Rural Wisconsin
Health Cooperative

Eye On Health

Review & Commentary on Health Policy Issues for a Rural Perspective – May 1st, 2008

What Were They Smoking?

by Tim Size, RWHC

We are regularly reminded that people can think and act really strangely. Those of us who grew up in the '60s often ask, "What were they smoking?" Given recent news alerts, kids growing up today will ask, "What 'meds' were in their water?"

Maybe I'm just getting older and crankier, but this winter seemed to bring a lot of bad ideas about health care. Here are just three of my favorites. They each break medicine's oldest rule, "first, do no harm."

Any Data Will Do: To sell more health insurance, a national company has decided to be a "quality leader." Their approach is simple. "Better" doctors get more stars by their name. Patients are encouraged to go to "better" doctors by owing less out of pocket when they see doctors with more stars. Many rural doctors don't have any stars. They don't have stars because the company doesn't have enough data about rural doctors, not because the doctors aren't good doctors. It's like you get an "F" because your teacher's dog ate your paper. The fact that we have a growing shortage of doctors and need all those we have, isn't on their radar. But that is a topic for another column.

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"They seem to think we won't smell that it's bull if they say it with a straight face."

Anything But Flexible: If you think the Federal government doesn't have a sense of humor you would be wrong. Most rural hospitals participate in Medicare through something called the "Rural Hospital Flexibility (Flex) Program." It is becoming anything but flexible. Try being a rural community with a fifty-year old hospital that needs to be torn down and rebuilt. In that case you may be out of luck, as Medicare requires you to prove that the community is exactly as it was when the hospital first entered the Flex Program. If the hospital has recruited more doctors, or if unemployment has gone down or if younger families have moved into the area, the hospital is probably stuck with an out of date facility.

Blocking Federal Funds: We are in an era when shouting slogans masquerades as leadership. I love a good one liner at least as well as the next guy; but to get something done, you eventually need to sit down and think through an issue. In Wisconsin, the so-called hospital "tax" or assessment is just such an issue. Yes, hospitals would have to pay into a State fund in order that the State would be eligible for additional federal dollars. This isn't rocket science. If a rich uncle offers me two dollars for every one I raise at home, I'd take the deal. Everyone knows that there is a much larger "hidden tax" in every hospital bill to make up for what the Medicaid program doesn't pay. This is the tax people need to focus on.

"I like an escalator because an escalator can never break, it can only become stairs. There would never be an escalator temporarily out of order sign, only an escalator temporarily stairs. Sorry for the convenience." Mitch Hedberg

I started this column thinking I was writing about stupid ideas. In fact, I realize I am talking about decisions made by some very smart people. The insurance company wants to sell policies and is less concerned about the impact on patients and physicians due to misleading data. Some of the people running Medicare seem "just not to like" the Flex Program so it makes sense to them to try to force hospitals out of the Program. And all sides understand the need to reduce the Medicaid "hidden tax" but some would rather take the "I'm tough on taxes" story line into the next election.

The bottom line is that we live in a world with many competing agendas, and that if the idea from a business, agency or politician doesn't make sense to us, we need to keep digging. It probably makes sense from some perspective, even if we disagree with it. Figuring out to whom and why a bad idea makes sense is a necessary step in dealing with it.

Patients Give Rural Hospitals High Marks

by Tim Size, RWHC

Hospitals have been anxiously waiting the public reporting of a new national survey, which for the first time gives a standardized report of patients' perspectives of hospital care. If RWHC member hospitals are any example, there is good news for rural hospitals. They are doing as good or better than their often more acclaimed urban counterparts.

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.

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The average score for all hospitals reporting across the country was 67%; the average for RWHC hospitals reporting was 73% and for a selection of urban hospitals closest to the RWHC hospitals, the average score was 70%. While this report shows room for improvement all around, it is heartening to see data that affirms the support rural hospitals have earned in their communities.

