



Rural Wisconsin Health Cooperative

Senator Herb Kohl's Health Care Reform Advisory Committee

Expansion of Talking Points by Tim Size for the Rural Wisconsin Health Cooperative

Marshfield Clinic Boardroom, 1000 North Oak, Monday, June 29th, 2009, 1:30 p.m. – 2:30 p.m

I. Three Rural Health Priorities

Assure Local Access to Quality and Cost Effective Care

- **Protecting access to local care must be a high priority.** Rural health's many successes in Wisconsin are a testament to the endurance and creativity of rural communities. State and federal laws have long required health insurers to respect the right of people to receive health care locally.
- **We believe that if a Wisconsin community has available local providers, health plan enrollees should not be forced to travel beyond that community because the health plan refuses to contract with local providers, when those providers would accept a contract with financial and quality terms comparable to other providers with whom the health plan contracts.**

Address Forecasted Health Workforce Crisis in Both Rural and Urban Communities

- The soon to explode retirement of baby boomers will lead to a critical shortage of workers, particularly in rural America for which we are ill prepared. Many rural communities already face staff shortages.
- **Make sure promoting diversity in the health workforce addresses the unique recruitment and education needed for rural and inner-city practice.**
 - Programs like the University of Wisconsin School of Medicine and Public Health's Wisconsin Academy of Rural Medicine (WARM) and TRaining In Urban Medicine and Public Health (TRIUMPH) acknowledge the uniqueness of rural and inner city practices. Investments in expanding the pipeline needs we must support programs that emphasize recruitment from and training in these target communities.
 - **The expansion and/or reallocation of resources that currently go into Graduate Medical Education needs to be made more flexible so as to include both new rural training tracks and rural rotations.**

Make Workplace Wellness and Healthy Communities a National Priority

- **Reform must help individuals and communities to become healthier, to not need as much health care.** Rural patients face the most daunting of health care challenges: they are older, poorer and sicker. Rural America is less healthy due to too much smoking, drinking and eating, and too little exercise, education, jobs and income.
 - **Healthcare reform must address factors unique to the rural context.** It should lay down a road map to make our communities healthy. Prevention and Wellness provisions must present a comprehensive policy designed to ensure that all Americans will receive the state-of-the-art in both

clinical and community preventive services, undertaking a coordinated effort to make comprehensive prevention research, evaluation, and delivery a permanent part of the national landscape.

- **Eliminate cost-sharing on recommended preventive services delivered by Medicare, Medicaid, and insurance available in the Health Insurance Exchange.**
- **Support incentive models to stimulate multi-sectoral action toward community health improvement** such as the University of Wisconsin's Mobilizing Action Toward Community Health (MATCH). As repeatedly noted by the UW's Population Health Institute, our health status is affected by multiple determinants beyond Health Care which also need to be addressed: Health Behaviors, Socioeconomic Factors and the Physical Environment.

II. Key Threats to Rural Health in Current Congressional Reform Proposals

Failure to Recognize and Incent High Quality and Appropriate Utilization

- **Payment reform must be built on quality of outcomes and efficiency of delivery, not simply historic cost and utilization data.** Parts of the country, such as the Upper Midwest, should be rewarded, and not penalized, for developing systems of care that have led to Medicare per beneficiary spending that is consistently in the lower quartile for the country and Medicare quality measures place care to beneficiaries in the upper quartile.
- A "Value index" for Medicare payments that realigns payments towards better clinical outcomes, better patient care and higher patient satisfaction by rewarding those who provide health care in this manner. Ideally, this value indexing would be built into payment formulas to help align incentives for all providers towards better care at lower costs. Recently, Rep. Ron Kind introduced a value-indexing payment proposal (HR 2844) for physicians; a similar approach is needed for hospitals, sensitive to the rural context and based on rural relevant metrics. We very much appreciate that both of Wisconsin's Senators have cosponsored the companion bill (S. 1249) introduced by Senator Klobuchar.

Assuming that Medicare Payment Levels Can Sustain the Rural Health Safety Net

- **Any proposal that calls for provider reimbursement in a public plan to be the same as under Medicare would be a disaster for rural providers, inclusive of those who receive "cost based reimbursement."** Non-governmental payers provide the funds to make up for the cost of inpatient, outpatient and community services not recognized in the Medicare cost report, but which are necessary for the long-term ability of a provider to remain strong. Medicare does not recognize all costs necessary for operations. No organization can continue indefinitely without a reasonable positive operating margin as ultimately even non-profits must attract capital from private markets to sustain their work.

Congress Relinquishing It's Role to the Medicare Payment Advisory Committee

- Creating a coherent national strategy requires that individuals who understand rural health be at the table. The Medicare Payment Advisory Commission (MedPAC) is the major public forum for Medicare's new payment and reporting strategies, but the rural perspective continues to be under represented.

