***2003**: ORHP assumes responsibilities for U.S.-Mexico Border Health activities.*

nate, at least temporarily, many of the major payment discrepancies between rural and urban providers.

With each year, new challenges emerge. In 2003, Dr. Duke asked ORHP to assume responsibility for managing the Agency's Border Health activities, recognizing that much of the U.S.-Mexico border was made up of rural communities. It also made sense given the ORHP's tradition of working across Agency and Departmental programs. In 2006, Dr. Duke also asked ORHP to take on another cross-cutting function by creating a focal point for HRSA's Intergovernmental Affairs activities.

The Office of Rural Health Policy Commemorates 20 Years

Staff at ORHP have come and gone and new functions have been added. At its core, however, ORHP's original charge to be a focal point for rural health within the Department remains the same. To understand the impact ORHP has had, one needs to look back at the state of rural health prior to 1987.

"*There was little to no understanding of how private markets and government policy hurt or failed to help rural health care and rural communities*," said Tim Size, a longtime rural health leader and executive director of a rural hospital cooperative in Wisconsin. "*It was policy development by feeling around in the dark. Without ORHP, we would not have the policy development and communication platform within the Federal Government, nor the means of financing rural-relevant health policy research outside of the government. Those of us in the field would continue to develop and advocate rural health policy, but with significantly less efficiency and efficacy.*"

The Office of Rural Health Policy continues to build on its successes from the past 20 years and learn from its challenges. With a staff committed to ensuring that the rural voice is heard in Federal health care policy, ORHP and its many allies around the Nation provide an active platform for rural health concerns in the Federal landscape. Those involved with ORHP in the past 20 years have witnessed how well-implemented, rural-focused programs and resources can make a lasting difference in the lives of those living in rural areas. Rural America matters, and thanks to the Office of Rural Health Policy, the special health and human service needs of rural Americans will continue to be addressed.

***2007**: ORHP commemorates 20 year anniversary.*

U.S. Department of Health and Human Services, Health Resources and Services Administration

The Office of Rural Health Policy Celebrates 20 Years

A Look Back at the History of the Office and Its Continued Mission to Improve Health Care in Rural America

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

1980s: *Ten percent of all rural hospitals closed.*

The 1980s: Finding Solutions for a Fractured Rural Health System

A former director once likened the Office of Rural Health Policy to an "Office of Unintended Consequences" and that may have been a more apt moniker.

It was a confluence of several factors that came together unexpectedly and illustrated the need for a rural voice within the policymaking of the U.S. Department of Health and Human Services (HHS). In the early 1980s, the economic outlook for rural America was bleak. Around 650,000 American farms were foreclosed and nearly 2,000 independent farmers quit farming each week. For every seven farms that shut down, it is estimated that one other rural business went under as a result. More than 500,000 low-wage manufacturing jobs were lost to foreign competition.

Rural health care providers were not immune in this environment. Rural areas had long struggled to attract health care providers, leading to the creation of programs such as the Community and Migrant Health Centers, the National Health Service Corps, and the Rural Health Clinic program. While these programs helped, new challenges were emerging. Rural hospitals were buffeted by an economic downturn in rural areas and declining populations. At the same time, the health care system was changing, with rapid growth in the cost of providing health care. Congress charged Medicare with developing a new prospective payment system (PPS) for inpatient services to better manage growing costs. This new administered pricing system moved away from the customary and reasonable charge-based system and set firm price prices for all services.

While this move helped policymakers take an initial step toward containing costs, it also created some stark winners and losers. The new PPS had a rural-urban payment differential as policymakers believed it cost less to provide care in rural areas, and rural hospitals saw a significant reduction in their payments. In addition, the PPS put some rural hospitals at risk financially because it paid based on a system of averages and smaller facilities had fewer cases over which to spread those costs. Between the inception of the new payment system in 1983 and 1987, nearly 400 rural hospitals closed and many others were at risk of closing.

1985: *Medicare moves from a cost-based reimbursement to Prospective Payment System (PPS)*

2002*: HHS Rural Task Force Created.*
2003*: "One Department Serving Rural America" published by HHS Rural Task Force.*

Act, Benefits Improvement and Protection Act, and Medicare Modernization Act provisions and was able to make sure rural concerns were taken into account as these bills became law. In addition, the launching of the Flex grant program, ORHP worked hand-in-hand with the States to identify small rural hospitals that would benefit from conversion to CAH status. The numbers of CAHs grew quickly, and by 2007, there were more than 1,286 CAHs as these small rural hospitals found that the CAH designation provided needed financial stability.

