Post Election Analysis and the Future of Healthcare in America

Linda Rouse O'Neill
VP, Government Affairs
HIDA
rouse@hida.org

2016 Elections In Review

Final 2016 Presidential Election Tally

- **Donald J. Trump**
  - 306 Electoral Votes
  - 46.3% - 62,693,993

  Won:

  - **30 of 50 States**
  - **2,623 Counties**
- **Hillary R. Clinton**
  - 232 Electoral Votes
  - 48.2% - 65,260,513 (+2.567 million)

  Won:

  - **20 of 50 States**
  - **489 Counties**

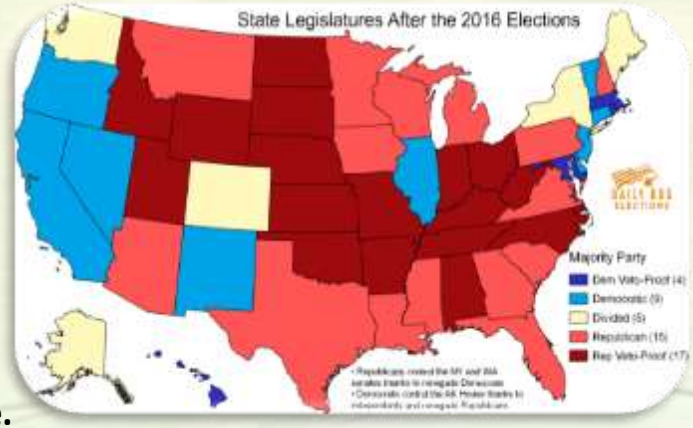
- Trump won more electoral votes than any Republican since George H.W. Bush in 1988.
- Clinton spent $2.79 million per Electoral College (EC) vote, while Trump spent $2.03 million per EC vote.
- **Latino Vote: Exit polls found that 29% of Latino voters supported Donald Trump.**
  - According to Pew Research there were 27.3 million Latino voters this year, meaning that 7.9 million Latinos voted for Trump.

2016 Elections In Review

- **Republicans now control the governor's office in 33 states - 60% of the US population**
- **Democrats control just 16 states with 40% of the US population**
- **In the last 8 years, more than 15 Democrat Governors were defeated**

GOP has control over 25 states outright and another two where they can override a Democratic governor's vetoes.

- These 27 states cover 56% of the population.
- This is where the GOP has the edge in setting themselves up for long-term control.
- With every new census, comes a new opportunity to draw lines for Congressional districts – advantage Republicans in a large majority of states.



Democrats have total control outright in 6 states outright and veto-proof majorities to override a Republican governor in just two more.

- These 8 Democratic-controlled states add up to only 19% of the population, or roughly 1/3 as much as Republicans control.

Healthcare Under a New Administration

President Trump's Healthcare Policy

- Repeal the Affordable Care Act (ACA)
- Block-grant the Medicaid program
- Create the ability to purchase health insurance across state lines
- Create and fund state high-risk pools
- Expand tax-free Health Savings Accounts (HSAs)
- Open avenues for prescription drug importation
- Increase provider price transparency in order to empower consumers
- Defund Planned Parenthood

Healthcare Under a New Administration

"A Better Way" Proposal

Not a bill *– a proposal put forth by Speaker Paul Ryan:*

Medicare:
The proposal hints at Medicare privatization. The plan would slowly raise the age of eligibility, cap federal spending, increase subsidies for low-income seniors, raise out-of-pocket costs for higher-income retirees.

Medicaid:
Give states the option to opt in to receive their federal funds in the form of a block grant. The default option would be per capita caps. Impose a work requirement for receiving Medicaid.

Employer-based Coverage:
Expand the ability of employers to offer Health Savings Accounts.

- Allows health insurance to be **sold across state lines**.

KEEPS:
Allowing children to remain on their parents plan until 26, banning insurers from charging people with pre-existing conditions higher premiums, and forbidding insurers to drop coverage if a policyholder gets sick.

Healthcare Under a New Administration

Health and Human Services (HHS) Secretary
Former House Budget Committee Chairman Tom Price, M.D. (R-GA)

Background:

- Elected first in 2004, he currently represents Georgia's 6th district in the House of Representatives.
- Served on the House Committee on Ways and Means, as Chairman of the Republican Study Committee, and currently as Chair of the House Budget Committee. Worked in private practice for 20 years as an orthopedic surgeon.
- Served as Medical Director of the Orthopedic Clinic at Grady Memorial Hospital in Atlanta.

Policy Positions:

- Supports the repeal of the Affordable Care Act (ACA).
- Has written his own bill to replace the ACA and was an instrumental part of the House Better Way Plan that will be the basis of much of the Repeal and Transition plan in 2017.
- Supports eliminating much of the federal government's role in healthcare, specifically through:
  - a free-market framework built on privatization, state flexibility, and changes to the tax code.
  - a plan to privatize Medicare so seniors would receive fixed dollar amounts to buy coverage.
  - limited federal spending on Medicaid by giving states block grants.

Healthcare Under a New Administration

Administrator of the Centers for Medicare and Medicaid Services (CMS)
Nominee: Seema Verma, CEO, SVC Strategic Health Policy Solutions

Background:
Is President, CEO, and founder of SVC, Inc., a national health policy consulting company. Served as Vice President of Planning for the Health & Hospital Corporation of Marion County. Served as Director with the Association of State and Territorial Health Officials in Washington, D.C. Has a close relationship with Vice President-Elect Mike Pence due to her past work in Indiana's healthcare system.

Policy Positions:
Helped to implement health policies favored by Republicans, such as:

- Health Savings Accounts
- limits on non-emergency transport
- healthy lifestyle requirements for beneficiaries

- Is considered the architect of the Healthy Indiana Plan (HIP), the nation's first consumer-directed Medicaid program.
- Developed many of the recent Medicaid reform programs, including waivers for Iowa, Ohio, and Kentucky, and helping to design Tennessee's coverage expansion proposal.

Affordable Care Act

What is IN the ACA:

- Acute Care: Readmissions, Value Based Purchasing (VBP), Infection Policies
- Center for Medicare & Medicaid Innovation (CMMI)
- Accountable Care Organizations (ACOs)
- Medical Device Tax
- Medicaid Expansion
- Health Insurance Exchanges/Marketplaces

What is NOT IN the ACA:

- Electronic Health Record (EHR) Meaningful Use
- Protecting Access to Medicare Act (PAMA)
- Medicare Access and CHIP Reauthorization Act (MACRA)
- Value Based Purchasing (VBP) for Post Acute
- Improving Medicare Post-Acute Care Transformation (IMPACT) Act

GOP 3-pronged Plan for ACA

1. Repeal parts under budget reconciliation process
2. Separate health bill to address other issues for replacement:

   Medical Liability, Association Health Plans, Purchasing Across state lines

3. Regulatory Action

Budget Reconciliation & Repeal

Key Repeal Provisions from House Energy and Commerce Bill:

- Repeals Medicaid expansion by removing the state option to extend Medicaid coverage to adults above 133% of the federal poverty line by 2020.
- Repeals the requirement that state Medicaid plans must provide the same "essential health benefits" that are required by plans on the exchanges.
- Repeals the Medicaid Disproportionate Share Hospital (DSH) cuts for non-expansion states beginning in 2018. Medicaid expanded states would have DSH cuts repealed in 2020.

