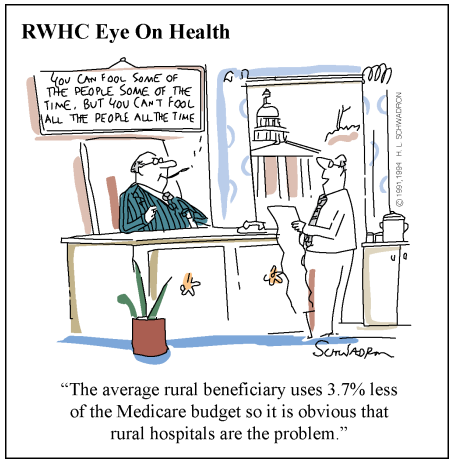
Rural Health in Wisconsin: Taking the Long View



Tim Size
Executive Director
Rural Wisconsin Health Cooperative
Sauk City

WI Rural Health Conference

Wisconsin Dells
June 28th, 2013

RWHC

Rural Health in Wisconsin: Taking the Long View

Overview

I. Rural Health: History of Meeting Challenge

II. Mission: Rural Won't Be Collateral Damage

III. ACO & Market Reform "Opportunities"

RWHC

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I. Rural Health: History of Meeting Challenges

- 1970s: Regional planners propose **consolidation of rural hospitals** ➔ blocked; RWHC born as advocate.
- 1980s: **HMO explosion** with closed networks seen as threat ➔ RWHC starts HMO; Fed anti-trust protection.
- 1980-90s: **Shift to Medicare PPS** payments closes 100s of rural hospitals ➔ birth of CAHs in 1997.
- 1990s to Today: Growth of **MD Maldistribution** ➔ WARM, WCRGME & MCW expansion plans.
- 2000: **IOM Reports poor quality** of USA health care ➔ Triple Aim of better health and care at lower cost.

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Overview of Rural Costs

- "The people served by rural hospitals are **more likely to report a fair to poor health status, suffer from chronic diseases, lack health insurance, and be heavier, older, and poorer** than residents of urban areas."
- Yet overall, **the average cost per Medicare beneficiary is 3.7 percent lower in rural areas** than in urban areas, and rural hospitals perform better than urban hospitals on three out of the four cost and price efficiency measures on Medicare Cost Reports."

"Implications of Proposed Changes to Rural Hospital Payment Designations Policy Brief," by The National Advisory Committee on Rural Health and Human Services, December, 2012

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Over Long Term: Health Care ➔ Community Health

It's no longer about what we charge for a hospital visit but what it costs to keep an insured population healthy.

"We must help all reach highest potential for health and reverse the trend of avoidable illness."*

*American Hospital Association's "Health for Life, Better Health, Better Health Care" August, 2007

RWHC 5

Both Public & Private Markets Driving Reform

- Top providers along with their patients will **improve individual health**.
- Top providers and communities will "go upstream" to **address factors that influence population health**.
- Top communities will **employ metrics that assess more global outcomes** of population health.
- Top **providers** and **communities** will **partner to create healthy communities**.

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Details Differ: Big Picture Unchanged

	Current State	Future State
Cost:	Reduction Viewed as Discrete Projects	Continuous Process Improvement
Quality:	Public Relations/Liability Issue	Drives Reimbursement
Physicians:	Drive Volume	Drive Value
Collaboration:	Limited Amount Required for Financial Success	Clinical and Finance Staff Must Work Together
Financial Risk:	Revolves Around Cost Position	Revolves Around Utilization of Services Across Continuum

Healthcare Financial Management Association

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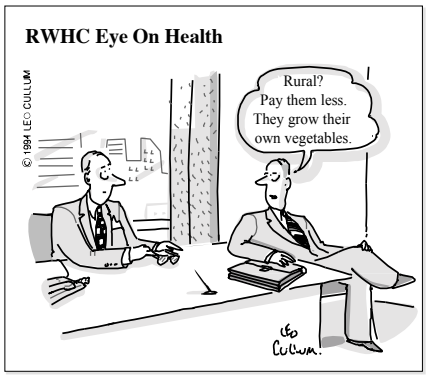
II. Mission: Rural Won't Be Collateral Damage

Actual quote by senior CMS official in 2005

RWHC 8

Ongoing Need for Rural "Myth" Busting

- Rural residents don't want to get care locally.
- Rural folks are naturally healthy, need less.
- Rural health care costs less than urban care.
- AND Rural health care is inordinately expensive.
- Rural quality is lower; urban is better.
- Rural hospitals are just band-aide stations.
- Rural hospitals are poorly managed and/or governed.

