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Telehealth Bill Advances to Governor Evers' Desk

The Wisconsin State Assembly unanimously approved important telehealth improvement legislation Nov. 7, approving Senate Bill 380 on a voice vote. With the State Senate having approved the bill earlier that week, the legislation is now eligible for final action from Gov. Tony Evers. The Governor's approval is expected, with the bill enjoying 67 bipartisan cosponsors.

"Telehealth is one of the most rapidly-growing areas of health care, and we sincerely thank the Assembly for today's approval," said WHA President & CEO Eric Borgerding in a statement following the Assembly vote. "The bipartisan recognition that enhancing telehealth services can allow more patients in both rural and urban settings to access our state's high-quality health care in a cost-effective way is the kind of forward thinking all of Wisconsin can appreciate."

Numerous studies, including Wisconsin's own state employee health insurance program, have determined that creating access to care through telehealth is a cost-effective strategy for the state's Medicaid program. The legislation is the culmination of three years of work by WHA's Telemedicine Work Group, and includes provisions implementing the work group's four recommendations for the state's Medicaid program:

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WHA Urges WI Congressional Delegation to Support Federal Telehealth Reform

"CONNECT for Health" Act would break down Medicare barriers to telehealth

With state Medicaid modernization legislation nearing its final stretch before being signed into law, WHA is turning attention to much-needed federal reforms to reduce barriers to telehealth in Medicare. WHA was in Washington, D.C. Oct. 29 to discuss a number of issues, including the need for Medicare telehealth reform. In a follow-up letter sent Nov. 6, Eric Borgerding, WHA president and CEO, urged Wisconsin's Congressional Delegation to sign on to new bipartisan legislation being introduced in the U.S. House and Senate to modernize how Medicare covers telehealth.

In the letter, Borgerding noted the work of WHA's Telemedicine Work Group which included nearly 40 members from across the state of Wisconsin and met several times over the last three years. Using their recommendations, WHA crafted bipartisan state legislation that will break down significant barriers to telehealth in the Medicaid program and allow any covered Medicaid service to be provided via telehealth if it can be offered in a functionally-equivalent manner as a face-to-face visit. It will also allow Medicaid to cover telehealth services in any setting – rural or urban – including a patient's home. While WHA is eagerly awaiting this state legislation to be passed and signed into law in the near future, significant barriers will remain in the federal Medicare program which currently covers only limited services provided in a rural, health professional shortage area, and even then will not reimburse for telehealth delivered to a patient's home or other non-clinical setting.

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(WHA Urges WI Congressional Delegation to Support Federal Telehealth Reform . . . continued from page 1)

The CONNECT for Health Act of 2019 would not entirely eliminate the above-mentioned barriers to telehealth, but it would significantly improve telehealth coverage under Medicare and will help build momentum toward their eventual removal. Some of the main improvements include:

- Stating that Congress has found research suggesting telehealth can expand access to care, reduce workforce shortages, improve the quality of care and reduce spending.
- Expressing the sense of Congress that barriers to telehealth should be removed.
- Allowing the Secretary of Health and Human Services to waive barriers to telehealth if certain criteria are met.
- Allowing behavioral health telehealth to be covered by Medicare in any setting (urban and rural) including in a person's home.
- Removing geographic barriers by allowing EMS telehealth services to be covered in both rural and urban settings.
- Allowing telehealth to be delivered by and originate at Federally Qualified Health Centers (FQHCs) and rural health clinics.
- Providing flexibility for telehealth in hospice care.
- Requiring the Medicare Payment Advisory Commission (MEDPAC) to study the benefits of allowing Medicare to cover telehealth delivered to a patient's home.

WHA is one of more than 120 organizations nationally who have endorsed this legislation. Contact WHA Director of Federal and State Relations Jon Hoelter for more details.

