Chapter 8

Collaborative Opportunities Between Rural Health Facilities and Government

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Chapter 8

Collaborative Opportunities Between Rural Health Facilities and Government

INTRODUCTION

In recent years, many rural health care facilities have found that their prospects for survival are enhanced by working with Federal, State, and local governments interested in developing new approaches to improve facilities and services. This chapter will first discuss efforts by some States to conceptualize an appropriate or minimally acceptable array of services for rural communities. Second, the chapter examines work by some States, and more recently the Federal Government, to develop alternative delivery models for rural facilities. These efforts focus mostly on redefining what is meant by a "hospital" and rearranging the existing regulatory framework to enable rural hospitals--especially those that are financially troubled or are the only local facility-to have a structure more appropriate to local needs and capabilities. Next, it offers some unique examples by States to support the integration of health services by rural facilities. Finally, the chapter examines how some local governments in rural areas are finding ways to provide sorely needed tax support to area facilities.

DETERMINING A STANDARD OF SERVICES FOR RURAL COMMUNITIES

Ideally, the development of services and facilities that reflect local needs and conditions begins by determining the essential service requirements of a community. This task is not an easy one. Each rural community has its unique set of service delivery problems, resources, and priorities. Some small hospitals, struggling with declining utilization and poor operating margins, have considered severely limiting their scope of services. But for sole community providers serving wide and sparsely settled geographic areas with few health care alternatives, determining what services can be eliminated is difficult. Community health centers (CHCs) have traditionally been a major source of comprehensive primary care for the poor, but many CHCs face increasing demands for uncompensated care (see ch. 5) that may require them, too, to rethink the scope of services they can afford to provide.

At least two States have developed conceptual frameworks of basic services and delivery models that should exist in rural communities. These frameworks, described below, address such fundamental questions as:

- *Current* scope—What are the scope, volume, purpose, and effectiveness of services now being delivered? Who is delivering them?
- *Appropriateness—Are the* services appropriate for the current and expected level of demand and community capability to support them? Are they meeting basic health needs? Have the community's perceptions and feelings been adequately understood and addressed?
- *Facility/community cooperation—Are local* facilities doing enough to deliver appropriate services, assure their accessibility and quality, and control costs? Would the community be willing to accept the loss of certain services it could no longer support?
- *Maintaining* access-Can local facilities continue to meet their traditional obligations to the poor and underserved? If so, how? If not, who will?
- *Changing mission--Should the* hospital or other local health care facility shift some or all of its resources to other services or business activities?
- *Facility organization-Should* **area** facilities continue to operate independently or should they engage in cooperative arrangements with other providers? Is the community willing to relinquish any or all control over the delivery of local services?

Washington: Five Health Service Groups

The Washington Rural Health Care Commission, as part of a 1989 report to the State legislature that examined ways of maintainingg and improving access to care for rural residents, identified five levels of basic health services to reflect the range of service resources that should be available in most rural areas. Basic services are divided into five priority groupings (''bands' that represent levels of patient immediacy or use and complexity of patient conditions and care (table 8-l). The five bands are:

Table 8-l—Basic Health Services for Rural Areas (Washington State)

Band l--prevent death, disability, serious illness
- 24-hour emergency medical services (first responder/emergency medical technician)
  - ■ Stabilization
  - ■ Communications
  - ■ Air to ground ambulance transport
- Essential public health services
  - ■ Environmental services monitoring and response
  - ■ Personal health services monitoring and response
- Primary care (e.g., provided by a physician or midlevel practitioner) including:
  - ■ Routine health maintenance
  - ■ Prevention
  - ■ Care for acute conditions
  - ■ Prenatal care
- Mental health
  - ■ Crisis intervention

Band2--necessary support services for band 1
- **Diagnostic services**
  - ■ **X-ray: extremities, chest; fluoroscope; ultrasound**
  - ● Laboratory: chemistries, urines, blood, bacteriology
  - ■ Other services at same level of complexity and demand

Bad 3--short-term inpatient and home health
- Home health services
  - ■ Visiting nurse
  - ■ Medical services
- Selected acute short-term hospital services
  - ■ Acute conditions (e.g., pneumonia, gastroenteritis, and certain accidents)
  - ■ Childbirth services (level 1)
- Selected acute alternative facility services[a]

Band 4--community-based care for chronic conditions
- Mental health services
  - m Evaluation
  - ■ Mental health consultation
  - ■ Psychological therapy
- Long-term care services
  - ■ Community-based care (e.g., chore services, home meals, adult day health)
  - ■ Supervised living, boarding housing, respite care
  - ■ **Skilled and intermediate nursing facilities**
- **Substance abuse and chemical dependency**
  - ■ **Counseling**
  - ■ Treatment referral

Band 5--other services
- Dental care
  - ■ Routine examination, mechanical cleaning, fluoridation
- Vision and hearing care
- Hospice care
- Other treatment modalities

NOTE: The first band of services contains the most emergent services as well as those services of greatest use.

