THE NEED FOR BETTER FOCUS IN THE RURAL HEALTH CARE CLINIC PROGRAM—PART II

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES

OF THE

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

SEPTEMBER 11, 1997

Serial No. 105–90

Printed for the use of the Committee on Government Reform and Oversight

U.S. GOVERNMENT PRINTING OFFICE

47–203 WASHINGTON : 1998

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-056433-6

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THE NEED FOR BETTER FOCUS IN THE RURAL HEALTH CARE CLINIC PROGRAM—PART II

THURSDAY, SEPTEMBER 11, 1997

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HUMAN RESOURCES,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2247, Rayburn House Office Building, Hon. Christopher Shays (chairman of the subcommittee) presiding.

Present: Representatives Shays, Snowbarger, Pappas, Towns, Kucinich.

Staff present: Lawrence J. Halloran, staff director and counsel; Marcia Sayer, professional staff member; R. Jared Carpenter, clerk; and Cherri Branson, minority counsel.

Mr. SHAYS. On February 13, we heard testimony that the Rural Health Clinic [RHC] program was off course and out of focus. Designed to improve access to primary care in rural and underserved areas, the program had grown, dramatically, for the wrong reasons and in the wrong places.

We learned ill-conceived Medicare reimbursement policies drove RHC growth while outdated, ineffective determinations of need permitted that growth in areas already well-served by existing health care systems. The General Accounting Office [GAO] concluded the program was adrift, poorly targeted and lacking controls on costs that could reach $1 billion by the year 2000.

The two Department of Health and Human Services [HHS] agencies responsible for the RHC effort promised both legislative and regulatory proposals to address acknowledged weaknesses in the program. The Health Care Financing Administration [HFCA] committed to pursue effective cost controls. The Health Resources and Services Administration [HRSA] pledged imminent regulatory action to improve the timeliness and accuracy of the designations used to determine where RHCs are needed.

Now, 7 months later, statutory changes included in the Balanced Budget Act of 1997 will cap Medicare payments to the rapidly growing numbers of provider-based RHC's, and eligibility criteria have been tightened somewhat. But HRSA has yet to unveil promised fixes to the flawed system used to designate medically underserved areas [MUA] and health professional shortage areas [HPSA], the key eligibility determinations upon which the RHC program, and many others, still rely.

Today, as we continue our oversight of the Rural Health Clinic Program, we focus on the impact of inaccurate MUA and HPSA designations on those trying to expand access to primary care in truly underserved areas. We also asked our witnesses to help us, and the Department, fashion meaningful performance criteria against which we all can measure the success, or failure, of rural health clinics.

In the end, that may be the most significant improvement the Department can make to a program that, over 30 years, has designated areas of medical need in 88 percent of all U.S. counties, but cannot demonstrate any of its efforts have improved access to primary care.

I hope and suspect they have. But until the RHC program, and other programs like it, can prove they are achieving the intended results, resources will be wasted and rural needs unmet. Until we can measure, and reward, successful rural health clinics with some more permanent status in the health care delivery system, MUA and HPSA designations will remain a cruel trap, a catch-22, in which success is punished by loss of the very status that enables RHC's to succeed.

As the subcommittee continues our consultations with the Department under the Government Performance and Results Act, testimony from this hearing will help us establish the right strategic goals and measurable performance standards for the RHC program.

We appreciate the time, expertise and unique perspective of each of our witnesses today. We welcome all of them.

[The prepared statement of Hon. Christopher Shays follows:]

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Statement of Rep. Christopher Shays
September 11, 1997

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As the Subcommittee continues our consultations with the Department under the Government Performance and Results Act, testimony from this hearing will help us establish the right strategic goals and measurable performance standards for the RHC program.

We appreciate the time, expertise and unique perspective of each of our witnesses today. Welcome.

Mr. SHAYS. Mr. Towns.

Mr. TOWNS. Thank you very much, Mr. Chairman, for holding this hearing on rural health care clinic programs. This is our second hearing on this subject. Today we will focus on actions taken by the Department of Health and Human Services and the Health Resources Administration to address the problems of designating RHC in examining HHS use of its strategic plan to develop a reasonable goal and measures to improve access to primary care in rural areas.

Before we begin, Mr. Chairman, let us not forget the need which led to this program. One quarter of the U.S. population, or about 65 million, reside in rural areas. In rural areas, like in other areas, the major factor affecting the health care are access and affordability. Rural residents not only have unique problems of geography, but, also, encounter affordability issues usually associated with inner-city urbanites, such as a lack of health insurance coverage and poverty-level incomes.

As late as 1994, there were 149 counties with over one-half million residents without an active physician. In 1995, the Federal Government had designated 2,617 areas experiencing shortages of primary care practitioners. The Rural Health Clinic Program was established by Congress as a funded mechanism which would enable the private sector to step in and solve this problem with a little help from a Federal agency, the Health Care Financing Administration.

When the RHCA was passed, projections of participation were optimistic, everybody was excited. But by October 1990, only 581 clinics had signed on. To increase participation, Congress enacted several amendments to the original RHC law to encourage participations or providers in the program. In 1987, we increased payment caps and established annual payment increases. In 1989, we gave Governors the option of designating health care shortage areas within the States and required HCFA to disseminate RHC application material to all Medicare providers, hospitals, skilled nursing facilities and home-health agencies.

As a way of promoting participation in the program, in 1990, we required HCFA to expedite the approval time for RHC certification. These changes increased the number of RHC significantly from 581 in 1990 to 3,270 in 1997.

Now I am told that our efforts alone did not increase participation, but that fraud played a major role in this increase. Needless to say, I find this very disturbing. As the agency responsible for the management and oversight of the Medicare and Medicaid Program, I expect HCFA to guide and direct this program as well. Because of HCFA's role in setting the payment rates, examine the programs for fraud and other important functions in the administration of this program, it seems to me that they are the proper party to question about the use of designation and overall integrity of the Rural Health Care Program.

As I recall, HCFA was here at our first hearing on this subject. I'm disappointed today, Mr. Chairman, that they are not here. In any event, it is my understanding that the Health Resources and Services Administration has used the previous 7 months to develop measures that would address the portion of the designation prob-

lem within its control. However, it should be noted that any such regulation will require inspections and reassessment of applications on an ongoing basis. In essence, while necessary to avoid waste and fraud on the program, enforcement of such a rule will probably require the same kind of Federal interference in private business which the majority often finds objectionable.

Finally, it is my understanding that there is some concern about whether the Rural Health Clinic Program actually improves access to care. It seems to me that this should be our core concern: access to care was our primary reason for enacting this program. Therefore, it seems to me that this is the true yardstick by which we should measure the success of the program in both human and financial terms. However, those questions cannot and will not be answered here today, Mr. Chairman.

It is my understanding that HCFA has contracted with Mathematica Policy Research Inc., to conduct a study and write a comprehensive about the relationship between RHC and access to care. A final report is expected sometime this year. I believe that the report will help us to look at the issue more fully, which we should do. I suggest that, when the report is issued, we hold another hearing to examine its findings.

Again, thank you for holding today's hearing and I look forward to hearing from the witnesses and am looking forward to working with you to see what we can do to improve this situation.

Mr. Chairman, on that note, I yield back.

[The prepared statement of Hon. Edolphus Towns follows:]

OPENING STATEMENT OF

REP. EDOLPHUS TOWNS
RANKING DEMOCRATIC MEMBER

BEFORE THE SUBCOMMITTEE ON HUMAN RESOURCES

SEPTEMBER 11, 1997

Mr. Chairman, thank you for holding today's hearing on the Rural Health Care Clinic program. This is our second hearing on this subject. Today, we will focus on actions taken by the Department of Health and Human Services and the Health Resource Services Administration to address the problem of designating RHC's and examine HHS' use of its strategic plan to develop reasonable goals and measures to improve access to primary care in rural areas.

But before we begin this hearing, let us not forget the need which led to this program. One-quarter of the U.S. population, or about 65 million people, reside in rural areas. In rural areas, like in other areas, the major factors affecting health care are access and affordability. Rural residents not only have unique problems of geography but also encounter affordability issues usually associated with inner-city urbanites, such as a lack of health insurance coverage, and poverty level incomes. As late as 1994, there were 149 counties with over half million residents without an active physician. In 1995, the Federal government had designated 2,617 areas experiencing shortages of primary care practitioners. The Rural Health Clinic Program was established by Congress as a funding mechanism which would enable the private sector to step in and solve this problem with a little help from a federal agency, the Health Care Financing Administration (HCFA).

When the RHCA was passed, projections of participation were optimistic. But by October 1990, only 581 clinics had signed on. To increase participation, Congress enacted several amendments to the original RHC law to encourage participation of providers in the program. In 1987, we increased payment caps and established annual payment increases; in 1989, we gave governors the option of designating health care shortage areas within the states and required HCFA to disseminate RHC application materials to all Medicare providers (hospitals, skilled nursing facilitates and home health agencies) as a way of promoting participation in the program. In 1990 , we required HCFA to expedite the approval time for RHC certification. These changes increased the number of RHC's significantly, from 581 in 1990 to 3,270 in 1997.

Now, I am told that our efforts alone did not increase participation but that fraud played a major role in this increase. Needless to say, I find this a little disturbing. As the agency responsible for the management and oversight of the Medicare and Medicaid programs, I expect HCFA to guide and direct this program as well. Because of HCFA's role in setting the payment rates, examining the program for fraud and other important functions in the administration of this program, it seems to me that they are the proper party to question about the use of designations and the overall integrity of the rural health care program. As I recall, HCFA was here at our first hearing on this subject. I am disappointed that they are not here today.

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Mr. SHAYS. Thank the gentleman. I will call our first panel, which is actually panel two, Bernice Steinhardt, Director Health Service Quality, Public Health, General Accounting Office, accompanied by Frank Pasquier, Assistant Director, Health Issues, Seattle General Accounting Office. Did I pronounce your name properly?

Mr. PASQUIER. Correct.

Mr. SHAYS. Accompanying them is Lucinda Baumgartner, Senior Evaluator, General Accounting Office. OK. We swear in witnesses and I would ask you to rise and raise your right hand.

[Witnesses sworn.]

Mr. SHAYS. If I might, just let me get some housekeeping out of the way before we begin with you Ms. Steinhardt.

I ask unanimous consent that all members of the subcommittee be permitted to place any opening statement in the record and the record remain open for 3 days for that purpose and without objection, so ordered. And I ask further, unanimous consent that all witnesses be permitted to include their written statement in the record and without objection, so ordered.

My sense is, Ms. Steinhardt, that you will be giving the testimony and that we will be asking questions in which all three will participate.

Ms. STEINHARDT. Correct.

Mr. SHAYS. OK. Nice to have you here again.

Ms. STEINHARDT. Thank you very much, it is always a pleasure. I wanted to introduce one other person who is a key member of the team, Kim Yamane.

Mr. SHAYS. Is it possible that she may also respond to questions as well?

Ms. STEINHARDT. I don't think so.

Mr. SHAYS. OK.

Ms. STEINHARDT. But, I wanted her to be recognized.

Mr. SHAYS. Where is she? Way in the back? Why don't you come up in the front, if you're going to be recognized by this committee? Nice to have you here. OK.

STATEMENT OF BERNICE STEINHARDT, DIRECTOR, HEALTH SERVICES QUALITY AND PUBLIC HEALTH ISSUES, HEALTH, EDUCATION AND HUMAN SERVICES DIVISION, ACCOMPANIED BY FRANK PASQUIER, ASSISTANT DIRECTOR, HEALTH ISSUES, SEATTLE GENERAL ACCOUNTING OFFICE, AND LUCINDA BAUMGARTNER, SENIOR EVALUATOR, GENERAL ACCOUNTING OFFICE

Ms. STEINHARDT. Good morning to all of you.

Mr. SHAYS. Good morning.

Ms. STEINHARDT. Since our testimony earlier this year on rural health clinics, a number of changes have occurred that I would like to talk about in our testimony this morning, but I also want to talk about rural health clinics in a larger context as part of the array of Federal programs that are intended to improve access to health care.

We believe it is important to look at these programs as a whole to see how well they are meeting this broad goal and we believe that the Government Performance and Results Act, whose objective

is to improve accountability for results, offers a helpful framework for doing that.

Let me start with some background. The Federal Government, along with State and local governments, support more than 30 programs that are aimed at helping people get the primary health care services they need. The largest and best known, of course, is the Medicaid Program, but in addition to Medicaid, the Federal Government spent another $1 billion or so last year on programs to improve access to care. One of these, of course, is the Rural Health Clinic Program. But others include community health centers and the National Health Service Corps which places physicians in areas that are considered to have a shortage.

Over the last several years, we have looked at a number of these programs and we found that, while they provided a number of benefits, historically they haven't been held accountable for showing that access has indeed been improved. In fact, in some places, we found little resulting change. You may recall when we testified on rural health clinics, that our review had showed that at least for 90 percent of the Medicare and Medicaid beneficiaries in a very large sample of clinics, their care had not changed appreciably as a result of the program.

We also found similar problems with programs that place providers in underserved areas where we found that some communities had more than they needed while others had received none. In our view, a major cause of these problems is a reliance on flawed systems for measuring need.

HHS has two ways of classifying communities that are underserved, which you mentioned Mr. Shays, the HPSA, health professional shortage area system, and the MUA, medically underserved area, shortage system.

There are a number of problems with these systems. We found, for example, that more than half of the under service designations may be invalid because they're outdated, or because they don't take into account all of the primary care providers, like nurse practitioners and physician assistants, that might be available in communities.

So today, as you pointed out, after decades of Federal efforts, there are no fewer areas classified as underserved than there were originally. What's more, as you said, close to 90 percent of all U.S. counties contain HPSA's, MUA's or both, so that it's difficult even to tell where the needy areas really are. And finally, even if it were possible to tell which areas are really needy, the designation system does not permit one to judge what type of assistance a community might benefit from. Again, the Rural Health Clinic Program offers a good illustration.

Under the program, all providers in rural MUA's or HPSA's can request certification in order to receive higher Medicaid or Medicare reimbursement. But, if the underserved group in that community is the uninsured poor, the program does little or nothing to improve their access.

For the most part, we think the problems that we identified in the Rural Health Clinic Program were addressed in the Balanced Budget Act passed last month. First of all, the act placed limits on payments made to clinics owned by hospitals, which was one of the

steps we recommended, you will recall. And the act also narrowed eligibility. Rural health clinics now have to be located in areas that, in addition to being a rural HPSA or MUA, also have an insufficient number of health care practitioners as defined by the HHS Secretary. And, second, clinics are allowed only in shortage areas that have been designated within the past 3 years. And finally, if an existing rural health clinic is in an area that's no longer a rural shortage area, it can keep its designation only if the Secretary finds that it's essential for the delivery of primary care.

While these are important changes, until they are implemented, HHS will still be relying on the HPSA and MUA systems—systems that assume that providing services to anyone living in a designated shortage area is going to improve their access to care.

The Department has been studying changes to the shortage area systems for at least the last 5 years, but it has not yet published any formal proposals. And, in the meantime, new programs are being developed that continue to rely on these systems for targeting. The Balanced Budget Act, for example, authorizes Medicare to pay for telehealth services for beneficiaries living in rural HPSA's. But some communities that qualify as rural HPSA's, in fact, are located near a wide range of specialty providers and facilities, while some remote frontier areas are not. And, since the HPSA criteria don't distinguish between the two, resources can't be targeted specifically to the more needy, isolated communities.

Clearly, if the programs that are intended to improve access are to produce the intended results, HHS is going to have to develop a more effective means to measure need and to evaluate individual program success in meeting this need. In our view, the management approach that's called for under the Results Act offers precisely this opportunity.

By the end of this month, the Department will have to submit to the Congress its first multi-year strategic plan and then beginning early next year, the first of its annual performance plans. These plans are to contain specific performance goals and measures for the programs included in its proposed budget.

In its Healthy People 2000 initiative, HHS has already set a national goal of increasing the proportion of Americans with a usual source of primary care from 84 percent, which was the level they found in 1994, to 95 percent by the year 2000. Presumably, its access programs will be measured against this goal.

From what we have seen thus far, though, it is not clear to us how well this assessment will work. Let me give you an example. HHS considers its health centers program to support its access objective, but the budget justification for fiscal year 1998 also lays out other goals for its health centers, such as creating 3,500 additional jobs in medically underserved communities. Although creating jobs may be a desirable by-product, it's not clear how this employment goal ties to national objectives to assure access to care. Under the Results Act, though, HHS has an opportunity to clarify the relationships between its various program goals and define their relative importance at the program and national levels.

In closing, I want to just reiterate a couple of points. First, going back to the Rural Health Clinics Program, Congress has largely addressed in the Balanced Budget Act the problems with the program

we talked about in our earlier work. But one of the underlying problems with this program and others that are supposed to improve access is the system or systems used to measure need. It still remains for HHS to come up with some way of measuring underservice, or need, that is much better targeted to those populations that lack access.

And my second point is simply that this is an opportune time for the Department to correct this problem. The Results Act will challenge the agencies to measure the results of their spending and that means, in this case, measuring not merely how many additional physicians are added to the community, or how many clinics are established, but whether Americans who now lack access to care are able to get the primary care they need.

This concludes my remarks, Mr. Chairman.

[The prepared statement of Ms. Steinhardt follows:]

Mr Chairman and Members of the Subcommittee:

We are pleased to be here today to expand on our testimony regarding the Rural Health Clinic program that we presented to you last February. In that testimony, we said that the program did not focus on improving access to care in areas that most needed it. Today, we would like to discuss our findings in the broader context of our past reviews of federal efforts to improve access to primary health care. The federal government spends billions of dollars each year on programs like the Rural Health Clinic program that, in whole or part, are aimed at achieving this objective. I would like to (1) summarize the common problems we found and some recent initiatives to address them, and (2) discuss how the type of management changes called for under the Government Performance and Results Act of 1993 (the Results Act) can help the Rural Health Clinic and related programs improve accountability.

In brief, our work has identified many instances in which the Rural Health Clinic program and other federal programs have provided aid to communities without ensuring that this aid has been used to improve access to primary care. In some cases, programs have provided more than enough assistance to eliminate the defined shortage, while needs in other communities remain unaddressed. Our work has identified a pervasive cause for this problem: a reliance on flawed systems for measuring health care shortages. These systems often do not work effectively to identify which programs would work best in a given setting or how well a program is working to meet the needs of the underserved once it is in place. For several years, the Department of Health and Human Services (HHS) has tried unsuccessfully to revise these systems to address these problems. The goal-setting and performance measurement discipline available under the Results Act, however, appears to offer a suitable framework for ensuring that programs are held accountable for improving access to primary care.

BACKGROUND

All communities contain populations that may have difficulty accessing primary health care services for reasons such as geographic isolation or, more often, inability to pay for care. Multiple federal agencies, often with state and local governments as partners, have long supported a broad range of programs to remedy these access problems. The largest and best known is Medicaid, which spent over $161 billion in fiscal year 1996 on health and long term care for low-income Americans considered to be unable to purchase services.[1] However, over 30 other programs exist. (See attachment 1

[1]Medicaid is a joint federal-state program, which in fiscal year 1996 financed health care for about 37 million low-income, blind, disabled, and elderly people. The federal contribution to state Medicaid programs in that year amounted to $91.9 billion or about 57 percent of the $161.2 billion total. In 1995, more than 70 percent of Medicaid expenditures paid for care for the elderly, blind, and disabled and for payments to

for an overview of some of these programs.) These other programs, which collectively spent more than $1 billion a year as of 1996, use one of three strategies aimed to ensure that all populations have access to care.

- Providing incentives to health professionals practicing in underserved areas. Under the Rural Health Clinic and Medicare Incentive Payment programs, providers are given additional Medicare and/or Medicaid reimbursement to practice in underserved areas. In 1996, these reimbursements amounted to over $400 million. In addition, over $112 million was spent on the National Health Service Corps program, which supports scholarships and repays educational loans for health care professionals who agree to practice in designated shortage areas. Under another program, called the J-1 Visa Waiver, U.S. trained foreign physicians are allowed to remain in the United States if they agree to practice in underserved areas.[2]

- Paying clinics and other providers caring for people who cannot afford to pay. More than $758 million funded programs that provide grants to help underwrite the cost of medical care at community health centers and other federally qualified health centers. These centers also receive higher Medicare and Medicaid payments. Similar providers also receive higher Medicare and Medicaid payments as "look-alikes" under the Federally Qualified Health Center program.

- Paying institutions to support the education and training of health professionals. Medical schools and other teaching institutions received over $238 million in 1996 to help increase the national supply, distribution, and minority representation of health professionals through various education and training programs under Titles VII and VIII of the Public Health Service Act.

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hospitals serving large numbers of Medicaid and low-income patients under the Disproportionate Share Hospital program.

[2]In 1995, 4 federal agencies and 23 states requested waivers to requirements that foreign physicians return to their home country after completing U.S. medical training under a J-1 Visa.

PROGRAMS NEED TO IMPROVE
THEIR FOCUS ON ACCESS PROBLEMS

Over the past several years, we have issued a number of reports examining most of these programs.[3] Our findings show that while the Rural Health Clinic program and other federal programs have provided resources to improve access to primary care, the programs historically have not been held accountable for showing that access has indeed improved. Here are some examples:

- The Rural Health Clinic program--which had an original purpose to subsidize health care in remote rural areas lacking physicians--now costs Medicare and Medicaid more than $295 million a year[4] to primarily subsidize care in cities and towns already having substantial health care resources. Our review of a sample of clinics showed that the availability of care did not change appreciably for at least 90 percent of Medicare and Medicaid beneficiaries using the clinics. Staff we interviewed at most clinics said they did not use the subsidies to expand access to underserved portions of the population or need the subsidies to remain financially viable.[5]

- The Medicare Incentive Payment program, created out of concern that physicians would not treat Medicare patients due to low Medicare reimbursement rates, pays all physicians in designated shortage areas a 10-percent bonus on Medicare billings. Physicians receive bonus payments now totaling over $100 million each year, even in shortage areas where Medicare patients are not underserved or where low Medicare reimbursement rates are not the cause of underservice.[6]

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[3]We have not reviewed how health center grants or benefits provided to other federally qualified health centers improved access to care. However, we did review HHS budget documentation for programs directed at relieving underservice, including the health center programs.

[4]This is the estimated additional cost to the Medicare and Medicaid programs due to higher payment rates to rural health clinics.

[5]We reviewed the health care resources of a sample of communities where 144 rural health clinics were certified in 4 states: Alabama, Kansas, New Hampshire, and Washington. We analyzed past access to care for Medicare and Medicaid beneficiaries using 119 of these clinics, and subsequently interviewed staff at 76 of the clinics. See Rural Health Clinics: Rising Program Expenditures Not Focused on Improving Care in Isolated Areas (GAO/HEHS-97-24, Nov. 22, 1996) and related testimony (GAO/T-HEHS-97-65, Feb. 13, 1997).

[6]See Health Care Shortage Areas: Designations Not a Useful Tool for Directing Resources to the Underserved (GAO/HEHS-95-200, Sept. 8, 1995).

- Federal and state programs placing providers in underserved areas have oversupplied some communities and states with providers while others receive none. Considering the National Health Service Corps program alone, at least 22 percent of shortage areas receiving National Health Service Corps providers in 1993 received providers in excess of the number needed to remove federal designation as a shortage area,[7] while 785 shortage areas requesting providers did not receive any providers at all. Of these latter locations, 143 had unsuccessfully requested a National Health Service Corps provider for 3 years or more.[8] Taking other provider placement programs into account shows an even greater problem in effectively distributing scarce provider resources. For example, HHS identified a need for 54 physicians in West Virginia in 1994, but more than twice that number–116 physicians–were placed there using the National Health Service Corps and J-1 Visa Waiver programs. We identified eight states where this occurred in 1995.[9]

- While almost $2 billion has been spent in the last decade on Title VII and VIII education and training programs, HHS has not gathered the information necessary to evaluate whether these programs had a significant effect on changes that occurred in the national supply, distribution, or minority representation of health professionals or their impact on access to care. Evaluations often did not address these issues, and those that did address them had difficulty establishing a cause-and-effect relationship between federal funding under the programs and any changes that occurred. Such a relationship is difficult to establish because the programs have other objectives besides improving supply, distribution, and minority representation and because no common goals or performance measures for improving access had been established.[10]

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[7]In creating the federal Health Professional Shortage Area designation system, federal intervention was considered justified only if the number of health care providers was significantly less than adequate, indicating that the needs of these areas were not being met through free-market mechanisms or reimbursement programs.

[8]See National Health Service Corps: Opportunities to Stretch Scarce Dollars and Improve Provider Placement (GAO/HEHS-96-28, Nov. 24, 1995).

[9]For these eight states, the number of J-1 Visa physicians for whom waivers were processed in 1994 and 1995, combined with the number of National Health Service Corps physicians in service at the end of 1995, exceeded the number of physicians to remove health professional shortage area designations in the state. See Foreign Physicians: Exchange Visitor Program Becoming Major Route to Practicing in U.S. Shortage Areas (GAO/HEHS-97-26, Dec. 30, 1996).

[10]See Health Professions Education: Role of Title VII/VIII Programs in Improving Access to Care is Unclear (GAO/HEHS-94-164, July 8, 1994) and Health Professions Education: Clarifying the Role of Title VII and VIII Programs Could Improve Accountability

Limitations of Existing Approaches Used to Measure Need and Target Assistance

Our work has shown that these programs share a common problem: HHS does not have a way to effectively match the various programs with the specific kinds of access problems that exist. Its systems for identifying underservice are so general that they often are of little help in identifying who is underserved and why. Likewise, these systems are often of little use in measuring whether a program, once applied, is having any effect on the problem. Despite 3 decades of federal efforts, the number of areas HHS has classified as underserved using these systems has not decreased.

HHS uses two systems to identify and measure underservice: the Health Professional Shortage Area (HPSA) system and the Medically Underserved Area (MUA) system. First used in 1978 to place National Health Service Corps providers, the HPSA system is based primarily on provider-to-population ratios. In general, HPSAs are self-defined locations with fewer than one primary care physician for every 3,500 persons.[11] Developed at about the same time, the MUA system more broadly identifies areas and populations considered to have inadequate health services, using the additional factors of poverty and infant mortality rates and percentage of population aged 65 or over.

We previously reported on the long-standing weaknesses in the HPSA and MUA systems in identifying the types of access problems in communities and in measuring how well programs focus services on the people who need them, including the following:

- The systems have relied on data that are old and inaccurate. About half of the U.S. counties designated as medically underserved areas since the 1970s would no longer qualify as such if updated using 1990 data.[12]

- Formulas used by the systems, such as physician-to-population ratios, do not count all primary care providers available in communities, overstating the need for additional physicians in shortage areas by 50 percent or more. The systems fail to count the availability of those providers historically used by the nation to improve access to care, such as National Health Service Corps physicians and U.S. trained

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(GAO/HEHS-97-117, Apr. 25, 1997).

