

Rural Healthcare, Critical Access & the Future

RWHC Eye On Health



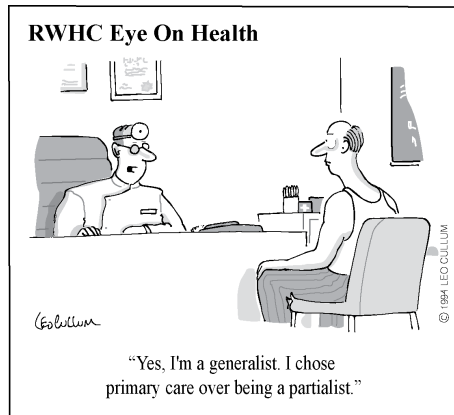
Tim Size
Executive Director
Rural Wisconsin
Health Cooperative
Sauk City

ACHE Leadership Day
Prairie du Chien
Memorial Hospital
August 24, 2012

Presentation Overview

- I. Perspective of Speaker & RWHC
- II. Brief Overview of Rural Health
- III. Critical Access Hospital Fundamentals
- IV. What Can Rural Expect in the Future?

I. Perspective of Speaker: RWHC



Our work at RWHC is based in the context of rural health and on the evidence. But like us all—our beliefs, stated purpose, values and economic realities create a complex set of forces that drives that work.

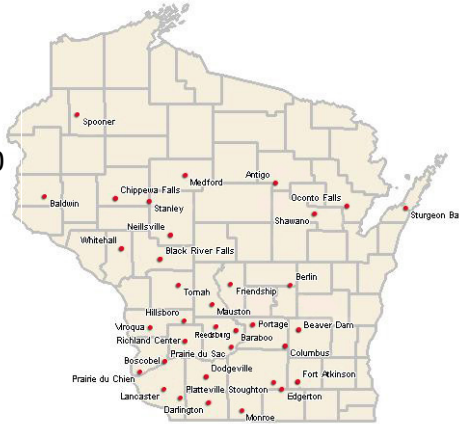
RWHC Mission & Vision

Mission: Rural WI communities will be the healthiest in America.

Vision: RWHC is a strong and innovative cooperative of diversified rural hospitals; it is (1) the "rural advocate of choice" for its Members and (2) develops & manages a variety of products and services.

RWHC by the Numbers

- Founded in 1979 for advocacy & shared services.
- Non-profit cooperative owned by 35 rural hospitals.
- 8 PPS & 27 CAH, about 50/50 “independent”/system.
- RWHC budget ≈ \$11 million with ≈ 60 FTE.
- Revenue ≈ 70% member; 20% other sales; 5% dues, 5% grants.



RWHC Shared Services*

Professional Services

Financial & Legal Services
Negotiation with Health Insurers
Medical Record Coding,
Workforce Development

Educational

Professional Roundtables & Leadership Training
Nurse Residency Program & Preceptor Workshops
Lean Lab (with Lean Six Sigma Master Black Belt)

Quality Programs

Credentials Verification & Peer Review Services
Quality Indicators & Improvement Programs

Technology Services

Data Center Services
Electronic Medical Records & Technology Management

** Partial List*

RWHC Advocacy Agenda

1. Federal **Healthcare Reform** that recognizes rural realities.
2. Fair **Medicare & Medicaid** payments to rural providers.
3. Rural sensitive **Federal & State regulations**.
4. Non-profit hospitals retain **property tax exemption**.
5. Solve growing **shortage of rural physicians and providers**.
6. Bring rural voice to **regional provider networks & payers**.
7. Bring a rural voice into the **quality improvement** movement.
8. Continue push for workplace and community **wellness**.
9. Strong link between **economic development** and rural health.

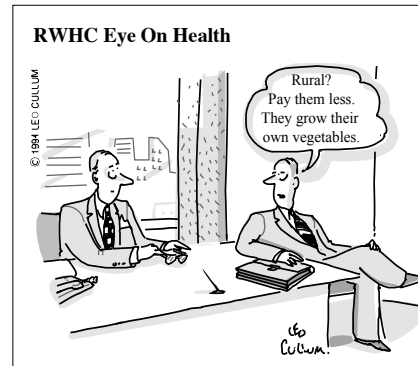
RWHC Strategic Partners

- Cooperative Network
- Federal Office of Rural Health Policy
- La Crosse Med. Health Science Consort.
- Marquette University
- Medical College of WI
- MetaStar, Inc.
- National Cooperative of Health Networks
- National Rural Health Resource Center
- National Rural Health Association
- UW School of Medicine & Public Health
- UW School of Nursing
- UW School of Pharmacy
- WI Area Health Education Centers
- WI Center for Nursing
- WI Collaborative for Healthcare Quality
- WI Council on Workforce Investment
- WI Dept of Health Services
- WI Dept of Workforce Development
- WI Dept Safety & Professional Services
- WI Hospital Association
- WI Health & Ed. Facilities Authority
- WI Healthcare Data Collaborative
- WI Medical Society
- WI Office Rural Health
- WI Primary Care Association
- WI Public Health Association
- WI Rural Health Development Council
- WI Statewide Health Info. Network

