Rural Wisconsin
Health Cooperative

Eye On Health

Review & Commentary on Health Policy Issues from a Rural Perspective - January 1st, 2001

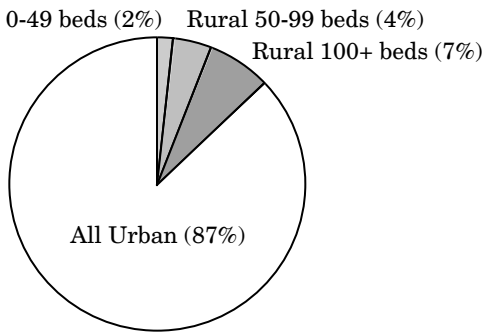
Rural Hospitals Proposing Medicare Reform

From *NRHA Task Force: Cost+ Medicare Option For Rural Hospitals, Charge, Participants, Key Questions, Logistics, Ground Rules & Background*, 12/11/00:

Charge

"On November 9, 2000, the Hospital Constituency Group (CG) of the National Rural Health Association (NRHA) submitted a policy proposal to the NRHA Policy Board that rural hospitals should have the option of electing to be cost-based for Medicare reimbursement. It was unanimously adopted."

Distribution of Medicare Payments By Urban & Rural Bed Size



Source: *ProPAC Report To The Congress,* 6/97
Graph: RWHC 12/00

"The impetus for the request was the Hospital CG's growing concern with the proliferation of special interests that help some but not all small rural hospitals, and the energy required to defend and correct issues of Medicare reimbursement for small rural hospitals."

"On November 16th, the Texas Organization of Rural and Community Hospitals (TORCH) hosted a cross-section of rural advocates from around the country to explore a similar initiative and advocated a collaborative effort be undertaken."

"Members of the American Hospital Association's (AHA) Small and Rural Governing Council members and staff have been discussing these same concerns."

"With these common concerns and upon passage of the NRHA Policy Board's Policy Statement, David Sniff, Chairman of the NRHA Hospital Constituency appointed Tim Size, Past President of the NRHA and Executive Director of the Rural Wisconsin Health Cooperative, to be chairman of the task force with the following charge:

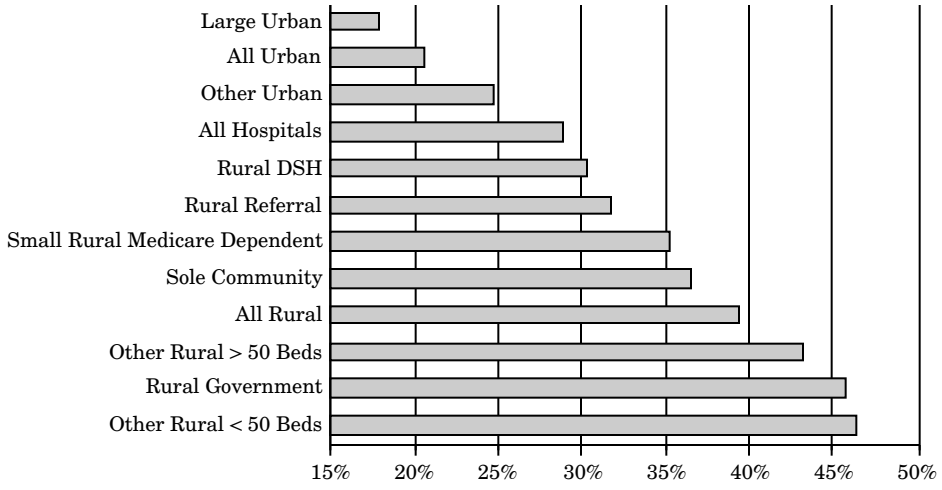
"To develop a specific proposal which will offer rural hospitals the option of being paid by Medicare their reasonable costs plus a reasonable operating margin."

"The twelve members were drawn from hospital leadership in AHA, TORCH and NRHA as well as other individuals with technical and/or rural health policy expertise."

