Letter to the Secretary: June 3-5, 2001, Squaw Valley, California

June 2001

Dear Secretary Thompson,

The National Advisory Committee on Rural Health recently met in Squaw Valley, California and I would like to share with you the results of that field meeting and site visit. As you may know, I was asked by our former chair, Nancy Kassebaum Baker, to serve as acting chair for this meeting. Our visit to this rural community on the eastern slope of the Sierra Nevadas afforded the committee a chance to continue work on our 2001 topic of assessing the rural health care safety net and to visit several health care providers in the remote mountain communities of this region.

As always, the field visit provided a forum for us to hear from a variety of local health care providers and state health officials from both California and Nevada. Our visit took us to the Placer County Public Health Department as well as Eastern Plumas County District Hospital and Plumas District Hospital where we heard from providers, administrators and beneficiaries. The information gathered during the meeting will help inform our safety net report that we expect to complete by our February, 2002 meeting. The speakers at the meetings and the hosts of the site visits also raised several important rural health issues that we wish to share with you.

First, the Committee continues to be concerned about the fragile state of basic dental services in rural communities. We have become increasingly aware of the urgent need to address oral health needs in rural areas. We believe the Department of Health and Human Services could do more to improve access to dental services. For the past two years, HCFA and HRSA have worked together on a formal oral health initiative. One of the primary thrusts of the initiative is to look at ways to improve access to preventive oral health services for children. While dentists remain the primary providers of oral health services, the HCFA-HRSA initiative advocates the use of other healthcare providers to provide some basic services in those areas that lack access to dentists. The two agencies funded grants in North Carolina and California that use primary care providers to conduct screening, provide oral health education to parents and children and apply fluoride varnishes to children in underserved communities.

The Committee believes this type of initiative is vitally important in improving the nation's oral health. Rural communities, in particular, face severe shortages of oral health professionals. The Committee recommends that the Secretary use the authority under Title XVI of the Public

Health Service Act to build on the work of these initial projects. This would help expand the number of grants available to encourage other innovative models for improving access to oral health care for rural children.

The second issue we would like to make you aware of deals with the growing concern about implementation of the regulations connected with the Health Insurance and Portability and Accountability Act of 1996. Each of the providers we visited in California raised concerns about the potential impact of these regulations. The Committee recognizes their concerns and hopes that the Secretary, in preparing the final regulations, will ensure that rural providers are not disadvantaged.

Our principal concern is that well-intended regulations often result in a much larger financial burden on rural providers than on urban providers. Urban providers with larger practices can better afford the implementation costs of new data requirements than rural providers.

We are also concerned that there are widely varying assessments of the impact of these new regulations. The Committee urges the Secretary develop information resources for the health care community that clearly spell out what the true impact of these regulations will be along with the implementation options and time frames. This will be particularly important in those rural communities that may be most affected by the administrative burden.

The Committee is aware there are studies underway by Project Hope and the Rural Policy Research Institute that will focus on the impact of HIPAA on rural providers that may help inform the situation.

Committee members also heard additional concerns from providers about several other regulatory issues. The first involves the new rules that allow certain ambulance providers at Critical Access Hospitals to qualify for cost-based Medicare reimbursement if they are sole providers of care in the community. The legislation that created this provision requires that a CAH ambulance service can be paid on a cost basis only if it is at least 35 miles from another ambulance providers. One CAH administrator in Plumas County said this threshold is too high and fails to take into account the access problems faced by providers in mountainous communities. Others noted that the 35-mile threshold is inconsistent with other mileage requirements in the CAH designation that require that the hospital be located at least 25 miles from another inpatient facility (or 15 miles in mountainous terrain). The Committee wants to bring this issue to your attention and would hope that the Department would look into the issue to determine if the current policy is the most appropriate situation for ensuring access to emergency medical services in rural areas.

On behalf of the Committee, I want to thank you for the opportunity to share these issues and we look forward to hearing from you. If the Committee can be of any help on these or other issues, please let me know.

Sincerely,

Thomas S. Nesbitt, M.D., M.P.H.
Acting Chair