Recommendations for the Department of Health & Human Services Rural Task Force

Submitted by the Wisconsin Health & Hospital Association and the Rural Wisconsin Health Cooperative

9/07/01

#	Issue	Recommendation	Rationale
1.	AHRQ	Fund research and dissemination of best practices relevant to the scale and context of typical rural facilities.	The federal investment in health care research and quality should reflect the diversity of settings in which patients are seen, not just those most convenient for researchers.
2.	AHRQ	Fund research and dissemination of best practices relevant to local leaders seeking to create organizational and systemic change.	Quality improvement is more than just the medical science about desired outcomes but is also dependent on and informed by the behavioral and political sciences.
3.	CAH—Emergency Expansion 15 Bed Limit	Be explicit that in the case of an epidemic or an emergency, the fifteen bed limit can be exceeded without penalty.	The role of the hospital is to serve the local community in unusual situations, even if it means violating the fifteen bed ceiling.
4.	CAH—Flexibility Program Grant	Work with Congress to assure the continuation of the Flexibility program grant.	These focused investments in state offices of rural health and the development of local critical access hospitals have become a key component of the states' rural health infrastructure.
5.	CAH—JCAHCO	Finalize, as soon as possible, an agreement with JCAHCO which gives them deemed status authority for CAHs.	Many but not all CAHs wish to continue JCAHCO accreditation and until a new agreement is reached between CMS and JCAHCO, CAHs need to incur duplicative facility surveys by their State. As for all hospitals, JCAHCO needs to continue as an option, not a requirement.

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6.	CAH—Long-Term Care	Work with Congress to assure that CAH based home health and skilled nursing facilities should be reimbursed based on reasonable costs.	Home health services health and skilled nursing facilities are critical and natural components of critical access hospitals.
7.	Capital—Mandates	Work with Congress to assure transition funding is made available for the capital cost required of rural hospitals to implement need mandates such as HIPAA and new Patient Safety requirements.	A convergence of demands for major unanticipated regulatory driven capital investments comes at the same time when Hill-Burton era facilities face replacement of their core facilities.
8.	Capital—FHA 242 Program (1 of 5)	Remove the need for an initial state approval or certification that the hospital requesting financing assistance is critical and needed for the state's health care plan.	The primary federal government financing program for rural hospitals capital improvement is the FHA 242 insurance program. Less than half of the states today have certificate of need legislation and processes. Failure to make this change will limit the use of this program to primarily certificate of need states and preclude others equally deserving.
9.	Capital—FHA 242 Program (2 of 5)	Each project should be the responsibility of one person in only one agency and services required from other agencies should be transparent to the borrower.	The FHA 242 program is currently administered in part by two federal agencies, HUD (for receipt of the mortgage insurance) and HSS (for review of financial feasibility). This process, while understandable, requires extra diligence in order to avoid delay, conflicting directions and a positive outcome.
10.	Capital—FHA 242 Program (3 of 5)	Procedures, filings and forms should be reviewed to determine their necessity and whether a better way is possible.	The current HHS handbook of requirements for participation in the FHA 242 program should be reviewed and revised with an eye towards fewer requirements and faster processing time.

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11.	Capital—FHA 242 Program (4 of 5)	Either the program needs to address filling all gaps to provide complete coverage or the use of Ginnie Mae wraps must be approved for use.	The current mortgage insurance provided by FHA 242 has gaps in coverage. Currently AAA ratings can be obtained when other FHA insurance products are combined with Ginnie Mae securities to fill the gaps in coverage. This structure is currently not approved for use with FHA 242 and should be.
12.	Capital—FHA 242 Program (5 of 5)	A change is needed in collateral requirements. Current collateral requirements are that all revenues and all insured properties that no future lenders to the hospital can receive a parity position in this pool of collateral as new projects are undertaken by the hospital.	This makes subsequent borrowings difficult to so on favorable terms with other lenders and other non-FHA insured collateral structure which allows future lenders to share in the FHA insured collateral pool on a parity basis, adding new projects and revenues to the collateral pool for the benefit of all lenders.
13.	Community Health Clinics	Rural specific barriers such as geography, weather, lack of providers and lack of transportation should be more explicitly considered when allocating funding.	This would enhance access nationally by facilitating a more geographically diverse array of CHCs.
14.	Community & Economic Development	DHHS proposals which affect local health care need to explicitly consider the impact on the rest of the rural community and economy.	"Every two jobs created (or lost) in the Sauk County health care industry will cause the number of jobs in other industries to increase (or decrease) by one job." From the most recent study supported by RWHC, *The Economic Value of the Health Care Industry In Sauk County, Wisconsin, 11/00* (Attached).

