June 4-6, 2000, Checotah, Oklahoma

Health Resources and Services Administration
Office of Rural Health Policy

Checotah, Oklahoma
June 4-6, 2000

Meeting Summary

The 35th meeting of the National Advisory Committee on Rural Health (NACRH) was held June 4-6, 2000, at the Fountainhead Resort and Conference Center in Checotah, Oklahoma.

Sunday, June 4

Call to Order

Nancy Kassebaum Baker, NACRH Chair

Former Senator Nancy Kassebaum Baker convened the meeting by thanking the participants for their attendance at this site visit. The following members attended the meeting: James F. Aherns, Dr. J. Graham Atkinson, H.D. Cannington, Dr. William H. Coleman, Shelly L. Crow, Dr. Barbara Jean Doty, Dr. Steve Eckstat, Dana S. Fitzsimmons, Rachel A. Gonzales-Hanson, Alison M. Hughes, John L. Martin, Dr. Thomas S. Nesbitt, Dr. Monnieque Singleton, and Dr. Mary Wakefield. Chairwoman Kassebaum Baker then asked Dr. Wayne Myers to give an update on the activities of the Office of Rural Health Policy (ORHP).

Office of Rural Health Policy Update

Wayne W. Myers, M.D., NACRH Executive Secretary; Director of the Office of Rural Health Policy

Dr. Myers provided NACRH members with an update of the Office's activities. First, he noted that Dr. Marcia Brand has succeeded Jake Culp, who retired as Deputy Director of ORHP May 1, 2000. Mr. Culp now works for the American Academy of Family Practice on Capitol Hill. He also explained that his 22-member Office is divided into two sections. One section is responsible for the implementation of grants and awards and the other section develops and presents policy positions. As Deputy Director, Dr. Brand will manage the information gathering

for policy statements and policy distribution. The supervision of grants, operations, and budget functions will be handled by Sahi Rafiullah, another ORHP staff member.

Dr. Myers reported that the grants program is on course, with five rural health research centers nearing the end of their 4th year of operation. A sixth center will be designated by August 1, 2000. One of the six centers will focus on health status and health access difficulties of rural minority groups. ORHP currently has about 22 applications for those six rural health research center slots.

Dr. Myers briefly discussed fiscal year 2001 funding. He noted that ORHP's funding requests have been noted in both the Senate and the House. But he expressed disappointment in the fact that the Office will receive only $5 million for funding in the area of research and policy development, down $1 million from last year. This area funds the six rural health research centers, ORHP, and other policy development activities. But he expressed hope in recapturing the $1 million in the future.

ORHP continues to work collaboratively with the Health Care Financing Administration (HCFA) and Medicare with periodic meetings under the leadership of Tom Morris for ORHP and Tom Hoyer for HCFA. ORHP is also working with the Medical Payment Advisory Commission (MedPAC) to arrange for a series of site visits to West Virginia, Iowa, Texas, Mississippi, and Montana for the purpose of gathering information on rural issues in the field. The information collected from these visits will be published in several reports that were requested by the Balanced Budget Refinement Act (BBRA) of 1999. These reports will be compiled into one final report scheduled for publication next May.

Next, Dr. Myers reported on several Office initiatives currently under way. ORHP participated in a meeting with the American Dental Association in early June 2000 to discuss the issue that oral health is becoming a major national problem, especially for those people who have no money. He also commented on the Surgeon General's mental heath report, which, in his opinion, did not fully address rural issues. A supplemental report on mental health issues for rural minorities is coming out in July. Staff member Blanca Fuertes is currently gathering resource materials on the mental health of rural minorities for potential inclusion in a follow-up report.

The Institute of Medicine issued a report on sustaining the safety net in rural communities, which it defines as a core safety net that includes community health centers, academic medical centers, and health departments. The Institute added that the safety net covers a relatively small fraction of the total uncompensated care in this country. ORHP believed that a funded safety net is very important, especially because most rural areas do not have access to community health centers, comprehensive primary care, or health department services.

Dr. Myers then shifted to the issue of the Community Access Grant Program (CAP), which is a program funded in the last fiscal year to make grants of $1 million each for organizations that present ways to organize access to care for the uninsured. HRSA has mailed 2,600 applications for not more than 20 or 25 grants. Dr. Myers posed several rhetorical questions to the Committee: What can we conclude from this outpouring of interest? Have we been looking too much at indigent care as a money issue rather than an organizational issue? Have we been listening too much to the economist and not enough to the people who have to provide that indigent care? Are there other ways in which we can address this issue? He expressed disappointment in the House of Representatives' reduced budget for CAP, from $125 million to $25 million, for the coming fiscal year.

In regard to racial and ethnic disparities, Dr. Myers reported that a controversy exists surrounding a measure to convert the NIH Office of Research on Minority Health to a center that will be involved with health disparities. Although most agree that disparities in health care should receive more attention, the controversy focuses around the question of whether those disparities should be defined and whether the mission of the new center should be defined on the basis of race and ethnicity or whether major consideration should also be given to poverty per se.

Next Dr. Myers reported that the Critical Access Hospital Program is proceeding well, with about 170 Critical Access Hospitals (CAHs) designated nationwide. The program allows small rural hospitals to redefine their scope of work so that they may receive some flexibility in Medicare conditions of participation and secure cost-based reimbursement. Before a hospital converts to CAH status, ORHP strongly suggests that the affected community becomes involved in the development process. Community members should obtain sufficient data and information so they can understand the new health care system and the manner in which this system relates to delivery of services that are locally required and desirable. Dr. Myers expressed concern that some hospitals will be attracted by the cost-based reimbursement incentive and will overlook improving their patient management skills and their relationship with the community.

According to Dr. Myers, ORHP has just started to officially address two work force issues: the rural supply and distribution issue and the rural graduate medical education (GME) issue. Staff member Dr. Forest Calico, together with Dr. Kathy Hayes, is taking the lead in addressing these concerns, while a policy fellow from the University of North Dakota School of Medicine is investigating the realities, in HCFA terms, of GME for rural areas, with an emphasis in special population training. Changes to the program's provisions have already been made by the BBRA of 1999, but HCFA has not yet acted upon those changes. Dr. Myers hopes some action will be taken soon.

Dr. Myers mentioned several future efforts that interest ORHP:

- Low-volume costs. How Medicare is handling small-volume issues is a recurring problem. ORHP needs to develop ways to frame the issue of legitimate costs associated with low volumes in a way that could be applied across different programs.
- Special payments to rural hospitals. Dr. Myers acknowledged that special payments are being made to rural hospitals because they receive about two-thirds of the funds that urban hospitals receive. He agreed that funding programs appear to be focusing solely on community hospitals, CAHs, and medical-dependent hospitals. Because of the accepted belief that small rural hospitals will eventually "wear out because of the lack of funds and that rural America is gradually fading away anyway," ORHP anticipates an uphill fight in its battle to appropriate funds to build new hospitals in rural areas.
- Hospital access to capital. Access to modest capital construction funds is necessary to cover such major expenses such as malfunctioning air conditioning units or other equipment failures. Dr. Myers asked if it would be possible to help hospitals find access to money if they agreed to change their mission by focusing more on inpatient care than on outpatient care.

In closing, Dr. Myers asked the Committee to define what is really important for rural America in terms of Medicare and to present its findings and any recommendations in a letter to Department of Health of Human Services (DHHS) Secretary Donna Shalala.

Discussion

In the discussion that followed the ORHP update, several issues were raised:

- Ms. Crow voiced concern about billing for outpatient ambulatory surgery visits once HCFA has activated its new billing system on July 1, 2000. Apparently, the billing codes have not yet been programmed into the computer, and many providers do not want to commit fraud by billing with incorrect codes. Mr. Morris of ORHP responded that HCFA has acknowledged this concern, but that Congressman William M. Thomas (R-CA), Chief of the Health Subcommittee of the House Ways and Means Committee, is pushing to implement the new system as soon as possible because of his concern about the high beneficiary co-pays and deductibles currently being faced under the old system. There is a possibility that the July 1 date will be moved back to accommodate the ongoing debate on the new system and because HCFA's internal billing system is currently not in place.
- Several Committee members had comments and questions about CAHs. Dr. Monnieque Singleton questioned the benefits and effectiveness of these types of hospitals and said that more and more of them are closing. In response, Dr. Myers agreed that CAHs are not the "saving grace" for all rural hospitals but that many hospitals have become very successful with the conversion. He added that he knows of only a couple of converted hospitals that have closed. He admitted that, due to a drafting error in the BBRA of 1999, there is an immediate problem with laboratory reimbursement. Because this error has caused confusion about how CAHs get reimbursed for laboratory work, some rural hospitals are "putting on hold" the conversion to critical access status.
- Mr. Ahrens offered his views on the subject. He believes that CAHs, of which Montana has had 15 since 1990, stabilize one's reimbursement policy and are a great opportunity to maintain access to very rural areas, especially if the community gets involved in the

process. He stated that "of themselves, CAHs won't save rural America, but they give you another opportunity to provide quality health care and to keep people in the rural areas."

