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State Challenges and Opportunities in Rural and Frontier Health Care Delivery*

Summary
The demographics and health care needs of rural and frontier populations differ from those in urban communities. The number of elderly is increasing, nearly 20 percent of these populations are uninsured, and residents often have to travel long distances to access needed health services and facilities.

Rural and frontier communities are constantly struggling with how to build and support their limited health system capacity and infrastructure. They face difficulties in recruiting and retaining providers, establishing telemedicine systems, and maintaining adequate emergency medical services. In recent years, states’ primary rural and frontier challenges have expanded to include developing more long-term care options and determining whether and how to incorporate managed care into rural health care delivery. States are responding to these challenges by:

• improving provider recruitment and retention;
• developing telemedicine capacity;
• increasing the availability of emergency medical services;
• exploring long-term care options; and
• promoting community-based managed care approaches that respond to rural health needs.

The passage of the Balanced Budget Act of 1997 also has created some important opportunities for states trying to deliver and pay for health services in rural and frontier communities. Two programs authorized by this legislation—the Medicare Rural Hospital Flexibility Program and the State Children’s Health Insurance Program—are particularly relevant for these communities. States need to consider how they will take advantage of these opportunities. In the short term, program implementation could pose a challenge for them.

At a recent National Governors’ Association (NGA) Center for Best Practices’ roundtable on rural health in Bismarck, North Dakota, participants discussed the continuing challenges and new opportunities facing states’ frontier and rural areas as well as successful tools to build and support health care capacity and infrastructure in these communities. Representatives from eight states participated in the roundtable—Idaho, Montana, Nebraska, Nevada, North Dakota, South Dakota, Utah, and Wyoming. Many of the issues and examples highlighted in this Issue Brief are drawn from the discussions at this May meeting. The Issue Brief describes the unique characteristics of rural and frontier populations, outlines the barriers to rural and frontier health care delivery, describes some
successful state responses to these challenges, and examines new rural health care delivery opportunities for states.

**Unique Characteristics of Rural and Frontier Communities Affecting Health Care**

Rural and frontier residents comprise approximately one fifth of the U.S. population. However, they do not have the same level of access to basic health care services that is available to other Americans. Poverty, inadequate transportation, large geographic distances, and an aging population base complicate health care delivery in rural and frontier communities. Frontier areas differ from rural areas in that they are characterized by more extreme remoteness, isolation, and population densities of less than seven people per square mile. It is these characteristics, coupled with a fragile or nonexistent health care infrastructure, that make the delivery of rural and frontier health care services a formidable challenge for states.

The changing demographics of rural and frontier populations exert pressure on the limited range of health care services and providers that exist in these communities. Younger people have been leaving many rural and frontier communities for urban centers, which makes filling professional and voluntary health care positions from within the community more difficult. Moreover, the number of elderly in these areas has increased, and this population is living longer because of advances in medical pharmaceuticals and technology. From 1990 to 1996, the number of elderly ages sixty-five and older living in rural and frontier areas increased by 7.3 percent. However, the growth in rural and frontier elderly ages eighty-five and older was even more dramatic, increasing more than 20 percent during the same period. These elderly residents also are very interested in alternative health care service options that enable them to age at home.

Rural and frontier residents of all ages also are more likely to be uninsured, 19.8 percent compared with 16.3 percent for those in urban areas. This is because private health insurance coverage is less available through rural and frontier workers’ employers. In addition, farm families are less likely than other working families to have employers who contribute to health insurance premiums. Further, poverty is more widespread in rural and frontier areas, so many residents have difficulty purchasing their own health insurance.

**Barriers to Effective Health Care Delivery in Rural and Frontier Areas**

States recognize that the rural and frontier health infrastructure must be strengthened to develop a statewide health care delivery system. Although states are at various stages of developing and implementing approaches to address systemic health system change, rural and frontier areas pose unique challenges. The most prevalent challenges to rural and frontier health care delivery include recruiting and retaining providers, overcoming barriers to telemedicine development, maintaining an adequate emergency medical services system, developing long-term care options, and determining how managed care could be structured to meet rural health needs.

