WISCONSIN HOSPITAL ASSOCIATION

The Valued Voice

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WHA Opposes Bond Provision in House Tax Bill

PABs tax exemption eliminated for not-for-profits

A fast-moving tax reform package released by the U.S. House of Representatives Ways & Means Committee includes a provision to eliminate the tax exemption for private-activity bonds (PABs) for certain entities, including qualified 501(c)(3) organizations. The Wisconsin Hospital Association opposes this provision and relayed its opposition to the Wisconsin Delegation.

"These bonds play a critical role in helping not-for-profit hospitals and health systems access low-cost capital, enabling them to keep infrastructure expenditures low so they can efficiently fulfill their mission and focus on the work they do for the public good," said WHA President/CEO Eric Borgerding in a statement.

Under Section 3601 of the House tax legislation, HR 1, interest on newly issued PABs would be included in income and thus subject to tax. Section 3601 would be effective for bonds issued after 2017.

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WI Health News Panel: Wisconsin Worker's Comp Works Now Without a Fee Schedule

The facts and data show the Wisconsin Worker's Compensation program is working well. That's the message from the Wisconsin Hospital Association (WHA) and the Wisconsin Medical Society during a panel discussion moderated by Wisconsin Health News Editor Tim Stumm, November 7 in Madison.

Joanne Alig, WHA senior vice president, policy & research, joined Mark Grapentine, senior vice president of government relations, Wisconsin Medical Society; Charles Burhan, assistant vice president and senior public affairs officer, Liberty Mutual; and Chris Reader, director, health and human resources policy, WMC, to discuss the latest proposal to implement a medical fee schedule in Wisconsin.

In his introductory comments, Reader noted one reason Wisconsin should want a fee schedule is that 44 other states have found that as a policy solution to rising medical costs.

But Alig questioned that logic. "Just because 44 other states have a fee schedule, why should we?" She noted that premiums have been coming down in Wisconsin—8.46 percent starting October 1, on top of 3.19 percent the year before—resulting in about $220

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Guest Column

This column appeared in the Wisconsin State Journal November 3, 2017.

Inside Wisconsin Measuring quality: Why health care can attract business, workers

By: Tom Still, Wisconsin Technology Council

Tom Still

Every few years someone in state government laments, "We need a better brand for Wisconsin!" Cabinet secretaries scurry about, agency communications directors scratch their heads over possible slogans and marketing campaigns go largely unfunded.

Here's an idea: Let's talk about Wisconsin's tangible business assets without making it all about tourism and cheese (as much as Badger state loyalists value both).

One such asset is quality health care, a commodity largely taken for granted inside Wisconsin and largely unknown to people and companies who may be thinking of moving or expanding here.

Much like an educated workforce, reliable public utilities and affordable business costs for land and talent are worth bragging about, so is quality health care. That's the conclusion of a report issued this month by the Wisconsin Technology Council.

"Taking the pulse: How quality health care builds a better bottom line" examined leading indicators of health-care quality, based on public and private data. It also compared quality rankings to costs. Key findings were:

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NPR's Mara Liasson to Keynote Advocacy Day 2018 on March 21

Registration now open!

Mara Liasson

Each year, the WHA Advocacy Day event grows both in number of attendees and in the impact made on our legislators in Madison. Advocacy Day is one of the best ways hospital employees, trustees and volunteers can make an important, visible impact in the state capitol. Help make the 2018 event a great success by assembling your hospital contingent for 2018 Advocacy Day, set for March 21, at the Monona Terrace in Madison. Registration is now open at www.whareg4.org/2018AdvocacyDay.

As always, Advocacy Day 2018 will have a great lineup of speakers, including morning keynote Mara Liasson, national political correspondent for National Public Radio (NPR). Her reports can be heard regularly on NPR's award-winning newsmagazines, *All Things Considered* and *Morning Edition*. Liasson provides extensive coverage of politics and policy from Washington, DC, focusing on the White House and Congress. As the 2018 Advocacy Day keynote speaker, Liasson will explore the current political climate and health policy, discuss what it means for America, and what impacts individuals, communities and health providers might expect during the next few years.

