

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

Non-Profits Fighting Threat To Mission

This editorial, "Keep YMCA Tax-exempt," appeared in the *Milwaukee Journal Sentinel* on March 12, 2001; increasingly rural hospitals are beginning to recognize similar concerns:

"It's hard to imagine that anyone even vaguely familiar with the vast amount of good done by the YMCA would question its legitimate entitlement to a tax exemption. Yet that is exactly the point being raised by many private health clubs, both locally and nationally."

"The clubs contend that the YMCA's new, state-of-the-art fitness centers, such as the one in the Grand Avenue mall, should not be exempt from property taxes because they compete with the clubs and generate revenue. What they choose to forget is that membership in YMCA fitness centers, as impressive as they are, is

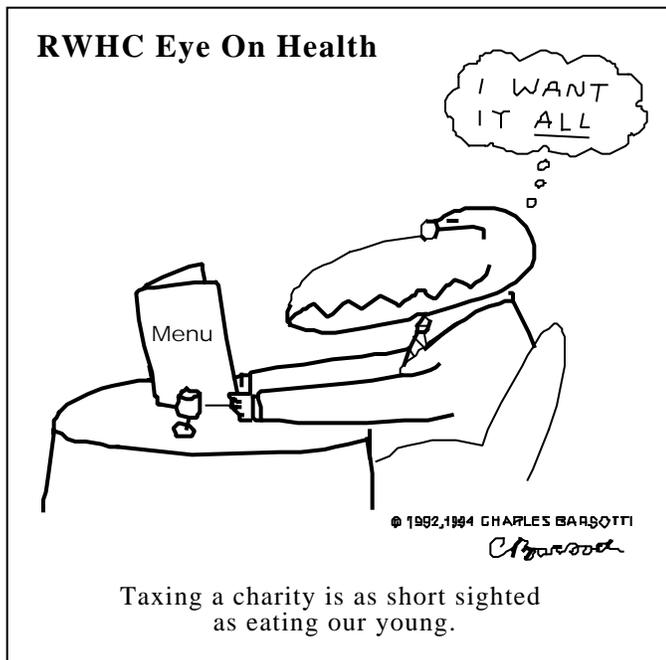
not tied to ability to pay; the dues of many members are, in fact, heavily subsidized. What's more, the revenue is plowed right back into the community. Wisconsin YMCAs provide more than \$10 million every year for charitable activities as diverse as housing, child care and services to troubled families."

"Although the YMCA currently has a property tax exemption under state law, some municipal assessors question whether it technically applies to the fitness centers and other YMCA operations. To their credit, state Sen. Gary George (D-Milwaukee) and Rep. John Gard (R-Peshtigo) intend to answer that question in the affirmative. They are introducing legislation that would clarify state law to specifically exempt."

"YMCAs, including fitness centers, should be exempt from property taxes in the same way other charitable organizations such as the Salvation Army and the Scouts are exempt. Pardon the pun, but this is an exercise in good sense and sound public policy."

Historic Medicare Payment Bias Recognized

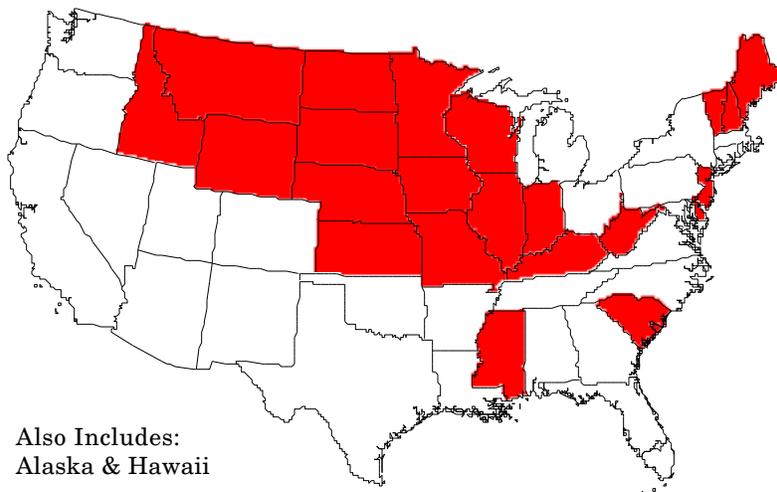
RWHC first testified in Washington, DC, in 1984 regarding significant problems with the Medicare wage index, the single biggest reason for the systemic underpayment of rural hospitals by the Medicare Program. The March report of the Medicare Payment Advisory Commission (MedPAC), an independent federal body which advises Congress on issues affecting the Medicare Program, goes a long way acknowledging the wage policy reform which RWHC and other rural advocates have been requesting for nearly two decades. While not included in this report, MedPAC is also addressing a "companion" issue, growing consensus that too large a proportion of Medicare payments are modified by the wage index. The following is from the *Report to the Congress: Medicare Payment Policy*, "Chapter 4--Developing Input-Price Indexes for All Health Care Settings", March, 2001:



