



Rural Wisconsin Hospital Cooperative

Executive Director's Report

as of November 2, 2010

A monthly report of experiences and observations to RWHC hospitals & colleagues.

Bratwurst-Makers Debate in Top Gear

In today's Washington Post, Dana Priest did the best job I've yet seen of capturing the sense of chaos that is going to permeate the congressional health care debate over the next three months. Several excerpts follow:

"The last three months of the congressional health care debate were a whirlwind of lobbying, vote-trading and last-minute U-turns on the most far-reaching legislation Capitol Hill has considered in a generation. The next three promise to be crazier."

"Earlier, thousands of industry, consumer, labor and political organizations converged on a dozen swing legislators and the five committees writing health bills. Now, most interest groups' target lists include upwards of 60 undecided members in the House and Senate, where floor debate is targeted for the second week in August. The result is the microwave effect; a focused intensity of money and political power on an incredibly complex piece of legislation."

"Yesterday, the Democratic National Committee announced it would spend \$400,000

on a week of ads pitching reform as a middle-class issue. A coalition of labor, seniors and health professionals have organized a \$1.8 million, two-week-long bus tour of 36 states. The Health Care Reform Project has \$1.5 million for ads. The Health Care Leadership Council, a collection of the largest for-profit hospital, insurance, medical equipment and pharmaceutical companies, is putting up \$300,000 for radio ads in 25 congressional districts to condemn price controls. The "Strike Title 10 Coalition," an insurance-business alliance, is spending \$200,000 to fight the inclusion of worker's compensation in any health reform bill."

"The Leadership Council has an annual budget of \$6 million, all aimed at influencing health reform legislation. The Anti-Mandate Coalition is a recent marriage of the National Federation of Independent Business, the National Restaurant Association, the National Retail Federation and some giant chains—McDonald's, Pepsico, General Mills, J.C. Penny's, K mart Corp. and Marriott – to defeat "employer mandates.""

"Clinton and First Lady Hillary Rodham

Clinton plan yet another round of town meetings and speeches aimed at raising the profile of health care. Hillary Clinton is tentatively scheduled to kick off the bus tour in Portland, Ore., on July 22.”

“After 18 months of national attention, after the excruciating process of writing and explaining Clinton's health plan, after more than a year of public barnstorming by Clinton and his wife and months of private Oval Office meetings with lawmakers, there is still no majority for Clinton's bottom line: guaranteeing health insurance to every citizen by a date certain. Nor is there a clear majority of support for second-tier issues, like how to control costs, how to finance academic medical centers, how to cut Medicare and Medicaid without endangering the quality of care or how to simplify the insurance bureaucracy.”

The Occupational Mix Ping-Pong Fix?

And you wonder why Congress is confused?

Recommendation #15 of the March 1st *ProPAC Report And Recommendations To The Congress* stated that “The Secretary should develop and implement improved methods for collecting data on employee compensation and paid hours of employment for hospital workers by occupational category. Once these data become available, the Secretary should implement an adjustment to the hospital wage index under PPS. This adjustment would correct the wage index for the inappropriate effects of including geographic differences in the mix of occupations employed.”

The rationale given was that “hospitals located in large cities tend to employ a substantially more expensive mix of labor than hospitals located in rural areas. Conse-

quently, the current wage index values for large urban areas tend to be too high, while those for rural areas tend to be too low. This results in overpayment for some hospitals and underpayment for others.”

“Adjustment of the wage index for occupational mix would substantially improve payment equity among hospitals under the current PPS labor market definitions. It would be equally desirable for a wage index based on nearest neighbor labor market areas. In this case, ProPAC believes an occupational adjustment would reduce variation in wage index values among nearby hospitals and would help the wage index more accurately reflect the labor price levels hospitals face.”

HCFA’s response in the May 27th *Federal Register*? “We are not convinced that an occupational mix adjustment would improve the accuracy of the wage index, as we have discussed most recently (sic) in the 1991 final rule... Hospitals would not be compensated for a mix of employees above the standard while hospitals with a mix of employees below the standard would be overcompensated relative to their cost of labor.”

I.e. ProPAC is saying that the lack of an occupational mix adjustment causes an underpayment of rural hospitals while ProPAC says just the opposite, that its implementation would cause an underpayment of urban hospitals. Go figure.

HCFA offers no explanation for their rationale and does not reference the existing case mix adjustment that already reimburses those hospitals with more complex cases that may justify a “richer” occupational mix of staff.

HCFA assembled a discussion work group with representatives from the hospital industry and “presented ProPAC comments concerning the equity of adopting a method to

collect data to assist in the development of an occupational mix. The work group's consensus was that the data required to implement the proposal is not currently available and the likelihood of obtaining such data would be minimal. There seems to be little support among hospital industry representatives for developing a system that in their opinion clearly creates additional reporting burdens with an unproven or minimal impact on the distribution of payments."