- Ms. Hughes mentioned that her State has a law that allows hospitals to form hospital districts. These districts usually affect the geographic areas that are served by a single hospital and are not combined with other hospital districts. Each district poses taxes on its residents, the revenues of which go directly to the hospital.
- Dr. Doty suggested that NACRH continue to look at the issue of special populations in rural areas that have some Federal resources (e.g., Department of Veteran Affairs and the Indian Health Service [IHS]), their access issues, and the duplicity of systems, such as the EMS system. In discussing the latter issue, Dr. Doty pointed out that systems like EMS are not well organized so therefore people lose access to those resources.
- Dr. Wakefield asked whether the series of issue briefs on selected rural health issues that HRSA was developing, and mentioned by Dr. Earl Fox in the February minutes, were now available to the public. According to Mr. Morris the draft is still in production.

State Planning Grant Program

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

Dr. Brand provided NACRH with an overview of two activities in which she is currently involved. The first activity, the implementation of the State Planning Grant Program, was created in appropriations report language of the FY 2001 Labor Committee/HHS bill. The program gives selected States funds to develop a plan to propose options for ensuring that every citizen has access to affordable health insurance coverage. In developing materials for this grant, ORHP had to first determine the correct definitions for "access" and "affordable" as they applied to health insurance coverage.

ORHP's preference is to award 10 grants of $1 million each to fund options for those States with low numbers of uninsured rather than funding options for those States with large numbers of uninsured because it believes that the success rate for the former will be better. The overarching goal of the program is to encourage States to provide access to affordable health insurance coverage, plan for the access, and provide results in a report to Secretary Shalala.

At present, 33 States have attended workshops outlining the program's plan, and three or four other States have expressed interest in developing such a plan, including Texas and California. Dr. Bland pointed out that, like the CAP grant programs, States are not looking to the Federal Government to solve their problems; instead they are looking at local solutions, such as public and private health insurance coverage initiatives, that will help provide residents with access to low-cost insurance.

ORHP is scheduled to review the grants in August 2000 and to award them in September. After the end of the 1-year grant period, the Office will prepare a report on the results for the HHS Secretary.

Dr. Brand has observed that most States are committed to State-level planning to achieve near-universal health insurance coverage or at least have expressed an interest. Some States are already determining their percentage of uninsured, whereas others are starting analysis and policy development. She also anticipates that the Secretary's report will be a "window" into States' needs and will suggest possible ways for "Federal policy and programs to support States' efforts in providing health insurance coverage."

Mississippi Delta Initiative: Delta Health Ventures

Dr. Brand has also been involved in the Mississippi Delta Program, a 3-year project that was funded in fiscal year 1999. This program serves as a crosscutting convener of health care stakeholders in 10 counties in the Mississippi Delta. These counties are burdened with excess morbidity and mortality, exceedingly high poverty and unemployment, and marked racial disparities in health.

Dr. Brand explained that the project created Delta Health Ventures (DHV) to help maximize the impact of efforts in the 10-county area by using HRSA resources to leverage additional public and private resources. In other words, DHV's mission is to encourage HRSA's community health centers, maternal and child health initiatives, and Area Health Education Centers (AHECs) in the targeted area to work collaboratively and to share resources so as to improve the outcome of all HRSA grants that affect that area. Dr. Brand added that if the Mississippi Delta initiative model is successful in the 10-county area in Mississippi, it will probably be replicated in other parts of the country.

In closing, Dr. Brand reported on a recent meeting she attended in the Mississippi Delta area that brought representatives from the human services, Head Start, and child and foster care fields together with local health care providers to discuss how to improve access to both human services and health services. The meeting participants agreed that "throwing more money at health care problems" is not the answer but that better collaboration among key stakeholders (in both public and private sectors) is the answer to improving health care services.

Legislative and Regulatory Update

Tom Morris, Policy Analyst, Office of Rural Health Policy

Mr. Morris provided an overview of Federal legislation and regulations regarding health policy. He began by reviewing the provisions of the Balanced Budget Act of 1997 (BBA) and its affects on the health services system. As a result of the Act's drastic cut in health care spending and in Medicare by $112 billion, Congress passed the BBRA of 1999 that reinstated $16.1 billion back into health care. The hospital industry reacted to this new legislation by demanding an additional $25 billion in relief this year and by lobbying to change the way it is paid for inpatient services. The proposed rule for inpatient care regarding Medicare is currently awaiting public comment, which is due by July 5, 2000.

As part of lobbying effort by the hospital industry, HCI Sachs just released a report maintaining that the Nation's smaller hospitals are still in the greatest financial jeopardy. The report estimates that in 2000-2001 hospitals with less than 100 beds will report total margins of less than 1 percent. It also says that hospital cuts are expected to level off in the final years of BBA.

Recent reports from the Congressional Budget Office and from the trustees of the Medicare Hospital Insurance Trust Fund project extended life of the trust fund, which alleviates some of the current pressure for immediate reform of the Medicare program. Mr. Morris is watching with interest how "the lobbying for more money plays out this year."

On the basis of an update of the inpatient hospital regulation, which came out in June 2000, rural hospitals will receive more Federal money than urban hospitals in 2001. Rural hospitals will receive an increase of 2.8 percent, whereas urban hospital funds will increase by 0.9 percent, sole community hospitals by 3.1 percent, and Medicare-dependent hospitals by 2 percent. These figures are part of President Clinton's Medicare Reform Plan that was released last year.

Comments on the Home Health Prospective Payment System were solicited this past winter, and Mr. Morris expects implementation by early October. Enforcement of this system will allow a move away from the interim payment system.

Mr. Morris indicated that the Medicare+Choice regulation should be out by the latter part of June 2000, but in his opinion, it doesn't contain any important rural issues. The Ambulance Fee Schedule regulation, which is of greater interest to NACRH, should also be in effect by the end of June. This regulation proposes, in an aggregate sense, a redistribution of dollars from urban to rural and from hospital to sole providers.

The BBRA of 1999 also contains some rural GnE provisions and a new provision, which should be out in June, that allows certain urban providers to qualify for rural payment under the Medicare program. ORHP will work closely with HCFA to design these provisions.

Another directive that will soon go public is the Physician Fee Schedule regulation, which will standardize practice expense payments for primary care givers and specialists. Congress and health care provider groups are still complaining about practice expense. This complaint stems from BBA's refinement of the way it pays for practice expense-by trying to pull money away from the specialists and directing it toward primary care. Specialist groups are currently lobbying Congress to put language into appropriation bills to stop the redirection of these funds.

Another issue that is still in debate is the implementation of new rules that would give more autonomy to nurse anesthetists. Not only are regular anesthetists fighting this proposal, but Congress is split on the issue.

On the legislative front, Senator Kent Conrad (D-ND) will introduce a bill that includes several rural "fixes" that did not get into the BBRA of 1999.

Senators James Jeffords (R-VT) and John D. Rockefeller IV (D-WV) have introduced a telemedicine bill (S. 2505) to address problems with telemedicine reimbursement and to expand reimbursement beyond rural HPSAs to all rural areas. It also requires HCFA to make telehome care a reimbursable service. Mr. Morris pointed out that the problem with this bill, as with every telemedicine bill, is that the score will likely come in so high that the bill will remain inactive. He believes that the telehealth industry is trying to work with the CBO to address questions about how some of those telemedicine bills have been scored in the past.