The annual legislative panel discussion will round out the morning session, followed by a luncheon keynote address from Gov. Scott Walker (invited). The highlight of Advocacy Day is always the hundreds of attendees who take what they've learned during the day and then meet with their legislators in the state capitol in the afternoon. In fact, over 650 visits were made last year that directly impacted the outcomes of priority legislation. Speaking up on behalf of your hospital by meeting with your legislators during Advocacy Day is essential in helping educate legislators on your hospital and on health care issues.

Join over 1,100 of your peers from across the state at Advocacy Day 2018 on March 21. More information and online registration are available at www.whareg4.org/2018AdvocacyDay. For Advocacy Day questions, contact Jenny Boese at 608-268-1816 or *jboese*@*wha.org*. For registration questions, contact Kayla Chatterton at *kchatterton*@*wha.org* or 608-274-1820.

Assembly, Senate Wrap Up Fall Floor Session

WHA-led team-based care, behavioral health priorities move forward

Wisconsin's Assembly and Senate wrapped up their work for this fall legislative session by approving two key WHA legislative priorities, including legislation to reform Wisconsin's emergency detention law and legislation clarifying the ability for advanced practice clinicians and other providers to order services for Medicaid enrollees. The Legislature can come back in 2018 for three general business floorperiods in January, February and March before they adjourn the entire 2017-2018 biennial legislative session.

On the evening of November 7, the Senate unanimously approved Assembly Bill 529, legislation that clarifies a section of Wisconsin state law referencing the ability for providers to order services for Medicaid patients. The bill, which was drafted by the Wisconsin Department of Health Services (DHS) and is supported by WHA, provides better clarification to health care providers that Wisconsin's Medicaid program recognizes orders made by physicians and non-physician providers alike. WHA led a coalition memo and testified in support of the bill at both the Senate and Assembly hearings. Months ago, WHA met with DHS to begin discussing solutions to address the concerns being addressed by this legislation.

The bill does not change any provider's scope of practice and maintains the already recognized Medicaid policy acknowledging valid orders made within a provider's scope of practice under statutes, rules and regulations governing the provider's practice.

Prior to being approved by the Senate, Assembly Bill 529 passed through the state Assembly November 2. The bill will now be sent to Gov. Scott Walker for his signature—which is expected to occur in the coming weeks. ***(continued on page 3)***

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In addition, the Assembly unanimously approved Assembly Bill 538, a WHA-led bill reconciling Wisconsin's emergency detention law with federal EMTALA (Emergency Medical Treatment and Active Labor Act) requirements for appropriate transfers of patients and providing additional liability clarity for health care providers treating patients during a mental health crisis. The bill has been in development for several years in conjunction with WHA, the Wisconsin Counties Association and in consultation with law enforcement organizations.

Assembly Bill 538 was led by a bipartisan group of four lawmakers: Reps. John Jagler (R-Watertown) and Eric Genrich (D-Green Bay) and Sens. Rob Cowles (R- Green Bay) and Janis Ringhand (D-Evansville). The bill passed unanimously out of the full Assembly November 9.

Wisconsin Tied for 4th in the Nation for Most Top-Rated Health Plans

Provider-owned plans lead the way

Provider-owned health plans serving the commercial market were rated the best in Wisconsin by the National Committee for Quality Assurance (NCQA). NCQA noted Wisconsin is among the states with the highest percentage of high-quality health plans, and it placed Wisconsin in a tie for 4th among the states with the highest number of plans receiving a top rating.

The NCQA ranked more than 1,000 health insurance plans based on clinical quality, member satisfaction and NCQA Accreditation Survey results. The report notes their rating system emphasizes care outcomes and what patients say about their care.

"Wisconsin is fortunate to have choices and competition in our insurance market, unlike other states where one or two big, national insurance companies dominate and dictate the market," said WHA President/CEO Eric Borgerding. "In a state known for high-quality health care, it is not surprising the highest-rated health plans are provider-owned and based right here in Wisconsin."

See all NCQA health insurance plan ratings at http://healthinsuranceratings.ncqa.org/?uthttp://healthinsuranceratings.ncqa.org/2017.

