

Review & Commentary on Health Policy Issues for a Rural Perspective – November 1st, 2005

## Old Rivalry Distracts from Common Need

On October 7<sup>th</sup> the University of Wisconsin (UW) Board of Regents authorized the renaming of the University of Wisconsin Medical School to a School of Medicine and Public Health. It was an important marking of a milestone in a long sought transformation of health sciences within the UW System. Less positively, it also marked the latest chapter in a dysfunctional sibling rivalry between Wisconsin's two largest urban centers.

In response to passionate but often unfocused opposition from Milwaukee, the Regents untangled the mess by directing the School to "commence a good faith dialogue with the city of Milwaukee and the chancellor of University of Wisconsin-Milwaukee on specific strategies to increase collaboration on public health education, research, and service with the purpose of addressing the challenging public health issues facing Milwaukee."

The Regents took particular note, and perhaps some relief, that "health representatives from other areas of the state, including rural Wisconsin, are equally concerned that their health care needs are being addressed and are supportive of the UW Medical School's name change, commitment to collaboration, and further extending its resources statewide."

"Statewide rural voices were consistent in their message. What follows is edited from a Rural Wisconsin Health Cooperative (RWHC) letter published in the *Milwaukee Journal Sentinel* on October 2<sup>nd</sup> and RWHC invited testimony given before the University of Wisconsin Board of Regents on October 6<sup>th</sup>:

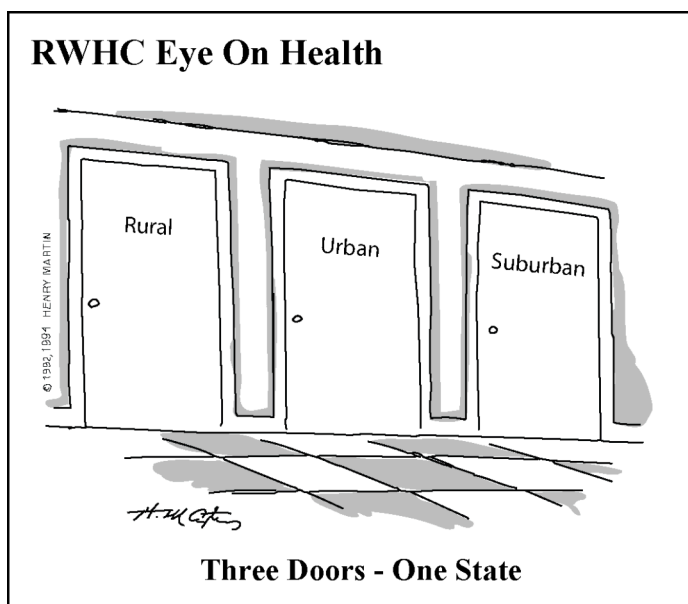
" 'Milwaukee trumps Madison when it comes to social needs, health crises' was a great headline. But the attempt to stop the University of Wisconsin Medical

School from integrating public health into its curriculum is a classic 'right diagnosis, wrong treatment.' "

"Half of the urban counties in Wisconsin score in the top quarter of counties for overall health. Only 10% of rural counties do as well. Yes, Milwaukee and two other metro counties are in the bottom quarter. But 15 rural counties are also in the bottom quarter, seven with worse health

than Milwaukee. Rural Wisconsin needs UW-Madison to help us change that reality."

"Our country is calling on doctors to change what they call 'good medicine.' Good medicine has always meant caring for individual patients. But it now also means working to improve a community's health. The treatment is community-wide change, not just a pill. Public health can no longer be just the responsibility of under-funded government agencies."



“The proposed changes at UW-Madison are an overdue start to train a new generation of physicians. We need physicians who will help lead us to a healthier Wisconsin. We need UW-Madison to stay on track. Blocking change at the UW Medical School does not help Milwaukee.”

### **Transformation in Health Care & the Role of the University November 17-18, Monona Terrace Convention Center**

“Academic Health Centers and their Universities have a critical role in research, education and health care delivery toward improving health and health care. A dialogue to consider... transforming the healthcare system and the University.” Register at: <<http://www.pophealth.wisc.edu/UWPHI/>>.

“For the last 26 years, RWHC has a public record of advocating that the UW-Madison change, as proposed in a series of innovations which are to be marked by the proposed name change. It is absolutely intolerable for rural Wisconsin that any politics between Milwaukee and Madison justify a last minute blocking or delaying of the affirmation of this long overdue integration of public/community health into the medical school curriculum.”

