



## Medicare Agency Acting Out Against Rural?

An analysis from Tim Size, executive director of the Rural Wisconsin Health Cooperative:

The Centers for Medicare & Medicaid Services (CMS) is the US federal agency that administers Medicare, Medicaid, and the State Children's Health Insurance Program. Over the last few months, CMS has taken one action after another that have been widely seen as hostile to rural health and communities.

These actions may be intentional or the result of agency staff unfamiliar with rural health. What is known, is that real harm will be done if these policies are not reversed. Below is a summary of five major problems along with the source of the information. There is no single remedy nor yet a consensus on the fix for each issue.

Given the diverse nature of the issues and constituencies affected, different groups have begun to focus on different parts; this analysis is an attempt to show the larger picture and bring the larger rural health community together to draw a line in the sand against this pattern of anti-rural policies.

**#1: CMS Bans Building/Remodeling by "Necessary Provider" Critical Access Hospitals (CAHs)—**  
"They can not relocate one bed without CMS Regional Office permission; permission that will be denied if even one of the criteria used for the CAH's original designation, can no longer be met.

"CAH is expected to continue to provide services based on the criteria that the State used when initially determining that the CAH was a necessary provider. For example, if the determination was based on the CAH being located in a health professional shortage area (HPSA), then the relocated CAH must continue to be located in a HPSA." **Source:** CMS S&C Letter #07-35 of 09/07/07.

Q: "If an applicant originally indicated that they met more than a minimum number of criteria (e.g., minimum 5, met 8 of 10), would they only need to meet any 5 of the original 10 criteria?" A: "They would

need to ensure the Regional Office that they are still the same provider and must meet all the criteria they met when they were originally certified by the State as a necessary provider." **Source:** Email from CMS to RWHC on 9/30/07.

"The relocation process... is triggered if as a result of its construction, renovation, remodeling, and/or rebuilding the NP CAH will be moving/relocating ANY of its up to 25 CAH beds (i.e., even if such a bed move is to occur on campus)..."

**Source:** CMS PowerPoint: CAH Revised Relocation Guidance, CMS Region X, Alma Hardy, External Affairs Liaison/Rural Health Coordinator, 12/18/07.

**#2: CMS Quarantines New "Necessary Provider" CAH Services to Campus—CMS has banned all CAHs from operating any new offsite facilities not 35 miles from another hospital. For "Necessary Provider" CAHs that means, in most situations, no new services off campus.**

### RWCH Eye On Health



"Federal agencies can have a heart,  
just rarely a rural one."

From CMS: “We believe the necessary provider CAH designation cannot be considered to extend to any new facilities not in existence when the CAH received its original necessary provider designation. Accordingly, we believe the creation of any new location that would cause any part of the CAH to be situated at a location not in compliance with the distance requirements at 42 CFR 485.610 would cause the entire CAH to violate the distance requirements.” **Source:** Final OPPTS Rule for CY 2008, November 1st, 2007.

**#3: CMS Freezes Rural Health Clinic Startups by Blocking Certification Surveys—CMS exempted rural health clinics from the prohibition on new CAH provider-based off campus services but then classifies certification surveys of new Rural Health Clinics as a “Tier 4 survey” also known “as a practical matter, it ain’t ever going to happen” survey.**

“Tier 4 consists of other important work, but work that is considered reasonable to accomplish only if higher priority functions can be accomplished within the federal budget limitations... The affected Medicare providers/suppliers include... Rural Health Clinics.” **Source:** CMS S&C Letter #08-03 of 11/5/07.

**#4: CMS Strips Rural Component from Quality Improvement Organizations’ Draft Contracts—In the evaluation of a CMS funded Quality Improvement Organization (QIO), the QIO will actually be hurt by working in rural areas because of the “inefficiencies” associated with the distance and lower population and provider density.**

**Rural Wisconsin Health Cooperative**, begun in 1979, 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 to partner with others to make their communities healthier... generates additional revenue by services to non-Members... actively uses strategic alliances in pursuit of its Vision.

