



### Graying Wisconsin Leads to Growing Conflict

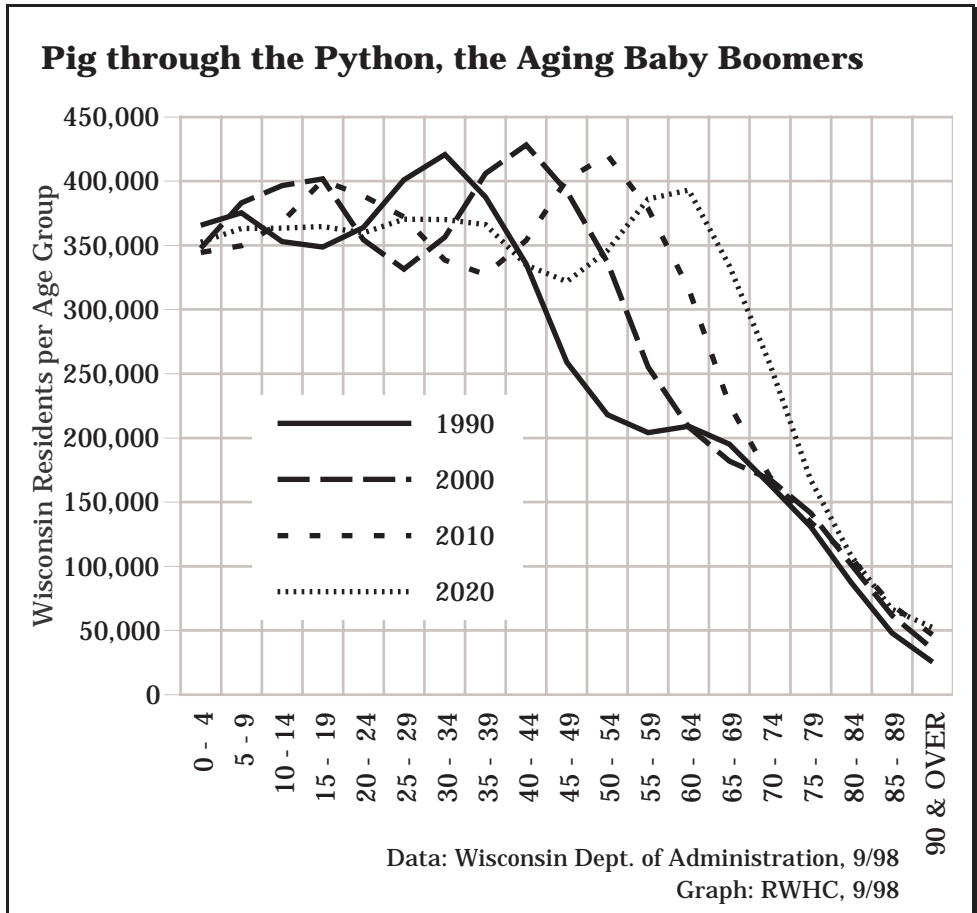
The enabling legislation for a State of Wisconsin long term care system will be a lightning rod for potential conflicts in the upcoming 1999-01 biennial budget bill deliberations. Providers, state and county government and Wisconsin's aging residents will each bring a major voice and sometimes differing perspectives to this complex but critical initiative. Like any commercial product, public programs/policy are now more easily popularized with a brand name--this one has been coined Family Care by Governor Thompson. As described by the Wisconsin Health and Hospital Association, "Family Care would be designed to meet the needs of the elderly and of adults with physical or developmental disabilities. Family Care is intended to:

- combine multiple programs into one system;
- provide one-stop shopping for services;
- enhance participant choice while at the same time managing the type and cost of services they receive;
- reduce the state's cost per person served so as to effectively manage the state's budget and higher number of participants as the population ages;
- eliminate waiting lists for eligible participants; and
- remove a perceived 'institutional' bias in the current system."

