Rural Wisconsin
Health Cooperative

Eye On Health

Review & Commentary on Health Policy Issues for a Rural Perspective - July 1st, 2002

Argument For Rural Community Hospitals

by Tim Size, RWHC Executive Director

There are hundreds of small and rural hospitals across the country that are "too busy" to be eligible for the Critical Access Hospital (CAH) program but not "busy enough" for the fixed cost assumptions inherent in the Prospective Payment System. Many of these hospitals don't have Medicare-Dependent Hospital or Sole Community Hospital status and of those that do, many don't receive significant assistance. As a group, these hospitals are heavily Medicare dependent with negative Medicare margins and meager or nonexistent operating margins.

Representatives Jerry Moran (R-KS) and Jim Turner (D-TX) introduced HR 4515, The Rural Community Hospital Assistance Act to enhance the Critical Access Hospital (CAH) program and create a new Medicare payment classification for rural hospitals with 50 or fewer acute care beds. Senators Frank Murkowski (R-AK) and Paul Wellstone (D-MN) have introduced a companion bill, S 2615. This new classification would be called Rural Community Hospital (RCH).

RCH protects the core infrastructure of rural health in America that does not undermine or contradict the public policy inherent in the Medicare Prospective Payment System. Rural hospitals, on average, are paid 9.6% less than their reasonable costs (as defined by Medicare) for providing services to Medicare beneficiaries. Rural hospitals under 50 beds not eligible for an existing fix are paid 14.2% less than their reasonable costs. (*MedPAC Report To The Congress,* 3/01) In 1999, 54.5% of these hospitals had a negative inpatient Medicare margin; almost all lost money on their outpatient services. (ibid.) This is doable—all rural hospitals under fifty beds account for about 2% of inpatient PPS payments and presumably roughly that same share of all Medicare payments. (*ProPAC Report To The Congress*, 6/97) Acknowledging that Medicare simply doesn't work for the communities served by these hospitals is not a threat to the Prospective Payment System.

RWHC Eye On Health

"Looks like the rural private sector has finally realized they are paying twice for Medicare."

RCH is a cost based option for rural hospitals with 50 or fewer acute care beds that are not eligible to be a CAH. With the Rural Community Hospital Assistance Act, CAHs would receive an add-on payment for infrastructure and technology improvement, cost-based reimbursement for additional post acute care services, including skilled nursing, home health and geriatric psychiatric service (10 or fewer beds) and elimination of the 35-mile test to receive cost reimbursement for ambulance services. RCH would provide the following: cost-based reimbursement for inpatient and outpatient services plus a technology and infrastructure add-on; cost-based reimbursement for home health services where the provider is isolated, cost-based reimbursement for ambulance services and the restoration of Medicare bad debt payments at 100%.

Some have argued against this initiative based upon a Darwinian notion of the "survival of the fittest"—that

any assistance to rural hospitals inappropriately saves the inefficient. While these same commentators seldom note other long standing urban based Medicare subsidies that dwarf what rural communities are asking, the question is a fair one and can be squarely answered.

- Inefficiency means not producing the effect intended, compared to similarly situated organizations. When a major cohort of hospitals, on average, are losing money serving Medicare beneficiaries, the problem is the payment system, not hospital inefficiencies.

- The traditional Federal methodology for managing other reimbursement schemes based on reasonable costs allows them to administratively limit costs to rule out clearly inappropriate expenditures. Historically administrative pricing has been used to "hold the line" on spending by setting arbitrary limits on spending, which can be done by formula, a fee schedule, or policing "reasonable and allowable" controls.

- If a hospital receives cost-based reimbursement from Medicare it still has to operate in a community where much of its revenue from other payers is NOT cost-based. This provides an ongoing major external incentive to keep RCH hospitals mindful of costs.

- Efficiency in the best of situations is a difficult value to judge and inherently subjective.

