

Don't Abandon Rural Payment Adjustments

by Mike Wallace, President & CEO, Fort HealthCare, Fort Atkinson, Wisconsin:

Much can be said about what's not working in Washington D C. However, there is a mechanism that is working, and it's called the Low Volume Medicare adjustment.

The Low Volume Medicare adjustment is just what it says—an adjustment of Medicare payments to hospitals like Fort HealthCare who are too “busy” to be classified as a Critical Access Hospital, but lack the volume of larger urban facilities.

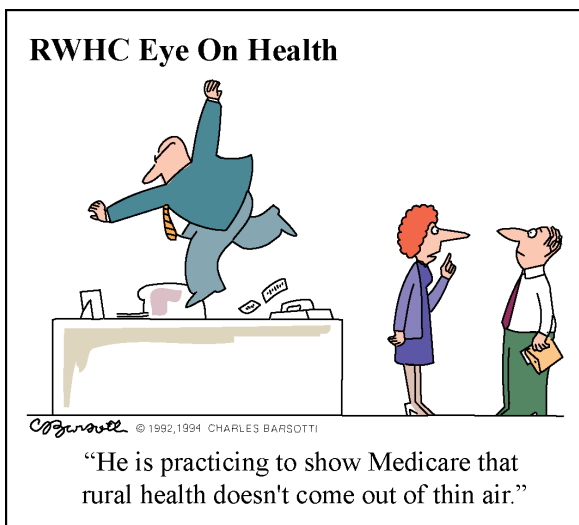
The intent of rural payment adjustments is to assist hospitals like Fort HealthCare who have fixed costs that they struggle to meet because of a lack of economies of scale. The Low Volume Medicare adjustment has helped a number of rural facilities address this reality and still provide critical services at the local level.

The Low Volume Medicare adjustment amounts to almost \$500,000 for Fort HealthCare. Make no mistake about it, these are not “bonus” payments. At a time when my facility is paid by Medicare 75 cents for every dollar of expense and by Medicaid only 60 cents for every dollar of expense, every dollar counts.

Medicare and Medicaid account for over 50% of the business of most rural hospitals. As the saying goes,

when you're selling it at a loss, you can't make it up on volume. The Low Volume Medicare adjustment doesn't make us whole, but it does help us make good decisions about the programs we offer in our community. For example, the \$500,000 we receive allows us to fund a provider for a “free clinic” in our service area. Not only does this provide access to a very vulnerable population, but it also allows us to mitigate the inappropriate utilization of our ER for primary care.

RWHC Eye On Health



We already have evidence that this is working in our community. Another program we are able to fund is our Community Health and Wellness Department. Working with local governments, employers, and school systems, we are able to provide education and counseling about the benefits of health and wellness activities.

Weight loss challenges, step challenges and farm-to-school initiatives are direct investments we are making to improve the health of our community. These are vulnerable if we lose the Low Volume Medicare adjusted payment. Other programs (people) also become vulnerable if we were to lose the adjustment. There is plenty of evidence that demonstrates that as you decrease access to care, you increase the cost of care.

Healthcare providers like Fort HealthCare are “doing the right thing”. Our investments in our community are just such an example; we are spending money to keep people healthier and out of the hospital (which is how we generate revenue). Why are we doing this? We do it because it's the “right thing to do”. As importantly, we believe we are transforming a broken delivery sys-

tem (which rewards us for generating volume) and increasing consumer/patient engagement in their health. It is about health care, not sick care.

Today, we are straddling the gap between an out of date payment system and the one just emerging for tomorrow. This is a balancing act with little room for error. There isn't a revenue stream in keeping people healthy—at least not yet.

The payer community needs to help us incent behavior that promotes health and wellness, improved chronic disease (diabetes, coronary artery disease) management. It also needs to significantly invest and partner with the provider (doctors and hospitals) community to establish a model that pays for “value” over “volume”. We'll get there, but sooner is preferable.