"Key Questions to be Addressed by the Task Force"

- "Why is it good public policy for Medicare beneficiaries and rural communities to offer rural hospitals the option of being paid by Medicare for their reasonable costs plus a reasonable operating margin?
- Which problems faced by rural hospitals and rural communities is this proposal intended to solve? Which problems are not intended to be solved by this proposal? (e.g., How much of a hospital's uncompensated care should be covered by Medicare?)
- CAHs are reimbursed on a reasonable cost basis for inpatient and outpatient services provided to Medicare beneficiaries; how does our early experience with CAHs inform this proposal?
- Should this proposal just focus on hospitals with less than 50 beds, less than 100 beds or some other size or census limit?

Hospital Medicare Margins In 1998 (Excluding GME)
Percentage With Negative Inpatient Margin



Source: *MedPAC Report To The Congress*, 6/00
Graph: RWHC, 12/00

- How much money will be saved in the long run by limiting unnecessary out-migration to urban hospitals which will continue to receive higher payments for the same services?
- As is the case with Critical Access Hospitals, will for-profit hospitals have access to this option?
- What should this option be called? (The right name helps sell the concept, both in Congress and in the rural hospital community.)
- What if any administrative simplification can be woven into this proposal?
- Is this proposal structured to consolidate or replace other 'fixes' for rural hospitals (Sole Community, Rural Disproportionate Share, Medicare Dependent, Critical Access) or to stand as a safety net under these and all other rural hospitals (with or without an upper size limit)?
- Is a 'low volume adjustment' an appropriate alternative methodology (already being discussed in some quarters as lower volumes and high fixed overhead costs are frequently mentioned as unique problems for small and rural hospitals)?
- What hospital sponsored services are included: inpatient only, inpatient and outpatient only, home health, hospice, swing bed, skilled nursing, reference laboratory, etc.
- What, if any, changes in HCFA's current set of definitions of 'reasonable' costs should be proposed? (What should the proposal say regarding cost limits, base years (if anything)?)
- What is the recommended definition or formula for a 'reasonable' operating margin?
- What are the rules regarding timing for electing into or out of this option?
- What limits, if any, will be needed re newly licensed hospitals or previously closed hospitals?
- Whether funded with 'new money' or is budget neutral, how much will this proposal initially cost?
- What are the main objections which will be raised and how should they best be answered?
- What if any 'strings' might be proposed regarding expanded access to cost+ reimbursement and what should be the proposal's response(s)?"

Timeline

"An initial set of recommendations will be completed in time to be mailed to the NRHA Health Policy Board

The **Rural Wisconsin Health Cooperative**, begun in 1979, intends to be a catalyst for regional collaboration, an aggressive and creative force on behalf of rural communities and rural health. RWHC promotes the preservation and furthers the development of a coordinated system of rural 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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for consideration during their May meeting. It is hoped that the Task Force will be able to meet with MedPAC staff in the first quarter of 2001 to discuss their thinking re rural hospitals. The Task Force will continue in order to draft a response to MedPAC's *Report & Recommendations Re Rural Hospitals* which is anticipated to be made public by June of 2001."

Debate On Market Reforms Requested

At its last meeting, the Board of the State of Wisconsin's Private Employer Health Care Coverage Program (PEHCCP) agreed to ask the newly-appointed Small Employer Health Insurance Task Force, chaired by Insurance Commissioner O'Connell, to consider changes to current underlying health insurance regulations which would create an environment more favorable to the Program. Potential changes are:

"**Full disclosure of plan design options**: Several states require health plans and their agents to disclose to each prospective small employer group all plan design options for which that group is qualified. Over time, this provision streamlines plan offerings, simplifies comparisons between insurers, and reduces confusion for small business decision-makers."

"**Modification of mandatory benefit requirements**: Currently, Wisconsin law requires that all health insurance policies cover a host of specific treatments and providers. Self-insured employers are exempt from these 'mandated inclusion' provisions pursuant to ERISA (the 1974 Employee Retirement and Income Security Act). Requiring insurers to offer these coverages as options and/or allowing insurers to offer mandate-free policies returns the choice of providing specific coverages to the employer. This is likely to reduce premium costs, especially for small businesses, which can least afford the financial risk of self-insurance, and may encourage small businesses not currently offering insurance to do so."

