

Review & Commentary on Health Policy Issues for a Rural Perspective – February 1st, 2010

## First Steps & Unintended Consequences

By Tim Size, RWHC Executive Director

The healthcare reform bill pending in Congress will help rural communities by more people having health insurance, beginning to address some rural payment inequities and to continue some important protections for rural providers that were expiring.

The bill needs to be seen as only a really important first step on long over due changes for our country. This is not a criticism of Congress but a statement of reality when a country goes about trying to fundamentally improve a huge part of itself, like its healthcare system—a sixth of its economy.

It will take years for healthcare providers, insurers and local communities to adapt to a complex array of new expectations, incentives and resources. In particular, those of us who care about rural health need to be nimble to address the risk of ideas developed in urban communities and frequently not tested in rural ones.

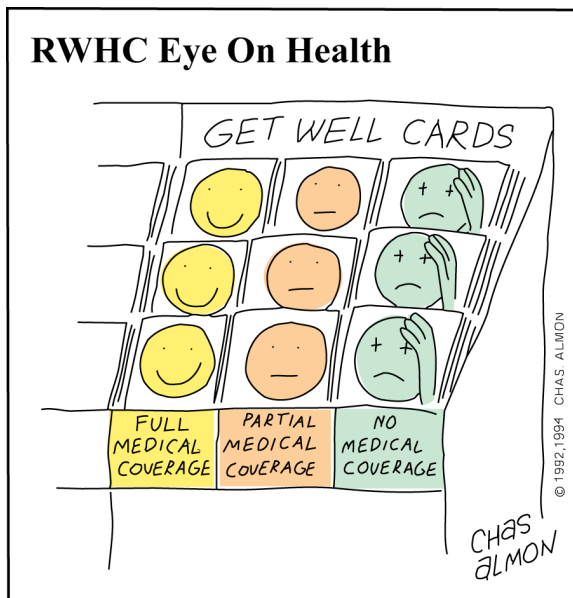
The health reform bill leaves significant challenges for future legislation and regulation and all of us to do outside of government.

No amount of “healthcare reform” can fix our own

behaviors. We must work to reduce the amount of care our system needs to deliver. We must get serious about doing what we can to get and stay healthy. We need to do this as individuals, workplaces and communities.

The current system penalizes those states who have already begun to move in the right direction with higher quality and relatively low costs.

### RWHC Eye On Health



Wisconsin Congressman Ron Kind was instrumental in getting into the House Bill language that requires a study about how Medicare should create incentives for value of care rather than volume of care. The study will be done by the country’s highest medical authority, the Institute of Medicine and its recommendations will be implemented unless Congress takes action to block the changes.

Most disappointing is that Congress did not make a simple change that would have saved money and reduce headaches for rural communities. Current Medicare law limits the number of patients the typical rural hospital can see (those paid as a “Critical Access Hospital”) to a 25 bed cap. We and other rural advocates proposed changing that to a 20 bed average to allow for seasonal spikes in the number of patients like during a flu epidemic. Maybe this will be changed in the final Bill but currently this problem remains.

Many people have praised the new Medicare Commission as a way to modernize Medicare without “good” ideas getting bogged down in Congress. But it has been

key Members of Congress, in both the Senate and the House that have stood up for rural health. It is unlikely that there will be a rural perspective invited into a small Commission. A Federal law that requires proportional rural representation on the current Commission, which is only advisory, has never been implemented.

Don't underestimate the importance of unintended consequences. It took the country the greater part of 20 years to work through problems caused but not anticipated when the way Medicare pays hospitals was fundamentally changed in 1983. It will take at least that long to digest this much change.

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## No Master Cost Control Plan a Bad Thing?

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*Editors note: "The Cost Conundrum, What a Texas town can teach us about health care" in the June 1st issue of The New Yorker by Atul Gawande was easily the one single article most quoted in 2009 about the American health care system, by people with all sorts of political leanings.*

*Gawande has a new piece in The New Yorker (12/14/09)—"Testing, Testing: The health-care bill has no master plan for curbing costs. Is that a bad thing?" In an era of some cynicism, and endless unproductive arguments and sound bites seeking the single right answer, you need to be warned to be prepared to be optimistic. Anyhow, many have found his central idea clear and compelling.*

From "Testing, Testing" by Atul Gawande in the 12/14/09 issue of *The New Yorker*; the complete article is available at [www.newyorker.com](http://www.newyorker.com):

