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DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Washington, D.C. 20201

OCT 18 1996

Jennifer Klein
Special Assistant to the President
for Domestic Policy
The White House
Washington, D.C.

Dear Jennifer:

You asked for the status of the Community Nursing Organization (CNO) demonstration project that the Health Care Financing Administration is conducting.

The CNO demonstration began January 1994, and is scheduled to end December 31, 1996, following the completion of the 3-year operational period specified in the legislation. If the demonstration were to end on the currently scheduled date, sites would have to cease new enrollment in November and cease providing services by December 31, 1996. However, HCFA has begun the process to extend the demonstration for a year using regular Medicare waiver authority.

HCFA believes that an extension will provide additional information to better evaluate whether CNO enrollment is associated with an increase or decrease in overall Medicare expenditures. Demonstration projects such as the CNO require an initial period of adjustment in which various management and care approaches must be tried in order to find the most efficacious approaches. Moreover, the initial months of the project were characterized by extensive marketing and enrollment activities, therefore, the project may need a longer period of operations in order to assess its full impact.

I will keep you informed of HCFA's progress in extending the demonstration for an additional year.

Sincerely,

Barbara

Barbara S. Cooper
Acting Director
Office of Research and Demonstrations

Sent letter clarifying that it will not sunset

AMERICAN NURSES ASSOCIATION

600 Maryland Avenue, SW
Suite 100 West
Washington, DC 20024-2571
202 651-7000 • Fax 202 651-7001

Beverly L. Malone, PhD, RN, FAAN
President

Geri Marullo, MSN, RN
Executive Director

To: Jennifer Klein
Office of Domestic Policy

From: Marjorie W. Vanderbilt - 651-7085
Director, Federal Government Relations
American Nurses Association

Subject: Community Nursing Organizations

Date: September 16, 1996

Pursuant to our recent telephone conversations, I wanted to bring you up to date on the Congressional efforts to reauthorize the Community Nursing Organization (CNO) demonstration project.

In 1987, Congress authorized four CNO demonstrations to test the efficacy of capitated nursing delivery organizations at providing quality services outside the nursing home setting. CNOs serve Medicare beneficiaries in home and community-based settings under contracts that provide a fixed, monthly capitation payment for each beneficiary who elects to enroll. A fact sheet describing the CNOs is attached.

At the end of this year, the three-year authority expires for these effective projects, which serve approximately 6,000 Medicare beneficiaries in Arizona, Illinois, Minnesota and New York,. To conduct a thorough study of CNOs with valid outcomes to assess, it is necessary to extend the work of the four projects. Results from a comprehensive study will allow Congress and HCFA to assess the viability of offering Medicare CNO services permanently. More importantly, extending the projects allows beneficiaries to remain in their homes while containing Medicare costs.

To continue the work of the CNOs, bipartisan legislation (H.R. 3337/S. 2067) has been introduced in the House and Senate to extend the demonstration authority for the four CNOs for three years.

In addition, Rep. Martin Sabo (D-MN) was successful in having report language included in the House Labor/HHS Appropriations bill for FY 1997 which encourages HCFA to continue the CNO demonstration project through FY 1997. For your review, I am enclosing a copy of that report language as well as a copy of the CBO cost estimate (which is negligible).

If there is not definitive action by October 1, 1996, HCFA has indicated that the CNOs will have to begin their phase-down process. In other words, if Congressional action has not occurred by

October 1, the sites will no longer be permitted to accept new enrollments and must begin the necessary phase-down procedures. A copy of this directive (dated July 22, 1996) is enclosed. In addition, I have enclosed a letter from HCFA Administrator Bruce Vladeck to Rep. Jim Ramstad (R-MN) in response to an inquiry about the CNO demonstration. That letter states that "Considering the uncertainties of the legislative process and the limited number of days remaining in this year's legislative schedule, we [HCFA] are also examining whether we could use alternative statutory authorities to continue the projects for a year to permit Congress time to act."

The extension of the CNO demonstration project was on the list of ten issues which ANA regards as top priorities for immediate Administration action that we presented to Harold Ickes, yourself and others last year.

It is imperative that the CNO demonstration project be reauthorized and that the CNOs receive a clear indication from HCFA by October 1, 1996 that the project will be reauthorized. I would appreciat any assistance you can provide in this regard.

