

The 2010 Report  
to the Secretary:  
Rural Health and  
Human Services Issues

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NACRHHS

The National Advisory Committee on  
Rural Health and Human Services

May 2010

# Acknowledgements

The 2010 Report to the Secretary is the culmination of a year of collective effort by the National Advisory Committee on Rural Health and Human Services (NACRHHS). I would like to thank each of the Committee members for their hard work and acknowledge the subcommittee chairs of each of the three chapters: Todd Linden, Health Care Provider Integration; Maggie Blackburn, Rural Primary Care Provider Workforce; and Donna Harvey, Home and Community Based Care for Rural Seniors. Meghana Desale, Jenna Kennedy, Laura Merritt, and Kai Smith, Truman Fellows with the Office of Rural Health Policy (ORHP) at the Health Resources and Services Administration (HRSA), provided research support and assistance in drafting key sections of the final report. Beth Blevins edited the report.

The Committee benefited from the hospitality and rich information provided by various individuals connected with the Committee's two field meetings in 2009. The opportunity for the Committee to learn about rural health and human services delivery in the field from those who are actually providing the services was critical in informing this report and the recommendations that are included. The number of people who helped to make the field meetings possible is far too many to list here, but I want to acknowledge the help of a few individuals.

In June 2009, the Committee visited Rapid City, South Dakota. Marcia Taylor of Rapid City Regional Hospital Hospice, Jason Petik of Custer Regional Hospital, and Kent Olsen of Hans P. Peterson Memorial Hospital all hosted informative site visits. NAC members Dave Hewett and Deb Bowman assisted in planning the site visits.

The South Dakota meeting also featured important presentations by a number of individuals including Sidney Goss of the South Dakota School of Mines and Technology, Tom Dean of Horizon Health Care, Matt Michels, a health law attorney, Scot Graff of Community HealthCare Association of the Dakotas, Deb Bowman of the South Dakota Department of Social Services, State Senator Jean Hunhoff, Cindi Slack of Sanford Health, Bruce Vogt of the Sanford School of Medicine at the University of South Dakota, Charles Hart of Regional Health System, and Sandra Durick and Josie Petersen, both of the South Dakota Office of Rural Health.

In September 2009, the Committee visited Sacramento, California. Dennis Dudley of the San Francisco Regional Office of the Administration on Aging played a key role in coordinating the meeting. Dr. Thomas Nesbitt, a former Committee member, also was critical in planning the meeting and also presented to the Committee. In addition, the Committee benefited from site visits hosted by Anne Platt of Sutter Amador Hospital in Jackson, California, Teresa Rincon of Sutter Health's eICU Hub in Sacramento, and Deanna Lea of the Area 4 Agency on Aging. John Rigg of the California Hospital Association also provided important counsel in planning the meeting and arranging site visits.

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The Committee is grateful to many others, too numerous to mention, for their support of the Committee's mission to inform and make recommendations to the Secretary and others on the state of health and human services in rural America.

Sincerely,  
The Honorable David M. Beasley, Chair

## About the Committee

The National Advisory Committee on Rural Health and Human Services (NACRHHS) is a citizens' panel of nationally recognized rural health and human services experts. The Committee, chaired by former South Carolina Governor David Beasley, was chartered in 1987 to advise the Secretary of the U.S. Department of Health and Human Services (HHS) on ways to address health problems in rural America. In 2002, the Committee's mandate was expanded to include rural human services issues and a 21-member limit was set.

The Committee's private and public-sector members reflect wide-ranging, first-hand experience with rural issues, including medicine, nursing, administration, finance, law, research, business, public health, aging, welfare, and human services. Members include rural health professionals as well as representatives of State government, provider associations, and other rural interest groups.

Each year, the Committee highlights key health and human services issues affecting rural communities. Background documents are prepared for the Committee by both staff and contractors to help inform members on the issues. The Committee then produces a report with recommendations on those issues for the Secretary by the end of the year. The Committee also sends letters to the Secretary after each meeting. The letters serve as a vehicle for the Committee to raise other issues with the Secretary separate and apart from the report process.

The Committee meets three times a year. The first meeting is held during the winter in Washington, D.C. The Committee then meets twice in the field, in June and September. The Washington meeting serves as a starting point for setting the Committee's agenda for the coming year. The field meetings include rural site visits and presentations by the host community, with some time devoted to ongoing work on the yearly topics.

The Committee is staffed by the Office of Rural Health Policy, located within the Health Resources and Services Administration at HHS. Additional staff support is provided by the Administration on Aging at HHS.

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# The National Advisory Committee on Rural Health and Human Services

## **CHAIRPERSON**

The Honorable David M. Beasley  
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Darlington, SC  
Term: 04/01/06 – 03/31/10

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Center for Health Organization Transformation  
School of Rural Public Health, Texas A&M  
College Station, TX  
Term: 11/01/08 – 10/31/12

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Community Action Partnership Head Start  
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Term: 07/01/06 – 06/30/10

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Graham Adams, PhD  
CEO  
South Carolina Office of Rural Health  
Lexington, SC  
Term: 11/01/07 – 10/30/11

David Hartley, PhD, MHA  
Research Professor  
Muskie School of Public Service  
University of Southern Maine  
Portland, ME  
Term: 07/01/08 - 06/30/10

April M. Bender, PhD  
Owner, Partnerships for Quality  
Hannawa Falls, NY  
Term: 08/01/07 – 07/30/11

Donna K. Harvey  
Executive Director  
Hawkeye Valley Area Agency on Aging  
Waterloo, IA  
Term: 08/01/07 – 07/30/11

Maggie Blackburn, MD  
Assistant Professor  
Department of Family Medicine and Rural Health  
Florida State University College of Medicine  
Tallahassee, FL  
Term: 11/01/07 – 10/30/11

David R. Hewett, MA  
President and CEO  
South Dakota Association of  
Health Care Organizations  
Sioux Falls, SD  
Term: 07/01/06 – 06/30/10

Deborah Bowman  
Secretary  
South Dakota Department of Social Services  
Pierre, SD  
Term: 08/01/07 – 07/30/11

Thomas E. Hoyer, Jr., MBA  
Consultant  
Rehoboth Beach, DE  
Term: 07/01/06 – 06/30/10

B. Darlene Byrd, MNsc, APN  
Owner, APN HealthCare  
Cabot, AR  
Term: 11/01/07 – 10/30/11

Thomas E. Hoyer, Jr., MBA  
Consultant  
Rehoboth Beach, DE  
Term: 07/01/06 – 06/30/10

# The National Advisory Committee on Rural Health and Human Services

Todd Linden, MA  
President and CEO  
Grinnell Regional Medical Center  
Grinnell, IA  
Term: 11/01/07 – 10/30/11

A. Clinton MacKinney, MD, MS  
Family Physician, Senior Consultant  
St. Joseph, MN  
Term: 07/01/06 – 06/30/10

Karen Perdue  
Associate Vice President for Health  
University of Alaska Fairbanks  
Fairbanks, AK  
Term: 07/01/06 – 06/30/10

Robert Pugh, MPH  
Executive Director  
Mississippi Primary Care Association  
Jackson, MS  
Term: 11/01/07 – 10/30/11

John Rockwood, Jr., MBA, CPA  
Retired Health System CEO  
Maple City, MI  
Term: 11/01/08 – 10/31/12

The Honorable Maggie Tinsman, MSW  
Former Iowa State Senator  
Policy Analyst and Consultant  
Davenport, IA  
Term: 11/01/07 – 10/30/11

## 2008-2009 Subcommittees

### *Home and Community Based Care for Rural Seniors*

Donna Harvey - Chair  
Deb Bowman  
Sharon Hansen  
Tom Hoyer  
Maggie Tinsman

### *Rural Primary Care Workforce*

Maggie Blackburn - Chair  
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Darlene Byrd  
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### *Rural Health Care Provider Integration*

Todd Linden - Chair  
Graham Adams  
David Hartley  
Dave Hewett  
Clint MacKinney  
John Rockwood

For Committee members' biographies, please visit the National Advisory Committee on Rural Health and Human Services' Web site at <http://ruralcommittee.hrsa.gov/>.

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## Executive Summary

This is the 2010 Annual Report by the National Advisory Committee on Rural Health and Human Services (NACRHHS). This year's report examines three key topics in health and human services and their effects in rural areas: home and community based care for rural seniors, rural primary care workforce, and rural health care provider integration. All are pertinent and timely issues that the Committee chose during its February 2009 meeting. The chapters draw from published research and from information gathered during site visits to rural South Dakota and rural California.

### **Home and Community Based Care for Rural Seniors**

The elderly population in rural America is growing at a rapid rate. An estimated 69 percent of people turning 65 years old will need some form of long-term care in the future. Studies have shown that seniors are happier remaining in the home as long as possible, but too often seniors are ushered into retirement homes without being offered an alternative. Allowing seniors to age-in-place is more difficult because the existing infrastructure and available resources are concentrated on supporting nursing home care.

The Committee believes that options for home-based care need to be expanded in rural areas. Barriers such as geographic accessibility, ineligibility, workforce shortages, and limited awareness of options all affect seniors' decisions when choosing care. The Committee's recommendations to the Secretary include evaluating current laws prohibiting payment to family members for care and coordinating with the Secretary of Transportation to ensure seniors are able to access care.

### **Rural Primary Care Workforce**

Declining interest in primary care has most notably affected rural communities. An aging rural population and a retiring medical workforce exacerbate the shortages rural America already faces. Additionally,

fewer medical school graduates are interested in practicing in rural areas. There are 55 primary care physicians for every 100,000 people in rural areas, compared to the 95 per 100,000 that are needed. An expansion of health care insurance would intensify the unmet demand for primary care in rural America. The Committee recognizes the importance of not only attracting primary physicians to rural America, but in utilizing physician assistants and advanced practice nurses who can act as the sole primary care provider in a community. The Committee recommends that the primary care system be strengthened through local leadership, an emphasis on preventative measures, and by attracting and training a workforce dedicated to care in rural areas.

### **Rural Health Care Provider Integration**

The majority of patient care in the United States is uncoordinated due in large part to an incomplete transfer of important patient information between providers. This fragmentation of care is acutely problematic in rural areas, which face higher rates of chronic diseases that require greater managed care. This is cause for concern since 88 percent of annual Medicare spending is concentrated among only 25 percent of beneficiaries, 75 percent of which have one or more chronic diseases.

The Committee believes that the quality of care and efficiency of delivering care will both increase if integration — seamless patient and information flow among providers — is achieved. In this report the Committee recommends specific ways to achieve integrated care. These recommendations include fixes to Stark regulations to prevent unintentional hindrance of provider integration, and a call to include rural providers in future demonstrations of Accountable Care Organizations (ACO), bundling, and patient-centered Medical Homes.

# Home and Community Based Care for Rural Seniors

## Chapter Recommendations:

### Dual Eligibles

1: The Secretary should evaluate whether rural seniors who are dually eligible for Medicare and Medicaid are able to take part in programs such as Money Follows the Person, Cash and Counseling, Home and Community-Based Services (HCBS), the Program of All-Inclusive Care for the Elderly, and Medicare Advantage Special Needs Plans to the same extent as urban seniors.

2: The Secretary should support an evaluation of current law prohibitions against payment to family members for care otherwise covered under Medicare or Medicaid, with a view toward determining whether they should be eliminated in light of current economic conditions.

### Medicare

3: The Secretary should instruct the Centers for Medicare and Medicaid Services (CMS) to develop a uniform assessment tool that works across post-acute care settings and Health and Human Services programs, as required under current law.

4: The Secretary should work with the Congress to change the requirements for coverage of the “Welcome to Medicare” physical to include provision of information about available home-based options for seniors. This information should also be a discharge planning function with a “handoff” to the Community Living Programs, Eldercare Locator Service, and Aging and Disability Resource Centers (ADRCs).

5: The Secretary should instruct CMS to find a method for claiming and reporting hospice payments for general inpatient services on a Critical Access Hospital (CAH) cost report in a manner that permits the CAH to claim the full cost of caring for the hospice patient.

### Transportation

6: The Secretary should develop a report in coordination with the Secretary of Transportation to identify all available legal authorities that provide transportation for those in need of health and human services and to determine their effectiveness in serving the elderly population, with particular emphasis on the availability and effectiveness of programs for the isolated rural elderly.

## Rural Significance: Why the Committee Chose this Topic

The Supreme Court’s landmark *Olmstead* decision (1999, *Olmstead v. L.C.*) and the New Freedom Initiative (2001) were a victory for people seeking to receive home and community-based care in their communities. Some advocates for rural seniors saw this as a particularly promising change given the high percentage of the elderly in rural areas and the health status challenges they face.

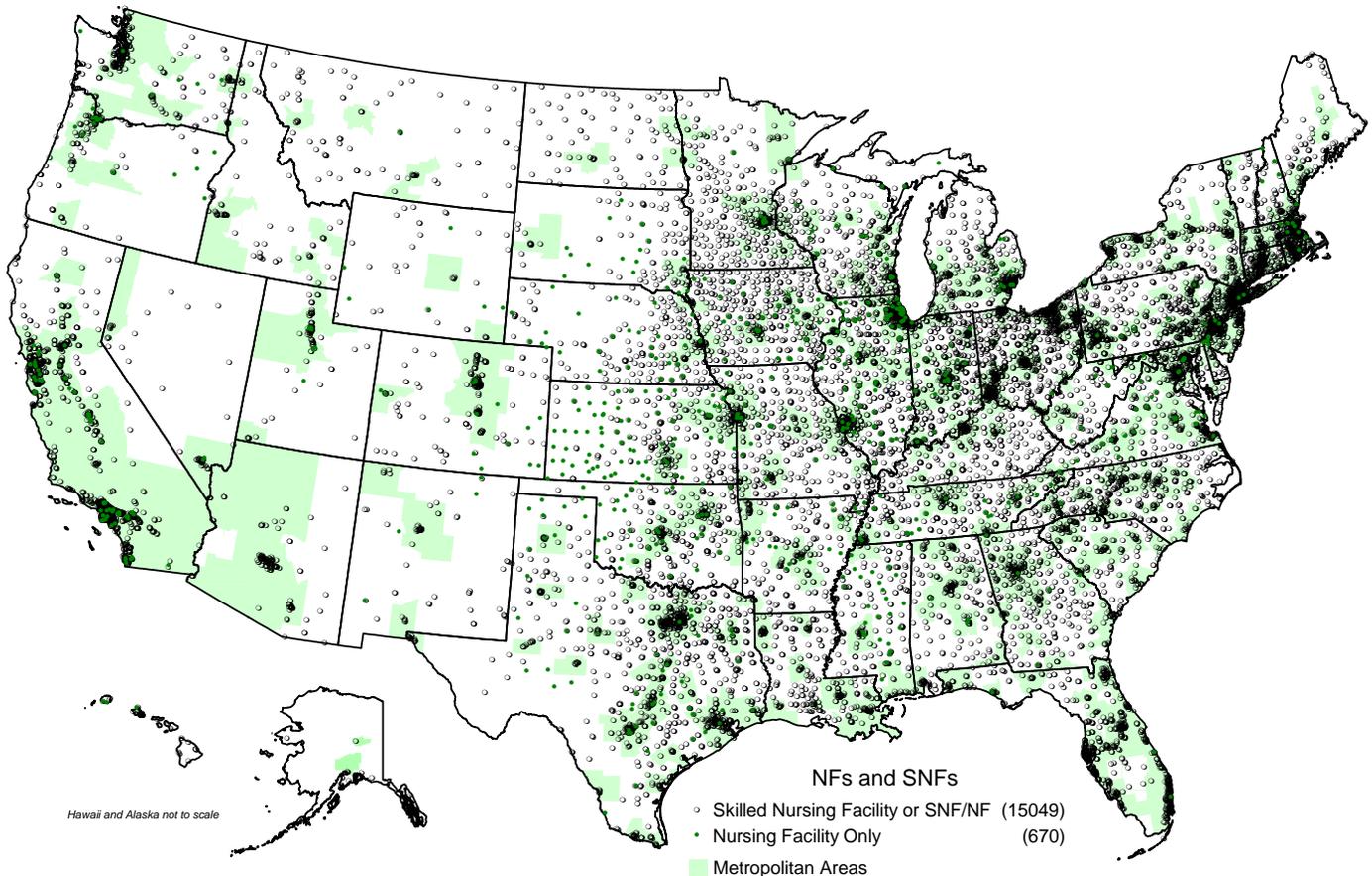
Approximately 7.5 million of the 50 million people who lived in rural America in 2005 were over age 65.<sup>1</sup> Although the difference in percentage of the elderly between rural and urban areas is not dramatic (15 percent versus 12 percent), the rural elderly population is growing at a more dramatic rate. In one quarter of all non-metropolitan counties, the percentage of elderly residents already reaches 18 percent. In non-metropolitan areas, 15.3 percent of seniors have at least one limitation in Activities of Daily Living (ADL) compared to 12.7 percent in metropolitan areas.<sup>2</sup> Nationally, the supply of

certified nursing home beds to seniors is 50 beds per thousand. The ratio of nursing beds to seniors in rural counties, however, is 62 per thousand, or 35 percent higher than the same measure for urban counties.<sup>3</sup> The greater supply of nursing homes in rural areas, along with a lack of home and community-based options for rural seniors, may result in increased nursing home placements.