Key Replacement Provisions from House Energy and Commerce Bill:

- Provides $10 billion over five years to non-expansion states for safety net funding to adjust payment amounts for Medicaid providers between 2018 and 2019.
- Reforms Medicaid financing by creating a per capita cap model, or per enrollee limits on federal payments to states, starting in FY 2020.
- Establishes the continuous coverage incentive, designed to limit adverse selection in healthcare markets beginning in 2018.

Budget Reconciliation & Repeal

Key Repeal Provisions from House Ways and Means Bill:

- Repeals numerous taxes and mandates—including the individual and employer mandate penalties and taxes on prescription drugs, over-the-counter medications, health insurance premiums, and medical devices.

Key Replacement Provisions from House Ways and Means Bill:

- Expands and enhances the use of Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs), including the allowable contribution limits.
- Creates an advanceable, refundable tax credit for the purchase of state-approved, major medical health insurance and unsubsidized COBRA coverage – providing assistance to those who don't receive insurance through work or a government program.

Congressional Budget Office

CBO Coverage Estimates:

- House proposal would cause 24 million people to lose coverage over 10 years.
  - Medicaid accounts for 14 of the 24 million

CBO Cost Estimates:

- House proposal saves $337 billion
  - Mostly from ending Medicaid expansion funding and subsidies to individuals

CBO Predicts:

- 52 million uninsured by 2026 compared to 28 million under current law

Enactment Process for Reconciliation

House:

~~Energy and Commerce Committee~~
~~Ways and Means Committee~~
~~Budget Committee~~
~~Rules Committee~~
House floor debate and vote

Senate:

Receive House-passed bill
Senate floor debate, amendments and vote

If Senate version different, then what?:

Goes back to House **OR** Conference Committee appointed

Ultimately, House and Senate must pass identical versions then sent to President to sign.

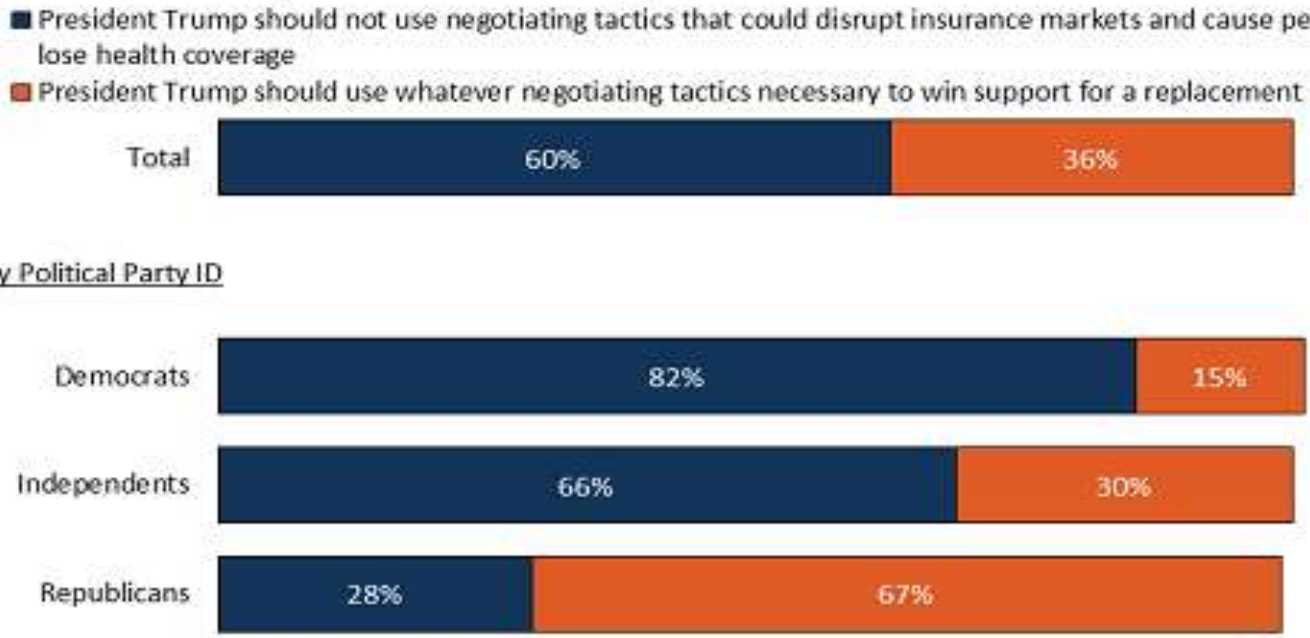
Challenges

1. Lack of industry support
2. Lack of conservative/moderate support
3. Lack of consensus between House and Senate
4. Messaging

Challenges

Views on Pres. Trump's Use of Cost-Sharing Reductions as a Negotiation Tactic Vary by Party

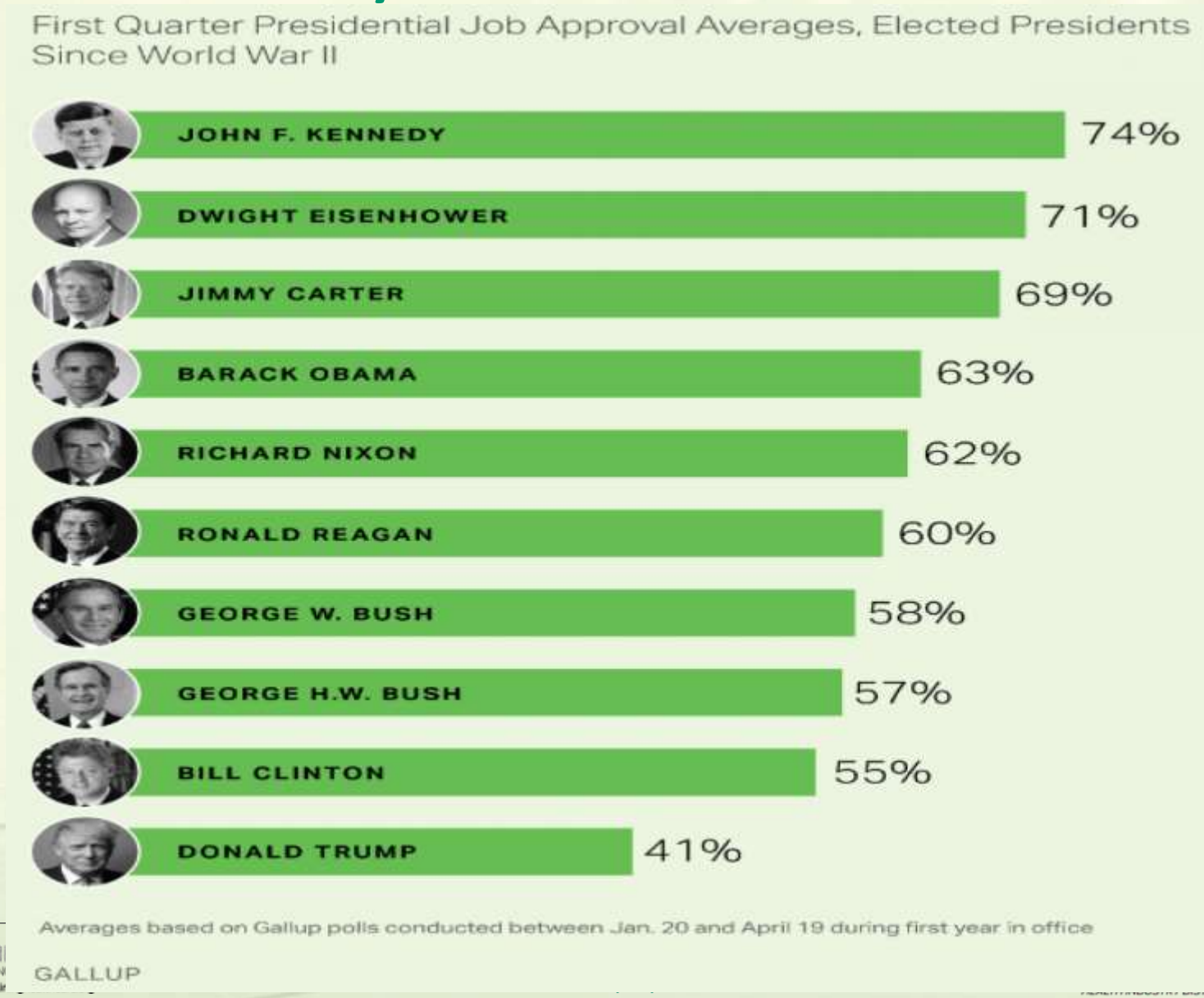
President Trump has said that the federal government may stop making cost-sharing reduction* payments, which experts say could lead to the collapse of the individual insurance market. Trump has suggested that the threat of collapse will encourage Democrats to start negotiating with him on an Obamacare replacement plan. Which of the following two statements comes closer to your own view of this strategy?



