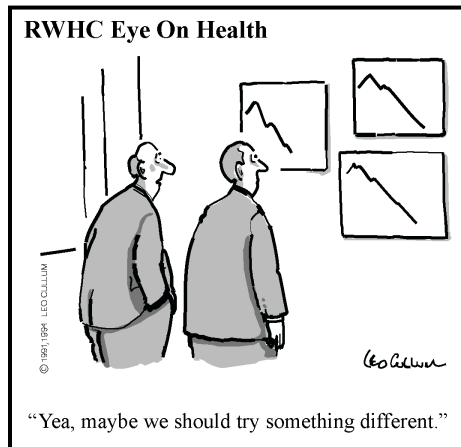




How are Federal & State Policies Likely to Affect Rural Health?



Tim Size
Executive Director
RWHC

for the
Sauk County
Institute of Leadership
March 12th, 2009



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Talk Outline: A Mix of Opportunities & Challenges

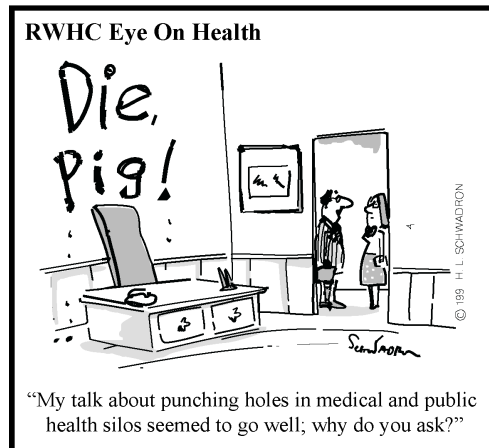
1. Context Matters – RWHC Turns 30 in 2009
2. Why Change on Multiple Fronts?
3. Federal & State Health Reform Overview
4. From Reimbursement to Transparent Payment
5. Quality or Price, “Show Me the Numbers”
6. Workforce: Supply Going Down, Demand Up
7. Healthcare Reform ≠ Health Reform



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1. Context Matters – RWHC Turns 30 in 2009



Advocacy at
RWHC is based
on the evidence
but like us all,
we have a set of
experiences and
beliefs that
drive our work.



RWHC Mission & Vision

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

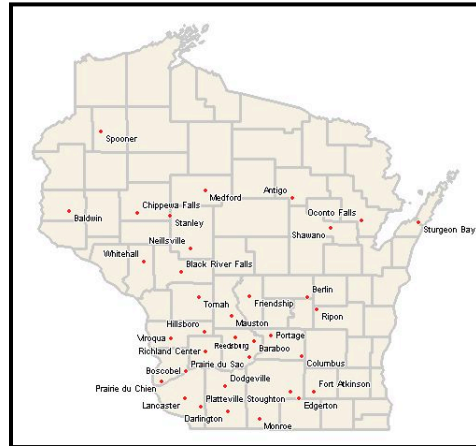
Vision: RWHC is a strong and innovative cooperative of diversified rural hospitals; it is (1) the “rural advocate of choice” for its Members and (2) develops & manages a variety of products and services.





RWHC by the Numbers

- Founded 1979
- Non-profit coop owned by 35 rural hospitals (net rev \approx \$3/4B; \approx 2K hospital & LTC beds)
- \approx \$7M RWHC budget (\approx 70% member fees, 20% fees from others, 5% dues, 5% grants)
- 6 PPS & 29 CAH; 24 freestanding; 11 system owned or affiliated



2. Why Change on Multiple Fronts?

RWHC Eye On Health



“Tell me again, who is reforming whom?”

