

## WHA Prepares for MACRA as Proposed Rule is Released

In his column May 6, 2016 ([www.wha.org/pubarchive/valued\\_voice/WHA-Newsletter-5-6-2016.htm#5](http://www.wha.org/pubarchive/valued_voice/WHA-Newsletter-5-6-2016.htm#5)), WHA President/CEO Eric Borgerding described why the implementation of MACRA is a high priority for WHA. MACRA—the Medicare Access and CHIP Reauthorization Act of 2015—combines and streamlines several existing Medicare physician payment systems including the Physician Quality Reporting System (PQRS), the Value Modifier Program and the Medicare Electronic Health Record Incentive Program. The existing programs are being consolidated into a choice of one of two new systems: MIPS—the Merit-Based Incentive Payment System, and APMs—Alternative Payment Models.

The implementation of MIPS and APMs will have a significant impact, not only on physicians, but also on the hospitals and health systems with whom they partner. Hospitals that employ physicians directly may bear some cost from the implementation of and ongoing compliance with the new physician performance reporting requirements, as well as be at risk for any payment adjustments. Hospitals that contract separately with physicians may be called upon to participate in APMs so the physicians with whom they partner can qualify for the APM track.

Performance in the MIPS and APM programs will be used to adjust Medicare payments. The budget-neutral program calls for maximum reduction in payments from 4 percent in 2019 to a maximum of 9 percent in 2022 and after. Providers that demonstrate high performance will receive increases in reimbursement, up to a maximum of 14.5 percent in 2019 and increasing to 19 percent in 2022. The following table summarizes the reimbursement adjustments for 2019 through 2026. Providers who participate in an approved APM will receive an automatic 5 percent bonus. *(continued on page 10)*

### **HCAHPS, Patient Satisfaction & Opioid Prescribing: Debunking the Myths** *Wednesday, June 1, 2016, 12:00-1:00 pm*

Register today at: <https://events.SignUp4.net/HCAHPS-0601>

## Will You Be on the First Contributor Listing for 2016?

***To be listed, contribute before May 27 to the Wisconsin Hospitals State PAC or Conduit***

The 2016 Wisconsin Hospitals State PAC & Conduit campaign is in full gear. To date, over \$110,000 has been raised from 120 contributors. Is your name among the 120? The first contributor listing will be published in the May 27 edition of WHA's *Valued Voice* newsletter. Make sure your name is on the list and help the 2016 Wisconsin Hospitals State PAC and Conduit campaign surpass \$120,000 by next week with a contribution before May 27.

The Wisconsin Hospitals State PAC and Conduit 2016 campaign goal is to raise \$300,000, a 10 percent increase over last year. This is an aggressive but reachable goal if everyone pitches in to continue to support candidates of both parties who value hospitals and health systems. To date, the 2016 campaign is at 37 percent of goal.

Elections matter and participation is important. Be a part of the success story by contributing to the Wisconsin Hospitals State PAC and Conduit today. Contribute online at [www.whconduit.com](http://www.whconduit.com) or contact Jenny Boese at 608-268-1816 or [jboese@wha.org](mailto:jboese@wha.org).

## Group Insurance Board Details Self-Funding RFP Timeline

On May 18, the Group Insurance Board (GIB) again discussed the development and issuance of a Request for Proposals (RFP) to evaluate the impact of self-insuring the state employee group health insurance program. After authorizing the Department of Employee Trust Funds (ETF) to move forward in implementation of the RFP this past February (see February 19 *Valued Voice* article at [www.wha.org/pubarchive/valued\\_voice/WHA-Newsletter-2-19-2016.htm#3](http://www.wha.org/pubarchive/valued_voice/WHA-Newsletter-2-19-2016.htm#3)), on May 18 the GIB received more details about the timeline and feedback from the State's latest consultant, Segal.

