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**The 1990-91 Budget:  
Perspectives and Issues**

*Health Care in  
Rural California*



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# Health Care in Rural California

## How Can the Legislature Improve Health Care Services in Rural California?

### Summary

Access to health care in rural areas is limited, in part due to long distances between isolated communities, rough weather conditions, and depressed economies. Over the years, access has been further restricted by the closure of rural facilities and the failure of rural communities to attract and retain health personnel. Existing reimbursement and regulatory policies also play a role in limiting the number of providers, and thereby restrict access to health care.

Currently, there are various state programs designed to address some of these issues. However, our review suggests that these programs have limited success in improving access to health care in rural areas, partly because these programs are not coordinated. To address this concern, we recommend that the Legislature strengthen the state's leadership role and designate a lead agency on rural health issues. In addition, we recommend that the lead agency develop a systematic approach to assisting rural health care providers and that state agencies evaluate adjustments to the regulatory and reimbursement systems affecting rural health providers.

### INTRODUCTION

Over the past several years, the Legislature has taken numerous actions to address problems with rural health services. Primarily, these actions have been in response to rural hospital closures, continued financial distress of current facilities, and difficulties in recruiting and retaining health professionals. Our review indicates that, despite these legislative efforts, current state programs do not address these problems in a comprehensive way.

In the following pages, we examine health care services in rural areas within the state. Specifically, we (1) review the characteristics of rural areas and health care services in these areas, (2) discuss current state programs, (3) highlight specific problems we identified within the existing services, and (4) suggest ways the Legislature could improve the provision of health care services to rural areas.

## WHAT ARE THE CHARACTERISTICS OF RURAL AREAS?

### Defining "Rural"

There are numerous inconsistent definitions of "rural" in use by different state and federal programs. For this analysis, we have chosen to focus on counties that (1) are not classified as a Metropolitan Statistical Area (MSA), (2) are not part of a Consolidated Metropolitan Statistical Area (CMSA), and (3) have a total population of 200,000 or less. Under this definition, 25 of the 58 counties in California are considered rural. Figure 1 lists these counties and displays data on the population and the number of hospitals and clinics in each county.

This definition has the limitation of excluding rural areas *within* urban counties. We did not include these areas because most of the data are available only by county. We recognize that these areas within urban counties share many of the characteristics and problems of rural counties.

### Low Population Density

Rural counties in California are sparsely populated. The average population density for these 25 counties is 29 persons per square mile with a range of 1 (Alpine) to 99 (Colusa) persons per square mile. In comparison, the density is 2,131 persons per square mile in Los Angeles, 568 in Sacramento, and 16,251 in San Francisco. The total permanent population living in rural counties is 4 percent of the state's population.

### Population Swings

Some rural areas experience large swings in their population. Seasonal workers, for example, contribute to temporary population growth in counties where agriculture is a major economic activity. Counties with national and state parks and other resort areas also host significant numbers of seasonal tourists and workers.

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Figure 1

**Rural Counties in California  
Population and Number of Health Facilities**

County	Population <sup>a</sup>	Number of Hospitals <sup>b</sup>	Number of Clinics <sup>c</sup>
Alpine	1,190	--	--
Amador	29,150	1	2
Calaveras	32,400	1	--
Colusa	15,500	1	--
Del Norte	20,400	1	--
Glenn	23,600	1	1
Humboldt	116,800	6	4
Imperial	115,700	3	4
Inyo	18,200	2	1
Kings	96,000	4	--
Lake	52,100	2	1
Lassen	28,800	1	4
Madera	83,800	2	3
Mariposa	14,800	1	--
Mendocino	76,900	5	5
Modoc	9,375	2	1
Mono	9,800	2	--
Nevada	78,800	2	--
Plumas	20,050	4	2
San Benito	35,250	1	1
Sierra	3,600	1	1
Siskiyou	43,750	2	3
Tehama	47,250	3	--
Trinity	14,000	1	1
Tuolumne	49,000	3	1

a Source: Department of Finance 1989 population estimates.

b Source: Office of Statewide Health Planning and Development (OSHPD) Licensed Services and Utilization Profiles, 1988.

c Source: OSHPD 1985 Annual Report of Clinics as reported in Community Clinic Fact Book, 1987.

### **Isolated Communities and Sparse Services**

Rural counties characteristically have sparse services, and their communities are relatively isolated from one another in terms of miles and physical terrain. Travel along a limited network of roads is made even more difficult by rain, fog, or snow. For example, winter conditions in Modoc County can close the roads into Cedarville, leaving that community isolated for days at a time.

### **Weak Economies**

Rural counties generally have weaker economies than the rest of the state. Economic growth in California has occurred in industries that, for the most part, are not located in rural counties. For example, the statewide job growth rate during the 1980s was 18 percent. Eighty percent of this growth occurred in the service (primarily business and financial services), trade, and finance industries. These sectors account for a very small part of the economic activity in rural areas. The economic base in most rural counties includes manufacturing, agriculture, tourist services, mining, and government. In the past decade, manufacturing employment grew by only 5 percent, employment in both agriculture and mining actually fell, and government employment increased only modestly.

