Record Number of Physicians Attend WHA Annual Leadership Conference

More than 210 physician and hospital leaders attended the ninth Annual Physician Leadership Development Conference. The 2015 event is scheduled for March 13-14.

As WHA’s ninth annual Physician Leadership Development Conference officially opened, David Nash, MD, the event’s keynote speaker internationally recognized for his work in quality outcomes management and medical staff development, shared his amazement of so many physician leaders coming together to learn at one event. And, he was even more amazed that it was the state’s hospital association who brought them together. This year’s event, held March 14-15, drew more than 170 physicians and 43 hospital leaders, representing 70 different hospitals, health systems and physician groups.

With more than 210 in attendance, the 2014 conference was the largest to date, as growing numbers of physician and hospital leaders use WHA’s annual Physician Leadership Development Conference as one tool to help new and seasoned physician leaders bridge the gap between their traditional clinical training and the new approaches to decision-making and problem solving they need to consider in their leadership roles.

While discussing the history of the quality and safety movement in the United States, Nash recognized Wisconsin as a leader in improving quality outcomes, as well as public reporting of those outcomes. He also discussed the connection between quality improvement and health reform, its effect on physicians, and shared strategies for physician leaders to engage their physician colleagues in supporting a culture where quality improvement is the expectation.

In addition, WHA President Steve Brenton discussed the Association’s top priorities, and WHA Chief Quality Officer Kelly Court shared highlights from WHA’s 2013 Annual Quality Report and discussed practical ways physician leaders can engage their colleagues in the many efforts occurring in hospitals throughout Wisconsin.

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The conference’s closing presenter was Tim Keogh, PhD, focusing on the importance of communication and how physician leaders can be more successful by understanding their own communication style and those of their physician colleagues.

According to WHA Senior Medical Advisor Chuck Shabino, physician leaders and hospital leaders alike find great value in participating in the conference.

“The opportunity to learn essential leadership skills, network with fellow physician leaders and build relationships with hospital colleagues away from the everyday rush makes this conference successful. The fact that physicians attend year after year speaks well of their perception of its value to them,” said Shabino.

The 2015 event is scheduled for March 13-14 at The American Club in Kohler. Mark your calendar, share this date with your medical staff and encourage your new and potential physician leaders to consider attending as part of your team.

Congress Passes SGR “Patch”

**Legislation includes one-year ICD-10 delay**

Though aggressive efforts have been made this year to finally repeal the much-maligned Sustainable Growth Rate (SGR) under Medicare’s physician reimbursement system, the $130-180 billion estimated cost of a permanent fix continues to confound Congress. Instead of moving forward with full repeal, this week Congress approved legislation to “patch” the SGR for another year, until March 31, 2015.

Physicians had faced a 24 percent payment cut without Congressional action. Under the package, physicians will see a 0.5 percent increase through the end of this year (Dec. 31, 2014) and a 0 percent increase from January 1, 2015 - March 31, 2015. The House of Representatives approved the legislation on voice vote. The Senate approved the bill by a 64-35 vote with both Wisconsin senators voting against.

While the legislation did not include major hospital cuts and included important Medicare “extender” policies for rural hospitals, it did, unexpectedly include a year-long delay of ICD-10. The ICD-10 delay caught most by surprise and stops what has been significant progress by hospitals and health systems to go live with the new coding system.

Provisions impacting physicians and hospitals in the legislation would:

- Provide no permanent fix to SGR, while providing a 0.5 percent increase in reimbursement for CY 2014.
- Delay implementation of ICD-10 until October 1, 2015.
- Extend various Medicare policies including Medicare Dependent Hospitals, low-volume adjustment, therapy caps, Work GPCI and ambulance add-on payments through April 1, 2015.
- Delay the “two-midnight” rule an additional six months, through March 31, 2015.
- Delay Medicaid disproportionate share hospital (DSH) payments cuts one year (until 2017) but then extends the cuts out an additional year (to FY 2024).
- Adjust application of the Medicare sequester in FY 2024.
- Create a value-based payment for skilled nursing facilities based on individual SNF performance on a hospital readmission measure (October 1, 2018).
- Provide for some technical corrections to long-term care hospitals (LTCHs) site-neutral payment policy to clarify that only Medicare fee-for-service discharges will be used to calculate the LTCH discharge payment percentage, and establishes an exception to the LTCH moratorium.
- Require CMS to use private payer rate information to reform Medicare payment rates for clinical labs.
Was Two-Midnight Rule Necessary?

CMS should deal with the real problem: the RACs

The Centers for Medicare & Medicaid Services (CMS) keeps digging an even deeper hole as it attempts to manage a new rule creating confusion. Last summer, the federal agency issued an ill-advised rule (dubbed “Two Midnights”) that determined hospitals would be paid Medicare outpatient rates (Part B) for care lasting less than two midnights. Those stays were previously paid for under Part A.

The impetus for the rule? Recovery Audit Contractors (RACs) second guessing clinical decisions made when a Medicare patient sought care at their local hospital—second guessing that can occur years after the care was provided.

The impact of the rule continues to reverberate for hospitals, physicians and for Medicare patients who may find themselves facing significant out-of-pocket costs amounting to thousands of dollars for treatments they expected to be covered as inpatient stays.

First, the rule establishes an arbitrary, time-based policy bearing no clinical foundation. It assumes that physicians will know the length of hospital stay for a yet-to-be-determined medical condition.

Next, the rule is punitive in that it penalizes hospitals and physicians for being efficient users of health care resources. It also penalizes Medicare beneficiaries and creates confusion and potential conflict between seniors and their caregivers.

