A Targeted Look at the Rural Health Care Safety Net

A Report to the Secretary,
U.S. Department of Health and Human Services

The National Advisory Committee on Rural Health

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About the Committee

The National Advisory Committee on Rural Health (NACRH) is a 16-member citizens' panel of nationally recognized rural health experts that provides recommendations on rural health issues to the Secretary of the Department of Health and Human Services. The Committee was chartered in 1987 to advise the Secretary on ways to address health care problems in rural America. Chaired by former South Carolina Governor David Beasley, the Committee's private and public-sector members reflect wide-ranging, firsthand experience with rural issues—in medicine, nursing, administration, finance, law, research, business, and public health.

The Committee is currently composed of 16 members, including the Chairman, who serve overlapping four-year terms. The members represent expertise in the delivery, financing, research, development, and administration of health care services in rural areas. Several members are involved in training rural health professionals. Others are representatives of state government, provider associations, and other rural interest groups.

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Executive Summary

One of the key features of the modern health care system is the safety net, the web of professionals and institutions that provide care to the poor and uninsured regardless of ability to pay. Unfortunately, changes in the health care environment are buffeting and in some cases battering the safety net. As a result, the safety net needs both mending and expanding—particularly in rural areas. To help facilitate that, this report examines several key safety net programs under the purview of the Secretary of Health and Human Services that the National Advisory Committee on Rural Health feels are critically important to rural communities. It also includes recommendations for improving the programs and strengthening the rural safety net.

The Rural Safety Net

While the rural and urban safety nets are similar in purpose and many of the pressures they face, the two vary a great deal in structure and context. As a result of these differences, the rural safety net may be more vulnerable. There are so few providers in rural areas, that the weakening of even one could ultimately unravel the entire net.

Programs That Support the Rural Safety Net

Because the rural safety net is broad, many programs support it directly or indirectly. The foci of such programs include: workforce development and retention, capacity expansion, public health, capital improvement, telemedicine, and insurance assistance. Some of these programs are targeted to rural areas; others are not. Some fall under the purview of the Secretary; others do not.

Key Rural Safety Net Programs: A Deeper Analysis

Important as the range of programs are, the Committee is charged with advising the Secretary of Health and Human Services. Therefore, it focuses in this report on several programs under the Secretary's purview that it considers critical in providing safety net services in rural areas. They fall into three categories according to their primary purpose:

Ensuring Access to Hospital Services

Rural hospitals play a critical role in the safety net because they are so often the locus of care in rural areas. The Department of Health and Humans Services (DHHS) has several formal hospital safety net authorities: Medicare disproportionate share hospital payment adjustments; Medicaid disproportionate share hospital payment adjustments; and Critical Access Hospitals and the Medicare Rural Hospital Flexibility Grant Program.

Ensuring Access to Primary Care

Access to primary care is a key feature of any health care safety net. DHHS operates several programs and payment mechanisms that help ensure access to primary care and prescription drugs for the rural poor and uninsured: Federally Qualified Health Centers; Rural Health Clinics; The Community Access Program; Charity Care and Medicare; the 340B Discount Drug Program.

Maintaining an Adequate Workforce

The safety net depends upon the availability of an adequate health care workforce. Three programs within the Secretary's purview focus primarily on building and strengthening the workforce that serves the rural poor and uninsured: National Health Service Corps; J1 Visa Waiver Program; and Medicare Incentive Payments.

Conclusions: Mending the Net, Extending the Net

Because elements of the rural safety net are interdependent, deterioration in one part of the system adds stress to other parts. Likewise, mending one part of the net will in all likelihood strengthen other parts. Therefore, while the issues raised in this report are in one sense discreet and require focused attention, they cannot be considered in a vacuum.

This mending, however, will not be enough. The Committee, therefore, urges that the net also be extended. Doing so will require the efforts of many Federal agencies, Congress, State and local governments, and the private sector. As a result, coordination will be critical, and the Committee urges the Secretary to convene an intergovernmental, interagency group to examine ways to mend, modify, and extend the rural safety net.

Introduction

One of the key features of the modern health care system is the safety net, that web of health care professionals and institutions that provide the care to the poor and uninsured regardless of ability to pay. Unfortunately, that safety net is currently buffeted, and in some cases, battered by two forces. First, throughout most of the 1990s, the number and percentage of people in the United States without health insurance rose across all regions. While the numbers did drop in the most recent accounting, poor economic performance (as is projected for the near term) could well erase those gains. Second, the health care payment system—both private and public—is undergoing significant changes: managed care continues to expand its role, insurers increasingly cover only the costs of those they insure and there is continuing pressure to restrain the growing costs of the Medicaid and Medicare programs. This comes at a time when both of these programs are seeing payment reductions.

Not surprisingly then, concern for and attention to the safety net is increasing in the research and policy arenas, as well as among the general public. Reports from the Institute of Medicine, The Urban Institute, the Kaiser Family Foundation and others have brought much-needed attention to the issues.[1] While some of the work has dealt with rural issues, most has focused primarily on the urban safety net. With this report, the National Advisory Committee on Rural Health takes a targeted look at several key safety net programs under the purview of the Secretary of Health and Human Services that the Committee feels are critically important to rural communities. This group of programs, however, is not meant to represent the full Federal investment in the safety net. Rather, it is a snapshot of the handful of programs identified by the Committee as being key components of that safety net in rural settings.

Definitions

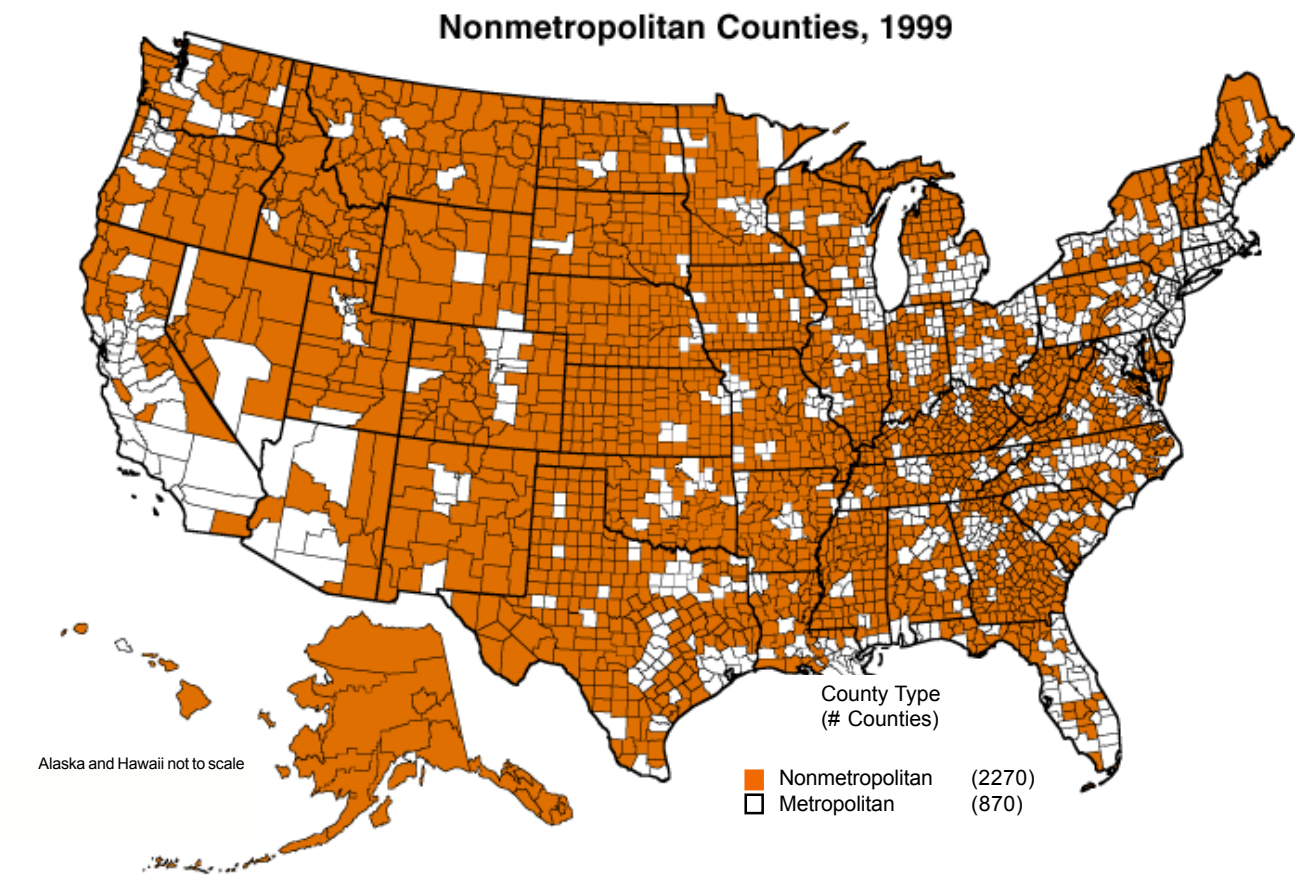
While there is no legal or technical definition of the rural safety net, it is best described as:

> A complex web of public and private professionals and institutions—including public and or community hospitals, public health departments, Federally Qualified Health Centers, Rural Health Clinics, free clinics, and private providers—that deliver a disproportionate share of health care and related services to the uninsured, underinsured, low-income, Medicare and Medicaid recipients. They provide this care because of legal requirements or out of a sense of charity and duty.[2]

Others would also add to the list of safety-net providers in a range of other important entities including home health, nursing homes and adult day care providers.

