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Senate Introduces ACA Repeal/Replace Bill

On Thursday, June 22nd, the Senate GOP Leadership released a "discussion draft" of its version of legislation to repeal and replace the Patient Protection and Affordable Care Act (ACA). The bill follows many of the same general pathways towards "repeal and replace" of the ACA as were included in the House-passed American Health Care Act (AHCA).

Similar to the AHCA, the Senate leadership proposal, called the Better Care Reconciliation Act of 2017 (BCRA) would repeal the individual mandate penalties as well as the employer mandate penalties included in the ACA. Both bills also repeal the taxes created by the ACA. It also includes similar changes to Federal Medicaid policy and the individual health insurance market as the AHCA. However, there are some significant differences.

On June 26th the Congressional Budget Office (CBO) released its official score of the Senate proposal. The CBO is a non-partisan congressional body that provides economic and financial analysis of a piece of legislation. The CBO's analysis is required to show that the BCRA saves at least as much money as the AHCA. The CBO estimates that the BCRA will indeed save more than the AHCA. According to the score, the BCRA will reduce the federal deficit by $321 billion over ten years, about $200 billion more than the AHCA saves.

The CBO also estimates the impact the BCRA will have on insurance coverage. If the BCRA were to pass in its current form, the CBO projects that over ten years, 22 million fewer people will be insured under the BCRA than if the ACA remained the law. The CBO estimated this figure to be 23 million for the AHCA. For both bills, the CBO attributes most of these coverage losses to people choosing not to purchase insurance rather than being unable to purchase insurance.

One of the most notable differences between the House and Senate bills is that the AHCA replaces the ACA's income-based advanced premium tax credit (APTC) with a tax credit based solely on age whereas the BCRA maintains the ACA's format of income-based subsidies but applies an age-based adjustment to the tax credits.

Both the AHCA and the BCRA would give states greater flexibility in determining what types of insurance could be sold that would still allow consumers to qualify for the premium tax credits. The AHCA and BCRA allow states to seek waivers from HHS to design alternative benefit packages with fewer "essential health benefits." However, they differ in that the AHCA allows states to waive the ACA's community rating requirement whereas the BCRA does not include such a waiver.

Both the AHCA and the BCRA would also adjust the so-called rate bands (the differential between the highest cost plan and the lowest cost plan) from the 3:1 ratio in the ACA to 5:1.

The CBO believes that after an initial spike, premiums will decrease for most people over ten years compared to current law.

Each bill proposes a different enforcement mechanism to replace the individual mandate penalty. The AHCA would impose a 30% premium surcharge when individuals who did not maintain continuous coverage seek to re-enter the insurance market. Continuous coverage is defined as no lapses in coverage of more than 63 days during the previous year. Instead of a surcharge, the BCRA would institute a six-month waiting period for coverage to take effect if an individual did not maintain continuous coverage (defined the same as the AHCA).

Both bills include a state stability and innovation fund to help states stabilize the current markets and adopt new market stabilization policies such as high risk pools and reinsurance programs. While there are some small difference in how each bill designed these funds, they are functionally very similar.

Similar to the AHCA, no Democrats are expected to lend their support to the BCRA. This means that the Senate will have to pass the bill exclusively with GOP support. With a 52 – 48 majority, the Senate Republican leadership can only afford to lose two GOP Senators if they have any hope of passing this bill (The Vice President will break a 50-50 tie). While several GOP Senators expressed concerns about particular aspects of the bill, many – both conservatives and moderates – seemed intent on moving in a direction that would get 50 GOP Senators to "yes."

Negotiations will continue with the goal of holding a vote in July after Congress returns from a week-long July 4th recess. Senate Leadership can dip into the $200 billion extra in savings compared to the AHCA mentioned above to cut deals with hold out Senators. A major focus of the negotiations will be providing extra protections for low-income, "elderly" (but not yet Medicare-eligible) individuals who stand to face significant premium increases that according to the CBO will far-exceed the tax subsidies they receive.