“In 2003-2004, the Institute of Medicine (IOM) Committee at the National Academy of Sciences looked at the future of rural health care, and what healthcare system and educational reform was needed. Their principle conclusion was that: ‘Rural communities must reorient their strategies from an exclusively patient- and provider-centric approach to one that also addresses the problems and needs of rural communities and populations.’ ”

“The Committee did not invent this idea, but applied previous long-held IOM findings to the rural context. One example is from the IOM’s 2002 Report *Fostering Rapid Advances In Healthcare: Learning From System Demonstrations*: ‘The healthcare system of

the 21st century should maximize the health and functioning of both individual patients and communities. To accomplish this goal, the system should balance and integrate needs for personal healthcare with broader community-wide initiatives that target the entire population.’ ”

“We are not qualified to say how the needs of Milwaukee may best be addressed. What we do know is that the UW Medical School must affirm a new integrated vision regardless of what additional public health investments are developed in Milwaukee. This is fundamentally not about adding to Madison at the expense of Milwaukee but allowing Madison to continue restructuring current resources as previously envisioned and approved.”

“The one issue before the Regents is to stop the dysfunctional separation in education between individual and community health in ALL of our schools and in ALL of our communities.”

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### **Medicare’s New Prescription Drug Benefit**

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The following is from <<http://www.medicare.gov/>> as is written directly to the beneficiary:

“For the first time ever, everyone with Medicare, regardless of income, health status, or prescription drug usage, will have access to prescription drug coverage. This new coverage begins on January 1, 2006. While information is available now and educational sessions are taking place in communities across the country, you can’t enroll until November 15<sup>th</sup>. By now, you should have received your *Medicare & You 2006 Handbook* which explains in detail what prescription drug coverage means to you and which plans are available in your area.”

#### **The Rural Wisconsin Health Cooperative,**

begun in 1979, is 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

<mailto:office@rwhc.com>   <http://www.rwhc.com>

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“Medicare Advantage and Prescription Drug Plans have started their advertising across the country. You may want to find out more about some of these options. It might be a good idea to save these materials for review when it gets closer to November 15, 2005.”

“Because this new coverage is so important, the Centers for Medicare & Medicaid Services (CMS) wants to promote a national conversation to make sure that all people with Medicare, and those who care for them, understand this new coverage. This conversation will take place in many different places and in many different ways—it will occur across the kitchen table, in senior centers, at churches, between friends, neighbors, parents and their children, pharmacists and their customers.”

“Because this new coverage is a vital addition to Medicare that will help people save money and live better, healthier lives, it's important to have information about it. It will extend the promise of modern drug treatment to everyone with Medicare. If you have Medicare, we strongly urge you to learn more about this new coverage. You can talk about this with many different people and start thinking about the coverage you want. And, if you have family and friends with Medicare, we ask that you help them learn more about it, too.”

“People are talking about Medicare prescription drug coverage right now in many different settings. To provide additional help and places for these conversations to occur, the Centers for Medicare & Medicaid Services (CMS) has created more than 140 community-based education networks and is working with nearly 10,000 local partners including the State Health Insurance Programs (SHIP) and Area Offices on Aging all across the country. These networks and partners provide a variety of services, from distributing materials to educational meetings to personalized counseling for people with Medicare. To help these groups and to help you, CMS has developed a variety of resources such as

consumer brochures, on-line tools, and educational materials.”

“All of the CMS materials and on-line tools are available now. They are listed below as part of a four-step process to help you understand the process of choosing Medicare prescription drug coverage. For each step in the process, there's an on-line tool that can help you. **Remember that Medicare is here for you—24/7—at 1-800-MEDICARE. Our customer service representatives will provide information and answers to your questions. Also, to find out about local counseling and assistance in your area, visit <<http://www.medicare.gov>>.**

