☞ **05hr_SSC-HCR_Misc_pt06**

☞ Details: Informational hearing to discuss GAO report 05-856 and health care cost, quality and access in Southeastern Wisconsin. Hearing held in Milwaukee, Wisconsin on April 11, 2006.

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2005-06
(session year)

Senate
(Assembly, Senate or Joint)

Select Committee on Health Care Reform...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (August 2012)

WHA
WISCONSIN HOSPITAL ASSOCIATION

APR 17 2006

The Valued Voice

April 14, 2006

Volume 50, Issue 15

Senate Hearing Takes Testimony on Health Reform Issues

"Government's role in health care reform should begin with paying the cost of its own program," WHA president Steve Brenton said in testimony on April 11 before members of the Senate Select Committee on Health Care Reform, meeting in Milwaukee.

Brenton's testimony came at a public hearing designed to gather information and ideas designed to improve access and lower health care cost inflation. Invited speakers were specifically asked to comment on the 2005 General Accounting Office (GAO) study and health care cost and access issues "in the Milwaukee area." Senator Alberta Darling (R-River Hills), the Committee's co-chair, requested that speakers provide "input that will identify the factors behind the rising costs of care and coverage and recommendations for policy changes at the state level that will lower the cost of coverage and improve the quality of care."

Brenton told Committee members that the GAO study has unfortunately been "widely discussed without actually being widely read." He noted that the report's focus on physician and hospital prices, as opposed to actual health care costs, has created "a hugely misleading snapshot of overall Wisconsin health care spending." Brenton noted that the GAO report concludes that when the focus is on actual spending, "no Wisconsin metropolitan area is found among the top 20 highest spending regions in the nation." Brenton also cited Medicare data that demonstrates, "that compared to most of the nation, Wisconsin is a veritable bargain when it comes to Medicare spending per average beneficiary."

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Hospitals Generate Workforce Solutions

WHA Report: Hospitals' Doing Their Part to Stem Workforce Shortage

In its most recent report on the status of the health care workforce, WHA surveyed its member hospitals to determine what contributions they are making in their communities to create and maintain their own health care workforces. A copy of the report is in this week's packet and is available at www.wha.org.

See page 4 to read a copy of the news release which was issued to the statewide press on April 10, 2006.

Hospital CEO Dan Hymans Testifies Against Taxpayer Protection Amendment

An Assembly Committee Narrowly Approves Measure 7-6

On April 12 the Assembly Ways & Means Committee narrowly approved a Taxpayer Protection Amendment (TPA), Assembly Joint Resolution (AJR) 77 by a 7-6 vote. Republican Steve Nass voted with all Democrats on the Committee against the proposal.

TPA amends the Wisconsin Constitution by putting in place strict limitations on the growth of governmental expenditures by capping the revenue that government can take in. Unlike legislation that must be signed or vetoed by the Governor, a constitutional amendment must pass both houses of the Legislature twice before it is then put to the voters for their final approval and the Constitution is amended.

WHA urges you to contact your state representative and senator in the next two weeks and urge them to vote "no" on the Taxpayer Protection Amendment because of the harmful impact it will have on the Medical Assistance budget and health care in Wisconsin.

Email your legislators by logging on to www.wha.org/speakUp/emailLegislator.aspx

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Continued from page 1 . . . Senate Hearing Takes Testimony on Health Reform Issues

The WHA testimony also examined unique and problematic characteristics of the health care environment in southeastern Wisconsin. "There should be no debate over the fact that access to primary health care services in the greater Milwaukee area is in a state of profound crisis," Brenton told the Committee. "The time has come to shine a bright spotlight on the specifics of this crisis and the fact that identification of solutions must be a statewide public policy priority that requires engagement by the Doyle Administration and by the Wisconsin Legislature." The testimony noted that just a handful of Milwaukee hospitals and Racine's sole hospital system absorb 40 percent of annual statewide hospital Medicaid losses amounting to $200 million. "Fixing this crisis will require targeted new state funding that focuses on at least two initiatives—expansion of additional primary care infrastructure—and—enhanced Medicaid DSH funding for hospitals that have become *de facto* safety net providers of primary care services."

The WHA statement also suggested that lawmakers embrace health care transparency as the cornerstone of health reform efforts. "There is agreement by virtually all stakeholders in the health, delivery and financing environment that measuring and reporting performance will lead to greater efficiencies and improvements in patient outcomes," WHA's statement suggested. The written testimony encouraged lawmakers to allow current and future transparency initiatives to "blossom and evolve."

Brenton also encouraged legislators to closely examine Governor Doyle's BadgerCare Plus initiative and the Healthy Wisconsin program initiative as "two promising proposals that can advance access and affordability of health care services for 'at risk' populations." Brenton also said that Wisconsin must recognize income tax deductibility of Health Savings Account (HSA) contributions. "HSAs are not the entire solution to access and coverage issues, but they represent a real opportunity, especially for individuals and small groups," Brenton observed.

The Senate Committee heard from representatives of the Wisconsin Medical Society and the Milwaukee area business community. Much of that testimony also focused on the need to advance quality, safety and pricing transparency as priority health reform initiatives.

The Senate Select Committee on Health Care Reform will hold additional public hearings this spring and early summer. Public hearings are likely to be scheduled for Madison, west central Wisconsin and a Fox Valley venue.

Hill - Rom Settlement Information Available

Recently, many hospitals received a **Notice of Proposed Settlement of Class Action, Certification of Settlement Class and Hearing Regarding Settlement** that was sent to entities that purchased or rented Hill-Rom products from January 1, 1990 through February 2, 2006, as identified by Hill-Rom. A list of the Hill-Rom products involved is included in the notice. If you received the notice, then you have been identified as a class member and no further action is required at this time to preserve your rights.

Class members have a right to be excluded from the Settlement (and may then present a claim against Hill-Rom by filing their own lawsuit). If you choose to be excluded from the Settlement, you must mail a written request to Spartanburg Settlement Attn: Exclusion Department, PO Box 9000#6394, Merrick, NY 11566-9000. The request must be sent via first class mail and be **postmarked no later than April 17, 2006**. Additional information concerning this matter is available on the WHA web site.

President's Column

April 14, 2006
[My column this week reflects specific excerpts from WHA's prepared written testimony for the Senate Select Committee on Health Care Reform's Milwaukee meeting.]

