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Divider Title: 13

OVERVIEW OF EXPENDITURE CAPS/GLOBAL BUDGETS IN HEALTH REFORM

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Materials:

- Presentation Slides
- * (Draft article by Dan Beauchamp)

MacPlan

Managing the Contradictions of Health Care Reform

by

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This is a draft of a talk to be given in Little Rock on health care reform and rural health policy, March 11, 1993. The meeting is sponsored by the Robert Wood Johnson Foundation. The views are the author's only. PLEASE DO NOT QUOTE WITHOUT PERMISSION.

Abstract

President Clinton has urged a strategy for health care reform that merges the main features of classical universalism—universal benefits, universal coverage, community rated insurance, and global budgets—with managed competition and market efficiency.

Classical universalism attempts to limit spending through membership in a single plan, often (but not always) government-financed. Its top goals are security and stability. Managed competition seeks to limit spending by letting competing plans and the purchasing power of new health insurance purchasing cooperatives help hold down costs. Managed competition's main goals are security and market efficiency.

President Clinton wants to merge these two approaches in yet undefined ways.

Using some of the ideas of the proposal developed by the New York State Department of Health for Universal New York Health Care (or UNY*Care), I propose a strategy for merging these two ideas and for managing their implementation. I call it MacPlan, because it builds on computer or virtual technology, and because it provides for a faster way of getting the essential mechanisms of universal health care (and managed competition), in place.

At the heart of the strategy is the Clearinghouse for Health Information Policy (CHIP) and its capacities to stimulate major reforms in administration, payment, and to capture data for global budgets. The CHIP would be rapidly organized (at first for hospitals) across the United States, to serve as the universal payer (MacPayer) for the Clinton plan. As the data for actual payment is accumulated, strategies for controlling costs will shift from rate-setting to global budgets for hospitals, as well as fee schedules for physicians outside of managed care settings.

Simultaneously, MacPlan offers a strong way to integrate managed competition with global budgeting. MacPayer and its data capacities will provide direct support for the workings of the new health insurance purchasing cooperatives, which will serve as public authorities linked to state payer authorities. State payer authorities will set statewide expenditure limits, and through national and regional CHIP networks, pay hospitals on the basis of budgets and rate schedules, as well as provide budgets to the growing managed competition sector. The state payer authorities will also establish budgets and other forms of payment for those sectors where managed competition will not easily work, such as rural areas.

Indeed, MacPlan foresees a world in which managed competition, with global budgets based on capitation arrangements contains within it large islands of direct, global budgets, such as for hospitals, as well as more traditional, fee-for-

service methods of payment. In this world state payer authorities perform a strong integrative and policy leadership role, supported by the work of the HIPCs overseeing the development of competitive plans. Put another way, the HIPCs are part of a larger health policy framework that includes a national board, state payer authorities with responsibilities also for health planning and allocation, and competition. Such an integration is essential if the contradictions of the overall strategy are to be effectively managed and balanced.

This approach to marrying managed competition and classical universalism can be further strengthened by making Medicare the platform for change, even if later in the reform process, moving the whole system to a single overall framework, a single health care card for all, a universal benefit, and the strength of a nationally-accepted plan to manage the forces of competition.

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Divider Title: 4

RURAL ISSUES TO BE ADDRESSED IN HEALTH REFORM

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- Jon Christianson, Ira Moscovice, "Health Care Reform: Issues for Rural Areas," March 1993. (Paper was distributed to participants in advance of the conference.)

HEALTH CARE REFORM: ISSUES FOR RURAL AREAS

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March, 1993

This paper was prepared under contract from the Federal Office of Rural Health Policy for the invitational meeting on Health Care Reform in Rural Areas to be held in Little Rock, Arkansas on March 11-12, 1993 under the sponsorship of the Robert Wood Johnson Foundation and the Arkansas Department of Health.

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HEALTH CARE REFORM: ISSUES FOR RURAL AREAS

I. INTRODUCTION

The gathering momentum for health care reform at the federal and state levels has been accompanied by concerns about how reform initiatives could affect rural areas (National Rural Health Association, 1992). It is generally accepted that rural areas are different from urban areas in their population demographics and the availability and organization of their medical care resources (Cordes, 1989; Moscovice, 1989). Therefore, it seems reasonable to expect that health care reform could raise unique issues for rural communities and providers. We identify and discuss a variety of these issues in this paper, with a particular focus on the potential relationship between health care reform and rural health networks. The intent of the paper is not to develop a list of "barriers to change" (e.g. why this won't work in rural areas), but rather to suggest issues that are likely to arise as reform proposals are fleshed out in concept and in legislation.

In order to focus, and impose limits, on our discussion of rural issues, it is necessary to make some preliminary assumptions about the structure of health care reform, as it will emerge from the current ferment. While some of our assumptions may later turn out to be false, we believe that the issues we identify within the framework of these assumptions will continue to be relevant. In general, we assume that future health care reforms will contain elements of both "managed competition" proposals and "global budgeting" initiatives (see, for instance, Starr and Zelman, forthcoming; Enthoven, 1992; Enthoven, 1993; and Zelman and Garamendi, 1992). A summary of the main assumptions that provide a context for our discussion follows.

1. A mandated set of benefits is defined at the federal level.

2. All individuals and employers share the cost of health insurance, with subsidies provided for the poor.

3. Everyone, except employees of very large firms, obtains coverage through health insurance purchasing cooperatives (HIPCs) that serve defined geographical areas.

4. HIPCs contract with private health plans, including HMOs, PPOs, and one free-choice-of-provider option, and manage the enrollment process.

5. The plans are paid by risk-adjusted capitation, although providers within the plans could be paid using a variety of different methods.

6. The HIPC pays an amount equal to the lowest cost plan; a consumer choosing a higher cost plan must pay the difference between this payment and the plan's premium.

7. Community-rated premiums are charged enrollees; no medical underwriting by health plans is allowed.

8. States have authority to supervise HIPCs and license health plans. They also have the ability, with federal approval, to experiment with different administrative approaches in order to adapt to local needs.

9. The federal government employs "benchmark budgeting" by annually determining a maximum allowable rate of increase in the premiums of the "benchmark" (lowest cost) health plan option and a target for discretionary after-tax spending.

10. In areas where managed competition does not result in increases consistent with these goals, HIPCs have discretionary authority to set rates; they have this authority in all regions for the fee-for-service plan.

11. Medicaid is eliminated, but the elderly continue to receive coverage under Medicare, at least in the initial stages of health care reform.

Clearly, within the limits of this paper we cannot address all of the topics raised by health reform that are likely to be important for rural providers and communities. However, whether "managed competition" or "global budgeting" or some hybrid eventually becomes the dominant approach to health care reform, we expect that a large percentage of rural providers will be organized in networks for the purpose of contracting with health plans or with HIPCs to serve rural areas. Therefore, an important objective of the paper is to identify those issues relating primarily to rural provider networks that will merit attention under health care reform.

The paper is divided into four sections; each section begins with a general discussion of the topic to be addressed and ends with a list of important issues related to that topic. The first section discusses the ways in which rural providers might be organized as networks and the ways in which these networks might relate to HIPCs. The second section discusses alternative reimbursement arrangements for rural providers participating in health plans or contracting with HIPCs. Section three raises issues relating to service delivery and the recruitment and retention of providers in rural networks under the marriage of managed

competition and global budgets. Section four discusses potential roles for state government under health care reform.

II. ORGANIZATION OF RURAL HEALTH NETWORKS

A. What is a Rural Health Network?

Networks of organizations have been defined at a general level as "...organizational arrangements that use resources and/or governance structures from more than one existing organization" (Borys and Jemison, 1989). With respect to rural health care, the New York State Department of Health (1992) defines a rural health network as "...a locally directed or governed organization which provides...a set of defined health related and administrative services needed in the community served by the network." In existing rural health networks, participants usually continue to function independently, but work together to deliver specific services or share resources. While participants consist mostly of rural-based providers, urban providers often participate in rural networks as well. The New York State definition would also include as a network "a health maintenance organization which serves a rural area and integrates existing area providers of care."

The actual organization and structure of rural health networks varies depending on the goals of participants, the availability of providers, and the characteristics of rural communities. The many different types of existing rural health networks illustrate the range of possibilities. For example, in a recent survey Moscovice, Johnson, Finch, et al (1991) found 127 different organizations in the United States that fit their definition of rural hospital consortia. Christianson, Shadle, Hunter, et al, (1986) reported the presence of 14 rural-based HMOs in 1984, with many other urban-based HMOs serving rural areas through contracts with organizations of rural physicians. As one example, the Rural Wisconsin Hospital Co-operative established a very successful HMO as a collaborative effort of a rural hospital network and a rural-based physician individual practice association (Christianson, Shadle, Hunter, et al, 1986).

The development of rural networks has received support from several foundations over the past decade including the Robert Wood Johnson Foundation, which recently funded a demonstration to provide support to thirteen rural hospital consortia. At the federal government level, the Essential Access Community Hospital Program was initiated in 1991, in part to link smaller to larger rural facilities (Christianson, Moscovice, and Tao, forthcoming).

At the state level, Minnesota has introduced the concept of "integrated service networks" in the implementation of its reform legislation (Minnesota Health Care Commission, 1993), while New York State is sponsoring a demonstration in the development of rural health networks (New York State Department of Health, 1992).

Despite all of the recent activity relating to rural health networks, examples of rural-based networks that provide the full range of acute inpatient and outpatient services to rural communities are relatively rare, being confined primarily to a small number of successful rural-based HMOs. Instead, existing rural networks tend to be groups of similar providers that form to address common problems or to respond to reimbursement opportunities (e.g. rural hospitals participating in a hospital consortia or rural physicians organizing individual practice organizations). The experience of these more limited networks has demonstrated that rural providers can work together cooperatively but it provides little evidence regarding the ability of rural networks to effectively assume responsibility for all of the medical care of entire communities, operate within a constrained budget, or guarantee access to needed services.

B. What Relationships Will Develop Between Rural Health Networks, Health Plans and HIPCs?

Rural health networks have the potential to play a key role in the development of coordinated systems of care in rural areas under virtually every health care reform scenario. Health plans seeking to serve rural communities will attempt to contract with networks of rural providers in order to provide access to care for their enrollees. Where existing network relationships are not available, health plans will create networks through contractual relationships that aggregate rural providers into risk pools for reimbursement purposes. In rural areas that health plans decline to serve, proactive HIPCs are likely to serve as catalysts for the creation of rural networks. Where this fails, HIPCs will need to,in effect, assemble rural networks to serve as free-choice-of-provider plans for rural areas that would otherwise not be served by health plans.

The ways in which rural networks develop, and the responsibilities they assume, are likely to depend in part on geographic considerations and in part on prior collaborative relationships among rural providers, both of which vary considerably across states and regions. For example, in most states there are rural areas that are in relatively close proximity to urban areas and are relatively densely populated. In these rural areas, it seems likely that

rural networks will form primarily through contracts with urban-based health plans that may already serve residents of their communities. For example, an urban health plan may organize proximate rural providers (hospitals and/or physicians) into a "risk pool" for the purposes of payment and utilization management, developing and maintaining referral arrangements (some of which may already exist) with urban physicians and hospitals under contract to the plan. The common contractual linkages with the health plan could, over time, result in collaboration among these rural providers over other issues as well.

As we noted above, in some rural areas collaborative, network arrangements among rural providers already exist, although they are not generally structured as vertically-integrated delivery systems. It seems likely that health plans seeking to serve rural areas will attempt to take advantage of these existing networks in establishing their delivery systems. This could, in turn, cause these networks to organize more formally so that they can function as contracting entities in negotiating with health plans. Existing networks might also broaden the composition of their membership in order to offer a full range of health services when contracting with health plans. Once organized in this manner, rural networks could conceivably contract with multiple health plans to serve community residents.

In more remote, sparsely populated rural areas the development of integrated, rural health networks will be more difficult. While networks do exist in some areas such as these, examples of provider networks contracting with prepaid health plans are relatively rare. In part, this reflects the fact that prepaid health plans have not found these areas attractive for a variety of reasons (Christianson, 1989). For instance, some rural providers have a"captive market" in these areas; there is little incentive for them to contract with a health plan to attract new patients or retain existing ones. Health care reform is not likely to alter this situation, so HIPCs may have to provide prepaid plans with strong incentives to serve sparsely populated rural areas. For example, contracts to serve more densely populated areas might be awarded only if health plans also demonstrated their ability to serve less-populated areas as well. This may require that the HIPC regulate prices charged by rural providers so that health plans are not forced to pay abnormally high prices to induce rural providers to contract with them.

If the HIPC does not provide strong incentives to prepaid plans to serve remote, sparsely-populated rural areas, it seems likely that residents of these areas will be offered a choice between a statewide PPO or a free-choice-of-physician plan, with regulated fee

schedules for rural providers. The HIPC could sponsor and manage the free-choice plan itself or, as envisioned under some reform proposals, contract with an insurer for this purpose. In either case, defacto networks of rural providers would likely be created to facilitate negotiation over reimbursement and the carrying out of quality assurance and utilization management activities.

C. In What Form Will Managed Competition Occur In Rural Areas?

In a recent article, Kronick, Goodman, Wennberg, et al, (1993) argue that meaningful managed competition can only occur when providers have exclusive affiliations with health plans. Then, when individuals change their health plans they also must change their providers, presumably creating a strong incentive for providers, under contract to health plans, to compete for patients. Rural provider networks would contract with only one health plan, or form their own health plan and not subcontract with existing health plans. Under this scenario, as Kronick, Goodman, Wennberg, et al, (1993) note, "In a geographically isolated area with a population base large enough to support only one hospital and one group of physicians, it is difficult to envision how competition would work." As a result, they urge "...care on the part of state governments in setting the rules for structured competition" and suggest a possible role for "...alternative models of reform (based on planning and the promotion of cooperation as the basis for achieving the efficiencies that the population-based perspective of the classic HMO brings to the health care economy)."

Rural health networks would seem well-suited for alternative models of reform that rely on some version of "sole source" contracting in rural areas. One of the motivations for the development of rural health networks in the past, and particularly for the formation of rural hospital consortia, has been to facilitate cooperation among providers and to take advantage of scale economies in the delivery of services (Christianson, Moscovice, Johnson, et al, 1990). More broadly inclusive rural health networks could serve as accountable organizational units for resource rationalization in rural areas as well as vehicles for contracting with HIPCs. In regions where competition was thought not to be feasible, "franchises" could be granted by HIPCs to rural health networks to serve specific geographic areas in return for capitated payments. After granting the franchise, HIPCs would then play an essentially regulatory role to ensure not only that future premium increases fell within permissible boundaries, but also

that the network was carrying out its contractual responsibilities to coordinate and rationalize services within its geographic area of responsibility.

It should be noted that the limitations that Kronick, Goodman, Wennberg, et al, (1993) see for the viability of "managed competition" in rural areas are not universally acknowledged. For instance, in designing its health care initiative the Minnesota Health Care Commission (1993) focused on competition among "integrated service networks" (ISNs) for enrollees, rather than direct competition among providers for patients. It suggested that "ISNs are likely to begin to form in rural areas not currently served by managed care health plans because of the incentives for providers to join or form ISNs in order to avoid the regulatory controls on non-ISN services and to take advantage of the benefits and support services that ISNs will offer providers." Furthermore, the Commission foresees the potential for ISNs to compete actively in rural areas in ways that could benefit consumers. It intends to "...promote and facilitate competition between ISNs even in rural areas of the state where only one provider system exists. Just as multiple health insurance plans are available now, ISNs will compete in terms of the coverage they offer, their costs and efficiency, and the extent to which their contractual relationships with local providers are more efficient or offer better quality or service."

Under this scenario, rural networks could contract with more than one health plan, but would generally not risk the loss of patients when rural residents switched their health plans. No single health plan would be "accountable" for the coordination of resources in a given geographic area, but the rural network would continue to have a financial incentive to promote an efficient configuration of resources under some capitated reimbursement arrangements (see our discussion of payment arrangements below). Some analysts view competition among health plans, all of which employ the same provider network, as potentially inefficient, because it would impose excessive administrative burdens on participating providers, who would need to comply with the administrative and reimbursement practices of multiple plans. This should be of less concern under managed competition, where there presumably would be a standardized benefit plan, common administrative and data collection procedures for health plans, and control exercised by the HIPC over the number of plans offered in a given region. In rural areas, in particular, it seems unlikely that providers would simultaneously participate in large numbers of plans.

A related concern, however, would seem more relevant. If rural networks serve enrollees from multiple plans, it may be difficult for a single plan to exercise sufficient leverage on network providers to ensure meaningful participation in the plan's cost containment efforts. Then, the potential benefits from competition among health plans in rural areas, as anticipated by the Minnesota Health Care Commission, might be difficult to realize in practice. Health plans finding they cannot control costs might withdraw from the area, forcing the HIPC to grant exclusive franchises to providers serving specific rural areas and to engage in extensive oversight activities.

D. Issues Relating to the Organization of Rural Health Networks

Local health care delivery systems in rural areas exhibit considerable diversity. Some rural areas are served by technologically sophisticated acute care facilities and large multispecialty group practices, while others struggle with financially marginal, understaffed hospitals and a shortage of primary care physicians and mid-level health practitioners. Rural areas contiguous to urban centers often have relatively high population densities, especially in comparison to sparsely populated frontier areas in many western states. These differences suggest that health care reforms are likely to unfold in different ways across rural communities. In this section, we summarize some of the issues to this point, with the understanding that these issues will vary in their importance across rural areas.

- **How quickly will rural providers react in developing rural health networks under the stimulus of health care reform? Will the initiative for network formation come primarily from rural providers or from urban-based health plans and health care organizations?**

  The number of rural health networks will need to be expanded and existing networks will need to be modified if they are to play significant roles under health care reform. Given the conservative nature of many rural providers, and the constraints on their financial capacity to invest in network development, there may be limited potential for rapid network formation under the leadership of rural providers. If rural providers do not exercise leadership in network formation, rural networks may be formed instead as the result of "shotgun marriages" of providers who happen to contract with the same urban-based health plan, with network leadership provided by health plan staff.

- **What providers will be included in rural health networks?**

  In establishing contractual relationships with rural providers, prepaid health plans typically create separate risk pools for different types of providers (unless the health plan contracts with a multispecialty group practice). For

reimbursement purposes, specialists are grouped with specialists, primary care physicians with other primary care physicians, and hospitals with other hospitals. (The reimbursement received by these groups is often tied together through interlocking financial incentives, as discussed below). Thus, the provider networks that result from this process tend to encourage the horizontal integration of providers. However, advocates of greater coordination, or regionalization, of health services in rural areas usually argue for vertical integration of health care delivery as well. Their conceptualization of rural health networks emphasizes the inclusion of a full range of services and providers (New York State Department of Health, 1992). While health care reform is likely to stimulate the formation of networks that aggregate providers of similar types, it may require intervention on the part of HIPCs to accomplish greater vertical integration of providers and coordination of service delivery where comprehensive service networks do not develop spontaneously.

- **What steps should HIPCs take in areas where rural providers decline to participate in health plans or otherwise coordinate services to improve quality of care and contain costs?**

  In this case, most reform proposals suggest that these areas be subject to regulatory oversight, including the administration of price controls for providers, coupled with stringent utilization management. If these steps are sufficiently onerous, it is assumed that providers will eventually choose participation in a health plan as the least objectionable alternative. However, providers in remote rural areas may respond by moving their practices to more populous areas, creating access problems for some rural communities. HIPCs will need to balance their efforts to ensure that services are provided within a fixed budget with the need to maintain access to care for rural residents. How will HIPCs manage this "balancing act" in rural areas where providers choose to "opt out" of health reform?

- **Should rural networks be encouraged to participate in multiple health plans? Or, should they be awarded "franchises" to serve designated geographic areas?**

  In both instances the concern is that an integrated, organized rural health network consisting of virtually all providers in a given area will be in a position to exercise monopoly power in negotiations with health plans or HIPCs. The issue is whether countervailing power can be most effectively brought to bear by health plans or HIPCs in these negotiations. The fallback position for the network, if an agreement cannot be reached, is to withdraw from the plan, in the first case, or from the franchise, in the second. Withdrawal from the franchise presumably would trigger direct regulatory oversight of individual rural providers on the part of the HIPC, as described above. Under what conditions should rural networks be encouraged to contract with multiple plans? When will it serve public policy better if they are awarded exclusive contracts to serve specific rural areas?

III. REIMBURSEMENT OF RURAL PROVIDERS

A. Reimbursement of Rural Providers Participating in Prepaid Health Plans

It seems very likely that most rural providers will continue to be reimbursed under some form of fee-for-service payment whether they participate in prepaid health plans or their rates are regulated under a global budget approach. It is also probable that they will be required to assume some degree of financial risk for the delivery of care to rural residents, and there are innumerable variations in the way that payment schedules and risk-sharing arrangements can be structured. However, the basic features of these arrangements can be illustrated by describing two of the more common variations currently used by prepaid health plans.

To illustrate the first type of arrangement, we assume that rural providers participate in an urban-based, IPA-model plan. Within a designated rural area, the plan groups primary care physicians, specialists, and hospitals into separate risk pools for reimbursement purposes. Primary care physicians are reimbursed according to a fee schedule established by the plan, with 20 percent of each payment withheld and placed in a "withhold" fund. This money is returned to the primary care physician after one year (or some designated time period) if expenditures for primary care do not exceed a prespecified, designated amount. If expenditures are greater than budgeted, only a portion (or none) of the withhold pool dollars are returned. Physicians receive distributions from the withhold pool according to the numbers of services they provide.

It is common for distribution of the withhold funds to be tied to experience in the hospital and specialist risk pools as well. If the funds allocated to these risk pools are not sufficient to cover all expenditures, shortfalls are covered through a transfer of funds from the primary care physicians' withhold pool. This linkage acknowledges the importance of the "gatekeeper role" that primary care physicians play in providing enrollees with access to specialty and acute inpatient services. Usually, a referral from a primary care physician is required for enrollees to see a specialist, and "pre-admission certification" is required for all non-emergency hospital admissions.

Under this scheme, rural providers are at limited financial risk, since the most they can "lose" in a given year is their contribution to the withhold pool. The strength of the incentive they feel to contain costs is related to the number of providers participating in the risk pool. The larger the number of providers, the less likely that any single provider will receive a significant reward for cost-containment activities that improve the financial performance of

the health plan. Of course, if projected expenditures for any provider group (or the health plan as a whole) are exceeded in a given year, the health plan is likely to propose lower payment schedules, more substantial withholds (or more substantial risk sharing through other mechanisms, such as paying primary care physicians on a capitated basis), and/or more aggressive utilization review policies in subsequent years. Ultimately, health plans that cannot "break even" in a particular rural area will terminate their contracts with providers, leaving it to the HIPC to determine provider reimbursement and utilization review policies for that area.

A second type of arrangement would require rural providers to assume a greater degree of direct financial risk for the delivery of services. To illustrate this arrangement, assume that the HIPC contracts with an integrated rural health network to act as the health plan for a designated geographic area (the "franchise" model described above). The network is "owned" and administered by the rural providers and receives a capitated payment for each enrollee to provide all covered medical services. The same options are available to structure provider reimbursement and risk-sharing as are used by prepaid health plans more generally. However, providers participating in the capitated rural network may feel stronger incentives to contain costs, in comparison to participating in an urban-based IPA, for two reasons. First, depending on the size of the network, the number of providers participating in a risk pool could be smaller. (An urban-based IPA conceivably could combine providers in many rural areas in structuring a risk pool.) Second, by virtue of their "ownership" of the network, the participating providers must make up any differences between aggregated capitation payments and expenditures for care at the end of the budget period. Of course, they also have the potential to share in any savings. As is the case with health plans, rural networks could protect themselves against substantial losses, incurred on an aggregate or a per-patient basis, through the purchase of reinsurance.

B. Reimbursement of Rural Providers Participating in PPOs or Free-Choice-of-Physician Plans

Providers participating in these plans will be reimbursed based on fee schedules established through negotiation with the plans. Participating providers in PPOs would accept discounts from their usual fees in return for the potential to increase the number of patients they treat. PPO enrollees who elect to obtain care from a provider that does not contract with the PPO must pay part of the cost through copayments or deductibles. Thus the PPO creates

financial incentives for patients to seek care from "preferred" providers. PPOs usually employ the same types of utilization controls as prepaid plans, but providers are not at direct financial risk for the performance of the PPO. However, if the PPO's premiums increase more rapidly than the targets established by HIPCs, then rural providers will likely face reductions in fee schedules and more aggressive application of utilization management techniques. Providers that are not responsive to efforts to change their utilization patterns could be dropped from the panel of participating providers.

The free-choice-of-physician plan has the least flexibility in the options it has available to control costs. As in PPOs, providers would be reimbursed using a fee schedule established by the plan. Since all providers can participate in the plan, the managers of the plan (or the government agency charged with enforcing budget limits) cannot drop providers that are not responsive to efforts to control utilization. Therefore, the only direct way to control expenditures is by adjusting provider fee schedules so that expenditures fall within established targets. Thus, providers may well find their reimbursement per unit of service to be the lowest under this approach.

In some cases, it may not be possible for any health plan (prepaid, PPO, or free-choice-of-physician) to serve a given geographic area and maintain premium increases within the amounts targeted by the HIPC. If no private health plan is available in a rural area, the HIPC could form and administer a plan. In this case the HIPC would establish reimbursement rates and attempt to control utilization (or contract with a private firm to undertake utilization management activities.) Presumably, as in the free-choice-of-physician plan, the primary mechanism for restricting expenditure growth would be the regulation of fees and charges. In this case, providers could only "quit the plan" by refusing to see plan patients (in which case their incomes would depend solely on revenues from Medicare patients), by moving to another location (an option that would presumably be available to noninstitutional providers), or by retiring (for individual providers) or ceasing operations (for institutional providers).

C. Issues Relating to the Reimbursement of Rural Providers

There are likely to be limits in the way in which reimbursement can be used to alter provider behavior in rural, as opposed to urban, areas, and in the degree of risk-sharing that can be expected of providers. These limits probably will be most apparent with respect to

providers located in more remote rural areas. This raises several important issues that must be considered in designing health care reform initiatives.

- **How should rural providers be grouped for risk-sharing purposes?**

  There are two facets to this issue, and they are inter-related. The first concerns the kind of providers that should be grouped together, while the second concerns the size of the group. In rural areas it may be appropriate to consider the grouping together of different provider types so that providers located in closer geographic proximity can be part of the same risk pool. (This could occur, for instance, if vertically-organized rural provider networks received capitated payments to care for enrollees.) This would facilitate efforts on the part of providers to work cooperatively together to more effectively manage care. In contrast, if only similar providers were grouped together (e.g. primary care physicians) the geographic area covered by the providers could be quite large in order to accomplish risk pooling among an appropriate number of providers. In this case, the distances among providers participating in the risk pool could prove to be a barrier to cooperative activity.

- **Under different reimbursement approaches, how strong should the financial incentives be for rural primary physicians to control or alter referrals to specialists?**

  As described above, in many prepaid plans primary care physicians play a "gatekeeper" role, with financial incentives to control referrals to specialists. However, one commonly expressed concern about the health care available in rural areas is that rural residents don't always have appropriate access to specialty care. Providing primary care physicians with financial incentives to control access to specialists could heighten these concerns. Often rural primary care physicians have constructed their referral networks carefully over time, developing collegial relationships with particular specialists that enhance the quality of care received by their patients. Strong financial incentives to channel referrals to particular specialists contracting with the health plan could threaten these relationships.

- **How will fee schedules be established and enforced for rural physicians?**

  The basis for establishment of rural physician fee schedules will be a contentious issue, whether those fee schedules are implemented by health plans or by HIPCs. Rural providers fear that new fee schedules will "lock in" perceived inequities in the present relationships between fees received by urban and rural physicians, and between primary care and specialist physicians. In addition, there is the question of whether fee schedules can be used in rural areas as instruments to reduce costs, if necessary, without causing physicians to leave their rural practices, thereby jeopardizing access to care for rural residents in underserved areas. Finally, it seems likely that establishing the appropriate relationship between fee schedules for the non-elderly and Medicare fee schedules will be particularly important in rural areas. Due to the demographic composition of many rural areas, the preponderance of patients

seen by primary care physicians are elderly. Where this is the case, non-Medicare physician fee schedules may be crude and relatively ineffective instruments for influencing provider behavior and providers may be unwilling to accept financial risk. Again, attempts to impose financial risk on providers, or reduce their fees, could result in reduced access to medical care for the non-elderly in some rural communities.

- **Will rural networks have sufficient capital to accept financial risk under prepayment?**

  When the federal HMO Act was implemented in 1974, funds were set aside to support the development of prepaid health plans in rural areas. However, because of the restrictions placed on accessing those funds, relatively little money was actually spent on this activity. If rural health networks are seen as desirable to facilitate health reform in rural areas, then government may need to allocate funds for investment in network building (see section IV below). Also, in order to protect fledgling networks that assume risk under capitated contracts, it may be necessary for the government to provide reinsurance to contracting networks in their initial stages of development. Networks that serve sparsely populated areas and consequently have relatively low enrollments could benefit from reinsurance provided by the government even after they become well-established. As one of their functions, HIPCs could aggregate the experience of all rural network enrollees into one risk pool for reinsurance purposes and possibly provide rural networks with reinsurance at subsidized rates. Alternative arrangements involving the pooling of rural network enrollees across HIPCs might also prove attractive.