The Committee believes the rural elderly population would likely benefit from an expansion in options for home and community-based care as alternatives to being placed in a nursing home. Yet the Committee has learned that rural communities face particular challenges in taking advantage of some of the new options emerging post-*Olmstead*.

This chapter will look at the current state of home and community-based care options for rural seniors through the lens of the Health and Human Services programs that focus on this population. This includes an analysis of key programs in the Centers for Medicare and Medicaid Services (CMS) as well as the Administration on Aging (AOA), and how various programs and initiatives in HHS meet the needs of rural seniors seeking to remain in their homes as they age.

### Nursing Facilities (NFs) and Skilled Nursing Facilities (SNFs), 2009



Sources: OSCAR Provider of Services file, CMS, 2009; U.S. Census Bureau and Office of Management and Budget, 2009. Prepared by the North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

## The 2010 NACRHHS Report

As people age, they often become less mobile due to physical limitations, chronic diseases or disability. They may not be able to fully care for themselves, and a chronic disease or disability may require constant care, supervision, and frequent medical attention. An estimated 69 percent of people turning 65 years old will need some form of long-term care assistance before they die.<sup>4</sup> The 85-and-over population is the fastest growing segment of the U.S. population and is expected to grow from four million in 2000 to 21 million by 2050, with much of that growth concentrated in rural areas.<sup>5</sup> Many individuals requiring primarily unskilled services may need services in such volume and variety as to require professional management and supervision. Seniors and their families are faced with the decision of how to best access long-term care for themselves or their loved ones. The decision can be particularly challenging in a rural area where long-term care options are limited due to geographic accessibility.

One ongoing need is to find a way to support better case management for individuals with chronic problems. This is an issue that cuts across both Medicare and Medicaid, which have taken steps in that direction utilizing various programs discussed in this report. However, the Committee believes larger and more systematic reform is needed.

Although the population in need of services continues to grow and decisions such as Olmstead require less restrictive care, neither Federal nor State funding has been made available for enough home and community-based services to meet the need that exists today. The Committee recognizes that this situation represents choices at all levels of government, but also believes these choices need to be re-examined.

The Committee agrees with national experts that the guiding principles of caring for seniors should include independence, choice, dignity, and the ability to live at home for as long as possible in order to maintain a higher quality of life.<sup>6,7</sup>

Despite evidence that home and community-based care allows a higher quality of life,<sup>8</sup> is preferred by seniors,<sup>9</sup> and often saves money,<sup>10</sup> over 1.8 million people in the United States live in nursing homes, funded both by Medicaid waivers and privately.<sup>11</sup> Different studies disagree on a projected overall amount of savings that care in a home and community-based system would bring to the Federal government, but sources generally agree that nursing home care is more expensive than home and community-based care. The amount of Medicaid dollars that can pay for one person to receive nursing home care may pay for as many as three people to receive home and community-based care,<sup>12</sup> yet 75 percent of Medicaid payments for

long-term care for older people and adults with physical disabilities continues to go to nursing home care.<sup>13</sup>

The Committee recognizes that the value of home and community-based care is well established; that HHS has made these services available under waivers and as State Plan services; and that States, to varying degrees, have taken advantage of these Medicaid options. The Committee recognizes these positive efforts, but has identified two kinds of barriers that continue to impede access to home and community-based care.

One barrier is presented by the limitations in the scope and availability of services themselves; the second barrier is the complexity of the system under which the benefits are provided and administered. It is not enough for Federal and State governments to enact a variety of programs that can, with persistence and skill, be assembled to provide the necessary home and community-based care. Governments must take the additional step of providing a useful interface between the citizens and the programs.

In terms of scope and availability, the Committee has identified several barriers that stand in the way of rural seniors receiving home and community-based care. They include:

- lack of access
- ineligibility
- lack of awareness about options
- workforce shortages
- inadequate funding
- lack of transportation

These barriers often lead individuals and families to make early nursing home admittance the default choice, which is particularly important to be aware of in rural areas because it compromises a higher proportion of the elderly population.<sup>14</sup> This proportion is increasing as parts of rural America are becoming more popular retirement destinations, the rural elderly “age in place,” and there is an outmigration of young people from rural areas.<sup>15</sup> Research also shows a higher percentage of poor elderly residents in rural areas than urban areas,<sup>16</sup> and a higher proportion of elderly people with disabilities in rural areas than urban areas<sup>17</sup> These populations place an increased demand on States’ programs as they seek long-term care.

## HHS Program Role

The Department of Health and Human Services plays a key role in ensuring access to services for seniors, either through direct reimbursement of care and services through Medicare and Medicaid at CMS or through programs authorized under the Older Americans Act through the Administration on Aging.

### Medicaid

The Medicaid program is the primary source of payment for both institutional and non-institutional long-term care in this country. Medicare has traditionally focused on acute and restorative care in institutions and in the home—its statute specifically forbids payment for custodial care. As a result, Medicaid policies and eligibility requirements have a significant influence on rural seniors' access to home and community-based services. Medicaid paid for nearly 50 percent of long-term care services in 2004, making it the nation's primary payer of long-term care services.<sup>18</sup> However, less than one-third of total Medicaid spending on long-term care went to home and community-based services. When a beneficiary is in a nursing home, Medicaid will pay for meals and housing, but Medicaid will not cover these services outside of this setting except in the context of a home and community-based services waiver program. Thus, some beneficiaries may not be able to afford living at home using Medicaid home health and/or personal care services, as these costs are expenses they would not continue to personally incur if in a nursing home. Many States and communities have not organized their home and community-based services into a system of care, so beneficiaries may find it easier to navigate care in a nursing home setting. Additionally, as a result of current economic challenges States are facing, many may be cutting back Medicaid services such as home and community-based care funding.

Another rural aspect to keep in mind when considering Medicaid's influence on rural seniors' access to home and community-based services is geography and the distances that separate rural seniors from their providers. Medicaid can cover transportation services for patients but its rates for home care and other services often fail to reflect the true cost of travel in rural areas (i.e., the actual cost of transportation and the opportunity cost of the service time consumed when providers are traveling between appointments). Such payment limitations curtail the ability of organizations to serve widely dispersed rural

patients and result in reduced service levels.

### Medicaid Home and Community-Based Services

In 1981, Congress added section 1915(c) to the Social Security Act to authorize States, subject to Federal approval, to cover home and community-based services under a waiver program. Today, Home and Community-based Services (HCBS) waivers are the primary vehicles through which Federally funded health and health-related services are provided to eligible individuals in a home or community-based setting. HCBS waivers give States some flexibility in Medicaid provisions, which allows them to develop and implement creative alternatives to placing Medicaid-eligible individuals in hospitals, nursing homes, or intermediate care facilities, thereby allowing long-term care services to be delivered in community settings.

Some experts believe there is potential for HCBS waivers to decrease overall costs to Medicaid if States would require case management services through their Medicaid HCBS waiver programs.<sup>19</sup> This could be particularly beneficial for rural areas because rural populations have a higher prevalence of chronic diseases, for which the cost of treating is often greatly reduced with intensive case management.<sup>20,21,22</sup> The Committee would note that such management is an integral part of the "patient-centered Medical Home" concept, which it endorsed in last year's report.

### Other Medicaid Home and Community-Based Care

The Cash and Counseling program supports seniors who want to live independently by giving them a budget to hire personal care aids, purchase services, and make home modifications.<sup>23</sup> Cash and Counseling allows the beneficiary to manage a flexible budget and decide which services best meet their needs each month. Participants of Cash and Counseling select a care coordinator who helps them develop a care plan that maximizes quality of life in the community. Additionally, Cash and Counseling provides a support system to aid in plan management. This consumer-directed care program, originally only available in Arkansas, Florida, and New Jersey, is now available in 15 States and is available to Medicaid beneficiaries who receive personal assistance services.<sup>24</sup> Participating States, in addition to the aforementioned, include Illinois,

Iowa, Kentucky, Michigan, Minnesota, New Mexico, Pennsylvania, Rhode Island, Vermont, Washington, and West Virginia. When the program was evaluated in 2004, more than half of the Cash and Counseling participants reported that the program had improved their lives a great deal.<sup>25</sup> Cash and Counseling gives beneficiaries the flexibility to pay a family member or friend to provide those services. In rural areas, the availability of home health agencies and professional caregivers is limited, so this is a particularly promising program to help support the rural family caregiver workforce. In addition, the program can provide participants with some financial counseling services. Enrollment processes for Cash and Counseling vary by State, and information on eligibility and enrollment for all participating States is available at [cashandcounseling.org](http://cashandcounseling.org).<sup>26</sup>

### **The Need for Integrating Senior Services**

A flaw in the U.S. health care system is the frequent failure of its components to coordinate with one another in caring for individual patients, often leading to duplicative services or gaps in services.

Rapid City Regional Hospital, part of a non-profit health care system, Regional Health, in South Dakota, has been working on a solution to this problem in administering home care services. The home care services they provide – hospice, home health, and homemaker services, among others – are administered from offices located at the hospital's Hospice House. This allows nurses, aides, and administrators to know the patients' names and situations and to work as a team to assure that the full range of individual needs are met by involving all the available services. Providing a central location for services and administration is important for the active coordination of home care services.

Because the management of Regional Health System believes in providing patient-centered and coordinated care, they were also willing to look across program boundaries to assure quality care. A pharmacist was hired to work across the home care and hospice programs to monitor medications and do drug regimen reviews. While it seems like a simple choice for a health care system to hire an individual to work across several provider types, it is too often the case that these needs are ignored because none of the individual programs can individually support a full-time equivalent. The willingness of Regional Health System's administrators to see its programs as a whole is evidence of its strength.

Money Follows the Person (MFP) is a concept based on the idea that flexibility in spending could help patients access and receive the most appropriate level of care

as they transition among a variety of settings, even if funds were originally budgeted for institutional care.<sup>27</sup> In 2001, The New Freedom Initiative created the Money Follows the Person Rebalancing Demonstration.<sup>28</sup> This CMS demonstration has the aim of reducing reliance on institutional care by aiding beneficiaries' transitions from institutional care to home and community-based care.<sup>29</sup> The MFP demonstration also allows more flexibility in spending, but it takes the concept one step further. It funds these transitions for up to one year after an individual leaves an institution. MFP demonstration funding will be 1.75 billion dollars over five years in competitive grants to States for a minimum of two years and a maximum of five years.<sup>30</sup>

An optional benefit under both Medicare and Medicaid, the Program of All-Inclusive Care for the Elderly (PACE) provides home-based care services for those over age 55.<sup>31</sup> PACE organizations serve nursing home-eligible patients with the idea of keeping them in a home-based setting. These organizations use a team approach to provide a full range of care to enrollees, including primary care, social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy, transportation, and meals. Providers receive monthly Medicare and Medicaid capitation payments for each eligible enrollee.

Although PACE has largely been an urban program, rural interest in the model is growing. In 2006, CMS provided \$500,000 to 15 organizations for a rural PACE demonstration. This provided start-up funding for the development of PACE sites to specifically serve rural residents. Expansion beyond these grant-supported PACE sites has been limited. Some rural areas struggle to meet some of the PACE requirements in terms of assembling the care team, enrolling enough participants to make a program economically viable, and addressing how to provide the broad range of services over a large geographic area. Stand-alone rural PACE programs may not be financially viable given low population density and high fixed costs. However, it may be possible to extend services from urban-based PACE providers to rural residents since these organizations will already have developed many of the economies of scale for providing services efficiently.

## **Medicare**

Medicare also plays a key role in supporting rural seniors' efforts to receive needed services while aging at home. Not all inpatient or rehabilitation services are going to be available in every rural area, but basic primary and

emergency care, limited inpatient, and post-acute care services being available within a reasonable distance is a realistic expectation. The emergence of more than 1,300 Critical Access Hospitals, which offer most of those basic services either directly or through arrangement, has played an important role in keeping rural seniors viable in their home communities.

Over the years, there has been concern about access to basic services for rural seniors due to payment rates for primary care, inpatient, and post-acute care services. Medicare has a number of special payment designations for rural areas designed to address some of those concerns.

The Medicare Modernization Act of 2003 made it possible for beneficiaries to develop Special Needs Plans (SNPs) under Medicare Advantage (MA), and Congress has affirmed the worth of SNPs by passing subsequent legislation to keep this option available. SNPs are coordinated care plans targeted for beneficiaries with special needs, including individuals who are institutionalized, dually eligible for both Medicaid and Medicare, or have severe or disabling chronic conditions.<sup>32</sup> SNPs can focus on monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations, and helping beneficiaries move from high risk to lower risk on the care continuum. A higher proportion of people with disabilities live in rural than urban areas<sup>33</sup> and utilizing SNPs could allow more rural seniors to live at home with improved coordination and continuity of care.

#### RECOMMENDATION

The Secretary should evaluate whether rural seniors who are dually eligible for Medicare and Medicaid are able to take part in programs such as MFP, Cash and Counseling, HCBS, PACE, and MA Special Needs Plans to the same extent as urban seniors.

### Assessment and Care Planning Instruments

Medicare and Medicaid programs both use certain assessment instruments, e.g., the Minimum Data Set (MDS) instrument for Nursing Facility (NF) care and the Outcome and Assessment Information Set (OASIS) data set for home health, but their data elements are not interchangeable. Medicare and Medicaid efforts have continued for almost 20 years to develop uniform

assessment instruments with uniform data definitions, including provisions in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and other statutes. These efforts have consistently failed because of the difficulty in achieving standardization and the ongoing resistance of providers to the burden of completing lengthy assessments. This is a concern that affects both rural and urban providers. It can create challenges for some low-volume rural home health agencies that do not have a great deal of experience with OASIS. Failure to conduct this assessment properly has a downstream effect on both patient and provider. It can result in the home health agency shortchanging itself on reimbursement while the patient may not get the level of services needed.

#### RECOMMENDATION

The Secretary should instruct CMS to develop a uniform assessment tool that works across post-acute care settings and HHS programs as required under current law.

### Informing Rural Seniors

The Committee believes that home and community-based care options should be explained to seniors long before they are in a time of crisis. When it becomes apparent that an individual requires long-term care, there is little time to act. Planning for long-term care, although difficult, is essential. Knowing the types of options and what resources are available is invaluable, when the time comes. While statistics can be used to anticipate what percent of the population will need long-term care, people cannot anticipate when they, as individuals, will require long-term care, or what level of assistance they will need.

Opportunities exist for CMS to collaborate with rural providers to encourage rural seniors to access home and community-based systems of care. One potential opportunity for collaboration is during the beneficiary's Welcome to Medicare exam. This would allow the beneficiary to learn about accessing home and community-based services and begin long-range planning. At this time, the provider could give the patient information about the National Eldercare Locator Service, Administration on Aging (AoA) programs, such as National Elder Services, and HHS' National Center for Long Term Care Information, which distributes the "Own Your Own Future" starter kit. Discharge planners may

also refer seniors in need of advanced care to an Aging and Disability Resource Center (ADRC).

The need to inform seniors of their care options is particularly important at the time of discharge from a hospital or a skilled nursing facility. Medicare's hospital conditions of participation (CoPs) contain strong and detailed requirements for discharge planning, and appropriately so. However the typical discharge planning tends to focus heavily on nursing home placement, both skilled and non-skilled, reflecting an institutional bias that is not consistent with Federal and State efforts to focus on a broader range of options for seniors. The challenge is how to revise the CoPs to reflect these options and to provide discharge planners with the information and resources to assist patients and families in gaining access to home and community-based care.

Following an episode of acute care, discharge planners help patients make the transition to the next care setting. In many hospitals, a nursing home is the current default option. This may be due, in part, to discharge planners being more knowledgeable about hospital and nursing home resources than they are about community resources. Providing education on home and community-based services and the resources available to those involved in discharge planning could help decrease the number of people referred to nursing homes who do not require that level of care.

#### **RECOMMENDATION**

The Secretary should work with the Congress to change the requirements for coverage of the "Welcome to Medicare" physical to include provision of information about available home-based options for seniors. This information should also be included as a discharge planning function with a "handoff" to the Community Living Programs, Eldercare Locator Service, and Aging and Disability Resource Centers.

