

The Rural Community Hospital Assistance Act

While this legislation is a work in progress, the following was shared with the National Rural Health Association's Government Affairs Committee and was supported by the American Hospital Association at NRHA's March 2002 Policy Institute.

Background

"Rural hospitals provide essential inpatient, outpatient and post-acute care, including skilled nursing, home health and rehabilitation services, to nearly 9 million Medicare beneficiaries."

"Small rural hospitals, in particular, face unique circumstances that merit special consideration when developing Medicare payment policies. Because of their small size – a median of 58 beds compared to 186 for urban hospitals – rural hospitals have a lower capacity to manage within a prospective system due to few financial reserves and significant volume fluctuations. Their population base also lends to a greater reliance on Medicare as a source of revenue than urban hospitals."

"These challenges, coupled with isolation, high levels of poverty and shortages of health professionals, make it much more difficult for small rural hospitals to absorb the impact of policy and market changes."

"We often speak the loudest when we don't speak at all." Appropriately, anonymous. RWHC Eye On Health, 3/22/02

Medicare Payment System

"The prospective payment system (PPS) was implemented for hospital inpatient services in 1984 and for hospital outpatient services in August 2000. Under this system, a fixed hospital payment is established in advance of the provision of services, rather than paid retrospectively based on a hospital's reasonable costs."

"While special reimbursement is available to certain rural hospitals today, it is limited. The Medicare Payment Advisory Commission (MedPAC) has observed in its reports to Congress that PPS is not working for small rural hospitals."

"Rural hospitals have lower Medicare inpatient margins than urban hospitals, and the gap has widened from less than a percentage point in 1992 to almost 10 percentage points in 1999."

"Rural hospitals with fewer than 50 beds have seen total Medicare margins decline precipitously, falling to an average of negative 5.4 percent in 1999."

Proposal

"The Rural Community Hospital Assistance Act would provide enhanced cost-based reimbursement for critical access hospitals and extend such reimbursement to post-acute care services. It also would provide an option for rural hospitals with less than 50 inpatient beds to receive enhanced cost-based reimbursement for inpatient, outpatient and select post-acute care services."



Improve and Expand CAH Reimbursement

“The Medicare Rural Hospital Flexibility Program (MRHFP), established by the Balanced Budget Act (BBA), allows some rural hospitals to be reclassified as limited-service ‘critical access’ hospitals (CAHs). This program provides an opportunity for low-volume, rural hospitals to receive Medicare payments based on reasonable costs for inpatient and outpatient services with the added incentive that facilities maintain the patient length of stay to less than an average of 96 hours. Without such a payment alternative, many of these hospitals might be forced to restrict access to certain services or face possible closure. The MRHFP helps ensure that residents located in isolated rural communities continue to have access to vital emergency and inpatient medical care.”

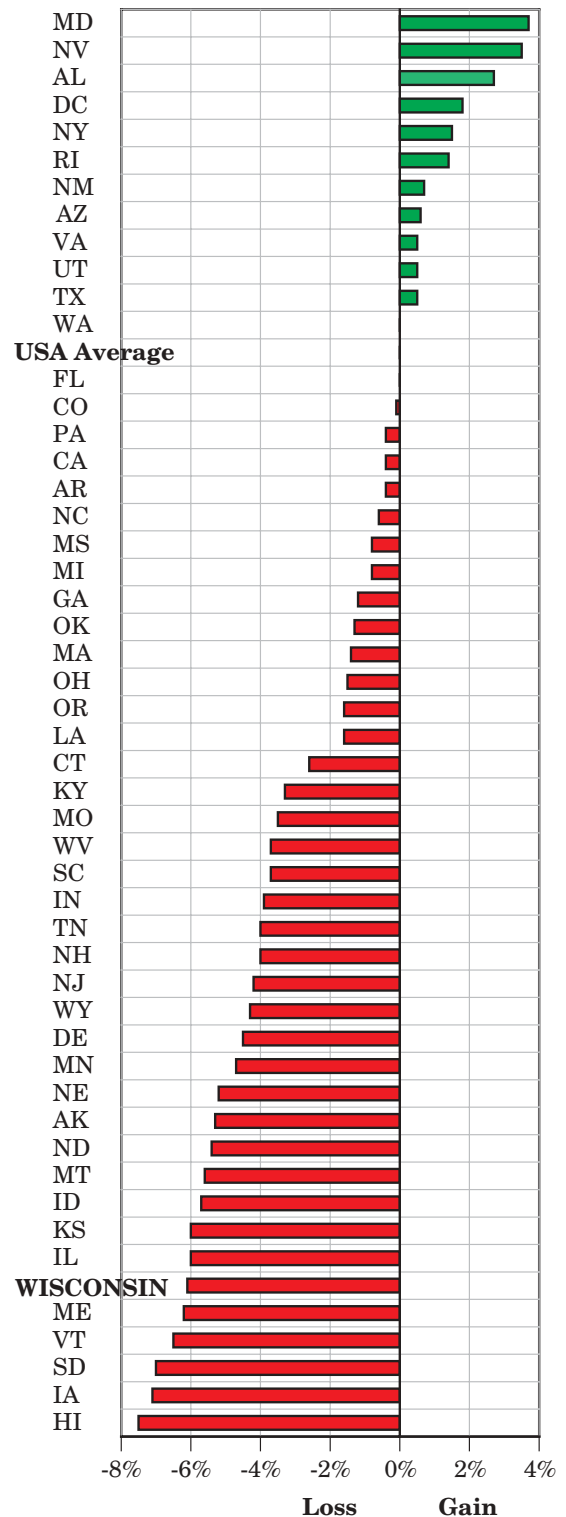
“The Rural Community Hospital Assistance Act would update the current CAH program and preserve it as a viable option for communities deciding whether to downsize inpatient hospital services. While the CAH program has grown to more than 500 designated facilities, demonstrating the fragility of our nation’s rural health care delivery system, financial constraints have not escaped these hospitals causing many to forego facility upgrades, new information systems, technological advancements and other infrastructure improvements.”