Rural hospitals have served as a “laboratory” for studying what ails the US delivery system. The evidence shows that we are not only a lower cost provider, but our quality is as good or is some cases better than what is delivered in urban hospitals.

Rural healthcare is what's right about the delivery system. We need to preserve it, fund it and grow it. In addition to both the effectiveness and efficiency of rural hospitals, we play a large role in being an economic driver for the communities and service areas in which they reside. If you want to see the demise of rural America, start with the decline of the rural hospital.

Eye On Health is the monthly newsletter of the Rural Wisconsin Health Cooperative. Begun in 1979, RWHC has as its **Mission** that rural Wisconsin communities will be the healthiest in America. Our **Vision** is that... RWHC is a strong and innovative cooperative of diversified rural hospitals... it is the “rural advocate of choice” for its Members... it develops and manages a variety of products and services... it assists Members to offer high quality, cost-effective healthcare... assists Members in partnerships to make their communities healthier... generates additional revenue by services to non-Members... ongoing use of strategic alliances in pursuit of its Vision. Tim Size, Editor, 880 Independence Lane, Sauk City, WI 53583

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Lake Wobegone is Anything But Safe

From the PRNewswire-USNewswire, 7/23:

“Large cities in the U.S. are significantly safer than their rural counterparts, with the risk of injury death more than 20 percent higher in the country. A study published in the *Annals of Emergency Medicine* upends a common perception that urban areas are more dangerous than small towns (“Safety in Numbers: Are Major Cities the Safest Places in the U.S.?”).

“ ‘Cars, guns and drugs are the unholy trinity causing the majority of injury deaths in the U.S.,’ said lead study author Sage Myers, MD, MSCE, of the University of Pennsylvania in Philadelphia, PA. **‘Although the risk of homicide is higher in big cities, the risk of unintentional injury death is 40 percent higher in the most rural areas than in the most urban.** Overall, the rate of unintentional injury dwarfs the risk of homicide, with the rate of unintentional injury more than 15 times that of homicide among the entire population. This has important implications about staffing of emergency departments and trauma care systems in rural areas, which tend to be underserved as it is.’ ”

“Analyzing 1,295,919 injury deaths that occurred between 1999 and 2006, researchers determined that the risk of injury death was 22 percent higher in the most rural counties than in the most urban. The most common causes of injury death were motor vehicle crashes, leading to 27.61 deaths per 100,000 people in most rural areas and 10.58 per 100,000 in most urban areas. Though the risk of firearm-related death showed no difference across the rural-urban spectrum in the entire population as a whole, **when age subgroups were studied, firearm-related deaths were found to be significantly higher in rural areas for children and people 45 years and older;** however, for people age 20 to 44, the risk of firearm-related death was significantly lower in rural areas.”

“Race was also a factor. Rural counties with large black populations had significantly lower risk of injury death than those with small black populations. The opposite was true for Latino populations: Rural coun-

ties with large Latino populations had significantly higher risk of injury death than rural counties with small Latino populations.”

“Surprisingly, rural counties with the highest levels of college-educated inhabitants and median income had significantly increased risk of injury death compared to rural counties with the lowest levels of each.”

“ ‘By digging deep into the data, we may be able to tailor injury prevention efforts to the populations that need them, such as seniors in cities who are more likely to fall and rural children who are more likely to drown,’ said Dr. Myers. ‘This data is relevant to staffing issues as well. Injury-related mortality risk is highest in the areas least likely to be covered by emergency physicians and least likely to have access to trauma care, which argues for using a population-planning approach to improve emergency and trauma care systems in the U.S.’ ”

Annals of Emergency Medicine is the peer-reviewed scientific journal for the American College of Emergency Physicians, the national medical society representing emergency medicine. For more information, visit www.acep.org.

