American Hospital Association

Max S. Baucus

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STATEMENT OF SENATOR MAX BAUCUS
AMERICAN HOSPITAL ASSOCIATION
Toronto, Canada
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Thank you, Gary [Gary Fletcher, Administrator of Central Montana Hospital, Lewistown].

In May, I visited Gary's hospital in Lewiston. He gave me a crash course in keeping a small rural hospital alive on the Montana High Line.

I can't think of a better person for you to have on your board. And I appreciate your kind words, Gary.

I'd also like to thank Jack Owen for inviting me to speak with you today.

I'm told that this may be the last AHA convention that's 100% tax deductible. I sure hope that you're going to make it a good one!
THE LAST TIME I Addressed THE RURAL HOSPITAL SECTION WAS AT THE 1983 HOUSTON CONVENTION.

Remember 1983? Back then, we were all speculating about a small technical change that Congress had just approved—called prospective payment.

Well, many things have changed since 1983. But some things haven't.

HHS is still shopping around for support for its capital cost plan. And HHS is still trying to make sweeping policy reforms by administrative regulations.

In the end, Congress steps in and that's when things tend to go into low gear.

THE STRUGGLE IN WASHINGTON

If you've observed Congress for any length of time, you know that we work in two-year cycles.
FOR THE FIRST YEAR-AND-A-HALF, WE WORK VERY SLOWLY AND DELIBERATELY. WE MAKE LONG LISTS OF THE THINGS WE PLAN TO FINISH BEFORE WE ADJOURN.

INEVITABLY, WE FALL BEHIND, AND

SO, WE SPEND THE LAST FEW MONTHS OF EVERY CONGRESS WORKING FRANTICALLY TO GET JUST ENOUGH DONE IN TIME TO CAMPAIGN FOR REELECTION.

RIGHT NOW, WE'RE IN ONE OF THOSE FRANTIC STAGES.


LOOMS THE SPECTER OF GRIM, ON TOP OF ALL THIS, THE FEDERAL BUDGET DEFICIT REMAINING GRIM.

UNCLE SAM IS STILL OPERATING IN THE RED.
This year's budget deficit will be another $200 billion. And we're finally starting to pay the price, as the budget deficit and the trade deficit begin to drag the economy.

We can argue about whether the federal budget deficit is caused by high spending or low taxes. I tend to think it's caused by a good measure of each.

But whatever the cause, it's clear that the solution will require further reductions in federal spending. And, yes, that means further curbs on federal health spending.

As a result, for the foreseeable future, budget policy will continue to drive health policy.

And remember, health programs are one of the three "big ticket" spending items in the federal budget, coming right after defense and Social Security.
Last year, total U.S. health expenditures increased by 9%, to $425 billion. That consumes nearly 11% of our gross national product.

Medicare spending alone increased by 12%, the fastest growing component of the federal health dollar which peaked at $124 billion last year.

For now, this means more tinkering. Congress will continue making pragmatic adjustments here and there to save a buck.

But tinkering will only get us so far. At some point, the law of diminishing returns will take over. We'll have to roll up our sleeves and start debating fundamental health policy.

Rural Health Policy

I wish that I had a crystal ball to tell you where the health policy debate will take us in the year 2000. What those changes will be.
But let me tell you about one issue that is certainly here to stay: quality health care for rural Americans.

Policy makers in Washington seem to believe that "bigger is better." Or, at least, that bigger is more important.

There's nothing sinister going on here. It's about this... It's just human nature.

When someone comes to Washington, they usually want to work on the glamorous policy issues. Grand schemes. Billions of dollars and millions of people.

As a result, the problems of small communities often get overlooked. Even worse, federal rules and policies begin to reflect a distinct urban bias.

This discrimination has been painfully apparent in the formulation of health care payment policies.
THE PROBLEMS OF A 30-BED HOSPITAL JUST AREN'T GLAMOROUS. THEY'RE DOWNRIGHT THORNY. SO, THEY TEND TO BE IGNORED.

