Rural Health Policy: One Perspective in Forty Minutes

Outline of Presentation

I. Ongoing Change is Story of Rural Health
II. Key Rural Health Policy Issues
III. Uncertain Status of Affordable Care Act
IV. ACO/Exchange Opportunities (Partial List)
I. Ongoing Change is Story of Rural Health

- 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 health care → Triple Aim of better health and care at lower cost.

Current Market Reform Underway

- **Cost:** Reduction Viewed as Discrete Projects → Continuous Process Improvement
- **Quality:** Public Relations/Liability Issue → Drives Reimbursement
- **Physicians:** Drive Volume → Drive Value
- **Collaboration:** Limited Amount Required for Financial Success → Clinical and Finance Staff Must Work Together
- **Financial Risk:** Revolves Around Cost Position → Revolves Around Utilization of Services Across Continuum

Healthcare Financial Management Association
Over Long Term: Health Care ➔ Population Health

“We must help all reach highest potential for health and reverse the trend of avoidable illness.* Multiple forces along with the IRS mandated community assessment is leading to major new opportunities for hospital and public health partnerships.


Bottom Line: Collaborating to Create Health

- Providers and patients need to connect to community health resources to improve individual health.
- Providers and the community need to “go upstream” to address factors that influence population health.
- Rural communities need to employ metrics that assess more global outcomes of community health.
- Rural providers and their communities need to partner in creating health.

“The High Performance Rural Health Care System of the Future,” RUPRI Health Panel, 9/2/11
II. Key Rural Health Policy Issues

*There is an 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.

---

Rural Health’s Multifaceted 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.
Politics Trump Policy & Research

Both public and private policy makers have constituencies that drive the process more than the best data or policy.

Elected & Appointed Officials Can Be At Odds

“Tell me again how this works for people to re-elect me.”

“No need to rebuild old rural hospitals when we have perfectly good Army surplus MASH tents.”
Tradition Conceals Important Questions

Why do we try not to chop off infected toes but we routinely pull out ‘bad’ teeth?

Rural Faces Challenge of Smaller Data Sets

ACO focus on financial and quality reporting designed for large organizations creates a statistical challenge for smaller hospitals and physician groups.
Fear Often Trumps Hope & Delays Change

Machiavelli & Thomas Jefferson both understood that change required “that the hope of gain be greater than the fear of loss.”

Don’t Underestimate Economic Self Interest

“We don’t have to tackle healthcare reform until voters’ hope of gain outweighs their fear of loss.”

“That’s where you’re wrong. We are businessmen first, dentists second.”
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

National Rural Health Snapshot – 2010 (1 of 2)

Access to Health Services

<table>
<thead>
<tr>
<th></th>
<th>Rural</th>
<th>Non-Rural</th>
<th>Rural Rate Higher Than Non-Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>No form of health coverage (age 18-64 years)</td>
<td>20.6</td>
<td>17.0</td>
<td>21.2%</td>
</tr>
<tr>
<td>Needed to see doctor but could not because of cost/past year</td>
<td>15.6</td>
<td>13.6</td>
<td>14.7%</td>
</tr>
<tr>
<td>No personal doctor</td>
<td>18.1</td>
<td>19.3</td>
<td>-6.2%</td>
</tr>
<tr>
<td>No dental care in previous year</td>
<td>35.6</td>
<td>28.3</td>
<td>25.8%</td>
</tr>
</tbody>
</table>

Health Behavior/Risk Factors

<table>
<thead>
<tr>
<th></th>
<th>Rural</th>
<th>Non-Rural</th>
<th>Rural Rate Higher Than Non-Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Smoker</td>
<td>22.0</td>
<td>17.8</td>
<td>23.6%</td>
</tr>
<tr>
<td>Obese (Body Mass Index ≥30)</td>
<td>30.5</td>
<td>25.9</td>
<td>37.9%</td>
</tr>
</tbody>
</table>

www.shepscenter.unc.edu/rural/snapshot.html
National Rural Health Snapshot – 2010 (2 of 2)

<table>
<thead>
<tr>
<th>Age-Adjusted Mortality</th>
<th>Rural per 100,000 population</th>
<th>Non-Rural per 100,000 population</th>
<th>Rural Rate Higher Than Non-Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-cause</td>
<td>893.8</td>
<td>821.1</td>
<td>8.6%</td>
</tr>
<tr>
<td>Infant (age&lt;1)</td>
<td>755.0</td>
<td>640.9</td>
<td>19.3%</td>
</tr>
<tr>
<td>Diseases of the heart</td>
<td>249.4</td>
<td>230.2</td>
<td>8.3%</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>27.6</td>
<td>24.6</td>
<td>12.2%</td>
</tr>
<tr>
<td>COPD</td>
<td>49.0</td>
<td>42.2</td>
<td>16.1%</td>
</tr>
<tr>
<td>Unintentional Injuries</td>
<td>51.9</td>
<td>34.7</td>
<td>49.6%</td>
</tr>
<tr>
<td>Suicide</td>
<td>13.4</td>
<td>10.3</td>
<td>30.1%</td>
</tr>
</tbody>
</table>

www.shepscenter.unc.edu/rural/snapshot.html

Rural Hospitals: Backbone of Rural Health

North Carolina Health Research Policy Analysis Center, 8/12

1,327 CAHs as of 6/30/12
Critical Access Hospital Medicare Cuts?

