June 3-5, 2001, Squaw Valley, California

Health Resources and Services Administration
Office of Rural Health Policy

Squaw Valley, California
June 3-5, 2001

Meeting Summary

The 38th meeting of the National Advisory Committee on Rural Health (NACRH) was held on June 3-5, 2001, at the Squaw Valley Lodge.

Sunday, June 3

Call to Order

Tom Nesbitt, Acting Chair

Dr. Nesbitt, acting chair, convened the meeting by welcoming the Advisory Committee members to California and asked each member to give a brief self-introduction. In addition to Dr. Nesbitt, the following members were in attendance: Sally Richardson, Stephanie Bailey, Mary Wakefield, Alison Hughes, Monnie Singleton, Keith Mueller, Rachel Gonzales-Hanson, H.D. Cannington, Shelly Crow, Dave Berk, Jim Ahrens, and Steve Eckstat. Also present from the Office of Rural Health Policy (ORHP) were Tom Morris and Sahi Rafiullah.

Office of Rural Health Policy Update

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

Ms. Rafiullah prefaced the update by explaining that Marcia Brand's (director of ORHP) absence was due to her involvement in ongoing fiscal year 2003 budget discussions. She also mentioned that Michele Pray, an ORHP intern, has permanently joined the staff. Ms. Pray was instrumental in the preparation of the Advisory Committee's recent report to the Secretary of the Department of Health and Human Services (DHHS) titled Medicare Reform: A Rural Perspective. Other highlights of Ms. Rafiullah's presentation follow:

- Former Senator Nancy Kassebaum Baker had to resign her position as chair of NACRH because of the appointment of her husband, former Senator Howard Baker, as

ambassador to Japan. Ms. Baker also resigned her position with the Robert Wood Johnson Foundation (RWJ) and the Kaiser Family Foundation. On behalf of the Advisory Committee, Ms. Rafiullah extended a thank you to Senator Kassebaum Baker for her extraordinary leadership and vital contributions in furthering Advisory Committee goals during her term as chairperson. Senator Kassebaum Baker suggested former Senator Paul Simon (D-IL) as a possible replacement candidate, although his party affiliation and the current Administration hiring freeze might hinder approval. Former Senator David F. Durenberger (R-MN), who has expressed interest in the position in a few preliminary conversations, was suggested as a potential backup candidate.

- The Advisory Committee's Medicare report was well received by DHHS Secretary Tommy Thompson, although some rural advocates believed it was too balanced and not critical enough of certain individuals. Ms. Rafiullah commended Mr. Morris for "crafting and phrasing" the document and steering the project to completion, as well as the Advisory Committee members for developing an agenda and for reviewing multiple drafts.

Next, Mr. Morris provided an update on the following legislation:

- The inpatient prospective payment system (PPS) regulation for Medicare, which was released April 1, 2001, included several changes regarding critical access hospitals (CAHs); these adjustments, which have yet to be made, showed flexibility on the part of the regulatory environment. As a result of pressure from ORHP and the rural community, one such change involved allowing certified registered nurse anesthetists employed by CAHs to perform preoperative and postoperative evaluations.
- The Benefits Improvement Protection Act is an interim final rule passed last year that includes changes for all sole community hospitals and Medicare-dependent hospitals. It is possible that these changes will merge with the inpatient PPS in one final rule.
- In addition, the physician fee schedule, which continues "the redistribution of the practice expense from specialists toward primary care providers," was finally released.

Mr. Morris affirmed that the Medicare Payment Advisory Commission (MedPAC) report is scheduled for release June 15. The report proposes several positive recommendations involving rural health issues:

- It provides policy recommendations related to patient reimbursement.
- It recommends a low-volume adjustment.
- It calls for phasing out some of the wage index costs for teaching physicians.
- It asks the DHHS Secretary to examine some of the issues related to the wage index in terms of what constitutes a local labor cost or a national labor cost.
- It recommends increasing the current disproportionate share hospital (DSH) payment cap of 5 to 10 percent.
- It proposes that peer review organizations within Medicare provide more assistance to rural hospitals and rural communities.

The MedPAC report also portrays some weaknesses. It insinuates that there is not much of an access difference between urban and rural communities, a perspective that could engender some interesting debate after the document's release. It also does not address the question of

the viability of a Medicare outpatient program and the home health PPSs that were first introduced last year.

Mr. Morris noted that the House Rural Health Care Coalition and the Senate Rural Health Caucus will likely introduce their own omnibus bills, which are a collection of different issues, before the release of the MedPAC report. Discussion is still ongoing about whether to include several of the recommendations from the report in this piece of legislation. The House Ways and Means Committee has not yet committed to mark up legislation related to rural communities. ORHP is waiting until after Dr. Mueller testifies before that committee during the week of June 10 before offering a reaction.

Discussion

Dr. Mueller questioned the status of a couple of regulations included in the implementation of the Balanced Budget Act of 1997 (BBA) (e.g., the Medicaid regulation on a sole Medicaid managed care plan in rural areas) and whether a system is in place to track these kinds of regulations. After commenting that he did not know whether a mechanism of this type is still in existence, Mr. Morris noted that the Medicaid managed care rule is currently working its way through DHHS, after which it will be sent to the Office of Management and Budget (OMB) for review. He also mentioned that two rules associated with BBA involving the ambulance fee schedule and rural health clinics (RHCs) are still outstanding but that a rehab hospital PPS rule from the Balanced Budget Refinement Act of 1999 (BBRA) will be introduced soon, although how the minimum data set applies to it is still being debated.

In response to a question about the distribution status of the Advisory Committee's Medicare Reform: A Rural Perspective report, Mr. Morris said that in addition to sending the report to the Secretary, the DHHS Office of Communications has been asked to issue a formal press release announcing the document's release. Even though it has been posted on the Web and is a matter of public record, the report will be withheld from the general public until ORHP receives final approval from the Secretary's office. At that time, Mr. Morris will inform Advisory Committee members through e-mail about the report's next steps.

Public Health Proposal: Overview and Brief Discussion

Alison Hughes, Advisory Committee Member
Stephanie Bailey, Advisory Committee Member

Ms. Hughes and Dr. Bailey provided NACRH members with an outline of their proposal to create a flexible funding stream and technical assistance through a community assessment process so that public health facilities can improve quality and accessibility of public health

resources in rural areas. Ms. Hughes explained that their proposal is an extension of recommendations presented in the recent NACRH commissioned report titled Rural Public Health: Issues and Considerations and in two reports by the National Association of County and City Health Officials (NACCHO) titled Assessment Protocol for Excellence in Public Health and Mobilizing for Action Through Partnerships and Planning. The overall goal of this project is to implement a joint Federal-foundation-supported pilot program to conduct community public health assessments at the local level.

Dr. Bailey's initial interest in this public health proposal stemmed from her experience touring the hollows during the NACRH onsite visit to Hazard, Kentucky. She was appalled by the squalid housing conditions, the lack of proper sewage and sanitation, and the lack of a basic public health system. Dr. Bailey concluded from this site visit that rural communities, similar to Hazard, could benefit from community public health assessments to help identify and prioritize local health needs and from the allocation of Federal funds to support specific health care initiatives. Local leaders, representatives, and other health care stakeholders would be asked to participate in all community-level decisionmaking and priority setting.

After several Advisory Committee comments, Ms. Hughes concluded that a decision by the Committee to support the development and implementation of the proposed pilot project need not be immediate and will probably require additional thought and discussion during subsequent NACRH meetings. She also noted that there were similarities between her proposal and the ORHP-supported Delta Project (the RFP will be out shortly) and asked whether there could be some joint effort on the part of the two initiatives. Ms. Rafiullah believed this to be a good idea and will brief Dr. Brand on the matter. Ms. Crow noted that Oklahoma conducted a project similar to the Delta Project with the Choctaw Nation and agreed to send the project's report to Ms. Rafiullah.

Dr. Wakefield voiced several concerns about the public health proposal as worded. Although she endorses the effort, she believes that the Committee needs to explore more thoroughly some of the political and environmental issues involved before it agrees to support an endeavor of this scale. Specifically, the initiative should determine the type of funding level to use-who receives the funds and over what period of time-and should identify other players who could offer assistance, such as the American Public Health Association, any of the community access program (CAP) agencies, and possibly a NACRH subcommittee to help develop outcome measures. Ms. Gonzales-Hanson added that more details need to be provided about the use of year one funds for conducting the community public health assessment.

The 2001 Project: A Targeted Look at the Rural Safety Net

Review of the February Charge

Mr. Morris gave a brief overview of the Advisory Committee's decision made at the February 2001 meeting to take a targeted look at the rural health care safety net for submission in its annual report to the DHHS Secretary. Respective speakers at the February meeting from the National Association of Rural Health Clinics and the National Association of Community Health Centers greatly influenced this decision. This project will focus on specific rural safety net issues that fall under the purview of the Secretary and will try to avoid duplication of previous work already produced by the Institute of Medicine and the Urban Institute.

