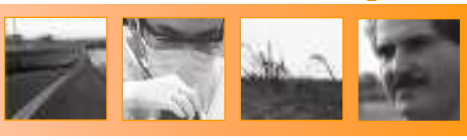
csrha
POLICY BRIEF



California Health Reform: What's at Stake for Rural Communities?

Introduction

According to Governor Arnold Schwarzenegger, "California's medical care, its medical knowledge, its medical technology, is as strong and vibrant as a body builder. Yet our health care system itself is a sick old man."[1]

In response to this crisis, the Governor and the California legislature have made health care reform a top priority in 2007. Several competing proposals aiming to overhaul the state's dysfunctional health care system have sparked debate among legislators, the business community, advocacy groups, insurance providers, county officials, health care professionals and the public.

While the authors and supporters of the various initiatives all insist their proposals will improve access to affordable coverage for Californians, health care reform raises unique concerns for rural communities. Many provisions currently included in the proposals not only fall short of adequately addressing the distinct issues that rural providers face when delivering care, but they also have the potential to negatively impact access to health care for the 5 million people currently living in California's rural regions. Rural health care providers and their patients have much at stake as reform policies are developed.

The message of this brief is simple: health care reform policies must be responsive to rural communities in order to avoid unintended and potentially dire consequences for safety net providers, the patients they serve, and other entities that serve rural areas. Whether or not health care reform is achieved in 2007 or in years to come, the distinct issues and challenges that rural communities face in delivering health care remain and must be addressed.

Project Summary

All Californians deserve to experience the benefits of statewide health care reform. It is the goal of the California State Rural Health Association (CSRHA) to ensure that rural populations realize the benefit of new health policies by providing a strong, unified rural health perspective in the reform discussions. To that end, CSRHA, in partnership with the Central Valley Health Policy Institute (CVHPI) and the California State Legislative Rural Caucus (Rural Caucus), brought together over 50 diverse rural stakeholders, including local health care providers, regional and state-wide coalitions, county representatives and others for roundtable discussions on health reform.

This policy brief reflects the perspective and feedback of the stakeholders who took part in these discussions. It considers the major elements of the health care reform proposals as they relate to rural health, outlines the major concerns that emerged from the stakeholder meetings and discussions and provides key recommendations that address those concerns. It should be noted that these priorities and recommendations are the top issues identified by stakeholders and should not be considered an exhaustive list of recommendations necessary to address the significant challenges faced by rural providers when delivering health care to their communities.

Summary of Top Rural Health Concerns:

Health Professional Shortages: The expansion of health care coverage will not improve the health status of rural residents unless it incorporates specific strategies for *training, recruiting and retaining* rural health care professionals, such as increasing reimbursement for services in rural areas.

Adequacy and Affordability of Coverage: Expansion of employer-based coverage will not sufficiently address the insurance needs of rural residents unless there are specific provisions to address gaps in coverage caused by part-time or seasonal employment. Also, high deductible plans that offer "affordable" coverage by lowering premiums will leave rural residents, many of whom are the working poor, severely underinsured should they or their family require major medical or emergency care.

Availability of Insurance Products in Rural Areas: Insurers serving rural areas should not exclude rural providers from their networks. Health plans must be required to provide access to products in rural areas so this population can actually experience the benefits of expanded coverage.

Payment for Chronic Disease Management (heart disease, asthma and diabetes management services): Comprehensive, integrated benefits are a vital part of disease management programs. Health insurers must be required to cover a broader range of chronic disease management services as part of their minimum benefit packages, such as nurse care coordination, health education and nutritionist visits.

Recommendations can be found on page 4 of this document.

Background

According to 2000 Census data, rural California represents 80 percent of the state's landmass and is home to more than 5 million people — about 15 percent of the state's population. Rural California is a major player in the state's economy, generating billions through agriculture, forestry and mining industries. Despite these important economic contributions, rural residents are among the state's poorest and sickest and do not have the same access to health services as their urban counterparts.[2]

According to the Center for Disease Control, there are 935 residents per doctor in rural California compared to 460 in urban areas of the state, and approximately 45 percent of rural Californians live in regions designated as Primary Care Health Professional Shortage areas. A greater percentage of rural residents compared with urban residents experience chronic, debilitating health conditions that require regular medical attention.[3] They are less likely, however, to have health insurance and more likely to depend on Medi-Cal (16.2% rural vs. 11.2% urban) to pay for health care services.[4]

The safety net: Clinics that provide primary care are a critical source of health care for California's underserved rural residents; these include Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs), some of which are Migrant Health Clinics and Indian Health Clinics, as well as some private medical practices that serve patients regardless of their insurance status. In addition, there are many public, private, and Critical Access safety net hospitals that provide medical services to a disproportionate number of indigent and underinsured patients. Counties also finance and/or manage a number of safety net facilities and programs.