“Many of Medicare’s prospective payment systems rely on the hospital wage index to adjust national average payment rates to reflect local market prices for labor and other inputs. However, the hospital wage index does not accurately reflect local market wage levels for two reasons. First, because the wage index is based on aggregate hospital wage data for

each area, it combines differences in wage rates with differences in the mix of occupations, overstating wage levels in some markets and understating them in others. Second, although wage index values are calculated for 374 labor market areas, the areas often include two or more distinct labor markets. To address these problems, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 required the Secretary to collect data on wage rates by occupation. The data will be used to construct

**Half Of The States With The Worst Medicare Hospital Losses...
A Bad Coincidence For The Heartland Or Just Poor Federal Policy?**



Source: MedPAC Report To Congress, Table B-17, 3/01
Graph: RWHC 3/01

a new wage index for application beginning October 1, 2004. The Commission recommends methods for collecting occupation-specific data for improving input-price indexes used in Medicare’s payment systems as well as providing a basis for improving the labor market definitions.”

“Medicare uses separate pay-

ment systems to compensate each type of provider for furnishing covered services to beneficiaries. To ensure beneficiaries’ access to high-quality care in the most appropriate clinical settings under the Medicare+Choice and traditional fee-for-service programs, Medicare’s payment rates must approximate the costs efficient plans and providers would incur in furnishing services under the conditions of each local health care market. Consequently, Medicare’s payment rates for services in each setting should accurately reflect the effects on providers’ costs of local factors that are beyond their control.”

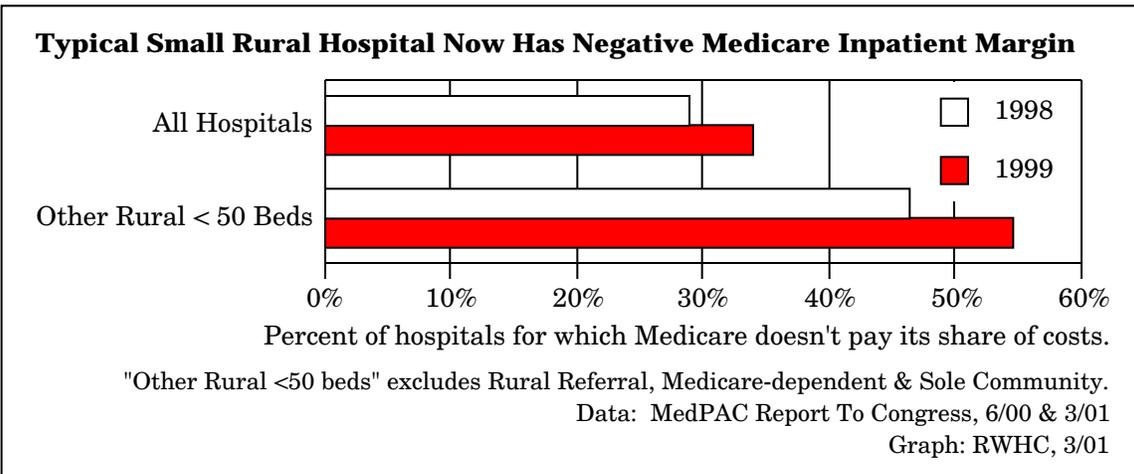
“Two factors account for most of the variation in providers’ unit costs: differences in the mix of outputs they produce—often called their case mix—and variation in the level of market prices for labor and other inputs. Case-mix measurement systems are intended to capture differences in providers’ expected costs associated with differences in their mixes of services, cases, or beneficiaries. Case-mix payment adjustments thus account for expected differences among providers in the quantity and mix of labor and other resources required to produce care, given their case mix.”