According to a memo prepared by staff from ETF, the RFP is expected to be released by July 22, 2016, and ETF staff would expect to receive and evaluate responses in time for the November GIB meeting. Before the release of the full RFP, ETF expects to release a draft that will be available for a short time for comment. Key dates include:

- June 3, 2016: Request for Information Issued
- July 22, 2016: RFP Issued
- Aug. 5, 2016: Proposer Questions and Letter of Intent Due
- Aug. 19, 2016: ETF Posts Answers to Questions on ETF Extranet
- Sept. 9, 2016: Proposal Due Date
- Nov. 15, 2016: Board Presentation

After two separate consultants developed vastly different estimates of the costs and potential savings of a move to self-funding, the Board is interested in the RFP as a means for obtaining additional information that can help inform their decision.

Lisa Ellinger, director of ETF's Office of Strategic Health Policy, and staff from Segal consultants provided more detailed information about the components of the RFP. In particular, ETF notes the RFP will require the vendor to confirm their ability to provide an acceptable level of administrative services, describe their experience and results in several areas including "high-value" networks, disease management, provider-level tiering, reference value/pricing, and centers of excellence. Finally, the vendor will be required to demonstrate adherence to performance metrics and reporting requirements in the future, and compare current population health performance metrics related to medical management programs.

In addition, the RFP would be designed to allow the GIB to compare potential costs/savings associated with different program models, such as a self-insured program under a regional structure using multiple insurers versus a single, statewide administrator approach, or a hybrid structure that includes regional and statewide vendors. Vendors would be allowed to submit multiple network options for comparison. For example, a vendor could submit a network that is lower cost with narrower provider access, but also submit a broader access network and the administrative costs associated with that offering. Vendors will be required to demonstrate satisfactory provider access in the regions they propose to serve. Importantly, ETF and Segal believe the RFP will enable the Board to compare costs for the different scenarios described in the program structure and provider access sections above, and compare anticipated savings in a regional/statewide and/or self-insured structure versus the likely future costs of the current fully-insured model.

Overall cost savings is a key factor in deciding whether to self-fund, given that two different consultants have wide ranging estimates, from a potential cost to the state of \$100 million to a potential savings of \$42 million. Segal noted several key differences between the program model under the RFP and the current program model, but no specifics were given on exactly how and what data the RFP will elicit that could allow the state to have a true comparison of costs with the current fully-insured model. Under the current model, the state saw a reduction in overall costs for the 2016 benefit year of close to \$90 million.

The materials provided to the GIB at the May 18 meeting with regard to self-funding can be found at [www.wha.org/pdf/SegalPresentation5-18-16.pdf](http://www.wha.org/pdf/SegalPresentation5-18-16.pdf) and [www.wha.org/pdf/DETFMemoGIBRFP5-13-16.pdf](http://www.wha.org/pdf/DETFMemoGIBRFP5-13-16.pdf).

## Statsick Joins Wisconsin Hospitals State PAC and Conduit Fundraising Team



Nora Statsick

Nora Statsick recently joined the WHA government relations team as a political affairs consultant for the Wisconsin Hospitals State PAC (Political Action Committee) and Conduit. She replaces Jodi Bloch who has worked with WHA since 2003.

"We are proud of the unparalleled progress we have made during Jodi Bloch's tenure, becoming one of the most—if not the most—prominent conduit and PAC in the state. We look forward to expanding on that success with Nora, who is a highly talented individual who will complement the work of WHA's political and government relations team," said WHA President/CEO Eric Borgerding.

Statsick will be responsible for meeting WHA's goal of disbursing \$350,000 to campaign committees in the 2016 election cycle and managing Wisconsin Hospitals State PAC-sponsored fundraising events across the state. By meeting the 2016 goal, WHA will maintain its presence as the largest political conduit in Wisconsin.

Statsick most recently served as the political affairs director for the Wisconsin Builders Association, where her duties included administration of the political action committee and conduit, assisting local associations with legislative relations, political fundraising and campaign involvement. Statsick previously worked in the Wisconsin State Capitol for Gov. Tommy Thompson handling constituent relations. She is a graduate of the University of Wisconsin-Madison.

"This is an exciting election year, and I am delighted to have the opportunity to be part of a team of a highly-respected organization such as WHA," said Statsick. "I look forward to building on the tremendous accomplishments of WHA and helping hospital and health system supporters be even more engaged advocates."

