

**PUBLIC POLICY ISSUES AND  
RURAL HEALTH NETWORK DEVELOPMENT**

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## EXECUTIVE SUMMARY

Rural health networks have the potential to play a key role in developing coordinated systems of care in rural areas. While more work is needed to evaluate the impact of health care networks, the growing level of interest in rural health networks and the pace of network development nationwide suggests the need for an analysis of public policy issues and a discussion of actions states and the federal government can take if they desire to support rural health network development.

The focus of this paper is on integrated rural health networks. We define an integrated rural health network as a group of more than one type of rural health care provider that may also include social service providers and/or insurers. The organizational arrangement between the members is formal and legal, for example, a contractual relationship or incorporation of the network with individual members as board members or shareholders. An integrated network uses the resources of more than one member organization, and performs functions or activities according to an explicit plan of action. We recognize that the number of rural health networks which currently meet this definition may be limited, but believe that integrated rural health networks have significant potential for improving health care in rural areas.

For this study, we conducted structured telephone interviews with rural health policy experts in eight key states, and analyzed background materials on networks in each state and relevant state legislation, regulations, guidelines and reports on network development. Our recommendations, which are directed primarily at state policymakers, are summarized below.

## RECOMMENDATIONS

### Defining, Licensing and Certifying Rural Health Networks

- ***Adopt a formal rural health network definition*** that includes minimum governance, organizational and service requirements.
- ***Do not require rural health networks to make network membership available to all service providers***, unless the state determines that this is the best way to achieve an important state health policy such as the equitable distribution of uncompensated care.
- ***Require networks to include "essential community providers"***, and to reimburse these providers on a reasonable cost basis, at least until the successful implementation of universal coverage or alternative mechanisms to ensure access for medically underserved populations.

- ***Determine an overall policy on rural health network service areas*** (i.e. whether a single or multiple competing networks should serve an area, whether more isolated or frontier areas should be considered differently) ***and then allow networks to define their own service areas, with state oversight*** to prevent inappropriate exclusion of at-risk populations, and to address conflicts over service areas and state border issues.
- ***Adopt a method of approving networks that meets the state's criteria***, (e.g. licensure, certification, or a less formal designation) and ***coordinate it***, to the extent possible, ***with regulatory requirements imposed on individual network members*** by the state and the federal government.
- ***Give priority for state funded network incentives*** such as grants or loans to approved networks, but do not restrict the operation of undesignated networks unless they raise quality of care problems that cannot be resolved through other regulatory means (e.g. facility licensure.)

### The Impact of State Health Laws and Regulations on Rural Health Networks

- ***Exempt networks from regulations that already apply to network members*** and would be duplicative, or allow networks to meet the requirement on behalf of their members.
- ***Modify regulations*** identified as problematic for rural health networks in general, ***and develop a waiver process*** that allows a rural health network to apply for waiver of specific regulatory requirements that are problematic for the network.
- ***Assess the availability and affordability of reinsurance*** in the private market for rural health networks that assume risk. ***If problems are found, change state insurance law if necessary to allow development of a reinsurance risk pool*** for rural health networks.
- ***Develop and implement risk adjustment mechanisms*** to help assure the financial viability of rural health networks that assume risk for service areas that are sparsely populated and/or have large high risk populations.

### Antitrust Laws and Rural Health Network Development

- ***Implement the state action immunity doctrine*** by establishing a state policy that supplants competition with cooperation in rural areas and actively supervises rural health networks.

- The ***U.S. Attorney General***, in consultation with the Commissioner of ***the Federal Trade Commission***, ***should continue to describe the conduct of rural providers*** that the agencies generally will not challenge under the antitrust laws.

### State Incentives for Rural Health Network Development

- ***Provide financial incentives for rural health network development***, such as matching grants or loans. Give special consideration to high need rural areas, and pay special attention to developing networks that will be financially self-sufficient after the grant or loan period.
- ***Provide or arrange technical assistance*** for grantees, loan recipients, and others interested in rural health network development.
- ***Implement demonstrations to examine ways that financing systems can be changed*** to support rural health network operations over time (e.g. provision of capitation payments or global budgets to networks.)

### Medicare and Medicaid Issues for Rural Health Networks

- ***Revise Medicare risk contracting policies for rural areas*** to adjust rate setting for the distinctive characteristics of rural markets.
- ***Allow networks to receive Medicare and Medicaid non-risk payments on behalf of their members*** and distribute the funds to members according to the needs of the network.
- ***Clarify Medicare/Medicaid fraud and abuse safe harbors*** in regard to rural health networking activities.

### CONCLUSION

Although officials in the eight key states recognize the need to address the policy issues discussed in this report, for the most part they are just beginning to do so. A few states have made considerable progress in defining rural health networks, establishing formal designation processes, and providing incentives for network development. However, a number of states are still considering these issues, and much work remains to be done in several policy areas, notably the effect of state health insurance and HMO regulations on networks which take on risk and network financing issues, including Medicare and Medicaid. As policymakers address issues

related to rural health network development, they should bear in mind the costs of developing networks, and their limitations as well as their potential. Networks may help improve the delivery and financing of rural health care, but they are not necessarily a panacea for all of the challenges facing health professionals and policymakers involved with assuring the accessibility and affordability of health care services in rural America.

## INTRODUCTION

Rural health networks have the potential to play a key role in developing coordinated systems of care in rural areas (Christianson and Moscovice, 1993.) State and federal policies clearly influence rural health network development and operation.

The purpose of this paper is:

- to identify and discuss public policies that support, shape and deter rural health network development;
- to examine rural health network policy initiatives in key states; and
- to recommend actions that states and the federal government can take to support the development of rural health networks.

In recent years, the Federal government has funded several initiatives to help support rural health network development. The Essential Access Community Hospital/ Primary Care Hospital (EACH/RPCH) program has provided \$17.1 million over three years for rural hospital networks and state activities in seven states (California, Colorado, Kansas, New York, North Carolina, South Dakota, West Virginia) (Campion, Lipson, and Elliot, 1993). Through its Rural Health Network Reform Initiative, HCFA recently announced that it was awarding \$1.7 million in grants in FY 94 to six states (Florida, Minnesota, Mississippi, Nebraska, North Carolina, and Washington) to address rural health issues within the context of comprehensive statewide health reform. The Bureau of Primary Health Care's Integrated Service Network Development Initiative, funded at \$4.5 million in FY 94, will make awards ranging from \$100,000 to \$250,000 to federally funded urban and rural community health centers that are collaborating with at least one other health care provider or entity "to form an

integrated delivery system for managed care purposes that will ensure access for the medically underserved" (Bureau of Primary Health Care, 1994). The Agency for Health Care Policy and Research recently announced that five Rural Centers (located in Arizona, Maine, Nebraska/Iowa, Oklahoma, and West Virginia) will receive a total of up to \$10 million over the next five years to assist in the development and demonstration of rural managed care networks.

States have policy and coordination roles in the EACH/RPCH and Rural Health Network Reform programs. Several states have also implemented their own initiatives to support rural health networks, either in the context of state health care reform efforts or as separate initiatives. The state initiatives include rural health network policy development, grant and loan programs, technical assistance, rate enhancement, regulatory flexibility, and antitrust exception processes.

These initiatives anticipate that networks will have significant positive benefits for rural health care systems, including improved access to care, cost reductions, and enhanced quality of care. To date, research on network outcomes has been very limited, and considerably more work is needed to evaluate the impact of health care networks on outcomes such as provider performance and the health status of populations (Moscovice, Christianson, and Wellever, 1994.) At the same time, the growing level of interest in rural health networks and the pace of network development nationwide suggests the need for an analysis of public policy issues and a discussion of actions states and the federal government can take if they desire to support rural health network development.