II. Brief Overview of Rural

Ongoing Need for Rural "Myth" Busting

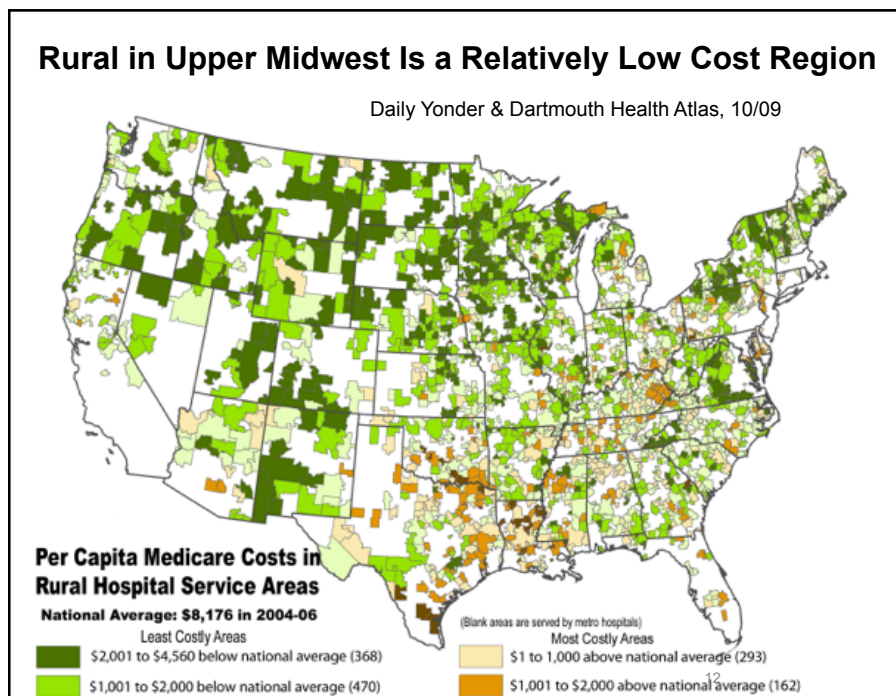
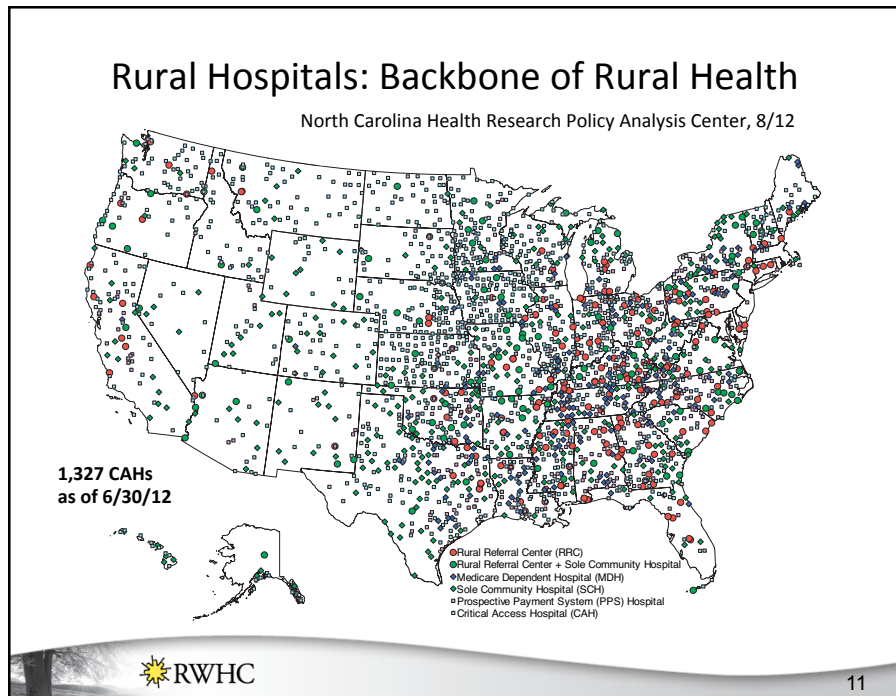
- Rural residents don't want to get care locally.
- Rural folks are naturally healthy, need less.
- Rural health care costs are less than urban care.
- AND Rural health care is inordinately expensive.
- Rural quality is lower; urban is better.
- Rural hospitals are just band-aide stations.
- Rural hospitals are poorly managed/governed.



