// Health Law Wisconsin NEWS

Published by the Health Law Section

Wisconsin Legislature Takes Quick Action in Response to Wisconsin Supreme Court's 'Columbus Park' Decision

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In November 2003, the Wisconsin Supreme Court held that otherwise exempt property owned by a benevolent association lost its exemption from property taxes when leased to low income individuals. *Columbus Park Housing Corp. v. City of Kenosha*, 2003 WI 143; 671 N.W.2d 663 (November 19, 2003). The Wisconsin Legislature quickly responded by enacting a measure to modify the statute at issue in the decision, Wis. Stat. § 70.11, and restore the tax exemption of property leased for residential housing purposes. In addition to amending Wis. Stat. § 70.11, Senate Bill 512 also requires the Legislative Council to study the issues and report its findings and recommendations to the Legislature no later than December 15, 2004. SB 512 was signed into law by Governor Doyle on April 8, 2004.

Health Care Funding and Reform In Wisconsin: The Issues in 2004

Tony Driessen

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Health Care Funding

Wisconsin's Medicaid (Title 19) Program is currently substantially underfunded. The open question is whether the growth in state tax revenues and jobs will occur soon enough that the problem will resolve itself. If the problem does not self-correct, Governor Doyle and legislators in Madison will need to find hundreds of millions of dollars to address the problem.

While Wisconsin's tax revenues fortunately seem to be ahead of forecasts, the state's spending for Medicaid is growing faster than those tax revenues. Unless Wisconsin can pull over a hundred million dollars out of the federal Medicaid "hat" (a bi-partisan effort is underway to do just that), the state will have to find the money somewhere else, prior to July 1, 2004.

Hence, we may have a budget review bill in late March or May to address the problem, but it may not be called a "budget review bill." Then, looking forward to 2005, the combination of a greater Medicaid caseload and higher utilization could produce a total 2004-2005 "shortfall" approaching $400 million.

If that happens, will Wisconsin try the proposed California approach and issue longer term bonds to fund the short-term Medicaid revenue shortfall? Or will benefits be cut, reimbursements reduced, or eligibility standards tightened up? Stay tuned for further developments!

Health Care Reform

The results of statewide polling in Wisconsin show that health care concerns are one of the top priorities of voters. With Governor Doyle and legislators in Madison anxious to have voters think positively about them, we can be sure that various proposals to address rising costs, availability of care and reforms will be advanced.

One of the major healthcare reform initiatives in Wisconsin was recently put forward jointly by the Wisconsin Manufacturers and Commerce, the Wisconsin Hospital Association, and the HMO Association. It largely revisits issues that each of the three groups have promoted previously, but have not

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yet caught on with policymakers. For example:

- Eliminating health insurance mandates.
- Providing grants, loan guarantees, and low-cost financing to promote programs oriented to quality of care.
- Have the state and federal governments pay more for Medicaid, HIRSP, and Medicare in order to reduce cost-shifting to the private sector.
- Spend more to educate nurses, radiology technologists, pharmacists, lab technicians, and surgical technologists who are in short supply in Wisconsin.
- Cut government regulations, especially those that are duplicative, inconsistent, or wasteful.
- Promote healthier lifestyles, including:
    - School exercise and education
    - Reduce alcohol consumption
    - Eliminate tobacco use
    - Make drug abuse programs available sooner to people who need them
    - Address end-of-life care issues
    - Bring the healthier choices message into the workplace

Will this health care reform "package" of the WMC, the Hospital Association, and the HMO Association pass and be signed into law? Probably not in its entirety, but several major components could advance.

Conclusion

Governor Doyle and key legislators in Madison report that they are hearing from their constituents about health care costs and availability. Whether true health care reforms will occur before universal health care is demanded by a majority of voters, remains to be seen!

Mark Your Calendar!

