The State of Health Care in Wisconsin
Rural Opportunities and Challenges

RWHC Eye On Health

"If I catch the person who keeps mumbling, 'Does this make sense for rural?' they're out of here."

Tim Size
Executive Director
RWHC
Sauk City
Wisconsin Rural Health Conference
Osthoff Resort
Elkhart Lake
June 20, 2014

Outline of Talk

1. Big Challenges Not New to Rural
2. Operation MASH & CMS
3. Network Adequacy
4. Performance Metrics & Context
5. Rural Health Care Equals Rural Jobs
6. Population Health Trumps Health Care
7. Today's Core Challenges
8. Bottom Line Principles
1. Big Challenges Not New to Rural (1 of 2)

1970s: Federally funded planners proposed massive consolidation of rural hospitals in Wisconsin; that plan was blocked and an era of rural advocacy was born.

1980s: Growth of health plans with closed provider networks were seen as threat; rural's started a rural based plan and received federal anti-trust protection.

1980-90s: Medicare radically changed how they paid hospitals and 100's of rural hospitals closed; in response, rural's championed the CAH program as well a variety of other enhancements for Tweeners such as the low volume and sole community adjustments.

Meeting Big Challenges Not New (2 of 2)

• 1990s: Growth in the shortage of physicians working in rural Wisconsin led to the Wisconsin Academy of Rural Medicine, the Wisconsin Collaborative for Rural Graduate Medical Education and a major rural expansion by the Medical College of Wisconsin.

• 2000s: The National Institute of Medicine highlighted major gaps in American health care quality—rural's lead call for rural relevant metrics.

• 2010s: That providers will be paid not for volume but for value has led rural's to focus on services preparing for the new era of Accountable Care Organizations.
The Rural Advocacy Agenda is Multifaceted

- “Volume to Value” reforms that work for rural
- Fair Medicare and Medicaid payments to rural providers
- Rural relevant quality and performance metrics
- Network access standards that work for rural
- Federal and State regulations that recognize rural realities
- Solve growing shortage of rural physicians and providers
- Rural conscious regional provider networks and payers
- Ongoing push for workplace and community wellness
- Strong link between economic development and rural health

2. Operation MASH & CMS

There is an Ongoing Need for Rural “Myth” Busting

- Rural residents don’t care about local care.
- Rural folks are naturally healthy, need less.
- Rural health care costs less than urban care.
- Or 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 governed.
CMS Needs to Talk with Us to Understand Us

- Ron Kind and Reid Ribble have contacted DHHS regarding an observed ongoing pattern of CMS actions against the value and role of rural hospitals.
- E.g.: OIG Reports, impact of the two-midnight rule, the 96-hour rule, physician supervision rules, the campaign against the “ten milers,” rural GME limitations
- Requested DHHS Secretary and senior leadership to initiate a constructive dialogue between CMS, Members of Congress and rural hospital representatives.
- Other States have begun to make similar requests

Rural Health Typically Does More With Less

- “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 communities than in urban ones, 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
However, in recent years, the majority of the enrollment in PFFS plans has shifted to PPO plans in rural areas. The ACA created quality-based bonus payments for MA plans with ratings of 4.0 stars or higher. Using this rating level as a dividing line, a higher proportion of urban MA enrollees (36.0% compared to 31.6% in rural areas) are enrolled in an MA plan that receives a bonus payment. However, nearly all MA enrollees both in rural areas (91.9%) and in urban areas (94.4%) are in plans with a quality rating of 3.0 stars or higher (Figure 2), qualifying them for bonus payments under the current demonstration program. Nearly one-half (49.8%) of rural HMO enrollment is in a plan with a 4.0-star or higher rating, while only 24.7% of rural PPO enrollment is in such a plan. The majority (73.6%) of rural PPO enrollment is in plans with an average quality rating of 3 or 3.5 stars. Many rural Medicare beneficiaries have limited access to MA plans and in some areas do not have an HMO option available to them, leaving them with PPO plans as their only option.

Figure 2. Percentage of Plans and Enrollment by MA Plan Star Rating and Location, 2012

The quality rating of rural MA plans varies significantly across the country, with the highest quality ratings in rural areas in Minnesota, Iowa, Wisconsin, Oregon, Pennsylvania, and Maine (Figure 3). MA beneficiaries in southern and some central midwestern rural areas are, in general, enrolled in MA plans with lower quality.

Figure 3. Medicare Advantage Star Ratings by County

3. Network Adequacy Under Health Reform

- Key question: Does the consumer have “reasonable” access to providers in order to receive services that are covered under the plan’s benefits?
- Regulators’ views are from a consumer perspective. (But both state and federal regulations have long had language requiring networks “consistent with local community patterns of care.”)
- ACA/Exchange: Insurer must maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible without unreasonable delay.

