Rural Health in Wisconsin:
Taking the Long View

Overview

I. Rural Health: History of Meeting Challenge
II. Mission: Rural Won’t Be Collateral Damage
III. ACO & Market Reform “Opportunities”
I. Rural Health: History of Meeting Challenges

- 1970s: Regional planners propose consolidation of rural hospitals → blocked; RWHC born as advocate.
- 1980s: HMO explosion with closed networks seen as threat → RWHC starts HMO; Fed anti-trust protection.
- 1980-90s: Shift to Medicare PPS payments closes 100s of rural hospitals → birth of CAHs in 1997.
- 1990s to Today: Growth of MD Maldistribution → WARM, WCRGME & MCW expansion plans.
- 2000: IOM Reports poor quality of USA health care → Triple Aim of better health and care at lower cost.

Overview of Rural Costs

- “The people served by rural hospitals are more likely to report a fair to poor health status, suffer from chronic diseases, lack health insurance, and be heavier, older, and poorer than residents of urban areas.”

- Yet overall, the average cost per Medicare beneficiary is 3.7 percent lower in rural areas than in urban areas, and rural hospitals perform better than urban hospitals on three out of the four cost and price efficiency measures on Medicare Cost Reports.”

"Implications of Proposed Changes to Rural Hospital Payment Designations Policy Brief," by The National Advisory Committee on Rural Health and Human Services, December, 2012
Over Long Term: Health Care ➔ Community Health

It’s no longer about what we charge for a hospital visit but what it costs to keep an insured population healthy.

“We must help all reach highest potential for health and reverse the trend of avoidable illness.”*


Both Public & Private Markets Driving Reform

- Top providers along with their patients will improve individual health.
- Top providers and communities will “go upstream” to address factors that influence population health.
- Top communities will employ metrics that assess more global outcomes of population health.
- Top providers and communities will partner to create healthy communities.
II. Mission: Rural Won’t Be Collateral Damage

"No need to rebuild old rural hospitals when we have Army Surplus MASH Tents."
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 less than urban care.
- AND Rural health care is inordinately expensive.
- Rural quality is lower; urban is better.
- Rural hospitals are just band-aid stations.
- Rural hospitals are poorly managed and/or governed.

Ongoing Support of Core Rural Health Agenda

- Federal healthcare reform that recognizes rural realities.
- Fair Medicare and Medicaid payments to rural providers.
- Federal and State regulations that recognize rural realities.
- Retain property tax exemption for nonprofit hospitals.
- Solve growing shortage of rural physicians and providers.
- Bring rural voice to regional provider networks & payers.
- Bring a rural voice into the quality improvement movement.
- Continue push for workplace and community wellness.
- Strong link between economic development and rural health.
SEQUESTRATION - 2% CUT TO ALL RURAL HOSPITALS

ELIMINATION OF CAH STATUS FOR NEARLY 50 HOSPITALS (President’s budget)

PROPOSED CUTS IN FLEX AND OUTREACH GRANTS

PROPOSAL TO ELIMINATE ALL CAHs (CBO budget proposal)

35% CUT UNCOMPENSATED CARE

PROVIDER TAX (ASSESSMENT) CUTS

Source: National Rural Health Association

Rural PPS Hospital Medicare Cuts?

MDH EXPIRATION - 12% INPATIENT CUT to 200 RURAL HOSPITALS

LVH EXPIRATION - 13% INPATIENT CUT to 650 RURAL HOSPITALS

SEQUESTRATION - 2% CUT TO ALL RURAL HOSPITALS

25% CUT in DSH PAYMENTS TO RURAL HOSPITALS (Non-CAH)

HOLD HARMLESS - 4% CUT IN OUTPATIENT PAYMENTS

5% CUT UNCOMPENSATED CARE TO RURAL HOSPITALS (Non-CAH)

CODING AND DOCUMENTATION CUTS

Source: National Rural Health Association
Healthcare Coverage ≠ Access

RN Supply & Demand Projections
Wisconsin, 2010-2035
(Base case, FTE, Broad Nursing Workforce)

WI Department of Workforce Development, Nov, 2011
"The Health Impact Pyramid," Centers for Disease Control and Prevention
III. ACO & Market Reform “Opportunities”

Rural health is driven by political and market forces incenting the Triple Aim (to lower costs, to improve individual health care and population health).

"When the obvious becomes obvious, the time to adjust is limited."
Obamacare’s 5 Big Challenges Impact Rural

1. **Extending the scope of Medicaid expansion.** Was to cover 17 million people. When the Supreme Court ruled states could opt out, many took up the option.

2. **Building the health-insurance marketplaces.** The health-insurance exchanges are Obamacare’s backbone. These are the online marketplaces—something like an Expedia for health coverage—where Americans can shop for private insurance or Medicaid coverage.

3. **Getting the word out about the health law’s new program(s).** Polls of low- to middle-income Americans whether they were aware of the new law’s provisions. Seventy-eight percent were not.

Washington Post, 3/23/13

4. **Swaying public opinion on Obamacare.** Ever since the ACA became law in 2010, public opinion has remained stubbornly split. The same number (40 percent) oppose it now as did three years ago. Favorable ratings, meanwhile, have fallen by 9 percent.

5. **Controlling health-care costs.** It’s one thing to hand out health-insurance cards; that’s relatively easy. It’s quite another to ensure that an insurance card guarantees access to affordable health care.

Washington Post, 3/23/13
Financial Incentives for CAHs?
Not If but When and How

The Goal

Electronic Health Records

Healthcare Financial Management Association

Top 100 CAHs Give Hope What Rural Can Do

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Reform: 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

Reform: Collaborating to Integrate Services

- Collaborative providers 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.

"The High Performance Rural Health Care System of the Future," RUPRI Health Panel, 9/2/11
Reform: 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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Reform: 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
Rural Impact as Insurers Respond to Exchanges

*Insurer financial success in exchanges depends on:*

- Create products that attract healthy people (*rural disadvantage as healthier people may be incented to migrate to plans in urban/suburban markets?*)
- Adequate risk adjustment to fairly compensate health plans with higher risk patients (*will Feds adequately protect rural markets with older, sicker patients; indirect continuation shift of funds to FLA, CA & NY?*)
- Manage chronic conditions better than other health care organizations (*do rural have the resources to do as aggressively as will be needed?*)

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Reminder #1: Healthcare Coverage ≠ Access

*RWHC Eye On Health*

“Urban?” “Rural?”
Reminder #2: Rural Healthcare = Rural Jobs

- **Local rural health = local health care jobs.**
- Rural health has the **same economic impact as export commodities** like milk, soy beans or rural based manufactured goods.
- Rural insurance **premiums and taxes only return** to create jobs **if there are local health care providers** there (and people use them)
- **The rural economy and health of rural communities is extremely dependent on WHERE health care dollars are spent.**

Rural Health Resources

- **RWHC Web:** [http://www.rwhc.com/](http://www.rwhc.com/)
- **Wisconsin Office of Rural Health:** [http://worh.org/](http://worh.org/)
- For the free **RWHC Eye on Health e-newsletter**, email office@rwhc.com with “subscribe” on subject line.
- **Rural Assistance Center** at [www.raonline.org/](http://www.raonline.org/) is an incredible federally supported information resource.
- The **Health Workforce Information Center** is RAC’s “sister” for health workforce programs, funding, data, research & policy [www.healthworkforceinfo.org/](http://www.healthworkforceinfo.org/)