Nevada Academy of Family Physicians
29th Annual Summer CME Meeting
August 3–5, 2018

National Policy Update

Presented by:
Robert Hall, JD, MPAff

Approved for 1.0 Prescribed CME

Friday, August 3, 2018
8:00—9:00am

NOTES

National Policy Update

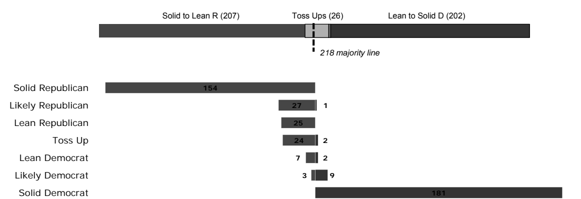
Robert Hall, JD
Director, Government Relations
August 3, 2018

Agenda

- Midterm update
- The debate on ACA and health care reform
- Health care legislation this year
- 2019 Medicare Physician Fee Schedule and Quality Payment Program Proposed Rule

How big of a swing? Control of the House will depend on whether Democrats can win most "Toss Up" races

Cook Political Report 2018 House ratings



Nevada House elections

Dina Titus (D-NV01): Rep. Titus is running in a race that is "solid Democratic," according to the Cook Political Report. Titus is in favor of funding CHIP without ties that change ACA

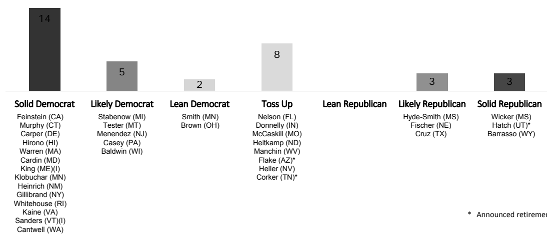
Mark Amodei (R-NV02): Rep. Amodei is running in a race that is "solid Republican," according to the Cook Political Report. Amodei is in favor of replacing ACA, but keeping the infrastructure during a transition period to a new system

Jacky Rosen (D-NV03): Rep. Rosen is running for Senate, leaving the 3rd District seat open. According to the Cook Political Report, this race "leans Democratic"

Ruben Kihuen (D-NV04): Rep. Kihuen is not seeking reelection, leaving the 4th District seat open. According to the Cook Political Report, this race is "likely Democratic"

Control of the Senate will depend on the eight "Toss Up" seats

Cook Political Report 2018 Senate ratings



Nevada Senate election

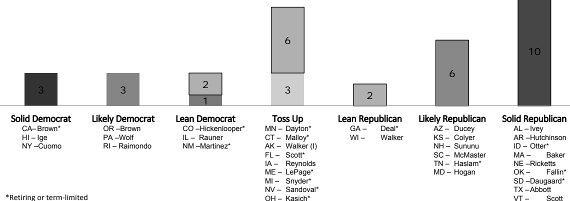
Dean Heller (R-NV): Sen. Heller is widely considered the most vulnerable Senate Republican up for re-election in 2018. Heller opposed ACA, and introduced a bill to fund CHIP through December

Sen. Heller is the only Republican senator up for re-election in a state won by Clinton in 2016. Clinton won by a 2.4% margin, while Heller won in 2012 by a 1.2% margin

Jacky Rosen (D-NV03): Rep. Rosen is running against Sen. Heller. She introduced a bill to lower prescription drug costs and cap out-of-pocket copays, and she proposes fixing ACA to bring down costs

Republicans will attempt to retain 12 governorships without an incumbent running

Cook Political Report 2018 governor rankings



Nevada gubernatorial election

Brian Sandoval (R): Gov. Sandoval is retiring, and the Nevada governorship is one of the most likely to change parties, according to Hotline's power rankings

Adam Laxalt (R): State Attorney General Adam Laxalt is the Republican candidate. Laxalt said he would consider work requirements for Medicaid

Steve Sisolak (D): Clark County Commissioner Steve Sisolak is the Democratic candidate. Sisolak supports ACA and the expansion of Medicaid

Developing debates in health care legislation

Changes to ACA | ACA constitutionality | Medicaid work requirements | Rising costs

Arguments for reforming or limiting ACA continue

A Democratic task force unveiled "Solutions over Politics" to combat high costs by stabilizing and improving the individual market:

- Create a permanent reinsurance program
- Reduce copays and deductibles for low-income families
- Promote coverage and ensure people pay their fair share
- Create more affordable options (flexible HSA, premium assistance, etc.)
- Improve health insurance market (guidance for states, balanced bidding areas, etc.)