Attachments

cc: Barbara Woolley
Ken Choe

COMMUNITY NURSING ORGANIZATION
Demonstration Project
(CNO)

A. The Community Nursing Organizations* and the American Nurses Association propose:

1. extending the demonstration through 1999
2. enrolling more Medicare beneficiaries in current sites

B. The Community Nursing Organization (CNO) demonstration:

1. is testing managed care for Medicare home care and non-physician services
2. maintains consumer choice and control
3. provides easy access within the community
4. emphasizes health promotion and wellness
5. encourages people to take responsibility for their own health

C. The four demonstration sites in Arizona, Illinois, Minnesota and New York have:

1. reached projected enrollment goals during the first year
2. exceeded enrollment projections in 2 competitive HMO environments
3. exceeded enrollment projections in 2 communities without HMOs
4. enrolled approximately 10,000 Medicare beneficiaries

D. The CNO experience has shown:

1. extremely high enrollee satisfaction
2. overall lower costs than projected
3. decreased traditional Medicare home care costs
4. more cost-effective mix of services
5. shorter duration of traditional Medicare home care
6. utilization of less expensive equipment
7. anticipated decreases in hospital and emergency room costs

*Community Nursing Organizations (CNOs) were created to provide Medicare Part A home care and Part B non-physician services in OBRA legislation in 1987. They were established as a 3 year project and were funded in the 1992-1993 budget. The CNO sites are:

Carondelet Health Care
1120 South Swan Road
Tucson, AZ 85711

Visiting Nurse Service of NY
34-05 Steinway Street
Long Island City, NY 11101

Carle Clinic
602 West University
Urbana, IL 61801

Living at Home/Block Nurse Prog.
#322, 475 N. Cleveland
St. Paul, MN 55104

AMERICAN NURSES ASSOCIATION
600 Maryland Avenue, SW, Suite 100 West, Washington, D.C. 20024-2571, (202) 651-7000

LABOR-HHS APPTS. - FY 1997 HOUSE COMMITTEE REPORT

PAYMENTS TO HEALTH CARE TRUST FUNDS

The bill includes $60,079,000,000 for the Payments to the Health Care Trust Funds account. This is a decrease of $3,234,000,000 below the 1996 level and the same as the Administration request.

This entitlement account includes the general fund subsidy to the Medicare Part B trust fund as well as other reimbursements to the Part A trust fund for benefits and related administrative costs which have not been financed by payroll taxes or premium contributions. The amount provided includes $142 million for program management administrative expenditures, which is the 1997 estimate of the general fund share of HCFA program management expenses. This general fund share will be transferred to the Federal Hospital Insurance Trust Fund to reimburse for the funds drawn down in 1997 from the trust fund to finance program management.

PROGRAM MANAGEMENT

The bill makes available $1,733,125,000 in trust funds for Federal administration of the Medicare and Medicaid programs. This is $391,156,000 less than the amount available for this purpose for fiscal year 1996 and $470,027,000 less than the Administration request.

Research, demonstration, and evaluation

The bill includes $42,000,000 for research and demonstrations. This total is $8,810,000 less than the amount requested by the Administration and $2,000,000 more than the amount provided in 1996. These funds support a variety of studies and demonstrations in such areas as monitoring and evaluating health system performance; improving health care financing and delivery mechanisms; modernization of the Medicare program; the needs of vulnerable populations in the areas of health care access, delivery systems, and financing; and information to improve consumer choice and health status.

The Committee encourages HCFA to conduct demonstrations of promising claims processing systems developed in the private sector designed to detect duplicate payments, diagnosis codes inconsistent with the treatment rendered, unbundling of services, and overcharges.

The Committee encourages HCFA to conduct research demonstrations involving advanced telecommunications networks that are designed to provide primary care to urban, underserved and culturally diverse populations.

The Committee supports the efforts of HCFA and the Department of Defense to negotiate a Medicare subvention demonstration. Subvention has the potential to provide additional healthcare options at a reduced cost. The Committee urges HCFA to act expeditiously in concluding this negotiation.

The Committee encourages the Health Care Financing Administration to continue funding for the Medicare Community Nursing Organization Demonstration Projects through fiscal year 1997. These projects operate in four States to test the efficacy of nursing

organizations at providing managed care for Medicare home care and non-physician services.