As the development of an occupational mix adjustment appears to clearly advantage rural hospitals at the expense of urban hospitals and as a rural hospital perspective was probably under-represented or not represented at HCFA's invitational meeting, the alleged "consensus" is, at a minimum, highly suspect.

We need to call on the National Rural Health Association, the Small and Rural Section of the American Hospital Association and the National Advisory Committee on Rural Health to continue to push this issue.

Footnote: It is important to note that in the same May 27th *Federal Register*?, HCFA announced that it is circulating a draft document proposing to severely adjust the DRG classification system. A copy has been sent to state hospital associations for review and comment. As any additional severity adjustment to the DRG payment system is likely to shift dollars away from rural hospitals, the need for an equitable system of wage indices becomes more critical than ever.

Bruce Vladeck to Challenge Co-ops

As previously reported, I have been invited to speak at the Cooperative Economic

Summit in Washington on the 20th. The good news is that today I learned they have restructured the session with HCFA Administrator Bruce Vladeck giving the principle address and the rest of us becoming responders; the bad news is that we are each given only five minutes to talk about the expansion opportunities for co-operatives in a reformed health care system.

Outreach Grant Screen to be Revisited

Jeff Human, Director of the Office of Rural Health Policy, has confirmed our discussion that they would reexamine the definition of consortium for purposes of outreach grant applicant eligibility. (They currently regard any existing organization with a tax identification number as a single entity, even if that organization has multiple members.)

He has stated that the down side of allowing incorporated consortiums to be considered consortiums is that they currently tend to be relatively homogenous groupings—like hospital cooperatives. However, this perspective implicitly places an additional criteria on incorporated consortia that is not a requirement for other applicants – that three consortia entities (members) be of different types. Notwithstanding what I consider to continue to be a confusing line of thinking, I am optimistic that the review will at a minimum result in the screening criteria being made public, and hopefully less discriminatory against our particular type of cooperative.

Potential Rural Grant Program Merger

Millicent Gorham from NRHA has reported that Washington representatives from NRHA, AAFP and the National Association

of Rural Health Clinics are discussing with Senator Nancy Kassebaum's staff the idea of consolidating rural health categorical grants, i.e. Rural Health Outreach, Rural Transition Grants, EACH/RPCH and any categorical grants passed as part of reform. The consolidated programs would be put in a "block grant or an expanded outreach program" and administered by the states. The basis for this consideration is to use the funding more effectively to build rural community-based health networks.

On a related issue, I was asked by several different people working in the U.S. Senate and the Administration about how to improve some language related to the development of rural networks. My primary response was to empower rural communities and providers by giving resources to them to form or buy network services rather than to be the subject of the proposed academic health center outreach efforts. Such an approach would help to lend to a more level playing field as additional regional relationships are negotiated.

CHIPs Implementation & Replication

Yesterday I participated in the Community Health Intervention Partnership (CHIPs) National Advisory Committee conference call. I am proud to report that the pilot sites complemented as being right on target with their work plans included at the head of the list RWHC participants—Prairie du Chien and Viroqua!

The second piece of good news was that the CHIPs sponsor, the Hospital Research and Educational Trust (an AHA affiliate) has lived up to its commitment to move forward and seek substantial additional funding from the Robert Wood Johnson Foundation to help implement the plans developed by the pilot sites as well as to substantially expand

the initiative to additional rural and urban sites.

This continues to be an exciting project that is demonstrating the viability of strong and equitable partnerships among health care providers and community groups.

Technical Leadership Comes to OHCI

I had the opportunity yesterday to talk big picture stuff over breakfast with Trudy Karlson, the new Director of the Office of Health Care Information. I have been friends with Trudy for a good many years so I was not surprised by the quiet competence I could see her bringing to OHCI. Given the very central and critical role of this office under most future health reform scenarios, the timing is very good for an individual, unlike a number of her predecessors, who brings actual experience with health data and analysis to the position.

Rural Medical Center Project Update

Yesterday, I had the pleasant opportunity to spend a couple hours with Larry Hartzke, recently hired by the Division of Health to work full time on the Rural Medical Center Project. The good news is that he is enthusiastic about our project and clearly has the capacity to do this job well; he is already well into his review of the draft enabling legislation and necessary revision of Chapter 127 rules. We will finally be accelerating the Project's output and the Advisory Committee will begin to meet bimonthly to review specific recommendations instead of the rather well spaced meetings to date. The bad news is that his supervisor and a high quality point of continuity for the Project, Allan Stegemann is changing jobs. He

leaves his position as Provider Regulation Section Chief in the Bureau of Quality Compliance to take a job at the UW's Center for Health Systems Research and Analysis, continuing the musical chairs that seems to plague DHSS.