Tim Size, RWHC Executive Director & EOH Editor  
880 Independence Lane, Sauk City, WI 53583

[office@rwhc.com](mailto:office@rwhc.com)

<http://www.rwhc.com>

Email us with *subscribe* as Subject for free e-subscription.

**Source:** Representatives of the American Health Quality Association and others have indicated that working with rural providers is no longer explicitly required in the draft 9th Scope of Work, as it is required in the current Scope of Work.

**#5: CMS Prohibits CAHs from Submitting Data for Public Reporting—In 2008, CAHs will not be able to submit outpatient quality data to CMS, a set specifically designed for rural hospitals.**

“Non-eligible hospitals (e.g., critical access hospital [CAH]) will not be able to submit data.” **Source:** December 12th Web Cast by CMS and the Florida Medicare Quality Improvement Organization regarding the Hospital Outpatient Quality Data Reporting Program.

---

## Rural ER Wait Time Half of Urban Hospitals

---

From an article, “Waits to See an Emergency Department Physician: U.S. Trends and Predictors, 1997-2004” by Andrew P. Wilper et al in a *Health Affairs Web Exclusive*, 1/15/08:

“As emergency department (ED) patient volumes increase throughout the United States, are patients waiting longer to see an ED physician? We evaluated the change in wait time to see an ED physician from 1997 to 2004 for all adult ED patients, patients diagnosed with acute myocardial infarction (AMI), and patients whom triage personnel designated as needing ‘emergent’ attention. Increases in wait times of 4.1 percent per year occurred for all patients but were especially pronounced for patients with AMI, for whom waits increased 11.2 percent per year. Blacks, Hispanics, women, and patients seen in urban EDs waited longer than other patients did.”

**Buried in the report is a very interesting fact for those interested in rural health. Patients seen in urban emergency departments waited a median of thirty minutes, while the median wait for those seen in rural emergency departments was only fifteen minutes. Patients diagnosed with a heart attack, at an urban hospital waited fifteen minutes while only seven minutes at a rural hospital.**

---

## The Business Case & Role for Primary Care

---

From a Commentary, “Primary Care: Can It Solve Employers’ Health Care Dilemma?” by Martin-J. Sepulveda, Thomas Bodenheimer and Paul Grundy in *Health Affairs*, Jan-Feb/08:

**Overview**—“Employers are beginning to recognize that investing in the primary care foundation of the health care system may help address their problems of rising health care costs and uneven quality. Primary care faces a crisis as a growing number of U.S. medical graduates are avoiding primary care careers because of relatively low reimbursement and an unsatisfying work life. Yet a strong primary care sector has been associated with reduced health care costs and improved quality.”

**Background**—“Employers are ‘between a rock and a hard place.’ The ‘rock’ is that health care, once considered an ancillary issue for employers engaged in making cars or in providing banking services, is now recognized by employers to be central to strategic management of human capital. The ‘hard place’ is that although many employers are paying for their employees’ health coverage, costs appear to be beyond their control, and quality varies from one health care provider to another.”

“Over the past twenty years, employers have tried a number of ways to climb out of the abyss lying between the rock and the hard place. Managed care, wellness and health promotion, free preventive care, value-based tiered networks, nurse advice lines, disease management, employee cost sharing, low-premium/high-deductible plans with health savings accounts—each of these strategies contains major flaws, and none is likely to eliminate employers’ pain. Yet one strategy—adopted by the health systems of virtually every developed country—is rarely discussed in the United States: investing in primary care.”

“Research studies demonstrate that a strong primary care foundation to the health system can reduce costs and improve quality. Yet U.S. primary care is underfunded and undervalued, which limits its effectiveness in cost and quality spheres. Employment-based health care coverage pays for more than 40 percent of

total U.S. spending for personal health services. With a common voice, employers have the clout to change health care priorities by demanding a strong primary care foundation. Over time, employers would reap benefits through stabilization of health care costs and increased worker productivity.”

**Threats to Primary Care**—“The U.S. health care system has never had a strong primary care foundation. Although 52 percent of visits to doctors in 2000 were to PCPs, only 35 percent of U.S. physicians practice primary care. In most European nations and Canada, 50 percent of physicians provide primary care.”