Rural Health Has a Lot to Brag About

- Approximately \$2.2 billion in annual cost differential (savings) occurred in 2010 because the average cost per rural beneficiary was 3.7% lower than the average cost per urban beneficiary.
- Rural hospital performance on CMS **Process** of Care measures is **on par** with urban hospitals.
- Rural hospital performance on CMS **Outcomes** measures is **better** than urban hospitals.
- Rural hospital performance on **HCAHPS** inpatient experience survey measures is **better** than urban hospitals.
- Rural hospital performance on **price and cost efficiency** measures is **better** than urban hospitals.

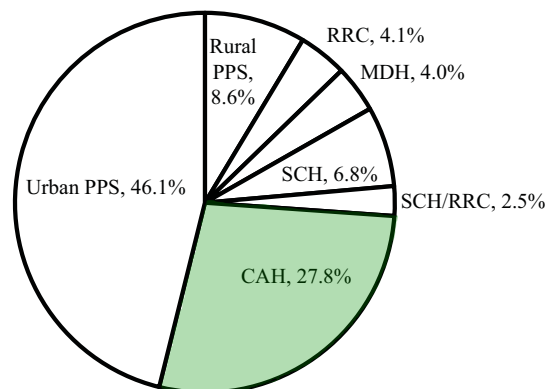
"Rural Relevance Under Healthcare Reform"
(based on Medicare Shared Savings Data Files) 1/23/12
<http://www.ivantagehealth.com/>



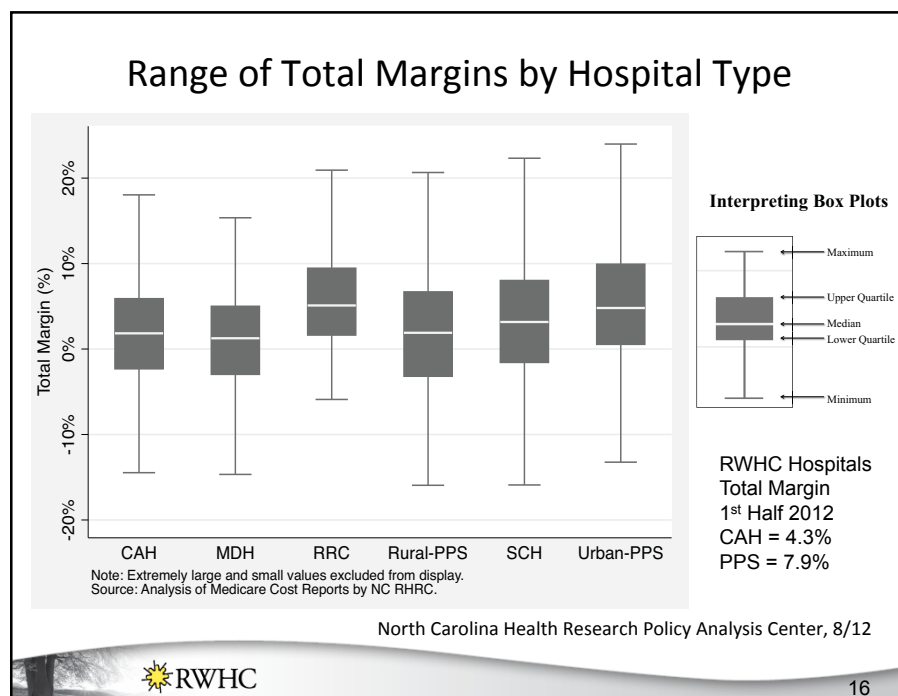
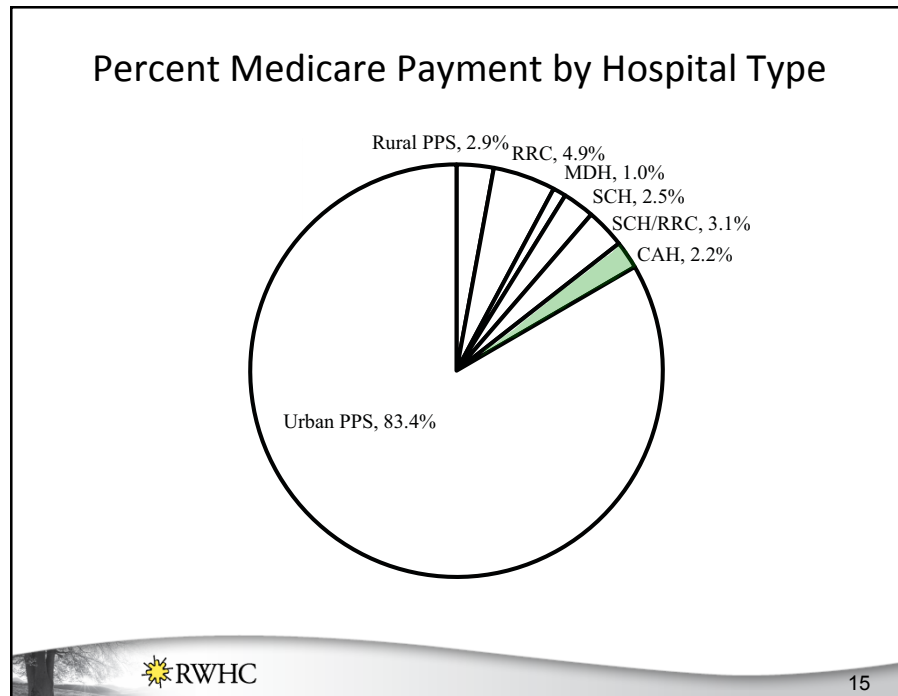
Urban & Rural WI Hospitals Are Leaders

