September 9-11, 2001, Presque Isle, Maine

Health Resources and Services Administration
Office of Rural Health Policy

Presque Isle, Maine
September 9-11, 2001

Meeting Summary

The 39th meeting of the National Advisory Committee on Rural Health (NAC) was held on September 9-11, 2001, at the Northeastland Hotel.

Sunday, September 9

Call to Order

John Martin, Acting Chair

Mr. Martin convened the meeting by welcoming the National Advisory Committee on Rural Health (NAC) to Maine. In addition to Mr. Martin, members in attendance included Stephanie Bailey, Mary Wakefield, Alison Hughes, Monnie Singleton, Keith Mueller, Rachel Gonzales-Hanson, H.D. Cannington, Shelly Crow, Jim Ahrens, Steve Eckstat, and Dana Fitzsimmons. Present from the Office of Rural Health Policy (ORHP) were Tom Morris, Sahi Rafiullah, Michele Pray, and Jennifer Riggle.

Office of Rural Health Policy Update

Sahi Rafiullah, Acting Deputy Director of ORHP and Acting Executive Secretary of NAC
Tom Morris, Policy Analyst, ORHP

After introducing ORHP staff, Ms. Rafiullah noted that the NAC meeting agenda included an update on the safety net report, predeliberative work on EMS issues, and a couple of site visits. She explained that the Presque Isle visit is not considered an official meeting because ORHP was unable to get the Federal Register notice out in advance of the meeting. The notice was

delayed because the Office had not yet received approval of a temporary chair for the Committee meeting. Marcia Brand is currently working with the Secretary's Office on the selection of an appropriate chairperson.

Ms. Rafiullah also discussed the Secretary's new Initiative on Rural Health Issues and the role ORHP is playing in its implementation. Highlights of the discussion follow:

- ORHP, together with the Department's Office of Intergovernmental Affairs, is assuming a major role in orchestrating and staffing the Secretary's initiative. Ms. Pray, Ms. Riggle, and Mr. Morris, all heavily involved in this project, have until October 25 to develop a strategic plan.
- Possible actions associated with this initiative include both internal and external activities:
    - Internal-Take actions within the Department to assist rural areas on both the health and human services side. Focus on approaches specific to rural health. (Mr. Morris is the designated coordinator of this activity.)
    - External-Present a selected model to other Government agencies. Ask the Domestic Policy Council for its support.
- An interdepartmental task force was established to (1) take inventory on the number of rural health programs in existence and determine what types of investments, if any, have been made in rural areas; (2) determine what affects different rural areas throughout the country; and (3) define any barriers (legislative, administrative, regulatory) that impede the implementation of rural health care programs. The August 29 Federal Register announced that individuals outside the Department are welcome to provide the task force with input.
- The Secretary signed off on a list of tasks ("the seven wonders") that ORHP hopes to accomplish under the new initiative. These tasks include the following:
    - Improve access to capital for rural hospitals. ORHP is conducting surveys with the University of Minnesota to determine some of the issues surrounding access to capital.
    - Improve small hospital performance in the seven Mississippi Delta States.
    - Improve primary care coordination. Bring together representatives from HRSA agencies and CMS to inspect models that work in rural areas (i.e., CAHs working with community health centers [CHCs] or rural health clinics [RHCs] working with rural hospitals) so opportunities can be identified.
    - Examine HIPAA to help rural providers comply with its many provisions.
    - Strengthen the NAC for better utilization within the Department.
    - Examine physician training, GME, and the rural recruitment and retention network. Share that information across the Department. Bring together rural medical educators and representatives from NRHA and CMS to single out one message about the new GME laws. Determine how to publicize workforce models for rural that work effectively.
    - Strengthen EMS by examining how Title XII can help these services and share this information with the Department. Also, examine ways to create a stronger focal point for EMS within HHS.
    - The Federal Notice of August 29 requested public comment on the Secretary's initiative. ORHP will place this information on its listserv (rural.comments@hhs.gov). Comments are due by September 28.
- Five goals/themes associated with the Secretary's initiative are

- Improving rural communities' access to quality health and human services
- Strengthening rural families
- Strengthening rural communities by supporting economic development
- Partnering with State, local, and tribal governments to support rural communities
- Supporting a rural voice in Federal policymaking

