RURAL AMERICA'S HEALTH CARE SAFETY NET PROVIDERS

Rural Americans make up 20% of the nation's population, but only 9% of the nation's physician practice in rural counties (Rural Health in the United States, 1999). Economic and demographic changes over the last ten years have put the health status and health care resources of rural America at risk.

Access to health care is very important in helping to determine the health status of rural populations. Rural populations tend to be poorer than their urban counterparts and therefore many of the illnesses associated with poverty are more pronounced in rural areas. Rural America is growing more slowly and its population is older than that of the rest of the nation. Rural populations have higher rates of chronic disease, infant mortality, and occupational injuries related to agriculture, mining, forestry and fishing. Migrant and seasonal farmworkers are subject to poor working conditions including substandard housing, exposure to pesticides and other chemicals, and poor sanitation. The Immigrant Reform and Immigration Responsibility Act of 1996 limits health care options for undocumented foreign-born persons and has placed the responsibility of providing health care (charity care) on local safety net providers.

Affordability of health care is an important factor in access to care by rural residents. Rural residents have lower average incomes and higher poverty rates than do urban residents. More than 44 million people, or 18 percent of the total nonelderly population in the United States, lack health care coverage, an increase of 11 million over the past decade. Lack of employer sponsored health insurance or high deductibles and copays also preclude access to care in rural communities. New studies forecast that, absent major reform, the ranks of the uninsured will continue to grow substantially over the foreseeable future (Custer and Ketsche, 1999).

The health care safety net has served as the default system for caring for many of the nation's uninsured and vulnerable populations. In the absence of universal comprehensive coverage, the health care safety net has served as the default system for caring for many of the nation's uninsured and vulnerable populations. The past ten years witnessed dramatic changes in health care delivery. Major changes in Federal health programs have placed the long-term viability of the rural health care delivery system for uninsured and vulnerable populations in jeopardy. It has become increasingly important to define "safety net", as it becomes more and more essential that federal, state, and local policy makers protect and perhaps enhance the ability of the "safety net" to continue to provide services.

A tremendous misunderstanding exists and there is a large disparity between rural and urban health care delivery systems. The changes in financing and delivery of health care over the last ten years impact rural and urban differently. The structure of the health care system, the characteristics of the population, and other facts of rural life differ in significant ways from the urban experience.
The Balanced Budget Act of 1997 (BBA) reduced some of the major direct public subsidies that have financed safety net providers. These reductions included significant cuts in Medicaid DSH payments and a 5 year phase-out of cost-based reimbursement for Rural Health Clinics and FQHCs, placing even more pressure on an already strained safety net system. Although recent revisions to the Balanced Budget Act of 1997 have substantially modified these impacts, the overall effect of this legislation has been to financially squeeze rural hospitals, much more than urban hospitals, because of their smaller operating margins.

When managed care penetrated into rural areas it had an immediate adverse effect on rural safety net providers and their ability to provide services. Patients were often channeled away from local safety net providers, as employers and federal and state mandates (Medicaid and Medicare) locked employees into plans that restricted a choice of provider. Decreased reimbursement, extra paper work generated, extra time spent handling bureaucratic requirements of managed care plans and less money available to shift to the uninsured have dramatically impacted rural safety net providers. Rural safety net providers enter into managed care contracts (Medicare, Medicaid) with a higher unit cost than their urban counterparts. Low health status of rural populations, an under supply of providers and resources, declining population and an increase in the elderly population have all contributed to these higher unit costs. As managed care plans determined their expansion into rural areas had been a failed effort they deserted the rural communities they once fought to enroll. This has left the rural safety net providers in a more difficult situation than the one they were in before managed care arrived. Even in cases where paying patients come back to safety net providers, they still suffer from lower payments and reduced revenues.

