of-pocket expenses. She asked whether the Family USA and HIAA initiative would help subsidize health care costs for these people. Mr. Rosen responded that the primary reason for negotiating hard to mandate Medicaid and CHIP is to ensure significant benefit coverage with relatively low co-payments or co-insurance. He noted that many people, particularly in rural areas, opt for private coverage over public coverage because of the stigma involved with the latter. In the case of the underinsured, many accept the high deductibles as a tradeoff for low premiums. Mr. Rosen believes his mandated Medicaid benefit package will alleviate, to an extent, the concern most low-income people have about high co-payments.
- Dr. Mueller threw out several suggestions for consideration by Families USA and HIAA:
    - Try to learn from parallel experiences what gaps might remain in your proposal,
    - Determine the results in those States that do provide good comprehensive coverage to everybody below 133 percent of poverty,
    - Determine the reasons why employees have been declining insurance coverage in the past 4 or 5 years when there has been an increase in employers offering it. This information could be used in determining how to make the employer tax credit proposal more attractive; for example, the initiative could recommend a fully refundable tax credit to the employee.
    - Beware of the unintended consequences of using Medicaid as a vehicle without, at the same time, providing incentives on both the benefits and the provider payment side.
    - Make sure that the plan really opens up access to care across the spectrum of services for people who sign up through Medicaid.
- Dr. Nesbitt pointed out that even if Medicare is expanded, if it does not cover a significant portion of the cost of health care services, then it really has not increased access. As an example, he pointed out that the primary reason why so many patients use California's extensive telemedicine program is because most primary care physicians do not take Medicaid.
- In summary, Mr. Metz provided some suggestions for increasing the visibility of this issue. He suggested not to follow all the traditional approaches to providing coverage for the uninsured and said that there are a lot of potentially innovative approaches waiting to be tested. At present, Medicare only covers about 50 percent of the cost of medical expenditures and does not cover prescription drugs.

In closing the NACRH meeting, Chairwoman Kassebaum Baker thanked Ms. Waxman and Mr. Rosen for their informative presentations and offered the Panel's support in their efforts.