Next, Mr. Morris provided a legislative update:

- A markup of the Labor/HHS bill is expected within the next 2 weeks, at which time a series of resolutions could take place in an attempt to balance the bill's budget.
- All ORHP programs are expected to be intact for the new fiscal year, and funding will likely be available for the Office to continue with its PPS transition grants. It is feasible that the Senate will put a considerable amount of money back into the health education training programs that were cut by the President's budget.
- ORHP is confident that Congress will pass S. 1281, specifically the Health Care Safety Net Amendments of 2001, which ORHP authorized as the core of its CHC and grant programs, with little trouble. The House is currently reviewing a draft of the bill, which is similar in scope to the Senate version that passed this past July.

Introduced on July 31, 2001, S. 1281 reauthorizes and strengthens the health centers program and the National Health Service Corps (NHSC), establishes the Healthy Community Access Program, allows part-time demonstration programs, and authorizes the CHC program. A revised version of the bill includes implementation of the Small Health Care Provider Quality Improvement Grant Program, which will allow ORHP to award grants to individuals not required to create networks or partnerships to perform a range of quality activities. This version also separates the telemedicine program from ORHP's outreach authority.

Two other programs added to this safety net bill during Senate markup are

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- A rural emergency medical services training and equipment assistance grant program, which provides matching grants to State offices of rural health, State EMS offices, local governments, and State and local ambulance providers, as well as recruitment services, training, equipment certification, and public education. Funds will be allocated as necessary.
- A rural telemental health program, which is a demonstration program providing mental health and educational services to older people and children in rural areas, as well as training for health care professionals who serve these populations.

- The Senate Finance Committee is still planning to mark up either the prescription drugs or the Medicare bill. The markup will likely contain most of the provisions from the Conrad/Thomas bill (S. 1030). This bill hopes to turn many of the MedPAC recommendations into law, including the following:
  - Low-volume adjustment of Medicare inpatient PPS.
  - Equalization of DSH formulas.
  - Standardized payment equalization.

    - Reclassification change of the wage index to allow reclassification to extend to other payment settings rather than to just inpatients. This provision also would preserve lab reimbursement under the physician fee schedule for independent labs and increase rural health clinic reimbursement comparable to FQHCs.
- The movement of legislation affecting rural is less certain in the House. On the regulatory side, there is still no word on the final rules for RHCs or the ambulance fee schedule. The physician fee schedule ruling was July 2, and the outpatient PPS ruling was July 24.

Committee Administrative Work: Safety Net Report

Rachel Gonzales-Hanson, Subcommittee Chair
Tom Rowley, Report Author

As chair of the subcommittee on safety net issues, Ms. Gonzales-Hanson gave a brief background summary of the subcommittee's safety net report and noted several actions that have transpired since the Squaw Valley meeting. She then thanked ORHP staff, subcommittee members, and Mr. Rowley for their help and cooperation.

Next, Mr. Rowley presented an overview of the report's current status. The subcommittee and ORHP staff held a conference call several weeks ago, resulting in a draft version of "A Targeted Look at the Rural Health Care Safety Net." The subcommittee is largely satisfied with the report's focus, with a few exceptions.
Mr. Rowley noted that the report's focus needs to go beyond simply spotlighting the uninsured and the underinsured to include persons living in isolated rural areas, because often the safety net is the only source of health care for these individuals. In addition to the usual "wordsmithing," the report needs to include "samples of requirements that work against one another" and a discussion about factors that have an indirect impact on the safety net (i.e., a more in-depth discussion on workforce issues). In addition to workforce, other sections require further development, such as public health departments, mental health, and dental care. The topic of free care also needs some attention.

Mr. Morris requested that the Committee refine the safety net topics as much as possible and include only those issues that fall directly under the Secretary's purview. Members were asked to review the draft report and share comments with Mr. Morris and Mr. Rowley over the next couple of months. The final report will be presented at the March meeting.

Discussion

Concerns raised about safety net issues included the following:

- The safety net report glosses over the fact that the true providers of the safety net in many rural communities are the private providers. In response, Mr. Morris agreed that more information should be included on the rural physicians who provide uncompensated care, and this could possibly be done by tying the issue to the statutory program that is directly connected to the safety net.
- The report should mention that many residents living in remote rural communities are dependent on EMS personnel as their safety net; therefore better reimbursement for this service is needed.
- The report should use a global term that includes all community-based clinics in rural America or distinctly define each one to avoid any exclusions.
- The report should recognize what actions are within the Secretary's purview and what requires legislative authority for implementation.
- The report should note that no safety net for mental health or dentistry exists in rural areas, and a vast shortage of such providers is evident in these areas.