Top Concerns Expressed by Rural Stakeholders

This section summarizes the top concerns regarding health care reform communicated by rural stakeholders participating in this project. The proposals examined include Assembly Bill 8, co-authored by Assembly Speaker Fabian Núñez and Senate President pro Tem Don Perata, Governor Schwarzenegger's proposal, "Stay Healthy California," and Senate Bill 840, authored by Senator Sheila Kuehl. AB 8 and the Governor's proposal focus on employer mandated coverage, with the Governor's proposal also including an individual mandate. SB 840 takes a universal health care approach.

Health Professional Shortages:
The chronic and enduring shortage of health care professionals in rural California is not addressed in any of the leading reform proposals. Recognizing that health professional shortages plague both urban and rural communities, this issue is ranked among the *most* critical factors affecting the accessibility of core health care services in rural areas. ***The expansion of health care coverage will not improve the health status of rural residents unless it is coupled with targeted and ambitious strategies for training, recruiting and retaining rural health care professionals.***

The causes of health professional shortages in rural areas are numerous and directly linked to a number of institutional factors embedded in other policies and practices currently in place. These factors, among others, include low Medi-Cal reimbursement rates, a shortage of rural residency training programs and prison health reform strategies.*

Adequacy and Affordability of Health Coverage:
In order for health care coverage to be truly beneficial, it must be continuous, even for the worker whose employment status may change several times during the year. Rural employment is largely characterized by low-wage and part-time jobs, as well as labor-intensive seasonal employment.[5] Agricultural workers compose over 8 percent of the rural workforce, (compared to 1.8% statewide) and are typically among the lowest paid workers.[3, 6] Due to the seasonal and part-time nature of many occupations in rural communities, connecting coverage to employment does not ensure that rural residents will have continuous health care. ***Solutions that address "gaps" in coverage must be incorporated into employer-based health care models or they will provide little or no benefit for rural California's working poor.***

Employer mandated coverage also raises concerns for small rural businesses since many cannot afford to purchase health benefits for their employees. Unless provisions are included to protect small businesses, such a mandate could financially cripple these local establishments.

In addition to being continuous, coverage must also be affordable. The costs associated with using the coverage

* See additional issues on page 5.

must not be so prohibitive that patients forgo preventive and primary care services because of high co-pays. Furthermore, plans that feature high deductibles leave poor populations financially vulnerable in the event of an emergency or other major medical event.

Availability of Health Insurance in Rural Communities:

Rural areas share several common characteristics: low population density, relative isolation, a large Medi-Cal and Medicare population and limited access to health care services.[6] The absence of sizable markets and health care networks, as well as the shortage of health professionals and specialists, make insurers reluctant to offer products in rural areas. Therefore, rural communities have very limited health care coverage options. To make health care truly accessible to all Californians, health insurers must be willing to include rural providers in their networks.

Furthermore, insurers need to offer coverage products in rural communities that do not require an individual to drive long distances because of a lack of locally contracted providers. Geographic isolation and excessive travel are significant barriers to accessing care and a contributor to rural health disparities. It is not clear from any of the proposed plans whether geographic access will be addressed in health care reform.

Chronic Disease Management:

Chronic disease is one of the leading causes of illness, disability and death in rural America.[7] The combined effects of poverty, higher rates of underinsurance, a dearth of health care providers and geographic isolation produce a disproportionate number of rural residents affected by chronic illnesses such as asthma, diabetes and heart disease.[3] According to statistics provided by the California Legislative Analyst Office, rural residents are 25 percent more likely than urban residents to die of cancer, and about 16 percent more likely to die of heart disease.