“In 2006, the American College of Physicians, representing both PCPs and specialists, warned, ‘Primary care, the backbone of the nation’s health care system, is at grave risk of collapse.’ From 1997 to 2005, the number of U.S. medical school graduates entering family medicine residencies dropped by 50 percent. In 1998, 54 percent of internal medicine residents planned careers in primary care rather than specialty medicine; by 2004, only 25 percent entered primary care. Over the past ten years, medical subspecialty fellowship positions have increased by 40 percent, and the number of hospitalists, many of whom are internists, has risen from 500 to 15,000. The proportion of patient care physicians in primary care has dropped from 1997 to 2005, while the proportion of specialists has increased. Not only is the PCP pipeline drying up, but one study found that 21 percent of primary care internists are leaving their practices after only fifteen or twenty years. Lower incomes and a stressful work life discourage medical students and young physicians from choosing primary care careers.”

“The income of PCPs, adjusted for inflation, dropped by 10.2 percent from 1995 to 2003, while the amount of work increased. Median specialist income in 2004 was \$297,000, which is 180 percent of primary care income (\$162,000). Unadjusted for inflation, specialist income grew almost 4 percent per year from 1995 to 2004, while primary care income grew 2 percent per year. The income of major medical subspecialties is more than 200 percent of general internal medicine income, with gastroenterology and oncology income, \$369,000 and \$350,000, respectively, growing more than 7 percent per year during those years. Thus, the primary care–specialty income gap is growing. A specialist spending thirty minutes performing a surgi-

cal procedure, a diagnostic test, or an imaging study is often paid three times as much as a PCP conducting a thirty-minute visit with a patient who has diabetes, heart failure, headache, or depression. It is these realities that define the crisis of primary care.”

**What Can Employers Do to Address the Primary Care Crisis?**—“Rebuilding the primary care framework requires leadership with purchasing power. Private-sector and government purchasers of health care—powerful forces for change—have this opportunity.”

“A few employers are applying reengineering methods to strengthen the availability of patient-centered primary care—for example, by supporting a patient-centered medical home model of care. The Tax Relief and Health Care Act of 2006 authorizes primary care medical home demonstration projects, providing PCPs with care management fees and shared savings from positive health outcomes. At the state level, the Community Care initiative of the North Carolina Department of Health and Human Services has sought to provide designated primary care medical homes to Medicaid recipients with chronic conditions. On the private-sector side, early efforts in this arena include several initiatives.”

“The Patient-Centered Primary Care Collaborative, a coalition of major employer and physician groups, represents more than 300,000 PCPs. Its goals are to help transform how primary care is organized and financed to provide better patient outcomes; more appropriate payment to physicians; and better value, accountability, and transparency to purchasers and consumers. The collaborative has been active in integrating the primary care association models for medical homes to facilitate employer engagement; advocating in Congress for a central role for patient-centered primary care in all health care reform legislation; calling for governmental leadership through demonstration project funding of patient-centered primary care projects in Medicare; and creat-

ing a forum for diverse parties including employers, organizations such as AARP, providers, health plans, and others to collaborate in patient-centered primary care initiatives.”

“The National Business Group on Health’s workgroup on primary care was formed to develop strategies for employers to increase support for primary care. Its priorities for action are patient-centered medical homes, health information technology (IT) for practice transformation, payment policies that recognize the value of primary care services, and educational and loan programs that encourage physicians and other health professionals to work in primary care.”

“Individual employers are mounting demonstration projects such as the IBM Corporation’s patient-centered primary care initiative, which has engaged primary care providers such as the Austin Regional

Clinic in Texas and Geisinger Health System in Pennsylvania. These are efforts to undertake primary care practice transformation and payment reform to deliver improved patient access, counseling/coaching, preventive care, care coordination, and chronic disease management within primary care medical homes. The American Academy of Family Physicians’ Transfor MED initiative and the American College of Physicians’ Center for Practice Improvement are leading the practice transformation, change management, and evaluation components of the initiative.”



