ACHE-RI FEDERAL UPDATE

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How the first 100 days of the Trump Administration and 115th Congress are impacting healthcare

Congressional Healthcare Priorities

- Repealing ACA
- ACA Funding Taxes
    - Cadillac Insurance Plans
    - Medical Device
- Reauthorization of the Children's Health Insurance Plan (CHIP)
    - Expires Sept. 30, 2017, usually receives bipartisan support, however Republicans may call for Medicaid reform and block grants as part of a CHIP reauthorization

Congressional Healthcare Priorities

- Drug Pricing
  - Investigating pharmaceutical companies' price decisions and pharmaceutical misclassifying drugs under Medicare and Medicaid rebate programs
- Supreme Court nominee
- Medicare Reform
  - Structural Reform
    - Combine Parts A and B
    - Raise age
    - Delivery system reform/alternative payment models
  - Premium Reform

Continuing Resolution

- A type of appropriations legislation, a **continuing resolution** is a bill that appropriates money when Congress and the president fail to pass regular appropriations bills
- The funding extends until a specific date or a regular appropriations bill is passed
- FY 2017 Continuing Resolution ends April 28

Reconciliation

Since the ACA passage, several Republicans proposed using reconciliation to repeal major parts

What is reconciliation?

- A budget process that allows Congress to use a simple majority to pass a bill
  - Budget resolution to reconcile

Democrats used this process to pass the Affordable Care Act in 2010

In order to repeal the ACA, the reconciliation must be budgetary in nature

The Process

- Reconciliation
  - Stage 1
    - Vehicle: FY 2017 Budget Resolution
    - Focus: Repeal AHA
    - Timing: Winter 2017
  - Stage 2
    - Vehicle: FY 2018 Budget Resolution
    - Focus: Tax reform (and possibly Medicaid restructuring)
    - Timing: Fall 2017

Potential Timetable

- Mid-January — Congress adopts FY17 Budget Resolution with reconciliation instructions to repeal ACA
- January 27 — Committees must report 2017 reconciliation bills
- February 20 — Target date for reconciliation bill repealing ACA to White House
- March 15 — Debt ceiling suspension expires
- April 28 — Continuing resolution expires
- May 1? — Trump sends FY 2018 budget to Congress (maybe)
- June 30? — Congress adopts FY 2018 Budget Resolution
- September 1? — Committees must report FY 2018 reconciliation bills
- September 30? — FY 2018 reconciliation bill to White House
- October 1 — FY 2018 begins

Potential Executive Actions

- Create additional exemptions to employer mandate
- **Avoid IRS enforcement of individual penalties**
- **Fail to enforce employer mandate**
- **Regulatory reform – eliminate 2 for every new 1**
- Revise medical loss ratio
- Extend availability of non-compliant ACA plans
- Stop Justice Department suits defending ACA
- Failure to pursue premium stabilization actions
- Increases barriers to enrolling in marketplace plans
- Disable or defund the CMS Center for Consumer Information and Insurance Oversight
- CMMI constraints

The latest news on efforts to repeal the Affordable Care Act

Latest News on ACA

Draft legislative language became public regarding potential Affordable Care Act (ACA) repeal and replace legislation that may be considered by the House.

- From a Feb. 10 discussion draft, and some reports indicate that it may be outdated.
- Could give an indication of the general direction House Republicans may take on ACA repeal and replace.
- The committees of jurisdiction intend to mark up a bill, perhaps as early as next week.

Coverage Incentives

- The bill would reduce the individual and employer coverage mandate penalties to $0 beginning in 2016 and instead would, beginning in 2019, use penalties for failure to maintain coverage as the incentive to enroll in coverage.
- Insurers would assess a penalty on any individual who experienced 63 or more continuous days without coverage during a 12-month look-back period.
- The penalty would be 30 percent of the monthly price of the health plan premium and would be assessed on all monthly premium payments made during the coverage year (or the remainder of the year for partial-year enrollees).

