

Review & Commentary on Health Policy Issues for a Rural Perspective – March 1st, 2003

Arguing For Rural Community Hospitals

The following is from a briefing by Tim Size, RWHC Executive Director and National Rural Health Association Past President, on 2/14/03 in Washington, DC, for staffers of Members of the U.S. Senate Rural Health Caucus and House Rural Health Coalition. The complete statement as well a "side by side" comparison of the Rural Community Hospital Assistance (RCH) Act and Critical Access Hospital (CAH) program, prepared by John Sheehan, BKD Health Care Group, is at <www.rwhc.com>.

“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 (PPS). 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 massively negative Medicare margins and meager or nonexistent operating margins.”

“In 2002, The Rural Community Hospital Assistance Act was introduced to enhance the Critical Access Hospital (CAH) program and to create a new Medicare payment classification for rural hospitals with 50 or fewer acute care beds. This classification would be called Rural Community

Hospital (RCH). Reintroduction in 2003 in both the Senate and the House is expected. RCH protects the core infrastructure of rural health in America while not undermining the policy inherent in the Medicare Prospective Payment System. For twenty years we have tried to adapt PPS for these hospitals; it is now time to admit that the theoretical model simply doesn’t fit this small minority of hospitals. Acknowledging that PPS is inappropriate for hospitals which account for only about 2% of Medicare hospital

payments is simply not a threat to, or contradiction of, the Prospective Payment System.”

“In 1999, rural hospitals were paid 9.6% less than their Medicare costs for providing services to Medicare beneficiaries. Rural hospitals with under 50 beds not eligible for rural referral, sole community or Medicare dependent status were paid 14.2% less than their reasonable costs. In 1999, 54.5% of these hospitals had a negative inpatient Medicare margin; almost all lost money on their outpatient services.”

RWHC Eye On Health

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"Fixing 2% of hospital payments doesn't undermine the Medicare PPS big picture."

“The arrival of CAHs doesn’t help those hospitals too busy to qualify unless they are willing to force significant numbers of Medicare beneficiaries to leave the community for care which could easily be done locally. Data collected by the State of Wisconsin for 2001, shows Total Medicare Margins of -21.9% for the then 32 rural hospitals with under 50 beds that were not CAHs. The margin drops further to -22.9% when seven hospitals who subsequently became CAHs are excluded. Hospitals with these losses cost shift to the private sector as long as they can, or close. **RCH is a cost based option for rural hospitals with 50 or fewer acute care beds that are not eligible to be a CAH.”**

“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 whole cohort of America’s hospitals, on average, are losing money serving Medicare beneficiaries, the problem is the payment system, not hospital efficiencies.

- 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.
- 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.”

“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. **The Medicare rural cost shift nationwide equates to approximately a 30% tax on private payers** (according to rural payment to cost ratios, MedPAC 6/01). **In an increasingly price competitive environment, this tax is not sustainable.**”

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

Fed. Way: Higher Quality = Lower Payment

The following is from an article by Rich Donkle, RWHC Director of Financial Consulting Services, in *News & Profiles*, the official newsletter of the Healthcare Financial Management Association - Wisconsin Chapter, March/April 2003:

“ ‘It was the best of times. It was the worst of times.’ ‘Less filling ... tastes great!’ ‘Higher quality, lower payment.’ The first quote is from a work of fiction, while the second is from a beer commercial. The third could be a slogan for the Centers for Medicare & Medicaid Services (CMS).”

“The January 15th, 2003, edition of the *Journal of the American Medical Association* (JAMA) reported that Medicare patients are receiving better care than they

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.

