Rural Wisconsin
Health Cooperative

Eye On Health

Review & Commentary on Health Policy Issues from a Rural Perspective - May 1st, 2001

## REACH For Rural America

A national Task Force, convened last November at the request of the NRHA Hospital Constituency Group, adopted on March 29th a proposal calling for the establishment of Rural Essential Access Community Hospitals (REACH). The proposal, "REACH For Rural America," calls for a new Medicare payment category which could be elected by rural hospitals with fewer than fifty available beds. REACHs would receive cost reimbursement for all hospital inpatient and outpatient services. In addition, REACH hospitals would be paid cost reimbursement for other hospital based services including ambulance, home health, skilled nursing units, swing beds, hospice, etc. All REACHs would be paid a reasonable return on equity for all reimbursable services.

National policy leaders recognize that the Prospective Payment System (PPS) does not work in rural areas. After twenty years attempting to adjust PPS to the reality of rural community hospitals, it has become clear that it is time to stop trying to fit a round peg into a square hole. There are hundreds of small and rural hospitals across the country that are "too busy" to be eligible for the Critical Access Hospital (CAH) program but not "busy enough" to have a PPS margin. Few of them have Medicare-dependent Hospital or Sole Community Hospital status and most that do, don't receive significant advantage from those programs. As a group they are heavily Medicare dependent with negative Medicare margins and meager or nonexistent operating margins.

The basis for the rural claim for a new approach lies in the government data showing that they are paid less than urban hospitals for the same service.

1) Rural hospitals, on average, are paid 9.6% less than their reasonable costs (as defined by Medicare) for providing services to Medicare beneficiaries, 14.2% less for "other rural hospitals under 50 beds." (In this context, Medicare defines beds as allocated beds and "other rural hospitals under 50 beds" as hospitals not having special designations such as Sole Community or Medicare Dependent.)

2) In 1999, 54.5% of hospitals designated as "other rural hospitals under 50 beds" had a negative inpatient Medicare margin.

3) All rural hospitals under fifty beds only account for 2% of inpatient PPS payments.

The Task Force was comprised of individuals connected to a variety of organizations, including the National Rural Health Association, the American Hospital Association and the Texas Organization of Rural and Community Hospitals. All three groups had begun to discuss over the last year the need to explore expanding cost-based reimbursement for rural hospitals and the need for a collaborative advocacy effort. In addition, a variety of other individuals were invited to provide additional perspective and expertise. This proposal is intended to be advisory to these and other advocacy groups. The NRHA Hospital CG leadership group has endorsed the proposal and within NRHA, it now goes to the Government Affairs Com-

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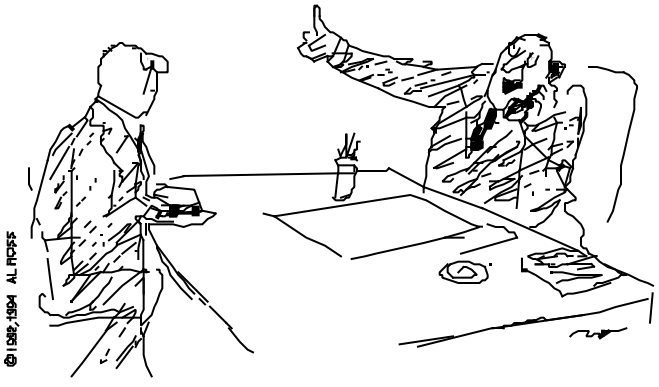


"I'll tell you what I told him. Just overcharge the private sector to make up the difference."

mittee and Policy Board in May. AHA and TORCH are also formally reviewing the proposal.

This is the beginning of what will surely be an "interesting" process and the Task Force understands that the original proposal is a starting point, not the final word, as the idea makes its way into and hopefully through Congress and is signed into law. Comments on the proposal can be sent to Tim Size at the Rural Wisconsin Health Cooperative, who chaired the Task Force, at <timsize@rwhc.com>. The complete report is available at <www.rwhc.com/new>.