In a large number of the 25 rural counties, the unemployment rate and the percentage of the population living below the poverty level are higher than the statewide average. Based on 1988 Employment Development Department data, 23 of the 25 rural counties had an unemployment rate higher than the statewide average. In 1987-88, 17 of the 25 rural counties had higher monthly average AFDC caseloads per capita than the statewide average.

### **WHAT ARE THE CHARACTERISTICS OF RURAL HEALTH SERVICES?**

Our review of rural health services is based on visits to 30 facilities in 16 counties; discussions with local providers, program administrators, and other interested parties; and examination of data on rural health services. We discuss our findings below.

#### **Inpatient Care**

There are 51 hospitals in the 25 rural counties. All of the counties except Alpine have at least one hospital. Distances between hospitals can be as great as 100 miles.

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Most rural hospitals are small. All but two of the 51 hospitals in rural counties have fewer than 100 beds; and one-half have fewer than 50 beds. The occupancy rate for acute care beds in these hospitals is low, averaging 33 percent in 1988. In comparison, the statewide occupancy rate was 53 percent. The occupancy rate for rural hospitals varies significantly from day to day, and many facilities experience seasonal fluctuations associated with the influx of tourists and workers. Rural hospitals generally focus on primary care and emergency services. For instance, 63 percent of these hospitals have licensed intensive care units, and 55 percent have designated obstetrical beds. These hospitals generally do not have extensive specialty departments.

**Many Rural Hospitals Are Financially Distressed.** In 1988, 29 out of 42 rural hospitals (data were not available on the other 9) had negative operating margins. In other words, patient service revenue did not cover operating expenses. On the average, patient service revenues for 28 of the 29 hospitals were 7.3 percent below operating expenses. (We excluded Mono General Hospital because it had one-time revenue problems that gave it an extremely low operating margin.)

Generally, this gap is made up with nonpatient revenue such as district tax revenue (for district hospitals), private contributions, and county contributions (for county hospitals). Over time, operating shortfalls mean that the hospitals are unable to maintain the physical plant, replace equipment, and make other capital improvements. For some hospitals, it leads to closure. (Ten rural hospitals have closed during the last 13 years.)

The reasons for this financial distress appear to be:

- **Difficulty in Covering Fixed Costs.** Hospitals cannot cover their fixed costs due to low patient volume. Fixed costs are those incurred by the hospital regardless of how many patients they have.
  - **Costly Supplemental Services.** Hospitals that are unable to cover their fixed costs may further contribute to their financial distress by adding costly supplemental services. This is in response to community demands for a full range of services, and the hospitals' attempts to attract and retain health professionals. For example, some hospitals purchase sophisticated medical equipment, such as computerized tomography (CT) scanners. In some cases, however, these hospitals do not have the patient volume to support such expenditures or services.
  - **Cash-Flow Problems.** Rural hospitals have relatively small budgets that cannot easily absorb fluctuations in
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revenues. These fluctuations are due to swings in occupancy and delays in Medi-Cal and Medicare reimbursements. These revenue fluctuations create cash-flow problems for many of these hospitals.

- **High Personnel Costs.** Rural hospitals are affected by the statewide nursing shortage. As a result, many of them hire “registry” nurses provided by personnel agencies on a temporary basis at a *higher* cost than permanent nursing staff.
- **Difficulty Attracting Personnel.** Hospitals have difficulty in attracting health professionals and administrators due to geographic isolation and limited resources to offer competitive wages. Without sufficient personnel, a hospital can lose patients and, therefore, revenue.
- **Variations in Administrative Effectiveness.** Hospital administrators have varying levels of sophistication and knowledge of state programs which, in turn, determine the extent to which they are successful in securing technical assistance and funding. Administrators also vary in their ability to deal with regulatory and reimbursement requirements, as well as the day-to-day operation of the hospital.

### Emergency Medical Services

There are two components of emergency medical services: pre-hospital emergency care and hospital emergency room care. Pre-hospital emergency care includes ambulance services and emergency medical personnel. Because of the distances between hospitals in rural areas, pre-hospital emergency care is critical.

One of the primary functions of the rural hospitals is to provide emergency services. All rural hospitals have emergency rooms where patients can be stabilized prior to their transfer to a facility with comprehensive medical services.

***The Availability of Emergency Vehicles and Their Staffing Vary Among the Counties.*** In some counties, emergency vehicles are staffed with paramedics, who are able to provide advanced life support services. In other counties, emergency vehicles are staffed with emergency medical technician-IIs (EMT-IIs), who can provide “limited” life support services, or EMT-IIs, who can provide “basic” life support services only.