Appointment of a Subcommittee and Chair

Ms. Crow, Ms. Gonzales-Hanson, Ms. Richardson, Ms. Hughes, Dr. Singleton, and Dr. Mueller agreed to serve on an NACRH subcommittee to help in the preparation of the safety net report. Dr. Mueller agreed to serve as the liaison between what the Advisory Committee is doing and what some of the research centers might be doing. Ms. Gonzales-Hanson agreed to be chairperson. The subcommittee's duties will include participating in one conference call, helping to develop the report's outline with the contractor, reviewing the first draft before full review by the Committee, and sending the final product to the Secretary. Noting that this report will not be as involved as either the public health report or the Medicare reform report, Mr. Morris asked that the rural safety net report be completed by the February 2002 meeting.

Discussion on the Proposal Framework

Advisory Committee members were asked for their thoughts about the preliminary report outline as presented in the conference binder. Several members suggested including health departments, individual practitioners, and free health care delivery to the list of safety net providers. Dr. Eckstat, a proponent of free care, explained that those individuals or clinics providing this type of care need to know the proper avenues to better access some of the different Federal funding streams that are currently available. Previously, access to Federal funds has been a cumbersome and time-consuming process. Ms. Richardson mentioned that many States now operate well-organized and well-managed voluntary free care and that this fact should be noted in the report. Additional suggestions from the Advisory Committee are as follows:

- Emphasize the need to facilitate the move of more free clinics into the Federally Qualified Health Centers (FQHCs) program.
- Note the increasing trend of rural health centers (RHCs) and FQHCs developing relationships with behavioral health agencies and the possibility of these agencies becoming part of the safety net.

- Concentrate on quality outcomes (i.e., overall health outcome or health status of a community), not just access to care.
- Include dental, training, and education as part of the safety net mix. Note the deficit of health care providers in rural America and the need to train the next generation of professionals.
- Determine who the primary providers are of the rural safety net.
- Decide on a definition for safety net as it pertains to rural communities (a possible task for the subcommittee).

Dr. Mueller cautioned the Committee not to get locked into thinking only about those providers who are normally considered safety net providers (e.g., FQHCs, RHCs, free clinics) but to consider other issues such as

- Financial issues. Some type of funding mechanism is necessary to provide compensation above a certain level.
- Cultural issues. In many parts of the country, the mix of people and the mix of people with needs are changing considerably, as shown by the 2000 census data. Therefore, the rural health care safety net's financial need should be modified to reflect this change and to ensure that new groups of people are included.
- Outreach issues. The rural safety net should make better use of outreach components such as the Children's Health Insurance Program (CHIP). Many of these programs are not receiving high enrollments in most States.

In addition to those issues, Ms. Richardson suggested that the report look at (1) how classes of providers are created, (2) how providers are educated, and (3) the lack of flexibility to place providers in communities where they are best needed. At the end of the discussion, Mr. Morris introduced Tom Rowley, the contractor charged with pulling together the rural safety net report. The Advisory Committee members were encouraged to share their thoughts or ideas about the rural safety net with Mr. Rowley.

Maintaining the Rural Health Care Delivery System Safety Net

Dr. Nesbitt informed the Advisory Committee members that the following presentations on the rural health care delivery system safety net would provide important data that could be used in the Committee's upcoming report on the subject. He introduced each speaker in turn.

Challenges Facing California's Rural Health Care Providers
Sharon Avery, Executive Director, Rural Health Care Center,
California Healthcare Association

Ms. Avery provided Advisory Committee members with an overview of rural hospitals in California and the many challenges facing California's rural health care providers today. She began with a discussion about the size and service characteristics of the 71 small and rural hospitals that serve the State's 2.6 million rural residents. Of these 71 hospitals, 41 are

classified as sole community providers, 10 are rural general acute care hospitals, 39 have hospital-based RHCs, 51 operate skilled nursing services, and 20 have swing beds. Most of the hospitals are not-for-profit and few are county-owned.

After diagnostic-related groupings (DRGs) were implemented, outpatient care began to increase in rural areas while use of inpatient services began to decline. This trend resulted in financial loss for rural and small hospitals. For example, these types of hospitals are now facing a minus 3.9 percent patient-operating margin; 76 percent of them lost money on operations in 2000, and together they carried $61 million in bad debts; and more than 20 percent have closed or have entered into bankruptcy over the last 3 years. Other forces responsible for significant changes in rural hospital care include implementation of the changes to the Medicare program under BBA, BBRA, and the Benefits Improvement and Protection Act of 2000 (BIPA).

Under BBA, Medicare payments will be reduced for services associated with RHCs, home health, skilled nursing, and acute care. In addition, RHCs face a phase out of Medi-Cal cost-based payments and a cap on provider-based clinics (rural hospitals under 50 beds are exempt). Clinics are restricted to areas designated as shortage areas within the last 3 years and are allowed no more "grandfathering." BBA also states that RHCs that lose their health professional shortage area (HPSA) designation cannot continue unless they are "essential to the delivery of primary care services that would otherwise be unavailable." To be exempt from this ruling, RHCs must meet certain criteria: (1) they must be sole community providers, (2) they must participate in graduate medical training/physician training, (3) they must be specialty providers (e.g., pediatrics, OB-GYN), and (4) they must be major community providers.

In addition to the implementation of the changes to the Medicare program, the State of California employs its own set of forces that helps in the erosion of rural health care providers and RHCs. The State requires RHCs to implement 8-hour workdays and specific nurse/staff ratios. Small and rural hospitals must adhere to SB 1953 that requires hospitals to meet Hospital Facilities Seismic Safety Act standards. To meet these standards, hospitals must replace or retrofit all general acute care inpatient buildings (1) to a level by 2008 that they will not collapse and (2) to a level by 2030 that they remain operational. Other State impediments to the viability of rural providers include the challenge of access to capital, increased energy costs, an HMO exodus from rural areas, and a weak local economy. Rural communities in California have not experienced the economic boom like other areas in the State.

The shift to the outpatient PPS will also have a significant impact on California's rural and small hospitals. Some of the negative changes caused by this shift to a more sophisticated reimbursement system include (1) providers are placed in a risk management position; (2) small hospitals have to deal with fixed costs and low utilization; (3) a new, more complicated business

operation is required; and (4) assessment and coding, a critical function, will require additional staff and training. On the positive side, PPS is considered by some health care providers as a fairly reasonable reimbursement system, especially if it is updated regularly, for several reasons. First, the system increases the ability to predict cash flow; second, it may support better clinical care for patients; and third, it increases pressure to make sure costs are in line with the average cost of health care.

Furthermore, there are a number of internal problems that can contribute to the failure of a small or rural hospital. Individual facilities must undertake a portion of the solution to these problems themselves to help strengthen their operational and financial base. Some of these internal problems that can restrict a rural hospital's success include

- Lack of organizational structure due to limited resources
- Lack of proper training and access to appropriate continuing education
- Limited professional abilities to maintain today's sophisticated health care delivery system
- Lack of the community's understanding of the industry and the requirements placed on acute care providers
- Difficulty in recruiting and retaining quality staff

A possible solution to some of the smaller and critically located rural hospitals lies in the CAH program. This program is a BBA provision requiring that eligible hospitals have under 15 acute care beds (25 beds if the facility has swing beds) and are located 35 miles (15 miles on mountain roads) from another facility. Of the 25 eligible CAH hospitals in California, 8 are in metropolitan statistical area (MSA) counties. Even though these eight facilities are in extremely poor and rural communities, they are located geographically in very large counties that contain metropolitan areas, so therefore they are not considered rural hospitals by the Centers for Medicare and Medicaid Services ([CMS] formerly called the Health Care Financing Administration or HCFA).

Ms. Avery explained that OMB sets MSA and non-MSA standards to "provide nationally consistent definitions for collecting, tabulating, and publishing Federal statistics. (The smallest unit one can retrieve data from is a county.) These standards do not equate to an urban/rural classification and are often inappropriately used, such as for implementing nonstatistical programs and for determining program eligibility. CMS has a tendency to use these statistics in this way.

She also noted that the financial situation is fairly grim for the whole health care industry in California. The operating margin for all hospitals, including CAHs and rural hospitals, is below 0 percent, which is cause for concern. More than 20 percent have closed or filed for bankruptcy in the past 3 years.

In conclusion, Ms. Avery offered several suggestions to be included on her wish list:

- When defining rural regions, always include either nonurbanized areas as defined by the Census Bureau and rural census tracts within MSA counties (Goldsmith model) or accept State-defined rural areas.
- Sustainability for rural telemedicine applications must be addressed through additional funding for site coordinators and/or communication charges.
- Incentive programs for nurses working in underserved rural areas are needed to help alleviate nursing shortages.
- Training and technical assistance needs of rural providers must be addressed as they try to keep up with reimbursement and regulatory demands.
- The effects of the ambulatory payment classification on small hospitals must be carefully reviewed.
- The effects of proposed reimbursement and regulatory changes on small rural communities must be carefully analyzed prior to enactment.