**Challenges in Recruiting and Retaining Providers**

Recruiting and retaining health care providers has been a long-standing challenge for most rural and frontier areas. Often there is an insufficient supply and/or mix of health care practitioners in the community to provide needed inpatient and outpatient health care services. The U.S. Department of Health and Human Services recommends that for an “adequately served population,” the provider-to-patient ratio should be one primary care physician for every 2,000 people. Most rural and frontier areas have a provider-to-patient ratio of 1 to 3,500 or worse, causing them to be federally designated as health professional shortage areas (HPSAs). In 1997 more than 2,200 physicians were needed in rural and frontier areas to remove all of these federal HPSA designations.
Provider recruitment and retention problems in rural and frontier areas are driven by several factors. Many rural and frontier providers lack backup from other qualified health care professionals, making it difficult for them to take sick or personal leave or a vacation. In addition, their salaries often are lower than their urban counterparts, particularly given costly malpractice insurance premiums. Rural and frontier areas also offer a limited range of local amenities for providers and their families (e.g., adequate schools, recreational activities, and career opportunities for spouses). Finally, extreme geographic isolation limits providers’ professional and personal interactions with their peers and access to continuing medical education and training opportunities. As a result of these factors, less than 11 percent of the nation’s physicians are practicing in rural and frontier areas.

Despite these challenges, many rural communities are making progress in addressing provider access problems. The nationwide increase in the number of primary care providers and innovative recruitment and retention strategies are contributing to their progress. However, many frontier communities and some rural communities continue to have difficulty recruiting and retaining providers.

**Problems in Telemedicine Development**

Telemedicine enables patients and providers to interact with health care professionals located miles apart. It increases patients’ access to specialists through video-imaging and real-time collaboration using computer and telecommunications technology. Telemedicine also brings continuing medical education and training to isolated providers. “Access to quality health care has a major influence on quality of life, and this is a significant issue for rural communities,” said North Dakota Governor Edward T. Schafer at the rural health roundtable. “New technology offers great hope for helping us deal with this challenge.” However, there are numerous barriers to using telemedicine in rural and frontier areas, including those related to provider licensure, malpractice, patient confidentiality, and insurance reimbursement.

**Provider Licensure.** Often a medical provider who is consulting via telemedicine lives in a different state and is not licensed to practice outside that state. This may cause a problem in paying the out-of-state provider for his or her services as well as raise questions about whether state licensing regulations are being violated.

**Malpractice Liability.** The use of telemedicine complicates determinations of the responsible party when an error occurs. For example, is the primary caregiver, specialist, or telemedicine equipment manufacturer liable? Which state has jurisdiction to hear the complaint in cases in which the parties are located in different states? It also is possible that malpractice suits related to the use of telemedicine will increase because of the impersonal nature of the service; it is easier to sue an image on a screen than a person. Conversely, malpractice suits may decrease because videotapes of the encounter would offer fairly definitive proof of whether malpractice has occurred.

**Patient Confidentiality.** Many health care consumers are unaware that their medical records often are transferred through data systems that are not secure. This means that employers, insurance companies, and other entities could have unapproved access to patients’ medical records. The problem is compounded because states have different rules governing patient confidentiality matters.

**Insurance Reimbursement.** Medicare and most insurance carriers are accustomed to traditional face-to-face encounters between physicians and patients and hesitant to accept telemedicine encounters as reimbursable services. However, some progress has been made in recent years. The Balanced Budget Act of 1997 now allows Medicare to reimburse for telehealth services. During the past several years, Medicaid regulations also have afforded states more flexibility in this area.
Through telemedicine, unnecessary patient travel to tertiary care facilities can be avoided. However, for telemedicine to reach its full potential, states will need to incorporate health-care applications into their telecommunications planning and develop interconnection capabilities among states.