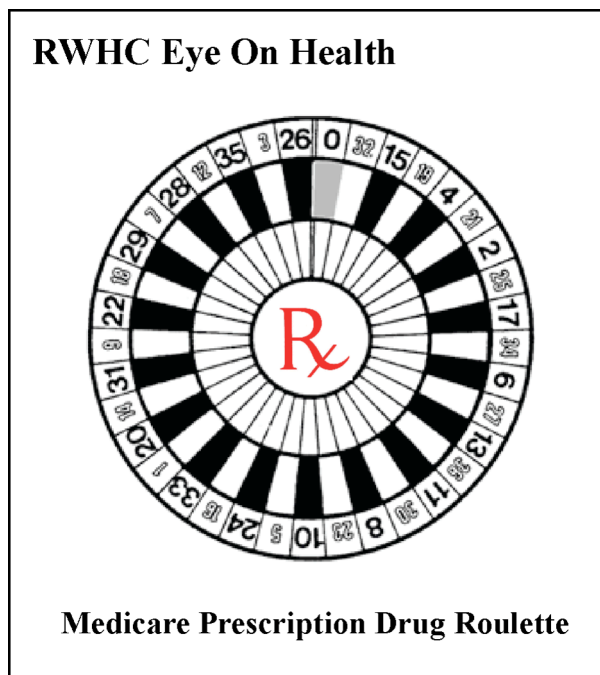
### To Get Medicare Prescription Drug Coverage:

“To help people with Medicare take advantage of the new Medicare prescription drug coverage, there are four steps you can think about to make a decision.”

#### 1. Getting Started

“The decision to get Medicare prescription drug coverage depends on how you pay for your drugs now and how you get your Medicare coverage. Most people with Medicare pay for drugs and get their Medicare in one of five ways:

- Original Medicare only, or Original Medicare and a Medigap (‘Supplement’) Policy without drug coverage. The new Medicare drug coverage will cover half of the costs for you if you have this kind of coverage now. Enhanced options are available that provide more coverage.
- Original Medicare and a Medigap (‘Supplement’) Policy with drug coverage. The new Medicare drug coverage will generally provide much more comprehensive coverage at a lower cost.
- Retiree or union coverage. In most cases, people with good retiree or union coverage can continue to get it, with financial support from Medicare.



- Medicare Advantage Plan (like an HMO or PPO) or other Medicare Health Plan, which already include drug coverage and other extra benefits.
- Dual coverage from Medicare with Medicaid drug coverage. These people will automatically get comprehensive prescription drug coverage from Medicare, starting on January 1.”

NOTE: “If you have limited income and resources, but you don't have Medicaid, you may qualify for extra help that may pay for about 95% of your drug costs. Visit **Extra Help for People with Limited Income and Resources** <<http://www.medicare.gov>> for more information.”

“Because the way that Medicare drug coverage works depends on your current coverage, Medicare has specific information available to help you no matter what type of coverage you have. These resources include the CMS brochure *What Medicare Prescription Drug Coverage Means to You: A Guide to Getting Started* and the *Medicare & You 2006 Handbook* that you got in the mail this fall. You can get the brochure and other free Medicare publications by visiting <<http://www.medicare.gov>> or calling 1-800-MEDICARE. You should also look for and review information from your current insurer about how your current coverage will work with the Medicare prescription drug coverage.”

“To find out how much you can save with Medicare prescription drug coverage, visit the **Medicare Prescription Drug Plan Cost Estimator** at <<http://www.medicare.gov>>. This information is also available by calling 1-800-MEDICARE.”

## 2. Determining what matters most and reviewing plan options

“Once you decide that you want prescription drug coverage, think about what matters most to you. There are a range of plan options available, so you can focus on the kind of coverage you prefer. There are two ways you can get your Medicare drug coverage. You can add drug coverage to the traditional Medicare plan through a ‘stand alone’ prescription drug plan. Or you can get drug coverage and the rest of your Medicare coverage through a Medicare Advantage plan, like an HMO or PPO, that typically

provides more benefits at a significantly lower cost through a network of doctors and hospitals. No matter what type of plan you choose, you can choose a plan that reflects what you want in terms of cost, coverage and convenience.”

**Cost:** “What you pay for the coverage, including premiums, deductible, and payments for your drugs.”

**Coverage:** “What benefits are provided (like coverage in the ‘coverage gap’ and other coverage enhancements), which drugs are covered and the rules (like prior authorization) for getting those drugs.”

**Convenience:** “Which pharmacies are part of the plan and whether the plan has a mail-order option.”

“The Centers for Medicare & Medicaid Services has created an online resource, **Landscape of Local Plans**. This resource helps you find Medicare prescription drug plans by state or Medicare Advantage plans with prescription drug coverage by county. It lets you see the plans in your area that offer drug coverage, including basic information to help you find ones that meet your needs based on cost, coverage, and convenience.”

