THE EFFECTS OF MARKET-DRIVEN REFORM ON RURAL HEALTH CARE DELIVERY SYSTEMS

Addressing the Policy Implications

Briefing Reference Document
Prepared for

The House Rural Health Care Coalition

May 24, 1995
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RUPRI Rural Health Care Delivery Expert Panel

For more information, contact:

RUPRI Office
University of Missouri
200 Mumford Hall
Columbia, MO 65211
(314) 882-0316
FAX [314] 884=5310
E-mail: rupri@muccmail.missouri.edu

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

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INTRODUCTION

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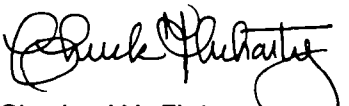

Charles W. Fluharty
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OVERVIEW

Special Project: The Effects of Market-Driven Reform on Rural Health Care Delivery Systems

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- Assess the impact of those changes on rural health care delivery and finance and identify issues amendable to public policy influence or action.
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- Recommend policies which make market forces helpful to rural health care delivery systems

The methodology of the study has included the following activities:

- A review of the published literature, including descriptions of changes that appear in trade journals and other sources
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MEDICAID

To what extent has Medicaid managed care been implemented in rural areas?

How has Medicaid managed care affected rural Medicaid beneficiaries and rural health systems?

FINDINGS

- States are rapidly moving to develop and implement the full range of Medicaid managed care programs and strategies, including risk-based contracting. The application of capitated programs in rural areas is limited but growing.

- In many rural areas, Medicaid managed care is providing rural citizens and providers their first experience with managed care.

- Medicaid managed care is stimulating rural network development in some areas.

- Most Medicaid managed care systems are limited to AFDC-related beneficiaries. There is very little experience with serving elderly and disabled Medicaid beneficiaries in managed care systems.

- The majority of state Medicaid programs are employing primary care case management strategies in rural areas. There are only a few states that have (selectively) implemented fully capitated managed care programs in rural areas. Partially capitated programs are more prevalent in rural areas, though still rare in most states.

- The fear (and reality) of financial liability are limiting the use of risk-based contracting in rural areas, particularly among providers with little or no managed care experience.

- The use of capitated programs is most likely in areas where urban-based plans or provider systems are able to extend their plan to rural communities and populations.

- The effects of Medicaid managed care systems on Rural Community Health Centers, Rural Health Clinics and other providers serving vulnerable, underserved populations is mixed.

    - Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) can adapt to managed care and, in some cases, have benefited financially under capitated arrangements.

- There are other circumstances where FQHCs and RHCs would have difficulty under capitated payment arrangements unless rates were set high enough to cover the costs of indigent care.

- Providers and others report enhanced access to care for Medicaid beneficiaries under managed care programs.

- Rapid implementation of Medicaid managed care programs in underserved rural areas has exacerbated rural access problems.

POLICY IMPLICATIONS

There will be growing pressures on states to move to risk-based managed care for all beneficiaries and providers, including those in rural areas. The expansion of Medicaid managed care in rural areas raises a number of important policy issues, including:

- The federal waiver process should explicitly take into account the difficulties in implementing Medicaid managed care in underserved rural areas.

- Where problems in primary care supply may limit access to care.

- More specific criteria and standards for determining the appropriate level of risk that can be assumed by smaller providers and networks are needed to assure the appropriateness and quality of care under Medicaid managed care.

- To protect rural providers and beneficiaries under capitated arrangements, the federal government and states need to develop mechanisms for providing financial protection in the form of stop loss and reinsurance for providers with a limited capacity for assuming financial risk.

- The development and expansion of Medicaid managed care programs through the federal waiver process requires greater participation and education of rural providers and beneficiaries.

MEDICARE

To what extent are rural Medicare beneficiaries enrolled in Medicare risk plans?

What are the policy issues that need to be considered if Medicare is to implement risk-based contracts in rural areas?

