Rural Wisconsin Health Cooperative

United States Senate Committee on Finance **Health_Reform@finance-dem.senate.gov**

Subject: Rural Focused Comments re *Description of Policy Options, Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options*

Submitted on: Tuesday, May 26th, 2009

Please accept this statement in response to the request for public comment; key observations and recommendations are in bold below:

RWHC is a member-owned network of 35 rural community hospitals, including both those designated by Medicare as Critical Access Hospitals (CAHs) and as Prospective Payment System (PPS) Hospitals. It is one of the earliest and most successful models for collaboration among health providers in the country. Incorporated in 1979, RWHC provides a wide range of programs and services to members and non-members alike, including: advocacy, coding consultation, continuing education, electronic medical records, financial consulting, legal services, professional roundtables, quality programs, various clinical services and workforce development.

We are proud to be part of Wisconsin healthcare which has long promoted and embodied, compared to other states, lower-cost and higher quality health care. According to the Dartmouth Atlas, Wisconsin was more than 15 percent below the national average in total Medicare reimbursements per enrollee in 2006. Wisconsin hospitals have been a leader in the quality movement, being ranked in the top two for quality by the Agency for Healthcare Research and Quality in each of the last two years.

How Can Healthcare Reform Help Rural Health?

Rural health is at risk with healthcare reform. It is at risk without it. Rural does not drive this train, but we have a voice that must be heard. Health care in America is neither fair nor can it continue to work just as we have known it. We must continue to make it better. Issues that must be addressed nationally include: cost, the uninsured, quality, fairness, benefits, choice of providers and making communities healthier.

Those of us who care about rural health have the same diversity of opinion about healthcare reform as the whole country does but we believe there is a strong consensus in rural America that reform must at least do no harm and hopefully address the following:

- **Access to care within the local community**
- **Medicare and other systemic payment biases against rural providers**
- **Growing workforce shortage hitting rural hardest**
- **National quality agenda that ignores the rural context**
- **Rural opportunity to model healthy communities**

Rural health's many successes are a testament to the endurance and creativity of rural communities. Reform needs to build on that strength, not weaken it. State and federal laws have long required health insurers to

respect the right of people to receive health care locally. These laws will continue to be stretched and tested. **Protecting access to local care must be a high priority.**

Our experience with the Federal Governments involvement in health care is largely through the Centers for Medicare and Medicaid (CMS). CMS over the last couple of years has repeatedly shown a prejudice against rural hospitals and clinics that must be addressed by Congress. As examples, CMS is forcing rural hospitals to update older buildings while at the same time putting up impediments from rebuilding. CMS is stopping many rural hospitals from offering new services except at the hospital. CMS is blocking new rural health clinics by making it very difficult, if not impossible, for the States to do the required start up inspections.

The soon to explode retirement of baby boomers will lead to a critical shortage of workers, particularly in rural America. Given the long educational preparation needed by many clinicians we can not avoid the crisis but more aggressive action now can limit its duration. Our current approach to growing the next generation of doctors, nurses, pharmacists and therapists is woefully inadequate. We don't know where we need to go or how to get there, but we look sincere and very busy. Many rural communities already face staff shortages.

We must get better at including patients in their own care. Rural providers must respond to patient expectations to "show me the numbers" about their quality and prices. We must be sure that rural relevant measures are developed and used. We must then actively participate in cooperative initiatives designed to drive improvement in our performance, rural and urban alike. **There is an urgent need for agreement about what we measure. We simply do not have the resources to waste addressing multiple versions of similar demands.**

Reform is about people getting the care they need at a cost they and our country can afford. Equally important, reform must help individuals and communities to become healthier, to not need as much health care. If the growing need for care is not reduced, costs will explode whatever financial reforms are implemented.

Rural patients face the most daunting of health care challenges: they are older, poorer and sicker. Two out of every three counties in rural Wisconsin are less healthy than the average Wisconsin county. This is not because of poor rural health care. **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. And at the very least, it must lay down a road map to make our communities healthy.

Please accept the following comments in response to the Committee's Third White Paper:

Re "Reducing Geographic Variation in Spending"

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, this approach should be given additional consideration. The current system is built on historic cost and utilization data without regard to efficiency of delivery and quality of outcomes.

Re "Updating Payment Rates for Home Health Services"

The majority of RWHC members do not offer home health care as a service. Several discontinued providing this service due to inadequate Medicare reimbursement. **Congress needs to recognize that providing home health services in a rural environment is much different and more expensive than providing the service in an urban area. The net result is that home health choices are limited or non-existent in rural areas.** Data from the Wisconsin Hospital Association for hospital-based home health services show a much different picture than the MedPAC data suggests for the financial performance of Home Health Agencies.

