



Review & Commentary on Health Policy Issues from a Rural Perspective - January 1st, 1999

Rose Bowl Fever Sweeps Countryside



Long Term Care Reform--a Rural View

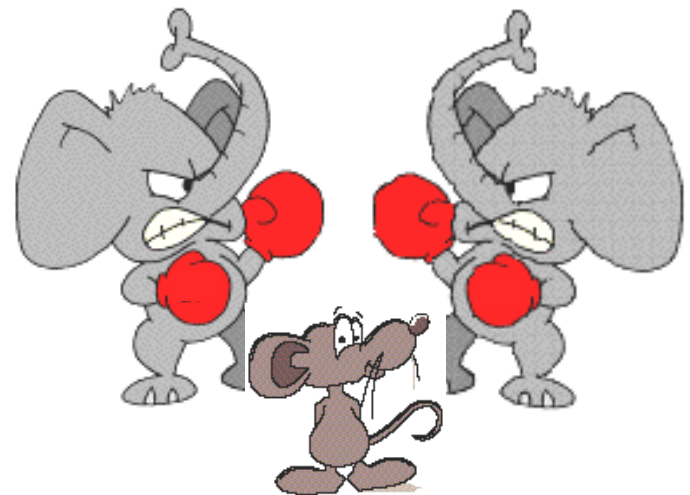
Family Care, Wisconsin's response to the fiscal reality of aging baby boomers, continues to move forward. Joseph Leean, Secretary of the Department of Health and Family Services met with the Cooperative at its quarterly members' issues forum to talk about this still evolving initiative.

As described in the 10/98 issue of *Eye On Health*, "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, a 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 our discussion with Secretary Leean, appreciation was expressed for his personal leadership on this difficult but absolutely necessary challenge and his openness to talk about ways to improve the administration's proposal. The Cooperative identified several issues specific to rural communities which it believes requires significant additional attention:

- **Monopoly purchasing power.** There is significant concern that a single or multi-county rural CMO could develop monopoly powers in rural communities without the restraint of either the marketplace or the legislature. At best, a CMO monopoly will create a cost shift to other payers, at worst it will tend to destabilize the local infrastructure.
- **Low volume barriers to economies of scale.** Risk models and capitated payment systems in health care have typically been developed based on assumptions of concentrated populations and high volume services. Rural realities are different. The economies of scale available to organizations serving a large number of people at one site are typically not available in rural communities. Explicit recognition is needed of the unique costs often in-

RWHC - Eye On Health



Holiday tip: avoid dancing elephants.

curred by rural providers serving smaller, more dispersed populations such as higher stand-by costs and lower average utilization rates.

- **Wage or geographic adjustments.** Any proposal to geographically adjust capitation payments to CMOs will, to say the least, face extraordinary technical and political challenges. Rural providers and communities have a long and unpleasant experience with the Medicare wage index being used as an arbitrary device to lower both rural and Wisconsin reimbursement--there will be a hard sell if such an index is used with CMOs to further reduce funds available in rural counties.
- **Validity of proposed risk pilots, particularly with small populations.** Our experience with managed care risk as rural providers has not been positive. Short comings experienced on the way from theory to practice have included (but have not been limited to) the inherent volatility of utilization and costs associated with small populations and the challenge of assuring the proper allocation of specific expenses to the relevant risk pool. The current risk pilots which effectively insulate county governments from substantial risk may be useful for any number of reasons but do not appear to test the validity of using risk models for long term care in rural communities.
- **Unique challenges of multi-county resource centers or CMOs.** Aggregating the population to be served from several small counties does facilitate the development of more stable risk pools as well as aid the development of the necessary local expertise to manage Family Care. However, this approach will bring challenges not faced by single county models (such as problems of coordination for any decentralized services and/or problems of ac-

cess for any centralized services.) At a minimum, careful planning will be needed based on the recognition that the multi-county "solution" will bring its own unique set of issues.