[11]Under certain circumstances, the ratio used to designate a primary care HPSA may be 1 to 3,000. HHS has different criteria for dental and mental health HPSAs.

[12]MUAs are designated based on a relative ranking of all U.S. counties, minor civil divisions, and census tracts that occurred in 1975 and 1976. All areas that ranked below the county median combined score for the four criteria were designated as MUAs. MUAs have been added since then on the basis of newer data and the same cutoff score.

foreign physicians, as well as nurse practitioners, physician assistants, and nurse midwives.

One result of such problems is the sheer number of HPSAs and MUAs that now exist, minimizing the usefulness of the systems in targeting assistance. Eighty-eight percent of all U.S. counties had HPSAs, MUAs, or both as of June 1995. Even when the systems accurately identify needy areas, they often do not provide the information needed to decide which programs are best suited to an area's particular need. Designations are generally made for broad geographic areas without considering the demand for services. As a result, the systems do not accurately identify whether access problems are common for everyone living in the area, or whether only specific subpopulations, such as the uninsured poor, have difficulty accessing primary care resources that are already there but underutilized. Without additional criteria to identify the type of access barriers existing in a community, programs may not benefit the specific subpopulation with insufficient access to care.

The Rural Health Clinic program, established to improve access in remote rural areas, illustrates this problem. Under the program, all providers located in rural HPSAs, MUAs, and HHS-approved state-designated shortage areas can request rural health clinic certification to receive greater Medicare and Medicaid reimbursement. However, if the underserved group is the uninsured poor, such reimbursement does little or nothing to address the access problem. Most of the 76 clinics we surveyed said the uninsured poor made up the majority of underserved people in their community, yet only 16 said they offered health services on a sliding-fee scale based on the individual's ability to pay for care. Even if rural health clinics do not treat the group that is actually underserved, they receive the higher Medicare and Medicaid reimbursement, without maximum payment limits if operated by a hospital or other qualifying facility. These payment benefits continue indefinitely, regardless of whether the clinic is no longer in an area that is rural and underserved.

Last February, we testified before this Subcommittee that improved cost controls and additional program criteria were needed for the Rural Health Clinics program. In August of this year, the Balanced Budget Act of 1997 made changes to the program that were consistent with our recommendations. Specifically, the act placed limits, beginning next January, on the amount of Medicare and Medicaid payments made to clinics owned by hospitals with more than 50 beds. The act also made changes to the program's eligibility criteria in the following three key areas:[13]

[13]The act also contains provisions related to quality assurance, staffing requirements, and payment for physician assistant services. In addition, the act allows states to begin limiting the higher Medicaid payments to rural health clinics starting in fiscal year 2000.

- In addition to being located in a rural HPSA, MUA, or HHS-approved state-designated shortage area, the clinic must also be in an area in which the HHS Secretary determines there is an insufficient number of health care practitioners.

- Clinics are allowed only in shortage areas designated within the past 3 years.

- Existing clinics that are no longer located in rural shortage areas can remain in the program only if they are essential for the delivery of primary care that would otherwise be unavailable in the area, according to criteria that the HHS Secretary must establish in regulations by 1999.

Limiting payments will help control program costs. But until, and depending on how, the Secretary defines the types of areas needing rural health clinics, HHS will continue to rely on flawed HPSA and MUA systems that assume providing services to anyone living in a designated shortage area will improve access to care.

HHS has been studying changes needed to improve the HPSA and MUA systems for most of this decade, but no formal proposals have been published. In the meantime, new legislation continues to require the use of these systems, thereby increasing the problem. For example, the newly enacted Balanced Budget Act authorizes Medicare to pay for telehealth services–consultative health services through telecommunications with a physician or qualifying provider–for beneficiaries living in rural HPSAs. However, since HPSA qualification standards do not distinguish rural communities that are located near a wide range of specialty providers and facilities from truly remote frontier areas, there is little assurance that the provision will benefit those rural residents most in need of telehealth services.

IMPLEMENTATION OF THE GOVERNMENT PERFORMANCE AND RESULTS ACT PROVIDES AN OPPORTUNITY TO ADDRESS IDENTIFIED PROBLEMS

To make the Rural Health Clinic program and other federal programs more accountable for improving access to primary care, HHS will have to devise a better management approach to measure need and evaluate individual program success in meeting this need. If effectively implemented, the management approach called for under the Results Act offers such an opportunity. Under the Results Act, HHS would ask some basic questions about its access programs: What are our goals and how can we achieve them? How can we measure our performance? How will we use that information to improve program management and accountability? These questions would be addressed in annual performance plans that define each year's goals, link these goals to agency programs, and contain indicators for measuring progress in achieving these goals. Using information on how well programs are working to improve access in communities, program managers can decide whether federal intervention has been successful and can

be discontinued, or if other strategies for addressing access barriers that still exist in communities would provide a more effective solution.

Establishing Results-Oriented Performance Goals and Measures

The Results Act provides an opportunity for HHS to make sure its access programs are on track and to identify how efforts under each program will fit within the broader access goals. The Results Act requires that agencies complete multi-year strategic plans by September 30, 1997, that describe the agency's overall mission, long-term goals, and strategies for achieving these goals.[14] Once these strategic plans are in place, the Results Act requires that for each fiscal year, beginning fiscal year 1999, agencies prepare annual performance plans that expand on the strategic plans by establishing specific performance goals and measures for program activities set forth in the agencies' budgets. These goals are to be stated in a way that identifies the results–or outcomes–that are expected, and agencies are to measure these outcomes in evaluating program success. Establishing performance goals and measures such as the following could go far to improve accountability in HHS' primary access programs.

- The Rural Health Clinic program currently tracks the number of clinics established, while the Medicare Incentive Payment program tracks the number of physicians receiving bonuses and dollars spent. To focus on access outcomes, HHS will need to track how these programs have improved access to care for Medicare and Medicaid populations or other underserved populations.

- Success of the National Health Service Corps and health center programs has been based on the number of providers placed or how many people they served. To focus on access outcomes, HHS will need to gather the information necessary to report the number of people who received care from National Health Service Corps providers or at the health centers who were otherwise unable to access primary care services available in the community.

Establishing performance goals will also help clarify how each program "fits" into HHS' overall portfolio of programs to improve access to primary care. HHS has established national outcome-based goals and objectives for the year 2000 through its Healthy People 2000 initiative,[15] including the objective of increasing the proportion of

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[14]The results of our review of HHS' draft strategic plan can be found in The Results Act: Observations on the Department of Health and Human Services' April 1997 Draft Strategic Plan (GAO/HEHS-97-173R, July 11, 1997).

[15]Healthy People 2000 is the U.S. Public Health Service's national public health initiative to improve the health of all Americans. In consultation with stakeholders, other government agencies, and the public health community, the Public Health Service

Americans with a usual source of primary care from 84 percent in 1994 to 95 percent in the year 2000. HHS uses the results from its National Health Interview Survey, an existing survey, to measure progress toward this goal by counting the number of people across the nation who do and do not have a usual source of primary care. For those people without a usual source of primary care, the survey categorizes the reasons for this problem that individual programs may need to address, such as people's inability to pay for services, their perception that they do not need a physician, or the lack of provider availability.

Although HHS officials have started to look at how individual programs fit under these national goals, they have not yet established links between the programs and national goals and measures. Such links are important so resources can be clearly focused and directed to achieve the national goals. For example, HHS' program description, as published in the Federal Register, states that the health center programs directly address the Healthy People 2000 objectives by improving access to preventive and primary care services for underserved populations. While HHS' fiscal year 1998 budget documents contain some access-related goals for health center programs, it also contains other goals, such as creating 3,500 jobs in medically underserved communities. Although creating jobs may be a desirable by-product of supporting health center operations, it is unclear how this employment goal ties to national objectives to ensure access to care. Under the Results Act, HHS has an opportunity to clarify the relationships between its various program goals and define their relative importance at the program and national levels.

Developing Better Information on the Cost-Effectiveness of its Programs

Viewing program performance in light of program costs–such as establishing a unit cost per output or outcome achieved–can help HHS and the Congress make informed decisions on the comparative advantage of continuing current programs.[16] For example, HHS and the Congress could better determine whether the effects gained through the program were worth their costs–financial and otherwise–and whether the current program was superior to alternative strategies for achieving the same goals. Unfortunately, in the past, information needed to answer these questions has been lacking or incomplete, making it difficult to determine how to get the "biggest bang for the buck."

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developed a series of outcome-based public health goals and measures.

[16]We previously reported on the type of information needed to oversee and evaluate federal programs; see Program Evaluation: Improving the Flow of Information to the Congress (GAO/PEMD-95-1, Jan. 30, 1995).

This is not just a theoretical point. Our work has shown the value of analyzing and comparing costs. For example, our review of the National Health Service Corps program showed the benefits of using comparative cost information to allocate resources between its scholarship and loan repayment programs. While both of these programs pay education expenses for health professionals who agree to work in underserved areas, by law, at least 40 percent of amounts appropriated each year must fund the scholarship program and the rest may be allocated at the HHS Secretary's discretion. However, our analysis found that the loan repayment program costs the federal government at least one-fourth less than the scholarship program for a year of promised service and was more successful in retaining providers in these communities. Changing the law to allow greater use of the loan repayment program would provide greater opportunity to stretch program dollars and improve provider retention. Comparisons between different types of programs may also indicate areas of greater opportunity to improve access to care. However, the per-person cost of improving access to care under each program is unknown. Collecting and reporting reliable information on the cost-effectiveness of HHS programs is critical for HHS and the Congress to decide how to best spend scarce federal resources.

CONCLUSION

Although the Rural Health Clinic program and other federal programs help to provide health care services to many people, the magnitude of federal investment creates a need to hold these programs accountable for improving access to primary care. The current HPSA and MUA systems are not a valid substitute for developing the program criteria necessary to manage program performance along these lines. The management discipline provided under the Results Act offers direction in improving individual program accountability. Once it finalizes its strategic plan, HHS can develop in its annual performance plans individual program goals for the Rural Health Clinic program and other programs that are consistent with the agency's overall access goals, as well as outcome measures that can be used to track each program's progress in addressing access barriers.

This program performance information can assist HHS' operating divisions, such as the Health Care Financing Administration (HCFA) and the Health Resources and Services Administration (HRSA), in better managing its programs toward a common goal. In addition, this information can assist in determining whether strategies such as providing higher Medicare and Medicaid reimbursement rates under the Rural Health Clinic program are still needed to improve access to care, or whether directing federal dollars to other strategies, such as those addressing the inability to pay for services, would have greater effect in achieving HHS' national primary care access goals.

Mr. Chairman, this concludes my prepared statement. I would be pleased to respond to any questions you or members of the Subcommittee may have.

Selected Federal Programs Addressing Medical Underservice

Total FY96 federal funding (in millions)	Overall strategy to address cause of *underservice*	Program (amount of federal funding)	Program strategy used to address cause of *underservice*	Agency administering *program*
$514	Providing incentives to health professionals in underserved areas	Rural Health Clinic ($295)[a]	Pay higher Medicare and Medicaid rates to physicians and nonphysicians in underserved areas	HCFA
		Medicare Incentive Pay ($107)	Provide 10% bonus on Medicare payments to all physicians in shortage areas	HCFA
		National Health Service Corps ($112)	Pay education costs of providers agreeing to locate in shortage areas	HRSA and states
		J-1 Visa Waiver ($0)	Allow foreign physicians (exchange-visitors) to remain in U.S. if they practice in shortage areas	Multiple federal agencies and states
$758+	Paying clinics and providers caring for people unable to pay	Health Centers Grants[b] ($758)	Subsidize certain providers willing to see patients regardless of their ability to pay	HRSA
		Federally Qualified Health Center[c]	Higher Medicare and Medicaid payments to certain providers willing to see patients regardless of their ability to pay	HCFA
$238	Paying institutions to support education and training of health professionals	Title VII/VIII Health Education and Training Programs[d] ($238)	Pay health professions schools to support training of health professionals	HRSA

[a]Estimated additional cost to Medicare and Medicaid programs due to higher payment rates to rural health clinics.

[b]Includes four health center programs: Community, Migrant, Homeless, and Residents of Public Housing. Prior to the Health Center Consolidation Act of 1996 (P.L. 104-299, Oct. 11, 1996), these programs were authorized under sections 329, 330, 340, and 340A of the Public Health Service Act.

[c]Includes health center grantees, as well as health centers that qualify for a federal grant but do not receive one. Medicare and Medicaid costs associated with this program are unknown.

[d]Includes 30 programs for increasing the supply, distribution, and minority representation of health professionals.

Mr. SHAYS. Thank you. We will start with Mr. Snowbarger and then we will go to Mr. Towns, who will have some questions, and then we may do a second round.

Mr. SNOWBARGER. Thank you, Mr. Chairman, and thank you for your testimony. Actually, I had a number of questions ahead of time that you have already at least partially addressed and I appreciate your doing that.

Since our last hearing, how have HCFA and HRSA responded to the criticisms that you have made?

Ms. STEINHARDT. Well, I think HCFA, HRSA and the Congress have responded to the criticisms. The Balanced Budget Act deals with the eligibility criteria, at least conceptually, by setting further screens. HCFA, itself, has taken some steps to set caps on payment limits and the act also sets caps, as I said, on the reimbursement rates for hospital-based clinics which was a big problem that we found.

Mr. SNOWBARGER. Could I ask—just describe the caps again for me.

Ms. STEINHARDT. Well, you remember that the reimbursement for rural health clinics is essentially a cost-based reimbursement system, unlike the Medicare reimbursement in general, which is a fee schedule.

Mr. SNOWBARGER. Yes.

Ms. STEINHARDT. And what we found was that, for about half the rural health clinics which are hospital-based, those facilities did not have any caps set on the reimbursements for visits. Unlike the practice-based, or individual-based clinics, although it was cost-based, they did have a cap, which was, I think, $75 you recall——

Mr. PASQUIER. Fifty-six dollars.

Ms. STEINHARDT. Fifty-six dollars. I am sorry. We found it was a $56 payment limit on reimbursement. Now that will change and hospital-based clinics will also have a payment cap.

Mr. SNOWBARGER. Most of what you have talked about, I think, are the things that have been put into the budget bill that was passed——

Ms. STEINHARDT. Right.

Mr. SNOWBARGER. I guess my question really goes internally within those agencies. Here is my question: "Are all the answers to these problems going to have to be dealt with by Congress through legislation, or are there things within those agencies that they could and should be doing and, if so, since the last hearing, have they done anything?"

Ms. STEINHARDT. Well, there is still a lot that the Department has to do to implement the Balanced Budget Act. The eligibility criteria, while they are narrowed under the act, they still have to be defined by HCFA and in our report, we suggested that this additional screen, or the criteria be limited to clinics that can demonstrate that Medicare and Medicaid beneficiaries are not able to see providers in their community, either because there are none or because the ones that are there cannot see any more patients. And that can be part of the definition that the Department still has to establish under the act, so, the proof is in the pudding and it still remains to be seen how the Department is going to implement the revisions.

Mr. SNOWBARGER. Mr. Pasquier, you seem to want to——

Mr. PASQUIER. The one other provision that we talked about at the last hearing that was causing trouble was the grandfather provision where once you grandfathered a rural health clinic, you are a rural health clinic forever, even though the area is no longer underserved or is no longer rural. That problem was addressed in the Balanced Budget Act, but it will not go into effect until the Secretary comes up with regulations, and the act sets a date of January 1999 for that to occur. So, I guess the response is that, legislatively the problems have been addressed, administratively it still remains to be seen.

Mr. SNOWBARGER. Were there things available though, I guess, after our hearing last time where I think we all expressed that we were pretty upset that did not seem to be seeing any progress and were not certain that the money that we were spending was actually getting us access, not getting us access, but getting patients access to care. Yes, I am trying to find out how responsive the agencies have been since that point in time, other than, perhaps, cooperating with Congress in getting the legislation passed. Cooperating or staying out of our way, one of the two.

Ms. STEINHARDT. Well, HCFA was responsive to the recommendations that we addressed to the agency that it had in its control, to get a better handle on the cost accounting and some of the administrative problems. But most of the recommendations we had were addressed to the Congress because they required legislative fixes.

Mr. SNOWBARGER. I think one of the other questions that we had early on were questions about the definitions which apparently had been around a long time for medically-underserved area and the fact that you had two different classifications for some of these programs, one coming from HRSA and one coming from HCFA. Have we started down the path of addressing that? Is that what you are talking about with the criteria and with the grandfathering situation that you talked about?

Ms. STEINHARDT. Well, we have not seen anything yet from HRSA and we know they have been working on this issue for a number of years. You know the problems with the systems is that they were originally designed for very specific purposes. The MUAs were set up as a basis for establishing community health centers. The Health Professional Shortage Areas were set up as a basis for placing National Health Service Corps physicians and these were both set up in the late 1970's. But since then, over time, they have become the basis for designation for lots of other programs, like rural health clinics, like the J1 Visa Waiver Program, which is another program we have looked at; like the Medicare Incentive Payment Program which is another program we have looked at. And they became the only criteria for eligibility under those programs and they are just much too broad and scatter-shot to be really effective as methods for getting care or improving access to the populations where that is a problem.

Mr. SNOWBARGER. Is that because Congress has linked these programs to these measures?

Ms. STEINHARDT. Yes.

Mr. SNOWBARGER. In other words, we have more work to do maybe in the other programs to get a better definition to accomplish the purpose of whatever that program might be?

Ms. STEINHARDT. Well, that is one solution. Or, as the Congress dealt with it in the Balanced Budget Act with rural health, to establish another screen and say that just being in a HPSA or MUA is not enough to be eligible to be a rural health clinic. You also have to demonstrate that there is a problem for this particular population.

Mr. SNOWBARGER. Mr. Chairman, I yield back at this time.

Mr. SHAYS. OK, let me call Mr. Towns. But, first, let me say to you that what I think one of the contributions that both you and this committee can make is the new law says any facility that is designated after January 1998 has to win reapproval every 3 years. We have 3,400 that are in the system now and we give that responsibility to the Secretary to decide how we graduate some of those facilities. And the requirement of the law is that the Secretary, he or she, has to come up with regulations by January 1, 1999, no later than.

We should be writing the committee to say let us do it real soon and you all should be encouraging that we take advantage and, you know, act quickly as well. So I am going to say to you the committee will be contacting the Secretary and it would be helpful if you all encouraged a speedy action as well.

Ms. STEINHARDT. And I can assure you that we will be very interested not only in watching the alacrity of the Department, but also in how the regulations themselves shape up, what the content——

Mr. SHAYS. That is a very valid, and probably the most valid, point. We do want to graduate some of these 3,400 and maybe they are phased out over a year or two, but we do need to graduate some and if we do not see this happening, then the regulations are pointless. Mr. Towns.

Mr. TOWNS. Thank you very much, Mr. Chairman. I need you to educate me a little bit here. Which agency of HHS is actually responsible for the direction and oversight of the Rural Health Care Clinic Program?

Ms. STEINHARDT. HCFA, because it is essentially a Medicare and Medicaid Program. HRSA is responsible for the HPSA and MUA systems, so they are responsible for the shortage area designations, but HCFA is responsible for a program that relies on the shortage area designations. If that is helpful at all.

Mr. TOWNS. Mr. Chairman——

Mr. SHAYS. It is a different language, it is not English, it is not Greek——

Ms. STEINHARDT. It is Federal.

Mr. SHAYS. It is Federal.

Mr. TOWNS. Let me move to another area. We have heard in the last hearing that the underserved designation is allowed to remain even where it is no longer necessary because removing it may make the clinic go out of business because of the loss of the higher Medicare or Medicaid payments. If the clinic closes, you will be back where you started from, no clinic, as a result of changing or removing the designation, therefore, it might be better to allow the

designation to stay. Although it may be technically incorrect. Would you respond to that?

Ms. STEINHARDT. Actually, that is not what we found. When we looked at a large sample of clinics, we found that the rural health clinic designation was not essential to the financial viability of most of them. Most of them, two-thirds of the rural health clinics were conversions of existing practices and many of them had been in existence for 15 years, or more by the time they got their rural health clinic designation. So, one of our key findings in fact was that the program was not targeted to those places that really needed and depended on these higher Medicare and Medicaid reimbursements for survival.

Most of the people, three-quarters or 90 percent of the people had already been getting access to care, many of them were seeing the same people before as after rural health clinic designation. So, I think that's where we felt the program had really gone adrift from its original purpose.

Mr. TOWNS. Well, let me ask you this. Can you tell me the kind of changes that you recommend? The reasons for those recommendations and the result that would be achieved by adopting your recommendations.

Ms. STEINHARDT. Sure. I think the main concern we have now is that the program be targeted to those people, those communities, who could really benefit from it, and that is communities that don't have Medicare, or don't have enough providers for the Medicare and Medicaid beneficiaries, either because they are not there or because they can't accept any new patients.

This was our recommendation after we finished our review and we think that if this additional screen is adopted now as the Secretary has to implement regulations under the Balanced Budget Act, that this will help target it to those communities that need it. While we found that there were a lot of existing rural health clinics that did not seem to have improved access in their communities, there were communities that did benefit from the rural health clinic and there are communities that meet some of those criteria that might not even have rural health clinics. So we think that if you refine the eligibility criteria, you have a better chance of making a difference for those communities that really need the Federal help.

Mr. TOWNS. I have about 12 practitioners from the National Health Service Corps in my district. They are there to provide medical service in an urban underserved area. So my interest in continuation of programs like this is more than academic. I would like for you to tell me, generally, whether, you believe programs such as this one, meant to bring services to underserved populations are generally a good economic investment. In other words, does providing primary care, preventative health care, save money in the long run? That is my real question.

Ms. STEINHARDT. I suppose that is one way in which you could support the provision of care. There are other reasons. You may think from a humanitarian [view], that it is good social policy to make sure that people are able to lead healthy, productive lives. But, I think in your community and in other communities, it may be that the needs are, let's say, not among the Medicare/Medicaid

population. Maybe their needs are being addressed. Maybe the need in your community is among the uninsured poor, people who are just above the Medicaid eligibility level but don't have sufficient income or jobs that provide them with private insurance.

The issue there is getting those people the care that they need, not setting up a program that benefits just Medicare and Medicaid beneficiaries, but finding out what it is that prevents people from getting the access they need and then providing them the services that will be of most use to them.

Mr. TOWNS. May I ask this one last question, Mr. Chairman?

Mr. SHAYS. Sure.

Mr. TOWNS. Part of my concern here today is about the availability of increased Medicare and Medicaid payments made possible by RHC status. In 1987, we in Congress increased payment caps and established annual payment increases for this program, if I remember. Is there a sense that we should repeal this?

Ms. STEINHARDT. The Rural Health Clinic Program?

Mr. TOWNS. Yes, right.

Ms. STEINHARDT. I do not think anything we found suggested that it should be eliminated. I think there are communities, clearly, that benefited from it that do need to have these higher reimbursement rates for financial viability and to get care because they are in small isolated communities. I think what we are suggesting is that the intended recipients of those programs are not necessarily the only people that are benefiting from this policy today and we need to get it to them.

Mr. SNOWBARGER. I think one distinguishing characteristic of the Rural Health Clinic Program, on the very positive side, is it is one of the few programs we have that can be established in a community without an infrastructure in place. It can support nurse practitioners, physician assistants or sole practitioners where there is no practice that exists by this increase reimbursement. Where some of the other programs that we have, a National Health Service Corps Program that you mentioned, really requires there be a provider, a clinic, a physician in place before placement occurs. So I think the trick here is to make sure we are targeting the program to where it can do the most good in those kinds of situations.

Mr. TOWNS. Right. Thank you very much, Mr. Chairman.

Mr. SHAYS. Thank you, gentlemen. I want to tell you the logic and get your response. We decided not to ask HCFA here for several reasons. One, they are going to have a new director and the new director is being looked at now by the Senate, and we felt we would just really get old testimony and understood that would be the case.

And second, the law that we passed has basically dealt with the rate setting. We're capping the different rates and HRSA is looking at the issue of who qualifies and who does not. Who can't be a clinic? Did you want to make a comment?

Ms. STEINHARDT. I think there was some buzz here. I think HRSA might say that they are not establishing eligibility, well certainly for rural health clinics, I mean, that's by statute. What I think they are doing, and have responsibility for, is trying to understand who is underserved and where need for access to care——

Mr. SHAYS. It comes close, in my judgment, to being idiotic to have 87 percent of the counties in this country with rural health care clinics, in a sense, because we basically have covered the entire country. And my sense was we were really trying to go into areas that were rural and, in fact, needed them. We know the reason why there is an incentive to be a clinic, because you get a far more significant reimbursement rate. This is the breakdown in Government that we're not able to quickly go back and undo the mess that we find ourselves in. So, and this is your point, we obviously have to pay tremendous attention to the new regulations that are being drawn up to figure out how we graduate some of the 3,400 clinics that we now have.

Can you give me an outline of the differences in rates between what you would get under Medicare and Medicaid in one rural-based health care clinic versus one——

Ms. STEINHARDT. What is the cap? I think it is like——

Ms. BAUMGARTNER. We estimated that——

Mr. SHAYS. You want to put the mic right next to you?

Ms. BAUMGARTNER. We estimated that Medicare would be paying about 43 percent more under the Rural Health Clinic Program, on average, across the Nation and Medicaid would be paying about 86 percent more.

Mr. SHAYS. Eighty-six percent more?

Ms. BAUMGARTNER. Right.

Mr. SHAYS. If you can get designated as a clinic, you are going to get a far greater reimbursement rate and that obviously is the incentive we have. Is there documentation that we are, in fact, reaching out and going to the areas that truly are rural and truly have the need?

Ms. STEINHARDT. No. We found the definition of rural under the statute was nonurbanized areas of 50,000 or less. Yet we found, 20 percent of RHC's, were in areas of 50,000 or more. So, even by the eligibility criteria already established, 20 percent of the 3,400 or so RHC's are in areas larger than the definition of rural.

Mr. SHAYS. This is really brought out in the first hearing we had. Some of the outrageous results of what we have done and how it is costing us billions of dollars were documented in our first hearing. So we are focused now on the solution.

I would like you to give me a little guidance as to what you would like to see. How should we refine the criteria so that we better target the RHC Program? This will provide some potential assistance to the Department and the Secretary when we look at how we graduate some of these 3,400 facilities and have them compete like everyone else with the regular Medicare and Medicaid rates.

Ms. STEINHARDT. Well, obviously, they need to meet the original criteria.

Mr. SHAYS. Let me just say, the obvious things I want you to outline. I want you to go through some of these points. They may be obvious to you, but I want them obvious on the record.

Ms. STEINHARDT. They need to obviously meet the definition of rural under the statute.

