Rural Task Force Report
for the
Blue Ribbon Commission for Health Care Reform

October 18, 2007

Blue Ribbon Commission for Health Care Reform

I. Executive Summary

The Rural Task Force Members are pleased to submit this report to the SB 208 Blue Ribbon Commission for Health Care Reform. It is our hope that this report will provide the commissioners with the information necessary for them to complete their mandate in providing recommendations to the Governor and Legislature on how to improve health care in Colorado. The observations and recommendations contained in this report were reached using a consensus decision making process. This report was taken very seriously by the task force members and reflects many hours of meeting time, telephone conferencing and travel. We would also like to acknowledge the excellent work performed by staff assigned to our committee.

The participation in the task force very accurately captured the full range of what "rural" can mean in Colorado. With over 75% percent of the state's land mass, rural is a very big tent to live in, for the nearly one million Coloradoans who call it home. Rural Colorado means everything from living in one of our frontier counties where the population density can be as low as 3 people per square mile, to our resort communities which experience huge, seasonal population swings.

Given the disparity of what "rural" can mean the task force agreed on several key characteristics which we felt could be applied universally throughout rural Colorado. These characteristics are as follows: large numbers of uninsured and underinsured, an economy dependent on small employers, distance, workforce availability, reliance on safety net, less access to capital and an IT infrastructure less developed than in urban areas. This list served as the lens which we used to examine the five proposals.

In the course of this examination a list of specific recommendations was developed. The recommendations contained in the final section of this report are meant as a guide for the SB 208 Commission as they contemplate their own recommendations for reforming health care for the benefit of all of Colorado's citizens.

II. Key Considerations about Rural Colorado and General Reactions to the Proposals

The Rural Task Force met three times and specific detailed input on each of the proposals is available. In response to a request from the Proposals Committee, the Rural Task Force is also developing specific recommendations regarding effective strategies in rural Colorado.

Key Considerations about Rural Colorado

The group identified certain key characteristics of rural Colorado that informed their analysis of the proposals:

- Large numbers of uninsured and underinsured
- Economy dependent upon small employers
- Distance
- Workforce availability
- Reliance on safety net
- Less access to capital
- IT infrastructure less developed than in urban areas

General Reactions to the Proposals

Workforce considerations

- Access to coverage doesn't equal access to care, especially in rural Colorado. Expanding insurance coverage in rural areas is moot unless there are sufficient providers, of all types, to serve them. Some counties in Colorado have no Medicaid providers, mental health clinicians or dental providers.
    - Network adequacy is an associated problem. Even in areas that have sufficient numbers of providers, all may not participate in the insurance plans available.
    - Many of the proposals rely on multidisciplinary approaches to care delivery but that model presents challenges in rural Colorado when providers of all types are scarce.
    - Reimbursement is key in rural areas. Higher Medicaid reimbursements would be a boon to most providers. Providers (e.g., FQHCs, RHCs,CAHs) that receive cost-based reimbursement should be able to retain that system.

- Plan designs that depend on economies of scale – e.g., managed care and case management models – are more problematic in rural areas, because of lack of infrastructure, providers, support staff and distance.

- Healthcare providers in rural communities are many times the primary – or indeed only – source of access to health care services. They act as the safety net and any proposal that weakens or transitions this resource must be carefully implemented.
    - For example, as insurance rates go up, we may lose federal dollars for providing care to the uninsured through FQHCs and RHCs. In many communities, these are the only providers available. If these resources are diminished, we could conceivably lose providers. Similarly, many rural health clinics and hospital-based clinics cannot qualify to receive Primary Care Fund (tobacco tax) dollars with current HCPF eligibility criteria.

- Delay or phase in the penalty aspect for the individual mandate until access is fully understood and available. Rural communities will need time and capital to build the healthcare infrastructure before the mandate can be imposed.

- The provider tax is a disincentive for rural providers and is counterproductive to recruitment and retention.

- Recruitment and retention of health care providers is much more challenging in rural areas. Incentives are preferred over subsidies to ensure an adequate workforce.

Impact on employers, employees

- To the degree that we can make things simple for employers, it's beneficial for rural business. For example, anything that is funded through an administratively simple, relatively low payroll tax, is potentially attractive. Mandates/required buy-in, however, can be cumbersome. Small rural employers don't have administrative or personnel resources to manage complex compliance issues.