IV. IMPACT ON RURAL MEDICAL PRACTICE

The success of health care reform initiatives will be diminished unless the delivery system can be significantly altered in ways that improve the public's health (Zelman and Garamendi, 1992). Rural health networks can serve as the building blocks for the implementation of reform initiatives in rural areas and lead to major structural changes in the rural health system. In fact, the quid pro quo for rural support of health reform initiatives might be development of the capacity and infrastructure necessary to build rural provider networks. How this is accomplished will, in part, determine the impact of health reform on rural medical practice.

Traditional rural primary care physicians have been characterized as overworked, inadequately reimbursed, and with insufficient professional support (National Rural Electric Cooperative Association, 1992). They have approximately 20 to 30 percent more patient visits yet earn 10 to 20 percent less than their urban counterparts (Wyszewianski and Mick, 1991). A recent study of rural physicians in Colorado found that two-thirds were in solo

practice and more than one-half were on call at least every other night (Moscovice, Rosenblatt and McCabe, 1993).

These data suggest that many rural physicians might be receptive to organization and delivery system changes that improve the circumstances of their practices. This is particularly true if the implementation of health reform initiatives in rural areas is receptive to rural physician input. Enthoven (1993) has described one scenario that may be attractive to some rural physicians:

> HIPCs might request proposals from established urban comprehensive care organizations to establish and operate a network of primary care outposts, paying doctors and nurse practitioners what is needed to attract them to provide high quality ambulatory care in rural locations, while giving them professional support in the form of telephone consultations, temporary replacements, continuing education, and transportation and referral arrangements.

Our current research on rural hospital networks has found that more than half of these networks have an urban, financially stable hospital that often provides energy, leadership, and financial support critical to the success of the network (Moscovice, Johnson, Finch, et al, 1991). These larger institutions appear more willing to assume the financial risks involved in network joint ventures and to consider the longer-term benefits of cooperative relationships among rural providers.

Urban-based initiatives are in marked contrast to locally developed networks consisting of formal horizontal linkages among rural providers that are organizationally similar. To assume responsibility for meeting the health needs of a rural population, networks of this type would need to expand their membership and/or develop other arrangements necessary to ensure the delivery of a comprehensive range of services.

Either "top-down" or "horizontal" approaches to rural network development could occur under health care reform, depending on the supply and organizational relationships among existing health professionals in a rural community and the geographic proximity of that community to an urban center or a large rural referral institution. Top-down networks can be effective if they are sensitive to local issues and concerns and are able to identify and support the positive attributes of rural medical practice (Rural Wisconsin Hospital Cooperative, 1993). Locally-developed, horizontal networks can be effective if they have the necessary leadership and resources to expand the scope of activities of existing providers to meet new responsibilities. This might require the financial support and technical assistance of non-local

entities interested in developing meaningful bilateral relationships with networks of rural providers.

If one of the results of health reform is to stimulate the widespread development of rural provider networks, rural medical practice is likely to be dramatically transformed from the description of the traditional rural primary care physician offered earlier. The remainder of this section discusses five specific aspects of this possible transformation.

A. Response to Increased Management and Oversight

At present, most rural providers have very little, if any, experience with managed care arrangements. Under the proposed health reform initiatives, including global budgeting, it is likely that rural physicians will practice under a variety of utilization management techniques that attempt to control costs. These techniques include pre-admission certification for inpatient care, pre-authorization review for surgery, physician profiling, practice guidelines, and so on. They could be implemented either by health plans that contract with rural providers or by government attempting to control expenditures within a global budgeting framework.

The level of micro-management of individual clinical decisions of rural physicians imposed by government or health plans, and the corresponding response of rural physicians to these efforts, will be a defining characteristic of health care reform, as viewed by rural providers. On the one hand, under managed competition, health plans and networks may be under strong pressure to closely micro-manage physicians to maintain their competitive position (Brown, 1993). And, regional governments may feel the same pressure in order to stay within budget caps. On the other hand, the goal of these techniques has been described as not to remove the decision making power of individual physicians, but rather to improve their ability to make better decisions (Hillman, Greer, and Goldfarb, 1992). The degree to which rural physicians accept, or rebel against, the imposition of new utilization management techniques on their practice clearly will be related to the manner in which they are implemented.

If utilization management consists primarily of complex information compiled and interpreted by distant urban-based institutions or government agencies, and then fed back to local rural providers, it will meet with substantial resistance. This is particularly true if it is accompanied by requirements that telephone approval for treatment be sought from anonymous utilization review professionals with limited knowledge of the rural practice

environment. On the other hand, where a rural-based provider network has organized as a health plan or budgeted cost center (under global budgeting), has developed a mechanism for integrating local physician input into the formation of practice guidelines, and carries out utilization management efforts with a sensitivity to local conditions, rural providers are likely to be much more receptive. That is not to suggest that appropriate vehicles for education of providers, feedback of information, and development of financial and behavioral incentives for providers cannot be developed in top-down networks. However, it may be easier to incorporate local physician input and exhibit sensitivity to local consumer values and beliefs and the constraints of local medical care delivery environments in rural-based networks.

Another factor that will influence the receptivity of rural providers to increased management and oversight is the responsibility given to primary care physicians in networks. Historically, the fortunes of rural health have depended very much on the relative supply of primary care generalists (Moscovice, 1989). In managed care networks, rural primary care physicians may serve as case managers, regulating the flow of referrals and specialty services throughout the network (Hillman, Greer, and Goldfarb, 1992). Depending on the financial relationships that are established, this role may also place the rural primary care physician (or physician group) in a position of financial risk for the services provided to their patients (as described in section III). Although the gatekeeper role can increase the status of the rural primary care physician vis a vis specialists, it still may be an uncomfortable position for many rural solo practitioners with minimal experience in risk-bearing roles.

B. Location and Availability of Specialist Services and Technology

In their proposed guidelines and requirements for rural health networks, the New York State Department of Health (1992) states that:

> Rural health networks hold the promise of stemming an almost inevitable hemorrhage of health care services and resources away from rural areas...

Others have pointed out that the majority of dollars rural residents spend for health care are spent outside their local communities (Amundson and Hughes, 1989). If the majority of health care funds were spent at the local level, the range and quality of services available in rural communities conceivably could be expanded.

An important issue related to the development of health plans and rural provider networks is the location and availability of specialist services and technology used by rural

communities. During the past decade, rural hospitals have used several strategies (including consortia participation, mobile technology, and specialty outreach clinics) to improve the availability of specialist services and technology in local communities. These efforts have improved the public perception of rural hospitals but questions remain concerning their costs and effectiveness. Can they improve the financial performance of rural hospitals and the incomes of rural physicians by redirecting patient flows? Are technologies and services being used appropriately? What effect does their provision locally have on patient outcomes and quality of care?

It is not clear how the above efforts will mesh with the strategies developed by health plans under managed competition, or government agencies under global budgeting. At some level, subspecialty services will need to be provided outside the local community and health plans will need to contract for these services with non-local providers. Urban-based plans may encourage referrals of the full range of specialty care to urban specialists and hospitals under contract to the plans, thereby increasing the leakage of funds from rural areas. On the other hand, rural-based plans may attempt to limit referrals to urban-based specialists to assure that more care is provided locally. These plans would likely encourage consultants in many specialties to provide outreach clinics in rural areas.

The comparative short-term budget costs of these alternatives will heavily influence the decisions of health plans and government agencies. However, the decision making process should also take into account costs imposed on rural residents and the quality of care provided under the two scenarios. How this issue is addressed will affect the magnitude of cost savings attributed to reform initiatives, public perception of rural providers, the economic base for health care institutions in rural communities, medical outcomes for rural residents, and the acceptability of health care reform efforts to rural physicians.

C. Differences in Urban/Rural Practice Styles

All things being equal, the enhanced role and status of primary care physicians under managed competition proposals bodes well for the many rural physicians who are generalists. However, one salient issue that needs to be addressed is how differences in urban/rural practice styles will be resolved under health care reform initiatives. Rural physicians practice in less resource intensive environments where technology and consultant specialists are less readily available. Therefore, differences are likely to exist in the practice styles of urban and

rural physicians who are members of the same network or health plan. How these differences are resolved will encourage, or discourage, the participation and commitment of rural physicians to a network or health plan.

Under one option, a federal board would be responsible for setting standards to eliminate unnecessary care and to assure the use of the most cost-effective technology (Etheredge, 1992). Its work would be facilitated by national data systems that would track utilization, expenditure, and outcomes information. Thus, the responsibility for technology assessment and the development of practice parameters and guidelines would rest at the federal level (Zelman and Garamendi, 1992).

The question of interest to rural physicians is how such national standards would be applied to them. At one level, the medical profession clearly will have the responsibility for setting practice standards and guidelines. In rural areas, reaction to and appropriate use of these standards most likely will relate to whether rural physician input is incorporated into their development, and whether some flexibility in their application is shown. At another level, health plans may focus on quality improvements for enrollees through a system-wide approach. Rural physicians may feel the pressure to alter their practice patterns to conform to health plan guidelines and protocols, which may be based largely on the practice styles of urban physicians. Is this a better approach than allowing the possibility of different standards depending on environmental and professional factors? The answer is not clear because the impact of managed care arrangements on quality improvement and outcomes is not yet well understood. It is clear, however, that the pooling of data and the use of large-scale management information systems by health plans will facilitate comparisons of patient outcomes across rural providers to a degree that is not now possible.

D. Physician Relationships With Hospitals and Other Entities

As described earlier, the majority of existing rural networks consist of similar groups of providers (hospitals or physicians) organized to address issues of common interest. It is the rare instance when vertically integrated delivery systems have been developed in rural communities, and physicians have very little experience in these types of arrangements. In rural communities that currently have a difficult time maintaining access to services for their residents, dysfunctional relationships often exist between local physicians and hospitals, with no apparent linkages between physicians and other providers.

Health reform initiatives may create opportunities for the development of new physician linkages with hospitals and other providers. Nationally, 64.2 percent of the 2,361 rural counties (i.e. non-SMSA counties) had no HMOs providing services to county residents in 1992 (Wholey, 1993). Rural counties adjacent to SMSAs were more likely to have at least one HMO serving residents of the county than rural counties not adjacent to SMSAs (56.2% versus 22.9% of counties served by at least one HMO; Wholey, 1993). In Minnesota, which has a mature managed care environment, almost half of the 71 rural counties were not served by HMOs in 1991 and 86 percent had less than 10 percent of their population enrolled in HMOs (Minnesota Department of Health, 1992a). These data suggest that physicians in many rural counties (particularly those further away from metropolitan areas) will have little experience delivering medical care within a managed care system with formal organizational linkages to hospitals and other providers.

Rural networks can be viewed as opportunities to develop shared business units that protect the common interests of rural physicians, hospitals and other providers and help them to take risks together in activities such as the creation of HMO/PPO organizations; development of satellite clinics; joint capital ventures; physician recruitment; purchase of new technology; quality assurance, malpractice, and risk management activities; and service diversification initiatives. Physicians could legally own a network, partner with hospitals or other members in network ownership, or function in a traditional provider role with no network ownership responsibilities. In any of the above scenarios, network development provides an opportunity for physicians and other network partners to assume joint responsibility for the health care provided to the residents of rural communities.

The New York State Department of Health (1992) explicitly recognizes that rural health networks will need to provide a complete range of services and suggests they should include as members (or have formal relationships with) one or more hospitals, office-based physician groups, diagnostic and treatment centers, prenatal care clinics and other public health clinics, community health centers, emergency medical service providers, certified home health agencies, nursing homes, mental health providers, mental retardation and developmental disabilities providers, providers of alcohol and drug abuse services, local transportation services, and other human service agencies and local governments.

Unfortunately, many of the services offered by the above providers are in limited supply in rural areas. How health plans and rural provider networks work together to assure

the availability of a complete range of services will significantly affect the acceptability of health reform initiatives to rural residents and the ability of these initiatives to alter traditional physician practice patterns.

E. Physician Recruitment and Retention

A final issue relating to rural medical practice is the impact of network development under health reform on the willingness of physicians to move to rural areas, and to remain there over time. The central health care issue for many rural communities is not cost, but rather the inadequate supply of physicians and limited access of rural residents to medical services. Physician recruitment and retention remains a widespread problem throughout rural America. Horner, Samsa, and Ricketts (1992) have found that almost 50 percent of rural primary care physicians in North Carolina left their rural practice setting within three years. Physician turnover is an important factor that could hinder the implementation of new health care initiatives in rural communities, and the development of integrated service networks.

The organizational characteristics of the physician practice can have an important impact on rural physician recruitment and retention (Crandall, Dwyer, and Duncan, 1990). It is desirable that rural practices are structured to encourage the provision of technical, collegial and referral support and to decrease the perception of isolation, overwork, and marginality among rural physicians. Network development can directly address many of these. For example, physician recruitment, training and continuing education often can be accomplished more effectively on a network-wide basis rather than by individual entities (Crandall, Dwyer, and Duncan, 1990). More than half of the rural hospital networks in the United States reported physician and staff recruitment as one of their major activities (Moscovice, Johnson, Finch, et al, 1991).

Another aspect of the recruitment and retention issue is the ability to attract providers to isolated rural areas. These areas will continue to be difficult to serve under any health care reform initiative and it is not clear what incentives can be created by networks to attract physicians or other health professionals to practice in these areas. Many of the physicians who practice in frontier areas can be characterized by their extreme independence; they may seek to avoid practicing as part of an organized medical system. These providers will require technical assistance to understand how to become part of a network or how to contract with a health plan. Health plans will be faced with the dilemma of balancing their desire to alter

physician practice patterns with the potential impact that might have on the desire of physicians to continue to practice in underserved rural areas. How this balance is addressed will directly affect the isolation of physicians and the accessibility of health services in sparsely populated, underserved rural areas.

F. Issues Relating to the Impact on Rural Medical Practice

This section has raised a variety of issues related to the potential impact of health reform initiatives on rural medical practice. The most significant of these issues are:

- **How will rural physicians react to increased management and oversight of their practice?**

  Rural physicians generally have little experience participating in managed care systems. If utilization management is to be carried out effectively in rural areas, it will need to be somewhat adaptable to the varying conditions present in rural areas and receptive to input offered by local providers. How will local physician input be incorporated into utilization management approaches?

- **How will the location and availability of specialist services and technology be affected by health care reform? Which services and technology will be provided locally in rural areas? How will referrals to specialists be managed?**

  Health care reform must be structured to strike the appropriate balance between providing specialty services and technology in rural communities and requiring that rural residents travel to urban areas for this care. The considerations that enter into defining that balance are complex, relating to the nature of the service, the availability of specialists already in the rural area, the willingness of urban specialists to conduct outreach clinics, the outcomes of care under different approaches, and relative costs, including costs imposed on patients. Which services and technology should be provided locally in rural areas? How will referrals to specialists be managed?

- **How will differences in urban/rural practice standards be addressed?**

  Practice standards differ significantly between urban and rural areas, and among rural areas. Attempts, through health care reform, to develop and implement practice standards on a broad scale are likely to meet resistance in rural areas unless these standards are flexible enough to accommodate the unique characteristics of some rural practices. Should there be different standards depending on environmental and professional factors? How will rural physician input be used in the development of standards?

- **What implications does network development have for organizational relationships between rural physicians, hospitals, and other health providers?**

  In many rural communities, physicians, hospitals and other health care providers are operated independent of each other, sometimes in adversarial relationships. Health care reform could provide a vehicle for better service delivery integration at the local level. How can reform initiatives best be designed to achieve this objective?

- **Will the recruitment and retention of rural physicians be enhanced by health care reform?**

  The maintenance of access to medical services will continue to be the primary issue for many rural areas, even in the context of national efforts to control costs through health care reform. Efforts to reduce fees, implement utilization management techniques, and institute practice standards could discourage physicians from locating or remaining in rural areas, if they are not sensitive to rural needs. On the other hand, if health reform stimulates the formation of rural health networks that support rural practices, then the ability to recruit and retain physicians would be enhanced. What incentives can be created by networks to attract physicians and other health professionals to practice in underserved rural areas?

V. ROLES FOR STATE GOVERNMENT

The goal of state health policy has been described as assuring access to quality health services at a reasonable cost (Altman and Morgan, 1983). Historically, states have been active in paying for health care services, providing health care services directly, establishing rules governing health care providers and marketplace activities, developing and training health care resources, and protecting the public health and safety (Helms, 1991). In the debate over health care reform, several analysts have proposed various roles for federal and state government (Starr and Zelman, forthcoming; Kronick, 1992). Most agree, however, that implementation of managed competition and global budgeting in many rural areas will be difficult and that states should be provided with as much flexibility as possible to develop solutions appropriate to local circumstances. In this light, the following discussion highlights five roles for state government in administering health reform initiatives. These roles include purchasing health care, building network capacity and infrastructure, balancing antitrust enforcement and network establishment, informing consumers, and allocating and enforcing budgets.

A. Purchasing Health Care

States have traditionally played a central role in the purchasing of health care for public employees and low-income populations eligible for Medicaid and General Assistance. Many health reform initiatives would eliminate that role but give states authority to supervise and charter or license HIPCs (Starr and Zelman, forthcoming; Zelman and Garamendi, 1992). States would support HIPC efforts in contracting with health plans, developing risk adjustments across plans, enrolling eligible groups, collecting premiums and so on (Helms, Gauthier, and Campion, 1992).

In overseeing the activities of HIPCs, states could also ensure that rural concerns were addressed by:

- facilitating the entry of new health plans and networks in rural areas
- requiring HIPCs to assure geographic access to services in rural areas
- awarding exclusive franchises when special incentives are necessary to attract health plans to serve rural areas
- requiring HIPCs to have a rural advisory board
- maintaining a safety net (perhaps a state-run health plan) for vulnerable rural populations (e.g. migrants) that may have special needs
- requiring HIPCs to enroll the poor in the same plans that serve the wealthy and the middle class.

An alternative to this purely administrative role would have states serve as HIPCs. As Starr and Zelman (forthcoming) have pointed out, HIPCs are very similar to existing state health benefits programs. Several states have taken aggressive positions in trying to contain health care costs for their employees. In Minnesota, state employees comprise the largest employer-based health insurance group in the state serving almost 120,000 employees, dependents and retirees (Dowd, Christianson, Feldman, et al, 1992). The state has employees in all 87 counties of the state, many of which include rural areas not served by managed care plans. In 1989, the state replaced the statewide fee-for-service plan with a preferred provider organization (PPO) resulting in changes in physicians or higher out-of-network costs for state employees in some rural areas. In response to the threat of losing patients, physicians in 11 rural counties joined an HMO plan that had not previously served the county (Dowd, Christianson, Feldman, et al, 1992). In this instance, the state, functioning in essence like a

HIPC for the pool of state employees, served as a catalyst for rural managed care development. In California, the public employee health benefits system also includes smaller county and local governments as part of the system. In these states, it may not be difficult to add the small employer insurance market to the existing public employee insurance market. Other states (e.g. Florida, Washington, and West Virginia) are currently examining the feasibility of this approach.

Do states have the capacity and willingness to go at risk for the financing and delivery of health care services, particularly in riskier situations such as serving isolated rural areas? What does it mean to have a state or local government "at risk" for cost overruns? Won't this simply shift health care costs from one government budget to another? Enthoven (1993) indicates that HIPCs should not be risk-bearing entities but rather serve as the broker among such entities. Rosenberg (1992) suggests that state or local governments may be able to go at risk for the financing and delivery of services provided by networks and points to the current efforts of New York State in that regard. Another example is provided by the Minnesota Medicaid program, where one rural county contracts with the state on a capitated basis to assemble a delivery system and serve all Medicaid eligibles in the county. Although not necessarily a comfortable role for all states, policymakers need to examine the feasibility of expanding the state purchasing role beyond an administrative function. Exploring various options for HIPCs would facilitate the development of locally-sensitive solutions to providing health services under a managed care system to rural populations.

B. Building Network Capacity and Infrastructure

The discussion in section IV suggests that most rural areas are not now served by managed care systems. An important role for states might be to support the development and maintenance of rural provider networks, as building blocks for managed care systems or accountable units for global budgeting. States can create incentives to stimulate the formation of networks in several ways including:

- the use of loans and/or grants to support the capital investment necessary for network building
- the provision of reinsurance to networks in their early stages of development

- the protection of existing capacity building programs such as community health centers, rural health clinics, federally qualified health centers, and migrant health centers

- the provision of necessary technical assistance to support local network development

- the creation of financial, education, and licensure incentives that support the training of health professionals likely to participate in rural health networks.

A current example of state activities that provide support for rural network development are the efforts of the Office of Rural Health, New York State Department of Health and the New York State Rural Health Council (New York State Department of Health, 1992). State policymakers identified the lack of recognition of networks in existing reimbursement methods and the uncertainty of support beyond grant periods as barriers to rural network formation. As a result, New York State has established a framework for rural network development based on the publication of proposed network guidelines and requirements and proposed criteria and standards for network delivery models. Under one legislative proposal, network development in New York will be promoted through planning grants (up to $50,000 per year for up to two years), start-up grants (up to $500,000 to support infrastructure costs such as transportation, communication, medical records), and administrative grants ($100,000 to $200,000 per year for up to three years to provide operational support for network administration). The annual cost of this program is expected to be $4.7 million with most of the support coming from the reallocation of funds from existing state programs. The state has proposed to enact permanent fiscal incentives to support networks through adjustments to existing payment methods and categorical grant programs.

The New York State proposals highlight how a state that believes there is a pressing need to develop new delivery systems in rural areas can take a proactive role in rural network development. The legislature and the State Department of Health have worked together to promote a Hill Burton-like program that supports the development and funding of rural network capacity and infrastructure.

C. Balancing Antitrust Enforcement and Network Establishment

While the formation of rural provider networks may facilitate the implementation of health reform initiatives in rural areas, it also raises antitrust questions. The major goal of antitrust law is to preserve and enhance competition by making it illegal to enter into contracts or arrangements in restraint of trade or that create a monopoly. Antitrust laws attempt to assure that private arrangements do not reduce public access to services through price increases or output limitations (Struthers, 1991; Motenko and Busey, 1992).

How then should the formation of rural health networks be viewed vis a vis antitrust considerations? In particular, how should this issue be resolved in underserved rural areas where a competitive market is not likely to be established? It has been suggested that federal and state enforcement of antitrust laws be adjusted as necessary to permit the undertaking of HIPC-approved joint endeavors, such as rural network development (Zelman and Garamendi, 1992). Underlying this suggestion is the possibility that the literal application of existing antitrust laws to the delivery of medical care in rural areas may not yield net benefits for consumers. Rather than promoting access to care and containing costs, it could pose a threat to the availability of health care services in some rural communities (Struthers, 1992).

The Supreme Court has recognized that states can insulate certain activities by private parties that would otherwise be viewed as illegal under antitrust law. The state action exemption applies to arrangements that are (Rural Health Advisory Committee, 1993):

- conducted pursuant to a clear state policy to supplant competition, and
- actively supervised by the state.

For the state action exemption to hold, a state must provide prior approval to an arrangement or activity between the parties involved and supervise the arrangement or activity after it is initiated. In Minnesota, the legislation that underpins current state health care reform has a provision for state action immunity for arrangements that the Commissioner of Health believes may improve cost, quality, or access.

State action immunity could be used to address antitrust issues regarding rural network development in isolated rural areas that are not likely to be attractive to health plans or networks. For these areas, it may be desirable to award exclusive franchises or monopolies that will need to be closely monitored to ensure that they operate in the public's interest. The

monitoring or regulating function could be the responsibility of the HIPC, the state, or the federal government (Rural Wisconsin Hospital Cooperative, 1993).

D. Informing Consumers

For health care reform to be successful, the average person will need to understand the changes being proposed and how these changes will affect him or her personally. As Shofar (1992) has suggested, an early challenge will be to explain the reform package meaningfully to lay people to avoid the substantial implementation barriers that can arise otherwise. This is not an easy task. Proponents of market-oriented approaches have lamented the lack of good information on the quality of care provided in health plans and the price and quality of care provided by individual health professionals. The problems inherent in constructing acceptable measures of quality of care, be they outcomes-based measures or patient satisfaction measures, have been well documented (Shofar, 1992; Reinhardt, 1993). In addition, where such measures are available, it is not obvious what methods are most effective in disseminating information to the public. Nevertheless, the development and dissemination of such measures are essential to the success of a reform process that envisions consumers comparing and choosing health plans based on cost, quality, and access considerations.

Several analysts have suggested that reform initiatives include standardized and streamlined billing systems that will eventually move toward electronic transmission and result in detailed information becoming available on the location, use, cost, and quality of health care services provided in local and regional markets (Etheredge, 1992; Kronick, 1992). States can play several roles in this effort including (Helms, Gauthier, and Campion, 1992):

- Collecting and analyzing utilization, expenditure, and outcomes data
- Monitoring quality of care and financial and geographic access to care
- Establishing a state data commission with mandatory disclosure requirements
- Disseminating performance and cost information to consumers in an accessible Consumer Reports type format
- Certifying "centers of excellence" for certain procedures
- Developing and monitoring a consumer grievance and complaint system

States will vary substantially in their ability to assume the types of roles described above. Florida has proposed entering into a public/private partnership to collect and disseminate health data through its State Center for Health Statistics (Agency for Health Care Administration, 1992). Minnesota plans to take advantage of its decentralized community health boards (i.e. local public health agencies) to disseminate information at the local level (Minnesota Department of Health, 1992b). Most states will require substantial resources and technical assistance to carry out these roles.

There are several aspects of the state's "informing consumers" role that are idiosyncratic to rural areas. Many providers and health plans offering services to rural populations will have a limited volume of specific types of patients they have treated in a given time frame. In the past, small sample sizes have limited the ability of researchers to evaluate the outcomes of care provided by rural health professionals. Aggregating data to the health plan level may alleviate the problem somewhat, but will not permit individual physician/hospital/health professional comparisons that may be particularly useful in providing input to consumer decisions. Establishing relevant comparison groups is another issue that is particularly important for isolated rural areas that may be served by only one provider or health plan. Typically, in this case, comparison groups are constructed using providers or health plans in other isolated rural areas of the state or in neighboring states. Finally, it will be important to examine what services are not provided in rural areas as well as those services that are provided. Analysis of the patient referral processes used by rural providers would be helpful in understanding the appropriateness of care provided in rural areas and the short and long-term impact of patient referrals on costs.

In summary, states could play a major role in the collection of information from health plans and providers and the dissemination of this information to consumers. Rather than acting solely as a conduit for the passage of information to the federal government, many states are likely to experiment with developing innovative approaches to disseminating information to their residents. States will need to be sensitive with respect to the relative effectiveness of different approaches in informing residents of rural areas.

E. Allocating and Enforcing Budgets

The role of a global budgeting approach as part of a health reform package has not been settled. Enthoven (1993) has stated that managed competition is not compatible with

a global budget established by the government. Others insist that health care costs cannot be controlled without global budgets and that managed competition could readily support the imposition of global budgets through the use of capitated health plans (Aaron and Schwartz, 1993; Reinhardt, 1993; Starr and Zelman, forthcoming). For the purposes of this paper, we have assumed that reform initiatives will contain a global budgeting process that is initially triggered at the federal level.

From the state perspective, a key issue is how a federally set global budget will be allocated to the states, and the role that states will play in managing its implementation. Kronick (1992) suggests that if states are accountable for their level of health expenditures, they should have the freedom to experiment with different approaches for setting and meeting a budget. Others suggest that the federal government may need to set state expenditure targets and create disincentives for exceeding those targets (Zelman and Garamendi, 1992). In either case, there are political and technical tradeoffs involved with using different strategies for implementing a global budgeting approach.

Assuming that states are given some flexibility with respect to meeting expenditure limits allocated to them, several issues are particularly relevant for rural constituencies. The first issue is whether allocation procedures will treat urban and rural providers and consumers equitably. If initial expenditure targets and payment rates are based primarily on historical expenditure and/or payment data, the controversies surrounding the early implementation of the DRG system are likely to be repeated. Rural areas have typically had lower per capita health expenditures than urban areas. As Helms, Gauthier and Campion (1992) suggest, expenditure limits need to account for:

> the difficult problem of not unduly penalizing states which have already achieved efficiencies in their delivery systems and states which have not made adequate investments to assure adequate health services for all residents.

A second issue involves clearly defining which items would be included in a state budget constrained by expenditure limits. Items of special interest to rural areas include public dollars that currently flow to categorical programs, income subsidies to attract providers to underserved areas, and the costs associated with building rural network capacity and infrastructure.

A final issue relates to mechanisms for containing costs for providers not participating in health plans. This is particularly relevant for underserved rural areas where competitive

markets will be difficult to establish. In these cases, it is anticipated that exclusive franchises or monopolies may be established and paid on a regulated fee-for-service basis. The response of providers to this type of payment mechanism and controls on technology and specialized services will need to be monitored by states. Potential provider responses include changes in patient volume, quality, or casemix and highlight the broad set of implications and tradeoffs that global budgets or expenditure limits may have on the cost, accessibility and quality of services available in rural areas.

F. Issues Relating to Roles for State Government

This section has discussed potential roles for state government as health reform initiatives are implemented. Important issues raised in the discussion include:

- **Should states go at risk for the financing and delivery of health care services, particularly in higher risk, underserved rural areas?**

  The budgetary problems of many states suggest that it may not be timely for states to take on the additional risks associated with the financing and delivery of health care services. On the other hand, it may be relatively straightforward for some states to add all of the small employers in rural areas or entire rural portions of the state not served by health plans to their existing public employee insurance plan. It remains to be seen whether states can expand their current health care purchasing programs to include other groups.