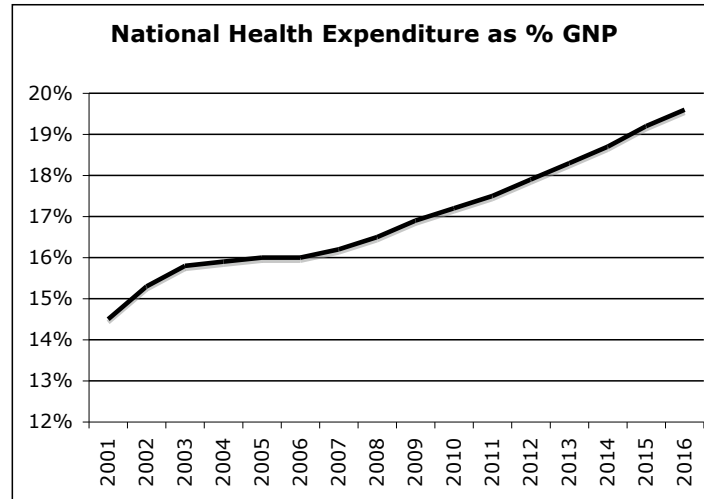
“Without change, America’s health care capabilities and finances will be overwhelmed.”

American Hospital Association’s “Health for Life, Better Health, Better Health Care” August, 2007





Spending Trend Is Widely Seen as Unsustainable



Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at <http://www.cms.hhs.gov/NationalHealthExpendData/>



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Medicare Hospital Insurance Trust Fund Tanking

- In 2013, starts running an annual deficit
- In 2019 years, runs out of money
- Long-term actuarial balance required in 2007
 - an immediate 122% increase in the payroll tax,
 - or an immediate 51% percent reduction in program outlays
- Guess who will take the financial hit (and it won't mostly be the taxpayer or beneficiary)?

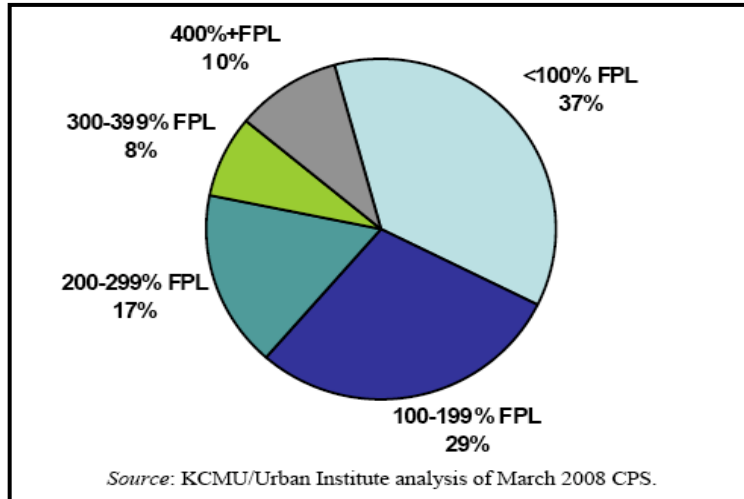
2007 Annual Report, Social Security and Medicare Boards of Trustees



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15% of America Uninsured—46 Million & Growing



Gaps in Where We Need to Be (1 of 2)

Principle	Wisconsin Status/Gap
Access to coverage	5.5% uninsured rate; 18/19% for poor/near poor; 4% non-poor
Sustainability of cost trends	Drivers are demographics, technology, & inappropriate care
Government has a role	Fails at guaranteeing access, funding education, adequate payment
Individuals have a role	Pay small portion of their costs; healthy lifestyles not a norm; are not sophisticated HC shoppers

Presentation by George Quinn to WHA Task Force
on Access & Coverage, April 23rd, 2008





Gaps from Where Wisconsin Needs to Be (2 of 2)

Principle	Wisconsin Status/Gap
Providers have a role	Wide variation in HC practice; are increasingly transparent and accountable
Employers have a role	Only 70% provide coverage; little use of incentives for choosing lower cost plans, etc; wellness programs in infancy
Payers have a role	Payment still based on units of service; little use of P4P
Diffusion of technology	Surveys show relatively high and growing use of IT, with higher use among larger organizations

Presentation by George Quinn to WHA Task Force
on Access & Coverage, April 23rd, 2008



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Why Reform May Likely Still Be Incremental

“Despite the prominent role that health care reform is playing in the 2008 presidential election, leading pollsters agree that deep partisan divides & a worsening economy limit major change.” Health Affairs, May/June, 2008

“Altman Conundrum: Various groups advocating different programs to cover the uninsured do indeed represent a majority view. But for each group, the next best alternative to its preferred solution is to do nothing, and no single group constitutes a majority.” Mark Pauly on Stuart Altman, renown economist, Brandeis University.