Senator Thomas Daschle (D-SD) is preparing legislation to revise an amendment in the BBRA of 1999 that he believes is in error. The intent of the amendment was to get away from the deductible and coinsurance payments that beneficiaries had to pay for lab services in CAHs. Unfortunately the wrong part of the Social Security Act was amended. As a result, beneficiaries now have to pay on a fee schedule rather than on a cost basis. HCFA agrees that this issue is a problem but believes its hands are tied because the legislation points directly to the fee schedule. As a result, some hospitals are hesitating with their conversion to CAH status because they don't know whether to collect the deductible and coinsurance now or wait until after conversion.

Following Mr. Morris's presentation, Dr. Wakefield provided a brief report on an upcoming MedPAC activity. Over the next 6 months, MedPAC will site visit a number of rural locations across the country to get a firsthand perspective on health care delivery in these areas. The site visits were requested in part by Congress and the BBRA of 1999 for the purpose of looking at a number of issues related to rural health care. The primary product of these visits will be a report on rural health issues presented to Congress next June. Dr. Wakefield believes that this report

will be critically important in influencing future House and Senate actions on rural health matters.

In a final comment, Dr. Wakefield asked that NACRH write a letter to the Comptroller General or to the Commissioner of MedPAC, or both, requesting that they work closely with ORHP and tap its expertise in developing the final report. Dr. Myers expressed enthusiasm about the request and then asked for questions and comments about MedPAC activities from the Committee.

Discussion

In the discussion that followed Dr. Wakefield's remarks on the MedPAC initiative, several comments by Committee members were made.

In response to a question about what areas in the country MedPAC staff plan to visit, Mr. Morris cited West Virginia, Texas, Mississippi, and Montana as possible sites. To help organize the site visits, the Commission plans to hire a contractor to work through State Rural Health Offices.

Dr. Singleton asked to make Dr. Wakefield's recommendation for the Advisory Committee to write a supportive letter to the MedPAC Commissioner a formal motion. The Committee passed the motion unanimously. In response to a question about the rural health report that will be submitted by MedPAC to Congress next June, Mr. Morris strongly reiterated the importance of such an all-inclusive report and the possibility that many of its recommendations may become part of upcoming legislative proposals. (Note: To receive a copy of the rural report, or copies of MedPAC's yearly reports, visit the Commission's web site at www.medpac.gov.)

Ms. Gonzales-Hanson was happy to hear that the reimbursement methodology for primary care providers versus other specialists was finally receiving some attention, because she believes it is an issue that must be addressed as the onset of managed care approaches. According to Ms. Gonzales-Hanson, if this issue is not properly dealt with, the newly introduced managed care system will not work well, and rural areas will not have access to adequate health care. She also expressed concern about the lack of focus on attracting health care professionals back to their rural communities to provide medical services to the residents.

Oklahoma Introductions

Shelly L. Crow, Policy Analyst, Muscogee (Creek) Nation

After Committee members briefly identified themselves, Ms. Crow welcomed NACRH and guests to the Muscogee (Creek) Nation's jurisdictional boundaries. She acknowledged the Committee's hard work in promoting rural access to health care but noted that NACRH must

continue to work closely with ORHP to maximize efforts to effect resources for rural health issues. She also mentioned a concern that the grant period does not allow enough time for local approval and asked Mr. Morris if upcoming grants could provide for more processing time after they are released by ORHP. Another concern brought up was the Muscogee Nation's difficulty in accessing Medicare. Tribal members either refuse to buy it or they don't think they need it because they are Native Americans.

Ms. Crow then introduced a number of notable guests in attendance who work closely with the Muscogee (Creek) Nation on Oklahoma rural health issues.

- A.D. Ellis-Mr. Ellis, Second Chief of the Creek Nation, spoke on behalf of Perry Beaver, Principal Chief of the Creek Nation, by first welcoming the members to his tribal boundaries and then expressing his appreciation for their continuous work in the health care area. Mr. Ellis reported that his people receive $850 per person per year in health care funding from IHS, whereas Native Americans living on reservations in the West receive $1,450 per person. He and Mr. Beaver were recently in Washington, D.C., to lobby for more funding from IHS, but the trip proved unsuccessful.
- Ms. Crow then gave a brief summary on the components of the Creek Nation's health care system. She reported that the one hospital and four clinics in the area respond to about 30,000 to 40,000 visits per year. The hospital's Board of Directors answers to the National Council and works closely with the Principal Chief in determining a workable budget. Of primary concern is the recruitment of competent medical professionals to work in this rural area and educating the Creeks so that they stay within the community's health care system.
- The Honorable Harley Little-Hon. Mr. Little is an elected official from the Muscogee District who contributes to increasing the tribal hospital's budget and improving the quality of its health care. He talked about clinic problems and current hospital service cutbacks. Because the Muscogee (Creek) Nation makes up 24 percent of Oklahoma's Native American population but receives only 4 percent of the State's budget, Hon. Mr. Little asked, on behalf of the National Council, for financial help from ORHP.
- Charles Coleman-Mr. Coleman is Chairman of the Health Board of the Muscogee Health System. He emphasized that cooperation, understanding, and collaboration are needed to produce a strong and effective rural health care system. He also mentioned that Public Law 437 is going back for the reauthorization of the Indian Health Service.
- Nancy Graham-Ms. Graham is a certified nurse who works with the Creek Nation. She also works at the Tulsa City County jail providing health care needs to inmates.
- Carolyn Torix-Ms. Torix is a procurement, property, and supply officer with the Muscogee (Creek) Nation's Division of Health Administration. She works closely with Ms. Crow and the Muscogee (Creek) health care system.
- Joanne Myers-Introduced by Dr. Myers, Ms. Myers, a public health anthropologist, has worked in rural health planning and program development.
- State Senator Angela Munson-Noting that this is an exciting but vulnerable time for health care, Senator Munson stressed the necessity of building a good health care infrastructure, "or the system will crumble." She also stressed the importance of continuing the provision of health care services across the United States, particularly in rural areas, and ensuring that these services are delivered in the most effective and efficient manner. She asked everyone to write or phone Congress requesting the reauthorization of the National Health Service Corps.

- Richard Perry-As Program Director of the Oklahoma AHEC, Mr. Perry reported on a recently won grant to provide the first Rural Parish Nursing Program in Harper County, Oklahoma. With this grant and with Marquette College providing a Preparation Nurse Institute in Oklahoma, a strong foundation for parish nursing is being built in the State. Mr. Perry passed out copies of the Oklahoma AHEC News to Committee members explaining that the paper, which circulates to 13,000 people in Oklahoma and across the country, looks at different health issues in Oklahoma. Each Committee member will also receive the next issue in about 3 months.

Shortly before the meeting closed, Mr. Little honored Chairwoman Kassebaum Baker, Dr. Brand, and Dr. Myers with awards of appreciation. Next Ms. Kassebaum Baker expressed disappointment at Faye Gary's absence due to personal reasons, remarking that this meeting marked the end of Dr. Gary's tenure on NACRH. Ms. Kassebaum Baker encouraged the participants to think about locations for the next NACRH site visit scheduled September 10-13, 2000.

Monday, June 5

Chairwoman Kassebaum Baker opened the meeting by briefly outlining the day's agenda. She then turned the floor over to Mr. Morris.

Update of the Year 2000 Topic: Medicare Reform

Tom Morris, Policy Analyst, Office of Rural Health Policy

Mr. Morris gave a brief update on the current status of the Medicare program, specifically by referring to the two Medicare redesign proposals now before Congress. He explained that the Rural Policy Research Institute (RUPRI) has been contracted by ORHP to prepare two background papers. The first of these papers, and the focus of this meeting, provides a critique of the two proposals to redesign the Medicare program. The second report, which will be discussed at the September meeting, will present a global overview of the key rural issues that would be inherent in any restructuring of the Medicare program.

In RUPRI's first report A Rural Assessment of Leading Proposals to Redesign the Medicare Program, a copy of which was distributed to each Committee member, the leading Senate proposal (Breaux-Frist 2000) is compared with President Clinton's Medicare reform proposal released earlier this year. The driving force behind both these proposals is the call for adding a prescription drug benefit to the Medicare program. Senator John Breaux (D-LA) recently signaled his intent to modify his proposal in an effort to get some type of legislation passed this year.

