Reflections on the History of Rural Health

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Introduction

I have had the pleasure of working in rural health for almost 40 years, both nationally and at the Rural Wisconsin Health Cooperative in Sauk City.

I appreciate having been asked to share my perspective about the start of the rural health movement in the 1980s and 1990s. To do so, I had to review quite a few original materials from those days in order to refresh my memory and hopefully give you a reasonable account, at least as I saw things then.

If there had been Google then and you googled “rural health policy” you would not have found much. Most people thought in terms of big/small; hospitals/clinics but did not typically define a subset of issues as rural.

When we started the RWHC, one state leader actively argued against the need for a rural health policy agenda—he believed all hospitals were equal with no differences in policy issues.

But rural ceos knew better and were saying they had unique needs that were not being addressed.

The 1980s was different in many practical ways:

• The biggest difference was that our largest funder, Medicare, had just implemented an entirely new way of paying providers—the Prospective Payment System (PPS)—a model with a far reaching and negative impact for rural hospitals that I will talk more about shortly.

• There wasn’t a national voice for rural health, the National Rural Health Association was just getting organized, there wasn’t a Federal Office of Rural Health Policy and there were very few state offices of rural health. Bottom line, we were just starting to develop a presence in Washington; more on this in a few minutes.

• We didn’t have the Critical Access Hospital designation until 1997. Much of the 1980s and 1990s was spent trying to adapt the PPS to the rural context. Contrary to a current myth at CMS, CAHs were not developed as a federal charity but the results of a long search to develop a rural alternative to the PPS that never worked for small rural hospitals. More on this later.

• In addition, there was only a small and fragmented rural research community who were just beginning to gather the data and do the analysis needed for us to understand who we were and how we might think differently.
• Very relevant to a far flung network of advocates, we didn’t have email and the internet to bring us together across significant distances with limited resources so exchange of thought and ideas was a lot slower.

• On the positive side there was less competition, less steerage of patients out of rural communities, and fewer threats of forced acquisition.

**Chris: Regarding Hospital Closures of the 1980s, what caused the closure of hospitals in the 1980s?**

Overwhelmingly, it was the implementation of the Prospective Payment System that created the rural hospital closure crisis in the 1980s. (While problems with Medicare reimbursement are playing a significant role in the current closure crisis, its role was even more significant in the 1980s.)

Through the 1980s, a broad acceptance was developed that the design of PPS was particularly flawed and that it negatively impacted on rural hospitals in ways that made neither professional nor political sense.

But building that awareness took time and many advocates.

**Why was Medicare’s Prospective Payment system hard on rural hospitals?**

It would take a much longer video than anyone would be interested in viewing to fully answer that question of why Medicare’s Prospective Payment System was so hard on rural hospitals. I will try to briefly make sense of the problem in very general terms.

Basically, on the first of October, 1983 Medicare implemented a payment model for most hospitals that was tested only in several large teaching hospitals in New England—they didn’t do a trial run in small rural settings or to the best of my knowledge, thought very deeply about the impact on smaller, rural hospitals.

It really should not have been a surprise that the PPS would be a disaster for rural providers. It started by carving rural out from all other hospitals and giving them their own lower national base rate. They then added a very urban centric wage model to further lower rural reimbursement as well as a system of individual payment groups driven by diagnosis (DRGs)—that needed volume to smooth over the rough edges.

The structure of the Medicare Wage Index added insult to injury, calculating an individual index for each metropolitan area while dumping all rural providers into one statewide bucket.

Apart from where boundaries that were artificially drawn on state maps, there were many technical issues that further lowered the wage index. My personal wonky favorite, that many people got tired of me talking about, was the failure to occupationally mix adjust the data that determined the wage index—a short coming that further advantaged large urban hospitals.
and disadvantaged small rural hospitals by further penalizing rural hospitals having fewer specialists on staff.

As an example of these adjustments was that the initial Medicare wage index dropped over 20% when you crossed the Wisconsin river from Dane County into Sauk County—I can assure you that geographic variation of nursing and other salaries didn’t follow that pattern in southern Wisconsin or anywhere else.

**In PPS Year 2, hospitals in Madison, Wisconsin had a standardized base payment rate (after controlling for the mix of patients) 25 percent greater than rural Wisconsin counties and after applying the wage index, a difference of nearly 50 percent.**

*What was it like to watch hospitals closing across the country? What concerns did the hospital closures raise? How would you describe the mood across rural America as this was happening?*

For the communities who lost a local hospital, it was very personal. It meant a loss of jobs, a blow to pride in their local community, less ability to attract new job creating businesses and above all, a loss to a closer source of care during a medical emergency.