If you have questions about contributing to the Wisconsin hospitals conduit and state PAC or supporting candidates through your conduit account, contact either Nora or Jenny Boese at [nstatsick@wha.org](mailto:nstatsick@wha.org) or [jboese@wha.org](mailto:jboese@wha.org).

## Lt. Governor Kleefisch Visits Fort HealthCare

On May 17, Lt. Gov. Rebecca Kleefisch visited Fort HealthCare in Fort Atkinson. Her stop at Fort HealthCare was a continuation of her desire to visit hospitals to talk with cancer patients, as Kleefisch is now celebrating five years cancer free.

During her visit, Kleefisch was able to tour and see patients in the hospital's Healing Breast Care Center and learn about how the center provides a coordinated team effort of care from diagnosis to recovery.

"We greatly appreciate Lt. Governor Kleefisch spending time at Fort HealthCare and for her desire to personally connect with our patients and staff," said Mike Wallace, Fort HealthCare president/CEO.

"While she was with us in Fort she also highlighted the excellent health care we have all across Wisconsin and how the state is working to keep that health care system strong by protecting important programs like the Medicaid Disproportionate Share Hospital program," added Wallace.

Wisconsin Hospital Association  
May 17 at 9:45am · 🌐

Lt. Governor Rebecca Kleefisch shares hope during Fort HealthCare visit

Kleefisch shares hope during Fort visit

Lt. Gov. Rebecca Kleefisch visited Fort Memorial Hospital in Fort Atkinson Monday, spreading hope as part of a tour celebrating her transition from cancer patient to cancer survivor.

DAILYUNION.COM

Read an excellent article from the Fort Atkinson Daily Union at [www.dailyunion.com/news/article\\_b2b03b24-1c39-11e6-b92a-576b38dd13a3.html](http://www.dailyunion.com/news/article_b2b03b24-1c39-11e6-b92a-576b38dd13a3.html) about the Lt. Governor's visit to Fort HealthCare or visit WHA's Facebook page at <https://www.facebook.com/Wisconsin-Hospital-Association-172480133665>.

## **Hospital Package Released in Congress, Includes Targeted HOPD Fix**

On May 18 the U.S. House Ways & Means Committee released legislation that includes various hospital provisions. Among the policies is an attempt to provide flexibility for certain hospital outpatient department (HOPD) projects caught up in a prohibition enacted last year.

Within the span of a week in late 2015, a provision was enacted under the Bipartisan Budget Act (BBA) of 2015 that banned new off-campus provider-based HOPDs from using Medicare's Outpatient Prospective Payment System (OPPS) beginning in 2017. The abrupt November 2, 2015 enactment date of this policy meant a variety of projects across the country that were already well under construction but not yet able to bill under the OPPS were no longer able to use this entire Medicare reimbursement system. Congress has been working since that time to craft a targeted fix to address these mid-build situations.

The legislation released May 18, the Helping Hospitals Improve Patient Care Act (HR 5273), includes several limited options for these mid-build projects to use in order to qualify for an exemption from the BBA's prohibition on using the OPPS. There are two small pathways for an exemption. One is if the HOPD had already attested by December 2, 2015. The second would include a multi-part process for an HOPD to attest by July 1, 2016 in order to be exempted. In order to pay for this legislation, hospitals will see an additional reduction in their market basket for FY 2018.

In addition to this HOPD fix, the legislation contains other provisions of interest. Among those are changes to the hospital readmission reduction program in order to address socioeconomic status. This provision would initially require the Centers for Medicare & Medicaid Services (CMS) to make an adjustment based on the proportion of a hospital's dually eligible Medicare and Medicaid patients. CMS may modify risk-adjustments in the future. Another provision in this legislation is Speaker Paul Ryan's bill requiring CMS to study and report on how the inpatient and outpatient hospital codes for similar services can be cross-walked. The basis of this provision was Ryan's original bill, HR 3291.

If you have questions, contact WHA Vice President, Federal Affairs & Advocacy Jenny Boese at 608-268-1816 or [jboese@wha.org](mailto:jboese@wha.org).

