

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

## Payers Not Waiting for “Healthcare Reform”

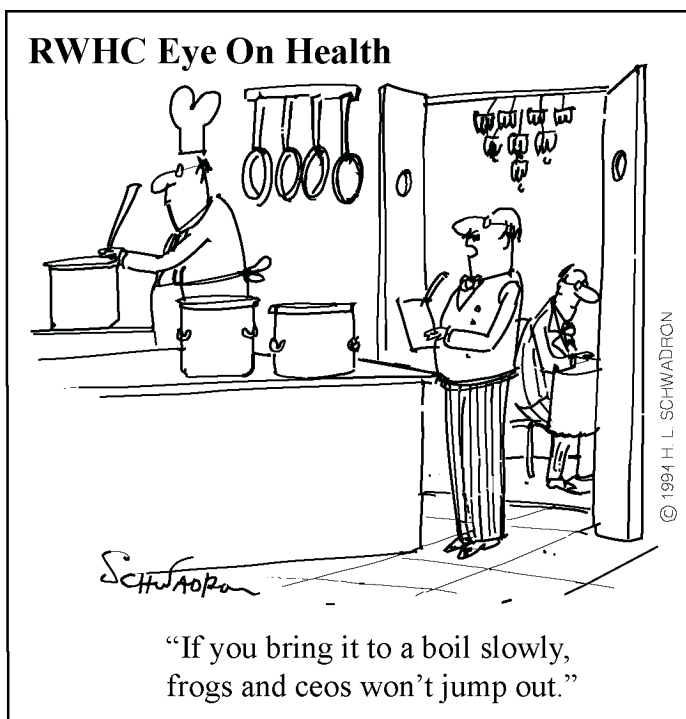
From “Financial Fitness Test: 10 ways to get in shape for a new payment era” by Chris Serb in *Hospital & Health Networks Magazine*, 6/06 ( the full article is available at <http://www.hospitalconnect.com> ):

“More than a decade ago, Harvard Business School professor Regina Herzlinger predicted a revolution in health care toward a consumer-based model, with greater choice, ‘focused factories’ of provider teams, flexible insurance products and widely available information on quality and cost. Many dismissed her ideas, and Herzlinger herself delayed publication of her award winning book, *Market-Driven Health Care*, until after the heyday of HMOs, whose gatekeepers, top-down management and tight networks seemed the antithesis of consumerism.”

“Now some of the trends that Herzlinger foresaw are emerging, and they could have a profound effect on how hospitals get paid for the services they deliver. Insurers have eagerly added one consumer-oriented tool, the health savings account, to their portfolios since they were introduced two years ago. Payers increasingly reward providers who rate highly on quality measures and penalize those who don’t.

Medicare now withholds some payments from hospitals that fail to report quality measurements, is tinkering with pay for performance and is overhauling diagnostic related groups (DRGs) to more accurately reflect cost and case severity.”

“ ‘We need to keep moving toward paying for quality, toward paying for keeping overall costs of health care down, toward paying for more personalized health care. In many ways, that hasn’t been the case in our programs,’ Centers for Medicare & Medicaid Services Administrator Mark McClellan said at the American Hospital Association’s annual meeting in April. While he was referring specifically to government programs, he very well could have been describing a new world order—increased accountability, lower costs, more consumer control.”



“It’s too early to judge whether these trends constitute a true revolution, but as they converge, millions of dollars in hospital payments could be at stake. Hospitals and health systems must prepare now if they stand any chance of making the trends work to their advantage and not against them.”

“CMS also plans what the American Hospital Association and others describe as the most significant changes to the inpatient prospective payment

system since it began in 1983. CMS proposes replacing its 526 diagnostic related groups with 861 DRGs that are more refined for patient severity, eliminating the proverbial ‘profitable’ Medicare patient, as well as the practice of ‘cherry-picking’ healthier patients that is often associated with specialty facilities. Also, starting this October, DRGs would reflect actual costs instead of charges, reducing hospitals’ ability to cost-shift.”

