NATIONAL RURAL HEALTH POLICY:

RECOMMENDATIONS FROM THE FIRST EIGHT YEARS OF THE NATIONAL ADVISORY COMMITTEE ON RURAL HEALTH

January 1997

Prepared for
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U.S. Department of Health and Human Services

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CHAPTER 1: INTRODUCTION

1.1 Background

The National Advisory Committee on Rural Health (NACRH) was chartered in October 1987 by Otis R. Bowen, M.D., then Secretary of the Department of Health and Human Services (DHHS). The Committee was created to work with the Department in seeking solutions to health care problems in rural communities. Since its first meeting in September 1988, the Committee has been carrying out this mandate. The Committee's work is summarized annually in its report to the Secretary. Reports contain recommendations, relevant background material, and a rationale for each recommendation.

Since its inception, the Committee has been comprised of eighteen experts who serve staggered, two-year terms. Members have represented the various dimensions of rural health, including provision and financing of services, research and development, workforce training, and health services administration. The Committee once divided its work among three work groups, defined to reflect the Committee's concentrated efforts--financing, personnel, and service delivery. It now operates with two work groups--financing and education/service delivery. In general, each group's approach has been to identify key issues for deliberation, develop means of obtaining information pertinent to each issue, and formulate conclusions and recommendations. The Committee has received significant staff support from the Office of Rural Health Policy (ORHP), which was established in December 1987 within the Health Resources and Services Administration (HRSA).

1.2 Purpose and Plan of Report

The purpose of this report is to document accomplishments of the Committee, and in so doing, provide a portion of the history of rural health policy research and analysis. Committee recommendations that have been influential in rural and national health policy making are reviewed. In historical summaries such as this, lessons from the past are often used to help identify and articulate future directions; in this way, this report should also provide a context for identification of policy-relevant work to be undertaken by the Committee during the next several years.

This report is organized by subject area. In Chapters 2 through 4, Committee recommendations that have either affected policy directly or have been influential in policy deliberations will be discussed. Subject areas are workforce policy (Chapter 2), Medicare payment policy (Chapter 3), and special needs of rural populations (Chapter 4). In the final chapter, past recommendations that have yet to have a direct policy effect--but that continue to be of potential policy importance--will be discussed, along with additional topic areas for which the Committee may wish to formulate recommendations.

CHAPTER 2: WORKFORCE ISSUES

Since the beginning of its existence, the National Advisory Committee has been concerned about the inadequate supply of health professionals in rural areas, and has crafted numerous recommendations in the area of rural workforce development. In making these recommendations, the Committee has recognized the diverse factors affecting the availability of health professionals in rural areas, and has adopted a "multi-pronged" approach to resolve problems in this area. Thus, over the years, the Committee has made recommendations designed to:

- increase the *awareness of health career opportunities* in rural areas and ensure that students are academically prepared to pursue these opportunities;

- ensure the availability of *financial support for students in health professions training programs* and target this support to students most likely to provide primary care services in rural and other underserved areas;

- *target health education financing* to programs that are the most likely to be successful in meeting the health workforce needs of rural areas;

- provide an *educational experience* that prepares the students for the unique situations that will be encountered in rural practice; and

- provide *financial incentives* to support rural practice through third-party reimbursement policies and other means.

Within this framework, the Committee has focused on the need to increase the supply of personnel who can provide primary care, and has recognized the important role that can be played by nurse practitioners, physician assistants, and nurse-midwives in providing primary care services to rural populations. Additionally, the Committee has generally emphasized the availability of these services to underserved populations, such as minorities and people residing in Health Professions Shortage Areas (HPSAs)[1] and Medically Underserved Areas (MUAs).

2.1 Awareness of Health Career Opportunities

The Committee's recommendations in this area have dealt with efforts to promote health career awareness and academic enrichment among rural students, with an emphasis on rural minority students. In **Recommendation 90-7**, the panel focused on improvements to existing DHHS programs--such as the Health Career Opportunities Program (HCOP) and the Area Health Education Center (AHEC) and Health Education and Training Center (HETC) programs--and

[1] We will use the term HPSA throughout this report, even though some of the Committee's earlier recommendations dealt with what was then called Health Manpower Shortage Areas (HMSAs).

recommended that the interventions targeted to minority and disadvantaged students begin well prior to the student's final high school years. In **Recommendation 92-17**, the Committee targeted the Youth-at-Risk Initiative of the USDA Extension Service's 4-H Development Program, and recommended that this program be expanded to include a new focus on ethnic and cultural minorities.

The Secretary responded by developing a demonstration project in 1991 to provide minority students in seventh and eighth grades from rural areas in Alabama and Oklahoma with summer internships in community-based health service programs. The demonstration was expanded to additional states in 1992, and in 1993 the Secretary sought $3 million to fund a "Junior" National Health Service Corps (NHSC) program for adolescents in underserved areas. The Junior NHSC/Junior Health Career Opportunities Program that resulted was funded as a three-year demonstration project, with an annual budget of approximately $1.25 million and ten demonstration sites. The program focuses on students in the sixth through twelfth grades, and provides them with enhanced math and science training as well as first-hand experience in health careers through internships in health centers. Since the demonstration is currently in its final year, grant recipients are being asked to develop a "how-to" manual describing the program so that local communities can seek private funding to replicate the program after Federal funding has ended.

Additionally, in 1992, ORHP sponsored the production by Tuskegee University of a videotape entitled "Be a YADAH Kid" (Young Aspiring Doctors and Health Care Kids). This tape is designed to promote interest in health careers among African-American middle school students from rural areas. Copies of the tape were distributed to all rural junior and senior high schools in Alabama. A brochure was also developed that was distributed through ORHP. In response to the Committee's Recommendation 92-17, the YADAH tape was also made available to the USDA's Youth-at-Risk Initiative program so that the program could more easily focus on reaching minority students.

The Department also supports several other programs to ensure that rural minority students have the strong backgrounds in science and mathematics necessary to complete health professions educational programs (e.g., the Minority High School Student Research Apprentice Program and the Minority Access to Research Careers program). In 1995, ORHP produced a monograph describing many of the more innovative and comprehensive programs being conducted by the states to recruit rural students to health care careers and to strengthen their academic preparation for such careers (ORHP, 1995a). Many of these programs are being conducted as part of either the Health Career Opportunities Program or state Area Health Education Centers.

2.2 Financial Support for Students in Health Professions Training Programs

The Committee made two recommendations in 1989 designed to support the National Health Service Corps (NHSC) as a way of increasing the availability of primary care providers in rural HPSAs. The first of these recommendations (**Recommendation 89-14**) responded to concerns over the dramatic reductions that had occurred during the 1980s in the scholarship component of the NHSC. This recommendation called for the Secretary to seek increased

appropriations for FY 1990 and beyond to support the scholarship program, and to make additional programmatic changes to the selection process and post-placement support activities so as to revitalize the program. For example, the Committee recommended giving scholarship priority to primary care providers, minority/disadvantaged applicants, and applicants from rural areas; and providing additional funds to support program participants once they are placed in an underserved area. The Committee noted the importance of mid-level personnel (MLP), i.e., nurse practitioners, physician assistants, and nurse-midwives, as sources of primary care, and advocated inclusion of these types of personnel in the program. The second NHSC recommendation (**Recommendation 89-15**) dealt with deficiencies in the existing NHSC loan repayment program, and recommended that the Secretary assist states in developing more effective loan repayment programs in addition to strengthening the Federal program. Specifically, the Committee sought increased funding for both the state and Federal programs and changes to make the Federal loan repayment program more attractive (e.g., eliminating the Federal tax liability of the loan repayment, increasing the maximum annual repayment amounts, and making undergraduate loans eligible for repayment).