WDC Rural Advocacy Critical in 1999

From "A Stormy Season for Rurals" by Jan Greene in *Hospitals & Health Networks*, 11/20/98:

"Rural Americans often mark time by recalling storms that scoured out the landscape, forcing them to rethink and rebuild. For many rural hospitals, 1983 lives in infamy for unleashing a whopper: Medicare's prospective payment system (PPS) for inpatient care. Now, just when many rurals had learned to extend their services and take advantage of cost-based payments via skilled nursing and home care, a new Medicare payment storm is bearing down."

"'We have good reason to be very concerned,' says Tim Size, executive director of the Rural Wisconsin Health Cooperative. 'Our experience with PPS is they took a system designed for large, urban facilities and crudely applied it to rural hospitals.'"

"Even without knowing the full effects, rural executives and advocates know enough to worry. Inpatient PPS, they say, was conceived in a way that automatically disadvantaged rurals. 'That took us about 10 years to correct and we still haven't fixed the wage index,' says Keith Mueller, a University of Nebraska researcher affiliated with the Rural Policy Research Institute. 'Let's not make those mistakes again.'"

"According to 1995 statistics from the Medicare Payment Advisory Commission, rural hospitals as a group still make money from inpatient prospective payment. Yet it's less than half the average Medicare margin earned by urban hospitals--5.2 versus 11.3 percent. What's more, the positive margin only emerged in 1994, after seven years in the red. Rurals are still more likely than urbans to have negative margins overall, 37 versus 30 percent. As for changing the wage index, the American Hospital Association and other groups recently reached a consensus on revising it and have taken their proposal to HCFA."

"Mueller and others worry that red ink will return to rural hospitals as the new payment systems roll out. Skilled nursing PPS began on July 1, and an interim home health payment formula, a stopgap while HCFA readies the real thing, is already shaking up home care agencies. Meanwhile, HCFA has delayed the debut of the finished systems for home and outpatient care until after 2000, once the agency has eradicated the millennium bug from its computer systems."

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 that best meet the needs of rural residents in a manner consistent with their community values.

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"The conversion to prospective payment was Congress's response to huge increases in Medicare's home health and skilled nursing budgets. In passing the Balanced Budget Act of 1997, legislators attempted to check years of spiraling growth. At the same time, rural advocates persuaded Congress to include items they'd championed for years: payment for telemedicine and the extension of a rural hospital flexibility program that allows small, remote hospitals to become limited service facilities and receive cost-based payments."

"Of all the changes in the Balanced Budget Act, the biggest challenge for rural hospitals centers on upgrading their computer systems and accounting programs. 'Rural hospitals are first and foremost frustrated by the fact that they are inundated by regulatory changes that challenge their ability to focus on care because they are funneling their money into administrative needs,' says John Supplitt, director of the AHA's section for small and rural hospitals."

"Mueller, who was initially optimistic about rurals' weathering the next prospective payment storm, changed his outlook after testifying in early September before the Bipartisan Commission on the Future of Medicare. 'I was one to say, 'Ah, another bipartisan commission and another report on the shelf,' he recalls. 'But this time, it looks like these commissioners mean business in making serious spending cuts for the long term.' If such changes get applied in the next Congress, before the full effects of the Balanced Budget Act of 1997 are known, it could be a double whammy for rurals."

"Despite the challenges, nobody's predicting widespread closures just yet. 'Rural providers are extraordinarily resourceful and they will find a way to function under PPS,' says Supplitt. 'They won't like some of the compromises and consolidations, but they will find a way.'"

The Rural Health Policy Institute



National Rural Health Association

February 8-10, 1999
Washington, D.C.

202-232-6200 to register or
www.NRHArural.org

This conference is designed to educate participants about the federal legislative and regulatory processes and current policy issues affecting the nation's rural health care delivery system. Conferees will have the opportunity to express to federal policy makers the importance of strengthening the rural health care delivery system, to ensure that they understand the challenge and obstacles faced by rural providers.