"**Tighter rate bands**: Current Wisconsin law allows health insurers to vary rates by as much as 30 percent above or below their midpoint rate for a specific policy, based on the health status or claims experience of a particular small employer group. Tightening this range, to 20 percent, 10 percent, or even eliminating the use of health status/claims experience in setting rates (while continuing to allow the use of other factors such as age, sex and geography), would enhance the Program's ability to compete."

"**Standard age categories**: California statute specifies the age categories by which health insurance rates may vary for small businesses. Of necessity, the PEHCCP will standardize age categories across all participating insurance companies; an industry-wide standard would simplify that process and virtually eliminate the opportunity for unfair competition based on age categories."

"**Industry-wide reinsurance of high-risk groups and individuals**: This alternative to the Health Insurance Risk-Sharing Program (HIRSP) would allow health insurers to cede responsibility for specific high-risk groups and individuals when they first enroll to a reinsurance pool funded via a mechanism similar to HIRSP's. The greatest advantage of this approach is its transparency to employers and employees: They remain in the health plan they select and are not even aware that the risk shift has taken place. Such a mechanism could increase the likelihood of health plan participation in the Program, facilitate simpler underwriting and rating guidelines within the pool, and reduce the risk of adverse selection in comparison to the outside market."

RWHC Eye On Health

"They were a great account before they became unclean."

Historical note: In the early years of the 21st Century, health insurance competition was all about who could attract the most "clean" groups--employees that didn't tend to use the health care access they and their employer were buying.

Employers To Drop Insurance Broker Role?

From "Defined Contributions: Future or Fad" by Robert Stone-Newsom and Chris Queram, in the Wisconsin Network for Health Policy Research's *Issue Brief*, 11/00:

"The resurgence in health care costs has prompted a renewed interest in an idea that dates back to the early days of managed competition. Simply stated, the question many employers are beginning to ask is 'Why don't we get out of the health care purchasing business and simply hand over to the employee the money we normally pay for health benefits--let them decide how to spend their health care dollars?"

"The idea of giving an employee a defined contribution (cash) instead of first defining and then purchasing a benefit (insurance) goes back to at least the late 1970s. Generally, a defined contribution plan involves the employer giving the employee a set amount of money with which they can purchase a health plan, insurance or other benefits. Traditionally such cafeteria or flexible spending accounts provided a limited range of employer-chosen spending options. Importantly, the employer selects the menu ahead of time. Recently, however, employers and some of the large benefit-consulting firms have been exploring a more radical idea. Why not allow the employee, using funds provided by the employer as well as their own money, to evaluate and select their own plans from the health care options available in the marketplace?"

"Basically the employer will continue to provide an economic contribution as always but will turn over the responsibility of choosing health benefits and options to the employee. Over 46% of Fortune 1000-level employers were interested in this idea according to a recent survey."

"In the authors' view, at least four events must occur before the defined contribution health care benefit option will become wide spread. One, the new plans must provide the same tax incentives to employers as the old. Two, insurance regulations must be adjusted to allow group pricing with individual purchasing. Three, employers must work through complex cost-subsidies questions so as to ensure all employees (regardless of age and health status) are treated equitably and given a reasonable amount of funds with which to purchase coverage. Four, until researchers and policy-makers agree upon and implement a technical quality measure of health outcomes consumers will be no more able than employers to select quality or high value health care providers."

Rural Health Policy Institute

National Rural Health Association
February 5-7, 2001
Washington, D.C.

Put this trip on your calendar today to find out what the new Administration and Congress has in mind for health care and what specifically are your opportunities and threats.

Sowing Seeds Of Hope

The Wisconsin Rural Health Development Council at its December meeting took action to formally request "that the Secretaries of the Wisconsin Departments of Commerce, Health and Family Services and Agriculture, Trade and Consumer Protection convene a Wisconsin Farm Stress Summit to share ideas, learn about unique programs and projects and develop strategies for working together to improve the mental health services and support needs of our state's farming community."

This action followed an earlier request for a white paper to be prepared on the issue. The following is from that paper, *The Mental Health Crisis for Wisconsin Farm Families* drafted by Roger T. Williams, Professor & Chair, Professional Development & Applied Studies, Division of Continuing Studies, University of Wisconsin-Madison.