For the rest of us (and Wisconsin had relatively few of the hundreds of closures nation-wide) it created an feeling of being attacked by our own government and reinforced the stereotype that rural wasn’t very important– that we didn’t need rural hospitals.

There was a very strong sense of anger, not all that different than that seen in the 2016 election cycle as driving Trump and Sanders supporters.

But on the positive side, as I’ll talk about later, it did help lead to a more rapid development of some positive changes, like the development of a rural health community as evidenced by RWHC, other regional rural initiatives and NRHA.

*What else was going on in rural America during this time? For example, how was the economy? How did those factors play into the rural health crisis?*

The 1980s and 90s were generally good economic times for the nation as a whole but not so much for rural communities as we witnessed rural economic decline that amplified the problems with Medicare as well as under funding by Medicaid in many states.

As a partial response to try an understand what was happening to health care across rural America, an amazing resource was developed in the late 1980’s that many of us came to refer to as the “big yellow book”–“Health Care in Rural America,” basically all you would want to know about rural health published by the US Congress in 1990. It was about the size of an old Sear’s Catalog, once the retail lifeline for many small rural communities; it is still worth a read.

*What was the response to the hospital closures? How was that response organized?*
During February of 1985, right after the first year of PPS, the National Health Policy Forum at George Washington University hosted an invitational workshop on "PPS Design: Tackling Major Structural Issues"—it was the National Rural Health Association's (NRHA) first opportunity to present a rural perspective in Washington that seemed all but absent from the initial design.

On behalf of the NRHA and Rural Wisconsin Health Cooperative (RWHC), I presented testimony to “challenge the justice of a system based on two national rates perpetuating historical urban and rural payment inequities not related to legitimate wage or care intensity differentials.”

We requested the development of a model more sensitive to actual labor markets than one where the wage scale takes a nose dive at the urban county line.

In response, a senior representative of the then Health Care Financing Administration (HCFA) that managed the Medicare program, responded with a dismissive "of course, all models have their boundary problems.”

This was the beginning of years of we in rural health not feeling heard by those working in the Medicare Program. But more and more we began to be heard in the Congress.

To give our cause further visibility, in November 1987, the NRHA Board agreed to sponsor a class action suit against the Department of Health and Human Services (DHHS) and in November of 1988, filed its initial complaint in the United States District Court in Washington D.C.. The basic claim was that the relatively lower PPS payment rates for rural hospitals constituted a “taking without just compensation,” a violation of the Due Process guarantee of the Fifth Amendment to the Constitution by unconstitutionally burdening a class of rural hospitals with the cost of subsidizing Medicare operations at their respective hospitals. We argued that:

- From its inception, PPS had been biased against rural hospitals, in large part, through misunderstanding and manipulation of the model used to describe each hospital's relevant labor markets:

- That in reality, professional markets varied little over large areas of a state and variations in non-professional labor markets can be best visualized as gently rolling hills. I.e. wages change slowly over a region, not dropping abruptly at the county line.

- That the inequity was self-perpetuating, that Rural hospitals adversely effected by earlier PPS inequities had not been able to spend money that they did not have; the salaries of the employees of these hospitals have been artificially suppressed. Historical expense data for these facilities is a particularly poor proxy for local labor markets.

- That rural hospitals made a disproportionate use of professional contract labor: the exclusion of a contract labor artificially depresses reported Full Time Equivalent wage expenses for rural hospitals.
• Growing shortages of professional labor in rural areas had put a disproportionate upward pressure on rural salaries not reflected in wage indices calculated using old data of hospital expenses.

While our case was eventually dismissed on technical grounds, it was very clear at the time that the credible pursuit by NRHA of this law suit played a significant role in focusing attention on the seriousness of the structural defects in PPS and the need for Congressional action.

By 1990, rural hospitals had made some progress towards equity. The improvements that have taken place were the result of both creative adaptations by rural providers and national initiatives to improve the equity of PPS payment formulas.

Of greatest importance was the Omnibus Reconciliation Acts of 1989 and 1990 with their commitment to phase out the urban/rural differential in the standardized base payment rate, expanding the number of rural Disproportionate Share Hospitals, improved payments for Sole Community Providers and recognition of the special needs of small rural Medicare-dependent hospitals.