Federal EMS Activity

Jennifer Riggle, ORHP Staff

Ms. Riggle began her presentation on rural EMS activities at the Federal level by first providing a brief background of EMS. The Department of Transportation established the first EMS program in 1966, created block grant programs with CDC in the 1970s, and developed emergency medical systems for the Children's Act under HRSA in 1984. During this time, trauma and EMS were marred by service gaps, inadequate and uneven distribution of resources, confusion of roles and responsibilities, and lack of State leadership. Some of these problems are still evident today.

To help address these concerns, ORHP is in the process of forming partnerships with Federal agencies, EMS and rural organizations, trauma surgeons, and rural advocates to encourage open dialog about EMS and trauma issues. It also strongly supports Title XII of the Public Health Service Act (P.L. 101-590), which promotes the establishment of programs and research for improving trauma and EMS care in rural areas. Highlights of Title XII activities include the formation of the Division of Trauma and EMS (DTEMS) within HRSA in 1990, a congressional reauthorization for $6 million per year in 1998, a $3 million appropriation for EMS and trauma in 2001, and a $2.4 million appropriation by the President for 2002. The 2001 Title XII funding is being jointly administered by ORHP, the Maternal and Child Health Bureau, and the National Highway Traffic Safety Administration.

With 2001 Title XII funding, ORHP is tasked with several initiatives:

- Conducting State-by-State trauma needs assessments-Grants averaging between $30,000 and $45,000 will be awarded to selected States by September 30 to (1) identify critical needs and best-practice models, (2) provide Federal assistance for States and

local regions to develop a trauma and EMS plan, and (3) provide a forum to bring together State trauma systems and EMS and rural health stakeholders.
- Implementation of rural initiatives-The legislation earmarks 10 percent of the funding specifically for rural initiatives.
- Strengthening partnerships-ORHP is forming a joint committee with the National Organization of State Offices of Rural Health (NOSORH) and the National Association of State EMS Directors (NASEMSD). Committee goals include examining rural EMS priorities and developing a joint message on rural EMS issues for delivery by next March.
- Forming a stakeholders group-Stakeholders will be asked to complete a survey to provide a national outlook on trauma and EMS system development for 2001.
- Conducting automated external defibrillator (AED) demonstration projects in rural areas-About $25 million has been authorized to conduct AED demonstration projects in Wisconsin, Vermont, and Maine.
- Development of rural AED needs assessment and placement-ORHP has contracted with NASEMSD and the National EMS Data and Research Center (NEDARC) to create a model based on population, age, risk criteria, and incidence that will provide guidance to States in the placement and distribution of AEDs in rural areas by December 2002.
- Development of ORHP-sponsored research-Project Hope is currently establishing a fair Medicare reimbursement for low-volume ambulance providers and is examining the Federal role in funding emergency medical services in the United States. Two papers on rural EMS are scheduled for release at the end of September: "Access to EMS in Rural Areas," from the University of Minnesota's Rural Health Research Center and "Working Together Makes Rural and Frontier EMS Work," from NRHA.

Next, Ms. Riggle provided a review of the EMS portion of the Medicare Rural Hospital Flexibility Program (Flex). In year one of the program, States concentrated on the CAH conversion processes, so EMS issues were not a priority, although some needs assessments were conducted and State regulations were reviewed. In year two, 44 to 47 States proposed EMS activities, for which ORHP dedicated between $3 and $4 million. EMS activities under the Flex Program include the following:

- Training and scholarship programs
- EMS needs assessments
- Collection and analysis of prehospital data
- Grant writing assistance
- Uniform patient treatment/transfer protocols
- Small equipment purchases/capital improvement

Ms. Riggle then reported on a number of problems concerning ambulance payment in rural areas. She noted that Medicare traditionally reimburses ambulance cost on the basis of transportation, which automatically creates problems for rural communities because of the high number of low-volume providers that serve these areas. Many of these rural providers have difficulty recovering the high fixed costs associated with providing three or fewer runs per day. Other problems surfacing in the rural ambulance system include declining volunteerism, bad debt as a result of poor billing services, and poor working conditions.