GAO Report

- √ "This report has been widely discussed without actually being widely read by many pundits. The report's focus on physician and hospital *prices*, as opposed to actual health care *costs*, has created a hugely **misleading** snapshot of overall Wisconsin health care spending."
- √ "Unless one factors in the volume of services consumed, there is an incomplete picture of dollars being spent on total health care services. Another way to look at it is, five widgets purchased at $5 ($25) are less expensive than seven widgets purchased at $4 ($28), even though the price of the individual widget may be less. Indeed, the GAO itself states that only about one-third of total cost differences are the result of unit prices."

Medicaid Cost-Shifting—The "Hidden Tax"

- √ "From 1997 to 2005...just eight short years...Wisconsin Medicaid hospital reimbursement dropped dramatically from 82 percent of costs to 49 percent. **Government's role in health care reform should begin with paying the cost of its own program."**
- √ "The Medicaid cost-shifting issue is particularly severe in the greater Milwaukee community where a handful of hospitals care for close to 40 percent of the state's total Medicaid population. While the average Wisconsin hospital has about 10 percent of its patient base paid for by Medicaid, the Milwaukee average approaches 30 percent, and for two hospitals exceeds 40 percent!"
- √ "The ability of a handful of disproportionally burdened hospitals to manage the uncompensated care burden is not sustainable."

Health Care Transparency

- √ "The Wisconsin Hospital Association's CheckPoint and PricePoint initiatives, and the Wisconsin Collaborative for Health Care Quality's health care performance reporting initiative are so well respected nationally that they are being discussed and replicated by organizations throughout the country."

- √ **"We (WHA) firmly believe that transparency is the cornerstone of health care reform** and a key ingredient in achieving a moderation in health care cost inflation."

Steve Brenton
President

Leadership Satisfaction Survey Response Deadline Extended to April 24

Thank you to all who have completed the WHA leadership satisfaction survey. We have 50 percent response to date, but it's important to hear from as many leaders as possible in order to get a true picture of member needs. **Remember – this is your opportunity to rate WHA's value and effectiveness.**

If you have not yet completed the survey, using the following URL address, you can complete the survey on-line: http://www.satisfactionworks.com/WHA_Leadership_2006.htm

Otherwise, to get another copy of the written survey, contact Jennifer Frank at 608-274-1820 or *jfrank@wha.org*. The response deadline has been extended from April 17 to April 24 in order to accept some additional completed surveys.

Hospitals Generate Workforce Solutions

WHA Report: Hospitals' Doing Their Part to Stem Workforce Shortage

(The following news release was issued to the statewide press on 4-10-06.)

MADISON -- Advances in technology, population demographics and a rising demand for health care from an aging Wisconsin population are combining to create a future in which Wisconsin may not have enough health care workers to care for Wisconsin residents.

It is a problem that hospitals can't wait for others to solve. That's why Wisconsin hospitals are using their own resources to ensure that students are recruited, supported and provided sufficient facilities to receive the education they need to join the health care workforce.

In its most recent report on the status of the health care workforce, the Wisconsin Hospital Association (WHA) surveyed its member hospitals to determine what contributions they are making in their communities to create and maintain their own health care workforces. The report, "Building a Health Care Workforce for Wisconsin's Future: *Hospitals' Contributions*" is available at www.wha.org.

Hospitals Promote Health Careers

While some health occupation classes now have more students than they can accommodate for some careers, that has not always been the case. Interest in health careers fell in the 1990s, leading to lower enrollments in health care programs. As a result, technical schools and university campuses reduced or eliminated some health care training courses.

This trend alarmed health care providers in Wisconsin. In 2001, WHA launched a statewide media campaign to attract more students to health occupations. It was successful in creating renewed interest in health careers.

"Students have so many choices when they consider what career to choose; it is critically important that hospitals emphasize the fact that they offer family-sustaining jobs in a stable industry, along with a career ladder that doesn't always exist in other industries," said WHA President Steve Brenton.

Hospitals promote health careers at all grade levels by:

- Sponsoring health career camps.
- Building career awareness through classroom presentations.
- Meeting with high school guidance counselors to build awareness.
- Creating job-shadowing opportunities in the workplace.

Hospitals Create Learning Environment

Hospitals help students receive the training they need to enter the health care workforce by bringing them into the clinical setting. Many hospitals provide both clinical and laboratory space for students in training. A shortage of faculty or faculty positions often limits schools' ability to add capacity. So, hospitals pay their own qualified staff to serve as classroom instructors. By doing this, hospitals help educational facilities expand their capacity, which in turn, helps eliminate long waiting lists for key occupations, such as nursing and radiological technologists.

Hospitals Support Employee Advancement

Training is an ongoing process at hospitals as they adopt new technology and apply advances in medical treatment in caring for their patients. In addition to continuing education for their own employees, hospitals "build their own workforce" within the community by offering scholarships, tuition reimbursement and loan forgiveness to prospective and new employees.

"Many hospitals have a great 'grow your own' approach to workforce. Through reimbursement policies, they encourage employees to attain the next degree or credential which increases the depth and skill of the existing workforce, and often opens up an entry level position for a new employee. Everyone wins," Brenton said.

Hospitals are doing their part to address the forthcoming workforce shortages. It will take collaboration, cooperation and participation from educational, professional, policymaking and many other groups to meet the challenge of building tomorrow's workforce today.

Pride Program Recognizes Health Care Employees

The Employee Pride Program will recognize health care employees at a special reception, dinner and ceremony on May 4 at the Blue Harbor in Sheboygan. Here is the list of hospitals that have sent WHA the name of the employee who will be honored that evening. If your hospital is NOT listed and your information WAS submitted, or if your hospital HAS NOT submitted this information to WHA but plans to participate, contact Mary Kay Grasmick at 608-274-1820 or *mgrasmick@wha.org*. The deadline for submitting the employee's name to WHA was April 7, so ACT NOW if you plan to participate in this very special event.

