

MARKET UPDATES

March, 2018



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New CMS Enforcement on ER Physician Standby Costs Could Threaten CAHs

- CMS has recently begun to enforce a provision of Provider Reimbursement Manual §2109 indicating that in order for physician availability services costs to be allowable, **the provider must demonstrate that it explored alternative methods for obtaining physician coverage but was unable to do so**
- In order to claim Emergency Room Availability costs, the provider must have certain specific documentation, including **evidence that the provider explored alternative methods for obtaining emergency physician coverage before agreeing to physician compensation for availability services**
 - For example, advertisements for emergency room physicians to be compensated on a fee-for-service basis placed in appropriate professional publications
- CMS Auditors are enforcing this regulation in 2015 desk reviews
- **Lack of the above documentation could expose hospitals to Medicare audit risk, and place Medicare reimbursement in jeopardy, threatening the viability of many CAHs**

Cancellation of Episode Payment and Cardiac Rehab Incentive Payment Final Rule 12-01-2017



This document is scheduled to be published in the
Federal Register on 12/01/2017 and available online at
<https://federalregister.gov/d/2017-25979>, and on [FDsys.gov](https://www.fdsys.gov)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 510 and 512

[CMS-5524-F and IFC]

RIN 0938-AT16

**Medicare Program; Cancellation of Advancing Care Coordination through Episode
Payment and Cardiac Rehabilitation Incentive Payment Models; Changes to
Comprehensive Care for Joint Replacement Payment Model: Extreme and
Uncontrollable Circumstances Policy for the Comprehensive Care for Joint
Replacement Payment Model**

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule; interim final rule with comment period.

- **Specific changes to the program effective 1/1/2018 include**
 - Cancels the Episode Payment Models (EPMs) and Cardiac Rehabilitation Incentive Payment model
 - Finalizes proposal to make participation voluntary for all hospitals in approximately ½ of the geographic area selected for participation in the Comprehensive Care for Joint Replacement (CJR) model, as well as all low volume and rural hospitals in all geographic service areas



Home > Newsroom > Media Release Database > Press releases > 2018 Press releases items > CMS announces new payment model to improve quality, coordination, and cost-effectiveness for both inpatient and outpatient care

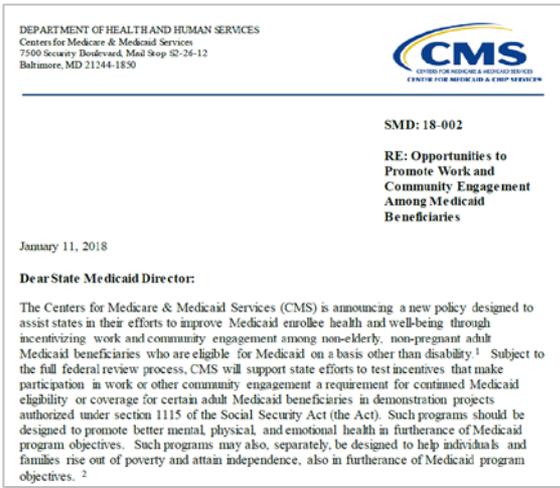
CMS announces new payment model to improve quality, coordination, and cost-effectiveness for both inpatient and outpatient care

Date	2018-01-09
Title	CMS announces new payment model to improve quality, coordination, and cost-effectiveness for both inpatient and outpatient care
Contact	press@cms.hhs.gov

CMS announces new payment model to improve quality, coordination, and cost-effectiveness for both inpatient and outpatient care

- CMS announced the Bundled Payments for Care Improvement (BPCI), a new voluntary bundled-payment model that will be considered an Advanced APM under MACRA
 - The model includes 32 clinical-care episodes that providers can choose from, 29 of which are in the inpatient setting and three in the outpatient setting
- Under the model, clinician payment will be based on quality performance during a 90-day episode of care
- Participants must select at least one of the 32 clinical episodes to apply to the model
 - Clinical episodes include major joint replacement, percutaneous coronary intervention provided in both the inpatient and outpatient settings, and spinal fusion.

