RURAL HEALTH CARE ISSUES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

SECOND SESSION

SEPTEMBER 12, 1996

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HEARING ON RURAL HEALTH CARE ISSUES

THURSDAY, SEPTEMBER 12, 1996

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:06 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisories announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
September 5, 1996
No. HL-23

CONTACT: (202) 225-3943

Thomas Announces Hearing on Rural Health Care Issues

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on rural health care issues. **The hearing will take place on Thursday, September 12, 1996, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 9:30 a.m.**

Oral testimony at this hearing will be heard from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

One-quarter of the U.S. population, about 65 million people, reside in rural areas. Assuring access to health care services in rural areas is an important component of national health care policy. Rural communities have unique characteristics and special needs which pose certain challenges to providing health care services. In general, rural communities have higher concentrations of elderly persons, higher levels of poverty, and higher unemployment than urban areas.

Nearly half of all general hospitals in the United States are located in rural areas. Many of these hospitals face financial pressure as a result of declining economies. Many rural hospitals have closed while many rural areas continue to experience shortages of primary care physicians and other health care professionals. Existing physician shortages are expected to grow worse as many of these rural providers retire -- almost 20 percent of physicians practicing in rural counties are over age 65.

States are heavily dependent on the Federal Government for assistance in maintaining and enhancing rural health care resources. These rural resources include personnel as well as maintaining the capital investment in the rural health care infrastructure. Providers in rural areas are also very dependent on the existence of Federal health insurance programs such as Medicare for the financing of health care in their communities.

The Federal role in rural health is carried out primarily through four different types of programs. These programs include: (1) health care financing such as the Medicare and Medicaid programs which pay directly for health care services; (2) health block grants which allocate funds to States to spend on any variety of programs in a general topic, which include the Maternal and Child Health block grant, and the Preventive Health and Health Services block grant; (3) Federal programs for which enhancing rural health resources is an explicit goal, such as the National Health Service Corps, Community and Migrant Health Centers, and the Rural Health Care Transition Grant program; and (4) the coordinating, undertaking, and funding of research on rural health topics.

Congressional concern over the special health care needs in rural areas over the years has prompted the creation of numerous programs designed to address some of the special needs of rural communities. Congress has created programs, demonstration programs, and studies aimed at ensuring continued rural access to health care. These programs are authorized under Medicare, Medicaid, the Public Health Service Act, and the U.S. Department of Agriculture.

FOCUS OF THE HEARING:

This hearing will focus on these Federal programs and demonstrations created to address the special needs of rural communities. The hearing will specifically highlight the programs operated under the Medicare program, while providing an overview of the many programs that currently exist in other areas of the Federal Government. Key issues include the lack of health care resources in rural America, trends in the delivery of medical care in rural America, and the coordination of rural health initiatives specifically targeting rural health needs or predominantly serving rural areas under the Medicare programs as well as the Public Health Service programs.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Thursday, September 26, 1996, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are now available on the World Wide Web at 'HTTP://WWW.HOUSE.GOV/WAYS_MEANS/' or over the Internet at 'GOPHER.HOUSE.GOV' under 'HOUSE COMMITTEE INFORMATION'.

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NOTICE -- CHANGE IN TIME

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
September 11, 1996
No. HL-23-Revised

CONTACT: (202) 225-3943

Time Change for Subcommittee Hearing on Thursday, September 12, 1996, on Rural Health Care Issues

Congressman Bill Thomas, (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee hearing on rural health care issues previously scheduled for Thursday, September 12, 1996, at 9:30 a.m., in 1100 Longworth House Office Building, **will begin instead at 10:00 a.m.**

All other details for the hearing remain the same. (See Subcommittee press release No. HL-23, dated September 5, 1996.)

* * * * *

Chairman THOMAS. The Subcommittee will come to order. This morning's meeting will focus on rural health care issues and the effectiveness of Medicare demonstration programs, reimbursement modifications, and block grants under the Public Health Service in providing assistance to rural communities.

A number of us, including myself, represent rural areas. Mine is largely dependent upon agriculture. There is a shortage of providers, as is usually the case, and I therefore understand the importance of providing assistance to rural communities.

I just make note of the fact that in working with the Justice Department's newfound flexibility after the passage of the most recent health insurance legislation dealing with antitrust provisions. We have been able to secure a waiver for Ridgecrest, California. It would be interesting to you only that it is a community of 42,000 people with one hospital and the nearest acute care hospital is over 100 miles away. That is stretching the rural definition and that is why I often want to talk about frontier rather than rural.

But, this hearing gives us the opportunity to highlight the major problems facing rural America regarding access to quality health care and will provide us with direction on how to best address these issues.

It is noteworthy that there have been a number of initiatives over the past decade which try to address these access issues. Some of them have worked; others have not. What these initiatives have done is provided us with insight and guidance on what direction to take in the future with regard to these rural health care programs.

I think, we need to stop and think of our goals. To me, it is to bring access to health care to rural communities rather than to enable financially strapped hospitals to remain open in rural communities. If we can do both, so much the better.

The Subcommittee welcomes Representatives Steve Gunderson and Glenn Poshard, the cochairs of the House Rural Health Care Coalition, to our hearing this morning and we welcome their testimonies on these important issues. And I might add, that for years Pat Roberts, our colleague who is attempting to move over to the Senate, has also been extremely interested and involved in, these areas.

Additionally, I would like to express my appreciation to Harry Foster, chief operating officer of the Family HealthCare Network, who comes from Porterville, California, in my district. He has a unique perspective on bringing quality health care to a rural community that, in a microcosm, represents virtually all of the problems in terms of economic level, language barriers, and distance that we are focusing on.

[The opening statement follows:]

OPENING STATEMENT OF HON. BILL THOMAS

This morning's hearing will focus on rural health care issues and the effectiveness of Medicare demonstration programs, reimbursement modifications, and block grants under the Public Health Service in providing assistance to rural communities. I represent a rural area largely dependent on agriculture with a shortage of providers, so I understand the importance of providing assistance to rural communities.

This hearing gives us the opportunity to highlight the major problems facing rural America regarding access to quality health care, and will provide us with direction on how best to address these pressing issues. It is noteworthy that there have been

a number of initiatives over the past ten years which try to address these access issues. Some of them have worked; others have not worked. What these initiatives have done is provide us with insight and guidance on what direction to take in the future with regard to these rural health care programs. Most importantly, we need to stop and think if one of our goals is to bring access to health care to rural communities or is it to enable financially-strapped hospitals to remain open in rural communities.

The Subcommittee welcomes both Representatives Gunderson and Poshard, the Co-chairs of the House Rural Health Care Coalition to our hearing this morning, and we welcome their testimonies on these important issues.

Additionally, I would lie to express my appreciation to Harry Foster, the Chief Operating Officer of Family HealthCare Network has made the long trip from Porterville, CA to provide his unique perspective on bringing quality health care to a rural community.

Now, I would like to turn to the ranking member of the Health Subcommittee, Representative Pete Stark for his opening records.

Now, before I recognize our colleagues, I will ask the gentleman from California, the Ranking Member, Mr. Stark, if he has any comments he wishes to make.

Mr. STARK. Thank you, Mr. Chairman.

I claim very little rural area in my district, but I would claim, along with our former colleague, Mr. Gradison, the authorship of EACH, Essential Access to Community Hospitals and PCH, the Primary Care Hospital Programs and many programs during the past 10 or 12 years to aid rural hospitals and rural medical delivery.

But, it would be fair to comment that the difference between a rural hospital not having as much margin or profit as it would like and closing is great. Quite frankly, very few rural hospitals have closed in the past 10 years. In the State of Wisconsin, for example, the last study we have, unfortunately, is 1988 to 1993, there were three or four hospitals that closed. None in Illinois closed in that period of time.

I am afraid that what is more the problem, and I understand this is the same problem we had in Wisconsin, in the thirties, before Mr. Gunderson was there, when the Kindergarten through grade 12 schools consolidated into regional high schools. It was a good idea but everybody wanted the regional high school in their town. Crandon wanted the high school, Leona did not get it and there was hell to pay. We have that same problem. There has never been a hospital in Leona, and they have a big lumbermill there that cuts off lots of hands and feet and the injured go to Rhinelander. That has been the way for a long time.

There is a local political inertia here to us doing what would be best, and in many cases, that means consolidating because so many of the rural hospitals are of such a size that they cannot afford the modern equipment that you have to have. A 10-bed hospital cannot afford a CAT scan or an MRI machine.

So there are a lot of things that we could do, but we do come up against local pride. I understand that. I am sure Chairman Thomas understands it. Our hope has always been that the Rural Caucus could, in the broad sense, help us with that.

I am going to ask that my two colleagues take a look at this fairly short study, the 1993 study by, I think, the OIG on rural hospital issues and give me some comments on it. We will continue, I think, on this Subcommittee to try and help. But, it is interesting to note that in the rural hospitals that closed, and this is in the

period of 1987 to 1991, three-quarters of those communities had another acute care hospital within 20 miles and there were emergency care facilities available to 82 percent of those communities within 20 miles, and that 20 miles gets to be less and less of a burden as we get more highways and more modern transportation.

So we will try, I am sure, on this Subcommittee to do what we can, but my plea to the Rural Caucus has always been to figure out a way for us to get offstage. Some hospitals will have to what is called consolidate or change to become more of a skilled nursing facility and less of an acute care facility. What we have to figure out is a way to make them proud to do it and not get into this fight where there are six little local communities in each of your districts and each one wants to have the facilities of a 100-bed hospital but they cannot afford it.

So we have a political problem that you can help us—it is not partisan, it is geographic—to solve. I am sensitive to the fact that when it is in your district, it is a big problem, and when it is in the other guy's district, it gets very academic. But, your help in that regard would help this Subcommittee take the limited resources we have and more fairly distribute them.

Thank you, Mr. Chairman.

Chairman THOMAS. With that admonition, in a bipartisan way, I would ask either of you gentlemen to address us in whatever manner you see fit to focus on what I and the Ranking Member had to say.

STATEMENT OF HON. STEVE GUNDERSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN; ON BEHALF OF THE RURAL HEALTH CARE COALITION

Mr. GUNDERSON. Thank you very much, Mr. Chairman, and I want to thank you for allowing myself and Mr. Poshard to testify on behalf of the Rural Health Care Coalition. This is a bipartisan group of over 100 members dedicated to improving the access and health care in rural areas.

I think the opening statements of both of you are, frankly, moving in the right direction, and I think you will find a lot of support from both of us, from the Rural Health Care Coalition and from the legislation we are advocating, which is trying to, frankly, recognize realities, give these local institutions the flexibility they need to change their mission in order to operate under a very different environment today than they have had in the past.

This Subcommittee and this Full Committee has been very patient with the Rural Health Care Coalition, as we have been here before asking for things, as you all well know, especially in the area of Medicare reimbursement formulas. To the credit of this Subcommittee, you have responded in kind with some very strong, positive legislation that was included in the Balanced Budget Act, as you all know. I will not go into that in the interest of time today, but I want to thank you for that. Unfortunately, as we all know, that legislation was vetoed, so we are back here again today looking at a different approach.

It was in June of this year that we introduced H.R. 3753, the Rural Health Improvement Act which is a consensus bill that tries to deal with these issues one more time. I will talk about limited

service hospital designations and networking, whereas my colleague will talk about the rest of the bill in depth.

As you both have articulated, in rural America, 25 percent of our population faces a very different kind of delivery system than suburban and urban America. Most importantly, however, you cannot make changes in this area unless you deal with the reality of Medicare reimbursement. In rural health care facilities, someplace between 50 to 70 percent of our rural hospital revenue comes from Medicare. So we have to deal with eligibility for Medicare in the process of dealing with flexibility, and this really is the key, gentlemen.

Number one, we have to allow rural America and rural hospitals to respond to the changing realities of the marketplace in their communities. However, in doing so, it is essential that we allow them to remain Medicare eligible because otherwise they simply economically cannot make those changes and survive.

I would point out to Mr. Stark that, yes, the hospital in my hometown is still open. It is open, frankly, because the city council is subsidizing it, because it simply cannot survive on its own. Until we can give that community, and they keep asking me every year, you keep telling us you are going to do this and it never gets done. Until we give them the flexibility to respond to the economics and the realities of that geography, they simply cannot shut down the existing facility because they will then lose the emergency room and they will lose those lifesaving, stabilizing elements which are essential before patients can be moved to the more urban areas.

I hate to tell you this, but I have had a coroner in my district recently indicate that there was a person who died in my district because they could not get them to an emergency room in time to get them stabilized. Frankly, that was in an area not far from home where a rural hospital was closed during my time in Congress. This is unacceptable in the nineties, I think we would all agree. That is why we are trying to respond.

What are we suggesting? We are suggesting a number of measures which we believe are flexible in nature and, frankly, very low cost. As you all know, H.R. 3753 is paid for, so we are not coming here asking for new money or anything of that sort.

First, we want to advocate something known as rural emergency access care hospitals. What is this? It would be a limited designation to allow a rural hospital to downsize to an emergency room facility with a 24-hour limit on inpatient care. A REACH facility would be designed to stabilize patients until they can move to a full-service facility.

That kind of a vehicle would allow my hometown to become a 24-hour acute care clinic with an emergency room. That, we can financially maintain, and that will serve the needs of my community. But we cannot do that today, because, frankly, the present definition does not allow that to happen. So those are the kind of changes that we need.

The second change——

Chairman THOMAS. Excuse me. Can those acute care clinics be staffed with paramedics and physician assistants?

Mr. GUNDERSON. The criteria is that a physician has to be on call and available over the telephone.

Chairman THOMAS. On call?

Mr. GUNDERSON. Right. That is the criteria that we have established in the legislation itself. There would also have to be a written affiliation with a nearby full-service hospital to coordinate the needs, after stabilization. We also have a criteria from a funding mechanism that this has to be the sole provider in that community so that we are not getting into any kind of overlap or duplication, and a midlevel practitioner must be on site at all times. So those are the four criteria we have articulated in the legislation.

A second designation is a little bit broader, the rural primary care hospital. This designation, much like the critical access hospitals provisions that were passed as a part of the Balanced Budget Act. It would consolidate existing limited service reimbursement demonstration programs, EACH/RPCH, you are all well aware of those, to allow HCFA a more streamlined process, similar to the RPCH that I just mentioned, however, a bit more broad. HHS could designate a RPCH under these new circumstances if it found the hospital was located in a rural area more than 20 miles from another hospital or certified by the State as being a necessary provider of health care, makes available 24-hour emergency care, has no more than 15 acute care inpatient beds, provides inpatient care for a period not to exceed 96 hours.

So this is just one step above the REACH, requiring a State certification that this must be done in order to make inpatient care available for those who need it. So we have tried to deal with the two realities of rural America as we have seen them.

Let me quickly move on, in the interest of time. You all would, I am sure, not like me to spend a lot of time on AAPCC reimbursement because I know we are not going to get into those changes yet this year.

But, I do want to articulate quickly one other issue that we are trying to deal with that is a problem for us as we deal with the appropriation bills, and that is the whole transition and networking process. Rural America is trying to do what both of you have articulated. That is to downsize, to network, to outreach, and so forth.

The problem is, as you know, our outreach and transition grants have not been reauthorized. As a result, neither the House or Senate appropriations Subcommittees will fund them. They have both articulated to us that if these were authorized, the money would be there and they would fund them, but they simply, as you know, are not going to fund unauthorized programs.

I could go into at length, as my written statement does, the experience we have had just in Wisconsin in responding to this area. How have we tried to deal with this? We have tried to deal with it in the interest of streamlining by simply creating a new grant program established under this bill which would provide a planning grant for underserved areas. These would be 3-year grants to States to develop networking plans for chronically underserved rural areas. We would provide technical assistance grants or we would provide development grants for networks with limits and very strict criteria on each of these particular areas.

I will conclude my remarks there, Mr. Chairman, and simply turn it over to Mr. Poshard for the remainder of our testimony.

Mr. Poshard.

[The prepared statement follows:]

STEVE GUNDERSON
...DISTRICT, WISCONSIN

MEMBER
AGRICULTURE COMMITTEE
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Congressman Steve Gunderson

Testimony Before the Subcommittee on Health

House Ways and Means Committee

September 11, 1996

Statement Summary

Thank you, Mr. Chairman, and Mr. Stark for providing me and my colleague Glenn Poshard with the opportunity to testify before you today. As you know, Congressman Poshard and I serve as Co-chairs of the House Rural Health Care Coalition, a bipartisan organization of over one hundred members with a keen interest in rural health issues.

Just over a year ago, I sat before you as we considered changes to Medicare in the context of a balanced budget. I am pleased that with your help, Mr. Chairman, the Medicare portion of the Balanced Budget Act included key provisions to provide for a flexible rural health infrastructure and to attract qualified personnel to underserved areas. Unfortunately, we were unable to get the package signed into to law, and we must come back again, with a similar, but slightly different approach.

As you know, on behalf of the Rural Health Care Coalition, I introduced the Rural Health Improvement Act of 1996, H.R. 3753, in late June to address rural health issues. While I will discuss all parts of the bill in context of the needs of rural communities, the key to the future of rural health is medicare-eligible reimbursement. Consider these statistics:

- Twenty-Five percent of the United States population lives in rural areas.
- The Rural health infrastructure varies greatly by state and geographic location. This makes developing comprehensive rural health legislation difficult.
- Rural residents are more than twice as likely as their urban counterparts to travel more than 30 minutes to reach their usual source of care. This is partly due to dwindling local providers and the influence of managed care.
- Medicare represents between 50 and 70 percent of rural hospital revenue. However, with limited exceptions, only full-service hospitals are eligible for Medicare reimbursement.
- In Wisconsin, hospitals receive only 88% of their costs of providing service. That number is projected to drop to 86% by the year 2000, under current law.

What inferences can we draw from these facts? The mechanisms of providing health care are changing, just as rural demographics are changing. Many rural hospitals need to eliminate excess capacity to stay in business. The role of Congress is clear: (1) Congress must provide the flexibility necessary to allow rural hospitals to respond to these changes by assuming limited service roles. (2) Given rural hospitals' dependence on Medicare, once Congress provides flexibility, we must ensure that the

downsized facilities continue to remain eligible for Medicare reimbursement. Although I understand that changing reimbursement formulas outside of Medicare reform is not likely, we should provide for medicare eligible limited service hospitals as soon as possible.

My home town hospital provides a good example of why flexible hospital designations are necessary. The Osseo Area Hospital is struggling to stay afloat. Many area residents are members of HMOs, where the provider is at least one-half hour away and as far away as a two and one-half hours drive. Obviously, I support the movement toward more cost-effective health care. However, what do residents in and around Osseo do when immediate emergency service is needed? For now, they can go to the Osseo Hospital. But as the utilization rate of the hospital continues to drop, Osseo must downsize.

Two New Limited Service Hospitals

As part of the Rural Health Improvement Act, we have constructed two limited service designations which preserve a local emergency room without maintaining long-term inpatient services. One is the Rural Emergency Access Care Hospital, which was included in the Balanced Budget Act. The other, the Rural Primary Care Hospital is a variation of the Critical Access Hospital section that was included in the Balanced Budget Act.

Rural Emergency Access Care Hospitals (REACH) -- This is a more limited designation which provides the Department of Health and Human Services to waive the Federal Medicare conditions of participation to establish a limited service category hospital for facilities in danger of closing due to low inpatient utilization rates and net operating losses. Conversion to a REACH facility could occur if the Secretary finds:

1) Access to critical services would be severely limited to residents in the community if the sole community hospital were to close or closes;

2) There is a written affiliation with a nearby full service hospital to coordinate patient referrals and other service needs;

3) a physician is available by telephone and is on-call to provide emergency services.

4) a mid-level practitioner is on site 24 hours.

REACHs would only be allowed to keep patients for a maximum of 24 hours. The intent is to have an emergency facility stabilize patients and then transport them to a full-service facility. The only exemption is where bad weather prevents immediate transport to a full-service facility.

Rural Primary Care Hospitals (RPCH) -- this designation would allow for a consolidation of existing limited service reimbursement demonstrations, while providing a slightly extended version of the REACH. The idea is very similar. The Department of Health and Human Services could designate a Rural Primary Care Hospital if it found the hospital:

1) Is located in a rural area that is:

   - more than a 20-mile drive from a hospital or another facility
   - is certified by the State as being a necessary provider of health care services because of local geography or service patterns.

2) Makes available 24-hour emergency care.

3) Provides not more than 15 acute care inpatient beds.

4) Provides inpatient care for a period not to exceed 96 hours.

5) Each Rural Primary Care Hospital must have an agreement with at least 1 other hospital for patient transfer, electronic data, telemetry and emergency/nonemergency transportation between the facility and the hospital.

Although the Rural Primary Care designation allows for an extended time of patient stay over the REACH, it does provide for an increased incentive for rural hospitals to network. It is broad enough to encompass the EACH/RPCH program and the Medical Assistance Facility (MAF) program to fall under an umbrella designation, reducing the bureaucracy required to administer these programs. This is always useful at a time we are trying to balance the budget.

AAPCC Adjustment: An Issue of Fairness

It is difficult to discuss hospital designations without making mention of actual reimbursement formulas. Many of you are familiar with the Average Annual Per Capita Cost formula, used to set the monthly payment rates. I realize that this issue is more properly considered within the context of comprehensive Medicare reform, but I believe it is so important that I need to mention it briefly.

The AAPCC formula is used to set monthly payment rates for Medicare managed care providers. Although managed care will not reach all rural areas, we must even out the disparities in the capitation rate if we expect managed care to appear in any rural communities.

The numbers say it all:

- The 1996 Highest payment, in Richmond, NY = 758.53
- The 1996 National Average = $400
- 1996 Lowest Wisconsin County (in my district) Vernon County = $237.09

- 1996 Lowest Payment, in Fall River, SD $207.31

By correcting these disparities in a revenue neutral fashion, we can ensure that managed care, especially preferred provider organizations, begin to take root in rural areas.

Rural Health Network Grants: Creating Economies of Scale

Mr. Chairman, another mechanism to bring managed care into rural areas more quickly is to provide limited support for rural health networks. Because rural health infrastructures vary so widely among states and geographic areas, there is no set definition of what is included in a rural health network. However, the concept behind a network is to develop a consortium of doctors, full or limited service hospitals, rural health clinics and other rural health providers and link them together. The purpose behind the network grant section of the Rural Health Improvement Act is to provide a federal incentive to plan and implement such networks.

The network grants would replace the Rural Health Outreach and Transition Grant programs that have served rural america well over the years. However, the authorization for these programs has long run out, and no new grants were funded in FY 1997 in the House. Especially in latter years, a portion of both outreach and transition grants have gone for networking purposes.

In my state, many of the Rural Health Transition Grants have been used to develop innovative networks among the state's rural areas. For example, Berlin Hospital Association used a Transition grant to plan and implement a spoke and hub network with the Hospital acting as a hub and four affiliated clinics providing outreach services. Eagle River, Reedsburg and Tri-County Memorial Hospitals received a grant to develop a new type of coordinated health provider, the Rural Medical Center. An Oconto Memorial Hospital and Bay Area Medical Centers used a grant to develop a rural health network plan and implement the network.

The rural health network grants in H.R. 3753 are based on the concept that in an era when managed care is taking over, rural areas need limited federal assistance, along with state and local assistance, to secure coordinated delivery systems. In keeping with the notion of state-based solutions, the Rural Health Improvement Act provides a system of three grants to mirror the basic phases of designing and implementing a network: planning, technical assistance and implementation grants.

A. Planning Grant for Underserved Areas Under this grant, states designate chronically underserved areas based upon criteria set by the Secretary. Chronically Underserved Areas are determined by a lack of basic health care providers for local residents and a lack of assistance from other private, state and federal sources. The grant is used to plan a rural health network.

These grants provide for 3-year grants, 100%, 50% and 33% each year, not to exceed $100,000 per year.

B. Technical Assistance Grants for Networks -- Provide technical assistance for a state or a consortium of three entities within a proposed network.

These grants are 1-year, $50,000 per grant area.

C. Development Grants for Networks -- This is a 3-year, $250,000 per year limit grant for the development and implementation of a rural health network. The Department of Health and Human Services is directed to give priority to entities with a comprehensive network plan. The purpose is to allow rural health clinics, hospitals, physicians and other providers to network.

We believe that these grants will provide a boost for the physical development of managed care in rural areas. In fact, these grants are an extension of the networking grants that were part of the Critical Access Hospital section in the Balanced Budget Act.

Personnel -- an Essential Rural Resource

Mr. Chairman, it may seem a bit ironic that at a time we are trying to downsize the rural health infrastructure we are also providing incentives to attract qualified personnel. This should not be all that surprising. Few medical programs are located in rural areas, and few rural areas offer the latest techniques or the newest technology. In order to provide an incentive to practitioners, the National Health Service Corps (NHSC) provides scholarships and loan repayment assistance to those who agree to serve a Health Professional Shortage Area for two years in return for each year of scholarship or loan repayment.

Prior to the 1986 tax reform act, the Scholarships and loan repayments did not count as part of NHSC members gross incomes. However, following 1986, with the great increase in student debt load, it has become obvious that including these amounts in gross income provides a significant barrier to participation. In fact, the tax burden to a professional student could be up to 39 percent of the annual amount

awarded, effectively reducing the value of the scholarship by 39 percent. If the federal government has decided that providing the incentive through a scholarship is a priority, why should it blunt that incentive through taxes? Obviously, we are in an era of declining appropriations, but we must make the best use of limited resources.

The Rural Health Improvement Act of 1996 would exempt both scholarships and loan repayments from income, thereby allowing the full effect of those amounts to be used by the medical professionals. The bill also requests that the Secretary conduct a study of allocation of Corps members among shortage areas and to grant priority in assigning members to areas planning or implementing a rural health network.

The bill would also increase the Health Professional Shortage Area (HPSA) bonus payment from 10 percent to 20 percent. Hospital administrators and other health professionals believe strongly that an increased bonus payment is the key to attracting full-time professionals to rural areas.

Rural Health Center Grants

The geographic diversity of the United States means that not every program will work for every area. Community Health Centers (CHCs) have served the country well. Unfortunately, CHCs are not located in many areas. For that reason, the Rural Health Improvement Act allows the Secretary of Health and Human Services to give priority in making new health center grants to a project where a CHC is not already located. The bill then makes a provision for health centers located in or adjacent to a community hospital. The rationale here is simple. Most areas that do not have CHCs, have community hospital. Distributing new grants to downsizing hospitals ensures continued rural health access.

Antitrust

A quick word about antitrust. The RHCC has been very concerned about the heavy handed approach of the Justice Department and the Federal Trade Commission toward hospital mergers and networking. Last month, these agencies jointly released a new, more flexible approach toward these combinations. The full effect of their promise to provide "more flexible antitrust treatment" has yet to be analyzed, but represents an important first step toward providing the flexibility our rural
areas need.

Conclusion

On behalf of my colleagues in the RHCC, I again thank you for holding this hearing, Mr. Chairman. In closing I would stress that access to health care in rural areas should not be underemphasized. While people are certainly more mobile today than they were thirty years ago, there is a limit to how far people will travel, especially among the older rural populations. As we move toward the finale of the 104th Congress, I urge the Ways and Means Committee to consider the proposals that we have laid forth in the Rural Health Improvement Act of 1996, and to work with the RHCC to provide access to care and a flexible rural health infrastructure as quickly as possible.

Chairman THOMAS. Thank you very much, Mr. Gunderson.

STATEMENT OF HON. GLENN POSHARD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS; ON BEHALF OF THE RURAL HEALTH CARE COALITION

Mr. POSHARD. Mr. Chairman, Members of the Subcommittee, I, along with Congressman Gunderson, want to thank you for holding this hearing. As co-chairman of the Rural Health Care Coalition, it has been a pleasure working with this Committee over the years on the many health care issues that affect our Nation.

I represent a district in Central and Southern Illinois, a rather large rural district, one that is almost exclusively rural, in fact, and during my travels throughout the district, I witness all kinds of distresses that Steve articulated on our rural health care system today, from communities without the services of a primary care physician or an OB/GYN to small hospitals facing closure due to their increasing dependence on Medicare and Medicaid reimbursements. The distress in our rural communities in terms of trying to ensure quality and affordable and accessible health care services is greater, I think, than it has ever been.

Of the 2,100 rural communities or rural counties, in this nation, 1,400, that is fully two-thirds, are in federally designated primary care provider shortage areas. This number should not be surprising, because only 16.5 percent of our primary care providers choose to practice in rural areas. Additionally, over 400 rural hospitals have closed, with many facing the same fate, should we allow a disproportionate share of reductions in Medicare and Medicaid spending to be directed toward our Nation's health care providers, that is, our hospitals and our physicians.

Let me say before I go on that I think every member of our Rural Health Care Caucus realizes that it should be Congress's top priority to balance our Federal budget. I may disagree with some of my colleagues in how we achieve that goal, but I believe it is a goal that all of us on both sides of the aisle have to embrace.

I also understand that in order to achieve a balanced budget, the Congress will have to make some very tough decisions and realign our priorities. However, I also believe that with 22 million Americans living in health professional shortage areas, the closure of 400 rural hospitals across the country in the last 15 years and a significant lack of managed care services available to rural Americans that rural health care has to be a top priority for this Congress and for the country.

Many of our federally funded rural health programs and initiatives are working well and we are obtaining the goals that we set out when we designed them. However, the Rural Health Care Coalition recognizes that we must continue efforts to balance the budget. We must do all we can to get the maximum return for every dollar that Congress appropriates.

For this reason, we introduced the Rural Health Improvement Act of 1996. The legislation includes provisions that not only move rural health care into the 21st century, but reform and consolidate a number of federally sponsored rural health care initiatives.

While I do not believe that managed care is the simple solution that some believe it is to the problems that our rural health care

delivery system currently faces. I do believe it has the potential to increase access of care in rural communities and improve the continuity of care for our rural citizens. However, the introduction of attractive and affordable managed care into rural America depends greatly on our rural communities' willingness to adapt to new and innovative delivery systems and on Congress's willingness to pass legislation that gives incentives for managed care to competitively enter into these markets.

Because the coalition sees the delivery of health care moving in the direction of managed care, especially with regard to Medicare and Medicaid, we included changes to the adjusted average per capita cost in the Rural Health Improvement Act that would have the effect of raising the Medicare capitation rates in most rural areas, thus reducing the current rural-urban differential. While our proposed change is relatively small, we do believe it is a step in the right direction, a step that has to be taken if managed care is to survive in rural America.

It does not seem just to me or even logical that in the 27 rural counties that I represent, when managed care enters into our counties and tries to deliver services, that we get an average cost for a managed care person in Medicare of less than $300 per month per person when just 200 miles away in Cook County in Chicago, that same person gets an average cost of over $530 a month paid on their managed care. How can we expect managed care to move into the rural areas if there is such a differential in our payments between the rural and the urban areas?

There is a question here that has to be addressed, and I know we are not going to do it this year, but I hope next year, when we fully address Medicare reform and include rural health care reform in that, that we seriously take a look at the AAPCC and the way it affects rural areas and the unjust nature of that reimbursement formula.

The Rural Health Improvement Act also works to foster the networking of rural health providers. We believe the rural health care community has a greater understanding of the need and advantages to working together. Whether it is sharing of physician services or medical equipment to communicating through telemedicine, providers are finding that they can offer more quality services in a more cost-effective manner through health care networking.

Mr. Stark, I went through years ago in my rural communities a consolidation of schools, too, and I learned one thing. Every time you talk about consolidating something in rural communities, 1,000 red flags go up because the schools, other things are the glue that hold them together. I learned something pretty simple in that process. If you talk about sharing resources, not as many red flags go up.

We think that, fundamentally, we have to change the approach for hospitals in rural America. We know not every hospital can stay, not every hospital can provide a full range of services. What we are advocating is that hospitals perform the service that they can do well and cost effectively and that we help them with that. We know that some hospitals are going to have to become urgent centers or emergency care centers. They are going to have to convert some unused bed space to long-term care or swing beds.

We know that we are going to have to strike some of the antitrust laws that currently prevent our hospitals from sharing technology or human resources and these kinds of things because those are outdated in our rural areas now. No one is dominating rural health care.