Rural Issues Across HHS

Rural health issues drew the attention of a new Secretary in 2002 when Tommy Thompson, a former Wisconsin Governor, took over HHS and created a rural task force to find out how the Department served rural communities. It resulted in a year-long effort, co-chaired by HRSA Administrator Dr. Elizabeth Duke, that brought together all of the key HHS agencies and operating divisions to quantify how they served rural areas and identify new strategies for improving that service delivery. The Task Force's 2003 Report, "One Department Serving Rural America," was a comprehensive rural assessment for HHS. It led to spin-off rural initiatives in CMS, the Substance Abuse and Mental Health Services Administration, and the Administration on Aging. The initiative also resulted in the expansion of the National Advisory Committee on Rural Health to add human service delivery in rural communities to its focus areas. The Task Force also pushed for the expansion of ORHP's clearinghouse activity into a broader focus on all of HHS programs which led to the creation of RAC.

Recent Changes and Activities

In 2003, ORHP also saw another dramatic change to Medicare reimbursement and the creation of a Medicare drug benefit with the passage of the Medicare Modernization Act of 2003. Again, the passage of this landmark legislation made even more significant changes to Medicare than the BBA and included $25 billion in reimbursement changes for rural health care providers. ORHP staff worked directly with CMS to help implement these provisions, which helped elimi-

1997 —2003*: Rural hospital margins begin to improve.*
2007*: 1,286 Critical Access Hospitals in the United States.*

***1998**: Dr. Wayne Meyers named director of ORHP.*

ORHP director, Dr. Wayne Myers, whose express charge was to revitalize the policy activities of ORHP.

The timing was opportune. Congress passed the most sweeping changes to the Medicare program since its inception with the Balanced Budget Act of 1997 (BBA), which included dramatic changes to rural hospital reimbursement as well as significant changes in other areas of care. The BBA and two subsequent pieces of legislation (the Balanced Budget Refinement Act of 1999 and the Beneficiary Improvement and Protections Act of 2000) were implemented during Dr. Myers' tenure, all of which provided ORHP with an opportunity to take part in the rulemaking process and live up to its original charge of ensuring a rural voice in implementing policy. As Director, Dr. Myers worked to strengthen the Office's role in policymaking, relying on the experience of his deputy director, Jake Culp, who had worked for years at HCFA and whose connections with staff in the Medicare program were essential. Dr. Myers also created a new position at the Office by naming a policy coordinator, whose sole role was to focus on the rural implications of the many regulations that are issued by the Department each year on Medicare, Medicaid, and other key issues. That role was initially filled by Tom Morris, who was succeeded by Emily Cook, and now Carrie Cochran leads in that position. Each of the three individuals has ensured that the rural voice is taken into account in the policymaking process at HHS.

The BBA legislation also included another key provision, the State Children's Health Insurance Program (SCHIP) that affected rural communities. HRSA played a key role in helping administer this program along with HCFA. Dr. Marcia Brand, who at that time was coordinating HRSA's SCHIP activities, worked extensively with ORHP staff to push for innovative enrollment strategies in rural areas, which had higher rates of uninsured children. This close association led to Dr. Brand joining ORHP as Deputy Director in 2000 and succeeding Dr. Myers as director in 2001.

During the tenures of Dr. Myers and Dr. Brand, rural hospital margins began to improve thanks to payment changes made by the Congress between 1997 and 2003. More importantly, ORHP was able to take an active part in the rulemaking process for the implementation of the BBA, Balanced Budget Refinement

***2001**: Dr. Marcia Brand named Director of ORHP.*

***1986-1987**: National concern about the hospital closures taking place in rural communities grows.*

Policymakers Pay Attention

This situation of unintended consequences got the attention of lawmakers. In the Senate, rural advocates led by a former North Dakota Senator formed the Senate Rural Health Caucus, followed shortly by the creation of the House Rural Health Care Coalition, led by the efforts of two Iowa Representatives. These groups, made up of members who represented rural States and districts, created a newfound voice for rural health interests within the halls of Congress. Throughout 1986 and 1987, several Congressional Committees held hearings on the viability of the rural health care delivery system and in particular on the plight of small rural hospitals. On June 4, 1987, the Select Committee on Aging and the Task Force on the Rural Elderly held a joint hearing on "The American Rural Health Care System: What Should It Be and How Do We Sustain It?" This hearing brought a new level of attention to rural health care issues and soon calls for a focus on rural health within HHS began to emerge.