Building a Rural Provider Network
Speranza Avram, Executive Director, Northern Sierra Rural Health Network

Ms. Avram presented an overview of the Northern Sierra Rural Health Network (NSRHN), its structure, history, and key challenges, and a description of its current projects, such as the NSRHN Regional Telemedicine System, as well as other issues. She explained that the network is a consortium of rural hospitals, RHCs, and public health departments located in eight rural counties in the northeast portion of California. The network came together in 1995 to determine what effect the new managed care system would have on rural providers. Since that time, NSRHN has been promoting the health and well-being of the 300,000 rural residents who live in this isolated part of the State regardless of their ability to pay.

Incorporated in 1996 as a nonprofit, tax-exempt corporation, NSRHN has a 15-member board representing primary care clinics, FQHCs, rural hospitals, and other health care providers in the 8-county region. Its membership currently includes 40 health care providers consisting of 100 percent of the primary clinics in the region, all but two rural hospitals, one-half of the public health departments, and two regional tertiary hospitals. The network structure primarily aggregates health needs in these remote counties, designs regional solutions to rural health care problems, and secures funding or resources to help implement these solutions. More specifically, some of the key issues addressed by NSRHN that affect the role of rural health care providers in these areas include the large number of uninsured and low-income patients, the location of specialty and tertiary care many miles away from the patient, the difficulty in recruiting and retaining all types of health care providers, and the shrinking local, State, and Federal support for rural facilities.

After receiving a 3-year rural network grant from ORHP in 1997, NSRHN immediately began to improve the quality of health care for the rural communities in this area and to expand access to this care, particularly specialty care. To help do this, the NSRHN Regional Telemedicine System was activated in 1999. The network maintains the telecommunications and infrastructure for this complex system so that rural community hospitals can conduct special consults with larger medical centers in northern California through T1 lines. NSRHN's other projects include promoting the use of technology to improve community health through regional technology solutions, providing support services and technical assistance to safety net providers, and promoting collaboration between primary care and county mental health providers to improve mental health services.

Recently, the NSRHN board and its membership determined that mental health was one of the major issues facing primary care providers today. Local providers indicated that between 25 and 75 percent of their patients are tackling either primary or secondary mental health issues. Because of the high number of patients and because of the lack of psychiatrists in this region, many mental health issues are being addressed by either primary health care providers not trained in psychiatry or midlevel mental health practitioners. Also there is an apparent disconnect between the development of county mental health systems and primary care systems possibly due to provider training or funding issues. To help bridge this gap, NSRHN is currently working with the California Institute for Mental Health on a conference slated for fall 2001 to bring the county systems and primary care providers together to explore unique aspects of primary care/mental health collaboration in a rural context. The use of telemedicine is another way of bridging this gap.

Since its inception in 1996, NSRHN has made great strides toward fulfilling its goals. Some examples of the network's successes are as follows:

- Telemedicine now links patients with needed specialty care. NSRHN recently received funding for 2 more years, for both site coordinators and the equipment warranty for all 25 sites.
- Video conferencing has expanded educational opportunities for isolated providers and has helped with retention.
- Capital funds have increased (more so for clinics than for hospitals).
- Private, State, and Federal support for rural health providers has increased.
- NSRHN now has a regional rural voice to affect policy agendas.
- With help from the Centers for Disease Control and Prevention, NSRHN was instrumental in California's adoption of a frontier designation (the Health Manpower Commission).

Ms. Avram closed her presentation by asking for continued Federal support for a number of rural health concerns. She specifically requested

- Continued and expanded support for both emerging and ongoing rural health networks
- Expanded support for telemedicine so that technology can be used to improve patient access to care
- Recognition of the unique data collection and reporting challenges of rural communities that affect NSRHN's ability to qualify for Federal programs (e.g., 330 funding programs)
- Development of a more flexible approach to Federal funding by removing the categorical strings that are currently attached to grants
- Recognition that rural health will always rely on subsidy to maintain access to needed services for rural communities

Discussion

In the discussion that followed Ms. Avram's presentation, several issues were raised:

- Dr. Bailey asked whether more human resources (e.g., counselors, mental health specialists) could be used to alleviate the psychiatrists' heavy patient load in NSRHN's geographic area. Ms. Avram replied that midlevel mental health practitioners can meet many of the needs of mental health patients, and in fact, NSRHN is developing a project to find funding to place more midlevel mental health providers in rural clinics and to link these clinics with other psychiatry programs throughout California.
- In addressing a query about the data collection and reporting challenges of rural communities, Ms. Avram noted that a number of problems exist with the use of county-level statistical data for rural areas. Because accurate reporting of data directly affects a rural community's ability to qualify for Federal programs, the State needs to reevaluate its methods of data collection-possibly collecting data by subcounty units.
- Ms. Hughes noted that in Arizona individuals with no advanced degrees provide much of the behavioral health care. It is now mandatory that these individuals receive extra training in their field, resulting in funding and course accessibility problems. Ms. Hughes asked if similar problems existed in California. Ms. Avram noted that in her State Medicare pays for mental health services, counseling provided by a licensed social worker, and therapy by a marriage family therapist. Because of Medicare reimbursement, California has many midlevel mental health practitioners, especially in rural areas. The problem lies in attracting more midlevel practitioners to these rural communities to provide these services and linking them to psychiatrists who can provide backup care and medication management.

Community Hospital Network-Outreach Model
Patricia Keast, Rural Affiliation Officer, University of California at Davis Health System

Ms. Keast's presentation focused on an overview of the Community Hospital Network, which was developed by the University of California at Davis (UC Davis) in collaboration with numerous rural health providers. This innovative model provides the expertise and resources of the UC Davis Health System (UCDHS) and extends them into rural communities in California to support the delivery of care in those communities as well as the viability of their rural health systems. She also discussed how telehealth and Internet technologies are being used to expand resources into these areas.

Ms. Keast began her discussion by noting that rural health care providers face a multitude of challenges today. One of the most significant challenges is the maldistribution of clinical resources. Some patients drive 4 or 5 hours to receive health care services located in more urban settings. To address this problem, UCDHS developed a couple of strategies. First, it trained primary care physicians and midlevel practitioners with the help of Federal training dollars as a vehicle for extending services into rural communities. The training, which emphasized the rural aspect of health care as well as rural rotations, was conducted through the UCDHS Rural Residency Track Training and Rotation programs. Second, it established a regional community hospital network with a number of rural hospitals.

Established in 1997, the Community Hospital Network (CHN) focuses on improving the quality and access to health care service delivery in rural areas through telehealth technology and its communication information systems, as well as through continuing medical education (CME) and continuing nursing education (CNE). Unlike the managed care delivery system, the CHN created an integrated delivery system based on the structure of a hub/spoke model. This model emphasizes the critical importance of the primary care physician in the rural community and the hospitals and clinics as the portal through which the patient enters this integrated system.

CHN supports the independence of the hospitals that are part of this integrated network by creating closer linkages between clinicians at UC Davis and clinicians in rural communities (telemedicine plays a key role) and by reinforcing the primary role of local providers as the managers of care in their communities. Some of the services provided to CHN members include

- Video-based specialty consultations and teleradiology services
- Onsite and video-based CME and CNE
- A clinical resource center-an Internet-based program in which rural physicians can access clinical information from a variety of sources
- Grant collaboration
- Referral coordination and clinician communication
- Specialty service partnerships

As part of her discussion on telehealth at UC Davis, Ms. Keast noted that the strategy was launched in 1992 with a telefetal monitoring linkage between the UCDHS obstetrics department and a hospital on the brink of closure because it had lost its only obstetrician. Establishment of this link was a contributing factor in saving the hospital. In 1996 the use of video consultation was first introduced, and through a grant from ORHP and the Office for the Advancement of Telehealth (OAT), the Northern California Rural Telemedicine Network was established. At that time there were only four hospitals in the network. During the following year, the telemedicine sites expanded into rural clinics with help from a USDA Rural Utilities Services grant. As more Federal dollars were used to increase the network of telemedicine sites throughout California,

State "funders" and private foundations became more interested in the use of telemedicine as a way to address issues of rural access to care.

Today, the UCDHS telehealth program provides more than 3,500 video consultations in over 25 different specialties, with consultation provided at 50 different sites. It has moved from an ambulatory care setting into an inpatient pediatric and adult critical care venue. With a recent grant from OAT, the availability of the telehome health network is being expanded throughout several rural areas in California. UCDHS will soon launch a program to conduct adult intensive care with different hospitals.

Although tremendous progress has been made over the last 5 years in creating the networks of telemedicine linkages, efforts need to continue in several areas to sustain the system:

- Medicare reimbursement must be expanded to include all telemedicine modalities in all suburban and rural sites.
- Telemedicine site coordinators, technicians, and clinicians must continuously be trained and retrained. Access to this training must be increased.
- Affordable connectivity in rural areas must be improved.

At the close of the presentation, Dr. Eckstat asked about who will be responsible for paying for the telemedicine program in the "real world." Dr. Nesbitt responded that in California law dictates that third-party payers, the State Medicaid program, or Blue Cross will cover the costs of the services.