"There are, in human affairs, two kinds of problems: those which are amenable to a technical solution and those which are not. Universal health-care coverage belongs to the first category: you can pick one of several possible solutions, pass a bill, and (allowing for some tinkering around the edges) it will happen. Problems of the second kind, by contrast, are never solved, exactly; they are managed. Reforming the agricultural system so that it serves the country's needs has been a process, involving millions of

process, involving millions of farmers pursuing their individual interests. This could not happen by fiat. There was no one-time fix. The same goes for reforming the health-care system so that it serves the country's needs. No nation has escaped the cost problem: the expenditure curves have outpaced inflation around the world. Nobody has found a master switch that you can flip to make the problem go away. If we want to start solving it, we first need to recognize that there is no technical solution."

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## 2009's Best Healthcare Political Whoppers

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FactCheck.org is a critically important resource throughout the year. Their "Whoppers" article "presents just a selection of what we consider our most important findings, with special emphasis on the misinformation being most heavily repeated during the year. We don't attempt to assign rankings to particular claims — your opinion is as good as ours when it comes to deciding whether one falsehood is worse than another." The following is from [www.FactCheck.org](http://www.FactCheck.org)

### Liberals: Killer Insurance Companies

- **False Fingerprinting:** "Obama falsely claimed that an insurance company was responsible for the death of an Illinois cancer patient whose coverage was canceled be-

**RWHC Eye On Health** is the monthly newsletter of the Rural Wisconsin Health Cooperative, begun in 1979, has as its **Mission** that rural Wisconsin communities will be the healthiest in America. Our **Vision** is that... RWHC is a strong and innovative cooperative of diversified rural hospitals... it is the "rural advocate of choice" for its Members... it develops and manages a variety of products and services... it assists Members to offer high quality, cost effective healthcare... assists Members to partner with others to make their communities healthier... generates additional revenue by services to non-Members... actively uses strategic alliances in pursuit of its Vision.

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General Rural Advocacy Blog: [www.ruraladvocate.org/](http://www.ruraladvocate.org/)  
Rural HIT Blog: [www.worh.org/hit/about/](http://www.worh.org/hit/about/)

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cause he hadn't reported gallstones. 'They delayed his treatment,' Obama said, 'and he died because of it.' Not true. As the *Chicago Sun-Times*' Lynn Sweet reported, Otto Raddatz of Downers Grove, Ill., did have his insurance canceled by Fortis Insurance, but the coverage was reinstated in April 2005 and his chemotherapy went forward after only a brief delay. Raddatz lived for nearly another four years and died early this year. Obama got this whopper from an online magazine article; the author later admitted jumping to a wrong conclusion. 'Sweet: Another Stretch by Obama,' Sept. 13; 'Too Good to Check?' Sept. 18."

- **Double Trouble:** "Obama exaggerated by at least a factor of two when he said that health care 'causes a bankruptcy in America every 30 seconds.' And we've noticed the claim popping up elsewhere, such as, believe it or not, in a new iPhone app. But data from the U.S. Courts showed about 934,000 *total* personal bankruptcies in the 12-month period ending June 2008. Even if we accept a Harvard study's conclusion that half of bankruptcies are related to medical expenses—and some have criticized that study—that would still be only one healthcare bankruptcy every minute. 'Fact-Checking Obama's Speech,' Feb. 25."

- **Puffed-up Premiums:** "We twice caught Obama saying that the 'average American family is paying thousands' or 'a thousand dollars' in health insurance premiums to pay for uncompensated care for the uninsured. But he used a figure from a group that lobbies for expanded coverage. Nonpartisan experts at the Kaiser Family Foundation put the figure much lower—about \$200. 'Obama's Health Care Claims,' June 16 and 'Obama's Health Care News Conference,' July 23."

- **Saving \$2,500:** "Obama repeated his claim that the average family could save \$2,500 a year

under health care overhaul legislation. We picked apart his optimistic calculations during the 2008 presidential campaign, but he repeated the claim as recently as May 17, saying that 'comprehensive reform' and some other private sector measures could save '\$2,500 per family every year.' Since then we haven't heard much about this. His claim is not supported by the nonpartisan

