

September 10-12, 2000

Hazard, Kentucky

Health Resources and Services Administration
Office of Rural Health Policy

Hazard, Kentucky
September 10-12, 2000

Meeting Summary

The 36th meeting of the National Advisory Committee on Rural Health (NACRH) was held on September 10-12, 2000, at the University of Kentucky Center for Rural Health and at Hazard Community College. A reception was held for NACRH members on the evening of Saturday, September 9.

Sunday, September 10

A brief orientation for new members (Dr. Stephanie Bailey, David L. Berk, Dr. Keith J. Mueller, and Sally K. Richardson) was conducted at the Hazard Hotel prior to the meeting's formal opening. In addition to the new members, the following participants attended the Hazard meeting: Nancy Kassebaum Baker, James F. Ahrens, H.D. Cannington, Shelly L. Crow, Dr. Steve Eckstat, Dana S. Fitzsimmons, Alison M. Hughes, John L. Martin, Dr. Mary Wakefield, Tom Morris, Sahi Rafiullah, Dr. Marcia Brand, and Dr. Wayne Myers. Rachel Gonzales-Hanson, Dr. Monnique Singleton, and Dr. Thomas Nesbitt were unable to attend. A list of current NACRH members follows the meeting summary.

Call to Order

Nancy Kassebaum Baker, NACRH Chair

Chairwoman Kassebaum Baker convened the meeting at the University of Kentucky (UK) Center for Rural Health by first welcoming NACRH members and then announcing the retirement of Dr. Myers from his position as Director of the Office of Rural Health Policy. She thanked him for lending his leadership, guidance, and direction to the effectiveness of the rural health policy section of the Department of Health and Human Services (HHS). She then called

on Dr. Myers to introduce several NACRH guests who were present at this opening session. They included the following:

- Dr. Emery Wilson, Dean of the UK Medical School
- Tony Goetz, Associate Dean of the UK Medical School
- Joe Smith, Head of the Kentucky Primary Care Association
- Loyd Kepferle, Executive Director of the UK Center for Rural Health
- Dr. Joe Florence, Director of the Family Practice Residency in Hazard
- Greg Bausch, Director of the Area Health Education Center in Morehead, KY, and head of a small rural health network in Morehead
- Dr. Karen Main, Deputy Director of the UK Center for Rural Health

Next, Bil Gorman, Mayor of Hazard and former head of the Appalachian Regional Healthcare (ARH) Center for 13 years, welcomed the Committee members to Hazard and thanked them for all the work they have done in the rural health care arena.

Welcome and Opening Remarks

Benny Ray Bailey, Kentucky State Senator

Senator Bailey provided NACRH members with a brief historical perspective of the central Appalachian region in eastern Kentucky and of the people who work and live in this area. He also discussed the impact of Medicare on the residents of Hazard and eastern Kentucky.

Senator Bailey began his overview of the area by explaining that the term Appalachia was first used around 1890 to describe an area of the country where "the people lived, worked, spoke, and behaved differently than other people of the United States." The Scotch-Irish, who were considered the best educated of all the groups that immigrated to the New World, first settled the region. Upon arrival, they immediately established schools in the area that were similar to the ones they had left behind in Ireland. These schools, which had to temporarily close because of the onset of the Civil War, later became the model on which the American system of education is based.

The Appalachian area has been scrutinized many times, both in literature and legislation. In 1960, during the War on Poverty, many young, misguided young people came to southern Appalachia from wealthy urban areas to offer their services to the local populace. They came without any type of guidance, supervision, or skills in social engineering, only to leave in failure. Around the same time, Senator Bailey, accompanied by 250 local college students and armed with the appropriate skills, was successful in his efforts in forming health care teams to improve the lives of the rural residents.

Next, Senator Bailey reported on the seriousness of the health care needs of the Appalachian people by presenting some dramatic statistics on health care in Kentucky. He stated that the average rate of hospitalization for children in the United States is 8 cases per 1,000 cases of children seeking treatment under age 15. In comparison, the State of Kentucky reports 12 cases per 1,000, while southeastern Kentucky reports 35 cases per 1,000. When the death rate was recently calculated per 1,000 people for a number of minority groups in which Appalachian Kentucky was included, it was determined that this region has the highest death rate. This minority group also included the largest number of uninsured.

Senator Bailey explained that Medicare and Medicaid are the two staples that have allowed for the development of health care programs in rural areas but that they have not yet reached their full potential, and in some instances, have actually stultified the growth of health care services in these areas. It is common knowledge that Medicaid pays physicians the same amount of money no matter where they live. This shortcoming has resulted in a shortage of primary care physicians in rural America. Therefore, the key to retaining these physicians in rural communities is to increase payment for service.

Senator Bailey then pointed out some specific problems he had encountered with Medicare and the Health Care Financing Administration (HCFA). In 1972, Knot County in eastern Kentucky asked for additional funds from several Federal Government programs to support the construction of a much-needed clinical facility in the region and was repeatedly turned down. County officials were told that their health care programs did not fit the Federal profile of what was considered best for rural America. The clinic was finally built with private funds. But surprisingly, even after the clinic was named the model program for the Horizon '76 Programs for the American Revolution Bicentennial, had received numerous awards for its health care programs, and had treated 400,000 patients, and even after the Robert Wood Johnson Foundation gave the University of North Carolina \$12 million to duplicate the clinic's programs across rural America, clinic officials were told that they did not qualify for cost-based Medicare reimbursement because they had not shown a need for their programs.

