WISCONSIN HOSPITAL ASSOCIATION

The Valued Voice

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Hospital Regulatory Reform Bills Advance with Strong Bipartisan Support

Unanimous votes from Assembly and Senate Committees

The Assembly and Senate Health Committees held a joint public hearing on one of WHA's priorities for this legislative session, reforming Wisconsin's outdated hospital regulations. Both committees voted unanimously to support the companion bills (AB 728 and SB 560).

After the committee votes, WHA Executive Vice President Eric Borgerding hailed the two committees for their support.

"We are especially pleased with the unanimous bipartisan support this received in the Assembly and Senate Health Committees."

Borgerding added, "We want to thank the bills' authors – Rep. Howard Marklein and Sen. Leah Vukmir—for their dedicated efforts to reform Wisconsin's hospital regulatory system."

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Guest Column

Time for Congress to Fix Medicare Hospital Rural Floor Payment 'Boondoggle'

by Michael Abrams, Steve Brenton, Andrew Davidson & William Pully

Abrams is president and chief executive officer of the Ohio Hospital Association (www.ohanet.org); Brenton is president/CEO of the Wisconsin Hospital Association (www.wha.org); Davidson is president/CEO of the Oregon Hospital Association (www.oahhs.org); and Pully is president/CEO of the North Carolina Hospital Association (www.ncha.org). The authors are members of the Alliance of America's Hospitals, who are joining to urge Congress to repeal the Medicare rural floor provision in the Affordable Care Act.

Since 2011, Massachusetts hospitals have benefited from more than half a billion dollars in additional payments through a one-sentence amendment in Section 3141 of the Affordable Care Act (ACA).

Added by then-Sen. John Kerry (D-Mass.), the amendment adjusted payments through an obscure Medicare funding

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Guest Column

Wisconsin MEB Changes Physician Assistant Supervision Requirements

By Attorneys Robin M. Sheridan and Rachel S. Delaney, Hall, Render, Killian, Heath & Lyman

The Wisconsin Medical Examining Board (MEB) approved significant changes to the regulations governing, among other things, the physician supervision requirements of physician assistants (PAs). Effective March 1, 2014, the modifications to Wisconsin Administrative Code Section Med 8 (referred to as the Revised Regulation) include an increase in the number of on-duty PAs a physician can supervise at the same time as well as changes to the requirements for documenting the supervision. The Revised Regulation also simplifies the documentation requirements associated with the supervising physician review of a PA's prescriptive practice.

Supervising Physician to PA Ratio

Currently, one physician may supervise up to two PAs concurrently. The Revised Regulation states that "no physician may supervise more than four on duty PAs at any time unless a written plan to do so has been submitted to and approved by the board." The Revised Regulation also modifies the current regulation that "a PA may be supervised by more than one physician" by adding "while on duty." This language clarifies that the supervising physician to PA ratio applies to the number of PAs providing patient care at a given time, not the total number of PAs that a physician supervises. Over time, a physician is permitted to supervise an unlimited number of PAs.

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Johnson Joins WHA as VP, Workforce and Clinical Practice


Jodi Johnson

Jodi J. Johnson will join the WHA staff as vice president of workforce and clinical practice starting March 3, 2014. Johnson brings more than 15 years of experience to the position in the fields of clinical, instructional and nurse leadership. Most recently, Johnson served as vice president of patient care services and was chief nursing officer at Memorial Medical Center in Neillsville. Prior to that, Johnson worked with Ministry Saint Joseph's Hospital from 1996-2012 in key leadership positions.

Johnson has experience as a staff nurse in both pediatric nursing and the pediatric ICU at Saint Joseph's and later she managed the critical care nurse residency program at Saint Joseph's. While at Saint Joseph's, she also coordinated the hospital's efforts related to its Magnet re-designation. Johnson's experience also includes working with Mid-State Technical College as an instructor in the nursing program.

"We are very excited to welcome Jodi to the WHA team," said WHA Executive Vice President Eric Borgerding. "She will bring valuable knowledge and experience to our policy and governmental relations efforts."

Johnson holds a master's degree in nursing from the University of Wisconsin-Madison and is a pediatric nurse practitioner. She is also a certified Lean Six Sigma black belt.

Johnson follows Judy Warmuth, who held the position until her retirement in January 2014.