If the Senate passes the BCRA, either the House will vote on the Senate bill or the House and Senate will go through the Conference process to reconcile the differences between the two bills. Both chambers would then have to vote to approve the Conference report that unifies the two bills.

A more detailed summary of the BCRA is available on the HBMA website.

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HBMA Government Relations Committee Holds Annual Visit to CMS and Capitol Hill

The HBMA Government Relations Committee held its 2017 federal advocacy trip this year between June 20th and 22nd. This annual visit features a day of meeting at the Centers for Medicare and Medicaid Services (CMS) headquarters in Baltimore, Maryland, as well as a day of meetings in Washington, D.C. split between a visit to Capitol Hill and a roundtable discussion with fellow industry stakeholders.

This annual trip by the Committee is a unique opportunity to discuss important policy issues that affect how the healthcare revenue cycle management (RCM) industry interacts with the Medicare program on a day-to-day, operational level, as well as a broader discussion of long-term priorities.

These meetings reinforce HBMA's status as an expert resource to policy makers. Having held these meetings every year for over a decade, HBMA has made great improvements in how we actively serve as a resource to federal policy makers. Just as with any successful business, HBMA is building relationships with the policy makers with whom we meet. We focus on being honest brokers of information and a trusted voice for how Medicare policy affects the healthcare system.

Although HBMA submits questions and topics we would like to cover during these meetings ahead of time, these visits are also an important opportunity for CMS staff to solicit HBMA feedback on policies or problems CMS might not be hearing about. HBMA members can provide "real time" feedback on how a particular policy may be operationally impacting providers and their business/administrative staff. Policy makers acknowledge that despite their best efforts, they often cannot see below the "30,000 foot" level of a policy's impact and they look to HBMA for an on-the-ground perspective that they do not hear.

Often times, policy makers will pass a new law or regulation that they believe achieves financial savings or an easing of administrative burdens in one place but fail to realize how this policy might actually increase costs and administrative burdens elsewhere in the healthcare system.

These policy makers are always eager to meet with us to hear how their work is impacting providers, patients and everything in between. It has been our experience that when administrative/operational problems are brought to their attention, they are generally open to working with HBMA to develop changes and/or improvements where we can identify challenges and shortcomings.

The Government Relations Committee also used this visit to make policy makers aware of HBMA's recent name change and rebranding as the Healthcare *Business Management* Association. Many of the topics we discussed went beyond the traditional claims processing and revenue cycle management operations. Medicare reimbursements are increasingly being tied to quality and cost of care. This has reshaped the services healthcare RCM companies provide to our clients. This also provides another way for HBMA to be a resource to policy makers.

Towards the end of 2016, the Government Relations Committee developed a Strategic Plan for 2017 with many priorities likely to carry over into future years. The Strategic Plan outlines key initiatives for the Committee beyond its normal functions of monitoring and responding to important regulations and legislation. These initiatives include a focused effort on improving HIPAA Administrative Simplification standard electronic business transactions, improving EHR interoperability and increased collaboration with other industry stakeholders.

In addition to discussing policy topics within the jurisdiction of each office we met with, HBMA made sure that the initiatives identified in the Strategic Plan were prominently featured in the meetings at CMS and on Capitol Hill.

HBMA also facilitated a meeting with other industry stakeholder organizations. This meeting brought the American Medical Association, the Medical Group Management Association, the Radiology Business Management Association, the Workgroup for Electronic Data Interchange and the Healthcare Administrative Technology Association into the same room to discuss opportunities for collaboration on policies of mutual interest.

The Government Relations Committee was able to secure commitments from policy makers to make notable improvements to specific business functions of the Medicare program that will greatly benefit the healthcare RCM industry. The meetings also helped foster new opportunities to collaborate on future policy changes and education for the HBMA membership.

A more detailed summary of the meetings will be published in the coming weeks.

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CMS Proposes Changes to Quality Payment Program for 2018 Reporting Year

The Centers for Medicare and Medicaid Services (CMS) has released its proposed rule detailing its planned changes to the Medicare Quality Payment Program (QPP) for the 2018 reporting year.