CMS Finalizes 2020 Physician Fee Schedule Rule

Each year, the Centers for Medicare & Medicaid Services (CMS) updates the payment policies, payment rates and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) for the upcoming year. On Nov. 1, CMS published the final 2020 Medicare Physician Fee Schedule Rule for calendar year 2020. The rule incorporates many positive changes that WHA and other commenters suggested. Key provisions of the final rule include:

Evaluation and Management (E/M) Documentation Revisions and Payment Changes. In this final rule, CMS retreated from last year's controversial rule which would have paid a blended rate for Levels 2 through 4 E/M visits. In 2020, CMS will assign separate payments to all E/M visit levels for new and established patients. This change was strongly supported by WHA. For new patients, there will be four visit levels (Levels 2 through 5). Level 1 is eliminated for new patients; Level 1 visits only describe or include visits performed by clinical staff for established patients. This results in four visit levels for new patients (Levels 2 through 5) and five levels for established patients (Levels 1 through 5). CMS will require histories and exams only when medically necessary. Clinicians will instead use medical decision making or time with the patient to determine the appropriate level of an E/M visit.

CMS is also adopting the American Medical Association's recommended valuations for all E/M codes, which will increase payment for the codes above the payment amount that would have resulted from a blended payment rate had it gone into effect.

Further, CMS extended to additional types of clinicians the flexibilities finalized in last year's rule, which permitted physicians, residents and nurses to document a teaching clinician's presence during the time the teaching clinician participates in services involving residents, rather than requiring the teaching clinician to document this information him or herself. WHA expressed strong support for these changes.

Myocardial PET scan payments. In the final rule, CMS backed away from its proposed significant reductions to the relative value units the code set that describes myocardial PET scans. As stressed by WHA and many other commenters, CMS agreed the proposed pricing would result in significant reductions in payment and said there is substantial work to be done to assure the new valuations for the technical components of these codes accurately reflect the technical inputs. In the interest of maintaining payment stability and protecting patient access to these important services, CMS is delaying the adoption of active pricing for these codes until such time as more accurate sets of inputs can be developed.

Coinsurance for Colorectal Cancer Screening Tests. CMS requested comment on whether it should introduce a notification requirement under which physicians, or their staff, would be required to inform beneficiaries before a colorectal cancer screening that they may incur a coinsurance payment if the physician discovers and removes polyps. WHA strongly recommended that CMS use its existing resources to inform beneficiaries of their possible coinsurance requirement, and that it is inappropriate to require providers to make this notification.

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(CMS Finalizes 2020 Physician Fee Schedule Rule . . . continued from page 2)

In response, CMS said it intends to undertake a comprehensive review of all their outreach materials, such as the Medicare & You Handbook and Medicare Preventive Services, to see if Medicare policies on payment and coverage for screening colonoscopies can be made clearer.

Payment for Therapy Services. CMS finalized a proposal implementing claims modifiers to identify therapy services furnished in whole or in part by physical therapy and occupational therapy assistants, as required by statute. If 10% or more of services in a therapy visit are furnished by a PT or OT assistant, the visit must be coded with a modifier which indicates that. Once the modifiers attach, the visit would be paid at the 85% of the PT/OT reimbursement rate. The new coding requirements would take effect in the 2020 payment year. Payment cuts would be effective in the 2022 payment year.

In the final rule, responding to comments by WHA and others, CMS revised its proposed policy regarding payment of therapy services furnished concurrently by physical therapists/PT assistants and occupational therapists/OT assistants. In the final rule, the time spent by a PTA/OTA furnishing a therapeutic service "concurrently," or at the same time, with the therapist will not count for purposes of assessing whether the 10% standard has been met. Only the minutes that the PTA/OTA spends independent of the therapist will count toward the 10% de minimis standard.