"The implementation plan envisions the establishment of a statewide system of Aging and Disability Resource Centers by the year 2002. Resource center services

would be provided through the counties. Resource centers would conduct participant needs assessments, as well as assist families with understanding the care options that are available. Once a county has a resource center in place, the care management concept will be introduced. Long term care funds will be pooled and a set of services purchased from one or more care management organizations (CMOs) under a capitated arrangement to manage and deliver the set of services covered under Family Care. Counties can act as CMOs or contract with other entities to perform this function. The goal is for CMOs to cover every part of the state by the year 2004.

In rural communities, Family Care is seen as a threat by many providers given their substantial capital and program investments, money spent based on a long-



standing set of state policies. Family Care is seen by those who advocate for the elderly as an overdue opportunity to have more community based services closer to home. Family Care is seen by some county governments as a way to gain additional financial support for public infrastructure. The State is trying to manage its responsibilities for the long term care of its aging population. To further complicate the political mix, many providers are also advocates, residents are also taxpayers and governments are often long term care providers.

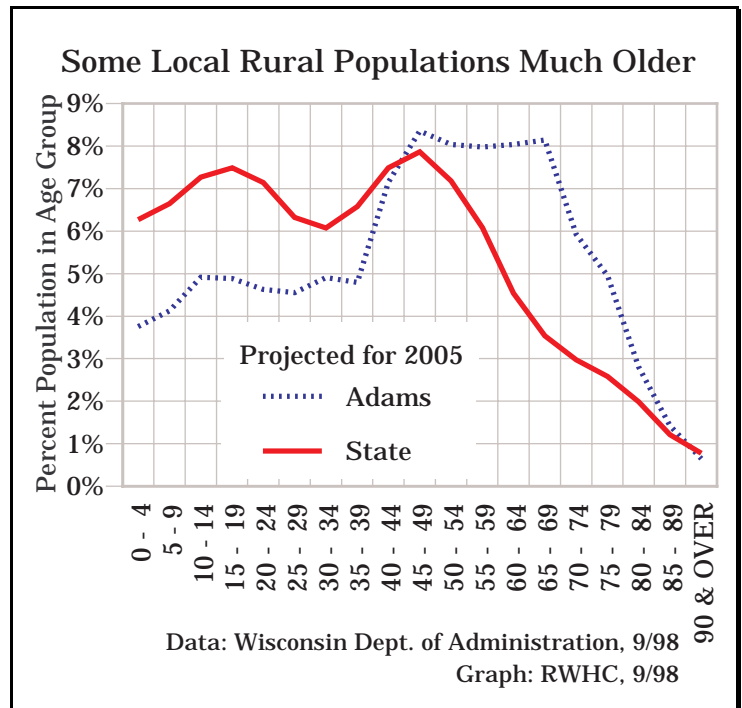
In any event, we can all agree on one thing--Wisconsin is aging--most dramatically demonstrated by the mammoth cohort of "Baby Boomers" born after World War II that are beginning to think of retirement as not something about their parents but about them. Currently thirteen percent of Wisconsin's population is over age 65, in twenty years it will be seventeen percent. In the fifteen most rural counties served by RWHC providers, the proportion of the population over age 65 goes from sixteen percent to twenty percent. Individual county and community rates will obviously vary widely; in the case of Adams County, thirty-five percent of its population is projected to be over the age of 65 in 2020. The mix of local services needed will be very different as this shift begins to take place.

Given that we consume most health services when we are older, meeting future service needs for all of us will be a major challenge. Wisconsin is wise to start the debate and pilots now, whether the current rendition of the Family Care proposal is the "right one" remains to be seen; substantial questions have been raised about the reasonableness of the financial modeling and the conflict of interest if counties become both resource centers/gatekeepers and care management organizations.

