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Federal & State Health Care Policy Status Report

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Minnesota Hospital Association

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Discussion Overview

- Federal Update
  - King v. Burwell
  - Sustainable Growth Rate repeal and future physician payment methodologies
  - Congressional issues

- Minnesota Update
  - 2015 legislative session recap
  - Ongoing/upcoming issues
Federal Update

King v. Burwell: ACA Survives

- Premium subsidies available in states with federally run health insurance exchanges
- Shift in policy focus
  - Court challenges will continue; none that appear capable of a “death blow” to ACA
  - GOP majorities in US House and Senate likely to turn to proposing changes to (rather than repeal of) ACA
  - Presidential candidates will be asked for specific ACA changes they support
Physician Payments: The next “big” reforms

- Legislation repealing Sustainable Growth Rate calls for significant payment reforms
- Through 2018: 0.5% payment increase per year
- 2019: Pick your payment
  - Option 1: Merit-Based Incentive Payment System (MIPS)
    - 9% loss to +19% bonus based on performance by ‘26
  - Option 2: Alternative Payment Model

Option 1: MIPS (Merit-Based Incentive Payment System)

- -4% loss to +19% bonus by 2026 based on performance

Eligible professionals will be measured in 4 performance categories, and receive a composite score ranging from 0-100

Source: Healthcare Quality Coalition
Option 2: APM
Alternative Payment Model

- CMMI Model
- MSSP ACO
- Health Care Quality Demo under § 1866C
- Demo required by federal law

Requires use of certified EHR

And

Payment based on quality measures

And

Bears financial risk for losses

OR

Medical home expanded under CMMI

Eligible Alternative Payment Entity

Source: Healthcare Quality Coalition

Congressional Issues

- Press for value-based payment reforms
  (oppose across-the-board cuts, “site neutral” proposals, etc.)
- Support medical education; lifting cap on residencies
- Urge continuation of designations and payments for access-sensitive providers, services (e.g., CAH, DSH, 340b, low-volume, Medicare-dependent, sole community provider)
- Seek to reduce regulatory burdens
  - Recovery Audit Contractor program improvements
  - Physician supervision requirements
  - 2-midnight rule
  - 96-hour limit for CAHs
State Update: 2015 Legislative Session Recap

MHA’s Priorities for 2015 Session

- **Highest priority:**
  - Defeat nurse staffing quota legislation and respond to MDH study
- Mental health
- Telemedicine
- Budget
- Workforce
- Infectious disease preparedness
- All-Payer Claims Database
Mandated Staffing Quotas: Continued need for strong advocacy

- House informational hearing on bill to impose mandated nurse-to-patient staffing quotas
  - Strong testimony MHA-member nurse leaders, MHA
  - Bill’s author acknowledged that committee hearing was held only because House GOP was upset with MHA’s radio ads regarding HHS budget targets

- No bill introduced in Senate
- MNA accused hospitals of being “thinly staffed”

Expanding Access to Mental & Behavioral Health Services

- $48 million to increase access to mental and behavioral health services
  (e.g., child residential treatment, crisis teams, 10-15 additional beds at AMRTC, behavioral health homes and “protected transportation”)

- Increased inpatient hospital payments to offset projected mental health rate cuts
- Identified by hospitals throughout the state as one of their community’s top health care needs
- Great partnerships with mental health advocacy groups
- More to come . . .
  - Focus of upcoming MHA Board planning retreat
  - Exploring public-private approaches in addition to policy
### Minnesota Telemedicine Act

- Requires health plans to cover services delivered via telemedicine if service is a covered benefit in patient’s policy (parity of coverage)
- Requires health plans to pay no less for service delivered via telemedicine than face-to-face (parity of payment)
- Bill did not include MHA’s proposal for an originating site facility fee
- Effective January 2016 for Medical Assistance and January 2017 for commercial plans

