EXPANDING MEDICARE COVERAGE IN RURAL HEALTH CLINICS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-FIFTH CONGRESS

FIRST SESSION

ON

S. 708 and S. 1877

TO AMEND TITLE XVIII OF THE SOCIAL SECURITY ACT TO PROVIDE PAYMENT FOR RURAL HEALTH CLINIC SERVICES

JULY 21, 1977

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EXPANDING MEDICARE COVERAGE IN RURAL HEALTH CLINICS

THURSDAY, JULY 21, 1977

U.S. SENATE,
SUBCOMMITTEE ON PUBLIC HEALTH
OF THE COMMITTEE ON FINANCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:30 a.m. in room 2221, Dirksen Senate Office Building, Hon. Herman E. Talmadge (chairman of the subcommittee) presiding.

Present: Senators Talmadge, Bentsen, and Dole.

Senator TALMADGE. The subcommittee will be in order.

The subcommittee will now turn its attention to the legislative question of expanded medicare coverage in rural health clinics. Specifically, the subcommittee will consider the Clark-Leahy bill, S. 708 and the Rostenkowski bill, H.R. 2504, introduced into the Senate by Senator Bentsen as S. 1877.

[The committee press release announcing this hearing and the bills S. 708 and S. 1877 follow:]

FINANCE SUBCOMMITTEE ON HEALTH TO HOLD HEARINGS ON EXPANDING MEDICARE COVERAGE IN RURAL HEALTH CLINICS

Senator Herman E. Talmadge, (D., Ga.), Chairman of the Subcommittee on Health of the Senate Finance Committee, announced today that the Subcommittee will hold a hearing on legislative proposals to expand Medicare coverage of services provided in rural health clinics located in medically-underserved areas.

The hearing will be held at approximately 10:30 A.M. on Thursday, July 21, 1977, in Room 2221 Dirksen Senate Office Building, immediately following Subcommittee consideration of testimony by the Comptroller General on the establishment of the Health Care Financing Administration by the Department of Health, Education, and Welfare. The Comptroller General's report will be made at 9:00 A.M.

Senator Talmadge said that he anticipates introduction in the Senate, early next week, of a revised version of the rural clinics proposal (H.R. 2504) sponsored by Congresman Dan Rostenkowski (D., Ill.), Chairman o fthe Subcommittee on Health of the Committee on Ways and Means. Senator Talmadge commented: "The Rostenkowski bill contains important perspectives dealing with Medicare payments to rural clinics which should be formally available for Subcommittee consideration."

Senator Talmadge stated that the other principal proposal to be considered would be the "Clark-Leahy" bill, S. 708. Invited witnesses include Senators Clark and Leahy, as well as representatives of the Administration.

Written statements.—Those individuals or organizations who desire to present their views to the Subcommittee should submit a written statement for inclusion in the record of the hearings These written statements should be submitted to Michael Stern, Staff Director, Committee on Finance, Room 2227 Dirksen Senate Office Building not later than August 1, 1977.

[S. 708, 95th Cong., 1st sess.]

A BILL To amend title XVIII of the Social Security Act to provide payment for rural health clinic serivces

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) section 1833 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(l) With respect to rural health clinic services, payment shall be made, on behalf of an individual, on the basis of costs reasonably related to providing such services or on the basis of such other tests of reasonableness as the Secretary may find appropriate. The provisions of subsection (b) shall not apply to this section.".

(b) Section 1861 of such Act is amended by adding at the end thereof the following new subsection:

"(aa)(1) The term 'rural health clinic services' means such services and supplies as would otherwise be covered (under subsection (c)(2)(A)) if furnished as an incident to a physician's professional service, and such additional services provided by a physician extender, furnished by a rural health clinic to an individual as a primary care patient.

"(2) The term 'rural health clinic' means a facility which—

"(A) is primarily engaged in providing rural health clinic services;

"(B) has an arrangement with one or more physicians under which provision is made for the regular review by such physicians of all medical services furnished by physician extenders;

"(C) provides for the preparation by the supervising physicians and physician extenders of medical orders for care and treatment of clinic patients, and the availability of such physicians for such referral and consultation for patients as is necessary, and for advice and assistance in the management of medical emergencies;

"(D) maintains clinical records on all patients;

"(E) has arrangements with one or more hospitals for the referral or admission of patients requiring inpatient services or such diagnostic or other specialized services as are not available at the clinic;

"(F) has written policies to govern the management of the clinic and all the services it provides;

"(G) has appropriate procedures or arrangements, in compliance with applicable State and Federal law, for storing, administering, and dispensing drugs and biologicals; and

"(H) has appropriate procedures for utilization review.

For purposes of this title, such term includes only a facility which is not located in an urbanized area (as defined by the Bureau of the Census) where the supply of medical services is not sufficient to meet the needs of individuals residing therein (including such rural areas as are designated by the Secretary as areas having medically underserved populations under section 1302(7) of the Public Health Service Act, and clinics that receive a majority of their patients from rural medically underserved areas).

"(3) The term 'physician extender' means a physician assistant, nurse practitioner, nurse clinician, or other trained practitioner who is certified as a physician's assistant by the National Commission on Certification of Physician's Assistants or its successor, or who is certified as an adult-family nurse practitioner by the American Nursing Association or its successor, and who is legally authorized to provide any physician services, as defined in section 1861(q), in the jurisdiction in which such services are provided.".

(c) Section 1862(a)(3) of such Act is amended by striking out "in such cases" and inserting in lieu thereof "in the case of rural health clinics, as defined in section 1861 (aa)(2), and in other cases".

(d)(1) Section 1861(s) of such Act is amended—

(A) by striking out "and" after the semicolon at the end of paragraph (8);

(B) by striking out the period at the end of paragraph (9) and inserting in lieu thereof "; and";

(C) by inserting after paragraph (9) the following new paragraph:

"(10) rural health clinic services."; and

(D) by redesignating paragraphs (10), (11), (12), and (13) as paragraphs (11), (12), (13), and (14), respectively.

(2) Section 1864(a) of such Act is amended by striking out "paragraphs (10) and (11)" and inserting in lieu thereof "paragraphs (11) and (12)".

(e) Section 1122(b)(1) of the Social Security Act is amended by inserting after the term "health care facility" the following: "(including a rural health clinic as defined in section 1861(aa)(2) of this Act)".

(f) The amendments made by this Act shall apply to services rendered on or after the first day of the third calendar month which begins after the date of enactment of this Act.

(g) Nothing in the amendments made by this Act shall be construed as superseding any State law regarding the use of physician extenders and the provision of health services.

[S. 1877, 95th Cong., 1st sess.]

A BILL To amend title XVIII of the Social Security Act to provide payment for rural health clinic services

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) section 1833 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(i) With respect to rural health clinic services, payment shall be made, on behalf of an individual, on the basis of costs reasonably related to providing such services or on the basis of such other tests of reasonableness as the Secretary may find appropriate.".

(b) Section 1861 of such Act is amended by adding at the end thereof the following new subsection:

"(aa)(1) The term 'rural health clinic services' means such services and supplies as would otherwise be covered (under subsection (s)(2)(A)) if furnished as an incident to a physician's professional service, and such additional services provided by a physician extender as he is legally authorized to provide in the jurisdiction in which he performs such services, furnished by a rural health clinic to an individual as an outpatient with respect to whom such services are periodically reviewed by a physician (as defined in section 1861(r)(1)).

"(2) The term 'rural health clinic' means a facility which—

"(A) is primarily engaged in providing rural health clinic services;

"(B) has an arrangement (consistent with the provisions of State and local law relative to the practice, performance, and delivery of health services) with one or more physicians under which provision is made for the periodic review by such physicians of all services furnished by physician extenders, the supervision and guidance by such physicians of physician extenders, the preparation by such physicians of such medical orders for care and treatment of clinic patients as may be necessary, and the availability of such physicians for such referral of patients as is necessary and for advice and assistance in the management of medical emergencies;

"(C) maintains clinical records on all patients;

"(D) has arrangements with one or more hospitals for the referral and admission of patients requiring inpatient services or such diagnostic or other specialized services as are not available at the clinic;

"(E) has policies, which are developed with the advice of (and with provision for review of such policies from time to time) a group of professional personnel, including one or more physicians and one or more physician extenders, to govern the services referred to in subparagraph (A) which it provides;

"(F) has a physician or physician extender responsible for the execution of such policies relating to the provision of the clinic's services;

"(G) directly provides routine diagnostic services, including clinical laboratory services, and has prompt access to additional diagnostic services from facilities meeting requirements under this title;

"(H) has appropriate procedures or arrangements, in compliance with applicable State and Federal law, for storing, administering, and dispensing drugs and biologicals; and

"(I) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are furnished services by the clinic.

For purposes of this title, such term includes only a facility which (i) is located in a rural area where the supply of medical services is not sufficient to meet the needs of individuals residing therein (including such rural areas as are designated by the Secretary as areas having medically underserved populations under section 1302(7) of the Public Health Service Act), (ii) is not a physician-directed clinic under direct personal physician supervision, and (iii) has filed an agreement with the Secretary by which it agrees not to charge any individual

or other person for items or services for which such individual is entitled to have payment made under this title, except for the amount of any deductible or coinsurance amount imposed, with respect to such items or services, pursuant to subsection (a) and (b) of section 1833.

"(8) The term 'physican extender' means, for the purposes of this subsection, a physician's assistant, medex, nurse practitioner, or any other such practitioner who performs, under the supervision of a physician (as defined in section 1861 (r)(1)), such services, as he is legally authorized to perform (in the State in which he performs such services) in accordance with State law (or the State regulatory mechanism provided by State law) and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.".

(c) Section 1862(a)(3) of such Act is amended by striking out "in such cases" and inserting in lieu thereof "in the case of rural health clinics, as defined in section 1861(aa)(2), and in other cases".

'd)(1) Section 1861(s) of such Act is amended—

(A) by striking out "and" after the semicolon at the end of paragraph (8);

(B) by striking out the period at the end of paragraph (9) and inserting in lieu thereof "; and";

(C) by inserting after paragraph (9) the following new paragraph:

"(10) rural health clinic services."; and

(D) by redesignating paragraphs (10), (11), (12), and (13) as paragraphs (11), (12), (13), and (14), respectively.

(2) Section 1864(a) of such Act is amended by striking "paragraphs (10) and (11)" and inserting in lieu thereof "paragraphs (11) and (12)".

(e) The amendments made by this Act shall apply to services rendered on or after the first day of the third calendar month which begins after the date of enactment of this Act.

Senator TALMADGE. Most of these bills call for medicare reimbursement on a cost basis to rural clinics which make extensive use of the services of physician assistants and nurse practitioners.

I should point out that extensive hearings have been held by other committees on the subject before us. The House Ways and Means Committee held hearings earlier this year on rural clinic proposals. A subcommittee of the Senate Agriculture Committee some months ago held a nonlegislative hearing on the question of reimbursement of rural clinics, so a substantial body of testimony is now available to the Finance Committee and to the Congress generally.

The witnesses this morning will help summarize the concerns and issues surrounding the question of appropriate reimbursement to appropriate rural clinics.

Our first witnesses this morning will be Senators Clark and Leahy who serve on the Agriculture Committee with me. Senator Clark is chairman of the Rural Development Committee. Both of them have been extremely interested in trying to make health care available for people in rural areas and have held extensive hearings, both here in Washington and outside Washington in their areas.

Before we proceed, I would like to submit a statement from Senator Dole for the record. It will be inserted in full.

[The prepared statement of Senator Bob Dole follows:]

STATEMENT OF SENATOR BOB DOLE

Over the past decade, the Department of Health, Education, and Welfare, in addition to other Federal agencies, has provided substantial financial support for programs to educate nurse practitioners and physicians assistants. Support of these programs was forthcoming in response to the documented and increasingly critical need for health manpower personnel in designated service short-

age areas. While the need was recognized, the actual utilization, deployment and reimbursement of these professionals has not been decided upon.

In my own State of Kansas, the delivery of health care to those who reside in rural areas is an issue of vital importance. At this time, to the best of my knowledge, the majority of nurse practitioners and physician assistants are working in physician offices or in county health department clinics. Legislation permitting their utilization outside of these settings has not been enacted in the State. Because of this, I am very concerned with the type of clinics eligible for reimbursement.

I believe our concern should be for those citizens who are prevented from receiving health care because of their location. We have available to us physicians, nurse practitoners, and physician assistants who wish to work to alleviate this problem. I welcome the discussion today, of legislation, that is designed to make accessible those resources we so desparately need.

Senator TALMADGE. Senator Clark, we are delighted to have you and Senator Leahy. You may proceed in any manner that you see fit.

STATEMENT OF HON. DICK CLARK, A U.S. SENATOR FROM THE STATE OF IOWA

Senator CLARK. Thank you very much, Mr. Chairman. Let me say at the outset that we are very grateful to you as chairman for scheduling these hearings. The hearings are on S. 708 and the other bills as filed to permit medicare reimbursement for rural health clinics staffed by nurse practitioners and physician assistants

On several occasions during the past year, as you said in your opening statement, you encouraged Senator Leahy and me to explore this matter through hearings by the Senate Rural Development Subcommittee and indicated at that time that you would be holding hearings in this subcommittee, so we are very pleased at your encouragement and at what has occurred so far in terms of building a record for the importance of this legislation.

Over the course of this past year and a half, Senator Leahy and I have explored the problems rural Americans face in getting access to primary health care services.

Our inquiry began in February 1976 with hearings in Vermont chaired by Senator Leahy. Last October, we took the Rural Development Subcommittee to my home State of Iowa where we held public hearings in six different areas of the State. Our study continued with our hearing here in Washington in March of this year, at which time we gathered testimony for this legislation.

I would like to provide the Senate subcommittee members with copies of these three hearings, which I have in hand here this morning. I will leave them for the record.

Senator TALMADGE. They will be filed for the membership and will be available for all members of the subcommittee.[1]

Senator CLARK. In addition, I have summaries and a series of recommendations with regard to this legislation. In each of these hearings we discovered a persistent obstacle confronting rural Americans in their present effort to obtain basic health care services. The obstacle is a medicare policy requiring a physician to directly supervise the services provided by physician assistants and nurse practitioners.

[1] The three hearings referred to were made a part of the official committee file.

[The following was subsequently supplied for the record:]

[Congressional Record, 95th Congress, first session, vol. 123, No. 91, Washington, Thursday, May 25, 1977]

Senate

RURAL HEALTH HEARING

Mr. CLARK. Mr. President, on March 29, the Senate Rural Development Subcommittee conducted a hearing in Washington on the subject of medicare reimbursement for rural health clinic services. The hearing was a useful tool to gage the impact of a restrictive medicare policy upon health care delivery in small towns and rural areas.

Witnesses from every corner of the Nation told the subcommittee that medicare should permit payment for primary care services provided by nurse practitioners and physician assistants. Their testimony, and that submitted by hundreds of persons from across the country, gave us a better understanding of the type of corrective legislation that is needed to remove a clear inequity from the medicare program.

In order to assist the Senate Finance Committee in it deliberations on this matter, my staff has written a report that summarizes the proceedings of the March 29 hearing. The report concludes with several recomendations for changes in S. 708, a bill that Senator Leahy and I have introduced and that now has 51 other cosponsors.

The major recommendations are:

First. The term "physician extender" should be changed to "primary health care practitioner."

Second. Payment for rural health clinic services should go to the person or entity with responsibility for the provision of clinic services.

Third. Payment should be allowed for primary care services provided by physicians, in addition to those provided by primary health care practitioners.

Fourth. The term "clinic" should also encompass physician practices that utilize primary health care practitioners either onsite or in satellite settings.

Fifth. Provisions that deal with physician supervision should be clarified to emphasize that it involves arrangements for protocols for medical care and treatment and periodic review of medical services.

I ask unanimous consent that the entire report be printed in the Record, so that my colleagues will benefit from the insights we gained through the rural health hearing.

There being no objection, the report was ordered to be printed in the Record, as follows:

SUMMARY AND RECOMMENDATIONS OF THE SENATE RURAL DEVELOPMENT SUBCOMMITTEE HEARING ON RURAL HEALTH CLINICS

SUMMARY

Background

Field hearings by the Senate Rural Development Subcommittee conducted in Iowa and Vermont last year disclosed a common problem with health care in rural communities. Small clinics staffed by nurse practitioners and physician assistants are not reimbursed for their services by Medicare. As a result, these clinics, whose income will always be marginal, may have to close when private and public sources of funding end. For some clinics in Appalachia and the South, that day will come this year.

S. 708 would amend the Medicare Act, Part B, Supplemental Medical Insurance to include rural clinic services. The key elements of the bill are as follows:

1. The clinic itself, rather than any particular provider within the clinic, would be reimbursed for primary health care services.

2. The reimbursement would be based upon the costs—rather than charges—of providing those services.

3. While S. 708 does not require the continual presence of a physician at the clinic it does allow reimbursement to clinics where physicians and other primary health care practitioners are simultaneously providing care.

4. The clinic must serve a rural, medically underserved population.

Dick Warden, speaking for the Department of Health, Education and Welfare, pointed out that in most states, the supply of physicians concentarte in Standard Metropolitan Statistical Areas (SMSA's). Figures collected by the Department show that of the 45.7 million persons who live in areas designated as medically underserved, 31.6 million—or fully two-thirds—live outside SMSA's. Others noted that urban residents of such areas experience inconvenience, but travel is not as great a problem as it is for rural residents of underserved areas.

To address the problem, over 500 of the 3400 rural medically underserved areas have organized small clinics with the help of public and foundation grants. Urban areas have an additional 225 clinics. These clinics are staffed by nurse practitioners and physician assistants who are trained to provide primary health care under some type of physician supervision. In some clinics, doctors also staff the clinics.

Vernon Wilson, Vice Chancellor for Medical Affairs of Vanderbilt University, challenged the DHEW suggestion that urban be included within this legislation. Speaking from Tennessee's experience with 70 such clinics, Wilson felt "that in fact rural clinics take a different kind of approach to the medical care problems; and to confuse the two would wind up doing neither as well as it should be."

Others, speaking on behalf of the "rural only" position, cited experience with other federal programs that permit urban and rural mix. In those cases the sophistication of users of urban programs helps them to get most of the benefits.

One physician, Dr. Corbett, who is practicing a network of rural Virginia clinics, explained that Medicare should pay for what is provided, not who provides it. In his opinion reimbursing both urban and rural clinics would increase the supply of care in the cities and force the physicians to move out to the more rural areas in order to avoid intense competition. Ms. Dykstra, a nurse practitioner, cited the North Carolina experience to counter this suggestion.

Opponents of urban also cited the need for more and tighter regulations if urban clinics were included, referring to the recently publicized information on "Medicaid Mills." Dr. Fickel, a practicing Iowa physician pointed out that "a satellite in the city is not a good thing; there is too much temptation for over-utilization."

Definition

The terms "physician extender," "supervision" and "clinic' drew heavy reaction. None of the professional groups liked the term "physician extender." Alternatives proposed were: "nurse practitioner and physician assistant," "clinical nurse practitioner and nurse clinician," "health care practitioners," and "non-physician primary health providers."

The term "supervision" stirred mixed reactions. In all of the states, in all of the clinics represented, there was some physician participation in the care rendered by extenders. In none were the physicians required to be physically present when services were rendered, directly overseeing the care provided. Yet participation of both the physician and the physician extender in the preparation of protocols, or standing orders, was favored by all the witnesses, except the representatives of the AMA, Edgar Beddingfield, M.D. In his opinion, the protocols would be prepared by the physician. Many of the witnesses pointed out that some of the services provided are nursing services, that can legally be offered without physician supervision. All agreed that the bill should in no way require direct oversight by physicians of all care needed in the clinics.

All of the witnesses were in favor of insuring that the clinics exercised some type of quality control. Many suggested internal audits, or audits conducted by local teams. Several echoed the recommendation of Eugene Corbett that the physician should be available to the clinic when help was needed. Dr. Ewell from Oregon included for the record the standards for his state, which spell out the type of relationship between the nurse practitioner and the method of quality control to be applied.

The question most frequently asked about the word "clinic" was whether or not it was intended to include a private physician's office. None of the witnesses objected to the specific requirements for clinic services, except the American Medical Association, which argued that this was creating a new and artificial provider. Instead, AMA asked that the bill simply expand the definition of physician to include the services of nurse practitioners and physicians assistants provided under the supervision of physicians.

Clinic sizes

Representatives testifying on behalf of clinics cited towns of 5,000 and fewer in size. Oregon and Georgia representatives told of repeated attempts to attract and hold physicians in such towns, only to lose them to others that had hospitals and could support group practices. Iowans repeated the story and the nurse practitioners from Vermont stressed the fact that most of the care that was needed in these sparsely settled areas was of the nature that was best handled by a non-physician. Bob Ewell from Oregon confirmed their suggestion, pointing out that the utilization of the small clinics in Oregon actually increased when physicians were replaced by nurse practitioners, because the care became more appropriate to the setting. The distance to nearby and referring physicians ranged from 10 to 80 miles, increasing as the terrain became less a barrier. All of the clinics reported high populations of elderly patients—18 to 30 percent.

Impact

Faye Henning, a nurse practitioner from Georgia and Sally Sundberg, a consumer from Iowa, reflected one of the clinics' major benefits—care closer to home caused people to use more preventive health care services. Others suggested that this resulted in less frequent hospitalization among clinic users. John Runyan, M.D., of Tennessee, confirmed this with data from 26 clinics in Shelby County. His data compare favorably with date from both Kentucky's Frontier Nursing Service and the Los Angeles County Health Department.

Cost of Care

Average costs per visit reported by the witnesses were in the $10 to $15, with the higher costs reflecting inclusion of laboratory and prescription services. Most of the witnesses favored the cost-related reimbursement. However, Senator Bellmon proposed that the current Medicare rates be continued and increased from 80 percent to 115 percent for providers in rural medically underserved areas, as an incentive to attract practitioners.

Offering the benefit of their experience with cost reimbursement, Steve Canfield of UMW and Oliver Fifield of New Hampshire-Vermont Blue Cross/Blue Shield both agreed that this could be done with a minimum of paperwork. In the past year, Fifield has been reimbursing two clinics in Vermont on this basis. UMW has been in the business for 20 years, and from that experience, Mr. Canfield made several suggestions for controls on this type of reimbursement, i.e., including:

1. Compensation for personnel should be adequate to retain them in the rural area.
2. The reimburser must have productivity standards—low productivity is the major hazard with this type of reimbursement.
3. Eligible costs should include continuing education, recruitment and quality control.

Cost of S. 708

The cost to implement this bill would vary with both the number of clinics and the scope of eligible areas. If it is confined, as written, to rural medically underserved areas, the FY 1977 cost would be $20 million, according to estimates from the Social Security Administration. By 1982, the number of clinics would be expected to increase to 950, and the costs to $60 million. If the DHEW recommendations to include urban MUA clinics is accepted, the FY 1977 cost would be $25 million for 725 clinics, and the number of clinics would increase to 1,952 by 1982, costing $115 million.

Both estimates took into consideration the fact that physicians' offices would want to qualify as "clinics" and apply for cost reimbursement.

Recognition of Physician Extenders

The two exams proposed for credentialling of physician extenders under the bill troubled a number of the witnesses. Nurse practitioners complained that the ANA exam is given infrequently, only in major population centers, and excludes those who have not specifically trained as family or adult practitioners (such as pediatric nurse practitioners). Physician assistants were content with the American Academy of Physicians Exams, but were concerned that they

would not be eligible for reimbursement until the date they passed the exam. Most witnesses favored deference to state laws in this regard. An exception was DHEW, which preferred criteria set by the secretary. All witnesses supported the concept of some minimum standards.

Other Suggestions

Many of those who testified requested that home visits and nursing home visits be included as eligible for reimbursement when performed by a nurse practitioner or physician assistant.

RECOMMENDATIONS

The March 29 hearing allowed the Rural Development Subcommittee to hear from citizens on ways in which S. 708 should be improved. We conclude that S. 708 should be enacted as a separate piece of legislation, distinct from other Medicare reform legislation, and exclusively directed to rural, medically underserved Americans.

We further recommend that S. 708 be modified, or committee report language be included, to clarify the following issues:

1. Throughout the bill, the term "physician extender" should be replaced by "primary health care practitioner".

2. Report language pertaining to page 1, lines 6 and 7, should state that payment for rural health clinic services should go to the person or entity with responsibility for the provision of clinic services.

3. Page 2, lines 5 through 11 should allow payment for primary care services provided by physicians, in addition to those provided by primary health care practitioners.

4. Page 2, line 12, should be clarified in report language, so that a "clinic" would also encompass physician practices that utilize primary health care practitioners either on site or in satellite settings.

5. Provisions on page 2, lines 16 through 25, that deal with physician supervision should be retained, but clarified in report language to emphasize:

(a) That supervision would not require the physical presence of a physician where care is rendered; and

(b) That supervision should take the form of arrangements for standard orders for medical care and treatment and periodic review of medical services.

6. The bill should be amended on page 3, line 22, to state that clinics receiving reimbursement in areas that lose their designations as "medically underserved" should continue to receive reimbursement.

7. The bill should be amended on page 4, line 6, in the following two ways:

(a) Reimbursement for primary health care practitioner services should be permitted prior to full certification of the practitioner, in states where services may be provided by those practitioners; and

(b) The Secretary should review the certification requirements one year from the date of passage, and if necessary to insure high quality health care, set new standards of eligibility.

Senator CLARK. The policy may not be so burdensome in many cities where an abundant supply of physicians exist in some cases. However, in remote rural areas, the policy constitutes a tremendous barrier.

Access to medical services is a serious problem in sparsely populated areas, and the presence of clinics staffed by physician assistants and nurse practitioners fills a gap caused by the declining number of practicing physicians.

The medicare policy blocks the use of these clinics by many medicare recipients. It is a severe problem in medically underserved areas throughout the country as evidenced by hundreds of supportive letters that we have received on S. 708.

The Department of Health, Education, and Welfare has determined that 31.6 million Americans reside in medically underserved small towns and rural areas. 70 percent of all medically underserved Americans live in these rural areas.

It is the responsibility of the Federal Government not only to pursue policies that expand access to primary health services for these citizens, such as through our health manpower programs, but also to insure that our Federal health insurance programs do not constitute barriers to health care.

I firmly believe that the problem of getting basic health services to small towns and rural areas will never be resolved unless this legislation is enacted. The longer we delay, the longer rural senior citizens must pay out of their own pockets for the same services that urban residents depend upon medicare for.

Furthermore, communities that want and need health centers staffed by nurse practitioners will continue to be discouraged from pursuing this approach and will continue to have no local source of primary health care. For these reasons, I am very pleased that Congress is moving closer toward enacting legislation along the lines of S. 708—55 Senators are now cosponsors of S. 708, including 7 members of the Finance Committee.

I want to note the special contribution of Senator Nelson, of this committee, who brought to the Senate's attention in 1972 and the need for medicare reimbursement under the services of physician assistants.

I know that Senator Bentsen has been particularly interested as well in this legislation, as Chairman Talmadge has said earlier.

There are several recommendations that I would like to propose that relate to specific provisions of S. 708 and of the bill that was reported on Tuesday by the House Ways and Means Health Subcommittee. In order to save time, these specific proposals shall be submitted to you for the record.

[The following was subsequently supplied for the record:]

[Congressional Record, 95th Cong., first session, vol. 123, No. 25, Washington, Thursday, Feb. 10, 1977]

Senate

RURAL HEALTH CLINIC BILL

By Mr. CLARK (for himself, Mr. Leahy, Mr. Abourezk, Mr. Bayh, Mr. Bumpers, Mr. Burdick, Mr. Church, Mr. DeConcini, Mr. Gravel, Mr. Hart, Mr. Haskell, Mr. Hathaway, Mr. Heinz, Mr. Huddleston, Mr. Humphrey, Mr. Inouye, Mr. Kennedy, Mr. Matsunaga, Mr. McGovern, Mr. McIntyre, Mr. Metcalf, Mr. Randolph, Mr. Riegle, Mr. Stafford, Mr. Zorinsky, Mr. Pearson, and Mr. Mathias):

S. 708. A bill to amend title XVIII of the Social Security Act to provide payment for rural health clinic services; to the Committee on Finance.

Mr. CLARK. Mr. President, today Senator Leahy, and I are joined by 24 cosponsors in introducing legislation giving rural Americans greater access to primary health services.

The bill would change an existing medicare regulation that prohibits reimbursement to clinics that lack full-time physicians. It would allow the use of medicare funds for small, rural health clinics that use physician extenders to provide primary care and treatment to citizens who generally lack other sources of basic health care.

During field hearings by the Senate Rural Development Subcommittee over the last year—in Vermont and Iowa—we learned that this medicare policy represents the single most serious obstacle to health services for rural Americans.

As we all know, rural America is losing its primary care physicians. The country doctor has disappeared with the horse and buggy. Many of the doctors who still practice are approaching retirement, leaving thousands of small communities and millions of Americans with no alternative but to travel many miles to larger cities to receive health services.

