

ACOs Not Ready for Rural Primetime

A Commentary by Tim Size, Editor, *Eye on Health*:

Like many who try to understand healthcare policy, I have begun the job of getting my arms around Medicare's proposed 429 page rule for today's buzz word in health care, "Accountable Care Organizations (ACOs)." I need to admit to a bias upfront of having helped to develop and then sell (twice) a health insurance plan based on similar principles. Also, before reading further, you may want to watch two widely circulated brief videos that present unquestioned ACO development in a somewhat irreverent light:

<http://www.youtube.com/watch?v=IF8bK7AJyL0>

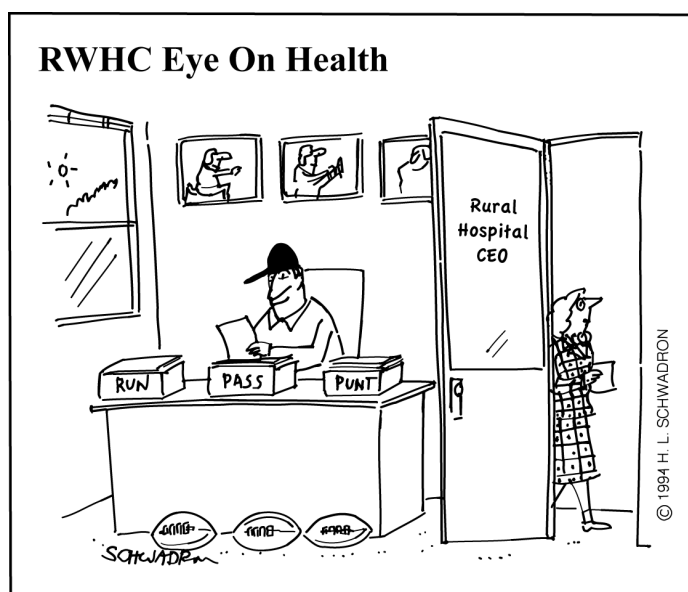
<http://www.youtube.com/watch?v=ULy5vjcGuDc>

From a March 31st Press Release from the Centers for Medicare & Medicaid Services (CMS): "CMS, an agency within the Department of Health and Human Services (HHS), proposed new rules under the Affordable Care Act (ACA) to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). ACOs create incentives for health care providers to work together to treat an individual patient across care settings—including doctor's offices,

hospitals, and long-term care facilities. The Medicare Shared Savings Program will reward ACOs that lower growth in health care costs while meeting performance standards on quality of care and putting patients first. **Patient and provider participation in an ACO is purely voluntary.**"

According to the widely respected Deloitte Analytics Institute in an April 4th *Health Care Reform Memo*: "The ACO is one of several programs in the Accountable Care Act that advance clinical integration and physician-hospital alignment. The common thread running through episode-based payments, value-based purchasing, the medical home, avoidable readmissions, and ACOs is clinical integration in an organized delivery system that is capable of taking risk for results—cost savings, outcomes, and service delivery. **The ACO is not for everyone.**"

Personally, I believe those of us in rural health need to sit back, take a few deep breaths and put the Program into perspective. As written, ACOs are unlikely to attract much rural participation. Neither ACA nor CMS see it as immediately relevant to all situations or the only model that needs to be tested. As this model further evolves, **rural providers need to focus on developing the core competencies related to care coordination** and not get distracted by trying to become an early adopter of an urban-centric set of federal incentives.



The current CMS ACO proposal fails to recognize the uniqueness of health care in rural communities.

Unlike in most urban communities, there are usually not enough providers in rural communities to support multiple ACOs having closed primary care provider networks competing with each other. Many rural communities are located in areas that will have the potential for overlapping ACOs with multiple urban-based networks. To retain local access over the long run, rural communities will need local providers to be able to offer their services to these multiple ACOs. CMS needs 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.

Here are a few ACO paramount strategic issues from a rural perspective:

How do we promote collaboration between urban and rural while respecting the competitive model inherent in regional ACO development? I believe we need to propose that CMS develop a rural model in addition to their current urban centric model. The current lack of a rural ACO vision is like when CMS introduced the wage index and every MSA got its own index and the rest of the state was thrown into one pot of leftovers. I believe CMS should develop a two step

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

attribution model for costs to ACOs. First, as now proposed, costs would be assigned based on use of primary

care physicians. Then a second step would be added—attribute costs among ACOs depending on which specialists predominated with a primary care physician's patients. This would require specialists to declare a principle ACO affiliation as primary care physicians are asked to do. CMS would also need primary care physicians to declare a primary ACO affiliation for patients where no specialty care was provided.