- High overall quality (2nd in 2011 - AHRQ)
- Low rate of uninsured (tied for 4th in 2010)
- Low cost state in Medicare program
- Relatively strong physician/hospital cooperation
- Hospitals'/systems' relatively better finances
- Robust adoption of HIT, especially with EHR
- Supportive tort environment
- Leadership promoting county health rankings

Percent Hospitals by Type



North Carolina Health Research Policy Analysis Center, 8/12



Overview of Rural Hospital Services

TABLE 3-2

Shares of urban and rural hospitals offering specific services, 2005-2010

Type of service	Urban		Rural	
	Percentage of hospitals in 2010	Percentage point change 2005-2010	Percentage of hospitals in 2010	Percentage point change 2005-2010
High-tech services				
Robotic surgery	36%	22	2%	1
PET or PET/CT scanner	60	10	16	4
MRI	93	3	85	9
Core services				
Palliative care	54	9	22	2
Indigent care clinic	37	9	11	4
Orthopedics	87	5	60	8
Open heart surgery	48	5	4	1
Cardiac catheterization	63	4	7	0
Oncology	76	1	39	2
Geriatrics	53	1	32	-1
Trauma center	46	1	37	4
Post-acute services				
Skilled nursing	35	-6	43	-3
Home health	61	-3	56	-5

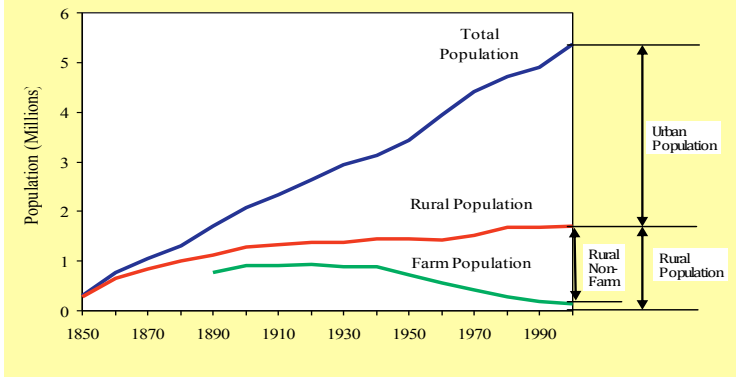
MedPAC: March, 2012



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USA Less Rural & Rural Farms Less

