

WISCONSIN HOSPITAL ASSOCIATION, INC.



June 16, 2009

The Honorable Herb Kohl
United States Senate
330 Hart Senate Office Building
Washington, DC 20510

Dear Senator Kohl:

On behalf of the members of the Wisconsin Hospital Association (WHA), please allow us to provide comments on the various health care reform proposals currently being discussed in Congress.

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 various proposals being discussed. Where applicable, the "Wisconsin experience" is provided.

The Future for Health Care...

Recent articles in *The New Yorker* and *Washington Post* have focused on something Wisconsin hospitals have known for years: Wisconsin provides higher quality, lower cost health care. In fact, President Obama's budget chief, Peter Orszag, said in a June 9 *Washington Post* article. "*If we could make the rest of the nation practice medicine the way that Green Bay does, we would have higher quality and significantly lower cost.*"

From Green Bay to La Crosse, Wisconsin hospitals have been a leader in the integrated health care delivery model and providing high quality and value to our patients. Wisconsin ranked #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).

We believe our state can provide a hands-on perspective for the nation on the importance and value of quality health care and specifically would like to comment on the following as you develop a health care reform package.

Geographic Disparity in Medicare Payments – In addition to AHRQ’s quality rankings, which put Wisconsin at the top in providing quality health care, the Dartmouth Atlas Health Study has also ranked Wisconsin communities as some of the most efficient and low-cost in the country when caring for Medicare patients. The Dartmouth Atlas specifically highlighted the La Crosse area as one of the best; yet, Wisconsin communities continue to be some of the lowest in Medicare reimbursement. Studies indicate that integrated delivery system models, like La Crosse’s Gundersen Lutheran and Franciscan Skemp (of the Mayo System), could save Medicare upwards of \$100 billion a year. Therefore, WHA believes the current QUANTITY OVER OUTCOMES payment formulas must be replaced with an appropriate outcomes-quality-value based proposition. We urge Congress to address this issue head on and reward those states providing health more efficiently and at higher quality. We know you and Senator Feingold are strong supporters of this approach and greatly appreciate your letter to Senators Baucus and Grassley urging them to include this approach in the Senate Finance Committee’s legislation. We encourage you to relay this sentiment to the Senate HELP Committee and your colleagues as health care reform legislation progresses.

WHA would like to provide a few more thoughts on this geographic disparity:

- **Value Index** – One option WHA supports as a means to achieving more equity is the “Value Index” payment model developed by the Mayo Clinic in Rochester, MN – another high-quality, low-cost, integrated health care delivery system. Their model 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.
- **Sustainable Growth Rate** – WHA also urges Congress to finally address physician payments in whatever health care reform legislation is crafted. 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.
- **Rural Disparity** – Legislation introduced this year by Senator Feingold under the Rural Medicare Equity Act as well as Senator Conrad’s Rural Hospital and Provider Equity Act demonstrate the need to address very specific and distinct Medicare issues involving our rural communities. WHA also urges Congress to maintain Medicare’s direct and indirect medical education payments (DGME and IME) as well as provide greater flexibility in Medicare GME reimbursement.

Public Plan Option – As outlined earlier, WHA continues to support reform ideas that build upon and improve employer-based coverage plans while preserving the pluralistic payment system for health care services. We have concerns that a public plan option may work to supplant this fundamental component of the current system. Proposals ranging from a full Medicare-like plan to a plan that levels the playing to a cooperative model have already been tossed around. WHA understands this issue will likely be one of the most controversial within the health care reform debate—we also would like to express our concerns with the concept. Initial drafts of the Senate Finance Committee work would set provider payments in a public plan at 110% of Medicare payment rates. Medicare payment rates to Wisconsin hospitals are already grossly inadequate - paying only 80% of the cost to care for Medicare beneficiaries. If a public plan is put into place with these inadequate payment rates, two things will happen: first, since the plan’s premiums will reflect artificially low provider payments, it will become preferable over private plans and begin to crowd them out. Second, the inadequate payments will spread

to a larger population of patients, making the overall payment shortfalls even greater. The ultimate outcome will be an inadequately financed health care system, with greatly diminished access and lower quality care.

Providing Coverage – Wisconsin is, once again, a leader in providing coverage to its residents. WHA has partnered with Governor Doyle over the years on his goal of reaching 98% coverage for the state. We have actively engaged in supporting his BadgerCare Plus expansions—BadgerCare Plus-*Kids* and, most recently, BadgerCare Plus-*Childless Adults*. Through an innovative federal waiver and through the WHA-supported hospital assessment enacted earlier this year, BadgerCare Plus-*Childless Adults* is beginning to accept enrollees at a time when many other states are reducing their Medicaid responsibilities. It is estimated 100,000 individuals could receive coverage under this expansion, this in addition to the 80,000 currently covered under BadgerCare Plus-*Kids*. These innovative, public-private partnerships are moving Wisconsin forward in terms of covering those in need. It is consistent with WHA’s reform principles and demonstrates what can be accomplished when multiple health care stakeholders with shared responsibilities work toward common goals. We encourage Congress to consider this as they debate health care reform.