*The Wisconsin county level projections of population by age group is from the Dept. of Administration at <[www.doa.state.wi.us/deir/boi.htm](http://www.doa.state.wi.us/deir/boi.htm)>. Thanks to Pat Guhleman, Program Coordinator at the State of Wisconsin's Center for Health Statistics for her help in finding county level population projections (any interpretation errors came from elsewhere). A useful page of links to population health data available on the internet is under development by The Collaborative Population Health Data Group at*

*[www.medsch.wisc.edu/prevmed/network/collab.htm](http://www.medsch.wisc.edu/prevmed/network/collab.htm)*

*An excellent example of what is possible by such an approach can be seen by visiting Health Information Tennessee at <<http://server.to/hit>>. "HIT allows the user the opportunity to query various Tennessee health data bases in such a way that personalized charts and tables can be produced upon demand. The requested information is calculated at the moment the query is submitted... In this way, information can be presented in an infinitely flexible manner, statewide and substate comparisons can be made locally."*



## Where is Ken Starr When We Do Need Him?

The White House isn't the only Washington address with a credibility gap--add to the list the Health Care Financing Administration (HCFA, which runs Medicare). Rural hospitals across the country spent a lot of time this year defending frivolous complaints from HCFA under the federal "false claims act." Some would argue that we now need a false claims act for HCFA.

Under Congressional pressure to uphold the original Congressional intent, HCFA switched direction in July to say that they would not include transfer to rural swing beds under its new rule to reduce payment for hospitalizations that end in a transfer to another service. ("Swing beds" allow for a brief transition with a nursing home level of care.) While not citing any tortuous legal distinctions of what they didn't do and didn't say they did do, they have announced, with only a few days warning that they are again reversing their decision about swing beds. HCFA says it is too busy with the Year 2000 computer bug to meet its commitments.

**Please contact your Members of Congress and ask them to insist that HCFA follows through on their commitment to Congress and to rural communities to remove swing beds from the new transfer rules.**

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## Rural Principles for Rural Medicare Reform

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From testimony by Keith Mueller before the National Bipartisan Commission on the Future of Medicare <<http://medicare.commission.gov/medicare/index.html>> on behalf of the National Rural Health Association, 9/8/98. The complete testimony is available at <[www.rwhc.com/papers/mueller9.98.html](http://www.rwhc.com/papers/mueller9.98.html)>:

**“First, opportunities enriching Medicare for beneficiaries should be available to all rural beneficiaries.** Medicare Managed care plans will not blossom quickly in rural areas. The June 1998 enrollment rate was 2.5 percent in nonmetropolitan counties, compared to 18.8 percent in metropolitan counties, and that is after a more rapid growth rate in rural versus urban counties, December 1997 to June 1998. To the extent managed care plans offer advantages to enrollees in terms of more benefits for lower premium contributions, Medicare policies need to create comparable advantages for rural residents, perhaps through supporting supplemental insurance plans.”

**“Second, Medicare policies must be designed to sustain the rural health care delivery infrastructure.** Medicare payments are a higher share of provider income in rural areas, often more than a majority of patient income. Small changes in Medicare income for rural providers can have large consequences, as already seen in negative inpatient margins. Fee-for-service payments will continue to be the primary vehicle for Medicare payment in rural areas. Payments must be set at levels that do no harm to rural providers and potentially contribute to their abilities to remain in practice.”

**“Third, Medicare policies should help sustain the safety net in rural and underserved areas.** The rush to paying for Medicare through a competitive market place cannot ignore the reality that there is no competition in places that are difficult to serve because of sparse population and prevalence of households with low incomes. Medicare beneficiaries residing in such

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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areas will not have access to services if safety net providers, such as community health centers, rural health clinics, and small rural hospitals, close because changes in payment policies reduce their incomes below sustenance levels. Medicare must continue to pay those providers using cost-based formulas; the net impact on any savings proposal is very little as compared to the consequences in service availability.”

**“Fourth, Medicare policies should be consistent with the drive to integrate health services in rural areas.** Medicare policies related to home health, community services, and long term care facilities need to be considered. Issues of adequate payment are of course important. Equally important are policies that encourage utilization of the appropriate service given the needs of the beneficiary. As is so often the case, the need in rural areas is to build and sustain the infrastructure to provide those services, which Medicare can help or hinder with payment policies.”