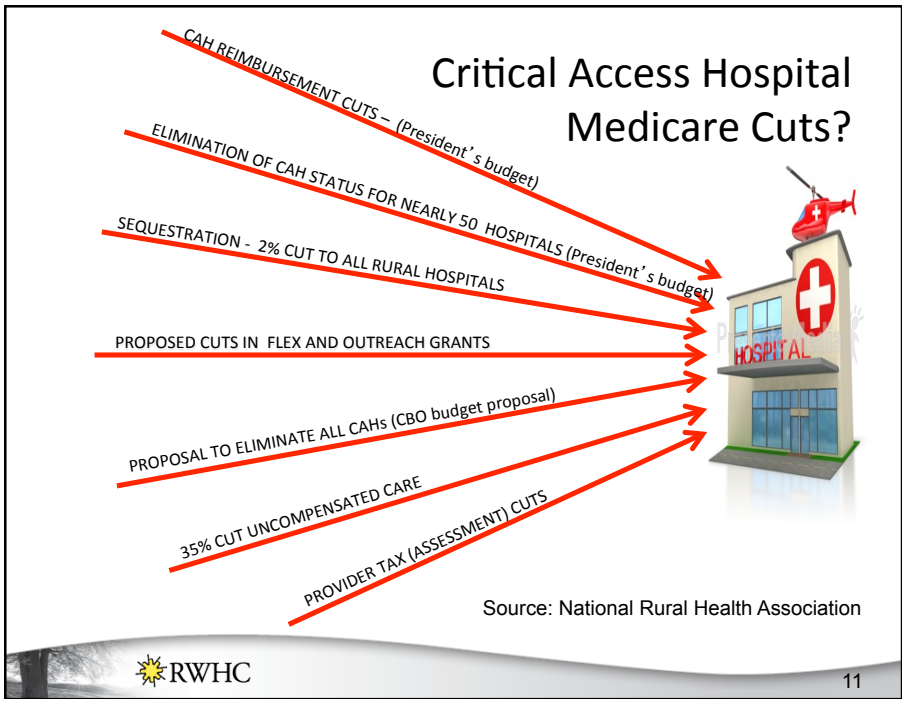


RWHC 9

Ongoing Support of Core Rural Health Agenda

- Federal **healthcare reform** that recognizes rural realities.
- Fair **Medicare and Medicaid** payments to rural providers.
- **Federal and State regulations** that recognize rural realities.
- **Retain property tax exemption** for nonprofit hospitals.
- Solve growing **shortage of rural physicians and providers**.
- Bring rural voice to **regional provider networks & payers**.
- Bring a rural voice into the **quality improvement** movement.
- Continue push for workplace and community **wellness**.
- Strong link between **economic development** and rural health.