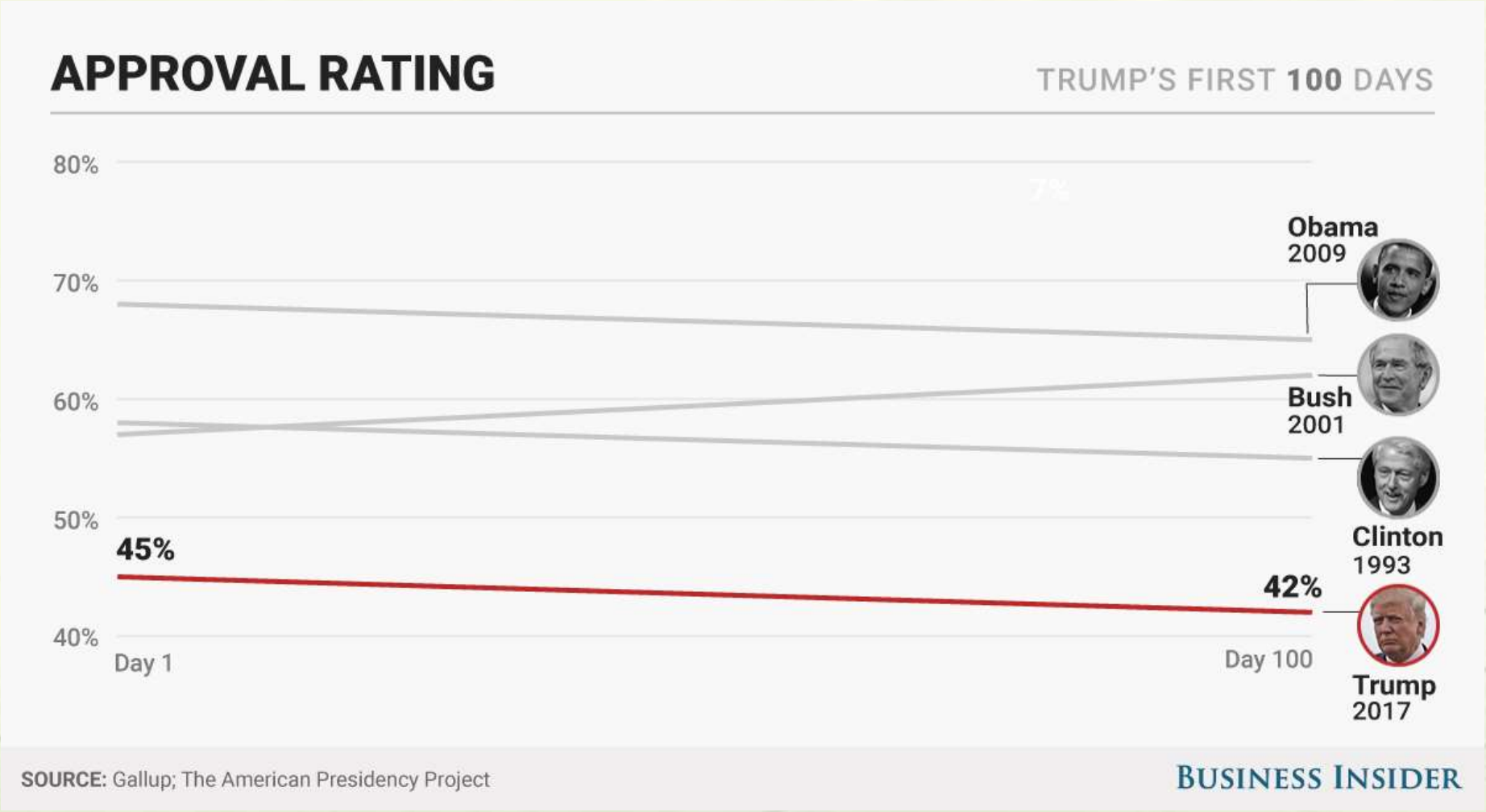
NOTE: *Question wording modified. See topline for full question wording. Don't know/Refused responses not shown.
SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted April 17-23, 2017)