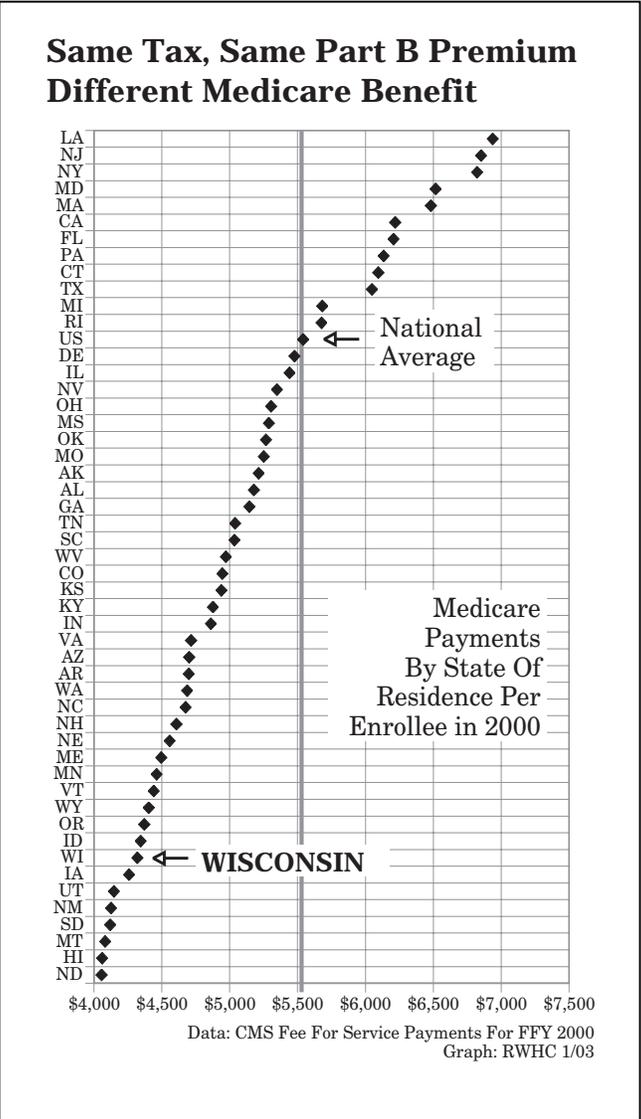
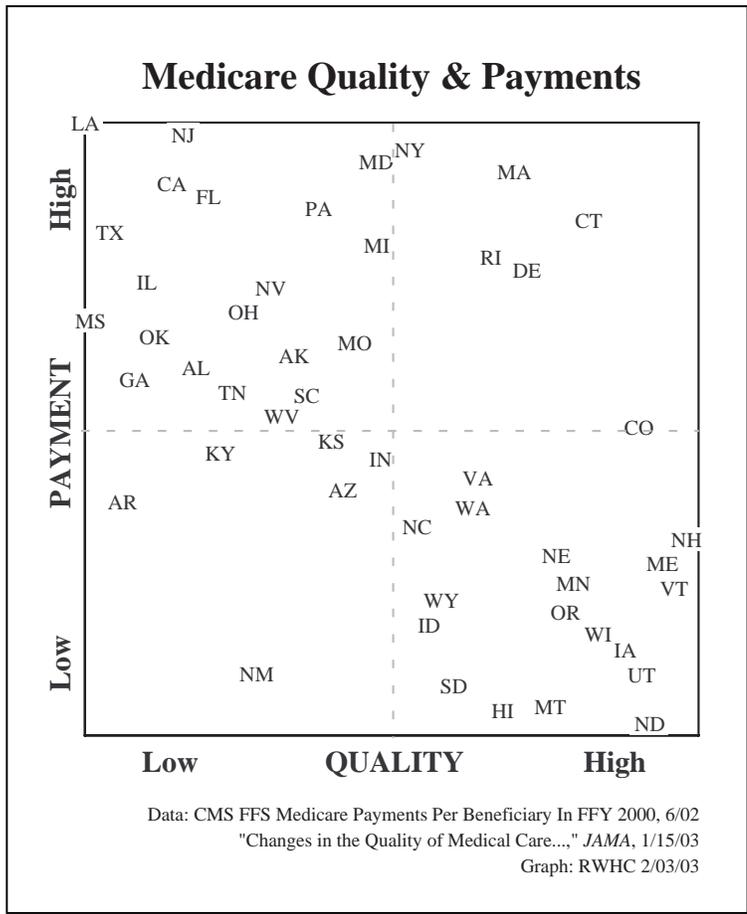
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did just a few years ago for ailments such as heart attacks, pneumonia and diabetes. Twenty-two quality indicators were abstracted from statewide random samples of medical records for inpatient fee-for-service and from Medicare beneficiary surveys or Medicare claims for outpatient care. Based on these measures, Wisconsin ranked eighth in the nation in quality. This may not be a surprise to those in the health care industry in Wisconsin. We have long prided ourselves on the level of clinical services provided to our patients.”