### **Family as Caregivers**

The preferred means of care for the elderly is most often by family and friends. Training family and friends to care for seniors in their neighborhood would provide seniors the comfort of remaining in their homes. Unfortunately, there are multiple deterrents to this option. There are some provisions, such as State practice acts for health

practitioners, which can prevent care by family, friends or lower level practitioners. In some cases, Nurse Practice Acts permit nurses to teach certain skilled services (injections, for example) to family members but prohibit them from teaching friends and neighbors how to care for elderly neighbors in their homes. Another disincentive is the prohibition under both Medicare and Medicaid of paying relatives for care. The original prohibitions, enacted in the 1960s, were based on the assumption that such services would otherwise be available to the beneficiary at no cost. That assumption is no longer valid in today's world, in which most family members routinely work outside the home. Family members willing to provide care often cannot do so without some source of income. The Committee believes that both of these problems should be remedied: that State practice acts for health care practitioners, at all levels, should be examined and revised to allow for broader training for family caregivers and that Medicare and Medicaid program prohibitions against the payment of relatives be re-examined in light of today's employment market.

#### **RECOMMENDATION**

The Secretary should support an evaluation that examines current law prohibitions against payment to family members for care otherwise covered under Medicare or Medicaid, with a view towards determining whether they should be eliminated in light of current economic conditions.

### **Hospice**

The Committee believes it is important to address home and community-based service options along the entire care continuum. Hospice services primarily provided in the home are covered by Medicare, Medicaid, and most private insurance companies. Rural seniors tend to "age in place," so the availability of hospice providers in rural areas is very important. Some rural areas face a challenge in providing hospice general inpatient services (GIP) and respite days to hospice patients in communities with a CAH. GIP days for hospice services have the potential to dilute the overall inpatient payments for other Medicare services. The Committee is concerned this may act as a disincentive for CAHs to partner with hospices to provide needed care to rural beneficiaries. Many CAHs operate with small operating margins, and concern over the bottom line may cause them to avoid hospice patients if providing

services to them has a negative effect on their overall rate.

### RECOMMENDATION

The Secretary should instruct CMS to find a method for claiming and reporting hospice payments for general inpatient services on a CAH cost report in a manner that permits the CAH to claim the full cost of caring for the hospice patient.

## Administration on Aging Programs

Congress passed the Older Americans Act (OAA) in 1965, in response to concern by policymakers about a lack of community social services for persons over 60. The legislation established authority for grants to States for community planning, nutrition, supportive services, research and development projects, and personnel training. Administration on Aging (AoA) programs play a key role in providing home and community-based services to seniors through a national network of 56 State Agencies on Aging, 629 Area Agencies on Aging, nearly 20,000 service providers, 244 Tribal organizations, and two Native Hawaiian organizations representing 400 Tribes. The mission of AoA is to help elderly individuals maintain their dignity and independence in their homes and communities through comprehensive, coordinated, and cost effective systems of long-term care, and livable communities across the United States.

Title III of the OAA authorizes a number of programs and services. Title III, Part B provides flexible funding to State agencies and local agencies that they can use to provide a wide range of needed supportive services. This includes home and community-based support services as well as case management and transportation; information and assistance; in-home services, such as personal care, chore, and homemaker assistance; and community services, such as legal, mental health, and adult day care services. These services are generally provided to individuals who do not qualify for Medicaid-funded programs and services.

Title III-C covers nutrition services, including Meals on Wheels and congregate meals at senior centers, community centers, and churches. These programs play a key role in rural communities, which the Committee has witnessed during multiple site visits over the past few years. Many rural seniors are both socially and geographically isolated

and these meals programs offer a way to create a link between rural residents and local service providers.

Title III-D Preventative Health funding is provided to Area Agencies on Aging to address disease prevention and health promotion education and activities to encourage healthier living for older persons. Many Area Agencies on Aging have adopted evidence-based chronic disease and fall prevention programs to address this issue. The AoA works closely with the CDC to ensure an appropriate focus for these funds.

The National Family Caregiver Support Program (NFCSP) is also part of Title III-E and provides grants to States and Territories, and funds a range of supports that assist family and informal caregivers. Studies have shown that the NFCSP services can reduce caregiver depression, anxiety, and stress for the caregivers, thus enabling them to provide care longer and avoiding or delaying the need for costly institutional care. The Committee has previously examined the rural implications of the National Family Caregiver Support Program in its 2006 report and reiterates that, while NFCSP is successful and has expanded its scope of services, the program funding has not expanded and is in great need of enhancement. Inadequate funding results in service gaps and availability issues.

The Aging and Disability Resource Centers (ADRC), co-funded by CMS and AoA, provides grants to 45 States to develop “one-stop shops” for all of the long-term care services within a community. In 2008, an additional two new States were funded, bringing the total number of States receiving funding to support ADRC to 45.<sup>34</sup> The States without ADRC grants are North Dakota, South Dakota, Nebraska, Utah, and Oklahoma,<sup>35</sup> each a State with a large rural population. By creating a single point of entry into a community’s long-term care system, the ADRC help individuals make informed decisions based on the options that are available. One barrier that the Committee identified to rural seniors receiving home and community-based care was the fragmentation of services within the community.<sup>36</sup> ADRC begin to address this issue by simplifying the process of identifying and acquiring services. ADRC are funded through Title IV of the OAA under the Choices for Independence initiative.<sup>37</sup> AoA estimates that by 2004, ADRC were serving 600 counties.<sup>38</sup>

Beginning in June 2007, 12 States began participating in an 18-month effort called the Community Living Program, also known as the Nursing Home Diversion Grant Program.<sup>39</sup> The State grantees receiving, in combination, \$8.8 million dollars are Arkansas, Connecticut, Georgia,

Illinois, Kentucky, Maryland, Michigan, Minnesota, New Hampshire, New Jersey, Vermont, and West Virginia.<sup>40</sup> The initiative was funded and administered by the State Units on Aging in partnership with the Area Agencies on Aging. The program targeted those who were at risk for being placed in a nursing home and/or at-risk for Medicaid spend-down. It provided flexible funding to individuals and allowed them to participate using models such as Cash and Counseling. It also focused on complementing and supporting family caregiving, not replacing the systems that are already in place.<sup>41</sup>

## **Rural Communities and Block Grant Funding**

Many of the Federal programs for seniors, such as AoA programs, allocate money in the form of block grants to States. When distributed at the State-level, formulas used to determine funding are typically based on population. Often, this results in rural programs not being allocated sufficient funds to mount a credible effort. This is because there are certain fixed costs associated with starting a program, regardless of the number of people the program will serve. Block grants should take these fixed costs into account and keep in mind that rural areas are not easily able to leverage economies of scale, and allocate the budget accordingly. This would help prevent funding from being completely consumed before a rural program can start serving beneficiaries.

## **The Centers for Disease Control and Prevention**

Centers for Disease Control and Prevention (CDC) administers several disease management and population health programs for rural seniors. CDC's Healthy Aging Program is an effort to integrate public health and aging networks. By promoting health, the program aims to keep seniors healthy while maintaining a high quality of life.<sup>42</sup> CDC partnered with AoA and over 11 State Agencies on Aging to support State-Based Examples of Network Innovation, Opportunity, and Replication (SENIOR) Grants.<sup>43</sup> By promoting collaboration between local public health systems and Area Agencies on Agings, the grants aimed to foster good health among seniors.<sup>44</sup> Similar to the SENIOR Grants, the Racial and Ethnic Approaches to Community Health (REACH) grants helped promote community health and eliminate disparities.

## **Cross Cutting Issues**

### **The Promise of Technology**

Rapid advances in telecommunications technology holds promise for expanding access to information and services regardless of geographic location. Over the past 10 years, the explosion of information available through the Internet has created new ways to inform clients about important services. In addition, telehealth technology has expanded the range of clinical services available to rural seniors through direct video consultations and remote home monitoring. Both of these tools, used correctly and efficiently, can be part of a strategy that helps rural seniors remain independent and living on their own. Technology, however, is only a tool and there are still challenges in taking full advantage of these services to benefit rural seniors.

The percent of seniors taking advantage of new technologies has increased for Internet usage from 12 percent in 2000 to 37 percent in 2008.<sup>45</sup> As time passes and technology becomes widely implemented, a new group of people will age in to the "Senior" classification. This group will have had more exposure to using technology than current seniors, and will therefore be more comfortable with it. Problematically, rural residents do not have the same level of Internet access as their urban counterparts. Broadband technology enables greater information-carrying capacity and faster Internet access,<sup>46</sup> which is important to medical data transmission. In 2007, 70 percent of rural households with in-home Internet access had broadband access while 84 percent of urban households with in-home Internet access had broadband access.<sup>47</sup> The Federal Communications Commission released a report on a Rural Broadband Strategy acknowledging that the Commission and other Federal agencies have not collected sufficient data to indicate what the current state of broadband is in rural America. The Commission has been charged to develop a national broadband plan by February 17, 2010 that will detail an actionable plan to ensure that every American has broadband access.<sup>48</sup> On the plus side, the American Recovery and Reinvestment Act of 2009 further addresses the broadband issue by including significant funding to support broadband deployment through programs at the U.S. Department of Commerce and U.S. Department of Agriculture (USDA).

### **VA Depends on Home Monitoring**

The Veterans Health Administration (VHA) uses telehealth to treat veterans in over 30,000 homes. The VHA provides patients who would benefit from daily monitoring with a computerized device to take home. The device sends information, such as vital signs, disease management data, and e-health information, that goes to the National VHA Care Coordination. Other medical services provided over telehealth include high resolution imaging, telepresence, telepathology, and mental health counseling. Currently, the VHA is attempting to reach 32 percent of the veteran population in rural areas.

The Committee was particularly impressed by the quality of the leadership in providing telehealth at the VHA. Lori Aberly, the Chronic Disease Risk Manager for the Fort Meade Veterans Health Care System, is highly committed to the possibilities of telemedicine and enabling veterans to successfully accept and use the equipment in their homes. In order to work properly, telehealth programs require strong commitment to the education of patients and consistent follow-up to assure that the equipment is working correctly and the patients are using it correctly. As in the case of Fort Meade's Chronic Disease Management initiative, it was clear that the commitment of the individuals running this program was a key factor in its success.

Fort Meade's Chronic Disease Management initiative provides portable telehealth devices to rural patients who qualify for chronic disease risk management. The patients use the device daily to communicate their vital signs to doctors at Fort Meade. This allows better care management and immediate response when the patient is at risk. In addition, daily management can lengthen the time between doctor visits, thus reducing costs for the health care system. Some patients drive more than four hours to go to Fort Meade, so reduction in doctor visits is valuable to them in terms of both time and costs.

With proper funding and leadership, the Committee believes that telemedicine can significantly improve the health of rural seniors, and would like to see this efficient system expanded.

Telehealth services continue to expand and play an important role in ensuring access to a broader range of services in some rural communities. The use of tele-home monitoring technology appears to be a cost-efficient way of monitoring seniors' health status. The equipment costs have come down considerably in recent years. Telehealth, however, still faces some regulatory challenges, ranging from cross-State licensure of telehealth providers to reimbursement. Additionally,

there is only a small range of services that CMS will reimburse clinicians for under Medicare.

## **Workforce Shortages**

Increased demand does not always result in an equal supply, and this is especially evident when examining the health care workforce shortages in rural areas. As the rural population ages and there is continued out-migration of young adults from farm-dependent communities, the workforce available to care for this elderly population will become stretched even more thinly.<sup>49</sup> To address these shortages, rural residents and providers have needed to adapt to meet some of the workforce needs. For example, some States' Medicaid programs and grants now allow legally responsible relatives to be paid to assist the beneficiary through the aforementioned CMS program Cash and Counseling.<sup>50</sup> Also, some States have modified their Nurse Practice Acts to allow trained caregivers to do the tasks normally performed by a nurse. Medicaid also provides limited funding for personal assistant services.<sup>51</sup> While a step in the right direction, these advancements are limited. Cash and Counseling is only operating in 15 States and additional modifications to more State's Nurse Practice Acts would allow more family and friends to be caregivers.

## **Transportation**

Getting people to needed services is a problem across the aging population but is particularly acute for rural residents. Medicare does not pay for transportation generally. Medicaid can cover some basic transportation costs but budgets and capacity for these services is limited. Some rural clients may be difficult to reach during bad weather conditions because they live along unpaved roads or in mountainous terrain. In many cases, payment for transportation of patients or travel expenses for caregivers and providers is determined on an average basis and embedded in the payment rates for the services themselves. When home care options rely on health care practitioners commuting to the patient, not only is service time lost, but paying professionals to commute is an ineffective use of monetary resources. This is known in the rural health care community as "windshield time."

If not specifically addressed, these rural issues can result in many problems, including "institutionalization of people with disabilities solely as a result of the lack of adequate transportation to medical appointments," according to a 2005 National Council on Disability report.<sup>52</sup> Federal

grant funding for transportation remains very limited and is primarily offered through the Department of Transportation. Better utilization of transportation mechanisms already in place, such as bus routes, would be beneficial.

to determine if they pose unintended barriers that affect care delivery. Perhaps the most challenging task facing HHS is how to better coordinate both its programs and services to meet the needs of the rural elderly. Certainly, the need to provide better information about services and care options tops that list. The recommendations included in this chapter offer a step forward in that direction.

### **RECOMMENDATION**

The Secretary should develop a report in coordination with the Secretary of Transportation to identify all available legal authorities to provide transportation for those in need of health and human services and to determine their effectiveness in serving the elderly population with a particular emphasis on the availability and effectiveness of these programs to serve the isolated rural elderly.

## **Accessible Housing**

One prerequisite of being able to age in place is accessible housing that meets the needs of the individual. The U.S. Department of Housing and Urban Development (HUD) offers a number of options for seniors who wish to stay in their homes or to continue living independently in an apartment. However, the availability of these programs in rural areas varies from community to community. Rural seniors can receive help from a HUD-approved housing counselor in or near their community by contacting their local HUD organization. If appropriate, a rural senior could apply for a reverse mortgage through HUD. For low-income rural seniors who need to rent a place to live, HUD offers subsidized housing, public housing, and vouchers<sup>53</sup>. USDA also has a number of services for rural seniors, including a housing search service, loan programs, and assistance with repairs for low-income individuals.<sup>54,55</sup>

The Committee notes that, too often, providers and programs are not meeting the needs of the beneficiaries because they view their functions too narrowly and fail to see the larger picture. The Committee has repeatedly stressed the need for improved leadership in rural communities so that disparate activities can be unified around the beneficiaries' needs rather than program requirements. The Committee recognizes the importance of individual efforts at the local level in achieving the kinds of coordination that can make a service system work for its users. The challenge lies in making existing programs work more effectively, particularly for rural communities given the demographic challenges they face. Policymakers also face ongoing challenges in assessing current regulations

# Rural Primary Care Workforce

## Chapter Recommendations:

### **Title VII and VIII Programs**

- 1: The Secretary should work with the Congress to re-authorize Title VII and VIII of the Public Health Service Act to include the authority for allocating funding to better meet emerging workforce needs in the health professions based on the most current data and projections available.
- 2: The Secretary should work with the Congress to ensure that any reauthorization of Title VII of the Public Health Service Act includes demonstration authority.
- 3: The Secretary should expand the Critical Shortage Facility list used for Nursing Scholarship and Nursing Loan Repayment programs to include Critical Access Hospitals.

### **National Health Service Corps**

- 4: The Secretary should work with the Congress to revise the legislation that defines “primary care” used by the National Health Service Corps Scholarship and Loan Repayment programs to create an exclusion for awardees employed by rural hospitals with less than 50 beds, so that time spent seeing patients in the emergency room, a nursing home, or hospital outpatient clinic will count toward the 32 hours of required weekly clinical time.

### **Medicare Graduate Medical Education**

- 5: The Secretary should revise regulations to define an “integrated rural training track” as:
  - At least four rural block months to include a rural public and community health experience. During a rural block rotation, the resident is in a rural area for a minimum of four weeks or a month.
  - A minimum of three months of obstetrical training or an equivalent longitudinal experience.
  - A minimum of four months of pediatric training to include neonatal, ambulatory, inpatient, and emergency experiences through rotations or an equivalent longitudinal experience.
  - A minimum of two months of emergency medicine rotations or an equivalent longitudinal experience.

6: The Secretary should revise the regulations for “Community Preceptors” to allow preceptors to volunteer their time in serving as preceptors to residents.

7: The Secretary should redefine the definition of “all or substantially all” to allow the cost of GME residency training to be shared between hospital and non-hospital based providers.