The QPP offers two participation tracks for eligible clinicians: the Merit Based Incentive Payment Systems (MIPS) and Advanced Alternative Payment Models (Advanced APMs). The QPP is the product of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

The QPP is designed to reward clinicians for the value of their treatment instead of the volume. Last year, under the Obama administration, CMS proposed a "transitional year" participation policy which made it easy for clinicians to avoid penalties under the new law. The new proposed rule shows the Trump Administration is continuing to make it easier for clinicians to avoid penalties in 2018.

MIPS is a quality reporting program consisting of four performance categories: quality, resource use, clinical practice improvement activities, and use of certified EHR technology. Eligible Clinicians (EC) receive a composite performance score (CPS) which combines their score from all four categories. ECs can earn a positive, negative or neutral payment adjustment based on how their CPS ranks against that of every other MIPS EC. For 2018 reporting, the maximum upward and downward adjustment is +5 percent and -5 percent respectively. Payment adjustments are budget neutral meaning the aggregate amount awarded in positive adjustments is equal to the aggregate negative adjustments.

Advanced APMs are new approaches to paying for Medicare services provided by eligible clinicians. Clinicians who participate in Advanced APMs are exempt from MIPS reporting and penalties. Clinicians who qualify as Advanced APM participants can earn an end-of-year five percent lump sum bonus payment.

The proposed rule makes specific alterations to both MIPS and Advanced APMs. Perhaps the most significant proposed change is a proposed increase of the low-volume threshold from $30,000 or less in Medicare revenue or 100 or fewer Medicare patients to $90,000 in Medicare revenue or 200 or fewer Medicare patients.

The low-volume threshold allows small medical practices (or potentially ECs in large practices with limited Medicare billing) to be exempt from the MIPS requirements. Increasing the benchmark three-fold will drastically reduce the number of MIPS eligible clinicians. According to CMS calculations, the updated low-volume exception – if finalized – would exclude approximately 585,560 clinicians from mandatory compliance with the quality reporting program under MACRA.

When combined with other exemptions (newly enrolled clinicians, Advanced APM eligible clinicians, etc.) CMS estimates that just 37 percent of the 1.5 million ECs billing Medicare will participate in MIPS in 2018.

CMS has proposed an "opt-in" clause for the 2019 reporting year that, if adopted, would allow clinicians to opt-in to MIPS if they exceed one of the two low-volume thresholds.

CMS proposes to begin allowing voluntary "virtual groups" in 2018 which would allow clinicians in small practices to participate in MIPS. Virtual groups would be comprised of solo practitioners and groups of 10 or fewer ECs who enter into a "virtual group" with other solo practitioners or groups of less than 10. The virtual groups would report data and receive payment adjustments as a single entity.

The proposed rule continues the "pick your pace" reporting options for MIPS to help clinicians avoid penalties for the first performance period. The proposed rule maintains this option but increases the amount of data ECs must report in order to avoid the negative payment adjustments. In 2017, ECs only need to achieve a CPS of three points to avoid negative payment adjustments. This performance threshold would be increased to 15 points in 2018 if adopted as proposed.

By 2019, CMS is required to use either the mean or median CPS score as the performance threshold. It will therefore be much harder to make 2019 another transition year.

CMS is also proposing to allow ECs to use more than one submission mechanism within a performance category. The 2017 final rule only allowed for one submission mechanism per category.

CMS is also proposing to maintain the same weighting for each of the four MIPS reporting categories. Quality would account for 60 percent of an EC's CPS while the Advancing Care Information (ACI) and the Clinical Practice Improvement Activities (CPIA) categories would count for 25 and 15 percent respectively. The Cost category would remain weighted at zero percent. Although Cost would not count towards an EC's MIPS score, ECs would still receive feedback on their performance under the Cost category.

By and large, many of the proposed Advanced APM requirements remain unchanged. For example, the total potential risk an Advanced APM must bear is proposed to stay at eight percent.