Population by Rural and Farm Residence, Wisconsin: 1850 to 2000



Gary Paul Green, UW-Madison/Extension
Presentation in Mosinee, 1/12-13/06



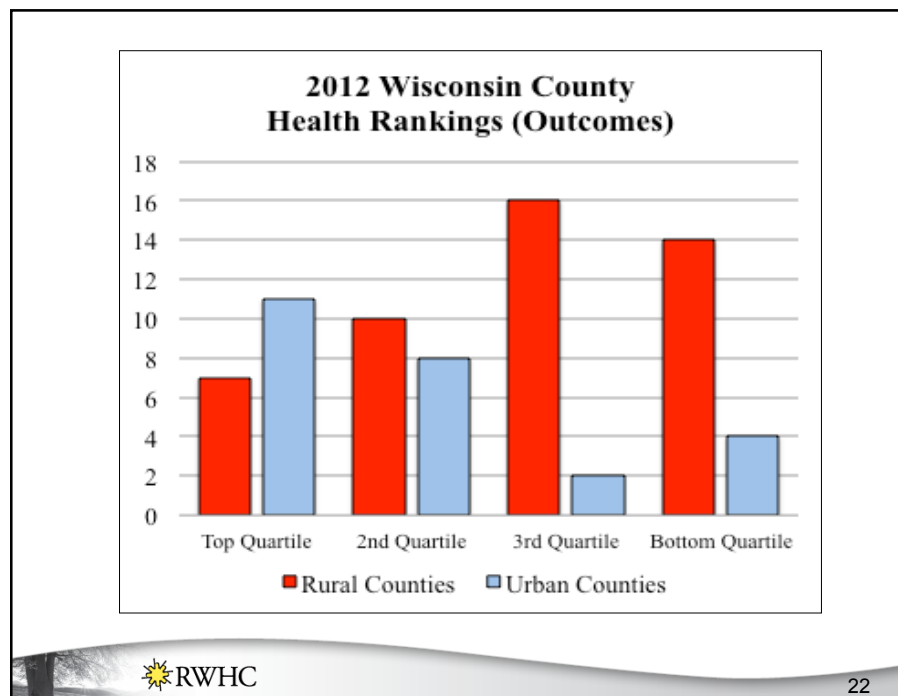
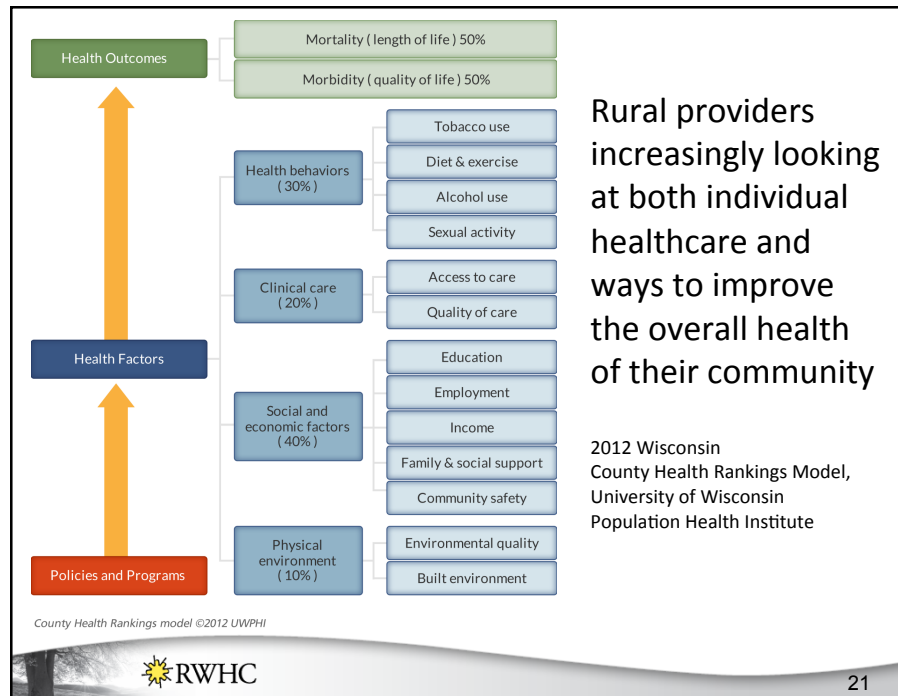
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Rural = < Access, > Risk, > Mortality

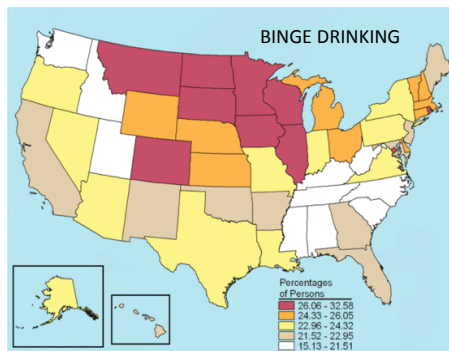
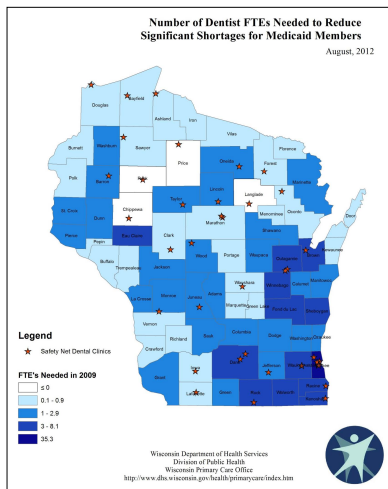
National Rural Health Snapshot – 2010 www.hhs.gov/ncsc/rural/snapshot.html				
Access to Health Services				
	Rural % population	Non-Rural % population	Rural Rate Higher Than Non-Rural	
No form of health coverage (age 18-64 years)	20.6	17.0	21.2%	
Needed to see doctor but could not because of cost—past year	15.6	13.6	14.7%	
No personal doctor	18.1	19.3	-6.2%	
No dental care in previous year	35.6	28.3	25.8%	
Health Behavior/Risk Factors				
	Rural % population	Non-Rural % population	Rural Rate Higher Than Non-Rural	
Current Smoker	22.0	17.8	23.6%	
Obese (Body Mass Index ≥30)	30.5	25.9	17.8%	
Age-Adjusted Mortality				
	Rural per 100,000 population	Non-Rural per 100,000 population	Rural Rate Higher Than Non-Rural	
All-cause	893.8	823.1	8.6%	
Infant (age<1)	755.0	690.9	9.3%	
Diseases of the heart	249.4	230.2	8.3%	
Diabetes mellitus	27.6	24.6	12.2%	
Chronic obstructive pulmonary disease (COPD)	49.0	42.2	16.1%	
Unintentional Injuries (including motor vehicle traffic)	51.9	34.7	49.6%	
Suicide	13.4	10.3	30.1%	

Rural Health Care Also About Rural Jobs

- **Rural health is an “export commodity”:** insurance premium and tax **dollars only come back to circulate in the community and create jobs if there are local health care providers** there (and people use them) to attract those dollars.
- For every rural primary care physician, another 23 jobs are created (FORHP, '12); a **rural hospital's closure is same as a 4% tax in loss of community income** (UNC, '06).
- **Bottom line: Rural America is affected by where our health care dollars are spent; rural communities are hurt badly when policy and politics ignore the local economic impact of rural health.**



Rural Wisconsin Faces Significant Challenges



The state dental association and tavern league may look at these maps differently.