Dr. Myers continued the discussion with several comments. He asked the Committee to generate recommendations that "go beyond one proposal over the other" and focus on the important basic considerations from "the rural perspective." He noted that for the last 45 years the fraction of our economy that goes into health care has been increasing inexorably, by about 3 percent in 1950 to about 14 percent today. The growth is driven not by the increase in the aging population, but by the increase in the desire for more technically advanced health care. It is predicted that this increase is not going to stop, which leads to the question: Will our economic system have enough resources to be able to afford the more elaborate health care that continues to be projected?

Medicare Reform in a Rural Context: Comparison of the Breaux-Frist Proposal and the President's Proposal on Reforming Medicare

Keith Mueller, Ph.D., Professor and Director of the Nebraska Center for Rural Health Research, University of Nebraska

Dr. Mueller began his discussion on the RUPRI Rural Health Panel's first report on the two proposals to redesign the Medicare program by presenting a brief overview of the Panel's history. Formed in 1993, the Rural Health Panel has been investigating Medicare policy since 1995. At this time, the members began introducing more drastic changes to the Medicare program as part of the BBRA legislation. By 1997 they were using funds from ORHP and the Agency for Health Care Policy and Research to examine the Medicare+Choice program, which was a part of BBA.

The Rural Health Panel is currently involved in a 3-year research project that is looking at the response, or lack of response, to the lack of Medicare+Choice plans in rural areas. As part of this project, the Panel is tasked with producing three reports. The first report, and the subject of Dr. Mueller's discussion, is a policy paper that provides a rural perspective on two proposals on reforming the Medicare program: the HCFA-sponsored Medicare plan (S. 1895 [Breaux-Frist 2000]) and the President's proposal (the "Medicare Preservation and Improvement Act of 1999").

The second report consists of two papers that focus on the issue of the wage index used to create a geographic adjustment in payment streams regarding inpatient hospitals. The first of these two papers, which will be released soon, is a short policy brief that lays out the elements of the wage index and how these elements vary between urban and rural locations. The final report, which will be presented at the September ORHP meeting, looks at global issues involving Medicare reform.

Dr. Mueller then proceeded with an overview of the two current proposals for Medicare redesign. For this assessment the Panel first examined the implications that these proposals would have on health care for rural citizens in terms of the affordability of extra benefits, the complexity of payment issues, and the effects on the infrastructure.

The introduction to the report reminds readers that there are important differences between urban and rural health care environments and that rural Medicare beneficiaries face different circumstances than their urban counterparts. Some of these differences include the following:

- Geographically large service areas with fewer persons residing in those areas;
- Lower volume of patient business for institutional providers, such as hospitals;
- Absence of competing providers in most communities; and
- Lower revenue to expenditure margins and therefore a greater likelihood that the local provider is in a financially precarious situation.

The Panel characterized the rural environment by the following determinations:

- Few Medicare+Choice plans, even after the BBA 1997 tried to make them more widely available;
- Difficulty accessing some plans that are "available" because of underwriting practices;
- Difficulty accessing services due to distance and difficulty traveling great distances due to a lack of personal and public transportation;
- Generally lower incomes among the rural Medicare population, which means less ability to purchase supplemental plans or to buy specific services if one is not in a supplemental plan; and
- Fewer competing supplemental Medicare plans, including limited availability of supplements with prescription drug benefits.

Upon investigation, the Panel found that Medicare supplemental plans are licensed State by State and that they are licensed for the entire State. These available plans offer plans H, I, and J as well as prescription medication plans. Panel members also found that although these plans are available statewide, few people actually buy them.

Next, Dr. Mueller highlighted the similarities and differences of the two proposals and how these factors would affect Medicare beneficiaries in rural areas. Both proposals rely on the use of the competitive model to achieve their objectives. Many of these objectives are related to introducing new initiatives into the delivery of health care services and taking advantage of funds generated by the efficiencies to expand the benefits and to produce innovations in benefit packages. Because of this reliance on the competitive model, the applicability of this type of model in rural environments should be closely examined.

S. 1895 relies on a marketplace, with few regulatory directives, to provide expanded Medicare benefits at an affordable cost. "Two types of health plans would be marketed: a low-option plan

that includes only those benefits that are part of traditional Medicare and a high-option plan that adds benefits and includes prescription drug benefits. A HCFA-administered plan would replace the currently traditional Medicare plan and would compete with other plans for enrollment. Except for requiring that they offer core benefits and a minimum actuarial value for prescription drugs, plans are free to vary the amount of both benefits and premiums. Plans that charge more than the weighted national average premium would, in essence, charge beneficiaries the difference, while those below the average would contribute to savings for beneficiaries and the Medicare program."

The President's proposal is also market-based, but it is more directive or prescriptive and would not treat the traditional Medicare program as a HCFA-sponsored competing plan. All current payment streams would stay in tact; however, HCFA would be allowed to use some of the same purchasing strategies, particularly those strategies related to preferred provider organizations in the Centers of Excellence, with some selected contracting currently used by many of the private-sector health plans. These strategies are not used now in the traditional Medicare plan. Plans would compete based on price, presumably attracting more enrollees as the Part B premium, which is retained in the President's plan, comes down.

The approach of S. 1895 to funding prescription drug benefits is different from the approach of the President's proposal. S. 1895 requires that all competing plans include prescription drug benefits in their high-option offering and allows the market to determine the cost to the Medicare beneficiaries above the set Government contribution. The President's proposal requires that all beneficiaries have the same prescription drug benefit, the new Medicare Part D, which will be available as a separate benefit to all Medicare beneficiaries. Funding is expected from a Government source. The President's proposal will also extend some of the BBA provisions that are not necessarily favored by a number of providers.

The President's proposal is less aligned with the philosophy and logic of the competitive model than is S. 1895. Furthermore, it does not want to rely on the competitive model to finance the major new benefit of the expansion of prescription drugs. According to the proposal, the new prescription drug benefit will be contracted out through private-sector entities, for example, pharmacy benefit managers, retail drug chains, health plans or insurers, States (Medicaid), or multiple entities in collaboration.

Dr. Mueller then turned to the rural implications of the two proposals, which he summarized as follows:

- To the extent that competing plans are relied upon as the source of affordable benefits, rural areas are at a disadvantage. This implication reflects the empirical reality that there

are no competing plans in rural areas nor is the likelihood of that going to happening any time soon, if at all.

- The adjustments derived from national and area averages for rural payment could be improved through refined definitions of service areas and minimum payments in each area that account for costs associated with prescription drug benefits and plan administration. Both proposals attempt to correct for the deficiencies of the competitive model in rural areas. S. 1895 uses refined geographic adjusters, and the President's proposal adds a guarantee of the BBA minimum payments to geographic adjusters.
- If traditional Medicare is the only option in rural areas, fiscal difficulties encountered by that plan (perhaps through adverse selection) would pose special problems for rural residents. It will be difficult to sustain a restructured Medicare plan with the payment provided through a national weighted average premium, especially if the plan faces adverse selection.
- The provisions of the BBRA of 1999 allowing for additional payments for Medicare+Choice plans entering new markets should be continued, and perhaps increased above the 5 percent available the first year and the 3 percent available the second year. Neither proposal includes any adjustment for pent-up demand, which has been experienced by at least some rural Medicare+Choice plans.
- Proposals relying on cost savings from managed care to provide affordable benefits should include provisions to encourage locally based plans in rural areas. Some experiences in rural America indicate that in rural areas locally based plans have a greater chance of lasting success.

Dr. Mueller then presented a rundown of beneficiary choices for rural residents.