### Outpatient Services

Rural counties have high population-to-physician ratios. The average ratio is 1,034 persons per physician in rural counties,

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with a range of 371 persons per physician in Inyo to 3,371 in Glenn. By comparison, the ratio is 381 in Los Angeles, 497 in Sacramento, and 161 in San Francisco. According to the Office of Statewide Health Planning and Development's (OSHPD's) 1987 California State Health Plan, 20 of the rural counties do not meet the OSHPD's standard of adequacy for primary care physicians--no more than 1,205 persons per primary care physician. (Note: These ratios do not reflect the availability of other professionals who practice in conjunction with physicians.)

Outpatient services are also provided by community clinics. As Figure 1 shows, there were 35 such clinics in 16 of the 25 rural counties in 1985. Nine of the counties did not have a clinic.

***Certain Outpatient Services Are Difficult to Find.*** Access to specialty services such as orthopedics and obstetrics often is particularly limited. For example, during our visit to Mendocino County, we found that there are *no* practicing obstetricians providing prenatal services.

Access problems are even more difficult for Medi-Cal recipients. In Needles, for example, none of the three local physicians accept new Medi-Cal patients, nor does the hospital provide outpatient services. In this case, a new Medi-Cal patient has to travel long distances to see a physician who accepts Medi-Cal.

## WHAT PROGRAMS CURRENTLY AFFECT RURAL HEALTH SERVICES?

Figure 2 provides specific information on state programs that affect rural health services. Below we discuss some of these programs.

### Department of Health Services

***Licensing and Certification.*** The Licensing and Certification Division licenses health facilities and performs certification reviews on behalf of the federal government at facilities that seek to qualify for Medicare or Medi-Cal funding.

In addition to its licensing and certification functions, the division conducts other programs that benefit rural facilities. Under the "swing bed" program, rural hospitals with up to 50 beds designate certain licensed general acute care beds that may be used as skilled nursing beds. For rural hospitals that have a low acute care patient load, the program allows filling a bed that would have been empty otherwise. According to 1988 data, the state has 202 designated swing beds located in 14 rural facilities.

The division has also had for many years the authority to allow facilities to use alternate approaches and techniques to

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Figure 2

### State Programs Affecting Rural Health Services

Division	Specific Programs or Activities Affecting Rural Providers	Amount of Funding 1989-90
<b>Department of Health Services</b>		
Licensing and certification	"Swing bed" program	--
Medical care services	1. Provides reimbursement for medical services	Unknown amount for rural areas
	2. Supplementary rates for outpatient services provided by rural hospitals	\$4 million
	3. Distinct-part skilled nursing facility and swing bed reimbursement programs	Unknown amount for rural areas
Rural and community health	1. County Medical Services Program	\$60 million General Fund; \$10 million from AB 75 (Proposition 99) funds; \$4 million from Immigration Reform and Control Act (IRCA) funds
	2. Other AB 75 provisions	Share of \$82 million for county capital outlay; \$7 million for hospital uncompensated care
	3. Rural Health, Indian Health, Farmworker Health, and Clinics Programs	\$9 million General Fund; \$23 million from IRCA funds; share of \$20 million from AB 75
	4. Hospital and medical standards program	--
Family health services	Various	Unknown amount for rural areas
<b>Office of Statewide Health Planning and Development</b>		
	1. "Program flexibility"	--
	2. Review of state regulations applicable to small and rural hospitals	--
	3. Alternative Rural Hospital Demonstration Project	--
	4. Health professions development	--
	5. Song-Brown Family Physician Training Program	\$2.9 million
	6. Rural Hospital Grant Program	Depends on amount of excess Cal-Mortgage reserves; not implemented yet

Program	Specific Programs or Activities Affecting Rural Providers	Amount of Funding 1989-90
<b>Emergency Medical Services Authority</b>		
	Financial support for rural regional emergency medical services agencies	\$1.2 million
<b>California Health Facilities Financing Authority</b>		
	1. County Health Facilities Financing Assistance Fund	\$10 million one-time funds
	2. Hospital Equipment Loan Program	\$3.9 million one-time funds
	3. Short-term adjustable-rate taxable securities	Not fixed--depends on loan applications; started 1989
	4. Pilot program providing loans for capital expenditures required by state regulations	Total of \$3 million over four years; started 1989

meet statutory requirements or regulations. Chapter 67, Statutes of 1988 (AB 1458, Jones), transferred the responsibility for reviewing "program flexibility" requests by small and rural hospitals to the OSHPD.

**Medi-Cal.** Medi-Cal reimburses necessary health care services provided to public assistance recipients and to other individuals who meet the program's income requirements. Medi-Cal is an important source of revenue for many rural providers. For example, on average, Medi-Cal represents 17 percent of patient revenues for the 42 rural hospitals for which data were available. Generally, Medi-Cal reimburses inpatient services in rural hospitals based on facility-specific costs. Outpatient services, including physician and clinical services, are reimbursed on a flat-rate fee-for-service basis.