III. Critical Access Hospitals



CAHs are a distinct Medicare provider type with a cost based payment method. Conditions of Participation **basically same except: 25 bed max. and average 96 hr. LOS max.**

The History of CAHs before 1997 (1 of 2)

1946 The Hill–Burton Act financed the vast majority of hospitals built in rural America following World War II.

1965 “Medicare was established, adopting the private health insurance sector’s ‘retrospective cost-based reimbursement’ system to pay for hospital services.”

1982 “Congress mandated the creation of a prospective payment system (PPS) to control costs—a per-case reimbursement mechanism called diagnosis-related groups (DRGs). In this DRG prospective payment system, Medicare pays hospitals a flat rate per case for inpatient hospital care so that ‘efficient’ hospitals are rewarded.

Office of Inspector General, 8/01

The History of CAHs before 1997 (2 of 2)

In **1988** “Montana Hospital Research and Education Foundation designed a demonstration of a hospital called a medical assistance facility (MAF) that received cost-based reimbursement from Medicare. MAFs were isolated, limited-service hospitals that could admit patients for no more than a four-day length of stay. In **1989** Congress authorized the Rural Primary Care Hospital (RPCH) program, a second demonstration program for small, rural hospitals would receive cost-based payments from Medicare. In **1997**, the Balanced Budget Act of 1997 merged the MAF and RPCH programs into Critical Access Hospitals (15 acute bed limit).”

MedPAC, October, 2002

CAH Law Never Quiet for Long

- Balanced Budget Act (BBA), '97
- Balanced Budget Refinement Act (BBRA), '99
- Benefits Improvement and Protection Act (BIPA), '00
- Medicare Prescription Drug, Improvement, and Modernization Act (MMA), '03
- The Medicare Improvements to the Patients and Providers Act, '08
- Conrad Improvement Act, '08
- Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, '08
- American Recovery and Reinvestment Act (ARRA), '09

<http://www.aha.org/>



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Startup: Balanced Budget Act (BBA), '97

- CAHs receive reimbursement of “reasonable” costs.
- CAHs must be located in a rural area > 35 mile distance from another hospital, or 15 miles in mountainous terrain or areas with only secondary roads.
- Must have 15 or fewer acute inpatient care beds (or, in the case of swing bed facilities, up to 25 beds).
- Must restrict patient length of stay to no more than 96 hours unless a longer period is required due to emergency conditions is waived.
- Must offer 24-hour emergency services.
- Must be owned by a public or nonprofit entity.

<http://www.aha.org/>



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Major Improvements with BBRA, '99

- Replaced 96 hour LOS limitation per patient with an annual average.
- Permitted CAHs to bill at the all-inclusive rate or continue to bill hospital and physician services separately.
- Granted CAH status to hospitals that have closed in the past 10 years or downsized to a health clinic or center.
- Allowed CAHs to continue providing long-term care services via the swing bed program and not under PPS.
- Extended CAH eligibility to for-profit hospitals.

<http://www.aha.org/>



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Big Gains & Tradeoffs with MMA, '03

- Flexibility for **25 beds** as acute care inpatient beds.
- Increase CAH **reimbursement to cost plus 1%**.
- Provide cost-based reimbursement for certain emergency room staff who are on-call.
- Reinstate the Periodic Interim Payments (PIPs).
- Expand by 15% billing for outpatient services to any practitioner who assigns billing to CAH.
- Permit CAHs to operate Psychiatric and/or Rehabilitation (DPUs) of up to 10 beds.
- **Eliminate state authority to waive 35-mile rule** (1/06).

<http://www.raonline.org/>



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“Rest of the Story” (1 of 4)

1983 Medicare payment equity became an issue when with PPS introduced based on model developed for large tertiary hospitals in New England-**closures start.**

1985 NRHA and Rural Wisconsin Hospital Cooperative (RWHC)* “challenged the justice of a system based on two national rates perpetuating historical urban and rural payment inequities not related to legitimate wage or intensity differentials.” We 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.” ***Harold Brown & AHA**

“A Pause On The Road To Rural Hospital Equity”
National Rural Health Association,
Newsletter, Oct-Dec 1992



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“Rest of the Story” (2 of 4)

1987 In good part fueled by the equity issue, the National Rural Primary Care Association and American Small and Rural Hospital Association merge to form the National Rural Health Association (NRHA), creating a “new unified voice for rural health.”