Medicaid

- Until Dec. 31, 2019, states may receive enhanced Federal Medical Assistance Percentage (FMAP) for expansion adults. It appears that additional states may expand during the interim and receive enhanced FMAP.
- After Dec. 31, 2019, states would no longer receive the enhanced FMAP except with respect to expansion adults who were enrolled in coverage as of Dec. 31, 2019 and do not have a break in eligibility for more than one month after the cut-off date.
- After Dec. 31, 2019, states may elect to cover expansion adults at their standard rate.
- Starting in fiscal year (FY) 2019, states would be subject to an aggregate medical assistance expenditure cap. The cap would be based on each state's average spending in FY 2016 in five different categories trended forward by medical Consumer Price Index plus one percentage point, multiplied by the number of enrollees. To the extent the state's actual spending exceeds the cap in any year, the federal funds relative to the excess spending would be recouped in the next fiscal year.

Medicaid

- Spending for Medicare cost-sharing, disproportionate share hospital (DSH) and administrative expenses are carved out of the cap.
- The following individuals are carved out of the cap: Children's Health Insurance Program beneficiaries, Indian Health Service beneficiaries, Breast and Cervical Cancer Treatment Eligible Individuals, immigrants not otherwise Medicaid eligible who receive Emergency Medicaid, family planning-only enrollees, dual-eligible who only receive Medicare premiums and cost sharing, and enrollees receiving premium assistance for employer coverage.
- The cap amounts are adjusted to reflect the percentage of total Medicaid expenditures in 2016 that were attributable to non-DSH supplemental payments in 2016.
- Waiver expenditures appear to be treated in the same manner as State Plan expenditures.
- The ACA's DSH cuts would be restored.

State Innovation Grants

The bill would make $100 billion available to states over a nine-year period (2018-2026) to implement high-risk pools, establish premium stabilization programs, make payments to providers, and assist individuals with premiums and cost-sharing, among other potential uses. Allocation of the dollars to the states would be based on “relative costs.”

Marketplace Stabilization

- The bill would take several steps to stabilize the Health Insurance Marketplaces for 2018, including increasing the permissible age-rating bands to 5-1 from 3-1 and giving states the authority to select the range for their state.
- The amount of the advanced premium tax credit (APTC) also would be modified based on age with younger enrollees in the same income bracket as older enrollees receiving a larger tax credit.
- Also, beginning in 2018, both the federal and state-based Marketplaces would be required to verify eligibility for special enrollment periods prior to enrollment.

Other Parts of the Bill

- Repeal of the APTC, Cost-sharing Reductions (CSRs) and Small Business Health Care Tax Credit: Beginning in 2020, APTCs and CSRs for individuals and health care tax credits for eligible small businesses would no longer be available.
- Refundable Tax Credits for Health Insurance Coverage: Beginning in 2020, the federal government would make available age-based, advanced, refundable tax credits to individuals without another source of coverage. The value of the tax credit would start at $2,000 annually for individuals under age 30 and increase with each decade of age to a maximum of $4,000 annually for individuals over age 60. Families claiming tax credits for multiple family members would be capped at a maximum tax credit of $14,000 annually. The amounts would be updated by an inflationary factor annually.
- Repeal of Essential Health Benefits: Beginning in 2020, the federal essential health benefit requirements would be repealed and states would have authority to set any minimum benefit standards.
- Changes to Health Savings Accounts (HSAs): The bill would increase the maximum amount an individual could contribute to his or her HSA to align with limits on deductibles and co-pays.
- Changes in Employer-sponsored Insurance Tax Exclusion: The bill would tax employer-sponsored coverage with current premiums above the 90th percentile. Currently, employer-sponsored health coverage is not taxed. The ACA included a similar provision – known as the "Cadillac tax" – that would collect an excise tax on certain high-value plans. However, that provision has been delayed until 2020.
- Repeal of the ACA Taxes: The bill would repeal essentially all of the new taxes authorized by the ACA, including the increase in the Medicare payroll tax for high earners, as well as fees on insurers, prescription drugs and medical device manufacturers, among others. The date of repeal varies by tax.

