MARKET UPDATES
December, 2017

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Bypassing Congress, Trump Signs Executive Order Relaxing Health Insurance Rules

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On 10/12/17, President Trump signed an executive order intended to give consumers access to cheaper, skimpier health plans by easing some policy restrictions

- The order directs government to consider expanding coverage through **low-cost, short-term health plans that are exempt from Affordable Care Act insurance market rules**
- Such plans **would not have to comply with ACA requirements** that plans cover 10 categories of minimum essential benefits or accept all applicants at the same rates without regard to **pre-existing medical conditions**
- The order would allow individuals to buy such short-term plans lasting up to 364 days
- The order apparently would *not* allow these expanded association plans to market to individuals, which many observers had expected the White House to do

Health policy experts warn that Trump's order could drive up premiums and make coverage less available for people who are older and who have pre-existing health conditions because healthier customers likely would move into the cheaper, leaner plans

Source: Modern Healthcare, *Trump signs executive order to relax health insurance rules,* Harris Meyer, 10/12/17
http://www.modernhealthcare.com/article/20171012/NEWS/171019959/trump-signs-executive-order-to-relax-health-insurance-rules

Trump Ends Funding of ACA Subsidies 10-13-2017

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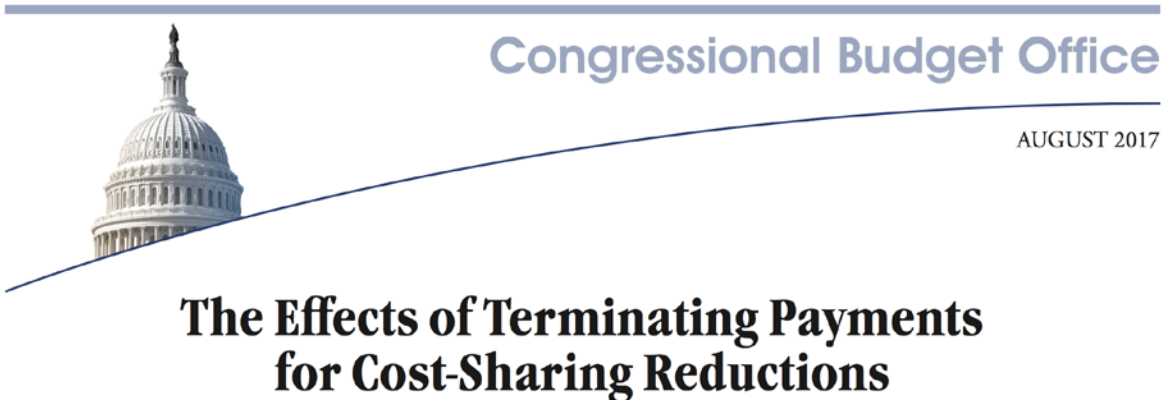
- On October 13, in a continued effort to dismantle the ACA without the support of Congress, **President Trump scrapped ACA subsidies that allowed low-income Americans to afford health insurance**
- Without the subsidies, known as cost-sharing reductions or CSRs
  - Insurance companies will be forced to charge higher premiums and may pull out of the Exchanges entirely
  - Single-digit premium increases for individuals could rise to 20-25%, making health insurance unaffordable for many low- and middle-income Americans
- The subsidies were expected to total $9 billion in the coming year and nearly $100 billion in the coming decade
- Senator Lamar Alexander (R-TN) and Senator Patty Murray (D-TN) are working on a bipartisan deal that would continue the subsidy payments while making it easier for states to obtain waivers from some requirements of the Affordable Care Act

Sources: Forbes.com, *Trump's Termination Of Obamacare Subsidies Hurts Patients, Not Insurers,* Bruce Japsen, 10/1 3/17 https://www.forbes.com/sites/brucejapsen/2017/10/13/trumps-end-to-subsidies-hurts-patients-not-insurers/#1cd1c1834c61; nytimes.com, *Trump to Scrap Critical Health Care Subsidies, Hitting Obamacare Again,* Robert Pear, Maggie Haberman and Reed Abelson, 10/12/17 https://www.nytimes.com/2017/10/12/us/politics/trump-obamacare-executive-order-health-insurance.html

CBO Report on Terminating CSR Payments (8/15/17)



- Summary Effects:
  - Gross premiums for silver plans would be 20% higher in 2018 and 25% higher in 2020 which would boost premium tax credits
  - Most people would pay net premiums (after premium tax credits) of the same amount through the next decade
  - Federal deficits would increase by $6B in 2018, $21B in 2020, and $26B in 2026
  - Number of uninsured would be slightly higher in 2018 and slightly lower starting in 2020

CMS Proposed Rule: Notice of Benefit and Payment Parameters for 2019 (10/27/2017)

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- A CMS proposed rule would give states greater flexibility in defining the ACA's minimum essential health benefits, ostensibly in an effort to increase affordability of coverage and stabilize the ACA insurance market
- Under the proposed rule, states would
  - play a larger role in the certification of qualified health plans offered on the federal insurance exchange
  - have more leeway in setting medical loss ratios for individual-market plans
  - not be held to the ACA requirement that at least 80% of premium revenue received by individual-market plans be spent on members' medical care
  - be allowed to lower the 80% medical loss ratio standard if they demonstrate that a lower MLR could help stabilize their individual insurance market
- The basic benefits that could be affected include outpatient, inpatient and emergency care; prescription drugs and labs; preventive care; pregnancy, maternity and newborn care; mental health and substance abuse; rehabilitation; and children's services
- **The changes in this proposed rule would mean, for example, that insurers could choose to cover certain drugs, but not others, for a given medical condition, or that expensive treatment for complicated chronic illnesses can be subject to limits on the number of visits the plan will cover, putting patients with certain conditions at risk of being unable to access necessary care**

Sources: Modern Healthcare, *CMS to allow states to define essential health benefits,* Harris Meyer , Shelby Livingston and Virgil Dickson, October 27, 2017, http://www.modernhealthcare.com/article/20171027/NEWS/171029872?utm_source=modernhealthcare&utm_medium=email&utm_content=20171027-NEWS-171029872&utm_campaign=mh-alert; Talking Points Memo, *Trump Admin Proposes Weakening Essential Health Benefits Rule In 2019,* Ricardo Alonso-Zaldivar, October 28, 2017 http://talkingpointsmemo.com/livewire/trump-admin-proposes-weakening-essential-health-benefits-rule-in-2019

Tax Cuts and Jobs Act 11-16-2017

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DESCRIPTION OF THE CHAIRMAN'S MODIFICATION TO THE CHAIRMAN'S MARK OF THE "TAX CUTS AND JOBS ACT"

Scheduled for Markup
Before the
SENATE COMMITTEE ON FINANCE
on November 15, 2017

Prepared by the Staff
of the
JOINT COMMITTEE ON TAXATION

November 14, 2017
JCX-56-17

Tax Cuts and Jobs Act 11-16-2017 (continued)

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On November 16, both the House of Representatives and the Senate Finance committee advanced separate tax bills

- Important provisions impacting healthcare providers include:
  - $1.5T increase in budget deficit over 10 years, breaking statutory budget caps and leading to automatic cut of an estimated $25B to Medicare program
  - Repeal individual mandate penalty (Senate version only)
  - Limiting the use of tax-exempt bonds
  - Expanding unrelated business taxation
  - New excise taxes on executive compensation on income over $1M

The CBO and the Joint Committee on Taxation estimate that repealing the ACA's individual mandate starting in 2019 would result in the following:

- **The number of people with health insurance would decrease by 4 million in 2019 and 13 million in 2027**
- **Average premiums in the nongroup market would increase by about 10 percent in most years of the decade** (with no changes in the ages of people purchasing insurance accounted for) relative to CBO's baseline projections
- Federal budget deficits would be reduced by about $338 billion between 2018 and 2027
- Non-group insurance markets would continue to be stable in almost all areas of the country throughout the coming decade

FY 2018 OPPS Proposed Rule 7-20-2017 / *Final Rule 11-1-2017*

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On July 20, 2017, CMS released its OPPS Proposed Rule for 2018. Rule was "Finalized with Comment Period" on November 1, 2017:

- **Medicare OPPS conversion factor to increase 1.35%**
  - 2.7% inflation less .6% productivity and .75% ACA adjustment
  - 2% reduction for hospitals not meeting the OP Quality Reporting Requirements

Proposed:

	Projected 2018 Impact
All Facilities*	1.9%
All Hospitals	2.0%
Urban Hospitals	2.0%
Rural Hospitals	2.0%
Major Teaching	1.7%
Minor Teaching	2.0%
Non-Teaching	2.1%
Ownership	
Voluntary	1.9%
Proprietary	2.3%
Government	1.9%

*Excludes hospitals permanently held harmless and CMHCs

Final:

	Projected 2018 Impact
All Facilities*	1.4%
All Hospitals	1.5%
Urban Hospitals	1.3%
Rural Hospitals	2.7%
Major Teaching	-.9%
Minor Teaching	1.7%
Non-Teaching	2.9%
Ownership	
Voluntary	1.3%
Proprietary	4.5%
Government	0.0%