The Farm Crisis that Won't End

"When media attention dissipated following the 'farm crisis' of the 1980s, most people believed the farm crisis was over. Yet in Wisconsin, the crisis raged on."

- "The plummeting land values of the 1980s were followed by a severe drought in 1988; feed shortages in 1989; low milk prices in 1990-91; a drought in 1992; floods in 1993; feed shortages in 1994; intense heat in the summer of 1995; a cold, wet spring in 1996; low milk prices in 1997; low beef, hog, soybean and corn prices in 1998-99; and extremely low milk prices throughout 2000.
- The price of a tractor is 5 to 6 times the price it was in 1973, yet the price the farmers receive for the milk they produce is only 1 times the price it was in 1973.
- Wisconsin has lost an average of 1,200-1,500 farms each year since 1995."

Chronic Stress for Wisconsin Farm Families

"While not all Wisconsin farmers have experienced all of these stressors, most have experienced chronic, prolonged stress over a period of 15 years. This stress can manifest itself in physical (headaches, ul-

cers, exhaustion), mental (anxiety, depression), behavioral (withdrawal, substance abuse, violence), and cognitive symptoms (memory loss, inability to make decisions). Feelings of inadequacy and failure are also common."

The combination of effects will be different for every farm family member, but many experience a deadly combination of problems that creates a situation where harm to self and others is a real possibility.

Rural Values, Beliefs and Attitudes Make it Difficult to Seek Help

- "The 'rootedness' of farm families (often the third or fourth generation on the land) can keep them from choosing a different career or life outside the community.
- The work ethic of families causes them to work longer hours, to milk more cows, to farm more acres and to take off-farm work to supplement their income.
- The pride, independence and self-reliant spirit of farm families keep them from reaching out for help or limit helpers to a close network of family and friends.
- The attitude toward communication causes families to hold things close to their chests since they don't want the 'community grapevine' to know about their problems.
- The traditionalism of farm families often keeps them from making life and career changes that might be in their best interest."

Today's Farming Realities

"Farmers operate at great risk and usually without disability insurance"

"In Wisconsin, 25-35% of fatal occupational injuries annually involve farmers according to a recent report by the Wisconsin Department of Workforce Development, yet less than 2% of our population is involved in farming. According to farm safety experts, for every farm fatality, there are 3 permanent disabling injuries. Wisconsin has, on average, 33 fatal farm accidents annually and 100 farm accidents a year resulting in permanent disability."

RWHC Eye On Health

"Sounds like you and your wife just need to learn to work less and take more time off the farm."

"Farmers and farm families often have limited health insurance or are completely uninsured."

"The federal government recognizes that at least 18% of farmers lack health insurance; the percentage is closer to 40 or 50% for farmers in financial distress."

"Farmers and farm families typically do not seek counseling for mental health problems."

"Farmers are one and one half to two times as likely to commit suicides as other men in our society, according to a major study by the National Farm Medicine Center in Marshfield, WI."

"Even when the farming community does seek counseling services, those services may not exist in a reasonable proximity to their home or may be delivered in a manner that does not understand or appreciate the unique issues inherent in farming."

Texas Uses Tobacco To Support Rural Health

Sam Tessen, Executive Director, Center for Rural Health Initiatives, the Texas State Office of Rural Health, "Texas Puts Tobacco Dollars into Rural Health Care", *Rural Health News*, Fall-2000:

"State settlements with tobacco companies have generated widespread interest and discussion across the country. Much of this discussion has centered on how the dollars should be used, with many people contending that they be used for health related purposes. Texas has gone a step further with an innovative approach in our tobacco settlement decisions. We have allocated a significant portion of our settlement dollars to improvements in rural hospitals."

"Our settlement established two payments tracks—the bulk of the money going to the State of Texas, and in a later development, an additional settlement going to individual counties."

Wisconsin's 4th Annual Rural Health Conference

April 26th and 27th in Mosinee. Among other keynotes: Marcia Brand, Interim Director, Federal Office of Rural Health Policy & Wisconsin's own national television personality, Dr. Zorba Paster.

"The state portion ($475 million) was the subject of legislation in the 1999 session of the Texas Legislature. The result was HB 1676, a comprehensive approach to health care improvement with a long-term consideration. The bill was passed, signed by the Governor, and went into effect January 2000."