Private/Commercial	Type	Rating
Dean Health Plan, Inc.	HMO	4.5
Group Health Cooperative of South Central Wisconsin	HMO	4.5
Gundersen Health Plan	HMO	4.5
HealthPartners Administrators, Inc.	HMO/POS/PPO	4.5
HealthPartners, Inc.	HMO/POS/PPO	4.5
Security Health Plan of Wisconsin, Inc.	HMO/POS	4.5
Unity Health Plans Insurance Corporation	HMO/POS	4.5

Medicare	Type	Rating
Group Health Plan, Inc.	HMO	5.0
Gundersen Health Plan, Inc.	HMO	5.0
Medical Associates Clinic Health Plan of Wisconsin dba Medical Associates Health Plans	HMO	5.0
Aetna Life Insurance Company (Wisconsin)	HMO	4.5
Dean Health Plan, Inc.	HMO	4.5
Network Health Insurance Corporation (NHIC)	HMO	4.5
Security Health Plan of Wisconsin, Inc	HMO/POS	4.5

Ratings based on NCQA Health Insurance Ratings 2017-2018. *Plans with partial or no data reported did not receive a rating.*

Quality Payment Program Final Rule Issued November 2

Last week, the Centers for Medicare and Medicaid Services (CMS) released the final rule for year two of the Quality Payment Program (QPP; also known as MACRA). This rule, which is of great importance to WHA members and their covered providers, will go into effect January 1, 2018. In the final rule, CMS heeded many of the comments submitted by WHA and other commenters that continues the incremental, flexible implementation of QPP called for by hospitals, health systems and the employed and contracted physicians with whom they partner to deliver care.

Highlights of the final rule include the following:

- Raised the low volume threshold in 2018 for required participation in the Merit-Based Incentive Program (MIPS) to $90,000 and over in Medicare Part B allowed charges and 200 or more Part B beneficiaries (up from $30,000 in Part B charges and 100 beneficiaries in 2017). CMS anticipates that this increase in the low-volume threshold will exclude 134,000 more clinicians than would have been excluded under the previous low-volume threshold, which means that many more clinicians no longer must demonstrate meaningful use of EHR technology in order to avoid Medicare penalties.

- Adjusted the weights to the 2018 MIPS final score as follows:
  - » Cost: 10 percent (increased from 0 percent in 2017)
  - » Quality: 50 percent (decreased from 60 percent in 2017)
  - » Improvement activities: 15 percent (same as 2017)
  - » Advancing care information: 25 percent (same as 2017)

- Changed the method and timing of removing topped-out measures. Topped-out measures are those measures that the whole country is scoring at or very close to the highest possible score (usually 100 percent). They get removed because there is no further opportunity to improve care around that measure. Under the final rule, topped-out measures will be removed and scored on a four-year phasing out timeline. Topped out measures with measure benchmarks that have been topped out for at least two consecutive years will earn up to 7 points.

- Added virtual groups as a way to participate in MIPS for 2018. Virtual groups may be made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together virtually to participate in MIPS for a one-year performance period.

- Added a complex patient bonus where clinicians can earn up to 5 bonus points for the treatment of complex patients.

- Added a small practice bonus, which will add 5 points to any MIPS-eligible clinician or small group who is in a small practice (defined as 15 or fewer eligible clinicians), as long as the MIPS-eligible clinician or group submits data on at least one performance category in an applicable performance period.

- Extended the 8 percent revenue-based standard under the Alternative Payment Model (APM) Program for two additional years, through performance year 2020. The revenue-based standard is the risk assumed under the APM which is equal to at least a percentage of estimated Parts A and B revenue of the participating APM entities for the performance period.

- Provided an additional year to the phase-in period for the total potential risk for an APM entity under the Medical Home Model standard. The following percentages will apply to the estimated average total Medicare Parts A and B revenues of all providers and suppliers in participating APM entities that will be at risk:
  - » 2.5 percent for performance year 2018
  - » 3 percent for performance year 2019

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  - » 4 percent for performance year 2020
  - » 5 percent for performance years 2021 and after

- Modified the timeframe on which to consider the Medicare fee-for-service payment amounts and patient counts for certain advanced APMs. For advanced APMs that start or end during the performance period (January 1 - August 31 of each year) threshold scores are calculated using dates that the APM entity was able to participate in an advanced APM, as long as they were able to participate for at least 60 continuous days during the applicable QP performance period.

- Added a provision that payers may submit payment arrangements authorized under Medicaid, Medicare Advantage and payment arrangements aligned with a CMS multi-payer model. Payers will also be able to request that CMS make other payer advanced APM determinations before the relevant performance period.

