A Rural Texan Talks About Policy and Health Care in Rural Texas

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Abstract

What can we say about health care for our rural areas in Texas these days? A lot has happened in recent years and we often talk more about the loss of services than we talk about improvements and access. However, we can say that policy, whether from the federal, state, or private level, has impacted the health care services we receive, and most of it has been in the budget arena. For every two steps forward, we seem to take one step back!

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Rural Health Issues

Access to Care

An issue that has always been on the minds of rural citizens has been access to quality health care. This was recently pointed out in a research project by the Southwest Rural Health Research Center at the Texas A&M University School of Rural Public Health that conducted a rural *Healthy People 2010* project. It assessed the levels of agreements on priority areas among state and

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local rural leaders nationwide. A survey was mailed to 999 rural health leaders, with 501 respondents. Respondents were asked to rank rural health issues. There was substantial agreement on the top rural priorities among state and local rural health level agencies across the 50 states. “Access to quality health services” was the top priority among leaders of state-level rural agencies and health associations, local rural public health agencies, rural health clinics and community health centers, and rural hospitals. It was the top priority across all four major census regions of the nation as well. The next top four ranking rural priorities— “heart disease and stroke,” “diabetes,” “mental health and mental disorders,” and “oral health”—were selected as one of the top five rural priorities by one-third or more of the respondents across most groups and regions.

Quality of Care

Debbie Phillips, M.D., the task force leader for the National Rural Health Association’s (NRHA) group that is developing an association policy brief on “Rural Quality Care,” addressed some of these quality of care issues. In her initial draft to the work group, Dr. Phillips said that the concept of quality health care does not vary from urban to rural settings. The focus of quality clinical efforts remains on providing the right service at the right time in the right way to achieve optimal outcome. The elementary differences in the rural/urban context are within scope and scale. Whereas the urban setting features a high volume of patients with an emphasis on technology-intensive and inpatient services, the rural setting focuses more on ambulatory care and lower patient volume. But then again, the volume of patients will depend on each clinical site and some may actually have a higher volume than urban sites.

Rural health care systems tend to take care of a higher proportion of elderly patients and patients with more advanced or chronic conditions, possible due to delays in seeking health care. Also, rural residents have higher risk factors than the general population. Rural areas also face greater shortages of health care providers, and even where primary care is covered, there is no depth, making it difficult to replace those that leave or suffer burnout. Always there is a shortage of specialists and reimbursement for providers who practice in rural areas tends to be less than their urban counterparts. While issues of workforce and reimbursement are not explicitly quality issues, they do impact the system’s ability to produce quality care. However, none of these factors, in and of themselves, means that rural residents should expect or receive a lower quality of care.

As mentioned in the draft by Phillips, managed care has infiltrated rural health and implemented their methods of “disease management” and data collection, but some experts question the effectiveness of these methods in rural areas. Access and quality health care problems in rural areas seem to be a combination of:

- lack of providers;
- lack of transportation to health care providers;
- lack of trust of the medical system, which is not unique to rural America; lack of money; and
- lack of education/illiterate (embarrassment/cultural factor).

If experience has taught us anything, we know that rural citizens need more than a one-size-fits-all system. The unique and complex dynamics of living in a rural community need

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to be considered when health care delivery systems are designed and implemented.

Physician Retention

Physician retention is also an ongoing problem for many rural communities. Financial issues are often at the heart of this problem. Many doctors want the lifestyle that suburban/urban life brings. However, rural doctors infrequently make as much money as their suburban/urban counterparts, but they have just as much student debt. In addition, most physicians who have started practices in rural areas will tell you that insurance reimbursement rates are lower in rural areas, making it difficult to sustain a profitable practice. In addition, rural primary care doctors suffer longer hours due to less coverage and have less specialist response and availability. The reimbursement will need to be equalized. Some suggest subsidizing medical school for those who will commit to practicing in rural areas.

Family practice physicians do a great deal of basic counseling in all areas. It is this counseling time and expertise that often makes the difference in the patient's life, but insurance companies refuse to acknowledge this financially. Rural communities need the best primary care doctors that schools can produce.

THE LOCAL HOSPITAL

There is another provider that plays a very large part in providing health care services in rural communities and that is the local hospital. This article will not address the hospitals' concerns, because they are mainly budget issues for the hospitals that are complex and tied heavily to the Medicare and Medicaid policies for reimbursement. Hospitals have their advocates constantly working hard to maintain these services in rural Texas. But what should be noted is information in a recent report from the Department of Health and Human Services' Office of the Inspector General (OIG) that addressed the trends in rural hospital closures from 1990 to 2000. The OIG's findings on this national review of rural hospital closures that occurred during this period revealed that:

- Two hundred-eight hospitals closed—7.8% of all rural hospitals.
- Rural hospitals that closed were generally smaller and treated fewer patients than rural hospitals nationally.
- Generally, rural hospital closures resulted from business-related decisions or low number of patients.
- Following a closure, alternative forms of health care were often available within the community.

