$25 Million for Rural Health

Federal Office of Rural Health Policy to Administer New Grant Program

Tucked within the 4,000 page omnibus spending bill that Congress sent to President Clinton last month was a $25-million appropriation to fund grants to the States under the Medicare Rural Hospital Flexibility Program. This appropriation will increase the ability of States and rural communities to identify and address rural health problems.

The purpose of the grant program is to help States work with rural communities to develop more integrated health care systems. At a time when rural providers are facing increasing financial pressures, these grants will enable communities to obtain much-needed technical assistance. Grants will be awarded to States for developing and implementing rural health plans, developing community health networks, designating facilities as critical access hospitals, and integrating rural emergency medical services with other components of the health care delivery system.

Although grant money was not appropriated until fiscal year 1999, the Medicare Rural Hospital Flexibility Program was part of the Balanced Budget Act of 1997. Sponsored by Senator Max Baucus (D-MT), this legislation established the critical access hospital, a limited-service facility that can get Medicare cost-based reimbursement. The critical access hospital is modeled after Montana's Medical Assistance Facilities and Rural Primary Care Hospitals, which were developed through the EACH/RPCH demonstration project in several States. Critical access hospitals are a viable alternative for small rural communities who wish to provide some acute care services locally while ensuring access to primary care and emergency medical services.

While critical access hospitals are a critical part of the legislation, the Medicare Rural Hospital Flexibility Program is more than a life preserver to keep at-risk rural hospitals afloat. The grant program will provide States with resources to develop and implement a comprehensive rural health plan that will lead to the development of community health networks. These networks are based on the precept that communities themselves can best determine how their local health care should be delivered. Rural communities should find that creating networks improves the stability and quality of health care services. Grant funds will be especially useful to support community involvement in education and development programs.

Congress is authorized to appropriate $25 million for the grant program each year through fiscal year 2002. The grant program will be administered by the Office of Rural Health Policy (ORHP) within the Health Resources and Services Administration. ORHP is in the process of developing guidelines for this new grant program and expects that grant applications will be available to States in the spring. Grants will be awarded by September of 1999.

Draft for Discussion (12/01/98)

STATE RURAL HOSPITAL FLEXIBILITY (SRHF) GRANT PROGRAM

Authority

The SRHF Grant Program is authorized by Sec. 4201 of the BB Act of 1997 (PL 105-33) with $25M appropriated by the OCA Act of 1999 (PL 105-277).

HISTORY

This new authority is based on the EACH/RPCH and MAF demonstration programs which showed that states could improve access to health services by helping their rural communities develop limited-service hospitals and networks of care. The SRHF Grant Program authorizes states to (1) develop and implement a rural health plan, (2) designate Critical Access Hospitals (CAHs), (3) develop networks and (4) improve emergency medical services and other activities. CAH hospitals receive cost-based reimbursement from Medicare. Over the past year, HCFA has had the responsibility for administering this program although no funding was approved. For FY 99, Congress appropriated $25M to the ORHP/HRSA to help states work with rural communities in the planning and development of more integrated health care systems.

VISION

After 5 years and $125M, this program will improve access to health care in those rural area that participate by:

1. Developing systems of health care that are more integrated.
2. Significantly increasing the number of CAHs and networks.
3. Improving the availability, stability, quality, and satisfaction with services.
4. Increasing the capacity of States and rural communities to identify and address rural health problems.

PRINCIPLES

Prior program experience identifies a number of principles for success:

1. Allow flexibility - one size does not fit all.
2. Planning and implementation should be broad and community based.
3. Developing community health networks takes time, money, and TA.
4. Integrate EMS and other key services into networks including primary care, long term care, telehealth, mental health, and public health.
5. Planning is an evolving and continual process.
6. Focus on implementation and monitor outcomes.
7. Get all states to participate.
8. Get resources to communities and hospitals.

PROGRAM IMPLEMENTATION

The challenge is to provide adequate program guidance while maintaining sufficient flexibility for states and their rural communities. Focusing on the development and implementation of the SRH Plan should provide that balance. Planning and implementation are a continuum and State capacity to do both varies widely. While governors have the authority to designate the element of State government to apply for, and administer, these funds - we anticipate the SORH will take the lead on this program.

A: Starting Feb. 1, States are eligible for a 5 - month supplement to their SORH grant of up to $200K.

These grants are available to attend regional TA workshops, support communities in their planning efforts, or other activities related to SRH Plan development. Funds can be passed through to another agency designated by the State. Applications due Jan. 15.

B. Starting Sept. 30, States are eligible for a grant of up to $600K for year 1.

1. Up to $100K is available for the development of a comprehensive SRH Plan for ORHP approval and a CAH Plan for HCFA approval. Funding will be based on capacity and needs proposed by State including: Prior investment in planning, capacity to do data collection and analysis, staffing, etc. Applications due May 21.

2. Up to an additional $500K is also available for the implementation of the comprehensive SRH Plan. Funding will be based on level of activities proposed by the State including: Number of CAH-eligible involved, level of integration of EMS and other services, number of community health networks, number of rural people served, etc. Applications due May 21.

To obtain funds for implementation in year 2, States will need to have their SRH Plan approved by the ORHP in year 1. The plans that have been approved by HCFA will need to be more comprehensive to insure funding under this grant program. A description of a comprehensive SRH plan is attached. Plan approval from HCFA will still be needed for the certification of CAHs.

We are seeking your comments on the attached (1) description of a comprehensive SRH Plan and (2) definition of a community health network.

Applications and SRH Plans will be reviewed by a panel of non-federal experts.
No more than 10% of grant can be used to buy equipment.
Grant funds cannot be used for building/renovation, routine hospital operating costs or clinical services.
States will need to submit a minimal application to HCFA containing an assurance that it will develop a SRH Plan.
States will be asked to provide a brief, semi-annual progress report.
This program should address the needs of CAHs or CAH-eligible hospitals (approx 800) identified by the State as necessary providers.
States should create an advisory committee to this program that includes a wide range of other State-level entities.
The 3R Net is available to support recruitment and retention activities.
We will be funding a program evaluation.
We plan to help States apply for this grant program.

TECHNICAL ASSISTANCE

Much of the funding in this grant program will be used by the feds, states, hospitals, communities, etc., to support TA activities such as financial and legal analysis, community development, conflict resolution, planning and facilitation, information systems and marketing. We are working to identify ways to help organize, build and improve the availability of TA resources. The National Rural Health Resource Center will be available to support TA activities.

OTHER

Identify activities that can not be funded
What is HCFA role and responsibility?
How can OAT help us/States, esp in planning stage?
Must a network include a CAH eligible? Yes
How can we make sure almost all States participate in this program?
How can we get TA to States ASAP?
In a year or two, most states will receive about $500K.
Are we focused on networks too much?
We need to ID State participation at Marathon.
How can we coordinate with RWJ Southern Project?

Draft 11/30/98

Comprehensive State Rural Health Plans

The scope of comprehensive State rural health plans should go beyond just planning and implementing CAHs. Plans should also address: network/regional systems development, emergency medical services, primary care, long term care, public health, mental health and other services. State rural health plans should also go beyond just plan development and over time should have an increasingly greater focus on plan implementation. State rural health plans should include two major sections: plan development and plan implementation.

A: PLAN DEVELOPMENT

Six basic plan development components should be included in State rural health plans. They include a description of the process by which plan development occurs, profiles and analyses of rural health care in the State, a profile and analysis of rural hospitals, delineation of systems development strategies and recommendations, discussion of State programs and supports and discription of plan to build technical assistance capacities. Key elements that should be included within each of these plan development components are listed below.

1 Development Process - This component should describe the process by which the rural health plan was or will be developed. It should delineate the participants in the process and the organization for plan development (committee structures). It should specify the role of communities and providers in the planning process. Information should also be included that shows that there is or will be broad support/buy-in of key players to implementation of the plan and that will lead to appropriate community development. A monitoring and revision process should also be identified.

2 Profile of Rural Health Care -This component should include an inventory of health services and resources available in all rural areas of the State. It should also include analyses of community health needs and identification of priority/key rural health care issues.

3 Rural Hospital Profile - This component should include analyses of rural hospitals in the State. It should cover changes in hospital utilization (i.e. ADC, LOS, Discharges, Emergency room visits, outpatient visits). It should also cover financial trends (i.e. inpatient & outpatient revenues, reimbursement shifts by payor category, financial ratio indicators). These analyses should lead to the identification of at-risk rural hospitals and potential/eligible critical access hospitals.

4 Systems Development Strategies and Recommendations - This component of the plan should delineate system development strategies and recommendations. Several specific strategic areas should be addressed including critical access hospital designation processes and criteria, network/regional development approaches, emergency medical care systems integration approaches, as well as integration approaches related to primary care, long term care, public health, mental health and other services. Recommendations should be identified for each strategic area included in the plan.

5 State Programs and Supports – This component should describe the State programs and resource that will support the implementation of the plan. It should describe both dedicated programs and supports for rural health care, as well as related programs and supports.

6 Technical Assistance Capacities – This component should describe State plans to build capacities (within or outside state government) and provide technical assistance to rural communities and providers in converting to CAHs and developing community networks.

B: PLAN IMPLEMENTATION

State Rural Health Plans should include implementation sections. Over time, the implementation section should become the primary focus of the plan. At a minimum, this section should include three components: critical access hospital, rural health network and emergency medical services. Other components may be needed dependent upon the system development strategies contained in the plan development section of the plan. Key elements that should be included in each of these components are listed below.

1 CAH Implementation – This component should delineate specific activities related to bringing critical access hospitals on-line. This should include CAH activities related to outreach and education, designations, conducting start-up surveys, submission of designation applications, completion of community needs assessments and financial feasibility studies, development of network agreements and provision of technical assistance to communities & providers. It should also describe State efforts to extend reimbursement policy supports for CAHs, development and/or modification of certification and surveillance procedures for CAHs and monitoring of CAHs. Supporting activities of other key organizations such as the State's hospital association should also be specified.

2 Rural Health Network Implementation – This component should identify specific rural health networks that will be implemented. It should specify the outreach and education efforts that will be carried out by the State to promote network development in other areas with critical access hospitals. Technical assistance support activities to networks should also be identified including those related to information, communication & telehealth systems development and primary care and other systems development. Monitoring activities related to network development should also be specified.

3 Integration of EMS in Networks – This component should identify specific CAH service areas in which EMS systems will be integrated within network development efforts. Activities should be specified related to the development/modification of referral and transfer protocols and training and upgrading of emergency personnel. Monitoring activities related to improvements in EMS systems should also be specified.

4 Integration of Other Services in Networks – This component(s) should identify specific services and service areas that will be integrated within network development efforts. Other services covered in this component may include primary care, long term care, public health and mental health. Activities should be specified related to integration, development and/or enhancement of care capacities.

Draft 11/30/98

Community Health Networks

Community health networks (CHNs) are formal organizational arrangements among health care providers and other key segments of a community (e.g. hospitals, medical clinics, community health agencies, local public health agencies, emergency medical services providers, social services agencies, local government and business and consumer organizations) that provide or support the delivery of health services in a particular area.

Community health networks are based on the precept that communities themselves can best determine how their local health care should be delivered, what resources are needed, and what problems and barriers must be overcome in achieving better health for all community members.

By establishing CHNs, health status and health care delivery will be improved by:

1) Putting patients and communities at the focus of health care delivery;
2) Making the system more user-friendly for patients;
3) Improving the continuity and quality of services;
4) Preventing the occurrence of health problems, in addition to treating existing conditions; and focusing on cost-effective uses of scarce health resource.
5) Including those who are currently outside the existing health care systems (the poor and uninsured);

A community health network will have the following characteristics:

1) Has formal organizational relationship through either by-laws or a signed memorandum of agreement;
2) Is composed of at least three already existing organizations;
3) Members of a network contribute financial and/or in-kind resources to support network activities;
4) Membership is specified in writing and involves diverse participation by both health care providers and consumers;
5) Has governance arrangements that reflect involvement on the part of the community it serves.
6) Has a defined purpose laying out a written mission and goals, as well as an explicit plan of action.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Health Resources and
Services Administration
Rockville MD 20857

December 4, 1998

Christopher Jennings
Deputy Assistant to the President for Health Policy Development
White House, Office of Domestic Policy
Old Executive Office Building
Washington, DC 20502

Dear Mr. Jennings:

I am writing to seek your input about how we should implement an exciting new rural health program called the State Rural Hospital Flexibility (SRHF) Grant Program.

As you may know, the Congress has (1) provided $25M in FY 1999 to implement the SRHF Grant Program and (2) mandated that this program be administered by the Federal Office of Rural Health Policy, HRSA.

The goal of this grant program is to help States work with rural communities, providers and hospitals to develop more integrated systems of health care. With a potential funding of $125M over five years, this program offers an unprecedented opportunity for rural America.

Over the past few weeks, we have developed the enclosed draft document that describes our working vision for the effective and efficient management of this program. I believe it is essential that organizations like yours have a chance to provide advice and comment before we begin actual implementation. To help facilitate this dialogue, please review the enclosed materials and submit your written comments to us by December 18. The address is: SRHF Grant Program, Parklawn Bldg., Rm. 9-05, Rockville, MD 20857.

I look forward to hearing from you, and thanks for your continued support of rural health.

Sincerely,

Wayne Myers

Wayne W. Myers, MD
Director
Office of Rural Health Policy

Enclosures

NATIONAL RURAL HEALTH ASSOCIATION

RURAL AND FRONTIER EMERGENCY MEDICAL SERVICES TOWARD THE YEAR 2000

Analysis and Policy Recommendations

An Issue Paper Prepared by the National Rural Health Association-May 1997

This issue paper briefly analyzes the current status of emergency medical services (EMS) in rural and frontier areas and recommends improvements to these vital services. The framework for analysis is a recently published national consensus document entitled *EMS Agenda for the Future*, which was supported by the National Highway and Traffic Safety Administration, Department of Transportation and the Health Resources and Services Administration (HRSA), Department of Health and Human Services, in conjunction with the National Association of EMS Physicians and the National Association of State EMS Directors. Fourteen EMS system attributes are identified in the issue paper, along with where we are, where we want to be and how to get there. The attributes included are as follows.

- Integration of Health Services
- Public Access
- Education Systems
- Human Resources
- EMS Research
- Medical Direction
- Public Education
- Communication Systems
- Legislation and Regulations
- Clinical Care
- Prevention
- Information Systems
- System Finance
- Evaluation

These attributes are combined and summarized in this issue paper, and the particular challenges and opportunities for rural and frontier EMS assessed. Policy recommendations are then identified for each attribute.

INTRODUCTION

As the effort to control the costs of health care alters the organization and financing of health services, health care providers are struggling to understand the dynamics of the new health marketplace in relationship to their traditional and future roles in the system. This is true for the private medical community, medical schools, community-based health services and the public health sector. Due to the sparsity and vulnerability of rural and frontier health providers, the need for them to understand and proactively engage in these changes is particularly critical. Emergency medical services, or EMS, has become an essential component of the rural health safety net.

