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RURAL NEGLECT

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NATIONAL RURAL HEALTH ASSOCIATION

To: Senate Rural Health Caucus Steering Committee
From: Darin Johnson, Government Affairs Director
Re: Balanced Budget Act Relief Priorities
Date: August 18, 1999

At the request of several members of Congress, the National Rural Health Association (NRHA) would like to share its members' legislative priorities as Congress begins to draft legislation providing relief to health care providers being adversely impacted by Medicare and Medicaid provisions contained in the Balanced Budget Act of 1997 (BBA). Because of the cumulative negative impact that reforms contained in the BBA are having on the rural health care delivery system, it is imperative that the reforms outlined below be included in any BBA relief measure considered by the Congress.

Attached is a report by the non-partisan Rural Policy Research Institute (RUPRI) that provides data and examples of how the BBA is cumulatively impacting our rural health care delivery system. The findings contained in the RUPRI report clearly support the need to implement BBA relief targeted at rural health care providers. Without such relief, access to health care for rural Medicare beneficiaries will be put at risk.

Recognizing the need for targeted BBA relief, both the Senate Rural Health Caucus and the House Rural Health Care Coalition introduced omnibus rural health care bills, S. 980 and H.R. 1344, which include a number of important BBA relief provisions. The NRHA, along with a number of other national health care organizations, has endorsed both the Senate and House rural health bills. Because of the scope of each of the measures, the NRHA would like to identify those provisions included the bills which are of greatest priority to our membership. Inclusion of these provisions in a BBA relief measure is crucial to the NRHA's support of any Medicare reform legislation considered by the Congress this year.

Below are the NRHA's BBA relief priorities in order of importance as identified by the association. If you need additional information or have questions about the NRHA's BBA relief priorities, please feel free to contact me at (202) 232-6200 or by e-mail at johnson@nrharural.org.

1. Medicare Hospital Outpatient Prospective Payment System
Exempt Medicare Dependent Small Rural Hospitals, Critical Access Hospitals and Sole Community Hospitals from the proposed Medicare hospital outpatient prospective payment system. [S. 980 - Section 107 and H.R. 1344 - Section 101]

2. Medicaid Reimbursement to Community Health Centers and Rural Health Clinics
Repeal the phase-out of Medicaid cost-based payments to Federally Qualified Health Centers and Rural Health Clinics that was contained in the BBA of 1997. [H.R. 1344 - Section 201 - technical change to language needed]

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3. Health Professional Shortage Area Designations

- Require consideration of pending physician retirements or resignations in designating Health Professional Shortage Areas (HPSAs);
- Require revised standards for HPSA designation through expedited negotiated rule-making process;
- Require DHHS to consider the needs of medically underserved populations and individuals and the percentage of the population over age 65 in developing such standards; and
- Prohibit new methodology for HPSA designation if the methodology is detrimental to rural or frontier communities including that it results in the provision of fewer services.
  [S. 980 - Section 201 and H.R. 1344 - Section 405]

4. Critical Access Hospital Reforms

- Allow hospitals that closed or downsized to a clinic within three years of enactment of this law to reopen as or convert to a Critical Access Hospital (CAH);
- Allow CAHs to choose between two options for payment for outpatient services: (1) reasonable costs for facility services, or (2) an all-inclusive rate which combines facility and professional services;
- Require Medicaid programs to reimburse for services in CAHs;
- Change the 96 hour length of stay limit to a 96 hour average;
- Exempt CAH swing beds from PPS for skilled nursing facilities; and
- Grant CAHs deemed status that will allow for accreditation.
  [S. 980 - Sections 102, 105 and 106 and H.R. 1344 - Section 104 - technical change to language needed]

5. National Health Service Corps Scholarships

Exempt National Health Service Corps scholarships and stipends from federal income taxes. [S. 980 - Section 202 and H.R. 1344 - Section 301]

6. Rural Impact Statements

Require the DHHS, when promulgating or proposing a regulation related to a health care program, to include an analysis of the impact of implementation of the regulation on rural areas, including its impact on: (1) rural safety net providers; (2) rural primary care providers; (3) rural hospitals; (4) FQHCs and RHCs; (5) the economies in rural areas; and (6) rural residents. [H.R. 1344 - Section 401]

7. Graduate Medical Education Reforms

- Increase indirect GME payments to some hospitals by changing the way interns and residents are counted, from including those who were in the hospital during the most recent cost reporting period ending on or before December 31, 1996, to those who were appointed by the hospital's medical residency training programs for the same time period;
- Allow a hospital that sponsors only one residency program to count one additional intern/resident for each calendar year up to a maximum of three more than the limit otherwise determined under this provision; and
- Require DHHS to give special consideration in rule-making not only to facilities that meet the needs of underserved rural areas, as currently required, but to facilities that are not located in an underserved rural area but have established separately accredited rural training tracks.
  [S. 980 - Section 103]

8. Wage Indices for Skilled Nursing Facilities and Home Health Agencies
Require that area wage adjustments for the skilled nursing facilities (SNFs) and home health agencies (HHAs) prospective payment systems be based on wage levels at SNFs and HHAs.
[S. 980 - Section 130]

9. Medicare Rural Waiver
For purposes of Medicare payments, establish waiver process to allow rural providers located in Metropolitan Statistical Areas (MSAs) to be classified as "rural" if they are located: (1) in a rural area as defined by the Goldsmith Modification published in the *Federal Register* on February 27, 1992; (2) outside of an urbanized area as defined by the U.S. Census Bureau; or (3) in an area designated by a State as rural. [S. 980 - Section 126 and H.R. 1344 - Section 123]

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safety net provider
↳ community
migrant health centers
Medicare managed care

Taking Medicare into the 21st Century: Realities of a Post BBA World and Implications for Rural Health Care

Rural Policy Research Institute
Rural Health Panel

February 10, 1999

P99-2

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The Rural Policy Research Institute provides objective analyses and facilitates dialogue concerning public policy impacts on rural people and places.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) **initiated** changes in the Medicare program that have significant potential to alter the landscape in rural health — changing the way care for rural beneficiaries is financed; and, subsequently, the structure of the rural health delivery system. BBA implementation is an evolving process, beginning with federal regulatory policies and eventually leading to local responses, which will require years to complete and assess. This analysis describes the likely impacts of fee-for-service payment changes, summarizes changes in Medicare plan offerings and enrollments in rural areas, and describes anticipated implications for public policy and private sector decision makers. These issues are summarized below.

General Impacts on Rural Health Care Services

Payment changes in Medicare can affect rural hospitals more dramatically than their urban counterparts, because rural hospital operating margins are lower; more rural hospitals experience negative total margins – 15.9 percent vs. 9.8 percent. Specific BBA changes in Medicare payment could have these impacts:

- Medicare outpatient payments, to become prospective payment under the BBA, represent 9.5 percent of revenues for rural hospitals, compared to 7.1 percent for urban hospitals, and changes that lower the total payment could lower operating margins.
- Shortfalls in Medicare revenues for rural hospitals include payment for a host of services, including home health, skilled nursing care, bad debt, and post acute transfers.
- The **net impact** of payment reductions is significant – $79 million for rural Missouri hospitals in the year 2002, 7.4 percent of anticipated revenues for rural California hospitals during 1998-2002, and 17.34 percent of net income annually for one rural Wisconsin hospital.

Other services for Medicare beneficiaries are affected by the BBA, including home health and skilled nursing care. Home health payments were reduced from a maximum of 112 percent of the national average to 106 percent. Nursing home payment will bundle previous separate payment for therapists into a single facility rate. These changes could precipitate the following changes in service delivery in rural areas:

- Home health agencies may avoid high cost patients or reduce services per user.
- Nursing homes may have difficulty recruiting physical therapists as employees of the homes.

Specific Impacts on Rural Safety Net Providers

Community and Migrant Health Centers (C/MHCs) are affected by a provision in the Balanced Budget Act of 1997 (BBA) that allows states to phase out Medicaid cost-based reimbursement.

bad debt

Current reimbursement policy allows C/MHCs to include non medical enabling services in their charges, which would not be the case if new payment systems such as managed care are calculated based only on costs of medical treatment. The impacts are likely to be the following.

- Some states will likely choose to no longer use a cost-based reimbursement approach for Medicaid patients treated at C/MHCs.
- Medicaid managed care plan payments are estimated by Centers to be much less than reasonable cost rates (current basis for reimbursement) to C/MHCs.
- Thirty-three percent of C/MHC revenue is from Medicaid, seven percent from Medicare.
- Without change, current policy may reduce the ability of C/MHCs to provide care to the uninsured.

This issue could be addressed by:

1) requiring cost-based reimbursement for Medicaid patients seen at C/MHCs,
2) devising a prospective payment system that encompasses all services provided by C/MHCs and is appropriately adjusted for service utilization among C/MHC clients, or
3) increasing grant funding to compensate for reduced revenues from public payment.