An Additional 15,700 People in Wisconsin Choose an Exchange Plan in January

Just over 60,000 people found eligible for Medicaid through the exchange since October

By the end of January, 56,436 people in Wisconsin had selected a health plan through the exchange marketplace, an increase of 15,700 people compared to December. These latest figures were released on February 12 by the federal Department of Health and Human Services (HHS). The report shows how many selected a qualified health plan, and how many were found eligible for Medicaid by state from October 1, 2013 through February 1, 2014. The full HHS report can be found on WHA's website at: www.wha.org/exchangemedicaidenrollment.aspx.

The 53-page report contains no information about how many enrollees had actually paid their premium, which is the final step that is required for actually obtaining coverage and being enrolled into a health plan.

HHS again provided data on the age of participants and the type of plan chosen. In Wisconsin, 43 percent of those who selected a plan were between the ages of 55 and 64, and 20 percent were under the age of 35. Since January, HHS has said it plans to increase efforts to encourage young adults to enroll in exchange plans. The administration had been concerned that the pool would be overloaded with too many unhealthy people, which would mean rates for exchange plans may increase in 2015.

The figures released by HHS also indicate which type of plan enrollees have selected, with 74 percent of those eligibile for financial assistance choosing a silver plan. This helps to alleviate some concerns that the majority of enrollees would choose the bronze plan, which generally has the lowest premiums, but higher deductibles and copayments. Nevertheless, many silver-level plans can still have high cost sharing, and providers remain concerned about the risk for unpaid costs.

The enrollment numbers also show just over 60,000 people have been deemed eligible for Medicaid in Wisconsin through the exchange marketplace. This is an increase of 16,000 people since January. The Department of Health Services (DHS) indicates a large percentage of those are expected to be childless adults, based on the initial files they have received from the federal government. At the beginning of February, DHS also began accepting applications directly from childless adults for coverage beginning April 1. ***(continued on page 3)***

Guest Column

Health Care = Washington's ATM Machine

By Eric Borgerding, WHA Executive Vice President

Congress made another visit to the ATM machine this week, and they have health care's PIN number. For the second time this year—and third time since December—Congress voted on extending Medicare provider cuts (euphemistically known as "sequester") to fund spending in completely unrelated areas.

This week, the House and Senate voted to extend Medicare provider cuts to pay for an increase in military pensions (see how Wisconsin's delegation voted on page 4). Last month, the Senate narrowly defeated a measure to extend provider cuts by 12 months to buy three months of unemployment benefits (Sen. Baldwin voted in favor, Sen. Johnson voted against). And late last year, the budget deal that sailed through extended Medicare provider cuts by another two years. For those keeping track, Medicare provider cuts scheduled to end in 2021 have now been extended to 2024, and that's just in the past few months. Congress still has a physician payment "fix" to pay for and who knows what else the health care ATM will be tapped for down the road.

Of course all this comes on top of $4 billion in cuts already absorbed by Wisconsin hospitals, (including $2.6 billion for Obamacare). These are cuts that nail high value states like Wisconsin hardest but that are quickly forgotten inside the beltway—convenient amnesia that paves the way for more visits to the health care ATM. The vote this week proves that, in spades.

Nowhere, in any of this discussion, is there an effort at real reform, substantive changes to Medicare that actually address demand for services. Across-the-board cuts that hit high value states like Wisconsin hardest are not "reform."

Slashing reimbursement has become the "painless" way for Washington to pay for the latest budget deal, debt ceiling increase, pension increase, unemployment extension and any other issue du jour. The last few months illustrate how health care providers are quickly becoming the bank of choice in Washington. These last few months should be a wake-up call.

Some in Washington believe health care is laying down. Some are probably counting on it. WHA will be helping our members stand up in 2014 and aggressively spreading the message that "Enough is Enough."

Cont'd. from page 2 . . . An Additional 15,700 People in WI Choose an Exchange Plan in Jan.

Next week DHS is expected to begin officially notifying those Medicaid/BadgerCare recipients who will be disenrolled from the program beginning April 1. Letters will go out beginning February 17 to those who are affected by the income eligibility changes. DHS has been conducting outreach, including phone calls, to those individuals informing them of the changes to the program and that they should seek coverage through the exchange marketplace.