“Because case-mix payment adjustments account for expected differences in the quantity and mix of resources, the input-price adjustments in Medicare’s payment systems should account only for differences in the market prices for these resources. Providers have some control over the mix and quantity of employees used, consistent with the local supply of nurses

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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and other occupations and the kinds of services delivered. They have limited ability, however, to affect market levels of input prices.”

“All of the prospective payment systems (PPSs) for facilities—hospitals, ambulatory surgery centers, skilled nursing facilities, rehabilitation facilities, psychiatric facilities, and long-term hospitals—include (or will include) input-price adjustments that raise or lower national base payment rates to reflect local market wage levels.”

“Currently, the Health Care Financing Administration (HCFA) uses a single measure of geographic differences in area wage levels—the hospital wage index—to adjust the payment rates for services furnished in all facility settings. There are significant issues regarding the current wage index: first, it is inaccurate because it is based on hospitals’ total labor costs in each market area, reflecting differences in wage rates for each occupation and differences in the mix of occupations employed; second, it is inaccurate for skilled nursing facilities, home health agencies and others because they employ different mixes of occupations than do hospitals; and third, problems with the labor market definitions and the age of the data used for the wage index affect the accuracy of payment across all types of facility services.”

Work Force Shortage & Civil Disobedience

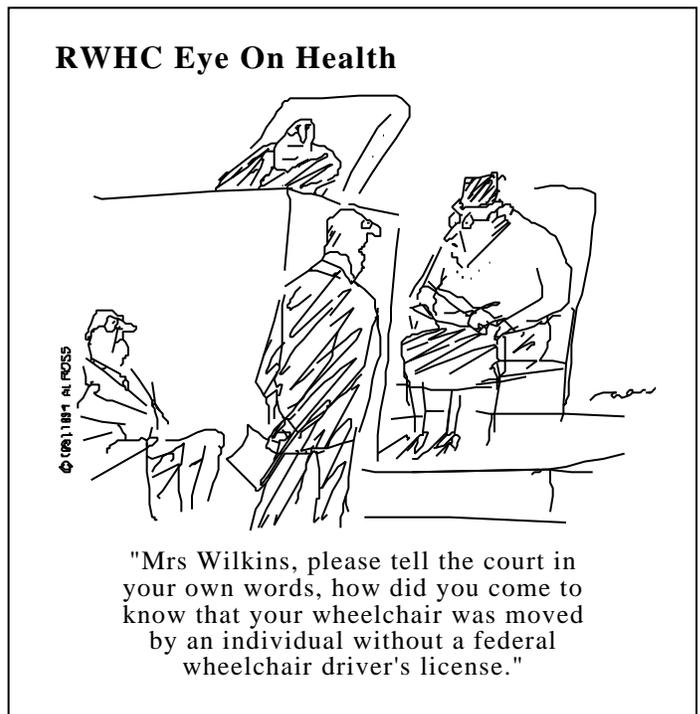
From “Single-Minded, Nursing Homes Willing to Flout Law” by Vince Galloro, *Modern Healthcare*, March 12, 2001:

“A few North Dakota nursing homes would rather commit civil disobedience against HCFA than stop us-

ing workers the facilities consider vital to patient care.”

“The workers are known as ‘feeding assistants’ or ‘single-task workers,’ and North Dakota nursing homes have been employing them since the late 1980s. They are trained to perform simple tasks such as helping with meals or transporting residents in their wheelchairs, but they do not take a complete certified nursing-assistant’s course.”

“Officials from several homes said publicly they will flout the regulation if some of their feeding assistants decide against taking the extra training, said Shelly Peterson, president of the North Dakota Long Term Care Association.”



“‘People, I think at this point, would rather risk a deficiency (during an inspection) than risk worsening patient care or outcomes,’ Peterson said.”

Wisconsin’s 4th Annual Rural Health Conference

April 26th and 27th in Mosinee. Among other
Keynotes: Marcia Brand, Director, Federal
Office of Rural Health Policy & Wisconsin’s own national
television personality, Dr. Zorba Paster.
To Register, email: bduerst@facstaff.wisc.edu

“HCFA got wind of the practice about three years ago. The agency ruled last summer that feeding assistants must receive nurse-assistant training to continue in their

“Wisconsin is in the same boat, with homes there having employed single-task workers since the early 1990s.”