## Medicare Redesign: Ask The Rural Questions

From *Redesigning Medicare: Considerations for Rural Beneficiaries and Health Systems* by the RUPRI Rural Health Panel, 2/01; the complete Brief is available at <www.rupri.org>:

"This Brief presents a framework to assess proposals to redesign the Medicare program, to be used by those interested in the future of health care services in rural areas. Following standard procedure for the RUPRI Health Panel we are not building an argument for any particular change in the Medicare program; instead, we are specifying the rural interests to be considered in any proposed change."

**"Does the proposal strive for equitable distribution of health care resources?** Equity, a fundamental philosophical concept of social justice, serves as the rural cornerstone of the Medicare redesign dialogue. Since all Medicare beneficiaries should have equal opportunity to maximize health, the goal of Medicare equity seems inarguable. Yet the dialogue raises critical questions about Medicare equity. How do beneficiary demographic characteristics determine rural health care utilization and reimbursement patterns? Are we unsuspectingly 'rationing' health care by making it less accessible or less affordable to rural populations? Is the burden of payment for Medicare services appropriately distributed? Do options for more generous Medicare benefits in certain geographic areas conflict with original Medicare intent? In sum, does Medicare treat all beneficiaries with fairness and justice? Many Medicare redesign proposals rely on market-based competition to achieve Medicare equity."

"However, unique rural characteristics such as low population density, limited managed care experience, decreased access to health care providers, and poorer beneficiary health tend to thwart market-based efficiencies and equity in rural areas and place rural beneficiaries at risk in market-driven Medicare redesign. As the nation explores an expanded role for competition in Medicare, proposals that rely on a competitive market model should be assessed as to the extent to which remedial programs are included that guarantee a basic level of rural health care access, quality, and service."

**"Does the proposal have features that address quality of care?** Any redesign of the Medicare program should ensure that quality of care furnished by all types of providers is monitored through standardized measures that are used across both managed care and traditional fee-for-service. Relevant rural circumstances associated with structure and process should be taken into consideration in monitoring for both quality assurance and quality improvement. The proposal should recognize that additional efforts to obtain and analyze data on quality of care among rural providers (both inpatient and outpatient) and beneficiary outcomes are needed, and that these efforts should compensate any significant burdens of data collection borne by rural providers."

"If the proposal relies on market-based approaches to reform Medicare, does it include mechanisms to ensure choice for rural beneficiaries? For market approaches to work, strategies for disseminating information need to take into consideration communication vehicles that will be viable in rural communities. Participation of rural beneficiaries in any Medicare program based on the competitive model is enriched if they have choices among: providers in their local area; health insurance plans (including traditional

The **Rural Wisconsin Health Cooperative**, begun in 1979, intends to be a catalyst for regional collaboration, an aggressive and creative force on behalf of rural communities and rural health. RWHC promotes the preservation and furthers the development of a coordinated system of rural health care, which provides both quality and efficient care in settings that best meet the needs of rural residents in a manner consistent with their community values.

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FFS Medicare), at least some of which include benefits not presently offered in the Medicare program; and different combinations of out-of-pocket expenses and parallel benefits. Conditions of participation imposed on competing health plans must include: uniformity of a basic benefit package (standardized benefits), availability of information about the plan (including measures of consumer satisfaction), and ensuring that beneficiaries are helped to understand the choice they make."

**"Does the proposal address financial barriers to health care access?** Rural Medicare beneficiaries face greater income-related financial barriers to health care access as a result of their lower incomes. In the framework of Medicare redesign proposals, the level of beneficiary responsibility for paying for health care services can be affected by many features, including the levels of premium contributions required, other cost sharing features, and the effectiveness of competition or plan regulation to hold down plan costs. In general, redesign proposals should consider the differential impact of these and other features on vulnerable low-income beneficiaries™ abilities to access needed services."