In related news, just under 7,000 of HIRSP state members and just over 700 of HIRSP federal members maintained their HIRSP coverage for January, according to the HIRSP Authority. These figures represent just over 30 percent of the HIRSP members who were eligible to maintain HIRSP benefits into 2014. The sunset of the HIRSP program was delayed from December 31, 2013, until March 31, 2014, in order to provide HIRSP members additional time to enroll in Exchange plans and, for some members, to align with coverage for Medicaid beginning April 1.

Congress Votes to Extend Medicare Sequester...Again

This week the U.S. Congress voted to extend Medicare cuts under sequester an additional year (now through FY 2024) to pay for yet another cause du jour. This is the third Congressional vote since December targeting payments to Medicare providers.

"The proposal last month to extend sequester cuts on Medicare reimbursement to pay for a three-month extension of unemployment benefits and now, in February, to pay for military pensions, illustrates how Medicare payment cuts have become the bank of choice in Washington," said WHA President Steve Brenton. "Enough is enough."

"Wisconsin's high-value hospitals and health systems are taking punch after punch while still maintaining some of the highest quality care in the nation," said WHA's Executive Vice President Eric Borgerding.

The Congressional vote this week was on restoring military pension payments that had been cut last year. In order to pay for doing so, Congress approved adding an additional year to the Medicare sequester (ie: two percent cut). In other words, the original sequester is now extended out 12 years, through FY 2024. Wisconsin's Congressional Delegation voted as follows:

- Voting In Favor: Senators Johnson, Baldwin; and Representatives Duffy, Kind, Moore, Petri and Sensenbrenner
- Voting Against: Representatives Pocan, Ribble and Ryan

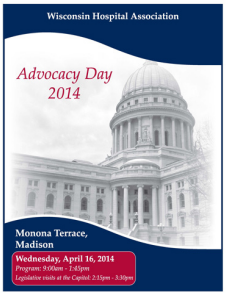
Unfortunately, this week's vote continues a troubling trend of cutting Medicare providers to pay for other programs or priorities. Two additional recent examples include:

- December 2013 – In order to pay for a three-month patch to the sustainable growth rate (SGR), Congress approved two additional years of Medicare sequester cuts (FYs 2022, 2023). WHA estimates the two-year, two percent Medicare cut will be roughly $212 million to Wisconsin hospitals in addition to the previous $1 billion in cuts from the first nine years of sequester.
- January 2014 – In an attempt to extend unemployment insurance for an additional three months, the U.S. Senate took up a measure to pay for that by extending sequester cuts. That attempt failed on a close vote.

In related news, Congress voted in favor of lifting the debt ceiling through March 15, 2015. This was a "clean" debt ceiling bill, meaning no other policies or offsets were included. For Wisconsin, the vote was party line with Wisconsin's Democrats supporting and Republicans opposing.

Over 900 Expected at Advocacy Day, April 16

Register your hospital contingent today



The Wisconsin Hospital Association's annual Advocacy Day continues to be a powerhouse event in Wisconsin's State Capitol each year because of the commitment of hospital leaders, staff, trustees and volunteers to the event. Make sure you are assembling your hospital contingent for 2014 Advocacy Day in Madison and plan to stay for the afternoon legislative meetings.

Building relationships with elected officials during the afternoon's legislative meetings are the priority of Advocacy Day. More than 500 meetings were made in 2013 and we're looking for more in 2014. In addition to an issue briefing at Advocacy Day itself, WHA will again offer two optional pre-event webinars for those going on legislative visits. Topics to be covered in the webinars include frequently asked questions, what to expect during meetings and a brief overview of issues. Speaking up on behalf of your hospital by meeting with your legislators during Advocacy Day is essential in ensuring legislators know how valuable your hospitals are in your communities. ***(continued on page 5)***

Continued from page 4 . . . Over 900 Expected at Advocacy Day, April 16

As always, Advocacy Day 2014 will have a great line up of speakers so you won't want to miss this important event. A complete brochure and registration information is available online at: http://events.SignUp4.net/14AdvocacyDay0416. See you April 16 at the Monona Terrace in Madison.

For Advocacy Day questions, contact Jenny Boese at 608-268-1816 or *jboese*@*wha.org*. For registration questions, contact Lisa Littel at *llittel*@*wha.org* or 608-274-1820.