Small rural hospitals (under 50 beds), which are often the safety net providers in many communities, are subject to the same payment changes that affect all hospitals, unless they are exempt because of sole community hospital or Medicare dependent hospital status. The impacts are likely to be significant because:

59%

- forty-seven percent of rural hospital costs are paid by Medicare,
- twelve percent of rural hospital costs are paid by Medicaid,
- rural hospitals lost 3.7 percent of costs on Medicare business in1994, and
- under the BBA, PPS inpatient payment for all rural hospitals will be reduced 9.6 percent in 2002; accounting for 0.6 percent of all revenues.

This issue could be addressed by:

- extensive use of designations as critical hospitals among the smallest of the rural hospitals, and/or
- policies to protect the financial viability of small rural hospitals that serve as the local safety net provider.

Impacts on Rural Medicare Beneficiaries

The evidence on enrollment of beneficiaries into managed care plan thus far shows:

- only modest increases in the number and percent of rural Medicare beneficiaries enrolled in managed care plans;
- very few health plans being formed and/or offering managed care options in rural counties; and
- managed care plans opting to discontinue operating in 120 rural counties affecting 56,142 beneficiaries, and
- of the affected beneficiaries 15,158 are in counties there will now be no managed care plans available.

Implications

- Constraining Medicare spending by imposing continuing and significant reductions on small rural providers could jeopardize access to care for rural beneficiaries.

- Given low enrollment into managed care and limited use of any Medicare-risk plans in rural areas for the foreseeable future, the impacts of changes in traditional Medicare are of vital concern for the welfare of rural beneficiaries.

- Any changes in payment policies should include a "rural differential," accounting for different impacts on providers as a function of size and location.

- Policies designed to encourage change in the organization of health care services should include resources and suggested models that encourage rural input.

- Reductions in Medicare payment may threaten the financial viability of many rural providers.

- Rural providers might move into other options for organizing facilities, including Critical Access Hospitals, Medicare dependent hospitals, and participating in managed care networks.

- Certain rural providers, especially home health agencies and skilled nursing facilities, might reduce services offered to beneficiaries and/or be selective in who they see.

- Rural health care providers will need to find and implement measures to reduce costs of care, but they are unlikely to find sufficient savings to absorb all revenue reductions.

- Rural health care providers are likely to look increasingly to consolidation of service networks, including participating in urban-based systems.

OVERVIEW

The Balanced Budget Act of 1997 (BBA) **initiated** changes in the Medicare program that have significant potential to alter the landscape in rural health — changing the way care for rural beneficiaries is financed; and, subsequently, the structure of the rural health delivery system. BBA implementation is an evolving process, beginning with federal regulatory policies and eventually leading to local responses, which will require years to complete and assess. There are **opportunities to affect the substance and impact of these changes; both to alter the direction of policy and to influence developments in rural health care delivery systems**. The objectives of this analysis are to:

- describe the likely impacts of the changes made to fee-for-service payment to rural health care providers,
- provide information about changes occurring in Medicare plans offered to rural beneficiaries and enrollment in different plans, and
- describe implications for public policy and private action.

The various provisions of the BBA each affect a component of the rural health delivery system; their combined impact could lead to radical restructuring of the system. In general, the BBA is intended to:

- influence payment in traditional Medicare program (restricting fee for service reimbursement);
- encourage initiatives to change to different payment systems (changing payment policies for risk contracts, including implementing risk adjustment methodologies);
- create incentives for beneficiaries to enroll in capitated plans (presumably to enhance their insurance benefits);
- encourage changing the delivery system (enabling rules for Provider Sponsored Organizations, the rural hospital flexibility program);
- encourage an emphasis on measuring quality of services (quality assurance provisions in the June 1998 regulations); and
- expand insurance coverage for children, and redirect financial support of graduate medical education.

While each provision of the BBA should be assessed on its merits and impacts, a complete understanding of the Act's impact requires integration of clusters of provisions, and then of the entire Act. This analysis will integrate provisions related to payment in the traditional Medicare program, and provisions designed to encourage expansion of choice for rural beneficiaries.

PAYMENT POLICIES

Most of the savings in the BBA were the result of changes in reimbursement paid through the traditional Medicare program, $100 billion during the years 1998-2002.[1] Those savings were achieved by limiting annual payment increases, converting cost-based reimbursement to prospective payment systems, and changes in policy (including reducing payment for certain cases where discharges are from hospitals to other Medicare providers, capping payment to certain rural health clinics, phasing out requirements for Medicaid cost-based reimbursement, and reducing payment for certain services). Individual reductions may not lead to drastic changes in availability of services. However, when considered in total, they may threaten certain health care providers in rural areas.

Can Institutional Providers Adjust to the Changes?

The BBA achieves budget savings by constraining payment to health care providers, and specifically to institutions providing care (there is some adjustment in payment to health care professionals in Section 4502, which matches updates to the conversion factor to a "sustainable growth rate"). An important way to view the changes is to consider the effects on *services being provided* to Medicare beneficiaries, and *services available* to everyone in a given community. Each major change in payment, including conversions from cost-based reimbursement to prospective payment, potentially affects the abilities of providers to deliver services. Since the changes are being implemented in the context of achieving budget savings, we assume new payment levels will be set to lower expected expenditures, which of course means less than anticipated revenue for providers. When all such payment adjustments are considered together, the total impact on small rural systems serving disproportionate shares (higher percentages than most other providers) of Medicare beneficiaries and/or uninsured persons could be quite severe. Consider that each of the payment for each of the following categories was changed by the BBA:

- Hospital inpatient services
- Hospital outpatient services
- Home health services
- Skilled nursing services
- Hospice services
- Ambulatory services provided by federally qualified health centers
- Ambulatory services provided by rural health clinics
- Ambulance services
- Outpatient rehabilitation services
- Ambulatory surgical services

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[1]U.S. Congressional Budget Office. "Budgetary Implications of the Balanced Budget Act of 1997." CBO Memorandum. December, 1997.

In addition to changes in payment for services, other changes in the BBA affect payment to providers for specific purposes:

- Certain hospital discharges to post acute care (lowering hospital payment)
- Reduction in disproportionate share payments
- Reduction in capital payments for PPS hospitals
- Payment for clinical diagnostic laboratory tests
- Reductions in payments for graduate medical education
- Medical education and disproportionate payments attributable to outlier payments
- Cap on TEFRA limits (PPS-exempt hospitals)
- Reductions in allowable costs of bad debt [2]

The net impact of these changes is best illustrated by more thorough consideration of the impact on three groups of providers, which may be combined in single organizations: hospitals, skilled nursing facilities, and home health agencies. Combined, these categories account for a majority of Medicare expenditures, and home health is the most rapidly increasing component of Medicare expenditures.[3]

Impacts on Rural Hospitals

The BBA affects the major categories of payment to hospitals — inpatient and outpatient services — as well as a host of other services offered by hospitals. The impact in any given category may be absorbed as only a small percentage of any hospital's total Medicare payments, but the combined impacts could threaten the viability of providing Medicare services, and perhaps the financial security of the hospital. At this early time in the post-BBA era, we cannot be certain about the ultimate outcome in service availability, but we can develop scenarios to illustrate the potential outcome.

Changes in Medicare payment can have a ***disproportionately negative impact on many rural hospitals***, as a function of hospital size, dependency on Medicare revenues, share of Medicare business that is through the traditional program, and hospital management. In hospital fiscal year 1995 (actual months vary across hospitals), 15.9 percent of rural hospitals experienced negative total margins, as compared to 9.8 percent of urban hospitals. Among rural hospitals, only 2.5 percent of rural referral centers had negative margins, compared to 18.2 percent of sole community hospitals

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[2]For details of these provisions, see the Health Care Financing Administration web site <www.hcfa.org> and locate the summary of provisions from the Balanced Budget Act of 1997; or contact RUPRI through Keith Mueller at the Nebraska Center for Rural Health Research, <kmueller@unmc.edu> or phone: (402) 559-5260.

[3]It should be noted that prescription drugs are not included in Medicare expenditures, since the only means of collecting Medicare payment for them is when they are dispensed in the hospital.

and 15.8 percent of all other rural hospitals.[4] To be more specific to a provision of the BBA, use of prospective payment to derive savings from hospital outpatient payment, those payments account for 9.5 percent of revenues for rural hospitals, as compared to 7.1 percent for urban hospitals. All types of rural hospitals are between 9 and 10 percent dependent on Medicare outpatient payment for their revenues.[5] Further analysis shows that the smallest hospitals are the most vulnerable to Medicare outpatient revenue.