[a]Would be developed through changes in State licensure standards.

SOURCE: Washington Rural Health Care Commission, A Report to the Legislature on Rural Health Care in the State of Washington (Olympia, WA: January 1989).

1. those services most critical to survival or most often utilized (e.g., emergency and primary care services);
2. basic diagnostic support services;
3. unessential core of basic acute care and home health services;
4. community-based care for chronic conditions; and
5. services that help residents in larger populated rural areas stay within the community for care.

This model assumes that, for certain levels of care, providers must use referral arrangements and cooperative agreements to ensure continued access to needed services. Only larger rural communities could afford to provide services in all five bands.

When assigning services to the bands, the Commission applied certain criteria to determine the degree of urgency and appropriateness for the service. These included:

- the primacy of preventing death, disability, or serious injury;
- the need for immediate diagnosis or treatment to prevent illness or injury from becoming more serious and more costly or difficult to treat;
- the need for medical monitoring to prevent disability or injury;
- the need to prevent conditions from occurring that would threaten the health of the general population;
- the length of time a health condition can exist before treatment is needed; and
- the physical, psychological, emotional, financial, and time advantages to community and providers of having certain services locally available (714).

Utah: Basic Needs

The Utah Department of Health has outlined a list of minimum health services that should be available to small communities in sparsely populated or

Table 8-2—Recommended Health Services by Size of Community (Utah)

Population/ service area	Emergency medical services	Primary care	Specialty care	Hospitalization
Fewer than 500 persons	**First responder EMT**	**Intermittent MLP or MD by appointment Satellite/part-time clinic: EMT supervision via tele-communication and written protocol**	**Referral**	**Referral**
500-900 persons	EMT first responder network in outlying areas	Full-time MLP or part-time MD Arrangement for emergency coverage and EMT supervision	Referral or periodic arrangement in the community	Referral
900-1,500 persons	EMT first responder network	Full-time MD or MLP, or combination full and part-time group practice Emergency coverage and EMT supervision	Referral or periodic arrangement in the community	Referral and infirmary model
1,500-4,000+ persons	EMT first responder network	Small group practice: combination of MD and/or MLP; medical specialists (MD/MLP); IM,PED or OB, CNM as determined by community need; Emergency coverage and EMT supervision	On-site full-time regularly scheduled clinic within primary care practice Referral	Small community hospital or infirmary referral

ABBREVIATIONS: CNM = certified nurse midwife; EMT= emergency medical technician; IM = internist; MD = medical doctor; MLP = midlevel practitioner; OB = obstetrician; PED = pediatrician.

SOURCE: G. Elison, "Frontier Areas: Problems for Delivery of Health Care Services," Rural Health Care 1, September/October 1986 (newsletter of the National Rural Health Association, Kansas City, MO).

frontier areas (table 8-2). Its recommendations specify that emergency medical personnel would be the first responders in all small communities, with regular primary care by a midlevel practitioner or physician made available in communities of at least 500 persons. Specialty care in most small communities would be available only through out-of-area referral or through arrangements under which outside providers periodically conduct local clinics. In some cases, hospital care could be provided in communities of 1,500 to 4,000 or more persons (183).

CREATION OF ALTERNATIVELY LICENSED FACILITIES IN RURAL AREAS

Despite their conceptual importance, State attempts to define minimum service goals for rural health care have not directly affected rural areas. A few States have recently begun to intervene more directly in the structure of basic rural health services by experimenting with the development of new models of health care facilities that require changes in State licensure rules. Most of these alternative models focus on strengthening underutilized and financially unstable small, isolated rural hospitals. Implementation of these models (typically by "downsizing" existing hospital capacity and services) is intended to ensure access to basic acute and emergency care without burdening the facility with the requirements of a full-service hospital.