Sophisticated disease management programs are most frequently found in managed care environments.[8] However, at least 37 percent of California's rural counties do not have a Health Maintenance Organization (HMO) that provides services on a county-wide basis.[9] Furthermore, chronic disease management is not a funded service under Medi-Cal. With higher percentages of Medi-Cal patients in rural areas, safety net providers have no financial support to provide disease management services for its patient population.

Chronic disease management and disease prevention are addressed in the Governor's proposal, SB 840 and AB 8. A cornerstone of the Governor's proposal is its emphasis on prevention and wellness, with provisions to promote healthy lifestyles, obesity prevention and tobacco cessation programs. SB 840 also includes preventive care, but would use funds currently earmarked for disease management as a funding component of the single-payer system. While AB 8 incorporates disease management into all state-funded health care programs, the disease management services which would be eligible for reimbursement are not currently defined.

Recommendations on next page

Recommendations

Health Professional Shortages:

- ***Reduce oversight requirements to allow nurse practitioners and physician assistants to function independently in cost-efficient outpatient clinics:*** This strategy would reduce wait-times for appointments and help address health care access issues in rural communities.
- ***Expand scope of service for Doctors of Optometry, Licensed Clinical Social Workers and Marriage Family Therapists:*** In order to address the lack of providers in rural areas, the scope of practice for non-physician professionals should be expanded to increase access to care.
- ***Make increased Medi-Cal reimbursement rates for physician and non-physician providers a budget priority:*** Low reimbursement rates discourage physicians from practicing in rural areas, where a large segment of the population relies on subsidized coverage. Increasing rates will create some incentive for physicians to serve in rural communities. *Proposals that recommend increased reimbursement rates must also be coupled with corresponding appropriations of state funds.*
- ***Stabilize and expand funding for the Steve Thompson Loan Repayment Program (STLRP):*** The purpose of the *Steven M. Thompson Physician Corps Loan Repayment Program* is to increase the number of culturally and linguistically competent physicians who practice in medically underserved areas of California. While the STLRP will not completely solve physician shortage in rural communities, it is a proven, effective way to immediately increase access to physician services in the most underserved areas of the state with minimal investment. This program is extremely effective in a rural setting because, unlike the National Health Service Corps/State Loan Repayment Program, it does not require the provider to match funding.
- ***Strengthen National Health Service Corps (NHSC)/ State Loan Repayment Program (SLRP)***: Under the NHSC/SLRP, California administers federal grant funding to repay outstanding tuition loans, living expenses and other education expenses incurred by a medical professional who chooses to practice in a medically underserved area, rural or urban. This program funds specified medical personnel, such as physician assistants, dentists, pediatricians and certain other specialists. Funds distributed by the state must be matched by the local health care provider that employs the individual receiving assistance. This requirement is a burden on struggling rural health providers. The state should increase its allocation of funds to this program and determine the provider's portion on a sliding scale.
- ***Ensure that rural areas are given priority as resources become available for technological infrastructure and telemedicine programs:*** The use of telemedicine can address workforce shortages by connecting rural patients with specialists located throughout the state. Telemedicine is often the only way that rural communities can access critically needed health care. These communities, however, do not always have the connectivity to make telemedicine a reality. As technological resources become available throughout the state, it is critical that rural communities receive their fair share of funding for infrastructure (broadband deployment) and equipment.
- ***Establish funding for distance learning programs:*** Expand and build on partnerships between the University of California and rural providers to increase the number of health care professionals able to receive continuing medical education through the utilization of two-way video conferencing.

Adequacy and Affordability of Coverage:

- ***Include provisions that address seasonal and temporary employment:*** Unless health care reform specifically addresses "gap" coverage for these workers, an expanded employer-based health reform strategy will cause a "churning" effect of individuals who will need to enroll in subsidized coverage at varying points throughout the year. This will disrupt continuity of care, while also creating administrative ramifications.
- ***Limit the out-of-pocket expenses related to obtaining and accessing coverage***. "Shared responsibility" should be realistic and take into consideration the economic realities of those living and working in rural communities.

Insurance Product Availability in Rural Areas:

- ***Require insurers serving rural areas to include rural providers in their networks:*** Additionally, regulations that prohibit insurers from marketing plans in rural areas where patients must drive long distances to see a provider must be enforced.

