

Review & Commentary on Health Policy Issues for a Rural Perspective – November 1st, 2006

Rural Must Face Risk of Privatizing Medicare

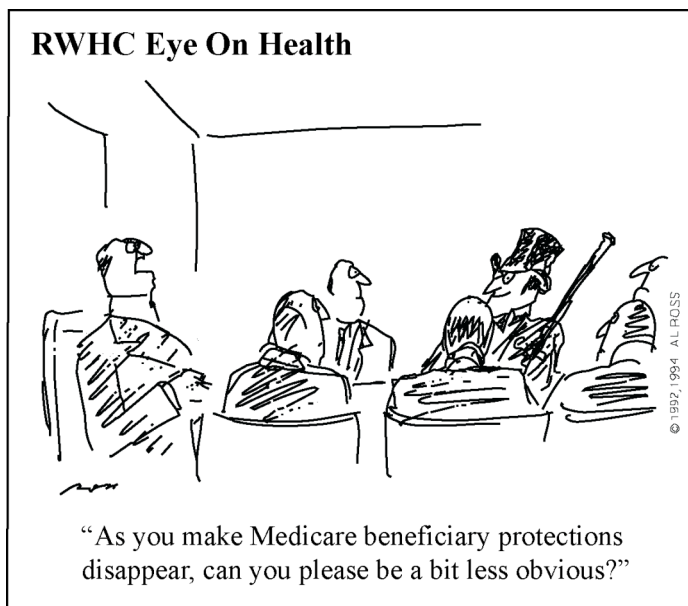
The following article is a summary from notes taken by Tim Size, RWHC Executive Director, of public sessions of the National Advisory Committee on Rural Health and Social Services subcommittee on Medicare Advantage. The Committee is advisory to Department of Health and Human Services Secretary Michael Leavitt. At its winter meeting, the report and recommendations to the Secretary will be finalized.

The enactment of the Medicare Prescription Drug Improvement and Modernization Act of 2003 fundamentally changes Medicare in ways not yet understood by either the public or providers. The lion's share of attention to date has understandably gone to implementation of the new prescription drug benefit. But over the long haul, it is Medicare Advantage's shifting of beneficiaries to private insurance health plans, the "privatization" of Medicare, that will transform rural health in America, for better or for worse.

It is the intent of Congress and the Administration that Medicare Advantage fulfill two major goals of the federal government: 1) to substantially increase the number of Medicare beneficiaries enrolled in pri-

vate health insurance and; 2) to utilize competition among these private health plans and between these plans and the traditional fee-for-service Medicare program to reduce federal spending.

While Medicare has experimented with the use of private managed care plans in the past, the scope of the planned shift of Medicare enrollment out of traditional Medicare engineered by advocates of Medicare Advantage dwarfs previous expectations and is explicitly intended to include rural America.



If rural advocates, inside and out of the Congress do not assure that Medicare Advantage is implemented in a manner that is sensitive to the unique needs of rural communities, the negative impact on the health care delivery system in rural communities could take a generation to rebuild. While the subcommittee was concerned about Medicare Advantage overall, the focus of their discussion was on the new multi-state Regional Pre-

ferred Provider Organizations and the rapidly expanding Private Fee-for-Service (PFFS) plans as these plans are the ones most expected to be offered to rural communities.

Why Should You Care? Neither rural beneficiaries or beneficiaries are in any way prepared for this radically new kind of Medicare. Testimony received by

"A team is a small number of people with complementary skills who are committed to a common purpose, set of performance goals, and approach for which they hold themselves mutually accountable." Jon Katzenbach and Douglas Smith in "The Discipline of Teams," *Harvard Business Review*. March-April 1993.

RWHC *Eye On Health*, 10/10/06

the subcommittee described a program that was designed to be implemented more slowly than the Part D prescription drug plan but that is every bit as confusing to the public, if not more so.

