Rural Wisconsin
Health Cooperative

The Department of Health and Human Services (DHHS)
Secretary's Advisory Committee on Regulatory Reform
Regional Hearing #3, Wednesday, April 17th
Plaza Suites and Conference Center
Pittsburgh, Pennsylvania

Topic: **Rural Health**

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Witness Background

I appreciate the opportunity to testify today at the request of Secretary Tommy Thompson. I have been the RWHC Executive Director since helping to found it in 1979 and began working with the then State Representative from Elroy shortly thereafter. We have never doubted that rural health would be a priority for this Secretary.

The Cooperative is owned and operated by twenty-eight diversified rural community hospitals in southern and central Wisconsin and works to be a catalyst for regional collaboration. RWHC's focus is on (1) clinical and management products and services tailored to the needs of small rural hospitals, (2) collaborative managed care contracting and (3) advocacy for rural health. We started HMO of Wisconsin (now a BlueCross company, Unity Health Insurance) in 1984, leading to a varied experience with rural managed care. I have been privileged to serve as president of the National Rural Health Association and as a member of the National Advisory Committee on Rural Health.
A free subscription to RWHC's on-line monthly newsletter and "political" cartoon series, *Eye On Health*, is available at our web site.

Outline Of Testimony

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II. Continue To Develop An Understanding Of Rural Realities/Context
III. Support The Rural Community Hospital Assistance Act (RCH)
IV. Address Longstanding Medicare Regulatory Rural Biases
V. Help To Educate A Rural Workforce
VI. Stand Firm On DHHS Proposed Improvements in HIPAA Privacy Rule

I. Continue To Build Federal/Rural Collaboration

Departmental leadership and attitude throughout DHHS is critical; keep up the work to create a "culture of responsiveness." For those of us "in the trenches," it has appeared easier in the past for too many to play off of embedded stereotypes about the so called "provincialism" of rural hospital boards and administrators then to look inward at the Department's historic and systemic failure to design and manage an equitable Medicare program. Secretary Thompson, with his symbolic act of renaming HCFA, told us that he was committed to a cultural shift unprecedented in the agency's history. I would encourage people to take him at his word as I know "failure" on a key priority isn't in his leadership vocabulary.

It is clear that CMS head Tom Scully is equally committed. We are beginning to see a real difference as a result of the "Open Door" and related initiatives. We have found the CMS Regional Rural Health Coordinators to be very helpful. In particular, the Region V Office has done an exemplary job reaching out to rural providers and responding to individual regulatory questions and problems.

DHHS should continue to proactively involve its Office of Rural Health Policy early within the policy and regulatory process on all issues affecting rural health. Many rural regulatory and payment problems can be avoided by accessing ORHP's rural focused expertise.

Rural communities need a fundamentally new federal relationship if they are to prevail over an intimidating array of major challenges. This is not to blur government and provider responsibilities but it is to say that collaborative models are an alternative to the failed mythology of micromanaging the providers of American health care.

II. Continue To Develop An Understanding Of Rural Realities/Context

It has often been said that rural communities tends to be older, poorer and sicker. There are also key organizational differences. These differences should inform how DHHS works with rural communities and providers; here are but two examples:

- Increasingly, rural providers are networking to solve problems. Sufficient time needs to be built into federal requests for input or response as rural providers (including hearing witnesses) are likely to want in turn to work with others outside their own organization to develop a broader perspective. Wisconsin's coalition to address the challenges of HIPAA is another good specific example described at the end of this testimony.

- Dr. Ira Moscovice at the University of Minnesota states convincingly that differences in context between rural and urban hospitals result in systems of different complexity which in turn result in different types of errors and different demands for managing errors. High volumes and large bureaucracies tend to create one kind of management or regulatory challenge while the low volume, more personal settings creates another.

Specific suggestions for regulatory reform include:

Consistently Disaggregate Data—DHHS should consistently disaggregate data so that the rural context is explicit. Rural realities are often masked through a failure to collect or present data that adequately describes actual conditions, a reality hidden by averages.

Do Rural Impact Analysis Before Proposing Regulation—With any regulatory proposal to change a federal program, the DHHS should include a rural health impact statement that includes an impact analysis on vulnerable rural providers—safety net providers, primary care providers, hospitals, RHCs, FQHCs as well as the impact on local rural communities and economies.

