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WHA Promotes Progressive Billing Guidelines with Wisconsin Attorney General

“Few care more for our communities than the hospitals and the people who volunteer in those hospitals.” - Van Hollen to hospital supporters

WHA President Steve Brenton and Attorney General J.B. Van Hollen jointly announced at WHA’s Advocacy Day May 1 that they have reached an agreement to support a set of meaningful and progressive hospital collection and billing guidelines. The newly revised billing and collection guidelines (www.wha.org) will help hospitals as they review and revise the policies they currently use when assisting uninsured patients. The new guidelines, unanimously approved by the WHA Board of Directors, suggest income eligibility levels for financial assistance, ways to address catastrophic hospital bills, and reasonable collection practices.

“It is not surprising to me when I became Attorney General, and I wanted to work with the Wisconsin Hospital Association on issues of public policy that mattered to the health and welfare of people throughout the state, that you were more than willing to come to the plate. We didn’t have to approach you for these policy discussions, you approached us,” Van Hollen said. “That reconfirmed the belief that I have had my whole life, that few people care more about public safety, care more about public policy and care more about our communities than the hospitals and the people who volunteer in those hospitals.”

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J.B. Van Hollen

WHA Advocacy Day Attracts Hundreds of Hospital Supporters to Madison *Hospital backers send strong message to legislators: No Tax!*



WHA Counsel Laura Leitch, Steve Brenton, J.B. Van Hollen, and Bob Fale

They arrived in Madison with a united message for their legislators: **No hospital tax.** Rising as early as 4 a.m. on May 1 to arrive on time for the 9 a.m. start of WHA’s 2007 Advocacy Day, 570 hospital volunteers and employees from all over Wisconsin boarded buses and carpooled their way to the State Capitol.

WHA President Steve Brenton welcomed the enthusiastic crowd to Monona Terrace, by saluting their “dedication and support for community hospitals.”

Diane Westbrook, president of Partners of WHA, an organization that represents 13,000 members in 77 hospitals, emphasized in her welcome, “We’re here today in Madison to deliver a resounding ‘NO’ to the hospital tax!”

WHA Chair Bob Fale noted the record-setting attendance of 570 is even more impressive given that hundreds of the hospital supporters were scheduled to visit their legislator in the afternoon.

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Diane Westbrook

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"My legislator told me recently he was overwhelmed by the number of contacts he recently received from his constituents on an issue, which was a total of eight. It gives you an idea of the power that we can bring with a single message today. That speaks to the importance of visiting your legislator. They listen to us. This year counts. Our voice matters," Fale said.

"Go...tell your legislators exactly what is important to you..."
- Kellyanne Conway, president, the polling company, inc.



Kellyanne Conway and Bob Fale

As Kellyanne Conway, well-known pollster and president of the polling company, inc., looked across the large audience assembled at Monona Terrace, she was clearly impressed. "I am truly honored to kick off your great day. Go across the street to your state capitol and tell your legislators exactly what is important to you and to the people you serve because those are the same people they serve. I commend you for that," she said. "It is easy to look the other way and be an ostrich when it comes to public policy activation rather than going and meeting with the people who are charged with making these decisions in our lives."

Conway noted that there is universal agreement among the American public that health care should be a top priority. Access has emerged as the top concern for the public, overtaking both cost and quality, which is a fundamental change from polls on the same topic taken in the 1990s.

"People feel that access is the initial threshold. Two in five adults already say they have had problems with access or cost," Conway said. "The amount of time they spend on paperwork is a problem for them working within the system. They feel like they are dealing with the IRS."

A lack of facts and figures doesn't stop Americans from having an opinion, or from filling in the knowledge vacuum with bad information. She said the WHA Hospital Tax Myths v. Fact publication was an "inspired" way to move people from "shrugging their shoulders to raising their eyebrows and taking up the cause." (See www.wha.org/governmentRelations/hospitaltax_2007.aspx)

Regarding the hospital tax proposal, Conway said, "Two things that rankle people are when you don't have the guts to call it a tax (instead calling it an assessment), and the other is when the item for which the tax is collected is not the item for which it is used, or it is used to fill a black hole or free up money for something else."

Lastly, Conway shared what she believes people want to know how about the health care system in America:

Safety — People want safety. They hear too much "shock the conscience stuff;" but rarely do they hear about the truly remarkable things hospitals do to keep people safe and alive.

Security – People believe that hospitals are the first responders and the last lines of defense for them.

Solvency –It's a priority to keep Medicare and Medicaid solvent.

Specifics - People want straight talk from their health care provider. They want to know what the end is, even if it is not positive.

Solution – Give them a few points that provide them with a solution, and be truthful and specific.