Another means of examining effects of BBA changes on hospitals is to forecast lost revenues as the difference between Medicare payment before and after the BBA provisions take effect. All hospital services are threatened if the cumulative impact of the BBA changes force decisions to cease operations or to reduce levels of services (either by dropping services or groups of patients such as the uninsured or Medicare beneficiaries). ***The impact of the changes in inpatient prospective payment can account for as little as only approximately 1/3 of the reduced Medicare revenue predicted for rural hospitals, as in the case of the example from Missouri hospitals described below; and the conversion to outpatient PPS is not yet included in these calculations.*** The **net impact on rural hospitals is the sum of a number of different payment changes that affect PPS hospitals**.

Some hospitals have estimated annual impacts through the year 2002. Missouri's rural hospitals estimate annual shortfalls to be $32 million in 1998, $45.3 million in 1999, $62.1 million in 2000, $70.4 million in 2001 and $79 million in 2002, from the aggregate total of reduced growth or cuts in the following payments:

- Payment for post acute transfers
- DRG payment rate of growth
- Elimination of formula-driven overpayment for certain hospital outpatient services
- Reduced capital payments
- Reduced disproportionate share payments
- Tax Equalization and Fiscal Responsibility Act (TEFRA) cap (applies to non-PPS hospitals)
- TEFRA relief payments
- TEFRA bonus payments
- TEFRA capital payments
- Bad debts
- Indirect Medical Education (IME) payments
- Home health cost limits

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[4]Penny E. Mohr, Bonnie B. Blanchfield, C. Michael Chen, William N. Evans, and Sheila J. Franco. "The Financial Dependence of Rural Hospitals on Outpatient Revenue." Working Paper. The Project Hope Walsh Center for Rural Health Analysis. July,1998.

[5]Ibid.

- Home health per beneficiary limits
- Skilled nursing facility payment [6]

Hospitals in California used the following categories to calculate impacts for the years 1998-2002, inclusive:

- Update reduction
- PPS capital reduction
- IME reduction
- Graduate medical education reduction
- Transfer payment change
- Elimination of outlier add-on
- Outpatient PPS (using preliminary estimates)
- Reduction in PPS exemption

The current payment and total impacts were calculated for each of the 52 Congressional districts in the state. The totals for eight rural districts were:

- $8043.1 million expected payment, and
- $598.7 million in reductions (7.4 percent of anticipated revenues).[7]

A rural hospital in Wisconsin estimated annual losses from the following changes:

- Reduction of DRG weights
- Reduction in Federally Driven Overpayment calculation
- Home health cost limits and per beneficiary cost limits
- Bad debt reimbursement
- Transfer rules for home health

The resulting impact on hospital income was estimated to be 6.1 percent of Medicare reimbursement, and 17.3 percent of net income.[8]

As evident from the above analyses, rural institutions can only estimate impacts since final decisions about the specifics related to new payment formulas (e.g., prospective payment) have not been made. As a result, the estimates tend to be underestimates because not all possible impacts are considered

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[6]From the Missouri Hospital Association, with assistance from the accounting firm of Baird, Kurtz & Dobson. December, 1998.

[7]California Hospital Association. December, 1998.

[8]Calculations completed by the Chief Financial Officer of the Hospital.

in any of the calculations. The important question for service delivery to rural beneficiaries and others is can these reductions in reimbursement be absorbed by rural hospitals? While only the test of time could answer the question definitively, an intuitive answer would be no, not without changes in hospital finance and/or organization.

Impacts on Skilled Nursing Facilities and Home Health Agencies

Some impact from conversion to prospective payment for these services was evident in the analysis of hospital revenues above. For skilled nursing facilities the BBA extends the cost limits already in place and requires a three-year phase-in of prospective payment. During the fiscal years 1998 and 1999 the update in the rate will be one percentage point less than the update in the market basket increase for that year. Prospective payment is also to be phased in for home health services, with a new interim payment system (IPS) to be used until PPS is operational. The IPS restricts cost-based payments to home health agencies.

For skilled nursing facilities the phase in of prospective payment has just begun, and the full impact on rural services will be evident only as the rate is determined more by the national PPS rate (only 25 percent national in the first year). The new payment system also bundles payments previously made separately into a single payment to the facility. Facilities that had contracts with providers that billed Medicare directly will now have to pay for those therapy services out of their facility rates. This could affect payment for those services. In places where there are current or potential shortages of physical therapists, the new system may affect the facility's and community's abilities to recruit and retain these health professionals.

For home health agencies, payments per visit are limited to 106 percent of the national average (reduced from 112 percent), and each agency is capped on how much payment it will receive from each beneficiary. The per beneficiary limits may induce agencies to screen the patients served, avoiding high cost patients. The per beneficiary limit may have a differential effect in rural areas where fewer beneficiaries use home health services but have more visits per user. In the absence of such changes, home health agencies, and/or their branch offices, may close.

Are Rural Safety Net Providers at Greater Fiscal Risk?

When the federal government joins other (private) health plans in the rush to find fiscal savings by reducing payment for care delivered to insured persons, the margins needed to finance care to the uninsured are threatened. Resolving what becomes a fiscal bind shared by safety net providers (those "institutions, programs, and professionals devoting substantial resources to serving the uninsured or social disadvantaged"[9]) becomes an important public policy problem, whether

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[9]R J Baxter and R E Mechanic, "The Status of Local Health Care Safety Nets." Health Affairs 16 (4) July/August, 1997: 7 - 23.

addressed by changes in payment for publicly insured persons, or separately with direct assistance to safety net providers. Rural safety net providers include the following:

- Community and Migrant Health Centers
- Federally Qualified Health Centers
- Hospitals
- Physicians
- Rural Health Clinics

The burden of providing uncompensated care varies among rural providers, but all on the list are, at least in some rural communities, the primary source of care for the uninsured and therefore treat a significant proportion (above 5 percent) of non-paying patients. Rural safety net providers, because of the overall preponderance of Medicare patients for all rural providers, and because of the special niche the safety net providers occupy, are more likely than others to rely on public insurance programs for a high percentage of their patient revenues. Therefore, reductions in payment from those programs could reduce abilities to provide uncompensated care and create holes in the safety net. Two classes of rural safety net providers illustrate this point.

Community and Migrant Health Centers

Revenue dependency: 33 percent of all revenues for C/MHCs is from Medicaid
7 percent is from Medicare
29 percent is from federal grants
9 percent is from private insurance
7 percent is from patients
15 percent is from other (than Medicaid) state and local[10]

BBA Provision: Allows state government to phase out cost-based reimbursement, without requesting Medicaid waivers. If C/MHCs participate in Medicare+Choice plans, those payments would likely be reduced.

Potential Impact: Medicaid revenues would likely be reduced. One estimate is that Medicaid managed care plans, on average, pay less than 60 percent of the Centers' reasonable cost rates (basis for cost-based reimbursement).[11]

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[10]Taken from Daniel R. Hawkins, Jr. "Statement on The Effects of Managed Care and Other Health System Trends on Community Health Centers." Presented to the Institute of Medicine. May 8, 1998. Figures represent 1966 revenues.

[11]Daniel R. Hawkins and Sara Rosenbaum. "The Challenges Facing Health Centers in a Changing Healthcare System." Ch. 6 in Altman, Reinhardt and Shields, eds. The Future U.S.

Resolution: Three approaches have implications for the federal budget, but are the only solutions that would assure C/MHCs continued financial viability. First, the requirement for cost-based reimbursement could be reinstated, perhaps modified to apply only to certain services (the "wraparound" services provided by centers). Second, a separate prospective payment formula for health centers could be developed that reflects the costs of all the services they provide which would otherwise not be reflected in a formula based on costs of all ambulatory care providers. Third, federal grants could be increased to substitute for the previous margins in the public programs.

Other potential resolutions would include increasing private funding through successful competition for managed care contracts, increasing funding from state and local sources, and increasing funding from private contributions. While Centers should be expected to pursue these options and implement management efficiencies, these approaches are not certain to fill in all gaps.

Small Rural Hospitals

Rural hospitals with fewer than 50 beds are "important in the fabric of the safety net." These hospitals are disproportionately represented in the highest decile of hospitals classified according to ratio of uncompensated care costs to operating expenses.[12]

Revenue Dependency: 47 percent of all rural hospital costs covered by Medicare
12 percent covered by Medicaid
5.4 percent uncompensated care
3.7 percent loss on Medicare in 1994
4.7 percent loss on uncompensated care in 1994
1.3 percent loss on Medicaid in 1994[13]

Healthcare System: Who Will Care for the Poor and Uninsured? 1998. Chicago: Health Administration Press. Data are taken from a letter prepared by the National Association of Community Health Centers.

[12]Linda E. Fishman. "What Types of Hospitals Form the Safety Net." Health Affairs 16 (4) July/August, 1997: 215-222.

[13]Stuart H. Altman and Stuart Guterman. "The Hidden U.S. healthcare Safety Net: Will It Survive." ch 9 In Altman, Reinhardt and Shields, eds. The Future U.S. Healthcare System: Who will Care for the Poor and Uninsured? 1998. Chicago: Health Administration Press. Data are taken from the Prospective Payment Advisory Commission analysis of American Hospital Association Annual Survey of Hospitals data.