Medicare beneficiaries, like everyone else with health insurance, benefit only when they can access services. To be useful, services which are covered as insured benefits must be accessible and to be accessible they must be available timely and conveniently to the beneficiary and their care-givers (family). Rural hospitals offer the essential services that Medicare beneficiaries need and how they need them, that is timely and conveniently. For benefits to be accessible, rural hospitals must be viable.

In most of America, health care for Medicare beneficiaries is paid for by the Federal government and the beneficiaries themselves. In rural America there is a third payer—the "hidden tax" of the cost shift to the private sector and their insurers. Rural counties across the country are facing the future of America today—the waning ability of the private sector to absorb the Medicare induced cost shift. The Medicare cost shift to private payers (workers) which currently holds the rural infrastructure together, is not sustainable—fewer workers per beneficiary are fueling a rapidly increasing price resistance in rural markets. The Congressional advisory body, MedPAC tells us we don't have a problem as all payer rural hospital margins, financed by the cost shift, are adequate—they need to look more closely.

The estimated cost of the Rural Community Hospital Assistance Act is less than $500 million a year, about one half of one percent of annual Medicare expenditures—a small adjustment to assure stable health services for America's rural communities.

Tim Size chaired the joint Task Force between the American Hospital Association, the National Rural Health Association and the Texas Organization of Rural Community Hospitals, which developed the initial RCH concept.

People Choose Health Security Over Tax Cuts

From the "NPR/Kaiser/Kennedy School Poll on Health Care: Americans Face Problems, But Don't Want Radical Change" at <www.npr.org>:

"A new survey by NPR, the Kaiser Family Foundation, and Harvard's Kennedy School of Government points to a significant medical divide in the United States along socio-economic lines. The vast majority of people in the top income categories have very few problems getting health care or paying for it."

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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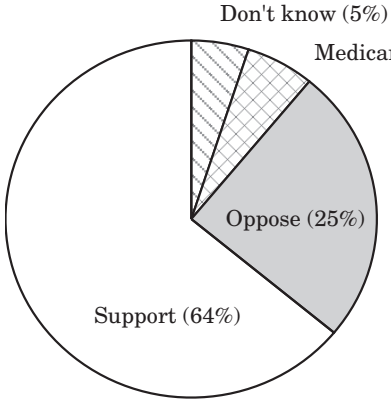


Question: Would you support or oppose Congress rolling back the tax cut that they passed last year and using that money to provide a prescription drug benefit under Medicare for Seniors?

Data: NPR/Kaiser/Kennedy School Poll on Health Care, 6/02
Graph: RWHC, 6/02

"But in the bottom income categories, many people are burdened by such problems, and when they are, the problems are likely to be serious. Moreover, the divide reaches beyond the lowest-income Americans and well into the middle class. Although Americans with higher incomes say they experience few such problems, many of them are worried that their good fortune will not continue. Only one in five Americans thinks the health care system works pretty well, and that proportion holds across all but the highest income grouping."

"However, it does not appear that people's worries and experiences are causing them to push for sweeping change in the health care system. On key health policy questions, the survey found that most people favor sticking with current methods of providing health insurance through guaranteed benefits from employers and public programs. Most do not want to switch to what is called a defined contribution system, in which they would be given money to choose among available insurance options in the marketplace. Americans also recognize how important it is to have health insurance. One in four even say they have stayed in jobs longer than they otherwise would in order to keep their insurance."

"When it comes to one of the biggest health care issues being discussed in Washington today -- helping seniors pay for prescription drugs -- most Americans say it is important. But a majority also believes that helping the uninsured is more important. In addition, the survey shows how difficult it will be to come up with a workable plan: Most seniors would not be willing to pay significantly more than they pay now for drug coverage under Medicare, and nearly all of the plans being discussed would require them to pay something."

"People agree that the government should do something to help seniors with prescription drug costs. Two-thirds of Americans (64 percent) would support rolling back last year's tax cut and using the money to provide a prescription drug benefit under Medicare.