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President's Column

One of WHA's "top three" public policy priorities was achieved this week with the announcement that WHA and Wisconsin Attorney General J.B. Van Hollen have agreed to promote a newly-revised set of hospital billing and collection guidelines. The WHA Board-approved guidelines are designed to assist uninsured patients with their medical bills in a manner largely consistent with current practices. As developed by a WHA Task Force Chaired by Tom Bayer, Interim CEO, St. Vincent Hospital, Green Bay, the initiative demonstrates our member's commitment

...the initiative demonstrates our member's commitment to make their billing practices visible to the public, easy to understand and consistently applied.

Van Hollen said that the guidelines are "patient-centered" and will "ensure transparency" for the uninsured.

to make their billing practices visible to the public, easy to understand and consistently applied.

Speaking at the WHA Advocacy Day on Tuesday, Attorney General Van Hollen applauded the statewide hospital commitment to the initiative and noted that his approach as Attorney General, consistent with this new partnership, will be to "pursue collaboration over confrontation" as he deals with public policy issues. Van Hollen said that the guidelines are "patient-centered" and will "ensure transparency" for the uninsured.

The new WHA Billing and Collection Guidelines are a revamped initiative that builds upon earlier standards approved by the WHA Board in 2003. We believe that the new guidelines represent a meaningful and comprehensive approach that is among the most progressive in the nation. And importantly, flexibility is built into the guidelines, allowing community-specific conditions to be incorporated into hospital-specific policies—a departure from the "one size fits all" regulatory approach that is the alternative suggested by activists and by Attorney Generals in other states.

Initial response to our recent "ask" for commitments has been remarkable...

The next step is for Wisconsin hospital and health system leaders to sign "Confirmation of Commitment" pledges, indicating that hospital-specific policies and practices will align with the new guidelines. Initial response to our recent "ask" for commitments has been remarkable...in just four days we have received signed commitments from hospitals and health systems that together account for almost one third of statewide admissions. We'll keep this campaign in front of you over the next few weeks.

Special thanks to WHA's George Quinn and Laura Leitch for their work on this significant project!

Steve Brenton
President

WHA Community Benefits Survey Deadline is May 30

WHA's Community Benefits Coordinator Mandy Ayers reports that 96 of 132 Wisconsin hospitals have started entering FY2006 community benefit data in the WHA online survey tool. Hospitals are encouraged to start entering data soon as the deadline for completing the survey is May 30. Last year, 100 percent of the hospitals in Wisconsin completed the survey. WHA expects to issue a statewide community benefit annual report in late summer. In addition to the data collected in the survey, the report will emphasize the personal aspect of the care that is extended by hospitals to the people they serve by featuring stories about patients who received free or discounted care or about people who attended a community health education class or participated in a free health screening. (See story on page 13.)

Direct questions about the survey to: Mandy Ayers, mayers@wha.org; questions about stories to: Mary Kay Grasmick, mgrasmick@wha.org.

Legislative Panel Tackles the \$418 Million Hospital Tax Question



Jon Erpenbach and Leah Vukmir

“Every year, hearing from our legislative leaders is one of the highlights of the Advocacy Day event. This year is no exception,” said WHA Senior Vice President Eric Borgerding as he introduced the four legislative panelists, including Assembly Speaker Mike Huebsch. The



Judy Robson and Mike Huebsch

panelists were first asked to share advice on how constituents can have effective meetings with their legislators. Not surprisingly, the second question from audience member Emily Hiatt, Gundersen Lutheran, La Crosse, was not quite so comfortable:

“The state budget bill contains many important hospital issues. One of those is the tax on hospitals. Tell me if you support it and if you do, what can we do to persuade you otherwise?”

“I am absolutely opposed to a hospital bed tax as well as to the gross receipts tax. Look what happened in the long-term care industry. The money does not necessarily go to increase reimbursement, and it goes to fund other programs. I will be doing whatever I can to prevent the tax from happening.”

Rep. Leah Vukmir (R-Wauwatosa)

“I am open to the idea of leveraging the federal money if it stays where it is supposed to stay. If it is not going to work, clearly we should not be going down this road. The budget process has a ways to go yet, and from what I understand, the Governor may work on other ideas. I am open to the concept if we assess or tax this, as long as we don’t grab the money for something else.”

Jon Erpenbach (D-Middleton)

“The number one issue facing people is health care. Jon articulated it best saying it is not necessarily about access or quality, it is cost. So under what scenario would we then say, ‘if nobody could afford it why don’t we tax it?’ This is clearly not the direction we are going to go...the “Mediscam” game where we tax people for a certain level of money and we send it to the federal government so they will send us a certain amount of money back. They will figure it out. They will not allow us to continue to do it, and the funding dries up. Then the General Purpose Revenue that we have that should go to provide K-12 and should go to those on Medicaid—all that money will be gone and spent someplace else. When the funding source dries up, where will we find the dollars? This is a priority for the people. If they are going to pay a tax, they want to know where it is going to go. Taxing is clearly not the direction we are going to go.