BBA Provisions:	PPS payments for *all* rural hospitals reduced 9.6 percent in 2002. Net impact of 0.6 percent on all revenues in 2002[14]
Potential Impact:	For small rural hospitals not qualifying for full cost-based reimbursement under rules of exception (such as sole community hospital designation), reductions in the PPS payment could cause financial ruin and trigger decisions to close the hospitals. While the overall impact on revenues may seem small, these hospitals operate on narrow or often negative operating margins.
Resolution:	Policies may be required to protect the financial viability of small rural hospitals that are the safety net providers in their communities.

[14]Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy Vol II: Analytical Papers. March, 1998.

CHOICES FOR BENEFICIARIES

The BBA created a new Medicare+Choice (M+C) program, intended to provide beneficiaries with a menu of options from which to select the Medicare health plan of their preference. Among the choices are to be: traditional Medicare, managed care plans (HMOs), preferred panel organization plans (PPOs), medical savings accounts (MSAs) and hybrids that combine fee-for-service payment to providers with capitation to Medicare and beneficiaries. Experience with the impact of the BBA on Medicare managed care is limited because the policies have been in place for only a few months, and some policies are still being phased in slowly over a period lasting six years. In addition, new Medicare+Choice plans could not be formed until January 1999, and so far the only one of those choices receiving response in the market is the HMO option, in large part because it existed already under earlier enabling legislation.

Payment Changes in Medicare+Choice

Much of the future growth of options in M+C is contingent on the payment rates being attractive to health plans. So far, the experience is mixed, as indicated by the data just presented concerning some plans withdrawing from certain counties.

Concerns about the BBA have focused on the implementation of the payment policy changes. In particular, although the BBA promised to eventually use a "blended" rate methodology to set Medicare capitation rates in most counties, no counties had their rates set by this method in 1998 and 1999. Instead, every county either got only a 2 percent increase over the previous year's rates, or was raised up to the payment floor (roughly $380 per person per month in 1999). This outcome occurred for several reasons, but the main reason was that the slow growth in Medicare per capita spending, slower than what was anticipated at the time of the passage of the BBA, coupled with the "budget neutrality" provision in the BBA to eliminate the funds needed to "fund the blend."

Future payments to Medicare managed care organizations will likely be significantly impacted by another provision of the BBA that will be phased in over a number of years. Recently, HCFA has announced that it will begin phasing in a "new risk adjustment methodology," which will be in effect for a small portion (10 percent) of payment rates paid in the year 2000, and phased in over a period of five years (fully phased in by the year 2004). The proposed methodology would adjust the AAPCC county rate paid to Medicare+Choice organizations, based on inpatient medical diagnoses, along with demographic factors, to predict total health spending in the following year.[15] Preliminary analysis of the published adjustments suggests that they would favor rural counties, in the sense that rural rates would be adjusted slightly upward, and urban rates slightly downward. However, it is important to note that the rate paid to a plan will depend on the characteristics of recipients who

[15]Memorandum from HCFA to Medicare+Choice Organizations and other Interested Parties, "Medicare+Choice Rates -- 45 Day Notice: Advance Notice of Methodological Changes for the CY 2000 Medicare+Choice Payment Rates," January 15, 1999.

enroll in the plans, if any enroll. Thus, even though the risk adjustment might seem to favor rural counties in the short run, that could change as experiences of enrollees change (fewer rural enrollees in the expensive inpatient treatments and/or more urban enrollees in those treatments). Thus, we cannot comment with certainty on any ultimate "windfall" for rural managed care plans.

Changes in Enrollment

Despite the slow growth of options to Medicare HMOs, some of the payment policy changes were implemented immediately as of January 1998, so current and new Medicare HMOs will be affected by these policy changes. The early evidence indicates that the percentage of rural beneficiaries in managed plans increased from 2.15 percent in December 1997 to 2.62 percent in September 1998. This translates into an increase in enrollment of roughly 45,000 enrollees in rural counties over the period.

A great deal of attention has been paid in the popular press to reports that existing Medicare HMOs are either dropping counties from their service areas, or planning to not renew their Medicare contracts altogether. In a recent report, HCFA found that 95 risk contracts (health plans paid on a prepaid capitation basis) are not renewing their Medicare contracts or reducing their service areas (with these plans continuing to serve other parts of their current service areas).[16] A total of 414,292 beneficiaries in Medicare risk plans (about 7 percent of total risk enrollment of roughly 6 million persons) are affected by non-renewals and service area reductions in 371 counties. Of these, 56,142 beneficiaries are in 120 rural counties.

HCFA notes, however, that only 11 percent of the beneficiaries affected by plan non-renewals live in counties where no other Medicare managed care option exists. No other risk (or cost) plan will be available in 72 of the 371 counties described above. This will affect 45,074 beneficiaries, less than one percent of current risk enrollment. Of the counties with no other plans available, 51 of these counties are rural counties, affecting 15,158 beneficiaries. It is worth noting that 13.6 percent of beneficiaries losing their coverage, and 33.6 percent of those without another HMO option, reside in rural counties, even though only 4.1 percent of Medicare HMO enrollees overall reside in rural counties. This indicates that the problem of Medicare HMOs not renewing is disproportionately affecting rural residents.

Although RUPRI has not completed a full analysis of the reasons why plans might be dropping out, some evidence on the reasons for change can be found from studying individual cases of plans dropping their service contracts. From that analysis, RUPRI has concluded that the counties dropped from the service area were often those counties "at the margin," either with capitation rates lower

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[16]Health Care Financing Administration. (1998) "Managed Care Organization Service Termination and Service Area Reductions," message from Administrator, October 8, 1998 [downloaded on October 8, 1998, from World Wide Web at address http://www.hcfa.gov/Medicare/nonrenew.htm].

than other counties in their service area, or counties with low enrollment. In addition, the BBA, and subsequent regulation, require a single premium rate and benefit package throughout the service area of a given plan. Therefore, firms are making decisions based on *relative* payment in the same area, where the difference across counties may exceed $100 per member per month.

IMPLICATIONS AND OPTIONS

There should be little or no doubt that changes in the Medicare program introduced by the BBA are significant and will have an impact on the delivery and use of services in rural areas. The impacts will be felt by Medicare beneficiaries, and because of Medicare revenues to rural providers, by all who use the rural health care delivery system. In this section, general implications for the delivery system and beneficiaries are drawn from the specific impacts illustrated in previous sections. Responses to the changes in Medicare policy will include how providers and others respond, and how policy makers will make adjustments in Medicare policy as the implications of what was enacted in 1997 become more clear.

Implications for the Delivery System in Rural Areas

This analysis focused on the impacts of payment change on institutional providers in rural areas, community and migrant health centers, small (less than 50 beds) rural hospitals, all rural hospitals, skilled nursing facilities and home health agencies. For each group of providers, payment changes have the net effect of reducing Medicare revenues. The following fiscal realities make these reductions especially troubling:

- **Many of the rural providers affected by the Medicare payment changes operate on very narrow and sometimes negative operating margins.**
- **For many rural providers Medicare payments (for hospitals including multiple sources of payment) represent a substantial portion of their total revenues.**
- **Therefore, reductions in Medicare payment may threaten the financial "bottom line" of many rural providers.**

Absent any response from the delivery system, or change in public policy, rural providers may be forced to cease operations. Since many of these providers represent the safety net in rural communities, closures need to be carefully monitored so that rural citizens are not left without viable options for care. Other changes in the BBA should be considered in tandem with those that reduce payment in the traditional Medicare program. For example:

- **The new Rural Hospital Flexibility Program allows small (fewer than 16 acute care beds) to convert to a new Medicare certified category that enables them to reduce operating expenses and receive cost-based reimbursement.**
- **Small rural hospitals may qualify for designation as sole community hospitals or Medicare dependent hospitals, which would mean cost-based reimbursement.**
- **Rural providers could participate in Medicare+Choice plans that, based on realizing more Medicare revenues than the total of fee for service payments in traditional Medicare, pay more to providers.**
- **The new Child Health Insurance Program may result in payment for previously**

unpaid claims.

These provisions will not eliminate all of the financial concerns of safety net providers losing cost-based reimbursement from Medicaid, or those of hospitals not qualifying for exemption from prospective payment systems. Other actions are likely to be needed, as discussed below.

Implications for Rural Medicare Beneficiaries

The data concerning enrollment into Medicare managed care plans is not very promising if equity of choice among beneficiaries across urban and rural residence is a goal. However, the full effects of the changes in risk contract payment mandated by the BBA will not be evident for some time to come. Increases in managed care offerings that follow implementation of a blended formula cannot be detected until the blend has begun, at the earliest in 2000. Even though enrollment of rural beneficiaries into managed care plans is increasing at a higher percentage than in urban areas, the total number remains small, and rural counties have experienced disenrollment resulting from plans not renewing Medicare managed care contracts. Further increases in rural beneficiary enrollment into managed care plans will be related to:

- **implementation of the blended formula for payment to risk contracts,**
- **impact of any use of risk adjustment in determining payment,**
- **readiness of managed care organizations to enroll rural beneficiaries, and**
- **willingness of rural beneficiaries to enroll in new Medicare plans.**

Given low enrollment into managed care and limited use of any Medicare+Choice plans in rural areas for the foreseeable future, the impacts of changes in traditional Medicare are of vital concern for the welfare of rural beneficiaries.