Several ways in which government can facilitate rural health network development include providing loans and/or grants to support the capital investment necessary for network building; providing reinsurance to networks in their early stages; protecting existing capacity building programs such as community and migrant health centers, rural health clinics, and federally qualified health centers; providing technical assistance to support local network development; and creating financial, education, and licensure incentives that support the training of health professionals likely to participate in rural health networks (Christianson and Moscovice, 1993; Coburn and Mueller, 1994.)

In addition to helping build the infrastructure to support network development directly, states also have significant potential to shape network development through their roles as health care policymakers, regulators, and payors. State policies can influence the number and type of networks that are developed, their membership, governance structures, and the services they provide. Through their regulation of health care facilities, health professionals, health plans, and networks themselves, states can have a significant impact on network development. Both the federal government and states can influence network development through their roles as payors and administrators of Medicare, Medicaid and other publicly funded health care programs.

### **Study Methods**

Many different types of rural health networks exist, ranging from networks of similar providers, such as rural hospital networks to integrated networks that provide

or coordinate a full range of acute inpatient and primary care services. Health care providers may have multiple network affiliations at the same time, and network membership may change over time. The focus of this paper is on integrated rural health networks. We define an integrated rural health network as a group of more than one type of rural health care provider that may also include social service providers, insurers, or both. The organizational arrangement between the members is formal and legal, for example, a contractual relationship or incorporation of the network with individual members serving as board members or shareholders. An integrated network uses the resources of more than one member organization, and performs functions or activities according to an explicit plan of action.

Individual networks may pass through stages of development before becoming fully integrated (D'Aunno and Zuckerman, 1987). We recognize that the number of rural health networks which currently meet our definition may be limited, but believe that integrated rural health networks have significant potential for improving health care in rural areas.

For the most part, integrated rural health network development initiatives are just beginning to be implemented, and thus have not yet been extensively documented in the health care literature. Accordingly, we conducted structured telephone interviews with rural health policy experts in key states to obtain current information for this study, and analyzed relevant state legislation, regulations, guidelines and reports. Eight states (Colorado, Florida, Kansas, Minnesota, New York, North Carolina, Washington, and West Virginia) were chosen for the study based on our

knowledge of states that are actively involved in state and federal legislative and grant initiatives to support health care network development. In each state, we interviewed the director or relevant staff person in the state Office of Rural Health, using a standard set of questions. Offices of Rural Health were selected because of their broad perspective and up-to-date knowledge regarding rural health network public policy issues in their states. (See the Appendix for a list of the persons interviewed.)

Colorado, Kansas, New York, North Carolina, and West Virginia participate in the federal EACH/ RPCH program. New York has also supported the development of rural health networks through a significant commitment of state grant dollars for network projects and a focus on rural health network policy development. Florida has a state funded rural health network grant program as well, while West Virginia has benefitted from a rural health network project funded by private foundations. Minnesota and Washington have implemented rural health network initiatives as part of state health care reform efforts.

## **PUBLIC POLICY ISSUES RELATED TO RURAL HEALTH NETWORKS**

This paper addresses five major categories of public policy issues relating to rural health networks: rural health network definition issues; the potential impact of state health laws and regulations; antitrust laws; state incentives for rural health network development; and Medicare and Medicaid policy issues.

## **Defining, Licensing and Certifying Rural Health Networks**

A fundamental public policy issue that states need to address regarding rural health networks is whether the state should adopt a formal rural health network definition in legislation, regulation, or guidelines and, if so, what form the definition should take, and how it should be implemented. A state's decision to adopt a formal definition is likely to be based on its perception of the purposes of rural health networks, and the extent to which it views state policy as a means of helping to achieve those purposes.

By specifying the components and functions of state-approved rural health networks, a legal definition provides a framework for future network formation. A legal definition also separates rural health networks that conform to state standards from those that do not. It may be used as the criterion by which states award incentives for the establishment and operation of rural health networks (e.g. grant support, enhanced reimbursement, regulatory waivers), and may also be needed to establish state antitrust policy regarding network activities under the state action immunity doctrine. In addition to limiting eligibility for some or all incentives to networks that meet its legal definition, a state may also choose to place restrictions on the establishment and operation of networks that do not meet the criteria.

A state's decision to adopt a formal definition, the content of the definition, and the process used to implement it will be influenced by the state political environment and attitudes toward health care regulation. The extent of rural health network development in the state will also be an influencing factor. Some states with limited

network development may choose to gain experience with informal guidelines and demonstration projects before proceeding with legislation or regulation. Other states may use authorization of networks in statute or rule early in the process to set the direction for state policy development. A state may also choose to adopt multiple definitions for networks in different stages of development; for example, a fledgling network might have contractual relationships among its members, while a more mature network might involve incorporation of the network with network members as members of the governing board.

#### Elements of A Rural Health Network Definition

States need to decide whether a rural health network definition should specify network membership requirements. A network definition may include an "any willing provider" requirement which obligates a network to accept all potential members willing to meet certain conditions of membership, or a network may be allowed to select participating providers based on criteria developed by the network.<sup>1</sup> Existing "any willing provider" state laws developed to regulate managed care plans may also apply to rural health networks. In rural areas with a small number of health care providers, an any willing provider requirement may not have much impact since

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<sup>1</sup> The converse of "any willing provider" requirements are exclusive relationship or "lock-in" requirements used by health plans to prevent their affiliated physicians and other providers from participating in more than one network. Although "lock-in" requirements may violate antitrust laws, the National Rural Health Association (NRHA) reports that rural providers face increased pressure from managed care systems to enter into exclusive relationships. On November 11, 1994, the NRHA Rural Health Policy Board passed a resolution stating that: "Local rural providers who are able and willing to meet specific managed care organization standards for quality, utilization, and cost should be allowed to work with multiple managed care systems and not be forced into exclusive relationships."

networks will probably include most if not all providers in the service area. However, in more populated rural areas, such a requirement may limit a network's ability to choose only the providers it needs to effectively and efficiently provide health care services. It may also allow some organizations to continue outdated patterns of service provision rather than make the transition to providing services currently needed by the area population.

A network definition may include an "essential community provider (ECP)" provision that requires inclusion of certain provider types (e.g. local public health agencies, community health centers, or sole community hospitals). Such a provision may also require networks to reimburse ECPs differently than other providers (e.g. on a cost basis). In a state that requires networks to include any willing provider, a requirement that networks include ECPs presumably would not be necessary, although the level of reimbursement would still need to be addressed. However, states that do not have any willing provider requirements should still evaluate the benefits of requiring networks to include ECPs. The inclusion of local public health agencies in rural health networks is consistent with the idea of integrating services provided by the public health system, including community needs assessment and population based community health services, more closely with the medical care system. Requiring networks to include community and migrant health centers and similar providers can be justified as a means of assuring access for medically underserved populations. To limit ECP designation to organizations that are essential for access,

states may want to establish ECP criteria in state law and evaluate designation applications on a case-by-case basis.

A network definition may also address the inclusion of urban entities such as large hospitals and clinics, health plans, and other insurers, as rural health network members. By virtue of their greater resources, large urban entities may dominate the rural health networks in which they participate and discourage the development of community-based networks. However, the participation of these entities in rural health networks potentially may benefit the network if they provide needed resources, e.g., capital and technical assistance. The states we surveyed have not taken official positions either encouraging or discouraging the involvement of urban entities in rural health network development, but have focused on supporting local decision-making and the development of community-based networks through the use of state incentives.

States should also consider whether to require networks to provide, either directly or by referral, a minimum set of health care services within defined travel times or distances. In recognition that some rural areas may not currently have the capacity to provide these services, a minimum services requirement may only be achievable if additional resources are allocated to these areas, or links are made to institutions that can provide these resources.

Another definitional issue for states to address is whether to establish governance and organizational requirements for rural health networks, such as non-profit status, or majority consumer membership on a network's governing board.

States vary in the extent to which their health care institutions are non-profit or for-profit, but non-profit status may be required if a network is to receive state or private foundation funds. States that are strongly committed to the establishment of community-based rural health networks will want to encourage network governance structures that emphasize community control.