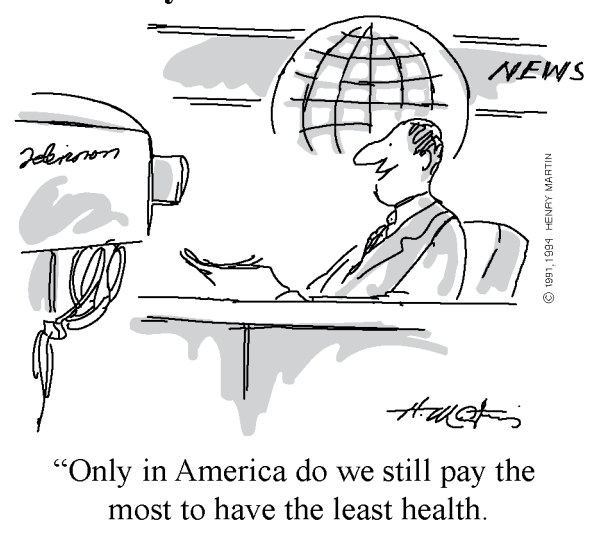
- “79 Medicare ACOs operate in both metropolitan and non-metropolitan counties.”
- “Medicare ACOs operate in 17.5% of non-metropolitan counties.”
- “9 ACOs operate exclusively in non-metropolitan counties, including at least 1 in every U.S. Census Region.”

Medicare Accountable Care Organizations—“The Medicare Shared Savings Program (MSSP), more commonly referred to as the Medicare ACO Program,

was created by the Patient Protection and Affordable Care Act of 2010 (ACA). The first Medicare ACOs were announced in April 2012. Private sector demonstrations of the ACO model began as early as 2009 with 5 sites. Currently, 220 Medicare MSSP ACOs operate across the United States, and 32 ACOs operate under Centers for Medicare & Medicaid Services demonstration authority as Pioneer ACOs. Other ACOs have formed through commercial insurer and provider agree-

ments, bringing the total as of April 2013 to more than 400. This policy brief presents data collected from Medicare ACOs regarding their presence in metropolitan and non-metropolitan counties.”

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The Inevitable Expansion of Market Reforms

From “Accountable Care Organizations in Rural America” by Clint MacKinney, Tom Vaughn, Xi Zhu, Keith Mueller; Fred Ullrich, in a *RUPRI Center for Rural Health Policy Analysis Rural Policy Brief*, 7/13:

Key Findings

- “Medicare Accountable Care Organizations (ACOs) operate in non-metropolitan counties in every U.S. Census Region.”

“An ACO is a health care provider group (generally hospitals and/or physicians) that contracts with a payer (Medicare for the purposes of this policy brief) to provide high clinical quality and positive patient experience at reduced cost. During the 3-year initial ACO contract period, Medicare pays the allowed charges for submitted claims while collecting ACO performance data, measuring clinical quality and patient experience with 33 indicators across 6 domains. Reduced cost is calculated as the difference between the total paid for all Medicare claims and the predicted Medicare costs for beneficiaries assigned to the ACO. If an ACO’s clinical quality and patient experience are acceptable, and if total payments are at least

2% less than predicted costs, Medicare will pay the ACO 50% of the cost savings if the ACO is not risk sharing for excessive costs, or 60% of the cost savings if the ACO is sharing risk (also 60%) for excessive costs. Starting in the second year of the ACO contracts, a pay-for-performance system will be implemented using the 33 quality indicators.”

Conclusion and Implications—“The MSSP and associated demonstrations represent a new health care delivery and payment model intended to support clinical quality, patient satisfaction, and controlled costs. If health care providers organized as an ACO deliver high quality care, positive patient experience, and lower costs than predicted, Medicare shares the cost savings (above a threshold value) with the ACO. As with other programs and demonstrations (e.g., the Value-based Payment Program and the Bundled Payment Program), Medicare is increasingly rewarding health care providers for delivering health care value, not simply service volumes.”