In addition to these general reimbursements, the Medi-Cal Program has two provisions directed specifically towards rural providers. First, Medi-Cal currently provides supplementary rates for outpatient services provided by small and rural hospitals. Chapter 1476, Statutes of 1987 (SB 1458, Keene), established the program with a one-time appropriation of \$4 million (\$2 million General Fund). Each of the eligible hospitals received rate augmentations based on their share of paid outpatient services claims. This augmentation has been continued in later Budget Acts and the 1990 Budget Bill.

In addition to hospital, physician, and clinical services, the Medi-Cal Program reimburses skilled nursing services. Some rural hospitals have converted a wing to a "distinct-part skilled nursing facility" (DP/SNF). Because skilled nursing patients generally stay longer than acute care patients, DP/SNFs provide

the hospital with a more stable patient base. Other rural hospitals participate in the swing bed program (discussed above).

**Rural and Community Health.** The Rural and Community Health (RCH) Division distributes funds to counties and local providers through various programs.

The Medically Indigent Services Program (MISP) funds counties to provide health care for indigents. Through the County Medical Services Program (CMSP), the state provides these services in counties with populations of less than 300,000 (based on the 1980 census) that wish to participate. All but two (Lake and Mendocino) of the 25 rural counties we identified for this analysis are participants in the CMSP. Funding for the CMSP in 1989-90 is \$60.4 million from the General Fund and \$4 million from Immigration Reform and Control Act (IRCA) funds for services to newly legalized persons.

The CMSP has been expanded in the current year under Ch 1331/89 (AB 75, Isenberg), which implemented the Tobacco Tax and Health Protection Act of 1988 (Proposition 99) and established a variety of programs. For 1989-90, AB 75 includes \$10 million to expand the scope of benefits covered under CMSP and reimburse health care providers in CMSP counties for emergency services provided to out-of-county indigent patients. Some of these funds are being used to encourage innovative approaches to providing rural health services, such as rotating dentists through multi-county areas.

Assembly Bill 75 also includes \$82 million for county capital outlay, a portion of which will go to rural counties, and \$7 million to reimburse CMSP counties and providers for uncompensated care.

The Rural Health, Indian Health, Farmworker Health, and Clinics Programs provide grants to counties, clinics, and other providers for services to special populations primarily in rural areas. General Fund support for these programs had remained virtually unchanged for the past five years at \$9.5 million, with essentially the same providers receiving grants each year. In the current year, this funding was reduced to \$8.5 million due to the availability of IRCA funds. In addition to receiving a share of IRCA funds, rural clinics receive a share of AB 75 funds.

In addition to distributing funds to counties and health care providers, the RCH Division provides technical assistance to counties and facilities. Some of this assistance is provided by RCH staff in the course of administering the various grant programs. Chapter 1209, Statutes of 1988 (SB 2549, Keene), required the department to (1) establish a process for identifying strategically

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located, high-risk rural hospitals and (2) provide expert technical assistance for those hospitals. Although this program, called the Hospital and Medical Standards Program, provides technical assistance to rural hospitals in distress, a specific listing of strategically located, high-risk rural hospitals has not yet been developed.

**Family Health.** The Family Health Services Division addresses the special needs of women and children through various programs. Although funds are not targeted specifically at rural providers, they provide a major source of funds for many rural community clinics.

**"Safety Net Policy."** The Department of Health Services (DHS) established a "safety net" policy in 1988, under which county facilities, providers serving a disproportionate share of Medi-Cal patients, community clinics, and other "safety net" providers have priority for obtaining financial and technical assistance and flexibility in the application of licensing statutes and regulations. Under this policy, a number of financially distressed rural facilities have been assisted by licensing and certification, Medi-Cal, and public health program staff.

#### **Office of Statewide Health Planning and Development**

**Demonstration Projects.** In addition to transferring responsibility for reviewing "program flexibility" requests from the DHS to the OSHPD, Ch 67/88 required the OSHPD to:

- Undertake a comprehensive evaluation of small and rural hospital licensing and building regulations.
- Adopt emergency regulations waiving or modifying unnecessary or unduly burdensome requirements for small and rural hospitals.
- Report to the Legislature on whether or not alternative standards for small and rural hospitals should be adopted permanently.

Pursuant to Chapter 67, the OSHPD is also designing an alternative rural hospital model pilot project. The model would emphasize regulatory relief rather than increased reimbursement. Under this project, participating hospitals would be subject to a different set of state requirements. For example, they would provide five "core" services deemed minimally necessary to ensure basic health services in rural areas. In addition, they would employ a new health profession category. In connection with developing the model, the OSHPD is reviewing licensing requirements that apply to small and rural hospitals.