A rural health network's service area boundaries have several implications for service delivery and the financial status of the network. From the state's perspective, network service area policy issues include whether the state should have a role either in determining or approving service area boundaries; whether it should allow or encourage multiple networks to serve a single service area; whether service area designation should be considered differently in more isolated or frontier areas than in more densely populated rural areas; and how the state will deal with network service areas that cross state lines. State decisions regarding network service areas will depend in part on whether the state envisions a competitive or a cooperative model of rural health networks, and whether the state has a long range goal of statewide coverage of rural areas by networks.<sup>2</sup>

States that adopt a legal rural health network definition face several public policy issues relating to implementation of the definition, including whether to license or certify networks as organizational entities; how the process should be coordinated with licensure or certification of individual network members; and whether network

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<sup>2</sup>Minnesota, for example, expects that multiple community integrated service networks will compete in the same service area, while Florida plans to have a single rural health network in each service area, and prohibits grantee networks from having overlapping service areas.



licensure or certification requirements should replace any of the regulatory requirements currently imposed on network members. The process of regulating health care networks will be easier to accomplish and more meaningful in states that have modified their licensure and certification processes to focus more on outcomes and less on structural issues relating to individual types of facilities. For example, Wisconsin's rural medical center (RMC) model uses a unified survey process for integrated health care organizations (Wellever and Rosenberg, 1994.)

States may also want to consider how the recently developed Joint Commission on the Accreditation of Health Care Organizations (JCAHO) network accreditation process relates to the state licensure or certification of networks. The JCAHO standards constitute a framework for evaluating network performance that incorporates both information about individual network components and the network as a system of care. Networks may apply for JCAHO accreditation if they offer comprehensive or specialty services to a specific population and if they have a centralized structure to coordinate services provided by individual practitioners and component organizations (JCAHO, 1994).

#### Key States' Rural Health Network Definitions

The states surveyed for this study have taken a variety of approaches to defining rural health networks. Florida and New York defined rural health networks in state statute in 1993, and are now finalizing network regulations. West Virginia has a definition from the Rural Health Networking Project funded by the Benedum Foundation, and plans to introduce rural health network legislation in the 1995

session. Minnesota's health care reform legislation defined a community integrated service network (CISN), an integrated financing and service delivery model that is expected to serve mostly rural areas. Washington State's rural health network definition comes from its Rural Investigation Group's recommendations to the Health Services Commission. North Carolina uses the federal EACH/RPCH network definition, while Kansas has an expanded EACH/RPCH network definition in state law.

Table 1 lists, by state, the rural health network definition(s) being used in the state, the source of the definition, and the status of licensure, certification, or other efforts to formally recognize rural health networks. Table 2 describes each state's requirements for rural health networks, including membership, governance and organizational structure, services, and service area.

### Conclusions and Recommendations

The experience of states that have adopted a formal rural health network definition suggests that it can be a useful means of articulating state policy and setting a direction for network development in the state, if the definition is flexible enough to allow local development of a variety of network models and to accommodate networks in various stages of development. Therefore, we recommend that states that want to encourage rural health network development take the following steps to define networks.

- ***Adopt a formal rural health network definition*** that includes minimum governance, organizational and service requirements.
- ***Do not require rural health networks to make network membership available to all service providers***, unless the state determines that this is the best way

Table 1

## Rural Health Network Definitions

State	Rural Health Network Definition	Source of Definition	Licensure, Certification, Other Formal Recognition
Colorado	<p>1) Provider network "means a group of health care providers formed to provide health care to individuals."</p> <p>2) Rural health network "means a network created to integrate all levels of health care services and providers in a rural area to improve access to health care. Members of rural health networks have entered into agreements regarding patient transfers, referrals, and use of communication systems."</p>	<p>1) State statute (Antitrust legislation).</p> <p>2) Essential Access Hospital/Rural Primary Care Hospital (EACH/RPCH) regulations.</p>	State approval of EACH/RPCH networks only.
Florida	<p>A rural health network is "a non-profit legal entity, consisting of rural and urban health care providers and others, that is organized to plan and deliver health care services on a cooperative basis in a rural area, except for some secondary and tertiary care services."</p>	State statute, regulations for certification are in process.	Certification to start early 1995.
Kansas	<p>A rural health network is "an alliance of members including at least one rural primary care hospital and essential access community or supporting hospital which has developed a comprehensive plan submitted to and approved by the secretary of health and the environment regarding patient referral and transfer; the provision of emergency and nonemergency transportation among members; the development of a network-wide emergency services plan; and the development of a plan for sharing information and services between hospital members concerning medical staff credentialing, risk management, quality assurance, and peer review."</p>	State statute (EACH/RPCH legislation).	State approval of EACH/RPCH networks only.

Table 1 (continued)

State	Rural Health Network Definition	Source of Definition	Licensure, Certification, Other Formal Recognition
Minnesota	A community integrated service network (CISN) is "a formal arrangement licensed by the Commissioner for the purpose of providing prepaid health services to enrolled populations of 50,000 or fewer enrollees."	State statute.	CISN licensure under state HMO law, regulations as modified by CISN statute.
New York	A rural health network is "an affiliation of health care providers serving a rural area, pursuant to a contract or joint or cooperative agreement." It may plan, coordinate, provide or arrange for the provision of health care services to residents of the area and/or provide related administrative services among health care providers.  A central services facility rural health network (CSFRHN) is a rural health network organized as a not-for-profit corporation and approved by the Commissioner of Health "which provides or arranges for the provision of health care services... which shall include at a minimum, comprehensive primary care, emergency care, outpatient and inpatient care."	State statute, regulations are in process.	CSFRHN licensure under Article 28 of NYS Public Health Law (starts early 1995).
North Carolina	No rural health network definition in state statute or rule. Uses federal definition for EACH/RPCH networks.	None	State approval of EACH/RPCH networks only.

Table 1 (continued)

State	Rural Health Network Definition	Source of Definition	Licensure, Certification, Other Formal Recognition
Washington	"Rural health networks are community-based and controlled entities that integrate local services, facilities, assume risk for the care of the community residents, work with all certified health plans (CHPs) in the area, and provide the Health Services Commission all necessary information."	Final report of the Rural Investigation Group (RIG), adopted by the Health Services Commission.	RIG recommended that rural health networks meeting Health Services Commission criteria receive special consideration for antitrust immunity.
West Virginia	A rural health network is "a voluntarily-formed, legally-recognized, not-for-profit organization with three responsibilities: 1) assessing the access, cost, and quality of health care services for a geographically-defined area of the state and planning for their continuous improvement; 2) providing or arranging for the integration of preventive, primary, acute care, and emergency medical services for the residents of and visitors to the defined geographic area; and 3) providing or arranging for the delivery of other health, social and transportation services as deemed necessary."	Foundation funded grant program RFP guidelines.  Plan to introduce legislation including rural health network definition in 1995 session.	State approval of EACH/RPCH networks only.

Table 2

## Rural Health Network Requirements

State	Membership	Governance and Organizational Structure	Services	Service Area	Other Requirements
Colorado	Essential Access Hospital (EACH) and Rural Primary Care Hospital (RPCH) hospitals, emergency medical services (EMS).	Federal EACH/RPCH requirements.	Federal EACH/RPCH requirements: 24 hour emergency care, acute care not to exceed 72 hours, routine diagnostic services, dispensing of drugs and biologicals.	None	None
Florida	Network membership must be available to all service providers, if they agree to provide care to all patients referred to them by other network members. Must include providers of public health, comprehensive primary care, emergency medical care, acute inpatient care.	Must be non-profit, and legally incorporated. Draft rules require that the board have at least one member representing local government, county public health, a rural hospital, a community or migrant health center if one is in the area, other type of health care provider, local business and consumers; and that at least 51% of board members be residents of the network service area.	Required core services are disease prevention, health promotion, comprehensive primary care, emergency medical care, acute inpatient care. Law specifies additional services that networks, to the extent feasible, should make available directly, by referral, or through contracts within 30 minutes, 45 minutes and 2 hours travel time.	Network service areas do not need to conform to local political boundaries or state administrative district boundaries, but networks must not have overlapping or competing service areas.	Networks are required to establish standard protocols, coordinate and share patient records, develop patient information exchange systems, and develop risk management and quality assurance programs.