WHA Network Adequacy Council working papers, 4/7/14
Examples of Issues In & Out of the Exchange

- “The health plan has contracted with the hospital, but not with a specialist/provider within the hospital.”
- “The health plan contracts with community clinic, but not the specialist/hospital affiliated with the community-based clinic.”
- “The health plan does not contract with any hospital in the county.”
- “The health plan offers a contract at Medicaid rates or expresses they don’t really need/want a contract.”
- “The health plan has contracts with the hospital for all hospital services for all products the plan offers, but clinic is considered not in network.”

RWHC Survey, Spring 2014

4. Performance Metrics & Context

NQF, the country’s most influential voice on health care standards, has reversed field and issued draft recommendations calling for adjusting metrics for socio-demographic factors as RWHC suggested to WHIO last year.
Education and Income Effect Outcomes

- “Failing to adjust measures for socio-demographic factors can harm patients and worsen health care disparities by diverting resources away from hospitals and other providers treating large proportions of disadvantaged patients.”
- “It also can lead to patients drawing incorrect conclusions about a provider’s quality of care because many outcomes—such as hospital readmissions and costs—are influenced as much by sociodemographic issues outside of providers’ control.”
- “Many safety-net hospitals have experienced disproportionately high readmission penalties because readmission measures are not adjusted for socio-demographic factors.”

AHA News Release, 3/21/14

5. Rural Health Care Equals Rural Jobs

Rural health has the same economic impact locally as export commodities like milk, soybeans, manufactured goods because of its ability to bring dollars and jobs into the community.
Jobs in All Sectors Depend on Rural Health

- Rural insurance premiums and taxes only come back to the community and create jobs if there are local health care providers there (and people use them) to attract those dollars.
- For every 2 rural health jobs created (or lost), the number of other community jobs increase (or decrease) by 1+ jobs.
- The rural economy is very dependent on where its health care dollars are spent.

6. Population Health Trumps Health Care

RWHC Eye On Health

“For what they charge, they should keep us healthy regardless of what we do.”

It’s no longer just about what we charge for a clinical service but also what it costs to keep a population healthy.

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

County Health Rankings – 2014

Rural WI Counties Predicted to Not Do as Well

Percent of Urban and Percent of Rural Counties in Each Quartile of Factors*

* Factors are determinants of health like income, education and individual behaviors.
Rural Lags But Is Doing Better Than Predicted

Percent of Urban and Percent Rural Counties in Each Quartile of Outcomes

- Best
- Q2
- Q3
- Worst

Urban  |  Rural
---|---

Where Bars Trump Grocery Stores

http://flowingdata.com/
7. Today’s Core Challenges

Rural Health faces an alignment of forces, with or without Obama Care driving reform to improve individual health care, the health of populations and lower costs (The “Triple Aim”).

Details Differ: Big Picture Unchanged

<table>
<thead>
<tr>
<th>Current State</th>
<th>Future State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost: Reduction Viewed as Discrete Projects</td>
<td>Continuous Process Improvement</td>
</tr>
<tr>
<td>Quality: Public Relations/Liability Issue</td>
<td>Drives Reimbursement</td>
</tr>
<tr>
<td>Physicians: Drive Volume</td>
<td>Drive Value</td>
</tr>
<tr>
<td>Collaboration: Limited Amount Required for Financial Success</td>
<td>Clinical and Finance Staff Must Work Together</td>
</tr>
<tr>
<td>Financial Risk: Revolves Around Cost Position</td>
<td>Revolves Around Utilization of Services Across Continuum</td>
</tr>
</tbody>
</table>
The Four Questions Facing Every Provider

1. How do we provide local patient-centered care that is team-based and outcome-focused?

2. How do we collaborate with regional organizations to emphasize value of care over volume of care?

3. How do we partner with others locally and regionally to foster healthy communities?

4. How do we adapt urban-based federal models to the unique characteristics of our rural communities?

8. Bottom Line Principles

RWHC Eye On Health

“When the obvious becomes obvious, the time to adjust is limited.”
Vision Matters

“Health is More Than Health Care”

“Get over the Doc Welby thing, what you do makes a lot more difference to your health than what I do.” (Yogi Berra)
Follow Your Passion

"Yes, I'm a generalist. I chose primary care over being a partialist."

Cooperate In Order to Successfully Compete

"I like it, but 'Thou Shall Not Fail To Cooperate When Resources Are Scarce' makes eleven."

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 14