Health Law Section 2004 CLE
May 5, 2004, 12:30 – 4:20
Monona Terrace, Madison

- **12:30 – 1:45** **Impact of Sarbanes-Oxley and Related Regulation on Health Care Providers' Directors and Officers***
  Shawn D. Guse, Quarles & Brady LLP
- **1:45 – 3:15** **Health Law Update**
  Brian R. Purtell, Wisconsin Health Care Association
  Daniel L. Icenogle, M.D., Whyte Hirschboeck Dudek SC
- **3:15 – 4:20** **Representing Non-Profit Health Care Providers***
  Kennard N. Friedman, Yakes, Bauer, Kindt & Phillips SC
  Thomas H. Taylor, Gunderson Lutheran Inc.

Ethics credits will be applied for.

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Recent Cases of Interest

Julie M. Rusczek
Michael Best & Friedrich LLP

Meriter Hospital, Inc. v. Dane County

No. 02-2837, 2003 Wisc. App. LEXIS 1112 (Wis. Ct. App. November 26, 2003)

In *Meriter Hospital, Inc. v. Dane County*, No. 02-2837, 2003 Wisc. App. LEXIS 1112, at *1 (November 26, 2003), a Wisconsin Court of Appeals held that a county is responsible for paying an inmate's medical bills only as long as the individual is held under state criminal laws, regardless of the length of the individual's hospital stay.

Michael Gibson ("Gibson") was an inmate in Dane County when he became severely ill. The Dane County Sheriff's Department transported Gibson to Meriter Hospital, Inc. ("Meriter"), where he was admitted. Shortly after his admission, the sheriff informed the prosecutor of Gibson's hospitalization. The prosecutor moved to dismiss the charges against Gibson, and the trial court granted the motion. The Department of Probation and Parole also cancelled an order to detain Gibson. Following dismissal of charges and cancellation of the order to detain, Gibson was no longer guarded by a deputy at Meriter. The Department of Corrections issued an Apprehension Request, stating that Meriter was to contact the sheriff or Gibson's probation officer prior to releasing Gibson from the hospital. Meriter complied with the Apprehension Request before Gibson's discharge, and the sheriff declined to detain Gibson. Gibson was hospitalized at Meriter for 34 days, and his medical bills amounted to $187,569, which he was unable to pay. *Id.* at *2.

The trial court found that Dane County was liable to Meriter pursuant to Section 302.38 of the Wisconsin Statutes for that portion of the hospitalization prior to the dismissal of charges against Gibson, and ordered Dane County to pay Meriter $8,623. The court determined the amount of the award by prorating the diagnosis related group ("DRG") value over the number of days Gibson was in the hospital prior to dismissal of the charges. *Id.* at *10. Both Meriter and Dane County appealed.

Section 302.38 of the Wisconsin Statutes provides that, if a prisoner needs medical or hospital care, the superintendent or other keeper of the jail or house of correction shall provide appropriate care or treatment and may transfer the prisoner to a hospital, making provision for the security of the prisoner. The prisoner is liable for the costs of medical and hospital care outside the jail or house of correction. The county shall pay the costs for any person held under state criminal laws or for contempt of court who is unable to pay. The maximum amount that a governmental unit may pay for the costs of medical or hospital care under Section 302.38 is limited to the amount that would be payable for the care by Wisconsin's medical assistance program ("Medicaid") pursuant to Chapter 49, Subchapter IV of the Wisconsin Statutes, if the care were provided to a beneficiary of such program. *Id.* at *3.

Meriter contended that Section 302.38 does not sever Dane County's liability for Gibson's medical costs following dismissal of the charges against him. *Id.* at *4. In support of this argument, Meriter claimed that Section 302.38 determines a county's liability upon admission of the inmate for care, irrespective of any future events. Alternatively, Meriter argued that Gibson did not lose his criminal status when the court dismissed the charges because Gibson could be considered "otherwise detained" based on the Apprehension Request and thus would meet the definition of "prisoner" in Section 301.01(2) of the Wisconsin Statutes. *Id.* at *6. The court rejected both of these arguments, applying the plain meaning of the language in Section 302.38, which requires that the county pay the medical bills of a patient held under the state criminal laws. *Id.* at *5. The court reasoned that once the charges against Gibson were dismissed, he was no longer held under the state criminal laws. In addition, the court stated that Section 302.38 did not allow it to substitute an Apprehension Request for criminal charges in determining whether an individual is held under the state criminal laws. *Id.* at *8.