“This bill would modify CAH reimbursement to include some limited margin for technology and infrastructure needs. It also would extend such reimbursement to post-acute care settings, including home health, skilled nursing and geriatric psychiatric services. One of the most troublesome aspects of the BBA is its collective impact on the rural health delivery system and its contribution to a patient’s inability to access a full continuum care of services. In fact, MedPAC found that rural beneficiaries utilize post-acute care services 15 percent less than their urban counterparts.”

“Under the bill, the CAH program would be updated in the following manner:

- Continue providing cost-based reimbursement for inpatient and outpatient services plus a ‘return on equity’ to assist small hospitals in addressing technology and infrastructure needs.
- Extend enhanced cost-based reimbursement to post-acute care services, including skilled nursing facility, and home health.

**Medicare & Medicaid Loss and Gain
As Percent Total Hospital Costs**



Data: For 1999, MedPAC 3/01
Graph: RWHC 3/02

- Permit and extend enhanced reimbursement to geriatric psychiatric care through the distinct part unit program.
- Provide cost-based reimbursement to ambulance services eliminating the current 35-mile test.”

Provide Enhanced Cost-Based Reimbursement for Rural Hospitals with less than 50 Acute Care Beds

“Many rural hospitals are too large to qualify for CAH status but too small to absorb the financial risk associated with PPS programs. The Rural Community Hospital Assistance Act would allow rural hospitals with 50 or fewer acute care beds the option of receiving Medicare payments based on reasonable costs plus some limited margin for technology and infrastructure needs. These payments would apply to inpatient, outpatient and ambulance services. The payments also would extend to home health services only if the hospital were the sole provider of such services in the community.”

“The new model of reimbursement for small rural hospitals with 50 or fewer beds would have the following characteristics:

- Cost-based reimbursement, including a provision for ‘return on equity’ to assist small hospitals in addressing technology and infrastructure needs, for inpatient and outpatient services.
- Enhanced cost-based reimbursement for home

health services if the hospital is the sole provider of these services in the area.

- Cost-based reimbursement for ambulance services.
- Prospective payment for distinct part unit services (if applicable).
- Restoration of Medicare bad debt payments at 100 percent.”

“National payment policies, specifically the prospective payment systems, fail to recognize the special characteristics and unique circumstances of rural hospitals. An alternative payment structure based on a reasonable cost-based reimbursement system is necessary to ensure the survival of these essential providers of care and to ensure that Medicare beneficiaries located in small rural areas continue to receive access to quality health care services.”

Permissible Vs. Suspect Lab Competition?

From a March 22nd request submitted by RWHC to the Office of the Inspector General, U.S. Department of Health and Human Services seeking program guidance regarding permissible or suspect competition among clinical laboratory services:

“We are requesting that OIG issue supplemental guidance with respect to billing for clinical laboratory services. The particular question that prompts this request has to do with how rural hospitals are to meet competition from commercial laboratories that are offering services at charges that are equal to or substantially less than Medicare reimbursement and, we suspect in certain instances, below cost as well.”