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3. Federal & State Health Reform Overview



A common thread in “reform” from the “left,” “right” and “middle” is that American “healthcare” delivers pretty much what it is financially incented to deliver.



Policy Options to Limit Health Spending (1 of 2)

Very limited impact (in short run)

- Encourage greater use of preventive services

Limited impact

- Provide better price and quality information
- Require patients to pay more
- Restrict use of harmful care
- Create a governmental “high cost reinsurance system” with effective case management for chronic conditions
- Reduce expense/waste of medical malpractice system
- Pay-for-performance reimbursement

Presentation by Stuart Altman to Massachusetts’s Health Care Quality and Cost Council, 9/07.





Policy Options to Limit Health Spending (2 of 2)

Greater impact

- Restructure delivery system (integrated care)
- Develop government programs to conduct “comparative effectiveness studies”
- Restrict use of marginally useful care
- Limit supply of expensive services

Greatest potential

- Regulate payments to providers
- Establish global budgets

Presentation by Stuart Altman to Massachusetts’s Health Care Quality and Cost Council, 9/07.



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Outline of Obama Health Plan (1 of 3)

The plan creates a 10-year reserve fund of \$630 billion to finance health reform efforts, with half of that amount coming from new revenues such as higher taxes on wealthier Americans, and the other half from Medicare program savings including:

- Bundling payments for hospital care and post-acute care
- Cutting payments to Medicare Advantage plans
- Paying hospitals with certain readmission rates less.
- Linking a portion of inpatient payment to performance.

In order to achieve the common goals of constraining health care costs, expanding access, and improving quality, he will work with Congress over the next year using the following set of eight principles:

President's Budget Remarks, politico.com, 2/26/09



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Outline of Obama Health Plan (2 of 3)

Protect Families’ Financial Health. The plan must reduce the growing premiums and other costs paid for health care.

Make Health Coverage Affordable. The plan must reduce high administrative costs, unnecessary tests and services, waste, and other inefficiencies that consume money with no added health benefits.

Aim for Universality. The plan must put the United States on a clear path to cover all Americans.

Provide Portability of Coverage. People should not be locked into their job just to secure health coverage; end preexisting conditions.

Guarantee Choice. The plan should provide Americans a choice of health plans and physicians. They should have the option of keeping their employer-based health plan.

President’s Budget Remarks, politico.com, 2/26/09



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Outline of Obama Health Plan (3 of 3)

Invest in Prevention and Wellness. The plan must invest in public health measures proven to reduce cost drivers in our system—such as obesity, sedentary lifestyles, and smoking—as well as guarantee access to proven preventive treatments.

Improve Patient Safety and Quality Care. The plan must ensure the implementation of proven patient safety measures and provide incentives for changes in the delivery system to reduce unnecessary variability in patient care. It must support the widespread use of health information technology and the development of data on the effectiveness of medical interventions to improve the quality of care delivered.

Maintain Long-Term Fiscal Sustainability. The plan must pay for itself by reducing the level of cost growth, improving productivity, and dedicating additional sources of revenue.

President’s Budget Remarks, politico.com, 2/26/09



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Medicare Reform: Current & Proposed

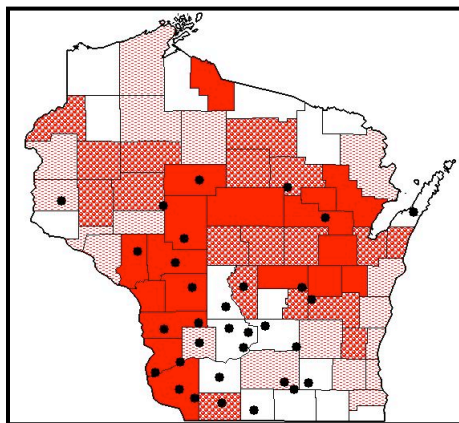
- Medicare Advantage (aka Medicare privatization)
- Value Based Purchasing (aka P4P)
- *Medical Home: pmpm fee care coordination
- *Primary Care: +\$ with modifier to CPT codes
- *Bundling: one payment for episode of care that combines hospital, physician and post hospital
- *Medicare as leverage on entire health system