1987 NRHA to develop a class-action suit advocated by RWHC against the Department of Health and Human Services for a Constitutional “unjust taking of property” due to a failure to provide just compensation to rural hospitals for services to Medicare patients.



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“Rest of the Story” (3 of 4)

1988 The Dartmouth Atlas of Health Care: “The reality of health care in the United States is that geography is destiny. The amount of care consumed by Americans depends more on where they live—the local supply of resources and the prevailing practice style—than on their needs or preferences.”

1998 In a Budget Resolution, the United States Senate recognized that while “all Americans pay the same payroll tax of 2.9 percent to the Medicare trust funds and deserve the same choices and services regardless of where they retire, some regions receive 2.5 times more in Medicare reimbursements than others.”

“Rest of the Story” (4 of 4)

2000 RWHC “Business Card” states that “Medicare spending in Wisconsin per beneficiary was 7th from the bottom—\$4,319 in Wisconsin vs. \$5,541 nationally. Wisconsin is penalized for our more efficient provider systems and for ongoing inequitable federal payment policies, particularly the application of technically flawed adjustments for regional wage differences.”

2003 “I will insist our rural policies be conferenced first.” Opening Floor Statement of U.S. Sen. Chuck Grassley of Iowa, Chairman, Senate Committee on Finance, 6/17/03. Paul Ryan did the heavy lifting in the House.

Challenges Facing CAHs - I

Cost reimbursement is a blessing and a curse – “You don’t lose money on Medicare services, but you also do not make any (even considering the 1% over Medicare cost), so there is no contribution to margin. The more Medicare business that you have, the harder it becomes to generate operating margin. Providing non-hospital services can become a challenge due to the absorption of overhead costs required by Medicare cost accounting.”

Rich Donkle, RWHC Director
of Financial Consulting Services



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Challenges Facing CAHs – (1 of 4)

Operating within regulatory constraints – “The 25 bed (physical beds) limit can present a challenge if a variety of patients are served, such as OB, ICU, surgical and medical. The uncertainty that accompanies the relocation of a CAH (not knowing for certain that you will maintain status until after the relocation is complete). In addition, CMS seems to come up with ways to complicate operating as a CAH (physician supervision requirements for example).”

Rich Donkle, RWHC Director
of Financial Consulting Services



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Challenges Facing CAHs – (2 of 4)

Non-acute services absorb disproportionate amount of costs – “Medicare uses full absorption cost accounting, not discrete or incremental costing, so non-hospital services are allocated overhead costs in the same manner as if they were hospital services. This makes the provision of services such as SNF, assisted living, and even a home meals program a challenge to provide under the umbrella of the hospital corporation.”

Rich Donkle, RWHC Director
of Financial Consulting Services



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Challenges Facing CAHs – (3 of 4)

Maximizing cost reimbursement can bring unintended consequences – “Maximizing Medicare cost reimbursement means minimizing non-Medicare cost reimbursed services. OB, Psych, SNF and other non-hospital services are all ‘losers’ when it comes to cost reimbursement. Even increasing non-Medicare acute hospital patient days can have a detrimental impact on Medicare cost reimbursement.”

Rich Donkle, RWHC Director
of Financial Consulting Services



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Challenges Facing CAHs - (4 of 4)

Impact of Medicare Advantage Plans – "Currently, Medicare Advantage Plans reimburse at levels equivalent to regular Medicare, but without an actual cost settlement. This means that a hospital may get paid more or less than cost depending on its interim rates from Medicare. Cost reimbursement, or its proxy, is more costly for Medicare Advantage Plans, so they have an incentive to try to have patients treated elsewhere. They have to balance this with keeping patients in their plan, but this can pose a threat to a CAH with a lot of Medicare Advantage Plan patients in their service area."

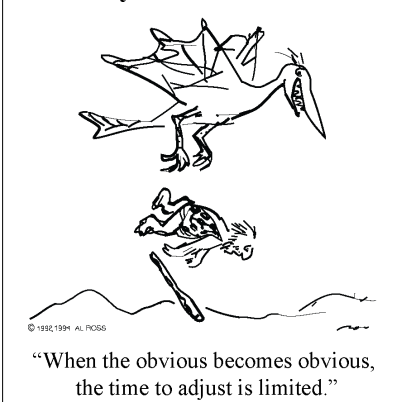
Rich Donkle, RWHC Director
of Financial Consulting Service



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The Future for Rural Health?

RWHC Eye On Health



Rural Health is not exempt from the alignment of forces driving reform—better individual health care, better population health and lower costs (the Institute for Health Improvement & CMS' Triple Aim).