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15.	CRNA	Reinstate the 1/18/01 final rule (over the 7/5/01 proposal) re physician supervision.	From the NRHA 8/6/01 letter to Secretary Thompson, "HCFA and its experts took seven years to finalize this rule and found 'no compelling evidence that an across-the-board Federal physician supervision requirement for CRNAs leads to better outcomes.' " It is false comfort to go forward with a federal standard based on a state by state exemption process—this approach needlessly politicizes an issue already resolved by state legislatures.
16.	CRNA	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.
17.	EMTALA	Permit a surgeon on call to do elective surgery if the only alternative is to have no surgeon on call.	Rural hospitals are not typically required to have a surgeon on call. Given the limited surgical service available in many rural communities, it is counterproductive to expect surgeons to not schedule any elective surgery when they are on call—it limits the amount of call surgeons are willing to take.
18.	Federal Office Of Rural Health Policy	Further enhance the ombudsman role of both the National Advisory Committee on Rural Health and the Federal Office of Rural Health Policy within DHHS.	The expertise inherent in both the NACRH and the FORHP has been historically underutilized by DHHS as a whole.
19.	Federal Office Of Rural Health Policy	DHHS should proactively involve the FORHP early in the policy and regulatory process on issues effecting rural health.	Many rural regulatory and payment problems could have been avoided, having been caused by not adapting generic industry wide policies to rural realities.

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20.	Medicare—Conditions Of Participation	Integrate the federal regulations impacting diversified rural hospitals with multiple provider types.	Wisconsin's pioneering "rural medical center" concept—a single license for rural provider campuses providing multiple services (e.g. hospital, SNF, home health).
21.	Medicare—Cost Report	Simplify the cost report. A national task force of external and CMS experts should be convened to report out specific recommendations by a time certain in 2002. The work already complete by an existing AHA task force on this issue should facilitate an expedited review.	The cost report should be limiting to the information actually needed by PPS or if not a PPS provider, the information needed by the applicable payment system.
22.	Medicare—Intermediary/Carrier	Require Intermediary/Carrier responsiveness, accessibility, and consistency and continuously evaluate their performance based on solicited provider feedback.	The lack of Intermediary/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.
23.	Medicare—MedPAC	DHHS should encourage that the statutory requirement for rural representation on MedPAC proportionate to the rural population be met or exceeded. In particular representation of rural providers is sorely needed.	The rural voice must be part of all MedPAC deliberation; when only one or two members represent a rural perspective, it is very difficult for even the most skilled advocate to be effective.

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24.	Medicare PPS—General	Work with Congress to assure that the Prospective Payment System adopt as an explicit goal that the AVERAGE Medicare Operating Margin for rural hospitals should be the same as the AVERAGE for urban hospitals. Support MEDPAC's current sensitivity to rural vs. urban margins and encourage them to drill even deeper into rural issues.	To do otherwise is to perpetuate an unearned stereotype that rural boards and rural administrators are less able. The public policy basis for PPS has always been to hold hospitals harmless for costs outside of their control to influence; the classic example is the adjustment is for higher than average case mix or area wage levels. The concept needs to be more uniformly applied to rural hospitals which face high fixed costs and low volumes.
25.	Medicare PPS—Disproportionate Share	Work with Congress to make disproportionate share eligibility and add-on payment formulas the same for all hospitals; include uncompensated care in the formula.	As noted by MedPAC in its June, 2001 Report, there is no policy rationale for the anti-rural bias in the current formula.
26.	Medicare PPS—Emergency Room	. Assure that, subsequent to the cost reporting process, standby costs are reimbursed.	Just as urban providers have been historically protected from the relatively higher wages inherent in most urban communities, rural providers should be protected from the higher then average standby costs inherent in serving most rural communities. Payments for standby costs are currently now allowed but in practice are lost during the cost reporting process. In the future with outpatient PPS, the unique standby costs of rural hospitals need to be recognized and paid.

