



Rural Wisconsin Hospital Cooperative

Executive Director's Report

as of November 2, 2010

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

Anti-Trust Principles For Networks

On September 27th, the U.S. Department of Justice and the Federal Trade Commission issued a revised "Statement of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust"; 106 pages that include a long awaited section on "Analytical Principles Relating To Multiprovider Networks (Statement 9)."

This is absolutely critical to RWHC and rural providers if rural based strategic alliances are able to represent member interest before a concentrating number of insurers and alliances who control an increasingly larger share of the market.

"Health care providers are forming a wide range of new relationships and affiliations, including networks among otherwise competing providers... As used in this Statement, multiprovider networks provide health care services to the subscribers of health benefits plans, and may or may not assume insurance risk or be affiliated with an insurer. A multiprovider network may or may not require complete integration of the practices of its members."

"Because multiprovider networks are relatively new to the health care industry, the Agencies do not yet have sufficient experience evaluating them to issue a formal statement of antitrust enforcement or to set a safety zone."

"The Agencies recognize, however, that guidance on antitrust issues raised by multiprovider networks is of vital importance to the health care industry."

"The Agencies will evaluate a particular multi-provider network to determine its likely effect on competition. If the multiprovider network involves agreements among competitors that restrict competition (such as setting a single price for their services), the Agencies first will determine whether the competitors are sufficiently integrated through the network so that the agreement should be treated under the rule of reason (i.e providers have a shot at making an appeal to reason) rather than being held per se unlawful (i.e better opportunity for the government to kick some "butt")."

"Antitrust law prohibits naked agreements among competitors that fix prices or allocate markets. Where competitors economically integrate in a joint venture, however, agreements on prices or other terms of competition that are reasonably necessary to accomplish the procompetitive benefits of the integration are not necessarily unlawful."

"In multiprovider networks that include some direct competitors, such competitors either must avoid price and market (or service) allocation agreements by making unilateral decisions on the prices they will charge and the markets they will serve, or they must assure that such joint decisions are necessarily related to significant economic integration

among them. Substantial financial risk-sharing among competitors ... evidences such integration.”

“The following are examples of situations in which substantial financial risk is shared among the members of a multiprovider network joint venture:

- (1) when the venture agrees to provide services to a health benefits plan at a “capitated” rate; or
- (2) when the venture creates significant financial incentives for its members as a group to achieve specified cost-containment goals, such as withholding from all members a substantial amount of the compensation due them, with the distribution of that amount to the members only if the cost-containment goals are met.”

“In addition, the Agencies will consider other forms of economic integration that amount to the sharing of substantial financial risk; the enumeration of the two examples above is not meant to foreclose the possibility that substantial financial risk can be shared in other ways.”

State-Action Immunity And Antitrust

An alternative to passing a federal antitrust test is to be exempt from it by obtaining a “certificate of public advantage.” A number of states, including Wisconsin, have such a statute. The Kansas Hospital Association commissioned a report that reviews issues for them related to “immunizing health care cooperative agreements.”

Rosenberg & Associates reviews and analyzes “(1) the doctrine of state-action immunity under the antitrust laws and (2) whether state-action immunity is achieved under specific legislation enacted by the State of Kansas.” They conclude that the Kansas statute “properly contemplates active supervision, but the State must follow-up on the legislature’s recommendations. This statute , standing alone, will probably fail to adequately immunize cooperative health care providers from antitrust liability.” Wisconsin

is in the same situation—it also needs to go beyond just having a statute on the books.

Building A Collaborative Advantage

“Alliances between companies, whether they are from different parts of the world or different ends of the supply chain, are a fact of life in business today. ...being a good partner has become a key corporate asset. I call it a company’s *collaborative advantage*. In the global economy, a well-developed ability to create and sustain fruitful collaborations gives companies a significant competitive leg up.” So begins Rosabeth Moss Kanter’s recent article in the Harvard Business Review (J/A ‘94, 72(4): 96-108), “Collaborative Advantage: Successful partnerships manage the relationship, not just the deal”.

Her research uncovered three fundamental aspects of business alliances:

☞ “They must yield benefits for the partners, but they are more than just a deal. They are living systems that evolve progressively in their possibilities. Beyond the immediate reasons they have for entering into a relationship, the connection offers the parties an option on the future, opening new doors and unforeseen opportunities.”

☞ “Alliances that both partners ultimately deem successful involve *collaboration* (creating new value together) rather than mere *exchange* (getting something back for what you put in). Partners value the skills each brings to the alliance.

☞ “They cannot be “controlled” by formal systems but require a dense web of interpersonal connections and internal infrastructures that enhance learning.”

Sec. Shalala’s Committee Backs RWHC

I left my first meeting of Donna Shalala’s National Advisory Committee on Rural Health (NACRH) feeling that maybe something had

been accomplished. They agreed to make a recommendation to the Secretary that supports ProPAC's (and the Cooperative's) position on the need to standardize wage data by occupational mix. This is a necessary technical change if Medicare's payment for inpatient care is to reflect the price of labor faced by rural hospitals—their labor market.

