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MACRA Implementation Policy Key Issue For Next Congress

Members of the next congress--from both sides---will be watching to see whether the Medicare Access and CHIP Reauthorization Act (MACRA) is being properly implemented over the next few years, congressional staff members said. Staff members at the briefing agreed to be quoted if they were not identified by name.
"Making sure MACRA is a success is important; we all held hands and jumped on that one," a Republican congressional aide said at a Alliance for Health Reform and the Jayne Koskinas Ted Giovanis Foundation for Health and Policy event. "We all own it and it needs to be a success, because this was our effort to take ideas from both sides and say 'This is how we want to slowly start reforming the Medicare program'." As The Centers for Medicare & Medicaid Services explains it in a fact sheet , MACRA "provides that solo and small practices may join 'virtual groups' and combine their reporting" under Medicare's Merit-Based Incentive Payment System (MIPS). "CMS is seeking public comment on how virtual groups should be constructed, and anticipates being able to implement virtual groups in the second year of the program."
The Democrats, for their part, will be watching to see if the Republicans' numbers add up when it comes to repealing the Affordable Care Act (ACA), said a House Democratic staff member. "We will hold folks accountable to their own statements and their own commitments." For example, "We've heard that the preexisting condition exclusion will be protected. Analyze that carefully, because not all preexisting exclusions or protections look alike...under what situations can you be charged more, and can you be denied?" she asked. "How can the underlying subsidies and underlying revenues be repealed, and [the Republicans] still find a way to maintain the same level of support, coverage and subsidy for the average working family?"

Incoming Congress Will Immediately Pick Up Obamacare Repeal

A bare-bones budget resolution acting as a vehicle to break apart the Affordable Care Act will get a House Floor vote soon, according to a memo from Rep. Greg Walden (R-Ore.), the incoming chairman of the House Energy and Commerce Committee. "They are eager to prove they are capable of governing and keeping their promises," said John Gorman, a former CMS official who is now a Washington healthcare consultant.
Should the ACA be repealed by GOP leaders, the process would allow Republicans to strip funding for major parts of the healthcare law, such as cost-sharing subsidies, Medicaid expansion and premium stabilization programs. GOP leaders also signaled that they will ax the mandate requiring people to enroll in health coverage as soon as possible. Leaders in Healthcare warn that delaying a replacement plan could cause the individual insurance market to collapse and endanger hospitals that would provide uncompensated care for the more than 20 million people who would become uninsured once the ACA program is dismantled. Many leaders in the Healthcare industry have urged the incoming administration under President-elect Donald Trump to put transition period policies in place to keep the individual market afloat until a new plan is in place. For example, industry lobbying group America's Health Insurance Plans has warned against repealing the cost-sharing subsidies. It's not known whether the GOP leaders plan to retain any key ACA provisions.

> "Budget reconciliation bills can only include provisions with a budgetary impact and do not raise spending, so there would likely be a delay before implantation."

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2010 CMS Program Reduces Hospital Readmission Rates In 49 States

Federal efforts to curb readmission rates using payment penalties appear to be working, with an 8% overall reduction in hospital readmissions since the program's beginning in 2010, according to chief medical officer of CMS Patrick Conway, MD. Some of that success can be attributed to the increasing role pharmacists are playing in patient care, and some hospitals are even reporting steeper reductions of 50% or more. The CMS Hospital Readmissions Reduction Program was launched in 2010 as part of the Affordable Care Act to penalize hospitals with higher-than-average 30-day readmission rates with reduced reimbursements. These reimbursements cost CMS more than $17 billion annually, according to the agency. Initially the program targeted readmissions specifically for patients treated for myocardial infractions, heart failure and pneumonia. But additional conditions, including chronic obstructive pulmonary disease and elective hip or knee replacement, have been added over time, leading to higher fines, according to a recent analysis by the Henry J. Kaiser Family Foundation. "The data show these efforts are working," wrote Dr. Conway in a blog post about the data. According to CMS, all but one of the 50 states and the District of Columbia have reduced their 30-day readmission rates for Medicare patients, with an estimated 565,000 readmissions avoided between 2010 and 2015. Only Vermont saw an increase in readmissions of 0.70%. Strategies to ensure patients clearly understand discharge instructions, that better coordinate postacute care and that reduce inpatient complications have all been shown in studies to reduce complications, said Ms. Cristina Boccuti, MA, MPP, who co-authored the Kaiser Family Foundation analysis with policy analyst Giselle Casillas. She is also the associate director on the Medicare policy program. Hospitals may be considering developing systems to reduce readmissions for all patients that can be applied to the new conditions as they are added to the program, Boccuti noted. They may also want to determine whether they have worse readmission rates for specific conditions and try to understand why, she said.

> "All but one of the 50 states and the District of Columbia have reduced their 30-day readmission rates for Medicare patients."

Regardless of the strategy hospitals use to reduce readmissions, these efforts are likely to benefit patients as well as unnecessary medical spending, Ms. Boccuti noted. Hospitals are likely to be even more motivated to engage these efforts as CMS penalties increase from $420 million in 2016 to $528 million in 2017 as more conditions are added to the program.

CMS Unveils Medicare-Medicaid ACO Model

CMS plans to enlist states in a new experiment allowing Medicare accountable care organizations to also manage Medicaid costs for patients who are enrolled in both programs. This new model builds on the Medicare Shared Savings Program, in which Medicare ACOs that hit spending and quality targets are able to share in savings with CMS. However those ACOs often don't consider Medicaid savings, even when beneficiaries are enrolled in both Medicare and Medicaid programs. "Dual eligible" patients are often at a higher risk and have higher healthcare costs. CMS intends to enter agreements with as many as six states, with the preference given to states with low saturation of providers already participating in a Medicare ACO program. These participating states will be able to design certain parts of how they implement the model. As of last April, there were 433 ACOs in the program, which covered 7.7 million patients. Only a few of the participating ACOs are in tracks that carry the risk of losing money if they fail to control costs. A change we will see going forward is that starting next year, the program's cost benchmarks will take into account regional spending factors, a response to complaints that highly efficient providers were disadvantaged because their performance was measured against past results. Starting this month and ending in February, CMS will begin accepting applications for new practices and payers in the Comprehensive Primary Care Plus Model and new participants in the Next Generation ACO model for 2018.