Since the late 1960s when civilian EMS was first conceptualized and implemented, it has become institutionalized throughout the United States at the intersection of the public safety and the medical care systems. EMS is particularly critical to rural and frontier residents because they experience disproportionate levels of serious injuries and their distance from traditional health resources increases the morbidity and mortality associated with trauma and medical emergencies.

Today, most citizens expect that they can call 911 and immediately receive life-saving medical advice from trained dispatchers, while paramedics and an ambulance race to their aid. In many areas of the country, including some rural areas, EMS consistently meets these expectations. In other areas, including most rural and frontier communities, these expectations are not met for a variety of reasons identified in this paper. Despite the challenges, the EMS community is actively evolving its future roles with an emerging emphasis on acute-care triage, enhanced integration with primary care, increased participation in public health and prevention activities, and limiting transportation to medical emergencies. However, the challenges of organizing and implementing EMS in rural and frontier areas continue to be significant. Many rural areas struggle with increasing demand and heightened public expectations, organizational instability, under-financing, inadequate access to training and medical direction, a lack of volunteers willing to commit to the considerable demands of emergency response, underdeveloped infrastructure for public access and communications, and much more. In such communities, the uncertainties in today's dynamic health care environment exacerbate concern about the viability and performance of their EMS system.

The NRHA reaffirms its commitment to access to comprehensive health services for all citizens and the critical importance of EMS in rural and frontier areas. It is timely that we once again assess the status of EMS in rural and frontier areas in regard to its unique requirements in both its traditional emergency response roles and its evolving integration with broader community health efforts.

BACKGROUND

In the late 1980s, the NRHA formed a broad-based committee to analyze the status and needs of rural EMS and develop recommendations for public policy. Utilizing the results of a national survey of rural service providers, the NRHA hosted a conference of rural EMS experts, providers, planners and administrators in March 1989. The results and recommendations were published later that summer and combined with a more formal analysis by the federal Office of Technology Assessment to provide a reasonably clear picture of the strengths and weaknesses of rural EMS going into the 1990s.

As a result of the NRHA's efforts, then Rep. Jim Cooper of Tennessee introduced the Rural EMS Improvement Act of 1989 to "establish a program of grants to the states for improving the availability and quality of certain EMS and EMS systems in rural areas." Although this effort failed, some of the concepts and concerns were crafted into the federal Trauma Care Systems Act that passed in 1991 with an appropriation of about $5 million and several specific set-asides for "rural."

Throughout the early 1990s, there have been several rural EMS initiatives funded federally, but mostly for research and demonstration purposes. Except at some state and local levels, there has been no specifically targeted, rural EMS development. It is hoped that this paper will provide the basis and stimulus for much needed rural and frontier EMS development. In 1993 and 1994, the NRHA and the Office of Rural Health Policy (ORHP) convened a work group to produce *Health Care in Frontier America: A* Time for Change. This report emphasized the necessity of EMS as the essential safety net for frontier communities.

INTEGRATION OF HEALTH SERVICES

Description. Integration refers to the horizontal and vertical linkage of health care providers to achieve a higher degree of continuity of services and perhaps greater efficiency. EMS integration can help ensure that out-of-hospital care is incorporated into the management of ill or injured patients. Historically, EMS has been effectively linked with the public safety sector (dispatch, law enforcement and fire service), with nearby EMS providers for mutual aid, with the emergency department of nearby hospitals and, in some areas, with designated trauma centers as part of regionally designed trauma care systems. In the future, successful EMS providers will need to integrate more fully with public health and social service agencies, primary care providers and other health care facilities to ensure that patients are referred or transported to the most appropriate and cost-effective facility. Care should not occur in isolation; rather

it should be part of a seamless system that provides patients with well organized and high-quality care.

Rural and Frontier Issues. The successful incorporation of EMS into an overall health care system or network requires the cooperation and availability of each component of the system. This includes access to physicians trained in EMS, health care facility staff, system planners and others. The rural and frontier environment has limited local health care resources, often with personnel that have no training or experience in EMS, a fact that greatly hinders efforts toward effective integration. These same characteristics also make network integration even more critical.

In the traditional EMS system, patients in rural and frontier settings often are transported long distances to health care facilities that are not closely affiliated with local health care resources. In some cases, this is appropriate due to the requirement for sophisticated tertiary care for some emergency patients, particularly for severely injured trauma patients. However, far too often this long distance transportation simply reflects the traditional separation of the EMS service from local primary care providers, public health and social service agencies that might be able to deal effectively with the needs of the patient.

In either case, the ability to provide integrated health services is often impeded by the geographic separation of health system components and the lack of regular communication or organizational networking between them. These problems are compounded by financing mechanisms that have traditionally reimbursed EMS for its transportation role, rather than for its triage, care and referral capacity. On the other hand, rural and frontier areas provide a unique opportunity to demonstrate the capability of the EMS system to fulfill broader public health and primary care outreach roles for traditionally underserved communities.

The successful Red River Expanded EMS Demonstration Project in northern New Mexico, demonstrates that with increased training and medical supervision, expanded public health and primary care protocols for selective rural EMS personnel enhance appropriate access to the overall health care system. In many areas emergency medical technicians (EMTs) are being more fully integrated with primary care providers to supplement evening and weekend coverage by triaging and referring patients back to the local primary care providers. These expanded EMS developments need ongoing evaluation, but are already showing promise in some communities. As these systems develop, opportunities also exist to address the needs of special populations that have sometimes been overlooked, including children, the elderly, minority groups and persons with disabilities.

Integration of Health Services Policy Recommendations. It is essential to the health of rural and frontier communities that the EMS system be integrated into a health care system that is cooperative, shares limited health care resources, provides a broad education to the EMS providers, recognizes innovative methods of health care delivery and is appropriately reimbursed. Specifically, the NRHA recommends that federal legislative efforts enhancing the establishment of rural networks (such as was proposed in the Rural Health Improvement Act of 1996) include EMS and trauma care systems as mandatory components. Also recommended is federal legislative efforts defining or supporting innovative hospital conversions such as the essential access community hospitals and rural primary care hospitals, limited service hospitals or medical assistance facilities recognize the importance of integrating EMS as part of the overall system of care in rural areas. Continued support and study for expanded EMS developments and appropriate reimbursement is a priority to enhance access to health care systems in some rural and frontier areas. EMS workers and EMS systems must be supported to meet the needs of special populations, including children, the elderly, minority groups and persons with disabilities.

LEGISLATION AND REGULATION

Description. All states have legislation that provides at least a statutory basis for EMS activities and programs, regulation of EMS personnel and services, scopes of practice, systems design, funding, training and other such issues. However, these laws and regulations vary considerably in

comprehensiveness, flexibility, relationship to local government EMS ordinances and resources committed to EMS system planning, implementation and oversight. At the federal level, there are a variety of programs that have some interest, activity or initiatives that relate to different aspects of EMS. Currently, the major federal programs supporting EMS system building at the state and local levels are the Preventive Health and Health Services Block Grant administered by the Centers for Disease Control and Prevention and the EMS for Children Program administered by the Maternal and Child Health Bureau of HRSA. State and federal policy-makers are sometimes reluctant to include rural and frontier providers in developing EMS policy.

Rural and Frontier Issues. This variability in the legal framework for EMS is particularly true and problematic in relationship to rural and frontier EMS that require special support, flexibility, expertise and state-level leadership due to its unique challenges and requirements. Rural EMS still relies on volunteer personnel in most areas. Volunteers can be effective, but only with adequate resources, a clearly delineated context and strong nurturing.

A state and regional EMS infrastructure that both sets expectations and provides assistance to meet those expectations is critical. Similarly, the fine line between a clear regulatory framework that protects the public and the flexibility to pragmatically meet local needs is essential because of the variability of rural and frontier areas.

Rural and frontier areas frequently require proactive assistance to meet, or exemptions from, even minimal standards. A process for openly negotiating these realities is critical for effective public policy. The issue of cross-border relationships is particularly difficult in the nation's vast rural areas where sparse populations and resources require interstate cooperation, rather than rigid, state-by-state regulation.

Legislation and Regulation Policy Recommendations. A federal EMS lead agency should be authorized by law and adequately funded to ensure that federal agencies are well coordinated and focused to assist national, state and local EMS development. The lead agency would provide national leadership and facilitate the development of model systems, innovative demonstration programs, consensus standards, information sharing, and assist states with funding, technical assistance and research. State EMS lead agencies should be clearly authorized by law and adequately funded in each state to ensure that EMS has a sufficient legal basis, authority, resources and leadership to provide adequate training, communications, medical direction, personnel, systems development and integration, vehicles and equipment, data collection, quality improvement and research.

Federal funds for the Preventive Health Services Block Grant, of which almost 10 percent ($11 million to $13 million annually) is used by states to fund EMS efforts, and the EMS for Children Program need to be held at current or higher levels. The Rural Health Outreach Program should continue to support EMS, particularly activities that support EMS training.

EMS lead agencies at all levels should have a legislative mandate, expertise, flexibility and resources to provide needed support and technical assistance to EMS systems in rural and frontier communities. At the state, local and federal level, rural and frontier providers need to be fully represented on boards, committees and other policy bodies.

EMS SYSTEM FINANCING

Description. EMS must have a solid financial foundation to provide its critical safety net services in a consistent and reliable manner. It is recognized that one of the costs of EMS is its commitment to preparedness, or full-time service availability, although costs do vary considerably according to the requirements and expectations of local communities. Primary revenue streams for EMS are fees for

service (Medicare, Medicaid, private insurance, private pay and special service contracts), governmental subsidies (local or statewide) and, in some cases, subscription services. Historically, reimbursement for EMS has been tied primarily to the transportation function and not necessarily to the delivery of emergency medical care. Managed care organizations (MCOs) have in some cases sought to limit access to EMS for their beneficiaries by narrowing the definition of "emergency care" to an after-the-fact medical decision, rather than one made by a reasonable or prudent layperson at the time of the event. Some MCOs also have instructed patients to call their primary care physicians prior to calling 911, which may unnecessarily delay needed emergency care.

Rural and Frontier Issues. The financing of rural and frontier EMS is a particular problem because of the relatively low volume of calls in relationship to the essential overhead costs of full-time preparedness. In addition, the traditional reliance on volunteer personnel in many areas, with little or no infrastructure for collecting fees or maintaining the business functions, contributes to the challenge. This traditional lack of a solid business perspective has made it difficult to assess the true cost of providing EMS in rural and frontier areas. In turn, this allows payers to "under-reimburse" and actually pay below cost. Payment for EMS by Medicare fluctuates widely across the country, but rural, and especially frontier areas, receive the lowest reimbursement. Also, there is a reluctance in many volunteer EMS, particularly those combined with fire service, to charge at all, because it is viewed as a public safety service that should be supported entirely by governmental subsidy (taxes) and individual giving. Although this belief is changing, it still is detrimental to securing adequate financing for rural EMS.

As MCOs cover more rural and frontier populations, it is essential that they fully integrate EMS into their provider networks, not limit access to the 911 emergency response system, and compensate EMS providers at an appropriate level. Rural populations should not suffer due to their distance from after-hours care.

EMS System Financing Policy Recommendations. It is recommended that sufficient financing mechanisms be developed and supported to ensure that a consistent and adequate level of rural and frontier EMS is sustained through a combination of governmental subsidies, contracts and fee generation.

Specifically, the NRHA recommends that EMS must be adequately compensated for preparedness, reducing volume-related incentives and recognizing the unique costs of sustaining an emergency safety net in rural and frontier areas. Compensation for EMS must be based on emergency response, assessment, treatment, triage and disposition that may, or may not, involve traditional transportation. The "prudent layperson" definition of emergency care and the requirement that all MCOs guarantee access to the 911 emergency response system should be mandated (as contained in the American College of Emergency Physicians/Kaiser bill that will be introduced into the 105th Congress, as the successor to H.R. 2100/S. 1233.) Medicare reimbursement for EMS services needs to be adjusted to eliminate imbalances in payments between urban, and rural and frontier services.

EMS EDUCATION

Description. To ensure that the patient care provided by EMS is part of the overall management of the ill or injured patient, innovative approaches to education must be employed. These innovations must address the quality, content and accessibility of the educational programs, both for initial training and for ongoing continuing education of EMS providers.

Rural and Frontier Issues. The implementation and success of EMS education in rural and frontier areas has a variety of challenges that must be addressed to provide quality education. Specifically, it must focus on:

- the limited student pool that may include a high percentage of adult learners with little formal education and full-time jobs that require flexible scheduling;
- a small number of qualified instructors;
- insufficient educational resources and support;
- limited access to health care facilities for supervised clinical experiences;
- limited exposure to various conditions and patient presentations during training;
- problems with skill maintenance in low-volume systems, especially for problems relating to children;
- the lack of knowledgeable and active physician supervision; and
- inadequate quality assurance of the educational programs.

These problems are exacerbated as the educational programs move from the EMT Basic program to advanced life support training.

EMS Education Policy Recommendations. It is essential that educational resources at the federal and state level are readily available and flexible enough to meet the needs of rural and frontier EMS providers. Specifically, this can be accomplished with innovative strategies that include financial subsidies for low-enrollment courses, development of distance learning using telecommunications techniques, provision of incentives for instructors to conduct satellite courses in remote areas, involvement of university medical centers and area health education centers to provide outreach educational programs to rural and frontier areas and flexible scheduling to accommodate the lifestyle realities of rural volunteers.

PUBLIC ACCESS AND COMMUNICATIONS SYSTEMS

Description. The length of time to definitive care is a key patient outcome variable for many critical emergencies. The entire EMS system is initiated by a call for help or assistance. Most people in the United States (about 78 percent) have access to the 911 emergency response call system. Increasingly, this system has been technologically upgraded to include the enhanced 911 capability that automatically displays the name, address and other key information about the caller.

Once the call is received at the dispatch center, the next critical step is the dispatching of appropriate resources and the provision of pre-arrival medical instructions via the telephone (emergency medical dispatch, or EMD). The ability of EMS components to communicate with one another is important as the patient moves toward definitive care. Although these aspects of EMS access and communications have improved enormously in recent years, they still face significant challenges, particularly in rural and frontier areas.

Rural and Frontier Issues. Response times of the EMS system to the scene of emergencies and from the scene to definitive care are almost always longer in rural and frontier areas. On average, response times can be two or three times as long as in urban or suburban areas. This is due to sparse populations, long distances, poor roads, difficult terrains, severe climate conditions, lack of or limited telephone service, inadequate public education, and insufficient infrastructure resources to support advanced emergency call systems or reliable radio communications systems between the field and base hospitals. These are all significant challenges, some of which can be affected with additional funding and technical support, and some that only can be overcome with creative and innovative service delivery and technological approaches.