Finally, the rule attempts to fix a symptom rather than the underlying problem—the RACs—audit organizations that have been aggressive in second guessing clinical decisions. RAC denials have forced providers to appeal countless claims which now wait in adjudication limbo at the federal Office of Medicare Hearings and Appeals (OMHA). The OMHA backlog is so bad it recently was forced to freeze new appeals while it seeks to reduce the 350,000 appeals already in the system. OMHA indicates it could take years before claims are heard. Instead of “fixing” the problem, the CMS “fix” made a bad problem worse.

CMS has delayed enforcement of the two midnight rule until October 1 and recently made several changes to the RAC program. In the meantime it is attempting to “probe and educate” providers on a rule so ill conceived that such action is and will certainly be insufficient.

The wiser course of action would be for CMS to withdraw the Two Midnight rule immediately. If not, Congress must act by passing legislation like the “Two Midnight Delay Act (HR 3698)” which pulls the rule back and replaces it with a suitable solution, or better yet, Congress should pass the “The Medicare Audit Improvement Act (HR 1250/S. 1210),” which puts parameters around the actions of the RACs. Wisconsin Members of Congress—Representatives Ribble, Duffy, Pocan, Sensenbrenner, Moore and Petri—have already signed onto HR 1250 and Reps. Kind and Pocan to HR 3698.

Steve Brenton
President
Match Day Results Show Slight Dip in Number of Med School Grads Staying in WI

“Match Day” results revealed that Wisconsin medical students are continuing to show a growing interest in primary care careers, but only 32 percent of Wisconsin medical school graduates will stay in state to complete their first-year residency. That is slightly under the number of graduates who stayed in state in 2013. “Match Day” is when graduating medical school seniors across the country learn where they will be going for their first-year residency training.

Wisconsin’s two medical schools, the Medical College of Wisconsin and the University of Wisconsin School of Medicine and Public Health graduated a total of 358 medical students in 2014. The Wisconsin Academy of Rural Medicine (WARM) reported that two-thirds of their 20 graduates will stay in Wisconsin.

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<th>UW School of Medicine &amp; Public Health</th>
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<td></td>
<td>2013</td>
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<td>Medical school graduates who chose primary care (%)</td>
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<td>Medical school graduates who will begin first-year residency in WI (%)</td>
<td>38%</td>
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According to the Wisconsin Hospital Association report, “100 New Physicians a Year: An Imperative for Wisconsin,” (www.wha.org/Data/Sites/1/pubarchive/reports/2011physicianreport.pdf) almost half of the physicians who complete a residency in Wisconsin stay here. That percentage jumps to 80 percent if the student is a Wisconsin native and attended both medical school and completed an in-state residency here, according to the WHA report. Where a physician does his or her residency is a leading indicator of where they will practice medicine.

“It is critical that we increase the percentage of graduates that enter a Wisconsin residency program, especially primary care, so we can count on those physicians to establish a practice in Wisconsin in the future,” according to Chuck Shabino, MD, WHA senior medical advisor. In addition, Shabino said Wisconsin must increase the number of in-state residency positions.

The Medical College of Wisconsin will begin admitting students to its Green Bay campus in 2015. WHA has been enthusiastic about the plan to increase the medical school class size in Wisconsin, but is concerned about having an adequate number of residencies available for the new graduates.

“It’s imperative that we create more residency positions in Wisconsin so we can keep these physicians in our communities,” Shabino added. “If we don’t, we’ll lose these doctors to other states.”

Governor Scott Walker included several initiatives in the state budget that are aimed at increasing capacity in Wisconsin’s medical schools and expanding opportunities for medical school graduates to complete their residency training here.

“The Governor’s strong support of strengthening our medical education infrastructure in Wisconsin will go a long way toward increasing capacity in Wisconsin’s medical schools and expanding opportunities for medical school graduates to complete their residency training here,” said WHA Executive Vice President Eric Borgerding.

Walker provided $5 million in state funds for graduate medical education (GME) initiatives in Wisconsin. The funding is being used to expand current residency programs ($1.5 million) and to develop new residency programs through creation of multi-stakeholder consortia. Both these initiatives target specialties identified as high need including family medicine, internal medicine, pediatrics, psychiatry and general surgery. The new positions in existing residency programs created by the first grants awarded in 2014 (family medicine, psychiatry and general surgery) were all filled in the match.
Apology Legislation Passes Senate on Bipartisan Vote

*Bill moves to Governor for final action*

The Wisconsin State Senate has approved legislation that, according to Charles Shabino, MD, chief medical officer at WHA, “would encourage open conversation among providers, patients, and the patients’ families.” Assembly Bill 120 provides that a statement, gesture, or conduct that expresses apology, benevolence, compassion, condolence, fault, liability, remorse, responsibility, or sympathy to a patient or the patient’s relative or representative would not be admissible into evidence in a civil action, administrative hearing, disciplinary proceeding, mediation, or arbitration regarding the health care provider as evidence of liability or admission against interest.

The bill, which passed the Assembly on a voice vote, garnered the support of 19 senators while 14 senators opposed the bill. Sen. Tim Cullen (D-Janesville) and Sen. Kathleen Vinehout (D-Alma) joined nearly every Republican in voting in favor of the legislation. Sen. Glenn Grothman (R-West Bend) was the only Republican senator to vote against the bill.

Shabino previously said, “Statements of concern by providers involved in patient care can allow the patient, family, and provider to move toward solution and resolution. These positive outcomes are more difficult to achieve when there are barriers to good communication.”

The bill now moves on to the Governor for his consideration.