Hospital Sector Begins to Fragment?

Several months ago Holy Family Medical Center terminated its membership with the WHA over a policy disagreement around Certificate of Need. Now the Novus Health Group (Appleton Medical Center and Theda Clark Regional Medical Center in Neenah) has left, reportedly not over an issue of policy but an institutional consideration of their own cost/benefit of remaining. While our state hospital association stills stands out as having an unusually good percent of state hospitals as members, these events "up the anti" for this summer's WHA board retreat.

National commentators have been saying that health reform will tend to bring rural providers together and tear urban ones apart—this may or may not be evidence of that trend.

G. Johnson Supported for WHA Slot

On behalf of RWHC I wrote enthusiastically in support of the nomination of George Johnson as WHA Chairman-Elect. Given Dan Manders and Terry Potter's recent contributions in this capacity, they may claim some myopic need to look for leadership outside of the Southern District. In any event it is a real honor for George to be considered and it is clear that at some point he will have the opportunity to bring a strong and knowledgeable rural voice to the WHA leadership.

Wisconsin Primary Care Consortium

As most of you know Robert Wood Johnson decided not to fund the implementation grant that so many of us spent so much time over the last year preparing. However, there is life after rejection and I can only say that I see everyone moving full steam to convert the grant application into a viable corporate work plan.

Of course the highest priority is the securing of a funding base for core corporate support; in the last few weeks over \$60,000 in new moneys have already been secured. To that end RWHC has pledged a minimum of \$10,000 from the Executive Director's Discretionary Fund (honorariums). With core support beginning to look like "less of a problem", the Steering Committee can now spend more of its energies on seeking and obtaining the program funds necessary to expand primary care initiatives in Wisconsin.

RWHC Donates to NRHA Foundation

RWHC has become a "charter member" of the newly established National Rural Health Association Foundation through a contribution of \$1,000 from the Executive Director's Discretionary Fund. An additional \$4,000 has also been pledged (over the next five years dependent upon its availability). NRHA is committed to raising \$1 million to provide innovative programs and education for association members through this not-for-profit foundation.

Avoiding Intra-Rural Reform Conflict

While in North Carolina Monday at the invitation of their Health Reform Commission I was once again reminded of the significant differences among states. While many of the differences were expected, I was saddened by the gulf that appeared to be present between rural hospitals and rural public health departments. It certainly appeared to interfere with the discussion of how rural acute care providers could have a voice in their future as very aggressive corporate take-overs of rural clinics are accelerating.

I responded by speaking very much in support of enhancing public funding for core public health responsibilities. However, I did remind the group that rural hospitals and physicians are facing increasingly aggressive and acquisition oriented competitors. I had not recently heard of any large urban insurer or clinic doing a hostile takeover of a rural county's health department.

I hope that we can continue to be more successful in Wisconsin in fostering mutual support among multiple rural players.

HCFA's 2nd Rural HMO Workshop

Last month I was invited by HCFA to join a number of private and public sector people to brain storm about how managed care options can better serve rural populations.

While it is clear that the agency is sincere in wanting to move forward, it is not clear the political will is there to tackle the most significant barrier—ongoing discrimination in the AAPCC (adjusted average per capita cost) system used to reimburse HMOs. The AAPCC payment “carries forward” a distillation of all of the inequitable reimbursement policies inherent in non-capitated Medicare Part A and B payments.

Once again, the difference in perspective

between the “suits” (corporate insurer types) and more grass roots bred rural health folks was very apparent. Just one example was very revealing; while some of us were aware of AHA's quality standard for community networks related to committing to working on enhancing the health of the community as a whole (a la the CHIPs project), the “suits” tended to not even be aware that networks might rightly be expected to behave in such a manner.

On a possibly related note, we met in the DHHS Inspector General's Conference Room; while the mug shots were only imagined to be on the wall (like in the WHA Board room), the spirit of many fraud and abuse cases was clearly present.

Russian Emigrant Seeks New Position

Helen Sternberg emigrated from Russia to Wisconsin in 1991 (fluent in English) who with the support of the Madison Jewish Community Council has just received her certification as a Radiology Technologist from the University of Wisconsin. Her entry into the field of medicine is a childhood goal that she was unable to pursue in the Soviet Union. Please call me if you would like to see a copy of her resume or know of any job openings in southern Wisconsin.

Exploring Washington's Wilderness

No, this is not another report on my misadventures in the corridors of our nation's capitol. My youngest son Sean and I along with a friend of Sean's will be back-packing in the State of Washington around Mount Rainier. I'll be out of the office from Tuesday July 26th through Wednesday, August 3rd.