**“Fifth, Medicare policies must contribute the overall quality of life in rural communities.** The inter-dependency of economic development and health care services is readily apparent in most rural communities. The health care sector is often the largest employer, and always an attraction of dollars to the local community's economy. Most of the elderly in rural communities have chosen to remain because they value the lifestyle they can enjoy, and being secure with local health care services is an important consideration.”

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## Medicare HMOs on Sick List

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From “Medicare Panacea Turns Patient; H.M.O.s Now Must Treat Their Own Ills” by David Morrow in *The New York Times*, 9/9/98:

“After aggressively recruiting the elderly and the disabled into their Medicare plans, many of the nation's H.M.O.s are now heavily retreating... With Medicare costs escalating wildly, Congress has long looked to managed-care plans as the prime remedy. Introduced in 1985 to allow private insurers to cover the elderly, Medicare H.M.O.'s provide health care more cheaply than the Government does. They also tend to offer more benefits to consumers and reduce the amount of claims paperwork.”

“Despite the H.M.O. problems in the Medicare market, Washington is now pushing for even more people to enroll in the plans. Yet financial setbacks for some H.M.O.'s have raised serious questions as to whether they can prosper covering Medicare patients. Though critics of managed care are quick to say they cannot, analysts say that several H.M.O.'s -- namely Humana Inc. and Pacificare, two of the nation's largest Medicare providers -- are making money on their plans, at least

for now. But even these companies have had to make adjustments.”

“Several problems have bedeviled Medicare H.M.O.’s. For one thing, only 15.6 percent of Medicare’s 37.5 million members are enrolled in Medicare H.M.O.’s. Though the Government says it has overpaid the Medicare H.M.O.’s, the companies say the Federal monthly stipend for each enrollee is not enough to provide extensive benefits. That is especially problematic in rural areas, where Medicare H.M.O.’s cannot enroll enough members to negotiate discounts with local providers.”

“As a result, analysts say, H.M.O.’s must focus primarily on urban markets and must avoid offering generous prescription drug plans, which can attract a disproportionate number of sickly people. Uncle Sam’s stipend comes with strings attached. The H.M.O.’s usually agree to provide more benefits than traditional Medicare does -- allowances for prescription drugs, hearing aids and eyeglasses. And they accept the premise that they can make profits by controlling costs better than the Government can.”

“A key to a healthy bottom line is to avoid a large percentage of sick patients, which can quickly devour revenues. The odds appear to be in the Medicare health maintenance organizations’ favor: 90 percent of all Medicare enrollees are generally healthy and require only about \$1,200 on average from the Government each year for medical bills, according to the Urban Institute’s analysis of the 1996 Medicare Current Beneficiary Survey, the latest figures available. In contrast, the analysis found, the remaining 10 percent, who are sick, cost Medicare \$37,000 a year each.”

“To be profitable with their Medicare plans, H.M.O.’s may have little choice but to establish capitation policies wherever they can. Before the Balanced Budget Act, it was common for the Government to give H.M.O.’s annual stipend increases of 10 percent in

some counties, a sum that many complained was too little. The increase has now been reduced to about 2 percent.”

“H.M.O.’s have also struggled to control their administration fees. Medicare plans, which must be sold in person, are more expensive than traditional commercial accounts, which may be pitched by telephone. Elderly people like to meet with company representatives, and they prefer seeing the plans’ benefits and costs displayed in writing.”

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## HMO Backlash Fed by Lack of Plan Choices?

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From “Does Dissatisfaction With Health Plans Stem From Having No Choices?” by Atule Gawande and others in *Health Affairs*, September/October 1998:

“Discontent with managed care is running high, and the public favors remedial government action. The source of the ‘backlash’ against managed care, however, is unclear. Is the problem that its restrictions are too onerous, or is it something else?”