FINDINGS

- Medicare risk-based contracts are extremely rare in rural areas.
- Medicare risk contracts are most likely to develop in rural communities adjacent to more urbanized areas.
- The expansion of Medicare risk contracting is viewed by many as a potentially important stimulus to rural network development given the large Medicare populations in many rural areas.
- Medicare risk-based contracts would likely place financial pressure on rural hospitals as health plans negotiate discounts and control utilization.
- Low Medicare capitation rates have limited the ability of HMOs and others to develop risk-based contracts in rural areas. Because of low historical costs, the Adjusted Average Per Capita Cost (AAPCC), which is used to calculate capitation rates, is substantially lower in most rural than urban counties.

POLICY IMPLICATIONS

There are substantial barriers to the development of Medicare risk-based contracts in rural areas. Nevertheless, the expansion of Medicare risk-based contracts is seen by some as important to rural systems development. Among the most critical policy challenges are:

- The methodology for calculating Medicare capitation rates should be revised if health plans and providers are to be able to develop successful risk-based contracts in rural areas.
    - Such changes should adjust for urban-rural payment and expenditure differences associated with rural health care capacity and access problems.
    - The development of rural capitation rates should take into account differences in risk characteristics between urban and rural Medicare beneficiaries.

- Partial capitation and other payment options, many of which have been developed and used in the Medicaid program as well as the private sector, should be considered as appropriate options for rural plans.

- Specific criteria and standards for determining the appropriate financial risk that can be assumed by smaller providers and networks are needed to assure the appropriateness and quality of care under Medicare risk-based contracts.

- Federal health personnel, network assistance and telecommunications policy and assistance programs could be instrumental in assuring the appropriate availability and use of physicians and other rural providers under Medicare risk plans.

PRIVATE AND PUBLIC PURCHASING

To what extent are changes in private and public sector purchasing strategies occurring in rural areas?

How have changes in private and public sector purchasing strategies impacted rural areas?

FINDINGS

- The private sector is not a major stimulus for initiating managed care in rural areas. First, rural health care costs in most areas are already relatively low--partly because of the historically-based, low fee structure, and partly because expensive tertiary care is not the centerpiece of the rural delivery system. Second, the number of rural providers is small (at least the personnel resource), and most are at capacity. This reduces the opportunity for aggressive competitive bidding. Additionally, existing cost-based rural systems that are targeted to hard-to-serve populations do not represent a conducive environment for managed care.

- Where firms or coalitions of firms have formed to strengthen their bargaining power, most have not aggressively pursued capitated managed care arrangements. The more common strategy is to work with the local providers on utilization review, and perhaps initiate a PPO arrangement. These initiatives from the business sector may increase local utilization, even if total utilization per capita decreases.

- Capitated managed care arrangements are sometimes seen as a double-edged sword: both consumers and providers like the (typical) first-dollar coverage, but providers feel an increased administrative burden due to pre-authorization requirements, and other administrative requirements.

- There is movement to managed care by public employers and employee groups but indemnity products continue to dominate in rural areas.

- Where managed care arrangements have begun, little data on financial savings or satisfaction is available due to the relatively short time state and local employee managed care plans have been in operation.

- The perception that urban-based care systems are attempting to secure a rural population base has been a stimulus for organizing locally, or for advocating for any-willing-provider legislation.

- Although there are exceptions, there is limited movement toward employer-based self-insurance in rural areas. Where self-insurance exists, it is primarily by larger rural firms; most rural firms are quite small, however.

- Where businesses move to self-insurance there is a tendency to keep costs to the business low by establishing higher employee cost sharing. Self-insurance appears to generate some increased interest by employers in health promotion and prevention.

- Private sector self-insurance often leads to greater involvement with and support for the local provider community.

- Many Multiple Employer Welfare Associations (MEWAs) exist in rural areas, including those formed by cooperatives, farm bureaus, electric associations, and farm cooperatives. Additionally, there is a small but growing movement to establish formal Health Insurance Purchasing Cooperatives (HIPCs).

- There are differing models for joint public purchasing arrangements directed at cost containment and assuring choice. The models include state and local government employee pools and using state employees as a basis for an alliance structure with private employees.