Model Rural Hospital Design Project
Catherine Quinn, Executive Director, California Health Collaborative

Ms. Quinn provided NACRH members with an overview of the California Health Collaborative and its current projects, with particular emphasis on its model rural hospital design project. She noted that the collaborative, with 5 offices and a $15 million annual operating budget, is currently involved in a number of programs throughout California, including breast cancer screening in all 58 counties, 2 cancer registries, 3 teenage pregnancy prevention programs, and 5 tobacco programs.

Ms. Quinn then explained that one of the major public health challenges the California Health Collaborative is facing in its conglomerate of services is the continuance of a rural safety network. To that end, the collaborative is now supporting an endeavor called the Rural Health Design Consortium. The major impetus for the formation and emergence of the consortium is the recently passed SB 1953 requiring that all acute care hospitals in the State meet stringent seismic safety standards by 2008. If these requirements are not met by that time, the hospitals lose their acute care designation. This regulation, together with the fragile financial condition of

California hospitals and the lack of capital funding needed to meet these kinds of requirements, places the State's safety net providers in a precarious position.

On the other hand, the Rural Health Design Consortium, whose primary goal is to ensure that residents in rural communities have continued access to health care services, believes that these seismic regulations provide an opportunity to actually rebuild existing hospital facilities in a way to better serve both patients and providers. A coalition of 23 small rural hospitals (i.e., with an average daily census of 15 patients or less and located at least 30 miles or 30 minutes from another acute care facility) is now emerging to explore and respond to SB 1953. These 23 hospitals provide health care to some of the most isolated parts of the State.

The Rural Health Design Consortium has established a framework to identify the minimal requirements for a core hospital facility that could be built as a model for retrofitting rural acute care facilities meeting the criteria for census and location. The consortium also is evaluating feasibility and demand for services in each rural area to help determine what the very small rural hospitals of the future should look like. Block funding is being sought from a variety of sources for the planning and building process.

The core facilities will be specially designed, with input from community members and local health providers, to be more efficient and more responsive to the current market. Retrofitting existing hospitals to meet seismic standards without the benefit of a model could result in a continuance of the same inefficiencies of operations as before-the same nursing shortages, the same difficulties with the use of complicated codes, and the same high maintenance costs-both in human and natural resources.

The Rural Health Design Consortium is now in phase 1 of the 4-phase initiative. Twelve hospitals have already pledged their boards of trustees and offered start-up funds. The consortium has engaged several design consultants and is in the process of reviewing design requirements and evaluating individual markets. It is working closely with the Office of Statewide Health Planning and Development to ensure that all clearances and approvals are relevant to the regulations. Funds will be allocated in phase 3 of the initiative, and the core facilities finalized in phase 4.

The cost of this project depends on the number of participants. At present, 12 of the 23 small hospitals have committed with board resolutions and payments of $5,000 each. Phases 1 through 4 will cost about $45,000 to implement, with an additional cost of $40,000 to complete the construction documents.

The idea of small hospitals coming together to develop a model, and ultimately core facilities, that addresses economies of scale could have value and application throughout the United States. Several other States have already contacted the Rural Health Design Consortium about its design model initiative.

Rural Migrant Health Services
Elia Gallardo, Migrant Health Coordinator, California Primary Care Association

Ms. Gallardo spoke about health care problems facing today's California farmworkers, one of the largest uninsured industries in the nation, and some of the solutions being offered by local community and migrant health centers. She began her presentation with an overview of the farmworker population, which numbers about 1.3 million in California. About 61 percent of the national farmworker population lives under the Federal poverty line, with an incredibly low annual income of between $5,000 and $7,000 per year. This ethnically diverse population is a family-oriented community made up of a large contingency of Mexicans and aging nonmigrant workers.

In 1999 the California Institute for Rural Studies conducted a baseline health status analysis of California's agricultural workers. The findings included the following:

- The male farmworker population had higher serum cholesterol than the U.S. adult population.
- Male and female subjects exhibited higher blood pressure than their U.S. adult counterparts.
- About 81 percent of male subjects and 76 percent of female subjects were in the unhealthy weight category.
- More than one-third of male farmworkers had untreated tooth decay. One-half of the male subjects and 44 percent of the female subjects had never seen a dentist.
- Nearly 70 percent of the sample subjects lacked any form of health insurance.

Ms. Gallardo explained that a significant portion of this population is income eligible for Government-sponsored and State-sponsored health care, such as Medicaid, Medi-Cal, and the State Children's Health Insurance Program (SCHIP), but is not participating. One reason for this is that State subsidized health care is often poorly suited to address the needs of most farmworkers. The migrant population is predominantly covered under Medicaid or Medi-Cal in California. The problem is that in mixed families some members are Medi-Cal eligible, some are SCHIP eligible, and some are not eligible for either one.

Although much of the farmworker population is eligible for Medi-Cal, it still faces huge barriers to this county-based system. There are portability issues of migrants spending only a couple of months in California, then moving on to Oregon and Washington with the picking season. Medi-Cal also entails unnecessary verification and reporting requirements. A lot of paperwork,

including numerous forms, is also required with both Medicaid and the SCHIP program (less paperwork is required in Mexico). Other barriers to Medi-Cal include restrictive immigration policies and cultural, illiteracy, and linguistic competence issues. Furthermore, some of these programs do not address the needs of independent single adults.

To address these barriers, California has created some innovative programs-the Seasonal Agriculture Migratory Worker Program and rural demonstration projects/special population initiatives (under SCHIP). To be eligible for the Seasonal Agriculture Migratory Worker Program, health care providers must serve at least 25 farmworkers as part of their patient load. The program's intent is to improve accessibility to comprehensive primary and preventative health care for this population and to avoid the high cost of emergency room care. The rural demonstration projects have created a portable insurance product specifically designed for the farmworker population. They target rural areas likely to contain significant levels of uninsured children, including children of seasonal and migrant workers. Currently, about 1,000 farmworkers are enrolled in these projects.

New opportunities are surfacing to serve this migrant population. A new SCHIP 1115 demonstration waiver has been introduced to expand the portable model to include the Medicaid population, which would increase the current enrollment considerably. Efforts are now under way to provide health coverage for all parents, including qualified immigrant parents, up to 250 percent of the Federal poverty line. (It is currently 200 percent of the Federal poverty line.)

Next, Ms. Gallardo spoke about local community/migrant health centers and their commitment, as a safety net link, to all populations located in medically underserved areas and in HPSAs. These centers are one of the only national networks in which farmworkers can get primary and preventative health care. In 1999 these networks served 2.7 million patients and provided service to 9 million medical/dental encounters, 2 million of whom were uninsured. About 1.7 million of these patients were under 100 percent of the poverty level, 44 percent spoke limited English, and 370 were farmworkers.

Discussion

Dr. Singleton asked whether SCHIP-eligible or Medi-Cal-eligible patients have the proper access to the care they need. Ms. Gallardo responded that much of this population seeks health care in Mexico because of the absence of cultural and linguistic barriers and extensive paperwork.

In replying to a concern about linguistically appropriate providers, Ms. Gallardo admitted that recruitment and retention of rural providers who have the necessary language capabilities is a considerable challenge. She also mentioned that another problem associated with cultural competence is the preference of alternative medicines by seasonal farmworkers. Traditional healers who prescribe homeopathic types of medicine often migrate with the farmworkers.

Public Comment

Laurie Paoli, Executive Director, California State Rural Health Association

Ms. Paoli offered Advisory Committee members another perspective about the condition of rural health in California and an understanding of the challenges and successes surrounding safety net providers and health care in the State. On the basis of her travels visiting health care professionals and facilities throughout rural areas in California, Ms. Paoli found that

- Of the 4 million people who live in these areas, 20 percent have no insurance coverage.
- Adequate health care has decreased, many hospitals have closed, and a number of rural health clinics have entered into bankruptcy.
- An estimated 78 percent of rural citizens have no access to a medical HMO, and the number of doctors, nurses, and other health professionals has decreased.

Other problems with rural delivery uncovered by Ms. Paoli were the stigma associated with welfare clinics, the high turnover rate among rural health providers because of financial hardships, and the difficulty of developing policies, regulations, and laws that are both equitable and suitable for these providers. On a positive note, it appears that rural health facilities are still attracting patients and health professionals and are continuing to provide dedicated quality care in "the rural way," a term coined by Ms. Paoli. The term implies that these types of facilities, with their limited resources, always keep the doors open and are committed to serving a large population of people "who tend to be older, sicker, and poorer than a decade ago."

Dr. Nesbitt closed Sunday's meeting by thanking all participants and presenters. He extended an invitation to those present to attend a reception sponsored by the California Health Care Association and the UC Davis Health System shortly following adjournment.