The Rural Safety Net

As of 1998, some 9 million people in rural America were without health insurance. More than 2 million of them were children. An increasing number are foreign-born immigrants. In addition, others are underinsured. Often, the uninsured and underinsured are poor, even though many of them have jobs. Finally, other rural Americans, despite the fact they may have some form of insurance, live in areas so geographically isolated, that they too are underserved. The care of these people falls primarily on the web of providers known collectively as the rural safety net.



Source: U.S. Bureau of the Census; Office of Management and Budget, 1999.
Produced by: North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

In the past, safety net providers were able to cover the cost of caring for the poor and uninsured by cost shifting—using revenues from various payers to subsidize non-reimbursed expenses. According to Ricketts et al, cost shifting was possible for several reasons:

- reimbursement from self-pay patients, State employee benefit systems, or private insurance was often higher than the actual cost of covered services;
- prior to the prospective payment system, Medicare or Medicaid payments to hospitals incorporated the cost of service provision to indigents and;
- other special governmental funding systems recognized the need to support costs beyond direct service.[3]

However, the health care environment is changing. Changes in payment policy have made cost shifting more difficult. The changes began in

1983 when Medicare moved to an inpatient prospective payment system and in subsequent years to a physician fee schedule. Many private payers, particularly managed care and state Medicaid programs, followed suit. This creates trouble for many charity care providers, particularly if other public subsidies for care of the uninsured are reduced.[4] That is even more pronounced in rural communities, where third-party payers make up a smaller amount of the payer base compared to Medicare and Medicaid.[5]

In its June 2001 report, *Medicare in Rural America*, the Medicare Payment Advisory Commission (MedPAC) found that changing population demographics, specifically the emigration of working-age residents, have had a dramatic effect on rural communities. These changes, the Commission notes, can affect the amount and types of health facilities and practitioners that rural communities need while also increasing their vulnerability to changes in Medicare and Medicaid policy.[6]

While the rural and urban safety nets are similar in purpose and in many of the pressures they face, the two vary a great deal in structure and context. As for structure, urban systems often depend heavily on teaching hospitals and professional educational programs that use trainees to care for low-income patients. The rural safety net, however, rarely has access to those resources. It depends on a variety of different individual providers and provider types. This includes rural health clinics, private practitioners, community health centers, and outpatient departments in rural hospitals.[7] Public health departments also play a critical role. Local public health departments in rural areas are more likely to list family planning and home health care services as a priority than their urban counterparts.[8]

The context within which the rural safety net operates also differs. MedPAC's notes in its June, 2001 report that some rural communities face challenges in sustaining the infrastructure needed to meet their residents' health care needs. The challenges come from a combination of conditions, including small and declining populations, low household incomes, high unemployment, the aging of the population or disproportionate numbers of minority residents. This makes it difficult to attract and retain providers by limiting the demand for services, raising providers' unit costs, and/or reduce revenues by increasing uncompensated care burdens.[9] Although focusing on the larger rural health care system, MedPAC's characterization also accurately describes the rural safety net.

According to The Urban Institute, changes in the health care sector threaten many providers—rural and urban. The consequences of provider failure are potentially greater in rural areas, however, because alternative sources of care in the community are scarce. Each provider plays a critical part in maintaining access to health care services and should be considered part of the health care safety net—"if not directly through their care for vulnerable populations, then indirectly through their contribution to the stability of the community's health care infrastructure."[10]

As a result of these differences, the rural safety net may be more vulnerable because of concerns about the economic viability of key individual providers who care for the poor and the uninsured in rural areas. There are so few providers in rural areas, the weakening of even one could ultimately unravel the entire rural health care safety net.

The safety net is a complex web of providers and programs. This report attempts to shed light on the U.S. Department of Health and Human Services (DHHS) role in supporting that web. The first section begins with a description of some general programs and authorities that play a role in supporting the rural health care safety net. The next section identifies in greater detail a range of other safety net programs that the Committee believes are particularly important to ensuring access to care for the poor and uninsured that are within the purview of the Secretary. The final section examines some of the common themes among the elements of the rural safety net and lays out the challenges ahead. Where appropriate, the Committee offers recommendations on ways to mend, extend, and improve those programs that serve the rural health safety net.

Focus of the Report

The Committee's report identifies a range of safety net programs that serve rural communities and then examines several key programs in greater detail. The Committee is charged with advising the Secretary of Health and Human Services on rural health issues and purposely limited the scope of this report to those programs and issues that fall within the purview of the Secretary.

Selecting "critical rural safety net programs" is a subjective task. The issues that are discussed in this one report cannot represent the entirety of the rural safety net. The programs that support the rural safety net are far too many to focus upon in great detail in this report. As a result, the Committee chose to focus in detail on only a subset of the many important safety net programs that are critical to rural communities. The selection of these issues should not be interpreted as support for some programs at the expense of others.

Programs That Support the Rural Safety Net

DHHS operates many programs that support the rural health care safety net. The Medicare, Medicaid and the State Children's Health Insurance programs (SCHIP) are key players in the safety net by virtue of their respective missions and the large number of beneficiaries or enrollees. Medicare is a nationwide health insurance program for the aged and certain disabled persons. Medicaid is a Federal-State partnership that pays for medical assistance for certain individuals and families with low incomes and resources. Medicaid is the largest source of funding for medical and health-related services for low-income or disabled Americans.[11] SCHIP, like Medicaid, is operated as a partnership between the Federal government and the States to provide health care services to low-income children otherwise not eligible for Medicaid.

There are a variety of other programs and authorities and providers that also support the rural health care safety net. Some of these are targeted to rural communities. Others may not have a specific rural focus but have become valuable parts of the larger health care safety net in rural communities. The following is a loose grouping of those programs, authorities and provider types that fall into that category:

- DHHS operates several programs aimed at maintaining the health care workforce (the backbone of the health care safety net), yet are broader in scope than the rural safety net. These programs include the Quentin N. Burdick Rural Interdisciplinary Training Grants, which promote collaboration among rural providers; Title VII Primary Care Training Grants, which help train primary care providers; the Health Career Opportunity Program, which helps minority students enter the medical profession; and the Area Health Education Centers, which promote community-based training.[12] Each of these programs supports the rural safety net by helping to train and retain health care workers in underserved areas.

- DHHS operates several grant programs designed to support the rural safety net by expanding capacity in rural areas. The State Offices of Rural Health program helps states develop and maintain a focal point for rural health. Rural Health Outreach Grants support innovative demonstration grants in rural areas that focus on improving access to care. Network Development grants support the development of vertical and horizontal networks of care in rural communities.

Medicare GME

Medicare payments for graduate medical education (GME), which support resident training, also play a role in the overall safety net but mostly in urban areas. The justification for Medicare payment of GME is that teaching hospitals—facilities that operate approved residency training programs—generally incur higher expenses than hospitals without teaching programs. In FY 1999, for example, these payments were approximately $6.2 billion.[13] Medicare GME payments, as currently constructed, are geared primarily toward residents in a large, multi-specialty hospital setting. Consequently, this means the bulks of GME funds go to urban hospitals. In the most recent year for which accurate cost reports are available, only slightly more than 1 percent of GME funding went to rural hospitals.[14] So while GME funding plays a key role in the ability of academic medical centers to support safety net activities, it is largely an urban phenomena.

