

Referral Referral Center File



FAX COVER SHEET

OFFICE OF LEGISLATIVE & INTER-GOVERNMENTAL AFFAIRS

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| | |
|---------------------------|------------------------------------------------------------|
| To: <u>Chris Jennings</u> | From: Sharon Arnold Director Div. Of Medicare Part A |
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REMARKS: Attached are talking points to respond to Sally Rosenberg's concerns about our policy on RRC's. Please let me know if you need anything else.

HEALTH CARE FINANCING ADMINISTRATION
 200 Independence Ave., SW
 Room 341-H, Humphrey Building
 Washington, DC 20201

To: Chris Jennings

From: Debbie Chang
OLIGA

Sally Rosenberg, Rural Referral Center Coalition, questioned the Administration's reasoning in supporting "tiers and modified benefits for RRCs depending on how far below the 108% threshold they fall and [why we] would not reopen the current application process (February 2, 1996). The following is our response:

- o The Coalition's proposal is to fully exempt RRCs from the 108% wage index threshold. The Administration's proposal would create tiers for RRCs depending on how far below the 108% threshold they fall.

HCFA Response: While not as advantageous towards RRCs as the Coalition proposal, the Administration bill would provide these facilities with favored status not accorded other Medicare providers. A tiered approach provides RRCs special consideration under the Medicare Geographic Classification Review Board (MGCRB) wage index reclassification process. This affords additional protection to rural facilities which may encounter large fluctuations in their costs and utilization over short periods of time. The proposal would allow RRCs to qualify for some increase in their wage index, although not the full amount, when their wages are between 100 and 108 percent of the average wage.

We are supporting a tiered approach in order to assist rural hospitals better serve their communities, while maintaining our commitment to the wage index approach.

- o The Administration's proposal does not reopen the current application process for RRC applications before the MGCRB.

HCFA Response: We do not support the idea of retroactively reopening the application process for the geographic reclassification review. Applications were due October 1995 for review by the MGCRB Spring 1996. The statute sets forth strict deadlines and timelines for submitting and reviewing MGCRB applications and makes the Secretary's reclassification decisions final and unreviewable once they are rendered. The decision-making process has to be completed in time for the Agency to calculate PPS rates. We are currently in the middle of the process and to disrupt this would cause the system to undergo severe turmoil.

EXEMPT RRCs FROM THE MGCRB 108% WAGE INDEX THRESHOLD

A rural referral center (RRC) is a Medicare designation for the larger and more specialized hospitals in rural areas.

For purposes of wage index reclassification, hospitals must meet two thresholds: (1) the hospital's average hourly wage (AHW) must be 108% of the statewide rural AHW; and (2) the hospital's AHW must be at least 84% of the AHW of the target urban area to which the RRC is applying. RRCs have difficulty satisfying the 108% threshold because of their unique labor mix. In fact, when HCFA imposed the 108% criteria in 1993, almost half of the previously reclassified RRCs no longer were able to qualify for wage index reclassification.

Both the Republican leadership (H.R.2491, Sec. 8704(a)) and Democratic coalition (H.R.2530, Sec. 3504(a)) budget bills include provisions that would exempt RRCs from the 108% threshold requirement. The Administration's proposal includes a far less beneficial tiered approach that would provide for increasing benefits to RRCs that fall either within 100-104%, 104-108%, or over 108% of the state rural wage index. RRCs that are below 100% of the state rural wage index would receive no benefit under the Administration's proposal.

The Administration should support the blanket approach included in H.R.2491 and H.R.2530 for the following reasons.

- (1) The blanket approach would benefit all RRCs equally. The Administration's approach, on the other hand, would only benefit, and at a reduced rate, the approximately 40 RRCs that have AHWs between 100-108% of the state rural wage index; another nearly 50 RRCs would realize no benefit.
- (2) The blanket approach would serve as an appropriate proxy for benefits RRCs lost with the convergence of the rural and other urban standardized amounts.
- (3) The tiered approach appears regulatory instead of legislative. The blanket exemption is cleaner, simpler, and more appropriate to a legislative solution.
- (4) We believe that the tiered approach was initially suggested by Senator Rockefeller as an anticipatory compromise designed to head-off expected opposition to the blanket approach. The expected opposition never materialized. In fact, the blanket approach has garnered widespread bipartisan support. Accordingly, RRCs should not have to settle for a less advantageous, unnecessary compromise.
- (5) The blanket approach would impose no additional cost over the tiered approach. Both approaches would be accomplished on a budget neutral basis.

IMPACT OF REPUBLICAN BUDGET CUTS ON RURAL AMERICA

October 11, 1995

HEALTH CARE IN RURAL AMERICA

The Republican MEDICARE Cuts Will Force 9.6 Million Older And Disabled Americans In Rural America To Pay Higher Premiums and Higher Deductibles For A Weakened Second Class Medicare Program.

Medicare Spending For People In Rural Areas Of America Will Be Cut By \$58 billion Over Seven Years -- A 20% Percent Cut In 2002 Alone.

- **The Republican Cuts Will Increase The Severe Financial Pressure On Rural Hospitals In America And Force Some Rural Hospitals To Close.** Today, rural hospitals lose money on Medicare patients while urban hospitals make a small profit. Medicare accounts for almost 40% of net patient revenue in the average rural hospital, and as much as 80% in some rural hospitals.
- **According to the American Hospital Association, under the Republican cuts, the typical rural hospital will lose \$5 million in Medicare funding over seven years.**
- **Rural Medicare Recipients Would Lose Much-Needed Doctors.** America's rural Medicare recipients would need 5,084 more primary care physicians to have the same doctor to population ratio as the nation as a whole. Yet the American Medical Association has stated that the cuts in Medicare are so severe that they "will unquestionably cause some physicians to leave Medicare." [*New York Times*, October 10, 1995.]

The Republican MEDICAID Cuts Will Further Hurt Rural Hospitals And Eliminate Coverage For Millions Of Rural Americans.

- **Rural Hospitals Will Suffer Additional Revenue Losses From The \$45 Billion Republican Medicaid Cuts.** In addition to the average of \$5 million rural hospitals will lose from Medicare cuts, rural hospitals will also face revenue shortages due to the severe Republican Medicaid cut.
- **As Many As 2.2 Million Rural Americans Will Be Denied Medicaid Coverage, Including:**
 - 1 Million Children
 - 230,000 Older Americans
 - 350,000 People With Disabilities
- **Over 77,000 Rural Older And Disabled Persons In America Could Be Denied Nursing Home Coverage in 2002.** Most of the 350,000 people living in nursing homes in rural America are covered by Medicaid. Under the Republican Medicaid plan, approximately 77,000 rural nursing home residents (22%) could be denied coverage.
- **Over 55,000 Rural Older And Disabled Persons In America Could Be Denied Home Care Benefits in 2002.** Most of the 365,600 poor elderly in rural America who need home care are covered by Medicaid. Under the Republican Medicaid plan, approximately 55,000 (17%) rural poor elderly who need home care will lose coverage.

FARMING IN RURAL AMERICA

The Republican Budget Slashes Farm Spending By 25% over seven years. Farm spending in America will be reduced by \$13 billion -- drastically reducing support for commodity programs.

The Republican Budget Will Reduce Farm Income Nationwide. As a result of the Republican cuts, net farm income for target price crops and soybeans is expected to decline by \$9 billion over seven years -- a 4% reduction in earnings.

TAXES ON WORKING FAMILIES IN RURAL AMERICA

The Republican Budget Raises Taxes On 4 Million Working Families In Rural America By An Average Of \$352 in 2002. Republican cuts to the Earned Income Tax Credit will impose a \$59.2 million tax increase on working families and their children in rural America.

EDUCATION IN RURAL AMERICA

The Republican Education Cuts Will Deny 113,000 Children Basic And Advanced Skills In Rural America in 1996. Title I funds in rural areas will be cut by \$113 million -- more than 17% -- denying crucial assistance at a time when many small-town and rural schools are already having trouble making ends meet.

PUBLIC HEALTH AND THE ENVIRONMENT IN RURAL AMERICA

The Republican Budget Will Reduce The Amount Of Money That States Can Spend To Keep Water Clean In Small Communities And Rural Areas By 20% Compared To The President's Balanced Budget. These cuts will derail initiatives that are working to fight water pollution and protect public health.

The Republican Budget Proposal Will Stop Or Slow The Clean-up Of At Least 115 Toxic Waste Sites In Rural America. Nationwide, the Republican Budget reduces spending on toxic waste cleanups by 36% -- or \$560 million -- below the President's balanced budget. These cuts will restrict or stop clean-ups of sites nationwide that pose a threat to public health and the environment.

TRANSPORTATION IN RURAL AMERICA

The Republican Budget Will Cut Transportation Grants For Rural Areas By 20%. Republican proposals cut \$57.4 million for rural transportation in America. These funds are essential for giving residents access to medical services, supermarkets and grocery stores, and job training.

NUTRITION IN RURAL AMERICA

Republican Cuts Will Slash Up To 15% From Food Assistance To Rural America.

Republican budget cuts will fall particularly hard on the rural poor, cutting as much as \$46.7 billion in food assistance from rural areas over seven years.

Republican Nutrition Cuts Will Eliminate Jobs In America. These cuts will reduce farm prices and incomes, and result in the loss of as many as 328,900 jobs nationwide -- including up to 57,800 rural jobs.

HOUSING IN RURAL AMERICA

The Republican Housing Cuts Will Reduce Spending On Public Housing Capital In Rural America 46% Below The President's Request in 1996. Cuts to public housing capital assistance in rural areas will total \$460 million in 1996, severely hindering efforts by rural housing agencies to rehabilitate run down public housing projects and provide much needed security and anti-crime programs.

The Republican Budget Will Cut 40% From Assistance To Homeless Persons in Rural Areas in 1996. The Republican plan will cut \$108 million in homeless assistance to rural areas. The reduction will mean 4.9 million fewer nights of shelter for America's rural homeless.

**INVESTING IN THE FUTURE OF RURAL AMERICA VS.
CUTTING EDUCATION AND TRAINING
THE FACTS ON THE WAR ON RURAL EDUCATION**

FACT: President Clinton wants to invest in the future of Rural America by **INCREASING** funding for improving education, training, and financial aid to students while balancing the budget in 10 years. The Republican proposals **CUT** education and training, denying education and training opportunities to millions of students and increasing costs to families, many of whom live in rural areas.

GOALS 2000 --- EDUCATION QUALITY

FACT: Both the House and the Senate have approved a bill that would eliminate all funds for high poverty rural areas, depriving about 20 rural districts of at least \$9 million in funds that could be used to design and implement their own school reform plans.

IMPROVING BASIC AND ADVANCED SKILLS --- TITLE ONE

FACT: Republican cuts will deny 113,000 rural children basic and advanced skills education --- at a time when many small-town and rural schools are already having trouble making ends meet.

SAFE AND DRUG-FREE SCHOOLS AND COMMUNITIES

FACT: Republicans want to dismantle the program used by school districts to keep crime, violence, and drugs out of schools and away from students. Rural school districts, most of which have small enrollments, are likely to be disproportionately affected, because the majority of funds are allocated on a per-pupil basis.

SCHOOL-TO-WORK

FACT: House Republicans would reduce the amount of direct grants to local partnerships, depriving 25 rural areas of grants to institute school-to-work systems. Under both House and Senate proposals, no new state awards could be made.

STAR SCHOOLS

FACT: House Republicans have voted to eliminate this funding for 1996, which promotes statewide or multistate telecommunications partnerships to enhance educational opportunities for rural areas.

EISENHOWER PROFESSIONAL DEVELOPMENT

FACT: House Republicans would cut this program by 80%, severely disabling professional development for educators in rural areas. Eisenhower funds are distributed on a formula basis and due to small enrollments, most rural districts will be unable to operate effective programs.

ADULT EDUCATION AND LIFELONG LEARNING

FACT: Congressional Republicans have approved bills that would deny approximately 9,000 rural adults the adult education and literacy services they need and deserve.

Effect of Proposed FY '96 Congressional Action: Technology Challenge Grants and Rural Areas

On October 10th, the President announced the award of the first 19 challenge grants for technology in education. These grants provide funding to local school districts and their community partners to harness technology to help all students learn to challenging academic standards. Leveraging matching funds from other public and private participants (roughly three times the size of the federal investment), the grants will support the involvement of 380 local partners, including 153 school districts--70 of which, nearly half, are rural school districts.

The President has proposed that the Department of Education increase its commitment for this initiative from \$9.5 million this year to \$50 million for FY '96. This would allow as many as 40 new grants to as many as 750 new partners. A significant portion of the new grants would likely go to rural districts which present innovative proposals for working with their partners to get technology into the classroom. Meanwhile, the House appropriations bill only includes \$25 million for technology challenge grants, and the Senate only includes \$15 million -- only enough to continue those grants that have already been made.

Here are some approved grants and how they can improve teaching and learning in rural areas:

South Dakota's "Technology in Education Challenge for Rural America" consortium, led by the **Black Hills Special Services Cooperative, Sturgis, South Dakota**, has organized a state-wide, community-focused education program to advance the effective use of technology in school improvement by introducing innovative education technologies in a statewide redesign of K-12 curricula, instruction and assessment and capitalizing on new technologies to promote student achievement. The program will help over 14,000 rural students in the first year, and over 35,000 throughout its duration, improving teaching and learning and leading to the attainment of challenging academic standards by all children.

The Newaygo County Advanced Technology Service, Newaygo County Intermediate School District, White Cloud, Michigan, is a consortium that has been established to develop and maintain an advanced fiber optic cable telecommunication network that will enrich the education process throughout this isolated, rural, low-income county. The service's education program enhances education opportunities for over 9,000 disadvantaged students and adults. Moreover, the network supports data, video, and voice communications capabilities that are available to all county residents. It provides student access to challenging curriculum in science, mathematics, and modern languages, and it supports professional development opportunities for teachers. The program has strong school-home, school-community, and school-work components.