I LEARNED THIS SHORTLY AFTER I ARRIVED IN WASHINGTON AS A FRESHMAN CONGRESSMAN.

YOU MAY REMEMBER THE NATIONAL HEALTH PLANNING GUIDELINES THAT HEW ISSUED IN THE 1970'S.

THESE GUIDELINES WERE TAILOR MADE FOR LARGE, METROPOLITAN HOSPITALS. IF THEY HAD BEEN APPLIED TO SMALL HOSPITALS, MANY WOULD HAVE BEEN FORCED TO CLOSE THEIR DOORS.

JOE CALIFANO WAS THE HEW SECRETARY THEN. I KNOW JOE PRETTY WELL. HE'S A GREAT GUY, AND DID A GOOD JOB AS SECRETARY.

BUT NEITHER HE NOR THE PEOPLE WORKING FOR HIM HAD GIVEN THE CONCERNS OF SMALL HOSPITALS MUCH THOUGHT.

WE HAD TO GET HIS ATTENTION. SO I FILLED A SMALL TRUCK WITH LETTERS I'D RECEIVED FROM
Angry Montanans drove over to HEW, and dumped the letters on Joe Califano's desk. This may not be the typical procedure for commenting on regulations, but it worked, and the regulations were modified. That was one small victory.

But the overall problem persists. The current administration worships what they call the "efficiency theory." The idea is that competition among health providers will keep costs down. But the theory only works if patients have reasonable options.

It's a fine theory, and I'm sure that you recognize it in the descriptions of the prospective patient system. Today it has a unique twist.

But the overall problem persists.
IF AN INEFFICIENT HOSPITAL SHUTS DOWN, THE THEORY GOES, PATIENTS CAN TRVEL TO A MORE EFFICIENT HOSPITAL 5 MILES ACROSS TOWN.

But what if the nearest hospital is 50 MILES ACROSS THE STATE AND IT'S WINTER?

THE ECONOMIC EFFICIENCY THEORY SIMPLY DOESN'T WORK IN MANY TOWNS ACROSS AMERICA.

Don't get me wrong. I think efficiency is a fine goal. But, it's not the only goal. In health care, other goals are just as important, such as ACCESS TO CARE AND THE QUALITY OF CARE.

THE MEANING OF RURAL

Think I'm just

Now, before you accuse me of "preaching to the choir," I want you to know that I have made these same points to Dr. Otis Bowen, the new Secretary of HHS.
I also made them to his Undersecretary, Don Newman. And, just for good measure, I made them to the new HCFA Administrator, Bill Roper.

All three came by my office before their confirmation hearings in the Senate Finance Committee.

Here's what happened. I'd start talking about small towns in rural Montana like Cut Bank and Poplar.

"Doc" Bowen and Don Newman would counter with the names of a few towns in rural Indiana where they used to live. Then, Bill Roper would tell me about rural Alabama.

Well, it occurred to me that I was up against a difference of perspective. Their experience was in the rural East, not the Rocky Mountain West.

Again, I felt I needed to get the attention of the top leadership of HHS. So, when Don Newman came before the Finance Committee, I was ready with a little lesson in arithmetic.
I pointed out that Indiana has 36,000 square miles and 10 congressional districts. That's an average of one congressional district for each 3,600 square miles.

Then I asked him to take a look at Montana, which has about 150,000 square miles and two congressional districts.

That's an average of one congressional district for every 75,000 miles.

So, when you think about a rural hospital in Montana you're talking about an area that is 25 times less densely populated than rural Indiana.

That's what rural means in the Far West. Vast open distances. Small towns connected to each other by miles and miles of state highways. Huge space.

And what sets some of these towns apart from the place down the road is a small community hospital.
These small hospitals are the backbone of rural health care. And for many small towns, the hospital is much more than that.

