

December 12, 2008

IHA Board Meets

The IHA Board met December 11 at IHA offices in Des Moines. Agenda and action items included:

- Approved the 2009 IHA operational and capital budgets, as well as the budgets and year-end reports for ServiShare and the Iowa Hospital Education and Research Foundation.
- Approved the 2009 IHA Board standing committees and membership of IHA's three councils.
- Received a president's report regarding federal legislative activities and outlining 2008 IHA Strategic Plan accomplishments and goals and objectives included in the 2009 IHA Strategic Plan.
- Received a government relations report highlighting activities of the IowaCare Workgroup, results of the November general election and issues surrounding the state budget process, and IHA's comments regarding changes to Iowa's mandatory reporter law.
- Reviewed reports from workgroups addressing hospital physician leadership and physician workforce issues and received on update on the Iowa Rural Health Telecommunications Project.
- Heard a report on the Iowa Medicaid program from Medicaid Director Jennifer Vermeer.
- Heard a presentation on medical homes from Dave Swieskowski, M.D., CEO of Mercy Clinics.
- Approved Associate Member applications from Hirease of Southern Pines, South Carolina, Opus Healthcare Solutions of Austin, Texas, Sullivan Lakier Group/Novia Solutions of Poway, California and TEAM Companies of Cedar Falls.

Study Quantifies Cost Shift from Medicare, Medicaid Underpayment

Low Medicare and Medicaid reimbursements to hospitals and physicians lead to significantly higher health insurance costs for consumers and employers, according to a study released this week by Milliman Inc. The report found that annual health care spending for an average family of four is \$1,788 higher than it would be if Medicare, Medicaid and private employers paid hospitals and physicians similar rates, with total provider reimbursement unchanged.

The Milliman study measured the cost shift as the difference between actual payment rates and average payment rates for Medicare, Medicaid and private payers; total payment to

hospitals and physicians is held constant. The study does not assess appropriate levels of payment, but rather the disparities among current payment rates. The study found that cost shifting:

- Adds an estimated \$1,512, or 10.6 percent, to the average premium for a family of four.
- Of this amount, employers pay approximately \$1,115 and the employee share is \$397.
- Families pay an additional \$276 more in coinsurance and deductibles due to the cost-shift.

In 2006, the hospital cost shift from Medicare was \$34.8 billion and \$16.2 billion for Medicaid. In 2007, the physician cost shift was \$14.1 billion for Medicare and \$23.7 billion for Medicaid. Taken together, the estimated annual cost shift is \$88.8 billion.

Overall, the cost shift represents 15 percent of the current amount spent by commercial payers on hospitals and physicians. Stated differently, if there were no cost shift, hospital and physician costs for privately insured patients would be 15 percent lower.

Also hospitals and physicians in some areas may not be able to offset low public payments with higher commercial payments creating additional financial pressures. In addition to this hidden tax, the privately insured also must bear the costs associated with bad debt and charity care provided to individuals without insurance, which is not separately quantified in this report.

Hospital findings were based on analysis of the 2006 AHA Survey data. The survey includes data on the 4,927 short-term, community hospitals in the U.S. The data represent each hospital's FY 2006 results. The physician findings are based on 2007 fee schedule levels for Medicare, Medicaid and commercial payers.

Wellmark Outpatient Payment Redesign Delayed

During a Wellmark/Hospital Workgroup meeting this week, Wellmark announced that it will be delaying the implementation of the outpatient Enhanced Ambulatory Patient Group (EAPG) payment design until January 1, 2010.

Many Wellmark customers have unique benefit designs that place limitations on the number of services a subscriber can receive. The EAPG payment system will package numerous services into one payment rather than paying by line item. Wellmark will continue to work with the bi-monthly CFO workgroup on remaining issues related to the implementation of the outpatient payment redesign, including establishing peer groups.

The reporting of the Present on Admission (POA) indicator will still be required on July 1, 2009. Payment policies related to the reporting of the POA indicator will be determined at a later date.

Public Hospitals and Open Meetings

(This is one of a series of articles provided by IHA counsel offering guidance on hospital-related legal issues.)

As many public hospital boards are transitioning with newly elected board members and with recently passed legislative changes effective in July of 2008, below are a few reminders regarding public board meetings.

Public hospital boards, like other governmental bodies, are subject to Iowa's sunshine laws. Among the requirements is prior public notice so citizens can see what's on the agenda and attend if they wish. This is a basic open-government principle of Iowa law. Under Chapter 21 of the Iowa Code, a meeting is defined as:

- **Any gathering** in person or by telephone conference call or other electronic means, whether formally noticed or informally occurring;
- **Of a majority of the members;** and
- **At which there is any deliberation or action** upon any matter within the scope of the governmental body's policy-making duties.

Trustees may gather informally if the conversation is not a discussion of business relating to the business of the board. Trustees should be aware of situations when a quorum of the board is present so that hospital business is not discussed without proper notice of a meeting.