- Proposals that expand coverage for public programs could incent these employers to stop offering insurance themselves, putting even more rural Coloradans into public programs. Need to consider the implications of such transitions in coverage.

- Using the tax system to enforce an individual mandate could push more people into the underground cash economy and it would encourage tax fraud.

Plan design

- Subsidies for care when the federal poverty level is increased will cover a proportionately larger number of people in rural Colorado. In many areas this will include community leaders, politicians and professionals.

- Some of the plans had dramatic cliff effects that would disproportionately affect rural populations, because of the large number of individuals who fall between 200 and 300% FPL in rural areas.

- The steadily and substantively increasing deductibles offered by insurance plans to limit plan costs creates an added burden on the 200 to 300% of poverty population more prevalent in rural areas – decreasing access to healthcare and undermining prevention initiatives.

- Dental health must be included in preventive health care services. Many rural areas lack fluoridation, so access to dental care is especially important in these areas.

- Modified community rating, when based on geographic considerations, can be problematic in rural areas. In rural areas, acquisition of care is typically more

costly; patients are older, less affluent, less likely to be insured. We encourage inclusion of rural areas with urban regions in ratings calculations.

- Connector is an important mechanism for rural communities where access to health insurance plans can be limited.

- Regarding the Continuous Coverage concept in the Fifth Proposal, the Rural Task Force is willing to support the modeling phase as it has the potential to have positive impacts for rural Coloradans.

- Concern exists about geographic rating issue. Even though residents of rural communities currently may have lower health care costs, there's a considerable lack of providers available. There may be substantial pent up demand. Once people have access to affordable health care, rural residents may have a spike in their utilization of services.

Administrative considerations

- The IT infrastructure is less developed in rural Colorado. Solutions to health care access that depend on this resource, for either providers or consumers, need to be carefully evaluated.

- Rural areas and providers have less access to capital. Any reform proposal that requires capital investment will require State support to level the playing field and will be slower to develop in rural areas.

- Processes – application, enrollment, billing – should be simplified. We encourage more entry points to the public system and simpler administrative systems.

- Auto Enrollment should occur at point of service. Front office staff will require training to effectively implement this new enrollment function.

General comments

- Distance will always have an impact on any reform ideas in rural Colorado. Lack of integrated services, not just co-located services (medical, mental health, and dental providers), will impact cost, access and efficiency.

- While the Rural Taskforce included numerous constituencies, including businesses and consumers, it was largely provider focused. The group was conscious of the need to ensure that all constituencies' views are included in their final report.

- Medicare reimbursement needs to be accelerated in Health Professional Shortage Areas to 100% Medicare reimbursement.

- For proposals moving forward that will have boards, committees and other decision-making entities, there must be rural representatives on a Congressional basis from rural zip codes.

- Utilize the following language when speaking about expanding scope of practice: "Non-physician providers within their scope of practice." This will help rural communities expand health services beyond primary care.

III. Specific Recommendations

Definition of Rural

1. Healthcare reform, which considers the needs of rural residents, must begin with a definition of rural that meaningfully distinguishes rural populations from urban populations. The Rural Health Task Force proposes the use of the **Rural Urban Commuter Area** methodology, which describes urban census tracts in relation to predominant commuter patterns. *This approach will distinguish geographically isolated rural areas from less densely populated areas that can reasonably access urban health services and providers.* *depts.washington.edu/uwruca/rural.html*

Rural Provider Capacity

2. Test reform proposals to assure that **safety net** providers, such as Federally Qualified Health Centers, Rural Health Clinics, Sole Community Hospitals and school based clinics are not negatively impacted. *Rural communities are dependent upon safety net providers, often because they are the only source of care in a community. Safety net providers also have expertise in providing care to traditionally underserved population groups in rural areas such as non-English speaking and low income persons.*
3. Expand the **scope of practice** for non-physician healthcare professionals. *Midlevel providers can substantively improve health care access and are an important and valuable part of the heath care resource mix in rural areas.*
4. Increase funding to **healthcare provider loan repayment** for providers who serve in Health Professional Shortage Areas. *Increasing the incentives for providers to locate in rural areas is crucial to healthcare access. Health insurance coverage alone will not assure access. Most rural counties have insufficient numbers of primary care, oral health, mental health and substance abuse providers to meet the care needs of the population regardless of their insurance status. Decreasing the numbers of the uninsured will not correlate to increased care access in many rural areas without more provider capacity.*
5. Increase funding and marketing for **medical education** of providers who are on a rural track program in a primary care specialty. *The health care workforce is older in rural areas and thus the demand for new health personnel is greater than in urban areas.*

