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Tomorrow's Doctors, Tomorrow's Cures

Learn
Serve
Lead

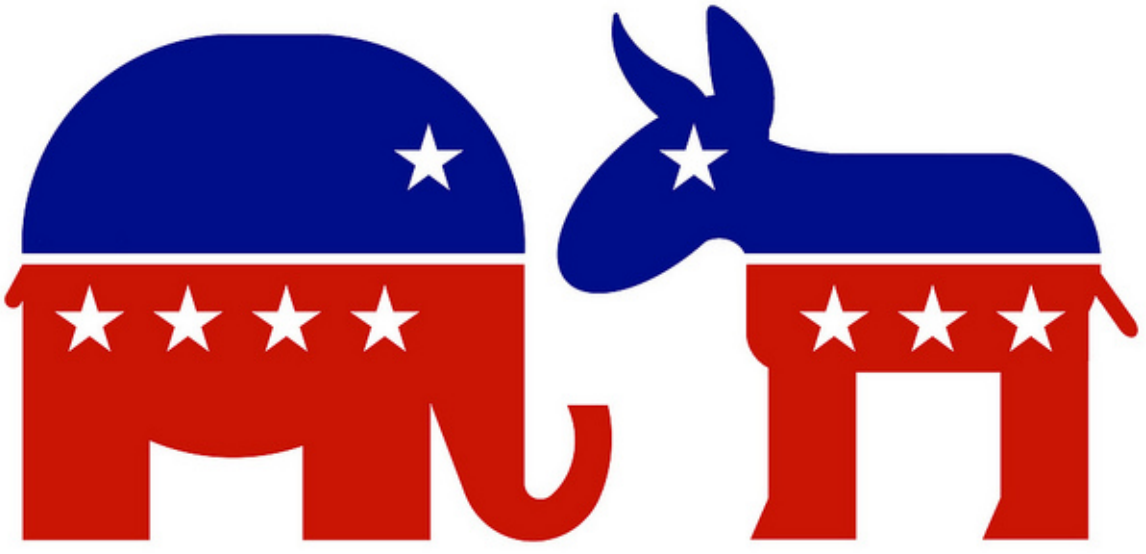
Washington Update

APPD Spring Meeting
Sarasota, FL

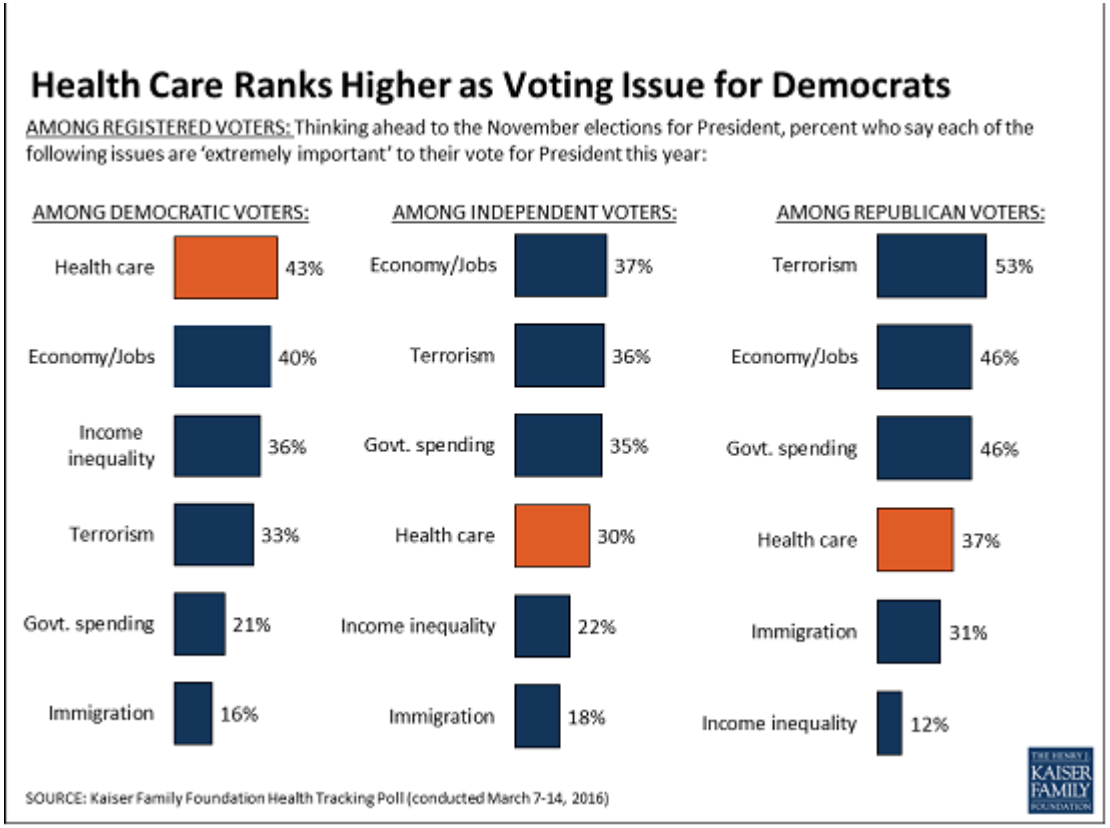
Ivy Baer
Sr. Director and Regulatory Counsel
April 10, 2016