### Budget Issues: MinnCare & Medical Assistance

- Retained MinnesotaCare as a Basic Health Plan
- $138 million and payment reforms for long-term care
- Modified rebasing of Medical Assistance fee for service inpatient rates
  - Retroactive to Nov. 1, 2014 for larger hospitals and to July 1, 2015 for Critical Access Hospitals (CAHs)
  - $5 million additional state funding for CAHs
  - New CAH rates set at 85%, 90% or 100% of costs
  - MHA’s mitigations to protect against drastic payment variations extended until next rebasing
Health Care Workforce

- Increase funding for loan forgiveness programs
- Expanded list of providers eligible for loan forgiveness
- Funding for apprenticeship programs (“Earn while you Learn”)
- Modest increases in residency programs (MERC, primary care, and foreign-trained)
- Interstate Physician Licensure Compact

Infectious Disease Preparedness

- Secured supplemental funding to partially offset costs of MN’s four Ebola treatment hospitals
- Still tracking federal funding for Ebola/infectious disease preparedness to ensure all MN hospitals receive some resources
  - $5 million allocated for MN so far
  - U of M Medical Center designated as regional treatment hospital
  - More than $300 million unallocated
All-Payer Claims Database (APCD)

- Authorized MN Department of Health (MDH) to create public use files from APCD
  - Aggregate data only – no identifiable patient, provider or health plan data
  - Supported by MDH, MHA and MN Medical Association
  - This is a start -- but not as robust as other states with APCDs.

Medical Cannabis

- New protections under state law for hospitals and their clinics and employees
  - Note: state law protections do not extend to federal law or its various consequences for violating Controlled Substances Act
- Minnesota law as of July 1, 2015
  - Patients with certain medical conditions are eligible to obtain and use medical cannabis
  - Requires provider certification that patient has one of the conditions (not a prescription)
MHA’s Medical Cannabis Resources

Potential policy templates
1. Hospital will not allow medical cannabis
2. Hospital will allow medical cannabis and treat it as a . . .
   A. Patient self-administered substance; or
   B. Medication and integrate it into the medication workflows

Workers’ Compensation Reform

- Workers’ Compensation Inpatient Payment Reform
  • Negotiated agreement between MHA, MN Department of Labor & Industry, workers’ compensation insurance carriers
  • CAHs remain at 100% charges (no change)
  • Larger hospitals shift from a charge-based system to 200% of the Medicare rate
  • Study of impacts in 2 years
  • Attention will turn to outpatient payment reforms
State Update: Looking Ahead

New Mandates: Workplace Violence Prevention

- Each hospital must have a workplace violence prevention and response plan by January 15, 2016
  - Must be developed with input from a committee that includes non-managerial staff. Does not need to be a new committee.
- Violence prevention training at time of hire and annually for all staff with direct patient contact
- The plan and incidents of violence need to be reviewed annually by the Committee
- Must provide plan to law enforcement or labor union representing employees upon request
- $50,000 to MDH for statewide training
- **No new reporting mandates, as requested by MNA**
Reminder of available MHA resources regarding violence prevention

- “Preventing Violence in Healthcare” gap analysis
- Educational videos
- Toolkit

New Mandates: Observation Status & PAC Information

- Hospitals must provide oral and written notice to Medicare patients of their observation status within 24 hours of such placement.

- Before discharge to post-acute or long-term care provider, hospitals must provide patient with list of nearby providers.
New State Task Force on Health Care Financing

- Task Force’s Work Plan:
  - Health care delivery system reform, especially Medical Assistance ACOs
  - MNsure: governance, structure, financing, oversight
  - MinnesotaCare: coverage options for this population, long-term financing
- 29 Members: 11 appointed by governor, 14 appointed by legislative majority and minority leaders and 4 commissioners

Prospective issues for 2016?

- Non-budget year
  *(although always a potential for budget issues)*
- Focus on bonding bill, taxes and transportation
- Expect relatively few hearings and expedited legislative activity because Session starts very late (March 8) and Capitol will be closed
- All state senate and house seats up for election
Highlights from the 2015 Session

- **Health Care Financing Task Force.** A new Task Force on Health Care Financing will look at the state’s options for MNsure, MinnesotaCare coverage and financing, and health delivery system reforms. Task Force members will be appointed by the Governor, and majority and minority leaders in the Senate and House.