“‘If we’re not successful with getting a waiver or pilot program, or passing legislation, I don’t know whether people will (flout) the law or not,’ said Brian Purtell, legal services director of the Wisconsin Health Care Association. ‘I’ve heard some people say, ‘I don’t care. We’re going to keep doing this.’”

“Wisconsin’s involvement in the issue may be a key factor in whether the two states win a reprieve. Industry officials are hoping that Tommy Thompson, the former Wisconsin governor who now is HHS secretary, will influence HCFA to change its ruling.”

“‘Certainly, (former) Gov. Thompson knows the experience of the resident assistants firsthand,’ said Terrence Kavanaugh, executive director of the Illinois Council on Long Term Care. Illinois legislators approved a single-task worker law in 1999, just as HCFA signaled it would disapprove of them, Kavanaugh said. A Minnesota state legislator is interested in pushing for passage of a similar law there.”

“U.S. Rep. Paul Ryan, a Wisconsin Republican, also is lobbying Thompson to weigh in with HCFA on the matter. Ryan also plans to introduce a bill to allow feeding assistants in the next month. He filed a similar bill last year, but it stalled.”

“HCFA’s ruling affects about 450 workers in North Dakota and from 500 to 1,500 workers in Wisconsin. Nursing home officials question how many feeding assistants will take courses that can run 75 to 120 hours, depending on the state. Many are part-time workers, such as students or younger retirees, or work primarily in an administrative setting in a home and are available to help during meals.”

“Unions adamantly oppose the use of feeding assistants because they believe nursing homes will use them to replace more highly trained and higher-paid workers. Resident advocates are leery of feeding assistants for the same reason.”

jobs. HCFA said the workers perform ‘nursing or nursing-related’ tasks, and only workers with the full training course may do so under the Social Security Act governing Medicaid and Medicare payments to nursing homes.”

“HCFA approved each state’s plans to comply with the statute—or what providers in both states see as HCFA’s interpretation of it—in separate letters, with Wisconsin’s dated Jan. 23 and North Dakota’s Feb. 5.”

“In North Dakota, all single-task workers must be enrolled in or have completed a certified nursing-assistant training program by Sept. 30. Wisconsin’s remediation plan gives workers there until the end of October to complete the training.”

Work Force Shortage & Vocational Training

From “Workforce Training” by RWHC’s own Garrison Keillor, Glen Grady from Neillsville:

“We in most rural areas of the United States and all through the Midwest, are looking at a new Federal legislative year with more hope than in years past, at least as far as health care is concerned. This cautious optimism that many of us feel is due largely to the impending confirmation by the Senate of Wisconsin’s own Tommy Thompson to head the Department of Health and Human Services. And by the fact that several key House and Senate health care committees have a much stronger rural and Midwestern presence than in the recent past.”

“This should give us a better shot at a fair hearing when we go to Congress with our arguments that everyone in the United States contributes an equal amount based on their income in payroll and income taxes to fund Medicare, Medicaid and other social programs. But the return in payment for services to rural areas and to the Midwest as a whole is, in many cases, less than half of what it is in urban areas, particularly those on the East and West coast, and in many areas in the South and Southwest. I’m sure we will not get any quick fixes, but I think we can expect

RWHC Eye On Health



"Schools are paid for student-hours taught, not for worrying about health care workforce shortages."

some compromise and some movement to a more equitable, balanced approach to determining these reimbursement levels."

"But there is a looming health care manpower shortage that cannot be solved, at least in the short term, by putting more dollars into the systems. We have plenty of hospital beds to care for the current demand. It is the lack of available RN's, LPN's, CNA's, laboratory and radiology techs, etc. to care for patients waiting to occupy those beds that makes the care unavailable. The nursing homes of the state and nation have been in this quandary for some time--now it is extending rapidly to many other areas of health care."

"In the past this has been attributed to a loss of interest in the caring professions, a booming economy, low unemployment, and the attractiveness of high tech professions to our youth. But we are starting to identify a more basic cause to our health care staffing woes. It appears that our state technical college and university systems have reduced class sizes in nursing and many other health care occupations. Reductions not due to a lack of interest in these programs, but because it costs more to train students to become nurses, lab techs, x-ray techs, than it does to train computer programmers or marketing majors or accounting majors, etc."