Furthermore, despite a recent trend among medical school graduates to practice in family medicine, the overwhelming majority of young physicians are not attracted to remote rural areas. They correctly recognize that solo practice in a small rural community often means overwork, fewer opportunities for professional consultation and continuing education, and lack of access to well-equipped hospitals.

Thousands of communities throughout the country are relying upon the services provided by physician extenders in rural health clinics. The populations of these areas are insufficient to financially support a full-time physician, but they are able to support a small primary care clinic staffed by a primary care provider with back-up supervision by a physician.

Most of these practitioners, or physician extenders, are nurse practitioners or physician's assistants. Reports and studies have come to near-unanimous agreement that they not only provide high quality health care, but they are also likely to locate in smaller communities.

The clinics where the extenders work have several benefits. First, the extenders tend to emphasize preventive health care. They educate patients about proper nutrition and other self-help techniques, in order to prevent the necessity for care by a physician or hospital personnel. In these remote areas, where one extender is responsible for the health of hundreds or even thousands of people and where physician and hospital care is not readily accessible and costly to use, maintaining good health is a necessity.

Second, rural health clinics become the first step of a health system. Most extenders are, and should be, linked to a physician and to a hospital to which they can refer patients with critical health problems. Other patients with a routine problems are not required to go to a physician, and they are thereby saved the extra cost of transportation and physician care. As a result, extender-staffed clinics are cost-efficient and make sense in terms of the organization of a health system.

However, rural Americans receiving care in these primary care clinics are penalized because medicare will not reimburse for extender services unless a physician is physically present during the provision of health services. The effect of this policy is to completely exclude from reimbursement the satellite clinics which are increasingly prevalent in areas. While physicians do provide general supervision of the extender services, they naturally are unable to physically oversee those services on an hour-to-hour basis.

I ask unanimous consent that a chart illustrating how the medicare program discriminates against rural America be reprinted in the Record.

There being no objection, the table was ordered to be printed in the Record, as follows:

AMOUNT OF PART B MEDICARE BENEFITS PAID PER BENEFICIARY BY STATE: FISCAL 1976

State	Benefits	Percent of population rural, 1970	State	Benefits	Percent of population rural, 1970
District of Columbia	$439.02	0	Montana	$160.49	46.6
Hawaii	334.53	16.9	Alaska	156.26	51.6
California	325.45	9.1	North Carolina	154.47	55.0
New York	293.83	14.4	Maine	154.22	49.2
Nevada	284.35	19.1	New Hampshire	147.98	43.6
Arizona	251.24	20.4	Indiana	146.82	35.1
Florida	250.94	19.5	Arkansas	146.21	50.0
Massachusetts	241.67	15.4	South Carolina	143.16	52.4
Rhode Island	236.98	12.9	Nebraska	142.59	38.5
Michigan	220.28	26.2	Illinois	137.28	17.0
Colorado	215.78	21.5	Idaho	135.91	45.9
Connecticut	214.92	22.6	Iowa	131.91	42.8
Oregon	211.34	32.9	Kentucky	130.91	47.7
Maryland	210.66	23.4	South Dakota	124.74	55.4
Ohio	210.40	24.7	Wyoming	113.05	39.5

Sources: Bureau of the Census and Office of Research and Statistics, Social Security Administration.

Mr. CLARK. This chart ranks States by the average amount of medicare medical insurance benefits paid to each beneficiary in fiscal 1976. While none of the 15 highest ranking States have populations that exceed one-third rural, all but one of the 15 lowest ranking States have significant rural populations.

The range of benefits between States is extraordinary. Average benefits in the District of Columbia, which is 100 percent urban, are 3.5 times as large as those in South Dakota, which is 45 percent urban.

There are several possible explanations for the evident urban bias of the medicare program. But surely one important reason is the fact that rural health clinics using extenders are not reimbursable.

This medicare policy conflicts with several Federal health programs that support the training of nurse practitioners and physician's assistants. The Federal Government also provides startup grants to health clinics that utilize extenders through the Appalachian Regional Commission, rural health initiative, and migrant health centers programs.

Secretary of Health, Education, and Welfare Joseph Califano identified this problem in a report to President Carter entitled "American Families: Trends, Pressures, and Recommendations". Among several examples of policies that Secretary Califano considered to have an adverse impact on American families was the "narrow range of medical benefits and health personnel which are reimbursable under medicaid and medicare."

Califano stated:

"The Appalachian Regional Commission sponsors 'physician extender clinics' in isolated rural areas but Medicare reimbursement is not permitted."

He also cited the examples of the HEW's rural health initiative and Robert Wood Johnson Foundation clinics, which face financial problems because of the medicare extender policy.

The policy not only discriminates against rural citizens in communities that have such clinics, it also discourages the establishment of additional clinics in medically underserved areas. I reecntly received a letter from a resident of the town of Albert City, Iowa—population 183—typical of communities across the Nation that are searching for some solution to their lack of health services. The letter, which I ask unanimous consent be printed, summarizes the problems as follows:

"It now seems financially impractical for these doctors to hire a physicians assistant, thereby leaving the Albert City community without any medical services whatsoever. It seems most confusing to a rural community trying to secure medical services when a department of the government, mainly HEW encourages rural health care through a physicians assistant type of service and on the other hand disallows payment of Medicare funds."

There being no objection, the letter was ordered to be printed in the Record, as follows:

ALBERT CITY ELEVATOR,
Albert City, Iowa

HON. DICK CLARK,
Russell Building,
Washington, D.C.

DEAR SIR: The small rural community of Albert City, Iowa, is located in Northwest Iowa, approximately 35 miles from Storm Lake, Iowa, which is the county seat and also where the hospital serving our community is located. For several years, efforts have been made by our community organizations to secure the services of medical service for our community. During the last six months we have made an arrangement with a group of doctors from Storm Lake to establish a Satellite Clinic in our town, providing us with part time medical services. As of February 1st, these doctors, as a result of losing some doctors in their practice will be unable to serve our community any longer. Therefore, again leaving us without medical service for our community.

However, we have been successful in recruiting a physicians assistant to move to the Albert City community as of February 1, 1977, working in conjunction with and for the Storm Lake doctors. The physicians assistant is to live in Albert City and to provide full time coverage with back up and supervisory service from the Storm Lake doctors on a part time basis.

Now for the problem. The problem has come up, due to HEW regulations forbidding payments to a physicians assistant of Medicare or Medicaid funds. It now seems financially impractical for these doctors to hire a physicians assistant, thereby leaving the Albert City community without any medical services whatsoever. It seems most confusing to a rural community trying to secure medical services when a department of the government, mainly HEW encourages rural health care through a physicians assistant type of service and on the other hand disallows payment of Medicare funds.

It is therefore imperative and most urgent for this law to be changed in order that our community is able to recruit and secure the services of this type of medical service for our community. Your early and urgent assistance in this matter will be much appreciated by the Albert City community.

If there is any way that we can provide other supportive assistance in securing proper legislation, feel free to call on us. I remain,

Sincerely yours,

BRUCE G. ANDERSON,
Member of The Albert City
Clinic Committee.

Mr. CLARK. Mr. President, the bill we are introducing today would amend title XVIII of the Social Security Act to allow medicare, part B, reimbursement for the primary health services provided by rural clinics. Payment would be based on the costs associated with the provision of these services. This would avoid the fee-for-service reimbursement mechanism that encourages expensive crisis care, and at the same time permit reimbursement for health-related costs of operation.

The reimburseable services would consist of all primary care services and supplies that would be covered if they were furnished by a physician, in addition to others that are provided by a physician extender.

Clinics would be required to meet several criteria beyond providing primary health services in order to qualify for medicare reimbursement. Among the requirements are:

First, an arrangement for the regular review by physicians of all medical services;

Second, the preparation by the supervising physician and physician extender of medical orders for care and treatment;

Third, the availability of physicians for referral and consultation purposes and for advice and assistance in emergencies;

Fourth, clinical records for all patients;

Fifth, arrangements for referral or admission of patients into hospitals;

Sixth, written management policies;

Seventh, procedures for storing, administering, and dispersing of drugs; and

Eighth, procedures for utilization review.

All of the above requirements are intended to insure that medicare dollars are used to provide high-quality health services to beneficiaries. They also promote the existence of a health system involving clinics, physicians, and hospitals.

The bill addresses the problem where it is most acute—in rural areas. While there are undoubtedly medically needy Americans living in large cities, these people are more likely to have access to such alternatives as extender-staffed clinics with full-time supervising physicians, hospital outpatient clinics, and federally sponsored health maintenance organizations and neighborhood health centers.

Our definition of "rural" is broad enough to include all areas in the United States that would be generally accepted as rural in size and by nature. Only communities of 50,000 or more inhabitants, and their closely settled "fringes," would be excluded because they would be considered urban.

The other prerequisite would be that the area's supply of medical services is insufficient to meet the needs of its residents. At the minimum, this definition would include all rural areas that have been designated by HEW as "medically underserved." Using our definition of rural, at least 35 million Americans live in areas that would qualify for reimbursement.

This bill uses the term "physician extender" to signify the types of primary health providers that work in rural health clinics. While this currently is the most generally used term, we ought to explore other possible ways to clearly denote the concept of a primary health practitioner. The bill would define "physician extender" as one who is certified as an adult-family nurse practitioner by the American Nursing Association or as a physician's assistant by the National Commission on Certification of Physician's Assistants. Nothing in the bill would supersede any State law or policy regardng either the use of extenders or the provision of health services.

We are hopeful that the Senate Finance Committee will soon give its close attention to this matter, perhaps as a part of its consideration of changes in the mode of reimbursement under medicare. Rural Americans are looking to Congress for assistance, and the principle of equity demands that we respond promptly to their pleas.

I ask unanimous consent that this bill be printed in the RECORD, in addition to a transcript of a recent segment of the CBS Evening News, that brilliantly illustrates the basic problems of rural health care.

There being no objection, the bill and transcript were ordered to be printed in the RECORD, as follows:

S. 708

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) section 1833 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(i) With respect to rural health clinic services, payment shall be made, on behalf of an individual, on the basis of costs reasonably related to providing such services or on the basis of such other tests of reasonableness as the Secretary may find appropriate. The provisions of subsection (b) shall not apply to this section.".

(b) Section 1861 of such Act is amended by adding at the end thereof the following new subsection:

"(aa)(1) The term 'rural health clinic services' means such services and supplies as would otherwise be covered (under subsection (s)(2)(A)) if furnished as an incident to a physician's professional service, and such additional services provided by a physician extender, furnished by a rural health clinic to an individual as a primary care patient.

"(2) The term 'rural health clinic' means a facility which—

"(A) is primarily engaged in providing rural health clinic services;

"(B) has an arrangement with one or more physicians under which provision is made for the regular review by such physicians of all medical services furnished by physician extenders:

"(C) provides for the preparation by the supervising physicians and physician extenders of medical orders for care and treatment of clinic patients, and the availability of such physicians for such referral and consultation for patients as is necessary, and for advice and assistance in the management of medical emergencies;

"(D) maintains clinical records on all patients;

"(E) has arrangements with one or more hospitals for the referral or admission of patients requiring inpatient services or such diagnostic or other specialized services as are not available at the clinic;

"(F) has written policies to govern the management of the clinic and all the services it provides;

"(G) has appropriate procedures or arrangements, in compliance with applicable State and Federal law, for storing, administering, and dispensing drugs and biologicals; and

"(H) has appropriate procedures for utilization review.

For purposes of this title, such term includes only a facility which is not located in an urbanized area (as defined by the Bureau of the Census) where the supply of medical services is not sufficient to meet the needs of individuals residing therein (including such rural areas as are designated by the Secretary as areas having medically underserved populations under section 1302(7) of the Public Health Service Act, and clinics that receive a majority of their patients from rural medically underserved areas).

"(3) The term 'physician extender' means a physician assistant, nurse practitioner, nurse clinician, or other trained practitioner who is certified as a physician's assistant by the National Commission on Certification of Physician's Assistants or its successor, or who is certified as an Adult-Family Nurse Practioner by the American Nursing Association or its successor, and who is legally authorized to provide any physician services, as defined in section 1861(q), in the jurisdiction in which such services are provided."

(c) Section 1862(a)(3) of such Act is amended by striking out "in such cases" and inserting in lieu thereof "in the case of rural health clinics, as defined in section 1861(aa)(2), and in other cases".

(d)(1) Section 1861(s) of such Act is amended—

(A) by striking out "and" after the semicolon at the end of paragraph (8):

(B) by striking out the period at the end of paragraph (9) and inserting in lieu thereof "; and";

(C) by inserting after paragraph (9) the following new paragraph:

"(10) rural health clinic services"; and

(D) by redesignating paragraphs (10), (11), (12), and (13) as paragraphs (11), (12), (13), and (14), respectively.

(2) Section 1864(a) of such Act is amended by striking out "paragraphs (10) and (11)" and inserting in lieu thereof "paragraphs (11) and (12)".

(e) Section 1122(b)(1) of the Social Security Act is amended by inserting after the term "health care facility" the following: "(including a rural health clinic as defined in section 1861(aa)(2) of this Act)".

(f) The amendments made by this Act shall apply to services rendered on or after the first day of the third calendar month which begins after the date of enactment of this Act.

(g) Nothing in the amendments made by this Act shall be construed as superseding any State law regarding the use of physician extenders and the provision of health services.

CBS EVENING NEWS WITH MORTON DEAN

DEAN. Some of the good life in rural America is not so good anymore. The reason—the country doctor is an endangered species. Joan Snyder, CBS News, Clairfield, Tenn., reports.

JOAN SNYDER. He drives many miles a day over winding mountain roads to reach the people who need him. Jesse Walker, a country doctor practicing in Appalachia, a rare breed. The problem is: his kind of doctor is much too rare.

JESSE WALKER, M.D. Here in this section, I think it's about the same as it is all over the country. We have a problem getting not only doctors but other professionals also to come to the rural areas.

SNYDER. Government figures show that 35-million Americans living in rural areas are medically under-served, with too few doctors or none at all.

The little town of Walnut, Mississippi, has a fully equipped clinic, but it's silent and empty. The town can't find a doctor to work here. Since the last doctor left, after only a brief stay, this part of northeastern Mississippi has been among 700 areas defined as having a critical shortage of health care, many of them unable to attract doctors because of their isolation, lack of cultural and educational facilities, and the long working hours of a country practitioner.

GATHA JUMPER [Chmn, N.E. Mississippi Devel. Corp.]. Some people get here sick and they don't have anywhere to turn to. And we need doctors here to treat our sick just like they do anywhere else in the United States.

SNYDER. But this year, in one of the neediest areas, Appalachia, the situation may get even worse. Thirty-nine health care clinics are coming to the end of a five-year funding period, provided by the government's Appalachian Regional Commission, and may be forced to shut down if they can't find money elsewhere. That would leave some of the most isolated and impoverished Americans without medical attention, like the more than 4,000 people served by two clinics in eastern Tennessee and Kentucky—coal mining country—where many mines have played out, deepening the poverty of the residents whose shacks often have no running water or indoor plumbing.

Many Appalachians have chronic diseases like heart trouble, diabetes and respiratory infections. Before the clinics opened people had to drive long distances over the mountains to find medical care—a difficult or impossible trip in bad weather. Clinic patients are afraid those days will return.

QUESTION. And how would you feel if the clinic had to close down?

Mr. JANICE HUDDLESTONE. Well, I'd feel bad about it because people up in here just wouldn't have no way of being doctored and, you know, getting medicines.

SNYDER. That's what worries the people who work at the Clear Fork Clinic in Tennessee and the Laurel Fork Clinic in Kentucky, both of which will run out of funds this April. The original idea was to make all 200 Appalachian regional clinics self-sufficient at the end of five years. But for many, it hasn't worked out that way, partly because the patients can afford to pay only low fees—as little as six dollars a visit. Another major financial problem has been the government's controversial policy of not paying the clinics for visits by Medicare patients unless a physician is on the premises—like Dr. Walker who works part-time at both the Tennessee and Kentucky clinics. But since there aren't enough doctors to go around, many patients are treated by what are called physician-extenders, who have medical training but no M.D.—like physician's assistant Chuck Ward, a former medical corpsman in Vietnam, who works at the Clear Fork Clinic.

One clinic service is home visits.

CHUCK WARD. Have you been having any dizziness at all?

ROY KING. Um-hmm.

SNYDER. Sally King, who has been treated for severe asthma attacks, worries about the future.

SALLY KING. Well I feel wonderful to know that we have medical care close if we—you know, in emergency. It's—It's a—an awful dreadful thing to think that you might die just for the need of medical help.

Dr. WALKER. I frequently tell doctors that if they're interested in providing service to people that really need it, that this is the place to come and that they can get a lot more satisfaction out of that than they can dollars, sometimes.

SNYDER. To help solve the medical crisis in rural areas, the Appalachian Regional Commission is hoping for legislation this year that would provide Medicare compensation to physician-extenders. It's also been proposed that Medicare and Medicaid payments to physicians—now a good deal lower in rural than in urban areas—be raised to attract more doctors to needy areas and that more young people from rural areas be recruited for medical schools, so that they can return as country doctors.

But as they search for more government or foundation money, time is running out for the struggling clinics of Appalachia.

Mr. LEAHY. Mr. President, it is with great pleasure that I join the distinguished senior Senator from Iowa in introducing legislation to allow medicare reimbursements to cover the reasonable costs incurred by rural primary health care clinics. I think it is important to emphasize that in formulating this measure we took great care to assure that these health services are of high quality, including requirements that relate to the nature of the clinics and the training and supervision of the health practitioners involved.

The Health Manpower Act of 1976 contained a number of provisions to help alleviate the shortage of physicians and other health professionals in many parts of rural America. In addition, the Department of Health, Education, and Welfare has initiated a number of innovative projects for improving health care delivery in those areas. Notable in that regard is the increased use of nurse practitioners who treat patients under the supervision of physicians in nearby communities.

However, I have serious doubts whether we here in Washington can design and impose any system of health care on any community in Vermont or Appalachia or Wyoming, if that commitment and support does not exist at the local level.

It is a lesson all of us in Washington should have in mind as we try to solve the broad national crisis of maldistribution of primary care facilities.

One direct we should move in is to break down some of the barriers erected by the Federal Government which tend to discourage local efforts to provide rural care.

One perfect example of a barrier is the current policy of medicare prohibiting reimbursement to nurse practitioners and other physician extenders unless a doctor is physically on site.

This policy obstructs the access of many elderly and unpoverished rural Americans to the health care they need. In some cases, it has forced badly needed clinics to close down. In others, they do not open in the first place, because of the threat of having to close down 1, 2, or 3 years after development funding runs out.

Let me cite one example of how this policy adversely affects an otherwise successful clinic.

Grand Isle County, which is an island community of 3,750 people between northern New York State and Vermont, connected at the north and south by roads to Vermont, had no primary care facility for years.

In 1974 the Champlain Islands Health Center was established primarily through the efforts of a local consumer health council and the visiting nurses association.

The key elements of the health center are: First, consumer involvement and governing responsibilities; second, utilization of nurse practitioners as primary care givers with physician backup and audit; third, an active volunteer organization, providing 24-hour telephone coverage; fourth, nurse practitioners who have been able to handle well over 90 percent of the cases, the remainder being trained elsewhere in the health system; and fifth, a cost effective system because nurses and physicians alike are used to their full potential.

The main problem at the center is long-range financing. To date, they have been able to put together a mix of funding primarily through foundation and Government developmental grants. When those sources dry up in a year or two,

the center may be forced to close unless there is a change in the Federal reimbursement policy.

In that particular case I am glad to report that representatives of the center and the New Hampshire/Vermont Blue Cross/Blue Shield working cooperatively with my office were able to fashion a pilot reimbursement project for residents in the islands who carry Blue Cross. Periodically they calculate the percentage of patient population their members make up, and reimburse that percentage of the clinic's operating costs.

While this was a dramatic step in the right direction, it does not answer the larger health problems for rural America. The bill we have introduced today will go far toward that end by making medicare reimbursement available to rural health clinics.

Without reform of medicare to compensate these clinics adequately for the services they provide, hundreds of them, in rural communities throughout the Nation may be forced to close thereby denying millions of Americans the quality accessible health care they require and desire.

REIMBURSEMENT AND THE RURAL HEALTH CLINIC

Mr. CHURCH. Mr. President, I am joining Senators Clark and Leahy in introducing legislation which will result in a more equitable reimbursement policy for physician extenders in serving in rural health clinics in order to help provide adequate health care treatment in the rural sections of our country which are medically underserved.

The Congress has intermittently discussed national health insurance proposals in the past decade. Throughout those discussions, I have repeatedly warned that financial access to the health care system in itself will not solve the health problems of Americans. Financial access without physical access means little.

We are beginning to come to grips with this problem of physical access. The first graduates of the National Health Service Corps program are now making their way to medically-underserved areas. But the question as to how many of these young physicians will remain in these communities after their obligation is fulfilled goes unanswered. Clearly, this program alone cannot begin to handle the immediate need for health care delivery in rural areas.

Therefore, the addition of the physician extender to the health care delivery system holds special promise for rural areas. These health care practitioners—physicians assistants, nurse practitioners, MEDEX, and similarly trained individuals—have provided the necessary link to health care access in rural communities throughout the Nation. Unfortunately, medicare reimbursement procedures do not recognize the enormous potential value of such personnel.

Under current provisions, the medicare program will not reimburse services provided by physician extenders in a clinic setting unless a doctor is present. Some communities can support a rural health clinic, but they have not been able to attract a full-time physician. Rural elderly persons receiving care from these clinics find that even though they are dutifully paying their monthly part B medicare premium—physicians services—they are denied reimbursement for their treatment at the clinic. Under the legislation offered today, medicare reimbursement would be given for care provided by a certified physician extender in a clinic setting with periodic review by a licensed physician.

To my way of thinking, this would correct an injustice in the medicare program without jeopardizing the quality of care for persons in rural areas. It is widely accepted that certain health care procedures generally associated with physician visits can be competently performed by persons with less professional training. The certified health care practitioner undergoes a degree of education and testing commensurate with the responsibilities undertaken. Further, this individual has direct access to a physician as well as to a hospital nearby.

In Idaho, medicare reimbursement policy has been a major obstacle to the provision of care for elderly persons in rural areas. If medicare is to serve all persons in all geographic areas with some degree of equity, it is high time for corrective action.

Mr. President, I hope that the Senate Finance Committee will give prompt and favorable consideration to this proposed change in the medicare reimbursement system.

Senator CLARK. I would like to just briefly discuss a few of the major issues that your subcommittee will consider.

I should note that my views were greatly influenced by a coalition of some seventeen organizations with diverse interests, each of which endorsed the resolutions that I submit for the record. I will not list all of these, just a couple: The American Nurses' Association, the American Hospital Association, the Appalachian Regional Commission, the American Academy of Physician Assistants, et cetera.

[The following was subsequently supplied for the record:]

The organizations listed below endorse the following principles as the basis of legislation to bring health services to medically underserved areas—

1. The most urgent, critical need for health services exists in medically underserved small towns and rural areas, many of which rely upon primary health clinics staffed by nurse practitioners or physician assistants. Therefore, Medicare reimbursement should be expanded to cover health services provided by those clinics, as a first step toward reimbursement by all third-party payers, for primary health services in all medically underserved areas.

2. Reimbursement for clinic services should be related to the cost of providing the primary health services, should go to the clinic rather than to any particular provider, and should cover physician services in addition to those provided by nurse practitioners and physician assistants.

3. Public primary health clinics and primary health clinics that receive Federal operating funds that are located in urbanized medically underserved areas should be eligible for cost reimbursement on a demonstration basis.

4. In recognition of the fact that physicians in private practice that employ nurse practitioners and/or physician assistants help fill the gap of primary health services in small towns and rural areas, and since many such physicians are reluctant to become salaried providers within a clinic, they should be allowed another option. On a one-year demonstration basis, they should be permitted to choose fee-for-service reimbursement covering the services of the nurse practitioners and physician assistants they employ, at a rate that is equivalent to the physician's usual and customary rate. Physicians that select this option should not be permitted to employ more than two physician assistants or nurse practitioners.

5. The Secretary of Health, Education, and Welfare should report to Congress one year after implementation of this legislation on the rural and urban demonstrations and on the rural cost reimbursement arrangement. This report should address the questions of expanding the program to urban areas and continuing the fee-for-service arrangement.

6. Except for the urban demonstration component, a clinic or practice eligible for reimbursement should be one that serves a rural, medically underserved population. "Rural" should be defined as an area that is not "urbanized", a Bureau of the Census term that would, in effect, exclude communities over 50,000 and their suburbs. Clinics or practices receiving reimbursement in areas that lose their designations as "medically underserved" should continue to receive reimbursement.

We urge the House Ways and Means Committee and the Senate Finance Committee to promptly act upon these principles, so that primary health services will be more accessible to medically underserved Americans.

American Academy of Physician Assistants
American Nurses' Association
American Hospital Association
Appalachian Regional Commission
Association of Physician Assistant Programs
Friends Committee on National Legislation
National Association of Community Health Centers
National Association of Counties
National Association of Farmworker Organizations
National Association of Social Workers
National Council on the Aging
National Council of Senior Citizens
National Farmers Union
National Retired Teachers Association/American Association of Retired Persons
National Rural Center
National Rural Electric Cooperatives Association
United Mine Workers of America Health and Retirement Funds

Senator CLARK. There seems to be substantial agreement that the permanent expansion of a medicare program should entail the cost-related reimbursement to clinics located in rural, medically underserved areas in order to cover the primary health care services of nurse practitioners and physician assistants.

Beyond this point, opinions diverge as to the extent to which the program should be further expanded.

In my mind, our basic objective should be to make health services more available to medically needy citizens without enlarging the opportunities for overutilization of health services or program abuse.

First, clinics that are fortunate enough to have a full-time physician onsite should not be disqualified from reimbursement. In many small communities, the patient load within the clinic, as well as those in nursing homes or private homes, is large enough to necessitate the use of both the physician and the nurse practitioner or physician assistant.

Second, many States in the West and Midwest, such as my own State of Iowa, have few clinics, community health services that are publicly owned and operated, we have very few of them. However, private physicians in these States have responded to the access problem in small communities by establishing satellite offices, staffed by nurse practitioners or physician assistants. Indeed, I have visited a great number of them in my own home State.

My fear is that we will discourage this trend in the future if these physicians have no option to receive reimbursement for the "extender" services on a fee for service basis to physicians.

For that reason, I propose that Congress establish a demonstration program that would permit fee for service reimbursement covering the services of physician assistants and nurse practitioners who are employed by physicians in rural, medically underserved areas.

Third, in response to the problem of reimbursement for clinic services in urban areas, I favor the approach taken by the House Ways and Means Health Subcommittee this week. In order to test the feasibility of expanding this program to urban areas on a permanent basis, we should establish a demonstration program for physician-directed clinics staffed by nurse practitioners or physician assistants in urban medically underserved areas.

I want to thank you very much for this opportunity to present these views. I know that you and your staff will look at them carefully.

Certainly I am prepared to meet with you at any time to discuss these issues further.

Senator TALMADGE. Thank you, Senator Clark, for an excellent statement. As you know, I have discussed this with you and Senator Leahy many times and it is a serious problem and we must take affirmative action.

We have two courses as you know, legislatively. One is to accept the House bill as a revenue measure that must originate in the House. We have another alternative, which is to attach it to some tariff bill as an amendment when it comes over from the Ways and Means Committee and send it back.

I am inclined to think the second alternative is the best route to take. How would you define a medically underserved area?

Senator CLARK. We define rural as 50,000 or less. As you know, in the Rural Development Act, there was a debate on definitions of what rural was. We have taken the broadest kind of definition.

Senator TALMADGE. Does the Rostenkowski bill have the same population?

Senator CLARK. You know, I am not positive. I think they leave it very vague. I think they left HEW define it, if I remember correctly.

Senator TALMADGE. The Rostenkowski bill, I believe, leaves it to the Secretary.

Thank you very much.

[The prepared statement of Senator Clark follows:]

STATEMENT OF HON. DICK CLARK

Over the course of the past year and a half, Senator Leahy and I have explored the nature of problems of access to primary health care services in rural America. Our inquiry began in February, 1976, with Rural Development Subcommittee hearings, chaired by Senator Leahy, in Vermont. In October of that year, we took the Subcommittee to Iowa, where we held public hearings in six different parts of the State. Our study continued with a hearing here in Washington in March of this year, at which we gathered testimony on S. 708.

In each of these hearings, we discovered a persistent obstacle to the effort to obtain basic health care services in rural areas. This obstacle is a particular Medicare policy that requires a physician to directly supervise the services provided by physician assistants and nurse practitioners. This policy may not be so burdensome in many cities, where there is an abundant supply of physicians to oversee such services. But in remote rural areas, the policy constitutes a tremendous barrier—in many of these areas, physician assistants and nurse practitioners are the only real hope for providing health care services because there are no doctors. And it is clearly counterproductive to restrict their ability to serve these areas by imposing upon them a requirement that cannot be fulfilled.