Currently, only Medicare APMs can qualify as Advanced APMs but eventually all-payer APMs will be allowed to qualify as Advanced APMs. The proposed rule offers more detail about how the All-Payer APM option will be implemented. CMS also provided more information on how clinicians participating in certain APMs will be assessed. Rather than use the general MIPS scoring standard, participants will be scored under the APM standard. Additional detail must be provided by CMS regarding any potential changes to guidelines for qualifying advanced APMs.

A more detailed summary of the proposed rule is available for members on the HBMA website.

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MedPAC Suggests Redesigning MIPS Reporting

On June 15th, The Medicare Payment Advisory Commission (MedPAC) submitted its annual June Report to Congress. MedPAC is a non-partisan, independent Congressional body that is tasked with evaluating the Medicare program and making recommendations to Congress on Medicare payment policy. MedPAC's scope covers all Medicare payment systems.

The June 2017 report included a particularly noteworthy chapter titled "Redesigning the Merit-based Incentive Payment System and strengthening advanced alternative payment models." Although the chapter does not include any formal recommendations, the Commission puts forward suggestions for a radically different approach to implementing the new Medicare Quality Payment Program (QPP).

The QPP replaced the Medicare Sustainable Growth Rate (SGR) formula for calculating annual updates to Medicare Physician Fee Schedule (MPFS) payments. The QPP creates two participation options, the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APM). Under MIPS, eligible clinicians (EC) report data under four performance categories: quality, cost, practice improvement, and electronic health record use. MIPS applies positive, negative or neutral payment adjustments based on a clinicians total score across all categories.

ECs can be exempt from MIPS reporting if they qualify as a participant in an Advanced APM. ECs can also earn bonus payments for participation in an Advanced APM and are subject to potential financial risk/rewards under the design of the model.

In general, MedPAC is critical of the reporting structure of MIPS. MedPAC thinks the reporting measures are overly complex, overly burdensome and will not actually be useful in determining which clinicians are high- or low-performing clinicians. For example, many quality measures are either topped-out or undeveloped in that they lack a performance benchmark. MedPAC criticizes MIPS as another pay for reporting program rather than a program that effectively rewards or penalizes clinicians for the quality and efficiency of care they provide.

MedPAC puts forth several proposals for how to strengthen the incentives of MIPS. One proposal is to automatically withhold some fee-for-service (FFS) payments to eligible clinicians. This money would fund a "quality pool." ECs can participate in MIPS or Advanced APMs to earn some or all of the withhold back plus the possibility of additional quality incentive payments. ECs who do nothing would lose the withheld money.

Another proposal is to eliminate all of the reporting requirements for ECs under MIPS. Instead, ECs would report data on broader population health measures automatically through claims and through surveys. While this would greatly reduce a practice's administrative burden, MedPAC acknowledges that population health measures are not yet reliable on an individual clinician level. MedPAC proposes to assess performance and adjust payment based on performance at a group or local area level. MedPAC believes this will help "counter the silo-driven FFS system that encourages providers to focus only on the service they provide."

Examples of population outcome measures MedPAC has in mind include:

- Potentially preventable admissions and emergency department visits
- Mortality and readmission rates
- Patient experience
- Healthy days at home
- Rates of low-value care
- Relative resource uses

MEDPAC also includes suggestions to expedite the transition from MIPS participation to Advanced APM participation. MedPAC does not like how ECs can earn a five percent bonus just for participating in Advanced APM. MedPAC wants this bonus to actually be tied to performance in some way. It also wants to change how ECs qualify for the bonus from a percentage of MPFS revenue to a percentage of total revenue. MedPAC also wants a less restrictive definition of Advanced APMs to make this option more available to ECs.

Again, MedPAC is not making a formal recommendation (i.e. not endorsing any particular option). MedPAC will continue to examine the details of implementing the options and potentially make formal recommendations in a future report to Congress. Congress is not required to adopt MedPAC recommendations but it will certainly be interesting to see if Congress takes any of these suggestions into consideration.

