

CAPITAL AREA RURAL HEALTH ROUNDTABLE

Selected Federal Programs

Meeting the Health Care

Needs of Rural Americans

2001

Table of Contents

Introduction: Selected Federal Programs	5
Special Medicare Hospital Reimbursements	7
Sole Community Hospitals (SCHs)	7
Medicare-Dependent Hospitals (MDHs)	8
Disproportionate-Share Hospitals (DSHs)	8
Rural Referral Centers (RRCs)	9
Medicare Physician Incentive Payments	9
Rural Health Outreach, Network Development and Telemedicine Grants	10
Medicare Rural Hospital Flexibility Program (including Critical Access Hospitals)	12
State Offices of Rural Health Grant Program	13
The National Health Service Corps	14
Community Health Centers and Migrant Health Centers	15
Federally Qualified Health Center ‘Look-Alike’ Program	16
Rural Health Clinics	17
Rural Health Research Centers Program	18
Area Health Education Centers (AHECs)	19
Quentin N. Burdick Interdisciplinary Rural Training Grants	20
Health Professions Education Programs	21
Rural Recruitment and Retention Network (3-R Net)	22
The Rural Information Center Health Service (RICHS)	22
State Children’s Health Insurance Program (SCHIP)	23
National Rural Health Resource Center	24
Operation Rural Health Works	25
Federal and Other Rural Health Websites	26

Selected Federal Programs Meeting the Health Care Needs of Rural Americans

The following is a brief description of some *federal* programs and federally-supported initiatives that are significant in the support of rural health care services. Many are federal-state partnerships. Today, individual states play an active role in supporting rural health; and while their individual programs are not noted here, information about them is available through state offices of rural health or through state rural health associations.

Maintaining access to quality health care services and developing a sustainable delivery system in rural America remains a challenge. Health care must be local—at least primary and emergency care. The economic viability of a community depends on it. But small and remote rural communities often lack the critical mass of population and resources to support today's ever more complex technologies and specialty practices. Rural providers must spread their fixed costs, for example, over a relatively small volume of paying customers.

In the last decade, a national and state focus on rural health needs has developed to not just stave off the decline of rural services but to seed new initiatives and stimulate development of delivery models that will be sustainable. Rural health issues are becoming an accepted corollary of national health care policymaking as recognition grows for the importance of well-distributed health care service. Also fundamental to rural health service has been the need to overcome classic rural isolation. An activist state and national approach has been to create a rural information highway through which rural leaders can share the latest research, information and technical assistance.

Today, with national and statewide coalition-building and information sharing, some rural communities are starting to rebuild their health care systems. They are laying a foundation of basic primary care and tying local service into an area network of acute care and emergency services. Many have formed local consortiums, employed physician assistants and nurse practitioners, transformed ailing hospitals, and formed recruitment networks to draw interested practitioners to their communities.

The federal programs of assistance and economic stimulus described here vary in their strategies -- from providing direct funding for services to needy populations, to increasing the supply of rural practitioners, to supporting rural services research and disseminating information, to seeding new initiatives. Some are national grant programs, others are programs of enhanced reimbursement under Medicare and Medicaid. Still others provide seed money for local innovation. They are not all exclusively rural in focus, nor are they a complete list of supportive federal programs. For more information, contact the Office of Rural Health Policy, Health Resources and Services Administration; or the Rural Information Center Health Service (RICHS), a federal reference service sponsored jointly by the Department of Health and Human Services and the Department of Agriculture and available at (800) 633-7701 or on the Internet at www.nal.usda.gov/ric/richs.

Special Medicare Hospital Reimbursements

Facing rising costs for Medicare in-hospital payments, Congress in 1983 introduced a prospective payment system that limited Medicare's obligation to a schedule of pre-determined payments for varying procedures. The procedures are catalogued in a complex system known as DRGs or diagnostic-related groups and the entire payment program is known as the prospective payment system (PPS). Because PPS has affected the financial position of many inner-city and also rural hospitals, Congress over the years has added a variety of special payment schemes to assure that seniors will have access to hospital care. Some payment provisions are for both urban and rural hospitals while others are exclusively for rural hospitals.

Sole Community Hospitals

Sole Community Hospital (SCH) designation is intended to identify hospitals that are the only providers of hospital care in their market area either because they are geographically isolated or severe weather or travel conditions prevent travel to another hospital offering similar services. SCHs are reimbursed by Medicare according to calculations of their base year costs for 1982, 1987, or 1996. They receive the higher of their 1982, 1987 or 1996 costs trended forward if those amounts are higher than the current prospective payment.

Alternatively, a sole community hospital may opt for PPS payment plus a Disproportionate Share Hospital (DSH) payment, instead. DSH is an add-on to the DRG payment reserved for hospitals whose share of low income patients is high enough to meet a threshold set in legislation. [See Disproportionate Share Hospitals] Sole Community Hospitals also receive preferential treatment if they seek geographic reclassification to a higher, urban-area wage index.

To qualify for SCH status under Medicare, a hospital must be 35 miles from any other like hospital, or the hospital could be between 25 and 35 miles from any other like hospital by meeting one of the following criteria:

- No more than 25 percent of all inpatients or 25 percent of inpatient Medicare beneficiaries in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital,
- The hospital has fewer than 50 beds and would have met the above criteria except that some beneficiaries or residents were forced to seek care outside the service area due to the unavailability of necessary specialty services,
- Because of local topography or periods of prolonged severe weather conditions, nearby like hospitals are inaccessible for at least 30 days in each 2 out of 3 years.
- Because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.