Association of American Medical Colleges

In case you hadn’t noticed . . .



Kaiser Poll: March 2016



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TRUMP
MAKE AMERICA GREAT AGAIN!

POSITIONS STATES GET INVO

HEALTHCARE REFORM TO MAKE AMERICA GREAT AGAIN

Since March of 2010, the American people have had to suffer under the incredible economic burden of the Affordable Care Act—Obamacare. This legislation, passed by totally partisan votes in the House and Senate and signed into law by the most divisive and partisan President in American history, has tragically but predictably resulted in runaway costs, websites that don't work, greater rationing of care, higher premiums, less competition and fewer choices. Obamacare has raised the economic uncertainty of every single person residing in this country. As it appears Obamacare is certain to collapse of its own weight, the damage done by the Democrats and President Obama, and abetted by the Supreme Court, will be difficult to repair unless the next President and a Republican congress lead the effort to bring much-needed free market reforms to the healthcare industry.

But none of these positive reforms can be accomplished without Obamacare repeal. On day one of the Trump Administration, we will ask Congress to immediately deliver a full repeal of Obamacare.

However, it is not enough to simply repeal this terrible legislation. We will work with Congress to make sure we have a series of reforms ready for implementation that follow free market principles and that will restore economic freedom and certainty to everyone in this country. By following free market principles and working together to create sound public policy that ***will broaden healthcare access, make healthcare more affordable and improve the quality of the care available to all Americans***.

Any reform effort must begin with Congress. Since Obamacare became law, conservative

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ISSUES


RESTORE
THE
CONSTITUTION


SECOND
AMENDMENT
RIGHTS


SECURE
THE
BORDER


DEFEND
OUR
NATION


STAND
WITH
ISRAEL


RELIGIOUS
LIBERTY


LIFE,
MARRIAGE,
AND FAMILY


JOBS
AND
OPPORTUNITY

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A CONSERVATIVE APPROACH TO BETTER HEALTH CARE

EXPERIENCE AND RESULTS LIKE NO OTHER

Obamacare Is the Wrong Diagnosis and Must Be Repealed and Replaced: Access to affordable health insurance is an important priority but Obamacare has failed to achieve this because it has driven up the cost of health insurance approximately 80 percent in Ohio's individual and small group market and raised taxes to help subsidize health insurance coverage for families making up to $94,000 annually. Too often Obamacare mistakes treating symptoms for solving problems which only worsens the overall, long-term problem. John Kasich believes Obamacare must be repealed and replaced with efforts that instead improve access by actually lowering health care costs without interfering with Americans' personal health care decisions or imposing punishing burdens on job creators.