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**Health Professions Development.** The office administers various health occupations pilot projects, some of which are specifically oriented to address rural needs. For example, 1980 pilot projects demonstrated that it was safe for ambulance drivers to perform selected medical and nursing procedures on trauma and heart attack patients before they reached the hospital. This resulted in a 1981 statute recognizing emergency medical technician IIs. Other pilot projects resulted in the recognition of nurse practitioners and nurse midwives, as well as regulations allowing appropriately trained physician assistants to furnish and dispense drugs.

The office also administers programs designed to increase and improve the recruitment and retention of health professionals. The largest program is the Song-Brown Family Physician Training Program. In the current year, the program has \$2.9 million from the General Fund to support the training of approximately 300 family physicians, family physician assistants, and family nurse practitioners. The Song-Brown program is not specifically designed for rural areas. Rather, it helps rural areas to the extent that it supports the training of family practitioners. Based on our visits and 1987 OSHPD data, family practitioners provide most of the physician care in rural counties.

**Facilities Development.** The office reviews health facilities construction projects to assure that they conform with federal, state, and local building requirements, including seismic safety requirements. Facilities may seek "program flexibility" on building requirements from the office.

The office also administers the California Health Facilities Construction Loan Insurance (Cal-Mortgage) Program, which insures facility loans. The program is funded by annual premiums paid by insured health facility projects. Under Ch 898/89 (SB 1293, Maddy), any excess Cal-Mortgage reserve funds are available to support the Rural Hospital Grant Program. Small and rural hospital projects meeting specified criteria would be eligible for grants of up to \$250,000 from this program, when, and if, it becomes operational.

### **Emergency Medical Services Authority**

The Emergency Medical Services (EMS) Authority reviews local emergency medical services programs and establishes statewide standards for emergency personnel. The authority also administers General Fund support for certain rural regional EMS agencies. The 1989 Budget Act includes \$1.2 million for five rural regional EMS agencies. Each agency may receive up to one-half of the total cost of operating a minimal EMS system for that region, as defined by the authority.

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### California Health Facilities Financing Authority

The California Health Facilities Financing Authority (CHFFA) issues revenue bonds to assist nonprofit agencies, counties, and hospital districts in financing the construction and renovation of health facilities. Because of its ability to issue tax-exempt bonds, the CHFFA provides lower-cost financing to qualified institutions than they would be able to secure on the open market.

In the past, some rural counties and providers have found it hard to take advantage of this source of funds due to their difficulty in proving they can repay the bonds. In some cases, the Cal-Mortgage Program has guaranteed repayment of covered facility loans in the event of a default. In addition, the CHFFA has initiated several special programs targeted at county facilities and small and rural hospitals (detailed in Figure 2). The Legislature has also passed legislation to assist rural facilities in obtaining CHFFA funding. Through these efforts, many rural facilities have received limited financial assistance.

### The Federal Government

In this section, we briefly highlight four federal programs and policies that affect rural health care: the Medicare Program, the National Health Service Corps, the Rural Health Clinic Act, and the Office of Rural Health Policy.

**The Medicare Program.** The Medicare Program is a major revenue source for rural providers. Medicare represents, on the average, 34 percent of patient revenues for the 42 rural hospitals for which data were available. In 1983, Medicare established a fixed payment schedule for hospitals based on a patient classification system known as Diagnostic Related Groups (DRGs). This system assumes that, on average, actual costs will be covered by DRG reimbursement levels. However, low-volume providers (including most rural hospitals) face a higher degree of financial risk than high-volume providers because they see a relatively small number of Medicare patients and they experience dramatic fluctuations in patient volume. As a result, their chances of offsetting high-cost cases with profits from lower-cost cases over a given time period are diminished.

In addition, rural hospitals receive a lower reimbursement rate for the same diagnosis than urban hospitals. Overall, average Medicare payments to rural hospitals are *40 percent less* than those to urban hospitals. Rural providers and others have argued that this reimbursement differential does not reflect actual costs of providing health care in rural areas. In response to this, Congress has taken steps to narrow the differential between urban and rural reimbursement rates.

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Different reimbursement formulas apply to hospitals designated as Sole Community Hospitals (SCHs) or Rural Referral Centers (RRCs). SCHs receive a partially cost-based reimbursement rate and additional payment protections. Currently, 40 hospitals in California are designated SCHs (not all of them are rural). Being designated an SCH is not always an advantage, however; a hospital with relatively low costs may get a higher level of reimbursement under the DRG system.

Hospitals qualifying as RRCs are reimbursed at the higher urban rate. However, in order to qualify, a facility must have at least 275 beds. This requirement precludes rural facilities in California from obtaining RRC status, because all have fewer than 275 beds.