“A Medicare Payment Advisory Commission (MedPAC) report dated May 13, 2002, contains data that seems, at face value very inconsistent. Many states that JAMA says provide the highest quality of services to Medicare beneficiaries (like Wisconsin) are also the states with the lowest Medicare payment per beneficiary (like Wisconsin).

“What is troubling about the quality findings is the lack of correlation to Medicare payments per beneficiary. According to the MedPAC report, which uses CMS data, Wisconsin is 43rd in payment per benefi-



ciary. The CMS data ranks states by annual Medicare payments per beneficiary. The state receiving the most in payment per beneficiary was Louisiana, while the state with the lowest payment per beneficiary was North Dakota. Wisconsin ranks 43rd in payment per beneficiary, that is 42 states receive higher amounts.”

“MedPAC makes several observations and recommendations regarding the disparity in Medicare payments. Their recommendations address:

- Restructuring the hospital wage index to correct numerous flaws that reward urban areas at the expense of rural areas
- Inequity in disproportionate share payments
- Creation of a low volume adjustment for inpatient payments

- Unified base rate for inpatient payments
- Differentiated cap on payments for psychiatric facilities
- Revision of rural home health payments
- Creation of a low volume and increased base rate for rural outpatient PPS services
- State-level adjustment of Part B premium and inpatient deductible”

“Adoption of these recommendations would not solve all of the inequities for providers built into the Medicare system, but they would help. (See previous article on the RCH proposal.) Unfortunately, the system seems to be more motivated by politics than by equity.

It is important that all providers in Wisconsin understand the issues surrounding the current inequity and continue to fight for a more rational system.”

NRHA 26th Annual Conference,
 “The Changing Rural Landscape”
 May 13-16
 Grand American Hotel, Salt Lake City.
 Register at www.NRHArural.org

and mid-level providers. It should be emphasized that this service was developed to augment a human resource department’s existing recruitment efforts – not replace them. Recruitment strategies include preparing a needs assessment and opportunity profile for each site, and disseminating information about position openings via: direct mail, journal/newspaper ads,

displays at career fairs/professional meetings, networking with schools/training programs, and listings on the WORH Employment Exchange. The recruiter is also available to provide supplemental training for those facilities in need of internal recruitment assistance.

Qualified prospects will be referred to every posted position that matches their qualifications and preferences. Neither the recruiter nor RWHC will steer candidates toward one facility or another. RWHC members will not be charged a placement fee for successful matches or incur any additional procurement/marketing costs. This service is paid for from each RWHC member’s quarterly assessment so all members are encouraged to fully take advantage of the service!

For additional information about the RWHC/WORH Recruitment Service, contact Denise Siemers at: 800-385-0005 (ext. 6) or dmsiemers@wisc.edu.