There are many changes that have to come about and we have to do it in a cost effective, efficient way, but it is going to mean the changing role of hospitals. I do not think we have to do away with every hospital but we have to find a way that it fits a particular niche and delivers a cost-effective service to its people. That is our key here, in the next few years, and that is what Steve and I and the other members of the caucus or the coalition have tried to draft.

So, I am going to leave it at that and then hopefully we can discuss some of these things.

[The prepared statement follows:]

Statement
of
Representative Glenn Poshard
19th District of Illinois

September 12, 1996

Chairman Thomas and members of the Subcommittee, along with Congressman Gunderson, I want to thank you for holding this hearing. As Co-Chairmen of the Rural Health Care Coalition, it has been a pleasure working with this Committee on many of the health care issues affecting our nation's rural communities.

I represent a district in central and southern Illinois, the third largest congressional district east of the Mississippi River and one that is almost exclusively rural. During my travels throughout my district, I continue to see the serious problems that plague those trying to meet the health care needs of our families living and working in rural America. From several communities being without the services of a primary care physician or an OB-GYN to small hospitals facing closure due to their increasing dependence on Medicare and Medicaid reimbursements, I witness the distress our rural communities face in insuring quality, affordable and accessible health care services are available to all.

Of the 2,100 rural counties in this nation, 1,400 are in federally designated primary care provider shortage areas. This number should not be surprising as only 16.5 percent of primary care providers choose to practice in rural areas. Additionally, over 400 rural hospitals have closed with many more facing the same fate -- especially should Congress allow an disproportionate share of reductions in Medicare and Medicaid spending to be directed toward our nation's health care providers -- our hospitals and physicians.

Before I go on let me state -- it should be Congress' top priority to balance our federal budget. Though I may disagree with some of my colleagues on how we achieve that goal, I believe it is a goal all of us, on both sides of the aisle, must embrace. I also understand that in order to achieve a balanced budget, this Congress will have to make some very tough decisions and realign our priorities. I believe, however, that with 22 million Americans living in Health Professional Shortage Areas, the closure of 400 rural hospitals across this country over the last 15 years, and a significant lack of managed care services

available to rural Americans, rural health care must be a priority of this Congress and this nation.

Many of our federally funded rural health programs and initiatives are working well and are obtaining the goals we set out upon their design. However, the Rural Health Care Coalition recognizes that as we continue efforts to balance the budget, we must do all we can to get the maximum return for every dollar Congress appropriates. For this reason, the Coalition introduced the Rural Health Improvement Act of 1996 earlier this year. This legislation includes provisions that not only move rural health care into the 21st century, but that reform and consolidate a number of federally-sponsored rural health care initiatives.

While I do not believe managed care is the simple solution to the problems our rural health care delivery system currently faces, I do believe it has the potential to increase access of care in rural communities and improve the continuity of care for our rural citizens. However, the introduction of attractive and affordable managed care into rural America depends greatly on our rural communities willingness to adapt to new and innovative delivery systems and on Congress' willingness to pass legislation that gives incentives for managed care to competitively enter these markets.

Because the Coalition sees the delivery of health care moving in the direction of managed care, especially with regard to Medicare and Medicaid, we included changes to the Adjusted Average Per Capita Cost (AAPCC) in the Rural Health Improvement Act that would have the effect of raising the Medicare capitation rates in most rural areas, thus reducing the current rural-urban differential. While our proposed change is relatively small, we believe it is a step in the right direction -- a step that must be taken if managed care is to work in rural America.

I look at Illinois and the fact that a manage care plan serving a Medicare beneficiary in Cook County, Chicago, would be eligible to receive a monthly capitation rate of $528 -- while at the same time a managed care plan providing the same Medicare services in a number of counties in my district would receive less than $350 a month per beneficiary. There is no question of whether there is a problem in the AAPCC formula that needs to be addressed. In fact, last year both the Republican Budget Reconciliation Act and the Blue Dog Balanced Budget bill made great strides in decreasing the variation in payments. We

must continue our commitment to finding a solution that will allow managed care to offer meaningful and affordable benefits to rural families.

The Rural Health Improvement Act also works to foster the networking of rural health providers. We believe the rural health care community has a greater understanding of the need and advantages to working together. Whether it is the sharing of physician services or medical equipment to communicating through telemedicine, providers are finding they can offer more quality services in a more cost-effective manner through health care networking.

First, our Act provides financial and technical support for planning and developing community rural health networks through a grant program that consolidates a number of current rural health care programs, including rural transition and outreach grants. The Coalition also promotes the formation of health networks in the Medicare Rural Primary Care Hospital designation, which Congressman Gunderson earlier described, by requiring that the designated hospital have an agreement with another hospital for patient transfer and referral, telemetry, sharing of patient data, and emergency services.

The Rural Policy Research Institute stated in its analysis of our Act that "it serves a very important function of targeting limited federal support to the development of network structures in underserved rural areas that will help these areas sustain accessible and financially viable health services." The Coalition believes that with limited federal dollars available, we must use them to assist in achieving the goals leaders in the rural health care community have set for themselves.

The Rural Health Care Coalition commends the work of the National Health Service Corp. -- a program that has been extremely successful in encouraging providers to practice in rural communities. Through its scholarship and loan repayment programs, the Corp. has been able to have a direct impact on the health care services available to many once underserved communities. Studies now demonstrate that a significant number of Corp. participants continue to practice in rural areas after completion of their work requirements. However, because the Corps.' funding is limited, many rural communities continue to express concern regarding the recruitment and retention of physicians and other health care practitioners, especially those providing primary care services.

The Coalition supports allowing for the tax deductibility of payments for National Health Service Corp. scholarships and for payments under the Loan Repayment Program. We believe that the greater financial incentives we give to Corp. members, the more attractive it will be for providers to participate and locate in a rural community.

We also have included in our legislation an increase in the Medicare bonus payment to physicians practicing in rural areas. I recognize the fact that some argue the Medicare bonus payment has not been effective in the recruitment and retention of primary care physicians, but instead specialists have taken advantage of the incentive. I would say the bonus payment has not been as successful as predicted because it is not high enough, nor does it target primary care providers who are needed by our communities the most.

Our legislation increases the Medicare bonus payment to 20 percent, and more important limits the payment to primary care services provided by not only physicians, but physician assistants, nurse practitioners and nurse midwives. While we limited the scope of services that were eligible for the payment to primary care, the Coalition recognized the need for other levels of providers to deliver primary care to those in rural areas. Additionally, we direct the Secretary of Health and Human Services to study the statutory criteria used by the Corp to insure its participants are being placed in areas that are truly underserved. However, it is our understanding the Department is already undergoing the very study suggested in our legislation -- a move that will assist the Corp. in better allocating its resources.

Before I conclude, I would like to address the future of many of the rural health initiatives I spoke of this morning. First let me emphasize, that the Rural Health Care Coalition and its 115 members believe government has a role to play in insuring rural Americans have access to quality and affordable health care. During this Congress, we have seen many federally-funded rural health programs attacked -- programs that have made considerable differences in my district, and I am sure many of yours. For example, the House passed a budget resolution that calls for the elimination of the Federal Office of Rural Health Policy and an appropriations bill that zeros out the rural hospital transition grant program and nearly eliminates the rural outreach grant program. Do I recognize the need to

reform or restructure these programs? Yes, but to eliminate them before we have a chance to make them work better for our rural constituents is a mistake.

I understand this Committee does not have jurisdiction over all of these and some of the other programs that will be addressed today. I bring them to your attention, so you realize how important it will be for your Committee to not only support, but to be an advocate for those rural health care initiatives such as changes in the AAPCC formula or an increase in the Medicare bonus payment for rural physicians over which you have jurisdiction.

As Co-Chairman of the Rural Health Care Coalition, I plan to continue to push for passage of the Rural Health Improvement Act during the 105th Congress. I believe it is inevitable that Congress and the President will debate and pass substantive Medicare reform legislation that puts solvency back into the Medicare system. At the same time, we must make the necessary changes to make the Medicare program work better for rural Americans.

I believe this Coalition has demonstrated the bipartisan support for a partnership between the federal government and those trying to make accessible, quality and affordable health care a reality in their rural communities. We stand ready to move legislation, like the Rural Health Improvement Act, and support initiatives, such as the restructuring of the Federal Office of Rural Health Policy, in Congress that will continue to make federally-supported rural health programs work for our rural constituents. Some of the Coalitions goals for the future of rural health care in this nation may be easier to achieve than others -- but I know the Coalition and this Congress is ready to meet the challenges necessary to providing security that the health care needs of those of us that call rural America home.

I want to again thank the Committee for allowing Congressman Gunderson and me to testify today. I look forward to answering any questions you may have, and to working with you during the remainder of this Congress and more importantly the 105th Congress in passing legislation that will make a difference to the delivery and future of rural health care in America.

Chairman THOMAS. Thank you very much, both of you. We would appreciate it, more so than most members' testimonies, if we can ask you some questions, because you do represent a significant chunk of folk. Not just in the rural areas do we need to have a dialog and an understanding of the need for change, but among some of our members, we also need to understand the nature of change and the possibility of that change.

In looking at your legislation, in title VIII, I hope all of us are pleased with what appears to be a willingness on the part of the Justice Department in the Antitrust Division to begin to change. I mentioned briefly the legislation which just passed, H.R. 3103, which moved some of the criteria from the rule of reason and I feel very good about the Ridgecrest area. Virtually, there are 98 percent of the doctors in a single hospital are creating a managed care structure, and in looking at the consequences, the Justice Department has felt with one-third party management, there would not be the concerns about collusion on prices that seem to concern them.

It is that kind of creativity, working with a supportive and nurturing Antitrust Division, that will allow us to be as creative as we can be. What we have to do is provide as many models as possible for folks to find one that they are comfortable with.

We went through an analysis of the AAPCC funding structure and looked at some alternatives, like moving to a metropolitan statistical area rather than the counties. A lot of those switches really did not move us forward. In some ways, they created problems.

It is true that there is a maldistribution, but when you go back in and try to figure out what is a fair distribution with intent, and that is what is the purpose for trying to put more money into those areas that perhaps have a lower payment, the argument obviously is to try to create more of a competitive marketplace and perhaps attract managed care structures. It does not make a lot of sense to me to up the AAPCC if all we do is increase those who are under the current fee-for-service structure, since they are there and operating anyway.

I personally am quite disappointed in our inability, to take what I thought was a real opportunity when there was a 10-percent increase in the AAPCC and not redistribute it as a first step forward. In fact, this administration simply sent it out on the straight 10 percent rate. So, Dade County at about a $600 rate got the 10 percent multiplier and the counties in Wisconsin or in some of the other Midwestern States, especially in Iowa, which would be at about a $220 or $250 rate, got their $25 rate and we did not get an adjustment which would have been a significant first step forward.

Let me ask you a question about title V. There is some concern about the administration's recent reclassification for payment purposes doing away with the old urban, rural, and other categories, and creating only two categories, urban and other, denying payments that otherwise had been made on the Medicare disproportionate share payments. I know some of our concerned colleagues are in the audience. Bob Inglis from South Carolina, for one. Your legislation would not allow for what in essence has occurred. There

is obviously a cost factor there. Have you been able to cost that out at all?

Mr. GUNDERSON. Just a second here. According to CBO's advisory draft statement, it is de minimis and it falls under their basic guidelines for illustrating a particular number.

Chairman THOMAS. Which is usually $50 million, I believe. It is an asterisk if it is $50 million.

Mr. GUNDERSON. Actually, there is nothing on this sheet that shows any cost projections on title V for the whole bill. If you do not have this, we would certainly be willing to share this. This is an informal CBO report.

Chairman THOMAS. I have it. We think the number, if we have not firmed it up, is $37 million in 1997 and then revenue neutral after the adjustment has been made.

I guess these are the kinds of arrangements we are talking about, which may make a significant difference in particular areas. But, when you look at the larger picture and the dollar amounts that need to be shifted, they are not significant, other than de minimis amounts of money are significant.

Mr. GUNDERSON. Sure. In the broader context of comprehensive Medicare reimbursement reform, this may not be a justifiable provision and something I think you correctly articulate you would want to look at in a much more comprehensive fashion. What we are frankly trying to do here is survive until that day comes.

Chairman THOMAS. Thank you very much.

Mr. Stark.

Mr. STARK. I just want to thank the gentlemen for their offer of cooperation. I would like further, Mr. Chairman, just to point out that during the time that this hearing was scheduled, the Democrats have a caucus scheduled. I believe the topic is to discuss changing your title from Chair to Ranking Member. [Laughter.]

In finding out what is going on, I am sure Congressman Poshard and Congressman Gunderson will excuse me. I would like to get over and find out what they are talking about in that secret session. I assure the gentleman that the absence of my fellow Democrats does not signify a lack of interest in your problem.

I also wonder whether there will be any witnesses here from Health and Human Services, after reading about all the resignations there were in the paper yesterday, so this may be a much shorter hearing than you think.

But, I appreciate the Chair's indulgence in letting me sneak away to find out what is going on.

Chairman THOMAS. As long as you will inform us when it is over.

Mr. STARK. You will be the first to know. [Laughter.]

Chairman THOMAS. We have with us someone who is not a Member of the Subcommittee but obviously a Member of the Full Committee and has a significant interest in legislation of this type, the gentleman from Iowa, Mr. Nussle. I believe he wants to inquire.

Mr. NUSSLE. First of all, I appreciate the Chairman allowing me to come and visit the Subcommittee. I just have two observations.

First, just to let everybody know of how tough a negotiator you were last year with us and how fair you were with us on the whole area of AAPCC. We believe that we made some significant reforms

last year and it was because of your leadership, Mr. Chairman, that we were able to get that done. That is not to suggest that it was easy and that you were not a tough negotiator in the process, because, as we all know, there is a finite pool of money and if you push down on one side to raise the other, it means that somebody else is discouraged or concerned.

So, as the leaders of the Rural Health Care Coalition were working with you, and I had the honor of observing that and participating in that, I just wanted to thank you for your leadership. It was done very fairly and with the concerns of rural areas in mind.

Then just a final observation about Mr. Gunderson. I really believe that if a farmer falls off a tractor today because he has a heart attack in Southwest Wisconsin or if a mom needs to go and deliver a baby today in Iowa or even in Illinois, that they have a much better chance of finding a hospital open and rural health care delivered for them because of your leadership in the Congress over the last many years. I want to thank you for that service.

I have had an opportunity to watch both of you, but because you are leaving, I wanted to single you out, Steve, and just say thank you for that leadership, because we are not done yet. We will not be done when I am done here, I am sure. This is an issue that will continue to be at the forefront. But, I wanted to single you out and say thank you for that service, because I really believe that.

I think much of what we were talking about today is not so much once you get in the front door of the hospital as it is, where is the hospital? How long does it take you to get there? Is there going to be an ambulance to get you there, and how far do you have to go? The closing of one hospital is not just a 20-mile issue. It means 40 miles, because it just doubled the amount of time and minutes that it takes you to get there.

So, I really believe that with harvest season coming and all the different things that are going on in your area and in mine, I wanted to thank you, because I think there is probably a better chance that the people are going to get assistance because of your leadership over the last few years.

Mr. MCCRERY. Would the gentleman yield?

Mr. NUSSLE. I would be happy to yield.

Mr. MCCRERY. I just want to say that as a person who has been here for several years, and interested in health care ever since I got here, I want to associate myself with the remarks of the gentleman from Iowa about Steve Gunderson. Steve has been a leader as long as I have been here in fighting for rural health care. He has not been a member of a committee of jurisdiction as far as I know, but he has been a true leader in bringing to light the problems of rural health care, and coming up with solutions that fit within the framework of what we are all trying to do here.

So, I want to add my commendation to the gentleman's efforts and urge Mr. Poshard to take up where Mr. Gunderson is going to leave off and continue his battles, because they are worthwhile.

I thank the gentleman for yielding.

Mr. GUNDERSON. Mr. Chairman, if I might respond——

Chairman THOMAS. Certainly.

Mr. GUNDERSON [continuing]. I want to thank both my friends for their kind eulogies. I hope you will also give me a going away present known as H.R. 3753. [Laughter.]

Chairman THOMAS. I will tell the gentleman that oftentimes in those negotiations, the Rural Caucus looked a lot like the Agriculture Committee, and as an alumnus of that Committee, my concern always is not that we can come to an agreement, but that what we agree on can pass the House. That is a secondary requirement on anything that we come up with. So, usually my exhortations were to the fact that we would be taking it away from someone else and we could only take so much away.

In that regard, I thought we had put together an excellent working package. That does not mean we will not be able to recreate most of the pieces. It is pretty obvious in the timeframe that we have left, it may not be possible, but the groundwork that you folks have laid in rethinking, restructuring, and sensitizing certainly will not be wasted, notwithstanding the fact you may not be able to vote for the final change, Mr. Gunderson, you will be there in spirit, clearly.

I want to thank both of you for your continued leadership. Thank you very much.

Mr. GUNDERSON. Thank you.

Mr. POSHARD. Thank you, Mr. Chairman.

Chairman THOMAS. And now, apparently two individuals who have not yet resigned from the Health Care Financing Administration, as per Mr. Stark's comments, Jeffrey Human, Director of the Office of Rural Health Policy, and Kathleen Buto, Associate Administrator for Policy at HCFA.

I want to welcome both of you and, obviously, your written statements will be made a part of the record and you may inform us in the time that you have in any way that you see fit. Thank you very much for coming.

STATEMENT OF JEFFREY HUMAN, DIRECTOR, OFFICE OF RURAL HEALTH POLICY, HEALTH RESOURCES AND SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. HUMAN. Thank you very much, Mr. Chairman. I am real pleased to be here as a part of this important hearing.

There are two major components of the unique problems rural Americans face in getting health care. First, there is a shortage of physicians and other health care professionals in rural areas, as you have alluded to yourself, and second, rural hospitals have been closing at a disproportionate rate.

With respect to physician shortages, on a per capita basis, there are almost twice as many primary care physicians practicing in urban areas as there are in rural areas. There are also documented shortages of nurses, psychiatrists, dentists, social workers, psychologists, and other health professionals in rural areas.

The other problem is the viability of rural hospitals, and we have already had a good bit of testimony on the number of rural hospitals that have closed over the past 15 to 20 years. About 25 percent of the remaining 2,100 rural hospitals have negative operating

margins. That is, they are losing money and may be at risk of closure.

More than a few urban hospitals also have closed during this period, but the consequences of the closure of a rural hospital are frequently more difficult for local people than the consequences of the closure of an urban hospital. Many of us who live in the Washington, DC area have several hospital choices. Hospitals that closed in rural areas may leave local people with no choice or a very long distance to travel.

Any strategy to improve health care in rural America will also benefit rural viability. Towns without physicians usually cannot attract employers or even hold the employers they already have. Rural hospitals are typically the second or third biggest employer in a town. When the rural hospital closes, the local physicians typically also leave, and the prognosis for the economic viability of the community darkens considerably and immediately. The availability of health care in America's smaller communities and the economic viability of those communities are inexorably entwined.

We can count many Federal initiatives that assist rural people to get health care. We must, however, resist the temptation to define rural health as a Federal problem that requires a Federal solution. It is a national problem that cannot be solved without the involvement of the States, the local governments, and the private sectors. What we do in government at any level merely compliments the efforts of the thousands of dedicated physicians and other health professionals who serve rural areas.

Through the years, the Congress has passed a number of acts designed to assist rural populations to get the health care they need and to support the health professionals who serve them. Some of these public laws fall under the jurisdiction of this Committee. Kathy Buto of the Health Care Financing Administration will discuss those programs and I will move on to the office I direct, the Office of Rural Health Policy.

We administer some programs which I describe, but our principal roles are to serve as a voice for rural health in the Federal establishment and to develop information and policy alternatives that help rural America. Most of the rural health programs under this Committee's jurisdiction are reimbursement programs under title XVIII. A number of other programs, including some we administer, compliment these reimbursement programs with direct assistance to rural communities in need.

Among these are Community and Migrant Health Centers in rural areas. Over 3.7 million Americans in 1,100 of the poorest communities in this country receive their day-to-day primary care from these private medical clinics. Federal support from the Health Resources and Services Administration allows these clinics to offer discounted fees to the poor and the near-poor, who are the bulk of the centers' patients.

Another is the National Health Service Corps. Under the Corps programs, physicians receive their medical education at government expense, either through scholarships or later by loan repayment, and pay the country back by serving in the communities that experience the greatest difficulty recruiting physicians. Currently,

about 1,300 of the 2,200 physicians and other health professionals in Corps service are in rural areas.

Area Health Education Centers in 36 States link medical schools and teaching hospitals with rural communities and help them recruit physicians, as well as provide continuing medical education to those who already are there.

Rural Interdisciplinary Training Grants prepare health profession students for rural practice.

My office supports the Rural Information Center Health Service, we call RICHS, in collaboration with the U.S. Department of Agriculture. By dialing 1-109-800-633-7701, rural communities can get information on such diverse topics as how to recruit a doctor or how to build a community water and sewer system.

We fund grants to communities for rural health outreach projects to help each community develop unique solutions to its particular problems. Under outreach rules, the projects must be directed locally, the money must be spent locally, and the patients served must be local people. A consortium of three or more organizations need to coordinate the services provided. Thus, our grants help local community groups work together to build self-sufficiency and economic viability while improving health care. More than 70 percent of our grantees have been able to continue their projects after the 3-year period of Federal support has ended.

We also provide grants for rural health research centers. These centers are exploring many important issues, such as policy options for increasing the number of health professionals in rural areas.

We administer the Rural Telemedicine Grant Program, which is designed to systematically evaluate rural telemedicine. We currently fund 12 projects in 11 States, all of which also are facilitating the development of rural health networks.

The office helps to shape departmental policies and programs on rural health care by reviewing regulations and legislative proposals that affect rural health care providers and rural populations. For example, we review Medicaid waiver applications from the States from a rural perspective.

The office also staffs the Secretary's National Advisory Committee on Rural Health, which is chaired by former Iowa Governor Bob Ray. Over the past 6 years, the Committee has produced a wide array of recommendations on rural health care financing issues and ways to improve access to health care in rural communities.

We help the 50 States each fund rural health offices, much like our own. State efforts have led to the placement of more than 1,000 physicians in rural practices in recent years.

Madam Chairman, there are other rural health problems that are pervasive, such as EMS shortages, mental health shortages, and occupational health problems. There are also other Federal programs I have not had the time to describe and thousands of State, local, and private efforts that help, as well. Thank you very much.

[The prepared statement follows:]

STATEMENT OF JEFFREY HUMAN, DIRECTOR
OFFICE OF RURAL HEALTH POLICY,
HEALTH RESOURCES AND SERVICES ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good morning,

Mr. Chairman, I am pleased to be here to be a part of an important hearing on the availability of health care in rural communities. This is a significant problem that has plagued the Nation for many years. We are appreciative of the support the House Ways and Means Committee has provided through the years in addressing rural health care concerns.

There are two major components of the unique problems rural Americans face in getting health care. First, there is a shortage of physicians and other health care professionals in rural areas. Second, rural hospitals have been closing at a disproportionate rate for the past 15 years.

With respect to physicians shortages; on a per capita basis there are almost twice as many primary care physicians practicing in urban areas as there are in rural areas. When we consider all physicians, not just those practicing primary care, there are well over twice as many physicians - on a per capita basis - practicing in urban areas.

If we look at the problem on a county basis, about 1400 of the nation's 2100 rural counties are classified as Health Professions Shortage Areas, because of a shortage of primary care physicians. For the most part these are the more remote counties, those that are farthest away from the Nation's cities. Most of the counties on the Great Plains, for example, are shortage areas and more than 100 have no physicians at all.

There are also documented shortages of nurses, psychiatrists, dentists, social workers, psychologists and other health professionals in rural areas.

The other problem is the viability of rural hospitals. According to the Office of the Inspector General, there were 2,489 rural hospitals in 1987. By 1995, the number had declined to 2,141 -- a 14% decrease. The rate of closure has slowed during the past five years and the average total margin for rural hospitals was 5.5% in 1994, the highest in over a decade. Despite the improvement in the average rural hospital margin, however, about 25% of the remaining 2141 rural hospitals have negative operating margins - that is they are losing money and are at risk of closure.

More than a few urban hospitals also have closed during this period, but the consequences of the closure of a rural hospital are frequently more difficult for local people than the consequences of the closure of an urban hospital. Many of us who live in the DC area have several hospital choices. Hospitals that close in rural areas may leave local people with no choice, or a very long distance to travel.

Before we talk about solutions to these problems we should put them into a broader context. In 1900 over 60% of the nation's population lived in rural areas. Today that figure is under 25% and falling. It is not only the hospitals that are closing but also the schools, grocery stores, farms, and manufacturing plants. There are not only shortages of health professionals, but of professionals of all stripes.

And any strategy to improve health care in rural America will benefit rural viability as well. Towns without physicians usually cannot attract employers, or even hold the employers they already have. Rural hospitals are typically the second or third biggest employer in a town. When the rural hospital closes, the local physicians, typically, also leave. And the prognosis for the economic viability of the

community darkens considerably and immediately. The availability of health care in America's smaller communities, and the economic viability of those communities are inexorably entwined.

There is also a close relationship between rural poverty, uninsurance, and health care. In 1994, 16.3% of rural people were below the poverty level, compared to 14.9% of urban people. This is approximately 8 1/2 million rural people. About 17% of all rural Americans are uninsured.

As we look at the problem of accessability to health care in this country's more remote areas we can count many federal initiatives that assist rural people. We must, however, resist the temptation to define rural health as a federal problem that requires a federal solution. It is a national problem that cannot be solved without the involvement of the States, the local governments and the private sector. What we do in government at any level, or in foundations or associations, merely compliments and helps fill in the gaps for the thousands of dedicated physicians and other health professionals who serve rural areas, despite lower compensation. They need and deserve our support.

Through the years the Congress has passed a number of acts designed to assist rural populations to get the health care they need and to support the health professionals who serve them. Some of these public laws fall under the jurisdiction of this committee. Let me just mention some of these. Ms. Kathy Buto of the Health Care Financing Administration, the next witness, will discuss some of these programs in more detail:

- The Medicare Resource Based Relative Value Fee System (or RBRVS) pays primary care physicians more than used to be the case. These are the physicians rural areas depend on most.

- Primary care physicians in rural areas that are classified as Health Professional Shortage Areas receive a 10% bonus for each service paid for by Medicare.

- Medicare certified Rural Health Clinics receive cost based reimbursement in shortage areas for the physicians, nurse practitioners and physician assistants they employ.

- Several special reimbursement programs for rural hospitals have helped many survive that might otherwise have perished. These include the Swing Bed Program which allows rural hospitals to use some beds for long term care when necessary, and the Sole Community Hospital reimbursement program, which pays higher Medicare rates to many of the most isolated and remote hospitals. Rural Healthcare Transition Grants also are under the jurisdiction of this committee. These grants help rural hospitals re-examine their roles in the community, change their service mix, or offer new services as necessary.

- The office I direct, the Office of Rural Health Policy, is authorized under section 711 of the Social Security Act, even though we are located administratively in the Health Resources and Services Administration (HRSA), so we also fall under this committee's jurisdiction. While we administer some programs, which I will describe, our principal roles are to serve as a voice for rural health in the federal establishment, and to develop information and policy alternatives that help rural America.

Most of the rural health programs under this committee's jurisdiction are reimbursement programs under Title XVIII. A number of other HRSA programs, including some we administer, compliment these reimbursement programs with direct assistance to rural communities in need. Among these are:

- Community and Migrant Health Centers in rural areas. Over 3.7 million Americans in 1,100 of the poorest communities in this country receive their day to day primary care from these private medical clinics. Federal support from HRSA allows the clinics to offer discounted fees to the poor and near poor who are the bulk of the centers patients. A reimbursement program under this Committee's jurisdiction known as Federally Qualified Health Centers (FQHC) helps these centers receive cost based reimbursement for Medicare and Medicaid patients.

- The National Health Service Corps. Under the Corps' scholarship program physicians receive their medical education at government expense and pay the country back by serving in the communities that experience the greatest difficulty recruiting physicians. The Corps also repays the educational loans of other young physicians at up to $20,000 per year in return for service in underserved areas. Currently about 1,300 of the 2,200 physicians and other health professionals in Corps service are in rural areas. Three quarters of a million people receive their care from Corps' practices as well as many more in community and migrant health centers served by Corps professionals.

- Area Health Education Centers in 36 states link medical schools and teaching hospitals with rural communities and help them recruit physicians as well as provide continuing medical education to those who already are there. More than one and a half million health professionals have received AHEC sponsored training, most of them in rural areas.

- Rural Interdisciplinary Training Grants train students to work effectively in multi-disciplinary teams that enhance the capability of every member of the team to help the patient. More than 55% of the 1,700 students who have participated in this program now practice in rural areas. This program thus serves as a recruitment program for rural areas.

- My office supports several important rural programs including the Rural Information Center Health Service (RICHS), in collaboration with USDA. By dialing 1-800-633-7701 rural communities can get information on such diverse topics as how to recruit a doctor or how to build a community water and sewer system. RICHS operates a World Wide Web Site that is hyperlinked to many rural health programs throughout the country. RICHS also publishes monographs and bibliographies on topics of concern to rural leaders and health providers.

- We fund grants to communities for Rural Health Outreach projects to help each community develop unique solutions to its particular problems. Thus we fund an Alaska tribal consortium that brings itinerant physician services to two remote villages, an elementary school district in Arizona that brings preventive and primary care to school children in eleven school districts and a hospital in Iowa that is providing training to nurses, paramedics and emergency medical

technicians. We currently fund about 150 projects in 48 states and three territories.

Under outreach rules the projects must be directed locally, the money must be spent locally, and the patients served must be local people. A consortium of three or more local organizations need to coordinate the services provided. Thus our grants help local community groups work together to build self sufficiency and economic viability while improving health care.

One of the key criteria by which we evaluate the Outreach Grant applications is the ability of the applicant to maintain the health care services funded by the grant after the federal support is completed. Results to date indicate that more than 70 percent of our grantees have been able to continue their projects after the federal grant has ended, often through third party payments, local tax support, community contributions, or a combination of these and other strategies.

We also provide grants for rural health research centers. These Centers are exploring many important issues: how market driven reform is affecting rural areas; barriers to the formation of rural networks and rural-based managed care organizations; policy options for increasing the number of health professionals in rural areas; and how to provide rural people with access to mental health services.

Our office administers the Rural Telemedicine Grant Program, which is designed to create the information base necessary for a systematic evaluation of rural Telemedicine. We currently fund 12 projects in 11 states, all of which also are facilitating the development of rural health networks. In addition, the office also funds an additional 18 Telehealth/Telemedicine projects under its Outreach Grant Program. Most projects also involve distance education. In addition, the Office also has just completed the first comprehensive survey of rural Telemedicine. A report describing the survey findings will be available by early October. Later this month, we will be entering into a cooperative agreement with the Telemedicine Research Center in Portland, Oregon, to create an ongoing system for evaluating Telemedicine. Development of the system will be coordinated with other federal agencies sponsoring Telemedicine demonstrations, including the Health Care Financing Administration.

Finally, my Deputy Director chairs the Joint Working Group on Telemedicine, an interagency committee under the Vice President. Federal agency representatives meet twice a month to coordinate various Telemedicine programs of the Executive Branch to ensure the best use of Federal dollars. The working group will be providing an update to Congress in January which describes all of its activities to date, including development of a joint evaluation strategy for Federal Telemedicine program.
The report will also include findings from current Federal projects and a discussion of strategies for overcoming the barriers to the cost-effective use of Telemedicine, such as cross-state licensure barriers and reimbursement. A group sponsored information base on federally funded Telemedicine projects will be available on the World Wide Web in late Fall.

The Office helps to shape Departmental programs and policies on

rural health care by reviewing regulations and legislative proposals that affect rural health care providers and rural populations. For example, we review Medicaid waiver applications from the states and provide HCFA with comments on the potential effects of state plans for bringing Medicaid managed care to rural areas.

- The Office also staffs the Secretary's National Advisory Committee on Rural Health. Over the past six years the Committee has produced a wide array of recommendations on rural health care financing issues and ways to improve access to health care in rural communities. Some of the recommendations have been of interest to Congressional Committees involved with rural health care issues.