  It may be difficult to attract health plans and providers to serve remote rural areas. As a last resort, it has been suggested in section III that exclusive franchise agreements may have to be awarded as an incentive for plans and providers to meet the needs of isolated rural populations. What role should the state play in granting and overseeing these franchises?

- **What are the most effective ways for states to stimulate rural network formation? How can existing capacity building programs be incorporated into a managed care system reimbursed under capitated rates?**

  In many states, there is a minimal infrastructure available to support managed care systems in rural areas. Existing health plans and providers will need support to develop rural provider networks that can serve as the foundation for health reform initiatives in rural areas. What specific types of support will be useful? Some rural areas have existing cost-based programs (e.g. CHCs, RHCs, FQHCs, MHCs) that meet the health care needs of vulnerable rural populations such as the poor, migrants, and individuals living in frontier areas. How can these programs be blended into a managed care system?

- **How aggressive should states be in enforcing antitrust laws when considering rural network formation? Will state action immunity be a successful strategy for permitting joint ventures that improve access and contain costs for rural populations?**

  In recent years, enforcement of anti-trust laws has reduced joint venture opportunities among providers. Does antitrust enforcement promote access and contain costs or represent a threat to the availability of services in rural communities? Several states are planning to use state action immunity to provide relief from antitrust laws for appropriate joint ventures. Will this strategy be successful and how will states ensure that the public's interests are met in situations involving the award of exclusive franchises? Who should have the specific responsibility for developing and implementing rules for exclusive franchises?

- **What role should the state play in collecting and disseminating health care information to the public? How will the special considerations of rural environments (e.g. low volume, relevant comparison groups, interest in patient referral process) be addressed?**

  It is difficult and potentially expensive to adequately inform the average person about the cost, quality, and accessibility of health care available in local markets. Several states have developed data commissions that have entered into partnerships with private groups to collect and disseminate health data. Information collection and dissemination may need to proceed differently in rural areas. Rural providers who treat limited numbers of patients with particular diagnoses may need to be compared with providers in similar environments rather than the "typical" provider with access to a broader range of resources. These issues need to be considered explicitly or rural consumers may be misled by the health care information made available to them.

- **How will a federally determined global budget be allocated to the states? Would budgets be based solely on historical expenditure levels, which have typically been lower on a per capita basis in rural areas? What role should states play in implementing and enforcing budget limits?**

  If a global budgeting approach is implemented, perceived inequities in the existing system could be incorporated into the new system. Any approach that depends solely on historical expenditure or payment data is likely to raise concerns in rural areas. What other kinds of factors need to be considered in allocating budgets to rural providers and areas? Would budgets include public dollars that flow to categorical programs, subsidies to attract providers to underserved areas, and costs associated with capacity building and infrastructure improvements?

VI. CONCLUSION

One of the measures of success of the health reform package developed by the Clinton Administration will be how it addresses the unique needs of the approximately one-fourth of the population that lives in rural areas of our country. This paper should be viewed as a first step in the development of a health reform package that is sensitive to the realities of health care delivery in rural America. The primary purpose of the paper has been to identify and discuss the major issues raised by health reform, as they are likely to be important for rural providers and consumers. Of particular interest are those issues that relate to the development and operation of rural provider networks, which are likely to be stimulated by health care reform and, in turn, play an important role in implementing reform initiatives.

The paper seeks to provide a framework for discussion of these issues at the upcoming meeting on Health Care Reform in Rural Areas to be held in Little Rock, Arkansas on March 11-12, 1993 under the sponsorship of the Robert Wood Johnson Foundation and the Arkansas Department of Health. One outcome of this meeting will be a list of recommendations on how health reforms can address issues that are critical to the financing and delivery of health care services in rural America.

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PANEL DISCUSSIONS

Moderator: W. David Helms

Panel 1: *Organization and Financing of Networks*

Alain Enthoven, Ph.D.
Steve Rosenberg, Ph.D.
Sandral Hullett, M.D.
Tim Size

Panel 2: *Impact on Medical Practice*

Paul Ellwood, M.D.
John Coombs, M.D.
Kevin Fickenscher, M.D.
Roland Gardner
Dian Pecora

Panel 3: *State Roles*

Dan E. Beauchamp, Ph.D.
James Bernstein
Denise Denton
Charles McGrew
Sally Richardson

PANEL 1

ORGANIZATION AND FINANCING OF NETWORKS

Panelists:

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Materials:

- Discussion Questions
- Richard Kronick, David Goodman, John Wennberg, Edward Wagner. "The Marketplace in Health Care Reform: The Demographic Limitations of Managed Competition," *The New England Journal of Medicine*, January 14, 1993.

Panel 1: Issues Relating to the Organization and Financing of Networks

1. How quickly will rural providers react in developing rural health networks under the stimulus of health care reform? Will the initiative for network formation come primarily from rural providers or from urban-based health plans and health care organizations?

   The number of rural health networks will need to be expanded and existing networks will need to be modified if they are to play significant roles under health care reform. Given the conservative nature of many rural providers, and the constraints on their financial capacity to invest in network development, there may be limited potential for rapid network formation under the leadership of rural providers. If rural providers do not exercise leadership in network formation, rural networks may be formed instead as the result of "shotgun marriages" of providers who happen to contract with the same urban-based health plan, with network leadership provided by health plan staff.

2. What providers will be included in rural health networks?

   In establishing contractual relationships with rural providers, prepaid health plans typically create separate risk pools for different types of providers (unless the health plan contracts with a multispecialty group practice). For reimbursement purposes, specialists are grouped with specialists, primary care physicians with other primary care physicians, and hospitals with other hospitals. (The reimbursement received by these groups is often tied together through interlocking financial incentives, as discussed below). Thus, the provider networks that result from this process tend to encourage the horizontal integration of providers. However, advocates of greater coordination, or regionalization, of health services in rural areas usually argue for vertical integration of health care delivery as well. Their conceptualization of rural health networks emphasizes the inclusion of a full range of services and providers (New York State Department of Health, 1992). While health care reform is likely to stimulate the formation of networks that aggregate providers of similar types, it may require intervention on the part of HIPCs to accomplish greater vertical integration of providers and coordination of service delivery where comprehensive services networks do not develop spontaneously.

3. What steps should HIPCs take in areas where rural providers decline to participate in health plans or otherwise coordinate services to improve quality of care and contain costs?

   In this case, most reform proposals suggest that these areas be subject to regulatory oversight, including the administration of price controls for providers, coupled with stringent utilization management. If these steps are sufficiently onerous, it is assumed that providers will eventually choose participation in a health plan as the least objectionable alternative. However, providers in remote rural areas may respond by moving their practices to more populous areas, creating access problems for some rural communities. HIPCs will need to balance their efforts to ensure that services are provided within a fixed budget with the need to maintain access to care for rural residents. How will HIPCs manage this "balancing act" in rural areas where providers choose to "opt out" of health reform?

4. Should rural networks be encouraged to participate in multiple health plans? Or, should they be awarded "franchises" to serve designated geographic areas?

   In both instances the concern is that an integrated, organized rural health network consisting of virtually all providers in a given area will be in a position to exercise monopoly power in negotiations with health plans or HIPCs. The issue is whether countervailing power can be most effectively brought to bear by health plans or HIPCs in these negotiations. The fallback position for the network, if an agreement cannot be reached, is to withdraw from the plan, in the first case, or from the franchise, in the second. Withdrawal from the franchise presumably would trigger direct regulatory oversight of individual rural providers on the part of the HIPC, as described above. Under what conditions should rural networks be encouraged to contract with multiple plans? When will it serve public policy better if they are awarded exclusive contracts to serve specific rural areas?

5. Under different reimbursement approaches, how strong should the financial incentives be for rural primary physicians to control or alter referrals to specialists?

   As described above, in many prepaid plans primary care physicians play a "gatekeeper" role, with financial incentives to control referrals to specialists. However, one commonly expressed concern about the health care available in rural areas is that rural residents don't always have appropriate access to specialty care. Providing primary care physicians with financial incentives to control access to specialists could heighten these concerns. Often rural primary care physicians have constructed their referral networks carefully over time, developing collegial relationships with particular specialists that enhance the quality of care received by their patients. Strong financial incentives to channel referrals to particular specialists contracting with the health plan could threaten these relationships.

6. How will fee schedules be established and enforced for rural physicians?

The basis for establishment of rural physician fee schedules will be a contentious issue, whether those fee schedules are implemented by health plans or by HIPCs. Rural providers fear that new fee schedules will "lock in" perceived inequities in the present relationships between fees received by urban and rural physicians, and between primary care and specialist physicians. In addition, there is the question of whether fee schedules can be used in rural areas as instruments to reduce costs, if necessary, without causing physicians to leave their rural practices, thereby jeopardizing access to care for rural residents in underserved areas. Finally, it seems likely that establishing the appropriate relationship between fee schedules for the non-elderly and Medicare fee schedules will be particularly important in rural areas. Due to the demographic composition of many rural areas, the preponderance of patients seen by primary care physicians are elderly. Where this is the case, non Medicare physician fee schedules may be crude and relatively ineffective instruments for influencing provider behavior and providers may be unwilling to accept financial risk. Again, attempts to impose financial risk on providers, or reduce their fees, could result in reduced access to medical care for the non-elderly in some rural communities.

Wennberg
fwd to Mitchell

SPECIAL REPORT

THE MARKETPLACE IN HEALTH CARE REFORM

The Demographic Limitations of Managed Competition

Abstract *Background.* The theory of managed competition holds that the quality and economy of health care delivery will improve if independent provider groups compete for consumers. In sparsely populated areas where relatively few providers are required, however, it is not feasible to divide the provider community into competing groups. We examined the demographic features of health markets in the United States to see what proportion of the population lives in areas that might successfully support managed competition.

Methods. The ratios of physicians to enrollees in large staff-model health maintenance organizations were determined as an indicator of the staffing needs of an efficient health plan. These ratios were used to estimate the populations necessary to support health organizations with various ranges of specialty services. Metropolitan areas with populations large enough to support managed competition were identified.

Results. We estimated that a health care services market with a population of 1.2 million could support three fully independent plans. A population of 360,000 could support three plans that independently provided most acute care hospital services, but the plans would need to share hospital facilities and contract for tertiary services. A population of 180,000 could support three plans that provided primary care and many basic specialty services but that shared inpatient cardiology and urology services. Health markets with populations greater than 180,000 would include 71 percent of the U.S. population; those with populations greater than 360,000, 63 percent; and those with populations greater than 1.2 million, 42 percent.

Conclusions. Reform of the U.S. health care system through expansion of managed competition is feasible in medium-sized or large metropolitan areas. Smaller metropolitan areas and rural areas would require alternative forms of organization and regulation of health care providers to improve quality and economy. (N Engl J Med 1993; 328:148-52.)

MANAGED competition has received widespread support from members of Congress, President-elect Bill Clinton, large insurance companies, and editorialists writing in influential publications.[1-4] A central tenet of the managed-competition theory is that providers are divided into competing economic units. As discussed by Enthoven and Kronick,[5,6] the most effective competition occurs when all the doctors in a community are grouped into several prepaid practices with each doctor fully committed to one organization. Health care services, however, are largely purchased locally, and there are sparsely populated areas of the United States where providers have a natural monopoly. In a geographically isolated area with a population base large enough to support only one hospital and one group of physicians, it is difficult to envision how competition would work. If the hospital decides to increase its scope of services or its prices substantially, threatening to build a competing hospital is a poor option, and transporting patients to another city may be unacceptable. Similarly, if most physicians are members of a single multispecialty group practice, purchasers have little recourse if the physicians use more, rather than fewer, resources.

We estimated the minimal population size for a health services market area that could support managed competition and the proportion of the population of each state and of the nation as a whole that is in such areas.

METHODS

An estimate of the minimal population required to support managed competition is based on four assumptions: the extent to which competing health care organizations need to be independent; the minimal number of health care organizations needed to support healthy competition; the ratios of physicians to enrollees and of hospital beds to enrollees in efficiently managed health plans; and the geographic boundaries of health services markets. This section

presents the assumptions and methods we used to make our estimates.

To What Extent Must Competing Organizations Be Independent?

The "classic" health maintenance organization (HMO) — the large, staff-model prepaid group practice epitomized by Kaiser–Permanente or Group Health Cooperative of Puget Sound — is the prototype of the efficient competitor. Unlike many other forms of managed care, classic HMOs are capable of health planning: they regulate the supply of hospital beds, physicians, and other providers in relation to the size of the population they serve. Physicians employed by classic HMOs, because they are salaried, are not subject to the tendencies toward supplier-induced demand inherent in fee-for-service medicine; they are able to allocate their workloads efficiently among various tasks, such as evaluating and counseling patients, performing operations or diagnostic tests, and performing the duties required for continuous improvement in the quality of care. This flexibility makes it possible for classic HMOs to adapt easily to the changes in demand that occur when patients are informed about medical options and make decisions according to their preferences.[7]

The efficiency of the classic HMO model contrasts sharply with that of the independent practice association (IPA) model, particularly when individual physicians are affiliated with many health plans. Enthoven describes the inefficiencies of an IPA market in which each physician belongs to 10 plans:

> Each doctor would have to deal with the utilization controls and fee schedules of ten health plans, none of which would command his loyalty. If one health plan persuaded a doctor to adopt a more efficient health practice, the benefit would be likely to be spread immediately over all ten plans, reducing the incentive of any plan to make the effort to pursue innovation at the provider level. None of the health plans would be matching numbers of doctors to the needs of the population.[6]

Between the contrasting extremes of the mature classic HMO and the multiple-IPA model is a large, ambiguous middle ground. Each of a set of health plans might have its own primary care physicians and contract with the same specialists. Or, in addition to primary care, a plan might provide some specialty services (such as cardiology, urology, and gastroenterology), using its own physicians during regular business hours, but it might contract with overlapping sets of providers for after-hours specialty care and for inpatient services. When considering competition among health plans that are less comprehensive than classic HMOs, a key factor is the configuration of inpatient hospital services in a community. If health plans are not large enough to own their own hospitals and hire the full complement of specialists but, instead, contract separately with overlapping sets of hospitals, then no organization will be responsible and accountable for population-based health planning for hospital services.

In areas in which the population is too small to allow competing health plans to exert effective control over specialists' services and hospital resources, some alternative or adjunct to managed competition will be required in order to achieve effective health planning. Conceivably, this might be accomplished by cooperative planning efforts by the major health plans operating in a community. Alternatively, some form of government regulation of hospital capacity and budgets may be necessary.

How Many Competitors Are Needed?

Ideally, a large number of qualified health care plans would be available in each geographic area. No single plan would be able to have much influence on the demand for care, thus making collusion among plans difficult. However, the minimal number of plans needed to avoid a market with strong oligopolistic tendencies is not clear. One competitor is obviously not enough. If there are only two competitors, the temptation of implicit collusion will be hard to resist. Why should the competitors work hard to restrain the growth of costs or profits when both competitors will be better off if they engage in cozy behavior? There is no theoretical basis on which to infer the minimal number of firms that can successfully sustain competition, but the fewer there are, the greater the tendency toward oligopoly. Somewhat arbitrarily, we assumed that at least three health plans are needed in order to create a situation in which providers and plans will continually strive to improve quality and economy.

What Is the Critical Population Size Needed to Sustain an Efficient Firm?

The size of the population required for a managed-care firm to organize efficient primary care and specialty units varies according to specialty and according to assumptions about the minimal number of physicians needed to sustain the service. We grouped physician specialties into four categories. The first, primary care, included general internal medicine, pediatrics, and family medicine. For these specialties we assumed that at least five physicians are needed to provide full night coverage and to sustain the collegial relations required for high-quality care in the group-practice environment.

The second category included hospital-based specialties that involve frequent night and weekend consultation for emergencies or postoperative care and that are required in a full-service acute care community hospital — specifically, emergency medicine, obstetrics and gynecology, general surgery, orthopedics, anesthesiology, radiology, psychiatry, cardiology, and urology. For these specialties, we assumed that three full-time physicians are needed to staff a minimal service in order to meet coverage obligations and provide high-quality care. We used these specialties to estimate the lower limit of the zones where competition based on the classic HMO model might succeed if there were some sharing of hospital facilities, with staffs independent.

The third category included neurosurgery and cardiothoracic surgery, the additional three-physician specialty services required for a tertiary hospital. This sets the minimum for a classic HMO that is fully independent for all clinical specialties. The fourth category consisted of other specialties involving secondary and tertiary care that is usually not of an emergency nature — ophthalmology, otolaryngology, dermatology, pathology, hematology and oncology, neurology, gastroenterology, allergy and immunology, pulmonary medicine, nephrology, rheumatology, endocrinology, infectious diseases, and plastic and reconstructive surgery. On the basis of our estimate that 24-hour coverage is not essential for these specialties, we assumed that the services of only one specialist are required to achieve independence.

To estimate the population required for independence and efficiency, we examined the staffing patterns of the Group Health Cooperative of Puget Sound and four other large, nonprofit staff-model HMOs. For each classic HMO, data were provided by the organization's medical staff office. For most specialties the number of enrollees per specialist was averaged across plans to derive an estimate for the HMOs as a whole. To estimate the need for primary care practitioners we used the Group Health Cooperative's staffing ratio for family practitioners (1 to 2000). For emergency medicine, psychiatry, pathology, and thoracic surgery, we used data from other sources.[8,9] (Supplemental material on our procedures is available elsewhere.*)

The age structure of the enrollees was obtained for the age groups ≤14, 15 through 44, 45 through 64, and ≥65 years. The proportion of enrollees in each age group approximated the national age distribution except for the population 65 years of age or older. The elderly make up 12.5 percent of the national population, whereas the percentages for the five HMOs were 11.7, 9.4, 8.0, 11.4, and 8.2 percent.

HMOs typically use fewer than 2 beds per 1000 enrollees. The estimate of 2 beds per 1000 is compatible with the assumptions that the population under 65 years of age uses 350 hospital days per year

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per 1000 enrollees and the population 65 or older uses 2430 days per 1000; that 13 percent of the enrollees are 65 or older; and that hospital occupancy is 85 percent.

What Are the Location and Size of Health Care Markets?

We assumed that metropolitan areas, as defined by the Office of Management and Budget,[10] are the relevant market areas for health services in nonrural parts of the United States. Metropolitan areas are defined as a "place" with a population of at least 50,000 or an "urbanized area," as defined by the U.S. Bureau of the Census, with a population of 50,000 and a metropolitan area with a total population of at least 100,000. Surrounding counties are included if they have a minimal commuting rate to the central county. This definition of metropolitan areas results in high-density geographic units with economic and travel ties that are consistent with a regional economic market.[11,12] The size and location of health services markets for people living outside metropolitan areas are usually determined on the basis of small-area analysis. Although we were not able to perform such an analysis for the entire nation, previous studies in northern New England have resulted in the division of this territory into 72 distinct hospital market areas.[13] We used these areas to illustrate the constraints of demographic forces on managed care in nonmetropolitan areas.

Results

Population Requirements for Managed-Care Organizations

The minimal population necessary to support a classic HMO offering referral hospital services and using its own staff physicians is approximately 450,000 enrollees. A health plan with 300,000 enrollees would be able to offer virtually all ambulatory and hospital services with its own panel of providers and own a 600-bed hospital, but it would need to contract for some coverage of cardiothoracic surgery and neurosurgery. A plan with 120,000 enrollees could provide the full complement of acute care hospital services associated with a community hospital, using its own staff physicians, although the cardiology and urology services would be close to the minimal three-person service. This plan would need approximately 240 hospital beds; it would be able to exert substantial control over one or two hospitals, but it would have to share some inpatient facilities with other plans. A plan with 60,000 enrollees could support 71 full-time-equivalent physicians (Table 1) and a 3-physician service in most of the specialties required for general hospital services, but it would need to share cardiology and urology services and engage in substantial sharing of inpatient facilities with other plans. A plan with 10,000 members could support an independent primary care service but would be required to share both physicians and inpatient hospital services in all specialties.

Population Required for Managed Competition

Assuming that three health plans are the minimum required for competition, then at least 360,000 persons are needed to support three HMOs that can plan for and deliver most general hospital services, although sharing of acute care hospital facilities would be necessary. A smaller community of 180,000 could support three health plans capable of providing a large portion of physicians' services in hospitals, using physicians who are employed as staff by the health plan, but they would require shared inpatient services. A community of 30,000 might support three independent primary care networks, but all hospital services would need to be shared if the residents were to receive inpatient care locally. At the other extreme, a much larger community of at least 1.2 million persons would be required to support three HMOs capable of providing almost all services with their own resources.

Table 1. Estimated Number of Full-Time-Equivalent Physicians and Hospital Beds Needed, According to the Size of the Health Plan.

Specialty or Type of Service	No. of Enrollees				
	20,000	60,000	120,000	300,000	450,000
	number				
Physicians					
Primary care (family medicine)*	10.0	30.0	60.0	150.0	225.0
General hospital services					
Obstetrics–gynecology	2.2	6.5	13.0	32.6	48.9
General surgery	1.1	3.2	6.3	15.8	23.7
Orthopedics	0.9	3.0	5.9	14.9	22.3
Emergency medicine	0.9	2.9	5.9	14.7	22.1
Anesthesia	1.0	3.0	6.0	15.0	22.5
Radiology	1.2	3.6	7.3	18.2	27.3
Psychiatry	0.8	2.3	4.6	11.4	17.1
Cardiology	0.6	1.7	3.4	8.5	12.8
Urology	0.5	1.5	3.1	7.7	11.5
Subtotal	9.2	27.7	55.5	138.8	208.2
Tertiary hospital services					
Thoracic surgery	0.2	0.5	1.0	2.5	3.8
Neurosurgery	0.1	0.4	0.8	2.0	3.0
Subtotal	0.3	0.9	1.8	4.5	6.8
Other specialties†	4.1	12.2	24.3	60.8	91.2
Total	23.6	70.8	141.6	354.1	531.2
Hospital beds	40	120	240	600	900

*Staffing will vary depending on the mix of family practitioners, internists, and pediatricians.

†The other specialties are ophthalmology, otolaryngology, dermatology, pathology, hematology and oncology, neurology, gastroenterology, allergy and immunology, pulmonary medicine, nephrology, rheumatology, endocrinology, infectious diseases, and plastic and reconstructive surgery.

Proportion of the U.S. Population Living in Competitive Zones

Twenty-nine percent of the U.S. population lives in markets with populations below 180,000 and thus in areas where substantial sharing of hospital services would be required for use to be efficient (Table 2). Eight percent live in markets with populations between 180,000 and 360,000, where managed competition has some potential to organize acute hospital care at least semi-independently, but where plans would need to be supplemented with substantial public-sector involvement in health planning. Twenty-one percent are in markets with populations between 360,000 and 1.2 million, where the demographic requirements for HMO-based managed competition are largely met but where some public-sector efforts are likely to be required in the planning of tertiary hospital services. Forty-two percent reside in markets with populations of more than 1.2 million.

The location of these markets in the United States is shown in Figure 1. Twenty-three states and the District of Columbia have at least one metropolitan area

with a population of 1.2 million or more, sufficient to support three classic HMOs, each owning a referral hospital; in 10 (Arizona, California, the District of Columbia, Illinois, Maryland, Minnesota, Missouri, New Jersey, New York, and Texas) the majority of the people live in such areas. However, large land areas in the United States are outside the competitive zone for HMOs, and no state is entirely within it. Most states will require mixed strategies. Some part of their populations live in areas where managed competition could be effective in promoting HMOs, but many live in more sparsely settled areas where other strategies are needed. In 19 states the majority of the population lives in areas of less than 180,000 population, where hospital services must be extensively shared. In 42 states, 20 percent or more of the population lives in such areas.

Table 2. Percentage of State (or District) Populations in Different-Sized Health Market Areas.*

State or District	Population	Population of Market Area		
		>180,000	>360,000	>1.2 million
		percentage of state population		
Alabama	4,041,000	49	34	0
Alaska	550,000	41	0	0
Arizona	3,665,000	76	76	58
Arkansas	2,351,000	24	24	0
California	29,760,000	94	91	77
Colorado	3,294,000	74	61	49
Connecticut	3,287,000	79	53	0
Delaware	666,000	66	66	0
District of Columbia	607,000	100	100	100
Florida	12,938,000	88	72	41
Georgia	6,478,000	61	50	44
Hawaii	1,108,000	75	75	0
Idaho	1,007,000	20	0	0
Illinois	11,431,000	78	66	58
Indiana	5,544,000	53	44	23
Iowa	2,777,000	23	17	0
Kansas	2,478,000	44	44	24
Kentucky	3,685,000	42	29	8
Louisiana	4,220,000	59	42	29
Maine	1,228,000	22	0	0
Maryland	4,781,000	89	89	87
Massachusetts	6,016,000	79	68	48
Michigan	9,295,000	74	68	47
Minnesota	4,375,000	64	55	55
Mississippi	2,573,000	26	18	0
Missouri	5,117,000	60	55	55
Montana	799,000	0	0	0
Nebraska	1,578,000	47	34	0
Nevada	1,202,000	83	62	0
New Hampshire	1,109,000	59	10	0
New Jersey	7,730,000	98	90	55
New Mexico	1,515,000	32	32	0
New York	17,990,000	89	81	62
North Carolina	6,629,000	45	41	0
North Dakota	639,000	0	0	0
Ohio	10,847,000	74	69	40
Oklahoma	3,146,000	53	53	0
Oregon	2,842,000	63	44	44
Pennsylvania	11,882,000	81	72	49
Rhode Island	1,003,000	89	65	0
South Carolina	3,487,000	53	53	0
South Dakota	696,000	0	0	0
Tennessee	4,877,000	64	64	0
Texas	16,987,000	73	62	50
Utah	1,723,000	78	62	0
Vermont	563,000	0	0	0
Virginia	6,187,000	66	63	47
Washington	4,867,000	73	60	41
West Virginia	1,793,000	34	0	0
Wisconsin	4,892,000	49	38	30
Wyoming	454,000	0	0	0
Total	248,709,000	71	63	42

*In health markets that cross state boundaries, people have been allocated to their state of residence.

The health markets in northern New England illustrate the complexities of structuring competition in states with no large metropolitan areas. Maine, New Hampshire, and Vermont together contain 83 acute care general hospitals and 2.5 million people; 64 of the hospitals are the sole hospitals in their local areas. The vast majority of primary care services in these areas are delivered by local physicians who use the local hospital for their patients. None of these areas have a big enough population to support three independent cardiology services. Only two market areas — Portland, Maine, and Manchester, New Hampshire (containing 13 percent of the population) — are sufficiently large to support three independent general-surgery, emergency, and orthopedic services. Twenty-seven percent of the population of northern New England lives in hospital market areas that cannot support three independent primary care competitors, assuming that each plan would need to have at least five physicians.

Discussion

We recognize several limitations to our study that cause uncertainty about our estimates. We estimated the minimal population required to support three efficient organizations in a steady state; population estimates may be unrealistic, however, since the motivation of competition includes growth and in small markets this cannot occur without driving a competitor out of business. Our assumption that three competitors are sufficient to avoid collusion cannot be supported by empirical evidence, since managed competition is an experiment that has yet to run its course. Three may not be enough. Each of these factors would tend to cause us to underestimate the market size required to promote efficient competition. We have also not considered other potential limits to reform, such as barriers to enrollment of providers and bureaucratic inefficiencies in the case of public-sector health planning. On the other hand, since the enrollees of HMOs tend to be younger than the general population, smaller health markets could support managed competition with a higher proportion of elderly persons. The conclusion, however, is the same: demographic factors will limit the full implementation of managed competition as the vehicle for reforming the U.S. health care economy.