- CAH REIMBURSEMENT CUTS – (President’s budget)
- ELIMINATION OF CAH STATUS FOR NEARLY 50 HOSPITALS (President’s budget)
- SEQUESTRATION – 2% CUT TO ALL RURAL HOSPITALS
- PROPOSED CUTS IN FLEX AND OUTREACH GRANTS
- PROPOSAL TO ELIMINATE ALL CAHs (CBO budget proposal)
- 35% CUT UNCOMPENSATED CARE

Source: NRHA
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)

Source: NRHA

2013 Wisconsin County Health Rankings (Outcomes)

- Top Quartile
- 2nd Quartile
- 3rd Quartile
- Bottom Quartile

Rural Counties  Urban Counties

Source: NRHA
This Dental HPSA map is valid as of June 2012. The map illustrates the general location of shortage areas eligible for state loan repayment; please see the WI Primary Care Office web site (http://dhs.wisconsin.gov/health/primarycare/ShortageDesignation.htm) for more detailed information on shortage areas and associated benefits.

Bayfield
Sawyer
Rusk
Price
Ashland
Vilas
Door
Juneau
Monroe
Dunn
Chippewa
Eau Claire
Burnett
Douglas
Washburn
Langlade
Clark
Taylor
Grant
Milwaukee
Kenosha
Trempealeau
Forest
Barron
Vernon
Richland
Jackson
Pepin
Iron
Adams
Brown
Marinette
Marathon
Lincoln
Oneida
Dane
Rock
Portage
Waupaca
Waushara
Marquette
Crawford
La Crosse
Florence
Waukesha

Health Professional Shortage Areas
(For State Loan Repayment Eligibility)
Dental - June 2012

This Primary Care HPSA map is valid as of June 2012. The map illustrates the general location of shortage areas eligible for state loan repayment; please see the WI Primary Care Office web site (http://dhs.wisconsin.gov/health/primarycare/ShortageDesignation.htm) for more detailed information on shortage areas and associated benefits.

Bayfield
Sawyer
Rusk
Price
Ashland
Vilas
Florence
Oconto
Door
Calumet
Waushara
Marquette
Juneau
Monroe
Buffalo
Dunn
Chippewa
Eau Claire
Burnett
Douglas
Washburn
Oneida
Langlade
Shawano
Clark
Taylor
Grant
Sauk
Lafayette
Sheboygan
Waukesha
Milwaukee
Racine
Kenosha
Marathon
Trempealeau
Polk
St Croix
Pierce
Forest
Marinette
Vernon
Iowa
Outagamie
Waupaca
Kewaunee
Crawford
Richland
Jackson
Menominee
Pepin
La Crosse
Brown
Iron
Adams
Green Lake
Barron
Manitowoc
Fond du Lac
Rock
Walworth
Marquette
Dodge
Columbia
Sauk
Iowa
Lafayette
Crawford
Polk
Menominee
Shawano
Jefferson
Florence
Racine
Manitowoc
Walworth
Marquette
Dodge
Columbia
Sauk
Iowa
Lafayette
Crawford
Polk
Menominee
Shawano
Jefferson

Primary Care - June 2012

This HPSA map is valid as of June, 2012. The map illustrates the general location of shortage areas eligible for state loan repayment; please see the WI Primary Care Office web site (http://dhs.wisconsin.gov/health/primarycare/ShortageDesignation.htm) for more detailed information on shortage areas and associated benefits.