Invest In Rural Best Practices—DHHS should allocate the necessary funding to the Agency for Healthcare Quality and Research for research and dissemination of best practices relevant to the scale and context of typical rural facilities. Research should reflect the diversity of settings in which patients are seen, not only those most convenient for researchers.

Assure Rural Community Health Centers Equitable Access To Funding—DHHS should more explicitly consider rural specific barriers, such as geography, lack of providers and lack of transportation when allocating federal funding. This would significantly increase the geographic diversity of CHCs.

Eliminate Counterproductive Network/Outreach Grant Applicant Restrictions—DHHS should eliminate the recently implemented eligibility requirement that prohibits past grantees from applying for Rural Health Outreach and Network Development Grants. This barrier unnecessarily eliminates some of the potentially most innovative and useful applications.

Support Proportional Representation On MedPAC—DHHS should support that the statutory requirement for rural representation on the Medicare Payment Advisory Commission (MedPAC) proportionate to the rural population be followed to assure a rigorous and ongoing attention to rural issues.

III. Support The Rural Community Hospital Assistance Act (RCH)

While I understand the distinction between regulatory reform as the topic of this hearing and congressional initiatives such as RCH, the newly introduced RCH bill to restructure rural hospital Medicare payments should be noted. In brief, the proposal would:

- Enhance the Critical Access Hospital (CAH) program, which provides special Medicare reimbursement for certain rural hospitals with 15 or fewer inpatient beds.
- Help other rural hospitals with 50 or fewer inpatient beds by providing adequate Medicare reimbursement and additional funding for technology and infrastructure needs.

In 1985, during the second year of Medicare's Prospective Payment System (PPS), the National Health Policy Forum at George Washington University hosted an invitational workshop on "PPS Design: Tackling Major Structural Issues." On behalf of rural hospitals, I 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. A senior representative of the Health Care Financing Administration (HCFA), responded with a less then helpful "get used to it, all models have their boundary problems." Weeks later, Carolyne Davis, then head of HCFA, stated that they would answer questions about rural wages by the end of the year. **We are still waiting for a fair PPS wage policy.**

For rural providers, the fundamental inequity in PPS is in part a result of our not having been at the table back in the early 1980s when the foundation for the PPS model was set. Put less kindly, "rural advocates were asleep at the switch." Urban advocates were successful in seeing that their hospitals were compensated for the effects of their local markets through disproportionate share payments and the use of a wage index. Rural hospitals were lumped into statewide markets and were not compensated for the effects of their local markets—markets with low volume and requiring high overhead. Low volume and high fixed costs kill rural hospitals—it is a "condition" that they face, just as some urban hospitals face having a large safety net requirement or relatively higher labor market..

The ongoing failure of Medicare to address rural market conditions in a manner consistent with its recognition of urban conditions has led to Medicare operating margins disproportionately lower for rural providers, hospitals in particular. It has undermined the credibility of the Program and cast the federal government as an adversary to rural communities as they seek to provide local health care.

RCH Is A Measured Approach To A System In Crisis—RCH protects the core infrastructure of rural health in American that does not undermine or contradict the public policy inherent in the Medicare Prospective Payment System. Rural hospitals not in special programs and with fewer than 50 beds are paid 14% less than their reasonable costs. In 1999, 55% of these rural hospitals had a negative inpatient Medicare margin (based on Medicare's conservative definition of "allowable costs"). They had an average overall Medicare margin of a negative 5.4%. To keep the impact of addressing this problem in context, all rural hospitals under fifty beds only account for 2% of inpatient PPS payments. (*MedPAC Report To The Congress*, March, 2001 and March, 2002)

RCH Compliments And Builds On CAH—There are hundreds of small and rural hospitals across the country that are "too busy" to be eligible for the Critical Access Hospital (CAH) program but not "busy enough" to have a PPS margin. Many of these hospitals don't have Medicare-dependent Hospital or Sole Community Hospital status and of those that do, many don't receive significant assistance. As a group, these hospitals are heavily Medicare dependent with negative Medicare margins and meager or nonexistent operating margins.

Medicare Beneficiaries Benefit Only When They Can Access Services—Benefits must be accessible and to be accessible they must be available timely and conveniently to the beneficiaries and their care givers (family). Rural hospitals offer the essential services that Medicare beneficiaries need. For benefits to be accessible, rural hospitals must be viable.