“ ‘This is important and it’s urgent,’ McClellan declared during his speech. ‘Discrepancies between what we pay and what it costs create inappropriate incentives for promoting certain kinds of procedures over others.’ ”

“Amid these changing payment trends, hospitals and health systems need to stay ahead of the game, to make sure they get rewarded for quality and don’t get penalized by potential bad debt. *Hospitals & Health Networks* spoke with several health care finance and policy experts, who recommended strategies to help hospitals continue to thrive.”

**1. Follow the quality ‘road map’**—“Some hospitals grumble that pay for performance carries heavy administrative burdens, interferes with the way doctors normally practice and only measures processes rather than true outcomes. Each complaint may have merit. However, pay for performance also provides a clear picture to hospitals that want to earn rewards.”

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.

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**2. Treat your patients like customers**—“With the expansion of high-deductible plans, patients are expected to be choosier about where they spend their health care dollars, especially the portion that falls under the deductible.”

**3. Get ready for pricing transparency**—“As consumers foot the bill for more of their own health costs, they’re becoming increasingly savvy shoppers. And they want to know just how much they’ll pay for the health care they receive.”

**4. Anticipate what might be measured in the future**—“Even if your market hasn’t yet been touched by pay for performance, existing measurements in Medicare’s demonstration projects or in private payer programs are good predictors of what you should expect. They should also be good indicators of slightly different or more sophisticated processes that payers will use a couple of years down the road.”

**5. Get good at basic process measurements**—“Pay-for-performance quality measurements currently track processes that should lead to positive outcomes, but don’t track the outcomes themselves. That’s not surprising, since coherent and comprehensive outcomes measurement is still a vague goal for most institutions. Outcomes measurements are coming, though, and hospitals had better be prepared. Pay for performance will be more linked to outcomes, because that’s what consumers want. They don’t want to know if you gave a beta blocker; they want to know if your patients get better.”

**6. Anticipate more comprehensive reporting**—“While these measurements will take some time to define and develop, it’s never too early to start tinkering. ‘Hospitals need to be thinking about where measurement sets are going in the future,’ says Janet Corrigan, president and CEO of the National Quality Forum. ‘They need to anticipate some of the more comprehensive reporting requirements, and figure out what they need to do to comply with those requirements.’ ”

**7. Take more sophisticated approaches to charity care**—“With patients paying higher expenses up front, many will be less able to cover their deductibles at the point of care. While HSA backers contend that most patients will have mechanisms like health

care debit cards to cover those expenses, hospitals worry that bad debt will soar as more consumers are asked to dig into their pockets.”

**8. Share your ideas on quality**—“Most pay-for-performance programs are at an early stage, and payers seem fairly willing to adapt at this point. ‘This is an area where there’s tremendous innovation and creativity,’ Corrigan says. ‘If pay for performance structures in a way that’s not working for you, propose a different approach. Hospitals have an important role in shaping where this is going to go.’ ”

**9. Prepare for Medicare changes, but don’t over-commit**—“Ever since DRGs were introduced in 1983, Medicare has been an increasingly volatile payer: initially generous for many conditions, increasingly stingy during mid-1990s balanced-budget negotiations, then alternately loosening and tightening the purse strings ever since. In theory, the upcoming DRG changes and cost-based reimbursement will balance out some inequities in payments. Facilities that ‘cherry-picked’ by focusing narrowly on profitable patients could lose, while rural hospitals and hospitals that deal with more severely ill patients could make out OK financially.”

**10. Embrace, and lead, the emerging trends**—“As with most changes, emerging payment trends will lead to their fair share of grumbling, complaining and resistance. And that’s OK, but it doesn’t absolve hospitals from the need to prepare for these changes. The sooner hospitals adapt, the better—not only by getting their share of the changing payments more quickly, but by earning caché as innovators with both consumers and payers.”

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## Feds Need to Invest in Traditional Medicare

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From “Defining a Future for Fee-For-Service Medicare” by Susan Bartlett Foote and Gwen Wagstrom Halaas in *Health Affairs*, May/June, ‘06:

“The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) provides economic incentives that favor health plans over traditional fee-for-

service (FFS) Medicare. This reflects an ideological preference for private plans rather than government-administered pricing and recognition that private plans can use tools effectively to improve quality. However, enrollment projections indicate that FFS will continue to attract the majority of beneficiaries for years to come. We argue that MMA’s Medicare administrative contractors, or MACs reform provisions create the opportunity to build critical FFS infrastructure, and contractors have the potential to encourage quality and manage utilization to compete with private plans in a modernized Medicare.”

