Perspective: Health Care Reform In Rural Areas

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Health Care Reform In Rural Areas
by Daniel M. Campion, W. David Helms, and Nancy L. Barrand

Health care reform presents a critical opportunity for addressing fundamental problems in the rural health care delivery system. That was the major theme that emerged from the March 1993 invitational conference, “Health Care Reform in Rural Areas,” cosponsored by The Robert Wood Johnson Foundation and the Arkansas Department of Health. The purpose of the meeting was to develop a cogent statement of the major issues that should be addressed in developing health care reform as it would affect rural health care specifically, and to offer recommendations for consideration by the administration and Congress. This essay highlights the cross-cutting themes and describes the major recommendations that emerged from the conference.

Crafting the thirteen policy recommendations described here was a collaborative effort that involved more than 100 conference attendees who participated in workgroup sessions at the meeting. These participants represented a diverse range of health professions, provider organizations, and state and federal agencies responsible for the delivery of health services in rural areas. Additionally, members of the conference planning committee and the work-group facilitators and recorders offered their comments and editorial advice as we prepared the final conference report.

The conference participants made several assumptions about the potential structure of health care reform to focus their discussions. For example, workshop participants assumed that the federal government would define a standard set of health benefits, that employers and individuals would share the cost of health insurance, and that subsidies would be provided for the poor. They assumed that most persons, except employees of very large firms, would obtain coverage through health insurance purchasing cooperatives (HIPCs) that serve defined geographical areas. HIPCs, or health alliances, as such entities are now being called, would contract with private health plans, which would resemble what architects of managed competition proposals were calling accountable health plans. They also assumed that states would have authority to establish and supervise these HIPCs and that, in areas where competition among accountable health plans would not be feasible, HIPCs would be permitted to set payment rates for providers.

Cross-Cutting Themes

The following cross-cutting themes emerged from the conference: (1) The health care infrastructure—including people, structures, and systems—needs to be strengthened in many rural areas to assure access to essential health care services. (2) Dramatic changes will be needed to provide an adequate supply of primary care providers in rural areas. (3) The development of regional health care networks, which deliver primary care through locally based provid-
ers, should be a fundamental strategy for restructuring rural health care delivery systems. (4) Developing health care networks will require a variety of approaches from managed competition to managed cooperation. (5) Flexibility and a range of options will be necessary for implementing health care reform in rural areas in order to meet diverse local needs and use local resources. (6) The active involvement of rural residents and the meaningful representation of rural communities at the state level will be essential to assure successful implementation of health care reform in rural areas. (7) States should play a major role in implementing health care reform in rural areas.

These themes relate to the central reality that the rural health care delivery system is burdened by persistent problems that will require comprehensive solutions targeted at both the financing and the delivery of health care services. For example, rural residents often must travel long distances to health services and have more difficulty getting there. There is an acute shortage of primary care providers in rural areas, and many communities find it difficult to recruit and retain physicians and other health professionals. Small rural hospitals are more likely than their urban counterparts to be financially distressed. Furthermore, many rural providers have difficulty obtaining the capital financing needed to renovate aging facilities and replace outdated equipment. This web of interrelated problems will require a comprehensive set of solutions that will constitute no less than a major restructuring of the health care delivery system in many rural areas.

Recommendations

With these themes as a backdrop, conferrees urge that the following thirteen recommendations be considered in developing health care reform proposals.

**Define criteria for identifying areas where competition will or will not achieve the desired results.** Given the fundamental concern that a managed competition strategy as envisioned for urban and suburban markets may not work in “noncompetitive” rural health care markets, federal and state governments must develop criteria for identifying locations and conditions under which a competitively based health care reform program is likely, or not likely, to achieve the desired goals. Such criteria could be used for determining distinct populations or geographic areas to be served by HIPCs and accountable health plans, and for determining where exclusive franchises might be given to accountable health plans and/or rural providers. These criteria also would be useful for health care planning and resource allocation purposes. As an illustration, participants outlined a five-tier typology of regions for competition ranging from “frontier,” where competition would not be possible, to “major metropolitan,” where full competition would be sustainable.

**Let states determine the geographic areas served by HIPCs.** If a managed competition framework is adopted for health care reform, states should be given the responsibility for determining the geographic areas to be served by HIPCs. Given states’ interest in and responsibility for guiding the allocation of health care resources, such control would be appropriate given HIPCs’ function as a principal mechanism for pooling and allocating funds. States should be given the latitude to create substate regions for HIPC development, taking into account the boundaries of current health care markets, existing provider and network relationships, and the needs of vulnerable populations.