CMS Allows Work Requirements for Medicaid Eligibility (1/11/2018)



"Work requirements impose an additional, unnecessary barrier to allowing patients access to vital healthcare services for people who need access and coverage the most," Dr. Jack Ende, president of the American College of Physicians

- CMS issued new guidance allowing states to reshape their Medicaid programs, **including work/volunteering requirements for beneficiaries**
- Despite impending legal challenges, Administrator Seema Verma believes that **"The 1115 [statute] gives broad authority to the secretary to approve state experiments and programs that promote the objectives of the Medicaid program,"** citing studies showing that employment benefits a person's health
- Arizona, Arkansas, Indiana, Kansas, Kentucky, Maine, New Hampshire, North Carolina, Utah and Wisconsin have applied for Section 1115 waivers.
- **Kentucky's was accepted on 1/12/18.**

Tax Cuts and Jobs Act (12/19/2017)

115TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
1st Session } 115—__

TAX CUTS AND JOBS ACT

_____, 2017.—Ordered to be printed

Mr. Brady of Texas, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 1]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 1), to provide for reconciliation pursuant to titles II and V of the concurrent resolution on the budget for fiscal year 2018, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment, insert the following:

Tax Cuts and Jobs Act (12/19/2017) (continued)

- The final version of the [Tax Cuts and Jobs Act](#) **drops the elimination of private-activity bonds (PABs)**, which many small and rural hospitals rely on to provide infrastructure funding, but still carries some bad financial news for not-for-profit hospitals
- Provisions impacting not-for-profit hospitals include
 - ✓ **Creation of a 21 percent excise tax on any compensation over \$1 million paid to their five highest-paid employees**—with a carve-out for certain medical professionals
 - ✓ **Implementation of a new 1.4 percent excise tax for endowments**
 - ✓ **A requirement that unrelated business income tax be calculated separately for each business**, meaning losses could not cover the taxes on gains from other lines of businesses
 - ✓ **The end of the ability of not-for-profit hospitals to undertake a onetime advance refunding of a bond**
- The bill also
 - ✓ **Repeals the ACA's individual mandate**
 - ✓ **Reduces the medical deduction threshold to 7.5 percent of gross income for the 2017 and 2018 tax years, then returns it to the 10 percent threshold that the ACA established in 2010**
- For-profit hospitals are expected to largely benefit from the sharp reduction of the corporate tax rate and repeal of the corporate alternative minimum tax

Bipartisan Budget Act of 2018: Overview 2/9/2018



- Congress passed the Bipartisan Budget Act, which includes the most significant health legislation since the 21st Century Cures Act
- The healthcare package includes provisions that come as a relief to rural providers and those that serve seniors and other vulnerable populations, such as
 - ✓ **An extra four years of funding for the Children's Health Insurance Program (CHIP)**
 - ✓ **A repeal of the Affordable Care Act's Independent Payment Advisory Board**
 - ✓ **A provision to accelerate the closure of what's known as the Medicare Part D "donut hole" for seniors, which increases the discount drug manufacturers have to give beneficiaries from 50% to 70%**
 - ✓ **\$6 billion in funding over two years to address the opioid crisis**
 - ✓ **Funding for community health centers and expired Medicare programs for two years**
 - ✓ **A two-year delay to the already-in-effect payment cuts to Medicaid disproportionate-share hospitals**
 - ✓ **The Chronic Care Act, which opens up new flexibilities for Medicare Advantage and care for chronically ill Medicare beneficiaries**
 - ✓ **A provision to slow implementation of the Merit-based Incentive Payment System that makes providers accountable for Medicare savings**

"Congress made the right choice this morning for patients and communities by voting to halt damaging cuts to hospitals that care for low-income working families and others who face financial challenges"
– Dr. Bruce Siegel, CEO of America's Essential Hospitals, which represents the nation's safety-net facilities

Bipartisan Budget Act of 2018: Impact on Healthcare

CHIP

- **Extends funding for CHIP for four additional years (FY24 through FY27)**
- Extends the Child Enrollment Contingency Fund, the Qualifying States Option, the Express Lane Eligibility option, and continues to require states to maintain eligibility levels for CHIP children through FY27
- Extends funding for the pediatric quality measures program and requires states to report on a core set of pediatric quality measures
- Extends funding for the outreach enrollment grants at \$48 million for FY24 through FY27 and allows a portion of the funds to be used for evaluation and technical assistance

Medicare Extenders

- Two-year extension of the Geographic Practice Cost Indices (GPCI) floor through December 31, 2019
- **Permanent repeal of the Medicare payment cap for therapy services beginning on January 1, 2018**
- Five-year extension of the 2-percent urban, 3-percent rural, and 22.6-percent super rural ground ambulance add-on payments until December 31, 2022
- **Five-year extension of the Medicare low-volume hospital payments through September 30, 2022**
- **Five-year extension of the Medicare-dependent hospital (MDH) program through September 30, 2022**
- **Five-year extension with reforms of the home health rural add-on until October 1, 2022**