Mr. SHAYS. Which is?

Ms. STEINHARDT. A nonurbanized area with a population of 50,000 or less.

Mr. SHAYS. OK, that is the first thing. And many do not.

Ms. STEINHARDT. And in our view they need also to demonstrate that in their community, there are no providers who will accept Medicare or Medicaid beneficiaries, or that the providers who do accept Medicare and Medicaid beneficiaries don't have the capacity to accept any more patients.

Mr. SHAYS. One of the ironies is that we are potentially putting some people out of business who are willing to accept the Medicare and Medicaid rate because they are competing now with another organization that has a greater ability to make a profit, given the larger charges that they are learning.

Ms. STEINHARDT. Right, and I know you have heard from a number of physicians who say, "Wait a minute, I was accepting Medicare and Medicaid patients. I am willing to do that."

Mr. SHAYS. So, this is an important element, that if an area is being served already, then do not bring in more competition at an advantaged price.

Ms. STEINHARDT. Right. I think it raises all these elements of competition, but even if you tie it back to the original purpose, which is to improve access, if there is no problem with access in that community, then obviously it is not in need of assistance and let us put our resources where there is need.

Mr. SHAYS. Right. OK. What is another one. Mr. Snowbarger would like to jump in.

Mr. SNOWBARGER. Before we get too far beyond the first criteria that you mentioned, the nonurbanized, is there a definition of "nonurban"? Or, does somebody look at a map and say that does not look urban to me and——

Ms. STEINHARDT. It is a census definition outside of a metropolitan area.

Mr. SNOWBARGER. I was going to say, my next question is, "How do we define area?" I am thinking of my district where I have got two counties that are clearly urban, I have one county I would say, well the whole county is less than 50,000, so I am sure it would be rural. I have another county that has one town that would be more than 50,000, but the remainder of the county is rural. How do I figure out whether that is a rural county for this purpose or not? I do not want to determine that. I want somebody else to determine that.

Mr. PASQUIER. The Bureau of the Census basically classifies every town as being urbanized or nonurbanized.

Mr. SNOWBARGER. Well, OK, with the example of one city in the county that is over 50,000 but the remainder of the county——

Mr. PASQUIER. It would depend on the proximity of the remainder of the county to that city. They consider population density and distance. There is no easy, simple definition, it is a complicated formula that they use by the Census to divide the country into urbanized and nonurbanized. I think in terms of the Rural Health Clinic Program, that the policy that was set when the law was placed they used the term "nonurbanized". I think we are not quibbling with the definition of urban and rural because, if you do have a community that is on the top end of the 50,000, 40,000, but you do not have enough providers to treat your Medicaid and Medicare population, then the Congress must have felt at that time that they

could not have a rural health clinic. So, I think it just goes back to the fundamental criteria that you need to demonstrate that these beneficiaries have an acute access problem that the normal market forces don't address. That is really the key element I think that needs to be established in the new criteria.

Mr. SHAYS. I have the time but, Mr. Kucinich, you wanted to ask a question related to this or do you want to wait.

Mr. KUCINICH. I would actually like to ask a question of Ms. Steinhardt.

Mr. SHAYS. Why do you not just wait then for me to finish my questions, then I will call on you.

Mr. KUCINICH. Of course.

Mr. SHAYS. Unless it is related to this issue. Is it related to this issue?

Mr. KUCINICH. It is related to this.

Mr. SHAYS. Oh, no then, happy to yield.

Mr. KUCINICH. Thank you. Because I think market dynamics happens to be at the core of this dilemma which we find ourselves in as to whether or not you are going to be able to maintain adequate health care delivery service for rural areas because the logic of the marketplace—we are talking about health care services—works against programs like rural health care delivery because it is inherently inefficient to have to move services out to areas where there are not a larger population.

Markets function best where there is a density of population. Increase the demand. Increase the efficiency and increase the profits. In this area of managed care paradigm, we find ourselves where, even in urban areas as I represent, managed care organizations are making haste to jettison certain types of services as being unprofitable, simply from the logic which is driving a market-oriented health care delivery service system, rural health clinics are, by nature, not desirable in that particular logic. So, I think, Mr. Chairman, as we look at this, either we have to insist by law that these clinics are protected and remain, or we are going to see managed care destroy the system. Because these private, for-profit health care insurance companies do not give a damn about public health, they care about profit and we have different goals in this.

Ms. STEINHARDT. Well, I think clearly the Rural Health Care Program was intended to address those kinds of market failures and I think the issue here is finding those places where in fact there really were, or are, market failures and separating them from those where there was none.

Mr. KUCINICH. Right, thank you.

Mr. SHAYS. It is an interesting issue of the underserved versus the shortage. My sense is the shortage begins to be the micro of a particular kind of medical need that is not there. Maybe HMO's and other insurance organizations who are creaming some of the business and they are meeting some of the need, but some services are not being met and we come into an urban area to meet a certain need.

In Brooklyn, I am not quite sure there would be particular needs there that I bet are not being met and so you come in. But I think all of us can understand that if you get 87 percent of the counties, we are covering the vast majority of America and we are in a situa-

tion where these clinics are clearly competing with people who are only asking for the market rate. Yet, they are getting above market rate.

I realize this has been a long-term problem and it was not caused by HRSA, now that we have to deal with it. But, I have asked you two. You gave me two criteria, and I want to just pursue a little more. If you were sitting down with the Secretary, how would we graduate some of these facilities? We would re-evaluate the number of people as one of them and then we would see if they are being served——

Ms. STEINHARDT. Let me come back to this idea of graduation because I think from our study, it is not clear to me. There are some kinds of programs in which we develop a reliance on Federal support. It is not clear to me that that was the case for many of the RHC's. They were practices that had been ongoing for some number of years, and they took advantage of an opportunity that the Federal Government provided them.

Mr. SHAYS. They were already there and they took advantage of it.

Ms. STEINHARDT. They were already there, they were already seeing Medicare and Medicaid beneficiaries.

Mr. SHAYS. But if others qualified who were not there, then they qualified who were already there, in some instances. It is——

Ms. STEINHARDT. Well, I mean they were already there as existing practices. Then they discovered that they could also become rural health clinics.

Mr. SHAYS. Yes, OK.

Ms. STEINHARDT. Where I was heading with this was that the idea of having to graduate them, sort of ease them off, or help them through a transition—I do not know the extent to which that is really an issue.

Mr. SHAYS. In other words, you think they will still survive?

Ms. STEINHARDT. For most of the clinics we talked to, they were not dependent on this program for financial viability.

Mr. SHAYS. Well, that is a very important point.

Ms. STEINHARDT. Yes, I think it is.

Mr. SHAYS. And so maybe one way you look at it is to see what facilities were there before they got this designation and see if, in fact, they can survive without it.

Ms. STEINHARDT. Or, to take a look at how the community has developed, where it is today and whether it still depends on these designations for——

Mr. SHAYS. Now, is one of the problems, a kind of catch-22, that if some of these clinics become very successful by the mere fact that they are successful, they have met a need and then you can claim that they no longer have a need?

In a sense, and maybe this is all right, are we punishing them for their success? Or are we saying, "No, we got you to the point of success, now you can carry on without this additional reimbursement."

Mr. PASQUIER. In the new regulations that the Secretary is supposed to come up with in January that is supposed to address that issue where we would look at, in that case, a clinic would have to justify, using whatever criteria the Secretary determines, to say is

it still needed, because if it went out of business, there will be an access problem in that community. We can clearly demonstrate that. Perhaps some of the justification would be we treat a lot of indigents, we treat a lot of underserved, we treat a lot of Medicaid people and there's nobody else in this community that does that to the degree that we do. The regulations would provide that if that could be justified, they could continue their rural health clinic status, even though they are taking care of the access problem in that community. I think the Budget Act accounts for that condition, but again, it will be some time before it is implemented.

Mr. SHAYS. We are going to be having HRSA come to us in the third panel and we are going to go to the first panel.

Mr. Kucinich, would you like to ask your questions of the next panel or would you like to ask your question now?

Mr. TOWNS. I just want to make certain I understand and to sort of get it on the record. I think, Ms. Baumgartner, I need clarification on the rates. I understand that there are different rates for independent practice and practices associated with the hospital. When you mentioned the 43 percent and the 86 percent rates, which kind of practice were you referring to.

Ms. BAUMGARTNER. Together, we combined the expenditures from both the provider base and independent clinics.

Ms. STEINHARDT. One is Medicare and one is Medicaid.

Ms. BAUMGARTNER. Oh, Medicare and Medicaid. Right.

Mr. TOWNS. So it is both?

Ms. STEINHARDT. But under the new legislation the payment rate for the hospital or facility-based clinics will be set at the same cap——

Ms. BAUMGARTNER. Except for those with less than 50 beds.

Ms. STEINHARDT. Oh, right, that is right, except for the smallest ones. For all facility-based clinics that are larger than 50 bed facilities, they will be subject to the same payment caps as the independent clinics.

Mr. SHAYS. Which is the lower rate?

Ms. STEINHARDT. Which is the lower rate, right.

Ms. BAUMGARTNER. It is $56 a visit.

Ms. STEINHARDT. Right, it is $56 a visit. It is still not as low as the fee schedule.

Mr. SHAYS. No, I hear you.

Ms. BAUMGARTNER. The fee schedule is about $33, $35.

Mr. SHAYS. I am sorry, I interrupted you.

Mr. TOWNS. No, that is great. Thank you for helping out. Is there something here that is not being talked about this morning? And that is managed care. Is there some pressure from regular doctors to be able to treat Medicare and Medicaid patients in order to meet the competition they face from managed care organizations? You mentioned targeting and the benefits and this is a good idea, but now I want to make certain I understand. Could you define the target areas without using some kind of designations like are used here? And how do you make sure that those new designations do not become outdated? This is just not clear to me.

Ms. STEINHARDT. This is a hard subject. I do not think there is an immediate fix to how you define the criteria you use to define need and that is I think really where we think a lot of attention

needs to be paid. One measure, which is one that HHS now uses, is the number of people who don't have a usual source of care. That is one way of telling who might benefit from these kinds of programs. There are other measures that have been used, poverty rates, health status, and I think we are still searching for some better ways of defining need. That is still going on and I imagine HRSA can tell you more about what they are doing in this respect.

Mr. TOWNS. I yield.

Mr. SHAYS. Mr Kucinich, and then we will go to the next panel.

Ms. STEINHARDT. I wanted to come back, though, to your question about managed care.

Mr. TOWNS. Yes, and I want you to answer that, too. I was just yielding to him, I am not giving up my time.

Mr. SHAYS. Why do we not have you respond to that and then we will go to Mr. Kucinich.

Ms. STEINHARDT. This is more a philosophical answer than a factual one. I think one of the things that is very interesting and important about this whole subject is that in the time that we started addressing this—I mean, if you look at when we first set up these shortage area designation systems in the seventies, you know, going back even into the sixties when the Medicare and Medicaid programs were set up and all the years that we have been concerned about trying to improve access to care. In the last few years, the whole health care industry has started undergoing a very dramatic transformation. I think it's really important, and I think it's really important that you raise the question of managed care because I think it is very important to look at how all of these systems are being affected by the transformation of the whole health care delivery system and the health care industry now. I think it is critical to take that into account as we try and figure out how to take care of the needs of Americans today. I cannot emphasize that more strongly.

Mr. TOWNS. Agreed. I yield back.

Mr. SHAYS. OK. And, Mr. Kucinich, you have the time.

Mr. KUCINICH. How many people are we talking about affected by these programs to begin with?

Ms. STEINHARDT. The Rural Health Care Program or all of these?

Mr. KUCINICH. Rural Health Care.

Ms. STEINHARDT. We don't know.

Ms. BAUMGARTNER. That is not tracked.

Mr. KUCINICH. Sixty-five million, is that right?

Mr. PASQUIER. That is one of the problems. There is not a good way to track what we are accomplishing here just in terms of numbers.

Mr. TOWNS. I have heard the number 65 million. That make any sense?

Mr. PASQUIER. In terms of maybe people that are living in underserved areas, but does that mean that they are underserved or to what degree is each underserved. I think as we say in our statement, I think that one of the critical things that the Department could do over the next few years is to try to get a better measure of medical underservice so we can track how well we're doing. Right now we still have the same number of shortage areas as we

did 20 years ago. We know we have made more improvements than that.

Mr. KUCINICH. One of the things, Mr. Chairman, that occurs to me in addressing this question again, when we are talking about the rural poor. With that condition of poverty comes a certain amount of social disorganization which even the existence of these programs may not be enough to be able to get the service because people either do not know about them, they do not know how to get to them. They cannot get to them if once they know how. Coming from a background where I myself experienced the effects of social disorganization, it can be a nightmare for people to try to get help to begin with. Now you overlay on that a new paradigm of managed care and you don't have to know much about the structure of what you do to conclude that, despite your best efforts, there is going to be a lot of Americans who are going to fall through. There is no safety net, they are just going to fall through, they are not going to get care.

I think one of the things we need in this committee is some statistics and a baseline year before managed care so we can track our utilization, compare it with census figures and be able to come to some determination if millions of Americans are being excluded from care because of this new paradigm that's come up. I spent time in the Ohio Senate, where I led an investigation of managed care and HMO's and my guess is that the chance for them to reap the biggest profits would be in rural areas because they get credit for serving people they will never have to see. And so, I would like to get some help with the permission of the Chair, it would be useful I think if we could get some data so we can compare it down the road as these new schemes develop. Thank you very much.

Mr. SHAYS. Thank you, gentlemen. Let us get on to the next. I appreciate you serving the ball into play.

You were the second panel who went first. Now we will call the first panel, who is going second. And I will ask them to come to the table, but stay standing until we swear you in. Dr. Edward Feehan, pediatrician, private practice, Merced, CA; Dr. Douglas Slater, internal medicine and pediatrician, Mercy Health Services North, Grayling, MI; and Ron Nelson, physician assistant, Cedar Springs Clinic, White Clouds, MI. Remain standing and we will swear you in.

[Witnesses sworn.]

Mr. SHAYS. We will note for the record that all three have responded in the affirmative.

UNIDENTIFIED SPEAKER. Sometimes we get lost in rural areas also.

Mr. SHAYS. Well, it is great to have you here and we are going to ask all three to give testimony. We will start with you, Dr. Feehan. I am going to ask that we be really focused on our statements, so here we go. Dr. Feehan, I just know that your mic is not close enough, so I am going to ask you to, and then lower it a little bit, as you look down. Perfect. Thank you, great to have you here. Thanks.

STATEMENTS OF EDWARD B. FEEHAN, M.D., PEDIATRICIAN, PRIVATE PRACTICE, MERCED, CA; DOUGLAS SLATER, INTERNAL MEDICINE AND PEDIATRICIAN, GRAYLING, MI; AND RON NELSON, PHYSICIAN ASSISTANT, WHITE CLOUDS, MI

Dr. FEEHAN. Good morning, Chairman Shays and members of the subcommittee. My name is Edward Feehan and I appreciate the opportunity to appear before you today and in this discussion of rural health clinics and to review for you the research I have done on this program.

I come before you today with concerns as a physician, a citizen and a taxpayer. In the interest of time, I will limit my remarks as requested and refer you to important details in my written statement.

I entered the medical profession with a commitment to be of service to people in my community and in that regard, I remain very interested in the health-care profession. I am a pediatrician with over 26 years of practice in Merced, CA. I was there when rural health clinics started and also when federally-qualified health centers were authorized. I have been a witness to the growth of these clinics in Merced and the profound effect that they have on private practitioners.

There are many issues that concern me, but I will focus on four. They are the current shortage designation process used in the certification of RHC's is egregiously flawed, management of the RHC program seems to be weak at the Federal and regional and some State levels, accountability is absent from the program and, finally, the impact that such lax program management has on the ethics of the people involved in the program.

When I started my practice in Merced in 1971, there were no rural health clinics and there was one clinic, which was a predecessor to federally-qualified health centers. Parts of the city of Merced and many other areas within the county have held shortage designations. In 1985, for the purpose of obtaining a higher reimbursement rate for our hospitals and some city grants were dependent on being declared urban, a special census was performed which resulted in the city being declared urban and the county a metropolitan statistical area.

Since that time when we lost our rural status, we have had six new rural health clinics in the county and multiple new federally-qualified health centers, including one area where there are two on one block. So I began to ask questions and we also had in last year, we had two new——

Mr. SHAYS. I'm sorry to interrupt, but let me be clear on one thing. You are not a rural health care clinic.

Dr. FEEHAN. No, I am a private practitioner.

Mr. SHAYS. Right, private practitioner, and you are talking about rural health care clinics coming in and basically serving the same area you served?

Dr. FEEHAN. Definitely.

Mr. SHAYS. OK.

Dr. FEEHAN. Last year, in the city of Merced, which is not rural anymore, we had two new rural health clinics certified and we were able to get those rescinded because of overlooking the fact that they have to be in a rural area. All indications are that the billings from those locations are still going in to the rural health clinic program, even though the fiscal intermediary was informed of the withdrawals in a timely manner. The billings have not stopped even though the certifications were discontinued. There were $607,000 in billings in one recent year, 1993–94, from areas within the city of Merced that did not qualify for the shortage designation label. $900,000 in costs from the county were shifted to the hospital, allowing them to be put in the mix of costs reported to the rural health program.

In a similar scenario, I was interested to discover that in Boston the Roxbury HPSA included census tract 810 for 7.6 years, which meant that Harvard Medical School, let me repeat that Harvard Medical School, was within a shortage area, a HPSA for more than 7 years.

A physician working at Brigham and Womens Hospital, which is their flagship hospital, actually applied for loan forgiveness for serving at Brigham and Womens and it was granted, it was quickly taken away, but it was granted because it fit the rules for the HPSA definition; 42 of 169 census tracks in Boston are MUA's.

In the earlier discussion, medically underserved populations was overlooked, there is one other type of shortage designation. This is 25 percent, within a fraction of a point, of all of the census tracks in Boston that carry the label, "Medically Underserved Areas" and there is no schedule for re-evaluating MUA's.

Mr. SHAYS. Let me just say something, you have a statement that is going to run you over time, so I do not want you to ad-lib as well, so please try to stay on the statement.

Dr. FEEHAN. There is poverty, there are minorities and there are serious diseases in Boston, but it is not true that there is a shortage of medical care in Boston. The finding that Boston was so heavily labeled as a shortage area epitomizes the extreme lack of accuracy in our shortage designation process. There are 12 or 13 federally-qualified health centers in Boston, depending upon which authority one uses. In inner-cities care available within 30 minutes by public transportation is supposed to be counted in assessing shortage designations. There are enough residents in training in Boston to keep more than half of the population from being considered a shortage area. The details of the rules of counting are simply not being observed, nor are the rules ever updated.

The designation process is excessively responsive to special interest groups. The GAO has been openly and severely critical of the results of the process. The GAO says that 75 percent of all counties, boroughs, and parishes are connected with shortage designations but my own calculation places the result closer to 88 percent. How is this possible when the RHC program and several other Federal programs have been in place for 30 years to address, improve, and reverse the shortages in these areas?

Inaccurate data and erroneous interpretations of data lead to faulty decisions which can cause a program to flourish and grow in an area where it is not truly needed but, rather, is promoted for

the money it spreads around, costing taxpayers huge sums in waste, fraud, and abuse, while at the same time placing practitioners on a severely uneven playing field.

These scenarios are an indication that the current designation process is not working and is often based on outdated, inaccurate information. HRSA is required by statute to update HPSA's annually, but have chosen to do so on a rotating basis every 3 years. Updating MUA's is not required and MUA's remain virtually the same as they were 20 years ago. A list of shortage designations and withdrawals is to be published annually in the *Federal Register,* however, I question whether this happened in 1984, 1988, 1989, and 1993. This is an important finding because the date of publication in the *Federal Register* of the list of designated shortage areas is the date of withdrawal for most withdrawn shortage designations. Delay in publication is a delay in withdrawal most of the time.

As I have watched the RHC program grow in my community, seen them move from one location to another, change names, change hands, I have continued to ask who is paying attention? Is it possible to be billing the rural health clinic program as if on campus but be 2 miles away and in an area with no shortage designation at all? Is it permitted to bill an RHC program from a physician's private office, simply because he is associated with an RHC in delivering care? Is it permissible to continue to bill the RHC program once an erroneously made certification is recognized and withdrawn? Who is carefully looking at the cost reports to see if billing under a variety of questionable scenarios is taking place? These are important issues, but I have been unable to get answers and my inquiries are at times treated with suspicion and disdain. But if there are problems, these are our tax dollars being spent and they are not benefiting the underserved populations they were designed to benefit.

Mr. SHAYS. I am just going to quickly interrupt you to say that these questions you have asked, we have forwarded on to HQFA. These are very valid questions and you should not be treated with suspicion or disdain, or will the committee be as well. But I just want you to know we are following up on these things.

Dr. FEEHAN. Accurate physician demographic data is needed for all kinds of planning. The shortcomings of the presently used data and the handling of that data were published in my commentary in the June 1996 issue of the *Western Journal of Medicine.*

We are training foreign medical graduates as residents here with the idea that they will take their knowledge back to their country of origin. An agreement to go back to the country of origin for a minimum of 2 years is signed, but only 20 percent do so. If such physicians stay in the country under one of the J-waivers, they are not counted in assessing physician supply and often getting a J-waiver by serving in an area that is not truly underserved.

Physician extenders and 41 million nonemergency primary care-type visits per year in ER's, visits in urgent cares are not being counted in the assessment of shortage designations.

The physician extenders alone would lower the number of providers in our shortage count by 22 percent if they were to be counted. Residents are supposed to count as one-tenth of a provider, but

were not so counted in my area and are obviously not so counted in Boston, because they would take care of the needs of more than half the population, making it difficult, indeed, to have a shortage designation in Boston. These are not the results we are seeing.

In assessing primary care physician supply for shortage designation purposes, the division of shortage designation often counts using a term known as full-time equivalent, which means that only that portion of a practice devoted to the care of the indigent counts. Multiplier factors are not used, the list of counting errors is almost endless, resulting in the coining of a new Murphy's law—the possible permutations of counting errors is limitless.

As I have watched this proliferation of subsidized clinics in an area, Merced, that has not been underserved for some time, but was designated as such for a number of years because of inaccurate data, I have observed a variety of people content and eagerly protective, often with State and Federal assistance, of what I call the status quo. If the program is wasting money, who is concerned? If people are gaming the program, are the truly underserved getting the service the program is designed to provide? In a visit to HRSA a few years ago to acquire data, a staffer said to me, "Milking the system is built into a system."

As I have tried to watch what is occurring in my county, a couple of my colleagues have inferred that if there is an artificial financial gain, then it should be taken advantage of instead of attempting to fix that which is broken. Who are we to fight having money thrown at us is a paraphrase of what is being said.

In my effort to ascertain the facts of what is happening in my community, I have met with a great deal of indifference and at times annoyance as I have asked questions, made phone calls, written letters, and requested data. The message seems to have been, in some instances, the status quo is OK, why are you asking these questions? I would submit to you that the status quo is not OK, when the RHC program is so massively off course. Being off course involves the agencies in the deterioration of what is perceived as ethical activity.

As we have taken the opportunity today to discuss medically underserved areas, underservice, overservice, none of it makes any sense when we read Secretary Shalala's comments that we have too many physicians and that by the year 2000 we will have more than 100,000 too many physicians.

In addition, I understand the Federal Government is now paying teaching hospitals not to train as many residents and yet we have a large percentage of counties and communities still listed as underserved. Something is not working. Somehow shortage designation and supply are totally out of sync.

Former Governor Lanam from Colorado offers one explanation: "In medical care, demand is supply driven."

I ask, who is counting? What are they counting? And who is coordinating these Federal programs designed to ensure greater access they were meant to achieve?

Again, thank you for the opportunity to share my research and observations with you. There is an enormous amount of detail that I have had to omit and I would ask that the subcommittee request answers to these questions that I have been asking for a number

of years. Simply said, is the program achieving its goals and who is watching over this program, clinic by clinic?

[The prepared statement of Dr. Feehan follows:]

SEPTEMBER 11, 1997

STATEMENT TO THE SUBCOMMITTEE ON HUMAN RESOURCES

OF THE HOUSE GOVERNMENT REFORM AND OPERATIONS COMMITTEE

BY EDWARD B. FEEHAN, M.D.

Honorable members of Congress and staff members of the Human Resources Subcommittee, my name is Edward B. Feehan. I am a physician, a pediatrician, board certified, practicing in Merced, California since 1971. Merced has been designated as the future home of the next University of California campus if funds are ever put aside to build one. The county of Merced ranks seventh in the nation in agricultural income. The city of Merced is one of the access routes to Yosemite National Park. The city of Merced has the highest number of Southeast Asian immigrants on a per capita basis in the United States as well as a large number of farm workers in the surrounding areas. A high unemployment rate in the county is a chronic problem. Our lowest unemployment rate exceeds by far the highest unemployment rate in most of the rest of the country.

I was born in Tulsa, Oklahoma and grew up in Kansas City, Kansas and Missouri. I am a former Naval person and have been both a Naval Aviator and a Naval Flight Surgeon. I served in Viet Nam and have four Air Medals for service some of which involved air evacuation of wounded.

I met my wife, Brenda, while serving at Andrews Air Force Base at the Naval Air Reserve Training Unit. Brenda is the principal of Our Lady of Mercy school in Merced and is about to become a National Distinguished Principal.

I graduated from the University of Kansas in 1959 and the University of Kansas School of Medicine in 1963. My internship was at Chelsea Naval Hospital in 63-64 and I was the intern of the year at that hospital that year. I completed training in the U.S. Naval School of Aviation Medicine in 1965. My residency in Pediatrics was at Stanford University Hospital from 1969 through 1971 and I am a diplomate of the American Board of Pediatrics and a Fellow of the American Academy of Pediatrics. My recent work has led to a nomination to be a member of Who's Who in the United States.

I was a member of the county medical society and the state medical society for 25 years and chose not to continue to be a member after running into resistance on the local executive committee in getting the problems I am going to describe addressed.

During my time in Merced I served as the Chief of Staff for one of the hospitals for 1981. During 1981 and 1982 we addressed a significant over—utilization problem which was described by one internist at that time as the most important thing to happen in our medical community in years.

I have practiced continuously in Merced as a pediatrician since March of 1971 when I finished at Stanford and I have been a percipient witness to

the problems associated with being in private practice in a community with rural health clinics and also with federally qualified health centers as well. I was the leader in the successful struggle to get the inaccurate shortage designations in the city and county of Merced withdrawn. I was the chairman of the local medical society's shortage designation committee. Our medical society may have been the only medical society in the United States ever to have such a committee.