The Secretary responded positively to these two recommendations by requesting a nearly eight-fold increase in the FY 1991 level of appropriations for the NHSC scholarship and loan repayment programs combined ($8.8 million to $64 million). Both the scholarship and the state and Federal loan repayment components of the NHSC have continued since that time, with a total average annual funding level of approximately $70 million. The Committee's recommendation to include mid-level personnel as important sources of primary care for rural areas was heard, as well. Each year, 10 percent of the total budget for the loan and scholarships programs is now set aside to support scholarships for nurse practitioners, nurse-midwives, and physician assistants. With the exception of 1995, when a budget recision severely restricted the number of scholarships that could be supported, the proportion of NHSC scholarships awarded to MLP has grown steadily from a low of 30 percent in 1991 (the first year these types of personnel were awarded NHSC scholarships) to a high of 47 percent in 1996. Furthermore, funding priority is given to students training for primary care careers and to students from rural areas, and preference for scholarships is given to minority/disadvantaged students who qualify for the program.

2.3 Targeted Funding for Health Profession Education Programs

The Committee has on several occasions advanced recommendations designed to target the funding for DHHS health professions education programs to those programs most likely to meet the needs of rural areas. For instance, in both 1989 and 1991, the Committee recommended that funding for Bureau of Health Professions (BHPr) educational programs be maintained (**Recommendation 89-16**) or increased (**Recommendation 91-24**), and that the funds be targeted to programs that prepare individuals for primary care, rural practice, or practice with other underserved populations. **Recommendation 91-27** was even more specific and listed a number of funding "factors" (preferences and priorities) that should be taken into account explicitly when distributing Title VII and VIII educational funds. These factors included funding preferences for programs that provide clinical experience in rural or other underserved areas and for medical schools with a department of family medicine. Funding priorities were identified for programs linking teaching faculty with rural clinicians; programs including curricula to address

the health care needs of underserved populations and rural residents; and programs with selective admissions policies favoring applicants from rural or underserved areas, and/or minority/disadvantaged applicants.

At around this time, distribution of funds for many of the Title VII and VIII grant programs began to incorporate a number of the funding factors that had been recommended by the Committee. Specifically, the grant programs now give preference to educational programs that will increase access to primary care in rural and minority communities, and give priority to programs that encourage minority enrollment, provide education-service links, incorporate AIDS/HIV and geriatrics curricula, and/or train non-physician providers.

2.4 Educational Experience

In several of its recommendations, the Committee has recognized that the training process used to produce health care practitioners for rural areas must accommodate the special situations found in these areas. In particular, the Committee has spoken to the need for interdisciplinary training programs that maximize the use of scarce resources and promote cooperation between the various health professions, and for programs that provide clinical experiences related to providing primary care services in ambulatory care settings.

Interdisciplinary Training Programs. In **Recommendation 89-18**, the Committee called for the Secretary to seek an appropriation of $5 million to fund the Health Care for Rural Areas program that had been authorized (but not funded) in prior legislation. The program was to provide grants to support the development of innovative interdisciplinary training programs suited to rural practice needs. The Secretary responded by implementing the program in FY 1990 with approximately $2.1 million in funding. In its 1991 recommendations (**Recommendation 91-25**), the Committee again focused on interdisciplinary training opportunities and asked the Secretary to support legislation to make the Rural Interdisciplinary Training Grant program (i.e., the Health Care for Rural Areas program) part of Title VII of the Public Health Service Act and to seek an increased appropriation for this program. Since that time, the program has been authorized under Title VII and supported with annual funding of approximately $4 to $5 million. To date, the program has made 50 grants in 21 states.

Use of Rural Community/Migrant Health Centers as Training Sites. Realizing that the failure to coordinate the service programs of the Bureau of Primary Health Care (BPHC) and the educational programs of BHPr represented a lost opportunity for providing rural-based clinical experiences for health professionals in training, the Committee recommended in 1990 the establishment of a task force to improve coordination of these Federal programs (**Recommendation 90-6**). Specifically, the Committee called for the task force to develop strategies to encourage the use of rural community and migrant health centers (C/MHCs) as clinical training and career awareness development sites and to develop a demonstration project using C/MHCs for these purposes. The Committee also recommended that the productivity formula used as the basis for establishing reasonable practitioner workloads for C/MHC clinicians be revised to account for educational activities, mitigating the negative effect on productivity that engaging in clinical training often entails. At a minimum, the Committee wanted the formula to hold C/MHCs harmless for these activities; ideally, the Committee wanted

the productivity formula to provide incentives for C/MHCs to provide clinical training (see last part of **Recommendation 90-7**).

In the year following these recommendations, BHPr and BPHC began discussing alternatives for coordinating their programs, and early in 1992 the Bureau directors signed a memorandum of agreement to initiate a number of coordination efforts. Several of the BHPr training programs currently give funding preferences to academic programs that collaborate with rural health providers, including C/MHCs. These programs include the Grants for Predoctoral Training in Family Medicine, Grants for Training in Family Medicine and Residency Training in General Internal Medicine/Pediatrics, Grants for Physician Assistant Training, Grants for Nurse Practitioner and Nurse Midwifery, and Allied Health Project Grants, as well as the Rural Interdisciplinary Training Grants discussed earlier (NRHA, 1994). Additionally, the AHEC and HETC programs support the formation of affiliations between academic health centers and community-based clinical programs in rural and underserved areas. Today, many C/MHCs are formally linked with health professional training programs and academic health centers, and are being used as sites through which students can gain ambulatory clinical experience. Finally, the C/MHC productivity formula has been eliminated, and C/MHCs effectively set their own production goals in light of their specific situation (e.g., the amount of teaching they are performing).

Rural Medical Education Demonstration Projects. Similar concern about the lack of appropriate clinical training opportunities in rural areas led the Committee to recommend expansion of the Rural Medical Education Demonstration Projects program in 1989 (**Recommendation 89-19**). This program, which was authorized under the Omnibus Budget Reconciliation Act of 1987, was originally designed to help foster opportunities for physicians in primary care residency programs to gain clinical experience in rural hospitals. Early program participation was extremely limited, however. In its 1989 recommendation, the Committee affirmed its interest in the program and called for 12 new demonstration sites. In an attempt to increase program participation, the Committee recommended adoption of less restrictive geographic criteria for participating facilities and suggested that half of the new demonstration sites should use a rural ambulatory practice setting rather than a hospital setting.

The OBRA 1989 legislation responded to the Committee's recommendation by providing for ten demonstration sites and removing the geographic limitations included in the OBRA 1987 authorization. The authorization was not, however, extended to include rural ambulatory practice settings, and program participation continued to lag. In 1991, the Committee again asked the Secretary to expand the program to include ambulatory settings, and to amend Title VII of the Public Health Service Act to include the Rural Medical Education Demonstration program (**Recommendation 91-26**). Although the Secretary agreed that expansion to ambulatory settings would be appropriate, he called for an evaluation of the program before supporting Title VII expansion legislation. Results of that evaluation, which was conducted by one of ORHP's Rural Health Research Centers, showed that the program held potential for providing many of the nation's primary care residents with a rural rotation but that it was flawed in its design since it failed to provide financial support to rural hospitals providing the training slots. Rather, because of inflexibility in the medical education payment system, payment continued to flow to the sponsoring urban hospital at which the resident was officially based

(Ricketts and Woods, 1994). The Rural Medical Education Demonstration program eventually ended when its legislative authority expired.