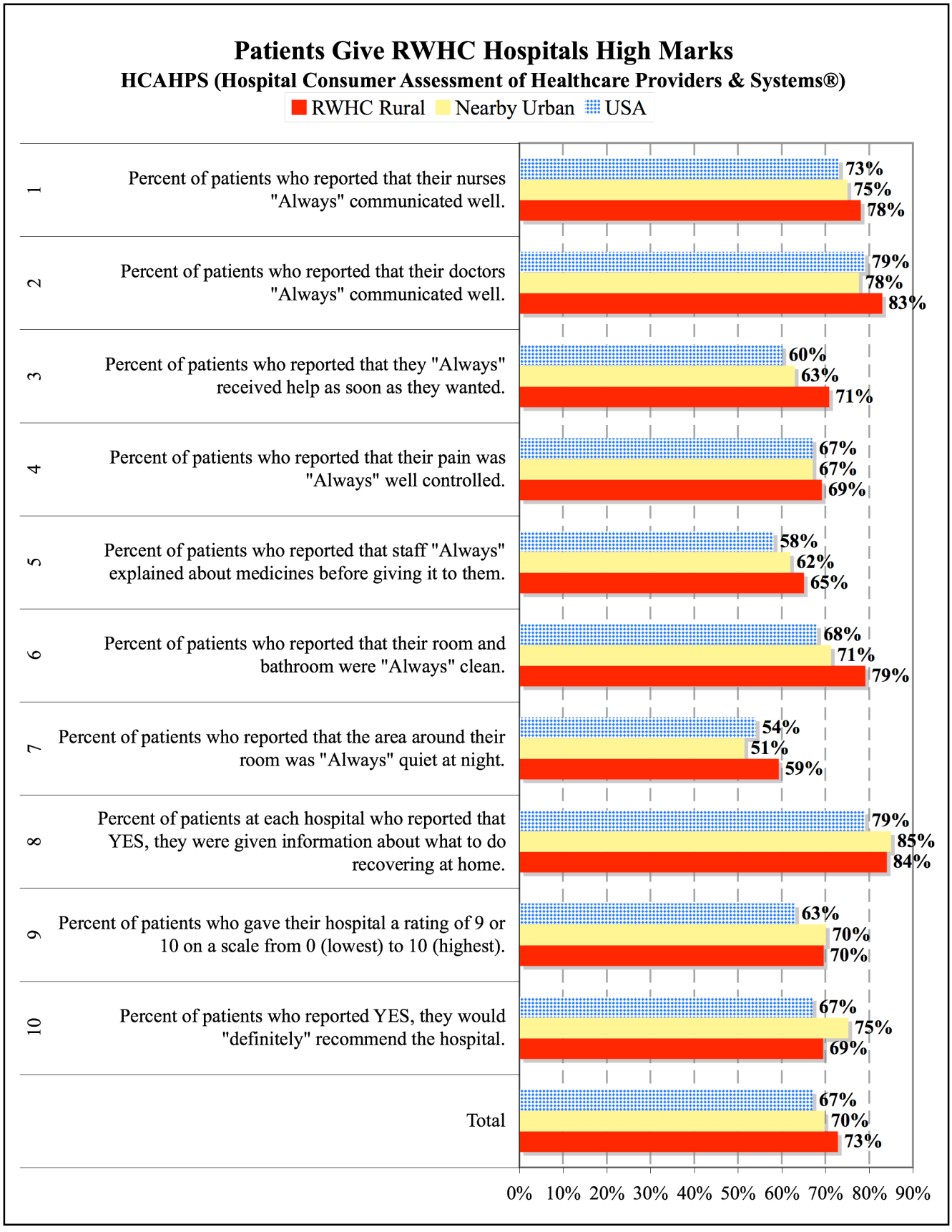
This analysis is based on information from the Centers for Medicare & Medicaid Services (CMS) within the Federal Department of Health and Human Services. CMS has added to its Hospital Compare web site a "Survey of Patients' Hospital Experiences," based on "what hospital patients say about the care they received during a recent hospital stay." The Hospital Compare web site is at:

http://www.hospitalcompare.hhs.gov/

Hospital Compare provides information on how well hospitals care for all of their adult patients. The patient satisfaction indicators come from data generated by a survey known as HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems). See below for a brief description of HCAHPS. The chart on the next page shows for ten questions an estimated average of the publicly reported information for RWHC member hospitals, for a selected group of nearby urban hospitals and for all hospitals nationally.