My work on the problems associated with excessive and inaccurate shortage designations and rampant billing of rural health clinics led to a paper written by me which was sent to the Honorable Secretary Shalala. After considerable delay this paper, along with the coordinated efforts of many other physicians in Merced, led to the withdrawal of all but one of the shortage designations in Merced county. There was subsequently a publication of a paper I wrote on counting doctors in a peer reviewed journal (Western Journal of Medicine, June 1996). I received a letter wishing me success in my endeavors from a Dean of the Harvard's JFK School of Government. This letter was in response to a letter of congratulations from me on being appointed a Dean.

I come before you as both a practicing physician and a concerned taxpayer with some concerns about the effects of some policies on the definition of what is ethical in medicine. I come as someone who has witnessed how rural health clinics and federally qualified health centers work in our community and also someone who has investigated in some depth how rural health clinics are certified. I have also investigated the workings of the Division of Shortage Designation in some considerable detail and am one of the few, if not the only, private physician who has ever made a call on the Division of Shortage Designation in person. I also come before you as an individual who has observed how at least one state uses rural health clinics in a manner other than what I believe Congress intended them to be-as an end run around complying with their Medicaid Plan. California admits to not having held a hearing to gather data to set rates for Medi-Cal since 1990 and that hearing addressed only obstetric rates. It has been more than eight years since California has held a hearing to gather information to assist in setting rates for non-obstetric Medi-Cal care. In effect the only change in rates in the last ten years has been a downward change which resulted from the adoption of the new CPT codes because the 99050 and 99060 both became a 99213.

California is not in compliance with their Medicaid Plan in this respect. Nor has California scheduled such a hearing after it was pointed out both to them and to HCFA that California is not in compliance with their Medicaid Plan. If California has been issued a variance to the requirement set forth in their Medicaid Plan to hold hearings to gather information before setting rates for Medicaid payments neither the federal government nor the state have so stated in response to having it pointed out that they, California, are not in compliance with their Medicaid Plan.

In the city and county where I practice, Merced, there are two hospitals. One of them has had a rural health clinic since 1978 when rural health clinics first were authorized. Like many other areas our rural health clinic remained relatively smaller until after 1989 when

the GAO recommended a switch to cost-based payments which is a recommendation that was carried out. Converting to cost-based payments may have been well intended but it is a key element in understanding why we are in the boat that we are in today.

A special census was held in Merced in 1985 the purpose of which was to get Merced declared an urban area. This was coordinated by the Merced County Association of Governments. The city of Merced was declared urban as a result of that census and the county was declared a metropolitan statistical area at the same time. Being a MSA has the effect of converting all payments to federally qualified health centers to the higher of the rural and urban caps. LeGrand with 1,684 people qualifies for the higher urban cap. The main effect of the urban status was to raise DRG payments for inpatient work at the hospitals in the city of Merced. The special census was more significant because the action was supported financially by all hospitals in the area. There was a fee of about $148,000 associated with this census and it took a qualifying phrase to get the city of Merced declared urban. This phrase was that the "sphere of influence" of the county hospital was taken into consideration to get the population up over 50,000. In other words it took the unincorporated areas around Merced to have a population that qualified as urban in 1985 but no such special considerations were required in 1990.

So after 1985 Merced was no longer rural using that extra census. The 1990 census showed Merced to be an urban area without having to use that 1985 census "sphere of influence" comment. The 1990 population for the city of Merced was 56,216 and the current 1997 population is 61,400.

In 1993 the county hospital applied for a facility shortage designation. The physicians in Merced did not learn of this until after this designation was granted and it took about a year for the request to be processed. I asked the state for a copy of their raw data used in the determination. They declined on the grounds that the data was "proprietary" even though they claim to make changes to what they purchase by consulting phone books and other sources of information. Such updating of the purchased lists probably invalidate the claim that the data was "proprietary" in my view. States probably should not be relying on data they cannot release in the first place. The same request to the Division of Shortage Designation was graciously fulfilled. This request was made immediately after my August, 1994, in person visit to the Division and it was made in writing. HRSA and the Division were very kind in sending me the information but it was also clear that the request had to be in writing. The request actually was directed to the FOIA office of the Health Resources and Services Administration. At one point in my investigations there were so many FOIA requests that the HRSA FOIA officer thought I was retired and I have had to lessen the frequency of my requests for data but they have not stopped completely.

While I was visiting the Division one of the employees there made a very interesting statement. That statement was that <u>"milking the system is built into the system"</u>.

After I got the raw data I could see that there were a huge number of

errors in the raw data leading to this facility HPSA designation and I wrote them up and sent them to the Honorable Secretary Shalala. I asked for a reevaluation of the shortage designations in Merced county. After many months I asked what the decision was on whether there would be a reevaluation and eventually they realized I was serious and was not going to go away and the ball got rolling and all shortage designations in Merced were withdrawn except for one in Gustine. This occurred on the last day of 1996. From original request for a reevaluation to final withdrawal of the designations took more than two years and it was a huge uphill struggle all the way because this action was clearly not what the state and the special interest groups wanted. When it was finally announced that the shortage designations would be withdrawn in Merced county an employee of the state OSHPD made a comment along the lines that "This has never happened before". No one quite knew what to expect as a result of the withdrawals because there were so few precedents to go by.

During 1996 an assistant surgeon general in charge of the Bureau of Primary Care issued a reconsideration of the recommendation for the withdrawals at the request of the special interest groups but the original recommendation was finally carried out on the last day of the year. **Three rural health clinic applications from within the county of Merced that had been submitted prior to the official recommendation to withdraw the shortage designations were certified during the time between the official recommendation on 4/11/96 and the publication of the list of designated shortage areas on 12/31/96.** The reconsideration letter also allowed loan forgiveness in the areas in question to continue.

In the process of getting the reevaluation done I was able to get the rank and file membership of the medical society to pass multiple resolutions in 1995 to the effect that there were no shortages of physicians in Merced-the city and the county.

During this time the county was discovered to be in the process of increasing the number of family practice residents in the city of Merced from 18 to 24 with no discussion at the medical society asking how they felt about this. It was interesting that the University of California at Davis described the expansion as a fait accompli but the county responded that the expansion had been only a test balloon. The attempt to increase the size of the residency program failed only because the attempt was exposed when the plan was still young enough to kill it off. And killed off it was because the physicians in the community did not feel that there was room in the community for an expansion of the training program. The director of the training program departed the scene within a year after this plan was exposed and stopped. There was simply no thought given by the county and the host hospital for the residency program to finding out how the community felt about increasing the size of the residency program. The control over the size of such programs is in the hands of the host institution according to U.C. Davis. The University of California at Davis controls the choosing of the residents themselves and the U.C. Davis logo appears on the residency certificates but other than these items the program is rather autonomous according to U.C. Davis. I bring up this matter of the

increase in the size of the training program because it was at a hospital having a rural health clinic and also related to the perception in the community that it would be difficult to absorb more physicians in training in the community. There was no feeling on the part of the physicians in the community that patients were having a hard time finding a physician. The proposed increase in the size of the training program without consultation with the community was deeply resented.

The faculty for this training program has since purchased and runs a free standing rural health clinic in the county of Merced. This is an interesting thing for a faculty to do because one would ordinarily expect a faculty to be situated in an area that would not qualify for a rural health clinic. The required notice to Licensing and Certification of the change of ownership was filed some nine months late and was not filed until a complaint was lodged that it had not been filed. The allowed time limit is ten days.

Since this document was started this same faculty has taken over the medical management of the two rural health clinics in Atwater. These two clinics are hospital based and one is located at the former Castle Air Force Base. The building is a very large building. At one of these Atwater RHCs there have been some problems with the physician assistants being in the employee of the medical group. It is reported that the medical group was receiving a fixed fee for each patient seen and paying the PA forty percent of the fixed fee while keeping sixty percent of the fixed fee. The fixed fee was of course less than what the hospital was receiving from the RHC program. The hospital involved was keeping about sixty percent of what it received for each visit.

One of the interesting things that is happening at the Castle RHC is that private patients and Medi-Cal patients used to have different colored charts and are seen in different parts of the building. One has to wonder what this means. Another interesting observation about this clinic is that many of the doctors are from the city of Merced and the same can be said for many of the patients. The doctors have offices in Merced, the patients live in Merced but they both go to the RHC at Castle where the private patients and the Medicaid (translation RHC) patients are seen in separate but equal rooms.

The leadership of the medical society was less enthusiastic in passing motions about getting rid of some of our shortage designations and passed only one such statement but they did make such a statement to the Division that there was no shortage of physicians in the city and county of Merced with a little reservation about whether that applied to Planada and Dos Palos. The general attitude of the leadership and some individuals in the leadership in particular was so obstructive to the process of getting more attention paid to the inequity in the level of payment at the rural health clinics compared to that which was being paid in private offices for Medi-Cal that I decided in late 1995 not to renew my membership in the local medical society and I had been a member for 25 years by this time. I quit the local medical society because I felt the executive committee had been less than stellar leaders in the effort to straighten out the problems I was witnessing. The leadership of the medical society told the general membership that the motions of

the general membership were not binding on the executive committee of the medical society. I was able to get the general membership to pass numerous motions, some on more than one occasion, along the lines of trying to straighten out the problems being reported in this document. The leadership of the medical society did more to thwart those corrective actions than they did to help them along in my opinion.

The state of California pays about half the national average for work done in private offices for Medicaid patients. The state of California put up as many barriers as they could in accomplishing the objective of getting more accurate shortage designations in Merced county. Examples included the writing of a letter by a Deputy Director of the California Office of Statewide Health Planning and Development to Director of the Division of Shortage Designation on December 15th of 1993. This letter stated that Merced was the closest service area to Livingston when that is not in fact accurate. Turlock is four miles closer to Livingston than Merced is. The discharge demographics for various hospitals are public documents and 41% of the discharges in a recent year from Emmanuel Hospital in Turlock were for residents of Livingston. On October 24, 1995 the Director of the California Office of Statewide Health Planning and Development wrote an explanatory letter to me setting forth the idea that the proximity of Livingston to Atwater was the basis for stating that Merced was the closest service area to Livingston. Livingston is 10 miles from Turlock and 14 miles from Merced. I would call this kind of reasoning Catch 22 reasoning and I have seen it repeatedly in the process of arriving at shortage designations. With this kind of reasoning it is not difficult to come to the feeling that any area in the United States can be labeled a shortage area one way or another and that is exactly what we seem to have.

An imminent judge used to say that the law is not just what is written but also that which is observed. The rules on designating an area or a population group a shortage area are so complex that it is almost impossible for the Division to observe all the rules all the time and this results in legislation by selective enforcement of the rules.

Another example of state officials putting up barriers to seeking information happened once when I was first seeking information about the billing practices of the rural health clinic in Merced. An official in the state told me that I could not have what I was asking for because I had not named the particular rural health clinic by its proper name. When I asked this same official for the name of the rural health clinic he told me that such information was proprietary and could not be released. An official of the state of California then was telling me that a clinic receiving more than five million dollars a year in federal rural health clinic subsidies could not be named. There was only one certified rural health clinic in the community being discussed at the time and it is a little difficult to imagine that there could have been confusion over which one was being discussed.

I enclose an attachment which is a multi page table of the rural health clinics and FQHCs in our area as a demonstration of the details that have been developed over the past few years about the names and ID numbers of the various RHCs and FQHCs in the area. The idea that I had

not identified the rural health clinic in Merced was a bit of a stretch in my opinion but the second statement that the name of the rural health clinic was proprietary and could not be released to me raises questions about what kind of information was this official trying to keep from seeing the light of day? The discovery that the cost report showed costs from five locations when there was only one certification and two of those were in areas that were not designated shortage areas sort of answers this question. One of the motions that I was never able to get passed was that rural health clinics should have to have those words in their title. It was obvious in Merced that some people thought that patients would stay away if the RHCs were actually identified as RHCs. My position is that if you want the money you have to accept the label.

There are so many rules and so many types of shortage designations that in essence any area can be a labeled a shortage area. The prime example of this is that all of Boston is in essence being treated as a shortage designation and Harvard Medical School seems inadvertently to have been in a Health Professional Shortage Area for 7.6 years.

One demonstration of this is that there are 11 FQHCs in Boston alone, a city that has three medical schools. This is possible only by selectively ignoring some of the existing rules. One such rule is that teaching physicians are supposed to count if they are not full time in their teaching. Care in inner city metropolitan areas is supposed to count if it is within 30 minutes by public transportation. These rules are hard to observe and in essence are ignored. Time in the office is not the only time that is supposed to count and this is taken care of by using multiplier factors for various kinds of primary care practices. These multiplier factors are observed only rarely. The multiplier factors are 1.4 for family practice and pediatrics, 1.5 for internal medicine and 1.9 for obstetricians. In other words 21.05 hours in the office is full time for an obstetrician, 26.67 hours in the office is full time for an internist and 28.57 hours a week in the office is full time for a family practitioner or pediatrician. Getting these multiplier factors accurately applied takes time and is simply not being done regularly in my opinion. Insisting that these factors be applied was a huge element in getting the shortage designations in Merced withdrawn and was quoted in a letter from HRSA as one of the reasons the decision could not be "more favorable". This federal official felt the need to apologize to the state of California that the demographic facts did not support what the state and special interest groups wanted.

I am guessing at the multiplier factor for pediatrics as I was never able to dig this out of the Division. I suspect that pediatrics has never actually been assigned a number as it was not mentioned in the same document where the other multiplier factors were found and there was no response to a FOIA inquiry along that line.

Below is a list of Boston federally qualified health centers as of December 1996 and the source is the Massachusetts League of Community Health Centers.

Dimock Community Health Center

Dorchester House Multi-Service Center*

East Boston Neighborhood Health Center

Harbor Health Services

Harvard Street Neighborhood Health Center*

Joseph M. Smith Community Health Center

Mattapan Community Health Center

North End Community health Center

Roxbury Comprehensive Community Health Center
Upham's Corner Health Center*

Whittier Street Neighborhood Health Center

* means not a Section 330 Health Center

South Cove Community Health Center was listed as an other Massachusetts Site however it is actually within the boundaries of the city of Boston. The listing might have been as it was because it serves a particular population group and many of those in this population group live outside of the city limits. Counting this as a Boston FQHC gives a 50-50 split of the FQHCs in Massachusetts as in Boston and out of Boston. Twelve in each category.

As a means of demonstrating to the Subcommittee that the situation has changed over the years with respect to teaching physicians I will mention here something that came up in a recent continuing education lecture. At one of the lectures given here in Merced recently the lecturer mentioned that one group of teaching obstetricians in the Midwest was receiving a compensation package of $600,000 per year per individual. Now you can't get this kind of compensation per year from just teaching. But the Division of Shortage Designation has not been paying close attention to counting teaching physicians not even those who have large and lucrative private practices taking up a generous part of their time. The idea of not counting teaching physicians may have had some validity back in the days when their principal compensation was the prestige and privilege of being associated with students. The idea that very many teaching physicians derive all of their income from teaching is simply out of date. But the Division of Shortage Designation has not kept up with the times on this point.

Residents are supposed to count as 1/10th of a provider and this also has been ignored in a wholesale fashion in my opinion. There are enough residents in Boston to keep a huge chunk, more than half, of Boston from being in a shortage designation if the residents alone in Boston were being counted.

Another example of California's unusual methods of handling shortage designations was a formal commission hearing concerning the boundaries

of the service areas in Merced. This hearing was on June 8th of 1995 but it was held in South San Francisco. A state commission presiding officer made a ruling that I could not testify on matters that related to economics since in his view service area boundaries have no economic effects. This was an absurd ruling and the ruling was pointed out to the Honorable Secretary Shalala and Dr. Bruce Vladeck of HCFA. The hearing officer also made a statement as he guided the hearing to a closing that a prior meeting in Merced had come to a consensus. When three people in the hearing audience tried to be recognized to discuss this erroneous statement that the Merced meeting had come to a consensus the presiding officer refused to recognize those who wanted to speak. The manner of conducting of this formal state hearing spoke volumes in and of itself.

Withholding data by the state and county were frequent occurrences. On one occasion I asked the county of Merced for copies of their rural health clinic cost reconciliation report and the county counsel replied denying the request quoting the California Public Records Act. Record protection under this act has a three year time limit and I wrote back asking for the annual cost report that was just beyond the three year time limit and the county never responded to that request. The lack of a response to this second request suggested a certain amount of insincerity to the original response.

In 1996 the county of Merced applied for two new rural health clinic certifications in the city of Merced. Merced is not rural now and has not been since either 1985 or 1990 depending on which census you choose as the determining census. Those two new rural health clinic certifications were granted and complaints then filed on the grounds that they were granted in an area that was not rural. The withdrawals were effective on 4/1/97 and a phone conversation with the administrator of the involved hospital shortly thereafter left me with the impression that the billings from these two locations continue under the old rural health clinic certification. A discussion with the HCFA Regional Office in SF left me with the impression that this was being allowed under the "on campus" rule. If the "on campus" concept was good enough to cover these clinics billing the rural health program why did the county apply for certifications for these two locations in the first place?

The minutes of the Board of Supervisors of Merced county in 1996 discuss a plan to "split" the existing rural health clinic certification into three certifications. Later minutes report that this plan had succeeded and mentioned that those two clinics would start to use their new certifications on 7/1/96. The applications that were filed mentioned nothing about splitting an existing certification. There is no provision in law or regulation for splitting a rural health clinic certification and the grandfather clause does not address the question of granting new rural health clinic certifications in an area that is no longer rural. This attempt to "split" a rural health clinic certification was simply an attempt to dress up the fact that this hospital had been billing from multiple locations for years when they had only one certification.

These two applications for rural health clinic certifications were allowed to go through without a statement that the applicant clinics

were located in a rural area. There could not have been such a statement. A FOIA request for copies of the attestations that the two clinics were in a rural area was sent to HCFA. HCFA passed the requests on to the Regional Office in San Francisco. The Regional Office in San Francisco has not replied to HCFA's FOIA office in Washington because there could be no other reply than such attestations did not exist. These two applications were approved in an attempt to dress up the fact that billings from those locations have been going on for years.

These two new certifications were for clinics named the General Medicine Clinic and Kids Care. So before 7/1/96 these two clinics were being billed under the certification the hospital had for years under a clinic currently named Family Care and formerly called Family Practice Center. After 4/1/97 these two clinics began being billed again under the old single certification. If there was any validity at all to the desire to obtain separate certifications for the General Medicine Clinic and Kids Care what happened to the validity of the need to have separate certifications after 4/1/97? If I am not correct that these two clinics have continued to bill the rural health program the fiscal intermediary had a written inquiry sent to them along that line and at the time of the writing of this document have not sent information along the line that services provided at these clinics are no longer being billed to the rural health program. The opportunity has been given to the fiscal intermediary to respond to the question about whether billing visits from these two clinics after the certifications were withdrawn is taking place.

I did obtain one cost report for the rural health clinic in Merced from the fiscal intermediary after writing to this committee. That cost report shows some interesting data and there follows below a table that I made up from this cost report. If one interprets the one location one certification rule strictly then less than 7 percent of the costs claimed on this report were from authorized locations at the rural health clinic in Merced. If one allows a liberal interpretation of the "on campus" rule then 68.34 percent of the billings were from authorized locations in 93-94.

Figures From Blue Cross Audited Cost Report
For 93-94
Non ER Outpatient Medicare Costs

Name of Clinic	Costs	Percentages
Diabetic Clinic	54,600.00	3.84%
Family Practice	86,895.00	6.11%
Pediatrics	331,313.00	23.31%
Clinic	395,209.00	27.81%
Cardiac rehab	553,052.00	38.92%
Totals	1,421,069.00	100.00%

Figures From Blue Cross Audited Cost Report For 93-94 Non ER Outpatient Medicare Costs	
Percent of costs on cost report which are from authorized locations if authorized is liberally defined as on campus.	57.24%
Percent of costs on cost report which are not from authorized locations if location in a shortage area is required	42.76%
Percent of costs on cost report which are from authorized locations if each location must have its own separate certification and must be in a shortage area.	6.11%
These costs are less than a third of the total costs because Medicare and Medicaid have different fiscal intermediaries and the fiscal intermediary for Medicaid would not supply their cost reconciliation report.	

That withdrawal of two incorrectly approved rural health clinic certifications has not seemed to have stopped the billings from those locations.

California allowed the certification of two rural health clinics in an area that was not rural at the time and the Regional Office of HCFA did not block or rescind such certifications until a complaint was filed.

The cost reports are filed electronically. The authenticity verification statement in the cost reports are filed using the statement "signature on file". The problem is that the signatures are not on file. Failure to file the required change of management and medical director reports is common enough that you can even find this listed on the internet in a list of common problems associated with rural health clinics. I do not propose abandoning the electronic filing of reports but I do suggest that the attestation of authenticity of such reports should be a paper filing by the CEO or CFO annually. There is a psychological deterrent value to signing one's name that is greater than the deterrent value to saying the signature exists somewhere. An additional reason for requiring such signed attestations is that the audits take so long even just to begin them. The signature on file trail is a really old trail by the time the audits are completed. The audits for the F.Y.E. June 30, 1995 for example are not finished at this writing.

In the folders in Fresno for the hospital and rural health clinic in Merced two interesting comments were found. One is a comment along the lines that the exact location of the rural health clinic in Merced was then and always had been difficult to pin down. The other was a letter to the hospital advising them that the emergency room was not then and never had been a part of their rural health clinic.

The federal papers describing rural health clinics mention that they are supposed to be primarily for primary care. Absolutely no attention is being paid to this guideline. Two rural health clinics in Merced county have a greater than 10 to 1 ratio of non-primary care providers to primary care providers. The very name of one of them on the hospital license includes the words specialty clinic.

In the last two years the county of Merced opened a clinic on Olive Avenue in Merced called Gateway Health Network. Prior to the opening of this clinic the then administrator of the hospital was asked at a medical society meeting whether the hospital was going to bill the rural health program from this proposed new clinic. The answer was that this had not been decided. The problem with this idea is that the hospital had no authority to decide that the rural health program would be billed from this location. The clinic was opened in spite of opposition to the plan from physicians in the community openly expressed in public forum. The lease for the building was for $25,000 a month and the clinic opened and since billing the rural health program from this location was never allowed to occur the clinic has become an albatross around the neck of the county. This among other things lead to the leasing of the hospital to a management corporation. This new clinic which has never been allowed to bill the rural health program is directly across the street from the cardiac rehab unit which does show up in the cost report for 1993-94.

Prior to this year the county hospital had been managed by contract. More than one organization had held that contract over the last decade or so. In the last three years of the management contract the amount of the management contract was for in excess of $492,000 a year which included the services of the CEO and one other officer. This is for managing a hospital that is supposedly serving a remote rural population in an underserved area.

The plan by the county to open a clinic some distance from their hospital is viewed by many as an attempt at pre-positioning the hospital for future capitated contract negotiations. In other words a presence in multiple locations appears better when it comes time to negotiate for things like Medicare capitation contracts and other similar capitation contracts.

There is precedent in our nation's history for the concept of runaway shortage designations. In 1944 a bill was introduced into the Senate which would have allowed moving workers from one area to another in the United States. Senator Truman knew that the worker shortage designations coming out of the War Manpower Board were not all that accurate. The bill did not pass. When there is a fiscal goodie attached to being labeled a shortage area the areas carrying such a description begin to multiply. That is how we ended up with 88.93% of our counties, boroughs and parishes being connected with a shortage designation. It is not possible in my opinion to study the phenomenal growth in rural health clinics without studying the manner in which we label areas as shortage areas. It is not possible to logically separate the two processes.

When the negotiations for the lease of the Gateway Health Network were

being discussed in open meetings one of the doctors who would have been a principal provider at this clinic made the following comment to another physician. "Doc, I know the hospital gets paid more for a Medi-Cal outpatient visit in the rural health clinic than you do in your office but if that is the way the government wants it who are we to fight government policy"?

The ratio between the two payments in one of the rural health clinic locations in Merced is 8.4 dollars to the rural health clinic for each dollar paid in a private setting for a 99213 visit for a Medicaid patient. The exact numbers in recent years have been $136.43 to $16.56. The amount of the payment varies according to the cost reconciliation document and the hospital based rural health clinic in Los Banos for example receives about 125.00 per visit. One of the doctors in Los Banos wrote a letter to the DOHHS describing these differences in payment as obscene. That letter has been provided to this committee.

In the process of discussing rural health clinics one has to discuss some of the requirements. One of the main requirements is that a rural health clinic be in a shortage area. Mr. Finerfrock of the American Association of rural health clinics has admitted that some rural health clinics have been certified in areas that were not short of physicians at the time of the certification and he also admits that some rural health clinics that originally were in shortage areas are no longer in shortage areas. There is presently no procedure for ensuring that a rural health clinic continues to provide services in a remote underserved area. The grandfather clause that allows a rural health clinic to continue to exists after the community has lost rural status did not take into consideration the cost-based payments because the cost-based payments did not exist at the time the grandfather clause was written.

The GAO has stated in one report that less than half of our shortage designations are accurate. They also named three teaching hospitals that are in shortage areas. These were Buffalo General Hospital, Mt. Sinai in Cleveland and Brigham and Womens Hospital in Boston.

After getting this clue from the GAO I looked into Boston's shortage designation in some detail. Boston has numerous subsidized clinics known as FQHCs and FQHC look alikes although they do not have any rural health clinics. Merced has two FQHCs on one block and numerous others in the county and there are also numerous FQHCs in nearby counties.

In Boston there are 169 census tracts. Of these 42 are designated as Medically Underserved Areas. This is 24.85% of the census tracts in Boston. These MUAs and their cohorts, MUPs, do not get scheduled periodic reevaluations. Perhaps it is a bit of a stretch for one fourth of a city having three medical schools to be labeled as a medically underserved area. Add in the HPSAs and MUPs and the concept of underserved networks (area Health Network #16 in and around Boston) and in essence something close to all of Boston is being treated as a shortage area. An earlier report from the Boston Census Bureau showed the census tract count to be 138 which resulted in an even higher percentage of census tracts that were MUAs. Whether the census tract count is 169 or 138 it is a stretch to think that very much of Boston is

more than 30 minutes away from medical care.

Calculation of Percentage of Boston's Census Tracts that are MUAs	
Number of census tracts in Boston as of August 97	169
Source: Boston Census Bureau	
Number of Boston CTs that are MUAs	42
Source: DSD	
Percentage of CT in Boston that are MUAs	24.85%

Census tract 810 in Boston was in a designated HPSA, Roxbury, for 7.6 years ending on May 19, 1993. The ending date was discovered in a FOIA request to the HRSA but the beginning date can be discovered by anybody with the time to read multiple issues of the FR.

An Assistant Surgeon General testified on 2/13/97 that there is a statutory requirement that HPSAs are reviewed annually. I believe in her verbal testimony that she clarified that this is not happening and that they get it done about every third year. The business of CT 810 in Boston being included in a HPSA for 7.6 years strongly suggest that even this every three year review is not happening with great precision. Harvard Medical School being in a HPSA for 7.6 years suggests that someone cannot see the forest for the trees.