**"Does the proposal provide for continued availability and accessibility of appropriate services?** The threat of hospital closures, fewer medical professionals, and a lack of specialty services contribute to health care access problems for rural Medicare beneficiaries. Since the early to mid 1980s, Congress and the Health Care Financing Administration have adopted and maintained a number of special payment provisions that support essential providers in rural areas, thereby contributing to preserving access to basic health care services for many rural beneficiaries. Many features of Medicare redesign proposals might change, and perhaps eliminate, these and other payments to rural providers, which could affect the ability of rural providers and communities to sustain a high quality and accessible health care infrastructure and could lead to higher out-of-pocket costs for beneficiaries. To assure appropriate access for rural beneficiaries the Medicare program must continue to recognize, in its payments to providers (and/or plans), the unique financial circumstances of certain essential rural providers."

**"Does the proposal provide incentives for consumers and providers to maximize other policy goals (especially health quality and access), while passing along a fair share of the costs to the beneficiary?** Many of the Medicare reform proposals under consideration seek to reduce the growth in Medicare expenditures in the future. Such a reduction is important because the costs of Medicare will burden taxpayers in all areas, including rural areas. Because the elderly population is projected to grow by over 50% in the next few decades, Medicare spending will grow significantly regardless of the reforms that are made, and Medicare redesign proposals must reflect this expectation. Thus, specific legislation to redesign Medicare should include: provisions that appropriately balance the goal of cost containment with the other goals for Medicare; provisions that reflect an understanding that market competition may not work as well in rural areas as it does in urban areas; and provisions that provide incentives for consumers and producers to maximize health quality and access, while passing along a fair share of the costs to the beneficiary."

**"Does the proposal reflect an understanding that market competition may not work as well in rural areas as it does in urban areas?** If urban plans can offer less expensive options due to economies of scale, the 'market' may be working 'better' but this will not lead to lower costs for rural people. As market forces are applied to a redesigned Medicare program, options that reduce out-of-pocket costs (such as prescription drug coverage) are not likely to be available to most rural elderly because of market factors, while they are widely available to urban elderly."

## Small Businesses Expect State Insurance Fix

From "Health Expenses Create Dilemma For Small Firms" by Joe Manning in the *Milwaukee Journal Sentinel*, 4/15/01:

"Many Wisconsin small business owners are increasingly facing a gut-wrenching choice: eliminate health insurance coverage for their workers or accept the consequences of absorbing skyrocketing premium costs."

"Health insurance is still an important benefit to attract and retain workers and many companies continue to provide it. But insurance and business executives said they expect to see more small businesses drop health insurance coverage for workers if premiums continue to climb by double- and triple-digit percentage rates."

"Many employers, struggling under increased health insurance premiums, are shifting fees to employees. But that has forced some lower-wage workers to give up their health insurance coverage because they can't afford the increased costs. 'Where companies used to have $100 deductibles, they now have $2,000 deductibles,' said Steve Miller, president of Beneco of Wis-

consin, an insurance brokerage firm. 'We are not seeing businesses dropping coverage, but really cutting back on the quality of the coverage,' he said."

"The declining economy also may play an increasing role in any decision by small businesses to cut back or eliminate coverage, said Wayne Corey, executive director of Wisconsin Independent Businesses Inc., which represents owners of 16,000 businesses and 9,000 farms in Wisconsin. 'Dropping insurance entirely will hinge on how this year shakes out in Wisconsin,' he said. If 'the current shakiness transferred into a real downturn,' then, he predicted, more small businesses would be forced to abandon health insurance for employees, he said."

"A small percentage of businesses have dumped health insurance coverage plans, according to a survey by the Wisconsin division of the National Federation of Independent Business. Bill Smith, state director of the NFIB, said small businesses were 'getting priced right out of the group health insurance market because they do not have the buying power of large corporations.' "

"Smith said nearly 40% of small businesses surveyed by the organization saw their health insurance premiums increase by more than 25% last year. Another 49% experienced premium increases ranging from 10% to 25%."

"The Wisconsin Insurance Commissioner's Office has set up a small-employer health insurance task force 'to look at the availability and affordability of health insurance,' said Eileen Mallow, assistant deputy commissioner. The task force will make recommendations to the governor later this year."