The Health Policy Consensus Group unveiled the "Health Care Choices Proposal" to give more power to states:

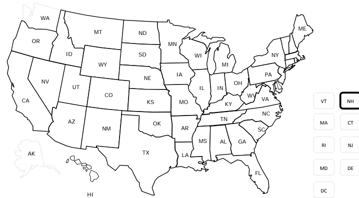
- Repeal ACA federal spending scheme
- Give block grants to states
- Restore state authority in health insurance regulation (e.g. ability to adjust rules to individual insurance market conditions)
- Give individual choice to opt-out of government-run program and enroll in private coverage
- Increase flexibility of HSA use

20 states file lawsuit that ACA is unconstitutional

These states claim that since the GOP eliminated the tax penalty associated with the individual mandate, the ACA is no longer constitutional

2012 Supreme Court ruling
In 2012, the Supreme Court ruled 5 to 4 that the ACA's individual mandate was constitutional because Congress has the power to levy taxes

2018 lawsuit
The new lawsuit was filed on February 26, 2018 by Texas Attorney General Ken Paxton (R)



The Dept. of Justice will no longer defend the ACA in court

DOJ decision on ACA lawsuit

The Trump administration stated that it would stop defending the ACA

- 17 Democratic-led states have taken over for the Department of Justice and will defend the ACA
- The Supreme Court has upheld its constitutionality twice, but Brett Kavanaugh's appointment could change the balance

Who will be affected?

- **21 million people** not insured by employers or Medicaid, and who get their insurance through the state or federal ACA marketplace
- **27% of people under 65 have a pre-existing condition,** according to the Kaiser Family Foundation
- Estimates vary widely because there is no standard definition of what counts as a pre-existing condition

When will the changes occur?

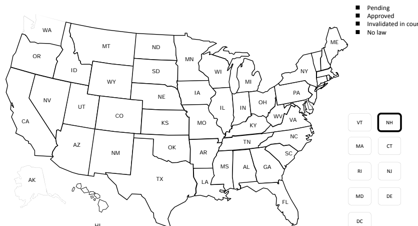
- The lawsuit could go all the way to the Supreme Court, in which case the provisions would stay in place until then
- There could be an immediate impact on health **insurance premiums for 2019**
- Recent ACA actions could prompt **young and healthy people to leave the individual market**

States file for waivers requiring work for Medicaid

States with Section 1115 Medicaid waivers for work requirements

Note: pending waivers include new applications, amendments to existing waivers and renewed/ extension requests

- Pending
- Approved
- Invalidated in court
- No law



District court blocked HHS's approval of Kentucky waiver, creating uncertainty about future waivers

Analysts believe Kentucky's work requirements would result in **95,000** people losing Medicaid coverage

> "The secretary never adequately considered whether Kentucky HEALTH would in fact help the state furnish medical assistance to its citizens, a central objective of Medicaid."
>
> – US District Judge James Boasberg

What's next?