- We help the 50 States each fund Rural Health Offices much like our own and work with them to develop joint programs such as a 44 state project to facilitate and coordinate the recruitment and retention of physicians, using an 800 toll free number and the existing staffs of the participating states.

  State office efforts have led to the placement of over 1,000 physicians in rural practices in recent years. All state offices serve as information clearinghouses for their state, coordinate state based rural health activities, and help local communities find financing for their activities.

I haven't discussed the various block grant programs out of HRSA, SAMSHA, and CDC because its difficult to disaggregate the various rural programs given the wide array of state programs.

It should be noted that the reimbursement programs and the grant programs compliment each other. The reimbursement programs create a general eligibility for groups of institutions and populations, and the grant programs provide resources to specific high need areas or populations.

Mr. Chairman, there are other rural health problems that are pervasive, such as emergency medical systems shortages, mental health shortages and occupational health problems. There are also other federal programs I have not had time to describe and thousands of state local and private efforts that help. These however are most of the federal programs that are most important to rural areas. Thank you for allowing us to introduce them to you and the committee.

STATEMENT OF KATHLEEN A. BUTO, ASSOCIATE ADMINISTRATOR FOR POLICY, HEALTH CARE FINANCING ADMINISTRATION

Ms. BUTO. Good morning. I am Kathy Buto. I am the associate administrator for Policy. I am very pleased to be here today to discuss rural health care, particularly in the Medicare Programs, which are targeted at improving access to health care services for Medicare beneficiaries living in rural areas.

Although 83 percent of the United States is rural, only 26 percent of the Medicare population, or about 8.8 million individuals, live in rural areas. Rural areas are different from urban areas in a number of ways that affect the supply and demand for health services. For example, rural areas have higher unemployment, lower average incomes, lower average health status, and a higher proportion of residents who are uninsured.

Medical care providers in rural communities face unique challenges. Hospitals located in rural communities are, on average, smaller, have lower occupancy rates, are more dependent on long-term care units, and are financially more fragile. Between 1987 and 1994, 249 rural hospitals closed. Rural communities have difficulty attracting and retaining physicians because of a lack of complete medical facilities, professional isolation, limited support services, insufficient continuing medical education, and excessive workloads and time demands.

Both Congress and HCFA have used the Medicare Program as an instrument for helping to address these issues. Since Medicare is the dominant payer in rural areas, it plays a major role in shaping the rural health care delivery system. In 1993, 23.4 percent of Medicare payments, or about $30.3 billion, went to rural areas.

The Medicare Program has a significant interest in assuring the ability of beneficiaries to obtain needed services, regardless of their geographic setting or location. We have worked with Congress and States to develop and administer a number of programs which target providers in rural settings in order to support the local health care delivery systems. However, in working to stabilize and support the rural delivery systems, Medicare cannot act alone. As Jeff said, we believe it is necessary for the other payers, provider groups, and affected parties to actively support the rural delivery systems and work to implement innovative service delivery programs.

Certain elements of our broader payment policies for hospitals and physicians are designed to provide additional financial support for rural areas. Second, there are special classifications for certain types of rural providers which qualify for preferred payment. Third, HCFA oversees several demonstration projects designed to improve health care delivery in rural areas. I will briefly describe examples in each of these categories.

The first category includes smaller pieces of Medicare's broad payment system for hospitals and physicians, the PPS, or prospective payment system, and the physician fee schedule, respectively. The pieces provide preferable support for rural areas, such as equalizing the base payment amount for rural and small urban hospitals in fiscal year 1995. Our proposals to raise reimbursement for evaluation and management services under the physician fee schedule which also will benefit rural areas.

In the second category, Medicare has preferential payment policies for sole community hospitals and specialty hospitals known as rural referral centers. It also provides additional flexibility for rural hospitals through the Rural Primary Care Hospital Program, a program which originated in this Committee, and the swing bed program that supports outpatient services in rural areas through the federally qualified health clinics and through rural health clinic designations. Medicare provides bonus payments to physicians who work in medically underserved areas, most of which are rural.

One area in which rural providers do not receive preferential payment, as was mentioned in the earlier panel, is in the area of managed care. Managed care payments are based on the same formula, a formula stipulated in the statute, whether the organization serves beneficiaries in urban or rural areas. It has been suggested that one reason managed care organizations do not contract in rural areas is because of low payment rates.

The President suggested changes to those rates in his latest balanced budget proposal in an attempt to address this problem, and I should point out that these changes are very similar to those contained in the conference agreement.

However, even without these changes, we are making progress. For example, HCFA recently approved a Medicare risk HMO contract that is expected to increase access and reduce costs for beneficiaries in rural Arizona. Premier Health Care is a consortium of rural provider-sponsored networks serving eight Arizona counties. Premier Health Care, which began enrolling Medicare beneficiaries in July, greatly expands the health plan options available to Medicare beneficiaries in that service area.

In the third category, HCFA oversees several grant and demonstration programs that specifically target improving access to services in rural areas and encouraging development of rural networks. The demonstration projects include the MMAF, Montana Medicare Assistance Facility Program, which is similar to the RPCH, Rural Primary Care Hospital Program, an upcoming demonstration on telemedicine services, and the upcoming Medicare Choices demonstration that will have 4 plans out of 25 that will be predominantly in rural areas. Grant projects have included the RHTG, Rural Health Transition Grant Programs, telemedicine, infrastructure grants, and the State Rural Health Care Network Reform Initiative.

HCFA has devoted considerable resources in supporting existing health care providers in rural communities and assisting rural communities to reconfigure their delivery systems to better match their needs through the programs that I have already described. The following are our four primary conclusions.

Recent evidence suggests that although payment changes for rural hospitals have resulted in better financial performance on the part of rural hospitals, the biggest problem affecting those hospitals is their declining utilization levels. Inpatient hospital utilization has been declining for both urban and rural hospitals, but the decline has been especially dramatic at rural hospitals. With Medicare payments on a per case basis, some rural hospitals simply cannot generate the volume of services necessary to remain viable.

Second, while the RHTG Program was designed to help hospitals respond to changing markets by diversification of services, physician recruiting and other methods and evaluation of the programs suggests that the grants did not have a major impact on the overall long-term financial stability of the participating hospitals.

Third, on a positive note, programs that take a more aggressive approach and assist hospitals to transition to alternative facilities appear to be more promising. Evaluations of the MMAF, Montana Medical Assistance Facility Demonstration and the Essential Access Community Hospital/Primary Care Hospital Program, or the EACH/RPCH program, suggest that these programs have had some positive results.

For instance, the presence of the inpatient medical assistance facility unit appears to boost the image and utilization of associated ambulatory and long-term care services provided by those hospitals. The EACH/RPCH Program appears to have been a significant catalyst in development of rural provider networks.

Finally, we need further research on the effectiveness of specific programs directed to increasing access to care. Ensuring access remains a primary goal of HCFA and we continue to study it and support programs that ensure appropriate access to health care services for Medicare beneficiaries.

I would like to summarize and comment quickly, and I will do this very quickly. The President has sent his balanced budget plan to Congress and it includes many Medicare provisions, many of which I have already touched on, to strengthen incentives for health care providers to locate and provide needed services in rural areas.

The conference agreement included a number of these provisions or provisions that were very similar in targeting rural providers. I just want to point out that the REACH, Rural Emergency Access Care Hospitals and CACH, Critical Access Care Hospital provisions that were mentioned earlier, we believe, would be more than included in the President's broader initiative to expand the EACH/RPCH program. Those kinds of institutions would be included, and many others up to 15 beds.

So, we think that there is a lot that we have in common. There are a number of provisions where we have concerns, and those are in our testimony submitted for the record, so I will stop there.

[The prepared statement follows:]

STATEMENT OF KATHLEEN A. BUTO
ASSOCIATE ADMINISTRATOR FOR POLICY
HEALTH CARE FINANCING ADMINISTRATION

Introduction

I am pleased to be here today to discuss rural health care, particularly the Medicare programs which are targeted at improving access to health services for Medicare beneficiaries living in rural areas.

Rural areas make up 83 percent of the United States, but contain only 23 percent of the general population and 26 percent of the Medicare beneficiary population (approximately 8.8 million individuals). Although rural and urban distinctions are less clear today than they were in the past, rural areas are different from urban areas in a number of ways that affect the supply and demand for health services. The unemployment rate in rural areas is higher; rural areas are poorer on average, and people living in poor rural areas have lower health status.

Rural Americans are more likely to be uninsured because of the different employment opportunities (many jobs in rural areas do not provide health insurance). Medicare is the dominant payor in rural areas, and thus plays a major role in shaping the rural health care delivery system. In 1993, 23.4 percent of Medicare payments ($30.3 billion) went to rural areas.

The Medicare program has been concerned with the ability of beneficiaries to obtain needed services, regardless of their geographic setting or location. We have worked with the Congress and States to develop and administer a number of programs which target providers in rural settings in order to support the local health care delivery systems.

Hospitals located in rural communities are, on average, smaller, have lower occupancy rates, are more dependent on long-term care units, and are financially more fragile. Between 1987 and 1994, 249 rural hospitals closed. Rural communities have difficulty attracting and retaining physicians because of a lack of complete medical facilities, professional isolation, limited support services, insufficient continuing medical education, and excessive work loads and time demands. In an effort to alleviate these problems, Medicare has operated specific programs to aid rural providers financially.

Medicare has a very significant role in supporting the health delivery systems operating in the country. Its primary focus is the provision of needed health services to the Medicare beneficiary population. However, in working to stabilize and support the rural delivery systems, Medicare cannot act alone. It is necessary for the other payers, provider groups, and affected parties to actively support the rural delivery systems and work to implement innovative service delivery programs.

Medicare Payment Policies Sensitive to Rural Concerns

In addition to specific programs and payment policies designed specifically for rural providers, I would first like to describe the changes in payment policy for hospitals and physicians that have served to increase payment rates to rural providers. In part, these policies were developed specifically to address the financial problems of rural providers and to encourage providers (particularly physicians) to locate in rural areas.

HCFA currently pays hospitals on the basis of a prospective payment system (PPS). Hospitals are paid a predetermined amount per discharge, adjusted for the severity of a patient's condition (casemix), the labor costs in the local area, and other factors such as whether the hospital operates a teaching program. In the early years of PPS, separate base payments were established for large urban, other urban, and rural areas. However, the differential in the base payments between "other urban" and "rural areas" has been phased out as of last year. This was accomplished through higher annual updates for rural hospitals, dramatically increasing payments to rural hospitals relative to urban hospitals.

HCFA currently pays physicians on the basis of a fee schedule with limits on the amounts physicians can charge beneficiaries. The physician fee schedule is based on a system of relative values for all procedures, a geographic adjustment factor, and a dollar conversion factor. The design of the fee schedule geographic adjustment factor resulted in increased payments to rural areas relative to urban areas.

Of significant importance to rural physicians, HCFA has moved to equalize payments between rural and urban localities, although Medicare payments still vary among geographic payment areas. There are presently 210 payment localities under the Medicare physician fee schedule, including 22 statewide localities. HCFA has proposed a further consolidation to 89 payment localities in a July 2 Proposed Rule, including an increase in the number of statewide localities to 34. This change would further equalize payments between urban and rural areas.

In a May 3, 1996 Proposed Rule, HCFA also proposed relative value changes in accordance with a 5-year review of all physician work relative value units. A significant element of the proposed changes would increase relative values for medical visits and consultations. This change should benefit rural areas since those services represent a larger share of rural physician practices than do procedural services.

Medicare programs affecting rural areas

Over the past twenty five years, HCFA has developed and administered a number of legislatively authorized programs to provide extra financial support to rural providers to enable them to continue to provide needed services to rural communities.

The rural hospital is often the centerpiece of rural communities' health care delivery systems. A

number of special programs have been implemented to provide enhanced payment for rural hospitals.

The Sole Community Hospital (SCH) program was implemented under the 1972 amendments to the Social Security Act. Under this program, special payment protections are provided to hospitals that are the sole source of hospital inpatient services reasonably available to Medicare beneficiaries. Hospitals can qualify to be an SCH if they meet certain criteria including: distance from other hospitals, travel time to other hospitals, and their market share in the local area. Payments for SCHs are based on 1982 or 1987 costs (updated to the present), if either of these base amounts are more favorable than the Federal rate that determines payments for all other PPS hospitals. Currently, 744 rural hospitals are designated as SCHs.

The Federal legislation which authorized the implementation of the prospective payment system for Medicare hospital payments in 1983 also implemented the Rural Referral Center (RRC) classification. The RRC classification identifies certain hospitals in rural areas that provide care at a volume and in a manner that is more comparable to urban hospitals than to their rural counterparts. These hospitals serve as "referral" sites for rural physicians and community hospitals that may lack the resources or expertise to handle cases outside the norm. Currently, there are 131 rural hospitals designated as RRCs.

Originally, payment for RRCs was higher than for other rural hospitals because RRCs were paid the standardized amount for "other urban" areas instead of "rural" areas. RRCs were also able to qualify for disproportionate share (DSH) payments and reclassify for a higher wage index under easier criteria than other rural hospitals. Since FY 1995, however, when the standardized amounts for rural and other urban areas were equalized, the financial benefit of being a RRC has decreased relative to other rural hospitals.

Congress also authorized the Swing Bed Program in the early 1980's to help meet rural residents' needs for long-term care services and to provide additional flexibility in service and bed use options to small rural hospitals. Under this program, certain hospitals can use the same bed for both acute care and skilled nursing care, depending on the needs of the patient. Currently, there are 1,356 hospitals participating, almost half of the eligible rural hospitals.

OBRA 1987 implemented the Rural Healthcare Transition Grant (RHTG) program to assist small, rural hospitals and their communities by strengthening the capability of these facilities to provide high quality care to Medicare beneficiaries. Grants can be used to plan and implement projects that modify the extent and types of services that hospitals provide in response to changing market pressures. Hospitals can apply to receive a grant of up to $50,000 per year for up to three years.

A wide variety of activities have been funded under this program. Common projects include physician recruitment, development of clinical and social services (e.g., prevention programs, rural health clinics, home health and hospice, and transportation), and development of management services (e.g., strategic planning and board and staff training.) Since the beginning of the RHTG

program, HCFA has awarded approximately $135 million to over 1,000 small rural hospitals. Approximately 40% of all eligible hospitals have received grant funding under this program.

In addition to these programs which assist individual hospitals, HCFA also supports programs that address broader rural health delivery system issues (e.g., assist hospitals to transition to alternative facilities, encourage development of provider linkages, etc.).

The Montana Medical Assistance Facility (MAF) demonstration provides funding for creating limited service hospitals in Montana. The design, development, and implementation of MAFs and rural health networks is directed by the Montana Hospital Research and Education Foundation (MHREF), which also receives grant funds for its activities. In 1990, the Congress authorized Medicare to pay for MAF services provided to Medicare beneficiaries on the basis of reasonable cost. In 1993, the Congress extended this authorization until July 1, 1997. Funding began in 1988, and the first MAF opened in 1991.

The medical assistance facility model is a limited service hospital that: (1) provides an option for rural communities that can no longer support a full service hospital; (2) preserves local access to primary care and emergency services; (3) more appropriately matches services to community needs and provider capabilities; and (4) expands the use of midlevel practitioners to augment/substitute for physician services. There are nine MAFs currently operating in Montana, and other rural hospitals continue to express interest in the program.

The Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program is similar to the MAF program except that it provides the permanent authority to reimburse limited service hospitals in certain states. This Subcommittee developed the original EACH/RPCH legislation. Subsequently, the EACH/RPCH program was authorized in 1990 in section 1820 of the Social Security Act. It is designed to assist States and rural communities in maintaining access to health care services through the creation of limited service hospitals, the establishment of rural health networks, and the development of State rural health plans. The EACH/RPCH program consists of: (1) a permanent operating program that establishes the RPCH as a new type of health care facility and the EACH as a new hospital category, and (2) grants to provide funds to States and hospitals to assist in the development and implementation of the program. The statute limits the program to seven states. HCFA chose the following states based on a competitive grant process: California, Colorado, Kansas, New York, North Carolina, South Dakota, and West Virginia. Grant funding began in 1991, with the first RPCHs certified in 1993.

RPCHs must meet several criteria covering size, scope of services, length of stay, and other criteria encouraging the formation of networks. They are reimbursed on a reasonable cost basis. EACHs are larger hospitals that agree to accept referrals from RPCHs and provide other types of support, and they are reimbursed like sole community hospitals. Currently, there are about 20 EACHs and close to 30 RPCHs participating in the program.

Based on the significant success of the MAF and EACH/RPCH programs, the Administration has developed a proposal to incorporate the best aspects of each program into a new program that is eligible to all states.

The Rural Health Clinic (RHC) benefit was enacted into law on December 13, 1977 in the Rural Health Clinic Services Act of 1977 (Public Law 95-210). Medicare and Medicaid coverage was extended to primary and emergency care services furnished in RHCs located in rural, medically underserved communities by physicians and nonphysician medical practitioners (including physician assistants, nurse practitioners, and certified nurse midwives). Medicare provides coverage of medical services by non-physician practitioners even when a supervising physician is not permanently on-site. The scope of services provided in RHCs is comparable to those provided in physicians' offices.

Between 1987 and 1993, Congress passed several amendments to the Act which were intended to overcome obstacles to participation in the program. Consequently, HCFA began paying for RHC services in 1992, with a rapid expansion of RHCs in the early 1990s. HCFA estimates that there were about 2,530 RHCs in October 1995, almost double the 1,350 RHCs that existed in January 1994.

At the time the RHC law was passed, independent clinics and a small number of rural hospitals which operated RHCs already existed. HCFA accommodated the provider-based clinics in order to achieve administrative simplicity and authorized a different payment method for provider-based RHC services than the one used to pay independent RHCs.

HCFA will be proposing to modify the payment method for provider-based RHCs in order to achieve uniformity and equitable treatment of both freestanding and provider-based RHCs. We have been consulting with the industry, and have considered their views. Under this proposal, HCFA would level the playing field for all RHCs by applying the same payment limitations and productivity screens that currently apply to services furnished in independent RHCs to provider-based RHCs. HCFA believes that the impact of this proposed change on providers is negligible, and that a new, uniform payment methodology for all RHCs will eliminate concerns of many independent RHCs who currently claim to be at a competitive disadvantage compared to provider-based RHCs.

In response to the accelerated growth in the number of RHCs and questions about their success in increasing access to care, HCFA has contracted for an independent evaluation of the RHC program. This study will be completed next year. This evaluation will focus on a number of issues, including: reasons for the rapid growth of RHCs; the impact of the program on rural populations; and the cost of the program to the Federal and State governments.

The Federally Qualified Health Center (FQHC) benefit was enacted by section 4161(g) of OBRA 1990 to provide Medicare coverage and payment for outpatient services furnished by clinics approved under the Public Health Service (PHS) Act. There are four categories of FQHCs:

Migrant, Community, and Homeless Health Centers, (including entities which the PHS determines meet the requirements for receiving such a grant, but which do not receive any grant funds), and outpatient programs operated by tribes, tribal organizations under the Indian Self-Determination Act, or by urban Indian organizations receiving funds under Title V of the Indian Health Care Improvement Act. This last category was added in OBRA 1993.

Payment for FQHC services is through an all-inclusive rate based on costs. Recognizing the primary mission of these health centers is to serve low income groups, there is no Medicare Part B deductible applicable for FQHC services, and the FQHC is authorized to bill the beneficiary for coinsurance based on a sliding fee scale.

Congress responded to the physician shortage problem in medically underserved areas by providing for a physician incentive payment in rural areas beginning in 1989; the legislation delayed urban bonuses for two years. A 5% bonus payment was provided to physicians treating Medicare patients in geographic health professional shortage areas (HPSAs) designated by the Public Health Service. Subsequent legislation extended the incentive to all HPSA shortage categories and raised the bonus to 10%.

Advances in telecommunications technology have also made possible the provision of increased consultation by specialists to rural areas. HCFA uses the term "telemedicine" to refer to two-way, interactive video systems over which medical consultations take place. Typically, a telemedicine encounter involves a primary care physician and a patient located at a remote, rural site, and a medical specialist or consultant located at a medical center. HCFA has funded five telemedicine demonstration projects to develop the infrastructure for telemedicine networks and perform preliminary evaluations of the effects of telemedicine services. The next phase of the project, which we plan to begin next month, will be to assess the feasibility, accessibility, costs, and quality of providing services through the use of telemedicine. A provision in the Health Insurance Portability and Accountability Act directs HCFA to complete its ongoing study and submit a report with a proposal for reimbursement for telemedicine services, although we recommend waiting for the results of the upcoming study before payment policies are set.

As this Subcommittee is well aware, many more Medicare beneficiaries are choosing to enroll in Medicare managed care plans. However, to date, enrollment in rural areas has been limited in part because many managed care plans do not operate in rural areas. However, some plans that have commercial operations in rural areas have opted not to contract with Medicare, reportedly because Medicare's payment rates in rural areas tend to be lower than payments in urban areas.

Under Medicare statute, risk contracting Medicare managed care plans are to be paid 95% of the Adjusted Annual Per Capita Cost (AAPCC), defined as the estimated amount that Medicare would have paid in a geographic area if plan enrollees had received service in Medicare's fee-for-service program. The AAPCC computations start with a projection of national per capita costs, which is then adjusted for each county's historical costs relative to these national average per capita costs. The AAPCC rate book has county-specific rates for each of the over 3,000 counties

nationwide. The payment for an individual beneficiary enrolled in a risk plan is the county rate (95% of the county's AAPCC) multiplied by a demographic factor representing the beneficiary's age, sex, institutional status, and Medicaid status.

The lower AAPCC rates in rural areas are the result of the statutory requirement that AAPCC rates reflect Medicare's cost experience in the local fee-for-service program; in general, fee-for-service costs in urban areas are higher than those in rural areas. Long-standing concerns about relatively low payments in rural areas, as well as concerns with wide variation in rates in urban areas, led both the Administration and the Congress to propose changes to the payment methodology. The Administration's FY 1997 budget proposes paying plans the greater of three amounts: (1) a blend of an area-specific and national rates; (2) a minimum payment amount ($325 per month in 1997); or (3) a minimum percent increase. This methodology would immediately increase rates in many rural areas, and it would also reduce the extreme variation in payment rates in general. We note that the Administration's proposal is similar in some respects to the payment methodology included in the 1995 budget reconciliation conference agreement.

HCFA recently approved a Medicare risk-HMO contract that is expected to increase access and reduce costs for beneficiaries in rural Arizona. Premier Health Care is a consortium of rural provider-sponsored networks serving eight Arizona counties. Premier Health Care, which began enrolling Medicare beneficiaries in July, greatly expands the health plan options available to Medicare beneficiaries in the service area.

The Medicare Choices Demonstration is designed to give Medicare beneficiaries expanded choices among different types of managed care plans and to test new ways to pay for Medicare managed care. The project is aimed at areas with low Medicare managed care penetration and was targeted to nine metropolitan areas and rural areas. Of the 25 plans selected as final candidates for participating in the demonstration, we are working with four which would serve predominately rural areas. These rural sites will provide an opportunity to test payment and delivery systems. while also providing a manage care option to beneficiaries in those areas for the duration of the demonstration.

Results of Research

HCFA has devoted considerable resources to supporting existing health care providers in rural communities and assisting rural communities to reconfigure their health care delivery systems to better match their needs through the programs I've just described.

Recent evidence suggests that the payment changes we have instituted for rural hospitals -- both the changes in PPS as well as special payment policies for distinct groups of rural hospitals -- has resulted in better financial performance on the part of rural hospitals. However, it appears that the biggest problem affecting rural hospitals is their declining utilization levels. Inpatient hospital utilization has been declining for both urban and rural hospitals, although the decline has been especially dramatic at rural hospitals. With Medicare payment on a per case basis, some rural

hospitals simply cannot generate the volume of services necessary to remain viable.

The Rural Health Transition Grant Program was designed to help hospitals respond to changing markets by diversification of services, physician recruiting, and other methods. However, an evaluation of the program suggests that the grants did not have a major impact on the overall long-term financial stability of the participating hospitals.

Programs that take a more aggressive approach and assist hospitals to transition to alternative facilities, however, appear to be more promising. Evaluations of the Montana MAF demonstration and the EACH/RPCH program suggest that these programs have had some positive results. For instance, the presence of the inpatient MAF unit appeared to boost the image and utilization of associated ambulatory and long-term care services provided by the hospital. The EACH/RPCH program appears to have been a significant catalyst in the development of rural provider networks.

There is a lack of evidence, however, regarding the effectiveness of specific programs on increasing access to care for Medicare beneficiaries. However, access to needed care remains a primary goal of HCFA, and we continue to study it and support programs that ensure appropriate access to all health care services for Medicare beneficiaries.

Future Directions

The problems facing rural providers are complex, and we have not yet developed the perfect solution to ensure their financial solvency. Because of this, proposals to address rural health care needs are necessarily piecemeal. Each proposal is designed to address a specific discrete problem.

Last May, the President sent his Balanced Budget Plan to Congress. The plan included Medicare provisions to strengthen incentives for health care providers to locate and provide needed services in rural areas. For example, the Plan included a provision to combine the best elements of the Montana MAF and Rural Primary Care Hospital programs and expand them to all states. It also included improvements to the SCH payment policy; permanently grandfathered RRCs and provided for special geographic reclassification standards; and reinstated the Medicare-dependent, small rural hospital program. The Plan also included provisions to reduce the variation in capitated payments to Medicare risk plans, and to increase the AAPCC in rural areas. Finally, the Plan included a grant program to promote the use of telemedicine.

The Conference Agreement also included a number of provisions targeted to rural providers. It created two new categories of rural providers -- Rural Emergency Access Care Hospitals (REACHs) and Critical Access Hospitals. While the Critical Access Hospital provision is identical in many respects to our PRCH program, the REACH provision creates a limited-service rural hospital with more restrictions than the RPCH program. In addition, the Conference Agreement would have increased the bonus payment for primary care services furnished in rural health professional shortage areas to 20% (from the current 10%).

The Rural Health Improvement Act of 1996 (H.R. 3753), introduced by Representative Gunderson and others, includes a number of provisions which are analogous to the Administration's proposals. Foremost among these are reducing variation in capitated payments to Medicare risk contractors and increasing the AAPCC rates in rural areas, and expanding the RPCH program to all states and modifying its requirements in ways that are similar to the President's expansion plan. It also contains other provisions that were in the Conference Agreement, including the establishment of rural emergency access care hospitals, and increasing bonus payments for primary care services to 20 percent. Finally, the Rural Health Improvement Act includes a provision for a new grant programs to encourage the development of community health networks in chronically underserved areas.

HCFA has specific concerns about some of the provisions that are in both the Conference Agreement and the Rural Health Improvement Act. In particular, we are concerned about provisions that are poorly targeted or that have no demonstrated benefit in increasing access to care. For example, we are concerned that the RRC provision is not sufficiently targeted to focus on RRCs with low wages compared to other hospitals in its area. Expanding direct payment to non-physician professionals would create yet another situation for billing Medicare on a fee-for-service basis. There is no compelling evidence for providing additional opportunities for non-physicians to bill Medicare directly, especially outside rural shortage areas. While all the plans allow for greater flexibility for certain rural hospitals, we believe that, given our successful experience with the RPCH program, the Administration's provision to expand that program would meet the needs of rural facilities better than the creation of two new limited hospital providers. In fact, the REACH program is redundant to the RPCH, i.e, the RPCH offers everything that the REACH does and more.

In spite of our concerns, we note the similarities in a number of provisions. We are looking forward to working with Congress to ensure that all Medicare beneficiaries have access to medical services.

Mrs. JOHNSON [presiding]. Thank you. I thank the panel for their excellent testimony. It was very helpful to get such a thorough review of the rural policies that are already on the statutes and how they are working.

Ms. Buto, I have been a strong supporter of REACHs and RPCHs, the REACH and RPCH grant programs to help rural hospitals restructure themselves to be economically viable and to provide the quality of services and the type of services that rural communities need. I am increasingly concluding that the difference between those grants is artificial, that to have one grant completely focus on emergency services is not useful for us, that really, we need much more flexibility. Those moneys need to be packaged and you need a lot more flexibility to respond to the specific needs of specific rural communities.

Would you agree with that? Is that something we should be moving toward, merging those grants?

Ms. BUTO. The RPCHs are the urgent care model or the critical care model that was mentioned earlier. Yes. We think that it is better to have a broader provision, as you state, that would allow the EACH/RPCH program to expand, or the RPCH program to expand up to 15-bed hospitals, give them entire flexibility to use those beds either for long-term care or acute care, or emergency services, so the whole spectrum.

Mrs. JOHNSON. Why is it that the RPCH program looks at creating the possibility for hospitals to offer inpatient services with a patient stay of up to 72 hours? What is the rationale behind the 72 hours?

Ms. BUTO. That is in the statute. I think the rationale at the time was to really look at what seemed to be a reasonable time to stabilize individuals. As you probably know, our proposal would expand that up to 96 hours, so that we have more time. We are looking at demonstrations up to 96 hours in Montana, and we think that is a reasonable timeframe.

Mrs. JOHNSON. This is probably the biggest problem that we face. I have a hospital, not categorized as rural, because nothing in Connecticut is categorized as rural because of our payment need, but they are certainly facing exactly the problems. I looked into REACHs and RPCHs for them, and certainly, the more narrowly focused of those programs is useless.

But, we do need more flexibility in thinking through whether it should be 23-hour stabilization or 72-hour stabilization or 96-hour stabilization, and as medical practice changes, those issues are going to change. So, I hope that in the next session, we will actually rethink these two grants and the amount of flexibility that communities need in restructuring.

Ms. BUTO. As you were talking, I wondered if you were referring to the EACH part, which is the hospital that gets referrals from the primary care hospitals, and for those, we agree. We think it is more appropriate to let those smaller hospitals have more flexibility as to where they refer patients, and they can then enter into payment arrangements to pay those referral hospitals. Then we do not need this other designation.

Mrs. JOHNSON. Mr. Human, I appreciate your review very much and was interested in your comments about the community health

centers, because they are not common in the rural areas and yet they really can provide a sense there, the missing piece in our health care system until we are able to do more.

In my urban areas, seniors who cannot afford copayments can go there and on a sliding scale fee they can get things that Medicare does not offer. For uninsured families, you do not have to be on welfare to go to a community health center, and, in fact, they are usually about as nice as the doctors' offices nearby. They are furnished the same way, the same examining rooms, and so on, and the service corps program has been very helpful in the community health center movement.

I would ask you, though, to begin looking between now and the next session as to why so many who have been involved in establishing community health centers now are doing it without Federal money because they find our money too restrictive. So, I now have a chain of community health centers, only the first of which was established with Federal money, and every one of the others thereafter, have not been established with Federal money—some State money, some private sector investment, because they feel they can respond to people's needs more effectively.

So I think what we need to look at, in the modern era, is the program structured as it was about 15 or 20 years ago still the program we need now? The concept is certainly important and the American people do not understand that it is there, that it is incredibly high quality, and that it serves everybody. But, I think we need to look at which pieces need to be redeveloped, refined, and expanded, versus trying to do quite so many things and particularly controlling so much of it from Washington.

Mr. HUMAN. We would be very interested in your comments on what specific changes ought to be made, to look at what we can do from an administrative standpoint. I can tell you that it still is a very popular program in terms of the communities that would like to be added to the list that are receiving the Federal funds to establish community health centers. There has been no lack of new applications, but we would still be very interested in those comments.

I would add one thing, just if I could go back to the last discussion for just a second. Another reason for the flexibility that you and Kathy Buto were talking about with respect to these limited service hospitals is that more than 20 States are currently involved in either licensure changes or contemplated licensure changes to redefine what a limited service hospital is. So, it is particularly important at the Federal level that we allow the flexibility for this incubation that is occurring nationwide, until we understand what works best.

Mrs. JOHNSON. I would hope that as you look toward the legislation for the next session, that you would think about the fact that a lot of these definitions do not fit anymore. My hospitals do not fit in the right definitions anymore. They did when they applied for that category. They fought hard to get out from rural, because at first, we treated rural hospitals so badly and costs are so high in Connecticut. Now, the resources they need are actually in the rural programs and they are not in the rural programs.