Assembly Speaker Mike Huebsch (R-West Salem)

“I am open to the assessment for a couple of reasons. The federal government has been squeezing down on the Medicaid program. It is a partnership between federal and state government and the feds have decreased Medicaid funding by over \$740 million dollars. The State of Wisconsin has been trying to backfill that loss of federal funds. As a result, providers have not seen an inflationary increase in their reimbursement. Other states have done this—the federal government allows us to put a five percent assessment on hospitals. Then we can leverage back additional funds, a 1 percent assessment, then we could leverage \$600 million and return half of it back to those hospitals that take care of Medicaid patients.... Let’s line up and get that money. If it goes away, then have a provision that sunsets the tax.

Senate Majority Leader Judy Robson (D-Beloit)

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Continued from page 4 . . . WHA Advocacy Day Attracts Hundreds of Hospital Supporters WHA Presents Awards to Senator Julie Lassa and to Gundersen Lutheran



Sen. Julie Lassa accepts WHA's Health Care Advocate of the Year Award at Advocacy Day. Pictured, left to right: Mike Blanchard, VP-St. Joseph's Hospital, Marshfield; Celse Berard, CEO, Riverview Hospital in WI Rapids; Janet Brown, CEO, Moundview Memorial, Friendship; Brad Neet, COO, St. Michael's Hospital, Stevens Point

Senator Julie Lassa (D-Stevens Point) received the Wisconsin Hospital Association's 2007 Health Care Advocate of the Year Award and Gundersen Lutheran Health System received WHA's 2007 All Star Grassroots Advocate Award during the 2007 Advocacy Day luncheon.

Brad Neet, COO, Saint Michael's Hospital in Stevens Point, along with Janet Brown, CEO, Moundview Memorial in Friendship; Celse Berard, CEO, Riverview Hospital in Wisconsin Rapids; and Mike Blanchard, VP, Saint Joseph's Hospital in Marshfield presented the award to Senator Lassa. "The Health Care Advocate of the Year is WHA's most distinguished award," Neet said. "It honors those who have gone above and beyond the call of duty to advocate for Wisconsin's community hospitals and for affordable, accessible health care."

Senator Lassa was honored for being a strong advocate for health care and wellness by supporting proposals to substantially increase the tobacco tax and improve provider payment rates in the Medicaid program; leading the efforts to protect infants from shaken baby syndrome; and her efforts in helping to reinstate the cap on non-economic damages that helped restore Wisconsin's stable liability environment for retaining and recruiting physicians.

In accepting the award, Senator Lassa thanked all Wisconsin hospitals for their dedication to community service and their compassion for those in need. "I am happy to work with the Wisconsin Hospital Association and the hospitals in my district to make sure that Wisconsin citizens have access to the best medical care possible," Lassa said.

"Senator Lassa always has an open ear and an open door for her constituents," Neet concluded. "She is the epitome of what a deliberate and effective Senator should be."

Gundersen Lutheran Named 2007 WHA "Advocacy All-Star"

Gundersen Lutheran Health System received the Wisconsin Hospital Association's 2007 All-Star Grassroots Advocate Award for doing what they do best—advocating for the communities they serve. The employees and volunteers at Gundersen Lutheran are closely watching the state budget unfold, but they are not standing idly by. They have already started contacting their legislators and they have testified at three public hearings to make sure Madison knows they are concerned about the impact a hospital tax and other proposals contained in Governor Doyle's budget would have on their community.



Gundersen Lutheran Health System accepts WHA's All-Star Grassroots Advocate Award at Advocacy Day

Jack Lockhart, MD, accepted the grassroots award for Gundersen Lutheran. Lockhart, Joan Curran and Emily Hiatt are all part of the team that provides leadership on its importance at Gundersen Lutheran.

"WHA depends on hospitals like Gundersen Lutheran because there is no substitute for grassroots involvement," said Jenny Boese, WHA vice president of external relations & member advocacy. "They knew the issues, they worked with WHA, they engaged their elected officials, and they mobilized others to be involved. This is the heart of grassroots!" *(continued on page 6)*

Continued from page 5 . . . WHA Advocacy Day Attracts Hundreds of Hospital Supporters

Borgerding Outlines WHA Priority Issues

WHA Senior Vice President Eric Borgerding outlined the Association's priority issues just prior to releasing the advocates to their legislative visits. The hospital tax was first on a short list of priorities.

Borgerding said the Governor intends to collect a \$418 million tax on hospitals and use it to capture additional federal dollars. "The WHA analysis of the hospital tax proposal shows that it will cost hospitals \$132-186 million over two years," Borgerding said. "You don't add to the price of health care without some of the cost being passed through to patients."



Eric Borgerding

Borgerding said only 19 states have a hospital tax, two recently repealed it, and a couple tried to enact it without success. He emphasized the importance of reminding legislators that 31 states do not have a tax. Illinois' hospital tax is often held as a good reason to pass one in Wisconsin, but Borgerding cautions that the difference between Illinois and Wisconsin is that the money Illinois collects will go back to hospitals. The same can't be promised in Wisconsin.