The spread of Medicare Advantage fundamentally changes how beneficiaries, providers, private health insurance plans and the Centers for Medicare and Medicaid Services (CMS), the government agency that

manages the Medicare program, will relate to and work with each other. As these relationships change, there is a real and significant risk to beneficiaries' access to care and to the ability of rural hospitals and doctors to provide local services. Medicare and our health care system must continue to improve, but the fragility of our seniors and rural health care demand something more than the haphazard approach observed to date.

RWHC Licensing *Rural Health Careers* Web Site

Based on requests from rural providers, state hospital associations and rural health networks from around the country, the Rural Wisconsin Health Cooperative (RWHC) is offering to license its *Rural Health Careers* web site to other rural focused organizations.

Rural Health Careers is an interactive, web-based recruitment and retention tool that was created by rural providers, for rural providers (hospitals, clinics, nursing homes). Currently, over 60 facilities are using the site in Wisconsin and seeing very positive results.

Based on that success, RWHC is making the *Rural Health Careers* available to rural health organizations in other states at an affordable price. This is an exclusive arrangement: only one license will be issued per state. RWHC experience shows that a state-based web site in combination with other recruitment sites and tools maximizes the number of successful placements.

To see how the *Rural Health Careers* website is used in Wisconsin go to <http://www.rhcw.org>. To learn more about how Rural Health Careers can have a dramatic impact on rural healthcare recruitment/retention in your state, or to arrange an online demo, please contact Dawn Johnson at RWHC: 608-643-2343 or djohnson@rwhc.com.

Apart from concerns within the MA program, the subcommittee expressed concern that the MA plans will expand by attracting healthier, lower-cost beneficiaries from traditional Medicare. This would have a negative effect on the traditional Medicare program, leaving it with a disproportionate number of sicker and older patients. Traditional Medicare would be left burdened with higher costs, increasing the pressure to reduce

benefits and provider payments under the traditional Medicare program.

The technical specifics of the MA bidding process create inequities in the availability of plans with reduced cost sharing or additional benefits in rural areas. The benchmarks used in the bidding process are based on historical Medicare fee-for-service payments at the county level, incorporating historical geographical variation in Medicare expenditures. In general, urban areas with high physician-to-patient ratios have higher rates of utilization and consequently higher benchmark rates.

Rural areas with low physician-to-patient ratios have lower utilization and therefore lower benchmark rates. Under this system, plans with aggressive care management and provider contracting that enter areas with high utilization and high benchmark rates can bid well below the benchmark and generate savings for beneficiaries. Because many rural areas have low utilization and low benchmarks, there are not the same opportunities for cost saving through utilization management and lower provider payments. The result is that beneficiaries in rural areas are less likely than those in urban areas to have access to MA plans with low premiums, reduced cost sharing or additional benefits.

The **Rural Wisconsin Health Cooperative** (RWHC) was begun in 1979 as a catalyst for regional collaboration, an aggressive and creative force on behalf of rural health and communities. RWHC promotes the preservation and furthers the development of a coordinated system of 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.

Eye On Health Editor:

Tim Size, RWHC

880 Independence Lane, PO Box 490

Sauk City, WI 53583

office@rwhc.com

<http://www.rwhc.com>

For a free electronic subscription, send us an email with "subscribe" on the subject line.

Opportunities for additional savings and benefits should not be based on a system that only rewards areas with excess utilization and does not provide incentives to maintain reasonable utilization in those places where the amount of care provided is already at a minimum.

What is Known about Medicare Advantage?—We don't yet nearly know enough. Regional Preferred Provider Organizations (RPPOs) are MA private health insurance plans that must provide uniform benefit packages and premiums for all of a state or all of a combination of states—rural and urban areas alike. They differ from other MA health plans in this respect since all other types of MA plans are able to determine their own service area. As an incentive for the growth of RPPOs, Congress created a “stabilization fund” of \$10 billion dollars that CMS can draw from to make “extra” payments to the RPPOs. With the creation of RPPOs, Congress definitely intended to encourage private plans’ growth in rural areas.