Public Access and Communications Policy Recommendations. There should be nationwide implementation of the enhanced 911 emergency number, coupled with rural addressing, to ensure that all citizens have better access to EMS and other public safety resources. All emergency personnel answering calls should have training in EMD techniques so that critical first aid and medical advice can

be given to callers prior to the arrival of the emergency responders. This component is critical in rural and frontier areas where response times are unavoidably longer.

Innovative communications approaches, including satellite, telecommunications, telemedicine and cellular technologies, must be supported nationwide, but particularly in rural areas, to allow for the effective exchange of information from the field to facilities and among facilities. Dispatch centers should be considered as partners in implementing triage systems to direct patients to the appropriate level and source of health care service.

HUMAN RESOURCES

Description. Ensuring an adequate supply of trained and motivated personnel to staff the EMS system is an ongoing challenge that involves public education, recruitment, training, personal support, career ladders, and appropriate awards or recognition for dedicated providers.

Rural and Frontier Issues. As the expectations and demands increase on EMS providers, so does the difficulty in recruiting and retaining them. This is particularly difficult in the many volunteer systems serving rural and frontier areas where compensation and the benefits of employment are not a factor. Since many such areas have an increasingly aging population and, in numerous cases, both parents must work outside the home, the ability to commit time for training and service is becoming increasingly limited. At the same time, many rural and frontier communities cannot, or have not chosen to, support paid positions for EMS. The problem of maintaining adequate staffing is exacerbated by increased risks from dangerous exposures (biological, chemical, interpersonal violence, critical incident stress, etc.); perceptions of increased personal liability; lack of enlightened leadership; inadequate physician participation; limited funding for training, equipment and supplies; and many other such issues. Many of these problems, including low wages, exist in paid rural EMS, often leading to frequent turnover or marginal performance. A particular concern is the current funding crisis in poison control centers that threatens the ability of rural residents to have timely access to poison control information and treatment.

Human Resources Policy Recommendations. State and regional EMS offices should provide leadership and technical assistance to help local communities recruit and retain EMS personnel. Financial support should ensure that volunteers do not have to pay their own expenses to obtain training, supplies or equipment. Leadership training, critical incident stress management services, safety training and other support should be provided to all EMS personnel. Recognition of performance should be accomplished at all levels-local, state and national. EMS workers must be more fully integrated into the delivery system team. Where necessary, federal and state funding strategies should be developed to train and support rural and frontier EMS personnel. Legislation should be developed to enhance and ensure public access to poison control centers.

EMS MEDICAL DIRECTION

Description. Medical direction involves licensed physicians granting authority and accepting responsibility for all aspects of the overall care provided by EMS, with the greatest priority being for ambulance services. It involves participation in all aspects of EMS including training, protocol development, quality assurance, and relationships with the wider medical community to ensure the maintenance of accepted standards of medical practice. Quality medical direction for ambulance services and other components of the system is an essential process to providing optimal care for EMS patients.

Rural and Frontier Issues. Persistent shortages of all health professionals in rural and frontier areas create an additional barrier to EMS medical direction. Where local physicians are present, they often lack the training, interest or incentives-including compensation-to participate actively as EMS medical directors. In some areas, EMS personnel are the only health care providers and must seek medical direction from distant areas. This situation increases the challenge by limiting the opportunities for training, case reviews and personal interaction between EMS medical directors and local EMS providers.

EMS Medical Direction Policy Recommendations. State EMS offices should be encouraged to develop specific outreach efforts for training and supporting rural and frontier physicians to serve as EMS medical directors, including the use of distance learning techniques. Technical assistance and incentives should be provided to physicians in community health centers and other rural practices to undertake such functions. In some remote, isolated areas, non-physician providers should assist in the supervision of EMS personnel under the direction of a physician in a more distant site. State and local EMS systems should be actively encouraged to make maximum use of all licensed and certified health personnel. Funds should be identified locally to pay EMS medical directors for their service.

PUBLIC EDUCATION AND PREVENTION

Description. These two attributes of EMS are interactive and mutually reinforcing. EMS requires a knowledgeable public if the system is to function successfully. This requires a proactive public education effort on behalf of EMS. Such an effort helps in two ways: (1) to help citizens understand how the system works when it is needed, and (2) to garner support for EMS both financially and politically. It also may help recruit new volunteers or other in-kind assistance. In a similar vein, prevention activities provide an opportunity to realize significant reductions in human morbidity and mortality. Engaging in prevention activities is the responsibility of all health care workers-including EMS workers. In fact, EMS personnel bring high credibility, motivation and skills to community prevention campaigns because they are the first called when help is needed.

Rural and Frontier Issues. In some ways, the opportunities for public education and prevention activities are greater in rural areas than in larger, more complex urban areas. Well-placed public service messages about when and how to call EMS can more easily reach all homes, workplaces and civic organizations. Since most rural and frontier EMS personnel are known in their communities, word-of-mouth also can be effective. Community-based prevention activities are targeted to issues of genuine local concern based upon immediate problems, i.e., hunting injuries, water safety or farm accidents. The lack of adequate financial and training resources, however, limit these efforts.

Public Education and Prevention Policy Recommendations. Federal and state EMS offices, in partnership with public health agencies, should continue to develop and distribute public information resources to local EMS providers to be tailored for local use. Training in public information strategies and prevention activities should be made available. Prevention should be built into the EMT curricula and become part of the mission of EMS. Payers should reimburse for community-based prevention efforts and look toward personnel as both organizers and field workers in prevention campaigns. EMS personnel should be recognized as appropriate providers of primary care and public health services in remote, isolated areas and should be reimbursed for providing services.

EMS RESEARCH, CLINICAL CARE, INFORMATION SYSTEMS AND EVALUATION

Description. During the last 30 years, EMS has evolved rapidly with little research to guide its evolution. System changes often have been predicated on resource availability, perceived needs, individual personalities and product vendors. Research has lacked funding and been limited by a shortage of academic interest, restrictive informed consent interpretations, and lack of interest and education among EMS personnel. As a result of the lack of data and findings, the clinical aspects of EMS systems vary dramatically between geographic areas. Although there is some commonality in training curricula, there is no common base from which to compare systems from a clinical care perspective regarding citizen access to field response, definitive care and rehabilitation. Quality assurance programs, to the extent that they exist, are generally functional within one component of the system, but rarely include participation by all system stakeholders or different levels of care. Quality assurance and evaluation is generally accomplished without the benefit of integrated data systems that can track patients from incident to definitive care. In spite of recent progress with defining pre-hospital and trauma registry data elements, implementation of standardized information systems remains limited.

Rural and Frontier Issues. The lack of data and research to guide the clinical and operational aspects of EMS as part of overall health care delivery systems for rural and frontier areas cannot be overstated. Limited health resources require that all resources be optimally used. Research must be accomplished to assess the clinical implications of long response and transport times, the use of new drug therapies, the best ways to assess and triage patients to the right level of care on the first attempt, and many other related issues. Integrated information systems are the building blocks for such research, as well as for the day-to-day quality assurance and evaluation of EMS systems. Rural and frontier areas do not have the resources to develop and implement such systems without substantial outside support.

EMS Research, Clinical Care, Information Systems and Evaluation Policy Recommendations. Federal and state EMS offices should develop and implement standardized EMS information systems with common data elements, universal participation, and an ability to track patients from the event to definitive care and rehabilitation as a goal. To achieve this goal, there is a need to subsidize outreach, training and hardware and software acquisition for rural and frontier areas.

A national EMS research agenda, with an emphasis on rural studies geared toward injury prevention and rural and frontier EMS systems development, should be established and funding made available through HRSA in cooperation with the ORHP, the National Institutes of Health, the Centers for Disease Control and Prevention and the Agency for Health Care Policy and Research. One possible avenue to effect this agenda might be to add a rural EMS emphasis to the mission of the existing federally funded fural health research centers, or to fund a new center with this specific focus. Academic departments of emergency medicine should be encouraged and funded to actively engage in the EMS research agenda. Guidance and technical assistance in utilizing information for evaluation and quality assurance of local services and overall systems must be accomplished.

CONCLUSION

In spite of enormous progress in rural and frontier EMS in recent years, many of the traditional challenges continue to exist in far too many areas, especially in frontier communities. Further, there are new challenges brought on by the rapidly evolving changes in the overall health care system that affect, and in some cases directly threaten, the stability and functioning of EMS as a critical safety net in rural and frontier areas.

The National Rural Health Association is committed to supporting these policy recommendations to ensure that rural and frontier EMS not only survives, but thrives, to continue its critical mission into the 21st century.

RURAL EMERGENCY MEDICAL SERVICES GRANT PROGRAM

Program Purpose:

The purpose of this grant program is to assist States and their communities in developing and strengthening emergency medical services systems in rural and frontier areas.

Rationale:

Devorah - use what you wrote yesterday. Don't forget the old ladies in Iowa.

Funds may be used for:

EMS Systems Development

- Improving access to 911 services or alternative systems where the 911 option is not economically viable;
- Integrating rural community medical services with other health care providers in rural communities;
- Programs to improve access for essential EMS services, particularly in frontier communities;
- Programs to help rural EMS services develop billing systems.
- Assisting communities at high risk of losing - or having lost- their local hospital or EMS providers.
- Implementing innovative methods to deliver EMS services, including developing collaborations with neighboring communities.

EMS Provider Recruitment, Retention, and Education:

- Programs to help rural communities train local citizens in CPR and first responder capabilities
- Programs to help rural communities recruit and retain EMS personnel
- Training programs to help EMS volunteers in rural areas obtain, maintain and upgrade their
  skills to meet state licensure requirements
- Distance learning programs for EMS volunteers, EMS physicians, hospital staff and others who would otherwise have to leave their communities to obtain appropriate

training and support.

Authority:

The Rural Emergency Medical Services Grant Program can be administered through Rural Health Outreach Grant Program, authorized by Section 330 A of the Public Health Service Act, as amended by the Health Care Consolidation Act of 1996.

The authorization level of that grant program is $36 million for FY 1996, and such sums as may be necessary for each of the fiscal years through FY 2000. (NOTE: We'll have to make sure that Section 330A gets reauthorized, to be able to make 3 + 2 year awards in FY 2000. That shouldn't be a problem. NO one likes to cut off funds in the middle of a grant program).

Requested appropriation:

$100 million over 5 years.

Eligibility:

Eligible entities would include States, or regional consortiums (which could include multi-state consortia) formed for this purpose. Applicants must be not-for profit entities.

Length of the Award:

Awards will be made for 3 years, with an optional two year renewal grant.

Restrictions:

Of the total funds awarded to the grantee, 25% of the funds must be spent in rural or frontier communities. States may retain 25% for administration, to include State-wide planning, technical assistance, evaluation, standards development, personnel, and overhead.

Evaluation

The Administering Agency may reserve no more than .05% of the annual appropriation for the development and implementation of program evaluation.

Grantees must submit a grant program evaluation plan as part of their application, and participate in program-wide assessment activities.

Application Procedures:

States and/or regional consortiums would be required to submit an application, describing the States' current needs for improved access to essential EMS services in rural and frontier areas.

A template would be developed, including criteria for application evaluation.

States may submit, as part of their application, a request for support of a six month planning period. Program activities to improve rural/frontier services must be implemented within the first year after award.

Allocation of funds:

DEVORAH - This gets tricky.

We could limit this to States that have rural populations that would fit Federal definition - this would exclude RI, NJ, DE - and we think that politically, you wouldn't want to do that. (DE = NGA).

We could give each State would $100,000 in the first year, for planning purposes. That way NO state walks away empty handed, and they all have a plan.

Then ask them to submit their plans. Plans would be reviewed by a peer review process, and selected for merit. States would be required to limit their request to a total of $5 million over five years.

We would fund down the merit review list until all funds appropriated for that year are spent.

HEALTH RESOURCES AND SERVICES ADMINISTRATION
OFFICE OF THE ADMINISTRATOR

DATE:_____ TO: Deborah Adler

FAX: (202) 456-5557 OFFICE:_____

NOTE:_____

FROM:_____

PAGES SENT:_____

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Rockville, Maryland 20857

Phone: 301 443-2216
Fax: 301 443-1246

Please confirm receipt of fax. Thank you.

Omnibus Spending Bill Holds $25 Million to Improve Rural Health

Tucked inside the nearly 4,000 page omnibus spending bill that Congress sent to President Clinton October 21st is a $25 million appropriation to enable states to implement the new Rural Hospital Flexibility Program. The program was part of the Balanced Budget Act of 1997, but its state planning function was left unfunded until now. [See *Capital Area Rural Health Roundtable Notes*, fall 1998.]

The $25 million grant program to states will be administered by the Federal Office of Rural Health Policy (Health Resources and Services Administration), which will make an announcement in March, with applications due in May.

The Rural Hospital Flexibility Program, sponsored by Senator Max Baucus (D-MT), provides Medicare cost-based reimbursement for Critical Access Hospitals (CAHs) - a limited service model for small rural communities that has been in the testing stage for several years in Montana and other states.

Strategic Effort's the Thing

The conference agreement provides the $25 million to help states develop and implement a rural health plan, develop networks, and designate Critical Access Hospitals, and to improve rural emergency medical services, as well as other activities. The funds may also be used to support local citizen, employer and provider efforts to carry out community development activities that would identify health local care needs and design a system of services to meet them.

Technical assistance will also be in the picture. States could make funds available to hospitals and other providers to develop integrated networks, examine prospects for conversion to CAHs, improve information systems and quality assurance programs, as well as other activities.

The $25 million covers the first year of an authorization that runs through 2002.

The new funding comes at a time when rural services are facing a manifold increase in pressure on their revenues as the Health Care Finance Administration plans a giant leap forward in prospective payment - to be applied in the next few years to out-patient care, home health, hospice, skilled nursing facilities, and even EMS. When the Medicare specified payment system was first introduced for in-patient care, hundreds of rural hospitals were closed in the late 1980s. Others began shifting their costs and operations to outpatient and post-acute care to survive.

No longer able to support a hospital in every hamlet, federal policy now stresses the potential for rural communities to pool resources and integrate primary care, emergency medical services, hospital and post-acute care through local network building.

Officials at the Office of Rural Health Policy say the $25 million will be administered to emphasize the need for comprehensive, community-based planning and technical assistance. The office expects to make awards by September of 1999.

authorization — 4 years
1 year of $

Appropriations Bill, 1999
Labor, HHS & Education
Conference Report
(October 1998)

The conference agreement provides $25,000,000 to fully fund the Medicare Rural Hospital Flexibility Grants Program authorized in the Balanced Budget Act of 1997. This program will provide grants to States to help them improve access to essential health care services in rural communities by: (1) developing and implementing a rural health plan; (2) developing networks; (3) designating Critical Access Hospitals (CAHs); and (4) improving rural emergency medical services and other activities. It will provide support for local citizens, employers, and health care providers to conduct the community development activities that are necessary to identify their health care needs and design a local system of care to address them. For hospitals and other providers, this program will provide technical assistance and support to: (1) develop integrated networks of care; (2) examine the conversion to CAHs; and (3) improve information systems, quality assurance programs, and other activities. The conference agreement would provide for the operation of this program as a new activity by HRSA. This activity was included within the Health Care Financing Administration in the Senate bill. The House bill contained no similar provision.