Quality Payment Program (MACRA) Changes. In its comments to the proposed rule, WHA supported many of CMS' changes to the Merit-Based Incentive Payments (MIPS) categories of Quality, Cost/Resource Use, Promoting Interoperability, and Improvement Activity, with the exception of adding 10 new measure to the cost category. WHA was pleased to see that CMS acknowledged, in the final rule, WHA's and other's concerns about the cost measures by maintaining the cost category weight at 15% for the 2020 MIPS performance year, rather than increasing it to 20% as initially proposed. WHA urged CMS to maintain the cost category at 15% until clinicians have experience with a correct mix of cost measures, and until more cost measures are endorsed by the National Quality Forum.

MIPS Value Pathways (MVPs). CMS finalized a proposal to create a framework known as MIPS Value Pathways (MVPs) to remove barriers to participation in Alternative Payment Models, move toward alignment of measures relevant to a clinician's scope of practice, and focus on cost and quality and improvement activities built on population health measures. CMS will develop the MVPs framework in future rulemaking, in consultation with stakeholders. CMS sees implementation beginning in 2021 and suggests that it may be 3-5 years before a transition to the new framework is complete. WHA expressed concern with beginning implementation in 2021. WHA will investigate how CMS will seek stakeholder feedback and report back to our members on this process.

For more detailed information or questions about the final rule, contact WHA Vice President of Policy Development Laura Rose.

Dr. Mark Thompson, WHA Board Member, Assumes New Role at SSM Health


Mark Thompson, MD

Mark Thompson, MD, a member of the WHA Board of Directors, was recently named President, Medical Groups - SSM Health Wisconsin Region. In this role, Mark will be responsible for directing physician and advanced practitioner services within SSM Wisconsin's ambulatory settings including those of the Dean Medical Group, Monroe Clinic, Agnesian Employed Physicians and contracted external physicians. Dr. Thompson will be especially focused on medical group integration and strategy. "We will continue to deliver high-quality and high-value care across all of our settings, along with innovative care delivery options that patients are looking for," Dr. Thompson said.

Prior to taking on this new role at SSM Health, Dr. Thompson was the Regional CMO of SSM Health Wisconsin Region. As Regional CMO, Mark's purview included patient safety, clinical quality and the integration of SSM Health hospitals and medical groups. SSM Health Wisconsin is conducting an active search for Mark's prior Regional CMO role.

Dr. Thompson has been a steadfast supporter and contributor to WHA. He has served on the WHA Board of Directors since 2016 and is a long-standing member of WHA's Physician Leaders Council. Prior to joining SSM Health, Mark was the CMO at Monroe Clinic and also served as a University of Wisconsin School of Medicine and Public Health Residency program director. Mark is board certified in Family Medicine.

Public Policy Council Hears from Governor Evers' Admin. Leadership, Discusses Draft Prompt-Pay Discount Legislation

Council conversations focus on regulatory and licensure processing reforms

On Nov. 14, WHA's Public Policy Council met with full attendance for a discussion with staff leadership from Governor Tony Evers' administration and to have a robust conversation focusing on state and federal regulatory reforms related to professional licensure, value-based purchasing arrangements and prompt-pay discounts for patient cost-sharing obligations.

WHA President/CEO Eric Borgerding welcomed Maggie Gau, Chief of Staff to Gov. Evers, and Wisconsin Department of Health Services Deputy Secretary Julie Willems Van Dijk as guest speakers to the Council. Gau discussed the first year of Gov. Evers' first term in office, including the work it took post-election to get the Governor's office established and create a state budget.

Maggie Gau and Julie Willems Van Dijk

"We all have a health care story," Gau said. "It's what makes the work you [hospitals] do so important. We have built the finest team to support the work you all are doing."

Gau thanked WHA for being a real champion for health care and for the regular communication during the biennial budget process. She specifically praised WHA's work on telehealth improvement legislation, which is currently awaiting the Governor's signature. "This bill is exactly what the Governor has asked for from the Legislature," Gau said, praising the bipartisan nature of the bill.