According to Senator Bailey, HCFA refuses to consider any assistance to a rural health care program if "the program doesn't fit HCFA's preconceived notions." He believes that Medicare reimbursement of services in rural areas is much less than in urban areas, even though State law prohibits this inequity, and that this inequity is pervasive throughout rural America.

In summation, Senator Bailey spoke about the great strides that the people of rural eastern Kentucky have made during the past 15 years in building a model for rural health care. Today, because of the hard work of the UK Center for Rural Health, Hazard has a new well-equipped hospital with 122 doctors on staff and the only mental hospital in eastern Kentucky. Also thanks

to Dr. Wilson, Mr. Goetz, and Dr. Main, the UK Center offers bachelor degree programs in medical technology and physical therapy, a master's degree program in nursing, and a family practice residency program. Furthermore, a number of foreign medical school graduates now practice in Hazard, allowing the UK Center access to practically "every foreign nation in the world." A future objective of the Center is to be known as an international center for rural health studies. The Center also is involved in health policy work and recently was instrumental in securing \$500,000 from the Kentucky State legislature to establish a cardiac rehabilitation center at the Appalachian Regional Hospital.

Office of Rural Policy Update

Wayne W. Myers, NACRH Executive Secretary; Director of the Office of Rural Health Policy

Before Dr. Myers provided NACRH members with an update of the Office's activities, he too announced his departure from the Office of Rural Health Policy (ORHP) immediately after the November elections and the imminent succession of Dr. Brand from her position as Deputy Director to Acting Director. He also introduced Michelle Pray, an intern at ORHP from Johns Hopkins University School of Public Health and a native Appalachian from Hazard.

Dr. Myers briefly commented on ORHP's work with the Balanced Budget Refinement Act and with following the progress of congressional members in the enactment of their Medicare packages in their entirety before the end of this administration or in positioning their bills for review by the next Congress. The 22-member Office is concurrently determining its own budget for the next fiscal year and is contemplating what decisions need to be made during the protracted period from the November 7 election to the January 20 inauguration.

Dr. Myers then shifted to the issue of Medicare reform, the main topic of discussion for this meeting. He asked that the Committee members review the various proposals for Medicare reform that were analyzed by Dr. Mueller at the June meeting and outline for ORHP issues they believe are important, from a rural perspective, for consideration in any plan to reform Medicare. To help with this task, Dr. Myers requested that members prioritize these issues by using the following five categories:

- What is our access to health care (including access to choices in care)?
- What are the workforce issues? Who is going to be available to deliver the care?
- How do we pay for Medicare services?
- How do we ensure, improve, and organize for quality of care?
- How do we ensure equity of access, equity in reimbursement, and equality in designing and redesigning Medicare?

NACRH responses to these areas of discussion are examined during Monday's session.

Dr. Myers suggested that a subcommittee composed of designated Committee members works closely with ORHP staff in drafting a document based on these responses. After a final review by all Committee members, together with input from the Rural Policy Research Institute (RUPRI), a final report incorporating this information on Medicare reform will be sent to the Secretary of HHS, most likely after the first of the year.

As a member of the Medicare Payment Advisory Commission, Dr. Wakefield reported that in June 2001 the Commission will produce a major document focusing entirely on rural health policy. She hopes that "the report will help publicize some of the really unfortunate structural hindrances that have been built into the Medicare Program to date. These are some, if not the same, of the problems that have been examined since 1964."

Framework Discussion: Medicare Reform

Keith J. Mueller, Professor and Director of the Nebraska Center for Rural Health Research, University of Nebraska

Dr. Mueller provided NACRH members with a brief summary on RUPRI's role in analyzing the topic of Medicare redesign. The task, which includes the development of three reports, has taken about a year to complete, with a couple of false starts. The first report, and the topic of discussion at the June NACRH meeting, reviewed the President's Medicare Reform Plan and the leading congressional reform proposal (S. 1895) put forth by Senators John Breaux (D-LA) and Bill Frist (R-TN).

The second report consists of two papers that focus on the issue of the wage index used to create a geographic adjustment in payment streams regarding inpatient hospitals. The first of these two papers is a short policy brief that lays out the elements of the wage index and how these elements vary between urban and rural locations. The final report, and the topic of Dr. Mueller's discussion at this meeting, looks at the global issues involving Medicare reform by "examining the desired state of being for health care delivery in rural areas." It incorporates input from the June meeting and is published by the RUPRI Center for Rural Health Policy Analysis.

Committee members each received a draft of the introduction and framework of the final report for review. Dr. Mueller hopes to have the final document ready for restricted circulation some time after Thanksgiving. Publication for the general public is scheduled for after the first of the

year to allow time to review comments from NACRH members and RUPRI advisers and to try and coincide with the Committee's release of its own Medicare redesign report.

According to Dr. Mueller, this final RUPRI paper will differ from the others by presenting "a framework for what should be included in any discussion of Medicare policies." It is not a paper based on impending legislation. Dr. Mueller explained that one problem in writing a document of this nature is the selection of proper language that will convey the same meaning to all readers, for example, the use of the word or words "rural" or "rural health care delivery system." The definition of rural varies considerably from place to place, as does the health care delivery systems in rural areas. This report uses the term "rural" when referring "to dominant characteristics of rural areas, usually of delivery systems or of beneficiaries living in most of rural America, defined in geographic and not population terms."

Dr. Mueller then presented several slides that explained rural as a place, health care services in rural areas, and implications for Medicare policy.