"James Mueller, president of the employee benefits group of Frank F. Haack & Associates, health insurance consultants and brokers, said it's pretty much up to Wisconsin to find its own way to solve small-business insurance problems."

"Attempts in other states to cut costs through efforts such as pooling employees from several businesses in small groups in order to create more price negotiating power, have fallen short, Mueller said. He said the experience in other states shows that the small employee pools do not spread risk far enough, resulting in no cost savings."

"Madison-based Wisconsin Independent Businesses is backing a Wisconsin Senate bill designed to help businesses hold down premium costs through the creation of a large, statewide pool of employees."

"Corey said the program would not lower health insurance premiums for businesses but could stabilize them. The bill will be taken up in May."

## Backlash Or Accessing Needed Labor?

From "A Hue, and a Cry, in the Heartland" by Susan Sachs in *The New York Times*, 4/8/01:

"The last of the state population figures from the 2000 census have been made public, creating a new picture of the nation. Details are still fuzzy, but the broad outlines are clear: Hispanic and Asian immigrants--and more important, their children and grandchildren--are remaking small towns and big cities across the American heartland."

"This means explosive issues like public services for illegal immigrants and bilingual education, which detonated over the past decade in California and a handful of other states, now affect communities in Iowa and Nevada. The exploitation of immigrant workers, once associated with New York City sweatshops or West Coast agribusiness, is on the agenda of towns in West Virginia and Georgia. And the question of how to integrate people from diverse backgrounds and colors into the American mainstream is debated everywhere, because immigrant families have settled just about everywhere."

"When the governor of Iowa started talking recently about creating incentives to attract immigrants to fill factory jobs, the state legislature began considering an English-only law that is seen by some as an attack on immigrants. A number of governors have trekked to Mexico to find ways to bring in Mexican workers. At the same time, however, officials in those same states are demanding that the Immigration and Naturalization Service come and check all immigrants to make sure they are legal."

"A similar dynamic is at work in the labor market. Nationally, organized labor has acknowledged its ranks must be replenished by immigrants and has embraced immigrant causes. But, in individual cities and towns, unions can be fickle allies. Bowing to union pressure, for example, West Virginia's governor barred any company using illegal workers from getting state contracts."

"An intertwining of immigrants and citizens can be found as much in the economy as in society, said Demetrios G. Papademetriou, a scholar at the Carnegie Endowment for International Peace in Washington.

'They're becoming imbedded in every labor market sector, in a mutual dependence so deep that you cannot extricate yourself from it,' he said."

"And this is no longer a problem for just a few regions but for the entire nation. 'The dispersion of immigrants,' said Dr. Papademetriou, 'will be a transforming event for the way we understand, study and talk politically about immigration for years to come.' "

## Rural Counties Need Proactive Med. Schools

From "2001 Match Results and Information" by the American Academy of Family Physicians, 3/22/01 at <www.aafp.org/match/>:

"Medical students in 2001 are clearly demonstrating a preference for medical subspecialties over primary care practice when compared with data from the past few years. This trend is apparent among graduates of both allopathic and osteopathic medical schools. As seen in the past three years, graduates are selecting careers which offer flexible lifestyle choices with regard to schedule demands and financial implications. They are also choosing practice environments that provide fewer external productivity pressures and more generous third party payor reimbursement. Family practice, the specialty most closely associated with primary care, has witnessed a decline in fill rate to the levels of the 1994 Match overall and of the 1992 Match for U.S. seniors. The result of this disturbing trend is a health care delivery system that is severely compromised."