Private Fee-for-Service (PFFS), unlike other MA plans, are similar to traditional Medicare in that they do not include a care management component. Presently, PFFS plans are in 96 percent of rural counties, and are the most prevalent type of private Medicare plan in rural areas. There are two models of PFFS plans. One PFFS model allows PFFS plans to operate without a contracted network of providers, but the plans must pay all providers at rates that are “comparable to traditional Medicare rates.” The other model allows PFFS plans to pay providers at rates lower than traditional Medicare, but requires plans to create formal provider networks that meet community access standards.

Under both models, providers can be “deemed” to be members of the PFFS plan network, meaning they have agreed to accept the plan’s terms and conditions, including the rate of payment. Three conditions must be met for a provider to be deemed a member of the PFFS plan network: the provider must know that the patient is a member of a PFFS plan, the provider must be aware of a PFFS plan’s terms and conditions, and the provider must perform a covered service for the patient. As a deemed member of the PFFS plan network, a provider must accept as payment in full whatever rate that particular PFFS plan pays their

other contracted providers. For PFFS plans with formal networks of contracted providers (providers that sign contracts with the plan as opposed to being deemed), this may mean that the providers must accept payments below the traditional Medicare rates. As PFFS plans gain market share, it is reasonable to assume that PFFS plans will use the option of formal provider networks and will be aggressive in negotiating rates below the cost of care in rural communities.

Rural Specific Enrollment Withheld by CMS. The work of the subcommittee was significantly impaired due to CMS’ half year delay in releasing county specific enrollment figures for MA plans (other than those with prescription drug benefits). Now that the data has begun to be released, it is in a format that makes it nearly impossible to describe the impact of Medicare Advantage in our rural communities. This lack of transparency does not bode well for the future of the MA program.

The Enforcement of Community Access Standards Is Absolutely Critical—the MA program statutes and regulations require that CMS ensures that plan enrollees have reasonable access to covered services. How CMS and MA plans interpret what is “reasonable” is critically important to rural beneficiaries and providers as well as to the acceptance of MA plans in rural communities. As stated in the CMS Medicare Managed Care Manual: “Plans must...ensure that services are geographically accessible and consistent with local community patterns of care.” The subcommittee has not been able determine how or whether CMS is enforcing this provision with PFFS and RPPO plans.

If beneficiaries enrolled in a MA plan are not well informed about their rights to access care locally, they are less likely to exercise that right. This knowledge is particularly important for enrollees in RPPO plans, since they may have the option of obtaining services from non-network providers at in-network rates if their plan’s provider network is inadequate in their area. If CMS does not diligently monitor and enforce plan compliance, plans will have significantly less incentive to contract with a region’s rural providers, undermining the rural health infrastructure in the effected communities. If health plans are allowed weak networks of providers in rural areas, plans could end up steering rural beneficiaries away

from their established health care providers and thus force some beneficiaries to leave their community for care previously available locally.



Beneficiary Confusion—the subcommittee heard multiple testimonies describing confusion among beneficiaries. While many options allow choice, too much variation about private health plan details can be very difficult for the elderly, about what is covered and where it is covered. The confusion extends to the type of private plans (HMOs, local PPOs, regional PPOs and PFFS) and the relative merits of the type of plans in comparison to each other. The subcommittee is concerned regarding potential abuse of the system. Recently, the HHS Office of the Inspector General announced that the Office is evaluating whether certain health insurers are coercing the beneficiaries to enroll in an MA plan that would include prescription drug benefit (MA-PD) versus a stand-alone drug benefit program.

Effects of Medicare Advantage on the Existing Safety Net—the subcommittee is concerned about the potential effect of MA plans contracting on the existing rural add-on payments for safety net providers. All MA plans, except non-network model PFFS plans, are permitted but not required to negotiate payment rates with providers at levels below that of traditional Medicare. This is a process that seems to favor the MA plans, particularly in rural areas where providers may have little managed care contracting experience or in rural communities within driving distance of urban-based providers.

Under the traditional Medicare program, many rural providers receive special payment rates to reflect the various financial challenges of providing health care in rural areas. These payments were factored into CMS' benchmarking process. The subcommittee is concerned whether the MA plans will recognize these rural add-ons that have been in place in traditional Medicare in their payments to rural providers.