There are 661 SCHs as of fiscal year 2001. Some have been grandfathered in the program, although they no longer meet the criteria because (for example) their counties have gained urban classification.

Federal Contact: Ann Tayloe
Health Care Financing Admin.
(410) 786- 4546

Medicare-Dependent Hospitals

The Medicare-dependent designation for certain hospitals was established in 1990 under the *Omnibus Budget Reconciliation Act of 1989*. The payment program expired in 1994 and was reauthorized in the *Balanced Budget Act of 1997* and subsequently modified under the *Balanced Budget Refinement Act of 1999* and the *Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000* (BIPA).

Medicare-dependent hospitals are small rural hospitals for which Medicare patients comprise a significant percentage of their patients and, hence, their revenues. They are considered more financially vulnerable under prospective payment than hospitals which are reimbursed for patient care through a more equitable mix of private and public insurance.

A rural hospital can be classified as Medicare-dependent if it has 100 beds or fewer, is not classified as a sole community hospital, and at least 60 percent of inpatient days or discharges are attributable to patients receiving Medicare. Medicare-dependent hospitals are reimbursed in the same manner as sole community hospitals, except that they receive half rather than all of the difference between the PPS rate and their base year costs trended forward. As of FY2001, there are 352 MDHs.

Federal Contact: Ann Tayloe
Health Care Financing Admin.
(401) 786-4546

Disproportionate-Share Hospitals

Based on the concept that poor patients are generally more costly to treat and consequently hospitals with substantial numbers of low-income patients incur more expense, Congress introduced disproportionate-share or DSH payments in 1986, principally for large urban hospitals. These payments were designed to offset the financial burden of uncompensated care and inadequate payments from Medicaid and other programs for indigent patients. They are distributed through a percentage add-on to the basic DRG rates. A hospital's share of low income patients is measured by its share of Medicaid patient days and patient days for Medicare patients with Supplemental Security Income.

The DSH formulas do not account for all of a hospital's care to the poor. Most notably they do not take into account uncompensated care provided to uninsured patients.

A number of changes have been made to the DSH payments since the program was first instituted. Over the years, Congress has legislated a number of special formulas tied to such

variables as hospital size and case mix. These formulas have tended to favor large urban hospitals. Until recently, rural hospitals had a much higher threshold (minimum low-income patient share) to meet to qualify for DSH payments.

Under the *Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000* (BIPA), the threshold for DSH eligibility is now the same for rural as for urban hospitals. However, urban hospitals still receive higher payment add-ons as BIPA placed a cap of 5.25% on additional DSH payments that rural hospitals can receive.

Federal Contact: Ann Tayloe
Health Care Financing Admin.
(410) 786-4546

Rural Referral Centers

Rural referral centers (RRCs) were authorized under the *Tax Equity and Fiscal Responsibility Act of 1982*. These are rural hospitals with generally high-volume whose costs more closely resemble those of urban hospitals because they treat regionally or nationally referred complex cases. Created when Medicare changed to prospective payment and when that payment system employed a differential (lower base payment rate) for rural hospitals, policymakers acknowledged that large rural facilities of 275 beds or more were likely to incur costs similar to urban hospitals with a similarly resource-intensive case mix.

Although Congress has subsequently eliminated the urban-rural differential, rural referral centers are still recognized under Medicare for their role in providing specialized care to rural beneficiaries from a wide geographic area.

Today some 150 RRCs receive a more generous DSH payment than is available to other rural hospitals. Also, under liberal criteria for geographic reclassification, more than 80 percent have switched to an urban category that permits a higher wage index in the Medicare PPS formula.

Federal Contact: Ann Tayloe
Health Care Financing Admin.
(410) 786-4546

Medicare Physician Incentive Payments

Special physician-incentive payments by Medicare were introduced by Congress in 1989 to help attract and retain qualified physicians to underserved rural communities. Under this program, a physician receives a 10 percent “bonus” payment for treating a Medicare patient. To qualify for the bonus, the physician services must be provided in an area designated by the federal government as a Health Professional Shortage Area (HPSA). Initially the bonus payments were for services provided in rural HPSAs only. Today they are also paid, as well, to physicians, including specialists practicing in urban sites with HPSA designation. The Health Resources and Services Administration administers the designation process and publishes information on geographic shortage areas.

Federal Contact: Tom Morris
Office of Rural Health Policy
Health Resources & Services Admin.
(301) 443-0835

Rural Health Outreach, Network Development, and Telemedicine Grants

Administered by the Health Resources and Services Administration's Office of Rural Health Policy, the following three programs are designed to support the direct delivery of services in rural areas by promoting institutional partnerships that will leverage scarce local resources. Although they are authorized under one legislative measure, the Consolidated Health Centers Act of 1996, they are distinct programs with separate requirements and grant cycles.

Rural Health Services Outreach Grants

Rural Health Services Outreach Grants are competitive grants made to rural community providers to support creative models of outreach to populations needing essential health services, health education, or prevention services. The emphasis is on creating institutional partnerships that will leverage scarce resources. Awards are made for up to three years, but require annual noncompeting continuing applications.