**Difficulties in Maintaining Adequate Emergency Medical Services**
Rural and frontier residents live in remote areas with limited access to comprehensive health care services, so it is critical that they have an adequate emergency medical service (EMS) system to provide immediate, crisis-oriented medical assistance. EMS systems also provide rapid transportation and triage patients to appropriate medical facilities.

Many rural and frontier areas have difficulty maintaining their emergency medical services system. A common problem is insufficient state funds to purchase the emergency medical vehicles and equipment needed to establish and maintain local and statewide EMS systems. In addition, many rural and frontier communities have an insufficient number of EMS personnel to serve local residents and must rely on a combination of volunteers and permanent EMS staff. Changes in state licensure and training requirements that force a reduction in the number of eligible volunteers exacerbate the shortages in EMS personnel and cause additional tensions.

**The Growing Demand for Long-Term Care Options for Rural and Frontier Elderly**
States are becoming increasingly concerned about the growing demand for long-term care services in rural and frontier communities. The proportion of elderly residents living in these communities is increasing, and they are living longer because of changes in medical pharmaceuticals and technology. Many are interested in options that enable them to age at home.

Some of the long-term care options that states are considering include:

- home and community-based services, which include home health services, personal care services, adult day health care, adult day care, and informal care given by a relative or friend, to help the elderly live at home for as long as possible; and
- assisted living facilities, which link health, social, personal care, and housing services, to enable seniors to continue to live independently in the community.

Some states will have to pass new legislation, change regulations governing long-term care facility development, obtain federal Medicaid waivers, or provide state waivers to implement these alternative care options.

**Issues Related to Rural Managed Care and Medicare + Choice**
Managed care is being used in many urban areas to hold down health care costs and help ensure the delivery of quality care. To date, managed care has had limited penetration into rural America, and it is unclear whether a one-size-fits-all approach to health care delivery can meet the unique and differing needs of rural and frontier communities. However, given the increase in the number of elderly living in rural areas; the development of Medicare + Choice, the Medicare managed care program under Part C of Medicare; and the maturation of managed care nationally, states will need to explore whether and how rural managed care could be structured to meet the needs of rural and frontier populations.

Managed care plans can be structured creatively to meet the unique health care needs of a community, or they can disregard the community’s needs and cause local conflict and financial tensions. To incorporate managed care successfully, rural and frontier areas need more flexibility in developing their financing structures and risk-sharing approaches with managed care entities. Other problems that could emerge depending on how managed care is implemented in rural and frontier areas include the following.
• Health plans could pressure local providers who are not willing to participate in managed care to leave the area.
• Health plan administrators could discontinue serving rural and frontier areas after a limited time if these markets do not prove profitable. For example, some private managed care companies recently withdrew their Medicare health maintenance organization (HMO) services in several rural areas in California, Ohio, South Carolina, and Utah because they were over-subscribed and losing money. However, in some cases, locally developed health plans are willing to make a long-term commitment to rural communities even when their profit from these markets is inconsistent. By including commercial, Medicare, and Medicaid products, these plans are able to maintain services to all residents in the community.

State Efforts to Address the Barriers to Rural and Frontier Health Care Delivery
Many states are implementing creative approaches to improve access to rural health services and tackle rural health care delivery problems. Their efforts are focusing on improving provider recruitment and retention, developing telemedicine capacity, increasing the availability of emergency medical services, exploring long-term care options, and promoting community-based managed care approaches that respond to rural health needs.

Improving Provider Recruitment and Retention
The backbone of any health care delivery system is access to primary and specialty care health professionals. The strategies used to recruit and retain health care providers have increased and improved over the years with the support of the state and federal governments and the implementation of new computer and telecommunications technology.

South Dakota Governor William J. Janklow launched the multifaceted Recruitment and Retention Initiative in 1996 when he appointed a blue-ribbon Task Force on Family Practice Residents. The task force had three primary goals: to determine the appropriate level of state subsidy for family practice residents to induce them to take placements in rural and frontier South Dakota; analyze and improve existing recruitment programs; and determine current and future needs for family physicians and primary care mid-level providers.