The Real Problems Remain Unchanged: Americans get what we pay for in health care, and too often what we pay for is more care instead of better care. In many areas a predominantly fee-for-service system creates financial incentives for health care providers to perform more services for a person who is sick rather than work to keep that person healthy. As a result, an estimated one-third of America's health care dollars are wasted on things patients don't need (IOM 2009) and, at the same time, 55 percent of Americans have been found to go without recommended treatments for preventive care and chronic care management (NEJM 2003). The time has come for leadership to fix it.

A New, Conservative Vision: In Ohio, health care purchasers, health insurance plans, and providers realize the current system is unsustainable and are working –together with Gov. Kasich's Administration–to explore new payment models that, instead of just rewarding volume, reward value that helps people stay healthier.

- ***Better primary care (patient-centered primary care):*** The first step is having a primary care system that helps promote long term good health instead of just reacting when someone gets sick. Ohio is working through its Medicaid system to encourage patient-centered primary care practices that go the extra distance to keep people healthy and thereby help control costs. Savings generated this way accrues, in part, to health insurance plans as avoided costs. To help incentivize more robust participation in this model,Ohio's four largest commercial insurers—Anthem, Aetna, Medical Mutual and UnitedHealthcare—as well as Ohio's five Medicaid managed care plans, are designing a system that also shares those savings with the providers whose work helps improve health and hold down costs.

- ***Rewarding value instead of volume (episode-based payments):*** Even with primary care payment reform, high-cost episodes will continue to account for most health spending. Today we pay for all of the inputs in these episodes separately, but if these inputs were considered as a whole then the providers involved would, similarly, work as a team to control costs and maximize quality. In a joint replacement, for example, surgeons, anesthesiologists, hospitals, device manufacturers, rehabilitation therapists, and drug makers all have separate roles and little incentive to worry about each other's costs. Instead, what if the surgeon earned more for meeting high quality standards while also better managing the entire procedure in order to produce lower costs? Many providers are actually doing this today but the savings only accrue to the health insurance plan, not the high-value provider who generates it. In March, 2015, Ohio began working with our state's four largest commercial insurers—Anthem, Aetna, Medical Mutual and UnitedHealthcare—and five Medicaid managed care plans, to set this model in motion for certain high-cost episodes.

The Path Forward: Everyone knows that Obamacare must be repealed and replaced with something that actually works in line with America's market-based principles to help Americans be healthy. So, let's not only oppose Obamacare but also put in motion real solutions that will work to improve health care access by holding down costs and help Americans live healthier lives. The Ohio model provides a path forward for the nation: patient-centered care, choices, market competition, decentralized decision-making, higher quality, respect for individuals and an end to Obamacare's big government interference.

Following the principles that have long served America well means returning control of health care choices to patients and returning full control of insurance market regulation to states. In doing so we will help more Americans get and stay healthy in a high-quality and affordable way that sustainably supports our country's long-term economic growth.

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Medicare for All

Health care must be recognized as a **right**, not a **privilege**. Every man, woman and child in our country should be able to access the health care they need **regardless of their income**. The only long-term solution to America's **health care crisis** is a single-payer national health care program.

Bernie

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Health care

Affordable health care is a basic human right.

Hillary will:

- Defend the Affordable Care Act and build on it to slow the growth of out-of-pocket costs.
- Crack down on rising prescription drug prices and hold drug companies accountable so they get ahead by investing in research, not jacking up costs.
- Protect women's access to reproductive health care, including contraception and safe, legal abortion.

Hillary led the fight to expand access to quality, affordable health care for decades—and she's not going to stop now. Throughout her career, Hillary led the fight to expand health care access for every American:

- In 1979, Hillary chaired the Arkansas Rural Health Advisory Committee, which focused on expanding health care access to isolated rural areas of the state.
- As first lady, she refused to give up when Congress defeated health care reform. Instead, she worked with Republicans and Democrats to help create the Children's Health Insurance Program, which now provides health coverage to more than 8 million children. Senator Ted Kennedy said that if not for Hillary, the Children's Health Insurance Program wouldn't be in existence today.