We need to be concerned how CMS's proposed model will evolve in commercial insurance markets and/or in future iterations under Medicare. We should anticipate a shift from retrospective to prospective attribution models and how that can lead to steerage of patients away from local care sites and the undermining of the rural safety net. **Enforcement of Community Access Standards is absolutely critical to prevent steerage of Medicare beneficiaries and inordinate leverage by Medicare ACO plans over local rural providers.**

There is much uncertainty in our country and in our field (maybe too acutely felt in Wisconsin given our own much reported political conflict and uncertainty). While we understand some of the general direction, we don't know what forms reform will or will not take. **We need to encourage all of us in rural health to look to strengthen the core competencies of doing more, better for less. That will be achieved through significantly greater care coordination and population health focused prevention,** using a full range of corporate integrated and virtual collaboration models.

Critical Access Hospitals (CAHs) are a valuable safety-net provider for almost 60 communities in Wisconsin and for more than 1,200 communities across the county. If you add in the number of smaller rural hospitals, the number of affected communities that will not have the ACO's required 5,000 Medicare beneficiaries, let alone the actuarial sound lower limit of 20,000 grow even larger.

ACOs are an important part of healthcare reform in America but as currently defined by CMS they are largely irrelevant for most of rural America.

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.

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

Website: www.rwhc.com Twitter: <http://twitter.com/RWHC>
Blogs: www.ruraladvocate.org/ www.worh.org/hit/

Email office@rwhc.com with *subscribe* on the subject line for a free e-subscription.

Wake-Up Call: County Health Rankings

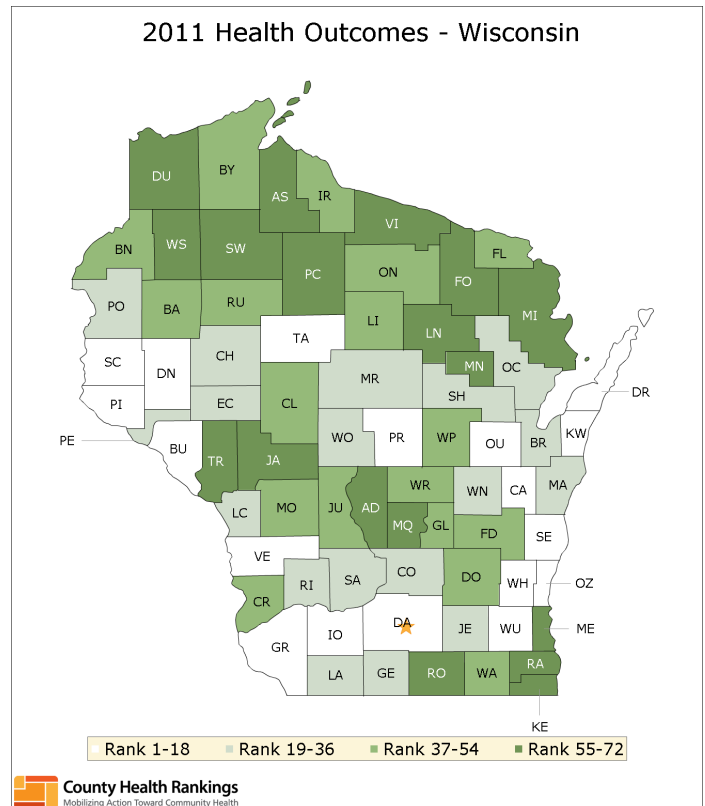
From the 3/29/11 blog post “Wake-Up Call: The 2011 County Health Rankings” by Bridget C. Booske, at www.improvingpopulationhealth.org/blog/ :

“The team at the University of Wisconsin Population Health Institute has released the 2011 *County Health Rankings* at www.countyhealthrankings.org/. These rankings provide snapshots of community health for over 3,000 counties throughout the country. In every state, people will be comparing how counties rank on their health outcomes and health factors, based on a wide variety of measures from mortality and quality of life to high school graduation rates, unemployment rates, obesity rates, and air quality. Our model emphasizes that health care is just one of many factors that determine how healthy we are and how long we live and underscores the importance of evidence-based programs and policies to drive population health improvement.”