- All rural beneficiaries will have access to a plan that includes coverage for prescription drugs, a significant improvement for rural persons. Rural beneficiaries currently do not receive this type of access.
- There is no assurance that the difference in the current plan offerings between urban and rural Medicare HMOs would not continue under these reform proposals. Rural beneficiaries may continue to experience a different, less attractive set of choices.
- The value of supplemental benefits for rural beneficiaries is related to the specifics of cost-sharing provisions. It is likely that adverse selection problems and other difficulties will occur, driving up beneficiary cost premiums, which would affect beneficiaries' choices. Rural beneficiaries will logically choose less expensive plans, which usually means that these chosen plans are less attractive than the urban plans.
- These proposals should address differences between rural and urban audiences in their educational efforts, and among rural residents with different cultural experiences. Not much exists in the Medicare Beneficiary Educational Package that focuses on different strategies needed to address rural beneficiary issues as opposed to urban beneficiary issues. Information on Medicare beneficiary options in the redesigned program must be distributed more effectively to different cultures.
- Establishing maximum beneficiary premiums as a function of household income, either by limiting cost-sharing or by subsidizing the beneficiary's premium, is critically important in rural areas, and is addressed specifically in S. 1895. Limiting premium cost sharing is important to rural beneficiaries, given their comparatively lower incomes. These redesigned proposals must make sure that rural beneficiaries have realistic access financially no matter what their level of poverty is.
- The ultimate impact on local rural pharmacists of the purchasing strategies used for the new prescription drug benefit cannot be determined, but it should be monitored. Creating

a prescription drug benefit that favors mail order in the use of a large centralized pharmaceutical offering could jeopardize the future of local rural pharmacies.

- The implications of allowing only one opportunity to enroll in Part D may disadvantage rural beneficiaries who have only one option when they initially enroll in Medicare, but who have more attractive opportunities later due to an increased number of options where they live. The President's proposal currently allows only one chance to enroll in the new Medicare Part D program, a provision that Dr. Mueller believes will not be in the final proposal.

Dr. Mueller then explained some of the effects of Medicare payment on rural providers. Those mentioned are as follows:

- Rural health physician or physician-hospital networks that demonstrate similar performance should be eligible for bonus payments. Under the President's proposal large physician groups who reduce excessive use and demonstrate positive medical outcomes could receive bonus payment. According to Dr. Mueller this provision could discriminate against small physician groups in rural areas.
- In the President's proposal, extensions of cost-saving provisions in the BBA, while less onerous than those in effect in 2000, perpetuate the problem of imposing several reductions on the same providers in rural communities. The February 2000 NACRH meeting addressed the problem of focusing on payment streams that all come from the same providers.
- Selective contracting could have serious implications for rural providers, especially essential providers. Dr. Mueller expressed concern that selective contracting could possibly "select out" rural providers.
- The HCFA-sponsored Medicare plan (S. 1895) could be required to continue special payment considerations for specified rural providers, but with a special subsidy so as not to affect the competitive position of that plan. Under current Medicare payment policies, certain providers are provided cost-based reimbursement to ensure access. In S. 1895 it is uncertain that those special considerations would continue.

In closing, Dr. Mueller recapped his discussion by presenting four basic summary questions that warrant attention during future discussions of Medicare redesign.

- What does it mean to rely on a competitive market model as a means of enriching the benefit package at an affordable price for the rural beneficiaries? Fundamental questions remain about whether competing plans will be offered in the two proposals and if they are not offered, whether the level of subsidy for the premiums (S. 1895) will increase.
- What is the basic plan when the competitive model cannot be implemented? What is the default plan? An environment should be created in which health plans could compete with one another. This competition would help drive prices down, sustain or possibly enhance the quality of care, and make health care widely available, especially with the use of aggressive marketing strategies.
- What should be done to change the payment streams to health care providers in rural areas? The issue of the low-volume provider and how payment streams might change must be addressed even if a beneficiary selects the President's proposal or elects to remain with the current Medicare program and adds Part D for prescription drug benefits.

- How does one make a Medicare package for the 21st Century that is affordable to all Medicare beneficiaries? The adequacy of the current Medicare program is still debated. The program covers about 50 percent of the actual expenditures for health care on the part of the beneficiary. That percentage varies and is likely to be lower in rural areas. RUPRI Rural Health Panel members suggest careful examination at modernizing the benefit package of the Medicare program in a way that is affordable for beneficiaries in both rural and urban America.

Discussion

In the discussion that followed Dr. Mueller's presentation, a number of concerns were raised about the effectiveness of the competitive model, especially its use in rural areas, as well as about other issues related to Medicare and rural health.

- Dr. Eckstat expressed concern that the use of the competitive model is not the answer to the current health care dilemma and that perhaps looking at some other model or some other way of funding health care would provide a more realistic approach to providing health care. He added that in pursuing the competitive model, one risks further loss of providers and hospital services.

In response, Dr. Mueller noted that it is not just the competitive model that engages in some kind of price-setting behavior, but that the Medicare program also engages in the same practice in trying to find savings to finance new benefits and to get out of deficit spending. Senator Breaux and others reasoned that if you allow the price to be determined by some kind of market behavior on the part of the health plans and health care providers, then an optimum price will be reached. But Dr. Mueller believes that this type of price setting could lead to monopoly setting by purchasers.

- Dr. Wakefield also responded to Dr. Eckstat's comment by referring to a March 2000 MedPAC report that determined that BBA had an adverse impact on access to health care. Furthermore, a survey conducted in response to the concern that fewer physicians were participating in the Medicare program concluded that this, in fact, was not true. If Medicare participation by physicians were to decline, then access would be directly affected.
- Dr. Martin also questioned the effectiveness of the competitive model, especially in rural settings, and the possibility of eliminating the model altogether. He strongly suggested focusing on other approaches to avoid "losing any more physicians or pharmacists in rural America." In response to Dr. Martin's comment, Dr. Mueller reiterated his belief that there are certain rural areas where the competitive model does work effectively, usually in rural counties adjacent to metropolitan counties.
- One participant stated that it is the responsibility of the Government to provide quality health benefits to all people, including those living in rural communities. He suggested that the competitive model should include certain parameters ensuring that access to these benefits is available for all rural residents. He also noted that the responsibility for providing access lies with the competitors.
- Dr. Singleton brought up two issues not addressed in the evaluation of the Medicare system, that is, the issue of fraud and abuse in the system and the issue of double

payment that is available to some recipients. As explained, double payment is when beneficiaries are covered under Medicare as well as under another provider, such as Veterans Administration Services. Dr. Singleton asked whether revenues collected from these two areas could help fund some of the services and benefits that are being addressed by the two proposals.

Dr. Mueller responded to this inquiry by stating that a fairly substantial percentage of the Medicare expenditure reduction of the last 3 years is due not to BBA cuts but to aggressive policing of fraud and abuse. Also, changed provider behavior during this time has resulted in revenue savings. The Clinton approach will use these savings, in part, to help fund Medicare Part D (unlike the S. 1895 approach). Furthermore, extra dollars could be available from the combination of Medicare and the paid spending that currently occurs on behalf of those beneficiaries who have signed into the dual eligible programs, a number that is fewer that the percentage of people who are eligible for these programs.

- Dr. Coleman thanked Dr. Mueller for his succinct presentation and asked that the Committee carefully review Dr. Mueller's four basic summary questions before adopting the approaches of the two proposals to redesign the Medicare program. He also asked the Committee to examine new approaches to the ones offered by the current plans. Another concern brought up was the added costs that will be incurred from providing drug benefits for the Medicare population and whether this addition will require new money. If it does, Dr. Coleman suggested that NACRH determine what programs need to be implemented to obtain that money.

Dr. Coleman also suggested several other topics on which the Committee could focus, including base level of reimbursement for rural areas, capitation, and the proper use of coding. Each rural community should determine what base level of reimbursement is required to keep its providers, who are imperative for an effective health care system. The use of a capitation system is one means to set up a bottom baseline cost of reimbursement in these rural communities. In his closing comment, Dr. Coleman asked that HCFA or Medicare establish national guidelines indicating the proper use of coding for documentation of specific medical charges. The current use of up coding and down coding is resulting in numerous physician errors during the documentation process.

- Ms. Hughes inquired whether anyone from the rural networks was consulted when the White House and the Breaux-Frist staffs began conducting research on their respective proposals. In response to this question, Dr. Mueller noted that he provided brief testimony before the Bipartisan Commission on the Future of Medicare on rural health concerns but that little was asked of rural health research centers, RUPRI, or other related organizations in terms of providing information to Breaux-Frist staff members on Medicare reform from a rural perspective. Mr. Morris said that ORPH was not consulted or asked any questions concerning the President's plan.

Ms. Hughes asked how the Committee could ensure that rural issues are not overlooked in future policy development at the executive or legislative level. She suggested inviting representatives from the White House Health Policy Office or from the Senate to attend a future NACRH meeting to discuss Dr. Mueller's four basic summary points presented earlier. Chairwoman Kassebaum Baker offered that a letter should be sent to Secretary Shalala, as well as to others who are involved in policy-making decisions in the House and Senate, outlining specific NACRH recommendations regarding Dr. Mueller's summary points.

