

For Better or Worse, ACOs New HMOs

According to the American Academy of Family Physicians, an Accountable Care Organization (ACO) is “an integrated health care delivery system that relies on a network of primary care physicians, one or more hospitals, and subspecialists to provide care to a defined patient population. Under the model, hospital and physician networks would be responsible for the quality of care delivered to patients and would receive bonuses for providing high-quality, low-cost care. It’s also possible that penalties would be levied for delivering low-quality, high-cost care.”

The Centers for Medicare and Medicaid Services (CMS) asked for comments to their proposal rules for ACOs. RWHC’s complete response to CMS is available at www.rwhc.com.

“ACOs will fundamentally change how Medicare beneficiaries, providers, private health insurance plans and CMS relate to and work with each other. There is the potential for good but as these relationships change, there is also the potential for a real and significant risk to beneficiaries’ access to local care and to the ability of rural hospitals and doctors to provide local services.”

“RWHC has more experience with ACO-like entities than most rural provider coalitions given Wisconsin

healthcare’s long history of integrated and coordinated care. RWHC started and operated a rural based health plan in the 1980s. Of our thirty-five members, fourteen are now members of a health care system and twenty-one remain independent; to various degrees they all work with multiple payers and medical groups.”

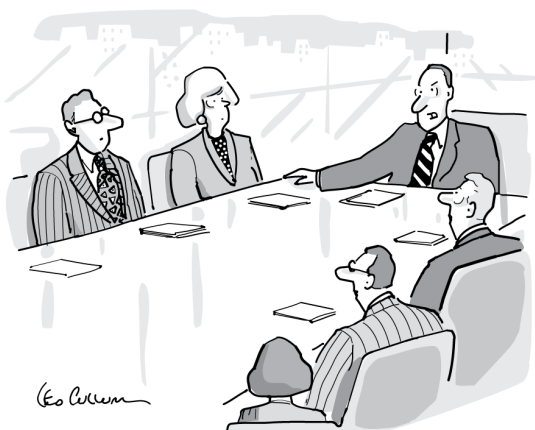
“First and foremost, we believe CMS must assure that ACOs recognize the uniqueness of health care in rural communities. Unlike most urban communi-

ties, there are usually not enough providers to support multiple ACOs having closed provider networks competing with each other. But many rural communities are located in areas that will have the potential for overlapping ACOs with multiple urban-based networks. To retain local access, rural communities will need local providers to be able to offer their services to these multiple ACOs. CMS will need to develop criteria that support this approach by allowing both affiliated and independent local rural providers to participate

in multiple ACOs and requiring ACOs to meet strong access standards.”

“CMS and Wisconsin have previously dealt with the issue of access in the context of managed health care regulation. Wisconsin Statute 609.22 requires health plans (with closed provider networks) to respect ‘...normal practices and standards in the geographic area,’ and Wisconsin Insurance Code 934(2)(a) requires, with respect to managed care plans, ‘geo-

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“Congress unilaterally excludes rural hospitals from the most significant proposed innovation in a generation and expects us to be grateful.”

graphical availability shall reflect the usual medical travel times within the community.’ The current CMS language for Medicare Advantage (MA) plans is similar and noted later in our comments.”

“Secondly, CMS must recognize that ACOs have the potential to destabilize the existing rural safety net with or without Critical Access Hospital (CAH) participation. Once we are beyond the initial CMS gain-sharing pilots, it is not known whether or not ACOs will be required to honor existing Medicare rural add-on payments for safety net providers such as CAH and Rural Health Clinics.”

“In the future, some are saying, regional ACOs should be able to negotiate payment rates with local rural providers and that they will be permitted to do so at levels below the rates the providers currently receive under Medicare. This is a process that seems to favor the ACO plans, particularly in rural areas where providers may have little managed care type contracting experience and little or no negotiating power. It would probably be most evident in those areas where ACOs may be able to steer patients to other contracted providers. Under traditional Medicare, many rural providers receive special payment rates to reflect the various financial challenges of providing health care in rural areas. There is a concern that ACOs will not recognize these targeted rural special payments that have been part of stabilizing

the rural safety net and have provided quality healthcare to Wisconsin residents.”