• Local public health departments help assure the conditions in which people—wealthy and poor, insured and uninsured—can be healthy. The primary mission of local health departments is to promote and protect the general health of the population. This focuses on regulatory activities related to food, water and air quality or through primary prevention activities like immunization. In many cases, they also provide direct care. As such, they are at the core of the safety net in many rural communities. DHHS plays a strong role in public health at the State level through two primary means. The first is through block grant funding such as the Preventive Health Services Block Grant and the Maternal Child Health Block Grant. The second is through Medicaid reimbursement for personal health services offered at public health departments. It is this latter authority that has the most direct link to the rural health care safety net. DHHS' Community Access Program (CAP) offers another link to the safety net and is discussed in greater detail later in this report.

Mental Health: A Hole in the Safety Net

One of the few key mental health safety net programs within DHHS is the Community Mental Health Centers (CMHCs). At its inception, the CMHC program proved to be a particularly good fit for rural communities because of its focus on meeting individual community needs. However, the move to block grant funding and subsequent funding reductions in the 1980s for this program and other changes in the fee-for-service sector have shifted the focus of CMHCs. The CMHCs have since become less able to respond to evolving community mental health needs and instead have tended to focus on the most seriously impaired.[16]

• Free care clinics and uncompensated care by physicians in general contribute directly to the rural health safety net by providing care to the poor and uninsured. There is, however, no program under the Secretary's purview related to free or charity care. This report, however, does discuss in greater detail the Department's role in allowing providers to use a sliding fee scale to treat low-income patients as it relates to Medicare law.

• There is one program under the Secretary's purview designed to help provide capital with which to build and maintain the buildings, facilities, and equipment that underpin health care services, including safety net services. Historically, the Hill-Burton program was the primary program that supported capital funding. That program funded more than 10,700 capital projects between 1948 and 1974 but is no longer in existence. The only DHHS avenue for capital funding is the Department of Housing and Urban Development (HUD) 242 program, which is jointly administered by DHHS and HUD and provides mortgage insurance for health care capital projects. The majority of program funds are geared toward larger, urban facilities.[15] However, this program has not been a viable option for many rural hospitals because they have trouble qualifying for the mortgage insurance or face difficulty in paying the loans back.

• DHHS supports many telemedicine demonstration programs that have helped to improve access to specialty care for isolated rural communities and train and support rural health care practitioners. These programs are supportive of the rural safety net and offer potential for serving poor and isolated rural communities. They can provide access to

specialty services via teleconsultations. They can also help retain key health care providers through practice support and continuing medical education for clinicians via videoconferencing. Telehealth consultations can also help strengthen rural health care delivery systems by retaining the patient care in the local community rather than having the patients travel to distant urban areas to see specialists. That also can help retain health care dollars in the rural community since any ancillary tests associated with the teleconsultation take place in the community.

- DHHS administers the State Planning Grant Program, which provides one-year grants to States to develop plans for providing access to affordable health insurance coverage to all their citizens. States are designing approaches that provide health insurance benefits similar in scope to the Federal Employees Health Benefit Plan, Medicaid, coverage offered to State employees, or other similar quality benchmarks. At the conclusion of the grant, each State will submit a report to the Secretary of Health and Human Services that identifies the characteristics of the uninsured within its State and proposals for providing them with affordable health insurance coverage. Together, these reports will provide additional data about the characteristics of the uninsured generally and potential models for other States seeking to provide comprehensive coverage. The Health Resources and Services Administration (HRSA) awarded 11 state planning grants in 2000 and another nine in 2001. These grants are broadly focused but have the potential to strengthen the rural safety net by reducing the number of uninsured.

- Medicare operates four separate dual-eligible programs that help low-income Medicare beneficiaries cover the costs of premiums, deductibles and coinsurance through the state Medicaid program. These programs (which fall under the authorities of the Qualified Medicare Beneficiary program and the Specified Low-Income Medicare Beneficiary program), may not always be thought of as primary parts of the formal safety net. They do, however, play a role if for no other reason than by targeting a low-income population in a way that increases access to care by removing financial barriers.

Oral Health: A Hole in the Safety Net

There are no formal or direct Federal programs to support access to oral health services for poor and underserved populations other than those oral health services that are offered through Community Health Centers and public health departments. The primary policy tool to reach out to poor and underserved populations is Medicaid and SCHIP, but payment rates are generally low and participation by private dentists in the programs is limited. The only other Federal tool for addressing oral health needs is the direct care provided by National Health Service Corps dental scholars or loan recipients.

Key Programs: A Deeper Analysis

In addition to the programs cited previously, there is a range of programs that the Committee considers critical in providing safety net services in rural communities. These programs fall into three categories according to their primary purpose:

- Helping to ensure access to hospital services;
- Helping to ensure access to primary and preventive health care services; and
- Helping to maintain the health care workforce.

For each program, the report presents a brief background discussion, followed by a description of challenges faced and recommendations to the Secretary on how existing Federal authorities can be improved to help meet those challenges.

The report concludes with a brief discussion of the need for a more comprehensive approach to both mending and extending the rural health care safety net.

Ensuring Access to Hospital Services

Rural hospitals play a critical role in the safety net because they are so often the locus of care in rural communities. More than in urban areas, where alternatives are more prevalent, "the hospital serves as the sine qua non of local health services in rural communities."[17] Consequently, Federal support for rural hospitals is essential if the safety net is to be maintained.

The Federal government uses several payment mechanisms in the Medicare program to support and stabilize rural hospitals financially (i.e., the payment designations of Sole Community Hospital, Critical Access Hospitals, Medicare Dependent Hospital, and Rural Referral Centers). However, these payment designations are not directly tied to a safety net role. The formal hospital safety net authorities are

- Medicare disproportionate share hospital payment adjustments;
- Medicaid disproportionate share hospital payment adjustments; and
- Critical Access Hospitals and the Medicare Rural Hospital Flexibility Grant Program.

Medicare DSH Payments

Since 1986, Medicare has made special payments to hospitals that provide care to a disproportionate share of poor patients. However, MedPAC and others have long noted that the current disproportionate share (DSH) payment policy favors hospitals located in urban areas.

Almost half of all urban hospitals receive DSH payments. In contrast, only one-fifth of rural hospitals receive Medicare DSH payments. To address this, Congress, in 2000, created uniform eligibility standards for all hospitals. The standardization of eligibility thresholds should result in significant payment gains for rural hospitals. However, the amount of DSH adjustments still differs for rural and urban hospitals, with urban hospitals of more than 100 beds being rewarded by steeply graduated payment adjustments.[18] Indeed, urban facilities can receive unlimited

Rural Hospital Programs and Policy Issues

There are a variety of hospital designations and payment adjustments under Medicare that play a key role in the financial viability of rural hospitals and in the ability of these facilities to be a part of the broader rural health care safety net.

Medicare allows certain rural hospitals to be designated as either Sole Community Hospitals (SCH), Medicare Dependent Hospitals (MDH) or Rural Referral Centers (RRCs). Hospitals designated as SCH or MDH get enhanced Medicare reimbursement. RRCs have more flexibility for reclassification to a higher urban wage index and may receive higher DSH payments than small urban or most other rural hospitals. These designations play an important role in providing a sound financial footing for small and isolated facilities.

The wage index and the base payment are two key Medicare policies that directly affect the financial viability of rural hospitals and, consequently, have an impact on their role in the health care safety net. The Committee continues to be concerned about the impact of the wage index on rural hospitals (see the Committee's recommendations from its May 2001 Report, "Medicare Reform: A Rural Perspective"). In addition, the Committee also questions the continued reliance on two separate base payment rates, one for large urban and the other for other urban and rural hospitals. Research by MedPAC and others indicates that this differential is not justified.

add-ons corresponding with the amount of patients served. Most rural add-ons, however, are capped at 5.25 percent of the total amount of the inpatient payment.[19]

In addition, "the current low-income share measure does not include care to all the poor, most notably omitting uncompensated care."[20] The Balanced Budget Refinement Act included a provision that directs the Secretary to begin collecting data on the costs incurred by hospitals for providing inpatient and outpatient hospital services for which the hospital is not compensated, including non-Medicaid bad debt, charity care, and charges for Medicaid and indigent care.[21] While these data are now being captured as part of the annual cost-reporting process, it will take several years before they can be verified and used as part of an improved DSH methodology.