Efforts to develop alternative delivery models for rural hospitals have a relatively brief history. In the early 1970s, the U.S. Department of Health, Education and Welfare (DHEW)--now the Department of Health and Human Services (DHHS)--permitted about 150 hospitals to waive the Medicare requirement that a registered nurse supervisor must be at the hospita1 24 hours a day. Most of these hospitals were in remote areas and served as sole local health care providers. In 1973, DHEW studied the feasibility of establishing a new category of "limited service"

the three agreed to participate and reduce their services to a level comparable to the model's core and expanded service restrictions. Hypothetical financial analyses indicated that both hospitals would be fiscally solvent under the alternative model. Because the hospitals would not immediately be expected to make significant staffing changes (in order to limit local economic upheaval) or to make physical changes in the facility, the Department believed it would not be necessary for them to obtain waivers of Medicare's conditions of participation (427).

However, a Federal waiver would still be required if the 96-hour length-of-stay limit was applied. To resolve this situation, the Department decided to use a facility's admissions criteria (i.e., the type of patients seen as dictated by the facility's licensed mix of services) as a de *facto* measure of service intensity (285). Initial analyses suggested that use of the length-of-stay limitation may not have been necessary inmost cases. For those targeted hospitals that already had "downsized" operations and were concentrating on providing essential services, about 85 percent of all patients were discharged within 96 hours (427).

In late 1989, the health department recommended that the State create a pilot project to test the alternative rural hospital model, providing regulatory relief and technical assistance to participating facilities (427). A final report, stating whether modified regulations and the alternative models should become permanent, is due to the State legislature in 1993 (117).

Colorado

In 1986, the State of Colorado developed a new licensure category for rural providers called Community Clinic/Emergency Centers (CCECs). CCECs are defined by regulation as health care institutions "planned, organized, operated and maintained to provide basic community facilities and services for the diagnosis and treatment of individuals requiring outpatient service and inpatient care, including inpatient accommodations for emergency care" (Code of Colorado regulations 6 CCR 1011.1). CCECs provide only emergency and outpatient services, but they must have a written affiliation with a nearby general hospital to coordinate patient referrals and other service needs. To ensure availability of inpatient accommodations for emergency care, the facilities must have no more than six beds to stabilize and hold patients for up to 72 hours. A physician is required to be available by telephone and to reside within 15 minutes travel time, and 24-hour skilled nursing coverage must be available on-site. Minimal laboratory and dietary services are also required. CCEC regulations waive many hospital facility standards, requiring facilities to operate much like small clinics and making them an attractive form of service provision for providers other than hospitals (391,524).

Much of the effort to promote provider interest and participation in the CCEC model appears to have been futile because of the lack of any involvement or support by HCFA. Thus far, the agency has shown no interest in certifying CCECs for Medicare and Medicaid participation and reimbursement, limiting the usefulness of this designation. As of 1989, only five CCECs had been certified, four of which were CHCs or nursing homes (which must rely on private insurance for reimbursement). No hospitals have become CCECs (524). Little information is available on the performance of CCECs, or on whether the State plans to make any changes to encourage greater involvement from rural facilities and the Federal Government.

Initiatives in Other States

Florida

Based on recommendations of a 1987 study of the problems facing rural hospitals in the State, the Florida Legislature in 1988 designated 27 small rural hospitals[4] to receive special consideration under State regulations (e.g., receipt of Medicaid reimbursement for swing-bed care, exemption from budget review by the State's Hospital Cost Containment Board) (478). In 1989, State lawmakers, intending to further help these hospitals, created an alternative licensure category for rural facilities called Emergency Care Hospitals (ECHs) (195). The ECH, modeled after Montana's MAFs, would provide emergency care and routine inpatient services for up to 96 hours under the care of a physician or midlevel practitioner. In addition, basic diagnostic services, primary and obstetric care, and various long-term care services (e.g., skilled nursing and

[4]Each of these hospitals (fewer than one-half of the State's rural hospital total) has 85 or fewer beds and an emergency room, and all are either the sole inpatient facilities in their counties or serve areas with no more than 100 persons per square mile.

. institutional liability issues; and
- possible Medicare and Medicaid reimbursement schemes and their impact on facility profitability (377,524).