### **Medicare Reimbursement**

8: The Secretary should work with the Congress to increase the Medicare cap for RHCs and rural FQHCs to match the rate for urban FQHCs.

### **Shortage Areas**

9: The Secretary should ensure that when regulations for shortage areas are updated the process should only update the Medically Underserved Areas and Medically Underserved Population process and maintain the basic methodology for the Health Professional Shortage Areas regulations.

10: The Secretary should ensure that when the shortage area regulations are revised, protections are put in place to reduce the “yo-yo” effect of removing resources from a community when it loses its Health Professional Shortage Area designation due to the addition of less than five primary care providers in the rational service area or county.

11: The Secretary should work with the Congress to revise the regulations for the Health Professional Shortage Area Medicare bonus payment to Advanced Practice Nurses and Physician Assistants.

### **International Medical Graduates**

12: The Secretary should remove the HPSA score requirement from the HHS J-1 Visa Waiver regulations and expand the list of potential practice sites to include Critical Access Hospitals, Sole Community Hospitals, Medicare Dependent Hospitals, and any Section 1886(d) hospital with less than 50 beds.

## **Rural Significance: Why the Committee Chose this Topic**

Primary care providers serve an essential role in our health care system by supporting prevention and wellness efforts, coordinating continuity of patient care, and managing chronic illnesses. Rural communities are particularly reliant on primary care providers as the leading source of health care. Currently, the national demand for primary care providers exceeds supply. Interest in a primary care career for physicians is declining nationwide, but has most notably affected rural areas. Twenty percent of the nation's population lives in rural America, yet only 9 percent of physicians practice in rural areas.<sup>56</sup>

In 2005, there were 55 primary care physicians for every 100,000 people in rural areas compared to 93 in urban areas.<sup>57</sup> The estimated requirement for primary care physicians per 100,000 people is 95; this indicates a significant shortage of physicians in nonmetropolitan areas and a small shortage in metropolitan areas.<sup>58</sup> Moreover, a recent study indicated that there is a greater percentage of aging generalists who are likely to retire soon in rural areas compared to urban.<sup>59</sup> The average age of rural physicians was 47.2 years in 1997 and almost 50 percent of primary care physicians have indicated they plan to reduce their practice hours or stop practicing completely between 2009 and 2011.<sup>60,61</sup>

Additionally, dwindling interest in primary care is exacerbating workforce shortages. Fewer medical school graduates, who could replenish the diminishing supply of generalists, have chosen to enter primary care than in years past. In 2009, about 42 percent of family practice residencies matched with U.S. medical school graduates compared to 75 percent in 1996.<sup>62,63</sup> Both the American Association of Medical Colleges (AAMC) and the Council on Graduate Medical Education (COGME) have released statements projecting a shortage in primary care physicians.

It is important to consider the role and supply of primary care providers, as policymakers work to improve our health care delivery system. This is particularly relevant in rural areas where it can be difficult to recruit or retain a physician. Physician Assistants (PAs) and Advanced Practice Nurses (APNs) provide essential primary care services and serve as the sole primary care provider in many communities.

A broader expansion of health care insurance, or an emphasis on developing Patient-Centered Medical Homes

(PCMH), would likely increase the need for primary care providers. In Massachusetts, where universal health insurance coverage has almost been achieved, patients have difficulty making appointments with primary care providers. The Boston metropolitan area has the longest average doctor wait times nationwide, and rural communities there are having an even harder time recruiting and retaining primary care providers.<sup>64,65</sup> Future health care reform efforts should examine solutions for rural and underserved communities that give them the ability to adequately compete for primary care providers.

In order to keep our rural communities healthy, the Committee finds that primary care systems must be strengthened through a variety of approaches. Local leadership and organizational partnerships are needed to leverage limited rural resources. A cultural shift from treating the symptoms of illnesses to one that concentrates on preventing diseases and maintaining wellness through services that support and lead to healthier lifestyles is necessary. The payment systems, both public and private, should reflect the importance of primary care as the backbone of the health care system. While there is a Federal role in developing a successful rural health care system, States and health sciences schools also have a responsibility to produce more primary care physicians, APNs, and PAs to meet the growing need.

As recommended by the Committee in its 2009 Report, it is essential to collect data to analyze national health care workforce needs.

## **HHS Program Role**

HHS administers a number of programs and provisions that affect the primary care workforce. This includes a number of training programs designed to support the development and placement of these clinicians in underserved areas. In addition to these programs, HHS, through the Centers for Medicare and Medicaid Services (CMS) also administers the Medicare program. Medicare reimbursement to physicians as well as Medicare support for the training of physicians also affects the supply of available primary care providers.

## **Title VII and Title VIII Programs**

Improvement of the supply of rural primary care providers begins with the education and training of health professions students so that they are prepared to work with the rural underserved population. Title VII of the

Public Health Service (PHS) Act established multiple programs administered by Health Resources and Service Administration's (HRSA) Bureau of Health Professions (BHP) that focus on educating and training primary care providers who can provide culturally appropriate health services to underserved populations, including rural areas.

One Title VII program is the Area Health Education Center (AHEC) Program, which contributes to expanding the supply of primary care professionals who are adequately trained and interested in working in rural areas. AHECs promote partnerships between academic institutions and communities to train health care providers in community-based settings and to improve the supply, distribution, diversity, and quality of the health care workforce. While the initiatives and achievements of AHECs vary by State, certain AHECs have been exceptional in their work with rural communities. Rural communities may not have the financial resources needed to provide their students with targeted health care opportunities and experiences. Therefore, AHEC programs can play a useful role in developing the interest and basic science education needed to encourage rural students to enter health professions.

### **A Grow-Your-Own Approach**

Like most States, Missouri has rising health care costs, large numbers of elderly and poor, and insufficient access to health care in rural areas.

Since 1994, the University of Missouri (MU) School of Medicine has relied on its Rural Track Pipeline Program to reach out to high school students, undergraduates, and medical students and provide them with the support they need to follow their dream of practicing in a rural community.

The sequential programs provide students with ongoing exposure to rural medicine. Programs include the AHEC Career Enhancement Scholars program, carried out by regional AHECs and designed to expose and recruit K-12 students to the world of health care at the local level, the Bryant Scholars Pre-Admission Program to encourage college freshman to commit to medical school and a career in rural health care, the Summer Community, the Rural Track Clerkship Program, and the Rural Track Elective Program, which allow second, third, and fourth-year medical students, respectively, to participate in a clinical program in rural community settings around the State. The Missouri Physician Placement Service (MPPS) then works to match the practice desires of the physician with communities in need. Half of the participants eventually practice in rural towns with 50,000 population or less.

Most of the other Title VII funding is separated by medical field or by health profession based on the initial legislation. For example, HRSA supports primary care training programs for physicians through the Training in Primary Care Medicine and Dentistry program. Another BHP program, the Preventive Medicine Residency program, supports educational institutions in developing, maintaining, and improving residencies in Preventive Medicine. Title VIII funding contains several Federal programs targeted to support nursing education and training: the Nursing Education, Practice, and Retention Program; the Advanced Education Nursing Program; and the Advanced Education Nursing Traineeship.

Primary care physicians who have participated in Title VII programs are between two and four times more likely to practice in underserved areas.<sup>66</sup> Additionally, Title VII funding supports the training of over 10,000 underrepresented minority graduates each year, including people from rural areas. Training rural minorities is essential because they are more likely to return to rural underserved areas to practice.<sup>67</sup> While data does not exist on the specific impact of Title VII programs on students' later career choices, some studies have looked at health care professionals who have chosen to provide primary care services for their communities and whether or not they had prior exposure to Title VII programs. More than 60 percent<sup>VIII</sup> of the physicians who work in Community Health Centers and more than 57 percent of National Health Service Corps (NHSC) physicians were involved in a Title VII program during medical school.<sup>68</sup>

Title VIII funding is currently broken down into small amounts by profession. While this categorical division is an equalizer among professions and keeps provider associations content, it limits everyone to the same amount each year, thereby limiting potential impact. HRSA should be able to target funds based on demonstrated need and provide those professions with a substantive amount of funding. Title VII and Title VIII are currently up for reauthorization, which provides an opportunity for the basic structure to be readdressed. Under current statutes, HRSA has no flexibility to spend funds. There is a need for some discretionary funding so the HRSA Administrator can fund activities beyond the current avenues, and to target dollars for workforce needs as they emerge.

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NHSC placements are determined to be rural if they self-establish that they are in a rural community.

## RECOMMENDATIONS

The Secretary should work with the Congress to re-authorize Title VII and VIII of the Public Health Service Act to include the authority for allocating funding to better meet emerging workforce needs in the health professions based on the most current data projections available.

The Secretary should work with the Congress to ensure that any re-authorization of Title VII of the Public Health Service Act includes demonstration authority.

The Secretary should expand the Critical Shortage Facility list used for Nursing Scholarship and Nursing Loan repayment programs to include Critical Access Hospitals.

## National Health Service Corps

The National Health Service Corps (NHSC) programs are designed to improve the supply of physicians, dentists, nurse practitioners, physicians assistants, and certified nurse-midwives in both rural and urban underserved areas.<sup>69</sup> HRSA's Bureau of Clinician Recruitment and Service (BCRS) administers the NHSC programs, which include the Scholarship and Loan Repayment programs. In return for each year of financial support for their health professions education, NHSC Scholars and Loan Repayers agree to dedicate a year of service in an underserved area. The NHSC targets a wide range of health professions students who focus on primary care, including physicians, advanced practice nurses, physician assistants, and dentists.

NHSC is an important source of primary care for rural areas, as approximately 60 percent of the NHSC's placements are in rural areas.<sup>70</sup> Many health care professionals who begin working in rural areas as a Scholar or Loan Repayer choose to continue their careers in those areas. In fact, 76 percent of the clinicians who had received NHSC funding were still working with the same underserved population a year after they had fulfilled the service requirement.<sup>71</sup> Since these clinicians continue to focus broadly on primary care, the effect of the NHSC Scholarship and Loan Repayment programs can be felt long after the financial support ends.

Although the NHSC programs are currently providing support for a significant number of primary care providers in rural areas, there are many more health professionals and students who are interested in and willing to serve in underserved areas. In the past several years, less than 20 percent of applicants received awards. The NHSC programs received an increase in Federal investment for Federal fiscal years (FY) 2009 and 2010 from the American Recovery and Reinvestment Act (ARRA). An additional \$300 million was allocated through ARRA and BCRS was able to grant \$71 million in new awards for NHSC loan repayment and \$9 million for additional awards for NHSC scholarships in 2009.<sup>72</sup>

### State Partnerships Keys to Recruitment and Retention

Workforce recruitment and retention has long been a challenge in rural areas, but in South Dakota a unique partnership between the State Office of Rural Health and rural communities like Phillip have paid off.

The Committee took a site visit to Phillip, South Dakota during its June meeting and saw firsthand how the local health system, Phillip Health Services, works closely with the South Dakota State Office of Rural Health to address workforce challenges.

The State Office is working with the community to update its health shortage areas, which will help the community qualify for programs like the National Health Service Corps, as well as other Title VII funding. The State Office also links the programs to other loan repayment and recruitment resources to help them fill needs not only in terms of medical services, but also allied health and nursing.

The NHSC places a large number of clinicians in primary care ambulatory settings; however, the requirements can make it difficult to place clinicians in certain rural settings. All of the NHSC Scholars and Loan Repayers are required to work full-time in an underserved community and 32 of the minimum 40-hour work week must be spent providing direct clinical services in the community. The definition of direct clinical services does not include time spent seeing patients in the emergency room, a nursing home, or hospital outpatient clinics. Therefore, the requirement often precludes rural hospitals and CAHs from serving as practice sites for NHSC clinicians. Furthermore, frontier areas or other very rural areas may be disadvantaged in recruiting NHSC Scholars and Loan Repayers, since these settings are so remote they may not be able to offer the patient volume for a full-time professional. There is no part-time option for NHSC Scholars and Loan Repayers, which could be more attractive to the younger

generation of primary care providers who are willing to work in underserved areas, but may also want a more flexible work schedule.

### RECOMMENDATIONS

The Secretary should create a part-time option for National Health Service Corps Scholarship and Loan repayment recipients.

The Secretary should work with the Congress to revise the legislation that defines “primary care” used by the National Health Service Corps Scholarship and Loan programs to create an exclusion for awardees employed by rural hospitals with less than 50 beds, so that time spent seeing patients in the emergency room, a nursing home, or hospital outpatient clinics counts toward the 32 hours of required weekly clinical time.

### Federal Support for Graduate Medical Education

Teaching hospitals and associated ambulatory settings offer resident physicians supervised, hands-on training in a particular area of expertise; this phase of their training is called “graduate medical education” (GME). The Centers for Medicare and Medicaid Services (CMS) plays a key workforce role through its payments to GME programs. In 2007, CMS spent \$8.8 billion to support residency training, most of which was targeted to large academic health centers and other hospital-based programs. CMS’ GME payments are, by far, the largest funding source for these residency programs in the United States. About 40 percent of CMS’ GME payments are for Direct GME (DGME), which covers part of the cost of operating a residency program. The remaining percent of the payments are for Indirect GME (IME), which helps to cover the added patient care costs associated with teaching settings.

Both DGME and IME payments are based on the number of full-time equivalent (FTE) residents a hospital has, up to a maximum of its total approved slots, which is known as its residency cap. Since the initial determination in 1996 of these residency caps, several minor adjustments have been made to the benefit of rural communities, such as increases in the FTE cap for rural hospitals with residency programs, and a national redistribution in 2003 of “unused” slots to residency programs with a need for

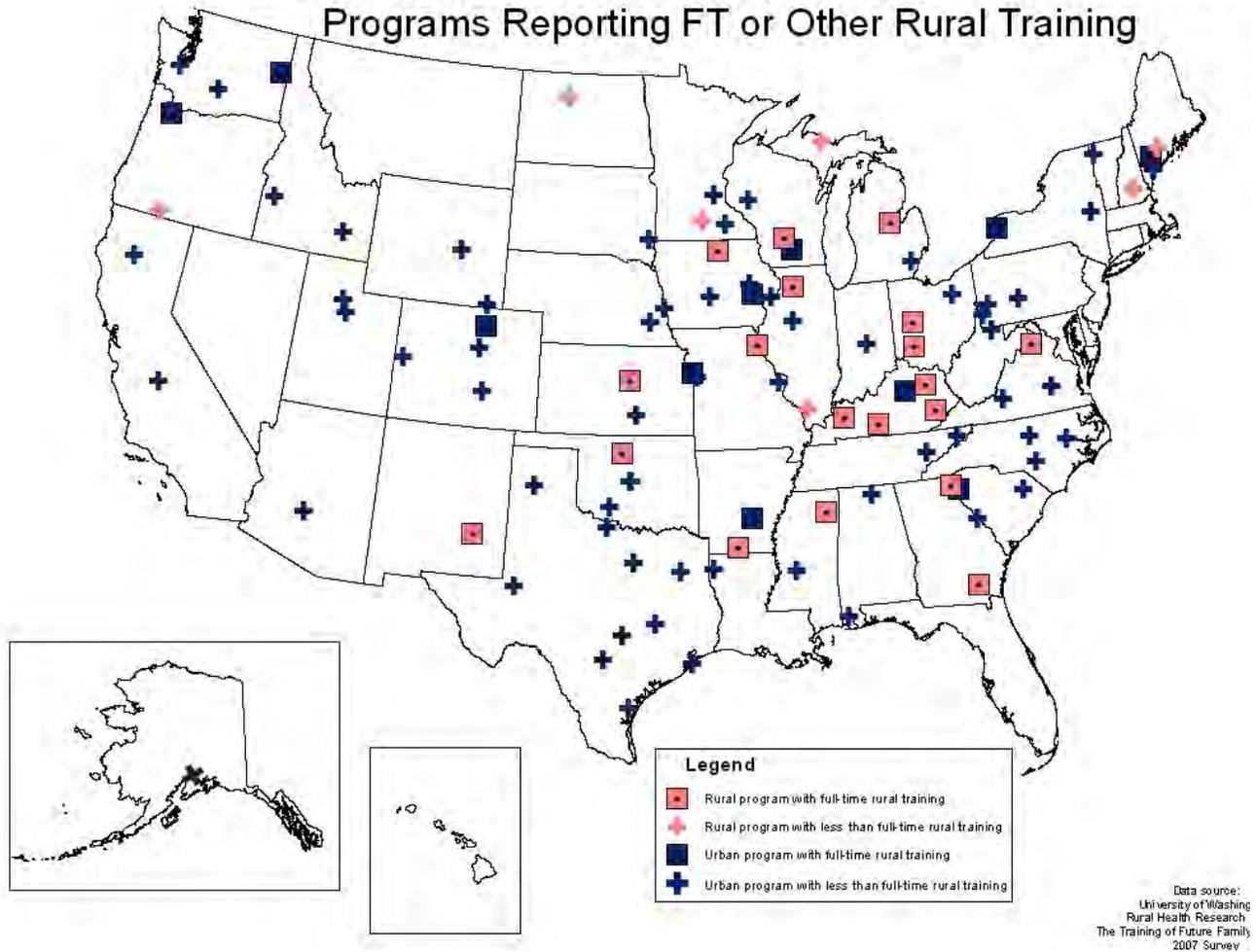
additional slots, during which priority was given to rural hospitals.