“Our members are concerned that as they attempt to meet competition they are without specific guidelines concerning what is permissible or suspect. Previous program guidance issued by OIG relative to laboratory services was not directly on point with respect to hospital laboratory services provided to physicians or other unrelated providers. The absence of directly applicable and clear guidance inhibits hospitals, such as ours, that wish to operate strictly in accordance with the letter and spirit of the law. It creates a competitive situation that rewards those willing to push unclear limits and in practice creates a competitive arena that is not level. We are requesting that OIG issue guidance that provides additional direction so that the hospitals can act competitively in the circumstances.”

The Rural Wisconsin Health Cooperative,
 begun in 1979, intends to be a catalyst for regional collaboration, an aggressive and creative force on behalf of rural communities and rural health. RWHC promotes the preservation and furthers the development of a coordinated system of rural health care, which provides both quality and efficient care in settings that best meet the needs of rural residents in a manner consistent with their community values.

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MD—Conflict, Coexistence, or Capitulation?

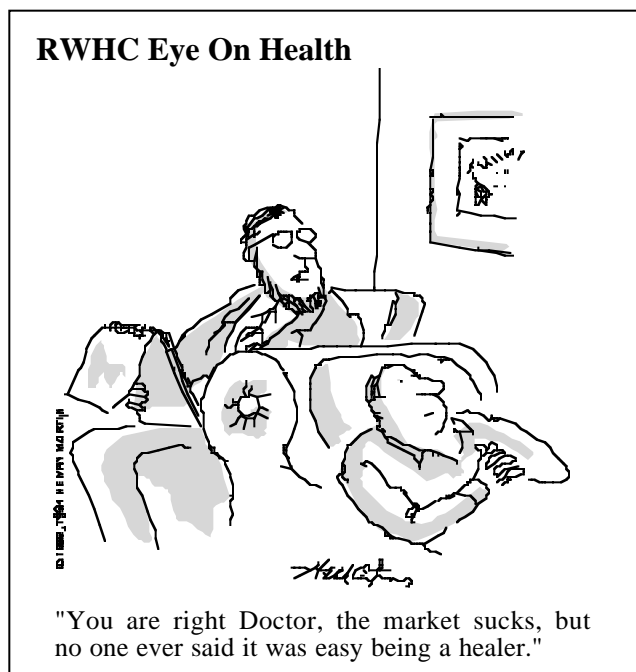
From “Professionalism Meets Commercialism—Conflict, Coexistence, or Capitulation?” by Tom Dean, MD, in the *South Dakota Journal of Medicine*, 9/01:

“The old adage ‘be careful what you wish for’ is deeply relevant to the stresses we experience in today’s health care system. Several decades ago we were told ‘medicine needs to operate more like a business.’ More recently we have heard ‘let the market function.’ The thought has been that the discipline and innovation of a free market, which has provided us with a vast array of consumer goods at competitive prices, would do the same for health services.”

“The advice was certainly well intended. Indeed, in a few instances it has proven true. In the big picture, however, the problems that have plagued us for at least three decades (in 1972 President Nixon proclaimed that we had a health care cost ‘crisis’) remain with us today. In many ways they are now worse than ever. After a brief respite in the mid 90’s, medical costs have again begun to accelerate and once more are increasing at several times the rate of general inflation. We have large numbers of the population without health insurance at a time when unemployment is low. Patients express skepticism and distrust of the health care system. Serious questions have been raised by prestigious authorities about the quality of care provided. In such an environment it is not surprising that levels of frustration and disillusionment among physicians are high and rising.”

“These problems are complex, deep-seated and not amenable to any quick fix. Nonetheless, I believe that the central element of our response should be that we as physicians need to thoroughly examine and reassert our role as professionals. We must think carefully about how this role fits – or fails to fit—in the commercial environment in which we find ourselves. We must clarify our identity as caring professionals both to ourselves and to the public. Much of the uneasiness present in medicine today is a direct result of our loss of direction and the sense that we are no longer in charge of the destiny of our patients or of our own careers.”

“What to do? If we are to fulfill the professional expectations which society legitimately has for us, we must do our best to understand the process as it is viewed by outpatients, a very difficult challenge. Where it works, we should support it. Where it fails, we must intervene and push for change.”