Resources on the QPP are available on the WHA website at www.wha.org/macra.aspx. For additional information on the final rule for year two and other QPP issues, contact Kelly Court, WHA chief quality officer, at *kcourt*@*wha.org*, or Laura Rose, WHA vice president, policy development, at *lrose*@*wha.org*.

CMS Releases Final 2018 Physician Payment Rule

Rule includes policy changes affecting hospital outpatient departments, PQRS measures, telehealth services

The Centers for Medicare & Medicaid Services (CMS) issued its final rule for the physician fee schedule (PFS) for calendar year 2018. In addition to increasing physician payment rates for 2018 by an estimated 0.41 percent compared to 2017, the final rule makes a number of important policy changes, including in the areas of hospital outpatient departments in the context of Section 603 of the Bipartisan Budget Act of 2015, required measures under the Physician Quality Reporting System, payable telehealth services and the value modifier program.

Hospital outpatient departments

Unfortunately, CMS continued to make changes to its policy implementing Section 603 of the Bipartisan Budget Act of 2015, which impacts various provider-based, off-campus hospital outpatient departments (HOPDs). Under the statute and subsequent regulations, CMS finalized in its rules that services furnished in impacted HOPDs were no longer able to bill under the outpatient prospective payment system (OPPS), but under the physician fee schedule at 50 percent of its previous OPPS rate. The good news is that in its 2018 PFS rule, the agency did not finalize its proposal to cut payments even further—to 25 percent of the OPPS rate—for non-excepted services in 2018. However, the bad news is that CMS did finalize an additional cut for these services, taking reimbursement down from the current 50 percent of the OPPS rate to 40 percent of those rates.

WHA continues to believe the analysis CMS used to formulate this most recent payment cut is deficient. Further, WHA believes the way CMS operationalized Section 603 in 2017 is overly restrictive and negatively impacts hospitals and health systems from locating services where those services are needed. This is especially problematic for rural areas.

Reduction in PQRS measure burden

While data submission for the CY 2018 Physician Quality Reporting System (PQRS) has passed, CMS will retroactively lower the number of required measures from nine to six to more closely align the program with the new Merit-based Incentive Payment System that will affect payment starting in CY 2019. WHA expressed its support for this provision in a September 11, 2017 comment letter to CMS.

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Other positive policy changes

In the final rule, CMS adds two new services to the list of telehealth services that are payable under Medicare: psychotherapy for crisis and counseling visits to determine low-dose computed tomography. In addition, CMS finalizes a policy to pay for the following services that are billed to Medicare as add-ons to codes already on the telehealth list:

- Interactive complexity;
- Administration of patient-focused health risk assessment instrument;
- Administration of caregiver-focused health risk assessment instrument for the benefit of the patient; and,
- Comprehensive assessment of and care planning for patients requiring chronic care management services.

CMS also lowers the maximum negative payment adjustment under the CY 2018 value modifier (VM) program from 4.0 percent to 1.0 percent for individual clinicians and groups of under 10 clinicians, and to 2.0 percent for groups of 10 or more clinicians. In addition, only those clinicians and groups failing to report data would experience a negative VM adjustment. WHA also expressed support for changes that reduced these penalties as providers transition to the new Quality Payment Program. Finally, the final rule delays until January 1, 2020, the appropriate use criteria program for advanced diagnostic imaging services.

Northwest WI Health Care Coalition Conducts Virtual Emergency Prep Exercise

Increased emergency preparedness exercise requirements from the Centers for Medicare and Medicaid Services and The Joint Commission, in conjunction with limited hospital and health system staff time and resources led the Northwest Wisconsin Health Care Coalition and Western Wisconsin Public Health Readiness Consortium to conduct its first virtual, community-based exercise November 6 and 7. The "Big Bad Thing" exercise simulated a ransomware cyberattack resulting in widespread power outages and telecommunication failures in the upper Midwest health care sector.

On November 6, exercise participants were alerted that a "Big Bad Thing" was going to happen the following day. On November 7, participants were guided through the exercise by logging into the web-based Adobe Connect platform. As situation reports were added to the scenario by the controller, Aimee Wollman Nesseth, coordinator of the Northwest Wisconsin Health Care Coalition, each participating organization played out the exercise in its own facility. The exercise encouraged participants to discuss and identify gaps in their plans and included the expectation of reaching out to community partners, which would be essential in a real-life shelter-in-place or evacuation scenario.

