Jan. 30
Mon
7-8:30 am

speak

American Hospital Association

Joyce

Capitol Place, Building #3
50 F Street, N.W.
Suite 1100
Washington, D.C. 20001
Telephone 202.638-1100
Cable Address: Amerhosp

7:00 Sheet Spk ?
7:45

at Wash. Hilton

November 30, 1988

The Honorable Robert Dole
United States Senate
141 Hart Senate Office Bldg.
Washington, D.C. 20510-1601

Dear Senator Dole

On behalf of the Section for Small or Rural Hospitals, it is my pleasure to invite your participation in the American Hospital Association's Annual Membership Meeting. The Section membership would be most appreciative if you would join them as the guest speaker for their annual breakfast meeting.

The Section for Small or Rural Hospitals is comprised of institutions from throughout the country. As you know, our rural members continue to struggle to provide health care in many areas. We have been encouraged by recent congressional action to assist many rural institutions. Our members would gain a great deal if you would address topics such as the legislative outlook for 1989, the prospect for improving Medicare payments to rural hospitals and the potential for expanding other activities such as the swing bed or rural health care transition grant programs.

The breakfast meeting is scheduled for Monday, January 30, 1989 from 7:00 - 8:30 a.m. at the Washington Hilton Hotel. I anticipate ~~some 250 to 300~~ now over 400 members to be in attendance. We will provide an honorarium if your schedule permits you to join us.

Sincerely

Jack W. Owen

Jack W. Owen
Executive Vice President

1/12 Advised (Mark Sekleski Sen) would do.

12-2 Interim letter

United States Senate

Rural Health Caucus

Quentin N. Burdick, Co-chairman
Robert Dole, Co-chairman

The Senate Rural Health Caucus is a bipartisan coalition of sixty Senators who share an interest in rural health issues and legislation.

Senator Quentin N. Burdick (D-ND) formed the Rural Health Caucus in 1985 along with Senator Mark Andrews (R-ND) in order to increase awareness of rural health concerns, and to provide a unified voice in the Senate to address these concerns. Membership grew quickly, and soon included more than a third of the Senate. In 1987, the beginning of the 100th Congress, Senator Burdick reestablished the Rural Health Caucus with Senate Majority Leader Bob Dole (R-KS) as Cochairman.

In the 100th Congress, the Senate Rural Health Caucus compiled an impressive record of achievements. The Caucus was an influential force supporting many rural health provisions included by Senator Lawton Chiles (D-FL), Chairman of the Appropriations Subcommittee for Labor, Health and Human Services, Education and Related Agencies, in his Appropriations bill for FY 89. Programs given funding priority by the Senate Rural Health Caucus included the National Health Service Corps, Health Professions Training, Community and Migrant Health Centers, Emergency Medical Service Demonstrations, Research and Development Projects, and Rural Health Transition Grant Programs.

In addition, the Caucus urged the Finance Committee to include several rural health provisions in its Medicare reconciliation legislation for 1988. Caucus members insured provisions to provide a hospital update factor, to make it easier for rural hospitals to become referral centers, to create an annual increase in Medicare physician payments, to provide a payment bonus for physicians who treat Medicare patients in rural underserved areas, and to improve sole Commnunity Hospital provisions. The Caucus also recommended rural health provisions to the Finance Committee when the Catastrophic Health Care Bill was in conference in early 1988.

Another major priority of the Rural Health Caucus during the 100th Congress was to promote awareness of the unique health care demands in rural areas. To this end, the Caucus sponsored legislation that designated the Week of May 15-21, 1988 as "National Rural Health Awareness Week". Furthermore, the Caucus requested that the Congressional Research Service

511 Hart Senate Office Building • Washington, D.C. 20510 • 202 / 224-2551
141 Hart Senate Office Building • Washington, D.C. 20510 • 202 / 224-6521

The bill you introduced on Wednesday (S. 10) ensures that medicare dependent (70% of their patients are medicare) small (100 beds or less) rural hospitals receive for a three year period at least their reasonable costs.

Additionally, this coming week you will be joining Senator Bentsen in introducing the "Equity for Rural Hospitals Act of 1989" which incorporates the provisions of S. 10 and also provides for a four year transition to a single national payment rate for all hospitals -- finally doing away with the urban, rural differential. The bill also authorizes funds for certain demonstration programs designed to help train nurses and physicians in rural areas, and to help hospitals change their services so they meet the real needs of their communities.

The hospitals will likely be very pleased with both of these legislative initiatives.