RWHC--A Quick Twenty Years

Editor's note: By chance, I recently came across what was probably RWHC's first media coverage. As we complete twenty years in 1999, a partial reprint seems in order. We've grown, some of the specifics differ but the basic idea is unchanged--rural communities and providers are stronger when they act cooperatively. From "Co-op of Hospitals Reaping Rewards" by Ann Boyer, *The Capital Times*, 3/30/81:

"Although the Rural Wisconsin Hospital Cooperative got underway just one year ago, membership is beginning to reap rewards for the 11 participating hospitals."

"Located in southern and central Wisconsin, the member hospitals serve the communities of Baraboo, Boscobel, Cuba City, Dodgeville, Edgerton, Lancaster, Mauston, Platteville, Sauk City, Prairie du Sac, Edgerton, Lancaster, Mauston, Platteville, Reedsburg and Stoughton."

"Operated in much the same fashion as an agricultural cooperative, it nonetheless has different goals; while its agricultural prototype might exist to obtain the best prices for the members' product, or increase group buying power, this organization works to insure the ability of its member hospitals to offer an adequate range of services to rural users."

"The motive is not financial returns, but increased strength. Expenses, says Executive Director Tim Size, who shares the Cooperative's small office in Dodgeville with a student assistant, are shared equally among all the member hospitals. Each hospital has an equal voice in decision-making."

"Some new service arrangements have been set up to improve the delivery of various specialized medical serv-

ices. Physical and respiratory therapy especially are in need, due to a recruitment shortage experienced by rural hospitals."

"Since no two facilities have the same strengths and weaknesses, each arrangement has different participants. 'I'd be real surprised if we ever design any program that everyone buys into,' says Size. 'That's the way we work.'"

"Here, the strong local tradition of agricultural cooperatives has created a favorable climate for development. While many urban hospitals share certain services with each other, the groups usually are small and dominated by one institution. Services shared are relatively narrow in scope. In this rural setting, the partners--with the exception of UW Hospital--are small and rurally based."

"Even with the trend toward urban medical centers with highly-developed health technologies, Size says small rural hospitals continue to play a unique role. 'These are not little 'big hospitals'--they provide immediate, basic medical care where people live. As a patient, you're not a nameless person or face. People go into a rural hospital and know a lot of people who work there.'"

"In the economic area, many small community hospitals are the largest employers in town. 'Small hospitals are well able to do a good job for a great number of medical procedures. Rural hospitals have to encounter a blind belief that bigger is better,' says Size."

"Hospital ownership is undergoing a dramatic change as well he says. 'Corporate America' is getting into hospital ownership--not just as suppliers, but as providers of hospital care. Although so far Wisconsin has experienced less buying up of community hospitals than other parts of the country, it could happen here. The greater strength in numbers provided by a cooperative protects against such a situation, encouraging local control."