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HDHP and Out of Network Providers

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HDHPs: What do we know?

- In next 3 years: 44% of employers will offer only HDHPs
- 1/2014: 17.4m people enrolled in these plans (up 74% from 2010)
- Broad lack of consumer understanding
- Increased cost sharing may challenge disease management programs

Source: “Trouble Ahead for High Deductible Health Plans,” by Ifrad Islam, October 7, 2015, http://healthaffairs.org/blog/2015/10/07/trouble-ahead-for-high-deductible-health-plans/

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Addressing Out-of-Network Providers

In Obama Budget proposal:

- Protect patients from having to pay unexpected fees to out-of-network providers. Requires:
  - Hospitals to take reasonable steps to match patients with physicians who are in their health plan's network
  - Physicians who regularly provide services in hospitals to accept in-network rates

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States and Out-of-Network Providers

Table 1. Summary of Laws and Regulations Affecting Out-of-Network Balance Billing in Study States

	California	Colorado	Florida	Maryland	New Mexico	New York	Texas
Hold harmless or provider prohibition on balance billing in emergency situations (Scenario 2)	Yes, for HMOs and some PPOs	Yes	Yes, for HMO plans	Yes, for HMOs and tied to assignment for PPOs[c d]	No	Yes	Yes, for HMOs and EPOs[f]
Hold harmless or provider prohibition on balance billing in surprise bills (Scenario 3)	No	Yes	Yes, for HMOs[b]	Yes, for HMOs and tied to assignment for PPOs[c d]	No	Yes, tied to assignment[d]	Yes, for HMOs and EPOs[f]
Hold harmless or provider prohibition on balance billing in other situations (Scenario 4)	No[a]	Yes	No	Yes, for HMOs and tied to assignment for PPOs[c d]	No	Yes, tied to assignment[d]	Yes, for HMOs and EPOs[g]
State mediation or dispute resolution process	Yes, not much used	No	Yes, not much used	No	No	Yes	Yes, if more than $1,000
Disclosure rules beyond standard notices	No	No	No	Yes[e]	No	Yes	Yes

Source: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf420966, Balance Billing: How Are States Protecting Consumers From Unexpected Charges, by Hoadley, et al

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A few regulatory and other issues

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HOPD Legislation

- Applies to HOPDs more than 250 yards from main campus that haven't billed under OPPS as of 11/2/2015
- Exception for a dedicated ED
- For remote HOPDs as of 1/1/2017: bill under MPFS or ASC
- Look for proposed regulations in 2017 OPPS
- Legislative efforts to revise

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HOPD Issues for 2017 OPPS

- Relocation of HOPD should not be penalized
- Merger or acquisition should not result in loss of ability to bill as an HOPD
- Exemption for items and services furnished in dedicated ED should extend to all services provided, even those that are non-ED services
- Expansion of services should continue to be billed under OPPS
- Fee schedule billing should be at practice expense non-facility rate

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Proposed Part B Drug Model

No earlier than 60 days after final rule	No earlier than January 2017
Control: 106% ASP	106% ASP
	106% ASP + value-based purchasing tools
102.5% ASP + $16.80 flat rate per day per drug payment	102% ASP + $16.80
	102% ASP + 16.80 + value-based purchasing tools