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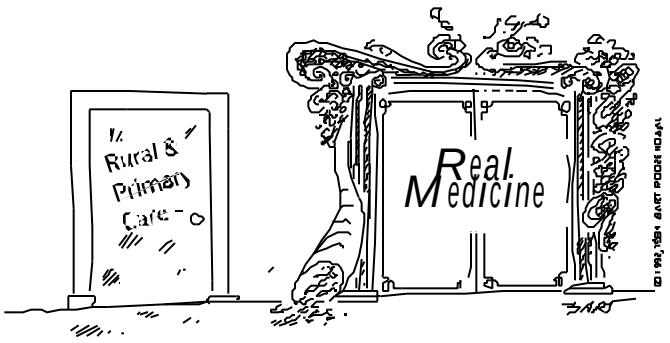


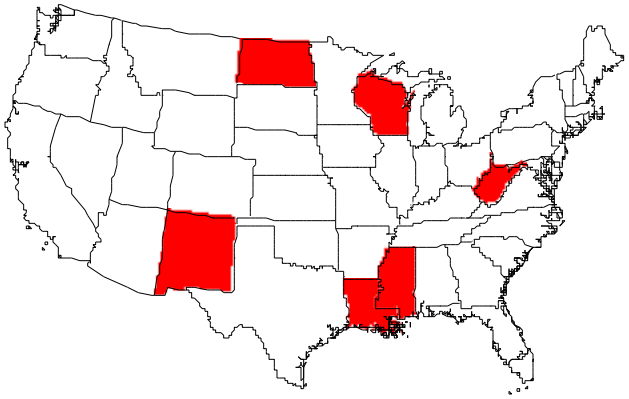

Unbiased Medical Education?

"Data from studies conducted by the Robert Graham Policy Center demonstrate that the United States relies on family physicians unlike any other specialty. Of Americans reporting a usual source of medical care, the majority identifies this source as a family physician, including those who are uninsured. Without family physicians, an additional 1,332 urban and rural counties in the United States would be designated as primary care health profession shortage areas (HPSA). This contrasts with 176 additional such counties if all general internists, pediatricians and ob/gyns were withdrawn in aggregate. In rural counties alone the reliance on family physicians is even greater, with family physicians outnumbering general internists and pediatricians by 3 to 1. An additional 1,050 rural counties would become primary care HPSA's without the work of family physicians. By comparison, only 33 counties would meet these criteria without general internists and without pediatricians. Without ob/gyns, only eight rural counties would be HPSAs."

**"Specialty choice is often shaped by experiences during medical school.** While today's students are being offered a primary care clinical experience early in their medical education they are also being exposed to a rapidly changing primary care

**Are Our Medical Schools' Cultures Supporting Their Primary Care Programs?**

**Wisconsin Ranks Among Lowest in 2001 Fill Rate For Family Practice Residency Positions**



Preliminary information available from the National Resident Matching Program (NRMP) indicates that the 2001 national fill rate for family practice residency positions was 76.3% (81.2% in 2000). In Wisconsin the fill rate was only 51.1% (70.2% in 2000); next to lowest state in the nation.

Source: American Academy of Family Physicians, 3/01
Graph: RWHC 4/01

practice environment. The demands of this environment as well as the uncertainty associated with change may result in experiences that cause students to choose subspecialty careers over primary care. **Increasing the number of subspecialist physicians at the expense of primary care continues to limit our capacity to meet the needs of our nation's most vulnerable populations including the uninsured, the underinsured and underserved rural and urban populations.** Without a solid foundation of primary care physicians it will be impossible to build a system of universal health care access."

## Our Great Failure—Rural Dental Health

From *Access to Oral Health Care for Medicaid Children in Illinois: A Focus on Rural Illinois*, prepared for the Illinois Rural Health Association by Gayle Byck, Judith Cooksey, Surrey Walton at the Illinois Center for Health Workforce Studies, 2/01; the complete report is available at:

<www.uic.edu/sph/ichws/pub.html>

"Children's oral health has improved over the past forty years, due to fluoridation, improved oral hygiene, better nutrition, and access to oral health care services. However, oral problems related to dental caries or cavities (painful teeth, missing teeth and poor appearance, impairments in chewing and nutritional limits) and other oral conditions affect the health and well-being of children and lead to missed school days and ongoing dental problems. While oral health care services are an important component of comprehensive primary care services, many children have inadequate dental care. In the last several years, national attention has focused on the problem of limited access to oral health care for low-income children. The Surgeon General's Report on Oral Health in America has called oral health disease a 'hidden epidemic.' "