Current legislation allows the Secretary of HHS to adjust the residency caps for non-rural hospitals that either have a Rural Training Track (RTT) or an integrated rural track. Although RTTs account for less than 2 percent of family medicine slots, at least 75 percent of their graduates choose to work in rural areas.<sup>73,74,75</sup> In order to qualify as an RTT, CMS requires residents to spend more than half of a three-year residency program in a rural setting. Rural advocates have pushed for more flexibility in the amount of rural-based community training necessary to qualify for an RTT. Some rural advocates would like to lower the threshold for rural training by supporting residency programs that have an integrated rural track. While CMS does recognize and provide exceptions to hospitals with RTTs, there is no government definition for “integrated rural track” and, therefore, the exception is not applied. These exceptions are only applied to the creation of new programs, so successful rural family medicine residency programs would not be eligible for additional GME payments.

Despite the slight adjustments for rural residency caps, the overall number of Medicare GME residency slots has not changed much since 1996, although there has been a significant increase in the U.S. population and its health care needs. Over the past several years, some teaching hospitals have chosen to create new residency positions without Medicare funding, causing the number of residents in GME programs nationwide to increase by 6.3 percent between 2002 and 2006.<sup>76</sup> However, the majority of these new residency spots were for subspecialty fellowships rather than primary care. In fact, the total number of family medicine residency slots has actually decreased by over 600 slots in the past decade.<sup>77</sup> The most recent study that examined the location of family medicine residencies was completed by the Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI) Rural Health Research Center based on data from 2000.<sup>78</sup> It noted that 92.4 percent of family residency programs were in urban areas, 6.4 percent in large rural areas, 1.1 percent in small rural areas, and no programs existed in isolated small rural areas. Even though 12.8 percent of the population lived in small rural and isolated small rural areas in 2000, only 2.2 percent of residents had trained in those locations. Problematically, the small patient volume in rural areas makes supporting a residency program difficult.

In addition to preparing future rural physicians, the presence of a residency program holds several other benefits to the rural community. Rural hospitals with

## US Family Medicine Residency Training Programs, 2007 Programs Reporting FT or Other Rural Training



residency slots tend to be more successful in recruiting and retaining physician staff.<sup>79,80</sup> The resident, as an addition to the medical staff, can help relieve a rural physician of some night call responsibilities, improve the financial viability of a rural hospital through increased admissions, and expand access to health care for the rural community.<sup>81,82</sup> Since the Accreditation Council for Graduate Medical Education (ACGME) does not track whether residency programs are located in rural or urban areas, it is difficult to note national trends in the expansion or closure of rural programs and the number of residents training in rural communities.

What is known is that the number of medical students choosing to enter rural residency programs is declining. The average fill rate for RTTs from 2003 to 2008 was 52 percent.<sup>83</sup> In the 2009 Residency Match, only 74 percent of the 47 residency slots available in RTTs were filled compared to 91 percent of overall family medicine residency slots.<sup>84</sup> Rural advocates note that an increase in the number of rural slots is not sufficient to address the problem of training primary care physicians for

rural practice; there is also an immediate need to make these rural training slots more attractive to prospective residents in order to achieve higher fill rates. Legislation that was introduced, but not passed, in the 110<sup>th</sup> Congress supported an increase in the residency caps.<sup>85</sup> In order to increase residency caps, legislation would have required HHS to determine whether a hospital seeking to expand its residency program would have been able to fill the additional slots within three years.<sup>86</sup> Based on recent data for fill rates, many rural residency programs probably would not have qualified for expansion, despite the continuing need for more rural residents.

Most residencies are located in large urban hospitals and academic health centers with an emphasis on specialty training. Many experts on primary care believe that the current residency training model needs to move beyond the hospital setting and into community-based training sites, where most health care takes place. To adequately train rural primary care residents, they need to be exposed to settings such as doctors' offices, where primary care is actually delivered. Current regulations

present financial disincentives for residency programs to send their residents off-site for training, as noted by both COGME and the Medicare Payment Advisory Commission (MedPAC). In determining the number of FTEs in a residency program, CMS distinguishes between time spent providing patient care and time spent in non-billable GME activities. The need to log patient care and non-patient care hours separately for each off-site setting presents an enormous administrative burden for residency programs that prepare residents for rural medical practice.

### **California's Rural PRIME Program Supports Rural Training**

Esteban Verduzco and Christopher White, medical students at the University of California, Davis, always had an interest in rural health, and thanks to a new program they are getting a chance to learn about it on the ground.

Both of these medical students are part of the University of California's "Programs in Medical Education" (PRIME). The program is designed to address the growing shortage of physicians in underserved rural communities. While similar programs exist in other states, PRIME is a unique and new approach in California. PRIME exists to expose medical students to rural practice, establish mentorships between rural physicians and medical students, and combine the M.D. with a Masters in Public Health. PRIME has more student diversity than is typical, and has given a new focus to health disparities.

Verduzco and White both testified to the Committee at the June meeting and said the program will help them in their plans to become small-town doctors. They also noted that PRIME places particular emphasis on telemedicine training, which has been shown to improve access to specialty care for rural communities that would otherwise not have regular access to specialists.

To receive Medicare GME payments for the time that residents spend providing patient care outside of the hospital, the residency program needs to meet a number of requirements. The payment can be made either to the hospital or to certain non-hospital providers, including FQHCs and RHCs, if either one incurs "all or substantially all" (currently 90 percent) of the costs of the training program. Therefore, if the costs are split between the two entities so that neither incurs 90 percent of the costs, neither entity would be eligible for GME payments. These costs of training include reasonable compensation to the teaching physician for the time spent in non-patient care GME activities. However, many of these physicians prefer to volunteer their time and while

this volunteerism is not outright prohibited by the current "Community Preceptor" regulation, it would not meet the requirement to provide reasonable compensation. Hence, residency programs tend to lose GME payments for the time residents spend in outpatient settings.

Medicare GME payments support the training of physicians; however, there is no equivalent program to support the training of Physician Assistants (PAs) or Advanced Practice Nurses (APNs). Although the U.S. Government Accountability Office (GAO) did note that if Advanced Practice Nurses and physicians were counted as primary care providers, the supply of primary care professionals would have increased slightly in recent years. The number of primary care physicians grew an average of 1 percent a year while PAs grew by 4 percent a year and APNs grew by 9 percent a year.<sup>87</sup> Due to the decline of rural primary care physicians, APNs and PAs are playing a greater role in rural areas; 20 percent of APNs<sup>88</sup> and 22 percent of PAs<sup>89</sup> work in rural areas.

Medicare GME for nursing and allied health education was established in 1965. The majority of the funding was directed at the hospital-based educational programs. Throughout the years the regulations have not kept pace with the changes in nursing education and Medicare money was shifted to third party payers, e.g., Health Maintenance Organizations (HMOs). The HMO reimbursement did not include subsidies for education programs, therefore reducing money for medical and nursing education. The education settings for nursing education has since moved from the hospital-based setting to the academic setting where the community and student bear a greater percentage of the educational cost. Now less than 7 percent of registered nurses are trained through the hospital-based diploma programs.<sup>90</sup> However there are increasing numbers of APNs being trained in academic centers, yet there is no GME money to assist the hospitals with training expenses. Additionally, when APNs are hired by the academic centers they assist in the training of the medical students, residents, and fellows. Under current Medicare GME regulations, there is no reimbursement allowance for the training of APNs in academic centers, nor is there reimbursement allowance for APNs assisting with the training of medical students, residents, and fellows.<sup>91</sup>

The Committee believes the current Medicare GME system perpetuates a training model that focuses on urban-based specialty training which undermines the ability to attract, train, and place primary care providers in rural communities. Medicare GME regulations should be reevaluated to address the education funding of physicians as well as other primary care providers.

## RECOMMENDATIONS

1. The Secretary should revise regulations to define an “integrated rural training track” as:

-At least four rural block months to include a rural public and community health experience. During a rural block rotation, the resident is in a rural area for a minimum of four weeks or a month.

-A minimum of three months of obstetrical training or an equivalent longitudinal experience.

-A minimum of four months of pediatric training to include neonatal, ambulatory, inpatient and emergency experiences through rotations or an equivalent longitudinal experience.

-A minimum of two months of emergency medicine rotations or an equivalent longitudinal experience.

2. The Secretary should revise the regulations for “Community Preceptors” to allow preceptors to volunteer their time in serving as a preceptor to residents.

3. The Secretary should redefine the definition of “all or substantially all” to allow the cost of GMA residency training to be shared between hospital and non-hospital base providers.

## Medicare Reimbursement

Numerous studies have shown that a heavier emphasis on prevention and quality chronic care management can provide better health care outcomes while cutting costs. However, the current payment system is procedure-driven for both rural and urban areas. Many specialty services are paid at a much higher level than standard primary care procedures, which typically promote wellness and coordinate patient care. Ultimately, this creates economic incentives that influence the choices medical students make. Between 1995 and 2004 primary care salaries increased by 21 percent, however in the same time period,

specialists’ salaries increased by 38 percent. The already large and growing income gap between specialists and generalists reduces the likelihood that a medical student would pursue primary care by 50 percent, would work in an FQHC or RHC by 30 percent, and would work in a rural area by 20 percent.<sup>92</sup> However, there is a growing recognition of the need to address the reimbursement inequity. The CY 2010 Medicare Physician Fee Schedule regulation made two changes that improved payments for primary care providers. The first was the elimination of consultation codes, which redistributed funds into primary care evaluation and management payments. The second was to use new survey data for physician practice expense methodology, which more accurately paid for specialty services and increased payments for primary care. COGME has also noted that these trends could be eliminated by bringing primary care incomes to just 60 percent of specialty income.<sup>93</sup> In order to encourage more students to enter primary care professions and work in rural areas, it is essential to address the current system of financing health care and ensure that reimbursement for primary care services reflects their relative value to the health care system and the population.

## Safety Net Clinics Receive Enhanced Reimbursement

Both RHCs and FQHCs mainly provide primary care services to their patient populations, making them an important part of the rural primary care safety net. A safety net includes providers that deliver a significant level of health care and related services to uninsured, Medicaid, and other vulnerable populations. RHCs and FQHCs receive cost-based reimbursement based on an average of the historical costs of that facility per patient visit, up to a certain cap. The 2009 Medicare reimbursement cap for RHCs is \$76.84 per visit. For FQHCs, the cap differs depending on whether the facility is in a nonmetropolitan (\$102.58 per visit) or metropolitan (\$119.29 per visit) area. An increase in the reimbursement cap for RHCs and rural FQHCs can help reduce the income gap and remove a significant barrier to recruitment of rural primary care physicians.

Under Medicare’s current Physician Fee Schedule (PFS), there are several ways to directly improve primary care reimbursement. Relative Value Units (RVUs) determine the value of a physician’s services and are used by CMS to calculate Medicare payments for physician services. When there is a rapid increase in value for a service, an external advisory committee may choose to recommend an increase in the RVU for that service. Since primary

care physicians tend to bill for a smaller number of services and use fewer billing codes, it is unlikely that primary care services would be frequently targeted for an increase in their RVUs. An increase in the RVUs for primary care services would help reflect the actual value of those services. The Sustainable Growth Rate (SGR) was established as a way to prevent rapid increases in the cost of physician services. If payment for a physician service exceeds a target set by the SGR formula, the payments are automatically adjusted. For the past several years, this has resulted in potential payment reductions; however, Congress has annually prevented the adjustments from actually occurring. Reallocation of funding to primary care services can occur through a revised SGR formula or by adding a primary care modifier to the current SGR formula, an option that has been recommended by MedPAC for a number of years. As mentioned earlier, Medicare also currently provides HPSA bonus payments for certain services that are provided in underserved areas or for underserved populations.

Another option would be to shift reimbursement from Fee-for-Service to Pay-for-Performance, in which providers are reimbursed for meeting certain quality markers. Initial demonstrations by CMS have linked Pay for Performance with performance improvement. The CMS Health Buddy initiative from the Health Hero Network, which incorporates technology into chronic care management, uses this reimbursement approach and initial results suggest that it is effective in reducing hospitalizations and improving the quality of care provided.<sup>94</sup>

### RECOMMENDATION

The Secretary should work with the Congress to increase the Medicare cap for RHCs and rural FQHCs to match the rate for urban FQHCs.

## Federal Designations

In order to target funding toward high-need areas, Federal programs use a number of designations to identify areas or populations that are underserved. A frequently used designation to determine eligibility is the Health Professional Shortage Area (HPSA). Communities must apply for designation as a HPSA, and status is reviewed annually by HRSA's Bureau of Health Professions (BHP). The purpose of the primary care HPSA designation is to identify geographic areas, populations, or facilities that have a shortage of primary care providers. In 2009,

68 percent of all whole or partial county primary care HPSA designations were in nonmetropolitan counties compared to 32 percent in metropolitan counties.<sup>95</sup> More information about designations is at <http://bhpr.hrsa.gov/Shortage/hpsadesignation.htm>.

This HPSA designation is directly used by at least 16 Federal programs in allocating resources.<sup>96</sup> When including all Federal programs that take HPSA designations into consideration, that number increases to roughly 40 programs.<sup>97</sup> Since rural areas may not have as easy access to multiple sources of funding as urban areas, they are often more dependent on the HPSA designation in order to receive needed resources. One such Federal program that is very important to rural areas is the HPSA bonus payment. Medicare provides a 10 percent bonus on a quarterly basis to physicians who provide professional services in geographic primary care HPSAs. In 2008, 45 percent of nonmetropolitan counties qualified for the primary care bonus payment. Thus, changes to the criteria for determining HPSA eligibility can significantly impact rural areas.

### The "Catch-22" of Being Underserved

Federal programs can often be a boon in helping provide primary care resources in a community, but they are not without their challenges.

Philip Health Services in Philip, South Dakota is an example of a community-owned health care facility that has sufficient but limited staff. Currently, Philip Health Services has a family Nurse Practitioner, a Physician Assistant, and two physicians, both nearing retirement. Should one of the physicians retire, Philip Health Services would become eligible to be designated as a Health Professional Shortage Area (HPSA). This designation would give them the ability to apply for other Federal resources such as the HPSA Bonus payment for physicians through CMS, which can be useful recruitment tools. However, once they successfully recruit new providers, their HPSA designation status would be in jeopardy, as would the recruitment tool used to attract the new physicians. Communities such as Philip are one or two providers away from being designated as a shortage area; they are in a constant cycle of designation and de-designation.

While researching the benefits and limitations of the HPSA designation, the Committee heard from several rural experts about the workforce "yo-yo" effect. The current HPSA de-designation threshold creates an artificial dichotomy between a community or population that is underserved

and one that is adequately served. When the number of providers in a community falls short of the specified full-time equivalents (FTEs) and is eligible to receive a HPSA designation, it is also able to apply for a number of other Federal resources. However, if it crosses the de-designation threshold, the community is at risk of losing these additional resources, which can hinder the ability to retain their existing health care providers. The current process can create a perverse incentive to be underserved enough to stay just below the de-designation threshold in order to receive these additional, and often temporary, resources rather than to address the underlying problems of recruiting and retaining health care professionals in a community. Over the past 15 years, there have been two efforts at revising the shortage designation process and both have been met with public resistance. Despite the aforementioned shortcomings of the current systems, it appears that a number of key constituent groups may prefer a flawed status quo over a chance at a more rational but untested process.

Nursing workforce development has been supported through Title VIII since 1964. It provides funding for academic nursing center programs for all levels of nursing education. Funding opportunities range from grant and loan forgiveness programs for individual nurses pursuing advanced practice nursing education, to grants to academic institutions for the development or continuation of advanced nursing education programs. Two Title VIII programs are designed to recruit registered nurses to work in facilities that have a critical shortage of nurses: the Nurse Education Loan Repayment Program and the Nursing Scholarship Program (NSP). The Nurse Education Loan Repayment Program repays 60 to 85 percent of nursing student loans in return for at least two years of practice in a Critical Shortage Facility (CSF).<sup>98</sup> Similarly, NSP award recipients are required to work full-time in a CSF for a specified number of years. The approval process for a site to become a CSF is categorical; if a facility falls into one of the CSF categories, registered nurses can count their years of service in that facility toward NSP repayment. The current list includes Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs), among others, but does not include Critical Access Hospitals (CAHs). If CAHs were considered safety net providers they would be designated as a HSPA, enabling nurses to count their years of service at CAHs.