Committee Recommendations:

- ***The Secretary should work with Congress to require the use of a uniform Medicare DSH adjustment policy that treats all hospitals the same regardless of their urban or rural location.***

- ***The Secretary should work with Congress to raise the cap on Medicare DSH payments for rural hospitals to an appropriate level that provides equity for rural hospitals.***

Medicaid DSH Payments

Medicaid, like Medicare, also makes DSH payments to offset the costs of providing uncompensated care and serving low-income populations. The Federal government and the States share in the costs of these payments, which were created in 1981. While many States use payment methodology similar to Medicare DSH, they also have a great deal of flexibility to develop their own methodologies. For example, States can determine:

- How much they spend on their DSH program;
- Which hospitals receive DSH payments;
- How payments are divided among facilities;
- What the size of the DSH payments are; and
- Whether there are any conditions on the hospitals that receive DSH payments.

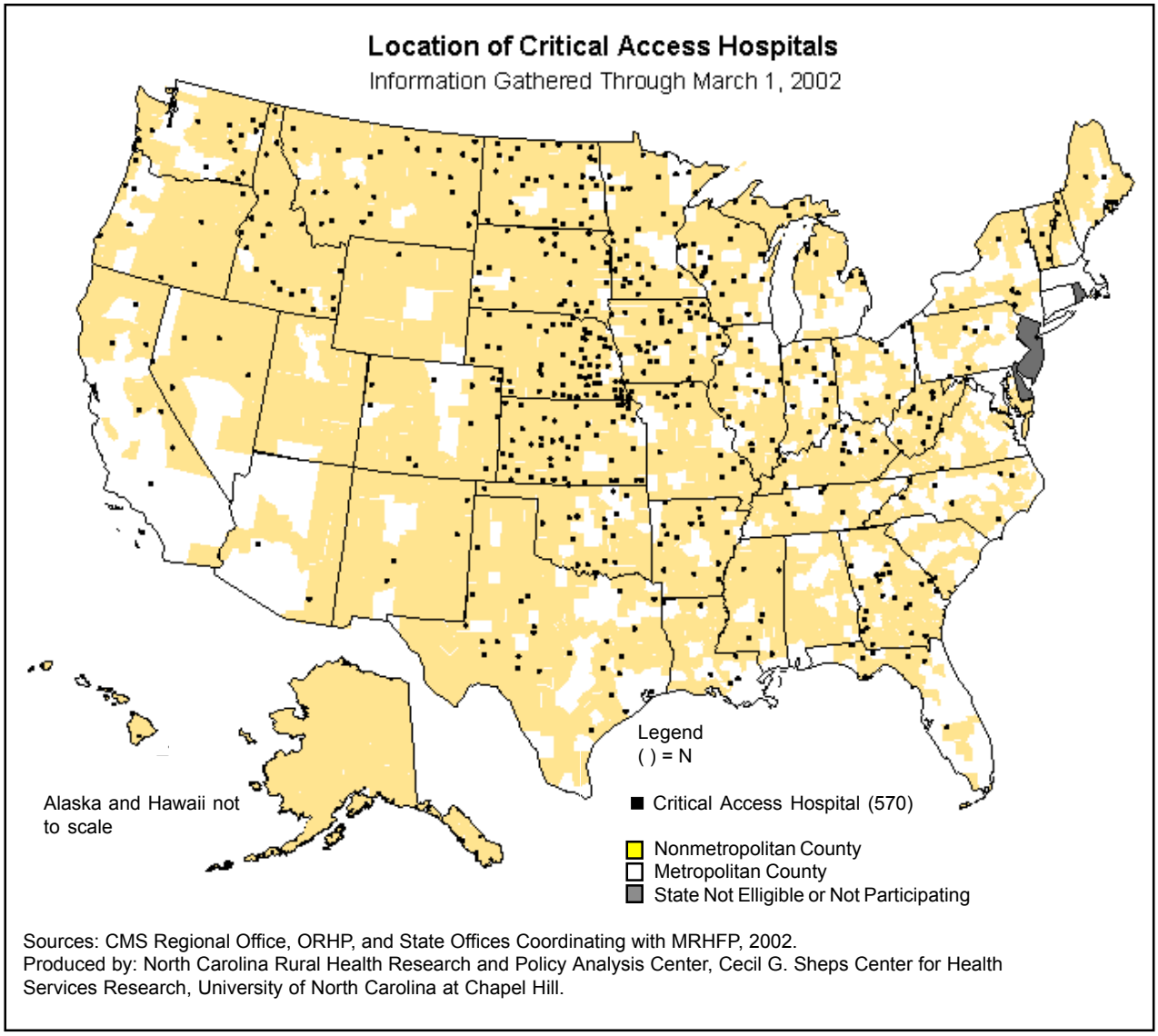
Medicaid DSH payments represent a significant part of Medicaid spending—some $9 billion. Indeed, the Congressional Budget Office estimated that the Federal government spent more than four times as much on Medicaid DSH as it did on SCHIP in FY2000.[22]

The extent of Medicaid DSH payments to rural hospitals is not known because the data on spending is broken down only on a State-by-State basis, not on a rural-urban basis. Experience suggests, however, that the States have not used Medicaid DSH payments as a way to help rural hospitals and that the funds represent an untapped resource, especially for rural hospitals in the South, where poverty, uncompensated care burdens and high Medicaid match rates prevail. As a result, DSH funds are not distributed evenly. The amount of Federal funds available per uninsured individual can average from $1 to $214 per person.[23]

To be fair, the States' determinations are subject to Federal requirements. Specifically, Federal law requires that a Medicaid Disproportionate Share Hospital have at least one percent of its total inpatient days attributable to Medicaid patients, and if the hospital offers obstetrical services, it must have at least two physicians who can provide non-emergent obstetrical care who also serve Medicaid beneficiaries. In addition, Federal law requires States to deem hospitals as DSH when those facilities meet one or more of a set of criteria pertaining to the relative number of Medicaid patients, low-income patients and charity patients it serves.[24]

Committee Recommendations:

- ***The Secretary should work with States to expand options for using Medicaid DSH payments for eligible rural hospitals, including the ability with current statutory authority to upgrade the financial stability of rural hospitals or to assist rural hospitals to develop physician or clinic networks.***



Sources: CMS Regional Office, ORHP, and State Offices Coordinating with MRHFP, 2002.
Produced by: North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

Critical Access Hospitals and the Medicare Rural Hospital Flexibility Grant Program

The Medicare Rural Hospital Flexibility Program—authorized in the Balanced Budget Act of 1997 and more commonly known as the Flex Program—has become a key support mechanism for rural health care delivery systems. The legislation has two distinct and related goals. The first, which falls under the authority of the Centers for Medicare and Medicaid Services (CMS), allows Medicare to certify certain hospitals as Critical Access Hospitals (CAHs). These CAHs serve as the sole source of inpatient care in a community either because they are geographically isolated or because severe weather conditions or local topography prevents travel to another hospital, and therefore play a critical safety net role. Under the program, CAHs are allowed to receive cost-based rather than formula-based reimbursement from Medicare for inpatient and outpatient Part A services and also have greater flexibility in dealing with staffing and coverage regulations.

The other key part of the legislation was the creation of a grant program, the Flex Program, which is administered by the Office of Rural Health Policy. This program provides grants to states to support conversion to CAH, promote networking and the integration of emergency medical services and to promote quality. In effect, the grant funding has helped states work with their rural hospitals and the communities they serve on a comprehensive and system-wide basis that heretofore has not occurred.

While the CAH designation and the Flex Program are not formally authorized as a safety-net, they have become a key part of the rural safety net. The cost-based reimbursement provided by Medicare has allowed many of these facilities to have a positive operating margin thereby keeping their doors open. The Committee believes that Congress' intent in combining the CAH designation with the grant program was to ensure that isolated rural hospitals that serve as key access points in their communities would remain viable to serve the needs of Medicare beneficiaries. There are more than 500 CAHs and more than 90 percent of those facilities are located in either a health professional shortage area or a medically underserved area.