- The insurance options available through pooled purchasing strategies are defined by existing products and providers in the areas.

- Many states are embarking on various dimensions of health insurance reform, including mandated portability, guaranteed issue, restrictions on pre-existing condition clause, community rating provisions, etc.

- Most of the changes in state health insurance laws and regulations have occurred within the past two years, and it is not possible to assess their effects at this time-especially on rural areas.

- A differential price in small group insurance and large group insurance remains in spite of insurance reforms and has a negative impact on rural employers.

POLICY IMPLICATIONS

- States, counties and local governments can serve as the foundation of purchasing strategies, including managed care in rural areas by using the large purchasing power of state and local employee health plans.

- Local feedback and/or governance seems critical for realizing the advantages to consumers and providers of employer self-insurance.

- The full benefits of purchasing strategies can only be realized if numerous small groups coalesce into larger purchasing alliances.

- Under the best case scenario, insurance reform at both state and federal levels, will have only a modest impact on lowering insurance costs and reducing the number of rural uninsured.

HEALTH CARE PERSONNEL

How are market changes affecting the supply of health care personnel, and the need for their services, in rural areas?

What policy challenges and opportunities are presented by these changes?

FINDINGS

- Market forces are exerting opposite effects on the rural availability of primary care versus consultative specialty physician services.
    - Primary care remains in short supply.
    - Specialty consultation is becoming more accessible.
- The reality and the anticipation of managed care is pushing up salaries for primary care personnel. Urban systems are better organized and capitalized and are stronger bidders than rural systems.
- Medicaid managed care systems, assigning Medicaid patients to specific physicians, are making existing shortages of primary care personnel more apparent.
- Weaker trends are improving primary care supply:
    - Some urban physicians are moving to rural areas to avoid managed care.
    - Some rural organizations are becoming more sophisticated in recruiting.
    - Some organized care systems are opening new rural clinics.
    - The potential of organized care systems to bring order to the lives of rural physicians is great.
- An abundance of specialists, and urban managed care, have reduced workload for specialists who are now looking for new patients by visiting rural areas.
- Specialty-based urban systems are trying to consolidate their "feeder" relationships with rural areas through visiting specialty clinics and "telemedicine" linkages.
- Access to immigrant ("J-1") physicians has been extended to rural areas of all states. Most of these physicians are referral specialists.

- "Telemedicine" can put the rural patient in contact with urban consultant without travel by either party.

- Capitated care reduces incentives for excessively frequent physician visits, and provides incentives for substitution of non-physician personnel.

POLICY IMPLICATIONS

Policy should be structured to:

A. Increase the effective supply of primary care personnel. Medicare managed care will increase urgency. Options include:

   - Permitting existing personnel, particularly physician assistants and nurse practitioners, to practice at levels for which they are trained.

   - Shifting federal Medicare support for graduate medical education from specialty to primary care, and allocating support according to state population.

   - Encouraging primary care training for physicians, physician assistants and nurse practitioners.

   - Leveling Medicare and Medicaid urban/rural reimbursement to permit more equal competition for existing personnel.

   - Developing performance standards regarding availability of local services for managed care systems proposing to serve rural areas.

B. Leave the supply and distribution of medical referral specialists to market dynamics and telemedicine by:

   - Reducing or eliminating Medicare support for graduate medical education of referral specialists.

   - Limiting eligibility of international medical graduates for waivers of J-1 visa requirements to physicians trained in designated primary care residency training programs.

RURAL HEALTH SYSTEMS

To what extent and how are the organization and financing of rural health systems changing in response to market forces?

What is the impact of these changes on rural communities?