Willems Van Dijk, who appeared before both the WHA Public Policy Council and the WHA Board of Directors earlier this year, provided the Council with an update regarding implementation of the state budget – including significant funding for key WHA priorities like the Medicaid Disproportionate Share Hospital program, behavioral health reimbursement increases, addressing needs related to post-acute care for patients and establishing a "hub and spoke" system to provide more comprehensive care for those trying to escape drug dependency.

Willems Van Dijk also discussed the Department's work coordinating with CMS to implement a Sec. 1115 demonstration waiver scheduled to take effect. Elements of this waiver include a monthly premium payment requirement for childless adults in Wisconsin's Medicaid program, as well as a co-pay if a Medicaid patient presents to an emergency department with utilization that may be deemed inappropriate emergency care. Willems Van Dijk said the Department expects to implement these provisions by Feb. 1, 2020.

WHA Sees Rapid Progress on Several Key Legislative Priorities

As reported by Willems Van Dijk, Borgerding further updated the Council on recent news from Gov. Evers' administration related to reimbursement improvements on key WHA priorities. While the Department has laid out its framework for these reimbursement priorities, DHS plans to work with WHA to further flesh out details.

WHA Senior Vice President of Government Relations Kyle O'Brien also briefed the Council on recent activity occurring quickly in the Legislature, including WHA-led legislation to reauthorize Wisconsin's participation in the Interstate Medical Licensure Compact, significant reforms to Medicaid's telehealth policies and new legislation enabling advanced practice clinicians to make certain determinations and diagnoses alongside physicians to effectuate an individual's advance directive.

Jon Hoelter, WHA director of federal and state relations, provided even more details regarding WHA's work on telehealth, discussing the process to move legislation from its origins in WHA's Telehealth workgroup to a product that finally passed the Assembly and Senate last week. The bill now awaits the signature of Gov. Evers, who is expected to sign the bill into law. Hoelter also commented about the new ways WHA deployed its grassroots advocacy network HEAT (Hospital Education & Advocacy Team) on this telehealth legislation.

"Considering we are in a new era of significant political divisiveness and disagreement, we have worked hard to keep WHA's priority issues above the political fray," Borgerding commented. "We are grateful to our legislative partners, both Republican and Democratic lawmakers, for working together to move forward on impactful health care policy.

"I've always said that in health care, good policy makes good politics. Never has that been more true than it is today," Borgerding said.

O'Brien and Borgerding also briefed the Council on legislation circulated earlier this fall creating new state-level regulations related to post-discharge care for patients. O'Brien called the legislation an unnecessary burden on hospitals and their health care workforce,

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(Public Policy Council . . . continued from page 4)

as Wisconsin hospitals lead the country in patient satisfaction scores related to discharge planning. WHA lobbied aggressively against the legislation, correcting misinformation being spread by the bill's advocates and making sure legislators understood how hospitals are strong partners in ensuring discharged patients succeed in their care plan.

WHA Focus on Improving Physician, Provider Licensure Processing Gaining Momentum

WHA Vice President of Workforce & Clinical Practice Ann Zenk presented to the Council on WHA's efforts to work with the state's Department of Safety and Professional Services and the Wisconsin Medical Examining Board to develop metrics that identify and proactively address delays in physician licensure processing. Zenk said that WHA has proposed rethinking the way the licensure board or staff determine which actions by an applicant require further legal or liaison review. In addition, Zenk encouraged Council members to provide feedback on other areas of focus or alternative changes WHA's government relations team might present to the state for consideration.

Council members supported the approach of targeted improvement. Council members also emphasized the critical nature of licensure as only the initial step in a physician being added to the health care workforce. Until a Wisconsin license is granted, the physician cannot be issued a DEA number or be credentialed by payers.

CMS Seeks Comment on Significant Changes Related to Federal Stark Law, Anti-Kickback Statute

Hoelter also discussed recently proposed rules from the Centers for Medicare & Medicaid Services (CMS) to reform regulations related to the Stark Law and Anti-Kickback Statute (AKS), both cited as barriers to enable providers who want to enter into contracts that take on financial risk or patient incentives to receive appropriate care.