The following institutions happen to be located in CT 810 in Boston: Brigham and Womens Hospital, Children's Hospital, Deaconess Hospital, Harvard Medical School, the Harvard School of Dental Medicine, the Dana Farber Cancer Institiute and Joslin Diabetes Center. If the inclusion of CT 810 in the Roxbury HPSA was a mistake it was a mistake that went without discovery or at least correction for the better part of eight years. A physician at Brigham and Womens explained that someone serving there actually applied for and temporarily received student loan forgiveness but that they subsequently lost that loan forgiveness. This was probably the manner in which this oversight was discovered. But this mistake lasted for 7.6 years.

The Harvard Dental School seems still to be in a Dental HPSA unless there has been a technical correction after I requested that Boston be reevaluated.

The importance of discovering that Harvard Medical School was in a HPSA for 7.6 years is that it serves to highlight the fact that there is a certain degree of impreciseness in the process of publishing the list of shortage designations.

A state health official in Massachusetts told me in 1996 that it was harder now to get a shortage designation than it had been in the past. What that statement meant to me was that the existing rules were having

a little more attention paid to them.

There is supposed to be an automatic withdrawal nomination for all HPSAs for which update data are not provided in a three year time period. Currently the Division is working on HPSAs certified in 1993 which means they are one year behind and it is my feeling that if the heat were not on that they would not be this close to being up to date and that in the past they have indeed been further behind on this than the one year that they are behind at present.

Some 88.93 percent of our counties, boroughs and parishes seem to be connected in some way, in whole or in part, with having a shortage designation of some kind. This figure is one that I calculated from a handout available from the HRSA. The HRSA does not respond when I write to them asking if my calculation on this is in error. Approximately one half of the designations are partial and one half are entire counties. The Division does not respond when specific details are asked for quite possibly because they do not actually keep track of all these details themselves.

This 88.93% designation connection is occurring at a time when the Secretary of HHS has written to other Secretaries reporting a predicted excess of physicians by the year 2000 of greater than 100,000 too many physicians. One article that seems likely to be the source of this figure suggests that the excess will be in the neighborhood of 167,000 too many physicians. All this at a time when our DSD has labeled 88.93% of our counties, boroughs and parishes as involved in a shortage designation of some kind. All this is at a time when we have almost unlimited importation of foreign medical graduates. The Secretary was attempting to get various branches of the government to speak with one voice concerning the J—1 waiver. The effort did not work. We are allowing up to one thousand FMGs to stay in the United States per year on the grounds that they are willing to serve in shortage areas but less than half of our shortages designations are accurate according to the GAO. The way the GAO report was phrased leaves room for a finding of much less than a fifty percent accuracy rate for our shortage designations.

In addition to being concerned about uneven playing fields, certification of rural health clinics in non-rural areas, billings from locations that have had their certifications withdrawn, billings from locations that are not on campus and not in a shortage area, huge wastes of taxpayers funds, I am concerned about the effects these happenings may have on what doctors perceive as ethical. When doctors see all this going on it is my belief that the definition of ethical will gradually become the following: If one does not go to jail for a particular action then it was ethical. That is rapidly becoming the definition of ethical in the medical community in some areas of the country. The determining factor of whether something is ethical or not is whether or not you go to jail for an action. If you go to jail the action was unethical. If you do not go to jail the action was ethical. It is my perception that the doctors in some cases adopt this low standard of ethics because they see shortage designations where there obviously are no shortages and they see states making nonsense statements in support of shortage applications and the like. We are expecting doctors to act more

ethically than those who oversee things like shortage designations and rural health clinic certifications.

We are observing shortage designations that have not got much connection with reality and rural health clinic certifications in areas that are not rural. We have observed rural health clinic certifications in an area that has already had a formal recommendation for removal of the requisite shortage designation before the finalization of the rural health clinic application. We have observed skip years in the process of publishing the shortage designation list. We have observed delaying publication of shortage lists until the last day of the year when this has the effect of delaying withdrawals until the last day of the year. We have observed the HRSA stop identifying in the FR which shortage designations are being withdrawn.

NBC received comment after the Fleecing of America segment ran in January of 1997 about rural health clinics from a hospital in the Midwest. This hospital had avoided getting involved in rural health clinics exactly because they felt that it would involve them in unethical activities.

Several years ago a physician told me that he had just signed a contract to be a provider in a hospital based rural health clinic. He also elaborated that this would mean that Medicaid patients seen in his office could then be billed to the rural health program. This physician later backtracked from that concept when it was brought up in a more open forum. He denied that it meant that he could see patients in his office and bill those visits to the rural health program. But this was exactly what he told me the contract meant and he stated that it was a common practice elsewhere in the state to do so.

The rural health program is supposed to be primarily for primary care. This and many other supposed goals of the program have been ignored in a wholesale fashion. We have rapidly reached a position where the money that can be made is the only consideration that is given in applying for a rural health clinic certification.

I come to you with concerns about waste, fraud and abuse of federal funds, uneven playing fields, ignoring of requirements of the program, lack of supervision of the program, inaccuracies in the shortage designation process and the potential for adverse effects all these things have on the average level of ethics in the provider community.

While these hearings have had the rural health program at their heart there are two ancillary government activities that need to be looked at while one looks at rural health programs. These are the FQHC program and the shortage designation program. Those who practice in a community with rural health programs are often found in the double whammy position of being caught between two types of subsidized clinics, i.e. rural health clinics and federally qualified health centers or their look-alikes. In some small communities there are a multitude of both, often within walking distances of each other, and within walking distance of those attempting to carry on a private practice. This is often in a community where the shortage designation is hugely erroneous in the first place. Sometimes subsidized clinics are certified after the

shortage designations have been nominated for withdrawal and occasionally this happens with the unwitting assistance of an Assistant Surgeon General.

It is hoped then that looking at the Rural Health Program will lead to looking at the federally qualified health center program and necessarily looking at either one of these programs will entail a detailed look at the work product and methodology of the Division of Shortage Designation. If we as a nation are allowing ourselves to be deceived in the area of counting physicians may we not also be allowing ourselves to be deceived in the area of how many physicians we need to produce, how many residents we need to train and how many physicians we need or allow to immigrate. Are we allowing ourselves to maintain high levels of importing physicians as a means of providing services allegedly cheaply during the training of those physicians? If we are doing this, and I think that we are, are we putting blinders on with respect to the post training costs of these extra physicians. We often say we are training some FMGs with the requirement that they go back to the country of origin for a minimum of two years but only twenty percent of these physicians do go back to the country of origin. This is inevitably tied closely to the large number of erroneous shortage designations. We are drowning in physicians in part because of the errors in shortage designations.

Former Governor Lamb of Colorado has stated that every additional physician in the country adds $100,000 every year to the baseline costs of medical care for the country as a whole. We may need to stop using residents as a means of cheap care during training solely on the grounds that doubling the number of physicians in the country will double your baseline costs of providing medical care in the country every year. It is not possible for 88.93% of our counties, boroughs and parishes to be shortage areas and at the same time be heading for a predicted excess of greater than 100,000 too many physicians by the year 2000. Yes we have a distribution problem but it is not a distribution problem alone that can account 88.93% of our counties, boroughs and parishes being associated with a shortage designation of some kind. The present shortage designation methodology and degree of precision in carrying out that methodology simply has no connection with reality but there are twelve programs that thrive and flourish based on these shortage designations. A physician can get $155,000 in student loans forgiven for serving five years within walking distance of Harvard Medical School in numerous locations in the Roxbury HPSA as long as he or she are not serving in C.T. 810. To the best of my knowledge the Harvard School of Dental Medicine is still in a dental HPSA as I write. The Dental HPSA definition for Roxbury has never been fixed to exclude C.T. 810. If it has been fixed the Division has failed to inform the person who asked for a reevaluation. If there has been no reevaluation of Boston one has to ask why because it has been requested.

Harvard Medical School is not truly in a shortage area but that is exactly the way the FR notices could have been interpreted for 7.6 years. These notices did not mention Harvard Medical School by name but they did include the census tract where Harvard Medical School is in the definition of the Roxbury Health Professional Shortage Area. If this had just been a one year blooper that would have been one thing but the

inattention to this detail went on for 7.6 years. This error exemplifies the level of inaccuracy in the work product of the Division of Shortage Designation in other areas. Even the GAO says that less than half of our shortage designations are accurate. An outline of the map of CT 810 in Boston is attached.

If I happen to be in error about the percentage of counties, boroughs and parishes that are connected in some way with a shortage designation it is not for lack of asking the DOHHS and the Division of Shortage Designation what the proper percentage is. I think they have not included the percentage in any of their handouts because it would be so embarrassing to admit that it is as high as it is. The Division provides a handout that contains enough information to get a start on figuring the percentage. All one has to do is to find out what the total number of counties, boroughs and parishes is and this is not excessively difficult to do. So if the DSD denies that the figure is 88.93% one would have to ask them if they ever got a request for definitive information on this point from me. The answer would have to be that they did get this question from me.

In the U.S. there are 643 metropolitan MUAs and 1,911 non-metropolitan MUAs for a total of 2,554 MUAs. There are 501 metropolitan counties designated as a HPSA in part or in whole and 1,635 non-metropolitan counties designated as a HPSA in part or in whole. Eliminating duplications there are 694 metropolitan MUAs and/or HPSAs and 2,158 non-metropolitan MUAs and/or HPSAs for a total of 2,852. There are 3,207 counties, parishes and boroughs in the US as a whole including 108 for outlying areas such as Puerto Rico, the Northern Mariana Islands, American Samoa, Guam and the Virgin Islands. The 2,852 over 3,207 is where the approximate 88.93% comes from. The Division does not do the calculations for anyone but they do provide a handout where the raw data can be found. The Division is not the source for how many counties, boroughs and parishes there are in the country. This comes from a list published by the World Almanac and Book of Facts for 1996.

Calculation of counties, boroughs and parishes that are connected in some way with a shortage designation taken from data supplied by the Division of Shortage Designation	
CBP in 50 States	3,099
CBP in outlying areas	108
Total CBPs	3,207
Source for the above is the World Almanac and Book of Facts for 1996	
Unduplicated CBPs having a shortage designation of some kind	2,852
Source for the above is the DSD	
Percentage of CBP having a shortage designation of some kind without duplication	88.93%

I have identified four skip years in which no regular listing of shortage designations could be found in the Federal Register. These years were 1984, 1988, 1989 and 1993. In 1988 and 1989 there were four listings (not evenly divided) of what are referred to as designer HPSAs. These are requests by a Governor for designation of specific areas as HPSAs. These may also be interspersed with special requests from state health departments. The effects of the skip years is that withdrawals of shortage designations are not effective until a list of shortage designations is published that does not have the particular shortage designation in it. Technical corrections such as removing CT 810 in Boston from the Roxbury HPSA are effective upon letter notification to the interested parties but normal withdrawals are not effective until the publishing of a regular listing in the FR. In 1996 the normal listing was not published until the last day of the year which had the effect of causing all routine withdrawals in that year to be delayed until the last day of the year.

In addition to any implied suggestions contained in this document I make the following two specific suggestions. The first is that any person who is receiving a compensation of any kind from one kind of subsidized clinic such as a FQHC or rural health clinic be barred from being on the board of any other subsidized clinic. In other words if you work for a FQHC you should not be receiving funds for guiding policy in a rural health clinic. If you work for a rural health clinic in any fashion you should not be being paid in any way for guiding policy in a FQHC. These situations are not presently barred and should be in my opinion. Close ties between organizations seeking federal funds should not be encouraged or allowed. Rules to prohibit such ties between FQHCs and rural health clinics have not been instituted because the government probably did not know it was happening.

The second specific suggestion is that rural health clinics should have to have those words in their titles and on their signs. Clinics that want the word specialty in their titles should not be certified in the first place because rural health clinics are supposed to be primarily for primary care. Wanting the word specialty in the title seems like prima facia evidence that the clinic in question is not primarily for primary care. One has to dig into the legislative intent documents to find the primarily for primary care phrase but it is there.

An additional specific suggestion is to get rid of the J-1 waiver and consider tightening the valve controlling the import of foreign medical graduates considering Secretary Shalala's letter that we are soon going to have too many physicians. The number of residency slots the government subsidizes should not exceed or not exceed by ten percent the number of graduates of U.S. Schools. We are getting into the business of paying hospitals not to train residents. If we are going to do that is it not inappropriate to be allowing unlimited importation of new physicians from elsewhere? Are we not taking away future employment opportunities from our future U.S. citizen graduates of U.S. medical schools?

I thank the Congressional members and staff who have allowed me to speak

and the public for listening.

Very respectfully,

Edward B. Feehan, M.D.

Mr. SHAYS. Thank you, Dr. Feehan. Let me just say, these are important questions and we have passed on some of the questions. We will be asking some of the questions today.

Dr. FEEHAN. I would like to answer one question.

Mr. SHAYS. No, you cannot do that now. No. Let me just also take this opportunity to thank the Acting Administrator for basically not insisting that, as is the common practice going first, so that we have the advantage of other testimony so that we are able to ask HRSA questions based on the testimony that has preceded and it is just really appreciated by the committee, Dr. Fox.

Dr. Slater, you are on.

Dr. SLATER. Good morning. Thank you very much for the chance to come. I would like to ask if I could condense even further my remarks and be more succinct than I wrote.

Mr. SHAYS. I would love that.

Dr. SLATER. I sensed that. I come from a small town in northern lower Michigan. I work in internal medicine and I work in pediatrics. That means Medicare and Medicaid are the bill-of-fare for me on a daily basis. I do not know Government, I do not know the gentlemen with whom I am seated. I do not know what you have been doing, but I do know what we have been doing.

You are our partners, you have always been our partners. Partners should speak to each other more, so I am pleased, at last, to meet you. On a daily basis, I take care of underserved populations. I can speak eloquently about that. What I would rather tell you is if I were in your position to try and understand how to serve best the mission you laid out, an honorable mission, to help underserved people gain access to quality care in a sustainable fashion. Build something that's here when we're gone. That I do understand, because when I went back to my hometown, no less than one-third of the doctors walked out. You can imagine the effect when only 30 doctors are in a small town and 10 walk out from the pressures that push doctors and providers away from the rural setting. These are intense pressures and despite my love and intense family commitment to my home, I feel those pressures. In the face of that adversity, with a partner, Mercy Health Services from Farmington who has been behind our hospital for 100 years, we were able to turn that around.

We did it based on three principles and I would like to highlight them to you so that you would also consider looking at them. Once you have decided which areas are underserved, a task I could never help you with as well as you can help yourself with, I think I could shed a little light on which organizations are likely to bring you back the investment you seek. Look for these three signs:

Organization structure. Doctors, providers of care in key positions actually deciding budget, compensation schemes, strategic planning, not administrators who decide it for them. That is a difficult thing to drill down to, but you can do it. I can do it and that is the way we structured the organization that I am in now and it succeeded where a FQHC that I worked for to our south did not succeed because it ignored that. It became a self-sustaining administrative situation where doctors were simply cogs in the wheel, replaceable, and have been replaced to the tune of approximately 15 to 20 physicians over about a 7- or 8-year period. The effect on the

rural population is, the most common question from the elderly person coming into the office now is, are you going to leave?

Look at the compensation structure. When I wrote the contracts for our providers, I took the mission of our organization of providing health care to the underserved and made it show up in that contract so that every minute of the day when that provider does that thing that we all sought, he is rewarded for it. When he does not, he is not rewarded for it and I don't have to be there to watch him.

The third piece is education. Not just education of our patients, that is critical, and not just education of ourselves. That is very important. But the education of the people of the community in which we live to want to help us do this work. We bring the high school students in. We have even gotten to the point where we were able to bring one person from the local area and promote him all the way into medical school to the point where he is in the training program that I helped develop at Hurley in Flint and he is coming back to be my partner. Now when I retire, he will be 10 years younger than me and I hope he does the same. But that type of support came through the Kellogg Foundation, working with Michigan State University.

So those three elements, if I were to see them, if you said to me, Dr. Slater, go and tell us is this place going to give us back the return, I would say, show me their mission statement, show me their compensation contract and show me how they're bringing the community in and getting them excited about being health-care providers.

With those three elements, I think you will have sustainable success. Thank you very much.

[The prepared statement of Dr. Slater follows:]

MERCY **Health Services North**
Community Healthcare System

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Network Executive Coordinator
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September 5, 1997

Honorable Representatives:

Thank you for asking me to address you on the issue of rural health. My name is Douglas Harley Slater, M.D., and I am a native of Grayling, Michigan, a small town in the northern lower peninsula of that state. I know the problems of rural health well, not only as a board certified practitioner in both internal medicine and pediatrics in my own hometown, but also because I was raised in Grayling under impoverished circumstances and have experienced first-hand the problems of access and shortfall in available medical services. Fortunately, I was able to aspire to and achieve physician status through the support of government programs, without which I sincerely doubt it would have been possible for me to have done so.

When I graduated from residency training in 1990 and returned home to Grayling, the local health care system was undergoing a profound exodus of no less than 10 providers from a medical staff that barely boasted 30 physicians; seven of these were internists, and three were family physicians. It is beyond the scope of this address to you today to delineate all the details of why that occurred, but it is sufficient to state that it was in direct response to the three vital areas I wish to highlight: organization, compensation, and education.

At the time of that loss I was the last member of the medical staff with internal medicine or pediatric certification. With the support and commitment of the Mercy Health Services organization, and the endorsement of a guiding vision that I have been privileged to lead, we have been able to rebuild and exceed those past numbers of physician providers in just five years. And, we have done it in a way that we believe will sustain lasting growth and service to our community. The principles behind this success are based in mission and partnership.

Grayling is a small town of less than 5,000, centrally located in the northern lower peninsula of Michigan. The nearest tertiary-care centers are more than 50 miles away, and centers with more advanced technology are 100 to 200 miles away. The demographics of the patient population are dominantly Caucasian and elderly, with more than 20% retirement age or older. In addition, a high level of the population have low or fixed incomes and high school education or less. The main industries involve tourism and wood production. The main employers in Grayling are the health care system and the public schools. My hospital is located in Grayling and contains less than 100 acute care beds with a small long care facility, outpatient surgery, obstetrics/pediatrics, a 24-hour emergency room, a six-bed critical care unit, and approximately 45 medical- surgical beds operating. We currently have approximately 35 members to our medical staff of which

approximately one-half are primary care physicians and one-half are surgeons. Our service population is approximately 35,000 and involves our county and the county to our south where there is no hospital. Seasonal variation and part-time residents effectively double that number for a good portion of the year. The hospital-employed physician groups we have built currently consists of seven internists, two family doctors, one obstetrician, and one full time pediatrician, with three mid-level providers. There are only five or six mid-level providers active in this service area, producing a low mid-level to a physician ratio. We plan to expand provider ranks by an additional obstetrician, two family doctors, and three more mid-level providers over the next 12 to 24 months. No clinic organization based in Grayling (Crawford County) currently has rural health clinic status.

During the last seven years I have worked for three separate organizations in this local area. During my term as hospital chief-of-staff, and now as president of our local physician-hospital organization I have become familiar with a variety of other organizations in this region. If I were in your place and attempting to ensure stronger program management while targeting available resources more responsibly, I would be concerned about three key quality characteristics that would need to be evident in any applicant or participant:

1. Organization: To be successful in a rural setting, a streamlined and effective organization must be present. Physician leaders who are truly the decision makers are essential. Administrations have a habit of becoming self perpetuating at the expense of providers without such physician leadership. I would examine carefully the governance structure of any organization, and would not endorse organizations that cannot demonstrate direct physician involvement in areas of budget, compensation, and strategic planning. I would not believe that such leadership was truly effective until I had verified satisfaction in the majority of providers on staff with that organization.

2. Compensation: I would carefully review provider contract structures, looking for a reflection of the mission of the organization that truly incents and rewards provider behaviors that are congruent with that mission. In my organization, compensation is set at the median level for standard pay, but extraordinary behavior is expected. We have found that we are able to attract, recruit, and retain extraordinary providers using this principle.

3. Education: A commitment to education needs to be evident at every level of the organization. This includes, but is not limited to, an outstanding patient education effort, continuing education of the providers, and a commitment to educating health care providers in training. I would endorse any organization that actively encourages and supports local people in pursuing health care careers. It is a proven truism that the people most likely to live and work in a rural area grew up in that same rural area. In my organization, we have successfully promoted individuals up to and including entrance into medical school, with plans to return to our organization as physician partners upon completion of training.

My first official contact with a federal rural health program occurred in 1992 when I was appointed medical director of the community health center in the county to our south, a Federally Qualified Health Center (FQHC), not a Rural Health Clinic (RHC). Although I was impressed with the concept, I felt that the program failed to examine closely what actually was happening with the money that was being awarded to the organization. I felt the organization needed stronger medical leadership, but was unable to convince their administration that this was necessary. I ultimately chose to join Mercy where I have been encouraged to assume such leadership. As an organizational partner, Mercy Health Service has been able to support our mission in this rural area for many years. With the tremendous new pressures coming to bear on health-care delivery, the ability to sustain and grow desperately needed services in our region will require the additional support of partners such as the Rural Health Clinic program. Our current evaluation of the Rural Health Clinic program has been the basis of my recommendation to the Mercy leadership that we formally apply for certification. Mercy values, goals, and mission of bringing quality health care to our local communities will be enhanced under the current RHC program guidelines, enhanced beyond what our current resources will allow. That "boost" translates to greater patient access, improved service delivery, and greater potential to sustain and grow an integrated health-care delivery system. It does not translate to greater compensation for individuals, or as competitive advantage in a well-served market area.

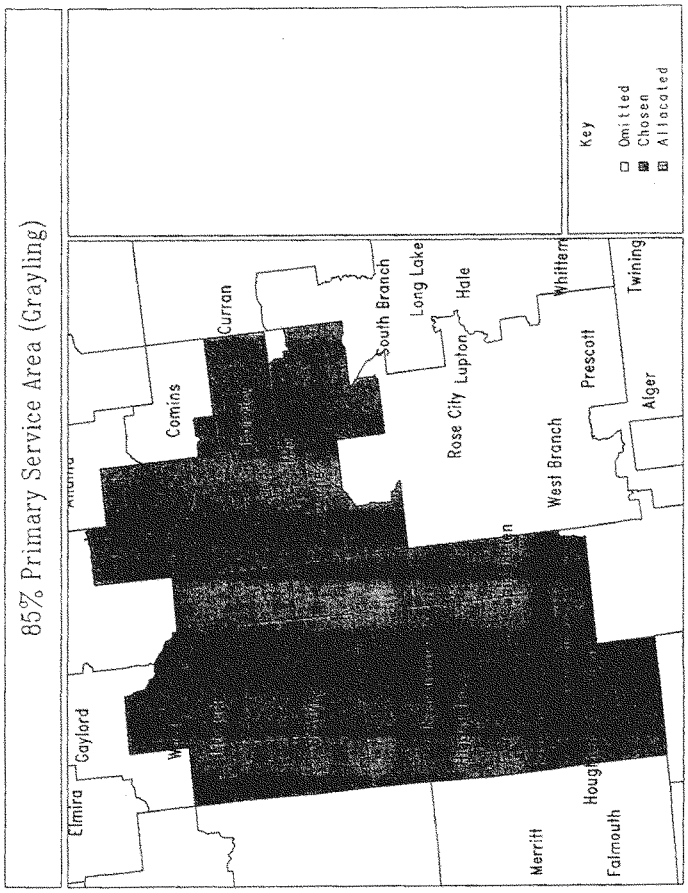
I appreciate all of your efforts to continue to improve the RHC program, and I believe if you can sharpen the focus to examine more closely the areas of organization, compensation, and education, it will serve our communities well. Thank you again for allowing me to address your committee.