“Wisconsin’s healthcare model has worked well; according to the Dartmouth Atlas, Wisconsin was more than 15 percent below the national average in total Medicare reimbursements per enrollee in 2006. In addition to Wisconsin hospitals being a leader in the quality movement, it was ranked in the top two states for quality by the Agency for Healthcare Research and Quality in each of the last three years.”

“RWHC supports the five guiding principles that the National Committee for Quality Assurance (NCQA) ACO Task Force set forth, the ACOs must: have a strong foundation of primary care; report reliable measures to support quality improvement and eliminate waste and inefficiencies to reduce cost; be committed to improving quality, improving patient experience and reducing per capita costs; work cooperatively towards these goals with stakeholders in a community or region; and create and support a sustainable workforce.”

“We would strongly echo the need to strengthen the country’s primary care workforce and make sure that the primary care workforce is adequately stocked in rural America. RWHC has been outspoken at state and federal levels on the need to improve the healthcare workforce in rural areas. Without a strong rural healthcare workforce, residents will not be able to receive care in a timely and convenient manner (a preference that has been well-documented) and the ACO model will not be successful.”

Organization of ACOs–“CAHs act as a valuable safety-net provider for more than 1200 communities across the county and almost 60 communities in Wisconsin. It is important to make sure that all rural hospitals are allowed to fully participate in ACOs. **Under the Patient Protection and Affordable Care Act (PPACA), CAHs are currently not included in the CMS ACO demonstrations for purposes of sharing in the cost savings and presumably governance.**”

“CAHs, along with rural Prospective Payment System (PPS) hospitals, should be full participants within any ACO offering to serve enrollees in rural

Eye On Health is the monthly newsletter of the Rural Wisconsin Health Cooperative, begun in 1979. RWHC 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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community. If rural hospitals cannot become full participants in ACOs, the ACO model may quickly evolve into a mechanism of exclusion for local rural health care. Rural beneficiaries might end up in ACOs, which do not allow them to receive care available in their home community. Protecting access to local care must be a high priority. RWHC is fighting for a change in the interpretation of the applicable PPACA language for the Medicare demonstration ACO projects.”

“The enforcement of Community Access Standards is absolutely critical to prevent steerage of Medicare beneficiaries and inordinate leverage by Medicare ACO plans against rural providers. The current MA program statutes and regulations require CMS to ensure that plan enrollees have reasonable local access to covered services. It is hoped that CMS will use a similar standard for any ACOs with closed networks. If so, we would be concerned how CMS and ACOs will interpret what is “reasonable”—this is a critically issue for rural beneficiaries and providers as well as to the acceptance of MA plans in rural communities.”

“As stated in the CMS Medicare Managed Care Manual: ‘Plans must...ensure that services are geographically accessible and consistent with local community patterns of care.’ It is critical that CMS be clear and transparent about how it intends to apply this principle to Medicare’s initial and subsequent generation of ACOs.”

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Earn a \$2,000 Prize by writing the Best Rural Health Paper by a University of Wisconsin student. 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

Opponents Drinking Fluoridated Kool-Aid?