## RECOMMENDATIONS

The Secretary should ensure that when regulations for shortage areas are updated the process should only update the Medically Underserved Areas and Medically Underserved Population process and maintain the basic methodology of the Health Professional Shortage Areas regulations.

The Secretary should ensure that when the shortage area regulations are revised, protections are put in place to reduce the “yo-yo” effect of removing resources from a community when it loses its Health Professional Shortage Area designation due to the addition of less than five primary care providers in the rational service area or county.

The Secretary should work with the Congress to provide the authority to include Critical Access Hospitals as safety net providers, which are given automatic HPSA designation.

The Secretary should work with the Congress to revise the regulations for the Health Professional Shortage Area Medicare bonus payment to Advanced Practice Nurses and Physicians Assistants.

## International Medical Graduates

International Medical Graduates (IMGs) are physicians who have completed their medical education in another country, but practice in the United States. Almost one in four physicians practicing in the United States is an IMG.<sup>99</sup> Additionally, 45 percent of CAHs have at least one IMG.<sup>100</sup> They play an important role in rural primary care because they are often more likely to start in the United States with a family practice residency and are more likely to practice in rural areas.<sup>101</sup> It is estimated that if all IMGs in primary care practice were removed, one out of every five “adequately served” rural counties would become underserved. The percentage of rural counties with physician shortages would rise from 30 percent to 44.4 percent.<sup>102</sup>

Outside of residency programs, it can be very difficult to track where IMGs are practicing, both in terms of geographic locations and specialty. This difficulty arises because the current data does not distinguish between the different types of IMGs (i.e., H1-B Visa, J-1 Visa Waiver, and U.S. citizens who studied abroad). The H1-B Visa allows U.S. employers to hire foreign workers in

specialty occupations. Physicians who had been practicing in another country can enter the United States with a H1-B Visa. International medical students who completed their training in the United States on a J-1 student visa can have their two-year home residency requirement waived through the U.S. Department of State's J-1 Visa Waiver program.

One avenue of obtaining a J-1 Visa Waiver is through State Health Departments, which manage the Conrad State 30 program. The Conrad 30 program allows each State to issue up to 30 waivers per year to J-1 visa holders. In 2001, the average number of Conrad 30 program applicants was 18 per State, but the average number of placements was 13.5 per State.<sup>103</sup> Physicians can also apply for the J-1 Visa Waiver through several U.S. governmental entities including the U.S. Department of Health and Human Services (HHS), the Department of Veterans Affairs (VA), the Department of the Interior's Bureau for Indian Affairs (BIA), the Appalachian Regional Commission (ARC), and the Delta Regional Commission (DRC).

The HHS J-1 Visa Waiver activity has the potential to increase the number of rural physicians, because it is not capped, but few foreign physicians apply through the HHS program. The HPSA score requirements are often too high, so that there are few attractive practice sites; these physicians may not be interested in the obligation to practice in a RHC or FQHC; or, it may simply be easier to apply via the H1-B process or the Conrad 30 program. Currently the current HPSA score requirement for the HHS/HRSA J-1 visa waiver program is a 7. There is also evidence that the number of J1 applicants has declined over the past 10 years. Although the J-1 Visa Waiver program and the Conrad 30 program provide an important source of physicians for rural and underserved areas, the Committee recognizes that these programs are not a perfect solution. A greater reliance on foreign physicians to practice in rural and urban underserved areas in the United States may take providers away from developing countries that likely have just as great a need, if not more, for health care professionals.

### RECOMMENDATION

The Secretary should remove the HPSA score requirement from the HHS J-1 Visa Waiver regulations and expand the list of potential practice sites to include Critical Access Hospitals, Sole Community Hospitals, Medicare Dependent Hospitals, and any Section 1886(d) hospital with less than 50 beds.

# Rural Health Care Provider Integration

## Chapter Recommendations:

### **Stark**

1: The Secretary should work with the Inspector General to develop regulations so that rural practitioners can be compensated for driving time at a fair market value.

2: The Secretary and the Inspector General should work together to assess the impact of the inurement rules on the ability of rural hospitals to hire practitioners in Health Professional Shortage Areas.

### **Medicare Demonstrations**

3: The Secretary should ensure that future demonstrations on quality improvement and care coordination, such as Accountable Care Organizations, payment bundling, and Medical Homes, incent the cooperation of the full range of rural providers.

### **Medicare Survey and Certification:**

4: The Secretary should place a moratorium on approval of any new specialty hospitals in order to determine the impact on access to care for Medicare beneficiaries, with particular emphasis on access to specialty services for rural beneficiaries.

### **Medicare Reimbursement**

5: The Secretary should revise current regulations so the sole emergency medical service providers (EMS) owned and operated by Critical Access Hospitals must be only a minimum of 25 miles (15 miles in mountainous terrain) from the nearest EMS provider in order to qualify for cost-based reimbursement rather than the requirement of 35 miles.

### **Federal Grant Programs**

6: The Secretary should work with Congress to reauthorize and support funding for the Healthy Communities Access Program with revisions to support projects that focus on development and implementation of Medical Home components, e.g., incorporation of HIT and EHRs, chronic care management, and medication management.

7: The Secretary should work with Congress to authorize and support the development of a Critical Access Hospital Health Information Technology Grant Program under the Medicare Flexibility program.

8: The Secretary should encourage the use of existing authorities and funding from the National Library of Medicine at the National Institutes of Health to make competitive grants and contracts to support the adoption of HIT by rural health care providers, given their current low level of HIT adoption.

## Rural Significance: Why the Committee Chose this Topic

The current U.S. health care system is largely fragmented, causing patient care to be uncoordinated. This frequently stems from incomplete transfer of a patient's care between providers<sup>I</sup>, causing practitioners<sup>II</sup> to be without important patient information, medical records or the patient's care plan. Studies show that fragmentation and lack of care management, especially for patients with multiple conditions or chronic diseases, result in inefficiencies and higher costs to the health care system.<sup>104,105</sup> Fragmentation of health care is especially problematic for rural populations because rural residents have higher rates of chronic disease than their urban counterparts,<sup>106,107,108</sup> including heart diseases, hypertension,<sup>109</sup> cancer,<sup>110</sup> diabetes, and obesity.<sup>111</sup>

The Committee believes that quality of patient care will improve if policymakers and regulators promote care coordination that provides seamless patient and information flow among and between providers along the continuum of care. Specifically, the Committee finds that achieving integration will align rural health care services, improve clinical quality, provide cost reductions, and increase patient access to care. Achievement of this goal will improve the health status of people living in rural areas by offering enhanced health care quality, service, and efficiency.

There is not a single model of integration that fits all rural areas. However, the Committee anticipates that models would encompass logical geographic areas that could deliver the full range of health services necessary for the population that it serves while being large enough to achieve significant economies of scale. This integrated structure should be inclusive to all types of health care providers in the impacted region and coordinate the efforts of varying providers and practitioners (e.g., community health clinics, home health agencies, mental health services, and other health professionals), as appropriate and feasible, in order to serve the full needs of a defined population. The legal structure of the integrated organization may vary from ownership to contractual arrangements. Regardless, the Committee believes that strong incentives will be required, either through payment

<sup>I</sup> The term provider will henceforth refer to an entity that provides health care (e.g., CHC, RHC, CAH, etc.).

<sup>II</sup> The term practitioner will henceforth refer to all health care professionals who administer medicine (e.g., Physician Assistants, Registered Nurses, and Medical Doctors).

## What Is Integration?

Several types of integration exist. Horizontal integration occurs when a health care delivery organization extends its core product or service, or when two or more similar providers maintain an interrelationship. Horizontal integration ranges from formal integration, such as combining the offering of medical services and use of facilities, to less formal relationships, such as collectively maintaining voluntary health councils.

Vertical integration links services at different stages in the production process and is overseen by a single organizational entity. One example would be the integration of EMS, primary care, and post-acute services if all were under one organization. Vertical integration can be achieved by offering new services and establishing joint ventures, alliances, and formal networks. Vertical integration is also achieved through the collaboration of separately owned provider types at all levels of care, such as RHCs, specialty care providers, and tertiary care facilities.

arrangements or regulatory means, to ensure an optimal level of participation among regional health providers.

Elements of an integrated model or structure would include the following attributes:

- fair and adequate reimbursement for rural health care providers, based on historical costs and patients served.
- leveraged technology to permit more services to be delivered locally through health information technology and telemedicine networks, including electronic intensive care units (eICU) and other applications, mobile technologies that could be shared among providers, and specialty clinics utilizing specialists from tertiary institutions that are part of the organization.
- centralized services such as purchasing/materials management, laundry, information systems support, credentialing, human resources, Chief Information Officers, and certain financial functions—all of which would achieve cost savings.
- close working relationships with primary care physicians through care coordination models, such as the Medical Home, which would promote continuity of care and encourage preventative care.

The U.S. Department of Health and Human Services (HHS) can have an impact, either directly or indirectly, on the ability of health care providers to work together through regulations and grant programs. The Committee believes that the Secretary of HHS should support integrated health care as a fundamental Departmental strategy. On the policy side, Medicare payment regulations, provider-based rules, and Stark and Anti-kickback regulations play a key role in how providers may or may not integrate with other provider types. On the program side, HHS administers a number of grant programs that promote either formal or informal integration. These include grants to support health information technology and grants focused on rural integration at the community level.

## Stark and Other Regulations Affecting Integration

A number of HHS regulations created to prevent money from adversely influencing health care decisions may have unintended consequences on providers' ability to collaborate. Established in 1972, the Federal Anti-kickback Law makes it a felony for anyone to knowingly and willfully receive or pay anything to influence referral decisions involving Federal health care programs, including Medicare and Medicaid.<sup>112</sup> Since the Anti-kickback Law was published, many safe harbors, or exceptions to the law, have been published.<sup>113</sup>

Related to Anti-kickback provisions, Stark Laws govern physician self-referral for Medicare and Medicaid patients. Physician self-referral is broadly defined as a physician referring a patient to a facility for "designated health services" in which the physician, or a physician's immediate family member, has a financial interest.<sup>114</sup> There are many exceptions to Stark Laws, including one which exempts designated health services provided by physician-owned providers if substantially all (not less than 75 percent) "of the designated health services furnished by the entity are furnished to individuals residing in a rural area."<sup>115,116</sup>

In addition to the rural exception, HHS created an exception to Stark Laws on health information technology (HIT) in October 2006 that is especially pertinent to rural providers. The HIT exception and its related safe harbor and IRS guidance allow hospitals to purchase HIT systems for physicians in affiliated practices.<sup>117</sup> The HIT exceptions remove regulatory barriers that were preventing physicians from being integrated with hospitals' electronic health record (EHR) systems allowing for further integration and

improvements in care coordination.

Due to the complexity of Stark Laws, the Committee believes providers may forgo exercising the rural exceptions in order to avoid facing penalties. For example, Stark Laws prohibit providers from compensating physicians for the time they spend traveling to outreach clinics. Regulators would argue that these outreach services would need to be provided at fair market value for services to meet the personal services exception, but whether driving is a service remains unclear. The Committee is concerned that this may act as a disincentive in providing access to needed services in rural communities.<sup>118</sup> The Committee believes that appropriate safeguards built into a driving time exception would avoid inappropriate utilization while allowing for necessary referral patterns.

Over time, updates to Stark Laws have triggered unintended consequences that stymie health care integration. A maze of regulatory definitions, special rules, and exceptions has resulted from the practice of making exceptions to exceptions. Some proposals around pay-for-performance, Accountable Care Organizations, and payment bundling are problematic under Stark Laws because they may not fit within a current exception.<sup>119</sup> Because these programs link physician payments to the volume or value of physician referrals, they may not qualify for Stark exceptions under the current compensation arrangement.<sup>120</sup>

Other health care regulations prevent providers from offering services that are priced below market value to practitioners. These rules, called inurement rules, prevent hospitals and other providers from influencing referrals and admissions from a particular practitioner. Inurement rules can adversely affect some severely underserved rural areas where a provider must pay above average rates to attract a clinician to a particularly challenging practice environment.

The Centers for Medicare and Medicaid Services (CMS) has regulations that have focused on administrative integration of commonly owned components through its provider-based regulations. These rules apply to providers and facilities considered to be an integral part of a main, or parent, facility. Provider-based regulations affect integration because they allow provider-based facilities to reallocate overhead costs to the parent facility. Provider-based designation integrates the following facility components: licensure, ownership and control, administration and supervision, clinical services, financial operations, and public awareness. Like many CMS regulations that incentivize provider collaboration, the focus of the integrated activities is on the provider and its administrative functions rather than on patient care. Thus,

## RECOMMENDATIONS

The Secretary should work with the Inspector General to develop regulations so that rural practitioners can be compensated for driving time at a fair market value.

The Secretary should work with the Inspector General to assess the impact of the inurement rules on the ability of rural hospitals to hire practitioners in Health Professional Shortage Areas.

these programs help providers coordinate administrative functions and build economies of scale, which increases efficiency and enables better continuity of care.

Other regulations that influence integration are CMS' Conditions of Participation (CoPs) and Conditions for Coverage (CfCs), which certain specialized providers must meet in order to participate in Medicaid or Medicare programs.<sup>121</sup> While many CoPs are basic standards regarding health and safety, some CoPs can increase integration because they require providers to integrate with other facilities. One of the CAH CoPs requires the CAH to have an agreement with at least one other network hospital for patient transfers and referrals, sharing electronic patient data, credentialing, and quality assurance.<sup>122</sup> CoPs and CfCs are different for every provider type, and they have been written for approximately 20 specialized providers, including CAHs, RHCs, FQHCs, and a number of other providers that serve rural patients.

## The Role of Medicare Provider Payment in Integration

The current U.S. health care system is based on a fee-for-service model where payment is established on individual services rendered. This is how the majority of payers operate, including Medicare's prospective payment system,<sup>123</sup> and to some extent, insurance companies.<sup>124</sup> Because providers are paid individually per procedure, there is limited financial incentive for fee-for-service providers to coordinate a patient's care with other providers. The lack of integration and coordination contributes to higher health care costs, inefficiencies, and lower quality of care. This is cause for concern because 88 percent of annual Medicare spending is concentrated

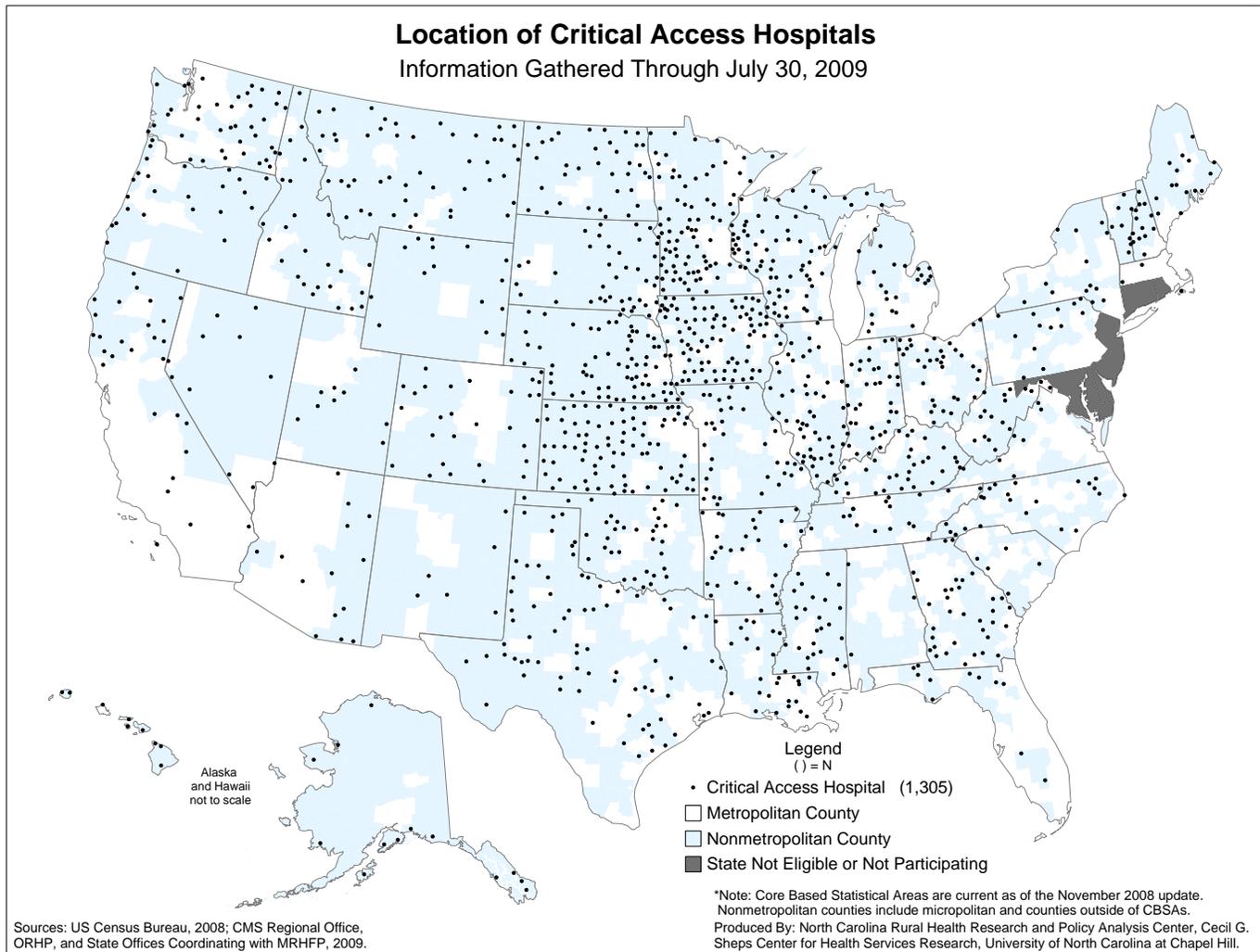
among only 25 percent of beneficiaries<sup>125</sup> and 75 percent of these high-cost beneficiaries have been diagnosed with one or more chronic conditions,<sup>126</sup> often requiring a higher level of care and coordination among providers. Thus, payment systems that incentivize provider collaboration, increase accountability among providers, and improve the quality of care could be especially beneficial to rural patients.