- **Expanding access to mental health services.** MHA partnered with the Department of Human Services (DHS), the National Alliance for the Mentally Ill (NAMI), the Mental Health Legislative Network and other groups to build bipartisan support for increased funding to address the urgent need for greater access to mental and behavioral health services throughout the state. MHA is grateful that legislators provided more than $38 million in new state spending to support crises teams, psychiatric residential treatment facilities, behavioral health homes and initial funding for protective transportation. Also, $2 million was allocated to hospitals that provide inpatient mental health services to compensate for rate cuts projected from the rebasing process.

- **Sustaining rural hospitals and hospital rebasing language.** MHA successfully advocated for new funding for Critical Access Hospitals and to advance a new distribution formula for Disproportionate Share Hospital (DSH) payments. MHA is very pleased that both of these provisions are included in the final HHS bill.
  - $5.096 million in new state funding will leverage federal matching funds and is allocated to Minnesota’s 79 Critical Access Hospitals, bringing all CAHs up to either 85%, 90% or 100% of their costs and to prevent otherwise destabilizing cuts from the rebasing process.
  - The HHS bill includes language supported by MHA extending the +5%/-5% payment bands and DHS authority to use certain policy adjusters that were put in place in response to the budget neutral rebasing process. This language provides some additional time for hospitals to adjust to a potentially large swing in their current Medical Assistance payment rates.
  - A new distribution formula for Disproportionate Share Hospital (DSH) payments will leverage more funding for Minnesota hospitals in total, and target funding for children’s hospitals, psychiatric DHS-contracted inpatient services, transplants and high volume Medical Assistance providers.

- **Improving access to care via telemedicine.** MHA’s Telemedicine Act (SF 981/HF 1246) is included in the final HHS Omnibus bill. Health plans will be required to pay for services on the same basis and at the same rate regardless of whether they are delivered via telemedicine or face-to-face. Medical Assistance will also be required to cover an expanded list of providers who deliver services provided via telemedicine. Telemedicine will allow people, especially those in rural communities, to have greater access to care and specialty services, like mental health, and avoid unnecessary travel time and expenses. Unfortunately, the provision requiring an originating site fee for health care providers was deleted from the bill.

- **Streamlining Multi-State Physician Licensure.** The Interstate Physician Licensure Compact, was enacted (SF 253/HF 321) to help expedite the process for physicians seeking to practice in more than one state.

- **Keeping the MinnesotaCare program as a Basic Health Plan.** MHA supported the Senate position of keeping MinnesotaCare as the coverage option for low income working Minnesotans. This aligned with our long-standing, bedrock value of ensuring affordable access to quality health care for all Minnesotans. Given that the federal financial participation for the MinnesotaCare program has been less than what was originally anticipated, MHA also encouraged a thorough study of the program’s financial sustainability which was included in the scope of the Task Force discussed earlier.
• **Reforming Minnesota’s Workers’ Compensation System in a Revenue Neutral Manner.** For more than a decade, Minnesota hospitals have been willing to reform the workers’ compensation inpatient payment methodology upon several conditions; such as ensuring that providers would see predictability in payments, increased administrative efficiencies through electronic claims processes and prompt payment. Reform legislation (SF 2056/HF 2193) was passed into law creating a DRG payment methodology for all PPS hospitals. The base workers’ comp payment rate was set at 200% of Medicare, which was determined to be the equivalent of the current level of payment. Critical Access Hospitals will continue to receive payments at 100% of charges. In addition, under the new DRG payment methodology, workers’ compensation carriers will be required to pay hospitals for inpatient services within 30 days of receiving a “clean” claim and will be required to follow e-billing standards.

• **Working to foster hospitals as places of safety and healing for patients, visitors and health care workers.** MHA is part of a coalition that came together to create and share best practices for preventing and responding to violence in health care settings. The HHS bill includes language mandating that hospitals have violence prevention plans in place by January 15, 2016, and provide violence prevention training for all direct health care workers. MHA agreed to this position on the condition that there would be no additional data reporting requirements imposed on hospitals as advocated for by the MNA. The legislation provides $50,000 to the Department of Health to help conduct violence prevention training.