We hope our study will help to move the policy debate beyond polarization, either for or against competition and regulation. The complexities and the highly localized nature of the health care economies in the various states indicate the need for care on the part of state governments in setting the rules for structured competition, or the need for alternative models of reform (based on planning and the promotion of cooper-

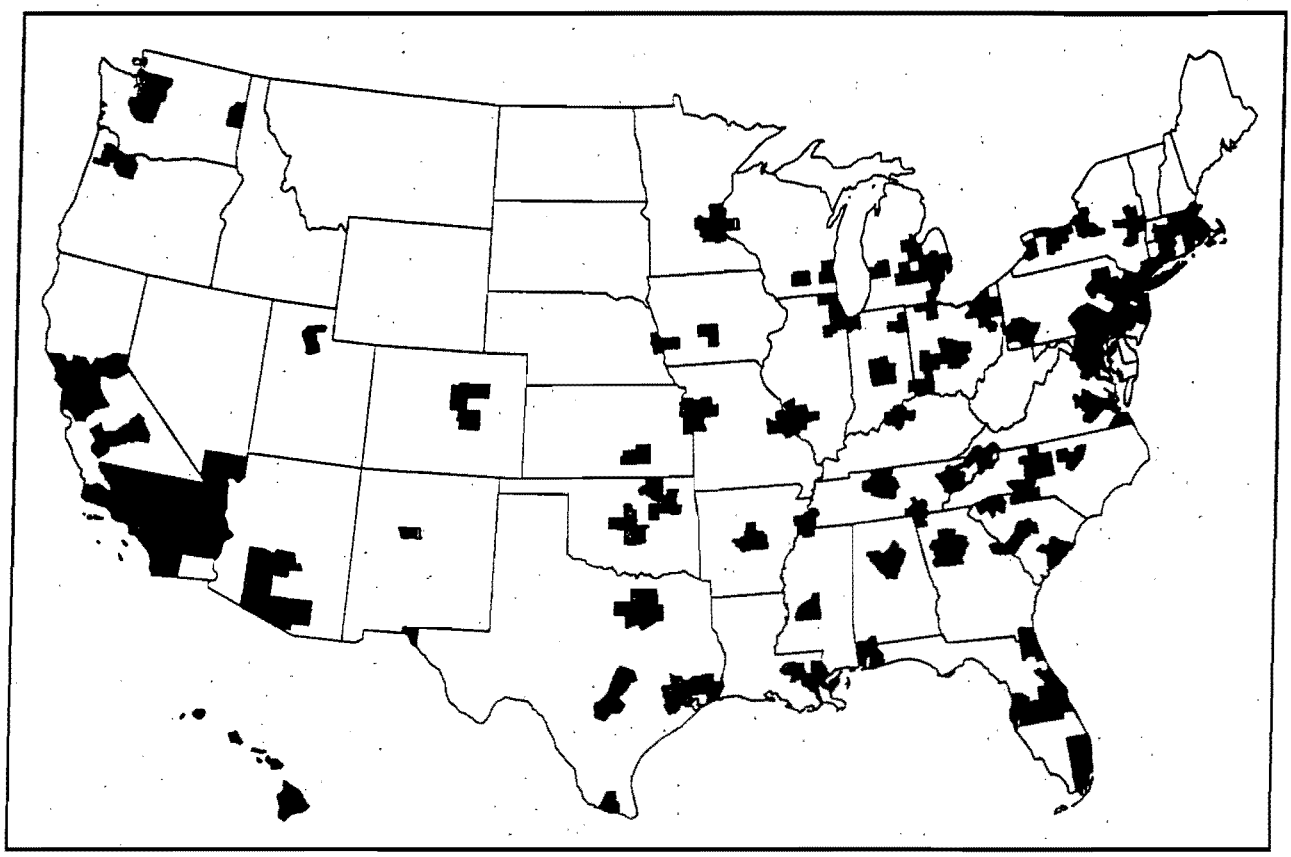

Figure 1. Health Markets with Populations ≥360,000 in the United States.
Metropolitan areas (health markets) with populations ≥360,000 are shown in black.

ation as the basis for achieving the efficiencies that the population-based perspective of the classic HMO brings to the health care economy). Monitoring by the states should be based on a sophisticated understanding of their health care systems, including detailed information about the location and level of use of resources in local and regional markets. Each state will need to recognize the limitations as well as the advantages of managed competition, particularly the need for support within an overall regulatory framework that can deal effectively with all the territory within its jurisdiction.

We recommend that the states be given wide latitude to undertake experiments in setting the rules for managing health care reform within their territory. We expect a provocative series of experiments that promote a variety of approaches to the complex problem of building population-based systems of care. Some will result in as yet unanticipated hybrid solutions that reflect demographic factors, the history of the state's health care industry, and regional traditions and preferences.

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PANEL 2

IMPACT ON MEDICAL PRACTICE

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Materials:

- Discussion Questions
- Material submitted by Dr. John Coombs
  - Case Vignette: Mount Carmel Hospital, Colville, Washington
  - Characteristics of Successful Rural Hospitals Under 50 Beds
  - Organizational Models for Physician and Hospital Relationships
  - Targeting Primary Care through WAMI Partnerships

Panel 2: Issues Relating to the Impact on Rural Medical Practice

1. What implications does network development have for organizational relationships between rural physicians, hospitals, and other health providers?

   In many rural communities, physicians, hospitals and other health care providers each operate independently, sometimes in adversarial relationships. Health care reform could provide a vehicle for better service delivery integration at the local level. How can reform initiatives best be designed to achieve this objective?

2. How will rural physicians react to increased management and oversight of their practice?

   Rural physicians generally have little experience participating in managed care systems. If utilization management is to be carried out effectively in rural areas, it will need to be somewhat adaptable to the varying conditions present in rural areas and receptive to input offered by local providers. How will local physician input be incorporated into utilization management approaches?

3. Will the recruitment and retention of rural physicians be enhanced by health care reform?

   The maintenance of access to medical services will continue to be the primary issue for many rural areas, even in the context of national efforts to control costs through health care reform. Efforts to reduce fees, implement utilization management techniques, and institute practice standards could discourage physicians from locating or remaining in rural areas, if they are not sensitive to rural needs. On the other hand, if health reform stimulates the formation of rural health networks that support rural practices, then the ability to recruit and retain physicians would be enhanced. What incentives can be created by networks to attract physicians and other health professionals to practice in undeserved rural areas?

4. How will the location and availability of specialist services and technology be affected by health care reform? Which services and technology will be provided locally in rural areas? How will referrals to specialists be managed?

   Health care reform must be structured to strike the appropriate balance between providing specialty services and technology in rural communities and requiring that rural residents travel to urban areas for this care. The considerations that enter into defining that balance are complex, relating to the nature of the service, the availability of specialists already in the rural area, the willingness of urban specialists to conduct outreach clinics, the outcomes of care under different approaches, and relative costs, including costs imposed on patients. Which services and technology should be provided locally in rural areas? How will referrals to specialists be managed?

5. How will differences in urban/rural practice standards be addressed?

   Practice standards differ significantly between urban and rural areas, and among rural areas. Attempts, through health care reform, to develop and implement practice standards on a broad scale are likely to meet resistance in rural areas unless these standards are flexible enough to accommodate the unique characteristics of some rural practices. Should there be different standards depending on environmental and professional factors? How will rural physician input be used in the development of standards?

IMPACT ON RURAL MEDICAL PRACTICE

Issue Identification

The following four supplements are submitted for assistance in discussion of questions that have been identified under the impact on rural medical practice of managed competition/managed care in rural areas.

ATTACHMENT I. This case vignette in Colville, Washington, centering around Mt. Carmel Hospital, was published in a report on "The Strategies and Environments of America's Small and Rural Hospitals" by the Hospital Research and Education Trust of the American Hospital Association in 1992. This case vignette very closely captures how one community created a network or relationship between physicians and hospitals so as to create the beginnings of a seamless mechanism for provision of health care.

Subsequent to the development of this initiative within Colville, an experiment in capitate care within the Basic Health Plan of Washington (gap insurance developed for uninsured citizens on a sliding scale basis) has been initiated. Because of the close working relationship between physicians and the hospital and other health care providers within the community, a successful model has been experienced during the first 18 months of it being in place. The significant impact has been to reduce the use of the emergency department for routine problems, a significant reduction in out-migration of patients from the primary care area to adjacent urban areas when the care could comfortably and in a quality fashion be provided within the community, and a reinforcement of outreach services which are provided within the community when specialty consultation is indicated.

ATTACHMENT II. Characteristics of small rural hospitals under 50 beds is a compilation of lessons learned from the above referenced study, "Strategies and Environments of America's Small Rural Hospitals" produced by the Hospital Research and Education Trust of the American Hospital Association in 1992 and supported by the Pew Charitable Trust. In many respects, this study captures what was learned in 10 rural hospitals and communities across the United States -- common themes that appeared to underscore success even in adverse environments. These characteristics are put forth as important issues to consider in developing characteristics of a health care reform package centered around managed competition.

ATTACHMENT III. The development of physician/hospital organizations within communities is currently an item of great interest across the United States. Three sample organizational charts are represented here as to different models which are being created within both urban and rural communities. They include: a management service organization (MSO), a clinic without walls, and an affiliated group practice. These are provided as examples of community relationships between hospitals and physicians which may potentially lay the groundwork for closer collaboration of services. An analysis of various characteristics of these three models are provided on the attached matrix.

ATTACHMENT IV. Targeting primary care through WAMI partnerships. This continuum diagram outlines the importance of various programmatic interventions which can be created in assuring a steady flow of primary care physicians, including those with special reference to care for rural or medically underserved populations, through involvement of the nation's medical schools and academic medical centers. Specific reference of programs listed in this diagram are those of the University of Washington School of Medicine and programs which have been developed through partnerships with various other agencies affiliated with WAMI in Washington, Alaska, Montana and Idaho. Although specifics are not mentioned of each of these programs, the continuum will provide reference for further discussion.

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WA

As in many rural areas, the local economy surrounding Mou
Carmel Hospital suffered severe setbacks in the early and m
1980s; yet the hospital has had a positive financial mar
equaling at least 3 percent of operating revenues for each fis
year from 1985 through 1989. Many factors have contributed
the hospital's success. There is a long history of goodwill betwe
the local community and the hospital. More recently, the hospi
has developed a reputation for high-quality, relatively intens
medical care. A strong, committed medical staff has also contribut

ATTACHMENT 1

to the success of Mount Carmel through proactive and cooperative relationships with both the community and the hospital. Mount Carmel is one of three hospitals in a small, regional, Catholic system. An equitable and supportive relationship with the corporate headquarters has helped ensure the hospital's success. A politically savvy and marketing-oriented management team, which is also internally liked, has also helped the hospital. Early familiarity with the prospective pricing system (PPS); utilization and cost analyses by diagnosis-related groups (DRGs); conservative and hard-nosed fiscal management; and strong relationships among the hospital, its employees, and the community have also contributed to the success of Mount Carmel Hospital.

The Local Environment

Mount Carmel Hospital, with 48 staffed beds, is located in the town of Colville, in the northeastern corner of Washington state. It is a not-for-profit Catholic hospital owned by the Dominican Health Services of Spokane. Colville rests in the ancient Columbia River basin, about eight miles from today's Columbia River. The local topography is hilly, with mountains to the east and on the western side of the river, and having peaks as high as 7,308 feet near the Canadian border. Historically a center for trade and commerce in this otherwise sparsely populated section of the state, Colville was originally settled by Jesuits. Called Fort Colville, it was the first trading post in the area.

Within the region's geography and markets, Colville can be visualized as a marble in a funnel. Forty miles to the north, and even beyond the Canadian border, there are no communities as large as Colville. Passes in mountain chains ranging north to south on both sides of Colville channel commerce from both east and west toward the town. However, like a marble in a funnel, Colville could capture and maintain the business that flows to it from three directions, if it does not allow its business to spill south through its funnel's spout to the much larger market 90 miles away in Spokane. In other words, in addition to other factors, Mount Carmel Hospital owes some of its success to its relatively strong geographic location.

Complementing its geographic position is the very strong feeling throughout the community that Colville's businesses, including Mount Carmel Hospital, can be and in some cases already are regional trade centers within their respective lines of commerce. In addition to being the seat of Stevens County, Colville has a larger and more stable economic and population base than other communities in the tri-county area of northeast Washington. The economic base of Colville and its immediate environment includes several major lumber and lumber-processing companies (about 600 employees in all), a large magnesium processing plant (490 employees), the Colville National Forest Service offices (315 to 450 employees, depending on the season), several state and northwest Washington agencies with responsibility for natural resources and social and health services (210 employees), and rail lines serving points west, north, and east, in keeping with the traditional flow of commerce.

As a regional trade center in this rural area, Colville has a growing industrial park, two grocery stores operated by major national chains, several car dealerships, a national card and gift shop, and two national fast-food restaurants. There are plans to construct a shopping mall and to expand the airport's runway in order to accommodate small corporate jets and four-engine propeller aircraft. The president of one of the two banks operating local offices in Colville indicated that the bank's market analysis of the region showed Colville to be, in many respects, a true regional trade center in spite of the town's small population of approximately 5,000.

However, the characterization of Colville as a regional trade center may become less indicative of potential future strength because, like many rural communities, its population is aging. Estimates developed by the Stevens County Office of Financial Management, shown in table 1, provide population projections to the year 2000.

Table 1 shows that the forecast is for continued growth of the county's population. However, there will be a decrease in the absolute number and percentage of those less than 34 years and an increase in older-age cohorts.

TABLE 1. POPULATION, 1980-2000
Stevens County

Age Cohort	1980	1990	1995	2000	% Change 1980-2000
[illegible]	10,684	10,263	10,289	10,199	-4.54
[illegible]	6,960	6,518	5,834	5,404	-22.3
[illegible]	4,843	7,011	7,735	7,845	61.9
[illegible]	3,526	3,293	3,593	4,403	24.8
[illegible]	2,966	3,568	3,653	3,687	24.3
Total	28,979	30,653	31,104	31,538	8.8

The State Environment

The state of Washington has 109 hospitals, of which 43 are rural according to the Washington State Hospital Association's classification. Between 1984 and 1990, there were approximately 16 closures in the state, 10 of which were associated with consolidations resulting from mergers.

A rural health commission, two members of which were from Colville, studied the issues of rural health in the state and made recommendations to the 1989 session of the state's legislature, resulting in several important pieces of legislation. The 1989 legislation affecting rural areas was part of a more comprehensive legislative effort to reorganize public health at the state level. A part of that reorganization, a new state Department of Public Health was created. Five specific pieces of rural health legislatio pertinent to hospitals were passed. They were:

1. The Rural Health Systems Project appropriated $450,000 for technical and limited financial assistance for 12 communi

ties as a means of ensuring "affordable basic health services" where these were at risk.

2. An alternative health care facility licensure model was passed, creating a mechanism by which small, rural hospitals could be downsized to centers for basic acute, emergency, and outpatient services. The regulations to implement this legislation are being written, following the 1989 federal Omnibus Budget Reconciliation Act's (OBRA's) regulations governing Essential Access Community Hospitals (EACHs) and Rural Primary Care Hospitals (RPCHs).

3. A loan-forgiveness program was established for rural providers, making $150,000 available in amounts up to $15,000 per year for physicians, nurses, and physician's assistants who practice in health professional shortage areas.

4. Standardization of nurse training was enacted. Although this law was not limited to rural areas, it directs the state's Higher Education Coordinating Board and others to develop a statewide plan for standardizing nurse training and education course content, and credit transfers and allowances between programs and for relevant work experience.

5. Cross-credentialing of rural health professionals, that is, the possibility of implementing a unified credentialing process for rural providers using multiple skills was to be studied by the Department of Licensing and others.

Other state initiatives will affect rural areas as well. For example, the Maternity Distressed Program identified 21 counties in need. This program will provide significant financial support for first developing and then implementing action plans for maternal health. The state has also given much public attention to its 400,000 underinsured or uninsured residents, many of whom live in rural areas.

The Washington State Hospital Association, state-level health officials, and rural health leaders worked well together in advancing the interests of rural residents and rural providers during the 1989 legislative session. Currently, the state environment demonstrates significant concern for, and action on, rural health care, although several hospitals in the state of Washington face very uncertain futures. Within this context, few rural hospitals, even in the relatively supportive general environment to which Washington state's actions contribute, have achieved the level of success enjoyed by Mount Carmel.

Mount Carmel Hospital

In the late 1930s and early 1940s, a group of Dominican sisters, fleeing the Nazi movement in Germany, settled in Colville, WA. In the early 1940s, the sisters purchased the old hospital, which had been founded in 1919. Through the goodwill of the sisters, Mount Carmel Hospital has long enjoyed a positive image in the community. With $222,664 in Hill-Burton support, the sisters moved Mount Carmel Hospital to its present location on a small hill a few blocks off Main Street in 1951. Through hard work, frugal administration, and not charging for their own time, the sisters eliminated the hospital's Hill-Burton debts, and positioned the hospital on what appeared to be a firm financial footing.

Mount Carmel Hospital was defined by our methods to be within a more competitive environment because Stevens County is contiguous with Spokane County immediately to the south. However, Stevens County is geographically quite large from north to south, so that Colville and most of the funnel to the north are not very near Spokane County.

Competition is also lessened by the fact that the hospital to the south of Mount Carmel, which controls the northern market of Spokane, is Holy Family Hospital (a 164-bed hospital that is part of the same system as Mount Carmel). Mount Carmel's other system-sister, St. Joseph's Hospital (24 beds in 1989), is about 45 miles north of Spokane in Chewelah, which is located approximately midway between Spokane and Colville. The location of these system-sisters between Colville and the larger, more competitive Spokane market helps buffer Mount Carmel from serious competition. At the same time, however, the presence of St. Joseph's Hospital to the south inhibits Mount Carmel's potential expansion in that direction.

Contrary to our data-based definition that Mount Carmel might face threats from a nearby urban area, the hospital now tends to see itself as the larger, more powerful competitor in markets barely controlled by weaker hospitals to the north, east, and west. Mount Carmel Hospital considers its principal competitors to be two major hospitals in Spokane, Sacred Heart Medical Center (631 beds) and Deaconess Medical Center (352 beds). Mount Carmel feels challenged but not threatened by this competition.

It is important to emphasize that the market security Mount Carmel currently enjoys is the result of a deliberate strategy to capture market areas that had previously been lost to the Spokane hospitals. Many people making up the funnel-shaped market that Mount Carmel now dominates had historically sought care in Spokane. Building on a reputation for clean and respectable but nonintensive medical care, and in cooperation with a strong group-based family practice, Mount Carmel has recently developed a regular series of clinics covering a broad range of specialties.

In the mid-1970s, a county-supported hospital also located in Colville was closed. However, although this institution did perform some surgery, it was in effect more like a nursing home. In the late 1970s, stimulated in part by a rapid influx of well-educated, young professionals, Colville and other communities in the area began to grow. Intercensus population estimates for Stevens County show an increase in population from 17,000 in 1975 to 28,000 in 1985, a rate of increase averaging 6 percent per year.

At the same time that a larger and more sophisticated population was expecting better medical care, state health planners were advocating increased regionalization and the potential elimination of rural hospitals. These forces inspired Colville's physicians to band together into a medical group practice that was committed to providing top-quality medical care and ensuring the community hospital's survival.

Mount Carmel Hospital's physical plant has been updated and expanded. In 1978, Mount Carmel received an $80,000 federal grant to help finance the expansion of the emergency department under a health initiative providing support to underserved rural areas. In 1988, the hospital received approval of a certificate of need (CON) for a $3.5 million expansion funded with $500,000 from local funds (reserves and fund-raising) and $2.5 million in low-interest loans through the Catholic Health Association. To be complete in 1991, this expansion involves remodeling the operating room, the intensive care unit

X-ray and lab, and outpatient services, and creating greater capacity for outpatient services.

Mount Carmel Hospital does not meet the criterion to be a sole community provider as defined by the Health Care Financing Administration (HCFA). In addition, the hospital has never participated in the swing-bed program. It was granted a three-year accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in 1988.

Table 2 provides utilization data for Mount Carmel from 1985 through 1989. In fiscal year 1989, Mount Carmel Hospital had 1,267 admissions and 4,889 patient days, resulting in an average length of stay (ALOS) of 3.86 days. It also had 10,739 outpatient visits, which included clinical outpatient visits, short-stay and day surgery, and 5,060 emergency visits. Figure 1 demonstrates the hospital's historical pattern of patient days and adjusted patient days. As both table 2 and figure 1 show, unlike most hospitals in the United States, Mount Carmel's patient days have increased rather than decreased.

Between 1985 and 1989, patient days increased 23.3 percent. There was a decrease in only one year, 1988. A smaller but important increase in the number of admissions also occurred. There was a substantial increase in the number of outpatient visits, which is reflected in the increase in adjusted patient days. The largest increase occurred in emergency department visits. The percentage of the hospital's total patient revenues derived from outpatient activities increased from 31.7 percent in 1988 to 37.2 percent in 1990.

In addition to Mount Carmel's increasing strength, the funnel shape of the hospital's service area can be illustrated by market share data. Table 3 compares patient origin data for all of Stevens County from 1985 through 1988 against 1988 patient origin data for the northern part of Stevens County only. One of the points made by the data is that the hospital has improved its market share in nearly all areas. In an attempt to strengthen its market share, Mount Carmel has recruited an orthopedic surgeon. The recent recruitment of a full-time radiologist and computed tomography (CT) services complement this

TABLE 2. UTILIZATION, 1985-89
Mount Carmel Hospital

Utilization	1985	1986	1987	1988	1989	% Change 1985-89
[illegible]	1,159	1,180	1,327	1,241	1,267	9.3
[illegible]	3,966	4,286	5,093	4,617	4,889	23.27
[illegible]	3.42	3.63	3.84	3.72	3.86	12.76
[illegible]	8,422	8,758	9,144	11,346	10,739	27.51
[illegible]	5,980	6,199	7,348	7,015	7,447	24.53
[illegible]	3,486	3,405	4,294	4,475	5,060	45.15

FIGURE 1. PATIENT DAYS, 1985-89
Mount Carmel Hospital

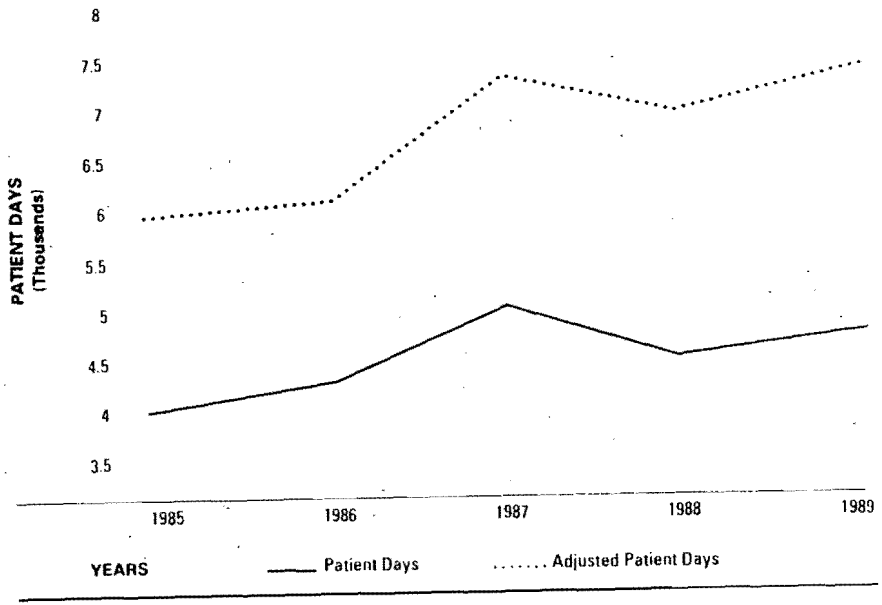


TABLE 3. MARKET SHARE DATA, PERCENT OF ADMISSIONS 1985-89
Mount Carmel Hospital

Product Line	All of Stevens County 1985	1986	1987	1988	Northe Stevens Coun 19
[illegible]	33	32	40	42	
[illegible]	26	31	31	34	
[illegible]	37	32	36	40	
[illegible]	41	43	49	54	
[illegible]	14	16	12	12	
[illegible]	30	28	29	32	
[illegible]	24	18	25	18	
[illegible]	16	21	17	17	
[illegible]	32	33	37	39	

effort as well. One of Mount Carmel's other notable areas of weakness is mental health. However, the hospital has no immediate plans to target this market, because patients are currently seen and evaluated by Stevens County Mental Health Services.

Local Physicians

In the most objective terms, Colville is the dominant community within the tri-county region, and Mount Carmel Hospital has been aggressive and very successful in making the most of the community's strengths. For example, Mount Carmel has been very successful in mobilizing community support. During the site visit in Colville, an impressive degree of commitment and cooperation among the hospital, the local community of physicians, and the community at large was evident. Indeed, if one word could summarize Mount Carmel's most effective success strategy, the word would be "integration."

The hospital and the community's only group practice are physically adjacent and engage in various cooperative arrangements. The physicians own and manage their own building. However, there is every appearance of a single medical campus. This appearance is enhanced by similar brick facades on the hospital and clinic. The medical campus also includes a nursing home, but its level of integration is more limited. At the time of the site visit, the town had eight family practitioners, two internists (one of whom was certified in gastroenterology), two general surgeons, one ophthalmologist, one physician assistant, and one nurse practitioner. Of these, only one of the family practitioners and the ophthalmologist were not associated with the group practice. The hospital-group practice alliance has added a radiologist since the site visit. All the physicians are board-certified.

The integrative relationship between the hospital and the medical group practice has been a driving force in enhancing the reputation of the hospital as a regional referral center capable of intensive treatment and performing high-quality services. Although efforts to educate local consumers about the scope of services available at the hospital have yet to achieve their maximum potential, local people are reported to be much less likely to drive 90 miles to Spokane than they were before.

Current construction for the expansion of the hospital's outpatient services brings the hospital and clinic even closer to each other. The visual imagery of this medical campus serves as a kind of metaphor for one of the integration problems that was noted by several interviewees: local consumers sometimes fail to distinguish between the hospital and the physicians' group practice. This can be problematic when a patient has a negative experience with a physician, the clinic, the hospital, or, to a lesser extent, the nursing home, and generalizes that feeling to the other components of the local medical community. It may also encourage patients to believe that the best way to access a physician's routine services is through the hospital's emergency department.

As noted earlier, Mount Carmel had long enjoyed a positive relationship with the community by providing caring and personal services. However, it did not have a reputation for being able to provide sophisticated or intensive services. In 1975, the chief of Mount Carmel's medical staff, who was also a leading local physician and active in observing state politics, unified most local physicians into a single group practice in response to the development of the regional medical program and state health planning. At the time, it was felt that state health planning and the federal government favored increased regionalization and the elimination of many small, rural hospitals. This physician unification sought to increase the physicians' local political power and permit them to have a more active role in the hospital's future. Also at the time, the physicians were all family or general practitioners. The centralization of almost all local physicians into the single group practice provided a firm foundation for additional recruitment. By 1977, the group included a surgeon and an internist. These first steps in developing a large physician group practice that was closely aligned with the hospital set the stage for much of Mount Carmel's more recent success.

One of Mount Carmel's key strategies has been to participate in the mutual development and management of interdependencies with the group practice in ways that advance the interests of both. For example, in physician recruitment the hospital typically contributes funds in the form of income guarantees and participates in the administrative, managerial, and marketing aspects of the recruitment process. Since 1985, the hospital-group practice alliance has successfully recruited two general surgeons, two family practitioners, an ophthalmologist, two internists, a radiologist, and an orthopedist. As a second example, the hospital's emergency department is covered 24 hours a day, 7 days a week by family practitioners from the group practice. They receive the nominal pay of $4.00 per hour and do their own billing for emergency services. And, in cooperation with the physicians, Mount Carmel Hospital houses a residency program in family practice. For second- and third-year students, the residency typically lasts three months. Together, the hospital and the group practice have also managed a variety of visiting specialty clinics to complement the relatively rich base of full-time local medical expertise. The hospital's consulting medical staff includes the following: a family practitioner, general surgeon, an orthopedic surgeon, a urologist, a pathologist, a plastic surgeon, two otolaryngologists, eight pathologists, and nine radiologists. At the time of the case-study visit, a cooperative arrangement between the hospital and the group practice to recruit a full-time orthopedic surgeon had just failed due to immigration problems. The hospital and the group practice have continued the search for an orthopedic surgeon after having successfully recruited a radiologist.

As another example of this cooperation, in 1990, the hospital purchased several pieces of imaging equipment, including mammography, CT, and a new X-ray unit to replace the old one the physicians had been using. The hospital leased space for this equipment in the group practice's building. Both groups have benefited from the arrangement. The physicians bill for their services related to the equipment, earn money on the lease, and keep their patients in town; the hospital earns money on the use of the equipment, maintains good relations with the physicians, and keeps the patients in town.

Relationships with the System

Dominican Health Services of Spokane exists within the corporate structure of the Dominican Network, the not-for-profit corporation to which Dominican Health Services, Holy Family Adult Day Health Center, and Dominican Health Investment Corporation are affiliated. It originates from

Dominican order of sisters that settled in Colville prior to World War II and later moved to Spokane. Mount Carmel is one of three hospital units within Dominican Health Services of Spokane. Mount Carmel gains certain advantages from being a member of Dominican Health Services, such as group purchasing, data-processing services, less expensive insurance coverage, financing, shared management educational programs, and other benefits from the Catholic Health Association and Catholic Health Corporation. For example, the recent tax-exempt bond issue that provided $3 million to Mount Carmel for the major physical expansion mentioned previously was part of a $19 million bond package that also provided $11 million to Holy Family Hospital in Spokane and $5 million to St. Joseph's in Chewelah.

Some less obvious advantages have been gained as well. Mount Carmel has been able to generate and retain local nonsystem resources, which, in turn, have enabled the hospital to negotiate on relatively equal terms with the system in order to advance local interests. Working and negotiating with the system has forced the hospital's administration, trustees, and medical staff members to see the "big picture," which has enhanced Mount Carmel's approach to strategic planning.

As part of its efforts to develop and maintain a wide range of services through specialty clinics, Mount Carmel has developed informal arrangements with Sacred Heart Medical Center in Spokane. Sacred Heart is also a major competitor of Holy Family Hospital, the largest hospital in Dominican Health Services. Mount Carmel's strategy is one of developing strong relationships with several large hospitals in order to limit the potential for aggressive competition. In the case of Mount Carmel, physical distance, system protection, and its relatively good control over much of its own market appear to contribute to the success of its linkages with larger hospitals.

Mount Carmel has developed a position of strength within the system. Not only is it able to control its own market, it has demonstrated its value to the system. For example, for several years Mount Carmel provided linen service, data processing, and an ultrasound machine to St. Joseph's Hospital in Chewelah, when the latter was especially pressed for help.

Partly in response to the need to ensure a more powerful basis for local authority, Mount Carmel has established the Mount Carmel Hospital Foundation for channeling local economic support to capital purchases. Local, direct fund-raising campaigns generated between $4,010 and $16,065 every year from 1984 through 1988. In 1990, the foundation began an ambitious campaign to raise $200,000 to buy surgical equipment. As outlined by a local businessman serving as president of the foundation, the campaign seeks 50 percent from major employers with local interests, 25 percent from local businesses, and 25 percent from individuals. There has been excellent employee support.