Contrary to the congressionally mandated Medicare ambulance fee schedule and the proposed rule issued in April 2000, the Benefits Improvement and Protection Act of 2000 (BIPA) exempted CAHs from the ambulance fee schedule if they operated the only ambulance service within a 35-mile radius. In this case, they would receive cost-based reimbursement. The Medicare ambulance fee schedule also is having problems, specifically in targeting and identifying low-volume providers. Consequently, CMS has asked GAO to review the matter.

In conclusion, Ms. Riggle explained that EMS still faces substantial obstacles, especially in rural communities. The systems are young, expensive, and not well understood in many circles. But EMS still offers a viable source of emergency care for rural areas, and its full potential remains untapped.

Maine Rural AED Demonstration

Michelle Mosher, Project Manager, Maine State Office of Rural Health

Ms. Mosher began her presentation by noting that ORHP is currently looking at an unfunded piece of legislation to devise three methods (in Wisconsin, Vermont, and Maine) of gathering information on the need for AEDs in rural communities. ORHP will use the gathered data to effectively dispense the defibrillators if and when Congress appropriates the money. Ms. Mosher focused her discussion on the implementation of the AED demonstration project in the State of Maine.

As part of the Maine demonstration project, the State Office of Rural Health will collaborate with the EMS Office and other community stakeholders to look at different types of providers and first responders and the role they play in their communities. The States require that a minimum of three emergency response entities participate in the proposed demonstration project. In addition to these required entities, the State Office of Rural Health is asking applicants to establish community partnerships made up of police, sheriff, and fire departments, hospitals, and ambulance (EMS) services. These partnerships must be verified by letters of support.

Another piece of the project involves selecting service areas for participation in the AED demonstration. The RFP requires that each service area provide feedback to the Maine Office of Rural Health as well as

- Qualify as rural (fewer than 10,000 people)
- Be contiguous and practical with regard to community partnerships and natural geography
- Show a minimum of 10 confirmed cardiac arrest incidents for 2000
- Provide medical direction for the project

- Secure FDA approval for the AEDs used
- Provide a community plan or placement strategy (i.e., demonstrations in community centers, malls, hospitals) that will make AEDs available to first responders
- Maximize existing resources
- Report how often an AED device is used
- Report how well the regular EMS personnel interacted, where the patient was taken, and what the outcome was for each incident

At the conclusion of the Maine demonstration project, ORHP will examine the tabulated data collected from the various service areas to determine the most effective strategies and to help decide future funding.

Monday, September 10

After presenting the NAC with a geographic, demographic, and political history of the State of Maine, Mr. Martin introduced Kevin McGinnis, a former State EMS director, who gave an overview of Maine's EMS system.

Overview of Maine's EMS

Kevin McGinnis, Director, Ambulance Services, Franklin Memorial Hospital

After Mr. McGinnis discussed how EMS has evolved over the past 30 years, he noted the different types of providers who make up the system. At present, the United States has four types of providers and four standardized levels of training for each provider. The provider, assigned duties, and level of training required are summarized as follows:

- First responder-assists ambulance workers and keeps the patient from further harm; required to have at least 50 hours of training.
- Emergency medical technician (EMT)-stabilizes the patient, administers necessary medication, and transports the patient to the hospital; required to have 150 hours of training.
- EMT intermediate-administers IV therapy, advanced airway care, defibrillation services, and emergency medication, and provides EKG interpretation.
- Paramedic-provides all types of emergency medical care; required to have a minimum of 600 hours of training (Maine requires between 600 and 1,000 hours) and in some States a 2-year associate degree.

To improve and update Maine's EMS system, the State Physicians' Medical Director Practice Board phased out "homegrown" licensing levels such as ambulance attendants, critical-care-level technicians, and all nonmedically supportive levels of care. Also, in 1993, Maine's EMS commissioned a scientific consumer poll to find out what people expected from these services. Approximately 87 percent of the respondents expected to be treated by a paramedic during an

emergency visit. In response to this finding, Maine created a permitting system at the paramedic level that guarantees paramedic care for
100 percent of all emergency responses. As a result, the number of locations that provided paramedic service increased.