In 1989, MHREF, as part of its request for 4-year funding of a full MAF demonstration, asked HCFA to waive: 1) Medicare's conditions of participation and requirements for prospective reimbursement, and 2) conflict of interest rules that would prohibit Peer Review Organizations (PROS) from helping MAFs to develop quality assurance programs.[2] In September 1989, HCFA approved continuation funding of the MAF project for 1 year (377). MHREF expected to receive approval of its waiver requests in mid-1990, allowing all MAFs to begin operating by fall of the year (377).

California

In 1988, the California Legislature passed a law (117) granting broad authority to the State Department of Health Services to study ways to facilitate the development of new delivery models for rural hospitals. The Department was given three charges. First, it was to undertake a comprehensive assessment of regulatory requirements applicable to small and rural hospitals (up to 76 acute-care beds and located in areas with 15,000 or fewer residents[3]). Second, it was to institute emergency regulations that waive or modify existing regulations found to be unreasonably burdensome or inapplicable to rural hospitals, including licensure requirements. And third, it was to conduct pilot projects in small and rural hospitals using alternative rural hospital standards and models.

In accordance with the law, the health department is creating a new model design that provides regulatory relief for rural hospitals and is based on local needs for an essential, core group of services. These core services include:

. standby emergency medical services, with 24-hour coverage by a physician or midlevel practitioner;
. basic patient holding and stabilization capacity offering short-term inpatient medical and nursing care for up to 96 hours, and patient transfer to a hospital if necessary;
- basic ambulatory care, limited to nonemergent diagnosis and treatment, minor surgeries requiring local anesthesia, and obstetric care for prenatal and postpartum conditions (these services may be provided through the emergency service component if they will replicate similar services already available in the area);
- basic lab and radiology services, including simple urinalyses, blood counts, and basic x-rays; and
- appropriate support systems such as dietary and pharmaceutical services, and protocols for quality assurance and utilization review.

Model hospitals choosing to provide only the core services would face the most lenient facility, staffing, and peer review requirements, and they would be expected to show the greatest savings in fixed costs. As an option, model facilities could supplement the required core services with additional, more specialized services to meet the specific needs of their communities. These might include expanded inpatient services (for acute care longer than 96 hours), expanded obstetric and radiology services, and selected inpatient and outpatient surgical services (427). The level of regulatory oversight would increase with the service scope of the facility.

Guidelines for eligibility currently being considered allow only certain rural acute-care hospitals to participate as new model facilities. Eligible hospitals would be small (e.g., have an average daily census of 10 or fewer acute-care patients) and typically would be the sole acute-care providers in their communities. They would maintain their licenses as hospitals and be encouraged to provide subacute skilled nursing care (with swing beds or a distinct-part skilled nursing facility). Hospitals also would have to have the support of their board and medical staff to participate as a demonstration site, and they would be required to develop a quality assurance plan (427).

In 1989, three hospitals were initially proposed by the California Department of Health for designation and demonstration as alternative model facilities. (An estimated 25 sites have been targeted.) Two of

[2]MHREF has requested that MAFs be paid initially on the basis of reasonable costs (400). Conflict of interest rules do not allow PROS to contract separately with hospitals to provide support (e.g., assistance with preadmission review) if they are already required to conduct peer review and monitor the facility's quality of care. MHREF has requested that PROS be allowed to enter into such contracts.

[3]Other conditions of eligibility also exist (117).

of time *(398,478).* Length-of-stay restrictions may be the most problematic in very remote areas where alternative sources of care are far away.

Recent National Developments

In 1989, Congress required DHHS (Public Law 101-239) to establish a program to provide grants for up to seven States to designate and develop two new types of rural hospitals: Essential Access Community Hospitals (EACHs) and Rural Primary Care Hospitals (RPCHs). In addition, up to 15 RPCHs may be designated in States without EACH programs. EACHs and RPCHs are to forma network of rural health facilities designed to ensure the regional accessibility and continuity of emergency, primary, acute, and long-term care services. Eligible hospitals must be located in States that have or are developing a plan calling for the creation of rural health care networks.

To be designated as an EACH facility, a rural hospital must be more than 35 miles from another designated EACH or rural referral center, and it must have at least 75 beds or be located more than 35 miles from any other hospital.[6] EACHs will provide emergency and medical backup services to designated RPCHs in the network; they must agree to accept patients transferred from rural physicians and RPCHs, receive and transmit data to RPCHs, and provide staff privileges to RPCH physicians. EACHs will be considered ''sole community hospitals" for the purpose of Medicare reimbursement.