Committee Recommendations:

- ***The Secretary should work with the Congress to ensure re-authorization and continued funding of the of the Medicare Rural Hospital Flexibility Grant Program, which is up for re-authorization in FY 2002.***

Ensuring Access to Primary Care

Access to primary care is a key feature of any health care safety net. DHHS operates several programs and payment mechanisms that help ensure access to primary care and prescription drugs for the poor and uninsured. The following programs are all under the purview of the Secretary and play a key role in supporting the rural health care safety net:

- Federally Qualified Health Centers
- Rural Health Clinics
- The Community Access Program
- Charity Care and Medicare
- The 340B Discount Drug Program

FQHCs and RHCs

Any discussion of key rural safety net providers tends to begin with Federally Qualified Health Centers and Rural Health Clinics. While both act as key access points in the rural health care safety net, they are very different in terms of their underlying legislative authority and orientation. FQHCs by their very configuration are community run and tend to have more of a program focus, especially those that receive Section 330 funding. By contrast, RHC designation is solely a payment designation under Medicare that aims to ensure access to care for Medicare and Medicaid beneficiaries in rural communities. So, while they are often linked together in discussion, they are, in fact, very different.

Federally Qualified Health Centers

The Community Health Center Program began in 1965 to meet both the medical and social needs of low-income and minority populations. The centers received direct Federal grants from Section 330 of the Public Health Service Act to cover the cost of providing care to this underserved population and included requirements that the centers be run by the community.

The success of that program led Congress in 1989 to create a new categorical definition, Federally Qualified Health Centers (FQHCs), that allowed these providers to receive cost-based reimbursement from Medicare and enhanced reimbursement from Medicaid. FQHCs can be located in urban or rural areas. They include community health centers, migrant health centers, public housing programs, and health care for the homeless.

In addition, community-based health care providers that satisfy 330 grant requirements, but do not receive the grants, can gain status as so-called "look alikes." While look-alikes do not receive 330 grants, these facilities are eligible for cost-based reimbursement under Medicaid and Medicare, they can serve as placement sites for National Health Service Corps (NHSC) providers and they are also eligible to participate in the 340(b) Federal Drug Pricing Program (See text box).[25]

FQHCs and look-alikes are required to provide care to any individual, regardless of ability to pay. In addition, FQHCs and look-alikes provide enabling services—outreach, translation, transportation, etc.—that help patients gain access to health care.

The Bureau of Primary Health Care deems a FQHC or an FQHC look-alike as being rural if it notes that it serves a rural population. Based on that standard, more than 4.8 million of the 9.7 million people served by health centers in 2000 were residents of rural communities. In addition, approximately 86 percent of the FQHC patient population is either publicly insured or uninsured.[26] Other analysis using the Office of Management and Budget's (OMB) definition of rural shows that 38 percent of FQHCs are in nonmetropolitan, or rural, counties. The OMB definition, however, is county-based, and fails to capture those FQHCs that are located in urban counties but serve rural populations or those FQHCs in large urban counties that have significant rural populations. It also does not pick up many of the satellite clinics operated by FQHCs on a hub-and-spoke basis. [27]

FQHCS and the Uninsured and Underserved

In recognition of the growing numbers of uninsured and underserved Americans and the declining ability of other providers to continue offering uncompensated care, a bipartisan majority in the Congress have endorsed a plan to double the capacity of health centers over the next five years (2001-2006), through the Resolution to Expand Access to Health Centers (REACH) Initiative. Under the initiative, funding for health centers would be doubled, to more than $2.2 billion annually, over that period. It is anticipated, because of provisions in the Section 330 health centers law, that half of the additional 10 million patients who will be served will be rural Americans. President Bush has also pledged to increase health centers' funding by nearly 70 percent (to approximately $2 billion annually) over the next 5 years, beginning with a $124 million increase in funding for FY 2002. The President's proposed FY 2003 budget includes $1.5 billion for community-based health centers, a $114 million increase.

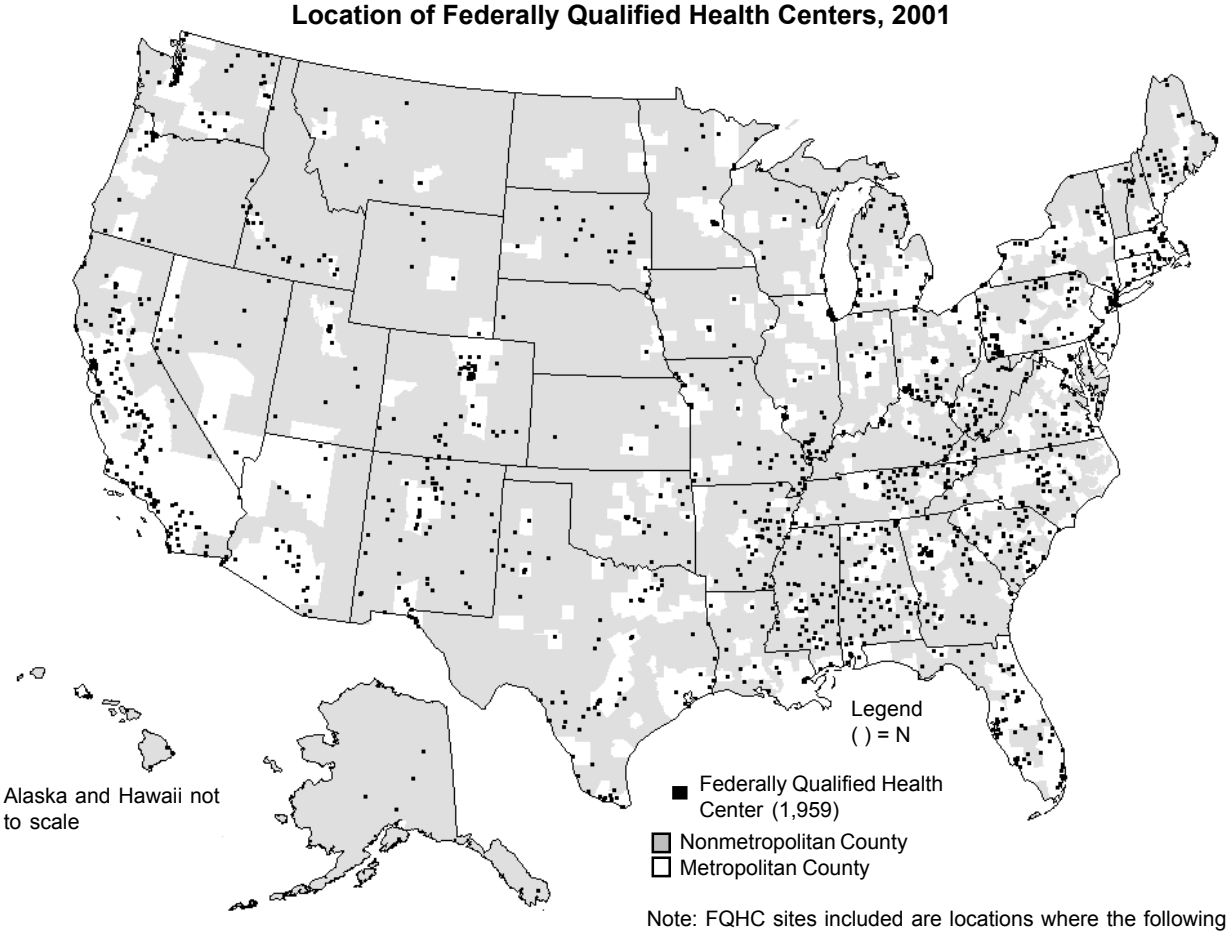
Health Care Shortage Areas

Health care shortage designations are the key targeting devices for Federal health care resources. The two primary designations used by DHHS are health professional shortage areas (HPSAs) and medically underserved areas or populations (MUA/Ps). These designations are based on criteria established through regulation to identify geographic areas or population groups with a shortage of primary health care services. The HPSA designation criteria includes primary medical care, mental health, and dental care. MUA/Ps designation is a prerequisite to requesting grant awards to plan, develop, and operate a community health center under section 330 of the Public Health Service Act.

While the HPSAs are updated on a regular basis, the MUA/Ps have never been updated. DHHS is revising the shortage designation process and issued a preliminary regulation on this in 1998. It was withdrawn, however, because of concerns among various constituency groups, including rural advocates, about its impact on the health care delivery system.