Today, Maine has approximately 187 ambulance services at EMT and paramedic levels to assist the State's 1.2 million residents. The State also has 30 nontransporting first-responder services, two helicopter and fixed-wing carrier services (one in Bangor and one in Lewison), and a two-level, all-inclusive trauma system made up of three trauma centers and 36 trauma-system hospitals. In total, the ambulance service responds to about 200,000 calls a year, of which one-half reflect emergency calls. Response time for these runs averages about 4 minutes in southern Maine, an area that serves the general population, to about 8 minutes in northern Maine, a more sparsely populated area.

Ambulance volunteers have been a large part of the Maine tradition. A vast majority of first responders are volunteers, whereas two-thirds of EMTs, one-half of intermediates, and about 5 to 10 percent of paramedics are volunteers. Maine is currently facing a significant volunteer shortage, especially in paramedic services, because of a lack of good training resources, bad call lines, and high financial burdens. The shortage of paramedics is especially critical in low-volume ambulance services. To survive in these low-volume service areas, paramedics must accept additional work in hospital emergency rooms, at fire stations, as an assistant to a primary care physician, or as part of the flight crew in emergency medical helicopters.

In addition to volunteer recruitment and retention problems, EMS systems have to rely on an aging radio communication system installed in the mid-1970s. Recent developments in communications technology are making Maine's current system untenable. For example, CB radios, which many consider inadequate, are still used to a great extent in the northern woods where a number of logging accidents occur. As one solution, new legislation now mandates that carrier cell phones containing an automatic location identifier system be used within the next 2 years. Regarded as a controversial device by some, the location identifier has the capacity of not only locating a vehicle or patient, but also relaying the most expeditious directions to the ambulance driver. In addition, many onsite supervisors in rural areas are now being trained as first responders, thus allowing them to provide basic emergency care before an ambulance arrives.

Another problem plaguing rural EMS is the lack of infrastructure grants to support the system. Unlike the 1970s and 1980s when money was heaped on EMS to develop their systems, now the ability of rural services to maintain or even buy new telecommunication equipment is much more difficult.

Over the years, Maine has tried to update its EMS system by implementing a number of initiatives. Maine was the first State organization to have an EMS authority board that chooses the State EMS director, sets the rules and regulations governing the system, and gives EMS providers a deciding voice about the system's organization. It also was first to have statewide prehospital protocols, a statewide EMS data-collection system, and a volunteer service manager's program; to allow wilderness EMS protocols; and to use a permitting system.

Mr. McGinnis then turned to Medicare and Medicaid reimbursement issues regarding the new ambulance fee schedule and ambulance transport. The problem is that Medicare has been trying to move all ambulance services onto Medicare Part B for the last 12 years. This move would have a significant effect on many rural services, especially because of their low-volume component. So far, most hospitals have managed to resist the change by claiming it is unfavorable in terms of rates and requires the creation of a different billing mechanism, a time-consuming and costly process. State Senator Susan Collins (R-ME) recently sponsored legislation (S. 1367) allowing hospital-based ambulance services to continue under Medicare Part A, while permitting providers who may benefit from the change to remain under Part B. If the legislation does not pass, ambulance services will most likely be driven out of hospitals, a dilemma that will critically affect rural areas.

Several bills are now in circulation that include a low-volume component or formula that would allow services to bill at a certain level to sustain the safety net or at least provide cost reimbursement. These bills include S. 1367 (Medicare Rural Relief Act), S. 1350 (Medicare Ambulance Payment Act), and S. 1587 (Sustaining Access to Vital EMS Act).

In closing, Mr. McGinnis emphasized that it is the responsibility of State EMS offices to offer guidance to Congress and the Bush Administration on what constitutes a critically necessary rural ambulance service and what does not. A distinction must be developed between those ambulance services that exist in close proximity and can financially sustain call volumes and those ambulance services in rural communities, with relatively small call volumes, whose loss of services would have significant patient impact.

Site Visits

Eagle Lake Health Care Facility

Gary Gardiner, an EMS paramedic at Eagle Lake, led a roundtable discussion on the types of services that he and his EMS staff provide the greater Fort Kent area. The facility uses five units for such services as treating victims of logging accidents to providing emergency transfer to Eastern Maine Medical Center and occasionally to Boston. As a paramedic, he is required to

renew his license every 3 years by taking 60 hours of coursework at the Northern Maine Medical Center in Fort Kent. After the discussion, NAC members toured the inside of an ambulance.