As a result of the task force’s work, the state made several changes. The family practice (FP) residency subsidy was changed from an annual, line-item special appropriation to a component in the department of health’s budget. Connecting the subsidies to the department’s budget improved the coordination of all recruitment activities among the health department, the University of South Dakota School of Medicine, and the two FP residency programs. The subsidy also was increased by $55,000 per year for the next four years. In addition, the state ended or replaced most of its scholarship programs with tuition reimbursement programs that retire loans after the completion of medical education training in exchange for practice in rural communities. The back-end reimbursement amounts for these positions also were doubled. The state took this action because scholarship recipients who had their education expenses paid for at the front end had higher default rates on their rural work commitments.

Further, South Dakota created a full-time state recruiter position. This recruiter is the central contact for communities interested in identifying, matching, and recruiting health care professionals. During spring 1998, the state piloted a Community At a Glance program that four times per year showcases different recruiting communities to FP residency program participants to induce them to consider placements in these communities. The state also now conducts an annual survey of practice sites to determine the supply of and demand for health care professionals across the state.
**Wyoming** Governor Jim Geringer established the Wyoming Health Reform Commission in 1994. The commission recommended that a statewide recruitment and retention program be created to assist communities and health care practitioners in all aspects of recruitment. As a result, the Wyoming Health Resources Network, Inc. (WHRN) was formed in 1995 as a public-private partnership. WHRN services for communities seeking health professionals include:

- preparing practice profiles for distribution to interested candidates;
- promoting practice opportunities and communities through local, regional, and national channels;
- forwarding resumes of providers whose background and training match community needs;
- advising communities on the process and techniques of recruitment; and
- assisting communities in conducting health planning processes that fit local needs.

Services to health care practitioners seeking practice opportunities in Wyoming include maintaining biographical and preference information in a database and cross-matching this information with opportunities; referring health professionals to opportunities; answering questions about loan repayment, licensing, salary ranges, and related issues; and enabling practitioners to access a large number of opportunities through a single source.

South Dakota, Wyoming, and numerous other states also participate in the National Rural Recruitment and Retention Network. This national network complements state efforts to recruit health professionals to practices throughout rural America by helping candidates locate rural practice sites that meet their needs.

**Developing Telemedicine Capacity**

Telemedicine is an emerging technology, so states are still debating and exploring ways to address the barriers to telemedicine development. To date, states have made the most progress in overcoming insurance reimbursement barriers. Medicare and Medicaid reimburse for telemedicine services in most states. In addition, several states, such as California, Louisiana, and Texas, have passed laws that require private insurance companies to cover telemedicine encounters. As states’ telemedicine systems mature, they will continue to develop and test solutions to provider licensure, malpractice liability, patient confidentiality, and insurance reimbursement problems.

**Nevada** implemented the Rural Utilities Services (RUS) project to connect rural communities and providers to training opportunities, medical specialists, and other health professionals. RUS provides distance education, continuing education, Internet access, teleradiology, and telemedicine services to nine rural counties and two urban counties. It uses a combination of funds to equip compressed-video systems, Internet, teleradiology, and audio conferencing for the participating counties. The project is responsible for training, education, statewide meetings, telehealth, and other activities that benefit rural residents, students, patients, and health professionals in Nevada. RUS is a joint effort of the University of Nevada School of Medicine, the Great Basin Community College, and the Nevada Rural Hospital Project.

A second grant awarded from the U.S. Department of Commerce’s Technology and Information Infrastructure and Assistance Program has been used to add equipment to the backbone of RUS. Six rural hospital sites have been added to the RUS rural network through a combination of compressed-video, high-speed modems for still-image capture and store-forward technology for data, voice, and picture. Linkages connect rural Nevada hospitals to urban specialists for consultations, to designated urban trauma centers for emergency treatment support, and to the University of Nevada and the Great Basin Community College system for Internet connection and educational support.