Communicating by e-mail: Hospital trustees should be aware that if they are communicating with a majority of the board members on a matter within the scope of the board's duties, this could be considered a meeting. Board members can communicate about necessary administrative matters but should refrain from communicating about any business that would fall under the confines of an open meeting.

Notifying the public: A notice with the time, date and place of the meeting as well as specific actions to be taken and matters to be discussed at the meeting must be provided at least 24 hours in advance of the meeting. The posting should be in a prominent place (i.e. bulletin board in the hospital designated for this purpose) and provided to any media that have requested the notice.

Recording of meetings by the public: Members of the public can record or use a camera at a public meeting, they cannot however, actively participate in the meetings. If members of the public would like to address a public body, they should make that request in advance and they may or may not be added to the agenda. Public bodies have the right to adopt reasonable rules of conduct so that meetings can be conducted in a meaningful and productive manner.

Discussing sensitive issues: As of July 1, 2008, public hospitals may go into closed session for issues involving patient care quality and process improvement initiatives or to discuss marketing, pricing strategies or similar proprietary information. Public hospitals must provide an audio recording of the closed session for public review when the hospital's competitive position would no longer be harmed by its release.

These are just a few issues to be aware of in complying with Iowa's sunshine laws. Specific questions can be directed to IHA's government relations staff. In addition, [the Iowa attorney general's office provides useful information in its Sunshine Advisories online](#).

IHI Rural Grand Rounds Series to Feature Iowa Hospitals

The last session of the Institute for Healthcare Improvement's (IHI) online Rural Grand Rounds Series will be December 18. The series is designed to highlight the learning and best practices of rural hospitals, support the sharing of improvement knowledge and encourage dialogue with and among small and rural hospital performance leaders. Through the magic of Webex, Rural Grand Rounds participants will be able to hear directly from the leaders of these performance improvement projects, follow along with their presentation and ask questions. Kathy Duncan, IHI faculty for the 5 Million Lives Campaign, will be moderating the session.

The December 18 session of the series begins at noon and will highlight the North Iowa Network. Four Critical Access Hospitals that are members of Mercy Medical Center-North Iowa Network will describe network-wide initiatives that have been a part of the network's journey to improve performance and safety. The focus of the 90-minute program will be on team work and readily sharing knowledge and resources as staff members work together to implement improvement projects.

Four directors of nursing will be the presenters for the session: Chris Eckhoff from Franklin General Hospital in Hampton; Laura Zwiefel from Hancock County Memorial Hospital in Britt; Steve Mulford from Ellsworth Municipal Hospital in Iowa Falls; and Dar Elbert from Kossuth Regional Health Center in Algona.

There is no charge and no password is needed to participate in this program. [For more information and to sign in, click here.](#)

Audioconference Offers Strategies on New CMS Payment Initiatives

Strategies health care facilities can use to minimize the risk of nosocomial pressure ulcers and catheter-associated UTIs will be identified in a January 22 audioconference co-sponsored by IHA and the Iowa Chapter of the Healthcare Financial Management Association. The program will also examine new payment rules and guidelines from the Centers for Medicare & Medicaid Services (CMS), including Present on Admission (POA) and "never events."

The target audience for this program, “Pressure Ulcers and Catheter-Associated UTI: Complying with the New CMS Payment Rules and Making Sense of ‘POA,’ ‘Never Events’ and the New CMS Payment Guidelines,” includes C-suite staff, reimbursement and financial service staff, wound and ostomy nurses and nursing home administrators. The program is scheduled for 9-10 a.m. [For more information and to register for this conference, click here.](#)

Iowa’s Public Health Emergency Readiness Has Improved, Report Says

Iowa’s ability to deal with bioterror attacks or other public health emergencies has improved markedly in just the last year, according to a national report released this week. Just last year, the Trust for America’s Health rated Iowa’s preparations among the worst states. However, this week’s report shows that Iowa is better prepared than most other states.

Iowa met eight of 10 indicators analyzed in the report. Those indicators include adequate statewide plans for distributing emergency supplies of vaccines and other medications; liability protection for health care volunteers who serve during an emergency; updated disease surveillance tools; and increased or maintained funding for public health services.

Iowa did not meet the report’s criteria on two measures: it does not have a “medical reserve corps coordinator” to manage volunteers who would supplement existing medical services and it was below the national average in identifying germs that cause food poisoning outbreaks. Nationally, the cause of those outbreaks is identified 44 percent of the time. In Iowa, the rate was 42 percent.

Including Iowa, 22 states had scores of eight or higher. Five states (Louisiana, New Hampshire, North Carolina, Virginia and Wisconsin) met all 10 measures. The bottom six states (Arizona, Connecticut, Florida, Maryland, Montana and Nebraska) met only five of the 10 measures. In the 2007 report, Iowa was joined by five other states at the bottom of the rankings.