There is no difference between seniors and younger people on this question. However, more Democrats (78 percent) than Republicans (52 percent) would support such a proposal. When forced to choose, more Americans favor covering the uninsured (55 percent) over helping seniors pay for prescription drugs (42 percent) as a government priority. However, a majority of Americans age 65 and over (57 percent) and half of Republicans (50 percent) favor the second option. By contrast, 58 percent of those 18-64, 57 percent of Democrats, and 58 percent of independents prefer to help the uninsured."

"Americans agree that access to health care and insurance are important issues for the government to deal with, and they favor building on existing programs as the best way to help. One in five Americans (19 percent) named health care issues as one of the two most important issues for the government to address, making health care the third most mentioned issue, right behind the economy (23 percent) and war (20 percent). However, fewer Americans see health care as one of the biggest problems that the country faces. When asked about the two most important problems facing the nation, 10 percent mentioned health care, ranking further behind problems such as the economy (37 percent), terrorism (29 percent), war (21 percent), and crime (16 percent)."

"When asked more specifically to name the two most important health care issues for the government to address, access to health care and insurance issues (54 percent) received the most mentions. Large majorities favor a wide variety of options to guarantee health care for more Americans, including expanding state government programs for low-income people (84 percent), expanding neighborhood health clinics (80 percent), requiring businesses to offer insurance to employees (76 percent), and offering tax credits or other financial assistance to help the uninsured purchase insurance on their own (73 percent). The only option asked in this survey that was not favored by a majority is a national, single payer health plan (favored by 40 percent). Also, this survey did not ask respondents to choose among the various options, but other surveys

have done so, and they have consistently shown that a majority of the public favors no single option. This fact, combined with the cost and winners and losers involved in any proposal, helps explain why consensus is often hard to reach in dealing with issues of expanding health coverage."

"The role of health care in the upcoming congressional election? As mentioned above, health care is at the top of many people's lists of issues for the government to address, ranking right behind the economy and the war. In thinking about the upcoming mid-term elections, it is worth keeping a few points in mind. First, seniors differ from younger Americans on which health care issues should be a priority for the government. While those under age 65 are more likely to pick helping the uninsured as a top priority, most seniors think that helping their peers with prescription drug costs is more important. And, as mentioned earlier, those over age 65 are more likely to favor helping the lowest-income seniors as opposed to providing more limited help to all seniors. Given that people over age 65 are more likely to vote than their younger counterparts, especially in a mid-term election, these differences in policy preferences by age may be particularly important."

"Second, as we have seen in the past, on most health care issues asked in this survey, independents hold views closer to Democrats than to Republicans. Similarly, those who identify themselves as moderates hold opinions closer to self-identified liberals than to self-identified conservatives. But other surveys show that independents do not agree with Democrats on all aspects of the health care issue. On cost issues they are more likely to line up with Republicans."

Rurals Aren't Exempt From Bioterrorism

From *Rural Communities and Emergency Preparedness* by the Office of Rural Health Policy Health Resources and Services Administration U.S. Department of Health and Human, 4/02:

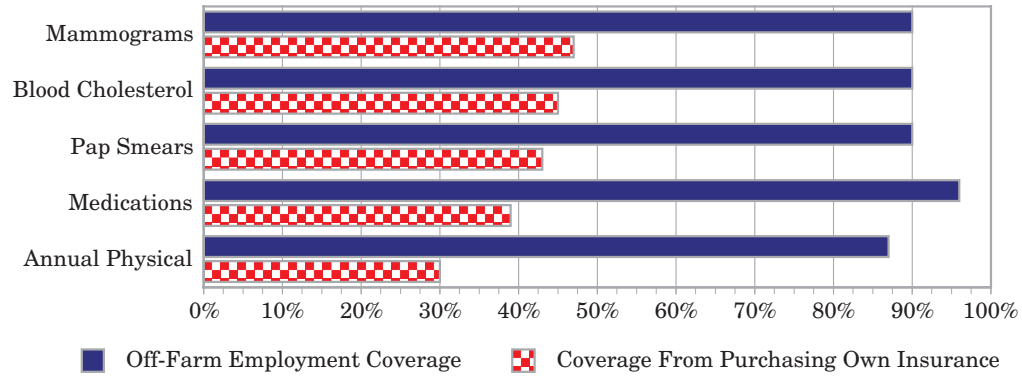
"The need for well-prepared emergency response agencies was never more evident than on September 11th. While much of the aftermath of those events has resulted in an increased focus on these agencies in urban areas, it has also become clear that such a focus is also necessary in rural areas. Rural areas are not only home to 65 million Americans, but are also the sites of most of the country's farms, numerous power facilities and weapons of mass destruction. A lack of emergency-related resources in rural areas may compromise rural readiness for future emergencies."

"Our national response to nuclear, biological, or chemical terrorism should include an examination of rural communities, their vulnerability and capacity to respond. The vulnerability of rural areas to nuclear terrorism is significant. Many nuclear power facilities, as well as uranium and plutonium storage facilities, are potential terrorist targets and are located in rural areas. Not to mention that all U.S. Air Force missile launch facilities are in rural areas and could be vulnerable to terrorist threats should a rogue group want to threaten national security. Bioterrorism, introduced by smallpox-infected individuals, could easily cross our Canadian or Mexican borders and first be identified by a rural provider. Our shared borders make the identification of a terrorist incident harder to control than in an urban area. With many agricultural chemical facilities and the interstate transit of hazardous materials, rural areas have a unique vulnerability to chemical threats as well."

"An act of bioterrorism quickly identified and contained in a rural community would significantly reduce morbidity and mortality not only for those of rural areas, but would also provide advance warning for urban areas to prepare and respond as well."

Health Insurance Sold To Farmers Protects Farm More Than Farmer

Low coverage, high deductible protects assets but limits preventative services.



Data: Barron County (WI) Health Department, 2000
Graph: RWHC, 6/02

Wisconsin's Health Alert Network

"HAN is a communications system for Wisconsin's Public Health departments, hospitals, clinics, emergency rooms, laboratories, law enforcement, EMS and other health agencies. It is funded by a grant from the US Centers for Disease Control and prevention with the goal of improved communications infrastructure for all Wisconsin Public Health Agencies and their partners. This is done by:

- Fostering high-speed and dedicated internet connections for our local public health agencies.
- Creating a secure web site and emergency messaging system for communications among health agencies for bioterrorism and all other public health threats.
- Establishing a distance learning capability to foster greater public health organizational capacity and public health professional development."

"The general public can view content that has been moved from behind the security perimeter to the 'Front Porch' of the website."

Selected staff at all rural hospitals and clinics should make sure they have access to and are familiar with how to use HAN. To allow for security screening, it may take a day or two to receive a password so it is critically important to register before you have a need to use the site; the HAN website is at <www.han.wisc.edu/>.

"Any terrorist event carried out in an urban area might result in a massive exodus out of targeted cities and into 'safer' rural areas. As a result, rural providers would be overwhelmed as fleeing sick or contaminated individuals fill their clinics and hospitals. In addition, rural providers from unaffected communities may provide the critical workforce needed to assist larger cities coping with a disaster. The ability of rural areas to respond is affected by weather, tourism, geographic isolation and a fragile economic base. Many rural communities lack access to hazardous materials (HAZMAT) units, making them exceptionally vulnerable to chemical or nuclear events. Moreover, such communities lack sufficient HAZMAT recognition capability and decontamination training even if they were fortunate enough to have a local HAZMAT unit. Without substantive investments, rural communities will continue to be vulnerable to these events."