Participants in the exercise included hospitals, skilled nursing facilities, home health and hospice agencies, and local public health departments.

"We had partners participating from throughout the 15 counties in the region comprising the Northwest Wisconsin Health Care Coalition," said Wollman Nesseth. "This virtual exercise was a great example of how the health care coalition model can build community and regional partnerships across the health care sector."

Gov. Walker Proclaims November 16 Wisconsin Rural Health Day

In a proclamation, Gov. Scott Walker declared November 16 Wisconsin Rural Health Day in honor of National Rural Health Day, to recognize the unique contributions of our rural communities and the health care providers that serve these communities. This is the seventh annual National Rural Health Day, and WHA is once again one of the cosponsors, along with the Wisconsin Office of Rural Health.

The Proclamation acknowledges that rural hospitals are sources of innovation and resourcefulness and are typically the economic foundation of their communities.

Earlier this year, Wisconsin's critical access hospitals (CAHs) were recognized as the best in the nation by the federal Health Resources and Services Administration (HRSA) for outstanding quality performance.

"Rural hospitals provide a safety net of care that reaches every corner of our state," according to WHA President/CEO Eric Borgerding. "We know rural hospitals support the physical well being of the people living in that area, but they are also a critical asset to the economic health of the community. They are an essential part of our high-quality delivery system."

View the proclamation at www.wha.org/pdf/2017RuralHealthDayProclamation.pdf.

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An entity in Wisconsin that has assisted many hospitals and health systems with PABs for decades is the Wisconsin Health & Educational Facilities Authority (WHEFA). WHEFA is a public Authority created by the Wisconsin Legislature in 1973 and authorized it to provide PABs to Wisconsin non-profit health care institutions in 1979. WHA joins WHEFA and many national groups in opposing this drastic provision.

On November 9, the House Ways & Means Committee approved the legislation on a party-line vote of 24-16. The legislation is expected to move quickly to the House floor for a vote in the coming week. Unless changed in the House Rules Committee, the package is unamendable on the House floor. The U.S. Senate Committee also released its tax reform package November 9. WHA is pleased to see their proposal does not include the PAB provision. Assuming both the Senate and the House pass their respective tax proposals, the final dispensation of PABs will come during negotiations between the two Chambers.

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Wisconsin is consistently one of the top states for quality health care, as measured by 200 metrics compiled by the federal Agency for Healthcare Research and Quality. It ranked No. 1 in the nation in 2017. In the seven-state region surrounding or within a day's drive of Wisconsin, only two other states (Iowa and Minnesota) ranked in the top quartile. Wisconsin has ranked no lower than 7th nationally since 2006.

Wisconsin ranked just $3 above the national median ($4,666 versus $4,663) in the average employer share of single premium health insurance in 2015. That placed the state in the second-lowest cost quartile among the 50 states. Wisconsin was $800 above the national median ($13,187 versus $12,387) in the average employer share of family premium health insurance for the same year, still outside the most expensive quartile.

Wisconsin health insurance premiums are growing slower than other states in the seven-state region and the nation, especially since 2010. For single coverage, the cost increase has averaged 2.2 percent per year versus 3.8 percent nationally. Wisconsin ranked second best in the nation in this category. For family coverage, the cost increase has averaged 4 percent versus 4.5 percent nationally. Wisconsin is tied for 10th nationally in controlling the growth in family coverage premiums since 2010.

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Wisconsin also ranks favorably in national and regional comparisons of deaths that could have been avoided by proper health care, Medicare 30-day hospital readmissions, hospital length of stays, mean inpatient charges, the percentage of the total population covered by health insurance and use of electronic health records. All are rankings that speak to quality while controlling costs.

The logjam over Obamacare in Washington. D.C., has upended the health insurance market as companies and workers come to grips with rising costs. That confusion is playing out this fall in Wisconsin and elsewhere as group health plan enrollments come due for employers and employees alike.

One potential asset for Wisconsin is that it's not a captive health insurance market. The report revealed that Wisconsin is one of only two states (New York is the other) in which the three largest insurers control less than 60 percent of the market. Other states in the seven-state region showed "top three" insurance market shares ranging from 67 to 97 percent. The U.S. median is 90 percent. More choice may lead to more competition over time, even if Obamacare is dismantled.