First 100 Days

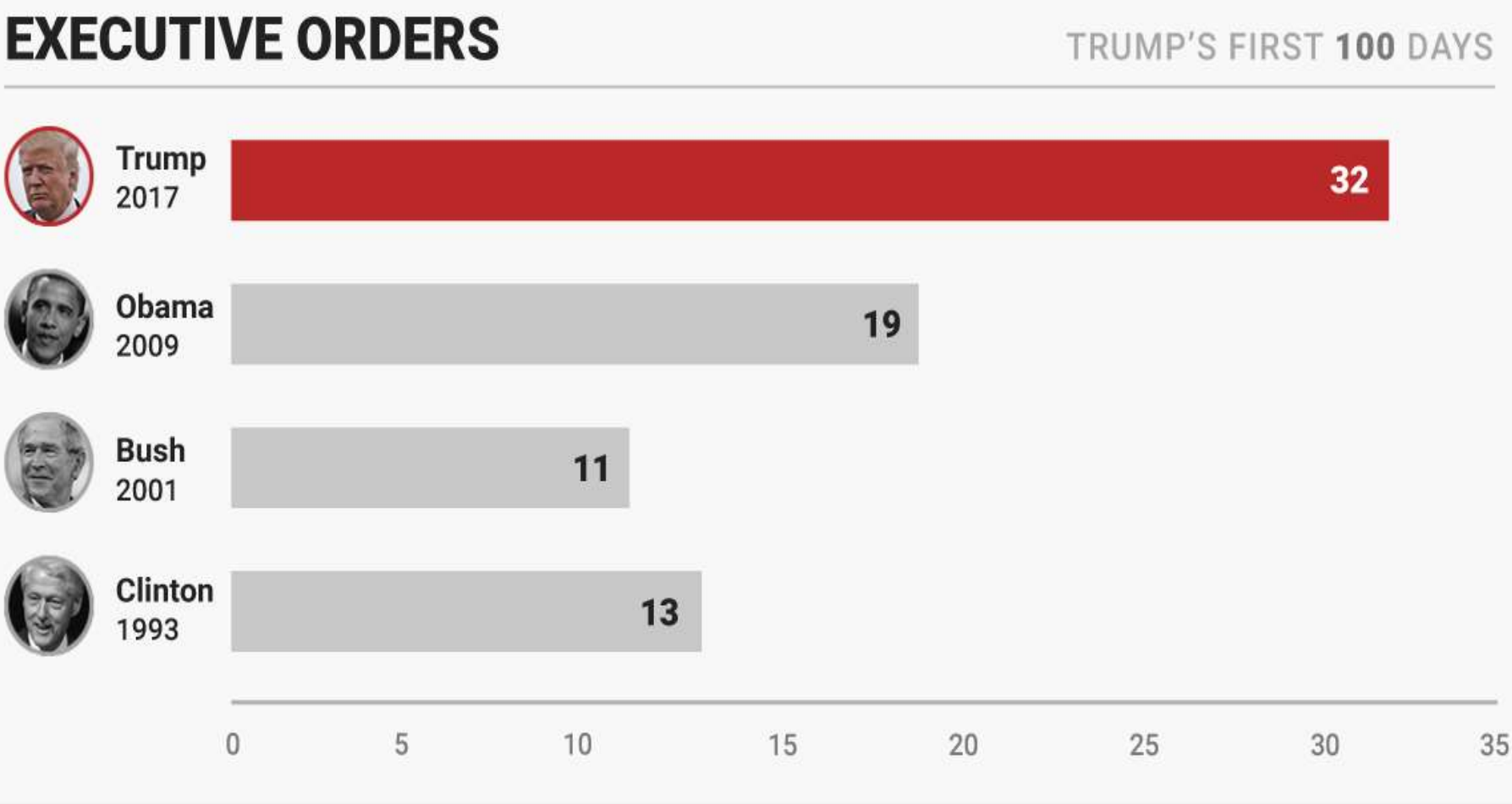
First 100 Days



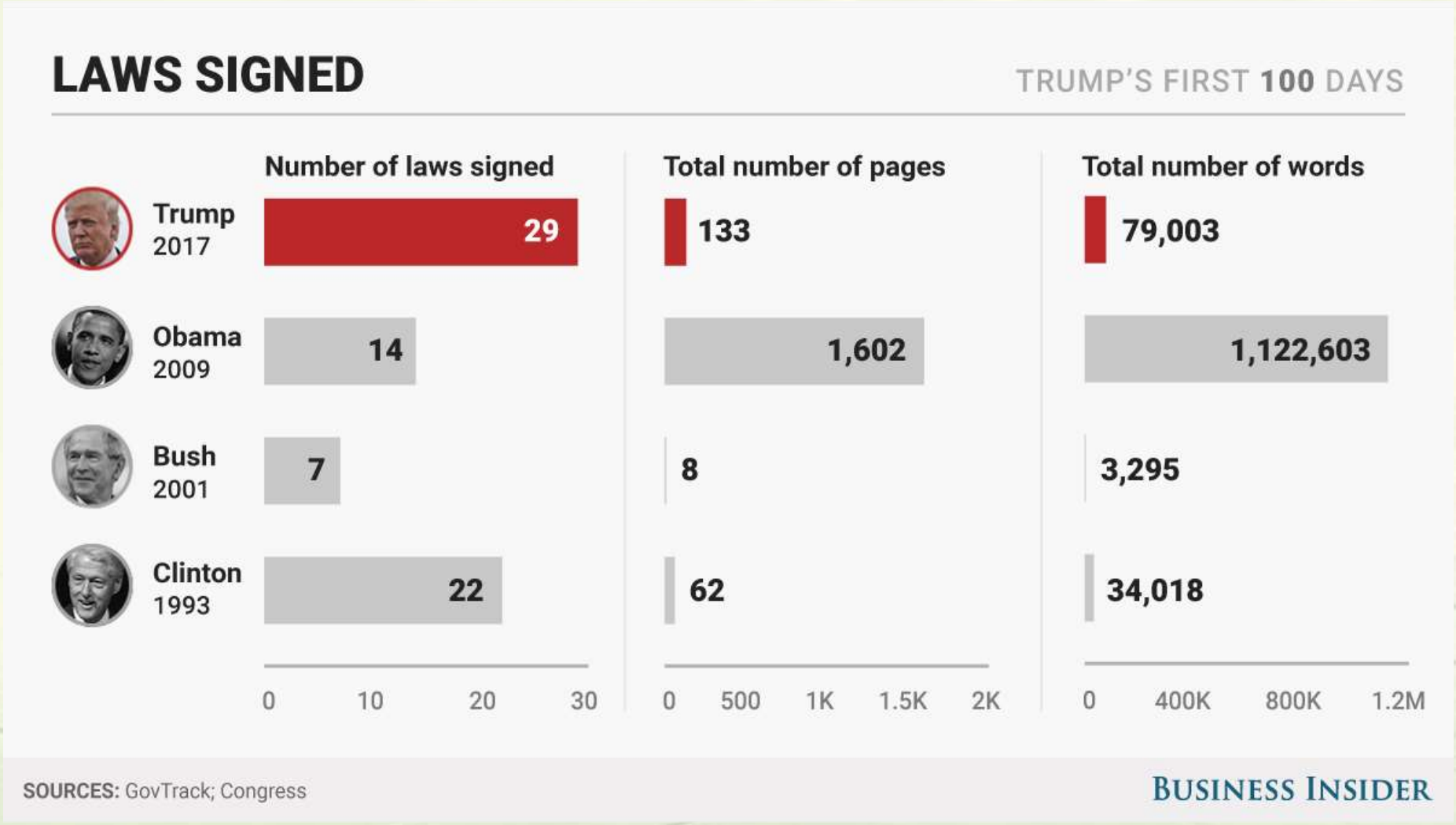
First 100 Days



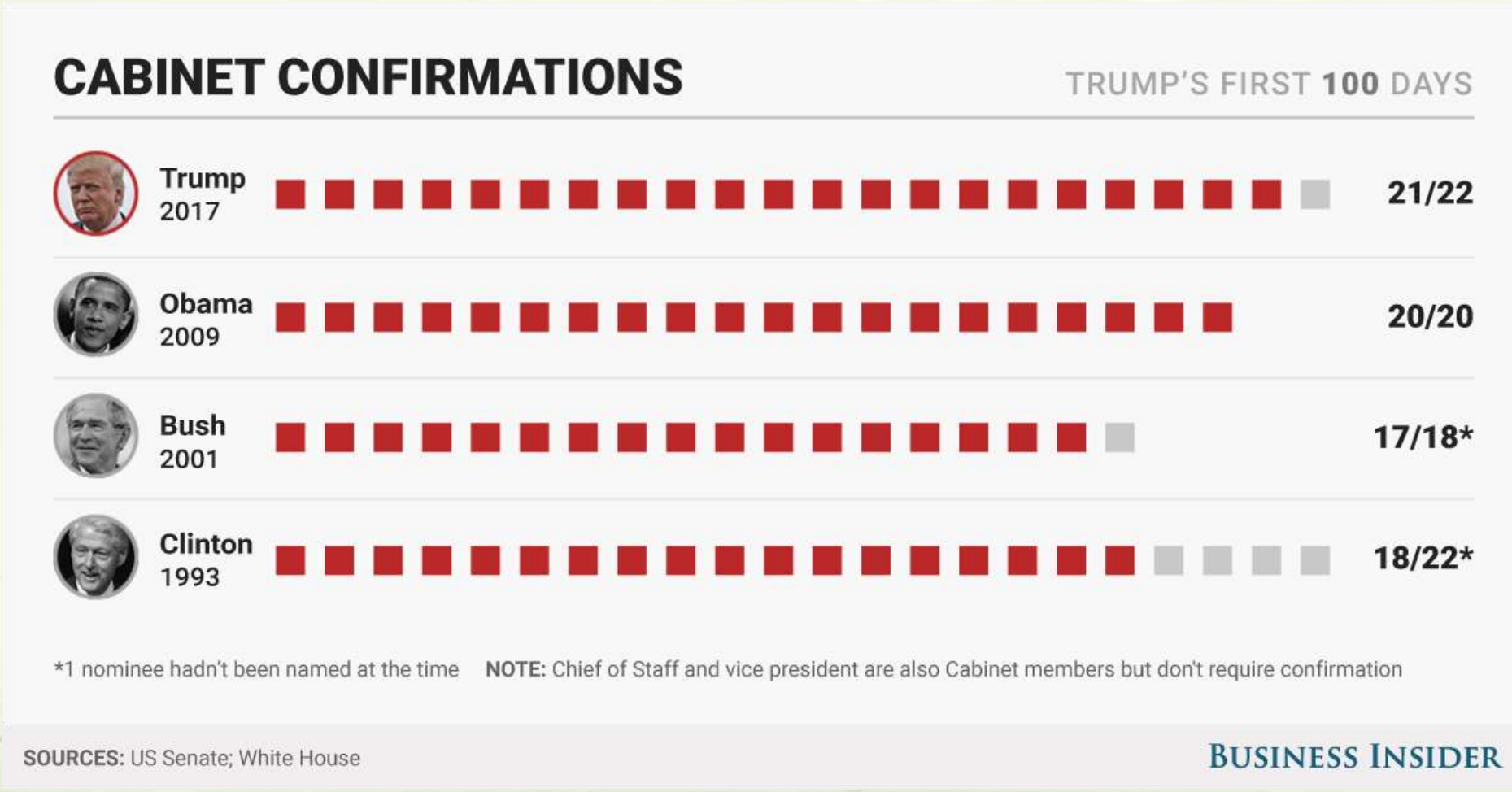
First 100 Days



First 100 Days



First 100 Days



Proposed Payment Regulations

CMS Administrator Verma and HHS Secretary Price have stated their interest in reviewing Medicare's regulations.

CMS included a substantial Request for Information (RFI) to gather feedback from stakeholders on how Medicare can be improved.

Specifically, CMS wants input on:

- regulatory policy
- practice and procedural changes to better achieve transparency
- flexibility
- program simplification
- innovation

What is Next?

1. Appropriations through Sept. 30, 2017
2. User Fee Agreements
3. Tax Reform
4. Another run at ACA repeal?
5. Budget/Appropriations
6. Campaigning for 2018

???

Linda Rouse O'Neill
VP, Government Affairs
HIDA
rouse@hida.org

Reimbursement Appendix

Acute Care

Acute VBP: Domain Re-weighting

Domain Weights Transitioning To:

Safety – 20%

Clinical Care – 30%

Efficiency and Cost Reduction – 25%

Patient and Caregiver Centered Experience of Care/Care Coordination – 25%

Readmissions: At the Max!

	FY 2013	FY 2014	FY 2015	FY 2016
# of hospitals penalized	2,211	2,225	2,620	2,592
# receiving maximum penalty	0	0	39	38
# receiving <3% to 2%	0	18	70	73
# receiving <2% to 1%	278	167	424	395
# receiving <1%	1,933	2,040	2,077	2,086
Maximum penalty allowed	1%	2%	3%	3%
Average hospital penalty	0.42%	0.38%	0.63%	0.61%
Average hospital readmission rate	19%	19%	18%	18%