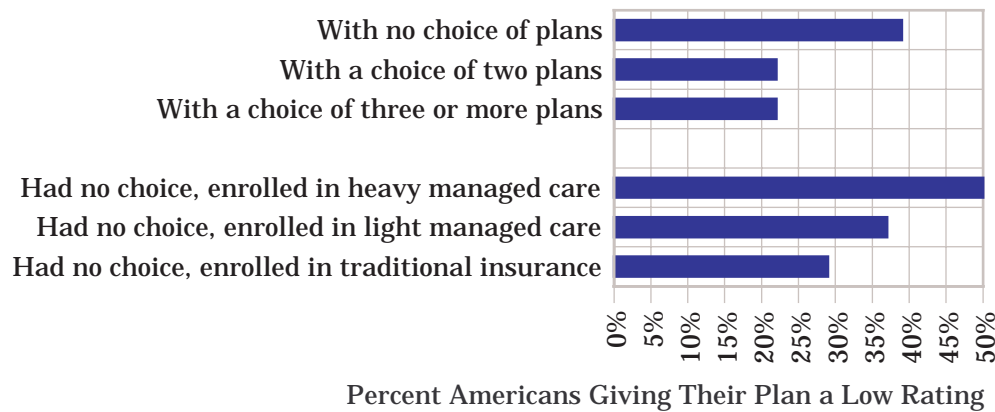
“A growing body of literature suggests that a lack of insurance choices could be a core problem driving the dissatisfaction with health care. Prior surveys have found that persons who were forced to enroll in managed care were significantly less satisfied with their plans and their care than were managed care enrollees who could choose a traditional insurance.”

“Respondents were markedly unhappier with the performance of their health plan when they did not choose that plan. Half of those in heavy managed care without choice gave their plan low grades, compared with 29 percent of those in traditional insurance without choice... **Persons without choice were 2.6 times as**

**likely as those with choices to give their plan a low grade...** Our findings indicate that an important factor driving opinion on managed care is not just the type of health plan enrolled in, but the extent to which they have a choice in the matter...”

“Whether lack of choice leads to discontentment with managed care because people simply prefer choice, because enrollees without choice are reacting against restrictions they did not agree to, or because their plans are actually inferior (or because of all three), choice clearly matters... Policies, whether of employers or

### Lack of Choice of Health Plans Undermines Public Confidence



Data: Health Affairs, September/October, 1998

Graph: RWHC 9/98

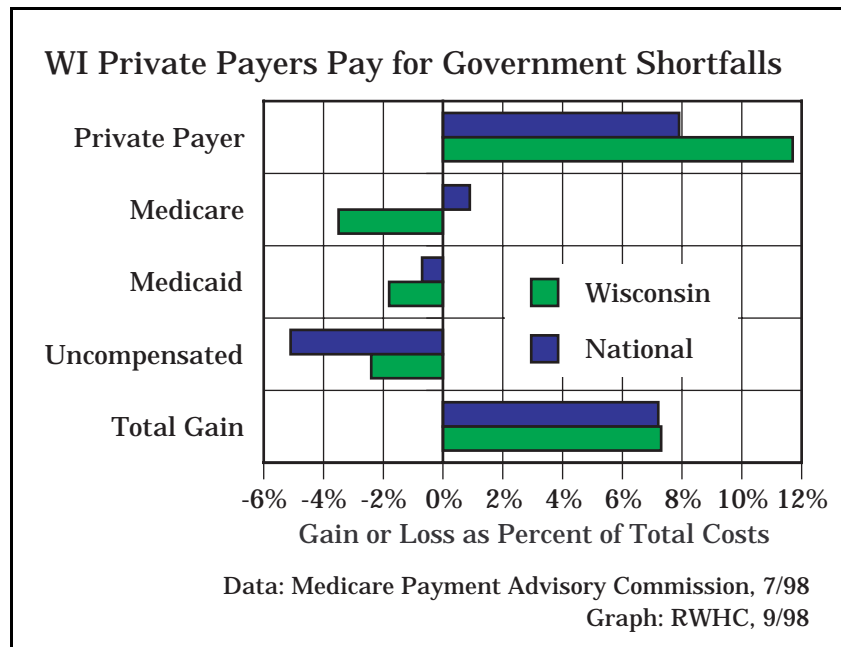
of government, to ensure even a small amount of choice may help to restore public confidence in health insurance and health care.”