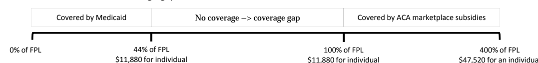
- Kentucky suspended Medicaid dental and vision coverage for about **460,000** people
- CMS Administrator Seema Verma talking to Justice Department to decide whether to appeal
- Governor Matt Bevin is counter-suing the challenge to Kentucky's work requirement plan
- Other states with HHS approval may face similar lawsuits

"Coverage gap" created by Supreme Court, where people are not covered by Medicaid and cannot afford Obamacare

The coverage gap: **2.6** million uninsured

- Medicaid expansion was intended to be national, but the Supreme Court ruled it optional for states in June 2012
- 19 states decided not to expand Medicaid and eligibility for adults in these states is only at 44% of the poverty line
- As a result, in states that do not expand Medicaid, many adults fall into a "coverage gap" of having incomes above Medicaid eligibility limits but below the lower limit for Marketplace premium tax credits

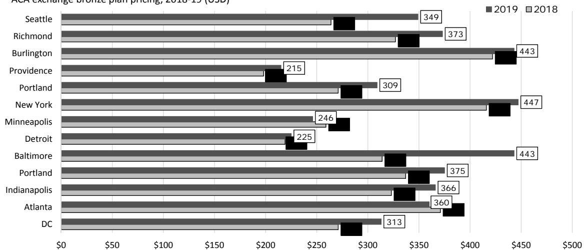
Total = 2.6 million in the coverage gap



0% of FPL | 44% of FPL $11,880 for individual | 100% of FPL $11,880 for individual | 400% of FPL $47,520 for an individual

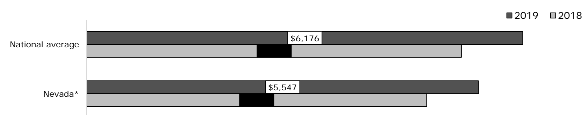
Insurance premiums are rising for 2019

ACA exchange bronze plan pricing, 2018-19 (USD)



2019 premiums are expected to rise due to short-term plans and individual mandate repeal

Projected ACA premium levels in 2019 for a 40-year-old



*Nevada limits short-term plans

Congress reauthorized CHIP funding for ten years, extending coverage for 9 million children in middle income families

Funding for CHIP expired in October 2017, and despite Congress passing a temporary spending bill in December, many states began to run out of funding

Why did it take so long to reauthorize CHIP funding?

- Lawmakers have been **unable to agree on how to pay for CHIP and Community Health Center (CHC) funding**
- Democrats opposed a proposal that passed the House in November because it cut Medicare and ACA funding to offset the cost of CHIP
- This time around, **Democrats refused to support a short-term spending bill** until Congress developed a plan for immigrant children who are no longer protected by DACA

New CBO report made it easier for Republicans to include CHIP funding in the latest spending bill

In a letter to Rep. Frank Pallone (D-NJ), CBO Director Keith Hall wrote that **funding CHIP for 10 years would "decrease the deficit by [approximately] $6.0 billion over the 2018-2027 period"**

- The CBO also explained that due to the repeal of the ACA's individual mandate, reauthorizing CHIP funding for five years would **cost only $800 million**, a far drop from the earlier estimate of $8.2 billion

Bipartisan Budget Act of 2018 provides FY18 and FY19 funding for Teaching Health Centers

Teaching Health Centers aim to ensure a primary care workforce for low-income communities by providing federally funded training

Funding for FY18 came through three bills, each extending onto the level and duration from the last:

- Disaster Tax Relief and Airport and Airway Extension Act of 2017 provided $15m for Q1 of FY18
- Division C – Health Provisions of the Further Additional Continuing Appropriations Act, 2018 provided $30m for Q1 and Q2 of FY18
- Bipartisan Budget Act of 2018 provided $126.5m for each of FY18 and FY19

Changes to Teaching Health Center Graduate Medical Education Programs:

- Expanded payments, so can be made to train new residents in existing and new programs
- Clarified priority for payments
- Increased reporting requirements

Tax bill effectively ends the individual mandate

Starting in 2019, there will no longer be a penalty for not having health insurance

- The Congressional Budget Office estimates that in 2019 there will be **four million** more people without health insurance
- In 2027, there will be **13 million** more uninsured
- Critics worry that with less healthy people insured, rates will have to rise to cover the remaining customer base

Majority of people think individual mandate is either still in effect or do not know

Responses to "As far as you know, has Congress passed a law repealing [the requirement that nearly all Americans have health insurance, or else pay a fine]?