This is not a small problem. The Department of Health, Education and Welfare has determined that 31.6 million Americans live in small towns and rural areas which are "medically underserved." These people represent 70 percent of the nation's medically underserved population. It is the responsibility of the federal government not only to pursue policies that expand access to primary health services for these citizens—such as through our health manpower programs—but also to insure that other federal health programs do not subvert this effort.

I firmly believe that the problem of getting basic health services to small towns and rural areas will never be resolved unless this legislation is enacted. The longer the delay, the longer rural senior citizens must pay out of their own pockets for the same services that urban residents depend upon Medicare for. Furthermore, communities that want and need health centers staffed by nurse practitioners or physician assistants will continue to be discouraged from pursuing this approach and will continue to have no local source of primary health care.

For these reasons, I am very pleased that Congress is moving closer to enacting legislation along the lines of S. 708. Fifty-five senators are now co-sponsors of S. 708, including seven members of the Finance Committee.

There are several recommendations that I'd like to propose that relate to specific provisions of S. 708 and of the bill that was reported on Tuesday by the House Ways and Means Health Subcommittee. In order to conserve time, these specific proposals shall be submitted to you for the record. I would like to briefly discuss a few of the major issues that your subcommittee will consider.

There seems to be substantial agreement that the permanent expansion of the Medicare program should entail cost-related reimbursement to clinics located in rural, medically underserved areas, in order to cover the primary health care services of nurse practitiones and physician assistants. Beyond this point, opinions diverge as to the extent to which the program should be further expanded.

In my mind, our basic objective should be to make health services more available to medically needy citizens, without enlarging the opportunities for overutilization of health services or program abuse.

First, clinics that are fortunate enough to have a full-time physician on site should not be disqualified from reimbursement. In many small communities, the

patient load—within the clinic as well as in a nursing home and in patients' homes—is large enough to necessitate the services of both a physician and a nurse practitioner or physician assistant. Enactment of legislation forbidding reimbursement for physician-directed clinics would result in reduced services for the elderly in their homes or within extended care facilities. The policy would also serve to hamper the ability of remote clinics to recruit physicians, for such recruitment would be accompanied by loss of medicare reimbursement.

Second, many states in the Midwest and West—such as my own state of Iowa—have few "clinics" as such—community health centers that are publicly owned and operated. However, private physicians in these states have responded to the access problem in small communities by establishing satellite offices staffed by nurse practitioners or physician assistants. My fear is that we will discourage this trend in the future if these physicians have no option to receive reimbursement for the "extender" services on fee-for-service basis to the physician. I am not an advocate for the fee-for-service method of reimbursement. I, like many of you, would prefer to move in the direction of a prospective, cost-related or capitation approach. However, if we are serious about responding to the geographic imbalance of primary health services, we should not ignore the important role played by the private physician.

For this reason, I propose that Congress establish a demonstration program that would permit fee-for-service reimbursement covering the services of physician assistants and nurse practitioners employed by physicians in rural, medically underserved areas. I have expanded on this point in the accompanying recommendations.

Third, I believe we should not immediately apply the cost-related reimbursement program to urban areas on the same basis as the rural program. While urban medically underserved areas do have great health needs, in terms of high infant mortality rates, large numbers of elderly people, and a high incidence of poverty, we cannot escape the conclusion that the greatest shortages of primary care physician services exists in rural medically underserved areas. Furthermore, we must be wary of the greater opportunities for program abuse in urban areas, where there is a concentration of elderly Medicare beneficiaries.

Consequently, I favor the approach taken this week by the House Ways and Means Health Subcommittee. In order to test the feasibility of expanding this program to urban areas on a permanent basis, we should establish a demonstration program for physician-directed clinics, staffed by nurse practitioners or physician assistants, in urban medically underserved areas.

Thank you very much for this opportunity to present my views on this subject. I hope you and your staff will call on me for any assistance I can provide in the coming weeks to facilitate passage of this legislation.

Senator TALMADGE. Senator Leahy.

STATEMENT OF HON. PATRICK J. LEAHY, A U.S. SENATOR FROM THE STATE OF VERMONT

Senator LEAHY. I first would like to compliment the chairman of the subcommittee for his well-demonstrated and very obvious concern in this area. I know the encouragement that the chairman has given to both Senator Clark and myself in our positions on the Senate Agriculture Committee in working in this area.

I compliment the chairman and thank him for having these hearings today.

Also, I thank Senator Bentsen and others of this subcommittee who have expressed a great deal of interest.

I would want very much to compliment Senator Clark who began work on this well before I came to the Senate and has been, of course, the leading and moving force in the Rural Development Subcommittee. He has made it possible for me to have hearings in my own State of Vermont and elsewhere on the subject.

I have a statement here, Mr. Chairman, which I will summarize, but I will ask that it be put in the record.

Senator TALMADGE. The statement will be included in full in the record.

Senator LEAHY. Thank you, Mr. Chairman.

Just let me talk for a moment of one of these health care clinics. A perfect example is in the Champlain Island Health Center in my home State of Vermont. This clinic is located in Grand Isle County in northwestern Vermont. Forgive me for saying so, but it is one of the most beautiful spots of the country, if it is the most rural. It is a series of islands. If you go up to Lake Champlain, it has barely over 3,000 people in it.

But the population characteristics and economics of the area probably typify many rural areas in all parts of the country—Vermont, Iowa, Georgia, California, or anywhere else.

Fifty-eight percent of the population of Grand Isle County earn less than 200 percent of the poverty level, there is double-digit unemployment. One part of the population utilizing the health center has no form of health insurance and only 15 percent are medicaid eligible.

Historically, solo physicians have come and gone in this county, with none being able to support a comprehensive practice over an extended period. The last physician in primary practice offered services two afternoons a week in the northern-most town of Alburg on the Canadian border; the remainder of time he practiced surgery in another county entirely.

This doctor, even this last one, discontinued his services in Alburg and this left the county with a crisis which faces hundreds of counties across the country—virtually no primary health care.

In response, the local communities through the Grand Isle Health Council banded together in a true community effort to establish the health center. The initial moneys were raised by volunteers with sales, showers, and donations and virtually everything. Then, with the help of grants, the health center was finally established.

Even though it has strong community support, it faces a critical financial problem. It has been kept open in the short run through grants. However, it still faces the problem of long-term financing and self-sufficiency.

The Federal Government could be part of this long-term financing solution, but this is part of the problem. The Federal medicare program discriminates against clinics like this.

It allows reimbursement of primary care practices only when a physician is present. This places rural health clinics in a Catch-22 situation: They do not have a doctor so it wishes to utilize a physician extender or nurse practitioner, but the area cannot attract these personnel because they would not be reimbursed for medicare services because no doctor is present. It is a vicious circle.

It can be changed by changing the medicare policy.

Mr. Chairman, S. 708 would do that. It provides for reimbursement of services performed by a nurse practitioner of physician extender in a clinic serving a medically underserved rural area. The reimbursement would be to the clinic on a cost-related basis.

It is important that the reimbursement mechanism be kept within a clinical system. It is care that is accessible; it is accountable, and it is low cost.

Ironically enough, somehow in these rural areas we are able to get physicians in there. We get them there at a much greater cost, but once getting them in there, they could be reimbursed.

But the lower costs, the care that is really available—in fact, the only care that is available—would only cost less, but it cannot be reimbursed.

You know, rural America has only 26 percent of the Nation's population but it contains 44 percent of the Nation's poor, two-thirds of the substandard housing and a relatively large elderly population.

So many of our programs through complete innocence on the part of the Federal Government, but they have an urban bias and they do not reflect the needs of rural America, and all of these practices contribute to the increased ill-health of rural residents.

Over two-thirds of the medically underserved areas are in nonmetropolitan areas, and the lack of doctors is further aggravated by massive rural transportation problems, and the health problems of rural America are much more severe than those of the cities.

Mr. Chairman, I believe that speedy passage of S. 708 is crucial. More clinic doors close in each month we delay. I think that a giant step forward has been taken by the hearings you are chairing, by the support, as I mentioned earlier, of Senator Bentsen in this area, and I like very much your second suggestion, Mr. Chairman, of attaching the Clark-Leahy bill as an amendment to legislation going forward. It is vitally necessary that we get starter. It is vitally necessary to all rural America, I think.

Thank you very much for this opportunity, and I submit my full statement for the record.

Senator TALMADGE. Thank you very much, Senator Leahy, for an excellent statement. I compliment both you and Senator Clark for your leadership in this matter. It is a very serious problem, as we all know, and I am sure that the members of this subcommittee and members of the Finance Committee will address it at the very earliest opportunity.

Any questions, Senator Bentsen?

Senator BENSTEN. I just want to thank you for the expeditious way that you have moved on this problem in holding these hearings. Senator Clark and Senator Leahy, we have as much of this problem in Texas as they have in any other State in the Union. It is a matter of deep concern to all of us. I want to evidence my very strong support and do everything I can to assist in that regard.

I appreciate your efforts, Mr. Chairman.

Senator TALMADGE. Thank you sir; thank you, gentlemen.

[The prepared statement of Senator Leahy follows:]

STATEMENT OF HON. PATRICK J. LEAHY

In February, 1976, the Rural Development Subcommittee, of which Senator Clark is Chairman and I am a member, began a series of hearings which explored the ways small rural communities were attempting to cope with the most serious health care problem facing rural America—the shortage of primary health care personnel.

We discovered that many of those areas which lack physicians' services have come to rely on local clinics for their primary health care needs. The clinics are staffed by specially trained health professionals called nurse practitioners or physician assistants, who are able to diagnose and treat primary and emergency

needs. Physicians in nearby communities provide both back-up and audit services.

A perfect example of this type of situation is the Champlain Islands Health Center in my home state of Verment. This clinic is located in Grand Isle County in Northwestern Vermont. The population characteristics and economics of the area probably typify many rural areas—58% of the population of Grand Isle County earn less than 200% of the poverty level, there is double digit unemployment, one-quarter of the population utilizing the health center has no form of health insurance, and only 15% are medicaid eligible.

Historically, solo physicians have come and gone in this county with none being able to support a comprehensive practice over an extended period. The last physician in primary practice offered services two afternoons a week in the northernmost town of Alburg and the remainder of the time practiced surgery in another county.

But this doctor discontinued his services in Alburg. This left the county with a crisis which faces hundreds of counties across the country—virtually no primary health care.

To respond to this situation, the local communities through the Grand Isle Health Council banded together in a true community effort to establish the health center. The initial monies were raised by volunteers with sales, showers, and donations. Then with the help of grants, the Health Center was finally established.

Although the clinic has strong community support, it still faces a critical financial problem. The clinic has been kept open in the short run through grants. However, it still faces the problem of long term financing and self-sufficiency.

The Federal government could be part of this long term financing solution. Instead, it is part of the problem. Unfortunately, the Federal Medicare program discriminates against clinics like the Champlain Islands Health Center. It does so by a policy which allows reimbursement of primary care practices only when a physician is present. This places rural health clinics in a Catch 22 situation: a rural area does not have a doctor so it wishes to utilize a physician extender or nurse practitioner, but the area cannot attract these personnel because they would not be reimbursed for Medicare services because no doctor is present. By permitting such a policy we are merely reinforcing the already extreme maldistribution of primary health care personnel.

Mr. Chairman, we can break this vicious cycle by changing Medicare policy. S. 708 will do that. This legislation provides for reimbursement of services performed by a nurse practitioner or physician extender in a clinic serving a medically underserved rural area. The reimbursement would be to the clinic on a cost related basis.

I would like to address a few specifics of the bill. First, I think it is important that the reimbursement mechanism be kept within a clinical system. Clinic care provides quality care that is accessible, accountable and low cost. By limiting the reimbursement to services performed under the clinic, we are encouraging the primary care practitioners to enter into the community supported center. It will encourage the nurse practitioner or physician extender to become part of a total health care system.

Another subject which I would like to address is a little more controversial—that is, the exclusion of clinics serving urban medically underserved areas. I believe that at this time limiting reimbursement to rural clinics is essential. It is clearly a matter of priorities. The health problems of rural America are much more severe than those of urban areas.

Although rural America has only 26% of the nation's population, it contains 44% of the nation's poor, two thirds of the substandard housing and a relatively large elderly population. All these factors contribute to increased ill health of rural residents. This situation is compounded by the maldistribution of health professionals—over two thirds of the medically underserved areas are in nonmetropolitan areas. The ill health and lack of doctors is further aggravated by massive rural transportation problems. Clearly, the health problems of rural America are much more severe than those of the cities. We have only so much money. Let us set priorities, and put the money where it is needed most.

In addition, I am afraid that if we include urban clinics at this point the same forces which attract physicians will attract the physician extender or nurse practitioner, and the rural areas will still be in the same spot as now. However, by reimbursing nurse practitioners or physician assistants in rural cities only, we may help shift the distribution of primary health care personnel.

Mr. Chairman, I believe that a speedy passage of S. 708 is crucial. More clinic doors close in each month we delay. I am hopeful that Congress can pass this legislation before our August district work period. I thank you for holding these hearings today and I am sure your committee will move expeditiously.

Senator TALMADGE. Is Congressman Duncan here?

The next witness will be Dr. Karen Davis, Deputy Assistant Secretary for Planning and Evaluation/Health, Department of Health, Education, and Welfare, accompanied by Larry Gage, Assistant to the Deputy Assistant Secretary for Legislation (Health) and Dr. Ronald Klar, Deputy Director, Office for Policy Development and Planning, Office of the Assistant Secretary for Health.

We are delighted to have you, Ms. Davis. You may insert your full statement in the record and summarize if you like. Please proceed in your own way.

STATEMENT OF DR. KAREN DAVIS, DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION/HEALTH, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY LARRY GAGE, ASSISTANT TO THE DEPUTY ASSISTANT SECRETARY FOR LEGISLATION (HEALTH) AND DR. RONALD KLAR, DEPUTY DIRECTOR, OFFICE FOR POLICY DEVELOPMENT AND PLANNING, OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

Dr. DAVIS. Thank you, Mr. Chairman and members of the subcommittee. It is a pleasure to be here today to share with you the Department's view on S. 708 and H.R. 2504, which provide for medicare reimbursement on a cost-related basis for services provided by physician extenders in rural clinics in medically underserved areas.

Now, Mr. Chairman, you and Senator Bentsen have expressed strong support for providing adequate access to the health care services for rural citizens, and we want to underline that the administration shares this concern and support.

The Department of Health, Education, and Welfare, through its rural health initiatives, the National Health Service Corps and related health and manpower activities, is committed to providing technical and financial support for training and placement of health personnel in health manpower shortage areas.

The National Health Service Corps has placed physicians and, in some cases, other health professionals in more than 300 health manpower shortage areas. The recently passed Health Professions Educational Assistance Act of 1976 requires medical schools participating in the capitation program to have at least 50 percent of their filled first-year medical residency training positions in primary care specialties by 1980.

The act also authorizes continued assistance for physician assistant training programs.

Providing technical and financial support for the training of physician extenders and development of service delivery sites and incentives for health professionals to locate in such areas are not enough.

In this regard, provisions of the medicare law have made it difficult for clinics to be reimbursed under medicare. Clinics have often been unable to obtain medicare reimbursement for services provided by

physician extenders simply because a physician was not on site at all times.

Over the last 3 years, the Department has undertaken research projects to learn how physician assistants and nurse practitioners affect access to primary medical care as well as the resulting costs and quality of care. Our preliminary findings indicate that these personnel help to redress inequities in the geographic and specialty distribution of physicians, thus improving access to primary care in medically underserved rural and urban areas.

Mr. Chairman, the Department supports S. 708 and H.R. 2504. However, there are several points we would like to raise regarding these bills.

Given recent experiences with the so-called medicaid mills in urban areas, we understand your concerns about extending coverage to clinics in these settings.

It is our opinion, however, that a cost-related reimbursement system with adequate productivity standards, information disclosure requirements, and cost limits can prevent the types of fraud and abuse experienced in medicaid mills.

With specific regard to H.R. 2504, we would like to recommend that the scope be broadened to include physician-directed clinics.

With regard to each of these bills, we would suggest the following additional changes, which we believe would strengthen the impact of this legislation.

We would propose to reimburse clinics for the supervisory services of physicians and for direct physician services on a cost-related basis, rather than making use of the combination of reimbursement mechanisms for physician services which is implied in both H.R. 2504 and S. 708. Cost-related reimbursement would be far more effective from the standpoint of cost control and fraud and abuse than a fee-for-service method.

Additionally, this approach is administratively less complex because it avoids the problem of differentiating between supervision and direct physician services, a problem which has been difficult to solve in the teaching hospital setting.

We do not believe that the Department's approach represents a radical departure from existing physician reimbursement practices. The Department's proposal in no way limits physicians from billing the program on a fee-for-service basis as they currently do. Our proposal merely gives practices utilizing physicians and physician extenders the option of being classified as a clinic and then being reimbursed as a clinic on a cost-related basis.

With respect to S. 708, we also recommend that the medicare part B deductible requirements be retained for beneficiaries receiving services in clinics covered under this bill. While we are aware of the administrative costs of retaining the deductible, we cannot at present justify varying beneficiary cost sharing by treatment setting or place of services.

We also recommend replacing the S. 708 provision prescribing certification standards for physician extenders with one which would allow the Secretary to develop appropriate qualification standards for physician extenders recognized under this program.

While S. 708 would allow clinics which are not located in medically underserved areas but which derive a majority of their clients from underserved areas to participate, we believe this provision should be limited to those clinics which are actually located in underserved areas. This would not only provide greater inducements for health professionals to locate in underserved communities, but it would also help to eliminate the long distances traveled by residents of such communities in seeking medical care.

Mr. Chairman, we view legislation in this area as an important and necessary start in promoting access to care for all Americans, regardless of where they live. My colleagues and I would be pleased to answer any questions you or other members of the subcommittee may have.

Senator TALMADGE. I congratulate you on an excellent statement, Dr. Davis. I have a few questions.

A case has been made repeatedly that many of these rural clinics are not adequately funded and, in some cases, barely able to keep their heads above water financially. Exactly how will additional medicare payments in what in most clinics is a relatively small portion of the payment, make these clinics financially sound?

Dr. DAVIS. You are touching upon a concern that is also shared by the Department. We feel that this bill would be an important first step in helping these clinics become more viable financially. We recognize that there are many other obstacles that stand in the way of their really obtaining enough revenue to break even.

We feel that this bill is a useful first step in that it addresses some of the deficiencies in the medicare program, but we recognize that other steps will be required to make these clinics financially sound.

Senator TALMADGE. I appreciate your concern over the need to have these rural clinics operate so as to bring care to people who would otherwise not have it available to them.

To what extent do State professional practice acts, those dealing with medicine and nursing, pharmacy and so forth, affect the ability of rural clinics to meet those needs?

Dr. DAVIS. Mr. Chairman, that is also a concern of ours. I would like to ask Dr. Klar of the Office of the Assistant Secretary for Health to comment on some of the State licensure requirements that do restrict this mode of delivery.

Dr. KLAR. It is true it is a State prerogative to set requirements for the practice of health care within its State. Currently, about two-thirds of the States do have enabling legislation for physician extenders and nurse practitioners and other paramedical personnel. Through activities of the Department as well as through some of those health care programs and clinics that are being supported, an effort is being made with the other States to relate the data that has concerned them in the past to the quality of practice and the requirements that should appropriately be placed on nonphysician manpower.

Senator TALMADGE. Dr. Davis, in your statement on page 4 you say that we should cover urban clinics as well as rural, that in your opinion, a cost-related reimbursement system with adequate productivity standards, information disclosure standards and cost limits, can prevent the types of fraud and abuse experienced in medicaid mills.

Has the administration submitted specific productivity standards, disclosure requirements, and cost limitations for use in dealing with medicaid mills that we now have?

Dr. DAVIS. Mr. Chairman, I would like to say that the administration, of course, supports the antifraud and abuse activities that are before the Congress, and we did not mean to imply that, through this bill, the clinics would take care of the fraud and abuse problems.

The administration, through the federally funded clinics over the past few years, has been developing productivity standards. We have set those standards for all federally funded clinics. Those would serve as the starting point for establishing productivity standards in clinics to be covered under this bill.

With regard to the information disclosure requirements, we would try to build into the cost-reporting disclosure on salaries, on cost of supplies, et cetera, going into the clinic, so there would be information available on this.

Senator TALMADGE. Of course, you realize that the medicaid programs that we have now are largely federally funded, the same as these rural clinics would be. What we now have in operation we would extend to these other clinics in underserved areas, rural, urban and otherwise. Is that not true?

Dr. DAVIS. Mr. Chairman, I think the big difference, the reason we favor this bill and its emphasis on cost reimbursement, is that the problem in the medicaid mills has been with the fee-for-service practice. Patients are ping-ponged from one provider to another, so there are a lot of unnecessary tests performed because they will generate additional fees.

We would prefer to go to a cost-related payment basis, because if the clinics then try to artificially increase the number of physician encounters or the number of visits, that would not result in additional compensation to the client.

Senator TALMADGE. This committee initiated the antifraud bill last year. It passed the Senate by a unanimous vote.

Unfortunately, there was a problem of legislative responsibility between Ways and Means and Commerce, so they are sending our bill back to us in the next few days and we expect to pass it speedily. We hope that will terminate some of the massive fraud and abuse that we have seen in many areas of the country.

We all heard a great deal about malpractice problems. Exactly how does potential malpractice liability operate with respect to these rural clinics? That is, what is the liability of the doctor who has supervisory responsibility, who is not present when the care is provided, and who may not even have seen the patients, and what is the malpractice liability of the physicians' assistant? What is the malpractice liability for the nurse practitioner?

Can you comment on that?

Dr. DAVIS. That varies, Mr. Chairman, from State to State. I can give you a description of the way that it is handled in the State of North Carolina, which has thought through this concept of using nurse practitioners and physician assistants very carefully. In that State, St. Paul's Insurance Co., which provides the medical malpractice insurance, covers both the nurse practitioner and the supervisory physician.

Under State law, the nurse practitioner must have a physician supervisor, who is not onsite all the time the nurse practitioner is seeing patients, but who accepts overall responsibility for the care rendered.

The physician has a rider attached to his or her medical malpractice policy. The nurse practitioner is also liable jointly with the supervisory physician and has her own policy.

In the case of North Carolina, supervisory physicians have had these riders attached to their policies without any increase in their premiums, and the nurse practitioners' premiums have been averaging about $35 a year, so malpractice, at least in the State with which I am most familiar, has not been a serious problem.

I think one characteristic of rural areas is that people know the providers, it is a small town, it is someone from the community, someone they know very well, and they are not so likely to raise malpractice suits, so that does not tend to be a serious problem. That is the situation in the State with which I am most familiar with.

Senator TALMADGE. You do not see that as a serious problem?

Dr. DAVIS. I think it has to be worked out from State to State, but at least in the instances I am familiar with, it has not been a problem.

Senator TALMADGE. In your statement, you refer to the Federal efforts to encourage the training and utilization of nurse practitioners and physicians assistants, I assume a good deal of research has gone into the development of such programs?

I am interested in knowing what differences you have noticed in the products of these programs and what differences should we expect in utilization of these professionals?

Dr. KLAR. The Department has supported several studies already, looking at the productivity, quality, and somewhat, now, the cost of services delivered by nonphysician manpower.

With regard to productivity, there is evidence that a physician extender can dramatically increase the amount of services that a physician can give, not in direct proportion as an individual physician, but often 50 to 70 percent of what a physician himself would have been able to do without a physician extender.

In addition, there have been several studies trying to document what part of a primary care physician's practice could be handled by somebody other than a physician and, in these cases, the numbers vary, anywhere from 50 percent to 90 percent of the services given by a primary physician could be delegated to a nonphysician practitioner under the supervision of a physician.

Senator TALMADGE. What we are trying to get at specifically is the difference between a physician extender and a nurse practitioner.

Dr. KLAR. Clearly, the physician assistants programs tend to be 2-year programs that are concentrated to allow a practitioner to do what a physician can do in a primary care setting. The nurse practitioner is usually a 1-year extension beyond the training of a licensed registered nurse.

Senator TALMADGE. Are the qualifications identical?

Dr. KLAR. They vary. The qualifications of individuals going into the programs vary. In the case of the nurse practitioner, it is somebody who has been already trained as a nurse who is now going for special training. In the case of a physician's assistant, it may be somebody who has a bachelors degree and has decided to go into the health field.

It may be an ex-corpsman or somebody who has been involved in other services who is now getting specialty training for this purpose.

There are now certifying boards accredited by the American Medical Association and the Nursing Association. Standards have been developed for the training programs. I think it is fair to say, at this point in time, that there is quite sufficient quality controls being placed on the education of these individuals.

Senator TALMADGE. Thank you very much.

Dr. DAVIS, will you and your associates work with our staff to try to perfect a bill that hopefully we can attach to a revenue bill that comes over from the House?

Dr. DAVIS. Mr. Chairman, we would be happy to do that.

Senator TALMADGE. Senator Bentsen?

Senator BENTSEN. Thank you, Mr. Chairman.

I was reading with interest concerning your testimony concerning a requirement that the clinic be located in rural medically underserved areas. That is appealing to us. The problem, however, is illustrated by a clinic that is located in the town of Harlingen, Tex., and derived its patients from the rural areas, which are medically underserved.

How would this clinic be affected? Would they have to move out into the rural area?

Actually, they would be less accessible to those clients than they would be, for example, in a little town.

Dr. DAVIS. It has been awhile since I have been there. We would go along with Senator Clark's definition of rural, which would include all nonurbanized areas or places of 50,000 or less. I would have to doublecheck on the population of Harlingen.

Senator BENTSEN. I am a little concerned with your comments concerning the reimbursement of clinics, specifically cost-related reimbursement being more effective from the standpoint of fraud and abuse than the fee-for-service method.

I am deeply concerned about fraud, and cosponsored the chairman's bill. I supported it very strongly. However, I am also worried about effectiveness and efficiency.

I am worried that you may end up with higher costs by reimbursing clinics on a cost-related basis than you would otherwise. Would you respond to that?

Dr. DAVIS. I think that one has to build in certain standards with regard to what is a reasonable cost and what is a reasonable volume of services for a clinic to be provided to get reasonable cost reimbursement methodology.

Our main concern, looking at clinics, particularly going back to some of the abuses that I know that this committee has identified, is that when you pay fee for service you can have this proliferation of testing, ping-ponging patients, and it turns out to be very expensive. Also, I think we need to take a somewhat broader view of the impact of these clinic services.

In hearings before the Ways and Means Committee, a number of studies were identified which found that patients treated in these kinds of clinic by nurse practitioners and physician assistants tended to reduce hospitalization by 10 to 30 percent.

If you factor in a savings on the hospital side, it comes from getting better primary care and easier access to health care services. You find that this is really a cost-effective way of providing care.

Senator BENTSEN. I seriously doubt that your safeguards are currently operational.

Dr. DAVIS. What we were particularly concerned about at that point was the problem of the supervisory physician who comes to the clinic 1 day a week, using the clinic as a rent-free laboratory, seeing patients in that clinic, then billing on a free-for-service basis.

Senator BENTSEN. A teaching hospital situation?

Senator TALMADGE. Excuse me a moment.

Senator Bentsen, will you preside?

Dr. DAVIS. Part of the problem arises when the physicians' services in the clinic setting are provided on a fee-for-service basis and the overhead of the clinic goes into the cost of the nurse practitioner's services. We do not want to see a mixing of the two.

We would not rule out any physician choosing to do as they do currently, to bill on a fee-for-service basis. We simply say, if you want to get in the clinic, get these services, that you cannot have part of the services rendered on a cost basis and part of the services within that clinic setting paid for on a fee-for-service basis. That is our concern; mixing the two together.

Senator BENTSEN [presiding]. Senator Dole, did you have some questions?

Senator DOLE. I apologize for missing your testimony. Like every other member, this is about my fourth committee meeting this morning.

In Kansas, the law does not provide for nurse practitioners to practice in what is known as an expanded role or for physicians' assistant, to function outside of the direct supervision of the physicians.

I am just wondering how many States nurse practitioners and physicians' assistants are permitted to practice in clinics other than those with a physician in attendance; in how many States are nurse practitioners permitted to practice in what we call an expanded role?

Dr. DAVIS. In about two-thirds of the States, the States have amended the acts to provide for expanded roles of nurse practitioner. However, this varies from State to State.

For example, there are nine States that do not permit physician's assistants to prescribe drugs or to make a diagnosis. That can be a very restrictive limitation on the physicians' assistant, seeing patients when the physician is not right there to sign for the medication.

Senator DOLE. Apparently in your statement you suggested that a clinic make appropriate provision for administering and dispensing drugs and biologicals. I understand there has been some trouble with the pharmacy boards of some States with this taking place without a pharmacist present.

Can you tell us any States in which this will occur and prevent clinics from dispensing needed medication? Do you have a breakdown on that by State?

Dr. KLAR. To the extent that a physician is present, there can always be the dispensing of pharmaceuticals. In most of the clinics that we are talking about, that is a frequent occurrence. In those cases where

it is a satellite or distant site, you get into a problem such as you raise. I would have to get you for the record specifically which States have that problem.

Senator DOLE. Is it a serious problem?