RWHC 10


Critical Access Hospital Medicare Cuts?
CAH REIMBURSEMENT CUTS – (President's budget)
ELIMINATION OF CAH STATUS FOR NEARLY 50 HOSPITALS (President's budget)
SEQUESTRATION - 2% CUT TO ALL RURAL HOSPITALS
PROPOSED CUTS IN FLEX AND OUTREACH GRANTS
PROPOSAL TO ELIMINATE ALL CAHs (CBO budget proposal)
35% CUT UNCOMPENSATED CARE
PROVIDER TAX (ASSESSMENT) CUTS
HOSPITAL
Source: National Rural Health Association
RWHC
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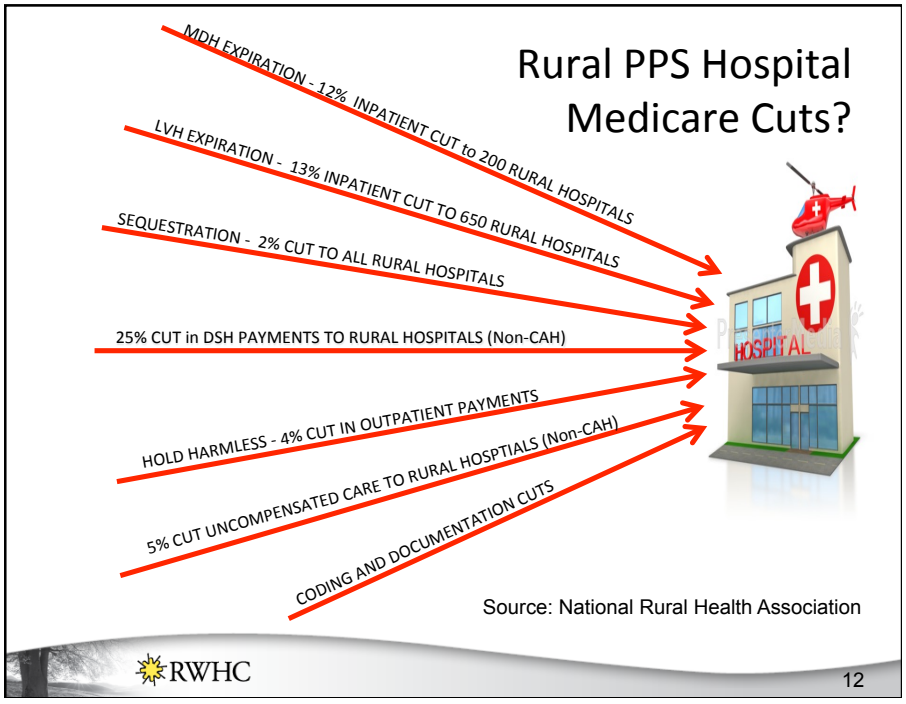
Rural PPS Hospital Medicare Cuts?
MDH EXPIRATION - 12% INPATIENT CUT to 200 RURAL HOSPITALS
LVH EXPIRATION - 13% INPATIENT CUT TO 650 RURAL HOSPITALS
SEQUESTRATION - 2% CUT TO ALL RURAL HOSPITALS
25% CUT in DSH PAYMENTS TO RURAL HOSPITALS (Non-CAH)
HOLD HARMLESS - 4% CUT IN OUTPATIENT PAYMENTS
5% CUT UNCOMPENSATED CARE TO RURAL HOSPTIALS (Non-CAH)
CODING AND DOCUMENTATION CUTS
HOSPITAL
Source: National Rural Health Association
RWHC
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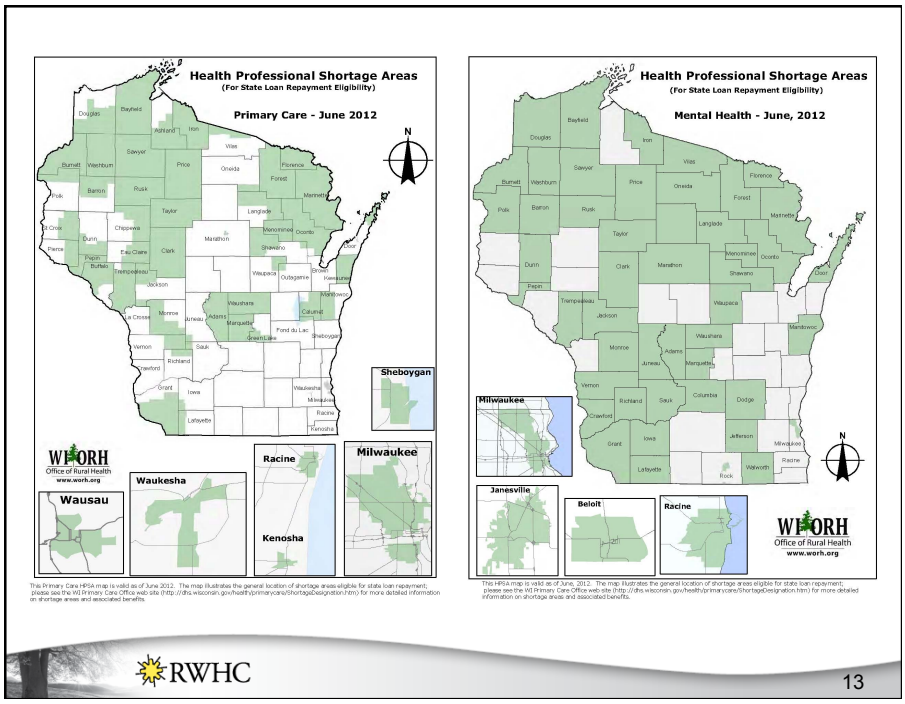