“This important work is being made possible in collaboration with and support from the Robert Wood Johnson Foundation (RWJF). We’re almost as excited about our refreshed and enhanced website as we are about the *Rankings* themselves. We’ve developed a variety of ways for users to explore and use the data, including state summary reports, downloadable maps, compare and sort capabilities, and both state and national data files. We have unveiled several new tools of our own, and linked to a new tool created by Steven Woolf and colleagues at Virginia Commonwealth University: a county health calculator that demonstrates the relationship between education and income with premature deaths.”

“As we embark on our second year, we’re aware that communities are looking for real-world examples to guide and inspire. Responding to this need, our 2011 website has an expanded section—*Action Steps*—to guide evidence-based program and policy development and a brand new section—*Your Stories*—to showcase how communities across the country are taking action to improve health.”

“For the past year, communities across the nation



have been using the *County Health Rankings* to galvanize support for and take action to create healthy communities. The 2011 *Rankings* is an opportunity to infuse new energy into this movement and bring more people on board. With the health of our communities at stake, this is one wake-up call we can’t afford to let anyone sleep through.”

Bridget C. Booske, PhD, MHSA, is a Senior Scientist with the University of Wisconsin Population Health Institute and is Deputy Director of the County Health Rankings.

Wellness Like Real Estate: Location, Location

From “Report shows which states’ counties are healthiest” by Lindsey Tanner, AP Writer, 3/30/11:

“Startling differences in the health of residents living just a few miles apart are highlighted in a new health rankings report that assesses wellness in nearly all the nation’s 3,000-plus counties.”

“A typical example is in Illinois, where the healthiest of its 102 counties, Kendall, is right next door to the one ranked 65th, LaSalle. Twice as many LaSalle County residents are in poor or fair health and smoking rates are double the national average.”

“Suburban versus rural and proximity to big cities and high-paying jobs partly explain the disparities. Kendall County is on the edge of Chicago’s metropolitan area, while LaSalle County is more farming-based.”

“ ‘Affluent suburbs tend to have higher paying jobs, often in the cities, whereas rural communities often are dealing with loss of businesses and declining populations of young people, who tend to be healthier,’ said Dr. Patrick Remington, a researcher at the University of Wisconsin’s Population Health Institute. The institute produced the rankings with the Robert Wood Johnson Foundation and their second annual rankings report was just being released online.”

“Residents of rural communities also tend to have less education, less access to health care, and higher rates of substance abuse and smoking—all factors that contribute to the rankings.”

“Still, counties encompassing big cities aren’t immune. Wyandotte County, Kansas, learned that when the researchers released their widely publicized first county health rankings report last year.”

“The county includes Kansas City and boasts two major medical centers, which officials figured would mean a top ranking. But Joe Reardon, mayor and CEO of Kansas City and county government, said the county’s listing—96th out of 98 in Kansas—was a wake-up call. It prompted several meetings with county authorities, local institutions and citizens, resulting in plans for more urban grocery stores and public works projects that aim to make sidewalks and roadways safer and more usable for pedestrians and bicyclists.”

“The rankings compare counties within each state. They’re based on data from vital statistics and government health surveys. In many cases, several years of data are used to calculate rankings, Remington said. For that reason, many rankings this year are similar to those from the 2010 report.”

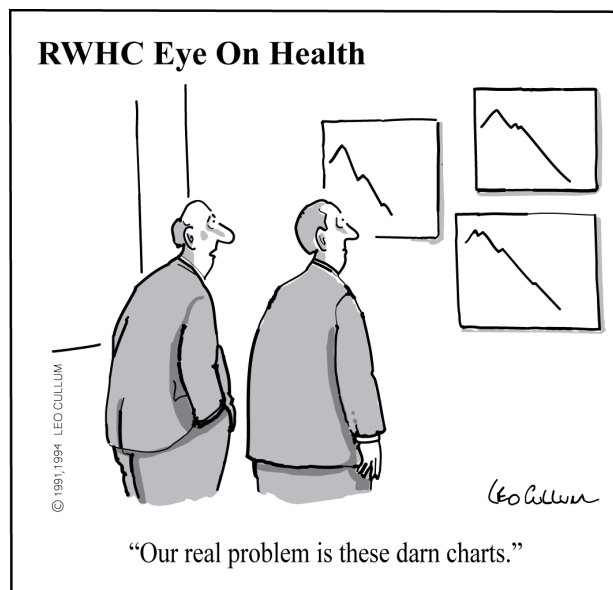
“Premature deaths—people dying before age 75 of preventable diseases; self-reported health status; and the percent of low birth-weight babies contribute to the rankings. Other measures include obesity rates, unemployment, high school graduation rates and pollution.”