NATIONAL RURAL HEALTH ASSOCIATION

FAX TRANSMISSION

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Date: 23 November

To: Sarah Bianchi - Office of Domestic Policy

Fax Number: 456-5557

From:

- ☒ Darin Johnson, Government Affairs Director
- ☐ Linda Rouse, Government Affairs Special Assistant
- ☐ Doretha Harris, Senior Administrative Assistant
- ☐ Other _____

Subject: Sarah - Here are some funding ideas on Rural EMS that the NRHA's Rural EMS Task Force put together for you. Hope our suggestions are helpful. I'm also sending you an article on Medicare + Choice plans which emphasizes the need for rural demos to be funded. Give me a call if you have any questions on either subjects. Hope Mrs. Gore's speech in Tennessee went well - let me know - Darin

Pages (Including Cover Page): 3

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Rural EMS Funding Ideas

- Develop new ways to educate emergency health care providers using technology-enhanced educational methods such as distance learning, use of human patient crisis simulators, etc. Dollars could flow through State EMS Offices to appropriate training institutions to do rural outreach courses to move from basic to Advanced Life Support in the rural areas that need it most. This could also support long-distance learning projects to facilitate reaching most in need (Develop web-based methods of life support sources).

- Support for training rural physicians and mid-levels providers in emergency care techniques and in serving as EMS Medical Directors for local EMS squads. This is an important function and few family practice types receive any training on this.

- EMS demonstration and innovation projects consistent with the "EMS Agenda for the Future" to facilitate enhanced integration of EMS into broader rural health care systems.

- EMS demonstration/innovation projects to enhance EMS as an adjunct to rural public health efforts regarding immunizations, injury prevention, community health education, and screening for alcohol, smoking, obesity, domestic violence, etc.

- Support the study of rural EMS reimbursement and financial viability. With low volumes, the challenge of ensuring preparedness and guaranteeing 24 hour / 7 days a week service availability is often impossible. HCFA needs to explore payment for response and triage, as well as for transportation.

- Develop methods and/or models of horizontal and vertical collaboration among health care providers in rural areas to include EMS as a partner.

- Improve reimbursement strategies for rural EMS providers based on an EMS medically underserved area model.

- Assist in the continued development of 911 center in rural areas considering the multi-county model as a way of maximizing on limited resources.

- Develop methods to assist rural areas and communities in recruiting or training true EMS managers to assist rural (often volunteer) agencies in operating their service as a business to keep the service operational. Develop a system to increase volunteerism among EMS providers in order to recruit new EMS personnel as well replace those leaving EMS.

- Develop more efficient system to easily identify rural locations in order to expedite response times. This could involve use of GPS systems.

should subject inherent reasonableness reductions to notice and comment procedures, SBA says.

Competitive Bidding. SBA advises HCFA to consider modifying its request for bids to impose the least burden on the industry -- an industry comprised primarily of small businesses. "Because large national companies/franchises may *initially* offer services and products at prices below those of smaller companies, it may be difficult for small businesses to participate effectively or successfully in the bidding process unless HCFA takes certain precautionary steps to guard against unfair competition. . . . Making the assumption that small businesses may not be able to offer the cheapest prices would seem to superficially buttress HCFA's goal of establishing a limited number of providers so as to save Medicare dollars. However, it is important to emphasize that HCFA's mission must be balanced with national objectives to preserve competition and to not use federal policy to upset regional economies."

SBA has been pushing for a larger role in HCFA's regulatory process. In August, HCFA told SBA that it would solicit SBA's input earlier in its rulemaking process (*Inside HCFA*, Aug. 20, p3). However, HCFA has not even come close to following through on this promise, a SBA source said.

Could be critical for AIDS patients

HCFA SEES 51,000 MANAGED CARE BENEFICIARIES FACING PLAN CHANGES

Top level HCFA officials delivered the latest report on the Medicare managed care nonrenewal crisis late last week, arguing that the issue is not a crisis, but conceding that 51,000 Medicare beneficiaries face higher medical costs because there is no Medicare managed care option now that their plan has terminated. HCFA officials also conceded that 3,800 of these beneficiaries are disabled under 65, many of them AIDS patients on expensive daily medication that is not now covered because of plan terminations.

HCFA officials reportedly tried to paint a positive picture, asserting that individuals affected by terminating plans have traditional Medicare/Medigap options and adding that only 6.5-million Medicare beneficiaries have had access to managed care options compared to the total beneficiary population of 39-million. But these officials did concede that in many states the Medigap option is not available for disabled Medicare beneficiaries under 65, and offered no relief for AIDS patients in this category whose $12,000-$18,000 annual medication bill is not now covered.

Overall, HCFA officials painted the following picture: Medicare managed care plan terminations or reductions in service areas have affected 30 states and the District of Columbia and that the current count is that 406,000 beneficiaries have been disenrolled. Forty-three plans have decided not to renew coverage and 53 plans reduced coverage in service areas. As a result of the White House initiative to encourage plans to enter these areas of lost service with expedited application review, only three plans have submitted new applications.

A total of 51,000 beneficiaries of the 406,000 have no managed care alternative. These 51,000 beneficiaries are in 75 counties nationwide, with 50 of these counties in rural areas.

In the category of disabled under 65 and end stage renal disease (ESRD) patients, HCFA reports that 34,000 have been disenrolled (500 ESRD patients) in 75 counties. A total of 3,800 (and 55 ESRD patients) disabled under 65 have no other managed care option. They are in 50 counties nationwide.

HCFA reported that 13 states have mandated guaranteed issue Medigap insurance to Medicare beneficiaries under 65 and 17 other states have some but not all kinds of Medigap coverage. But HCFA officials did not break down how many of the 3,800 are in these states.

While the agency sought to explain that the dislocations are less sweeping than currently portrayed in media accounts, HCFA officials did encounter strong criticism from a number of patient advocates, who argued that a significant number of beneficiaries are without options and facing astronomical drug bills because of the plan terminations. AIDS activists were reportedly the most vocal.

HCFA responded that new managed care plan applications would be final by Nov. 13, almost two weeks later than planned, and conceded that the first "open season" for Medicare+Choice would be limited, given the season is statutorily over by the end of November. Patient groups complained that because of the Thanksgiving holiday, the open season has effectively been reduced to Nov. 13 - 25. For some patients who are considering moving to a state with managed care plans that cover prescription drugs, this is a hardship, activists asserted. HCFA officials asserted they are encouraging plans to hold open enrollment beyond Nov. 30, but they conceded that statute does not require plans to do so.

HCFA officials promised new "interpretations" of the Balanced Budget Act of 1997 in the area of Medicare+Choice on Nov. 13, according to sources at the meeting. But officials said that no additional funds are available to bolster state health insurance professional counseling to manage the transitions needed because of plan terminations.

Federal Office of
RURAL HEALTH
POLICY

U.S. Department of Health and Human Services

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TO: D. ADLER

FAX NO. 202 456 5557

NO. OF PAGES 3 **(including this page)**

FROM: **Jerry Coopey**
Director of Government Affairs

MESSAGE:

ADDITIONAL INFO

Rural Hospital Flexibility Grant Program

Authorizing Legislation - Section 1820 of the Social Security Act as amended by the Balanced Budget Act of 1997, and OCA Act of 1999 (PL 105-227).

FY 1988 Enacted BA	FY 1999 President's Budget BA	FY 1999 House BA	FY 2000 Estimate BA
0	0	0	$25,000,000*

2000 Authorization.....Indefinite

* This funding transferred from HCFA to HRSA by Congress.

RATIONAL FOR THE BUDGET REQUEST

A total of $25,000,000 is requested for FY 2000 which is $25,000,000 more than the FY 1999 President's Budget.

Millions of Americans living in rural areas of the country do not have adequate access to even the most basic health care services. Sixty-eight percent of all primary care Health Professional Shortage Areas are rural. More than 2,000 physicians are needed to meet the basic needs of these Americans and the shortages of psychiatrists, nurses, and dentists are even larger. More than 260 rural hospitals have closed since 1985 and many others are at high risk of closure. Most rural Americans do not have access to integrated systems of care. The rural occupations of farming and mining are among the most dangerous in the country. Over 50 percent of all fatal vehicle accidents occur in rural areas, yet rural emergency services are understaffed, poorly financed and almost always fragmented from other health care services in rural communities.

The Rural Hospital Flexibility Grant Program provides grants to states to help them improve access to essential health care services in rural communities by: (1) developing and implementing a comprehensive rural health plan, (2) developing community health networks, (3) designating Critical Access Hospitals (CHAs), and (4) improving rural EMS and other activities.

The Rural Hospital Flexibility Grant Program provides support for local citizens, employers and health care providers to conduct the community development activities that are necessary to identify their health care needs, and design a local system of care to address them. Health care is the largest employer in rural America, and it's essential that these dollars stay at home.

For hospitals and other providers, this program provides technical assistance and support to: (1) develop integrated networks of care, (2) examine the conversion to CAHs, (3) develop information systems and telehealth activities, (4) improve their quality assurance activities, (5) conduct a financial feasibility analysis and (6) improve their rural EMS system through integration.

This program helps States develop their rural policies and regulations so as to: (1) proactively respond to market changes, (2) remove any restrictive standards and authorities, (3) support network development and regional approaches to health care and (4) support hospitals that want to respond to ongoing market reforms.

Outputs:

	FY 1998 Enacted	FY 1999 President's Budget	FY 2000 Estimate
Number of Awards.....	0	0	48

A:\BUDGET.DFT
November 24, 1998

RURAL PPS

predetermined amt per case for outpts

assume that volume of lower cost hosp cases will make up for more expensive cases

HCFA & HRSA; ones hurt the most are small, rural, govt owned, sole community providers, reduction 15-16% aggregate.

reg has an impact table

options: floor
phase in

budget neutral system.
so floor doesn't work.

after Y2K implemented
will be implemented;
system is complex.

any fix would have
to take larger urban
hospitals

exceptions - law says
that they can't.

average idea

Fed Reg: 9/8 p. 47-583

Teresa Tacoma.

HEALTH RESOURCES AND SERVICES ADMINISTRATION
OFFICE OF THE ADMINISTRATOR

DATE:_____ TO: Dewolf

FAX:_____ OFFICE:_____

NOTE:_____

FROM:_____

PAGES SENT:_____

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Phone: 301 443-2216
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Please confirm receipt of fax. Thank you.

don't include in cleared package - we've not run this through the Pgst.

RURAL EMERGENCY MEDICAL SERVICES

In its budget submission for FY 2000 the Health Resources and Services Administration has included an increase of $4 million in the Rural Health Outreach Grant Program for a small number of demonstration programs to better integrate rural emergency medical services (EMS) with other health care providers in rural communities (see attached). An additional amount up to $50 million could be used for a grant program to improve access to essential EMS services in rural and frontier areas of the country.

Viable EMS systems are particularly critical for residents in rural and frontier areas. The country's most dangerous occupations - farming, mining and fishing - are predominantly or exclusively rural, and rural residents experience disproportionate rates of trauma and medical emergencies. Long distances between hospitals, tertiary care centers and other providers can increase morbidity and mortality from medical emergencies. Many rural communities also have disproportionate numbers of elderly, placing even greater importance on creating and maintaining strong systems of emergency care.

The problems are great. Many areas of the country (about 22% of the land area) do not have access to a 911 capability. Most of these areas are rural. In too many communities the local hospital has closed or is in danger of closing. The closure of a hospital brings with it a loss of reasonable access to emergency care. This is particularly threatening to elderly citizens in these communities.

Financing modern emergency care systems in small rural communities is difficult at best. Many rural and frontier communities across the country are faced with shrinking tax revenues, difficulties in recruiting and retaining unpaid volunteers, problems in obtaining updated ambulance equipment and communications, difficulty in finding dollars to support training for volunteer EMS personnel, and a host of other problems. Funds that were once available from federal programs have largely disappeared and state funds are scarce.

there is no federal role — $50 million —

* An expanded federal role in strengthening rural EMS systems could address these problems. The Rural Health Outreach Grant Program is currently available to rural communities and to EMS providers in those communities. An expanded program of Outreach Grants could support projects in such areas as:

-Training programs to help EMS volunteers in rural areas obtain, maintain, and upgrade their skills to meet state licensure requirements.

-Programs to help rural EMS services develop billing systems for their services.

* the President is seeking infrastructure building
* use existing authorities for demonstration grants to States to improve their EMS capacity

-Programs to help rural communities train local citizens in CPR and first responder capabilities.

-Programs to help rural communities recruit and retain EMS personnel.

-Programs to improve access to 911 services or alternative systems where the 911 option is not an economically viable option.

-Distance learning programs for EMS volunteers, EMS physicians, hospital staff and others who would otherwise have to leave their communities to obtain appropriate training and support.

Grants to States

The grants would be available to non-profit organizations in rural communities, including hospital, EMS providers, local government entities, community colleges, etc. /State

NATIONAL RURAL HEALTH ASSOCIATION

November 9, 1998

The Honorable Nancy Ann Min DeParle
Administrator
Health Care Financing Administration
314-G Hubert Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20101

Dear Administrator DeParle:

The National Rural Health Association (NRHA) is writing to adamantly oppose as written the proposed rule published in the September 8, 1998 Federal Register regarding the implementation of a Medicare Prospective Payment System (PPS) for hospital outpatient services. The Health Care Financing Administration must reevaluate the outpatient PPS methodology which reduces payments for low volume rural providers, and ensure a proper payment methodology is put into place that guarantees health care services will continue to be available to Medicare beneficiaries residing in rural and frontier communities. At a minimum, a payment floor must be established to protect low-volume, rural providers from the effects of the proposed PPS system.

While others may argue that a phase-in of the proposed PPS payment methodology will assist small, rural providers, the NRHA strongly disagrees. HCFA's own analysis of this proposal highlights the dramatic impact this methodology will have on low-volume, rural providers. This fact will not change whether this PPS system is implemented now or over 5 years. Its effect will ultimately be the same - small, rural hospitals and Medicare beneficiaries will be placed in a more financially vulnerable situation. If rural hospitals are forced to close because of this proposed payment methodology combined with other reimbursement reductions and regulatory requirements incurred as a result of the Balanced Budget Act, access to care for seniors in rural areas will be jeopardized.

The dependency of small, rural hospitals on outpatient services was recently well documented by Project Hope's Walsh Center for Rural Health Analysis in the attached study entitled "The Financial Dependence of Rural Hospitals on Outpatient Revenue." The study concludes that rural hospitals are more vulnerable to outpatient payment reform than urban hospitals because of their smaller size and the historical difficulty of small hospitals in achieving a positive operating on patient activities.