Chronic Disease Management:

- ***Mandate Medi-Cal first dollar coverage (benefits that pay the entire covered amount without subtraction from or use of a deductible) for chronic disease management services, including specialty care:*** Insufficient coverage of chronic disease management services and increased cost-sharing for these services could create a population of patients who fail to adhere to the recommended protocols for the management of their chronic condition, thereby decreasing the effectiveness of their treatment. This may lead to increased costs as the chronic condition remains untreated.

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- ***Establish a minimum set of chronic disease services that must be included in any health plan:*** Health insurers must be required to pay for a minimum set of chronic disease management services, such as nurse care coordination, health education and nutritionist visits. Chronic disease management is a proven strategy for saving lives, while also reducing costs.

Additional Issues

The issues and recommendations in this brief reflect the top four priorities indicated by a geographic cross-section of more than 50 rural health stakeholders. Additional issues and challenges also continue to plague the rural health delivery system. CSRHA and participants of this project urge lawmakers to also address the following concerns:

The effect of prison health reform on the local workforce in rural communities: 21 of the 32 operating adult correctional facilities in the state are located in rural California. Recent prison health care reform strategies, including significant salary hikes for correctional health care professionals, has siphoned doctors and nurses away from many rural safety net providers to the prisons. This issue alone has had significant implications for local residents seeking health care services. The sudden exodus of rural health care professionals to prisons makes it even more difficult for rural patients to find a provider, regardless of their coverage status. Therefore, prison health care reform and rural health workforce shortages should not be considered separate issues. Pilot projects, such as the development of creative partnerships involving shared staff between the local health facility and the correctional institution, could address the need for health resources in the prisons, without destabilizing the local safety net that is so vital in delivering care to the community.

Seismic performance mandate for hospitals: Virtually no rural facility has the resources to implement seismic repairs and/or facility replacements. Rural hospitals and clinics, except for those facilities deemed to be the highest risk, should be granted extensions in the current statutory deadlines until retrofit funding is made available by the state.

Conclusion

Despite facing many challenges, rural communities are immensely valuable to California. Not only do the residents living and working in these areas play a vital role in the state's economy, but these regions also provide the state and the nation with historical, recreational and scenic assets. The era of health care reform provides California and its leaders with an unprecedented opportunity to help millions of people throughout the state by expanding access to health care.

Health care reform policies must be responsive to rural communities in order to avoid unintended and potentially dire consequences for rural people, safety net providers and other entities that serve rural areas. The consistent consideration of the rural perspective in policy development and the corresponding allocation of resources will eventually allow many rural communities to fully realize their potential as healthy, economically vital places to live and visit.

References

1. Office of the Governor, Arnold Schwarzenegger. (January 8 2007). *Schwarzenegger's Remarks to Tackle California's Broken Health Care System*. Available at : http://gov.ca.gov/index.php?/speech/5066/

2. The California State Rural Health Association. (2005). *The Rural Kaleidoscope: A Guide on Promising Practices to Diversify California's Rural Health Care Workforce*. Available at: http://www.csrha.org/outreach2/ruralkaleidoscope.pdf

3. California Health Interview Survey. (2007). Diabetes and Heart Disease search; rural/urban comparison. http://askchis.com/main/DQ2/geographic.asp

4. The California State Rural Health Association. (2004). *Stats & Facts.* Available at: http://www.csrha.org/factsheet.html