* Medicare Payment Advisory Meeting Minutes for April 9th, 2008



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Medicare Advantage Market Share by WI Counties



CMS Estimates as of 3/08

Average = 22%

Lowest Quartile (white)

8% to 19%

Second Quartile

19% to 23%

Third Quartile

23% to 29%

Highest Quartile (red)

29% to 58%

- RWHC Members



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SB562: Healthy Wisconsin Authority & Plan

- Healthy Wisconsin Authority: public board with 5 labor + 5 business + 2 farmers + 3 consumers. (Providers only on an advisory committee).
- Healthy Wisconsin Plan: same as current state employee health benefits paid for by employer tax.
- In each region a Fee For Service plan with provider rates set by HWA along with networks invited to submit bids.
- Users of lowest cost networks incur only standard co-pay and deductible; if not available, no added cost for FFS.
- I.e. default of “managed competition” is “single payer.”



Governor’s Incremental Reform to Cover 98%

- Phase I - BadgerCare+ for All Kids (2/1/08)
- Phase II - BC+ Childless Adults Expansion (1/1/09); waiver needed; individuals need to be uninsured for one year to prevent “crowd-out.”
- Phase III - BadgerChoice for Small Business (under development) A single community rated pool and buying group for about 800,000 individuals "to negotiate better rates from insurance companies ... and access affordable health insurance without having to pay broker fees or navigate through substantial paperwork." Subsidy for very small businesses (<10 employees).





4. From Reimbursement to Transparent Payment

RWHC Eye On Health



"Same problem. We were doing good until our patients couldn't afford us any longer."

Private & public sector payers are shifting to transparent payments through "Pay 4 Performance" & "Consumer Driven Health Plans" to create economic incentives for providers & patients.



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What is Pay 4 Performance?

RWHC Eye On Health



"I just don't see what's in it for us to care about helping people stay healthy."

- Financial incentives to improve quality of care as well as to control costs by reducing errors & inappropriate utilization.
- Steady increase nationally, already common in WI.
- Medicare calls it "Value Based Purchasing."

<http://www.ahrq.gov/>



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What is Consumer Driven Health Care?

- Stated purpose is to create new economic incentives by shifting cost/risk to the insured through increasing:
 - deductibles
 - co-payments or coinsurance for office visits
 - cost sharing for prescription drugs
 - the amount employees pay for premiums.
- Sometimes combined with a employer or employee funded Health Savings Accounts (HSAs) or employer funded Health Reimbursement Arrangements (HRAs).



Controversy Around Consumer Driven Health Care

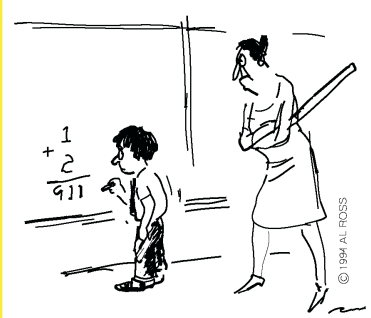
- An appropriate way for the insured to become better consumers?
- Nothing more than cost shifting to insured?
- A major health reform needed in America?
- No place in American health care?





5. Quality or Price? “Show Me the Numbers”

RWHC Eye On Health



One solution to a “small numbers” problem.

- Challenge: rural providers need to work collaboratively, harder and smarter to make up for fewer economies of scale and higher stand-by costs.
- Challenge: measures used to evaluate providers have often not addressed statistical issues of “small numbers,” mix of services and characteristics of population served.