Fish River Rural Health Center

Dr. Paul Pelletier, medical director of and family practitioner for the Fish River Rural Health Center, spoke to the Advisory Committee about the center's operations. With a staff of 28, the health center is the sole provider for the surrounding rural communities, which include a service area of about 15,000 people. Although the health center provides emergency services, it relies heavily on its ambulance service staff for emergency care. The staff is composed primarily of well-qualified volunteers with paramedic-level training. Medical oversight for the ambulance service is through the emergency department at the Northern Maine Medical Center.

Because the ambulance service handles most of the area's serious medical emergencies, the center's trauma unit is used only for acute trauma care. Most lab and x-ray services are performed at the Northern Maine Medical Center, with the exception of chest and bone x-rays. As part of its obstetrical services, the Fish River facility provides only prenatal and emergency care. All other obstetrical services, such as delivery, take place in Fort Kent.

Currently, the health center does not have access to any telemedicine technology but is in the process of developing a telemedicine unit to be housed at the center. Physician home visits are only made for older patients. Because almost all of the surrounding communities are designated as health professional shortage areas, the center receives a fair number of NHSC physicians and J-1 Visa placements. The Fish River facility is home to one part-time NHSC physician and several J-1 physicians from several foreign countries. The facility also receives medical school rotations every year from the University of New England College of Osteopathic Medicine and an occasional student through the Maine Ambulatory Care Coalition.

On average, providers at the facility see anywhere from 15 to 20 patients a day. Of these patients, about 75 percent are scheduled and 25 percent are acute. A large proportion of them are from local nursing homes and from several community homes for the severely mentally retarded.

Northern Maine Medical Center

Marty Bernstein, administrator of the Northern Maine Medical Center, discussed the Medicare shortfall and its impact on Maine hospitals, primarily those in rural areas. His talk reflected findings from an independent analysis recently conducted by the Maine Hospital Association.

The study was prompted by the fact that the Federal Government pays Maine hospitals much less than what it costs to care for older patients on Medicare. Its goal was to determine the amount of the shortfall and better understand its impact on health care premiums. Highlights of the study findings include the following:

- Maine has 39 hospitals scattered primarily throughout rural areas. These hospitals serve large geographic regions and have a high percentage of Medicare patients, who represent 44 percent of all hospital services. One of the most challenging problems facing a Maine rural hospital today is that for every dollar of care provided to a Medicare patient, the hospital is reimbursed only 88 cents. Medicaid pays roughly 43 percent of the charges on the dollar, about 80 cents.
- Cost shifting results in higher health insurance premiums for consumers (e.g., Maine has the fourth highest insurance rate in the Nation) and negative inpatient Medicare financial margins for hospitals. The average Medicare financial margin for the Nation is +5.6 percent, whereas the average margin for Medicare patients in the State of Maine is a -5.6 percent, a difference of 11.2 percent. Chronic underpayments by the Federal Government could eventually erode the financial health of Maine hospitals.
- Maine ranks 46th in the Nation in Medicare reimbursement, yet the State has a 10 percent higher Medicare population. According to 1999 data, Maine hospitals were reimbursed $115 million less than what it actually cost to care for their Medicare patients. This shortfall increased to $131 million in 2000 and $215 million in 2001.
- A large gap exists between what Maine hospitals are reimbursed and the national average for hospital reimbursement. To cover their Medicare costs, Maine hospitals charge about $2.44 billion in patient fees, whereas if they received 100 percent reimbursement like other States do, the dollar amount for charges would be $2.14 billion, a difference of $300 million.
- Federal payment policies tend to favor urban areas where there is a higher percentage of hospitals. It appears that the Medicare formula is biased more often toward urban than rural hospitals.

In answer to the question as to why Maine hospitals are in such a Medicare predicament, Mr. Bernstein provided this explanation: From 1983 to 1995, the Maine Health Care Finance Commission regulated the State's health care facilities, and as a result, hospital cost shifting-financial requirements, expenses, and charge rates-were automatically set. This gave hospitals little motive to aggressively pursue full Medicare payment. Consequently, Maine hospitals now lag behind in case mix and the wage index.