“The implications of ACOs for rural providers are significant. ACO participants (principally hospitals and physicians) can no longer rely exclusively on a business model that prioritizes service volume as an operational priority. Instead, they must direct attention and resources to increasing clinical quality, improving patient experience, and lowering the cost of care. We anticipate that ACOs will compete aggressively for patient loyalty to capture savings realized through care management and other value-driving strategies, placing non-participating providers at a competitive disadvantage. Rural hospitals and physicians that embrace strategies to improve value, not simply increase volume, will be best positioned for future success.”

Future Looks Good for Co-op Health Plans

From “Middle of the Pack: Co-op plan premiums suggest good long-term prospects” by Rich Daly in *Modern Healthcare*, 7/13/13:

“New, consumer-governed, cooperative health plans created by the healthcare reform law face some early challenges as they propose rates for plans they will



Rural Health Value Website Launched

“The Rural Health Systems Analysis and Technical Assistance (RHSATA) project—funded by the Office of Rural Health Policy—just launched its new website.”

www.RuralHealthValue.org

“The RHSATA vision is to help create high performance rural health systems by spreading innovation and providing specific tools and resources that help translate knowledge into local action. The website’s information, tools, and resources will address these questions (among others):

- As a local provider, how can I learn from, and adapt innovations succeeding elsewhere to my particular circumstances?
- What tools are available to help me educate others (including my board of trustees and potential partnering providers) about changes in payment and other policies that will require us to change how we approach organizing and delivering health care?
- How can I, as a nonprofit or government entity charged to help local communities and providers transition from a world based on volume to a world where value is the basis for payment and policy, facilitate and support winning strategies?”

“Rural Health System Analysis and Technical Assistance is a cooperative agreement between the Office of Rural Health Policy, the RUPRI Center for Rural Health Policy Analysis (RUPRI Center), and Stratis Health. The RHSATA Team will analyze rural implications of changes in the organization, finance, and delivery of health care services and will assist rural communities and providers transition to a high performance rural health system.”

“The RUPRI Center brings experience in a variety of research strategies including survey design, qualitative analysis, simulation development, and large national database query and report design. Stratis Health leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.”

offer for the first time in October. But higher-than-expected premiums suggest better long-term survivability, analysts say.”

“The authors of the Patient Protection and Affordable Care Act hoped the not-for-profit co-op plans would foster greater competition in the health insurance market and offer more consumer-friendly policies. Since then, those plans received nearly \$2 billion in federal loans to cover startup costs and to meet state solvency requirements.”

“In many states, one or two insurers control the bulk of the health insurance business. The promise of lower premiums from co-ops was a central part of the political pitch for authorizing the federal seed money for the Consumer Operated and Oriented Plan program.”

“But the early state rate filings for the exchanges show many of the co-op plans, which aim to operate in 24 states, propose to charge premiums that fall in the middle of the range of premiums proposed by other health plans. For instance, a rate analysis by the Colorado Consumer Health Initiative, a patient advocacy group, found premiums for plans offered by the state’s co-op, called Colorado HealthOP, will generally fall in the mid- to low-middle range of the 150 plans offered on the state exchange.”

“Bill Melville, a market analyst at HealthLeaders Interstudy, a Nashville-based health insurance research firm, said this is similar to the proposed co-op plan rates in other states that have released proposed premiums for plans on the exchanges, including Oregon and Connecticut. ‘They’re not coming in way lower than other exchange plans,’ Melville said.”

“But co-op plan advocates argue that the mere existence of the co-op plans already has lowered the overall premiums that other insurers have proposed on the exchanges. ‘If you look at pricing patterns in markets that have a lot of competition, like Oregon and Wisconsin, the prices tend to be more favorable than they are in markets where there is not competition,’ said Barbara Markham Smith, who previously headed the cooperative program at the CMS.”

“Forty-four proposals for co-op funding were pending at the time Congress cut the remaining start-up fund-

ing this year, from \$3.4 billion to \$2 billion, Smith said. The original allocation was \$6 billion. Republicans urged cutting the money because they opposed co-op plans as political handouts to entities traditionally allied with the Democratic party and saw them having little chance of long-term viability.”