Conditions measured	• Heart Attack • Heart Failure • Pneumonia	• Heart attack • Heart failure • Pneumonia	• Heart attack • Heart failure • Pneumonia • Hip/knee replacement • COPD	• Heart attack • Heart failure • Pneumonia • Hip/knee replacement • COPD

Focus on Infections

CMS has established two domains for national infection measures.

Domain #1 is the Patient Safety Indicator (PSI) 90 measure which is a composite of 8 measures.	**Domain #2** includes two healthcare-associated infection measures developed by the Centers for Disease Control and Prevention's National Health Safety Network for FY 2015. CMS also adopted additional infections for FY 2016 and FY 2017.
• Pressure Ulcer Rate • Iatrogenic Pneumothorax Rate • Central Venous Catheter-Related Bloodstream Infection Rate • Postoperative Hip Fracture Rate • Postoperative Pulmonary Embolism or Deep Vein Thrombosis Rate • Postoperative Sepsis Rate • Postoperative Wound Dehiscence Rate • Accidental Puncture and Laceration Rate	• Central Line-Associated Blood Stream Infection (FY 2015) • Catheter-Associated Urinary Tract Infection (FY 2015) • Surgical Site Infections (FY 2016) • MRSA (FY 2017) • C-Difficile (FY 2017)

Domain #1 and #2 are re-weighted each year.

Year	Domain #1	Domain #2
FY 2015	35%	65%
FY 2016	25%	75%
FY 2017	15%	85%

Physician

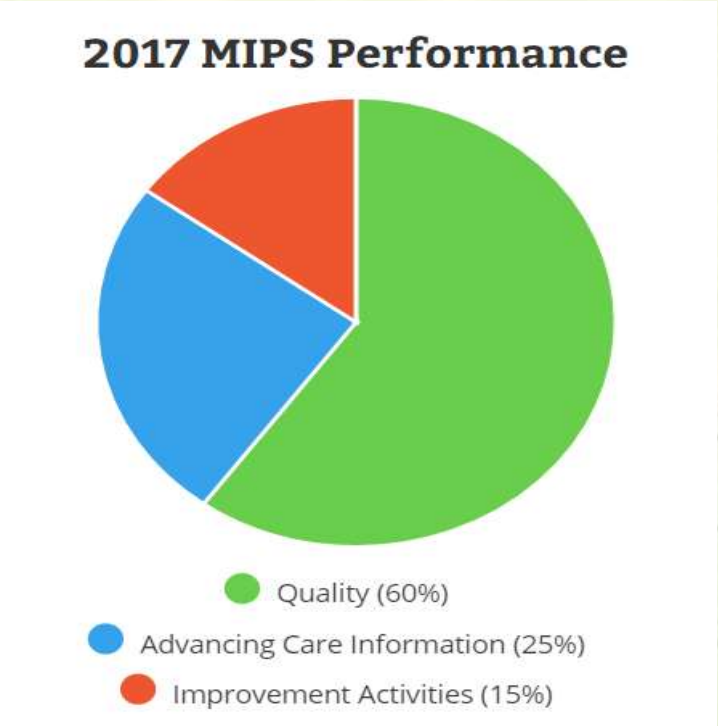
Merit-based Incentive Payment System

SGR is gone – MACRA replaces current quality reporting programs, and creates the Quality Payment Program (QPP):