**Data coordination, analysis, and reporting.** “Contractors could be the data repository for information about each region’s health plans and FFS providers. The CMS does not routinely publish Health Plan Employer Data and Information Set (HEDIS) measures for FFS providers. All existing and potential comparative data could be aggregated and analyzed at the regional level. This data repository could become the foundation for measuring performance. Contractors analyze claims data as part of the claims processing function but are not expected to aggregate the data and report them to the CMS, providers, or the public.”

**Regional quality improvement.** “Contractors could move beyond data gathering and analysis to an active role in improving population health. For example, the most costly Medicare patients are elderly people with multiple chronic conditions. Repeated hospitalizations for the same condition result in high costs and are preventable. These costs are higher in areas with reduced access to primary care. Contractors could encourage and reward practices that achieve high rates of flu shots, ensure the selection of a primary care physician, or reduce repeat hospitalization rates for certain chronic conditions.”

“Contractors could provide a ‘managed care’ function for the FFS providers in the region through the use of evidence-based guidelines and incentives to follow them. They could encourage competition and selection based on quality by publishing benchmark data for providers demonstrating the most cost-effective care with good outcomes. In turn, the CMS could reward contractors that demonstrate improvements in care, using bonus payments and other recognition.”

**Role in demonstration projects.** “In 2000, Congress authorized a project whereby Medicare would reward selected large group practices that improve outcomes measured against performance in the community. MMA mandates similar demonstrations to encourage quality improvements such as disease management. In many regions, the fragmented and highly competitive FFS providers are not well positioned to participate. Contractors could coordinate participation among smaller provider groups, encourage the use of evidence-based resources, and assist with data collection and evaluation.”

**Manage competition between FFS and private plans.** “The Medicare Payment Advisory Commission (MedPAC) has noted that giving beneficiaries the right to choose between FFS or a health plan, if properly structured, keeps the pressure on both options to perform. The challenge is to design the proper structure for both choices. Contractors could play a role in raising the bar for both sides of the Medicare program.”

“MedPAC has noted that for the two models to compete fairly, there must be fiscal neutrality between them. Paying private plans more than FFS ‘encourages inefficiency and contributes to the increased overall spending for the Medicare program.’ The current payment formulas favoring private plans violate the principle of neutrality and will hinder fair and effective competition. In addition, the CMS should encourage competition between FFS and health plans in terms of outcomes and quality.”

“It seems clear that the CMS does not envision competition between the two delivery models: It drew inconsistent regional divisions based on different rationales for the new preferred provider organizations (PPOs) and the MACs. Although the future of PPOs in the program is unclear, if the CMS had seen FFS as a competitive option, compatible regions would have been essential. We recommend that the CMS reconsider the regional and fiscal design to allow FFS and MA to truly compete.”

**Invest in FFS infrastructure.** “Congress appeared willing to invest in and, some would argue, overpay health plans to encourage participation. We hope that private plans, in turn, will be required to provide evidence of increased value to Medicare. We suggest

that additional investments in FFS would likely have major long-term economic and quality benefits. The CMS should raise the bar for performance for both health plans and traditional FFS Medicare.”

“Secretary Leavitt recently called Medicare FFS ‘a premier health plan that allows for comprehensive, quality care and world-class beneficiary and provider service.’ Those are admirable goals, but they are not a current reality. In fact, some decisions, such as private plan overpayment and divergent regions, raise questions about the administration’s long-term support for FFS Medicare. With appropriate reforms, however, FFS Medicare can assume its rightful place as an important option for beneficiaries in the future. An expanded role for contractors, the low-key workhorses of the Medicare program for many years, could make Leavitt’s vision a reality.

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## Strong Rural Communities: Made Not Born

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by Tim Size, RWHC Executive Director:

“Businesses will move to where healthcare coverage is less expensive, or they will cut back and even terminate coverage for their employees. Either way, it’s the residents of your towns and cities that lose out”—Thomas Donohue, President & CEO, U.S. Chamber of Commerce. “If we can change lifestyles, it will have more impact on cutting costs than anything else we can do”—Larry Rambo, CEO of Humana’s Wisconsin and Michigan health insurance markets.