The grants average \$180,000 per year, but applicants can request up to \$200,000 per year for up to three years. The funds may be used for a variety of health or educational services. Projects are based on community need. The applicant is required to demonstrate community involvement in identifying the needs that are to be addressed and the strategies for addressing the needs. To apply, the applicant's administrative headquarters must be rural-based, it must be a public or nonprofit institution and it must form an informal network with at least two other partners. Partners have included clinics, hospitals, churches, schools, Emergency Medical Service providers, universities, private practices, nursing homes, public health agencies, civic organizations and many other organizations that support the delivery of health services to the community.

Projects have ranged from creating hospice care to bringing health services to school, to training paramedics, providing mental health services, developing community health education, and offering prenatal care. The goal of the program is to develop models for providing services that would not otherwise be available while supporting the development of local networks. Grantees are also charged with developing a self-sustaining financial program to follow the grant period.

Federal Contact: Eileen Holloran
Office of Rural Health Policy
Health Resources & Services Admin.
(301) 443-0835

Rural Health Network Development Grants

In 1997, Congress expanded the rural Outreach program to include network development grants. These competitive grants are designed for organizations that wish to establish formal, vertically-integrated health care systems to ultimately improve the delivery of health care services in rural communities. A vertically integrated system would include three or more organizations that collectively provide a range of primary and acute care services. Network partners could include a hospital, a physician group, a nursing home and a home health agency, for example.

Grants averaging \$170,000 per year are made for up to three years. The grants support organizational development activities and services that may result from these activities. It is expected that the networks will be able to assume some degree of financial risk for their services at some point in their development and will be linked by shared clinical and administrative information systems. To be eligible, the network's administrative headquarters must be located in a rural area and the grantee must be a public or nonprofit entity.

Federal Contact: Jessamy Taylor
Office of Rural Health Policy
Health Resources & Services Admin.
(301) 443-0835

Rural Telemedicine Grants

This grant program is designed to help increase access to quality care services in underserved rural communities through the use of advanced telecommunications and information technology. These grants support clinical services provided over a distance such as radiology, dermatology, cardiology, orthopedics, obstetrics and gynecology, pediatrics, and mental health care.

The program is designed to reduce the isolation of rural providers, foster integrated delivery systems through network development, and test a range of telemedicine applications for feasibility, cost, appropriateness, and acceptability to practitioners and patients. The grants are competitive. Grantees are expected to participate in a program of information and data collection in order to provide the federal government with baseline information for more systematic evaluation of telemedicine.

The next round of competition will occur in early 2003. In the previous grant cycle, \$5.2 million was awarded for 19 projects. The average grant award is around \$274,000 annually for a three-year project period. Grant applicants must be a public (non-federal) or private nonprofit entity and part of a multi-specialty network that provides 24-hour access to a range of services. While the grantee may be located in either a rural or urban area, at least two network members must be rural health facilities, such as hospitals, physician offices, clinics, community health clinics, or nursing homes. Other network members may be private, for-profit providers. Grantees will be expected to offer a range of clinical services over the grant period.

Federal Contact: Karen Sleezer
Office for the Advancement of Telehealth
Health Resources & Services Admin.
(301) 443-0447
Also: <http://telehealth.hrsa.gov>

Medicare Rural Hospital Flexibility Program (including Critical Access Hospitals)

Authorized in the *Balanced Budget Act of 1997*, the Medicare Rural Hospital Flexibility Program represents national implementation of earlier demonstrations in limited-service hospital designs: the Montana Medical Assistance Facility, and the Rural Primary Care Hospital. The concept underlying the program is one of bolstering fragile rural services through network development. There are several goals of this state grant program: development of state rural health plans, conversion of small rural hospitals to Critical Access Hospital (CAH) status, development of rural health care networks associated with CAH's, integration and strengthening of rural emergency medical systems, and improving the quality of health care services for rural populations.

Authorized through 2002, the program offers \$25 million per year for four years to help states implement the CAH initiative. State awards have ranged from \$200,000 to \$700,000 per state, depending on need and the likely number of hospital conversions. Most, though not all of the grantees, are state offices of rural health, which are implementing the planning and development phases of the CAH program.

States are required to help local communities and their hospitals decide on the appropriateness of CAH status and to provide technical assistance for hospitals that do undertake the conversion. States are also required to work with emergency medical systems, hospital associations and other groups in doing so. In addition to these activities, states may use the funds to support communities as they develop or implement health care networks, support expansion of programs to improve and integrate rural emergency medical services into rural health networks, and develop or enhance local health system quality improvement activities.

To further facilitate implementation of the Rural Hospital Flexibility Program, the Office of Rural Health Policy created a cooperative agreement with a consortium of research centers to conduct ongoing evaluation of the program as it is implemented throughout the states. The first-year of funding for this undertaking is \$900,000. [See Rural Research Centers Program]

Critical Access Hospital Designation

The Critical Access Hospital designation gives very small, rural hospitals staffing flexibility under Medicare rules for providing emergency, outpatient, and short-stay inpatient services. Qualified CAHs receive Medicare reimbursement for inpatient and outpatient Part A services on a cost-basis, rather than the standard reimbursement Medicare formulas. Though not a requirement of federal law, some states have opted to provide cost-based reimbursement for CAH Medicaid patients.