Donna M. Williams
Executive Vice President

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According to the Walsh Center study, rural hospitals have come to depend on outpatient services as an important revenue source. For some rural hospitals (25-100 beds), outpatient services total 45 percent of total revenue compared to less than 33 percent for their urban counterparts. Many of these hospitals already have negative operating margins, making them extremely vulnerable to the effects of outpatient payment reform. It appears the effect is greater on government owned hospitals and hospitals with less than 50 beds. It is these hospitals that are providing services to the rural and remote areas of our nation, and generally serve communities with high Medicare populations.

Also, a significantly higher number of rural hospitals are experiencing financial difficulties besides their dependence on Medicare outpatient revenue, which makes them extremely vulnerable to any changes in payment methodology. The failure of HCFA to properly recognize the importance of these rural providers as the safety net for health care services in these rural communities will continue to erode health care services to many rural and frontier populations. A careful analysis of hospital closures since 1983 shows that with each payment methodology reform, hospital closures increase.

Below are a number of specific comments and concerns the NRHA would like to share regarding the proposed outpatient PPS regulation, and which only further justify the importance of HCFA establishing a payment floor or new methodology for low-volume, rural providers. The NRHA strongly urges HCFA to takes these items into consideration as it drafts a final rule.

Bundling Services Into The New Payment (p. 47560)
Some of the items included could have a disproportionate impact on rural hospitals:

- "Certain preventive services" may have varying costs as functions of distance from main facility and patient volume;
- including drugs could be more problematic for low-volume institutions if drug prices continue to escalate faster than can be accounted for by updating payment rates.
- low-volume providers will not be able to make use of volume purchasing discounts for supplies, driving their variable costs higher than average hospitals resulting in them losing money under a fixed rate PPS plan;
- if this provision includes "clinic visits" at all hospital affiliated clinics, including those at satellite settings, such clinics may be forced to absorb their own capital costs.

Payment For Services That Do Not Require Emergency Room Use (p. 47566)
While HCFA is correct in assuming many ambulatory visits need not take place in an emergency room, the availability of local resources should be considered in setting the payment. For example, a rural community with one physicians' office and a hospital may find it more practical to use the hospital emergency room than to staff a physicians' office. Rural communities will not have the "doc in a box" option available to urban communities.

Geographic Standardization (p. 47572)
To continue on a flawed wage index methodology will compound the damage already being done to the rural health care delivery infrastructure.

Adjustments For Rural And Teaching Hospitals (p. 47585)
The proposal not to adjust for the disproportionate costs incurred by these hospitals is based on the fallacy that the average is good for individuals. Even in the aggregate, differences between expected payment without PPS and payment under PPS are high for hospitals operating at low margins (e.g., rural hospitals and some teaching hospitals). Disaggregated, the consequences can be even more severe, affecting access for some Medicare beneficiaries. Teaching hospitals in the Midwest, that are not benefiting from other changes in payment under distribution of GME adjusters (for higher paid specialists) are among the most vulnerable to the proposed changes in outpatient payment. Small rural hospitals are extremely vulnerable, because they rely more on outpatient revenue (data in the regulations), have lower margins overall, and have less ability to shift costs to other payment streams. *At a minimum, the phase-in suggested in the first option should be adopted.*

Exception For "Main Provider" (p. 47591)
The regulation solicits comments on including as "main provider" providers located in an different state but in the same metropolitan area. This exception should apply in rural areas as well when a regional hospital is on the state border and establishes a provider-based entity across the state line that improves access to care.

Just as HCFA has recognized the special needs of small, rural hospitals in creating such programs as the Sole-Community Hospital program, the Medicare Dependent Hospital program, and the Medicare Rural Hospital Flexibility/Critical Access Hospital program, the NRHA believes it is consistent to make special considerations for low-volume, rural hospitals in this case.

In closing the NRHA requests that HCFA reevaluate the outpatient PPS methodology it has proposed and which reduces payments for low-volume rural providers. Instead, a revised payment methodology or a payment floor should be put into place that guarantees health care services will continue to be available to rural Medicare beneficiaries.

If you have any questions concerning the NRHA's comments, please feel free to contact us or Darin Johnson, the NRHA's Government Affairs Director, at (202) 232-6200. Thank you in advance for your consideration of our comments on this proposed regulation impacting rural and frontier health care beneficiaries and providers.

Sincerely,

Gail R. Bellamy, PhD

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President

Marvin Cole

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Date: 9 November

To: Sarah Bianchi ~ The White House

Fax Number: 456-5557

From:

- ☑ Darin Johnson, Government Affairs Director
- ☐ Linda Rouse, Government Affairs Special Assistant
- ☐ Doretha Harris, Senior Administrative Assistant
- ☐ Other _____

Subject: Sarah - This is a major issue for NRHA and rural hospitals. We really need the White House's help on this one as HCFA isn't showing any flexibility. I know the Ed. Office of Rural Health Policy made some very helpful suggestions which were completely ignored by HCFA. Call if you have questions. Thanks.

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Issue Brief

Health Policy Studies Division
Contact: Tracey M. Orloff, 202/624-7820
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State Challenges and Opportunities in Rural and Frontier Health Care Delivery*

Summary

The demographics and health care needs of rural and frontier populations differ from those in urban communities. The number of elderly is increasing, nearly 20 percent of these populations are uninsured, and residents often have to travel long distances to access needed health services and facilities.

Rural and frontier communities are constantly struggling with how to build and support their limited health system capacity and infrastructure. They face difficulties in recruiting and retaining providers, establishing telemedicine systems, and maintaining adequate emergency medical services. In recent years, states' primary rural and frontier challenges have expanded to include developing more long-term care options and determining whether and how to incorporate managed care into rural health care delivery. States are responding to these challenges by:

- improving provider recruitment and retention;
- developing telemedicine capacity;
- increasing the availability of emergency medical services;
- exploring long-term care options; and
- promoting community-based managed care approaches that respond to rural health needs.

The passage of the Balanced Budget Act of 1997 also has created some important opportunities for states trying to deliver and pay for health services in rural and frontier communities. Two programs authorized by this legislation—the Medicare Rural Hospital Flexibility Program and the State Children's Health Insurance Program—are particularly relevant for these communities. States need to consider how they will take advantage of these opportunities. In the short term, program implementation could pose a challenge for them.

At a recent National Governors' Association (NGA) Center for Best Practices' roundtable on rural health in Bismarck, North Dakota, participants discussed the continuing challenges and new opportunities facing states' frontier and rural areas as well as successful tools to build and support health care capacity and infrastructure in these communities. Representatives from eight states participated in the roundtable—Idaho, Montana, Nebraska, Nevada, North Dakota, South Dakota, Utah, and Wyoming. Many of the issues and examples highlighted in this *Issue Brief* are drawn from the discussions at this May meeting. The *Issue Brief* describes the unique characteristics of rural and frontier populations, outlines the barriers to rural and frontier health care delivery, describes some successful state responses to these challenges, and examines new rural health care delivery opportunities for states.

Unique Characteristics of Rural and Frontier Communities Affecting Health Care

Rural and frontier residents comprise approximately one fifth of the U.S. population.[1] However, they do not have the same level of access to basic health care services that is available to other Americans. Poverty, inadequate transportation, large geographic distances, and an aging population base complicate health care delivery in rural and frontier communities. Frontier areas differ from rural areas in that they are characterized by more extreme remoteness, isolation, and population densities of less than seven people per square mile.[2] It is these characteristics, coupled with a fragile or nonexistent health care infrastructure, that make the delivery of rural and frontier health care services a formidable challenge for states.

The changing demographics of rural and frontier populations exert pressure on the limited range of health care services and providers that exist in these communities. Younger people have been leaving many rural and frontier communities for urban centers, which makes filling professional and voluntary health care positions from within the community more difficult. Moreover, the number of elderly in these areas has increased, and this population is living longer because of advances in medical pharmaceuticals and technology. From 1990 to 1996, the number of elderly ages sixty-five and older living in rural and frontier areas increased by 7.3 percent. However, the growth in rural and frontier elderly ages eighty-five and older was even more dramatic, increasing more than 20 percent during the same period.[3] These elderly residents also are very interested in alternative health care service options that enable them to age at home.

Rural and frontier residents of all ages also are more likely to be uninsured, 19.8 percent compared with 16.3 percent for those in urban areas.[4] This is because private health insurance coverage is less available through rural and frontier workers' employers. In addition, farm families are less likely than other working families to have employers who contribute to health insurance premiums.[5] Further, poverty is more widespread in rural and frontier areas, so many residents have difficulty purchasing their own health insurance.[6]

Barriers to Effective Health Care Delivery in Rural and Frontier Areas

States recognize that the rural and frontier health infrastructure must be strengthened to develop a statewide health care delivery system. Although states are at various stages of developing and implementing approaches to address systemic health system change, rural and frontier areas pose unique challenges. The most prevalent challenges to rural and frontier health care delivery include recruiting and retaining providers, overcoming barriers to telemedicine development, maintaining an adequate emergency medical services system, developing long-term care options, and determining how managed care could be structured to meet rural health needs.

Challenges in Recruiting and Retaining Providers

Recruiting and retaining health care providers has been a long-standing challenge for most rural and frontier areas. Often there is an insufficient supply and/or mix of health care practitioners in the community to provide needed inpatient and outpatient health care services. The U.S. Department of Health and Human Services recommends that for an "adequately served population," the provider-to-patient ratio should be one primary care physician for every 2,000 people. Most rural and frontier areas have a provider-to-patient ratio of 1 to 3,500 or worse, causing them to be federally designated as health professional shortage areas (HPSAs). In 1997 more than 2,200 physicians were needed in rural and frontier areas to remove all of these federal HPSA designations.[7]

Provider recruitment and retention problems in rural and frontier areas are driven by several factors. Many rural and frontier providers lack backup from other qualified health care professionals, making it difficult for them to take sick or personal leave or a vacation. In addition, their salaries often are lower

than their urban counterparts, particularly given costly malpractice insurance premiums. Rural and frontier areas also offer a limited range of local amenities for providers and their families (e.g., adequate schools, recreational activities, and career opportunities for spouses). Finally, extreme geographic isolation limits providers' professional and personal interactions with their peers and access to continuing medical education and training opportunities. As a result of these factors, less than 11 percent of the nation's physicians are practicing in rural and frontier areas.[8]

Despite these challenges, many rural communities are making progress in addressing provider access problems. The nationwide increase in the number of primary care providers and innovative recruitment and retention strategies are contributing to their progress. However, many frontier communities and some rural communities continue to have difficulty recruiting and retaining providers.

Problems in Telemedicine Development

Telemedicine enables patients and providers to interact with health care professionals located miles apart. It increases patients' access to specialists through video-imaging and real-time collaboration using computer and telecommunications technology. Telemedicine also brings continuing medical education and training to isolated providers. "Access to quality health care has a major influence on quality of life, and this is a significant issue for rural communities," said North Dakota Governor Edward T. Schafer at the rural health roundtable. "New technology offers great hope for helping us deal with this challenge." However, there are numerous barriers to using telemedicine in rural and frontier areas, including those related to provider licensure, malpractice, patient confidentiality, and insurance reimbursement.

Provider Licensure. Often a medical provider who is consulting via telemedicine lives in a different state and is not licensed to practice outside that state. This may cause a problem in paying the out-of-state provider for his or her services as well as raise questions about whether state licensing regulations are being violated.

Malpractice Liability. The use of telemedicine complicates determinations of the responsible party when an error occurs. For example, is the primary caregiver, specialist, or telemedicine equipment manufacturer liable? Which state has jurisdiction to hear the complaint in cases in which the parties are located in different states? It also is possible that malpractice suits related to the use of telemedicine will increase because of the impersonal nature of the service; it is easier to sue an image on a screen than a person. Conversely, malpractice suits may decrease because videotapes of the encounter would offer fairly definitive proof of whether malpractice has occurred.

Patient Confidentiality. Many health care consumers are unaware that their medical records often are transferred through data systems that are not secure. This means that employers, insurance companies, and other entities could have unapproved access to patients' medical records. The problem is compounded because states have different rules governing patient confidentiality matters.

Insurance Reimbursement. Medicare and most insurance carriers are accustomed to traditional face-to-face encounters between physicians and patients and hesitant to accept telemedicine encounters as reimbursable services. However, some progress has been made in recent years. The Balanced Budget Act of 1997 now allows Medicare to reimburse for telehealth services. During the past several years, Medicaid regulations also have afforded states more flexibility in this area.

Through telemedicine, unnecessary patient travel to tertiary care facilities can be avoided. However, for telemedicine to reach its full potential, states will need to incorporate health-care applications into their telecommunications planning and develop interconnection capabilities among states.[9]

Difficulties in Maintaining Adequate Emergency Medical Services

Rural and frontier residents live in remote areas with limited access to comprehensive health care services, so it is critical that they have an adequate emergency medical service (EMS) system to provide immediate, crisis-oriented medical assistance. EMS systems also provide rapid transportation and triage patients to appropriate medical facilities.

Many rural and frontier areas have difficulty maintaining their emergency medical services system. A common problem is insufficient state funds to purchase the emergency medical vehicles and equipment needed to establish and maintain local and statewide EMS systems. In addition, many rural and frontier communities have an insufficient number of EMS personnel to serve local residents and must rely on a combination of volunteers and permanent EMS staff. Changes in state licensure and training requirements that force a reduction in the number of eligible volunteers exacerbate the shortages in EMS personnel and cause additional tensions.

The Growing Demand for Long-Term Care Options for Rural and Frontier Elderly

States are becoming increasingly concerned about the growing demand for long-term care services in rural and frontier communities. The proportion of elderly residents living in these communities is increasing, and they are living longer because of changes in medical pharmaceuticals and technology. Many are interested in options that enable them to age at home.

Some of the long-term care options that states are considering include:

- home and community-based services, which include home health services, personal care services, adult day health care, adult day care, and informal care given by a relative or friend, to help the elderly live at home for as long as possible; and
- assisted living facilities, which link health, social, personal care, and housing services, to enable seniors to continue to live independently in the community.

Some states will have to pass new legislation, change regulations governing long-term care facility development, obtain federal Medicaid waivers, or provide state waivers to implement these alternative care options.

Issues Related to Rural Managed Care and Medicare + Choice

Managed care is being used in many urban areas to hold down health care costs and help ensure the delivery of quality care. To date, managed care has had limited penetration into rural America, and it is unclear whether a one-size-fits-all approach to health care delivery can meet the unique and differing needs of rural and frontier communities. However, given the increase in the number of elderly living in rural areas; the development of Medicare + Choice, the Medicare managed care program under Part C of Medicare; and the maturation of managed care nationally, states will need to explore whether and how rural managed care could be structured to meet the needs of rural and frontier populations.