What are HCAHPS?–According to CMS, "HCAHPS (pronounced "*H-caps*") is the first national, standardized, publicly reported survey of patients' perspectives of hospital care. HCAHPS, also known as the CAHPS® Hospital Survey. is a standardized survey instrument and data collection methodology for measuring patients' perceptions of their hospital experience. While many hospitals collected information on patient satisfaction for their own use, until HCAHPS there was no national standard for collecting and publicly reporting information about patients' experiences that allowed valid comparisons to be made across hospitals locally, regionally or nationally."

"Three broad goals have shaped HCAHPS. First, the survey is designed to produce data about patients' perspectives of care that allow objective and meaningful comparisons of hospitals on topics that are


Patients Give RWHC Hospitals High Marks
HCAHPS (Hospital Consumer Assessment of Healthcare Providers & Systems®)
RWHC Rural
Nearby Urban
USA
1
Percent of patients who reported that their nurses "Always" communicated well.
73%
75%
78%
2
Percent of patients who reported that their doctors "Always" communicated well.
79%
78%
83%
3
Percent of patients who reported that they "Always" received help as soon as they wanted.
60%
63%
71%
4
Percent of patients who reported that their pain was "Always" well controlled.
67%
67%
69%
5
Percent of patients who reported that staff "Always" explained about medicines before giving it to them.
58%
62%
65%
6
Percent of patients who reported that their room and bathroom were "Always" clean.
68%
71%
79%
7
Percent of patients who reported that the area around their room was "Always" quiet at night.
54%
51%
59%
8
Percent of patients at each hospital who reported that YES, they were given information about what to do recovering at home.
79%
85%
84%
9
Percent of patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).
63%
70%
70%
10
Percent of patients who reported YES, they would "definitely" recommend the hospital.
67%
75%
69%
Total
67%
70%
73%
0% 10% 20% 30% 40% 50% 60% 70% 80% 90%

important to consumers. Second, public reporting of the survey results creates new incentives for hospitals to improve quality of care. Third, public reporting serves to enhance public accountability in health care by increasing the transparency of the quality of hospital care provided in return for the public investment. With these goals in mind, the HCAHPS project has taken substantial steps to assure that the survey will be credible, useful, and practical." (*The above description is from hcahpsonline.org by Centers for Medicare & Medicaid Services, Baltimore, MD, April 8th, 2008.*)

A Reporting Glitch?–Hospital Compare's Question #10 may need more work: "Percent of patients who reported YES, they would *definitely* recommend the hospital." RWHC hospitals still do better here than the national average, but much less so than compared to other measures. There is at least one published report from outside of Wisconsin highlighting the same inconsistency. In the actual survey you are asked "Would you recommend this hospital to your friends and family?" You can answer "Definitely no," "Probably no," "Probably yes" and "Definitely yes."

A potential explanation for rural hospitals seeming to do less well on this particular question may be that even if you were strongly confident about recommending your rural hospital, you may not answer "Definitely yes." You may choose "Probably yes" because you realize that most rural hospitals don't offer every specialized service that may be needed. This is less likely an issue for someone asked the same question about an urban hospital. To remove this reporting bias, the measure reported by Hospital Compare may need to count those who answer "Definitely yes" or "Probably yes" on the HCAHPS survey.

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"You seriously expect me to believe that rural did better than we did?"

The Rural Wisconsin Health Cooperative (RWHC) has met HCAHPS participation requirements and is approved to administer the CAHPS® Hospital Survey. For more information contact Mary Jon Hauge at 800-225-2531 or ***mjhauge@rwhc.com****.*