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Future: Information Used to Manage Care

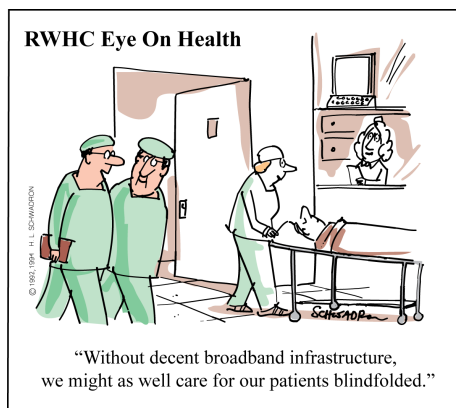
- Patients engaged in their own care plans (patient responsibility promoted by the system) and patient needs met (better care).
- Seamless transfer of clinical and administrative information among providers.
- Health information readily available in rural places and understandable to individual patients.
- Transparency of health care cost and quality information, access to proactive disease management and prevention assistance.

"The High Performance Rural Health Care System of the Future," RUPRI Health Panel, 9/2/11



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The Rural/Urban Digital Divide Continues



"ARRA provides CAHs, which have the lowest EMR adoption rates of any hospitals surveyed by HIMSS Analytics, with a fraction of the incentives that PPS hospitals will receive."

"Rural Health IT Blog" by Louis Wenzlow,
RWHC Director of Health Information Technology,
11/10/09



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Future: Paying for Value

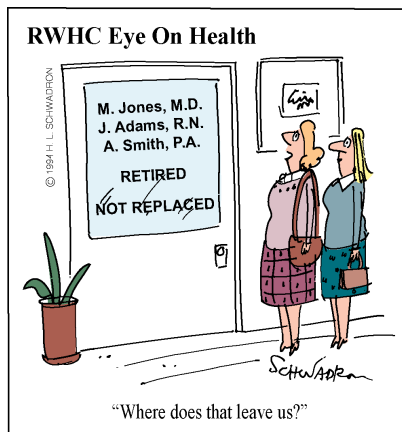
- Service will be accessed based on patient experience, care quality, and delivery efficiency.
- Health care value, not simply service volume, will drive payment.
- Rural health care systems will be organized around a robust primary care base.
- The focus will be on care in the community, supported by the hospital—anchored in primary care.

"The High Performance Rural Health Care System of the Future," RUPRI Health Panel, 9/2/11



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Even if ACA Survives, Coverage ≠ Access



Workforce shortages hit rural first, harder and longer:

Currently

Primary Care, Dental,
Mental Health,
Pharmacy & EMS

Coming Our Way

General Surgery & Nursing



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Future: Collaborating to Integrate Services

- Collaborative provider will deliver the continuum of care seamlessly to patients.
- Rural providers will collaborate locally for improved health outcomes and better financial performance.
- Rural providers will collaborate vertically to ensure timely access to services not available locally.
- Urban systems will collaborate with rural health systems to meet performance and financial goals.
- Rural providers will collaborate horizontally when negotiating with distant and/or urban systems.

"The High Performance Rural Health Care System of the Future," RUPRI Health Panel, 9/2/11

Competition and Cooperation Coexist



Future: Healthy People / Healthy Communities

- Providers and patients will connect to community health resources to improve individual health.
- Providers and the community will "go upstream" to address factors that influence population health.
- In concert with clinical quality and efficiency metrics, rural communities will employ metrics that assess these more global outcomes.
- Rural providers and their communities will partner in creating healthier communities.

"The High Performance Rural Health Care System of the Future," RUPRI Health Panel, 9/2/11



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Healthcare Reform ≠ Health Reform



"We must provide education and preventive care, help all reach highest potential for health and reverse the trend of avoidable illness. Individuals must achieve healthier lifestyles; take responsibility for health behaviors and choices... and act."

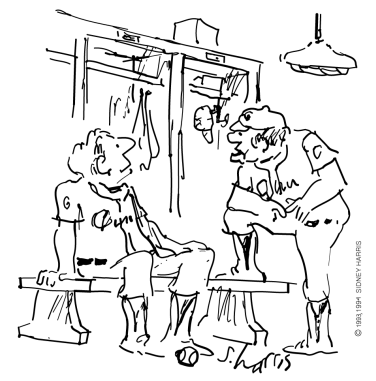
American Hospital Association's "Health for Life, Better Health, Better Health Care" August, 2007




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Vision Matters

RWHC Eye On Health




"I knew I was going to take the wrong train, so I left early." (Yogi Berra)

 **RWHC**

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Rural Health On-line Resources

- **RWHC Web:** <http://www.rwhc.com/> For the free **RWHC Eye on Health e-newsletter**, email office@rwhc.com with "subscribe" on subject line.
- **Wisconsin Office of Rural Health:** <http://worh.org/>
- **Rural Assistance Center** at www.raconline.org/ is an incredible federally supported information resource.
- **Health Workforce Information Center** www.healthworkforceinfo.org/
- **The Rankings & Roadmaps Team**
www.countyhealthrankings.org/roadmaps/action-center
- **Association for Community Health Improvement**
www.communityhlth.org/
- **Wisconsin State Journal Special Report: "Rural Health"**
http://host.madison.com/special-section/rural_health/

 **RWHC**

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