High Value Health Care—Wisconsin's Competitive Advantage

High quality, high value health care is a hallmark in Wisconsin. Hospital systems are improving quality, increasing efficiency and delivering value to employers and residents in their communities. This week, we feature the work of Memorial Medical Center, Neillsville.

Physician Champion Helps Memorial Medical Center Reduce Infections

Memorial Medical Center Neillsville credits the WHA Partners for Patients project for their success in reducing the use of Foley catheters in their organization. Their initial interventions focused on appropriate indications for insertion, and daily review of line necessity.

Their existing Foley catheter policy was revised to require that the "Urinary Catheter Decision Making Algorithm" be completed by the RN prior to insertion of a Foley, and daily thereafter. Medical and nursing staff received training on the new process and in the accepted indications for urinary catheter placement. Data was regularly shared via multiple communication avenues to the units and Emergency Department.

Another key component to their success was having a physician champion. At Memorial Medical Center, Amy Schneider, MD filled that role. Not only was she essential in communicating with the clinical staff the importance of the project, but also in encouraging alternatives to catheter use. The greatest majority of Memorial Medical Center Neillsville's other physicians have adhered to this new process, and if a RN contacts them regarding a urinary catheter that does not meet an indication for insertion, or that needs to be discontinued, they have been very willing to discontinue their Foley order.

The monthly webinars hosted by WHA also helped to outline the process the hospital staff needed to follow to reach success with this initiative, and also provided a feeling of "you can do this" whenever the medical and nursing staff shared a feeling of discouragement.

As a result, there are significantly fewer patients with Foley catheters, which results in lower cost, fewer infections, less discomfort to the patient, and less delay in discharge because previously the Foley often wasn't addressed until after the discharge orders had been written.

WHA MPA Council Confirms Need for Heroin, Opiate Abuse Education

WHA Government Relations Vice President Kyle O'Brien reviewed several pieces of legislation related to heroin and opiate abuse prevention and treatment with the WHA Medical and Professional Affairs Council (MPA) at their February 6 meeting in Madison. The bills are part of the Heroin, Opiate Education and Prevention (HOPE) package of legislation spearheaded by Rep. John Nygren (R-Marinette). Rep. Nygren's legislation is aimed at providing additional tools for first responders to administer life-saving opioid antagonist medication and provides certain criminal immunities for people who call for emergency care when someone is suffering from an overdose or reaction to a controlled substance. ***(continued on page 6)***

Continued from page 5 . . . WHA MPA Council Confirms Need for Heroin, Opiate Abuse Education

"Recent initiatives to curb heroin addiction in Wisconsin communities have garnered broad, bipartisan support in the Wisconsin Legislature," said O'Brien. "Rep. Nygren's dedication to this important issue will help Wisconsin families and communities combat this dangerous epidemic."

Council members from hospitals across Wisconsin reiterated the grave concern their communities face with opioid and heroin abuse. According to the WHA Information Center, in the first three quarters of 2013 there were 674 inpatient admissions and 587 ER visits related to accidental overdoses due to the use of heroin or opiates. The Council believes it is important for providers to educate their patients about this legislative package and encourage them to call for emergency care if someone they know is suffering from an opioid or heroin addiction or overdose.

See the legislation here:
AB 445: https://docs.legis.wisconsin.gov/2013/related/proposals/ab445.pdf
AB 446: https://docs.legis.wisconsin.gov/2013/related/proposals/ab446.pdf
AB 447: https://docs.legis.wisconsin.gov/2013/related/proposals/ab447.pdf
AB 448: https://docs.legis.wisconsin.gov/2013/related/proposals/ab448.pdf

David Gummin, MD, the Wisconsin Poison Center medical director, outlined the history and operation of the Center for Council members. Gummin said the Poison Center handles more than 110 poison-related cases every day and had more than 40,000 calls in 2013. Notably, only 24 percent of those calls originate from a hospital.

The Poison Center operates 24 hours a day, 365 days a year and is one of 56 such centers in the United States.

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At the hearing, Marklein explained how the bill would address the frustration with the existing hospital rules, "The outdated and unnecessary rules would sunset, removing red tape and inefficiencies. Adopting the Medicare Conditions of Participation as the state standards will maintain the state regulatory oversight of hospitals but allow the state regulators to apply more up-to-date and efficient standards."

Vukmir emphasized, "Regulations can be the most costly aspect of running a business. We need to do a better job of making sure our regulatory climate is not overly burdensome while still protecting the general public. SB 560 and AB 728 move us down that path."