Monday, June 4

Overview of Site Visits

Tom Nesbitt, Acting Chair

Before departure, Dr. Nesbitt gave an overview of the three sites that the NACRH members were scheduled to visit by bus. Brief descriptions of these sites follow:

- Placer County Medical and Public Health Clinic, Kings Beach-This facility is a fully functional health department with an impressive array of services. Dr. Richard Burton, public health officer for Placer County, gave a brief history of the public health structure in Placer County. He explained that through integration efforts conducted by Placer County's Board of Supervisors and other community advocates, the clinic has made significant improvements in its primary care for both Medicaid and Medi-Cal populations over the years. Recently, the Placer facility was remodeled to support a dental clinical after a survey showed low performance in local schools due to lack of proper dental services.
- Eastern Plumas District Hospital, Portola-This facility converted to a CAH after experiencing severe financial problems and a rapid turnover of hospital administrators. Charles Guenther, the hospital's current administrator, is scheduled to brief the Committee on the strengths and weaknesses of CAHs and the challenges his hospital is now facing.
- Plumas District Hospital, Quincy-Three years ago this facility was selected as one of the top 100 small hospitals in the United States by Modern Health Care magazine. The hospital, managed by Michael Barry, includes a number of primary care physicians, obstetric services, and a clinic.

Next, Fred Johnson, Executive Director of the Rural Health Policy Council, explained how district hospitals are structured. He noted that of the 71 small and rural hospitals in California, 29 are district hospitals. In the late 1940s and early 1950s, resident community voters agreed to carve out health care district boundaries to generate a tax base for the hospitals. Each hospital district is run by a Board of Supervisors composed of five members elected by resident voters. Each district is considered a branch of local government because it is governed by its own community residents.

Placer Country Medical and Public Health Clinic

Marylee Drake, Director

Dr. Burton and Ms. Drake, director of the Placer County Medical and Public Health Clinic, briefed the Advisory Committee on the clinic's services and the special challenges it faces serving a culturally diverse population. The facility, which has been in existence 6 years, provides a number of primary care and preventive services such as family planning, child health care, psychiatric care, immunization, HIV screening, and dental care. It treats about 25 to 30 patients per day.

About 60 percent of the clinic's patients are Hispanic migrant and immigrant workers serving the recreational industry in the Lake Tahoe area. A large percentage of this population speaks minimal English, thus challenging the clinic to have translators available on staff 24 hours a day.

Many are medically indigent, underinsured, or ineligible for a third party payer system. Only a small portion of this population receives Medi-Cal assistance because of the stringent income and residency requirements attached to this type of reimbursement. Although many of these migrant families qualify for SCHIP (Healthy Families), they are unable to use the health benefits because of the large number of private providers in the area who refuse to take on new patients. To add to this problem, some migrants refuse or are unable to complete the necessary paperwork. To help pay for patients with no medical coverage, the clinic uses funds from a $25,000 State grant. For the past few years, these funds have covered such services as primary care, mental health, dental, and laboratory.

Health conditions most often treated at the clinic are heart disease, cancer, sexually transmitted diseases (primarily chlamydia), diabetes, and liver disease (hepatitis C). Alcohol and drug abuse cases are on the rise, and dental decay is rampant, especially in the Hispanic population, caused by the lack of oral hygiene instruction and preventive care. The clinic does not provide home health care or telemedicine access.

After final comments by the clinic staff, the Advisory Committee toured the clinic.

Eastern Plumas District Hospital

Charles Guenther, Administrator

Mr. Guenther, joined by Christopher Stanton, chief of staff, spoke to the Advisory Committee about the Eastern Plumas District Hospital's history, its past and current medical services, its financial status, its economic impact on the community's health care, and its experience in becoming California's first CAH. The hospital opened in 1968 and was first managed by a large tertiary care facility from Reno, Nevada, from 1985 to 1990 and then by Brim Health Care from 1990 to 1995. Management by both organizations resulted in a decline in hospital services and then finally in bankruptcy in 1995. With help from UC Davis, Mr. Guenther and his staff toiled to rebuild the facility, experiencing success until the regulations under BBA affected its recovery.

Despite bankruptcy and the impact of BBA, Eastern Plumas District Hospital has managed a profit in 4 of the last 6 years. It has also implemented a series of changes to improve medical services to better meet the needs of the community. These changes include

- Reduction of emergency services.
- Addition of new physicians and specialties (e.g., teleradiology).
- Improvement in equipment (e.g., ultrasound). Through gifts from UC Davis and a grant from the Sierra Foundation, the hospital has been able to update its surgical equipment.
- Staff development to improve customer relations.

In addition to these changes, a number of new medical services were added such as telemedicine, teleradiology, internal medicine, orthopedic surgery, diabetes education, and a cardiology program. Although the hospital has experienced 4 years of profitability, the hospital's gross and net revenue has declined over the last couple of years, with further decline expected this year, indicating a great inconsistency in rural finances.

As a major employer in Plumas County, the county's health sector, which includes hospitals, clinics, dental offices, and pharmacies, has a total payroll of $24 million or about one-fourth of the total payroll of $100 million for all industries in the county. Eastern Plumas District Hospital contributes about $8 million to the local economy. Its 600-square-mile service area will soon increase to 1,000 square miles after it takes over another bankrupt hospital in the area.

Mr. Guenther then noted the top challenges facing Eastern Plumas District Hospital today. The primary challenge for the hospital is to battle bankruptcy and regain financial stability. One option is to cut back its services to the community. Other continuing challenges include maintaining a level of community understanding and support, creating and retaining medical quality in a rural area, addressing the growing shortage of qualified staff, keeping up with area growth and demand, meeting California's seismic standards, and reconciling reimbursement that is inadequate to support quality health care. A growing disparity exists between what it costs to provide medical care and what resources are available to rural hospitals.

Next Mr. Guenther spoke about Eastern Plumas District Hospital's experience in becoming a CAH. He explained that the facility applied for CAH status in April 2000 and, after meeting the prerequisites of the program, was certified in March 2001 (an 11-month process). After attaining CAH status, the hospital immediately experienced a cash-flow crisis. Other problems encountered at that time included (1) cancellation of provider numbers and issuance of new ones without prior notice, resulting in automatic denial of claims already "in the pipeline"; and (2) cancellation of the hospital's prospective interim payment agreement because it was attached to the old providers. The facility also was not receiving claims for outpatient services paid for the period immediately prior to the certification date as well as not receiving prospective payments. Furthermore, it received a $648,000 recoupment letter for failure to file a cost report on time (within 5 months of date of certification).

Mr. Guenther noted that since converting to CAH status, his hospital has lost any profit margin gained from DRGs on the inpatient side and has yet to receive any cost-based reimbursement. As a result of this delay in reimbursement, the hospital's accounts payable are climbing. Furthermore, the governor of California has vetoed State funding for the CAH program for the next 2 years. In anticipation of finding solutions to these problems, Mr. Guenther recommends several CAH policy changes:

- Advanced notice of new provider numbers must be given. Old numbers should be retired after 1 year (minimum 6 months) to allow for "the runoff in the pipeline."
- RHC productivity requirements/standards for physician assistants (PAs) and physicians must be adjusted because most rural hospitals are not run as efficiently as large urban multi-specialty practices.
- CMS must adjust the PPS requirements for RHCs on the basis that health care in rural communities is more expensive to provide because the cost-per-unit of service is higher.
- To make the system of cost-based reimbursement work more efficiently, CAHs should receive cost-plus reimbursement or grant money to increase their level of financial capital for investment in new programs, staff, or equipment.
- The wage index for rural health care facilities must be adjusted. Currently, rural facilities are having difficulty in recruiting competent staff.

Discussion

Ms. Hughes mentioned that other CAH-designated hospitals have experienced similar cash-flow problems as well as significant lag time between the issuance of new provider numbers and cancellation of the old numbers. Because CMS is currently addressing these issues, she asked whether recently certified CAHs are facing these same types of problems. Mr. Guenther acknowledged that he has received excellent cooperation from CMS officials and from fiscal intermediaries but that they still do not completely understand what a CAH is and the fiscal crises it can face. He suggested that a CMS representative visit his hospital and view the problems firsthand. To help Mr. Guenther achieve his CAH policy objectives, Mr. Morris suggested that he contact Terry Hill who runs a technical assistance center at CMS or contact ORHP directly.

In regard to a question about health insurance, Mr. Guenther responded that his outpatient volume is about 20 percent Medicaid and 50 percent Medicare. Although Medicare+Choice plans have largely been withdrawn from California's heavily penetrated managed care market, most of the Medicare beneficiaries are well covered by other supplementary plans. Because of the State's change in demographics, patients with private insurance have increased from 12 to 26 percent in the last 5 years, a substantial improvement according to Mr. Guenther.

A tour of the Eastern Plumas District Hospital followed the discussion.

Plumas District Hospital

R. Michael Barry, Administrator

After introductions from Committee members and hospital staff, Mr. Barry spoke about the 1997 selection of Plumas District Hospital as one of the top 100 hospitals in the United States, 1 of only 2 hospitals in California with less than 100 beds. Two other northern California hospitals

also were chosen for recognition: Mercy General Hospital in Sacramento and UCSF (University of California-San Francisco) Stanford Health Care in San Francisco. To help with this selection, HCIA, a Baltimore-based health care information company, reviewed statistical information on 7,500 hospitals nationwide, excluding specialty hospitals and those with less than 25 beds.