"Since all students pay virtually the same tuition, it appears, to be a budget issue. Indeed many university systems have reduced their nursing program sizes to the point that after two years of college, a student has to have a 3.80 grade point or better, just to be considered for admission to the program. This type of pressure does tend to reduce perceived demand as few students

express an interest in any major where the bar for entry into the major has been raised so high. **Internal budget considerations at our state tax supported institutions (institutions that are supposed to be committed to training the workforce our citizens need for a prosperous future) appear to be a major, if not often acknowledged, reason for the lack of sufficient health care workers coming out of the system.**"

"But again, maybe we haven't looked closely enough. Many of these programs, most noticeably pharmacy and nursing, have diverted dollars previously budgeted for undergraduate programs to graduate level programs, not because of a huge demand for a larger number of higher level practitioners in these areas, but because it adds to the prestige of the program. And because it adds to how its faculty is viewed, (and paid) by their peers both within their particular institution and by colleague in other institutes of higher learning."

"At least to some extent, our health care staffing crunch might be eased if our public supported institutions were more realistic and sensitive to the needs of the public that finance the majority of their operations. I don't pretend to know how and where these decisions are made, but as a tax payer, I think we should ask for some accountability for the way they are using the funds that we are providing them. And until problems like this become so acute that the health and safety of the public at large (not just a small periodic subset of that public) is threatened, elected officials will show little interest in addressing these issues."

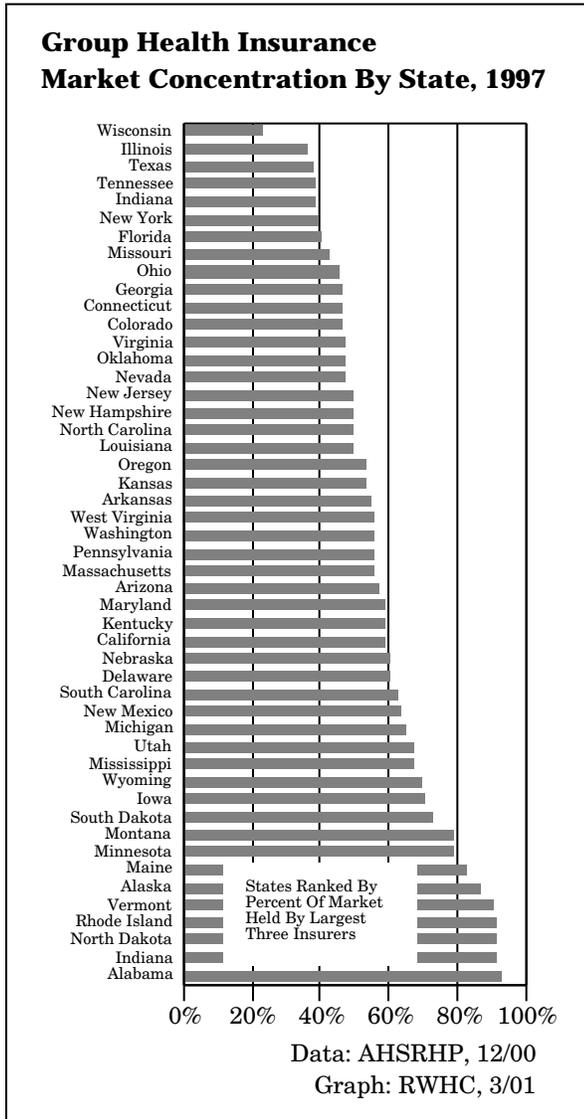
"There is one possible solution that no one is talking about yet that may help alleviate much of these shortages. Didn't hospitals use to run their own nursing and tech and other related health care professional training programs? What would it take for the big hospitals to get back into that business? Probably won't happen any time soon, but it's a thought."

Less Competition Among Health Insurers?

From "Group Health Insurance Markets" in *Mapping State Health Insurance Markets: Structure and Change in the States' Group and Individual Health Insurance Markets, 1995-1997* by Chollet, Kirk and Chow at <http://statecoverage.net/mapping.pdf>:

"Market Concentration--In nearly every state, a few large insurers dominate the group market. In 1997, the largest three insurers held at least half of the group market in 33 states, and in no state did they hold less

than 23 percent. Conversely, the smallest insurers typically hold very small market share. In every state, the smallest 50 percent of insurers held less than 9 percent of the market in 1997.”