“Some of the features of the Medicare Prescription Drug Plan Finder are not yet available. These features will allow you to further personalize your search for a drug plan that meets your needs. These features will be available well before you can choose to enroll in a plan on November 15. Right now, it is important to get ready to choose a plan by making a note of the drugs you take, the coverage features most important to you, and any specific pharmacies you prefer to use. The Landscape of Local Plans is a good resource for finding out about the plans in your area.”

## 3. Choosing a plan

“Beginning on November 15, people with Medicare can choose a prescription drug plan. There are many ways to choose a plan. You may rely on advice from people you know or trust, or choose a plan you are already familiar with, or use the **Landscape of Local Plans** at <<http://www.medicare.gov>> to find a plan that meets your needs. All of the plan options must meet or exceed Medicare's standards for coverage, including coverage for medically necessary drugs.”



“If you want to make more specific plan comparisons based on what matters to you, you can get personalized information from the **Medicare Prescription Drug Plan Finder**. The Drug Plan Finder can be accessed at <<http://www.medicare.gov>>, or through a customer service representative at 1-800-MEDICARE, or through the many organizations working with Medicare to help people take advantage of the new drug coverage.”

“This is the first week that you can see drug plan data. Some of the features of the Medicare Prescription Drug Plan Finder are not yet available. These features will allow you to further personalize your search for a drug plan that meets your needs. These features will be available well before you can choose to enroll in a plan on November 15. Right now, it is important to get ready to choose a plan by making a note of the drugs you take, the coverage features most important to you, and any specific pharmacies you prefer to use. The Landscape of Local Plans is a good resource for finding out about the plans in your area to get ready to make a choice.”

“Once the Medicare Prescription Drug Plan finder is fully operational, it will help you to personalize your search for a drug plan, and look at a side-by-side, personalized comparison of up to three plans at a time so you can find one that meets your needs. This list of plans provides a view of important plan information so you can compare plans based on cost, coverage and convenience.”

**Cost:** “The Medicare Prescription Drug Plan Finder will show you a list of drug plans in your area, sorted by the plan with the lowest total cost for the drugs you take now. It can also help you narrow down the choices based on deductibles or premiums.”

**Coverage:** “The Medicare Prescription Drug Plan Finder makes it easy for you to see what kind of coverage each plan offers and it gives you personalized information on plans that might meet your needs based on the coverage they offer and their other features.”

**Convenience:** “The Medicare Prescription Drug Plan Finder can identify plans that are accepted by your preferred pharmacy and other nearby pharmacies, and plans that provide mail-order prescriptions. It will also help you if you aren't sure whether:

- You qualify for extra help paying for a Medicare drug plan,
- Your employer/union is continuing your current coverage with a Medicare subsidy, or
- You are already enrolled in a Medicare Advantage Health Plan or in a Medicare drug plan.”

#### 4. Enroll

“You can enroll in a plan starting November 15. Medicare will have an online Enrollment Center available on that date at <<http://www.medicare.gov>>. You can also enroll by calling the plan's toll free number, by mailing in an application to the plan, or by visiting the plan's website. Coverage begins January 1, 2006, if you join a plan by December 31, 2005. The deadline to enroll to get coverage next year is May 15, 2006.”

**Other important information:** “If you work on behalf of a group of people with specific drug needs (like people with Lupus), Medicare has another tool that can help you. The Formulary Finder lets you enter a typical combination of drugs used by people with a certain condition to find out which plans in an area have formularies that cover these drugs.”

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### Wisconsin's Part D Helplines

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The following information is from the Coalition of Wisconsin Aging Groups' Elder Law Center, in partnership with the Wisconsin Medicare Part D Taskforce at <http://www.wismedrx.org/consumerinfo>

“Medicare Part D is a confusing and complex new program. You can get help with prescription drug coverage questions, choices and concerns by contacting one of the helplines listed below.”

#### Wisconsin Prescription Drug Helpline for Medicare Beneficiaries

Toll-free: 866-456-8211 Fax: 608-224-0607  
Email: [wismedrx@cwag.org](mailto:wismedrx@cwag.org)

“The Wisconsin Prescription Drug Helpline is a toll-free information line that provides free counseling to all Wisconsin Medicare beneficiaries (regardless of age or income) on prescription drug coverage options in Wisconsin, including Medicare Part D.”

### **Wisconsin Coalition for Advocacy Disability Drug Benefit Helpline**

Toll-free: 800-926-4862 Fax: 608-267-0368  
(Translation services and TTY available.)