## We All Pay When Government Doesn't

Hospitals in Wisconsin lose more money on Medicare than all but those in six other states even though Wisconsin costs are well below the national average. As this story has been told, over and over, the typical response is, “Why should I care? That’s just a provider problem” Not true--private payers pay more in Wisconsin directly as a result of the government not paying the fair cost of the care it purchases.

Private payers in Wisconsin (compared to the national average) contribute an additional 3.8% to the bottom line of hospitals in order to offset the fact that Wisconsin hospitals lose off their bottom line, 3.5% on Medicare (rather than the nearly one percent gain from Medicare enjoyed nationally). To a lesser extent the same is true of Medicaid. Without the state’s lower than average amount of uncompensated care, the amount of additional private payer payments would likely be even higher.

*Note: “Gains or losses are the differences between the cost of providing care and the payment received. Operating subsidies from state and local governments are considered payment for uncompensated care up to the level of each hospital’s uncompensated costs. Total gains reflect other government payers and non-patient sources of revenue in addition to the categories shown. Data for community hospitals reflect both inpatient and outpatient services. Most Medicare and Medicaid managed care are included in the private payers category.”*



## Rural Networking Gains New Support

From “New Program Launched to Help Expand Health Care Access in Rural Areas,” a Press Release by the Alpha Center <www.ac.org>, 9/98:

“Providing adequate health care in rural areas often requires overcoming geographic isolation, shortages of health care providers, and a lack of financial and capital resources. An increasingly popular strategy for meeting these challenges is to form collaborative provider networks that enable health care organizations to share resources and expertise and improve the local delivery system. In order to help rural communities seeking to build these vital networks, the Alpha Center is launching a project called *Networking for Rural Health*, which is funded by The Robert Wood Johnson Foundation.”

“A 3-year, \$3-million project, *Networking for Rural Health* will support both existing and newly emerging networks in advancing their visions. To address the unique needs of individual networks, the project will conduct on-site “network readiness assessments” and arrange consulting services, subject to a matching requirement of up to 50 percent. In addition, to address major cross-cutting issues that most network organizers face, the project will publish a series of technical assistance documents including a primer on network development processes, a guidebook on legal and anti-trust concerns, and a series of technical assistance reports on other topics.”

“Facilitating the development of mentor relationships between the leaders of existing rural health networks and those heading up newly emerging networks will also be one of our top priorities,” explains Ira Moscovice, Ph.D., co-director of the project and director of the Rural Health Research Center at the University of Minnesota. “We want to provide a forum for sharing the experiences and insights of more experienced rural network developers with those just starting out. For example, network leaders at the Marshfield Clinic, Hudson Headwaters Health Network, and Rural Wisconsin Health Cooperative have already expressed a willingness to serve as mentors.”

If you are involved with or know of a rural health network that has formed in the past two years, please notify the Alpha Center by sending an email message to [rural@ac.org](mailto:rural@ac.org) or faxing a note to *Networking for Rural Health* at 202.296.1825.

