

Rural Wisconsin Hospital Cooperative

Executive Director's Report

as of June, 1994

A monthly report of experiences and observations to RWHC hospitals.

A NGA Staff Review of State Reform

I recently had the opportunity to spend a morning with Alan Weil, Colorado Governor Romer's health policy advisor and staff for Governor Romer's chairmanship of the National Governor's Association Health Care Leadership Group as part of some work I periodically do with the Robert Wood Johnson Foundation. A summary of his observations follows:

Comprehensive health care reform—controlling costs and guaranteeing universal access was not on the federal agenda when in the early 90's the most recent state reform cycle was initiated by a small number of states: Washington, Oregon, Vermont, Massachusetts, Minnesota and Florida. (Hawaii's experience of actually implementing reform in the 70's was seen as "too long ago" and Massachusetts's '89 reform package had not been implemented.) Colorado was at the lead of a second tier of states (another half dozen) that were serious, enthusiastic but not out front with major comprehensive proposals.

With the election of Clinton and his commit-

ment to health care reform, the dynamics of state reform changed dramatically. In particular there was a compression of the degree of activity among all states. Those that had been moving ahead pulled back as questions of state and federal "fit" could not be answered; states that had not been involved found the political cover to justify setting up commissions to at least study the issues.

In 1993-94, state legislative initiatives has been more incremental; moving into those areas believed to be relatively low risk and roughly consistent with the common ground of many of the major proposals—voluntary purchasing alliances and insurance market reforms for small businesses. Insurance reforms being considered in many states (and recently passed in Colorado) include "development of standard benefit plans" to facilitate comparison shopping; "limitation of the pre-existing condition language" (i.e. situations when an insurer can legally say you are covered except for your heart condition, or your pregnancy, etc.); "guaranteed issue" of standard plans (i.e. if they sell you are allowed to buy it); modified "community rating" (i.e. limitations on the premium variation among

all small businesses buying the same benefit plan of a particular company).

There is a significant philosophical or political judgment difference among some advocates that leaves them split whether or not to support incremental reforms such as noted above. Those in favor believe that it is necessary to break ground and show that basic changes are possible and do improve the situation; that an issue this complex can only be addressed incrementally. The opposing perspective is that if you implement insurance reforms you take away the constituency and support for the harder reforms related to paying for universal access.

Political leadership requires being out front but not so out front as to be seen as irrelevant or too aggressive with a personal agenda. In any event, the number of governors and legislators who understand the issues has increased significantly over the last three years as well as necessary state data capabilities. As this is an election year for 36 Governors, there is also speculation that there is a tendency for Governors to stay away from potentially difficult issues, like who pays for cost of universal coverage. The politics are obviously complex. Ironically small businesses, among a long list of interest groups, are both the big winners and big losers under most health reform proposals. Small businesses that currently purchase health insurance will be the big winners while small businesses that do not currently provide insurance will be the big losers.

Several still possible federal/state scenarios were presented: (1) Congress defines a set of reasonably comprehensive objectives and it is left to the states to fill in the details, (2) Congress defines both objectives and how the state activities will be structured or (3) Congress stops short of much or any comprehensive legislation and the states are, at

least for the moment, back on their own.

Historical Note: Alan made a good case for the following: rather than talking about this as an era of state response to federal reform it has always been more accurate to talk about the state response to the federal response to the state response to the need for reform.

WI Cooperative Center of Excellence?

Fred Moskol, myself and several others have been working with Ann Hoyt, Associate Professor, University of Wisconsin Center for Cooperatives as she prepares a proposal in response at the request of the National Rural Cooperative Development Task Force.

The basic idea is that there are federal dollars available to the Task Force to establish a “center of excellence” in cooperative health care and Wisconsin is currently seen as the most likely site. I have already expressed on behalf of RWHC our support for the idea. Such a center would be likely to attract private funds for purposes of research, education and demonstration projects relevant to cooperative or collaborative health enterprises.

Federal Confusion re Consortiums?

This week we received a letter from the Rural Health Outreach grant program stating that RWHC was ineligible for funding because we did not constitute a consortium of three or more health care and/or social service organizations.

My initial response to this particularly bizarre federal bureau-think was coming to grips with a level of anger that I usually

discover only through parenting teenagers. After settling down, I formally submitted a request for the timely reconsideration of our application and any other applications during this review cycle that were similarly found to be ineligible, so that we may exercise our right to equitable access in 1994 to Rural Health Outreach funds.