• **Investing in health care workforce development.** The HHS bill funds several new investments in health care workforce development, which includes: $2 million added to the current MERC formula, $5.262 million for loan forgiveness with expansion of providers eligible for loans, $2 million for international medical graduate residency slots, $3 million for new primary care physician residency slots, and $2 million for home and community based services workforce scholarships. Unfortunately, previous funding for certain rural residencies was not reauthorized.

• **Hospital protections in state medical cannabis laws.** With advocacy efforts from several hospital systems, SF 1792/HF 1471 was amended with MHA-drafted language to add hospitals to existing safeguards already in place for nursing facilities, thereby providing state protection for hospitals when medical cannabis is brought into the facility. The language also extends some state protections to our employees who may need to handle or store medical cannabis on behalf of a patient.

• **Public use files from the All Payer Claims Database (APCD).** The Minnesota Department of Health (MDH) is authorized to create aggregate, public use files based on data from the APCD. MDH, MMA and MHA supported this language and the Minnesota Council of Health Plans agreed not to oppose it.

• **Financial assistance policy disclosures.** A new state mandate, which essentially mirrors an existing federal mandate on nonprofit charitable hospitals, requires hospitals to provide patients with their financial assistance policies.
Future Physician Payment Options in a Post-SGR World

Medicare policy regarding calculating reimbursement levels for services provided by physicians dramatically changed with congressional repeal of the Sustainable Growth Rate (SGR). For health systems that integrated with or employ physicians, as well as those who rely on their relationships with independent physician group practices, these reimbursement methodology reforms will have tremendous impact on future revenues, structures of risk-sharing agreements, and physician compensation packages.

Today, a small fraction of physicians are subject to a new Medicare payment incentive, called the Value Modifier (VM) or Value Based Payment Modifier (VBPM), that subjects one percent of their payment rates to their performance on quality of care, cost of care and patient satisfaction scores. The Value Modifier is similar to Medicare’s Value Based Purchasing (VBP) for hospitals. The Centers for Medicare and Medicaid Services (CMS) planned to gradually expand the Value Modifier’s applicability to more physicians by 2017.

Although the underlying premise of the Value Modifier’s attempt to begin shifting physician payment incentives to reflect the quality, efficiency, and patient satisfaction elements of the care they provide remain, the payment reforms in the SGR repeal legislation, substantially reshape the financial incentives and decisions physicians will face in a few years.

Initially, the reforms and consequences of the SGR repeal law will seem fairly intangible. Basically, physicians will receive a one-half percent annual increase to their Medicare rates under the current payment system until 2019.
Then, by 2019, all physicians will be subject to new, more financially significant value-based payment modifiers or incentives within the Medicare program. Each year, physicians will need to select one of two payment systems under which they will be paid. Each option contains strong incentives linked to performance on cost, quality and satisfaction:

- **Option 1: The Merit-Based Incentive Payment System (MIPS):** Largely retains the fee-for-service (FFS) system with additional performance-based incentives.

- **Option 2: Alternative Payment Models (APMs):** Physicians selecting this option will receive a five percent if they participate in payment models, such as an Accountable Care Organization (ACO) and receive a substantial portion of their revenues through Medicare Part B.

The Centers for Medicare and Medicaid Services (CMS) has not indicated how it will implement the new law’s payment structures. Some anticipate that CMS may include initial implementation approaches in the upcoming 2016 physician fee schedule. Until such proposed rules or requests for information from CMS are available, the following discussion lacks some of the specificity and details needed to deeply understand and develop financial impact modeling of each payment option.