Mr. Barry attributes his hospital's success to a number of factors:

- A doubling in the volume of patients
- A fast move from inpatient to outpatient services
- An expansion of staff from 2.5 local physicians to 6.5 physicians
- An investment in state-of-the-art equipment and competent, qualified employees

In addition, Mr. Barry credits a new program implemented by Plumas District Hospital that is responsible for the hospital's increase in physician retention. This program allows all hospital-based physicians to be paid a percentage of the money collected for their services, a provision that makes their working environment similar to private practice. The hospital physicians also can earn extra money by moonlighting in the emergency room or by increasing their patient load.

Advisory Committee members were then given a brief history of the hospital, followed by presentations by several staff members. The current 26-bed facility, with 160 employees, was built in 1959 with money primarily from the Federal Hill-Burton program. Over approximately the next three decades, the facility expanded to include a new ancillary department in 1977, mammography services in 1981, ultrasound in 1984, a new x-ray addition in 1986, and a new CT scanner in 1998. Telemedicine services with UC Davis were added in 1999, and rotation of third-year residents from UC Davis Medical School started in 2000.

Linda Buddenbrock, a staff member who wears many hats at Plumas District Hospital, noted that implementation of Federal regulations, specifically with respect to Medicare, is very costly for rural hospitals, and many times penalties are enacted if a hospital is not in compliance. Larger hospitals are better equipped to absorb these costs, and even they are having difficulty meeting this increasing price tag. If rural hospitals are expected to comply with these various regulations and, at the same time, are expected to provide quality care in a safe environment, then funding must be attached to those regulations. Without that funding, rural hospitals may not remain viable.

Sherry Fengler, head of the hospital's human resources, explained that one of the biggest challenges facing this rural health care facility today is the shortage of nurses, radiological technologists, and medical technologists, which causes concern about the hospital's ability to effectively care for its patients. During the last 5 years, enrollment in the nursing program has

steadily declined, prompting the hospital to try and develop innovative solutions to the problem. Rural hospitals are at a distinct disadvantage because of the lack of funding available to attract and retain nurses; unlike urban hospitals, they cannot afford the $10,000 sign-on bonuses. Ms. Fengler urged the Advisory Committee to support two pieces of legislation that could possibly help this situation: (1) the Nursing Employment and Education Development Act (Senator Tim Hutchinson [R-AK]) and (2) the Nursing Reinvestment Act (Senators John Kerry [D-MA] and Jim Jeffords [I-VT]).

Dick Kuhwarth, the hospital's CFO, spoke about the Federal Government's long history of participation in rural health and the fact that its sponsored programs to fund RHCs and FQHCs have helped tremendously to sustain rural health care in California. Plumas District Hospital is a good example of the success of these programs. As a designated RHC, the facility has garnered a number of advantages from the reimbursement services and therefore is able to provide a well-rounded system of health care to the Quincy area. The RHC program and its adequate level of reimbursement have also allowed the hospital to

- Provide much needed employment to the community
- Provide both family health services and surgical specialties
- Implement an active program to recruit new physicians
- Compensate physicians well
- Facilitate the purchase of much-needed equipment

Mr. Kuhwarth expressed concern that the entire health care community built by Plumas District Hospital could be destroyed by changes made by CMS. He gave as an example the closing of many home health agency services as a result of CMS restrictions. He also asked the Committee to continue to support rural health services and adequate reimbursement levels.

In response to an inquiry about the Health Insurance Portability and Accountability Act (HIPAA), Mr. Kuhwarth believes it will be an expensive program to administer and questions whether the hospital will be able to comply with all the requirements involved. He is primarily concerned about the privacy issues and the cost of the equipment that will be required to secure those standards. President Bush also has expressed concern about HIPAA and is talking about conducting a cost-benefit analysis on the regulation, which could result in its termination.

Marian Gonzalez, comptroller, explained about the delays associated with filing the hospital's Medicare cost reports, which in turn delays the hospital's audit, which ultimately delays Medicare reimbursement. Other rural hospitals are also experiencing this hardship, which is perpetuated by other fiscal hardships caused by rising energy costs and mandatory seismic standards.

Chuck Chinevere, head of hospital maintenance and safety, added to the previous discussion about the problems rural health care is facing with the implementation of new regulatory requirements. Not only do these regulations threaten to close some rural health care facilities because of the lack of funding, but many are faced with the prospect of funding their own upgrades and expansions. As part of the Rural Health Care Design Consortium, Plumas District Hospital currently has a new design package ready for submission to the Office of Statewide Health Planning and Development but is unsure whether it can finance the plan. Mr. Chinevere agreed with the previous speakers that Government assistance is critical if rural health care is to survive.

Mr. Barry mentioned that Plumas District Hospital should receive State funds of $1 million for its expansion program, which includes an upgrade required by seismic regulations, an addition of a new surgery room, and an extension of the emergency room. For any additional expansion, it would cost Plumas District Hospital another $7 million. The hospital could receive funds from the Hill-Burton program, funds that the hospital would pay back over a certain period of time. Mr. Barry added that a bill has been introduced in Senate that would fund $1 billion to help California facilities adhere to the seismic regulations. But because of the dedicated advocacy of California hospitals, there is a possibility of another piece of legislation being introduced that would either find additional funding for implementation of these regulations, delay them, or abolish them all together.

During the Plumas District Hospital tour, designated staff members pointed out a number of problems facing the hospital. A primary concern is that Medicare reimbursement is less than the actual cost of providing the service. Hospital statistics show that reimbursement from Medicare is 39 percent of the service cost, and reimbursement from Medicaid is 22 percent. For example, the Medicare mammography payments are less than the cost of providing the screening procedure, and annual cuts to Medicare reimbursement make it impossible for the hospital's laboratory to earn even a small profit. The charge for a complete blood count is $62, of that sum Medicare covers $7.59. For other surgeries, the scenario is about the same. For cataract surgery, the total cost is $3,650, of that sum Medicare covers $662; for knee arthroscopy/surgery, the total cost is $3,700, of which Medicare covers only $955.

The obstetrician supervisor brought up the problem of the critical nursing shortage mentioned earlier. She noted that "the best and the brightest are going elsewhere" because of better incentive packages. Furthermore, the quality of the graduates has declined. Many are poorly prepared or stay only 1 to 2 years. She suggested recruiting early in high school, but added that a competitive salary would be the primary attraction.

The hospital staff concluded the site visit by asking the Advisory Committee to share the responsibility of continuing rural health care access by supporting the following:

- Senate bill S. 548 sponsored by Senator Tom Harkin (D-Iowa) to increase Medicare mammography reimbursement from $69.23 to $90
- Senate bill 824 (Medications Errors Reduction Act of 2001) to allow hospitals to apply for grants to purchase computer equipment, software, technologies, education, and training
- Reduction of the regulatory barriers that health care providers find burdensome
- Increased telemedicine funding for rural areas

Tuesday, June 5

Site Visit Review and Opening Remarks

Tom Nesbitt, Acting Chair

After a quick recap of Tuesday's site visits by Dr. Nesbitt, Ms. Rafiullah acknowledged the hard work of Dr. Nesbitt, Mr. Morris, and Mr. Johnson for their diligent preparation for this Squaw Valley meeting. Mr. Morris also thanked Caroline Ford, director of the Office of Rural Health at the University of Nevada, for her contribution.

Review of the Public Health Proposal and Committee Action

Advisory Committee Members

Ms. Hughes continued the discussion of her public health proposal that was first introduced during Sunday's meeting. She again pointed out the similarities between her proposal and the RFP for the Mississippi Delta proposal and speculated whether the Delta initiative could take advantage of her proposed public health assessment concept and perhaps collaborate with NACCHO in conducting a demonstration in the targeted Mississippi Delta area. For those Advisory Committee members who were unfamiliar with the Delta Project, Ms. Hughes explained that the Delta RFP is basically asking Delta States to conduct community health needs assessments and to development intervention plans tied to these assessments. In response to these comments, Ms. Rafuillah noted that the Delta proposal is close to finalization but that ORHP will try to encourage the inclusion of Ms. Hughes's proposed activities in the RFP.

Some Committee members expressed concern about the public health proposal. Ms. Richardson said that some States are trying to legislatively move their public health departments away from providing individual services and more toward a focus on public health, which is an entirely different agenda from the one being proposed. Community needs

assessments would be difficult to conduct because they are so service-oriented. Ms. Richardson asked whether NACCHO also sees public health departments as moving away from acting as individual service providers. In reply, Dr. Bailey explained that NACCHO's focus is on local public health systems, not individual agencies, and on ensuring that these systems are served by the essential public health services.

Other proposal concerns, some of which were already discussed during Sunday's meeting, included whether the proposal is actually operational, whether now is a politically opportune time for submission, whether the proper funding mechanisms and partnerships have been determined, and whether it fits in with the Advisory Committee's safety net initiative.