**Assure an adequate supply of primary care providers for rural areas.** A health care reform program that appropriately places primary care and preventive services as its highest priority will increase the demand on an already limited supply of primary care providers in rural areas. To ensure an adequate supply of these providers, the number of family practice physicians and other primary care practitioners must be increased dramatically. It is imperative to establish national goals for the health professional work force consistent with general population needs and to allocate education and training dollars accordingly. In concert with these national goals, states should establish
state-specific goals that take into account the needs of accountable health plans. States also should be given the authority to oversee the allocation of training resources to increase the supply of primary care providers serving in rural areas.

**Focus medical education on primary care and provide clinical experience in rural practices.** Graduate medical education must be restructured from its current hospital-based focus to include more ambulatory training sites in rural areas. Additional funding should be allocated to rural-based training programs for all levels of primary care professionals, including physicians, nurse practitioners, physician assistants, and certified nurse midwives.

**Provide strong incentives for states to adopt scope-of-practice laws with nationally recognized criteria that enable mid-level practitioners to practice apart from physicians.** If nurse practitioners, physician assistants, and certified nurse midwives are to be an important resource for improving the supply of practitioners in rural areas, it will be necessary to overcome the current state-by-state variation in certification and licensure requirements. Recognizing national certification standards and adopting appropriate scope-of-practice acts at the state level would remove inappropriate restrictions currently codified in law and improve the mobility of this important supply of personnel. Such mid-level practitioners should be enabled to practice semi-independently at sites remote from physician preceptors.

**Require that plans wishing to qualify as an accountable health plan serving a rural region agree to make available the full range of services for all people in the service area, providing appropriate services especially primary care and preventive services through local providers whenever feasible.** Explicitly requiring accountable health plans to make available all of the services prescribed in the anticipated national standard benefit package would increase access to a wider array of health care services for many rural residents. At a minimum, primary care and preventive services should be provided at the local level, with the understanding that in communities that cannot support a general hospital, higher-acuity inpatient services would be available at a regional referral center or an urban hospital.

One way to give priority to local providers would be to allow well-qualified rural practitioners (for example, those who have completed residency programs or are board certified) to have the first option for “bidding” on contracts to serve their established markets. It also may be the case that such a priority status would give local providers the opportunity to establish rural-based accountable health plans or develop rural networks that selectively contract with urban and rural providers for specialty care services. Such arrangements could help to preserve existing doctor/patient relationships, as well as referral and collegial relationships already established by rural practitioners. In this way rural providers would be given the opportunity to take an active role in reforming and strengthening their community’s health care system.

**Establish rules to protect rural providers from unreasonable financial risk.** The imposition of “urban” provider risk-sharing models that pass significantly higher financial risks to individual providers may force some rural practitioners to go out of business or to move to other areas. If these providers leave, it may be difficult to replace them. Many solo practitioners and group practices in rural areas still operate outside of managed care systems and are inexperienced in dealing with the dynamics and financial incentives that drive such systems. There is major concern that such rural providers may not readily adapt to capitated payment systems or systems involving substantial performance-based “withhold” systems. Policymakers should be aware of this extremely sensitive issue.

**Allow for exclusive franchise arrangements for accountable health plans and/or provider networks serving rural areas, where needed.** Where markets are noncompetitive, franchises should be granted whereby certain accountable health plans and/or providers are given an exclusive option of serving local residents. There are
many questions about the ways such exclusive contracts should be structured and awarded. For example, what time limits would be reasonable for giving local providers an exclusive option on serving their region, before opening the area to outside provider groups? What discretion should local residents have in the development and monitoring of franchise agreements?

While franchises may be necessary in more remote, underserved, or vulnerable areas, it is not necessarily the case that this will be the dominant model in all rural areas. Again, a continuum of regulatory and financing options will be needed to accommodate the diverse range of local situations.