"National data consistently indicate that low-income children are worse off in terms of oral health status and dental services utilization than higher-income children. For example, 30% of low-income children age 0-18 years visited a dentist in 1996, compared to 49% of middle-income children, and 60% of high-income children. Oral health examinations showed significant differences in children's oral health status (as measured by decayed, filled, missing, and treated surfaces), with worse oral health status among older children, ethnic and racial minorities and low income children. In the mid-1990s, only one in five children with Medicaid nationally received dental care in a year.

"The reasons behind the low utilization of dental services by Medicaid children are complex and include problems within the Medicaid program (payments, billing, client eligibility, services covered); limited participation by dentists; a limited number and limited capacity of public facilities offering oral health care services; and a variety of barriers facing children and their families that range from beliefs and attitudes about oral health care to transportation problems. The limited number of dentists willing to provide care to children with Medicaid has been called the most significant barrier to dental care. Most states are taking steps to expand dentists' participation, with the expectation that this will increase the number of children treated."

Policy Recommendations Include:

- "More dentists should be recruited to enroll in the Medicaid program. Efforts should be made to increase the number of children treated by currently enrolled dentists. This recommendation includes discussion of: adequate reimbursement rates; outreach to enroll new dentists in Medicaid; increasing participation levels of currently participating dentists.
- Consider options to increase the dentist supply in under-served areas.
- Explore the feasibility of expanding the capacity of dental clinics known as safety net providers, such as community health centers, local health departments and others.
- Encourage the integration of oral health care with primary health care.
- Enhance dental school training to include population-based studies of oral and dental disease among the high-risk groups, the problems with access to dental care, and public health dentistry. Expose dental students to community based private practices and safety net clinics where high-risk children are receiving care.
- Expand the role of dental hygienists in the care of Medicaid children.
- Establish a statewide oral health surveillance system.
- Expand community based preventive programs."

## Nonprofits Are Fundamental To Who We Are

It is in the public interest to preserve a strong charitable, nonprofit health care delivery system. From the Coalition For Nonprofit Health Care (CNHC) at <www.cnhc.org/>:

**Mission-Driven**

"Nonprofit providers are locally, publicly, or religiously controlled and mission-driven, as opposed to being motivated by a need to generate profits to return to investors. Nonprofit providers are accountable to communities, charitable or religious sponsors, and regulatory authorities, not to private shareholders."

**Access To Treatment**

"*Patients*—"Emergency treatment (and often other treatment as well) is rendered without regard to the patient's ability to pay. Nonprofit providers are required, as a condition of tax exemption, to provide nondiscriminatory treatment to Medicaid patients."

"*Services*—"Nonprofit providers are more likely to operate needed, yet unprofitable services, such as trauma centers and neonatal intensive care units."

"*Communities* –"Nonprofit providers are more likely to be or remain in communities that need them, regardless of economic incentive."

**Innovation**

"Public and private nonprofit providers have a unique role in developing clinical and educational innovations that are adopted by the entire field."

**Charity Care & Community Benefit**

"Nonprofit providers' surplus is used to further the charitable purpose and mission of the nonprofit provider or their sponsors, not to benefit shareholders, resulting in numerous activities and the provision of charity care to the benefit of America's communities."

"America's nonprofit health care organizations do more than just treat the sick and injured. Nonprofit health care providers operate to fulfill a mission, a mission that goes beyond the normal perception of health care delivery. Nonprofit health care entities work effortlessly to build healthier, stronger, smarter, and safer communities. Disease prevention, health promotion, and education are key components of nonprofit health care."