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OIG Audit Estimates $729 Million in Incorrect EHR Incentive Payments Were Awarded

A new report from the Department of Health and Human Services (HHS) Office of Inspector General (OIG) has revealed that the Centers for Medicare and Medicaid Services (CMS) may have mistakenly paid $729 million in EHR incentive payments to participating clinicians.

These potentially wrongful payments are linked to the EHR Meaningful Use program which is intended to encourage providers to use Electronic Health Records (EHRs). The improper payments likely came between May 2011 and June 2014 according to the audit. Providers across all disciplines of medicine are eligible to receive the incentive payments if they meet the requirements of the program.

The audit revealed that professionals received erroneous payments for EHR reports that didn't meet meaningful use (MU) requirements, meaningful use periods, or showed insufficient use of certified EHR technology.

The $729 million makes up just a fraction of the $6 billion that Medicare paid in EHR incentive payments through June of 2014.

For the study, the OIG selected a random sample of 100 eligible providers (EP). Of those 100, 14 EPs did not meet the MU requirements due to "insufficient attestation support." The OIG identified a total of $291,222 in improper payments across this sample. Based off this finding, OIG extrapolated the data to estimate that CMS' inappropriate payments amounted to $729,424,395.

Some have criticized the audit for drawing generalizations from such a small sample.

The audit largely attributes this shortcoming to a lack of CMS oversight, failure to adhere to attestation standards, and insufficient documentation. All of this culminated in a MU program that was susceptible to a mismanagement of funds.

In light of their findings, OIG made a handful of recommendations. Among them, most notably, they suggest that CMS recover the $291,222 in payments made to EPs identified in its study. OIG also recommended CMS identify EPs who did not meet meaningful use requirement in each program year in an attempt to recover the $729,424,395.

In its formal response to the report, CMS indicated that it will try to recover the improper payments identified in the OIG study but does not plan to recover the extrapolated amount of $729 million beyond its normal targeted risk-based audit/recovery process. OIG does not believe these audits will be effective.

OIG also proposes that CMS modify the EHR program to strengthen program safeguards that make verification and reporting more reliable. OIG also suggested improving education on the proper documentation requirements.

2016 was the final reporting year for the Meaningful Use program. The new Medicare Quality Payment Program (QPP) replaced the MU program with the Merit-based Incentive Payment System's (MIPS) Advancing Care Information (ACI) performance category. The Advanced Alternative Payment Model (APM) participation option also includes an EHR component.

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Federal Budget Begins to Take Shape

Republicans on the House Budget Committee are beginning to coalesce on the FY 2018 budget however some differences still remain. President Trump's budget request proposed a significant increase to defense spending at the expense of cuts to domestic discretionary spending. The House Budget reflects this same concept however the exact dollar figures are still being discussed.

Although the President submits a budget request to Congress every year, Congress alone is responsible for crafting the actual federal budget which sets top-line spending caps across 20 broad policy categories. The Appropriations Committees in each Chamber then work from the Budget's top line numbers to allocate line item/programmatic funding for all federal Agencies and discretionary programs.

Congress is technically required to pass a budget each year; however, there is no penalty if either Chamber fails to do so.

House Republicans are trying to pass a budget that will be balanced within ten years. The budget would not include raising taxes and would therefore rely exclusively on spending cuts or reductions in the rate of growth in spending as a way of reducing future federal spending.

Passing this budget serves two primary purposes: altering the defense spending cap – an important initiative to Republicans – and opening the door to comprehensive tax reform using the budget reconciliation process.

Moderate and conservative Members of the Committee are debating just how much to increase defense spending. The higher they boost defense spending, the greater the cuts will be to non-defense domestic spending such as the budget for the Department of Health and Human Services (HHS).

There was a preliminary agreement between the two ideological factions, however conservatives then pushed for higher defense spending and deeper cuts to non-defense spending while moderates wanted to stick to the

agreed upon budget levels. That original agreement included $621 billion in defense spending and $511 billion in non-defense domestic spending for a total budget of $1.1 trillion for FY 2018. These negotiations are ongoing but a new agreement appears to be within reach.