Agnesian HealthCare	Fond du Lac	Kathleen Gardipee
All Saints Healthcare	Racine	Jan Leischow
Amery Regional Medical Center	Amery	Samantha MacDonald
Aspirus Wausau Hospital	Wausau	Lynn Yaeger
Aurora Medical Center of Manitowoc Co.	Two Rivers	LeeRae Coenen
Aurora Sinai Medical Center	Milwaukee	Tricia Jene
Aurora St. Luke's Medical Center	Milwaukee	Leslie Biernat
Beloit Memorial Hospital	Beloit	Amy Brandenburg
Black River Memorial Hospital	Black River Falls	Lois "Chipper" Wyss
Boscobel Area Health Care	Boscobel	Dawn Stephenson
Burnett Medical Center	Grantsburg	Brenda Rachner
Columbia St. Mary's Hospital	Milwaukee	Eric Goin
Community Memorial Hospital	Menomonee Falls	Dale Scherbert
Community Memorial Hospital	Oconto Falls	Tina Melnarik
Divine Savior Healthcare	Portage	Lorelei Karcz Vincent
Eagle River Memorial Hospital	Eagle River	Alicia Rouse
Elmbrook Memorial Hospital	Brookfield	Julie Scheibe
Flambeau Hospital	Park Falls	William Westphal
Fort HealthCare	Fort Atkinson	Shirley Brown
Good Samaritan Health Center	Merrill	Angela Acker
Gundersen Lutheran Health System	La Crosse	Cindy Vieth
Howard Young Medical Center	Woodruff	Roddi Franck
Lakeview Medical Center	Rice Lake	Susan Schaefer
Langlade Memorial Hospital	Antigo	Carol Philips
Memorial Health Center	Medford	Sharon Vesnefsky
Memorial Hospital of Lafayette County	Darlington	Cindy Humphrey
Memorial Medical Center	Ashland	Laurie Carlson
Memorial Medical Center	Neillsville	Marie Heck
Moundview Memorial Hospital & Clinics	Friendship	Linda Charles
Oconomowoc Memorial Hospital	Oconomowoc	Jennifer Andler
Orthopaedic Hospital of Wisconsin	Glendale	Amy Mueller
Our Lady of Victory Hospital	Stanley	Becky Herman
Reedsburg Area Medical Center	Reedsburg	LaReta Dischler
Sacred Heart Hospital	Eau Claire	David Mortimer
Sacred Heart-St. Mary's Hospitals	Rhinelander	Pamela Lohmeier
Saint Clare's Hospital	Weston	Sarajane Moucha
Saint Joseph's Hospital	Marshfield	Nancy Joch
Saint Michael's Hospital	Stevens Point	Randal Wojciehoski, DPM
Sauk Prairie Memorial Hospital	Prairie du Sac	Beth Ann Zick
Shawano Medical Center	Shawano	Lynn Spiegel
St. Clare Hospital & Health Services	Baraboo	Keri Jo Schmidtke
St. Joseph Regional Medical Center	Milwaukee	Jamie Phillips
St. Joseph's Community Health Services	Hillsboro	Marita Shaker, RN
St. Joseph's Hospital	Chippewa Falls	Nancy Fastner
St. Luke's South Shore	Cudahy	Doreen Parker
St. Marys Care Center	Madison	Cece Olson, LPN
St. Marys Hospital Medical Center	Madison	Janet Bergum
St. Mary's Hospital Medical Center	Green Bay	Marge Vande Hei
St. Michael Hospital	Milwaukee	Erin Schulte
St. Nicholas Hospital	Sheboygan	Cori Salchert
St. Vincent Hospital	Green Bay	Mary Pliner
Stoughton Hospital Association	Stoughton	Sarah Corbett, CNA
The Monroe Clinic	Monroe	Catherine Seffrood
Tri-County Memorial Hospital	Whitehall	Paulett Fox Beardsley
Waukesha Memorial Hospital	Waukesha	Ellen Marie Anders
University of Wisconsin Hospital & Clinics	Madison	Carrie Sparks
Upland Hills Health	Dodgeville	Toni Rochon
Vernon Memorial Healthcare	Viroqua	Janet Stalsberg

Continued from page 1 . . . Hospital CEO Testifies Against Taxpayer Protection Amendment

The current TPA proposal (AJR 77) is likely to be voted on in the State Assembly during the week of April 24. If passed, it would then go to the Senate later on that same week or the following week.

Due to the importance of the issue, two legislators – Senator Bob Jauch (D-Poplar) and Rep. Gary Sherman (D-Port Wing) – recently held a hearing in Ashland to hear from their constituents regarding the proposed TPA. Dan Hymans of Ashland's Memorial Medical Center testified at the hearing against the TPA.

"I am here to express strong opposition to this proposed amendment to the Wisconsin constitution," Hymans began. "While I can understand some of the rationale for such an amendment, now is not the time for such a radical alteration to our constitution."

Hymans joins with the Wisconsin Hospital Association and others in the health care industry, such as the Wisconsin Association of Health Plans, Wisconsin Medical Society, Wisconsin Health Care Association, in expressing serious concerns about the negative impact a TPA will have on the delivery of health care in Wisconsin. Hymans provided testimony at the hearing on how Wisconsin hospitals have been a partner with the state on the delivery of that health care to residents.

"In an effort to help the state meet its annual budget-balancing needs...[and] realizing we are partners in the process to ensure all Wisconsin residents have at least a minimum in health care coverage, we have agreed through the Medicaid program, the HIRSP program and any number of other health care programs to accept payment rates that do not cover the costs we incur to care for those patients."

This underfunding is commonly referred to as the "hidden health care tax." In 2005, it is estimated this hidden tax from Medicaid underpayments to hospitals alone resulted in $546 million being added to private sector health insurance costs.

Approval of a TPA would greatly exacerbate the hidden health care tax and lock in some of the worst Medicaid reimbursement rates in the country. If approved, a TPA would create an environment where payment rates will likely continue to spiral downward at an even more drastic rate, eroding access to high quality care.

> *"...experience in the only other state that has ever enacted such an amendment [Colorado] would suggest reimbursement rates would at best be forever frozen at their current levels or, even worse, would most likely spiral down at a dizzying rate."*
>
> **Dan Hymans, CEO**
> **Memorial Medical Center**
> **Ashland**

"...experience in the only other state that has ever enacted such an amendment [Colorado] would suggest reimbursement rates would at best be forever frozen at their current levels or, even worse, would most likely spiral down at a dizzying rate," said Hymans. "Such a scenario would eventually force virtually every health care provider to consider whether they would need to follow the example of the dentists and arbitrarily limit the number of state supported patients we will see in a given year. Such a constraint would cause substantial deterioration in the quality of life we have all come to enjoy in this great state."