“Small numbers are a big deal” by Tim Size,
Modern Healthcare, 5/14/07



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Quality Improvement? “Show Me the Numbers”

“Not everything that can be counted counts, and
not everything that counts can be counted.”

Albert Einstein

But what is reported, is changed!

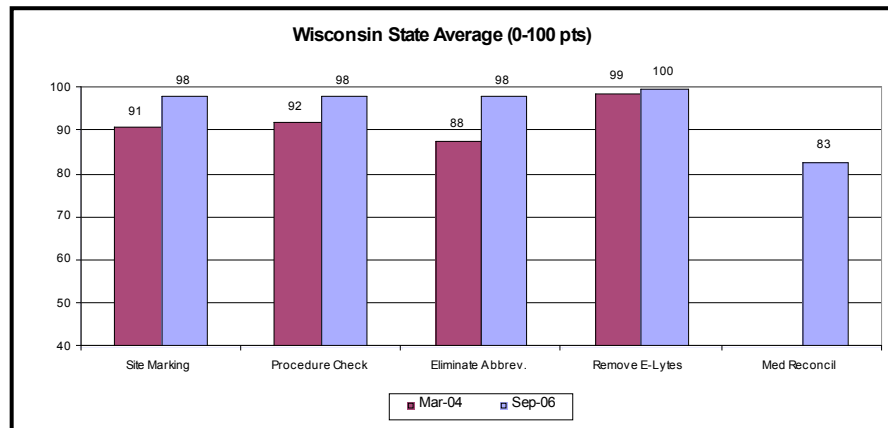
Dana Richardson RN, MHA, V.P. Quality, Wisconsin Hospital Association
To National Advisory Committee on Rural Health & Human Services, 9-13-07.



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WHA CheckPoint: Error Prevention



Dana Richardson RN, MHA, V.P. Quality, Wisconsin Hospital Association
To National Advisory Committee on Rural Health & Human Services, 9-13-07.



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Public Reporting Opportunities & Challenges

- Dysfunctional cacophony of measurement voices; multiple, similar demands is wasteful.
- All must have opportunity to demonstrate high quality of care and cost effectiveness.
- No Data = “Backwater Status”
- Rural providers must be “at the table.”
- Confounding factors need to be considered- sickest patients (dieing) may stay at hospital close to family others transferred out.

“Small numbers are a big deal” by Tim Size,
Modern Healthcare, 5/14/07



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6. Workforce Supply Going Down, Demand Up

RWHC Eye On Health

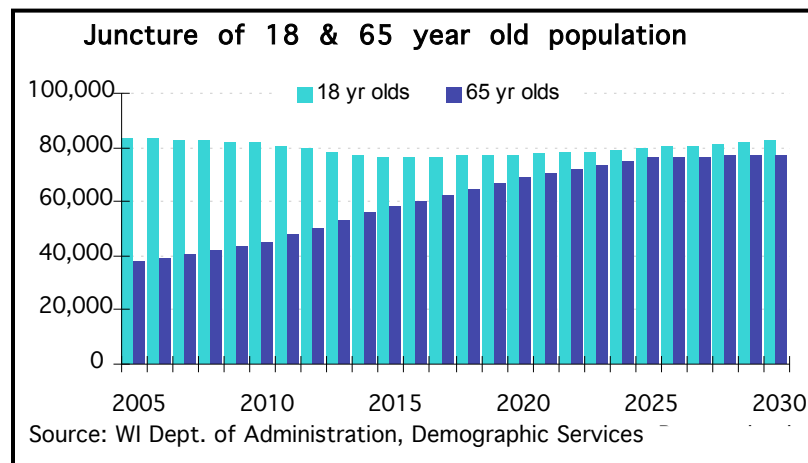


Attitudinal change
required for all
vocational and
professional
schools to fulfill
their major role in
increasing supply
and distribution.