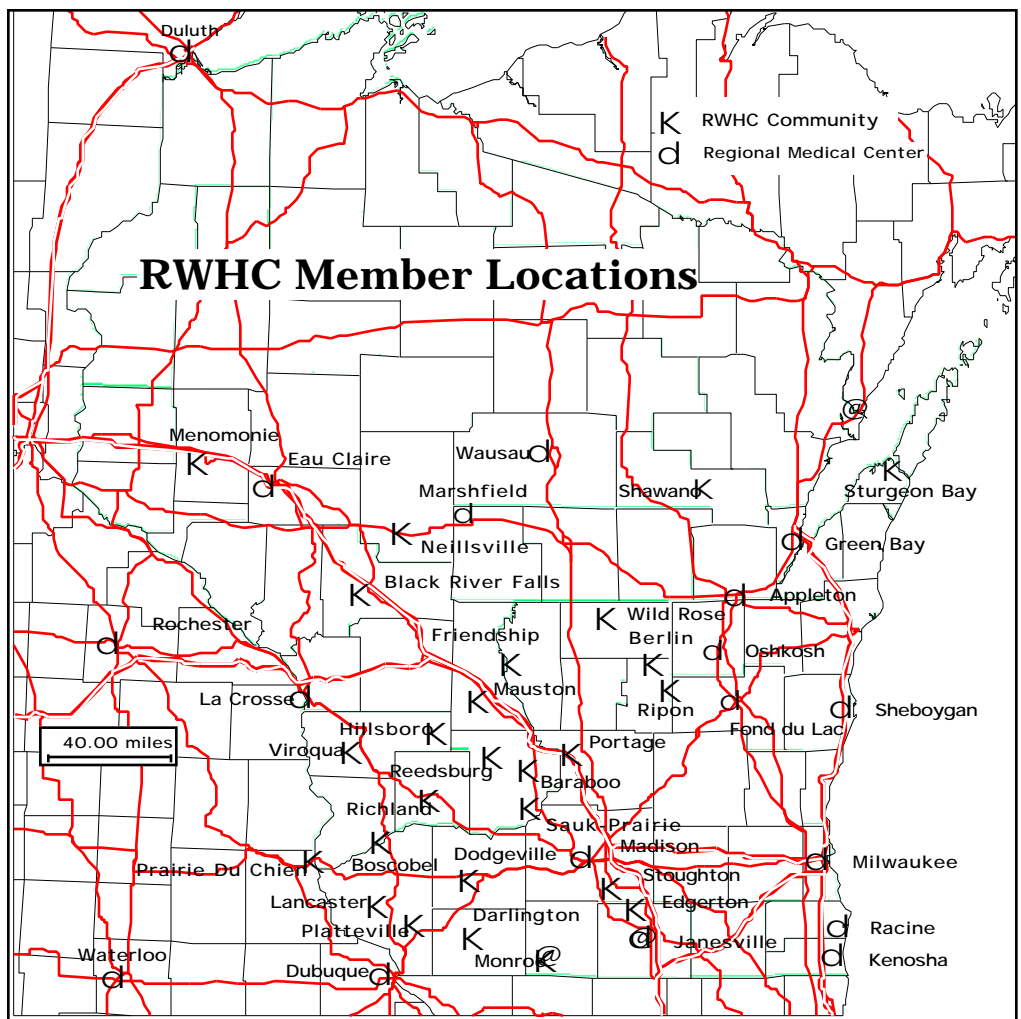
"Member hospitals share in other intangible benefits. New ideas in health care can spread rapidly through the cooperative grapevine. Needed changes can come about more

quickly. The relative isolation of a rural setting need not create a corresponding sense of professional isolation for a hospital's personnel. One of the group's next aims is shared in-service training programs for member administrators and staff."

"The very size of the Cooperative guarantees much higher visibility for the issue of rural health care in state-level planning bodies and hospital associations. Lobbying is a basic, although secondary role of the organization, says William Beach, Sauk Prairie hospital administrator. 'We have more bargaining power all down the line.'"

"Future directions will include developing community health education and computer software--a rural health maintenance organization is being explored. This could save rural subscribers the expense of traveling to Madison or Dubuque, where cost of prepaid treatment are substantially higher."

"There is 'something special' about the Cooperative. 'It's a belief that we're doing something that goes beyond health care to supporting an important part of Wisconsin life.'"



Why Wisconsin is Wisconsin

Some of you may find this book of maps and related commentary of interest-- "Wisconsin's Past and Present, A Historical Atlas" by the Wisconsin Cartographers' Guild:

"In this Sesquicentennial year, many Wisconsin citizens are asking what makes their state unique. How did 'Wisconsin' evolve from a collection of arbitrary boundary lines on the landscape to a cohesive and political entity--a place unto itself? The answer may lie, at least to some extent, in the state's location at the intersection of natural and cultural regions. Wisconsin has always been part of North America on the 'edge.' It was at the edge of great glacial ice sheets, and subsequently on the 'tension line' between the Northwoods and the Central Plains. It later became a meeting ground for many different Native American nations, and a new home to diverse groups of immigrant settlers who introduced new cutting-edge political and economic ideas to the rest of the country."