Even before the foundation came into existence, the support Mount Carmel was able to generate from local interests proved decisive in a key struggle for control with system headquarters in Spokane. The system's three hospitals are controlled by the single board of Dominican Health Services, which had installed a chief executive who sought to centralize all administrative and data management functions in Spokane. Mount Carmel Hospital was active in expanding the board's geographic representation to make it regional. A representative from the Colville area now serves as chairperson. By building effective and broad-based support throughout the region, the local faction was able to squelch attempts at centralization and, some would argue, ensure the removal of the system's chief executive.

Management

In keeping with Mount Carmel's strategy of integration, several other actions help illustrate decisions that may be contributing to the hospital's relative success. In 1983-84, when the hospital had experienced consistent if not precipitous drops in its daily census, and the local economy faced its darkest days, the hospital eliminated dietary services, obtaining them from the nearby nursing home. This reduced the hospital's overhead but, perhaps more important from a strategic point of view, created a win-win interdependency that has allowed services in both institutions to improve while reducing the degree of duplication in support services for the local health care system.

From a cost reduction standpoint, the hospital's methods of staff reduction during this crucial era were perhaps of equal importance in developing and maintaining a high degree of local community support. Mount Carmel used "last in, first out," across-the board layoffs, except for highly skilled nurses. In preparing for and implementing these changes, the hospital took great care to explain its situation to the staff and the community before actually cutting staff. It conducted job placement sessions and activities during the preparation phase for downsizing. The hospital also provided assistance in completing unemployment benefit applications, whenever appropriate. While employing these methods of reducing the suddenness and impact of changes in staffing levels, the hospital also implemented staffing by acuity and flexible staffing.

During this period, the hospital closed its entire third floor. In addition to accommodating the new and lower staffing levels, this helped to increase efficiency and decrease patient-call response times by concentrating patient rooms into a smaller space.

An important engine for these changes during the "dark days," and for many of the changes that followed, was a more decentralized decision mechanism based on relatively formal strategic planning. During this time, the administrator was often characterized as an "external change agent," someone capable of breaking the institution and its people out of the inertia in which they found themselves.

A very important part of the strategic planning process as it came to life at Mount Carmel Hospital was the implementation and use of DRG analyses. In 1982, more than a year before being phased into prospective payment, Mount Carmel's chief financial officer was producing reports detailing the costs of care for groups of patients, organized by DRGs and an attending physician. In large part, Mount Carmel has succeeded because it has responded strategically to imminent problems before they became crises.

Although that administrator has subsequently left, Gloria Cooper, head of the present administration, has capitalized on those strategies. Today, the hospital is more stable, confident, and forward-looking. She started as a telephone operator in 1974, served as assistant administrator from 1979 to 1985, and became the hospital's chief executive officer (CEO) in 1985. Although she has no formal degree in health management, she is currently enrolled in a program in communi-

cations and administration, and is active in local, state, and national organizations.

She uses a highly decentralized and strategic planning approach to setting the hospital's directions. This approach has proved very successful at Mount Carmel, as evidenced by the fact that virtually everyone interviewed was eager and able to describe the key components of the strategic plan: recruiting an orthopedic surgeon and a radiologist, finishing the current expansion and incorporating those changes into better outpatient capabilities, arranging new efficiencies through cooperation with the medical group practice, and continuing to capture ever larger portions of the northern Stevens County patient market.

Although the CEO is the chief decision maker, other administrative staff have been given substantial responsibility for working with department heads. In turn, department heads have been given significant authority for monitoring their unit's performance and developing unit-level plans for improvement.

Ms. Cooper's ability to communicate with people extends outside the hospital. People with little association with the hospital or with little knowledge of health care issues can also verbalize an understanding of the hospital's current status and directions. Integration with the community has been achieved. On a personal basis, she is the first and only woman chairperson of the Colville Chamber of Commerce. She is one of only two women serving in the local Rotary Club, another important locus of community power in the area. In addition, she has conducted a radio program seeking comments, good and bad, about the hospital and its services, providing live responses to callers.

Community Integration

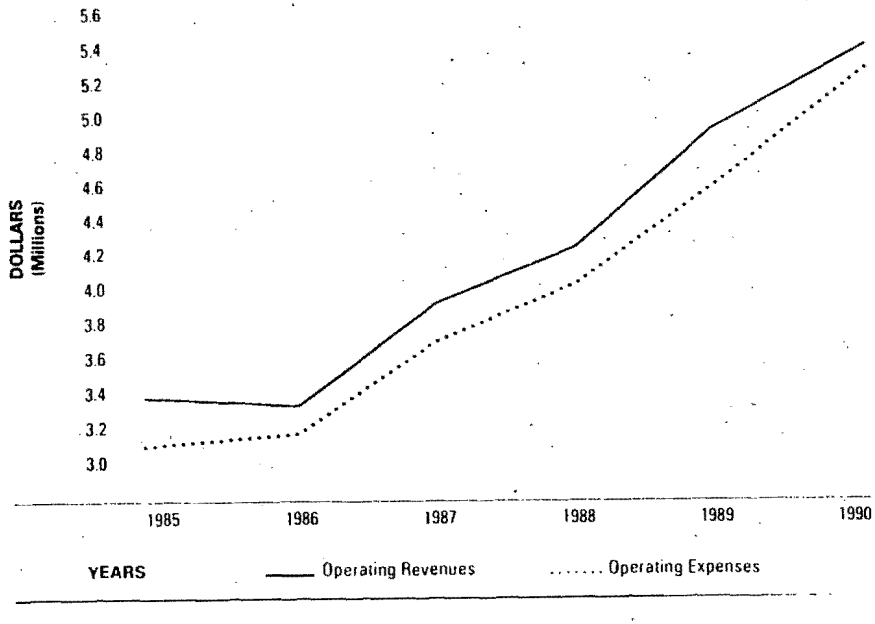
This strong community orientation was reflected many times by individuals with no vested interest in the hospital who referred to it as a "good neighbor" or a "good citizen in the community." Some of the circumstances that fed this network of support for the hospital have been mentioned previously: the long-standing goodwill between the town and the Dominican sisters; the hospital's downsizing effort; the hospital's importance in the regional system of trade; the strength of the ties between the medical group practice and the hospital; and the expansion of services, first through specialty clinics and then through bringing new physicians into the group practice. Some specific programs have given even more tangible proof to the community that Mount Carmel cares, and cares for it well.

Contrary to the much-publicized retreat from obstetrical care in rural hospitals, Mount Carmel, with the cooperation of several family practitioners, has emphasized the provision of high-quality obstetrical services as a signal to the community of its full-service capabilities. Market research from 1988 indicates that Mount Carmel Hospital has 76 percent of the northern Stevens County cases in maternal and child health. For all of Stevens County, the southern half of which is nearer Spokane than Colville, Mount Carmel is estimated to be capturing 29 percent of the obstetrics discharges. The hospital had one of the first birthing rooms in the state, and its obstetrics program includes a specially trained RN who helps provide prenatal care, gives prepared childbirth classes, is present for labor and delivery, and follows up after delivery to ensure the coordination of care. As part of this emphasis, the hospital has a contractual arrangement with the Northeast Tri-County Health Department to care for low-income obstetrical patients, which serves to enhance the hospital's image as a caring institution and also to garner support from and cooperation with the Tri-County Health Department in other areas.

Expanding on their role as the regional locus for health care, the local physicians and Mount Carmel Hospital serve as the primary resources for the NEW (North East Washington) Health Programs, which are sponsored by the Northeast Tri-County Health Department. Among other activities, the NEW Health Programs operate home health services throughout the area and satellite clinics in towns 18 and 35 miles north and 10 miles west of Colville. These "feeder clinics," staffed by registered nurse practitioners and physician's assistants, operate under the supervision of the nearby medical group's physicians and with substantial cooperation by the hospital. The Tri-County Health District's offices are in Colville and its chief health officer is also Mount Carmel's chief medical staff.

Mount Carmel Hospital sponsors a wide range of educational and health screening activities as part of its efforts to maintain and enhance a good relationship with the community. Among such activities are blood pressure and cholesterol screenings at the supermarket and other locations where people tend to congregate, the annual Fun Run, and exercise and education classes for diabetics. In addition, physicians in the group practice have been volunteer instructors at the local high school for years, and either a physician or a physician's spouse has been the school board for as long as anyone can remember.

FIGURE 2. OPERATING REVENUES AND EXPENSES, 1985-90
Mount Carmel Hospital



Financial Performance

The hospital has had successive years of financial gains. As figure 2 shows, the hospital's revenues and expenditures have tracked one another, with revenues consistently being higher than expenditures.

Figure 3 presents total profits, broken down by operating and nonoperating profits. As indicated, the hospital's profits have been fairly consistent. However, the percentage of the total profits coming from the nonoperating revenues has increased since 1985.

Figure 4 demonstrates the hospital's trends regarding deductions from patient revenues. As indicated, deductions have increased considerably (from $306,150 in 1985 to $1,955,429 in 1990). The stacked bars reveal that most of this increase has come in the form of third-party allowances as more and more payers are demanding deductions from full charges. Though uncollectibles and charity have grown, they have not been the driving force behind the increase in deductibles.

Table 4 presents selected financial ratios for the hospital for the years 1985 through 1990. In terms of profit-oriented ratios, the operating margin has been variable but strong, especially in comparison with the median for small hospitals in the far west. However, as indicated previously, the amount of deductibles, mainly third-party contractual adjustments, has increased each year. The hospital's return on equity has fluctuated over the years but has been consistently above 5 percent.

FIGURE 3. PROFITS, 1985-90
Mount Carmel Hospital

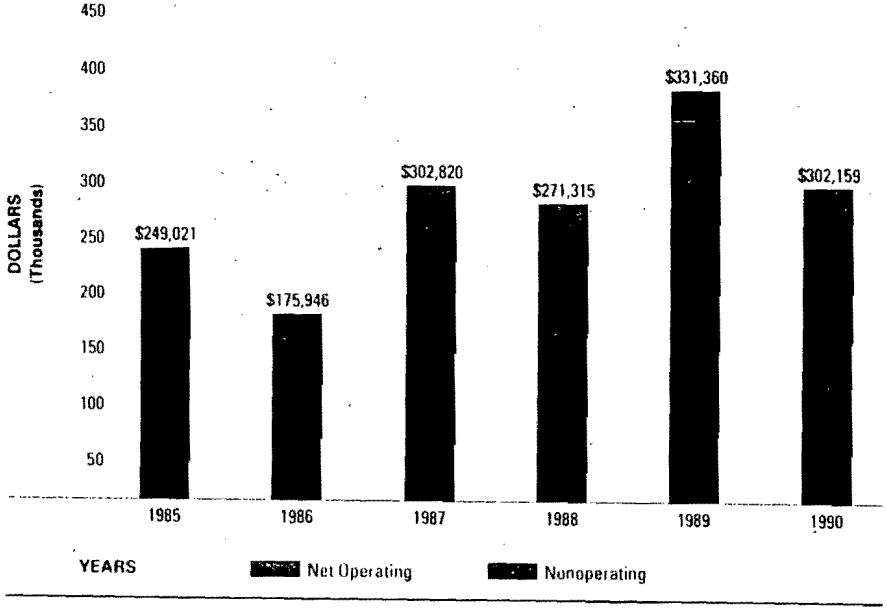


FIGURE 4. DEDUCTIONS, 1985-90
Mount Carmel Hospital

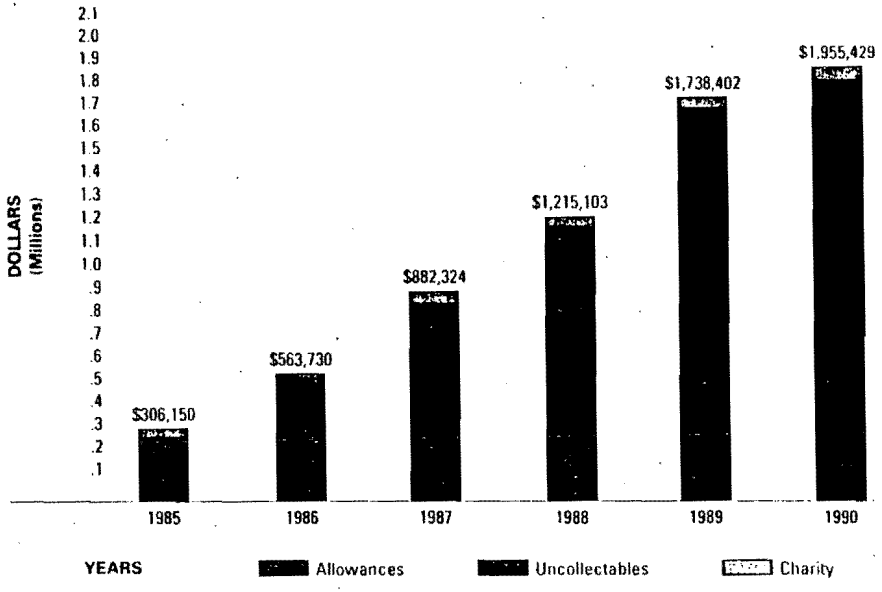


TABLE 4. FINANCIAL RATIOS, 1985-90
Mount Carmel Hospital

Financial Ratio	1985	1986	1987	1988	1989	1990	Median*
[illegible]	0.061	0.035	0.065	0.047	0.057	0.034	0.016
[illegible]	0.085	0.148	0.184	0.223	0.263	0.270	0.161
[illegible]	0.085	0.056	0.088	0.073	0.093	0.068	0.076
[illegible]	2.987	2.476	2.756	3.138	3.314	1.568	2.275
[illegible]	0.909	0.492	0.589	0.016	0.548	0.552	0.422
[illegible]	0.900	0.897	0.907	0.903	0.909	0.475	0.546
[illegible]	1.015	0.936	1.036	1.037	1.084	0.580	0.984

**Median is for hospitals in the far west region with fewer than 100 beds in 1986. William O. Cleverley.* Hospital Industry Financial Report, 1982-1986. *Westchester, IL: Healthcare Financial Management Association, 1987.*

n terms of liquidity r[illegible]he hospital's urrent ratio has increased yearly except for he most recent year. Consequently, the total ssets have more than doubled. The acid test atio is an indication of the hospital's cash nd marketable securities in relationship to ts current liabilities. This ratio has been olid except for 1988 when the hospital had bnormally low cash on hand.

The equity financing ratio indicates the ttractiveness of the institution in assuming dditional debt. Here again, the hospital's atios were very positive until 1990 when the hospital acquired new debt for its current enovation project.

The total asset turnover ratio is an indicator f the hospital's efficiency in using its assets. gain, the hospital's ratios are very positive. The only change occurs with the construction n 1990.

Mount Carmel's financial profile is one of a ospital that has been solid, but has not been fraid to invest in new construction in order o retain market share. It has not been overly onservative or liberal in its financial ondition.

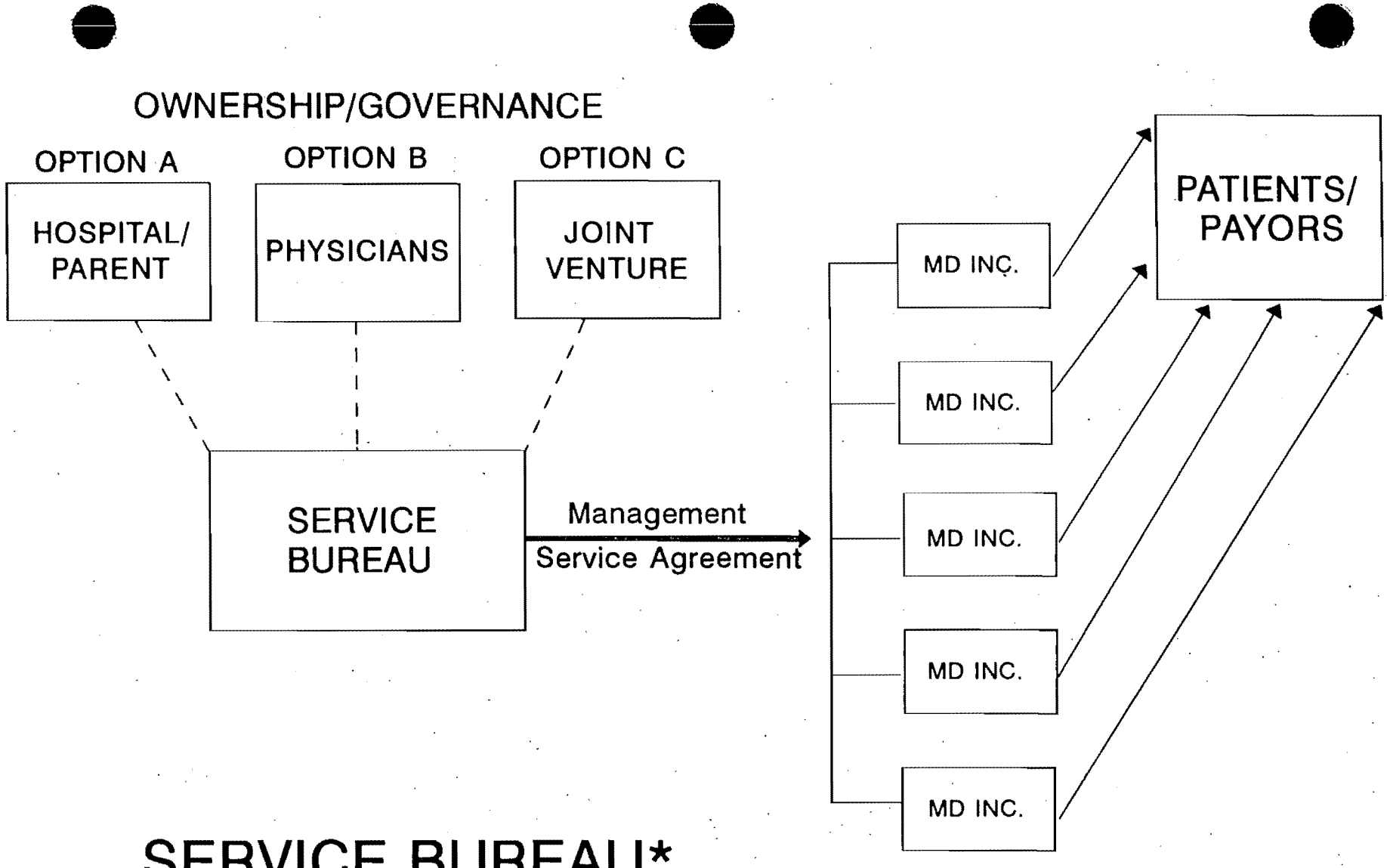
Summary

Integrative relationships form the centerpiece of Mount Carmel's success. From the hospital's beginnings to its relationship with the medical group practice and the community in general, this case exemplifies the power of broad-based, local cooperation. Geographic location and system affiliation have clearly strengthened the hospital's position; however, it's the hospital's strategy of integrating itself with the physicians and the community that has indeed made it a stable provider of medical care services in rural Washington.

CHARACTERISTICS OF SUCCESSFUL RURAL HOSPITALS UNDER 50 BEDS

- CEO FOSTERS RESPONSIBILITY WITHIN THE COMMUNITY TO INFLUENCE THE HOSPITAL'S FUTURE
- STRONG WORKING RELATIONSHIP WITH ONE PHYSICIAN GROUP PRACTICE
- HOSPITAL/PHYSICIAN RELATIONSHIPS CHARACTERIZED BY:
  - SACRIFICE OF SELF INTEREST TO REALIZE MUTUAL SUCCESS
  - PRIMARY CARE PHYSICIANS WITH SIGNIFICANT SAY ON TECHNOLOGY DECISIONS
- INCREASED OUTPATIENT CAPACITIES
- SERIES OF OUTREACH SPECIALTY CLINICS
- GENUINE COMMUNITY FOCUS; DEVELOPMENT OF COMMUNITY LOYALTY
- COHESIVE AND VISIBLE GROUP OF COMMUNITY LEADERS
- FISCALLY CONSERVATIVE - ONLY SIMPLE DIVERSIFICATION
- NURSING STAFF HIGHLY RESPECTED BY PHYSICIANS
- DECENTRALIZED DECISION MAKING; DEPARTMENT HEADS WITH SIGNIFICANT AUTHORITY

SOURCE: The Strategies and Environments of America's Small Rural Hospitals. Hospital Research and Educational Trust, AHA, 1992.