The relationship of payment decisions to the welfare of rural beneficiaries is illustrated by examining the impacts of changes in payment for home health services. The current per beneficiary limits may force agencies to restrict the types of patients they serve. Under the limits, agencies will have a strong incentive to avoid high cost patients. The per beneficiary limit may have a differential effect in rural areas where fewer beneficiaries use home health services, but have more visits per use. Similar implications arise regarding services from local hospitals, skilled nursing facilities, and community and migrant health centers. If payment changes force decisions to restrict services or persons served, access to services will suffer. In a worst case scenario, if the local provider is forced out of business because of negative operating margins, local access to essential services would end.

Responses to the Changes

The payment changes included in the BBA are predicated on the assumption that health care providers and delivery systems can adjust to lower than expected Medicare payment by finding cost

savings in their operations. This approach may prove difficult for small rural providers, but not impossible. For example, one home health agency administrator offered the example of introducing "clinical pathways" for some the most frequent diagnoses, which should result in better and less expensive care. Similar approaches could reduce the costs of other types of care, particularly in skilled nursing facilities and hospitals. For safety net providers, such cost efficiencies may be more difficult to discover and implement. However, the Bureau of Primary Health Care has been providing technical assistance and funding for technical assistance to C/MHCs to help them adopt new strategies of improving cost effectiveness in service delivery. ***The point being made here is that rural health care providers can find and implement measures to reduce per unit costs of care.***

However, ***individual health care providers are not likely to find sufficient savings to absorb the full amount of payment reductions anticipated as a result of the BBA***. Another response is to find savings through developing local networks of service providers. There are programs in place to encourage this activity; the network grant program of the Federal Office of Rural Health Policy, the network grant program of the Bureau of Primary Health Care, and the new State Rural Hospital Flexibility program. Experience with rural networks is still quite limited, and savings cannot be determined. ***Rural providers may be able to find savings through further development of local and regional networks, but this requires time and the yield is unknown***.

Another possibility for finding cost savings is to increase volume of service per provider such that economies of scale would yield savings. Individual rural providers are not likely to be able to do this, nor will small networks. Two possibilities exist: large rural networks, or consolidation of providers. ***A challenge for rural providers will be how to cooperate across a sufficient number of service locations to generate the number of patients needed to use new techniques of medical and administrative management, without sacrificing local autonomy.***

Policy Issues

Policy makers examining the Medicare program are obligated to be fiscally prudent in setting payment policies, but they are also charged with the responsibility of doing what they can to assure that services are available to the beneficiaries. These twin responsibilities pose what has become a core dilemma in recent years – meeting an obligation to finance services without spending more than is affordable in the context of the Medicare Trust Fund and the General Fund of the federal budget. ***The imperative to constrain Medicare spending cannot be met by imposing continuing and significant payment reductions on small rural providers; doing so jeopardizes access to care for rural beneficiaries***. Those providers should be able to cut costs in a manner that contributes to savings deemed necessary for the future of Medicare, but not at the same levels as larger providers. Therefore, we close with the following considerations for public policies:

- **Any changes in payment policies should include a "rural differential," accounting for different impacts on providers as a function of size and location,**
- **Policies designed to encourage change in the organization of health care services should include resources and suggested models that encourage rural providers to participate in the changes.**

MEMBERS
RUPRI RURAL HEALTH PANEL

Andrew F. Coburn, Ph.D., is the Director of the Institute for Health Policy and Associate Professor of Health Policy and Management in the Edmund S. Muskie School of Public Service at the University of Southern Maine. Dr. Coburn is also Director of the Maine Rural Health Research Center, one of seven national centers funded by the federal Office of Rural Health Policy. He is currently directing studies of rural health insurance coverage and rural long-term care. Dr. Coburn is an active member of the National Academy for State Health Policy.

Sam Cordes, Ph.D., is Director of the Center for Rural Community Revitalization and Development at the University of Nebraska-Lincoln. He is a past member of the National Advisory Committee on Rural Health, U.S. Department of Health and Human Services and the National Research Initiative Advisory Committee, U.S. Department of Agriculture. He has published extensively on the economics of rural health care, and served as President of the American Rural Health Association. He was the 1996 recipient of the National Rural Health Association Distinguished Researcher Award.

Charles W. Fluharty is Director of the Rural Policy Research Institute (RUPRI), a multi-state interdisciplinary research consortium which conducts research and facilitates public dialogue designed to assist policymakers in understanding the rural impacts of public policy choices. Fluharty was born and raised on a fifth generation family farm in the Appalachian foothills of eastern Ohio, where he returned following graduation from Yale Divinity School. As an educator, public policy analyst, association executive, and private consultant, his professional career has centered upon service to rural people, primarily within the public policy arena.

J. Patrick Hart, Ph.D., is President of Hart and Associates in Grand Forks, North Dakota. Before accepting his current responsibilities, Dr. Hart held faculty positions at the University of Minnesota-Duluth School of Medicine, Tulane University, the University of Oklahoma, the University of Texas Health Science Center and the University of North Dakota. He is past President of the Board of Directors of the National Rural Health Association and past Chair of the Rural Health Committee of the American Public Health Association.

A. Clinton MacKinney, MD, MS is a board-certified family physician practicing in rural Iowa. He earned his medical degree at Medical College of Ohio and completed residency training at the May-St. Francis Family Practice Program. His MS degree is in Administrative Medicine, University of Wisconsin. He has lectured and published articles regarding rural health, and has served on committees for the American Medical Association, the American Academy of Family Physicians, the Robert Wood Johnson Foundation, and the National Rural Health Association.

Timothy D. McBride, Ph.D., is Associate Professor of Economics, Public Policy and Gerontology at the University of Missouri- St. Louis. Dr. McBride's research concerns public economics, with special emphasis on the economics of aging and health. In the health policy area, Dr. McBride's research has focused on the uninsured, long-term care, and health care reform. He is the author of

over a dozen research articles and co-author of a monograph, titled The Needs of the Elderly in the 21st Century. Dr. McBride joined the Department of Economics in 1991 at the University of Missouri- St. Louis after spending four years at the Urban Institute in Washington, D.C. He received his Ph.D. from the University of Wisconsin in 1987.

Keith Mueller, Ph.D. is a Professor and the Director of the Nebraska Center for Rural Health Research, University of Nebraska. He was the 1996-97 President of the National Rural Health Association, and the recipient of the Association's Distinguished Rural Health Researcher Award in 1998. Dr. Mueller's Ph.D. is from the University of Arizona, in Political Science. He is the author of a University of Nebraska Press book, *Health Care Policy in the United States*, and has published articles on health planning, access to care for vulnerable populations, rural health, and access to care among the uninsured. He is the Chair of the RUPRI Rural Health Panel, and in that capacity has provided expert testimony to Committees and staff of the U.S. Congress. He recently testified on rural health issues before the Bipartisan Commission on the Future of Medicare.

Dr. Mary Wakefield is Professor and Director of the Center for Health Policy at George Mason University, Fairfax, Virginia. From January 1993 to January 1996, Dr. Wakefield was the Chief of Staff for United States Senator Kent Conrad (D-ND). Prior to that she served as Legislative Assistant and Chief of Staff to Senator Quentin Burdick (D-ND). Throughout her tenure on Capitol Hill, Dr. Wakefield advised on a range of public health policy issues, drafted legislative proposals, worked with interest groups and other Senate offices. From 1987 to 1992, she co-chaired the Senate Rural Health Caucus Staff Organization. Dr. Wakefield served on President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. She was appointed to the Institute of Medicine's Committee on Quality of Health Care in America.

rural policy research institute

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June 17, 1999

Ms. Sarah Bianchi
Domestic Policy Advisor
Office of the Vice President
Washington, DC

Dear Ms. Bianchi:

Thank you for taking time to meet with Mike Hall and me on June 15, 1999. As we discussed, the National Rural Behavioral Health Center seems to fit well with Mrs. Gore's initiative on mental health. The National Rural Behavioral Health Center will build the infrastructure in rural areas to create increased willingness to access mental health services. In addition, the Center will create significant gains in knowledge regarding behavioral health services among rural leaders.

Please let us know how we can help you in your efforts. Thank you again for meeting with us.