Medicare is currently administering a two-year Rural Health Care Transition Grant Program to assist small rural hospitals in modifying their services to adjust for changes in service population, clinical practice patterns, and other factors. Each hospital may receive a grant of up to \$50,000 a year. Four California hospitals have received grants to date, three of which are in rural counties.

For physician services, Medicare generally determines a "reasonable charge" and reimburses physicians 80 percent of this amount. To the extent that physicians' charges for the same services vary both across and within communities, Medicare reimbursements vary.

**National Health Service Corps (NHSC).** The NHSC was designed to provide health personnel to designated health manpower shortage areas. The NHSC consists of two programs. The scholarship program pays tuition for medical, dental, and other allied health students in return for a minimum two years of service in a designated shortage area after completion of training. The second program provides up to \$20,000 a year to practitioners at the end of their training to pay off school loans. In exchange, they commit to serve a minimum of two years in a designated shortage area.

Although the NHSC has played a significant role in providing personnel to rural areas, this role has been declining dramatically in recent years because overall funding for the program has declined, the scholarship program is being phased out, and the loan repayment program is limited.

**Rural Health Clinic Act (Public Law 95-210).** The Rural Health Clinic Act of 1977 (Public Law 95-210) increased the Medicare and Medicaid reimbursement rates for clinics that provide services in rural, medically underserved areas and

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employ a nurse practitioner or physician assistant. Currently, there are 47 designated "95-210 clinics" in 39 medically underserved rural areas in California. One obstacle to expanding the number of designated clinics is the limited information about the program at both the local and state levels. Apparently, the paperwork required for qualification also discourages many clinics from pursuing this option.

**Office of Rural Health Policy (ORHP).** The ORHP was established in 1988 to (1) advise the Department of Health and Human Services (DHHS) on the effects that Medicare and Medicaid programs have on access to health care for rural populations; (2) coordinate rural health research within DHHS and administer a grant program; (3) provide staff support to the National Advisory Committee on Rural Health, which was established in September 1988 to advise the Secretary of DHHS on rural health issues; and (4) develop a national clearinghouse for the collection and dissemination of rural health information.

The office maintains contact with state agencies on an "ad hoc" basis.

### **Counties**

Under Section 17000 of the Welfare and Institutions Code, counties are considered the "providers of last resort" for health services to indigent residents. The funds provided to counties through the MISIP, CMSP, and other state programs assist counties in meeting this obligation. Most state program funds allocated to counties may be distributed at county discretion. Urban counties generally play a major role in providing health services to indigent persons. Although the level of involvement varies among rural counties, most of them play a more limited role in health care service delivery.

### **WHAT ARE THE OUTSTANDING ISSUES IN CURRENT STATE PROGRAMS?**

As described above, there are many governmental programs designed to improve access to health care services in rural areas. In the following discussion, we identify problems that limit the effectiveness of these programs. We frame our discussion within the four main roles of the state: leadership, support, regulation, and reimbursement.

### **Leadership Role**

Our review indicates that there are several problems with the way the state currently implements existing programs.

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***State Programs Are Not Coordinated.*** Current state programs intended to improve access to health services in rural areas do so in a piecemeal and fragmented fashion. As described above, there are several divisions within several state departments, all providing services to rural areas. However, the various programs are not coordinated by a lead agency, thereby resulting in duplication of certain services and gaps in others. For example, there are several programs that are aimed at rural hospitals in distress but no existing program providing ongoing funding for hospitals. Additionally, multiple definitions of the term “rural” contribute to inconsistencies in eligibility requirements between programs. As a consequence, providers have difficulties determining what programs exist and whether they are eligible for assistance.

***The State Provides Limited Assistance.*** Providers cannot take full advantage of existing programs because, in addition to the lack of coordination and varying eligibility requirements, information regarding these programs is not readily available. From our field visits, we found that many rural health care providers were not aware of state programs designed to assist them. Currently, for example, although the RCH Division has implemented several programs for assisting rural clinics and hospitals, it provides technical assistance primarily *in response to* specific requests from facilities. Thus, facilities that are not aware that technical assistance is available from RCH may go without it. Moreover, the state has not assisted providers by making available information on federal programs. For example, no agency has taken an active role in assisting clinics to qualify for designation under federal Public Law 95-210.

***The State Has Not Provided Certain Key Central Services.*** Certain activities, such as designing data collection systems, evaluating services, and providing technical assistance, are more efficient and effective if carried out centrally. However, the state has not done this. For example, statewide evaluation of the adequacy of emergency medical services is very difficult because the state has not yet developed a uniform, standardized data collection system for the availability and utilization of emergency medical services. As a result, although the local EMS agencies maintain some data, these data cannot be used to draw conclusions about the status of the state’s EMS system.