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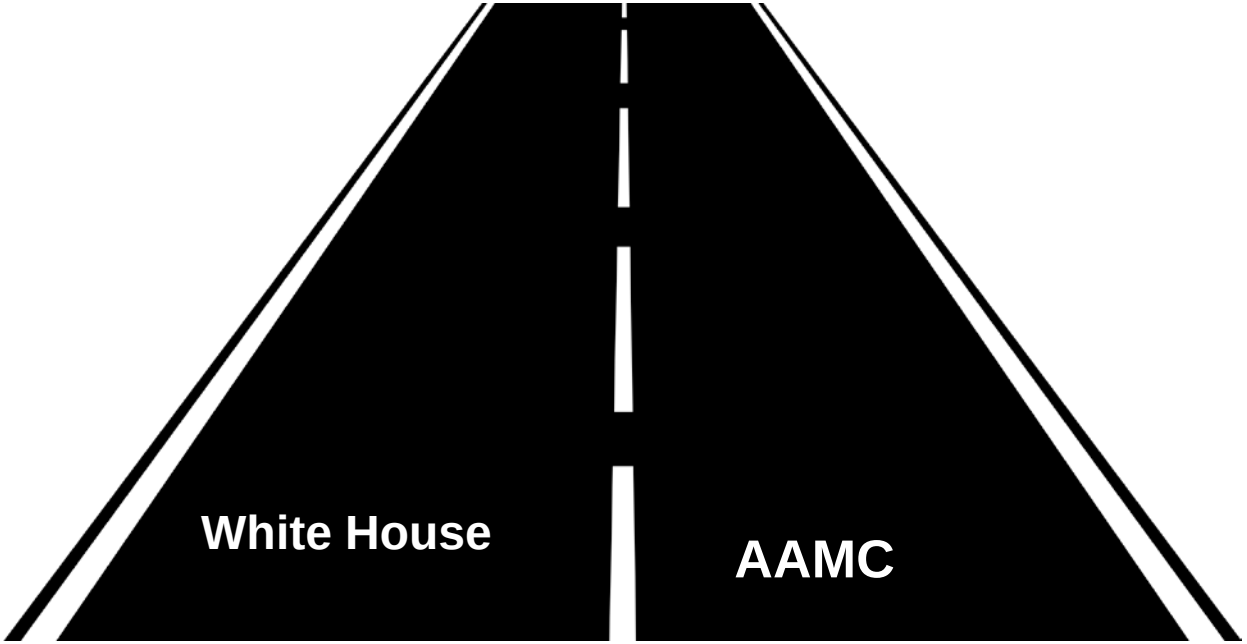
Opioids: The Role of Medical Schools



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A Quick MACRA Refresher

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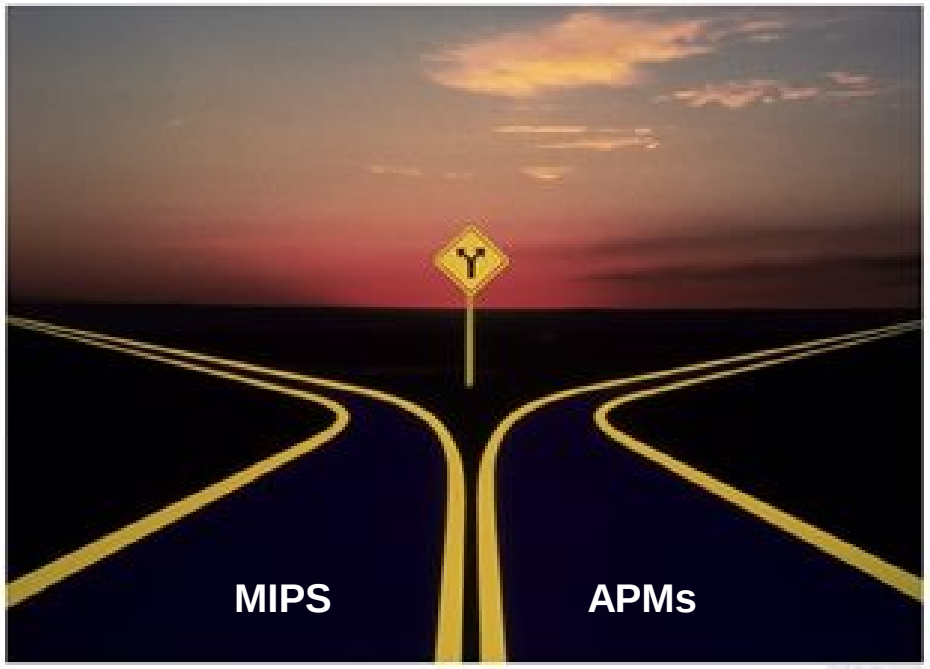
The Road to MACRA



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Timeline: How Much Payment Is At Risk?