Federal Policy Penalizes Community Service

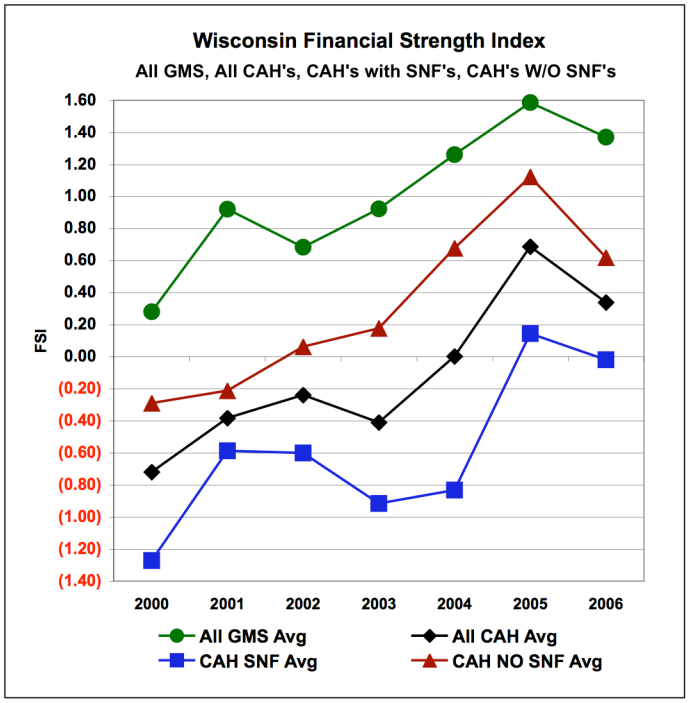
by Dale Gullickson and Tim Size, RWHC

"Today, more than ever before, users of a hospital's financial information whether they be investors, management, board members, community leaders, or donors need to be informed of the organization's true financial condition. Early detection of financial distress is critically important if a hospital's executive team is to have time to take corrective action and prevent further erosion of the organization's financial health. ("Distress Detectors Measures For Predicting Financial Trouble In Hospitals," by Corbett A. Price et al, *Healthcare Financial Management*, 8/05)

According to Price, the "Financial Strength Index" (FSI) is a simple measure of overall financial health that provides an excellent starting point for analyzing a hospital's condition. It is a composite measure of four critical dimensions of financial health: profitability, liquidity, financial leverage, and physical facilities.

Using "Wisconsin's Annual Hospital Fiscal Surveys," we calculated the "FSI" for Wisconsin's General Medical Surgical (GMS) hospitals and for the state's Critical Access Hospitals (CAHs). CAHs were further broken down into the roughly one half that operate Skilled Nursing Facilities (SNFs) and those that don't.

The results, as shown in the below graph were dramatic. As expected, the "All GMS" average was higher than the "All CAH" average. What wasn't fully expected was the consistently negative impact among CAHs based solely on whether or not they had a SNF.



SNF (nursing home) revenue mostly comes from the State's Medicaid program and given very low Medicaid reimbursement rates, many to most hospitals subsidize their nursing home. But CAHs with nursing homes are hit with a second and often more costly loss. CAHs receive reimbursement from Medicare for their reasonable costs. To simplify only a bit: if half of the hospital's patients are Medicare beneficiaries, Medicare will pay for their direct cost of care as well as half of the CAH's overhead (administration, housekeeping, utilities, insurance, etc.).

But if the CAH operates a SNF, hospital overhead that would have been reimbursed by Medicare, is "pushed" over to the nursing home "department" and not reimbursed. So the hospital loses twice–once for low Medicaid nursing home reimbursement and then again for lost Medicare hospital reimbursement.

The result is that, increasingly, CAHs are either downsizing their SNFs, spinning them off into freestanding entities or closing them. These restructurings don't change the underpayment by Medicaid for nursing home care but do reduce or eliminate the loss of Medicare funding to the hospital.

Medicare's policy to force overhead onto all CAH run community services is a harmful disincentive for them to start or continue non-medical health services for Medicare beneficiaries, and everyone else, in rural communities. This is particularly ironic given the push by another Federal agency, the IRS, for non-profit hospitals to expand their "community benefits."

Medicare Private Plans Grow in Wisconsin

by Richard Donkle and Tim Size, RWHC

"Most of the 44 million elderly and disabled people on Medicare (80%) have their health bills paid by the traditional fee-for-service program; 20% get their Medicare benefits through private health plans that receive payments from Medicare, now called 'Medicare Advantage' plans." (*Kaiser Family Foundation 2007 Fact Sheet*)

According to figures released by CMS in March of this year, almost 200,000 of Wisconsin's 850,000 Medicare beneficiaries are enrolled in Medicare Advantage plans. The comparable enrollment for 2007 was 150,000. This represents an increase of over 30% from 2007; 1 in 4 of Wisconsin beneficiaries are now enrolled in one of these plans. These plans are selected as a replacement for traditional "Fee for Service" Medicare. The Government Accountability Office, the nonpartisan investigative arm of Congress, reports that in the next four years, Medicare Advantage (MA) insurance plans will be paid $54 billion more than what would have been paid under traditional Medicare.