How to prepare for implementation of the Medicare Outpatient Observation Notice (MOON) on March 8

Medicare Outpatient Observation Notice (MOON)

Effective March 8, 2017

All hospitals and critical access hospitals must provide Medicare beneficiaries with the CMS-developed standardized Medicare Outpatient Observation Notice (MOON) both orally and in writing.

Purpose of MOON

- Explains beneficiary is outpatient, not inpatient
- Explains reason for outpatient status
- Explains implications of receiving observation services, e.g. cost-sharing, SNF eligibility
- Written in plain language, for beneficiary comprehension
- Includes blank section for additional information
- Includes dedicated signature area for beneficiary to acknowledge receipt/understanding of notice

(Hospitals may include contact information or logo here)

Medicare Outpatient Observation Notice

Patient name: **Patient number:**

You're a hospital outpatient receiving observation services. You are not an inpatient because:

Being an outpatient may affect what you pay in a hospital:

- When you're a hospital outpatient, your observation stay is covered under Medicare Part B.
- For Part B services, you generally pay:
  - A copayment for each outpatient hospital service you get. Part B copayments may vary by type of service.
  - 20% of the Medicare-approved amount for most doctor services, after the Part B deductible.

Observation services may affect coverage and payment of your care after you leave the hospital:

- If you need skilled nursing facility (SNF) care after you leave the hospital, Medicare Part A will only cover SNF care if you've had a 3-day minimum, medically necessary, inpatient hospital stay for a related illness or injury. An inpatient hospital stay begins the day the hospital admits you as an inpatient based on a doctor's order and doesn't include the day you're discharged.
- If you have Medicaid, a Medicare Advantage plan or other health plan, Medicaid or the plan may have different rules for SNF coverage after you leave the hospital. Check with Medicaid or your plan.

NOTE: Medicare Part A generally doesn't cover outpatient hospital services, like an observation stay. However, Part A will generally cover medically necessary inpatient services if the hospital admits you as an inpatient based on a doctor's order. In most cases, you'll pay a one-time deductible for all of your inpatient hospital services for the first 60 days you're in a hospital.

If you have any questions about your observation services, ask the hospital staff member giving you this notice or the doctor providing your hospital care. You can also ask to speak with someone from the hospital's utilization or discharge planning department.

You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

(Hospitals may include contact information or logo here)

Your costs for medications:

Generally, prescription and over-the-counter drugs, including "self-administered drugs," you get in a hospital outpatient setting (like an emergency department) aren't covered by Part B. "Self-administered drugs" are drugs you'd normally take on your own. For safety reasons, many hospitals don't allow you to take medications brought from home. If you have a Medicare prescription drug plan (Part D), your plan may help you pay for these drugs. You'll likely need to pay out-of- pocket for these drugs and submit a claim to your drug plan for a refund. Contact your drug plan for more information.

If you're enrolled in a Medicare Advantage plan (like an HMO or PPO) or other Medicare health plan (Part C), your costs and coverage may be different. Check with your plan to find out about coverage for outpatient observation services.

If you're a Qualified Medicare Beneficiary through your state Medicaid program, you can't be billed for Part A or Part B deductibles, coinsurance, and copayments.

Additional Information (Optional):

Please sign below to show you received and understand this notice.

Signature of Patient or Representative

Date / Time

CMS does not discriminate in its programs and activities. To request this publication in alternative format, please call: 1-800-MEDICARE or email:AltFormatRequest@cms.hhs.gov.

Form CMS 10611-MOON Expiration 12/31/2019 OMB approval 0938-1308

Who must receive MOON?

- Medicare beneficiaries who are OP and receiving observation services **for more than 24 hours.**
- Requirement applies regardless of whether or not services are payable under the Medicare program.
- Oral explanation of the MOON must be provided with delivery of the written notice.