A basic premise of the CAH program is to give facilities with very low inpatient volumes more administrative flexibility in services and staffing, while providing a bulwark of assistance through affiliation with full-service hospitals. For example, CAHs can have an emergency-room physician on-call rather than on site 24-hours. CAHs are also encouraged to strengthen their spectrum of services through networking and enhancing their relationship with their communities.

To qualify for CAH status, a rural hospital must be an essential provider in the area as defined by distance or some other criteria; must provide 24 hour emergency services; and it must have no more than 15 acute-care beds or 25 swing beds (of which no more than 15 can be occupied by acute care patients at any one time). Also, CAHs are limited to a yearly average length of patient stay of 96 hours. They are encouraged (and some states require) network affiliation with a full-service, acute care hospital. Under recent legislation, rural hospitals that have closed within the past ten years may qualify to reopen as CAHs.

The CAH program is being implemented through the states, which are required to do strategic planning, establish criteria for eligibility in terms of essential access, and assist interested hospitals. Actual Medicare certification (under Medicare conditions of participation) is granted through a regional office of the Health Care Financing Administration. As of January 2001, 303 CAHs in 35 states have been certified.

Federal Contacts:

Forrest W. Calico or Sahira Rafiullah
Office of Rural Health Policy
Health Resources and Services Admin.
(301) 443-0835
E-mail: fcalico@hrsa.gov
srafiullah@hrsa.gov

State Contacts:

The respective State Office of Rural Health, or see
<http://www.nal.usda.gov/orhp>

State Offices of Rural Health Grant Program

The State Office of Rural Health Grant Program is a small matching grant program to states to promote the operation of state offices of rural health. The program is funded at \$4 million and averages \$70,000 per state. Since the initiation of the program in 1991, the number of state offices has increased from 14 to 50. The concept behind the program is to create a state focus for rural health interests, bring technical assistance to rural communities, and help them tap state and national resources for rural health and economic development.

Most state offices are located in state health departments, but some are based at state academic institutions. While some of the older state offices have a sizeable staff, most are operated by one or two staffers who broker rural interests through a myriad of health and economic development agencies and organizations. Under the terms of the federal matching

funds, state offices have four responsibilities: to coordinate rural activities and interests across the state; provide technical assistance to rural communities-- especially to capture state, foundation, and national funding; to improve recruitment and retention of health professionals; and to collect and disseminate information. The state offices also play a rural coordinating role for national initiatives such as the State Children's Health Insurance Program and the Rural Hospital Flexibility Grant Program.

Another concept behind the program is for state offices to collaborate nationally, thereby linking otherwise isolated rural areas to national information and support. To support that goal, the program sponsors an annual meeting of state office directors.

Federal Contact: Roberto Anson
Office of Rural Health Policy
Health Resources & Services Admin.
(301) 443-0835

Also: Nat'l. Organization of State Offices of Rural Health
www.ruralcenter.org/nosorh

The National Health Service Corps

The National Health Service Corps is a federal program funded in FY 2001 at \$125 million to encourage health care professionals to practice in underserved communities. The Corps offers scholarships or loan repayments in exchange for a period of service at sites located in areas designated by the federal government as Health Professional Shortage Areas (HPSAs). By offering scholarships to students or loan repayment to already trained primary care clinicians, and matching candidates with communities in need of service, the Corps has fielded more than 20,000 clinicians since 1972.

The NHSC is designed to redress the maldistribution of health care services in the nation, promote more primary care practice, an ethnically diverse workforce, and adequate care in poor or remote communities that do not easily attract practitioners. It currently has 2,376 clinicians in frontier, rural, and inner city areas of every state, the District of Columbia, Puerto Rico, and the Pacific Basin. They meet approximately 12 percent of the identified need, according to the Health Resources and Services Administration, which administers the program. A majority of NHSC clinicians are primary care physicians, but the program also recruits nurse practitioners, physician assistants, and certified nurse midwives; dentists and dental hygienists; psychiatrists, psychologists, social workers, marriage and family therapists, and psychiatric nurse specialists.

The Corps is funded through two lines of appropriation: a recruitment line for loans and scholarships and a "field" appropriation for site development and support. Forty percent of the NHSC recruitment line appropriation must be utilized for scholarships. The law also sets aside ten percent of the recruitment budget for scholarships for nurse practitioners, physician assistants, and certified nurse midwives which annually produces forty-five percent of the scholars. The NHSC also partners with 33 states by providing matching grants for state loan repayment programs.

To identify potential host sites, the Corps works with state primary care associations and with state primary care offices. Approximately 60 percent of placements are in rural areas. The host clinic pays the salary of the NHSC practitioner, not the federal government. Many sites are grant-supported community and migrant health centers, although an increasing number of new sites include private practices and health department and hospital clinics. Approximately half of all NHSC clinicians continue to work in underserved localities following their service commitment.

Federal Contact: M.K. Berry
National Health Service Corps
Bureau of Primary Health Care
Health Resources and Services Admin.
(301) 594-4199

Also: Kathie Westpheling
Assoc. of Clinicians for the Underserved
(703) 448-8528

Community Health Centers and Migrant Health Centers

The Community Health Centers program is a more than \$1.1 billion federal grant program funded under Section 330 of the *Consolidated Health Centers Act of 1996* that provides for primary and preventive health care services in medically underserved areas throughout the U.S. and its territories. Migrant Health Centers, Health Care for the Homeless, and Primary Care for residents of Public Housing programs also fall under the act.