"We have a track record in Wisconsin of stealing from Peter to pay Paul. It's happened with the nursing home bed tax and for the third time, there is a proposal afloat to take money out of the Injured Patients and Families Compensation Fund. The budget also proposes a raid of Medicaid to the tune of \$873 million. Even the gas tax and transportation fund haven't been spared from raids," he said.

Borgerding said WHA supports an increase in the tobacco tax for the obvious reason that "if you drive up the price, fewer people will smoke." He also said health reform is an area to watch as a number of proposals reach the public. WHA is currently reviewing a number of proposals and preparing documents that will help member hospitals determine the impact they would have on the communities they serve.

Joint Finance Committee Begins Work on DHFS Budget

This week the Joint Finance Committee (JFC) acted on several provisions of the Department of Health and Family Services (DHFS) budget.

Among those of interest to WHA were proposals from Governor Doyle to establish an automated insurer payment intercept program, to amend state law relating to false claims against the state, and to increase DHFS staffing for Medicaid provider audits.

The automated insurer intercept program required all insurers, before paying a claim of \$500 or more to any individual, to verify with DHFS whether the individual has a Medicaid liability and check the statewide support lien docket to determine whether the individual has a support liability. The insurer needed to first pay the support liability followed by the MA liability. Any remaining claim proceeds could then go to the individual. The Committee voted 16-0 to delete the provision.

The proposal to amend state law to create a state false claims act that would meet the requirements of the federal Deficit Reduction Act of 2005, which, in the case of Medicaid, would permit the state to retain an additional 10 percent of collected recoveries, was approved but modified by the Committee. An amendment to exempt false claims from contracts relating to trunk highways, the Department of Transportation and miscellaneous highway provisions passed on a 16-0 vote.

The proposal to add five new DHFS positions to increase the number of audits of Medicaid providers was approved by unanimous consent.

The Committee is expected to act on larger issues relating to DHFS, including the hospital tax and the cigarette tax, over the next several weeks.

Notice of Discharge Changes Effective July 1

AHA asks for 60-day delay, other changes

This week the American Hospital Association sent comments to the Office of Management and Budget (OMB) regarding the Centers for Medicare & Medicaid Services' (CMS) proposed revision of the "Important Message from Medicare" (IM) and its related paperwork requirements.

Among other comments, AHA recommends OMB require CMS to evaluate the new IM process after one year to see if it yields enough benefits to warrant the increased administrative workload and cost (projected to be over \$100 million per year). AHA also urges OMB to give hospitals a minimum of 60 days before being required to implement the new process, and, urges OMB to require CMS to provide flexibility in and clarification of this new process.

Under the new regulations, hospitals must provide the IM to beneficiaries no later than two days following admission. Hospitals must also make sure beneficiaries understand the notice, have signed a copy of it, which shows when they received it and that they understand it, and then give beneficiaries a copy of the signed notice and then another copy of the signed notice no more than two days prior to discharge.

Access the full text of AHA's comment letter to OMB online at www.aha.org/aha/letter/2007/070502-cl-cms-r-193-obm-0938-0692pdf.pdf.

CMS to Increase IRF PPS Payments by 2.4 Percent for FFY 2008

The Centers for Medicare and Medicaid Services (CMS) has released the proposed rule for the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) that would increase IRF payments by approximately 2.4 percent for federal fiscal year (FFY) 2008.

Although the proposed rule provides a full marketbasket update of 3.3 percent to the standard payment rate, actual payments to IRFs will only increase by only 2.4 percent from FFY 2007 to FFY 2008 due to the impact of a decrease to the outlier threshold amount.

The significant provisions of the proposed rule include:

- Increase the outlier threshold from \$5,534 for FFY 2007 to \$7,522 for FFY 2008. CMS estimates that 3.8 percent was paid out for IRF outlier payments in FFY 2007. Therefore, CMS has proposed to increase the outlier threshold to maintain outlier payments at 3 percent of total IRF payments. This outlier threshold may change in the final rule based upon a CMS review of more recent data.
- Implementation of the final year of the three-year hold-harmless policy for facilities with labor designations that changed from rural to urban under the Core-Based Statistical Areas (CBSAs). The hold-harmless policy provided a phase-out of the 21.3 percent rural add-on for these facilities. Beginning in FFY 2008 these IRFs will no longer receive a rural adjustment.
- Continuation of the phase-in of the compliance threshold to 65 percent for cost-reporting periods beginning on or after July 1, 2007 and before July 1, 2008. The compliance threshold requires that at least that percentage of an IRF's total inpatient population have one of the 13 designated medical conditions for which intensive inpatient rehabilitation services are medically necessary.
- Continued use of the case-mix classification system that was used in FFY 2007 for FFY 2008.
- Update to the national cost-to-charge ratio ceiling used to calculate an IRF outlier payment. The updated cost-to-charge ratio ceiling is 0.475 for urban IRFs and 0.589 for rural IRFs.
- Continuation of the rate add-ons for teaching and rural IRFs and IRFs that serve low-income patients.