Sincerely,

Robert G Frank

Robert G. Frank, Ph.D.
Professor and Dean

cc: Mr. Mike Hall
Mr. Randy Moore
Dr. Gerold Schiebler
Dr. Ron Rozensky
Dr. Christine Waddill

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UNIVERSITY OF FLORIDA

Health Science Center
Office of the Vice President for Health Affairs

PO Box 100014
Gainesville, FL 32610-0014

June 28, 1999

Bart Chilton
Deputy Chief of Staff
US Department of Agriculture, Office of the Secretary
Whitten Administration Bldg.
14th and Independence Avenue, SW
Washington, DC 20250

Dear Bart:

This letter is to follow up on the meeting we had in your office on Tuesday, June 15, 1999. As you recall, we discussed the issue of delivering mental health services in rural areas, and the very significant role that could be played by the USDA extension service in this regard.

As you may also remember, we discussed the leadership role that Secretary Glickman and the Department have played in rural mental health. For example, Secretary Glickman recently was quoted in "American Health Line" as stating the following:

> "With their smaller and more dispersed populations, rural areas often have greater difficulty financing and maintaining mental health facilities. Yet alcohol, drug addiction, and the heartbreak of mental illness and mental disabilities are just as prevalent in rural America as they are in urban and suburban areas. USDA financial support can often make the difference in ensuring that mental health services are available to rural residents" (release, 6/8).

Further, we also discussed the bill-report language included in the House Agriculture Appropriations Report (Report 106-157) which urged the Department to explore the model developed by the University of Florida to train extension agents to better equip them to deliver mental health programs to the victims of natural disasters.

Enclosed, please find a proposal for a Washington workshop to focus on the issue of rural mental health and the role extension agents and other USDA employees could play to assist in the delivery of mental health services in rural areas.

Sincerely yours,

Bob Frank

Robert Frank, Ph.D.
Dean, College of Health Professions

cc. Office of the Vice President
Sarah Bianchi, Domestic Policy Advisor

USDA WORKSHOP ON RURAL BEHAVIORAL HEALTH
University of Florida

PROBLEM STATEMENT:

Life if Rural America is often described as being healthy to the heart, mind, and body. Many Americans view life in the "Heartland" as relaxing, uncomplicated, and relatively stress free. Unfortunately, the reality facing many rural residents disproves these myths. Rural residents, as compared to their urban counterparts earn lower wages, have poorer education, suffer more chronic health problems, and have access to far fewer health care resources. The health care shortage is a particular problem because rural residents account for approximately 25% of the total U.S. population and geographic area, and rural areas account for almost three-fourths of the mental health manpower shortage areas. For example, less than 10% of rural hospitals offer any type of mental health care.

The Farm Crisis of the early 1980's cast a spotlight on the danger of neglecting the mental and behavioral health needs of Rural Americans. Numerous studies documented an estimated two-fold rise in rates of depression in rural areas resulting in an estimated prevalence of depression among farmers and rural residents that hovered around 20%, as compared to 6-9% in the general population. Researchers also uncovered rising rates of childhood behavioral and emotional problems, child and spousal abuse, substance abuse, and suicide as the Crisis worsened. Faced with another potential Farm Crisis of the late 90's, researchers are again beginning their vigilance for increased mental health problems in Rural America.

The University of Florida Rural Psychology Program has adopted the position that waiting for the next crisis in Rural America is too late for an effective response. Through collaborative efforts between the College of Health Professions (UF Health Sciences Center) and the Institute of Food and Agricultural Sciences, we have developed a proactive response to meeting the mental and behavioral needs of Rural Floridians through research, extension, and clinical service programs.

PURPOSE OF THE WORKSHOP:

Our primary goal in this three hour presentation is to highlight some of the major issues of quality of life and emotional health that Rural Americans must face in their day-to-day lives. Even more importantly, we propose to offer participants some practical, take home information and materials, in order to begin to conceptualize the role that Extension Agents and other USDA employees in rural communities could play to facilitate the delivery of behavioral and mental health services. Well beyond concepts of traditional mental health services are such areas of "stress hardening" (learning to manage stress before problems occur), violence prevention, and crisis management after flood, fire, storm, or drought. We will illustrate approaches to these problems, and others, as well as community consultation and traditional, rural population focused behavioral health services, utilizing the existing activities of the "University of Florida Rural Psychology Program" as the exemplar. We will conclude the workshop with a discussion of future directions that the agricultural and rural community, and its leadership in Washington, in the states, and locally, can take utilizing our proposed National Rural Behavioral Health

Center as a vehicle and resource to help to improve the quality of life for all residents in America's heartland.

WORKSHOP PROGRAM OBJECTIVES:

1. To understand the need for addressing the personal, family, and community stressors of rural residents to improve their health.

2. To review current research regarding the incidence and impact of psychological stress on health and emotional well-being.

3. To update agricultural professionals on recent developments and understandings about key behavioral health issues affecting children and adults.

4. To examine special considerations for extending behavioral health care to specific rural populations.

5. To learn how to turn routine interactions into positive, supportive communications that facilitate psychosocial adjustment in appropriate ways.

6. To forecast the future possibilities of rural behavioral health with recognition of increasingly vital technologies and service delivery systems.

PROGRAM OUTLINE:

- **UPDATE ON CURRENT RURAL AND FARMING STRESSES**
  - Current threats to rural economics
  - Population trends in rural communities
  - The University of Florida Rural Psychology Program's Response (Video Presentation)

- **STRESS 101 AND ITS IMPACT**
  - What is stress and how does it affect our health?
    - Physical Health
    - Mental Health
  - What about rural stress?
  - How do rural residents respond differently to stress?

- **KEY ISSUES IN RURAL BEHAVIORAL HEALTH**

  This section is intended to review some of the key, current issues in rural behavioral health. Fingertip facts and rules of thumb will be presented related to preventing and managing potential problems as well as facilitating positive coping.

  - Depression and Suicide
  - School Violence

- Disaster Recovery
- Promoting Stress Hardiness and Optimism

- **EFFECTS OF STRESS ON SPECIFIC GROUPS OF PEOPLE**

Stress has differential effects on specific groups of individuals. This section will review how specific types of stress may discriminate against certain groups in its incidence and impact.

- Rural Men and/or Farmers
- Rural Women
- Children and Families
- Minority Group Members
- Rural Communities — Economic and Natural Disasters

- **SEVEN THINGS THAT EVERY RURAL PERSON NEEDS TO HEAR**

This section will specifically provide examples of routine, informal conversations that can serve as opportunities to provide help to individuals experiencing significant rural stress. Seven principles of supportive communication as determined by the research literature serve as the basis for this section and are demonstrated by these quotable conversations.

- **LEVELS OF INTERVENTION AND INDICATIONS FOR REFERING FOR MORE PROFESSIONAL HELP**

Most people routinely engage in some type of supportive communication on a daily basis but simply do not recognize it as such. This module highlights individual daily efforts to support each other's efforts in managing daily stress and provides a taxonomy to classify these contacts. Sometimes the severity of stress that our peers experience exceed our comfort or expertise in assisting with the problem. Specific emotional and behavioral indications of more serious psychological difficulties will be discussed. The four A's of how to help a distressed peer will be reviewed as well.

- **FORECASTING THE FUTURE OF RURAL BEHAVIORAL HEALTH AND THE POTENTIAL CONTRIBUTIONS OF THE USDA**

Emerging technology and innovative partnerships of established rural agencies fuel speculation about potentially effective delivery systems to more full address rural behavioral health problems in the future. Specific possibilities and opportunities will be explored in this section of the meeting.

RURAL BEHAVIORAL HEALTH CENTER
UNIVERSITY OF FLORIDA
BUDGET FOR PRESENTATION TO THE
US DEPARTMENT OF AGRICULTURE
WASHINGTON DC
FALL 1999

Travel to Washington DC from Gainesville FL				
6 participants		Subtotals	**TOTAL**	Participants from UF:
Airfare	$600	$3,600		Sam Sears
Hotel	$400	$2,400		Garret Evans
Meals	$100	$600		Ronald Rozensky
			$6,600	Robert Frank
				Christine Waddill
Videotape: "UF Model Rural Psychology Program"			$4,500	One additional IFAS person
Faculty Time to Prepare Workshop (x2)			$3,000	
Materials Preparation				
Production Assistant			$3,000	
Material Preparation & Copy			$3,500	
Slide Presentation			$1,000	
Video and Slide Presentation Equipment Rental			$400	
			$22,000	

NATIONAL RURAL HEALTH BEHAVIORAL CENTER
REPORT TO CONGRESS

I. Situation Statement

Citizens experience extreme emotional stress following natural disasters such as flooding, hurricanes, tornadoes, etc. During periods of economic fluctuations in agriculture such as the farm crisis of the 1980's, rural residents suffer with making key decisions about their future with often less than adequate support. Regardless of the source of the stress, there is a significant need and opportunity for education and outreach programs for farm and other rural families to address both short- and long-term mental health needs.