The parties also disagreed on the method to be used to determine the amount for which Dane County was liable. *Id.* at *9-*10. Meriter argued that Section 302.38 does not require that the DRG value be prorated, since the DRG value considers the entire scope of the treatment provided and thus is not divisible by the number of days a patient stays in the hospital. The court concluded that to hold Dane County liable for the entire DRG value would render the limit on Dane County's liability for medical care to indigent prisoners meaningless because, under Meriter's argument, a county would be liable for the entire scope of treatment

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provided, regardless of an individual's criminal status. *Id.* at *10.

Dane County argued that its liability for Gibson's medical expenses should be determined based on the rate the Department of Health and Family Services would pay for an indigent patient under a "relief block grant," rather than the DRG value. The court held that, due to the Department of Health and Family Services' determination that Meriter should use the DRG rate to calculate its fee for services it provided to Gibson, both Meriter and Dane County were bound to use the DRG rate as the basis for calculating payment. *Id.* at *14.

In conclusion, the Court of Appeals affirmed the trial court's judgment, which required that Dane County pay Meriter $8,623 for the medical care Gibson received at Meriter before criminal charges against him were dismissed. *Id.* at *15.

Hofflander v. St. Catherine's Hospital, Inc.

2003 WI 77; 262 Wis. 2d 539; 664 N.W.2d 545 (July 1, 2003)

In *Hofflander v. St. Catherine's Hospital, Inc.*, the Wisconsin Supreme Court held that survey reports by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") are privileged from discovery under Section 146.38 of the Wisconsin Statutes. 2003 WI 77, ¶122, 262 Wis. 2d 539, 612, 664 N.W.2d 545, 581.

Lori Hofflander ("Hofflander") sued St. Catherine's Hospital (the "Hospital") after she was involuntarily committed to the Hospital and suffered injuries while attempting to escape through a third story window. She asserted that the Hospital was negligent in failing to prevent her escape and consequent fall. During pretrial discovery, Hofflander sought production of reports from a survey of the Hospital by JCAHO. The Hospital refused to disclose the reports, asserting that they were privileged pursuant to Section 146.38 of the Wisconsin Statutes, which protects records of reviews and evaluations of health care providers. The circuit court agreed with the Hospital, and a Wisconsin Court of Appeals affirmed, as did the Wisconsin Supreme Court.

Section 146.38 prohibits those who participate in the review or evaluation of the services of health care providers or facilities from disclosing any information acquired in connection with such review or evaluation except as permitted elsewhere in the statute. Wis. Stat. § 146.38(1m). The statute requires that all organizations or evaluators reviewing or evaluating the services of health care providers keep a record of their investigations, inquiries, proceedings, and conclusions, and that no such record be released to any person except pursuant to an express statutory exception. In addition, Section 146.38 provides that no such record may be used in any civil action for personal injuries against the health care provider or facility, but information, documents, or records presented during the review or evaluation may not be construed as immune from discovery in a civil action merely because they were so presented. Wis. Stat. § 146.38(2).

First, Hofflander argued that JCAHO survey reports are not protected by Section 146.38 because the surveys were conducted by an outside agency unrelated to the Hospital. The court rejected Hofflander's argument, reasoning that JCAHO qualifies as an "organization" under Section 146.38, because it has at least some of the attributes commonly associated with organizations, such as a relatively constant membership, a body of officers, a purpose, and a set of regulations. *Hofflander* at ¶115 (citing *Franzen v. Children's Hospital*, 159 Wis. 2d 366, 379-80, 485 N.W.2d 603, 607-608 (Ct. App. 1992)). The court concluded that JCAHO is the type of organization contemplated under Section 146.38, and the survey materials in this case constitute a record of a peer review evaluation. *Id.* at ¶116.