*Excludes hospitals permanently held harmless and CMHCs

FY 2018 OPPS Proposed Rule 7-20-2017 / *Final Rule 11-1-2017* (continued)

Payment for Part B Drugs Acquired Under the 340B Program

- Beginning January 1, 2018, CMS to reduce payment for Part B drugs acquired under the 340B program from average sales price (ASP) +6% to ASP -22.5%
- Payment changes should be limited to separately payable drugs under the OPPS, with certain exclusions
- *Excludes Sole Community Providers, Children's Hospitals, and PPS-Exempt cancer hospitals*
- CMS expressed intention to use the savings to increase payments for other services under OPPS, and estimates that the payment redistribution will increase other payments under OPPS by approximately 3.2 percent, up from the original projection of 1.4 percent in the Proposed Rule

Inpatient Only List

- Removes total knee arthroplasty (TKA) from inpatient only list
  - And added it to the ASC list

Non Exempt Provider Based Clinics (under section 603 of Bipartisan Budget Act)

- Proposing to reduce payment for non-exempt provider-based clinics (new off-campus clinics that were not in process by 11/2/2015) from 50% of OPPS payment to 25%
- Final rule reduces payment from 50% to 40% of OPPS payment

Direct Supervision of Hospital OP Therapeutic Services

- *Finalized:* Reinstate non-enforcement of direct supervision requirements for OP therapeutic services for CAHs and small rural hospitals for CYs 2018 and 2019

Sources: McDermott Will & Emery, *CMS Cuts Payments for Most 340B Drugs,* Emily J. Cook, Drew Elizabeth McCormick, Nicholas Francis Alarif, 11/2/17 https://www.mwe.com/en/thought-leadership/publications/2017/11/cms-cuts-payments-for-most-340b-drugs; Healthcare Dive, *CMS finalizes 340B drug program cut,* Shannon Muchmore, 11/2/17 https://www.healthcaredive.com/news/cms-finalizes-340b-drug-program-cut/509892/

FY 2018 Physician Fee Schedule (PFS) "Major" Final Rule 11-15-2017

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This document is scheduled to be published in the Federal Register on 11/15/2017 and available online at https://federalregister.gov/d/2017-23953, and on FDsys.gov

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 410, 414, 424, and 425

[CMS-1676-F]

RIN 0938-AT02

Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program

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

ACTION: Final rule.

FY 2018 PFS "Major" Final Rule 11-15-2017 (continued)

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Conversion Factor - Updated by .41% to $35.9996

Physician Relationship Modifier

- Finalizes proposal that all Medicare claims for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, should include applicable HCPCS modifiers

No.	Proposed HCPCS Modifier	Patient Relationship Categories
1x	X1	Continuous/broad services
2x	X2	Continuous/focused services
3x	X3	Episodic/broad services
4x	X4	Episodic/focused services
5x	X5	Only as ordered by another clinician

Telehealth services – Medicare pays a facility fee to the originating site and a separate payment to distant site practitioner providing the service

- Several Conditions must be met:
  - Service furnished via interactive telecommunications system
  - Service furnished by physician or other authorized practitioner
  - Service furnished to an eligible telehealth individual
  - Individual receiving the service must be located in a telehealth originating site
- 2018 Facility Fee = $25.76

FY 2018 PFS "Major" Final Rule 11-15-2017 (continued)

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Payment rates under PFS for nonexcepted services furnished by nonexcepted off-campus provider based departments

- CY 2018 PFS relativity adjuster set at 40% of OPPS rate with additional study to be performed

Care coordination services and payment for RHCs and FQHCs

- *Background:* Beginning 1/1/2016, RHCs and FQHCs can bill for Chronic Care Management (CCM) services that furnish a minimum of 20 minutes of qualifying CCM services during a calendar month to patients with two or more chronic conditions that are expected to last at least 12 months, and that would place the patient at significant risk of death or significant decline
  - Includes services incident to CCM or TCM services which can be furnished under general supervision
  - Payment rate set at $42.71
- Final rule creates General Care Management code GCCC1 for RHCs and FQHCs, with payment amount set at the average of the 3 national non-facility payment rates for CCM and general BHI - $47.73
  - RHCs and FQHCs could bill the new General Care Management code when the requirements for any of the three codes are met
  - GCM code would be billed alone or in addition to other services furnished during the visit and only billed once per month
- Effective 1/1/2018, creates a psychiatric CoCM code for patients with payment amount set at the average of 2 national non-facility PFS payment rates fo CoCM codes (G0502 and G0503) at approximately $135

Medicare Shared Savings Program

- 1/1/2019 Modifications to beneficiary assignment include:
  - RHC and FQHC beneficiary assignment to ACOs based on services furnished by the RHCs and FQHCs and not just physicians
    - Discontinued requirement of specific physician attestation
    - Services furnished by NPs, PAs, etc. will be eligible for assignment to the ACO
  - Addition of CCM and BHI codes to the definition of primary care services for purposes of beneficiary assignment

FY 2018 MACRA Quality Payment Program (QPP) Final Rule with Comment Period 11-16-2017

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This document is scheduled to be published in the Federal Register on 11/16/2017 and available online at https://federalregister.gov/d/2017-24067, and on FDsys.gov

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 414

[CMS-5522-FC and IFC]

RIN 0938-AT13

Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year

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

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

FY 2018 QPP Final Rule with Comment Period 11-16-2017 (continued)

- CMS released a final rule on 11/2/17 intended to ensure that in year two of the Quality Payment Program:
  - **A. The program's measures and activities are meaningful**
  - **B. Clinician burden is minimized**
  - **C. Care coordination is better**
  - **D. Clinicians have a clear way to participate in Advanced APMs**
- The majority of the proposed changes appear to support the goal of **reducing clinician burden** (B), including
  - ✓ Decreasing the number of clinicians who must participate
  - ✓ **Adding an option to help clinicians and small, rural practices** join together to share the responsibility of participating in value-based payment
  - ✓ **Adding a new hardship exception** to help small practices and clinicians that were impacted by Hurricanes Harvey, Irma and Maria and other natural disasters.
  - ✓ Giving up to five bonus points on the final score for **treatment of complex patients**
  - ✓ Adding five bonus points to the final scores of **small practices of 15 or fewer clinicians**
  - ✓ Continuing to award small practices **three points for measures in the Quality performance** category that don't meet data completeness requirements
- Other initiatives clearly support **goal D (Advanced APMs)** as follows
  - ✓ The changes extend the 8% generally applicable revenue based nominal amount standard that allows APMs to qualify as Advanced APM for two additional years, through performance year 2020
  - ✓ Changes the requirement for Medical Home Models so that the minimum required amount of total financial risk increases more slowly

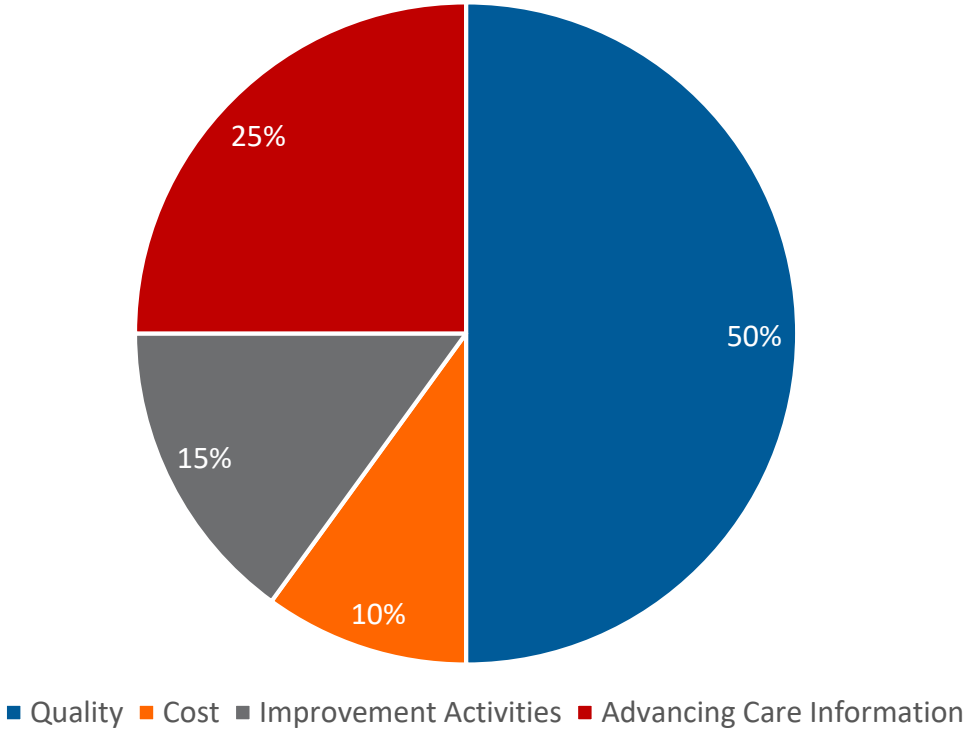
Sources: Fierce Healthcare, *CMS unveils final MACRA implementation rule: 10 changes to the Quality Payment Program,* Ilene MacDonald, 11/3/17 https://www.fiercehealthcare.com/practices/cms-unveils-final-macra-implementation-rule-10-changes-to-quality-payment-program; CMS Quality Payment Program Fact Sheet https://www.cms.gov/Medicare/Quality-Payment-Program/resource-library/QPP-Year-2-Final-Rule-Fact-Sheet.pdf

FY 2018 QPP Final Rule with Comment Period 11-16-2017 (continued)

- 2018 MIPS performance year final score distribution:
  - Quality = 50%
  - Cost = 10%
  - Improvement Activities = 15%
  - Advancing Care Information = 25%
- Payment Adjustments for the 2020 payment year will range from -5% to +5% times a scaling factor not to exceed 3, based on performance in the 4 performance categories
  - Structured to achieve budget neutrality

Overall, this final rule gives providers continued clarity that [providers] must develop an intentional Medicare risk strategy—and potentially prepare for risk within other payer segments—to succeed under MACRA.