- Rural as a place. Dr. Mueller explained that one must keep the variations of the definition of rural in mind when discussing rural as a place and when talking about what health care services are like in those places. All these variations could influence the effects of public policy.
- Health care services in rural areas. The characteristics of the health care system can and do vary by location, within rural areas as well as between rural and urban areas. Financing for health care services also varies tremendously among States, so policy makers must understand both the variation and the impact it can have.
- Implications for Medicare policy. Given the extensive variations in the implications for Medicare policy, it would be hard to reach a single generalization. Therefore, RUPRI has come up with a combination of two general approaches to deal with this variation in the context of analyzing specific Medicare proposals.
- Identify any likelihood that a particular policy initiative could leave at least some rural beneficiaries worse off than they would be in the absence of the new policy.
- Assess the net benefit for rural beneficiaries, assuming disparate impacts across rural areas.

Next, Dr. Mueller explained that policy makers have used two fundamental approaches when trying to redesign the Medicare program. The Government-based approach calls for Government intervention through a combination of regulation and financial actions (paying for new benefits or changing its payment reimbursement to providers and/or health plans). The private approach relies on actions of privately based health plans and providers to extend cost-effective services to beneficiaries. An "in between" approach, characterized as the managed competition approach, combines reliance on using new private initiatives with Government regulations that ensure a "level playing field."

These fundamental approaches to changing the Medicare program would have different impacts on health care for rural beneficiaries. They differ in

- Fundamental philosophy (Government guarantee; private-based with a Government-based minimum);
- Payment for health care services (by Government and used as a tool to control program costs; by the private sector and influenced by a desire to be competitive);
- Security of benefits (Government-based guarantee; market entry and exit by private plans); and
- Beneficiary decision making (little or none in a Government-dominated program; complete responsibility for selecting a plan).

RUPRI's latest prescription drug document, which Committee members will soon receive, uses the same kind of thinking that went into the redesigning Medicare document. The prescription drug document, which is an assessment of the rural implications of prescription drug benefits and a precursor to RUPRI's Medicare document, relied on the S. 1895 bill and the President's proposal to demonstrate what prescription drug benefits should look like for rural environments.

Dr. Mueller pointed out that the analysis of the policy paper under discussion is structured around a set of principles that should guide any Medicare redesign effort. These principles are

- Equity. A Medicare program should be equitable to its beneficiaries.
- Quality. A Medicare program should deliver quality care to all beneficiaries.
- Choices. Medicare beneficiaries should have comparable choices available to them (i.e., choices among providers, health care plans, and benefit packages weighed against the cost of the package).
- Affordable cost. A Medicare program should provide quality access choices at a cost that is affordable to the beneficiary.
- Governance and administration. A Medicare program should use rules and structures that remain fair and appropriate over time.

Dr. Mueller explained that each principle was devised on behalf of all Medicare beneficiaries who live in rural areas. In the final paper, each principle will be compared to the current situation, and recommendations will be made for developing a Medicare program of greatest benefit to rural residents. Dr. Mueller does not see the current Medicare program as being optimal against any of these principles and views this program as unsatisfactory.

Discussion

In the discussion that follows Dr. Mueller' presentation, several issues were raised:

- Ms. Crow voiced concern about the inequity of reimbursement rates for rural versus urban areas. She asked Dr. Mueller whether his research group has developed any means to change this inequity on the Federal level. Dr. Mueller responded by giving two different viewpoints. If it is a publicly funded program that provides a public benefit, one

could argue that reimbursement and payment should be the same for everybody. But if payment is based on what is a fair payment for a service rendered given the expense of that service, then it would be difficult to defend equal payment in all areas because the expense involved in rendering the service will change based on local economic situations.

Dr. Mueller also said that one has to either use the egalitarian principle that says everyone receives the same payment or use the economic principle, in which case one has to totally redefine service areas so that they make sense economically. RUPRI plans on doing something similar to the latter on service area definitions over the next year or so.

- Mr. Martin commented that he is not sure whether either model will work primarily because there are so many differences that occur. As an example, he cited the Providence of New Brunswick's teacher contracts. Every teacher receives equal base pay, but adjustments are made on the basis of where a teacher lives and the cost of living in that area (e.g., travel, living arrangements). The problem is that teaching positions in urban areas command higher salaries than they do in rural areas, so obviously more teachers are attracted to the cities. If one adheres to the egalitarian principle and simply says that everyone should get paid the same, then one might have a counter problem of a shortage of teachers in urban areas.
- In response to Ms. Hughes's inquiry about whether any bills or regulations concerning Medicare are going to pass in 2000, Chairwoman Kassebaum Baker replied that regulations on incremental prescription drug benefits would have the best chance of passing this year. She also reiterated an earlier request that the Committee, together with RUPRI, put together its own recommendations on Medicare redesign, with a strong focus on the rural aspect of Medicare, to send to the Secretary of HHS after the first of the year.
- In pursuance of the concept of the inequity of health care payments, Dr. Eckstat admitted he was having trouble understanding the concept and why it costs more to provide a particular service in a particular area. He asked whether there is scientific evidence for these inequities. Dr. Mueller replied by explaining that the payment system is based on Medicare cost report data that Congress made available in 1983, with both hospitals and physicians contributing to the data. Therefore, politicians use this data source to argue that two different payment systems are needed—one urban and one rural—and that the urban areas should receive higher reimbursement rates.