Enable HIPCs to arrange coverage for populations covered under Medicare, Medicaid, and the Federal Employees Health Benefits Program (FEHBP). Major policy decisions center on the issue of whether or not the financing resources for those currently covered under major federal programs (Medicare, Medicaid, and the FEHBP) would flow into HIPCs and require these individuals to receive their care through the contracted accountable health plans or other arrangements made by the HIPCs. Because enrollees in these programs often constitute a large percentage of insured persons in rural areas, the prospect of rural providers’ “escaping” reforms by establishing specialized practices to serve mainly, or exclusively, exempted payer populations is particularly disturbing. If these major payers operate outside of the HIPC system, the desired competitive approach, where otherwise feasible, may be undermined in some rural areas. Given that such programs represent a significant proportion of provider revenues in rural areas, special attention should be given to the impact of program exemptions and the payment policies of programs that are exempted.

Subject rural providers opting out of accountable health plans to regulatory oversight on prices and capacity. As noted above, the question of whether providers would join an accountable health plan must be considered in light of the alternatives available to them for opting out of such systems. Two scenarios would be possible: one in which providers can obtain sufficient income from payers exempted from HIPCs, the other in which providers choose to serve HIPC enrollees but operate as solo practitioners. Many believe that providers opting out of managed care systems that are under contract to a HIPC would need to be subject to regulatory oversight, such as through rate regulation and controls on capital expenditures for plant and equipment, to assure compliance with cost containment and quality objectives.

The stringency of such price and capacity controls could provide strong incentives for accountable health plan participation. Conversely, tight price controls on payments could jeopardize goals for recruitment and retention of rural providers, especially if prospects appear better elsewhere. Therefore, special attention should be given both to payment policies for health insurance programs exempted from the HIPC and to the HIPC policies for reimbursing providers who serve HIPC beneficiaries but do not participate in an accountable health plan.

Allow states to oversee the allocation of health care capital to support rural infrastructure development. Access to capital financing with affordable terms is a critical need facing rural health care providers with limited capital reserves. Older rural hospitals have a difficult time maintaining and upgrading their plant and equipment, and both rural hospitals and physicians find it difficult to obtain newer and more advanced health care technologies. Rural communities with little or no established base of networked providers or alternative health plans likely will require greater capital investments to upgrade or convert their existing facilities and form network systems.

States should be given authority to ensure the availability of adequate capital resources and to allocate those resources to support appropriate levels of service in underserved rural areas. States would identify areas needing infusions of new capital and create mechanisms for channeling investment funds to them. Important sources of capital include state bonding authorities, Medicare capital payments, and the portions of payments made by other insurers or
Health plans to cover providers’ capital expenses. Policymakers should be aware of the severe need for capital to build the rural health care infrastructure and how the financial incentives they create under health care reform will be vital to strengthening or weakening the capacity of rural providers to meet local health care needs.

Change federal and/or state statutes to ensure that antitrust laws are not an undue hindrance for rural network development. Some believe that antitrust enforcement practices of the U.S. Department of Justice and the Federal Trade Commission (FTC) have discouraged the formation of the kinds of joint ventures and other arrangements that are vital to network development. Others contend that antitrust rulings should have had little impact on collaborative relationships among hospitals and other providers. The extensive development of new networks that is anticipated, however, may require special attention by both federal and state lawmakers. One option would be modification of federal antitrust laws. An alternative would be for states to exercise “state action immunity” for arrangements that they consider desirable but that might otherwise be ruled unlawful under federal law. To create such immunity, a state must both articulate its policy allowing a particular anticompetitive arrangement and adequately monitor and oversee the resulting organization/arrangement.

If a national service program is developed, place a priority on strengthening the infrastructure for rural health. Rural health care should be given priority under the development of any national service program that would attract college graduates and others into public service. Given that improving rural health care is a major national concern, any such program should seek to strengthen the supply of not only health care professionals, but also managers, engineers, planners, and others vital to strengthening the rural health care infrastructure.

This essay is based on the proceedings of the invitational conference, “Health Care Reform in Rural Areas,” 10-12 March 1993, in Little Rock, Arkansas. The conference, cosponsored by The Robert Wood Johnson Foundation and the Arkansas Department of Health, was conducted by the Alpha Center. The authors express special appreciation to Charles McGrew and Linda Goldsmith of the Arkansas Department of Health for initiating and graciously hosting the conference. The views expressed do not constitute the official positions of The Robert Wood Johnson Foundation, the Arkansas Department of Health, or any other government or private organization represented at this conference.

NOTES
1. A list of the planning committee and work-group participants is included in the complete conference report, which is available from the Alpha Center, Suite 1100, 1350 Connecticut Avenue, N.W., Washington, D.C. 20036.