“Richard Sewell, a health policy specialist at the University of Illinois at Chicago, praised the report for including a wide array of important measures that affect health. ‘It’s a call to action’ that leaders beyond the medical realm pay attention to, Sewell said.”

“James Marks, director of the Robert Wood Johnson Foundation’s health group, said last year’s report resulted in an impressive amount of action in many counties that fared poorly. With annual rankings planned in the future, he said the reports likely will spur real improvement in Americans’ health.”

“Already, prompted by last year’s report:

- Jason Cook, an outreach pastor at Center Point United Baptist Church in Lincoln County, W.Va., started a wellness program to encourage parishioners to become more active, eat more healthy foods and lose weight. Overall, 18 people signed up and have lost nearly 250 pounds since January, Cook said.
- The chamber of commerce in Jackson, Tenn., in Madison County, is using health scores to help attract businesses to relocate in the area. Companies are asking about the region’s health, said Kyle Spurgeon, chamber president. The county fared better than the statewide average on some meas-



ures including the number of college graduates and primary-care doctors, in both reports. It slipped in other areas on this year's report.

- LaSalle County, Illinois authorities are continuing with recent programs to distribute nicotine patches to smokers and increase awareness to school officials about diabetes and obesity, said county health department spokeswoman Jenny Barrie. The report emphasized the need to do so, she said.
- Authorities in central Michigan, where the lowest-ranked counties are located, created a 'We Can' initiative to improve health measures including obesity, inactivity and poor nutrition. Monthly brainstorming sessions have been held involving officials from local health departments, mental health agencies, colleges and elsewhere, and a working plan is expected to be developed in April, said Mary Kushion, health officer for the Central Michigan District Health Department. 'We really do have a common theme and a common mission' Kushion said. 'We know that we are much better prepared and able to address the issues than we were' last year.' "

Medicare's Role in Setting Primary Care Pay

From "Bill seeks outside review of relative values in Medicare services" by Charles Fiegl in *American Medical News*, 4/11/11:

"A Democratic lawmaker has proposed changing the way the Medicare program identifies physician services for which it pays too little—or too much—by requiring independent contractors to review doctor fees annually."

"Since 1992, a panel convened by the American Medical Association and representing a wide range of specialties has recommended

thousands of pay changes to the individual services doctors provide to Medicare patients. The bill would add a review on top of the 29-member AMA/Specialty Society Relative Value Scale Update Committee, known as the RUC."

"Critics of the committee say it lacks transparency and is responsible for continuing payment discrepancies between primary care physicians and specialists. But supporters, including the AMA, disagree. They say the use of outside contractors would be duplicative and add an unnecessary layer of bureaucracy."

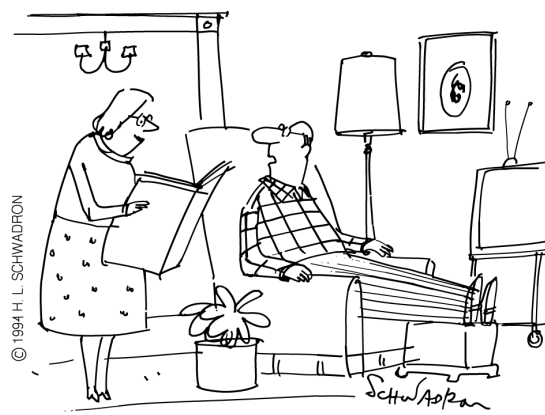
"The Centers for Medicare & Medicaid Services is required to consult with health professionals on adjusting relative values for services. Because the process is budget-neutral, any value change that results in Medicare paying more for a service means it will pay less for one or more other services. CMS routinely accepts the majority of the RUC's recommendations, although it is not required to do so."

"Rep. Jim McDermott, MD (D, Wash.), introduced the Medicare Physician Payment Transparency and Assessment Act of 2011 on March 30. The bill explicitly would require independent contractors to identify misvalued physician services on an annual basis and recommend adjustments. The national health system reform law already states that the Health and Human Services secretary 'may use analytic contractors,' but the new measure would make this mandatory."