-Rob Lazerow, Managing Director, Health Care Advisory Board



FY 2018 QPP Final Rule with Comment Period 11-16-2017 (continued)

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- Specific changes to the program for **2018** include:
  - **Decreasing the number of clinicians** required to participate in the program.
    - Will exclude individual MIPS eligible clinicians or groups with less than or equal to **$90,000** in Part B allowed charges or less than or equal to **200 Part B beneficiaries**
  - **Adding an option to help clinicians and small, rural practices** join together to share the responsibility of participating in value-based payment
    - Will give solo practitioners and small practices of 10 or fewer clinicians opportunity to form **Virtual Groups** with other practices
    - A Virtual Group is a combination of 2 or more Taxpayer Identification Numbers (TINs)
    - **Virtual Group election process for 2018 runs from October 11- December 31, 2017**
  - **Adding a new hardship exception** to help small practices and clinicians that were impacted by Hurricanes Harvey, Irma and Maria and other natural disasters
    - Will automatically weight Quality, Advancing Care Information, and Improvement Activities performance categories at **0% of final score** for impacted clinicians
    - Individual Clinicians in affected areas will NOT have a negative payment adjustment for 2017, if they are unable to submit any data
  - Weighing the **MIPS Cost Performance category at 10%** of total MIPS final score for 2018
    - Will include Medicare Spending per Beneficiary (MSPB) and total per capita cost measures
    - CMS will calculate cost measure performance; no action required from clinicians

Sources: Fierce Healthcare, *CMS unveils final MACRA implementation rule: 10 changes to the Quality Payment Program,* Ilene MacDonald, 11/3/17 https://www.fiercehealthcare.com/practices/cms-unveils-final-macra-implementation-rule-10-changes-to-quality-payment-program; CMS Quality Payment Program Fact Sheet https://www.cms.gov/Medicare/Quality-Payment-Program/resource-library/QPP-Year-2-Final-Rule-Fact-Sheet.pdf

FY 2018 QPP Final Rule with Comment Period 11-16-2017 (continued)

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- Specific changes to the program include (continued from previous slide)
  - **Raising the performance threshold to 15 points in year 2** (from three points in the transition year)
  - **Allowing the use of 2014 Edition and/or 2015 Certified Electronic Health Record Technology (CEHRT) in year 2,** but giving a bonus to those that use only 2015 CEHRT
  - **Giving up to five bonus points** on the final score for **treatment of complex patients**
  - **Adding five bonus points to the final scores of small practices** of 15 or fewer clinicians
  - **Providing more options to small practice groups of 15 or fewer clinicians,** including an exclusion of individual MIPS-eligible clinicians or groups with less than or equal to $90,000 in Part B allowed charges or less than or equal to 200 Part B beneficiaries.
    - It will also provide an opportunity to form or join a virtual group to participate with other practices, and
  - Continue to award small practices **three points for measures in the Quality performance** category that don't meet data completeness requirements
  - **Making it easier for practices to participate in Advanced APMs, which may allow them to quality for incentive payments**

Sources: Fierce Healthcare, *CMS unveils final MACRA implementation rule: 10 changes to the Quality Payment Program,* Ilene MacDonald, 11/3/17 https://www.fiercehealthcare.com/practices/cms-unveils-final-macra-implementation-rule-10-changes-to-quality-payment-program; CMS Quality Payment Program Fact Sheet https://www.cms.gov/Medicare/Quality-Payment-Program/resource-library/QPP-Year-2-Final-Rule-Fact-Sheet.pdf

Medicaid Program Improvement 11-7-2017

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Press releases
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Verma Outlines Vision for Medicaid, Announces Historic Steps Taken to Improve the Program

Date	2017-11-07
Title	Verma Outlines Vision for Medicaid, Announces Historic Steps Taken to Improve the Program
Contact	press@cms.hhs.gov

Verma Outlines Vision for Medicaid, Announces Historic Steps Taken to Improve the Program

New Policies Help Ensure States Can Focus More Resources, Time Achieving Positive Health Outcomes for Beneficiaries

- "Reset the federal-state relationship and restore the partnership, while a the same time modernizing the program"
  - Give more freedom to design innovative programs
  - Remove impediments that get in the way of states achieving their goals
- Specifically:
  - Web Site Content on 1115 Waivers updated to reflect broader view of demonstrations
    - Signals a new, broader view of Section 1115 demonstrations; and
    - CMS's willingness to work with state officials requesting flexibility to engage with their working-age, able-bodied citizens through demonstrations that will help them rise out of poverty.

Medicaid Program Improvement 11-7-2017 (continued)

- Specifically (continued):
  - Streamline and improve 1115 demonstrations, State plan amendments, and 1915 waiver process
    - CMS released new policies that improve federal and state program management, through improvements in review, approval process, and monitoring of 1115 demonstrations and CHIP state plan amendments and 1915 waivers
      - Request approval for certain 1115 demos for up to 10 years
      - Fast track federal review
      - Reducing certain 1115 reporting criteria
      - Expedite SPA and 1915 waiver efforts
  - Creation of Medicaid and CHIP Scorecard

House Ways & Means Committee: Medicare Extenders Package 11-15-2017

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Bipartisan Ways and Means Medicare Extenders Agreement

- Medicare Extender Policies
  - Two-year extension of Medicare Dependent Hospital Program and Low-Volume Adjustment Program
  - Five-year extension of rural home health add-on
  - Two year extension of Medicare geographic payment cost index for physician payments
  - Five-year extension of ground ambulance add-ons and payment modifications

Ways & Means Committee Leaders Announce Bipartisan Medicare Extenders Package

NOVEMBER 15, 2017 — PRESS RELEASES

WASHINGTON, D.C. – House Ways and Means Committee Chairman Kevin Brady (R-TX) and Ranking Member Richard Neal (D-MA) today announced a bipartisan agreement relating to Medicare "extenders," policies that expire unless Congress acts. Congress last extended these policies in the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015.

House Ways & Means Committee: Medicare Extenders Package (continued)

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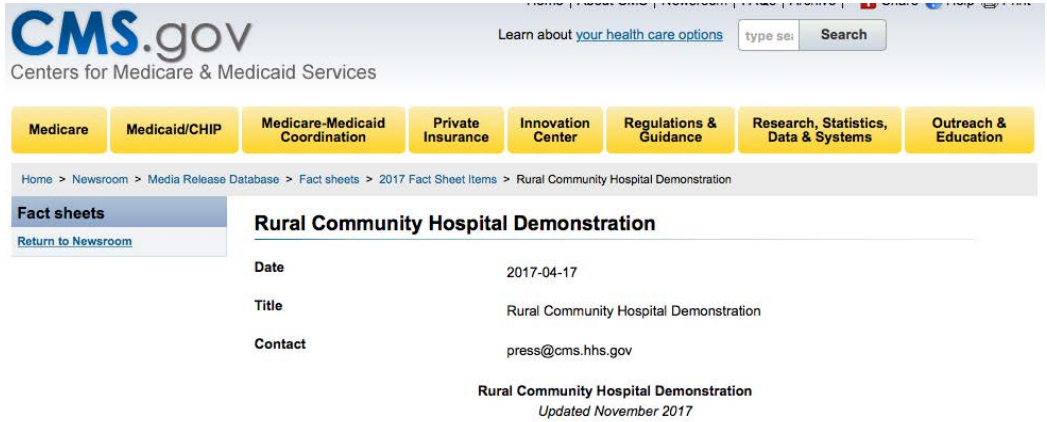
Bipartisan Ways and Means Medicare Extenders Agreement (continued)

- Medicare Extender Policy Offsets
  - Modification to skilled nursing facility payment, including MedPAC recommendations and building blocks to payment reform
  - Modifications to home health agency payment
  - ***Modifications to payments for CAH swing beds including HHS OIG recommendations and regulatory relief***
    - ***CAH swing bed payment modified to the lower SNF PPS rates***