In **North Dakota**, the *Medstar* project is a satellite-based distance learning network, facilitating one-way video and two-way audio and data transmission among members of the North Dakota Health...
Education Network (NDHEN). Network members include the University of North Dakota School of Medicine and community rural hospitals located across the state. The linked satellite network became operational in February 1995. Medstar is a joint venture funded by the U.S. Department of Agriculture’s Rural Electrification Administration and members of NDHEN.

The primary goal of the Medstar project is to provide continuing medical education and medical linkages to North Dakota’s rural health care professionals using innovative telecommunication technologies. Continuing medical education programs are offered to a range of health professionals, including rural physicians, nurses, emergency medical technicians, physical therapists, and physician assistants. In addition, the network enables interaction between the University of North Dakota School of Medicine and third- and fourth-year medical students and family practice residents during their rural rotations. A second project goal is to encourage network use for transmission of accredited continuing education programs sponsored by other organizations interested in rural health care. A third goal is to facilitate the delivery of nonhealth-related educational programs to rural and frontier communities in North Dakota.

**Increasing the Availability of Emergency Medical Services**

States recognize that sufficient financing, adequate staffing, and appropriate training are needed to maintain community emergency medical services systems. As demographics, financing, and health professional training and licensure requirements continue to change in rural and frontier areas, meeting the demand for emergency medical services is more difficult.

Colorado and Utah dedicate state motor vehicle violation fines and registration fees to help finance EMS. South Dakota funds EMS directly through state appropriations, while North Dakota provides state funds through ambulance taxing districts and state appropriations. North Dakota’s department of health also is establishing a process to assist local volunteer ambulance organizations in submitting claims to the Health Care Financing Administration and private insurers to recoup EMS expenses covered by the state that are eligible for reimbursement. A review revealed that the state was losing substantial amounts of money that could be recouped through the claims billing process.

To maintain and encourage EMS staffing by emergency medical technician (EMT) volunteers, Governor Janklow of South Dakota created a task force of EMT volunteers to review state regulations and licensure issues, update training approaches, and discuss how to enable EMTs to provide EMS services in the state. Iowa has an “at-home-mom” program for EMS volunteers. When an EMS volunteer mom is called to duty, a local grandma takes care of her children.

**Exploring Long-Term Care Options**

States are responding to the growing demand for long-term care in rural and frontier communities and are exploring ways to finance that care. A Long-Term Care Task Force in North Dakota is evaluating the state funding formula for long-term care facilities and reconsidering the state’s moratorium on the construction of new types of long-term care facilities. As part of Nebraska’s effort to find alternative ways to finance long-term care, a state grant program helps near-failing nursing homes convert to assisted living facilities. Grant approval priority is given first to state government facilities and then to nonprofit facilities.

**Promoting Community-Based Managed Care Approaches That Respond to Rural Health Needs**

States need to afford rural communities the flexibility to create managed care systems that meet their unique health care needs. Without this flexibility, many local providers may be forced out of business and may be difficult to replace if large commercial managed care plans discontinue service to these areas after several years.

To guide the development of managed care in rural and frontier markets, states can encourage health plans to consider several factors before bidding for rural managed care business. First, managed care
entities must gain acceptance from the local provider community to be successful. Second, managed care plans must factor in the higher costs associated with providing care in rural communities. Finally, the plans must factor in any positive or negative affects associated with state and federal legislation regulating health plan development and operations.

States and communities can encourage health plans to share risk with local providers in creative ways to accommodate the differences and financial constraints among rural providers. Several types of risk-sharing approaches that health plans and local community providers could use include:

- full or partially capped reimbursement rates;
- withhold that hold back a percentage of payments or set dollar amounts from the service fee or capped rate that may or may not be returned;
- shared percentages of both profits and losses; and
- bonuses that pay a physician or entity amounts above any salary, fee for service, or capped payment.

Managed care entities will need to change their operating methods to meet the health care needs of rural and frontier residents and establish a long-term relationship with the community. Health plans should build on and support the existing rural health infrastructure as well as include all local health care providers—hospitals, health departments, physicians, and mid-level providers.