New Vision, lead by the **Towanda Area School District in Towanda, Pennsylvania**, is a consortium of 23 school districts, six post-secondary institutions, museums and private industries that use emerging technologies to expand and improve educational opportunities in rural, remote, and poor school districts. Through video-conferencing, New Vision can offer high-level classes seldom offered due to low enrollment, use outstanding teachers to cover hard-to-fill positions in several districts at once, and offer advanced placement courses. The project will involve over 54,000 students in rural areas of three states: **Pennsylvania, New Jersey and New York.**

Methods for the State Rural Analysis

1. **Medicare:** The estimates of the number of rural beneficiaries and the Medicare loss are based on the county analysis released August 8, 1995. In that study, the Conference Agreement Medicare cuts were allocated to states and counties in proportion to the Medicare spending in those counties. For instance, if a county received 1% of all Medicare payments, then its Medicare loss over seven years would be equal to \$270 billion (the Conference Agreement seven-year savings) multiplied by 1%. The beneficiary counts are based on 1991 data updated to 1994. The county estimates were converted to metropolitan and non-metropolitan estimates for this analysis.
2. **Medicaid:** Three estimates are presented at the state level. The number of rural nursing home residents comes from the National Center for Health Statistics. The number of community-based poor elderly with long-term care needs comes from the Census Bureau, and is based on self-reported questions related to activities of daily living. The national number of rural Medicaid beneficiaries losing coverage and the dollar loss to rural areas are estimated assuming that states reduce their spending and coverage proportionally. According the Current Population Survey, approximately 25% of Medicaid recipients live in non-metropolitan areas.

* WILL ARRIVE FRIDAY AT 10am

| | Medicare Enrollment: 1994 | | | |
|----------------------|---------------------------|------------|------------|---------|
| | Rural | Urban | Total | % Rural |
| US | 9,637,000 | 26,614,405 | 36,251,405 | 27% |
| Alabama | 241,900 | 387,800 | 629,700 | 38% |
| Alaska | 19,400 | 12,300 | 31,700 | 61% |
| Arizona | 145,800 | 430,900 | 576,700 | 25% |
| Arkansas | 283,400 | 132,400 | 415,800 | 68% |
| California | 233,600 | 3,328,200 | 3,561,800 | 7% |
| Colorado | 96,500 | 312,800 | 409,300 | 24% |
| Connecticut | 15,200 | 481,300 | 496,500 | 3% |
| Delaware | 38,500 | 59,400 | 97,900 | 39% |
| District of Columbia | 0 | 78,600 | 78,600 | 0% |
| Florida | 286,200 | 2,268,300 | 2,554,500 | 11% |
| Georgia | 347,800 | 463,100 | 810,900 | 43% |
| Hawaii | 40,200 | 105,300 | 145,500 | 28% |
| Idaho | 120,100 | 25,700 | 145,800 | 82% |
| Illinois | 374,100 | 1,232,400 | 1,606,500 | 23% |
| Indiana | 279,000 | 534,300 | 813,300 | 34% |
| Iowa | 300,300 | 171,600 | 471,900 | 64% |
| Kansas | 214,700 | 165,000 | 379,700 | 57% |
| Kentucky | 328,200 | 246,100 | 574,300 | 57% |
| Louisiana | 196,000 | 376,200 | 572,200 | 34% |
| Maine | 87,100 | 111,000 | 198,100 | 44% |
| Maryland | 55,800 | 534,800 | 590,600 | 9% |
| Massachusetts | 63,800 | 859,300 | 923,100 | 7% |
| Michigan | 319,100 | 1,009,300 | 1,328,400 | 24% |
| Minnesota | 273,400 | 349,900 | 623,300 | 44% |
| Mississippi | 293,800 | 96,000 | 389,800 | 75% |
| Missouri | 329,600 | 492,800 | 822,400 | 40% |
| Montana | 97,600 | 29,100 | 126,700 | 77% |
| Nebraska | 155,900 | 91,100 | 247,000 | 63% |
| Nevada | 32,100 | 149,400 | 181,500 | 18% |
| New Hampshire | 51,800 | 100,500 | 152,300 | 34% |
| New Jersey | 0 | 1,157,600 | 1,157,600 | 0% |
| New Mexico | 110,300 | 94,600 | 204,900 | 54% |
| New York | 276,600 | 2,340,900 | 2,617,500 | 11% |
| North Carolina | 497,100 | 501,900 | 999,000 | 50% |
| North Dakota | 71,800 | 30,600 | 102,400 | 70% |
| Ohio | 353,500 | 1,292,400 | 1,645,900 | 21% |
| Oklahoma | 238,200 | 326,866 | 565,066 | 42% |
| Oregon | 166,100 | 294,000 | 460,100 | 36% |
| Pennsylvania | 334,300 | 1,721,300 | 2,055,600 | 16% |
| Rhode Island | 0 | 166,500 | 166,500 | 0% |
| South Carolina | 212,300 | 282,200 | 494,500 | 43% |
| South Dakota | 87,800 | 27,200 | 115,000 | 76% |
| Tennessee | 299,000 | 453,700 | 752,700 | 40% |
| Texas | 560,700 | 1,473,300 | 2,034,000 | 28% |
| Utah | 49,500 | 132,600 | 182,100 | 27% |
| Vermont | 67,000 | 14,300 | 81,300 | 82% |
| Virginia | 297,600 | 500,200 | 797,800 | 37% |
| Washington | 157,700 | 513,900 | 671,600 | 23% |
| West Virginia | 206,100 | 174,139 | 380,239 | 54% |
| Wisconsin | 289,400 | 463,400 | 752,800 | 38% |
| Wyoming | 41,100 | 17,900 | 59,000 | 70% |

Number of beneficiaries: 1994 states totals, estimated at the substate level using 1992 distribution of beneficiaries.

Source: US DHHS

| | Reduction in Medicare Spending: 2002 | | | | Reduction in Medicare Spending: 1996-2002 (\$ millions) | | | |
|-------------------|--------------------------------------|--------|--------|---------|---------------------------------------------------------|---------|---------|---------|
| | Rural | Urban | Total | % Rural | Rural | Urban | Total | % Rural |
| US | 15,070 | 55,545 | 71,000 | 21% | 57,860 | 210,689 | 270,000 | 21% |
| Alabama | 607 | 1,054 | 1,661 | 37% | 2,153 | 3,737 | 5,890 | 37% |
| Alaska | 25 | 17 | 42 | 60% | 100 | 66 | 166 | 60% |
| Arizona | 273 | 974 | 1,247 | 22% | 1,013 | 3,613 | 4,626 | 22% |
| Arkansas | 346 | 179 | 525 | 66% | 1,389 | 719 | 2,108 | 66% |
| California | 527 | 9,366 | 9,893 | 5% | 1,939 | 34,432 | 36,371 | 5% |
| Colorado | 194 | 765 | 959 | 20% | 696 | 2,738 | 3,434 | 20% |
| Connecticut | 31 | 1,011 | 1,042 | 3% | 118 | 3,850 | 3,968 | 3% |
| Delaware | 83 | 152 | 235 | 35% | 305 | 561 | 865 | 35% |
| District of Colum | 0 | 1,197 | 1,197 | 0% | 0 | 3,778 | 3,778 | 0% |
| Florida | 760 | 7,029 | 7,789 | 10% | 2,741 | 25,357 | 28,098 | 10% |
| Georgia | 708 | 1,029 | 1,737 | 41% | 2,656 | 3,862 | 6,519 | 41% |
| Hawaii | 90 | 272 | 362 | 25% | 311 | 942 | 1,253 | 25% |
| Idaho | 102 | 23 | 125 | 82% | 426 | 94 | 520 | 82% |
| Illinois | 421 | 1,798 | 2,218 | 19% | 1,721 | 7,357 | 9,078 | 19% |
| Indiana | 417 | 895 | 1,312 | 32% | 1,620 | 3,472 | 5,092 | 32% |
| Iowa | 252 | 162 | 414 | 61% | 1,065 | 686 | 1,751 | 61% |
| Kansas | 371 | 326 | 697 | 53% | 1,411 | 1,239 | 2,650 | 53% |
| Kentucky | 453 | 356 | 809 | 56% | 1,807 | 1,421 | 3,227 | 56% |
| Louisiana | 427 | 903 | 1,330 | 32% | 1,626 | 3,436 | 5,062 | 32% |
| Maine | 83 | 110 | 193 | 43% | 346 | 461 | 807 | 43% |
| Maryland | 66 | 826 | 891 | 7% | 269 | 3,395 | 3,664 | 7% |
| Massachusetts | 153 | 2,416 | 2,569 | 6% | 564 | 8,900 | 9,464 | 6% |
| Michigan | 354 | 1,473 | 1,827 | 19% | 1,462 | 6,078 | 7,540 | 19% |
| Minnesota | 478 | 787 | 1,264 | 38% | 1,714 | 2,821 | 4,534 | 38% |
| Mississippi | 414 | 149 | 563 | 73% | 1,640 | 592 | 2,232 | 73% |
| Missouri | 454 | 827 | 1,280 | 35% | 1,797 | 3,276 | 5,073 | 35% |
| Montana | 101 | 30 | 131 | 77% | 413 | 125 | 538 | 77% |
| Nebraska | 161 | 122 | 283 | 57% | 641 | 486 | 1,126 | 57% |
| Nevada | 75 | 459 | 533 | 14% | 261 | 1,600 | 1,861 | 14% |
| New Hampshire | 79 | 164 | 244 | 33% | 301 | 623 | 924 | 33% |
| New Jersey | 0 | 1,940 | 1,940 | 0% | 0 | 7,727 | 7,727 | 0% |
| New Mexico | 105 | 104 | 208 | 50% | 424 | 420 | 844 | 50% |
| New York | 329 | 4,153 | 4,481 | 7% | 1,325 | 16,733 | 18,058 | 7% |
| North Carolina | 896 | 914 | 1,810 | 50% | 3,342 | 3,408 | 6,749 | 50% |
| North Dakota | 93 | 41 | 133 | 69% | 373 | 164 | 537 | 69% |
| Ohio | 401 | 1,760 | 2,161 | 19% | 1,647 | 7,221 | 8,868 | 19% |
| Oklahoma | 303 | 330 | 633 | 48% | 1,223 | 1,335 | 2,558 | 48% |
| Oregon | 282 | 562 | 844 | 33% | 1,033 | 2,059 | 3,092 | 33% |
| Pennsylvania | 524 | 3,261 | 3,785 | 14% | 2,084 | 12,969 | 15,053 | 14% |
| Rhode Island | 0 | 403 | 403 | 0% | 0 | 1,451 | 1,451 | 0% |
| South Carolina | 395 | 528 | 923 | 43% | 1,439 | 1,922 | 3,361 | 43% |
| South Dakota | 98 | 30 | 128 | 77% | 396 | 120 | 516 | 77% |
| Tennessee | 804 | 1,185 | 1,989 | 40% | 2,931 | 4,316 | 7,248 | 40% |
| Texas | 1,150 | 3,389 | 4,539 | 25% | 4,304 | 12,686 | 16,991 | 25% |
| Utah | 77 | 200 | 277 | 28% | 295 | 766 | 1,061 | 28% |
| Vermont | 72 | 16 | 88 | 82% | 290 | 66 | 356 | 82% |
| Virginia | 314 | 566 | 879 | 36% | 1,293 | 2,332 | 3,625 | 36% |
| Washington | 184 | 634 | 818 | 22% | 740 | 2,549 | 3,289 | 22% |
| West Virginia | 247 | 147 | 394 | 63% | 994 | 592 | 1,586 | 63% |
| Wisconsin | 264 | 501 | 765 | 34% | 1,097 | 2,085 | 3,182 | 34% |
| Wyoming | 28 | 12 | 41 | 70% | 125 | 54 | 179 | 70% |

Based on total savings in the Conference Agreement, allocated to the state and county level by the historical distribution of expenditures.

Source: US DHHS

06-Oct-95

TABLE A: NON-INSTITUTIONALIZED PERSONS AGED 16-64
WHO ARE POOR & WHO NEED LONG-TERM
CARE BY STATE AND URBAN/RURAL STATUS: 1990

| STATE | Total Urban Population | # in Urban Population with LTC Needs in Poverty | % in Urban Pop. with LTC Needs in Poverty | Total Rural Population | # in Rural Population with LTC Needs in Poverty | % in Rural Population with LTC Needs in Poverty |
|----------------------|------------------------|-------------------------------------------------|-------------------------------------------|------------------------|-------------------------------------------------|-------------------------------------------------|
| United States | 119038486 | 1398871 | 1.18% | 38285436 | 406258 | 1.06% |
| Alabama | 1,523,475 | 29,819 | 1.96% | 1,006,032 | 18,350 | 1.82% |
| Alaska | 233,222 | 1,112 | 0.48% | 109,671 | 557 | 0.51% |
| Arizona | 1,990,193 | 19,131 | 0.96% | 266,214 | 7,762 | 2.92% |
| Arkansas | 757,787 | 13,412 | 1.77% | 668,104 | 11,516 | 1.72% |
| California | 17,847,915 | 174,941 | 0.98% | 1,316,189 | 10,434 | 0.79% |
| Colorado | 1,765,018 | 14,521 | 0.82% | 369,236 | 1,776 | 0.48% |
| Connecticut | 1,683,435 | 12,318 | 0.73% | 453,454 | 744 | 0.16% |
| Delaware | 316,819 | 2,132 | 0.67% | 111,849 | 800 | 0.72% |
| District of Columbia | 411,385 | 8,396 | 2.04% | 0 | 0 | ?? |
| Florida | 6,642,836 | 76,129 | 1.15% | 1,166,984 | 14,983 | 1.28% |
| Georgia | 2,642,386 | 38,022 | 1.44% | 1,518,733 | 20,461 | 1.35% |
| Hawaii | 601,557 | 3,479 | 0.58% | 71,271 | 540 | 0.76% |
| Idaho | 349,454 | 2,639 | 0.76% | 249,567 | 1,304 | 0.52% |
| Illinois | 6,178,739 | 77,197 | 1.25% | 1,082,959 | 6,789 | 0.63% |
| Indiana | 2,280,360 | 24,946 | 1.09% | 1,229,255 | 6,142 | 0.50% |
| Iowa | 1,049,686 | 8,461 | 0.81% | 641,387 | 3,375 | 0.53% |
| Kansas | 1,049,100 | 8,585 | 0.82% | 446,262 | 2,627 | 0.59% |
| Kentucky | 1,192,070 | 17,402 | 1.46% | 1,128,726 | 27,063 | 2.40% |
| Louisiana | 1,767,834 | 41,264 | 2.33% | 814,429 | 18,055 | 2.22% |
| Maine | 343,637 | 3,020 | 0.88% | 429,351 | 2,659 | 0.62% |
| Maryland | 2,562,880 | 25,687 | 1.00% | 574,604 | 2,925 | 0.51% |
| Massachusetts | 3,335,597 | 28,881 | 0.87% | 609,391 | 1,985 | 0.33% |
| Michigan | 4,206,548 | 57,230 | 1.36% | 1,718,374 | 11,442 | 0.67% |