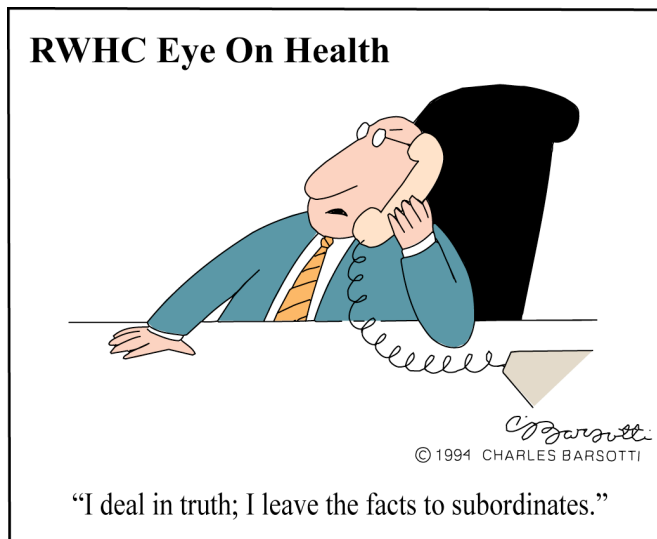
Congressional Budget Office, which estimated that under the Senate bill (as introduced), there wouldn't be much of a reduction at all. Those with coverage from large employers would see premium reductions of 0 percent to 3 percent, with the average family premium costing \$20,300 in 2016, CBO said. And for those buying their own insurance in the non-group market, CBO es-

timated that nongroup premiums actually would go up. That increase would be more than offset by new taxpayer subsidies for most policyholders—but not for all. 'Seven Falsehoods About Health Care,' Aug. 14."

### Conservatives: Pulling the Plug on Grandma

- **"Death Panels:"** "The 'pulling the plug on grandma' falsehood really took off once former vice presidential candidate Sarah Palin coined the term 'Death Panel,' but this falsehood got its first push from former New York lieutenant governor and health care overhaul opponent Betsy McCaughey."

"She misrepresented a provision (since dropped) that merely called for Medicare to pay for voluntary counseling sessions to help seniors make end-of-life care decisions, such as designating a health care proxy, choosing a hospice or writing a living will. McCaughey twisted that into 'a required counseling session' that would 'tell them how to end their life sooner.' Palin later wrote on her Facebook page that she doesn't want government bureaucrats to decide whether her parents or child with Down Syndrome are 'worthy of health care.' Who would? Certainly not legislators, who didn't call for the creation of any such 'Death Panel' in the health care bills. 'False Euthanasia Claims,' July 29; 'Palin vs.



Obama: Death Panels,' Aug. 14; 'SpotCheck.org'? We Disagree.' Aug. 25."

#### RWHC BLOGS

The Rural Health Advocate: [www.ruraladvocate.org/](http://www.ruraladvocate.org/)

Rural Health IT: [www.worh.org/hit/](http://www.worh.org/hit/)

leading. At one point the author, a conservative blogger, claimed that the bill contained 'more

#### ▪ **Socialized Medicine:**

"Several groups and politicians claimed that the major health care bills in Congress called for a single-payer system like Canada's, under which all citizens have health insurance provided by the government, or even a system like Britain's, where doctors and hospitals are employed by the government. The truth is that none of the major bills that were debated in Congress called for such a drastic change to the U.S. system, much to the chagrin of single-payer advocates. 'Government-Run Health Care?' April 30; 'Canadian Straw Man,' July 17; 'The Government-Run Mantra,' Nov. 6."

#### ▪ **Dictating to Doctors:**

"McCaughey falsely claimed that the stimulus bill (passed in February) required that doctors follow government orders on which medical procedures can and can't be performed. It didn't. All the bill really did was create a council on 'comparative effectiveness research,' which examines which treatments or drugs work best or are most cost-effective. It said none of the council's reports or recommendations 'shall be construed as mandates or clinical guidelines for payment, coverage, or treatment.' 'Doctor's Orders?' Feb. 20."

#### ▪ **Breast Cancer Massacre:**

"One TV spot claimed that '300,000 American women with breast cancer might have died' if our health care system was like England's. The ad's conservative sponsor cited the American Cancer Society as a source, but the cancer society never used such a number and an ACS epidemiologist called the ad sponsor's calculations 'really faulty.' 'A False Appeal to Women's Fears,' Sept. 4."

#### ▪ **"26 Lies" E-mail:**

"Judging from our editor inbox, one of the most widely circulated chain e-mails of 2009 was a lengthy list of 48 claims about specific sections of the House health care bill, complete with page numbers. We combed through every item and found that only four were true, 26 were false and the rest were mis-

payoffs for ACORN.' But ACORN has nothing to do with the medical home services funded by the bill. The author also claimed that illegal aliens 'will be provided with free healthcare services,' misrepresenting a provision that simply prohibits discrimination in health care based on 'personal characteristics.' 'Twenty-six Lies About H.R. 3200,' Aug. 28."