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Workforce Retiring More Rapidly than Being Replaced



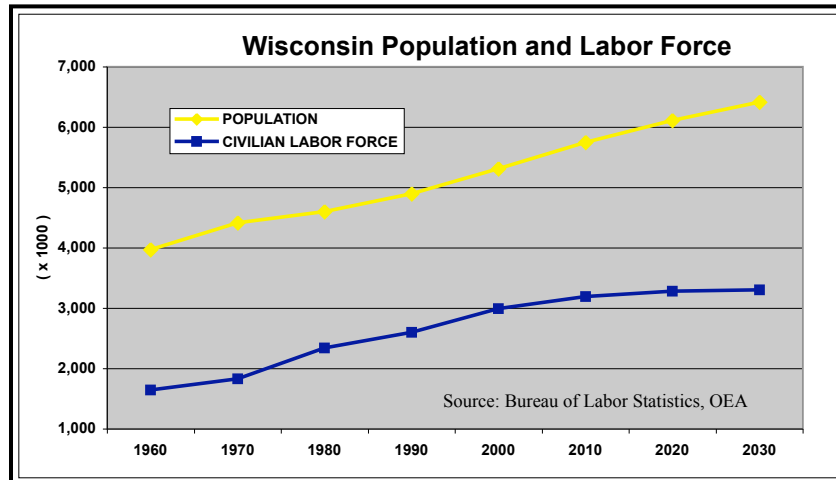
Dennis K. Winters, Chief, Office of Economic Advisors, Wisconsin
Department of Workforce Development to NACRHHS, 9-12-07.



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Workforce Growth Becomes Flat, Demand Grows



Dennis K. Winters, Chief, Office of Economic Advisors, Wisconsin
Department of Workforce Development to NACRHHS, 9-12-07.



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One Success Story; We Need More Of Them!

Wisconsin Academy for Rural Medicine

*Dedicated to improving the supply
of physicians in rural Wisconsin
and improving the health of rural
Wisconsin communities*



University of Wisconsin
School of Medicine and Public Health

- WARM is dedicated to improving the supply of physicians in rural WI & health of rural WI communities.
- Students receive extensive clinical training in rural Wisconsin during 3rd & 4th yrs.
- Students will learn to address medical issues that are unique to rural areas.
- Only rural focused program in the nation that supports a student's pursuit of any specialty.



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Retention, Recruitment & Continuing Education

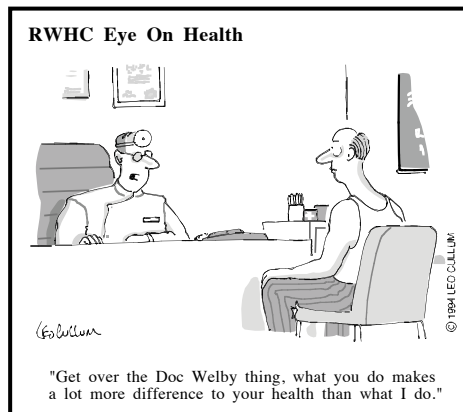
- Advisory Board memberships (Health Care Advisory Board, Nursing Executive Center, HR Investment Center)*
- Club Scrub*
- Healthy WI Leadership Institute*
- Retire & Departure Plan Surveys
- Rural Health Careers Web Site*
- RWHC Distance Learning Opportunities
- RWHC Education Coordinator
- RWHC H2H (Hospital to Hospital CEO Visits)
- RWHC Roundtables
- RWHC Workforce Development Coordinator_
- WI Academy Rural Medicine*
- WI Nurse Preceptor Training*
- WI Nurse Residency Program*
- WI Office Rural Health Physician Recruitment Service*
- WI Pharmacy Forum*
- WI Select Committee on Health Care Workforce Development*
- WI State Lab. Response Network*

* Program started or operated by or with a strategic partner.



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7. Healthcare Reform \neq 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.”