Information about Model Training Programs. In yet another effort to enhance the opportunities for health care professionals to obtain training that would prepare them for rural practice, the Committee recommended the development of a compendium of model rural training programs so that information about innovative training programs could be disseminated beyond the immediate geographic area and/or profession they serve (**Recommendation 89-30**). In response, BHPr contracted with the National Rural Health Association (NRHA) in 1991 to produce a study of alternative educational and service models to meet rural health care needs (NRHA, 1991). That report dealt with the full range of health professionals. A second report produced by the NRHA in 1993 under the same contract examined rural interdisciplinary education initiatives (NRHA, 1993). Additionally in 1991, the Association of American Medical Colleges also produced a state-by-state guide of academic programs training physicians for rural practice (AAMC, 1991).

2.5 Financial Incentives

The Committee's recommendations in this area have focused on enhancing Medicare reimbursement for rural providers and on providing tax incentives to providers serving rural populations. (Recommendations dealing with changes to Medicare reimbursement policies will be discussed in greater detail in the following chapter.) The Committee's first recommendation regarding financial incentives was **Recommendation 89-13**, which had two important components. The first was to raise the Medicare bonus payment to rural physicians from 5 percent to at least 10 percent, and to extend this incentive payment to primary care physicians practicing in all categories of HPSAs, not just the Class 1 and Class 2 HPSAs as authorized in OBRA 1987. The second component was to provide income tax credits to primary care providers working in HPSAs. Primary care providers were defined as MDs and DOs, physician assistants, nurse practitioners, certified nurse-midwives, and clinical nurse specialists who provide services mainly in the areas of general/family practice, general internal medicine, general pediatrics, or obstetrics/gynecology.

Medicare Bonus Payments. As will be discussed further in Chapter 3, the Medicare bonus payment to rural physicians was increased to 10 percent in January 1991 as part of the sweeping Medicare physician payment reforms contained in OBRA 1989, and this bonus was made payable to physicians providing primary care services in all types of HPSAs--all as recommended by the Committee.

Tax Credits. As for the incentive tax credits, the Secretary deferred consideration of this idea to the Department of the Treasury, and this portion of the recommendation was never implemented. It is interesting to note, however, that this idea resurfaced in November 1993 as part of the Administration's Health Security Act, which called for tax incentives for primary care practitioners who establish practices in HPSAs. The Committee responded in 1994 with its own **Recommendation 94-4** designed to fine-tune the proposed reform legislation by making the tax incentives available to practitioners in rural MUAs as well as rural HPSAs and by extending the incentives to providers who were already located in these rural areas (not just those establishing

new practices). The Secretary agreed with the Committee that it might be appropriate to consider MUA designation when targeting the tax incentives, and called for further assessments as health care reform was implemented. She disagreed, however, with the recommendation to extend tax credits to established rural providers, citing the numerous other provisions of the comprehensive Health Security Act that would enhance the practice environment for these providers (e.g., universal insurance coverage, 20 percent Medicare bonus payments to rural primary care providers, grants to support the development of provider networks, and stronger links between academic health centers and rural providers). One could speculate that the Secretary's response to the tax incentive recommendation was in part due to the politically-charged environment in which the Health Security Act was debated, and the public backlash at that time against providing tax credits to members of a profession that is, on average, very well compensated. Of course, with the demise of the Health Security Act, the provisions cited by the Secretary as being beneficial to rural providers also died. Thus, there may be a renewed need to consider tax incentives as a way to ensure an adequate supply of providers in rural areas (see Chapter 5).

CHAPTER 3: MEDICARE PAYMENT POLICY

The Medicare program is a significant source of revenue for health care providers in rural areas. Relatively more of the nation's elderly reside in rural areas. Furthermore, there is less breadth and depth of private insurance coverage among the nonelderly in rural areas, which impacts on provider revenues. Thus, Medicare payment policy reforms are very important to rural providers and to program beneficiaries, for whom access to care may be threatened by provider responses to payment policies.

The Committee has been concerned with a variety of Medicare payment issues since its inception. The Committee has issued recommendations that anticipated and supported significant reforms of the Medicare program, including the Medicare Fee Schedule, which has affected payment levels for physicians in rural areas. In addition, the Committee has addressed reforms that have affected the definition of eligible providers under the Medicare program. In this chapter, the Committee's work on Medicare payment reform is summarized under three headings: hospital payment policy, physician payment policy, and payment policies for other providers.

3.1 Hospital Payment Policy

Since 1983, short-term community hospitals have received Medicare payments determined on a prospective basis under the Prospective Payment System (PPS). Under PPS, hospitals are generally paid a fixed amount per inpatient stay. The amount is determined by formula, which takes into account the patient's diagnosis, various characteristics of the hospital, and the costs of inputs used by the hospital, such as labor and capital (e.g., the costs of plant, equipment, and funds for expansion).

By the mid-1980s, there were growing concerns over the financial viability of rural hospitals--especially smaller ones--and hospitals that play special roles in rural areas, e.g., Sole Community Hospitals. The financial viability of rural hospitals is especially dependent upon the

design of the PPS because a significant portion of rural hospital revenue is from the Medicare program.

Throughout the Committee's history, considerable discussion has addressed how Medicare payment policy has and will continue to affect rural hospitals. Several recommendations focused on aspects of Medicare hospital payment policy that were believed to threaten rural hospitals and, ultimately, access to care by program beneficiaries.

Single Standardized Payment Amount. The "standardized payment amount" is a key determinant of the Diagnostic-Related Groups (DRG) payment received by the hospital under PPS. When the PPS was first implemented, separate standardized payment amounts were used for urban and rural hospitals. Although the Committee strongly believed that DRG payment differentials between geographic areas should reflect "documented differences in market forces outside the control of individual hospital managers as well as documented differences in patient severity of illness and quality of care..." (NACRH, 1989, pp.6-7), the Committee was not convinced that the rural-urban differential resulting from differences in the standardized payment amounts was appropriate. The Committee recommended that the differential be eliminated through the application of a single standardized payment amount (**Recommendation 89-1**) and, that before urban-rural payment differences systematically become part of the payment system, "additional effort first should be directed toward improved measures of variation in cost of production among hospitals" (NACRH, 1989, p.6). The Omnibus Budget Reconciliation Act of 1990 called for the phase-out of the urban-rural differential by fiscal year 1995.

Hospital Wage Index. One of the most important determinants of hospital costs and geographic variation in DRG payments is the cost of labor employed by hospitals. The wage adjustment to the hospital payment is the single most important adjustment to DRG payments (ProPAC, 1990). For some time, the Committee has been concerned that the wage adjustment methodology is inequitable for rural hospitals. First, the adjustment methodology increases DRG payments to hospitals that incur higher-than-average labor expenses by using a more expensive mix of personnel. Second, the adjustment methodology has used data from prior years, in part because of the time lags between when the hospital incurs labor costs, when wage data are collected, and when the data are used to make payment adjustments. The Committee has argued that data that are out-of-date do not adequately reflect cost pressures confronted by rural hospitals.

In 1989, the Committee was concerned that the wage adjustment methodology unfairly penalized rural hospitals that tend to use less expensive mixes of employees but confront the same wage patterns as hospitals in more urban areas. The Committee recommended that the Secretary develop and test alternative methods to deal with the occupational mix problem **(Recommendations 89-03, 94-13)** and that the wage adjustment methodology be based on more timely adjustments to the wage index **(Recommendation 89-04)**. In fact, similar recommendations were made by the Prospective Payment Assessment Commission (ProPAC) in 1990, 1991, and 1993 (ProPAC, 1990, 1991, 1993). Although the wage index methodology has not been changed to account for the occupational mix problem, studies undertaken by ProPAC have confirmed that rural hospitals are penalized by the current methodology (ProPAC, 1993). (As indicated in Chapter 5, the wage index issue will likely continue to be of concern in the

future.) The Health Care Financing Administration (HCFA) is, however, now updating the wage index annually, in accordance with the Committee's recommendation for more timely adjustments.