Ms. Crow offered that the "whole rural payment system is higher in rural areas than in urban areas" most likely because of the lack of resources. She has found that in her area phone bills and overhead costs at rural clinics are higher, leasing or purchasing patient equipment is more costly, and grants are not available to purchase new buildings.

- Chairwoman Kassebaum Baker asked about the States' role in offering a base support for medical care under Medicare. Several participants responded to this inquiry. Dr. Bailey offered that Tennessee has created health councils in all 95 counties that decide on what the important health issues are for that particular area.

Dr. Brand mentioned that she recently participated in the review of 35 States that applied for a State planning grant program. This program provides States with the resources necessary to conduct 1-year assessments of what it would take to provide access to affordable health insurance for all citizens in that State. Each State was asked to identify a range of health care options that would work in their State; ORHP has agreed to fund 11 applicants. Dr. Brand believes that the high interest in this program indicates that States are not "waiting around for Federal solutions to access the health insurance process."

- Dr. Wakefield and Dr. Mueller both believe that the current Medicare Rural Hospital Flexibility Program is a good example of interplay between Federal financing of health care programs and State-level involvement in the development and planning of these programs. Although the States' role is not one of offering financial support, it does play an important part in health care decisions and in the development of necessary networks to ensure the financial stability of critical access hospitals (CAHs).

Dr. Wakefield then explained that the issues this panel is struggling with parallel the issues that the next MedPAC meeting will discuss at length, that is, whether or not to define "access" and "quality" in terms of the Medicare program, and if so, what are the definitions as they relate to rural areas in particular. Any information that this panel "could provide to MedPAC on the subject could be critically important over the next 9 months."

- In addressing the issue of the rural differential, Ms. Hughes mentioned that in New Mexico and Arizona practically all of the rural hospitals have sole provider status, which allows them a different code to receive 5 percent more funding from HCFA. A number of these hospitals believe their sole provider designation is in jeopardy if they become a CAH. Therefore, a lot hinges on the definition of "rurality," in terms of these hospitals being able to hang onto their sole provider status. Ms. Hughes asked the panel whether States could have some role in defining rurality for their particular State that would be acceptable to the Federal Government. She also inquired whether a formula could be devised to be used by the Medicare reform program to code certain areas as rural, thus allowing these areas to receive certain reimbursement payments.
- Dr. Mueller said that, like Dr. Bailey, he would like to start with a clean slate and think more in terms of the Medicare beneficiary and the ideal of ensuring access and quality instead of addressing "the whole laundry list of specific problems and issues that we have with the current program."

Following the discussion, Chairwoman Kassebaum Baker asked the Committee members to come up with two or three Medicare redesign priorities they consider important when addressing such issues as equity, quality, cost, access, and workforce, and to be ready to discuss these priorities at tomorrow's session. She then asked for comments from the floor.

- Dr. Florence expressed concern that Medicare funds educational programs for physicians but does not fund health educational programs in rural areas. He noted that working in rural environments requires specific training not offered by urban programs.

He also pointed out that all major medical centers in the United States are located within urban areas, with only one medical school located in a rural area.

- Mr. Bausch applauded the Committee for taking up the weighted issue of Medicare redesign. He noted that the placement of Medicare dollars is an overriding rural issue. For example, his hospital does not have a large tax base, industrial base, or much State support to help alleviate the high costs of operation. Lack of funds has also severely decreased home health services, which are crucial in most rural environments. He admitted that the task of transitioning from total Federal support to State and local support in many rural areas will be a difficult one because there are "no quick fixes."
- As a follow up to Mr. Bausch's comments, Ms. Richardson pointed out that in most States public health is funded so poorly because of Federal cuts that it has had to move away from its focused public health mission to providing services like home health and other personal services to survive. She also noted that there are some positive aspects to the current Medicare program. For example, it currently funds medical education, public health to some extent through certain types of payments, and rural health, although not very successfully. She asked NACRH members, as they discuss Medicare redesign, to determine which Medicare provisions should be considered for redesign and which provisions should not be changed.

Monday, September 11

Chairwoman Kassebaum Baker opened the meeting by asking Ms. Hughes to report on her participation at the 9th International Congress of the World Federation of Public Health Associations (WFPHA), held in Beijing, China, on September 6, 2000. A draft report on the challenges for public health was adopted by the Congress in Beijing and is expected to be adopted by the World Federation within the next couple of months. Sixty countries were represented at the Congress, including the U.S. Public Health Association. These countries, which are trying to eradicate disease around the world, agreed at this time to promote three main points worldwide for both urban and rural areas. These points are advocacy, partnerships, and mobilization, which when put together will bring about positive social change. Other issues discussed at the Congress were the lack of potable drinking water and environmental pollution and its impact on health care.

Following Ms. Hughes's comments, the Committee discussed the structure of this morning's session and how best to shape the parameters of the Committee's Medicare redesign recommendations, which will be presented in a final report to the Secretary of HHS. The group was asked whether they should consider reshaping Medicare in specific terms or use a broader approach in their discussion of Medicare redesign. Suggestions on this subject include the following:

- (1) Take a fresh look at the current Medicare situation and develop straightforward solutions to present to the Secretary.

(2) Think globally to determine clear rural-related objectives that should be included in any proposed Medicare change.

(3) Determine what this program should be doing for its beneficiaries.

(4) Determine what has or has not worked with certain elements of the program and decide whether or not they should be restructured, and if so how.

(5) Narrow the focus and use RUPRI as a guideline to address rural issues that are relative to anticipated changes in the Medicare program.