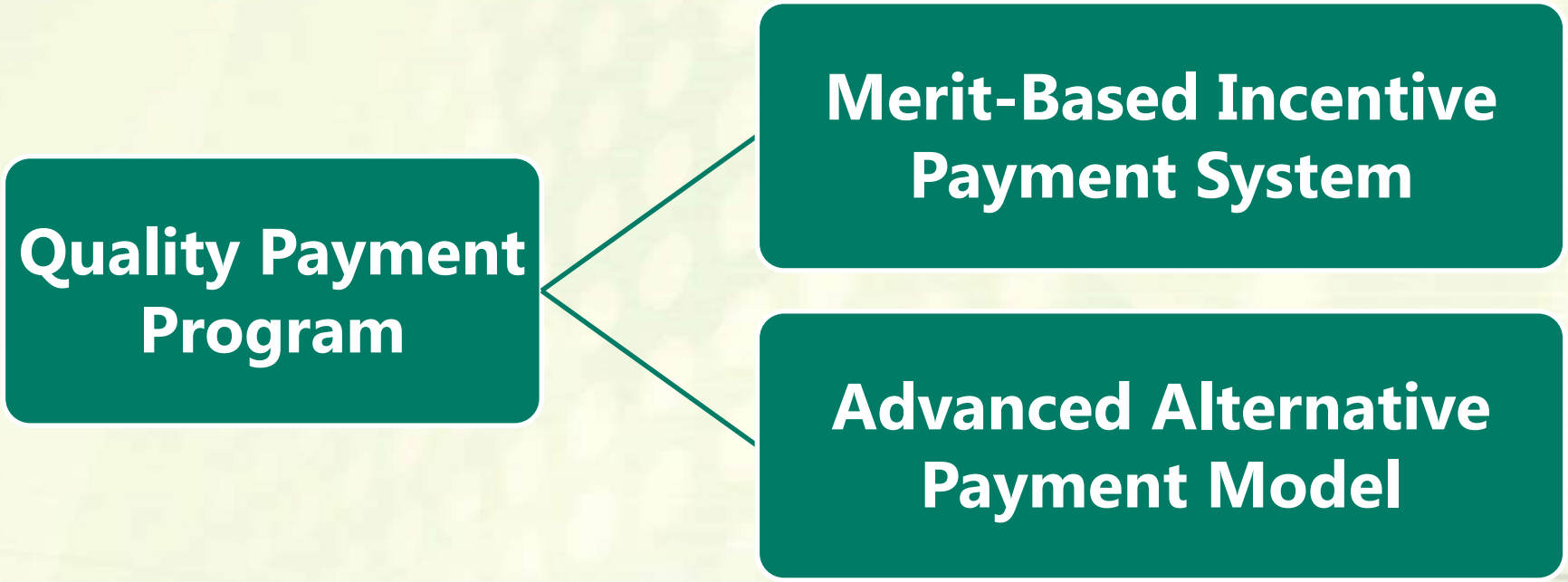
2 Options for QPP:

1. MIPS
2. APM

- **MACRA is NOT part of ACA**
- **MACRA had bipartisan support:** 392-37 in the House
- **Future of CMMI could have impact**



QPP: Two Tracks



Performance Period

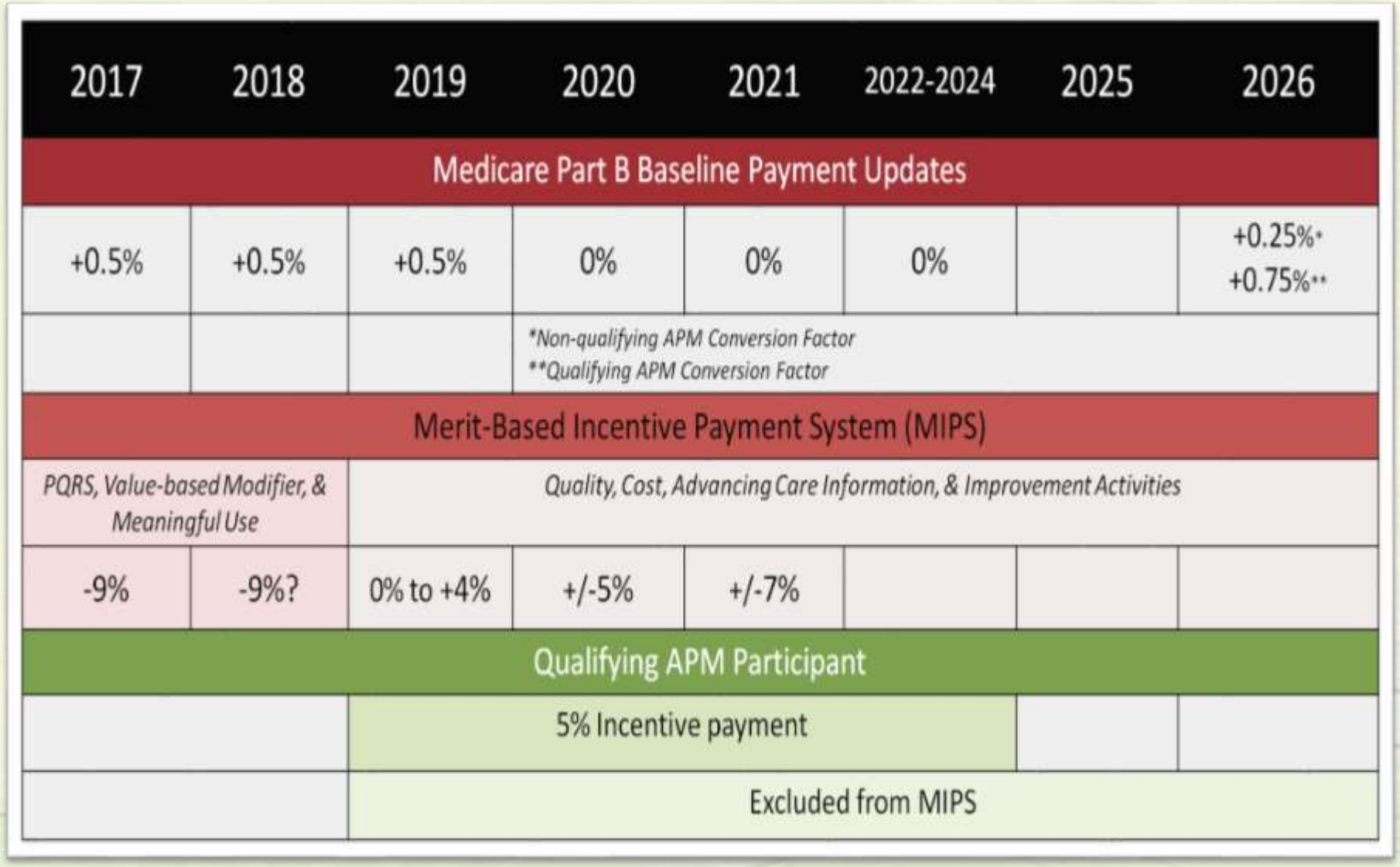
Performance:
The first performance period opens January 1, 2017 and closes December 31, 2017. During 2017, record quality data and how you used technology to support your practice. If an Advanced APM fits your practice, then you can provide care during the year through that model.

Send in performance data:
To potentially earn a positive payment adjustment under MIPS, send in data about the care you provided and how your practice used technology in 2017 to MIPS by the deadline, March 31, 2018. In order to earn the 5% incentive payment for participating in an Advanced APM, just send quality data through your Advanced APM.

Feedback:
Medicare gives you feedback about your performance after you send your data.

Payment:
You may earn a positive MIPS payment adjustment beginning January 1, 2019 if you submit 2017 data by March 31, 2018. If you participate in an Advanced APM in 2017, then you may earn a 5% incentive payment in 2019.