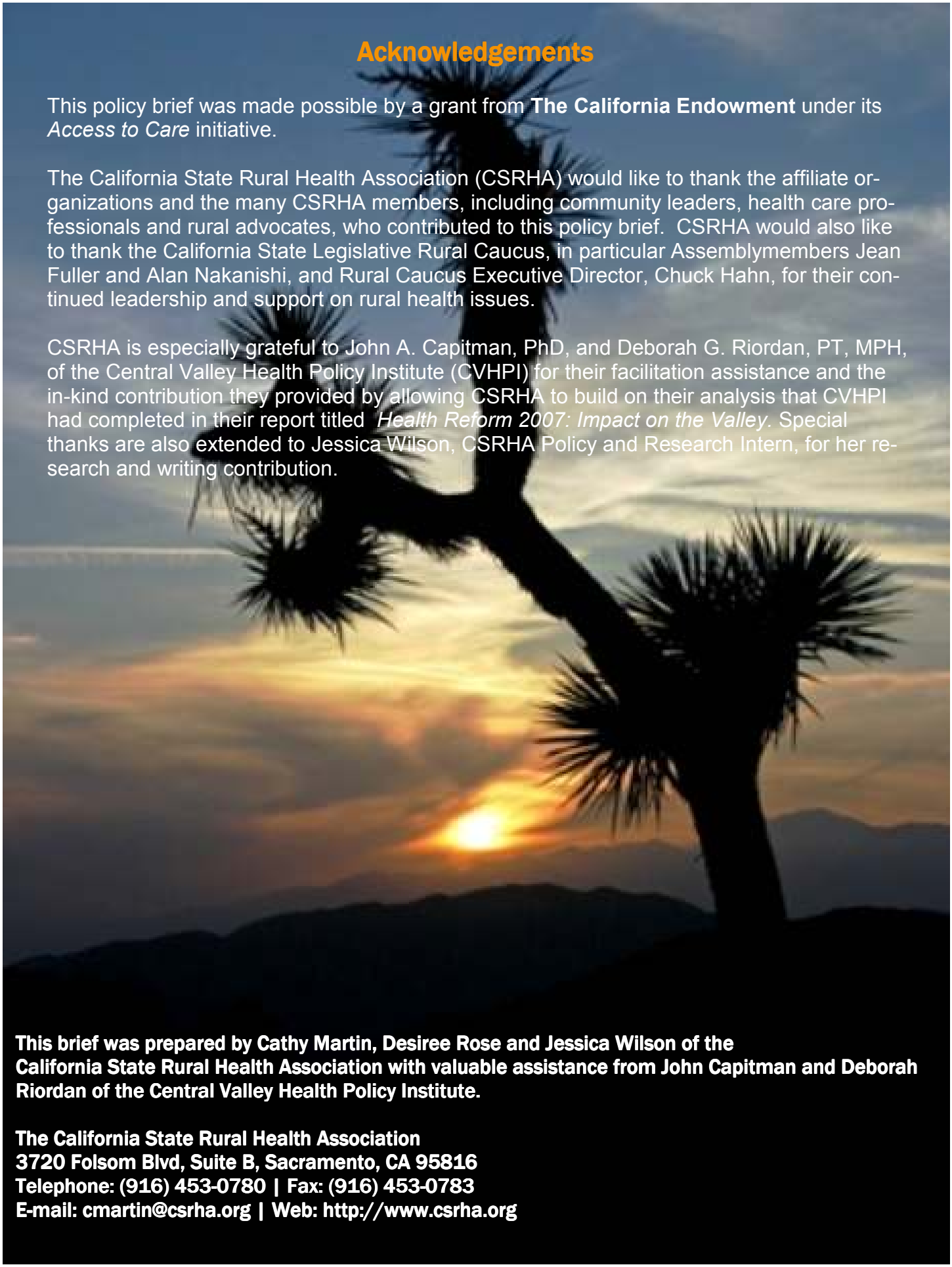
5. The California Endowment Task Force on Agricultural Worker Health. (2001). *The Bounty of Food: The Poverty of Health.*

6. American Academy of Physician Assistants. (1997). *Managed Healthcare and Rural America* http://www.aapa.org/policy/managed-health-care.html

7. Center for Disease Control and Prevention. (2004). *The Burden of Chronic Diseases and Their Risk Factors: State and National Perspectives.* U.S. Department of Health and Human Services.

8. Bolin J, Gamm L, Peck BM, Kash B. (2004). *Difficult Patient Populations: Implementing Disease Management in Rural and Underserved Patient Groups. Proc. of National Rural Health Association.* Southwest Rural Health Research Center, SRPH, TAMUSHSC.

9. Legislative Analyst's Office. (2002). *HMO's and Rural California.* Available at: http://www.lao.ca.gov/2002/hmos_rural_ca/8-02_hmos_rural_ca.html



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CALIFORNIA STATE
RURAL HEALTH
ASSOCIATION

Our Mission: *To preserve and enhance health in rural California*

The California State Rural Health Association (CSRHA) is a nonprofit, nonpartisan, grassroots organization that works to improve the health of rural Californians and the quality and accessibility of the heath care they receive. CSRHA brings together health care providers, consumers, educators, researchers, public health and economic development agencies and others to work on a variety of issues related to preserving and enhancing health in rural California.

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