"Dr. McDermott faulted the RUC for holding its meetings behind closed doors. But the RUC receives no public financing. The RUC also has been criticized for not publicizing individual members' votes on recommendations."

"The American Academy of Family Physicians and the Society of General Internal Medicine have endorsed Dr. McDermott's bill. AAFP President Roland Goertz,

RWHC Eye On Health



"Primary care physicians are at the heart of good health care, unfortunately they aren't paid like Cardiologists."

MD, said the academy doesn't blame the RUC for relatively low payments to family doctors, but it supports seeking a second opinion. 'It's not our position to do away with the RUC, but have a process that is complementary to the RUC that CMS can use.' ”

“Congress’s Medicare Payment Advisory Commission (MedPAC) has called for increases in primary care payments for the past several years. At the same time, the commission has been critical of the RUC for finding more services for which Medicare is paying too little than services for which it is paying too much. During the three five-year reviews of relative value units that it has conducted so far, the RUC recommended increases in work relative value units for 1,050 services and decreases for only 167 services, MedPAC said in its comments to the 2011 proposed Medicare fee schedule.”

“Paul Fischer, MD, a family physician in Augusta, Ga., and Brian Klepper, PhD, a health care analyst and consultant, are among those who want to go one step further when it comes to the RUC. They want the committee shut down completely. Dr. Fischer and Klepper recently launched a website devoted to replacing the RUC, which promotes the contention that Medicare’s payment system favors specialists over primary care physicians. They urge physicians representing primary care on the RUC to withdraw from it, thus delegitimizing the process and prompting CMS to go elsewhere for advice on revising rates for services.”

CAHs Taxed by CMS “Clarification”

From a blog post: “Rural Hospital Protection Act” by David Lee in the National Rural Health Association’s (NRHA) *Rural Health Voice*, 4/7/11:

“Due to the dire need for legislative action in order to protect Critical Access Hospitals (CAHs) from detrimental provider taxes, NRHA strongly supports passage of the Rural Hospital Protection Act and commends Reps. Graves and Kind for their work and leadership in this important area. Reps. Sam Graves (R-MO) and Ron Kind (D-WI) introduced the Rural Hospital Protection Act on Wednesday, April 6. This

legislation would ensure that critical access hospitals continue to be appropriately reimbursed for provider taxes.”

“Prior to this year, hospitals could include certain taxes (provider taxes) paid to states relating to the ‘reasonable and necessary cost of providing patient care’ and representing ‘costs actually incurred’ when submitting Medicare cost reports to the Centers for Medicare and Medicaid Services (CMS).”

“These taxes are levied upon hospitals in certain states to help fund Medicaid shares, and have long been considered a regular business operating cost for hospitals.”

“In the federal regulations pertaining to the 2011 inpatient prospective payment system (IPPS) for acute and long-term care hospitals, CMS implemented a ‘clarification’ that disallows such provider taxes to qualify on hospital Medicare cost reports.”

“In the rule, CMS states that this change is related to concern that these taxes do not represent the costs actually incurred on hospitals, and states that this will have ‘no financial impact’ on CAHs. NRHA believes this decision is more than a mere ‘clarification’ and would have severe impact on rural hospitals.”

Leadership Insights: Can We Collaborate?

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

www.rwhc.com/News/RWHCLeadershipNewsletter.aspx

“My crayons, your coloring book...can we collaborate?”

“Cooperation is great, but the word is not interchangeable with **collaboration**. Consider that in true collaboration, *all parties must give up something to achieve the greater good*. Cooperation is like parallel play in toddlers (independently and peacefully playing side by side with different toys) versus the pre-

school phase of learning about sharing, where we realize-as hard as it may be-that if you share your coloring book with me, and I share my crayons with you, everybody wins. I guess what we really need to know we actually needed to begin learning *before* kindergarten.”



“It sounds easy and obvious, and it can be... But when opinions clash, resources are scarce and priorities differ, collaboration is an effort that requires technical and interpersonal skill. It is worthwhile-it can get you more than you can ever achieve alone.”