Rural Community Hospital Demonstration 11-17-2017



- CMS is conducting the Rural Community Hospital Demonstration Program, which was extended for another 5 years by the 21st Century Cures Act
  - The demonstration tests payment under a reasonable cost-based methodology for Medicare inpatient hospital services furnished by rural hospitals with fewer than 51 acute care inpatient beds, with 24-hour emergency care services, and that are not eligible to be, or have not been designated as, Critical Access
- To be eligible to participate, a hospital must:
  - ✓ be located in a rural area;
  - ✓ have fewer than 51 acute care beds (not including beds in a psychiatric or rehabilitation unit that is a distinct part of the hospital), as reported on its most recent cost report;
  - ✓ make available 24-hour emergency services; and
  - ✓ not be eligible for designation or be designated as a Critical Access Hospital

Source: CMS.gov 2017 Fact Sheets, "Rural Community Hospital Demonstration" 4/17/17 updated 11/17 https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-04-17.html?DLPage=4&DLEntries=10&DLSort=0&DLSortDir=descending

Rural Community Hospital Demonstration 11-17-2017 (continued)

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- Participating Hospitals:

Newly selected hospitals:
• Montrose Memorial Hospital; Montrose, CO • Trinity Regional Medical Center; Fort Dodge, IA • St. John's Medical Center; Jackson, WY • Valley View Hospital; Glenwood Springs, CO • Great Plains Regional Medical Center; Elk City, OK • The Aroostook Medical Center; Presque Isle, ME • Anderson Regional Medical Center - South; Meridian, MS • McPherson Hospital; McPherson, KS • Avera St. Luke's Hospital; Aberdeen, SD • Highland Community Hospital; Picayune, MS • Morton County Health System; Elkhart, KS • St. Anthony Summit Medical Center; Frisco, CO • Avera Queen of Peace Hospital; Mitchell, SD

Hospitals that are continuing participation:
• Central Peninsula Hospital; Soldotna, AK • Bartlett Regional Hospital; Juneau, AK • Brookings Health System; Brookings, SD • Columbus Community Hospital; Columbus, NE • Delta County Memorial Hospital; Delta, CO • Yampa Valley Medical Center; Steamboat Springs, CO • St. Anthony Regional Hospital and Nursing Home; Carroll, IA • Grinnell Regional Medical Center; Grinnell, IA • Skiff Medical Center; Newton, IA • Lakes Regional Healthcare; Spirit Lake, IA • Mercy Hospital Fort Scott; Fort Scott, KS • Geary Community Hospital; Junction City, KS • Bob Wilson Memorial Grant County Hospital; Ulysses, KS • Inland Hospital; Waterville, ME • Maine Coast Memorial Hospital; Ellsworth, ME • Marion General Hospital; Columbia, MS • Alta Vista Regional Hospital; Las Vegas, NM

Source: CMS.gov 2017 Fact Sheets, "Rural Community Hospital Demonstration" 4/17/17 updated 11/17 https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-04-17.html?DLPage=4&DLEntries=10&DLSort=0&DLSortDir=descending

10/5/17: MedPAC Urges Repealing MIPS

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The Medicare Payment Advisory Commission (MedPAC) is pushing for the immediate repeal and replacement MIPS, a Medicare payment system and component of MACRA that aims to improve quality of care

MedPAC believes that MIPS is severely flawed, for reasons including

- MIPS measures provider performance instead of patient outcomes
- MIPS allows providers to choose the measures under which they will be evaluated
- Some MIPS categories rely on physician self-reporting
- CMS estimates that providers will spend over $1 billion to report and track MIPS measures in 2017

MedPAC's proposed alternative includes

Eliminating MIPS and withholding 2% of payments to physicians not in an APM

- To get the money back, doctors not in an APM could be a part of a new voluntary pay model in which they join a group of clinicians and are evaluated on performance-based measures
- Doctors could also choose to remain in fee-for-service and lose out on the 2% of reimbursement that was withheld

Source: Modern Healthcare, *MedPAC urges repealing MIPS,* Virgil Dickson, 10/5/17
http://www.modernhealthcare.com/article/20171005/NEWS/171009958

10/6/17: More from MedPAC

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One day after it urged a repeal of MIPS, MedPAC called for eliminating two major quality improvement programs

- Inpatient Quality Reporting Program
- Hospital Acquired Condition Reduction Program

MedPAC will also ask Congress to combine the Hospital Readmissions Reduction Program and the Hospital Value-Based Purchasing Program into one new program called the Hospital Value Incentive Program

- This new program would score hospitals on readmissions, mortality, spending rates, and patient experience
- Much like the proposed replacement for MIPS, this new program would withhold 2% of Medicare reimbursements

"There are currently too many overlapping programs, which creates unneeded complexity for Medicare and for hospitals. For simplicity, hospitals should have their payment adjusted under one program as opposed to separate programs."

-Ledia Tabor, MedPAC policy analyst

Source: Modern Healthcare, *MedPAC seeks to junk two hospital quality programs, merge others,* Virgil Dickson, 10/6/17 http://www.modernhealthcare.com/article/20171006/NEWS/171009937

CMS Seeks New Direction for Payment Models 9-20-2017

STROUDWATER

CMMI released a Request for Information **"seeking your feedback on a new direction to promote patient-centered care and test market-driven reforms that empower beneficiaries as consumers, provide price transparency, increase choices and competition to drive quality, reduce costs, and improve outcomes"**

This request indicates a potential interest in changing the alternative payment models the Obama Administration had employed to reduce Medicare costs and improve quality and patient safety

The Innovation Center is interested in testing models "that include increasing participation in advanced alternative payment models (APMs) and models focused on consumer-directed care and market-based innovation; physician specialty care; prescription drugs; Medicare Advantage innovation; and state-based and local innovation, including Medicaid-focused models mental and behavioral health and improving program integrity."

Sources: HFMA Healthcare Business News, *CMS Seeks New Payment Model Direction,* Mark Taylor, 9/26/17
and CMS Innovation Center *https://innovation.cms.gov/Files/x/newdirection-rfi.pdf*

Industry Feedback for CMS on Payment Models 11-20-2017

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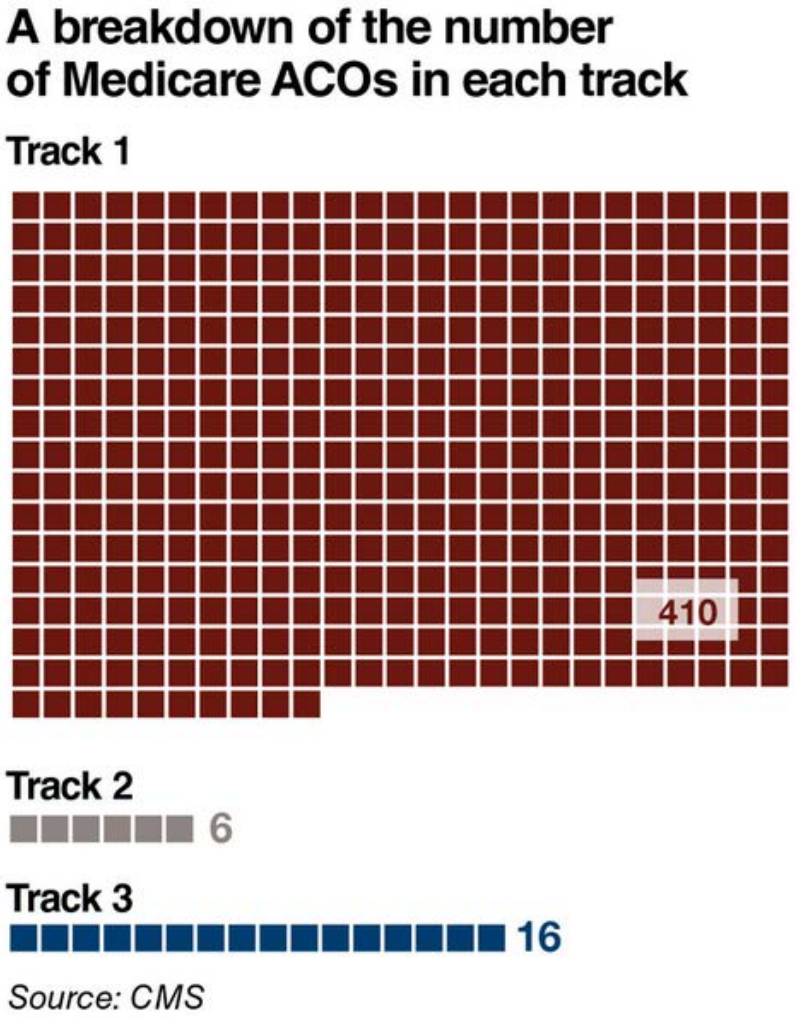
- In response to CMS's Request for Information, provider groups asked for advanced alternative payment models that are
  - **More flexible**
  - **Include specialty physicians to encourage more participation**
  - **Streamlined and less burdensome on providers**
- Some provider groups encourage the CMS to reconsider statutes that could make it difficult for providers to participate in advanced APMs
  - The Association of American Medical College urged CMS to consider lowering the threshold of Medicare payments required to be considered an advanced APM under MACRA
  - America's Essential Hospitals wrote that the CMS should take a "flexible approach when setting nominal risk thresholds for new models, to allow for greater participation by essential hospitals in advanced APMs"
- Hospital organizations including the Federation of American Hospitals supported the CMS' decision to make alternative payment models voluntary and scale back or cancel bundled payment models, but commenters asked for **even more voluntary payment models**