Dr. KLAR. For the most part, it has not been a problem in the past. Usually, provisions are made thorough the parent clinic to supervise the stocking of many of the routine items that are used, pharmaceuticals that are used, and they can be dispensed under guidelines that are usually prescribed for the physicians' assistants in that clinic.

Senator DOLE. Do you have any estimates on the number of nurse practitioners and physicians' assistants that are broken down into rural areas and urban areas?

Dr. DAVIS. Our current estimates are that there are about 5,500 nurse practitioners and physicians' assistants working in primary care settings. At most, about a third of those are in the underserved urban and rural settings, about 1,800 would be in those areas. About one-third of those are in the rural, underserved area.

Senator BENTSEN. Thank you, Senator Dole.

Dr. Davis, I am still not satisfied that what you are proposing is going to result in lower cost to the patient, and if we are really concerned about fraud, I am talking about the cost-prevailing basis as opposed to fee for service.

With H.R. 3, we provided for criminal penalties. That was directed at fraud. If it results in a less efficient thing, or a more costly basis under the proposal that you made, then I think we have made a mistake.

I wish you would give me more detail and tell me why this is actually going to save the patient some money? I should not think it is going to be administratively less complex, as you suggested. I think you are going to have more regulations and more audits and probably a lot more government.

So I would like some more detail for the record, if you would provide it, please.

Dr. DAVIS. We would be glad to do that.

Senator BENTSEN. Show me how you are going to get that patient less expensive medical service. That is what I want to see.

Dr. DAVIS. Fine. We will be happy to supply that for the record.

I think that one comment that I would like to make about the rural clinics is that we are talking primarily about extended medicare coverage in the situation where the physician is not present. The experience with the State of North Carolina, which has over 20 of these nurse practitioner clinics now throughout the State is that their average costs run about $13 per visit. However, some of us when we think about clinics are thinking about some of the more comprehensive health centers that have been established in urban areas.

I think what we are talking about is a very small order of operations whose costs, in fact, have been very economical. We would be happy to supply more information on this.

Senator BENTSEN. I agree with that. That is why I am wondering why this was appropriate in the situation, why this particular bit of testimony was.

Dr. DAVIS. We would be happy to provide you with more information.

[The following was subsequently supplied for the record:]

In planning for clinic reimbursement under Medicare the Department would develop several alternative reimbursement methodologies which would be applied according to the size of the facility and/or its volume of Medicare patient visits. One reimbursement method which could be used for any size clinic is an inclusive prospectively established rate. However, pending refinement of such a methodology, clinics will be reimbursed on a cost-related basis. While initially we anticipate using the standard Medicare "reasonable cost" methodology for large clinics, smaller clinics would be reimbursed on a basis of a negotiated rate or other cost-related method requiring only simplified cost reporting.

We have recommended payment of a prospective rate or on a cost-related basis instead of fee-for-service reasonable charge reimbursement for several reasons. First, we believe prospective rates and cost reimbursement generally lead to lower program payouts than fee for service. Second, these methods are less susceptible to fraud and abuse than fee for service (e.g., the "ping-ponging" of patients which occurs in Medicaid mills). Third, fee-for-service reimbursement to physician extenders (PEs) is highly controversial.

Currently, the Office of Policy, Planning and Research of the Health Care Financing Administration is conducting a reimbursement study to determine under what circumstances Medicare, Medicaid and other health programs should reimburse for the services provided by physician assistants and nurse practitioners and to determine the most appropriate, equitable, and noninflationary methods and amounts of that reimbursement. Until the results of this study are available, it would be premature to establish on a program-wide basis reasonable charge reimbursement for physician assistants and nurse practitioners.

Finally, it would be inequitable for physicians to be paid fee-for-service in a setting in which other practitioners are paid on a cost-related, per encounter basis, because physicians, while not likely to share in the costs of maintaining the clinic, would receive fees which are comparable to those of other physicians who bear the full costs of maintaining an office practice.

Senator BENTSEN. Thank you very much for your presentation. It will be very helpful to us.

[The prepared statement of Dr. Davis follows:]

STATEMENT OF DR. KAREN DAVIS, DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. Chairman and Members of the Subcommittee, it is a pleasure to be here today to share with you the Department's view on S. 708 and H.R. 2504, which provide for Medicare reimbursement on a cost-related basis for services provided by physician extenders in rural clinics in medically underserved areas.

The Department strongly supports efforts to provide access to quality medical care for all citizens.

Assuring access to care for residents in rural and other underserved areas is a difficult problem. These areas are often sparsely populated and poor. Currently, about 1,500 of the 3,000 counties in the United States and numerous subcounty areas are officially classified as medically underserved.

More than 20 percent of the population lives in these areas. These people generally have incomes significantly below the national average and infant mortality rates are far higher than those in other parts of the country.

The Department, through its rural health initiatives, the National Health Service Corps, and related health manpower activities, is committed to providing technical and financial support for training and placement of health personnel in health manpower shortage areas. The National Health Service Corps has placed physicians and, in some cases, other health professionals in more than 300 health manpower shortage areas. The recently passed Health Professions Educational Assistance Act of 1976 requires medical schools participating in the capitation program to have at least 50 percent of their filled first-year medical residency training positions in primary care specialties by 1980.

The Act also authorizes continued assistance for physician assistant training programs. Regulations being developed under this authority will encourage special efforts to direct primary care physician assistants into health manpower shortage areas. The Nurse Training Act of 1975 as amended provides traineeships for nurse practitioner students who agree to practice in shortage areas.

It has been estimated that, since 1969, $65 million in Federal funds have been expended to educate and promote the utilization of physician assistants and nurse practitioners in the health care delivery system.

Providing technical and financial support for the training of physician extenders and development of service delivery sites and incentives for health professionals to locate in such areas are not enough. Unless these facilities and professionals can be reimbursed from public and private insurance programs, they cannot be economically viable in the long run.

In this regard, provisions of the Medicare law have made it difficult for clinics to be reimbursed under Medicare. Clinics have often been unable to obtain Medicare reimbursement for services provided by physician extenders simply because a physician was not on site at all times.

Over the last three years the Department has undertaken research projects to learn how physician assistants and nurse practitioners affect access to primary medical care as well as the resulting costs and quality of care. Our preliminary findings indicate that these personnel help to redress inequities in the geographic and specialty distribution of physicians, thus improving access to primary care in medically underserved rural and urban areas.

Mr. Chairman, the Department supports S. 708 and H.R. 2504. However, there are several points we would like to raise regarding these bills.

First, we recommend that the scope of both bills be broadened to allow clinics in all medically underserved areas to participate.

Unfortunately, large numbers of Americans living in cities do not have access to a source of primary care. The Department estimates that of the 45 million people living in medically underserved areas, more than 14 million are urban residents.

Given recent experiences with the so-called "Medicaid mills" in urban areas, we understand your concerns about extending coverage to clinics in these settings.

It is our opinion, however, that a cost-related reimbursement system with adequate productivity standards, information disclosure requirements, and cost limits can prevent the types of fraud and abuse experienced in "Medicaid mills."

With specific regard to H.R. 2504, we would also recommend that the scope be broadened to include physician-directed clinics.

This will increase access to care, particularly in rural areas. We note that reimbursement for physician directed clinics is included in S. 708.

With regard to each of these bills, we would suggest the following additional changes, which we believe would strengthen the impact of this legislation.

We would propose to reimburse clinics for the supervisory services of physicians and for direct physician services on a cost-related basis, rather than making use of the combination of reimbursement mechanisms for physician services which is implied in both H.R. 2504 and S. 708. Cost-related reimbursement would be far more effective from the standpoint of cost control and fraud and abuse than a fee-for-service method.

Additionally, this approach is administratively less complex because it avoids the problem of differentiating between supervision and direct physician services, a problem which has been difficult to solve in the teaching hospital setting.

We do not believe that the Department's approach represents a radical departure from existing physician reimbursement practices. The Department's proposal in no way limits physicians from billing the program on a fee-for-service basis as they currently do. Our proposal merely gives practices utilizing physicians and physician extenders the option of being classified as a "clinic" and then being reimbursed as a clinic on a cost-related basis.

With respect to S. 708, we also recommend that the Medicare Part B deductible requirement be retained for beneficiaries receiving services in clinics covered under this bill. While we are aware of the administrative costs of retaining the deductible, we cannot at present justify varying beneficiary cost sharing by treatment setting or place of services.

We also recommend replacing the S. 708 provision prescribing certification standards for physician extenders with one which would allow the Secretary to develop appropriate qualification standards for physician extenders recognized under this program. We believe that leaving this technical issue to Secretarial discretion would give the Department needed flexibility and the capacity to respond to changing standards in training and certification of physician extenders. Such minimal Federal standards, of course, would not supersede more restrictive State standards.

While S. 708 would allow clinics which are not located in medically underserved areas but which derive a majority of their clients from underserved areas to participate, we believe this provision should be limited to those clinics which are actually located in underserved areas. This would not only provide greater inducements for health professionals to locate in underserved communities, but it would also help to eliminate the long distances traveled by residents of such communities in seeking medical care.

Finally, two changes should be made in the definition of clinic so that the conditions for participation will not be overly restrictive. First, we recommend changing the requirement that the clinic have the capacity to store and dispense drugs to a requirement that the clinic make appropriate provision for administering and dispensing drugs and biologicals. This would provide flexibility without compromising the level of services. Second, we recommend deleting the requirement for utilization review. At the present time, this is required in no other ambulatory setting.

In addition to these recommended changes, we would also be pleased to work with your Committee on some technical amendments we would like the committee to consider.

Mr. Chairman, we view legislation in this area as an important and necessary start in promoting access to care for all Americans, regardless of where they live. My colleagues and I would be pleased to answer any questions you or other members of the Subcommittee may have.

Senator BENTSEN. Our next witness will be Nancy Lane, who is a health program analyst for the Appalachian Regional Commission.

We are very pleased to have you this morning. We know of your very extensive work and we know of your interest in this field. We are pleased to have your testimony.

STATEMENT OF NANCY M. LANE, HEALTH PROGRAM ANALYST, APPALACHIAN REGIONAL COMMISSION

Ms. LANE. Thank you, Mr. Chairman. I am very pleased to be here.

For those who do not know me, I would like to explain the context in which I come here. I am a health program analyst on the staff of the Appalachian Regional Commission. For the past 5 years, I have been part of the Commission's program to place primary care clinics in communities where access to health care is an identified problem.

Appalachian Regional Commission programs are developed and administered in partnership between the administration and the Governors of the 13 Appalachian States. We have two cochairman, former Governor Robert W. Scott, who was just appointed by President Carter and Governor Marvin Mandel of Maryland, who was selected by the Governors as States' Cochairman. The member States pay half of the costs for administering the Commission and have an equal role with the administration in determining program goals and priorities.

I would like to submit my prepared statement for the record.

The population of the 13-State region is largely nonmetropolitan; hence our concern with rural issues.

We have, at the moment, 200 clinics already funded as a part of the primary care demonstration that we started in 1965. This year, we expect to add another 40.

By statute, the Commission can support projects, in this case, clinics, for up to 14 months. We are required in setting them up and keeping them going, to be very conscious of their financial self-sufficiency.

Four years ago, we realized that the clinics we had then started—some 50—would not meet this criteria for financial self-sufficiency.

The clinics themselves organized task forces to deal with the third parties and the Commission supported their efforts.

In many of the Appalachian States, particularly those that have the most primary care clinics, the medicaid reimbursement policies have changed to reimburse clinics for the services of their nurse practitioners and physician assistants.

Private insurance for the most part, Blue Shield, followed the medicaid pattern. However, medicare, which represents as much as 30 percent of the visits to these clinics, still has not changed, and we in the Commission are concerned about the viability of the clinics.

Before going further, I would like to thank you, Senator Bentsen and Senators Dole and Talmadge, Chairman Rostenkowski and Congressman Duncan for your many, many efforts on behalf of the rural clinics. I speak not only for myself, but for the people running these clinics in the field.

Formulating the perfect bill is not easy. We do not pretend it is. But it is encouraging that you are showing enough interest to, I hope, do something for the clinics this year.

That will, as you pointed out earlier, leave us with other problems to solve. Solving the medicare problem will not solve the problem of medical indigency, which is prevalent in many parts of the rural South, the rural Midwest and other rural parts of the Nation. Another is the problem of two-parent families. A large number of low-income people from the medicaid program because of their family structure.

I would be less than honest with you if I did not say that. This bill will not solve all of the clinics' problems.

Let me say from the start that we are generally happy with the bill that came through the Subcommittee on Health of the House Ways and Means Committee earlier this week. That deals with the problem of physician-directed as well as non-physician-directed clinics. It takes care of urban clinics on a demonstration basis.

Our Governors signed the Rural Coalition Resolution, recognizing that, in urban areas, we do not know all of the answers, hence they were willing to accept urban clinic reimbursement on a demonstration basis.

The rural problem is more simply solved. It is also more pressing, and we see a need to address it this year.

Why did Appalachia get into clinics? I think that is an important point in support of this case. We have a very broad mandate for our funding. We can fund comprehensive health care in rural areas. We have tried a lot of things: Hospitals, ambulances, helicopters, physician recruitment, home health. Over the past 5 years, we have found that the clinics work. They are the least expensive of these options in providing health care for rural areas.

They are not free. We would be less than honest in saying that something put into an area where you previously had nothing is not going to cost more. Of course it will.

A handful of the clinics that ARC funded have failed. We think we now know the formula that makes them work. Our successful clinics have written standing orders that a product of negotiation between a supervising physician and extendors. These orders apply to the medical care provider. The supervising physician is legally responsible for the quality of medical care. The clinics have problem-oriented medical

records kept on all regular patients and medical records kept on all patients. They are designed for a geographic or population-specific area. They do have internal quality control, such as regular record audit. They have a provision for regular and service conferences between the physician and the extendors and supervisory physicians. They have appointment systems to make professional care and advice easier for patients to obtain through available telephone consultation and home visits. They do emphasize patient education and counseling as a part of the medical visit. They provide followup on missed appointments.

These may seem like minor points, but they are important to the Commission's stand that these types of clinics contribute to reduced hospitalization among the people they serve.

ARC has often been asked, why did we choose the nurse practitioner and physician assistant? We actually fell into this solution. We tried for doctors, but our data still show that physicians are leaving rural romote Appalachia. This occurs notwithstanding the increased supply of physicians. We have no reason to expect that the increased supply in 1980 will do anything to change this, because in many cases we are talking about communities where the largest population you can gather in a 30-minute ride is 1,500 or 2,500 people—2,500 is the bare minimum you need to support a physician.

People in these areas are currently denying themselves care. They will travel 2 hours to go sit for a day in a physicians office to get acute care. This is not a fictitious story. I came back from Mississippi just a week ago and the mayor was late for a meeting because he went to the doctor in Memphis, 2 hours away. They are denying themselves preventive health care and health maintenance care.

Mr. Bentsen earlier asked about cost. We have found that you can start a rural satellite clinic with two physician extenders—nurse practitioners or physician assistants—with a budget of roughly $60,000. This is opposed to the cost of setting up one physician, $80,000. As you increase the number of people you serve, you can increase your scope of services.

I would like to make some specific comments on the separate bills that are under consideration at this time. In the House Ways and Means Subcommittee on Health, the decision was reached to include full-time physician staffed clinics as well as part-time physician staffed clinics, in the reimbursement. This is important for Appalachia, because we do find that more than half of our clinics are physician staffed. Does this contradict what I said a moment ago about physician supply? No, not quite. We have found that if the population is adequate, a physician will often be attracted to work with one or two non-physicians, once an extender-staffed clinic is opened. He obviates solo practice for the physician. New physicians will not accept solo practice.

But a physician finds, in the extender staffed clinics, the kind of professional challenge, companionship, relief that he or she needs.

ARC supports reimbusement based on cost and we welcome the tests of reasonableness that are included in both S. 708 and H.R. 2504.

We are very happy to see both of those bills permit reimbursement directly to the clinic. This greatly facilitates both management and billing.

S. 708 requires that clinics have a means for "utilization review." We are a little bit concerned that that this term implies additional staffing, thus driving up costs. We prefer that you use the term "quality control."

The Commission also notices that none of the bills have a grandfather clause to insure that the clinics can continue to receive reimbursement should their areas suddenly become designated nonmedically underserved. We would hate to see that by solving the problem of providing services that they would become disqualified for reimbursement. Lack of such a protective clause does another thing. It sets up, in the eyes of the user, the possibility that this is really just a second-class kind of care, good only for emergencies, one which should be abandoned as soon as one can get to something better.

We share the administration's concern that the wording in S. 708 regarding storage and dispensing of drugs should be changed, and we recommend changing that requirement, to one that the clinic have the capacity to store and dispense drugs. I am sorry, Mr. Dole, that I do not have the number of States where pharmacy service is a problem, but I do know that we are dealing with it now in Tennessee and we have dealt with it in North Carolina. In North Carolina, if the pharmacist is nearby, the clinic cannot have pharmaceutical services inside the clinic.

In referring to the new health practitioners, we have chosen a large number of different terms. I myself must have used three or four of them in this morning's testimony.

The Commission appreciates the concerns of the professionals who have been broadly grouped under various terms in previous years and could easily endorse using more specific terms "physician assistant" and "nurse practitioner." These two terms seem to encompass all the qualified people that we have been employing in our clinics.

As to who should define nurse practitioner or physicians' assistant, the Commission is concerned that this is a right traditionally given to the States and we would prefer to see it remain there. The States, we realize, have a very broad range of definitions to encompass these professionals but we find that they are also dealing with a very broad range of problems. We would prefer to continue to leave that choice with the States.

S. 708 defines the relationship between physicians and new health practitioners. We have found that when physicians and new health practitioners jointly prepare the medical protocols they develop a better sense of agreement of each others' skill levels and the patient benefit. We would prefer this wording over the wording in H.R. 2504.

H.R. 2504 authorizes other requirements that the Secretary may find necessary for the health and safety of clinic patients. We recognize, again, the importance of having certification of medicare providers. We would express some concern that broad discretionary authority to regulate by the Federal Government can lead to defining standards that may add to cost.

Minimum standards, such as those currently applied to physicians' offices, and the standards for hospital outpatient departments, should be the standards for rural health clinics.

None of the bills under consideration makes specific mention of the fact that some of the services of new health practitioners are rendered

outside of the physical boundaries of the clinics. These include home visits, nursing home visits, hospital and home visits similar to those provided by physicians.

We hope that it would be the intention of the committee to include these types of services as reimbursable in the rural clinic bill.

As to cost, we have seen many estimates. The Social Security Actuarial Office has estimated the cost of the rural coalition resolution to be $2.5 million, plus $1 million for the 1-year fee-for-service demonstration.

I have looked at cost data and my estimates come close enough to that to be willing to stand by it.

There are many studies that have shown the reduced hospitalization. This should not be overlooked. If you carefully define health care clinics, this is a benefit that you expect in the long range. Our studies show that you should not expect it the first year, because in fact you are offering health care to people who have been for a long time without it.

I would point out to you that the average cost per person year in the primary care clinic sponsored in Appalachia is $55 for medical services. This compares very well with the national outpatient figures which, in 1976, were $120.67.

Again, even if you agree that these primary care clinics provide only half of the medical services the average person would require, we are well within that boundary.

I would like to thank you again for the opportunity to testify, and I would be glad to answer any questions you have.

Senator TALMADGE [presiding]. Thank you very much, Ms. Lane. I have no questions. I am aware of the fine job that you have done and are doing, and I congratulate you.

Senator Dole?

Senator DOLE. Just briefly, the legislation that we have, I think both measures—maybe three measures—calls for cost reimbursement for those services ordinarily covered by medicare provided by physicians.

What other professional services, not determined to be medical care, are provided by physicians' assistants and nurse practitioners? I think you have alluded to one, or maybe Dr. Davis may have alluded to one.

Ms. LANE. The major nonphysician service that they provide comes under the broad rubric of patient counseling. This is very, very difficult to define. I have spent many hours with our staff asking them to tell me what one does in patient counseling.

Frequently, a physician who has extra time and who is not seeing 80 patients or 60 patients a day, as frequently occurs in rural areas, will spend time explaining the medication procedures with their patients; will spend time explaining how diet relates to hypertension.

This is one of the big differences that we see in clinics that is not traditionally considered medical care, although I have a hard time defining it. The two professions call it the gray area where their authorities overlap.

Another thing that does occur, and is closely related to patient counseling, are education classes. They will frequently bring hypertensive patients in for a class. They will sometimes bring in prenatal

patients for a class. Again, this is under that broad rubric of patient counseling.

Senator DOLE. I think my point was: Are these services, a large part of the total care?

Ms. LANE. That varies so much from clinic to clinic. No, it is not a heavy volume of the patient care. If I were to estimate, I would say that patient counseling is separate from medical care, not rendered in conjunction with a medical visit. It may account from 5 to 10 percent.

[The following was subsequently supplied for the record:]

THE APPALACHIAN REGIONAL COMMISSION,
Washington, D.C.

Senator ROBERT J. DOLE,
Committee on Finance,
2221 Dirksen Senate Office Building, Washington, D.C.

DEAR MR. DOLE: In the hearings on the Rural Health Clinic bills, S. 708 and S. 1877, July 21, 1977, you asked several questions that I was unable to answer in detail. One was on the volume of nonmedical services in the clinics; another on the population of areas in which the clinics are located also proved a stumbling block. I have attached two staff reports prepared for me this week.

The first shows that the volume of preventive care in rural health clinics tends toward 20 percent, when grants permit the flexibility, but drops to 10 percent when the nurse practitioners are dependent upon a reimbursement scheme that favors episodic and medical care.

The second, taken from the ARC data system, shows that the majority, 80 percent, of the Appalachian clinics are located in towns of 10,000 or fewer people. In noting this, I would caution you that the data systems used by HEW to define medically underserved areas do not refine locations to this level of detail. Except for metropolitan areas and heavily populated towns, DHEW uses the county as the smallest unit. Roughly 20 percent of Appalachia's rural counties have populations between 30,000 and 50,000, even though individual towns have 1,000 or less.

Once again, I would like to thank you and the other members of the Subcommittee for taking the time to consider this bill during this summer session.

Sincerely,

NANCY M. LANE,
Health Program Analyst.

Date: July 29, 1977.
Subject: Response to Senator Dole's Question Concerning P.E. Utilization.
To: Nancy Lane.

The data will be grouped by source for clarity.

Hot Springs Medical Clinic.—Data is based on three clinics from 1973 through 1975 inclusive, on 4,500 visits per year. Percentage of persons receiving illness or preventive care is: 81.5 percent illness care and 18.5 percent preventive care.

"Time Motion Study of Pediatric Nurse Practitioners: Comparison with Regular Office Nurses and Pediatricians," Henry Silver, M.D. and Burris Duncan, M.D., Journal of Pediatrics, Vol. 79, No. 2, August 1971.—Distribution of time spent by Pediatric Nurse Practitioners in Medical and Non-Medical Functions: 28 percent nonmedical (counseling, consultation) and 72 percent medical.

Unpublished Study by Mary O'Hare Devereaux on 300 Family Nurse Practitioners at University of California-Davis.—Findings were composed of a cross-section of 13,740 patient visits in rural primary settings. Percentage of patients receiving either general medical or preventive: 90 percent general medical and 10 percent preventive.

Miss Devereaux stated that the method of reimbursement determines the proportion of time to be spent on medical and preventive services. By reimbursing services traditionally labeled as non-medical (counseling), the distribution would change to 70 percent general medical and 30 percent preventive.

An example would allow reimbursement for group education seminars, substitute diets or exercise programs as an alternative to the presently prescribed use of propanabol, a drug regimen for hypertension.

STANLEY KOUSSIS,
Health Analyst Assistant.

Date: July 27, 1977.
Subject: Primary Care Practioner Survey.
To: Nancy Lane.

Pursuant to the hearings being held on the revision of Medicare legislation, I thought the following information might be useful. These data originated from the Project Information System reports from 1975 and 1976. They were taken from all available reports from primary care programs; however, you will note that the return rate of approximately 29 percent is much lower than for other ARC-funded health programs (75 percent).

1. Number of centers surveyed: 57=29 percent.
2. Number of centers, employing one or more of the following: Nurse Practitioners, Nurse Clinicians, Physicians Assistants and Physician Extenders: 43=75 percent.
3. Number of primary care practitioners: 68 (survey).
4. Number of ARC-funded primary care clinics with primary care practitioners: 150 clinics (estimate).
5. Number of PP/clinic: 1.6 (average).
6. Total number of ARC-funded primary care practitioners: 240 (est.)

GEOGRAPHIC DISPERSEMENT (NUMBER OF NPS, PES, PAS, NCS AND PERCENT OF TOTAL NUMBER)

1. Urban (at least one town with a population over 10,000); 13=19 percent.
2. Small Urban (at least one town with a pop. between 2,500 and 9,999): 4=6 percent.
3. Small Town (at least one town with a pop. between 1,000 and 2,499): 35=51 percent.
4. Dispersed Rural (no towns greater than 1,000): 16=24 percent.

VIRGINIA GEMMELL,
Health Evaluation Specialist.

TABLE I.—DISTRIBUTION OF CLINIC VISITS BY PAYOR

Payor	Percent by clinic [1]						
	1	2	3	4	5	6	7
Self	28	55	66	63	34	49	40
Medicaid	10	6	18	15	29	19	23
Medicare	17	30	7	7	9	9	20
Private insurance	4	9	9	15	10	23	17
UMW funds	41				18		

[1] Key: 1—St. Charles Community Health Clinic, St. Charles, Va. 2—Mitre Study, ARC Clinics, 1976. 3—Neighborhood Health Centers—Rural, March 1976. 4—Nurse Practitioner Clinics, Rural New Mexico, 1974. 5—Laurel Fork—Clear Fork, 1976. 6—Hot Springs, N.C., 1975. 7—Grand Isle, Vt., 1976.

Senator DOLE. Do I understand correctly, do you favor one approach over the other, the so-called Rostenkowski bill as opposed to the Clark-Leahy? Do you have a preference?

Ms. LANE. The Clark-Leahy bill is definitely preferable to us, and very distinctly preferable before the House Ways and Means Subcommittee markup the other day, because the Clark-Leahy bill does include the physician-directed clinic. That was the major distinguishing feature between the two bills.

Senator DOLE. Did they amend that?

Ms. LANE. They did amend that in the subcommittee markup. The new bill is 8422.

Senator DOLE. Do you have any suggestions on the definition of rural area? The two bills in this definition are rather wide. One is 2,500, the other is 50,000.

I am just thinking about my own State of Kansas. Most areas where the population is 50,000 also have a number of physicians, where many of our small towns of 2,500 have none at all.

Ms. LANE. We worked with Senators Clark and Leahy's staff.

Senator DOLE. I do not think either one is the proper definition.

Ms. LANE. You are right. When we first started, we found some 28 definitions of rural available in Federal law. In choosing the 50,000 we were trying to get at the exceptions, trying not to eliminate Harlingen, Tex., if Harlingen, Tex., is slightly larger than one or the other of the "rural" definitions.

Selecting 50,000 was choosing between metropolitan and nonmetropolitan. We found that there are small communities, although they may not be incorporated that fall within a county of that size.

Senator DOLE. I assume that there may be regional clinics that would extend beyond county boundaries.

Ms. LANE. It is an impossible thing to quantify. There are going to be some worthy and deserving people left out, drawing the line at 50,000. We would like to say that we know enough to define the cutoff crisply. At the other extreme one can argue that we should not even have to say rural; we should go everywhere. The Commission looks at this as a first step, and if you draw the line at 50,000, you will get to those most in need, and probably will leave out a few, but not very many.

In Appalachia where we have counties of 50,000, we have what you call nonfarm rural. The counties are remote. It takes a full day to get from here to Harlan County, Ky., but the population of Harlan County outside of the incorporated city is around 50,000.

Senator DOLE. I can think of many small counties and many areas of Kansas that are 2,000 or less as a county unit.

Ms. LANE. The West is so very different from Appalachia. You do have people very widespread.

If you would draw the line at the 2,500, you would eliminate a large part of Appalachia.

Senator DOLE. According to the staff summary, if you use the Clark-Leahy definition you would have 31 million people, 15 percent of the population would live in areas where the benefits would be available. About 3.6 million would be medicare beneficiaries.

Ms. LANE. That is about right.

Senator DOLE. They do not compute the other. I assume it would be sharply reduced?

Ms. LANE. These are communities that are defined as medically underserved. With the medically underserved qualifier you eliminate communities with a saturation of physicians.

Senator DOLE. The second method that is considered would eliminate some of those areas that I have thought about.

You do support the cost-related reimbursement rather than fee for service?

Ms. LANE. We do, and quite honestly, for the very small communities, we do it recognizing that it will be more costly to medicare on a unit of service basis.

We have communities in Appalachia that are on the pilot experimental social security demonstration fee-for-service reimbursement where they are being reimbursed a percentage of the physicians' fee for their nurse practitioner and physicians' assistants.

Those communities are getting $3.64 per visit. Senator Dole, we have reduced costs, but we have not been able to get them down that far. Fee-for-service reimbursement under today's fee-for-service structure of usual customary fees separates urban from rural and sets different rates for both places. That type of reimbursement will not be very much help for our rural clinics.