“Medicare beneficiaries under age 60 can contact the Wisconsin Coalition for Advocacy’s Disability Drug Benefit Helpline Medicare Part D assistance.”

### **Medigap Helpline**

Toll-free: 800-242-1060 Fax: 608-246-7001  
Email: BOALTC@lhc.state.wi.us

“The Medigap Helpline provides information about health insurance - primarily Medicare Supplements, Long Term Care Insurance, and other health care plans available to Medicare beneficiaries. Counselors at the Medigap Helpline can help you determine how Medicare Part D will affect prescription drug coverage provided by another insurance plan.”

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## **Rural Information Technology Update**

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From an American Hospital Association Press Release, “Hospitals are Embracing Information Technology: New Report,” 10/7/05; the report can be viewed online at: <http://www.ahapolicyforum.org/>.

“While 9 out of 10 hospitals are using or considering adopting health information technology (IT) for clinical uses, most hospitals, especially small or rural hospitals, cite cost as a considerable barrier to broader implementation, according to a new study released today by the American Hospital Association (AHA).”

“The results from more than 900 hospitals show that IT use falls along a broad spectrum, ranging from hospitals just getting started to hospitals using sophis-

ticated IT systems. While most are still in the beginning stages, the survey shows hospitals are making investments in IT, in large part, to make gains in the safety and quality of patient care. Some of the technologies and systems hospitals are using include bar coding devices, computerized physician order entry and electronic health records (EHR).”

“ ‘We have not fully tapped into IT's potential in the health care arena,’ said George Lynn, AHA chair and president of AtlantiCare in Atlantic City, N.J. ‘Other fields, such as banking, have embraced technology, helping to change the way we bank today. While the use of IT in health care is still in its infancy, hospitals recognize that IT can help them meet their mission of improving safety and quality. We need to move quickly to remove barriers to widespread IT use.’ ”

“Survey results suggest that the use of health IT in caring for patients is evolving as hospitals adopt specific technologies based on their needs and priorities. Factors such as hospital size and location are related to the level of use, as is a hospital's financial status.”

“Hospitals with the greatest use of IT had higher average margins, and those with positive margins use more IT. Among the hospitals surveyed, median amounts spent on IT in the last year included:

- More than \$700,000 in capital spending, or 15 percent of capital expenses, and
- \$1.7 million in operating costs, or 2 percent of operating expenses.”

“And hospitals remain committed to ongoing investment in IT. Those that reported the least amount of IT use plan on spending a greater share of capital on IT moving forward. Among surveyed hospitals, 53 percent reported sharing patient specific information with physician offices, laboratories and even school clinics to improve coordination of care.”

“ ‘Today, I can send and receive emails from virtually anywhere in the world. But if I need treatment outside of my doctor's office, it could take hours or days for my health records to catch up to me,’ said Lynn. ‘With many hospitals struggling financially and facing severe capital restraints, we need major investment in IT from both the public and private

sector. And we need a common set of standards so different computer systems can talk to one another within a hospital as well as from New Jersey to Arizona. Ultimately, the goal is a system that improves care and quality for patients.’ ”

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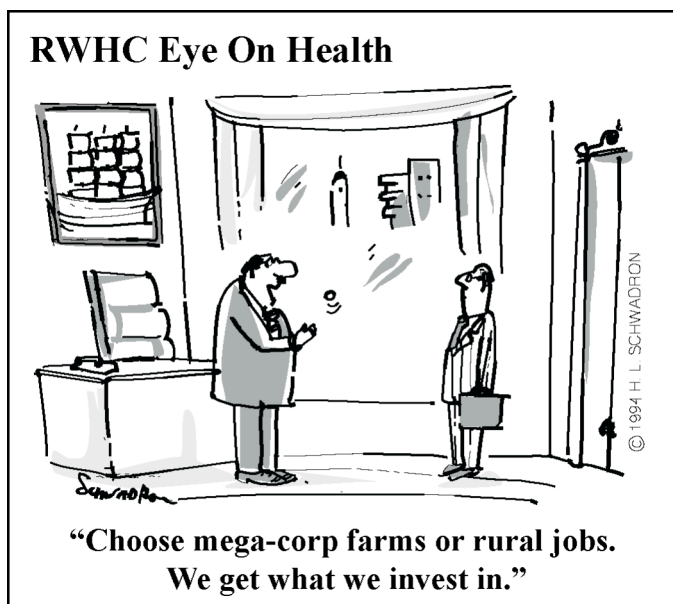
## Congress & Rural Policy Makers Listening?