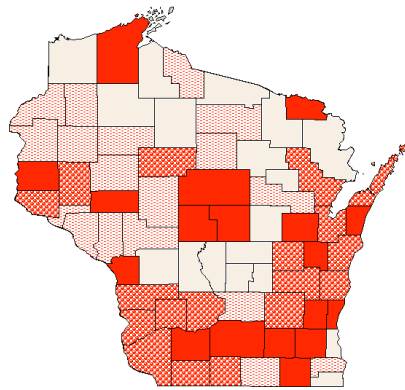
American Hospital Association's "Health for Life,
Better Health, Better Health Care" August, 2007



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Health Status by WI Counties



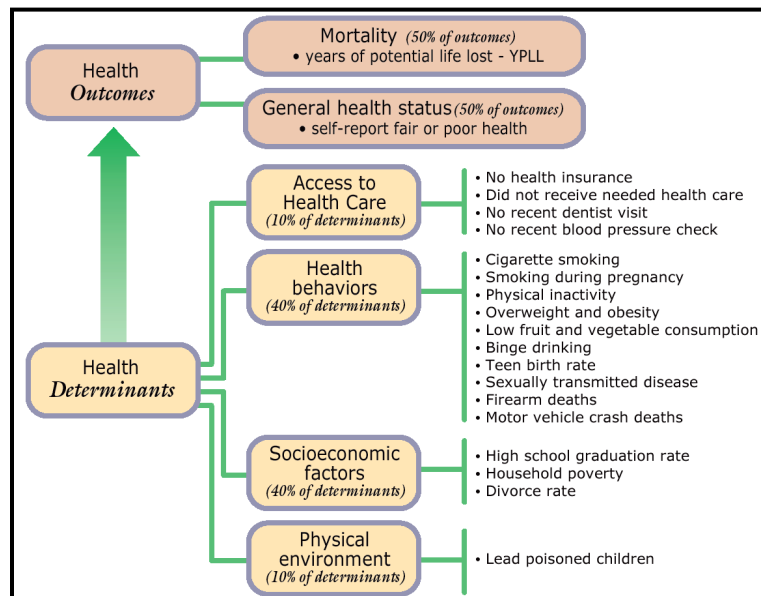
Worst Quartile (white)
Second Quartile (red)
Third Quartile (redder)
Best Quartile (reddest)

75% urban counties
better than average
compared to 33% of rural
counties better than
average.

Above calculated from the 2007 "Wisconsin County Health Rankings,"
University of Wisconsin Population Health Institute



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2005 Wisconsin County Health Rankings, University of Wisconsin
Population Health Institute



Health Status Also Driver of Economic Health

“If we can change lifestyles, it will have more impact on cutting costs than anything else we can do.”

Larry Rambo, CEO
Humana Wisconsin and Michigan

“Businesses will move to where healthcare coverage is less expensive, or they will cut back and even terminate coverage for their employees. Either way, it's the residents of your towns and cities that lose out.”

Thomas Donohue, President & CEO,
U.S. Chamber of Commerce



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Strategic Barriers to Getting Involved

- Resources. Hospitals and clinics struggling to address traditional responsibilities with tight budgets are not looking for new roles “that no one will pay us to do.”
- Tradition. The role of providers has been seen as treating individual patients. Population health seen as the job of local and state public health departments.
- Values. The discomfort that most of us feel when talking about addressing population health issues, many of which relate to individual behaviors – other people's choices and their freedom to make those choices.

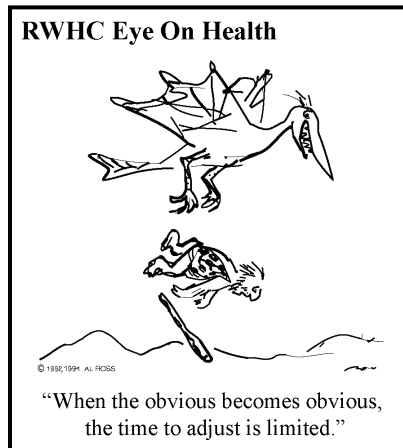
“Population Health Improvement & Rural Hospital Balanced Scorecards,”
Tim Size, David Kindig & Clint MacKinney, *Journal Rural Health*, Spring, 2006



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The Risk of Doing Nothing



For a free subscription RWHC e-newsletter, email
office@rwhc.com with “subscribe” on subject
line.