Nevertheless, the Minnesota Hospital Association (MHA) hopes that our members use the following information to better understand and begin preparing for the impacts of this legislation on the physician compensation packages, recruitment and retention strategies, integration or affiliation agreements, and a whole host of other structures and agreements between MHA members and the physicians with whom they partner in delivering care to Minnesota patients and our communities.
Option 1: Merit-based Incentive Payment System (MIPS)

Scope of Financial Incentives under MIPS

First, MIPS will include four escalating payment adjustments based on performance. The four adjustments between 2019 and 2022 are as follows:

- 2019: +/-4%
- 2020: +/-5%
- 2021: +/-7%
- 2022 and beyond: +/-9%

On top of the upward adjustments available to high performers each year, during a five year window between 2019 and 2024, $500 million will be available for Medicare to provide the highest performing physicians an additional adjustment of up to ten percent. Therefore, the MIPS option will offer physicians performing in the highest quartile of their field the opportunity to receive 14% to 19% enhancements in their Medicare payments.

On the other hand, for poorer performing physicians, the MIPS option will contain compounding challenges. Between 2019 and 2026, the performance-based payment incentives listed above will be the only adjustments to physicians’ Medicare payment rates. Consequently, the lack of an inflationary adjustment will exacerbate the consequences of the MIPS’s financial penalties.

Then, in 2026 and beyond, Medicare will provide a one-quarter percent annual update to the underlying base payment rates for physicians in MIPS.

MIPS Payment Structure

The financial incentives discussed above are not the only part of the reforms under the MIPS option. Another significant aspect of the reforms is Congress’s direction for CMS to consolidate three current incentive programs and one new initiative into a single payment methodology. Specifically, MIPS is intended to consolidate the current physician quality reporting system (PQRS), electronic health record incentives, the VBPM, and a new “clinical practice improvement” incentive.
As a result, for example, although the specific financial incentives tied to PQRS reporting today will be eliminated, Medicare will continue collecting and using the PQRS quality measures and reporting process to generate some of the performance scoring used in the MIPS formula. Congress also directed CMS to encourage the use of qualified clinical data registries for reporting purposes.

CMS will have discretion on the actual breakdown of these four areas within the payment structure through 2021.

“Clinical practice improvement activities” is a new a performance category for payment. The following subcategories are identified but undefined in the law:

- Expanded practice access
- Population management
- Care coordination
- Beneficiary engagement
- Patient safety and practice assessment
- Participation in an alternative payment model

Eligible professionals will be measured in 4 performance categories, and receive a composite score ranging from 0-100

*Weightings for 2021 and beyond
Source: Healthcare Quality Coalition
CMS is responsible for developing the methodology for assessing the performance of each provider and the formula for calculating payment adjustments, as well as setting the threshold for bonus payments for exceptional performance. At least for purposes of the resource use measure, CMS can compare physicians either to their peers in the same specialty or to their own past performance. Congress provided $20 million for CMS to make technical assistance available to small practices and practices in health professional shortage areas.

**Option 2: Alternative Payment Models**

*Participation in Qualifying APMs*

Physicians who participate in what the legislation calls “Alternative Payment Models” (APMs) will be eligible to receive a variety of extra payments or incentives based on the performance of their APM. These payments or incentives could include structures already in place, such as shared savings for ACOs or care management fees for patient-centered medical homes like Minnesota’s Health Care Homes initiative, or new incentives linked to APMs not yet developed.

Between the two options, the APM approach offers the highest possible payments. The APM option allows the opportunity for physicians to capture their shared savings or other financial reward under the APM in which they participate in addition to the additional incentive payments discussed below.

However, as with many CMS payment incentive programs, with high rewards comes high risks. Physicians selecting the APM option who do not meet the metrics required under the particular APM they participate in will not be eligible for any of the shared savings or upside incentives within those programs, which would likely result in lower total revenues than they would have received under the MIPS option.

In addition to the incentives within a particular APM, physicians in an APM could receive a five percent bonus if they receive a substantial portion of their revenues through those models. This bonus will be available from 2019 through 2024. To qualify, a physician must 1) participate in an “eligible alternative payment entity,” and 2) earn a significant share of Medicare Part B revenue through that entity. In other words, physicians who choose the APM option, but the APM accounts for a small portion of their total Medicare Part B revenues will not receive the five percent bonus.