“You have control over only one voice-your own. Here are some things you can do to build more success at leading collaboration:

1. Decide why collaboration is in **YOUR best interest**. Is there something big you really want to achieve? Could it be more attainable if you got the support of others? When you ask for their support, make sure to find out what is in it for them too.
2. Identify together a clear purpose that is in everyone’s interest. This is your guiding light in times of personal agendas and egos flaring. Redirect the group to the **mutual purpose** when *competition* threatens to overtake collaboration.
3. Look for opportunities to **share the credit**. As the visible leader you may get praise for the accomplishments of the collaboration. To keep the collaboration alive, take those moments to point out the contributions of the members. This is one of those times when it doesn’t cost much to be a good guy.
4. Aspire to achieve a **balance between ‘process’ and ‘outcome’**. The dilemma: you won’t reach your deliverables if you don’t maintain relationships, and you won’t maintain relationships if you don’t eventually deliver. So you have to do both. If your personality is more attuned to the agenda, partner with someone who has a good intuitive sense of how the people process is working, and vice versa.
5. More collaboration = **less control**. *Can you get more comfortable with that?*

6. Create a **‘go to’ mantra** for yourself, for when the going gets messy. For example, ‘Whatever we achieve together may *take* longer but will also *last* longer.’

7. Empathy goes a long way. Conflicts pop up when we see things differently. The old ‘seek first to understand’ softens the communication, opens up doors to understanding, and from there you can build. You **can’t build from a stalemate, so start by empathizing**. When you feel at odds with a collaborative team member, practice asking yourself, ‘How would I see this situation if I were in her shoes?’ and, ‘What would help him feel heard and understood?’ ***Listen and understand***: it doesn’t mean you have to agree.

8. **Work to eliminate jargon**. It’s safe to assume that if you use a lot of jargon, there will be some people who feel left out, not part of the group. Many will never tell you about it because they don’t want to look stupid. When you lose them, you lose your influence, so strive to keep your communication as clear as you can.

9. **Good facilitation skills** take the ‘personal’ out of differences. They help people process their thinking, make decisions that benefit the larger purpose and keep the focus on team. If you are not skilled in facilitation tools, either bring someone on the team to help with that, or learn them.”

“(Try this one: end your meeting with a ‘fist to five’ evaluation. Ask everyone, at the same time, to indicate by show of hands your level of commitment to the group’s decisions today. ‘Fist’ indicates zero-not at all committed; all five fingers-complete commitment; anything in between shows that you have to ask what it would take to get to a ‘five’ from everyone).”

Contact Jo Anne Preston for individual or group coaching at 608-644-3261 or jpreston@rwhc.com. For Info re the RWHC Leadership Series 2010-2011 go to www.rwhc.com and click on “Services” or contact RWHC Education Coordinator Carrie Ballweg at 608-643-2343 or cballweg@rwhc.com.

Hospital Focus on Family, Friends & Farm

The Wisconsin Hospital Association (WHA) annual survey shows in 2010 that state hospitals provided nearly \$1.18 billion in community benefits and more than 735 patients per day received their hospital care free of charge. The Association's excellent website, www.wiServePoint.org is designed to familiarize the user with the services, programs and assistance that hospitals offer at or below cost. One story is "Focus on family, friends and farm, not financial burdens" from Memorial Hospital of Lafayette County, Darlington:

"Two years ago, Steve Lincicum of Browntown and lifelong farmer, suffered a heart attack. Since then, he and his wife Helen have struggled with his lingering congestive heart failure, circulation problems and diabetes. Steve used Memorial Hospital of Lafayette County (MHLC) for his follow up and annual testing and has since accumulated a substantial bill. Because their insurance coverage does not pay until their hefty deductible has been met, the Lincicum's were still

responsible for well over \$6,000. Like most farmers, it was hard for the Lincicum's to accept financial help when they were used to paying their own way. Steve's doctor had encouraged the Lincicum's to apply to the hospital's Patient Financial Assistance Program many times."

" 'The staff of MHLC were so gracious in helping us fill out the required paperwork; we really thank them,' relayed Helen. 'We really encourage others to use the program if needed.' "

"Shortly after they applied in 2009, they were accepted into the program and MHLC was able to forgive the Lincicum's entire bill."

"Helen adds, 'We are so grateful to MHLC for offering this program. That is why we are sharing our story—it is a two way street!' "

"Even though Steve still struggles with breathing and his heart remains weak, they just take one day at a time, focusing on their family, their friends and their farm, not financial burdens."

Space Intentionally Left Blank For Mailing