



May 29, 2009

The Honorable Max Baucus
Chairman, Committee on Finance
United States Senate
Washington, DC 20510

Dear Chairman Baucus,

On behalf of Gundersen Lutheran we commend you for advancing the national health reform debate and specifically your commitment to advancing comprehensive health reform this year. With the aging population the demand for services will continue to grow. Without changes by 2017 health care expenditures are expected to consume nearly 20% of the GDP; \$4.3 trillion annually.ⁱ Spending on health care services will outpace the GDP – over ten years spending for Medicare and Medicaid is projected to increase by 114% while the GDP will only grow 64%.ⁱⁱ Gundersen Lutheran recognizes that significant, systemic changes are required to make government programs sustainable in the future. Specifically, without changes to the current Medicare payment structure, we are risking the viability of the quality medical care for patients living in Wisconsin, Minnesota, and Iowa.

Of primary concern to Gundersen Lutheran are three issues: (1) appropriate modifications to the geographically-based payment system; (2) appropriate payment for rural primary care providers; and (3) appropriate payment for end of life care services.

First, we encourage you to consider Medicare's reimbursement disparities across geographic areas. Wisconsin, Minnesota, and Iowa are ranked in the top quartile for having among the best quality health care in the country.ⁱⁱⁱ The Dartmouth Atlas Health Study identified La Crosse, Wisconsin as one of the most cost-efficient communities in the country in caring for Medicare patients. Yet the Midwest states have some of the lowest reimbursement rates in the nation.

Specifically, in 2008, Gundersen Lutheran was reimbursed \$150 million less than our costs (or approximately 50% of costs) from government-sponsored programs. Because about half of our patients are supported through government programs, we have to make up the difference by shifting costs to our businesses. In addition, Gundersen Lutheran lost over \$17 million dollars associated with our tri-state primary care regional clinic system that provides care to a population that is 80% rural. This is in part due to the costs of recruitment, labor, and technology that are often higher in rural areas but not recognized in the practice expense reimbursement methodology.^{iv} Gundersen Lutheran is often the only provider in these health shortage areas.

Congress and the Administration have articulated the need for a payment system that rewards quality and efficiency, rather than quantity. However, proposals to date continue to recommend a payment methodology that rewards high cost providers, rather than outcomes and clinical process improvements that lead to safer, less costly care. Although many agree that the SGR formula does nothing to improve quality, ensure clinical appropriateness, or accomplish other

Medicare goals, Congress has yet to advance a reimbursement plan to rectify SGR expenditure targets.^v

To address the geographic disparities in payment, we recommend the following:

- Creating an outcome or value-based payment methodology. Enclosed is one proposal that replaces the geographic adjustment of physician work with a quality/efficiency based co-efficient. Value is defined by an equation of $V=Q/C$ where Quality (Q) represents clinical outcomes, safety and patient reported satisfaction and Cost (C) represents the cost of care over time.
- Revising the cost of practice measurement. The practice cost determination has continued to erode funding for primary care and rural practices as it continues to favor urban over rural areas. An interim payment floor should be established for practice expense to assure that rural practices stay in place, allowing us to reduce rural health discrepancies.
- Adjusting the SGR to take into account the existing geographical variation in Medicare payments, rather than an across the board adjustment.

Second, rural physician shortages place access to care at risk. Currently rural physicians see 30% more patients per physician in their practice and their work hours are longer making it more difficult to recruit and retain staff. Historically, 33% of our internal medicine and general surgery residents go on to serve in communities of 8,000 or less and 67% stay in the Midwest. Although we are ranked in the top 7% in the nation for teaching hospitals, in 2008 Medicare direct (DGME) and indirect medical education (IME) paid \$1.5 million and \$2.6 million respectively for our medical residency program leaving Gundersen Lutheran to fund the shortfall of \$3.45million. If the proposed cuts to IPPS payments are enacted AHA estimates that Gundersen Lutheran would lose an additional \$16.85 million dollars in IPPS funding over the next ten years.

To ensure continued access to rural health care services, we recommend that you support rural physicians by:

- Maintaining IME and DGME payments to teaching hospitals recognizing that although the costs of those programs continue to grow. This is one solution to meeting the growing demand for primary care.
- Revisiting the amount of primary care and general surgery bonus payment for shortage areas that is currently set at 10%.
- Ensuring the retention of community based medical staff. Decreasing health disparities in rural communities requires that we promote the training of professionals that understand the dynamics of rural practice. We urge your support for the redistribution of unused GME slots and for strong consideration for community based residency programs.

Finally, we encourage you to support payment for the use of advance care planning tools for the chronically ill in their last two years of life. Gundersen Lutheran has supplied language to Senate Finance Committee and the House Energy and Commerce Committee. We have developed a model that fits in rural and urban settings and across a multitude of practice types. In our experience, appropriate plans of care at the end of life that are portable and implemented in

accordance with patients' wishes not only increase patients' and their families satisfaction, but also have the potential to create substantial cost savings.

We recognize that this is a critical time for the future of the health care system. Should the current system persist it will jeopardize the competitiveness of the health care providers in the Midwest. Reforms such as implementing a payment structure for advance directives, corrective geographical discrepancies, and shifting reimbursement to appropriately reflect quality will ensure that we can continue to provide quality care for our patients.

Thank you for the opportunity to share these comments with you. I will be in Washington on June 24th and am looking forward to scheduling some time with you to discuss these issues.

Please don't hesitate to call me or Joan Curran, Chief, Government Relations and External Affairs at 608-775-4347 or Ladd Wiley, Washington Counsel for Gundersen Lutheran at 202-887-4083.

Sincerely,

A handwritten signature in blue ink that reads "Jeff Thompson MD". The signature is written in a cursive style.

Jeff Thompson, M.D.
Chief Executive Officer

Enclosure: May 20, 2009, Mayo Clinic proposal for value based purchasing

ⁱ Sean Keehan, et.al., "Health Spending Projections Through 2017: The Baby-Boom Generation is Coming to Medicare," *Health Affairs* 27no.2 (2008):144-155.

ⁱⁱ Peter Orszag, "The Budget and Economic Outlook: Fiscal Years 2008 to 2018," (Testimony before the Senate Budget Committee, U.S. Senate, January 24, 2008.

ⁱⁱⁱ J. C. Cantor, C. Schoen, D. Belloff, S. K. H. How, and D. McCarthy, Aiming Higher: Results from a State Scorecard on Health System Performance, The Commonwealth Fund Commission on a High Performance Health System, June 2007

^{iv} Medical Economic surveys.

^v G. R. Wilensky, Reforming Medicare's Physician Payment System, *NEJM*, February, 2009