SENATOR BOB DOLE
AMERICAN HOSPITAL ASSOCIATION
WASHINGTON, D.C.
JANUARY 31, 1989 -- 7:45 A.M.

HEALTH CARE AGENDA: 101ST CONGRESS

THERE IS NO QUESTION THAT HEALTH CARE WILL BE NEAR THE TOP OF THE DOMESTIC AGENDA FOR BOTH THE CONGRESS AND THE NEW ADMINISTRATION.

PRESIDENT BUSH HAS CLEARLY INDICATED HIS PARTICULAR INTEREST IN CHILDREN AND THE NEW MAJORITY LEADER HAVING SERVED AS CHAIRMAN OF

THE FINANCE HEALTH SUBCOMMITTEE, HAS A LONGSTANDING COMMITMENT TO ASSURING ACCESS TO CARE FOR BOTH THE YOUNG AND THE ELDERLY.

THERE IS EVEN GENERAL AGREEMENT ON WHAT SOME OF THE KEY PROBLEMS ARE --

- O ACCESS TO CARE BY THE UNINSURED
- O ESCALATING HEALTH CARE COSTS

(CRS) design and develop seminars for members and staff on issues in rural health care. In the Spring of 1988, two seminars were held which focused on the issues of Medicare payments, health provider shortages, and provider problems in rural areas.

In 1988, the Rural Health Caucus requested that the Office of Technology Assessment develop a report addressing issues in rural health. The Caucus wanted a general overview of rural health, indicating trends which are influencing rural America. They also called for an analysis of how emerging technologies affect rural health care systems, and whether there should be specifically designed technologies for rural hospitals.

The Caucus requested a similiar summary and report from the Joint Commission on Accreditation of Hospitals when they considered changing standards for anesthesia service. The Rural Health Caucus was particularly concerned with the standards affecting nurse anesthetists practicing in rural areas.

The Rural Health Caucus was instrumental in passing legislation that created an Office of Rural Health Policy in the Department of Health and Human Services. The intent of the Caucus was to create a vehicle for addressing rural health problems from within the Administration. Additionally, individual Caucus members during the 100th Congress sponsored bills which would provide grants to rural hospitals, help equalize the rural/urban PPS differential, and provide qualified allied health professionals to underserved rural areas.

The Rural Health Caucus plans to continue its focus on the vital health issues affecting rural communities, and its efforts to provide quality health care to these areas.

- ALARMING RATES OF INFANT MORTALITY

- THE CONTINUING CRISIS OF AIDS

- THE FINANCING NEEDS OF THOSE WHO REQUIRE LONG-TERM CARE.

WHAT WE LACK IS A CONSENSUS ON HOW BEST TO RESOLVE THE PROBLEMS AND WHAT TO DO ABOUT AN EVEN BIGGER PROBLEM, THE DEFICIT.

TOP PRIORITY; THE DEFICIT

PRESIDENT BUSH HAS MADE IT CLEAR THAT RESOLVING THE DEFICIT CRISIS IS HIS TOP PRIORITY.

OUR INABILITY TO DO SO WILL CLEARLY RESTRICT WHAT WE CAN DO FOR HEALTH, EDUCATION, HOUSING -- ALL THE MYRIAD OF PROBLEMS THAT DESERVE OUR ATTENTION.

IT SHOULD COME AS NO SURPRISE THAT IN OUR BATTLE AGAINST THE DEFICIT THE LARGE HEALTH CARE PROGRAMS WILL NO DOUBT AGAIN RECEIVE OUR ATTENTION. THE REAGAN BUDGET PROPOSED REDUCTIONS OF APPROXIMATELY $5.7 BILLION IN

MEDICARE AND $1.7 BILLION IN MEDICAID. WHAT PRESIDENT BUSH WILL DO REMAINS UNCLEAR BUT MY GUESS IS THAT HE'LL ALSO PROPOSE REDUCTIONS OF SOME MAGNITUDE.

AS EXECUTIVES YOU KNOW THAT WHEN YOU CONFRONT A BUDGET PROBLEM YOU LOOK AT THE BIGGEST EXPENDITURES FIRST -- WE ARE NO DIFFERENT. MY QUESTION IS HOW DO WE PREVENT

DOING HARM. WHILE THE BUDGET DEFICITS LOOM LARGE -- SO DOES THE NEED FOR ACCESS AND QUALITY OF CARE, PARTICULARLY IN RURAL COMMUNITIES.

