 » *Joseph Mantone*

VIEW FROM THE COUNTRY

Rural healthcare lobbyist pushes policymakers, legislators to understand effects of their proposals on nonurban providers

Medicare's prospective payment system still troubles Tim Size.

The hospital reimbursement system went into effect about three years after Size, in 1980, became the first executive director for the newly formed Rural Wisconsin Health Cooperative, a post he's held ever since. Back then, there wasn't much of a rural healthcare lobby and few, if any, in the sector asked how PPS—a system that is based on averages—would affect the many low-volume rural hospitals.

"We totally missed the importance of the impact that PPS would have," Size says. "In a way, I've been haunted by that my whole career. Something like 400 hospitals closed."

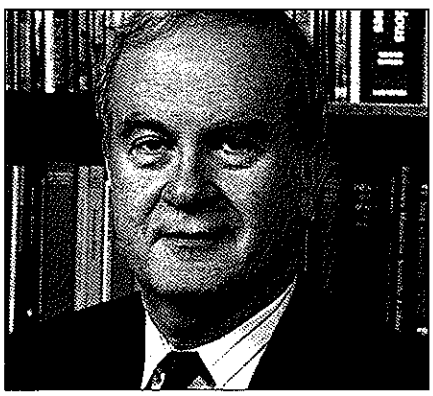
Partly in response to PPS' detrimental effects on rural healthcare, Congress established the Medicare Rural Hospital Flexibility Program in 1997, which provided states with grants to start critical-access programs, allowing rural hospitals with 15 or fewer beds to receive more lucrative cost-based reimbursement. Since then, some changes have been made to the program and now some 1,250 rural hospitals participate. The most notable changes were the result of the Medicare Modernization Act of 2003, which increased reimbursement to 101% of costs from 100% and gave the hospitals flexibility to have as many as 25 beds for inpatient care.

Looking for the rural angle

Size now says he tries to take a more active approach, rather than being reactive.

He analyzes bills, laws and policy proposals trying to sift through the arcane language and data to find any pieces of information that will have unattended consequences on rural healthcare. Size doesn't believe that lawmakers or policymakers deliberately have a bias against rural facilities; it's just that many of them often lack a full understanding of how changes will affect providers in rural areas, he says.

The reason for this is that research and policymaking tend to be concentrated on urban areas and those behind the work often don't take into account the rural framework, he says.



"This isn't about urban not liking rural."

—Tim Size, executive director, Rural Wisconsin Health Cooperative

"This isn't about urban not liking rural," Size says. "The decisions are just made by using urban models." And he says it isn't about developing rules that would favor rural providers over their urban counterparts, but rather it's all about "developing good policy."

Since the beginning of PPS, the need for a unified rural health lobby has become apparent. In the 1970s, the thinking was that all hospitals have the same needs and there was little need for a cooperative or association of rural hospitals, Size says. For example, in the Rural Wisconsin Health Cooperative, or the RWHC, 30 hospitals are full members and five regional health systems are affiliate members, up from 10 members when the cooperative started.

The RWHC allows the hospitals to network, sharing resources, concerns and ideas. Size then tries to address those concerns by speaking with the government or by developing cooperative shared services among the members.

These types of networks have become much more common across the country since the cooperative was established; Florida, for example, has nine rural health networks. The federal Office of Rural Health Policy, which operates under HHS' Health Resources and Services Administration, provides grants annually to develop rural networks and gave out five in 2005. The grants are typically worth about $600,000 over three years.

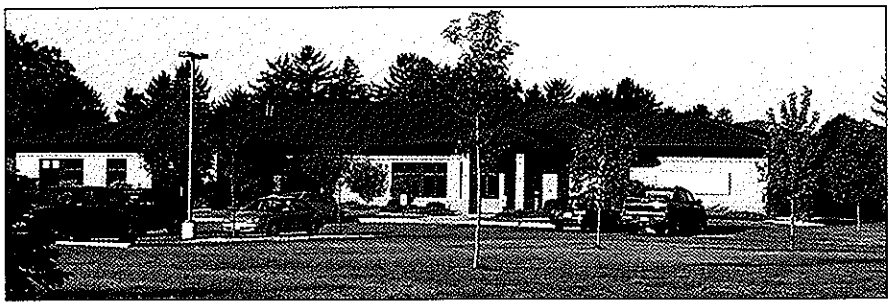
The establishment of the rural health policy office in 1987 was a sign of the federal government recognizing a need for a focus on distinctive rural healthcare issues. Along with the network development grants, the office funds such programs as the eight rural research centers around the country and the Rural Assistance Center, established in 2002 to help raise public awareness of rural health programs.

The fragmented rural healthcare lobby has grown significantly, and the advocates' associations have become more united. The National Rural Primary Care Association, founded in 1978, was an early rural health advocacy group and had 230 members in 1983. The group was later revamped and merged with the American Small and Rural Hospital Association to create the National Rural Health Association in 1987.

The NRHA now has 10,000 members and since it was established, the association has

increased its Washington policy office staff to six from one.