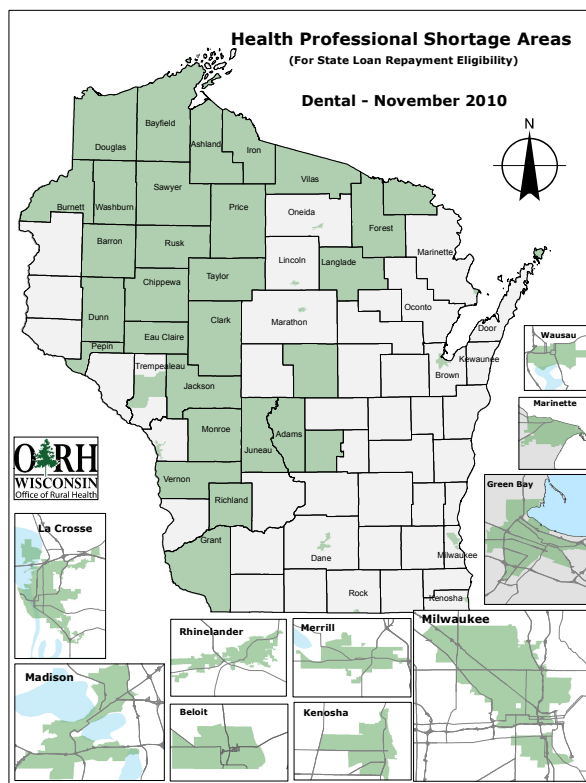
From “Marshfield Clinic affiliate gets state funds for dental program—Marquette slams action” by Guy Boulton in the *Journal Sentinel*, 12/16/10:

“An affiliate of Marshfield Clinic has secured a matching grant from the state by committing \$10 mil-

lion for a rural dental education program that would be the first step toward starting a second dental school in Wisconsin.”

“The State Building Commission voted 6-2 on Wednesday to release the \$10 million in matching funds despite opposition by the Wisconsin Dental Association and the Marquette University School of Dentistry.”

“ ‘If the state is going to invest in expanding dental education in Wisconsin, we would like them to invest in expanding our class and then having us produce more dentists,’ said William Lobb, dean of Marquette’s dental school.”



“The dental association and Marquette also contend the state grant was for an education center, not a dental school—though Marshfield Clinic’s interest in opening a dental school was well known before the state allocated the money.”

“The planned dental school would focus on training students who want to practice in rural areas. The students would receive their clinical training at the dental clinics run by the Family Health Center of Marshfield, a community health center affiliated with Marshfield Clinic.”

“Security Health Plan of Wisconsin, a nonprofit health insurance company affiliated with Marshfield

Clinic, committed \$10 million to the project with the goal of improving access to dental care in rural areas, said Steve Youso, the health insurer's chief administrative officer."

RWHC Social Networking:
The Rural Health Advocate: www.ruraladvocate.org/
Rural Health IT: www.worh.org/hit/

"Access to dental care is a long-standing problem for people covered by state health programs or those who are uninsured. 'We believe that this investment is going to help improve that situation,' Youso said."

"The planned dental school may not graduate its first class until a decade from now. And numerous obstacles remain such as recruiting faculty and seeking accreditation. Karl Ulrich, a physician and the president of the Marshfield Clinic, said that plans could change but that establishment of the school is the goal."

"Marshfield Clinic will start with a rural residency program for dentists who have just graduated. That will require recruiting faculty to teach at the school. 'This means we are well on our way,' said Greg Nycz, executive director of the Family Health Center of Marshfield, Inc."

"The Wisconsin Dental Association has noted that training more dentists will not change the economics of providing care to patients covered by state health programs. The fees paid by state health programs generally don't cover dentists' costs. As a result, many dentists don't accept or limit the number of patients insured by state health programs."

"Only about 2% of the total budget for BadgerCare Plus and Medicaid went to dental care in the fiscal year ended June 30. **Roughly one in four people covered by state health programs in Wisconsin received dental care in 2008, according to federal figures. Only one state—Florida—did worse than Wisconsin on that measure.**"

" 'My idea of a school from the start is this is a means to the end,' Nycz said. 'And the end is to ensure that all of the kids in the state get access to dental care.' "

"The dental association also questions the need for additional dentists—it contends that Marshfield Clinic proposed building a rural education center, not a school."

" 'They never said that this was automatically going to be a school,' said Gene Shoemaker, president of the Wisconsin Dental Association."