Re "Modifying the Requirements for Tax-Exempt Hospitals"

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." Rural hospitals were created and are maintained in order to provide care locally–care that would not otherwise be available without significant hardship to patients and families.

It is important that recognition be given to hospitals that are critical to the communities they serve for being able to meet a minimum charity care requirement. Because these facilities often deal in relatively small numbers, setting annual targets could easily prove to be problematic even though the hospital provides needed services and offers charity care in the community.

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.

The following issues were discussed in a prior Finance Committee white paper but are also very relevant to this paper's focus:

Re "Valued-Based Purchasing"

All of America's healthcare providers, including those in rural America, are called to be publicly accountable and to demonstrate that what they do makes a positive difference. Rural providers must be given the opportunity to demonstrate that their quality of care and cost effectiveness through access to rural relevant metrics.

Not participating is not an option. Saying there are no good data for rural providers is not the answer. Many patients may assume that if the data are not available it means the results are bad. **Rural providers must be given the opportunity and incentives to demonstrate that their quality of care and cost effectiveness are driven by evidence-based medicine and cost-effective leadership.**

Complicating the challenge of small numbers is the national context—a dysfunctional cacophony of measurement voices. There is an urgent need for a coherent national strategy for quality accountability.

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

representation in the process can subjective recommendations and decisions be credibly made.

Rural providers, clinicians and advocates must be allowed to actively engage with public reporting and value-based purchasing as well as redefining it to include our role in promoting healthier communities. While the cost of doing so is a barrier, rural must help to lead this movement, not be dragged along by it or left behind.

Re “Bundled Payments”

The potential application of “bundled payments” to CAHs and other small rural hospitals is a major concern, in particular it feels very much like our country may 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 experimentwith 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.

Ed Hannon, CEO of McDowell Hospital in Marion, NC, and chairman of the AHA’s Small or Rural Hospitals Governing Council noted that hospitals in many rural communities face the disadvantage of having fewer post acute care facilities to coordinate patients’ care. ‘Some of our members are organized in ways that would facilitate bundling payments,’ he said. 'But many are not and need the tools and infrastructure for coordinating care and managing risk.’ ”

Re “Hospital Readmissions”

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."

Until research is available to the contrary, we believe that 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 then urban and suburban hospitals. Explicit consideration needs to be made for the less resource rich pre and post rural hospital environment.

We again agree with EdHannon when he says that hospital readmission rates fail to account for all the circumstances involved in readmitting patients. Some readmissions are completely under the hospital’s control, but most are guided by a ‘complex series of conversations, circumstances and medical decisions’ that involve providers and patients, he said. ‘Any provision that does not recognize legitimate reasons for readmission may become an obstacle to patient care and safety.’ ”

Re "Public Plan Reimbursement Options"

We believe that a proposal, being considered by some, calling 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." We believe this would lead to substantial rips in the rural safety net and loss of local access in a fashion unrelated to community need.

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 and no organization can continue indefinitely without a reasonable positive operating margin. We know that one urban Federally Qualified Clinic in our region tries to negotiate at least 175% of Medicare from commercial payers to adjust for this effect.

Re "Health Information Technology"

The American Recovery and Reinvestment Act of 2009 (ARRA) included billions of dollars in incentive payments to support hospitals and health care professionals in adopting Electronic Health Record (EHR) technology. During debate on the ARRA,we strongly advocated that CAHs receive full parity with respect to PPS hospitals. The Senate proposal provided this parity but it was unfortunately removed during conference. In its place is 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.

ARRA requires Medicare incentive payments to hospitals to demonstrate 'meaningful use' of 'certified EHR technology' (including for information exchange and for the submission of clinical quality measures) with definitions of these terms to be finalized by the Secretary of Health and Human Services (HHS). Using the Healthcare Information and Management Systems Society (HIMSS) phasing recommendation as a template, **we recommend that Congress assure that the critically important thresholds for demonstrating "meaningful use" for CAHs and all other small rural hospitals be phased in.** The specifics of the complete recommendation can be found at **http://www.rwhc.com/Meaningful.pdf**

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 and earn their incentives, while the majority of small rural hospitals will effectively be left behind and problems will be exacerbated with any financial penalties in the HIT initiatives under the ARRA legislation.** Even the billions invested under the ARRA for EHR adoption will not be enough, as HIT start-up and maintenance costs are significant.

In Summary–Whether the reform is in small pieces over time or all at once like the birth of Medicare, every approach includes tradeoffs. Different ways, including doing nothing, will affect key interests and goals differently. These goals help and compete with each other. We appreciate the Senate Finance Committee's efforts and focusing on cost, the uninsured, quality, fairness, benefits, choice and making communities healthy. Thank you for consideration of our comments.

Sincerely,

Tim Size

Tim Size
Executive Director

cc: Wisconsin Congressional Delegation and RWHC Hospitals