***The State Could Foster More Innovation.*** Various departments are currently implementing innovative programs and policies to improve health care services in rural areas, such as the DHS “safety net” policy, the OSHPD’s alternative rural hospital demonstration project, and AB 75 rural health projects. Of these programs, the OSHPD’s alternative rural hospital demonstra-

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tion project appears to be the most promising because of its potential to permanently address some of the regulatory problems of small and rural hospitals. The future of AB 75 projects, on the other hand, will be uncertain unless funding is extended at the end of the budget year. Despite these creative steps, there are many other ways the state could help foster innovation. For instance, the state could encourage the development of third-party billing, rotating specialists, and risk pools.

### Support Role

***Band-Aid Approach to Assisting Hospitals.*** State efforts to assist hospitals through routine or emergency funding have been haphazard. The state has taken a "band-aid" approach by providing funding to hospitals on a reactive, emergency basis, as opposed to "stepping back" to assess such issues as whether the facility is critical to health care access and whether financial assistance is the solution to the facility's problem. For example, the Hospital and Medical Standards Program has not identified strategically located, high-risk rural hospitals as required by Ch 1209/88.

***Problems in Program Implementation.*** At times, program implementation limits the impact state assistance programs could have on rural health services. For example, the clinics programs have continued to fund the same providers year after year without reexamining the need for the subsidy. There are also state programs that, for various reasons, have not been implemented. For example, the RCH Division never implemented the California Health Services Corps, authorized in 1976. This was because of limited funding and problems with the program design (that is, implementing the program through state civil service).

***Some Program Requirements Preclude Participation by Rural Providers.*** Rural facilities have difficulties in obtaining funding under some programs due, in part, to specific program requirements. For example, some loan programs sponsored by the CHFFA have minimum loan amount requirements that rural facilities cannot meet. Although the CHFFA has taken steps to allow small and rural hospitals to take advantage of certain loan programs, these programs are generally limited in scope.

### Regulatory Role

***Licensing Regulations Do Not Recognize Unique Characteristics of Rural Providers.*** Current DHS licensing regulations make no distinction between rural and urban facilities.

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Given that rural facilities are a small percentage of total hospitals in California (the 51 rural hospitals in the 25 counties we examined account for only 10 percent of California's general acute care hospitals), regulations do not distinguish between urban and rural facilities. In some cases, these regulations may not address the circumstances in which rural providers find themselves. For example, by regulation, a general acute care hospital must include surgery as a basic service. However, some rural hospitals cannot economically equip and staff the number of operating rooms required by regulations because of their low occupancy rate. In addition, the hospitals may have trouble recruiting qualified surgical staff. One of the hospitals we visited has operating rooms that have not been used in years because it does not have the required staff to perform surgery. The OSHPD is currently reviewing regulations that apply to small and rural hospitals in view of this conflict.

***Inconsistent Interpretation of Regulations.*** A number of rural hospital administrators we interviewed cited inconsistent interpretation and enforcement of regulations as a major problem. They also expressed frustration with the lack of assistance provided by inspectors in addressing regulatory problems. We have no basis for determining how widespread these concerns are. Licensing and certification staff acknowledged, however, that there have been some problems. The department indicated it is taking steps to assure consistent interpretation and enforcement of regulations.

***Information Flow to Rural Providers Insufficient.*** Although there are a variety of programs designed to address regulatory problems of rural providers, we found that administrators are not always well informed of state regulatory changes, new legislation, and special policies like "program flexibility." Hospitals receive most of their information from organizations and associations, which require membership fees of thousands of dollars. There is minimal information that comes directly from the state.

### **Reimbursement Role**

***Reimbursement Procedures Are Complex and Technical Assistance Is Limited.*** Reimbursement procedures for state programs--primarily Medi-Cal--continue to be complex and burdensome for some rural providers. Billing errors result in payment delays, which contribute to the cash-flow problems of many rural providers. We found that many rural health care providers felt they had no recourse at the state level to address billing problems. They could not determine whom to call to resolve questions or billing problems in a timely fashion.

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***Medi-Cal Reimbursements May Not Cover Current Costs.***

Although the Medi-Cal reimbursement rate for most rural providers is cost-based, payments to facilities may not cover the current costs for Medi-Cal patients. This is because of two reasons. First, the payment formula includes adjustments for previous years' disallowed claims. Second, facilities' actual costs may not be covered because the maximum inpatient reimbursement level (MIRL) caps Medi-Cal reimbursements. The MIRL caps the level of increase in a facility's reimbursement rate based on a complex formula involving case mix and other factors. While these adjustments may be justified, a rural hospital may not have sufficient reserves to cover shortfalls in payments.

**HOW CAN THE LEGISLATURE IMPROVE  
DELIVERY OF RURAL HEALTH CARE SERVICES?**

Our review indicates that rural areas share common characteristics. Generally, rural areas tend to be geographically isolated, sparsely populated, and have relatively weak economies. These areas also share common problems with respect to the delivery of health care services. Specifically, they have a limited number of health care providers, hospitals are financially distressed, emergency medical services and specialty care are limited, and it is difficult to attract health professionals.