II. Examples of Cooperative Extension Program Responses

A. Relatively Short Term Natural Disasters

Following Hurricane Andrew in Florida in 1992, more than 80 of Florida's Institute of Food and Agricultural Sciences (IFAS) full- and part-time researchers lost their homes. They also lost what for some represented the culmination of their work when the storm's 165 miles per hour wind flattened experimental crops. IFAS headquarters in Gainesville, Florida, put together a response team which included clinical psychologists to assist with stress management of the disaster victims. This effort quickly focused on training IFAS Extension Agents from neighboring counties in crisis intervention and stress management. The extension agents, as a result of this training, were better able to deal with and identify the emotional and stress dimensions of the disaster and recognize cases that needed referral to mental health professionals. The model worked so well that the IFAS Extension Agents who were trained by the clinical psychologists were among the recipients of an award from the Department of Agriculture (USDA) "for outstanding leadership and interagency cooperation in delivering emergency services to victims of Hurricane Andrew."

Following the devastating effects of Hurricane Andrew in South Florida, a unique set of partnerships at the University of Florida was formed between the Department of Clinical and Health Psychology, the Florida Cooperative Extension Service, and the North Florida Area Health Education Center. The partnership resulted in the creation of the University of Florida (UF) Rural Psychology Program intended to provide clinical service and training in psychological and behavioral health services and programming in rural areas. The UF Rural Psychology Program provides a wide range of community education, clinical training, and behavioral health services. This range of services is rarely available to rural residents. The clinical service and training experiences of the UF Rural Psychology Program involve a range of activities including primary care consultation, health professional in-service education, community education programming through cooperative extension, hospital-based service delivery, and ethical and special considerations for rural practice. Formed in 1995, the UF Rural Psychology Program strives to serve as a model program for each of the collaborating partners to demonstrate the value of coalition building for rural community service.

Examples of behavioral health education programs created in partnership between the Rural Psychology Program and UF Cooperative Extension include multi-media programs in stress management, cardiac disease risk reduction, fall prevention for the elderly, depression and suicide prevention for the elderly, responsible fathering, behavior management techniques for young children, and techniques for teaching coping skills to children. In addition, separate, multi-session, manual-based Extension education programs have been completed for parenting adolescents and children ages 4 to 12, respectively.

More recently in 1997, following the North Dakota floods and a discussion between the Governors of Florida and North Dakota, the Director of the Cooperative Extension Service in North Dakota invited a team of clinical psychologists from UF to train North Dakota Extension Agents to work with flood victims. At the time, the Director requested and the Cooperative State Research, Education, and Extension Service (CSREES) agreed to support the effort, with limited special needs funds at the $50,000 level.

The workshop to train the North Dakota and Minnesota Extension Agents was conducted over 4 days. Once on site, the team of psychologists learned that residents of North Dakota and Minnesota were not only affected by flooding in the Red River Valley, but had been experiencing months of chronic stress from nine devastating blizzards and the resultant overland flooding. The loss of property and livestock was particularly devastating to farmers and ranchers in the expansive rural areas. During their stay, the UF team visited four separate regions of North Dakota and delivered workshops on stress management and coping with personal and property loss. Through these workshops, extension agents, USDA employees, school officials, other Government employees, and mental health professionals learned techniques for approaching victims of flooding, assessing problematic stress and emotional reactions, performing "threshold" counseling to those moderately affected and referring more severe cases to mental health professionals. Extension agents and USDA employees voiced a special gratitude for this training as they were themselves feeling the strain of working on the "front lines" with rural residents facing serious personal and financial losses.

It is important to note that while these initial efforts were focused on services for the victims of natural disasters, training the agents received in the model allows continuous long-term service by the agents and is broadly transferable to assist individuals in rural areas regardless of the cause of their distress.

B. Extended Rural Financial and Economic Crises

The Cooperative Extension Services (CES) have been very responsive, and successful, when specifically called upon to address rural mental health crisis situations. The primary example of this was the Congressionally targeted, 8-State, Dislocated Farmer and Rancher Program, under section 1440 of the Food Security Act of 1985, (7 U.S.C. 2662). Under subsequent amendments, the program became known as the Rural Crisis Intervention Program (RCIP). The impetus for RCIP was the farm financial crisis of the 1980's.

Activities conducted under RCIP included:

- Establishment of rural mental health/rural crisis toll free telephone hot lines, usually in collaboration with State mental health agencies and frequently staffed by volunteers.

- The placement of mental health outreach professionals in County Extension Service Offices; this was predicated on the stigma that exists in most rural communities on being seen going into a rural mental health clinic, and on the corollary that most rural people know and respect the local CES staff and are comfortable seeking help from them.

- Considerable training was provided in collaboration with State mental health agencies, for Cooperative Extension Agents and numerous other rural professionals (teachers, ministers, bankers, bartenders, law officers, judges, etc.) to enable them to recognize early signs of mental illness in farmers, rural youth, etc. Since mental illness tends to cause people to drop out of the mainstream of interpersonal contacts, the rural professionals also were taught to be alert for significant changes in farmer/family communication and social interaction patterns.

- In several States, CES took the lead in forming State and county level social services coordination councils. This generally facilitated the streamlining of bureaucratic procedures; the coordination of critical mental and physical health, financial assistance, counseling, and other urgently needed services; and the more rapid referral of mentally ill residents to appropriate mental health services.

Through the RCIP, the CES in the designated States quickly demonstrated they could play a significant role in addressing a critical rural mental health crisis -- lives were saved, suffering was reduced, and quality of life was greatly improved for thousands of rural residents in Iowa, Missouri, Nebraska, Kansas, North Dakota, Oklahoma, Mississippi, and Vermont. The following table provides funding levels for the participating States:

Rural Crisis Intervention Program
Section 1440 of the Food Security Act of 1985

	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992	FY 1993
Iowa	$480,000	$480,000	$480,000	$476,472	$365,415	$365,415	$365,415
Kansas	498,122	498,122	498,122	494,428	379,185	379,185	379,185
Mississippi	320,727	320,727	320,727	318,203	244,035	244,035	244,035
Missouri	480,000	480,000	480,000	476,472	365,415	365,415	365,415
Nebraska	480,000	480,000	480,000	476,472	365,415	365,415	365,415
No. Dakota	359,201	359,201	359,201	356,440	273,360	273,360	273,360
Oklahoma	411,527	411,527	411,527	408,310	313,140	313,140	313,140
Vermont	186,423	186,423	186,423	185,203	142,035	142,035	142,035
Subtotal	3,216,000	3,216,000	3,216,000	3,192,000	2,448,000	2,448,000	2,448,000
Fed. Admin.	134,000	134,000	134,000	133,000	102,000	102,000	102,000
Total	$3,350,000	$3,350,000	$3,350,000	$3,325,000	$2,550,000	$2,550,000	$2,550,000

III. Feasibility of Establishing a National Rural Health Behavioral Center (Center)

A. Relationship to USDA Mission

If a Center were to be established, its primary goal would be to enhance human health by assisting farmers and other rural residents in the detection and prevention of health and safety concerns. Such a goal is within the broad mission of USDA.

B. Program Description

Center Objectives

1. Develop and evaluate community-based and behavioral health promotion programs suitable to be offered through CES across the country.

2. Demonstrate and deliver innovative behavioral health programs designed for rural communities.

3. Train extension service employees from across the country to deliver behavioral health programs developed, demonstrated, and evaluated by the Center.

The Extension Service is increasingly called upon to help meet the family, health, and social service needs of rural residents. The training that could be offered by the Center would be designed to better equip extension agents to meet the program demands being placed on them by rural citizens.

National Training

An initial goal might be to train extension agents in five States a year. It should be emphasized that training would not be mandated for States or extension units within States, but would be presented as an available resource. The estimated budget is based on experience in Florida and North Dakota, and reflects differences in State size and the number of extension faculty. Determining the most effective type and combination of one-to-one, small group, and large group training is a goal of the Center.

Cost

The annual cost to establish and operate such a Center each year would be approximately $1 million, some of which may be within the scope of the U.S. Public Health Service, Office of Rural Mental Health Research (particularly to support the research needed to develop and validate community-based behavioral health programs). Additional costs are based on the assumption that the Center would train the extension agents from five States each year. The additional cost to train these extension agents each year is estimated to be $.5 million.

C. Alternatives

National Network for Health

One cost-effective alternative that has been demonstrated by the CES has been the establishment of "networks," or "virtual centers," including the National Network for Health (NNH). The mission of NNH is to marshal the resources of the Cooperative Extension System and collaborate with other organizations to engage children, youth, and families-at-risk in community-based programs which will enable them to become knowledgeable about health, enhance life skills, increase control over their environment, and improve or maintain their physical, mental, and social health status.