We have to think more effectively about how we do localize this and eliminate a lot of the definitions and regulations from Washington. I do not want to be too simplistic in the language, but it is not working and we have the money in the system.

Of course, communities want community health centers, but we are not able to staff them and to make them work the way they should, and yet other people in the movement are creating those models. I cannot believe I am the only one who has told you that the community health system also is spinning off all kinds of other community health centers out from under Federal law. I will try to work on that, but I would hope that I am not the only voice that is telling you that. I cannot believe I am.

I just do want to close my questioning by saying that a number of times, Ms. Buto, you mentioned that things were in the conference Committee. I am not sure that that is clear enough. The fact is that there is an enormous overlap between how the Republicans see health care problems in America and how the Democrats see them, also how the President and how the Congress see them, and it is really terribly unfortunate that given that broad commonality, we could not have been at the same table these last 2 years, because now we are 2 years behind on the Medicare problem. We will have 3 instead of 5 years to deal with a system that is extraordinarily important to each one of us in our lives of every age, and its impending bankruptcy.

So, I am glad you did note that in the conference agreement, which is the agreement between the legislation passed by the Senate and the House and primarily now Republican thinking because of the political problem that developed around Medicare premiums that prevented the legislative process from looking at where do we agree and how do we move forward.

There is so much we could have done, because there are so many areas of agreement. It is really a tragedy for the seniors of America that, in fact, we have not been able to move forward on so many things we should have moved forward on because of the politics of premiums.

We had others from your office, from HCFA, in here talking to us about how they wanted to develop Medicare Plus plans. We call them Medicare Plus plans. I do not care what you call them. They are Medicare managed care options. They were saying to us, but we need the law more flexible. We need the law to change. We should have done some of that changing. The world's pace of change is so much more rapid than ours and we have to find a way to keep up so that the health care resources can constantly be reconfigured to meet the access and quality demands of the American people of all ages.

Mr. Ensign, I understand, is in a meeting, and my colleague has no further questions, but I thank you for the quality of your testimony. It was very interesting. It will be very useful to us. Thank you.

Ms. BUTO. Thank you.

Mrs. JOHNSON. If the next panel will come to the front, and if Mary Wakefield will begin. Mr. Christensen will chair for a few minutes while I take a phone call. Thank you.

Mr. CHRISTENSEN [presiding]. Dr. Wakefield, will you go ahead and give us your testimony?

STATEMENT OF MARY K. WAKEFIELD, DIRECTOR, CENTER FOR HEALTH POLICY, GEORGE MASON UNIVERSITY

Ms. WAKEFIELD. Good morning. I am Mary Wakefield, the director of the Center for Health Policy at George Mason University in Fairfax, Virginia.

With 65 million Americans residing in rural areas and massive changes underway in health care, the Subcommittee's interest in this population is important, timely, and much appreciated.

Before briefly commenting on specific Federal programs, I would like to describe rural America. About one-quarter of the U.S. population lives in rural areas which are diverse and often as different from each other as they are from cities. The most remote rural counties are classified as frontier, with fewer than seven people per square mile. Other rural counties are adjacent to urban areas and offer easier access to many goods and services. Frontier Wyoming, then, poses very different challenges to providing health care than does rural Texas.

Rural areas have higher concentrations of elderly than urban areas and higher rates of disability and chronic illness which necessitate greater need for health care services. Yet rural residents have less access to health care services and rural Medicare beneficiaries have lower utilization rates for hospitals and physicians than their urban counterparts.

Poverty rates are higher among the rural population, yet fewer of them qualify for Medicaid. However, interestingly enough, rural health care providers are more dependent on Medicaid and Medicare for their income than are urban providers.

Meanwhile, health care has been a vortex of change in recent years. This may seem most noticeable in metropolitan areas, but rural America also has been caught up with changes that I believe are no less stressful or complex. Over the past 15 years, inequitable payment rates for services, difficulty in finding health care providers, and the closure of hospitals have characterized rural America's struggle with issues that are at least as difficult to wrestle with as the problems now facing our urban areas.

With these concerns in mind, I want to comment on a few Federal programs, beginning with Medicare, and specifically the methods used to determine the capitated payment rate, that is, the AAPCC rate. The AAPCC is based on historical cost data and I am concerned that rural areas will receive only the amount needed to maintain minimal services that they may have but not enough to expand access or enhance services or to give rural elderly a choice of health plans, which is one driving force behind Medicare managed care.

To date, managed care plans are not available in the counties with the lowest payment rates and managed care plans that do serve rural counties are concentrated in higher paying counties and located near urban areas.

However, as important as it may be to provide incentives so that rural elderly can access managed care plans if they choose, it is equally essential to ensure that those plans provide quality care

and services that match the needs of the rural elderly. It is not safe to assume that managed care plans based in urban areas and designed to serve a younger, healthier population and to save costs will automatically be appropriate for an elderly, rural population with higher rates of chronic illness and disability.

Particularly over the next few years, while enrollments in managed care plans are increasing, I think it will be critical to assess quality of health services offered by these plans, and I think that health outcomes will need to be evaluated every step of the way to determine what is happening with the health of our rural elderly population.

The chronically short supply of health professionals in many areas of rural America is another major issue, and this problem is bound to worsen, as over 20 percent of rural doctors are older than 65 and existing managed care plans are competing for primary care providers.

Medicare's bonus payment to physicians in health professional shortage areas is helpful in this regard, and I support the provision in H.R. 3753 to provide the bonus for primary care services rather than strictly for physician services. This is particularly important because many rural communities have access only to non-physician providers as their source of health care services. And, in fact, taking it a step further, instead of viewing shortage areas based on the number of certain health care providers, it may make more sense to change the question and ask, what is the availability of primary care services?

Currently, the health professional shortage area designation is based on the ratio of primary care physicians, dentists, and/or mental health providers to population. This means that an area with no primary care providers is considered the same as an area with two physicians' assistants and a nurse practitioner. Yet, I would assert that access to care in those two situations is markedly different.

I also want to express my support for the National Health Service Corps and to encourage you to consider exempting from tax the service-linked scholarships and loan repayment funds that the Corps provides.

Additionally, I want to draw your attention to a training program that I believe has been successful in helping to meet the manpower needs of rural areas, and that is the Interdisciplinary Training Program, which provides grants for team training of at least three disciplines in rural health care settings. The multiskill training the students receive, coupled with practical experience in rural health facilities, prepares them exceptionally well for rural practice.

While these and other training programs are important to rural areas, they are dwarfed when compared to graduate medical education funding of almost $6.7 billion per year. I urge you to consider targeting medicare graduate medical education to train more primary care physicians and fewer specialists. Borrowing ideas proven successful in other rural training programs, I would recommend using GME funds for training in nonhospital settings and for supporting rural clinical experiences.

Medicare education funds for nonphysician providers need to be directed, as well. Seventy percent of these funds go to hospital-

based diploma nursing programs that produce less than 10 percent of the nation's registered nurses. Instead, these Medicare funds should support training of nurse practitioners, certified nurse midwives, certified nurse anesthetists, and other clinical nurse specialists with advanced practice skills.

In rural areas, these advance practice nurses are especially important. For example, certified registered nurse anesthetists are the sole anesthesia providers in 85 percent of rural hospitals.

Bottom line, Medicare education and training funds need to catch up to the needs of today's Medicare beneficiaries and support the new array of facilities and providers who are meeting those needs. Where health services are provided and how health care is practiced today are very different from 30 years ago when Medicare was first established.

One of the ways in which health care practice is different is also one of the most striking innovations in health care now entering the marketplace and that is telemedicine, and I applaud the Federal Office of Rural Health Policy for their efforts to coordinate the work of Federal agencies that are engaged in telemedicine initiatives.

Finally, I think that research should be a priority to monitor quality of care and health outcomes during the transition to new health care systems and methods of service delivery. During these times of tectonic shifts in health care, I believe we must continue to support both the programs and research that most efficiently and effectively meet the unique needs of rural populations.

Thank you for the opportunity to testify.

[The prepared statement follows:]

STATEMENT OF
MARY K. WAKEFIELD, Ph.D., R.N., DIRECTOR
THE CENTER FOR HEALTH POLICY
GEORGE MASON UNIVERSITY

Mr. Chairman, members of the Subcommittee,

I'm Mary Wakefield, Ph.D., R.N., Director of the Center for Health Policy at George Mason University.

With 65 million Americans residing in rural areas and massive changes underway in health care, your interest in this population is important, timely, and appreciated. I want to thank you for holding this hearing and for inviting me to testify.

I will address two major issues in my testimony this morning: first, access to health care in rural areas, and how some of our federal programs address this. Second, and just as important, is the issue of quality.

Briefly describing rural America: about one quarter of the U.S. population lives in rural areas, which are diverse and often as different from each other as they are from cities. The most remote rural counties are classified as "frontier," with fewer than seven people per square mile; other rural counties are adjacent to urban areas and offer easier access to many goods and services. Frontier Wyoming, then, poses very different challenges to providing health care than does rural Texas, Georgia, the Mississippi Delta, or rural Washington.

Rural areas have higher concentrations of elderly than urban areas, and higher rates of disability and chronic illness, which necessitate greater need for health care services. Yet rural residents have less access to health care services, and rural Medicare beneficiaries have lower utilization rates for hospitals and physicians than their urban counterparts. And since rural Americans are more likely to be self-employed, it is thought that rural residents probably have less comprehensive coverage when they are insured.

Poverty rates are higher among the rural population, yet fewer of them qualify for Medicaid. However, interestingly enough, rural health care providers are more dependent on Medicaid and Medicare for their income than are urban providers.

Today, business and government leaders talk quite a lot about "downsizing." Well, rural areas have been "downsizing" since the start of this century. The decline of farming, mining, timber, and other rural industries has caused massive shifts in the rural economy. Rural citizens have had to make do with less.

Meanwhile, health care has been a vortex of change in recent years. This may seem most noticeable in metropolitan areas, but rural America also has been caught up with changes that I believe are no less stressful or complex. Over the past 15 years, inequitable payment rates for services, difficulty in finding health care providers, and the closure of hundreds of rural hospitals have characterized rural America's struggle with issues that are as difficult to wrestle with as the problems now facing urban areas.

If access to care is on a continuum, the preferable end to be on is to live close to health services. Unfortunately, many residents of rural communities are on the other end of the spectrum. Their situation in terms of access to care isn't quite as severe as that facing astronaut Shannon Lucid (currently orbiting Earth in the Mir space station) if she needed health care, but it's still a problem.

Rural communities across the country confront the challenge of access to care daily. The net effect of loss of providers and/or facilities has been a sudden lack of health care, and the odds of finding a replacement provider or creating an alternative facility are very often slim. The impact on the economy is also severe, as rural hospitals often are the largest or second largest employer in the community.

For many years, access to care has been a paramount issue in rural health. The two parts to this puzzle are health professionals and facilities. No matter what payment mechanism or program is under discussion, the question is, how to maintain access to quality health

services and adequate numbers of health professionals?

In these bottom-line-oriented times, small populations that characterize rural areas present a great challenge to ensuring access. Other challenges include poverty, geography, lack of transportation, and cultural barriers. But I believe that the greatest challenge is the chronic under-supply of health professionals, whether it's to staff a solo practice or a tertiary care center.

With these access and supply problems in mind, I'll turn to Medicare.

About 15 years ago, as members of this subcommittee well know, Congress mandated radical changes in Medicare by replacing the cost based hospital payment system with a new Prospective Payment System (PPS). To set the PPS payment rates, HCFA essentially took a snapshot of costs in urban and rural areas, and used these as a baseline.

Then as now, rural areas had mostly primary care physicians and small community hospitals. There were very few large health systems and medical specialists. With providers in short supply, naturally, Medicare utilization rates in rural areas were lower than in urban areas. Simply put, Medicare doesn't get billed for services that beneficiaries can't get.

The same situation existed regarding medical specialists. With very few specialists in rural areas, rural Medicare beneficiaries did not have access to specialists' services, which tend to cost more than primary care.

When the original PPS snapshot was taken, rural Medicare beneficiaries' lack of access especially to more expensive specialists, was reflected as lower costs. While data show that providing health services in many rural areas costs somewhat less than in many urban areas, the snapshot magnified the actual difference in costs.

In the early years of PPS, Congress and HCFA pursued the policy that payment should be based on what had been observed, with a cost of services index based on the same year. An urban-rural differential was observed, then locked into place. And all subsequent adjustments to the rates were made on an artificially low base, which reflected rural areas' under-supply of health providers and low numbers of specialists. While the policy may have seemed logical and even fair, it greatly contributed to maintaining the rural status quo: too few health care professionals and poorly-financed institutions.

The urban-rural differential was a one-two punch: low rural payments resulted in great financial strain, and created a disincentive for providers to practice in rural areas. Lacking adequate funds, rural hospitals could neither enhance services nor recruit staff. This hardship contributed to the closure of hundreds of rural hospitals, which aggravated the shortage of health professionals across rural communities.

Instead of the low payments to rural areas based on their under-utilization, what was needed to address the chronic provider shortages and ensure access to high quality care were higher payments.

There's a lesson in this. Using historical utilization and cost data to set payment rates for rural areas, without appreciating the context in which they occur, perpetuates rural communities' problems: a lack of health professionals and access to health services. This was the unintentional result of the original urban-rural differential.

Eventually, Congress addressed the urban rural differential in PPS payment rates -- but did so in the context of slowing the growth of Medicare spending, and also while protecting large urban hospitals and teaching hospitals. Essentially, rural providers got a slightly bigger slice of a shrinking pie, but not before hundreds of rural hospitals had closed, leaving many communities without any access to health services.

Now Congress is again looking at re-shaping Medicare to avoid a financial crisis in the program. And again, basing AAPCC payments on some measures of historical costs. The problem with this approach is apparent from the situation I've just described.

If the capitated payment is based on historical cost data, I'm concerned that rural areas will receive only the amount needed to maintain the minimal services they have – not enough to expand access or enhance services, or to give rural elderly a choice of health plans, which is one driving force behind Medicare managed care.

In 1995, AAPCC rates ranged by county from a low of $177/month in Fall River, SD, to $678/month in the Bronx. That yawning gap widened even further this year, with rates varying from under $230/month to over $750/month.

It appears that enrollment in managed care plans tracks the payment rates and that lower payments translate into lack of service. Rural counties receive payments about 30% below the national average, and most rural areas do not have managed care plans. To date, managed care plans are not available in the counties with the lowest payment rates. And managed care plans that do serve rural counties are concentrated in higher-paying counties and near urban areas.

If Congress intends to facilitate a choice of health plans for rural Medicare beneficiaries and preserve the health services currently available, then the capitated payment rates must be high enough to allow this.

However, as important as it may be to provide incentives so that rural elderly can access managed care plans if they choose to, and as important as it is to support the development of these and other networks of care, it is equally essential to ensure that those plans provide quality care and services that match the needs of the rural elderly. It is not safe to assume that managed care plans based in urban areas and designed to serve a younger, healthier population and to save costs will be appropriate for an elderly rural population with higher rates of chronic illness and disability. Particularly over the next few years, while enrollments in managed care plans are increasing dramatically, it will be critical to assess quality of health services offered by managed care plans. I believe that health outcomes need to be evaluated every step of the way to determine what is happening with the health of this population.

Now I'll turn briefly to several federal programs that benefit rural areas. Some of these fall under Medicare, others are part of the Public Health Service Act. The common theme in both types of programs is that they seek to address the fundamental problem of access to health services in rural areas.

Congress initiated several programs for rural health facilities, including Sole Community Hospitals and Rural Referral Centers, the Essential Access Community Hospital (EACH) and Rural Primary Care Hospital (RPCH, called "peach") program, and the Medical Assistance Facility (MAF) demonstration. All of these programs were designed to help rural hospitals maintain or enhance access to health services in rural areas.

Other programs focus on health care professionals. The chronically short supply of health professionals is a major issue in rural health care. This problem is bound to worsen, as over 20% of rural doctors are older than 65, and existing managed care plans are competing for primary care providers. Medicare's 10% bonus payment to physicians in health professional shortage areas is helpful in this regard. However, given the tremendous need, I support the provisions in H.R. 3753 to increase the bonus to 20%, continue it for three years after the HPSA designation lapses, and to provide the bonus for primary care services rather than physician services. This is particularly important because many communities have access only to non-physician providers as their source of health care services.

In fact, taking it a step further, instead of viewing shortage areas based on the number of

certain health care providers, it may make more sense to change the question to what is the availability of primary care services. Currently, the health professional shortage area designation is based on the ratio of primary care physicians, dentists , and/or mental health providers to the population. With regard to primary medical care, it doesn't distinguish among areas that fall below a specific physician-to-population ratio. This means an area with no primary care providers is considered the same as an area with two physician's assistants, a certified nurse midwife, and a nurse practitioner. Yet I would assert that access to care in these two situations is markedly different.

I'd like to point out some Public Health Service programs that address provider shortages, and may serve as models for needed changes to Medicare's graduate medical education funding.

The first among these is the oldest, the National Health Service Corps, which was authorized in 1970 and started in 1972. The NHSC was designed to reduce the shortage of primary care doctors in designated rural and urban "health professional shortage areas." The Corps has been a great success -- today, over 2,225 Corps professionals, including nurse practitioners, certified nurse midwives, psychologists, and physician assistants as well as physicians and other professionals, provide health care to four million people who otherwise would not have it. A 1994 survey of NHSC scholarship recipients found that, 6 years after the end of their service obligation, over half the respondents were still in rural practice. (NHSC Funding in FY96 is $115.7 million)

Yet the need for NHSC providers remains, since most rural areas of the nation still don't have enough health professionals. There are 2,677 designated primary care health professional shortage areas (as of 3/31/96). 68% are in rural areas, with a population estimated at 22 million.

One strategy to enhance this solid program is worth this Committee's consideration. The NHSC currently offers scholarships and loan repayment in return for service. The scholarships and loans are taxable. The tax on the NHSC loan repayment funds is paid by the Corps, but the Corps does not have the authority to pay taxes on scholarships. I do not recommend that the program be burdened with assuming the tax liability for scholarships. On the contrary, I question the logic of using scarce appropriated funds to pay taxes on the loan repayment funds. Nor do I think it's advisable to make NHSC students pay taxes on their scholarships, which is a substantial burden and a disincentive to serve in this federal program. Instead, I recommend that Congress exempt from tax the service-linked scholarships and loan repayment funds that the Corps provides.

I also want to draw your attention to two other training programs that I believe have been very successful in meeting the manpower needs of rural areas: one is the Interdisciplinary Training program, which provides grants for team training of at least three disciplines in rural health care settings. The multi-skill training students receive, coupled with practical experience in rural health facilities, prepares them exceptionally well for rural practice. Since the program's inception in 1988, 31 programs in 21 states have received support. 1,067 students participated in the program between 1990-1994. 54% of the graduates are working in rural areas. Through the inclusion of psychologists and other mental health providers, the program also has expanded access to mental health services in rural areas. (FY96 funding = $3.7 mil.)

The other program that's expanding access to health services in rural areas is the Rural Health Outreach grant program, administered by the Office of Rural Health Policy. This program offers grants to consortia of rural health facilities to expand or enhance health and mental health services. Currently funded as a demonstration, rural outreach grants ensure collaboration and foster networks by requiring at least three health providers to participate. Perhaps the program's best feature is that it allows local communities to tailor projects to meet their unique needs – it does not specify which providers should participate or what services should be offered, leaving maximum flexibility to local communities to determine their needs and how to meet them. (FY96 funding = $27.9 mil.)

I believe this kind of flexibility is key to the success of rural health programs, because rural communities are so diverse and have vastly different needs. A "one size fits all" approach is much less likely to succeed. Taking this into account, I agree with the recommendation of the Rural Policy Research Institute that Congress should support community-based primary care clinics that do not meet all of the requirements of Community Health Centers. I strongly believe that rural facilities that cannot offer the panoply of services mandated by the CHC statute should nevertheless be able to compete for funding to provide primary health services.

The programs I've just mentioned all help rural communities, and I urge your continued support of them. However, among them all, FY96 funding for rural training and health services totals just $90 million. (About half of NHSC funds are for urban sites.)

Compare that to Medicare Graduate Medical Education funding of almost $6.7 billion/year.

Congress has a right and a responsibility to direct Medicare GME funds to achieve policy goals. If these include alleviating the shortage of health professionals in rural areas, I urge you to consider targeting Medicare graduate medical education to train more primary care physicians and fewer specialists. Borrowing ideas proven successful in other rural training programs, I recommend using GME funds for rural traineeships, rural rotations, training in non-hospital settings, and rural clinical experiences to give students an honest assessment of the benefits and drawbacks of rural practice. The Area Health Education Centers (AHEC) program within PHS is a good model for this. AHECs train students through rotations in clinics and other non-hospital settings.

Medicare education funds for non-physician providers need to be redirected as well. By the year 2000, Medicare payments to hospitals for nursing education are projected to reach $420 million. But 70% of these funds go to hospital-based diploma programs that produce less than 10% of the nation's RNs. Medicare funds should support training of nurse practitioners, certified nurse-midwives, certified nurse anesthetists, and other clinical nurse specialists with advanced practice skills. In rural areas, these advanced practice nurses are especially important: many of the nation's 35,000 nurse practitioners provide primary care services in rural areas, and CRNAs are the sole anesthesia providers in 85% of rural hospitals.

Medicare education and training funds need to catch up to the needs of today's Medicare beneficiaries and support the new array of facilities and providers who are meeting those needs. Where health services are provided and how health care is practiced today are very different from 30 years ago, when Medicare was first established.

One of the ways in which health care practice is different is also one of the most striking innovations in health care now entering the marketplace, and that is telemedicine. The Telemedicine Grant Program is currently funded by the Office of Rural Health Policy as a demonstration. In addition to that program, several other federal agencies are involved in telemedicine demonstrations to enhance or expand services and training, foster provider networks, and reduce professional isolation.

Recently, the Federal Interagency Joint Working Group on Telemedicine (JWGT) was formed to ensure that the activities are coordinated. This group includes representatives from the Departments of Defense, Veterans Affairs, Agriculture, HCFA, and other agencies. Among other activities, the JWGT is developing a World Wide Web-accessible inventory of federally-sponsored telemedicine projects. While bringing the expertise of multiple agencies to the table, this effort, facilitated by the Office of Rural Health Policy, is a solid example of coordinating federal programs that directly and indirectly impact rural health care through telemedicine initiatives, and making that information available to the public.

Interactive telecommunications technology is currently being used in rural areas by a range

of providers, including dietitians, psychologists, nurses and physicians for home visits, nutrition counseling, psychiatric evaluation and case management, long-distance education, and surgery consultation, just to name some of the federally-sponsored projects. While technology is not a substitute for a basic complement of health care providers, it can be a very useful addition, particularly to enhance services or access specialists. Still, telemedicine is still very new, and we know very little about its costs, effects, and effectiveness. These areas as well as questions of licensure and reimbursement are ripe for evaluation.

This brings me to my final topic. Throughout my testimony, I have called for continuing research of pressing rural health questions, and evaluation of the impact of any major change in the ways health care is delivered to rural populations. I want to reiterate that concern and note how beneficial some of the research and evaluations have been to date.

The Agency for Health Care Policy and Research (AHCPR) has funded health services research on many topics important to rural areas, such as long-term care for the rural elderly, access to rural cardiac rehabilitation programs, rural emergency medical services and trauma outcomes, the effects of rural obstetric care provider shortages, and access to primary care services for persons with disabilities in rural areas.

The rural research centers supported by the Office of Rural Health Policy have produced important front-line research on rural health, which Jeff Human addressed in his testimony. Before this office began funding rural health research, there was no federal support for rural research, and no organized network to disseminate information to rural communities.

The Office of Rural Mental Health Research (of the Substance Abuse and Mental Health Services Administration) funds important research on mental health in rural areas, including development of new and innovative models to provide these services. This information simply was not available in the early 1980's when the farm crisis struck, and Congress was calling for proven interventions to help economically and psychologically stressed farm families.

HCFA's Office of Research and Demonstrations has funded important research on the Medicare programs for rural providers that I mentioned earlier. No other entity has access to the wealth and timeliness of data that HCFA has. I recommend that HCFA continue to support research on high priority rural health issues. For example, given the higher concentration of elderly, poor, and chronically ill in rural areas, research on the quality of rehabilitation and other non-acute care services and its availability to rural populations would be appropriate.

Technology and telemedicine present a host of research questions. What are the unique needs of rural communities and the rural elderly for health and mental health services, and how can the federal government work in partnership with states and local communities to meet those needs? And of course, research could well be directed at determining an appropriate mix of primary care providers for meeting the health needs of rural communities as well as how to increase the supply of health professionals and overcome barriers to access.

I believe the most pressing research task ahead is to monitor quality of care and health outcomes during the transition to new health care systems and methods of service delivery. How can quality health services and positive health outcomes be assured under managed care, with a reduced growth rate in Medicare spending, likely coupled with reduced growth in Medicaid spending?

Research on these and other questions may provide vital information on which to base future health policy decisions. During these times of tectonic shifts in health care, I believe we must continue to support both programs and research targeted to rural populations and their unique needs.

That concludes my testimony this morning. Again, thank you for the opportunity to testify. I'd be happy to answer any questions you may have.

Mr. CHRISTENSEN. Dr. Myers.

STATEMENT OF WAYNE MYERS, M.D., DIRECTOR, CENTER FOR RURAL HEALTH, UNIVERSITY OF KENTUCKY, ON BEHALF OF THE RURAL POLICY RESEARCH INSTITUTE

Dr. MYERS. Thank you. The Rural Policy Research Institute, or RUPRI, appreciates this opportunity to testify again before the Subcommittee.

I represent RUPRI's rural health care delivery expert panel, which is one of several panels assembled to provide research and advisory support on rural implications of Congressional policy alternatives. Three of these panels have presented testimony on various occasions regarding Medicare policy alternatives, including analyses of two legislative packages this season, the Balanced Budget Act of 1995 and the Rural Health Improvement Act of 1996. We appreciate the opportunity to have our written testimony included in the record.

I am a pediatrician. I live in Lost Creek, Kentucky, which is a suburb of Hazard in Central Appalachia. I have spent most of the past 25 years living out in the sticks, working for medical schools, trying to help with rural medical work force issues in Alaska, Montana, Idaho, Washington, and Kentucky.

My written testimony covers quite a range of rural health work force issues. The fundamental work force problem is that there are not enough appropriately trained primary care personnel to recruit, and I do emphasize appropriately trained. The best way I can use my brief time before you this morning is to ask you to consider overhauling in a very fundamental way the Medicare Graduate Medical Education Program.

The GME Program overshadows all other health work force programs. It puts out twice as many dollars each year as the 46 States with medical schools put into their State medical schools. It puts out more money in a year than the Bureau of Health Professions has had to expend in grants in its entire agency lifespan and it out spends the National Health Service Corps each year by 60 to 1. The Medicare Graduate Medical Education Program has never served rural needs, and now it has become a barrier to efforts to develop a more appropriate national medical work force.

The current program has two fundamental flaws as a work force program. First, it is not connected to work force needs in any way. Second, it is dominated by large hospital needs to the exclusion of all other considerations.

As you probably know, this program helps pay teaching hospital salaries and support costs of apprentice or resident physicians. It also pays these teaching hospitals a supplement on the assumption that if they have resident physicians, they must waste a lot of tests and supplies and they must provide a lot more indigent care than other hospitals.

If a hospital can get a residency training program accredited and can recruit some residents from U.S. or overseas, it gets the money. Nobody asks whether anybody needs the graduates of the program, of the residency program, either in terms of specialty or location. So to repeat, the Nation's largest health care work force program has no linkage to the Nation's health care work force needs.

Second, the program serves the needs of large hospitals to the exclusion of all other considerations. The program was designed around the assumption that everything a doctor needs to know can be learned in the beds of the tertiary care hospital. That is an assumption that was suspect in 1965 when the Act was passed and it is completely worn out now.

Rural areas have always needed primary care doctors who could talk to people as equals and members of their own communities, who could use judgment as well as advanced diagnostic technologies, who could help people avoid plugging up their coronary arteries instead of just rescuing them after the damage is done, and who could recognize spouse abuse, substance abuse, alcohol abuse, and so forth and not feel terribly anxious without subspecialists at their elbow.

Training for this kind of practice is simply not to be found in tertiary care hospitals. The hardest thing a physician or a nurse practitioner has to do is to pick out the one patient in 1,000 that is in serious trouble, and by definition, that is something you cannot learn in a teaching hospital. Everybody that is in there has already been identified as being in big trouble and the only way you are criticized is if you overlook the possibility that the person may have not one terrible problem but two, three, or four.

The second point I would make in terms of appropriate training is that the thing that keeps primary care people in the business is the satisfaction of watching people they have taken care of get older, the kid that had meningitis as a baby do reasonably well in the kindergarten plan. These are things of which people in tertiary care hospitals have no inkling, at least as trainees.

So now the stakes are rising. The kind of people that we have needed for decades in rural areas are now becoming precisely the people we need to run managed care, and you cannot learn that in a teaching hospital, tertiary care hospital, or tertiary care dominated training system.

It is easy to overcomplicate this issue. The first thing we have to do is divide the issue into manageable sizes; to divide the GME issue, and money, between hospital needs and training needs. We need to develop reasonable numbers for each but not commingle them anymore. We need to pay the hospital subsidy money to hospitals and the teaching money to training programs. We need to restrict or stop training in glutted specialties. We need to put the training programs and money where people need personnel, not where hospitals need personnel.

The $7 to $8 billion of graduate medical education money in the Medicare budget may be the most highly leveraged money in that budget. How we spend it now largely decides who will be available to provide care for the next 30 years. Sorting out all the claims about complex institutional missions and so forth will take wisdom and courage, but it really needs to be done.

I thank you very much, Madam Chairman, and I will be glad to entertain questions.

[The prepared statement follows:]



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RURAL HEALTH WORKFORCE POLICY ISSUES

Hearing Testimony Presented to

The Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

September 12, 1996

by
Dr. Wayne Myers
Representing the Rural Policy Research Institute (RUPRI)
Rural Health Care Delivery Expert Panel

Thank you, Mr. Chairman. The Rural Policy Research Institute (RUPRI) appreciates this opportunity to again testify before this Subcommittee regarding the rural implications of Medicare reform decisions currently confronting Congress. I am here as a representative of the RUPRI Rural Health Care Delivery Expert Panel, one of several national RUPRI Panels assembled to provide ongoing research and decision support regarding the rural implications of Congressional policy alternatives. As you may know, the RUPRI Health Care Delivery Panel, Rural Medicare Task Force, and Regional Modeling Work Group have all presented Hearing testimony on various occasions regarding the broad range of these Medicare reimbursement and program policy issues. Many of these issues will undoubtedly be discussed before this Hearing today, including specific proposals considered as part of prior legislation this session.

As you may know, RUPRI has already submitted detailed analyses of two legislative packages this Session, the Balanced Budget Act of 1995 and the Rural Health Improvement Act of 1996. These analyses detail our assessments of the rural impacts of specific components within these legislative proposals. Today, I will focus primarily upon the rural health workforce policy issues which must be addressed if significant systemic change is to occur in rural health care delivery and reimbursement.

Overview

In the testimony which follows, detailed attention is given to several critical rural health workforce issues, which are summarized below:

- The Medicare Graduate Medical Education (GME) Program is the nation's largest health workforce program. This program requires thorough overhaul. This process should be guided by national workforce needs, with priority given to primary care for underserved areas.

- Health workforce programs of the Health Resources and Services Administration, including the National Health Service Corps, are important resources for rural America.

- Leveling of the urban/rural Medicare reimbursement differential is essential to system reform.

- Increased federal/state coordination will be essential for development of managed Medicare and managed Medicaid in rural areas, and can contribute to development of more appropriate incentives for health professions education institutions.

- International medical graduate placement programs continue to be helpful in rural America. These physicians should be graduates of primary care residency training programs.

- Educational loan repayment programs are effective tools for improving workforce distribution.