This budget also has huge implications for comprehensive tax reform. Republicans are hoping to use the budget reconciliation process to pass a tax reform package. This would allow the bill to avoid a filibuster in the Senate which requires 60 votes for overcome. Republicans would need at least eight Democrats to reach 60 votes which is unlikely in this political environment.

Budget reconciliation is the same procedure currently being used by Republicans to pass an Affordable Care Act (ACA) repeal/replace bill. The budget reconciliation process requires both the House and Senate to pass an identical budget. The Senate would either have to pass the House Budget or pass its own version and then reconcile the differences into a single, unified budget.

Congress generally passes its budget independently from the President's Budget Request however some items from the President's budget could be included. Secretary of HHS, Tom Price, defended the President's budget request before two Congressional Committees. Secretary Price spent the morning of June 8th testifying before the Senate Finance Committee before heading over to the House Ways and Means Committee for a hearing on the same topic that afternoon.

The timing of the hearings, which occurred in the midst of the ACA repeal/replace debate, resulted in many of the questions from the Committees focusing on the ACA repeal/replace efforts rather than the reason the Secretary was present.

Secretary Price testified that President Trump's budget would directly help those most in need while addressing the nation's new health crises, which, according to the Secretary, are mental illness, opioid addiction, and childhood obesity.

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CMS Office of the Actuary AHCA Analysis Contradicts CBO

The Congressional Budget Office (CBO) is the arm of Congress that provides the official analysis that determines whether legislation that repeals and replaces the Affordable Care Act (ACA) meets the requirements of budget reconciliation – the procedure being used to pass a repeal/replace bill. The CBO's provides Congress with a financial "score" that estimates the effect the bill will have on the federal budget and the impact the bill will have on insurance enrollment.

As readers may recall from last month's Washington Report, the CBO analysis of the AHCA showed that the House bill, if signed into law, would reduce federal spending by a net of $119 billion over the next 10 years. More recently, CBO determined that the Senate's ACA repeal/replace bill would reduce federal spending by $321 billion over the next 10 years.

The CBO also predicts that over the next 10 years, the House and Senate repeal and replace bills will lead to fewer people having health insurance compared to what CBO believes to be the case if the ACA were to remain in place for the next 10 years. According to the CBO, 23 million (AHCA) and 22 million (BRCA) fewer people would be covered by health insurance (Medicaid or commercial insurance) over the next ten years compared to the ACA.

Much of the drop in commercial insurance coverage will occur because millions of people (mostly young people) will stop buying insurance if they are no longer mandated to do so by the Federal government. A significant percentage of people who would no longer have health insurance, CBO believes, will occur as a result of the phase-out of the federal government's enhanced match rate to state Medicaid programs that expand Medicaid eligibility to people earning up to 138 percent of the federal poverty line.

Although the GOP plans continue to allow states to provide expanded coverage to "able bodied" adults with incomes up to 138% of poverty, the "match rate" or FMAP would be tied to each state's regular FMAP (average 55% federal share) rather than at the enhanced FMAP (90% federal share) for able bodied adults.

Both the House and Senate repeal/replace plans would also authorize states to adopt a work/education requirement as a condition of able bodied individuals receiving Medicaid. Should states exercise this option, CBO believes many otherwise eligible individuals would reject Medicaid enrollment rather than find work or enroll in a qualified educational program.

Additionally, the House and Senate bills would eliminate the individual mandate penalty for not having health insurance. Although the bills replace the mandate with a different enforcement mechanism, the CBO does not believe either will be as effective as the individual mandate. The CBO assumes that many people choose not to purchase insurance as opposed to being unable to purchase insurance.

Another agency, the CMS Office of the Actuary (OACT), conducted its own independent analysis of the American Health Care Act and recently released its findings to the public. Although OACT is housed within CMS, the Actuaries are independent of the agency's political appointees and often provide an independent, objective analysis of pending legislation that could impact the Medicare or Medicaid program. OACT provided a similar analysis of the Patient Protection and Affordable Care Act (ACA) when it was being debated by Congress.