There is a strong state interest, as shown by the plethora of existing programs, in maintaining and improving access to health care in rural areas. In order to address the problem areas described above, we believe there are several steps the Legislature can take to improve health service delivery in rural areas.

**Major Legislative Decisions**

As a first step to improving access to health care in rural areas, the Legislature should explicitly address the following issues:

- ***Rural Areas and Rural Health Facilities.*** The existing variation in definitions of rural counties and areas and rural health facilities leads to confusing and overlapping categories. The state needs to develop a statewide definition of rural areas and rural health facilities.
  - ***Adequate Access to Health Services.*** The state needs to define the *minimum level* of health services it is willing to ensure in rural areas. Adequate access needs to be defined in terms that take into account the isolation, weather, and road conditions that characterize rural areas.
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- ***Distinctions Among Rural Providers.*** The state also needs to determine if all rural providers should be treated equally. It may be that certain rural providers (for example, geographically isolated ones) should be given priority in state assistance programs.
- ***Funding Commitment.*** Finally, the state must decide the level of funding dedicated to rural health services.

### Strengthen the State's Leadership Role

***We recommend that the Legislature designate a lead agency to coordinate the state's rural health programs.***

The state needs to exercise a greater coordinating role to ensure that existing and future programs improve health care in rural areas without duplicating services. Accordingly, we recommend that the Legislature designate a lead agency to coordinate these programs. The lead agency's mission should be to implement the major legislative decisions discussed above with respect to rural health care.

In addition, the lead agency should be responsible for overseeing technical assistance, coordinating state programs, providing information on rural health assistance programs, and ranking providers for purposes of targeting state assistance programs. Specifically, the functions of the lead agency should include, but not be limited to, the following:

- ***Provide Information on State and Federal Programs Available to Assist Rural Providers.*** For example, the lead agency could assist interested rural facilities in qualifying for programs that allow them to receive higher reimbursement rates or regulatory relief.
  - ***Establish Standards for EMS Adequacy.*** To assure availability and access to EMS services, the lead agency could direct the EMS Authority to (1) establish standards of adequacy for EMS services, (2) identify "unmet" EMS needs, and (3) evaluate alternatives to address these needs.
  - ***Lead in the Development of More Efficient Service Delivery Mechanisms.*** In light of the shortage of health professionals in rural areas and the limited resources available to rural facilities, it is critical that rural providers deliver services as efficiently as possible. The lead agency could identify better ways to make use of existing resources through such means as: the development of cooperative ventures to purchase equipment, the rota-
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tion of practitioners among counties, and the establishment of a referral system among providers. In addition to the self-insurance program for clinics currently supported by the state, the lead agency could promote and support self-insurance programs for other types of providers.

- ***Develop More Alternative Service Delivery Models.*** In addition to expanding the implementation of existing pilots, the lead agency could develop pilot models for other components of health care, like rotating specialists or new licensure categories.

### **Improve Support to Rural Health Care Providers**

***We recommend that the lead agency develop a systematic approach to assisting rural providers.***

In order to address the diverse needs of rural providers, we recommend that the lead agency implement existing legislation by identifying strategically located, high-risk rural hospitals. In addition, we recommend the agency develop a similar system for ranking other rural providers. This ranking would enable the state to systematically target its assistance programs.

### **Review of Regulatory and Reimbursement Systems**

***We recommend that state agencies evaluate adjustments to the regulatory and reimbursement systems.***

As discussed above, some regulatory and reimbursement procedures and requirements do not take into account the unique characteristics and needs of rural health care providers. A review and adjustment of existing regulations could ease the burden for rural providers of complying with inapplicable regulations. Adjustments to existing reimbursement rates and procedures could help relieve hospitals in financial distress. The OSHPD's review of regulations that apply to rural providers is illustrative of state efforts to make adjustments in its regulatory system. Other state efforts could include:

- ***A Review of Medi-Cal Regulations That Apply to Rural Providers.*** Similar to what is currently being done by the OSHPD, Medi-Cal regulations could be reviewed to take into account existing problems and needs of rural providers. For example, rural hospitals with distinct-part skilled nursing facilities (SNFs) could be exempt from the Medi-Cal patient transfer requirements to freestanding SNFs. Distinct-part SNFs help
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rural hospitals maintain a more stable revenue stream and occupancy rate. This option would result in net costs to the Medi-Cal Program since Medi-Cal reimbursement rates are higher for distinct-part SNFs than freestanding SNFs.

- ***Encouraging Providers to Use Centralized Billing Services.*** To reduce the burden of cumbersome billing procedures, the state could encourage providers to use privately operated billing services or even assist rural providers in establishing contracts with a centralized billing service. This option would be an efficient billing strategy for rural providers at minimal cost to the state. Another option is for the state to expand technical assistance on billing matters. This would require additional funds.
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