That is our primary reason for going for cost reimbursement. A secondary reason is that it should cut down on the pingponging and on revisits. That, however, depends on how you define costs. If you do not set a test of reasonableness, if you have charge-related costs, you can get some of the same abuses.

I want to be very upfront about that so you do not accuse us later of destroying the Nation's medicare program.

Senator DOLE. It may have destroyed itself. Thank you very much.

Senator TALMADGE. Thank you very much, Miss Lane.

[The prepared statement of Ms. Lane follows:]

STATEMENT OF NANCY M. LANE, HEALTH PROGRAM ANALYST, APPALACHIAN REGIONAL COMMISSION

Mr. Chairman, my name is Nancy M. Lane; I am a health program analyst on the staff of the Appalachian Regional Commission. For the past five years, I have been part of the Commission's program to place primary care clinics in communities where access to health care is an identified problem. Appalachian Regional Commission programs are developed and administered in partnership between the Administration and the Governors of the thirteen Appalachian States. We have two Cochairmen, former Governor Robert W. Scott, who was just appointed by President Carter and Governor Marvin Mandel of Maryland, who was selected by the Governors as States' Cochairman. The member states pay half of the costs for administering the Commission and have an equal role with the Administration in determining program goals and priorities.

The population of the 13-state region is largely non-metropolitan; 45 percent of the 19 million people live in open country or towns of less than 1,000 persons. Another 8 percent live in slightly larger, but still non-metropolitan areas. They account for more than 85 percent of the land mass. Consequently, we tend to be concerned about issues that affect rural people.

ARC Role

Since its inception in 1965, the Commission has tried to develop programs that would improve rural health status without draining rural purses. We have also tried to keep our focus on health problems rather than medical care. Primary health care clinics staffed by new health practitioners, nurse practitioners and physician assistants specially trained in diagnosis and treatment of common health problems, are one of our successful solutions. We have legislative authority to provide communities with deficit funding for both construction and operating costs, but that authority is limited to 60 months for operating costs. Four years ago, we recognized that these clinics would not meet the second legislated mandate—financial self-sufficiency—unless something was done to change reimbursement policies. Medicare, Medicaid and the insurance companies, in most cases, did not cover the services of the new health practitioners. The UMW Health and Retirement Funds were an exception. The clinics organized task forces to deal with each third party. The Commission supported them. as the number of clinics and extenders increased, the States have changed their Medicaid programs. Today, 27 Medicaid programs reimburse; 9 in Appalachia. [1, 2] In most cases Medicaid brought a similar change in Blue Shield policies. Medicare, which represent as much as 30 percent of the usage, remains unchanged. Since clinic budgets are tight, survival requires multilateral cooperation.

[1] Kalmans, Pat, "Initial Survey Findings: State Reimbursement for Reimbursement for Clinic Services," Georgetown University Health Policy Center, June 27, 1977.
[2] Ridley, Don, "Table of Medicaid Reimbursment for Physician Extender Services," staff paper, April 1977.

Concerned about the plight of the clinics, the Commission, at a meeting in Annapolis, Maryland, March 21 of this year, adopted a resolution calling upon President Carter to join us in a request to Congress to act quickly on legislation to permit Medicare reimbursement for these services. Specifically, that resolution states:

Whereas, the overall Commission program of developing primary health care services in underserved rural areas is seriously jeopardized by the failure of Medicare to reimburse physician extenders, and

Whereas, even though the total question of reimbursement is complex and affects other professions, the settlement of the question of reimbursement for physician extenders should not be postponed until all the complex issues on all related matters have been totally resolved, and

Whereas, the Carter Administration has endorsed legislation now pending before the Congress, which, when approved, will overcome existing limitations under Title XVIII of the Social Security Act, and

Whereas, the people served by these clinics have no alternative accessible sources of health care;

Now, therefore, be it resolved that:

The Appalachian Regional Commission hereby expresses its appreciation to President Carter for his support of pending legislation, and

Hereby requests priority attention to the Administration's efforts and prompt passage of appropriate Legislation.

June 1976, the Commission passed another resolution that outlines the conditions under which the members endorse reimbursement for physician extenders. Specifically, these are:

(*a*) The physician extender is functioning in an organized health care system;

(*b*) The physicina extender is providing medical services according to written standing orders agreed upon by a duly licensed physician (whether or not such services are performed in the office of, or at a place at which such physician is physically present;

(*c*) The physician participating in the written orders assumes full legal and ethical responsibility as to the necessity, propriety and quality thereof;

(*d*) The reimbursement be provided at a rate commensurate with the services provided, rather than the provider of services; and

(*e*) The reimbursement be made to the clinic or sponsoring organization.

Last month, the Governors, recognizing the need to start where the problem is acute and to open the issue gradually, accepted the language of the attached Rural Coalition resolution.

ARC Clinic Problems

Today, with the number of ARC-supported clinic projects expected to reach 240 by October 1, the problem is even more acute for the Appalachian people. Twelve of the clinics have been able, with the cooperation of the Secretary of DHEW, to obtain another temporary lease on life through the RHI grant program. A few have closed; nine have pending requests; ten more that will reach their 60 months October 1, are uncertain. In Central Appalachia, where many clinics became self-sufficient, the problem is growing. United Mineworkers Health and Retirement Funds, which formerly paid 100 percent of charges, fully intending to cover a share of indigent care costs, has been forced to cut back. The Funds have been seriously troubled by the strikes, floods, freezes and other events that reduced coal tonnage this year.

Once the grants have ended, the clinics must either find their support from non-federal sources or restrict services to people who can pay the total cost of the service. Unfortunately, many eligible people are thus required to pay twice because the service cannot be reimbursed under Title XVIII, Part B of the Social Security Act, to which they have subscribed. Currently, Title XVIII prohibits reimbursement for services of the new health practitioner, unless a physician is present and immediately reviews the diagnosis and treatment provided.

The Frontier Nursing Service, a network of seven nurse practitioner clinics in Southeastern Kentucky, faces a deficit of some $140,000 this year, attributable, in large part to care for Medicare and Medicaid patients whose services were not reimbursable. FNS has already closed three of its clinics because of the combined financial strain of the third parties' refusal to pay for the health services provided by nurse practitioners. Although it will be possible to solve the problems of these pioneer clinics with new temporary grants, the number will be less manageable when those started by the foundations and State programs, such as North Carolina are added to Appalachia's 240.

If these clinics fail, we will have destroyed the growth of an alternative to expensive hospitalization. At their current costs, these clinics provide visits for chronic care to Medicare patients at one-sixth (1/6) the price of a single day in the average hospital.[3] The study recently completed for the ARC by the Mitre Corporation[4] suggests that these clinics do, in fact, contribute to reduced hospitalization—10 to 80 percent over paired control communities.

National Problem

The problem is not confied to Appalachia. Since we first raised the issue, we have received letters from clinics across the country. Other Governors have joined ours in passing resolutions asking for change. The attached table of urban and rural per capita reimbursement under Part B Medicare shows it another way. In every one of the 21 States sampled, the urban-rural differential is marked. In one, the urban rate is almost twice the rural. The span is a product of many factors, but we looked more closely at West Virginia's, on a county by county basis. The counties with the lowest rates were also the counties without physicians.[5]

Residents of medically underserved areas do see doctors as frequently as residents of served areas—for purposes of acute care. In rural areas, the medically underserved short-change themselves for preventive services and health maintenance.[6]

The recent health manpower legislation notwithstanding, physicians are not moving to Apalachia. In some rural parts of Appalachia, particularly the rural South, physicians are still leaving.[7] Yet, with grant support, the practitioners have been willing to settle into the same towns vacated by the physicians. The current estimated 500 to 700 clinics nationwide,[8] represent only a partial answer. They serve only one-sixth (⅙) of the nation's rural medically underserved areas. Without passage of legislation, most of the remaining 83 percent of these areas will continue to be without service.

Will the need for the new health practitioners disappear in 1980, when the nation will have more primary care physicians? Data from the family practice residencies show that they tend to settle in towns of 20,000 or greater. The primary care shortage in these towns and the lack of incentives for the smaller ones will continue to work against the remote areas. With even the National Health Service Corps scholarships, the physicians will not want to choose the small remote town that has no social life and a poor economy when classmates are settling in strong economic areas and getting paid better by the third parties. The Corps continues to place nurse practitioners and physician assistants in clinic settings where the economy cannot support physicians—or where more than one provider is needed, but the economy cannot support two physicians.

If the new health practitioners could not be attracted to the remote settings like Clairfield, Elkland, St. Charles, Farmington, Briceville, and Washburn, the Commission program would not have grown so. Their turnover is still high; the average stay is 2.5 years; but they come. A recent study by the University of North Carolina Department of Economics showed that the financial stability provided by the grants is a major factor.[9] Their study included 101 rural clinics. We saw this in recruiting for Laurel Fork between grants.

One unepected benefit we have found is that the practitioners act as magnets for physicians in remote areas. Communities like St. Charles, that recruited more than four years for a physician, found one who would join the nurse practitioner six months after she was hired.

Clinic structure

This brings me to the importance of clinic structure. Personnel can turn over, but a well-organized clinic can absorb their changes. The North Carolina study also shows that the longer a clinic is in place, the less it is affected by a change

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[3] SSA/OPPP/ORS Health Insurance Statistics Bulletin No. HI–76, March 4, 1977, DHEW, Washington, D.C.

[4] Carol Anderson, Ed Nedham, Donald Vicary, *"Effect of Primary Health Care Provided by Physician Extenders on Total Community Health Costs,"* February 1977 (ARC, Contract No. TQ–41).

[5] Aston, Lydia, "What's Happening to West Virginia's Medicare Dollars?" *West Virginia Journal of Medicine*, February 1976.

[6] Joel C. Kleinman and Ronald W. Wilson, "Validation of the Medically Underserved Area Assignation," presented in part at 104th American Public Health Association meeting, National Center for Health Statistics/HRA/DHEW, April 1977.

[7] Jerome Pickard, ARC date file, January 1977.

[8] Unpublished SSA/DHEW actuarial estimate, February 1977.

[9] David M. Deitz, Roger Feldman and Edward F. Brooks, "The Economic Viability of Rural Primary Health Care Centers," research paper from NCHSR/HRA/DHEW grant number HS 01971, Chapel Hill, N.C., May 1977.

in personnel. This is in sharp contrast to the trauma caused by the departure of solo or partnership physicians from small towns.

Clearly, a bill to permit reimbursement to clinics is in the best interest of the small towns and rural areas of this country. Congressmen Rostenkowski and Duncan, with many others in the House, and Senators Talmadge, Clark, Leahy, Dole and Bentsen are to be commended for their leadership in this respect.

Critique of bills

With regard to the bills under discussion, I should like to make several points:

(1) Although the wording in S. 708 Section (b)(aa) appears to need amendment to include the term, "physicians services," in order to make their inclusion clear, we endorse reimbursement for services of physician extenders when they are provided in clinics staffed by full-time as well as part-time physicians. This occurs in more than half of the Appalachian clinics. H.R. 8422 has added this provision.

(2) Reimbursement based on costs reasonably related to the provision of services is also welcomed. We see the need for tests of reasonableness, rather than permission for the costs to escalate without control, as has occurred in other Medicare cost-reimbursement programs. Our clinics are presently operating on moderate standards that keep their costs low and make them accessible to their clientele. If the Medicare regulations were to discourage this, we would later be accused of contributing to unnecessary inflation in health care costs.

(3) Reimbursement should be direct to the clinics. This will greaty facilitate management and billing.

(4) S. 708 requires that the clinics have a means for utilization review. Some have expressed concern to us that this is a term of art, requiring sophisticated staffing. We suggest that the same intent could be preserved were the bill to require "quality control."

(5) I notice that you have not added a grandfather clause to insure that clinics can continue to receive reimbursement if their area is no longer designated medically underserved. This oversight appears to mark these as second-class services good only for emergencies. Though it is not an official Administration position, the Commission supports the quality of these clinics as permanent services.

(6) We share the Administration's concern that the wording in S. 708 with regard to storage and dispensing drugs, in the definition of clinic (Section (b) amending Section 1861 with (aa)(2)(G)) should be changed so that the conditions for participation will not be overly restrictive. We recommend changing the requirement that the clinic have the capacity to store and dispense drugs to a requirement that the clinic make appropriate provision for administering and dispensing drugs and biologicals. This would provide flexibility without comprising the level of services.

(7) In referring to the new health practitioners, S. 708 uses the term physician extenders. The Commission appreciates the concerns of the professionals who have been broadly grouped under this term in previous years, and endorses changing the term to the more specific terms "nurse practitioner and Type C Certified physican assistant."

(8) The definition of physician extender in S. 708 is left to two exams, administered by the American Nursing Association and the Commission on Certification of Assistants to Physicians. While we agree that these are carefully designed exams and represent proficiency testing at the best current state of the art, we would prefer to see the issue of certification and licensure left in its traditional place, with the States. This permits States to accept these exams, and we would endorse a recommendation to do so, but it does not deprive the States from experimentation and development of new and better vehicles.

(9) S. 708 appropriately defines the relationship between physicians and the new health practitioners in Section (C) of (aa)(2) amending Section 1861. We have found that when physicians and the new health practitioners jointly prepare the protocols (or standing orders) for medical care, they develop a better sense of agreement and of each other's skill and background levels. The patient benefits.

(10) One of these bills, H.R. 2504, authorizes such other requirements as the Secretary may find necessary for the health and safety of clinic patients. It later requires certification by the State agency that clinics meet the requirements of the bill and other regulations prescribed by the Secretary. Taken at face value,

these seem like reasonable requirements. Past experience shows that broad discretionary authority to regulate by the Federal Government can lead to defining standards that may add to costs. Minimum standards, such as those applied to physicians' offices, not the standards for hospital outpatient departments, should be the building standards for rural health clinics.

(11) None of the bills under consideration makes specific mention of the fact that some services of the new health practitioners are rendered outside the physical boundaries of the clinic. These are home visits, nursing home and hospital visits, similar to those provided by physicians. We would hope that it is the full intention of the Committee to include these as reimbursable.

Benefits and costs

It would seem that this bill will only add to and expand the already too large drain on the Health Care Insurance Trust Fund. Indeed, it will add some expenses, particularly in the short run. The Social Security Administration actuarial office has estimated that S. 708, with the demonstrations proposed by the Rural Coalition, would cost $26 million in fiscal year 1978. From ARC cost data and the number of graduate new health practitioners, I get similar figures.

We should not in this discussion overlook the potential long-range benefits. From studies by Davis,[10] Runyan,[11] Isaacs,[12] Anderson *et al.*,[7] we get repeating reports that the organized clinics reduce hospitalization for medical reasons, among their clientel. It would appear that the greatest reductions are among the hypertensives, diabetics and those with circulatory disorders. However, it is common knowledge that these account for more than half of the hospitalization rates among the elderly.

The average cost per person per year at a primary care clinic sponsored by the Commission is currently $55 for medical services. This compares well with national outpatient averages.

SUPPLEMENTAL MEDICAL INSURANCE PAYMENTS PER CAPITA, 1972

[Dollars per capita]

	Metropolitan County		Nonmetropolitan county
	With central city	Without central city	
U.S. average	107.59		
United States (+61.3 percent)	125.09	113.88	77.54
Alabama	91.41	75.72	70.79
Alaska	157.50		117.00
Arizona	135.64		84.50
Arkansas	105.14	82.30	79.54
California	165.92	165.64	130.61
Colorado	125.51	115.61	92.77
Connecticut	111.94		84.04
Delaware	104.03		74.19
District of Columbia	155.86		
Florida	153.80	103.00	98.48
Georgia	105.60	98.44	77.39
Hawaii	121.74		69.64
Idaho	94.82		81.00
Illinois	99.44	84.30	67.67
Iowa	83.28	99.55	70.94
Kansas	101.57	98.24	78.87
Nevada	148.00		110.12
New York	162.99	141.54	87.77
Wyoming			75.08
Texas	115.52	91.15	87.61

[10] Karen Davis, "Health and the War on Poverty," P 5–39, The Brookings Institution, Washington, D.C. (draft to be published).

[11] Runyan, John, M.D., "Ambulatory Health Care Approaches to Chronic Illness," paper presented at Naval Regional Medical Center, San Diego, February 12, 1976.

[12] Karen Gordon and Gertrude Isaacs, *"Reduced Hospitalization Through Decentralized Care of Chronically Ill,"* Frontier Nursing Service, Hyden, Kentucky, December 1975 (unpublished).

RURAL COALITION RESOLUTION REGARDING S. 708 AND H.R. 2504, JUNE 14, 1977

Members of the Senate Finance and House Ways and Means Committees, the organizations listed below endorse the following principles as the basis of legislation to bring health services to medically underserved areas—

1. The most urgent, critical need for health services exists in medically underserved small towns and rural areas, many of which rely upon primary health clinics staffed by nurse practitioners or physician assistants. Therefore, Medicare reimbursement should be expanded to cover health services provided by those clinics, as a first step toward reimbursement by all third-party payers, for primary health services in all medically underserved areas.

2. Reimbursement for clinic services should be related to the cost of providing the primary health services, should go to the clinic rather than to any particular provider, and should cover physician services in addition to those provided by nurse practitioners and physician assistants.

3. Public primary health clinics and primary health clinics that receive Federal operating funds that are located in urbanized medically underserved areas should be eligible for cost reimbursement on a demonstration basis.

4. In recognition of the fact that physicians in private practice that employ nurse practitioners and/or physician assistants help fill the gap of primary health services in small towns and rural areas, and since many such physicians are reluctant to become salaried providers within a clinic, they should be allowed another option. On a one-year demonstration basis, they should be permitted to choose fee-for-service reimbursement covering the services of the nurse practitioners and physician assistants they employ, at a rate that is equivalent to the physician's usual and customary rate. Physicians that select this option should not be permitted to employ more than two physician assistants or nurse practitioners.

5. The Secretary of Health, Education, and Welfare should report to Congress one year after implementation of this legislation on the rural and urban demonstrations and on the rural cost reimbursement arrangement. This report should address the questions of expanding the program to urban areas and continuing the fee-for-service arrangement.

6. Except for the urban demonstration component, a clinic or practice eligible for reimbursement should be one that serves a rural, medically underserved population. "Rural" should be defined as an area that is not "urbanized," a Bureau of the Census term that would, in effect, exclude communities over 50,000 and their suburbs. Clinics or practices receiving reimbursement in areas that lose their designations as "medically underserved" should continue to receive reimbursement.

We urge the House Ways and Means Committee and the Senate Finance Committee to promptly act upon these principles, so that primary health services will be more accessible to medically underserved Americans.

American Academy of Physician Assistants.
American Nurses' Association.
American Hospital Association.
Appalachian Regional Commission.
Association of Physician Assistant Programs.
Friends Committee on National Legislation.
National Association of Community Health Centers.
National Association of Counties.
National Association of Farmworker Organizations.
National Association of Social Workers.
National Council on the Aging.
National Council of Senior Citizens.
National Farmers Union.
National Retired Teachers Association/American Association of Retired Persons.
National Rural Center.
National Rural Electric Cooperatives Association.
United Mine Workers of America Heatlh and Retirement Funds.

APPALACHIAN REGIONAL COMMISSION RESOLUTION No. 407

A RESOLUTION CONCERNING MEDICARE REIMBURSEMENT OF PHYSICIAN EXTENDERS

Whereas, the 1972 Amendments to the Social Security Act, Public Law 92-603 directed the Secretary of the Department of Health, Education and Welfare to examine the quality, cost and range of health care that can be appropriately delivered by non-physician providers, and to determine the constraints that should be imposed in order to permit Medicare reimbursement for services provided by such persons; and

Whereas, in Senate Report 94-278 accompanying the 1975 Amendment to the Appalachian Regional Development Act, the Public Works Committee of the Senate noted, as a serious problem, that present Medicare regulations do not recognize or permit reimbursement for primary health care services provided by a nurse practitioner or other physician extender, unless a physician is physically present; and urged consideration of this problem by the Senate Finance Committee and the appropriate Committee of the House; and

Whereas, the Appalachian Regional Commission, together with the Tennessee State Health Department, the North Carolina Office of Rural Health Services, the Kentucky Health Resources Development Institute, the Frontier Nursing Service, the West Virginia Regional Medical Programs, the Tennessee Valley Authority, the United Mine Workers Health and Retirement Funds, the Southern Labor Union, and the Vanderbilt Center for Health Services, among others, have found by trial and careful testing that physician extenders do provide appropriate primary health care, especially to persons immediately underserved areas, who otherwise would have limited ability to exercise their entitlement to Medicare services; and

Whereas, physician extenders are physician assistants, nurse practitioners, nurse clinicians, or other trained practitioners, who have successfully completed a program of study approved by the National Board of Medical Examiners, or who are licensed or otherwise recognized by a State as qualified to provide primary health care services in the State in which such services are rendered; and

Whereas, the Commission and other sponsoring agencies above mentioned have also found the services provided by these physician extenders, who function in organized systems of care (whether or not performing in the office of, or at a place at which a physician is physically present), to be commendable quality; and

Whereas, the above-mentioned agencies have also found the services provided in this manner help to prevent escalation of health care costs for Medicare beneficiaries; and

Whereas, Section 102(a)(3) of the Appalachian Regional Development Act authorizes the Commission to review Federal, State and local public and private programs, and where appropriate, recommend modifications to increase their effectiveness in the Region;

Now, therefore, be it resolved, that:

The Appalachian Regional Commission recommends that Title XVIII of the Social Security Act, Part B Medical Insurance (42 U.S.C. 1305), and all such other medical entitlement programs be amended to permit:

(1) Reimbursement for primary health care services provided by physician extenders, as defined above, when the following safeguards are met:

(a) The physician extender is functioning in an organized system of care;

(b) The physician extender is acting under written standing orders agreed upon by a duly licensed physician (whether or not such services are performed in the office of, or at a place at which such physician is physically present at the time of the specific service); and

(c) The physician providing the written orders assumes full legal and ethical responsibility as to the necessity; propriety and quality thereof;

(2) Such reimbursement be provided at a rate commensurate with the service provided rather than according to the provider of care; and

(3) Such reimbursement be made to the clinic or sponsoring organization.

Approved: *June 22, 1976.*

DONALD W. WHITEHEAD,
Federal Cochairman.
MILTON J. SHAPP,
Governor of Pennsylvania, States Cochairman.

APPALACHIAN REGIONAL COMMISSION RESOLUTION NUMBER 433

A RESOLUTION CONCERNING THE NEED FOR IMMEDIATE ACTION TO PERMIT REIMBURSEMENT OF PHYSICIAN EXTENDERS

Whereas, the Appalachian Regional Commission has demonstrated that primary health care clinics staffed by nurse practitioners, physician assistants, and other physician extenders, specially trained for primary health care, are extremely effective in making quality health care accessible to people in more than 100 communities that would otherwise have no health care, and keep cost of health care within reasonable reach of the people; and

Whereas, building on this achievement, several member States, Kentucky, Tennessee, North Carolina, Maryland, and New York, that we know of, have developed special state-level programs to expand the use of physician extenders; and

Whereas, these clinics cannot be self-sufficient unless their services are reimbursed by Medicare, Medicaid and private insurance programs; and

Whereas, current Federal law restricts such payments; and

Whereas, the Commission, almost a year ago, in June 1976, unanimously approved Resolution 407 which asks that the Social Security Act be changed to accommodate reimbursement for services provided by physician extenders working in primary health care clinics; and

Whereas, legislation that would correct this problem has been introduced in both the United States House of Representatives and the Senate, but not acted upon; and

Whereas, the overall Commission program of developing primary health care services in underserved rural areas is seriously jeopardized by failure of Medicare to reimburse physician extenders; and

Whereas, even though the total question of reimbursement is complex and affects other professions, a settlement of the questions of reimbursement of physician extenders should not be postponed until all the complex issues on all related matters have been totally resolved; and

Whereas, the Carter Administration has endorsed legislation now pending before the Congress which, when approved, will overcome existing limitations upon Title XVIII of the Social Security Act; and

Whereas, the people served by these clinics have no alternative accessible sources of health care;

Now, therefore, be it resolved, that:

The Appalachian Regional Commission hereby expresses its appreciation to President Carter for his support of pending legislation and hereby requests priority attention to the Administration's efforts and prompt passage of appropriate legislation.

Furthermore, until such time as the Congress can complete it deliberation on the Amendments to Title XVIII of the Social Security Act, the Appalachian Regional Commission requests that the President waive Federal regulations that bar those Commission-sponsored rural primary health care clinics from eligibility under the Department of Health, Education, and Welfare program for health in underserved rural areas.

Approved: *March 21, 1977.*

MARVIN MANDEL,
Governor of Maryland, State Cochairman.
DONALD W. WHITEHEAD,
Federal Cochairman.

Senator TALMADGE. Congressman Duncan was scheduled to testify but being a member of the House prevented his appearance. At this point, we would insert his full statement in the record.

[The prepared statement of Hon. John J. Duncan follows:]

STATEMENT OF THE HONORABLE JOHN J. DUNCAN

Mr. Chairman, I would like to say, first of all, that I am extremely pleased to have the opportunity to appear today, and to provide the distinguished members of this subcommittee with my views on a most important subject and a very significant bill.

Just this week, the Ways and Means Health Subcommittee, on which I have the privilege of serving as the ranking minority member, voted 12–0 to report favorably the bill H.R. 2504, with certain amendments, that will provide coverage for services furnished to medicare beneficiaries by rural health clinics.

In a moment, I will describe very briefly what I believe are some of the more important provisions of that legislation, which this subcommittee is now preparing to consider along with other proposals designed to achieve the same ends. I recognize that the views of witnesses who testified before the Ways and Means Health Subcommittee and other committees are available to you. I believe that their testimony drives home the fact that there is a pressing need for this legislation, and that serious problems in our health care delivery system might be solved by its immediate enactment into law.

Last year, the chairman of our Health Subcommittee, Dan Rostenkowski, went with me to visit two rural health clinics in my own State of Tennessee. We observed, firsthand, how physician assistants and nurse practitioners could provide primary and emergency care of extremely high quality to many citizens—young and old—who otherwise would not have access to such treatment. Community support and acceptance of these clinics was expressed by virtually all the people we spoke with—the people who use these clinics and depend on them to provide medical care to their families.

We also learned, unfortunately, that many of these clinics are not eligible for medicare reimbursement, generally because they are located in areas where a physician is not present full time to directly supervise the care provided by the trained physician assistants and nurse practitioners who staff these clinics. The services provided to medicare beneficiaries in such cases often are paid for out-of-pocket by the elderly beneficiaries. Although most of them are financially "strapped", they pay their monthly part B premiums like all other program beneficiaries. But, since these people are unfortunate enough to be living in areas where reimbursable services are not available, the term "beneficiary" takes on a very hollow meaning. The services provided by these clinics for those who are unable to pay must now be paid for by grants and still others simply are written off as bad debts.

Unfortunately, some of these clinics may be forced to close within the next few months. In part, this is because their grants, particularly those from the Appalachian Regional Commission, are due to expire. It became clear to our Health Subcommittee that most of those clinics, and other State and locally funded clinics, can only continue to operate, and become financially stable, if medicare reimbursement is made available for the services of these physician assistants and nurse practitioners, and for the supplies provided by clinics.

Chairman Rostenkowski and I were quickly and firmly convinced that legislation in this area was needed urgently. Legislation was introduced almost immediately after our visit to the rural health clinics, was reintroduced at the beginning of the 95th Congress, and has been given top priority. Other Members, of both parties and on a variety of legislative committees, have expressed interest in, and support for, this legislation.

The bill, as reported, would make payment to clinics, on the basis of costs incurred, only for services already covered under medicare, when these services are provided to beneficiaries. The clinics would have to meet standards set forth in the bill. Reimbursement would be made for any service which would otherwise be covered under the medicare program if provided directly by a physician.

The bill, as amended, will allow medicare to pay for services provided by primary care practitioners in rural clinics when there is a physician available on a full-time basis and in clinics where only physician backup services are available.

In response to numerous recommendations received by the subcommittee, the term "physician extender" was changed to "primary care practitioner." It was also recognized by the subcommittee that primary care practitioners, particularly nurse practitioners, provide a number of services, such as counseling and health education, that are not appropriately supervised by a physician. However, the services covered under the medicare program, and under the bill, are actual medical care services such as treatment of infections and minor surgery. It was thought appropriate that primary care practitioners providing such medical services have adequate physician backup. Therefore, the bill was amended to require physician supervision and guidance only for services covered under the medicare program, rather than all services provided in the clinics.

Our subcommittee also recognized that there may be a need for similar coverage in certain urban medically underserved areas. However, many witnesses

pointed out that a variety of problems might be more likely to exist in such areas—such as rapid proliferation of clinics that would require substantially higher funding than the relatively small sum H.R. 2504 will cost our taxpayers, and the increased potential for fraud and abuse. Since, quite frankly, we do not feel that we have all the information that we need at this time, our subcommittee adopted an amendment that would direct the Secretary to conduct a broad-scale demonstration project that will help us find answers to questions concerning appropriate staffing of such clinics, the best methods of reimbursement, compensating physicians who provide services, and similar important but thorny questions. I believe that such a demonstration project is a wise and potentially valuable way to proceed.