"Shoemaker acknowledged that Marshfield Clinic said that opening a dental school was a possibility and that Nycz talked about opening a dental school in stories before and after the money was allocated. But he said the association's impression was Marshfield Clinic would not work toward opening a school."

"Nycz and others with Marshfield Clinic dispute this. 'I can tell you that there's no doubt in their minds that we've been interested in a school from the start,' Nycz said. 'That was my goal from the start, and I didn't hide that from anybody.' "

Nursing Shortage: Calm Before the Storm

From "Don't be fooled: Demographics ensure nursing shortage will return with better economy" by Karen Cox, Susan Lacey and Rand O'Donnell in *Modern Healthcare*, 12/13/10:

"As the recession started to accelerate, registered nurses who had eyed retirement found themselves facing an unsure future. Spouses and partners lost jobs, and the value of nest eggs plummeted, causing many to postpone their planned retirements. This has created a false sense of security in the nursing workforce, specifically as it relates to lower turnover and increased retention. Nurses continue to be wary as the economy slowly edges toward recovery, albeit so far a jobless rebound. This amalgamation of events has many in healthcare leadership claiming the nursing shortage is officially over."

"Not so fast. This pattern of nurses working past retirement cannot be sustained, and here are the numbers:

National Rural Health Snapshot – 2010 www.shepscenter.unc.edu/rural/snapshot.html			
Access to Health Services			
	Rural % population	Non-Rural % population	Rural Rate Higher Than Non-Rural
No form of health coverage (age 18 - 64 years)	20.6	17.0	21.2%
Needed to see doctor but could not because of cost—past year	15.6	13.6	14.7%
No personal doctor	18.1	19.3	-6.2%
No dental care in previous year	35.6	28.3	25.8%
Health Behavior/Risk Factors			
	Rural % population	Non-Rural % population	Rural Rate Higher Than Non-Rural
Current Smoker	22.0	17.8	23.6%
Obese (Body Mass Index ≥30)	30.5	25.9	17.8%
Age - Adjusted Mortality			
	Rural per 100,000 population	Non-Rural per 100,000 population	Rural Rate Higher Than Non-Rural
All - cause	893.8	823.1	8.6%
Infant (age<1)	755.0	690.9	9.3%
Diseases of the heart	249.4	230.2	8.3%
Diabetes mellitus	27.6	24.6	12.2%
Chronic obstructive pulmonary disease (COPD)	49.0	42.2	16.1%
Unintentional Injuries (including motor vehicle traffic)	51.9	34.7	49.6%
Suicide	13.4	10.3	30.1%

- In an article in the *Journal of Nursing Administration*, it was stated that 33% of RNs are 50 years old and over—the baby boomers.
- The American Association of Critical-Care Nurses reports that half of RNs indicate their desire to retire within 15 to 20 years.”

“The pipeline for new nurses continues to be clogged by an aging nurse faculty that also is poised to retire,

according to the AACN. The average age of nursing faculty with master’s and doctorates is roughly 60 and 56 years old respectively. AACN also found that nearly 55,000 qualified applicants were not accepted into schools of nursing due to shortages of faculty, adequate clinical sites and other resources.”

“In his book *The Age Curve*, Kenneth Gronbach wrote that, compared to the baby boomers who are leaving the workforce, there are 9 million fewer Generation Xers, those born between 1965 and 1984. That represents an 11% decrease in potential nursing school applicants.”

“In nursing, the shortfall has been estimated by the Bureau of Health Professions to be close to 1 million. This number was calculated before passage of healthcare reform. We have now entered the uncharted waters of reform with a tsunami of anticipated newly insured patients now having access to healthcare goods and services at the precise time when these retirements will start to accelerate. Let’s look at the demand numbers to complete the supply-demand picture.”

“In the book *The Future of the Nursing Workforce in the United States*, Peter Buerhaus and colleagues report that the number of people over age 65 is estimated to increase by 127% between 2000 and 2050. By 2030, it is estimated that 71 million Americans (1 in 5) will be over the age of 65. According to the Institute of Medicine’s *The Future of Nursing*, the passage of healthcare reform will bring in an additional 32 million people as newly insured.”