FINDINGS

- Network development is occurring most actively in response to two circumstances:
  - Positioning for future affiliations and contracts.
  - Medicaid managed care is providing a large stimulus for system development in the communities in which it is located.
- A full spectrum of networks are developing in rural communities ranging from loose associations to risk sharing groups.
- Most network development is horizontal (e.g. hospitals networking or doctors networking amongst themselves) with some vertical (e.g. doctors associating with one or more hospitals) development depending on the historical and other conditions in the local community.
  - Networks are found in many communities, but they usually have a limited share of the local market.
  - Hospital networks, physician hospital organizations, and physician groups are found in many states. These entities range from loose associations to highly structured organizations.
  - In some states networking is developing rapidly.
  - There are rural networks that assume insurance functions, but most don't.
  - Networks that are locally responsive, whether developed locally or from outside of the community, are valued by rural communities.
- Urban based networks are expanding into rural areas in many states.
- Fear of anti-trust litigation remains a major concern for rural providers.
- Providers dominate in decisions related to the development of networks. Broad community involvement is minimal except in times of crisis (e.g. a hospital closing).

- In general, market forces have not changed the availability of services in rural communities.
    - The record is fairly neutral at this point, but many rural residents believe that as managed care gets established, rural communities will lose access to local services.
    - Market changes are making small, low-volume rural hospitals vulnerable to closure.
- Networks are stabilizing some rural health systems. The presence of an organized health network has provided financial or organizational benefits in many rural communities.

POLICY IMPLICATIONS

- Network development:
    - Any legal structuring of networks, anti-trust exemptions, or support for their development should ensure that networks are locally responsive.
    - Support should be provided to increase the availability of mechanisms for stop-loss and capital financing for rural communities.
    - Rural networks often need support to overcome legal, organizational, and management information challenges.
    - Explicit anti-trust language would benefit rural health systems if the exemptions include requirement for local responsiveness.
    - Managed care systems need to include local networks in their provider networks.
    - Any government programs should include local involvement and priority setting as primary criteria for any aid, program, or incentive that are provided to health systems working in rural communities.
- Service Availability:
    - There should be constant assessment of service availability in rural communities to inform policy makers of service problems. Early detection is important to ensure long term survival of fragile rural health systems.
    - Performance standards should be developed that assure the provision of appropriate local care.

MEMBERS
RUPRI RURAL HEALTH DELIVERY EXPERT PANEL

Andrew F. Coburn, Ph.D. is the Associate Director for Research Programs and Associate Professor of Health Policy and Management in the Edmund S. Muskie Institute of Public Affairs 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, Medicaid physician payment policies and 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 past member of the National Advisory Committee on Rural Health, U.S. Department of Health and Human Services and a member of 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.

Robert A. Crittenden, M.D., MPH is currently the Health Policy Analyst for the Office of the Dean of the School of Medicine at the University of Washington in Seattle. He also is a primary care physician working with Native American and low-income people. In the past, Dr. Crittenden was staff for the commission that designed the Washington Basic Health Plan and a health policy fellow in the office of Senator George Mitchell where he worked on outcomes research, long term care and health reform. He has also served as health policy advisor to Governor Booth Gardner of Washington State and chaired the staff committee of the National Governor's Association when they developed their policy on health care reform.

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. He 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 a 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 Associate Professor and Director of Rural Health Education and Services Planning at the University of Minnesota-Duluth School of Medicine. Before accepting his current responsibilities, Dr. Hart held faculty positions at 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.

Keith J. Mueller, Ph.D. is Professor of Political Science and Director of the Center for Rural Health research in the Department of Preventive and Societal Medicine at the University of Nebraska Medical center. He has published extensively on a variety of state and federal health care policy research issues, including a book, *Health Care Policy in the U.S.*, and a series of rural health policy briefs on national and state health reform legislation. He currently serves as President-Elect of the National Rural Health Association.

Wayne W. Myers, M.D. is Professor of Pediatrics and Director of the University of Kentucky Center for Rural Health in Hazard, Kentucky. Dr. Myers has also held academic appointments at the University of Alaska, Fairbanks and at the University of Washington School of Medicine, Seattle, where he served as Director of the WAMI Program, a rurally oriented medical education program in Washington, Alaska, Montana and Idaho. In addition, he has considerable experience as a policy advisor in health planning and rural health system development in Alaska, the U.S. Bureau of Health Professions and Indian Health Service.