In closing, Hymans thanked the legislators for providing him the opportunity to present his concerns and for them to carry back his message to the full Legislature.

"Control and leadership at the local level has been a primary driver in making our local communities successful for many, many years. Now is not the time to imperil that legacy of success. I strongly encourage each of you to vote against any and all efforts to introduce this amendment to the Wisconsin constitution," he closed.

For questions, contact Jodi Bloch at *jbloch@wha.org* or Jenny Boese at *jboese@wha.org*.

Safe Place for Newborns Succeeds: Local Outreach Key to Saving Unwanted Babies

As Wisconsin's "safe haven" infant abandonment law turned five in April, Safe Place for Newborns celebrates the many lives saved. Terry Walsh, executive director of Safe Place for Newborns of Wisconsin asks hospitals to remind all their employees of the law and the procedures to follow if someone hands over a baby.

This law, commonly known as the "safe haven law" or Wisconsin Act 2, went into effect in April 2001. It says, a parent may confidentially hand over her unwanted, unharmed newborn, up to three days old, to any hospital employee, EMT, or police professional in the state without fear of prosecution.

Under Wisconsin's law, a parent can go to any hospital employee, tell them she wants to leave the baby with Safe Place for Newborns and she won't have to fear that police will be called, Walsh explained. The newborn will be given any needed medical attention then placed in foster care for adoption.

"More than 30 babies are alive today because Wisconsin recognized that we needed a safe place for newborns," said Terry Walsh, executive director of Safe Place for Newborns of Wis., Inc. "Just as important, there are many mothers who won't face years in prison because they safely relinquished their unwanted newborns to a hospital employee."

"We can't stop letting people know this law exists," Walsh said. "Today's youth were barely teens when the law passed. They need the information now."

For more information, contact Terry Spevacek Walsh at Safe Place for Newborns, 608-225-5544.

Manning Elected Wisconsin Medical Society President

Bradley Manning, MD, of Monona, was elected the 153rd president of the Wisconsin Medical Society during the Society's Annual Meeting at Madison's Monona Terrace on April 7.

Manning said his presidency will provide him with an opportunity to reinvigorate the medical community's dedication to improving the quality of care provided. "I am here to help us look at what we do every day and help us to find more effective ways to approach patient care," Manning added.

Manning noted that hospitals have taken a leadership role in collecting and reporting data to providers and the public through their CheckPoint and PricePoint Web sites. He currently serves on the Wisconsin Quality Steering Committee, the group that oversees the development of CheckPoint, and on WHA's Medical and Professional Affairs Council. Manning has also facilitated the Society's continued involvement in a number of key quality and safety improvement initiatives with WHA, including the Medication Reconciliation Statewide Improvement Team and Safe Care Wisconsin.

"Brad is a good friend of WHA and has been an active leader in the development and implementation of our quality and safety reporting agenda," said WHA President Steve Brenton.

Manning, a Madison plastic and reconstruction surgeon, will focus on health care quality issues during his presidential year because he says there's potential for significant improvement. He is especially optimistic in light of the advent of electronic medical records.

"By studying patient data across providers and over time, we, as physicians, could begin to see the foundation for a more complete, accurate and timely picture of our patients' care," said Manning in his inaugural speech. "We could see more of our patients' state of health and better organize a more timely and comprehensive plan for treating them. We could compare the treatment of multiple patients by multiple physicians. The electronic record offered us a way to put the patient pieces together," he added.

Wisconsin Hospitals:
Connecting With Our Communities

Stories From Our Hospitals

Gundersen Lutheran, La Crosse

Free Screening Saved My Life

I read an article in the paper about a free screening for abdominal aortic aneurysms with the attention-grabbing headline, "Aneurysm screening can save lives." It also caught my attention because my father had an abdominal aortic aneurysm in his 80s.

I was surprised to learn that as a man over the age of 60, with my family history and the fact that I've been a smoker for 50 years, I was five to six times more likely to develop an aneurysm. That was enough to convince me to call for an appointment.

As I left the house to go to the screening, I jokingly said to my wife, Barbara, "I'll call you from the ER." While I had no symptoms to suggest I had a problem, I still had a nagging suspicion they might find an aneurysm...after all, I had all these risk factors.

I first suspected something might be wrong when the young man doing the screening called over a more experienced person to verify the results. They were concerned enough at what they found to suggest I go straight to the emergency room. They were very convincing. I called my wife and told her I'd meet her at Gundersen Lutheran...this time it wasn't a joke.

Tests confirmed I had an enlargement in my abdominal aorta, the main artery that runs from the heart to the lower abdomen. The aneurysm was about the size of a lemon. Tests also showed I had a tear of the inner lining which is the first stage before an aneurysm bursts. Once an aneurysm ruptures, it usually means death.

Soon after the diagnosis, I had surgery to repair the aneurysm. Although it was my first time in the hospital, I wasn't scared. As a retired dentist I've learned to remain calm. I also knew I was in great hands. The surgery went very well and I got out of the hospital nine days later...just in time to celebrate my 45th wedding anniversary.

I credit Gundersen Lutheran and the screening for saving my life. And to celebrate my new lease on life, I quit smoking after 50 years! I feel good that I did the screening. I certainly was fortunate.

Not Our Typical Run

We got the call from Dispatch around 4:30 p.m. on a Saturday in October. A small 3-year-old child was missing in a rural area. He had been missing about an hour. It would be dark soon making search efforts nearly impossible and temperatures were dropping.

I am a flight nurse for MedLink AIR, Gundersen Lutheran's helicopter ambulance service. We receive calls a couple of times a month to help with an air search. We're asked to assist with river searches for missing fisherman, and searches for missing hunters and farmers, too. But when a child is involved, we feel a particular sense of urgency.

Within minutes, our pilot, Marc Wuensch, had us in the air on our way to where the boy was seen last. While en route, Scott Larson, the flight paramedic, talked to search crews on the ground to get a description of the boy and what he was wearing.

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Once the helicopter reached the search area, Marc began a standard search pattern. In particular, we were asked to fly over cornfields where it was difficult for teams on the ground to search. About 10 minutes into our search, we spotted the small boy on the edge of a wooded area about a mile from his home.