Background

Current restructuring of America's health care system includes a variety of efforts to avoid the continuing costs of surplus capacity and unnecessary intensity. These problems of excess capacity are relatively concentrated in metropolitan areas. As we reported to this committee in our testimony of July 20, 1995, Medicare payments in 1992 were 23 percent higher per urban than per rural enrollee. For part B payments, the urban/rural differential rose to 52%. We suggest the guiding principle that fragile, relatively low cost rural health care not be further damaged in efforts to control problems which are largely metropolitan.

Primary care personnel are the backbone of rural health care. Unlike their more specialized colleagues, they are able to provide a broad range of care, and need relatively small populations to make a living. Thus the size of the national primary care workforce pool is of critical importance to rural communities. About thirty percent of American physicians practice primary care compared to a widely recommended national goal of fifty percent.

Inability to attract and retain adequate numbers of locally credible primary care personnel is the limiting factor for the performance, and even the viability, of many rural care systems. For example, the lack of local medical staff capable of retaining adequate numbers of insured patients is probably the largest single factor in the closure of rural hospitals.

Although about 23 percent of Americans live in non-metropolitan counties, only about eleven percent of physicians practice in such counties. A national "doctor shortage" was largely resolved by the mid-1970's, but an increasing abundance of physicians has been confined to the referral specialties. There have been increases in numbers of family doctors, internists and pediatricians in counties adjacent to metropolitan areas, and in large, rural hub communities. We have not seen a general reduction of rural shortages.

Several prominent health workforce distribution programs were initiated in the early 1970's. These included the National Health Service Corps and the Area Health Education Center (AHEC) program. By 1980 states such as North Carolina which participated in both programs were reporting gain in rural primary care workforce. As the national perception of a doctor shortage receded, support for the Corps decreased while the AHEC Program continued. By 1990, the important contribution of the corps had become clear as perennially underserved areas struggled to cope with the lack of Corps personnel. The Corps has been revitalized. The AHEC Program has been shown to enrich the practice environment in selected communities, and to give health professions students a better understanding of rural practice, but has not been shown to influence student career decisions.

Most Americans live within thirty minutes drive of a primary care physician, but many of these physicians are seriously overloaded. The criterion for primary care shortage area designation of one physician for every 3600 people is about one third the national average supply, and one half the number of primary care physicians used by highly developed managed care systems.

The Practice Acts of many states tie nurse-practitioners and physician assistants very closely to physicians. For this and other reasons, the distribution of these professionals generally parallels that of physicians.

The Nation's medical schools and teaching hospitals have given us the world's most sophisticated medical research and intensive care capacity, but most have not been very responsive to rural and primary care needs. The faculty members of these institutions determine who will be admitted, what they will be taught, and where. Following World War II, NIH funding to medical schools grew explosively and came to play a major role in shaping medical school faculties and their values. In 1965, Medicare accepted a share of the costs of supporting clinical faculty members through Graduate Medical Education (GME) payments. This permitted academic medical centers to expand their full time subspecialty faculties. NIH plus GME payments to academic medical centers now total about fifteen billion dollars per year, of fifty times the annual grant resources of the USPHS Bureau of Health Professions. After several years of recognition of the need to expand primary care training, less than three percent of medical school faculty members are family practice physicians. While the success of Bureau programs in rationalizing the production of our health professions educational

system has been limited, these programs have served an important role in nurturing our academic primary care seed stock through decades of adverse institutional incentives.

Medicare is particularly important to rural care systems. In 1992, the enrollment rate for Medicare Part A in nonmetropolitan counties was 16.2 percent, compared to 12.7 percent of metro residents. Two other factors amplify the importance of Medicare. Older rural people are more likely to choose to remain in their home communities for care than younger people. A greater proportion of rural than urban people live in poverty. Few of the indigent are able to leave their home community for care. Thus Medicare enrollees make up an even larger proportion of the "paying patients" of rural providers than high rural enrollment rates would suggest.

Current Market Driven Trends

The recent growth of managed care, concentrated in urban and urban fringe areas, is influencing the rural health workforce. Recruitment and retention of primary care personnel are becoming more difficult. The services of medical referral specialists are becoming more accessible.

Starting salaries being offered newly trained family doctors and nurse practitioners have increased about fifty percent in the past two years. These raises are being driven by urban managed care systems. Many rural providers are unable to compete in this rising wage market. On the other hand, some areas are seeing managed care systems open new rural primary care facilities and bring in new practitioners to serve and existing or anticipated market..

In contract to the primary care picture, referral care is becoming more accessible to rural people. All over the country, insurance plans are using a variety of mechanisms to reduce the use of subspecialty services. Examples include requirements for preauthorization of various procedures, practice protocol based constraints, requirements for second opinions, etc. In fully developed managed care systems, these controls are much stronger. These measures are creating an actual or anticipated surplus of referral specialty care capacity in most metropolitan areas.

Even in cities with little highly managed care, hospitals and specialists are moving to recruit patients and consolidate feeder relationships in rural areas. Development of itinerant clinics and telemedical consultative ties are common examples.

In metropolitan areas dominated by stringently managed care, referral specialists are being squeezed out of practice. These displaced specialists are relocating to new locations including rural communities. The relocation of subspecialists from metropolitan California to rural Idaho communities is reportedly impressive.

Medical trainees appear to be changing career decisions in the face of the new market conditions. Choices of residency training are hard to interpret since many residents move from general internal medicine and general pediatrics ("primary care") directly into subspecialty fellowships. For many years about a third of medical school graduates said they intended to practice primary care and ultimately did so. By 1990, less than fifteen percent of medical school graduates expressed intent to practice primary care. By 1995, this figure had climbed back to thirty percent. Perhaps more meaningful, however, is the report that this July a substantial proportion of candidates for fellowship positions in internal medicine for subspecialty training failed to accept their appointments.

A national shortage of nurses has been resolved, primarily by rapid expansion of our capacity to provide two year Associates' Degrees in Nursing. This capacity, largely in community colleges, is geographically well dispersed. On the other hand, current changes in health care are increasing the demand for nurses with advance training and preparation for independent decision making and advanced practice. The increase in market demand for nurse practitioners has been mentioned. Similar increases in demand for Certified Nurse Midwives are evident. It has been demonstrated that the quality of nursing care in hospitals relates quite closely to the degree of involvement of nurses in managing nursing services. For these and other reasons, the number of programs for Masters' level preparation of nurse practitioners, midwives, advanced practice nurses and managers is growing rapidly and outstripping the supply of faculty. Although the absolute number of nurses in rural areas

is generally adequate, the number with advanced preparation is not.

Current Policy Context

Managed care, at least in its developmental stages, increases the primary care workload for two reasons; more care stays at the primary care level as less is referred, and the management of care and oversight of referrals takes time. Demand for primary care practitioners is being driven up because the capacity of managed care systems is largely dictated by its primary care capacity. Enrollees cannot be denied care because "the practice is full". Introduction of managed care into governmental entitlement programs converts individual difficulty finding a provider into a system difficulty. As managed care systems mature and patients become accustomed to new patterns, the number of annual visits per patient may decline and the primary care load decrease to some extent.

There is concern in some rural areas, particularly in the southeastern U.S., that there are not enough primary care personnel to meet the demands of managed care, particularly if the introduction of managed Medicare from the federal sector is coincident, but not coordinated, with state introduction of Medicaid managed care. Experienced managed care systems typically expect a primary care physician to take care of about 1800 people. This is twice the physician density threshold (1:3600) for a primary care shortage area. As the proportion of elderly people in the managed care population increases, primary care physician demand increases. Thus, the availability of primary care personnel in rural areas is a serious issue for the introduction of managed care, particularly for Medicare beneficiaries.

Rural communities compete with urban areas for all kinds of health personnel as well as paying patients. Medicare reimbursement formulae with lower rates for rural areas disregard this market reality and put rural health delivery systems at an additional competitive disadvantage for health care workforce recruitment and retention as the urban/rural primary care wage differential widens.

Federal and state governments have not traditionally collaborated to any great extent on health workforce issues. Today there are stronger incentives for such collaboration than in the past. Federal concern regarding Medicare costs are reflected at the state level as Medicaid consumes more and more of state budgets. Health professions education and managed care implementation are two candidate areas for stronger state-federal collaboration.

It will be extremely difficult to reconfigure the health care without sufficient primary care personnel where they are needed. As the nation tries to increase the proportion of primary care personnel in the workforce, and improve geographic distribution, it should be noted that most of the health professions education infrastructure is state owned. National health professions education policy should be based on the citizenry's need for care. State government may be better positioned to modify incentives of state educational institutions to meet these needs.

As the states implement managed Medicaid, and federal Medicare moves toward managed care, these efforts should be coordinated, particularly in areas where key resources such as primary care capacity may have to be strengthened to carry the combined load. Contracts should include performance standards requiring provision of primary care in rural areas.

In moving toward managed care, federal and state governments share a common interest in making it possible for all primary care providers to practice at the level for which they are trained. Thus, the federal government, as a purchaser of health care services, has a legitimate interest in providing incentives for states to permit nurse practitioners, nurse midwives, and physician assistants to practice at full capacity.

Education Issues

The Medicare Graduate Medical Education Program requires thorough overhaul. It should be guided by national workforce needs, with priority given to primary care and underserved area demands.

This program is by far the largest and most influential federal health care workforce program. Federal GME policy is often seen as a large city hospital issue. This perception points up the need for a

comprehensive redesign of the program. Most physicians practice near where they were trained and do what they were trained to do. Current Graduate Medical Education programs and payments lack any linkage to national workforce needs. They are concentrated in areas of greatest physician geographic and specialty surplus and reflect hospital subsidy and service needs, rather than population-based workforce needs.

Rural areas, and the rest of the country, have a compelling interest in the expansion of the proportion of physicians and nurses trained in primary ambulatory as well as hospital care, and prepared to work with less dependence on subspecialists and high intensity diagnostic equipment than is the current norm. This change cannot be achieved within the current federal GME hospital subsidy framework.

Essential subsidies for hospital high intensity care should be separated from educational program support. Educational support funds should go to educational programs rather than to hospitals. Programs in referral specialties deemed to be oversupplied should not be eligible for funding. Distribution among the states should be in proportion to state population. Educational support funding (as opposed to hospital patient care subsidies) should be factored out of the determination of payments to managed care organizations based on the Adjusted Average Per Capita Cost (AAPCC). It is particularly important that any reorganization of the GME Program not lock into place the current geographic and specialty training maldistribution.

The nursing workforce is geographically well distributed, but under prepared. Priority should be given to preparation of the nursing workforce for more advanced practice. Rural areas would be particularly well served by increasing the number of programs which prepare rural, place committed nurses for more responsible roles, using modern telecommunication. Training for allied health professionals, who are in short supply, should be targeted in rural regional hub communities rather than metropolitan medical centers.

Access to Primary Care

The National Health Service Corps is an important workforce resource for underserved areas. Deductibility of Corps payments, particularly for repayments of educational loans, would be helpful. In general, targeted repayment of practitioners' educational loans seems an effective way to provide incentives for people to practice where they're needed. The effectiveness of these programs will be increased if they can be regarded as reliably available for sufficiently far in the future that trainees can plan their careers accordingly.

The Rural Health Research Centers supported by the Federal Office of Rural Health Policy have become important sources of policy-relevant information regarding rural workforce issues.

Community and Migrant Health Centers are important as organizational nuclei for practice in many underserved areas. Lack of funding for new starts has resulted in many well qualified underserved areas being unable to develop such Centers. These Centers will become even more important as managed care eliminates the possibility of the cost shifting which has supported the indigent care "safety net."

As previously noted, rural areas compete with metro areas for personnel. Low rural reimbursement rates are a self-perpetuating burden. Any measure which reduces the urban/rural payment differential will benefit rural health care workforce recruitment and retention. The ten percent Medicare bonus payment for rural primary care in underserved areas has been helpful. It makes sense to increase it to twenty percent. Considering that only about three percent of doctors and nurse practitioners qualify for such payments, this is not a costly adjustment. Medicare cost bases for the AAPCC vary more than three fold from rural to urban extreme. Institution of measures to reduce the variation in AAPCC rates, especially a minimum AAPCC floor, will facilitate development of rural managed care and reduce organizational incentives to restrict system development to areas with redundant capacity.

Performance standards for appropriate local access to care should be developed for both managed Medicare and managed Medicaid. Throughout the country, large urban care systems with surplus capacity are organizing managed care programs to assure themselves of continuing business. In a sense these are market management rather than care management organizations. At least in the

transition to managed care, they may be less interested in buying the best care at the lowest cost, than in covering the costs of sustaining their own hospitals and clinics, even if only marginal costs can be recovered. Eventually this arrangement will fail, as the fee for service indemnity base disappears into highly penetrant managed care. In the meantime, however, lots of low cost, high quality, locally appropriate rural facilities may be eliminated. Medicare managed care, as well as Medicaid plans developed under federal waivers or capitation, should require provision of appropriate services near patients' homes. Provisions requiring accessible services "within thirty miles or thirty minutes" seem reasonable. This approach may be preferable to "any willing provider" provisions or attempts to identify particular categories of providers as "essential."

Access to Referral Care

The evolving surplus of referral specialists should be an asset to rural communities as some relocate and other extend their services through itinerant clinics or telemedicine. The latter has real promise of making referral care more reliably available and convenient for rural people. Properly structured, it may increase the proportion of people staying in their home communities for care (although many of the large urban hospitals sponsoring development of telemedicine links may assess these probabilities differently). Telemedicine is unlikely, however, to help with the fundamental rural problem of too few primary care providers.

International Medicine Graduates

Every year several thousand physicians enter the US on "J-1" visas to secure training and augment teaching hospital workforces. The J-1 visa requires the holder to return to his/her country of origin for two years before seeking permanent entry. The Appalachian Regional Commission has for many years been able to request waivers of the compulsory departure requirement in exchange for a commitment to practice under certain stipulations in an area of need. Recently this source of physicians has been opened to non-Appalachian states through new programs.

The long term experience with this approach in Appalachia has been positive for the following reasons. Most "J-1" doctors have been through several highly competitive selection processes. Most are extremely able and well trained, often having been through more than one residency or fellowship training program. Without them, medical care in many of the poorer parts of Appalachia might have collapsed. Although most move on to urban areas after their obligations have been fulfilled, many other have put down permanent roots and become key people in local professional and community groups.

Negative points include the following: Relatively few international medical graduates come to the U.S. for primary care training. Most are referral specialists who are not entirely comfortable in primary care and revert to subspecialty practice as soon as possible. Some patients complain of communication difficulties which arise when rural American speech patterns intersect a variety of accents from overseas.

The J-1 visa waiver programs for practice in underserved areas should be continued until there is reason to believe that U.S. graduates are prepared to meet rural needs. Eligibility for participation should be limited to physician graduates of designated primary care residency programs.

Thank you, Mr. Chairman, and Members of this Subcommittee, for this opportunity to share these concerns. I would be glad to entertain questions.

Mrs. JOHNSON [presiding]. Thank you very much, Drs. Wakefield and Myers.

Let me turn first to Mr. Christensen.

Mr. CHRISTENSEN. Thank you, Madam Chairwoman.

Dr. Wakefield, I want to thank you for your testimony. I grew up in a rural area, St. Paul, Nebraska, a small town that has a little hospital that faces this dilemma of whether or not we move it to a different type of facility because we are about 25 miles from a larger metropolitan city with full services there, so I am very interested in this whole issue of rural health care.

One of the things that came up during your testimony was the issue of providing improved health care to the States where the RPCH Program has been implemented. What evaluations have you done on the effectiveness of this program?

Ms. WAKEFIELD. Well, I have not personally done any kind of a structured evaluation but I have looked at some of the evaluations that have been done by the Health Care Financing Administration and have talked with HCFA's staff and there are a number of things that are said about the quality and the difference that that particular model makes.

The couple of comments that I would have to say about it are these. I do not think that the way it is structured currently is necessarily the model that will meet the needs of every rural area or of every small community hospital. It is something of a niche program and it works very effectively in some of the areas where it is currently located.

There have been hospital administrators who have looked at that program and have done feasibility assessments, and when they have done that, they have found that when they run the numbers, they do not necessarily come out better if they were part of that program in terms of the way it is currently structured.

So that is a mixed response, saying that in some cases, it would seem to work very well and in others, it may not be the best way to structure a delivery system. The point probably is, and the most important point is probably to look at the unique needs of different rural areas and try to come up with the configuration that best meets the needs of that rural community.

The situation that you described with the hospital 25 miles away from a larger, perhaps urban area are needs that are probably quite different from, obviously, whatever health care facilities might be available to a frontier community. So, I guess the best I could give you regarding RPCH is a little bit of a mixed review.

Mr. CHRISTENSEN. How would you change the RPCH Program so that it has more of a greater service rather than just a niche market?

Ms. WAKEFIELD. I think that looking at different models of care is really a good thing to do. For example, in the legislation that was introduced by the House Rural Health Coalition, they promote the notion of a slightly different structure, taking what I think are some of the strengths of the EACH/RPCH Program and of MAF from Montana and incorporating those in their legislation. That is a slightly different model but another alternative.

Mr. CHRISTENSEN. Also, concerning the National Health Service Corps Primary Care Doctor Scholarship Program, could you de-

scribe for us in greater detail why is this a barrier for attracting primary care doctors, the taxation service linked to the scholarships and the loans repayment program?

Ms. WAKEFIELD. Currently, the National Health Service Corps Program provides scholarships and loans both to physicians and to nonphysician providers, and depending on the load that a student carries while they are in school and their ability to pay for that schooling, it can make a difference, having to pay taxes on their scholarships.

So, while it may not be a high priority need for every single student who comes through a college or a university, it certainly would be true for a number of students, given the cost of tuition, and so forth. Paying for scholarships while students are in school and picking up the tax liability for that can make a difference.

In terms of the loan repayment program, that tax is paid for currently by the National Health Service Corps. So in a way, it is the Federal Government, i.e., the National Health Service Corps, paying the Federal liability on that loan repayment, which is paying the IRS back, paying another part of the Federal Government. So, the government's sort of circulating those moneys, taking away the opportunity to utilize the money to put into loan repayment specifically and instead taking those dollars and putting them into paying off a tax liability.

Mr. CHRISTENSEN. What has your research shown is the average tax paid for these scholarships from primary care doctors?

Dr. WAKEFIELD. I am sorry. I do not have the answer to that question but I would be happy to try and get it for you.

Mr. CHRISTENSEN. Thank you, Madam Chairwoman.

Mrs. JOHNSON. Thank you.

I appreciate the panel's testimony this morning. There are a number of questions that you raised. Dr. Myers, you made some very interesting comments about medical education that I think are very important. What is your opinion of funding consortia training groups?

Dr. MYERS. I think that that is very much a step in the right direction and it opens up some public deliberation about where programs are needed and in what specialties. Much depends on the mandated demography of the consortium, and to the——

Mrs. JOHNSON. Excuse me. Please say that again, a little closer to the microphone.

Dr. MYERS. A lot depends on the mandated makeup of the consortium. If it is constituted to be dominated by teaching hospitals and medical schools, I find that less sound than if it is dominated by someone, say, in the State public health or work force that is primarily driven by public needs rather than institutional needs.

Mrs. JOHNSON. Dr. Myers, I think it would be very unwise to pass legislation at this point that required certain structures to be consortia. Different communities have different resources. In some instances, the hospital might be the very best coordinator of that. I think we want to allow groups to apply to have the consortia as the reimbursable unit rather than the hospital and begin to see how it works. We need a lot more experience before we dictate that one or the other unit be dominant.

Dr. MYERS. The point that I guess I would defend is that there must be strong representation at that table to someone who is responsive to, and uncomfortable if, work force distribution problems and staffing problems in terms of specialty and geography are not getting better.

Mrs. JOHNSON. Yes, I do hear what you are saying. I think one of the points you made that was very interesting to me is that the hardest decision that a physician or a nurse practitioner has to make is to spot the 1 of 1,000. If your general practitioners do not have some training in sophisticated settings, they will not get enough knowledge of specialties to understand where that line is going to be, because they are not trained in some of the complexities that specialists are, nor could they possibly be or retain it. But to know when there might be a problem here, they have to have enough exposure in a hospital setting to be able to make that judgment. So, all of this issue of training settings is not something that you want Members of Congress deciding.

Dr. MYERS. Understood, and I would not disagree with the points you make. I think the point that I am trying to push is the idea that there is a legitimate place for training outside hospitals which has not been provided for in our current framework.

Mrs. JOHNSON. And to that point, I agree with you absolutely. In the Republican thinking on this issue, you may remember that we made a number of stabs at how to control this. In the end, in both bills, there a cap on the number of new residency slots because of the pros and cons of every action that the Federal Government takes in this area.

I also have been very impressed by what is happening out there in the real world in terms of the number of people who are looking now to family practice residencies, internal medicine residencies, as opposed to 5 years ago. So a different choice is being made, and I personally think that as the Bostons, New Yorks, Chicagos, and even the Hartford, Connecticuts, of the Nation integrate their hospitals, as Boston is doing at a dramatic pace, that the practice opportunities are going to be greater in the rural areas.

Dr. MYERS. I agree.

Mrs. JOHNSON. We are going to deal with our rural deficit of professionals in, in a sense, the best way. We are going to make rural practice desirable again.

Dr. MYERS. I would like to mention that there are structured ways to pick out the 1 in 1,000 rather than seeing only the 1 in 1,000 after they are picked, and some of the, say, family medicine training programs in decision matrices and so forth are structured to actually educate people in that skill as a thing to be valued in itself.

Mrs. JOHNSON. And actually, the specialists also need training in that matrix so that they know——

Dr. MYERS. If they want to make a living in managed care.

Mrs. JOHNSON. That is right. Even if they are not, they need to understand how the system perceives symptoms and what the communication is going to be. This is not something we can divide up.

But, I agree with you that our training sites can no longer be the traditional hospital sites alone, that we have to do a far more comprehensive and flexible job of training, and we have had some ex-

cellent testimony before this Subcommittee of things that are going on across the nation that is radically changing the training sites.

Last, I would just like to comment that I hear you speak in support of the J–1 visas. I think we do have to pay attention to the fact that the explosion in residency physicians has been to train non-citizen physicians, and while that is useful from the point of view of world health care quality, there is a limit to which American taxpayers can be asked to support that.

So we are going to have to engage, and I think legitimately so, with who pays for that training and more of the countries need to be paying for it and more of those people need to be going back and carrying the quality of training they got in America back to their home countries. I think that is part of also reconfiguring our care system, so that we have the quality but also have it where we need it.

Dr. MYERS. And I would mention that the support I expressed for those programs was not so much for the basic importation of 6,000 new physicians a year but was to make the point that the U.S. training program has pretty much not served rural areas, and as soon as the U.S. training program can meet rural and underserved area needs, I will be anxious to stem the alternative.

Mrs. JOHNSON. I appreciate that. It is important to remember why our system does not serve rural areas. In modern medicine, isolation is not only a personal problem, it is a professional problem, and so telemedicine and some of the things we have heard here, there is a whole development that has to take place to assure that being geographically isolated does not mean being professionally isolated and therefore compromising your ability to deliver care.

I think that the direction that we are moving is the right direction. We have to move far more rapidly, and I think we have to build in a far more integrated health care delivery system across America, outside of the whole debate about managed care, and it is already happening in an exciting fashion. I will read your testimony in preparation for next year's work because I particularly am involved in the medical education issue and I appreciate the thoughtfulness of your comments here today. Thank you.

We have one more panel. We also have a vote. I am going to recess the hearing for 10 minutes. So in 10 minutes, we will reconvene with the last panel before us. Thank you.

[Recess.]

Mr. CHRISTENSEN [presiding]. If we can ask our last panel to come forward, Dr. Keith Mueller, Wayne Nelson, Harry Foster, and Edward Wronski.

I am going to go ahead and introduce Dr. Mueller. He is a fellow Cornhusker from Nebraska and we are glad that you are with us today. I know you have been here before and we have talked several times. You have quite a history in working with rural health care. I appreciate your testimony today. I know that as president of the National Rural Health Care Association, Dr. Mueller, we would be pleased to hear your testimony at this time.

STATEMENT OF KEITH J. MUELLER, PRESIDENT, NATIONAL RURAL HEALTH ASSOCIATION

Mr. MUELLER. Thank you, Mr. Chairman, and, for the record, the other Members of the Subcommittee. I am here as president of the National Rural Health Association, which represents all of rural America, health care providers and consumers alike.

All of our members, hospital administrators, policy analysts, clinic administrators, physicians, and other health professionals, State rural health offices and associations, educators, and general consumers are deeply concerned about the future of health care services in rural areas as well as the continuing Federal commitment to sustaining affordable services that are accessible to all rural residents.

We believe that through both a general moral obligation and a more specific fiduciary responsibility for Medicare beneficiaries, the Federal Government must continue to provide leadership on behalf of rural residents. This does not mean that programs should not change. My testimony today will suggest changes that either warrant immediate adoption or further investigation and demonstration.

As the Medicare Program is changed to encourage greater use of managed care as an option, Congress must act to change the current means of funding risk contracts, the adjusted average per capita cost, or AAPCC. This methodology, based on previous expenditures within each county, results in gross urban-rural disparities that may make it financially impractical to offer capitated contracts in rural counties.

AAPCC payments for 1996 are as high as $692 per member per month in some urban counties and as low as $205 in rural counties. My home State of Nebraska has the dubious distinction of having 8 counties in the bottom 10 for payment, and all 93 of our counties are below the national average of $392. While some variation is appropriate to account for price differences, current differences serve as barriers to managed care for rural Medicare beneficiaries. To be more certain that managed care is a meaningful choice for rural residents, the National Rural Health Association supports a minimum payment of $350 in 1997 dollars.

There are currently several Medicare Programs, discussed in earlier testimony, that recognize the special circumstances of rural hospitals, different reimbursement for sole community providers and rural referral centers, and special programs for rural primary care hospitals associated with essential access hospitals and medical assistance facilities. These programs, meritorious as they are, do not meet all the needs of small rural hospitals seeking to reconfigure services to find an appropriate niche in today's system for health care delivery. The models for reconfiguration are currently limited to seven States with the EACH/RPCH Program and one State with the MAF Program.

Additionally, a financial category of importance for rural hospitals, Medicare-dependent hospitals, has lost its authorization.

The NRHA is committed to creating a single category of limited service hospitals that would include flexible regulatory and reimbursement arrangements for health care institutions to reconfigure in a manner consistent with the needs of their communities rather

than predetermined notions of what a hospital is. We will work with the Subcommittee and others to help craft specific legislative language to accomplish this goal.

Telemedicine holds great promise for rural America and for medicine generally. To the extent patients can use telemedicine to consult with physicians, travel is reduced significantly, as shown in data from its first full year of use in Kearney, Nebraska. Installation of more advanced communication lines to rural communities would help a great deal and may be accomplished thanks, at least in part, to the universal service provisions of the Telecommunications Act of 1996.

The National Rural Health Association supports efforts to encourage the Secretary of HHS to develop Medicare payment methodology for all telemedicine services and also supports the continuing evaluation of existing demonstrations of this technology.

The current mechanisms in place to fund graduate medical education, primarily through Medicare, are fundamentally flawed, as you just heard. Our needs now are for primary care physicians trained in ambulatory care settings with particular training for practicing in managed care systems. Instead, we have the remnants of a system designed to train specialists in large teaching hospitals.

The National Rural Health Association believes that the Medicare payment system to support GME should be altered in ways that support national and regional work force needs. I have submitted for the record a special white paper prepared by the NRHA on this topic.

Federal payment policies designed to favor location to underserved rural areas are an important tool in the struggle to attract and keep health care professionals in rural America. The NRHA favors increasing the current 10 percent Medicare bonus payment to 20 percent for primary care physicians practicing in underserved areas and expanding the scope of that program to include direct reimbursement for other primary care providers, such as physician assistants, nurse practitioners, and nurse midwives.

As both the private and public sectors increasingly adopt tough negotiating strategies to pay providers for services rendered to their beneficiaries, safety net providers who have relied on third party payment to help finance the cost of care for the uninsured are threatened. In rural areas, these providers are often community and migrant health centers. These centers deliver primary care services and other essential services that include transportation, translation, and family care, to rural residents unable to afford care.

The costs of running such centers is often higher than other primary care providers because of the health of the population being served, the full array of services offered, and the inclusion of supporting services. We cannot afford to leave safety net providers without the opportunity to participate in the new methods of financing health care.

The National Rural Health Association has taken the position of creating a set-aside for clinics in any block grants from Medicaid. Consistent with that position, any movement to managed care

choice in Medicare and Medicaid must be coupled with provisions that "level the playingfield" for safety net providers.

Mr. Chairman, I trust this brief description of health care programs of special interest to rural Americans and the suggestions it includes for retaining the best aspects while making some improvements is helpful to the Subcommittee. To reiterate, the following programs are critical to establishing a sustainable rural health care delivery system: Equitable reimbursement in Medicare, creating and supporting a flexible program for limited service hospitals, completing a plan for reimbursing telemedicine services as well as thorough evaluation of what works and why and how, reforming graduate medical education payment, and continuing to support safety net providers.

In this brief presentation, I have not had the opportunity to focus on other programs of importance to health care services in rural America but that are of less direct relationship to Medicare. They include the following: Federal support for health services research related to the health care needs of rural Americans. Federal grant programs, such as the Outreach and Transition grants that help rural providers and systems make the transitions in services and institutions to configurations more capable of participating in the new more cost-effective means of delivering health care services. The importance of maintaining an effective venue for rural health interests to be represented in Federal Government deliberations, particularly within the Department of Health and Human Services. The variety of ways Federal Government policies affect rural health, including transportation policies, agricultural policies, environmental policies, and welfare policies.

Mr. Chairman and Members of the Subcommittee, we can best serve rural America by constantly remembering the purpose of our efforts, to improve and then sustain the health of rural Americans. The National Rural Health Association is here to advocate on behalf of serving rural residents by the best means possible. Creative redesign of existing programs is welcome. Abandoning current programs to achieve savings at the expense of access to health care is not.

I know each of you agrees with this general approach, and the National Rural Health Association looks forward to working together with you to advance rural interests that are consistent with your broader policy objectives. Thank you.

[The prepared statement follows:]

STATEMENT OF
KEITH J. MUELLER, Ph.D., PRESIDENT
NATIONAL RURAL HEALH ASSOCIATION

Mr. Chairman and members of the Subcommittee:

I am here as president of the National Rural Health Association, which represents all of rural America—health care providers and consumers alike. All of our members—hospital administrators, policy analysts, clinic administrators, physicians and other health professionals, state rural health offices and associations, educators, and general consumers—are deeply concerned about the future of health care services in rural areas as well as the continuing federal commitment to sustaining affordable services that are accessible to rural residents. We believe that through both a general moral obligation and a more specific fiduciary responsibility for Medicare beneficiaries the federal government must continue to provide leadership on behalf of rural residents. This does not mean that programs should not change—my testimony today will suggest changes that warrant either immediate adoption or further investigation and demonstration.

Capitated Medicare Payment

As the Medicare program is changed to encourage greater use of managed care as an option, Congress must act to change the current means of funding risk contracts—the Adjusted Average Per Capita Cost, or AAPCC. This methodology, based on previous expenditures within each county, results in gross rural-urban disparities that may make it financially impractical to offer capitated contracts in rural counties. 1996 AAPCC payments are as high as $692 in some urban counties and as low as $205 in rural counties. My home state of Nebraska has the dubious distinction of having eight counties in the bottom 10 for payment, and all 93 of our counties are below the national average of $392. While some variation is appropriate to account for price differences, current differences serve as barriers to managed care for rural Medicare beneficiaries. **To be more certain that managed care is a meaningful choice for rural residents, the National Rural Health Association supports a minimum payment of $350 in 1997 dollars.**

Limited Service Hospitals

There are currently several Medicare programs that recognize the special circumstances of rural hospitals—different reimbursement for Sole Community Providers and Rural Referral Centers and special programs for Rural Primary Care Hospitals networked with Essential Access Care Hospitals (EACH/RPCH) and Medical Assistance Facilities (MAFs). These programs, meritorious as they are, do not meet all the needs of small rural hospitals seeking to reconfigure services to find an appropriate niche in today's system for health care delivery. The models for reconfiguration are currently limited to seven states with the EACH/RPCH program and one state with the MAF program. Additionally, a financial category of importance for rural hospitals—Medicare Dependent Hospitals—has lost its authorization. **The National Rural Health Association is committed to creating a single category of Limited Service Hospitals that would include flexible regulatory and reimbursement arrangements for health care institutions to reconfigure in a manner consistent with the needs of their communities rather than predetermined notions of what a "hospital" is.** We will work with the committee and others to help craft specific legislative language to accomplish this goal, which will satisfy delivery and cost-effectiveness objectives simultaneously.