Table 2 (continued)

State	Membership	Governance and Organizational Structure	Services	Service Area	Other Requirements
Kansas	EACH and RPCH hospitals, EMS. May also include supporting hospitals, local health depts, home health, medical clinics, mental health centers, adult day care homes, non-emergency transportation systems.	Federal EACH/RPCH requirements.	Federal EACH/RPCH requirements: 24 hour emergency care, acute care not to exceed 72 hours, routine diagnostic services, dispensing of drugs and biologicals.	None	Each network is required to have a comprehensive plan regarding patient referral and transfer, provision of emergency and nonemergency transportation among members, development of a network-wide emergency services plan, and a plan for sharing patient information and services between hospital members concerning medical staff credentialing, risk management, quality assurance and peer review.
Minnesota	Community Integrated Service Networks (CISNs) may choose providers, must document process and criteria in action plan.	Non-profit, 51 % of governing body must be residents of service area.	CISNs must provide comprehensive benefits under HMO law.	Service area to be determined by the network, with monitoring by the Commissioner of Health. Competing networks in the same service area are expected.	Must file an annual action plan which includes a description of credentialing requirements, number of FTEs used to provide services, policies and procedures for enrolling and serving high risk populations, and actions taken or planned to offer health coverage options to rural communities not currently served.

Table 2 (continued)

State	Membership	Governance and Organizational Structure	Services	Service Area	Other Requirements
New York	All providers within the network service area must be given an opportunity to become network members, if they agree to the terms and conditions set by the network and approved by the Commissioner of Health.	Central services facility rural health networks (CSFRHNs) must be non-profit and legally incorporated, and have a board with providers and consumers from service area.	CSFRHNs are required to provide or arrange for the provision of health care services to include, at a minimum, comprehensive primary care, emergency care, outpatient and inpatient care. They may offer any medical or health related service as long as they have appropriate resources, the quality of the service can be assured, and it is provided in accordance with state law and regulation, and in response to community need.	CSFRHN service areas must be approved by the Commissioner of Health.	Each CSFRHN must submit an operational plan to the Commissioner of Health for approval.
		Informal rural health networks (RHNs) must have a cooperative agreement approved by the Commissioner of Health.			RHN must have a network written agreement, which provides a plan for meeting unmet health care need(s), the roles and responsibilities of each participating provider, consumer input structure, and demonstrates linkages and resources will be available to implement the plan.



Table 2 (continued)

State	Membership	Governance and Organizational Structure	Services	Service Area	Other Requirements
North Carolina	EACH and RPCH hospitals, EMS	Federal EACH/RPCH requirements.	Federal EACH/RPCH requirements: 24 hour emergency care, acute care not to exceed 72 hours, routine diagnostic services, dispensing of drugs and biologicals.	None	None
Washington	Rural Investigation Group (RIG) recommended that all qualified providers in service area who deliver services offered by the network be allowed to participate, subject to meeting volume, quality, utilization, and efficiency standards of network.	"Community-based and controlled entities." RIG recommendation: rural health network (RHN) should have a legal relationship that creates a functional integration of network services, and involves the community in governance.	RIG recommendation: RHNs provide directly or through contract, the full Uniform Benefits Package, and coordinate other public health or personal health services in community.	Does not specify.	RIG recommendations: RHNs to assume maximum feasible risk for participating service area residents; agree to actively seek participation agreements with all Certified Health Plans offered in service area; provide data and assurances to Health Services Commission re: cost efficiency, quality, service availability and access.
West Virginia	At a minimum, must include preventive, primary, acute care and EMS providers.	Nonprofit, legally incorporated, board must reflect composition of service area. The governing board is responsible for establishing bylaws, policies, procedures, and formal agreements that establish the operating principles under which the network operates.	Provide or arrange for the integration of preventive, primary, acute care, and emergency medical services; other health, social, and transportation services as deemed necessary.	Networks define own service area.	Networks required to hold a public meeting in service areas to discuss plans; perform a local needs and resource assessment and develop a network integration plan.

to achieve an important state health policy such as the equitable distribution of uncompensated care.

- **Require networks to include "essential community providers,"** and to reimburse these providers on a reasonable cost basis, at least until the successful implementation of universal coverage or alternative mechanisms to ensure access for medically underserved populations.
- **Determine an overall policy on rural health network service areas** (i.e. whether a single or multiple competing networks should serve an area, whether more isolated or frontier areas should be considered differently) **and then allow networks to define their own service areas, with state oversight** to prevent inappropriate exclusion of at-risk populations, and to address conflicts over service areas and state border issues.
- **Adopt a method of approving networks that meets the state's criteria,** (e.g. licensure, certification, or a less formal designation) and **coordinate it,** to the extent possible, **with regulatory requirements imposed on individual network members** by the state and the federal government.
- **Give priority for state funded network incentives** such as matching grants or loans to approved networks, but do not restrict the operation of undesignated networks unless they raise quality of care problems that cannot be resolved through other regulatory means (e.g. facility licensure.)

### **The Impact of State Health Laws and Regulations on Rural Health Networks**

Whether or not a state chooses to adopt legislation or regulation specifically governing rural health networks, other state health laws and regulations may affect network development and operation. Certificate of need (CON) and health plan laws and regulations, which are discussed below, may be problematic in some states. In order to encourage network development, states may consider providing rural health networks with flexibility in the form of exceptions, modifications or alternatives to certain regulatory requirements. It may be difficult to identify in advance all of the health care regulations that may impede network development. States may want to

establish a regulatory waiver process similar to New York's, whereby a network can apply to the Commissioner of Health for a waiver by identifying the specific Department of Health regulation that is problematic, and providing justification of the need for a waiver as well as assurances that the quality of health care, patient rights, and informed consent will not be negatively affected by the waiver.

#### Certificate-of-Need

Certificate-of-need (CON) programs generally require institutional health care providers, especially hospitals and nursing homes, to obtain state approval for capital expenditures above a designated threshold or for substantial changes in services. While some states have repealed their CON laws, 38 states have retained their CON programs (Hudson, 1994). Many state CON laws require approval for changes in ownership or organizational structure, a provision that could present barriers to network development. CON laws may also affect network purchases of buildings and equipment. To the extent that networks include existing providers whose activities have already been subject to CON review, an additional review is likely to be a barrier to network formation that is difficult to justify. States should consider waiving CON review in these cases. State CON authorities might also provide preferential treatment for network activities that they determine will reduce duplication of services or involve shared use of equipment.

As shown in Table 3, two of the five key states that have CON programs have modified their CON requirements for rural health networks. Florida statute requires

**Table 3**  
**Regulatory Initiatives Affecting Rural Health Networks**

State	Regulatory Modifications
Colorado	No certificate of need (CON) program in state, no regulatory modifications.
Florida	CON modified for certified rural health networks, no regulatory modifications.
Kansas	No CON program in state, no regulatory modifications.
Minnesota	No CON program in state, HMO financial requirements modified for community integrated service networks (CISNs).
New York	Streamlined CON process will involve character and competence related review only.  Process to apply to Commissioner of Health for waiver of health regulations established.
North Carolina	No changes to CON or regulatory modifications.
Washington	No changes to CON or regulatory modifications.
West Virginia	No changes to CON or regulatory modifications.

that rural health network members receive preference in the award of a CON, if need is shown pursuant to statutory CON review criteria, and the proposed project would strengthen health care services in rural areas through partnerships between rural providers or increase access to inpatient health care services for rural Medicaid recipients or other low income persons. In New York, CON review will apply to central services facility rural health networks (CSFRHNs) in a modified form; two of the three CON tests, public need and financial feasibility, will not apply, but the third, character and competence of the provider, will apply.