The proposed rule will be published in the May 8 *Federal Register* and comments will be accepted until July 2. A display copy of the proposed rule is available on CMS' Web site at www.cms.hhs.gov/inpatientrehabfacpps/downloads/cms1551P.pdf.

CMS Proposes Significant Payment Changes for Medicare Home Health Services

The Centers for Medicare and Medicaid Services (CMS) has proposed changes to the Home Health (HH) Prospective Payment System (PPS) that would provide the first major refinement to the system since its implementation in October of 2000. The changes would be effective for calendar year (CY) 2008.

Although the rule provides a full marketbasket update of 2.9 percent, CMS is proposing to apply a 2.75 percent reduction to the national standardized 60-day episode payment rate to address what CMS is considering coding changes that do not reflect real changes in case mix. CMS is proposing to apply this reduction for three years beginning in CY 2008.

Other provisions in the proposed rule include:

- **Case-Mix Groups (CMGs):** CMS is proposing refinements to the HH case-mix classification system that would increase the number of CMGs from 80 in CY 2007 to 153 in CY 2008. In addition, CMS is proposing to revise the treatment of therapy visits in the service utilization portion of the classification system.
- **Non-Routine Medical Supplies (NRS):** Currently, payment for NRS is included in the national standardized 60-day episode payment rate at \$49.62. CMS is proposing to separate payment for NRS from the standardized payment rate. Under the proposal, the NRS would be case-mix adjusted using various scoring measures and placed into one of five "NRS Severity Groups." The payments range from \$12.96 to \$367.34 per episode.
- **Episodic Reimbursement:** Currently, all episodes are treated equally in terms of payment. CMS is proposing to alter payment for an episode based on when it occurs within a series of adjacent episodes. Episodes are considered to be "adjacent" if they are separated by no more than a 60-day period between claims. Under the proposal, payments for the first two episodes in a series of adjacent episodes will be less than payments occurring in episodes three and above. Therefore, in the case of two patients coded to the same home health resource group but in different episodes, payment for the patient in episode one will be less than payment for the patient who happens to be in episode three.
- **Quality Reporting:** A 2.0 percentage point reduction will continue to apply to Home Health Agencies (HHAs) that do not submit quality data on the ten measures finalized in CY 2007. For CY 2008, CMS is proposing to add two new outcome measures. These new measures are emergent care for wound infections or deteriorating wound status, and improvement in status of surgical wound. As is the case for the current ten reported measures, no additional reporting is necessary since the data elements used to calculate these outcome measures are currently captured by the Outcome and Assessment Information Set (OASIS) instrument.
- **Low Utilization Payment Adjustment (LUPA):** CMS is proposing an increase to the national per-visit amounts for certain LUPA episodes. The proposed increase of \$92.63 is applicable to episodes that occur as the only episode or initial episode in a sequence of adjacent episodes.
- **Significant Change in Condition (SCIC):** CMS is proposing to eliminate the SCIC adjustment in CY 2008. CMS believes that HHAs have had difficulty in interpreting when to apply the SCIC adjustment policy. As a justification for eliminating this adjustment, CMS cites a decline in the number of SCIC episodes and negative margins for SCIC episodes.

The proposed rule will be published in the May 4 *Federal Register*, and comments will be accepted until June 26. To view a display copy of the proposed rule, go to www.cms.hhs.gov/HomeHealthPPS/HHPPSRN/list.asp#TopOfPage, click on "Show only items whose year is 2008," and refer to CMS-1541-P.

CMS Updates SNF Payments

The Centers for Medicare and Medicaid Services (CMS) has issued a proposed rule updating the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) for Federal Fiscal Year (FFY) 2008. The proposal provides SNFs with a full marketbasket update of 3.3 percent.

Other provisions include:

- **SNF Marketbasket Revision and Rebasing:** The current SNF marketbasket is based on 1997 total facility costs. CMS proposes to update SNF marketbasket using a more recent base year of 2004 as well as using Medicare allowable costs instead of total facility costs. In addition, two new cost categories, postage and professional liability insurance, will be added to the current 21 cost categories. Also, several new price proxies will replace current price proxies within some of the existing 21 cost categories. The rebased and revised marketbasket for FFY 2008 will be 0.2 percent lower than the marketbasket under the current methodology.
- **Decrease in the Labor-Share:** Based on the proposed rebased and revised SNF marketbasket (see above), the labor-related portion of the Federal rate (the portion of the rate that is adjusted by the wage index) will decrease from 75.839 percent to 73.757 percent. This decrease will reduce payments for all SNFs with a wage index over 1.0.
- **SNF Marketbasket Forecast Error Adjustment:** The current SNF marketbasket forecast error threshold is 0.25 percentage points. CMS proposes to increase this threshold to 0.50 percentage points effective for FFY 2008. According to CMS, the forecasting error for FFY 2006 is 0.3 percent. Under the revised threshold, there would be no forecast error adjustment for FFY 2008.