Potential Reductions	2015	2016	2017	2018	2019	2020	2021	2022 & Beyond
Medicare EHR Incentive	-1.0% or -2.0%[c]	-2.0%	-3.0%	Up to -4.0%[d]	--	--	--	--
PQRS	-1.5%	-2.0%	-2.0%	-2.0%	--	--	--	--
Value-modifier (Max reduction)[b]	-1.0%	-2.0%	-4.0%	-4.0%	--	--	--	--
MIPS	--	--	--	--	-4.0%	-5.0%	-7.0%	-9.0%
Total Possible Reduction	-4.5%	-6%	-9%	-10%	-4%	-5%	-7%	-9%

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What are the MIPS Performance Categories?

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MIPS Composite Performance Score (scoring scale 0-100)

Performance threshold will be established based on the mean or median of the composite performance scores during a prior period.

Performance Categories*	Year 1 (2019)	Year 2 (2020)	2021-forward
Quality	50%	45%	30%
Resource Use	10%	15%	30%
Clinical Practice Improvement Activities	15%	15%	15%
Meaningful Use of EHR*	25%	25%	25%

- **Meaningful use weight can decrease to 15% and be redistributed if EHR adoption reaches 75%. If Secretary determines an EP does not have enough measures, then CMS may change weight distribution.**
- **As a Medical Home participant, you can receive the highest score in CPIA.**

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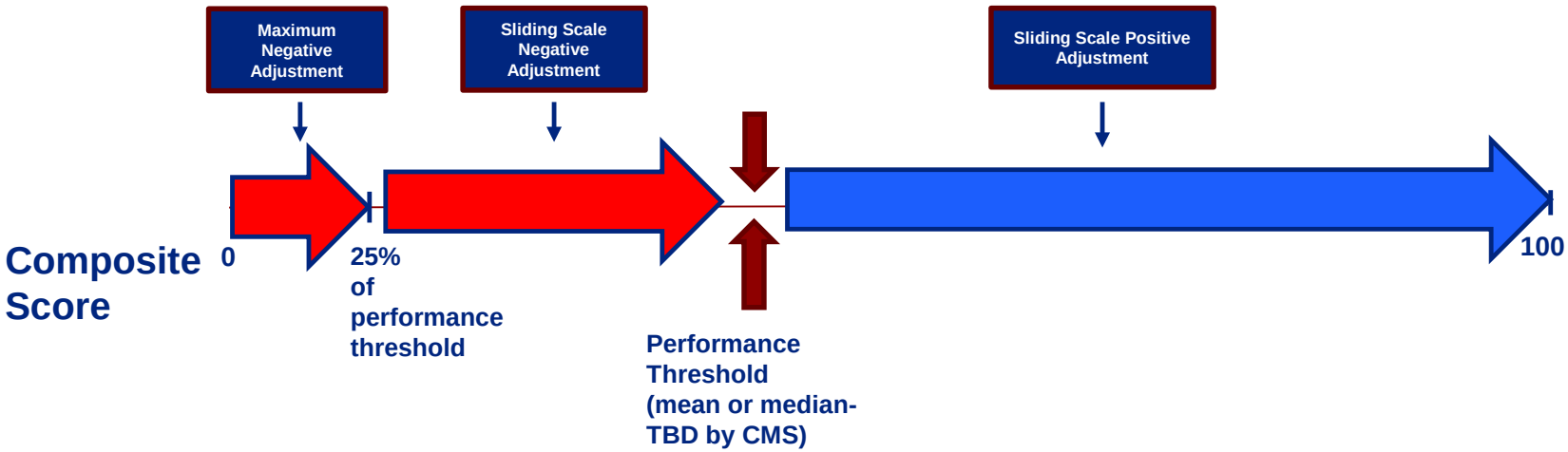
MIPS PAYMENT ADJUSTMENT