“Alabama, Idaho, and North Dakota had the most concentrated group markets in 1997. Of the 47 insurers writing group coverage in Alabama in 1997, the largest three insurers held 93 percent of the market, and the smallest 24 insurers collectively held just 1 percent. In Idaho and North Dakota (with 20 and 17 group insurers respectively), the largest three insurers in each state held 92 percent of the market. While Wisconsin, Illinois, and Texas had the least concentrated markets, even in those states the largest three group insurers held 23 percent (in Wisconsin) to 37 percent (in Texas) of the market.”

“Where just a few insurers control nearly all of the market, there is no reason to expect that competition

guides the market efficiently. **The economic incentive for insurers to become larger (and fewer) in every state is likely only to grow as public concern about health insurance costs and coverage escalates.** States concerned about insurers exiting their markets should be aware that their population size may support only a few insurers if each state is to operate at efficient scale. These states face a challenge to develop new strategies to promote economic efficiency in their health insurance markets and at the same time maintain the market stability that consumers value.”

A Conflicted Public View Of Health Care

From “Americans’ Views On Health Policy: A Fifty-Year Historical Perspective: Because Americans’ Views Conflict, Policymakers Must Be Cautious About Interpreting The Public’s Mood Based On Isolated Public Opinion Questions” by Robert J. Blendon and John M. Benson, *Health Affairs*, 3/01:

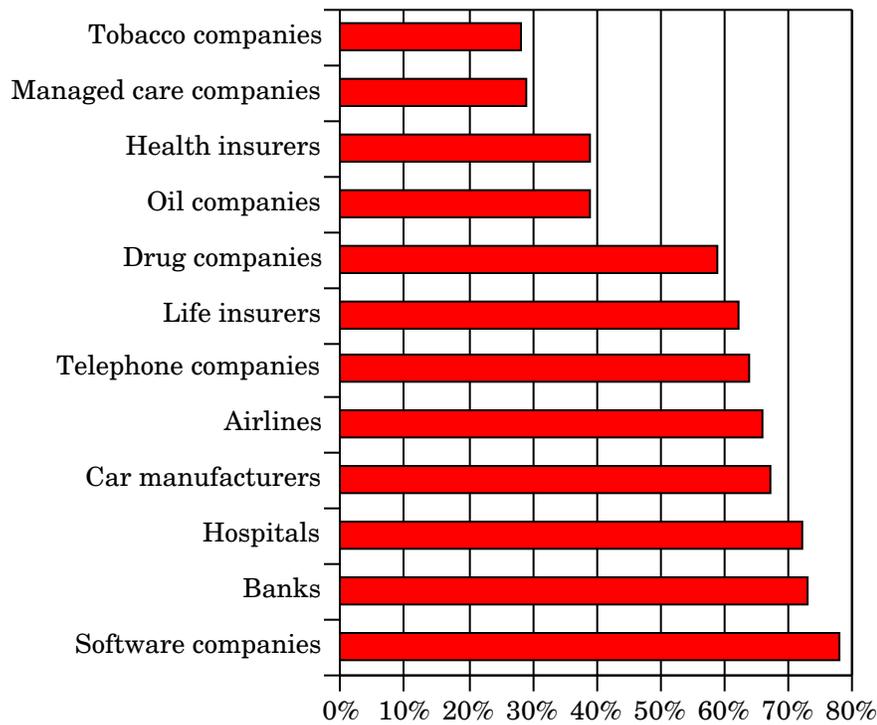
“A review of data from more than 100 public opinion surveys conducted over a fifty-year period finds that the American public has conflicting views about the nation’s health policy. They report much dissatisfaction with the health care system and with private health insurance and managed care companies, and they indicate general support of a national health plan. However, most Americans remain satisfied with their current medical arrangements, do not trust the federal government to do what is right, and do not favor a single-payer type of national health plan. The review also finds that confidence in the leaders of medicine has declined but that most Americans maintain trust in the honesty and ethical standards of individual physicians.”

“A number of key questions arise from this historical review of public opinion. First, what do we know about the stability of public opinion on health care policy over the past five decades? The picture presented here is mixed. On many of the issues we examined, public opinion has been stable over long periods of time. However, in the cases of national health care reform, the priority for government action on health care, confidence in the leaders of medicine and government, and concerns about federal taxation, public opinion has changed markedly over the years. Even more dramatic is the decline of public support for both the Clinton and Truman health plans over a short period of time.”

“Second, what do we learn about the consistency of public opinion over these many areas of health policy?”