New rural hospital openings, critical access hospitals, and rural health clinics have reduced the overall impact of the rural hospital closures.

Of the 58 rural hospitals that closed from 1998 through 2000, 40 of the facilities either converted to, or were located less than 20 miles from, a rural health clinic (RHC). In 32 of the communities, multiple RHCs were less than 20 miles from the closed hospitals. For example, a rural California community lost its hospital in 1998; however, five RHCs were located less than 20 miles from the closed facility. The OIG did not maintain such material prior to 1998.

Interestingly, even Texas has seen this type of scenario. An example is the hospital in Shiner, in South Texas, which closed in the mid-1990s. The RHC that existed at the time in

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Shiner eventually moved into the old hospital facility. And, not too long ago, a hospital in Hale County, West Texas, closed and now there is an RHC that has relocated its operations to an old hospital facility within the county. There is a new RHC next to the old hospital in Rosebud in Central Texas that recently opened to provide services to that small community. The community lost its hospital some time ago and the facility was converted to a nursing home. The nearest hospitals are about 30 miles away from Rosebud.

During the 11-year trend period, rural hospitals closed in 39 states. Texas had the greatest number of rural closures (24), followed by Minnesota and Mississippi (15), Kansas (10), Montana (9), and California and Louisiana (8). These seven states account for 43% of all rural hospital closures from 1990 through 2000.

Policy Implications

So how are other health care services in Texas rural communities? The *Austin American-Statesman* (July 28th edition) looked at the impact of state cuts in funding and found that rural areas fear the worst with these cuts looming in the future. The newspaper reported 36 counties have no licensed social workers. Twenty-four have no primary care physician. Regional mental health centers cover vast geographical areas and further cuts are being planned. There are 64 rural Texas counties without hospitals, 40 without dentists, and 13 without pharmacists, according to the Texas Office of Rural Community Affairs. There are only 20 of Texas' 196 rural counties that have a family violence shelter. In 1999, there were 444 certified rural health clinics; today that has dropped to 338 RHCs. Where there may be an expansion is in the community health center family with the new federal expansion grant funds to increase nationwide the Federally Qualified Health Centers (FQHC) to 1,000 more centers in the country. Currently there are about 80 community health centers serving rural Texans.

So what does policy have to do with all of this? Well, policy created the rural health clinic system, the community health centers, and the critical access hospitals. But policy gets changed over the years and some of the criteria for these establishments to continue to exist changed, for good or bad. In the Texas RHC world, the environment took on a seemingly gluttonous attitude to gobble up the countryside with a RHC in every nook and cranny. However, when "policy" on how RHCs were to be paid for their services changed in the late 1990s and curtailed some of the reimbursement, the larger hospital systems that owned RHCs started to shut their clinics. This trend continues today with a number of the large hospital systems shedding themselves of their clinics in all parts of Texas by either shutting down clinics or giving/selling them to small community hospitals or private physicians to run.

This has lent itself to a "policy" conflict for access to care in the rural area. Due to regulations, a physician assistant (PA) cannot be paid directly by Medicare or Medicaid for their services but reimbursement must be paid to their employer (the RHC) or supervising physician. There are now PAs who are starting their own rural health clinics to fill the gape in rural areas of the state where there was no health care or health care providers pulled out of a community. The policy glitch is occurring where the PA owns a RHC that has lab or x-ray facilities. (Medicare policy was clarified earlier this year and now allows PAs to own their own RHCs from the Medicare