### Payment Models That Incentivize Integration

CMS is in the process of developing methodologies to encourage further collaboration among providers. One CMS payment method that encourages rural providers to collaborate is the Critical Access Hospital (CAH) Method II Billing or "Optional (Elective) Payment Method." (See map on page 29.) It allows CAHs to jointly bill for both facility and professional physician costs for outpatient services. Each practitioner providing services to CAH outpatients can elect to reassign his or her billing rights to the CAH. The professional services can then be billed at 115 percent of the allowable amount<sup>127</sup> while the CAH can receive cost-based reimbursement for the facility portion.<sup>128</sup> The increased reimbursement rate for physicians can help CAHs attract practitioners and also eases administrative burden on physicians by centralizing billing through the CAH, which encourages collaboration between providers and physicians.

Recognizing the importance of improving health care quality and efficiency, Congress has authorized CMS to conduct several demonstrations to encourage provider collaboration and accountability through payment incentives.

One payment method currently being considered by Congress is bundling payments for episodes of care. Bundled payments would allow Medicare to disburse one global payment for all services provided to a beneficiary during an episode of care, specifically for a given acute hospitalization and post-acute episode, across multiple providers. In its June 2008 Report to the Congress, the Medicare Payment Advisory Commission (MedPAC) recommended that Medicare bundle payments for services around a hospital admission because hospital visits were the largest factor in explaining spending differences among providers.<sup>129,130</sup> Currently, CMS is exploring the concept of bundled payments for episodes of care in the Medicare Acute Care Episode demonstration. In the early 1990s, Medicare tested the concept in the Medicare Participating Heart Bypass Center demonstrations and found that, on average, quality of care remained high and spending on post-discharge care decreased.<sup>131</sup> While the concept of payment bundling may hold potential for



improving coordination of care, it is not clear how it would operate outside of large integrated delivery systems. As a result, policymakers need to consider how these models will impact small rural providers, particularly independent hospitals.

Congress is also considering utilizing the Accountable Care Organization (ACO) as a method to increase provider integration. ACOs are an integrated set of providers responsible for the quality and cost of health care for a defined population of Medicare beneficiaries. The focus of an ACO is on developing integrated health systems that span the continuum of care in a community. For example, an ACO may include a hospital and its primary care physicians, along with specialists, affiliated clinics, and a number of other post-acute providers.<sup>132,133</sup> Similar to the bundled payment concept, ACOs hold potential for rural areas where the need for care coordination is high. If rural providers are able to become more integrated players in larger health system coordination, care for rural patients may improve.

While ACOs offer many potential benefits for rural patients and providers, ACOs should be designed with the

unique situations of rural providers in mind as the push for efficiency may limit access to care in rural communities.

The Committee believes integration should initially focus on physician and hospital care reimbursed under Medicare and Medicaid, but should expand to engage other providers and payers with the goal of integrating health care and human services along the care continuum.

CMS is conducting a number of demonstrations on similar payment incentives. CMS is testing concepts embodied in the ACO model in its Physician Group Practice Demonstration. This demonstration is designed to encourage providers to reduce spending through improved care coordination. If the participating practices are able to improve the quality and efficiency of care, they will be able to share in a portion of the resulting savings. The Committee believes this model of integration should be extended to other providers in rural communities that accrue to Medicare.

Gainsharing is another payment method that could encourage providers to collaborate. Gainsharing is the idea that practitioners who reduce spending, either by

appropriate use of services or reduced readmissions, should be able to take part in the resulting savings.<sup>134</sup> The latter is an area in which cost savings can be found: MedPAC reported in June, 2008 that “18 percent of Medicare hospital admissions result in readmissions within 30 days of post-discharge.” These readmissions accounted for \$15 billion in spending in 2005, \$12 billion of which was deemed “potentially preventable.”<sup>135</sup> The Committee recognizes the potential early savings that can be realized through gainsharing but is concerned that long-term savings may be more difficult to achieve.

Regardless, gainsharing is currently not permitted, as Stark and Anti-kickback laws currently prohibit providers, such as hospitals, from sharing savings with the practitioners due to potential conflict of interest. Congress has mandated that CMS conduct two demonstrations<sup>III</sup> that will allow participating practices to share a portion of any savings with their practitioners.<sup>136,137</sup> These demonstrations began in 2007 and will evaluate if gainsharing promotes increased quality and reduces spending.

### RECOMMENDATION

The Secretary should ensure that future demonstrations on quality improvement and care coordination, such as Accountable Care Organizations, payment bundling, and Medical Homes, incent the cooperation of the full range of rural providers.

### Organization Factors Impacting Integration

The integration of health care services in rural America can also be impacted by organizational factors ranging from a procedure-driven reimbursement system to individual provider choices that undermine coordination and collaboration. These factors can result in segmentation of health care services ranging from mental health, emergency services, and pharmacy to acute and post-acute care. The Committee believes the organizational focus of rural providers should be on care coordination with the intent of establishing seamless patient and information flow between providers along the continuum of care.

III Section 646 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) amends title XVIII (42 U.S.C. 1395 et seq.) of the Social Security Act, giving authority for the Physician-Hospital Collaboration Demonstration. Section 5007 of the Deficit Reduction Act of 2005 (DRA) gives authority for the Medicare Hospital Gainsharing demonstration.

The organizational culture among providers within a community can impact integration, specifically when providers do not see the importance of collaboration. One example of this is the non-willingness of “community-based physicians to take emergency department (ED) calls or follow their patients into the hospital...”<sup>138</sup> which, in turn, has created an increased demand for hospitalists.<sup>139</sup> A high level of communication and coordination must take place between a primary care provider and a hospitalist in order to achieve a seamless care transition for a patient.<sup>140</sup> If there is a breakdown in any part of this line of communication, then the transition can create a fragmentation of care. There are different reimbursement methodologies and regulations that may encourage certain specialties to break away from a community’s health care continuum. One such regulation is the “whole hospitals exception,” which permits physicians to establish their own specialty

### Mental Health Services and Integration

In both of its 2009 site visits in California and South Dakota, the Committee visited communities where the least integrated aspect of the health care system is mental health services.

The expansion of the Community Health Centers (CHCs) program, through the American Recovery and Reinvestment Act and through previous expansions since 2001, has added mental health services in many underserved rural areas. However, because approximately only 33 percent of CHCs are located in rural communities, there are many rural areas not served by CHCs. One way to better integrate mental health care with rural providers is to encourage Rural Health Clinics (RHCs), which are exclusively located in rural areas, to provide mental health services. While CHCs often provide these services, the 3,751 RHCs in the United States rarely do.

A recent project at the Maine Rural Health Research Center examined 2,526 cost reports and found that only 90 (about 3.5 percent) employed either a doctoral-level psychologist or a clinical social worker. Barriers to providing mental health services include: poor reimbursement rates; chronic shortages of mental health professionals; administrative burden caused by complex and inconsistent regulations, licensing and reimbursement policies; high copays and deductibles for those with insurance; and limited resources to help administrators deal with these barriers. As other health care providers seek greater levels of integration through regional networks, Medical Homes, and accountable health organizations, the Committee hopes to see more consistency in eliminating barriers and facilitating the inclusion of mental health services.

hospital that is designed to provide a few specialized services for selected patients. Such facilities may focus on cardiac care, orthopedics, and/or neurological services. Specialty hospitals have an impact on integration of health care services in rural areas in a number of ways. While it may not be feasible nor advisable to remove existing physician-owned hospitals, the Committee believes a moratorium should be placed on future development of these facilities for several reasons, including:

- Specialty hospitals may increase the overall cost of health care through increased numbers of self-referrals and procedures performed. This increased utilization and its associated costs has a significant impact on the Medicare program as a whole and, consequently, on rural beneficiaries and providers.
- Specialty hospitals may limit access to specialty care for rural populations. As more specialists choose to practice almost exclusively in specialty hospital settings, there is a concern that there will be fewer specialists available to receive referrals in rural communities. Additionally, opportunities at specialty hospitals may create disincentives for urban-based specialists to take part in circuit-riding arrangements where they conduct periodic specialty clinics in rural community hospitals.
- Relative to rural community hospitals, specialty hospitals treat smaller percentages of Medicaid patients. Specialty hospitals attract patients who are less sick, leaving rural community hospitals to care for a higher proportion of high acuity patients with insurance that reimburses at lower rates.
- Specialty hospitals are not required to provide emergency medical services through Emergency and Medical Treatment and Active Labor Act (EMTALA) requirements that other acute-care hospitals are required to follow. Currently 45 percent of specialty hospitals have 24-hour emergency departments while 92 percent of general hospitals do. This can result in higher acuity patients going to rural community hospitals that provide a wide range of services to all patients regardless of their ability to pay.

## RECOMMENDATION

The Secretary should place a moratorium on approval of any new specialty hospitals in order to determine the impact on access to care for Medicare beneficiaries.

Another area of the health care sector that could benefit from greater integration is pharmaceutical services, particularly in rural areas that struggle to attract and retain pharmacists. Independent pharmacists provide essential services to residents of small towns and continue to serve many of the nation's communities as the sole provider of pharmacy services. Research from the University of North Carolina and the University of Nebraska shows that communities with only one pharmacist face increasing challenges in ensuring access to the full range of pharmaceutical services needed. The researchers noted that 216 rural places<sup>IV</sup> lost every one of their pharmacies between May 2006 and December 2008, and 118 rural places dropped from more than one pharmacy to only one.<sup>141</sup>

Due to these closures some rural patients have limited access to prescription drugs because the nearest retail pharmacy may be a long distance away from a patient's home or the hospital from which the patient was discharged. In these instances, rural patients often rely on mail order for their prescriptions. However, mail order pharmacies do not provide the patient counseling and medication management that are needed for high quality care, nor do they provide critical support to the local health care system. Most sole community pharmacists (83 percent) provided important services for other health care providers and facilities in their local health care system including hospitals, nursing homes, and home health agencies.

Finally, trauma care and emergency medical services (EMS) in rural areas are an essential component of access to care and need to be better integrated into the rural health care delivery system. In order for EMS to be financially viable in remote areas, they usually need to be owned and operated out of a hospital or other central point of health care delivery. The Committee has heard from several rural CAH administrators that they lose financially when they try to formally integrate emergency medical services

<sup>IV</sup> Rural places are defined as Zip codes in rural (nonmetro politan and nonmicropolitan) counties or ZIP codes within metropolitan or metropolitan countries with Rural-Urban Commuting Area (RUCA) codes of 4.0 or higher.

### **Ensuring Access to Specialty Care**

Access to specialty care has long been a challenge for rural communities, and that is certainly true in the Black Hills region of South Dakota.

At Custer Regional Hospital (CRH) in Custer, South Dakota, the Committee members heard firsthand about the challenges local physicians face in ensuring access to needed specialty care such as neurology and orthopedics. Typically, the patients are referred to Rapid City Regional Hospital (RCRH), which can draw on a larger pool of clinical resources. But even RCRH can face challenges on nights and weekends. While rural areas have long struggled with attracting specialists even on a traveling circuit basis, smaller urban areas such as Rapid City also face challenges in attracting these clinicians. The medical staff from CRH also noted that some specialists practice only in specialty hospitals which may not take referral calls on nights and weekends. Telehealth technology may offer a lifeline and increase access to specialty services; RCRH is looking into expanding the use of this technology. Hospitals in eastern South Dakota in the Sioux Falls area have been able to use this technology to improve access to these services.

by operating a hospital-based ambulance service. The administrators say the hospitals lose money when billing for ambulance services under the Medicare ambulance fee schedule due to the combination of low volume and high fixed costs.

Currently, there is a provision within Medicare that allows some CAH-based ambulance services to receive cost-based reimbursement for ambulance services provided there is no other ambulance service within 35 miles. Some rural advocates have questioned why CMS adopted a 35-mile standard for this distance requirement because the statute does not specify what constitutes a sole-community ambulance service. CMS officials appeared to defer to the 35-mile standard by citing the use of that mileage standard for another reference to “sole community” status in Medicare law dealing with sole

### **RECOMMENDATION**

The Secretary should revise current regulations so the sole emergency medical service providers (EMS) owned and operated by Critical Access Hospitals must be only a minimum of 25 miles (15 miles in mountainous terrain) from the nearest EMS provider in order to qualify for cost-based reimbursement rather than the requirement of 35 miles.

community hospitals (SCHs). The Committee believes that this creates a contradiction. CAHs have their own statutorily based mileage standard of being 35 miles from another provider (15 in mountainous terrain). It is not clear why CMS chose to use the SCH standard rather than the CAH standard.

## **Federal Grant Programs**

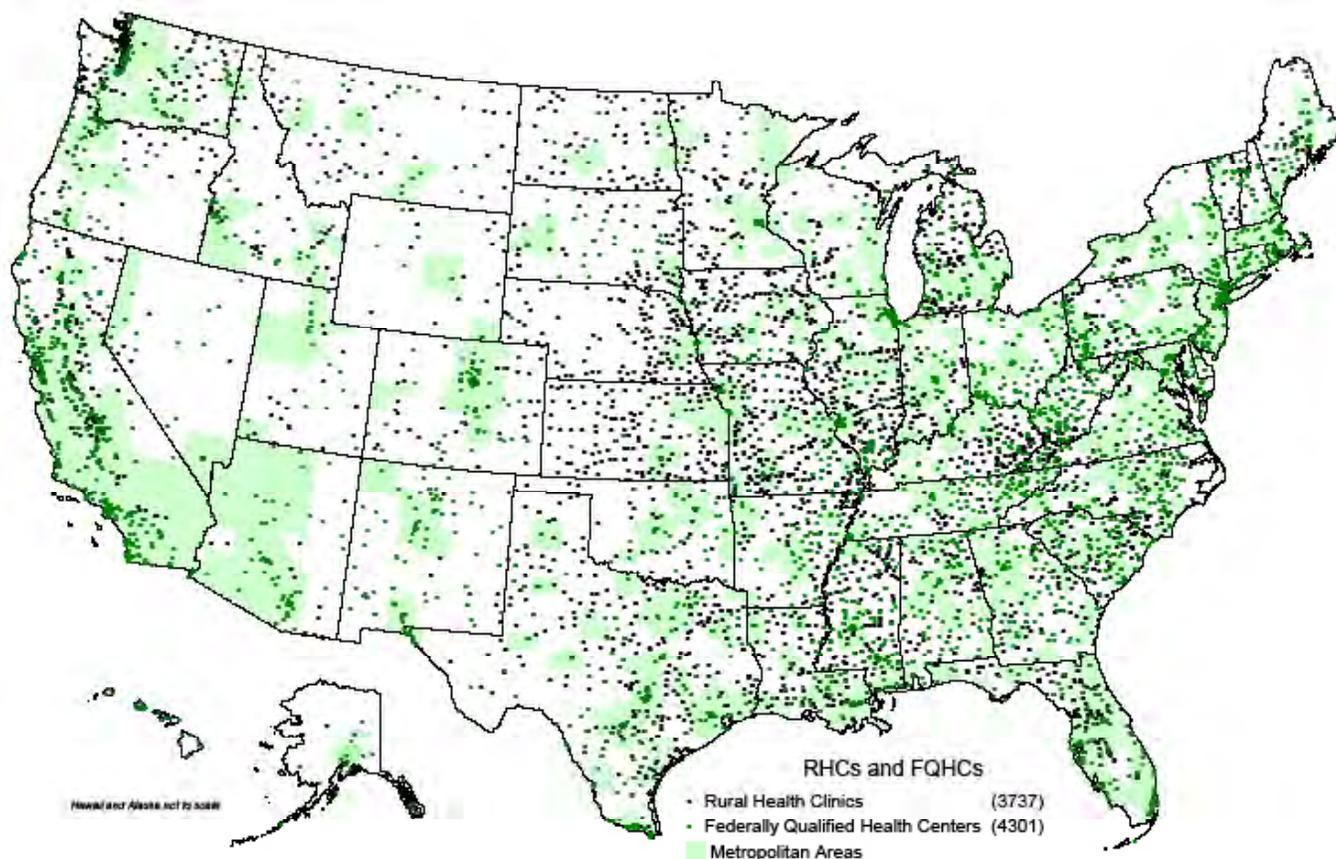
There are several types of grant programs that encourage provider integration in rural areas. A number of these grants require multiple providers to collaborate in order to receive funding, while others promote integration by requiring grant recipients to provide a broad range of services, such as primary care, dental, mental, and other health services. Grants can often support partnerships between government-funded health providers and private foundations. (Note: Please see Appendix A for further information about the grant programs mentioned in this section.)