Bipartisan Budget Act of 2018: Impact on Healthcare



CHRONIC Care Act

- Extends and expands the Medicare Independence at Home demonstration by two years, increases the cap on participating beneficiaries from 10,000 to 15,000, and gives practices three years to generate savings against their spending targets
- Permanently reauthorizes Medicare Advantage (MA) Special Needs Plans (SNPs) for vulnerable populations, along with a number of reforms to Dual-Eligible SNPs (D-SNPs) and Chronic Condition SNPs (C-SNPs) to improve care management
- **Expands the testing of the Center for Medicare & Medicaid Innovation (CMMI) Value-Based Insurance Design Model to allow MA plans in any state to participate in the model by 2020**
- Allows MA plans to offer a wider array of targeted supplemental benefits to chronically ill enrollees beginning in 2020
- Allows MA plans to offer additional, clinically appropriate telehealth benefits in their annual bid amounts beyond the services that currently receive payment under Part B beginning in 2020
- **Provides Accountable Care Organizations (ACOs) the ability to expand the use of telehealth services**
- ***Allows Medicare ACOs the choice to have their beneficiaries assigned prospectively at the beginning of a performance year. In addition, beneficiaries would have the option to voluntarily align to an ACO in which the beneficiary's main primary care provider is participating.***
- ***Establishes a new voluntary ACO Beneficiary Incentive Program, which would allow certain two-sided risk ACOs to make incentive payments to all assigned beneficiaries who receive qualifying primary care services***
- Directs the Government Accountability Office to submit a report to Congress within 18 months that would provide information on the prevalence and effectiveness of Medicare and other payer medication synchronization programs
- Requires the HHS Secretary to submit a report to Congress within 18 months that would evaluate long-term cost drivers to Medicare, including obesity, tobacco use, mental health conditions, and other factors that may contribute to the deterioration of health conditions among individuals with chronic conditions

BAKER DONELSON

Bipartisan Budget Act of 2018: Impact on Healthcare

Medicare Part B Improvement Act

- Creates a temporary transition service and education Medicare payment for home infusion beginning in 2019
- Allows dialysis providers to seek outside accreditation, from organizations approved by Medicare, in order to be able to bill Medicare for end-stage renal disease (ESRD) services
- Codifies the changes CMS made in regulations to streamline and clarify rules for providers regarding compliance with the Stark Law
- Makes coverage of speech-generating devices under durable medical equipment permanent under the Medicare program

Child and Family Services and Supports Extenders

- Extends the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program at current-law level of \$400 million per year for FY18 through FY22
- Allows HHS to continue to use Census Bureau data for states, making sure they use an appropriate alternative data source when determining funding for territories
- Extends the Health Workforce Demonstration Project, which provides funding to help low-income individuals obtain education and training in high-demand, well-paid health care jobs, through FY19 at the current funding level

Bipartisan Budget Act of 2018: Impact on Healthcare

Public Health Programs

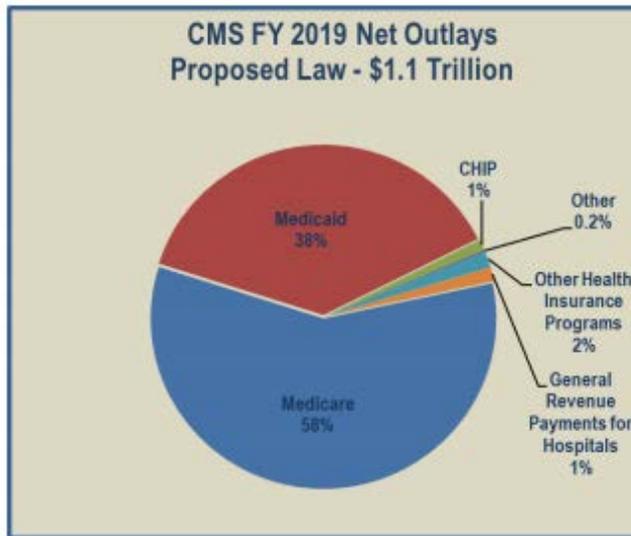
- **Extends and increases mandatory funding for community health centers from \$3.6 billion per year to \$3.8 billion per year for FY18 and \$4 billion for FY19**
- Provides \$3 billion per year in FY18 and FY19 to combat the opioid epidemic
- Provides \$1 billion per year in FY18 and FY19 for NIH research
- Extends mandatory funding for the National Health Service Corps
- **Extends and increases funding for the Teaching Health Center Graduate Medical Education Program from \$60 million per year to \$126.5 million per year in FY18 and FY19. Requires Congress to provide a report on the direct and indirect expenses associated with training residents at teaching health centers. Directs the Secretary of HHS to support the maintenance of filled positions at existing approved teaching health centers, as well as the expansion of existing or establishment of new such programs, as appropriate. In awarding grants to establish new teaching health centers, this section also directs the Secretary to prioritize qualified teaching health centers that are located in a rural area or serve a health professional shortage area or a medically underserved community.**