This has always been the reimbursement formula's stated intent but it has never been implemented due to problems getting the data. Without this correction, hospitals with a more expensive mix of labor in effect are paid twice; they receive a case mix adjustment to acknowledge their greater proportion of higher paid staff but then get the same adjustment again through the flawed wage index adjustment. Of course the opposite is true for hospitals with a less expensive occupational mix—they lose on the case mix adjustment and again through the flawed wage index adjustment.

The AHA position has generally been that the benefit of obtaining this data is out weighed by the expense. In lieu of occupationally adjusted data being available, HCFA uses an area's average hourly wage paid, data that usually results in a lower wage reimbursement for rural hospitals and communities.

As noted by NACRH: "In an area where hospitals employ a lower percentage of higher paid, specialized personnel than in a neighboring area, the area wage adjustment would be lower, even if both areas paid exactly the same wages for professional personnel." Standardizing wage data by occupational mix would be a major improvement in the equity of the Prospective Payment System. See the following story for an estimate of the potential benefit (or current loss) to rural communities.

Data Error Costs Rural \$225 M / Year

The failure to normalize rural hospital wage data for differences in occupational mix cost rural hospitals about \$225 million dollars in Federal Fiscal Year 1994. This calculation is based on ProPAC's Annual Congressional Medicare Report and on estimates from the

University of Minnesota in a soon to be published paper on alternative wage models.

On average individual rural hospitals would receive a three percent higher Medicare payment for inpatient services if the wage index was adjusted for occupational mix—dollars that go directly to the bottom line.

The Proposed "Refined" DRG

For years we have discussed the potential that one day DRGs would be adjusted for differences in severity within a DRG. That day appears to have arrived. HCFA made available this summer on a prerulemaking basis their proposal, "Refinement of the Medicare Diagnosis-Related Groups to Incorporate a Measure of Severity." HCFA's estimates that nationally, the total percentage effect on payment for urban hospitals is limited to a redistribution effect (i.e. a 0.0% net gain) and a loss of .6% for rural. The change in East North Central is a gain of .1% and a loss of 1.0% respectively.

From a rural perspective this seems to be a good time to insist that the introduction of refined DRG's should only occur in combination with the introduction of an occupational mix adjustment.

Fiscal Facts At End Of The Tunnel

☞ **Current Federal Budget Pie**

Entitlements		50%
Interest	18%	
Defense	17%	
All The Rest		15%

☞ **FICA TAX in the Year 2005**

Per employee	15%
Per employer	15%

(Due to demographics of continuing fall of ratio of workers to retirees.)

☞ **Bottom Line**

Means testing entitlements will be needed to keep the federal government solvent.

I had the opportunity this month to hear the above from former Senator Warren Rudman while in New Hampshire at a national meeting of health and education bond authorities and he is very persuasive. Some of the subsequent cross-generational discussions among conference attendees were on the heated side.

The basic position of the Concord Coalition which he helped to start is to “awaken the American People to the gravity of our nation’s fiscal crisis.” He did not expect means testing of Medicare and Social Security to happen until the AAWP (working people) balances the voice of AARP. but he does expect it to happen.

Expect less resistance from AARP and others to Medicare cuts as they are forced to chose between our cuts and their means testing.

The Arrogant Capital

After two years, Congress failed to pass even a limited national health reform bill and now it looks like the fall election will be particularly unpleasant for incumbents, regardless of their political party. If you are like me, you are pretty confused and trying to understand the relationship between all of us out here and those out there, inside the beltway. This is not an endorsement of all of his ideas but you may want to get hold of Kevin Phillip’s provocative book, *Arrogant Capital*. This is an easy to read, short book, but not for the faint of heart, as in:

“Everyone knows that Washington is completely out of touch with the rest of the country. Now Kevin Phillips, whose best selling books have prophesied the major watersheds of American party politics, tells us why.”

“Washington-mired in bureaucracy, captured by the money power of Wall Street, and dominated by 90,000 lobbyists, 60,000

lawyers, and the largest concentration of special interests the world has ever seen—has become the albatross that Thomas Jefferson and other Founding Fathers feared: a swollen capital city feeding off the country it should be governing.”

“To work again, Washington must be purged and revitalized. In his unique blueprint for political upheaval, Phillips puts Washington on notice by sounding a call for immediate action, offering us a wide variety of remedies—some quasi-revolutionary and others more moderate:”

- ✓ Decentralize power away from Washington
- ✓ Modify excessive separation of powers between legislative and executive branches
- ✓ Shift more towards direct democracy and open up the outdated two-party system.
- ✓ Curb the Washington role of lobbies, interest groups and influence peddlers.
- ✓ Diminish the excessive role of lawyers, legalism and litigation
- ✓ Remobilize national, state and local governments through updated boundaries and a new federal fiscal framework
- ✓ Regulate speculative financing and reduce the political influence of Wall Street
- ✓ Confront the power of multinationals
- ✓ Reverse the trend toward greater concentration of wealth
- ✓ Bring national debt under control.

Rougher Transition to Managed Care?