RPCHs are smaller facilities that will be required to provide 24-hour emergency care; to cease offering inpatient care except through using a maximum of 6 holding beds to stabilize patients for up to 72 hours; and to have patient transfer arrangements with the nearest hospital(s). Rural hospitals becoming RPCHs will be allowed to provide skilled nursing services, and they may use midlevel practitioners with physician oversight. These facilities will not have to meet existing hospital requirements for 24-hour operation (except emergency care), and the services of dieticians, pharmacists, and certain laboratory and radiology technicians need only be available on a part-time, off-site basis. Inpatient acute-care services will initially be reimbursed by Medicare at cost. For outpatient services, RPCHs will at first have the option of receiving either a cost-based facility fee (which does not include physician charges) or a comprehensive cost-based rate (combining facility and professional services). A prospective payment system must be developed by 1993 for both inpatient and outpatient RPCH services.

States will be responsible for designating and supporting the development of EACH networks. When designating RPCHs, States that have EACHs must give preference to hospitals participating in rural health networks. Grants for up to 3 years from the Rural Health Care Transition Grants Program (see ch. 3) and the Medicare trust fund will be available to help States and hospitals to plan and implement the EACH/RPCH designations and rural health networks.

The EACH program poses a dilemma for States that are developing their own alternative models for rural facilities. On the one hand, the State-developed models can be adapted to the needs of those States. For example, States may wish to:

- establish their own minimum mileage limits between designated facilities;
- establish their own limits on the number of acute-care beds and the allowed levels of service intensity in model facilities; and
- consider criteria for essential access facilities other than distance and facility size (e.g., community income or poverty levels).

On the other hand, States may also find the Federal program attractive because it enables RPCHs to receive Medicare payment—a valuable incentive for hospitals to shift their emphasis from acute care to emergency and primary care (87).

STATE-PROMOTED INTEGRATION OF SERVICES

Rather than (or in addition to) adopting a more sweeping approach, some States have focused their support (e.g., technical assistance, regulatory relief) on a few targeted facilities to improve the integration and accessibility of local health services in specific rural communities. Below are three examples of such initiatives.

North Carolina—The Roanoke Amaranth Community Health Group, a private, nonprofit primary care practice in rural North Carolina, was estab-

[6]These requirements maybe waived by the Secretary of DHHS.

home health) are authorized to be provided. Hospitals applying for ECH status will receive expedited review under Florida's CON process and may retain their hospital license. Regardless of whether they become ECHs, the 27 hospitals are also exempted from CON review of home health, hospice, and swing-bed services under the 1989 law. Plans to pursue Medicare waivers and implement the ECH legislation are being delayed until the State decides whether to apply for participation in the new Federal alternative rural hospital program discussed below.

Wyoming

In 1989, the Wyoming Legislature established new licensure and operation regulations for health care facilities (741). The law introduces the new licensure category of medical assistance facilities, modeled after Montana's MAFs, which would provide limited acute care to patients for a period of no more than 60 hours prior to their transfer to a hospital (if transfer is necessary). The medical assistance facilities must be located more than 30 miles from the nearest Wyoming hospital. As in Florida, regulations that would govern the specific operation of these facilities have not been established; the period for making these regulatory changes ends in 1993.

Comparison of State Efforts

Efforts by the above States to develop alternatively licensed facilities in rural areas have important similarities and differences.

To date, only Montana has obtained direct interest and support by HCFA that might lead to waivers of Federal conditions of participation, allowing the model facilities to receive Medicare and Medicaid reimbursement. However, as noted by differences between the Montana and California projects, there may be ways to minimize HCFA's role in such matters. The need for waivers will depend in part on the specific needs and objectives for developing new models and the extent of regulatory changes involved.

The amount of effort that has been invested by States in developing alternative facility models, as well as the specificity and flexibility of the laws defining and regulating them, varies considerably. Except for California, most States have chosen to establish alternative licensure laws before developing ideas for new delivery models.

Eligibility criteria vary for rural providers seeking to participate as alternative facilities (e.g., they may be restricted to hospitals or to facilities meeting only certain size and location criteria). For example, Montana's MAFs must be the only local inpatient care providers in remote areas. Four of the facilities operating as CCECs in Colorado are CHCs or nursing homes, and all are the sole providers in their communities.