As a result and as an example, in PPS Year 10, hospitals in Madison, Wisconsin had a standardized base payment rate only 4 percent greater than rural Wisconsin counties and after applying the wage index, a wage adjusted payment only 20% higher. Still too high but good progress compared to the 50% differential previously noted in PPS Year 2.

We still had a lot to do before the creation of the CAH program in 1997 but we had made a dent in the problem.

Regarding formation of the National Rural Health Association, how did the NRHA come about?

National Rural Health Association (NRHA) is now a national association with more than 20,000 members, started through the merger of several new rural health related associations that sprouted up in the late 1970s and early 1980s from a hand fall of activists in three different sectors.

NRHA has always been a “Big Tent” compared to the more typical national associations of one type of profession or one type of organization. From our earliest days we have been a diverse community of individuals and organizations with one strong common interest: rural health.

Its creation was not so much about us being against any of the then existing national associations, but more the need of rural advocates understanding the added impact of working together.

Having said that, the rise in NRHA membership and finances was significantly helped in the 1980s and 1990s by the frustration and anger felt by rural hospitals and others that they weren’t being heard in Washington and by the traditional trade associations.
The origin of NRHA goes back to 1978 when a small group of rural community health centers formed the National Rural Primary Care Association in Waterville, Maine to address the rural-specific needs of community health centers.

In the early 1980s two additional rural health associations were formed--the American Rural Health Association in 1980 primarily made up of rural health researchers and in 1981, the American Small and Rural Hospital Association.

In 1984, the Board of the NRPCA changed its name to the National Rural Health Care Association (NRHCA) and began to seek members beyond community health centers. With encouragement from Fred Moskol, already a national leader based at Wisconsin’s Office of Rural Health, I joined NRHA in 1984 or 85 and shortly thereafter was on the Board representing rural hospitals.

The American Small and Rural Hospital Association merged into the National Rural Health Care Association in 1986. Then the next year, the American Rural Health Association merged into the National Rural Health Care Association and NRHCA was renamed NRHA.

One of the earliest challenges was the tragic plane crash that took one of our founders, Terry Rilley, in 1986. We honor his memory each year at our annual conference when top billing goes to the keynoter giving the Terry B. Reilly Memorial Lecture.

NRHA having roots in three separate advocacy communities created a membership structure built on the diverse rural health perspectives that make up the rural health advocacy community.

These associations within an association, now joined with other interest groups, continue with separate blocks of seats on the NRHA board of trustees and its policy setting body. Many also have their own conference or tracks within larger NRHA conferences. [5]

**What was it like to start this new organization?**

Under Bob Van Hooks able ground breaking leadership as our Executive Director, the early years were often dominated with our need, not always successful, to balance the books and grow the membership.

For me, fair to say this time is something of a blur as I was also in the early days of helping to build RWRC as well as my own family.

But there was an exhilaration of doing something new, exciting and needed.

**How did this new organization get members? What sorts of people were involved in the beginning?**

As I mentioned earlier, the closure of rural hospitals with the introduction of PPS made rural hospitals angry and more politically aware. We realized we had been asleep at the switch
when PPS was dropped on us. We determined to fight back and were looking for new ways to do so. NRHA was at the right time and place to take advantage of that opportunity.

**Why did you feel it was important for rural healthcare stakeholders to have a membership organization?**

We have always had membership organizations, NRHA’s rural focus combined with a growing awareness that while urban and rural providers shared some issues, rural had its own unique set of issues that needed its own voice.

Rightly or wrongly, it was felt that the then existing organizations had failed rural hospitals as evidenced by the closures and negative financial impact of the PPS. It was felt that many of the tradition national organizations always had “bigger fish to fry,” with rural always a secondary priority.

On a more positive note, many of us began to realize that rural health was bigger than any one profession or organizational type and that our individual interests were best served in any event by coming together, that we could learn from other sectors.

**What were the first issues that the National Rural Health Association took on?**

Around the time NRHA was started, my own focus nationally, as already emphasized, was very much on the negative impact of Medicare on rural hospitals.

But NRHA has always had a diverse array of interests, as it does to this day: beyond payment issues to include access to care, assistance to underserved populations, maldistribution of work force, developing funding for a stronger rural health research community, to name just a few.