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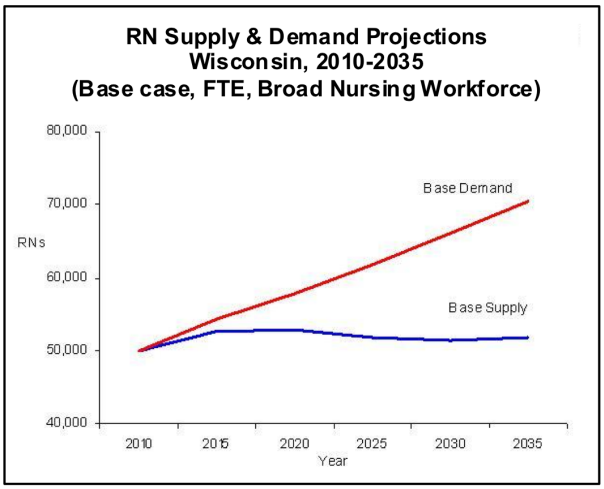
Healthcare Coverage ≠ Access



WI Department of Workforce Development, Nov, 2011

RWHC

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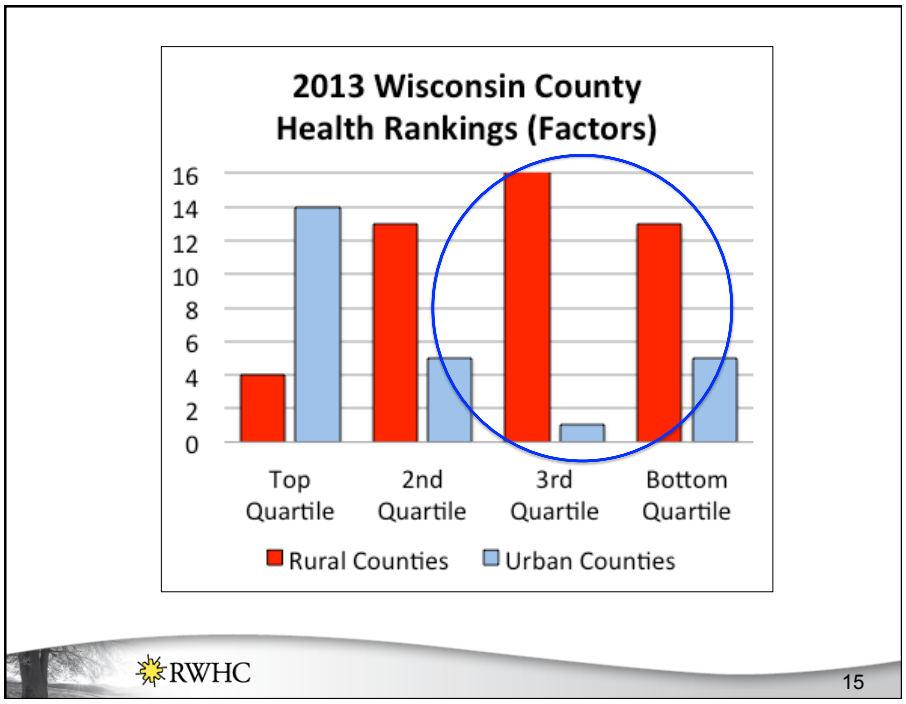
2013 Wisconsin County Health Rankings (Factors)
16
14
12
10
8
6
4
2
0
Top Quartile
2nd Quartile
3rd Quartile
Bottom Quartile
Rural Counties
Urban Counties
RWHC
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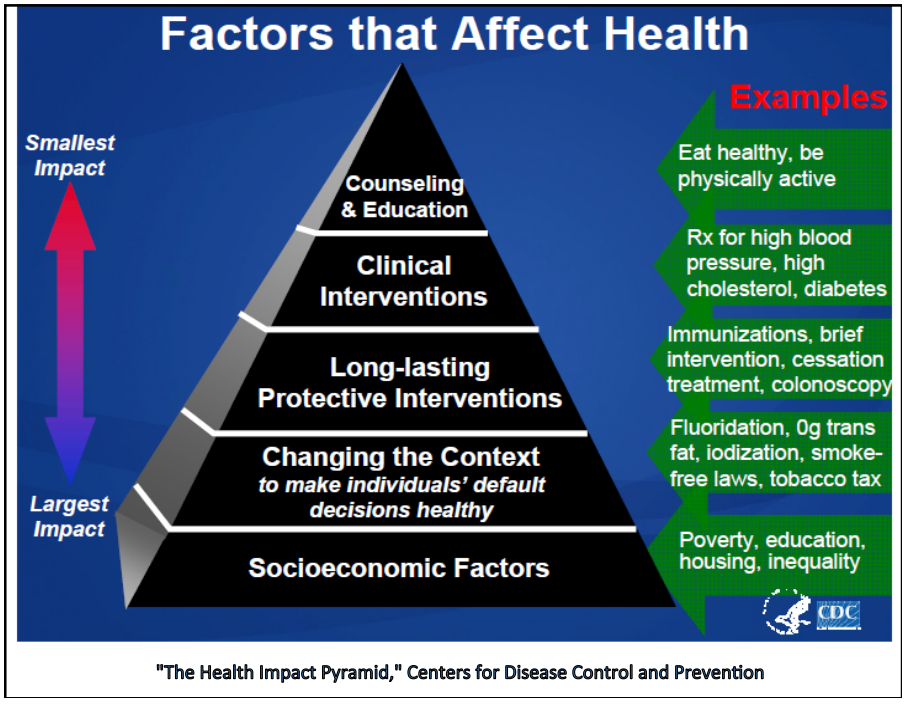
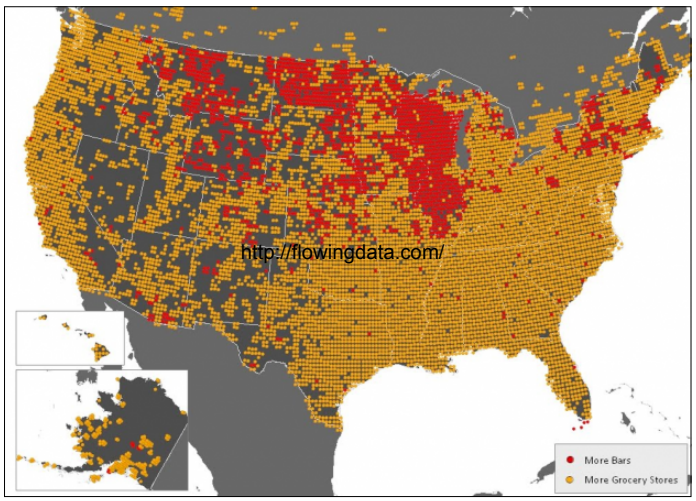

Factors that Affect Health
Smallest Impact
Largest Impact
Counseling & Education
Clinical Interventions
Long-lasting Protective Interventions
Changing the Context to make individuals' default decisions healthy
Socioeconomic Factors
Examples
Eat healthy, be physically active
Rx for high blood pressure, high cholesterol, diabetes
Immunizations, brief intervention, cessation treatment, colonoscopy
Fluoridation, 0g trans fat, iodization, smoke-free laws, tobacco tax
Poverty, education, housing, inequality
CDC
"The Health Impact Pyramid," Centers for Disease Control and Prevention

Where Bars Trump Grocery Stores

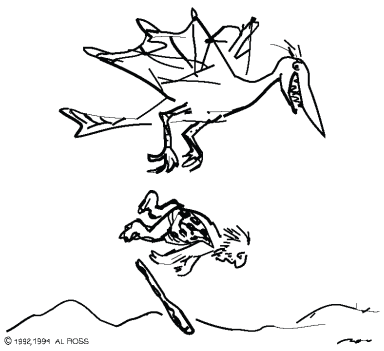


http://flowingdata.com/

RWHC 17

III. ACO & Market Reform "Opportunities"

RWHC Eye On Health



"When the obvious becomes obvious, the time to adjust is limited."