Dr. Atkinson agreed with Dr. Singleton's concern involving the overlap of Medicare and VA hospital payments and the erroneous way that Medicare calculates its per member per month payments. He also agreed with a previous point that capitation is a more sensible strategy of fostering cooperative development of a vertically integrated health care system in rural areas than is competition.

In closing, Dr. Atkinson asked Dr. Mueller what the risk or geographic adjusters might be because they were not well specified in the Medicare proposals. These adjusters, in Dr. Graham's opinion, will be important factors in determining whether rural providers succeed or fail. Dr. Mueller commented that details on risk and geographic adjusters are not yet known, although upon his examination of S. 1895, it appeared that different geographic adjusters would be used from the ones used now. It is also likely that the President's proposal would use the risk adjusters that are currently in final rule making at HCFA, which are those based on inpatient hospitalization.

- Mr. Fitzsimmons provided the Committee with a brief description on what has been accomplished in Texas on the behalf of rural pharmacists. Through regulatory and legislative means, rural pharmacists have been able to extend health care in new and different ways. About 30 counties in Texas depend on the local pharmacist for their health care needs. In many of these rural settings, the pharmacist participates in collaborative practice arrangements with physicians and other providers, which allows the pharmacist to serve in a variety of needed capacities. In some communities where the pharmacist is not the sole health care provider, he or she serves as a consultant at the local hospital as well as keeping the hospital pharmacy open.
- Dr. Wakefied agreed with some Committee members that office-based visits are not always necessary or appropriate but offered the comment that "the way we interact with patients and the relationship that is developed with Medicare beneficiaries and others could very well be 'operationalized' in a markedly different way than it is currently, and the reimbursement streams need to reinforce that variation. This topic will be addressed in the report Redesigning the Health Care Delivery System for the 21st Century, scheduled for release sometime between August and October of this year.
- According to Ms. Gonzales-Hanson, capitation rates and managed care will not work with minorities, especially with those who live in rural areas that have no local county health care. Many of these people wait until they are over 65 years of age and require emergency attention to receive health care services. She explained that her clinic, through an assortment of programs (e.g., disease management), is trying to encourage

patients to take more responsibility for their health care. Unfortunately, these prevention programs, which are held in community health centers, and the services they offer are not reimbursed very well, if at all. This is a problem that needs to be addressed.

Ms. Gonzalas-Hanson agreed with Dr. Singleton that training sessions, coding networks, and purchasing requests need to be shared by both the private and public sector to reduce costs and increase efficiency. She suggested that incentives be built into the Medicare program that promote these kinds of networking strategies.

Work Plan for the Medicare Reform Project

Keith Mueller, Ph.D., and Wayne Myers, M.D.

Dr. Myers reminded Committee members that the main purpose of their attendance at this meeting is to establish recommendations on how to better formulate the redesign of Medicare, especially regarding its application in rural areas. He suggested several key points cited earlier that the group could consider for this discussion:

- The competitive model is fundamentally flawed for application in many rural areas.
- There has been a massive shift of resources from health care to management costs without much moderation of the overall costs that are being borne by those who pay.
- The continued use of historic pay levels for rural areas is conceptually flawed.

To help set the direction for this discussion, Dr. Mueller offered seven categories or topics that RUPRI panel members are addressing in their follow-up report on Medicare reform due out this August. These topics are equity, quality, access, choice, cost, benefits, and governance. Dr. Mueller then summarized four issues he believed were of major concern to NACRH members on the basis of earlier discussions:

- The competitive model is not the best source of enhancing benefits in rural areas.
- The inclusion of rural beneficiaries in any kind of redesign program will require special efforts targeted at those beneficiaries.
- The current special payment approaches need to be retained and improved.
- Reasonable and enforced access standards that apply to both distance and culture are needed.

After a lengthy discussion on the four RUPRI considerations, NACRH members developed a number of their own targeted recommendations and comments pertaining to the two Medicare proposals. These comments will be sent by letter to Secretary Shalala in early September. Each member will be given an opportunity to review and sign off on each issue before the letter is sent.

The first concept agreed upon by the group was that the competitive model will not support increased benefits in many rural areas, so therefore it will not be applicable to those areas. The fee-for-service model will more than likely continue to be the "backbone" for health care in rural settings, but it needs restructuring so that it works more effectively. All models should be pilot tested in rural communities before refinement. Furthermore, the potential for capitated care as opposed to incident-by-incident payment needs to be explored.

The second concept noted that rural beneficiaries will require special efforts. For example, people from geographically and culturally diverse settings should be represented in the design, planning, and operation of health care models.

Third, the special needs and circumstances of the central providers (e.g., CAHs, sole community hospitals, and rural referral centers) need to be recognized. Special recognition should be given to low-volume providers and to providers with a high number of indigent patients. A final recommendation noted was the need for reasonable access standards in terms of distance, culture, and provider ratios.

Additional issues mentioned for possible inclusion in the Secretary's letter included (1) conducting additional studies of successful health care models that are effective in rural areas, (2) considering the special circumstances of the pharmacy community, (3) refining the features of geographic and risk adjusters, (4) examining the affordability of the Medicare plans, and (5) providing some type of oversight for pharmaceutical abuse.

Next Chairwoman Kassebaum Baker brought up the old issue of the ambulance fee schedule and said that Dr. Atkinson has been charged with working with NACRH members to draw up a letter on this issue for public comment. Another old issue that was raised was finding an appropriate central location to house the Emergency Medical Services (EMS). Currently, EMS is spread out among several different agencies, for example, the Department of Transportation, HRSA, and the National Highway Traffic Safety Administration. It was recommended that a letter be drafted in time for the September meeting that suggests a good centralized home for EMS. Dr. Myers suggested that this letter be sent to Secretary Shalala before Federal agencies determine their 2002 budgets sometime in late July 2000.

Committee Subtopic Reports

NACRH Members

Several Committee members reported on predetermined topic areas. Ms. Hughes began by reporting that the Centers for Disease Control and Prevention is developing performance

standards for essential public health services. This review focuses specifically on the prevention of bioterrorism at the local and county levels. Dr. Singleton noted that Secretary Shalala has allocated $270 million for bioterrorism research, and he asked if assurances could be given to direct some of that money toward rural settings. He believes that rural communities are far more vulnerable to this kind of attack than are urban areas.

Ms. Hughes offered that the Secretary has requested that a large portion of the bioterrorism money be allocated to setting up emergency one-way satellite transmission between public health offices nationwide. One use of this type of transmission will include bioterrorism prevention training.

For her topic of discussion on the uninsured population, Dr. Wakefield presented information and statistics on the uninsured problem in the United States from data compiled by The Urban Institute.

- The uninsured numbered about 44 million, or about 16 percent of the U.S. population, in 1998. Of this number, 11 million were children.
- Some of the highest uninsured rates are among low-income adults, particularly the Hispanic and African American population. About 47 percent of males aged 18 to 34 are uninsured, whereas 38 percent of females in the same age bracket are uninsured. Adults aged 55 to 65 make up only a small segment of the uninsured. This segment of the population receives more attention because of the increased incidence of health problems with older individuals.
- The vast majority of the uninsured are also unemployed.
- Rural residents are less likely to have health insurance coverage. About 14.3 percent of the urban population are without coverage compared with 19.6 percent of the rural population.
- Employee-sponsored coverage is lower in rural areas than in urban areas.
- The proportion of States with populations that are uninsured is wide ranging. Texas has the highest rate, with 24.9 percent uninsured, whereas Minnesota has the lowest rate, with 7.8 percent uninsured.
- Differences in access to services exist between urban and rural populations, but the percentages are not as far apart as the rates of the uninsured.
- The number of people who received their care at community health centers increased 10 percent from 1996 to 1998. A share of community health center patients without health insurance is now reaching 40 percent.

Dr. Wakefield reported that about 74 percent of those adults surveyed by Kaiser claimed that they were uninsured because of the high cost of health insurance. In her closing comments, Dr. Wakefield mentioned that several Federal proposals are now on the table to expand health coverage. These proposals offer such solutions as implementing tax credits and supporting association health plans to decrease the cost of health insurance for small employees, as well as pooling purchasing plans of small employees.