Telemedicine

Telemedicine holds great promise for rural America and for medicine generally. To the extent patients can use Telemedicine to consult with physicians, travel is reduced significantly, as shown in data from its first full year of use in Kearney,Nebraska. Installation of more advanced communications lines to rural

communities would help a great deal and may be accomplished thanks to the universal service provisions (Section 254H) of the Telecommunications Act of 1996. **The National Rural Health Association supports efforts to encourage the Secretary of the Department of Health and Human Services to develop Medicare payment methodology for all Telemedicine services and also supports the continuation of evaluation of existing demonstrations of Telemedicine technology and use in rural settings.**

Graduate Medical Education (GME)

The current mechanisms in place to fund Graduate Medical Education (GME), primarily through Medicare, are fundamentally flawed. Our needs now are for primary care physicians trained in ambulatory care settings, with particular training for practicing in managed care systems. Instead, we have the remnants of a system designed to train specialists in large teaching hospitals, with an emphasis on becoming referral physicians. **The National Rural Health Association believes that the Medicare payment system to support GME should be altered in ways that support national and regional work force needs.** I am submitting for the record a more detailed paper prepared by the National Rural Health Association that makes the argument for ambulatory site training of primary care physicians, consistent with recommendations of the Council on Graduate Medical Education (COGME).

Other Work Force Issues

Federal payment policies designed to favor location to underserved rural areas are an important tool in the struggle to attract and keep health care professionals in rural America. **The National Rural Health Association favors increasing the current 10 percent Medicare bonus payment to 20 percent for primary care physicians practicing in underserved areas and expanding the scope of the program to include direct reimbursement for other primary care providers, specifically physician assistants, nurse practitioners and nurse midwives.**

Supporting Safety Net Providers

As both the private and public sectors increasingly adopt tough negotiating strategies to pay providers for services rendered to their beneficiaries, safety net providers who have relied on third-party payment to help finance the cost of care for the uninsured are threatened. In rural areas, those providers are often community and migrant health centers. These centers deliver primary care services—and other essential services that include transportation, translation and family care—to rural residents unable to afford care. The costs of running such centers is often higher than other primary care providers because of the health of the population being served, the full array of services offered and the inclusion of supporting services. We cannot afford to leave safety net providers without the opportunity to participate in new methods of financing health care. **The National Rural Health Association has taken the position of creating a set-aside for clinics in any block grants for Medicaid.** Consistent with that position, any movement to managed care choice in Medicare and Medicaid must be coupled with provisions that "level the playing field" for safety net providers.

Mr. CHRISTENSEN. Thank you, Dr. Mueller, for your testimony. Mr. Nelson.

STATEMENT OF WAYNE NELSON, PRESIDENT, COMMUNICATING FOR AGRICULTURE, FERGUS FALLS, MINNESOTA

Mr. NELSON. Thank you, Mr. Chairman and Members of the Subcommittee. We thank you for the opportunity to express our views on rural health care.

My name is Wayne Nelson. I am a farmer from Winner, South Dakota. I live in a rural community of about 3,500 people. I am president of Communicating for Agriculture, which is a national non-profit organization with a membership of farmers, ranchers, and rural small business people in 50 States. Our members are consumers of the rural health care system who believe it is vital that we have access to the same quality health care services that urban communities enjoy.

California has long been an advocate of equality in Medicare reimbursement rates for rural health care providers, institutions, and professionals. Rural hospitals lean very heavily on Medicare, which is no surprise, considering rural areas are home to a higher percentage of seniors than the rest of the country. Typically, rural hospitals receive over half their income from Medicare patients, with one hospital in my State of South Dakota receiving almost 80 percent of their income.

The Medicare reimbursement rates are much too low in rural areas in comparison with their urban counterparts. Reimbursements for rural hospitals received do not reflect their true costs, forcing many hospitals to shift expenses to patients with private insurance. This cost shifting might be necessary for the hospital to stay in business, but it also drives up premiums for rural health care consumers.

Several legislative efforts have been introduced that would help solve the problem of unequal reimbursement rates, including last year's budget agreement and the Rural Health Improvement Act introduced this summer, but unfortunately, nothing has been signed into law that adequately addresses this growing problem.

Hospitals play a very important role in rural communities, not only as health care centers but also in terms of economic activity. In many cases, rural hospitals are the largest employers in town. This is the case in my home community in South Dakota. Losing our hospital would deliver a severe economic blow to my community, a dramatic example of why we need to save as many rural hospitals as possible.

Creating new classifications of rural hospitals under Medicare would be one way to help. Rural primary care hospitals could become intermediate State facilities and rural emergency access care hospitals could be designated emergency facilities, with treatment not exceeding 24 hours. These new categories might enable hospitals that are in danger of closing a chance to stay in operation, thus maintaining more health care options and better access at the local level.

Finding new doctors and keeping existing ones in rural areas is a continuing problem. Many things have been done. One thing in my community was private funds were used to pay part of the ex-

pense of a medical student going to a medical college and then, in turn, he agreed to practice in our community for 5 years. But, more needs to be done than just private participation.

We are lucky in my community that we have doctors available, but they do draw from a 50-mile radius. It is not uncommon for people in Western South Dakota to drive 50 or more miles to get to a health care professional. Physicians' assistants and nurse practitioner programs have helped, but we still need more incentive to attract doctors to practice in rural communities if we are to assure adequate access to quality health care for rural Americans.

Since many of these areas are underserved in terms of health care, you can understand why managed care is not always an option for us. As a result, we believe in the ability of rural people to help control their own health care costs. We have offered an Association-endorsed health plan, similar to a medical savings account, since 1978. It is one way of our members to hold down health care costs.

Recently passed legislation offering a trial on MSAs with important tax savings will make the program work even better. The increase in the deductibility of health insurance premiums for the self-employed is also very important to rural America.

Technological advances have opened up new ways of delivering health care to rural regions. Telemedicine services are offered in many rural areas, including my own. The ability to draw on the diagnostic skills of specialists hundreds of miles away through satellite communication is a tremendous advancement. A method to provide Medicare reimbursement for telemedicine services should be offered.

The Internet also serves to help those in rural areas learn more about health care in general. We have been involved in obtaining local access to health care information and other information to people in rural America, enabling them to review the myriad of data available. As you know, doctors are also using the Internet to communicate with other health professionals throughout the world, including reaching practitioners in remote rural areas.

In addition, we have worked for many years to help establish State risk pools or guaranteed access plans so those considered uninsurable will have an option for insurance coverage. This has helped many rural Americans keep coverage when their health condition normally would have made them ineligible for health insurance. The expansion of risk pools into more States would be an effective way for the uninsurable in rural areas to gain access to health care.

Finally, the last 5 years has shown an increase of 2.6 million people in rural America. Seventy-five percent of rural counties are growing today, compared to only 45 percent that were growing in the eighties. A desirable quality of life in rural areas, we think, is bringing people back to communities that were not growing 10 years ago. But, quality health care services are critical to keep these areas growing. We cannot forget about the areas that are not growing as quickly or may be even losing population.

This simply underscores the fact that rural health care needs and problems are very unique and that rural health solutions require a variety of approaches. We all recognize that a one-size-fits-

all program is not the answer. The Rural Health Improvement Act of 1996 addresses this uniqueness and offers a variety of improvements for rural health care that our Association supports. Thank you very much.

[The prepared statement follows:]

TESTIMONY

Wayne Nelson
President
Communicating for Agriculture
Committee on Ways & Means
Health Subcommittee
September 12, 1996

Rural Health Care

Mr. Chairman and members of the committee. Thank you for the opportunity to express our views on rural health care. My name is Wayne Nelson, a farmer from Winner, South Dakota, a rural community of 3500 people. I am president of Communicating for Agriculture, a national nonprofit organization with a membership of farmers, ranchers and rural small business people in 50 states. Our members are consumers of the rural health care system who believe it is vital that they have access to the same quality health care services that urban communities enjoy.

CA has long been an advocate of equality in Medicare reimbursement rates for rural health care providers, institutions and professionals. Rural Hospitals lean very heavily on Medicare which is no surprise considering rural areas are home to a higher percentage of seniors than the rest of the country. Typically, rural hospitals receive over half their income from Medicare with one hospital in my state of South Dakota receiving almost 80 percent. The Medicare reimbursement rates are much too low in rural areas in comparison with urban counterparts. The reimbursements rural hospitals receive don't reflect true costs, forcing hospitals to shift expenses to patients with private insurance. This cost shifting might be necessary for the hospital to stay in business but it drives up premiums for rural health care consumers. Several legislative efforts have been introduced that would help solve this problem of unequal reimbursement rates, including last year's budget agreement and the Rural Health Improvement Act introduced this summer, but unfortunately, nothing has been signed into law to address this growing problem.

Hospitals play an important role in rural communities not only as health care centers but also in terms of economic activity. In may cases, rural hospitals are the largest employers in town. This is the case in my home community in South Dakota. Losing our hospital would deliver a severe economic blow to Winner, a dramatic example of why we need to save as many rural hospitals as possible. Creating new classifications of rural hospitals under Medicare would be one way to help. Rural Primary Care Hospitals could become intermediate-stay facilities and Rural Emergency Access Care Hospitals could be designated emergency facilities with treatment not exceeding 24 hours. These new categories might enable hospitals that are in danger of closing a chance to stay in operation, thus maintaining more health care options at the local level.

Finding new doctors and keeping existing ones in rural areas is a continuing problem. I'm lucky that we have doctors available in my community but they draw patients from a 50 mile radius. It is not uncommon for people in western South Dakota to drive 50 miles or more to get to a health care professional. Physician Assistant and Nurse Practitioner programs have helped, but we still need more incentives to attract doctors to practice in rural communities if we are to assure adequate access to quality health care for rural Americans.

Since many areas are under served in terms of health care, you can understand why managed care is not often an option for us. As a result, because we at CA believe in the ability of rural people to help control their own health care costs, we have offered an association-endorsed health plan similar to a medical savings account since 1978. This plan offers a higher-deductible insurance policy which has a lower monthly premium. We couple it with a saving plan setting aside money to cover first dollar expenses for health care. It is one way for our members to hold down health care costs. Recently passed legislation offering a trial on MSAs with important tax savings will make the program work even better. The increase in the deductibility of health insurance premiums for the self-employed is also very important to rural America.

Technological advances have opened up new ways of delivering health care to rural regions. Telemedicine services are offered in many rural areas, including my own. The ability to draw on the diagnostic skills of specialists hundreds of miles away through satellite communication is a tremendous advancement. A method to provide Medicare reimbursement for telemedicine services should be offered. The Internet also serves to help those in rural areas learn more about health care in general. CA has also been very involved in obtaining local access to health care information for people in rural America, enabling them to review the myriad of data available. As you know, doctors are using the Internet to communicate with other health professionals throughout the world to make available a large window of information, including reaching practioners in remote rural areas.

In addition, we have worked over the last 20 years to help establish state risk pools or guaranteed access plans so those considered "uninsurable" will have an option for insurance coverage. This has helped many rural Americans keep coverage when their health condition normally would have made them ineligible for health insurance. The expansion of risk pools into more states would be an extremely effective way for the uninsurable in rural areas to gain access to health care.

Finally, the last 5 years has shown an increase of 2.6 million people in rural America. Seventy-five (75) percent of rural counties are growing today compared to 45 percent in the 1980s. The desirable quality of life in rural areas is bringing people back to communities that weren't growing 10 years ago. Quality health care services are critical to keep these areas growing. However, we cannot forget that some areas are not growing as quickly, or may even be losing population. This simply underscores the fact that rural health care needs and problems are unique, that rural health solutions require a variety of approaches. Congress and the Administration must recognize that a one-size-fits-all program is not the answer. Thank you.

Mr. CHRISTENSEN. Thank you, Mr. Nelson.
Mr. Foster.

STATEMENT OF HARRY L. FOSTER, CHIEF EXECUTIVE OFFICER, FAMILY HEALTHCARE NETWORK, PORTERVILLE, CALIFORNIA, ON BEHALF OF THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

Mr. FOSTER. Thank you, Mr. Chairman and Members of the Subcommittee. As a resident of the 21st Congressional District of California, I want to thank you for the opportunity to testify today. I also want to publicly acknowledge our appreciation for the leadership that the Chairman, Mr. Thomas, has provided us.

I am chief executive officer of the Family HealthCare Network, a community and migrant health center in Porterville, California. We provide accessible, comprehensive, patient-oriented primary health care services in Tulare County. We are especially oriented toward patients who experience barriers in obtaining health care services from other providers.

In 1995, Family HealthCare Network served 21,498 patients. Of these, 63 percent were Hispanic, 25 percent were Caucasian, and 12 percent were other non-Caucasian. Eighty percent of our patients were below 200 percent of the poverty level.

Tulare County is a sparsely populated rural area about 150 miles north of Los Angeles. It is the second most productive county in the world in annual crop production, with over 2.5 billion dollars' worth of agricultural products every year.

Tulare County is a classic rural area. Poverty is high. Over 15 percent of residents are on AFDC. Over 15 percent are unemployed. Education levels are low. Of the 39.8 percent do not have a high school education.

There are several barriers to accessing health care in the county. Transportation is a significant problem, particularly in Porterville. Many people have to travel on rural roads in excess of 30 miles to a provider. Most of our service area is without a fixed-route mass transit system.

Language is a barrier. Many local Hispanics prefer to communicate in Spanish. Others are fluent only in languages other than English. At the health center, we provide translation in four languages, English, Spanish, Hmong, and Lao.

Financial limits are another barrier. Almost 50 percent of the population is on Medi-Cal or uninsured. Very few new patients at Family HealthCare Network have had any preventive care. We regularly see children with no record of childhood immunizations, women who have never had a pap smear, and individuals who are clearly diabetic or hypertensive who have never been diagnosed or treated. It is not surprising that Tulare County has a higher rate than the State average rate for many communicable diseases.

Tulare County especially needs effective prenatal care. The birth and fertility rates are extremely high, as are teenage pregnancy rates. Every day, our providers see women, especially adolescent and foreign-born, who present in their second and third trimester of pregnancy with no prior prenatal care. Despite all this, we have improved birth outcomes. In 1978, the county infant mortality rate

was 14.8 deaths per 1,000 live births and today it is down to 6.2 deaths per 1,000 live births.

Family HealthCare Network is highly dependent on public sources of funding to pay for the care of our patients. Fifty percent of our revenues are from Medi-Cal, 3 percent from Medicare, 8 percent are from Public Health Service Act grants, 10 percent from private insurance, 4 percent are from State funds, and 25 percent are from uninsured patients.

Of critical importance to Family HealthCare Network is the system of reasonable cost reimbursement which health centers currently receive under Medicare and Medicaid. This system needs modification as rural health centers begin to participate in managed care networks. Managed care plans are unwilling to pay capitation payments which are enough to cover the costs of caring for patients. We do not have a large base of revenues from commercial patients to make up any losses from public programs. In my written statement, we have proposed a change in the Medicare and Medicaid Programs to remedy this problem.

Also important to rural health centers are Public Health Service Act grants for community and migrant health centers. These grants are directed toward serving the uninsured and to provide outreach, transportation, and other support services which help eliminate barriers to care. The House has provided an increase of $44 million for these grants for fiscal year 1997. We sincerely hope that this funding level is maintained in any final funding bill for fiscal year 1997.

Another significant problem for rural health centers is the recruitment and retention of health professionals. Even after recruiting doctors, other providers with significant financial resources try to recruit our doctors away from us by offering higher salaries which we simply cannot match.

A way to attract and retain doctors to rural areas is to provide opportunities for them to train in ambulatory care settings, where they can see the benefits and satisfaction of establishing a family practice. We recommend that any reform in the Medicare and Medicaid Graduate Medical Education Programs provide for payment for the training of residents at health centers and other ambulatory care sites.

Our comments about H.R. 3753 are outlined in detail in my written statement. Our most serious concerns are with section 602 of the bill, which requires the Health and Human Services Secretary, in making community health center grants, to give special consideration to projects involving collaborative agreements between health centers and community hospitals. These agreements must meet several overly restrictive requirements, including one that a health center be located in or adjacent to a hospital.

Health centers believe that while collaboration between providers should be encouraged, many hospitals in rural areas have sufficient resources and reserves to establish collaborative arrangements without the use of scarce health center grant funds. In addition, section 602 would discriminate against rural areas without a hospital, even if their need for primary health care services is greater than that of other rural areas which do have one.

We strongly recommend that the current language in section 602 be deleted and replaced with language allowing greater flexibility on these collaborative efforts. My written statement contains specific language for your consideration.

Thank you for the opportunity to provide our views on rural health care in America. We look forward to working with the Subcommittee on this and other important health care issues in the future.

[The prepared statement follows:]

STATEMENT OF HARRY L. FOSTER
FAMILY HEALTHCARE NETWORK, PORTERVILLE, CA
ON BEHALF OF
THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

My name is Harry Foster. I am Chief Executive Officer of the Family HealthCare Network, a nonprofit community and migrant health center in Porterville, California. I am submitting this testimony today on my own behalf and as a representative of the National Association of Community Health Centers. The purpose of my testimony is to describe the needs for, and barriers to, health care in rural central California and to provide you with my views on H.R. 3753, the Rural Health Improvement Act of 1996.

The Challenge of Providing Primary Health Care Services in a Rural Area

The mission of Family HealthCare Network is to provide accessible, comprehensive, patient-oriented primary health care services to individuals and families in our service area, Tulare County. Family HealthCare Network is especially oriented towards those individuals and families who experience barriers in obtaining health care services from other providers. We provide our care in a culturally sensitive and dignified manner. In twenty years, we have grown from a small gas station facility and attached temporary trailer to three facilities in different localities in the county. In 1995, Family HealthCare Network served 21,498 patients. Of these, 63 percent were Hispanic, 25 percent were Caucasian, and 12 percent were other Non-Caucasian (including Filipino, African-American, and Southeast Asian). Eighty percent of our patients were below 200 percent of the poverty level.

Tulare County is a rural area about 50 miles north of Bakersfield and 150 miles northwest of Los Angeles. It is sparsely populated. In 1990, the total population was 311,921 over an area of 4,863 square miles. The population is projected to grow to approximately 437,000 by the year 2000. The population breakdown is 52.8 percent Caucasian, 40.7 percent Hispanic, 4 percent Asian/Pacific Islander, 1.4 percent African-American, and 1 percent Native American. Over eleven percent of the population is enrolled in Medicare.

Tulare County is in the heart of California's San Joaquin Valley, one of the richest agricultural regions in the world. Tulare is the second most productive county in the world in annual crop production, producing over 2.5 billion dollars worth of fruits, nuts, produce, grain, and livestock every year. Two-thirds of the employment in the area is either directly or indirectly related to the agriculture industry. An important factor in the growth of the county's productivity and population are migrant agricultural workers. These workers have made the smaller communities of the county their "downstream" home, moving about the state to work in agriculture from their base in the community, and finding other work in periods when farm work is unavailable.

Because of the rural nature of the county and the seasonal availability of work, Tulare County has many of the characteristics common to rural areas. Poverty is high -- the total percent of population below the poverty level in the county is 22.5 percent, compared to only 12.5 percent for the entire state of California. Over 15 percent of county residents are on AFDC, compared to only 7.7 percent of the population of the entire state. Unemployment is also high -- 15.4 percent of the population of the county is unemployed, while only 9.3 percent of the state's population is unemployed. Education levels are low -- 39.8 percent of county residents over age 25 do not have a high school education. Statewide, only 23.8 percent of residents over age 25 are not high school graduates.

There are several barriers to accessing health care in the county. Transportation to health services is a significant problem, particularly in our Porterville service site area. Many people have to travel on rural roads in excess of 30 miles to accessible primary health care. A portion of the county is in the Sierra Nevada mountain range, making travel even more difficult. A winter-time phenomenon know as "Tule fog" makes it very treacherous to drive from December through February. And, with the exception of Visalia, the county seat, most of our service area is without a fixed route mass transit system. In Porterville, "Dial-A-Ride" programs are available, but there is usually a two-hour wait each way.

There are linguistic barriers in the community as well. About half of the Hispanic population prefers to communicate in Spanish, and there are individuals who are fluent only in languages other than English. At the health center, we provide translation for four languages: English, Spanish, Hmong and Lao.

Financial barriers make it difficult for county residents to receive care. Almost fifty percent of the population is covered by Medi-Cal or is uninsured. Because of the general lack of economic resources, very few of the new patients at Family HealthCare Network has had any preventive care before they are seen at our centers. Restrictions on the use of their resources are significant -- the small percentage of adults who are on Medi-Cal find that preventive health care is not covered. Generalized poverty means that their income must be rationed between immediate problems (such as food and housing) and more long-term needs such as preventive care. While our providers promote the need for prevention and early treatment, we cannot set financial priorities for our patients.

We regularly see patients coming to us for the first time with every indication of health care neglect -- such as children with no record of childhood immunizations; women who have never had a Pap smear; and individuals who are clearly diabetic or hypertensive, who have never been diagnosed or treated in the past. And it is not surprising that Tulare County has a higher communicable disease rate than the State average rate for hepatitis, measles, shigellosis and tuberculosis, and has a higher death rate than the State average for heart disease, stroke, unintentional injuries, pneumonia and influenza, chronic obstructive pulmonary disease, and diabetes.

Tulare County especially needs effective prenatal care. The birth rate in the county is 22.2 per thousand, higher than the 19.2 per thousand rate for the state. The fertility rate for the county is extremely high -- 103.1 per thousand as compared to 82.7 per thousand for the entire state. There are high educational barriers to effective prenatal care -- 51.1 percent of mothers in the county have less than 12 years of education, while 35.7 percent of mothers across the state are at that educational level. Teenage pregnancy is high in the county -- 17.7 percent, as compared to 11.8 percent for the state. More mothers begin their prenatal care after the first trimester -- 36.1 percent for the county, while only 24.9 percent for the state. Every day our providers see women, especially adolescent and foreign born, who present in their second and third trimester of pregnancy with no prior prenatal care. Improving birth outcomes is one area in which our work is having an impact -- in 1978, when we opened the health center, the infant mortality rate was 14.8 deaths per thousand live births for the county, and today it is 6.2 deaths per thousand live births.

Public Programs Are Critical in Serving the Rural Poor and Uninsured

Like other health care providers in rural areas, Family HealthCare Network experiences problems in meeting the many health care needs of the residents of our service area. Because of the lack of economic resources and high numbers of uninsured in our area, Family HealthCare Network is highly dependent on public sources of funding to pay for the care of our patients. Fifty percent of our revenues are from Medi-Cal; 3 percent from Medicare; 8 percent are from community health center grants under the Public Health Service Act (PHSA); 10 percent from private insurance; 4 percent are from State funds; and 25 percent are from patient payments.

Of critical importance to Family HealthCare Network is the system of reasonable cost reimbursement which health centers currently receive under Medicare and Medicaid. Under this system, Federally-qualified health centers (FQHCs) receive an average payment per visit which approximates the reasonable cost of providing services to a Medicare or Medicaid patient. Making sure that the level of payments are sufficient to cover the costs of services is extremely important for rural FQHCs who treat underserved patients, since there are few other resources from which to make up any losses. This system has worked well for centers under a fee-for-service system, but needs modification as rural health centers begin to participate in managed care networks. Our experience in California is that managed care plans are unwilling to pay capitation payments which cover the costs of caring for patients. As a health center dedicated to serving the indigent, Family HealthCare Network does not have a large base of revenues from commercial patients to make up any losses from public programs, and because of this, an adjustment in the reimbursement system for health centers is needed to accelerate their further integration into managed care systems.

We propose an amendment to the Medicare and Medicaid programs to solve this problem. The reasonable cost reimbursement system would operate slightly differently when a Medicare or Medicaid patient is served through a managed care plan. The FQHC would receive a "wrap-around" payment directly from Medicare or Medicaid that is equal to the difference (if any) between the reasonable cost reimbursement which would be paid to the FQHC under current law and the amount the FQHC receives from a managed care plan for services provided to Medicare or Medicaid managed care patients.

Also important to rural health centers are the grants under the Public Health Service Act (PHSA) for community and migrant health centers. These grants are directed towards serving the uninsured and to provide outreach, transportation, and other support services which can help to eliminate the barriers to care faced by rural residents. At Family HealthCare Network, we use our PHSA grants to subsidize the losses we incur by providing a sliding fee scale (based on income) to our patients.

About 50 percent of the funds appropriated nationally for the PHSA grants are used for projects in rural areas. There are many medically underserved rural areas which could benefit from the establishment of a health center if more funds were appropriated. For each $10 million appropriated, 100,000 new patients can be served and 20 new centers established. Between 1991 and 1995, almost 700 communities were identified as needing health care services, but were unable to receive PHSA grants because of inadequate program funding. Approximately half of these needy communities are in rural areas. In California, 65 new underserved communities in rural and urban areas applied and were approved for PHSA grants, but were not funded due to lack of available funds. Many underserved and interested communities throughout the country were discouraged from even applying for health center grants because of lack of funds.

The House Appropriations Committee has recognized the value of the health center programs in rural areas and has provided an increase of $44 million for PHSA grants for health centers for fiscal year 1997. We recommend that this funding level be maintained in any continuing resolution adopted for fiscal year 1997.

Another significant problem for rural health centers is the recruitment and retention of health professionals, particularly physicians. This problem is especially difficult in Porterville due to the lack of community infrastructure and other amenities which would make an area attractive for a health professional and his or her family. For example, in Porterville, the public schools are not ranked highly for academic preparation. There is only one movie theater and one playhouse, no professional sports, and few professional clubs. There are some local stores on our main street, but the nearest shopping mall is 35 miles away, in Visalia. There is significant pollution from agricultural chemicals. In addition, small town politics are still an important factor in the area. Newly arrived professionals are viewed as "outsiders", with one consequence being that the retention of hospital staff privileges is often a difficult process.

Family HealthCare Network is the main provider of primary health care services for the medically indigent in general and the migrant and seasonal farmworkers in particular. We have 23 medical and dental providers. We have experienced difficulties in recruiting and retaining our providers. Most recently, the district hospitals in our county have formed an exclusive consortium of clinics -- choosing not to collaborate or coordinate with community-based organizations like Family HealthCare Network. The consortium is using their huge financial reserves to try and take our providers from us by offering higher salaries. As a nonprofit provider serving a majority of uninsured and underinsured individuals, it is difficult and sometimes impossible to match their offers.

Retaining providers is a problem throughout Tulare County -- and as a result almost the entire county has been designated a health professional shortage area (HPSA) and a significant portion of the county has been designated a medically underserved area (MUA). One important provider resource for rural areas is the National Health Service Corps (NHSC). The NHSC is one of the very few successful efforts to address the acute shortage of primary care providers and the serious maldistribution of health services in rural areas.

Currently, there are 151 NHSC providers in the State of California, most in rural communities. Family HealthCare Network has been very fortunate to have participated in the NHSC scholarship and loan repayment programs. We have two physician assistants and six primary care physicians who are supported under the NHSC. This has helped us tremendously to relieve some of the provider capacity issues associated with our service area.

The House Appropriations Committee has provided $115 million for the NHSC program for fiscal year 1997. We are hopeful that the Senate Appropriations Committee will provide at least $120 million. **We recommend that the highest possible funding level be maintained for the NHSC in any continuing resolution which is adopted for fiscal year 1997.**

Another way to attract providers to rural areas is to provide opportunities for them to get their residency training in ambulatory settings in rural areas. In many cases, when providers receive their training in health centers or other rural clinics, they see the benefits and satisfaction of establishing a family practice in a rural area before they make a decision to practice in a specialty field in an urban area. As currently structured, the graduate medical education system discourages residencies in health centers and other ambulatory settings because the payment system is designed to reward training in hospitals, particularly urban hospitals. As managed care spreads throughout the country, including rural areas, the demand for primary care clinicians who can work in ambulatory settings will increase. **We recommend that any reform of the Medicare and Medicaid graduate medical education systems provide for payment to health centers and other ambulatory care sites for the training of residents.**

Comments on the Rural Health Improvement Act of 1996

I would also like to provide you with my views on some of the provisions of H.R. 3753, the Rural Health Care Improvement Act of 1996. In general, I support the bill and its efforts to improve health care in rural areas. However, I and many other health centers have serious concerns about several of the provisions of the bill, which I will outline in detail.

Section 101 of H.R. 3753 increases the capitation rate that will be paid to Medicare managed care plans that serve rural areas, and is designed to reduce the current differences between the capitation rates paid to plans in urban and rural areas. Inasmuch as the amendments made in this section to the Medicare managed care provisions of section 1876 of the Social Security Act are expected to heighten the interest of managed care plans in rural areas, **we would strongly recommend that an additional provision be added requiring entities with a Medicare managed care contract (under section 1876 of the Social Security Act) to contract with certain essential providers (including health centers, rural health clinics, community health networks funded under Title II, and others of the Committee's choosing) who are located in or serve residents of their service areas.**

In addition, we would recommend that the Committee consider adding a requirement that any such managed care plans serving a rural area under a section 1876 contract be required to meet certain standards for the accessibility and availability of care. We would recommend that you use standards similar to those in S. 839, a bill introduced by Sen. Chafee last year. In particular, standards regarding geographic access to both primary and other health services by managed care enrollees are vital to ensure the effectiveness of rural managed care systems.

Section 201 of H.R. 3753 establishes grants to States for the development of access improvement plans for chronically underserved areas. We note that, in the designation of chronically underserved areas under section 201(b)(2)(B)(i), one of the factors to be considered is whether the area is (or was previously) designated as a HPSA under section 332 of the PHSA, but not current or previous designation as an MUA or a medically underserved population (MUP) under section 330 of the PHSA. This oversight is quite surprising in view of the fact that the succeeding clauses ((ii) - (vi)) of section 201(b)(2)(B) of H.R. 3753 contain precisely the same elements used to determine medical underservice under section 330 of the PHSA. **We would recommend that you add an additional clause (III) as follows: "(III) is designated as an area with a medically underserved population under Section 330(b) of the Public Health Service Act), or meets the criteria for such designation."** We also have the same concern about section 204(b)(4) of H.R. 3753, which once again utilizes the term 'underserved' yet fails to include rural areas or populations designated as MUAs or MUPs under section 330 of the PHSA.

We strongly support the inclusion of the Community Health Advisors program under section 203 of H.R. 3753, which we have supported since it was first proposed in 1992.

Section 204(a) establishes a definition of community rural health networks that are eligible to receive grants under the provisions of title II of H.R. 3753. We note that other classes of providers, including rural health clinics, are listed as potential participants in community rural health networks, but community and migrant health centers are not. While health centers clearly fit into the "other" category, we believe that they should be clearly included, in particular because they serve 4.5 million rural Americans and will be important providers in many rural networks. **Moreover, we believe that any network funded under this new authority should be required to include all health centers and rural health clinics (and perhaps other essential providers of the Committee's choosing) that are located in or serve residents of the network's service area, as a condition of funding.**

We strongly support the provisions of section 401 of H.R. 3753, which excludes from gross income of a taxpayer any scholarship payment or loan repayment for a member of the NHSC. We have advocated for this provision since 1987, after learning that the Tax Reform Act of 1986 had made NHSC assistance taxable to recipients.

Section 403 of H.R. 3753 would give priority in the assignment of NHSC members to providers in community health networks. We strongly oppose the current language of this section. The National Health Service Corps Amendments of 1990 gave priority in the assignment of NHSC members to those HPSAs with the greatest needs. We firmly believe that this priority should remain in effect. With respect to the type of organizational placements, we strongly believe that organized delivery systems like health centers should have at least equal footing with networks, especially because health centers have for 30 years relied on NHSC as an important source of providers for the underserved, including the more than 4.5 million rural Americans who rely on them for health care today.