The shortage designation process will have a dramatic effect on the entire health care safety net but perhaps even more dramatically in rural areas due to limited access and the reliance of these communities on programs such as rural health clinics or the HPSA bonus payments that are dependent on shortage designation criteria. While a target date for the next version of the new designation process has not been set, the Committee urges the Secretary to ensure that the revised process does not have a differential impact on rural communities.

Location of Federally Qualified Health Centers, 2001



Note: FQHC sites included are locations where the following federally funded programs were in operation in 2001: Community Health Centers (CHCs); Migrant Health Centers (MHCs); Public Housing Primary Care (PH); Healthcare for the Homeless (HC). Does not include FQHC Look-Alikes.

Source: HCFA Online Survey and Certification Reporting System (OSCAR), April 2001.
Produced by: North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

New Start Applicants

Many rural advocates are hopeful that the increased funding will allow the rural areas without centers to tap into this funding and shore up gaps in local safety nets. FQHCs have long been a key element of the rural health care safety net, particularly in the South and the Southwest. However, there are some rural areas that have not attracted health center funding, particularly the upper Midwest and Great Plains States. This is driven partly by demographics. A clinic must be in a Medically Underserved Area (MUA) or serving a Medically Underserved Population (MUP) to be eligible to be an FQHC. Many of the underserved rural areas in the upper Midwest are more likely to be designated as Health Professional Shortage Areas (HPSAs) than MUAs or MUPs. Another contributing factor has to do with how new applications are scored. The current scoring for new applicants includes measures for demographic factors such as the percentage of minority residents in a service area or the incidence

of infant mortality. Both of those measures tend to be low in many of the upper Midwest and Great Plains States, which can make it hard for applicants from these areas to score high enough on the application to be reviewed for possible funding. Other communities in those areas may have trouble qualifying for funding because of low population in the service area. They may not have enough of a patient base to support a full-service community health center.

Frontier Issues

Some rural advocates believe that some of the administrative requirements for Community Health Centers (CHCs) fail to take into account the needs of sparsely populated frontier areas. The Bureau of Primary Health Care (BPHC), which administers the CHC program, has attempted to address the concern. The Bureau gives special consideration to Community and Migrant Health Center new start applications in sparsely populated rural areas, which are defined as geographic areas with less than seven people per square mile. Applicants that meet this requirement will be assessed separately on the need and project plan requirements. This policy is an acknowledgment that given the low patient volume and other demographic challenges of providing care in frontier areas, it may be difficult for an applicant to meet the same staffing and service mix as standard grantees. As an alternative, the frontier applicants are allowed to propose alternative methods of providing necessary support for isolated providers through networking with other provider groups. In addition, the frontier applicants may request a waiver from the governing board requirements if they can clearly demonstrate why any or all of the governing board requirements cannot be met.

FQHCs and Medicare

Health centers provide care for nearly one million Medicare beneficiaries. In many cases, health centers may be the only source of primary and preventive services to which these underserved beneficiaries have access. Because of this, Congress established the FQHC provider designation and the scope of Medicare-covered FQHC services,[28] and provided reasonable cost reimbursement for these providers in Medicare. Again, in requiring health centers to be reimbursed for their costs, Congress provided health centers with payments sufficient to cover the cost of Medicare services, thereby protecting access to care for the uninsured.

While Federal statute entitles FQHCs to receive their reasonable costs for providing services, CMS applies a payment cap to Medicare payments for FQHCs. Some rural advocates believe this cap undermines the mission of FQHCs because in most cases it reduces FQHCs' payment rates below their cost of providing care. Given the patient-payer mix at FQHCs, some FQHC providers argue that they are forced to subsidize capped Medicare payments with Federal, Congressionally appropriated grant dollars intended to provide care for the uninsured.

Committee Recommendations:

- ***The Secretary should work with Congress to eliminate any financial challenges to FQHCs' providing care to the uninsured by eliminating the Medicare per-visit payment cap.***

- ***The Secretary should work with Congress to increase access to capital and to***

expand eligible uses of grant funds to include construction, renovation, and modernization of health center facilities.

- ***The Secretary should encourage the development of criteria that will increase the number of FQHC sites in rural and frontier areas.***

Rural Health Clinics

Rural Health Clinics (RHCs) were authorized in 1977 and designed to improve access to care for Medicare and Medicaid beneficiaries. The clinics, which receive reasonable cost reimbursement under Medicare, can be either provider-based or free-standing and must be located in a rural area that is either a HPSA or a MUA. There are currently 3,448 RHCs. Approximately 70 percent of the RHC patient population is insured through Medicaid or Medicare.[29]

Uncompensated Care in RHCs

RHCs are not required to operate on a sliding fee scale, although some do. The clinics have done this despite some unintended consequences of the payment mechanism that act as a disincentive for RHCs to see uninsured patients. The problem stems from the so-called "denominator factor." The per-visit payment rate for RHCs is determined by dividing their annual aggregate cost by the number of patients seen. However, the numerator consists primarily of fixed costs (overhead, salaries, etc.); the denominator is, of course, variable. Consequently, as the number of patients seen by the RHC rises, the RHC's average cost (and therefore its per-visit payment rate) falls. Worse, many of these patients cannot afford to pay for services and are not insured—meaning the RHC gets little or no payment at the same time as their reimbursement rate goes down.

RHC Reimbursement Levels

Under current law, RHCs receive an all-inclusive payment rate capped at approximately $63 per visit. This cap does not cover the cost of services for more than 50 percent of rural health clinics.[30] The RHC payment methodology was developed before the introduction of the physician fee schedule and was based on the old customary and reasonable methodology.

Committee Recommendations:

- ***The Secretary should work with Congress to increase the RHC payment limit under section 1833 (f) of the Act to more closely correspond with the increase in payments for primary care services resulting from the full transition to the physician fee schedule.***

- ***The Secretary should amend the reimbursement methodology for RHC payment so that RHCs that 1) are non-profit, 2) see all patients regardless of ability to pay, and 3) elect to use a sliding fee scale do not have to count uninsured patients in determining the aggregate number of patients seen for calculation of the per-visit payment rate.***

Location of Rural Health Clinics, 2001

Source: HCFA Online Survey and Certification Reporting System (OSCAR), April 2001.
Produced by: North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

A Shared Challenge: Medicaid PPS

While the FQHCs and the RHCs face some different challenges in serving a safety net role, they are both affected by the advent of a new prospective payment for Medicaid reimbursement.

RHCs and FQHCs both rely heavily on Medicaid as a source of revenue. Indeed, Medicaid accounts for, on average, one-quarter to one-third of their funds. As such, Medicaid reimbursement policies have great impact on the ability of RHCs and FQHCs to provide safety net care. Unfortunately, recent changes to those policies may penalize some clinics and centers.

The Balanced Budget Act of 1997 allowed States to begin phasing out cost-based Medicaid reimbursement for FQHCs and RHCs with the full phase-out expected to be completed by FY 2003. The Benefits Improvement and Protection Act of 2000 (BIPA) eliminated the cost-reimbursement system by which FQHCs and RHCs formerly received payment from Medicaid, replacing it with a

Prospective Payment System (PPS) effective January 1, 2001. Under PPS, the first year's payment is set at an FQHC's or RHC's reasonable average cost per visit for 1999 and 2000 as defined by each State. Future year's payments are to be adjusted annually for inflation and, if necessary, for changes in the scope of services provided.[31]

According to the General Accounting Office (GAO), the new PPS "is likely to constrain future payments" because in many cases the State-defined reasonable average cost per-visit may be lower than what an FQHC or RHC received in 2000. On top of that, the 2001 PPS rate will not be updated for inflation from 1999 through 2001. Finally, the subsequent annual adjustments will be made using an inflation index independent of individual FQHCs' and RHCs' costs, and increases are likely to be lower than what had been historically provided.[32]

As a result, GAO concluded "an FQHC's and RHC's ability to manage under the new PPS will depend on its initial rate and its ability to keep its cost growth at or below the inflation adjustment. FQHCs or RHCs that, for example, had high per-visit costs when the rates were established, may be able to manage by increasing service volume or find other efficiencies to lower their per-visit costs. FQHCs or RHCs with low initial per-visit costs, however, may be less able to reduce their cost growth."[33]

Committee Recommendations:

- ***The Secretary should work with Congress to conduct strong, ongoing oversight of the implementation of the Medicaid PPS to ensure that States comply with requirements in the Federal PPS statute and that access to FQHC and RHC services are protected.***
- ***The Secretary should work with Congress to evaluate the Medicaid PPS to ensure that FQHCs and RHCs are being adequately reimbursed to protect access to care, including access to care for the uninsured. This includes examining whether the Medicare Economic Index (the current measure of inflation used in PPS) is sufficient to protect Medicaid reimbursement for these critical safety net providers.***

Community Access Program (CAP)

The CAP is a relatively new safety net initiative under the purview of the Secretary. This program seeks to help health care providers coordinate these "safety net" services for uninsured and underinsured Americans. The program builds on the success of some community-based models that looked at ways to reorganize their health care delivery systems to provide better coordinated, more efficient care for uninsured residents. CAP grants are designed to increase access to health care by eliminating fragmented service delivery, improving efficiencies among safety net providers and by encouraging greater private sector involvement. One of the great benefits of the CAP is that it requires applicants to work with their local health departments, thereby formalizing the critical role they play in the rural safety net.