Next, Mr. Ahrens provided a brief report on national veterans' issues and some of the problems that veterans are facing with an inadequate health care system. Service benefits for veterans are often complex and hard to understand, and the Department of Veterans Affairs is now reluctant to pay for transportation to tertiary care sites. As the veteran population grows, service vehicles in a number of States are having difficulties accommodating this increase.

Dr. Doty's assignment was to look at mental health issues as they relate to rural areas. Her observations included the following:

- There is a parity of resources that are disproportionate in urban and rural areas.
- Mental health is not perceived as basic health care, therefore mental health care is limited in most areas.
- There is a higher impact in rural funding than in urban funding because of the disproportionate distribution of providers and the multiplicity of providers that may not be skilled in certain health care areas.
- Databases contain little information about the distribution of basic behavioral health in the U.S. work force.
- The basic family mental health care provider does not exist. Delivery sources for mental health are not necessarily maintained, funded, or promoted.

According to Dr. Doty, one possible solution to these problems is the insistence, especially on the Federal level, of more dialogue on how to improve the quality of mental health services in the rural areas. Furthermore, rather than rejecting all current models for providing basic mental health services, redefine the current services, build incentives into new models, and develop some pilot models. In closing, Dr. Doty asked that NACRH continue to focus on mental health issues at future meetings.

As a final note to Tuesday's session, Chairwoman Kassebaum Baker announced that Hazard, Kentucky, is the site for the September 10-13 NACRH meeting.

Tuesday, June 6

Former Senator Nancy Kassebaum Baker convened the meeting of the National Advisory Committee at the Choctaw Nation's new health care center, located in Talihina, Oklahoma. She expressed her appreciation for the kind hospitality of the Choctaw Nation and to Ms. Crow for arranging the site visit. Ms. Kassebaum then introduced Gregory E. Pyle, Chief of the Choctaw Nation since 1997 and head of the National Health Board, whose primary interest is the delivery of health care to the people of his tribe.

Presentation on Health Disparities

Gregory E. Pyle, Chief of the Choctaw Nation

Mr. Pyle welcomed the National Advisory Committee on Rural Health (NACRH) to the Choctaw Nation and then gave a brief history of his people as well as a geographic description and interesting facts about the State of Oklahoma. He explained that his State has made considerable progress in modernizing its transportation system by building approximately 70 miles of new roads this past year and by constructing a number of new bridges. The Choctaw Nation receives a large portion of its revenue from transporting players from bordering States to the tribe's gaming tables. Mr. Pyle introduced Gary Batton, Executive Director of Health Services at the Choctaw Nation Health Care Center, who presented a video on health care needs of Native Americans residing within the boundaries of the Choctaw Nation.

As the video explained the Choctaw Nation is responsible for the health care needs of Native Americans residing within its boundaries. Hospital services are provided through the Choctaw Nation Health Care Center in Talihina and through the ambulatory clinics in the towns of Broken Bow, McAlester, Hugo, and Poteau.

The Choctaw Nation encompasses 10,985 square miles in the southeastern corner of Oklahoma. With a tribal enrollment of 120,000, the tribe's health care system is increasing at an alarming rate. During fiscal year 1998 through 1999, hospital admissions for children and adults increased 15.4 percent, newborn admissions increased 21.4 percent, and emergency room visits increased 48.9 percent. Even though the Choctaw community is increasing in size, it receives only minimal increases in IHS funds.

The video pointed out that the State of Oklahoma records the highest number of Native Americans of any State in the United States, yet it has the lowest level of IHS funding per capita. Oklahoma has about 22 percent of the entire Native American population but receives only 2 percent of the appropriated funding. To illustrate the disparity of funding by service area, the video explained that Native Americans living in Oklahoma receive $856 in funding per capita in comparison with Native Alaskans who receive $2,760 per capita. The Choctaw Nation has been unable to fulfill many of its unmet needs.

In response to this problem, IHS sanctioned a Federal tribal workshop in an attempt to assess the disparity of the funding issue. The effort produced the Level of Need Funded Report, now in the hands of the IHS Director, which offered a number of recommendations to help provide equity in funding. The Choctaw Nation asks that a new funding formula, such as the one provided in this report, be used for all new appropriated dollars. It also asks that the Oklahoma congressional delegation and IHS work together to bring the level of health care of Native Americans up to the standard received by the average American citizen.

Mr. Batton explained that the community as a whole uses the Choctaw Nation Health Care Center and that he wants to work closely with State officials, veterans, and the Federal Government to facilitate more health care to the entire State. After a brief introduction of hospital staff, Mr. Batton provided a description of the health facility. It is approximately 145,000 square feet in size, with 37 hospital beds for inpatient care and 52 examination rooms, and serves a town of 1,400 people. The $22-million hospital, complete with state-of-the-art equipment and furnishings that cost $6 million, is the center of the area's health care services, which cover 10.5 counties in southeastern Oklahoma. Four outpatient clinics and a diabetes treatment center are an integral part of this system.

In closing, Mr. Batton said that although many NACRH members believe that the Choctaw Nation receives sufficient annual funding from the Federal Government, Medicaid, and Medicare, in reality, the tribe is underfunded. He strongly noted that his people must have better access to available grants and that they need to better understand the political process so they can change the funding system.

Rural Health Care Delivery System

Val Schott, M.P.H., Director of the Oklahoma Office of Rural Health and President-Elect of the National Rural Health Association

Mr. Schott provided NACRH members with a summary of health care needs facing the rural population in Oklahoma and the planning process involved in producing a viable health care system in rural communities. On the basis of his experience in identifying the importance of health care in rural economies, Mr. Schott has found that the great distances between health care facilities and the bad condition of connecting roads have impaired access to critical medical care in Oklahoma's underserved areas.

Mr. Schott's main topic of discussion focused on the Medicare Rural Hospital Flexibility Program, also referred to as the Critical Access Hospital Program. This program, one of the most significant pieces of legislation requested by the World Health Organization, establishes CAHs, a new category of limited service hospitals that are eligible to receive reimbursement for Medicare patients on a reasonable cost basis rather than on a prospective payment system basis.

The Flex Program attempts to reinstate the financial stability of small rural hospitals. Mr. Schott explained that to be eligible, not-for-profit or public hospitals must be a certain mileage distance from other hospitals, bed capacity must not exceed 15 beds plus 10 swing beds, and emergency services must be provided on a round-the-clock basis. In addition, the hospitals

must form networking arrangements for referring patients for which the hospital does not offer services. Mr. Schott offered that this is not just a reimbursement program, but that it also allows prospective reimbursement for Medicare patients. He emphasized that for this program to work efficiently, an effective rural health delivery system that provides a broad range of services to rural residents must first be in place. To facilitate this need, Mr. Schott, with help from Oklahoma State University, the Public Extension Service, and several bordering States, has developed an experienced team of rural health officials to go into underserved areas, by invitation only, to set up health care infrastructures that best satisfy community needs.

Mr. Schott explained that his team supplies only the data and process for setting up a health care system and allows the communities themselves to decide what type of system will best serve their residents. Most of the major decision making issues reside at the community level. He also pointed out that it is crucial to first determine the economic potential of health care in the targeted community. After a brief panel discussion, Mr. Schott introduced Dr. Gerald Doeksen, who talked about the economic impact of the health care system on several Oklahoma counties.

Economic Impact of the Health Care System

Gerald Doeksen, Ph.D., Regents Professor and Extension Economist, Department of Agricultural Economics, Oklahoma State University

Dr. Doeksen provided NACRH members with a slide presentation that demonstrated the importance of the health care sector to the local rural economy and discussed how these rural areas can improve their primary health care. For every county in Oklahoma, Dr. Doeksen and his team of researchers have developed a model that measures and analyzes the total impact of the health care sector on the economy of local rural areas. The statistics developed for this model come from information gathered from community residents on the number of jobs and payroll associated with all health care sectors (e.g., hospitals, physicians, and pharmacies) in a particular rural area and how much of the money generated by these sectors is spent locally.