Source: Modern Healthcare, *Providers call on CMS for more flexible alternative payment models,* Maria Castellucci, 11/20/17

CMS Loses Money as ACOs Unprepared for Downside Risk

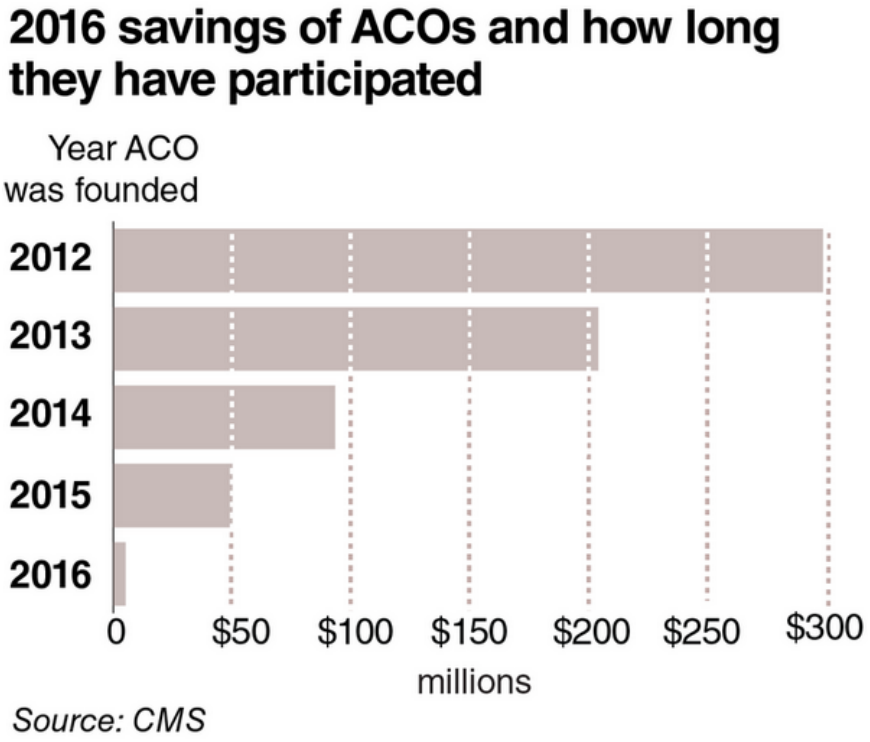
- Per a recent CMS dataset, about 56% of the 432 Medicare ACOs generated a total of $652 million in savings in 2016, but savings were outweighed by participant bonuses
  - CMS lost $39 million from the program in bonuses to ACOs
- Medicare ACO participants choose from three tracks, two of which have downside risk
  - Track 1 ACOs - 410 share in savings only
  - Track 2 ACOs – 6 share in both gains or losses
  - Track 3 ACOs – 16 share in both gains and losses



Source: Modern Healthcare, *CMS loses money as Medicare ACOs remain risk-averse,* Maria Castellucci, October 31, 2017
http://www.modernhealthcare.com/article/20171031/NEWS/171039979?utm_source=modernhealthcare

CMS Loses Money as ACOs Unprepared for Downside Risk

- The most veteran ACOs generated the most savings
  - 73 ACOs that have participated since 2012 generated $299 million in savings last year
  - 74 ACOs that began participation in 2013 generated $204 million in savings
  - 85 ACOs that joined the program in 2015 saved just $50 million
  - 100 ACOs that joined in 2016 saved $5 million



Source: Modern Healthcare, *CMS loses money as Medicare ACOs remain risk-averse,* Maria Castellucci, October 31, 2017
http://www.modernhealthcare.com/article/20171031/NEWS/171039979?utm_source=modernhealthcare

Overview of ACO PY 2016 Financial Results

- 31 percent of ACOs continue to share savings and 25 percent are trending positive in PY 2016, a 4-percentage-point increase from the prior performance year
- Physician-only ACOs continue to outperform compared to ACOs that include a hospital
  - 41 percent of physician-only ACOs shared savings, compared to 23 percent of ACOs including hospitals
- ACOs continue to show greater improvement in financial performance as they gain experience in the program
  - 42 percent of April and July 2012 starters shared savings, compared to 36 percent of 2013 and 2014 starters, 26 percent of 2015 starters, and 18 percent of 2016 starters

Source: CMS Performance Year 2016 Quality Performance and Financial Reconciliation Results for ACOs with 2012-2016 Start Dates
https://www.naacos.com/assets/docs/pdf/CMSWebinarSlidesPY16FinanceResultsOct%2019_Final.pdf

Summary of Performance Category Totals and Dollars

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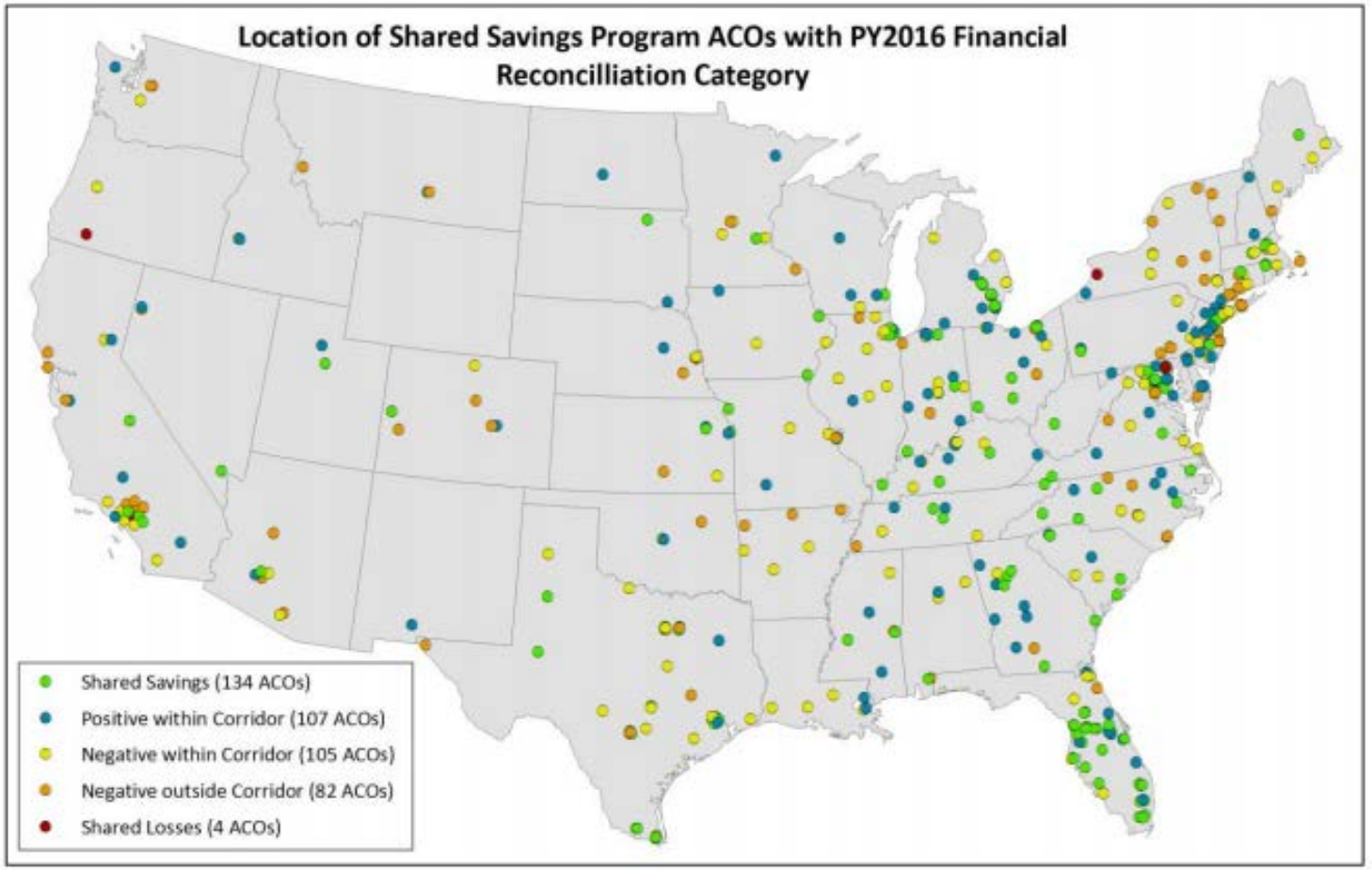
- 134 out of 432 ACOs (31 percent) generated shared savings
  - These ACOs earned performance payments totaling more than $700 million
  - 5 ACOs with shared savings will not receive payments due to AP or AIM recoupment
- 107 ACOs (25 percent) were positive within corridor
- 105 ACOs (24 percent) were negative within corridor
- 82 Track 1 ACOs (20 percent) had assigned beneficiary expenditures that were greater than their updated benchmark and fell outside their negative MSR corridor
- No Track 2 ACOs shared losses
- 4 Track 3 ACOs shared losses

Source: CMS Performance Year 2016 Quality Performance and Financial Reconciliation Results for ACOs with 2012-2016 Start Dates
https://www.naacos.com/assets/docs/pdf/CMSWebinarSlidesPY16FinanceResultsOct%2019_Final.pdf

Geographical Distribution of Shared Savings Program ACO Performance



Source: RTI analysis of PY 2016 financial reconciliation data. Note: ACO location based on county with plurality of assigned beneficiaries.