MedLink AIR typically helps with only the search, leaving rescue efforts to the specially trained and equipped teams on the ground. In this case, the boy was scared and started to run. So the decision was made: Marc landed the MedLink AIR helicopter in a cleared field nearby, and we recovered the child. We flew him home and reunited the boy with his very happy and relieved family.

It was a very positive experience for us all. We deal with a lot of tragedy in our work so we especially enjoy the happy endings. Assisting law enforcement and EMS agencies with search efforts is a very positive thing we do for our community and we're glad to be a part of it.

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

WHA

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Voluntary Benefits Getting More Attention

(From Solutions Spotlight, included in this week's packet.)

Voluntary benefits, also called worksite benefits, have been around for decades. However, they are increasingly being added to employers' menu of employee benefits.

The most popular benefits are still voluntary life and disability. The fastest-growing category of voluntary benefits consists of specialized medical coverage. Some types of coverage in that category are being expanded. For example, critical-illness insurance that once covered only cancer has been broadened in many instances to include heart attacks, major organ transplants, and other specific medical conditions or procedures. Typically, a lump-sum benefit of $10,000 or $50,000 is paid after a covered event occurs, and the money can be spent on medical or non-medical needs.

The Society for Human Resources Management's *2005 Benefits Survey Report* shows that 47 percent of employers offer supplemental health insurance, up from 42 percent in 2005, and 30 percent offer hospital-indemnity insurance, up from 26 percent. Critical illness insurance has risen every year since 2001, when it was offered by 26 percent of employers; in 2005 it was offered by 38 percent of companies surveyed.

Voluntary benefits not only can round out an organization's total benefits package and offer employees discounted coverage for their specific needs, but can also aid in recruitment and retention.
The first step in setting up a voluntary benefits program is deciding which products to include. Some employers offer a broad menu, while others narrow the choices to those they believe best suit their workers' needs and preferences. Consider having WHA Financial Solutions conduct an employee survey or prepare a benchmark report to help identify which products may make the most sense.

Contact Jon Braddock at *jbraddock@wha.org* or Michelle White at *mwhite@wha.org* for information about WHA Financial Solutions' comprehensive worksite benefits program.

CMS Releases 2007 Inpatient PPS Proposed Rule

The Centers for Medicare & Medicaid Services (CMS) released its hospital inpatient prospective payment system (PPS) proposed rule for fiscal year (FY) 2007. Based on our preliminary read, here are some of the rule's key provisions:

- Diagnosis-related Group (DRG) Changes: CMS proposes major changes in the calculation of DRG relative weights by using hospital-specific relative values and a modified version of costs instead of charges. CMS also discusses refinements to the DRGs to account for patient acuity, with implementation likely in FY 2008. WHA will analyze the data to determine the impact of the proposed changes on full-service community hospitals.

- Payment Update: The rule proposes a market basket update of 3.4 percent for those hospitals that submit data on the previously required 10 quality measures and pledge to report on 21 anticipated measures starting calendar year 2006. Per the Deficit Reduction Act of 2006, hospitals that do not report these measures will receive an update of market basket minus 2.0 percent, or 1.4 percent.

- Outliers: The rule would raise the outlier threshold from its current level of approximately $23,600 to $25,530, even though CMS did not spend all of the money set aside for outlier payments in FY 2006.

- Wage Index: The rule incorporates the expiration of Section 508 of the Medicare Modernization Act (MMA) of 2003, which was a one-time geographic reclassification opportunity for hospital that met certain criteria.

- Medicare Dependent Hospitals (MDH): The rule would implement the provision in the MMA that not only reauthorized the MDH program, but also added 2002 as an allowable base year, increased payments from 50 percent to 75 percent of the difference between the PPS payments and the hospital-specific rate, and removed the 12 percent disproportionate share hospital (DSH) cap.

Comments on the proposed rule will be accepted until June 12, 2006. The final rule will be released by August 1, 2006; policies and payment rates become effective October 1, 2006. The rule is available at: http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/itemdetail.asp?filterType=data&filterValue=2006&filterByDID=4&sortByDID=4&sortOrder=ascending&itemID=CMS061764. Look for a more detailed analysis of the proposed rule in the coming weeks.

AHA President Dick Davidson Announces Retirement

Board Taps Richard Umbdenstock As Successor

Dick Davidson, president of the American Hospital Association (AHA) since 1991, will retire from the post, effective January 1, 2007. Davidson, 69, is the second longest-serving president in the association's 108-year history.

The AHA also announced today that the Association's Board of Trustees has chosen Richard J. Umbdenstock, a top executive with Providence Health & Services in Seattle as Davidson's successor. Umbdenstock will be the tenth person to hold the chief executive position. Umbdenstock will join the AHA as chief operating officer and president-elect in June before assuming the presidency next year. Umbdenstock recently served as the AHA's Board chairman, a volunteer post from which he has resigned. The Board has asked AHA's immediate past chair, George Lynn, president and chief executive officer of AtlantiCare in Atlantic City, N.J., to fill the remaining months of Umbdenstock's term.

Davidson led the 4,800-member Association through one of the most tumultuous periods of change in hospitals and health care in America. It was early in his tenure that the nation debated comprehensive

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Continued from page 10 . . . AHA President Dick Davidson Announces Retirement

health reform under President Clinton. At the same time, many hospitals underwent a fundamental change in their structures, evolving into health systems with multiple sites and services, rather than the traditional hospital model. When the concept of "managed care" swept the health care field, causing major changes in health care delivery and payment, the AHA under Davidson's leadership undertook a wide range of policy and legislative initiatives to help its members cope with the rapidly changing environment.

While at the AHA, Davidson helped establish the Institute for Diversity in Health Management and spearheaded the Hospital Quality Alliance – a public/private partnership that created publicly available information on hospital quality measurement nationally for the use of both consumers and internal hospital quality improvement. In 2004 and 2006, the association established two centers devoted to improving hospital and health system governance and quality and patient safety.

A nationally recognized health care leader, Umbdenstock has deep roots with the AHA. Early in his career, Umbdenstock served as special assistant to then-AHA President Alex McMahon. While on staff at the AHA, he created the Association's outreach programs for hospital governing boards. He has remained active in the association serving on the Circle of Life Award Committee and joining the AHA Board in 2000. During his Board service, he was chairman of the operations committee and was on the Board's executive committee. He became Chairman of the AHA Board of Trustees on January 1.