“A few specific actions each of us can take:

1. Look carefully for and renounce affiliations which results in financial conflict of interest. These have always existed, but as medicine has become a more overtly commercial enterprise, they increasingly conflict with our professional responsibility to act in the best interest of our patients.
2. Demand scientific rigor in evaluation of new drugs and procedures. As we consider new interventions we must be confident that the value they add to care is consistent with the risks and the costs they entail. New is not always better, and more aggressive is not necessarily more effective. Physicians could do much to alleviate the problem of prescription drug costs by continually asking if there is an older, cheaper and equally effective alternative available.
3. Reject the cozy relationship which can exist between physicians and the pharmaceutical industry, the medical device manufacturers, etc. All too often such relationships lead to clinical recommendations that are driven by commercial affiliation rather than scientific validity.
4. Accept that professional practice entails some risk taking. Ordering the extra scan or consultation in order to make the chart look good, but which is unlikely to change the care of the patient is not an action that characterizes professionalism.

5. Demand that our professional societies function as truly professional bodies promoting education and professional improvement and not primarily as trade unions whose prime orientation is defending turf and protecting the financial well being of their members. All membership organizations must carry out the latter role to some degree. To remain professionally credible, however, they should explicitly separate their professional activities from their membership promotion roles.”

“As we contemplate the broader picture and try to find principles to guide our day-to-day decision making we should look to thoughtful observers such as philosopher Daniel Callahan. Callahan has argued convincingly that the assumptions underlying much of our current health care system are seriously flawed. The most basic of these is that a better understanding of human biology and more sophisticated technology can ultimately eliminate disease and suffering. Callahan believes this is an unrealistic goal. He argues that pursuing it distracts us from our basic responsibilities and consumes resources, which would be more effectively used seeking more modest objectives. In seeking a less grand agenda, we have the potential to achieve a system which is truly ‘sustainable.’ ”

“So what about the questions addressed in the title of this paper? What is the relationship between professionalism and commercialism?”

“Fundamental **conflict** does exist between the two approaches. The basic goal of commerce is to generate profit. The actions and strategies one employs to maximize profits are quite different from those which need to be employed to improve health. This must be recognized and addressed.”

“**Coexistence** is possible, inevitable, and, in reality, desirable. An enterprise as gigantic as health care requires management expertise and structures which we as professionals do not, and in my mind should not, possess. Costs must be contained and not all expectations can be met. However, for patients to be protected, for resources to be effectively utilized and for professionalism to be enhanced, it is vital that the relative roles and areas of responsibility of the managers and the professionals be defined and defended.”

“**Capitulation**, turning the whole of health care over to a market driven, commercial structure, is inconsistent with the basic tenets of our profession and is an abdication of our professional responsibility.”

“None of this is easy. Just as in clinical decision making we seldom have all the information we need.

There is never enough time. We all have financial obligations which must be met. At the end of the day, however, when we look at the things which make us feel good about what we do I would submit that helping those in need and being respected for those actions are the attributes which have enduring value.”

“Relman wrote a decade ago, and it remains true today; ‘We can afford all the care that is medically appropriate according to the best scientific standards. We cannot afford all the care a market-driven system is capable of giving.’ No one but physicians can appropriately determine where the boundary lies between the two categories. Our ability to rise to this challenge, to set aside our own self-interest and to lead our society to a fair and sustainable health care system will be the ultimate measure of our professionalism.”

Community Development Tips From Ireland

From “What is Local Development?” by Mark Hart and Michael Murray in *Community Economics* a newsletter of the University of Wisconsin-Extension, Cooperative Extension Service, 3/02 (This article was reprinted from a Northern Ireland Economic Council background paper in 2000 by the same authors, *Local Development in Northern Ireland, The Way Forward*):

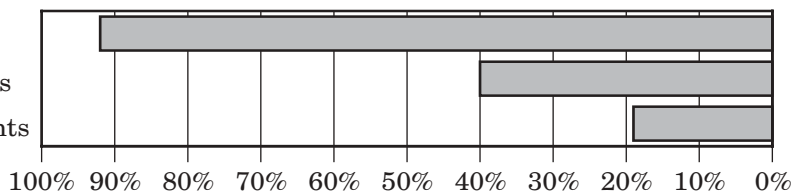
“Local development incorporates the following characteristics:

It is bottoms up—While the sensitivity to local needs and opportunities is important, it is also appropriate that development priorities should be determined in an environment which reflects the interest of local governments, the business sector, community groups and voluntary organizations. This is not to argue for the redundancy of the top down perspective, which remains vital for keeping a set of overarching policy and strategic contexts, and indeed for taking responsibility for some aspects of implementation. The important issue is to search for and agree the balance.

