Rural Health and those that provide care to people in rural America are currently under siege. Why is this happening at this point in our history? To begin with, this is not a pro or con article slanted against either Democrats or Republicans. However, this is an advocacy piece. I am advocating for rural providers and do not apologize for doing so. I passionately believe rural health is a truly non-partisan issue.

There is no question that we are facing a crisis situation in terms of our economy. The terrorist attacks on our country, two wars, a third military action, domestic unemployment, housing and related problems including a skittish stock market and multiple banking problems make this last decade a difficult and confusing time in our history. Add in the globalization of the market place, the expansion of foreign markets to our shores, and the assertion as Tom Friedman makes in his book, that “the world is truly flat or at least flatter.” Then add a significant debt and lack of a compressible budget. All this has contributed to our current economic malaise and has stoked our fears and concerns.

This process started several years ago when Congress and the Centers for Medicare and Medicaid Services (CMS) were so fearful of Critical Access Hospitals (CAH) and their cost based reimbursement, that they eliminated the right of the various states to designate CAHs that were closer than 35 miles by primary road or 15 miles by secondary road from other hospital facilities. CAHs are hospitals in rural areas that have no more than twenty-five beds and an average length of stay of no more than ninety-six hours. We have thirty-four of these hospitals in Oklahoma, scattered boarder to boarder. The mood at the time at CMS was that this cost base reimbursement would bankrupt the Medicare system. This has not proven to be accurate, as we will examine later. This change in the law essentially stopped the development of the program authorized under the Medicare Rural Hospital Flexibility (FLEX) Program, adopted in 1997. The FLEX program was in response to the closure of over six hundred rural hospitals in the 80s and 90s. Several of these hospitals were in Oklahoma. That included hospitals in towns and communities like Thomas, Okemah and Cherokee.

One can always argue whether such a program is necessary or advisable. The sad fact remains that these small communities and about six hundred like them have been without health care since their hospital closed. Some have been able to develop rural health clinics or federally qualified community health centers. A few have been able to reopen their hospital. Our research at the National Center for Rural Health Works at Oklahoma State University Cooperative Extension, shows that economic growth in rural communities requires good educational structure and access to quality health care. One could also argue that the lack of any public transportation in rural Oklahoma and many other rural states dictates that hospitals be located in places where they serve an increasingly smaller population. This phenomenon has been occurring in an area roughly stretching from west Texas up through the Canadian border for the past six decades. This is the area commonly known as the Buffalo Commons, the area from south Texas north to the U.S. - Canadian border that was previously occupied by the Native American Bison and the people who hunted and lived off them.

Irrespective of that discussion, rural health care and rural health providers are under unprecedented attack from very powerful groups. Representative Eric Cantor, Republican, Virginia, and the Republican leadership of the House recently proposed to balance the US budget in part by taking cuts of $14 Billion from rural providers (hospitals and physicians) to ‘reform rural health’ and another $2 Billion by repealing Frontier States Adjustments. Additionally, his proposal contained a $14 Billion cut in Direct Graduate Medical Education (DGME) and Indirect Medical Education (IMG).

CAHs are currently reimbursed at 101% of their reasonable costs, as defined by CMS, for their Medicare patients. This population is the most prominent demographic within most CAH service areas, sometimes reaching sixty to eighty-five percent of their patient mix. Any change in this reimbursement dramatically affects these small, rural hospitals.

There are currently 1327 CAHs in the country. That represents 26% of the nation’s community hospitals. Even though the payer mix of these hospitals is heavily weighted with a Medicare patient load, CAHs represent less than 2% of CMS’s entire budget. The CAH program is estimated to cost approximately $21 Billion nationally. That cost is the payment to CAHs and does not calculate the cost of providing care to the Medicare beneficiaries displaced from these hospitals into certainly more expensive urban hospitals. This does not consider transportation and related cost to this group of citizens. A $14 Billion cut
would devastate the program, causing many of these hospitals to close.

While we are at it, let’s agree to stop calling Social Security and Medicare ‘entitlement’ programs. There are many other programs that could be accurately described by this negatively applied moniker. However Social Security and Medicare are programs that the American people have paid into for all their working years. We have all been paying into Social Security since the late 1930s and into Medicare since 1965. It is no more fair to use this term for these programs than to call your work pension or your 401K an ‘entitlement.’ Granted we may have to tweak these programs from time to time but let’s remember that we who work have all paid into these programs with the promise of benefits when we reached a certain retirement age. Also, in this writer’s opinion, it is in our best interest to have a healthy, educated population. How we accomplish that is certainly subject to much discussion and debate. But we cannot stop making progress. We must continue to work on these issues. Our health care costs in 2008 were $7,558 per capita and 16.0% of our Gross Domestic Production (GDP). Both these figures are higher than all the other industrialized nations while our outcomes, considering primary care and disease prevention are not very good, really just middle of the pack or worse. Make no mistake about it. This is still the best place on earth to come and have a problem fixed. But our health outcomes related to primary care and prevention lag other countries. Our education system problems especially related to Asian countries, India, and even some parts of Europe have been well documented. These discussions are really for another time and place but they contribute directly to a lack of focus on rural health care problems. We can tackle all these problems. We simply must.