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### "Meaningful Use" Impact on Rural Providers

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From a blog by Louis Wenzlow, RWHC Director of Health Information Technology and the Chief Information Officer of the RWHC Information Technology Network, at "Rural Health IT" blog at: [www.worh.org/hit/](http://www.worh.org/hit/)

"Under the American Recovery and Reinvestment Act (ARRA), eligible physicians and hospitals must reach a certain threshold of EHR adoption ('meaningful use') in order to earn CMS incentive payments. In July, the ARRA-established HIT Policy Committee recommended a wide range of meaningful use objectives for CMS to consider in the development of a proposed HIT incentive rule. Released on December 30, the proposed rule largely follows the Policy Committee's recommendations."

"So how will the proposed rules meaningful use requirements impact rural providers? How long will providers have to achieve the meaningful use thresholds? And are these timing requirements reasonably achievable by small and rural providers?"

#### **CMS Proposed Definition of Meaningful Use—**

"Consistent with HIT Policy Committee recommendations, the CMS proposed rule creates 3 stages between 2011 and 2015 over which providers will need to meet increasingly stringent meaningful use requirements. The proposed rule identifies the requirements associated with Stage 1. Providers that reach Stage 1 meaningful use by the end of 2012 will maximize the value of their incentive. Providers that meet Stage 1 requirements by 2014 can still receive some level of incentive (see next section for detail regarding how this works)."



“The definition of Stage 1 meaningful use in the CMS proposed rule is similar to the definition established by the HIT Policy Committee in July. The major differences are:

- HIT Policy Committee recommended requirements (record advance directives, and provide access to patient-specific educational resources) have been removed.
- The HIT Policy recommendation to implement a single clinical decision support rule has been increased to 5.
- The information exchange requirement has been qualified so that it is allowable to exchange unstructured information, and the requirement can be met through a test of an EHRs ‘capacity’ to exchange.
- Specific measures have been defined for each one of the 20+ requirements.
- Numerous quality measures have been defined (I will be dealing with how the quality measures impact rural providers in a separate analysis).”

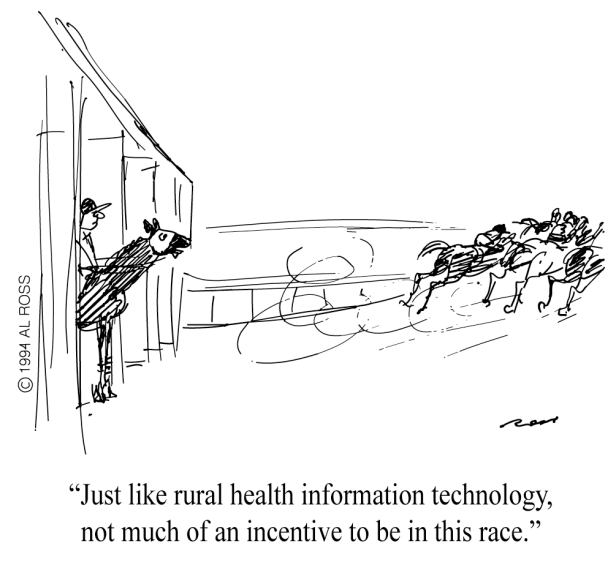
“As with the HIT Policy Committee recommendations, the greatest challenge in the CMS proposed rule for rural providers is the Stage 1 requirement to implement computerized provider order entry (CPOE). CPOE is a capstone implementation that is generally (and for good reason) implemented many years after other building blocks of a complete EHR have been laid.”

**How Long Do Providers Have to Achieve Meaningful Use?**—“Consistent with the HIT Policy Committee recommendations, the CMS proposed rule employs the concept of ‘payment year,’ so that providers that become eligible in later years will still only have to meet Stage 1 requirements, if only for their first payment year.

**“This will give early stage adopters at least some timing flexibility, though it will not do anything to make Stage 3 requirements reasonably attainable. All providers will need to reach Stage 3 requirements by 2015 as noted below:**

- *Eligible professionals and hospitals whose first payment year is 2011* must meet stage 1 requirements in 2011 and 2012, stage 2 requirements (not yet defined) in 2013 and 2014, and stage 3 requirements (not yet defined) in 2015.
- *Eligible professionals and hospitals whose first payment year is 2012* must meet stage 1 requirements in 2012 and 2013, stage 2 requirements in 2014, and stage 3 requirements in 2015.