Community Health Centers are community-run, non-profit or public clinics that offer services to all, regardless of ability to pay. They provide family-oriented primary and preventive health care services in rural and urban medically underserved communities where economic, geographic, or cultural barriers limit access to care. Services are tailored to the needs of the community.

Currently there are more than 700 CHC grantees in operation with over 3,000 sites throughout the country. CHCs serve over 9 million people annually, of whom 66% live below the poverty level. Approximately half are in rural areas.

The Migrant Health Program provides grants to more than 120 community-based health centers and state organizations that, in turn, care for some 600,000 migratory and seasonal farm workers. In fiscal 2000, the Migrant Health Center program expended \$88 million to these centers.

Under the Medicare/Medicaid program, Community Health Centers and Migrant Health Centers are considered “Federally-Qualified Health Centers,” which has meant that they also qualify for cost-based reimbursement for their Medicare and Medicaid patients. However, Medicaid terms began to change in 1997.

The *Balanced Budget Act of 1997* allowed states to reduce or phase-out cost-based

Medicaid. Subsequently, under the BIPA (*Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000*) a compromise was created that allows states (as of January 1, 2001) to use a prospective payment system based on the average of each clinic's costs calculated for FY 1999 and 2000. It will be adjusted in subsequent years for increases in the Medical Expenditure Index for primary care.

Many states have also moved their Medicaid beneficiaries into managed care plans. Consequently, Community Health Centers and Migrant Health Centers now compete with the private-sector for state Medicaid contracts.

CHCs and MHCs also rely on funding from state and local government, foundation grants, private insurance, and sliding-scale patient fees. However, Medicaid was reported to be the largest funding source (32 percent) in 1999, with federal grants (27 percent) being the second largest source.

Federal Contact: Richard Bohrer
Division of Community and Migrant Health
Bureau of Primary Health Care, HRSA
(301) 594-4300
www.bphc.hrsa.gov

Also: Dan Hawkins
Nat'l. Assoc. of Community Health Centers
(202) 659-8008

Federally Qualified Health Center 'Look-Alike' Program

Federally-Qualified Health Center (FQHCs) 'Look-Alikes' are community-run health clinics that qualify under Medicare to receive cost-based reimbursement. The 'FQHC Look-Alike' program was designed to extend federal support to as many clinics as possible beyond the Community Health Center grant program. The program makes it possible for health facilities similar to Community Health Centers serving the poor to qualify for the cost-based Medicare reimbursement, even though they do not receive grant funding, as do CHCs and MHCs. To qualify as an FQHC 'Look-Alike', the facility must meet the same qualifications as CHCs by being a nonprofit or public entity, offering services to all regardless of ability to pay, having a governing board with community representation, and being located in a medically underserved area.

Although the *Balanced Budget Act of 1997* allowed states to reduce or phase-out cost-based Medicaid, the BIPA (*Medicare, Medicaid and SCHIP Benefits Improvements and Protection Act of 2000*) subsequently created a compromise that allows states to use a prospective payment system. Payments are now based on the average of each clinic's costs calculated for FY 1999 and 2000 and adjusted in subsequent years for increases in the Medical Expenditure Index for primary care.

Approximately 125 FQHC 'Look-Alikes' provide care for an estimated 1.5 million people. The Health Care Financing Administration administers the reimbursements, but the HRSA Bureau of Primary Health Care reviews FQHC applications.

Federal Contact: Elizabeth Darling
Division of Community and Migrant Health
Bureau of Primary Health Care
Health Resources & Services Admin.
(301) 594-4342

Also: Dan Hawkins
Nat'l. Assoc. of Community Health Centers
(202) 659-8008

Rural Health Clinics

The Rural Health Clinic (RHC) program is not a grant program, but a reimbursement program that provides cost-based Medicare and Medicaid payments to private medical practices as well as public and nonprofit facilities that provide primary care in underserved rural areas. Some clinics are free-standing and others are owned by hospitals.

Although the *Balanced Budget Act of 1997* allowed states to reduce or phase-out cost-based Medicaid, the *Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000* (BIPA) subsequently created a compromise that allows states to use a prospective payment system based on the average of each RHC's costs calculated for FY 1999 and 2000. (In subsequent years, an RHC's Medicaid payment rate will be determined from its FY 1999-2000 cost base trended forward by the increase in the Medical Expenditure Index (MEI) for primary care.)

The Rural Health Clinic Services Act was passed in 1977 to help rural practices remain financially viable and encourage the use of mid-level providers in areas short of physicians. The rationale was that in such regions, clinics staffed by nurse practitioners, physician assistants, and certified nurse midwives can offer health care to rural residents under the oversight of an area physician, although the physician may not always be on site.

To qualify for Rural Health Clinic status, therefore, a clinic must be located in a *rural* health shortage area (designated either by the federal government or by a governor) and it must employ nurse practitioners, nurse midwives, or physician assistants. A Rural Health Clinic can be independent or owned by a hospital, nursing home, or home health agency.

Under Medicare, BIPA provides for RHCs and FQHCs (see Federally-Qualified Health Centers) to continue receiving payment on a per visit basis that includes a cap. The new law, however, waives the cap for those clinics owned by a hospital of under 50 beds (including those owned by a small urban hospital).

