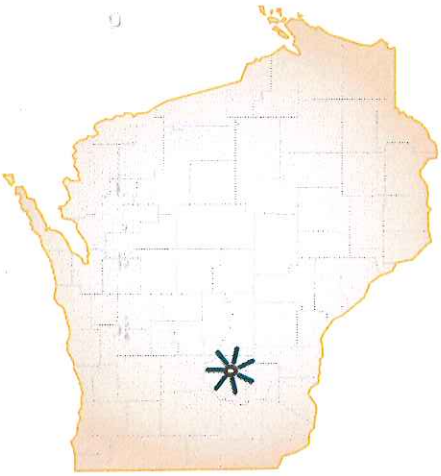
Baraboo 1-2 RTT Family Medicine Residency Program

The Baraboo 1-2 RTT Family Medicine Residency Program trains residents in a rural setting, providing them with a lifestyle that truly mimics private practice in a rural community.

The UW DFMCH is pleased to offer generous and competitive benefit packages for residents in our programs.

"What I love about Baraboo is that it allows me the flexibility and connections of a well-known and respected department of family medicine as well as the procedural and high-risk opportunities of rural family medicine. It is truly the best of both worlds!"
—Rachel Hartline, MD, PGY3 – Class of 2015

The program offers a flexible "hybrid longitudinal curriculum" in an apprenticeship model allowing residents to gain full-spectrum family medicine experience by participating in: hospital rounds, clinic, urgent care/ER call, hospital admissions, and obstetrics. In this setting, residents are involved in much of the hands-on continuity patient care.



Program Size

6 residents (2 per year)

City Size

12,000

Program Highlights

Unopposed training in a rural setting with a culturally diverse patient population; offers a flexible curriculum including strong continuity maternity care and procedure training. Access to additional elective training opportunities through the Madison program.

Community Highlights

Rural setting in the Baraboo bluffs; Devil's Lake, Circus World Museum, and WI Dells offer lots of indoor and outdoor activities. Thriving downtown features shopping, farmer's market, craft fairs, theater, and concerts

Practice Setting

Rural clinic with a two-minute walk from the hospital.

Facts and Figures

UW Health (FY17)

About UW Health

UW Health is the integrated health system of the University of Wisconsin-Madison caring for more than 600,000 patients each year with 1,500 employed physicians and 15,000 employees at seven hospitals and 87 outpatient clinics.

UW Health is governed by the UW Hospitals and Clinics Authority and partners with the UW School of Medicine and Public Health to fulfill its patient care, research, education and community service missions.

Mission:
Advancing health without compromise through service, scholarship, science and social responsibility

Vision:
Remarkable Healthcare

UW Health is a nationally recognized regional health system that includes:

- **University Hospital,** a 505-bed regional referral center that is home to a Level One adult and pediatric trauma center, American College of Surgeons-verified Burn Center, one of the nation's largest organ transplant programs, one of the nation's first certified comprehensive stroke centers and the UW Carbone Cancer Center, one of 41 National Cancer Institute-designated comprehensive centers in the country
- **UW Health at The American Center,** a 56-bed, community-based health and wellness facility
- **American Family Children's Hospital,** a nationally-ranked, 87-bed facility with pediatric and neonatal surgical intensive care units
- **UW Health Rehabilitation Hospital,** a 50-bed, post-acute inpatient rehabilitation facility
- **UnityPoint Health – Meriter*,** a 448-bed community-based hospital providing a complete range of medical and surgical services
- **SwedishAmerican Hospital,** a 333-bed community-based hospital and regional cancer center
- **Belvidere Medical Center,** a 34-bed inpatient/outpatient medical center
- **Six regional cancer centers:**
  - Beloit Hospital (Beloit, Wis.)
  - FHN Leonard C. Ferguson Cancer Center (Freeport, Ill.)
  - SwedishAmerican Hospital (Rockford, Ill.)
  - UW Cancer Center at ProHealth Care (Pewaukee, Wis.)
  - UW Cancer Center Johnson Creek (Johnson Creek, Wis.)
  - UW Cancer Center Aspirus Riverview Hospital (Wisconsin Rapids, Wis.)
- Regional services specialty clinics in approximately 83 locations
- **UW Medical Foundation,** the state's second-largest medical practice group, representing the 1,415 clinical faculty physicians of the UW School of Medicine and Public Health
- **Quartz Health Solutions, Inc.,** a subsidiary health insurance provider with more than 338,000 members in a 35-county region in Wisconsin, Illinois, Minnesota and Iowa
- **University Health Care,** a not-for-profit membership corporation that facilitates clinical and contracting relationships with insurance companies and regional providers
- **Joint ventures and affiliations** including cancer centers, surgery centers, dialysis programs, home health, infusion and many other programs and services