Wisconsin is listening. Among others, the State’s Rural Health Development Council (RHDC), embedded in the Wisconsin Department of Commerce, is taking up the challenge. RHDC works to link rural health and community development, is appointed by the Governor, confirmed by the Senate, and staffed by the Wisconsin Office of Rural Health.

This year, RHDC has acquired major funding for its Strong Rural Communities Initiative from the Healthier Wisconsin Partnership Program, Wisconsin’s Rural Hospital Flexibility Program and the Robert Wood Johnson Health & Society Scholars Program.

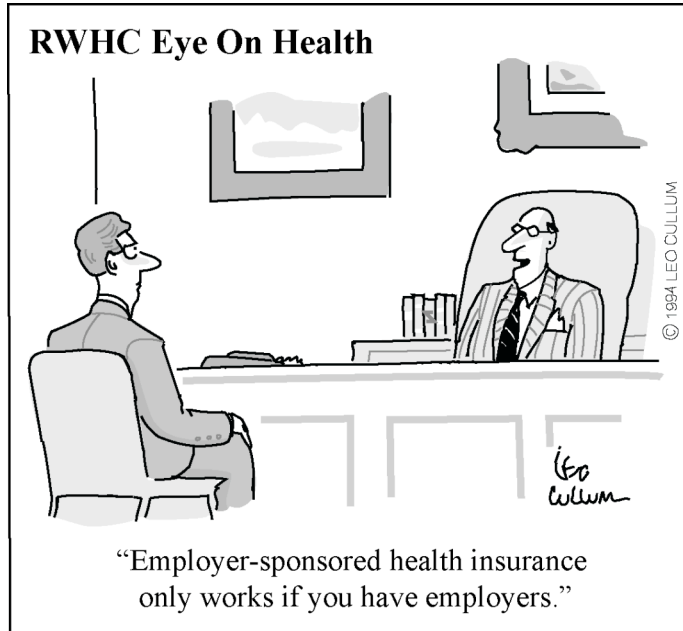
The goal of this initiative is to improve the health status of rural communities and reduce healthcare cost inflation by significantly accelerating the use of sustainable models for collaboration among medical, public health and business organizations that enhance preventive health services in rural Wisconsin.

Through a statewide competitive process, RHDC chose six local community projects from among 22 grant proposals. They are located in Jackson, Langlade, Manitowoc, Sauk, Sawyer and Waupaca Counties. The six projects use a variety of approaches that are intended to reduce the incidence of lifestyle related chronic diseases—for example, modifying poor fitness and nutrition habits through wellness programs at work and in the community.

RHDC believes that rural businesses and employees constitute a major subset of the community who in partnership with public health and the medical community, can significantly accelerate a community's overall acceptance/demand for prevention services.

The University of Wisconsin School of Medicine and Public Health (UWSMPH) and the Medical College of Wisconsin (MCW) have a history of sharing information and working in a parallel and supportive manner. However, the complexity of creating a Healthy Wisconsin requires a higher level of cooperation.

Just as the Strong Rural Communities Initiative is bringing together community sectors that traditionally have not worked closely together, the Center for Healthy Communities at MCW and the Wisconsin Office of Rural Health at UWSMPH are creating a new partnership. Faculty are actively working together along with representatives from the communities to developing the local interventions, and all participants are learning to create a statewide framework for effective long-term community-academic partnerships.



RHDC has begun to address a variety of related public and private policy questions. How can public, private and voluntary sectors most effectively promote the need for collaboration among rural medical, public health, and business partners to increase access to local preventive health services? What are “best practices” for community collaboratives focusing on preventive health services? What are the advantages and disadvantages rural communities face, com-

pared to urban communities when developing these multi-sector collaborative approaches?

RHDC has brought together six local community projects, two medical schools and a statewide policy council with the potential to improve the health of 1.7 million rural Wisconsin residents. This is just a start, collaboration for prevention must become the norm, not the exception, across Wisconsin. Our state's health, both of its people and its economic competitive position, depends on it.