"The legislation created five permanent tobacco endowments, each created for specific target populations. It mandates that the interest and earnings from the endowments be spent on programs for the targeted populations.

The Permanent Fund for Tobacco Education and Enforcement ($200 million)

The Permanent Fund for Children and Public Health ($100 million)

The Permanent Fund for Emergency Medical Services and Trauma Care ($100 million)

The Community Hospital Capital Improvement Fund ($25 million)

The Permanent Fund for Rural Health Facility Capital Improvement ($50 million)"

"The Texas Center for Rural Health Initiatives, serving as the Texas State Office of Rural Health, was awarded the Permanent Fund for Rural Health Facility Capital Improvement, targeted to rural public or non-profit hospitals in counties with populations of 150,000 or less. This program provides funds for rural hospitals with aging physical plants and needs for capital and information services equipment. This year, the program awarded grants to 32 rural hospitals, totaling $2,179,041 for projects such as roof repairs, telemetry systems, ambulance purchases, and mammography units."

RWHC CVO NCQA Recertified

The Rural Wisconsin Health Cooperative (RWHC) is proud to announce that our credentials verification service has been recertified by the National Committee for Quality Assurance (NCQA) for 10 out of 10 verification services. NCQA is an independent, non-profit organization that certifies credentials verification organizations.

Today, more and more organizations are outsourcing their credentials verification function because of the costs involved in doing it internally, along with the challenge of keeping up with regulatory requirements. The average cost of processing an application in-house is between $125-$250. RWHC can process both appointment and reappointment files for much less – typically in the $62-$80 range.

Other features of the RWHC Credentials Verification Service include:

- Flexibility – we can assume your credentialing functions entirely or work with your staff on an as-needed basis.
- Fast turn around times for primary source verification – within 30-45 days upon receipt of a completed application.
- No monthly volume contract or exclusivity requirement.
- File updates at no additional cost.
- Over 4,500 practitioners in our database.

For additional information about the RWHC Credentials Verification Service, please call (800) 225-2531.

Effective Advocacy Is Belief Driven

From "Organizational Lobbying: The Spiritual Journal of Leaders" by Bill Bazan, Vice President--Metro Milwaukee in the Wisconsin Health and Hospital Association's *The Heart of the Matter*, 12/00:

"Allow me to share a personal story about my children, Sammy and Jessie. As 9 year olds, they are at the end of a belief in Santa Claus – yet they still play it for all it is worth! In my home as I grew up (and now with my children) we celebrated the feast of St. Nick on December 6. In the morning, as the old German custom says, St. Nick would leave a stocking filled with fruit, candy and usually a small toy or pair of socks. I would wake up, go downstairs, and be filled with wonder over the stocking filled with goodies. St. Nick was a precursor to Santa Claus, emphasizing the spirit of giving that should surround the holiday sea-

son. In their eyes (and in mine too), this is the beginning of a wonderful time of the year when presents magically appear from all fronts. They are serious about anticipating Santa Claus--or gifts from mom and dad!"

"Both kids are anxious to point out gifts they would like. They call me into the living room whenever a special toy they want appears on a commercial. They read catalogues that come to the house. They even read the ads in the Sunday newspaper. Their focus, of course is putting energy and time into something they believe will happen to them…something exciting. In short, the days between St. Nick's on December 6 and Santa Claus on Christmas morning are filled with spirited energy. Nothing seems to deter them from fulfilling their mission that will come to fruition on Christmas morning. They come at me from all directions. **They are on a spiritual journey – a mission – totally grounded in the belief that they will get what they deserve if they play their cards right and stick with their process!"**

"Grassroots advocacy is both a function of and a result of leadership within organizations. If leaders truly believe in their mission to provide quality health care and contribute to the health of their communities, nothing will deter them from communicating their campaign to government leaders."

"Leaders believe that this activity is a spiritual one –integral to their own personal spiritual journey."

"Leaders become powerful when they consciously connect with and allow themselves to be influenced by what is best for the community…beyond the walls of their institutions."

"Leaders involve themselves and others in meaningful, purposeful activities. They believe that life is sustained by tension between where their organization is now and where they want it to be."