The CAP grantees are not broken down by urban or rural status, but the grantees are allowed to indicate if they believe they are serving rural areas. In FY 2001, the CAP program funded 137 projects, 36 of which served rural or tribal populations and another 45 of which claimed to serve both rural and urban populations.

Committee Recommendations:

- ***The Secretary should work with Congress to formally authorize the CAP program to support efforts by local providers to develop integrated care systems for uninsured and underserved populations and to fully permit and encourage rural communities to participate.***

Charity Care

Some health care providers have complained that Federal regulations may act as a disincentive for providers who want to provide charity care. Medicare rules allow health care providers to offer income-related sliding fee scales as a way of helping low-income patients afford care. Providers may offer them as long as the sliding fee scale is offered to all patients under the same conditions and there is public notice of its availability.

Unfortunately, this scenario may not work for providers. Some providers may mistakenly believe that Medicare rules preclude them from discounting fees for low-income patients. They believe that offering reduced fees would violate Medicare's anti-kickback statute and would amount to fraud. Others would say that what is really needed is the authority to waive fees on a case-by-case basis. The challenge with allowing that kind of behavior is the potential for discrimination against some patients.

Committee Recommendations:

- ***The Secretary should issue an advisory letter that spells out the legality and specific requirements of income-related sliding fee scales and disseminate it widely.***

The 340B Discount Drug Program

One of the glaring holes in the safety net, both urban and rural, is any program that would improve access to care for prescription drugs. Medicare does not include a true prescription drug benefit. Medicaid, however, does cover some prescription drugs. The only other program that addresses the issue of prescription drugs is authorized under section 340B of the Public Health Service Act. The program helps cover the costs of drugs for the uninsured. It requires drug manufacturers to sell outpatient prescription drugs to Federally Qualified Health Centers, Medicaid DSH hospitals and several other specified Federally supported health care safety net providers at a discount, which is currently approximately 15.1 percent below the Average Manufacturers Price.[34] If manufacturers do not agree with HHS to provide the discounts, they face significant penalties. According to some reports, the program has resulted in approximately $1 billion in savings. The program has proven especially valuable to FQHCs, given the high costs of pharmaceuticals and the low-income demographics of these clinics' patient base.[35]

Committee Recommendations:

- ***The Secretary should continue to support and enhance the 340B Discount Drug Program and support Medicare reforms that include access to prescription drugs.***

Maintaining an Adequate Workforce

The safety net depends upon the availability of an adequate health care workforce. Two programs within the Secretary's purview focus primarily on building and strengthening the workforce that serves the rural poor and uninsured.

- National Health Service Corps
- J1 Visa Waiver Program
- Medicare Incentive Payments

National Health Service Corps

The National Health Service Corps was created in 1970 to place health care professionals in areas that lacked access to health care—primarily distressed urban and rural areas. Almost 60 percent of the 2,400 providers in the Corps in 2001 serve in rural areas.[36] About half of the Corps providers are primary care physicians. Therefore, the NHSC can be considered an integral part of the rural safety net.

Under this program, medical personnel agree to serve in these areas for a minimum of two years in return for scholarships or school loan repayment. The role of the NHSC in the rural health care safety net is particularly important because these providers work in underserved areas and are required to see all patients during their placements. Since its inception as a program that primarily supported physicians, the NHSC now supports a range of non-physician providers (such as advanced practice nurses and physician assistants) in primary, oral, and mental health. As mentioned previously, there are few Federal programs that directly address either mental or oral health needs.

The NHSC has been and remains a key rural safety net program. However, the program has also been chronically underfunded at a time when it must also meet an increasingly diverse set of needs.

For fiscal year 2003, President Bush has proposed an additional 32 percent increase in the budget for the NHSC for a total of $192 million, up from $145.5 million this year. The additional resources will result in awards to about 1,800 physicians, dentists and other clinicians who practice in underserved areas.

Committee Recommendations:

- ***The Secretary should propose an increase in funding for the National Health Service Corps at levels sufficient to support the multi-year plan to expand health centers and to meet the pressing needs of other rural areas for health professionals.***

J-1 Visa Waiver Program

International medical graduates (IMGs) are proportionately more likely than U.S. medical graduates (USMGs) to practice in rural underserved areas and are a valuable addition to the rural safety net, shoring up health care systems in areas that have traditionally had trouble attracting physicians. Many of these more than 2,000 IMGs are here under the J1Visa waiver program.

The J-1 Visa allows foreign medical school graduates to pursue postgraduate training in the United States. When training is complete, the graduates must return to their home countries for a period of at least two years. A 1994 amendment to the Immigration and Nationality Act, however, created the J-1 Visa waiver. With a waiver, an IMG may forego the mandatory return to his or her home country and

stay in the United States to practice medicine in a health professional shortage area or medically underserved area. They must serve in such an area for at least three years. At the end of that time, foreign-born physicians may apply for permanent residency status. Interested Federal agencies may also request waivers. HHS requests waivers for research but not service. Early in 2002, the U.S. Department of Agriculture (USDA), which has been a prime sponsor of J-1Visa Waivers for primary care providers, announced that it would no longer issue J-1Visa Waivers. This decision, if it becomes final, will reduce the number of foreign doctors available to serve in rural communities.

Committee Recommendations:

- ***The Secretary should create a focal point within the Department to coordinate the J-1 Visa Waivers issued by all Federal agencies and the communities in which they are placed to ensure that the visa waivers are used to meet patient care needs.***

- ***The Secretary should consider allowing HHS to issue J-1 Visa Waivers for primary care physicians if the USDA declines to continue issuing those waivers. If USDA continues to offer J-1-Visa Waivers, the Secretary should work with the Congress to re-authorize and expand the scope of the Conrad State 20 program to more adequately meet the primary care needs of rural communities.***

Conrad State 20 program

The Conrad State 20 Visa Waiver Program gives States the option of supporting waivers for physicians willing to practice in underserved areas. Under this program, IMGs in participating States can apply to the State health department for a waiver. Participating States can support a maximum of up to 20 waivers a year. All State waiver requests must then be submitted to USIA for review and final approval is issued by the INS Commissioner.

Medicare Incentive Payments

Physicians, especially primary care physicians, are the backbone of the rural safety net. The Medicare Incentive Payments (MIP) offer one of the more direct ways the Federal government encourages physicians to practice in underserved areas and ensure access to care for Medicare beneficiaries. The program, which was created in 1989, offers a 10 percent "bonus" on reimbursements for physicians who provide services to Medicare beneficiaries in rural HPSAs who are covered under Medicare Part B. The program's effectiveness, however, is not without critics. Some say the 10 percent payments are too small to entice physicians to HPSAs.[37] Others feel that the program is quite underused.[38] One rural Medicare expert estimates that the 1998 bonus payments for care provided to rural, whole county HPSA beneficiaries may have been made on only about one-third of the eligible billings. Translated to dollars, doctors collected only $22 million of an estimated $67 million. The reasons for this include physicians' fear of being audited by CMS if they claim the bonus, a lack of help from the

insurance companies who process the bills for Medicare in collecting the bonus, and the fact that some physicians simply are not aware of being eligible.[39] One of the other issues with the MIP is its relevance to specialist care. The GAO in 1999 and the Physician Payment Review Commission (PPRC) in 1994 have both questioned the value of allowing urban specialists to qualify for the HPSA bonus payment. The HPSA designation is a measure of primary care in underserved areas and has little relevance for determining access to specialty care.