The Medicare Advantage plans fall into several different categories:

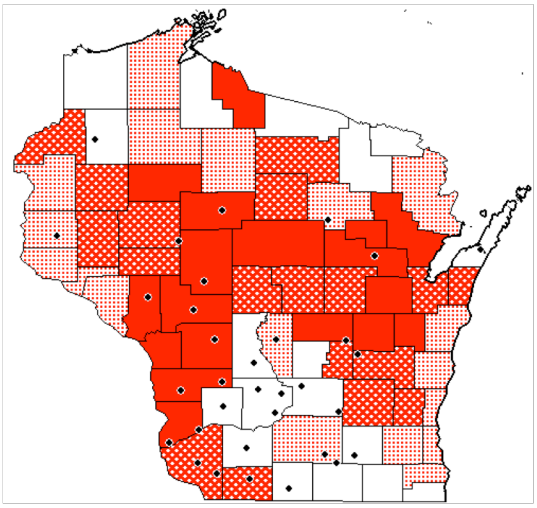
WI Plans by Type	Enrollment–3/08
Private Fee for Service (PFFS)	118,234
Local HMO/POS Plans	52,992
Local PPO Plans	12,902
1876 Cost Plans	11,540
Regional PPO Plans	997
National PACE Plans	728
Total	197,393

With the exception of the Regional PPO Plan, plans are approved and marketed by county. This means that within a given county, market penetration may

vary significantly from what the statewide average indicates. As indicated on the right, county level market shares range from 8% to 56%.

Since the Private Fee for Service (PFFS) plans comprise such a large segment of enrollment in replacement plans by Medicare beneficiaries in Wisconsin, it is important to understand how these plans operate. A Medicare PFFS plan is a Medicare Advantage health plan offered by a private insurance company under contract to the Medicare program. Medicare pays a set amount of money every month to the PFFS organization to arrange for health care coverage for Medicare beneficiaries who have enrolled in the Medicare PFFS plan.

Medicare Advantage Market Share by County
(Wisconsin Average = 22.9%)



Lowest Quartile	8.1% to 19.0%	☐
Second Quartile	19.1% to 23.2%	▩
Third Quartile	23.3% to 28.6%	▩
Highest Quartile	28.9% to 57.9%	■

• RWHC Member Hospitals

Enrollees in a Medicare PFFS plan can obtain plan covered health care services from any eligible provider in the U.S. who is willing to furnish services to a PFFS enrollee.

Medicare PFFS plans are not required to contract with <u>any</u> Providers. Providers become aware that beneficiary participates in a Medicare PFFS plan when the beneficiary presents their enrollment card. A provider is a deemed provider and must follow a PFFS plan's terms and conditions of participation if the following conditions are met: a) in advance of furnishing services the provider knows that a patient is enrolled in a PFFS plan and b) the provider either possesses or has access to the plan's terms and conditions of participation.

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"Tell me again how we act like we care about their quaint local ways."

It is important to note that a provider is not required to furnish health care services to enrollees of a Medicare PFFS plan. However, when a provider chooses to furnish services to a PFFS enrollee and the deeming conditions have been met the provider is automatically a deemed provider (for that enrollee) and must follow the PFFS plan's terms and conditions of participation.

The terms and conditions of participation establish the rules that providers must follow if they choose to furnish services to an enrollee of a PFFS plan.

A PFFS organization is required to make its terms and conditions of participation reasonably available to providers from whom its enrollees seek health care services. This generally means that the organization offering the PFFS plan will post its terms and conditions on a web site and make them available upon written or phoned request.

Given the ease with which hospitals will be "deemed" to be contracting providers, it is important that hospitals understand the basics concerning how Medicare PFFS plans operate and take steps to identify the specific Medicare PFFS plans that will be operating in their area (and their specific terms and conditions of participation).

Providers can decide to contract with a particular Medicare PFFS plan, either directly or by deeming, and make such decision known to admissions staff. Hospitals are not obli-

gated to serve Medicare beneficiaries enrolled in PFFS plans, except in emergency situations governed by EMTALA. It may be a difficult decision for providers to deny services to a Medicare beneficiary who participates in a Medicare PFFS plan.