"Another area of concern is complacency. The feeling of relative safety brought on by the belief that rural areas are at a lower risk for terrorism may reduce rural communities' sense of urgency and limit preparation and responsiveness. If rural communities are not actively included in local, State and Federal efforts to strengthen emergency preparedness, they may remain bystanders to their own fate. Effective emergency preparedness and mitigation efforts demand consensus and involvement from all stakeholders, including rural providers."

The Smallpox Vaccination Debate

From "The Many Variables of Smallpox Debate, Uncertainty Muddles Decision on Vaccine" in the *Washington Post*, 6/6/02:

"Over the next three weeks, a panel of medical experts will debate whether the federal government should make smallpox vaccine widely available for the first time in 31 years. The decision—one of many forced by last fall's episodes of biological terrorism—will require a tricky balancing of risks and benefits in a state of great uncertainty."

"The chance of a smallpox outbreak is unknown—the disease was eradicated from the globe in 1980—so the most important variable can't be calculated. The risks of smallpox vaccine are also murky, because the American population is biologically different from what it was in 1971, when the substance was last used routinely."

"Few doubt that paramedics, police, firefighters, physicians, nurses and epidemiologists are obvious candidates for vaccination because they would be likely to have early contact with victims of a bioterror attack. But precisely how to define the right group of 'first responders' isn't clear. There's also no recent experience to guide the decision; the country's last emergency smallpox vaccination campaign was in 1947."

"Beneath those large unknowns is a second order of uncertainty."

"The vaccine is a live virus, vaccinia, which causes a mild infection that protects against smallpox. Although in most people vaccinia infection causes nothing more than a sore arm and low-grade fever, in

those with abnormal immunity, vaccination can have serious and occasionally fatal results. The difficulty is that even some mild conditions, such as eczema, can signify that a person is at risk, and it is hard to identify all such people."

Tenth Year of the RWHC $1,000 Hermes Monato Rural Essay Prize—The 2002 Prize has been awarded for "Risk Perceptions on Skin Cancer and the Role of Community Pharmacies in Preventative Strategies" by David Eric Kepler. David is enrolled in the UW Madison School of Pharmacy, Pharm. D. Program, Class of 2005 and is from Richland Center.

"Furthermore, up to 20 percent of complications occur in people who were not themselves vaccinated, but acquired the virus from someone who was. Consequently, policymakers must consider such practical issues as whether anyone who gets the vaccine should stay off work for a week so they won't infect others."

"There are also mundane uncertainties. For example, much of the existing vaccine is stored in vials containing 100 doses. How hard will it be to gather that many people together to get vaccinated at one time? How much waste should be tolerated?"

"Routine smallpox vaccination continued in the military through 1989. Since then, only a few people, most of them scientists and epidemiologists affiliated with CDC, have gotten the procedure, which consists of scratching a drop of vaccinia-laden liquid into the skin with a pronged needle."

"The most virulent strains of smallpox—presumably what terrorists would use—cause death in about 30 percent of infections. Modern intensive-care treatment might reduce mortality somewhat. An antiviral drug, cidofovir, has shown promising early results in fighting viral infections similar to smallpox. Nevertheless, the virus remains one of the more dangerous ones on Earth."

"The government's current strategy against a smallpox outbreak is search-and-containment, also known as 'ring containment.' It consists of identifying people with the infection and vaccinating everyone who has had contact with them. During the global eradication campaign (which began in 1966 and officially ended in 1980), ring containment often had literal meaning, with health workers immunizing entire villages that contained smallpox cases, and sometimes even blocking roads in and out, to prevent the virus from escaping."

"But the strategy doesn't require that everyone in a geographic area be vaccinated, or that movement of large numbers of unexposed people be limited. Experts say that even in Chicago, for example, a case of smallpox caused by a bioterror attack would not require quarantining and vaccinating all Chicagoans. However, anyone having contact with the infected person would be vaccinated, isolated and observed for a fever heralding onset of the disease."