Our subcommittee agreed, in addition, to adopt an amendment that would direct the Secretary to develop and carry out demonstration projects to provide reimbursement for services provided in organized centers offering comprehensive outpatient mental health services, in order to evaluate changes which might be appropriate for the more efficient and cost-effective reimbursement of such services. The Secretary would report his findings and any recommendations by January 1, 1981.

In conclusion, Mr. Chairman, I would strongly recommend that the members of this subcommittee act quickly to enact legislation that will enable our elderly in rural medically underserved areas to receive the kind of care they already are entitled to, and which they desperately need.

Our Health Subcommittee began the necessary steps to enact H.R. 2504, which I feel is a fine measure that will add stature to the health legislation of our country. I am confident our full committee, and the House of Representatives, also will move promptly to support this legislation. I urge this subcommittee to provide the Senate with a similar bill, so that we can give the people a law that is equitable, cost-effective, and urgently needed. I hope that I may look forward to the passage of that legislation by the Congress as quickly as possible.

Thank you.

Senator TALMADGE. The subcommittee will stand in recess, subject to the call of the Chair.

[Thereupon, at 11:50 a.m., the subcommittee was recessed, to reconvene at the call of the Chair.]

[By direction of the chairman, the following communications were made a part of the record:]

STATEMENT OF CONGRESSMAN JAMES T. BROYHILL

Mr. Chairman and Distinguished Members of the Subcommittee:

I welcome the opportunity to share with you my views on legislation to reimburse the services of physician assistant and nurse practitioners under Medicare. I possess a dual interest in this legislation—not only am I a member of the Interstate and Foreign Commerce Health Subcommittee and the original sponsor in the House of Representatives of such legislation, but I am also a concerned representative of a state in which the survival of 30 rural clinics may very well hinge upon the passage of a bill this year.

I believe you all are aware of the need for this legislation. Over the past several years, we have committed millions of dollars to the training of physician assistants and nurse practitioners. We have injected tax dollars into the Medicare and Medicaid programs. We have encouraged the elderly and disabled to use the services of local clinics, and we have trained personnel to aid the physicians in providing these services. And yet, we deny reimbursement to these so-called "physician extenders," who many times are performing the same services for which physicians are eligible for reimbursement. Of course, the brunt of this situation is born by the elderly, the disabled, and America's needy, who are simply not receiving the health care services the Medicare and Medicaid programs were created to provide. This is especially true in the rural areas of our country.

There are several key differences between H.R. 2504, S. 708, and my bill H.R. 791:

I believe that both rural and urban medically-underserved areas should be included in the bill. However, at the same time, I realize that the inclusion of urban areas could be costly. The figures I have seen for the cost of the bill

with urban areas included vary as much as $25 million. In light of this uncertainty, I welcome the approach taken by the Ways and Means Health Subcommittee during recent mark-up, in which urban areas have been included on a demonstration basis.

Another point on which my bill and H.R. 2504 differ is that I believe physician-directed clinics should be reimburseable. To do otherwise would be to, in effect, penalize those rural areas which are fortunate enough to have found a doctor. To preclude physician-directed clinics from reimbursement is a measure I cannot support, and I am pleased that Senators Clark and Leahy have made provisions in their bill for physician-directed clinic reimbursement. Also, I am encouraged that in the Ways and Means Subcommittee mark-up a provision was adopted to reimburse physician assistants and nurse practitioners employed by physicians in rural, medically-underserved areas.

The third major suggestion I have is that we do not add cumbersome requirements which will bury the clinics in paperwork, add considerably to the costs of their administration, or delay implementation of the law. For example, the bill as marked-up by Ways and Means provides the Secretary of Health, Education and Welfare with at least five opportunities to promulgate regulations. Two other sections authorize him to carry out demonstration projects.

Where no detailed study is involved, I believe it is preferable for the Congress to enact the specific provisions, rather than give HEW the authority to do so. For example, in my bill, H.R. 791, I have defined the term "physician extender"; in H.R. 8422—the marked-up H.R. 2504—several definitions are given for "primary care practitioner," coupled with the necessity that the primary care practitioner meet requirements which may be prescribed by the Secretary of HEW.

The final point I would like to make is that, many times, the states have already existing mechanisms which are functioning on their own, and should be left that way if at all possible. This is why I prefer that any definition of physician extender be paired with the already-existing state definition. This is also why, although I support the concept of Medicaid reimbursement for the services of physician assistants and nurse practitioners, I would like to make certain that present state plans are not hampered by the bill. In North Carolina, we are already reimbursing rural clinics for services under Medicaid, on the basis of clinic cost as defined by the state. I am concerned that cost reporting systems as have been proposed would make a simple system too complex.

My overriding concern, and I believe the point of primary importance to the subcommittee, should be the end result of providing necessary medical services to our elderly and disabled citizens. Do not let definitions of "primary care practitioner" or "physician extender" sidetrack us from our goal. Let's try to make certain that the extenders are competent and well-trained, that the clinics are administered and guided properly. Let's try to make certain that our tax dollars are spent in the most responsible manner. Above all, though, let's make certain there is no further delay in enacting this needed legislation.

STATEMENT OF THE COLLEGE OF AMERICAN PATHOLOGISTS

The College of American Pathologists (CAP) appreciates the opportunity to present its views on several closely related bills which would provide coverage for services furnished to Medicare beneficiaries by rural health clinics.

The College is a nonprofit, voluntary medical specialty organization, headquartered in Skokie, Illinois. The CAP was founded in 1947, and has more than 7,000 physician-members who practice the medical specialty of pathology. CAP Fellows are certified by the American Board of Pathology.

Our members practice in hospitals, in independent medical laboratories, in medical schools, in military institutions, and in various facilities of Federal, state, and local governments. In addition, our members work in medical laboratory research institutions and in industry producing medical devices and in-vitro diagnostic products.

We recognize the need for improved access to health care in medically underserved areas; both rural and urban. We support efforts to improve that access.

We note, however, that several of the bills (S. 1877 and H.R. 2504) addressing this issue contain a provision that rural health clinics must directly provide "routine diagnostic services, including clinical laboratory services . . ." We assume that the term "directly provide" means "perform."

The College does not believe the performance of laboratory procedures to be an appropriate function of a rural health clinic and that it should not be included in this legislation.

To single out and identify a requirement for clinical laboratory services places the emphasis on a service that should not be the primary function of a rural health clinic. If one service is specified, all services to be directly provided by such clinics should be written into the legislation to ensure that rural health clinics offer the necessary scope of services.

Of utmost concern to the College is the quality of laboratory services in the United States. The specialty of medicine that encompasses clinical laboratory services is a constantly changing, technologically advancing medical science. We must question the ability of physician extenders and nurse practitioners to perform or to direct the performance of quality laboratory test procedures. Pathologist-directors of laboratories spend many years in training and study in order to assume the responsibility of interpreting the results of laboratory tests and the many other medical services required of them. Medical technologists are intensely trained, either through formal education or on-the-job experience for the precise procedures necessary to perform quality laboratory tests. We do not believe that the training and education of physician extenders or nurse practitioners prepare them for this discipline or for the interpretation of test results.

We must also question the use of the term "routine" diagnostic services. We assume this also means routine clinical laboratory services. What is a routine clinical laboratory service? A procedure that is considered routine in New York may not be considered routine in Kansas. Furthermore, a procedure may be routine, but the interpretation of the results of that procedure may be very "unroutine." For example, a complete blood count (CBC) is one of the most commonly performed laboratory procedures. However, the interpretation of a CBC result can be one of the most difficult.

It would also be possible that an energetic rural health clinic could escalate the concept of routine and thereby increase the costs of the program. For example, a clinic may decide that it needs an expensive and highly technical piece of equipment in order to run a servies of tests that the clinic consider routine. Who will run these tests? Who will run the equipment? Who will assure quality control? We do not believe rural health clinic personnel would be sufficiently trained to effectively operate and maintain highly sophisticated laboratory equipment.

The College recommends the requirement that a rural health clinic directly provide clinical laboratory services not be included in a bill approved by the Subcommittee.

We suggest that language be substituted that would require a rural health clinic "have access to diagnostic services, including clinical laboratory services . . ."

In many rural areas of the country, pathologists have established networks of central and satellite facilities in order to provide services to many medically underserved areas. It would seem appropriate and advisable that rural health clinics "tie into" these highly evolved systems and thereby benefit from the ready expertise of not only pathologists but also trained medical technologists.

The Subcommittee on Health of the House Ways and Means Committee has approved H.R. 2504. This bill contains the provision requiring that clinical laboratory services be provided. During markup, a phrase was added to the effect that what constitutes routine diagnostic services, including clinical laboratory services, would be prescribed by the Secretary.

If the Subcommittee sees fit to require clinics to directly provide clinical laboratory services, then we would urge the inclusion of the requirement that the Secretary prescribe the scope of routine diagnostic services. We believe the standards under which these services are to be performed should be no less stringent than those established for laboratories participating in the Medicare program.

The College supports the approach taken in S. 708 with regard to assuring access to diagnostic procedures including laboratory services.

This concludes the statement of the College of American Pathologists. We thank you for the opportunity to present our views on the issue of rural health clinics and the services which they would provide.

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. Chairman, I am Leo J. Gehrig, M.D., Senior Vice President of the American Hospital Association. The Association represents over 6,500 health care institutions (including most of the hospitals in the country; extended and long-term care institutions; mental health facilities; and hospital schools of nursing), and over 24,000 personal members. We appreciate this opportunity to share our views and recommendations on S. 708. While our Association supports the intent of this legislation to provide Medicare payment for certain services rendered in rural health clinics, we would like to offer for the Subcommittee's consideration some constructive suggestions for improvement of the bill.

BACKGROUND

The American Hospital Association has long recognized the need for innovative use of new and existing categories of health care professionals other than physicians to provide needed health care services in areas where primary care physicians are either unavailable or are insufficient in number to satisfy medical care needs. The AHA has encouraged the training and appropriate use of such health care personnel in order to make health care services more widely accessible, to extend the services of physicians by utilizing their time more efficiently, and to enhance the quality of medical services.

The Association is one of the founders and participants in the National Commission for Certification of Physician Assistants along with 17 other health care organizations. We have supported the use of these health care professionals in our hospitals and have disseminated recommended institutional procedures and guidelines for physician extenders in the hospital setting.

The Congress also has recognized the importance of the effective and efficient use of health manpower resources. Through enactment of the Health Professions Educational Assistance Act, funds are provided to schools of public health and allied health as well as scholarship and loan programs for students preparing for careers as health care providers, but not as physicians. Training programs of the military services have also been important sources of such personnel.

We would like to make a general observation at this point in order to facilitate discussion of this subject. We believe there is confusion regarding the definition of physician extenders which stems in part from the lack of a generally accepted terminology. While we understand the intent of the language provided in Section (aa)(3) of S. 708, we would recommend use of the term "nonphysician primary health care provider" as a generic substitute for "physician extender." This terminology is, in our view, more appropriate and more inclusive in describing the broad category of health care professionals who may be utilized in rural health clinics, inasmuch as some of them, for example, are nurse practitioners or physician assistants, who might not come under the definition of physician extender.

NEED FOR REIMBURSEMENT MODIFICATIONS

In some rural areas, clinics have been established to provide certain primary care and first aid services to patients who otherwise have no immediate access to such services. These clinics are operated frequently without the benefit of a physician on site to supervise the service of the nonphysician providers. Evidence of the problem to which your bill is addressed was pointed out in September 1976, in a joint statement of the Southern Governors' Conference and the Appalachian Regional Commission pointing out that 25 to 30 percent of the visits to 87 rural health clinics in that area were not reimbursed by Medicare due to lack of direct physician supervision.

It is, of course, the intent of S. 708 to revise the reimbursement provisions of the Medicare program with respect to the payment for services rendered in these settings. However, if reimbursement revision or amendment is to be most effective, the methods and conditions of payment must be consistent with Medicare principles. In all cases we strongly recommend that payment for services provided by rural clinics be provided as defined in section 1861(v)(1)(A) of the Social Security Act on the basis of reasonable costs related to providing such services.

We would oppose the provision of section (i) in S. 708 permitting payment "on behalf of an individual, on the basis of costs reasonably related to providing such services or on the basis of such other tests of reasonableness as the Secretary may find appropriate." We believe that the Secretary of HEW should not have the authority to approve alternative systems of reimbursement if such systems depart from this important principle in the existing Medicare program.

In view of the fact that nonphysician health care providers render service in some rural areas which lack other health resources and that there exists a problem of reimbursement in these situations, we support S. 708. Nevertheless, we are concerned about the lack of adequate physician supervision in these settings, and would recommend that reimbursement of nonphysician primary health care provider services be permitted only so long as sufficient physician direction—which would otherwise permit payment under existing provisions of the Medicare program—remains unavailable. Further, we believe that the provisions of S. 708 should be considered experimental and that an evaluation of the quality of services provided within its requirements be conducted within one year after the date of enactment to ensure that this amendment to the Medicare statute serves its intended purpose.

We would now like to summarize our specific recommendations which we believe will improve the provisions of S. 708.

1. The term "nonphysician primary health care provider" should be substituted for "physician extender" in the proposed section 1861(aa)(3) of the bill;

2. To assure that "nonphysician primary health care providers" meet necessary training and experience qualifications, they should be restricted in the proposed section 1861(aa)(3) to individuals who:

(*a*) are licensed by the state in which they provide services or are in compliance with state regulatory requirements that define the limits of their practice; and

(*b*) hold credentials from a nationally recognized organization, such as the National Commission on Certification of Physicians' Assistants, the American Nurses' Association, or the National Association of Pediatric Nurse Practitioners;

3. To be consistent with payment principles of the Medicare program, payments for services under S.708 should be provided on the basis of reasonable costs related to providing such services, as defined in section 1861(v)(1)(A) of the Social Security Act;

4. Nonphysician primary health care providers in hospital-based or operated clinics must be subject to the rules, regulations, and procedures of the institution with respect to the scope of services provided by such individuals; and

5. An evaluation of the quality of services as provided under the requirements of S.708 should be conducted within one year of the bill into law.

Mr. Chairman, we appreciate this opportunity to express our views and recommendations on S.708 for your Subcommittee, and we will be pleased to provide you and your staff with draft language to implement these recommendations at a time and in a manner which you deem appropriate.

STATEMENT OF THE ASSOCIATION OF PHYSICIAN ASSISTANT PROGRAMS

Mr. Chairman and Members of the Committee, I am Dr. Archie S. Golden, Chairman of the Government Relations Committee, President-elect of The Association of Physician Assistant Programs. I am offering written testimony on S. 708 and the Medicare reimbursement system. I am Associate Professor and Director of The Health Associate Program at The Johns Hopkins University School of Health Services. Also, I am Associate Professor of Pediatrics at The Johns Hopkins School of Medicine and Associate Professor of Maternal and Child Health at The School of Hygiene and Public Health.

I am pleased to have this opportunity to provide written testimony on behalf of the 50 physician assistant training programs in this country. This testimony is being submitted on my behalf by Dr. Donald W. Fisher, Executive Director of the Association.

The United States Congress has, in the past six years, actively promoted the training and development of physician assistants (PAs). The Comprehensive Health Manpower Training Act of 1970 was responsible for the development of 42 physician assistant training programs whose graduates would assist primary care physicians by providing routine medical and health care services in underserved areas. The Health Professions Educational Assistance Act of 1976 authorized continuation of federal support for physician assistant programs. It should be pointed out that the U.S. Department of HEW has funded physician assistant training and research to an amount over 48 million dollars.

The Congressional support, cited above, coupled with organized medicine's recognition of the need for formally trained assistants, has been responsible for the training and development of physician assistants. In 1970, the American Medical Association defined the physician assistant as ". . . a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant." In 1971, Educational Essentials (1) were jointly developed by the American Medical Association, the American Academy of Family Physicians, the American College of Physicians, the American Academy of Pediatrics, the American Academy of Physician Assistants, and the American Society of Internal Medicine.

Through this accreditation mechanism, more than 50 programs have been accredited to date. In 1973, the National Board of Medical Examiners administered National Certifying Examinations and continues to do so under the auspices of the National Commission on Certification of Physician's Assistants. Over 40 states have enacted legislation providing for the practice of physician assistants with legislation currently proposed or pending in the remaining states. In 1973, the Secretary's Commission on Malpractice stated that the then growing concern over malpractice should not be a deterrent to the utilization of physician assistants.

PHYSICIAN ASSISTANT IMPACT

Economics of Care

Educational cost data from the National Center of Health Services Research (NCHSR) on physician assistants show the education cost to be 15,100 dollars per year (2). The cost of producing a physician assistant is less than ¼ that of preparation of a graduate physician (3). Wert's (4) data shows that a PA can provide 2.6 years of physician equivalent services before a physician who simultaneously began his medical education can begin practice. Moreover, Record (5) estimates a saving of 20,000/PA/year in an HMO setting. Peterson (6) and his colleagues have shown very significant reductions in hospitalizations through the use of PA staffed ambulatory care clinics in a major V.A. Hospital.

Access to Care

Record (7) and Hill (8), in separate studies, have shown that the outputs of primary care services are similar for both physicians and physician assistants. Moreover, Scheffler (9) and Fisher (10) report wide distribution of PAs throughout all 50 states with a majority of PAs in primary care settings. 60 percent of PAs are in communities of less than 50,000. For example, in Oklahoma, 62.2% of program graduates are in communities of less than 25,000; in Utah, 72% of program graduates are in communities of less than 25,000, and in Washington, 57.7% in communities of less than 20,000. Also, significant numbers of physician assistants are working in inner city areas. The recent health manpower legislation not only authorizes funds for physician assistant training and National Health Service Corps Scholarships, but also requires that part of each Area Health Education Center include training for physician assistants or nurse practitioners. Also, it appears that the Health Resources Administration has decided that new funding for these centers will be directed at inner city urban areas.

Quality of Care

Numerous studies, Nelson (11), Pondy (12), Henry (13), and Norbrega (14), have shown that job acceptance, as a function of quality, is highly favorable. For example, Nelson found that more than 85% of patients rate PAs as highly competent and professional, and 71% report improvement in the quality of care.

Record reports no significant differences in morbidities or outcomes in primary care services delivered by MDs and PAs. More importantly, B.J. Anderson, J.D. (staff, American Medical Association Legal Council) stated that as a result of decreased waiting time, increased accessibility to professional care and overall patient satisfaction, it appeared that the inclusion of a physician assistant in a practice was an excellent deterrent to the ever present threat of malpractice.

In sum, a review of available research shows that the physician assistant concept has been successful in addressing the three major issues confronting the nation's system for health care: (1) a reduction in cost, (2) an improvement in access, and (3) the delivery of high quality care.

THE IMPEDIMENT: MEDICARE, PART B

In spite of evidence that the physician assistant concept has been successfully addressing major national health problems, further deployment of physician assistants into underserved areas is being seriously impeded by the current Medicare Law (Title XVII (Section 1861 (s)(2)(A)), its rules and regulations.

Excerpts from the Medicare Act and Part B. Intermediary Manual reveal the problem:

Title XVIII Sec. 1861 (s): "The term 'Medical and Other Services' means any of the following items or services . . . (2)(A) Services and Supplies . . . furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physician's offices and are commonly either rendered without charge or included in the physician's bills . . .".

Part B Intermediary Manual, Sec. 6103 (B): ". . . there is no provision under Part B which authorizes coverage of the services of physician assistants as independent practitioners, the only basis for covering their services under Part B would be as services furnished 'incident to' a physician's professional service and one of the . . . requirements . . . for services to be covered under this provision is that they must be of kinds that are 'commonly furnished' in physicians' offices. Thus, the performance by a physician assistant of services which traditionally have been reserved to physicians cannot be covered under Part B even though all the other 'incident-to' requirements are met".

The current attention drawn to the "non-reimbursement" policy has had negative impacts in rural underserved areas of this nation. Without reimbursement for services performed by physician assistants practicing in areas with large numbers of Medicare recipients, physicians cannot afford to employ a physician assistant even though the potential benefits to patients is well recognized. Physicians have had to sharply curtail the utilization of their PAs when Medicare would not reimburse the employing physician for their services. Many program directors fear that their graduates will be forced into affluent suburban or institutional practices because the employing physician cannot be reimbursed for services safely and legally delegated. Most importantly, many Medicare recipients are having to pay for the delegated services out of their meager incomes.

In summary, in the past decade, we have seen the development of a new health profession with an accreditation mechanism which is recognized by the Office of Education (DHEW); certification mechanisms through the National Commission on Certification of Physician's Assistants and legislation in 40 states granting statutory recognition for his profession. The evidence exists that physician assistants may reduce the physician's risk of medical negligence by improving the continuity of care. Research does exist which confirms excellent patient acceptance by physicians, that physician assistants are improving access to health care by practicing in geographical areas deficient in health manpower, physician assistant productivity—within their role—is comparable to physician productivities, and that the potential for reducing the cost of health care is present with the utilization of physician assistants.

RECOMMENDATIONS

The Association of Physician Assistant Programs recommends that Title XVIII of the Social Security Act, Part B Supplemental Medical Insurance (42USC1305), and all such other medical entitlement program be amended to permit reimbursement for physician assistant services in the following way:

(1) cost reimbursement to specific health clinics in medically undeserved rural areas,

(2) for other underserved areas, to attract providers to practice in these areas, that reimbursement be to the physician at usual and customary rates.

(3) and, for all other areas, taking into consideration cost control, there would seem to be room for discussion to come up with an amenable reimbursement rate.

Also, in order to put to rest concerns relating to quality of care, fraud and abuse, reimbursement should only occur when the following criteria are met:

(1) The practice of the physician assistant is not in conflict with the laws of the state in which the services are provided.

(2) The activities and patient care services by physician assistants shall be provided under the *responsible supervision* of (a) licensed physician(s). Services of physician assistants shall include services performed regardless of whether the physician was actually present and regardless of whether the services were performed in the physician's office, or at some other site. That a physician supervise no more than two physician assistants.

(3) Physician assistants be defined as individuals who have completed an education program for physician assistants accrediated by the American Medical Association or other recognized accrediting agency and/or are holders of current certificates from the National Commission on Certification of Physician's Assistants.

We feel that it is necessary and justifiable to apply the reimbursement on a nationwide basis.

Potential Costs of Nationwide Reimbursement

We understand and share the concern of Congress about escalating health care costs. At present, we have an economist working on the question of the cost of reimbursing physician assistants nationwide and will have more exact information within two weeks and would be pleased to share that information with this committee. However, the U.S. Department of Health, Education, and Welfare has developed some estimates taking into consideration physician income, number of Medicare patients, the increased intensity of care for older people and deductibles. From this they estimate the cost of Medicare reimbursement to be $1,782 per physician utilizing a physician assistant or nurse practitioner per year. Since there are about 5,000 physician assistants practicing with adults, the total cost would be $8.9 million. If one adds the approximately 3,000 nurse practitioners practicing with adults, the reimbursement nationwide would come to $14.3 million. This is not a large amount and, in fact, it appears that close to three quarters of that amount is in reality being reimbursed today to physicians employing these new practitioners, although not covered within the Medicare rules and regulations.

Therefore, we estimate that the net increase for nationwide reimbursement would not be higher than $3.6 million.

We feel that limiting reimbursement to only rural health clinics or only rural areas denies just payment to practices in many urban areas where important contributions to health care access are being made by physician assistants. In fact, there is a danger that the organizational mechanism necessary to administer such categorical reimbursement as only rural clinics or only rural areas may cost as much as the reimbursement itself.

We note that on page 58 of President Carter's fiscal year 1978 budget revisions released on Tuesday, February 22, 1977, related to proposed Medicare legislation, there were estimated outlays of $25 million which would promote the availability of primary and rural health care by extending cost reimbursement to nurse practitioners and physician assistants practicing in rural health clinics.

We feel that this amount of money would more than cover reimbursement nationwide under Medicare Part B for all physician assistants.

We recommend that S. 708 entitled "A Bill to amend title XVIII of the Social Security Act to provide payment for rural health clinic services" be adapted to provide for reimbursement for services provided by physician assistants and nurse practitioners throughout this country.

We believe that nationwide reimbursement is a necessary step not only to facilitate distribution of services and contain costs, but also to take us on the road toward equal rights for health care for all people of this country.

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THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC.,
July 21, 1977.

Hon. HERMAN E. TALMADGE,
Chairman, Subcommittee on Health, Committee on Finance, Dirksen Senate Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: The American Occupational Therapy Association is pleased to note that S. 708, to provide for the reimbursement of rural health clinic services, is the subject of hearings today before the Health subcommittee. Occupational therapists provide services to clients in a variety of rural health settings across the country and have long recognized the need for more health services to be available to people in these medically underserved areas. We, therefore, support the basic provisions of S. 708. We would, however, like to draw your attention to Section (b) of the bill, with which we have some concern.

Section (b) states that "rural health clinic services" include services which "would otherwise be covered . . . as an incident to a physician's professional service." Since rehabilitative services, such as occupational and physical therapy, and speech pathology and audiology are covered Medicare services when provided as "incident to a physician's professional service," it is our understanding that the bill intends to include these services as part of the covered "rural health clinic services." We would expect, moreover, that such services would be provided by qualified practitioners, as currently defined in Medicare regulations.

In the absence of specific language in S. 708 describing these services, it is possible that the bill might be misinterpreted to exclude rehabilitative services or the delivery of such services by qualified providers. This latter concern arises from language in the definition of physician extender which stipulates that, for reimbursement, even "other trained practitioners" who provide rural clinic services must be certified as physician assistants or adult family practitioners.

This could have the effect of allowing physician extenders to provide rehabilitative services in rural health clinics. Rehabilitative services are properly provided by rehabilitation specialists such as occupational and physical therapists, and speech pathologists and audiologists. The stipulation might also have the effect of requiring rehabilitation specialists to be certified as physician assistants or adult family practitioners. The qualifications and functions of these specialists do not require that they be certified as physician assistants or adult family nurse practitioners.

Rehabilitative services are an important part of the health care treatment which populations in underserved rural areas require. These services should be provided by qualified practitioners as currently stipulated in Medicare regulations and, in many instances, by State laws. We, therefore, request that in the mark-up of S. 708 an addition be made to ensure that coverage for rehabilitative services provided by qualified practitioners be clearly established.

Specifically, we urge that under the definition of "rural health clinic" (Section (b) of the proposed bill) the following clause be added: "provides rehabilitative services (including occupational and physical therapy, and speech pathology and audiology furnished by qualified practitioners, in accord with regulations established by the Secretary."

We appreciate the opportunity to offer this recommendation and we respectfully urge your support of its inclusion in S. 708.

Sincerely,

JAMES J. GARIBALDI,
Executive Director.

STATEMENT OF THE NATIONAL RETIRED TEACHERS ASSOCIATION AND THE AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. Chairman, our Associations support the passage of S. 708 and S. 1877, bills designed to provide Medicare reimbursement for the services of nurse practitioners or physician assistants in rural areas. The enactment of such a measure should prove to be a significant driving force which will increase the availability and improve the accessibility of primary care services for Medicare beneficiaries who reside in rural areas.

NRTA/AARP, organizations with eleven million members, look upon proposed legislation to provide Medicare reimbursement for the services of nurse practitioners or physician assistants as being consistent with our overall legislative objectives. While we have long articulated the need to make important changes in the Medicare program, we recognize that the structural underpinnings of this country's system for financing health care need to be modified.

The excessive inflation in the health care sector cannot continue unabated without having serious consequences. Until this unprecedented growth in expenditures is curtailed, it is unlikely that there will be any expansion of existing benefit packages. Instead, there is the threatening prospect that current benefits under Medicare and Medicaid might have to be reduced as a way of slowing down the inflation in these programs.

Meanwhile, the out-of-pocket costs of older persons for health care grow larger each year. In fiscal year 1975, the average health care expenditure for persons 65 years and over amounted to $1,360. Of this amount, the direct payment made on a per capita basis by the aged was $390 or 28.7 per cent of the total.[1] These payments represented the cost of items such as the following: drugs, routine dental and eye care, other preventive services, nursing-home care, unassigned physicians' charges in excess of the carriers' reasonable charge determinations, deductibles and coinsurance payments.

The various deductible, coinsurance and copayment features of Parts A and B of Medicare are evenly imposed on all beneficiaries. Such uniform cost sharing discriminates against low income persons and in some cases may act as a disincentive to their seeking necessary health care. Even though states have buy-in agreements through their Medicaid programs, the medically indigent are not always covered.

Residents of rural areas are discriminated against in another important way. Because of the relative paucity of physicians, sometimes the only care which may be available is that provided by nurse practitioners or physician assistants in

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[1] Gornick, Marian. Ten Years of Medicare: Impact on the Covered Population, *Social Security Bulletin*, July 1976.

rural clinics. Yet, the Medicare law does not recognize these providers for purposes of reimbursement. Thus, a situation has been created in which a large group of beneficiaries is contributing to the costs of the program without having equal access to all its benefits. It is our position that steps should be taken to correct this inequity by providing reimbursement to clinics which offer care provided by these categories of personnel.