Lastly, and most importantly, health centers around the country have serious reservations about section 602 of H.R. 3753, which requires the Secretary of Health and Human Services, in making community health center grants under section 330 of the PHSA, to give special consideration to projects in which community health centers have entered in to collaborative agreements with community hospitals. These collaborative agreements must meet several detailed requirements, including one that a health center be in or adjacent to a hospital. Health centers around the country believe that while collaboration between health care providers should be encouraged, the local community should determine where a primary care center should be located based on all local needs and resources. The current provisions of section 602 are too restrictive, particularly in requiring that the primary care center be located in or near a hospital and requiring that the center use hospital facilities. Moreover, many hospitals in rural areas have sufficient resources and reserves to establish collaborative arrangements with health centers and other providers without the use of scarce grant funds under section 330 of the PHSA. In addition, the provisions would discriminate against rural areas without a hospital, even if their need for primary health care services is greater than that of other rural areas which do not have a hospital.

We strongly recommend, as does the National Rural Health Association, that section 602 be amended by deleting the language in the bill that would add a new subsection (m) to section 330 of the PHSA and include instead the following new subsection (m):

"(m)(1) In making grants in rural areas for new or expanded services for each fiscal year, the Secretary shall give special consideration to projects which demonstrate collaboration with community hospitals or other local health care providers. Such collaboration may include agreements to share facilities and equipment, jointly developed patient triage and referral arrangements, or other agreements which demonstrate efficiency and cost-effectiveness in the use of available resources to increase access to underserved populations."

Thank you for the opportunity to provide our views on rural health care in America. We look forward to working with the Subcommittee on this and other important health care issues.

Chairman THOMAS [presiding]. Thank you very much, Harry. Mr. Wronski.

STATEMENT OF EDWARD WRONSKI, DEPUTY DIRECTOR, BUREAU OF EMERGENCY MEDICAL SERVICES, NEW YORK STATE DEPARTMENT OF HEALTH

Mr. WRONSKI. Thank you. I am Ed Wronski. I am the deputy director for the New York State Department of Health's Emergency Medical Services Bureau. I would like to thank Chairman Thomas and the Members of the Subcommittee on Health of the Committee on Ways and Means for inviting me to speak on this important issue that affects the quality of health care provided to all rural communities.

The Governor and the New York State Department of Health support the passage of H.R. 1757, the Community Ambulance Support Act of 1995, which amends title XVIII of the Social Security Act, allowing coverage under part B of the Medicare Program of paramedic intercept services in support of public, volunteer, or nonprofit providers of ambulance services.

A change in interpretation of Medicare regulations disallows payment for advanced life support medical care provided by a nontransporting ambulance service to patients being transported by a basic life support ambulance service. This change has placed an economic strain on many advanced life support ambulance services, which are continuing to provide this type of care, when requested by their neighboring basic life support ambulance service.

The change in policy has its most dramatic negative effect in rural areas of our State where cooperative sharing of this needed and scarce medical resource is most crucial. The ability to provide prompt and effective medical care in an emergency is an accepted principle of any well-designed emergency medical response system. In order to accomplish this, the system must be flexible in design and fit the needs and resource capabilities of the community it serves. This includes the capability to provide advanced life support services to those patients whose medical condition warrant it.

In the fifties and sixties, the ability to provide advanced life support care would not have been so critical to a system, as prehospital medicine was essentially first aid with rapid transport to a hospital. Developments in the decade since then have brought medical techniques and advanced medicine into the back of the ambulance, including the treatment of cardiac patients, patients in respiratory distress, stroke victims, and others, where advanced life support can make a critical difference in their survival. Failure on our part to support the availability of advanced life support medical care in the rural areas of our country is not acceptable.

In many areas of the country, as in New York State, the ability of rural communities to support advanced life support ambulance service is severely limited by their local financial and human resources. It costs approximately one-third more to operate an advanced life support ambulance service than a basic life support ambulance service. There are also limited numbers of trained and experienced paramedics in rural areas to staff these services. The sharing of advanced life support personnel when needed through

an intercept system has helped overcome this problem in many rural areas of New York State.

The negative financial impact of the current Medicare rule denying payment for advanced life support intercept is increased by the fact that the vast majority of New York State ambulance service in rural areas is provided by volunteers. Under the current Medicare guideline, the only way intercept services may be covered is if the volunteer ambulance service who transports the patient bills for the service. The long history of volunteer ambulance service in New York State has established a community-supported system whose organizational culture cannot support billing. Many of these services are also volunteer fire department services that are prohibited from billing by State law.

The current Medicare policy fails to recognize the existence of a clear cost savings to the public and to Medicare provided by dedicated volunteers. If volunteers were to bill for their services, this would substantially increase billing to Medicare in New York State alone. It would be more logical to allow direct reimbursement of needed advanced life support care that volunteer services cannot always provide.

It is important to understand that while 70 to 90 percent of all emergency patients are adequately cared for by basic life support medical care typically provided by the volunteer ambulance, the critically ill patient is not. This is compounded in rural areas due to long transport time, where advanced life support can often maintain the life of the cardiac victim and other critically ill patients.

Additionally, a 1986 GAO report on emergency services quoted in Health People 2000 objectives states, "Although pre-hospital care provided by personnel trained in basic life support is adequate for most injuries, personnel trained in advanced life support is preferable for care of more severely injured patients."

In order to provide this appropriate level of care to the small percentage of patients that require it, a two-tiered system of response has developed in many parts of New York State. This system resolves around the dispatch of a community-based ambulance to the scene of an emergency and dual dispatch of advanced life support service. That dual dispatch is often provided by a commercial ambulance service based outside of the rural community that sends a paramedic to the emergency scene or meets the ambulance en route to the hospital. In either instance, the dispatch of the advanced care unit is dictated by precise medical protocol.

This model has proven effective not only in rural areas of New York State but also in many other States. It fosters the sharing of existing medical resources. It provides the capability to supply the appropriate level of care to the patient. In many instances, it may result in decreased medical care costs at the hospital or rehabilitation center because early appropriate medical intervention has limited the amount of damage to the body systems involved. It has proven to be a cost-effective model in the rural areas.

We understand that the general cost of this type of system cannot be supported by Medicare alone. In New York State, we have supported the provision of advanced life support care in rural communities by application of both State and Federal dollars to programs that develop rural health care networks, utilizing paramedic

"fly car" nontransporting services. We provide millions of dollars for free training to support the growth and development of advanced life support human resources in rural areas. However, the removal of Medicare payments can and will result in discontinuation of some intercept services which depend on a combination of financial resources to survive.

The continued provision of a high quality pre-hospital emergency medical response system designed to meet rural needs is crucial to the health care of rural communities as a whole. It is not only the elderly Medicare patient who will suffer if advanced life support service is not available. It is also the productive 50-year-old farmer who suffers a cardiac arrest and dies who could have received cardiac medications from the paramedic, the non-breathing child whose life is lost because no one trained to intubate was available, and the diabetic who lapses into a coma and suffers irreversible damage during the trip to the hospital when the simple injection of D–50 by a paramedic might well have revived the patient early and prevented significant damage or death.

In urban and many suburban areas of New York State, the population density results in a larger call volume that creates the financial incentive for an ambulance service to have trained paramedic staff to provide advanced life support care. The rural patient has the same health care needs and should be provided the same level of care. Failure to support financial incentives that will provide the rural patient the same health care as the urban patient will result in unnecessary loss of life in our rural communities.

One of the things we would like to ask in final is that this Committee, besides supporting this bill, works with members of the industry and in the affected States to attempt to work out a dialog with HCFA about its current policy to see if we can come to some sort of compromise and return to a policy where these types of services were paid for by Medicare in the past in rural areas. Thank you very much.

[The prepared statement follows:]

STATEMENT OF
EDWARD WRONSKI, DEPUTY DIRECTOR
BUREAU OF EMERGENCY MEDICAL SERVICES
NEW YORK STATE DEPARTMENT OF HEALTH

I would like to thank Chairman Thomas and the members of the Subcommittee on Health of the Committee on Ways and Means for inviting me to speak on this important issue that affects the quality of health care provided to all rural communities.

The Governor and the New York State Department of Health support the passage of HR1757, the **Community Ambulance Support Act of 1995** which amends title XVIII of the Social Security Act allowing coverage under part B of the Medicare program of paramedic intercept services provided in support of public, volunteer, or non-profit providers of ambulance services.

A change in interpretation of Medicare regulations disallows payment for advanced life support medical care provided by a non-transporting ambulance service to patients being transported by a basic life support ambulance service. This change has placed an economic strain on many advanced life support ambulance services which are continuing to provide this type of care when requested by their neighboring basic life support ambulance service. The change in policy has its most dramatic negative effect in rural areas of our state where cooperative sharing of this needed and scarce medical resource is most crucial.

The ability to provide prompt and effective medical care in an emergency is an accepted principle of any well designed emergency medical response system. In order to accomplish this, the system must be flexible in design and fit the needs and resource capabilities of the community it serves. **This includes the capability to provide advanced life support services to those patients whose medical condition warrant it.**

In the 1950s and 1960s the ability to provide advanced life support care would not have been so critical to a system, as prehospital medicine was essentially first aid with rapid transport to a hospital. Developments in the decades since then have brought medical techniques in advanced medicine into the back of the ambulance, including the treatment of cardiac patients, patients in respiratory distress, stroke victims and others where advanced life support can make a critical difference in their survival. Failure on our part to support the availability of advanced life support medical care in the rural areas of our country is not acceptable.

In many areas of the country, as in New York State, the ability of rural communities to support advanced life support ambulance service is severely limited by their local financial and human resources. It costs approximately one-third more to operate an advanced life support ambulance service than a basic life support ambulance service. There are also limited numbers of trained and experienced paramedics in rural areas to staff these services. The sharing of advanced life support personnel when needed, through an intercept system, has helped overcome this problem in many rural areas of New York State.

The negative financial impact of the current Medicare rule denying payment for advanced life support intercept is increased by the fact that the vast majority of New York State ambulance service in rural areas is provided by volunteers. Under the current Medicare guideline, the only way intercept services may be covered is if the volunteer ambulance service who transports the patient, bills for their service as well. The long history of volunteer ambulance service in New York State has established a community supported system whose organizational culture cannot support billing. Many of these services are also volunteer fire department services that are prohibited from billing by state law. While preventing selective billing is appropriate in most instances this policy fails to recognize the existence of a clear cost savings to the public and to medicare provided by dedicated volunteers. If volunteers were to bill for their services this would substantially increase billing to Medicare in New York State alone. It would be more logical to allow direct reimbursement of needed advanced life support care that volunteer services cannot always provide.

It's important to understand that while 70% to 90% of all emergency patients are adequately

cared for by the basic life support medical care typically provided by the volunteer ambulance, the critically ill patient is not. This is compounded in rural areas due to long transport time where advanced life support can often maintain the life of the cardiac victim and other critically ill patients. Additionally, a 1986 GAO report on emergency services, quoted in Healthy People 2000 objectives, states, "Although prehospital care provided by personnel trained in basic life support is adequate for most injuries, personnel trained in advanced live support is preferble for care of more severely injured patients."

In order to provide this appropriate level of care to the small percentage of patients that require it, a two-tiered system of response has developed in many parts of New York State. This system revolves around the dispatch of a community-based ambulance to the scene of an emergency and dual dispatch of advanced life support service. This is often provided by a commerical ambulance service based outside of the rural community that sends a paramedic to the emergency scene or meets the ambulance en route to the hospital. In either instance the dispatch of the advanced care unit is dictated by precise medical protocol.

This model has proven effective not only in rural areas of New York State but also in many other states. It fosters the sharing of existing medical resources. It provides the capability to supply the appropriate level of care to the patient. In many instances it may result in decreased medical care costs at the hospital or rehabilitation center because early appropriate medical intervention has limited the amount of damage to the body systems involved.

We understand that the general costs of this type of system cannot be supported by Medicare payments alone. In New York State we have supported the provision of advanced life support care in rural communities by application of both state and federal dollars to programs that develop rural health care networks utilizing paramedic "fly-car" non-transporting services. We provide millions of dollars for free training to support the growth and development of advanced life support human resources in rural areas. However, the removal of Medicare payments can and will result in discontinuation of some intercept services which depend on a combination of financial resources to survive.

The continued provision of a high quality prehospital emergency medical response system, designed to meet rural needs, is crucial to the health care of rural communities as a whole. It is not only the elderly Medicare patient who will suffer if advanced life support service is not available. It is also the productive fifty year old farmer who suffers a cardiac arrest and dies ,who could have received cardiac medications from a paramedic; the non-breathing child whose life is lost because no one trained to intubate was available and the diabetic who lapses into a coma and suffers irreversable damage during the trip to the hospital, when the simple injection of D-50 by a paramedic might well have revived the patient early and prevented significant damage or death.

In urban and many suburban areas of New York State, the population density results in a larger call volume that creates the financial incentive for an ambulance service to have trained paramedic staff to provide advanced life support care. The rural patient has the same health care needs and should be provided the same level of care. Failure to support financial incentives that will provide the rural patient the same health care as the urban patient, will result in unnecessary loss of life in our rural communities.

Thank you for the opportunity to speak to this issue.

Chairman THOMAS. Thank you, Mr. Wronski.

To what extent is this in essence a New York problem because of New York State law? I am trying to get a feel for not just the physical inability to get transportation and paramedics and the ambulance service, because we have all fought that, but structured as difficultly as yours. Dr. Mueller, have you looked at this in terms of a nationwide problem? Obviously, it is a New York problem.

Mr. MUELLER. No. I confess I have not.

Chairman THOMAS. Mr. Wronski, do you know of any other States that are in the same predicament you are by virtue of the State law?

Mr. WRONSKI. There are other volunteer States. Virginia, Pennsylvania has a large volunteer population. Connecticut has a large volunteer. New York State law only prohibits the volunteer fire department-based ambulance services from billing. The remainder, and there are hundreds of them in New York State in rural areas, are nonfire based, and I have to say this is also with the fire department-based services. There is a culture that they are unable to bill and they really do not want to and that really does affect New York and a number of other States that have large rural areas.

Chairman THOMAS. Mr. Nelson.

Mr. NELSON. Mr. Chairman, in my State of South Dakota, there are only two communities that are not completely voluntary. I am not sure how the South Dakota State law affects them, but I do know that is an additional State that is all voluntary.

Chairman THOMAS. Understanding they are voluntary, there may be a way to work it out. I do not know. I will have to look at this.

Mr. WRONSKI. It was paid for by Medicare, and then it was changed in a policy in June 1995, so——

Chairman THOMAS. There have been a number of changes in Medicare payment structure that have affected the rural areas. My concern always is, were they aware of it when they did it. Fortunately, oftentimes I have to believe they were not, that they have not thought through the ramifications of their changes.

Basically to all of you, but perhaps some individuals might want to respond on their particular concerns, Mr. Foster, I am familiar with your clinic, but common to all the rural areas is the profile of those physicians who are in the communities are aging rapidly. There is a difficulty in getting replacements. But just the ongoing recruitment of the work force, professionally trained in the rural areas, what have you folks done? What have you learned? What works?

Should we be tying loans, medical school payments, residency arrangements for service in underserved areas, or do those people come into an area somewhat resentful of the fact they have to be there by virtue of having received the largess and never ever blend and focus on the community as a potential permanent location?

Mr. MUELLER. I will begin to answer that. There are two levels of response there. One would be a short-term or immediate response and that would have to do with the National Health Service Corps and its ability to place providers in shortage areas now so

that where, say, a retirement might occur next year, the example that you illustrate, we can put someone in that community to continue the care.

A longer term solution has to do with what was discussed previously by Dr. Myers and others and that is reforming or changing the entire scheme we have in place to train health care professionals so that we utilize ambulatory training sites for graduate medical education residencies so that we have a greater emphasis on recruiting medical students from rural areas, train them in environments that show them the benefits of practicing in rural areas.

The third strategy has to do with how we pay for medical care, and that is on the reimbursement side. We have done a lot to equalize basic formulas in PVS and RBRVS and this Committee has been heavily involved in that. We continue to believe maintaining the bonus payments and even increasing those is helpful, and as we move toward different options in Medicare payment, we need to pay attention to making sure that is equitable in rural areas. As you just said a few moments ago, it is very easy to overlook that in the haste and in the anxiety of getting a formula right so that it affects the overall budget correctly.

So those are three strategies, one short term and two longer term. On the one on graduate medical education, there are examples around the country of programs like the WAMI Program in Washington, the program in Minnesota that have demonstrated successfully some strategies for convincing students to locate in rural areas.

Chairman THOMAS. Now that we have seen the Justice Department's willingness to rethink its antitrust provisions in a general sense, do you think it might make sense to examine the whole question of the rules on antitrust to carve out perhaps some special rules or a focus on rural arrangements?

I mean, we are very pleased that we got virtually 100 percent of the doctors, but I think the thing that sold the Justice Department was the 100 miles to any other acute facility and the entire community in support of it. Those may not be all in place in other areas where you could have other structures that would work, and it bothers me a little bit that the only way you can do this is to go and wait for the entire waiver process to be approved before you can move forward.

Is this an area we could focus on in terms of perhaps separate antitrust rules for rurals, or does it elevate itself to that level?

Mr. MUELLER. It is an area that we should focus on. The National Rural Health Association, for example, has endorsed Representative Hyde's legislation in this session of Congress dealing with that. I think at the beginning, again, sort of a two-level answer.

Level one, going to and using rule of reason rather than per se is a major, major step in the right direction, because, of course, we believe reasonable people would see the light in looking at rural arrangements. But second, anything we can do to create more flexibility for how we structure service delivery systems in rural areas is helpful and I think a focus through antitrust is needed to do that.

Chairman THOMAS. One of the provisions that was more controversial in the recent health insurance legislation was medical savings accounts. Is this something? Obviously waiting for HMOs or other structures to move into rural areas, sometimes it may be a long wait if we cannot speed up some of the antitrust provisions. Have any of you looked at MSAs as a potential possible structure that would have some positive aspect, or is this something that is primarily going to be useful in urban areas? Did anybody look at it that way yet?

Mr. NELSON. Yes. We certainly feel that it is a very important program that hopefully will become more than just a 750,000 policy trial basis and we could improve that, especially in rural areas, as you mentioned, where managed care is not an option and, frankly, in some areas might never be a viable option, that this is one way where we can help bring down our own health care costs. So, we are very excited about it and hopefully it will prove to be a very good program.

We have had an MSA-type program without the tax advantages since 1978 that we have offered as an endorsed health plan to our members and some other groups have, as well, and it has worked out very, very well. We just use——

Chairman THOMAS. Even without the tax advantages?

Mr. NELSON. Even without the tax benefits, and so with the tax benefits, we see this as a great possibility for expansion and offering it to more people. So, we think it really offers some help.

Chairman THOMAS. And working directly with the patient in terms of payment structure, that gives you a great degree of flexibility in terms of how you operate without having to have the bureaucracy dictate method of payment and prerequisites to payment?

Mr. NELSON. It certainly does, and also a great deal of choice, albeit a problem if you do not have the access, the choice is not important, but where you do have the doctors and clinics available, then the choice is important.

Chairman THOMAS. Just as an aside, Mr. Nelson, since one of the focuses and the concerns about MSAs was that it was the fear of giving people choice, because after all, if they get choice, they could make the wrong choice, that is, not spend the money. What has your experience been within the structure that you had? Do people seem to understand what their options are and do they shop value for money and, in fact, do they get it?

Mr. NELSON. I think so, but more importantly, I think they get quality health care from their choices that they make are for quality. The dangers that have been pointed out in adverse selection or in no care, ongoing care, I think those are dangers that have proved to be false, and hopefully, like I said, we could get some permanent legislation to offer this to everyone.

Chairman THOMAS. Any additional comments? If not, does the gentleman from New York wish to inquire?

Mr. HOUGHTON. Yes. Thank you, Mr. Chairman.

Thank you, gentlemen, for being here. It has been a wonderful display of information on care and looking over the next hill to see what is going to be needed here.

I think that Mr. Nelson, when you were talking about the change in the demographics of the rural areas, I really resonate with that, and particularly picking up on what Mr. Mueller was saying about telemedicine. I guess where I am coming from is that being a Representative of a rural area, I want to do everything possible to keep the medical service and facilities alive during this transitionary economic period in medicine. Where it is going, I do not know. But, it is so important that we take the "one-size-fits-all" concept, and throw that away because it does not work.

Tell me a little bit about telemedicine, if you will, Dr. Mueller. You really say that it is important that the government step in and help fund some of it. With the new telecommunications bill, do you think it will be possible to make this something where there will be an incentive privately to do this?

Mr. MUELLER. What the new telecommunications bill does for us is require that the service be made available equitably across all areas of the country, and by that, we mean laying the right telecommunication lines out so that you do not have problems—I know we do in the Western part of our State—of multiple companies, different lines that are not compatible, and so on. It will really help a lot to iron out those difficulties.

That needs to be combined with a strategy, then, to make that infrastructure useful for the delivery of medical care, which takes us to the issues of reimbursement being created for services delivered through telemedicine. It takes us to the issues of evaluation, so that we understand what is the best medical use of this technology that is cost effective so that we do not go down a path of having telemedicine be one more way of demanding that rural residents, in effect, receive their services from some distant urban area but that they receive services from the distant urban area that are only available in the urban site but now we can get the service through telecommunications to the residents where they live.

The example I gave in the testimony from the experience in Kearney, Nebraska, it has been saving people a round-trip driving time of 135 miles by using telemedicine to get their consultation done for behavioral health problems where they live rather than driving in to see the specialist.

So there are some reimbursement issues. There are some issues related to understanding how to use the technology, all of that built on top of what the Telecommunications Act does for us in getting the hardware or the communication line infrastructure available in rural areas.

Mr. HOUGHTON. Are there tax incentives? I can understand the Federal Government and its administrative departments allocating funds for something like this, but are there tax incentives which could be developed by this Congress which would further enhance and speed up the use of telemedicine?

Mr. MUELLER. I have not looked specifically into the use of tax incentives, Mr. Houghton, but it makes sense to look at that, particularly from the view of the providers at both ends of that telecommunication line. Are there ways using tax incentives to get them to utilize that system.

Mr. HOUGHTON. I know that the telecommunications revolution is sort of a two-edged sword. One, it is a tremendous job producer

and tends to link people all over the world. You do not have to live anyplace other than where you want.

However, at the same time, if education and medicine is taken away from those areas where people really want to live, then it does not make any sense at all and it just seems to me that the ability of a small medical unit, whatever you call it, to be able to link to the big research centers and to have instant access to that is really very, very exciting and would enhance much more than just the medical area but would have a real economic impact.

Mr. Chairman, I would like to submit, if it is all right with you, the testimony of two people from the area in which I live for the record.

Chairman THOMAS. Without objection.

Mr. HOUGHTON. They really are responsive and totally supportive of Mr. Wronski and the whole concept of life support systems and the "fly car" area.

[The following was subsequently received:]



Rural/Metro Medical Services

The premier provider of health and safety solutions.

TESTIMONY SUBMITTED FOR THE RURAL HEALTHCARE
HEARING SEPTEMBER 12, 1996
WASHINGTON, DC

SUBMITTED BY: ALAN D. LEWIS SR. GENERAL MANAGER
RURAL/METRO MEDICAL SERVICES
(SOUTHERN TIER)

SUBJECT: PARAMEDIC INTERCEPT (FLY-CAR) PROGRAM
REQUESTING MEDICARE FUNDING

SUBJECT: PARAMEDIC "EXPANDED SCOPE" INITIATIVE
REQUESTING MEDICARE FUNDING

Emergency Medical Services (EMS) has over the past two decades made tremendous advancements in the delivery of Quality Pre Hospital Patient Care.

The EMS system has progressed from the days of a horizontal taxi to a Definitive Care Emergency Department Response System.
Paramedics provide invasive care, administering medications, interpreting electrocardiography following Advanced Life Support (ALS), Advanced Cardiac Life Support (ACLS) and Advanced Trauma Life Support (ATLS) Protocols.

With New York State being the third largest Rural Population in the Country. Many area's are without ALS services.
The Paramedic Fly-Car program as provided by EMS services from larger communities has reached out to Rural America by providing a non-transporting intercept vehicle equipped with a highly trained skill proficient paramedic and appropriate equipment needed to provide ALS as prescribed by local Pre Hospital Care Protocols.
While most rural areas are blessed with dedicated volunteer BLS services, they are very limited with sufficiently trained ALS providers.

The Fly-Car concept has developed a partnership between rural community volunteer Ambulance Corps and larger more sophistication EMS systems, thus creating a cost effective Two Tiered response system reducing mortality and morbidity in those areas.

Charter Member Southern Tier Regional E.M.S. Council
25 East Pulteney Street Corning, New York 14830
Phone (607) 936-4179 Fax (607) 936-0359

In the Southern Tier of New York State, and areas like Olean, Wallkill, and many others. The Paramedic Advanced Life Support (ALS) Fly-Car program has over the past decade made great strides to provide quality ALS to residents in rural communities.

In the Southern Tier specifically, most rural areas are provided ambulance service by Volunteer BLS services. Those Corps are very limited with sufficiently trained ALS providers.
Fly-Car units are strategically located in Corning, Bath and Wayland to respond and assist local volunteer ambulance corps with seriously ill and injured patients.

Over the past eight years we have provided ALS with Fly-Car units to the following Volunteer Ambulance Corps.

The Corning based Fly-Car provides ALS coverage for the following Volunteer Ambulance Corps:

Addison
Woodhull
Jasper
Tuscarora
Troupsburg

The Bath based Fly-Car provides ALS coverage to the following Volunteer Ambulance Corps:

Avoca
Bath
Wayne
Hammondsport
Cohocton
Wayland
Penn Yan
Pulteney
Prattsburg
Tyrone
Bradford

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The Wayland based Fly-Car provides ALS to the following Volunteer Ambulance Corps:

Dansville
Cuylerville
Dansville
Genesseo
Livonia
Lima
Mt.Morris
Nunda
Retsof
Springwater
Naples

reaching Across five counties twenty seven BLS Volunteer Ambulance Corps utilize three Fly-Car units to provide ALS to their community residents as prescribed by Protocols designed by the Southern tier Regional Emergency Medical Advisory Committee (REMAC).

Statistically at the three locations Volunteer Ambulance Corps utilize area Fly-Cars for approximately 15 to 20% of their total annual ambulance calls, which results in 1000 calls annually.
Medicare recipients constitute 55% of patients meeting the ALS protocol criteria to utilize Fly-Car services.

The two tiered system as developed for these rural communities is the most cost effective approach to the delivery of ALS. With the combination of free volunteer ambulance services and the fee of a ALS intercept Paramedic. The total charges remain far below that of proprietary service in nearby communities.

It is important to note that Medicare has recognized the advancement of ALS in Metropolitan, Urban and Suburban Communities with funding of ALS when provided by the transporting services. In many rural communities the availability of transporting ALS providers does not exist.

Unfortunately, Rural America volunteer resources have not and cannot provide The standard of pre hospital care more densely populated areas benefit from with local EMS resources.

Medicare should view the partnership between volunteer and proprietary services as a cost effective patient care delivery system savings to Medicare recipients. For the system to continue providing these services. Medicare must develop an equitable payment structure.

Legislative Changes Required

A. Modify Medicare Funding Regulations pertaining to Ambulance Transportation, to include reimbursement for quality two tiered BLS and ALS patient care services based on partnerships between local N.Y.S. Certified Volunteer, Municipal, and Proprietary Ambulance Services.
The partnership should allow for each provider of the two tiered system to bill Medicare for services rendered, filing under their individual Company Medicare Provider Number.
Further, Medicare should thoroughly review funding the proposed "Expansion of Scope" initiate being presented to fully utilize Paramedics in Rural communities as Physician extenders. The initiative is intended to reduce unnecessary ambulance transports and hospital emergency department visits.
Currently, Medicare will not reimburse Ambulance Service providers unless a actual transport is provided. The Expanded Scope of practice would enhance the Paramedics training level to properly assess the necessity of a ambulance transport, and refer certain patients to report to their physician at an appropriate time.
This iniative, if funded by Medicare will save money with the reduction of ambulance transports and emergency department visits.

There is definitely a pay back for these services in rural America. Not only are many lives saved by the partnership arrangement, many patients have reduced hospital stays (if even admitted) due to the definitive patient care provided by the Fly-Car Paramedics.

The situation is urgent, Paramedic intercept services are expensive to operate, but could be self supporting if Medicare updates the regulations to include Fly-Car Services. Failure of Medicare approved funding will eventually force EMS providers to withdraw their partnerships with rural Volunteer Ambulance Corps, and leave rural America without Advanced Life Support services.

It is the opinion of this writer that the current Medicare funding criteria is outdated, and discriminates against rural America, and if not changed, will result in the unnecessary loss of many lives.

Respectfully submitted,

Alan D. Lewis Sr.



New York State Ambulance Association, Inc.

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Schenectady, NY 12307
(518)346-5060 Fax (518)374-8511

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Marvin Raidman

September 11, 1996

Congressman Amory Houghton, Jr.
U. S. House of Representatives
Washington, DC

Dear Congressman Houghton:

The New York State Ambulance Association is comprised of proprietary ambulance services from all regions of the State of New York.

At our annual meeting held on September 10, 1996, the Board of Directors and members unanimously agreed to support revised legislation that will enable two licensed ambulance providers to jointly provide Advanced Life Support services and ambulance transportation and for these services to be considered covered and reimbursable by Medicare.

We respectfully request that all administrative efforts be utilized in achieving this goal.

Thank you for your consideration of this matter.

Sincerely,

James P. McPartlon
President

TESTIMONY TO THE U.S. HOUSE OF REPRESENTATIVES
WAYS AND MEANS COMMITTEE
SUBCOMMITTEE ON HEALTH
HEARING ON RURAL HEALTH ISSUES
SEPTEMBER 12TH , 1996

SUBMITTED BY
WALTER L. REISNER, VICE PRESIDENT
TRANS AM AMBULANCE SERVICES, INC.
1658 OLEAN PORTVILLE ROAD
OLEAN, NEW YORK, 14760
716-372-5871

Implementation of the concept of using specially trained physician extenders to provide out of hospital advanced life support interventions in the emergency setting - paramedics - first began about 30 years ago. One of the first successful programs was developed in Elmira, NY. Economics did not allow this wonderful lifesaving concept, which was spawned in this rural city to flourish and spread throughout the other rural communities. Paramedic programs are expensive to start, and expensive to operate. It is an economic fact of life that any enterprise that is engaged in activities that cost money, needs to have a corresponding source of revenues to offset these costs. In upstate New York other than in the cities, population density is low. The Emergency Medical Services agencies that provide ambulance service in these areas are, as a rule, low volume, low budget providers. Economics dictates that these services can be provided most cost effectively by using volunteer staff. Consequently rural New York State' s Emergency Medical Services are provided primarily by volunteers. Recruiting these volunteers continues to be a major challenge. Accordingly these agencies do not provide service at the paramedic level, they provide service at the level of their volunteers. In Southwestern New York most volunteer ambulance service is provided by volunteer fire departments organized under the provisions of the State's General Municipal Law. This law prohibits them from charging their patients for ambulance service. Contrast this with paramedics who are highly skilled and highly trained health care professionals, who, as a rule, expect to be paid for their services and who may only practice under the supervision of a physician - medical control. Given the low call volume , the lack of medical control, and lack of a mechanism for compensation, significant rural paramedic systems did not develop because they were not economically feasible. Accordingly from the late 60's through the early 90's these services were generally not available in many rural areas of the state.

The need for paramedic level intervention in rural areas continues to exist as visually portrayed by the picture on the cover. The van hit an Amish buggy. The remains of the buggy are integrated into the wreckage of the van. The occupants of the buggy , three teenagers, were all thrown through the windshield of the van and critically injured. Extrication of the third victim from the wreckage took about 25 minutes. He then faced a 20 mile ambulance ride to the nearest emergency room. The Advanced life support intervention provided by our flycar medic contributed significantly to his survival.