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## It Takes a Community

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From “It Takes a Community, Rural hospitals may have an edge in improving population health” by Jessica Zigmond in *Modern Healthcare*, 6/12/06:

“As the federal government pushes the health-care industry to adopt pay-for-performance, rural hospitals could have an advantage over their urban counterparts in one area: working collaboratively to improve the overall health of their community populations. ‘Pay-for-performance is a payer-driven initiative,’ says Tim Size, executive director of the Rural Wisconsin Health Cooperative, Sauk City. ‘We’re in a reactive mode, and haven’t had anything to react to yet,’ he says of rural hospitals.”

“Terry Hill, executive director of the Rural Health Resource Center in Duluth, Minn., says one of his organization’s goals is to educate rural hospitals on this issue. ‘There is no question that this is where the federal government is going,’ Hill says. ‘What we’re trying to tell rural hospitals is you have to develop capacity to measure your information and get ready for pay-for-performance.’ ”

“As rural hospitals learn more about traditional pay-for-performance initiatives, they might consider a concept that was introduced in the spring 2006 edition of the *Journal of Rural Health* and discussed at the National Rural Health Association conference in Reno, Nev., in May. Rural hospitals, with their well-established communitywide relationships, could lead efforts to involve other community players such as local businesses, clinicians, schools and employers in improving a population’s overall health.”

“The article emphasized that ‘the issue is not whether or not rural hospitals should be in charge, but whether or not rural hospitals have a collaborative leadership role to play.’ David Kindig, one of the article’s three authors, says factors besides healthcare are needed to keep a community healthy.”

“ ‘Ten years ago, most people were still in the mode of thinking that healthcare is the most important determinant,’ says Kindig, who serves as professor emeritus of population health sciences at the University of Wisconsin School of Medicine and Public Health. ‘The social factors, like education, income and individual behaviors could be right up there with medical care in terms of their impact on health outcomes.’ ”

“Kindig acknowledges that ‘the jury is still out’ on how well this concept will work, especially given that connecting different sectors in the community is not an easy task. ‘You really need people talking to each other from the school board, the community board, and the county board on maximizing the balance of the portfolio across these sectors for population health improvement.’ ”

“Hilda Heady, executive director of the West Virginia Rural Health Education Partnerships-Area Health Education Centers, says it is possible for rural hospitals to work with other members in the commu-

nity to improve a population’s health. The purpose of Heady’s group is to help retain West Virginia-trained health science graduates in underserved rural West Virginia by creating partnerships with the community, higher education, providers and government.”

“ ‘Rural communities are very accustomed to having to collaborate with limited resources,’ Heady says. If applicable, rural hospitals should link with the higher education institutions in their states, Heady says. In West Virginia, medical students in state-supported schools are required to complete three months of their training in any discipline in a rural community. ‘When you look at resource-limited communities, you don’t have the luxury of thinking in silos,’ Heady says. ‘You have to collaborate to survive.’ ”

“Size, who served on the Institute of Medicine’s Committee on the Future of Rural Health, worked on a report that culled the six quality aims the IOM introduced in its publication *Crossing the Quality Chasm* in March 2001. Those aims—safety, effectiveness, patient-centered care, timeliness, efficiency and equity—can also be applied when trying to improve rural health, where the entire community is seen as the patient (consequently, the committee changed ‘patient-centered’ to ‘community-centered’). Size says community leaders in business, faith organizations, public education and local government can work collaboratively to improve the overall health of a community.”

“Size, Kindig and third author, Clint MacKinney, outlined steps for rural hospitals to start promoting population health awareness and to establish collaborative efforts, such as adding board members with interests or expertise in population health measurement and improvement, including public health professionals, educators and economic development experts. Hospitals can also devote a periodic board meeting or a portion of every meeting to review available population health indicators, and create a ‘population health’ subcommittee of the hospital board to explore opportunities for hospital partnerships with other community organizations.”