Also testifying at the hearing, WHA's Chief Quality Officer Kelly Court noted, "Wisconsin hospitals are the hub of a health care system that provides among the best health care in the country. Wisconsin is consistently ranked among the top five states for providing excellent, high value health care to its patients. Like roads and schools, our health care is one of the many reasons to locate and grow a business in Wisconsin." Court continued, "In Wisconsin, we are fortunate to have committed leaders and staff working to improve patient outcomes. Compliance with regulatory standards is important and a significant commitment of hospital resources. We believe current and regularly updated regulatory standards are an important part of ensuring quality care."

Laura Leitch, WHA's general counsel, encouraged the committee members to support the bill, "This bill makes sensible changes to the current state regulatory scheme for hospitals. Because it, in important ways, syncs the state hospital regulations with the federal regulations, the hospital regulators and administrators can focus their efforts on issues beyond parsing regulatory language and technical compliance," Leitch said.

The bills now move to the Assembly and Senate for votes by both houses.

Guest Column (cont'd.)

From page 1 . . . Time for Congress to Fix Medicare Hospital Payment 'Boondoggle'

mechanism designed to ensure that hospitals in urban areas are reimbursed at a level no lower than those of a state's rural hospitals. However, Kerry's amendment included a pernicious catch—rather than drawing from new funding to balance payments, it triggered a budget neutral adjustment.

Massachusetts' gain came at the expense of hospitals across the country—from hospitals that are struggling to care for Medicare beneficiaries in their own states. What has become known as the "Bay State Boondoggle" is more than an unintended consequence of an amendment. There's clear evidence that the state's hospitals worked to create a system to advantage themselves through what even the Obama administration in federal regulations called a "manipulation" of the Medicare "rural floor" payment system.

What triggered this opportunity was best summed up in a Boston Globe article in January 2013. "Nantucket Cottage entered into the rural hospital payment system in 2008 after it was acquired by Boston-based Partners HealthCare," the article said. "The Nantucket hospital previously had been paid under a different formula, but made the switch to the rural hospital payment system to help the rest of Massachusetts hospitals reap a financial reward even though its own Medicare reimbursement would decline as a result. Partners had ensured that Nantucket Cottage would be made whole financially because the rest of its hospitals would benefit greatly."

A later Globe editorial affirmed, "Setting the wage floor in Nantucket resulted in the boon for the rest of the state."

What makes this issue so troublesome is the fact that a decade ago when Congress approved the Medicare Prescription Drug, Improvement, and Modernization Act in 2003, lawmakers worked to halt similar budget neutral adjustments. When a new round of adjustments were presented during consideration of this legislation, Congress moved away from the "robbing Peter to pay Paul" actions of the past and toward funding any adjustments with new money.

The "Bay State Boondoggle" turned the clock back a decade and it was bold—it improved payments by 8 percent for every hospital in Massachusetts. As noted, hospitals across the country, and the Medicare beneficiaries they serve, are paying for this overreach.

When these cuts are added to the Medicare cuts to hospitals through the ACA, sequestration and other subsequent legislation, they have contributed to layoffs, hiring freezes, service line reductions and cancelled capital projects at hospitals and health systems throughout the country.

The Medicare Payment Advisory Commission (MedPAC) noted in a June 2011 letter to the Medicare agency that this "… exception triggered in the state of Massachusetts will have a large impact on hospital payments … ." MedPAC, whose job is to offer counsel to Congress on Medicare policies, further stated that as a result of the budget neutral change, "… all hospitals—including rural hospitals—will absorb the financial loss… ."

The Centers for Medicare & Medicaid Services' suspicion of this maneuver isn't new; it's historical. During the Bush administration, CMS called the action a direct "manipulation" of the payment system and moved to implement regulations in 2008 to prevent gaming of the wage index.

The Obama administration reaffirmed this position during the 2012 rulemaking process, writing "as a result of actions not envisioned by Congress, the rural floor is resulting in significant disparities in wage index, and in some cases, resulting in situations where all the hospitals in a state receive a wage index higher than that of the single highest wage index urban hospital in the State" (76 Fed. Reg. 42,212). *(continued on page 8)*

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Former acting administrator of CMS, Donald Berwick, was critical of the system's potential for mischief. Interviewed by the Globe, Berwick said the system was "complex" and "susceptible to gaming and manipulation." Further, Berwick recognized the fundamental problem of the system, post-ACA, saying, "It's a zero-sum game. What Massachusetts gets comes from everybody else."