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- Most of the changes in state health insurance laws and regulations have occurred within the past two years, and it is not possible to assess their effects at this time-especially on rural areas.

- A differential price in small group insurance and large group insurance remains in spite of insurance reforms and has a negative impact on rural employers.

POLICY IMPLICATIONS

- States, counties and local governments can serve as the foundation of purchasing strategies, including managed care in rural areas by using the large purchasing power of state and local employee health plans.

- Local feedback and/or governance seems critical for realizing the advantages to consumers and providers of employer self-insurance.

- The full benefits of purchasing strategies can only be realized if numerous small groups coalesce into larger purchasing alliances.

- Under the best case scenario, insurance reform at both state and federal levels, will have only a modest impact on lowering insurance costs and reducing the number of rural uninsured.

HEALTH CARE PERSONNEL

How are market changes affecting the supply of health care personnel, and the need for their services, in rural areas?

What policy challenges and opportunities are presented by these changes?

FINDINGS

- Market forces are exerting opposite effects on the rural availability of primary care versus consultative specialty physician services.
  - Primary care remains in short supply.
  - Specialty consultation is becoming more accessible.
- The reality and the anticipation of managed care is pushing up salaries for primary care personnel. Urban systems are better organized and capitalized and are stronger bidders than rural systems.
- Medicaid managed care systems, assigning Medicaid patients to specific physicians, are making existing shortages of primary care personnel more apparent.
- Weaker trends are improving primary care supply:
  - Some urban physicians are moving to rural areas to avoid managed care.
  - Some rural organizations are becoming more sophisticated in recruiting.
  - Some organized care systems are opening new rural clinics.
  - The potential of organized care systems to bring order to the lives of rural physicians is great.
- An abundance of specialists, and urban managed care, have reduced workload for specialists who are now looking for new patients by visiting rural areas.
- Specialty-based urban systems are trying to consolidate their "feeder" relationships with rural areas through visiting specialty clinics and "telemedicine" linkages.
- Access to immigrant ("J-1") physicians has been extended to rural areas of all states. Most of these physicians are referral specialists.

- "Telemedicine" can put the rural patient in contact with urban consultant without travel by either party.

- Capitated care reduces incentives for excessively frequent physician visits, and provides incentives for substitution of non-physician personnel.

POLICY IMPLICATIONS

Policy should be structured to:

A. Increase the effective supply of primary care personnel. Medicare managed care will increase urgency. Options include:

   - Permitting existing personnel, particularly physician assistants and nurse practitioners, to practice at levels for which they are trained.

   - Shifting federal Medicare support for graduate medical education from specialty to primary care, and allocating support according to state population.

   - Encouraging primary care training for physicians, physician assistants and nurse practitioners.

   - Leveling Medicare and Medicaid urban/rural reimbursement to permit more equal competition for existing personnel.

   - Developing performance standards regarding availability of local services for managed care systems proposing to serve rural areas.

B. Leave the supply and distribution of medical referral specialists to market dynamics and telemedicine by:

   - Reducing or eliminating Medicare support for graduate medical education of referral specialists.

   - Limiting eligibility of international medical graduates for waivers of J-1 visa requirements to physicians trained in designated primary care residency training programs.

RURAL HEALTH SYSTEMS

To what extent and how are the organization and financing of rural health systems changing in response to market forces?

What is the impact of these changes on rural communities?

FINDINGS

- Network development is occurring most actively in response to two circumstances:
  - Positioning for future affiliations and contracts.
  - Medicaid managed care is providing a large stimulus for system development in the communities in which it is located.
- A full spectrum of networks are developing in rural communities ranging from loose associations to risk sharing groups.
- Most network development is horizontal (e.g. hospitals networking or doctors networking amongst themselves) with some vertical (e.g. doctors associating with one or more hospitals) development depending on the historical and other conditions in the local community.
  - Networks are found in many communities, but they usually have a limited share of the local market.
  - Hospital networks, physician hospital organizations, and physician groups are found in many states. These entities range from loose associations to highly structured organizations.
  - In some states networking is developing rapidly.
  - There are rural networks that assume insurance functions, but most don't.
  - Networks that are locally responsive, whether developed locally or from outside of the community, are valued by rural communities.
- Urban based networks are expanding into rural areas in many states.
- Fear of anti-trust litigation remains a major concern for rural providers.
- Providers dominate in decisions related to the development of networks. Broad community involvement is minimal except in times of crisis (e.g. a hospital closing).