“ ‘Health status is overwhelmingly not a function of healthcare but of (individual) behaviors and socioeconomic conditions,’ Size says. Bruce Behringer, assistant vice president for the division of health sci-



ences at East Tennessee State University, Johnson City, supports the idea, says hospitals have both an economic interest and social responsibility in a community. 'If in fact a hospital in a rural community—which is typically the largest employer—can take the benefit from being funded by tax dollars, there should be some sense of relationship between what happens in the quality of that hospital and the community,' Behringer says."

Prairie du Sac - **Pam Schreiner, R.N.**

Richland Center - **Mary Gillingham**

Ripon - **Delena Chappell-James**

Stoughton - **Joyce Williams**

Tomah - **Jan Path**

Viroqua - **Julie Steiner**

Whitehall - **Asher Niazi, M.D.**

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## RWHC '06 Rural Health Ambassador Awards

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The Rural Wisconsin Health Cooperative has presented its 2006 Rural Health Ambassador Award to fourteen individuals from across the state. The award recognizes health care employees at RWHC hospitals who have gone above the call of duty in promoting their respective organizations, while making significant contributions to rural health.

Each of the following recipients demonstrated a history of fostering positive communication and relations within their hospital's respective service area by: serving on community boards and service organizations; taking advantage of volunteer or public speaking opportunities; and supporting community health activities beyond the scope of the hospital.

The 2006 RWHC Rural Health Ambassadors are:

Baraboo - **Keri Olson**

Columbus - **Greg Tiedt**

Dodgeville - **Claire Holland**

Hillsboro - **Cory Frederick**

Medford - **Ron Bohn**

Monroe - **Kris Wisnfske**

Prairie du Chien - **Diane Koth**

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## A Real Wisconsin Rural Health Hero

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Ray Myers, Assistant Administrator, St. Joseph's Hospital, Chippewa Falls was honored by friends and colleagues at Wisconsin's Rural Health Conference. Ray and St. Joseph's Hospital in Chippewa Falls have demonstrated exceptional commitment to their community in a highly collaborative fashion.

Ray and St. Joseph's Hospital in Chippewa Falls were recognized for the exceptional commitment Ray has made, and the institution has supported, to address the protracted and growing oral health disparities between those with financial means and those without.

Ray has been an active leader in the statewide oral health coalition, helping to raise awareness and support policy options to address this growing problem. Ray is a self-effacing, effective, hardworking guy who really deserves this recognition.

While these efforts in and of themselves deserve recognition, Ray's untiring and dogged dedication to solve the oral health access problems for his city, his county, and surrounding area makes him our Hero.

### RWHC Eye On Health



Dental Association's Worst Nightmare:  
Hygienists and Barbershops Join Forces

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## The RWHC 2006 Monato Essay Prize Winner

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The Rural Wisconsin Health Cooperative (RWHC) Monato Essay Prize for 2006 went to Terese Gierach, who is majoring in physics at the University of Wisconsin—Eau Claire for her essay, “Why Do You Work Here? Intrinsic Benefits of Working in Rural Health Care.” Terese is considering a career in Medical Physics; her paper is available at:

<http://www.rwhc.com/Papers/Monato-2006.pdf>

“One of the first days that my mom was working as a night shift nurse in the emergency room at Our Lady of Victory Hospital (OLVH) in the small town of Stanley, my uncle, who was the lead ambulance worker for over forty years, didn’t expect to see her when he came through the doors with a patient.”

“ ‘Why on Earth would you want to work here?’ he asked in surprise, knowing that she had come from formerly working at a prestigious clinic in a nearby

city. He just couldn’t understand her desire to move to a rural community and work at a small critical access facility. I, however, could.”

The Essay Prize, established in 1993, is open to anyone who has been a student at the University of Wisconsin (UW) within the preceding year (all campuses, programs, graduate, under graduate, part-time, non-degree included.) The competition was established to honor the memory of Hermes Monato, Jr., a December 1990 graduate, as well as to highlight the importance of rural health. Hermes worked at RWHC for only a few years but his infectious spirit and creative mind left rural health an enduring legacy.

Information for the 2007 Competition can be found at ( <http://www.rwhc.com> ). The prize is awarded based on a blinded review and a consensus among two judges from the UW and one judge from RWHC.

The award recipient receives a check for \$1,000 paid from a fund established at the University of Wisconsin by RWHC, family and friends of Hermes.

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