After a brief discussion, NACRH members decided to start with the development of recommendations for specific changes to the Medicare program as they relate to rural objectives and later develop more global recommendations about the structure of the program. Chairwoman Kassebaum Baker suggested beginning the discussion with the issue concerning access to health care from a rural perspective, which raised the following comments and questions:

- Dr. Eckstat suggested to continue and expand support for CAHs in rural areas. This is a key access issue for the small hospitals that are closing at a rapid rate in rural areas. He also mentioned that the National Health Service Corps, which is not yet authorized, should also be supported, as should medical education with incentives for primary care.
- Dr. Wakefield asked the panel to think about what minimal medical services Medicare beneficiaries should have access to in rural areas. For example, should they have access to primary care or to medical services? And what is the minimum level of these services? Dr. Wakefield believes answers to these questions should be determined before the panel examines the Medicare infrastructure as a whole and the specific services it provides.

Dr. Mueller views access in terms of "access to the continuum of care and the services that are within that continuum of care." Currently, Medicare pays for a professional medical service and is not concerned with a beneficiary's access to that service, which could require driving considerable distances for just a consultation. Because Dr. Mueller would like to see health care services made as convenient as possible for the beneficiary, he recommended that Medicare start funding telemedicine or telehealth hookups between rural and urban health facilities.

- Chairwoman Kassebaum Baker asked about the exact benefits that Medicare should cover and if there should be special benefits for rural populations. Dr. Mueller responded by saying that benefits for urban and rural environments should be the same and that the term access is more the means of delivering those benefits and should not include the benefits themselves.
- Ms. Hughes views the access issue as "access to an integrated health care package that includes a whole spectrum of services (e.g., primary care, specialty care, rehab services, home health care, and prescription drug benefits) and reimbursement for those

services, with a particular need for equity adjustments based on rurality." She also believes that demonstrations of telecommunications, telehealth, and telemedicine applications are making a difference in a majority of rural areas.

- Mr. Berk suggested creating "financial incentives for beneficiaries who live in safety net areas to use safety net access." These incentives might also "keep the health care local." On the basis of Ms. Hughes's and Mr. Berk's comments, Chairwoman Kassebaum Baker recommended that a basic benefits package with adjustments for rural incentives be established.
- Mr. Cannington believes that it is imperative to have health care services that are both immediate and appropriate and that these services should be considered when redesigning payment mechanisms as they relate to access. These services also must be provided, at least at the minimum levels, to all rural populations.
- Ms. Richardson brought up the much-cited problem of retaining providers in rural areas and the disproportionate share of hospital payments that go only to hospitals and not to the uninsured in rural settings. Dr. Martin responded to the first part of her comment by pointing out that in rural Maine a provider usually opts for an urban practice because of his or her spouse's discontentment with the rural environment. Chairwoman Kassebaum Baker noted that the responsibility of keeping providers in rural areas falls on the State and on State medical schools. They should provide some type of support structure or respite measures for solving this problem.
- Some Committee members suggested a shift in emphasis from diagnosis to case management, as well as providing incentives to schools with good track records for placing graduates in rural locations.
- Mr. Berk agreed with all these suggestions, but believes that if patients do not use the rural facilities, the health care system will become ineffective and eventually close as a result of financial problems. Dr. Mueller remarked that this problem is a local concern, not a Medicare concern.

Ms. Hughes brought up the issue of consumer utilization in response to Mr. Berk's comments about the lack of utilization of rural health care systems. She noted that uninsured rural residents are less likely to seek medical care unless an emergency arises. These are the same people who will more than likely continue this practice after they become eligible for Medicare at age 65. Ms. Hughes asked whether some kind of consumer education exists that is responsible for educating people approaching Medicare age about the importance of attaining health care services. As an example of educating rural residents on a new type of health care technology so as to win their acceptance, Ms. Hughes cited the introduction of a telemedicine system to an Arizona Indian reservation. In this case, she introduced the new technology to the tribal leadership and community by asking the medicine man to bless the new telemedicine system. By doing this, cultural acceptance was secured and the new system was successfully implemented.

Ms. Hughes then briefly discussed the issue of asset management as it relates to Medicare. She pointed out that the panel is talking liberally about Medicare's shortcomings and not enough about the program's assets. She suggested that the Committee might want to discuss Medicare's positive features and then build on those.

As an example, she cited John McKnight's (Northwestern University) concept of asset mapping. This concept is used at the grassroots level in small communities to determine a community's assets. Once determined, a community can more easily establish policy because it is easier to build on positive attributes than build on negative ones.

Dr. Bailey would like to see Federal granting sources require States to conduct open dialog with their communities (e.g., via local health departments or rural health clinics) on local health care concerns. She questioned whether this same type of interaction could occur to better direct Medicare payments toward community needs.

Mr. Fitzsimmons believes that in addition to access to providers and services, beneficiaries should have access to different health plans. He reasoned that multiple plans lead to competition, which in turn leads to greater affordability for Medicare eligibles. He mentioned that Texas has seen a dramatic decrease in the number of plans available, in urban as well as in rural areas. In the Houston marketplace right now the number of Medicare HMOs has been reduced to one plan. In closing, Mr. Fitzsimmons said that the optimal health care situation does not exist anywhere right now but that possibly HMO-type plans or Medicare+Choice programs could be successful in rural areas.