Public-Private Partnership For Recruitment

Continuing workforce shortages and intense competition have forced healthcare providers to consider creative options for recruiting and retaining staff. With that in mind, the Rural Wisconsin Health Cooperative has contracted with the Wisconsin Office of Rural Health to provide recruitment services exclusively to RWHC hospitals. Modeled after WORH’s successful physician recruitment program, this service focuses on the following disciplines:

- Registered Nurses
- Certified Nurse Midwives
- Nurse Practitioners
- Physician Assistants
- CRNAs
- Radiology Technicians
- Laboratory Technicians
- Physical/Occupational Therapists
- Pharmacists
- Optometrists

The RWHC/WORH recruiter has extensive experience in healthcare, focusing primarily on physician

Tools For Improving Partnership Synergy

An absolutely “must read” article for anyone interested in health care networking is “Partnership Synergy: A Practical Framework for Studying and Strengthening the Collaborative Advantage” by Lasker, Weiss & Miller in *The Milbank Quarterly*, Vol. 79, No. 2, 2001. In this paper, the term “partnership” is used to encompass all of the types of collaborations “that bring people and organizations together to improve health, health care, and the functioning of the health system.” To obtain a reprint, contact Patricia Warmack at the New York Academy of Medicine <pwarmack@nyam.org>.

Within the paper there is a particularly useful list and discussion about “determinants of partnership synergy—The power to combine the perspectives, resources, and skills of a group of people and organizations has been called *synergy*.” The authors identify elements of partnership functioning that are likely to influence the ability of partnerships to achieve high levels of synergy. “Based on a review of the extensive literature on partnerships from the unique perspective of partnership synergy” they group these “determinants” into five categories:

- 1) Resources
 - a) Money
 - b) Space, equipment, goods
 - c) Skills and expertise
 - d) Information
 - e) Connections to people, organizations, groups
 - f) Endorsements
 - g) Convening power
- 2) Partner characteristics
 - a) Heterogeneity.
 - b) Level of involvement
- 3) Relationships among partners
 - a) Trust
 - b) Respect
 - c) Conflict
 - d) Power differentials
- 4) Partnership characteristics
 - a) Leadership
 - b) Administration and management
 - c) Governance
 - d) Efficiency
- 5) External environment
 - a) Community characteristics
 - b) Public and organizational policies

In a related effort, the Center for the Advancement of Collaborative Strategies in Health at the New York Academy of Medicine launched “its new **web-based Partnership Self-Assessment Tool**.” The tool is a

Good Fences Make Good Neighbors, The Rest Of The Story

“There is more to Robert Frost’s poem *Mending Wall*: ‘I let my neighbor know beyond the hill, and on a day we meet to walk the line and set the wall between us once again...’ Even this American icon to self-sufficiency is expressed within the cultural context of selective cooperation being used to maintain a local sense of self. From *Partners for the Dance: Forming Strategic Alliances in Health Care* (page 40) edited by Kaluzny, Zuckerman, and Ricketts.

unique resource for partnerships concentrating on health or any other issue. Unlike most evaluations, which focus on a partnership’s programs or goals, the Tool assesses how well a partnership’s collaborative process strengthens its ability to achieve those goals.

“Survey results shows a partnership how well its collaborative process is working and what it

can do to make the process work better. In this way, it enables partnership members to get more out of their collective efforts and make more of a difference in their community.” You can sign up to have your partnership or collaboration participate in an on-line self-assessment at <www.cacsh.org/satool.html>.

The Rural Lie—Media, Perceptions & Policy

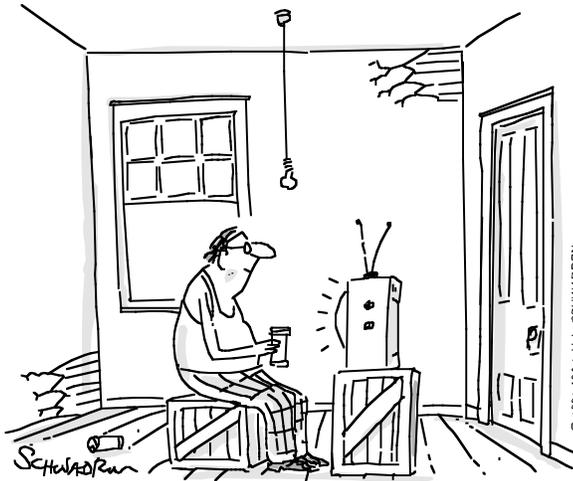
From a commentary “Media, Perceptions, and Policy” by Thomas D. Rowley, 2/7/03; this and other Rowley commentaries are at <www.rupri.org/>:

“When it comes to influencing the public’s perception on issues in this country, national media—news and entertainment—run second to nothing. Public perception, in turn, holds great sway over the policies crafted to address those issues. For rural America, the equation spells trouble. Two recent cases illustrate.”