Member News: Theda Clark Receives Medal of Honor

Tony D'Alessandro, MD, executive director of the UW Organ Procurement Organization, presented senior leaders of Theda Clark Medical Center with the U.S. Health and Human Services Medal of Honor on Tuesday, April 11. Theda Clark was one of 16 hospitals recognized for obtaining at least a 75 percent donation consent rate. Theda Clark's actual donation consent rate was 97 percent, while the national average donation rate for all hospitals is about 50 percent.

"This work is now more important than ever," said Kathryn Correia, senior vice president of ThedaCare™. "We are honored to receive this distinguished award for the second year in a row. Our staff is faced with the job of approaching family members who are experiencing the worst day of their life, and talking to them about the importance of the gift of life. This award recognizes our staff for successfully facing this difficult task with sensitivity and compassion."

Member News: Brenton Featured in Capitol Report Magazine

In the Spring issue of *Capitol Report Wisconsin*, a statewide magazine published by the Trails Media Group, WHA members will recognize the person featured in the "Lobbyist Profile." WHA President Steve Brenton shared his thoughts about the mission of the Association and the priority issues – a medical liability cap and Medicaid.

With Doyle's signature on the medical liability bill, that issue has hopefully been resolved. But Brenton notes in the article that WHA is focused on Medicaid as a long-term issue.

"We are simply leaving money on the table when it comes to Medicaid in Wisconsin," Brenton said. "The federal government provides $1.50 for every $1 we spend."

Both access and health care costs are also on his radar.

"In the long-range health care environment, costs have been the No. 1 issue for the past 25 years and will remain so for the next 25 years," he said. "Any steps we take to move forward to meet those costs are steps in the right direction."


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A Dose of Transparency

State-sponsored Web sites are enabling consumers to compare hospital and physician prices and performance.

By Penelope Lemov

If you suffer from heart disease and live in Florida, you can click on a state Web site and figure out which hospital in your county—or anywhere in the state for that matter—has the best record for cardiac care. FloridaCompareCare.gov will tell you each hospital's survival rates for, say, coronary artery bypass surgery—plus how well the hospital does with surgical infection prevention. And that's not all. The site lets you know how much each hospital charges for the procedure and its accompanying hospital stay—and how that compares to other hospitals in the state.

The idea behind the site, which lists information for a dozen health problems, is, says Alan Levine, who headed Florida's Agency for Health Care Administration when the site was being developed, to "improve care and reduce costs" by giving citizens "the tools to compare outcomes and prices between health care providers and medical services."

It's a consumer-driven world out there. Health care costs and provider performance are becoming the business of patients. That's because patients are increasingly bearing the brunt of a shift in who pays the health care bill. A significant number of employers, for example, are asking employees to pay not only a greater share of the insurance premium but also larger co-payments for doctor visits and various procedures. In addition, consumer-driven health plans, such as Health Savings Accounts, are edging into the mainstream of insurance coverage. HSA plans, for instance, put money in an account that employees use to pay for their day-to-day health care. If they use it all up, they can end up paying a significant portion of their health bills out of their own pockets.

With these new responsibilities, patients need more information about the cost and quality of care. Along with Florida, a handful of states—Maryland, New York and Texas, among them—are or will shortly be feeding that need with state-backed Web sites offering comparative information about hospitals and, in some cases, individual physicians.

But consumer service is only a piece of the picture. There is an even loftier goal: reducing overall costs within the health care system. That is, in the best of all possible worlds, patients would choose the highest quality facility—the hospital with, say, the lowest mortality rates and the best score on infection rates. Over time, the hospitals that perform poorly—those with, say, high infection rates that add unnecessary costs to the system—would be driven out of business. The information on price could push physicians at the high end of the spectrum to voluntarily lower their fees.

In the real world of day-to-day practices and habits, however, questions abound about whether consumers are in a position to benefit from the information available to them. Despite the increasing pressures on them to compare quality and price, the may actually be drowning in data and finding it difficult to make use of the information. That raises the issue of whether state efforts to create Web sites that offer quality and cost comparison shopping are worth the political hassle it takes to get them up and running.