**TABLE B: NON-INSTITUTIONALIZED PERSONS AGED 65+
WHO ARE POOR & WHO NEED LONG-TERM
CARE BY STATE AND URBAN/RURAL STATUS: 1990**

| STATE | Total Urban Population | # in Urban Population with LTC Needs in Poverty | % in Urban Pop. With LTC Needs in Poverty | Total Rural Population | # in Rural Population with LTC Needs in Poverty | % in Rural Population with LTC Needs in Poverty |
|----------------------|------------------------|-------------------------------------------------|-------------------------------------------|------------------------|-------------------------------------------------|-------------------------------------------------|
| United States | 22189910 | 839576 | 3.78% | 7373601 | 365608 | 4.96% |
| Alabama | 305,701 | 22,735 | 7.44% | 194,201 | 21,472 | 11.06% |
| Alaska | 13,888 | 209 | 1.50% | 7,228 | 204 | 2.82% |
| Arizona | 411,235 | 10,788 | 2.62% | 52,100 | 3,072 | 5.90% |
| Arkansas | 176,848 | 13,297 | 7.52% | 153,333 | 13,288 | 8.67% |
| California | 2,726,360 | 59,684 | 2.19% | 259,928 | 4,075 | 1.57% |
| Colorado | 254,869 | 8,404 | 3.30% | 56,573 | 1,434 | 2.53% |
| Connecticut | 347,263 | 8,534 | 2.46% | 70,141 | 783 | 1.12% |
| Delaware | 52,798 | 1,526 | 2.89% | 23,730 | 682 | 2.87% |
| District of Columbia | 72,259 | 4,339 | 6.00% | 0 | 0 | ?? |
| Florida | 1,970,142 | 63,478 | 3.22% | 322,197 | 11,119 | 3.45% |
| Georgia | 382,083 | 25,823 | 6.76% | 237,896 | 19,272 | 8.10% |
| Hawaii | 106,703 | 2,335 | 2.19% | 14,269 | 294 | 2.06% |
| Idaho | 65,028 | 1,874 | 2.88% | 50,250 | 1,268 | 2.52% |
| Illinois | 1,126,240 | 38,824 | 3.45% | 225,067 | 7,404 | 3.29% |
| Indiana | 435,613 | 14,722 | 3.38% | 214,869 | 6,566 | 3.06% |
| Iowa | 225,595 | 6,909 | 3.06% | 165,977 | 5,389 | 3.25% |
| Kansas | 205,537 | 7,095 | 3.45% | 112,790 | 3,691 | 3.27% |
| Kentucky | 240,236 | 13,734 | 5.72% | 201,649 | 18,757 | 9.30% |
| Louisiana | 304,766 | 23,042 | 7.56% | 134,542 | 13,652 | 10.15% |
| Maine | 74,781 | 2,797 | 3.74% | 78,825 | 2,927 | 3.71% |
| Maryland | 397,288 | 13,940 | 3.51% | 94,200 | 3,039 | 3.23% |
| Massachusetts | 667,169 | 19,463 | 2.92% | 100,108 | 1,976 | 1.97% |
| Michigan | 754,314 | 27,652 | 3.67% | 300,265 | 8,804 | 2.93% |

| | | | | | | |
|----------------|-----------|---------|-------|-----------|--------|-------|
| Minnesota | 1,976,313 | 13,722 | 0.69% | 776,297 | 4,061 | 0.52% |
| Mississippi | 727,511 | 18,656 | 2.56% | 830,077 | 24,938 | 3.00% |
| Missouri | 2,199,721 | 24,243 | 1.10% | 972,515 | 10,781 | 1.11% |
| Montana | 257,339 | 2,324 | 0.90% | 227,386 | 1,599 | 0.70% |
| Nebraska | 644,230 | 4,393 | 0.68% | 305,558 | 1,481 | 0.48% |
| Nevada | 701,774 | 5,321 | 0.76% | 86,682 | 407 | 0.47% |
| New Hampshire | 371,333 | 2,068 | 0.56% | 354,249 | 1,097 | 0.31% |
| New Jersey | 4,503,027 | 38,044 | 0.84% | 527,266 | 1,741 | 0.33% |
| New Mexico | 683,446 | 8,385 | 1.23% | 244,335 | 7,052 | 2.89% |
| New York | 9,882,315 | 165,227 | 1.67% | 1,773,574 | 10,771 | 0.61% |
| North Carolina | 2,112,875 | 25,128 | 1.19% | 2,130,783 | 24,519 | 1.15% |
| North Dakota | 209,036 | 1,253 | 0.60% | 168,094 | 748 | 0.45% |
| Ohio | 5,094,922 | 62,309 | 1.22% | 1,765,612 | 13,301 | 0.75% |
| Oklahoma | 1,306,227 | 17,144 | 1.31% | 616,284 | 8,888 | 1.44% |
| Oregon | 1,261,808 | 10,455 | 0.83% | 519,236 | 3,227 | 0.62% |
| Pennsylvania | 5,147,367 | 63,467 | 1.23% | 2,327,040 | 14,752 | 0.63% |
| Rhode Island | 547,004 | 4,578 | 0.84% | 91,809 | 450 | 0.49% |
| South Carolina | 1,178,931 | 19,466 | 1.65% | 1,004,501 | 17,966 | 1.79% |
| South Dakota | 209,655 | 1,809 | 0.86% | 194,170 | 1,374 | 0.71% |
| Tennessee | 1,893,700 | 27,694 | 1.46% | 1,229,440 | 17,357 | 1.41% |
| Texas | 8,669,490 | 122,221 | 1.41% | 2,026,336 | 26,476 | 1.31% |
| Utah | 870,919 | 4,470 | 0.51% | 119,657 | 1,301 | 1.09% |
| Vermont | 120,427 | 811 | 0.67% | 245,719 | 1,274 | 0.52% |
| Virginia | 2,753,466 | 22,726 | 0.83% | 1,213,407 | 13,365 | 1.10% |
| Washington | 2,372,579 | 19,116 | 0.81% | 704,794 | 4,307 | 0.61% |
| West Virginia | 401,950 | 6,118 | 1.52% | 725,067 | 15,473 | 2.13% |
| Wisconsin | 2,027,775 | 17,883 | 0.88% | 1,026,273 | 4,791 | 0.47% |
| Wyoming | 181,413 | 1,116 | 0.62% | 97,233 | 472 | 0.49% |

Source: 1990 Decennial Census. These data were derived from two questions: "because of a health condition that has lasted for six or more months, does this person have any difficulty taking care of his or her own personal care needs, such as bathing, dressing, or getting around the home OR going outside the home alone, for example, to shop or visit a doctor's office?"

RURAL HEALTH

I. BACKGROUND

In the existing health care system, major financial and non-financial barriers reduce access to health care services for a significant number of individuals living in rural areas. Consequently, individuals living in rural areas are more likely to experience reduced health status and quality of life.

- More than 22 million Americans live in rural areas with a severe shortage of primary care doctors and close to 8 million do not have health insurance.
- There are significant shortage of health care providers in rural areas, and needed services are not always available. needed services is not always guaranteed.
- In metropolitan areas, there are 225 doctors for every 100,000 residents, compared to 97 doctors for every 100,000 residents in non-metropolitan areas. Moreover, in 1990, there were estimated shortages of 45,000 registered nurses, 1200 psychiatrists, and nearly 1000 dentists in rural areas.
- A significant number of seniors with Medicare reside in rural areas. However, on average, rural hospitals lose money on their Medicare patients -- Medicare operating margins were a negative 5.6% in FY 1991 in these hospitals.

During the 103rd session of Congress, the Administration's Health Security Act made significant efforts to remove both the major financial and non-financial barrier to health care services for those residing in rural areas. In addition to guaranteeing private health insurance coverage to all Americans, the plan had proposed to improve the availability and quality of health care services in rural areas. Unable to reach a consensus, no reform initiative was enacted into law.

More recently in the 104th session of Congress, drastic cuts in the Medicare and Medicaid programs have been proposed -- combined Medicare and Medicaid cuts of almost \$500 billion dollars. The consequence of such action could have severe effects on the already stressed, rural health delivery system.

- For example, rural hospitals that largely depend on Medicare would be forced to close their doors or turn to local taxpayers to sustain them.
- Rural hospitals are often the largest employer in their communities. Closing these hospitals will result in job loss and physicians leaving rural communities.

II. ADMINISTRATION ACCOMPLISHMENTS

Although a final consensus was not reached on health care reform, the Administration, on a separate but a parallel track, has worked with rural communities to improve the delivery of health care services.

- During the past two years, Medicare reimbursement to rural hospitals has been increased to eliminate the urban/rural distinction that was once as high as 25%. Now, the Medicare "standardized amount" payments to rural hospitals are equal to those of urban hospitals.
- Federal funding for programs that most help rural areas, such as community health center, migrant health centers, and the National Health Service Corps have been greatly increased during the past two years. These programs provide primary medical care to nearly 3 million rural Americans in some of the poorest communities in this country.
- With Federal encouragement and some matching funds, we have seen the number of rural health offices at the state level increase from 26 in 1992 to all fifty states today. These state offices are very active partners with their rural communities, their state, and with the federal government in designing new strategies to solve rural health problems.
- With encouragement from this Administration, several states have begun working on a regional and now a national rural recruitment network, to share a rural practitioner database and make referrals across recruitment programs.
- We have put the means for innovation right in the hands of rural communities. Last year, we made over 100 Rural Health Outreach Grant in 46 states to help rural communities to link institutional arms with other in their town and show how they would stretch scarce resources more efficiently to care for their residents. These communities, for example, have brought care to isolated residents in vans, medical training to the doorstep of weary rural volunteers, and linked isolated doctors with fax machines and backup support.
- Through a collaborative effort with representatives of rural managed care and other health care entities, efforts to encourage expansion of managed care plans into rural areas have been made.
- The Administration has commenced eleven telemedicine demonstration projects to support rural practitioners and enable them to provide state-of-the-art medicine to their patients.
- The development of more rural health clinics have been fostered by the Administration. Medicare supported rural health clinics have grown during the past two years, increasing from fewer than 800 to more than 2,000. These clinics use nurse practitioners, physician assistants, and nurse midwives in support of physicians. As a result, Medicare provides cost-based reimbursement to help support the use of these mid-level providers.

III. ADMINISTRATION'S RECOMMENDATIONS

- Increase the supply of health care providers and delivery sites in rural, underserved areas.
 - Promote training of health care providers in rural areas.
 - Provide incentives to attract health care providers to rural, underserved areas.
- Help community-based providers to form networks and plans.
- Preserve and strengthen the rural telemedicine programs.
- Oppose deep cuts in Medicare and Medicaid that would undermine the delivery systems and programs serving rural residents, (e.g., the closure of hospitals in underserved, rural areas).

The Health Security Plan

RURAL COMMUNITIES

America's rural communities pose special challenges in health care-- both for those who need services and those who provide them. A total of 34 million people-- half of them with incomes under 200 percent of poverty--live in rural areas with inadequate health care.

The fragile economies of rural areas often mean that many residents have little or no insurance, making it difficult for rural communities to attract and keep doctors and maintain local hospitals. Twenty-one million rural residents are without consistent access to primary care providers, and the population of younger rural physicians has not expanded to replace those who retire. Rural communities worry that the current shortage of physicians will continue, and limit their access to care even further.

Americans living in rural areas also have a harder time getting to the services they need. More than half of the rural poor do not own a car, and nearly 60 percent of the rural elderly are not licensed to drive.

The Health Security plan will create a system that meets the unique needs of rural communities. The plan will develop strategies for delivering and financing health care in rural areas, making care more easily available, and attracting doctors and nurses to and keeping them in rural areas.

Guarantees Universal Coverage

- The Health Security plan will guarantee comprehensive health benefits for all Americans, no matter who they are or where they live. Since rural areas have a disproportionate number of uninsured, underinsured and Medicaid recipients, providing universal coverage will help channel significant new resources into rural health care systems.
- The plan will encourage cooperative relationships among rural and urban providers such as developing information sharing capabilities and referral mechanisms to link academic health centers and rural health providers.
- Under the plan, regional alliances may provide incentives to urban health plans to serve rural areas in their region. They may also be required to serve underserved rural areas as a condition of participation.

- These providers will either be offered contracts with plans, or receive reimbursement on a fee-for-service basis to ensure access to care and continuity of care for rural and other vulnerable populations.
- Federal grants and loans will help essential providers establish links with local practitioners, community hospitals, and academic centers, and form integrated practice networks or community-based plans.

Coordination of Programs

- During the phase-in of health reform, current block grants will continue to pay for clinical services for the uninsured as well as supplemental services for all low-income individuals.
- After universal coverage is achieved, funds which had been used to provide health services to the uninsured will be redirected and combined with new grants to pay for support services to ensure access to care. These services include outreach, follow-up, home visits, transportation, and child care during office visits.

December 15, 1993

Increases Access to Providers

- The Health Security plan will develop an infrastructure and provide support for primary care capacity to help serve rural citizens and providers. An additional 14 million Americans will receive improved health care services as the Health Security plan targets rural areas in which more than half of all residents earn incomes 200 percent or less of the poverty level.
- New workforce initiatives, including tax incentives, increased reimbursement, retraining, scholarships, and loan forgiveness programs, will encourage health care providers to practice in rural underserved areas.
- The Health Security plan will expand the National Health Service Corps, placing at least 3,000 primary care practitioners in rural areas by the year 2000.