States have different ideas on whether a hospital becoming an alternative facility should be allowed to keep its existing license to protect against the risk that its participation as a new facility is unsuccessful. Regulations in Montana require a hospital becoming a MAF to give up its acute-care license. In California, alternative model hospitals would retain their acute-care license. Hospitals in Florida that become ECHs but later decide to seek full acute-care relicensure would receive expedited review and reclassification.

Differences exist among States on the scope of services to be provided in alternatively licensed facilities, and the role rural providers and communities have in making these decisions. Most of the new models allow for use of both physicians and midlevel practitioners, and most proposals would require facilities to ensure appropriate transfer and referral of patients to other providers. Only minimal attention appears to have been given by most States (except Montana) to the effects of new models on quality of care and patient satisfaction.

Most models that provide for limited inpatient services in the form of holding and observation care units use a maximum time standard of 96 hours (Colorado and Wyoming use shorter periods). Existing data suggest that the average acute-care length of stay in a small rural hospital may already closely match these proposed limits.[5] The maximum length of stay is intended to act as a proxy for service intensity and severity of illness. However, some States (e.g., California) have suggested other measures (e.g., lists of approved admitting diagnoses or services, composition and skill mix of medical personnel) that might be more appropriate indicators of low-intensity care, while giving model facilities more flexibility to hold patients for different periods

[5]In 1985, the average length of stay for a rural hospital with fewer than 25 beds was 4.9 days, or about 118 hours (*236*).

Photo credit: Peter Beeson

Rural communities do not always agree on the best **solution for their ailing hospitals. In Giddings, Texas, a recent referendum was passed, despite considerable local opposition, that created a tax district to fund the county hospital.**

Washington—About 75 percent of Washington's rural hospitals are part of public hospital districts (714). Some of the State's rural hospitals have sought local tax support both through the establishment of hospital districts and the creation of special tax levies.

Whitman Community Hospital, a county-funded facility, had been losing money for several years, and in 1986 it requested the county to create a special tax district to support the facility. The county's commissioners turned down the request, because property tax rates were already at their limit mandated by the State, and a new hospital district would reduce amounts for existing special districts (e.g., fire protection, libraries). A 1987 State law, however, allowed local voters to increase their property tax rates, fueling again the hospital's interest to propose the new tax district. In 1988, to ease concerns from existing districts, the hospital decided to propose a new district under which it would agree only to seek special, temporary tax levies. These levies would not be affected by State limits on current property taxes or require existing districts to share tax monies. In September 1989, following a major campaign, voters approved the formation of the hospital district and a special l-year tax levy. Levies for the hospital, to be collected about 8 months following the election, were estimated to be $100,000 (379).

Oregon—In 1980, the rural community of Condon, Oregon, having been without a physician for 2 years, sought assistance from the State Office of Rural Health to establish a health service district for south Gilliam County. The State granted Condon $20,000 to develop primary care services and assist the county in the formation of the health service district. After a brief campaign, voters approved the creation of the district and a property tax rate expected to yield 50 percent of the budget of a new primary care clinic in the first year. Future tax subsidies were lowered as the clinic began showing a profit (441).

SUMMARY OF FINDINGS

Federal, State, and local governments have undertaken some extraordinary efforts to enable rural facilities and communities to preserve or enhance basic services. At least two States have developed conceptual frameworks for determining an appropriate or minimal set of services and providers for rural communities, although thus far these efforts have found little practical application. Several rural communities have enacted new mechanisms for improving local tax support for area health facilities and services. Some States are offering targeted financial support or regulatory relief to a handful of rural facilities for improving the local integration of services.

Increasing numbers of States, however, are taking a broader approach: the development of alternative licensure and delivery models for rural facilities-No collaborative effort between government and rural facility has been more dramatic than activities by a few States to change regulations and design new models intended to alter and improve the delivery of health services in rural areas. These efforts reflect differences (and similarities) among States in the need for structured change in rural facilities.

Montana and California have the most developed models thus far. Montana's new MAF licensure category alters regulations to allow small, underused acute-care hospitals to become providers of low-intensity, short-stay acute care. Federal support has helped develop ideas for demonstrating MAFs.

lished in 1976 with technical assistance from the State and funding from the U.S. Public Health Service. The State recently supported research that found that the area's elderly were using post-acute care resources in distant places near where they had been hospitalized, forcing many to relocate in order to obtain needed rehabilitation and support services. To address the need for accessible and comprehensive long-term care, the Roanoke Group decided to sponsor the development of a long-term care campus adjacent to the practice.