<b>Stages of Maturation In Health Promotion</b>	<b>Stage I: Patients First</b>	<b>Stage II: Putting Prevention into Practice</b>	<b>Stage III: Improving Population Health</b>	<b>Stage IV: Partners in Healthy Communities</b>
<b>Organizational Goal</b>	Improve patient role in self-management	Increase patient participation in preventive services	Improve health outcomes for enrolled population	Improve quality of life, social justice for entire community
<b>Motivation</b>	Increase patient compliance, patient satisfaction	Enhance continuous quality improvement, improve HEDIS measures	Improve member retention, health outcomes	Meet public trust mandates to benefit community
<b>Programs</b>	Classes, patient counseling, brochures	Patient risk assessment, targeting high-risk groups	Member risk appraisal, implementing prevention guidelines	Assessment of community assets, advocacy, activism for underserved
<b>Program Emphasis</b>	<b><i>Tertiary Prevention</i></b>	<b><i>Secondary Prevention</i></b>	<b><i>Secondary Prevention</i></b>	<b><i>Primary Prevention</i></b>
Data: Healthcare Forum Journal, September/October 1998 Regraphed: RWHC, 9/98				

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## Rural Initiatives Reduce Cost of Borrowing

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From: "Going To Market: Preparation Helps Small Hospitals Land High Ratings As They Tap Capital Markets" by J. Duncan Moore Jr. in *Modern Healthcare*, 8/24/98:

"You're the chief financial officer of a small hospital somewhere off the beaten path. You need to build a new wing, update your radiology equipment or overhaul the information system. It's going to cost millions, and you haven't borrowed money in 15 years. How should you think about approaching the capital markets?"

"Walker Batts, a partner in J.C. Bradford & Co., has a few pointers. The Nashville-based regional investment bank concentrates on not-for-profit hospitals. "Access to capital to finance new and replacement projects is critical to the continued strength of small, independent hospitals," Batts says. "Traditionally, small, independent hospitals used tax-exempt financing for projects, mostly general revenue bonds. Small hospitals have shown they can operate fine without tax revenues, and local governments don't want to use up their bond financing capacity on hospitals."

"The common assumption might be that small hospitals are hurting in these financially turbulent times. But in fact most small hospitals are keeping up pretty well, Batts says, and many are strong candidates in the bond market.' As executives consider their capital projects, Batts says it's advantageous for them to anticipate their credit ratings so they have realistic expectations of how much money to borrow."

"It's likely that a small hospital won't have the wherewithal to attain an A rating. But a BBB, which is still an investment-grade rating, shouldn't be out of reach. The difference between a BBB+ and an A1 is 30 basis points. For a \$20 million loan, that amounts to \$60,000 a year."

***The Wisconsin Health & Educational Facilities Authority (WHEFA) is initiating a program for unrated Wisconsin facilities to receive assistance in determining what their bond rating would be and if necessary, how that rating could be improved. More information about this very innovative pilot program can be obtained from WHEFA by calling (414) 792-0466 or emailing a request to whefa@execpc.com.***

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## Agreement on Medicare Wage Index Reached

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As previously reported, the American Hospital Association called together a cross-section of national, state and metro hospital associations in an attempt to develop a consensus on the very divisive issue of Medicare including medical education costs in its calculation of the wage index which significantly affects local Medicare payments. Highlights from the agreement reached are noted below:

“The cost of failing to develop a consensus position is that hospital organizations will have their attention diverted from other, broader issues while they fight with each other over the wage index.”

“Medicare should continue to recognize and pay the costs of graduate medical education.”

“Physicians involved in graduate medical education, both trainees and supervising physicians, should be excluded from the wage index.”

“Because changes in the wage index methodology will redistribute funds, a 5 year phase-in is needed.”

“A wage index should be used as an area adjustment in new prospective payment systems for specialty hospitals and specialty units in hospitals.”

“This dialogue on the wage index should continue and at a minimum address (1) the use of an index standardized for occupational mix, (2) the use of the hospital wage index for non-hospital payment systems, and (3) improved uniformity in the reporting of compensation and hours.”

*AHA has estimated the annual effect of these changes after the phase in; for example, \$156 million will shift from New York and Pennsylvania and \$106 to California and Florida (\$9 million shifts to Wisconsin).*

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## Are Patient Report Cards Worth Anything?