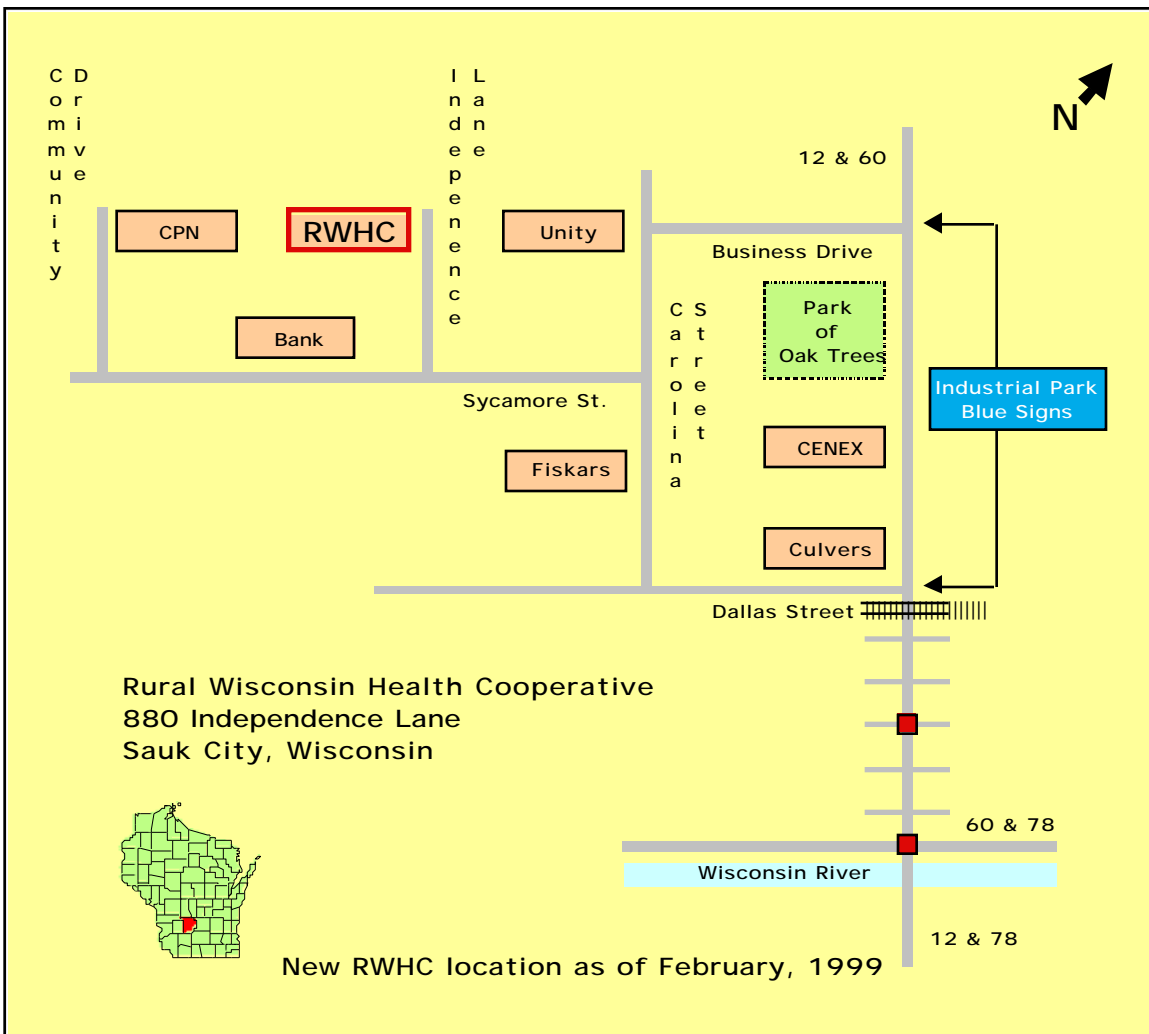
"Wisconsin developed between the urban centers of Chicago and the Twin Cities, and parts of the state became a hinterland to both metropolitan areas. The state still serves as a borderland combining the agricultural Midwest, the industrial Great Lakes region, and the Northern forests, and its people reflect this regional diversity. Drawing from its traditions, Wisconsin continues to stand on the forefront of innovative government policies and community based ethics. It continues to be a unique place where many different aspects of nature and culture clash, intersect, and sometimes find balance."