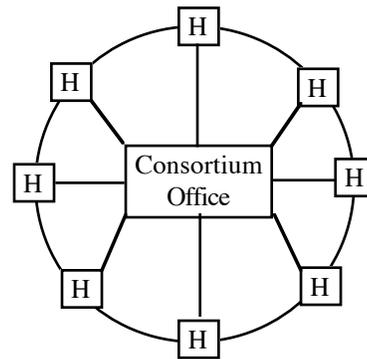
The development of good public policy for rural health requires that the ORC's implicit and limiting definition of a consortium be changed and not allowed to stand as a precedent for upcoming federal health reform initiatives.

As one part of our appeal I put forward the position that the Federal Office Of Rural Health Policy seems to have a fundamental misunderstanding of the structure of cooperatives. Most individuals inside and outside of Washington that I have consulted in preparation of this request for reconsideration have had a singular response—"What? The Cooperative isn't considered to be a consortium? You've got to be kidding." Many see initiatives like that which we proposed as a critically important model for the application of health reform principles in rural areas. How can we be a consortium in terms of health reform but not in terms of Rural Health Outreach grants? We assume that this question can be expected to be a particular concern of both the National Rural Health Association and the National Cooperative Business Association who have been leading advocates for the use of cooperatives and consortia as an organizational model under health reform.

What has apparently been misunderstood during the internal review process is that cooperatives are primarily about relationships, a network of otherwise independent entities; they are not primarily about central office operations, the piece of our consortium that has been characterized in the denial letter as

"an entity." It is the emphasis on developing a network among freestanding entities that is at the very heart of the cooperative movement and of the recognition that consortium development is particularly applicable to rural health reform. It is what makes cooperatives different from centrally owned and directed "systems."

Model Of A Hospital Consortium:



When we refer to the Cooperative, the reference has always included both the legal entity and the network of individual rural hospitals as represented in the above schematic. It appears that the ORC focused on the more easily visualized label on the "soccer ball" while missing the multiple parts that make up the Cooperative as a whole.

An Any Willing Provider Middle Way

As noted above, several weeks ago I was in Denver with Alan Weil, Governor Romer's health policy advisor. I learned that Governor Romer had just vetoed an "Any Willing Provider" bill for pharmacists but then immediately negotiated a deal that was formalized through an Executive Order that effectively mandates inclusion of any willing pharmacist in communities of under

25,000. This is exactly the model that RWHC had previously discussed and now it looks like Colorado may be the first to implement it for any provider group.

Media, Health Care & Rural Realities

Rural health is a very important and complex issue of broad public interest but when you think of it doesn't receive much attention from Wisconsin's media, particularly its radio and television stations. As one modest attempt to help plant a few signs I sent Steve Busalacki at WHA Radio a new made for radio tape, "Health Care: Rural Realities."

It was produced by the High Plains News Service for its stations in Montana, Wyoming, Colorado and the Dakotas. They did a great job of lining up a variety of local providers and citizens to explain some of the health related challenges faced by rural residents and communities. I expressed a hope hoping that he might be interested in either airing this tape or using it as a model for a Wisconsin specific piece.

Suggestions for UW Policy Program

Advisory board members were asked to suggest potential items to put on research agenda for the new UW Health Policy Program before our first meeting earlier this month. I submitted the following four suggestions with the antitrust issue appearing to stimulate the most interest from other members and faculty:

Antitrust Protection & Limitations For Rural Health? The formation of rural provider networks face antitrust issues "going and coming". On one hand, some want protection

from being plowed under by increasingly centralized and growing corporate entities but on the other hand some want the flexibility to organize joint ventures and collectively negotiate reimbursement arrangements. In short, antitrust laws can be used to both protect and limit the development of collaborative models seen as vital by many to the future of rural health.

Continuing Medicare Wage Index Differentials Into Health Reform? The rural/urban Medicare differential has not been eliminated; ProPAC and HCFA appear stalled on a mechanism to reform Medicare Wage Index and there is serious consideration of expanding Medicare rates as the basis of a single rate system for all payers. What would be the impact on rural providers of going to an "all payer at Medicare rates" system who currently balance significant Medicare shortfalls by "cost-shifting" to private payers?