It is integrative—Local development concerns itself with making connections vertically and horizontally between stakeholders and across programs. Integration seeks to enhance the capacity for seamless policy making and smooth management while recognizing that innovative organizational approaches must have regard to variations in authority and responsibilities, relationships with government, strategic preferences and bureaucratic culture.

Something More Than Teeth Is Rotten In Wisconsin

Dental Practices Accept New Patients
 Serve Any Medicaid/BadgerCare patients
 Accept New Medicaid/BadgerCare patients



Data: WI DHFS, *Dentist Workforce Data 2001*
 Graph: RWHC 3/02

It is strategically driven—Local development, in order to be effective, rises above an association with a series of ad hoc initiatives in any locality. A clear direction based on a local understanding of issues and supported by a confident but realistic vision of the future is vital. Development is about long-term targeted action to create change, both in places and with people. In conceptual terms, the challenge is to maximize the degree of fit between planning and delivery.

It is collaborative—Local development requires the involvement of multiple stakeholders, working together rather than on an individual basis. It is an inclusive activity that embraces the volunteerism within the community and voluntary sectors, elected representatives, public officials and private sector participants. Collaboration in its fullest expression is apparent in partnership governance.

It is interactive—Local development should not be perceived as solely a technical activity better left to others who appear more qualified. The hegemony of public officials and a dependency upon consultants for expertise can be tempered by a local development approach which recognizes the knowledge based input of local people and businesses into agenda setting and implementation. It requires an ongoing investment in local capacity through a combination of community development processes and initiative management skills thus allowing progress in one sphere to reinforce progress in the other.

It is multi-dimensional—Local development embraces a wide range of concerns. It does deal with job creation, business growth and connecting people to jobs within the locality. But it also extends across a wide range of social action; it reaches out to the most marginalized in local society, but requires the participation of those who may, in relative terms, be asset rich. Making places work better is a further dimension of local development and thus physical regeneration and environmental improvements are part of the product base.

It is reflective—Local development is always willing to learn from experience regarding what works well under different circumstances and that could work better. Monitoring and evaluation can strike a combination of terror and frustration into those using public money, and while accountability and the probity of spending are necessary, it is frequently the case that sufficient opportunities for open reflection and shared learning do not occur. Local development sustainability is dependent upon these being in place and in this context monitoring and evaluation can be an important part of the empowering process.

It is assets based—Local development requires some public funding since the arena in which it is operating is often one of market failure or weakness. The private sector, nevertheless, should be expected to play a significant part in local development, along with contributions from the community and voluntary sector. It is this bonding of multiple funding with local resources and opportunities which can stimulate local development to do more things better and lead to the desired goal of sustainability.”

Why Cartoons Actually Matter

From “Power Of Information: Closing The Gap Between Research And Policy” by Richard Soriano and Terry Baugh in *Health Affairs*, 3/02:

“States play an increasing role in setting U.S. health policy. A survey of 292 state government policymakers finds that officials are overwhelmed by the volume of information they receive and have a strong preference for information that is concise and more relevant to current debates. Younger officials are more likely to use electronic information, while older policymakers prefer printed material. Organizations of government professionals are trusted sources of information, and state agencies are a key source of data

and information. Policymakers expressed a strong desire for tools to help them identify research on specific topics.”

“The results of this study provide important implications for organizations and individuals seeking to communicate the results of policy research to state government leaders.”

“First, research is not always cut and dried. The key is to not underestimate the audience. Policymakers report recognizing and understanding the shortcomings of research. They also understand the challenges inherent in conducting research and will accept limitations of studies when the limitations are presented clearly, without using jargon and technical language. State policymakers say that they can deal with conflicting research if, again, the reasons for the differences are explained. Also, while policymakers prefer that researchers explain the implications of their research, they do not expect or want researchers to make statements going beyond those findings.”

“Second, the overwhelming focus of policymakers on relevance to current debates may be disconcerting to researchers who are working on long-term solutions to systemic problems that do not seem pertinent to the ‘issue of the month.’ Such research can be made applicable to current debates if authors identify current, relevant examples of the systemic problems and make obvious the links between that research and current agenda items.”