## **WHA Signs On to Alliance for American Hospitals Letter *Tells CMS to deny request to fix Massachusetts flawed wage index data***

The Wisconsin Hospital Association, a member of the Alliance for America's Hospitals, which represents 21 state hospital associations and the National Rural Health Association, joined a letter to the Centers for Medicare & Medicaid Services (CMS) regarding a manipulation of the Medicare hospital wage index.

"An orchestrated reclassification of a small critical access hospital on Nantucket Island off the coast of Massachusetts, coupled with the application of the national 'rural floor' standard, has allowed 60 Massachusetts hospitals to reap an estimated \$1.3 billion in redirected Medicare inpatient and outpatient payments in fiscal years 2012 to 2016," the Alliance's letter began, referencing a situation that happened several years ago. "The gains of these Massachusetts hospitals come at the expense of hospitals across the nation, which have their Medicare payments cut to offset the higher payments in Massachusetts. Both CMS and the Medicare Payment Advisory Commission previously have voiced concern about this manipulation of the wage index system. Despite strong bipartisan support of legislation to end the manipulation, repeal efforts have been stymied by those seeking to perpetuate it."

Flash forward to today, and that same Nantucket hospital is now asking CMS to fix the mistakes the hospital made because those mistakes will have the impact of lowering the wage index for Massachusetts and reduce their hospital reimbursements.

"Recently, the issue has come back into CMS' jurisdiction. The hospital on Nantucket Island—the 19-bed Nantucket Cottage Hospital—is seeking CMS' authorization to allow it to change the data it previously

*(continued on page 5)*

## Continued from page 4 . . . WHA Signs on to Alliance for American Hospitals Letter

submitted to CMS for use in calculating the wage indices for the nation's hospitals for the fiscal year beginning next October 1. Citing assorted errors, the hospital is seeking to revamp its data nearly two months after the CMS deadline for submitting final data. Because that hospital's wage data is the benchmark for Massachusetts' hospitals, the flawed data cuts the windfall payments they will receive for federal fiscal year 2017," the letter continued.

As can be imagined, the state hospital associations represented in the Alliance do not have much sympathy.

"If CMS chooses to ignore its own wage index data deadline in this case, our member hospitals will be held responsible for paying the estimated \$160 million in additional windfall to Massachusetts hospitals. Nantucket Cottage Hospital should bear responsibility for its errors. The other Massachusetts hospitals should accept the consequences of having cast their lot with Nantucket in this manipulation of the Medicare wage index system. In our view, scarce Medicare funding should reward actual costs, value and efficiency and not be diverted based on artful manipulation of obscure Medicare payment formulas."

Read the entire letter at: [www.wha.org/pdf/AllianceLetterNantucketAppeal5-17-16.pdf](http://www.wha.org/pdf/AllianceLetterNantucketAppeal5-17-16.pdf).

## Medical Examining Board Telemedicine Subcommittee Proposes Simplified Rules

At their May 18 meeting, the Medical Examining Board (MEB) Telemedicine Subcommittee proposed significantly scaling back their proposed telemedicine rules. Recognizing that a more expansive set of rules might potentially result in the unintended consequences of impeding safe and efficient telemedicine practice already in place, subcommittee chair Ken Simons, MD proposed a much more streamlined version. The model language Simons proposed is the recently-enacted Florida telemedicine rule (see at <https://www.flrules.org/gateway/ruleno.asp?id=64B8-9.0141>). This would replace the previous language proposed by the subcommittee that was based on the recently-enacted Iowa rule (see at <https://medicalboard.iowa.gov/images/pdf/Press%20release%20-%20New%20rule%20establishes%20standards%20for%20physicians%20who%20use%20telemedicine%20-%20June%203%202015.pdf>).

WHA's Telemedicine Task Force has been actively engaged in this issue since the MEB announced last year they were considering adopting new rules for telemedicine. As previously reported in *The Valued Voice* ([www.wha.org/pubarchive/valued\\_voice/WHA-Newsletter-1-22-2016.htm#2](http://www.wha.org/pubarchive/valued_voice/WHA-Newsletter-1-22-2016.htm#2)), WHA Vice President, Workforce and Clinical Practice Steven Rush testified at the MEB January 20, 2016 public hearing in opposition to the Iowa-based proposed rule language. More than an hour of testimony given by 13 different individuals or organizations resulted in the MEB deciding to suspend all formal action on their proposed telemedicine rule and, instead, take time to revisit sections of this rule for more thorough analysis by the Board. Apparently the MEB will no longer analyze section by section the Iowa model, as subcommittee members agreed to use the Florida rule as a starting point.