Not All APMS Qualify Under MACRA

Term	
Alternative Payment Model (APM)	• Model under CMMI (except innovation awards) • MSSP ACO • CMS demonstration projects • Demonstration required under law
Eligible APM Entity	Entity that meets the following requirements: • Use of CEHRT AND • Payment is based on quality measures comparable to MIPS And • Entity bears risk in excess of a nominal amount OR • Is a medical home expanded under section 1115A(c) or comparable medical home under Medicaid program
Qualifying APM Participant	Eligible professional who has a certain % of their patients or payments through an eligible APM. Beginning in 2021, payment may be Medicare or all-payer.
Partial Qualifying APM Participant	Eligible professional who participates in an eligible APM, but meets a lower threshold

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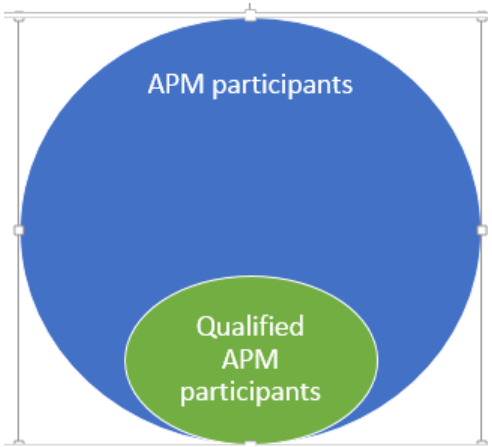
Qualifying APM Participants

Clinicians who participate in **the most advanced** APMs may be determined to be **qualifying APM participants ("QPs"). The QPs:**

- Are **not subject** to MIPS
- Receive 5% lump sum **bonus payments** for years 2019-2024
- Receive a **higher fee schedule update** for 2026 and onward



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Physician Options for 2019

Qualifying APM Participant

- Significant participation in APM (25% Medicare payments/patients)
- Eligible for 5% bonuses (2019-2024) paid in a lump sum
- Higher update starting 2026 (.75%)
- Avoid MIPS

Partial Qualifying APM

- Slightly lower threshold for participation (20% Medicare payments/patients)
- No APM incentive payments
- Lower annual updates
- Can avoid MIPS or choose to participate in MIPs; if participate in MIPs are considered to be a MIPS EP and may be subject to payment adjustment
- Starting 2026: .25% update

MIPS

- EPs for first 2 years: physician, PA, NP, CNS, and CRNA
- 3rd year onwards: additional EPs may qualify as per the Secretary discretion
- If exceptional performance, eligible for bonus from $500M pool (2019-2024)
- Starting 2026: .25% update
- Potential payment adjustment

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What Can You Do Now?

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Preparing for MACRA: It Takes a Village

Get your team together. Succeeding under MACRA is a multi-disciplinary effort that requires physician leadership and individuals with at least the following skills:

- Finance
- Contracting
- IT
- Quality
- Compliance

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Get your hospital partner involved!

This isn't just an EP issue:

- Does the hospital/health system employ physicians?
- If clinical income is reduced, how widely will the impact be felt?
- Are you part of a health system?
- What's the funds flow between the hospital and medical school/practice plan?
- What if Medicare isn't a big player in your payer mix?
- Are you seeing a movement toward bundled payments across payers?

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Getting Started

- ✓ Understand how your physicians, NPs, etc. perform on: MU, PQRS,VM
- ✓ What types of clinical improvement activities do you do?
- ✓ Understand options for your primary care physicians
- ✓ Look at your specialists—what are their options? Are their specialty societies developing APM models?
- ✓ Are you participating in any APMs that might qualify?
- ✓ Are you participating in any medical homes that meet CMMI definition or might be Medicaid equivalent?
- ✓ Monitor what CMS is doing; provide feedback; work with AAMC

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