January 16-21, 2018

2019 Medicare Physician Fee Schedule and Quality Payment Program Proposed Rule:

Overview & Key Provisions for Family Medicine

2019 Medicare Physician Fee Schedule Includes MACRA QPP Changes

- On July 12, 2018, CMS released a proposed rule on 2019 Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Medicare Part B
  - Combines the 2019 Medicare Physician Fee Schedule and MACRA's Quality Payment Program changes and updates
- Comments are due September 10, 2018

The AAFP policy team is reviewing the proposed rule for impacts on family medicine and drafting comments for Board approval.

Key MPFS Provisions for Family Medicine

Medicare Physician Fee Schedule

- **Updates to Conversion Factor**
- **Changes to E/M Payment & Documentation**
- **Payments for Telehealth**
- **Other Updates Impacting Family Physicians**
  - Updates to RVUs, GPCIs
  - Physician payment for administering new biologics
  - Identifies potentially mis-valued services
  - Updates to Appropriate Use Criteria (AUC) program
  - Potential episode payment for SUD treatment
  - Changes to MSSP quality measures

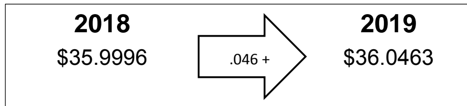
MACRA QPP

- **Updates to MIPS**
  - Performance Categories and Scoring
  - Promoting Interoperability Category
  - Low-Volume Threshold
- **Advanced APMs**
  - Increases CEHRT Threshold to 75%
  - Maintains 8% revenue-based nominal risk standard
  - Refines Other-Payer Advanced APM determination process for multi-year arrangements
  - Medicare Advantage Qualifying Payment Arrangement Incentive Demonstration (MAQI)

Key Physician Fee Schedule Provisions for Family Medicine

Proposed 2019 Conversion Factor and Total Allowable Charges for Family Physicians

- **2019 Conversion Factor.** 2019 estimated conversion factor slight increase from 2018



- **Total Allowable Charges.** Estimated total allowable charges of **$6.2 B** for family practices
  - 1% increase in practice experience relative value units (RVU)
  - No change for physician work or malpractice RVUs

Proposed Restructuring of E/M Payment Levels

- **Collapse Payment for E/M Services**
  - Blended, single payment for new patient office visits levels 2 - 5 (99202 - 99205)
  - Blended, single payment for existing patient office visits level 2 - 5 (99212 - 99215)

Level	Current Payment for New Patient	Proposed Payment
1	$45	$44
2	$76	
3	$110	$135
4	$167	
5	$172	

Level	Current Payment for Est. Patient	Proposed Payment
1	$22	$24
2	$45	
3	$74	$93
4	$109	
5	$148	

Proposed E/M Payment Changes

- **New Codes for Add-on Payments to Office Visits**
  - Specific specialties ($9)
    - *Allergy/Immunology, Cardiology, Endocrinology, Hematology/Oncology, Interventional Pain Management-Centered Care, Neurology, Obstetrics/Gynecology, Otolaryngology, Rheumatology, Urology*
  - Primary care physicians ($5) – definition TBD
  - 30-minute prolonged E/M visit ($67)
- **Multiple Procedure Payment Reduction**
  - 50% reduction on lower paid service when physicians report E/M service and certain procedures on the same date

Proposed Changes to E/M Documentation

- Expand documentation of history and exam to focus on changes since last visit or pertinent issues
- Allow physicians to review and verify certain information in the medical record that is entered by ancillary staff or beneficiary, rather than re-entering
- Removal of duplicative requirements for teaching physicians on notations that may have previously been included in the medical records by residents or medical team members
- Allow physicians a choice in documentation for E/M visits:
  - 1995 or 1997 guidelines, OR
  - Medical decision-making, OR
  - Time