Encourages Health Networks

- Under the Health Security plan, technical and financial assistance will be provided to develop networks. This will help the rural communities that need outside expertise to establish links with larger referral centers and academic health centers.
- The Health Security plan includes grants to support the development of telecommunications links between underserved providers and other providers, health care centers, and institutions. This will help facilitate "group practices without walls," allowing easier consultation and coordination among rural providers and with urban providers.
- New grants will be provided to academic health centers to help build information and referral infrastructure needed to support rural health networks.
- Investment in currently successful programs, such as community and migrant health centers, will be increased to help them establish and enhance contacts with other providers.

Assures Participation of Essential Community Providers

- For the first five years after implementation, the Health Security plan will designate as "essential providers" qualified practitioners and facilities in underserved areas.

WHAT IT MEANS FOR RURAL AMERICANS

Affordable insurance even if you farm, own a small business, or work in a small business.

You'll be able to get comprehensive insurance at the same rates that people that work for big businesses can today. What you pay will be based on your family status -- not on where you work, your medical history, or your age. The plan also includes tough measures against health care fraud and limits on how much insurance companies can raise premiums. And if you are self-employed in business or farming, you will be able to deduct 100% of your health care costs from your taxes, compared to only 25% today.

More doctors and nurses to serve rural America. The plan will expand Federal loan forgiveness and scholarship programs to increase the number of family doctors going to rural areas -- dramatically expanding the National Health Service Corps, placing at least 3000 additional primary care practitioners in rural areas by the year 2000. It will provide tax incentives to attract and retain rural providers. And it will promote the role of nurses in helping to provide primary and preventive care.

Guaranteed access to the services you need. The plan funds essential support for low-income rural Americans. That means transportation services to get to your doctor or hospital, translation services, and outreach so you know what health services are available. The plan also promotes school-based health care services in rural communities, to better enable our nation's young people to obtain essential preventive and other health services. There will also be investment in other prevention initiatives targeted to rural areas.

A single claim form to cut red tape. There will be a single claim form that all insurance companies will be required to use, reducing paperwork and red tape. You won't be forced to fill out form after form when you go to the doctor. You won't have to pore over fine print. Fill out one simple form -- and you're done.

More choice. With more doctors, nurses, and networks of doctors and hospitals, you'll have more choices as to how and from whom you get your care. All Americans will have their choice of doctor and health plan. And the plan guarantees all Americans that they can continue to receive services from their physician of choice in a traditional manner -- that is payment for each service, otherwise known as "fee-for-service."

Networks of rural doctors and leading medical centers to improve the quality of rural medical care. The plan will include incentives to build local networks of doctors, nurses and hospitals working together to provide high-quality care. The plan also supports telecommunications links between rural health providers and major medical centers to obtain expert advice. These linkages will not only improve the quality of care, but they will reduce the isolation of rural health providers, helping to recruit and retain doctors and nurses in rural areas.

**RURAL AMERICANS AND HEALTH CARE:
The Current System**

- 22.5 percent of the Americans live in rural areas. Many are isolated by economics as much as by distance. Small communities may not be able to support a physician practice -- and few young physicians are interested in taking over the solo practices of the many physicians who will retire in the next decade. [Bureau of the Census]
- 32 percent of rural Americans did not have health care for at least one month over a two year period ending in 1987. About 40 percent of all agricultural workers and their families have no health insurance at all. [Office of Rural Health]
- Rural Americans with insurance coverage typically have policies which cover less and cost them more out-of-pocket. [Working Group Paper]
- ~~Rural areas have less than one-half the number of doctors as urban areas. Twenty-eight percent of rural residents live in areas which have a shortage of primary care physicians compared to only 9.5 percent in urban areas.~~ [Office of Rural Health]
- In 1988, 68 percent of rural counties did not have enough doctors. In fact, 111 rural counties had **no physician at all.** [Office of Rural Health]

☆ Over 11m4

☆

☆ disproportionate number of uninsured. 1 in 3 rural Americans did not have health care for at least one month over the last 2 years.

RURAL AMERICANS AND HEALTH CARE: The Clinton Plan

REAL REFORM NOT JUST A PROMISE AND A PIECE OF PAPER ...

Rural Americans are hit hard by the current health care system. The Clinton health care plan provides real reform not just a promise and a piece of paper. We will help provide a more stable economic base for providers -- putting rural communities in a better position to get and keep providers.

- The Clinton plan will secure a **comprehensive benefits package** for America's rural communities -- farmers, small business owners, and families. We will end insurance underwriting practices that discriminate against people based on whether they're young or old, sick or healthy, married or single. **We will ensure greater stability in premiums from year to year.**
- Rural small business owners and farmers will get the advantages of being part of a large group -- gaining leverage to buy wholesale not retail and the safety in numbers that comes from being part of a large group including stable premiums.
- Rural Americans will have alliances working to get them good coverage and protect them from bad insurers.

HOW IT WORKS ...

- The plan makes rural settings more attractive for doctors and other providers by:
 - Removing the heavy burden of uncompensated care paid by providers and reduce paperwork
 - Making sure providers are paid on time by reliable and efficient insurers
 - **Breaking the isolation**, by setting up links with hospitals, other health networks and providers to increase rural access to the latest and best information.
 - Coordinating rural health care providers, hospitals, and home care services.
 - Providing emergency service support
- The Clinton plan will **train and recruit providers** for rural areas by building strong financial incentives into student loan programs, providing rural medical school residency locations, and building links between rural physicians and regional medical schools. We will expand the **National Health Service Corps**.

**RURAL AMERICANS AND HEALTH CARE:
Questions and Answers**

Q. How will managed competition work in a rural area when there are no providers to compete?

A. The Clinton reform provides secure coverage to all Americans regardless of where they live. Rural Americans will be able to choose to go to their local doctor through traditional insurance plan or an integrated health plan. Rural hospitals and providers will develop community-based health plans in rural areas linked to regional medical centers. In some cases, urban health plans will expand to cover rural areas.

Q. How will the plan help rural areas?

A. The biggest help for rural areas is providing secure coverage. That means that all rural Americans -- regardless of where they work -- can get secure coverage to a good benefit package for a fair price. By building in economic incentives for doctors to practice in rural areas and encouraging community-based networks to form, rural Americans will be able to get the high quality care they need. Providers won't have to continue to provide even more uncompensated care than urban providers. They will get paid and paid on time.

Q. How will reform work in rural America?

A. State flexibility is a dominant feature of the Clinton health reform. The President, as a former governor, is fully aware of the tremendous differences among the states. That's why this plan encourages states to find the solution that's best for them -- it may mean alliances in one state and a single-payor model in another. We don't want to micromanage what states do so long as they meet the federal guarantees of universal coverage, access, quality and cost containment.

Q. Anti-trust and other state anticompetitive laws seem to be hampering rural network development. What does the plan do to alleviate this problem?

A. The proposes that the federal government develop model legislation, which can be adopted by states, to protect developing networks from federal anti-trust laws.

Q. How will rural health interests be represented and assured?

A. Rural residents will be members of the governing board of the alliance in

direct proportion to the percentage of rural residents who are members of the alliance.

HEALTH SECURITY ACT OF 1993:
BENEFITS TO RURAL AND FRONTIER AREAS

RURAL AND FRONTIER AREA BENEFITS

The Health Security Act will greatly benefit rural and frontier areas. Provisions affecting rural and frontier areas are scattered throughout the Act. Together they provide a comprehensive array of improvements.

- Universal coverage will provide comprehensive and continuous benefits to millions of uninsured and underinsured rural residents and assures reimbursement for providers who care for them
- Financing provisions are tailored to assist self-employed residents and small businesses pay for coverage.
- Special programs assure that health care providers will be available to care for rural areas.
- Flexible alternatives are offered for creating rural systems of care.

UNIVERSAL COVERAGE

The Health Security Act:

- Provides health insurance for the estimated 8 million uninsured rural Americans.
- Improves the benefits available to many million more underinsured rural residents.
- Relieves rural providers' uncompensated care burden which amounts to billions of dollars, over \$1.5 billion for rural hospitals, alone.

FINANCE AND INSURANCE REFORM

- Self-employed people will be able to deduct 100 percent of the cost of their health insurance premiums for the comprehensive benefit package purchased through a health alliance, which will help many farm families.
- Alliances will provide increased purchasing power for individuals, small businesses and self-employed people, often at less costly rates.
- Alliances will make health insurance purchasing decisions easier and more rational for individuals and small businesses.

- Cost sharing, even under fee-for-service plans, will be less than many rural residents currently pay with their commercial insurance.
- Insurance industry reforms will prohibit current practices of redlining, previous condition exclusions, etc. which affect individual insurance rural purchasers.

INCREASING THE AVAILABILITY OF PROVIDERS THROUGH EDUCATION

- National effort will increase primary care physician trainees to 55 percent.
- New funding for training primary care physicians and underrepresented minorities.
- New funding for training of non-physician providers:
 - Graduate nurse education programs receive \$200 million per year
 - Additional funding for training physician assistants, advanced practice nurses, and administrators

ASSURING THE AVAILABILITY OF PROVIDERS THROUGH PLACEMENT AND RETENTION

- Universal coverage will eliminate uncompensated care and pay providers for what they do.
- National Health Service Corps (which places about 60 % of their providers in rural areas) will expand nearly five-fold.
- Tax credits are offered for primary care providers serving in underserved areas - up to \$1,000 per month is available for primary care physicians and \$500 for non-physician providers for up to 5 years of service.
- Allowable depreciation expense for medical equipment is increased an additional \$10,000 for primary care physicians practicing in designated underserved areas.
- Medicare's 10 percent bonus payment for primary care physicians practicing in underserved areas is increased to 20 percent, while other specialists continue to receive a 10 percent bonus.

DEVELOPING SYSTEMS OF CARE

- States may require health plans to cover all or specific parts of a regional alliance area as a condition of contracting with an alliance.
- Alliances are permitted to offer incentives to health plans to encourage them to provide coverage in rural areas.
- Many rural providers will be eligible for transitional protection as essential community providers.
- Guidelines for risk adjusting premiums may have geographic factor.
- States or alliances may opt for single payer systems.
- Academic health centers may apply for grants to develop service relationships with rural and inner-city areas, including information and referral networks and telecommunications.
- PHS Capacity Expansion programs will provide:
 - grants for communities to form "community health plans and networks", enhancing their ability to compete in the new system and to maximize their control of their own destiny.
 - loans and loans guarantees to help capitalize programs serving low-income patients and underserved areas, including construction.

IMPACT ON RURAL HOSPITALS

- Universal coverage will relieve the burden of over \$1.5 billion in uncompensated care.
- Linkages with other providers will increase as health plans seek to assure benefit package coverage.
- Access to larger, more appropriate workforce pool for recruiting.
- May apply for Essential Community Provider designation.
- May apply for PHS capacity expansion grants and loans.
- Largest Medicare cuts are in programs that have smaller impact on rural hospital reimbursement rates (disproportionate share and graduate medical education).

IMPACT ON RURAL DOCTORS

- Universal coverage will provide new source of revenue.
- Paperwork burden on doctors' offices should be lightened.
- Primary care doctors will be in great demand and in a good bargaining position with health plans.
- Medicare bonus payments for primary care doctors in underserved areas will rise from 10 percent to 20 percent.
- Tax credits and accelerated equipment depreciation will be available to doctors in underserved areas.
- May apply for Essential Community Provider designation.

IMPACT ON SMALL EMPLOYERS

- Discounts for low-wage small business will be provided.
- Small employers with low-wage employees will be able to obtain coverage for as little as \$1.00 to \$2.00 per day per employee.
- Most employers now providing insurance probably will see their costs go down.
- Insurance industry practices of red-lining, price baiting, gouging and dropping coverage when employees or their families get sick will be eliminated.
- Cost increases in health insurance premiums will be controlled.
- Alliances will increase small business purchasing power and dramatically reduce administrative costs of obtaining coverage.

ESSENTIAL COMMUNITY PROVIDERS

The Essential Community Provider program provides transitional protection to federally-funded and others delivering care in difficult-to-service areas. The program will assure that providers caring for vulnerable populations are included in health plan development.

- Health plans must contract with all ECPs in service area.
- ECPs must be paid at a negotiated, contracted rate or, at the election of the ECP, at an appropriate Medicare rate (e.g., FQHC, RHC, or Medicare capitation rate) or on the alliance fee schedule.
- Some providers are automatically certified, including:
 - Community and Migrant Health Centers
 - Rural Health Clinics
 - Federally-Qualified Health Centers
 - Indian Health programs (including tribal units and 638 contractors)
 - other federally-funded providers
- Other providers may apply for certification, including
 - rural hospitals
 - physicians
 - health departments

SUMMARY OF RURAL HEALTH AMENDMENTS

NATIONAL HEALTH SERVICE CORPS

- Funding for the National Health Service Corps (NHSC) would be increased.

COMMUNITY SCHOLARSHIP PROGRAM

- The Community Scholarship Program under the National Health Service Corps would be funded at \$2 million annually for fiscal years 1996 through 2000.

CLARIFICATION OF ANTITRUST SAFE HARBORS FOR RURAL HEALTH PROVIDERS

- This provision would instruct the Department of Justice (DOJ) and Federal Trade Commission (FTC) to clarify existing and subsequent antitrust safe harbors specifically for rural providers by providing more illustrative examples in their policy guidelines.
- The DOJ and FTC would also be instructed to work with HHS' Office of Rural Health (or Assistant Secretary for Rural Health) to develop methods to disseminate this information to providers.

MEDICARE BONUS PAYMENTS FOR NPPs AMENDMENT

- This provision would make non-physician practitioners (NPPs) such as nurse practitioners and physician assistants practicing in underserved rural areas eligible for Medicare bonus payments at the same rate as physicians providing primary care services in underserved areas.
- This provision is budget neutral relative to the Mitchell bill. The 20 percent bonus payment for physicians included in the Mitchell bill would be slightly reduced, and the savings achieved would finance the NPP bonus payment. The Secretary would determine the corresponding bonus payment rates for physicians and the NPPs based on these savings. The physicians would still receive a bonus payment substantially greater than the 10 percent bonus payment they currently receive under Medicare.