Medical Risk Adjustments—what can we learn from current medical underwriting practices that will guide us to design the medical risk adjustments seen as critical to networks under either managed competition or single payer reform alternatives? The future of health care is widely predicted as making less use of "fee for service" payment methodologies and more use of capitated arrangements—a fixed payment per capita per month regardless of utilization. With this trend comes the worsening of the current financial disincentive for insurers or networks and providers to serve individuals, communities and populations with higher than average per capita expected costs or lower than average payments from Medicare, Medicaid and uninsured patients. It is fundamental to the future success of health care reform in rural communities that insurance payments to insurers as well as insurer/network capitated payments to providers be risk adjusted. Risk adjustment mechanisms, either prospective or retrospec-

tive, must be developed and implemented.

“Any Willing Provider” Statutes: Potential Impact On Rural Health? Legislative proposals to force HMO’s to accept “any willing providers” are moving across rural states like prairie fire. Governor Romer recently vetoed such legislation for pharmacists in Colorado as anti-competitive but then proceeded to negotiate and implement through Executive Order an arrangement that introduces “any willing provider” protection for pharmacists in communities of less than 25,000.

Talk: USDA Rural Development Staff

This week I had the opportunity (being local) to represent the National Rural Health Association at a meeting in Milwaukee of the national field staff of the USDA’s Rural Development Administration. This agency operates the Farmers Home Administration so the focus of the workshop was on access to capital in by rural providers. I was joined by Larry Nines from WHEFA who did the lion’s share of the presentation. It was a very good opportunity to reemphasize the critical connection between rural health and rural economic development.

RMC Project Again Moving Forward

Bob Taylor and I recently wrote Gerald Whitburn in an effort to prompt more aggressive support for development of Rural Medical Center draft legislation and regulations. Perhaps that communication had some effect—the authorizing paperwork was released from State personnel processing limbo to enable the hiring of Dan Jehl’s replacement as project director. A Larry Hartzke has been appointed and will be at

the June 20th RMC meeting His prior work experience includes positions with DHSS, the Institute for Health Planning and WIPRO.

Need for Primary Care Consortium?

As part of the upcoming Wisconsin Primary Care Consortium annual election I offered the following thoughts about why Wisconsin needs the Primary Care Consortium:

I have been fortunate in being able to allocate a substantial amount of my time over the last year to working with many good colleagues to begin to turn the WPCC vision into a reality; we are off to a good start but that we still have a series of challenges before us. Given RWHC’s fifteen year experience as a strategic alliance working with rural communities I know that it takes time to develop a consortium approach but that this is the right way for Wisconsin. All of our agencies, working alone or in small competing groups are not enough to get the job done.

I believe in the need for communities to empower themselves with outside assistance in order to make a difference in their own future. I continue concerned about an increasing pressure on many local communities and providers to acquiesce to a dependency on out-of-community corporations for the local provision of health care. While fully acknowledging that for some communities this may be the only practical option, my bias is that we should continue to work to address local need through a pluralistic system with local control and individual choice of providers or plans wherever possible.

Wisconsin has nationally recognized and innovative regional and statewide organizations. However, our collective experience has most often been characterized by

parallel play and competition rather than deliberate, cooperative joint action. Our Legislature's recent failure to pass any health reform after a year of promising development may be the result of partisan political posturing. But it is also a failure of the rest of us in a position to provide health policy leadership.

I feel strongly that the organizations that have been working on the Practice Sights Planning Grant may be facing a major turning point. I believe that we either go forward with an enhanced ability to work collectively or risk falling backward into an era of increasingly individualistic and competitive interventions. The genie is out of the bottle—individual organizations that once were comfortable leaving to others the responsibility for the state's primary care shortcomings now see that they we must be involved. For reasons of self-interest and good public policy the issue is no longer will we be involved, but how.

They were doing all right until the last sentence; we need to embrace the very real and substantive potential benefits of "tele-medicine" without in falling into the trap of overstating the case as done above. Tele-medicine is no more a silver bullet for rural health than any of the many major public and private initiatives that need to occur.



A Rural Information Superhighway?

Supporters of the "superhighway" bill currently before the Wisconsin legislature have circulated an information packet (ironically, the paper kind) highlighting key provisions of the legislation. Of special interest is the section on the benefit to rural Wisconsin. Under rural health the following is noted:

"Rural areas will gain access to more doctors and other health care services, enabling the health care delivery system to be more cost effective and efficient. Doctors will make electronic house calls via interactive video and run tests over the phone. This will remove distance and travel as hindrances to receiving adequate medical care."