"I am pleased the subcommittee has taken the feedback from WHA and other stakeholders into account," according to Rush. "WHA has been concerned from the beginning that excess rules and regulations are at best redundant, and at worst, restrictive and unnecessary." Rush added, "I look forward to WHA's Telemedicine Task Force examining the newly-proposed language in the very near future."

For more information contact Rush at [srush@wha.org](mailto:srush@wha.org) or 608-274-1820.

## WHA Physician Leaders Council Focuses on Key 2016 WHA Goals

As health care evolves, the WHA Board of Directors, which includes broad representation of WHA's members across the state, has directed WHA to engage in issues that impact not just the hospital, but also physicians and other clinicians as part of the overall continuum of care. The WHA Physician Leaders Council is a key part of that engagement. The Council met May 18 and focused on several physician and clinical practice-related items in WHA's 2016 strategic goals:

- The addition of two physician leaders for appointment to the WHA Board
- Development of a WHA physician retention toolkit
- WHA's MACRA agenda
- Member education discussing opioid prescribing practices and patient satisfaction measures
- Advancing hospital and health system physician leaders to the Medical Examining Board



*Clockwise, from left: Sarjoo Patel, MD, Stoughton Hospital Association; Brad Manning, MD, University Hospital; Kim Drone, WHA; Matthew Stanford, WHA; Chuck Shabino, MD, WHA; Donn Dexter, MD, Mayo Clinic Health System and Wisconsin Medical Society; Bill Wessels, MD, Aspirus Wausau Hospital; Eric Borgerding, WHA President/CEO; John Dyer, MD, ProHealth Care.*

### **WHA Board creates two new Board positions for physicians**

Staff reported to the Council that the WHA Board, during its April meeting, approved the addition of two physician leader positions to the Board. The action is a continuance of efforts begun in 2014 to involve physician leaders such as CMOs and VPMAs more closely in Association activities and was a 2016 WHA goal. Staff explained that the nomination and election process will occur concurrently with the process for electing At-Large Directors for the 2017 WHA Board, and the process will begin with a call for interest in the positions by the WHA Nominating and Awards Committee early this summer.

### **Development of a WHA physician retention toolkit**

Another 2016 WHA goal includes the consideration of the development of a physician retention toolkit for WHA members. Chuck Shabino, MD, WHA chief medical officer, and Matthew Stanford, WHA general counsel, said this WHA goal builds on WHA advocacy efforts to address physician supply needs at the state level. They said this member value related goal stemmed from four staff observations:

- **Wisconsin's high level of integration** – 70-80 percent of Wisconsin's physician workforce is employed by or contract closely with WHA member health systems. This is much higher than the national average.
- **Physician retention is a strategic priority for WHA members** – Integrated care models are particularly dependent on organizational-level physician retention.
- **Physician satisfaction and burnout concerns** – WHA members are aware of physician satisfaction and burnout concerns being raised by professional organizations.
- **Availability of relevant organizational-level strategies to maintain/improve satisfaction** – Does Wisconsin's advanced integrated environment create unique needs for organization-level physician satisfaction strategies and guidance? *(continued on page 7)*

## **Continued from page 6 . . . WHA Physician Leaders Council Focuses on Key 2016 WHA Goals**

The Council engaged in a long-form discussion of potential direction for, content of, and uses of a WHA physician retention toolkit for WHA members. The wide-ranging discussion touched on observations and existing and potential strategies regarding communications, correlations with physician engagement, internal physician retention and satisfaction measures, fit within organizations' overall strategic priorities, and areas where WHA could leverage its advocacy expertise to address public policy that negatively impacts physician satisfaction.

Staff will continue work on this project with the Council throughout this year, with a goal of presenting a recommended toolkit to the WHA Board in December.