Second, Hofflander argued that the survey reports are not protected by the statutory privilege because the surveys were conducted before the incident giving rise to the litigation—Hofflander's attempted escape and fall—rather than in response to the incident. The court explained that the timing of the creation of information, whether before or after the event giving rise to litigation, is irrelevant; rather, it is the source of the production of the information which determines whether or not it is discoverable. *Id.* at ¶118. Therefore, records produced from the investigations, inquiries, proceedings, and conclusions of reviewing organizations are protected by the privilege, while information presented to evaluators during a review and matters within the evaluators' own knowledge are not protected by the privilege.

Finally, the court reasoned that permitting discovery of the JCAHO reports, aimed at enabling hospitals to improve their services above the minimum levels set by the state, would subvert the central purpose of Section 146.38, which is to encourage hospitals to perform quality control reviews aimed at improving their services prospectively. *Id.* at ¶119. The court concluded that JCAHO is an organization that performs functions equivalent to a peer review committee, and that it provides information concerning how hospitals may improve their health care services. Thus, JCAHO site survey reports are immune from discovery pursuant to Section 146.38. *Id.* at ¶120.

Need HIPAA forms?

The HIPAA Collaborative of Wisconsin ("HIPAA COW") offers free, downloadable sample forms, and other HIPAA compliance information on its Web site at http://www.hipaacow.org/.

Overview of the Medicare Prescription Drug, Improvement and Modernization Act of 2003

Health Law Section of von Briesen & Roper s.c.

On December 8, 2003, President Bush signed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the "Act") into law. This broad piece of legislation (678 pages) will have a tremendous impact on the health care industry. A large and widely publicized portion of the Act expands federal health care programs to provide prescription drug coverage to seniors. Other sections of the Act, which have received little media attention, amend the current laws and establish new provisions that will significantly impact health care suppliers and providers. This article summarizes these less publicized but key provisions of the Act.

Stark Law Moratorium on "Specialty Hospital"

The Act establishes an 18-month moratorium on the Stark law exception that allows physician ownership of hospitals for any new "specialty hospital," including those located in rural areas. Specialty hospitals are defined to include single specialty hospitals focusing exclusively on cardiac, orthopedic, surgical, or any other specialized category of services deemed by the Secretary of the Department of Health and Human Services (the "Secretary") as inconsistent with the purpose of permitting physician ownership and investment in hospitals. Multi-specialty hospitals are not affected, but may be included by regulation. The Act allows physician ownership of specialty hospitals that are operational or under development as of November 18, 2003 to continue, but prohibits such hospitals from increasing the number of physician investors, changing the type of services provided, or increasing the number of beds by more than five.

On March 19, 2004, the Centers for Medicare and Medicaid Services ("CMS") issued further guidance explaining that an entity may request an advisory opinion to determine whether CMS would deem a hospital to be sufficiently "under development," such that it is exempt from this moratorium.

Importation of Prescription Drugs

The Act requires the Secretary to promulgate regulations with appropriate safeguards to allow pharmacists and wholesalers to import some prescription drugs from Canada into the United States.

New Covered Services, New Programs and Changes in Reimbursement

The Act establishes several new programs and makes several changes to Medicare covered services and reimbursement as follows:

- Medicare will cover the following: (a) initial preventive physical examinations; (b) cardiovascular screening blood tests; and (c) diabetes screening tests. Screening mammography and diagnostic mammography services will be paid under the physician fee schedule beginning on January 1, 2005.
- There is a two-year moratorium on the $1,500 annual therapy cap during 2004 and 2005.
- Payments for Medicare services furnished in ambulatory surgery centers ("ASCs") are changed in 2004 by a factor of CPI minus 3%. During 2005 through 2009, the Medicare ASC fee schedule will remain fixed (e.g., no increase).
- Medicare payments for clinical diagnostic laboratory tests are fixed from 2004 through 2008 (e.g., no increase).
- Medicare reimbursement is allowed for Part B services that are furnished by certain Indian hospitals and clinics for a five-year period beginning on January 1, 2005.
- The Act includes a demonstration project for Medicare coverage of chiropractic services.
- Either a physician or a patient may request a determination of whether a physician's services will be eligible for reimbursement. Requestors will be provided written notice explaining coverage determinations.
- A loan program for qualifying hospitals (e.g., those engaged in cancer research, prevention and treatment; those designated as a "cancer center" by the National Cancer Institute; and those designated by a state as the official cancer institute) is established to provide funds for capital costs associated with construction, renovations, or other improvements.