Managed care plans can be structured creatively to meet the unique health care needs of a community, or they can disregard the community's needs and cause local conflict and financial tensions. To incorporate managed care successfully, rural and frontier areas need more flexibility in developing their financing structures and risk-sharing approaches with managed care entities. Other problems that could emerge depending on how managed care is implemented in rural and frontier areas include the following.

- Health plans could pressure local providers who are not willing to participate in managed care to leave the area.
- Health plan administrators could discontinue serving rural and frontier areas after a limited time i these markets do not prove profitable. For example, some private managed care companies

recently withdrew their Medicare health maintenance organization (HMO) services in several rural areas in California, Ohio, South Carolina, and Utah because they were over-subscribed and losing money.[10] However, in some cases, locally developed health plans are willing to make a long-term commitment to rural communities even when their profit from these markets is inconsistent. By including commercial, Medicare, and Medicaid products, these plans are able to maintain services to all residents in the community.

State Efforts to Address the Barriers to Rural and Frontier Health Care Delivery

Many states are implementing creative approaches to improve access to rural health services and tackle rural health care delivery problems. Their efforts are focusing on improving provider recruitment and retention, developing telemedicine capacity, increasing the availability of emergency medical services, exploring long-term care options, and promoting community-based managed care approaches that respond to rural health needs.

Improving Provider Recruitment and Retention

The backbone of any health care delivery system is access to primary and specialty care health professionals. The strategies used to recruit and retain health care providers have increased and improved over the years with the support of the state and federal governments and the implementation of new computer and telecommunications technology.

South Dakota Governor William J. Janklow launched the multifaceted Recruitment and Retention Initiative in 1996 when he appointed a blue-ribbon Task Force on Family Practice Residents. The task force had three primary goals: to determine the appropriate level of state subsidy for family practice residents to induce them to take placements in rural and frontier South Dakota; analyze and improve existing recruitment programs; and determine current and future needs for family physicians and primary care mid-level providers.

As a result of the task force's work, the state made several changes. The family practice (FP) residency subsidy was changed from an annual, line-item special appropriation to a component in the department of health's budget. Connecting the subsidies to the department's budget improved the coordination of all recruitment activities among the health department, the University of South Dakota School of Medicine, and the two FP residency programs. The subsidy also was increased by $55,000 per year for the next four years. In addition, the state ended or replaced most of its scholarship programs with tuition reimbursement programs that retire loans after the completion of medical education training in exchange for practice in rural communities. The back-end reimbursement amounts for these positions also were doubled. The state took this action because scholarship recipients who had their education expenses paid for at the front end had higher default rates on their rural work commitments.

Further, South Dakota created a full-time state recruiter position. This recruiter is the central contact for communities interested in identifying, matching, and recruiting health care professionals. During spring 1998, the state piloted a Community At a Glance program that four times per year showcases different recruiting communities to FP residency program participants to induce them to consider placements in these communities. The state also now conducts an annual survey of practice sites to determine the supply of and demand for health care professionals across the state.

Wyoming Governor Jim Geringer established the Wyoming Health Reform Commission in 1994. The commission recommended that a statewide recruitment and retention program be created to assist communities and health care practitioners in all aspects of recruitment. As a result, the Wyoming Health Resources Network, Inc. (WHRN) was formed in 1995 as a public-private partnership. WHRN services for communities seeking health professionals include:

- preparing practice profiles for distribution to interested candidates;
- promoting practice opportunities and communities through local, regional, and national channels;
- forwarding resumes of providers whose background and training match community needs;
- advising communities on the process and techniques of recruitment; and
- assisting communities in conducting health planning processes that fit local needs.

Services to health care practitioners seeking practice opportunities in Wyoming include maintaining biographical and preference information in a database and cross-matching this information with opportunities; referring health professionals to opportunities; answering questions about loan repayment, licensing, salary ranges, and related issues; and enabling practitioners to access a large number of opportunities through a single source.

South Dakota, Wyoming, and numerous other states also participate in the National Rural Recruitment and Retention Network. This national network complements state efforts to recruit health professionals to practices throughout rural America by helping candidates locate rural practice sites that meet their needs.

Developing Telemedicine Capacity

Telemedicine is an emerging technology, so states are still debating and exploring ways to address the barriers to telemedicine development. To date, states have made the most progress in overcoming insurance reimbursement barriers. Medicare and Medicaid reimburse for telemedicine services in most states. In addition, several states, such as California, Louisiana, and Texas, have passed laws that require private insurance companies to cover telemedicine encounters. As states' telemedicine systems mature, they will continue to develop and test solutions to provider licensure, malpractice liability, patient confidentiality, and insurance reimbursement problems.

Nevada implemented the Rural Utilities Services (RUS) project to connect rural communities and providers to training opportunities, medical specialists, and other health professionals. RUS provides distance education, continuing education, Internet access, teleradiology, and telemedicine services to nine rural counties and two urban counties. It uses a combination of funds to equip compressed-video systems, Internet, teleradiology, and audio conferencing for the participating counties. The project is responsible for training, education, statewide meetings, telehealth, and other activities that benefit rural residents, students, patients, and health professionals in Nevada. RUS is a joint effort of the University of Nevada School of Medicine, the Great Basin Community College, and the Nevada Rural Hospital Project.

A second grant awarded from the U.S. Department of Commerce's Technology and Information Infrastructure and Assistance Program has been used to add equipment to the backbone of RUS. Six rural hospital sites have been added to the RUS rural network through a combination of compressed-video, high-speed modems for still-image capture and store-forward technology for data, voice, and picture. Linkages connect rural Nevada hospitals to urban specialists for consultations, to designated urban trauma centers for emergency treatment support, and to the University of Nevada and the Great Basin Community College system for Internet connection and educational support.

In **North Dakota**, the *Medstar* project is a satellite-based distance learning network, facilitating one-way video and two-way audio and data transmission among members of the North Dakota Health Education Network (NDHEN). Network members include the University of North Dakota School of Medicine and community rural hospitals located across the state. The linked satellite network became operational in February 1995. *Medstar* is a joint venture funded by the U.S. Department of Agriculture's Rural Electrification Administration and members of NDHEN.

The primary goal of the *Medstar* project is to provide continuing medical education and medical linkages to North Dakota's rural health care professionals using innovative telecommunication technologies. Continuing medical education programs are offered to a range of health professionals, including rural physicians, nurses, emergency medical technicians, physical therapists, and physician assistants. In addition, the network enables interaction between the University of North Dakota School of Medicine and third- and fourth-year medical students and family practice residents during their rural rotations. A second project goal is to encourage network use for transmission of accredited continuing education programs sponsored by other organizations interested in rural health care. A third goal is to facilitate the delivery of nonhealth-related educational programs to rural and frontier communities in North Dakota.

Increasing the Availability of Emergency Medical Services

States recognize that sufficient financing, adequate staffing, and appropriate training are needed to maintain community emergency medical services systems. As demographics, financing, and health professional training and licensure requirements continue to change in rural and frontier areas, meeting the demand for emergency medical services is more difficult.

Colorado and **Utah** dedicate state motor vehicle violation fines and registration fees to help finance EMS. **South Dakota** funds EMS directly through state appropriations, while **North Dakota** provides state funds through ambulance taxing districts and state appropriations. North Dakota's department of health also is establishing a process to assist local volunteer ambulance organizations in submitting claims to the Health Care Financing Administration and private insurers to recoup EMS expenses covered by the state that are eligible for reimbursement. A review revealed that the state was losing substantial amounts of money that could be recouped through the claims billing process.

To maintain and encourage EMS staffing by emergency medical technician (EMT) volunteers, Governor Janklow of **South Dakota** created a task force of EMT volunteers to review state regulations and licensure issues, update training approaches, and discuss how to enable EMTs to provide EMS services in the state. **Iowa** has an "at-home-mom" program for EMS volunteers. When an EMS volunteer mom is called to duty, a local grandma takes care of her children.

Exploring Long-Term Care Options

States are responding to the growing demand for long-term care in rural and frontier communities and are exploring ways to finance that care. A Long-Term Care Task Force in **North Dakota** is evaluating the state funding formula for long-term care facilities and reconsidering the state's moratorium on the construction of new types of long-term care facilities. As part of **Nebraska**'s effort to find alternative ways to finance long-term care, a state grant program helps near-failing nursing homes convert to assisted living facilities. Grant approval priority is given first to state government facilities and then to nonprofit facilities.

Promoting Community-Based Managed Care Approaches That Respond to Rural Health Needs

States need to afford rural communities the flexibility to create managed care systems that meet their unique health care needs. Without this flexibility, many local providers may be forced out of business and may be difficult to replace if large commercial managed care plans discontinue service to these areas after several years.

To guide the development of managed care in rural and frontier markets, states can encourage health plans to consider several factors before bidding for rural managed care business. First, managed care entities must gain acceptance from the local provider community to be successful. Second, managed care plans must factor in the higher costs associated with providing care in rural communities. Finally, the plans must factor in any positive or negative affects associated with state and federal legislation regulating health plan development and operations.

States and communities can encourage health plans to share risk with local providers in creative ways to accommodate the differences and financial constraints among rural providers. Several types of risk-sharing approaches that health plans and local community providers could use include:[11]

- full or partially capped reimbursement rates;
- withholds that hold back a percentage of payments or set dollar amounts from the service fee or capped rate that may or may not be returned;
- shared percentages of both profits and losses; and
- bonuses that pay a physician or entity amounts above any salary, fee for service, or capped payment.

Managed care entities will need to change their operating methods to meet the health care needs of rural and frontier residents and establish a long-term relationship with the community. Health plans should build on and support the existing rural health infrastructure as well as include all local health care providers—hospitals, health departments, physicians, and mid-level providers.

Rural Health Plan Implementation and Monitoring. The Rocky Mountain Health Maintenance Organization (HMO) in **Colorado** has worked hard to structure its managed care plans to ensure access to quality health care at affordable rates for a broad cross-section of rural residents, including the indigent. It is a nonprofit, independent practice association-model HMO that began operations in Grand Junction, Colorado, in 1974. Statewide, Rocky Mountain HMO contracts with approximately 3,660 primary care and specialty physicians and 144 hospitals, rehabilitation centers, and skilled nursing facilities. It has three HMO plan product lines: commercial, Medicare, and Medicaid.

Over the years, Rocky Mountain HMO has entered into financial risk-sharing arrangements with individual rural communities to encourage local providers to participate in its plan. For example, one arrangement calls for a physician HMO network that splits profits and losses on an equal basis with local providers. Under another arrangement, a physician independent practice association pays participating providers on a fee-for-service basis with a withhold of between 10 percent and 20 percent held by Rocky Mountain HMO, which is guaranteed 3 percent of all revenues. In exchange, Rocky Mountain HMO facilitates electronic claims submissions, collects patient copayments, handles billing activities associated with Medicare and Medicaid beneficiaries, and performs other administrative functions to expedite the contractual relationship with local providers.

Rocky Mountain HMO tries to promote a stronger and more productive relationship with the community. It has created internal physician peer report cards, which are shared among plan providers and have resulted in improved practice patterns, outcomes, and cost-effectiveness. Rocky Mountain HMO also has hired consultants to help local hospitals improve their operations. Consultants conducted systems evaluations of how hospital operations could be streamlined and made more efficient. In another hospital, physician consultants were brought in to educate staff on trends in the health care marketplace and disease stage management. In addition, Rocky Mountain HMO has established local and regional committees to oversee and provide input to the HMO and its partners.

Utah passed legislation to safeguard the viability of local providers not included in a managed care plan panel that is serving their rural area. The law requires all HMOs to pay rural hospitals, federally qualified health centers, and their credentialed staff the same reimbursement rate as other HMO providers for services rendered to rural residents who reside within thirty miles of these facilities or private offices.[12]

One of the reasons why Utah passed this legislation is that HMOs can exclude rural hospitals and clinics from their provider panels. Such exclusion could threaten the financial viability of many rura

providers and force rural residents to travel long distances to obtain care. This was a concern in Utah because the state travel council was promoting tourism to many national parks, monuments, and scenic byways located in rural areas of the state and the tourists might need access to these local health care services. In addition, many employers in rural areas of Utah are large entities that negotiate a statewide contract or are part of a group plan. These entities desire the least expensive health care plan and, for this reason, many commercial HMO plans are operating in many rural areas.

Rural Health Network Development as a Building Block to Managed Care. Rural health networks also are being used widely to shore up rural communities' competitiveness and participation in managed care. They are composed of providers, such as hospitals, private providers, primary care clinics, local health departments, emergency medical service agencies, and specialty services providers, that choose to work together for a variety of reasons. Some networks share administrative and technical medical equipment and/or share quality monitoring systems. Others create their own integrated managed care organizations to take on varying amounts of risk so they can negotiate discounted service rates. Some of the risk-based health plans being developed include health maintenance organizations, preferred provider organizations, and provider sponsored organizations.

In **Nebraska** rural health networks have combined their resources to recruit and retain health professionals; maximize reimbursement in all clinics and facilities through improved management practices; build integrated systems that involve physicians, hospitals, mental health clinics, public health departments, and EMS agencies; and retain health care dollars by offering some type of managed care plan. Several networks are implementing Medicaid rural managed care, and five other rural networks have been meeting to determine the feasibility of creating an umbrella organization to be a risk-bearing entity under a Medicare + Choice managed care program.

New Opportunities for States to Improve Access to Rural Health Services

The Balanced Budget Act of 1997 created the Medicare Rural Hospital Flexibility Program and the State Children's Health Insurance Program (SCHIP). States can use both programs to improve access to health care services for rural and frontier residents.

The critical access hospital component of the Medicare Rural Hospital Flexibility Program offers states the opportunity to help convert full-service rural hospitals that have low hospital-bed occupancy rates to limited service hospitals that provide a reduced complement of inpatient services needed by a community.[13] In contrast, SCHIP can infuse new funding into rural and frontier communities to pay for health care services for uninsured children. Although the implementation of these new programs may present some short-term challenges to states, these programs could dramatically change the way health care is delivered in rural and frontier America.

Establishing Critical Access Hospitals

The Medicare Rural Hospital Flexibility Program can help states and rural communities improve access to essential health care services by establishing limited service hospitals referred to as "critical access hospitals"(CAHs).[14] The program allows states to designate rural facilities as critical access hospitals if they are located a sufficient distance from other hospitals, make available twenty-four-hour emergency care, maintain no more than fifteen inpatient beds, and keep patients hospitalized no longer than ninety-six hours.[15] Rural hospitals converting to CAH status do not have to meet all of the Medicare staffing requirements that apply to full-service hospitals. Critical access hospitals are reimbursed on a reasonable-cost basis for inpatient and outpatient services provided to Medicare beneficiaries.

To take advantage of this opportunity, states must submit a rural health plan to the federal Health Care Financing Administration, encourage local hospitals to participate in the program, and establish a

process for designating local hospitals that meet specific program criteria as critical access hospitals.[16] States may choose to participate in this program at any time. However, they should be aware that their Medicaid reimbursement rates could either raise or hinder interest in CAH conversions, depending on whether local providers consider these rates high, reasonable, or low.