In March 1986, the Under Secretary for HHS asked the Health Resources and Services Administration (HRSA) to investigate the pressing health concerns of health in rural America. HRSA convened a department-wide Work Group, whose membership was also pulled from the Health Care Financing Administration (HCFA, now known as the Centers for Medicare and Medicaid Services or CMS), the Public Health Service (PHS), and the Office of the Secretary. Outside interests' input was also included through the creation of an external Advisory Group. The resulting report, "Rural Hospitals/ Health Services – Executive Summary" pulled together all of the existing knowledge on the status of health care services in rural America and made recommendations as to how to strengthen and expand access to health care services for non-metro areas. The Work Group chose not to focus solely on reimbursement policies under Medicare PPS, but also other "unique environmental and institutional circumstances" that contributed to the financial instability of rural hospitals, including lack of available capital, size, location, and lack of expertise.

After 12 months of investigation and analysis, the Work Group issued its findings, calling on HHS to establish a centralized Federal voice for rural health within the U.S. Department of Health and Human Services. This "institutional focal point" for rural issues would be charged with collecting and analyzing information

***March 1987**: HHS Work Group issues report calling for creation of Department focal point for rural health issues.*

relevant to rural health concerns, working with State and local partners to enhance the delivery of health services at the local level and coordinate rural health issues department-wide.

Creating the Office of Rural Health Policy

It was one of those opportune times when the Executive and the Legislative Branch came to a mutual agreement independently. While members of Congress were introducing bills calling for the creation of a rural health office, HHS, acting on the findings of its rural work group, created the Office of Rural Health Policy (ORHP) administratively July 24, 1987, followed by the formal authorization of the Office by Congress in December 1987 under Section 711 of the Social Security Act. In its authorization, Congress charged ORHP with informing and advising the U.S. Department of Health and Human Services on matters affecting rural hospitals and health care, coordinating activities within the department that relate to rural health care, and maintaining a national information clearinghouse.

One of the major concerns for all involved in the very beginning was where to place ORHP. Since one of the main precipitating factors of its creation came from changes to the Medicare program, some believed that the office should be in HCFA. However, many worried that placing this office in HCFA would hamper its ability to be an independent voice. Others pushed for ORHP to be located in the immediate Office of the Secretary to give it a more visible position. The HRSA Administrator at the time asked to house ORHP within HRSA, arguing that the Agency's focus on primary care and the underserved made it a logical fit. From the very beginning, there was an understanding that ORHP would have a Department-wide focus, even if it was physically located within HRSA.

The legislative authority for ORHP created a strong link to HCFA, charging it with advising the Secretary on issues related to Medicare and Medicaid. The idea was to ensure that future payment system regulations would take rural concerns appropriately into context. At the time, another change in the Social Security Act (Section 1102(b)) required HCFA to issue rural health impact statements on regulations. That link in the rulemaking process provided the basis for an ongoing working relationship between ORHP and HCFA. This relationship continues to allow ORHP to voice concerns over rural provisions of Medicare payment systems.

tions, provided SORHs with input directly from the "grass roots," and an opportunity to keep local communities informed. ORHP recognized the value of these Associations and encouraged their development in all the States. Today, there are 36 SRHAs.

Early on, those involved with the creation of ORHP recognized the need to develop practical tools that rural communities could use to improve their local health care system. In 1998, ORHP began investing in a project that became the "National Center for Rural Health Works." The Center develops tools, trains State teams and provides ongoing technical assistance so they can help communities conduct a strategic planning and engagement process, measure the impact of health care on their local economy, and identify new services that could be supported locally.

ORHP also became heavily involved in telehealth issues under the leadership of Dr. Puskin, who served as both deputy director and acting director during her tenure. ORHP administered the Telemedicine Network grants through the mid to late 1990s and also served as a repository of national expertise on telehealth issues during this time. In fact, the success of the telehealth work led to the creation of the Office for the Advancement of Telehealth (OAT) within HRSA in 1998. OAT is now housed within the HRSA, Office of Health Information Technology.