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From “An Evaluation of the Current and Potential Impact of Consumer-Survey-Based Report Cards on the Health Care Market Place” in *Health Care Financing & Organization (HCFO) News & Progress*, 7/98. HCFO is a national initiative of the Robert Wood Johnson Foundation with technical assistance and direction provided by the Alpha Center:

“There is not much evidence available that individual consumers are relying on consumer survey-based report cards when they choose among competing health plans and providers. Initial research shows most individuals continue to base their choices on personal experience and on the recommendations of family and friends. So, are consumer-survey-based report cards on the quality and access features of health plans and providers worth the time and expense?”

“A study conducted by researchers in Minnesota suggests that even if consumer-survey-based report cards on health plans and providers are not yet having much effect on individual consumers, they may be having an important effect on the behavior of health plans. Jinnet Fowles Ph.D., and David Knutson, both at HealthSystem Minnesota in Minneapolis, studied the impact of several rounds of report cards issued by the Minnesota Department of Employee (sic) Relations on the performance of eight health plans that have served state employees and their families.”

“We found that all of the eight health plans that have served Minnesota state employees were significantly affected by the consumer-survey-based report cards

issued by the Minnesota Department of Employee Relations--and all of them took some action to improve their performance,’ says Fowles. The health plans’ responses included:

- Using the report card to marshal support for internal quality improvements initiatives,
- Using the report cards to gather additional support for quality improvement structures,
- Increasing the amount of and refocusing the direction of internal measurement and monitoring efforts,



- Reconstructing key front line positions; organizing, documenting, and focusing services initiatives, and
- Reorienting clinics and clinical professionals within the health plan toward service quality initiatives.”

“The primary driver of change,’ according to Fowles, ‘was the plans’ concern about their reputation, independent of any immediate financial consequences due to shifting enrollment.”

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### Cooperatives Part of Wisconsin’s Economy

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In Wisconsin, 2.9 million citizens depend on more than 800 co-ops to market and supply agricultural products, as well as to provide credit, electricity, telephone service, health care, housing, insurance, and many other products and services. Cooperative businesses employ approximately 20,000 Wisconsin residents and pay millions of dollars in taxes each year.

- Wisconsin was one of the first states to enact a law authorizing cooperatives in 1887.
- Anne Pickett started the first dairy cooperative in the state in 1841, pooling milk from neighborhood farms, processing it into cheese and shipping it to Milwaukee for sale.
- The first grain farmer cooperative and elevator was started in Madison in 1857. It was called the Dane County Farmers’ Protective Union.
- Wisconsin’s earliest town mutual associations were organized in February 1860--one in Manitowoc County and one in Kenosha County.
- The Cochrane Cooperative Telephone Company, incorporated in 1905, was among the first telephone companies in the state.
- The first Wisconsin rural electric cooperatives were formed in 1936 in Richland Center and Columbus.

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### New Option for Rural Health Students

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The Wisconsin Program for Training Regionally Employed Care Providers Fellowship (WIS-TREC), under development by the statewide AHEC system for the last few years with assistance from the Robert Wood Johnson Foundation, now has its first students. “The features which make WIS-TREC unique are: the emphasis on maintaining the student in their own community for the majority of their education and the use of interactive video and computers for course and individual study.” **WIS-TREC brings education to the community of the student.** The schools currently

participating represent certified nurse-midwives, nurse practitioners and physician assistants. For information, contact Sharon Nellis at 608-263-5167.

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### Rural Advocates & Information Age Issues

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Cindy Chicker, Director of Health Information at Richland Hospital has been appointed to Wisconsin’s Health Care Information Advisory Board which will oversee the expansion of the State’s data system to include physician and other outpatient services.

Carla Gorski, Health Information Specialist at RWHC as been appointed to serve as a Public Member of Wisconsin’s Joint Legislative Council Special committee on Telemedicine Issues. It will “study issues arising from the electronic transfer of medical information, particularly regulation of providers, privacy, liability, reimbursement and patient access.”

