WISCONSIN HOSPITAL ASSOCIATION, INC.

May 14, 2009

On behalf of the members of the Wisconsin Hospital Association (WHA), please allow us to provide comments on the Senate Finance Committee's recently released "options" paper—*Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs.*

By way of background, WHA has played a leading role in shaping the reform debate and supporting initiatives in Wisconsin based on sound principles that lead to rational improvement of our health care delivery and finance system. For the past two years WHA's Task Force on Access and Coverage has worked with hospitals and key policymakers to identify principles and policies aimed at improving health care in three primary areas: increasing health insurance coverage; increasing access to health care services; and slowing health care cost growth.

This Task Force has also developed a set of eight principles that should define the health care reform debate, including:

- Initiatives must directly address the reality that current trends in health care costs and insurance premiums are not sustainable and are contributing to access and coverage challenges,
- Each health care stakeholder has *shared* responsibilities,
- Coverage and access are related issues but will require different strategies,
- Initiatives should build upon and improve employer-based coverage and preserve the pluralistic payment system for health care services,
- Initiatives must include fair and adequate provider payments, reward value, be simple and promote innovation,
- Information technology should be encouraged, coordinated and funded by providers, government and payers to improve quality, patient safety and cost efficiency.

With all this in mind, WHA believes health care reform as it progresses nationally should be a bipartisan process, should appropriately cover provider and physician payments, include necessary flexibility and build upon the current employer-based system. It is within this contextual background that WHA provides the following comments on several of the proposals in the recently released "options" paper. Where applicable, the "Wisconsin experience" is provided.

1. **Section I: Promoting Quality and Value** – the options paper includes numerous provisions related to improving quality. Wisconsin hospitals have been a leader in the quality movement, ranking #1 in 2007 for quality by the Agency for Healthcare Research and Quality and #2 in 2008. Voluntarily, proactively and collectively Wisconsin hospitals have moved forward with publicly reporting quality data through our CheckPoint (www.wicheckpoint.org) website. To date, Wisconsin hospitals report on 51 quality measures related to: heart attack, heart failure, pneumonia, surgical infection prevention, indexes, error prevention, inpatient quality indicators (IQI), and patient experience of care survey (HCAHPS survey). We believe our state can provide a hands-on perspective of the importance and value of quality health care. Therefore, we would like to provide our comments on:

   a. **Valued-Based Purchasing** (or pay-for-performance) – VBP can be a logical next step for the quality frontier; however, as VBP moves forward, we urge the Senate Finance Committee to do several things: 1) create a budget-neutral approach for VBP so that savings result in better quality care, not that VBP is used to reduce health care spending as a cost-cutting measure; 2)

enumerate that only consensus-based approved measures be included in a VBP program; 3) limit the incentive pool to 1 percent; and 4) move thoughtfully and deliberately in implementing this type of significant payment reform.

2. **Section II: Payment Reforms**

   a. **Bundled Payments** – We recognize the potential of integrated and coordinated care, something a variety of Wisconsin hospitals and systems have shown is effective and can reduce costs. However, bundling payments will be another significant change to the current health care financing and delivery systems with very little known about its actual impact. There are any number of ramifications under such an approach which requires evaluation of measures and approaches *before* implementation. Additionally, we see that physician services are not included in the bundled payments, yet physicians are key to admitting patients to our hospitals and in directing their care. It seems bundled payments should, therefore, incorporate physician services. Finally, in order to effectively coordinate care and management of patients by hospitals and physicians, a variety of legal and regulatory restrictions would need to be reviewed and/or removed.

   b. **Hospital Readmissions** – accompanying bundled payments is a proposal to reduce payment for hospital readmissions. On its face, readmissions may seem an easy payment target, but we feel there is still much to learn in this regard. For example, some readmissions may be within the control of the hospital while others are not, and some readmissions are planned while others are not. In general, the focus of any hospital readmission proposal should be on those *unplanned* readmissions related to the *original* admission. That being said, even in these cases a variety of other factors are still in play that occur outside of the hospital's control, including access to necessary post-hospitalization care, patient compliance to recommended treatments and behaviors, access to family/friend support systems and others. Any policy proposal must be cognizant of all of these factors as well as the differences in communities, hospitals, patients and then apply evidence-based policies to these payment reforms.

   c. **Sustainable Growth Rate** – year after year physicians are forced to the brink of the payment cliff, and year after year physician groups and hospital associations lobby Congress to pull them back from it. In 2010 that payment cliff will be a 21 percent cut for physicians unless Congress takes legislative action. While the "options" paper provides for a short-term fix, there still is no permanent fix to the underlying physician payment formula problem. We support a short-term fix but urge Congress to work with appropriate groups to find a viable, long-term solution.

   d. **Chronic Care Management Innovation Center** – the chronically ill account for a disproportionate share of health care costs. In 2008 researchers at Dartmouth College found that nine out of 10 deaths among people covered by Medicare were associated with nine chronic illnesses (ex: congestive heart failure, chronic lung disease, cancer, diabetes). The research also found that chronically ill patients in the last two years of life account for roughly 32% of Medicare spending. The study showed Wisconsin's costs were relatively low compared to the nation. Addressing regional variations and discrepancies will not easy, but the proposed CMIC could provide an innovative way to pilot programs and determine models that may work.

3. **Section III: Infrastructure Investments**

   a. **Health Information Technology Incentive Payments** – the American Recovery & Reinvestment Act included billions of dollars in incentive payments to support hospitals and health care professionals in adopting electronic medical records. During debate on the ARRA we strongly advocated that Critical Access Hospitals (CAHs) receive full parity with respect to their Inpatient Prospective Payment System hospital counterparts. The Senate proposal provided this

parity but it was, unfortunately, removed during conference. In its place was a moderate "bonus" payment for CAHs. While we understand the value of moving forward with incentive payments for other health care professionals, we strongly believe full incentive payment parity should be provide to CAHs *before* expanding the pool of payment recipients. Additionally, even the billions invested under the ARRA for EMR adoption will not be enough, as HIT start-up and maintenance costs are significant. Again, we encourage the committee to keep this in mind before broadening the pool of recipients.

b. **Workforce**

i. **Redistributing unused GME slots to increase access to primary care and generalist physicians and promoting greater flexibility in residency training programs.** With the creation of the Wisconsin Academy of Rural Medicine (WARM), the University of Wisconsin School of Medicine and Public Health will increase it medical student class size by 25 students per year. These students are committed to a curriculum preparing them for careers in rural parts of our state. Recognizing that the best predictor of where a physician will practice is where they train as Residents, it is imperative that we have not only an adequate number of Residency positions for these additional students, but also that positions are in primary care and located in settings that promote careers serving rural and underserved populations. Redistribution of unused Residency positions and greater flexibility in Medicare Graduate Medical Education reimbursement are important strategies in achieving these goals.

ii. **Develop a National Workforce Strategy** – we believe a national workforce strategy is a needed and important goal. States are currently struggling with how to prepare for the future and national efforts seeking to address shortages and encourage training in key focus areas that support delivery system reform goals, such as improving care coordination, health provider use of HIT and increasing access to primary care services, will be beneficial.

We appreciate this opportunity to provide comments to Members of the Senate Finance Committee with respect to Medicare payment reform. Please feel free to contact me if there are any questions or would like additional details with respect to Wisconsin hospitals.

Best regards,

Stephen F. Brenton
President