Bayfield
Sawyer
Rusk
Price
Vilas
Oconto
Door
Juneau
Monroe
Dunn
Burnett
Douglas
Washburn
Langlade
Clark
Taylor
Grant
Milwaukee
Trempealeau
Forest
Barron
Vernon
Richland
Jackson
Pepin
Iron
Adams
Brown
Marinette
Marathon
Lincoln
Oneida
Dane
Rock
Portage
Waupaca
Waushara
Marquette
Crawford
Richland
Jackson
Menominee
Pepin
La Crosse
Brown
Iron
Adams
Green Lake
Barron
Manitowoc
Fond du Lac
Rock
Walworth
Marquette
Dodge
Columbia
Sauk
Iowa
Lafayette
Crawford
Polk
Menominee
Shawano
Jefferson
Florence
Racine
Manitowoc
Walworth
Marquette
Dodge
Columbia
Sauk
Iowa
Lafayette
Crawford
Polk
Menominee
Shawano
Jefferson

Health Professional Shortage Areas
(For State Loan Repayment Eligibility)
Mental Health - June, 2012

RWHC, 880 Independence Lane, Sauk City, WI 53583  (T) 608-643-2343
Email: timsize@rwhc.com  World Wide Web Site: www.rwhc.com  Tweet: www.twitter.com/RWHC  Page 12
III. Uncertain Status of Affordable Care Act

As you may know, a health reform bill was signed into law in 2010. Given what you know about the health reform law, do you have a generally favorable or generally unfavorable opinion of it?

---

Kaiser Family Foundation Tracking Polls

Where Bars Trump Grocery Stores

http://flowingdata.com/
Many ACA Provisions Popular

Percent who say they feel favorable about each of the following elements of the health reform law:

<table>
<thead>
<tr>
<th>Provision</th>
<th>Total</th>
<th>Dem</th>
<th>Ind</th>
<th>Rep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax credits to small businesses to buy insurance</td>
<td>88%</td>
<td>96%</td>
<td>87%</td>
<td>83%</td>
</tr>
<tr>
<td>Close Medicare “doughnut hole”</td>
<td>81%</td>
<td>90%</td>
<td>80%</td>
<td>74%</td>
</tr>
<tr>
<td>Create health insurance exchanges</td>
<td>80%</td>
<td>87%</td>
<td>78%</td>
<td>72%</td>
</tr>
<tr>
<td>Extension of dependent coverage</td>
<td>76%</td>
<td>84%</td>
<td>79%</td>
<td>68%</td>
</tr>
<tr>
<td>Subsidy assistance to individuals</td>
<td>76%</td>
<td>91%</td>
<td>69%</td>
<td>61%</td>
</tr>
<tr>
<td>Medicaid expansion</td>
<td>71%</td>
<td>88%</td>
<td>70%</td>
<td>42%</td>
</tr>
<tr>
<td>Guaranteed issue</td>
<td>66%</td>
<td>75%</td>
<td>67%</td>
<td>56%</td>
</tr>
<tr>
<td>Medical loss ratio</td>
<td>65%</td>
<td>72%</td>
<td>60%</td>
<td>62%</td>
</tr>
<tr>
<td>Increase Medicare payroll tax on upper income</td>
<td>60%</td>
<td>80%</td>
<td>54%</td>
<td>37%</td>
</tr>
<tr>
<td>Employer mandate/penalty for large employers</td>
<td>57%</td>
<td>79%</td>
<td>54%</td>
<td>36%</td>
</tr>
<tr>
<td>Individual mandate/penalty</td>
<td>40%</td>
<td>55%</td>
<td>39%</td>
<td>21%</td>
</tr>
</tbody>
</table>

Awareness of ACA Provisions Weak

To the best of your knowledge, would you say the health reform law does or does not do each of the following?
Misperceptions of What Is NOT in Law

To the best of your knowledge, would you say the health reform law does or does not do each of the following?

<table>
<thead>
<tr>
<th>PROVISION</th>
<th>CORRECT</th>
<th>INCORRECT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cut benefits for people in Medicare</td>
<td>No, law does not do this</td>
<td>43%</td>
</tr>
<tr>
<td>Establish a government panel to make decisions about end-of-life care for people on Medicare</td>
<td>39</td>
<td>40</td>
</tr>
<tr>
<td>Allow undocumented immigrants to receive subsidies to purchase insurance</td>
<td>33</td>
<td>47</td>
</tr>
<tr>
<td>Public option</td>
<td>28</td>
<td>57</td>
</tr>
</tbody>
</table>

Kaiser Family Foundation Tracking Polls

Major Variance Cost & Quality Expectations

Under the health reform law, do you think each of the following will get better, worse, or will it stay about the same?