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From “Are Farm-Policy Makers Listening?” by Thomas D. Rowley, 9/20/05:

“In preparation for the 2007 farm bill, the Secretary and other USDA officials have already been to some 20 states on a national listening tour offering citizens the chance to comment on farm policy. That’s all well and good. The folks in Washington ought to listen to the folks on the ground. But if history is any indicator, one important truth won’t make that long obstacle-strewn journey from the ear to the brain to the pen of policymakers: agricultural policy is not the same thing as rural development policy.”

“Indeed, in the 17 years that I’ve now been tracking rural policy, two things have remained absolutely constant: 1) analyst after analyst making the case that desirable as it is, helping farmers does not necessarily help the rural economy and 2) policymaker after policymaker ignoring that case. I can’t count the number of times I’ve heard the refrain, ‘Give me ten-dollar-a-bushel corn and I’ll give you rural development.’ ”



ment.’ ”

“Not surprisingly then, federal spending aimed at rural America goes overwhelmingly into agricultural payments. The last farm bill—ironically if not deceptively named the Farm Security and Rural Investment Act of 2002—directed a whopping 82 percent of its funds to farmers and a paltry 0.7 percent to rural development initiatives. That farm bill, like others before it, assumed that raising farm income would promote rural economic growth. It, like previous farm bills, was wrong.”

“Don’t believe me? Ask the Kansas City Federal Reserve Bank.”

“According to a recent study by Mark Drabenstott, bank vice president and director of its Center for the Study of Rural America, farm payments fail to boost the rural economy in counties most dependent on them. The payments don’t promote job growth, prompt new business establishment or stem population decline. Sometimes the payments even hurt those counties. Twenty-one percent of the 783 counties dependent on farm payments lost jobs from 1992 to 2002. Nearly 60 percent lost population.”

“ ‘In short,’ writes Drabenstott, ‘farm payments are not yielding robust economic and population gains in the counties where they should have the greatest impact. If anything, the payments appear to be linked with subpar economic and population growth. To be sure, this quick comparison cannot answer whether growth would have been weaker in the absence of the payments. Still, farm payments appear to create dependency on even more payments, not new engines of growth.’ Why?”

“According to Drabenstott, the payments promote consolidation of farms by rewarding the low-cost production of corn, cotton, rice, wheat and dairy. To produce these commodities at low cost, farmers have to take advantage of economies of scale. They have to get big or get out. That means fewer farms, which in turn ‘means fewer jobs for all associated businesses—from implement dealers to bankers.’ ”

“In spite of all that, cutting commodity payments is a tough sell in rural America. Folks there know that a bird in the hand is worth two in the bush and that 82 percent is a whole heck of a lot more than 0.7 per-

cent. They know too that money saved from cuts in commodity programs isn't going to end up in rural development programs—non-farm rural interests just don't have the political muscle to make that happen. As evidence, a July poll conducted for the W.K. Kellogg Foundation shows that nearly two-thirds of voters in Iowa, Kansas and Minnesota oppose cuts to commodity subsidy programs. Interestingly enough, however, they do support capping payments at \$250,000 per farm, perhaps in recognition of the destructive consolidating tendencies of larger subsidies. They also oppose cuts in rural development, nutrition and conservation programs.”

“So, while the path to moving money from commodity payments to rural development investments remains unclear, it is now clear—if it hasn't been for years--that the former are no substitute for the latter.”

“As Drabenstott puts it, ‘If sustaining rural economic growth remains a primary goal [of farm policy], then new policy instruments must be found. Traditional programs simply do not provide the economic lift that farming regions need going forward. While society

may continue to have a separate goal of lifting farm income, funds spent there can no longer be expected to spur broader growth in the rural economy.’ ”

“Is anybody listening?”

*Previous columns by Thomas D. Rowley, a Fellow at the Rural Policy Research Institute (RUPRI) may be found at <<http://www.rupri.org/editorial>>. RUPRI provides objective analysis and facilitates public dialogue concerning the impacts of public policy on rural people and places.*



**National Rural Health Association's  
2006 Rural Health Policy Institute**

will be held February 27 - March 1, 2006 at the Grand Hyatt in Washington, D.C. Rural health advocates face a number of renewed threats over the next couple of years. Please put this meeting on your 2006 calendar of must participate events.

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