Competitors Can Collaborate Around Quality

RWHC is currently working with multiple HMOs and insurers in a federally funded initiative we call the Rural Zones of Collaboration Initiative. (A quarterly newsletter for the program, the Collaboration Connection can be obtained from the RWHC office.)

Support for Zones of Collaboration type approaches has just been published in the November/December issue of the country's foremost health policy journal, Health Affairs in an article entitled "Bringing Collaboration Into The Market Paradigm" by Robert Berenson:

"Although markets are designed primarily to foster competition, the market paradigm, as interpreted through antitrust statutes, countenances collaboration among health care competitors for select purposes, such as protecting consumer safety, conducting research, and improving quality of care... Vigorous price competition has developed over the past decade of managed care, but so far there has been few examples of collaboration



among competing managed health care organizations (MCOs) to improve quality.”

“Although business pressures and cultural differences impede competing firms’ willingness to collaborate, some industries have found collaboration a mutually beneficial activity, particularly for new product development. For example, U.S. automobile manufacturers have established fifteen research consortia, including the Partnership for a New Generation of Vehicles since 1988. These activities have been spurred by social and political pressures, not by market demand, and the federal government has played a major role in promoting collaborative research.”

“Some arrangements among competitors are strongly anti-competitive and constitute violations of antitrust laws. MCOs certainly should not be permitted to get together, for example, to set premiums based on nebulous claims that they need more money to ensure that quality remains high. However, competing health plans should be encouraged to initiate specific, clearly identified quality improvement activities that otherwise would not occur and that pass antitrust scrutiny under a rule-of-reason analysis.”

“For all the logic of targeted collaboration in competitive markets, organizations in most industries commonly refuse to collaborate or else do so halfheartedly. As enumerated by former Council of Economics Advisors member George Eads, organizations often refrain from engaging in collaboration because they may (1) fear losing important proprietary technology or knowledge, (2) fear losing ‘first mover’ advantage, (3) be reluctant to forgo opportunities to differentiate products and services, or (4) be reluctant to surrender the ability to ride free.”

“At a practical level, competing organizations will be reluctant to expend the substantial time and resources necessary to break through cultural and business barriers when there are no obvious market benefits for doing so. If there are no market rewards for improving quality independently (*the author and others argue this point elsewhere*), what would be the rewards for doing so collaboratively?”

“One possible answer to this question is that the consumer backlash against managed care is threatening managed care’s ability to continue impressive cost savings... More likely, collaboration among MCOs will need to be motivated by purchasers, both private and public.”

“The nature of evolving health care markets suggests that collaboration among competing health plans should be a variant of competitive strategy to improve quality of care. Many activities, including research, information sharing, new product development, and standard setting are commonly performed in other industries and could be performed in the health care system within the constraints of antitrust laws. The challenge is to find the proper catalyst to convene competi-

tors. Although health plans themselves should have a political interest in improving quality of care to respond to the anti-managed care consumer backlash, it is unlikely that competitors will voluntarily participate in collaborative ventures that do not have an immediate market payoff. To foster the collaborative strategy, purchasers--both private and public--will need to take the initiative.”