“Such approaches challenge the accepted wisdom that employers cannot directly engage caregivers in a buyer-producer dialogue. By structuring demonstration projects around medical-home models, willing primary care practices and employers can experiment with new modes of reimbursement that support prompt access, population management of chronic conditions, patient self-management support, electronic medical records (including personal health records), and care coordination between primary care practices and other sites of care.”

“Some employers are examining PCP reimbursement embedded in private health plans’ contracting arrangements to understand how they have, perhaps inadvertently, reduced income for primary care doctors. The failure of PCPs’ income to keep pace with that of specialists—aggravated by diminished influence in contracting negotiations compared to their specialist colleagues—contributes to driving down the supply of PCPs. Employers can help stem the tide by building a more balanced allocation of spending between primary and specialty care into their health plan partner network and contracting strategies.”

“Employers are key stakeholders in containing Medicare costs. For Medicare Part B, the galloping volumes of procedures and imaging services and the large discrepancy in Medicare costs among different regions of the country are driven to a large extent by high Medicare fees for certain medical specialties. As noted above, Medicare costs are lower when primary care, rather than specialty, resources are greater. Employers have the opportunity to advocate for fixes to the Medicare cost problem that also remedy the disparity in payment for cognitive versus procedural services.”

---

## Curing the Overtreatment Epidemic

---

From a Book Review, “No. 1 Book, and It Offers Solutions” by David Leonhardt in *The New York Times*, 12/19/07:

“In 1967, Jack Wennberg, a young medical researcher at Johns Hopkins, moved his family to a farmhouse in northern Vermont.”

“Dr. Wennberg had been chosen to run a center based at the University of Vermont that would examine medical care in the state. With a colleague, he traveled around Vermont, visiting its 16 hospitals and collecting data on how often they did various procedures.”

“The results turned out to be quite odd. Vermont has one of the most homogenous populations in the country — overwhelmingly white (especially in 1967), with relatively similar levels of poverty and education statewide. Yet medical practice across the state varied enormously, for all kinds of care. In Middle-

bury, for instance, only 7 percent of children had their tonsils removed. In Morrisville, 70 percent did.”

“Dr. Wennberg and some colleagues then did a survey, interviewing 4,000 people around the state, to see whether different patterns of illness could explain the variations in medical care. They couldn’t. The children of Morrisville weren’t suffering from an epidemic of tonsillitis. Instead, they happened to live in a place where a small group of doctors — just five of them — had decided to be aggressive about removing tonsils.”

“But here was the stunner: Vermonters who lived in towns with more aggressive care weren’t healthier. They were just getting more health care.”

“Dr. Wennberg would eventually move to Dartmouth and, over the last 30 years, has done versions of his Vermont study for the entire country. Again and again, he has come up with the same broad result. And that result holds the key to health care reform — how to spend less on health care while not making the population any less healthy.”

“Dr. Wennberg’s story forms the backbone of ‘Over-treated,’ by Shannon Brownlee, which is my choice for the economics book of the year... As you’ve doubtless heard, this country spends far more money per person on medical care than other countries and still seems to get worse results. We devote 16 percent of our gross domestic product to health care, while Canada and France, where people live longer, spend about 10 percent.”

“Some of this difference is unavoidable. The United States does more than its share of medical research and bears much of those costs. It also has a diverse, economically unequal population, which, in turn, leads to a diverse and complicated set of health problems.”

“But health care spending simply can’t continue to rise at its current pace. If it did, it would ‘eventually overwhelm both the federal budget and workers’ paychecks,’ as Peter Orszag, director of the Congressional Budget Office, told me. ‘Slowing such growth is the single most important step we can take to assure our fiscal future and lift a growing burden on workers.’ ”

“Fortunately—if that’s the right word—there is an obvious candidate for cost-cutting: all that care that brings no health benefit. ‘We spend between one fifth and one third of our health care dollars,’ writes Ms. Brownlee, a senior fellow at the New America Foundation and former writer for U.S. News & World Report, ‘on care that does nothing to improve our health.’”