When discussing the difficulties these safety net providers are facing, it's important to have a universal understanding and definition of what a safety net provider "is". Unfortunately, a universally accepted definition of Safety Net Providers does not exist. While NRHA endorses the Institute of Medicine's definition for the nation, NRHA must clarify that in rural America we know that teaching and community hospitals, private physicians and ambulatory care sites <u>are</u> the safety net providers.

The Institute of Medicine (IOM) defines the "health care safety net" as:

"Those providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable patients."

IOM further defines a subset of the safety net as "**core** safety net providers".

"These providers have two distinguishing characteristics (1) either by legal mandate or explicitly adopted mission they maintain an "open door", offering access to service for patients regardless of their ability to pay; and (2) a substantial share of their patient mix is uninsured, Medicaid, and other vulnerable patients."

IOM further defines core safety net providers as ***"public hospital systems, federal, state, and locally supported community health centers (CHC's) or clinics (of which federally qualified health centers {FQHCs} are an important subset); In most communities several smaller special service providers (e.g., family planning clinics, school-based health programs, and Ryan White AIDS programs) also are considered a part of the core safety net. In some communities teaching and community hospitals, private physicians, and ambulatory care sites with demonstrated commitment to serving the poor and uninsured fulfill the role of core safety net providers***.[1]"

The IOM's safety net definition includes those providers who accept as part of their mission the un- and underinsured and Medicaid patients. Free clinics, FQHC Look Alikes, Public Health Departments and any entity that provides charity care and/or a sliding fee scale are therefore included. The composition of the safety net and the concentration of responsibility for care for vulnerable populations vary dramatically between urban and rural. The "safety net" in rural areas is a function of demand, with care being delivered jointly by clinics, public, private and teaching hospitals, private professionals, organizations and emergency rooms.

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[1] Institute of Medicine. 2000. *America's Health Care Safety Net*. Washington, DC: National Academy Press

NRHA concerns for the future of the **Rural** Safety Net

1) Economic conditions in rural areas have caused an increase in the number of un- and underinsured. Current and proposed payment methodologies for federally funded primary care health clinics lack economies of scale.

2) Compared to the urban population, the rural population is older and poorer, and more reliant on Medicare and Medicaid, with a smaller proportion of health care payments coming from commercial insurance. This means it is more difficult to shift costs to the well insured when payments do not cover costs.

3) Current and proposed payment methods for community health centers, rural health clinics and other safety net providers do not cover costs for many rural safety net providers, due in part to the need to spread costs over a smaller number of visits.

4) Many rural providers provide free or reduced-fee care without participating in safety net subsidies. These are the most fragile members of the safety net. Many of these providers will be forced to relocate if compensation for their services is not dramatically improved.

5) Efforts should be made to ensure manpower programs such, as the National Health Service Corps (NHSC) continue and expand or the safety net will be unable to expand and/or continue to meet demands. Since NHSC is in jeopardy, the safety net is in jeopardy.

NRHA believes the rural safety net is in extreme jeopardy and requests the immediate attention of public policy officials. As such, NRHA recommends the following:

- Rural reimbursement should be sufficient to cover all costs, including the cost of providing safety net services.
- Expansion of the National Health Service Corps;
- Strengthening rural economies in general;
- Strengthening rural health infrastructure through acknowledgment and advocation for expansion of existing programs (Critical Access Hospitals, Community Grants etc.);
- A pilot grant program to allow support to all safety net providers including for-profits and Rural Health Clinics with charity care and/or sliding fee scales. Specifically, support through programs like NHSC to entities that are clearly safety net providers but have not been eligible for these programs in the past;
- More flexible regulations for rural health entities along with decreased paperwork; requirements are needed. Regulations make it difficult for a small-scale operation to be efficient. Critical Access Hospitals, Provider Based Rural Health Clinics and Emergency Rooms that work in tandem need more flexible regulations to avoid commingling issues; and,
- Quick action to save all Safety Net Providers that are in danger of collapsing through grant, assistance or loan support.
- The NRHA reiterates its position favoring universal insurance coverage and access for all rural residents.

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