MACRA Timeline

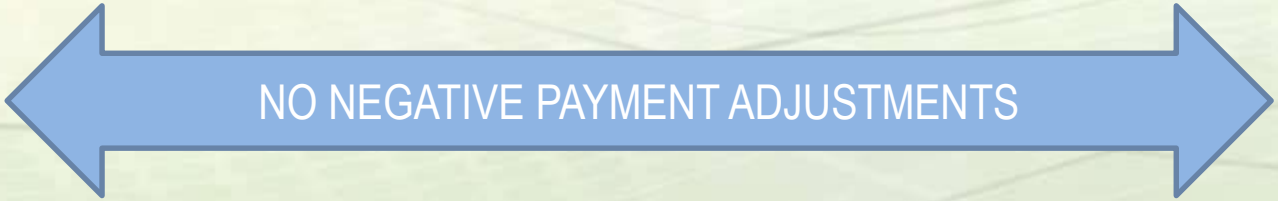


2017	2018	2019	2020	2021	2022-2024	2025	2026
Medicare Part B Baseline Payment Updates							
+0.5%	+0.5%	+0.5%	0%	0%	0%		+0.25%* +0.75%**
			*Non-qualifying APM Conversion Factor **Qualifying APM Conversion Factor				
Merit-Based Incentive Payment System (MIPS)							
PQRS, Value-based Modifier, & Meaningful Use		*Quality, Cost, Advancing Care Information, & Improvement Activities*					
-9%	-9%?	0% to +4%	+/-5%	+/-7%			
Qualifying APM Participant							
		5% Incentive payment					
		Excluded from MIPS					

Source: American Academy of Family Physicians

'Pick your Pace' Options for 2017

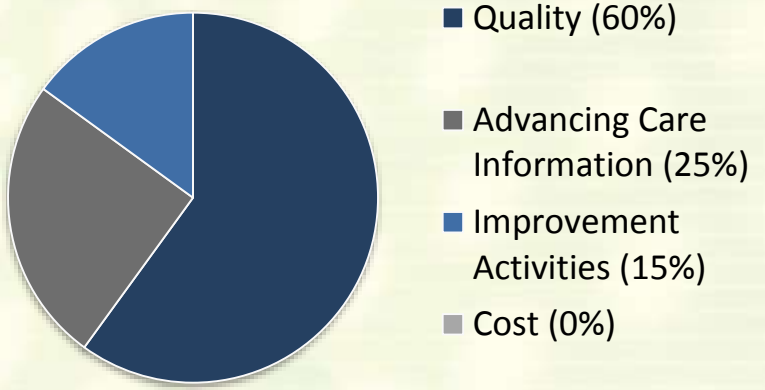
Test	Partial Participation	Full Participation	Advanced APM
• Submit some data to QPP • No adjustment	• Report part of the year • **Small** positive adjustment	• Report full year • **Modest** positive adjustment	• Qualifying Program & Eligible Clinician • 5% incentive payment



MIPS

Merit-based Incentive Payment System, receive performance-based payment adjustments based on scores in four categories.

2017 MIPS Performance



Quality	Improvement Activities	Advancing Care Information	Cost
Replaces PQRS.	New category.	Replaces the Medicare EHR Incentive Program also known as Meaningful Use.	Replaces the Value-Based Modifier.

Who is Included In MIPS?

- **Physicians (MD/DO)**
- **Physician Assistants**
- **Nurse Practitioners**
- **Clinical Nurse Specialists**
- **Certified Registered Nurse Anesthetist**

Who is Excluded from MIPS

- **Low Volume Threshold Exemption:**
  - Bill ≤$30,000 in Medicare Part B allowed charges
  - Treat ≤100 Medicare patients
- **First year Medicare participants are not required to participate**
- **Clinicians significantly participating in Advanced APMs**
  - Receive 25% of your Medicare Part B payments through an Advanced APM
  - See 20% of you Medicare patients through an Advanced APM

Quality (60%)

- Replaces the Physician Quality Reporting System (PQRS)
- Report up to 6 quality measures, including an outcome measure for a minimum of 90 days

Examples:

Outcome-All-cause Hospital Readmission:
Risk-standardized readmission rate for beneficiaries age 65 or older, hospitalized at a short-stay acute care hospital and experienced an unplanned readmission for any cause to an acute care hospital within 30 days of discharge.

Preventive Care and Screening-Influenza Immunization:
Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization

Improvement Activities (15%)

- New Category, supports broad aims within healthcare delivery including care coordination, beneficiary engagement, population management, and health equity
- Complete up to 4 improvement activities for a minimum of 90 days

Examples:

Achieving Health Equity-Engagement of new Medicaid patients and follow-up (Weighted High):
Seeing new and follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid and Medicare.

Behavioral and Mental Health-Diabetes Screening (Weighted Medium):
Diabetes screening for people with schizophrenia or bipolar disease who are using antipsychotic medication.

Advancing Care Information (25%)

- Replaces the Medicare EHR Incentive Program, also known as Meaningful Use. Focus on the secure exchange of health information and the use of certified electronic health record technology.
- Report on the 5 required measures. You can choose to submit up to 9 measures for a minimum of 90 days for additional credit.

Required Measures:

- Security Risk Analysis
- e-Prescribing
- Provide Patient Access
- Send Summary of Care
- Request/Accept Summary of Care

Cost (0%)

- Replaces Value-Based Modifier
- No data submission required, calculated from adjudicated claims.
- NOTE: The cost performance category contribution to the final score will gradually increase from 0% to 30% by the third MIPS payment year 2021

Weighting by Category

	2019	2020	2021
Quality	60%	45%	30%
Cost	0%	15%	**30%**
Advancing Care Information	25%	25%	25%
Improvement Activities	15%	15%	15%

Source: American Academy of Family Physicians

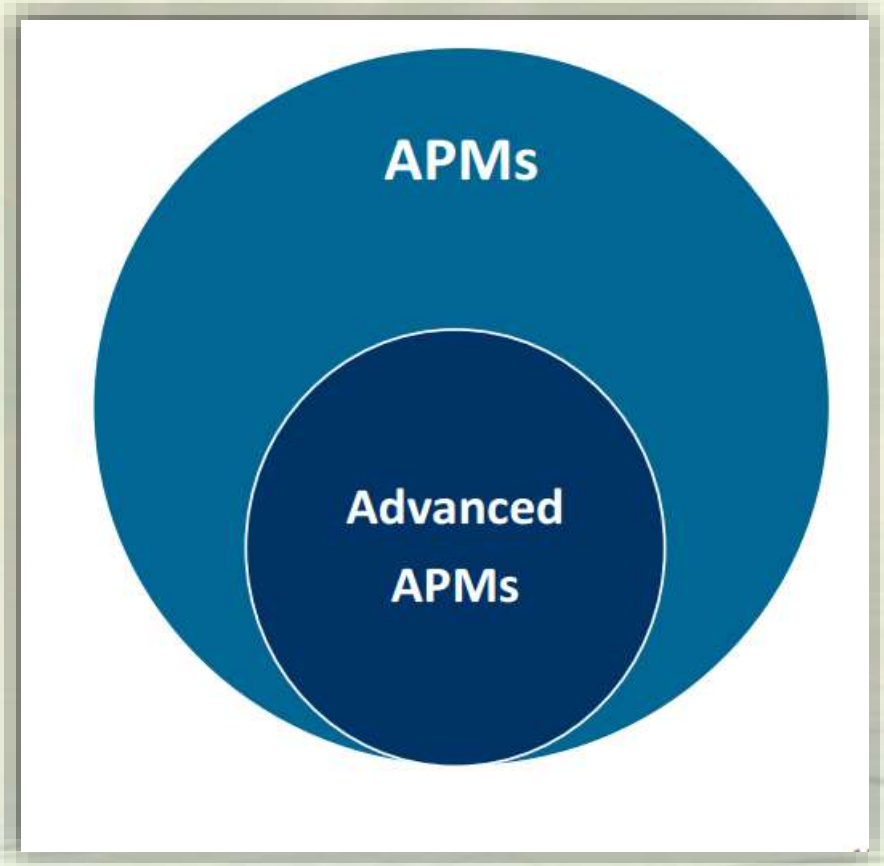
For a complete list of measures visit:

www.qpp.cms.gov

Alternative Payment Models (APMs)

- An APM is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

- Advanced APMs are a subset of APMs, and let practices earn more for taking on some risk related to their patients' outcomes.