Proposed Payments for Telehealth

- **New Codes and Payment for Remote Services**
  - Time spent with beneficiaries via select telecommunications methods to assess if office visit/service is needed
  - Time spent reviewing video/image sent by patient to assess if office visit is needed
  - Evaluation and communication technology-based services in Rural Health Clinics and Federally Qualified Health Centers

Other Proposals Impacting Family Physicians

- Updates to Practice Expense RVUs, Malpractice RVUs, and geographic practice cost indices across specialties
- Identifies potentially mis-valued services
- Updates to the Appropriate Use Criteria (AUC) program for Advanced Diagnostic Imaging
- Solicits comments on creating a bundled episode of care for management and counseling treatment for substance use disorder
- Reduces number of quality measures in the Shared Savings Program from 31 to 24, adds 2 patient experience measures to align with MIPS

Key QPP Provisions for Family Medicine

Proposed Updates to MIPS Performance Categories and Weighting

- **2019 Performance Year Reporting Periods maintained at 2018 levels**
  - Quality and Cost categories – One Year
  - Promoting Interoperability (formerly Advancing Care Information (ACI)) and Improvement Activities - 90 days
- **2019 Performance Category Weights**
  - Quality weighted at 45% — down from 50% in 2018
  - Cost weighted at 15% — up from 10% in 2018
  - Promoting Interoperability remain at 25% and Improvement Activities at 15%

Provisions that Support Small Practices

- **2019 Proposed Provisions include:**
  - Maintains bonus points for
    - Small practices (under the quality category),
    - Care for complex patients (available to all practices), and
    - End-to-end reporting (available to all practices),
  - Proposing to continue 3-point floor for quality measures submitted by small practices that do not meet data completeness

Scoring and CEHRT Changes to Promoting Interoperability Category

- **New Scoring for Promoting Interoperability (PI) Category**
  - Formerly Advancing Care Information (ACI)
  - Removes ACI base and performance categories
  - Reduces number of measures in PI category
  - Does not remove “All or Nothing” Scoring Criteria
- **Requires MIPS Eligible Clinicians to Adopt 2015 Edition CEHRT**
  - Uses one objectives and measure set based on 2015 Edition CEHRT, instead of two options (2014 and 2015) previously permitted

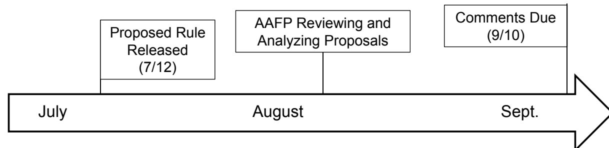
Proposed Updates to Low-Volume Threshold and Virtual Group Option

- **Low Volume Threshold:** New criteria ECs for exclusion from MIPS
  1. Have ≤ $90K in Part B allowed charges for covered prof. services
  2. Provide care to ≤ 200 beneficiaries
  3. Provide < 200 covered services to Part B patients
  - Allows ECs to opt-in if they meet at least one of LVT criterion
  - Consolidates LVT determination period for small practices and other specific clinician categories
- **Virtual Groups:** For virtual group eligibility determination period, TINs would be able to inquire about their TIN size prior to making election

Updates to Advanced APMs Track

- **CEHRT Changes.** Increases CEHRT use threshold to require at least 75% of eligible clinicians use CEHRT
- **Nominal Risk Standards.** Maintains 8% revenue-based nominal risk standard for Advanced APMs/ Other Payer Advanced APMs through PY2024
- **Other Payer Advanced APM Determination.** Refine Other Payer Advanced APM Determination Process, to allow for multi-year payment arrangements and not require annual attestation unless payment arrangement changes
- **MAQI.** Introduces Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration
  - Allows clinicians in Medicare Advantage (MA) payment arrangements—similar to Advanced APMs—to be exempt from MIPS requirements
  - Allows participation in “Qualifying Payment Arrangements” with MA plans that meet Other Payer Advanced APM criteria one year before All-Payer Option is available

Next Steps – Data Analysis on MPFS Impacts on Family Medicine Will Shape Comments to CMS



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