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payment aspect.) However, the PA cannot get paid by Medicare or Medicaid for these lab/x-ray services. Commercial payors have not found it a problem to reimburse for the lab and x-ray services. One PA-owned RHC was able to work out the problem with this Part B payment with the Central Office in Baltimore for the Centers for Medicare and Medicaid Services (CMS) and the clinic is now being paid for the services without the funds going to a supervising physician. Policy was adjusted to help this clinic continue to be paid for the services rendered. However, Medicaid does not issue a Texas Provider Identification number (TPI) to physician assistants. TPI numbers are issued to physicians, advanced nurse practitioners, and Rural Health Clinics. And in this case, the state's Medicaid policy personnel have tried to solve the problem by including the expenses for lab and x-ray in the clinic's cost report so that it is reflected in the RHC Medicaid Prospective Payment System encounter rate. However, the PA owner does not agree with this policy decision because it is not adequate compensation nor does it come close to the expense for the operation of the lab testing equipment or x-ray machine. An extra dollar or two added to each Medicaid visit does not cover the costs for each time a Medicaid patient has an x-ray taken or extensive lab work done in the RHC. A possible solution (the owner's policy) is to send that Medicaid patient 30 miles to the nearest health care provider, a hospital, for lab and x-rays. Whose policy is correct or best for …the provider …the patient …the business…the state? It is not a denial of RHC services because, other than the mandated six RHC-waived lab procedures, lab services are not a RHC service requirement. That is policy also! So, is this two steps forward for access to care in that community, and one step back because of the policy on reimbursement?

Another policy that could conflict with services in rural areas is the expansion of community health centers. An example of this unfortunately occurred earlier this year. A community health center desiring to expand its services went into a couple rural towns about 90 miles and 60 miles from its base clinic and approached the community leaders about all the services it could provide and take care of the areas' under-served populations. However, it was perceived as a strong-arm approach by the existing dentists, pharmacies, and rural health clinics that had been in operation in these communities for many years. Although the results were that it did not set up clinics in those towns, it left a bad impression. So much so, in fact, that some people made visits to the congressional representative of the district where the community center was located and cited the situation as a poor example of federal policy without consideration for existing providers. But then, it is national policy to expand these community health centers in the country and the governor of Texas has also backed this policy for the state. Now, there are rural physicians and hospitals researching as how they can apply to become a federally qualified health center because of higher reimbursement and federal tort protection on malpractice.

Managed care insurance policies are not provider friendly as evidenced in their policy to bundle or down code procedures. Is it a good business practice to bundle codes differently than the national Medicare bundling methods just to save money or manage the care given to patients by withholding funds using their own proprietary formulas? What will be the consequences when providers start managing health care according to how they are reimbursed? Again, it is someone's policy that has put this into

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action. Is this a situation of two steps forward in providing quality health care only to take one step back in reimbursement?

How do we take care of the uninsured and under-insured? With the budget cuts to Medicaid and the resulting fallout, do we turn patients away? Do we take the mushrooming medical discount card business from patients that walk in the door? It is simply a discount program that buys doctors' names from the health care provider networks and requires the patient to pay for services received at the time of service according to the provider's contracted rates. It is interesting that some discount programs charge up to $99.95 a month for a family plan and they advertise a discount of up to 80% on health care services. This does not work in my area. I don't know any doctor who will discount 80% off the services provided; it's really more like a discounted contract rate from 10% to 25 % with the networks. In this situation, the rural patients end up taking two steps forward in trying to help themselves and then six steps backward when one considers the amount of money they will eventually pay. Whose policy was at play here? It must have been a business policy of some company to sell the discount cards. What has been the state's policy on this? The Texas Department of Insurance does have an informational handout cautioning people to be careful and understand fully what they are buying with these programs. My experience is that most people don't really understand that it is not insurance and they must pay in full at the time of the office visit for the services they received according to whatever contracted network rate the doctor is on. It is "only" policy to do it that way in order to receive the discounted rate.

Conclusion

Does policy affect how we as rural Texans receive our health care services? You bet it does! As was pointed out at the beginning of this article, there is concern for access to quality care. And a high concern for the treatment of heart disease, diabetes, mental health, and oral health that should be made our priorities for policy development in rural Texas. We can monitor and react to policy. Whether it involves federal or state budgets or new programs, we can be vigilant and speak out when it affects access to not only the health care we receive, but also the quality we must have as rural citizens. Do not be intimidated by regulations, especially those dealing with health care policy. Regulations are only a guide and while they should be followed in spirit, apply large doses of common sense to their interpretation. Be wary of well-intentioned but misguided policy people who sometimes use rules as justification for unfair or unwise decisions. A good thing to consider is that for every regulation that flies in the face of common sense, prohibits a reasonable action, or validates wrong-headed judgment, there is usually a companion rule that addresses your particular circumstances, authorizes a more reasonable solution, and thus allows smarter, provider-friendly decisions. Beware of statisticians who look only at numbers to judge units. They may know a lot about arithmetic, but many don't know that much about patients or why some providers are better than others are. Don't confuse changes from haphazard planning or careless assumptions with flexibility. Protect your health care services by making it one of your life's primary missions to reduce the number of anti-rural Texan policies or changes caused by poor prior planning. And finally, don't be afraid to ask

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the so-called dumb question, because that's smarter than the dumb mistakes later.

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