Quality Improvement Measures

The Act creates several new quality improvement measures as follows:

- A new federal grant program is created to provide funds to acquire, upgrade, and implement electronic prescription drug programs.
- A five-year quality improvement demonstration program is created in which qualifying integrated health systems will be contracted to evaluate safety improvement, best practices guidelines, variation reduction, shared decision making with patients, and quality improvement incentives.
- Within 12 months of the enactment of the Act, the Department of Health and Human Services ("DHHS") is required to begin testing chronic care improvement programs at selected pilot sites. Participating entities must enter into three-year agreements with

DHHS requiring them to provide participating patients with individualized, goal-oriented care management plans, and monitor and track patient outcomes.

Combating Waste, Fraud and Abuse

The Act implements the following measures to combat waste, fraud, and abuse:

- Primary payors, including insurers and self-insured employers, are required to reimburse the Medicare program for payments made when Medicare is not the primary payor. The federal government is authorized to bring collection actions against primary payors and recover up to twice the amount paid by the Medicare program.
- The Secretary must, within one year, implement durable medical equipment quality standards to be applied by a designated independent accrediting organization to govern the receipt and retention of durable medical equipment Medicare provider or supplier numbers.
- A safe harbor is added to Medicare's anti-kickback rules for remuneration between a health care entity and any individual providing goods, items, services, or donations to that entity pursuant to an agreement, provided the agreement contributes to the health care entity's effectiveness in service to medically underserved populations.
- Providers and suppliers are allowed, under some circumstances, to repay overpayments over an extended period.
- The Secretary must develop a process for providers and suppliers to correct errors or omissions that are detected in submitted claims without initiating an appeal. Providers and suppliers will also be given the ability to resubmit corrected claims.

Part A Services and Hospital Reimbursement

The Act makes the following changes to Medicare Part A services and hospital reimbursement:

- Hospitals paid under the inpatient prospective payment system are subject to a 0.4 percentage point reduction in the update to the Medicare standardized amount for a fiscal year if the hospital does not submit required data related to the quality of care.
- A wage index adjustment is established for hospitals located in counties that meet certain criteria based on out-migration of hospital employees.
- Hospitals paid under PPS that have not met requirements based on distance or commuting may appeal to the Medicare Geographic Reclassification Review Board for a review of a hospital's wage index classification. The appeal must have been filed by February 15, 2004.
- Hospitals that are not otherwise subject to the OSHA requirements must comply with the bloodborne pathogen standard and are subject to civil monetary penalties for failure to comply. The effective date is July 1, 2004.
- Additionally, a host of other provisions are included which will affect rural providers.

Delivery of Part B Services and Physician Reimbursement

The Act makes the following changes with respect Medicare's reimbursement of physicians and physician re-assignment:

- A floor on the work geographic adjustment is created for physician services furnished between January 1, 2004 and December 31, 2006.
- Physician services furnished between January 1, 2005 and December 31, 2007 in physician scarcity areas will be paid an additional 5%.
- The Medicare physician fee schedule will increase at least 1.5% per year during 2004 and 2005.
- Physicians are allowed to reassign their right to bill for services rendered to any entity with which the physician has a contract if under the contractual arrangement, the entity submits the bill for the service and the contractual arrangement meets certain safeguards.

Graduate Medical Education and Residents

Graduate medical education programs and residency programs will be affected by the following changes made by the Act:

- Effective for cost reporting periods beginning July 1, 2005, the Act reduces the limit for hospital residents based on the number of resident positions available that a hospital did not use.
- The first two years of a geriatric specialty resident's training will not be counted against any limitation on the initial residency period if the two years are required for the program.
- For calendar year 2004, a moratorium allows hospitals to count residents training in non-hospital sites without regard to the financial arrangements between the hospital and the non-hospital site.