When the hospital should provide MOON

- No later than **36 hours** after observation services are initiated, or sooner, if the beneficiary is transferred, discharged, or admitted
- Medicare Manual: Observation services initiated when ordered by physician; documented medical record.
- Valid documentation should always contain clock time when observation initiated.

When the hospital should provide MOON

- “Condition Code 44” situation (beneficiary initially admitted as I/P but subsequently placed in O/P observation)
- MOON must be provided within required timeframes, and the period for outpatient observation services would begin upon the physician order for observation.

When is MOON **not** required

- MOON is not required if inpatient services deemed not medically necessary ***after beneficiary discharged***, either via CMS reviewer denial of claim or via hospital U.R. decision.

How should MOON be delivered

- Both in writing and orally.
  - Hospitals must follow their usual procedures to ensure that beneficiaries comprehend the written contents and the oral explanation (such as use of translators, interpreters, and assistive technologies).
  - Spanish language version is also available.

Signature Requirements

- **MOON must be signed to acknowledge receipt and understanding.**
- Beneficiary, or person acting on their behalf, must sign.
- If beneficiary (or person acting on their behalf) refuses to sign, MOON must be signed by hospital staffer who presented the notice, and would include:
  - Staff name and title
  - Certification statement that the notice was presented
  - Date and time the notice was presented.

CMS-Issued MOON Instructions

Notice Instructions: Medicare Outpatient Observation Notice

Page 1 of the Medicare Outpatient Observation Notice (MOON)

The following blanks must be completed by the hospital. Information inserted may be typed or legibly hand-written in 12-point font or the equivalent.

Patient Name:

Fill in the patient's full name or attach patient label.

Patient ID number:

Fill in an ID number that identifies this patient, such as a medical record number or the patient's birthdate or attach a patient label. This number should not be the patient's social security number.

"You're a hospital outpatient receiving observation services. You are not an inpatient because:"

Fill in the specific reason the patient is in an outpatient, rather than an inpatient stay.

Page 2 of the MOON

Additional Information:

This may include, but is not limited to, Accountable Care Organization (ACO) information, notation that a beneficiary refused to sign the notice, hospital waivers of the beneficiary's responsibility for the cost of self-administered drugs, Part A cost sharing responsibilities if the beneficiary is subsequently admitted as an inpatient, physician name, specific information for contacting hospital staff, or additional information that may be required under applicable state law.

Hospitals may attach additional pages to this notice if more space is needed for this section.

Oral Explanation:

When delivering the MOON, hospitals and CAHs are required to explain the notice and its content, document that an oral explanation was provided and answer all beneficiary questions to the best of their ability.

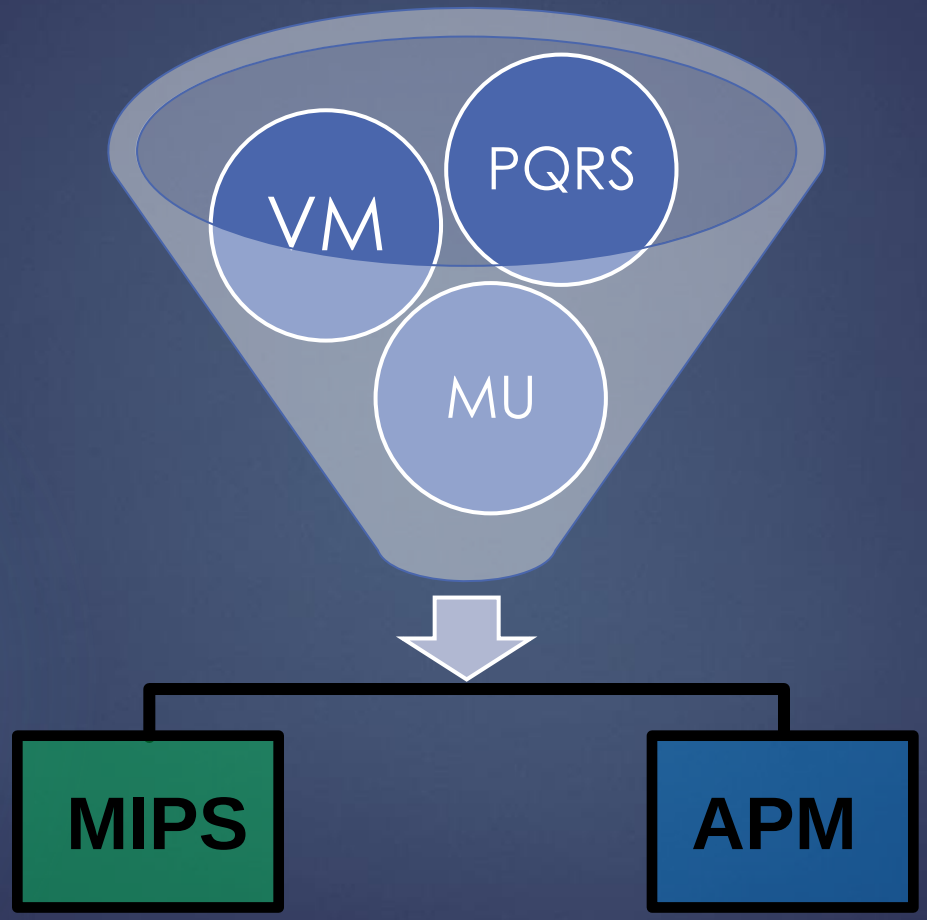
Signature of Patient or Representative:

Have the patient or representative sign the notice to indicate that he or she has received it and understands its contents. If a representative's signature is not legible, print the representative's name by the signature.

Date/Time: Have the patient or representative place the date and time that he or she signed the notice.

How performance in 2017 will impact your facility's transition to the Medicare Access and CHIP Reauthorization Act (MACRA) payment programs

Physician Quality Payment Program



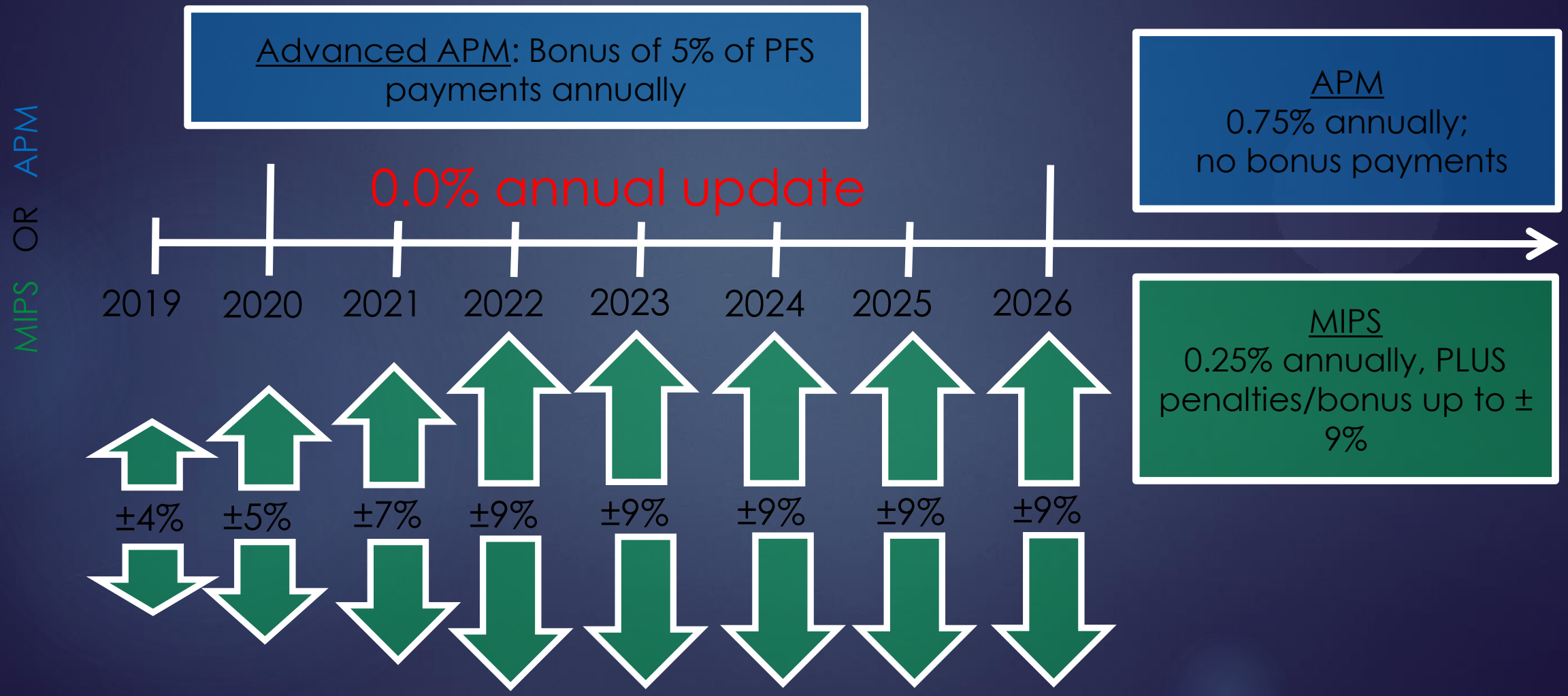
Importance of MACRA

- Physicians: impact on payment, performance measurement requirements.
- Hospitals: may defray cost of implementation and compliance by employed/affiliated physicians.
- Continued shift in hospital-physician relationships.
- Incentives to participate in alternative payment arrangements increasing interest in risk-bearing arrangements.

Overview

- “Pick Your Pace” - QPP started as of January 2017, but CMS will allow clinicians to report data from any continuous 90 day period in 2017.
- Few advanced APMs qualify for incentives in 2016.
- More data reported in 2017 means better chance of payment increase.
- Fewer clinicians than expected are subject to MIPS in 2017.
- Expectations will increase over time.

Payment Under MACRA



MIPS: Overview

- Merit-Based Incentive Payment System (MIPS) is default payment system
- Applicable to PA, NP, CNS, CRNA's starting in 2019
- Participate as individual or practice
- Exemptions:
  - Certain providers in alternative payment models
  - Clinicians in first year of Medicare
  - Low-volume threshold: providers are excluded from MIPS if they bill $30,000 or less of Medicare charges, OR see fewer than 100 patients
    - Threshold may change in future years

MIPS: Performance Categories