Source: CMS Performance Year 2016 Quality Performance and Financial Reconciliation Results for ACOs with 2012-2016 Start Dates
https://www.naacos.com/assets/docs/pdf/CMSWebinarSlidesPY16FinanceResultsOct%2019_Final.pdf

2016 Performance Compared to Previous Years

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Financial Performance	Shared Savings	Positive w/in Corridor	Negative w/in Corridor	Negative outside Corridor
PY 2016 (N=432)	31%	25%	24%	20%
PY2015 (N=392)	31%	21%	22%	26%
PY2014 (N=333)	28%	27%	26%	20%
PY1 (N=220)	26%	27%	27%	20%

Source: RTI analysis of PY1, PY 2014, PY 2015, and PY 2016 financial reconciliation data.
Notes: PY1 final includes the 21-month period (4/1/2012- 12/31/2013) for April 2012 starters, the 18-month period (7/1/2012- 12/31/2013) for July 2012 starters and Calendar Year (CY) 2013 for January 2013 starters. Due to rounding, percentages may not sum to 100 percent.

Source: CMS Performance Year 2016 Quality Performance and Financial Reconciliation Results for ACOs with 2012-2016 Start Dates
https://www.naacos.com/assets/docs/pdf/CMSWebinarSlidesPY16FinanceResultsOct%2019_Final.pdf

Percentage of ACOs Meeting Quality Standards

	2012 Reporting Period	2013 Reporting Period	2014 Reporting Period	2015 Reporting Period	2016 Reporting Period
Met Quality Performance Standard	109 (96%)	214 (97%)	322 (97%)	388 (98%)	428 (99%)
Did not Meet Quality Performance Standard	5 (4%)	6 (3%)	11 (3%)	9 (2%)	4 (1%)
Total Number of ACOs	**114**	**220**	**333**	**397**	**432**

Source: CMS Performance Year 2016 Quality Performance and Financial Reconciliation Results for ACOs with 2012-2016 Start Dates
https://www.naacos.com/assets/docs/pdf/CMSWebinarSlidesPY16FinanceResultsOct%2019_Final.pdf

More Than One-Quarter of Insured Adults Were Underinsured in 2016

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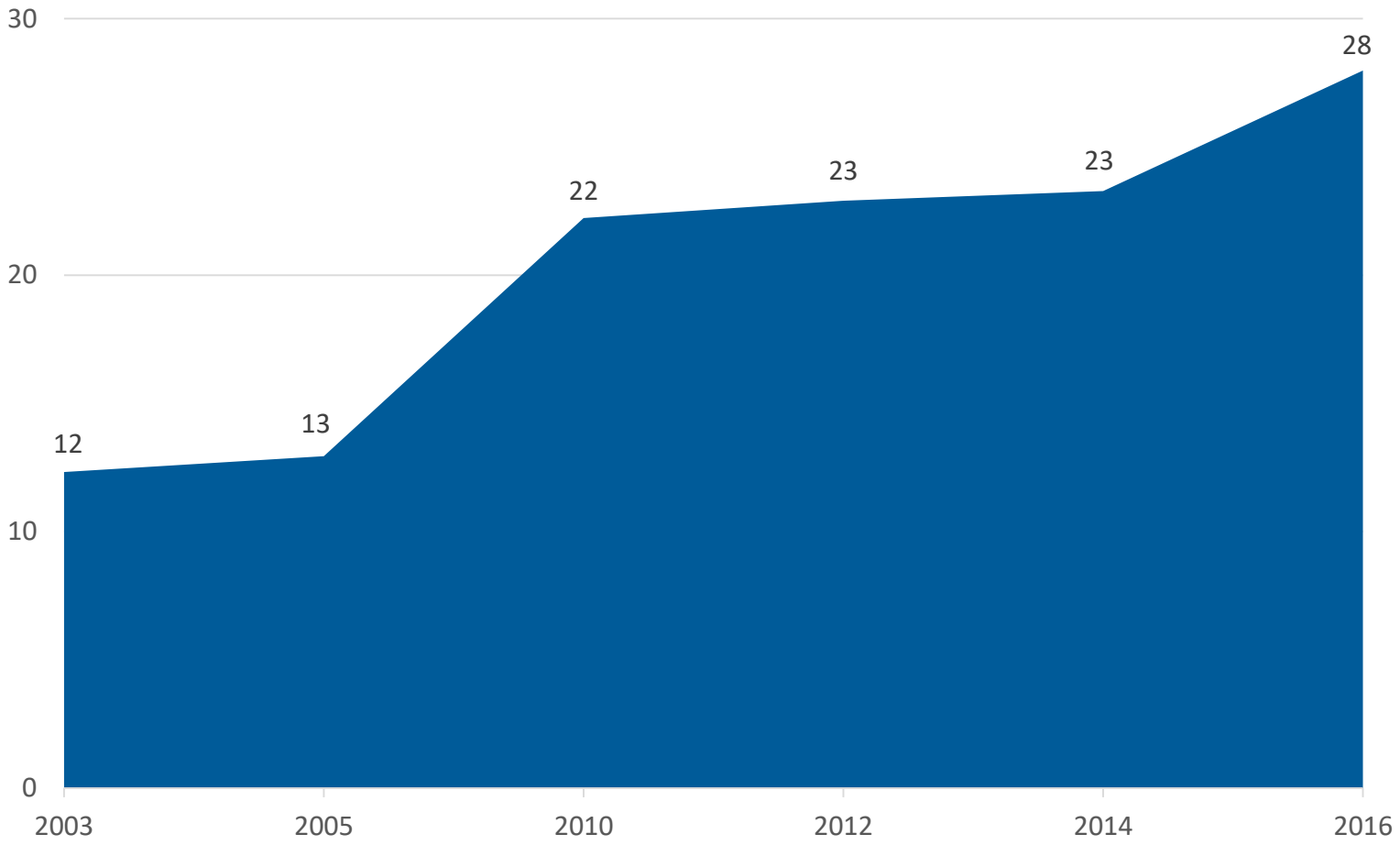
*Percent adults ages 19–64 insured all year who were underinsured**



- * Underinsured defined as insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income.
- Data: Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, and 2016).