#### Health Plan Regulation

State regulations governing health plans, including HMOs, typically include benefit, financial solvency, underwriting, quality assurance and consumer protection requirements. The degree to which these requirements apply to rural health networks will depend in large part on the extent to which the networks assume direct financial risk for the delivery of services. A risk-bearing network may exhibit many characteristics of an HMO or health insurer and as such will be subject to state laws and regulations governing HMOs and insurance companies.

Most states have had little experience regulating rural managed care plans due to the limited presence of managed care entities in the majority of rural areas (Wellever and Deneen, 1994). However, as integrated rural health networks begin to take on a financing role in addition to their health care delivery role, states will need to determine whether specific health insurance or HMO regulations will be problematic for rural health networks that assume financial risk, and then decide whether and how

the state should modify these regulations to address the circumstances of rural health networks. For example, financial requirements established to protect health care consumers from insolvent health plans may prevent small, community-based networks from forming, unless the network includes an entity such as a large urban hospital or health plan which is able to underwrite potential losses. State options for modifying these requirements include providing state funding or allowing local governments to provide the funds networks need to meet reserve requirements, phasing-in requirements over a period of time, or allowing network providers to pledge the future provision of uncompensated services in lieu of a portion of cash reserves.

Florida's HMO law allows public health agencies to form HMOs and use county financing for the \$1 million reserve required. In Minnesota, a CISN's net worth requirement may include reinsurance credit, may be phased in over 3 years, and may be reduced by use of contracts with "accredited capitated providers" (network members who agree to provide services without compensation to enrollees of an insolvent CISN for up to six months), or use of guaranteeing organizations. As they evaluate options for modifying health plan requirements, states will need to ensure that mechanisms remain in place to protect health care consumers and assure continued provision of care in the event of network insolvency.

Low population densities and concentrations of high risk individuals in some rural service areas may create unacceptable levels of risk for potential rural health networks with a managed care component. Jones, Cohodes, and Scheil (1994) suggest several actions for federal or state government to help manage the increased

risk inherent in a health care system undergoing rapid transition which might be adapted for risk-bearing rural health networks. These actions include assuming the role of a reinsurer for a transitional period of time by establishing a "risk-sharing fund" to share with health plans the financial risks associated with new coverage arrangements and unpredictable changes in price and volume of health services resulting from health care reform, or a "risk equalization fund" derived from assessments on each participating plan/network's premium and redistributed among plans/networks according to their favorable or adverse risk selection.<sup>3</sup>

### Conclusions and Recommendations

Certain state health laws and regulations, including certificate of need and health plan regulations, may present potential barriers to rural health network development and operation. Low population densities and concentrations of high risk individuals in some rural service areas may create unacceptable levels of risk for potential risk-bearing rural health networks. States should take the following steps to address these problems.

- ***Exempt networks from regulations that already apply to network members*** and would be duplicative, or allow networks to meet the requirement on behalf of their members.

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<sup>3</sup>We are not aware of any states that currently assume the role of reinsurer for networks. However, Minnesota, Florida, Connecticut and North Carolina have private sector Small Employer Reinsurance Associations that provide reinsurance for carriers in the small group market and might serve as models for a network reinsurance association. A reinsurance association could be structured so that networks still have incentives to manage care. In the Minnesota Small Employer Reinsurance Association, for example, the insurance company pays the first \$5,000 of claims and 90% of the amount between \$5,000 and \$55,000, while the reinsurance association pays 10% of the amount between \$5,000 and \$55,000, and 100% above \$55,000.

- ***Modify regulations*** identified as problematic for rural health networks in general, ***and develop a waiver process*** that allows a rural health network to apply for waiver of specific regulatory requirements that are problematic for the network.
- ***Assess the availability and affordability of reinsurance*** in the private market for rural health networks that assume risk. ***If problems are found, change state insurance law if necessary to allow development of a reinsurance risk pool*** for rural health networks.
- ***Develop and implement risk adjustment mechanisms*** to help assure the financial viability of rural health networks that assume risk for service areas that are sparsely populated and/or have large high risk populations.

### **Antitrust Laws and Rural Health Network Development**

The collaborative activities of rural health network members may be subject to litigation brought by the U.S. Department of Justice, the Federal Trade Commission, or private parties under two federal laws, the Sherman Act and the Clayton Act. The Sherman Act prohibits conspiracies, contracts, and combinations in restraint of trade; the Clayton Act prohibits mergers and acquisitions of stock or assets that may substantially lessen competition or tend to create a monopoly. The policy of limiting market concentration through antitrust law is based on the assumption that a lack of competition will result in higher prices or costs than those of a competitive market. The public interest is best served, therefore, by limiting market concentrations and promoting competition.

Many rural areas are unable to support more than one provider network. Rural providers who cooperatively plan and operate rural health networks in these areas may be liable to antitrust actions. Although we are aware of only one antitrust suit that



has been filed against a rural health network,<sup>4</sup> survey respondents report that the fear of antitrust liability has, in some cases, retarded the development of collaborative activities in rural areas.

To overcome these real and perceived barriers to rural health network formation, several states have passed legislation to protect rural providers from antitrust liability. These legislative efforts are based on the doctrine of state action immunity, which exempts certain activities from antitrust liability in the belief that cooperation, in defined circumstances, serves the public interest better than competition. The antitrust exemption for rural providers is based on the following assumption: rather than raising prices and costs, rural health network collaboration is intended to reduce costs and improve quality and access to health care through the sharing and coordination of services. While several states (e.g., Maine) have immunized hospitals from antitrust liability for hospital-to-hospital collaboration, a smaller number of states (e.g., Florida and Kansas) have attempted to immunize all participants in rural health networks. Table 4 describes the status of antitrust initiatives in the key survey states. Seven of the eight states surveyed have passed

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<sup>4</sup>On February 16, 1994 Blue Cross/Blue Shield United of Wisconsin filed suit in federal district court alleging that the Marshfield Clinic and its health maintenance organization, Security Health Plan, have attempted to monopolize health care and control prices in central and northern Wisconsin. The Clinic has asked that the suit be dismissed. It employs approximately 400 physicians and contracts with approximately 100 affiliated doctors in 10 northern Wisconsin counties. Through a network of 21 regional centers, the Marshfield Clinic provides service to a number of previously underserved areas of Wisconsin. The Marshfield Clinic system also has a strategic alliance with the Ministry Corporation, Milwaukee, Wisconsin, which owns and operates four hospitals in the Marshfield Clinic service area, including 525-bed St. Joseph Hospital in Marshfield, Wisconsin.

**Table 4**

**Antitrust Initiatives Affecting Rural Health Networks**

<b>State</b>	<b>Antitrust Exception Process</b>
Colorado	Policy in statute covers provider networks, rules have just been developed.
Florida	Policy in statute covers providers who are members of certified rural health networks, rules for supervision to be developed.
Kansas	Policy in statute provides protection for network members. Standards for supervision need to be developed, anticipate legislation in 1995 to address antitrust further.
Minnesota	Policy and standards for supervision in statute, covers providers or purchasers wishing to engage in contracts, business or financial activities, or arrangements that may be construed to be violations of state and federal antitrust laws. Law passed in 1993 session, no applications from rural providers as of 8/94.
New York	Policy in statute, covers "the planning, implementation and operation of rural health networks and central services facility rural health networks and health care providers participating in or members of such networks", rules for supervision being developed.
North Carolina	Policy and standards for supervision in statute, covers agreements "among two or more hospitals or between a hospital and any other person, for the sharing, allocation or referral of patients, personnel, instructional programs, support services and facilities, or medical, diagnostic, or laboratory facilities or equipment, or procedures or other services traditionally offered by hospitals."
Washington	Policy in statute, covers cooperative activities among health care providers and facilities, rules being developed.
West Virginia	Plan to include antitrust provisions in 1995 legislation.

antitrust legislation, and West Virginia plans to do so in the upcoming legislative session.