Rural health is driven by political and market forces incenting the Triple Aim (to lower costs, to improve individual health care and population health).

RWHC 18

Obamacare's 5 Big Challenges Impact Rural

1. Extending the scope of Medicaid expansion. Was to cover 17 million people. When the Supreme Court ruled states could opt out, many took up the option.

2. Building the health-insurance marketplaces. The health-insurance exchanges are Obamacare's backbone. These are the online marketplaces–something like an Expedia for health coverage–where Americans can shop for private insurance or Medicaid coverage.

3. Getting the word out about the the health law's new program(s). Polls of low- to middle-income Americans whether they were aware of the new law's provisions. Seventy-eight percent were not.

Washington Post, 3/23/13

RWHC 19

Obamacare's 5 Big Challenges Impact Rural

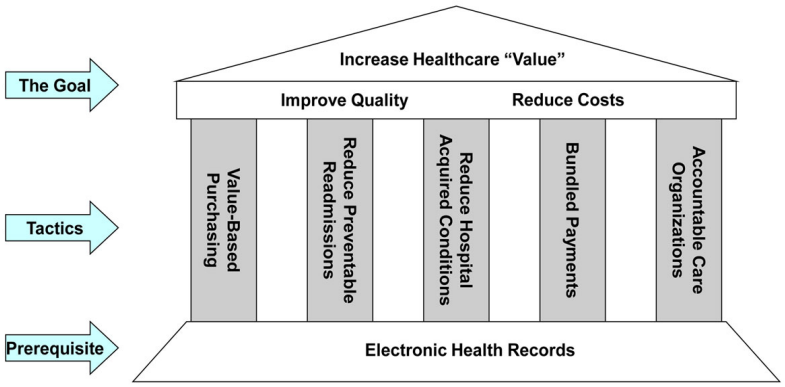
4. Swaying public opinion on Obamacare. Ever since the ACA became law in 2010, public opinion has remained stubbornly split. The same number (40 percent) oppose it now as did three years ago. Favorable ratings, meanwhile, have fallen by 9 percent.

5. Controlling health-care costs. It's one thing to hand out health-insurance cards; that's relatively easy. It's quite another to ensure that an insurance card guarantees access to affordable health care.

Washington Post, 3/23/13

RWHC 20

Financial Incentives for CAHs? Not If but When and How



Healthcare Financial Management Association

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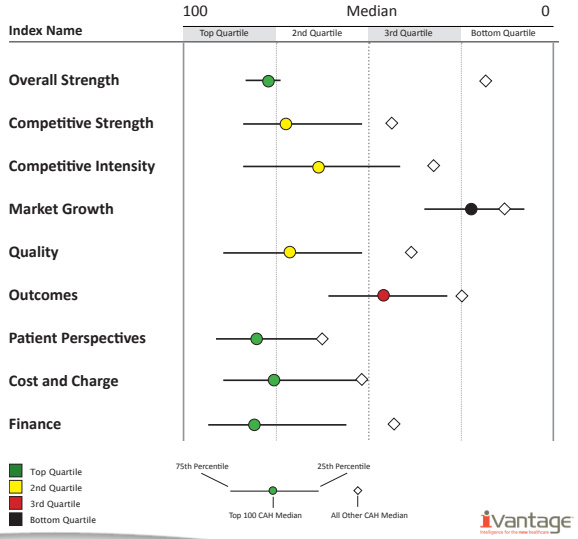
Top 100 CAHs Give Hope What Rural Can Do



RWHC

Reform: Paying for Value

- Service will be accessed based on patient experience, care quality, and delivery efficiency.
- **Health care value, not simply service volume, will drive payment**.
- Rural health care systems will be organized around a robust primary care base.
- **The focus will be on care in the community, supported by the hospital–anchored in primary care.**

"The High Performance Rural Health Care System of the Future," RUPRI Health Panel, 9/2/11

RWHC 23

Reform: Collaborating to Integrate Services

- Collaborative providers will **deliver the continuum of care seamlessly** to patients.
- Rural providers will **collaborate locally** for improved health outcomes and better financial performance.
- Rural providers will **collaborate vertically** to ensure timely access to services not available locally.
- **Urban** systems will **collaborate** with **rural** health systems to meet **performance and financial goals**.