UW Health

*Joined UW Health in July 2017

uwhealth.org

National Recognition

- UW Hospitals and Clinics and SwedishAmerican Hospital are **Magnet® Hospitals** for nursing excellence (American Nurses Credentialing Center)
- UW Hospitals and Clinics ranks in the **top 50 U.S. hospitals** in nine specialties and is rated high-performing in two additional specialties *(U.S. News & World Report)*
- UW Hospitals and Clinics is designated **Wisconsin's #1 hospital** *(U.S. News & World Report)*
- American Family Children's Hospital ranks in the **top 50 children's hospitals** in seven specialties *(U.S. News & World Report)*
- UW School of Medicine and Public Health ranks **14th in the nation for primary care** and **28th for research** *(U.S. News & World Report)*
- UW Hospitals and Clinics is among **100 Great Hospitals in America** *(Becker's Hospital Review)*
- UW Organ Transplant Program recognized as **nation's fourth largest** by volume
- UW Hospitals and Clinics is among the **Most Wired** and **Most Wireless hospitals** *(Hospitals and Health Networks magazine)*
- UW Hospitals and Clinics and SwedishAmerican Hospital are among **150 Great Places to Work in Healthcare** *(Becker's Hospital Review)*
- SwedishAmerican Hospital has earned the **Distinguished Hospital Award** (J.D. Power and Associates)
- UW Health is recognized as an **LGBT Healthcare Equality Leader** (Human Rights Campaign Foundation)
- UW Health is recognized as one of the top five academic health centers in the nation for ambulatory care (UHC Ambulatory Care Quality and Accountability Award)

Fast Facts*

- UW Health care locations: 52
- UW Health Regional care locations: 83
- Patients: 577,678
- Inpatient admissions: 50,190
- Surgeries: 47,264
- Outpatient visits: 2,797,865
- Emergency department visits: 157,414
- Inpatient beds: 1,015
- ICU beds: 126
- Employees: 14,988
- Physicians: 1,586
- Residents and fellows: 660
- Volunteers: 1,100
- Contributions to UW School of Medicine and Public Health: $70.8 million
- UW School of Medicine and Public Health extramural research support: $355.8 million
- Charity care: $24.3 million
- Total community benefit: $344.4 million

UW Health net revenue: $2.9 billion

**Does not include UnityPoint Health – Meriter data*

UW Health

University of Wisconsin Hospital and Clinics
University of Wisconsin Medical Foundation
University of Wisconsin School of Medicine and Public Health
Swedish American Hospital System

7974 UW Health Court
Middleton, WI 53362

Administrator Seema Verma
Centers for Medicare & Medicaid
Department of Health and Human Services
Attention: CMS-1677-P
Submitted electronically at http://www.regulations.gov

Dear Administrator Verma:

On behalf of the University of Wisconsin Hospital and Clinics Authority (UW Health), we thank you for the opportunity to offer comments on the Center for Medicare and Medicaid Services (CMS)' proposed rule governing the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals.

UW Health is the integrated health system of the University of Wisconsin-Madison, serving more than 600,000 patients each year in the upper midwest and beyond with 1,400 physicians and 16,500 staff at six hospitals and 80 outpatient sites. UW Health partners with the UW School of Medicine and Public Health to fulfill patient care, research, education and community service missions.

UW Health deeply appreciates the opportunity to address reduce the regulatory burden on hospitals and providers. We would like to offer a few specific comments for your consideration in the area of improving access to high quality patient care.

Reform the Recovery Audit Contractor (RAC) Program

The first relief area we suggest is the Recovery Audit Contractor (RAC). In keeping with CMS' goals for reducing the regulatory burden, we believe reforms to the RAC program will improve transparency, flexibility, and program simplification. While we agree that Medicare fraud and abuse is not tolerable, we are concerned that the current RAC structure places undue burden on hospitals, detracts from high quality patient

care, and lacks transparency. Specifically, the program incentivizes inappropriately aggressive audits which question physician judgment and tie up hospital resources in lengthy and burdensome appeals.