**Rural Health Plan Implementation and Monitoring.** The Rocky Mountain Health Maintenance Organization (HMO) in **Colorado** has worked hard to structure its managed care plans to ensure access to quality health care at affordable rates for a broad cross-section of rural residents, including the indigent. It is a nonprofit, independent practice association-model HMO that began operations in Grand Junction, Colorado, in 1974. Statewide, Rocky Mountain HMO contracts with approximately 3,660 primary care and specialty physicians and 144 hospitals, rehabilitation centers, and skilled nursing facilities. It has three HMO plan product lines: commercial, Medicare, and Medicaid.

Over the years, Rocky Mountain HMO has entered into financial risk-sharing arrangements with individual rural communities to encourage local providers to participate in its plan. For example, one arrangement calls for a physician HMO network that splits profits and losses on an equal basis with local providers. Under another arrangement, a physician independent practice association pays participating providers on a fee-for-service basis with a withhold of between 10 percent and 20 percent held by Rocky Mountain HMO, which is guaranteed 3 percent of all revenues. In exchange, Rocky Mountain HMO facilitates electronic claims submissions, collects patient copayments, handles billing activities associated with Medicare and Medicaid beneficiaries, and performs other administrative functions to expedite the contractual relationship with local providers.

Rocky Mountain HMO tries to promote a stronger and more productive relationship with the community. It has created internal physician peer report cards, which are shared among plan providers and have resulted in improved practice patterns, outcomes, and cost-effectiveness. Rocky Mountain HMO also has hired consultants to help local hospitals improve their operations. Consultants conducted systems evaluations of how hospital operations could be streamlined and made more efficient. In another hospital, physician consultants were brought in to educate staff on trends in the health care marketplace and disease stage management. In addition, Rocky Mountain HMO has established local and regional committees to oversee and provide input to the HMO and its partners.

**Utah** passed legislation to safeguard the viability of local providers not included in a managed care plan panel that is serving their rural area. The law requires all HMOs to pay rural hospitals, federally qualified health centers, and their credentialed staff the same reimbursement rate as other HMOs.
providers for services rendered to rural residents who reside within thirty miles of these facilities or private offices.¹²

One of the reasons why Utah passed this legislation is that HMOs can exclude rural hospitals and clinics from their provider panels. Such exclusion could threaten the financial viability of many rural providers and force rural residents to travel long distances to obtain care. This was a concern in Utah because the state travel council was promoting tourism to many national parks, monuments, and scenic byways located in rural areas of the state and the tourists might need access to these local health care services. In addition, many employers in rural areas of Utah are large entities that negotiate a statewide contract or are part of a group plan. These entities desire the least expensive health care plan and, for this reason, many commercial HMO plans are operating in many rural areas.

**Rural Health Network Development as a Building Block to Managed Care.** Rural health networks also are being used widely to shore up rural communities’ competitiveness and participation in managed care. They are composed of providers, such as hospitals, private providers, primary care clinics, local health departments, emergency medical service agencies, and specialty services providers, that choose to work together for a variety of reasons. Some networks share administrative and technical medical equipment and/or share quality monitoring systems. Others create their own integrated managed care organizations to take on varying amounts of risk so they can negotiate discounted service rates. Some of the risk-based health plans being developed include health maintenance organizations, preferred provider organizations, and provider sponsored organizations.

In **Nebraska** rural health networks have combined their resources to recruit and retain health professionals; maximize reimbursement in all clinics and facilities through improved management practices; build integrated systems that involve physicians, hospitals, mental health clinics, public health departments, and EMS agencies; and retain health care dollars by offering some type of managed care plan. Several networks are implementing Medicaid rural managed care, and five other rural networks have been meeting to determine the feasibility of creating an umbrella organization to be a risk-bearing entity under a Medicare + Choice managed care program.

**New Opportunities for States to Improve Access to Rural Health Services**

The Balanced Budget Act of 1997 created the Medicare Rural Hospital Flexibility Program and the State Children’s Health Insurance Program (SCHIP). States can use both programs to improve access to health care services for rural and frontier residents.