Capital Costs. One of the Committee's interests in the financial viability of rural hospitals was the concern that rural hospitals may not have ready access to capital markets for new and needed repairs to plant and equipment. In response to the Secretary's 1990 proposal to extend the principles of PPS to hospital *capital* costs, the Committee responded with interim recommendations that were delivered to the Secretary in January 1991. These recommendations requested: that hospitals receive capital payments for no less than 80 percent of their recent capital costs under Medicare (a "payment floor," **Recommendation 91-7**); that the definition of reimbursable capital costs that were already incurred include leasing costs (**Recommendation 91-8**); and that Essential Access Community Hospitals (EACHs) and Rural Primary Care Hospitals (RPCHs) receive special protection under the prospective treatment of capital costs (**Recommendation 91-9**). In general, the Committee's recommendations were addressed by the Secretary in the Final Rule for the Medicare capital prospective payment system, issued in November 1991. Payment floors were established for all hospitals, with special considerations given to Sole Community Hospitals; leasing and rental costs were recognized as legitimate capital expenses; and the Final Rule treats EACHs like Sole Community Hospitals, and exempts RPCHs from the capital prospective payment system.

3.2 Physician Payment Policy

Beginning in 1989, the Committee exhibited considerable interest in the development and evolution of the Resource-Based Relative Value Scale (RBRVS) as a basis of payment for physicians under Part B of the Medicare program. This interest was based, in part, on the belief that the new Medicare Fee Schedule (MFS) could and should be used to help reform incentives facing physicians in rural areas, and that this reform could help relieve the critical and persistent shortage of physicians--in both primary care and other specialties--in many rural areas.

The Committee focused its attention on whether the structure of the MFS would preserve urban-rural payment differentials, thereby hindering access to services in rural areas. In 1989, the Committee recommended: that geographic payment differentials be eliminated by increases in rural payments; that payment increases for rural primary care physicians be accelerated during the transition to full implementation of the MFS; that provisions for updating the MFS allow for differential updates to address access problems of the underserved; and that adoption of any geographic adjustments for differences in practice costs be deferred, at least until analysis of alternative geographic cost-of-practice indices was completed by the Physician Payment Review Commission (PPRC) (**Recommendation 89-12**).

The difficulties of adjusting fees for geographic differences were respected by the Congress. OBRA 1989 instructed PPRC to study and report on effects of geographic indices on payments to rural physicians. While the Congress did not eliminate urban-rural differentials from the MFS because such differences are believed to reflect differences in the cost of providing services, special consideration--in the form of a 10 percent bonus--was granted to physicians who provide services in a HPSA, beginning in January 1991.

Several years later, the Committee's concerns for the rural underserved populations was voiced again. The Committee recommended that the bonus payment be increased for all rural physicians, and that it be the largest for physicians who practice in HPSAs and MUAs (**Recommendation 92-5**). Several months earlier, PPRC had echoed similar concerns, recommending that bonus payments be available to physicians for several years after HPSA status is withdrawn, and that poverty be considered a criterion for the payment of bonuses in non-HPSA areas (PPRC, 1992). The Administration's Health Security Act reflected these recommendations by proposing to increase the rural bonus payment to 20 percent (PPRC, 1994).

3.3 Payment Policies Affecting Other Providers

In the past, the Committee has recognized that a partial solution to the shortage of primary care physician services in rural areas is additional use of mid-level providers (MLPs) such as physician assistants, nurse practitioners and clinical nurse specialists. Prior to 1990, however, use of these personnel in areas of under-service was severely constrained because payment policies, including those of the Medicare program, either did not allow payment or severely limited payment for ambulatory, primary care services provided by such professionals.

In 1990, the Committee recommended that MLPs be eligible for direct payment under the Medicare program (**Recommendation 90-1**). The Committee recommended that direct payments be made for primary care services provided by MLPs who meet state licensure requirements and practice in rural HPSAs, rural MUAs, and other rural areas with relatively few physicians. Formal arrangements between MLPs and primary care physicians would be required. Medicare payments to eligible MLPs would equal payments received by primary care physicians for the same service. OBRA 1990 authorized direct payment for services provided by all rural nurse practitioners and clinical nurse specialists working in collaboration with a physician, but payment levels were limited to 75 percent of the MFS payment for services provided in hospitals, and to 85 percent of fee schedule payments for other ambulatory primary care services.

CHAPTER 4: SPECIAL NEEDS OF RURAL POPULATIONS

4.1 Mental Health and Substance Abuse Issues

Rural Americans exhibit similar risks for mental illness and higher risks for alcohol abuse compared to urban Americans. However, there is a lack of access to specialized health services in many rural areas. To ensure that rural needs would be met, the Committee felt that each state should describe how it would address these needs when procuring Alcohol, Drug Abuse, and Mental Health Services (ADMS) block grants (**Recommendation 91-30**). Legislation in 1991 incorporated this recommendation: the new Mental Health Block Grant program required states' plans to provide such descriptions. In addition, the Center for Treatment Improvement, located within the Substance Abuse and Mental Health Services Administration (SAMHSA), encouraged and assisted states in developing State Systems Development Plans (SSDPs). SSDPs address the service needs of various state sub-populations and allow states to identify rural resource needs at the community level.

The Committee also called for legislation to modify substance abuse set-aside requirements. More specifically, the Committee asked for the elimination of the mandated drug abuse set-aside within the ADMS block grant's intra-state substance abuse funding component (**Recommendation 91-29**). The elimination would enable states to allocate funds in a manner that would more accurately reflect rural alcohol and drug abuse service needs. The Committee also recommended that, until legislation to ensure a more equitable distribution of substance abuse monies within each state existed, SAMHSA should expedite granting waivers for the intravenous drug abuse set-aside. In response, 1992 Congressional legislation eliminated the intravenous drug use set-aside for small states as well as for Wyoming, Guam, and the U.S. Virgin Islands.

Looking at the larger picture, the Committee wanted to identify trends in rural mental health and substance abuse problems as well as the availability of personnel to treat such problems. The Committee asked that SAMHSA examine the epidemiology of substance abuse and mental health problems in rural areas, identify rural mental health professionals, and measure the current level of service availability (**Recommendation 91-33**). In 1991, ORHP and the Office of Rural Mental Health Research collaborated to fund development of a comprehensive summary of current rural mental health information. The report (Wagerfeld, et al., 1993) provides a narrative overview of rural mental health issues and the latest research addressing them, as well as an annotated bibliography. Additionally, several Federal data systems measure the amount of illicit drug/alcohol use and the capacity to serve these populations, and thereby address the Committee's concern regarding information about rural mental health issues. For example, the National Drug and Alcohol Treatment Unit Survey (NDATUS) collects information on treatment facilities available in both urban and rural areas; the Client Data System (CDS) reports the characteristics of patients found in treatment units; and the National Household Survey on Drug Abuse and the High School Senior Survey collect incidence/prevalence data for both urban and rural areas. The National Institute of Mental Health (NIMH) also conducts a study every two years for the purpose of identifying mental health providers, staff availability, and the number of people served per year in both rural and urban areas.

Early in 1995, SAMHSA began funding a "Frontier Mental Health Services Resource Network," a concept consistent with the Committee's 1991 recommendation. In this three-year project, selected experts in rural mental health will synthesis the body of knowledge on specific topics related to the need for and delivery of mental health services in frontier rural areas, and will disseminate the syntheses to persons and organizations delivering mental health services in these areas. In addition to SAMHSA's efforts in this area, NIMH currently funds four research centers devoted to studying rural mental health issues. Finally, the Secretary also convened an Ad Hoc Working Group to examine the delivery of rural mental health services by non-physician providers.