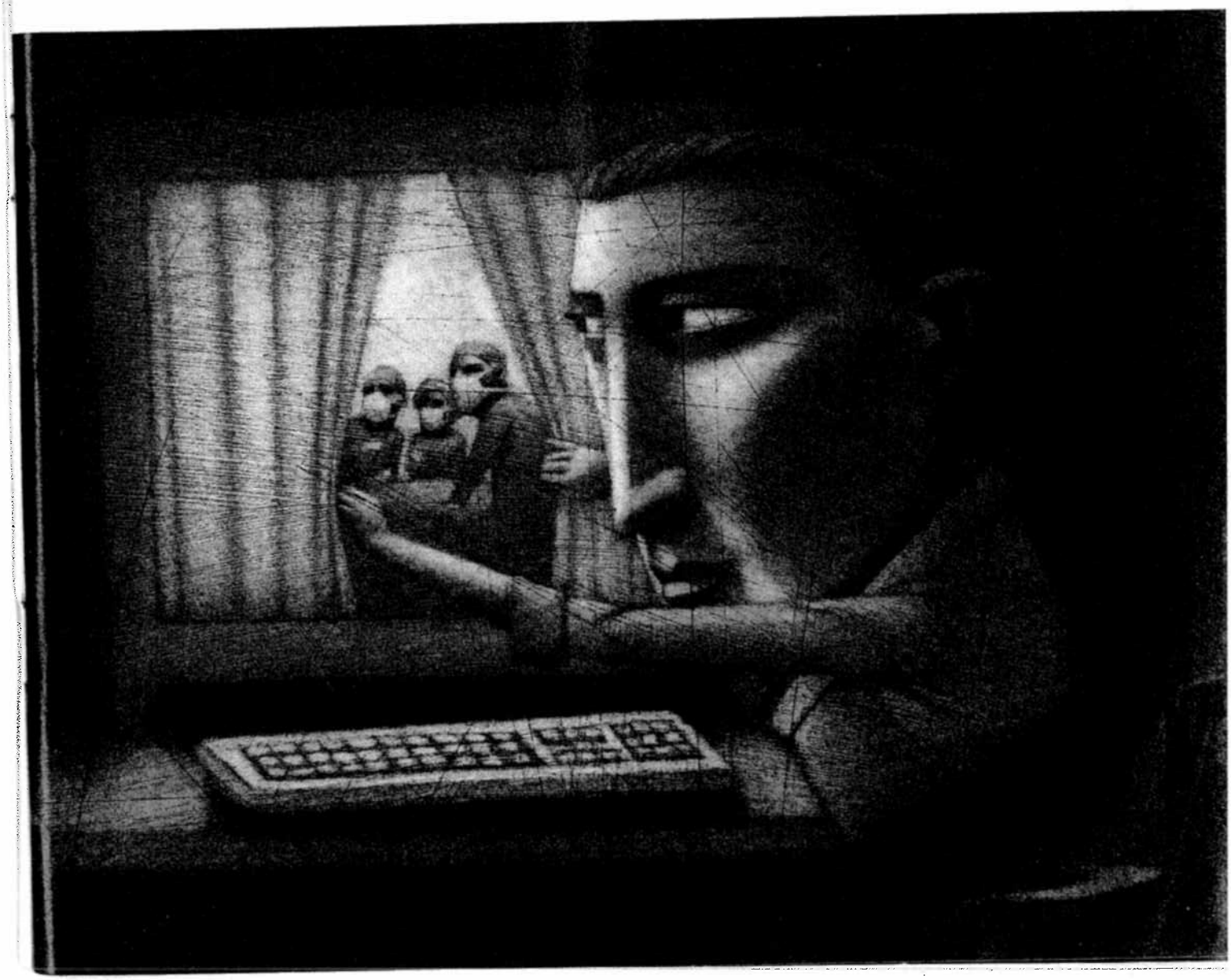
Changing Behavior

It would seem prudent for a patient who is ill—facing, for example, heart surgery or hip replacement—to check out the best

fides of possible service providers. But many factors run counter to that instinct. Patients may, in fact, have little choice. "If you're desperately ill," says Elizabeth Teisberg, co-author with Michael E. Porter, of *Redefining Health Care: Creating Value-Based Competition on Results*, "you are in your doctor's hands and not likely to argue with him about which hospital he's going to send you to for an operation—or to change physicians to use a doctor who operates at a high-rated facility."

The record on consumer reaction to Web site information echoes Teisberg's observation. Take a recent assessment of New York's public report card on deaths from coronary bypass surgery. For 15 years, the state has been keeping tabs on hospitals and doctors who perform the surgery, and researchers have found that heart patients who pick a top-performing hospital or surgeon from that report card are half as likely to die as those who pick a poor-scoring provider. However, according to the recent analysis of patient behavior, patients and their cardiologists are not flocking to the top-rated providers. "Patients can dramatically cut their chances of dying by selecting a top performer," says Ashish Jha, lead author of the study and a professor at Harvard University's School of Public Health. "But there's no real evidence that patients use the information to pick a better hospital, even though it's free and easy to access."

Jha's findings are confirmed by a study of another program. Mathematica Policy Research analyzed Hospital Compare, a federal program that gives patients a means of comparing hospitals in terms of quality measures and thereby choosing the best one for the type of care they need. To provide potential patients and their families with information to make such judgments, Hospital Compare asks the institutions—4,200 acute-care and critical-access hospitals nationwide participate—to submit data on quality measures for treating heart attacks, heart failure and pneumonia, and for preventing surgical infection. Hospitals are asked, for instance, how often they prescribe a beta-blocker drug when heart attack patients are discharged and whether they check to see if pneumonia patients have received an influenza or pneumococcal vaccine. These are accepted as "best practices" or appropriate performance measures for hospitals, and now



that information is available for patients and their families to use.

As in Jha's study, however, Mathematica researchers found that patients aren't benefiting all that much from Hospital Compare. There is, Mathematica senior health researcher Mary Laschober notes, "little empirical evidence that consumers have altered their behavior in response to publicly reported quality measures."

Laschober's next point, however, keys in on what may be the ultimate importance of a Web site that provides comparative data. "Hospitals," she writes, "respond in positive ways to public reporting." Many of the those in the Hospital Compare database immediately began improving their scores from one reporting period to the next. Eight in 10 reported significant improvement on one or more scores while only 5 percent reported a decline in one measure or more.

Similarly, when the state of Maryland began putting a hospital reporting system in place a few years ago, hospitals were given several years to prepare for the public disclosure and even practiced the data review process for six months before the data went online. During the tune-up phase, the hospitals were able to spot their failings, and most of them changed policies to meet the standards.

Teisberg points out that, unlike patients, providers—doctors, hospitals, clinics—are competing and "they don't want to show up in the bottom 25 percent." Teisberg, who is an associate professor at the University of Virginia's Darden Graduate School of Business, adds that "the importance of reporting results is to enable not just patients to get information but physicians to improve."

Pressure from the Feds

While many hospitals do act to improve, plenty of them don't. The Mathematica study asked hospital administrators what they saw as the barriers to boosting their scores. Several fobbed off the low scores by saying their poor showing was simply a failure of physicians and other staff members to document that appropriate care was given. But other hospitals reported that they were unable to get physicians involved in quality-improvement efforts or that they did not have the financial resources to devote to improvement strategies.

It's also true that some hospitals—and many hospital associations—are less than enamored with the whole exercise in transparency, in part because prices for any one procedure are likely to vary widely even within a single hospital, with different tabs for various insurers and others for the unin sured. For years, hospital and insurance as sociations have been successful in lobbying to keep lawmakers from mandating Wel sites that would provide comparative qual ity and pricing data on hospitals. Bu change is in the air. One reason is a cour tervailing pressure from the federal gov ernment. Hospitals that treat Medicare pa tients are rewarded financially for reportin their performance data.

But pressure is being felt in the states, a well. Comparative sites are seen as a way get a handle on quality and price an thereby, force down the cost of health car The new mood was palpable in Ohio th year when the legislature considered a b to have the health department set up a s

so consumers could measure hospital mortality rates on certain procedures and compare various charges, such as private and semi-private rooms and common services available through emergency, operating and delivery rooms. The road to passage was far from easy. "It took about two years to work through and pass," says state Representative Jim Raussen, who sponsored the measure. Legislators had to work closely with health insurance companies and the hospital association to craft a bill everyone could live with.