To be effective, the state action immunity doctrine requires more than a simple legislative declaration of a policy to replace competition with cooperation. It also requires active supervision of the cooperative activities by qualified state officials. States appear to be moving more slowly to implement the active supervision requirement of state action immunity, although Colorado, Minnesota, and North Carolina have established processes that require providers seeking antitrust immunity to apply to a state agency, commission or board for an exemption. To be approved for an exemption, the provider must show that cooperation is likely to result in lower cost, greater access, or better quality of health care than would otherwise occur under existing market conditions. Providers who are approved for exemptions are required to submit periodic reports to assure the state that the professed benefits of collaboration are actually achieved. Specific procedures and criteria for evaluating rural health networks for state action immunity in these states have yet to be developed. To date, rural providers in these states have not applied for exceptions, making it difficult to judge how effective the state action immunity doctrine will be in providing antitrust relief to rural health network participants.

Even in the absence of state action immunity, there are cooperative activities that rural providers can engage in legally. Nevertheless, many rural providers have not pursued these cooperative activities because they are fearful that they may be breaking the law. The U.S. Department of Justice and the Federal Trade Commission

attempted to provide some direction to health care providers contemplating mergers and other joint activities when they published their "Statements of Antitrust Enforcement Policy in the Health Care Area" (1993). In the statements, the agencies list six "antitrust safety zones" that describe the circumstances under which they will not pursue prosecution for anticompetitive acts. Unfortunately, none of the six antitrust safety zones specifically address the activities of rural health networks.

The antitrust safety zones do not immunize providers from antitrust liability. They are merely statements of enforcement policy. That is, they indicate the circumstances under which the federal government will not pursue antitrust prosecutions. However, private parties are still at liberty to bring suit. Even a successful defense of an antitrust suit can be extremely expensive and detrimental to a newly emerging rural health network.

On September 27, 1994, the Department of Justice (DOJ) and the Federal Trade Commission (FTC) attempted to provide additional guidance to the health care industry by issuing updated and expanded enforcement policy statements clarifying how they would enforce the antitrust laws ("Statements of Enforcement Policy and Analytical Principles Relating to Health Care Antitrust"). In this latest statement of policy, the agencies discuss multiprovider networks. The agencies did not, however, describe an antitrust safety zone for multiprovider networks, claiming that they need more experience in evaluating the costs and benefits of these types of activities. Instead, the agencies listed the analytical principles they will use in evaluating the likely effect a particular multiprovider network will have on competition. The analytical

principles address the following antitrust issues: financial integration, joint pricing and joint marketing, market definition, competitive effects, exclusivity, exclusion of providers, and efficiencies. This policy statement does not offer blanket protection from enforcement, but it does provide a framework for the analysis that should be undertaken on a case-by-case basis by emerging networks and their local legal counsel.

Additionally, the Department of Justice set forth its policy on expedited business reviews and the Federal Trade Commission described its policy on advisory opinions, procedures through which providers may obtain information concerning the agencies' antitrust enforcement intentions. The agencies pledge to respond to requests for business reviews or advisory opinions within 120 days. The agencies suggest that "persons who are considering forming multiprovider networks and are unsure of the legality of their conduct under the antitrust laws can take advantage of [these reviews]" (DOJ/FTC, 1994).

Some of the uncertainty experienced by rural providers who are interested in greater cooperation might be alleviated by petitioning the Department of Justice or the Federal Trade Commission for a business review or advisory opinion. These reviews, however, will slow the process of network formation. The applicants must assemble information relative to the case -- the review time limit does not begin until "all necessary information is received" -- and the review agencies have up to four months to issue an opinion. The process of preparing and obtaining an opinion could easily

take six months. During this time, progress on network development will likely be suspended.

Rather than reviewing networks on a case-by-case basis for possible violations of antitrust law, the agencies should provide emerging networks with guidelines that clearly define legal and illegal activities. In the final days of the 103rd Congress, the Senate passed an amendment to the health care reform bill sponsored by Senator Mitchell that called for the Attorney General and the Commissioner of the Federal Trade Commission to "clarify existing and future policy guidelines, with respect to [antitrust] safe harbors, by providing additional illustrative examples with respect to the conduct of activities relating to the provision of health care services in rural areas" (S.2351, Amendment No. 2564). If issued, such guidelines might expedite network development in areas of the country where fear of antitrust liability is viewed as a meaningful deterrent.

#### Conclusions and Recommendations

Several states have passed legislation based on the doctrine of state action immunity to protect rural providers, including rural health networks, from antitrust liability, and the Department of Justice and the Federal Trade Commission have issued enforcement policy statements regarding multiprovider networks. However, states and the federal government should take the following steps to further reduce the negative effect of antitrust laws on rural health network development.

- ***Implement the state action immunity doctrine*** by establishing a state policy that supplants competition with cooperation in rural areas and actively supervises rural health networks.

- The ***U.S. Attorney General***, in consultation with the Commissioner of ***the Federal Trade Commission***, ***should continue to describe the conduct of rural providers*** that the agencies generally ***will not challenge*** under the antitrust laws.

### **State Incentives for Rural Health Network Development and Operation**

Rural health networks face start-up costs, as well as ongoing operating costs. It may be difficult for small, community-based networks to obtain capital, and health care reimbursement systems typically do not pay for network administrative activities. Developing rural health networks also need access to technical expertise, including financial and legal consultation. To help meet these needs, states may consider implementing a variety of incentives for network development, including grant and loan programs, technical assistance, and enhanced reimbursement. (Another potential incentive, regulatory relief, was discussed earlier.)

Table 5 describes incentives for rural health network development in the surveyed states. New York and Florida have state funded rural health network grant programs, and West Virginia has a network grant program which is funded by private foundation dollars and administered by the state. Minnesota is developing a state funded CISN loan program. Washington and North Carolina have rural health grant programs which are not specifically for networks, but have funded some projects that involved network development.

New York, Florida, West Virginia and Minnesota provide technical assistance specifically for rural health network development. The focus of network technical assistance in Kansas and Colorado is mainly on EACH/RPCH networks, while

Table 5

## Incentives for Rural Health Network Development

State	Incentive		Enhanced Reimbursement
	Grant or Loan Program	Technical Assistance (TA)	
Colorado	Federal Essential Access Hospital and Rural Primary Care Hospital (EACH/RPCH) grants.	State provides TA to EACH/RPCH networks. Some networks are also using grant dollars for consultants.	No
Florida	State funded rural health network grant program. In Phase I, 4 planning and development grants of \$75,000 in FY 1993-94 and 4 more in 1994-95. Phase II implementation grants will require 1995 legislative appropriation.	State provides TA to grantees on state and federal laws, needs assessments, options open to networks, community involvement, licensure and financing issues. Some networks are also using grant dollars for consultants.	No
Kansas	Federal EACH/RPCH grants.	State provides TA to EACH/RPCH networks.	No
Minnesota	Community Integrated Services Network (CISN) loan program being developed with state appropriation of \$212,000 in FY 1995.	State provided TA includes community facilitation, CISN manual with list of private consultants, toll free line, workshops available to all potential CISNs.	No
New York	Federal EACH/RPCH grants. State funded rural health network grant program funded 4 demonstration projects in 1992. 1993 law provides \$1 million annually for two years for planning grants up to \$50,000 and implementation grants not expected to exceed \$100,000. Central Services Facility Rural Health Networks (CSFRHNs) and rural health networks (RHNs) are eligible applicants.	State provided TA includes organizational design, negotiating skills, community development, system planning and program development, primarily for grantees. In process of developing "blueprint" for TA through contract.	Yes, for hospitals, upgraded diagnostic and treatment centers in CSFRHNs and RHNs through all payer system; authorization for enhanced reimbursement for primary care but no funding yet.