Today, officially designated rural health clinics number approximately 3,500 and make up one of the larger outpatient primary care programs for rural underserved communities. The program has added to the cadre of practitioners available to rural communities. Many RHCs are located in regions where there are no federally subsidized community health centers. The Health Care Financing Administration, with the participation of state survey agencies, administers the Rural Health Clinic program.

Federal Contact: David Worgo
Center for Medicaid and State Operations
Health Care Financing Admin.
(410) 786-5919

Also: Bill Finerfrock
Nat'l. Assoc. of Rural Health Clinics
(202) 543-0348

Rural Health Research Centers Program

Under this \$3 million program, the federal government funds rural health services research. The Program objective is to increase the amount of high quality, policy relevant, rural health services research being conducted. Through cooperative agreements with universities and other centers of health services research, the program supports applied rural research and policy analysis to help inform health policy decision-making. Grants are approximately \$500,000.

A cooperative agreement provides for the government agency and the awardee to work as partners to jointly define, refine and shape research and analytic projects as they progress and as the need arises.

A concept underlying the program is that in the absence of rural research, national policymakers tend to operate on assumptions derived from urban conditions, with rural needs and conditions often left unexamined. The rural research program is designed to focus on the needs of the approximately 20 percent of the U.S. population that is rural, a population that often falls outside urban norms for density, incomes, and access to services. Another concern underlying the program is that unlike urban health services, a discrete (rural) population can be entirely dependent on a single existing service.

Established in 1988, to cultivate the fledgling field of rural health services research, the program strategy has been to bring researchers and policymakers together on common ground to pursue answers and to collaborate where possible. The program supports a website for describing research in progress, and sponsors annual meetings among research center directors.

Six centers have cooperative agreements in this program for FY 2001-2004. Three awards for "general rural health research" were made to three centers to concentrate on health services issues. Additionally, three awards were made for "analytic centers" to focus on studies, usually of national data sets to inform national policy development. The three general research centers are: the University of South Carolina, Texas A&M University, and

the University of Washington. The three analytic research centers are: Project HOPE, the University of Nebraska, and the University of North Carolina. The next competition will occur in FY 2004.

Federal Contact: Joan Van Nostrand
Office of Rural Health Policy
Health Resources & Services Admin.
(301) 443-0835

Also See: "Research in Progress" at <http://www.rural-health.org>

Area Health Education Centers (AHECs)

The Area Health Education Centers (AHEC) program provides federal matching funds to medical schools, health science centers, and nursing schools to support practice and promote both urban and rural community-based training. In terms of rural areas, AHEC's goals are to increase the availability of health professions training and continuing medical education services in underserved rural areas by bringing the resources of health care's academic institutions to rural communities. AHECs are usually operated through a federal, state, and local funding effort. Nursing schools became eligible for AHEC program awards in 1999 in states where there are no AHEC programs. There are as yet no nursing school awardees.

The AHECs provide a variety of support to the local practitioner community such as locum tenens, continuing medical education courses, access to health science libraries, and access to colleagues in medical specialties. AHEC center staff also promote rural health care career choices by arranging local rural preceptorships and training sites for health professions students. They also sponsor community health initiatives and some have developed programs to interest local youth (K-12) in rural health careers. An AHEC may also initiate projects that draw on the strengths of the academic institution to meet area needs. The development of a telecommunications program to upgrade the skills of frontier EMS personnel is an example of such an initiative.

Under the program, an AHEC program office is established through a cooperative agreement with the awarded school, and affiliated AHEC centers are subsequently developed in community settings. A cooperative agreement is similar to a grant, but requires a partnership between the government and the grantee. States usually assume an increasing portion of the matching funds each year. In fully developed AHEC programs, 75% of the federal funds are allocated to AHEC centers.

The program, which is funded at \$33.4 million for FY 2001, is administered through the Health Resources and Services Administration's Bureau of Health Professions. An AHEC may qualify for federal funds for up to six years for development and implementation of a basic AHEC center, and up to 12 years for a full program that may cover a substantial area of a state. Small recurring awards are also available for model AHEC programs. A total of 40 AHEC programs with 170 affiliated AHEC centers are currently operating in forty states.

Federal Contact: Louis D. Coccodrilli, M.P.H.
Chief, AHEC Branch
Division of Interdisciplinary Community-Based Programs
Bureau of Health Professions
Health Resources & Services Admin.
(301) 443-6950

Also: Jeffrey F. Butler, M.S.
Nat'l. AHEC Organization (NAO)
(503) 494-4248
E-mail: butlerj@ohsu.edu

Quentin N. Burdick Interdisciplinary Rural Training Grants

The purpose of this grant program is to promote rural health care practice by supporting interdisciplinary training at rural sites. First authorized in 1988, a total of \$41 million has been offered over the last ten years to colleges, universities and various professional training institutions to allow a mix of students to train in an interdisciplinary manner in a rural environment. Federally funded at \$5.9 million for FY 2001, grants are approximately \$190,000 per institution.