"Historically, ring containment worked for smallpox for several reasons. All infections are obvious because of the disease's dramatic, bumpy rash; people don't transmit the virus until the rash appears; and, most important, if someone is vaccinated within seven days of exposure, the risk of becoming infected is reduced substantially (by as much as 70 percent, according to old studies). The disease is less contagious than some viral infections, such as measles and influenza, with data from pre-eradication outbreaks in Asia suggesting that infection usually requires days of close exposure to someone who is sick."

"Numerous veterans of the global eradication campaign say scenarios of wildfire smallpox epidemics -- such as "Dark Winter," a simulation sponsored by the Center for Strategic and International Studies last year in which a three-city bioterror event caused 100,000 deaths in five weeks -- are unrealistically extreme."

"But proponents of making vaccine widely available argue that ring containment may not work in highly mobile, modern America, where almost the entire population—and certainly everyone younger than 35—is susceptible to the virus. Only vaccination now will lower the risk of an out-of-control outbreak, they say."

Complex Problems Require Collaboration

From *Working Better Together, How Government, Business, and Nonprofit Organizations Can Achieve Public Purposes Through Cross-Sector Collaboration, Alliances, and Partnerships*. The Executive Summary (PDF) is available free of charge by visiting www.IndependentSector.org/. The full report costs $15 for nonmembers and can be ordered on-line.

"During the closing decades of the 20th century a series of powerful forces delivered jarring shocks to the conventional roles and relationships among government, business, and nonprofit organizations. These forces—including dramatic new technologies, intense economic competition, accelerating globaliza-

tion, the more obscure effects of regionalization, and a complex mix of social and political factors—have been altering the way each sector defines and carries out its core role and changing the relationships among all three of them."

"Government, business, and nonprofit organizations in the United States historically have worked together to achieve important public purposes. Today, such cross-sector collaborations, partnerships, and alliances are more important than ever in addressing the increasing number of complex public issues that spill over sectoral boundaries. The three sectors have been exploring new ways of carrying out their core roles, employing strategies and practices that are changing the relationships, and blurring the distinctions among them. So cross-sector collaboration today is required not only to tackle complex public problems that no one sector can handle alone, but also to better understand and redefine the relationships and strategies of the three sectors."

"The purpose of this report is to shed light on these tasks. Part I identifies how driving forces are changing the strategies by which government, business, and nonprofit organizations define and carry out their roles, and how those new strategies are changing the relationships among the three sectors. Part II suggests some lessons learned about cross sector collaboration, and the ways that government, business, and nonprofits can more effectively work together."

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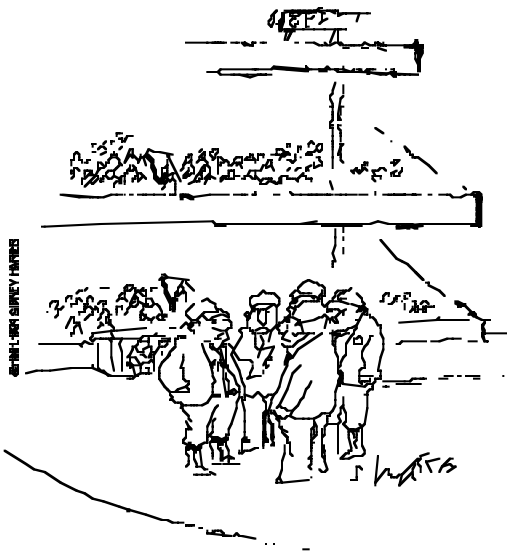

"This isn't a co-op picnic--we need one winner and one loser."