Through a grant from the Federal Office of Rural Health Policy, Dr. Doeksen is teaching other states to use this model to determine how important health care facilities are on the economic well-being of rural communities. According to his figures, "the health care sector as a group is often the largest employer in rural counties, accounting for up to 20 percent of the local salary base. Hospitals are often the second largest employers in these areas." The model indicates that if small communities want to attract retirees, new business, industry, or other economic opportunities to their area, they must first provide good educational opportunities, an efficient health care delivery system, and a safe environment.

Following Dr. Doeksen's presentation, Mr. Schott outlined the strategic health planning process used to help rural communities adopt a health care system that is best suited to their needs and to their economy.

After Mr. Schott and his resource team are invited to assist a rural community with their health care needs, a local community facilitator who is generally connected with the local hospital and a steering committee made up of a cross section of community leaders are selected. The steering committee, which consists of about 30 to 40 people, is broken down into four task forces (publicity, inventory, survey, and data and information), each with different duties and each producing a different product.

The task forces inform the community about what is being done to improve health care, conduct inventory of all the health and human services that are available in the area, and establish techniques to keep the community involved in the evolving nature of the health care delivery system. For example, one task force conducts telephone surveys by asking rural residents such questions as where they go for their primary care and if they use local doctors or hospitals. The results from past surveys found that people do not use local hospitals because (1) they are not sure of the services available, (2) they believe the quality of health at these facilities are poor, and (3) they want to visit a metropolitan area.

After the task forces have tabulated and reviewed their findings, they work together to define the local problems and devise a plan, which is usually different in all rural areas, to solve those problems. The steering committee then reviews and revises the plan, implements it, and conducts follow-up work. For all targeted communities, the resource team inventories all available health and human services in the area as well as conducts telephone surveys. The results, in the form of products, are then given to the designated task forces to determine what type of health care infrastructure needs to be developed or what health care services need to be purchased (i.e., emergency medical services, primary care services, adult day care, assisted living, or outpatient care).

It is the responsibility of the resource team to estimate the capital and operating costs, as well as associated labor costs, for these new or improved health care services proposed by the service area. It then analyzes the data and determines if the targeted community can afford these services. The team believes that the adoption of a health care system should not put any community further into the red.

Critical Access Hospital Model

Paul D. Moore, CEO, Atoka County Healthcare Authority

Following a tour of the Choctaw National Health Care Center, Paul Moore gave his perspective on the Critical Access Hospital Program and the possible effect this program may have on rural health care facilities in Oklahoma. Mr. Moore began his discussion with a brief history of the BBA of 1997 and its effect on rural hospitals.

The Critical Access Hospital Program, which was an attempt to reinstate the financial stability of small rural hospitals, was an "outshoot" of BBA. For a hospital to be eligible for the program, certain rules and regulations had to be met:

- The rural hospital must be a participant in the Medicare program.
- It must be an acute care facility with 24-hour emergency service.
- The length of stay cannot exceed an average of 96 hours.
- The facility cannot have more than 15 acute care beds or 25 total beds.
- Hospital accessibility must not exceed at least 35 miles by primary roads or at least 15 miles by secondary roads.
- The facility must be deemed as a "necessary provider" by the State.

Oklahoma currently has 70 potential hospitals that meet these criteria. Ten hospitals have already converted to the CAH Program and four are on the verge of converting.
Mr. Moore enumerated both the positive and negative factors of CAHs. The positive factors include the following:

- Establishes cost-based reimbursement. CAHs will receive reimbursement for Medicare patients on a reasonable cost basis rather than on a prospective payment system basis.
- Provides staffing flexibility. This type of flexibility is built into the program and allows hospital administrators to adjust staffing according to patient need.
- Promotes physician retention. The financial stability offered by the CAH Program to small rural hospitals will attract reputable physicians to these areas.
- Encourages networking with upstream providers. Rural facilities will profit from networking with area organizations and larger metropolitan hospitals.
- Aligns services with community need. The program allows CAHs to provide the local community with services they need.

The negative factors of a CAH include the following:

- Limits bed size. The CAH Program limits bed size to 15 acute beds plus 10 swing beds. This limitation was not a problem for the Atoka hospital because the daily census was about five or six patients.
- Limits length of stay. The length of stay was originally not to exceed 96 hours. Now, a patient may stay an average of 96 hours, which gives the hospital more clinical freedom.
- Could reduce reimbursement.
- Could create adverse community or physician perceptions. Physicians may feel threatened about certain program provisions and may also believe that the program is taking patient control away from them by insisting on the length of stay in CAHs.

Mr. Moore pointed out that his CAH is located in the rural county of Atoka, a county not unlike many of those found in Oklahoma. He explained that Atoka County covers about 990 square miles and has a 1998 estimated population of 13,200 people, 15 percent of whom are over 65 years of age. Medicaid recipients add up to 21.3 percent of the population in comparison with 12.9 percent nationwide. The per capita income of Atoka County is $13,286 compared with $22,034 statewide.

Mr. Moore then explained why the Atoka Memorial Hospital changed over to critical access by presenting its financial history. In 1996, the hospital reported an operational loss of almost $1.2 million and a net loss of $512,185. After adopting critical access regulations and cost-based reimbursement in 1999, the hospital had an operating loss of $422,579, but finished the year in the black for the first time in 7 years with a net gain of $311,189. In 1996, the average cost per Medicare inpatient discharge in excess of DRG was $l,076, and the outpatient cost in excess of reimbursement was $55,434. In 1998, the Medicare inpatient cost was $99, and the outpatient cost was $21,344, plus $16,914 in formula-driven overpayment due to BBA regulations.

On the basis of his experience, Mr. Moore discussed the reasons why he converted the Atoka hospital to a CAH. The primary reason for this conversion was economic survival. The decreasing revenues for services had created financial difficulties for the hospital. Other reasons for the conversion included the following:

- Impact on the community. The community needed accessible health care and a boost to the economy. It was determined that the implementation of a CAH would be economically beneficial by increasing the community's payroll.
- Maintenance of crucial services. The community needed state-of-the art equipment (e.g., a CT scanner), high-tech programs (e.g., a teleradiology system), and the latest available drugs (e.g., thrombolytic drugs) to save the lives of its residents and to prevent them from driving long distances to metropolitan hospitals for emergency services.
- Need for personal service. As with most rural communities, most of the current Atoka population grew up in the area and want personal health care service in a comfortable facility staffed with local residents.
- Mr. Moore then outlined the steps he took in making the transition.
- First he determined whether his health care facility qualified as a CAH.
- Next he examined the financial feasibility of such a move.
- Mr. Moore then looked at the utilization trends. He had already decreased the length of patient stay, but he knew some additional action was needed if the hospital were to survive.
- Finally, inventory of all provided services was taken. Some services had to be eliminated because they didn't adhere to the CAH Program regulations. If a service had not been performed in several years, such as OB/GYN services or surgery, they were removed.

Mr. Moore relayed a number of lessons learned from his experience with the conversion to a CAH. The actual conversion process, from the application stage to implementation, was made

easier with help from the State Rural Health Office and from HCFA. He emphasized that a collaborative and cooperative effort is necessary to implement a task of this magnitude. He also learned that community perceptions can cause misunderstandings that, if not addressed, can affect the success of the project. The targeted communities must be made aware of the type of services and the high quality of care offered at CAHs, as well as the positive affect these types of hospitals may have on existing health care jobs.

Mr. Moore also learned from his experience that horizontal networking is imperative in improving patient care. Currently, Atoka conducts CT scans for several other hospitals, which creates a revenue string for his hospital. Sharing medical testing equipment with other hospitals is one way to keep a CAH afloat; getting into industrial medicine is another.

In closing, Mr. Moore opened up a committee discussion on the high cost of ambulance service, an issue that is of great financial concern to his hospital. Even after HCFA agreed to pay rural hospitals with EMS $2.50 a mile for the first 17 miles, Atoka is still subsidizing its service. Mr. Moore asked that the Office of Rural Health Policy (ORHP) draft a letter to Secretary Shalala requesting cost-based reimbursement for CAHs with EMS. Mr. Morris agreed to consider this request as a first step toward examining the ambulance fee issue.

On behalf of the Advisory Committee, Ms. Hughes officially thanked departing members Dr. Doty, Dr. Atkinson, Dr. Gary, and Dr. Coleman for their invaluable service to the committee. She also thanked the Choctaw Nation of Oklahoma and Shelly Crow for their gracious hospitality as hosts for the Checotah, Oklahoma, site visit.