In a similar manner, the Committee asked the Secretary to direct NIMH to seek funding for mental health education programs, develop financing mechanisms for mental health services, and identify and eliminate any additional barriers to service utilization in rural areas (**Recommendation 91-34**). The NIMH grant program, "Research on Mental Disorders in Rural

Populations" (RFA-91-52B) provides funding for the study of problems associated with the stress of rural life, methods to assess and possibly lower the incidence and prevalence of mental health disorders, and economical methods to provide more accessible and integrated mental health services. Another program, "Drug and Alcohol Use and Abuse in Rural America" (PA-95-060), is supported by the National Institute on Drug Abuse (NIDA), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the Agricultural Research Service of the Department of Agriculture. This grant program encourages research on the consequences of substance abuse in rural areas and the delivery of appropriate prevention and treatment services. In addition, NIMH sponsored the Seventh International Primary Care Mental Health Research Conference and, in conjunction with ORHP, sponsored a post-conference technical assistance session to address rural primary care mental health research needs.

Continuing with its focus on education, the Committee asked for an expansion of educational programs, including continuing education for rural providers of mental health and substance abuse services (**Recommendation 91-35**). More specifically, the Committee wanted to create special initiatives and review existing initiatives that would enhance skills of diagnosing, treating, and preventing rural mental illness and substance abuse problems in rural areas. The Committee learned that such existing initiatives included the Depression, Awareness, Recognition and Treatment program (D/ART program), one of NIMH's major public education programs. Additionally, the NIMH "Institutional Clinical Training Grant Program" has included the mentally ill in rural areas as one of five target priority populations since 1991. As a result, several educational institutions receiving these grant funds have developed both a strategy to recruit students from rural areas and a curriculum that addresses rural mental health issues. NIMH also created an informal work group to provide input on developing rural mental health clinical training guidelines.

The Committee also learned that the D/ART program has developed new agendas in states with large rural populations, and that NIMH has established a Community Partners Prevention and Education Program for panic disorders. This program reaches rural populations by utilizing the successful strategies in the D/ART program. In addition, an interagency agreement with the Indian Health Service provided for training Native American caregivers in the diagnosis and treatment of depression disorders. The Center for Treatment Improvement and the Center for Substance Abuse Prevention (CSAP) have both worked with ORHP to ensure that SAMHSA, NIMH, NIDA, and NIAAA target and more effectively address rural needs.

The Committee also recognized a need to assist mental health professionals in financing their education. Therefore, the Committee asked that the Secretary direct the National Health Service Corps (NHSC) to establish scholarship and loan repayment programs for individuals in the following five core mental health professions: psychiatry, clinical psychology, clinical social work, psychiatric/mental health nursing, and family and marriage therapy (**Recommendation 91-36**). Congress subsequently allowed social workers and clinical psychologists to be eligible for scholarship and loan repayment programs. In addition, new criteria for the designating areas with shortages of mental health professionals were published in the February 1992 Federal Register. For the first time, the formula for designating such areas included the presence of clinical social workers, clinical psychologists, psychiatric nurse clinicians and family marriage therapists in addition to the presence of psychiatrists. States were asked to provide their list of

priority mental health shortage sites to the HRSA Office of Shortage Designation for review. The Department evaluates this information on a continual basis in response to this recommendation.

4.2 Agricultural Health and Safety Issues

Tractor Rollovers. Along with construction and mining, agriculture is one of the three most hazardous industries in the U.S. (National Safety Council, 1994). In 1986, for example, approximately 1,600 adults and 300 children perished in farm-related accidents (National Coalition for Agricultural Safety and Health, 1989). A large proportion of these deaths was related to the operation of tractors, and the majority of the tractor-related deaths resulted from overturns of tractors without Rollover Protective Structures (ROPS) and seat belts. In 1991, ORHP funded one of its Rural Health Research Centers to develop a catalogue of businesses from which tractor owners and operators could purchase retrofit ROPS and ROPS cabs (Wisconsin Rural Health Research Center, 1991). The directory was widely distributed in rural counties. In 1993, a second edition of the directory was printed by John Deere and widely distributed by Deere and the Marshfield Medical Foundation. In 1992, the Committee asked the Secretaries of the Departments of Labor, Commerce, and Agriculture to seek legislation for the mandatory inclusion of ROPS and seat belts on all new tractors. In addition, the Committee asked for a five-year incentive program to retrofit ROPS and seat belts on tractors currently in use (**Recommendation 92-18**). The Committee focused on ROPS because findings from many European studies had demonstrated that ROPS and seat belts dramatically reduce the number of deaths by overturn, but no action on the recommendation has been taken.

Continuing Education Programs. The Committee also has been concerned that the prevention, diagnosis, and treatment of agricultural injuries and occupational illnesses were not a part of most professional education programs, and that continuing education programs in agricultural health and safety are critically needed. In **Recommendation 92-15**, the Committee called for the Secretary to seek a budget appropriation to permit BHPr to develop such continuing education programs. Currently, there are two federal programs within BHPr that address this need: the AHEC program of the Division of Medicine and the continuing education program of the Division of Nursing. Additionally, ORHP has just co-sponsored, with the American Academy of Family Practice, the Spring 1997 publication of "Ag-Med: The Rural Practitioner's Guide to Agro-Medicine." This publication is targeted to physicians practicing in rural settings, and is designed as a quick reference document for diagnosing and treating health problems related to agriculture. Finally, the National Institute for Occupational Safety and Health (NIOSH) of the U.S. Centers for Disease Control currently sponsors eight Rural Research Centers throughout the country whose work includes research on agricultural and occupational safety and health. FY 1997 appropriations for NIOSH were not only 10 percent higher than FY 1996 appropriations, but included an additional $5 million to support research, public education, training, and policy enforcement activities aimed at preventing childhood agricultural injuries.

4.3 Viability of Rural Outpatient Health Facilities

Reconfiguration and Integration of Rural Health Services. Many rural communities have extremely limited health care resources. Hospitals, non-hospital providers, physicians,

businesses, schools and other community groups could integrate, re-organize, and coordinate their resources in order to ensure the maintenance and expansion of needed health services. Even so, the Committee believes that certain essential health care facilities may always require special protection. The Committee has observed that long-term strategies to define "essential access facilities" and determine the types of protection to be afforded to these facilities should be encouraged. As noted earlier, the Committee recommended that Essential Access Community Hospitals (EACHs) and Rural Primary Care Hospitals (RPCHs) receive special financial protection under the prospective payment system for capital (**Recommendation 91-9**). Subsequent legislation (Public Law 101-239) excluded RPCHs from the "hospitals" category, thereby exempting them from the capital prospective payment system. While no such exemption was granted for EACHs, these facilities are paid as Sole Community Hospitals, and are protected by the 90 percent payment floor that applies to these hospitals.

In addition, the Committee believes that the long-term professional commitment of health professionals to rural medicine depends upon proper preparation for rural practice and equitable reimbursement for services. Influential Committee recommendations addressing Medicare physician payment policies were described in Chapter 3. Primary care initiatives such as the Federally Qualified Health Center (FQHC) program and the National Health Service Corps help provide professional preparation for rural medicine and continue to hold much promise for expanding access to health care in rural areas.

For many rural communities, access to primary care is provided by private medical practices and through the Community and Migrant Health Center (C/MHC) programs. Funding levels for the C/MHC programs have remained relatively level over the past few years, while operating expenses, malpractice insurance costs, and the demand for services have all increased. Increasing funds to support existing centers and to establish new ones in rural areas will provide primary care services to populations that are poorer and less likely to have insurance coverage than those in urban areas. Thus, the Committee recommended that at least 50 percent of the increase in the DHHS FY 1991 budget be earmarked for projects in rural and frontier areas (**Recommendation 89-20**). In fact, the FY 1991 budget requested a total increase of funding for C/MHCs of $19 million. In subsequent years, over 50 percent of budget increases have been awarded to centers located in rural areas.