A show of unity in the sector came last year when the CMS proposed a new regulation that would have limited critical-access hospitals that are designated "necessary providers" from moving out of aging facilities and relocating to new sites. "Necessary provider" status is a state waiver given to rural hospitals that don't meet all the requirements of the critical-access program.



The Rural Wisconsin Health Cooperative, headquartered in Sauk City, represents 30 hospitals and five regional healthcare systems.

The proposal in the fiscal 2006 payment update for acute-care hospital inpatient stays said a necessary provider critical-access hospital would have to build a replacement facility within 250 yards of its current location or risk losing its necessary provider designation (May 23, 2005, p. 17). The rural community was up in arms about the proposal because states could no longer grant necessary provider waivers after 2005, and once that designation is lost, those hospitals would have to revert back to PPS.

Rural advocates contend that many hospitals didn't have space within 250 yards of their current facility to build a new hospital. Also, renovating a current facility could be more costly, and running a hospital during the reconstruction would be a disruptive, if not disastrous, task.

"They (Congress and the CMS) were very much surprised at the level of rural uproar," says Terry Hill, executive director of the Rural Health Resource Center, Duluth, Minn. The center is a public-private organization that was established in 1991 and provides information and tools to improve rural healthcare.

About 90 comments were sent to congressional members and the CMS, and the 250-yard provision was dropped from the final regulations. "In response to comments, CMS is allowing a necessary-provider CAH to relocate if the facility in its new location meets all three of the '75%' criteria," according to an August 2005 news release from the CMS. The 75% criteria state that after relocation, hospitals have to serve at least 75% of the population they were serving before they moved; 75% of the services must be the same as at the prior facility; and 75% of the staff must be the same as at the prior facility.

And while that achievement is a sign of how far the rural lobby has come, the CMS' implementation of the 75% criteria is a sign of how far rural advocates need to go, says Ruben King-Shaw, a former deputy administrator with the CMS who is now a senior partner with Pine Creek Healthcare Capital, which helps rural hospitals access funding for building projects.

King says the 75% criteria provision is reasonable to rural advocates, but what is unreasonable is that the CMS won't audit the population until after the hospital moves, he says. Without the guarantee that hospitals will keep the critical-access status, they won't move, he adds. King-Shaw says it seemed that the policymakers who wrote the final regulation—which took into account rural concerns—weren't the same people who issued the implementation guidelines.

"You don't see that type of about-face anywhere else," he says.

One of the reasons for the change was because the critical-access program "is budget dust" compared with the rest of the Medicare allocations, King-Shaw says. Like Size, King-Shaw doesn't believe there's an anti-rural bias among CMS staff. Instead, he believes that CMS officials aren't in tune with rural health because the majority of their work is on policy that affects urban areas, where the bulk of government spending is focused.

Wakefield: Size gives "early warning" on rural health issues.

Industry watchdog

Since the rural impact of healthcare policymaking isn't always thought through, many in the rural lobby are happy that Size dedicates himself to closely examining rural issues. Mary Wakefield, executive director of the Center for Rural Health at the University of North Dakota, sees Size as the "canary in the mine. ... He's our early warning sign for adverse events."

Size jokes that the canary analogy is a bit emasculating, but others such as Hill call him a "watchdog."

Wakefield, a former member of the Medicare Payment Advisory Commission, says Size would often read MedPAC meeting transcripts and then offer his opinion on how those policy suggestions could affect rural providers.

Along with his research, Size has cultivated a network of people who will tip him off when there's an issue developing. Many observers say he's built that network by talking to anyone who will listen and maintaining a dialogue with colleagues around the country.

He also sends a monthly newsletter, *RWHC Eye On Health,* to his network of contacts. "I don't read many newsletters, but I read that one," Hill says.

Size didn't always know all of the rural health issues. When he started with the RWHC, he didn't have a rural background. A native of suburban Philadelphia, Size previously worked as the associate superintendent at the University of Wisconsin Hospitals and Clinics in Madison. He holds a bachelor's degree in commerce from Duke University and an MBA from the University of Chicago.

"They saw me as a blank slate," Size says.

But as Size began developing his expertise, others started to notice. He was reluctant to take the role of president at the NRHA because he thought it might detract from his position at the RWHC. However, the board coaxed him into running for the position and after being elected by NRHA members, Size served a one-year term as president of the NRHA in 1997.

Now he tries to instill in others the view that developing sound healthcare policy requires people to look through a rural scope, Size says.

One current example is the long-standing problem of recruiting adequate numbers of healthcare workers into rural areas, especially physicians. Size says he understands why medical students who train and learn in urban areas might not feel comfortable working in a rural setting.

One solution Size has been advocating is that more schools should set up programs similar to the Wisconsin Academy for Rural Medicine that's being established at the University of Wisconsin at Madison Medical School. The rural academy is "a medical school within a medical school" and is aiming to enroll its first students in 2007, Size says.

Students in the program will train in rural settings, and the goal is to get the students more interested in working in rural communities.

Alan Morgan, chief executive officer of the NRHA, says on his first day with the association, he was instructed to call Size to learn about the wage index and related issues. "I still turn to Tim more often than not," Morgan says. "He knows the history." «