Dr. Wakefield cited the definition of access from the Physician Payment Review Commission as being the ability to obtain needed medical care. This definition asks two questions: (1) What type of infrastructure should be in place? and (2) What are the payment mechanisms that need to be in place to ensure that Medicare beneficiaries in rural areas are able to obtain the needed health care? Dr. Wakefield also mentioned that a local web site or a network of essential services for Medicare beneficiaries should be available in rural areas. This network should provide the location of services that are close to where beneficiaries live.

Next, Chairwoman Kassebaum Baker steered the discussion toward the design and financing of a basic Medicare package. She favors a basic plan that would be offered to everyone, with adjustments and flexibility for the rural population. She asked the panel whether the State or Federal Government should be responsible for providing the extra resources for the additional continuum of care needed, that is, how can a program be adjusted and put together that meets the additional services over and above the basic package of benefits. Highlights of the groups' varying opinions follow:

- Dr. Mueller questioned the relationship between the financing of the benefit and the delivery of the service. He wondered how the benefit would be used to pay for the service, especially in rural areas.
- Dr. Eckstat favors a plan based on models that work and would allow flexibility in the use of Federal dollars as opposed to prescribing how each Federal dollar should be spent.

State plans should not be relied on because of the possibilities of vast inequities in their resources. Dr. Eckstat prefers to use a model that is based on community-based decision making because it is more specific to the needs of the community.

- Ms. Richardson suggested that Medicare examine the infrastructure of rural areas as well as intercity areas in terms of its financing system and the benefits that it is financing.
- Chairwoman Kassebaum Baker asked the Committee whether they agreed that the dollar amount Medicare pays to beneficiaries should be the same regardless of geographical location. She also asked whether adjustments of the payment structure should be made at the community, State, or Federal level. Mr. Martin responded that certain benefits should be the same in all States but that the dollar amount would have to shift. He also said that the basic package and the payment structure should be a national decision but that add-ons could be debatable. Mr. Cannington agreed that the basic package should remain at the Medicare level but added that decisions concerning adjustments should also be made at this level.

In response to Chairwoman Kassebaum Baker's statement that the decision making for adjustments in financing and its flexibility should be in the hands of the State or local communities, Mr. Martin stated that he has no problem with the State picking up 5 or 10 percent of the access costs but that he wants assurance that the benefits will remain the same throughout all States. Mr. Cannington would like to see Medicare pick the access costs, which would ensure that rural beneficiaries are not paying these costs.

- Ms. Hughes proposed a basic package that includes some level of the core services suggested by the Committee. These services include:
 - ambulance and emergency,
 - primary care,
 - rehab,
 - medical/behavioral health,
 - dental,
 - inpatient care,
 - home health care,
 - prescription drugs, and
 - prevention/health education.

She also asserted that States should negotiate some type of formula in the establishment of adjustments to individual services because of State differentials in providing these core services. States should be closely monitored to make sure they give rural areas the same amount of money as they give urban areas.

In continuing the discussion on financing a basic set of benefits, Chairman Kassebaum Baker asked if the adjustment in the financing could be a "Federal and State mix" rather than just a Federal operation. Dr. Mueller noted that access and finance are mixed now and that everyone has the opportunity to access appropriate services. What he would like to see is Federal financing for a basic set of benefits that is the same across the board. Chairwoman Kassebaum Baker voiced concern that as the number of Medicare eligibles grow, financial problems will

increase; therefore you must have either greater beneficiary support, possibly with a Part B benefit or a Part C benefit (i.e., a prescription drug program), or a mix of State, regional, or community support to help structure additional funding to ensure rural area access to services. These comments evoked discussion from the Committee.

- Dr. Eckstat's suggestion for an equitable and flexible system would include capitation-based payments at the community level. In other words, this system would allow communities the flexibility to determine their resources and then allocate those resources on a per capita basis for whatever need they may have. This concept is different from a system in which the Federal Government determines community needs and where to allocate the dollars. He also suggested offering beneficiaries a choice of systems, such as a combination of a capitated system, a fee for service system, or some other successful model, from which to choose.
- In reference to building flexibility at the community level, Dr. Wakefield affirmed that flexibility is currently a part of the Medicare program. Although the amount of reimbursement may vary by the location of the service, there is flexibility in terms of what delivery system is in place to get that service out to the communities. She then posed several questions to the NACRH members. She first asked for a definition of flexibility in terms of infrastructure, services delivered, or types of providers, and then asked whether the panel was inferring that States should ensure the infrastructure to be accessed by the entire community or that States should have responsibility for just ensuring access for Medicare beneficiaries.

Although these questions weren't answered directly, Ms. Richardson noted that many inequities will exist in infrastructure payments because the socioeconomic status of each State is different.

- Mr. Ahrens asserted that it would be difficult to have a Federal program subsidized by the States. Each State's subsidy would be a different amount, causing inequities in benefits among States. He believes that beneficiaries are entitled to the same benefits no matter where they live and that the States should be responsible for designing a delivery system that ensures a certain amount of access. He was unsure whether he would keep the same rural/urban differential design as it is today.

Chairwoman Kassebaum Baker added that Medicare should be responsible for some the basic overhead costs. The financial burden of overhead costs is a dominant problem in low-volume areas. Dr. Myers commented that Medicare should be structured so that the State and the community would have discretion in allocating those overhead funds.

In response to a comment that many people do not understand how Medicare works, Mr. Morris explained that money for Medicare comes from payroll taxes to provide health care services for individuals in their retirement. Medicare recipients are guaranteed the Part A benefit and pay an additional contribution for the Part B benefit.