The critical access hospital component of the Medicare Rural Hospital Flexibility Program offers states the opportunity to help convert full-service rural hospitals that have low hospital-bed occupancy rates to limited service hospitals that provide a reduced complement of inpatient services needed by a community.¹⁴ In contrast, SCHIP can infuse new funding into rural and frontier communities to pay for health care services for uninsured children. Although the implementation of these new programs may present some short-term challenges to states, these programs could dramatically change the way health care is delivered in rural and frontier America.

**Establishing Critical Access Hospitals**

The Medicare Rural Hospital Flexibility Program can help states and rural communities improve access to essential health care services by establishing limited service hospitals referred to as “critical access hospitals” (CAHs).¹⁵ The program allows states to designate rural facilities as critical access hospitals if they are located a sufficient distance from other hospitals, make available twenty-four-hour emergency care, maintain no more than fifteen inpatient beds, and keep patients hospitalized no longer than ninety-six hours.¹⁶ Rural hospitals converting to CAH status do not have to meet all of the Medicare staffing requirements that apply to full-service hospitals. Critical access hospitals are
reimbursed on a reasonable-cost basis for inpatient and outpatient services provided to Medicare beneficiaries.

To take advantage of this opportunity, states must submit a rural health plan to the federal Health Care Financing Administration, encourage local hospitals to participate in the program, and establish a process for designating local hospitals that meet specific program criteria as critical access hospitals. States may choose to participate in this program at any time. However, they should be aware that their Medicaid reimbursement rates could either raise or hinder interest in CAH conversions, depending on whether local providers consider these rates high, reasonable, or low.

Beginning in 1998, the Medicare Rural Hospital Flexibility program authorizes $25 million in grant funding for each of the next five years to help states develop and implement a rural health plan, develop rural health networks, designate CAHs, and improve rural EMS systems. States also can use the funds to provide technical assistance and support for hospital CAH conversions to:

- develop integrated networks of care;
- examine the conversion to CAHs;
- conduct a financial feasibility analysis;
- develop information systems and telehealth activities;
- improve quality assurance activities; and
- improve rural EMS systems.

However, no funds were appropriated in fiscal 1998. Congress has not yet decided on the fiscal 1999 appropriation for this program.

**Facilitating Critical Access Hospital Conversions.** State policymakers have the opportunity to develop creative and comprehensive CAH models that can include the integration of network development, emergency medical services, telehealth services, mental health services, and public health, depending on the needs of each community. To expedite appropriate and successful CAH conversions, states can encourage facilities considering conversions to:

- conduct a financial feasibility study;
- educate the physicians, the hospital staff and their governing board, and the community about the conversion;
- partner with a fiscal intermediary that understands the nuances of the CAH program so that claims processing is simplified.

To facilitate CAH conversions, **South Dakota** decided to review its regulations to identify any barriers affecting rural hospitals. The department of health used a public review process to get input from a wide range of constituencies. As a result of this effort, the state redefined its “at-risk” rural hospital category, and Governor Janklow approved the implementation of an enhanced Medicaid reimbursement rate for “at risk” and “access-critical” rural hospitals.

**Implementing the State Children’s Health Insurance Program**

The State Children’s Health Insurance Program was established by Title XXI of the 1997 budget legislation. It provides states with approximately $4.8 billion annually for five years to provide health insurance to uninsured children. According to Medical Expenditure Panel Survey data for the first half of 1996, 27.9 percent of all uninsured children live in rural and frontier areas and might be eligible for this program.