The NNH is a collaboration of USDA-CSREES and the 30 Land-Grant University Cooperative Extension Services. NNH provides training and technical assistance to community and State Extension education programs in a variety of health areas. NNH maintains a home page on the worldwide web with hundreds of educational resources for educators and citizens. The NNH members are mining the Cooperative Extension/Land-Grant University System for research-based program materials, curricula, and training programs which they review and publish electronically. They publish information about programs, materials, and training and funding opportunities for education and prevention programs in health areas such as substance abuse, mental health, teenage pregnancy and parenting, HIV/AIDS, immunization, etc.

The NNH is expected to move into extension agent training activities, and these could be expanded to include the training activities envisioned for the National Rural Health Behavioral Center.

Extension Disaster Education Network

A second alternative would be to utilize and build upon the Extension Disaster Education Network that has been developed over several years by a consortium of State CES and is located at Louisiana State University.

Veterans Affairs' Post Traumatic Stress Syndrome Center

Another alternative would include a partnership between a land-grant university and the U.S. Department of Veterans Affairs' Post Traumatic Stress Syndrome Center located in Vermont.

D. Expected or Potential Impact

The potential impact of the Center, or an alternative network, might be substantial. In addition to enabling rural families to effectively cope with natural disasters at reduced care cost to them and their communities, the longer term programs delivered by extension agents could be effective in preventing numerous side effects of clinical depression in rural adults -- from spouse and child abuse, to substance abuse, physical assault, murder, and suicide -- as well as enabling farm

families to make adjustments so that they can retain and maintain their farming operations or transition smoothly to non-farm employment. Rural social service agencies, public schools, community organizations, and other rural entities would be better equipped to recognize mental health needs of their friends, neighbors, and clientele. 1/

IV. USDA Recommendation to Congress

While we found the establishment of a behavioral health center feasible, given the constraints on Federal discretionary funding under which both the Executive Branch and Congress operate, the basic question is whether we believe funding for such a center should be accorded higher priority than current CSREES programs, or other USDA programs. Our conclusion at this time is that it should not be given higher priority. Our recommendation to the House and Senate Agriculture Appropriation Subcommittees is to consider funding for a rural health behavioral center only if it can be accommodated within their discretionary funding constraints and only after recommendations for additional funding for the National Research Initiative, food safety, pest management, and other recommendations in the President's 1999 Budget are addressed.

106TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
1st Session } { 106–157

AGRICULTURE, RURAL DEVELOPMENT, FOOD AND DRUG ADMINISTRATION, AND RELATED AGENCIES APPROPRIATIONS BILL, 2000

MAY 21, 1999.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. SKEEN, from the Committee on Appropriations, submitted the following

REPORT

together with

ADDITIONAL VIEWS

[To accompany H.R. 1906]

The Committee on Appropriations submits the following report in explanation of the accompanying bill making appropriations for Agriculture, Rural Development, Food and Drug Administration, and Related Agencies for fiscal year 2000.

SUMMARY OF ESTIMATES AND RECOMMENDATIONS

	FY 1999 appropriation	FY 2000 estimates	FY 2000 recommendation	FY 2000 recommendation compared with	
				FY 1999 appropriation	FY 2000 estimates
Title I—Agricultural Programs	$14,481,998,000	$20,174,117,000	$20,055,493,000	+$5,573,495,000	−$118,624,000
Title II—Conservation Programs	793,072,000	866,820,000	800,012,000	+6,940,000	−66,808,000
Title III—Rural Economic and Community Development Programs	2,175,234,000	2,194,349,000	2,135,508,000	−39,726,000	−58,841,000
Title IV—Domestic Food Programs	36,067,199,000	41,381,688,000	35,520,668,000	−546,531,000	−5,861,020,000
Title V—Foreign Assistance and Related Programs	1,196,718,000	1,056,853,000	1,160,191,000	−36,527,000	+103,338,000
Title VI—Related Agencies and FDA	1,046,138,000	1,209,355,000	1,169,700,000	+123,562,000	−39,655,000

56–830

RESEARCH AND EDUCATION—Continued

[In thousands of dollars]

	FY 1999 enacted	FY 2000 estimate	Committee provisions
Payments to the 1994 Institutions	1,552	1,500	1,552
Federal Administration:			
Agriculture development in the American Pacific	564	.....	564
Agriculture waste utilization (WV)	250	.....	250
Alternative fuels characterization laboratory (ND)	218	.....	218
Animal waste management (OK)	250	.....	250
Center for Agricultural and Rural Development (IA)	355	.....	355
Center for North American Studies (TX)	87	.....	87
Cotton research (TX)	[2]	0	200
Data information system	1,000	2,000	1,000
Geographic information system	844	.....	844
Mariculture (NC)	250	.....	250
Mississippi Valley State University	583	.....	583
National Center for Peanut Competitiveness	300	.....	300
Office of extramural programs	310	588	310
Pay costs and FERS	1,100	1,100	1,100
Peer panels	350	350	350
PM–10 study (CA, WA)	873	.....	873
Shrimp aquaculture (AZ, HI, MS, MA, SC)	3,354	.....	3,354
Total, Federal Administration	10,688	4,038	10,888
Total, Research and Education Activities	481,216	468,965	467,327

[1] For FY 2000, this program is proposed to be funded under Integrated Activities.
[2] Project funded under special research grants in fiscal year 1999, under Federal Administration in fiscal year 2000.

Citrus tristeza virus research.—The Committee recognizes the importance of Citrus tristeza Virus (CTV) research. The project was funded at $750,000 in FY 1998 and $500,000 in FY 1999 for cooperative CTV research. However, the Committee believes the most effective use of these funds is through the Special Research Grants account administered by CSREES. Funding in the amount of $750,000 is provided in that account in FY 2000 for CTV research. The balance is to remain in support of the in-house Ft. Pierce citrus research program.

National Rural Behavioral Health Center.—In light of the continuing frequency of recent devastating natural disasters, the Committee urges the Secretary to examine the Department's full range of programs and services that might be employed to assist residents of rural areas deal with the emotional impact of these disasters. In particular, the Committee is aware of the outstanding work being done by the National Rural Behavioral Health Center at the University of Florida. Working in the wake of Hurricane Andrew and the North Dakota floods, the Center has developed model programs for training extension agents who are often the first responders in natural disasters, in crisis intervention and stress management, and to better equip them to deliver behavioral health programs to the victims of natural disasters. The Committee urges the Department, within this and other accounts, to provide support for the Center to build on its initiative and to extend the knowledge gained so that it might be used to assist rural victims of such disasters throughout the nation.

Peanut allergies.—The Committee recognizes the severe difficulties that peanut allergies cause to individuals with sensitivity to this important commodity. Progress is being made in developing

From "American Health Line," June 9, 1999:

USDA Supports Rural Mental Health

Agriculture Secretary Dan Glickman announced this week that the Department of Agriculture has provided more than $70 million for mental health facilities in rural areas since 1992. The facilities range from drug and alcohol treatment centers to group homes for developmentally disabled people. Glickman said, "With their smaller and more dispersed populations, rural areas often have greater difficulty financing and maintaining mental health facilities. Yet alcohol, drug addiction, and the heartbreak of mental illness and mental disabilities are just as prevalent in rural America as they are in urban and suburban areas. USDA financial support can often make the difference in ensuring that mental health services are available to rural residents" (release, 6/8).

Congress of the United States

Washington, DC 20515

March 17, 1999

Hon. Joe Skeen
Chairman, Subcommittee on Agriculture,
Rural Development and Related Agencies
2362 Rayburn HOB
Washington, D.C. 20515

Dear Chairman Skeen:

We request your inclusion of $1,500,000 in the Cooperative State Research, Education, and Extension Service (CSREES) Account to establish a National Rural Behavioral Health Center to help meet the behavioral health needs of rural Americans.

As a result of your leadership, the Committee's FY98 report included language requesting the USDA to conduct a study on the feasibility and cost of establishing a National Rural Behavioral Health Center. The study has been completed and submitted to the Committee with a very favorable review.

The Center would train extension agents in crisis intervention and stress management to better equip them to deal with emotional and stress related problems. This training will permit extension agents to provide threshold behavioral and mental health counseling and to recognize serious cases in need of referral to mental health professionals. Following Hurricane Andrew in Florida in 1992, a training program for extension agents to work with the emotional and mental health issues of disaster victims was successfully initiated and recognized by the USDA "for outstanding leadership and interagency cooperation." Following the 1997 floods, the University of Florida was invited to train extension agents in North Dakota and Minnesota, and this effort was also well reviewed.

Due to financial disincentives, it is unlikely that rural areas of America will ever enjoy the full array of health services available to their urban counterparts, notwithstanding the best efforts of the National Health Services Corps and the emerging use of telemedicine. Therefore, training Extension Service Agents to be better able to deal with behavioral and threshold mental health issues may offer the best likelihood of reaching rural population with these services.

We will greatly appreciate your assistance in this matter.

Sincerely,

Karen L. Thurman Clay T. Condy Cliff Stearns

Carrie P. Meek Tillie K. Fowler _____

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