They are the places where people were born.

And they are the places where many expect to return when the end of life is near.

Hospitals are often the largest employer in town. They provide some of the best paying, most challenging jobs.

They make the town a better place to live. A better place for kids to grow up. A better place for new firms to locate.

Even with the rural economy facing a crisis, small hospitals are backed by tremendous community pride and support.

And nobody is quite sure what the town would be like if the local hospital is forced to close its doors.
That's the message I think every new HHS appointee needs to hear.

And that's the point that has to be made on every proposed health regulation, every new budget proposal, and every new change in the Medicare statute.

If that doesn't work, we have to try something else. We have to let them know that you do mean business.

In the meantime, I think it is important in my case, I decided to write a rural health bill. Just to be sure the point is made.

Rural Health Legislation

Early this year, I decided that the time had come for some nuts and bolts amendments to the Medicare statute to help make sure federal health care policy fits the unique needs of small rural hospitals.

The result was the Rural Health Care Improvement Act of 1986, which I introduced in May. Senator Chuck Grassley of Iowa was the lead
cosponsor, and Congressman Jim Jones of Oklahoma introduced the same bill in the House.

We wanted to accomplish two objectives.

First, we wanted to hit HHS over the head with a two-by-four, and let them know that rural concerns must be reckoned with.

Second, we wanted to make immediate changes in Medicare's prospective payment system to correct existing biases against small rural hospitals.

After the bill was introduced, the Senate Finance Committee held a hearing on the subject of rural health care. Gordon Russell testified on behalf of the [AHA Rural Hospital] section, and we got our message across loud and clear.

I am pleased to tell you that two weeks ago, the Finance Committee took action that will accomplish all three of our bill's key payment provisions.
ONE KEY PROVISION OF THE BILL ESTABLISHES SEPARATE, LOWER STANDARDS FOR OUTLIER PAYMENTS FOR SMALL RURAL HOSPITALS AND SOLE COMMUNITY HOSPITALS.

ANOTHER PROVISION MAINTAINS THE CURRENT CAPITAL COST PAYMENT POLICY FOR SOLE COMMUNITY HOSPITALS.

AND A THIRD PROVISION REQUIRES THAT MEDICARE "CLEAN" CLAIMS BE PAID WITHIN NO MORE THAN 24 DAYS.

ONCE WE GOT THE BALL ROLLING, SEVERAL OTHER SENATORS PROPOSED ADDITIONAL RURAL HEALTH AMENDMENTS, AND SEVERAL WERE APPROVED.

WE ADOPTED A PROVISION PROTECTING RURAL REFERRAL CENTERS FROM SUDDEN REGULATORY CHANGES. WE ALSO ADOPTED A PROPAC PROPOSAL TO RECALCULATE PPS RATES ACCORDING TO THE AVERAGE COSTS PER DISCHARGE. THIS WOULD RAISE RURAL PAYMENT AMOUNTS BY AN AVERAGE OF OVER 3 PERCENT.
All of these proposals move in the right direction. If they make it into the final budget bill, they'll help restore more balance and fairness for health care in rural America.

Conclusion

Plato said that "A good start is half the job." We've made a good start.

But only a start.

We have many other important issues to address.

We need to attract doctors and other health professionals to rural communities, and keep them there.

We need to reduce the wide gap in PPS payments between urban and rural hospitals.
AND we need to help rural hospitals find innovative ways to serve their communities at the lowest possible cost.

And, so, my message to you is to keep up the fight. Make your voices heard within the American Hospital Association, in your state legislatures, and with your delegation in Congress.

But, don't just tell us the problems. Give us some solutions to work with. And give us honest and reliable information on which to base our decisions.

America's rural citizens deserve equal access to outstanding health care. They're counting on all of us to come up with the answers.

The stakes are high -- but with your continued help, we can make sure that the health care needs of millions of rural Americans are not forgotten.