In addition to adequate funding, the success of programs to increase access to primary care services depends on awareness of these programs and their requirements by potential providers, state legislators, and various other professionals. To promote an increase in the number of rural health clinics (RHCs), the Committee requested the Secretary to disseminate information on the RHC program (**Recommendation 89-22**). The Committee also asked for technical assistance to be provided to assist potential providers in qualifying for RHC designation. Subsequently, Congress enacted legislation requiring that HCFA write to all hospital administrators about the program. In addition, HCFA updated a brochure on rural health clinics that included a description of the conditions of participation for these centers, covered services, payment mechanisms and other aspects of the program. ORHP collaborated with HCFA on this project, and helped disseminate information to states, national associations, and other relevant groups.

Several years later, the Committee believed that providers were unsure about the relative advantages of the FQHC program compared to the RHC program, and recommended that more information on the programs be made available (**Recommendation 92-24**). In response, ORHP developed a primer that discussed similarities and differences between FQHCs and RHCs, and distributed it to state Offices of Rural Health and other local entities. This primer was updated in 1995 (ORHP, 1995b) and very widely distributed.

The Committee also felt that the Secretary should continue to work closely with the Department of Justice to support legislation that would provide relief to community and migrant health centers from excessive malpractice insurance costs. **Recommendation 91-14** called for amendment of the Federal Tort Claim Act by extending coverage to C/MHCs, employees or contractors of C/MHCs, or through some alternative mechanism. Dollars currently being utilized by health centers for malpractice premiums were to be directed to risk management, quality improvement activities, and patient care enhancement. Congress subsequently passed the Community Health Center Liability Risk Retention Act of 1992 to achieve these goals. The bill includes provisions that assist C/MHCs to obtain affordable insurance and help the Centers to retain control over the risk retention and purchasing groups established under the bill.

Clinical Laboratory Improvement Amendments. Rural Health Clinic regulations specify nine laboratory services that must be provided for certification as an RHC. Under the proposed regulations for implementing the Clinical Laboratory Improvement Amendments (CLIA) of 1988, six of these tests were to be considered "certificate of waiver" tests. The remaining three tests were to be considered "moderate complexity" tests, a category for which there were also new personnel requirements. The Committee was concerned that the limited resources of RHCs might make it difficult for them to meet these new personnel requirements, as well as to pay the higher registration and inspection fees for moderate complexity laboratories. Removing certain tests from the list of required laboratory services for RHCs and changing regulations to enable RHCs to have "certificate of waiver" laboratories were seen as possible mechanisms for preventing these difficulties. In **Recommendation 90-2**, the Committee asked the Secretary to delay implementation of CLIA '88 until its impact on access to care in rural areas could be adequately assessed. Implementation was delayed, and the final CLIA implementing regulation accommodated some of the concerns of the Committee. Specifically, 75 percent of the test systems were placed into the "moderate complexity" level, and the personnel standards were designed to ensure that access to clinical laboratory services is not inappropriately hindered. In addition, phase-ins and enforcement sanctions were incorporated to help smooth the transition for the newly-regulated laboratories.

While the Committee found that the final rules to implement CLIA '88 provided more flexibility in personnel standards than the proposed rule, concerns remained about the application of the final rules to RHCs. Thus, the Committee recommended that RHCs be allowed to comply with the requirements of both the CLIA and RHC programs as "certificate of waiver" laboratories (**Recommendation 92-6**). Subsequently, RHC regulations were modified so that RHCs are now required to provide only the six certificate of waiver tests, rather than all nine laboratory services formerly required for certification.

Finally, the Committee called for rural representation on the Clinical Laboratory Improvement Advisory Committee (CLIAC) (**Recommendation 93-4**). The Committee felt it

important that there be someone with first hand experience on rural areas present when the CLIAC discussed issues affecting the needs and problems of rural communities. In response, the Secretary appointed a rural representative to the CLIAC.

4.4 Rural Health Information and Research Needs

Research and Demonstrations. The Committee has focused on information as a key to the development of better health care policies for rural communities. For this reason, the Committee has consistently promoted the creation of demonstration programs and information networks that will increase the quality and quantity of data available to rural health providers and policy makers.

In 1989, the Committee not only supported HCFA's "10 percent set-aside" of research and development funds for rural health (**Recommendation 89-29**), but called for improvements in the integration and coordination of health services in rural areas through demonstrations. In **Recommendation 89-10**, the Committee proposed that the Secretary develop, by October 1992, a series of programs aimed at improving both the horizontal and vertical integration of rural health services. This recommendation was re-affirmed in the 1990 report to the Secretary. By 1992, a variety of cost-effective, comprehensive models to promote the integration and coordination of services had been implemented. One of these models was the Rural Health Outreach Grant Program initiated by ORHP and HRSA during FY 1991. This program has funded projects that develop new and innovative models of outreach and health care service delivery to underserved rural populations. Additionally, ORHP has just launched a major solicitation within this program calling for demonstration projects that focus on the development of vertically-integrated health delivery networks.

The Committee recommended that the Secretary continue to expand its support for the Medical Assistance Facility (MAF) Demonstration Project in Montana (**Recommendation 89-6**). The Secretary reaffirmed support for this demonstration, and outlined its importance for the development and success of alternative rural provider models. MAF demonstrations have been authorized through July 1997 by OBRA 1990, and HCFA is currently seeking renewal through the year 2000. Besides promoting the initiation of new, alternative provider models, the Committee has advocated the evaluation of existing models and the elimination of barriers that threaten their success.

The Committee asked the Secretary to propose legislation that would modify the Essential Access Community Hospital and Rural Primary Care Hospital Program (EACH/RPCH) by giving states and rural hospitals more flexibility in designing their health care networks (**Recommendation 90-3**). Specifically, the Committee asked for flexibility in: 1) the 72-hour limit of RPCH's inpatient stays, 2) the state's definition of EACHs, and 3) the creation of regional networks that involve cross border providers. This recommendation was viewed favorably by the Secretary, and legislation containing major features of the recommendation was enacted by the House of Representatives in 1991. More recently, the President's budget for FY 1997 called for expanding the EACH/RPCH program to all states and provided for even greater flexibility in its implementation.

Besides continuing its support for existing rural health care delivery demonstrations (**Recommendation 94-9**), the Committee proposed the implementation of pilot projects to evaluate and test payment methodologies for telemedicine (**Recommendation 94-10**). These pilot projects came as a response to ORHP's Rural Telemedicine Grants, which were already funding the development of rural networks and medical specialty consultation services through the use of telecommunications. The Committee asked the Secretary to expand support for this program by setting up pilot projects that would test payment methodologies and collect data on costs, utilization, outcomes, and patient/provider satisfaction with the program. In October 1996, HCFA began testing various telecommunications payment methods through a series of demonstrations in several sites involving numerous facilities.

Data Collection and Information Dissemination. In order to assist rural communities in addressing their health care problems, the Committee has set forth a series of recommendations aimed at improving the collection and dissemination of information in rural communities. The Committee began by addressing the difficulties faced by rural health care providers in obtaining up-to-date scientific and health education information when it asked the Secretary to provide adequate funding for the National Library of Medicine's (NLM) Rural Outreach Activities (**Recommendation 89-32**). This recommendation was supported by the Secretary, and approximately $3.8 million was made available for the funding of NLM's outreach efforts during FY 1990. The Committee has also been concerned about updating rural practitioners on HIV/AIDS treatment, drug trials, and referral information. Thus, the Committee requested an expansion of the activities of AIDS Education and Training Center (ETC) to reach rural primary care providers through the provision of hotline services and educational workshops (**Recommendation 90-15**). In 1991, the Secretary reported that sixteen out of the seventeen AIDS ETCs were addressing the educational needs of rural health care through the use of these communication tools.

