

Talking Points on FY '05 Budget Cuts in the President's Budget

- These cuts represent a 70% reduction in HRSA's rural specific programs, the largest reductions to rural programs in more than 10 years.
- Included within the cuts, the elimination of the Rural Hospital Flexibility Grant (FLEX) program, elimination of the Small Hospital Improvement Program (SHIP), and a 71% cut in the Health Services Outreach Grant (Outreach) Program. These two cuts alone represent a cut of more than 30% to the budget of the Federal Office of Rural Health Policy.
- The Administration previously stated its goal to limit discretionary spending to less than 1%. This rifle shot cut in rural health care of 70% does not match Administration rhetoric. It is also worth noting, that no other health service program under HRSA faces these kinds of cuts.
- Both the Ship and Flex programs were recently reauthorized by Congress, and approved by the Administration. The Flex program was reauthorized just a couple of months ago in the Medicare Prescription Drug Bill. The Outreach program was reauthorized in the Safety Net Amendments of 2003. There were no concerns raised about the efficacy of these programs. Being that the President signed both of these bills within the past 15 months, I have to assume they had no questions regarding the benefits of these programs then. What has changed?

It is likely the Administration will argue the provider provisions in the Medicare Prescription Drug bill addressed rural health problems. However, several points can be made to refute that argument:

- The Medicare bill did provide more than \$20 billion in payment adjustments for rural providers. However, these adjustments addressed the long-standing inequities in the Medicare payment system. These provisions will greatly help lessen the losses many rural providers face but are no guarantee for long term financial viability. These provisions serve to bring rural providers closer to a level playing field with their urban counterparts.
- Many of the provisions in the Medicare bill were based upon recommendations made by MedPAC. MedPAC never thought these provisions would end the losses. During MedPAC consideration, MedPAC staff specifically noted even if all the recommendations were implemented, they would not ensure positive operating margins for all rural hospitals.
- It is wrong to assume the provisions of the Medicare bill eliminates the need for grant programs that specifically address the health needs of rural communities. The Medicare provisions address only Medicare payment policy. Rural communities face a number of issues apart from Medicare payments. Making this

assumption shows a clear lack of understanding of the problems rural areas face in the health care delivery systems.

Notes on the Medicare Rural Hospital Flexibility Grant Program

- The elimination of the Flex program destroys many of the advances made last year in the Medicare Prescription Drug bill.
- The Flex program gives rural hospitals needed resources to make decisions about how they operate. Rural hospitals cannot afford to hire specialized professional expertise or other business services as urban hospitals, or large health systems can. Among other things, Flex funding allows rural hospitals to determine whether a conversion to CAH status is in the best interest of their community, to participate in quality improvement programs, to work with other providers to expand rural health networks, and to integrate services with their local EMS providers.
- 800 hospitals have received Flex funding to convert to CAH status. Another 300 rural hospitals used Flex funding to explore the CAH program but determined they would best serve their community by remaining a PPS hospital.
- The Medicare bill contained a number of changes to the PPS and CAH reimbursement methodology. Many of these changes created new eligibility standards for CAHs. As such, many more hospitals face the decision as to whether to convert to CAH or remain under the PPS. Without Flex funding, very few of these rural hospitals will be able to properly determine the best course of action for their specific facility and community.
- Flex has also been a valuable resource in allowing rural hospitals to focus on quality improvement programs. While urban providers have been able to work with Medicare Quality Improvement Organizations, rural hospitals have been left out in responding to quality requirements brought by third-party payers.
- Flex has also been successful in bring rural hospitals together with EMS providers to provide a more coordinated service to their communities.

Notes on the Rural Health Services Outreach Grant Program

- The \$17 million reduction in Outreach grants effectively eliminates two of the more popular rural grant programs. Rural Health Outreach Grants and Rural Network Development Grants are both funded under this line.
- It is my understanding, the \$11 million budgeted will only serve as close-out funding to current grantees. Outreach grants are awarded for three years, meaning grantees awarded grants the past two years will be unable to complete their projects. Project directors will lose their jobs and rural communities will face an

economic loss caused by the loss of the projects. It is estimated these cuts will affect as many as 80 rural health projects and rural health networks across the country.

- Outreach grantees generally do not involve hospitals. The funds go to a variety of providers that saw no benefit from the Medicare Prescription Drug Bill, such as public health departments, CHCs, RHCs, mental health providers, and other community based organizations.
- Focus areas funded by Outreach grants include primary care, health education and health promotion, children's health, oral health, mental health, and diabetes. These programs represent 57 grants in 27 states in 2003 accounting for \$31.3 million.
- Outreach grants run for three years with applicant's being eligible for up to \$200,000 a year. The idea of the grants is to provide start up funds to innovative approaches to health problems in rural areas, with the applicants using the three years to make the program self sustaining. According to a study by the University of Minnesota, more than 80% of Outreach grants were still operating five years after federal funding expired.
- Outreach grants also emphasize collaboration by key community groups, requiring at least three health care providers to come together to apply for funding. Historically, programs with broad based community support are most likely to succeed after federal funding ends.

Impact of budget cuts on ORHP:

If the FY 05 budget cuts hold, the following will be some of the direct and indirect impacts on the Federal Office of Rural Health Policy:

- When program budgets are cut, it affects the staffing of the Federal Office. Without the Flex program, the Office will lose several staff positions. The loss of staff leads to a loss of influence -- fewer staff and the Office is able to do less. The hallmark of the Office has been its ability to not only offer grants but also to research policy issues facing rural providers, explain statutory reasons for why some policies are in place and to also help others in HHS understand the unique nature of rural hospitals and their communities.
- Since the creation of the Flex program, the Office has brought in an experienced physician and former rural health care system administrator to direct the program. That, in turn, led to expanded work in the quality arena at the same time that a larger national focus on quality was taking place due to the IOM reports. The timing has been perfect. It has helped the Office be a voice for rural quality concerns so that any quality-focused policies take into account the unique nature of rural, low-volume environments. This has helped ensure that as HHS looks at

quality issues, it does not solely focus on large urban models of quality measurement that have no relevance for rural communities.

- The Flex program has served as the bridging program between the Office and the rural hospital community. ORHP staff effectively makes arguments within the Department about policy impacts on rural hospitals. It's not coincidence that the Office's ability to serve as a policy resource to rural communities has greatly expanded in the past few years. Prior to 1999, the Office had no direct relationship with rural hospitals and it showed.
- The loss of the Flex program also means the end of the Technical Assistance and Services Center, which has not only served as a resource for CAHs but also been a bridge to CMS by helping to identify regulatory issues that are affecting significant numbers of these facilities and bring them to the attention of the CAH Rural liaison contact at the CMS Central Office. This informal feedback loop allows CMS to more quickly ascertain if a problem is localized or is having more of a national or regional impact.
- These budget cuts will directly impact the Federal Office of Rural Health Policy, and its ability to serve rural America from within the Administration.