“Finally, it is important to recognize that all policymakers are not the same and do not have the same information needs. Very few elected officials have the time to read long reports that are heavy on methodology. For them, information must be distilled into a one- or two-page summary written in concise, non-technical language. Legislative staffs, however, appear to have the biggest need for information, as their jobs require them to apply detail to policy making. Consequently, staff members will take more time to read and absorb research data. They also want information that enables them to explore its accuracy and credibility and to fully understand the methodology and the limitations of the research. Yet, like their bosses, they also want it short.”

“Therefore, it is important for researchers to tailor information to their target audience and to ‘layer’ information so that readers can go as shallow or as deep

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as they want. A one- or two-page summary heavy on bullets and key data should accompany a longer article or study. Authors should provide easy-to-follow directions (for example, a contact name

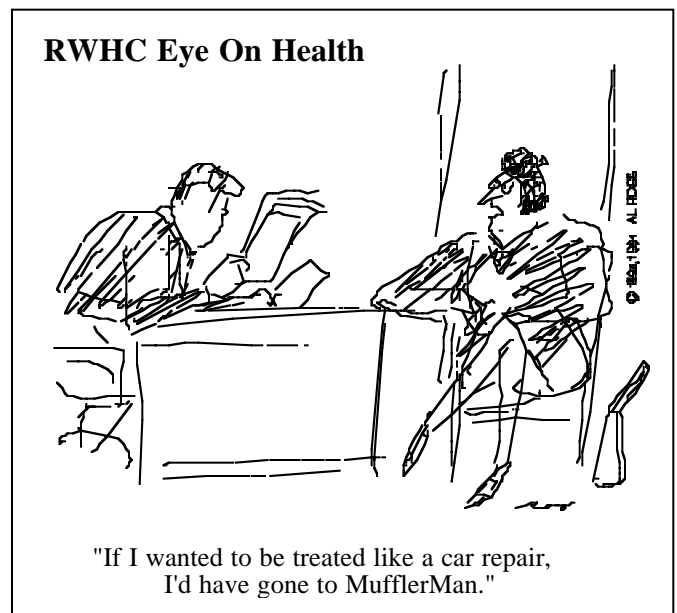
and telephone number or a Web address) for those who want or need to examine supporting data or other material. To put it simply: **If research is to be useful to policymakers, short is better than long, bullets are better than paragraphs, and a picture really is worth a thousand words.**”

Maximize Your Chance For Good Health Care

From “Patients, Know Your Rights,” by Dr. Isadore Rosenfeld in *Parade Magazine*, 2/24/02:

“You have the obligation to yourself—and the right—to participate actively in the decisions concerning your health care. Here are some of the important rights to keep in mind:

1. **You Have the Right to Select Your Doctor**—Choose a health plan that allows you to find a physician with whom you are compatible. It’s nearly as important as selecting a spouse.



2. **You Have the Right to be Fully Informed About Your Health Status**—There are many ways to diagnose and manage illness.
3. **You Have the Right to a Second Opinion**—When your life is on the line, ask for a second opinion.
4. **You Have a Right to Preventive Medicine**—An ounce of prevention is worth a pound of cure. Some health plans still refuse to reimburse you for doctor’s visits when you’re well.
5. **You Have the Right to Know Your Surgeon’s and Hospital’s Track Record for the Procedure you Need**—How many operations does the surgeon perform each year, and what is the success rate.
6. **You Have the Right to Know About Any Financial Relationship Between Your Doctor and Your Insurance Provider**—This may influence your medical care.
7. **You Have the Right to a Rapid Medical-Review Process**—If your claim for reimbursement has been denied, and you know enough to realize that you are being short-changed, appeal the unfair decision.”

Wisconsin Again A National Innovator

From “Performance-Based Contracting in Wisconsin Public Health: Transforming State-Local Relations” by John Chapin and Bruce Fetter in the *Milbank Quarterly*, 3/02 at <<http://www.milbank.org>>:

“In 2000, the Wisconsin Division of Public Health re-organized its allocation of federal and state funds by basing contracts on performance rather than audited costs. This created a quasi market in which the state acted as the buyer and the local health departments as the sellers of public health services. In its first year of operation, the program more effectively defined public health objectives to its funders and constituencies, linked its fiscal accountability more closely to attainment, and documented performance more carefully. In the next two years, the program will focus on improving the quality of objectives and training all parties in negotiation skills. The 2003–6 contract cycle will concentrate on multiyear and multi-program objectives and a Web-based contract management system. This new contract system will not be permanent until its long-range impact on funding levels and population health status is known.”

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