In response to a question about the similarities between the public health proposal and the Turning Point initiative, Dr. Bailey replied that there are similarities in that the Turning Point initiative also emphasizes creating systems to better coordinate State and local health care activities. In other words, the initiative focuses on strengthening the rural public health infrastructure by encouraging communication and interaction between State agencies and officials.

The discussion on the public health proposal ended with a motion by Dr. Wakefield to table the issue until the next meeting scheduled for September. The Committee unanimously passed the motion.

State Presentations: Federal Safety Net Issues in Rural Areas

Nevada Safety Net Legislation
Caroline Ford, Director of the Office of Rural Health, University of Nevada

Ms. Ford spoke about several pieces of legislation in Nevada involving safety net issues. The first bill discussed was AB 603 (the safety net bill), a governor-sponsored bill that establishes a $5 million trust to promote the availability of health care benefits for uninsured families in Nevada and to assist families in the State to access essential health care services. Ms. Ford's primary concern with this particular bill was that safety net providers were defined as those who provide a sliding fee scale and who present no financial access barriers to care for the uninsured, thus excluding a majority of the rural health practitioners from the funding. Although Ms. Ford did not support the bill for this reason, she did favor two of its components: (1) the $3 million set-aside for medical facilities to access new equipment or for start-up funds to build new practices, including new dental sites, and (2) the $1 million targeted as an incentive to community-based organizations to develop outreach programs similar to SCHIP and the Senior RX Program. AB 603 did not pass.

The second piece of safety net legislation discussed was a jointly sponsored bill (AB 350) that makes reimbursement available to FQHCs that provide primary health care to uninsured residents of Nevada. Basically, this bill involves the appropriation of $1 million to pay for uncollected monies tied to services provided to patients on a sliding fee scale or for fees that were not collected at all. This bill also did not pass.

Ms. Ford then discussed other pieces of legislation or options that either are under consideration or have passed in Nevada involving health care and dental access. One such piece, which is still in the strategic planning phase, calls for a 4-year extension of RWJ's "Covering Kids Program" in Nevada. This piece will be written as a grant instead of being proposed through a primary care association and will be submitted through the State Medicaid office to allow the State to match RWJ funds at 65 percent.

Another piece of legislation called the dental access bill (SB 133), which passed, authorized Nevada's Board of Dental Examiners to issue certain licenses, under certain circumstances, without examination or clinical demonstration to dentists and dental hygienists licensed in other jurisdictions. Specifically, dentists can apply for a restricted license to practice in Nevada providing they have been in good standing in another State for a 5-year period and have no prior drug or alcohol violations. The bill also requires them to work a minimum of 30 hours per week for a 3-year period. A major weakness of the bill is that issuance of a restricted license provides no incentives for dentists to practice in rural areas; therefore, it is believed many will opt for the high urban salaries.

The final piece of legislation discussed by Ms. Ford was SB 403, which enacts the Frontier and Rural Health Care Improvement Act of 2001. This piece, which is currently facing defeat, makes appropriations for certain medical services, training, and equipment, such as establishing a rural emergency medical services (EMS) training academy, enhancing the Nevada Health Service Corps Program, increasing mental health services, expanding a perinatal health care program that includes telehealth components, and developing incremental adjustments for rural practitioners and facilities under Medicaid.

In reply to a question about California/Nevada border issues, Ms. Ford noted that significant issues exist with telemedicine, transfer of information, and the licensing of health care professionals across borders, especially surrounding nonphysician practitioners. Because of a restriction limiting the number of PAs and nurse practitioners supervised by a physician, a special consideration had to be created for isolated and border areas. Ms. Ford also has had to grapple with Medicaid issues in both States. A few years ago, she participated in a Medicaid study that examined reimbursement and health care access issues in the eastern Sierra region of the two States.

Ms. Ford concluded by asking the Committee to craft a recommendation to the Secretary emphasizing the importance of having national standardized licensing for telemedicine. Currently each State has its own variation of requirements for licensing practitioners to perform any kind of service within State boundaries.

California Rural Health Policy Council Activities
Fred Johnson, Executive Director, California Rural Health Policy Council

Mr. Johnson provided an overview of the California Rural Health Policy Council (CRHPC), including its history, mission, structure, achievements, and benefits. He began by framing California's rural environment of 6 years ago before the establishment of CRHPC in 1996. At that time, rural health providers of California were having difficulty accessing State agencies because of their considerable size and organizational fragmentation. Overwhelming provider frustration eventually led to legislation that set up the Council as a model to make State government more accessible and responsive to California's rural safety net providers and to promote and support collaboration, communication, and networking among these agencies, as well as among rural constituency organizations and rural providers.

CRHPC serves all types of rural health providers, including 55 county health agencies (e.g., medical/dental, public health, and behavioral health), 71 general acute care hospitals, 300 licensed primary care clinics, 160 long-term care facilities, and hundreds of community-based organizations.

The Council, which consists of six State directors from California Department of Health and Human Services agencies, is collectively responsible for more than $30 billion in public funds. Immediately below the Council body is a coordinating committee composed of 20 senior midlevel managers designated from within each of the six agencies.

The Council performs five basic functions:

- Information services. Gathers and disseminates information about health organizations and services through its web site links, publications (e.g., annual report, newsletter, special reports), and a toll-free number (800/237-4492).
- Coordination. Coordinates four quarterly public meetings; receives, tracks, and records health care issues to ensure that a response or solution is generated; and coordinates the development and review of statewide rural health policies.
- Assistance. Provides technical assistance in such areas as opening a new health care clinic or implementing a CAH program. Conducts site visits to hear problems firsthand and coordinates resources between providers and State government agencies.
- Workforce development. Helps health care employers recruit qualified personnel through CRHPC's "jobs available" web site (www.ruralhealth.ca.gov/ruraljob). This free service lists jobs and vacancies for rural health providers as well as for administrative personnel.

Of the 1,500 jobs listed so far, 90 percent have been filled. Nursing and behavioral medicine positions are the most frequently listed.

- Funding. Meets with public and private funders to help coordinate funding efforts. Twenty-eight community foundations have agreed to support the Council's Internet-based funding clearinghouse, which provides information on more than 150 funders (Federal, State, and private organizations) and links to other funding web sites. The Council also operates and administers two rural health grants programs-a small grants program for uncompensated care and a capital grants program. In addition, it manages the CAH program (Flex), which provides small grants to CAHs for technical assistance and EMS development.

California Department of Health Services Activities
Sandra Wilburn, Acting Chief of Primary and Rural Health Care Systems Branch, Department of Health Services

Ms. Wilburn explained that the California Department of Health Services (DHS), with more than 5,000 employees, administers 300 primary care rural clinics located within an 80,000-square-mile area. Its annual budget is $30 billion, of which two-thirds includes Medicaid funds. The DHS Primary and Rural Health Care Systems Branch administers six core programs that focus primarily on rural primary care clinics. Of these programs, the branch manages several programs established by California legislation in the mid-1970s:

- Indian Health Services programs-Funded through State general funds, these programs provide grants to 30 Indian Health Services clinics throughout California.
- Seasonal Agricultural Migratory Workers Program-This program sets up migrant health clinics.
- Rural Health Services Development Program-This program provides funds to rural health clinics. The Primary and Rural Health Care Systems Branch works with about 165 clinic corporations to serve about 300 clinic sites.
- Expanded Access to Primary Care Program-Funded through State general funds, this program provides rural health clinic providers with a set rate of $71 for services that they would otherwise be uncompensated for. Patients at these clinics are 100 to 250 percent below the Federal poverty level.

Currently, the department is facing a number of financial problems related to these programs. Funded through State general funds (currently about $55 million a year), these programs are subject to the whim of the legislature, which means monies could be "zeroed out" by the governor at any time. Each year the department struggles with either maintaining the current funds or securing budget increases. The current energy crisis in California adds to this financial strain by increasing the cost of electricity at rural facilities 200 to 300 percent. With State funds in jeopardy and mounting energy costs, rural health care services are at risk of being cutback.

Next, Ms. Wilburn described four major issues affecting rural providers that DHS is currently addressing: (1) the difficulty in recruiting dentists to rural counties, (2) the impact of converting of FQHCs to PPSs, (3) the difficulties in allocating funds for the Indian Health Service programs,

and (4) the shortage of Title 5 Federal funds for special populations. California is facing a monumental problem in attracting dental providers, especially pediatric dentists, to rural areas. This problem has been exacerbated by the development of SCHIP in California. Of the 39 million people who live in the State, only 405 are pediatric dentists. Ms. Wilburn asked the Advisory Committee for help in alerting the Secretary to the need of continued recruitment and retention of dental students so States will stop competing for dental services. Additional dental funds are also needed to target hard-to-reach populations, such as American Indian and Hispanic populations.