"**Building the Capacity to Collaborate.** Several kinds of capacity are required to successfully initiate and execute cross-sector collaborations, including:

- *Leadership,* which can come from any or all of the three sectors, from the national to the neighborhood levels, and from ordinary citizens;
- *Citizenship,* to provide the base, reservoir, support, action arm, and accountability of leadership;
- *Knowledge and understanding* about economic and social trends, about successful and unsuccessful experience elsewhere, and about the respective agendas, cultures, and operating practices of partners in all three sectors;
- *Communication and network management*, including such skills as visioning, strategic planning, convening, facilitating, deliberating, attentive listening, coaching, consensus building, brokering, mediating, negotiating, contracting, monitoring, evaluating, assessing, reflecting, learning, and collaborative problem-solving.
- *Industry and service system structures*, including well-designed markets, industries, social service systems, and policy arenas.
- *Performance and accountability*, including a means of defining performance, monitoring progress, and establishing accountability for results that is compatible with each sector; and
- *Ethics* that accommodate the highest standards and particular culture of each sector, with priority placed on honoring important public values and focusing on the accomplishment of the public purpose to which the collaboration is addressed."

> "Today, cross-sector collaborations, partnerships, and alliances are more important than ever in addressing the increasing number of complex public issues that spill over sectoral boundaries."

"In today's dynamic environment, learning how to change has become a 'core capacity' of successful cross-sector collaboration. It requires a special emphasis on a clearly defined context; performance of public purposes; accurate knowledge and information; adaptability, flexibility, innovation, and continuous improvement; ethics and accountability; and communication. Accommodating all these challenges requires balance and integration, and the anticipation of unintended consequences. Perhaps the greatest challenge is to consciously adapt to and constructively shape the process of social change itself."

"The transcending lesson from this series of dialogues is that collaboration among the sectors will continue to be important not only to address critical public purposes that no one sector can achieve alone, but also to fashion a new set of relationships that will help the three sectors and the public at large shape a productive and just society in an era of rapid change."

Real Brat Is Boiled, Grilled & Then Stewed

In "The Meat That Made Sheboygan Famous" (6/5/02), The *New York Times* engaged in a misguided albeit well intended effort to describe the indigenous preparation of the true Wisconsin Bratwurst (Brat—rhymes with otter). The following recipe is offered to *Eye On Health* readers as a public service from Sheboygan's own Bobby "The Brat" Zimmerman:

"Here's the way a good Jewish kid from Sheboygan cooks these babies. First: cook a dozen Brats in simmering water for about 5-10 minutes (gets some of the grease and fat out). Second: start cooking the Brats on the grill. In the meantime, prepare the fluid to stew Brats in after they are done being grilled--which is 2-3 cans of beer (cheap beer is OK) in a pot with 2 sliced onions and a 1/4 pound of butter. Heat to a boil and then turn heat down to medium. When Brats are done put them in the beer solution—simmer for an additional 5 minutes or so and serve. If you need a official cook I'm for hire (I get $2.50 an hour and at least 3 Brats). Enjoy."

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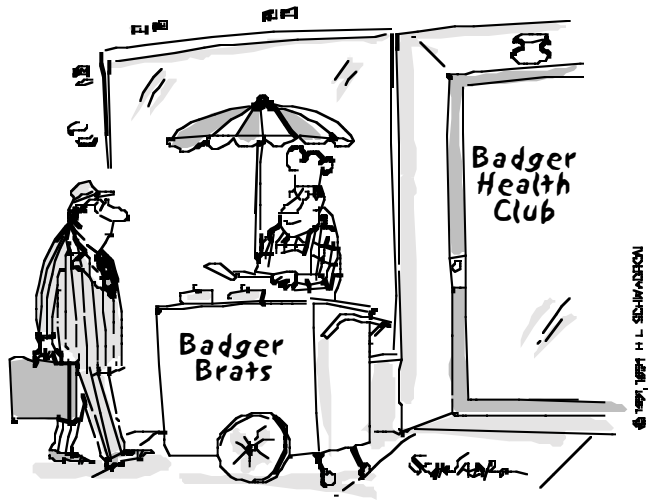

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