“The ability to offer the lowest-priced option for consumers has been complicated by early startup costs that established commercial insurers do not face, according to leaders of the health cooperatives. For example, co-op plans lack consumer name recognition and must engage in heavy marketing.”

“ ‘The promise of the co-op being low cost is not necessarily a Year 1 proposition,’ said Julia Hutchins, CEO of the Colorado Health Insurance Cooperative, in an interview. Melville said the fact that the co-op plan premiums fell into the mid-range of premiums is a good sign for the long-term viability of these new plans.”

“Overall, the co-op plan rate filings have given analysts confidence in their long-term viability. ‘We’re not seeing them falling behind in any ways that raise any red flags for us,’ said Matthew Valeta, a health policy analyst at the Colorado Consumer Health Initiative, in an interview.”

“Rep. Darrell Issa (R-Calif.), chairman of the House Oversight and Government Reform Committee, issued subpoenas to HHS in June for documents related to approval of the federal funding for many of the cooperatives, and he has requested similar information directly from 13 of the 24 cooperatives. ‘It’s not a very productive environment for cooperatives in Congress,’ Smith said.”

The Small Town Healer

The winner of RWHC’s 22nd Annual \$2,500 Prize for the University of Wisconsin Best Rural Health Paper is Jonathan Fricke, MD Candidate, Class of 2015, Wisconsin Academy of Rural Medicine, University of Wisconsin School of Medicine and Public Health. In

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“The community holds him to high standards. They expect a lot of him, and rightfully so. On top of that, many people know what his car looks like, know where he lives, and know his family. It’s a position of significant responsibility. If it’s not phone calls keeping him up at night, it’s the stress of the work.”

“At the same time, it’s a career that has great rewards. Not necessarily financial rewards, and certainly not a downtown high rise office. The greatest compensation is intangible—the respect, honor, and generosity of the people he serves. It’s a chance for a career guided by values. More than a career, it’s a calling, a chance to do work with a lasting impact.”

“Who is this small town healer? One day, I hope it’s me. But the person I’m writing about is a healer of a different sort. That man is my father, a pastor.”

“It took me until just recently, well into my second year of medical school, to realize my dad’s influence on my career choice. He never sat me down and told me I should become a doctor. But 23 years of seeing him faithfully do his work have been a far more powerful influence than any fifteen-minute talk could ever do. He did more than tell me the *what*, he showed me the *how* and *why*.”

the opinion of the judges, this is a short but powerful essay that goes to the very heart of rural health:

“The phone rings in the middle of the night. ‘You’re wanted at the hospital.’ He quickly wakes up from his sleep and tiptoes out of the door with the rest of the family still sound asleep. Would he rather still be sleeping too? Maybe. But being available in times of need is part of his job, and it outweighs any inconvenience that the call might cause him.”

“It’s a challenging career. He frequently sees people facing the trials of aging. Some do so gracefully, others not without significant difficulty. He sits by the side of a dying patient far more often than most would care to think about. Much of his work comforts broken bodies, but even more so he addresses broken souls. Adult survivors of childhood abuse. Alcoholism. Marriage troubles. Loneliness.”

“This is the value that I see in rural medical education. We aren’t always conscious of the ways that people influence and inspire us. Each day, our goals, values, and motivations are reinforced or challenged by those around us. Rural medicine training gives students the chance to witness the *how* and *why* of rural medicine in a way no guidebook or physician recruiter could ever do. Students want to know ‘will I feel comfortable in a rural community?’ ”

“Though I did not grow up in the family of a small town physician, I did grow up in the family of a small town healer. I had little experience with the medical side of health care, but I did experience the human side. Now is my turn to learn the medical side. This summer and fall, I’ll be learning the science and art of primary care in a town of 2,500. I hope to find physicians thrilled by the chance to do work with a lasting

impact. I hope to meet physicians akin to my father: compassionate, of integrity, and humble. I hope to encounter working not for a paycheck, but for a chance to contribute to the community. If this is what rural medicine is all about, then I'm all in."