<table>
<thead>
<tr>
<th>NATIONAL IMPACTS</th>
<th>WORSE</th>
<th>STAY</th>
<th>BETTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>The cost of health care for the nation as a whole</td>
<td>55%</td>
<td>18%</td>
<td>21%</td>
</tr>
<tr>
<td>The quality of health care in the nation</td>
<td>45%</td>
<td>26%</td>
<td>24%</td>
</tr>
<tr>
<td>Consumer protections for the average person with private health insurance</td>
<td>39%</td>
<td>36%</td>
<td>16%</td>
</tr>
<tr>
<td>Access to health care for the uninsured</td>
<td>28%</td>
<td>24%</td>
<td>49%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PERSONAL IMPACTS</th>
<th>WORSE</th>
<th>STAY</th>
<th>BETTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>The cost of health care for you and your family</td>
<td>49%</td>
<td>31%</td>
<td>15%</td>
</tr>
<tr>
<td>The quality of your own health care</td>
<td>34%</td>
<td>48%</td>
<td>55%</td>
</tr>
<tr>
<td>Your ability to get and keep health insurance</td>
<td>28%</td>
<td>46%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Kaiser Family Foundation Tracking Polls
Health Insurance Exchanges

| Washington Post, 3/23/13 |

Obamacare’s Five Biggest Challenges

1. Extending the scope of Medicaid expansion. Was was to cover 17 million. When the Supreme Court ruled states could opt 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. 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
Obamacare’s Five Biggest Challenges

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

IV. ACO/Exchange Opportunities (Partial List)

Rural Health is not exempt from political chaos and the alignment of forces driving reform to improving population health, individual health care, and lower costs (the Triple Aim).
Accountable Care Organization 101 (1 of 2)

- **ACOs** are **voluntary groups** of doctors, hospitals, and other health care providers giving coordinated quality care to Medicare patients.
- Goal of coordinated care is to ensure that patients, especially the chronically ill, get right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.
- When an ACO succeeds in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for Medicare.

[www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/)

---

Accountable Care Organization 101 (2 of 2)

- **Medicare offers 3 ACO programs**: (1) **Medicare Shared Savings Program**—a program for Medicare fee-for-service program providers, (2) **Advance Payment ACO Model**—a supplementary incentive program for selected participants in the Shared Savings Program. (3) **Pioneer ACO Model**—a program designed for early adopters of coordinated care.
- Participating in an ACO is **voluntary for providers**.
- Fee-for-service Medicare patients maintain all their rights, including right to choose their providers.

[www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/)
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?*)

Healthcare Delivery System Reform

Reform Bill uses $ incentives that will significantly impact hospitals (more than mandates) to Improve the delivery system.
As part of the Triple Aim, rural providers increasingly looking at both individual healthcare and ways to improve the overall health of their community.

2012 Wisconsin County Health Rankings Model,
University of Wisconsin Population Health Institute

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
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

---

Healthcare Coverage ≠ Access

Workforce shortages hit rural first, harder and longer:

**Currently**
- Primary Care, Dental,
- Mental Health,
- Pharmacy & EMS

**Coming Our Way**
- General Surgery & Nursing
“By 2020, our nation will face a serious shortage of both primary care and specialist physicians. The shortfall will be most severe on vulnerable and underserved populations. Unless we act now, America will face a shortage of more than 90,000 doctors in 10 years.”

-- Association of American Medical Colleges
June 2010

“Wisconsin will need to add 100 new physicians annually to avoid an expected shortfall of 2,000 by 2030. The need is most urgent in primary care, general surgery and psychiatry – in both rural and underserved urban areas.”

-- Wisconsin Hospital Association
November 2011

“If students complete both their medical education and residency training in Wisconsin, nearly 70% will remain in the state to practice medicine.”

-- AAMC State Physician Workforce Data Book
December 2011

* The green shaded areas denote federally-designated rural and urban locations where there are significant shortages of primary care physicians


Rural Health’s Two-fer: Health & Jobs

Rural health is all about the natural tension between the power of capital and the power of place.

This makes rural health dependent on the local community, local employers, local schools & vice versa.
Jobs Depend on Rural Health (1 of 2)

- Local rural health = local health care jobs.
- People often know that business relocation decisions are influenced by the cost and quality of health care available locally.
- But as or more importantly, rural health has the same economic impact as export commodities like milk, soy beans or rural based manufactured goods because of its ability to bring dollars and jobs into the community.

Jobs Depend on Rural Health (2 of 2)

- Rural insurance premiums and taxes 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 2 jobs created (or lost) in rural health care, the number of jobs in other local businesses increase (or decrease) by at least 1 job.
- The rural economy and health of rural communities is extremely dependent on WHERE health care dollars are spent.
Summary #1: Competition & Cooperation Coexist

“Rural Health Policy: One Perspective in Forty Minutes”
by Tim Size for NRHA Student CG, 5/8/13

“RWHC Eye On Health

“I like it, but ‘Thou Shall Not Fail To Cooperate When Resources Are Scarce’ makes eleven.”

Summary #2: Follow Your Passion

“RWHC Eye On Health

“Yes, I’m a generalist. I chose primary care over being a specialist.”
Summary #3: Vision Matters

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

Rural Health Resources

- 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 new “sister” for health workforce programs, funding, data, research & policy [www.healthworkforceinfo.org/](http://www.healthworkforceinfo.org/)