### ***WHA's MACRA agenda***

Physician payment reform—another 2016 WHA priority—was the focus of a discussion led by Kelly Court, WHA chief quality officer, and Joanne Alig, WHA senior vice president, on WHA's MACRA (Medicare Access and CHIP Reauthorization Act) agenda and work plan. MACRA combines and streamlines several existing Medicare physician payment systems into a choice of one of two new systems: MIPS—the Merit-Based Incentive Payment System, and APMs—Alternative Payment Models.

Staff provided a high-level overview of MACRA and received input from the Council on WHA's multi-part and multi-staff strategy. That strategy includes both helping WHA members understand and prepare for MACRA implementation, as well as how input from WHA members can help shape WHA's advocacy on continuing MACRA rulemaking.

Additional information regarding WHA's MACRA agenda is discussed on page 1 of today's *Valued Voice*.

### ***Preview and input on member education: HCAHPS, patient satisfaction, and opioids***

Court provided the Council with a preview of the next webinar in WHA's series focused on health care leaders' roles in addressing Wisconsin's opioid abuse epidemic. The Council provided input on that webinar, scheduled June 1, which focuses on what HCAHPS (CMS' inpatient-focused Hospital Consumer Assessment of Healthcare Providers and Systems survey) measures regarding patient satisfaction and pain management.

The discussion included the importance of understanding what HCAHPS does and does not measure when considering opioid prevention strategies. A key observation of the Council was that there are likely different and important correlations between unintended opioid prescribing incentives and patient satisfaction surveys depending on whether the surveys are focused on inpatient versus emergency department versus outpatient patient encounters.

### ***Advancing hospital and health system physician leaders to the MEB***

Working to advance hospital and health system physician leaders to the Wisconsin Medical Examining Board (MEB) is another 2016 WHA goal discussed by the Council. The Council expressed support for a de-centralized, but supportive role for WHA to have WHA help advance such physician leaders to this key policy-making board. Members should look forward to an email with more information about how to seek appointment by the Governor to the Medical Examining Board and how WHA can help support such appointments.

## Department of Labor Issues Final Rule on White Collar Exemptions for Overtime

On May 18, the U.S. Department of Labor (DOL) announced that it published its long-awaited final rule updating the exemption of white collar employees from the overtime requirements of the Fair Labor Standards Act (FLSA). Key provisions of the rule include:

- Increases the salary threshold to \$47,476. In order to be considered “exempt” from overtime, executive, administrative, and professional employees who are salaried must be paid \$913 per week or \$47,476 annually. (The current salary threshold is \$23,660 annually.) Up to 10 percent of the threshold may be met by non-discretionary bonuses, incentive pay, and commissions, provided these payments are made on at least a quarterly basis.
- Increases the salary threshold for “highly compensated employees.” The new salary threshold for the “highly compensated employee” exemption is increased from \$100,000 to \$134,004. As under current regulations, a “highly compensated employee” must perform office or non-manual work and must customarily and regularly perform one of the duties specified by the DOL for executive, administrative or professional employees.
- Provides for automatic salary threshold updates. Updates to the new salary thresholds will occur automatically every three years, beginning January 1, 2020. For 2020, the DOL estimates the \$47,476 threshold will increase to \$51,168 and that the threshold for highly compensated employees will increase to \$147,524.
- Does not change the “duties test.” The rule does not change the duties that an employee must perform in order to be exempt from the overtime requirements of the FLSA, nor does the rule change the salary thresholds for outside sales employees or computer professionals.

The final rule goes into effect December 1, 2016. It may be read here: <https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-11754.pdf>. The DOL has released resources regarding the rule, which may be found at <https://www.dol.gov/whd/overtime/final2016>.

As Wisconsin hospitals employ over 100,000 employees at many different compensation levels, this is an excellent time to review exempt classifications of employees. For more information, contact Andrew Brenton, WHA assistant general counsel, at [abrenton@wha.org](mailto:abrenton@wha.org) or 608-274-1820.

## DHS Now Accepting Applications for 2015 Physician Meaningful Use Payments

The state Department of Health Services (DHS) Medicaid EHR Incentive Program is now accepting physician meaningful use applications for Program Year 2015. The application deadline is July 31, 2016.