The discussion then turned to addressing more conceptual and innovative ways to improve the Medicare package. Mr. Ahrens suggested that the Federal Government determine the price for

a basic package by per population eligibility in a particular State and provide that State with a lump sum of money, or block grant, for a basic benefit package for each resident. Resources would not be used for services (e.g., burn units or kidney transplant operations) in a particular area if they were not in great need. Patients would always have the option to receive these specialized services at other locations.

Ms. Richardson proposed the need for some type of risk adjustment attached to these block grants to accommodate more populated areas and rural areas in which more resources are required. In response to this comment, Chairwoman Kassebaum Baker noted that block grants would allow for a certain amount of overhead, and the States would determine its use.

As another innovative option for the Medicare program, Ms. Hughes suggested to create rural health service districts or areas that are funded by local community taxes to address community needs. Although these service areas have worked well in Arizona, Mr. Martin admitted they have not worked well in Maine because of the politics involved.

Although she thought these innovative concepts were somewhat radical, Chairwoman Kassebaum Baker recommended that the group think about the issues for future debate.

Next, in response to several inquiries on the actual cost of health care delivery in rural areas, Dr. Myers claimed that the current spending is 29 percent less for a rural beneficiary than for an urban beneficiary. Mr. Morris mentioned that no one really knows what the true cost of health care delivery is in rural areas. He suggested that the Committee include in its final Medicare report costs for health care delivery in rural environments and a payment system designed around those costs. Cost figures currently used are pulled from a 1983 database that has not been updated. Mr. Morris noted that the health care system has changed dramatically since then and "yet we're still applying Band-Aids to the shortcomings of an antiquated system."

Chairwoman Kassebaum Baker then turned to the floor for comments.

- Lyle Snyder, a research director for the UK Center for Rural Health, proposed drafting a healthy rural people 2010 policy paper similar to the current Healthy People 2010 document that is being promulgated through the NRHA. The proposed policy paper will contain more health care provisos and entries for rural areas than the current document, particularly regarding the type of health care services needed in these areas and the methods for organizing these services.

Mr. Snyder asked rural health care professionals to closely monitor the number of physicians coming into rural areas and find ways to encourage them to remain in these areas. He also stressed that if the current system is going to improve, then nontraditional health interventions must be introduced. He encouraged the Committee to consider optimal collaboration among

agencies that could have an impact on health care (e.g., social support systems, educational systems, the Public Health Service, and health care organizations from the nonprofit sector).

- Mr. Goetz gave a brief historical perspective of health care planning and how it has affected rural eastern Kentucky. Previously, eastern Kentucky's health care system was regulated by a health systems agency, with more than two-thirds of the board from rural regions and 10 out of 30 employees from the blue grass area. After the building boom hit the nation in the 1980s, most of the major health care facilities and their resources ended up in urban areas. Because these large urban facilities were overbuilt, they were more costly and underutilized. Yet they continued to receive more funds from public institutions than health facilities located in sparsely populated areas, even though these rural facilities provided the same kinds of medical services.

He also mentioned inconsistencies with graduate medical education reimbursement. Hospitals located in urban areas receive five to six times the graduate medical education reimbursement than rural areas receive, and the quality of education provided by both has been proven to be the same.

Mr. Goetz then discussed a number of problems, as he sees them, with health care access, human health care resources, and the lack of support systems in rural environments. Although the KY Center for Rural Health does not have solutions to many of these problems, it has taken a couple of steps in that direction. The Center works closely with a number of communities so as to solicit funds to supplement the Center's programs. In return, the Center encourages University of Kentucky faculty members to live in these communities. The Center also finds faculty members to relieve those who need some time off.

- Loyd Kepferle noted that a partial solution to health care problems in rural areas is "getting health care professionals into the rural communities, training them, and then holding on to them." Eastern Kentucky has had a fairly high success rate in this respect. About 70 percent of health care professionals trained in rural Kentucky remain in the area. The physicians alone, those who have graduated from the University of Kentucky and are living in the local communities, have generated \$35 million for those communities and have incurred training costs of only about \$6 million.

Chairwoman Kassebaum Baker, in following up on Dr. Myers' suggestion to form a subcommittee to help ORHP draft the report on Medicare redesign, called for volunteers to serve on the subcommittee. Mr. Cannington was designated as chairperson. Each Committee member will receive a copy of the draft for review.

Dr. Myers agreed to formulize all the points made at today's session for presentation tomorrow. Chairwoman Kassebaum Baker thanked NACRH guests for their contributions and then gave Committee members last-minute instructions for their afternoon site visits with staff from ARH Home Health Services and the Homeplace Project Lay Healthworker Project.

Tuesday, September 12

Roundtable Discussion on Home Health Care

Les Rogers, ARH Home Health Care Services

Mr. Rogers provided NACRH members with a brief history of the ARH Division of Home Health Care Services. This division was created in 1983 because the local hospital administration was largely ignoring the value of its on-site health care agencies and paid little attention to new developments across the continuum of care. Under the direction of a new hospital president, home health care became a highly visible autonomous unit with a \$3 million budget, growing from 3 employees to 800 professionals over a short period of time.

Over the years ARH, with help from the University of Kentucky, has provided quality health care to the residents of Appalachia, offering a continuum of care such as occupational, physical, and speech therapy, nursing assistance, and AIDS services. The agency was fortunate to survive the impacts of the Balanced Budget Act of 1997 (BBA), even though its budget was reduced from \$80 million to less than \$40 million, and it lost a number of skilled nurses and other health care professionals. At present, ARH is trying to eliminate an additional 15 percent budget reduction that BBA is trying to impose on its services.