Ambulance

The Act provides the phase-in payment methodology for rural and urban ambulance services beginning with services furnished on or after July 1, 2004. The Act also provides Medicare coverage of rural air ambulance services.

Hospice and Home Health

Hospice and home health care providers will be affected by the following changes made pursuant to the Act:

- The definition of "attending physician" is changed to recognize attending nurse practitioners as attending physicians who are permitted to serve hospice patients.
- Home health services payments increase in rural areas by 5% for those home health services provided in conjunction with episodes and visits ending between April 1, 2004, and March 31, 2005.

- Hospice consultation services furnished by a physician serving as medical director or an employee of a hospice program beginning January 1, 2005 will be covered.
- The requirement for collection of non-Medicare/Medicaid OASIS information is suspended until two months after CMS publishes final regulations regarding the collection and use of this information.
- The Secretary is required to provide information that enables hospital discharge planners, Medicare beneficiaries, and the public to identify skilled nursing facilities that are participating in the Medicare program. Hospitals are also required to provide in their discharge plans the availability of hospice care and post-hospital extended care services.

Taxpayer Benefits

The Act amends the Internal Revenue Code to create health savings accounts ("HSAs"). HSAs will work very much like IRAs except that funds are designated for medical expenses. Individuals covered by high deductible health plans will be eligible for a deduction from adjusted gross income for contributions to an HSA.

EMTALA

The Act clarifies the payment provisions related to stabilization services to focus on the information available to treating practitioners at the time the service was ordered.

Medicare Prescription Drug Benefit for Seniors

Finally, the Act includes new prescription drug programs including the following:

- **Discount Card.** The Act provides a transition period (beginning in Spring, 2004 and ending December 31, 2005) during which interim benefits are available via a drug discount card. This will reduce prescription drug costs for beneficiaries who purchase it. The card is expected to cost about $30 and to save beneficiaries 10 to 15% off of pharmacy drug prices. Low-income individuals (incomes of $12,390 or less for an individual, or $16,720 for couples) will have a $600 credit on their drug discount card during the interim period.
- **Drug Benefit.** Starting in 2006, Medicare will pay 75% of prescription drug costs for people who choose to enroll in the Medicare drug plan. Drug plans are expected to have premiums of about $35 per month and cover 75% of drug costs (with a $2,250 cap on prescription medicine) after a $250 deductible. After the $2,250 cap is met, enrollees must pay the next $1350, until the drug costs hit $3600 in out-of-pocket costs. At that point catastrophic coverage kicks in, and enrollees will pay 5% of the cost of additional prescriptions plus a small co-pay.

  Enrollment in the Medicare drug plan is voluntary. Beneficiaries will have the choice to remain in traditional Medicare, or a Medicare HMO without signing up for the drug benefit; they can remain in Medicare and enroll in a stand alone drug plan; or they can enroll in a private health plan offering drug coverage and Medicare health services. However, while initial enrollment is voluntary, seniors who elect other coverage, or who skip coverage and then enroll later, will pay extra monthly premiums. The penalty is 1% for each month not covered, and the extra monthly premium continues indefinitely.
- **Employee Benefit Plans.** Employer subsidies are available to encourage employers to maintain their current drug coverage plans.

Summary

The Act will have a dramatic impact on the health care industry and beneficiaries in a variety of areas. It has already been the subject of debates and controversy and we anticipate considerable changes before it is fully implemented.

Wisconsin Legislature Enacts Measure to Address Conflict With HIPAA

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To reconcile a significant conflict between Wisconsin Statutes and the regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Wisconsin Legislature recently enacted 2003 Senate Bill 372. The Bill amends Wisconsin's confidentiality of patient health care records statute, Wis. Stat. § 146.82, to permit patient health care records to be disclosed without patient authorization or consent, for purposes of "health care operations," as that term in defined in the HIPAA regulations at 45 C.F.R. § 164.501. This change broadens the permissible disclosures under Wisconsin law, permitting patient health care records to be disclosed without authorization for such purposes as quality assessment, peer review, case management, health care provider training, licensure, legal services, audits, business planning and development, and business management and administration. SB 372 is expected to be signed by Governor Doyle.

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