Miscellaneous Health Care Policies

- **Repeals the IPAB that is charged with making recommendations that reduce Medicare spending when per-capita growth exceeds an expenditure growth target**
- Requires the HHS Secretary to reform the current home health payment system and implement a 30-day episode for payment, beginning January 1, 2020
- Includes technical corrections to the Quality Payment Program (QPP) under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- Extends the blended site neutral payment rate for certain long term care hospital discharges for two additional years through FY19
- **Permits physician assistants to serve as the attending physician to serve hospice patients, which allows them to manage and separately bill for hospice care**
- **Allows physician assistants, nurse practitioners, and clinical nurse specialists to supervise cardiac, intensive cardiac, and pulmonary rehabilitation programs beginning January 1, 2024**

Administration's FY2019 Budget (2/12/2018)

- President Trump unveiled his \$4.4 trillion fiscal 2019 budget proposal
- Since Congress just passed the Bipartisan Budget Act, **it is unlikely that the budget will be enacted, but it sheds light on the Trump administration's priorities**
- The budget proposal eliminates the ACA and makes deep cuts to Medicaid, SNAP, and other social assistance programs, while increasing funding to battle the opioid crisis and lowering prescription drug prices for seniors



NEW INITIATIVE

The Budget Repeals and Replaces Obamacare

The Budget supports a two-part approach to repealing and replacing Obamacare. First, the Budget supports the enactment of legislation modeled after the Graham-Cassidy-Heller-Johnson bill. Second, the Budget includes reforms to help set government health care spending on a sustainable fiscal path. This proposal reduces the Federal deficit by \$679.7 billion over 10 years.

(dollars in millions)

Step One – Proposal Modeled After Graham-Cassidy-Heller-Johnson	
	FYs 2019-2028
HHS Impacts	\$458,711
Medicaid (non-add)	-\$1,083,570
Other HHS Programs (non-add)	\$1,542,281
Non-HHS	-\$373,133
Step One Impact	\$85,578

Step Two – Improving Program Sustainability and Achieving Deficit Reduction	
	FYs 2019-2028
HHS Impacts	-\$765,284
Medicaid (non-add)	-\$305,665
Other HHS Programs (non-add)	-\$459,619
Non-HHS	\$0
Step Two Impact	-\$765,284

Total	
	FYs 2019-2028
HHS Impacts	-\$306,573
Medicaid (non-add)	-\$1,389,235
Other HHS Programs (non-add)	\$1,082,662
Non-HHS	-\$373,133
Total Budget Impact	-\$679,706

Administration's FY19 Budget (2/12/2018) (continued)

- **Cuts Medicaid and subsidies for private coverage in the marketplace by \$763 billion** over the next decade, with cuts reaching \$172 billion annually by 2028
- **Embraces the ACA Graham-Cassidy ACA repeal bill**, then cuts funding for health coverage programs well below the already shrunken levels in that bill
- **Eliminates the ACA's Medicaid expansion and subsidies**, replacing this funding with a block grant whose funding would fall further and further behind current-law funding each year
- **Imposes a per capita cap on federal Medicaid funding** for seniors, people with disabilities, and families with children
- **Cuts \$878 million** from the CDC discretionary budget
- **Eliminates the Preventative Health and Human Services Block Grant**
- **Modifies Medicare prescription drug benefits** to lower drug costs to beneficiaries and creates an out-of-pocket maximum
- **Provides \$10 billion in funds to address the ongoing opioid crisis** through prevention and treatment services
- **Cuts \$688 million** from the Substance Abuse and Mental Health Services Administration (SAMHSA)
- **Eliminates the Agency for Healthcare Research and Quality (AHRQ)** which is tasked with researching and improving the effectiveness of health services; eliminates various health care training and workforce programs
- **Reduces Supplemental Nutrition Assistance Program (SNAP) vouchers** and introduces “USDA food packages” that would include shelf-stable food products and canned goods
- **Eliminates the Community Services Block Grant** which provides \$700 million in grants for various state-based health care, food, and workforce programs