Conclusion—the subcommittee understands that the issues being raised in this report and the overarching topic of MA in rural areas are still unfolding. MA's full effect on rural communities is yet to be determined, however, the MA changes will likely result in a

significant transformation of the rural health landscape. It is imperative that (1) attention be paid to ensuring rural beneficiaries have adequate access to care, (2) payment rates are high enough to sustain a viable rural health system, and that (3) the relationship among beneficiaries, providers, plans and CMS be well integrated.

A Credible Roadmap for “System” Reform

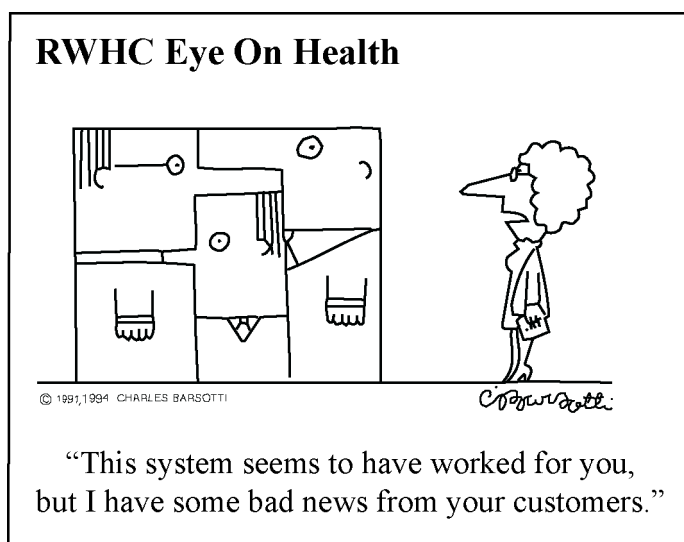
The following is from the executive summary of “Why Not the Best?” by the Commonwealth Fund Commission on a High Performance Health System. Given the prominence of the Commission members, the findings of their “Scorecard” are likely to inform many of the “system reform” discussions expected to accelerate after the election. An executive summary as well as the complete report (rich in data) can be found at: <<http://www.cmwf.org>>.

“The central messages from the Scorecard are clear:

- Universal coverage and participation are essential to improve quality and efficiency, as well as access to needed care.
- Quality and efficiency can be improved together; we must look for improvements that yield both results. Preventive and primary care quality deficiencies undermine outcomes for patients and contribute to inefficiencies that raise the cost of care.
- Failures to coordinate care for patients over the course of treatment put patients at risk and raise the cost of care. Policies that facilitate and promote linking providers and information about care will be essential for productivity, safety, and quality gains.
- Financial incentives posed by the fee-for service system of payment as currently designed undermine efforts to improve preventive and primary care, manage chronic conditions, and coordinate care. We need payment incentives to reward more effective and efficient care.

- Research and investment in data systems are important keys to progress. Investment in, and implementation of, electronic medical records and modern health information technology in physician offices and hospitals is low—leaving physicians and other providers without useful tools to ensure reliable high quality care.
- Savings can be generated from more efficient use of expensive resources including more effective care in the community to control chronic disease and assure patients’ timely access to primary care. The challenge is finding ways to re-channel these savings into investments in improved coverage and system capacity to improve performance in the future.
- Setting national goals for improvement based on best achieved rates is likely to be an effective method to motivate change and move the overall distribution to higher levels.”

“Our health system needs to focus on improving health outcomes for people over the course of their lives, as they move from place to place and from one site of care to another. This requires a degree of organization and coordination that we currently lack. Whether through more integrated health care delivery organizations, more accountable physician groups, or more integrated health information systems (in truth, likely all of these), we need to link patients, care teams, and information together. At the same time, we need to deliver safer and more reliable care.”



“Furthermore, the extremely high costs of treating patients with multiple chronic diseases, as detailed in this report, serve as a reminder that a minority of very sick patients in the U.S. account for a high proportion of national health care expenditures. Payment policies that support integrated, team-based approaches to managing patients with multiple, complex conditions—along with efforts to engage patients in care self-management—will be of paramount importance as the population continues to age.”