Another advantage available through the APM option is that Medicare’s fees for physicians in an APM will increase three quarters of a percent beginning in 2026, compared to the one quarter percent increase provided to MIPS physicians.
Finally, for physicians under the APM option who practice in certified patient-centered medical home, they will initially be guaranteed the highest possible score in the clinical improvement category, which represents 15 percent of the total overall score. Thus, these physicians will have an even better chance of securing the additional payments or incentives offered under the APM option.

For MHA members participating in a Medicare ACO program, it is important to note that Congress precluded these new payments under the APM option from counting as part of an ACO’s total cost of care or for determining future cost benchmarks for the ACO.

*Eligible Alternative Payment Entity Participation*

Pending CMS rulemaking or requests for information, meeting the requirement of participating in an “eligible alternative payment entity” means the physician must satisfy three criteria:

(1) The physician is part of a Centers for Medicare and Medicaid Innovation (CMMI) model or demonstration program, a Medicare ACO, a health care quality demonstration project, or some other demonstration project required by federal law;

(2) the project, model or program requires both the use of an electronic health record and payments tied to performance on quality of care; and

(3) the providers under the project, model or program either bear financial downside risks or part of a CMMI-expanded medical home.

Source: Healthcare Quality Coalition
Significant share of Medicare Part B revenue through alternative payment entity

Physicians who satisfy the criteria for participating in an eligible alternative payment entity will not be eligible for the five percent bonus unless they also demonstrate that they receive a significant portion of their Medicare Part B revenues through that entity. The new law establishes different thresholds for meeting this requirement.

From 2019 through 2020, a physician meets this threshold if 25 percent of all revenue is generated from Part B payments. This threshold, in essence, will test whether the provider serves a sufficient number of Medicare patients relative to the overall patient population.

Then, from 2021 through 2022, physicians in alternative payment entities meet the threshold for the five percent bonus if they achieve either of the following measures:

1) A Medicare threshold, in which 50 percent of their Medicare revenue comes from Part B, or

2) An all-payer threshold, which requires 50 percent of total revenue to come from all payers, 25% of which must be from Part B.

In 2023 and thereafter, physicians will have to meet one of the two following thresholds to be eligible for the five percent bonus:

1) A Medicare threshold, under which the physician demonstrates that Medicare Part B payments account for 75 percent of the physician’s Medicare revenue, or

2) An all-payer threshold in which 74 percent of an all-payer mix of the physician’s revenue must include at least 25 percent from Medicare Part B payments.

The SGR repeal law does not provide details about how CMS will calculate Medicare Part B revenue will be determined. For example, the law states that CMS will calculate all Part B payments made “during the most recent period for which data are available,” but does not define whether the “most recent period” is a calendar or fiscal year, a quarter or even a single month. Likewise, the law does not specify how CMS will determine which Part B payments were attributable to the alternative payment entity and which were paid for services delivered to other Medicare beneficiaries not attributed to that entity.
Conclusion

Minnesota’s health care delivery system features significant integration of hospitals and physicians with increasingly inter-dependency regarding reputation and, increasingly, payment for quality, efficiency and patient satisfaction. New payment models through Medicare have begun to insert greater, more direct connections between hospital payments and measures of value, including process of care, outcomes of care, costs of care and patient satisfaction with care. Physician payments, on the other hand, have been less impacted by these payment reforms.

With new legislation requiring CMS to two payment methodologies, there is a possibility that even more physicians will seek to participate in an alternative payment entity, such as an ACO. On the other hand, for the very best performing physicians, there may be greater financial incentives for avoiding participating in an ACO and, instead, selecting the MIPS option with the possibility of higher bonus payments.

In either case, in less than five years, many physicians will be facing significant strategic decisions about their own tolerance for risk, value of independence, and openness to new delivery and payment models. Similarly, hospitals and health systems will need to adjust their internal incentives for physicians and better understand the choices and corresponding motivations Medicare will be bringing to physicians.

References

“Overview of Payment System Reforms in the Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2),” Healthcare Quality Coalition presentation (April 28, 2015), and subsequent email exchanges with the presenter, Brian Vamstad (May 22 and 28, 2015).