Proposed Rule Increases Access to Short-Term Health Insurance (2/20/2018)



- HHS, Labor, and Treasury Departments issued a proposed rule that would **“expand the availability of short-term, limited-duration health insurance by allowing consumers to buy plans providing coverage for any period of less than 12 months, rather than the current maximum period of less than three months”**
- Short-term health insurance **is not required to comply with federal requirements for individual health insurance coverage**, and is designed to provide temporary coverage for individuals transitioning between healthcare policies
- Per CMA Administrator Verma, “Americans who find themselves between jobs or simply can’t afford coverage because prices are too high will be helped by President Trump’s Healthcare for All Executive Order”
- However, insurers can reject applicants with preexisting medical problems from short-term plans, and plans may not cover services such as behavioral health and substance abuse
- As a result, the proposed rule also noted that some people who switch to them from ACA coverage may see “reduced access to some services,” and “increased out of pocket costs, possibly leading to financial hardship.”
- The proposed rule may also cause ACA insurance premiums to rise



House Bills Would Define 340B-Eligible Patients (1/16/2018)



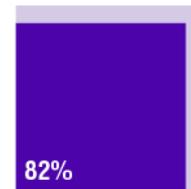
- Led by Rep. Chris Collins, House Republicans are introducing a package of bills that would limit the patients qualifying for the 340B drug discount and expand reporting requirements for how hospitals use the money
- A crucial piece of the package, known as "patient definition," ties the 340B discounts to **uninsured patients only**
- Hospitals that use the 340B program are concerned because patient definition means reduced savings. Money saved through drug discounts often funnels into safety-net care and outreach programs.
- If Congress narrows the scope of the discounts, hospitals warn the programs largely funded through the 340B discount dollars will also shrink

More Medicare ACOs In Risk-Based Contracts in 2018

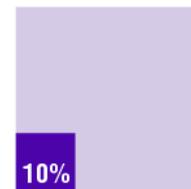
- Per CMS, about 18% of Medicare shared savings program ACOs will participate in a downside risk contract in 2018, up from just 9% in 2017
- Of 561 Medicare ACOs in the program this year, 101 are in a downside risk-based contract. Of those 101, 55, have joined Track 1+, the newest risk model that doesn't require ACOs to take on as much financial risk as Tracks 2 or 3 of the program.
- The number of ACOs overall in the program rose by 81 from 480 in 2017 to 561 this year. About 10.5 million Medicare beneficiaries now receive care from a clinician in a Medicare ACO, up from 9 million beneficiaries last year.

2018 Medicare ACOs in each track

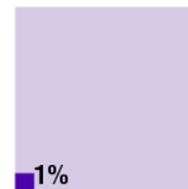
Not based on risk
Track 1



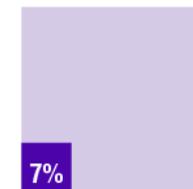
Risk Based
Track 1+



Track 2

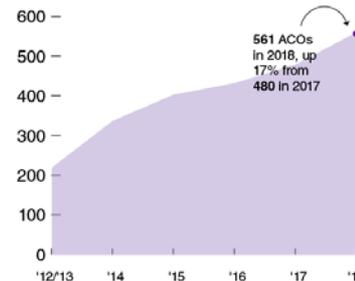


Track 3



Source: CMS

Medicare ACOs rise in 2018



Source: CMS

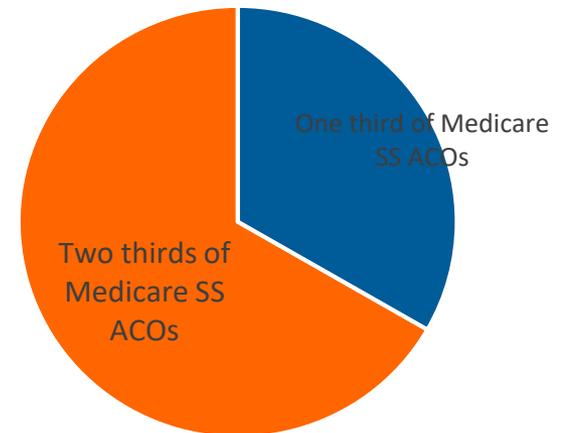
Medicare ACOs Cut \$1B Over Three Years

Accountable care organizations participating in the CMS' Medicare shared-savings program reduced spending by about \$1 billion in three years [per the HHS OIG](#)

Most of the 428 ACOs in the first three years of the shared-savings program reduced Medicare spending compared to their benchmarks, and a small group of those ACOs produced "substantial" savings

82% of the ACOs also improved the quality of care they provided, based on data from the CMS on 33 individual quality measures, outperforming fee-for-service providers in 81% of the quality measures

"While policy changes may be warranted, ACOs show promise in reducing spending and improving quality," the OIG report concluded.