RURAL BASED MANAGED CARE PROGRAM

- Few managed care plans have entered rural areas. By providing development and operational grants, more managed care plans would enter rural areas.
- This amendment would establish a grant program for the development and operation of rural-based managed care networks. These grant funds could be used for the development

of a rural-based managed care network, for data and information systems including telecommunications, for meeting solvency requirements under Medicare, for the recruitment of health care providers and for enabling services including transportation and translation.

- The grant program would be authorized at \$10 million for 1996 through 2000.

RURAL EMERGENCY MEDICAL SERVICES

- A grant program would be established for states for the development of a rural emergency medical systems. States would receive grants for the creation or enhancement of air medical transport systems that provide victims of medical emergencies in rural areas with access to treatment.

GRANTS FOR TELEMEDICINE

- Funding would be provided for grants for telemedicine -- \$15 million for FY 1996 through 2001.

RURAL REPRESENTATION ON ADVISORY COMMITTEES AND COUNCILS

- This provision would guarantee rural representation on several advisory committees and councils established under the Mitchell bill.

ALLOCATION FOR PARTICIPATION OF PHYSICIANS ASSISTANTS IN NHSC SCHOLARSHIP AND LOAN PROGRAM

- As currently drafted, the NHSC sets aside 20% of NHSC funds for nurses only. This amendment would include PAs in the set aside.

ELIGIBILITY OF RHCs TO RECEIVE FUNDS

- The Mitchell bill establishes several grant and loan programs to improve access to health care in urban and rural underserved areas including -- (1) grants for the development of plans and networks and the expansion and development of health care sites and services, (2) direct loans and grants for capital costs (3) enabling and supplemental services.
- Under the Mitchell bill, rural health clinics could only receive developmental, enabling and supplemental services funds as part of a consortium of community based providers.
- This amendment would allow non-profit and public Rural Health Clinics (RHCs) to be eligible to receive -- (1) grants for the development of plans and networks and the expansion and development of health care sites and services, (2) direct loans and grants for capital costs (3) enabling and supplemental services.
- Under this amendment, for-profit RHCs would only be eligible to receive loans for capital costs.

OFFICE OF THE ASSISTANT SECRETARY FOR RURAL HEALTH

- The Mitchell bill elevates the position of the Director of the Office of Rural Health to the Assistant Secretary for Rural Health.
- However, as currently drafted this provision does not transfer the current functions performed by the Office of the Director of Rural Health to the newly established Office of the Assistant Secretary of Rural Health. These functions would be transferred to the OASRH.

TECHNICAL AMENDMENTS TO MEDICAL ASSISTANCE FACILITIES

- Several technical amendments would be made to the MAF provisions in the Limited Service Hospital Program

ANTITRUST SAFE HARBORS FOR RURAL HEALTH CARE PROVIDERS

AMENDMENT

- This amendment would instruct the DOJ and FTC to clarify existing and subsequent antitrust safe harbors specifically for rural providers by providing more illustrative examples in their policy guidelines.
- The DOJ and FTC would also be instructed to work with HHS' Office of Rural Health to develop methods to disseminate this information to providers.

CURRENT LAW

- Providers can seek guidance from the agencies for activities they fear could be challenged under federal antitrust laws.
- In September 1993, the DOJ and FTC jointly issued antitrust guidance to health care providers in the form of **The Health Care Antitrust Enforcement Policy Statements**.
- The statements cover six areas -- (1) hospital mergers, (2) hospital joint ventures involving high technology or other expensive medical equipment, (3) physician's provision of information to purchasers of health care services, (4) hospital participation in exchange of price and cost information, (5) joint purchasing arrangements among health care providers and (6) physician network joint ventures.
- The DOJ and FTC expect to release **additional and revised statements** within the next few months. Critics allege that the policy statements do not address many of the issues that will be increasingly common in a managed competition framework.
- The policy statements contain antitrust **safety zones** for each category. For example, agencies will not challenge joint ventures among hospitals to purchase, operate and market the services of high technology equipment if the venture includes only the number of hospitals necessary to support the equipment.

- The statements also summarize the **rule of reason analyses** the agencies will use to review activities that fall outside the safety zones.
- If these statements do not offer enough guidance, providers can request a **business review and advisory opinion** from the DOJ and FTC to review the antitrust implications of a proposed activity. The agencies have established an expedited review process; reviews are completed within 90 days if the arrangement falls within a safety zone and 120 days otherwise.

RATIONALE FOR AMENDMENT

- Despite the issuance of the DOJ's Health Care Antitrust Enforcement Policy Statements, rural providers still require additional guidance and clarification on antitrust matters.
- It also appears that many rural providers are unfamiliar with the DOJ's guidelines and business review and advisory opinion processes. Hospital associations have made some efforts to distribute guidelines to their members in the states. **But the guidelines still need to be more widely distributed to all types of rural providers. Rural providers should also aware of the DOJ's business review and advisory opinion process.**
- Although the DOJ is already planning to issue more illustrative guidelines for rural health providers, this amendment would be a positive symbol to rural providers.

TALKING POINTS

- Rural health care providers cite an increased need to collaborate with colleagues and other facilities to share sparse equipment and decrease the fragmentation of care. Rural providers in South Dakota discuss efforts to merge hospitals, clinics, and physician practices to form "integrated health delivery systems." Unfortunately, they believe many of these activities are stymied because providers worry that they will be deemed collusive.
- **The mere threat of lawsuits, especially among isolated rural providers who often do not have access to sophisticated legal advice, may be inhibiting provider collaboration. The threat of lawsuits by competitors and DOJ and/or FTC, the potential for treble damages and criminal prosecution, and the expense associated with antitrust challenges may create a chilling effect on provider collaboration.**
- The DOJ's safe harbor guidelines were an important first step in delineating safe harbors from antitrust prosecution. **However, additional clarifications from the DOJ and FTC are still needed.**
- Rural health providers would be more likely to pursue more collaborative ventures and establish networks with additional guidance from the DOJ and FTC.

- **In addition, it also appears that many rural providers are unfamiliar with the DOJ's guidelines and business review and advisory opinion processes. This amendment would instruct the DOJ and FTC would also be instructed to work with HHS' Office of Rural Health to develop methods to disseminate the policy guidelines and information on DOJ's business review and advisory opinions procedures to rural providers.**
- **This amendment does NOT establish broad antitrust exemptions for rural providers. The amendment simply clarifies existing and subsequent guidelines for rural providers and ensures adequate dissemination of this information. This amendment responsibly addresses the concerns of rural health care providers.**

MEDICARE BONUS PAYMENTS FOR NPPs

AMENDMENT

- This provision would make non-physician practitioners (NPPs) such as nurse practitioners and physician assistants practicing in rural HPSAs eligible for Medicare bonus payments at the same rate as physicians providing primary care services in underserved areas.
- This provision is budget neutral relative to the Mitchell bill.
- The 20 percent bonus payment for physicians included in the Mitchell bill would be slightly reduced, and the savings achieved would finance the NPP bonus payment.
- The Secretary would determine the corresponding bonus payment rates for physicians and the NPPs based on these savings.
- The physicians would still receive a bonus payment substantially greater than the 10 percent bonus payment they currently receive under Medicare.

CURRENT LAW

- Non-physician practitioners are not eligible to receive Medicare bonus payments under current law.
- Physicians practicing in rural underserved areas receive a 10 percent bonus payment for services provided to Medicare beneficiaries.

RATIONALE FOR AMENDMENT

- Non-physician practitioners are critical to ensuring that rural residents have access to primary care services.
- Just like physicians, non-physician practitioners need to be enticed to practice in rural underserved areas. Medicare bonus payments may be one way to attract NPPs to rural underserved areas.

TALKING POINTS

- The Physician Payment Review Commission (PPRC) which advises Congress on Medicare Part B and other issues, has recommended that the Medicare bonus payments be extended to non-physician practitioners.
- There continues to be a need to attract primary care providers to underserved areas.
- It makes sense to extend the bonus payments now available to physicians to advanced practice nurses and physicians assistants since these providers very often treat patients in rural underserved areas.
- The potential for NPPs to meet the needs of the rural underserved populations has been a major factor in encouraging their training over the past twenty years.
- Most nurse practitioners and PAs are trained and educated as primary care providers -- that is why they become nurse practitioners. Making HPSA bonus payments available to them is sure to increase access to primary care services.
- Many of the same disincentives to relocating to rural HPSAs that exist for physicians exist for NPPs. These include lack of professional peers, lack of health care facilities, and insufficient population base to sustain a practice. Providing stronger economic incentives to locate in rural areas is the one way to overcome these other disincentives.
- Moreover, advanced practice nurses receive only 75% to 85% of what physicians receive for the same service more. These lower payments make it more difficult for advance practice nurses to set up independent practices. Extending the Medicare bonus payments to advance practice nurses would help to offset this lower rate of payment and make it more feasible for them to open up practices in rural underserved areas.

RURAL MANAGED CARE DEMONSTRATIONS

AMENDMENT

- Few managed care plans have entered rural areas.
- This amendment would establish a grant program for the development and operation of rural-based managed care networks. These grant funds could be used for the development of a rural-based managed care network, for data and information systems including telecommunications, for meeting solvency requirements under Medicare, for the recruitment of health care providers and for enabling services including transportation and translation.
- The grant program would be authorized at \$10 million for 1996 through 2000.
- Special priority would be given to those plans that would serve rural underserved areas and those that involve rural residents and providers in the planning and development of the managed care network.

CURRENT LAW

- There is no provision under current law.

RATIONALE FOR AMENDMENT

- Few managed care plans have entered rural areas. By providing development and operational grants, more managed care plans would enter rural areas.

TALKING POINTS

- Few managed care plans have entered rural areas. By providing development and operational grants, more managed care plans would enter rural areas.
- This amendment would establish a grant program for the development and operation of rural-based managed care networks. These grant funds could be used for the development of a rural-based managed care network, for data and information systems including telecommunications, for meeting solvency requirements under Medicare, for the recruitment of health care providers and for enabling services including transportation and translation.
- The grant program would be authorized at \$10 million for 1996 through 2000.

- Special priority would be given to those plans that would serve rural underserved areas and those that involve rural residents and providers in the planning and development of the managed care network.

RURAL HEALTH CLINIC FUNDING

AMENDMENT

- The Mitchell bill establishes several grant and loan programs to improve access to health care in urban and rural underserved areas including -- (1) grants for the development of plans and networks and the expansion and development of health care sites and services, (2) direct loans and grants for capital costs (3) enabling and supplemental services.
- Under the Mitchell bill, rural health clinics could only receive developmental, enabling and supplemental services funds as part of a consortium of community based providers.
- This amendment would allow non-profit and public Rural Health Clinics (RHCs) to be eligible to receive -- (1) grants for the development of plans and networks and the expansion and development of health care sites and services, (2) direct loans and grants for capital costs (3) enabling and supplemental services.
- Under this amendment, for-profit RHCs would only be eligible to receive loans for capital costs.

RATIONALE FOR AMENDMENT

- All rural health clinics are located in areas that are designated by the Federal government as medical shortage areas, and they serve a disproportionate number of patients that have traditionally lacked access to health care.
- A 1994 survey of RHCs revealed that nearly 30% of the patients in RHCs are on Medicare, 28% are on Medicaid, and 14% are uninsured. While 63% of the US population has private insurance, only 28% of the patients cared for in an average RHC have private insurance.
- RHCs, as important providers to the underserved in rural areas, must be given the same opportunities Sen. Mitchell's bill gives other rural providers to enhance their ability to serve the rural communities that depend on them.

RURAL HEALTH CLINICS IN SOUTH DAKOTA

- **I would like to tell you about a rural health clinic that I visited in Wall, South Dakota.** Wall is a community of about 850 people. The clinic is run by Dave Custis who is a physicians assistant.
- Dave has been working in the clinic for the past ten year. He is a PA practicing alone in the rural health clinic. The physician affiliated with his clinic is in Rapid City. The physician comes to the clinic a half a day a week.
- The clinic was one of the first rural health clinics in the country, opening in the late 1970s. **Prior to the clinic opening, there had been no one provider consistently providing care for the community.**
- **Physicians had practiced in Wall, but because of hospital closures and other factors, the town was not able to consistently keep a rural health care provider until the rural health clinic opened.**
- **The clinic estimates that between 20 and 30 percent of the population in uninsured.** Without Dave and his clinic, these people probably not receive any health care services, and certainly not preventive services.
- Attached is an article that appeared in USA Today that featured Dave's clinic.

- There are 40 Rural Health Clinics in South Dakota compared to 15 Federally Qualified Health Centers -- 2 urban and 13 rural FQHCs. The 13 rural FQHCs were RHCs before being designated FQHCs.
- All the RHCs in South Dakota are non-profit entities.

Rural Health Provisions in Mitchell Bill

- Senator Mitchell's bill already includes a substantial set of rural health provisions. He listened to the concerns many of us expressed about how rural areas would be affected by changes being proposed in our health care system, and the bill he introduced reflects his commitment to ensuring that health reform does not pass by rural communities.
- This package of amendments builds on the solid base the Majority Leader's bill establishes for rural America.
- Below is a summary of the rural provisions in the Mitchell bill.

LIMITED SERVICE HOSPITAL PROGRAM

The Mitchell bill establishes a limited service hospital program which establishes alternative hospital models for small rural hospitals. A limited service hospital program could include a rural primary care hospital program (RPCH), a medical assistance facility program (MAF) or both. These limited service hospital programs would be relieved of many regulatory burdens under Medicare as well as receive reasonable cost reimbursement from Medicare which limits the financial risks faced by these small rural hospitals. Limited service hospitals would be encouraged to develop integrated provider networks. Any state wishing to participate in this program would submit applications to the Secretary. Grants would be awarded to states that have submitted applications for planning and developing a rural health care plan and designating PRCHs or MAFs.