Although the CBO score is the official analysis that Congress must use, the OACT offers a much different evaluation of the AHCA. The OACT has yet to provide an analysis of the BCRA as it has not yet been passed. The OACT analysis also does not represent the Administration's official position on the bill.

In a preface to their report, OACT states the following:

> *The Office of the Actuary has prepared this memorandum in our longstanding capacity as an independent technical advisor to both the Administration and the Congress. The costs, savings, and coverage impacts shown herein represent our best estimates for the American Health Care Act. The statements, estimates, and other information provided in this memorandum are those of the Office of the Actuary and do not represent an official position of the Department of Health & Human Services or the Administration.*

The OACT believes the coverage gap will be much smaller than the CBO predicts. In its score of the House and Senate bills, the CBO assumes that if the ACA remained law, states that have not yet expanded Medicaid will do so. However the OACT developed its projections based on states that have already expanded and does not build in an assumption that more states will expand Medicaid in the future.

The OACT estimates that if the AHCA were to be signed into law, the number of uninsured will be roughly 13 million higher compared to the ACA. According to OACT, this decline in the number of insured individuals will primarily result from a decline in eligibility for Medicaid.

This estimate shows 10 million fewer people without insurance than the CBO predicts. In calendar year 2026, the OACT predicts Medicaid enrollment will be 8 million lower under the AHCA than under current law meaning and five million fewer people will be insured in the individual market.

The OACT also differs from the CBO on how much savings the AHCA will generate. The OACT estimates that the AHCA will reduce federal expenditures by over $328 billion over a decade. The primary driver of the savings is lower Medicaid spending. The CBO predicts the AHCA will only generate $119 billion in savings. The OACTs savings projection is more in-line with the CBO's score of the BCRA. The CBO projects the BCRA would save $321 billion.

The differences in the estimates between the CBO and the OACT are substantial and not inconsequential. The two projections make fundamentally different assumptions which lead to starkly different estimates. However it should also be noted that both assumptions are just that – assumptions.

As we have seen over the past few years, many of the CBO's initial projections for the ACA were inaccurate, however it should also be noted that the OACT's original assumptions about the impact of the ACA on the both the federal budget and the number of uninsured were also inaccurate. As with the CBO, OACT believed the ACA would result in far greater coverage and at far lower cost than has been the case over the past four years.

The repeal/replace legislation is not yet in final form and there is a considerable likelihood that there will be changes before the bill is voted on by the Senate. Changes to secure the votes necessary to pass a repeal and replace bill would likely affect the findings and conclusions of both the CBO and OACT.

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Global Cybersecurity Attacks Lead to Increased Attention from Administration

In light of recent global cyber-attacks that have affected major healthcare systems among other industries, the US government is trying to help US companies prevent a similar attack in the future.

In May, a massive ransomware attack crippled computer systems in over 150 countries, including the British National Health Services (NHS). Another global ransomware attack occurred in June. Only a few US companies were affected while other countries bore the brunt of the attack. This does not mean that US companies cannot and will not be targeted in the future.

The vulnerability of computers, files, and personal information is of great concern to many federal agencies. Healthcare institutions have been a primary target of ransomware attacks due to the importance and sensitivity of the systems which present an urgent need for restoration and therefore a higher likelihood of a ransom payment. The Department of Health and Human Services (HHS) has been increasing its efforts to educate healthcare institutions on how to safeguard their IT infrastructure from future attacks.

On June 8th, the Health and Human Services (HHS) Cybersecurity Task Force released its report on improving cybersecurity in the healthcare industry. The 96 page report amounted to a strong call to action for all healthcare stakeholders. However, the unique makeup of the American healthcare system can make coordination across states, localities, the federal government, and the private sector very difficult.

According to the task force, the two main culprits for the vulnerability of the healthcare industry are a lack of resources available to providers to address potential threats and a workforce shortage.

Most healthcare entities simply lack the resources or infrastructure to properly police cybersecurity threats. With very tight profit margins, often below one percent, healthcare organizations might find it difficult to fund in-house information security personnel or devote IT staff members specifically to cybersecurity. Additionally,

outdated software, hardware, and computing methods leave many groups vulnerable with no easy way to phase out old technology for new methods.