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- *Eligible professionals and hospitals whose first payment year is 2013* must meet stage 1 requirements in 2013, stage 2 requirements in 2014, and stage 3 requirements in 2015.
- *Eligible professionals and hospitals whose first payment year is 2014* must meet stage 1 requirements in 2014, and stage 3 requirements in 2015.
- *Eligible professionals and hospitals whose first payment year is 2015* must meet stage 3 requirements in 2015.”

**Is Meaningful Use Achievable for Small and Rural Providers?**—“Many small and rural providers are at the beginning stages of EHR adoption. For most of these early-stage providers, meeting Stage 1 meaningful use requirements by the end of 2012 would likely be unachievable. The provision to allow providers to meet Stage 1 requirements by 2014 (if 2014 is their 1<sup>st</sup> payment year) is therefore welcome and critically important. However, many providers who meet Stage 1 requirements in later years will likely find meeting Stage 2 and 3 requirements (assuming Stage 2 and 3 requirements are consistent with the HIT Policy Committee’s recommendations for those stages) unachievable within the timeframes allowed.

These providers will therefore receive reduced incentives and eventually be subjected to penalties.”

#### 18<sup>th</sup> Annual \$2,000 Monato Essay

A \$2,000 Prize for the Best Rural Health Paper by a University of Wisconsin student. Write on a rural health topic for a regular class and submit a copy by April 15th. Info re submission is available at [www.rwhc.com](http://www.rwhc.com)

**Conclusion**—“I believe that it’s fundamentally unfair to set a single meaningful use standard for all providers. The result of a single-standard strategy is that providers who already have EHRs (and therefore don’t need assistance) will get the lion’s share of the incentives; whereas providers who are disadvantaged at low stages of adoption (who particularly need the assistance) will be much less likely to get help.”

“This is like starting a 40 yard dash with some runners at the starting line, others at the 20, and still others standing past the finish line, and only those that finish in 4 seconds get a prize.”

“For whatever reasons, CMS and ONC have structured the incentive program in a way that will dramatically expand the digital divide between our country’s EHR haves and have-nots. Given that many studies have shown that rural providers have significantly lower EHR adoption rates than general hospitals, as well as additional barriers to EHR implementation (such as lack of capital, minimal HIT staffing levels, and reduced EHR system ROI), this will disproportionately negatively impact rural providers.”

See “ARRA History” for more information: [www.worh.org/hit/arra-history](http://www.worh.org/hit/arra-history).

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### Evidence Based Regulation?

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From a Commentary, “Follow the evidence: Administrative rules, regulations should get comparative-effectiveness treatment” by Patricia Galloway in *Modern Healthcare*, 12/14/09:

“In recent years, healthcare providers have been urged to embrace evidence-based medicine, to use existing data to deliver high-quality, appropriate and necessary care, while avoiding useless-

and even harmful inter-ventions. This would improve outcomes and reduce healthcare expenditures.”

“Studies have shown that as much as 11% of the care rendered in America represents overuse. Such care is not good for patients, and adds to U.S. healthcare spending every year. To aid in achieving evidence-based medicine, \$1.1 billion has been added to the federal budget for comparative-effectiveness studies.”

“Unfortunately, the discussion of using evidence has stopped short of the mark. To date, we have exclusively looked at the delivery side of the healthcare equation, while nobody is sounding a call for reform on the administrative and regulatory side of the equation. As we reform our health system, the time is right to demand evidence-based, coordinated regulation and administrative rules.”

“There are data demonstrating that administrative costs consume between 18% and 25% of the U.S. healthcare dollar. However, cost is likely a significantly low estimate, because it does not include the costs that hospitals and other healthcare providers incur in complying with government and other regulatory bodies’ administrative rules and regulations.”

“While the Congressional Budget Office creates detailed estimates of the cost to the federal government of changing the delivery and payment systems, it does not look at the cost of new regulations and guidelines to providers.”

“The CMS is just one of more than a dozen federal organizations that promulgate rules and regulations for healthcare delivery systems. These regulations cover virtually every process: from the minute details of billing to direct patient-care processes, laboratory and radiology tests, workforce rules, building specifications, investments, research and waste disposal. The number of these rules and regulations each organization issues is staggering. Medicare has 12,000 pages of billing rules alone. Entire industries have sprung up to help hospital and physician billing clerks ensure that billing is correct and that errors do not lead to costly investigations for fraud and abuse.”