EACH/RPCH PROGRAM

The Mitchell bill improves the EACH/RPCH program by providing more flexibility to RPCHs. For example, RPCHs would have to meet an average 96 hour length of stay requirement instead of the current requirement that any individual hospital stay cannot exceed 72 hours. The bill also increases the allowed number of SNF beds for a PRCH and repeals the development of a PPS system for inpatient and outpatient RPCH services. PRCHs could establish a network with at least one hospital (not necessarily an EACH) that furnishes services that the PRCH cannot furnish.

As part of the limited service hospital program, the EACH/RPCH program would be expanded to all states. The authorization for the program would be extended through 1999. The authorization level would be raised to \$15 million from 1993 through 1995 and \$25 million for 1996 through 1999.

MEDICAL ASSISTANCE FACILITIES

As part of the limited service hospital program, the MAF program would be opened up to all states.

RURAL HEALTH TRANSITION GRANT PROGRAM

The Mitchell bill permits RPCHs to be eligible for these grants, extends the authorization of appropriations for this program through 1999 and requires grantees to submit reports annually instead of every six months.

MEDICARE DEPENDENT, SMALL RURAL HOSPITALS

The Mitchell bill extends the current law classification of Medicare-dependent hospitals which benefits many hospitals by offering higher reimbursements relative to the PPS rates.

TAX PROVISIONS

The Mitchell bill includes tax credits for providers in rural underserved areas (\$1000 for physicians and \$500 for non-physician practitioners) and increased expensing limit provisions for medical equipment.

TELEMEDICINE AND RELATED TECHNOLOGY

The Mitchell bill would establish additional grants for telemedicine. The bill also establishes an interagency task force to coordinate evaluations of telemedicine and related technology demonstrations. The Mitchell bill establishes demonstration projects to establish payment methodologies for telemedicine.

MEDICARE BONUS PAYMENTS

Medicare bonus payments would be increased to 20% (from 10%) for all primary care services provided by physicians in a rural HPSA.

J-1 VISAS

The Immigration Act would be amended to allow an "interested state agency" (rather than an "interested federal agency") to certify there is a need for the foreign doctor to remain on the hospital's staff.

OFFICE OF THE ASSISTANT SECRETARY FOR RURAL HEALTH

The position of the Director of the Office of Rural Health would be elevated to the position of the Assistant Secretary for Rural Health, thus enabling the Office to promote departmental policies that effectively address rural needs. The Office's mission would be expanded to include advising on how health care reform would impact rural areas.

PA/NP REIMBURSEMENT

Under Medicare, all NPs and PAs (including those in rural areas) would be directly reimbursed by Medicare at 85% of the RBRVs rate for services performed in all outpatient settings. Under Medicare, rurally-based NPs would be directly reimbursed at 65% of the RBRVS rate for assisting at surgery in urban areas. States would also be required to directly reimburse all NPs in rural area under Medicaid.

COMMUNITY HEALTH GROUPS AND HEALTH CARE SITES

The Mitchell bill establishes several grant and loan programs for to increase access to health plans, networks, sites and services by rural Americans. Entities can apply for grants and loans for the development and expansion of plans, networks, sites and services as well as for capital costs associated with these activities (modernization, construction or expansion of facilities). Grant funds could also be used to finance enabling services such as translation and transportation and supplemental services not covered in the standard benefit package. Eligible entities for these grants and loans include rural health clinics and federally qualified health centers, among others.

NATIONAL HEALTH SERVICE CORPS

The Mitchell bill increases funding for the NHSC and requires that at least 20% of those funds in the Scholarship and Loan Repayment Program would be designated for nurses.

GRADUATE MEDICAL EDUCATION

The Mitchell bill would also alter GME funding to encourage an increase in the supply of primary care providers which are in short supply in rural areas. GME payments could be made directly to the "applicant program" so that community health centers, rural health clinics and others could run training programs.

ESSENTIAL COMMUNITY PROVIDERS

The Mitchell bill requires all health plans to either have a participation agreement or contract with essential community providers. ECPs include federally qualified health centers and rural health clinics, among others. RHCs and FQHCs without a participation agreement would be guaranteed reasonable cost reimbursement.

GENERAL BACKGROUND

RURAL HEALTH CARE DELIVERY KEY ISSUES

The key issues in the effective delivery of health care to rural America can be examined under the headings of -- insurance coverage, providers, capacity, and Medicare.

Insurance Coverage

- 7.7 million rural Americans now lack basic health insurance
- 14% of rural residents are without health insurance at some point during a year
- 26.5% of the rural uninsured are children.
- 32% of the nonelderly rural uninsured have family incomes below the poverty level
- 6% of nonelderly rural uninsured are farm families
- 42% of the rural uninsured are working
- 60% of the nonelderly uninsured who work are employed in firms of less than 25 employees
- 15.1% of rural school age children are uninsured compared to 13.1% in urban areas
- 55.5% of rural workers are insured through their workplace or union compared to 61.8% for urban workers

Providers

- Increasing the supply of primary care physicians and attracting them to rural communities is the top priority for in rural areas.
- Next on their list is enhancing the numbers of non-physician providers and enlarging their roles.
- A more recent, but equally critical problem, is the increased competition for primary care

physicians and non-physician providers from urban managed care plans. Rural areas fear that there may be a drain of primary care physicians from rural areas to urban-based employment packages offered by HMO's that provide both a shorter, more predictable work schedule and a guaranteed higher income.

Capacity

- Rural areas have too few points of access to care. Many of the providers work in relative isolation.
- There are many small rural hospitals that must provide the full range of medical services without adequate speciality back-up.
- There have been hospital closings due to under utilization and payment shortfalls. There were, in fact, 330 rural hospital closings between 1980 and 1990.
- It is important to note that the rural hospital is often the core institution of an integrated health delivery system and a hospital's failure can bring down the entire network.

Medicare

- In rural hospitals today, Medicare payments account for about 40% of net patient revenue. While that is the average, in some rural facilities Medicare accounts for nearly 90% of patient revenue. In 1992, 31% of rural hospitals had negative total operating margins, comparing total revenue with total expenditures, not just Medicare.
- Financing health reform through savings in Medicare is of major concern to rural America. Due to the high proportion of elderly in rural areas, any continuation of the Medicare program with a reduction in Medicare outlays has the potential to put many rural providers at a significant financial risk.
- Under health reform, if Medicare does not pay its fair share, and there is no significant cost shifting from private sources, the hospitals will suffer. Even though universal coverage will end these hospitals long history of delivering uncompensated care, it is possible that the gains from this will not offset the losses from Medicare.
- Further, under Medicare there is a decade long history of inequitable funding of rural areas as compared to urban areas. Rural areas are opposed to any perpetuation of this payment scheme under any new health reform measures.

RURAL HEALTH CARE DELIVERY SELECTED STATISTICS

National

- A higher percentage of rural residents than urban residents are without health insurance.
- Up to 25% of rural doctors will retire or relocate within the next five years.
- The government has identified about 2,000 "primary care shortage areas" with a total population of 35 million citizens. It would take more than 4,000 doctors to fill these areas.
- Rural areas receive 42% fewer health service dollars per capita than the US average.

South Dakota

- 145,000 SD residents (20.3%) had no health insurance at some point during 1993.
- In 1980, a typical SD family spent \$1,623 on all its health care. In 1991, the same family spent over \$3,863 and, by the year 2000, it can expect to spend \$8,365. This would be a 413% increase from 1980.
- During the last decade, the average SD family's health payments rose 281% faster than wages.
- SD is 60% frontier (less than 6 people per square mile.) Twenty percent of the state's population resides in frontier counties.
- 43 of 66 counties in the state, with 70% of the land and 25% of the population, are in health professional shortage areas (HPSAs.)
- Sixteen counties in SD have no hospital.
- Only 9% of SD doctors practice in frontier areas.
- SD ranks 47th in the country in terms of the physician to population ratio, with one primary care doctor for every 1,433 people.
- Three-fourths of the state's nearly 1,100 doctors are practicing in towns of 10,000 or more.
- A survey of second year students at USD School of Medicine indicates that students would consider serving in rural SD but think they would prefer to practice in larger cities.

DRAFT

THE HEALTH SECURITY ACT OF 1993
Responding to the Needs of Rural Americans
Health Care That's Always There

Every American citizen will receive a Health Security Card that can never be taken away and guarantees a comprehensive package of benefits, no matter where you live.

Guaranteeing comprehensive benefits that can never be taken away. Assuring that quality health services are available, no matter where you live. Cost savings so rural Americans get the care they need without bankrupting rural businesses and farms. Simplifying the system. Making everyone responsible for health care. These are the principles of the Health Security Act of 1993 and they are not negotiable.

WHAT'S WRONG WITH HEALTH CARE IN RURAL AMERICA

Rural communities are suffering under the current health care system. They lack vital health care services and often the means to pay for them.

- ◆ **Lack of Insurance.** 8 million (17%) rural Americans have no health insurance, including 18% of those living in farm families. Rural residents have higher rates of chronic or serious illness, and many, especially those engaged in farming, mining, and other high risk occupations, face a constant fear that their insurance will be cancelled if they get sick or have an accident. They often cannot get further insurance because they now have a "pre-existing condition."
- ◆ **Skyrocketing Premiums.** Even rural Americans with insurance face skyrocketing premiums because they usually have to purchase coverage alone or through a small business. They do not have the protection of being part of a large business or purchasing group that can successfully negotiate lower premiums.
- ◆ **Inadequate Coverage.** The insurance which rural Americans have often does not cover the health services they need, such as primary and preventive care.
- ◆ **Lack of Choice.** Rural Americans have very little choice as to what type of health insurance they will buy. Most rural Americans work for small businesses that offer no choice of coverage: Only 3 out of every 10 employers with fewer than 500 employees offer any choice of health plan.
- ◆ **Lack of Providers.** Physicians and other health care providers currently find few incentives to practice in rural areas. The fragile economies of rural communities and poor health insurance coverage provide little financial stability for rural health care

practitioners and hospitals. Long hours and isolation wear rural providers out; the network of care-givers is stretched past the point of breaking. As a result, over 400,000 rural Americans live in counties without a single doctor and 34 million people live in rural areas with inadequate health care.

- ◆ **Lack of Transportation Services.** Rural Americans have a harder time getting to the services that are available. Most rural communities lack any public transportation system. More than half of the rural poor do not own a car, and nearly 60% of the rural elderly are not licensed to drive.

For a long time, rural Americans have known that much of what is wrong with our health care system -- insecurity, high cost, and inadequate basic primary care services -- threatens what is right -- quality and innovation.

HOW THE PLAN WORKS

Every American citizen and legal resident will receive a Health Security Card. The Act creates large insurance pools to which all Americans belong, whether employed or unenmployed, rural or urban. These pools, called alliances, are established by the states in accordance with national standards for quality, access, and cost control. All employees and employers in businesses with less than 5,000 employees are part of area health alliances. These alliances give consumers and small businesses the power to buy affordable care. Businesses with 5,000 or more employees will be allowed to operate as "corporate alliances."

Everyone will have a choice of health plans. You'll be able to follow your doctors and nurses into a traditional fee-for-service plan, join plans composed of networks of hospitals and health professionals, or join a plan composed of large multi-specialty clinics.

Almost everyone will be able to sign up at work for a health plan. You will receive brochures that give you easy to understand information on the health plans -- doctors and hospitals included, evaluation of quality of care, consumer satisfaction ratings, and prices. If you are self-employed or unenmployed, you can sign up at your area health alliance.

Generally, most individuals and families in which at least one person works will pay a maximum of 20% of the average health plan premium in their area. Those who choose a lower cost plan - - from among those offered in the area -- will pay a little less than the 20% average. Those who choose a more expensive plan will pay a little more, as they do today. Employers who currently pay 100% of health benefits may continue to do so.

AN UNPRECEDENTED FOCUS ON RURAL HEALTH CARE

The challenge of health care reform in rural America is to create a system that meets the unique needs and circumstances of rural communities. Health care reform must provide acceptable and appropriate programs for delivering and financing health care in rural areas,

increasing the availability of care and opportunities for providers.

The Health Security Act targeted the needs of rural Americans from the earliest stages of its development.

- ◆ The special Working Group on Rural Health Care was formed to advise the White House Task Force on Health Care Reform.
- ◆ Rural health care experts from all over the country were deliberately brought to Washington to assist in the development of all aspects of the health care reform policy.
- ◆ Consultations with rural consumers, businesses, farmers, health care providers, and rural organizations occurred throughout the process.

The result is a health care reform plan with an unprecedented focus on rural health care based on the following principles: Security, Comprehensive Benefits, Savings, Quality, Choice, and Simplicity.

PRINCIPLES OF THE HEALTH SECURITY ACT WHAT IT MEANS FOR RURAL AMERICANS

Principle 1:

Security: Health Care That is Always There

The Health Security Plan guarantees that rural Americans will always have insurance coverage, with good, comprehensive benefits -- no matter where they live or work.

Security comes in two forms: (1) affordable, secure insurance coverage, and (2) adequate health care services available.

Here's how the plan guarantees security for rural Americans.

Affordable and Secure Coverage

- ◆ **Provides coverage no matter where you work or if you work**

The Plan will guarantee coverage if you lose your job or switch jobs. Under the current system, if you lose your job, you lose your health insurance. If you switch jobs, start a small business, you are also likely to lose your health insurance.

- ◆ **Makes it illegal for insurance companies to deny or limit coverage because of "pre-existing conditions", sickness, or the kind of work you perform.**

All health plans will be required to accept anyone who applies -- healthy or sick, young or old. It also prohibits insurance companies from dropping sick subscribers or selectively raising their premiums.

Even during the three years before this plan is fully implemented, insurance companies will be prohibited from dropping subscribers or selectively raising premiums due to illness or accident. It also seeks to set up a government-sponsored insurance plan for consumers who cannot buy private coverage during the transition period.

- ◆ **Provides affordable insurance even if you farm or own or work in a small business.**

Through the Health Alliances, all Americans will be able to get the lower prices now available only to large groups, giving rural Americans greater bargaining clout.

If you are a self-employed in business or farming or are an independent contractor, you also will be able to deduct 100% of your health care costs from your taxes, compared to only 25% under the current system.