States have three options for implementing SCHIP. They may expand their current Medicaid program, establish a separate state-designed insurance program, or combine these two approaches. The most significant challenge in implementing SCHIP in rural and frontier areas will be to promote easy access
to the program, as well as a positive image of the program, so all parents, including those in working families, enroll their children. SCHIP implementation in these hard-to-serve communities is complicated by the limited choice of primary care providers, the limited number of multicultural and multilingual service providers, the lack of public transportation, and the travel required to receive health care services. Outreach is one way that states can address these issues and implement SCHIP successfully. Strategies that states can use in rural and frontier communities include the following:

- Offer bilingual application information and assistance. For example, Utah has a special information campaign targeted to Native American populations and employs bicultural and bilingual workers.
- Use mail-in application forms. For example, Utah parents can submit applications via the mail.
- Establish presumptive eligibility so uninsured children can be covered while their eligibility is being determined.
- Offer continuous eligibility so children are covered continuously up to one year without a redetermination of their eligibility during that period.
- Conduct school-based outreach. For example, the Nevada Check Up program disseminates a brochure on Medicaid and SCHIP and includes an application form in the packet.

In addition, states will have to persuade enough providers to serve SCHIP children regardless of the Medicaid and state program reimbursement rates established. Managed care providers might be more willing to serve rural uninsured children under SCHIP if states buy reinsurance for managed care plans to cover catastrophic cases in the first few years of the new program.

State policymakers also should encourage public and private sector collaboration, as well as state interagency coordination, in planning and implementing SCHIP. For example, Governor Philip E. Batt of Idaho appointed a task force with representation from businesses, Native American tribes, and a range of public and private entities to assist in SCHIP planning. Further, at the local level, policymakers should include local community-based providers (e.g., public hospitals, rural health clinics, community and migrant health centers, local provider practices, local health departments, and tribal clinics) in the provider network that will cover SCHIP children in rural and frontier areas.

**Conclusion**

There are some significant barriers to rural and frontier health care delivery, but states are taking active steps to address them. States need to continue exploring how to ensure an adequate number and mix of rural health professionals, promote the use of telemedicine in rural areas, increase the availability of rural emergency medical services, address the long-term care needs of the growing rural and frontier elderly population, and integrate managed care into their rural health service system. The newest opportunities and challenges facing state policymakers include developing critical access hospitals, implementing other 1997 budget legislation changes, and using the new children’s health insurance expansion program to reach rural uninsured children.

As the rapidly changing health care marketplace evolves, states may want to consider periodically reassessing the strengths, weaknesses, and new challenges and opportunities facing their health care delivery systems. Rural and frontier markets will need to be assessed separately from urban markets. States could use the programs authorized by the Balanced Budget Act of 1997 as a springboard to reassess their rural and frontier health care delivery systems and bring new resources and delivery approaches to rural America.
Endnotes

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2 A new definition of “frontier” developed by the Consensus Development Project recommends that a matrix of population density, distance to the closest market for services, and travel time be assessed to determine accurate frontier status. The project was funded by the Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services.


4 Vistnes and Monheit.


7 U.S. Department of Health and Human Services, Bureau of Primary Health Care, “Selected Statistics on Health Professional Shortage Areas as of September 30, 1996, Table 2” (Bethesda, Md.: Division of Shortage Designation, Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services, 1997).


9 Western Governors’ Association, Health-Care On-Ramps: A Road Map to Western States’ Information Highways (Denver, Colo.: Western Governors’ Association, April 1998).


11 I. Moscovice, M. Brasure, and B. Yawn, Rural Physician Risk-Sharing: Insights and Issues (Minneapolis, Minn.: Rural Health Research Center, Division of Health Services Research and Policy, School of Public Health, University of Minnesota, April 1998).

12 Credentialed staff include visiting and part-time professionals who have been given staff privileges at one of the local facilities. The facility decides which staff to credential.
13 The focus is on the critical access hospital component of the Balanced Budget Act of 1997 changes associated with this program because the rural health roundtable participants believed the CAH conversions could be complex and were a high priority for their states.

14 The CAH program replaces the Essential Access Community Hospital/Rural Primary Care Hospital program and the Montana Medical Assistance Facility demonstration. All states are eligible to participate in the program.

15 This definition is from the program regulations in the Federal Register on August 29, 1997.

16 The state rural health plan must provide for the creation of rural health networks, promote regionalization of services, and improve access to care. Each state must develop this plan in consultation with the state hospital association, rural hospitals, and the state office of rural health.