Rural Access to Health Care Services

6. Assure basic plan coverage to include **oral health, behavioral health (mental health and substance abuse) and vision care** services*., Covering only the medical/physical part of health care perpetuates fragmentation and does not address the complexity of the many people who present with co-occurring conditions. This is especially applicable in rural areas, where people have less access and substantial unmet needs for holistic care. The Colorado Clinical*

Guidelines Collaborative offers strong support for delivery systems that utilize integrated approaches. Substantial evidence exists that providing coordinated care results in lowered utilization of ER and inpatient services.

7. Modify state **regulations**, which prevent or set unacceptably high standards for the co-location and mixed use of some healthcare facilities. *Often rural areas cannot afford the infrastructure costs of separate healthcare facilities, particularly when small patient populations are served.*
8. Increase **Medicaid reimbursement** to parity with Medicare reimbursement in designated Health Professional Shortage Areas, which are located in rural zip codes. *Rural providers lack economies of scale and higher commercial insurance populations, which can offset reimbursements that are well below the cost of care delivery.*
9. Assure adequate technical infrastructure and staff for **Telemedicine programs** in rural areas to deliver chronic disease management and specialty consultation. *Telemedicine is not, however, a suitable substitute for most primary care services.*
10. The use of a 24-hour telephone triage **nurse line** for patients will benefit rural populations. *A triage line is also likely to reduce the use of emergency departments for non-emergency healthcare services, reducing costs to small rural providers*.
11. Increase **support for community based organizations and local governments** to assist families through eligibility and enrolment process. *Many local organizations in rural areas will not have sufficient capacity of training to assist families in enrolling in a plan*.
12. **Enrollment** in any state mandated health plan must occur automatically at point of service, if the patient has not previously enrolled in an insurance plan.
13. The use of an **insurance connector** is likely to benefit rural populations, however, access to a connector should not be limited to the web. *Rural areas have less Internet connectivity and some populations, particularly the elderly, will not reasonably be able to use web-based services*.

Rural Parity with Urban Populations

14. Any governing body, which emerges from reform efforts, must include at least **proportional representation** from rural areas of Colorado. *The reality of healthcare acquisition is different in rural areas and must be represented on any governing body to assure that policies consider rural experiences*.
15. Test any geographic **community rating** proposals, which isolate rural populations from urban populations to assure that they do not disadvantage rural populations. *Rural populations require more medical attention since they are generally older, poorer, and more hazardously employed than are urban populations. Though the per unit cost of care may sometimes be lower in rural areas, health care utilization may be higher.*

Containing Costs

16. Test all proposed **financing mechanisms** to determine if they will disparately affect rural populations. *Because rural populations tend to have fewer liquid assets and less personal income, financing approaches must consider the socioeconomic differences between urban and rural populations.*

17. Test **economic incentives** to providers and insurance plans to assure that modeling considers the limited healthcare provider capacity in most rural areas of Colorado. *Meaningful competition among providers seldom occurs in rural areas because there may be only one provider, or even no provider, in a county or service area. Higher percentages of Medicaid, Medicare and uninsured in rural areas discourage other providers from entering the market.*
18. Establish rules to **protect rural providers** from unreasonable financial risk. *The imposition of provider risk-sharing models that pass significantly higher financial risks to individual providers may force some rural practitioners into more concentrated risk environments. Furthermore, rural providers do not have adequate capital reserves (cash or investments) to bear prolonged risk or cash flow shortages.* Healthcare reform must place a greater emphasis on wellness and prevention by increasing funding for the **public health system**. *Health departments and public health nursing services play an important role in preventing disease, alleviating health disparities, reducing the burden of disease, and containing the costs of healthcare in rural areas. Moreover, behavior and environment, the key areas of emphasis in public health, are known to be stronger determinants of individual health than insurance status. Public health can help assure the desired outcome of reform, which is a healthier public, by addressing the non-medical determinants of health status.*