- Reduced spending enough to receive a portion of the savings during the first three years of the program
- Reduced spending for at least one of the years they participated in the program.

MedPAC Votes to Scrap MIPS (1/10/2018)

- MedPAC voted 14-2 to repeal and replace MIPS, a Medicare payment system intended to improve care quality
 - Under MACRA, providers must currently follow one of two payment tracks: MIPS or Advanced APMs
- CMS estimates that up to 418,000 physicians will be submitting 2017 MIPS data
- Believing MIPS to be too burdensome for docs, MedPAC voted to ask Congress to eliminate MIPS and establish a new voluntary value program in which clinicians join a group and are compared to each other on the quality of care for patients
- Industry physicians voiced concern about the suggested replacement, arguing that only providers with healthy patients would band together, while those with high risk patients would face difficulty finding a group

"I think they're wrong," Dr. Stephen Epstein, an emergency physician at Beth Israel Deaconess Medical Center in Boston said in a tweet. "MIPS could change practice patterns by aligning incentives with performance measures."



Recommendations to Modernize RHC Provisions - 12/2017



The National Advisory Committee on Rural Health and Human Services (NACRHHS)'s 2017 Policy Brief focused on recommendations to modernize Rural Health Clinic provisions. Recommendations to the Secretary of HHS include:

Payment Options

Adjust the payment cap for RHCs, creating a formula for payments that ties payment cap increases to the current average cost per visit for RHCs currently under the cap.

Program Support

Provide grants to State Offices of Rural Health to support a state program that would provide technical assistance on quality reporting and other services to support the transition of RHCs to value-based care.

Services

Allow RHCs to be distant site providers for telehealth services under Medicare.

Allow all RHC (non-physician) providers to order hospice and home health services and also allow RHC providers to be attending clinicians for hospice services.

Workforce

Allow masters trained behavioral health providers to be RHC practitioners for purposes of Medicare reimbursement if they are licensed to provide those services in their state.

Lab Requirements

Publish a RFI to RHCs on current RHC laboratory needs. Based on this information, use the authority granted in Public Law 95210 to review and modernize lab requirements to reduce regulatory burden and allow flexibility.

Reinventing Rural Healthcare - 1/2018



Bipartisan Policy Center (BPC) and Center for Outcomes Research and Education (CORE) spoke with over 90 national thought leaders on current state of rural health care in upper Midwest. Key takeaways include:

Rightsizing

Not all communities need a CAH; communities should tailor available services to the needs of the community

Rural Funding Mechanisms

Funding mechanisms and payment models should reflect the specific challenges that rural areas face – such as small population size and high operating costs

Primary Care Workforce

With appropriate services and funding, rural communities can build sustainable diverse workforces. Alternative providers practicing at the top of their license. Communities should start young and think local for recruitment

Telemedicine Services

Telemedicine is a tool that can be used to support both rural patients and providers. Telemedicine may prove to be critical in improving provider recruitment.

Insurers' Disruptive Growth Strategies Pose Threat to Hospitals

Per Moody's, health insurers are engaging in new, disruptive growth strategies aimed at lowering healthcare spending that threaten the credit quality of not-for-profit hospitals

- **Hospitals will be vulnerable to direct competition as insurers purchase providers.** The purchase of these providers (the CVS-Aetna merger is a prime example) move care away from higher-cost hospital settings.
- **Health insurers are moving to value-based payment models that emphasize quality over quantity of care, leaving hospitals with less volume.** By owning physicians, insurers can take greater control of premiums and expenses, including those related to hospital care.
- **Hospital revenues and margins will come under additional pressure as insurers gain negotiating power.** When negotiating contracts, insurers will benefit from increased scale. At the same time, hospitals are becoming increasingly reliant on commercial payments to cover operating costs as governmental payors reduce rates. As insurers impose more restrictions on what types of care they will provide coverage for, hospitals will be vulnerable to rising bad debt levels and fewer emergency room visits.