Focus on Workforce – WHA has been a strong leader in forging Wisconsin’s health care workforce. We have proactively worked with our members to survey the landscape and help prepare for future needs. From nursing, physician and pharmacist shortages, we have sounded the alarm and worked collaboratively across the state to set plans in motion to address current and future needs. Congress can help us continue to chart this course in the following ways:

- **Redistribute Unused GME Slots** – With the creation of the Wisconsin Academy of Rural Medicine (WARM), the University of Wisconsin School of Medicine and Public Health will increase its 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 is a positive strategy to ensure access to providers in rural areas.
- **National Workforce Strategy** – Several reform proposals include reference to the need for a national workforce strategy and we believe this is a needed and important goal. Health care worker education is costly with a long implementation time. Physician education, for example, takes in excess of 10 years. It is important that money spent to prepare health care professionals be spent on the right occupations at the right time. We can no longer afford to guess at how many schools, how many students and how many residencies. States need reliable forecasting, cooperative planning and supported implementation of a workforce plan to address shortages and encourage training in key focus areas that support delivery system reform goals.
- **Create or Increase Health Care Loan Programs** – Congress must make sure an adequate health care workforce is available. Expanding access does not necessarily translate into expanding coverage; there needs to be appropriate health care workers available to provide that care. To assist in training and encouraging health care workers, WHA supports several of the reform proposals which include expanding or creating appropriate loan repayment or grant programs.

Health Information Technology – The American Recovery & Reinvestment Act (ARRA) included billions of dollars in incentive payments to encourage hospitals and health care professionals in adopting health information technology (HIT). The ARRA also includes concomitant HIT privacy provisions. During debate on the ARRA we strongly advocated on both of these elements. First, we advocated Critical Access Hospitals (CAHs) receive full parity with respect to their Inpatient Prospective Payment System hospital counterparts for incentive payments. In the end, a moderate “bonus” payment for CAHs was included. WHA continues to urge full parity for CAHs. Second and equally important to our hospitals are onerous privacy provisions. Wisconsin hospitals and health care providers are concerned that the consent requirements and accounting of disclosure requirements create new administrative burdens and costs, and, consequently, create a substantial barrier to the

further adoption of electronic medical records. WHA continues to be concerned with the cost of compliance of these provisions, especially the accounting for disclosures requirement. We believe this provision works contrary to President Obama's goal of HIT adoption and will add significant cost without significant benefit. We encourage Congress to correct these troubling provisions to instead reflect a more balanced approach.

MedPAC Authority – We are aware of proposals to increase the authority of the MedPAC board. WHA would like to express concern with any proposal that would elevate MedPAC into an outright policy or reimbursement setting board. 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). Congress should pay close attention to this issue to ensure MedPAC is given appropriate but not overriding health care powers.

Containing Cost – We would also like to indicate our commitment to working towards cost containment measures as outlined recently by the American Hospital Association (AHA) and five other national groups. The AHA outlined these goals as the “Hospitals in Pursuit of Excellence Campaign.” These goals include:

1. Facilitate hospital and health system performance improvements that have meaningful quality improvement and associated cost savings;
2. Further the use of known best practices, initially in the areas of infection prevention and patient safety and expanding over time into other areas;
3. Facilitate the sharing of best practices among hospitals, health systems and national, state, regional and metropolitan hospital associations; and
4. Demonstrate the commitment of the hospital field to achieve these improvements.

AHA listed items that hospitals may initially begin work on, including items such as reducing surgical infections and complications; reducing pressure ulcers; reducing central line-associated blood stream infections (CLABSI); and reducing methicillin-resistant Staphylococcus aureus (MRSA). The recommendations are consistent with many of the quality efforts already under way in Wisconsin by our hospitals and other providers. We are committed to doing our part to advance important performance improvements.

In fact, WHA and our member hospitals are already engaged on a variety of these quality improvement priorities and anticipate moving quickly on others. One example is the collaborative learning projects our hospitals have engaged in to reduce surgical site infections and other complications of surgery. Hospital specific performance on these national measures is reported on CheckPoint (www.wicheckpoint.org). Other examples are statewide improvement initiatives under the Wisconsin Pressure Ulcer Coalition project, the MetaStar MRSA project and the upcoming WHA CUSP: STOP BSI project on bloodstream infections.

As you know, WHA and our hospitals are committed to excellence and we work towards it each and every day. We have national thought and practice leaders whom we know are setting the bar for rest of the nation. We encourage you to continue to do whatever you can to take the Wisconsin message to the Senate as it drafts and debates health care reform, and, we encourage you to call upon us and our members if we can assist.

Sincerely,



Stephen F. Brenton
President