Over the last three years, UW Health, in conjunction with John's Hopkins Hospital and the University of Utah, collected and examined RAC audit data to determine the length of time spent in the appeals process by each institution as well as the rate of successfully contested complex Part A reviews. The results of the analyses (published in the *Journal of Hospital Medicine* in 2015 and 2017) clearly demonstrate the need for reform of the RAC program to improve transparency and accountability.

For example, in our initial analysis, we found that there was a year-over-year increase in volume of Part A complex review overpayment determinations by RACs even though the hospitals disputed and won a greater percent of such cases each year. Specifically, RAC Part A complex review overpayment determinations increased nearly 3-fold (680 vs. 1,856), while the hospitals won more of these determinations each year (36.0% in 2010, 38.5% in 2011, 46.1% in 2012, and 68.0% in 2013)[1]. As hospitals have seen a greater number of decisions overturned in their favor, there has been an increasing willingness to appeal initial RAC determinations, which has led to the current backlog of appeals. In our 2017 analysis, hospital data showed that the mean total time since date of service for Level 3 appeals was 1663.3 days, which includes mean days between date of service and audit (560.4) and total days in appeals (891.3)[2]. Moreover, the appeals process was problematic, as government contractors and judges met legislative timeliness deadlines less than half the time (47.7%), with declining compliance at successive levels (discussion, 92.5%; Level 1, 85.4%; Level 2, 38.8%; Level 3, 0%)[3]. This data is consistent with the recent GAO report showing a 2000% increase in inpatient Level 3 appeals between 2010-2014, [4]which has resulted in 650,000 claims awaiting Level 3 adjudication, despite

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[1] Ann M. Sheehy, MD, MS1*, Charles Locke, MD2,3, Jeannine Z. Engel, MD4, Daniel J. Weissburg, JD, CHC5, Stephanie Mackowiak, RN, ESQ6, Bartho Caponi, MD7, Sreedevi Gangireddy, MD7, Amy Deutschendorf, MS, RN, ACNS-BC8. *Recovery Audit Contractor Audits and Appeals at Three Academic Medical Centers*. Journal of Hospital Medicine Volume 10, Issue 4, pages 212–219, April 2015.

[2] Ann M. Sheehy, MD, MS1*, Jeannine Z. Engel, MD2, Charles F.S. Locke, MD3,4, Daniel J. Weissburg, JD, CHC5, Kevin Eldridge, JD6, Bartho Caponi, MD1, Amy Deutschendorf, MS, RN, ACNS-BC3. *Hospitalizations With Observation Services and the Medicare Part A Complex Appeals Process at Three Academic Medical Centers*. Journal of Hospital Medicine Volume 12, Issue 4, pages 251-255, April 2017.

[3] Ann M. Sheehy, MD, MS1*, Charles Locke, MD2,3, Jeannine Z. Engel, MD4, Daniel J. Weissburg, JD, CHC5, Stephanie Mackowiak, RN, ESQ6, Bartho Caponi, MD7, Sreedevi Gangireddy, MD7, Amy Deutschendorf, MS, RN, ACNS-BC8. *Recovery Audit Contractor Audits and Appeals at Three Academic Medical Centers*. Journal of Hospital Medicine Volume 10, Issue 4, pages 212–219, April 2015.

[4] http://www.gao.gov/assets/680/677034.pdf

Administrative Law Judge (ALJ) capacity to hear just 92,000 appeals a year.[5] This means that if not a single new appeal was filed, it would still take more than 7 years to clear the backlog. This time spent in the appeals process requires hospitals to utilize scarce Medicare dollars which ultimately takes away from resources intended to care for patients. CMS should take steps to reduce these burdens and allow hospitals to focus resources on serving patients.

Further, we believe that steps must be taken to improve transparency in data reporting to hold RACs accountable for poor performance. The majority of successfully contested complex Part A review cases occurred in the discussion period, leading to an underestimate of RAC auditing accuracy because the discussion is not considered part of the formal appeals process and does not appear in CMS or OIG reports of RAC activity. This finding was apparent across the three RAC regions included in the 2015 study, indicating a systemic problem in the RAC program. The result of our 2015 analysis of data showed that 33% of RAC Part A Complex Review overpayment determinations disputed by hospitals with a final outcome/decision were won in discussion and the majority (66.8%) of such cases with decisions in favor of the hospital were won in discussion[6]. To address this discrepancy we suggest that audit and appeals data be reported by type of audit (i.e. Part A complex Review vs. Part B complex Review vs. automated review) and that appeals data include denials overturned in the discussion period.