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27.	Medicare PPS—Hospital Inpatient Outliers	Rural hospitals with fewer than 100 beds should receive no less than 90% of their reasonable costs associated with an inpatient "outlier."	The typical rural hospital does not have the volume (within a reasonable timeframe) to make up for the payment shortfall associated with an inpatient outlier occurrence.
28.	Medicare PPS—Wage Index—Hospital (1 of 3)	Eliminate (1) the mileage limit for geographic reclassification and (2) the requirement that you can only apply reapply after three years.	Reclassification criteria needs to reflect the reality of the price of the labor faced by the hospital not an arbitrary division that cuts through natural labor markets.
29.	Medicare PPS—Wage Index—Hospital (2 of 3)	The percentage of the DRG modified by the wage input should be lowered to reflect the actual proportion of goods and services effected by the area wage.	The input categories included in the labor share are long outdated, having been selected in 1983.
30.	Medicare PPS—Wage Index—Hospital (3 of 3)	Fast track implementation of the occupational mix adjustment so that it is in effect for FY 2003 or 2004.	There is an anti-rural bias in the wage index due to a lack of an occupational mix adjustment which represents an inequitable underpayment of numerous rural facilities; its correction is long overdue. The statutory requirement is for implementation no later than October 1st, 2004; but the occupational mix adjustment can and should be implemented earlier.

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31.	Medicare PPS—Wage Index—SNF & Other Providers Types Subject to PPS	Fast track the implementation of a SNF PPS wage index based on nursing home specific wages. Implement similar systems for other provider types subject to PPS along with appropriate geographic reclassification safeguards.	• SNF and other provider specific data is available • The geographic variation in nursing home wages and among other provider types is different then that of hospitals as nursing homes employee a significantly different mix of employees • The use of the wage index and its bias against rural hospitals, further and inappropriately reduces payments to all rural providers subject to PPS
32.	Medicare— Rural Hospital Cost Based Reimbursement	Support legislation to allow hospitals not eligible for CAH but under 50 beds the option of cost based reimbursement.	There is a significant number of hospitals with volumes to high to be eligible for CAH but too low to survive under PPS.
33.	Network & Outreach Grants	Eliminate the newly discovered eligibility barrier which prohibits past grantees from applying.	This unnecessarily eliminates some of the potentially most innovative and useful applications.
34.	Network & Outreach Grants	Aggressively seek leading practitioners and administrators from the field to make up a larger share of the reviewers.	Notwithstanding the difficulty of recruiting individuals from the field, their substantive involvement is critical in identifying credible applicants and projects.
35.	PROs	Require PROs to make consultation available to rural providers.	The current 6th Scope Of Work (SOW) creates incentives for PROs to NOT work with rural providers but to focus their technical assistance on large volume providers.

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36.	Regional Offices	Make the system and work of the CMS Regional Rural Health Coordinators more visible to a broader array of rural providers.	They are doing good work but are not as visible as they and DHHS deserve them to be. In particular, Greg Chesmore in the Region V Office has done an exemplary job reaching out to rural providers.
37.	Regulatory Simplification	Fully implement the regulatory simplification process initiated by Secretary Thompson.	Lower volume facilities, in particular, do not have the capacity to absorb the cost of implementing unnecessary regulatory complexity.
38.	Research & Analytic Studies	Consistently disaggregate data so that the rural context is evident.	Rural realities are constantly lost through a failure to collect or present data that adequately describes local conditions.
39.	Swing Beds	Repeal the requirement for MDS reporting and maintain swing beds on a reasonable cost based reimbursement system	There is not sufficient evidence of abuse to justify this new and costly regulatory approach.
40.	Telehealth	Balance funding of hub and spoke models with funding for intra-rural networking alternatives	The early involvement of DHHS in telehealth was disproportionately effected by the expertise and interest of specialty medical centers.
41.	Workforce (1 of 5)	Fast track regulation re role and training of single-task workers appropriate to the specific task(s).	Requiring the same training (a minimum of 75 hours) as that required for nursing assistants is a barrier to this needed diversity in the work force.
42.	Workforce (2 of 5)	HRSA needs to expand its investment in distance learning technology and systems to include more populated but still very rural communities.	HRSA understandably focused its early investments in distance learning in frontier areas. Now as workforce shortages are endemic across most rural communities, HRSA needs to expand its focus.

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43.	Workforce (3 of 5)	Reimburse the cost to rural providers of hosting clinical rotations, including the incentives necessary to attract rural based educators and clinical practitioners.	Addressing the rural workforce shortage requires maintaining and expanding rural training sites. As rural operating margins continue to be severely challenged, fewer rural providers are able to subsidize education and training clinical rotations. The bias of GME being primarily for teaching hospitals must be ended.
44.	Workforce (4 of 5)	All workforce related grants to educational and training institutions must be required to demonstrate the active involvement and concurrence by effected providers.	Creating an ongoing dialogue and collaboration between "academe" and rural providers must be a fundamental goal of any workforce initiative; historically and to date, this has been a significant barrier.
45.	Workforce (5 of 5)	Work with the Departments of Labor and Education to facilitate their furthering health sector work force development as a priority.	For too long, workforce planning and funding has suffered from fragmented federal and state interventions.