The bill does not include funding for health insurance information, counseling and assistance grants, which is $4,500,000 less than the President's request and the same as the 1996 level. These grants provided funding to States to counsel Medicare recipients about insurance benefits and plans. All States have received grants—a total of $30 million. Fifteen States receive funding from other sources for this program. The counseling is largely done on a volunteer basis; HCFA grants were used for a coordinator and some travel.

No funding is provided for rural hospital transition grants, which is $13,089,000 less than the 1996 level and the same as the Administration request. These grants provide $50,000 awards to small rural nonprofit hospitals to help them adapt to changes in the demand for different types of services, changes in the populations served, or changes in the hospital's ability to provide staffing. This program has distributed $149 million since its inception in 1989. Studies suggest that these grants have had only limited impact in stabilizing the financial situation of these small hospitals. Grants tend to be used for consulting services and personnel hiring rather than to make systemic changes to improve the institution's viability.

Medicare contractors

The bill provides $1,207,200,000 to support Medicare claims processing contracts. This is $407,000,000 below the amount requested by the Administration and $390,442,000 below the operating level provided in fiscal year 1996.

The Committee has reduced funding for Medicare contractors in anticipation of the appropriation provided for contractor payment safeguard activities in H.R. 3103, the Health Coverage Availability and Affordability Act of 1996. That legislation, currently in conference, directly appropriates not less than $430,000,000 and not more than $440,000,000 for payment safeguard activities. If H.R. 3103 is not enacted into law, the Committee will consider funding for these activities at the time of conference.

Medicare contractors are responsible for paying Medicare providers promptly and accurately. In addition to processing claims, contractors also identify and recover Medicare overpayments, as well as review claims for questionable utilization patterns and medical necessity. In addition, contractors provide information and technical support both to providers and beneficiaries regarding the administration of the Medicare program. In 1997, contractors are expected to process 861 million claims.

Based on the President's request, the Committee assumes the Medicare Transaction System will be supported at a funding level of $75 million in fiscal year 1997.

	1996	1997
Contractor operations	$1,181,442,000	$1,132,200,000
Payment safeguards	396,000,000	[1](435,000,000)
Medicare Transaction System	20,200,000	75,000,000

MEMORANDUM

TO: Margaret Prinzing
Office of Congressman Martin Sabo

FROM: Robin Rudowitz, CBO

DATE: June 19, 1996

SUBJECT: Preliminary Staff Estimate of a One Year Extension of the Medicare Community Nursing Organization Demonstration Projects

cc: Murray Ross

As you requested, I have reviewed the draft legislative language to extend the Community Nursing Organization (CNO) Demonstration Projects for one year. There are currently CNO demonstration programs operating in 4 sites serving 6,086 Medicare beneficiaries for a total cost of about $7 million. These programs cover a set of Medicare services (including home health, durable medical equipment, prosthetics, orthotics, supplies and ambulance services) which are financed through a capitation payment and administered by a system of nurse case-management. Whether extending this program would cost the federal government money depends on what these beneficiaries would have cost Medicare had they not been enrolled. At this point in time there are not sufficient data to evaluate whether the demonstrations are cost effective, budget neutral or have small costs. Given the size of the program, however, it is unlikely that the net budgetary impact of this extension would be significant. If you have any further questions, I may be reached at 226-9010.

DEPARTMENT OF HEALTH & HUMAN SERVICES — Health Care Financing Administration

6325 Security Boulevard
Baltimore, MD 21207

1 page

To: Marjorie VanderWolf

From: Joan Duhl x 7085

DATE: JULY 22, 1996

TO: CNO SITE DIRECTORS
BOB SCHMITZ
MARY KEOGH

SUBJECT: CNO PHASE-DOWN

Given the uncertainty of the CNO extension legislation, HCFA would like to postpone initiation of the CNO phase-down process until October 1, 1996. By this time, we hope to have more definitive information on the status of the demonstration. It is HCFA's perception that postponing phase-down until October 1, 1996 will not cause undue burden for any of the sites. Please let me know as soon as possible if the postponement is a problem for any of the sites.

To clarify, on October 1st, provided no Congressional action has been taken, the sites will no longer accept new enrollments and begin the necessary phase-down procedures.

If you have any questions or comments, please give me a call at 410-786-8494.

Melissa

Melissa Hulbert

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

SEP - 9 1996

The Honorable Jim Ramstad
House of Representatives
Washington, D.C. 20515

Dear Mr. Ramstad:

Thank you for your recent inquiry regarding the Community Nursing Organization demonstration.