"The spiritual quest is enhanced when I turn away from my standard and customary ways of being involved in the community and turn towards fresh questions that will animate me towards a fresh and/or renewed leadership role…especially that of advocacy."

RWHC Eye On Health

"As a trained advocate, I have a mission, I've played my cards right; so now I believe the ball's in your court."

Piedra Negra

A periodic *Eye On Health* feature are excerpts of letters from Dr. Linnea Smith from the Yanamono Medical Clinic in the remote Amazon basin of northeastern Peru. The clinic operates with grass roots support from family and friends and many others. AMP is a non-profit, tax-exempt organization. Donations are welcomed c/o: Amazon Medical Project, Inc., 7600 Terrace Avenue, Suite 203, Middleton, Wisconsin 53562.

"There is the matter of the *piedra negra*, the black stone. The black stone is a fondly held concept in our area, where snakebites are common and sometimes fatal. Since there is no rock in our part of the Amazon, I suppose anything called a stone is appealing, and when one lives far from ambulances, med-flights, hospitals, doctors, and when one is confronted with a potentially lethal problem, anything seems better than nothing."

"Still … black stone is not actually a stone (since we have none). It is a small, rectangular piece of cow bone, which has been charred in a fire and looks sort of like a stone. It is to be applied to the site of a poisonous snakebite and tied firmly in place. It is left there for several days, during which time it supposedly draws the venom from the wound. Once the poison is all removed, the 'stone' loosens of its own accord and falls off."

"Personally, I'd rather have antivenin. Then again, if nothing else is available, what is one to do? And placebo effect is undoubtedly real. I firmly believe that we all have a great deal more influence over our own health status than most of us realize, and it is entirely possible that if one believes deeply and truly, the belief itself may help. In any case, better that a person stricken by a snake have some hope than feel completely without recourse; so I can see a place for the black stone in the local pharmacopoeia."

"Nonetheless, I find it a bit alarming that despite the fact that the state nursing course book admits that no evidence has ever been produced to document the effectiveness of the black stone, each student is required to make and include one in the small medicine chest that is to be put together as a part of the first aid module.

They are cautioned to smooth the stone/bone carefully with a file and make it a really good one. Hmmm."

"Meanwhile, the clinic continues busy. Vaccine day brought the usual crowd, and other days, people seem to be trying to make up for whatever they didn't come in with during my absence. Furthermore, I brought back from the U.S. a novel medicine, which I think will be very useful, and we have been applying it."

"The state of peoples' teeth in the Amazon has always been a concern for me. There is no fluoride in the river, and not everyone has access to toothpaste, so many people have horrible dentition. It is terribly sad to see these cute-as-a-button little kids, who then smile to reveal brown and rotting stubs of teeth, even as toddlers. Fluoride treatments would help this problem, but fluoride has always needed to be applied weekly."

"There is a dental company in the U.S., though, which is manufacturing a form of fluoride meant to last for at least six months. It has been in use in Europe for some years, and is now licensed in the U.S. as well. The company has most generously offered us a bunch of it, and I brought back a number of packets with me. It is in the form of a varnish, which comes in a tiny tray with its own, little brush. The stuff is simply painted on, and I am told that it is not technique-sensitive, i.e., even a doctor can do it."

"So, we have been gleefully varnishing the teeth of all the children who come for well-child care, as well as the teeth of everyone who comes in to have a tooth pulled. It will take a few years to see much effect, but I am hopeful that a few years from now, we will be looking at more white and pearly smiles."

"One somber note, my father has just died. You don't need to send condolences. It has been an ongoing trial for him, for Mother, and for all of us for the last few years, as Parkinson's Disease robbed him gradually of his strength and independence. He was a really good man and we miss him, but I think he was ready to leave. I might not be in the Amazon at all if it were not for him. He and my mother raised me and my two sisters in an atmosphere of unconditional love tempered by enough discipline to keep us from being total hooligans. They encouraged us to stretch our wings, and to do and be what we wanted, with no restrictions except that we be honest and fair and decent. That is the best gift that any parent can give to his children."

RWHC Hospital Named In Top 100

Sauk Prairie Memorial Hospital

was honored by *Modern Healthcare* in its annual list of the country's 100 premier acute care hospitals.

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