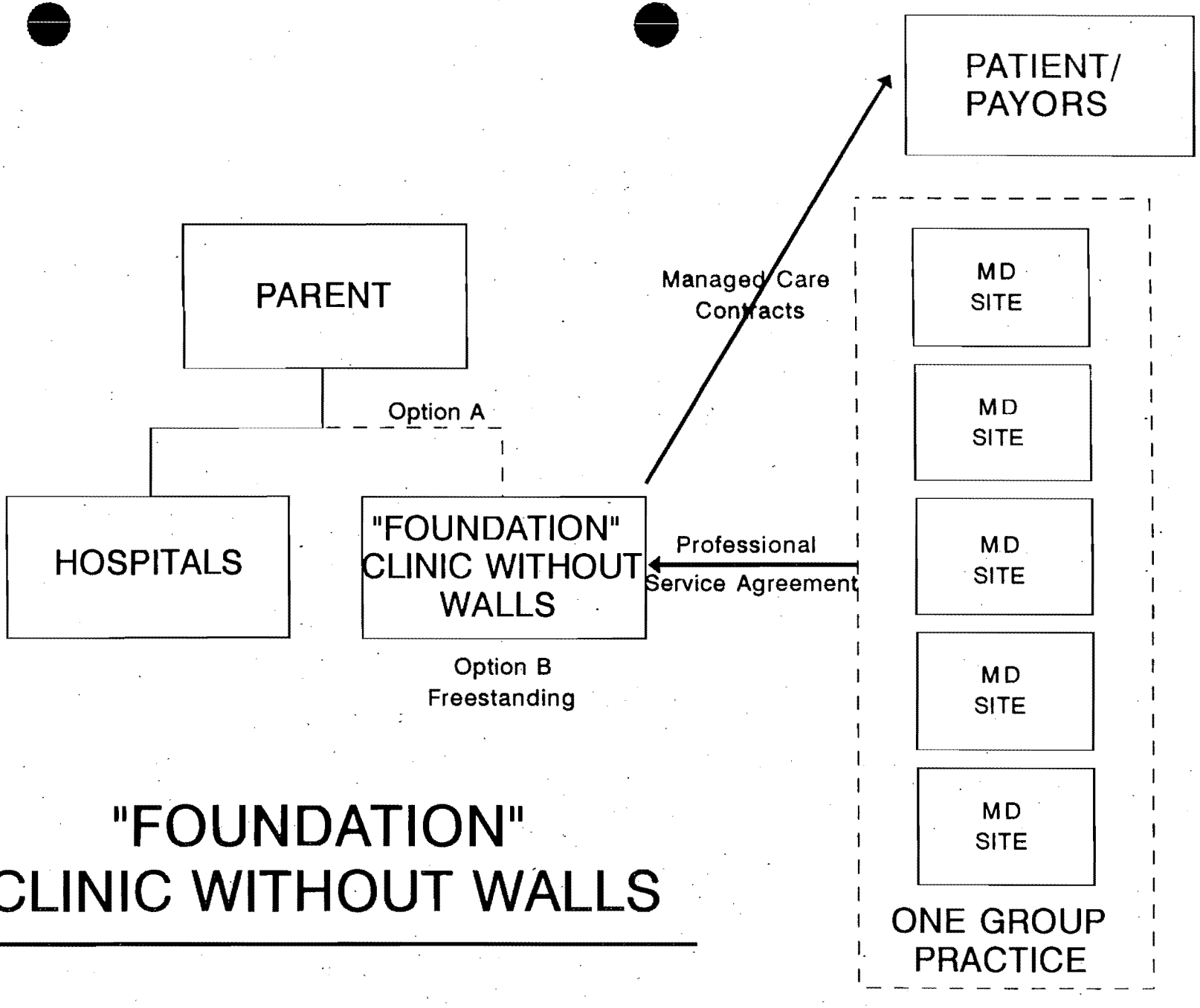


SERVICE BUREAU*

*Also known as a Management Service Organization - MSO

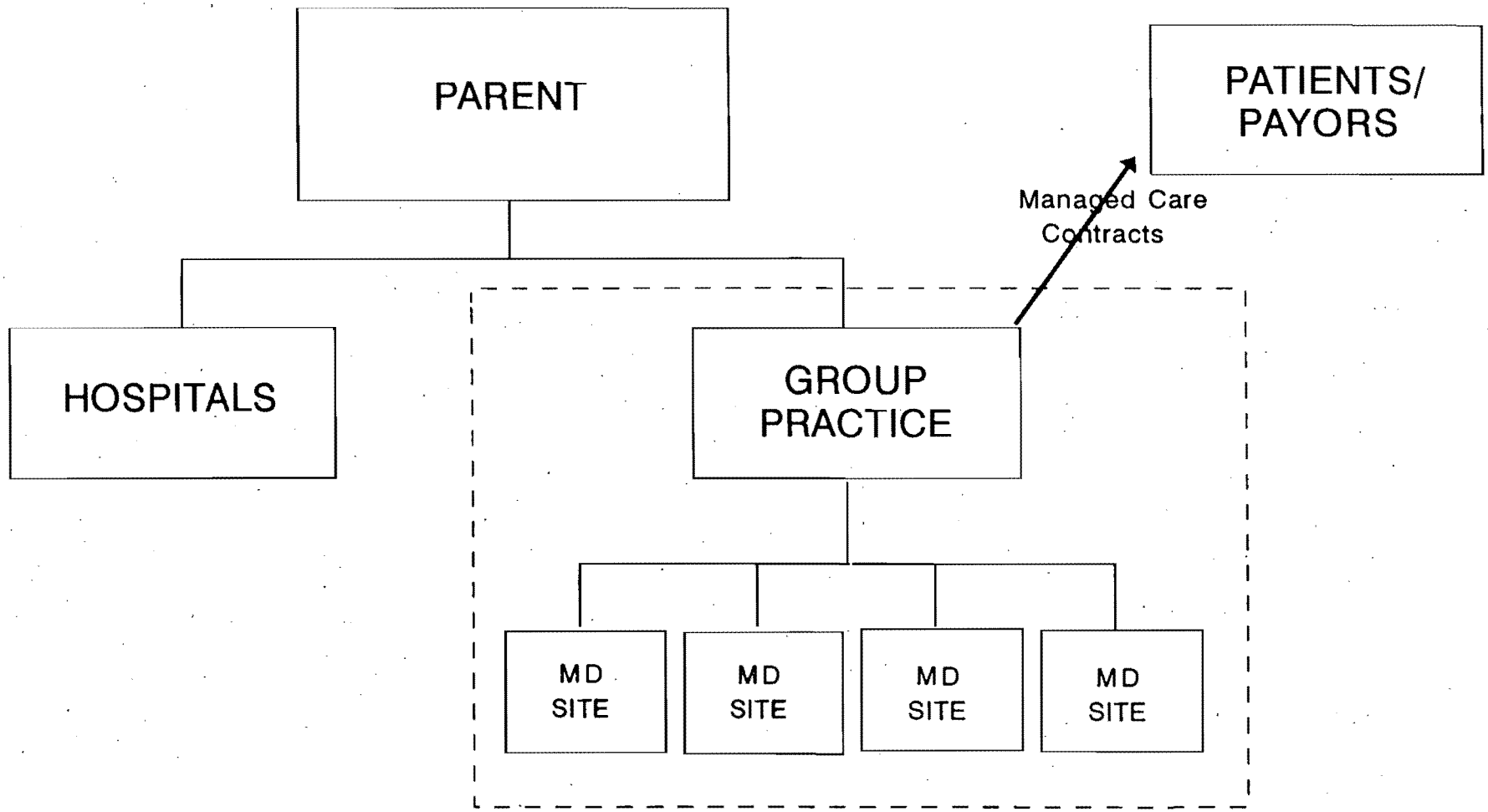
Source: John B. Coombs, M.D., 1993

ATTACHMENT III



"FOUNDATION" CLINIC WITHOUT WALLS

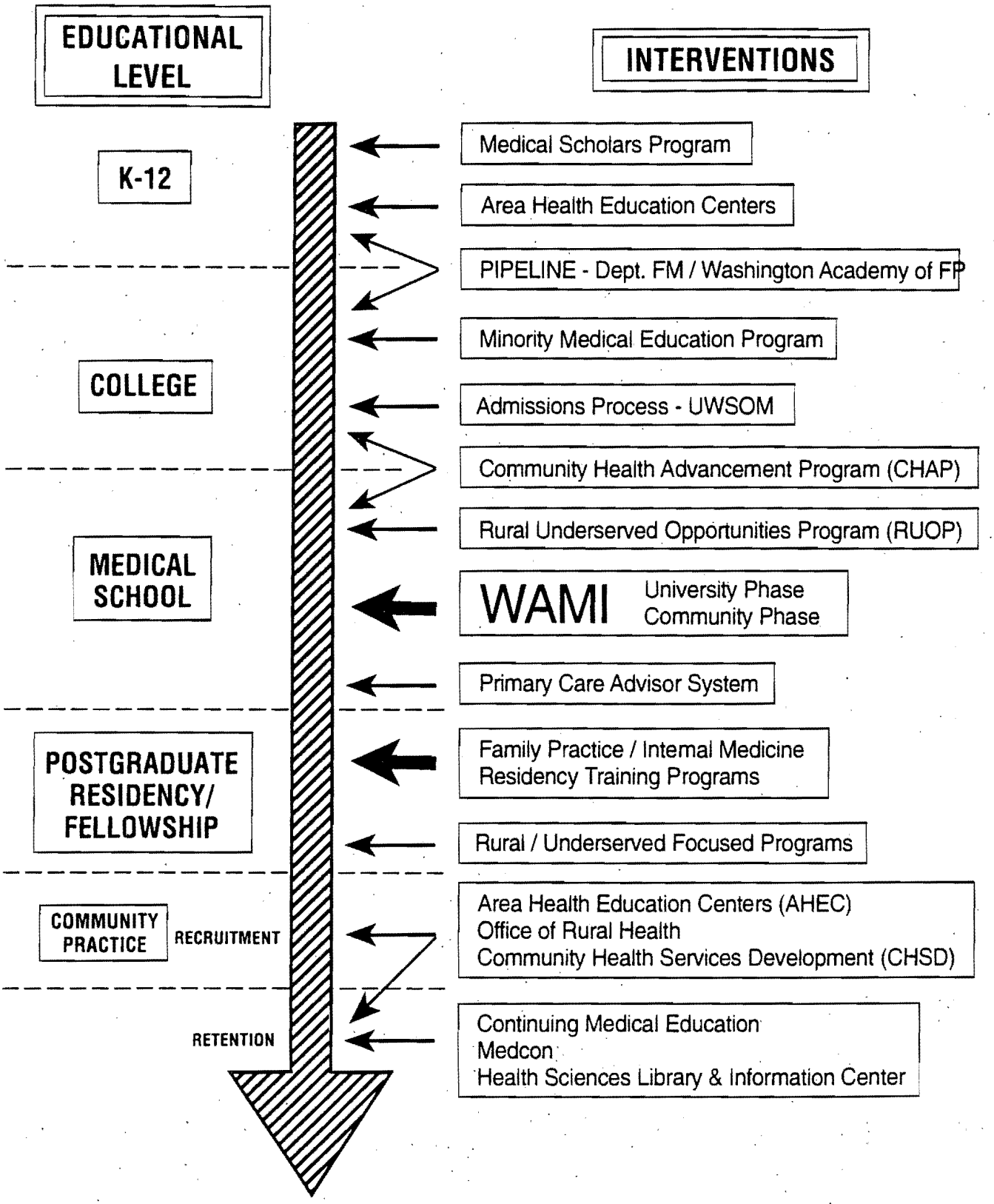
Source: John B. Coombs, M.D., 1993



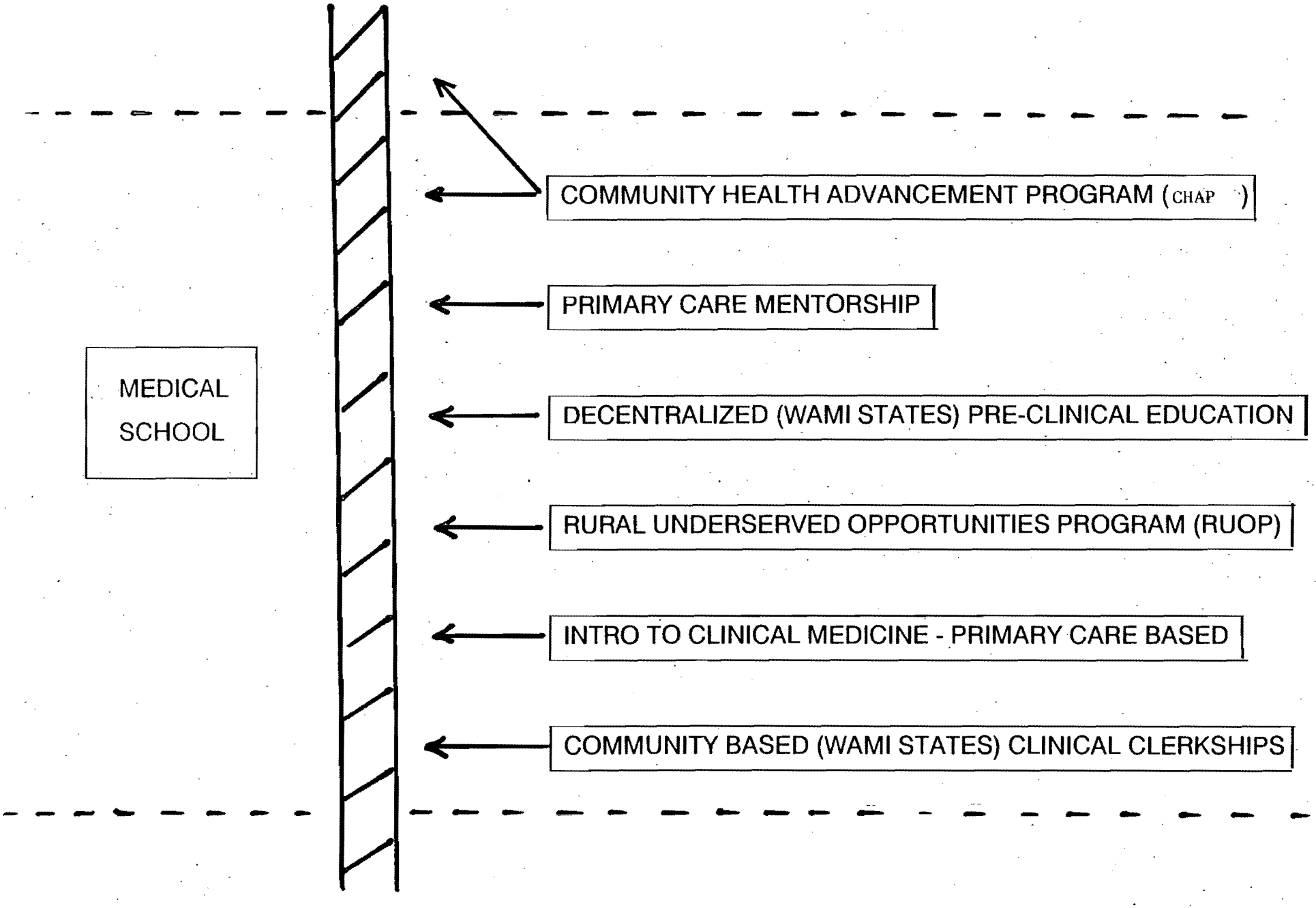
HOSPITAL-AFFILIATED GROUP PRACTICE

Source: John B. Coombs, M.D., 1993

TARGETING PRIMARY CARE THROUGH WAMI PARTNERSHIPS



GOAL Assuring Adequate Numbers and Distribution of Primary Care Physicians


MEDICAL SCHOOL
COMMUNITY HEALTH ADVANCEMENT PROGRAM (CHAP)
PRIMARY CARE MENTORSHIP
DECENTRALIZED (WAMI STATES) PRE-CLINICAL EDUCATION
RURAL UNDERSERVED OPPORTUNITIES PROGRAM (RUOP)
INTRO TO CLINICAL MEDICINE - PRIMARY CARE BASED
COMMUNITY BASED (WAMI STATES) CLINICAL CLERKSHIPS

PANEL 3

STATE ROLES

Panelists:

Dan E. Beauchamp, Ph.D.
Professor
State University of New York
Albany, New York

James Bernstein
Director
North Carolina Office of Rural Health
Raleigh, North Carolina

Denise Denton
Executive Director
Colorado Rural Health Resource Center
Denver, Colorado

Incoming Pres. of Nat. Rural Health Conf.

Charles McGrew
Director
Section of Health Facility Services and Systems
Arkansas Department of Health
Little Rock, Arkansas

Sally Richardson
Director
West Virginia Public Employees Insurance Agency
Charleston, West Virginia

Materials:

- Discussion Questions

Panel 3: Issues Relating to Roles for State Government

1. What are the most effective ways for states to stimulate rural network formation? How can existing capacity-building programs be incorporated into a managed care system reimbursed under capitated rates?

   In many states, there is a minimal infrastructure available to support managed care systems in rural areas. Existing health plans and providers will need support to develop rural provider networks that can serve as the foundation for health reform initiatives in rural areas. What specific types of support will be useful? Some rural areas have existing cost-based programs (e.g. CHCs, RHCs, RQHCs, MHCs) that meet the health care needs of vulnerable rural populations such as the poor, migrants, and individuals living in frontier areas. How can these programs be blended into a managed care system?

2. How aggressive should states be in enforcing antitrust laws when considering rural network formation? Will state action immunity be a successful strategy for permitting joint ventures that improve access and contain costs for rural populations?

   In recent years, enforcement of anti-trust laws has reduced joint venture opportunities among providers. Does antitrust enforcement promote access and contain costs or represent a threat to the availability of services in rural communities? Several states are planning to use state action immunity to provide relief from anti-trust laws for appropriate joint ventures. Will this strategy be successful and how will states ensure that the public's interests are met in situations involving the award of exclusive franchises? Who should have the specific responsibility for developing and implementing rules for exclusive franchises?

3. What role should the state play in collecting and disseminating health care information to the public? How will the special considerations of rural environments (e.g. low volume, relevant comparison groups, interest in patient referral process) be addressed?

   It is difficult and potentially expensive to adequately inform the average person about the cost, quality, and accessibility of health care available in local markets. Several states have developed data commissions that have entered into partnerships with private groups to collect and disseminate health data. Information collection and dissemination may need to proceed differently in

rural areas. Rural providers who treat limited numbers of patients with particular diagnoses may need to be compared with providers in similar environments rather than the "typical" provider with access to a broader range of resources. These issues need to be considered explicitly or rural consumers may be misled by the health care information made available to them.

4. How will a federally determined global budget be allocated to the states? Would budgets be based solely on historical expenditure levels, which have typically been lower on a per capita basis in rural areas? What role should states play in implementing and enforcing budget limits?

If a global budgeting approach is implemented, perceived inequities in the existing system could be incorporated into the new system. Any approach that depends solely on historical expenditure or payment data is likely to raise concerns in rural areas. What other kinds of factors need to be considered in allocating budgets to rural providers and areas? Would budgets include public dollars that flow to categorical programs, subsidies to attract providers to undeserved areas, and costs associated with capacity building and infrastructure improvements?

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DRAFT

Networking for Rural Health

The Essential Access Community Hospital Program

ALPHA CENTER

MARCH 1993

DRAFT

Networking for Rural Health

The Essential Access Community Hospital Program

Daniel M. Campion
Deborah J. Lipson
Robert M. Elliott

A Report from the
Technical Resource Center on
Alternative Rural Hospital Models

Alpha Center
Washington, DC

March 1993

Supported by a grant from
The Robert Wood Johnson Foundation

Table of Contents

DRAFT

Introduction

Viable alternatives to the traditional acute care hospital for delivering essential health care services in rural communities are critically needed. In sparsely populated areas, smaller hospitals often find it difficult to meet both state licensure regulations and the federal Medicare program's conditions of participation. These facilities need greater regulatory and financial flexibility in order to cut back on the provision of costly acute inpatient care services, which require specially trained personnel and expensive equipment, and to focus on the provision of primary care, emergency care, and lower-acuity inpatient care services. Because not all services can be provided locally, regional networks are needed to better assure access to higher levels of care provided at full-service hospitals in larger communities.

The Alpha Center has established a Technical Resource Center on Alternative Rural Hospital Models under a grant from The Robert Wood Johnson Foundation. In its first year of operation, the center's primary focus has been to assist the seven states participating in the federal Essential Access Community Hospital (EACH) Program. The EACH Program is a joint federal-state effort to assure the availability of primary care, emergency services, and limited acute impatient services in rural areas where it is no longer feasible to maintain full-service hospitals. The Health Care Financing Administration's Office of Research and Demonstrations manages the EACH Program which includes the following seven states: California, Colorado, Kansas, New York, North Carolina, South Dakota, and West Virginia.

HCFA has awarded over $17 million in grants to both states and facilities participating in the EACH Program. The funds support state efforts to develop rural health plans and designate facilities as either EACHs or Rural Primary Care Hospitals (PCHs). Grants made to facilities cover their costs to convert to EACHs and PCHs and form "rural health networks."

Federal and state officials asked The Robert Wood Johnson Foundation to support the development of the Technical Resource Center. This public-private collaboration represents the first time the Foundation has provided technical support for the grantees of a federal program. The Foundation has undertaken this unique collaboration because of its strong commitment to support alternative models for strengthening the health care delivery system in rural areas.

The primary objectives of the Technical Resource Center are: first, to facilitate interaction and communication among project directors of the EACH Program and provide a forum for the exchange of information and ideas between state grantees; and second, to provide technical assistance on the organization of rural health networks and the development of EACH and PCH facilities. In developing the Technical Resource Center's workplan, the state project directors and hospital association officials from the seven states were asked to identify and rank their major technical assistance needs. The key needs identified through this process include:

- guidance in interpreting HCFA's program rules,
- avoiding violations of antitrust law,
- developing emergency medical services plans and protocols,
- assuring quality of care in PCH facilities,
- developing sound financing strategies,
- defining admissions criteria for PCH's,
- linking facilities through telecommunications,
- using effective community education strategies.

The Alpha Center conducted a workshop for federal and state officials responsible for implementing the EACH Program on January 14-15, 1993 in Baltimore, Maryland. The meeting included four major sessions on key technical assistance topics: Organizing Regional Emergency Medical Systems, Antitrust Issues for Rural Health Networks, Options for Financing Alternative Rural Hospitals, and Community Education and Decision-Making. The workshop also provided opportunities for the states to report on their

efforts to implement the program and for HCFA officials to address specific questions posed by the states in advance of the meeting.

This report on the Essential Access Community Hospital Program has six parts. The first article provides an overview of the EACH Program, including a description of the facility criteria for EACHs and PCHs and a discussion of some of the program's major implementation challenges. The next four articles summarize the four major sessions from the January workshop on organizing emergency medical services, antitrust, financing, and community education and decision-making processes. The final section provides a profile of the EACH Program in each of the seven participating states.

For further information about the EACH Program or the Technical Resource Center on Alternative Rural Hospital Models please contact the Alpha Center at 1350 Connecticut Avenue, N.W. Suite 1100, Washington, DC 20036.

EACH Program Overview: States Seek to Amend Law While Awaiting Release of Final Regulations

Congress established the Essential Access Community Hospital Program over three years ago as part of the Omnibus Reconciliation Act of 1989. The program represents a unique federal-state partnership to assure the availability of primary care, emergency services, and limited acute inpatient services in rural areas, where it is no longer feasible to maintain a full-service hospital. The Program creates a new category of limited-service, or "down-sized," rural hospital under Medicare called the Rural Primary Care Hospital (PCH), which must establish a network relationship with a larger, supporting EACH facility. The Health Care Financing Administration's (HCFA) Office of Research and Demonstrations, oversees the program and has awarded over $17 million in grants to seven states and 73 hospitals within those states to develop rural health plans and to establish networks of EACH and PCH facilities.

Despite the awarding of grants, however, implementation of the EACH Program has stalled and fundamental concerns about the structure of the PCH facility remain unresolved.

Despite the awarding of grants, however, implementation of the EACH Program has stalled and fundamental concerns about the structure of the PCH facility remain unresolved. HCFA issued draft regulations in October 1991 to collect public comments, but has yet to publish the final regulations needed to fully implement the program. The states have provisionally designated facilities as EACHs and PCHs, but no hospital has received final federal designation due to the lack of final rules. Several states are also seeking Congressional amendments, citing problems with both the original statute and HCFA's interpretation of it as expressed in the draft regulations. While they wait for clearer signals to emerge from Washington, however, the states participating in the program are, to varying degrees, using this opportunity to develop state-specific models for rural health networks and to examine the broader issue of creating limited-service rural hospitals.

This article provides an overview of the statutory requirements for Essential Access Community Hospitals and Rural Primary Care Hospitals. It discusses some of the major problems with the EACH Program as perceived by the participating states and facilities and how HCFA is seeking to address these problems through the regulations.

Facility Criteria for PCHs and EACHs

The EACH Program is based on the concepts of regionalization and network formation and utilizes a hub-and-spoke design to link small and large facilities that have varying service capacities. Rural Primary Care Hospitals form the outer points of the network and are linked by referral agreements, communication systems and emergency transportation services to a larger Essential Access Community Hospital, which serves as the network hub.

In becoming a PCH, a licensed hospital chooses to limit its scope of inpatient services in exchange for less restrictive licensure requirements and cost-based reimbursement under Medicare. It must agree to maintain no more than six inpatient beds for acute care services and provide only temporary inpatient care for periods of 72 hours or less (unless a longer period is required because transfer to a hospital is precluded due to inclement weather or other emergency conditions) to patients who require stabilization before being discharged or transferred to another hospital. A physician, physician's assistant (PA) or nurse practitioner (NP) must be available to provider routine diagnostic services and to dispense drugs and biologicals, and inpatient care provided by the PA or NP must be subject to the oversight of a physician. The PCH facility must also "make available" 24-hour emergency care, however, the facility is not required to keep staff at the facility if beds are unoccupied. This means, for example, that medical personnel could be on-call, rather than on-site, during the night if the facility has an inpatient census of zero. Medicare

payments for PCH inpatient services will be based on the reasonable costs for the facility determined on a per diem basis. For outpatient services, the facility may elect either of two payment methods: a cost-based facility service fee with reasonable changes for professional services billed separately, or an all-inclusive rate combining both the professional and facility service components. See Appendix I for additional facility requirements for PCHs.

An EACH facility must have at least 75 inpatient beds and agree to provide emergency and medical backup service to the PCHs in its network. The EACH must be located more than 35 miles from any hospital that is either designated as an EACH, classified as a regional referral center, or located in an urban area but meets the criteria for classification as a regional referral center; or meets other geographic criteria imposed by the state and approved by the Secretary of the Department of Health and Human Services (DHHS). It must accept patients transferred from PCHs and agree to receive data from and transmit data to PCHs. Under Part A of Medicare, the EACH will be reimbursed as a "sole community hospital" (SCH) for which payments are based more heavily on hospital-specific costs than under the Prospective Payment System. See Appendix II for a more detailed description of the facility requirements for EACHs.

Role of the State

State governments play a central role in the EACH Program. To be eligible for the program states must have developed or be developing a rural health care plan in consultation with the state hospital association and must designate (or be in the process of designating) rural nonprofit hospitals within the state as EACHs and PCHs. In addition to the federal requirements, the state may impose additional eligibility criteria for EACHs and PCHs. Before HCFA can designate EACHs and PCHs, the state must approve the facilities' applications for designation and show that their plans for forming a network are consistent with the state's rural health care plan. States selected to participate in the program receive grant funds that may be used to carry out the program and to improve communications and emergency transportation systems.

The law currently limits the EACH Program to no more than seven states. In September 1991, after reviewing 21 applications, HCFA awarded grants to California, Colorado, Kansas, New York, North Carolina, South Dakota and West Virginia. It classified the states as either "Type A" or "Type B". Five type A states (California, Kansas, North Carolina, South Dakota, and West Virginia) were those that had already identified specific networks and wanted to implement their programs immediately. Two Type B states (Colorado and New York) were those that sought additional time to identify specific facilities for their networks.

OBRA 1989 also permits the Secretary to award grants to facilities of up to $200,000 to support their conversion to EACHs and PCHs. In 1991, HCFA made funds available to facilities in the Type A states. In September 1992, grants were awarded to facilities in the Type B states, as well as to facilities in both new and established networks in Type A states. Supplemental grants were also awarded to each of the seven states in this second round. HCFA awarded all of the grant funds—$9.8 million—available under the EACH Program in fiscal year 1991, but only $7.4 million of the additional $9.8 authorized for fiscal year 1992. Congress authorized no funds for the program in fiscal year 1993.

HCFA Releases Draft Regulations

In January 1990, shortly after passage of OBRA 1989, rural health experts gathered to discuss the EACH Program at a national invitational meeting on alternative rural health care delivery models sponsored by the Federal Office of Rural Health Policy. Participants were particularly sensitive to the potential difficulties of balancing federal needs for a uniform policy and basic standards with an array of unique local circumstances.[1] They noted that considerable challenges would be posed by the diversity between states regarding licensure/certification requirements, planning capacities, and varying levels of experience in addressing rural health needs. There was also a general consensus that the program must

[1]Alpha Center. *Alternative Models for Delivering Essential Health Care Services in Rural Areas: Summary Report of an Invitational Workshop held January 16-17, 1990,* sponsored by the Federal Office of Rural Health Policy, January 1991, p.vii.

be "flexible" if it is to succeed, such as allowing states to use different criteria for designating EACHs and PCHs, or permitting experimentation with various approaches to limiting the scope of services at PCH facilities. They noted that further clarification was needed regarding the law's statement that PCH facilities could participate in Medicare's Swing Bed program, which allows licensed acute care beds to be used as skilled nursing beds, in rural hospitals where patients could not otherwise be discharged due to a shortage of nursing home beds in the area. They also questioned how flexible HCFA would be in granting waivers, especially regarding the 6-bed and 72-hour length-of-stay limits for PCHs.

HCFA utilized its waiver authority under OBRA 1989 to address many of these concerns when it published its draft regulations, or "proposed rules," for the EACH Program in October 1991. Congress gave the Secretary of DHHS two types of waiver authority. One is to designate as PCHs hospitals that have more than six beds or keep people more than 72 hours. The other is an authority to waive other requirements of the Medicare statute, except those relating to EACHs and PCHs, in order to make the program work. In January 1993, at Alpha Center's workshop for federal and state officials responsible for the EACH Program, Thomas Hoyer, Director of HCFA's Division of Provider Services Coverage Policy, who is responsible for creating the regulations, explained that the swing bed portion of the OBRA 1989 statute is inconsistent with its PCH provisions. According to Hoyer, "The waiver authority was designed to allow us to correct such problems. It was not designed to allow us to change the EACH/PCH program." Rather than have individual hospitals ask the Secretary for waivers because they need more than six beds or regularly keep some patients more than 72 hours, HCFA chose to address the issue on a national basis by writing a regulation that says a PCH facility can have up to 12 beds if it is a swing bed hospital. This regulation, which is expected to be part of the final rule, would allow a PCH that was certified for the swing bed program prior to conversion to hold patients longer than 72 hours, if appropriate, by switching their bed status from "acute care" to "nursing care." No more than 10 patients, however, could occupy these nursing care/swing beds at any time, leaving two available for acute care patients. HCFA officials created this 10-patient limit on swing beds in their proposed regulations in light of the limited staffing and resource capacity of most hospitals that might elect to become PCHs. In accordance with Medicare rules, the swing-bed length-of-stay is not capped.

States Propose Amendments

Beginning in January 1992, the project directors of the seven states participating in the EACH Program began a consensus-building process to focus on changes to the program that would facilitate implementation. In a letter detailing "critical issues" for the EACH Program that they sent to HCFA officials in April, 1992 the project directors wrote, "while none of the seven states believe that the EACH is an end product of rural health delivery restructuring, it is currently the only alternative recognized in law. Without a base in the Medicare program, change in rural health care delivery is a moot point. We believe the EACH concept is an alternative of value... and will assist policy-makers, regulators and change-makers in the long process of refocusing rural health delivery."

The states have developed a set of proposed amendments to the federal law that they believe would improve and expand the program. These amendments are now being considered by Congress as part of HR-11. The amendments would allow greater flexibility for urban hospitals to be designated as EACHs by dropping the requirement that they be located a minimum of 35 miles from other EACH facilities. Bi-state rural networks would be allowed where the grantee state believed that the most appropriate partner for either an EACH or a PCH was located across the border in another state. HCFA would also be authorized to designate up to nine EACH states expanding the current program by two.

If passed, however, several of the proposed amendments would impose additional constraints as well as freedoms in attempting to

redress what the states' perceive to be OBRA 1989's most onerous requirements. For example,the amendments would change the current limit on inpatient lengths of stay at PCHs to an average 72 hour length of stay. According to Hoyer, if HCFA officials detected that the current 72-hour limit was breached, they would assess the deficiency and ask the PCH for a plan of correction. Under the proposed amendment, however, HCFA would be given the authority to simply cancel the facility's Medicare agreement if it had an average length of stay over 72-hours.

The states also believe that requiring a physician to certify that a PCH admission is for "temporary and immediate care," as stipulated under the proposed rule, would be too restrictive. Under their proposed amendments, physicians would be required to certify that PCH services "may reasonably be expected to be completed within 72 hours, or that a decision to transfer the patient may reasonably be expected to be reached within 72 hours." In practice however, this level of specificity may actually be more restrictive than the regulation now envisioned by HCFA. According to Hoyer, HCFA's current enforcement process would be "relatively merciful in cases where some folks ended up staying longer." Similarly, the current law allows PCHs to deliver any hospital services that takes 72 hours or less, including surgery. On the other hand, HR-11 would permit only surgical procedures that can be done in an ambulatory surgery center.

While these changes may turn out to be less desirable than the states originally thought, one provision of HR-11 could delay the release of final regulations even further. HR-11 would permit PCHs to provide swing bed services up to the hospital's licensed acute-care bed capacity at the time of conversion to a PCH, minus the number of inpatient beds (up to six) retained by the PCH. Under Medicare's general swing bed program, where hospital beds may be used for nursing home patients, there is a presumption that hospitals are well-staffed 24 hours a day. That is, however, not true of PCHs. Hoyer explained that if HR-11 passes, PCHs with swing beds may be required to comply with HCFA's regulations for nursing homes. Putting the current 10-patient swing bed limit for PCHs into proper context, Hoyer noted that because of nursing home reform in 1987, "nursing home requirements are probably more burdensome in a rural area than hospital requirements, so if you are looking at an area with no manpower, nursing home beds are not necessarily the easy answer."

Conclusion

The EACH Program is the only federal program that creates a new category of limited service hospital facility under Medicare—the Rural Primary Care Hospital. The legislation that created the program, OBRA 1989, stipulated very specific criteria for the PCH, giving the Health Care Financing Administration little latitude in drafting regulations for the program. HCFA has chosen to use its available waiver authority to establish the EACH/PCH initiative as a national program with a single set of implementation rules, rather than to encourage waivers on a facility-by-facility or even a state-by state basis. HCFA's final rules for the EACH Program were cleared by the Secretary of DHHS in December 1992 but now await final approval by the Office of Management and Budget. How quickly OMB will choose to act on the rules is uncertain, especially given the Clinton Administration's fast-track effort to create a broader health reform policy agenda. Congress may be the next player to mold the program it created three years ago. Amendments crafted by several of the seven states participating in the EACH Program, are moving forward as part of HR-11, a legislative vehicle carrying several higher priority bills that were vetoed by President Bush last fall. Some of these amendments would give states and local facilities some of the flexibility they feel they need to establish viable rural health networks, but others would require HCFA to go back to the regulatory drawing board and delay the release of "final" rules even longer. While the lack of final regulations has delayed implementation of the EACH Program, this federal-state partnership has broken important new ground in the development of rural health policy. The EACH Program provides an intergovernmental framework for creating regionalized health networks, or systems of care, that can better assure access to emergency care, primary care, and limited inpatient care services in rural areas.

EMS: The Missing Link in Rural Health Networks

A California rural health network has used EACH/PCH resources to buy two ambulances. The state of West Virginia has used EACH Program funds to improve emergency medical services (EMS) system components, such as equipment, communication linkages and training. But these examples are the exception, rather the rule, according to early reports. "EMS remains the missing link in most rural health networks," said Janet Reich, an EMS Consultant from Arizona and author of a book called *Success and Failure of Rural EMS Systems*. All EACH/PCH grantees will have to deal with EMS system improvements at some point, but it is better to deal with them *before* a crisis happens warned the panelists in the session on "Organizing Regional Emergency Medical Systems."

Organizing EMS systems is, "about as grassroots as you can get", Wolff said."

Sooner or later, EMS issues rise to the top of EACH/PCH grantee concerns for several reasons. First, federal program rules specifically mention the development and support of emergency transportation systems as one of the purposes on which grant funds can be spent. Second, EMS is a critical part of the rural health safety net; if a rural hospital closes or the sole doctor retires, frontier and rural areas have only EMS to turn to for basic health care access. Third, national trends are increasing the demand for EMS in rural areas—more elderly people, growing public expectations, earlier hospital discharges, need for more transfers to tertiary care hospitals, and higher risk for certain types of injuries. Perhaps most important, however, are the profound concerns of rural citizens for maintaining EMS services. At the meeting in January, Robert McDaneld, Administrator of the Kansas Board of Emergency Medical Services in Topeka recalled meeting with a group of 30 people in the small community of Lakin, Kansas during the planning stages of the EACH Program. Their primary concern, he said, was access to health care. "The focus was not specifically on keeping the hospital open. It was on being able to get emergency treatment, and on being able to have primary services," he said.

While most people think of EMS as ambulance transportation, a comprehensive EMS system includes much more. Barak Wolff, session moderator and Chief of Primary Care and Emergency Medical Services for the New Mexico Department of Health, defined an EMS system as, "a coordinated system of centralized access to a comprehensive range of emergency care." It starts with emergency access (e.g. CBs, 911 lines) and dispatch capabilities, trained first responders, rescue squads and ambulance services. But it also includes communication with physicians during transport, hospital emergency departments, transfers to specialty care facilities, and overall medical direction and quality assurance.