“Between 2000 and 2020, the Health Resources and Services Administration projects a 73% growth in the demand for RNs employed in nursing homes and a 91% growth in home health. Between 2000 and 2020, HRSA also projects a 40% growth in the demand for RNs employed in hospitals and in nursing education. To meet the demand for RNs, HRSA officials estimate the U.S. must graduate 90% more nurses from nursing programs.”

“The Centers for Disease Control and Prevention estimates that up to 1 in 3 Americans may be diabetic by 2050, with diabetes being one of the highest lifetime usages of healthcare resources of all diagnoses.”

“So, what is a prudent hospital leader to do? You certainly cannot hire unless positions are open. You can tinker with nurse-to-patient ratios, but there are quality and patient satisfaction issues associated with those strategies. However, the visionary leader will understand this developing perfect storm and plan accordingly. The winners in the Nursing Shortage, Part 2, will implement the following strategies:

- Improve the work environment for nurses, using Magnet principles for which a strong business case has been made.
- Employ knowledge transfer workshops that allow RNs nearing retirement to share expertise before this major brain drain occurs in your organization.
- Implement phased retirement for older RNs as a way to keep them in the workforce longer.
- Work with older employees to transfer within the organization, yet away from the physical demands of direct patient care, allowing them to use their extensive clinical expertise.
- View nurses as valued professionals, not commodities, with the requisite input into clinical management and decision-making.
- Utilize the IOM’s recommendations on nursing, particularly the one calling on organizations to ‘expand opportunities for nurses to lead and diffuse collaborative improvement efforts.’ ”

“There is no silver bullet. In fact, as the workforce landscape emerges, the best organizations will remain nimble in terms of their planning. What works in today’s market will become obsolete given a new set of social, economic and political developments. But, to be sure—**the nursing shortage will be back. It is not a matter of if; it is a matter of when.**”

Rural Hospitals Focus on Buying Local Food

From a press release, “Hospitals Announce Commitment to Local Food, 15% of combined food budget will go to locally-produced and processed food,” 10/13/10:

“At the annual meeting of the Producers & Buyers Cop held at Sacred Heart Hospital in Eau Claire, Wisconsin, Steve Ronstrom, Hospital Sisters Health System Divisional President and CEO with responsibilities for Western Wisconsin announced that Sacred Heart and St. Joseph’s hospitals would commit 15 percent of their food budgets to locally-produced food.”

“ ‘Sacred Heart and St. Joseph’s hospitals together will commit 15 percent of their combined food budgets to the purchase of local food,’ he added. ‘This commitment supports the health and wellness of our patients, cafeteria patrons, physicians and Meals on Wheels patrons. It supports our family farms, creates jobs, and our local economy and community.’ ”

“The hospitals’ budgets total \$2.3 million in a 12-month period; 15 percent would be approximately \$345,000 toward purchasing local food over a 12-month period. The two hospitals’ local food purchases have included beef, poultry, buffalo, pork, fish, cheese and fresh produce grown year-round in local greenhouses.”

“In 2008, Sacred Heart Hospital pledged 10 percent of its \$2 million food budget to purchase local food. ‘The hospital’s commitment provides local farmers a guaranteed market to sell products at a fair local price and provides local food to benefit our patients, visitors, employees and Meals on Wheels program,’ said Ronstrom. St. Joseph’s Hospital committed a portion

of its food budget to local food, as well.”

“ ‘Following the Hospital Sisters Mission and our Franciscan tradition, we are proud to invest in our community by purchasing local food to support local agriculture,’ said Stacey Meinen, Foodservice Director, St. Joseph’s Hospital, and a Co-op Product Committee member.”