Mr. Rogers then introduced three coworkers from ARH: Russ McGuire, Floyd Davis, and Ellen Peets. In response to a question about the prospective payments system and the possibility of it causing ARH to lose some of its services, Mr. McGuire informed the panel that the agency is working hard at maintaining the highest quality of care for its patients throughout the service area despite issues surrounding the BBA and the PPS. The agency is also prepared to work closely with physicians in the community in establishing appropriate protocols and appropriate delivery of services. As new regulations are passed that affect home health care services, ARH's goal will remain the same-"to provide top-quality health care and to adjust the service delivery to the appropriateness of care."

Mr. Rogers noted that ARH finished out its fiscal year losing more than \$2 million in home services by providing care for 27,000 patients and making less than 400,000 home visits. Approximately 30 to 40 percent of home health agencies in the nation that were operating in 1996 are no longer in existence. He expressed concern that hospitals are going to start having financial difficulties again because they are losing their ability to shift costs. (Two hospitals have already closed because of financial problems, although none have closed recently in eastern Kentucky.) In addition, soft money cannot be relied on anymore to keep the health care system

solvent, and the reimbursement payment system has completely changed, causing problems for both providers and beneficiaries.

Mr. Rogers also is concerned about the cost of maintaining state-of-the-art knowledge within health care agencies, such as keeping abreast of new medications, new medical procedures, new equipment, and new approaches to inpatient care. He noted that as the baby boomers move into middle age, they will make up the largest single cadre of people in the United States. In about 15 years, this group will cause large drains on the medical system, and "there will not be enough money in the world to take care of them in an inpatient setting." One possible solution in alleviating this drain is to start putting funding in place now to develop the necessary clinical expertise so that a large portion of medical care can be done in the home.

Discussion

Following Rogers' presentation on the ARH Home Health Care Services, Committee members offered respective comments.

- Both Ms. Hughes and Mr. Ahrens were concerned about recent hospital closings and the impact these closings might have on the local communities. In response to Ms. Hughes's question about how many hospitals in the area were switching to CAHs to prevent their termination, Mr. Rogers said that two hospitals, one in Summers County and one in Morgan County, were about to convert to CAHs.

Mr. Ahrens commented that if you lose hospitals, you lose home health care. He suggested soliciting help from senators and representatives at the Federal and State levels not only to help save hospitals financially but also to help put together a seamless health care system in which the system follows a patient throughout all stages of treatment and care, with the dollars following the patient accordingly. The challenge lies in "keeping the bucks with the patient."

- Several Committee members were impressed by ARH's well-organized system of care and asked if other models similar to this one existed in the United States. It was mentioned that ARH, a couple of years ago, was ranked the second or third largest rural care system in the country.
- Mr. Cannington asserted that he would like to see a redesign of the payment system so that a portion of the resources could be used for preventive medicine, for example, automatically testing a diabetic patient's family for symptoms of the disease. He asked about special challenges faced by home health agencies or health care systems operating in rural environments as opposed to the challenges faced in urban areas. Mr. McGuire responded that topography and the highway infrastructure were the most severe challenges for health care workers in eastern Kentucky and southern West Virginia. Some health care professionals travel more than 100 miles a day to see patients.

Another challenge for health care workers in rural areas is increasing the health care knowledge of the populace. In many areas of eastern Kentucky, deeply ingrained traditional beliefs about health care exist, as well as a traditional bias toward certain vices. For example, it is difficult to convince those who live this area of the health risks of smoking, especially when the tobacco lobby is so strong in this part of the State. Furthermore, as young people move from rural to urban centers, rural populations become older and sparser, resulting in rural communities having more difficulty supporting a large range of medical services that are available in urban areas.

ARH realizes it must take the necessary steps to address these challenges and bring its organization into the 21st century. It has installed 83 laptops with state-of-the-art information systems in the hands of the center's nurses. An improved highway infrastructure and improved computer applications (e.g., telehealth) in rural health care have already helped negate some of these problems.

- Mr. Cannington questioned the adequacy of health care data received by rural communities, hospitals, and health systems and asked whether this information is reliable for making good medical decisions. Mr. McGuire replied that ARH health care providers have done an excellent job collecting data but that these data have yet to be analyzed and presented in a format appropriate for decision making. An increase in Internet use in rural areas will soon make data collection, analysis, and delivery more efficient.

Ms. Hughes expressed appreciation to the family health advisors for conducting Monday's site visits and commended them for their devotion and hard work. On behalf of NACRH, Chairwoman Kassebaum Baker thanked Mr. Rogers and his coworkers for their insightful presentation on home health care activities and expressed gratitude to Mr. Rogers and his wife Audrey for generously hosting the Committee dinner Monday night. After presenting Dr. Myers with a departing gift from NACRH members, Chairwoman Kassebaum Baker discussed the Medicare reform priorities compiled by Drs. Myers and Calico from Monday's discussion. She asked the members to carefully review these priorities and pass any comments onto ORHP staff as soon as possible so that the comments may be incorporated into a final report to be put before the incoming HHS Secretary after the first of the year. The report will be discussed at the next NACRH meeting to be held in Washington, D.C., on February 4-6, 2001. The next on-site visit has been tentatively scheduled for the second week in June in Sacramento, California.