Deductibles in Private Plans Have Grown over the Past Decade

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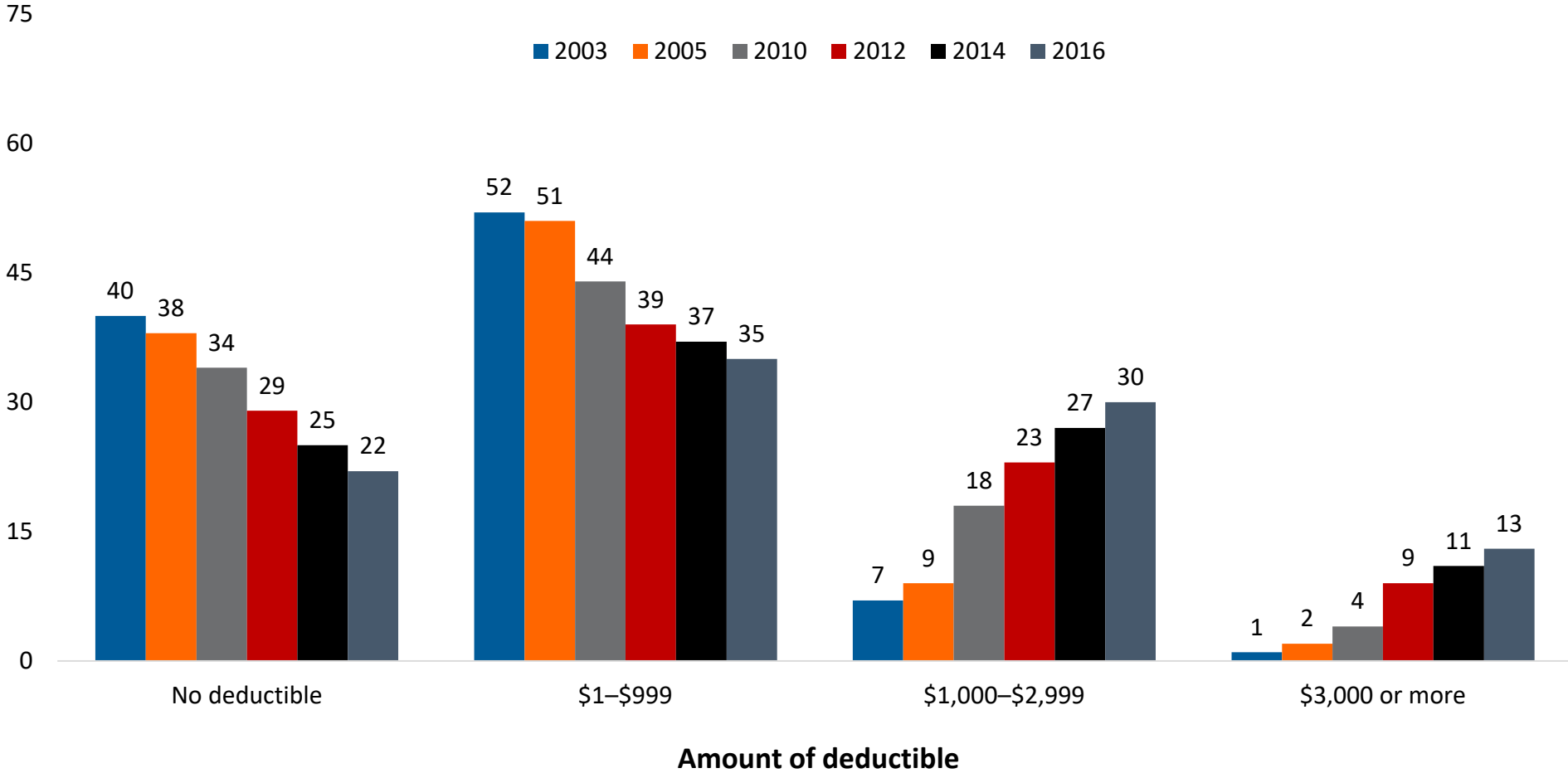
*Percent adults ages 19–64 with private coverage**



* Base is those who specified deductible.

Data: Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, and 2016).

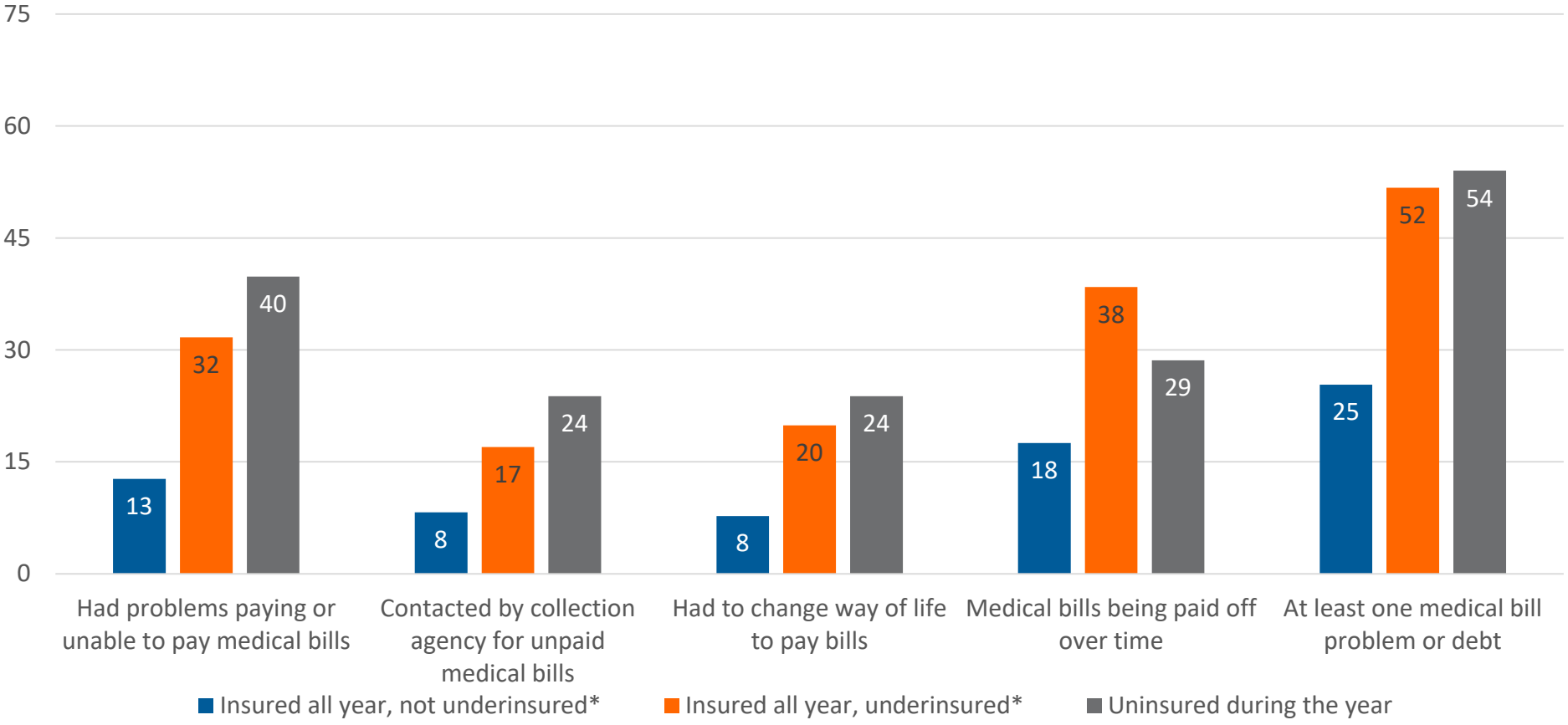
The Commonwealth Fund

Source: S. R. Collins, M. Z. Gunja, and M. M. Doty, *How Well Does Insurance Coverage Protect Consumers from Health Care Costs? Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016,* The Commonwealth Fund, October 2017.

More Than Half of Underinsured Adults Reported Medical Bill Problems, Close to Rate of Uninsured

STROUDWATER

Percent adults ages 19–64



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Adults with High Deductibles Reported Problems Paying Medical Bills at Twice the Rate of Adults Without Deductibles

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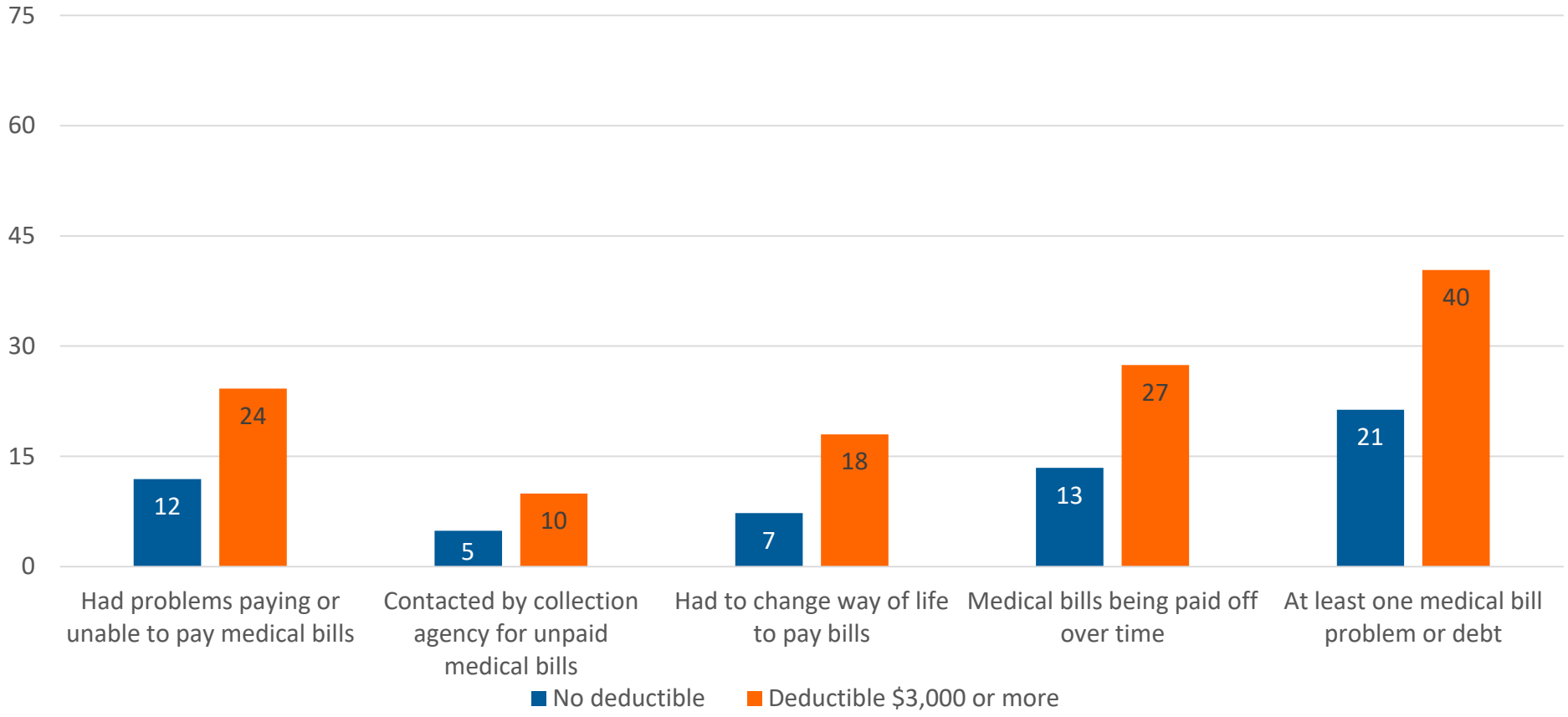
Percent adults ages 19–64 with private coverage who were insured all year



Data: Commonwealth Fund Biennial Health Insurance Survey (2016).