But some issues were largely absent that we now take for granted: the importance of rural economic development and the responsibility we all have with population health are two major issues that come to mind.

**How did NRHA work with other organizations and agencies in the early days to advance rural health issues?**

By definition, NRHA has always been about working with any and all organizations willing to work with us on behalf of rural health.

That was not always easy as some saw the new kids on the block more as a competitor than as a potential collaborator.

While collaborative work it is never easy, it was the work we needed to do then and still need to do.

But some hard feelings don’t die easily, as recently as a three years ago, after having been invited as a guest by a member of another national association, I was told I wasn’t welcomed ☹️
RE BBA of 1997, how important do you feel the provisions included in the Balanced Budget Act of 1997, such as the Critical Access Hospital program, the Flex program, telehealth payments, and the CHIP program, have been for rural health? Which provisions do you think have had the most impact?

The BBA of 1997 was absolutely critical to the survival and ongoing development of rural health. While the multiple parts of the Act were important; the creation of the Critical Access Hospital as a unique Medicare payment designation had the greatest impact—particularly when the bed limit was expanded in 2003 with the Medicare Modernization Act.

(It should be noted that now House Speaker Paul Ryan from Wisconsin and Steve Brenton from the Wisconsin Hospital Association played an absolutely key role in the number of allowed beds going from 15-25!)

Wisconsin now has 58 CAHs; 32 of the 40 rural hospitals in the Cooperative are CAHs. It is likely that, without the BBA in 1997, that quite a few of them would have closed and certain few of them would have been as strong as they now are. As we enter another time of major change, they would have been a lot less likely to survive.

Once the Critical Access Hospital designation was available, how quickly did rural hospitals convert? What was the conversion process like?

The response was more varied than I would have expected. For example, compared to many states, Wisconsin was an early adopter. We quickly understood the importance of the program and saw a steady increase (two in the year after passage, 5 in 2000 and a total of 30 by the end of 2003.

RWHC, along with the Wisconsin Department of Health & Family Services, the Wisconsin Hospital Association and the state Office of Rural Health wrote the Wisconsin Rural Health Plan, assuring that the “necessary provider” designation criteria to become a Critical Access Hospital reflected Wisconsin context and values.

The process was, in part, accelerated in Wisconsin because it built on a preexisting series of partnerships that had formed to develop an instate designation called the Rural Medical Center, intended to support rural hospitals through more rural centric regulatory review and support.

When the Medicare Modernization Act in 2003 with its expansion of inpatient capacity from 15 to 25 beds there was a second wave of CAH designations—17 CAHs were added in 2004 and 9 in 2005.

What did the new CAH designation mean for your hospitals and the communities they serve?

CAH designation has been critical to the progress rural hospitals have made in so many ways; here are just a handful of examples of what it has enabled:
• Of the 251 five star hospitals on CMS’s Hospital Compare in 2015, 25 were in Wisconsin and of those, 22 are rural.

• Of the top 100 top CAHs named by iVantage Health Analytics in 2015, 11 were in Wisconsin.

• In Wisconsin, CAHs as a group have the highest patient satisfaction scores.

• Rural also does well on more technical procedures: with the Wisconsin Hospital Association’s CheckPoint showing that 93% of CAHs have a 3 of 3 star rating for knee surgery and the same number for hip surgeries.

**In addition to providing quality health care, we have come to understand how critical rural hospitals are to their to local economy.**

People often know that business relocation decisions are influenced by the cost and quality of health care available locally.

But as or more importantly, rural health has the same economic impact as export commodities like milk, soybeans or rural manufactured goods because of its own ability to bring/keep dollars and jobs into/in the community.

Rural insurance premiums and taxes only come back to circulate in the community and create jobs if there are local health care providers there (and people use them) to attract those dollars.

For every 2 jobs created (or lost) in rural health care, the number of jobs in other local businesses increase (or decrease) by 1+ jobs.

The rural economy is very dependent on where its health care dollars are spent.

• As an example, RWHC Hospitals Provide jobs for over 14,000 hospital workers and supports an additional almost 9,000 jobs.

• RWHC Hospitals Account for $2 billion in direct economic impact as well as an additional 1 billion in indirect economic impact.

**All in all, we believe that the rural tax dollars returned to rural Wisconsin through the support of rural hospitals is one of Feds best investments. These investments need to be protected so that we can 'keep local care, local' and I believe RWHC and NRHA will be around for many years to do just that."**

Thx.