The Committee has also promoted investment in information dissemination services that address the issues affecting rural elderly and minority populations. The Committee urged the Secretary to improve the availability of information regarding the rural elderly through its support of the Rural Information Center/Health Services (RICHS), the National Resource Center for Rural Elderly at the University of Missouri-Kansas City, and the Rural Outreach Program of the NLM (**Recommendation 91-23**). Although funding for the National Resource Center for Rural Elderly has ended, the NLM's Rural Outreach Program and RICHS are still very active in communicating information about the rural elderly, as part of their broader mission to collect and disseminate information on rural health research. For instance, RICHS operates a toll-free line where rural residents and researchers across the country can access information. Some of the information services provided by RICHS include database searches, publication and educational materials and, when necessary, referrals to organizations and experts in the field.

In 1990, the Committee brought to the attention of the Secretary the need to address the needs of rural minority populations within the Department's global initiatives concerning minority health. As an initial step in this process, the Committee recommended that ORHP, in cooperation with the Office of Minority Health, conduct a conference to identify common problems and establish an agenda to improve minority health in rural areas (**Recommendation 90-5**). *A Shared Vision--Building Bridges for Rural Health Access* (1993) was the title of the

first, broad-based, nationwide minority rural health conference that resulted from this recommendation. That conference resulted in the publication of a book of proceedings. The second and third national minority health conferences were convened in 1995 and 1996 respectively.

CHAPTER 5: RURAL ISSUES FOR THE FUTURE

In this chapter, we briefly highlight some of the Committee's past recommendations that were not enacted, yet which remain important to rural health. We also identify additional topic areas in which policy developments that could impact rural health are anticipated. The Committee may wish to revisit the selected past recommendations and consider the new topic areas when formulating its 1997 recommendations.

5.1 Workforce Issues

As discussed in Chapter 2, the Committee has made numerous recommendations throughout the years designed to improve the availability of primary care providers for rural and other underserved populations and areas. Despite some success in this area, the geographic maldistribution of physicians remains a pressing concern for rural areas, many of which experience a chronic shortage of physicians even in the face of a national oversupply of physicians, particularly specialists. Contrary to the expectations of some policy makers, this oversupply of physicians has not resulted in significant movement of physicians into rural and underserved areas. With market forces failing to redress the rural/urban geographic inequities, special policy interventions are needed.

Concerns about the general oversupply of specialists in the United States have led to several proposals in the past few years to restrict the number of training positions eligible for Federal funding, with the heaviest reductions proposed for International Medical Graduate (IMG) residency positions (e.g., Pew Health Professions Commission, 1995; Council on Graduate Medical Education, 1995). Consequences of such proposals for rural areas have not been widely considered, however. Some experts argue that IMGs play a critical role in the provision of health care for rural and underserved areas, so that reducing the number of IMG training slots may exacerbate the urban/rural geographic maldistribution of physicians. The NRHA generally supports the proposal to gradually reduce IMG residency funding, but calls for a study of the impacts of such an action on rural communities. They also support the development of transitional strategies that would help IMG-dependent institutions adapt to such changes. The Committee may wish to consider similar recommendations.

Graduate Medical Education. Reforms to the graduate medical education (GME) financing system are on the national policy agenda and may warrant renewed Committee attention in 1997. Several organizations, including ProPAC and the American Medical Association, have recently advocated broadening the financial support for GME beyond the Medicare program to an *"all-payor" financing system*. This position echoes reforms envisioned in the Administration's Health Security Act as well as the Committee's own **Recommendations 93-7** and **96-2**. Whether financed predominantly by Medicare or by all payers, *allocation of GME funds* is another topic area in which reforms are being considered. For example, the

NRHA advocates GME allocations based on general population distribution or on population-based needs, rather than on the current distribution of hospital residency positions. (Related to this discussion is the concurrent recommendation to remove GME payments not only from Medicare hospital payments but also from payments to Medicare risk plans, through revisions to the capitation payment methodology--see below for more detail.) The Committee has in the past recommended allocation based on institutions' track record of training providers who are consistent with the nation's health workforce goals, e.g., more primary care providers and fewer specialists (**Recommendation 93-6**), and so as to ensure an adequate health workforce for rural areas (**Recommendation 96-2**). ProPAC, however, is recommending allocation of funds in a way that maintains neutrality with regard to specialty composition. Changing the way medical education funds are allocated also holds the potential for fixing the design flaw of the failed Medical Education Demonstration projects (see Chapter 2), and suggests that a similar program might be resurrected that would entice rural hospitals to participate, giving primary care residents in urban hospitals the opportunity to gain clinical experience in rural hospitals. Additional topics for consideration in the area of GME finance reform include permitting funds to flow directly to *non-hospital settings* (NRHA, ProPAC, **Recommendations 93-8** and **93-13**), as well as permitting them to be used to train *non-physician providers* (**Recommendation 93-12**) and to support *interdisciplinary training programs* (**Recommendation 93-10**).

Financial Incentives for Rural Providers. Several proposals to provide financial incentives to encourage primary care providers to establish and maintain practices in rural and underserved areas have surfaced repeatedly during the 1990s, but have not yet been enacted. Much attention in this area has centered around proposals to *increase the Medicare bonus payments* to primary care providers in HPSAs and MUAs to 20 percent from the current 10 percent. Most recently, this proposal was included in the Rural Health Improvement Act of 1996, and has been supported by the NRHA. The Committee should note, however, that any recommendation to provide additional Medicare remuneration to rural providers through higher bonus payments will almost certainly need to be placed in the larger context of expected global reductions in payments to Medicare providers (see Section 5.2). Additionally, there has been sporadic interest in providing *income tax credits* to rural primary care providers (e.g., Health Security Act, **Recommendations 89-13** and **94-4**).

5.2 Medicare Payment Policy Issues

Medicare Payments to Risk Plans. The adjusted average per capita cost (AAPCC) methodology for establishing capitation payments to Medicare risk plans has long been recognized as flawed in several respects, and reforms to this methodology are being widely proposed by ProPAC, PPRC, and Congress (e.g., the Rural Health Improvement Act of 1996). Legislative action on this issue in the near future appears very likely.

One problem with the current methodology is that capitation rates are generally much lower in most rural areas than in metropolitan areas. This discrepancy may inhibit managed care plans from offering services in these low-priced markets. Furthermore, since most Medicare risk plans elect to share their excess profits with beneficiaries in the form of enhanced benefits (rather than sharing them with the government), the higher payment rates in metropolitan markets mean that beneficiaries in these areas have access to a much richer benefit package than is available to

rural beneficiaries. Recent proposals to reduce the geographic inequities in capitation payments rely on adoption of a blending methodology--whereby local payment rates are computed as a weighted average of local and national rates, payment floors and ceilings, or a combination of these approaches. The impact of these proposals on rural areas obviously depends on the specific details of the proposed approach (e.g., the weights used in the blends, the level at which floors and ceilings are set, how adjustments for budget neutrality are to be applied, and the length of the transition period).

Another problem with the current methodology is that, because the capitated payments are based on fee-for-service (FFS) costs in the area, they include payments for GME and disproportionate share (DSH) status made to hospitals treating beneficiaries in the FFS sector. Inclusion of these factors tends to inflate the capitated rates unnecessarily, often exacerbating the unfavorable urban/rural differential. If the managed care plan does not contract with the higher-cost teaching or disproportionate share hospitals, the plan experiences a windfall gain. Similarly, many teaching hospitals argue that when they *do* treat Medicare beneficiaries enrolled in risk plans, they do not receive payments that cover their associated teaching costs (unless they had negotiated higher payment rates directly with the risk plan). Current proposals to reform the risk plan payment methodology advocate removing GME and DSH payments from the base rates used to set capitation payments. (These proposals are often coupled with other proposals to make GME and DSH payments directly to the providers incurring the costs--see below.) It is generally held that such action would reduce payments in metropolitan areas by more than they would be reduced in rural areas, further helping to narrow the urban/rural differential. The exact impact on specific types of rural areas and how these reductions would interact with payment floors remains to be explored, however.