The proposed rule will be published in the May 4 *Federal Register*, and comments will be accepted until June 29. To view a display copy of the proposed rule, go to www.cms.hhs.gov/SNFPSP/LSNFF/list.asp#TopOfPage, click on "Show only items whose year is 2008" and refer to CMS-1545-P.

CMS Releases an Update Notice for the IPF PPS Rule for RY 2008

The Centers for Medicare and Medicaid Services (CMS) has issued a notice updating the rates for the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) for Rate Year (RY) 2008. These rate changes are effective beginning July 1, 2007. Since CMS is not making any policy changes for RY 2008, this rule is being issued as a notice to update the prior year's rates. Therefore, there is no comment period for this update.

More specifically, CMS will:

- Increase the per diem rate to \$614.99 for RY 2008;
- Increase the outlier fixed dollar loss threshold to \$6,488; and
- Increase the payment for electroconvulsive therapy (ECT) treatment to \$264.77

For RY 2008, CMS will continue to use the current Diagnosis Related Group, Rural, Teaching, Variable Per Diem, Age, and Comorbidity Conditions adjustment factors as in RY 2007.

In addition, the three-year transition period from a reasonable cost-based reimbursement to full prospective payment for IPFs expires in 2008. Facilities will be paid 100 percent of the federal IPF PPS rate starting with cost report periods beginning on or after January 1, 2008. CMS has made no changes to the 70 percent Stop-Loss provision for RY 2008.

CMS will publish the IPF PPS proposed rule in the May 4 *Federal Register*. A display version of the rule is available online at www.cms.hhs.gov/InpatientPsychFacilPPS/02_regulations.asp#TopOfPage.

\$125 Million Cut Proposed for Workers Compensation

“40 percent reduction for hospitals untenable”

At the Workers Compensation Advisory Council meeting on May 3, “management,” represented by Wisconsin Manufacturers and Commerce, proposed a 40 percent cut in the payments hospitals receive for treating Workers Compensation patients. While proposing a new fee schedule that would reimburse hospitals at the same rate they are paid by Medicare plus 40 percent, WMC argued that the current Workers Compensation system pays more for health care services than many commercial insurers pay for the same services. Other provisions in the proposal include a reimbursement rate of Medicare plus 100 percent for non-hospital providers; annual increases to the fee schedule that are tied to the annual increases provided by Medicare; and the use of Medicare billing and payment rules. A copy of management’s medical fee schedule proposal is available on WHA’s Web site.

David Newby, president, AFL-CIO, criticized management’s proposal asking why management wants to jeopardize Wisconsin’s excellent Workers Compensation system. Newby pointed to Workers Compensation Research Institute data that shows Wisconsin’s system as having among the lowest medical costs per claim, the best return to work numbers, the best access to care, and high satisfaction with care when compared to the 12 other WCRI study states. “Our system is a great value. We should be touting that, not criticizing it,” Newby observed.

George Quinn, WHA senior vice president, explained to the Council the impact management’s proposal would have on hospitals. “A 40 percent reduction for hospitals is untenable. You cannot cut \$125 million in reimbursement and expect there to be no impact on access to care,” said Quinn.

Management’s proposal is part of the biennial “agreed to” bill process during which management and labor representatives on the Council negotiate changes to the Workers Compensation program that are then sent to the Legislature as a bill. The Legislature traditionally passes the bill without amendment. While WHA, the Wisconsin Medical Society, and the Wisconsin Chiropractic Association have appointed liaisons to the Council, health care providers do not have a vote on the Council. WHA will continue to work with its liaison partners as this biennium’s “agreed to” bill develops. “WHA appreciates labor’s efforts to protect Wisconsin’s system. We, of course, want to work with management if the goal is improving our system, but not in any way that ultimately would harm injured workers or our members,” said Laura Leitch, WHA liaison to the Council. The next meeting of the Council is in two weeks.

The following table from WCRI shows Wisconsin’s ranking as the best state overall on the “key value proposition for Workers Compensation.”