A \$2,500 Prize for the Best Rural Health Paper by a University of Wisconsin student is given annually by RWHC's Hermes Monato, Jr. Memorial Fund. Write on a rural health topic for a regular class and submit a copy by June 1st. There are no rigid requirements for the length, format, etc. To date, winning papers have ranged from first person essays to formal "journal ready" articles. Please note that papers already written for a class or other purposes during the previous twelve months are also eligible for this competition. Go to www.RWHC.com for more information.

Leadership Insights: "Hit Pause"

The following is from RWHC's *Leadership Insights* newsletter by Jo Anne Preston, RWHC Organizational Development Manager. Back issues are available at: www.RWHC.com/:

"In weight lifting, it's recommended you do as many reps—with care and control—as you can, until you can do no more. If you can do more than a dozen or so repetitions, your weights are too light and you likely won't see results. If you can only do a couple, they are too heavy and you risk injury. The ideal is in the middle of that. The goal is to somewhat tear down the muscle, give it a rest day in between to restore and grow stronger, then go at it again."

"Research on highly successful athletes reveals a key strategy for success with this very pattern: push yourself as far as you can, then recover. If our work was like that, we would work hard, give it our all, and take breaks throughout...*but we're often not good at the 'take breaks' part.*"

"In terms of longer breaks, the U.S. ranks as one of the lowest nations in the amount of vacation time we have, and most Americans don't even take all of what they have. **But science tells us that just paus-**

ing for moments throughout the day makes us more productive, creative, innovative and alert. So why don't we?

- We feel guilty because no one else is taking breaks (it's a vicious circle).
- It feels like we are wasting time.
- We believe we get more done when we stay longer and continue to push.
- Our self esteem is tied to phrases like 'I'm SO BUSY!'
- We are afraid that others will think we are lazy, goofing off.
- We believe others expect us not to stop.
- We don't trust ourselves...we are afraid if we stop we'll never start again!"

"Energy, more than time, is the currency we have to manage. For optimum results we need both the stress of expending energy and the rest to recover it. When we have too much of either, it's like those weight lifting muscles. Too much expenditure, we get injury (mistakes, rework, spinning, irritability, LESS productive with longer hours). With too much rest we go slack (bored, restless, unmotivated)."



“Take a few minutes—*yes minutes*—to rebalance. Try these ideas:



- Set an alarm to have **hourly 1 minute stretch breaks**. You may think it feels silly and not helpful; research on productivity tells us you would be wrong.
- **Get up out of your chair** hourly if you have a desk job. Go outside for a couple of deep breaths. Nature is restorative and refuels us even if it is not out in the woods.
- **Do an hourly body scan**. Take one minute at the top of the hour to check if you are hunching forward in your chair, slumping, frowning, clenching your jaws or your fists, holding your breath or holding tension in any part of your body. For that minute, just release that tension. Being aware of it and letting it go for a minute is a break. (It's not like a week in the Caribbean, but it does restore energy).
- **Be a friend**. This is related to engagement research. People with a good friend at work are more

likely to be engaged, which also means higher productivity and achieving more results. When I see Lauri and Kim walk by a couple times a day to get coffee together, I smile because I know their friendship and these couple of minutes of talking about something other than work energizes the work that they return to in their cubicles. Research shows that they get more accomplished by taking this short break than if they spent those minutes staying on task at their desks.

- **Keep a glass of ice water close by and drink it**. It replenishes energy and burns calories. Often when we feel tired or hungry, the real need is thirst. *(I know what you are thinking: if I drink ice water I'll have to take a bathroom break, and I don't have time for that...consider how ridiculous that is).*

Contact Jo Anne Preston for individual or group coaching at jpreston@RWHC.com or 608-644-3261. For Info re the RWHC Leadership Series 2013 go to www.RWHC.com and click on “Services” or contact RWHC Education Coordinator Carrie Ballweg at cballweg@RWHC.com or 608-643-2343.”

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