As you know, the field period for this demonstration, specified as three years in the enabling legislation, will conclude on December 31. We hope Congress will act to extend the demonstration in time to avoid any disruption in project operations. Considering the uncertainties of the legislative process and the limited number of days remaining in this year's legislative session, we are also examining whether we could use alternative statutory authorities to continue the projects for a year to permit Congress time to act. We will inform you of the outcome of this review.

Sincerely,

Bruce C. Vladeck
Administrator

MARJORIE W. VANDERBILT

DIRECTOR
FEDERAL GOVERNMENT RELATIONS
AMERICAN NURSES ASSOCIATION
600 MARYLAND AVENUE SW, #100W
WASHINGTON, DC 20024
(202) 651-7085
FAX (202)651-7001

Sept. 12

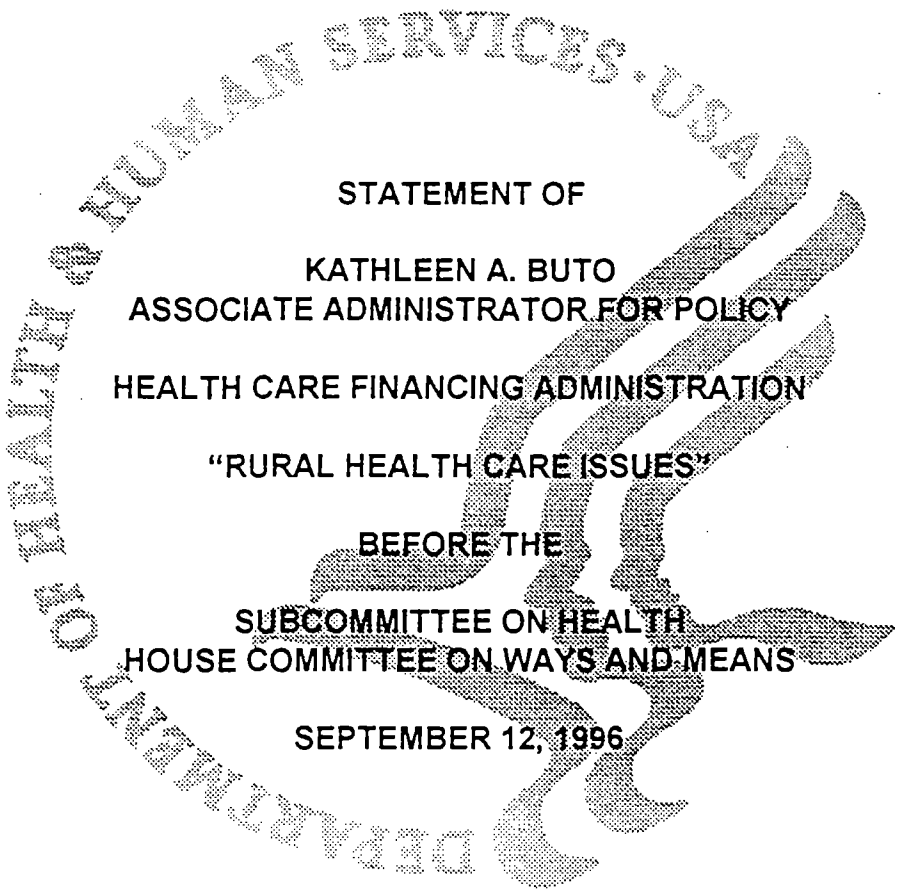
Jennifer -

See page 9

any assistance that the White House can provide in correcting/amending this statement would be greatly appreciated,

thanks very much.

Marjorie



STATEMENT OF

KATHLEEN A. BUTO
ASSOCIATE ADMINISTRATOR FOR POLICY

HEALTH CARE FINANCING ADMINISTRATION

"RURAL HEALTH CARE ISSUES"

BEFORE THE

SUBCOMMITTEE ON HEALTH
HOUSE COMMITTEE ON WAYS AND MEANS

SEPTEMBER 12, 1996

HCFA
MEDICARE · MEDICAID
Health Care Financing Administration

Introduction

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

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

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

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

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

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

Medicare Payment Policies Sensitive to Rural Concerns

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

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

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

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

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

Medicare programs affecting rural areas

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Results of Research

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

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

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

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

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

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

Future Directions

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

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

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

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

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

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