THE NEED FOR RURAL SERVICES

IN THOSE PARTS OF THE COUNTRY WHERE THERE ARE A NUMBER OF LARGE, REMOTE AREAS WITH LOW POPULATION DENSITY, ACCESS TO CARE BECOMES

CRITICAL. IF WEATHER OR DISTANCE ARE A PROBLEM, THESE COMMUNITIES NEED ACCESSIBLE LOCAL HOSPITALS.

WHEN WE FIRST PUT THE MEDICARE PROSPECTIVE PAYMENT SYSTEM INTO PLACE WE ACKNOWLEDGED THAT THIS NEW SYSTEM MIGHT WELL HAVE A NEGATIVE IMPACT ON CERTAIN INSTITUTIONS, INCLUDING RURAL HOSPITALS. AS YOU KNOW BETTER THAN I DO, THESE

HOSPITALS TEND TO BE SMALLER, HAVE FEWER PATIENTS, FEWER SPECIALIZED AREAS, AND OFTEN SERVE A POPULATION OLDER THAN AVERAGE.

IN MY VIEW, ITS TIME TO ACKNOWLEDGE THAT A PAYMENT SYSTEM LIKE THE DRG SYSTEM WHICH IS BASED ON AVERAGES JUST DOESN'T WORK FOR MANY OF YOU. YOU FACE THE COMBINED PROBLEM OF HAVING TOO FEW PATIENTS -- MANY OF WHOM ARE COSTLY.

WE HAVE IN YEARS SINCE THE ENACTMENT OF THE DRG SYSTEM AGREED TO A NUMBER OF CHANGES DESIGNED TO ASSIST THOSE OF YOU IN RURAL AREAS, BUT FOR SOME, IT JUST HASN'T BEEN ENOUGH. I WAS ASTOUNDED TO LEARN THAT SINCE 1983, 188 RURAL HOSPITALS HAVE CLOSED. IN 1988 ALONE, 46 RURAL HOSPITALS CLOSED. AND AS THOSE OF YOU FROM RURAL AREAS KNOW, MANY OF OUR COMMUNITIES CANNOT AFFORD TO LOSE THEIR HOSPITALS AS THEY PROVIDE THE ONLY REASONABLY ACCESSIBLE HEALTH SERVICES.

TO HELP SOLVE THIS PROBLEM, JOINED BY TEN OF MY COLLEAGUES, I INTRODUCED S. 10 WHICH SIMPLY HELPS THOSE HOSPITALS OF 100 BEDS OR LESS, IN WHICH MEDICARE PATIENTS COMPRISE AT LEAST 70 PERCENT OF YOUR DISCHARGES.

THE SOLUTION WE PROPOSE, WHICH ARGUABLY MOVES US AWAY FROM THE PROSPECTIVE PAYMENT SYSTEM, IS NOT A PERFECT ANSWER TO THE PROBLEM.

IN FACT, I AM WORKING WITH MY DISTINGUISHED COLLEAGUE SENATOR BENTSEN ON A PROPOSAL THAT WOULD HAVE US SOLVE THE PROBLEM OVER THE LONG TERM BY MOVING TO A NATIONAL RATE FOR ALL HOSPITALS.

HOWEVER, IN THE SHORT RUN WE CANNOT ALLOW OUR RURAL HEALTH CARE SYSTEM TO FURTHER DECLINE. THIS BILL PROVIDES A SMALL STEP IN AN EFFORT TO PREVENT THAT FROM OCCURRING.

OTHER HOSPITALS HAVE ALSO BEEN DISADVANTAGED, INCLUDING SOME SMALL URBAN HOSPITALS. NO DOUBT WE NEED TO RELOOK AT WHAT WE CREATED IN 1983. WE NEVER INTENDED THE SYSTEM TO BE STATIC. WE EXPECTED TO LEARN FROM EXPERIENCE AND WE HAVE -- NOW WE NEED TO PUT THE EXPERIENCE TO USE IN FINDING SOLUTIONS. BUT, I WARN YOU THAT WE WILL LOOK AMONG YOU AS WELL

AS OUTSIDE TO HELP SOLVE THE PROBLEMS OF INEQUITY. JUST AS THERE ARE THOSE OF YOU WHO ARE DISADVANTAGED, THERE ARE THOSE WHO ARE UNFAIRLY ADVANTAGED.

OTHER LEGISLATIVE PRIORITIES

IN ADDITION TO THE PROBLEM FACED BY SMALL AND RURAL HOSPITALS, THERE ARE OTHER CRITICAL HEALTH CARE ISSUES WHICH MUST BE ADDRESSED;

INCLUDING INCREASING SERVICES TO CHILDREN AND FINDING A SOLUTION TO THE LONG-TERM CARE DILEMMA. BUT UNTIL WE TACKLE THE DEFICIT, NEW MONIES ARE GOING TO BE HARD TO FIND.