Development of the long-term care complex began with construction of a 60-bed nursing home and an 18-bed board-and-care facility, which opened in early 1990. Other facilities that have begun operations are a senior center (supported by a State grant) and 20 elderly housing units subsidized by a loan from the U.S. Department of Housing and Urban Development (HUD). Additional plans call for opening 30 market-rate rental units and an outpatient rehabilitation clinic.

The State has helped the Roanoke Group overcome several regulatory obstacles during the course of the project. Technical assistance from the State helped Roanoke receive a CON to build the nursing home and gain loan approval from HUD to develop the subsidized rental apartments. Efforts by Roanoke to secure a Farmers Home Administration (FmHA) loan to build the 30 market-rate apartments have been delayed, however, because of FmHA claims that no comparable market rate exists from which to make lending decisions. The State is also providing assistance to help the proposed outpatient clinic become certified as a provider-based rural health clinic (see ch. 3), enhancing the facility's Medicare and Medicaid reimbursement (418,479).

California—The Mono (County) General Hospital, a 29-bed public facility in rural northern California, had been suffering annual operating deficits of over $300,000 since 1984. After an unsuccessful attempt to have the hospital managed by a multihospital system based 2 hours away, the county considered closing the facility. In response to concerns that closure would severely limit access to basic health services for area highway travelers, the State in 1986 appropriated funds to maintain hospital operations for 1 year.

A study of the facility recommended a plan to convert 10 of the 29 beds from acute care to skilled nursing care and improve outpatient services. The plan would allow the county to operate the facility ona''breakeven' basis (in which revenues would at least equal expenses). Despite pressure from the county's other hospital, the county eventually agreed to accept the State's restructuring plan. To assist the restructuring process, the State altered California regulations (i.e., approved use of a joint nursing station for the acute-care and skilled-nursing units, and hospital-based skilled nursing beds for Medicaid patients). Provisions were made also to cross-train and certify staff lab and x-ray technicians to reduce standby costs (418).

Florida-The North Central Florida Health Planning Council, a State-funded district health planning agency covering 16 rural counties, assisted in the recent expansion of State-supported primary care services to indigent populations. The Council realized that the increased delivery of such services by area county health departments was insufficient to meet many indigent patients' needs for followup care. The Council worked with local health departments participating in the State program to establish a referral network of specialists and hospitals, and to set up a centralized Medicaid billing system to be used by participating physicians (222).

LOCAL TAX INITIATIVES

In order to maintain health services, local governments in many rural areas have increased their tax support for public hospitals and other facilities (see ch. 5). (In Montana, for example, nearly 60 percent of the nonoperating revenue of the State's small rural hospitals in 1985 came from tax funds of local counties and hospital districts[7] (73).) Rural communities in States with enabling laws can create tax support through the establishment of health care districts. In addition, some rural facilities may seek local approval of special, temporary tax levies to alleviate immediate financial problems. Two examples of local tax initiatives are described below.

[7]Hospital districts are one type of special district that exist to support a single public function or purpose. Special districts are independent governmental units tbat have, among other things, the autonomous power to tax. The idea of special districts is not new; by 1982 there were 28,000 nationwide, mainly serving local requirements for schools, water, fire protection, health care, or other needed services (441). Most special districts are located in rural areas (63 percent in 1977); often they are the only means by which small communities can obtain a critically needed public service (*137*).

Waivers of Federal conditions of participation for the new facilities are now necessary in order for MAFs to receive Medicare payments and begin effective operations as part of a demonstration project; however, the Federal Government had not yet approved the State's waiver requests as of June 1990. California is designing a new delivery model that would allow rural hospitals, through proposed changes in State licensure standards, to operate and provide services under conditions more appropriate to local needs and capabilities. These conditions permit underutilized rural hospitals that provide only a core group of basic services to function under more lenient State regulations and with lower freed costs. At present, the State does not consider waivers of Federal conditions of participation to be necessary for the rural hospitals initially targeted to participate in a demonstration project.

National legislation passed in late 1989 created a program in up to seven States to develop EACHs and RPCHs. Up to 15 RPCHs maybe developed in States without EACHs. Eligible EACHs and RPCHs will be designated by participating States and are intended to operate as part of a rural health network, reducing excess capacity of acute-care beds and ensuring regional accessibility of services. As of June 1990, regulations had yet to be developed and many questions remain about the program's benefits and feasibility.