More Than Two of Five Underinsured Adults Reported Problems Getting Needed Care Because of Cost

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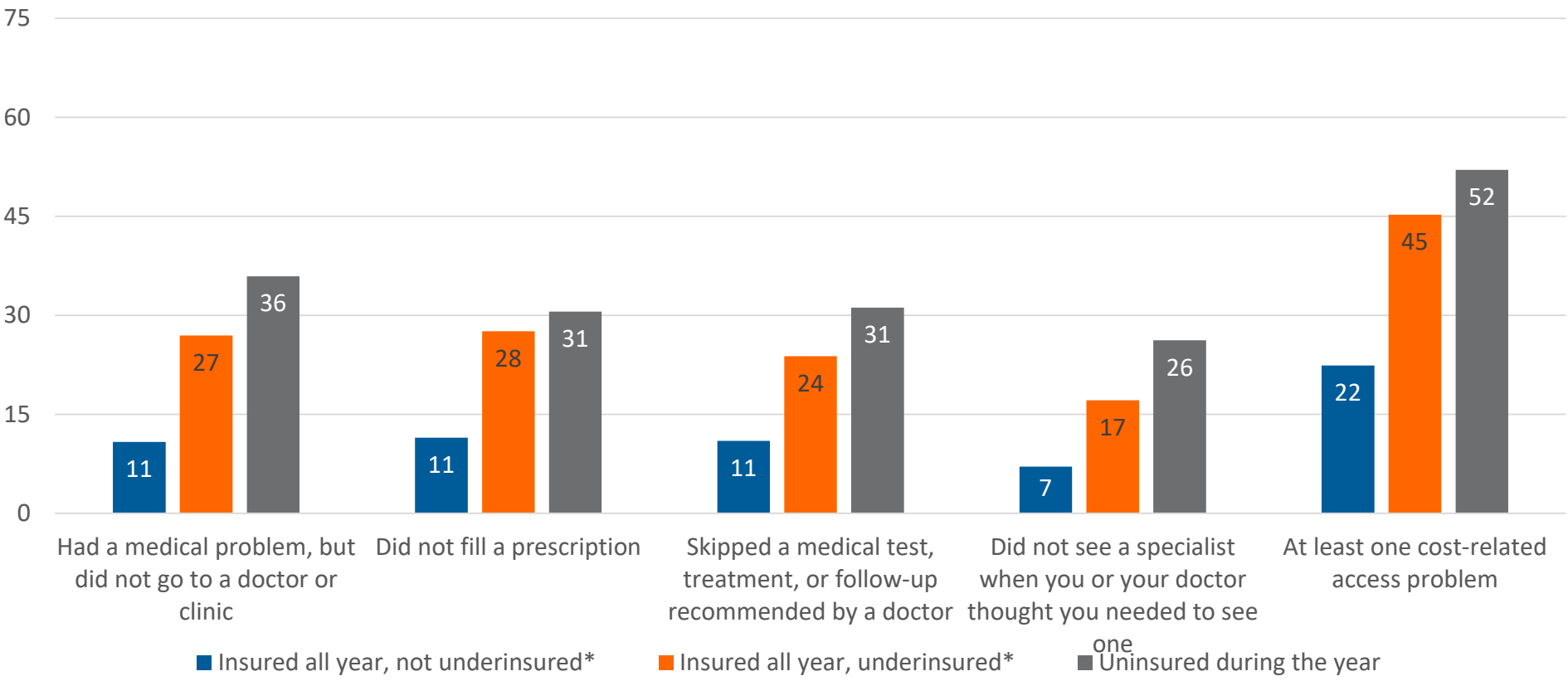
Percent adults ages 19–64



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Source: S. R. Collins, M. Z. Gunja, and M. M. Doty, *How Well Does Insurance Coverage Protect Consumers from Health Care Costs? Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016,* The Commonwealth Fund, October 2017.

Adults with High Deductibles Reported Problems Getting Needed Care Because of Cost

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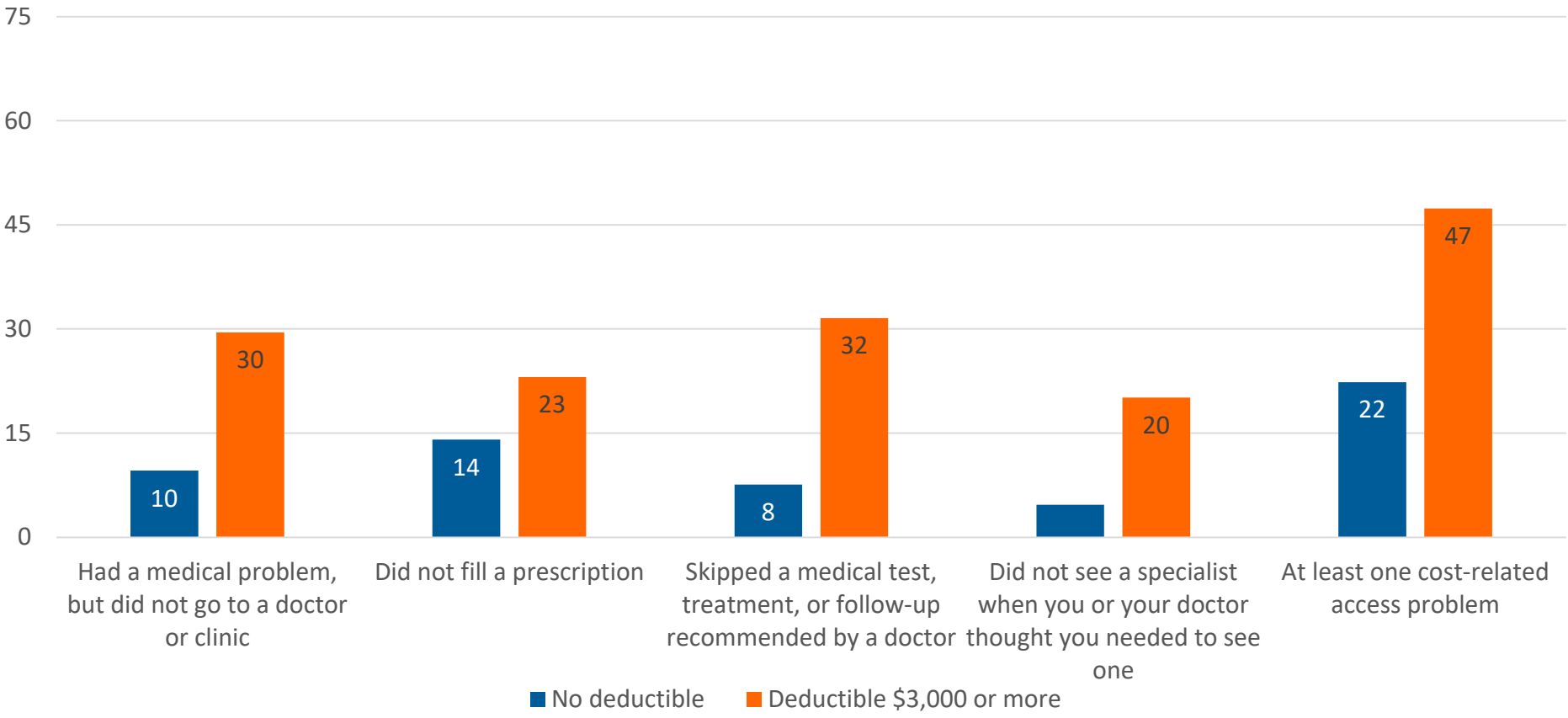
Percent adults ages 19–64 with private coverage who were insured all year



Data: Commonwealth Fund Biennial Health Insurance Survey (2016).