- For the first year, cost performance will not be tied to MIPS incentives or penalties

Category	CY 2019	CY 2020	CY 2021 and beyond
Quality	60%	50%	30%
Resource use (Cost)	NA	10%	30%
Clinical practice improvement activities	15%	15%	15%
Advancing Care Information (i.e., Meaningful Use)	25%	25%	25%

MIPS Reporting: Year 1 Flexibility

- Three options for 2017 MIPS Participation
  1. Report **"some" data** to avoid penalty (but receive no incentive)
     - One measure, one improvement activity or meet base ACI requirements
  2. Report **more than minimum data for 90 days** to avoid penalty and potentially receive small incentive
     - More than one measure, more than one improvement activity or meet more than base ACI requirements
  3. Report **all required data across all categories for at least 9**0 days to maximize opportunity for incentive

MIPS: Data Reporting Mechanisms

MIPS Category	Individual Data Reporting Options	Group Data reporting Options
Quality	- **Part B claims-based reporting** - **Qualified Clinical Data Registry (QCDR)** - **Qualified Registry** - **EHR**	- **Qualified Clinical Data Registry (QCDR)** - **Qualified Registry** - **EHR** - **CAHPS Survey Vendor (groups 25 or more)** - **CMS Web Interface (groups 25 or more)**
Resource use (Cost)	- **Part B claims-based reporting (no submission required)**	- **Part B claims-based reporting (no submission required)**
Clinical practice improvement activities	- **Attestation** - **QCDR** - **Qualified Registry** - **EHR**	- **Attestation** - **QCDR** - **Qualified Registry** - **EHR** - **CMS Web Interface (groups 25 or more)**
Advancing Care Information (i.e., Meaningful Use)	- **Attestation** - **EHR** - **QCDR** - **Qualified Registry**	- **Attestation** - **EHR** - **QCDR** - **Qualified Registry** - **CMS Web Interface (groups 25 or more)**