Next, Mr. Bernstein gave some specifics about the Northern Maine Medical Center and its ER staff. As a sole community provider (i.e., it is the only hospital within 45 miles), the facility serves a 70 percent Medicare/Medicaid mix and has an average daily consensus of about 17 patients. Its total service area is about 14,000 people. The center does not qualify for critical access, does not have a license for swing beds, but is qualified for DSH payments under the new standards. Although a constant struggle, it has operated in the black for the last 18 years.

Northern Maine Medical Center's ER staff consists of one full-time physician on duty 24 hours, 7 days a week, and several board-certified ER nurses. The ER physician staff, provided by the National Emergency Services of New York, treats about 15 to 20 patients a day; about 60 to 65 percent of hospital admissions come through the ER.

Mr. Martin followed Mr. Bernstein's comments with a brief discussion on the center's volunteer ambulance service, which is housed at the hospital but is considered a separate corporation. The ambulance service was originally provided by two funeral homes until a Hill-Burton grant allowed the hospital to purchase its own ambulances. After an initial struggle securing equipment and a qualified staff, the service grew to a current total of 35 volunteers spread over four sites and 75 woodland townships, an area larger than Rhode Island. In its 26 years of operation, the center's ambulance service has faced a constant battle to retain volunteers, who are paid $1.25 an hour. Other problems include the high cost of replacing ambulances every 3 years, incurred bad debt, the difficulty of passing certification criteria, and the difficulty of adhering to HIPAA's privacy provisions. The Northern Maine Medical Center's budget for EMS/prehospital care is between $30,000 and $40,000 a year, an amount that requires EMS staff to pay for their own mileage and meals.

The ambulance service also is having difficulty securing adequate Medicare reimbursement, which is about 60 to 70 percent of the amount charged. This shortfall results in a gross loss in revenue, especially because the service conducts about 1,400 Medicare runs a year. Further problems are caused by a slow billing process; submitted bills are often rejected and returned for lack of documentation, and there is no consistency in Medicare's review of the invoices.

For comparison, Mr. Bernstein offered a look at another ambulance service located in Madawaska, an affluent community slightly northeast of Fort Kent. Established 12 years ago and serving a population of 5,600, the Madawaska ambulance service makes about 480 runs a year with a paid staff of six paramedics ($10 an hour) and three intermediate-level technicians. Although Madawaska approved $350,000 in funds for running the service, that amount only covers about 40 percent of the actual cost. Consequently, the service requires sufficient Medicare reimbursement to survive, which it is not getting. Other Medicare reimbursement problems include unreasonable requests for documentation, discrepancies in reimbursement rate interpretations, and a substantial delay in payment.

A final topic of discussion focused on the EMS certification test offered by the Federal National Registry and the difficulty it presents for prospective personnel. Although the test's pass rate is in the 70th percentile for Maine applicants, for those living in the northern part of the State where the primary language is French, the verbal portion of the test presents a problem. Initially, the State conducted its own EMS testing, but the exam proved educationally unsound, so the

State EMS Board decided to adopt the Federal test. Several proposals to make testing more equitable and to ensure a higher pass rate include developing better training techniques for instructors, requiring instructors to teach to the test, and providing students with practice tests and quizzes.

Following the presentation, Jane Rio, an ER nurse at the Northern Maine Medical Center, conducted a tour of the facilities.

Tuesday, September 11

Saftey Net Report Wrap-Up

Mr. Rowley and Ms. Gonzales-Hanson prefaced the safety net report wrap-up by asking for Committee comments by the first week in December so they can be incorporated into the report by the end of the month. Comments may be sent by fax, e-mail, or phone. Final editing and formatting will take place in January and February, with formal Committee approval scheduled for the March 3-5, 2002, NAC annual meeting in Washington, D.C. Another subcommittee conference call will be scheduled soon for a discussion of crosscutting issues.