Study: Word of Mouth Still Drives Health Care Choices

Most Americans still rely on word-of-mouth and physician recommendations to choose health care providers, according to a national study released this week by the Center for Studying Health System Change (HSC) and funded by the California HealthCare Foundation. In 2007, 11 percent of American adults looked for a new primary care physician, 28 percent needed a new specialist physician and 16 percent underwent a medical procedure at a new facility, according to findings from HSC’s 2007 Health Tracking Household Survey.

When selecting new primary care physicians, half of all consumers relied on word-of-mouth recommendations from friends and relatives, but many also used recommendations from other physicians (38 percent) or their health plan (35 percent), the study found. Nearly two in five used multiple information sources when choosing a primary care physician, but when choosing specialists and facilities for medical procedures, most consumers relied exclusively on physician referrals, according to the study. Other key findings include:

- Use of online provider information was low, ranging from 3 percent for consumers undergoing procedures to 7 percent for consumers choosing new specialists to 11 percent for consumers choosing new primary care physicians.
- About 10 percent reported looking for a new primary care physician at some point in the previous 12 months. Almost half of this group failed to find a new physician. Among those who found a new primary care physician in the past year, half relied on recommendations from friends and relatives, while 25 percent used such recommendations as their only information source.
- Almost 63 million adults – nearly three in 10 – said they needed a new specialist in the previous year, with 46 million actually seeing a new specialist. Almost 70 percent relied on referrals from their primary care physician to find a specialist, with nearly 60 percent relying exclusively on this source, while 20 percent used recommendations from friends and relatives and only 15 percent used multiple sources of information.
- People with chronic conditions and those in fair or poor health were more likely to rely solely on their primary care physicians’ referrals than younger and more-educated consumers, who were more likely to turn to the Internet health plan information and other sources.
- About 60 percent reported undergoing a medical procedure at a new facility in the past year and nearly 75 percent of these patients relied on the referral of the physician performing the procedure; almost all of these consumers used no other source of information.

Americans Most Concerned with Health Care System, not Diseases

Americans’ perceptions of the most urgent health problem facing the United States focus on systemic factors such as access to health care and the cost of it rather than specific medical conditions. According to Gallup’s annual poll on health and health care, 55 percent of Americans said the availability of health care and the financial challenges of the entire system presented “the most urgent health problem” facing the U.S.

For the last seven years – and eight of the last nine – either health care cost or access has topped the list, and these two issues have been first or second on the list for the last six years. Only in 2001, when the anthrax scare pushed bioterrorism to the top of the list, did some other health concern trump either cost or access as the most urgent health concern. Prior to this decade, the public was most likely to mention a specific medical condition AIDS – as the greatest health concern.

After cost and access, obesity and cancer are the next most pressing health issues in the public’s mind this year. Obesity has been more commonly mentioned in recent years, and the 12 percent who mention it in the current survey is the highest Gallup has found to date.

Concern about cancer has diminished slightly in recent years, down to 11 percent since a high of 23 percent mentioned it in 1999. But that decline pales in comparison to the steep drop in concern about AIDS, which had been the top concern from 1987 to 1999, but has registered in the single digits since 2001 and is mentioned by just 2 percent of Americans this year.

AHRQ Study Examines Hospital Error Reporting Environment

More than ninety-four percent of U.S. hospitals have centralized systems for collecting reports of adverse events, but only 21 percent fully distribute and consider adverse event summary reports, according to a study released this week by the Agency for Healthcare Research and Quality (AHRQ). The new study, published in the December 8 issue of *Quality and Safety in Health Care*, is based on a national survey of more than 1,600 hospital risk managers. Hospitals participating in the random, voluntary survey described how their adverse event reporting systems work, the status of reporting practices and how they use reporting to improve care.

According to the new AHRQ-funded study, successful reporting systems share common elements, including provisions that protect the privacy of staff who report adverse events; encourage reporting by a range of hospital staff; and distribute timely summary reports that are reviewed by senior-level staff and used to develop event reduction strategies.

The survey found only 32 percent of hospitals have established “supportive environments” that allow anonymous reporting. Only 13 percent have broad staff involvement in reporting adverse events (96 percent of adverse events are submitted by nursing staff members). Authors said the study’s results provide a baseline for future evaluations of how hospitals report adverse events.

Links:

1. [Newsstand](#)
 2. [Employment Opportunities \(IowaHealthJobs.net\)](#)
 3. [Friday Mailing Archive](#)
 4. [IHA Education Program Calendar](#)
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“As businesses struggle to cut costs to match sagging revenues, employee health benefits are increasingly at risk. The faltering economy makes fair payment by Medicare and Medicaid more important than ever.”

– Rich Umbdenstock, American Hospital Association president and CEO, on the impact of Medicare and Medicaid underpayment