Assuring Adequate Services Available

Here's how the Plan helps assure that adequate services are available;

- ◆ **Holds states, alliances, and plans accountable for ensuring that rural residents have access to health services.**

Alliances will be given specific responsibility and authority to address the specific access problems of rural communities. Health plans, alliances, and states will be required to monitor rural health care access and quality of care. They may assist in the development of health plans in underserved rural areas, and may also require urban health plans to serve rural areas within an alliance region. In addition, they can offer long-term contracts to health plans serving rural areas.

- ◆ **Helps bring health care where its needed. The Plan helps train, recruit, and keep rural primary care practitioners:**
 - Changes federal funding of medical education to increase the number of primary care practitioners who are trained for rural practice
 - Develops model legislation to promote the expanded role of nurse practitioners, physicians assistants and clinical nurse midwives to help them better serve rural communities.

- Expands Federal loan forgiveness and scholarship programs to increase the number of primary practitioners going to underserved rural areas -- would dramatically expand the National Health Service Corps, placing at least 3000 additional primary care practitioners in rural areas by the year 2000.
- Increase bonus payments for primary care physicians practicing in underserved rural areas.
- Provides tax incentives to attract and retain rural providers.
- Supports telecommunications linkages between rural practitioners and major hospitals and teaching centers to obtain expert advice, specialty consultation and professional continuing education. These linkages reduce the isolation of rural providers and thus help to recruit and retain practitioners in rural areas.
- Provides Federal grants and loans for rural practice expansion and renovation.
- Creates incentives to build rural community-based networks that reduce isolation of rural professionals and enhance local control.

Principle 2:

Comprehensive Benefits: Keeping You Healthy

All Americans will receive a Health Security card that guarantees a benefits package that is as comprehensive as those offered by most Fortune 500 companies -- a package that exceeds the average coverage of most rural Americans. The comprehensive package goes beyond most current rural Americans' insurance plans by covering a wide range of preventive services, including mammograms, Pap smears, and immunizations, **at no charge to you**. In addition, the package would provide for the following expanded services:

- ◆ Expands coverage of long-term care services for elderly and disabled rural Americans.
- ◆ Funds essential support services for low-income rural populations to ensure that they have access to high quality care: transportation, translation services, and outreach, for example.
- ◆ Promotes of school-based health care services in rural communities, where desired, to better enable our nation's young people to obtain essential preventive and other health services.
- ◆ Invests in public health and prevention initiatives targeted to rural areas.

Principle 3:

Savings: Controlling Health Care Costs

The Health Security Act cuts costs for rural Americans:

- ◆ Allows self-employed farmers and businesses to deduct 100 percent of their health care costs. Currently, the self-employed can deduct only 25 percent of these costs.
- ◆ Secures for farmers and small businesses the purchasing power of large groups to negotiate reduced insurance premiums through the Health Alliances.
- ◆ Eliminates excessive administrative costs associated with individual insurance policies for small businesses and farmers through the Health Alliances.
- ◆ Decreases excessive administrative costs for rural doctors and hospitals by reducing the number of claims forms and reporting requirements.

Principle 4:**Quality: Making the World's Best Care Better – and Available Everywhere**

The Health Security Act puts a new emphasis on preventing illness before it becomes a crisis. The Plan provides a variety of incentives and programs to increase the supply of quality health services in rural communities.

- ◆ Promotes good health through expanded coverage of preventive and primary care services which all Americans need.
- ◆ Reduces professional isolation and the quality of medical consultation through the use of telecommunications technologies to link rural providers and major hospitals, allowing expert advice and information to be exchanged rapidly.
- ◆ Provides incentives for more family doctors to practice in rural communities, through enhanced reimbursement, tax incentives, and other financial incentives.
- ◆ Provides special training for providers to prepare for practice in rural areas.
- ◆ Requires states, alliances and plans to monitor their performance according to Federal standards to ensure that rural Americans have access to quality health care services.

Principle 5:**Choice: Preserving and Expanding Choices for All Americans**

- ◆ Expands choice by expanding the supply of health practitioners in rural communities.

Under the Health Security Act, a variety of programs are created to improve the training

of practitioners for rural practice, and enhance the recruitment and retention of practitioners in rural communities.

- ◆ **Guarantees all Americans that they can continue to receive services from their physician in a traditional manner – that is payment for each service, otherwise known as the "fee-for-service."**

In many rural communities, there are no integrated health care plans; that is, plans in which people pay a fixed fee to receive all or most of their services from a group of providers. Under the Health Security Act, rural Americans will continue to have a fee-for-service plan available to them.

- ◆ **Encourages the Development of Rural, Community-based Health Networks of Providers and Integrated Plans.**

Rural health provider networks operated locally bring the benefits of greater cooperation and integration of services to rural communities. These integrated networks can provide good linkages to more specialized services. In many instances, these plans will contract with HMOs and insurance companies to manage the care of rural residents in their area that enroll the plans. In other instances, such networks may have the financial and population base to be able to become plans themselves.

The Clinton Plan supports the development of locally sponsored rural health care networks and rural plans by removing legal barriers, providing market incentives and offering federal grants and loans to support build networks and plans.

- ◆ **Encourages or Requires Urban Health Plans to Offer Coverage in Rural Areas.**

Secure coverage and fair payment rates provide incentives for health plans to locate in rural areas for the first time. The health alliances can provide incentives or require urban plans to expand to rural areas if it is in the best interest of rural residents.

Principle 6: Simplicity

- ◆ **Reduces Paperwork and Cuts Red Tape**

Rural physicians and other providers complain that insurance paperwork takes away from patient care. In rural areas, this paperwork is particularly burdensome since rural hospitals and physicians rarely have the resources to keep up. The plan will reduce the burden on physicians and hospitals for reporting and claims processing and will provide incentives for electronic data processing to reduce paperwork. It requires insurance companies to use a single claims form.

◆ **Reduce Regulatory Burden -- Reform of the Clinical Laboratory Improvement Act (CLIA)**

CLIA was passed in the late 1980's in response to major quality problems in our nation's medical laboratories. Unfortunately, regulations implementing CLIA were insensitive to the needs of rural communities and seriously threatened the existence of quality laboratories in those communities. The Health Security Act would reform CLIA to ease the regulatory burden on laboratories performing simple and moderately complex tests. It would revise laboratory personnel standards to better reflect the needs of rural and urban underserved areas.

PAYMENT SCENARIOS

The following examples highlight how the Health Security Plan would affect rural Americans.

Scenario 1: Young Family

Mary Jones and her husband, Dave, have two young children. Mr. and Mrs. Jones work at the local rural canning factory. Together, they earn \$35,000 per year. They have no insurance through their employer and have to pay \$5,000 per year for very limited insurance that covers hospitalization and limited doctor services, but no preventive services. When they visit the doctor or outpatient clinic, they must pay 40% of the charges. When they add their out-of-pocket costs for preventive and routine medical care to the premium costs, the Jones family pays approximately \$6,500 for medical and dental care.

Under the Health Security Plan, the Jones family will a maximum of 20% of the average plan premium for two-parent families in their area. Assuming the average plan in their area costs \$4,500 per year, the Jones Family would pay no more than \$900 per year for their health insurance coverage -- coverage that includes preventive for their family and dental services for their children.

Scenario 2: Small Business Owner/Self-Employed Farmer

John Smith is a farmer employing 4 full-time equivalent workers (2 full-time and 4 half-time workers) with children. Mr. Smith's average wage per-worker is \$20,000, so that his maximum contribution is capped at 6.2% of total payroll. For simplicity sake, assume his total payroll is \$140,000 (\$80,000 for workers and \$60,000 for himself). Currently, he provides no health insurance coverage for his employees. He also must purchase health insurance for his family, which costs him \$7,200 per year, since he is considered in a high risk category and has had two serious farm accidents. Only 25% (\$1,800) of the premium is currently tax deductible.

Let us also assume that the average premium in Mr. Smith's alliance area is \$4,200 per

family. Under the Clinton Health Plan, he would pay a maximum of \$8,680 (6.2% of \$140,000) for health care coverage for all his workers and the employer contribution for himself. In addition, he would be required to contribute as an individual \$1,140 – the difference between the employer contribution for his premium or \$3,360 (80% of \$4,200) and the cost of the plan he has chosen (\$4,500). So in total, John Smith will be paying \$9,820 to cover himself and all his employees under the Clinton Plan. This is compared to \$7,200 under his current plan to cover just himself and his family. However, all of his employer contribution (\$8,620) will be tax deductible as a business expense. Assume that Mr. Smith is in the 30% tax bracket; his insurance coverage for all employees and himself will cost \$xxx in after-tax dollars . This compares to a current cost of \$5,400 in after-tax dollars to cover just himself and his family.

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To: Lynn Margherio

From: Lois Quam

Re: Rural Health Care

Date: November 26, 1993

I am attaching background material on rural health care which you may find useful for the December 2nd meeting in Maine. Dena Puskin at the federal Office of Rural Health Policy is separately sending you some additional material.

I have included an outline of what I have found to be the most effective arguments on rural health care and responses to the two most often answered questions.

In general, I want to underscore two points. First, the parts of the plan with the most significant benefits to rural areas are the central initiatives of the reform: universal coverage, standard benefits, insurance reform, large group purchasing, integration, and administrative simplification. The strength of these initiatives outweighs the impact of all the special rural initiatives, because rural areas suffer more now from the problems of our health care system. Therefore, rural areas stand to benefit even more from the reform.

This point is often missed by rural health policy activists. During the last two Administrations, rural health care reform focused on special grant and loan programs. While important, these initiatives are a drop in the bucket. However, this history leads rural health care activists to focus on these special programs and therefore sometimes lose sight of the overall impact of the plan.

Second, the strongest rural criticism of the plan is of the Medicare savings and their disproportionate impact on rural hospitals. There is great concern that these savings will speed the closing of small rural hospitals. We have argued that the benefits of reform outweigh the impact of these savings, but this argument is not generally accepted.

This issue is complicated by the fact that the closure of some of these hospitals is almost inevitable given health care reform or not. However, this is a highly emotional issue in rural areas and reform is often labeled as the cause. In Minnesota, the big hospitals always hide behind these small hospitals when they argue for more funding. As a result, they whip up a far amount of hysteria.

I am of course happy to assist you in any further way. Sunday morning I will be at home (612) 647-9624. Sunday through Tuesday I will be in Anchorage at a rural health care conference. I can be reached there at (907) 272-7411. Wednesday late afternoon I will be back in Minnesota.

The Central Guarantees of the Reform

Comprehensive health care coverage to all Americans provides security to rural Americans -
- and the prospect of stability for rural practitioners.

Ending the harmful insurance practice including pre-existing condition exclusions helps rural Americans get needed primary and preventive care to avoid illness.

The limits on out-of-pocket payments protects farmers and small business people from losing their farm or business because of unexpected, high medical bills.

The health alliance, a purchasing cooperative for health insurance, gives rural Americans the advantage of more affordable coverage and better insurance choices - even if they work for themselves or for a small company.

The paperwork reduction frees rural hospitals, clinics, and small businesses from unneeded overhead costs.

The improvements in long term care provide new opportunities for older rural Americans and their families for community and home based care.

The Targeted Rural Initiatives

Access to Practitioners

The reform plan includes targeted initiatives to get and keep doctors and nurse practitioners in rural areas:

- Training more primary care doctors and nurse practitioners;
- Providing more rural training sites;
- Providing incentives to go to rural areas through loan forgiveness programs and tax incentives;
- Providing the support and incentives to keep doctors in rural areas through linkages with academic and regional medical centers; telecommunications; loans and grants for infrastructure development; rural health plan development.

Restoring Investment in the Public Health

The reform plan includes targeted investment in rural areas in:

- Rural health clinics in underserved areas;
- Flexible grant and loan programs to provide support for practitioners and

communities in developing integrated health plans or linked services;

-Support for local public health departments;

-Support for transportation services.

Telecommunications

The reform provides support for innovative telecommunications programs which can bring the state of the art medical care to the most remote rural areas.

Monitoring the Quality of Care

The quality monitoring measures used in the Reportcard includes rural health care measures such as the distance to a local provider.

The measures which monitor the performance of a health alliance and a state as they implement the plan include special rural measures and provide an analysis of the quality of access and services received by rural Americans.

Rural Mental Health Care

The plan recognizes the shortage of mental health providers in rural areas and calls for study and demonstration projects to link rural mental health care provision to acute medical services in rural areas.

RURAL HEALTH CARE REFORM ISSUES

Although we have limited our discussion to rural issues, we would expect the President to receive questions about the basic benefit package and other general issues related to guaranteeing universal coverage.

1. **In our area, non-profit clinics like this are the linchpin of the community's health care system and serve those whom no one else will serve. How can we be assured that clinics like this will be included in the plans?**

The Health Security Act provides a 5-year protection to certain types of providers that are essential for ensuring access to health care in underserved rural areas. This provision requires health plans to contract with and pay essential providers for the services they provide under the benefit package. Some specific providers are included as automatically designated essential community providers:

- CHCs and MHCs
- Rural Health Clinics
- Federally-Qualified Health Centers
- Indian Health System facilities (including tribal units and 638 contractors)
- Other federal grantees serving special populations, such as MCH, family planning, Ryan White, and school-based providers.

In addition, independent health professionals and facilities (such as public hospitals, sole community hospitals, and local health departments) may apply to the Secretary for designation as an essential community provider. These providers must demonstrate that, in their absence, people would lack access to services guaranteed under the comprehensive benefit package.

2. **What happens after 5 years?**

In general, we expect that most essential providers will be integrated into health plans in their areas by the end of the 5-year transition period and will not require continuation of the essential provider protections.

However, we are concerned that five years may not be adequate in some communities. Therefore, the Secretary is charged with conducting a study and making recommendations to Congress, by no later than March 2001, as to whether, and to what extent, the essential provider protections should continue for some or all essential community providers beyond the five year transition period.