The concept behind the program is that health care practitioners can strengthen their interdisciplinary training and practice perspectives with exposure to a full range of health care professionals outside their own disciplines – whether in nursing, pharmacy, dentistry, public health, mental health, or medicine. Rural practitioners, in particular, are less likely to have a cohort of similar practitioners available to them, so that professional training experience in a rural site with a mix of practitioners can predispose them to collaborations that can assist in overcoming their rural isolation.

Since 1990, 10,000 providers, preceptors, and students have been trained under the program grants. Fifty-four percent are reported to be currently working in rural or frontier areas. All Interdisciplinary Rural Health Programs target federally-designated Health Professions Shortage Areas (HPSA).

Federal Contact: Judith Arndt
Bureau of Health Professions
Rural Health Interdisciplinary Training Grant Program
Health Resources & Services Admin.
(301) 443-6887 ext. 2

Health Professions Education Programs

Under *Title VII and VIII of the Public Health Service Act*, the HRSA Bureau of Health Professions administers some \$353 million in grant dollars for health professions education. Various grants are available for medicine, dentistry, nurse education, and allied health training with funding priorities that emphasize generalist training, community-based training, and students from under-represented rural and minority communities. In 2000, some \$73 million of these programs had a specific rural component, such as rotations in rural training sites.

While 10 percent of the graduates of all U.S. health care programs work in medically underserved communities, bureau-funded graduates are three to ten times more likely to serve in such areas, according to the agency. These health professions education programs also include Geriatric Education Centers, all of which have a rural component. The bureau's allied health workforce training programs also have a largely rural focus.

The Bureau of Health Professionals does not annually break out data on rural components of its health professions training programs. The following information was available for specific years: forty-three of the primary care physician training programs receiving funding through the Division of Medicine and Dentistry in 1998 (\$16.7 M) had a rural component or a preference for institutions with a history of placing graduates in underserved areas. Eighty-seven of the nursing programs administered by the Division of Nursing had a rural health component in 2000. Those with a rural health component included nurse anesthetists, advance nurse education, nurse practitioners, certified nurse midwifery, and special nursing projects. Also, 35 of 42 grant programs for the support of physician assistant training in 1998 had a rural component.

Federal Contacts:

Denise H. Geolot
Division of Nursing
Bureau of Health Professions
Health Resources & Services Admin.
(301) 443-5688

Bernice A. Parlak
Division of Interdisciplinary, Community Based Programs
Bureau of Health Professions
Health Resources & Services Admin.
(301) 443-1648

Jeff Dunlap
Center for Public Health
Bureau of Health Professions
Health Resources & Services Admin.
(301) 443-6853

Carol J. Bazell
Division of Medicine & Dentistry
Bureau of Health Professions
Health Resources & Services Admin.
(301) 443-6190

The Rural Recruitment and Retention Network (3-R Net)

The National Rural Recruitment and Retention Network, or 3-R Net, consists of state organizations created to assist health professionals locate suitable practice sites in rural areas. The network functions as a clearinghouse for 46 state recruitment programs that help rural communities recruit and retain health professionals. Network members are nonprofit organizations, such as state primary care associations, state offices of rural health, Area Health Education Centers and other statewide not-for-profit groups.

Health professionals can get help by simply visiting the 3-R Net website or calling the 1-800 number. Specific services in each state differ, but many include the provision of practice and community profiles, assistance with transportation and site visits, and advice on the recruitment process, as well as other assistance. The program is funded through federal and private grant support. Since 1995 the HRSA Office of Rural Health Policy has provided some federal funds for the annual operation of the network -- currently \$81,000.

The 3-R Net collaborates with two federal recruitment programs, those of the National Health Service Corps and the Indian Health Service. It has also collaborated with the Robert Wood Johnson Foundation to develop a database-driven website, which currently yields about 700 visits a day.

Federal Contact: Jerry Coopey
Office of Rural Health Policy
Health Resources & Services Admin.
(301) 443-0835

Also: Fred Moskol
3-R Net, Inc.
1-800-787-2512
<http://www.3rnet.org>

The Rural Information Center Health Service (RICHS)

The Rural Information Center Health Service is a national reference service that collects and disseminates information on rural health issues. It is a joint project of the HRSA Office of Rural Health Policy, and the National Agricultural Library of the U.S. Dept. of Agriculture, and is part of the USDA's Rural Information Center. The RICHS service is staffed by professional librarians and provides reference help to those seeking information related to

rural health – such as health professionals, educators, researchers, government officials, insurers, community decision makers, or journalists.

RICHS also produces a series of reference publications, including federal funding guides. Its website posts rural health conference notices, grant descriptions and schedules, subject information resource sheets, bibliographies, directories, and some full-text documents. While not a clearinghouse for dissemination of documents, the staff does perform complimentary database searches on requested topics and will makes selected publications available.

The reference service is provided through a toll-free phone line (1-800-633-7701) and through its website (www.nal.usda.gov/ric/richs), which receives more than 11,000 visits a month. The program is funded through the HRSA Office of Rural Health Policy at \$460,000 annually.

Federal Contacts:

Tom Morris
Office of Rural Health Policy
Health Resources & Services Admin.
(301) 443-0835

Lisa Boyd
Rural Information Center Health Service
USDA
(301) 504-5360

State Children's Health Insurance Program (SCHIP)

The *Balanced Budget Act of 1997* created the State Children's Health Insurance Program (SCHIP) to make publicly-funded health insurance available to the children of working families whose incomes are too high for Medicaid but too low for private insurance. Congress authorized \$24 billion over the ensuing five years and placed administration of the program with the states, giving them flexibility to decide income eligibility and strategies for implementation.