Congress itself has moved to fix the "Bay State Boondoggle."

In January 2013, Sens. Claire McCaskill (D-Mo.) and Tom Coburn (R-Okla.) introduced the Hospital Payment Fairness Act (S. 183) to sunset the provision of the ACA that adjusted hospital wage index payments through Medicare. The bill garnered 28 bipartisan co-sponsors.

In March 2013, the senators offered a non-binding amendment to the Senate Budget Resolution to strike the provision. The amendment passed with 68 votes and strong bipartisan support, a rare feature in today's typically partisan environment.

In the House, Rep. Kevin Brady (R-Texas) introduced a companion bill (H.R. 2053), known as the Medicare Wage Index Equity Act, in May 2013. The House bill has 74 Republican and Democratic co-sponsors.

Although neither the Senate nor the House bill has received a stand-alone vote, pressure continues to build for action on the legislation. Collectively, the states we represent—North Carolina, Ohio, Oregon and Wisconsin—will forego $42 million in Medicare payments in 2014 due to the provision. The total for all hospitals represented by the Alliance of America's Hospitals is much larger.

According to the Congressional Budget Office, returning to the pre-ACA system isn't costly from a budgetary perspective. The wage adjustment index is budget neutral. However, returning to a more just system would reallocate $3.5 billion in payments to those states that are incurring the costs of care for their Medicare beneficiaries, but are purposefully being underpaid. At the same time, these payments will be reduced to Massachusetts and other wage index "winners" throughout 10 years.

In a better system, the rural floor would help support hospitals in states where an anomaly in wages occurs. CMS and Congress could work together to identify where changes were appropriate and fund those changes as needed. That's how it worked pre-ACA, and how it should work again. The wage index wasn't intended to raise hospital rates throughout an entire state based on the single highest rate in the state.

Without question, the hospital wage index system is flawed and cries out for meaningful and long-term reform. Until such time, fixing the Boondoggle provides one small step to restoring more accurate pricing for Medicare.

The pricing structure is important because mispricing can distort the market and lead to issues such as overutilization of services and a lack of flexibility to invest. Moreover, underpricing will harm hospitals' ability to implement important quality and efficiency programs like those embodied elsewhere in ACA, harming hospitals, beneficiaries and the Medicare program.

Funding for Medicare shouldn't be a zero-sum game. Creating winners and losers does nothing to improve the delivery of health care, reduce costs or improve health—the bedrock principles of health reform. And a better system would reduce the incentive for a financial arms race, with states and hospitals vying to capture revenue from other states or each other.

Guest Column (cont'd.)

From page 1 . . . Wisconsin MEB Changes Physician Assistant Supervision Requirements

Identification of Supervising Physician

The Revised Regulation adds a requirement that the supervising physician must be "readily identifiable" by the PA. The Revised Regulation does not specify how to comply other than stating "through procedures commonly employed" in the PA's practice. Given that a PA is permitted to be under the supervision of more than one physician at a time and a PA may provide patient care in multiple settings, it is necessary to have a system for tracking the supervising physician that is documented and accessible.

Requirements for Review of PA Prescriptive Practice

The requirement for a physician to review a PA's prescriptive practice is simplified under the Revised Regulation.

- A PA must initially, and at least annually thereafter, meet with the supervising physician for review of the PA's prescriptive practice.
- The reviews must be documented and signed by the supervising physician and PA and be made available to the MEB upon request.

The Revised Regulation provides no specific instructions on what the initial and subsequent annual reviews must entail which allows the supervising physician and PA flexibility to develop a review process and documentation that fits their practice arrangement. The existing regulations can serve as guidance however, for how to comply with this requirement. The supervising physician and PA should determine the scope of the PA's prescriptive practice, taking into consideration the PA's training and experience, and establish written guidelines that outline the patient situations in which the PA can issue a prescription and the categories of drugs the PA is authorized to prescribe.

Other Supervision Requirements Repealed

- A supervising physician is no longer required to make a monthly on-site visit and review of all locations a PA practices outside of the supervising physician's main office.
- A PA is no longer required to notify the MEB of any substitute supervising physicians.