“Worst of all, overtreatment often causes harm, because even the safest procedures bring some risk. One study found that a group of Medicare patients admitted to high-spending hospitals were 2 to 6 percent more likely to die than a group admitted to more conservative hospitals.”

**“Why is this happening, then?”** Above all, it’s the natural outgrowth of our fee-for-service health care system. It turns doctors into pieceworkers, as Ms. Brownlee puts it, ‘paid for how much they do, not how well they care for their patients.’ Doctors and hospitals typically depend on the volume of work for their income, and they are the gatekeepers who decide when work needs to be done. They also worry about being sued if they do too little. So they err on the side of overtreatment.”

“Patients play a role, too. We’re entranced by the wonders of modern medicine and fooled by our byzantine health insurance system into thinking that we’re not really paying for all those unnecessary spinal fusions.”

“The typical book about current affairs is better at describing problems than solutions. But there is a nice surprise at the end of ‘Overtreated.’ In plain English, Ms. Brownlee lays out an agenda for reform that is usually confined to academic journals.”

“It includes some steps that should be widely popular, like giving doctors incentives to explain the risks and benefits of procedures more clearly than they do now. Research has shown that patients frequently de-

cide against marginal care when they know the true risks and benefits. Malpractice laws would also need to be changed so doctors were not sued by patients who later changed their minds.”



“Other solutions would be more difficult—because medical evidence is often murky, because hospitals and insurers would fight to keep their revenues and because most Americans think it’s the other guy who’s getting unnecessary treatment. These are the reasons that presidential candidates don’t focus on wasteful treatment.”

“As I’ve written before, there is nothing wrong with devoting a large chunk of our economy to medical care. Since the 1950s, doctors have made incredible

progress against diseases that were once inevitably fatal. That progress is probably the finest human achievement of the last half century.”

“If we weren’t wasting so much money on overtreatment, it would be a lot easier to repeat the achievement over the next half century.”

---

## Medicare Private Plans Grow in Wisconsin

---

From research brief, “Wisconsin Medicare Advantage Enrollment Up Significantly” by Timothy McBride, Yolonda Lahren, & Steven Meyer, *RUPRI Center for Rural Health Policy Analysis*, 11/07:

“The number of persons enrolled in Medicare Advantage (MA) and prepaid plans in Wisconsin more than doubled between December 2005 and September 2007, from over 83,400 to over 174,700 persons. The enrollment in MA plans represents 20.4% of Wisconsin Medicare beneficiaries, exceeding the national enrollment rate of 19.8%. Wisconsin remains a state with one of the most robust MA markets in rural areas in the country. Over 21% of rural Wisconsin beneficiaries were enrolled in MA or prepaid plans,

and enrollment more than doubled, from over 29,100 persons to over 59,100 persons between December 2005 and September 2007.”

“Most of the increase in MA enrollment in Wisconsin has been in private fee-for-service (PFFS) plans. While in December 2005 there were only about 35,200 enrollees in PFFS plans statewide, enrollment in PFFS plans jumped to almost 104,000 in September 2007 (Table 1). Only two states in the country (North Carolina and Michigan) had higher enrollment in PFFS plans. About one-third of the PFFS enrollees in Wisconsin were in rural areas. Enrollment growth was also vigorous in health maintenance organization (HMO) and point of service plans (over 40% growth) and in preferred provider organization plans (increased more than 10 times) in the same period.”

“Medicare Advantage Plans Described—MA plans are private-sector plans that contract with Medicare to provide all Medicare-related services, plus additional benefits (e.g., prescription drugs, vision care, preventive care), sometimes at an additional cost to beneficiaries. Prepaid plans are special plans created over the years by legislation and comprise mostly ‘cost’ plans. PFFS plans, created by legislation in 1997, are private MA plans that contract with Medicare like other MA plans, but for the most part do not operate networks of providers, such as HMOs operate. Instead, PFFS plans pay providers on a fee-for-service basis after receiving payment from Medicare.”