3. What incentives does the plan have to encourage health care providers to locate in rural areas?

Changes in funding policies for health professions education will increase the supply of primary care providers, the type of provider most needed in rural communities. Funding will be doubled for nurse practitioner, certified nurse-midwife, and physician assistant training programs. The National Health Service Corps (NHSC) will be expanded from its current field strength of about 1,600 to about 7,700 by 2004. About 55 percent of NHSC providers locate in rural areas. Primary care providers in underserved areas may receive a tax credit of up to \$1,000 for physicians and \$500 for non-physician providers for up to 5 years of service. The allowable depreciation expense for medical equipment is increased for doctors practicing in underserved areas. Physicians serving in underserved areas will receive a 20 percent bonus payment for services provided to Medicare beneficiaries. In addition, development of rural health care networks and improvements in the health care system will make rural practice more attractive.

4. OK. So the plan has incentives for doctors to go to rural areas, but what will benefit the doctors already there and make them want to stay?

The 20% bonus and the tax benefits for medical equipment apply to both new and existing physicians in health professional shortage areas. In addition, the plan will help reduce the isolation of rural practitioners by improving linkages with academic and regional medical centers, partly through improved telecommunications. The plan also will encourage the development of rural training sites for health care professionals. Involving rural practitioners in training health professionals promotes their interaction with colleagues and fosters their own continuing education.

Health plans will be required to assure adequate access in the areas they serve. Therefore, health plans will have an interest in establishing locum tenens programs and other services for rural physicians to maintain adequate access in rural areas.

5. Right now, I contract with several HMOs to provide health care to local residents. Each HMO has its own administrative procedures and requires me to use a particular laboratory and hospital. How will health care reform affect this?

Administrative procedures will be streamlined under the Health Security Act. Each health plan will use the same forms for documenting the health care you provide.

Your patients work for many different employers, each of whom is likely to offer only a few health plans to their employees. Because each employer may offer a different choice of plans than other employers in the area, you may feel it is necessary to

contract with numerous health plans so your patients can continue to choose you for their physician. Under health care reform, everyone in your community who is enrolled in the health alliance will have the same choice of plans. You may then find it advantageous to contract with only a few HMOs because all your patients would have the option to select one of the plans in which you participate.

6. The plan relies on HMOs, but we don't have any HMOs and never will.

The reform offers Americans choices of different types of insurance -- all providing the comprehensive benefit package. A traditional Blue Cross-type plan will be available to everyone, whether or not there is an HMO. The plan also will foster development of managed care plans where there currently are none.

7. With all the copayments, I don't think the health plan is going to be affordable for a lot of rural people.

Subsidies for premiums and cost-sharing (e.g. copayments and deductibles) will be available for low income people. This is a big improvement over the way things are now. The plan also makes health care more affordable by providing everyone with the advantages of purchasing health insurance as part of a large group and by restructuring the health care system.

8. The plan does not cover undocumented persons. How will they get health care? Will hospitals and practitioners be required to provide care to undocumented persons? How will they get paid for the care they provide to undocumented persons?

The plan continues the current financing of care for undocumented persons. Federal funds will continue to be available to help hospitals and clinics that care for a large number of undocumented people.

If undocumented persons are employed, their employers will be required to contribute toward their health insurance premiums. Undocumented persons could then pay the remainder of their premium themselves. However, they will not be eligible to receive federal subsidies to pay for their premiums.

9. The plan is not adequately portable for migrant workers.

The health care choices of migrant workers will be improved in several ways. Migrant workers who are American citizens or legal residents will receive a health security card that entitles them to the same health care coverage as every other

American. Migrants will be members of the health alliance in their home area. Transfers between health alliances allow them to use their health security card for care wherever they are. Outside their home area, migrants can receive emergency services at no additional cost. Routine care is available through the point of service option, but higher copayments would apply to those in HMOs and PPOs. In addition, additional funding will be available to migrant health centers, which provide health care services along the migrant streams.

10. The Indian Health Service is a big provider here, but I understand it's off limits to non-Indians.

An Indian Health Service Center may serve non-Indians on a contract basis. The plan fosters greater cooperation between the IHS and other health care providers in rural areas.

11. It's not fair that American Indians don't get subsidies if they use IHS facilities.

This was corrected in a technical amendment. American Indians now can receive subsidies for care provided at an IHS center.

12. Won't the Medicare cuts force our rural hospitals to close?

Savings in the Medicare program will come about from the restructuring of certain aspects of the Medicare program and a lower rate of increase in Medicare spending as health care costs come under control. Let me explain. Currently, Medicare expenditures are growing at 3 times the rate of general inflation. Projections for Medicare expenditures are based on this rate. Under our proposal, the rate of increase will initially slow to 2 times the general rate of inflation. Medicare will save money when health care costs are controlled and the rate of increase in health care expenditures is reduced.

Another major source of Medicare savings is through changes in the way teaching hospitals are paid. Few rural hospitals receive payments for training physicians. Therefore, few rural hospitals will be hurt by this change. In fact, changes in the way the federal government finances health professions education will make it easier for rural hospitals to participate in training programs and receive financial support for their role in educating health care professionals. In addition, grant programs will be available to build rural health care networks that could help rural hospitals expand local capacity.

Finally, under the Health Security Act, everyone will have health insurance. Rural

hospitals will no longer be providing health care to large numbers of people who cannot pay for their care.

13. Aren't rural areas hurt by the budget targets because our costs are already low?

In rural areas, like the rest of the country, health care costs are increasing much more rapidly than people's wages. The budget targets try to bring the rate of increase of health care expenditures down to the same rate of increase as people's wages. Then we can have money for education, roads, vacations, and the other things we want.

The plan works over time to even out the differences in the amount rural and urban states spend per person.

14. The Health Security Card does not do any good if transportation is not covered.

Grants are available for states to cover transportation to ensure access in rural areas. Controlling health care costs will also mean that rural counties have more money left over for transportation.

15. Wouldn't it be simpler to have a single-payer system?

We believe it is important for the states to be involved in the health care system and to have the flexibility to develop the health care system that will work best for them, within the parameters established by the federal government. States may opt to develop a single payer system if they assure that federal requirements under health care reform are met. However, we do not believe that a single-payer system is the preferred choice by all Americans. Moreover, we view this as an opportunity to preserve the good parts of our health care system and improve upon that which doesn't work, without creating a totally new system.

Medicare Rural Referral Center Act

To: Chris Jennings

From: Debbie Chang
OLIGA

Sally Rosenberg, Rural Referral Center Coalition, questioned the Administration's reasoning in supporting "tiers and modified benefits for RRCs depending on how far below the 108% threshold they fall and [why we] would not reopen the current application process (February 2, 1996). The following is our response:

o The Coalition's proposal is to fully exempt RRCs from the 108% wage index threshold. The Administration's proposal would create tiers for RRCs depending on how far below the 108% threshold they fall.

HCFA Response: While not as advantageous towards RRCs as the Coalition proposal, the Administration bill would provide these facilities with favored status not accorded other Medicare providers. A tiered approach provides RRCs special consideration under the Medicare Geographic Classification Review Board (MGCRB) wage index reclassification process. This affords additional protection to rural facilities which may encounter large fluctuations in their costs and utilization over short periods of time. The proposal would allow RRCs to qualify for some increase in their wage index, although not the full amount, when their wages are between 100 and 108 percent of the average wage.

We are supporting a tiered approach in order to assist rural hospitals better serve their communities, while maintaining our commitment to the wage index approach.

o The Administration's proposal does not reopen the current application process for RRC applications before the MGCRB.

HCFA Response: We do not support the idea of retroactively reopening the application process for the geographic reclassification review. Applications were due October 1995 for review by the MGCRB Spring 1996. The statute sets forth strict deadlines and timelines for submitting and reviewing MGCRB applications and makes the Secretary's reclassification decisions final and unreviewable once they are rendered. The decision-making process has to be completed in time for the Agency to calculate PPS rates. We are currently in the middle of the process and to disrupt this would cause the system to undergo severe turmoil.

NOTE TO CHRIS JENNINGS

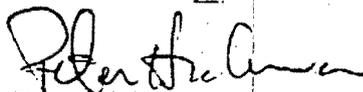
RE: McDERMOTT, WILL & EMERY PHYSICIAN REFERRAL LANGUAGE

I have reviewed the material that you sent us and talked with Kathy Buto and her staff in Baltimore. You should know that the characterization of HCFA staff's position as "generally supportive" is only accurate to a point. We support replacing the current multiple compensation exceptions with one broad exception as is proposed in the current version of the President's bill. Most of the language in the MW&E attachment deals with this issue. There are, however, some significant differences between MW&E's and our version of a general compensation exception. In addition, the MW&E document contains a number of other provisions that are problematic. At the meeting, with HCFA staff, MW&E indicated that they would consider making changes to their language. No changes were made in the language that they shared with you.

The following comments compare what M,W & E propose relative to what we have in the current draft:

- o As indicated above, we both support eliminating the 8 existing exceptions for compensation arrangements in favor of a single broad exception.
- o In M W & E's suggested general compensation exception, we have the following concerns:
 - + In regard to their 1877(e)(3)
 - ++ We don't believe that it is necessary to address physician incentive plans in this exception since the entities for whom this would be an issue would be able to qualify for one of the prepaid plan exceptions. This is especially true given that PSO's would now be able to contract with Medicare.
 - ++ M, W & E's language would broaden the exception by excluding situations where compensation is indirectly based on the volume or value of referrals. This a significant change from current law which we oppose. Therefore, it was not included in the draft bill.
 - ++ While we would continue to exclude productivity bonuses under the exception, we do not want to exclude such bonuses when they are for designated health services.
 - + Our bill includes a provision in 1877(e) that would allow the Secretary to establish additional standards for the exception. This provision is not included in M.W & E's draft
- o In regard to the suggested changes to definition of group practice, we have the following comments:

- + As indicated above, we are against allowing compensation based indirectly on the volume or value of referrals.
- + Changes to 1877(h)(4)(B)(I) would allow productivity bonuses directly related to the volume or value of referrals for designated health services if the payment is made in a subsequent year. Clearly this would create a major new loophole and for that reason we would oppose the change.
- o We do not see the need for including a definition of physician incentive plans in the definition section of 1877. The only reason for including this definition would be to delink the provision from the existing definition in 1876 and the regulations implementing the 1876 provision. We oppose this change. Again, as indicated above, we do not see the need to include reference to physician incentive plans in the revised compensation arrangements exception.


Peter Hickman

GMEDPARTBDRAFTMW&EREFF.PJH February 27, 1996

FROM M. W. & E 1200 18TH ST WASH. D. C

(FRI) 02' 96 15:11/ST. 15:10/NO. 3560704114 P 2

McDermott, Will & Emery
Washington, D.C.

M E M O R A N D U M

VIA FACSIMILE

TO: Chris Jennings

DATE: February 2, 1996

FROM: Sally A. Rosenberg *SA*

RE: Physician Self-Referral and Rural Referral Centers

PHYSICIAN SELF-REFERRAL

I am pleased to transmit to you the attached draft proposed legislative language that would amend the exceptions to the compensation physician self-referral prohibition in current law. As we have discussed, this approach may be a viable alternative to repeal of the compensation prohibition that is in H.R. 2491 and H.R. 2530. We have shared this language with Kathy Buto and other HCFA staff who seem generally supportive. We also discussed this concept with Chip Kahn and Melody Harned who indicated a willingness to entertain a proposal from the Administration in this regard.

We still consider the attached to be a working draft. I, and representatives from the American Group Practice Association, would be most pleased to work with you and your staff to finetune the proposal so that it could be included in the Administration's next budget offer.

RURAL REFERRAL CENTERS (RRCs)

We are pleased that the Administration is now supporting a permanent RRC grandfather and special consideration for RRCs under the Medicare Geographic Classification Review Board wage index reclassification process. However, the Administration apparently is in favor of an approach to the wage index issue that is far less favorable to RRCs than that included in H.R. 2491 and H.R. 2530. Specifically, those measures fully exempt RRCs from the 108% wage index threshold and allow RRCs to submit applications applicable to FY 1997. The Administration approach would create tiers and modified benefits for RRCs depending on how far below the 108% threshold they fall and would not reopen the current application process. This proposal would fail to provide many RRCs with the benefits they seek while achieving no budget savings since this provision is budget neutral. I welcome the opportunity to discuss this matter with you at your convenience.

Thank you for your continued interest. I can be reached at

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FROM M, W & E 1200 18TH ST WASH. D. C

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DRAFT

1/30/96 - 4:12pm

**Revision to Physician Self-Referral
Exceptions to the Compensation Prohibition**

Section 1877(e) of the Social Security Act (42 U.S.C. § 1395nn(e)) is amended to read as follows:

(e) Exception Related to Compensation Arrangements--An arrangement, including a physician recruitment arrangement, which meets the following criteria shall not be considered a compensation arrangement described in subsection (a)(2)(B):

- (1) The arrangement is in writing and is signed by the parties;
- (2) The arrangement is consistent with fair market value;
- (3) The amount of compensation, or, where applicable, the compensation per unit of services, under the arrangement must be determined in advance and (except in the case of a physician incentive plan) not be based directly upon the volume or value of any referrals or other business generated between the parties; provided however, that nothing in this subsection shall prohibit the payment of remuneration in the form of a productivity bonus based on services personally performed by the physician (or an immediate family member of such physician).
- (4) The items or services compensated or contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement; and
- (5) The arrangement would be commercially reasonable even if no referrals were made between the parties.

**Clarification of Permissible Compensation
of Group Practice Physicians**

Section 1877(h)(4)(A)(iv) of the Social Security Act (42 U.S.C. § 1395nn(h)(4)(A)(iv)) is amended by striking the words "or indirectly" in line 3 and by adding "for designated health services" after the word "referrals" in line 4.

Section 1877(h)(4)(B)(i) of the Social Security Act (42 U.S.C. ss 1395nn(h)(4)(B)(i)) is amended by adding "for designated health services" after the word "referrals" in line 7 and adding "in the year for which the bonus is paid" after the word "physician" in line 8.

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FROM M. W & E 1200 18TH ST WASH, D. C.

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Definition of Physician Incentive Plan

Section 1877(h) of the Social Security Act (42 U.S.C. § 1395nn(h)) is amended by adding the following as 1877(h)(7):

(7) Physician Incentive Plan-- The term "physician incentive plan" means any compensation arrangement between an entity and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the entity.

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