Even before considering the organizational challenges associated with EMS system development, the structural problems facing rural EMS systems can seem overwhelming. For example, volunteers are hard to recruit and must be provided with high quality training. Often, there are outdated or weak communications infrastructures, so upfront investments are needed in equipment and technology. Major sources of financing for emergency services are often inadequate, especially since ambulances and hospital emergency rooms must serve everyone, including those who cannot pay. And it can be particularly difficult to recruit and retain qualified health care professionals to staff the system. Many rural areas lack qualified physicians who have the time and interest to supply vitally important medical direction.

While the panelists did not offer any "magic bullets" to solve these problems, they highlighted some strategies that have contributed to successful rural EMS systems development. First, they underscored the importance of careful planning,

before a real crisis develops, by all potential players in the system. Organizing EMS systems is, "about as grassroots as you can get", Wolff said. Janet Reich also emphasized how important it is to consider "who to invite to the party". They urged EACH Programs to involve all the organizations that currently or are expected to participate in each stage of the process: from dispatch and pre-hospital care, to hospital emergency treatment of patients, to medical transportation of a patient from one facility to another. There are virtually no parts of the country where all EMS system components are handled by only one organization.

One set of players include all of the ambulance services operating in the region, both those that are staffed by paid, professional paramedics and those staffed by lay volunteers, as well as fire and police departments. Since there is a wide range of organizations providing emergency services and many types of EMS personnel that vary from state to state, planning across state borders can be particularly difficult. There are approximately 35 different levels of pre-hospital personnel in the country recognized in some states but not in others. A second set of players are the emergency department personnel in the EACH and the PCHs. Ms. Reich asserted that the federal law requirement for EACH hospitals to provide backup emergency services "will demand new approaches for how hospitals interact with the pre-hospital care providers. Strict lines delineating the roles of the pre-hospital and hospital care providers will have to change. . . [because] pre-hospital care personnel will be called on to perform functions which are beyond their current scope of practice." For example, some hospitals may need to change their staffing configuration, or allow R.N.s to provide advanced life support and initial diagnosis prior to the arrival of the physician, or permit paramedics and EMTs to provide care in emergency rooms to ensure a smooth transition from one level of care to another. State officials may need to enact new state legislation or provide waivers to allow providers to take on these new roles.

The provision of emergency back-up by EACH hospitals "will demand new approaches for how hospitals interact with the pre-hospital care providers... pre-hospital care personnel will be called on to perform functions which are beyond their current scope of practice."

Several panelists recommended that explicit agreements be written, which clarify relationships between each hospital and each ambulance service. Such agreements assure that each party understands its role in the system and its relationship to each other. In some cases, the agreements will need to incorporate fairly explicit medical protocols, so that physicians and other stakeholders can define what level of care can be provided by whom. Tertiary hospitals must also get involved to support the EACH/PCH emergency transfer process.

The third set of players are the political leaders who have legal responsibility for the EMS system. In most parts of the country, that means a county board of commissioners. Because they tend to fight for resources for their constituents rather than for the entire county, Bobbie Hatfield, R.N., an EMS consultant in West Virginia and former state legislator, recommended removing direct oversight responsibility from this body and vesting it in an emergency medical advisory board, made up of public safety, pre-hospital, medical and nursing personnel. However, local politicians as well as local businesses and other community leaders should still be involved in systems development.

Ms. Hatfield discussed the importance of dealing with cultural issues unique to each rural area. "You cannot understand how to develop a program by sitting in meetings with people, asking what their problems are. You have to let them develop their own program." She recounted a story about her involvement in developing a local paramedic training program. "Somebody in the higher echelons [of state government] in West Virginia decided that the [paramedics] were going to wear pink smocks to go into the hospitals to do their clinical training. As a result, the whole class quit...you do not put loggers and miners in pink smocks." State officials can help the most, she said, by removing bureaucratic barriers.

Another panelist, Dr. Nicholas Benson, Medical Director for the North Carolina Office of EMS, and current President-Elect of the National Association of EMS Physicians, stressed the importance of medical direction in an EMS system. He talked about two types: 1) on-line or real-time medical direction, i.e. the actual giving of orders or giving of permission to do certain interventions, and, 2) physician oversight of all aspects involving patient care of a pre-hospital system. "Medical direction ensures that there is a patient advocate, that the patient will get the best care possible," he said. At the same time, he warned that many areas of the country face "a crisis of medical direction. There is a lack of physicians who are qualified...who are interested...[or] who are educated in emergency medicine."

To recruit well-qualified physicians, he strongly advocated for the addition of funds to an EMS budget to adequately compensate a medical director. Yes, it costs more, but in return he said, "You get contractual accountability so that you can pin down the medical director to what your expectations are, and what he or she needs to deliver." He also suggested using nurses to relieve some of the burden from medical directors; they can help physicians with some day-to-day administrative tasks and in some cases deliver on-line medical direction.

His recommendations served to remind the audience about how difficult it can be to secure sufficient funds to establish a high-quality EMS system. While EACH/PCH funds provide welcome financial supplements to a few communities, they are only a drop in the bucket. Most communities have less resources to work with, not more.

But there are reasons for optimism. First, some states have enacted legislation which targets dedicated revenues to support local EMS providers. Second, McDaneld urged participants to think creatively about which services to maintain in distressed rural areas. While rural communities and their hospitals may not be able to provide specialty medical services, they may still be able to offer good basic primary care and emergency services. To do so, however, requires communities to develop appropriate expectations about can be performed **within their own community**. He concluded, "Until we are able to do that, [networks] are not going to be successful either in rural Kansas or nationally."

Antitrust Facts and Fears: Skidding on Ice?

After hearing two legal experts discuss antitrust issues surrounding rural network development, one is tempted to recall the words of Franklin D. Roosevelt: "The only thing we have to fear is fear itself." Although their presentations noted certain situations that merited caution, they contended that EACH/PCH grantees' fears concerning possible violations of antitrust laws were largely misplaced.

The EACH Program's attempt to foster the development of rural health networks justifies a certain amount of antitrust apprehension. Such networks may involve arrangements between hospitals to apportion services, consolidate operations, and perhaps even close some facilities entirely. While these actions may result in lower health care costs and improvements in quality, they have also been challenged by the Federal Trade Commission and the U.S. Department of Justice, as both agencies increased their oversight of antitrust activity in the health care field during the last 10 years.

Networks become more suspect if the joint venture is undertaken by competitors to disguise anti-competitive conduct.

Thus, grantees came to the EACH/PCH workshop on "Antitrust Issues for Rural Health Networks" desperately seeking some legal rules of the road. What can facilities do legally in terms of collaboration and networking activities? If they cannot do something prohibited by antitrust laws, can state governments provide "state action immunity" to permit certain mergers or collaboration to occur?

Neil Motenko, a partner in the law firm of Nutter, McClennen and Fish in Boston, who specializes in antitrust litigation and counseling, explained that antitrust law has few hard and fast principles or regulations. Instead, much of it has evolved through case law and judicial decisions in state and federal courts. Because of this, Motenko compared fears of antitrust suits to "being on a plane that is skidding around on the ice as it taxis up the runway." He conceded, "There are serious issues to be considered," but added, "there is a lot that you can do."

Essentially, antitrust law prohibits certain types of: a) agreements or "conspiracies" to restrain trade, for example, through price-fixing or allocating markets among certain competitors; b) conduct by monopolists or those attempting to monopolize particular markets; c) price discrimination; and, d) exclusive or preclusive dealing. Antitrust law also governs the structure of mergers and joint ventures—and potentially the networks in the EACH Program—so as to promote competition. Prohibited joint ventures include agreements among separate entities that restrain trade and those that consolidate entities in a way that would invoke the merger law (Section 7 of the Clayton Act).

In general, antitrust enforcement has been favorable toward joint ventures in the health care arena because they can be pro-competitive. They can produce efficiencies by reducing transaction costs, consolidating research and development, or pooling resources, all of which can allow organizations to compete more effectively. Networks that help to introduce new products or allow entities to buy or share services and equipment that they could not have done on their own are likewise viewed as pro-competitive. When networks serve to integrate facilities or services, or improve access and quality of care as in the EACH Program, the result can be seen as generally promoting efficiency and competition.

The key test in these examples concerns the **effect on competition**; if a bona fide joint venture promotes competition, then judges are more likely to rule in favor of the arrangement. Those that improve health care and lower health care costs are generally allowable under the antitrust laws. Motenko also advised that, "if you integrate

and share risk in order to provide more efficient health care services, you have a legitimate joint venture." The mere appearance of merging operations may not be sufficient absent meaningful integration and risk-sharing. He also said that "if providers are not talking about price, [there is] a lot more room to maneuver."

The major issue in networks and joint ventures concerns the players; if competitors are involved, there are more antitrust issues than if a single hospital develops its own network. Networks become more suspect if the joint venture is undertaken by competitors to disguise anti-competitive conduct. Antitrust questions may also be raised if the network "aggregates power" in the relevant product or geographic market to such an extent that it can easily raise prices or exclude competitors or otherwise create market distortions. But what constitutes the relevant geographic market in a rural area? And with the scarcity of providers in rural areas, can any joint venture truly be said to increase competition? While few suits have been brought against providers in rural areas, a recent opinion in a case involving a hospital in Ukiah, California treated the geographic market as relatively large. Since bigger geographic areas are likely to contain more competitors, there is less opportunity for adverse competitive effects. But other decisions have viewed the geographic market more narrowly.

Many people remain concerned that the lack of clear guidelines and conflicting federal court decisions creates a "chilling effect" on network formation, particularly since small rural hospitals lack the resources to challenge antitrust suits. However, Motenko believed that, "there is misplaced fear about antitrust laws in the context of networks and joint ventures." He advised those with any doubts to seek guidance from legal counsel, from publications prepared by the American Bar Association's Antitrust Section Health Care Committee (of which Motenko is Vice Chairman), and by consulting with their state Attorneys General offices, the FTC or Department of Justice—"on a no-names basis."

"The lack of clear guidelines and conflicting federal court decisions creates a "chilling effect" on network formation, particularly since small rural hospitals lack the resources to challenge antitrust suits."

Those who feared that their rural health care networks could violate federal or state antitrust laws were intrigued by Ellen Cooper's presentation on "state action immunity". Cooper is the Chief of the Antitrust Division of the Maryland Attorney General's Office, and chair of the Multi-state Antitrust Task Force's Health Care Working Group of the National Association of Attorneys General. She explained that this doctrine, which dates back to a 1943 Supreme Court decision in *Parker v. Brown*, exempts state actions from antitrust law. Thus, state entities and state employees acting pursuant to a clear authorization from the state are protected. Furthermore, a 1980 Supreme Court decision clarified that the state action doctrine also immunizes **private entities** from antitrust liability if the state has: 1) clearly articulated a policy to displace competition with regulation; and 2) the state actively supervises the anti-competitive conduct.

State policy, expressed by the state legislation or the state's highest court, is clearest when it pertains to a particular, rather than general class of, activity. She warned however, that other expressions of state policy, such as decisions of licensing boards, are not necessarily covered by the state immunity doctrine. And the need for

state supervision has come to mean "that the state has to exercise ultimate control over the challenged anti-competitive activity. The mere presence of some state activity or some state monitoring is not sufficient. State officials . . .must have and exercise power to review particular anti-competitive acts of private parties and disapprove those that fail to accord with state policy."

Cooper advised state officials that wanted to enact legislation to incorporate language protecting all of the parties involved. This would include not just the state and the state officials or municipalities or counties involved, but the private parties, private hospitals and medical staff that may also be implicated. She emphasized that the legislation should, "set out the state's intent to increase access by replacing competition in rural health care areas with a system of regulation, to have the legislation delegate authority to a state agency to establish regulations, and to provide for staffing and funding of some kind of oversight of the rural health care scheme. Then—and this is extremely important—the state must actually review the network's activities on an ongoing basis to make sure that state policy is being executed properly."

Until such laws are passed, however, Motenko suggested that EACH/PCH networks consider the strength of the arguments they can make to support the "rule of reason" test, which is used by judges to examine the effects of a particular activity on competition. In order to have a violation of the rule of reason, there has to be a substantial adverse effect on competition that is not outweighed by pro-competitive benefits. For example, if EACH/PCH networks constitute legitimate joint ventures that allocate services in a way that promotes quality of care or access to health care, the arrangement, "could be viewed as a reasonable restraint ancillary to a legitimate joint venture," he said. In other words, the networks could be sacrificing some types of competition in order to enhance other benefits in a competitive marketplace.

Since it remains largely true that competition is more difficult to achieve in isolated markets, some still argue that explicit exemptions from antitrust laws should be made for rural networks. Under a managed competition approach, for example, there may need to be an explicit acknowledgement that competition cannot occur in rural areas. W. David Helms, President of the Alpha Center, believed that a federal law may be necessary to encourage certain arrangements that could be perceived as anti-competitive. "State action is wonderful," he concluded, "but the ultimate protection would be federal legislation that gives rural networks an explicit exemption from the antitrust laws."

Throwing the Dice? Risks and Realities in Rural Health Network Financing

For the past year or so, Dian Pecora, administrator for Southern Humboldt Community Hospital District in North California, has been trying to figure out whether it is financially worthwhile for her hospital to become a Rural Primary Care Hospital (PCH). The process she said, "has been extremely fluid [because] information has been conflicting and confusing. Rural hospitals have been asked to make choices about financing and licensure status before they knew the final rules." Because of this uncertainty, Pecora and many other rural hospital administrators may come to view the decision to become a PCH as a gamble. It remains unclear which set of financing strategies will be most favorable for their facilities. Should they retain risk-based DRG payments for inpatient services? How should they bill for outpatient services—separately or through a blended rate? Is it better to provide long-term care services through a skilled nursing facility or home health care? To help make sense out of the confusion and reduce the degree of risk-taking, three panelists at the workshop session on "Options for Financing Alternative Rural Models" presented findings from PCH financial feasibility studies. In each case, they tried to determine whether cost-based reimbursement would be more advantageous than risk assumption under Medicare's prospective payment system (PPS). They also offered some thoughts on factors other than reimbursement methods that contribute to a successful financial strategy for rural hospitals.

Steve Rosenberg, a California-based health care financing and the workshop's moderator, explained the basic financial options for PCHs. Rural hospitals that become PCHs can be expected to provide three sets of services, each of which are paid according to different reimbursement rules:

- **Limited inpatient services.** The PCH program limits hospitals to no more than six inpatient beds, and restricts length-of-stay to 72 hours on average. If a hospital becomes a PCH, it will be reimbursed on the basis of reasonable costs. If it does not seek PCH certification, the hospital will continue to be reimbursed under Medicare Part A (prospective payment using DRGs) rules.

- **Outpatient services.** The PCH program allows facilities to choose between: a) a cost-based facility service fee with reasonable charges for professional services billed separately; or b) a cost-based blended or all-inclusive rate that combines both the professional and facility services.

- **Long term care.** PCHs can provide skilled nursing services in a distinct part skilled nursing facility, and/or in a swing bed, and/or as home health services, each with different Medicare and state Medicaid reimbursement systems.

Almost any reimbursement alternative to the Medicare prospective payment system (PPS) has been welcome news to small rural hospitals. Many of them had been financially harmed by PPS, so a cost-based reimbursement system looked as if it might be a financial blessing— even if they had to downsize to qualify for it. The blended Part B rate was also viewed as one that could help rural communities build systems and networks between inpatient and outpatient services.

But certain rural hospitals may not find it to their advantage to abandon the PPS system just yet. Federal legislation that changed PPS rules in OBRA 1989 is beginning to improve the financial picture for many rural hospitals. It began to phase out of the rural-urban rate distinction, established a single national rate which will be in effect by 1994, and finalized capital rules which tend to favor rural hospitals that have older facilities. In fact, one of the studies featured in the workshop confirmed that risk-based reimbursement could be more beneficial if certain changes were made in hospital operations.

Pecora, who administers one of the PCHs in California, described both the process and substance of those changes for her facility. The near closure of the hospital in 1986 prompted the

hospital to explore a number of alternatives. They tried to develop networks with other hospitals and clinics in nearby counties and began to study their operations with the help of a state Alternative Rural Hospital Models program. In the process, they learned that the hospital's average length-of-stay (ALOS) was fairly high for Medicare patients. They revitalized the utilization review committee, whose efforts were instrumental in increasing the number of patients admitted for short-term outpatient observation, which is eligible for Medicare Part B reimbursement. The hospital also added a new distinct-part skilled nursing facility (DP-SNF). These initiatives helped to reduce ALOS, and as a result, Pecora discovered that the advantages of cost-based reimbursement were reduced.

"...a successful financial strategy is dependent on the allocation of joint costs between inpatient, outpatient, and long-term care services...not solely on whether a PCH is reimbursed on a cost or risk basis."

Contrasting these findings were those of a study performed by John Wendling, managing partner of Wendling, Noe, Nelson and Johnson, a certified public accounting firm in Kansas. The study's purpose was to determine how a select group of rural hospitals, some of which were historically Medicare-dependent and very small, would fare as a PCH. The study retrospectively reviewed medical records to assess where patients would have been cared for—in the PCH, in an EACH, in a swing bed, etc. Hospital managers were then asked how they would have staffed the hospital under those conditions. Based on their responses, the study compared the financial impact of cost-based reimbursement to the hospitals' previous experience under PPS.

Generally, the Kansas study found that for facilities with smaller volume, cost-based reimbursement was preferable to risk. But the advantage was not strong; while six of the nine hospitals in the study would have improved their financial status as a PCH receiving cost-based reimbursement for facility costs, only one of the nine would have had a positive bottom line—assuming that Medicare payments were limited to charges rather than costs.

The third study was the only one to examine the impact of a "blended" rate of facility and professional service costs on a hospital's bottom line. It was performed by Karen Travers, President of Travers Associates, a consulting firm in Augusta, Maine, for a hospital in Webster Springs, West Virginia. In that state, hospitals must perform a community needs assessment before receiving state certification as a PCH. The needs assessment disclosed that the community needed additional primary care providers, expanded home health services, and significant improvements in both the emergency response system and mental health care. It also found that the hospital was overstaffed, given its average daily census.

Based on the results of the needs assessment, West Virginia rules also require potential RCPHs to undertake a financial feasibility study of the reorganized rural health system. The community designed the PCH as the hub of an integrated system combining limited hospital services, primary care, home health care, and emergency medical services. Travers' financial projections found that the hospital's conversion to PCH would likely result in a precipitous drop in its proportion of Medicare days—from 78% to 9% of all patient days. Since the community wanted to maintain current health care personnel and reduce net loss of jobs, they planned to shift hospital-based staff to other positions. Some public health personnel and functions were even brought into the hospital to complete the service continuum.

After projecting costs and estimating revenues under various reimbursement options, her analysis found: 1) acute care services would continue to generate a net loss, 2) primary care would

generate surpluses using Rural Health Clinic (RHC) cost-based reimbursement; and 3) home health services would be budget-neutral. The bottom line was positive overall, largely because the RHC rate represents an all-inclusive blend of Medicare Part B professional fees and allowable facility costs. The blended rate is high—again, as long as Medicare payments are not limited to the lower of costs or charges.

The findings from all three studies suggest that a successful financial strategy is dependent on the allocation between inpatient, outpatient, and long-term care services and not solely on whether a PCH is reimbursed on a cost or risk basis. Their results indicate substantial benefits may be possible by beefing up primary care services and billing for them using a blended rate of facility costs and professional services, which are paid on the basis of reasonable costs. It also appears that, in some situations, distinct part SNFs may be more advantageous than swing beds. Rosenberg speculated that "PCHs with multiple service centers over which to spread fixed costs, an integrated Part B rate, and a distinct part SNF, may not need cost-based reimbursement for inpatient services, especially as DRGs move to a single national rate after 1994."

While many hospitals are still unsure about the financial implications of the EACH Program, the studies stressed the importance of performing financial analyses and ongoing efforts to reorganize or improve the management of existing services. Rosenberg believed that the process of making a rural hospital financially viable is "three-quarters management". Pecora's financial studies have also shown her that "the most important part of the process has been the work that is done to develop, implement, and put **systems** of patient care together for rural communities." Financial analyses and system reforms, they concluded, replace the high-stakes risk usually associated with network formation with a stronger sense of reality.

From Hospital to Health System: Making Progress through Process

There's a joke that goes: How many psychiatrists does it take to change a light bulb? Only one, but the bulb has to want to change. So too, it seems with changes in the way rural hospitals or health care providers deliver services. Networks, augmented primary care, or any other significant changes in rural health services do not happen overnight. And they will not occur just because federal or state policies dictate them. Rural communities must adopt these goals as their own, and take part in a process to reach them or they will never be achieved, according to panelists in the session on "Community Education and Decision Making."

"Without appropriate community education and decision-making processes, federal or state efforts to develop regional health networks in rural areas are destined to fail."

Robert Van Hook, a rural health consultant and former director of the National Rural Health Association opened the session by presenting an overall framework, which he and Victor Cocowitch developed, that portrays all of the inputs and outputs of rural health systems change.

The process begins with the catalysts for change: external incentives and pressures, new information, leaders or change agents, and the methods and structure for considering alternative options. These catalysts plant the seeds of change that are then fertilized by community debate, organizational development, and technical assistance. When it works, the interaction between all of these elements results in improvements in the way rural communities use and organizations deliver health services. When it fails, communities and organizations risk further deterioration.

It is difficult to gain community involvement, panelists stressed. For one thing, apathy abounds. "One in five families moves every year. People do not solve problems locally anymore. They move away from them," said Paul McGinnis, Project Director for the Mountain States Health Corporation and a private consultant specializing in strategic planning. Another problem he encounters is the tendency of, "communities to blame outsiders. They say, `It's the fault of federal reimbursement policies, it's the fault of state licensure and regulatory requirements, it's the fault of greedy doctors who don't want to come here to practice.'"

Then why even bother with community education and community decision-making processes? Because without them, federal or state efforts to develop regional health networks in rural areas are destined to fail, McGinnis asserted. Everyone may agree on the need for better access to health care, but unless everyone also agrees on how best to achieve it, the goal will much harder to attain. For example, few communities can understand the benefits of downsizing a beloved hospital without knowing what will replace the services that are lost. Decisions that require people to travel further to receive health care are hard to implement without community consent.

In order to gain their participation, McGinnis advised state-level officials to help local people see that, "We are not fixing blame, we are fixing problems," and added, "people will only become involved in public policy decisions when they can see the results of their participation." Though it takes more time and effort, he said, gaining the support of businesses, educators, clergy and other community leaders is absolutely essential. Their input ensures that changes in hospital services will enhance health services overall and benefit or at least not harm the local economy.

McGinnis offered a few basic guidelines for state-level officials to follow in order to make it easier for community members to become and stay involved:

- Provide all of the information that is relevant in language they can understand, and then trust them to make good decisions.

- Make sure that all of the people who have power and influence to actually implement decisions are sitting at the table.
- Ensure that the decision-making process precedes changes, rather than the other way around.
- Help communities implement their decisions by intervening with federal agencies where necessary.

State level officials must also carefully consider how and where to enter a community to help it begin to change, according to Victor Cocowitch, a management and strategic planning consultant who specializes in working with rural hospitals. Offering technical assistance to rural communities is, "like throwing a few stones into the middle of the pond and watching the ripples go on for three or four years," he observed. "You have to sort out how those reverberating circles are going to work together."

Cocowitch primarily enters communities through hospital boards of directors. In his practice, he finds that hospitals pursue systems change according to three different models:

- developmental change, which improves that which already exists;
- transitional change, which uses strategic planning to create a new model over a period of time; and
- transformational change, which is often prompted by severe crises, and facilitates the fundamental change that rural hospitals must undertake in order to adapt to a rapidly changing environment.

At the beginning, Cocowitch often observes that, "People have this belief that they do not have a health care system in their community unless it has two stories of brick and an emergency room and a hospital sign." But if he can get hospital CEOs and trustees to confront the magnitude of the changes they must make to survive in the new health care environment, they quickly see that they cannot do it alone and begin to appreciate how important it is to bring others into the process. At that point, the ripples of concern that have spread to the community and to physicians can be merged with those of the hospital. And in so doing, hospital officials may realize, for example, that it is not just possible but necessary to move the public health department inside its walls or work with physicians to form a PPO or capitated system.

Steve McDowell learned the basic principles of community education and decision-making from one of the founders and most successful practitioners of rural health systems development. Several years ago, he asked Jim Bernstein, Director of the North Carolina Office of Rural Health and Resource Development, how to develop rural health systems. McDowell recalls him saying, "You need four things to affect change: data, an outside facilitator, money, and leadership." Since then, McDowell, a former Director of the Kansas Office of Rural Health and currently the Director of the Integrated Community Health Development Project for the Kansas Health Foundation, has been putting those words of advice into practice. Through the project, the Foundation provides support for data collection and analysis, outside facilitation and financial assistance, although it cannot supply local leadership.

Developing such leadership is one of the most important functions of community needs assessment, education and decision-making, McDowell said. When done correctly, these methods not only develop community leaders, but help them reach consensus about an appropriate scope of services and a structure for the delivery of those services. The real sign of success, he said, is when "people know exactly what those words mean."

McDowell too finds the hardest part of the process is getting rural communities to change their perception of the hospital as the beginning and end of a health care system. Unfortunately, the EACH Program requirements don't help; they assume that hospitals are at the center of decision making and restrict the health network requirements to the hospital.

Getting people to understand that a health care system means more than just a hospital is half the battle, he said. It helps to perform a community health assessment on a complete scope of services, from public health and home health

services to hospital and nursing homes. It also helps to provide information about current utilization patterns and financial performance, so people begin to understand what's working and what's not. And when the community group is ready to examine various alternatives, it is especially important to provide rural-specific options. "Rural is not small urban. You cannot downsize an urban model and make it work," McDowell said.

While it is important to offer as much technical assistance and information to local communities as possible, the state government's role in initiating change at the local level is more encompassing, according to Paul FitzPatrick, Director of New York State's Office of Rural Health. State officials must also work to create a positive climate for change in rural health delivery systems by educating other state-level policymakers, including state legislators, state provider associations, and state executive agencies about how they can help.

In New York, a State Rural Health Council was formed for this purpose. It has been instrumental in persuading state policymakers to approve $50,000 grants to local communities to help them develop rural health networks or systems. In addition to these financial incentives, the state has set up a framework to ensure that state-level and local-level "conversations for change", as FitzPatrick called the two processes, are complimentary. The framework is expressed in a set of rural health development guidelines which permit local flexibility, while still assuring some basic accountability to state policymakers.

Lindy Nelson, Director of Rural and Primary Health Policy and Planning for the Colorado Department of Health, stressed that meaningful opportunities for involvement are as important at the state level as they are at the local level. In Colorado, for instance, a state task force was set up to help plan the EACH Program. Task force members were given responsibility for developing criteria, drafting regulations, and approving the applications of hospitals that wanted to be designated as EACHs or PCHs. This not only involved them personally, but gave them incentive to get input on the structure of rural health networks from other people in each of the communities they represented.

At what point should state program officials involve the community in the development of networks? When should they transfer major responsibility for network development to the local level? The sooner the better, panelists agreed. While most of the states participating in the EACH Program were unable to involve every affected community in the process of change before submitting their federal application, panelists made it clear that it is never too late. The product is the process, they said. Delaying the community's involvement will only make it more difficult to change the light bulb.

DRAFT

Profiles of State EACH Programs

This section of the report discusses the Essential Access Community Hospital (EACH) Program as it is being developed in the seven states that have received grant funding from the Health Care Financing Administration. The information is based on progress reports that were presented by the states at a recent workshop conducted by the Alpha Center for federal and state officials responsible for implementing the EACH Program. Maps identifying the rural health networks under development in each state were prepared by Mathematica Policy and Research, Inc. and updated by the Alpha Center. The following symbols are used to designate various types of facilities or networks.

E = EACH Grantee

P = PCH Grantee

M = Member Hospital, not an EACH or PCH Grantee

* = State Program Network, not receiving federal funds

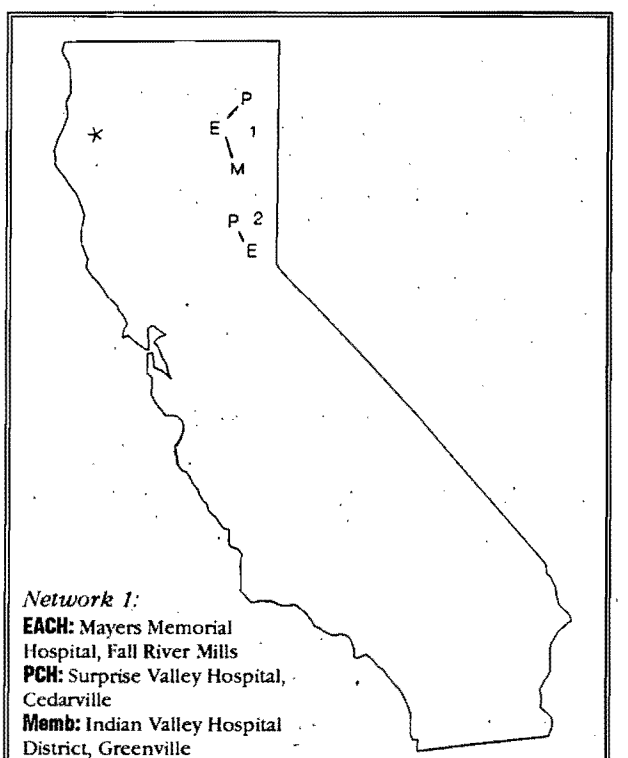
California

California's recent involvement in shaping the health care delivery system in rural areas dates back to 1978, when the state legislature established criteria to identify small, rural hospitals for planning purposes. A decade later, the legislature passed Assembly Bill No. 2148 which directed the Office of Statewide Health Planning and Development (OSHPD) to review acute care operating and building code regulations; to assume responsibility for granting waivers or exceptions to regulations that were determined to be excessively burdensome to rural hospitals; and to research existing alternative rural hospital models and develop a new model for California.