Next, NAC members offered some additional comments on the safety net report:

- The document should include a segment that acknowledges that EMS is part of the safety net for rural health. Mr. Morris agreed to include a segment on EMS as a safety net function but in a section in which safety net issues do not fall under statutory authority.
- Dr. Singleton suggested that the last bullet under recommendations on page 7 of the report-"the Secretary should work with the Congress to amend current law…"-be eliminated because he believes that ob-gyn services are provided under Medicaid.
- In response to a workforce/NHSC query, Mr. Morris pointed out that the topic falls under "direct authority that is safety net related." He agreed to include words to the effect that indirect programs exist under Federal authority that contribute to the workforce but that they are not specific. One participant asserted that the workforce/NHSC is such a broad issue that it should be handled separately and could even constitute a separate report.
- In referring to the last paragraph under Medicaid PPS on page 8, Dr. Singleton noted that prevention strategies must be found and funded to reduce the cost burden of health care. He noted that more prevention programs, such as health screenings, would probably exist today if they were reimbursable.
- In referring to the information on uncompensated care in RHCs on page 9, Mr. Martin recommended that the Federal Government assist RHCs if they in fact provide sliding fees.
- In a discussion about whether local health departments are considered part of the safety net, it was pointed out that many State and local public health departments are beginning to turn away from providing primary health care to focus more on public health issues. Dr. Bailey stated that statistics indicate that more than half of community health departments nationwide are still active in providing primary health care, and those that

do not provide direct service act as facilitators of this type of care (i.e., through Community Access Program grants).

Mr. Morris acknowledged that local public health departments are considered part of the safety net because limited Medicaid reimbursement is forcing them to reach out to partners, such as CAP grants, CHCs, and private physicians, to create a system or network for providing health care, even though they will not directly be compensated from Medicaid. The report will include words to this effect.

- Dr. Singleton recommended that the workforce section on page 11 mention a need to train technicians so they can operate new technological equipment related to telecommunication and telemedicine. Committee members were reminded that the report is not intended to be about the full safety net. Instead, it should look at the direct Federal authorities that have a specific or explicit role in the issue. The Secretary is more interested in improving existing Federal programs involving the safety net than in creating new ones.
- It was agreed to change "insured patients" to "uninsured patients" on page 11, second bullet.
- A number of concerns were raised about the J-1 Visa waiver program as it currently exists. The waiver allows international medical graduates (IMGs) to remain in this country to practice medicine and forego the mandatory return to his or her home country after receiving graduate medical education or training in the United States. Highlights from this discussion are as follows:
    - Dr. Singleton strongly believes that the reauthorization of the Conrad State 20 Program should not include a cap increase from 20 to 35. An increase would override the intent of the IMG program, that is, to provide medical training for foreign-born students so they may practice in rural underserved areas for a couple of years before returning to their native country to practice. Dr. Singleton suggested that internal steps be taken to obtain more American physicians to practice in these underserved areas as opposed to "draining foreign countries of their best and brightest physicians." Ms. Gonzalez-Hanson pointed out that these IMGs fill the many vacancies found in rural health centers across the country, but agreed that U.S. medical schools should try to get their primary health care physicians distributed more evenly throughout the country.
    - Mr. Morris agreed to reflect Dr. Singleton's perspective in the report by changing the language to suggest that the Conrad State 20 Program should be reauthorized but should not expand the cap. Language also could be added indicating that the United States is not producing enough of its own physicians and is relying too heavily on foreign-born medical professionals.
    - Ms. Hughes suggested including a recommendation with those found on page 13 reflecting the need to conduct research on the impact of J-1's in rural America. Dr. Wakefield offered that the American Academy of Family Physicians is currently compiling statistics on the number of foreign physicians who remain in this country and those who return to their native countries after receiving medical training in the United States.
    - Dr. Mueller proposed that the recommendations on page 13 be restructured to reflect "some kind of hierarchy because they are not all doable simultaneously." He suggested shifting the recommendation for an NHSC funding increase from the fourth to the first bullet, followed by bulleted recommendations for an

increase in funding for the other Federal programs. Dr. Mueller also stated that HHS should not have the authority to issue J-1 Visa waivers for primary care providers who practice in rural health professional shortage areas; the authority should remain with the States (i.e., through the Conrad State 20 Program).

    - In response to these concerns, Mr. Morris proposed including a discussion in the report suggesting that more research is needed to determine whether the Conrad State 20 Program or cabinet-level agencies should be the primary vehicles for authorizing V-1 Visa waivers.

- It was suggested that the section on public health departments include a discussion on the interplay of those departments with such organizations as State offices of rural health, the primary care associations, and CAHs.