- Any proposal to increase the authority of the MedPAC board and elevate MedPAC into an outright policy or reimbursement setting board would be deeply concerning. We do understand the premise of this approach; however, we are concerned that MedPAC would hold significant power over setting Medicare payments and fees which would be unconstrained by any democratic forces (ie: an elected governing board, etc).

Experimenting with Bundled Payments in Rural Communities Without Prior Testing

- **The notion of “bundled payments” to CAHs and other small rural hospitals is a major concern in regards to the specifics and the potential for major unintended consequences.** Our country could be poised to repeat a disaster similar to the misapplication over twenty years ago of Prospective Payment System demonstrations to small rural hospitals when that concept had only been tested in large urban hospitals. We believe that the rural safety net is too frail to experiment with it by applying reimbursement models with untested efficacy in the rural context. Rural relevant demonstration projects must precede the application of bundled payments to small rural hospitals.
- The following cautions are from the Policy Brief “Rural Issues Related to Bundled Payments for Acute Care Episodes” by the Upper Midwest Rural Health Research Center (at the University of Minnesota), June, 2009:
 - Bundled payments may improve the quality of care in rural areas but the impact is likely to be unevenly distributed across geography and care systems.
 - Bundled payments may lead to greater provider consolidation and fewer provider options in rural markets.
 - Incorporating Critical Access Hospitals payment mechanism may be infeasible.
 - Under a bundled payment system, safeguards may need to be implemented to protect consumer choice and patient/provider relationships.

Readmission Rates and Penalties that Ignore the Limited Resources of Rural Communities

- **Penalties for higher than average hospital readmission rates will disproportionately and unfairly harm rural hospitals and communities.** Rural hospitals often play a role different within the larger health care system than urban and suburban hospitals. Explicit consideration needs to be made for the less resource rich pre and post rural hospital environment.
 - According to the Upper Midwest Rural Health Research Center, "not all readmissions are preventable, but some may be prevented through the application of proven standards of care. Policymakers are increasingly focusing on this care dimension as a potential quality measure that can be linked to payment. Despite such significant potential impact, no research has examined the characteristics of and the extent to which these types of readmissions occur across categories of rural hospitals or by diagnoses of rural patient populations."

Rural Providers Not Being Given a Fair Chance to Demonstrate the Quality of Their Care

- **Rural providers must be given the opportunity to demonstrate their quality of care and cost**

effectiveness through access to rural relevant metrics. Providers must then actively participate in cooperative initiatives designed to drive improvement in our performance, rural and urban alike. Incentivizing participation would be the desired path.

- Complicating the challenge of small numbers is the national context—a dysfunctional cacophony of measurement voices. **There is an urgent need for agreement about what we measure and a coherent national strategy for quality accountability. We simply do not have the resources to waste addressing multiple versions of similar demands.**

Inequitable Access to Capital for Health Information Infrastructure

- **CAHs need to receive full parity with respect to PPS hospitals for implementation of Health Information Technology.** The American Recovery and Reinvestment Act of 2009 (ARRA) included billions of dollars in incentive payments to support hospitals, CAHs and PPS, in adopting Electronic Health Record (EHR) technology. Unfortunately, the final outcome created disproportionate incentives, with CAHs receiving only a moderate “bonus” payment for CAHs. We strongly believe full incentive payment parity should be provided to CAHs *before* expanding the pool of incentive payments to other recipients. The initial capital costs remain a barrier to implementation under the final CAH payment bonus.
- **Assure that the critically important thresholds for demonstrating “meaningful use” for CAHs and all other small rural hospitals be phased in.** By phasing in reasonable and achievable requirements, we believe that 5 years from now it will be possible to look back and see significant improvement relating to both EHR adoption and quality for the vast majority of small rural hospitals.
- **If standards are set unreasonably high, without accounting for the current EHR adoption disparity between large and small hospitals, we believe the result will be that a minority of small rural hospitals will achieve the ‘meaningful use’ standards.** The majority of small rural hospitals will be left behind, without any incentive payments and problems will be exacerbated with any financial penalties in the HIT initiatives under the ARRA legislation.
- **Onerous privacy provisions need to reflect a more balanced approach.** Potential consent requirements and accounting of disclosure requirements create new administrative burdens and costs that would create a substantial barrier to the further adoption of EHRs.

Eliminating Rural Hospitals’ Key Justification for Tax-Exemption

- **Rural hospitals were created and are maintained in order to provide care locally. Any change in tax status would have a significant impact to their viability.** Rural hospitals provide significant charity care and other community benefits as defined by the IRS. But in addition, they provide a critically important community benefit which is not quantified in most national discussions of “community benefits.”
- While most rural non-profit hospitals would meet any definition of community service, most definitions fail to acknowledge a non-profit rural hospital’s central purpose. Running a rural hospital has always been hard work given the uncertainty of patients’ needs from one day to the next, the higher rural costs of doing business and the perpetual challenges of recruiting professional staff.