In its proposed regulations, CMS has identified new exceptions and "safe harbors" for providers to consider as they look at becoming part of a value-based enterprise or value-based purchasing arrangement. These safe harbors depend on, among other things, the level and type of financial risk assumed by a health care provider.

WHA's Public Policy Council Meeting, Nov. 14, 2019

Hoelter solicited feedback from the Council in preparation for WHA's comments to CMS, due by the end of 2019, focusing on whether the proposed changes would help hospitals – regardless of their decision to join a valued-based payment arrangement. Hoelter also requested feedback from Council members regarding areas that CMS may have missed in their proposed changes.

All WHA members are encouraged to contact Jon Hoelter with any additional feedback or questions regarding to Stark/AKS proposed changes.

Council Supports Aligning State Law with Federal Law Regarding Prompt-Pay Discounts

WHA's Laura Leitch led a conversation with Council members regarding the complex interplay between federal and state statutes and regulations that have caused some confusion regarding a health care provider's ability to offer patients a discount for cost-sharing obligations paid timely.

Leitch provided Council members with background regarding a relevant Wisconsin statutory provision and the original intent of that provision. Leitch also discussed letters exchanged between a Legislator and the WI Attorney General in 2004. In his letter, the Legislator made the point that a prompt-pay discount would not be the health care provider offering an inappropriate inducement for the patient to receive health care services, but rather an inducement for the patient to pay the bill in a timely manner, thereby reducing collection costs.

In addition, Leitch discussed the federal Anti-Kickback Statute, an AKS safe harbor, and an Office of the Inspector General Advisory Opinion from 2008 that laid out the safe harbor conditions and other features that would allow the requesting health care provider to implement a prompt pay discount program for the purpose of more successful bill collection.

Leitch then described proposed legislation that would clarify state law to help health care providers trying to navigate the potential inconsistencies between state and federal law and other guidance and asked for comments from Council members.

For questions or comments, contact Laura Leitch.

State Assembly Approves WHA-Supported Advance Directive Legislation

The Wisconsin State Assembly overwhelmingly passed WHA-supported legislation during its floor session on Nov. 12, approving Assembly Bill 287 on a voice vote. The legislation addresses a regulatory bottleneck in Wisconsin's health care workforce that results in unnecessary delays in acting upon a patient's advance directive wishes for treatment. The bill helps address these delays by recognizing the education and training of nurse practitioners and physician assistants to make the medical diagnoses necessary to activate the patient's written medical wishes. Under the bill a physician must still confirm the diagnosis.

Wisconsin Hospital Association President and CEO Eric Borgerding thanked the Assembly for their strong bipartisan support: "Bipartisan recognition of the need to utilize the skills of the entire health care team is gratifying," Borgerding said. "Identifying and updating regulations and laws that interfere with providing efficient, high-quality care is a WHA priority, and it's good to see that the Assembly also recognizes this need."

WHA strongly supported AB 287 at October's public hearing before the Assembly Committee on Health. The Committee approved the bill Oct. 30 on an overwhelmingly bipartisan 12-1 margin. The companion bill, Senate Bill 254, is scheduled for a public hearing Nov. 20 in the Senate's Committee on Health and Human Services.

Contact WHA General Counsel Matthew Stanford for more information.

(Telehealth Bill Advances to Governor Evers' Desk . . . continued from page 1)

- Cover telehealth the same as in-person care when the quality of the care provided is functionally equivalent.
- Catch up to Medicare in the number of telehealth-related services that are covered.
- Cover in-home or community telehealth services.
- Increase access to behavioral health via telehealth.

The legislation's lead authors are State Assembly Reps. Amy Loudenbeck (R-Clinton) and Deb Kolste (D-Janesville) and State Senators Dale Kooyenga (R-Brookfield) and Janet Bewley (D-Mason).

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