We also recommend that a more equitable payment system be established for Medicare beneficiaries. It was just indicated that low income persons feel the impact of the $60 deductible, the monthly premiums, and the 20 percent copayment aspects of Medicare more severely than higher income persons. The combined effect of these fees needs to be lessened to guarantee that no aged individual will be deterred from seeking health care because of insufficient personal resources.

Inhabitants of rural areas are at a disadvantage in a second important way. Access to health services often involves travel over considerable distances. The gradual reduction of bus systems in small towns and the absence or high cost of taxis have made it difficult to travel unless an individual either owns a private automobile or can obtain the use of one. Time, search, and transportation costs pose barriers to obtaining health care.

Since overcoming these obstacles is a considerable challenge in itself, we advocate that steps be taken to alter the present payment system as a way of reducing one of the major disincentives which stands in the way of obtaining care. The deductible and premiums should be eliminated. Co-payments for services should be related to one's ability to pay for them.

Related to this issue is the failure of the Medicare program to protect patients from physicians' charges in excess of the carriers' reasonable charge determinations. The percentage of claims and the percentage of charges reduced have been steadily increasing for both assigned and unassigned claims. These increasing cost differentials have to be assumed by patients.

As a way of correcting this imbalance, NRTA/AARP recommended that the system of retrospective reimbursement of providers on the basis of reasonable charges be changed. This method of paying for services has led to higher rates of inflation and unnecessary expenditures while providing less financial protection for patients.

Instead, our Associations favor a system of prospective reimbursement. Unlike retrospective systems, a prospective system provides a greater opportunity for providers and payers to project outlays more accurately. It should also allow for more effective administrative control.

The Medicare program should pay a percentage of a rural clinic's predetermined budget on the basis of the percentage of services rendered to Medicare beneficiaries. Additionally, each clinic should have a community governing or advisory board. Older persons should be present on such boards. One way of judging the extent to which they might be represented would be to look at the percentage of clinic services which they use. This same percentage could then be applied to determine their proportional representation.

The most costly form of health care is that provided by hospitals. If patients do not have access to rural clinics, it is inevitable that they will eventually travel to hospitals when their health problems become serious. It is our belief that these clinics can reduce hospitalization. In light of the present need to control costs, it is imperative that less expensive types of care be made available in the form of these clinics.

Medicare reimbursement for the services of nurse practitioners or physician assistants in rural clinics should provide the stimulus necessary to keep existing clinics in operation. It should also help to remove barriers which impede the establishment of new clinics in medically underserved areas. The federal government has identified 3,000 rural areas as being medically underserved. We currently have about 700 rural clinics nationwide. Expanding Medicare reimbursement to these clinics affords an opportunity for increasing the supply of such facilities.

A related consideration is the fact that we now spend $30 million a year to train physician extenders, but existing Medicare legislation discourages their employment in settings where their contributions are badly needed. Correcting this situation would be a significant step in the direction of reducing some of the inconsistencies in our federal programs.

Our nation currently has about 31 million persons who have difficulty obtaining health care services. Most of them are residents of what are commonly known as rural areas. NRTA-AARP have taken the position that these rural areas must receive priority attention.

We are aware, however, that sentiments have been expressed over the need to include urban clinics in the proposed legislation. It should be evident from recent hearings on Medicare-Medicaid fraud and abuse that the inclusion of urban clinics will require many more stringent control mechanisms.

Another issue is that physicians who employ nurse practitioners or physician assistants are often reluctant to become salaried providers within a clinic. An option would be to permit them to choose fee-for-service reimbursement covering the services of the paraprofessionals they employ at a rate equivalent to the physician's usual and customary rate.

As a way of resolving these two questions, we believe that the following steps should be taken. First, medically underserved urban areas should be included in the legislation. Public primary health clinics and primary health clinics receiving federal operating funds in these areas should be eligible for cost reimbursement on a demonstration basis.

Second, physicians should be allowed to choose the fee-for-service option. This will be done on a demonstration basis only. Furthermore, physicians who select this option should not be permitted to employ more than two nurse practitioners or physician assistants.

In conclusion, NRTA–AARP are in favor of Medicare reimbursement for the services of nurse practitioners or physician assistants. Apart from whatever savings may result, we believe that fairness alone dictates that Medicare beneficiaries are entitled to a share of the services for which they pay. Their health needs are considerable while their financial resources are in many instances meager.

It is our position that these needs should be met without further delay. Our Association support S. 708 and S. 1877 and would like to see them enacted before the close of this legislative session.

AMERICAN MEDICAL ASSOCIATION,
Chicago, Ill., August 1, 1977.

Hon. HERMAN E. TALMADGE,
Chairman, Subcommittee on Health, Committee on Finance, U.S. Senate, Washington, D.C.

DEAR SENATOR TALMADGE: The American Medical Association submits the following comments on S. 708 and H.R. 2504, bills that would extend Medicare payments to certain rural health clinics. In addition, enclosed please find copies of AMA testimony on these bills presented earlier this session. We request that this letter and the attached documents be made part of the Subcommittee's hearing record.

The AMA has been at the forefront in supporting the utilization of physicians' assistants, and early recognized their special utility in medical care shortage areas, including rural areas. We have previously pointed out the need to develop proper legislation recognizing the role of the physicians' assistant in serving to "extend" the services of a physician into shortage areas.

The AMA believes that, if Medicare is to reimburse for the services of extenders, certain basic concepts must be adhered to. These include (1) proper supervision and control by the physician, (2) proper training of all physician extenders, (3) responsibility in the physician for the services as evidenced by the billing for the services in the physician's name, and (4) compliance with all state requirements for physician extenders. We believe that if these principles are followed, the use of physician assistants would be encouraged.

We suggest that a simple amendment to the Medicare law giving recognition to the true nature of the extender's service would be more appropriate than creating a Medicare defined "rural health clinic" in order to recognize the extender's service. An amendment to include the extender's service as an integral part of the physician's service would foster the development of extenders and help provide quality care in rural areas.

The AMA has specific concerns about the two bills pending before the Subcommittee. Since our attached statements spell these out in detail, we will merely sumarize some of them here.

(1) The definitions of "physician extender" could conflict with state law governing these providers.

(2) The creation of the new "rural health clinic" as the entity to be recognized for payment of physician extender services when furnished through a physician. Further, under H.R. 2504 a clinic directly under the supervision of a physcian would be excluded from this reimbursement scheme.

(3) The bills are not clear as to who would be ultimately responsible for the actions of the extender. The role of the supervising physician is too limited.

(4) The payment mechanism proposed is inconsistent because it would reimburse for extender services in the clinic setting, but would not recognize them for payment if performed in another setting. We are concerned that this restriction would retard the development of the physician extender concept.

The AMA believes that the proposed system of reimbursement for physician extenders could, for the reasons outlined above, lead to a decrease in the quality of patient care and ultimately to increased costs to patients.

Accordingly, we recommend that S. 708 and H.R. 2504 be amended to reflect the basis concepts outlined above.

We offer our assistance to the Subcommittee in the development of appropriate changes to the Medicare law to provide for the reimbursement of the services of physician extenders provided in any setting and regardless of the physicial presence of the supervising physician.

Sincerely,

JAMES H. SAMMONS, M.D.

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION

Mr. Chairman and Members of the Subcommittee, I am Edgar E. Beddingfield, Jr., M.D., a physician in family practice at Wilson, North Carolina. I serve as Chairman of the Council on Legislation of the American Medical Association. Appearing with me today is Harry N. Peterson, Director of our Department of Legislation.

We are pleased to appear on behalf of the American Medical Association to express its views on a subject which has long occupied activities of the AMA—that of services provided by a physician's assistant. Although we do have concerns over the particular legislation before the subcommittee—S. 708—we hope that the hearing today will serve as a focal point, or a catalyst, for continuing discussion of the issue.

The AMA has been at the forefront in supporting the utilization of physicians' assistants and early recognized their special utility in medical care shortage areas, including rural areas. In the past we have pointed out the need to support salutary legislation recognizing the role of the physician's assistant in serving to "extend" the services of a physician into shortage areas.

To this end we support legislation under which Medicare would recognize reimbursement to the physician for services performed by him through his supervised assistant and would recognize reimbursement whether the assistant performs services at or away from the physician's office. We believe that this would encourage wider use of the assistant and give proper recognition to the essential nature of the assistant, which is to extend the physician's services. Such provision of service can be of proper quality when the assistant has received sufficient formal training from appropriately accredited training programs, meets any State requirements for provision of services, and remains subject to, and answerable to, the supervision of a physician. The latter qualification makes clear the proper, critically essential role of the supervising physician, which is to assure that his assistant is properly trained and supervised and that the physician responsible for the assistant's actions must remain answerable to, and take responsibility for the proper treatment of, the patient. Failure to retain such a relationship would be detrimental to quality patient care in the long run.

While an assistant can be especially advantageous in shortage areas in which no physician is located, caution must be taken to assure that the care provided by the assistant is quality care. In a rush to provide some care to an area which may otherwise have little or no care it would be easy to brush aside proper safeguards. We must preserve for all patients—including those in rural areas—a high standard of care.

The bill before you—S. 708—does address certain of our overall considerations.

EXTENDER REQUIREMENTS

The bill defines the "physician extender" as a "physician assistant, nurse practitioner, nurse clinician, or other trained practitioner who is certified as a physician's assistant by the National Commission on Certification of Physician's Assistants or its successor, or who is certified as an adult-family nurse prac-

titioner by the American Nursing Association or its successor, and who is legally authorized to provide any physician services, as defined in section 1861(q), in the jurisdiction in which such services are provided."

A requirement that the extender meet State requirements is a provision which we have supported, and we believe that such a provision properly recognizes the primary (and exclusive) power of the individual State to determine the qualifications and scope of practice of an extender. However, the definitions in S. 708 create ambiguities. Under one interpretation the definition of extender would be met only when the extender was authorized to perform *any* physician services, meaning *all* the services which a physician could perform. This broad requirement would in effect exclude intended coverage. On the other hand it may be met if the extender could perform *any*, meaning just *one* such physician service. Moreover, the reference to the local jurisdiction does not in any way circumscribe eligible services, but serves merely to identify the extender. In addition, as discussed below, the definition of "rural health clinic services" is very broad, the only limitation being the services "performed by an extender." Thus the effect from the language may be an unintended broad scope of coverage beyond services recognized in the local jurisdiction. We do recognize that one later provision states that the bill should not supersede state law.

In addition, we question the advisability in the definition of a physician extender of the provision that such an individual be legally authorized to provide "any physician services, as defined in section 1861(q)" of the Social Security Act. The term "physicians' services" under Title XVIII of the Act means "professional services performed by *physicians* . . .". It would further appear that to require a physician extender to be authorized under State law to provide physicians' services as that term is used under the Social Security Act may well conflict with a state's requirement that only physicians may practice medicine.

We believe the bill could overcome these concerns with the definitions by clearly stating that services of a physician extender would be recognized *only to the extent* that he is legally authorized to perform such services in the jurisdiction in which such services are provided.

We are also concerned that the bill specifies certain "accrediting" agencies for educational qualifications of extenders. We believe that it is more appropriate, in an area traditionally within the purview of the state, for the state to establish eligibility requirements for providing health services.

As we have indicated, the term "rural health clinic services" raises a particular problem. There does not appear to be sufficient limitation on what may constitute a rural health clinic service, since a requirement is only that such services be furnished by a physician extender.

The term "rural health clinic services" also makes reference to the term "primary care patient." The scope of medical care encompassed in the term "primary care" has not been universally defined, and accordingly the term would introduce many problems relating to coverage and eligibility.

RURAL HEALTH CLINICS

Certain portions of S. 708 recognize concepts on which an extender program should be built. However, other portions of the bill are troublesome. While the objective, ostensibly, is to provide payment for services of the physician extender, the bill in fact would add a new payment authorization for "rural health clinic services." Thus, after defining a physician extender and rural health clinic services, the bill then goes to great length to set up a new exclusive type of entity under Medicare Part B for purposes of reimbursement. Reimbursable services under the bill (principally those of the extender) would be those services provided only by a "rural health clinic," would be reimbursed *only to the "clinic"*, and would be reimbursed on the basis of "costs reasonably related to providing such services or on the basis of such other tests of reasonableness as the Secretary may find appropriate."

The "rural health clinic" itself would be defined as "a facility" which complies with all of the following: (1) provides rural health clinic services, (2) has an arrangement with a physician for review of all services provided by the physician extender, (3) provides for the preparation by the supervising physicians *and physician extenders* of medical orders for care and treatment of clinic patients, (4) provides for the availability of the supervising physicians for such referral and consultation for patients as is necessary. (5) maintains clinical

records, (6) arranges for referral and admission to hospitals, (7) has written policies to govern the management of the clinic and all the services it provides, (8) has appropriate procedures and arrangements in compliance with state and federal laws concerning drugs and biologicals, and (9) has appropriate procedures for utilization review.

As a further limitation, such a clinic could only be one which is "*not* located in an urbanized area (as defined by the Bureau of the Census) where the supply of medical services is not sufficient to meet the needs of individuals residing therein. . . ." This language is somewhat confusing since the clause "where the supply of medical services is not sufficient to meet the needs of individuals residing therein" could be read to apply to the nonurbanized area or to the urbanized area.

The bill would reimburse only the new type of "clinic" for services of an extender plus those services which are "incident" to a physician's services.

A glaring inconsistency is created by the provision limiting payment to a "clinic." By what reasoning should be a *facility* be the exclusive entity reimbursed for what must be identified essentially as physician's services? The fundamental concept is that the extender is providing an extension of "physician" services. The physician character of the services furnished by the clinic is further emphasized since the bill would only recognize, in addition, services "incident to a physician's professional service." We believe that the provisions of the bill in this regard strain logical analysis, in attempting to have Medicare pay a specially recognized facility—the rural health clinic—for physician services performed by a non-physician.

While a physician directed and operated clinic is not specifically excluded under the language, we find it difficult to conceive of a situation in which a physician would operate a "rural health clinic." In fact disincentives for participation by physicians are contained in the bill. If he did operate such a clinic, he would be reimbursed for extender services on the basis of "cost" as determined by the Secretary. Moreover, physicians would be reluctant to allow the extender to participate in preparing "medical orders" for patients. We believe the bill discourages physician operated "rural health clinics."

In addition, the bill does nothing to encourage physicians to comply or to make greater use of physician extenders outside of the so-called "clinic" setting. If in fact it would turn present satellite settings into "clinics," the bill could well be directly counterproductive.

The disincentives are compounded when read in conjunction with the requirement of the bill that such "clinics" be subject to capital expenditure review under section 1122 of the Social Security Act. A physician's office is not, nor should it be, subject to such review. However, if under the bill such a review, this would surely discourage physicians from participation.

More importantly, however, is the *failure* of the bill to allow reimbursement for extenders employed directly by physicians outside any "clinic" setting. We believe that this failure, by creating a distinct bias in allowing reimbursement only to a "clinic," will hinder the expanded use of the physician extender.

Another ambiguity relating to the concept of a rural health clinic concerns the organizational makeup of such a clinic, i.e., the "facility" as an entity recognizable for receipt of payment. To what entity or person would payment be made?

RESPONSIBILITY FOR EXTENDER

As we pointed out earlier in our statement, we have long supported the use of the physician assistant. However, we believe that this person should be utilized as originally intended, i.e., as an extension of and assistant to the physician with the physician remaining *primarily responsible* for the assistant's patient care functions. We believe that actions of the extender should be viewed as the extension of the physician and therefore the physician should retain sole supervision of the extender.

As the bill is written, however, it is unclear exactly who is responsible for the actions of the extender. Although in the definition of the clinic there is a requirement for a review of the extender's services by a physician, the definition also "provides for the preparation by the supervising physicians and *physician extenders* of medical orders for care and treatment of clinic patients." (Emphasis added.)

We must question the language in this provision which might be interpreted as sanctioning the preparation of medical orders by the physician extender. This language of the bill does not assure sufficient supervision of medical services provided by an extender and could well lead to Medicare reimbursement for services which would not be reimburseable under other circumstances.

PAYMENT INCONSISTENCY

Because payment under this bill is limited to the clinic, the extender's services would be paid in the clinic setting but payment would *continue to be* denied when services are furnished in another setting.

For example, under present HEW interpretations, the only way in which the extender's services could be reimbursed now would be if they were performed "incident to" a physician's professional service. Furthermore, under HEW interpretation this ". . . limits coverage to the services of nurses and other assistants that are commonly furnished as a necessary adjunct to the physician's personal in-office service. Thus, the performance by a physician's assistant of services which traditionally have been reserved to physicians cannot be covered under Part B even though all the other 'incident-to' requirements are met."

Now, however, S. 708 proposes to reimburse a clinic the costs for extender services, but would not allow reimbursement directly to the physician if such services are not "incident to" a physician's services. Yet, as we have pointed out, under present Medicare practice, services recognized as "incident to" physicians' services would *not* include many extender services when performed under the direction of a physician while those same services would be recognized under the bill where the extender is essentially unsupervised. We believe that services of an extender should be reimbursed, but we do not understand the rationale for allowing such reimbursement to a facility for services performed while those same services would not be reimbursable when performed under the direction or supervision of a physician such as in his own office.

The bill also creates a further inequity among beneficiaries because payment for "clinic" services would be made under Part B without being subject to the Medicare deductible. At present, payment of benefits under the Medicare program is subject to a deductible of $60 during a calendar year. Not requiring such a deductible for services received by a patient in a rural health care clinic would appear to be discriminatory, not only with respect to the type of service involved, but also as to other Medicare beneficiaries.

We believe that the bill as presently written in its attempt to reach a laudable end could create many unintended problems which could adversely affect development of quality care.

AMA ACTIVITIES

The AMA is not unmindful of the needs of shortage areas. We have long advocated increased medical manpower for shortage areas and to that end have strongly supported programs under the manpower law, including the National Health Service Corps program. We have also developed and have had introduced our own bill on Rural Health Care.

We have also long carried out the Project U.S.A. program, designed to fill temporary vacancies for National Health Service Corps personnel temporarily absent for vacations or leaves.

In addition we have also encouraged the development of rural health care delivery models with utilization of physician extenders to increase the scope of services and with the use of satellite arrangements in sparsely populated areas. Our annual National Conference on Rural Health and our Extension Seminars on Health Education as well as our publications in the rural health field prepared for public distribution also attest to our support for such developments.

However, while the AMA has provided a leadership role in rural health, we have always adhered to the principle of rural health care equal in quality to that of the rest of the nation.

As to the physician's assistant, we have also long advocated recognition of their services as part of physicians' services under Medicare irrespective of where the extender actually performs the service and irrespective of the physicial presence of the supervising physician. We support demonstration projects designed to study the utilization of the physician assistant. The subcommittee is undoubtedly aware of the reimbursement studies now being undertaken by HEW.

CONCLUSION

Mr. Chairman, we are indeed sympathetic with the problem which the Committee has before it, and we recognize the desirable objective of the legislation. The bill emphasizes the difficulties which arise when the Medicare program is sought to be used and tailored to reach what is perceived to be very limited and special situations. However, once a payment system is provided and an entity created and recognized for payment purposes, proliferation will certainly follow, so it is important that proper medical safeguards be provided. While we recognize also the exigencies that pertain to certain rural situations, we must be careful to avoid a duplication of problems, as recently came to light concerning quality and propriety of services in the so-called Medicaid Mills, generally identified with urban area.

We have already pointed out the bill creates some anomalies. If the Medicare program is to recognize payment for services of physician extenders, discrimination should not be created against the fundamental situation out of which the physican extender movement developed. The basic concepts must include (1) proper supervision and control by the physician of a properly trained physician extender, (2) responsibility in the physician for the services as evidenced by the billing for the services in the name of the physician, and (3) compliance with state requirements. If these are adhered to, the use of physician assistants would be encouraged in shortage areas.

To this end, a simple amendment to the Medicare law giving recognition to the true nature of the extender's service would be more appropriate than creating the Medicare-defined "rural health clinic" in order to recognize the extender's service. Accordingly, a simple amendment to include the extender's service as an integral part of the physilcan's service would foster the development of the original concept and help provide quality care in rural areas.

S. 708 as presently written should not be adopted.

Mr. Chairman, we will be pleased to respond to any questions which the Subcommittee may have.

STATEMENT OF THE NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS

This statement is submitted on behalf of the National Council of Community Mental Health Centers (NCCMHC) representing 365 community mental health centers, most of which receive federal grants under the CMHC Act, and another 211 agencies which are developing CMHC programs or which have a direct interst in community mental health.

NCCMHC supports the concepts of amending Medicare so as to include coverage for the important services provided by rural health clinics, and allowing such clinics to provide services in the most appropriate manner utilizing the skills of physician-extenders.

This is a long overdue initiative which would begin to coordinate the various different federal health programs, which too frequently work at cross-purposes. However, the problems which face the rural health clinics and which are addressed in HR 2504 are similar to those facing over 600 federally-funded CMHC programs. Like the rural health clinics these programs must rely on third party payments to survive, particularly once their federal eight-year grants terminate, and must utilize the services of all mental health professionals to provide high quality care at reasonable cost.

CMHCs are now facing conflicting requirements in federal statutes. The CMHC Act requires all centers to obtain maximum third party reimbursements including specifically Medicare funding, but CMHCs are not able to participate to any great extent under Medicare partly because they do not qualify as providers and partly because of the restrictive definition of physician supervision which is excluding many CMHC services from coverage.

THE ROLE OF CMHCS IN HEALTH DELIVERY SYSTEM

Community mental health centers were devised primarily to bring comprehensive mental health services into the community—to provide a more appropriate alternative to state mental institutions for those unable to meet the cost of care.

However, community mental health centers, along with other federally initiated programs such as rural health clinics, have the capacity to make substantial changes in the system for delivering health services.

Community mental health centers, for instance, represent a complete system of care for the mentally ill in the community. Each CMHC serves a specifically defined geographic area, termed catchment area, and provides a full range of services to all residents in that area including preventive services, early intervention and emergency services, an appropriate range of outpatient and other ambulatory care programs, partial hospitalization (day care and night care), half way houses where appropriate, and 24-hour inpatient services. In addition, each federally-funded center is required under recently enacted legislation to provide a comprehensive program for mental health of children and of the elderly, two groups which have traditionally been underserved by the centers as well as by other mental health programs.

CMHCs emphasize outpatient services, with 78.3 per cent of patient care episodes being provided on an outpatient basis, compared to 15.3 percent inpatient care and 6.4 per cent partial hospitalization. In other mental health facilities, inpatient services, as a percentage of all patient care episodes, represents a much greater proportion of services (40%). Even for those patients hospitalized in CMHCs, stays are kept to a minimum (on average 17 days).

CMHCs are also required by law to ensure that all services are coordinated with the provision of other mental health, health and social services in the community. This requirement means that in planning CMHC services, agencies are required to review all existing services in the area, to pull these together to the maximum feasible extent into a coordinated program, to make provision for filling gaps in services in the catchment area and to attempt to eliminate unnecessary duplication. CMHCs have developed extensive outreach programs to ensure that all individuals in the catchment area who have need of services are both aware of their availability and encouraged to seek assistance.

The centers preventive programs, consultation and education, include a wide range of indirect services which also help to establish an effective system of mental health care. Through C&E, the centers reach into the schools, health agencies, law and corrections agencies, welfare departments and so on to educate personnel in these agencies about the services of the center and on mental health issues in general so that appropriate individuals are referred to the center for care.

Thus a community mental health center, as defined in federal law, is designed to make substantial impact on some of the most difficult and pervasive problems in health delivery, such as:

- accessibility—both in terms of geography and socio-economic factors
- emphasis on preventive care and health education
- emphasis on ambulatory care and other innovative alternatives to expansive 24-hour a day inpatient services where these services are not in the best interests of the patient
- utilization of all mental health professionals and para-professionals in mental health teams
- elimination of costly duplication of services to the extent this is feasible

Much discussion in the health planning field now focuses on these very issues. For instance, the Forward Plan for Health developed by HEW last year included as major themes such issues as preventive care and health education; ways to discourage inappropriate hospital stays and to keep all hospital stays short; and accessibility, and coordination of services to improve continuity of care and eliminate duplication. The Forward Plan then suggested that CMHCs and other PHS clinics be given provider status under Medicare.

FINANCING OF CMHC PROGRAMS

Yet while CMHCs are now, and have been for years, working towards the goals which are being given high priority by various federal health planners, they are still faced with enormous financial problems. Centers at this time are caught in a squeeze play at the federal level. On the one hand, federal categorical grants are being phased out because centers are expected to become self-supporting through collections of various third party payments, fees, and state and local funding, and on the other hand federal third party payments are frequently unavailable.

The federal CMHC legislation provided funding on a time limited basis, now eight years, except for those centers which can demonstrate exceptional financial distress in which case eleven years of support is available. Moreover, this

funding is never 100% of costs. Funding begins for nonpoverty area centers at 80%, for poverty centers at 90% of costs, and is then reduced substantially year by year to an eventual level of 25% and 30%. Clearly, then this federal seed money *must* be supplemented with all available alternative funds if the programs are to become viable.

Indeed the federal ligislation recognizes this. Section 20(c)(1) requires a CMHC applying for a federal grant, to assure HEW that it—

"will develop a plan for adequate financial support to be available, and will use its best efforts to insure that adequate financial support will be available to it from Federal sources (other than this part) and non-federal sources . . . so that the center will be able to continue to provide comprehensive mental health services when financial assistance provided under this part is reduced or terminated as the case may be"

"has made or will continue to make every reasonable effort to collect appropriate reimbursement for its costs in providing health services to persons who are entitled to insurance benefits under title XVIII of the Social Security Act, to medical assistance under a State plan approved under title XIX of such Act, or to assistance for medical expenses under any other public assistance program or private health insurance program"

Similar requirements are placed on the centers for collecting appropriate fees, based upon ability to pay.

Hence the centers are obligated to obtain maximum feasible amounts through programs such as Medicare, and indeed if they are to survive once their federal grants terminate, they must be able to receive reimbursement for individuals covered by these programs.

MEDICARE AND CMHC'S

Federally-funded CMHCs are now unable to qualify as providers under either Part A or Part B of Title XVIII unless they are directly operated by a provider hospital, in which case the CMHC program comes under the auspices of the hospital and bills through the same provider number. However, currently only about 15 percent of federally-funded centers are operated by a hospital, while 62 percent have agreements with a provider hospital for the hospital to provide inpatient care to CMHC patients. The problem is most acute, then, for outpatient services—which is the primary service that CMHCs provide. Provider status under Part B is now denied to about 85 percent of the CMHCs, which can thus only collect for extremely limited reimbursement through physician fees for service.

A further restriction is the definition of physician supervision which makes it impossible for many of the CMHC services to be reimbursed. At the present time there are insufficient psychiatrists to supervise all community mental health care, even if that were desirable. But in fact, it is not necessary, practical or desirable to require that a psychiatrist or physician be present when all care is provided. Not only is this unworkable because of psychiatrist shortages, but it is unwise since much of the psychological treatment required by CMHC patients can be provided by other members of the CMHC professional treatment team at less cost.

Within an organized setting, such as a CMHC, controls on the appropriateness of care and the quality of service rendered can be made by setting conditions for operation of the provider agency, including peer and other reviews. Thus, the provider agency can be held accountable for ensuring that services are appropriate and of high quality and that patients' rights are protected. Lines of responsibility and accountability in such CMHC providers should be clear. Once such controls on quality care are in place, it is not necessary or desirable to include in the federal statute conditions regarding the day-to-day operation of the programs, especially the appropriate roles of members of their professional staff.

NCCMHC PROPOSED AMENDMENTS

NCCMHC supports a complete revision in the mental health benefits under Title XVIII, but is also aware that such a review and revision cannot be considered at this time. Therefore, in order to address the most pressing needs—provider status, coverages of outpatient services, and quality controls through restraints on the provider agency instead of on which professional may deliver care—NCCMHC supports amendments to Title XVIII which would:

- amend Part A to include coverage of CMHC outpatient services with limits set on the number of visits per annum;
- require periodic and repeated reviews of services to ensure that treatment is appropriate;
- provide reimbursement for services provided on an outpatient basis by a qualified clinical staff member, including various outpatient therapies, day treatment and home visits;
- include the definition of CMHCs only those agencies meeting both Medicare requirements and the requirements in the CMHC Act.

These amendments have been introduced by Congressman James Corman (D, Calif.) as H.R. 6260.

Since the great majority of mentally ill persons do not need long-term institutional care, nor long-term outpatient services, this proposal is designed to ensure that Medicare beneficiaries could utilize community mental health center outpatient services, with appropriate limits on care per annum and regular reviews of services. It would also ensure that inpatient services be reduced to a minimum. A limitation on the number of visits has been set in order to conform this coverage to that under Part B, and also because of the difficulty of defining spell of illness with respect to outpatient mental health services for the elderly.