Growth and Sustainability: New Leadership and a Revitalized Policy Role

Through the development and expansion of these programs ORHP began to grow and the grants became an area of greater focus and became important resources for rural communities. Still, many challenges remained. The financial status of rural hospitals had stabilized somewhat by the late 1990s, but many were still operating with double-digit negative operating margins and political pressure was growing to address the issue. ORHP was also going through some leadership changes at this time as Jeff Human retired and Dr. Puskin, the acting director, had left to become the director of OAT. After a nationwide search in 1998, HRSA welcomed a new

***1990**: Rural Information Clearinghouse initiated.*
***2002**: An updated version of the Rural Information Clearinghouse, the Rural Assistance Center, is launched. (www.raconline.org)*

Grants and Grantmaking

As ORHP became established, Congress began adding grant programs to the porfolio. As noted, the first grant program supported the rural health research centers. The State Office of Rural Health program was created in 1991, which provided funds matched on a 3:1 basis by the States to create individual State Offices of Rural Health (SORHs). By 1994, there were State Offices in each of the 50 States. ORHP also began a small demonstration program in 1991 that eventually became the Rural Health Care Outreach grants. These grants provided funding to improve program delivery and increase access to care in rural communities. Rural Network Development grants came online in 1996, which provided support for rural health care providers to join together to build better systems of care.

In 1997, Congress created the Rural Hospital Flexibility Grant program to support grants to States to work with small rural hospitals to see if they would benefit from conversion to Critical Access Hospital (CAHs) status and funding for this program finally emerged in 1999. The following year, Congress added the Rural Access to Emergency Devices (RAED) program, which provided grants to communities to support the purchase of automatic external defibrillators and training in the use of these devices by first responders. The Delta Network Development grant program, serving the eight-State Delta region from Mississippi to Illinois, was created in 2001. Network Planning Grants came along in 2002. Congress also added funding for the Denali Commission to support primary care construction in Alaska, which began in 1999. In a similar vein, Congress created the Delta Health Initiative in 2006 to support primary care delivery in Mississippi.

Just as important as the grant programs were some special initiatives created during the early years of ORHP. To help address the shortage of health care providers in rural America, ORHP worked with the States to start the National Rural Recruitment and Retention Network (3RNet) in 1995. This not-for-profit organization functions as a Web-based clearinghouse that health professionals use to identify places that need them and States use to help recruit those providers into rural and underserved communities. Membership in 3RNet now includes 46 States.

During 1994, as SORHs began to mature, some of them started to help States develop State Rural Health Associations (SRHAs). These organizations, whose membership includes providers, consumers, and organiza-

***1991**: State Offices of Rural Health Grant Program created.*
***1994**: All 50 States have SORHs.*

***1990**: Research grant program is created. ORHP begins to fund Rural Health Research Centers.*

Rural advocates were pleased to see a voice for rural concerns created within HHS but there were calls for an additional external voice. During the course of the rural health hearings in 1987, some of the members of Congress and the experts who they called to testify also urged for the creation of an external group of advisors on rural health issues. Jeff Human, who was appointed the first director of ORHP in 1987, acted upon that advice quickly, establishing the National Advisory Committee on Rural Health.

Advocates felt that there was a need for an outside group of experts to also advise the policymaking process and ensure that rural interests were addressed. That Committee, under the initial leadership of four-term Iowa Governor Bob Ray and subsequently by former U.S. Senator Nancy Kassebaum Baker and currently by former South Carolina Governor David Beasley, has remained a strong and independent rural voice. To date, the Committee has made more than 300 recommendations, 35 of which eventually found their way into law.

Establishing the Office of Rural Health Policy: The Early Years

In some ways, establishing and authorizing the Office of Rural Health Policy within the U.S. Department of Health and Human Services was the easy part. After the Office's creation, the early years were spent determining the core mission of ORHP and how best to tell the story of rural health in America. The early leadership team, Jeff Human, Dr. Dena Puskin, Jake Culp, Jerry Coopey, Arlene Granderson, and Cathy Wasem, faced the task of creating from scratch an office designed to meet significant and longstanding needs. The stakes were high – rural health care was in crisis and the problems needed to be quantified, publicized, and addressed with public policy solutions.