A Medicare PFFS plan must establish uniform payment rates for all contracted providers (those with written contracts and those deemed to be contracted providers). The Medicare PFFS plan must pay both contracted and "deemed" contracted providers the fee-for-service amount specified by the plan in the terms and conditions of payment for the particular service minus any applicable enrollee cost-sharing.

If a Medicare PFFS plan has an insufficient number of contracted hospital providers to furnish the services covered under the Medicare PFFS plan, it must pay all hospital providers (contracting, deemed and non-contracting) at least what they would have been paid under original Medicare and may not vary beneficiary cost sharing.

Warning–The PFFS plan may have discretion in setting payment rates for contracted and deemed contracted providers. **A Medicare PFFS plan can establish payment rates that are less than traditional Medicare for designated types of providers if the plan demonstrates to CMS that it has a sufficient number of providers of each such type under written contract to meet Medicare access standards.** CMS assesses the sufficiency of a PFFS plan's contracted network on the same basis as network sufficiency for a coordinated care plan. Stay tuned!

CMS Improves CAH Bed Definitions

by Sheila Goethel, RWHC

Medicare has limited Critical Access Hospitals (CAHs) to 25 beds, including acute care, hospice, swing bed, observation, and delivered obstetric patients. In addition, 10 additional beds can be allowed for a distinct unit (psych/rehab) without counting towards the 25 beds limit.

Medicare recently announced that observation beds are no longer included in the 25 bed maximum. This revision is a welcomed increase in flexibility for managing the utilization of CAH beds.

CAHs are reminded that observation status is a furnished service that is "…reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient…" Hospitals must acknowledge appropriate documentation guidelines for admission and discharge of the observation patient. In addition, CAHs will need policies and procedures to distinguish inpatient status from observation status. Hospitals may provide a separate observation unit; but overall, regardless of payer status, CAHs must be able to provide documentation that denotes a differentiation between the inpatient and observation patient/bed.

This is a great opportunity for hospitals to expand their patient volume but CAHs must assure that the observation status is utilized appropriately, and not as a means to circumvent bed or length of stay limits. The complete Medicare transmittal is available at:

http://www.cms.hhs.gov/transmittals/downloads/R34SOMA.pdf

Addressing Rural Men's Health

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 the Monroe Clinic, "A New Take In Targeting Men's Health Issues":

"While the nation has grown increasingly aware of women's health issues in recent years, reaching and educating men on health risks and disease prevention continues to be a challenge. In order to specifically address men's health needs in the community, Monroe Clinic physicians Dr. Kenneth Sparr and Dr. Andrew Rikkers took their message to the Southern Central Wisconsin Archers for a guys-only event."

"The evening was part of Monroe Clinic's ongoing HealthADVANTAGE Series, a program that offers health presentations and screenings, most often at no cost, to the general public. It was the second year for a Men's Night–the prior year's event was at a local Harley Davidson dealership."

" 'Taking health information and screenings to untraditional settings benefits men by exposing them to important information in a setting that is more comfortable, casual, and convenient,' explained Dr. Sparr, who presented at both the 2005 and 2006 Men's Nights. Men's Night 2006 featured free blood pressure, cholesterol, diabetes, and body mass index screenings. Dr. Sparr, a urologist, and Dr. Rikkers, a general surgeon, presented 'Straight Talk: Get the Facts on Prostate Health, Groin Pain, & Heartburn.' "

"In an unconventional take on the typical health presentation, the program also included demonstrations and tips on archery, as well as food and prizes. Men were soon asking questions and taking part in lively discussions. 'The men who had interest in finding out about reflux disease as well as groin pain and hernias had good questions that other members of the audience also seemed to learn from as well,' said Dr. Rikkers."

" 'After my talk on prostate health, I found that several gentlemen came in to get treatment for their enlarged prostates that had been causing problems for years. They convinced some of their friends to come in to get checked also,' Dr. Sparr said."

"The most common comment from the participants was that they were grateful for the presentation and appreciated the opportunity to come out and ask questions. The audience surveys confirmed that the men were hearing much of the presented health information for the first time in their lives. 'Discussions like these go a long way to help people in their daily lives,' Rikkers said. As Dr. Sparr explained, 'This event definitely reaches the 'hard to reach' men–the ones who tend to push aside or ignore health issues due to fear, anxiety, and embarrassment. It gives them a chance to see they are not alone in their experience.' "

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