The problem is not unique to New York. Rural residents nation wide continue to suffer from trauma as well as medical emergencies - heart attacks, strokes, diabetic emergencies, respiratory distress, seizures, and a host of other medical problems. Rural populations have higher accident rates. Farming is an extremely hazardous occupation, as is logging. These are rural activities. Additionally when a medical emergency occurs in a rural area which requires rapid ALS intervention, and the local squad does not have ALS staff, the length of time that the patient must go without ALS treatment, is a function of the distance to the emergency room. As more hospitals close or become Urgicare centers this distance is increasing. Sometimes this simply adds to the pain and suffering that the patient endures, in other situations, it results in the patients condition worsening with the worst outcome being death. The need for ALS in rural areas is self evident. Through the 80's this need remained unmet. The technology to meet the need existed. The personnel to do the job existed. The desire to provide the service existed. A reliable revenue stream to allow it to happen did not exist.

In the early 90's, an idea was developed which would generate a revenue stream that could support rural ALS paramedic systems. The concept was based upon the premise that prehospital paramedic intervention under the control of a physician is a form of healthcare, and as such should be covered by a patient's health insurance. This idea was supported by the fact that most health insurance's covered Paramedic level ambulance services, and reimbursed providers for their services. It seemed logical that a paramedic in a nontransporting intercept unit or flycar could assist a number of small volunteer units who otherwise could not have the service. Since the insurance carriers paid for transporting paramedic ambulance services, it also seemed logical that they would pay for a less expensive paramedic intercept which did not have the transportation charge built into it.

Depending on the area, one flycar can provide ALS coverage for 10 to 20 volunteer units. This cost effective approach to providing rural ALS was initially implemented in Southwestern New York by the Corning Ambulance Service. The concept was accepted by the medicare intermediary The Upstate Medicare Division of Blue Shield of Western New York. This acceptance was crucial: a.) because about half of the rural flycar patients are Medicare recipients, b.) other insurance carriers reimburse according to medicare guidelines. Now there was an economic incentive to provide the service.

The obvious need, coupled with an economic incentive to address it, lead to the development of a number of flycar systems in the region. By mid 1994 Flycar programs had been developed in Jamestown, Dunkirk, Salamanca, Olean, Bath, Wayland, Hornell, and Corning. There were plans to set up flycars to cover the northern areas in Cattaraugus County , as well as the northern and Western portions of Allegany County. But in June of 1995, The Upstate Medicare Division was instructed by HCFA that they could no longer cover "nontransporting" paramedic services billed by the providers. Only the transporting service or their billing agent could bill for ALS Ambulance services. This ruling has no positive effects, but the negative effects include the following:

1.) It negatively impacts the providers of flycar service by removing the reimbursement mechanism for them to be paid for providing the service.

2.) It negatively impacts the patient financially. These senior citizens, mostly on limited fixed incomes in our area, now have to pay for a service which was previously covered, and that people who happen to live in areas that have paramedic ambulance service receive as a covered medicare benefit.

3.) It negatively effects the health of some patients. Some patients find other inappropriate means of transportation to the hospital, rather than requesting a free ambulance that will call the flycar by protocol resulting in thier recieving a flycar bill.

4.) It negatively impacts the volunteer departments because it forces them to spend time and money analyzing how to meet the publics expectations of paramedic service if the more cost effective flycar programs die.

5.) It negatively impacts the Medicare system financially because it has encouraged squads that provided BLS ambulance service with out charge to Medicare or the patient, to reorganize and begin charging for all of their services.

6.) It negatively impacts the more than 40,000 people in Cattaraugus and Allegany counties, and I estimate millions nationwide, who do not yet have this service available, because it removes the economic incentive to provide it

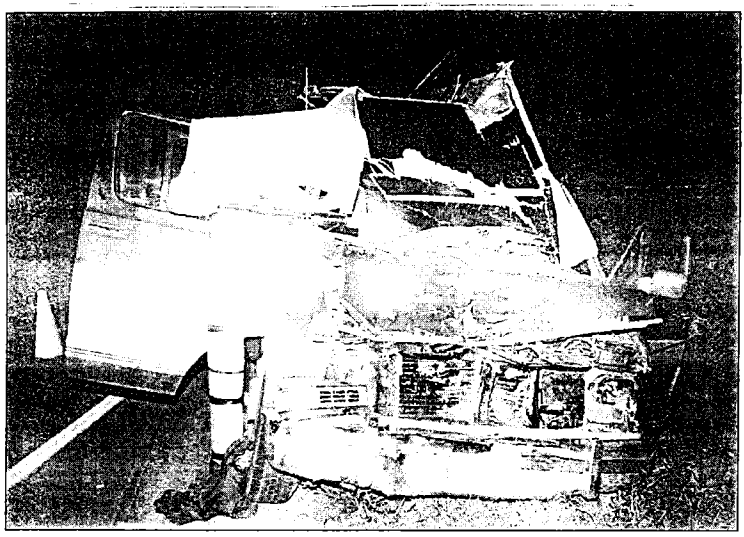
Today the need to provide fycar services continues to exist In fact recent closures and changes at small rural Hospitals enhance this need. HCFA has removed the economic incentive necessary for providers to step up and meet these needs. The flycar providers across the Southerntier, WCA Services Corp., Trans Am Ambulance Services Inc., and Rural Metro Corning continue to absorb these operating losses. We continue to provide flycar service to all who need it without regard for the patients ability to pay. Yet the fact of the matter is, since the service is not covered by medicare, most medicare patients can't afford to pay, and don't. We will not be able to continue to absorb these losses indefinitely. Without a Medicare reimbursement mechanism, some, if not all of these services face extinction. The senior citizens of our area should not be burdened with the total cost of their medically necessary flycar bills, while their urban counterparts get as this service as a covered Medicare benefit. It makes good sense to allow a needed and cost effective program to survive. We need your help so we may continue to provide rural residents with the level of prehospital health care that nonrural residents receive and which they all deserve.

I respectfully submitt the following suggestions for the Subcommittee's consideration:

1. Review the rationale for the HCFA order to no longer allow nontransporting flycar providers to bill for their services. If a HCFA rule change is possible ; consider this course of action as it applies to rural area flycar services, especially those involved in coordinated Rural Healthcare Networks.

2. If no HCFA consideration can be obtained and a legislative change is needed, develop legislation which will allow for medicare coverage of nontransporting flycar services provided in rural areas that are part of rural health care networks or other state defined criteria .

3. As medicare managed care programs are developed be sure that provisions for coverage of nontransporting flycar services are included for rural residents.



AMISH BUGGY VS VAN

The need for prehospital advanced life support (ALS) service appears obvious. This need seems even more obvious the further away from a hospital the emergency happens. A fair but flexible medicare reimbursement mechanism must be established to ensure prehospital ALS for the varying rural populations.

Mr. HOUGHTON. If I could just take a minute and try to spell this out, or ask you to spell it out for me a little more, what you are saying is the rural areas are different from the urban areas, but there is the same level of need. Therefore, it must be attacked differently. It would be nice if service A and service B and service C and service D could all be billed directly, but that is not the way it works, either practically or psychologically. So, you feel that what was taken away in 1985 from Medicare payments is a real detriment to the "fly car" or the life care system in the rural areas.

Do you want to spell that out a little more? I just want to cement it in my own mind.

Mr. WRONSKI. Sure. I would be happy to. You have summed it up well. What the change in policy really did was very simple. It said, we will not pay for a service which we have paid for in the urban areas and the suburban areas which we have identified as needed, which we have promoted in various pieces of literature that we support, and which the country basically has moved toward. That is advanced life support, early response for certain types of care.

But in the rural areas, because of, one, a lack of resources and trained personnel, and because in many States, because of volunteers who provide free services and do not have the administrative capability of handling billing—they literally take a cardboard box home with whatever paperwork they have to do, and often the person who is doing that is also the person who is responding to calls in the middle of the night. So, it is really an unfair burden on the volunteers to ask them to also be a billing agent for Medicare and for another service who is assisting them.

In New York State, as in other areas, this system really has been a cooperative effort by commercial services who have the trained people, who have their ambulances located within the small neighborhood, communities in the rural areas, but can provide a "fly car", and a "fly car" being simply usually a four-wheel-drive vehicle, and they put a paramedic in it with a bag and some drugs and that person can cover a much larger area and serve a variety of volunteer ambulance services.

In one area in New York State, and I believe it is the Corning System, they help provide ALS with a "fly car" system for 27 separate volunteer ambulance-covered communities. So when it is needed, the paramedic care is there and it makes a difference in a small percentage of patients.

Medicare used to pay for it. They will no longer pay for it and it has caused a real burden, and some of these systems are currently financially stressed to the point they may shut down, and that would end ALS service in parts of New York and in other States in this country.

Just as a final, I did, Chairman Thomas, speak to the president, the current president of the EMS State Directors Association and ask before I came here if this is a problem that the other States feel is there and is affecting them, and he very clearly said it is and he wanted copies of our testimony here and asked that we strongly support this.

Mr. HOUGHTON. As you know, Mr. Wronski, I am very partial to the State in which you live and represent, but I would imagine that

this service would be equally as important, not only in Corning, New York, but in Corning, California.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you very much. I would only say to the gentleman from New York, I think telemedicine also is an exciting area, but my concern is, as we are sometimes want to do in looking for the magic pill or the silver bullet, it makes enormous sense to me in an emergency situation, for diagnostic purposes, where time is critical, but I think one of our biggest problems, frankly, are GPs, prenatal care, gynecologists, simple dental, nutritional information that provides a quality of daily life improvement for a lot of these folk that we are really looking for, as well.

I have found around this place that if we do something like allow you to hook up by computer via satellite relay, we think we have taken care of rural health care problems because you can actually dial this number to determine whether or not the EKG is a concern.

So yes, we have to deal with this 21st century stuff, but we have to try to move what we know from the 20th century into all of America. My concern is we can never afford all of the equipment, but we are not talking about MRIs. I know my colleague from California talked about MRIs in local communities and that does not make sense, but I think we are talking about decent prenatal care and minimal dentistry, as well, and that is not being done.

Is that a fair statement to make?

Mr. WRONSKI. Yes.

Mr. HOUGHTON. Would the gentleman yield?

Chairman THOMAS. Certainly.

Mr. HOUGHTON. I think you are right. Obviously, the meat and potatoes of medicine will always be personal. It is a one on one. That is why you cannot get this tremendous productivity.

Chairman THOMAS. Or, if the gentleman will yield, as the current phrase is, they need "face time."

Mr. HOUGHTON. Face time, OK, but individual rather than TV face time.

Chairman THOMAS. That is correct.

Mr. HOUGHTON. But at the same time, I have seen in a little town called Cuba, New York, the connection between Buffalo Children's Hospital and it has really been breathtaking, because all of a sudden people feel that that hospital is needed because not only does it give it the face time service, but also it has access, which no other area does around there, to the best medical minds and the research going on.

Chairman THOMAS. I thank the gentleman, because these connections are important. As we move forward with antitrust reform and others, these what were initially telemetry links begin to develop into communicative links which develop into relationships which may, in fact, promote long-term structural changes, if we can make sure that the bureaucracy does not stand in the way. So the gentleman has a definite point.

I want to thank the panel very much. The Subcommittee hearing stands adjourned.

[Whereupon, at 12:33 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement for Printed Record of September 12, 1996 Hearing on Rural Health Care Issues

Submitted To: Subcommittee on Health of the Committee on Ways and Means

Submitted by: Representative Maurice D. Hinchey (NY-26)
Designated Representative: Kevin O'Connell

In December 1995 I was contacted by one of my constituents who had recently been rushed to the hospital with chest pains. He had telephoned 911 and a volunteer ambulance corps responded. As it was clear that the patient would require Advanced Life Support, a private ambulance company was also summoned since the volunteers are not qualified to provide this type of assistance. For the simple reason of geographic proximity, the volunteer ambulance was able to reach the patient much more quickly than would have been possible for the private company's Advanced Life Support (ALS) vehicle.

The volunteers placed the patient in their ambulance and began the trip to the nearest hospital. On the way, they were met by the ALS paramedics. Following the standard (and safest) procedure, one paramedic boarded the volunteer ambulance with the necessary equipment and provided Advanced Life Support for the remainder of the trip. Thanks largely to the combined efforts of the volunteers and professionals, my constituent survived the trip to the hospital, eventually recovered and returned home.

Not long after, he received a bill from the paramedic company for $360. Medicare would not pay the bill; nor would my constituent's supplemental insurance carrier. This is why I was contacted. I soon learned a great deal about the circumstances which had led to this unfortunate predicament.

Prior to 1995, the Health Care Financing Administration's (HCFA) Region II office in New York had routinely allowed this type of claim. Then in May 1995, the Corning Ambulance Company in Corning, New York received a letter from HCFA advising of a "change in policy that affects companies... which supply ALS personnel to a volunteer ambulance." The letter went on to say that because ambulance services are defined in Medicare regulations as "transportation by means of an ambulance" and because Medicare does not have a separate "paramedic" benefit, this type of service will no longer be covered.

This letter quickly circulated among the other ambulance companies in the state and soon the practice of submitting ALS intercept claims to Medicare stopped. The paramedic companies were forced to bill the patients directly.

I contacted HCFA to determine whether or not it had any discretion to reverse this change in policy. HCFA responded that, although Medicare provides for an increased amount of reimbursement when a transporting ambulance also provides Advanced Life Support, there is no statutory basis for the issuance of Medicare checks to paramedic intercept providers.

This policy change has resulted in some absurd inconsistencies in Medicare's payment practices. Consider the following three scenarios:

1) As in the case described above, a volunteer, or Basic Life Support (BLS), ambulance reaches the patient first, which is usually the case in rural areas, and administers Basic Life Support. An ALS vehicle meets the BLS vehicle on the way to the hospital and the ALS paramedic boards the BLS vehicle and administers Advanced Life Support. Medicare will not pay its 80% share of the $360 charged by the ALS company.

2) In the same situation, instead of having the paramedic board the BLS vehicle, the patient, on the side of the road or in a parking lot, is transferred to the ALS vehicle and receives Advanced Life Support from the same paramedic with the same equipment as in the first scenario. Medicare pays 80% of the ALS company's $470 bill.

3) Instead of calling 911, the patient calls the ALS company directly, waits longer for it to arrive, and then, if still

alive, receives Advanced Life Support from the same personnel with the same equipment. Medicare pays 80% of the $470 bill.

Several more constituents have contacted me about this problem since that first call in December. Numerous articles and editorials have appeared in local newspapers and magazines. The subject has also been discussed at length at meetings of senior citizens and volunteer ambulance companies. I am deeply concerned by what might happen as more and more of my elderly constituents, living on small, fixed incomes, become familiar with this problem. It would take little imagination to envision a case of a senior citizen having a medical emergency and deciding to avoid the $360 bill by either calling the ALS company directly and waiting for it to arrive, or worse, attempting to transport him or herself to the hospital. In fact, it is not a question of whether or not this will ever happen, but rather how often and at the cost of how many lives.

HCFA has repeatedly suggested that the volunteer companies enter into some sort of arrangement with the professional companies whereby the volunteers would bill Medicare and reimburse the professionals. For several reasons, this is not an acceptable solution. First, as demonstrated by the three scenarios described above, it would be significantly more costly than simply adding a Medicare billing category for ALS Intercept. Second, many of the volunteer companies in New York State are prohibited from billing. Third, those that could make arrangements to bill would probably have to start billing for all services to recover the cost of the additional apparatus that would have to be put in place to manage the billing process. Fourth, it likely that if volunteer companies began billing patients at all, even if just to pass the checks on to ALS companies, misunderstanding on the part of the public would lead to a drastic reduction in donations. Ultimately this could put the volunteer companies out of business. I again refer to the three scenarios described above to make the point that the demise of the volunteer ambulance companies would be quite costly to Medicare. It would be infinitely more costly in loss of human life.

I have cosponsored legislation introduced in the 104th Congress by Rep. Rosa DeLauro (HR 1757) which would correct this foolish policy and provide HCFA with the statutory basis to cover ALS Intercept. I am aware that this legislation has been introduced in previous Congresses, but has never made it out of committee. I urge the Subcommittee to look beyond the short term cost of this measure and see the long term gain, in both monetary and human terms.



Jim Ramstad, M.C.

Committee of Ways and Means
Subcommittee on Health
Rural Health Care Hearing
Thursday, 12 September 1996

Chairman Thomas, I appreciate this opportunity to share some of my thoughts on health care. I commend you for highlighting a challenge to our American health care system -- access to affordable, quality health care in rural communities. However, let's face it, the challenges discussed here today are not uniquely or solely rural concerns.

The western suburbs of Minneapolis do not conjure up pictures of Norman Rockwell's rural America, but there are some commonalities in terms of health care. Many of the issues to be raised at this hearing have a broader impact on the delivery of health care throughout Minnesota and ultimately to the health and well-being of our nation's health care system.

Mr. Chairman, before delving into my statement, I want to salute one of today's witnesses, my good friend and colleague from western Wisconsin, Steve Gunderson. I commend him for his tireless commitment to improving access to and delivery of quality health care in rural communities. During this Congress, as Co-chair of the Rural Health Care Coalition, Steve has literally taken the "bull by the horns" to respond to a variety of health care issues. One of these issues, however, which knows no distinct, definable boundary and is of great importance to Medicare beneficiaries and health care providers in my district is reforming the payment for Medicare risk-based managed care plans.

Currently, Medicare payments to risk-based health care plans are calculated on the basis of Medicare spending in each county's fee-for-service sector -- medical care outside of managed care plans. The variation in adjusted average per capita cost [AAPCC] formula reflects different utilization of health care services.

Dr. John E. Wennberg, Director of the Center for the Evaluative Clinical Studies at the Dartmouth Medical School recently published *The Dartmouth Atlas of Health Care.* The Atlas definitely documents that the rates of hospital beds and physicians per 1,000 residents determines how much care Medicare beneficiaries use. Revising the highly variable AAPCC payment formula will result in greater equity for Medicare beneficiaries regardless of where they live, allowing choices among plans and more equitable distribution of out of pocket costs and additional benefit packages.

Because of the need to correct the inequity in the AAPCC payment formula for millions of Medicare beneficiaries, I strongly supported changes to the formula during Ways and Means Committee consideration of the Medicare Preservation Act. Regrettably, progress made by this Congress to reform our Medicare program, including the geographic disparity and inequities in the AAPCC formula, was vetoed by the President.

Since that time, I have continued to be concerned about this issue and am an original cosponsor of H.R. 3753, the Rural Health Improvement Act, legislation incorporating a number of rural health care reforms including improvements to the AAPCC payment formula.

Title I of this legislation narrows the AAPCC payment gap between rural and urban areas by ending the practice of basing the formula on utilization rates, and it does so in a budget neutral fashion. At a minimum a county would receive 80 percent of the national input-price-adjusted capitation rate. This change helps reflect the true cost of doing business -- uncontrollable factors, such a wage rates or supply costs. The language also implements a three year average for the baseline rather than one year, which was in the *Balanced Budget Act of 1995.* This change gives greater representation of historical health care costs for an area. This provision of H.R. 3753 is based on the Physician Payment Review Commission's *1996 Annual Report to Congress.*

Realizing reforms to the AAPCC formula are not doable in the remaining days of this Congress, it is helpful to know where the debate will begin in the 105th Congress.

About a week before this hearing, the Health Care Financing Administration [HCFA] released the 1997 payment rates for Medicare Managed Care Plans. What HCFA told us was nationally Medicare risk payments will increase an **average** of 5.9 percent as of January 1, 1997 -- lower than the 1996 national **average** increase of 10.1 percent.

In terms of the solvency of the Medicare Trust Fund this is good news -- slowing the growth of Medicare. The bad news is that this average increase reflects wide variation in percentage increases from county to county. Four counties actually will receive **negative** percentage decreases. Because of actual dollar variations are also extreme, many low payment areas get a double whammy -- lower percentage increases off of a lower base.

This situation continues a trend which is inherent in the flawed formula. The table below illustrates the vast variation between counties across the country. I believe it is important to point out that even through the 1996 AAPCC payment increased an **average** of 10.1 percent, not all counties shared in the bounty of that increase. Counties that typically "lost" ground were those in efficient markets and rural counties with historically lower reimbursement rates. Because of these lower rates and lower annual increases these regions will continue to lack the ability to attract managed care options to their area or offer enhanced health care benefits often found in higher payment communities.

Monthly Payments Rates to Medicare Managed Care Plans						
Area/County	1995 Payment	1995 % Increase	1996 Payment	1996 % Increase	1997 Payment	1997 % Increase
National Average	$400.52	5.9	$440.90	10.1	$466.95	5.9
Richmond, NY	668.48	6.2	758.53	13.4	767.35	1.1
Kern, CA	439.15	5.8	478.33	8.9	512.08	7.0
Hennepin, MN	359.33	2.0	386.77	7.6	405.63	4.8
Tulare, CA	333.96	2.9	360.38	7.9	390.78	8.4
Vernon, WI	209.28	6.6	237.09	13.2	250.30	5.5

The payment figures also illustrate the overall instability and unpredictability of AAPCCs -- factors that discourage health plans from entering new markets and remaining in other markets.

If there is a silver lining to HCFA's release of the 1997 risk-based managed care payment rates was in Dr. Vladeck's remarks:

> The formula used to set HMO payment rates is flawed. It shortchanges rural areas and markets where care is delivered more efficiently, and may limit beneficiary choice.

Dr. Vladeck's comments indicate HCFA's understanding of the inequity in the current AAPCC formula and the need for change if we are to offer all Medicare beneficiaries true choices in the type and form of health care they want to receive. I see this as a signal in the future we can work in a bipartisan, pragmatic way to improve the AAPCC payment formula.

Mr. Chairman, correcting the AAPCC payment formula is vital. In this Congress, we have come a long way to improve our understanding the many dimensions of the AAPCC payment issue and the need to make the formula more equitable. I look forward to working with you in the future to make the needed changes to the AAPCC formula. The longer we continue to use our current formula, the longer efficient health care markets will be penalized and rural areas will lag behind leaving Medicare beneficiaries with fewer choices.

STATEMENT BY REP. PAT ROBERTS
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
RURAL HEALTH CARE ISSUES
9/12/96



Mr. Chairman, I thank you for holding this important hearing today to discuss federal programs and demonstrations created to address the special needs of rural communities. We in rural America face unique barriers to receiving high quality health care services. Many rural Americans must overcome vast distances and geographical barriers in order to visit health care providers. In addition, communities have a difficult time attracting and retaining health care providers and hospitals generally face lower reimbursement rates.

I strongly support the Essential Access Community Hospital/Rural Primary Care Hospital program. In Kansas, seven EACHs support ten RPCHs in seven rural health networks. Three additional RPCHs are going through the certification process; four more are actively considering the option. I strongly urge my colleagues to read the testimony submitted by the Hays Medical Center regarding the EACH/RPCH network established in this largely rural area. This testimony is an excellent example of strategies that are working to improve the health care services in rural and underserved areas.

In addition, I thank my colleagues, Rep. Steve Gunderson and Rep. Glenn Poshard, co-chairs of the House Rural Health Care Coalition, for their leadership, hard work and dedication to the improvement of health care services in rural America. I look forward to working together with members of the Rural Health Care Coalition and the Ways and Means Committee to pass legislation to improve rural health care.

Essential Access Community Hospital/ Rural Primary Care Hospital (EACH/RPCH) Rural Health Network

Northwest Kansas Health Alliance

Prepared by
Hays Medical Center
Hays, Kansas

SAVE THE ESSENTIAL ACCESS COMMUNITY HOSPITAL/
RURAL PRIMARY CARE HOSPITAL (EACH/RPCH)
PROGRAM

PROPOSAL
July 1, 1995

Protecting Medicare requires change for everyone. For Medicare providers, the challenge is to maintain quality patient care while reducing the cost of providing service. In urban areas, this can be accomplished through the institution of appropriate managed care practices already successful in the private sector. In rural areas, healthcare networks must be formed to provide an organized, cost effective system of service throughout an entire region. In this manner, primary care is provided in rural communities and supported by a secondary hospital through telecommunications and a predetermined system of care.

Many rural hospitals are heavily dependent on the Medicare program, which does not cover the full cost of providing service. Medicare losses in these rural communities are currently subsidized through local taxes. At the same time, it is generally more expensive to provide essential medical services in a rural area than an urban. For example, recruitment and retention of the necessary professionals such as physicians, physical therapists and registered nurses is significantly more difficult without an available labor pool. Rural hospitals lack the economies of scale necessary to purchase supplies and equipment, and to maintain the technology necessary to meet medical standards.

When essential health services are not available or adequately coordinated, Medicare beneficiaries are denied early diagnosis and treatment, and ultimately Medicare program costs are increased as more extensive and expensive intervention is required elsewhere. Without a transition to a more efficient regional health system, the proposed cuts will close many rural hospitals, jeopardizing the very existence of small towns. A hospital is often times a rural community's largest employer, and critical in maintaining both population and local business.

Due to this rural dependency on Medicare, a program providing funds to develop and operate regional rural networks is critical. The Essential Access Community Hospital/ Rural Primary Care Hospital (EACH/RPCH) initiative is a strong example of such a program. Care coordination between a primary and secondary hospital, utilizing advances in tele-communication, will ensure quality and be cost justifiable in the long term. If cuts are made without providing for this system, Medicare program costs may in fact rise. Careful planning is needed to prevent a future rural health care crisis.

Rural Medicare beneficiaries in the seven EACH/RPCH states are now beginning to receive the benefit of a regional rural medical care delivery system through the program's two components. The grant program has met its objectives, providing seed money for the development of network structure. The operating component should be maintained, throughout any changes in Medicare, to keep progress moving forward.

One of the best examples of a regional rural healthcare network, sponsored by the EACH/RPCH program, is saving costs and improving quality patient care in Northwest Kansas. In an unprecidented move, the National Rural Health Association recently recognized the Kansas EACH/RPCH program as the 1995 recipient of the Outstanding Rural Health Program Award for coordination, networking, innovation and lasting impact. Within Kansas, the most developed EACH/RPCH network is the Northwest Kansas Health Alliance. Hays Medical Center is the designated EACH facility for this region. Grisell Memorial, Ransom, is designated the Rural Primary Care Hospital and Rawlins County Hospital, Atwood, has completed the application process. There are 40 other hospitals that are collaborating with Hays Medical Center across the region.

As an EACH facility, Hays Medical Center began to receive additional Medicare funding under the sole community provider formula in October, 1993. Prior to that designation, Hays Medical Center experienced significant difficulties and was forced to layoff 15% of its workforce following the sunset of Medicare Dependent legislation. During this era, the Medical Center also lost nearly 50% of the active Medical Staff. By the spring of 1993, only one family practitioner was providing service in a community of nearly 20,000 people. At that time, a local poll identified the number one social problem as access to medical care.

The EACH/RPCH grant funds provided Hays Medical Center the opportunity to conduct a long range strategic planning process, creating a vision of rural health networking for Northwest Kansas. In this network, primary care would be provided by not-for-profit community providers in rural communities. Secondary care, including specialized surgery, emergency care and diagnostic imaging services, would be provided by Hays Medical Center. Tertiary care services involving subspecialists would be provided through KU Medical Center in Kansas City and through agreements with not-for-profit community hospitals in Wichita.

This rural health system would be supported by telecommunications, information systems linkage and a patient transportation system. In addition, the plan would be supported by speciality clinic visits to rural areas, transfer agreements and mobile technology services.

The strategic planning process underscored serious problems in recruitment and retention of physicians and healthcare specialists. Several rural hospitals in the service area were operating at a deficit, some relying on no fund warrants to keep the doors open. There was poor coordination of service, with little communication

between providers. Transportation of patients was available mainly through volunteer ambulance services, and the urban provider planned to remove air ambulance service.

With the approval of EACH status, Hays Medical Center officials went to work implementing a regional medical network. In the last two years, the following has been accomplished:

- A 24-hour regional emergency center staffed by physicians, providing rapid emergency support region wide.

- A center for telemedicine, providing specialty consults for patients, vacation relief to rural physicians, continuing medical education, and service coordination between providers.

- Recruitment of 30 primary care and specialty physicians, resulting in national recognition as turnaround of the year by the National Association of Medical Care Recruiters. Specialists recruited to meet documented regional health needs included: orthopedic surgery, radiation oncology, medical oncology/hematology, family practice, physical medicine and rehabilitation, neurology, geriatric and adolescent psychiatry, internal medicine, pediatrics, and emergency medicine. One fourth of the active Medical Staff has been recruited due to the EACH/RPCH program.

- Teleradiology equipment installation in eight hospitals, providing the timely interpretation of results and a significant improvement in rural patient care.

- Mobile technology expansion including mobile CT scanner, mobile mammography and mobile sonogram units.

- An air ambulance, provided through unique partnership, now services the region. Flight nurses and paramedic staff work in emergency and intensive care units while not in the air, thereby reducing service costs.

- Major capital equipment expenditures were made in critical areas including surgery, intensive care, and radiology. A cardiac cath lab plan is now underway as several Northwest Kansas counties exhibit three to four times the national average of cardiac related mortality and morbidity.

- A 37 hospital rural medical information network entitled the High Plains Medical Information System now exists, and with upgrading will soon provide state-of-the-art programming to rural hospitals and physician clinics. Plans include development of a virtual medical center linking remote professionals with clinical support resources.

- Assistance in integrated community planning with administrators, public health officials, and county commissioners is further coordinating rural health services.

- Four rural health clinics have been established in the service area and shared staffing programs, providing professional education and vacation relief to rural hospitals, have been successful.

- Biomedical engineers in Hays service x-ray and other clinical equipment at 41 regional healthcare facilities.

- Expansion of a network of visiting physician clinics, both from Hays and KU Medical Center, bring needed subspecialists to service the region.

- Ongoing development of a primary care physician network, with physician practices receiving EACH facility financial and clinical support. HMC's Office of Rural Health was created through EACH/RPCH to identify and meet the needs of rural hospitals and physicians. This office is currently providing emergency assistance to a community which recently lost its hospital in a hailstorm.

- Expansion of home health services including rural satellite offices, and one of the nation's first home health telemedicine programs, providing care at less than 1/6 standard costs.

- Network participants have been afforded introduction to the latest in healthcare systems development including collaborative pathways and continuous quality improvement workshops, professional staff and department manager exchanges, and shared staffing arrangements. Provision of traditionally expensive professional consultation services, such as dietary and physical therapy, are also improving both healthcare efficiency and patient care.

- Plans are underway to develop a managed care system for Medicare beneficiaries encouraging wellness, prevention and early diagnosis of disease.

The EACH/RPCH network is successfully collaborating with other rural health entities including the Great Plains Health Alliance, a rural healthcare management organization, and Med-Op, a rural hospital cooperative. Our vision is to include the physicians as leaders in a healthcare network for the Northwest Kansas region.

There are many anecdotal stories regarding lives saved, cancers detected in time, and babies born early but treated at less expensive, local facilities. Our rural doctors are no longer alone and are receiving specialty support, continued medical education and vacation relief. We believe the EACH/RPCH network will continue to encourage physicians to locate to our area and spend their years serving an appreciative community.

Like most rural communities, as we look to the future we see a significant increase in the portion of elderly residing in our counties. We believe through proper healthcare planning and the applicable use of technology, these elderly citizens can enjoy a secure and healthy retirement in the communities that they help to build and maintain.

The EACH/RPCH program is working very well in Northwest Kansas, offering a responsible vision for the future. The alternative is closed hospitals, disorganized care and an alienated population. The rural hospital of the future will no longer be a full service acute care facility. It will be a primary care facility, linked in partnership with a full service secondary care hospital and networked through shared planning services and technology. The incentive to become a rural primary care hospital should be cost reimbursement from Medicare. The incentive to develop appropriate services to support a regional health network should remain EACH Medicare funding. Without it, secondary hospitals will be forced to focus solely on the needs of their immediate communities, jeopardizing the future of rural healthcare networks.

We are urging the following legislative action:

1) Support legislation which will grandfather in existing EACH/RPCH Medicare reimbursement status for existing networks.

2) Protect Rural Essential Access Community Hospitals which are utilizing reimbursements to improve the efficiency of the rural health care delivery system itself.

3) Support action on the Senate spending bill which would restore funding to the Federal Office of Rural Health Policy and the State Offices of Rural Health.

It is only together that rural healthcare facilities can remain viable. The EACH/RPCH program, appropriately funded, provides the infrastructure to create networks that will assure rural healthcare for generations to come.
If you have questions regarding the Northwest Kansas EACH/RPCH program, please contact:

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