“First, is CBS’s planned new reality television show modeled on the old *Beverly Hillbillies*. The idea is to take a poor rural family from the hills, give them a fortune, plo p them in the middle of swimming pools and movie stars (and our living rooms), and kick back and laugh as they fumble along.”

“The fun, of course, would come at the expense of the family, but also at the expense of rural America. How could policies that are based on perceptions that are based on glimpses of people designed to stereotype and humiliate (the purpose of reality TV) be anything but inadequate if not downright harmful?”

RWHC Eye On Health



"Pamper yourself, use your tax rebate for that long dreamed of tropical cruise."

"That's just entertainment, you say? Not meant to be accurate or even informative? Perhaps, but news coverage of rural issues (claiming to be both accurate and informative), it seems, isn't much better."

"A recent study commissioned by the W.K. Kellogg Foundation and conducted by the Center for Media and Public Affairs examined the news media's portrayal of rural America. It analyzed 337 news stories about rural life and rural issues that appeared in the first half of 2002 in ten major national television and print news outlets. The results are disturbing."

"More than 75 percent of the examined television stories focused on rural crime (due in large part to the serial mailbox bomber at work in the Midwest during that time). The top story in print—appearing in 29 percent of the articles—was land use issues, such as sprawl. Finally, one of every ten stories, on television and in print combined, depicted rural people as 'poor, backwoods hillbillies and country bumpkins.'"

"What exactly do these findings say about national news coverage of rural America?"

"According to Matthew Felling, Media Director for the Center, the findings suggest 'a disconnect' between urban, coastal journalists (who dominate national news reporting) and rural America—to them,

unknown territory, fly-over country. 'Coastal reporters,' he says, 'are not fluent in rural issues.'"

"As a result, national media rarely get at the deeper issues and deeper truths of rural life and people. Instead, coverage is limited to the sensational—crime—and issues that are arguably as much urban as rural—sprawl. If it doesn't bleed, it doesn't lead. If it affects rural people but not urban, forget it."

"While no one is arguing that media treatment of rural America—scant and/or bad as it is—alone drives rural policy, the connection is, according to Felling, direct. The failure of the media to provide adequate and accurate coverage of rural issues means that policy often gets made without informed public input. That, he says, 'effectively removes checks and balances from rural policies.'"

"Which is why Rural Strategies, Inc.—a tiny non-profit in Whitesburg, Kentucky—is taking out ads in major papers around the country calling for CBS to pull the plug on the *Hillbillies*, Rural Strategies Tim Marema explains."

"All of us would agree that on the list of things that need fixing, reality television doesn't on its face rank very high. We do feel very strongly, however, that U.S. media have left rural people behind... The influence of the media in what gets attention in a de-

The Rural Assistance Center (RAC) Web Site

"RAC is a new national resource on rural health and human services information. Our information specialists are available to provide customized assistance, such as web and database searches on rural topics and funding resources, linking users to organizations, and furnishing relevant publications from the RAC resource library."

"HHS Secretary Tommy Thompson committed to creating this single-point of entry for rural Americans in July. The Secretary said at the time, 'Government should not be a hindrance to providing service to rural Americans: we should make it easier.' The RAC can be accessed at: <http://www.raconline.org> or by dialing 1-800-270-1898."

"The RAC is the result of collaboration by the University of North Dakota's Center for Rural Health and its partners the Rural Policy Research Institute, the Welfare Information Network, and HHS's Office of Rural Health Policy in the Health Resources and Services Administration."

mocracy is tremendous. Media inform public perceptions, which, in turn, inform the policies our public and private institutions create. In the absence of accurate perceptions, the national policies affecting rural communities are inadequate.’ ”

“All of which leaves rural policy, and rural America, in a bad way.”