Another complaint about the program is that payments may be inappropriately targeted. First, nurse practitioners and physician assistants, who provide significant amounts of primary care in rural areas, are not eligible for bonus payments.[40] Others have noted that another problem with the program is its reliance on a HPSA designation that is considered unstable. They note that the addition of even one physician can remove an area's designation, and because a physician's willingness to remain in the area can hinge on receiving the bonus payment, the uncertainty of HPSA designation may work against keeping doctors in underserved areas.[41]

Committee Recommendations:

- ***The Secretary should work with the Congress to increase the amount of the Medicare Incentive Payment to 20 percent.***

- ***The Secretary should work with the Congress to allow nurse practitioners and physician assistants to qualify for the Medicare Incentive Payments.***

- ***The Secretary should work with the Congress to eliminate Medicare Incentive Payments to urban specialists.***

- ***The Secretary should change the current auditing procedures used by the Medicare Contractors to ensure that providers who claim the Medicare Incentive Payment will not have any greater likelihood of being audited than providers who do not claim the extra payment.***

Mending the Net, Extending the Net

Although the examination and Committee recommendations contained in this report have by necessity dealt with discreet, individual issues related to existing Federal statutory authorities, none of them exists in isolation. The rural safety net is after all a net—intertwined, interwoven, interdependent.

Because of this interdependence, deterioration in one part of the system adds stress to other parts and ultimately contributes to their deterioration. Without an adequate workforce, it is difficult to maintain access to primary care or to stabilize rural hospitals. Absent hospitals, it is difficult to attract and retain an adequate health care workforce.

The reverse, however, is also true. Mending one part of the net will in all likelihood strengthen other parts of the net. For example, strengthening the workforce will help improve access to primary care. Stabilizing rural hospitals will improve access to primary care and help retain an adequate workforce as well as to the benefit of the community. The payoff, therefore, to any one fix will multiply. As a result, though the issues raised in this report are in one sense discreet and require focused attention, they cannot be considered in a vacuum.

Likewise, while this report has taken a targeted look at existing authorities under the purview of the HHS Secretary and made recommendations to mend those authorities where necessary, the Committee urges in the strongest possible terms that efforts to improve the rural safety net not be restricted to simply mending. That is not enough. The net must also be extended.

This report has discussed the strands of the net which help ensure access to hospital services, ensure access to primary care, and maintain an adequate workforce. However, the Committee believes there are a range of ancillary issues that are also critical not only to the safety net but the broad health care delivery system. These support strands would

- ensure access to mental and oral health services;
- improve and expand the services of local public health departments;
- recognize and account for the uncompensated care provided by hospitals, free clinics and physicians;
- provide the capital necessary to build and maintain facilities;
- extend care to isolated and underserved areas;
- increase health insurance coverage; and
- provide affordable access to prescription drugs
- increase access to transportation
- improve reimbursement mechanisms to compensate for lifestyle and behavior change to improve health status

Extending the net will cost money. In many cases, the cost will be borne by the Federal government because extending the safety net offers little if any profit incentive. That does not, however, mean that money spent on extending (or mending) the rural safety net should be viewed as subsidy.

While the equitable treatment of rural citizens by the

Federal government is certainly a worthy endeavor, such spending represents more than an attempt to provide equity. It represents an investment on several levels. It is an investment in a healthy, productive workforce. It is an investment in local economies, in which the health care sector is generally one of the largest employers and which cannot attract and retain other economic activities absent adequate health care. Finally, it is an investment in prevention against the enormous costs—monetary as well as social—of both untreated illness and the isolation and decline of rural communities that lack adequate health care services.

Extending the net will require the efforts of many Federal agencies, Congress, State and local governments and the private sector; HHS cannot extend the net on its own. As a result, coordination will be critical. Therefore, as a final recommendation, the Committee recommends that the Secretary of HHS, as part of his rural initiative, convene an intergovernmental, interagency group to examine ways to mend, modify and extend the rural safety net. In so doing, the Committee urges that the rural safety net not be viewed merely as a last ditch effort to catch those who have fallen, but rather as what it truly is: a support structure undergirding the health of rural Americans and of rural America.

Endnotes

[1] Institute of Medicine, *America's Health Care Safety Net: Intact but Endangered*, National Academy Press, 2000; Ormond, B., S. Wallin, and S. Goldenson. *Supporting the Rural Health Care Safety Net.* Occasional Paper Number 36. Assessing the New Federalism. The Urban Institute. March 2000; Kaiser Family Foundation, *Access to Health Care: Promises and Prospects for Low-Income Americans,* Kaiser, August 1999.

[2] From definitions by the Institute of Medicine and Ricketts et al.

[3] Ricketts, T., R. Slifkin, and P. Silberman, "The Changing Market, Managed Care and the Future Viability of Safety Net Providers—Special Issues for Rural Providers," *Background Paper for Institute of Medicine*, Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill, November 1998.

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[5] Medicare Reform: A Rural Perspective. A Report to the Secretary, U.S. Department of Health and Human Services. The National Advisory Committee on Rural Health. May, 2001.

[6] Medicare Payment Advisory Commission, *Report to the Congress: Medicare in Rural America*, June 2001, p. 9.

[7] Ricketts et al, p.2.

[8] National Association of County and City Health Officials, *Local Public Health Agency Infrastructure: A Chartbook.* October, 2001, p. 18.

[9] Medicare Payment Advisory Commission, *Report to the Congress: Medicare in Rural America*, June 2001, p. 20.

[10] Ormond, B., S. Wallin, and S. Goldenson, "Supporting the Rural Health Care Safety Net." *Occasional Paper Number 36*, Assessing the New Federalism, The Urban Institute, March 2000, p. 1.

[11] Health Care Financing Review, Medicare and Medicaid Statistical Supplement, 1999.

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[17] Ormond, B., S. Wallin, and S. Goldenson, "Supporting the Rural Health Care Safety Net", *Assessing the New Federalism, Occasional Paper Number 36*, The Urban Institute, March 2000, p. 21.

[18] National Advisory Committee on Rural Health, *Medicare Reform: A Rural Perspective*, May 2001.

[19] HR 2157, "The Rural Health Care Improvement Act of 2001".

[20] MedPAC, p. 80.

[21] Sec. 112 of the Balanced Budget Refinement Act of 1999.

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[23] ibid

[24] Section 1923 (D) of the Social Security Act.

[25] Section 1905(l)(2))B) of the Social Security Act as noted in http://bphc.hrsa.gov/CHC/CHCInitiatives/fqhc_lookalike.asp.

[26] Ricketts et al., pp. 5 and 8.

[27] Analysis by the Rural Health Research Center at the Sheps Center for Health Services Research at the University of North Carolina, 2001.

[28] See 42 USC § 1395(x)(aa). These services include – "(A) physicians' services and such services as are covered under section 1861(s)(2)(A) if furnished as an incident to a physician's professional service and items and services described in section 1861(s)(10); (B) such services furnished by a physician assistant or a nurse practitioner (as defined in paragraph (5)), by a clinical psychologist (as defined by the Secretary) or by a clinical social worker (as defined in subsection (hh)(1)), and such services and supplies furnished as an incident to his services as would otherwise be covered by a physicians or as an incident to a physician's service; and (C) in the case of a rural health clinic located in an area in which there exists a shortage of home health agencies, part-time or intermittent nursing care and related medical supplies (other than drugs and biologicals) furnished by a registered professional nurse or licensed practical nurse to a homebound individual under a written plan or treatment (i) established and periodically reviewed by a physician described in paragraph (2)(B), or (ii) established by a nurse practitioner or physician assistant and periodically reviewed and approved by a physician described in paragraph (2)(B)".

[29] Ricketts et al., pp. 5 and 8.

[30] HR 2157.

[31] General Accounting Office, " Health Centers and Rural Clinics: Payments Likely to Be Constrained Under Medicaid's New System". GAO-01-577, Washington, DC, June 2001.

[32] GAO

[33] GAO, p. 3.

[34] Public Law 102-585, the Veterans Health Care Act of 1992.

[35] Health Resources and Services Administration's Office of Pharmacy Affairs web site. http://www.hrsa.gov/odpp.

[36] NHSC Data Collection.

[37] MedPAC, p. 35.

[38] RAND study

[39] *Rural Health News*, Summer 2001.

[40] MedPAC, p. 35.

[41] ibid