Table 5 (continued)

State	Incentive		
	Grant or Loan Program	Technical Assistance	Enhanced Reimbursement
North Carolina	Federal EACH/RPCH grants. State funded primary care grant program not specifically for networks but some projects have involved network development.	State currently provides TA to EACH/RPCH networks including organizational development, and is planning to develop focus on rural health networks as part of Office of Rural Health's comprehensive TA program.	No
Washington	State funded rural health systems development program supports community assessments which lead to network development in some cases.	State currently provides community assessment TA as part of Office of Rural Health's TA program.	No
West Virginia	Rural health network grant program funded by private foundations and administered by the state: 3 Phase I planning grants of \$15,000 each in 1994. Phase II implementation grants of \$150,000 each to be awarded in 1995.	State provides TA through contract with Center for Rural Health Development: including workshops and working with grantees on organizing, grant writing, community needs assessment, planning.	No

Washington and North Carolina assist with network development as part of their overall technical assistance. Through its all-payer system, New York will provide rate enhancements for hospitals in CSFRHNs and RHNs starting in January 1995.

To date, the states that have rural health network grant programs have found them to be a successful means of encouraging network development that other states may want to implement. States designing a network grant or loan program will need to address several policy and programmatic issues such as eligibility, award criteria and amounts, allowable uses of the grant/loan dollars, and match requirements. Required local matches for both grants and loans help to ensure community "ownership" of the project as well as increase the overall funds available. Given that the demand for grant dollars is likely to be much greater than available funds, states need to consider whether state grant funds should be targeted to encourage network development in rural areas that are especially lacking in local resources (e.g. high poverty, medically underserved areas); whether grant funds should be distributed geographically within the state; and to what extent the state should seek to fund different types of networks to serve as models for other rural areas of the state.

The experience of states that have implemented network grant programs suggests that states should pay special attention to developing networks that will be financially self-sufficient after the grant period. Possible ways to accomplish this include requiring increasingly greater local matches over the life of the grant, and helping networks to focus on efforts that have a relatively immediate economic benefit to the network.

Loans have some advantages over grants for network development. They force a network to focus on financial self-sufficiency early in the process in order to be able to repay the loan. In contrast, the availability of grant dollars may delay difficult decisions on the part of network members. Repaid loan funds can be loaned out to other potential networks, so the initial state investment is recycled. However, loans are likely to be more difficult for a state to administer. They are also less appealing to potential network members. Rural providers in financial difficulty may be especially reluctant to take on the risk of a loan, thereby limiting network development in underserved rural areas.

States with limited resources need not be discouraged from providing grants or loans. Even small grant awards allow networks to pay expenses that may be difficult to fund otherwise, such as staff salaries and consultant fees for initial networking activities, including joint planning and establishment of an organizational and governance structure. Another option for states with limited resources is to encourage potential network members to tap into other state and federal rural health grant programs such as rural health transition, outreach or primary care grants that can support network development activities.

Like grant programs, technical assistance programs present a number of design and implementation issues such as eligibility and the types of assistance that should be provided. States will need to decide whether the state should provide technical assistance directly to networks, contract with private consultants, or a combination of approaches. Initially, many states will probably need to rely on consultants to some

extent, but should plan how they might build internal capacity over time to provide the types of assistance needed by networks. A technical assistance program should facilitate the sharing of knowledge between existing rural health networks and potential networks. Workshops and resource manuals can be cost effective means of disseminating information of interest to many potential rural health networks.

Enhanced reimbursement for network members is another short-term option for encouraging rural health network development that states may want to consider. Through its all-payer system, New York plans to provide enhanced reimbursement to network hospitals from all payers except Medicare in January 1995. The state also has authority to provide rate enhancements for primary care, but has not yet implemented them due to insufficient funding. The use of enhanced reimbursement for network members may not be feasible for other states due to competing demands for limited Medicaid dollars and the lack of an all-payer mechanism to set rates for other payers.

A combination of the incentives described above can effectively encourage rural health network development in a state. However, as discussed further in the Medicare and Medicaid section, financing of network operations over time is an issue that will need to be addressed cooperatively by states and the federal government.

### Conclusions and Recommendations

The states that provide grants have found them to be major motivating forces in network development. Loans are another option for rural health network development worth exploring. States' experiences suggest that technical assistance

for rural health network development is in high demand, time consuming to provide, and essential for grant program success. In addition to their practical value in assisting networks, grants, loans, technical assistance and other incentives have value as evidence of the state's commitment to rural health network development. Therefore, we recommend that states take the following actions.

- ***Provide financial incentives for rural health network development***, such as grants or loans. Give special consideration to high need rural areas, and pay attention to developing networks that will be financially self-sufficient after the grant or loan period.
- ***Provide or arrange technical assistance*** for grantees, loan recipients, and others interested in rural health network development.
- ***Implement demonstrations to examine ways that financing systems can be changed*** to support rural health network operations over time (e.g. provision of capitation payments or global budgets to networks.)

### **Medicare and Medicaid Issues for Rural Health Networks**

The Medicare and Medicaid programs pay for a considerable portion of rural health care services. Commercial insurers often follow the lead of Medicare in determining coverage, covered providers, and payment mechanisms. The payment and operating rules for Medicare and Medicaid, therefore, play potentially significant roles in rural health network development.

Making modifications to the Medicare and Medicaid programs is likely among the most difficult policy challenges facing the advocates of rural health networks. Network development may require states to apply for waivers under the Health Care Financing Administration's (HCFA) current authority, or it may involve expansion of HCFA's waiver authority through federal legislation. The Medicaid program, which is

a shared federal and state responsibility, has established a process for applying for and granting waivers. Several types of Medicaid waivers are available, for example, waivers of mandatory services (e.g., nursing home care) and waivers of the freedom-of-choice requirement. To obtain a Medicaid waiver, a state must submit a proposal to HCFA justifying the waiver and estimating program costs with and without the waiver. The proposal is subjected to intensive review by HCFA. Medicare waivers are much less common than Medicaid waivers. Before a Medicaid or Medicare waiver can be granted, Congress must specify the authority of the Secretary of Health and Human Service (HHS) to make waivers of established laws and regulations. To date, Congress has extended that authority to the Secretary in a very limited number of areas. Those wishing to extend the waiver-making authority of the Secretary of HHS to create Medicare/Medicaid incentives or remove Medicare/Medicaid barriers to network development first may have to change the law.

#### Medicare and Medicaid Reimbursement of Rural Health Networks

Integrated rural health networks, by definition, are composed of existing health care providers. Many members of integrated rural health networks will be providers who are recognized by the Medicare and Medicaid programs and who have been assigned their own provider numbers. Other members, particularly social service and community organization members, may not be recognized providers. To date, the Medicare and Medicaid programs do not recognize networks as providers. Network members are reimbursed individually by Medicare and Medicaid through an assortment of payment mechanisms, varying from prospective payment to allowable costs to

reasonable charges to fee schedules. This mix of payment mechanisms may not produce an alignment of member incentives sufficient to bond the members together in a network. If networks are to be clinically and fiscally accountable for the outcomes and the health status of the populations they serve, networks themselves will have to be recognized as provider entities. As provider entities, networks would receive payments and allocate resources to network members in relation to the needs of the network.

In Minnesota, CISNs and ISNs will be recognized as providers. The Minnesota Department of Human Services has requested waivers of Medicaid regulations covering freedom-of-choice and capitation contract requirements to allow it to make Medicaid payments to CISNs and ISNs. Additionally, citing its dissatisfaction with Medicare risk-based contract rates, the state of Minnesota has announced its intention to work with HCFA to explore alternative competitive pricing strategies.

Others have also identified problems with Medicare risk-contracting (Nycz, Wenzel, Freisinger, and Lewis, 1987; Serrato and Brown, 1992). They argue that the rate, based on historical cost, does not adequately control for enrollment selection, unmet medical needs, or recent regional cost variations. Although integrated rural health networks hold the promise of reducing Medicare program expenditures and of improving the health status of the Medicare population served, it is unlikely that many rural health networks will soon contract with HCFA under the existing Medicare risk contracting regulations.