Under current law, payment for mental health services may be made only if a physician certifies and recertifies that such services are required and that treatment can or could reasonably be expected to improve the conditions for which such treatment is necessary. Under H.R. 6260, these same quality controls would also apply to outpatient CMHC services.

The proposal defines outpatient services in a CMHC to include active diagnostic, therapeutic and rehabilitative services provided in the CMHC, in the patient's home or in a CMHC (or CMHC-affiliated) day treatment program.

The term outpatient services should be interpreted broadly, so as not to restrict the setting in which these services can be provided. Currently, Medicare includes under the term outpatient both traditional outpatient visits and day reatment services. However, it is equally appropriate on occasion for the therapist to visit the patient as for the patient to come to the center.

Many patients discharged from long-term care facilities will require more support than the traditional outpatient visit, and for these patients in particular day treatment programs are essential. However, day treatment requires that active therapeutic care be provided more or less continuously throughout the day—day care services such as custodial or socialization programs should not be covered under this definition.

H.R. 6260 provides coverage for services of all qualified CMHC clinical staff members when certified as necessary and provided through a qualified CMHC with appropriate reviews. CMHCs qualified under this proposal and licensed in their state should then be free to establish appropriate roles and responsibilities for each staff member.

Under H.R. 6260 the definition of a qualified CMHC is deliberately restrictive because of the absence of any appropriate nationally recognized standard for CMHCs other than the federal grant program. The major purpose of the NCCMHC proposal is to open up to Medicare beneficiaries the services of qualified CMHCs and to ensure coordination of the federal CMHC program and Medicare. Thus only centers meeting the federal definition would be eligible for reimbursement.

The need for action on this or a similar plan is urgent, as about 100 centers are already operating without categorical assistance (many of them with great difficulty and only after reducing services). Without Medicare coverage, it will be extremely difficult, if not impossible, for these and other CMHC programs to survive.

Statement of Ruth E. Kobell, Legislative Assistant, National Farmers Union

Senator Talmadge and Members of the Committee, we appreciate the opportunity to support S. 708 and S. 1877 which would provide medicare reimbursement for physician extenders practicing in rural health clinics.

Mr. Chairman, we commend your leadership in sponsoring this legislation to help shore up financial support for health care delivery in rural areas. Rural areas

lack the needed doctors and other health personnel to deliver adequate health care even to those residents who can pay for such care. Many small towns and rural areas do not have the population density required to support a full time doctor. Yet their health problems are compounded by delayed attention to easily treated injury or disease because of the difficulty and expense of traveling long distances to reach such health care.

The members of National Farmers Union have urged improved health care delivery to rural areas for more than thirty years and have continued to point out, both in their policy statements and testimony to Congress, the disadvantages under which many farm families and other residents of rural areas must labor in trying to provide their health needs. Our citizens are medically disadvantaged if they do not have such care available, regardless of income.

Skyrocketing health care costs are requiring us to focus on the ways in which quality health care can be delivered to those needing it at less cost and special attention is being given to Medicare and Medicaid procedures.

An article from the February 27 Sunday New York Times reviews some of the approaches to reimbursing hospitals for care to those covered by Medicare, pointing out "According to health care experts, a one-day reduction in the average length of hospital stay in this country would save nearly $2 billion a year."

If we could move more rapidly to preventative treatment and monitoring which can be more accessible at local clinics, the savings could be even greater.

Such savings are particularly important to our farm families who are always faced with fluctuating farm incomes and rapidly escalating health insurance premiums. Farmers today are experiencing collapsing farm prices, continued drought and heavy costs of a hard winter. Lacking national health insurance, support for local health service becomes even more important.

Delegates to our National Farmers Union 75th Anniversary Diamond Jubilee Convention meeting, March 1977, in San Antonio, Texas, adopted a policy statement for the coming year. I want to quote from the statement adopted by our delegates that section bearing directly to this legislation:

"Greater attention should be given to the extension of health services to rural areas, including a rural health corps, expanded use of medical aides, paramedics, nurse-practitioners, and other innovative approaches so as to alleviate the scarcity of health personnel in rural areas.

"We urge increased appropriations for search in diet and nutrition, heart disease, cancer, and the prevention and cure of mental illnesses, including alcoholism and drug addiction.

"We oppose efforts to shift Medicaid and other federal health programs to the states without provision for maintaining equality and availability of service. Such a shift would worsen the maldistribution of health care without reducing costs to the consumer or taxpayer.

"We urge expansion of programs to provide home health and housekeeping services under Medicare and Medicaid to those who need it in order to make it feasible for many to delay or prevent their commitment to nursing homes or other institutions. . . ."

Rural health clinics staffed by physician extenders can and, in many instances, do provide the preventative health services that decrease the incidence of illness and improve the health of the citizens of the community. A senior citizen needing such help as blood pressure monitoring can get to a local clinic but may not be able to afford or have available transportation to the nearest doctor's office. The time and effort involved in travel, waiting in line for a few minutes time of an overworked doctor or the service of an office nurse many times seems more of an effort than it is worth.

Public transportation is nonexistent in many rural areas and many older people covered by Medicare and Medicaid do not have private transportation, either because they can no longer afford a car, or are no longer able to drive. Pride and independence makes it hard to ask their neighbors to take them to town and wait for them to get any but the most pressing medical care.

Mr. Chairman, we appreciate your recognition of the flexibility needed in proposing the Medicare reimbursement be provided to clinics which have been set up and operated in a variety of patterns. One such example is the community clinic which was established by the citizens of Dove Creek, Colorado, a small isolated community in the southwestern corner of the state and staffed with the help of the National Health Service Corps. The story of its organization was told in some detail by the Denver Post Empire Magazine, March 7, 1976, and I

have attached a copy to my statement as an example of the efforts to which rural people will go to provide their families with needed care. Medicare reimbursement for services which could be provided by such a clinic would help provide the financial support needed to continue this worthwhile service.

Admittedly such financial support is but a first faltering step to assuring available health care to rural America, but as the Chinese proverb reminded us, "A journey of a thousand miles is taken one step at a time", and it appears that such a step is long overdue.

A TOWN TOO SMALL TO HAVE A DOCTOR—AN INCREDIBLE COMMUNITYWIDE EFFORT PRODUCED A UNIQUE MEDICAL CLINIC IN REMOTE DOVE CREEK. WILL IT WORK?

(By Zeke Scher, Empire Magazine)

Colorado's last frontier is on the banks of a small, spring-fed stream called Dove Creek. A U.S. highway crosses the creek and along each side the pioneers have built a town. It became county seat in 1941 and is the state's youngest.

Dove Creek (population, 650) is in isolated Dolores County near the Utah line in the Four Corners. Even more sparsely populated is the eastern half of the county with Rico, the former county seat, and its surrounding La Plata and San Miguel mountain ranges.

The peaks plus the rugged Dolores River Canyon divide the county, making a Rico-Dove Creek drive some 70 twisting miles through another county (Montezuma). Children in Rico go to school in the town of Dolores, deep inside Montezuma County.

So while Dolores County is 65 miles wide, the bulk of its 1,600 population is in the western edge around Dove Creek, and about half of that is within the town.

The county was created in 1881 as an influx of miners boomed the Rico valley for gold and silver. By 1891 there were 10,000 persons packed into the mountains and Rico claimed the largest ore shipments in the world.

Scrub cedar and brush still covered the high plains beyond the Dolores River. An early freighter following the trail from Cortez to Monticello, Utah, saw flocks of watering wild doves and provided the Dove Creek name. It wasn't until 1914 that this frontier was challenged in numbers as the land was opened to homesteading.

These latter-day pioneers cleared the stumps, rocks and sage acre by acre before they could start their risky dry-farming operations. In the 1930s, more farmers moved in from Dust Bowl states. The demand for uranium in World War II and thereafter brought in new miners and a second facet to the economy.

Today, U.S. 666 is paved through Dove Creek. So are four blocks of Main Street. But that's all. There are no curbs, gutters or sidewalks. The streets have names but the houses and buildings have no numbers.

Both restaurants offer good menus, and at least one is open (the owners take turns on vacationing). The town has a fine dry goods store and a good hardware store. A second grocery store will open soon. The Empire Theatre offers top features Friday through Sunday evenings.

There is no work problem in Dove Creek. Most men, and women, too, have two or three jobs. Some farm, mine and handle a town job. Dove Creek claims to be Pinto Bean Center of the World, and nobody challenges that seriously. A small oil field nearby pumps taxes into the county government, its primary revenue source.

Like many small towns, everybody knows everybody but they are too busy to sit and visit. But, when someone has a problem, almost everyone offers to help.

In recent years, Dove Creek has had a big problem: No doctor or any other health care facility in the county.

Clara Louise Small lives in a small frame home on Dove Street, having come to Dove Creek 55 years ago from Maple Hill, Kan., after a brief stopover in Colorado Springs.

Miss Small homesteaded 40 acres northwest of Dove Creek in 1921 (she still gets pinto beans off the property). She taught school and then began a 28-year term as Dolores County welfare director.

Now at 82, she still enjoys Dove Creek, resides alone on "a good-visiting block" a short distance from "the highway," occasionally writes articles for the Dove Creek Press, tries to stay healthy and cooks Scotch shortbread.

"In time of trouble this is the friendliest town I've ever known," she says. "But other times everybody is too busy even to visit. This is still a frontier town with a lot of unchurched people."

That was hard to believe since the little town has 13 churches.

"A great many people are coming to Dove Creek every year—seven or eight families," she says. "I think Dove Creek will grow but it won't become a metropolis. We have some good stores but we can't break the people's habit of shopping in Cortez because they get a ride out of it."

For years that 86-mile trip to Cortez had been more than just a jaunt for shopping. It was a life-or-death raceway to the closest doctor and hospital.

Just beneath the consciousness of most Dove Creek residents was the fear of sudden illness or serious accident, especially in bad weather, far from medical help. It was bad enough for less-than-emergency complaints—losing a day of work to travel to Cortez for a doctor's appointment.

More often than not, self-treatment—or no treatment—suffered.

Mrs. Nellie Bradfield was well aware of this daily emotional and physical drain. She was born 50 years ago at Yellow Jacket, in a canyon just south of the Dolores County line. The wife of a rancher at Cahone near Dove Creek, she has been concerned with area medical problems as a member—also a president—of the five-county Southwest Comprehensive Health Planning Council.

Council goals in 1971 were to establish medical clinics at Pagosa Springs in Archuleta County and in Dove Creek. Pagosa Springs, with twice the population of Dove Creek, obtained a physician. Dove Creek wasn't big enough to do that and had to follow a different, uncharted course.

Mrs. Bradfield turned to Raymond Rabe, a 34-year-old health planning consultant who came to Durango in July 1972, the month after earning a masters degree in health administration at the University of Colorado Medical Center in Denver.

"I provided only limited technical assistance and the Dove Creek people did the rest," says Rabe. "I passed along a new idea on getting a level of care to rural people and developing a mini-health-care system that could tie into the larger system."

Dove Creek wanted—still wants—a full-time doctor. Rabe suggested an alternative: a nurse practitioner, provided by the U.S. Public Health Service's National Health Service Corps.

A nurse practitioner is a registered nurse with postgraduate training in assessing medical conditions and administering to the ill, injured or infirm—"at or under the general directions of a physician."

How could remote Dolores County attract such a qualified person? With no doctors around, how would such a person comply with the law to act under the direction of a physician? Where would the nurse work? What about medicines and drugs? Dove Creek has no pharmacist or drugstore. And then there were the little matters of reimbursement, equipment, expenses. . . .

The potential problems almost persuaded Dove Creek supporters to forget the matter. A cool reception to the idea from the doctors of the Montelores Medical Society didn't help.

Rabe drew up an application to the U.S. Public Health Service for appointment of a nurse practitioner under the Emergency Health Personnel Act. This federal law permits assignment of doctors or nurses to areas with a critical scarcity of health personnel. Salary is paid by the government for two years under a pilot program aimed at making the clinic self-sufficient—and hopefully able to repay the government at least part of the salaries.

The Dolores County Health Association was the applicant, as soon as it could be created as a nonprofit, charitable corporation. Cortez lawyer Guy Dyer, who has been Dolores County attorney for 25 years, took care of that.

In July 1973 the application (signed by Nellie Bradfield, president) went to the regional office in Denver of the National Health Service Corps, which recruits and hires the nurse. Dolores County was adequately described as a remote Four Corners area that had tried futilely for a decade to attract a doctor.

A nurse practitioner would bring "a more acceptable level of emergency health services to the community and allow for the provision of some primary health care," the application said. "This also will reduce the need to travel considerable distances and spend a lot of time to receive follow-up care that could be available locally."

A clinic in Dove Creek would be unique in several respects: A private corporation would run it; the small community would have to raise its own funds for equipment and operating expenses; the clinic would set its own fees and deal with any—and all—doctors available, by telephone or otherwise.

On Nov. 3, 1973, the Denver office approved two nurse practitioners.

"We figured it would be easier for two to work there than one," says Marva Jean Collins of the regional office.

Nowhere in the Denver region—Utah, Wyoming, Montana, South Dakota, North Dakota and Colorado—were nurse practitioners running a community health clinic without supervision by a physician. Problems were expected. A year after the search began, Shirley Collins of Tucson, Ariz., and Mrs. Thomasine Scherer of Boulder, Colo., accepted the challenge at Dove Creek.

When the two women arrived in October 1974, there was no clinic building, no equipment and no money. They began administering in their rented homes or in patients' homes. Association members spread the word of the nurses' availability.

It was a difficult period but 1975 began with high hopes. Almost everyone in town was either on a special committee for a clinic or was being solicited by them.

Union Carbide Co. owned a one-story building formerly used as a drafting and core analysis office but for a decade relegated to storage. The inside was described as "a standing disaster." But the health association sought it for the clinic.

As negotiations dragged—New York headquarters had to decide on the Dove Creek rent—the fund-raising committee shifted into high gear. A spaghetti and piet dinner was held in February. The spaghetti was for eating and the pies were for acutioning, with all proceeds going to the clinic.

Some 200 turned out at the elementary school, ate spaghetti and then bid up to $11 for each of 75 donated pies. The association netted $466.50, and the campaign was launched.

The budget committee reported that it would cost $16,812 to run the proposed clinic for one year. That didn't include nurses' salaries—$30,000 paid by the health corps. The fund raisers tried a new gimmick: "Sick" coupons that could be applied to future clinic charges. But only $316 was invested in the $2 coupons.

Skeptics wondered if the clinic would become a reality.

The Dove Creek Grange sponsored a clinic carnival in April with more pies plus cakes and white elephant items for sale, which raised $848.41 for the clinic.

In mid-June, after a lease was signed with Union Carbide to rent its building for $150 a month, an auction of donated items at the proposed clinic continued most of the summer. This raised $972.90 from items ranging from sacks of flour and puppies to old cars and a Knous chair (owned by the late Gov. Lee Knous).

The fund-raising events, while enthusing the community and increasing support, produced comparatively small sums for the clinic. Summer-long volunteer labor would convert the Union Carbide building into an attractive office, but financing would still be $15,000 short.

Then John Mitchell, executive director of the Boettcher Foundation in Denver, announced a $10,000 grant to the association.

"We felt these people were really helping themselves and we wanted to add a boost or stimulus," explains Mitchell. "It was an unusual grant for us because we usually require the money be used for capital improvements. In this case we provided that the money could be used for operating expenses."

The Dolores County government, which scrapes to provide services from a minimal tax base, permitted the clinic to draw up to $10,000 for equipment, not operating expenses. The clinic was assured.

But before the building could open, illness forced Mrs. Scherer to resign and Miss Collins took another job outside Colorado. As work neared completion on the clinic, the health corps searched for two more nurse practitioners.

About 100 volunteers spent last July and August—an estimated 2,000 man-and-woman hours—changing the storehouse into a bright, sterile-clean Community Health Clinic. Frank Zehm, who "retired" from the construction business 14 years ago and moved from Inglewood, Calif., to Dove Creek "because there's not a lot of traffic here and the people are friendly," built partitions and cabinets in the clinic—for free.

Virgil Morton, 65, left Parker, Ariz., for Dove Creek and tends a few cattle, goats and chickens plus a garden on six acres. A painter, he provided all the signs for the clinic. (A son, Roger, is director of health education at Denver's Porter Memorial Hospital. He makes signs too.)

Charlie Campagna did the dry walling. Harmon Randolph the plumbing, Wilmer Dicken the electrical work, Mrs. Louis Pribble the landscaping, with a lot of help from town kids, and most of the women of Dove Creek had a hand in cleaning, painting and decorating.

By the end of August, the clinic had a trauma room (with outside door to meet the VFW volunteer ambulance), X-ray room (with World War II vintage machine "that works", major examining room, pediatric examining room, laboratory ("our pride and joy"), storage and reception room. But, the search for health personnel continued.

After spending three years in a Harlingen, Tex., migrants' clinic and a year as an Army nurse in Vietnam, Marian Thornton found the offer to work in Dove Creek very attractive. She jests that she is an unwed mother, but her story is different.

She was serving in an evacuation hospital at Chu Lai in 1971 when an orphan was brought in suffering multiple shrapnel wounds. She nursed the 7-year-old boy and then decided to adopt him. Ms. Thornton, now 27, feels Tim has adapted well to America. "He placed second last fall in the punt-pass-kick competition," she says.

She and Tim arrived in Dove Creek and last week in August and moved into "Ila Randolph's rental house" on Colorado Avenue.

A Detroit native, Ms. Thornton graduated from Borgess School of Nursing at Kalamazoo, Mich., and obtained her nurse practitioner certificate from Wichita (Kan.) State University in 1974.

Meanwhile, Mrs. Sandra Vorwaller was director of nursing at Wasatch County Hospital in Heber City, Utah, when she quit "for personal reasons" and came to Dove Creek with her 9-year-old son, Patrick.

A native of Kimball, Nebr., she was the daughter of a physician who wanted her to become a doctor, too. She settled for registered nurse, adding nurse practitioner certificate at the University of Utah in 1974. The 37-year-old nurse and her son live in a trailer house next to the clinic in Dove Creek.

Some new problems surfaced, beginning with the high school football physical exams.

Dolores County High School in Dove Creek is a member of the San Juan League, which is a member of the Colorado High School Athletic Association in Denver, a nonprofit corporation run by 251 schools.

A bylaw provides that no pupil can participate in inter-school athletics until he files a consent statement by parents or guardian, and a certification by a practicing physician that the pupil has passed an adequate physical exam in the past year and in the opinion of the examining physician is fit to play high school athletics.

Nurse practitioners perform physicial exams as a routine matter, usually spending much more time with the patient than a physician can afford. The unequipped Dove Creek clinic wasn't supposed to open until Sept. 2, but to accommodate the football players, Mrs. Vorwaller examined five of them on Aug. 22. By the end of the month, 18 boys had gotten physicals there.

In November all the physical exam forms were returned from Denver. The athletic association wanted to know why the examining physician's signature wasn't included.

"We have no right to change the requirement," we were told by Gene Bennell, association assistant commissioner. "Personally, I'd never heard of nurse practitioners before this. Our legislative body will meet in April and the San Juan League can petition the board of control for change, or the executive committee could move on its own."

So, rightly or wrongly, two Cortez physicians with confidence in the nurse practitioner's abilities "legalized" the physicial exam forms by signing them. The exams were not repeated.

Then there was the matter involving the drugstore.

Despite the expertise of the nurse practitioners, only a physician may "diagnose" illnesses and "prescribe" drugs. The nurses can "assess" medical conditions and "administer to"—not treat—patients at the clinic.

The nurses deal with the physician of the patient's choice and this doctor may prescribe medication. When a Dove Creek patient has no doctor preference, the nurses urge the patient "to just pick one."

In an emergency, however, the nurses call whichever doctor is on duty in the Cortez hospital emergency room, or possibly one of three doctors who agreed to alternate weekly visits to Dove Creek.

Diagnosing and prescribing by a doctor in Cortez from information phoned in by a nurse practitioner raised ethical (and legal) questions. Practicing medicine by telephone isn't recommended by any medical society, and the doctors in Cortez are aware of malpractice possibilities.

But what choice is there when there is no doctor in Dove Creek? Something or nothing. So the Cortez doctor responds.

Next problem: Getting the drug dispensed and delivered promptly to the patient 36 miles away. There are four drug stores in Cortez; none in Dove Creek. Doctors and nurses aren't supposed to recommend one licensed pharmacist over another.

Patients in Dove Creek may not know any. So what happens? It is hit or miss again. Getting the prescribed drugs to the Dove Creek patient was solved "by mutual consent," if not by legal authority.

It was impractical to make every patient drive 72 miles roundtrip to pick up a prescription. So three Cortez pharmacies agreed to deliver their Dove Creek drugs to the fourth one where, at 5:30 p.m. daily, Mrs. Peggy Wells becomes "the drug shuttle."

Mrs. Wells resides in Dove Creek and works at a Cortez tile company. She picks up all the drugs on her way home and delivers them to the clinic. Patients pay $1 for this service, half of which goes to Mrs. Wells. The drug stores bill the patients directly.

This expeditious way of doing business—and the issue of keeping small amounts of common and emergency drugs at the clinic—reached the State Board of Pharmacy in Denver. Says Mike Simmons, board executive secretary: "Nurses are governed on what they can do by the nursing act, pharmacists by their law and doctors by the medical practice act. The gals can administer to the patients only as directed by the doctor."

Dr. Robert H. Carlson, as president of the Montelores Medical Society and one of the three physicians visiting Dove Creek each month, sent a letter to the pharmacy board seeking an okay on clinic plans to keep some drugs.

The board took the position of having no position—and no objection—to the clinic maintaining a drug supply so long as it was prescribed by a physician.

The clinic's application to the Federal Drug Enforcement Agency for permission to purchase drugs was referred to the Colorado Health Department with an inquiry whether the clinic was licensed. That created more circular motion.

A clinic needs to be licensed—as a community clinic and emergency center (there were four in Colorado, all with doctors)—if it is to qualify for third-party reimbursement. That means that until Dove Creek got a license number, it couldn't collect anything from Medicare, Medicaid or health insurors.

Why hadn't the clinic been licensed? Clarence Horton, director of health facilities in Denver, says: "They have a very independent operation, very unusual situation there. It's the only one we know of that has no physician on the spot giving advice."

Horton says the health department had checked the physical plant last fall and approved it. Licensing only required another inspector to approve the staffing of the clinic. This had dragged on, he concedes, because of Dove Creek's remote location.

The clinic has had to write off many bills because it couldn't collect from third-party sources. In mid-January an inspector went to Dove Creek and approved the staff. So early in February Dove Creek got its long-awaited license.

The clinic problems on reimbursement may not end with licensing. There are various requirements for "direct supervision" by a physician on claims for reimbursement. So the legal ramifications go on.

Glenn Watmore and Robert James are well known in Dove Creek. Watmore is the banker. James is the extension agent. Less well known are their crucial roles in creation of the clinic.

Watmore became president of the Dove Creek State Bank four years ago after living in Denver, Littleton, Buena Vista and Fairplay. He supported the clinic but maintained a low profile.

"Our ultimate goal is to have a doctor and turn the clinic over to him to staff it," says Watmore. "Like most people in the West, we want to be independent and self-supporting. The clinic grew because people supported it. There's community effort available everywhere and all you have to do is open doors to tap it."

Watmore, in the early months, made telephone calls on behalf of the clinic, wrote letters, attended meetings and paid for expenses. His wife, Shirley, is health association secretary and submitted the successful application for the Boettcher Foundation grant.

"Most clinics of this sort are in impoverished areas," adds Watmore. "Dove Creek is different. Nobody has his hand out here. The people are unspoiled, like most pioneers."

County Agent James, a 32-year-old Lakewood, Colo., native, taught political science for six years at Roaring Fork High School in Carbondale.

He accepted the job of Dolores County extension agent two years ago and later took the nonpaying job of the health clinic administrator.

"I jump in where I'm needed," he says. "I get all the reports and when a problem comes up—like they do all the time—I have all the information and help coordinate things. I'm the contact with the National Health Corps, I manage the building and contact members on what needs to be done.

"We've been operating on the theory that the government—the laws—will accept us eventually. There've been so many obstacles set up for us, but we feel nothing is impossible. All 18 on the board are dedicated—nobody has ever quit—and they know when you're first you have to take a lot of flak."

Dove Creek has no employment problem. Watmore has pushed bank deposits from $1.2 million to $6 million with his "open door" policy. And if the dam is ever built on the nearby Dolores River, irrigation and recreation should boom the area.

So there are no handouts at the clinic. A complete fee schedule has been drawn up and charges, while reasonable, are comparable to many doctors' office calls.

Much of the clinic's equipment was purchased from government surplus agencies in Denver and hauled over the Divide in new trucks being delivered to Cecil Martin, Dove Creek implement and Ford dealer (who is chairman of the clinic's building and equipment committee). Some $6,000 worth of gifts helped furnish the clinic.

The clinic officially opened last Sept. 2. Drs. P. W. Donesky, Paul Bostrom and Robert Carlson agreed to a monthly visit each (nobody came the fourth week). It didn't work out for the doctors since patients were going to the physician of their choice as needed. At year's end only Carlson was a regular, and the medical society urged the clinic to accept one physician to perform all purposes.

Carlson, 34, operates a clinic in Mancos, lives in Dolores (where he previously practiced five years) and has patients in Cortez. He has agreed to be the regular Dove Creek doctor for the clinic.

"I think it is a real asset for the people and community that can't support a physician," he says. "More people have got to learn that the girls are there and can give good immediate coverage. Some people are still going to other communities to see their doctor. The girls are well-trained and are doing a commendable job.

"Generally we don't want non-MDs giving drugs but the trend is in that direction. Some doctors who scream the loudest about this allow their assistants to do the same thing, and they don't have the formal training of the NPs."

In the nine months before the clinic opened, the Dove Creek nurses averaged seeing one patient a day. Since September the figure has grown each month, totaling 173 in December. The month's record included 106 for acute illnesses or accidents, 39 for chronic ailments or follow-ups, 12 for obstetrics and 16 for physical exams.

The clinic files—270 families are listed—testify to the magnitude of its role in Dolores County life. Less visible but just as important is a new feeling in the community as voiced by a farmer's wife who was having her blood pressure checked and her eyes examined.

"It sure eases your mind to know there's medical attention closer than Cortez or Monticello," remarked Mrs. Faye Carhart.

In November, Ella Leffel was cutting cedar and pinon wood about 100 feet from her Dove Creek home. It was 10 in the morning and nobody else was home.

"I've cut wood all my life and I was using my long-handled, single-bit ax," Mrs. Leffel says. "Then I dropped the ax. It hit my left foot, high in the instep.

When I reached to pick it up, blood spurted out. I was wearing tennis shoes and it had cut through the tongue of the high-laced shoe."

She had severed an artery, two veins and a tendon. She hobbled across the yard and into the house where she put her foot up on a chair and tried to apply pressure to the cut with one hand while phoning her husband, Eldon.

He was the right one to call. For a decade he has driven the VFW volunteer ambulance. Leffel owns a hardware store and several blocks away a service station, where the ambulance is kept.

The store phone was busy. Mrs. Leffel called the service station. Barry Hamilton answered. He phoned the clinic, and it answered the first time.

Within 10 minutes Eldon drove up to the home in the ambulance—with Nurse Thornton aboard.

"She did what had to be done to stop the bleeding," Mrs. Leffel says. "She continued applying pressure as Eldon drove right to the Cortez emergency room. I lost about two pints of blood."

Mrs. Leffel will have to undergo corrective surgery to repair the tendon but she is happy to hobble around in otherwise good health. The clinic has made follow-up exams and blood tests.

"I'd forgotten the clinic number at the time but I won't ever again—7-2291," she says.

Mrs. Marcia Mahlman, pregnant 22-year-old wife of the high school business teacher and basketball coach, was losing weight and feeling weak when she came to the clinic last fall.

The nurses ran tests in their laboratory and discovered Mrs. Mahlman had an excess of ketones in her system that could threaten the baby's normality. The job was to reduce the woman's acidity which made her use more calories than she consumed.

Dr. Carlson confirmed the nurses' findings and recommended foods to neutralize the acid. The nurses continue to check her weekly (the baby is expected in April).

"So now I drink a lot of cranberry juice and eat more," says Mrs. Mahlman. "I've really felt cared for."

The nurses, working with the county public health nurse, Patricia Smith, use their spare time to provide pre-natal classes, teach first-aid, plan a day-care nursery school and assist a new search and rescue unit (headed by Rob James). They put a weekly health update column in the newspaper. And although on 24-hour call, they always seem to have a smile and a kind word.

Mrs. Nerita Medley keeps the books, makes the appointments and acts as receptionist. She also thinks about what might have been if Dove Creek had a clinic two years ago.

Her 8-year-old daughter, Patricia, was playing with a friend in the yard and the children found a can with gasoline. Somehow it exploded over the child. There was no immediate treatment available for the severely burned girl.

Despite super efforts later—ambulance planes to Denver and to a Texas burn center—Patricia died. And the mother wonders, "If we had just had something in Dove Creek then. . . ."

Dove Creek has something now. Something special.

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