**Rural Hope For Medicare—Become More A Partner, Less An Adversary**

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"Sizing Up Medicare in Rural America: What's Next After the MedPAC Report?"
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Tim Size, Executive Director
Rural Wisconsin Health Cooperative
Sauk City, Wisconsin
timsize@rwhc.com
www.rwhc.com

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 rural providers, the fundamental inequity in PPS is 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 urban hospitals face having a large safety net requirement and high wage rates.

The 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.

Congress needs to compensate for the environmental disadvantages rural hospitals face as they have historically done for urban hospitals. As most of you know, H.R. 1609 and S. 885 propose to create an area wage index floor of 92.5% of the national average and bring all hospitals to the higher, large urban Medicare inpatient payment amount. I am not in a position to know how likely it is or isn't that either of these proposals will be adopted. I do know that there being proposed by the American Hospital Association marks a major watershed within the hospital sector of acknowledging the dysfunctional legacy of exaggerated PPS urban/rural payment differentials. This movement builds on the earlier success in BIPA when Congress

finally required HCFA to implement an occupational-mix adjustment for the wage index, to undo an overpayment to high wage areas due to inadequate data. MedPAC's June recommendation to substantially increase disproportionate share payments, if adopted, will further balance the PPS model.

In addition to the reforms noted, national policy leaders are increasingly recognizing that PPS simply does not work for most providers in rural areas. After twenty years attempting to adjust PPS to the reality of smaller rural community hospitals it is clear that either it is not doable or the trouble of creating a PPS model relevant for the smaller rural hospital is simply too complex.

The growing acceptance of Critical Access Hospitals (CAHs) and the momentum behind introducing cost based reimbursement for rural hospitals with fewer than fifty beds is testament to the fact that we have entered a new era in rural health policy. The National Rural Health Association and the American Hospital Association have recently reached agreement (not a common event in my own experience) to ensure essential access to rural hospital services. And none too soon.

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. Few of them have Medicare-Dependent Hospital or Sole Community Hospital status and most that do, don't receive significant advantage from those programs. As a group they are heavily Medicare dependent with negative Medicare margins and meager or nonexistent operating margins. The basis for rural hospitals' claim for a new approach lies in the government data showing that they are paid less than urban hospitals (and their costs) for the same service.

- In 1999, rural hospitals were paid 9.6% <u>less</u> than their reasonable costs (as defined by Medicare).

- In 1999, the five hundred rural hospitals under fifty beds with no "special designation" were paid 14.2% <u>less</u>.

- In 1999, 54.5% of the rural hospitals under fifty beds with no "special designation" had a negative inpatient Medicare margin.

Turning away from legislative issues I would like to briefly comment on Medicare's administration, the Centers for Medicare and Medicaid Services. For those of us "in the trenches," it has appeared easier for too many to play off of embedded stereotypes about the so called failure of rural hospital boards and administrators then to look inward at Medicare's historic and systemic failure to design and manage an equitable Medicare program. Secretary Thompson with this early symbolic act of renaming has told us that he is committed to a cultural shift unprecedented in the agency's history.

His track record in Wisconsin leads me to hope that he will fundamentally change the relationship between CMS and rural providers--failure on a key priority isn't in his leadership vocabulary. I hear Secretary Thompson telling us that a fundamental shift in the quality of the relationship between Medicare and the beneficiaries as

well as between Medicare and providers is required if we are to successfully address upcoming demographic, financial and technical challenges.

Notwithstanding the cynics, CMS can best address its fiduciary responsibilities to by continuing its shift from provider adversary to provider partner. 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 the distinctly different set of responsibilities between payer and provider but it is to say that collaborative alternative models exist and should be explored. The Secretary and Congressional leaders recently visited the Pittsburgh Regional Healthcare Initiative, a consortium of providers, consumers, insurers and employers whose goal is to demonstrate that sense can be made of our health care system. We need more such models and visits.

In addition to the many already existing challenges of running a small rural operation, rural hospitals and others providers are facing a new generation of challenges; among others:

- The application of HIPAA privacy and security regulations
- A national workforce shortage (on top of historic patterns of maldistribution)
- A shift from paper to electronic administrative and clinical data systems, including the demand for Computerized Physician Order Entry Systems well in advance of their design and manufacture for small facilities
- Distressed rural municipalities increasingly looking to tax rural non-profit providers or at a minimum, receive service payments in lieu of taxes
- Increased resistance to cost shifting by private payers to subsidize Medicare's underpayments
- Increases in bad debt and charity care as the economy slows
- Urban systems pulling back on longstanding support in rural areas
- American Red Cross has increased its annual charges for blood by fifty to sixty percent

In conclusion, I would like to offer a number of recommendations from the perspective of those of someone working in rural health that would facilitate the development of a Medicare-rural partnership.

1. In all matters, **attitude matters**; begin to see and behave towards rural providers as partners with Medicare, not as adversaries. Over time, they will begin to respond in kind.
2. Make explicit the public policy goal that the average rural hospital should have the same Medicare operating margin as the average urban hospital; to do otherwise is to perpetuate an unearned stereotype that rural boards and rural administrators are less able.

3. Adopt H.R. 1609 and S. 885.

4. Pass legislation to allow hospitals not eligible for CAH but under 50 beds the option of cost based reimbursement.

5. Make addressing the workforce shortage a national priority, particularly for traditionally underserved areas who enter this new crisis already understaffed.

6. Work with rural providers to find cost effective means to address the extraordinary new capital investments required to comply with HIPPA and patient safety concerns.

7. Make the system and work of the CMS Regional Rural Health Coordinators more visible to a broader array of rural providers.

8. Enhance the ombudsman role of the National Advisory Committee on Rural Health and the Federal Office of Rural Health Policy.

9. Meet or exceed the legislative requirement for rural representation on MedPAC proportionate to the rural population so that the rural voice is integral to MedPAC debates, and not so readily marginalized.

10. Assure the rigorous inclusion of a rural perspective as the Government tackles Medicare reform.

11. Work with rural advocates to assure that CMS is adequately funded for its administrative duties; many of our historic problems with the agency are due to the lack of agency resources to fine tune generic industry wide policies to specific rural realities.

12. Fully implement the regulatory simplification process initiated by Secretary Thompson; a community impact analysis before enacting substantive new regulations.

13. The lack of Intermediaries/Carrier responsiveness, accessibility, and inconsistencies among them, are legendary with local providers. Opinions are currently divided whether rural providers would be better served through better local access to intermediaries or through one separate intermediary that could address all specialized rural needs. Regardless of the particular path taken, intermediary performance and accountability is a critical weak link that must be aggressively addressed.

14. In all of analysis, consistently disaggregate the data; rural realities are constantly lost through a failure to collect or present data that adequately describes local conditions.

Thanks for taking the time today to come, listen and talk about rural Medicare issues.