More broadly, to reduce currently existing incentives for aggressive and unsuccessful RAC audits, we suggest that RACs face financial penalties for poor performance based on an accurate and fully-inclusive appeal overturn rate. We also agree with others, such as the Federation of American Hospitals, who have suggested that payments only be recouped from hospitals after a final Administrative Law Judge (ALJ) decision upholding the denial is issued.

Implement Regulatory Change to Improve Physician Access in Rural Areas

[5] https://www.federalregister.gov/documents/2017/01/17/2016-32058/medicare-program-changes-to-the-medicare-claims-and-entitlement-medicare-advantage-organization

[6] *Ibid*

In the interest of building a health care delivery system that is more accessible, we would like to draw your attention to a simple regulatory fix that could increase access to health care for rural America.

Today, rural America suffers from a significant shortage of primary care physicians. Of the nation's 2,050 rural counties, 1,562 (77%) include primary care health professional shortage areas. The situation has the potential to worsen in the coming years, as many of the physicians currently practicing in these areas are nearing retirement. Rural residency training programs, which support medical residents' training in rural areas, are critical to maintaining adequate access to healthcare services in these communities. Data has shown 75% of physicians who train in rural areas ultimately practice in rural areas, many of them in the same area where their training occurred[7].

In 1997, the *Balanced Budget Act* (BBA) directed the Secretary of Health and Human Service (HHS) to promulgate rules for medical residency training programs, stating that the "Secretary would be required to give special consideration to facilities that meet the needs of underserved rural areas." The BBA specifically authorized HHS to increase individual institutions' cap on residency positions in order to accommodate residents training in rural areas through rural training programs. Many institutions, including UW Health, have created successful rural residency programs in family medicine. Given the success of these programs, these institutions have looked to replicate the model in rural communities that currently lack training programs. However, they have come up against an administrative obstacle we encourage you to address.

Despite explicit statutory direction to make special consideration for rural areas, CMS has promulgated regulations that apply the definition of a "new" residency program to rural residency programs. Therefore, if an urban institution that operated a rural training program sought to create another rural training program – training *new* residents at *new* rural training sites – CMS would view that second track as an expansion of a current residency program, and therefore ineligible for additional Graduate Medical Education funding. CMS' interpretation fails to take advantage of the efficiencies gained by leveraging urban institutions' infrastructure to enable rural training, and directly stifles the training of new physicians in rural communities.

[7] Rural Training Track Residency Program, http://bit.ly/2dUUMkQ

We encourage you to amend your regulations to clarify that the establishment of a rural training program with new residents in a new community should be considered a new rural training program, rather than an expansion of a preexisting program, for the purposes of cap-setting in both the urban "mother" hospital and in the rural hospital, no matter when that rural training program is established. All full time equivalent (FTE) residents training in a rural program should be counted and added toward increasing the urban hospital's cap during the years they are training at the urban hospital, and then toward the rural provider's cap during the years they are completing their rural rotation.

As a related matter, rural hospitals seeking to partner in rural residency programs or build their own are facing a separate administrative barrier – an artificially low cap on GME residency slots that was triggered by medical resident rotators before the hospital sought to build a full residency program. We believe that CMS has the statutory authority to view caps triggered by rotator programs separately from new residency programs, and we encourage you to issue regulations accordingly.

Implement the use of Worksheet S-10 in Calculating Uncompensated Care

In addition, we strongly support the immediate implementation of the Worksheet S-10 as the new methodology for uncompensated care calculation. As an academic health center we provide care in a non-Medicaid expansion state with a large underserved patient population. UW Health is committed to providing quality care to all individuals; in FY 2016, UW Health provided nearly $73 million in uncompensated care. We provide care to all medically complex patients, no matter their insurance status. Because of this unique situation, we encourage CMS to implement the use of Worksheet S-10 as the methodology for determining uncompensated care. We believe transitioning to the new methodology brings equity across the states regardless of their decision to accept Medicaid expansion funds.