Under this authority, OSHPD appointed a technical advisory committee which was charged with the development of the Alternative Rural Hospital Model (ARHM) Program. In some ways a precursor to the federal EACH program, the state's application to the federal government was a direct outgrowth of its work on the ARHM program. Indeed, the two programs have become closely linked; participation in the ARHM program is an eligibility requirement for PCH designation in California.

The ARHM program provides exceptions from certain state hospital certification and licensure requirements for hospitals in rural or remote areas of the state, whose financial viability has been jeopardized by these rules. The program adopted a limited service hospital model by allowing ARHM hospitals to drop inpatient surgical services. All ARHM facilities must offer five basic core services: standby emergency medical services; basic medical holding/stabilization capacity; basic ambulatory care for outpatient services; basic laboratory services; and basic radiology services. Beyond that, ARHM rules allow facilities to select their own scope of services using a "building block approach". Facilities have the option of adding additional service modules such as ambulatory surgical services, obstetric services, and expanded radiology services.

Individuals involved in the planning process for the state's EACH application believe that the federal program introduced an important new requirement for limited service facilities—networking and local integration of services. California currently has two networks (and one network that was initially rejected by HCFA for technical reasons, which is now under appeal). The two networks were developed with substantial input from EMS personnel, the public health department, primary care groups, and private practice groups. While several facilities in other areas have expressed interest in the concept of networks, they are waiting to see the Health Care Financing Administration's final regulations for the EACH program before seeking PCH designation. In the meantime, however, the fact that all PCHs are also designated ARHM facilities suggests that the ARHM process may become an incremental step in the hospital downsizing process in California.



Network 1:
EACH: Mayers Memorial Hospital, Fall River Mills
PCH: Surprise Valley Hospital, Cedarville
Memb: Indian Valley Hospital District, Greenville

Network 2:
EACH: Tahoe Forest Hospital, Truckee
PCH: Sierra Valley Community Hospital, Loyalton

Colorado

Over the past several years, the problem of assuring access to health care in Colorado's rural and frontier areas has become more pronounced due to hospital financial pressures and a dwindling supply of rural physicians. Such factors led the state to experiment with a number of innovative rural health delivery models that in turn, spurred the state's interest in participating in the federal EACH Program.

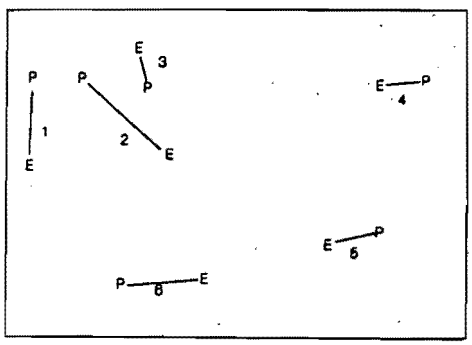
For example, in 1979, Colorado established a new class of health facility, called the "Community Clinic Emergency Center" (CCEC), which integrates ambulatory primary care with limited inpatient services. The CCEC can be considered a prototype to the rural primary care hospital (PCH), because they too, may have a maximum of only six beds in which patients can stay for no more than 72 hours. Most CCECs cannot be designated as PCHs, however, because they have never been licensed as hospitals, which is a requirement for receiving Medicare certification.

Another model program is the Silverheels Health Center in mountainous and isolated Park County. After a nine-bed county hospital closed, energetic local leaders opened this primary care/emergency care center, that is staffed by non-physician providers and integrates public health services. A third program—the Rural Healthcare Initiative—is sponsored by The Colorado Trust, a state-based foundation. This program has supported the development of local, regional health care systems by awarding grants to groups of rural health care centers, rather than individual facilities.

In order to build on these programs, the Colorado Department of Health decided to apply for participation in the EACH Program as a "Type B" state because more time was needed to design a statewide approach for developing rural health networks. State officials have pursued a strategy that ensures the networks are designed to meet the needs of local communities. It has approved funds for six self-identified networks to hire their own consultants who can perform local needs assessment and other planning activities. The networks must also establish advisory and oversight boards comprised of representatives from local social service agencies, public health departments, schools, and local government bodies.

The state health department has also sought to involve local representatives in the design of the state's overall strategy. State officials created a task force which includes interested individuals, hospital administrators, and state personnel. The task force is charged with establishing state criteria for PCHs, EACHs, and networks, reviewing all facility grant applications, and making recommendations to HCFA for designation.

Currently, Colorado officials are trying to determine how to implement the 72 hour maximum length of stay for PCHs. Substantial distances between the EACHs and PCHs makes this a potential problem for some facilities. Lindy Nelson, Director of Rural and Primary Health Policy and Planning in Colorado, remarked, "The thought of having to send somebody 70 or 100 miles down the road when they could actually be taken care of within their own community is something that our hospitals are struggling with."



Network 1:
EACH: St. Marys Hospital, Grand Junction
PCH: Rangely District Hospital, Rangely

Network 2:
EACH: Valley View Hospital, Glenwood Springs
PCH: Pioneers Hospital, Meeker

Network 3:
EACH: Routt Memorial, Steamboat Springs
PCH: Kremmling Memorial, Kremmling

Network 4:
EACH: Sterling RMC, Sterling
PCH: Haxtun Hospital, Haxtun

Network 5:
EACH: Arkansas Valley RMC, La Junta
PCH: Weisbrod Memorial, Eads

Network 6:
EACH: San Luis Valley RMC, Alamosa
PCH: St. Joseph Hospital, Del Norte

Kansas

The EACH Program in Kansas, which consists of 10 networks, is the largest among the seven state grantees. Currently, there are eight EACH hospitals, two supporting hospitals, fourteen RPCH facilities, and nineteen member hospitals included in the program. Eight of the 10 networks have received federal funding while the remaining two did not qualify for the federal grant. Those two include one that crosses state lines and is based on a supporting hospital in Oklahoma, and another that depends on an urban supporting hospital.

The Kansas Hospital Association and private foundations have been instrumental in supporting the development of several rural health initiatives in Kansas including the EACH Program. In 1985, the Robert Wood Johnson Foundation awarded a grant to the Kansas Hospital Association to analyze the potential for providing nontraditional health and human services in small rural hospitals. Additionally, the Kansas Health Foundation (formerly known as the Wesley Foundation) has funded a special Primary Care Bridging Program that supports residency training in rural communities. Perhaps the greatest impact on the state's EACH Program came from a 1990 Kansas Health Foundation grant that jointly funded the Kansas Hospital Association, the Department of Health and Environment, and the Emergency Medical Services Board to analyze the potential for EACH/PCH networks in Kansas and to prepare an application for a HCFA grant.

Kansas has created a three-pronged approach to developing their networks. The first involves community education. Kansas program officials found that the initial process of designating networks failed to educate the affected communities adequately about the EACH Program. Consequently, network participants find themselves in communities that have no knowledge of the program, and have heard some negative publicity surrounding the proposed regulations and standards. Kansas officials believe it is important to ensure that residents in these communities understand the EACH program and its goals. Program staff are working with each hospital in the program to conduct an objective appraisal of community and provider perceptions and based on that appraisal, develop a plan for community education.

The second area of the network development process focuses on the Emergency Medical Services (EMS) plan. EMS systems must be capable of providing care to patients with urgent medical problems and ensure that the services of a physician or midlevel provider are available within a reasonable length of time. The PCH will be responsible for providing an initial diagnostic evaluation, a limited range of definitive treatments, necessary resuscitation and stabilization, and for initiating transport to the EACH or other back-up hospital for services not offered at the RPCH.

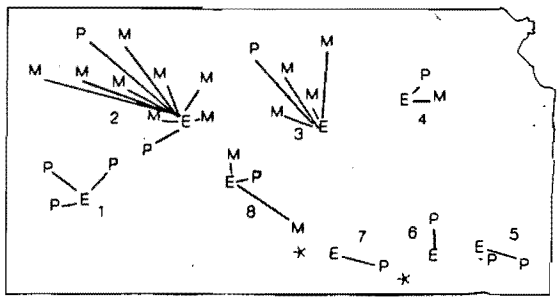
The final area of the network development process examines physician relationships and referral protocols. The purpose of this process is to devise ways for physicians within a network to relate to each other and decide how medical staffs at EACHs and RPCHs will interact on a regular and formalized basis.

Because of the varying situations of the individual networks, Kansas decided not to impose a state-wide approach or a single type of consulting procedure to the process of network development. Instead, they have written a Request for Proposals for consultants to work with the networks on the three major planning tasks. The objective is for each network to select its own consultant in order to develop a process that it feels will best fit its needs.

A unique feature about the Kansas program is the inclusion of facilities that are neither EACHs nor RPCHs. Kansas refers to these networks as "member facilities." Many hospitals were interest-

ed in participating in a network, but were not eligible to become RPCHs or were not willing to enter into the designation process. Kansas saw no logical reason to exclude these hospitals from taking part in a mutually supportive networking process and have included them from the beginning.

Additionally, Kansas views the EACH Program and other alternative service delivery models has being on a continuum with options available to rural communities. They have discussed three levels of potential network systems: first, the EACH/PCH network as defined and conceived in the federal program; second, a network which is based on the concept of the EACH/PCH program, but without the federal rules and guidelines; and third, an integrated service model network which includes a broader set of services in a network system concept that goes beyond hospitals envisioned in the EACH/PCH program.



Network 1:
EACH: St. Catherine Hospital, Garden City
PCH: Kearney County Hospital, Lakin
PCH: Lane County Hospital, Dighton
PCH: Wichita County Hospital, Leoti

Network 2:
EACH: Hays Medical Center, Hays
PCH: Grissell Memorial, Ranson
PCH: Rawlins County Hospital, Atwood
Memb: Plainville Rural Hospital, Plainville
Memb: Decatur County Hospital, Oberlin
Memb: Graham County Hospital, Hill City
Memb: Trego County Hospital, Wakeeney
Memb: Northwest Kansas Regional Medical Center, Goodland
Memb: Citizens Medical Center, Colby
Memb: Sheridan County Hospital, Hoxie

Network 3:
EACH: Asbury-Salina RMC, Salina
PCH: Jewell County Hospital, Mankaro
Memb: Republic County Hospital, Bellville
Memb: Mitchell County Hospital, Beloit
Memb: Lincoln County Hospital, Lincoln
Memb: Ottawa County Hospital, Minneapolis

Network 4:
EACH: Memorial Hospital Association, Manhattan
PCH: Dechairo Hospital, Westmoreland
Memb: Wamego City Hospital, Wamego

Network 5:
EACH: Central Kansas Med Center, Great Bend
PCH: Labette County Med Center, Parsons
PCH: Baxter Memorial Hospital, Baxter Springs

Network 6:
EACH: Mercy Hospital, Independence
PCH: Wilson County Hospital, Neodesha

Network 7:
EACH: William Newton Memorial, Winfield
PCH: Cedar Vale Community, Cedar Vale

Network 8:
EACH: Ellinwood District Hospital, Ellinwood
PCH: Oswego City Hospital, Oswego
Memb: Clara Barton Hospital, Hoisington
Memb: St. Francis Regional Medical Center

New York

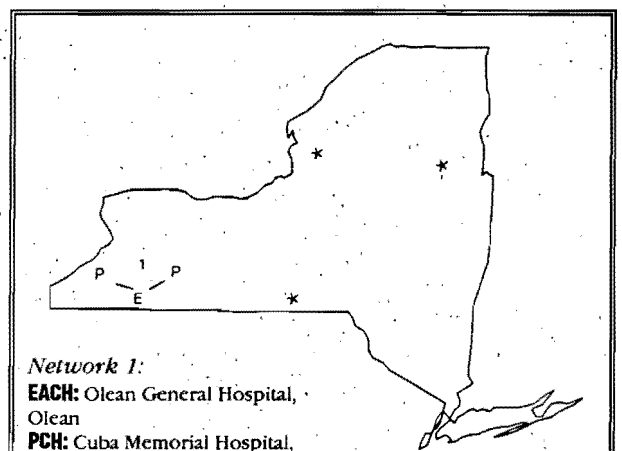
New York State was actively involved in the development of rural health networks even before the EACH Program. Since 1982, the state has provided network planning grants to over twenty projects under its Rural Health Network Demonstration Program. The state asked the Health Care Financing Administration to accept four of these networks under the EACH Program, but only one of the sites has been awarded EACH/PCH grant funding. The other three applications were not accepted for technical reasons.

In June 1992, the New York State Department of Health, in cooperation with the New York State Rural Health Council, drafted a set of *Proposed Rural Health Network Guidelines and Requirements* to assist with the state's rural health network initiative. The document presents guidelines for two different alternative facility models, one of which is a primary care hospital (PCH). The other model envisions an upgraded diagnostic and treatment center that would enable community health centers to add capacity to serve urgent and limited emergency medical care needs.

The proposed guidelines are intended to serve several purposes in rural health network development. First, they outline the current policy directions being promoted by the Rural Health Council and the Department of Health. Second, they define the process and establish requirements for rural health network development that will allow rural communities throughout New York to avail themselves of the fiscal benefits and regulatory flexibility of this initiative. Third, the document provides a framework for identifying and assessing other new approaches to organizing and financing rural health services. Finally, the network guidelines provide an overall structure for state support of network delivery approaches.

In addition to these guidelines, the Department of Health and the Rural Health Council have developed three strategies to enhance the effectiveness of the proposed EACH/PCH networks in New York: First, all four networks have developed operational plans that describe the networks' mission, goals, organizational structure, operating principles, service area, and functions and ability to conform with selected service delivery model. Currently, these operational plans are being evaluated for conformity with New York's proposed rural health network guidelines and requirements.

The second strategy is the development of a legislative proposal to be incorporated into the next set of changes in New York's hospital reimbursement methodology. The proposed legislation defines networks, alternative service facilities, including upgraded ambulatory care centers and primary care hospitals, and core full service hospitals (including EACHs). It also establishes a three-part grant program for promoting the development of networks: a planning grant to provide up to $50,000 a year for up to two



Network 1:
EACH: Olean General Hospital, Olean
PCH: Cuba Memorial Hospital, Cuba
PCH: Salamanca Hospital District Authority, Salamanca

years to allow communities and providers to develop a network operational plan; a start-up grant of up to $500,000 to support infrastructure costs associated with implementing the network; and an administrative grant of $100,000 to $200,000 per year for up to three years to provide operational support for the administration of the network. The legislation would also establish a permanent reimbursement stream for key network providers once they have become fully operational. Annual rate enhancements would be provided to the core full- service hospital to cover its additional costs for supporting the network, and to upgraded care centers for the additional costs of providing emergency services. Finally, the legislation would allow a facility that converts to a primary care hospital to maintain its historical revenue stream under the current hospital reimbursement system. It is estimated that on average this package would amount to $5.75 million annually.

The third strategy is the creation of a rural health provider panel to assist in establishing admissions criteria, developing an exceptions process, and reassessing the currently proposed criteria and standards for primary care hospitals.

North Carolina

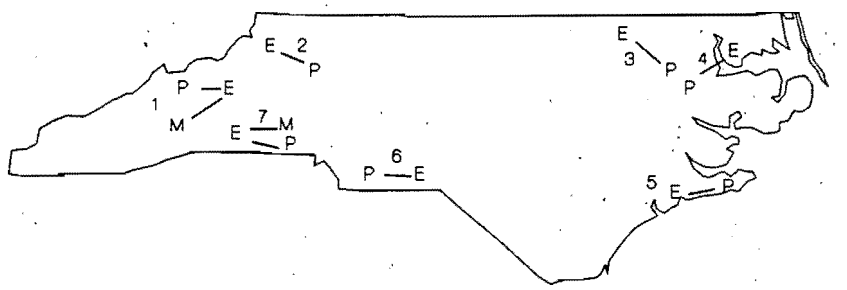
The approach to the EACH Program in North Carolina is consistent with many years of work in the development of rural health resources. It combines support to communities to ensure their active involvement in decision-making with a comprehensive range of technical assistance to facilities and community leaders.

When it becomes clear that their hospital can no longer survive in its current form, state program officials believe that community members must be involved in decisions regarding the preferred type of service delivery model. At the same time, they understand that information and technical assistance can help these communities make informed choices and implement changes most appropriate to their area.

Consequently, North Carolina's Program provides many types of technical assistance to EACH and PCH facilities to support their conversion efforts and strengthen their networks. The Office of Rural Health and Resource Development (ORHRD) spends a great deal of time on basic organizational development with both hospitals and communities, which includes strategic planning sessions with the hospitals' board of directors and board of trustees, as well as development of public relations strategies for overcoming problems often associated with the transition to PCH hospitals. ORHRD staff also assess management strengths and weaknesses and are in the process of developing training programs for all of the EACH and PCH facilities.

Reimbursement is another area in which ORHRD staff spend a great deal of effort. For example, one of its specialists helps hospitals analyze financing options, such as the relative advantages of Rural Health Clinic versus Federally Qualified Health Clinics (FQHC) reimbursement for outpatient services. They also work with private physician practices, particularly where they are having trouble surviving and their retention is key to staffing the RPCHs. Therefore, ORHRD is devoting more time in reimbursement and billing procedures to help those struggling practices.

Finally, North Carolina officials provide assistance to the networks in health professional recruitment, fundraising, and specific program development. Over the course of the past year they have helped to find 10 to 12 physicians for EACH and PCH hospitals in the state. They have also conducted two fundraising drives with PCH facilities, which raised $65,000 and $250,000 to support conversions. They have also helped to set up long-term care units in hospitals and are currently in the process of developing Medicaid case management programs for the elderly.



Network 1:
EACH: Spruce Pine Hospital, Spruce Pine
PCH: Burnsville Hospital, Burnsville
Memb: Memorial Mission Hospital, Asheville

Network 2:
EACH: Watauga Hospital, Boone
PCH: Blowing Rock Hospital, Blowing Rock

Network 3:
EACH: Halifax Memorial Hospital, Roanoke Rapids
PCH: Our Community Hospital, Scotland Neck

Network 4:
EACH: Chowan Hospital, Edenton
PCH: Bertie Memorial Hospital, Windsor

Network 5:
EACH: Carteret General Hospital, Morehead City
PCH: Sea Level Hospital, Sealevel

Network 6:
EACH: Richmond Memorial Hospital, Rockingham
PCH: Anson County Hospital, Wadesboro

Network 7:
EACH: Rutherford Hospital, Rutherfordton
PCH: Crawley Memorial, Boiling Springs
Memb: Cleveland Memorial Hospital, Shelby

South Dakota

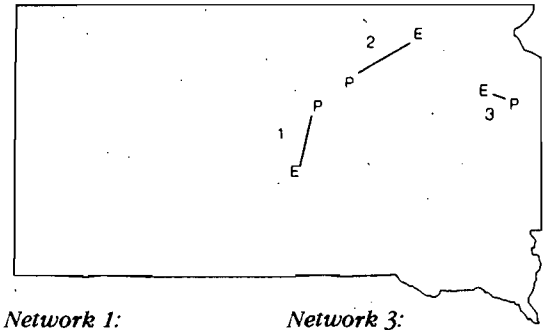
A major goal of the South Dakota EACH Program is to preserve and improve access to a set of basic or essential health services in rural areas of the state. These services have been defined as primary care (which includes preventive health services), acute care (which includes emergency room services), ambulance services, and nursing care. To accomplish this goal, South Dakota has developed several strategies.

The first step involves a basic determination regarding which rural hospitals are either "at-risk" or "access-critical." The former includes hospitals that face a high probability of closing in the next year as well as those in which continued operation over a two to five year period is in question. "Access-critical" rural hospitals are those that provide access to essential health services (emergency, primary, acute, and nursing care) in a service area where few, if any, other providers of such essential services exist. By identifying hospitals that fit into these two categories, South Dakota has been able to structure the type and level of technical assistance needed to help stabilize their operations.

Since it is difficult to accurately predict which hospitals are likely to close, South Dakota officials have developed a system to assess the relative risk of closure. They have identified characteristics of hospitals that have closed, developed standards to measure degrees of risk, and applied these standards to each hospital to determine its degree of risk. Through the risk-identification process, and provision of technical assistance, three hospitals that were at greatest risk of closing are still operating. They are in the process of converting to PCHs and are establishing networks with EACHs.

South Dakota's second strategy focuses on providing technical assistance to designated EACHs and PCHs as well as activities designed to foster the development of health care networks. One area involves resolving critical health professional shortages in rural areas. For example, they have begun to study the feasibility of sharing personnel among network facilities. Although the study is not yet complete, one EACH has already started a locum tenens program which brokers professional services on a temporary basis. Other technical assistance areas include improving the delivery of emergency medical services within networks, establishing telecommunication linkages between EACHs and PCHs and examining financial reimbursement issues for PCHs.

Additionally, South Dakota offers two services to assist communities with financing health projects and community-based planning efforts. The first is the "Health Project List", which is a roster of projects that have been approved by the Department of Health, in accordance with criteria and standards of the state's Primary Care Plan. Those on the list are eligible to receive funding from the Governor's Office of Economic Development and its Community Development Block Grant Program.



Network 1:
EACH: St. Mary's Healthcare, Pierre
PCH: Gettysburg Memorial, Gettysburg

Network 2:
EACH: St. Luke's Midland Regional Medical Center, Aberdeen
PCH: Holy Infant Hospital, Hoven

Network 3:
EACH: Prairie Lakes Health Care Center, Watertown
PCH: Deuel County Memorial Hospital, Clear Lake

The second is the "Charting a Healthy Future" program which helps communities give local residents a voice in configuring a health care delivery system that meets their needs more effectively. This program fits well with one of the state EACH Program's highest priorities of getting broader community participation in the process of network development. As Bernard Osberg, Branch Manager of the South Dakota Office of Rural Health explained, "we need to spend more time working with folks in the community to inform them about the purpose and the goals of the program." The Charting a Healthy Future process not only educates the community but helps residents become involved in decisions affecting community health care services.

West Virginia

The West Virginia EACH Program has already made great headway. Its networks are conducting thorough community needs assessments, carrying out financial analyses, and purchasing sorely needed equipment for providing emergency medical services.

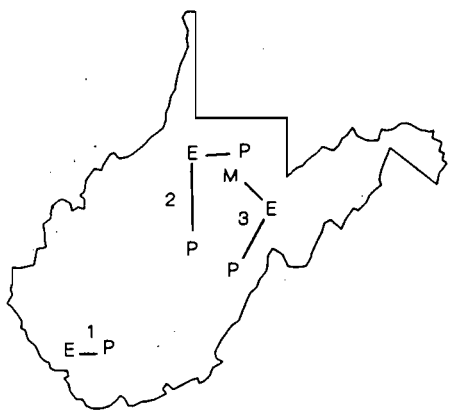
These early achievements are due in large part to a strong and committed leadership. A solid partnership has been formed between the state Office of Community and Rural Health Services and the West Virginia Hospital Association, which fosters open communication between the two organizations and allows frequent discussions about program goals and directions. Furthermore, the state's EACH Advisory Council has been operational since 1990 and continues to be instrumental in directing program policy.

The Council has developed a two-step process for network designation. Upon receiving preliminary designation, a network must conduct a community needs assessment according to state specifications, conduct a financial feasibility study, and submit a budget to the state before applying for final designation. Throughout this process, the state periodically brings together the grantees to provide advice, clarify state requirements, and allow the grantees to share their experiences with one another. Finally, a public hearing is held in the network's area before the commissioner of public health makes the final designation.

Improvements in the emergency medical service (EMS) constitute a central component of West Virginia's EACH Program. The state has installed a microwave tower in mountainous Webster County in order to enhance direct communication between ambulance personnel, the PCH, and a regional emergency medical command center. The use of this technology allows the emergency medical command center to direct an emergency case to the most appropriate care facility and, most importantly, bypass the PCH when treatment is recommended in a higher-level facility. Currently, the state's microwave communications network covers 40 percent of the state's population.

In addition to the EACH/PCH model, West Virginia officials are interested in promoting other network models for areas with different combinations of providers. "We are looking for state resources, foundation resources, grants, etc., because there are hospitals and primary care centers that are ready to implement other models," said Mary Huntley, Director of the Office of Community and Rural Health Services.

To further their efforts, the state has initiated a study to determine which models can work in three areas of the state: one with a primary care center, two physicians, and a local health department, but no hospital; one with two competing hospitals and a primary care center; and one with a tertiary care center that currently has an affiliation with three rural hospitals. The study is to be completed by early March.



Network 1:
EACH: Logan General Hospital, Logan
PCH: Guyan Valley Hospital, Logan

Network 2:
EACH: United Hospital Center, Clarksburg
PCH: Grafton City Hospital, Grafton
PCH: Webster County Memorial, Webster Springs

Network 3:
EACH: Davis Memorial Hospital, Elkins
PCH: Pocahontas Memorial Hospital, Marlinton
Memb: Broaddus Hospital, Philippi

Appendix I
Rural Primary Care Hospital (PCH) Facility Requirements

Criteria for the Designation of Facilities

- Be located in a rural area (an area outside a metropolitan statistical area) or in an urban county whose geographic area is substantially larger than the average area for urban counties and whose hospital service area is similar to the service area of hospitals located in rural areas (OBRA-90)
- Comply with Medicare hospital conditions of participation at the time it applies
- Participate in the network's communication and data-sharing system
- To have been closed for not more than one year prior to the application date for PCH designation (OBRA-90)

Service Criteria[1]

- "Make available" 24-hour emergency care
- Agree to cease providing inpatient care, except as specified below:
  - Not more than 6 inpatient beds
  - Temporary inpatient care for periods of 72 hours or less (unless a longer period is required because transfer to a hospital is precluded due to inclement weather or other emergency conditions) provided to patients who require stabilization before being discharged or transferred to another hospital
- May maintain swing beds
- Have a physician, physician's assistant or nurse practitioner available to provide services, provide routine diagnostic services (including clinical lab services), and dispense drugs and biologicals in compliance with state and federal law

Linkages and Referral Relationship Criteria[2]

- Enter into agreements with the EACH for the referral and transfer of patients
- Agree to participate in the network's communications system including electronic sharing of patient data, telemetry, and medical records if the network operates such a system

Personnel/Staffing Criteria

- Meets staffing requirements of other rural hospitals, except for the following:
- Need not meet standards for hours or days of operation, as long as it meets requirement to provide 24-hour emergency care
- Furnish the services of a dietician, pharmacist, laboratory technician, medical technologist, or radiological technologist on a part-time, off-site basis
- May allow a physician's assistant or nurse practitioner to provide required inpatient care subject to oversight by a physician

Medicare Reimbursement

- Inpatient PCH services to be covered under Medicare Part A and defined the same as inpatient services delivered in any other hospital. Payment will be made only if a physician certifies that services had to be furnished immediately on a temporary, inpatient basis
  - For the first 12-month cost reporting period: a per diem payment to be made based on the reasonable costs of the facility

SOURCE: OBRA-1989, except as noted, as summarized by Suzanne Felt and George Wright in *Diversity in State's Early Implementation of EACH Program*, Mathematica Policy Research, Inc., July 27, 1992.

[1]The Secretary has authority to waive the 6-bed, 72-hour service limits.

[2]Applies to PCHs that are members of a rural health network. The Secretary is required to give preference to facilities participating in a rural health network, but may designate not more than 15 PCHs outside grantee states that would not meet rural health network requirements as defined in the law.

- Later periods: payments to be the per-diem payment amount for the preceding 12-month cost reporting period, increased by the PPS update factor for rural hospitals

- On or after January 1, 1993: a prospective payment system to be used for inpatient PCH services

■ Outpatient PCH services to be covered under Medicare Part B, for services defined as hospital outpatient services

- Before 1993, facilities may elect either of two payment methods:

  (1) a cost-based facility service fee with reasonable charges for professional services billed separately, or

  (2) an all-inclusive rate combining both the professional and facility service components

- By January 1, 1993, a prospective pay ment system for outpatient PCH services is to be developed

Appendix II

Essential Access Community Hospital (EACH) Facility Requirements

Criteria for the Designation of Facilities

- Be located in a rural area (an area outside a metropolitan statistical area)
- Be located more than 35 miles from any hospital that is designated as an EACH, classified as a rural referral center, or located in an urban area but meets the criteria for classification as a regional referral center; or meet other geographic criteria imposed by the state and approved by the Secretary of Health and Human Services
- Have at least 75 inpatient beds, or be located more than 35 miles form any other hospital (the Secretary may waive these restrictions)
- Agree to provide emergency and medical back-up services to PCHs in its rural health network and staff privileges to PCH physicians
- Accept patients transferred from PCHs
- Agree to receive data from and transmit data to PCHs
- Meet any other requirements imposed by the state with the approval of the Secretary

Medicare Reimbursement

- Hospitals designated as EACHs by the Secretary will be treated as "sole community hospitals" for payment purposes
- If the Secretary determines that an EACH incurs increases in reasonable costs during a cost reporting period and will incur increases in subsequent periods because it became a member of a rural health network, the hospital's target payment amount will be increased to account for the increased costs

SOURCE: OBRA-1989, as summarized by Suzanne Felt and George Wright in *Diversity in State's Early Implementation of EACH Program*, Mathematica Policy Research, Inc., July 27, 1992.

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