Employers have a right to complain about health care costs, but they aren't powerless to control the rate of increase or the outcomes.

As the report noted, individual companies, groups of companies or institutions have found ways to work with health systems. This is often accomplished through on-site clinics, incentive programs and prevention strategies that engage employees. Results include lower rates of absenteeism and people showing up sick; avoiding procedure costs through preventive care; and lower costs of care due to better physical fitness and health habits.

Examples cited in this report include Colony Brands and Monroe Clinic; Ashley Furniture and Gundersen Health System; Hoffmaster and Thedacare; Organic Valley and Vernon Memorial Healthcare; Northeast Wisconsin Technical College and Bellin Health; a collection of companies working with Columbus Community Hospital; and a mix of Chippewa Valley institutions working with Mayo Clinic.

Quality health care is not only nice to have; it's an asset in the state-to-state race to attract and retain companies and workers. Let's market one of the things Wisconsin does best.

Find at: http://wisconsintechnologycouncil.com/2017/inside-wis-measuring-quality-why-health-care-can-attract-business-workers.

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million in savings to employers over the past two years. Grapentine added that in October when the rates took effect, it was the health care sector that was touting what a great benefit that was to Wisconsin business.

Alig also took issue with the basic premise that medical costs in Wisconsin are higher than other states. She noted the Worker's Compensation Research Institute (WCRI) adjusts their data, automatically resulting in Wisconsin's costs looking higher compared to the other 18 states it includes in its study. Alig pointed out that WCRI has at least four different numbers on how Wisconsin compares to other states on medical costs per claim, all depending on how the data is displayed. Rather, relying on data from the National Council of Compensation Insurance (NCCI) and looking at the last three years of data, Alig said Wisconsin is below the national average.

The fee schedule, as proposed by the Worker's Compensation Advisory Council, would take rates negotiated between health insurers in the group market and providers, and apply those rates to the worker's compensation program. Burhan noted that "most employers cannot negotiate in worker's

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compensation." Burhan went on to say they believe they need the state to help them negotiate.

L to R: Chris Reader, Director, Health and Human Resources Policy, WMC; Charles Burhan, Assistant Vice President and Senior Public Affairs Officer, Liberty Mutual; Joanne Alig, WHA Senior Vice President, Policy & Research; Mark Grapentine, Senior Vice President of Government Relations, Wisconsin Medical Society

Alig and Grapentine both explained that the worker's comp program is looking for the same discounts that group health receives; however, the proponents of a fee schedule take no interest in doing the hard work to reduce the "worker's comp industrial complex" that operates behind the scenes and adds costs to the system. They both noted there is a give and take in negotiations. Alig pointed out that group health insurers negotiate lower prices with providers based on factors such as prompt payment.

"In the worker's comp program, only 8 percent of the claims are paid within 30 days. In group health, over 70 percent of the claims are paid in 30 days," Alig said. "No other business would wait 12 to 18 months to get paid."

They also pointed out the loss ratio in worker's comp is 62 percent. "That means 38 percent or about $760 million is going to insurers' administrative costs and profit," Alig said. Grapentine added that it would be "fair to have transparency in that area."

Grapentine also emphasized that injured employees have rapid access to care and treatment, they return to work three weeks faster than the national average, they receive the highest quality of care and the program's medical costs are at the national average.

According to Reader, however, health care shouldn't take any credit for the great return to work statistics.

"No doubt we have excellent care," he said. "But that's not why workers get back to work faster."

WHA and WMS took issue with that sentiment. Grapentine described a recent op-ed that highlights the difference in opinion. "Management said that it's laughable that health care would have anything to do with getting people back on the job. That's the difference between where health care is, taking care of patients and concentrating on patients, which is every chiropractor and PT and physician and hospitals' number one job."

"We are just really proud of health care overall, when it comes to taking care of people, and we don't think we need to take a sledgehammer to the system," Grapentine said.

Alig said if a fee schedule goes into effect, injured patients will still get high-quality care."We are number one in the country, and it's what we do in Wisconsin," she said. "But, if a fee schedule goes into effect, we won't have done the hard work of getting at the underlying costs of the system."