Medicare Dominate Payer Of Small Rural Hospitals—Medicare is the primary payer for rural hospital services, accounting for about half of rural admissions. The long-term underpayment of small rural hospitals is causing significant deterioration of physical plants and equipment due to lack of capital to reinvest. In a time of increasing private sector insurance premiums and cost pressure, the payment to cost ratio for rural hospitals

remains at a destabilizing 133% (compared to 113% for urban hospitals, *MedPAC Report To The Congress*, June, 2001). For rural hospitals to maintain inpatient and outpatient services and be able to replace an aging infrastructure, they need to be reimbursed at least their reasonable costs.

IV. Address Longstanding Medicare Regulatory Rural Biases

Specific suggestions for regulatory reform include:

Do Not Water Down The Occupational Mix Adjustment—BIPA requires an implemented occupational mix adjustment to the wage index no later than October 1st, 2004. We believe that some of those who will lose under this long awaited technical adjustment are working to delay or water it down by arguing within the Department for "less onerous" data submission requirements and for as much of the status quo as they can retain.

Lower The Percent Of DRG Adjusted By Wage Index—The percentage of the DRG modified by the wage input should be lowered to reflect the actual proportion of goods and services effected by area wages. The input categories included in the labor share are long outdated, having been selected in 1983. The current national average labor share of 71.1% is thought by many, if not most reviewers, to be 5 to 10 points too high, particularly prejudicial to rural providers with wage indices well below 1.000.

Reform Hospital Wage Index Use & Reclassification—As soon as possible, limit the use of the current wage index based on hospital wages to hospital services. Until a separate index is developed for other PPS services, the hospital wage area reclassification of hospital services should apply to all PPS services. CMS should allow hospitals that receive a three-year period of wage index reclassification to re-apply in each of the final two years of the original three-year classification period to avoid unexpected payment fluctuations. By allowing hospitals to apply in two of the three years, some of the year-to-year fluctuations will be accounted for and only those hospitals that show two straight years of lower costs will actually have to revert back to the original wage index classification.

Provide A Medicare Managed Care Wrap Around For Cost Based Providers—CMS should provide wrap-around payments to rural health clinics (RHCs), federally qualified health centers (FQHCs) and Critical Access Hospitals (CAHs) for Medicare managed care services.

Recognize The High Fixed Cost Of Lower Volume Rural Services

- **Ambulance**—In this instance, I agree with the American Hospital Association recommendation to maintain the current cost based payment system to rural providers until a more adequate and acceptable methodology is developed. According to their testimony: "The September 12, 2000 ambulance proposed rule established an additional per mile payment amount for rural providers, but this enhanced payment covered only the first 17 miles of an ambulance trip. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) mandated that rural ambulance mileage greater than 17 miles and up to 50 miles be increased by *not less than* one-half of the additional payment per mile established for the first 17 miles of a rural ambulance trip. CMS set the final payment rate at *exactly* one-half, or the minimum

amount required by law. This amount is not enough to offset the costs of many rural ambulance providers, especially essential ambulance services that may furnish few trips over the course of a typical month because of a small rural population."

- **CRNAs**—Eliminate the limit on the number of procedures eligible for a pass through of CRNA service costs in rural hospitals with less than 100 beds The current eligibility limit of 500 procedures is artificial for the typical rural hospitals and is leading to a substantial underpayment in many facilities of the actual cost of providing the service.

- **Home Health**—CMS should include a low volume adjustment for rural home health services within the prospective payment system to address the inability of small and rural providers to spread their fixed costs, as well as costs associated with high-cost cases, among a large volume of cases.

Refine Home Health PPS Requirements—The use of the OASIS is particularly burdensome for rural providers given limited resources and a questionable cost/benefit. OASIS regulations should be changed to include only the 23 questions that are needed for establishing the Medicare Home Health PPS and the home health resource groupings. There are 94 OASIS questions and 127 questions in all. It requires 2.5-3 hours/patient to complete and if a "complicated" case, even longer. OASIS data should be collected only for Medicare patients. Agencies should be allowed seven days from the start of care visit for completion of the comprehensive assessment to lock in the OASIS data. Finally, the guidelines should be revised for OASIS resumption of care assessment for patients that have been hospitalized such that the assessment is required only if the patient has been hospitalized for 72 or more hours. (Source: David Sniff, Chief Operating Officer, Graham Hospital, Canton, Illinois and Chairman of the Hospital Constituency Group, national Rural Health Association)

Simplify Medicare Cost Report—It simply is very burdensome. With the exception of the previously noted need for occupational mix data, we strongly suggest HHS work with the existing AHA Task Force on this issue. The cost report should be limited to the information actually needed by PPS or if not a PPS provider, the information needed by the applicable payment system.