Awesome Online Resource on Rural Issues

The following is from The Rural Assistance Center (RAC) at <<http://www.raonline.org/>>.

Free Resource for Information on Rural Issues—“Do you live or work in a small community? Ever look for research or statistics on a rural topic? Could you use some leads on funding opportunities to support rural health and human services? The Rural Assistance Center (RAC) is a free resource that can help. RAC is a federally-funded information resource with a range of products and services addressing rural health and human services issues. Here are a few resources available to you and your customers.”

Seeking Funding Opportunities?—“The RAC website <<http://www.raonline.org/>> has a searchable database of funding opportunities. Anyone who has a project in mind to benefit a rural community can request an in-depth search for funding specific to their project and location.”

Guides on Rural Topics—“The RAC website has information guides on over 70 topics such as dental health, domestic violence, tribal health, and grant-writing. Guides include frequently asked questions on the topic, links to publications and online tools, organizations and contacts for more information.”

Online Clearinghouse—“The RAC website includes news on rural issues taken daily from the Federal Register, U.S. Department of Health and Human Services press releases, and other sources. The website also provides a calendar of events, a directory of

experts and organizations interested in rural topics, access to key rural publications and maps, and a compilation of success stories that can serve as model projects for rural communities.”

Research and Statistics—“Librarians staff the RAC toll-free phone (1-800-270-1898) and email reference service <info@raconline.org> and offer free search services to support rural health and human services. RAC can do literature searches, funding searches, help find statistics, and connect users to experts within the federal government and research communities.”

State Resources—“Each State Resource page features an overview of the state and its rural health and human services environment. The pages are designed to help rural communities find information and resources that can assist them in important activities such as locating and competing for funding opportunities and networking within their state. The pages also feature tools, such as websites with demographic and statistical information; documents and resources; state-level contacts and organizations and groups involved in rural health; funding programs available in your state; news and upcoming events of interest to rural health; and examples of successful projects in your state that can serve as model projects in rural communities.”

How to Take Advantage of RAC Services?—“In addition to the above resources, sign up on the RAC website for twice-monthly email notices of rural news, funding opportunities, events and publications. Please help spread the word about RAC in your organization and your community.”

Work Site Wellness Key to a Healthy State

The following is from Wisconsin’s Department of Health and Family Services Nutrition and Physical Activity Program with funding by the Centers for Disease Control and Prevention:

“More than 61% of Wisconsin adults are overweight or obese. The annual obesity-related medical cost is estimated to be 1.5 billion dollars. Overweight and

obesity also increases the risk of many chronic diseases such as diabetes, heart disease, some cancers, arthritis and others. This epidemic is placing a huge burden on our healthcare system and economy.”

“Worksites are an important venue to address nutrition and physical activity issues. The *Wisconsin Worksite Wellness Resource Kit* was developed to assist businesses in starting, adding to or maintaining a wellness program for their staff. Unlike other resource kits, the focus is on reducing the risk factors to chronic disease: poor nutrition, inactivity and tobacco use. Worksites will have a step-by-step guide to use in assessing their worksite, identifying what types of activities to implement, links to information on how to implement and ways to determine effectiveness.”

“We know it will take the active involvement of many public and private partners to change systems, community and individual behaviors. Worksites are one key environment for that change to take place.”

“Worksite wellness programs that support employees and the environment that they work in have been shown to be a good return on investment. Program returns range from 2 to 10 times the cost of the program when important factors such as health care costs and productivity are evaluated. Worksite wellness programs can be extensive and sometimes expensive. However, there are ways for even small employers to make positive changes at little or no cost.”

RWHC Eye On Health



“This wellness stuff probably comes from the same people who never had fun in high school; I’ll start wellness after the first heart attack.”

Where to Start—Download the “Worksite Wellness Resource Kit” from:

<http://dhfs.wisconsin.gov/health/physicalactivity/>

1. “Make sure management believes in and is supportive of the wellness program.
2. Assess the worksite for both facilities and worker interest to help determine what programs to offer.
3. Support an employee wellness committee.
4. Make the connection with community activities.