Reform Electronic Submission for the Hospital Inpatient Quality Reporting (IQR) Program

Reduce measures, align across CMS programs

While we appreciate the efforts that CMS has made to reduce the number of electronic quality measures we still concur with comments by the American Medical Informatic Association on February 1, 2016 that "the task of gathering and reporting eCQMS overshadows the benefits of tracking measures in many instances."[8]

We applaud CMS for reducing the number of quality measures and reporting periods for CY 2017 eCQM reporting. These changes will alleviate the current strain at UW Health to comply with these requirements. For CY 2018, CMS is proposing to scale the program up by requiring reporting for the first three quarters of CY2018 and require at least six self-selected QCMs. While we appreciate CMS slowing down the transition between 2017 and 2018, UW Health still has significant concerns about the burden the current quality measures strategy will place on hospitals and other healthcare organizations. With the growing number of quality measures required each year, many are increasingly in conflict and overlap across different programs. UW Health believes that CMS should refocus its efforts on quality measures that drive care improvement aligned across care settings. In addition, UW Health urges CMS to utilize the work completed by the National Academies of Medicine in the *Vital Signs* report published in 2015, and the subsequent work, *Whole System Measures 2.0: A Compass for Health System Leaders*, published by the Institute for Healthcare Improvement (IHI) in 2016 to redefine the CMS Quality Measure roadmap.[9]

Facilitate submission of e-CQMs to increase efficiency and safety

A redefined roadmap should support the efforts of providers and healthcare organizations to measure quality while ensuring that the efficacy and safety of care provided is not compromised. In that spirit we encourage CMS to continue to work with professional specialty societies to develop strategies for e-CQM development and data submission which can reduce the current burden. Implementation of e-CQMs should enhance the patient/physician relationship, not negatively impact clinician efficiency. The current methods and framework are more likely to increase the documentation burden instead of reducing it. According to a recent

[8] [8] AMIA. Letter to Acting Administrator – CMS. CMS-3323-NC, 2/1/2016

[9] Institute of Medicine. 2015. Vital Signs: Core Metrics for Health and Health Care Progress. Washington, DC: The National Academies Press. doi:https://doi.org/10.17226/19402
Martin L, Nelson E, Rakover J, Chase A. Whole System Measures 2.0: A Compass for Health System Leaders. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. (Available at ihi.org)

study on the allocation of providers' time, the researchers found that "During the office day, physicians spent 27.0% of their total time on direct clinical face time with patients and 49.2% of their time on EHR and desk work. While in the examination room with patients, physicians spent 52.9% of the time on direct clinical face time and 37.0% on EHR and desk work. The 21 physicians who completed after-hours diaries reported 1 to 2 hours of after-hours work each night, devoted mostly to EHR tasks."[10] As CMS works to improve the relationship between a patient and their provider, UW Health encourages the agency to look for ways to streamline these measures and allow providers to spend more time on direct patient care.

Reduce burden of data Submission methods and standards

UW Health applauds the steps CMS has taken to define the role that specialty societies and specialty registries can play in the development of electronic quality measures. In addition, UW Health believes that registries can provide alternative data capture and data submission methods to support improvements in data quality without significantly increasing specific documentation requirements for quality measure data. UW Health encourages CMS to continue in this direction by expanding the ability for vendors to electronically submit data and working in partnership with specialty societies and technology innovators to define additional data submission frameworks more flexible than the current Quality Reporting Document Architecture (QRDA).

We are encouraged by the introduction of a hybrid e-CQM measure which uses administrative data supplemented with routinely collected EHR data. UW Health agrees with the authors of the IOM position paper, *Making the Case for Continuous Learning from Routinely Collected Data*, published in 2013, that "as health care records move to electronic systems, the data routinely collected as part of medical care (such as blood pressure measurements, weight, medications lists, disease diagnoses, and past medical histories) hold the promise to dramatically increase the opportunities for learning and improving care on a national scale." UW Health encourages CMS to continue to look for ways to make the system less burdensome on clinicians.

[10] http://annals.org/aim/article/2546704/allocation-physician-time-ambulatory-practice-time-motion-study-4-specialties

We greatly appreciate your consideration of our suggestions for reducing the regulatory burden on hospitals and providers and we hope you see fit to include our ideas in the final rule.

Sincerely,

Alan S. Kaplan, MD

CEO, UW Health