Price Points

Most state Web sites have a price list of sorts: what hospitals charge for a limited number of services. Unlike Web sites sponsored by health insurance companies, which carry the fees the insurance company has negotiated with the provider (and whose sites are available only to those insured by the company), the state sites are open to everyone and carry a range of charges or average prices. The New York State Health Accountability Foundation, a public-private partnership, maintains a Web site that offers, county by county, the average length of stay in the hospital for 14 different procedures and the average charge. At Albany Medical Center, for instance, surgery for a hip replacement currently means three to four days in the hospital (3.7 is the hospital's average) at an average cost of $21,425, while over at St. Peter's Hospital, hospitalization is closer to four days (3.98 days on average) but the charges are slightly lower at $20,905.

For a patient with a consumer-driven health plan or insurance that requires significant co-pays or deductibles, price is an important factor. But the charges listed are not necessarily what the patient will end up paying. Complications can arise; additional therapies may be needed. And the listed price does not factor in what a particular insurance plan allows or will pay for. "The idea of posting prices poses difficulties," says Robert Doherty, a physician who is also senior vice president of public policy for the American College of Physicians. "There is not a single retail price."

Moreover, Doherty points out, most of the health care dollar is spent in the last few months of life where "people aren't going to pay much attention to price. They just want to get the care they need. So I'm pretty skeptical that posting prices will be a huge boon to lowering health care costs."

Even for those willing to shop for the best price, the information is often difficult to digest. If the prices are presented on a piece-by-piece basis—a site might show that a hospital charges $1,000 for a surgical procedure, $1,200 for the operating room, $500 per day for the hospital bed $30 for two aspirin—they won't be able to make much sense of it. Moreover, prices for every procedure are not available. Usually, a site will list up to 30 of the most common procedures. But that doesn't mean the surgery or therapy the patient faces is on the list.

Gerard Anderson, a professor of health policy at Johns Hopkins University, sees a possible solution to comparison-shopping in having providers list what percentage of the Medicaid charge they pay. A hospital might report that it charges 125 percent or 200 percent more than the Medicaid base. "That would give people one number to compare," he says. "It would be one number that people could understand."

What health economists such as Teisberg note is that the point of the quality and price reports is not necessarily to put consumers in charge but to drive quality and efficiency simultaneously. "In most industries, that's what happens," she says. "But it requires competition at the right levels. And that is not currently the case in the health care industry."

To the extent that public and easily accessible information puts pressure on hospitals to perform up to a gold standard, the Web sites may be worth state efforts. They could be a force for driving down costs—if they bring about pressure for the widespread use of evidence-based medicine and a beefing up of quality and performance measurements. Otherwise, they are nothing more than another trend-of-the-day solution. "It's just this year's model," Anderson says, "unless we get the methodology right, and we're many years away from getting it right."

For additional resources on this topic, go to Governing.com/articles/9hcare.htm

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Theorists compete on health care reform

Posted: July 22, 2006

John Torinus

It is only fitting that two of the country's leading thinkers on competition theory should duke it out over how competition should be used to cure the plague of health cost hyperinflation.

Wisconsin has had a front row seat in that debate with the visits of two Harvard business professors: Michael Porter, the godfather of competition theory, and Regina Herzlinger, who wrote the seminal book on health care reform in 1997.

The real competition between them, though, is in their central arguments. Porter maintained in his 2006 book and his speeches here that the health care industry must restructure itself to provide value-based results.

The chasm between the two thinkers comes over the change process. Porter calls on the industry to transform itself and relies on visionary leaders on the provider side, like John Toussaint of ThedaCare, to drive the reform.

In effect, he says, industry, as dysfunctional as you are, heal thyself.

 Herzlinger trusts the marketplace and the consumer to drive the reform.

She believes that, if each person takes charge as a consumer of health care, the providers will either change to meet their needs or go out of business.

I'm with Herzlinger. Only when a customer - a word that doctors, clinics and hospitals seldom use - threatens to move the business does a vendor truly change its behavior.

Change can be driven by the big companies, which is what the coalition of large businesses in the metro Milwaukee area is trying to do. But reform can be doubly effective if all employees are given incentives by their employers to drive change toward better prices and quality.

Maybe because Herzlinger got there first with her 1997 book "Market Driven Health Care," Porter takes a different tack and is dismissive of how much change consumers can cause.

"Consumerism is a fad. Consumers can't reform health care. The systems must do it themselves," Porter

said in Appleton. Essentially, Porter believes the quest for value should and will come from within the health care industry.

To his point, some systems like ThedaCare have embraced total quality management and lean disciplines. But most systems just have a toe in those waters. It could be years before those internal initiatives bear fruit.

Payers in the private and public sectors don't have that kind of time. We need a fix in the present tense.

Besides, internal reform has long been around as an option. Despite provider initiatives, hyperinflation has persisted for decades. So far, reform hasn't worked. Institutional inertia and dysfunction have trumped change efforts.

What Porter should have picked up in his cameo appearance in Appleton and Milwaukee is that private companies that have endorsed consumer-driven health care in Wisconsin are taming the beast.

The main message from Wisconsin is that reform is about individuals taking responsibility for their health and its costs. It's about behavior change.

When employees are given the right incentives and they take charge, health improves and costs go down. At a minimum, the inflation drops into the low single digits.

Alain Enthoven, a Stanford economics professor and earlier visitor to Wisconsin, had it right when he said, "It's the incentives, stupid."

Humana, another pioneer in consumer-driven reform, was the first to test this concept with its own employees five years ago. Its cost increases have been below 5% a year ever since.

Frank F. Haack & Associates and Associated Health Group, which advise hundreds of companies in Wisconsin on health plans, report that their clients that have gone consumer-driven have all enjoyed cost moderation or reduction.

In Herzlinger's theory, when those consumers take charge en masse, the providers will be forced to offer better value. She believes change will be pushed from without, not from within.

The world owes Porter a great deal because of his contributions to economic thought. His cluster theory has been a building block for Wisconsin's economic strategy, even though his extension of that theory to inner city dynamics, including Milwaukee, has proved a bit of a fizzle.

His call to providers to reform themselves is loaded with solid points, but Herzlinger has the better argument that individual responsibility and consumerism are more powerful drivers of reform.

John Torinus is chief executive officer of Serigraph Inc. of West Bend. Contact him at torcolumn@serigraph.com.

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