"The High Performance Rural Health Care System of the Future," RUPRI Health Panel, 9/2/11

RWHC 24

Reform: Information Used to Manage Care

- **Patients engaged in their own care plans** (patient responsibility promoted by the system) and patient needs met (better care).
- **Seamless transfer** of clinical and administrative **information among providers**.
- Health information readily available in rural places and understandable to individual patients.
- **Transparency of health care cost and quality information**, access to proactive disease management and prevention assistance.

"The High Performance Rural Health Care System of the Future," RUPRI Health Panel, 9/2/11

RWHC 25

Reform: Healthy People / Healthy Communities

- Providers and patients will connect to community health **resources to improve individual health**.
- Providers and the community will "**go upstream**" to **address factors that influence population health**.
- In concert with clinical quality and efficiency metrics, rural **communities will employ metrics that assess these more global outcomes**.
- Rural **providers and their communities will partner** in creating healthier communities.

"The High Performance Rural Health Care System of the Future," RUPRI Health Panel, 9/2/11

RWHC 26

Rural Impact as Insurers Respond to Exchanges

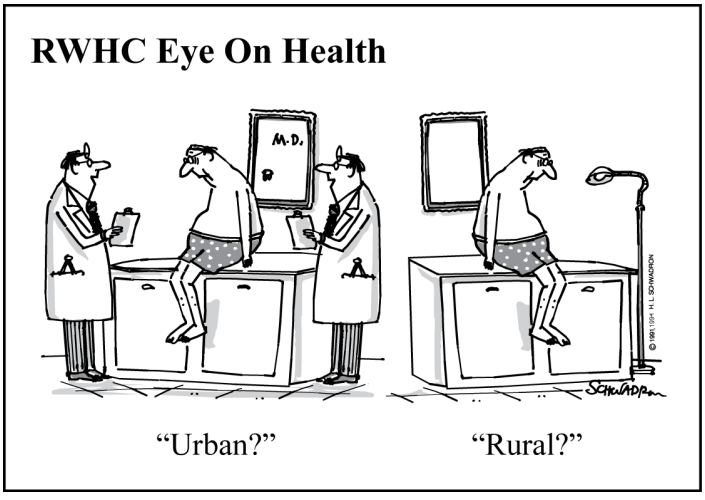
Insurer financial success in exchanges depends on:

- Create products that attract healthy people (***rural disadvantage as healthier people may be incented to migrate to plans in urban/suburban markets?***)
- Adequate risk adjustment to fairly compensate health plans with higher risk patients (***will Feds adequately protect rural markets with older, sicker patients; indirect continuation shift of funds to FLA, CA & NY?***)
- Manage chronic conditions better than other health care organizations (***do rural have the resources to do as aggressively as will be needed?***)

Unity Health Insurance
Affiliated with UW Health

RWHC 27

Reminder #1: Healthcare Coverage ≠ Access



RWHC 28

Reminder #2: Rural Healthcare = Rural Jobs

- **Local rural health = local health care jobs**.
- Rural health has the **same economic impact as export commodities** like milk, soy beans or rural based manufactured goods.
- Rural insurance **premiums and taxes only return** to create jobs **if there are local health care providers** there (and people use them)
- **The rural economy and health of rural communities is extremely dependent on WHERE health care dollars are spent.**

RWHC 29

Rural Health Resources

- **RWHC Web**: **http://www.rwhc.com/**
- **Wisconsin Office of Rural Health**: **http://worh.org/**
- For the free **RWHC Eye on Health e-newsletter**, email **office@rwhc.com** with "subscribe" on subject line.
- **Rural Assistance Center** at **www.raconline.org/** is an incredible federally supported information resource.
- The **Health Workforce Information Center** is RAC's "sister" for health workforce programs, funding, data, research & policy **www.healthworkforceinfo.org/**

RWHC 30