### **Grants to Communities**

Grant opportunities to communities may facilitate integration by promoting the coordination of networks, helping consortiums initiate and thrive, and supporting the building of the infrastructure necessary for integration.

The Health Resources and Services Administration’s (HRSA) Office of Rural Health Policy (ORHP) is one entity that administers these types of grants. In acknowledgement of the need for providers to work together in an integrated fashion and the time that it takes to establish relationships, ORHP offers Rural Health Network Planning grants with the purpose of improving the coordination of health services and strengthening the existing health care systems’ rural communities. This integration of functions and services helps to overcome the fragmentation of health care services in rural areas, improves coordination of those services, and achieves economies of scale. ORHP’s Rural Health Care Services Outreach grants encourage the development of new and innovative health care delivery systems in rural communities that lack essential health care services. The emphasis of this grant program is on collaboration, requiring the grantee to form a consortium with at least two additional and separately owned partners. ORHP’s Medicare Rural Hospital Flexibility (Flex) program provides grants to help rural communities integrate their health care systems. This can include helping to establish EMS systems and developing system-wide

## Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs), 2009



Sources: OSCAR Provider of Services file, CMS, 2009; U.S. Census Bureau and Office of Management and Budget, 2009.  
 Prepared by the North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

quality improvement programs. Additionally, CAHs that participate in Flex must all have referral relationships with an upstream referral hospital. Given that CAHs have a limitation on the number of beds and length of stay, these facilities often triage patients and refer them to a larger facility or they may receive patients for post-acute care services in their swing beds.

The Community Health Center (CHC) program is funded and regulated by HRSA and is authorized under Section 330 of the Public Health Service Act.<sup>142</sup> CHCs play a critical role in providing care to underserved populations through integration of several outpatient health and human services under one roof including primary medical care, dental care, and mental health/substance abuse services.<sup>143</sup> However, CHC board and governance requirements<sup>V</sup> may create challenges for clinical integration beyond the immediate primary care services provided at the CHC. Thus, CHCs and other community providers must creatively design integrative strategies that promote care coordination, shared information, and seamless patient transitions. V To be eligible for a Section 330 Grant, a CHC must be governed by a board with a user majority of at least 51 percent.

From 2000 to 2005, HRSA administered the Community Access Program (CAP) and its successor, the Healthy Communities Access Program (HCAP) grants. The grantees for these programs, comprised of health providers, were charged with improving access to health services by developing or strengthening integrated community health care delivery systems that coordinate health care services for individuals who were uninsured or underinsured.<sup>144</sup> Some consortia developed coordinated systems with system-wide case management, coordinated referrals, or integrated management information systems.<sup>145</sup> A total of 193 grants have supported 158 communities (34 percent of which were awarded to rural communities)<sup>146</sup> in 42 States. Funding for HCAP grants ended at the close of Federal fiscal year 2005 because the program was assessed by the U.S. Office of Management and Budget to be duplicative of other efforts.<sup>147</sup> However, an independent study conducted by the National Opinion Research Center reported that HCAP grantees were able to develop “systems of care that coordinated health services among primary care providers, hospital systems and other secondary and tertiary care providers.”<sup>148</sup> The Committee continues to believe

in the potential for integration through this program and supports the reauthorization of HCAP funding.

### **Health Information Technology**

Health Information Technology has the potential to help disparate rural providers from across the spectrum of care to better coordinate the care of their patients. Tools such as electronic medical records (EMRs) can be especially useful for rural Americans who travel to numerous providers to seek care. Beyond quality of care, HIT has the ability to improve population health, monitor chronic disease, and improve access to health care in rural areas.

The American Recovery and Reinvestment Act (ARRA) provided approximately \$25 billion in health information technology (HIT) across the health care sector. There are incentive payments to Medicare and Medicaid providers to encourage them to adopt electronic health records (EHRs) between 2011 and 2015. There are also grants available to the States to encourage health information exchange, to train workers in HIT, and to support adoption of EHRs in community health centers.

In addition to the ARRA funding, HHS has a number of programs that have focused on HIT adoption over the past few years. In 2007 the Flex program, through a one-time appropriation of \$25 million, provided funding to create health information exchanges (HIE) through the Critical Access Hospital Health Information Technology Network Grant program. The State grantees were required to create a network that included at least one CAH, as well as any ambulatory and specialty providers with which it regularly worked. The State networks were required to implement HRSA-created Health Center Controlled Networks (HCCN) to improve the operational effectiveness and clinical quality at CHCs through the provision of management, financial, technological, and clinical support services. HCCN integration activities are wide-ranging and include coordinating the acquisition of high-cost, highly specialized personnel or large infrastructure systems, developing clinical guidelines, providing services such as accounting or human resources management, and maximizing purchasing power. One key component of the HCCN grant is the support of HIT implementation. This allows providers to enhance their technical or quality improvement infrastructure using HIT, in order to improve clinical, operational, and technical activities. The majority of HCCN grants focus on CAH networks that feature vertical integration rather than horizontal integration.

The Agency for Healthcare Research and Quality (AHRQ) has also assisted providers in implementing HIT. AHRQ's HIT initiative works to harness the power of HIT

### **Electronic Intensive Care Units**

Most small rural hospitals do not have the volume or staff to fully staff an intensive care unit (ICU), but that does not mean they cannot offer the full range of ICU services.

In California, the Committee was able to see the use of an Electronic Intensive Care Unit (eICU) at Sutter Health's eICU's Sacramento hub, which links rural hospitals in the region with an urban tertiary care center to provide remote intensive care services. This allows a patient with complex needs to be cared for in their home rural hospital by their local providers with the watchful eye of intensive care specialists hours away. Sutter officials say the eICU can result in shorter patient stays, lower morbidity, improved quality and access to specialists for rural residents. The Sutter eICU has also been able to gather regional-level data on a real-time basis, a benefit which allowed them to identify, evaluate, and analyze outbreaks of H1N1 and the effectiveness of treatments. This information was passed along and utilized by health officials in Sacramento.

### **Rural Networks of Care**

For many years, rural providers have learned that working together in formal and informal networks is a necessity to keep the doors open.

There are variety of factors driving this, including limited economies of scale, workforce challenges, and the need to share costs. For many operating in these fragile frameworks, these networks are necessary to provide a basic level of stability for their local health care delivery system. The collaboration needed to make a rural network viable is not necessarily easy, but there are a number of organizations that have become national models, such as the Rural Wisconsin Health Cooperative in Sauk City, Wisconsin or SISU in Duluth, Minnesota, which mostly serves the northern part of Minnesota.

Organizations like this have long been a virtual community under the auspices of the National Cooperative of Health Networks (NCHN), a national association of health networks and strategic partners whose mission is to assist health alliances through education, networking, and collaboration.

The success of networking as a rural survival strategy was not lost on Congress, which in 1996 created the Rural Network Development grant program to support efforts to build viable health care networks in rural communities.

to improve the health of all Americans through improved quality of care and increased efficiencies. The HIT initiative includes more than \$260 million in grants and contracts in 41 States to support and stimulate investment in HIT, especially in rural and underserved areas. It also includes additional resources for rural communities including the ARHQ National Resource Center for HIT at <http://healthit.ahrq.gov>.

In addition, the National Library of Medicine at the National Institutes of Health (NIH) funds informatics and HIT through the Applied Informatics Grant. This grant is mainly for large academic research centers to use information technology to optimize the utility of clinical and research information. While these grants have been helpful to those communities, the Committee believes that the low rates of HIT adoption in rural areas warrant increased outreach to and special consideration for rural areas.

## RECOMMENDATIONS

The Secretary should work with Congress to reauthorize and support funding for the Healthy Communities Access Program with revisions to support projects that focus on development and implementation of Medical Home components, e.g., incorporation of HIT and EHRs, chronic care management, and medication management.

The Secretary should work with Congress to authorize and support the development of a Critical Access Hospital Health Information Technology Grant Program under the Medicare Flexibility program.

The Secretary should encourage the use of existing authorities and funding from the National Library of Medicine at the National Institutes of Health to make competitive grants and contracts to support the adoption of HIT by rural health care providers, given their current low level of HIT adoption.

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# Acronyms

|       |  |        |  |
|-------|--|--------|--|
| AAMC  | American Association of Medical Colleges               | CoP    | Conditions of Participation                          |
| COGME | Council on Graduate Medical Education                  | CfC    | Conditions for Coverage                              |
| ACGME | Accreditation Council for Graduate Medical Education   | CFS    | Critical Shortage Facility                           |
| ACO   | Accountable Care Organization                          | CRH    | Custer Regional Hospital                             |
| ADL   | Activities of Daily Living                             | DGME   | Direct GME   |
| ADRC  | Aging and Disability Resource Center                   | eICU   | Electronic Intensive Care Unit                       |
| AHEC  | Area Health Education Center                           | ED     | Emergency Department                                 |
| AoA   | Administration on Aging, HHS                           | EHR    | Electronic Health Record                             |
| ARRA  | American Recovery and Reinvestment Act                 | EMR    | Emergency Medical Records                            |
| APN   | Advanced Practice Nurses                               | EMS    | Emergency Medical Services                           |
| ARC   | Appalachian Regional Commission                        | EMTALA | Emergency and Medical Treatment and Active Labor Act |
| BCRS  | Bureau of Clinician Recruitment and Service, HRSA, HHS | Flex   | Medicare Rural Hospital Flexibility                  |
| BIA   | Bureau of Indian Affairs, U.S. Department of Interior  | FQHC   | Federally Qualified Health Center                    |
| CDC   | Centers for Disease Control and Prevention, HHS        | FTE    | Full-Time Equivalents                                |
| DRC   | Delta Regional Commission                              | FY     | Fiscal Year  |
| BHPr  | Bureau of Health Professions, HRSA, HHS                | GAO    | General Accountability Office                        |
| CAH   | Critical Access Hospital                               | GIP    | General Inpatient Services                           |
| CAP   | Community Access Program                               | GME    | Graduate Medical Education                           |
| CHC   | Community Health Center                                | HCAP   | Healthy Communities Access Program                   |
| CMS   | Centers for Medicare and Medicaid Services, HHS        | HCBS   | Home and Community-based Services                    |
|       |  | HIE    | Health Information Exchanges                         |
|       |  | HIT    | Health Information Technology                        |
|       |  | HHS    | U.S. Department of Health and Human Services         |
|       |  | HMO    | Health Maintenance Organization                      |

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|         |  |        |  |
|---------|--|--------|--|
| HPSA    | Health Professional Shortage Area                                      | ORHP   | Office of Rural Health Policy, HRSA, HHS                                 |
| HRSA    | Health Resources and Services Administration, HHS                      | PA     | Physician Assistant  |
| HUD     | U.S. Department of Housing and Urban Development                       | PACE   | Program of All-Inclusive Care for the Elderly                            |
| ICU     | Intensive Care Unit  | PCMH   | Patient-Centered Medical Home  |
| IME     | Indirect GME   | PFS    | Physician Fee Schedule   |
| IMG     | International Medical Graduate   | PHS    | Public Health Service  |
| MA      | Medicare Advantage   | PRIME  | Programs in Medical Education, University of California                  |
| MDS     | Minimum Data Set   | RCRH   | Rapid City Regional Hospital   |
| MedPAC  | Medicare Payment Advisory Commission                                   | REACH  | Racial and Ethnic Approaches to Community Health                         |
| MFP     | Money Follows the Person   | RHC    | Rural Health Clinics   |
| MMA     | Medicare Prescription Drug, Improvement, and Modernization Act of 2003 | RTT    | Rural Training Track   |
| MPPS    | Missouri Physician Placement Service                                   | RVU    | Relative Value Units   |
| MU      | University of Missouri's School of Medicine                            | SENIOR | State-Based Examples of Network Innovation, Opportunity, and Replication |
| NACRHHS | National Advisory Committee on Rural Health and Human Services         | SGR    | Sustainable Growth Rate  |
| NCHN    | National Cooperative of Health Networks                                | SNP    | Special Needs Plans  |
| NF      | Nursing Facility   | USDA   | U.S. Department of Agriculture   |
| NFCSP   | National Family Caregiver Support Program                              | VA     | U.S. Department of Veterans Affairs                                      |
| NHSC    | National Health Service Corps  | VHA    | Veterans Health Administration   |
| NSP     | Nursing Scholarship Program  | WWAMI  | Washington, Wyoming, Alaska, Montana, and Idaho                          |
| OAA     | Older Americans Act  |        |  |
| OASIS   | Outcome and Assessment Information Set                                 |        |  |

# Appendix: Key Federal Programs for Integration

## ORHP GRANTS TO COMMUNITIES

| Program  | Budget (FY '09) | Description   |
|--|-----------------|---|
| <b>Rural Health Network Development Planning</b><br>HRSA | \$1.6 million   | One year of funding to rural organizations that seek to develop a formal integrated network with the purpose of improving the coordination of health services in rural communities.   |
| <b>Rural Health Network Development</b><br>HRSA          | \$8.7 million   | Funding to support rural providers for up to three years that work together in formal networks and alliances to integrate administrative, clinical, financial, and technological functions.   |
| <b>Rural Health Care Services Outreach</b><br>HRSA       | \$19.1 million* | Funding to encourage the development of new and innovative health care delivery systems in rural communities that lack essential health care services. Requires the grantee to form a consortium with at least two additional and separately owned partners. Authorized by Section 330A of the Public Health Service (PHS) Act. |

\*This was distributed across many grant programs and services, including the Network Development Planning and Network Development grants.

## ORHP GRANTS TO STATES

| Program   | Budget (FY '09)                   | Description   |
|---|-----------------------------------|---|
| <b>Medicare Rural Hospital Flexibility (Flex)</b><br>HRSA               | \$22.3 million                    | Funding to support integration in rural communities. CAHs must all have upstream referral relationships. Additionally, Flex has a strong focus on integration of EMS with CAHs because CAHs often triage patients and refer them upstream or provide post-acute care in their swing beds. |
| <b>Critical Access Hospital - Health Information Technology</b><br>HRSA | \$ 25 million<br>(one time, 2007) | Funding to 16 State pilot networks to create health information exchanges (HIEs). Each network had to include at least one CAH and any ambulatory and specialty providers with which it regularly worked.   |

# Appendix: Key Federal Programs for Integration

## HRSA GRANTS FOR COLLABORATION

| Program   | Budget (FY '09)    | Description  |
|---|--------------------|--|
| <b>Community Access Program (CAP) and Healthy Communities Access Program (HCAP)</b><br>HRSA | \$0<br>(2000-2005) | 193 grants have supported 158 communities (34 of which were rural) in 42 States by facilitating provider integration and access to primary care for individuals who were uninsured or underinsured. Grants were awarded to providers with a low-income utilization rate of 25 percent or more and providers that traditionally serve the medically underserved. (Operated from 2000-2005.) |
| <b>Health Center Controlled Networks</b><br>HRSA  | \$36.8 million     | Funding to improve operational effectiveness and clinical quality in CHCs through the provision of management, financial, technological and clinical support services. Many used the grants for HIT implementation.  |