Last summer, DHS announced the Medicaid EHR Incentive Program would not accept Program Year 2015 applications for meaningful use payments for physicians until further notice. According to DHS, this delay in accepting applications was the result of proposed rulemaking by the federal Centers for Medicare & Medicaid Services (CMS) in the spring regarding modifications to the meaningful use reporting requirements of the Medicare and Medicaid EHR Incentive Programs. After that rule was finalized in the fall, DHS did not accept applications while it updated its attestation system to align with the new reporting requirements.

For Program Year 2015 of the Medicaid EHR Incentive Program, physicians may select as their EHR reporting period any continuous 90-day period between January 1, 2015, and December 31, 2015. Additional information regarding the Medicaid EHR Incentive Program can be found at the Program website or by contacting Medicaid EHR Incentive Program staff at [dhsehrincentiveprogram@dhs.wisconsin.gov](mailto:dhsehrincentiveprogram@dhs.wisconsin.gov).

For more information about the new meaningful use reporting requirements starting in 2015, contact Andrew Brenton, WHA assistant general counsel, at [abrenton@wha.org](mailto:abrenton@wha.org) or 608-274-1820.

## Call for Nominations: 2016 Global Vision Community Partnership Award

**Nominations due to WHA Foundation by July 15**



Honor one of your hospital's community health projects by submitting a nomination for a 2016 Global Vision Community Partnership Award, presented by the WHA Foundation.



This competitive grant award is presented to a community health initiative that successfully addresses a documented community health need. The Award, launched by the WHA Foundation in 1993, seeks to recognize and support ongoing projects that support community health.

Any WHA hospital member can nominate a community health project. The project must have been in existence for a minimum of two years and must be a collaborative or partnership project that includes a WHA member hospital and an organization(s) within the community. The official call for nominations for the 2016 Award is included in this week's packet.

Nominations are due July 15, 2016. Nomination forms can also be found on the WHA website at [www.wha.org/global-vision-comm-partnership.aspx](http://www.wha.org/global-vision-comm-partnership.aspx). For more information about the Award, contact Jennifer Frank at [jfrank@wha.org](mailto:jfrank@wha.org) or 608-274-1820.

### Fast Facts from the WHA Information Center

#### May is National Stroke Awareness Month

According to the Centers for Disease Control, stroke is the fifth leading cause of death in the United States, killing nearly 130,000 Americans each year—that's 1 of every 20 deaths. Someone in the U.S. has a stroke every 40 seconds. Every four minutes, someone dies of stroke. Every year, about 800,000 people in the U.S. have a stroke. About 610,000 of these are first or new strokes; 185,000 are recurrent strokes.

According to the WHA Information Center, in Wisconsin in calendar year 2015 there were 9,997 inpatient admissions, 2,842 emergency room visits (treated and released), 845 observation care visits, and 8,354 hospital ancillary service visits where primary or secondary treatment was for stroke.

Stroke is an important cause of disability and reduces mobility in more than half of stroke survivors age 65 and over. Stroke costs the nation \$34 billion annually, including the cost of health care services, medications, and lost productivity. You cannot control some stroke risk factors, such as heredity, age, gender, and ethnicity. Some medical conditions—including high blood pressure, high cholesterol, heart disease, diabetes, overweight or obesity, and previous stroke or transient ischemic attack (TIA)—can also raise your stroke risk. Avoiding smoking and drinking too much alcohol, eating a balanced diet, and getting exercise are all choices you can make to reduce your risk.

*Data provided by the WHA Information Center ([www.whainfocenter.com](http://www.whainfocenter.com))*

*The WHA Information Center is dedicated to collecting, analyzing and disseminating complete, accurate and timely data and reports about charges, utilization, quality and efficiency provided by Wisconsin hospitals, ambulatory surgery centers and other health care providers.*