A third problem with the current methodology is that total medical expenditures for certain beneficiaries may be systematically under-estimated, which in turn will bias AAPCC payments. Medicare does not incur the costs of medical care obtained by Medicare beneficiaries in Department of Veteran's Affairs (VA) and Department of Defense (DoD) facilities. Thus, program expenditure estimates will under-estimate the costs of care in those counties where beneficiaries obtain VA/DoD services. Potential Medicare risk contractors may be discouraged from marketing to Medicare beneficiaries in places where use of VA/DoD facilities is believed to be high, as the Medicare capitation payment may be perceived as inadequate. This issue looms large in some rural areas where VA/DoD facilities play a large role in the local health care delivery system.

Payment rates can also be quite volatile over time. This is particularly true in small rural areas having few Medicare beneficiaries upon which to base fee-for-service cost experience, even though five years of historical expenditure data are currently used to estimate county-level per capita expenditures (PPRC-ProPAC, 1995). Several alternative payment methods have been proposed that would reduce the effects of expenditure volatility. For example, county payment rates could be calculated by blending county and supra-county (i.e., national or regional) rates. Another approach would be to change the geographic unit for which capitated payments are computed; use of metropolitan statistica area (MSA) and statewide rural payment areas in place of individual counties has been suggested. Since these approaches would sacrifice some

accuracy at the county level in exchange for enhanced stability, the Committee may wish to assess the impacts of such modifications carefully.

Fee-for-Service Physician Payment Issues. Although modification of the structure of AAPCC payments is likely to generate considerable policy interest during the coming years, modifications to the Medicare Fee Schedule (MFS) are also expected. Each fee is calculated from four components: a resource-based relative value measure of the amount of "physician work" required to provide the service or procedure; measures of the costs of non-physician resources and malpractice insurance associated with the service or procedure; and an adjustment for geographic differences in prices of resources confronting physicians.

Currently, measures of the non-physician resource cost and malpractice cost components are not resource-based. During the next year, HCFA is charged with replacing the non-physician resource cost component of the MFS with a newly-designed resource-based version, as has been repeatedly recommended by PPRC (e.g., PPRC, 1990, 1996). There is also significant pressure on HCFA to refine the malpractice cost adjustment measure (e.g., PPRC, 1990, 1991, 1996). Many analysts expect that the new non-physician resource cost adjustment will increase payments for relatively time-intensive, evaluation and management visits, and decrease payments for tests and procedures that have traditionally been viewed as "over-priced." Because the non-physician resource cost component of the fee schedule accounts for 40 to 50 percent of Medicare fees and Medicare revenue is relatively more important to rural providers, this fee schedule change may have significant effects on providers in rural and underserved areas. The impact is expected to vary by specialty, too; specialists in rural areas may see large payment decreases while primary care providers experience increases in rates.

The Committee's involvement with issues concerning Medicare physician payment policy during the next few years would be consistent with tradition. In previous years, the Committee has made numerous recommendations related to physician payment policy (see Chapter 3), including recommendations that have addressed design and implementation of the resource-based relative value scale as the basis of the Medicare Fee Schedule. In 1991, for example, the Committee recommended that the malpractice portion of the fee schedule for services provided by rural physicians be based on services provided by rural providers (**Recommendation 91-06**). Continued Committee involvement with these issues may also be warranted, as reductions in provider payments are viewed as important means of containing program expenditures.

Hospital Payment Issues. As indicated in Chapter 3, the Committee has also been extensively involved in monitoring Medicare hospital payment policy--work that the Committee may wish to continue because significant changes in hospital payment policy are expected during the next few years. First, there is some interest in replacing current definitions of hospitals that are of special importance to rural areas with a single, more encompassing designation. The NRHA, for example, has expressed support for defining and "nationalizing" the concept of limited service hospitals. Such a designation would replace hospitals currently designated as EACH/RPCH, for example.

Second, changes in the calculation of payments received by hospitals are likely to be proposed. Changes may affect payment for GME and DSH. The former are especially likely to

affect rural providers and beneficiaries. Changes have been proposed for both the indirect (IME) and direct (DME) components of GME expenses. Proposed changes in the level of IME, under consideration by ProPAC, may significantly alter the distribution of payments to hospitals. In addition, ProPAC is considering a recommendation that would encourage flexibility in the use of DME funding to support training in non-hospital settings and a "neutrality" recommendation that would make the distribution of DME funds "neutral" with respect to affecting the number and mix of residents. Whether DME funding is neutral and how "flexibility" is defined and implemented could significantly affect access to care in rural areas.

Finally, a serious problem in the calculation of hospital payments remains--the use of a hospital wage index that fails to adjust for differences in the occupational mix of the hospital's employees. The Committee has addressed this issue on several occasions, noting that the wage index has significant effects on the distribution of hospital payments and that adjustment for occupational mix is necessary to compensate rural hospitals fairly for the costs of labor (e.g., **Recommendations 89-03, 94-13**). Development and implementation of an appropriately refined index, however, has not occurred.

Home Health Payment Issues. A component of Medicare expenditures that is rapidly increasing, and hence attracting increasing attention among policy makers, is expenditures for home health services. Analysis of ways of containing these expenditures is expected in the near future. Policy options include development of a fee schedule to control payment levels, and shifting a share of the costs of services (e.g., 20 percent) to program beneficiaries. (At present, there is no cost sharing for these services.) It has also been proposed that home health service coverage be shifted from Part A to Part B of the Medicare program. Given the "principle" that has guided Part B financing in the past that about 25 percent of the costs of Part B services be absorbed by beneficiaries, this shift could effectively increase the Part B premium. Such policy changes may be of interest to the Committee, insofar as they are expected to have significant impacts on rural beneficiaries. With average incomes of the elderly lower in rural areas than in urban areas, any increase in cost sharing will comprise a disproportionately large share of total income for rural beneficiaries. Also, potential supply responses of home health providers to such policy changes in rural areas have not been a focus of study.

5.3 Alternative Delivery System Issues

For some time, the Committee has addressed the impacts of health system reforms and alternative delivery systems on rural areas. In 1994, the Committee released a series of recommendations on the Administration's health reform package. Since that time, the Committee has addressed a variety of issues related to systems development and the growth of managed care. This involvement is expected to continue because many of these recommendations continue to be of interest and importance, and because the development and impacts of alternative delivery systems in rural areas are not well understood.

The importance of technical assistance and information pertaining to the development and implementation of alternative delivery systems in rural areas has been the focus of Committee deliberations. The Committee has recommended that the Secretary assist in development of technical assistance programs to help prepare rural areas for health reform

(**Recommendation 94-06**), and the Committee has recognized that valuable information may come from demonstrations and evaluations that require Medicare and Medicaid waivers (**Recommendations 94-09** and **95-03**).

As alternative delivery systems are implemented in rural areas, the Committee may wish to study a variety of issues, including the following:

- What kinds of new delivery systems are being implemented in rural areas and what are the implications for public policy?

- What means are used by providers to improve access to acute services, preventive services, and mental health services by rural residents?

- What implications do new delivery systems have for the existing rural community hospitals and rural health clinics? Is their financial viability threatened by new contractual relationships with health plans?

- What implications does the delivery system have on the supply of primary care providers, including both physicians and non-physicians? Are practices of fee-for-service physicians threatened by new contractual relationships with health plans?

- How is the antitrust climate for alternative delivery systems evolving, and how can rural providers be kept informed of these developments? (Information of this type is clearly of interest to the Committee, e.g., **Recommendation 94-08**).

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