Beginning in 1998, the Medicare Rural Hospital Flexibility program authorizes $25 million in grant funding for each of the next five years to help states develop and implement a rural health plan, develop rural health networks, designate CAHs, and improve rural EMS systems. States also can use the funds to provide technical assistance and support for hospital CAH conversions to:

- develop integrated networks of care;
- examine the conversion to CAHs;
- conduct a financial feasibility analysis;
- develop information systems and telehealth activities;
- improve quality assurance activities; and
- improve rural EMS systems.

However, no funds were appropriated in fiscal 1998. Congress has not yet decided on the fiscal 1999 appropriation for this program.

Facilitating Critical Access Hospital Conversions. State policymakers have the opportunity to develop creative and comprehensive CAH models that can include the integration of network development, emergency medical services, telehealth services, mental health services, and public health, depending on the needs of each community. To expedite appropriate and successful CAH conversions, states can encourage facilities considering conversions to:

- conduct a financial feasibility study;
- educate the physicians, the hospital staff and their governing board, and the community about the conversion;
- partner with a fiscal intermediary that understands the nuances of the CAH program so that claims processing is simplified.

To facilitate CAH conversions, **South Dakota** decided to review its regulations to identify any barriers affecting rural hospitals. The department of health used a public review process to get input from a wide range of constituencies. As a result of this effort, the state redefined its "at-risk" rural hospital category, and Governor Janklow approved the implementation of an enhanced Medicaid reimbursement rate for "at risk" and "access-critical" rural hospitals.

Implementing the State Children's Health Insurance Program

The State Children's Health Insurance Program was established by Title XXI of the 1997 budget legislation. It provides states with approximately $4.8 billion annually for five years to provide health insurance to uninsured children. According to Medical Expenditure Panel Survey data for the first half of 1996, 27.9 percent of all uninsured children live in rural and frontier areas and might be eligible for this program.[17]

States have three options for implementing SCHIP. They may expand their current Medicaid program, establish a separate state-designed insurance program, or combine these two approaches.[18] The most significant challenge in implementing SCHIP in rural and frontier areas will be to promote easy access to the program, as well as a positive image of the program, so all parents, including those in working families, enroll their children. SCHIP implementation in these hard-to-serve communities is complicated by the limited choice of primary care providers, the limited number of multicultural and multilingual service providers, the lack of public transportation, and the travel required to receive

health care services. Outreach is one way that states can address these issues and implement SCHIP successfully. Strategies that states can use in rural and frontier communities include the following.[19]

- Offer bilingual application information and assistance. For example, **Utah** has a special information campaign targeted to Native American populations and employs bicultural and bilingual workers.
- Use mail-in application forms. For example, **Utah** parents can submit applications via the mail.
- Establish presumptive eligibility so uninsured children can be covered while their eligibility is being determined.
- Offer continuous eligibility so children are covered continuously up to one year without a redetermination of their eligibility during that period.
- Conduct school-based outreach. For example, the **Nevada** Check Up program disseminates a brochure on Medicaid and SCHIP and includes an application form in the packet.

In addition, states will have to persuade enough providers to serve SCHIP children regardless of the Medicaid and state program reimbursement rates established. Managed care providers might be more willing to serve rural uninsured children under SCHIP if states buy reinsurance for managed care plans to cover catastrophic cases in the first few years of the new program.

State policymakers also should encourage public and private sector collaboration, as well as state interagency coordination, in planning and implementing SCHIP. For example, Governor Philip E. Batt of **Idaho** appointed a task force with representation from businesses, Native American tribes, and a range of public and private entities to assist in SCHIP planning. Further, at the local level, policymakers should include local community-based providers (e.g., public hospitals, rural health clinics, community and migrant health centers, local provider practices, local health departments, and tribal clinics) in the provider network that will cover SCHIP children in rural and frontier areas.

Conclusion

There are some significant barriers to rural and frontier health care delivery, but states are taking active steps to address them. States need to continue exploring how to ensure an adequate number and mix of rural health professionals, promote the use of telemedicine in rural areas, increase the availability of rural emergency medical services, address the long-term care needs of the growing rural and frontier elderly population, and integrate managed care into their rural health service system. The newest opportunities and challenges facing state policymakers include developing critical access hospitals, implementing other 1997 budget legislation changes, and using the new children's health insurance expansion program to reach rural uninsured children.

As the rapidly changing health care marketplace evolves, states may want to consider periodically reassessing the strengths, weaknesses, and new challenges and opportunities facing their health care delivery systems. Rural and frontier markets will need to be assessed separately from urban markets. States could use the programs authorized by the Balanced Budget Act of 1997 as a springboard to reassess their rural and frontier health care delivery systems and bring new resources and delivery approaches to rural America.

Endnotes

*The preparation of this *Issue Brief* was supported by a grant from the Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services.

[1]J.P. Vistnes and A.C. Monheit, *Medical Expenditure Panel Survey Health Insurance Status of the Civilian Noninstitutionalized Population: 1996, Research Findings No. 1*, AHCPR No. 97-0030 (Rockville, Md.: Agency for Health Care Research and Policy, Center for Cost and Financing Studies, August 1997), Table 1: Health Insurance Coverage of the Civilian Noninstitutionalized Population: Percent Distribution by Type of Coverage and Selected Population Characteristics, United States, First Half of 1996.

[2] A new definition of "frontier" developed by the Consensus Development Project recommends that a matrix of population density, distance to the closest market for services, and travel time be assessed to determine accurate frontier status. The project was funded by the Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services.

[3] U.S. Bureau of the Census, Population Division, *United States Population Estimates, by Age, Sex, Race, and Hispanic Origin, 1990 to 1997*, release PPL-91, 1998 (Washington, D.C., 1998).

[4] Vistnes and Monheit.

[5] P.D. Frenzen, "Health Care: Premiums and Coverage in Rural Areas," in *Agricultural Outlook*, AO-209 (Washington, D.C.: U.S. Department of Agriculture, Economic Research Service, July 1994), 22–25.

[6] M. Nord, "Rural Poverty Rate Edges Downward," in *Rural Conditions and Trends*, vol. 8, no. 2 (Washington D.C.: U.S. Department of Agriculture, Economic Research Service, October 1997), 31–34.

[7] U.S. Department of Health and Human Services, Bureau of Primary Health Care, "Selected Statistics on Health Professional Shortage Areas as of September 30, 1996, Table 2" (Bethesda, Md.: Division of Shortage Designation, Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services, 1997).

[8] North Carolina Rural Health Research Program, "Rural Physicians" (Chapel Hill, N.C.: Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, prepared for the Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services, 1998).

[9] Western Governors' Association, *Health-Care On-Ramps: A Road Map to Western States' Information Highways* (Denver, Colo.: Western Governors' Association, April 1998).

[10] American Health Line, *Medicare HMOs: N.Y. Times Looks at Ohio Experience* (Alexandria, Va.: National Journal Group Inc., July 31, 1998).

[11] I. Moscovice, M. Brasure, and B. Yawn, *Rural Physician Risk-Sharing: Insights and Issues* (Minneapolis, Minn.: Rural Health Research Center, Division of Health Services Research and Policy, School of Public Health, University of Minnesota, April 1998).

[12] Credentialed staff include visiting and part-time professionals who have been given staff privileges at one of the local facilities. The facility decides which staff to credential.

[13] The focus is on the critical access hospital component of the Balanced Budget Act of 1997 changes associated with this program because the rural health roundtable participants believed the CAH conversions could be complex and were a high priority for their states.

[14]The CAH program replaces the Essential Access Community Hospital/Rural Primary Care Hospital program and the Montana Medical Assistance Facility demonstration. All states are eligible to participate in the program.

[15] This definition is from the program regulations in the *Federal Register* on August 29, 1997.

[16] The state rural health plan must provide for the creation of rural health networks, promote regionalization of services, and improve access to care. Each state must develop this plan in consultation with the state hospital association, rural hospitals, and the state office of rural health.

[17] K.M. Beauregard, S.K. Drilea, and J.P. Vistnes, *Medical Expenditure Panel Survey Highlights: The Uninsured in America*—1996, *Health Insurance Status of the Civilian Noninstitutionalized Population, No. 1*, AHCPR No. 97-0025 (Rockville, Md.: Agency for Health Care Research and Policy, Center for Cost and Financing Studies, May 1997).

[18] For a detailed summary of the health-related provisions of the Balanced Budget Act of 1997, see Jeff Harris, *Summary of the State Children's Health Insurance Program, Medicaid, and Other Provisions of the Balanced Budget Act of 1997 and Taxpayer Relief Act of 1997* (Washington, D.C.: National Governors' Association Center for Best Practices, September 3, 1997).

[19] "How States Can Increase Enrollment in the State Children's Health Insurance Program," *Issue Brief* (May 29, 1998), National Governors' Association Center for Best Practices, Washington, D.C.; and Capital Area Rural Health Roundtable, *Capital Area Rural Health Roundtable Notes: Outreaching to Rural Children with the State Children's Health Insurance Program*, vol. 2, no. 2 (Fairfax, Va: Center for Health Policy and Ethics, George Mason University, summer 1998).

NATIONAL RURAL HEALTH ASSOCIATION

October 20, 1998

The Honorable John Baldacci
U.S. House of Representatives
1740 Longworth House Office Building
Washington, DC 20515

Dear Congressman Baldacci:

On behalf of the National Rural Health Association (NRHA) I am writing to share with you our association's support for your legislation (H.R. 4219) to increase medical residency opportunities in rural areas through the Graduate Medical Education (GME) program.

The NRHA believes the GME provisions contained in the Balanced Budget Act of 1997 (BBA) unintentionally restrict the ability of new primary care residency programs from meeting the continually growing need of rural communities. H.R. 4219 promotes the placements of primary care providers in rural areas by expanding the exception to the funding caps to include separately accredited rural training tracks, changing the cut-off date for adjusting the direct medical education (DME) funding cap, and recalculating the indirect medical education (IME) and DME caps based on the number of interns and residents who were appointed for fiscal year 1996 .

The NRHA is pleased that the provisions contained in your bill were included in an omnibus rural health care bill recently introduced by Senators Daschle and Baucus which will be reintroduced at the beginning of the 106th Congress.

The NRHA commends you for addressing this important rural health issue and looks forward to working with you and your colleagues toward securing passage of this legislation. If there is anything the NRHA can do to assist you in your efforts, please do not hesitate to contact Darin Johnson, the NRHA's Government Affairs Director, at (202) 232-6200 or by e-mail at johnson@nrharural.org.

Sincerely,

Gail R. Bellamy, PhD

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Based on our analyses, we are not proposing to make adjustments to the [illegible]patient payment rates for [illegible]proportionate share patient [illegible]ercentage and teaching intensity and rural location for the following reasons.

1. Estimated effects of teaching intensity and disproportionate share patient percentage on costs were small and, in some cases, not statistically significant.

2. Payment impacts without such adjustments do not vary considerably, the largest being a reduction of 5.8 percent for major teaching hospitals. These impacts should also be evaluated in terms of the overall effect on Medicare payments since on average, outpatient services account for 10 percent of hospitals' Medicare payments. For example, the associated reduction of total Medicare payments for major teaching hospitals would be about 1 percent.

3. With the threshold adjustments we considered, estimated payment reductions for rural hospitals would be 1.9 percent under the proposed system, rather than 1.5 percent. These hospitals also receive a greater percent of their Medicare income (14.7 percent) from providing outpatient services. Similarly payment reductions for low-volume [illegible]l hospitals would be 13.9 percent of [illegible]ent payments, rather than 13.7 percent, and these hospitals also earn a greater percentage of their Medicare income (18.2 percent) from providing outpatient services. Because of these potential shifts in payments, any adjustment should be based on stronger analytic results than those found with the current data.

4. We also believe the issue of payment adjustments should be reexamined using data from initial years of the implemented system because current cost calculations and relationships among key factors and costs probably are affected by variation in coding patterns.

5. HCFA is working towards standardizing payment across all sites of service. Fewer adjustments to the outpatient PPS would allow HCFA to move ahead more quickly with this approach.

6. We believe that we should further analyze the impact of basing APC weight calculations on the median rather than the geometric mean because better correlation between costs and service mix would impact the size of [illegible]djustments.

[illegible]lthough the payment simulations [illegible]w potentially large percentage losses and low payment to cost ratios for low-volume hospitals, we are not proposing an adjustment for volume. The low-volume hospitals get a much greater percent of their Medicare income from the provision of outpatient services than the average, and total Medicare payments would drop by 3.1 percent for rural low-volume hospitals and 1.8 percent for urban low-volume hospitals. Low-volume hospitals have higher than average standardized unit costs, which may be attributable to economies of scale, under-coding, or cost allocations to the outpatient departments that are not volume related. However, an adjustment to the rates based on volume alone might reward inefficiency and create adverse incentives such as a reduction in services in order to increase payment rates. Moreover, these hospitals do not comprise a large enough proportion of other hospital types to substantially benefit from other adjustments (for example, teaching or disproportionate share).

We are particularly concerned about the potential impact of the outpatient PPS on low-volume rural hospitals that are sole community hospitals or Medicare-dependent hospitals. Approximately 60 percent of the rural hospitals furnishing fewer than 5,000 visits fall into these categories. We are investigating the reasons for their higher costs and are assessing whether a temporary adjustment is needed to moderate the impact of moving to an outpatient PPS. One option we are considering would be to phase-in the outpatient PPS for low-volume Medicare-dependent and sole community hospitals by paying a portion of the payment based on PPS rates and a portion based on the current payment system. For example, payment could be based on 75 percent of payments under the current system and 25 percent on PPS rates in the first year, 50 percent current system payments and 50 percent PPS rates in the second year, 25 percent current system payments and 75 percent PPS rates in the third year, and completely on PPS rates in subsequent years. Another option we are considering would phase-in outpatient PPS if a low-volume sole community hospital or Medicare-dependent hospital has a negative Medicare margin for outpatient services. For example, payment could be based on the amount payable under outpatient PPS plus a percentage of the difference between those amounts and the amounts payable under the current system. The percentage of the difference that would be payable could phase down, for example, 75 percent in year one of implementation, 50 percent in year 2, 25 percent in year 3, and no adjustment in year 4 and subsequent years. We solicit comment on this and other alternatives we might consider. By statute, any adjustment would have to be budget neutral.

We also are not proposing adjustments for cancer or TEFRA hospitals at this time. We believe that claims from cancer and TEFRA hospitals have been under-coded for many of the services cancer hospitals provide due to the lack of payment incentives for proper coding of these services under the current system. Further analysis will be conducted to determine if current coding practices explain the negative impact. If we determine that cancer hospitals would be unduly harmed because of the new outpatient PPS, we will consider whether an adjustment or perhaps a transition period is needed to moderate the impact. By statute, any adjustment would have to be budget neutral.