ANOTHER AREA WHICH MAY DESERVE OUR ATTENTION IS THE NEW PREMIUM BEING CHARGED FOR MEDICARE CATASTROPHIC COVERAGE.

I'M HEARING FROM A LARGE NUMBER OF MY CONSTITUENTS WHO AREN'T VERY HAPPY ABOUT BEING FORCED TO PAY THE NEW PREMIUM. WE MAY NEED TO RELOOK AT WHETHER OR NOT COVERAGE SHOULD BE OPTIONAL.

BUT FIRST -- THE BUDGET

BUT GOING BACK TO MY ORIGINAL POINT, THE MOST IMPORTANT CHALLENGE FACING OUR COUNTRY TODAY IS THE DEFICIT.

REDUCING THE DEFICIT WOULD HAVE MANY POSITIVE EFFECTS ON OUR ECONOMY, RANGING FROM LOWERING INTEREST RATES TO LOWERING OUR TRADE DEFICIT TO MAKING MORE MONEY AVAILABLE FOR SAVINGS AND INVESTMENT. THESE BENEFITS TRANSLATE INTO MORE HOMES, MORE JOBS AND A BETTER LIFE FOR OUR CHILDREN.

SOME PEOPLE HAVE ARGUED THAT DEFICITS AREN'T IMPORTANT, BECAUSE IN TIME WE WILL GROW OUR WAY OUT OF THE PROBLEM. BUT IF YOU LOOK CAREFULLY

YOU'LL FIND MANY OF THESE PEOPLE ARE THE SAME BRIGHT THINKERS WHO HELPED GET US INTO THIS MESS IN THE FIRST PLACE -- THE SUPPLY-SIDERS.

GROWTH IS IMPORTANT, BUT GROWTH ALONE WILL NOT RELIEVE THE PRESSURE. WE HAVE TO FACE UP TO OUR RESPONSIBILITIES, BECAUSE SOONER OR LATER SOMEONE WILL HAVE TO PICK UP THE TAB. PEOPLE IN MY STATE UNDERSTAND THIS, AND THAT IS WAY THEY STILL THINK DEFICITS MATTER.

AGAIN, LET ME STATE MY POSITION THAT TO BALANCE THE BUDGET WE NEED TO LOOK AT SPENDING CUTS AND NOT NEW TAXES, AS THE AMERICAN PEOPLE HAVE SAID.

MAJOR DECISIONS ON THE BUDGET WILL HELP SHAPE DECISIONS ON OTHER POLICY MATTERS -- FROM NATIONAL SECURITY TO HEALTH CARE. RIGHT NOW THE DEFICIT SEVERELY LIMITS THE AMOUNT OF MONEY WE

CAN SPEND ON NEW INITIATIVES, AS WELL AS ON OLD PROGRAMS. AS A RESULT, MANY NEW PROGRAMS MAY HAVE TO BE SCALED BACK OR HAVE SOME FORM OF SELF-FINANCING INCLUDED. IN THE AREA OF MILITARY SPENDING, WE MAY NEED TO DISCUSS WHETHER OUR ALLIES SHOULD ASSUME A GREATER RESPONSIBILITY FOR THEIR OWN DEFENSE.

CHOICES NOT MANDATES

PRESIDENT BUSH HAS BEGUN HIS ADMINISTRATION WITH A RENEWED SENSE OF COMMITMENT TO BIPARTISANSHIP. THIS HOLDS TRUE FOR OUR NEGOTIATIONS ON THE BUDGET AS WELL AS ON ISSUES SUCH AS HEALTH CARE. BUT IT IS CLEAR THERE ARE SOME BIG DIFFERENCES OF OPINION ON HOW BEST TO MEET OUR HEALTH CARE NEEDS.

WE ALL HAVE A STAKE IN MAKING SURE THAT THE HEALTH CARE SYSTEM WE BELIEVE IN SURVIVES THESE DIFFICULT BUDGET TIMES. BUT, I CAUTION YOU TO BE REALISTIC. A PHILOSOPHY CALLING FOR CUTS IN EVERY AREA EXCEPT HEALTH WON'T HELP -- ANYMORE THAN A CALL FOR UNREASONABLE REDUCTIONS IN ANY ONE PROGRAM.

I LOOK FORWARD TO WORKING WITH YOU IN THE WEEKS AND MONTHS AHEAD. WE HAVE A GREAT DEAL TO DO.