- In general, market forces have not changed the availability of services in rural communities.
    - The record is fairly neutral at this point, but many rural residents believe that as managed care gets established, rural communities will lose access to local services.
    - Market changes are making small, low-volume rural hospitals vulnerable to closure.
- Networks are stabilizing some rural health systems. The presence of an organized health network has provided financial or organizational benefits in many rural communities.

POLICY IMPLICATIONS

- Network development:
    - Any legal structuring of networks, anti-trust exemptions, or support for their development should ensure that networks are locally responsive.
    - Support should be provided to increase the availability of mechanisms for stop-loss and capital financing for rural communities.
    - Rural networks often need support to overcome legal, organizational, and management information challenges.
    - Explicit anti-trust language would benefit rural health systems if the exemptions include requirement for local responsiveness.
    - Managed care systems need to include local networks in their provider networks.
    - Any government programs should include local involvement and priority setting as primary criteria for any aid, program, or incentive that are provided to health systems working in rural communities.
- Service Availability:
    - There should be constant assessment of service availability in rural communities to inform policy makers of service problems. Early detection is important to ensure long term survival of fragile rural health systems.
    - Performance standards should be developed that assure the provision of appropriate local care.

MEMBERS
RUPRI RURAL HEALTH DELIVERY EXPERT PANEL

Andrew F. Coburn, Ph.D. is the Associate Director for Research Programs and Associate Professor of Health Policy and Management in the Edmund S. Muskie Institute of Public Affairs 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, Medicaid physician payment policies and 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 past member of the National Advisory Committee on Rural Health, U.S. Department of Health and Human Services and a member of 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.

Robert A. Crittenden, M.D., MPH is currently the Health Policy Analyst for the Office of the Dean of the School of Medicine at the University of Washington in Seattle. He also is a primary care physician working with Native American and low-income people. In the past, Dr. Crittenden was staff for the commission that designed the Washington Basic Health Plan and a health policy fellow in the office of Senator George Mitchell where he worked on outcomes research, long term care and health reform. He has also served as health policy advisor to Governor Booth Gardner of Washington State and chaired the staff committee of the National Governor's Association when they developed their policy on health care reform.

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. He 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 a 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 Associate Professor and Director of Rural Health Education and Services Planning at the University of Minnesota-Duluth School of Medicine. Before accepting his current responsibilities, Dr. Hart held faculty positions at 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.

Keith J. Mueller, Ph.D. is Professor of Political Science and Director of the Center for Rural Health research in the Department of Preventive and Societal Medicine at the University of Nebraska Medical center. He has published extensively on a variety of state and federal health care policy research issues, including a book, *Health Care Policy in the U.S.*, and a series of rural health policy briefs on national and state health reform legislation. He currently serves as President-Elect of the National Rural Health Association.

Wayne W. Myers, M.D. is Professor of Pediatrics and Director of the University of Kentucky Center for Rural Health in Hazard, Kentucky. Dr. Myers has also held academic appointments at the University of Alaska, Fairbanks and at the University of Washington School of Medicine, Seattle, where he served as Director of the WAMI Program, a rurally oriented medical education program in Washington, Alaska, Montana and Idaho. In addition, he has considerable experience as a policy advisor in health planning and rural health system development in Alaska, the U.S. Bureau of Health Professions and Indian Health Service.

rural policy research institute

RUPRI OFFICE
200 Mumford Hall
University of Missouri
Columbia, MO 65211
(314) 882-0316
FAX [314] 884=5310
E-mail: rupri@muccmail.missouri.edu