Several states have begun to experiment with Medicaid managed care systems (James, Wysong, Rosenthal, and Crawford, 1993). Medicaid managed care programs may be an excellent means of introducing managed care to rural areas. Typically, these programs are physician case management programs, but increasingly, programs (e.g., in Arizona) require providers to accept some of the financial risk for the patients they serve. As with the Medicare program, managed care for Medicaid recipients may reduce cost and improve quality of care. States that are interested in encouraging managed care in rural areas and in developing networks capable of bearing risks, might consider applying for a Medicaid waiver.

Medicare and Medicaid payment may also be used as an incentive to network formation. The members of newly formed networks and networks that do not accept risk will continue to receive direct payments from Medicare and Medicaid. As an inducement to join a network, Medicare and Medicaid might provide enhanced reimbursement to providers who agree to participate in state-sanctioned networks. There are precedents for such payments. The federal government provides enhanced Medicare reimbursement to rural hospitals that agreed to participate in the EACH/RPCH program. Hospitals designated as EACHs are eligible to be reimbursed as sole community hospitals. The power of enhanced reimbursement is significant. The difference between sole community provider reimbursement and regular rural hospital reimbursement is so great that it induced several potential EACHs to search their states for potential RPCHs with which they could "network." Some of these unions were driven more by the reimbursement incentive than they were by a genuine



interest in networking. Nevertheless, the promise of enhanced Medicare reimbursement caused these hospitals to join and kept them in their networks. As discussed earlier, New York State, through its all-payer system, will also begin making enhanced payments from all payers except Medicare to hospital members of networks in early 1995.

In both of these examples, only hospitals receive enhanced reimbursement payments. The rationale for only paying hospitals is not clear. If the enhanced payments are meant to induce participation, the strategy is successful only at bringing hospitals into networks. If the purpose of enhanced payments is to defray the expenses of network formation and operation, the payment should more properly go to the network rather than a single part of it. Network functions would be more appropriately financed if the incremental amount of rate enhancements were payable to the network as a whole and not to hospital members alone.

#### Medicare Fraud and Abuse Issues

Medicare fraud and abuse statutes, like the antitrust statutes, are a source of confusion for network members. Scrupulously wishing to avoid violating the law, network members are often nervous and frustrated by the lack of clarity in regard to anti-kickback law and regulations. The federal anti-kickback statute outlaws offering or receiving anything of value in exchange for referring Medicare or Medicaid patients or for generating other business reimbursable under Medicare and Medicaid. Possible penalties for violation of this statute include fines and/or imprisonment as well as exclusion from future program participation (42 U.S.C. 1320a-7b). Congress intended

the anti-kickback statute to identify cases of legitimate fraud and abuse, but it did not intend for the statute to inhibit legitimate business practices. Accordingly, Congress directed that "to ensure that the regulations remain relevant in light of changes in health care delivery and payment and to ensure that published interpretations of the law are not impeding legitimate and beneficial activities...the Secretary [of HHS] will formally re-evaluate the anti-kickback regulations on a periodic basis" (House Committee Report accompanying PL 100-93, quoted in Federal Register, Vol. 58, No. 181, p. 49008).

In 1991, HHS issued ten "safe harbor" regulations outlining the activities in which providers may participate. Rather than providing clarification, the safe harbors were criticized for raising more questions than they answered. Critics argued that the safe harbors were so narrowly defined that they did not give providers the guidance they need (Hudson, 1991). In September 1993, HHS proposed eight new or expanded business arrangements that would not violate the law. Several of the newly proposed safe harbors might have implications for rural networks. The "Referral Agreements for Specialty Services" provision would allow a provider to refer a patient for specialty services in return for an agreement to refer the patient back at a future time under certain circumstances. The "Cooperative Health Services Organization (CHSO)" provision addresses CHSOs formed by two or more tax-exempt hospitals ("patron hospitals") to provide specially enumerated services such as purchasing, billing, and clinical services for the benefit of its patron hospitals. The safe harbor would protect payments from a patron hospital to a CHSO to support CHSO's

operational costs and those payments from a CHSO to a patron hospital that are required under IRS rules. The "Obstetrical Malpractice Insurance Subsidies" provision allows hospitals or other entities to pay all or part of the malpractice premiums for practitioners engaging in obstetrical practice in primary care professional shortage areas. Finally, HHS sought comments on the desirability of allowing rural hospitals to purchase existing medical practices as part of a practitioner recruitment program. Although the most recent set of safe harbor proposals provide more direction to rural providers than the first set, they still do not adequately address the newest and potentially most prevalent change in the health care industry's business practices -- the development of integrated delivery networks.

#### Conclusions and Recommendations

Medicare and Medicaid policies are difficult to change. A single policy change may require both Congressional and administrative action. Law-making and subsequent rule-making may take several years. Requests for waivers are difficult to prepare and the approval process can be extremely time-consuming. Nevertheless, we feel that Congress and HCFA should implement the following recommendations to improve the climate for integrated rural health network development.

- ***Revise Medicare risk contracting policies for rural areas*** to adjust rate setting for the distinctive characteristics of rural markets.
- ***Allow networks to receive Medicare and Medicaid non-risk payments on behalf of their members*** and distribute the funds to members according to the needs of the network.
- ***Clarify Medicare/Medicaid fraud and abuse safe harbors*** in regard to rural health networking activities.

## CONCLUSION

Rural health networks are widely discussed as a means of improving access and the quality of rural health care while reducing health care costs. However, the actual number of integrated rural health networks is small. Several rural health officials interviewed for this report stated that the rural health network development process has taken more time than they anticipated. One official concluded that his state had underestimated the factors involved in making networks operational. He noted that the establishment of rural health networks requires very fundamental changes in health care delivery and financing.

Although officials in the eight key states recognize the need to address the policy issues discussed in this report, for the most part they are just beginning to do so. A few states have made considerable progress in defining rural health networks, establishing formal designation processes, and providing incentives for network development. However, a number of states are still considering these issues, and much work remains to be done in several policy areas, notably the impact of state health insurance and HMO regulations on risk-bearing networks and network financing issues, including Medicare and Medicaid reimbursement. As policymakers address issues related to rural health network development, they should bear in mind the costs of developing networks, and their limitations as well as their potential. Networks may help improve the delivery and financing of rural health care, but they are not necessarily a panacea for all of the challenges facing health professionals and policymakers involved with assuring the accessibility and affordability of health care services in rural America.

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**APPENDIX**

**STATE OFFICIALS INTERVIEWED**



**Colorado**

Ms. Lindy Nelson, Director  
Rural and Primary Health Policy and Planning  
Colorado Department of Health

**Florida**

Ms. Jeannee Elswick-Morrison, Director  
Office of Rural Health and Migrant Affairs  
Florida Department of Health and Rehabilitative Services

**Kansas**

Mr. Richard Morrissey, Director  
Office of Local and Rural Health Systems  
Kansas Department of Health and Environment

**Minnesota**

Ms. Chari Konerza, Director  
Office of Rural Health  
Minnesota Department of Health

Additional information on antitrust and reinsurance issues was provided by David Abrams and Nanette Schroeder of the Minnesota Department of Health and John Gross of the Minnesota Department of Commerce

**New York**

Mr. Paul FitzPatrick, Director  
Office of Rural Health, Bureau of Health Planning and Policy Development  
New York Department of Health

**North Carolina**

Mr. Serge Dihoff, Health Care Consultant  
Office of Rural Health and Resource Development  
North Carolina Department of Human Resources

**Washington**

Ms. Kristina Sparks, Associate Director  
Office of Community and Rural Health  
Washington State Department of Health

**West Virginia**

Ms. Mary Huntley, Director  
Office of Rural Health Policy  
West Virginia Department of Health

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