We do not believe that this action will restrict beneficiary access because other hospitals provide many of the same services provided at TEFRA hospitals. In addition, children's and free-standing psychiatric hospitals are less dependent than other hospitals on Medicare revenues. Finally, the remaining classes of TEFRA hospitals, rehabilitation and long-term care, lose a much smaller percentage of their total Medicare income, 3.7 and 3.5 percent respectively than the average for all facilities.

We are not proposing adjustments for any eye and ear or trauma hospitals because payment simulations demonstrated an increase in payments under the proposed PPS. We will assess the need for additional adjustments and make any appropriate changes as data become available under the new system.

J. Volume Control Measures

Section 1833(t)(2)(F) of the Act requires us to develop a method for controlling unnecessary increases in the volume of covered outpatient department services, including partial hospitalization services in CMHCs. If the volume of services paid for increases beyond amounts established through methodologies determined in section 1833(t)(2)(F), section 1833(t)(6)(C) provides that the update to the conversion factor may be adjusted. MedPAC recommends in its report to the Congress that we implement an expenditure cap to help control spending for hospital outpatient services and that we monitor hospital outpatient volume to ensure that access to services and quality of care are not reduced under a cap.

In this proposed rule, we are proposing a volume control measure for services furnished in CY 2000. In the

CHANGES FOR 1999
OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

	Number of hospitals (1)	Outpatient percent (2)	No Teaching and DSH Adjustments: Percent change in Medicare Outpatient payment (3)	Conversion Factor Effect removed (4)	Stand-ardized payment to cost ratio (5)	Percent change in total Medicare payments (6)	Teaching and DSH Adjustments: Percent change in Medicare Outpatient payment (7)	Conversion Factor Effect removed (8)	Standardized payment to cost ratio (9)	Percent change in total Medicare payments (10)
ALL HOSPITALS	5,419	9.9	-3.8	-0.0	1.0000	-0.4	-3.8	-0.0	1.0000	-0.4
NON-TEFRA HOSPITALS	4,864	10.0	-3.7	0.1	1.0011	-0.4	-3.7	0.1	1.0012	-0.4
GEOGRAPHIC LOCATION: URBAN HOSPITALS	2,677	8.3	-3.3	0.5	1.0057	-0.3	-3.2	0.6	1.0069	-0.3
LARGE URBAN AREAS	1,516	8.1	-5.0	-1.3	0.9868	-0.5	-4.8	-0.8	0.9915	-0.4
OTHER URBAN AREAS	1,161	8.6	-0.9	3.0	1.0332	-0.1	-1.3	2.6	1.0293	-0.1
RURAL HOSPITALS	2,187	14.7	-5.2	-1.5	0.9816	-0.8	-5.7	-1.9	0.9770	-0.8
VOLUME (URBAN) 0- 4,999 UNITS	278	12.1	-15.6	-12.3	0.8164	-1.9	-14.8	-11.4	0.8244	-1.8
5,000- 10,999 UNITS	442	9.8	-6.3	-2.6	0.9559	-0.6	-5.8	-2.1	0.9607	-0.6
11,000- 20,999 UNITS	599	9.1	-5.8	-2.1	0.9574	-0.5	-5.6	-1.9	0.9593	-0.5
21,000- 42,999 UNITS	780	8.7	-3.6	0.2	1.0071	-0.3	-3.9	-0.1	1.0040	-0.3
43,000 OR MORE UNITS	578	9.7	-2.0	1.9	1.0266	-0.2	-1.7	2.2	1.0299	-0.2
VOLUME (RURAL) 0- 4,999 UNITS	816	18.2	-17.0	-13.7	0.7799	-3.1	-17.2	-13.9	0.7781	-3.1
5,000 - 10,999 UNITS	694	15.8	-10.0	-6.5	0.9144	-1.6	-10.3	-6.7	0.9122	-1.6
11,000 - 20,999 UNITS	420	14.6	-5.8	-2.1	0.9848	-0.8	-6.2	-2.5	0.9812	-0.9
21,000- 42,999 UNITS	215	13.5	-1.8	2.0	1.0368	-0.2	-2.5	1.3	1.0294	-0.3
43,000 OR MORE UNITS	42	13.2	5.3	9.4	1.1263	0.7	4.6	8.7	1.1190	0.6

We understand that about 60% of these are Sole Community Hospitals or Medicare Dependent Hospitals - See attached

	Number of hospitals (1)	Outpatient percent (2)	No Teaching and DSH Adjustments: Percent change in Medicare Outpatient payment (3)	No Teaching and DSH Adjustments: Conversion Factor Effect removed (4)	No Teaching and DSH Adjustments: Standardized payment to cost ratio (5)	No Teaching and DSH Adjustments: Percent change in total Medicare payments (6)	Teaching and DSH Adjustments: Percent change in Medicare Outpatient payment (7)	Teaching and DSH Adjustments: Conversion Factor Effect removed (8)	Teaching and DSH Adjustments: Standardized payment to cost ratio (9)	Teaching and DSH Adjustments: Percent change in total Medicare payments (10)
TEACHING STATUS										
NON-TEACHING	3,947	11.2	-3.1	0.7	1.0031	-0.3	-3.7	0.1	0.9975	-0.4
FEWER THAN 100 RESIDENTS	766	9.1	-1.8	2.8	1.0326	-0.2	-2.4	1.5	1.0268	-0.2
100 OR MORE RESIDENTS	250	9.2	-9.4	-5.8	0.9331	-0.9	-6.4	-2.7	0.9643	-0.6
DISPROPORTIONATE SHARE PATIENT RATIO										
0	25	25.1	-0.3	3.6	0.9250	-0.1	-1.2	2.7	0.9175	-0.3
0.001- 0.099	916	10.3	-4.9	-1.1	0.9750	-0.5	-5.8	-2.1	0.9692	-0.6
0.100- 0.159	1,016	10.9	-0.9	3.0	1.0447	-0.1	-1.9	1.9	1.0337	-0.2
0.160- 0.299	1,619	10.1	-3.8	0.8	1.0113	-0.3	-3.7	0.6	1.0039	-0.4
GREATER THAN 0.299	1,294	9.2	-6.6	-2.8	0.9617	-0.6	-7.5	-3.3	0.9234	-0.9

BILLING CODE 4120-01-C

RURAL HEALTH ACCOMPLISHMENTS

RURAL HEALTH OUTREACH AND RURAL NETWORK DEVELOPMENT GRANT PROGRAM

- Last October, HHS awarded over $25 million to health providers in 144 rural communities. This grant emphasizes service delivery through new and creative strategies and partnerships, extending services to at least 2 million rural citizens across the country including: hospice care, health check-ups to children at school, prenatal care to women in remote areas with mobile clinics, and vertically integrated networks of health care providers that includes local physicians and a community-incorporated clinic. Since 1991, Congress has allocated approximately $175 million to this program reaching over 300 rural communities.

COMMUNITY AND MIGRANT HEALTH CENTER GRANT PROGRAM

- In 1997, HHS awarded about $335 million to community and migrant health centers, serving some 3.8 million people living in rural areas. These health centers provide comprehensive primary and preventive health services, including substance abuse, mental health and dental care to rural communities.

THE BALANCED BUDGET ACT 1997

- **Blended Payment System.** To reduce the urban/rural disparities in payment for managed care, the BBA put in place a new blended payment system with a floor minimum to make it more attractive for managed care to offer services to rural areas.

- **Medicare Rural Hospital Flexibility Program**. To overcome the obstacles of cost, low-volume, distance, and shortage of practitioners in rural areas, BBA established a new rural hospital program under Medicare that would allow certain rural hospitals to convert to limited-service hospital status (with limits on bed numbers and length of stay), referred to as Critical Access Hospitals (CAH). These CAHs are given greater flexibility and relief from Medicare regulations designed for full-size, full-service acute care hospitals and are reimbursed based on cost.

- **Medicare Coverage of Telehealth Services.** BBA stipulates that Medicare for the first time pay for telemedicine consultations for patients living in rural areas that are designated as a health professional shortage areas (HPSA).

- **Historic Efforts to Enroll Children in Health Insurance: Children's Health Insurance Program**--In 1997, the President enacted the largest investment in children's health care since the passage of Medicaid in 1965. This program is designed to provide health care coverage for millions of children whose parents cannot afford private coverage but do not qualify for Medicaid. The President has also made historic efforts to

reach out and enroll the millions of uninsured children who are eligible but not enrolled in Medicaid or the Children's Health Insurance Program. Particular efforts have been made to reach out to children in rural communities, including: an extensive education campaign among all rural health outreach grantees to encourage immediate involvement in each state's CHIP program and a widespread distribution of information on CHIP to rural communities through health care providers.

NEW OFFICE FOR THE ADVANCEMENT OF TELEHEALTH

- In May 1998, the HHS created an Office for the Advancement of Telehealth (OAT) to expand telemedicine and distance learning initiatives to extend of state-of-the-art health care and information to isolated and poor communities. This office will administer the Rural Telemedicine Grant Program, which encourages the use of telemedicine technologies as it applies to rural health medicine and individual community needs. In FY 1997, OAT spent more than $7.7 million on both telemedicine and distance education projects.

COMBATING HIV/AIDS IN RURAL AMERICA

- In Atlanta 1997, the ORHP and NRHA jointly sponsored a first-of-a-kind conference in Atlanta called the *Southeastern Conference on HIV/AIDS.* Clinicians, businessman, and educators gathered there to discuss and develop latest strategies for delivering care to people in rural areas at-risk for HIV/AIDS. Out of which a report was published documenting new methods for overcoming rural barriers to care. In addition, ORHP administers a special grant initiative for AIDS education and prevention among rural minority youth who might not be exposed to existing educational efforts.****(***Sarah--unable to find $ value)***

IMPROVING ACCESS TO CARE FOR MINORITIES IN RURAL AREAS

- Although minorities only represent 15% of total rural population, they represent about 30% of the rural poor. To overcome a overall lack of national information on minority issues in rural health, the office funded a new publication through its research program, *Minorities and Rural Health 1997-1998*, to create new strategies to improve the health of minorities in rural communities. Over the past six years, 20% of rural outreach grant funds have been targeted to rural minority communities.

SPECIFIC EXAMPLES OF RURAL HEALTH OUTREACH GRANT PROGRAMS (mentioned at the beginning of this document) IN TENNESSEE

- **Community Health Outreach**--led by Cherokee Health Systems, this program is the sole provider of mental health services in Grainger, Union, and Claiborne counties. This outreach program teaches children, parents, and educators how to stay health mentally

and physically, and to access health services to attain this goal. It also works to improve the community's network of health services. Specific projects include: health care workers visiting schools providing physical and mental health education, screenings, and referrals; and staff conducting training for teachers and parents and providing teachers with mental health consultations regarding specific students. As of May 1997, the project has made more than 37,000 outreach contacts with children, and 2,000 contacts with parents and teachers through inservice trainings. Outreach workers had conducted more than 3,100 screenings.

- **Housing Health Education Rural Outreach (HHERO) Program**--led by LaFollette Housing Authority to provide health education and primary care services to the residents of public housing throughout a seven-county area in rural east Tennessee. Interventions include: community-wide screening for diabetes, vision, and dental health; mobile mammography; childhood immunizations; flu vaccines; nutrition assessments; and an eight-week parenting skills course. A rural health clinic "Health Corners" was established, staffed by family nurse practitioner and an outreach nurse. Families go there for both crisis care and preventive care. The network of organizations involved includes: The University of Tennessee Regional Medical Center, Monroe Maternity Center, and The University of Tennessee Social Work Office of Research and Practice.

- **Bolivar General Hospital Project**. This project provides programs in Hardeman county in rural west Tennessee that deal with issues of teenage pregnancy and sexually transmitted diseases. The second component of the project seeks to identify mothers at high risk for stress, to help reduce the incidence of child abuse and neglect, increase immunization rates for young children, ensuring prenatal care, and detecting and remedying developmental delays in young children. Some of the network members include: Bolivar General Hospital, the health department, a community health center, and the school system.

SARAH--I don't think this last one pertains to a rural area but it is extremely poor...

- **Columbia Area Mental Health Project**. This project is designed to provide mental health treatment, alcohol and drug abuse treatment and other support services for unmet needs of the low income residents of Lewis County, one of the poorest counties in Tennessee. These services include: transportation and emergency assistance for low-income elderly and housing assistance for pregnant teenagers.

Federal Office of
RURAL HEALTH
POLICY

U.S. Department of Health and Human Services

Parklawn Bldg., Room 9-05
Rockville, MD 20857
(301)443-0835 Fax (301)443-2803

TO: D. ADEE

FAX NO. 202 456 5557

NO. OF PAGES 2 **(including this page)**

FROM: **Jerry Coopey**
Director of Government Affairs

MESSAGE:

PLEASE CALL IF YOU HAVE ANY QUESTIONS

$25 Million for Rural Health

Federal Office of Rural Health Policy to Administer New Grant Program

Tucked within the 4,000 page omnibus spending bill that Congress sent to President Clinton last month was a $25-million appropriation to fund grants to the States under the Medicare Rural Hospital Flexibility Program. This appropriation will increase the ability of States and rural communities to identify and address rural health problems.

The purpose of the grant program is to help States work with rural communities to develop more integrated health care systems. At a time when rural providers are facing increasing financial pressures, these grants will enable communities to obtain much-needed technical assistance. Grants will be awarded to States for developing and implementing rural health plans, developing community health networks, designating facilities as critical access hospitals, and integrating rural emergency medical services with other components of the health care delivery system.

Although grant money was not appropriated until fiscal year 1999, the Medicare Rural Hospital Flexibility Program was part of the Balanced Budget Act of 1997. Sponsored by Senator Max Baucus (D-MT), this legislation established the critical access hospital, a limited-service facility that can get Medicare cost-based reimbursement. The critical access hospital is modeled after Montana's Medical Assistance Facilities and Rural Primary Care Hospitals, which were developed through the EACH/RPCH demonstration project in several States. Critical access hospitals are a viable alternative for small rural communities who wish to provide some acute care services locally while ensuring access to primary care and emergency medical services.

While critical access hospitals are a critical part of the legislation, the Medicare Rural Hospital Flexibility Program is more than a life preserver to keep at-risk rural hospitals afloat. The grant program will provide States with resources to develop and implement a comprehensive rural health plan that will lead to the development of community health networks. These networks are based on the precept that communities themselves can best determine how their local health care should be delivered. Rural communities should find that creating networks improves the stability and quality of health care services. Grant funds will be especially useful to support community involvement in education and development programs.

Congress is authorized to appropriate $25 million for the grant program each year through fiscal year 2002. The grant program will be administered by the Office of Rural Health Policy (ORHP) within the Health Resources and Services Administration. ORHP is in the process of developing guidelines for this new grant program and expects that grant applications will be available to States in the spring. Grants will be awarded by September of 1999.