“State and local governments also promulgate additional sets of regulations for healthcare organizations, including those that mirror federal organizations such as Medicaid

and the State Children's Health Insurance Program, and those that regulate professional disciplines such as medical examiners and nurses."

"There is a similarly large array of national organizations with various ranges of control that implement even more regulations, standards and guidelines. Some of these focus on patient safety and quality. Currently there are at least 21 organizations that have promulgated more than 3,000 quality measures."

"There is no systematic integration across organizations or central oversight to identify duplicative, overlapping or contradictory rules, nor is there any cost-benefit standard for this confusing array of regulations and rules."

"Added to all these regulatory bodies are the administrative burdens imposed by the insurance companies, each of which demands its own version of pre-authorization, claims adjudication and payment mechanisms."

"The cost goes beyond dollars to the impact on real patient care. The diversion of hospital nurses from bedside care to documentation tasks has been estimated by some at 30% of their time. Physicians in office practices are known to be discouraged by mountains of paperwork."

"Thus far, the healthcare discussion has focused on providing healthcare coverage for Americans who are uninsured or underinsured, on providing improved quality of care and on reducing the ever-growing and nationally debilitating cost of healthcare. Yet, the discussion has included little attention to the regulatory and administrative components that encumber and demoralize providers and add enormous costs—often without defined value to our healthcare system."

"Should we not use this period of reform to create evidence-based regulation and administration to match our evidence-based medicine? Should we not demand coordination of regulation just as we are demanding coordination of patient care? Should we not free providers from negotiating the maze of siloed regulations? Isn't it time to simplify the regulatory aspect of healthcare? This is

reform that everyone would embrace, and it will help us pay for our true goal—universal healthcare for all Americans."

*Patricia Gabow, a physician, is CEO of Denver Health, an integrated public safety net healthcare system.*

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## Rural Law Specialists: Quarles & Brady, LLP

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Beginning with this issue of *Eye on Health*, RWHC will take time to spotlight one of the Corporate Members. For more information on the featured corporate member or to inquire about our corporate membership program, please visit [www.rwhc.com](http://www.rwhc.com), or contact Dave Johnson: 608-644-3227 or [djohnson@rwhc.com](mailto:djohnson@rwhc.com).

Quarles and Brady, LLP has been a trusted partner with RWHC for many years. Working with the director and staff of RWHC as well as many of the member hospitals who comprise the RWHC Board, Quarles & Brady have proven to be committed to assisting rural health organizations navigate the complex landscape that is healthcare. The below info is from [www.quarles.com](http://www.quarles.com)

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## Columbus Community Care

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*We regularly showcase a RWHC member from the Wisconsin Hospital Associations' annual Community Benefits Report. Wisconsin hospitals provide over \$1.6 billion in community benefits; twice that if you include Medicare shortfalls and bad debt. This story is from Columbus Community Hospital:*

“At 6 years old, Danielle Storhoff shouldn’t have to worry about whether or not her physical therapy sessions are covered by medical insurance. Danielle was diagnosed with Moyamoya at age 3. The condition, only affecting one in two million children in the United States, causes strokes in Danielle due to the narrowing of blood vessels that carry blood to the brain. In 2006, Danielle underwent surgery to move the blood vessels and began occupational and physical therapy sessions at Columbus Community Hospital. The therapy assisted Danielle in regaining movement in her right side, which was nearly paralyzed from her original strokes. While the therapy was successful, insurance coverage for the sessions was

maxed out for the year by the fall of 2008. In November 2008, Danielle suffered three strokes and additional occupational and physical therapy was needed.”

“Without insurance to cover the bill and three other children at home under the age of 10, Danielle’s parents, David and Shelley, applied for community care at Columbus Community Hospital. The hospital covered over \$2,500 in physical therapy costs. In 2009, due to the intensified need for occupational and physical therapy, the coverage was maxed out by May, and Columbus Community Hospital once again covered over \$2,500 in physical therapy costs so Danielle could continue her sessions. ‘We are thankful to know that our family can continue to focus on Danielle’s recovery rather than just paying the bills,’ said Shelley. ‘We appreciate the fact that (Columbus Community Hospital) has payment options available for patients and their families.’ ”



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