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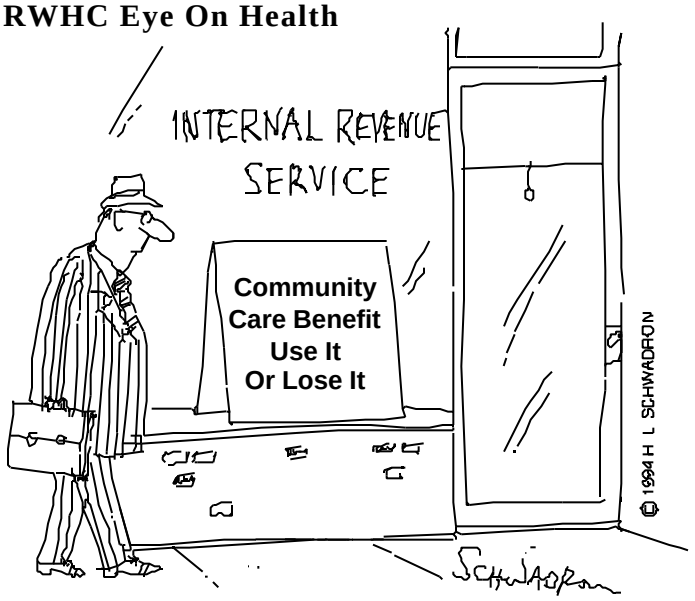


"The benefits that nonprofit health care organizations provide to infants, adolescents, teenagers, families, and communities--beyond the treatment of ailments and injuries--are numerous and significant. We need to more precisely identify and report the nature and scope of the community benefit provided by nonprofit health care organizations throughout the nation. It is only after this is successfully accomplished that one can begin to appreciate the full effect nonprofit health care providers have on our communities."

## A Friend To Rural Communities Moves On

Friends of Professor Ron Shaffer, retiring Extension Specialist Extraordinaire, recently honored him at the Center for Community Economic Development; most to the point was the following words recited from Longfellow's "The Fire of Drift-Wood":

> …And all that fills the hearts of friends
> When first they feel with secret pain
> Their lives thenceforth have separate ends
> and nevermore shall be one again"
>
> That first slight swerving of the heart
> that words are powerless to express
> and leave it still unsaid in part
> or say it in too great excess…

## RWHC Nursing Excellence Award Winners

We are pleased to announce that the Second Annual RWHC Nursing Excellence Awards have been awarded to Allison Philipps of Memorial Hospital of Iowa County in Dodgeville, WI, for clinical excellence as a staff nurse and Karen Sell of Columbus Community Hospital in Columbus, WI, for excellence in nursing management.

Nursing manager Karen Sell, a registered nurse since 1983, is a house supervisor at Columbus Community Hospital and also performs nursing duties in the emergency room. She was nominated by nurse executive Wendy Damm, based on her critical thinking skills, proficiency in several clinical areas, and involvement in improving the hospital's disaster preparedness program. Sell's positive attitude and outstanding dedication were factors, as well as her involvement in administering chemotherapy drugs and developing clinical pathways for pain management. She lives in Rio with her husband and their four children.

Clinical staff nurse Allison Philipps, a registered nurse since 1996, works in the Intensive Care Unit at Memorial Hospital of Iowa County and was nominated by nurse executive Nancy Caldwell, based on her outstanding clinical nursing practice and involvement in the community. As a health advocate, Philipps serves on the Iowa County Tobacco Coalition Steering Committee and is a trained facilitator in smoking cessation. She is a health services instructor for the Youth Apprenticeship Program offered through CESA #3 where she works with as many as 15-20 teens on a weekly basis, helping them to develop in their chosen vocations. Philipps will receive a baccalaureate degree in nursing from Viterbo College in May of this year. She was recently selected for induction into Sigma Theta Tau, the international society for nursing scholarship. Philipps resides in Dodgeville with her husband and two daughters.

The Nurse Excellence Awards were initiated to recognize the high quality of nursing practice provided by the hospitals serving rural communities. Nurses in community hospital settings must be highly educated, well-rounded in clinical practice, and have the ability to respond to a variety of age groups, diagnoses, and patient emergencies. The establishment of this award is public recognition that excellence in nursing practice is a valuable asset to rural communities and the state of Wisconsin.

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