Delay Provider-Based Rules Scheduled for October 1st—CMS should work with provider organizations to resolve providers' significant concerns that the provider based rules include provisions that are counter productive to both the Medicare program and effective, efficient provider operations. These rules, which are scheduled to become fully effective October 1, 2002, should be postponed until these issues can be addressed.

Simplify Signature Authority and Sequence Number Processes—Medicare Part B appropriately requires proof of delegated signatures from hospitals that bill for physicians. However each hospital has to complete a 30-page application to verify the physician signature. The application also requires the name, birth date, and social security number of each hospital board members. On a related issue, physicians holding more than five sequence numbers are now being required to re-verify all sequence numbers upon adding any additional number. This specifically effects many specialty physicians traveling to multiple rural sites and ER physicians in the rural communities who frequently work hours at multiple sites.

Limit Hospital Building Code/Regulations For Small Satellite Clinics—A RWHC hospital operates a satellite Physical Therapy outpatient clinic. They can serve all everyone there except Medicare/Medicaid patients because of an interpretation that building codes require that this satellite clinic (which is a rented, one story, modern existing building) to meet HOSPITAL level life/safety codes.

Return To States The Unencumbered Oversight Of Anesthesia Care—We disagree with the proposal to require physician supervision of CRNAs unless the a State's governor attests that it is in the best interests of the residents of the state to request an exemption from the federal requirement. The DHHS should provide States with the authority to regulate anesthesia care, removing the federal physician supervision requirement. Nurse anesthetists provide over 70 percent of the anesthesia in rural America, keeping the doors of operating rooms open in rural hospitals. State licensure and scope of practice acts already consider the health care needs of a state's population and the availability of health care professionals to serve those needs.

V. Help To Educate A Rural Workforce

Specific suggestions for regulatory reform include:

Fully Reinstate Rural Access To J1 Visa Waivers—The J1-Visa Waiver situation is a rural access to care issue. As such, the USDA should immediately reinstate the program, working with the INS to ensure security, and then the Department of Health and Human Services should assume responsibility as soon as the Department is prepared to properly oversee the program. **It would be an sad irony if all of the positive work being done by DHHS to improve rural access was negated by the failure to act on this one single issue.**

Remove "Cap" On Residency Positions For Programs In Rural Communities—DHHS should remove the "cap" on residency positions for programs in rural locations. The cap was based upon 1996 resident FTE's, at which time family physician residencies, the trainers of most physicians who provide care in rural areas, were already spending significant percentages of time in ambulatory care. That ambulatory time was excluded in the base year count, with the net result that the very programs leading the way in ambulatory training and in preparing doctors for rural practice, are ever afterwards penalized by failure to reimburse for a significant percentage of residents, unless program size is reduced.

Standardize Rural GME Guidelines—DHHS should standardize interpretation of Medicare reimbursement guidelines for rural GME. There exists no single source to which a program/institution may go for clarification. The rules are sufficiently complex to deter many teachers in rural areas, who could provide excellent educational experiences for residents and other learners, thereby increasing the likelihood of practice in rural or other underserved areas.

VI. Stand Firm On DHHS Proposed Improvements in HIPAA Privacy Rule

We strongly support the March 27 DHSS proposed improvements in the Privacy Rule. It represents an approach more consistent with what the vast majority of our rural patients and communities want and expect as we work to balance legitimate privacy needs and patient preferences with everyone's need for quality and cost effective systems.

HIPAA COW—As an example of how rural providers are collaborating to proactively address the significant challenge of implementing HIPAA, RWHC and others have initiated HIPAA COW (Coalition of Wisconsin) as a non-profit organization open to Wisconsin health care organizations that meet the definition of Covered Entity and/or Business Associate under the Health Insurance Portability and Accountability Act (HIPAA). The mission of HIPAA-COW is to:

- Create consistency among payers and providers regarding HIPAA implementation and develop a common HIPAA implementation vision.
- Facilitate and streamline HIPAA implementation through identification of "best practices" and benchmarking.
- Reduce duplicate efforts among payers and providers.
- Offer opportunities for partnering.
- Identify and elevate regulatory issues to state agencies and the legislature.

More information on HIPAA COW is available at http://www.hipaacow.org.

Additional specific recommendations, previously submitted to the Department of Health & Human Services Rural Task Force, are available at http://www.rwhc.com