Examples include:

- Join or form a local coalition to address nutrition and physical activity in a coordinated manner.
- Integrate business activities with community, school and healthcare initiatives. Partner with community organizations to support or develop programs or tie into existing campaigns.
- Integrate the family into worksite wellness initiatives by connecting worksite activities to the whole family or allowing family access to worksite facilities.”

General Strategies should include programming that is multi-faceted and includes both nutrition and physical activity components.

1. “Provide opportunities for individual, group, and at-home support for behavior change.
2. Provide employees with tools for self-assessment of eating and physical activity habits.
3. Send supportive reminders to employees via multiple means (i.e. email, posters, payroll stuffers).
4. Provide employee incentives for participation in nutrition, physical activity, and/or weight management/maintenance activities.”

Suggested Intervention/Program Strategies

“Experts agree that the causes of overweight are multidimensional. Download ‘What Works in Worksites’ at the above website for an outline of strategies representing the existing evidence for change at the individual, environmental, and policy levels based on six focus areas that CDC has outlined for overweight and obesity prevention. Stronger interventions have both nutrition and physical activity strategies.”

RWHC Offers Patient Satisfaction Surveys

The Rural Wisconsin Health Cooperative is an approved vendor for the CAHPS Hospital Survey Program. RWHC will be using the mail methodology approved by CMS. This consists of two mailings

within a prescribed time frame to each patient discharged from your hospital who meets the established criteria. Patients under eighteen years of age and psychiatric patients are excluded.

As with all of the RWHC programs, RWHC is focused on working with small hospitals. RWHC is sensitive to the limited resources of the small hospitals and thus try to keep your workload to a minimum. The only responsibility your hospital has related to the CAHPS process is to provide your patient information to us on a regular basis. This is done via a secure website; you do not need any type of computer interface to accomplish this. If your computer system cannot support a file upload to the website, a data entry tool is available on this secure website as an alternative. This same web-based tool also alerts you to any missing data and allows you to enter that data. RWHC will then process your patient level data, mail the surveys, track responses, mail follow-up surveys to non-responders, track the required time-frames, and upload the data to CMS per your direction.

RWHC will provide you with your survey response rate and generate trending reports and benchmarking reports on a quarterly basis. These reports will give

National Rural Health Association
30th Annual Conference: May 16-18, 2007
ANCHORAGE, ALASKA
Information at <http://nrharural.org/>

you an opportunity to review your data before it is available from CMS and allow you to use it for quality improvement plans as appropriate. RWHC will also host regular teleconferences to provide an avenue for sharing/networking among participants.

CMS requires hospitals planning to submit their data to CMS to participate in a dry run of the program. The dry run is available during certain months per CMS. Data collected during the dry run will not be publicly reported.

Critical Access Hospitals, as well as other small hospitals, with a minimum of 100 completed surveys within a 12 month period will be publicly reported. For the purposes of achieving statistical significance, all small hospitals are expected to survey all eligible discharges in an effort to increase the number of completed surveys. It is important to note that the first public reporting period will be only 9 months in length, so surveying all eligible discharges will be important.

RWHC has developed a straightforward and financially efficient program for small, rural hospitals. To

learn more, please contact Mary Jon Hauge at 800-225-2531 or email at <[mjhaug@rwhc.com](mailto:mjhauge@rwhc.com)>.

10 Tips for Establishing Quality Improvement Programs

by Carrie Vaughan for *HealthLeaders News*, 9/27/06

“Private and public funding sources, as well as employers and consumers, increasingly expect their healthcare providers to participate in quality improvement programs and to report the results back to them. Hospitals regardless of size can’t improve what they aren’t measuring, experts say. ‘You really need to understand where your facility does things well and what areas need improvement,’ says Ira Moscovice, Ph.D., director of the University of Minnesota Rural Health Research Center. Here are 10 tips to help small rural hospitals get quality improvement poised for success.”

Make it an organizational priority

Create a non-punitive culture

Promote teamwork

Start with national measures

Individualize the measures

Utilize the right data

Collect and report information

Invest in information systems

Establish networks

Ask the experts

Space Intentionally Left Blank For Mailing