This round of Washington’s debate on health reform is now over and the post mortem is well under way. But little has been written about the failure to enact those reform elements proposing government as “referee” in

an increasingly bare-fisted competitive environment. Dan Morgan in the Washington Post (8/31) is a relatively rare example of the mainstream media partially reporting the major private sector re-formation and potential downside implications; several excerpts follow:

“While the politicians have been talking, corporations, insurance companies, HMOs and hospital conglomerates - all driven by the business imperatives of cost-cutting, quality control, and efficiency - have been moving to introduce a new method of delivering health care services known as ‘managed care.’ If no legislation is passed, this “managed care” revolution will continue and possibly accelerate... But the federal government will play less of a role as referee.”

“Advocates of a market-oriented health system, who lobbied hard against proposals seen as interfering with the ability of businesses, HMOs and insurance companies to cut costs, say that this is good for the country. What should matter about a health care system, they say, is not who earns the profits but whether patients are receiving good, affordable treatment.”

“There is no way that the market will solve the problem of the uninsured,” said Drew Altman, president of the Kaiser Family Foundation. “The trick is to let the market work while making sure that protections are built in. Without health reform, what sort of ground rules will you have so that poor people and very sick people won’t be left by the way-side?”

“The 18-month-long health care policy debate in Washington often obscured the speed and depth of the changes that were sweeping through the health marketplace while the politicians talked... But the full repercussions of the push are only now becoming clear. They include a spate of mergers involving hospitals, pharmaceutical companies, drug benefit management firms, HMOs and insurance companies - all seeking to maximize their leverage in negotiations over the price of medical goods and services.”

“As more people enroll in health plans that negotiate fees with providers on behalf of big

blocs of customers, hospitals and doctors are seeking to increase their economic muscle by banding together in networks and alliances of their own...”

For-Profit RHC Chain Coming To WI?

About ten years ago, Dr. Paul Elwood proposed to us at the National Rural Health Association his vision to create a single national for-profit rural HMO; he called it REAP but after our initial “dialogue”, most of us called it potential rape. I’ve got to go back that far to find a personal example of a proposal that I believed in its initial draft, presentation and potential scope lacked as much cultural competence to rural network development.

This month, I was invited to hear and respond to several businessmen with an idea to establish a network of for-profit rural health clinics in Wisconsin as part of a multi-state plan “already well underway.” (They were not willing to share the names of other sites or states.) Depending on the particular moment in the discussion that I go back to, they were “going to work with existing rural providers” but the next they were “providing a needed option in the local rural community.”

The presenter’s initial erroneous references to the well known federal rural health clinic program were strange—in the memo I received and in their introductory remarks, an impression was left that they were confusing two separate federal programs, rural health clinics and community health clinics. But I believe we went from bad to worse when their responses to our initial concerns were not questions about why we felt the way we did or what might be alternative approaches but a reiteration of the sales pitch. This is a pattern of interaction that my experience associates with the aforementioned REAP.

In any event, this is a good reminder to all of us, we need to take advantage of existing federal programs to meet local community need or others will appropriately come forward to do so. The current potential for additional rural health clinic expansion is unclear to me but where needed, its worth seeing that they

are community owned and operated.

RWHC In State & National Media

- ✍️ **Health Care in Rural America: Symptoms and Solutions**, a new, 28-minute documentary, will be uplinked on October 25th to the Public Radio Satellite System by the Robert Wood Johnson Foundation. While I was left on the cutting room floor, Pat Ruff will be one of the voices you hear. The chances of Wisconsin's public radio network downlinking the program are significantly enhanced if folks call in and ask for it in advance. Thanks.

- ✍️ **The Milwaukee Sentinel & Tom Daykin** are doing a story that follows up on their major series last spring on the health care systems that are beginning to dominate the state. (The one illustrated with a map showing the infamous spreading globules.) We contacted the paper at that time saying that we felt the story was incomplete because it did not discuss any of the alternatives being developed. They promised to contact us at the time of the next story and they were good to their word. Sauk-Prairie Memorial Hospital was also interviewed as an example of the progressive rural hospitals that make up the Cooperative. The story is scheduled for October 31st and will hopefully make it clearer to a broader audience that urban based "outreach" is not the only way to serve rural Wisconsin.

The Spirit of Cooperation

A 56-minute documentary about cooperatives, **The Spirit of Cooperation** tells the story of America's cooperatives which are part of a self-help tradition that is as old as the nation itself. Presenting a broad overview of many types of cooperatives, the documentary describes cooperative businesses—businesses owned and controlled by the people who use their services—and shows how cooperatives help people grow and prosper.

I have a home-made copy from when it was shown on October 10th or a professionally made copy can be obtained for \$39.95 from the Cooperative Development Foundation, 1401 New York Avenue, N.W., Suite 1100, WDC 20005 (202-638-6222) which we will soon have available in the RWHC member lending library.

The First October Surprise

With little comment I will report that Dr. Jay Noreen is returning to the UW-Madison. Some of you will remember that we did not always see eye to eye re the University's responsibility to educate providers for rural Wisconsin.