Managed Care Companies Edge Out Tobacco

Percent Of Public In 2000 Who Said The Industry Was Doing A Good Job Serving Their Customers



Data: "Americans' View," Health Affairs, 3/01
Graph: RWHC, 3/01

Americans hold many beliefs that are consistent with a general view of what is right or wrong about health care in the United States. However, it is striking to see how many conflicting views the public holds on health policy issues.”

“On the one hand, Americans report substantial dissatisfaction with our mixed private/public health care system and with the private health insurance and managed care industries. A majority of Americans indicate general support for a national health plan financed by taxpayers, as well as increased national health spending. On the other hand, these surveys portray a public that is satisfied with their current medical arrangements, in many years does not see health care as a top priority for government action, does not trust the federal government to do what is right, sees their federal taxes as already too high, and does not favor a single-payer (government) type of national health plan. Over the years these conflicts in beliefs have been difficult to resolve in legislative debates, particularly around the issues of large-scale national health care reform. This is likely to remain the case in the years ahead.”

“Finally, are there lessons for better interpreting public opinion on health policies in the future? The answer from this review is clearly yes. Because Americans hold many conflicting values and beliefs that affect their views on health care policy, it is important to be cautious in interpreting the public mood based on single, isolated public opinion questions. To be useful for policymakers, surveys require enough depth in their question wordings so that respondents can work their way through their conflicting values and beliefs to come to judgment on the issue.”

Rural Environmental Scan

The following was generated for an upcoming meeting where invited participants will be discussing the future of rural networks. The following is not intended as a comprehensive list; additional speculation would be welcomed at <timsie@rwhc.com>.

Consumers/Patients -- (1) providers will be held more accountable for patient outcomes, (2) demand more information and choices and (3) continue shift from passive to proactive role as consumers/patients.

Employers Based Health Insurance -- (1) more premium/benefit resistance due to an aging work force, cost of pharmaceuticals and less forgiving international competition, (2) like consumers, hold providers more accountable for patient outcomes, and (3) significant possibility of shift to more price sensitive insurance models due to increase shift to employer fixed contribution plans as economy cools.

Managed Care -- (1) less risk sharing by rural providers, (2) but more “management of care” and (3) continued ambiguity regarding the appropriate role of competition vs. government as mechanism to allocate health care resources.

Medicare -- (1) less financial pressure on rural hospitals under Medicare as more rural hospitals become cost-based and/or the wage index is applied in a manner less prejudicial to rural; (2) more Medicare routed through private sector alternative arrangements.

Networking -- (1) a new generation of networks/alliances, less emphasis on hype, more on performance/value added and (2) more opportunities and pressures for traditional hospital and physician providers to partner with local public health and non-profits to address population based health issues.

Non-Profit Status -- (1) increased erosion of local property tax exemption, (2) increased pressure for non-profit to prove that they deserve the status and (3) more aggressive push back from non-profits.

Technology -- (1) gene therapies will move from the margin to the center; (2) health information systems will predominate, be web based and be largely transparent to the typical clinician and patient; (3) surgical and pharmaceutical innovations will continue to outpace our country's ability to pay for them, leading to an increasingly explicit multi-tier system of care.

Work Force -- (1) supply and demand driven shortages continue, forcing (2) increased wage inflation, and (3) areas such as the upper mid-west will actively recruit people of color to immigrate into the region to make up for a deficit of "home grown" labor.

A Voice Of Hope About The Next Four Years

From "Prospects for Expanding Health Insurance Coverage" by Steven A. Schroeder, M.D., President, Robert Wood Johnson Foundation in *The New England Journal Of Medicine*, 3/15/01:

"Lack of insurance coverage is a complex problem, and the obstacles to its solution are formidable. Skeptics might conclude that this is not a promising time to expand health insurance coverage. However, there are reasons for optimism. The fact that Congress is split evenly between the two parties could force partisans to seek common ground. In fact, President George W. Bush indicated in his acceptance speech that health care security would be one of his priorities. Both candidates for president said that they would allocate at least \$120 billion for the expansion of health insurance coverage over the next 10 years -- an amount two and a half times as large as the current federal contribution to the State Children's Health Insurance Program. This potential fiscal commitment, combined with a renewed sense of urgency on the part of key interest groups, such as the Health Insurance Association of America and Families USA, may spark the first concerted effort to address the problem since the demise of health reform in 1994."

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