These are not the only proposed cuts. Others cuts or failure to reinstate positive programs include:

- Positive adjustments in the geographic practice cost index (GPCI). This reinstates a floor that expired December 31, 2009. This is estimated to increase 5.7% in 2010 and 3.6% in 2011 in Oklahoma.
- Outpatient hospital hold harmless provisions
- Extension of the Medicare Dependent Hospital Program
- Section 508 Hospital Payments (reclassification)
- Rural Ambulance Super bonus
- Technical component cost for certain pathology services
- Low volume/high quality adjustment

Also at significant risk is any fix to the Sustainable Growth Rate (SGR). This provision would have devastating consequences for rural physicians because of the large percentage of Medicare beneficiaries in rural areas. Since 2002, Congress intervened on 12 separate occasions to prevent cuts. Five separate bills were passed to stop a 22 percent cut in 2010 alone. The current formula calls for cuts of 29.5 percent on January 1, 2012 for physician services in order to begin to close this massive gap in funding.

The second reason is simply a volume issue. While urban hospitals have the ability to do some ‘cost shift’ because of their much more diverse patient base and their much larger volumes, rural providers simply do not. Look at it this way. If you are the best widget maker in the country and make 100 widgets per day, you are happy and well paid. If you move to an area where you have the resources to only produce 40 widgets per day, are you less skilled or a worse craftsman? I doubt it. You simply are a low volume producer not unlike most rural providers.

Unpublished data from Sano Capital Group is both disturbing and revealing. Sano complied data from cost reports from approximately 1300 CAHs from all across the country from 2005 to 2009. Using regression analysis and other techniques, their studies show that about three fourths of CAHs in this group fail to make a profit.

Why is this? Are we simply incompetent to manage and provide health care in rural communities? While no group can claim 100% best management practices, most CAHs are well managed. What then is the problem? It is really two-fold. First, there are the patient base demographics. According to the Centers for Medicare and Medicaid (CMS) Statistical Supplement for 2004 (2001 data), rural beneficiaries comprise 26.8 percent of the overall Medicare population. As you know, rural seniors face unique challenges in both receiving quality health care. The rural elderly are generally sicker, older and frailer than their urban counterparts. Rural elderly are more likely to have chronic conditions such as arthritis, hypertension, diabetes and heart disease. They are also likely to be required to travel a greater distance when seeking care than urban counterparts. We are also poorer, more likely to lack other insurance and less educated than our urban counterparts. This makes for a sicker population base with fewer resources than others. Insurance coverage also lags urban areas. Health insurance in this country has generally been a function of your employment. The larger the employer, the better the insurance coverage. Most employers in rural communities are by definition small businesses. They simply cannot afford group coverage available to large urban employers.

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Another problem involves our political representation. While our Oklahoma delegation is certainly informed about rural problems and potential solutions, they are in the minority. While it used to be that virtually every Congressman and woman had some rural aspect to his or her districts, that is no longer true. Only about 20% of our population now resides in rural America with resulting representation. Now, many more of us live in cities than in rural areas. Our political representatives are in a distinct minority in the current Congress. Moreover, most members of Congress have experiences based in urban settings and not rural areas. Our experiences then become the ‘outliers’ rather than the norm. Congressional policy becomes geared toward the ‘normal’ situation. This generally means that policy and programs other than the norm are perceived as more costly and less efficient. This is certainly the impression within CMS toward any cost based reimbursement program and certainly toward CAH reimbursement. Unpublished data from Sano clearly shows that health care provided in urban hospitals is at least twice as expensive as care for the same illness or ailment regardless of the payment methodology.

There are many examples like this. All this is to say that we who represent rural people, communities and providers must be more forceful in our presentation of rural needs. We understand the problems facing our country. At the same time, we experience daily the fact that rural programs simply have not been equitably funded. While we in rural America have always been willing to do our part, we simply cannot function without adequate health care. Health care currently is among the two or three largest employers in rural America. No rural community can engage in economic development or growth without the basic building blocks of quality, accessible health care and good educational facilities. We also know that when our urban counterparts travel to rural America to visit and experience our communities, they also expect at least quality emergency health care services should the need arise.

This is a crucial year for health care in general. It is a critical year for rural health care. Any time a business closes, it is traumatic for the community where the business is located. When that business is involved in health care, because of the very personal nature of health care, it is even more traumatic. When a provider in a larger city closes, as traumatic as that is, there are generally other providers to provide those services. When a provider closes in rural America, there generally is no one to replace those services. When a rural hospital closes, the community generally loses those critical services without any real hope of replacing those services. If the ‘super committee’ just appointed in Congress cannot come to an agreement on how to meet the budget reduction goal of $1.2 Trillion by November 23, 2011 an automatic sequestration process will occur, reducing government spending programs essentially cutting an equal basis from both military spending and domestic spending. This sequestration process is estimated to cause an automatic reduction of 2% from Medicare. This 2% reduction in the amount of approximately $10 Billion would reduce $200 Million from Critical Access Hospitals. This would likely result in an immediate closure of forty CAHs with the immediate impact of the loss of 5,764 hospital jobs. In that event, “… the rippling effect in those communities alone could total near 8,000 jobs with an economic loss of over $400 Million.”

We value our free and open lifestyle in rural America. We value the communities we live in. We value the compassion and concern shown for each other in rural communities. We value the work ethic, the real family values and the real sense of community we find in rural America. For these reasons and many others, we must continue to advocate for rural health. Please let your voice be heard.

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