	Value Proposition	Medical Costs per Claim with More than Seven Days Lost Time	Utilization of Medical Care	Recovery of Health and Functioning	Return to Work	Access to Care	Satisfaction with Care
WI	Better Value	Lower	Lower	Middle	Better	Better	Better
MA	Better Value	Lower	Lower	Better	Middle	Middle/Better	Better
CT	Better Value	Lower	Lower	Middle	Middle/Better	Middle	Middle
PA	Better Value	Lower	Middle	Better	Middle/Better	Middle	Middle
NC	Moderate Value	Middle	Middle	Middle	Middle	Middle/Worse	Worse
TN	Worse Value	Middle	Middle	Middle	Worse	Worse	Worse
FL	Worse Value	Middle	Higher	Middle	Middle/Worse	Worse	Worse
CA	Worse Value	Higher	Higher	Middle	Middle/Worse	Middle/Worse	Worse
TX	Worse Value	Higher	Higher	Worse	Worse	Middle/Worse	Middle

Notes: The above table is based on the outcomes summarized in Table 6.2. The differences between states that are characterized as “better” or “worse” are notable. The differences at the margin between states labeled as “middle” and those labeled as “better” or “worse” are sometimes small. Where small, the characterizations are inherently subjective and reasonable readers could disagree at the margin.

Plan to Attend 2007 Rural Health Conference, June 27-29 in WI Dells

This year's Wisconsin Rural Health Conference will focus on improving the many relationships that are vital to the successful management of a community hospital - with physicians, patients, and the members of your community.

The event will open with a presentation by Karen Vernal, focusing on how to apply the concept of emotional intelligence as the leaders of your organization and why it is the ingredient that separates the extraordinary leader from the average. Dr. Jay Kaplan, an accomplished physician successful in driving service excellence, will wrap up the conference by sharing best practices and practical experiences to improve the vital relationships with physicians, employees, patients, and your community. He'll also discuss how to create an environment in your community hospital that is a great place for physicians to practice medicine, for staff to provide care, and one where local patients choose to receive care.

Conference attendees can also choose from a variety of concurrent sessions offered within one of the four tracks, each focused on one of these vital relationships. A track devoted specifically to governance will expose hospital trustees to their roles in maintaining these important relationships as well.

This year's conference will be held at the Kalahari Resort in Wisconsin Dells. Leadership staff members from small or rural hospitals, as well as board of trustee members, are encouraged to attend. The full conference brochure with registration information is included in this week's packet and is available online at www.wha.org.

For more information on the program content, contact Jennifer Frank at 608-274-1820 or email jfrank@wha.org. For registration questions, contact Lisa Geishirt at 608-274-1820 or lgeishirt@wha.org.

Wisconsin Chapter of ACHE Offers Category I Program – June 29

The Wisconsin Chapter of ACHE is presenting a workshop entitled "Making Sense of Performance Transformation Methodologies" on June 29, following the adjournment of the Wisconsin Rural Health Conference.

As health care organizations are challenged to maximize clinical, operational and financial performance, many hospitals have chosen to employ transformational process improvement initiatives. These efforts include Six Sigma, Lean, WorkOut™, and Change Acceleration Process, among others. Understanding the practical differences, barriers to use, and realized organizational benefits can be challenging. Practitioners versed in the use of various performance transformation methodologies will provide an overview of the methodology and share their experience regarding the use of these approaches.

This program has been developed and is presented locally by the Wisconsin Chapter of ACHE. The American College of Healthcare Executives has awarded 1.5 Category I (ACHE education) credit hours to this program.

The presenting panel will include Marguerite Powell, senior consultant for GE Healthcare Performance Solutions, who will act as moderator; Jayme Daniell, regional assistant vice president of laboratory services for Wheaton Franciscan Healthcare; Karen Kiel Rosser, vice president of quality and managed care for Agnesian Healthcare; and Bill Schmidt, chief executive officer for New London Family Medical Center.

The conference will be held at the conclusion of the Wisconsin Rural Health Conference, on Friday, June 29, 2007, from 11:15 a.m. to 12:45 p.m. at the Kalahari Resort in Wisconsin Dells. There is no cost to register for this event, but pre-registration is requested. A brochure with registration form is included in this week's packet and on the web site at www.ache-wi.org. Easy, online registration is available.

For more information on the program content, contact Janet Brown at 608-339-6814, email jbrown@moundview.org. For registration questions, contact Lisa Geishirt at 608-274-1820 or lgeishirt@wha.org.

CMS Releases 2008 Final Rule for Long-term Care Hospital PPS

The Centers for Medicare & Medicaid Services (CMS) has released the rate year (RY) 2008 final rule for the long-term care hospital (LTCH) prospective payment system (PPS). The final rule is available at www.cms.hhs.gov/LongTermCareHospitalPPS/downloads/cms-1529-f.pdf and is scheduled to be published in the May 11 *Federal Register*. Based on our preliminary read, here are some of the rule's key provisions:

- The final rule expands the "25 Percent Rule" to all LTCHs, including free-standing, satellite and grandfathered hospital-within-hospitals. Unlike the proposed rule, CMS will implement the 25 Percent Rule using a three-year transition. Currently, the 25 Percent Rule applies a payment reduction to referrals from a host hospital to co-located LTCHs that exceed a specific threshold (25 percent of admissions upon full transition for most affected LTCHS). While the transition minimizes the impact in RY 2008, the 25 Percent Rule is expected to cut LTCH payments by \$460 million over the next three years.
- As proposed, the short-stay outlier policy was expanded by adding a new payment alternative. Patients with a length of stay less than or equal to the comparable length of stay for general acute hospitals, plus one standard deviation, would be paid the inpatient rate. This new policy is estimated to cut 2008 payments by 0.9 percent.
- The final rule increases the RY 2008 LTCH standard payment by 0.71 percent to \$38,356.45. The update includes a market basket increase of 3.2 percent and a coding reduction of 2.49 percent.
- The final rule continues the implementation of the five-year phase-in of the wage index adjustment, which will reduce payments by 1 percent.
- The high-cost outlier threshold for RY 2008 is \$22,954, a 54 percent increase over 2007. The new threshold is well above the proposed fixed-loss amount of \$18,774 and the 2007 threshold of \$14,887. CMS believes that such an increase is necessary to keep 2008 outlier payments at 8 percent of total LTCH payments.
- As proposed, the LTCH diagnosis-related groups will be re-weighted in a budget-neutral manner to align the LTCH PPS with other Medicare payment systems.
- The net impact of the rule is negative 3.8 percent, a reduction of more than \$153 million over 2007 Medicare LTCH payments.

We are disappointed that CMS moved forward with blunt cuts to LTCHs by expanding the 25 Percent Rule to all LTCHs, further reducing payments for short-stay outlier cases, and making excessive reductions for coding change. We will continue to encourage Congress to draft legislation mandating a specific timeline for creating and implementing a common, standardized patient assessment tool, appropriate medical necessity standards and facility criteria. With good patient and facility criteria, the 25 Percent Rule should be eliminated for all LTCHs.



Stories From Our Hospitals

St. Clare Hospital, Baraboo

Making a difference in one life

As I read the October-December 2006 "Mission Possible" booklet, I thought it might be helpful if I shared what the St. Clare mission has meant to me so that those who work for St. Clare can see it from the receiver's viewpoint.

I know firsthand about the St. Clare mission because I received Community Care for the first time in my life during this past year. As a person who has paid for health insurance for 37 years, I found myself without health insurance six months after losing my job in 2004. A dull throbbing in my right side caused me to seek medical assistance at a regional clinic last February. A \$400 bill for blood work was paid out of pocket. I was told I needed a cat-scan and a colonoscopy before treatment could begin. The estimated cost was \$6,000. I had been able to pay some of the smaller bills but that bill represented close to a third of my income. In spite of being a substitute teacher, working outdoors scraping and painting windows for \$5 per hour, and teaching stress reduction classes, my income remains at the poverty level.

So when I learned I could apply to St. Clare Hospital for assistance, I did. I was made to feel okay about it. I was told that I had paid for health insurance for 37, and Patient Assistance was a program intended to help people like me. I was grateful to the people that were so kind and sensitive with me every step of the way through the application process. Adrian, as supervisor, always talked to me with much compassion and kindness.

In a society where I feel invisible, St. Clare Hospital was there when I needed medical help. It represents everything that I believe to be true concerning service for others.

I tell everyone how grateful and thankful I am for St. Clare Hospital and want St. Clare employees to know that you HAVE made a difference in my life! May each person that works there be blessed!

- Carol Bezin

Submit hospital community benefit stories to Mary Kay Grasmick, editor, mgrasmick@wha.org or call 608-274-1820.

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WHA Steve Brenton said, "Attorney General Van Hollen sets a refreshing tone that stresses partnership and collaboration as a high priority in achieving positive outcomes and seeks collaboration over confrontation when it comes to achieving core public policy objectives. Our hospitals are eager to be accountable on an issue that has received national attention. And we're eager to work together in the future."

In a news release issued by WHA May 1, Attorney General J.B. Van Hollen applauded the Association's billing and collection guidelines for providing clear guidance to hospitals in this highly sensitive, and often misunderstood, aspect of the American health care system. Van Hollen stated, "Wisconsin hospitals have stepped up to the plate to address concerns about certain billing practices for the poor and uninsured and moved forward with a set of patient-centered guidelines. My office worked with the hospital association and reviewed the new guidelines to ensure transparent billing practices for the uninsured and charity care. The uninsured are entitled to know what services will likely cost, before they incur charges. I am satisfied that the new guidelines provide a thoughtful approach to bill and to collect payments from those that are uninsured, and I applaud the hospital association's efforts," he added.

Wisconsin hospitals are being asked to confirm in writing that their policies and practices on charges, charity care, billing and debt collection meet or exceed the principles set down in the WHA Billing and Collection guidelines. The "Confirmation of Commitment" assures patients that hospitals' billing practices reflect respect and compassion for all patients while also communicating the need to obtain fair payment for services from patients who are able to pay. The WHA intends to publish a list of hospitals that have signed and returned a confirmation in the Association's newsletter, *The Valued Voice*.