Congress represented the program as an incremental approach to address the problem of uninsurance. The general target range of income is 100-200% of federal poverty level (FPL), but eligibility standards among states have varied from 125% of the federal poverty level to 300 percent.* Three years after the program was initiated, 36 states had extended SCHIP coverage to children up to 200% FPL. Under the program, states have had a choice to implement SCHIP through their Medicaid programs to create a separate program, or adopt a combined approach. Some states have favored establishing a separate program in order to avoid perceived stigma associated with Medicaid as a poverty program.

While rural children are 25-50 percent more likely to be uninsured than urban children, more likely to have spells of uninsurance, or limited non-employer coverage,* the SCHIP does not require states to seek out a proportionate share of rural children. However, up to 10 percent of federal funds may be used for administrative costs that could include outreach to eligible

rural families. The federal government has promoted vigorous outreach for this program through its national Insure Kids Now campaign which includes a national toll free hot line (1-877 KIDS NOW) that links callers with their own states program. Since the difficulty of reaching rural families with information about the program has been considered one of the biggest challenges to its implementation, some state offices of rural health have undertaken enrollment campaigns. All offices have been sources of information about the program through their own 1-800 numbers or information packets.

* Maine Rural Health Research Center, U. of Southern Maine

Federal Contacts:

Wendy Wolf

Office of the Administrator

Health Resources & Services Admin.

(301) 443-3621

Steve Hirsch

Office of Rural Health Policy

Health Resources & Services Admin.

(301) 443-0835

National Rural Health Resource Center

The National Rural Health Resource Center, a non-profit organization located in Duluth, Minnesota, is supported by federal and non-government funding to bring needed technical assistance, information and process tools to rural communities. The Center supports the work of state offices of rural health and helps to build state and local capacity. It focuses on managed care, network development, and community development, strategies considered important for rural communities in the rapidly changing health care environment.

The NRHRC operates a Technical Assistance and Services Center (TASC), funded by the Health Resources and Service Administration's Office of Rural Health Policy at approximately \$500,000 to help states, rural hospitals and their communities with Critical Access Hospital conversions. [See Critical Access Hospitals] This conversion often requires access to technical and informational resources not always available through state or local resources.

The Center is also a national clearinghouse of Rural Hospital Flexibility Program-related information that includes rural network development, quality assurance, EMS, community development, and CAH designation.

Federal Contact: Forrest W. Calico

Office of Rural Health Policy

Health Resources and Services Admin.

(301) 443-0835

E-mail: fcalico@hrsa.gov

Also: Terrence Hill or Ann Miller
National Rural Health Resource Center
(218) 720-0700
www.ruralresource.org

Operation Rural Health Works

Operation Rural Health Works is a national project to demonstrate the economic impact of the health sector on rural communities. The project is designed to promote public awareness of health care as an economic engine in small local economies. Supported with \$130,000 in federal funding for FY 2001, the initiative is a collaborative project of the HRSA Office of Rural Health Policy, the Rural Policy Research Institute, and the USDA's Cooperative Extension Service.

A premise underlying the initiative is that community leaders seeking to attract new industry often overlook the health care sector as an economic driver and anchor for retaining businesses. A strategy of the program is to collect county data that demonstrate for individual communities the multiplier effect in their own economies of locally-spent health care dollars, in terms of both services and employment. The information is then used to bring local citizens into a strategic planning process with health providers and the business community.

The project has supported economic assessment for Critical Access Hospitals in several states, according to its sponsors. In 2000, 17 states participated in training workshops led by a team with expertise in health planning and economic development. The workshops can be scheduled through a state's office of rural health and are provided without charge.

Federal Contact: Jerry Coopey
Office of Rural Health Policy
Health Resources & Services Admin.
(301) 443-0835

Also: Gerald Doeksen
Cooperative Extension Service
Oklahoma State University
(405) 744-9823

Also: The Rural Policy Research Institute
<http://www.rupri.org/programs/orhw>

Federal and Other Rural Health Websites

Office of Rural Health Policy (HRSA)

www.ruralhealth.hrsa.gov

Rural Information Center Health Service (RICHS)

www.nal.usda.gov/ric/richs

National Rural Health Services Research Database

www.muskie.usm.maine.edu/research

Office for the Advancement of Telehealth (HRSA)

http://telehealth.hrsa.gov

National Organization of State Offices of Rural Health

www.ruralcenter.org/nosorh

National Rural Recruitment and Retention Network

www.3rnet.org/index.asp

National Rural Health Resource Center

www.ruralcenter.org/nrhrc

National Rural Health Association

www.nrharural.org

National Association for Rural Mental Health

www.narmh.org

Rural PSYCH - Resource Center for Rural Behavioral Health

www.apa.org/rural/homepage.html

North Carolina Rural Health Research Center

www.shepscenter.unc.edu

WWAMI Rural Health Research Center

www.fammed.washington.edu/wamirhrc/default.html

Project HOPE Walsh Center for Rural Health Analysis

www.projhope.org/CHA

Rural Health Policy Research Institute (RUPRI)

www.rupri.org

Capital Area Rural Health Roundtable

http://rhr.gmu.edu