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Program	2019	2020	2021	2022	2023	2024	2025	2026
Annual Payment Update	+0.5%	0%	0%	0%	0%	0%	0%	APM: 0.75% Others: 0.25%
MIPS at-risk payment	+/- 4%	+/- 5%	+/- 7%	+/- 9%	+/- 9%	+/- 9%	+/- 9%	+/- 9%
MIPS bonus	≤ 10%	≤ 10%	≤ 10%	≤ 10%	≤ 10%	≤ 10%		
APM (bonus)	+ 5%	+ 5%	+ 5%	+ 5%	+ 5%	+ 5%		
Maximum Potential Increase	MIPS: 14.5% APM: 5.5%	MIPS: 15% APM: 5%	MIPS: 17% APM: 5%	MIPS: 19% APM: 5%	MIPS: 19% APM: 5%	MIPS: 19% APM: 5%	MIPS: 9% APM: 0%	MIPS: 9.25% APM: 0.75%
Maximum Potential Reduction	MIPS: 4% APM: 0%	MIPS: 5% APM: 0%	MIPS: 7% APM: 0%	MIPS: 9% APM: 0%	MIPS: 9% APM: 0%	MIPS: 9% APM: 0%	MIPS: 9% APM: 0%	MIPS: 9% APM: 0%

Source: American Hospital Association

### **CMS Releases Proposed Rule**

A proposed rule released by the Centers for Medicare & Medicaid Services (CMS) April 28 includes provisions for the MIPS and APM components of MACRA. MIPS will apply to physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists, including those who bill under Critical Access Hospital Method II billing.

The MIPS portion replaces the existing PQRS and calls for providers to report on six quality measures. Providers will also be required to report Clinical Practice Improvement Activities (CPIAs), choosing from a list of 90 options. The program also includes cost measures, which will be calculated by CMS using Medicare claims. Finally, MIPS includes a component called “Advancing Care Information,” which will replace the existing Medicare meaningful use program.

Clinicians who are enrolled in a CMS-approved APM will be exempt from participation in MIPS. An eligible APM entity must bear financial risk for monetary loss (more than nominal amount) or be a primary care medical home. An eligible APM must require use of certified electronic health record (EHR) technology and provide payment based on quality measures comparable to those in the MIPS quality category.

The initial six APM models that are proposed in the rule are: Comprehensive Primary Care Plus (CPC+); Medicare Shared Savings-Track 2; Medicare Shared Savings-Track 3; the Next Generation ACO Model; Comprehensive End-Stage Renal Diseases Care Model; and the Oncology Care Model Two-Sided Risk Arrangement.

The proposed rule also details some of the work of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review and assess additional physician-focused payment models suggested by stakeholders. Jeff Bailet, MD, president, Aurora Health Care Medical Group, chairs this new advisory committee.

### **WHA Engagement**

WHA’s goal is to ensure members have the information and tools they need to participate in MIPS and APMs, as necessary and/or to decide their level of engagement. As with any important initiative of this kind, WHA will stay on top of federal rules and regulations, submitting comments on behalf of our members to help improve the policy direction as needed. The work of MACRA may evolve to include legal, reimbursement, data and other issues that will be addressed by WHA’s staff and existing councils.

*(continued on page 11)*

## **Continued from page 10 . . . WHA Prepares for MACRA as Proposed Rule is Released**

WHA is fortunate to have a team of physician leaders working with us through our Physician Leaders Council, and we will work with those physician leaders to help guide our policy, education and communication efforts. The Council had preliminary discussion on the proposed rules at its meeting May 18. Council members will be providing feedback to WHA staff in the coming month, which will be incorporated into formal comments to CMS. WHA is also fortunate to have Dr. Bailet as chair of the PTAC, and we look forward to working with him.

WHA will also continue to develop its new subsidiary, Physician Compass, created as a joint venture with the Wisconsin Collaborative for Healthcare Quality, to position itself to be a quality improvement resource and reporting vehicle for physicians, both employed and independent, in the new MACRA world.

As WHA rolls out its MACRA activities, watch for a series of webinars later in 2016, which will cover the basic information members need to know about MIPS and APMs, and to address the elements that hospitals and physicians should consider preparing to be ready for these programs.

The new MACRA program will affect all providers and health systems to a varying degree, making it important to understand the program and determine the appropriate way to participate. WHA members can provide input to Joanne Alig, WHA senior vice president, at [jalig@wha.org](mailto:jalig@wha.org) or Kelly Court, WHA chief quality officer, at [kcourt@wha.org](mailto:kcourt@wha.org).