With regard to transitioning the FQHC payment status for Medicaid to a PPS, Ms. Wilburn noted that between 80 and 90 percent of DHS clinics will experience a financial loss with this new payment methodology. In response to this problem, she is now working with clinic associations and individual clinic providers in the State to develop an alternative payment method.

The third issue, obtaining equitable funds for the Indian Health Service hospitals and clinics, is of primary concern to 340,000 Native Americans residing in California. Basically, the State had no Indian Health Services facilities until the mid-1970s, at which time the Indian Health Clinic System was developed from already existing community services. To help appropriate money for this health care system, the tribes sued the Federal Government and won the right to receive equitable funding through the Federal Indian Services system. Although the Indian Health Clinic System was successful in securing these funds, it still believes it is not receiving its fair share. The Federal system's allocation formulas, even for equity funding, are built to address significant Indian populations residing on large reservations, which California does not have. Therefore, in the last round of equity funding, which was $40 million out of the Federal Indian Services budget, California received only $2 million, even though the State contains the largest Indian population nationwide.

Advocates for the California Indian Health Clinic System are also concerned about the rising Indian infant mortality rate among this special population. The State's recorded Indian infant mortality rate is 8.6 deaths per 1,000 births as compared with an overall State infant mortality rate of 5 deaths per 1,000 births. Actual Indian infant mortality is probably double that rate because many American Indians in California have Hispanic last names, so many infant deaths are factored into Hispanic infant mortality rate statistics.

The final DHS issue involves the way Title 5 Federal funds are allocated in California. Currently, the State receives funds on the basis of county and State population. The State American Indian population is less than 1 percent of the total population, so DHS has been unable to get targeted Title 5 dollars out to all the rural clinics that desperately need funds to provide maternal and child services to help curb the infant mortality rates. The department has been allocated

only $500,000 to provide assistance to 5 counties out of a total of 58. This shortage of funds results in many counties not receiving adequate health care funds for their special populations.

Discussion

In the discussion that followed the State presentations, three primary concerns were discussed: the oral health problem in rural America, the loss of reimbursement for rural health care providers under PPS, and the controversy surrounding the HIPAA regulations.

- Ms. Richardson pointed out that the oral health problem in rural areas is growing because of the continued shortage of providers caused by the closing of a number of dental schools throughout the United States in the last 10 to 12 years. Adding to this problem is the low reimbursement rate for Medicaid's dental coverage (DentiCal), which prompts most dentists to practice in wealthier urban areas. In response to a question about the development of innovative solutions to bring dentists into rural environments, Ms. Wilburn explained that DHS is investigating several avenues to improve the situation. For example, the department is currently trying to make the licensing process easier, is purchasing mobile dental units for use in rural school districts, and is supporting a legislative bill that will increase the $71-per-visit reimbursement rate for dentists. Ms. Ford added that graduate medical education dollars should be tapped in some way for both dental and nonphysician providers.

On the Federal side, HRSA, in cooperation with CMS, secured grant money 2 years ago for States to develop their own innovative solutions for the lack of dental health care. Because this program's future is currently in jeopardy, it was suggested that NACRH show support for its continuation in the 2003 budget in a letter to the Secretary. A motion was made and unanimously passed to craft a letter expressing NACRH support of the HRSA/CMS initiative and to forward it to the Secretary after Committee approval.

In answer to a question about the availability of midlevel dental providers, Ms. Richardson noted that dental hygienists/practitioners are usually the professional of choice for services such as dental health education, sealant application, and primary prevention care. The problem is that, in most States, dental hygienists are allowed to practice only under the direct supervision of a licensed dentist. This highly politicized restriction limits hygienists from servicing rural communities where no dentists practice.

- Dr. Mueller questioned the high percentage of rural health clinics that are losing money under the PPS formula. Ms. Wilburn pointed out that the percentage is based on an analysis of DHS' last audited cost reports for a number of rural clinics in California. In answer to an inquiry about whether the Federal Government or the State is responsible for setting PPS rates, Ms. Richardson said that States are responsible for determining whether the rate is set at the minimum or maximum level.
- Ms. Hughes brought up the issue of the HIPAA regulations and some of the unintended consequences posed by their implementation for rural health providers. Because of the

controversy surrounding these regulations, which are coming out for comment in about 2 weeks, she suggested writing a letter to the Secretary not only thanking him for his attention on the issue but also expressing NACRH concern about the serious rural implications of HIPAA. This suggestion prompted considerable debate by the Committee.

- Some members pointed out that the HIPAA regulations need to be researched more thoroughly before true impacts can be determined. ORHP's research center and several private consultants are in the process of reviewing some of these issues.
- Mr. Cannington suggested looking at HIPAA's cost implications on rural providers.
- Mr. Berk remarked that rural hospitals need to know what the reality of HIPAA is rather than ferreting through the regulations and taking the advice of financially biased consultants.
- It was suggested that the Committee ask the Secretary to assuage some of the hysteria being generated in rural communities by making explanatory information about the regulations available to the public as soon as possible. Publicizing this information in a timely and user-friendly way could prevent rural facilities from investing their small amount of resources on decoding HIPAA issues.
- Dr. Wakefield suggested that the Secretary's letter mention HIPAA's broad implications for such rural providers as hospitals, clinics, pharmacists, and behavioral health providers. The Secretary should be made aware that the cost burden related to these regulations will be greater for rural providers than for urban.
- Positive aspects of the regulations, such as the implementation of information systems, should also be incorporated into the letter.
- The Secretary should be encouraged to use ORHP, as well as the State Offices of Rural Health, as a vehicle to get information about HIPAA out to rural areas. The State offices could also provide educational seminars for this purpose.

On the basis of these remarks, Dr. Nesbitt motioned that Committee members send Mr. Morris their comments about what to include in the Secretary's letter within the next 2 weeks. Mr. Morris will then summarize the comments, both positive and negative, and e-mail a draft to the Committee for review. If a majority of the group votes in favor of its contents, he will then forward those comments onto the Secretary. The motion was seconded and passed unanimously.

Committee Report: A Targeted Look at the Rural Safety Net

Rachel Gonzales-Hanson, Advisory Committee Member

Ms. Gonzales-Hanson explained that the Committee's final report on the rural safety net will focus on timely issues that are under the purview of the Secretary. She asked Committee members to submit comments and thoughts about the topic in a paragraph or bulleted format to ORHP by early July. A conference call will be set up for mid-July or early August to discuss these comments, and a detailed outline or early draft of the report will be sent to members for

review before the September meeting. ORHP will create a Listserv to manage the flow of comments.

September Meeting

The next onsite visit is scheduled for September 8-11, 2001, at a yet-to-be-determined location in Maine. Limited ORHP resources will be an important factor in determining the location. The meeting will focus on EMS issues as a primary topic.

Public Comment

Several people offered their comments. Mr. Johnson began by urging the Advisory Committee to look at the area of Medicare and Medicaid reimbursement with regard to behavioral medicine. He explained that California is experiencing a considerable shortage of behavioral medicine practitioners, specifically psychiatrists, licensed clinical psychologists, and licensed clinical social workers. Because of this shortage and the high demand for services, a large number of master-level behavioral medicine practitioners (known as marriage, family, and child counselors in California), who are licensed by the State, are serving rural areas. The problem is that these practitioners cannot receive reimbursement because they are not listed in the regulations that allow for Medicare and Medicaid reimbursement.

Mr. Johnson asked the Committee to consider adding language to Medicare and Medicaid regulations that allows reimbursement for master-level licensed behavioral practitioners. This addition would be a huge step forward in opening up access to behavioral health care in rural California.

In response to this concern, Mr. Morris noted that a report is coming out next year from southern Maine that will examine all State practice acts and evaluate who is covered to provide what service and which States are affected. The study will provide a forum for further discussion of this issue.

Next, Dr. Mueller motioned that ORHP's letter to the Secretary on the status of the Squaw Valley onsite visit include three important elements from Monday's clinic/hospital visits. First, the letter should recommend that the federally written guidelines for ambulance service follow the ambulance payment rule for CAHs that makes an exception to the 35-mile rule for mountainous terrain or extreme weather conditions. Second, the Secretary should be observant of the details of prospective payments for rural health clinics and community and migrant health centers to make sure rural providers are treated fairly. Third, the letter should also caution the Secretary

about the long delays in getting data ready for cost report audits and subsequently the use of these cost reports for current policy purposes after they have been delayed 12 months.

Mr. Morris asked Dr. Mueller to e-mail him a brief paragraph on his last two points, after which a motion was passed to include Dr. Mueller's suggestions in ORHP's status report to the Secretary after it is reviewed and approved by the Committee.

On behalf of the Advisory Committee, Ms. Hughes and Ms. Gonzalez-Hanson expressed special thanks to Mr. Morris and Ms. Rafiullah for the invaluable support they provide to the work of the Committee and to Dr. Nesbitt and Mr. Johnson for graciously hosting and organizing the Squaw Valley visit. Ms. Gonzalez-Hanson also acknowledged the inspiring way that UC Davis has reached out to rural communities to improve their health status.

Dr. Nesbitt adjourned the meeting at 11:30 a.m.