Douglas H. Slater, M.D., F.A.A.P.
DHS/mhk

j:/network/testimon.rhc

Available Health Facilities
Grayling Mercy Hospital Service Area

Hospital	Approx. distance in miles from GMH
Cadillac Mercy Hospital	60
Kalkaska Memorial Health Center	25
Munson Medical Center	50
Northern Michigan Hospital	60
Otsego Memorial Hospital	30
Tolfree Memorial Hospital	45


85% Primary Service Area (Grayling)
Key
Omitted
Chosen
Allocated
Elmira
Gaylord
Comins
Curran
South Branch
Long Lake
Hale
Rose City
Lupton
West Branch
Prescott
Alger
Whittemore
Twining
Merritt
Houghton Lake
Falmouth

Available Medical Practitioners
Grayling Mercy Hospital Service Area

Specialty	County	City/Town	Physician
Anesthesiology	Crawford	Grayling	Winkler, Felix, MD
Cardiology	Crawford	Grayling	Clayton, Kevin, DO
Cardiology	Crawford	Grayling	Meengs, William, MD
Cardiology	Roscommon	Houghton Lake	Fernandez, Ray, MD
Cardiology	Crawford	Grayling	MacIntosh, David, DO
Cardiology	Crawford	Grayling	Willens, Harold, MD
Dermatology	Crawford	Grayling	Saunders, Mark, MD
Emergency Medicine	Crawford	Grayling	Siddiqui, Sabet, MD
Emergency Medicine	Crawford	Grayling	Coatney, Ann, DO
Emergency Medicine	Crawford	Grayling	Gulow, Mark, DO
Emergency Medicine	Crawford	Grayling	Suminski, Elizabeth, MD
Emergency Medicine	Crawford	Grayling	Gosling, Charles, MD
Emergency Medicine	Crawford	Grayling	Bersted, Alan, MD
Endocrinology	Crawford	Grayling	Rushovish, Errol, MD
ENT	Crawford	Grayling	Borovik, Harry, MD
Family/General Practice	Crawford	Grayling	Rosi, Tomlin, MD
Family/General Practice	Roscommon	Houghton Lake	Suleman, Kausar, MD
Family/General Practice	Crawford	Grayling	Guno, Nestor, MD
Family/General Practice	Roscommon	Roscommon	Kieler, George, MD
Family/General Practice	Roscommon	Roscommon	Hanselman, Laurey, DO
Family/General Practice	Roscommon	Houghton Lake	Hanselman, Laurey, DO
Family/General Practice	Roscommon	Roscommon	Lawrence, Fred, MD
Family/General Practice	Roscommon	Houghton Lake	Mulhem, Elie, MD
Family/General Practice	Crawford	Grayling	Gulow, Mark, DO
Family/General Practice	Crawford	Grayling	Gosling, Charles, MD
Family/General Practice	Oscoda	Fairview	Carrion, Hector, MD
Family/General Practice	Roscommon	St. Helen	Bash, Theodore, DO
Family/General Practice	Oscoda	Fairview	Peszko, Edward, DO
Family/General Practice	Crawford	Grayling	Burkley, Donald, MD
Family/General Practice	Roscommon	St. Helen	Carrion, Hector, MD

Available Medical Practitioners
Grayling Mercy Hospital Service Area

Specialty	County	City/Town	Physician
Family/General Practice	Crawford	Grayling	McNamara, William, MD
Family/General Practice	Roscommon	Houghton Lake	Englemann, Theodore, MD
Family/General Practice	Roscommon	St. Helen	Wahl, Wayne, MD
Family/General Practice	Roscommon	St. Helen	Bash, James, DO
General Surgery	Crawford	Grayling	Rosi, Tomlin, MD
General Surgery	Crawford	Grayling	Ramaswamy, K, MD
General Surgery	Roscommon	Roscommon	Hamburg, Debra, MD
General Surgery	Roscommon	Houghton Lake	Wolf, Neil, MD
General Surgery	Roscommon	Houghton Lake	Ramaswamy, K, MD
Internal Medicine	Crawford	Grayling	Slater, Douglas, MD
Internal Medicine	Roscommon	Houghton Lake	George, William, MD
Internal Medicine	Oscoda	Mio	Luzuriaga, Admirado, MD
Internal Medicine	Crawford	Grayling	Todoroff, Charles, MD
Internal Medicine	Crawford	Grayling	Suminski, Jerry, MD
Internal Medicine	Crawford	Grayling	Macon, Timothy, DO
Internal Medicine	Oscoda	Mio	Lira, Lorraine, MD
Internal Medicine	Roscommon	Prudenville	McElroy, Marvin, MD
Internal Medicine	Crawford	Grayling	Korneli, Fred, DO
Nephrology	Roscommon	Houghton Lake	DeLaRosa, Jose, MD
Neurosurgery	Crawford	Grayling	Zimmerman, J. Eric, MD
OB/Gyn	Crawford	Grayling	LaGattuta, David, MD
OB/Gyn	Crawford	Grayling	Shin, Sangkyu, MD
Ophthalmology	Crawford	Grayling	Chaulk, Jeffrey, MD
Ophthalmology	Crawford	Grayling	Wallace, Silas, MD
Orthopaedics	Crawford	Grayling	Goetz, Angus, DO
Orthopaedics	Crawford	Grayling	Forness, Michael, DO
Orthopaedics	Crawford	Grayling	Thiel, John, DO
Orthopaedics	Crawford	Grayling	Habryl, Louis, DO
Orthopaedics	Crawford	Grayling	Halter, Robert, DO
Pathology	Crawford	Grayling	Gregg, Howard, DO

Available Medical Practitioners
Grayling Mercy Hospital Service Area

Specialty	County	City/Town	Physician
Pediatric Orthopaedics	Crawford	Grayling	Fomess, Michael, DO
Pediatric Urology	Crawford	Grayling	Bloom, David, MD
Pediatrics	Crawford	Grayling	Slater, Douglas, MD
Pediatrics	Crawford	Grayling	Ali, Samina, MD
Podiatry	Roscommon	Houghton Lake	Sanders, Ty, DPM
Podiatry	Crawford	Grayling	DiPonio, Carolyn, DPM
Radiology	Crawford	Grayling	McNamara, Patrick, DO
Radiology	Crawford	Grayling	Harlan, Carl, DO
Urgent Care	Crawford	Grayling	Guno, Nestor, MD
Urology	Crawford	Grayling	Murphy, Blair, DO

Number of physicians listed = 74
Number of actual physicians (without duplication) = 65

Source: "Directory of Physicians in Northern Michigan, November, 1996" and Grayling Mercy Hospital Active Medical Staff listing

Mr. SHAYS. Thank you very much. I will be asking you questions. That helps me decide whether it is a good health care clinic and provider. How does that help me decide whether, and I am just saying it up front, whether that great health care clinic is needed to have extra incentives to be there.

Mr. Nelson—It is Mr. Nelson, correct?

Mr. NELSON. Correct. Thank you for the opportunity to be here this morning. I will also try to paraphrase my testimony and there are some points that I would like to make based on testimony that has already been provided.

Mr. Chairman, I appear before you today in hopes of convincing you to support initiatives that will result in the discontinuation of the Rural Health Clinics Program. I want to repeat that, lest anyone did not understand what I am saying. That you will support initiatives that will result in the discontinuation of the Rural Health Clinics Program. If we think about that statement, that's what this is about. As was stated at the outset of this hearing, the concerns about access to care should be our major thrust and our major theme. If there were no rural underserved areas, we would not need programs such as the National Health Services Corps or Community and Migrant Health Centers or other programs that, in fact, are addressing the areas of underservice. But in attempting to achieve that objective, it's important that we do a complete and thorough analysis.

I would have to say that, first of all, my training is clinical. I was trained as a physician assistant to gather data and information both objective information in a physical assessment and historical information to accurately assess a patient's condition and formulate a diagnosis. And I would submit to you today that what we are doing is throwing out a treatment plan based upon data that is 18 years old and, in fact, data that in many cases may be flawed and inaccurate.

The fact that the treatment plan has been unsuccessful, I believe requires that we take a serious look at how we're evaluating this program and look at some of the facts and the information that's being considered.

Recent reforms that have been adopted by the Balanced Budget Act seek to ensure the future and, in fact, address some of the issues that have been identified.

I would like to tell you a little bit about where I come from. I practice in Newaygo County, which is a small rural county where I grew up. I was educated the first 6 years of my education in a one-room country school house. This county has 50,000 people, however, it's over 900 square miles and 50 percent of it sits within the Manistee National Forest.

Ten years ago, when I attempted to establish our practice as a rural health clinic, there were nine family physicians in the community, no other providers. One of those physicians provided obstetrical care. This particular ratio created a situation of 1 individual for 5,500 of population, which is well above the Federal standard of 1 per 3,500——

Mr. SHAYS. What do you mean individual? You mean one practitioner?

Mr. NELSON. Yes, 1 physician or provider per 5,500 individuals. The point that I would like to make is that Newaygo County has a primary care shortage issue. The physicians were overworked, there were difficulties with long waiting times and overtaxing of the emergency department. We attempted to become a rural health clinic upon establishing our practice in White Cloud, MI. We were told, we don't do rural health clinics. This State does not do rural health clinics. Again, in 1983 I was told this State does not do rural health clinics. After being involved in making some attempted changes to the program, in 1989 we were successful in making that change and, in fact, assisting the State not only in doing their first survey of a rural health clinic, but assisting them in understanding the program. That was not without frustration. We waited over 6 months to receive our reimbursement that we were due for becoming a rural health clinic.

The success of that program now demonstrates that we have over 12 primary care physicians, we have several nurse practitioners and physician assistants providing care in that community and we have a total of 7 rural health clinics, including what has been identified, or thought to be, the first mobile rural health clinic in the country.

Is that wrong? Some people have said, well you have seven rural health clinics in Newaygo County. In fact what we have done is address the problem and provided access to care within our community. One of the issues that has not been addressed today, when we talk about too many physicians or conversion of practices is retention. One of the original intents of this program was not only to ensure that there would be adequate professionals to provide health care but that those individuals would stay in those communities. Dr. Slater has just addressed the fact that there is major outmigration of practitioners within those rural communities.

I would just quickly like to tell you an example where I was called to examine and treat a child in a home by an Amish family who obviously had limitations in that they only traveled by horse and do not have insurance. I treated a young child in the home and provided care to this young child, suturing a laceration by lantern light. At the completion of the treatment, which included four or five subsequent visits for this child, I was paid $90 in cash and two rabbits. Now, I'm more than happy to take alternative forms of reimbursement. But one of the reasons that I'm able to stay in that community and provide care is because a large portion of our practice is Medicare and Medicaid and we're able to enjoy a revenue stream that does allow us to be there and be accessible to the entire population.

Finally, there are some issues that I think need to be addressed and were previously addressed by a member of the committee relative to the issue of managed care and Medicaid. We're extremely concerned that the managed care program as it relates to Medicaid creates a significant threat to the Rural Health Clinic Program.

In my State, as you know, Michigan has led the way in Medicaid and welfare reform. However, as recently as a few months ago, the Medicaid director from my State said to me, we love rural health clinics and the market will take care of you. I am here to tell you there is no Medicaid market in my rural community. The entire

county population of Medicaid recipients is 4,200 individuals. That does not constitute in a managed care environment a significant population to distribute risk. However, I am being told that I will be thrown into a program that will pay me a capitated rate that will result in our loss of revenue of approximately 30 percent of the total revenue to our facility. That will have a devastating effect.

Contrary to previous testimony, I believe there is a significant number of facilities, and I have visited approximately 500 in this country through my role as past president of the National Association of Rural Health Clinics, and I think there are a significant number that would have significant impact by the effects of managed care and the effects of taking away a reimbursement stream that will recognize the additional costs and enhanced need for revenue in those areas.

Finally, I will close by saying that I think that there are some significant issues and questions that need to be asked. We need to ask for the criteria as it relates to the underserved designation and we need to ask for them to be completed. We need to define access. What does it mean to say that we want to provide appropriate access. We need to take a serious look at Medicaid managed care and in that area, we need to ask the Health Care Finance Administration to be accountable.

I am aware that in our neighboring State, it has been acknowledged by the regional office of HCFA, by the central office of HCFA that their Medicaid plan has been in violation of the law since 1993 but we are not going to do anything about it. I think that has some serious concerns relative to how rural health clinics can move forward looking at accountability.

And, finally, I think we need to look at how we are going to monitor the program in the future. I appreciate the opportunity to present to you today and I am certainly available and happy to answer any questions.

[The prepared statement of Mr. Nelson follows:]

Thank you for the opportunity to speak to you today regarding the Rural Health Clinics program.

Mr Chairman, I appear before you today in hopes of convincing you to support initiatives that will result in the discontinuation of the Rural Health Clinics program. Let me repeat that lest anyone in the hearing room this morning didn't catch it the first time. My goal here today is to convince you to support initiatives that will result in the discontinuation of the Rural Health Clinics program.

This is a goal that should be supported by every Rural Health Clinic provider in America, as well as every Member of Congress.

This statement should not be as shocking as some might imagine.

Think about it. If there were no rural underserved areas in America, there would be no need for Rural Health Clinics. Shouldn't the goal of this hearing and government policy be to eliminate all underserved areas - urban and rural - and therefore, by natural extension, elimination of the Rural Health Clinics program, the National Health Service Corps, the Community and Migrant Health Centers program, Medicare bonus payments and a myriad of other programs aimed at improving access to health care!

But it in attempting to achieve that objective, it is important that we understand how and why the Rural Health Clinics program is important so that in adopting reforms or proposing change, we understand the ramifications of the proposed

changes.

Clearly, some of the federal and state initiatives to improve access to care have not always worked as we might have hoped. In the case of the Rural Health Clinics program, we have clinics getting certified in areas that are not truly underserved. The question we must ask ourselves is why? Was there a fundamental flaw in the Rural Health Clinics program? Were we using the wrong program or was there even a problem?

As a physician assistant, I am taught to diagnose and treat medical problems. Before even attempting to posit a final diagnosis of a problem, I am taught to undertake a thorough history and physical examination of the patient. The purpose of this process is to elicit all relevant information in order to develop an appropriate treatment plan. If in conducting that history and physical, I fail to obtain or take note of relevant information it could result in an inaccurate diagnosis and inappropriate treatment plan.

I would suggest, Mr. Chairman, that part of the problem we are attempting to deal with in this hearing is occurring because we are not basing our treatment plan on accurate, appropriate or relevant information.

If I were to attempt to diagnose and treat a patient using history and physical data that was 18 years old, I would guilty of malpractice. If, in diagnosing a patient, I were to ignore relevant information at my disposal, I would be guilty of malpractice.

The fact that my treatment plan was unsuccessful may not be

the result of an ineffective drug or medical procedure, I may have simply prescribed the wrong drug or procedure because I had not accurately diagnosed the problem. The fact that we have Rural Health Clinics in areas that don't need them doesn't mean the Rural Health Clinics program is flawed, it may simply be that we have prescribed the wrong solution. And we prescribed the "wrong" solution because we didn't have accurate information during the diagnostic phase of the process.

The recent Rural Health Clinic reforms adopted by Congress and approved by the President as part of the Balanced Budget Act seek to ensure that in the future, the use of the Rural Health Clinic program is an appropriate treatment plan.

But what of the other federal and state programs that are using inaccurate or irrelevant information. What is being done to ensure that similar problems don't occur.

I have patients, Mr. Chairman, that I have been caring for many 18 years. Some of my patients suffer from conditions for which we have no cure, such as diabetes. Barring new medical discovery, this disease will be with them for the remainder of their lives. In these cases, we are not able to cure their malady but simply attempt to make their lives more comfortable or livable.

Despite the inability to cure diabetes, though, I am continually examining these patients and reevaluating their treatment options. Some begin with medication and later are able to control their diabetes through observance of a strict diet. Others began on a diet but have since progressed to medication. The point being that although the diagnosis of diabetes has not

changed, the way we deal with the problem has.

I use this medical example by way of comparison to how the federal government seems to deal with problems. From the outside, it appears that the federal government presumes that once an area is medically underserved, it is always going to be medically underserved. Communities that were "diagnosed" as medically underserved in 1981 have not been reevaluated since that time. This makes no sense.

I would lose my license to practice medicine if I treated a patient in 1997 on medical information that was obtained in 1981. Yet, the federal government permits application of treatments in 1997 on problems diagnosed in 1981.

My county, Newaygo County Michigan, is a good example of how things can and do change over time. So, Mr.. Chairman, with your permission, I would first like to give you some history and background about the county and community where I live and practice.

First, I think it is important to note that I am a lifelong resident of Newaygo County. To give you a sense of the degree of rurality in Newaygo County, from grades 1 through 6, I was educated in a one-room school house.

I presently live in Fremont Michigan, population 3,600, the largest town in Newaygo county. We are approximately 50 miles north of Grand Rapids. The County sits on the edge of the Manistee National Forest. In fact, approximately half of the county is within the boundaries of the forest. The fact that half the county falls inside a national forest presents some unique

problems for both the county and the health care delivery system which I would like to discuss a bit later in my testimony.

Newaygo County covers 900 square miles and has approximately 50,000 residents. The major source of employment in the county is agriculture and logging. 36% of the county's residents have a family income at or below 200% of the poverty level. In other words, Mr. Chairman, Newaygo County is a typical rural county populated by many small towns spread out over a large geographic area.

10 years ago, health care delivery in Newaygo County was typical of many rural underserved areas throughout the United States. The 50,000 residents were served by one acute care hospital and nine primary care physicians. Of the nine primary care physicians, only one provided obstetrical care. There were also two physician assistants in the county. The primary care physicians reported that patients were waiting anywhere from two to six weeks for appointments and the hospital emergency room was severely overtaxed.

Based on the federal criteria, Newaygo County qualified as a Health Professional Shortage Area because there was a primary care physician - population ratio of 1 - 5,500. Federal HPSA criteria establish a ratio of 1 - 3,500 as the basis for being considered underserved. In 1988, the national average of primary care physician to population ratio was 1 - 1,000 and the rural ratio was 1 - 1,800.

The point here, Chairman Shays is that 10 years ago, by any standard, Newaygo County had a shortage of primary care.

The physicians we had were being over-worked and threatening to leave and the financial stability of many of the practices was perilous at best.

In 1989, the decision was made to try, once again, to have our practice in White Cloud, Michigan designated as a federally certified Rural Health Clinic. I say, "once again" because between 1983 and 1988, we were continually told by the state of Michigan that it didn't certify Rural Health Clinics and even if it did, we were not eligible to participate in the program. Clearly this was incorrect but that's the way things were in most states in the mid to late 1980s.

With the help of some sympathetic individuals in the Health Department and a great deal of perseverance, we were able to succeed in having the White Cloud Clinic designated as the first Rural Health Clinic in Michigan. While we were excited about our victory, we soon realized that our work had only just begun.

Because we were the first Rural Health Clinic in the state of Michigan, the state surveyor who inspected our clinic had never done an RHC certification. She had never reviewed an RHC policy and procedure manual and frankly, had little knowledge of primary care, let alone rural primary care. At times, Mr. Chairman, the process became rather humorous. For example, the actual inspection of our office was supposed to be a surprise so that we couldn't "clean things up" just for the benefit of the inspector. Unfortunately, the element of surprise was lost when the surveyor had to call for directions because she had gotten lost on her way to the clinic. I've spoken to many other RHC colleagues who had similar

experience with their state survey and certification offices.

We were also the first to submit an RHC claim to the state's Medicaid department. This too proved to be a challenge. How many providers - whether urban or rural - get to tell their state Medicaid office how they are supposed to process their claims? We did because they didn't have a clue how they were supposed to reimburse Rural Health Clinics.

Since this first clinic was created, 6 more RHCs have been certified in Newaygo County. One of these, we believe, was the first mobile Rural Health Clinic in the United States. The hospital owns and operates the mobile clinic, and one other RHC. The remaining 5 RHCs are all independently owned by physicians and or physician assistants.

I would like to take a moment to describe how the mobile clinic operates.

Staffed by a nurse practitioner, the mobile RHC operates on a regular schedule bringing health care to 4 communities that are too small to support full-time health care. The clinic travels to a local fire barn, a grocery store parking lot, a church parking lot and a senior citizen center.

The clinic is a motor home that has been converted into a clinic with an exam room, small lab and a waiting area. A hospital-based physician serves as the Medical director and is available via cell phone in the event the nurse practitioner needs to consult with the physician. This arrangement has proved to be an effective mechanism for delivering health care to these communities that would otherwise be unavailable if it were not

for the Rural Health Clinic program.

Although some of the Rural Health Clinics in our county were conversions of existing practices (a point the General Accounting Office seems to consider inappropriate) the effect of the Rural Health Clinic program in our county has been to allow us to retain quality health care providers, expand access to quality, cost-effective health care to all residents of Newaygo county and stabilize the economic base of health care delivery in the county.

Not unlike other rural underserved communities, approximately 40 - 50 percent of the people in Newaygo County are either on Medicare or Medicaid. In addition, between 10 and 15 percent have no insurance. Therefore, the health care delivery system in our county is heavily dependent on these two government programs for survival. If we are underpaid by either Medicare or Medicaid, the economic viability of the practice is jeopardized. The Rural Health Clinic program guarantees that the clinics will recoup their reasonable costs associated with caring for the Medicare and Medicaid population of our county. By ensuring that we do not suffer an economic loss when caring for these patients, we are able to ensure continued access to care for not only those on Medicare and Medicaid, but those who have not insurance as well. Let me give you an example.

Prior to the certification of our clinic as a Rural Health Clinic, we lost money when we cared for Medicaid patients in our community. For example, it cost my practice $20.00 to perform an X-ray. This is for the cost of the film, depreciation on the equipment, space and overhead. Traditional Medicaid would reimburse me $9.00 for this X-ray. Mr. Chairman, the

film alone costs $7.00. The additional $2.00 I got from the state was to cover everything from the equipment costs to asking a radiologist to review the film. You can imagine how reluctant we were to order X-rays!

But under the Rural Health Clinic program, I don't have this dilemma. The cost of the film, depreciation, overhead and staff costs are all now considered reasonable and included in my cost-report. I no longer have a disincentive to order X-rays. More importantly, because my Medicare and Medicaid costs are covered, I can use whatever "profit" I earn on the rest of my practice to subsidize the care of uninsured individuals

Allow me to share with you a recent example that I think will help clarify the importance of this issue.

One evening about three weeks ago I was paged at the hospital while working in the urgent care clinic. The page was about an Amish patient of mine who wanted me to come to his farm to look at his two year old child who had accidently been kicked by a cow. The fact that this family was Amish is important for two reasons:

> First, the family had no health insurance because they don't believe in health insurance; and,
>
> Second, the family only travels by horse and buggy so it was necessary for me to drive to his farm.

When I arrived at the farm, I found that the injury to the boy was rather significant. Fortunately, I was able to persuade the father to allow me to transport the child to the hospital so that

we could perform a CAT scan to determine if there was any skull fracture. We climbed into my truck and drove to the hospital. On the way to the hospital I contacted a radiologist and asked him to stand-by for transmission of a scan that I wanted him to evaluate. Upon completion of the scan, it was immediately transmitted via computer to the radiologist who reviewed the scan and concluded that there was no skull fracture.

At this point, I suggested we go down to the emergency room where I could appropriately suture and bandage the wound. The father, relieved with the negative results on the skull fracture, asked if we could return to the farm for the suturing. Because I knew the family would have difficulty paying for the CAT scan, I acceded to his request to avoid an additional emergency room charge. So, we climbed back into my truck and drove back to the farm where I sutured his son's laceration on the kitchen table by lantern light.

Because of the nature of the injury, 4 follow-up visits were required to ensure there was no neurological abnormality. At the last visit, the two year old was running around the barn with his brothers and sisters acting like a normal healthy two-year old.

For the two hours I spent with the family during the initial visit, driving back and forth between the farm and the hospital, suturing and bandaging the wound and 4 follow-up visits, I received $90.00 cash and two small rabbits.

Mr. Chairman, I am proud and happy to work in an environment that pays me in different forms. I'm a little unsure

of how the IRS may feel about payment in rabbits (do I declare their value as food or based on their reproductive capacity?) and there's certainly no place on our cost-report to account for this type of payment.

But the fact is, were it not for the Rural Health Clinic program and the knowledge that our practice will be reimbursed adequately for the care we provide to Medicare and Medicaid patients, I would not be able to provide the type of care to uninsured patients like the one described above.

An important point to bear in mind, Mr. Chairman, is that my experience is not unique. I have friends and colleagues throughout the United States who have even more interesting and compelling stories they could tell. People who have literally poured their life savings into starting Rural Health Clinics. Colleagues who are able to provide additional services to Medicare, Medicaid an uninsured patients because of cost-based reimbursement.

I have one colleague who went 2 months without any reimbursement from Medicare or Medicaid while he waited for his RHC application to be processed by the HCFA regional office. This individual and his wife, both PAs, decided to reopen a clinic in a small town in Iowa that a major university had decided to close because the clinic was losing money. These PAs bought the clinic and equipment from the University, found a physician 35 miles away who would serve as their supervising physician, and reopened the practice. Because they are PAs, the only way they could open this office was to do so as a Rural Health Clinic. Neither traditional Medicare nor Medicaid in Iowa would reimburse for their

services. This created a classic catch 22.

In order to have a surveyor perform the initial RHC survey, the practice must be open and seeing patients. For physician or hospital owned practices this is not an unreasonable problem because they can submit claims for services to Medicare and Medicaid under traditional fee-for-service billing and then do a cost-settlement with Medicare and Medicaid after the RHC status is approved. This makes sense.

Unfortunately, if you are a PA or NP, it hasn't always worked that way. One of the problems many PAs and NPs have had when they sought to start a Rural Health Clinic, was that traditional fee-for-service Medicare wouldn't reimburse practices for PAs or NPs for seeing these patients. Thus, in the case of this particular clinic, Medicare required on the one hand that the practice be open and see patients but refused to cover the cost of that care. Medicare will reimburse the practice retroactive to the date of RHC certification but due to the lengthy time it can take to achieve RHC status, this can create serious cash-flow problems.

Now fortunately, Mr. Chairman, the problem described above should not continue to occur. Recent changes in the Medicare law will result in obligating Medicare to pay for PA and NP services prior to RHC certification, just as it does now for physicians. In addition, the time between initial certification and receipt of payment has been substantially reduced. That's the good news.

The bad news, Mr. Chairman is that new language in the Balanced Budget Act of 1997 could also result in my colleagues

from Iowa losing their clinic.

As you know, Mr. Chairman, Congress recently amended the RHC program to provide a mechanism for the Secretary of HHS to decertify RHCs in areas where RHC status was no longer necessary to ensure continued access to care. Many of us supported this reform because it is clear that there are clinics that no longer need RHC status and as I stated at the outset, our objective should be to eliminate the need for all RHCs.

Unfortunately, despite our request for change, this particular provision, when enacted in conjunction with some other changes made in the BBA, could result in forcing PAs who own their RHC to close or sell the practice if and when it should lose RHC status.

If, for example, 10 years from now, the situation in rural Iowa improves sufficiently to no longer justify continued certification of RHCs, clinics with the RHC designation would lose that status and bill Medicare and Medicaid under traditional payment rules. Unfortunately, whereas the RHC program allows PAs to own the clinic, traditional Medicare fee-for-service **prohibits** PAs from owning the practice. Thus, in the event a PA owned Rural Health Clinic were to lose that status, they would be prohibited from billing fee-for-service Medicare. Being unable to bill Medicare fee-for-service would in effect force the PA to sell the practice to a physician, refuse to see Medicare patients or simply close the practice. Temporary relief was offered in the BBA but the fact is, that relief will be of no benefit in the out years.

Today, 6 years later, the clinic is still providing quality, cost-

effective care to the residents of this small Iowa town and the surrounding farming communities. It is our hope that they will continue to be allow to provide that care for years to come.

But, Mr. Chairman, there are those who would have listened to my description of health care delivery in Newaygo County today compared to 10 years ago and who might conclude that we have too many Rural Health Clinics. Why, some might ask, do we need 7 Rural Health Clinics in a county with 50,000 people?

Were it not for the Rural Health Clinics program, I am convinced that many of the physicians who have stayed in Newaygo county would have left. Furthermore, because of the RHC program, we have been able to attract 3 nurse practitioners and 4 physician assistants to our county. The addition of these health professionals have not only improved access to care, but they have substantially reduced the burden being carried by the physicians. One example, the PAs and NPs are able to share call with the physicians.

Because the RHC program treats PAs, NPs and Physicians equally, the practice has an incentive to utilize these health professionals to the maximum degree permitted by state law.

In addition, we now have uniform access to care throughout the county. Even the smallest communities have seen substantial improvement in travel time to receive health care. And finally, the primary care burden on the emergency room has been alleviated. The emergency room staff has been freed to handle truly emergent problems and no longer must serve as the primary care source of last resort.

Despite the relative calm that exists in Newaygo County, Mr. Chairman, there are storm clouds on the horizon. Those clouds are called Medicaid managed care.

As you know, the state of Michigan has been one of the leaders in Medicaid and Welfare reform. And while no one would argue that the Medicaid and Welfare programs didn't need reform, we in rural Michigan are worried that inappropriate reform would cause the greatest disruption in rural health care delivery my state has ever seen.

Ironically, at the very time many states seem most excited about the prospects of moving to a managed care system for Medicaid, the managed care community is running away from the Medicaid program. A recent issue of the Washington Business Journal identified two major HMOs in the Washington DC metropolitan area that have pulled out of Medicaid because they were losing money.