“ ‘In the 1990s alone, Wisconsin lost almost 40 percent of its dairy farms,’ said Rick Beckler, Director of Hospitality Services, Sacred Heart Hospital, and a Co-op board member. ‘It’s our responsibility to buy local food to not only provide the best in nutrition, but to support our local agriculture industry.’ ”

“ ‘Being fresher, local food has a longer shelf life, is more nutritious, tastes better and requires less fuel for transport,’ said Beckler. ‘We’ve had an outpouring of warm compliments on our food from patients and employees.’ ”

Contact the Producers & Buyers Co-op at P.O. Box 295, Elk Mound, WI 54739, or 715-579-5013.

Imagine a Successful Next Year

The following is from the November Issue of RWHC’s “Leadership Insights” newsletter by Jo Anne Preston. Back issues are available at:

www.rwhc.com/News/RWHCLeadershipNewsletter.aspx

“Imagination is everything. It is the preview of life’s coming attractions.” Albert Einstein, (1879-1955)

“A new study just revealed that if you look at a picture of M&Ms and *truly visualize* eating them, you

will eat fewer of the real ones after that visualization. The brain believes what it sees-for real, and in your mental pictures.”

“As 2010 closes, go ahead and visualize the end of **2011**. I’m not talking about New Year’s resolutions but rather creating a **vision** for your own success.

Spend a few minutes-alone or with a colleague or mentor-on the following questions *before* setting your goals for 2011 and you’re more likely to get there:

1. What would your work life look like if you *get it right* this coming year?

Spend a few minutes imagining what you will be doing, how you will come across to others, what it will feel like, what you will say ‘I have achieved /overcome/ learned/ conquered.’

2. Now go back...what are three of the most outstanding things you have

accomplished in 2010? Think of things that you did that were a stretch for you. For input, ask others to help you review the year’s accomplishments.

3. Do your own personal S.W.O.T. analysis.

S.W.O.T.-*strengths, weaknesses, opportunities and threats*-analysis is a tool used in organizational strategic planning to help an organization keep its eyes and ears attuned to the business environment. Use it for *your personal* strategic plan to be aware of the influences in your environment.

a. List 3 of your personal strengths. The common theme of characteristics most likely present in your success stories. (*A great book for you to explore this more systematically is Strengths Finders 2.0 by Tom Rath.*

b. List 3 of your weaknesses. Whether you call them weaknesses or opportunities, we all have

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“Yea, you were ‘great.’ But with less ‘all about me’ and more ‘about us,’ we might actually win a game.”

things to work on. Use this list to determine how well you are compensating for or working to improve on things that are not your strengths.



RURAL HEALTH CAREERS
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many as stand out significantly to you. Then cross off 3 of the ones you circled. And cross off 3 more. Then 3 more, continuing until there are only 3 left that you can't live without. Being keenly aware of key values helps when you are in a decision making dilemma."

- c. List 3 opportunities you see for yourself in the coming year. Think of the image of yourself in a year from now. Are there opportunities to capitalize on to help you reach that vision?
- d. List 3 threats to your success-what are the barriers or obstacles, forces outside of yourself that could get in the way of achieving your vision?

Maximize the strengths and opportunities, minimize the weaknesses and threats.

- 4. **Look through more than one lens.** Consider your key customers; what would you like them to say about you at the end of 2011?
- 5. **'I am a person who values _____.'** Fill in the blank. Google 'values list'. Print a list, circle as

"Let the answers to these strategic questions feed the creation of your SMART goals for the year. Put key words or phrases in sight-your brain will believe it."

Coaching available for this and other leadership challenges. To access the RWHC Leadership Series 2010-2011 and a catalog of what is available, go to www.rwhc.com and click on "Services" or contact RWHC Education Coordinator, Carrie Ballweg at 608-643-2343 or cballweg@rwhc.com or Jo Ann Preston at 608-644-3261 or jpreston@rwhc.com. The next RWHC Leadership workshop is "Coaching for Performance," Wed., 1/12/2011 in Sauk City.

Need help getting motivated? Listen to this 2 minute video: <http://vimeo.com/8480171>

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