Provider must select one mechanism per category, due to CMS by Mar 31, 2018.
Data completeness thresholds apply

MIPS: Quality Measure Requirements

- For most reporting mechanisms, clinicians and groups would report at least 6 measures. Of the 6:
  - **Report at least 1 outcome measure**
- Can choose any measure from list of available measures
  - Specialty measure sets also available
- For groups of 16 or more clinicians, CMS also will calculate a claims-based hospital readmission measure

MIPS – Cost Category

- Category not counted towards MIPS score for CY 2019 (but will for CY 2020)
- CMS will use:
  - Total costs per capita
  - Medicare spending per beneficiary for physicians
  - Clinical condition and procedure episode cost measures from a list of 10 measures
- Cost score = average score of all the measures that can be attributed to clinician / group
  - Various attribution methodologies

MIPS – Improvement Activities

- List of 93 activities from which clinicians can choose
- Each activity assigned a weight of "medium" or "high" towards score
  - Participate in up to 4 activities for full credit
- Participation in certified PCMH automatically receives highest score
- Participation in MIPS APM automatically receives at least half the highest score
  - CMS assesses APM requirements against improvement activities list
  - MSSP Track 1 and Next Generation ACO would receive full credit

Advancing Care Information

- Continuous 90-day reporting period for 2017 and 2018 for the ACI category
- Finalizes a Base Score, Performance Score and Bonus Point structure
- Offers the 2017 ACI Transition objectives and measures with fewer reporting requirements
- Modifies some measures in the ACI objectives available in 2017 and required in 2018
  - Reduction in the measure threshold for patient electronic access
- Reporting public health and clinical data registry reporting measures available for Bonus Points

MIPS Alternative Payment Models

- CMS will use alternative scoring approach for participants in "MIPS APMs"
- Defined as APM with:
  - Participation agreement with CMS
  - One or more MIPS-eligible clinicians
  - Payment incentives based on quality and cost

MIPS Category	Weight for MSSP and Next Gen ACO	Weight for other MIPS APMs
Quality	50%	0%
Resource Use	0%	0%
CPIA	20%	25%
ACI	30%	75%

Getting Started…..

- Determine whether to participate as individuals or group practice
- Identify applicable quality measures and improvement activities
- Determine a reporting mechanism (e.g., registry, EHRs)
- Examine readiness of EHR systems

Opportunities for regulatory reform

What Do We Need?

- Reduce regulatory burden
  - Costly upgrades to meet Stage 3 meaningful use
  - Recovery audit contractors unnecessary appeals
  - Safe harbors for anti-kickback to ensure clinical integration
- Enhance affordability and value
  - Address escalating drug prices
  - Protect 340B drug pricing
  - Explore medical liability reform (e.g.. caps or attorney contingency)

What Do We Need?

- Promote quality and patient safety
  - Simplify quality reporting
  - Suspend the hospital star ratings
  - Socioeconomic adjustment for readmission penalties
  - Medicare Graduate Medical Education (GME)
- Ensure access of care and coverage
  - Continue to fund the Children's Health Insurance Program (CHIP)
  - Remove barriers to mental health treatment
  - Veteran's choice program
  - No site neutral reductions

What Do We Need?

- Advance health system transformation and innovation
  - Preserve and improve upon delivery and payment reforms
  - Promote telehealth and expand coverage
  - Waive the skilled nursing facility 3-day rule

Lastly, any repeal must have a replacement that ensures access to care and consider restoration of the significant payment reductions utilized to fund expansion.

Get out the message

Questions