“Conclusion and Implications—MA plans have spread to more areas and enrolled a higher number of beneficiaries due to a number of factors, including significant growth in payment to MA plans. PFFS plans have gained a strong foothold in rural areas because the differential between the MA Medicare payment and traditional Medicare payment is large, and because it is less difficult to set up a PFFS plan than other types of MA plans (e.g., HMOs). Thus, there are strong incentives for PFFS plans to seek rural enrollment. While it is too early to gauge the full impact of MA plans, these plans give more options to Medicare recipients and lower out-of-pocket costs. On the other hand, providers have had to make significant adjustments in timing and

collection practices to deal with these new Medicare program payers. The U.S. Congress is now wrestling with how to pay for the rapid growth in MA plans, especially PFFS plans.”

---

## Rural Hospital Goes the Extra Mile

---

*Monthly, “Eye On Health” showcases a RWHC member story from the Wisconsin Hospital Associations’ annual Community Benefits Report. Wisconsin hospitals provide over \$1.6 billion in community benefits; twice that if you include Medicare shortfalls and bad debt. This month’s feature is from Memorial Health Center, Medford, “Health Screenings Save Lives”:*

“For a few years, Lorraine Thomsen of Medford attended the Taylor County Senior Health Fair as her opportunity to gather new healthcare related information from local organizations and to take part in the health screenings. One screening Lorraine had always participated in was the free diabetes or blood glucose screening offered by Memorial Health Center. The year of 2006 was no different; Lorraine again had her blood glucose tested during this annual event, but this time the results were a bit concerning.”

“ ‘I used to work at the hospital and knew a little about diabetes,’ said Lorraine. ‘I changed my diet right away.’ Lorraine followed up in February with her health care provider, Kathy Hemer, nurse practitioner with Memorial Health Center. She retested her at that point and found that her levels were a little better, but still needed medical attention. To help her with nutrition management, Lorraine was scheduled with Memorial Health Center’s registered dietitian and diabetes educator, Rosalyn Haase. ‘I learned a lot from Rosalyn about food planning to keep my diabetes under control through diet,’ said Lorraine.”

### Write for the 16<sup>th</sup> Annual Monato Essay Prize

A \$1,000 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 April 15th. Info re submission is available at

[www.rwhc.com/Awards/MonatoPrize.aspx](http://www.rwhc.com/Awards/MonatoPrize.aspx)

“Each year Memorial Health Center reaches out to hundreds of local seniors during the Taylor County Senior Health Fair, sponsored by the Commission on Aging organization. Memorial Health Center has a very large pres-

ence at the health fair, including offering free health screenings. Over 245 people were screened during Memorial Health Center's free diabetes screening in 2006."



"The screening was absolutely helpful," said Lorraine. "The symptoms aren't always obvious and if you don't go to the doctor or participate in a screening somewhere, you'd never know you have diabetes."

"According to WebMD, an estimated 18.2 million people in the United States—6.3 percent of the population—have diabetes, a serious, lifelong condition. Of those, 13 million have been diagnosed, and about 5.2 million people have not yet been diagnosed. Each year, about 1.3 million people aged 20 or older are diagnosed with diabetes. If diabetes is not kept under control, devastating complications can result."

"If diabetes isn't controlled, it can lead to very serious health conditions," said Haase. "Poorly controlled diabetes is the number one cause of adult blindness and kidney failure, and non-traumatic amputations of the foot or leg. Stroke and heart attacks are the most

frequent causes of death in people with type 2 diabetes. New research points to a link between poor diabetes control and Alzheimer's disease." Lorraine continued, "I feel much better now that I lost some weight and can control my diabetes without medication."

"Memorial Health Center, accredited by the Joint Commission, is a Critical Access Hospital serving Taylor, southern Price and parts of Clark and Marathon Counties in Wisconsin. Memorial Health Center was the recipient of the Ernest A. Codman national award in 2005 for diabetes care, a very prestigious award for healthcare organizations. Memorial Health Center was also the recipient of a National Rural Health Quality Award in 2006. Memorial Health Center is an Aspirus Partner."

**National Rural Health Association  
2008 Annual Conference  
New Orleans, LA, May 7-10, 2008**

**Information at <http://www.nrharural.org>**

Space Intentionally Left Blank For Mailing