To me, Mr. Chairman, that in and of itself is what distinguishes us from the Managed Care plans the states are looking to "save" their Medicaid programs. If things don't work out, if the business isn't "profitable", these companies just drop that line of business and move onto more profitable areas of endeavor. The community based providers don't operate that way. We are in the community because we are committed to the community.

I recently met with our State's Medicaid Director who said, "We love Rural Health Clinics and the market will take care of you." Well, I am here today to tell you that there is no

Medicaid market in rural America. Just as the market didn't bring electricity and phone service to rural America - it took cooperatives - we are not holding our collective breaths waiting for the market to bring health care to the poor and uninsured in rural America.

I am concerned that the advent of Medicaid managed care will not recognize the additional costs associated with delivering health care in underserved areas. Nor am I confident that state officials appreciate the fact that unlike urban areas where you can negotiate a volume-price trade-off, you don't have the volume in rural underserved areas to trade-off.

When I started practicing in Newaygo County approximately 18 years ago, there were 9 physicians and no physician assistants in the county. We now have six PAs and three Nurse Practitioners practicing in our County in addition to the 9 physicians. This would not have occurred were it not for the RHC program.

While the RHC program is far from perfect - what program is - it has helped and most of the RHC reforms adopted by Congress last month will help to ensure that the program stays on track.

My fear is that there are those who would like to see the RHC program go away, not because they care about access, but because they have placed too much faith in the so-called market. As I mentioned at the outset, Mr. Chairman, I too, would like to see the RHC program go away. The difference is that in my vision, the RHC program goes away because we have ensured access to care for all Americans.

Mr. SHAYS. I am going to call on Mr. Towns in just a second, but what I think we have before us is, Dr. Feehan, you are basically competing with health care clinics and have pointed out in your testimony some tremendous abuses, as you feel. Dr. Slater, you are not a community health care clinic but are investigating the possibility of becoming one, is that correct?

Dr. SLATER. Correct, we are considering whether that's an additional partner or any Federal partnership that would help us continue.

Mr. SHAYS. And, Mr. Nelson, you are a, not a nurse practitioner——

Mr. NELSON. Physician assistant.

Mr. SHAYS. Physician assistant, and are in fact in a rural health care clinic and have been for how many years?

Mr. NELSON. Since 1989.

Mr. SHAYS. Let me just say again, before Mr. Towns, there is not a dispute on the part of this committee, I do not believe, on whether we need to have rural health care clinics. The question is when they cover 87 percent of the counties and we know in some areas we have practitioners already providing service, are we seeing an overuse of what is intended to be a good Government program? So that is really the issue that we are trying to define. I think that is fair to say, is it not?

Excuse me, let me go with Mr. Snowbarger first and then I will go with you. You go. You are in charge, you got the floor.

Mr. TOWNS. Thank you very much. Let me begin by asking, do you believe programs such as this one meant to bring services to underserved populations are generally a good economic investment? In other words, does providing primary preventative health care save money in the long run?

Dr. SLATER. Sir, were you addressing me?

Mr. TOWNS. Either one of you.

Dr. SLATER. Yes, I do. I think that if you look at what you are trying to do in a rural situation, you have accidentally created the opposite. We have a large uninsured population that rely on an emergency-room-type setting for high-cost, high-volume care, none of which is preventative. It is all after-the-fact or there is barely time for education before the next ambulance brings in someone.

If you look at the statistics where they are getting access, maybe they are. But is it what you wanted? If instead you look at a scenario that says, let us have these folks seen by someone that cares for them over a period of time, years, stopping problems before they start, we all know that's much more effective than letting the problem develop and trying to fix it. The program is not the part that's flawed in my mind. It is that the mission of getting that kind of care to occur is out of focus right now. You need to incent that kind of care delivery as opposed to what we currently have and I think that that answers your question as well as I can.

Mr. NELSON. Congressmen, I would like to say that one of the things that we have heard in previous testimonies comparisons of cost-based reimbursement to fee for service and that is a comparison of apples and oranges. The reality here is that the rates that have been talked about of $56 or $57 are all inclusive rates of all of the costs within that practice. An example being: I take care of

an individual with an uncomplicated injury, say a fracture to the leg, which under the fee screen I could be paid $250 for managing that care, I get whatever my rate is, $50 to care for that patient. So, there are some economic benefits to this program as well.

Mr. SHAYS. Mr. Nelson, that is a valid point to a whole host of health care providers, community-based health-care clinics in our urban areas that may not get the increased fee, do have to provide to the noninsured poor. And so, I would suspect, Dr. Feehan, that you provide health care to people who simply cannot pay their bill. Is that correct? Pardon me.

Dr. FEEHAN. Yes, many.

Mr. SHAYS. But it is a very valid question and I thank the gentleman for yielding. In a rural setting where you have potentially a lot of poor, but not in a densely populated area, so you do not have a tremendous number of patients, you are going to need that extra fee schedule in order to also provide health care to those who can't pay their bill. The question is, are there some rural health clinics that are right in the same area where Dr. Feehan is and he does not get that rate and another organization does, but he is still there doing his job just like they are? That is the issue that I kind of see.

Mr. NELSON. But I think it is important Congressman to understand that for the same patient, in a nonrural health clinic, Dr. Feehan would get $250, but as a rural health clinic, I would receive $55 for the same care to the patient.

Mr. SHAYS. OK, that is an interesting part. You say, you are not allowed to charge the fee even——

Mr. NELSON. No, I am paid——

Mr. SHAYS. No, just let me say, even if they are not part of Medicare or Medicaid?

Mr. NELSON. That is correct. Well, I charge a normal fee to non-Medicare-Medicaid individuals. But if it is a Medicare or Medicaid individual, I am held to that independent payment rate.

Mr. SHAYS. But so is Dr. Feehan.

Mr. NELSON. No, he is paid on a fee schedule. I am under cost-based reimbursement, I am paid based upon a rate that is determined and established and that is my rate. As an independent private practitioner, then you are paid for Medicare under the Medicare fee screen and under Medicaid whatever Medicaid fee schedule occurs. So there is a distinct difference there.

Mr. SHAYS. Let me let Dr. Feehan respond, and then I thank the gentleman for his kindness in yielding.

Dr. FEEHAN. I am dying to answer one of the questions that was asked earlier and has been touched on just now.

Mr. SHAYS. Is it related? OK.

Dr. FEEHAN. 840 percent is the difference between what the rural health clinic gets for an ordinary office visit and what I get for an ordinary office visit, and I am not talking about some theoretical place——

Mr. SHAYS. Give us a real number, because 800 sounds absurd.

Dr. FEEHAN. $136.43 versus $16.56.

Mr. SHAYS. Is what you get?

Dr. FEEHAN. Yes, I get $16.56. The rural health clinic in our area, their figures work out to $136.43.

Mr. TOWNS. I tell you, I think it is good to get it in the record, though, Mr. Chairman. I think I want to raise this with you Mr. Nelson. There is some concern about the hiring of consultants who teach doctors how to successfully apply for rural health clinic status. However, in 1990, we in Congress required HCFA to distribute application material to all Medicare providers. Could you tell me if there is anything illegal about hiring assistants if all the information used is correct and accurate and done in a timely fashion?

Mr. NELSON. Well, I think it is important to note that the process, on an average, based on a survey done by the National Association indicates it ranges about 6 to 7 months that it takes a rural health clinic to become certified and, in fact, they could reduce the time that it takes for them to become certified by as much as 2 months by using a consultant that would assist them. Consultants may consist of everything from an attorney to an accounting group that are providing reasonable and appropriate consulting advice relative to the issues of financial management and, in fact, becoming a rural health clinic takes a transition. You move from what is traditionally a cash-based mechanism to one of having to look out how to file a cost report appropriately and to looking at accruals that are appropriate under the Medicare regulations. So obtaining assistance from appropriate experts to assist them with that is not an inappropriate request for them to look at that issue.

Mr. TOWNS. Dr. Feehan.

Dr. FEEHAN. I do not have a lot of objections to the consultants. It cannot be too difficult in view of New Hampshire's 1,300 percent increase in 2 years in the number of rural health clinics. Thirty percent annual rate of increase every year. One State peaking out at 1,300 percent in 2 years.

Mr. NELSON. May I respond to the New Hampshire situation? In fact, I sat with the Robert Wood Johnson Foundation as part of a major national initiative they did on primary care development and as a member of that national advisory committee, sat with the New Hampshire leadership and, in fact, encouraged them to look in their underserved areas at this as a program and a way that they could address those underserved needs. And, in fact, at that time which was in I believe 1991, they had no rural health clinics. So the increase that occurred in the State of New Hampshire was based upon the fact that they began to understand how they could effectively utilize the program to address their underserved needs.

Mr. SHAYS. The percents are misleading if you go from zero to something or one to something, but the real question, which all of you want to answer is, how many more practitioners do we have there now and how many more people are being served are people who were previously not based in rural clinics now just changing their designation?

Mr. NELSON. There is an important point to that. One of the statutory requirements in having this program is the need to have PA or nurse practitioner or nurse midwife in that practice and having been involved a few years ago in requesting that there was a problem with maintaining, sometimes those practitioners would leave, and the clinic's certification was jeopardized. We were involved in asking Congress to make a change saying that a waiver could be issued.

Mr. SHAYS. I do not understand how that is responding to my point.

Mr. NELSON. Well, the point is, those practitioners are in those facilities that were not necessarily there before and in many cases they are additional practitioners.

Mr. SHAYS. That is the point and I would like to know that and I want the committee to followup. That would be a helpful piece of information, at least for me. Thank you.

[The information referred to follows:]

November 26, 1997

The Honorable Chris Shays
[redacted]
Committee on Human Resources
[redacted] Rayburn Building
[redacted], DC 20515

Dear Congressman Shays:

[redacted] the transcript of the hearing you conducted on the Rural Health Clinics program on [redacted] 11, 1997, there was an exchange between you and Ron Nelson that needs clarification and explanation.

During a dialogue with Mr. Nelson, you stated, "...the real question, which all of you want to have an answer to is, how many more practitioners do we have there now and how many more people are being served? Are people who were previously not based in rural clinics now just changing their designation?" These are two very valid and important questions.

Are we simply seeing a conversion of a practice to RHC status in order to increase reimbursement? Or are we seeing an improvement in access to care and an increase in the number of providers in the community?

Mr. Nelson stated in his response, that a primary requirement of the Rural Health Clinics [redacted] has been that there must be a physician assistant (PA), nurse practitioner (NP) or certified [redacted] (CNM) in the clinic at least 50% of the time the clinic is open to see patients. Thus, [redacted] physicians to convert his or her practice to RHC status, the practice must add a PA, [redacted] staff. Because of either restrictive or non-existent payment policies under [redacted] of Medicaid, it would have been unlikely that these offices had PAs, NPs or [redacted] of the practice.

[redacted] is an important point, legislation adopted in the late 1980's allowed the [redacted] of the PA, NP, CNM staffing requirement if the physician stated that he or she [redacted] actively recruiting one of these health professionals. Consequently, we did see a [redacted] convert to RHC status without meeting the additional staffing requirement. In [redacted] could be argued that the practice was receiving a higher payment but had done [redacted] to improve access to care.

[redacted] know the Balanced Budget Act of 1997 made an important change that will prevent this [redacted] continuing to occur. All clinics will now be required to meet the staffing

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[redacted] 225-2565

[redacted] November 27, 19..
[redacted]

[redacted] requirements at the time of initial certification. An application for a waiver of the PA, NP, CNM [redacted] staffing requirement will only be considered after the clinic has been certified. If a clinic cannot [redacted] the staffing requirements at the time of the initial survey, the clinic will not be certified. We [redacted] this is consistent with the intent of Congress in creating the waiver authority and strongly [redacted] prompt enactment of this change.

[redacted] difficult to ascertain specific changes in staffing or improvement in the availability of health [redacted] that have come about as a result of a clinic becoming a federally certified Rural [redacted] Clinic.

[redacted] interested to know that we are exploring the possibility of conducting a 2nd national [redacted] Health Clinics and believe this would be an appropriate question to ask as part of that [redacted] To the best of my understanding that Mathematica Policy Research - under contract with the [redacted] Administratin - has just concluded a study which shows that RHCs do [redacted] in underserved areas.

[redacted] information is helpful. We look forward to continuing to work with you to ensure that [redacted] Clinics program is strong, viable and meeting the needs of rural residents who [redacted] underserved areas.

[redacted]

[redacted]
[redacted] Director

Mr. TOWNS. Let me just put it this way, managed care versus rural health clinics. Yes.

Dr. FEEHAN. There is a tie-in in our community in the sense that the hospital that has a rural health clinic has been using that rural health clinic in an attempt to establish a presence in multiple areas so that they would better be in a position to get more contracts, specifically the Medicare contract.

Mr. TOWNS. Do you have a comment on that, before I close out. Yes, Dr. Slater.

Dr. SLATER. Actually, and Congressman Shays mentioned to me earlier, there was a point he wanted to come back and ask me specifically.

Mr. SHAYS. I am going to go to Mr. Snowbarger when you are done here.

Dr. SLATER. The comment about managed care and rural health. The principles behind management of care are sound principles of quality care. When they are misapplied in a profit-based structure, they become rationing of the worst type, financial-based rationing. In the rural setting, one of the criteria that Congressman Shays, I think, may be looking for in how to decide if an area should be helped by the Federal Government, might lie in the percentages of Medicare and Medicaid that are actually indigenous to that population. If you, as the Federal Government, can utilize effective managed care principles of delivering quality preventive-based medicine through the Medicare and Medicaid program, then the two come together very nicely. You have decided what area. You have a high percentage of those government-insured populations and you have a program of delivery and care that if it makes sense to the clinical providers in the area, you won't have to go and check on them. You will on a daily basis be building a sustainable system because in the rural health care market, we will never have the managed care penetration that you see in the urban markets. There are not large employers. You are going to be the managed care provider as the Federal Government some day.

Mr. TOWNS. I know that we have some big holes to fill here, Mr. Chairman, when we look at our health care system because there are still some areas that even after all of this, will not be served, no question about it. So let me thank you very, very much and let me also add in my closing, happy to meet you as well.

Mr. SHAYS. I am going to be asking HRSA if they will just tell me how a community-based health care clinic that you might find in Mr. Towns' and my district, how they are reimbursed because if they are reimbursed at the same rate of rural health care clinics, that is something that we have got to reconcile. Mr. Snowbarger, thank you for your patience. I basically asked my questions through Mr. Towns' time.

Mr. SNOWBARGER. Well, and I asked mine last time through your time, so I appreciate it. Maybe just an observation first. First of all welcome to my fellow Jayhawker, good to see you here. I would like to observe for the panel, I think you have done an excellent job in the witnesses here because although it sounds like they come from different perspectives, I think they are all three are on target for what we are trying to figure out.

We have in Dr. Feehan, expressing a concern that I have and that is rural health care clinics that don't seem to be what I think of as rural, they are not providing to medically underserved in a rural area. When you have that happening, it is pulling funds away from what you are looking for Mr. Nelson, which is you know the possibility of a greater expansion in other areas that are truly underserved that may not know about the program that may not have gone through the application process. And we also have a clinic looking to see whether or not this is a program that they ought to be involved in. So I do think that it kind of covers the whole ground.

Mr. SHAYS. I agree.

Mr. SNOWBARGER. And I appreciate that. I have an observation to make about Dr. Slater and Mr. Nelson and I am going to have to drop back and give a little history to the question, and it is really not a question, I am going to make a statement and have you give me your observations.

When we worked with medically underserved areas trying to figure out how do we get physicians, how do we get health care professionals to rural areas in the State of Kansas. When I worked with the Kansas legislature, I was upset that, for instance, one of our scholarship programs for doctors, preference was given to medical students who came from rural areas. My district at that point in time was totally urban and I had a medical or a prospective medical student who was very upset, she wanted to go practice in a rural area, but she could not get the scholarship because the scholarship committee said no, we are going to take people that come from rural areas first. That is going to be our preference.

Now, my observation is this: if I understood your testimony right, both of you have gone back home to practice in your community. Dr. Slater, you are not a rural health care clinic, you went back without that incentive, without that designation and I guess my question, my observation is that perhaps there are other incentives for being in a rural area that are more important than the financial ones that the Government tries to provide and that perhaps we are fooling ourselves in thinking that we can provide a stable base of providers that don't have some other connection to, not a particular rural community, but to a rural life style, things of that nature. The thing that concerns me about that is that if we're doing it just based on financial incentives, then we have got the situation that Dr. Feehan is talking about where it has nothing to do with a commitment to provide health care in a rural area or in a medically underserved area, it has to do with making money. And we have just given those kinds of folks a very good incentive to at least to appear that they are serving a medically underserved area.

In Dr. Feehan's situation, it seems to me that Merced and that county, we have got problems beyond that. It sounds to me like we have got a problem within the system that does not recognize the changes that has occurred in population or whatever it has been over the past 30 years. With that observation, I would open it up for anybody to respond.

Dr. SLATER. Well, that certainly cuts right to the heart of my life, if you will. And your observation is correct, I did not go home because you had a rural health clinic program. Did it help because

you were able to forgive some of the student loans that, out of impoverishment, your government programs allowed me to become a doctor and go home? Yes. I appreciated that help, what did I do with it. I was able to sustain myself probably better and longer. The key is this.

The program you mentioned in Kansas was designed to facilitate, to remove barriers between interested providers and the rural health scene. Instead, it blocked someone. The program is flawed if it creates barriers instead of removing them. Anything that removes a barrier to coming home or coming to a rural setting is useful to me when I'm recruiting people. I first sit down in the interview and I don't say to them, let me tell you how great it is to live here in northern Michigan. I say, you tell me what's so great about living here in northern Michigan. They have to explain to me, how I can trust my investment in them that they will stay. I do not need them pulling out in a year or two when they realize it was not what they thought and there is no shopping mall for 50 miles. So this idea, does the money make people go there?

People who go into primary care, clearly were not interested in wealth and fame. And there are statistics to show that there is a direct correlation with the amount of annual income in the medical profession and the number of applications for those residencies.

Mr. SHAYS. If the gentleman will yield, I think we have got it solved. If there is a shopping mall within 50 miles, it is not—it cannot be designated.

Mr. NELSON. It is not rural.

Dr. SLATER. This could be a useful criteria, sir.

Mr. SNOWBARGER. Let me go back to the Kansas situation. As angry as I was that they did that and that was not a criteria built into the program by statute or anything else, that was the predisposition of the committee that decided who gets—Despite my anger at that, they could show me statistically who was likely to stay there longer than the time period to repay the loans and things of that nature. And that was the person that came from that community or a similar community and understood the rural life style before they got out there. Now, with all due respect to my constituent who is angry that she did not get the money, and she may very well have had a commitment to staying in a rural area, statistically speaking, she was not going to. What I am saying is that we provided that incentive, the Government provided that incentive thinking that we were solving a problem when in essence, and everybody acting in good faith, including the student. That student was committed to going there but for whatever reasons, did not find the mall——

Mr. SHAYS. Did they go? Did the student go?

Mr. SNOWBARGER. That scholarship was pretty critical to her getting into medical school and being able to pay for it and I cannot tell you that I know. I do not know if she entered medical school or not because, again, it was one of the few ways that she could pay for it. So it was an incentive to get her into medical school. She understood the commitment and was fully committed to fulfilling that and beyond, at least in her way of thinking going into medical school, wanting to give primary care and I understand those things kind of change as you go through medical school and all kinds of

things. Because I had another constituent who went through the same kind of program, did get the scholarship and decided after they had gone through it that they did not want to be a primary care provider and wanted to get some kind of waiver so they could still get their way paid through medical school.

I think there are all kinds of problems. What I am trying to get at is that I think sometimes in trying to do the right thing and trying to get care to the right areas, we provide incentives that are then perverted later on. I had to finally tell the guy, "Sorry, you made a commitment, you have got to go to a rural area." So, he is going to be there for the period of time that is required under the contract and he is gone. I have not done anything to help that community in terms of the long-term solution to their health care program.

Dr. SLATER. You have done more than that, sir. You have hurt that community's chances because it will only support a given number of doctors at one time.

Mr. SNOWBARGER. Sure.

Dr. SLATER. When that billet is full by temporary workers, I cannot recruit in because the people come and say wait, where will my patients come from, you have got enough of this, you have got enough of that and yet 2 years later, I do not have enough. And, I do not mean one person, what I mean is five or six will go at once and suddenly everybody is under tremendous strains. Call structures are back to one out of every two nights and even the hardy, the committed, start to wonder, are we living in the right place with what we're doing to our families and ourselves. So this is a tough, tough issue in rural health.

Mr. SHAYS. Let me say this to you. You have been an excellent panel, I am eager to get to our last panel and conclude by one if we can. We are going to have votes right after that. Is there any short last statement that you all would like to make? Dr. Feehan.

Dr. FEEHAN. We would not be in as big a mess as we are if the shortage designation process had any resemblance at all to what is really out there. That is the key.

Mr. SHAYS. Fair enough. OK. Can we end on that? You have been a great panel and I thank you very much for being here.

Mr. TOWNS. It should be noted that they ended on agreement.

Mr. SHAYS. Yes, Dr. Feehan's comments were registered in the positive by Dr. Slater and Mr. Nelson and that their heads went up and down. The record will so note.

Dr. SLATER. I support my colleague.

Mr. SHAYS. Thank you very much gentlemen. And, again, we will call our last panel, Dr. Claude Earl Fox, the Acting Administrator, Health Resource and Services Administration, accompanied by Dr. Marilyn Gaston, Associate Administrator for Primary Health Care, Health Resource and Services Administration. It will be noted that Dr. Gaston came and spoke before this committee last time and that was helpful.

Now, let me ask you, is it conceivable, Dr. Fox, that we will have anyone else respond to a question, because if so I would like to——

Dr. FOX. No, sir; it will just be myself or Dr. Gaston.

Mr. SHAYS. Thank you. I hope that it is not your acting administrative status that made you so gracious in being willing to go last,

because it is a better way sometimes to hear what is said and then to have you all be able to respond. I would ask you both to stand. Raise your right hand please.

[Witnesses sworn.]

Mr. SHAYS. Thank you very much. It is wonderful to have you both here and I realize I erred once again. I pronounced your agency incorrectly when I started, and I also then said I was going to ask you a question about fee structure when that is really a HCFA structure and I was going to ask you to compare the community-based health-care clinics in urban areas.

Let me ask you though before we start, do you designate community-based health-care clinics in urban areas, is that one of your responsibilities?

Dr. FOX. We do designate community health centers and migrant health centers, yes, sir.

Mr. SHAYS. And let me just say, is there a difference in fee schedule other than, do they get some benefits in their fee schedules?

Dr. FOX. There is. The cap for the non-facility-based rural health clinics exists for them and for us. We get a slightly higher reimbursement for provision of preventive services, and actually one of the things I want to talk about is the scope of services. There is some difference between the scope of services we provide in CHC's and between the rural health clinics.

Mr. SHAYS. OK, good, that is helpful. Well, you have the floor, and you are on.

STATEMENT OF CLAUDE EARL FOX, ACTING ADMINISTRATOR, HEALTH RESOURCE SERVICES ADMINISTRATION, ACCOMPANIED BY MARILYN GASTON, ASSOCIATE ADMINISTRATOR FOR PRIMARY HEALTH CARE, HEALTH RESOURCE SERVICES ADMINISTRATION

Dr. FOX. Thank you. You have my written statement, I am just going to make a few comments and try to keep them brief, because I know you really want to get to the questions.

Let me just say overall that HRSA's mission is to try to have equitable access to care for vulnerable populations, and we do that through a variety of areas. As you already know, the problem with the uninsured and underinsured is not solved in this country, and I would propose that with the advent of managed care the ability to cost shift makes it even more of a problem. So I think it makes some of these programs that were trying to deal with more important.

We have a number of safety-net providers, and I want again to draw a clear distinction between the programs of HRSA and our responsibility within the agency to deal with the community health centers, the migrant health centers, National Health Service Corps and between the rural health clinics that are not a responsibility of HRSA and are not designated by HRSA. We do provide part of the framework for which the designation takes place, but HCFA does that designation.

In response to the GAO report, I just want to say that there were several issues in there that I want to address briefly and I am sure some others will come up in the question and answer period.

Mr. SHAYS. You do not have to speak quickly, you will have the time.

Dr. FOX. OK. Well, I have a southern drawl and so I try to speed it up if I can.

Mr. SHAYS. I know, you have got to speak in that slow, southern drawl.

Dr. FOX. OK. The GAO report had comment on the fact of the National Health Service Corps and that we would send National Health Service Corps personnel into shortage areas in places where it was not necessary. Let me just say that, in response to that, within HRSA we have a process where we place a cap both on the number of providers we send into a particular shortage area and also the number of providers we send into a particular site, which are some strategies to help alleviate that.

There also was a comment about the J–1 visa physicians, and again to say that there is a misconception that we place and approve J–1 visa physicians. We do not. We actually provide some information, and right now are trying to make sure that the U.S. Information Agency that does approve J–1 visa waivers has information not only about what we have as far as the shortage designations, but other providers that we are placing out there, so they are dealing with a full deck of cards in whatever decisions they make.

I will say that within the J–1 visa issue, State health departments, of which I was a State health commissioner for 6 years, do request waivers, often for places that you cannot get a U.S.-trained physician to go to. But, again, we do not; we are not the agency that approves those waivers.

The programs that we are required by statute in our programs to look at involve a number of things other than the criteria in the HPSA MUA designation. In the MUA designation, HPSA is kind of the minimum screen of the first set of criteria we look at. There are a number of things we look at on top of that for both placement of our health centers and the National Health Service Corps, and I will be glad to go into that in more detail.

I will also say that as far as the designation process, you already know the two types. We would also agree with the previous panel that, there are some things that need to be changed in that and the issues that have been raised by the GAO we think are in the process of being addressed within what HRSA is doing around the MUA HPSA designations. The designations are intended to identify shortage areas; again, the minimum requirement. We have cooperative agreements with the States and every State has a cooperative agreement with HRSA that they provide us information, and the information that we use to make the HPSA MUA designation actually comes from State and local data sources. So, this is really our source for the information we make.

It is a first screen. The MUA designation is the first screen for putting a health center in a community, and there is not a statutory mandate for an update there, as you probably know. The HPSA designation is the first screen for placement of the National Health Service Corps; it's recognition of actual personnel shortages. The rural health clinic program is tied to the designations through what HCFA does and—as opposed to what we do around commu-

nity health centers—the HPSA designation is the only screen for rural health clinic designation, as I understand it.

We are in the process of updating the designations. We have been working internally on this and have done a number of things that we think help address the GAO concerns. The first is improving the designation process, and I will just tell you that this has taken time because it obviously affects a lot more than HRSA programs and so we try to be very thoughtful in what we have done.

We are including, as the GAO suggested, the other practitioners, physicians assistants, and nurse practitioners—they will be included into the count. We are also including the J–1 visa physicians in the count. I will tell you that the current designation does include primary care residents, but does not include specialty residents, because, again, these folks do not go out and provide primary care.