Medicare Critical Access Hospital Program

Wisconsin has moved quickly to make Medicare’s new hospital program an available option; special thanks to the State Bureau of Quality Compliance who have been so helpful. The following is from a *Findings Brief* of the North Carolina Rural Health Research and Policy Analysis Program, “Medicare Critical Access Hospital Program: The First Year,” 11/24/98:

“The Medicare Critical Access Hospital (CAH) program, part of the Balanced Budget Act of 1997 (BBA) is a nationwide limited service hospital program built on earlier demonstrations. CAHs can provide outpatient, emergency and limited inpatient services in communities where local use no longer supports a full service hospital. To qualify as CAHs, this new type of hospital must be in a rural area, operate only a small number of inpatient beds, keep inpatients a maximum of 4 days, and be remote from the nearest full service hospital or designated as a necessary provider by the state. CAHs receive reasonable, cost-based reimbursement for their Medicare services.”

“Forty-three states expressed interest in the CAH program (in a survey by the authors). Twelve of these had federally approved state plans as of the date of the interview, four had submitted plans and were waiting for approval, and eighteen were in the process of drafting their state plans. Nine states were attempting to generate interest in the program. Six states did not plan to participate in the program at this time because of a lack of appropriate or interested hospitals.”

“Thirty-one hospitals in four states were designated CAHs. States that have developed or are developing their state plans estimated that between 158 to 203 hospitals would become CAHs.”

“In states where state plans had been approved, respondents expressed satisfaction with the federal flexibility in allowing states to determine the criteria for designating hospitals as ‘necessary providers.’ Most state respondents considered this flexibility crucial to the success of the program in their state.”

“In its first year, the CAH program could be implemented in the approximately 15 states where there is sufficient infrastructure at the state level to provide the planning for new conversions and where there is de-

mand from communities or institutions for the program. Other states found it difficult to move ahead effectively to support conversions without additional resources. The most pressing need for most states is for reliable fiscal consulting or analysis that could be applied to individual hospitals. The program should also be carefully evaluated to determine its effect on the financial status of hospitals, professional recruitment and retention, and quality of care.”

To view the full report of this evaluation, visit the NC Rural Health Research and Policy Analysis Program web site:

www.shepscenter.unc.edu/cah

Growing Beyond Grumbling & Griping

Good advice for physicians and non-physicians alike from “The Piñata Syndrome” by Thomas J. Marr, MD, in *The Physician Executive*, July-August, 1998:

“I feel like a piñata. Everyone is taking a whack at me.” -- anonymous physician.”

“The Piñata Syndrome is manifested by physician lounge grumbling and griping; sniping at medical and administrative leadership; resistance to examining best practices; refusal to hold colleagues responsible for their behavior, and general melancholy. This disease is characterized by grousing physicians who do not enjoy the practice of medicine and if self treated will leave medicine. It is accompanied by patients who receive inappropriate care and caring. The treatment, which can result in an excellent prognosis, is self-administered and must be vigorously pursued to avoid chronic Piñata Syndrome, a professional death.”

Symptoms & signs

“Results of a recent Minneapolis Star Tribune/Harvard Physician Survey published by the Minneapolis Star Tribune in December of 1997 revealed:”

- “49 percent of the Minnesota physicians surveyed believe that the health care system is worse in the past year in Minnesota.”
- “51 percent believe the quality of medicine has declined.”
- “34 percent believe the health plans are the cause of the decline.”
- “30 to 42 percent, depending on the health plan, would not recommend the health plan in which the physician participated to a family member.”

- “22 percent are somewhat or very dissatisfied with their practice.”
- “47 percent would not advise a qualified college student to pursue medicine as a career.”

Treatment

What can physician leaders do?