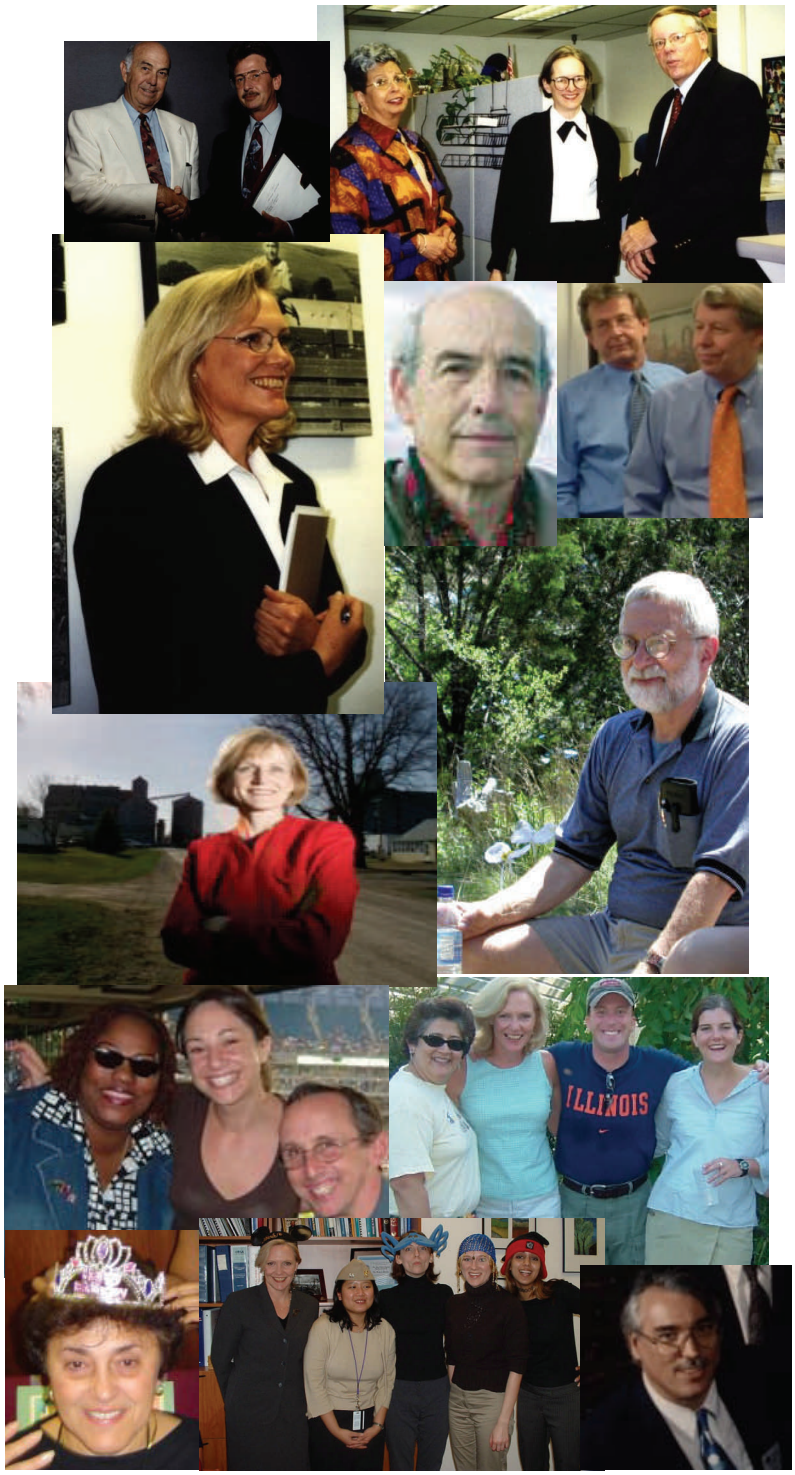
Congress provided some key early help by creating a specific line item within the budget to fund the Office. The staff quickly immersed itself into the policy process, reviewing key Medicare and Medicaid regulations. In order to inform that role and to build a scientific basis for sound rural policymaking, ORHP also began funding rural health research. The creation of the Rural Health Research Center program was essential to establishing ORHP as the national voice for rural health. Beginning with the premise that the research needed to be useful for the sake of informing rural health policy, the research team at ORHP sought to fund projects that would quantify how national health policies affected rural areas in unique ways. They also brought together rural health researchers, universities, foundations, and think tanks to

***1990**: Journal of Rural Health is launched.*

try to create a national rural research agenda that could be coordinated with the research centers.

The relationships established between the rural health research centers and ORHP continue to impact the status of health care in rural America. From the very beginning, those involved with rural health research were charged with discovering ways to use their research as practical assistance to the aims of ORHP as well as national and State policymakers. ORHP provided the initial support to work with others within the research community to create the Journal of Rural Health as a place where the work of rural health services researchers could be published in a peer-review journal.

Current and Former ORHP Staff



During its early years, ORHP also responded to another of its legislative charges, that of creating a national clearinghouse to establish the Rural Information Center for Health Services (RICHS). This service, operated in conjunction with the U.S. Department of Agriculture, became an important national resource. Staffed by reference librarians, RICHS allowed rural residents to call toll-free to get information about rural health issues and funding opportunities. With the emergence of the World Wide Web in the late 1990s, ORHP expanded this function and replaced RICHS with the Rural Assistance Center (RAC), housed at the University of North Dakota. RAC is one-stop information portal on a wide variety of rural health and human service issues.