Source: CMS

What Models Qualify?

Comprehensive ESRD Care (CEC) – 2-Sided Risk	Comprehensive Primary Care Plus (CPC+)	Next Generation ACO Model
Shared Savings Program – Track 2	Shared Savings Program – Track 3	Oncology Care Model (OCM) – Two Sided Risk

Why Participate In An Advanced APM?

- Not subject to MIPS
- 5% bonus 2019-2024
- Higher fee schedule update 2026

Source: CMS

5 Key Takeaways

- Value-based payment has arrived with 2017 as a transition year
- Pace of transformation will vary
- Physicians must develop a quality and resource strategy for their practice
- Technology (EHRs) remain a challenge for physicians
  - *Performance/Functionality*
  - *Cost*
  - *Interoperability*
- *> the age of the physician, < enthusiasm for MACRA*

Post Acute Providers

SNF Quality Reporting

Nursing Home Quality Reporting System – 39 measures reported via Minimum Data Set (MDS)

Reported to at least one of four programs:

Certification and Survey Provider Enhanced reporting (CASPER) Quality Measures Reports

Nursing Home Compare

Five-Star Quality Rating System

Facility and Resident Quality Measures Preview Reports
Not yet tied to reimbursement!

SNF Quality Measures

Short Term and Long Term Stay:

Falls

Pressure ulcers (new or worsened)

Flu vaccination

Pneumococcal vaccination

UTI rates (for long term stay residents – more than 101 days)

Home Health Quality Reporting

HHAs must submit data on 50+ outcome and process measures.

There are 3 types of outcome measures used in the HH QRP:

Improvement measures *(i.e., measures describing a patient's ability to get around, perform activities of daily living, and general health)*

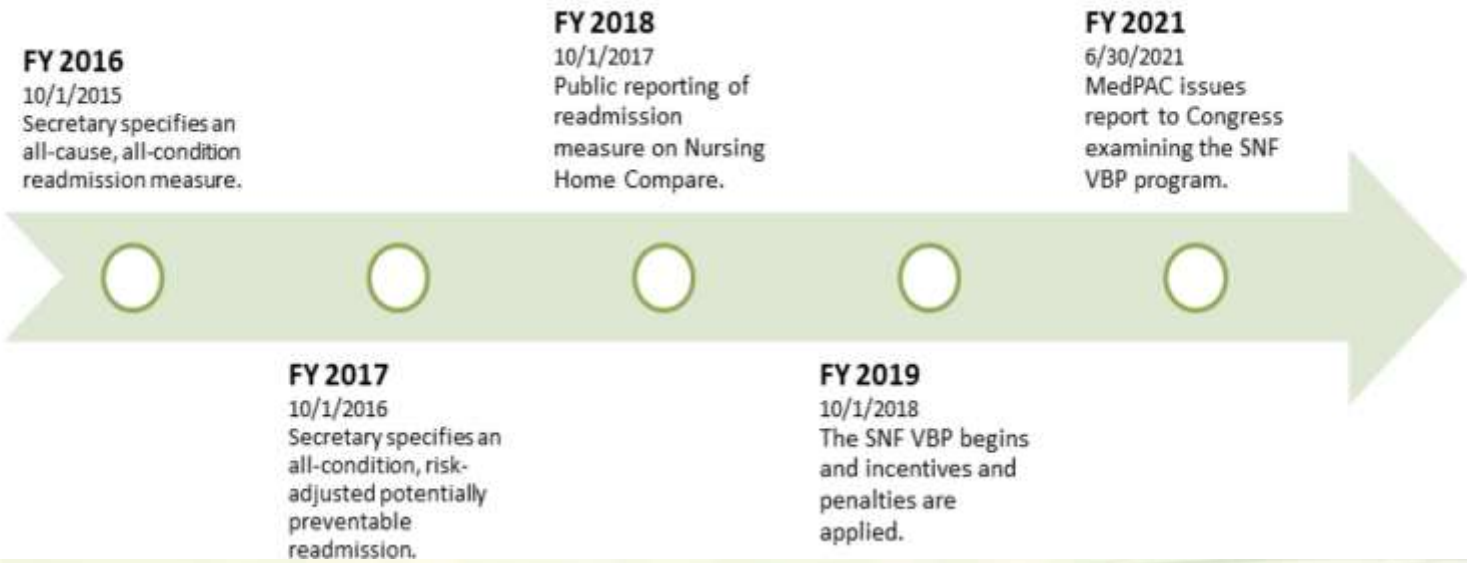
Measures of potentially avoidable events *(i.e., markers for potential problems in care)*

Utilization of care measures *(i.e., measures describing how often patients access other health care resources either while home health care is in progress or after home health care is completed)*

Process measures evaluate the use of specific evidence-based processes of care for high-risk, high-volume, problem-prone areas for home healthcare.

2% reduction to annual Medicare payment update for non-compliance.

SNF VBP Timeline



HHAs Impacted

States selected to participate:

- Arizona
- Florida
- Iowa
- Maryland
- Massachusetts
- Nebraska
- North Carolina
- Tennessee
- Washington

HHA VBP Outcome Measures

CMS is proposing the following outcome measures for inclusion in the new value-based payment model.

Proposed Outcome Measures

- Improvement in ambulation-locomotion
- Improvement in bed transferring
- Improvement in bathing
- Improvement in dyspnea
- Discharged to community
- Acute-care hospitalization: unlanned hospitalization during first 60 days of home health; hospitalization during first 30 days of home health
- Emergency department use without hospitalization
- Improvement in pain interfering with activity
- Improvement in management of oral medications
- Prior functioning of ADL/IADL
- Care of patients
- Communications between providers and patients – specific care issues
- Overall rating of home health care and willingness to recommend the agency
- Adverse event for improper medication administration and/or side effects

HHA VBP Process Measures

CMS is proposing the following process measures for inclusion in the new value-based payment model.

Proposed Process Measures

- Timely initiation of care
- Care management: types and sources of assistance
- Pressure ulcer prevention and care
- Multifactor fall risk assessment conducted for all patients who can ambulate
- Depression assessment conducted
- Influenza vaccine data collection period: does this episode of care include any dates on or between October 1 – March 31
- Influenza immunization received for current flu season
- Pneumococcal polysaccharide vaccine ever received
- Reason pneumococcal vaccine not received
- Drug education and all medications provided to patient/caregiver during all episodes of care
- Influenza vaccination coverage for home health personnel
- Herpes zoster (shingles) vaccination: has the patient ever received the shingles vaccination
- Advance care plan