- “**Talk about it** -- language forms the culture. Talk about values, caring, healing, and joy. At least 50 percent of all meeting and discussion time should be on clinical or values issues.”
- “**Speak to a higher order.** Challenge your colleagues to revert to their original professional values.”
- “**Question business decisions** on the basis of group mission, vision, and values.”
- “**Advocate for patients' benefits.** Organize to improve and maintain the well-being of physicians and patients, to promote the doctor-patient relationship, and to restore patient and physician control of health care. Learn to lobby effectively for appropriate care decisions.”
- “**Develop partnerships** with patients, payers, and purchasers to facilitate the trusting relationship which will allow physicians to manage the medical care of their patients.”
- “**Develop communities of practitioners** who determine best practice based on scientific evidence and negotiate for adequate funding for it. This requires a data-driven process with physicians devoting the time to developing a care management plan with profiles, guidelines, pathways, care management programs, referral management, and measuring severity-adjusted outcome.”
- “**Become outcomes driven, rather than input driven.** Move from inspection and utilization review to designing best practices and measuring outcomes.”
- “**Care for your patients.** Patients still want their doctor. Those who don't, do not because they have not been treated by a clinician who believes in providing accessible caring service to meet the patient's needs and expectations.”
- “**Lead organizational healing.** If you don't care for each other, you can't possibly give the best care to your patients.”
- “**Find allies**--hospitals, other physician groups, community agencies, your patients.”

- **“Examine your business practices.** Do they give the messages of commitment, trustworthiness, win/win resolutions? Are the paper and patient flow processes and systems designed to facilitate competent, efficient, and effective care?”
- **“Be joyful.** Most physicians still enjoy patient care. It is the obstacles to care that are maddening.”

Prognosis

“Physicians and physician groups that are vigorously self treated have an excellent prognosis to be joyful practitioners who provide a caring and healing environment in which appropriate care is delivered effectively and efficiently.”

RWHC WWW Site as Internet Starting Point

Going to RWHC's page of Recommended Links at <www.rwhc.com> is an easy way to start gaining a more in-depth understanding of the vast array of good, useful health care and policy information available on the internet. Recently updated with all links alive and well, you can click directly to a cross-section of other Wisconsin, regional, national and federal health related sites.

Hear AMA's Historic Opposition to Merger

From National Public Radio's archive at www.npr.org, Morning Edition, 12/22/98:

“Aetna's Merger Stirs Opposition -- NPR's David Welna reports from Chicago that the American Medical Association is opposing the acquisition of Prudential's health care business by Aetna/U.S. Health care, which already is the nation's largest health care provider. The AMA expressed its opposition to the merger in a letter to the Anti-Trust Division of the Justice Department.”

If you have the program RealPlayer already installed on your computer, you can hear this NPR broadcast simply by “dialing”:

www.npr.org/ramfiles/me/19981222.me.11.ram

Free copies of RealPlayer can be downloaded from:

www.real.com/products/player/index.html?src=404

Researchers, Please Don't Change Your Mind

From “Sweet news for sweet teeth” by Emma Ross in the *Wisconsin State Journal*, 12/18/98:

“Scientists already have suggested that eating chocolate may make you happy. (*duh*) Now they say that men who indulge in Chocolate may live longer. A study of 7,841 Harvard male graduates found that chocolate and candy eaters--regardless of how voracious their appetite for goodies--live almost a year longer than those who abstain.”

“The researchers from Harvard University's School of Public Health, whose study was published in this week's issue of the *British Medical Journal*, said they don't know why this is. They speculate, however, that antioxidants present in chocolate may have a health benefit. The scientists stress their findings are preliminary and that the research does not prove the results can be attributed to the antioxidants.”

“In this study, those who ate a ‘moderate’ amount of sweets--allowing themselves only one to three candy bars a month--fared the best, having a 36 percent lower risk of death compared with non-candy eaters. Although they fared worse than the moderates, the more ardent confectionery eaters--classified as those treating themselves to three or more sweets a week--still lived longer than those who banished candy from their lives, with a 16 percent decrease of death.”

“Scientists previously have found that chocolate contains phenols, antioxidant chemicals also present in wine. Antioxidants prevent fat-like substances in the blood from oxidizing and clogging arteries.”