We are consolidating the MUA and HPSA designation, putting them together, linking them. They have been separate before, and we feel that these need to be done in parallel, which again I think was part of the GAO's concern. Then the revisions in what we are looking at would also provide for regular, simultaneous updates for both MUA and for the HPSA designation. We think that as the congressional changes are implemented and with what we are doing around the HPSA MUA regs, that this will address some of the concerns.

Finally, let me just comment on the GPRA requirements or the comments that you had asked us to make around that. We also think that the goals that we are working on both around the new designations as well as the way we look at our community health centers and we have some 635 community health centers with over 3,000 sites that provide care to underserved areas. We are looking at performance measures with the community health centers that we think will help us know whether or not we're doing the job and whether or not the Federal funds are being well spent.

To give you an example, we are looking at issues such as the percent of the clients that we're serving that don't have insurance. That's probably 41 percent; 41 percent of the people that we see in the community health centers nationwide have no insurance. We look at the number who have Medicaid; that's currently 33 percent. We look at the number that are low income, who are below 200 percent of poverty, and currently 85 percent of the people we see in community health centers are below 200 percent of poverty.

We are also not just looking at those issues, we are looking at the quality of care and what care we are providing. We look at the percent, for instance, of women who get mammograms or Pap smears as compared to the general population. We are looking at all the morbidity issues and quality reviews also within the health centers. So, we have a number of performance measures that we believe are allowing us to not only look at actual numbers, sir, but some of the quality issues around the kind of services that we provide.

Finally, I just want to state that we believe that we are moving forward in a way that will be acceptable to Congress on the MUA/HPSA problem. We have worked hard to try to address the concerns of GAO and look forward to continuing to work with you on this issue, and I will be glad to answer any questions.

[The prepared statement of Dr. Fox follows:]

Mr. Chairman:

I am Dr. Earl Fox, Acting Administrator of the Health Resources Services and Administration (HRSA). I am pleased to be here today to discuss HRSA's role in the designation of shortage areas, and to respond to the Subcommittee's request for a status report on HRSA's efforts to ensure that the underservice designation criteria are refined, combined, and updated. In addition, I will briefly address our overall efforts to improve access to and the quality of primary health care services. I am accompanied by Dr. Marilyn Gaston, HRSA's Associate Administrator for Primary Health Care, who testified before your Subcommittee in February of this year on this general subject.

A COMMITMENT TO ACCESS

HRSA's mission is to assure equitable access to quality health care services for underserved and vulnerable populations. Through partnerships with State and local governments, community-based public and private service organizations, and health professions institutions, HRSA works to provide quality health care services to those who need them most.

The health care crisis in the United States for low income, underserved, and minority individuals continues despite overall national improvements in access and health status. There are inadequate numbers of primary care providers in rural, frontier, and urban underserved areas. In addition, there are population groups that have difficulty accessing local health care providers because of poverty or cultural barriers. Studies done by Harvard University and the Kaiser Family Foundation conclude that over 40

million people have difficulty accessing health care services when they need them.

HRSA works to alleviate these access barriers through a variety of safety net programs, including the National Health Service Corps (NHSC), community and migrant health centers, health care for the homeless programs, and health care for public housing residents. Our safety net programs provide care to all patients regardless of their ability to pay. As you know, the community health centers, migrant, homeless, and public housing programs provide grant funds for primary care services to underserved populations. The NHSC sends primary care clinicians to health professional shortage areas.

The November 1995 GAO report on the National Health Service Corps suggests that we sometimes send more NHSC personnel into shortage areas than is necessary to alleviate these shortages. I strongly

disagree. The NHSC has been able to expand its assistance to more shortage areas by placing a cap on the number of vacancies which can be filled at individual sites, as well as a cap on the number of placements approved in a particular shortage area. We also count NHSC clinicians serving in the areas, including nurse practitioners, physician assistants, and certified nurse midwives, in determining the clinician to population ratios used in determining an area's unmet need for placement purposes.

The GAO report also suggested that we inappropriately place an excessive number of physicians with J-1 visa waivers in shortage areas. In fact, we do not place these physicians at all. They seek, and often receive, visa waivers from States and other Federal agencies to work in shortage areas. Previously, some have located in shortage areas in which we have placed NHSC providers. As an interim solution, we will be providing data on designation thresholds, NHSC placements, and the location of physicians with J-1 visa waivers by shortage area to USIA, who is responsible for

approving J-1 waivers, and to other Federal agencies. Moreover, our plans for the revised shortage areas designation process, which I will describe later on in my statement, consider the inclusion of physicians practicing under J-1 visa waivers when making our designation determinations.

All of these programs are required by statute to evaluate unmet need by geographically defined service area. We must use this information as one aspect of determining need for Federal resources. Therefore, as a prerequisite for receiving Federal funding for health centers and NHSC personnel, a geographically defined service area or a population group within such an area must be designated as having a shortage of health care services or a shortage of primary care professionals.

THE DESIGNATION PROCESS

HRSA manages the underserved area designation process. There are

two types of designations indicating a shortage of primary care services: medically underserved area or population (MUA/P) and health professional shortage area (HPSA). These designations were required for specific safety net programs prior to their use for other programs such as Rural Health Clinics (RHCs).

The MUA/P designations are intended to identify areas and population groups with a shortage of primary health care services; this type of designation has been required for health center grant funding since 1975. The criteria for these designations are required to include indicators of health status, ability to pay for and access health services, and availability of health professionals. Historically, MUA/P designation looks at indicators such as the local infant mortality rates, percentage of the population below the poverty level, percentage of the population over 65, and primary care physician to population ratio.

The HPSA designations are intended to identify areas that have a shortage of primary health care professionals. A HPSA designation allows a community to request National Health Service Corps health professionals. Historically, HPSA designation has primarily emphasized the primary care physician to population ratio, using high rates of poverty and/or infant mortality to indicate unusually needy areas and populations of unusually high need.

DESIGNATION AS A FIRST SCREEN

I want to emphasize that underservice designations are designed as the first screen in determining need for health resources and services. For example, HPSA designation is the first screen in determining need for providers placed by the NHSC, but other scoring mechanisms are then used to determine priorities between HPSAs and between primary care delivery sites within HPSAs to ensure that NHSC personnel are allocated to the HPSAs of greatest

need.

Similarly, MUA/P designation is the first screen in determining potential need for a health center grant. However, an application is also required that confirms the need of the designated community. Other indicators include: the percent of the target population below 200 percent of poverty; the percent of the target population who are uninsured; the percent minority in the target population for urban health centers; travel time/distance to the nearest accessible source of care for rural centers; and other community health factors for the target population such as high unemployment rate, high growth rate of minority/special populations, cultural/language barriers, and high morbidity rates due to specific diseases. This allows us to compare relative need within the applicant pool and deliver our resources to the neediest areas.

The Rural Health Clinic (RHC) program, which is administered by the Health Care Financing Administration (HCFA), is also required to use the shortage designations to identify need in rural areas. Clinics within a rural MUA or a HPSA that use nurse practitioners or physician assistants may be certified as RHCs by HCFA, thereby becoming entitled to receive reasonable cost based reimbursement for Medicaid or Medicare services. However, in contrast to the NHSC and community health center programs, location in a federally designated underserved area is the only screen of need used by the RHC program.

UPDATE OF DESIGNATIONS

Dr. Gaston testified earlier this year that HRSA is determined to improve the designation process. We are now actively engaged in doing just that. The indicators and methodology used to define underservice are over 20 years old. Moreover, although HPSAs are reviewed regularly, we are also concerned that many areas

designated as MUA/P do not have their designations reviewed and updated on a regular basis. In addition, we are convinced that the State role in the designation process should be expanded and that there is a need to reduce the effort and data burden on States by simplifying and automating the designation process as much as possible.

We have undertaken an initiative to update the various designations on a regular basis and are committed to including physician assistants, nurse practitioners, certified nurse midwives, and physicians with J-1 visas in the practitioner to population ratios used to determine shortage designations. This effort will result in the consolidation of the processes for designating MUA/Ps and HPSAs. We would also seek to direct resources towards those underserved areas which have the greatest level of need and would provide for regular, simultaneous updates of both MUA/Ps and HPSAs.

We are confident our proposed initiative will significantly improve the shortage designation process. Because the shortage designations are an extremely important part of the needs assessment process, we also feel that these changes will help us to better target our available resources.

We believe that the HCFA-administered RHC program would also be able to better target its resources because of the proposed changes in the shortage designation process. In addition, the new legislative provision requiring RHCs to be located in areas which have been designated or updated within the previous three years as well as the implementation of payment caps for provider based clinics should help ensure that rural health clinics are placed in medically needy areas.

GPRA REQUIREMENTS

The changes envisioned are consistent with the goals HRSA has

submitted under the Government Performance and Results Act. HRSA is committed to promoting the growth and integration of health care delivery systems to increase access for underserved, vulnerable, and special needs populations. We have developed an Access Plan in order to meet current and future demands of the growing uninsured population, survive in an increasingly competitive system and address the remaining needs of underserved areas and populations. The Access Plan establishes the framework to significantly increase the number of people served by focusing on three areas:

- the development of new sites in areas that have not previously had Health Center/NHSC activity;
- the expansion of existing Health Centers to serve even greater numbers of patients in their areas; and
- the specific expansion of Health Center/NHSC health care capacity to uninsured and underserved children and U.S./Mexico border residents.

In order to evaluate the progress that we have made towards our goal, we will examine the total number of clients served, the number of additional uninsured and underserved people served, the proportion of health center patients below 200% of poverty, the proportion of health center clientele that are underserved minorities, the total number of new sites, and the total number of sites providing access to services. In addition, because our health centers strive to provide the highest quality care to our patients, we will track reductions in morbidity and mortality from hypertension, diabetes and immunizable diseases in our users as well as the percent of health centers that have undergone quality reviews. We are proud to say that we already have evidence that the provision of preventive services to our patient population exceeds the Year 2000 Goals for the general population.

HRSA is committed to eliminating national disparities in access

and health status between the general population and those who face geographic, sociocultural, and financial barriers when accessing health care services. We are working harder than ever to make health care services accessible and effective for populations with an array of social issues and complex medical requirements.

We believe that our initiative with regard to the designation process and the new RHC legislative changes are important steps towards reducing health care disparities, and we are excited to be a part of those changes. Our health centers, the NHSC, and the RHC program are critical participants in maintaining the fragile safety net of providers that serve vulnerable populations. We are committed to continuing to work together with HCFA in order to ensure that primary care providers are able to deliver needed care to those who need it most.

Thank you for the opportunity to present testimony today.

Mr. SHAYS. Thank you. Just for the record, you have been acting administrator now for how long?

Dr. FOX. I am in my sixth month.

Mr. SHAYS. OK. Well, it is nice to have you before the committee. Mr. Snowbarger, we will start with you and then we will go to Mr. Towns, and I will interrupt both of you and have a ball, with your permission.

Mr. SNOWBARGER. Always. Let me ask you first about a statement that you made because I want to make sure I did not misunderstand, but you said as you are reviewing these changes that need to be made in HPSA and MUA, you are going cautiously and need to be careful because it affects so many programs.

Dr. FOX. Right.

Mr. SNOWBARGER. That seems to be backward. Let me follow through with that. It seems to me what we want out of a HPSA or a MUA is to know where we have an underserved area. An underserved area should not be defined by what the program is, it ought to be programmed by what services are available and that should be independent of what the programs are, it would seem to me.

Dr. FOX. We would agree with you, but the issue——

Mr. SNOWBARGER. As a practical matter, you do not do it that way.

Dr. FOX. No. The issue is how do you define underserved and I think that what we are trying to do is make sure that what we use in the index or whatever the criteria that are part of this process really do reflect the need within the community. And part of my concern, having been health commissioner and run a State with 85 counties, is the issue of unintended consequences and we do something that we thought was fairly straightforward and plain and find out that we had really mucked everything up. I think here that what we want to make sure of is that the items that we picked really are reflective of need in the community.

Mr. SNOWBARGER. Again, you are not giving me any comfort level that that is your focus. I am still concerned that by taking this approach, your concern is more for the viability of the programs that are there than the need of the people that are in those areas and that may not be your intention, that's your unintended consequence of the statement that you made. That does concern me because I think that what we, as a committee, are trying to do is, we know what our intention was, and that was to make sure that we can provide services, or make sure that services are available where there is a need. Once you get 30 years into a program, or 20 years, wherever we are in this, it seems to me that Government often shifts its focus to, if the program is not working right, let us try to fix the program, when maybe the program is no longer needed or maybe it was the wrong direction to go in the first place and quite frankly needs to be scrapped and remodeled.

Again, going back to trying to address the original concern, which was access to health care. So your statement concerns me and if you are truly slowing down that process because you are concerned about how it is going to affect Government programs, my comment to you would be do not be concerned about government programs. Be concerned about the constituents that we are trying

to serve with those programs and if the program is not doing it, let us not protect the program, let us scrap it and start over and do something different.

Dr. FOX. If I could respond, make one other comment to that. One, we are not slowing the process down. In fact, I have been there 6 months. The second month I was there we had a full hearing on where we were with this process. We have moved along, we push to try to get it through the agency to make sure, again, that we have been thoughtful in what we have done because we think that we need to have a good process. We feel that these regs will be going out fairly soon. We are trying to get comment within the Department right now on the regs and then they will go out for public comment with a chance for people to give their opinion as far as whether they think it works or does not work, but we are doing everything we can to expedite these regs. We want to get them out. We want to move this forward; we know it is a problem, but, again, we want to make sure it does reflect need in the community.

Mr. SNOWBARGER. In that regard, it is my understanding that you are required to update the HPSA list annually? Is that accurate?

Dr. FOX. Right.

Mr. SNOWBARGER. And that it is not being done that often? Done once in every 3 years?

Dr. FOX. We do some updates every year on a rolling basis; we do not let any go past 3 years. If there is a need to do it sooner, we will. But, again, remember we do not generate this data. We get this data from the States. Some of these——

Mr. SNOWBARGER. You are assuming that that is the appropriate way to get this data and I would like to think that States would give you accurate data and would have accurate data, they may not.

Dr. FOX. Well, for instance, on the physician list, you take a physician list from the medical association of the State. We had the cooperative agreement when I was in Alabama; for 6 years we did this. So you get a list of 5,000 physicians in a State and the list is not accurate. It does not tell you if, say within a community, there are five active physicians; maybe some of them have retired. There are a lot of things that transpire that make that list inaccurate. A lot of times what we have to do is go back and get them to physically go into the community and look and try to see what really is there to validate that. It is more than just a list. But I just want to emphasize that the designations that we make are made from data we get from States and communities, and that puts the burden on them. We try to do it as expeditiously as we can but, again, we have to get the data from them and make sure the data are accurate and really does reflect what the providers are and what the health status is within that community.

Mr. SNOWBARGER. Now, it is my understanding that you are not responsible for the MUA's, determining those, or——

Dr. FOX. Well, there has not been a congressional mandate to update those for a number of years. We are responsive——

Mr. SNOWBARGER. It is my understanding it has not been updated since 1981, which gives rise to the question that Dr. Feehan

raised, if they're still considered a medically underserved area and it has not been reviewed for 26 years.

Dr. FOX. There has not been an official recent review of the MUA's. We do update a lot of the information that goes in the MUA's as we look at our programs, our community health centers. So we do look at that information, but there has not been a formal MUA review since then.

Mr. SNOWBARGER. OK. One other line of questions here, and that is that you kind of indicated agreement with the previous panel that there is a need to do this update, that changes need to be made in the system in terms of HPSA as well as MUA.

Dr. FOX. We do not dispute the GAO concern that there is a need to update and modify the things that go in the HPSA MUA and that it needs to be done with a relative degree of frequency. We certainly agree with that and that is where we are moving.

Mr. SNOWBARGER. And what is your understanding of what your shortcomings have been in that area?

Dr. FOX. Well, again, we have not reflected, for instance, all the providers in the area. That is something that has not been taken into account. Again, the MUA designation has really been, as we have already said, static, while the HPSA designation has been done on a repetitive basis. Those are two major concerns that I think really, you know, are not the only ones, but some that we are certainly addressing in the revisions.

Mr. SNOWBARGER. Do you feel like you need a legislative mandate to get the process started on MUA's?

Dr. FOX. No, sir; we are moving forward on both of these. And, again the Department——

Mr. SNOWBARGER. The reason I ask the question is that you acknowledge that MUA's have not been updated in some period of—I think it is since 1981. You said as far as you know there is no legislative mandate. It kind of sounded to me like you were waiting for one.

Dr. FOX. No, sir. The regulation that we are working on right now addresses both and it does link them, as well.

Mr. SNOWBARGER. Thank you, Mr. Chairman.

Mr. SHAYS. The gentleman raises concerns that I have as well and I would like to get into this just a little bit more. Mr. Towns, you have the floor.

Dr. GASTON. I wonder——

Mr. SHAYS. Dr. Gaston.

Dr. GASTON [continuing]. If I might, on the MUA issue. This is an important one and I really think it needs clarifying. The MUA's were originally designed to place services, specifically, community health centers. They are updated every year as we monitor our community health centers.

Mr. SHAYS. For our internal use?

Dr. GASTON. Right. And in fact, they have an onsite visit, 3-to-5 years, so that—OK, so that we do not have resources or keep resources. We do not put new resources in an area or keep our resources in there without having up-to-date information.

Mr. SNOWBARGER. OK, now that is for community health centers, not for rural health clinics, which is the topic of this meeting?

Dr. GASTON. No.

Dr. FOX. But, again, not part of our responsibility.

Dr. GASTON. But, again, it underlines why you have to have a second test of need and why you have to monitor these programs and the level of need in these communities and assess constantly.

Mr. SNOWBARGER. Mr. Chairman, I note that our previous panel is very, very anxious to respond to that and I realize that they have been dismissed at this point, but perhaps later in the period, they might have an opportunity to respond. I know it is nice for the administration now to be able to respond to their questions, but apparently what is happening out in the field does not reflect what the administration here is telling us. Thank you, Mr. Chairman.

Mr. TOWNS. Thank you very much. Mr. Chairman, let me begin by a question that I have been asking and asking. Which agency of HHS is actually responsible for the direction and oversight of the rural health clinics?

Dr. FOX. The Health Care Financing Administration, HCFA.

Mr. TOWNS. HCFA.

Dr. FOX. Yes, sir.

Mr. TOWNS. According to the Library of Congress, today there are 149 counties with a half-million people who do not have access to health care because they do not have an active doctor. I would like to know whether changing the designations will adversely affect the ability of these people to get health care.

Dr. FOX. You are talking about the HPSA MUA designations?

Mr. TOWNS. Yes, that is correct.

Dr. FOX. I would hope that where we are headed will, again, provide a more accurate and more timely reflection of those communities that have need. I think it will improve the process.

Mr. TOWNS. You want to add something to that?

Dr. GASTON. No, it will improve it, yes.

Mr. TOWNS. Would anyone on the panel—actually, let me just direct it to you, I guess. Dr. Fox, care to express an opinion whether this program has assisted in bringing health care services to rural areas?

Dr. FOX. Again, we do not have the responsibility for rural health clinics. I cannot speak to all rural health clinics. Some of them have. I cannot say with any certainty whether all of them have or not. But some of them have. Again, we do not have responsibility for that program. We do not have the evaluation data to make a broad statement about the program, and beyond that I do not think I could comment.

Mr. TOWNS. Mr. Chairman, recognizing your time constraints, I yield back.

Mr. SHAYS. What I really want to nail down before I go is, does HRSA believe that we have too many rural health care clinics?

Dr. FOX. Mr. Chairman, HRSA has not, again, looked at that. We have a lot of data on community health centers. I can tell you about where they are placed, who they are serving, what they are doing. We do not have that data on rural health clinics, and I do not think I can respond to that question.

Mr. SHAYS. OK. And so I am missing something here. You do play the role of determining who qualifies and who does not?

Dr. FOX. No, sir. HCFA makes that determination. We go into a community and we will look and see whether or not a community

is underserved based on the criteria that we use, that we collect, again from the States. We actually send that to HCFA.

Mr. SHAYS. You look at the shortage issues for HPSA and you look at the MUA underserved?

Dr. FOX. But we look at things like the primary care physician-to-population ratio. We look at the number under 200 percent of poverty. We look for the infant mortality rate. We look at issues like that, and those are the kind of things that go into whether or not an area qualifies as a HPSA. We do that, we use it internally, along with the grant applications for our own community health centers and for the National Health Service Corps. We sit and make the determination on those. We have nothing—we do not look at the applications that come in on rural health clinics. We do not sit down and look at anything about the rural health clinics.

Mr. SHAYS. That is HCFA that does it?

Dr. FOX. Yes, sir.

Mr. SHAYS. So HCFA is involved in setting the rate structure and also designating?

Dr. FOX. Yes, sir. We do the designation for the community health centers——

Mr. SHAYS. Slow down. You do it all in one breath besides. You determine community-based health care clinics in urban areas?

Dr. FOX. Yes, sir, urban and rural.

Mr. SHAYS. Well, why would it not be logical that you would determine the rural health care clinics? Why would we have one do that and the other do this?

Dr. FOX. I cannot comment on the logic. It is strictly the way the law is set up. And, again, we put funding—we actually——

Mr. SHAYS. But I can comment on the logic and you can respond to it. What would be the argument, and if there is no argument that you see, I want you to tell me. What would be the argument that would say that HCFA would do rural health care clinic designation and you would do community-based health care clinics?

Dr. FOX. The comment I would have on that, Mr. Chairman, is that I think that the type of things that we look at in addition to the HPSA MUA information—we look at issues like rates of certain illnesses in the county. We have all the things that we look at in addition when we make the decision about putting Federal money. I think those are rational ways of putting that second level of criteria.

Mr. SHAYS. I am not disputing that criteria, I am wondering. One of the things that happens in these hearings—I am going to school every day. I learn new things every day. The value that Mr. Towns and I bring to this process is that we were not part of the process. So we look at it somewhat fresh and we force you to have to look at it as well, and we get ideas and we write reports and we take those reports and we pass legislation based on them. You have introduced an element here that I would like to understand. This may be one of the reasons why we are in the mess we are in, you know, because to me the very logic that would have you designate a community-based clinic would be the logic of whether you would designate a rural health care clinic. Or, maybe that should not be your responsibility. I just do not understand.

Dr. FOX. I would rather not comment on what I think my responsibility should be since it is under the purview of other agencies, but just to say that I think the way that we designate community health centers is rational, it's very methodical and I think it does help us more accurately place where those centers should be.

Mr. SHAYS. OK, I accept that as an answer. I could infer from that answer that what is rational for community-based health care clinics could also be for rural health care clinics, but that is my determination and I could be wrong, maybe as I look at it more.

Dr. FOX. I would not disagree with that.

Mr. SHAYS. And basically, it is your testimony before the committee that you look at the issue of underserved and shortage and you review this criteria every—see, one of the things you are doing is you are determining—let me back up. Before you were there, Dr. Fox, GAO came in with a pretty strong report that we needed to have new regulations and that the regulations have not been forthcoming as quickly as possible. So what is the status of HRSA's regulations to modify and combine the shortage designation procedures?

Dr. FOX. The regulations have been drafted within the agency, they have been forwarded to the Department, they are in the process of undergoing departmental clearance, and I would hope within a relatively short period of time, would be out for public comment.

Mr. SHAYS. OK. And you define relative——

Dr. FOX [continuing]. Twenty plus years, that is a dangerous——

Mr. SHAYS. No, but it is one of the privileges I have as chairman, is to pin you down on these things.

Dr. FOX. I would say within a matter of weeks, a few months.

Mr. SHAYS. OK.

Dr. FOX. Hopefully, more of the former than the latter. Again, it is not a process at this point under my control.

Mr. SHAYS. OK, this is what I am going to do: I am going to ask you to monitor this, and if you think it is going to be more than 2 months, I want you to contact this committee. Otherwise, I am going to go under the impression that this will be out for public comment in 2 months.

Dr. FOX. I would love to see it as well. Mr. Chairman, there was one other comment that came up on multiple occasions about the 88 percent of the counties that were designated and if I could just comment on that?

Mr. SHAYS. Sure.

Dr. FOX. I would just point out that it is not 88 percent of counties that have whole county designations. Many of those are a single census track and, in fact, if you look at the population, it is only a fourth of the total population of this country that reside in a designated, underserved area.

Mr. SHAYS. I think that is a very important point. Let me put it in my words: you are saying that basically you have designated 25 percent of the population of the United States as an underserved area.

Dr. FOX. Is living in many rural and frontier areas.

Mr. SHAYS. OK, and I think that is valid and it should be. It still is a large number and the one thing we can't dispute, the testimony is just there. We have people that are providing health care

in an area and they are competing against rural health care clinics that receive a larger reimbursement and that is telling us that maybe you don't need the designation of a rural health care clinic in order to provide health care in some areas. We all know in Government, and Mr. Towns and I both know this, that when you designate someone and give someone an advantage, it's very hard to take away that advantage. But, over time, if you don't, then the program you provide becomes somewhat of a joke. And so, we are going to really try to wrestle this a little bit more and we don't pretend to know the answers. We're getting a sense that we're getting at some of them, but we are going to put pressure on those who ultimately have to so that we see some change and we wean some of the people off the program.

Would it be your testimony that the new regulations that we are requiring through the Budget Act to HHS to promulgate regulations to graduate some rural health care clinics, it's your testimony that the people who will be providing the greatest impact will be your office or would it be HCFA, or would it be a combination of both?

Dr. FOX. Probably the majority of that will be HCFA. I am sure we will have some input.

Mr. SHAYS. OK. I will just leave with this: I think it is important for this committee, especially Mr. Towns and I who represent urban areas and have the advantages community-based health care clinics which we think are pretty terrific, to wrestle with how this fits into the whole issue of rural health care clinics and understand what criteria we use for these two different clinic providers.

Dr. FOX. We will be glad to work with you on any way that you request Mr. Chairman on this issue.

Mr. SHAYS. We appreciate your participation. And also, I would like to, just before closing, thank the majority staff, Marcia Sayer, who has helped put this hearing together along with Jared Carpenter. From the minority staff, Cherri Branson and Jean Gosa, and our reporter, David Becker. Thank you, Mr. Becker, for your help as well. And we will just say, is there any closing comment that either of you would like to make before we hit the gavel?

Mr. TOWNS. I would like to acknowledge the fact that Annette said they were happy to be here.

Mr. SHAYS. They did not. Would you like to say that you are happy to be here so that it would be in the record? Thank you very much. I know they are happy to be here because they have smiles on their faces.

Mr. SHAYS. Hearing adjourned.

[Whereupon, at 12:29 p.m., the subcommittee was adjourned.]

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