“Felling puts an even finer point on it: ‘Our opinions of rural America were once informed by common-sense Midwesterners, now our perceptions ... are driven more by participants on Jerry Springer.’ ”

“Add to that the misperceptions about rural Americans that will be fostered by the *Real Beverly Hillbillies* and that bad way could get a lot worse.”

Fiscal Chicken’s Coming Home

From Glen Grady’s newsletter at the Memorial Medical Center (Neillsville, Wisconsin), 1/03:

“It is no secret to anyone that many states are currently facing huge budget deficits for the upcoming year and beyond. The boom times appear to be over, at least for now. And that means that income tax revenue is down sharply for both the federal and state governments. Unfortunately most states, including Wisconsin, counted on the good times going on and on. When the reality of the economic downturn hit, they found themselves unprepared to deal with a financial crisis of the magnitude that the sluggish economy has caused.”

“In Wisconsin for this current year, the legislature and governor postponed the crisis last year by using the tobacco settlement fund of something over a billion dollars to balance the budget. Unfortunately that was a one-time windfall and that didn’t quite make the State solvent for the whole year. For the fiscal year that will end June 30 of 2003, the State is now projecting a \$400 million deficit.”

“Things are projected to get worse- much worse. The State is now projecting a deficit of over 3 billion dollars for the upcoming two years. This is far more

problematic than the national debt. Unlike the federal governments, states can not print money and they are not as credit worthy as the Feds.”

“So we have a new governor and legislature facing an old problem. How do they deal with this huge deficit? The deficit looms a little bit larger than it may appear due to two very pernicious issues:

- 1) This is a structural deficit, which means that most all of the programs that past legislature and governors have put in place and need to be funded are ongoing, so the cost does not become less in succeeding years and;
- 2) The new governor and many of the legislators promised as candidates that they would not raise taxes.”

“When we do the math, this is very hard to reconcile. If the State is projecting that it will take in \$1.5 billion less than it is committed to spending in each of the next two years yet insist that there will be no tax increase or new taxes, something has to give. Not just a few state funded programs and services will have to be scaled back or done away with completely, or the State will very soon be insolvent.”

“For the most part, though, Joe citizen doesn’t seem to be too concerned. In a recent poll, less than 50% of Wisconsinites believed that services would have to be cut to balance the State budget. I guess they are counting on the economy getting much, much stronger in a hurry, increasing tax revenue enough to offset the deficit. Or they believe in the tooth fairy.”

“While I always try to remain optimistic, I am not counting on the economy making a robust recovery in such a short period of time—and as for the tooth fairy is concerned, I haven’t seen any evidence of him being around since I lost my last baby tooth. So I am looking for some cuts—hopefully not too major—in the programs that directly affect the way we do business around here. The State’s Medicaid program funds at least 70% of the residents we have in the nursing home at any given time. It also funds somewhere between 10% and 15% of our clinic patients and about 8% of inpatient hospital admissions. The Medicaid program itself is funded by about a 60% federal match—that means that out of every

three dollars of Medicaid spending, \$1.20 is State money and \$1.80 is federal money. Even with this rather generous federal match, however, State Medicaid spending is well over a billion dollars annually. So Medicaid, along with aid to local governments and state funding for public schools could easily be on the budget chopping block.”

“I assume that the State of Wisconsin will stay in the Medicaid business, and will likely continue local government revenues sharing as well as aid to schools. But it will not be business as usual. We anticipate reductions in the types of services that Medicaid covers. There also could be some attempt made to reduce the numbers of eligible Medicaid beneficiaries. At the very least, I think we can expect spending freezes in what these programs are paying us for these services. We could even see reduction.”

“These are challenging times that are only going to get more challenging. We only hope that the State finds enough money somewhere to continue to protect and support our financially disadvantaged children and elderly.”

“And we hope that the solutions are funded at a level that will allow us to continue to serve these—the most vulnerable of our citizens.”



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