The Task Force lays out plans and roles for certain HHS officials and offices in mitigating risk of a cyber-attack. The report recommends identification of a cybersecurity "designee" to head cybersecurity planning across the agency. HHS has already created the Health Cybersecurity and Communications Integration Center (HCCIC). This body will be responsible for collecting and distributing information across HHS. However, there is considerable uncertainly as to how the "designee" role or HCCIC will actually be implemented.

The Task Force also identifies challenges and goals to cybersecurity within healthcare. Among a variety of goals, defining leadership and expectations for the industry, increasing the security of medical devices and health IT, and improving information sharing within the industry, were some that topped the list. The majority of the HHS recommendations center on increased leadership and guidance for the healthcare sector broadly.

The report went so far as to say that cybersecurity is a pressing public health concern. The task force identified six "principles" that guide their broader recommendations:

1. Define and streamline leadership, governance, and expectations for health care industry cybersecurity.
2. Increase the security and resilience of medical devices and health IT.
3. Develop the health care workforce capacity necessary to prioritize and ensure cybersecurity awareness and technical capabilities.
4. Increase health care industry readiness through improved cybersecurity awareness and education.
5. Identify mechanisms to protect research and development efforts and intellectual property from attacks or exposure.
6. Improve information sharing of industry threats, weaknesses, and mitigations.

The report also discussed how the federal government can increase its role. The report recommends that a formal cybersecurity leadership role be developed within HHS.

Some of the greatest challenges to meeting the task force recommendations will be the amount of time, money, and resources required of healthcare stakeholders to make improvements. It may prove difficult to get small-medium sized providers to adopt the task force recommendations.

In addition to the report issued by the task force, the HHS Office of Civil Rights (OCR) released of cyber security checklist outlining how Business Associates should react in the wake of a cyberattack.

The checklist for HIPAA covered businesses associates recommends:

- The entity execute response and mitigation procedures
- Report the crime to law enforcement agencies
- Report all cyber threat indicators to federal and information-sharing and analysis organizations (ISAOs)
- Report the breach to OCR no later than 60 days after the discovery of a breach affecting 500 or more individuals

Just one day before the May cyber-attack, President Trump signed an Executive Order directing all federal agencies to strengthen the cybersecurity of federal IT infrastructure. The order calls for federal agencies to conduct broad risk assessments. The order also requires that a review of all sector-specific agencies be completed within 180 days and a risk management report be completed in 90 days.

On June 8th the House Energy and Commerce Committee's Subcommittee on Oversight and Investigations held a hearing to examine the role of HHS in healthcare cybersecurity and the HHS Cybersecurity Task Force report described above.

Ultimately, HHS acknowledges that cybersecurity efforts and preparedness must improve through better planning and coordination across sectors. The hyper-connectivity of the healthcare industry and delivery makes cybersecurity a critical issue.

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CMS Lifts Enrollment and Marketing Sanctions on Cigna MA and Part D Plans

The Centers for Medicare and Medicaid Services (CMS) has lifted sanctions and will allow Cigna to resume marketing and enrolling beneficiaries into its Medicare Advantage (MA) and Medicare Part D drug plans.

CMS' decision ends Cigna's 17 month ban on enrollment and marketing practices for "deficiencies" in the health insurers plans. A 2016 statement from CMS announcing the sanctions highlighted some of Cigna's shortcomings including Compliance Program Effectiveness (CPE); Part C Organization Determinations, Appeals, and Grievances (ODAG); Part D Coverage Determinations, Appeals, and Grievances (CDAG); and Prescription Drug (Part D) Formulary Administration (FA).

The ban also prohibited Cigna from marketing its plans to potential beneficiaries.

Cigna is able to begin marketing its products immediately upon the June 16th decision. Cigna can begin enrolling new beneficiaries on July 1st.

According to CMS' decision, Cigna has attested to correcting the issues identified in CMS' sanctions. Cigna's attestation is supported by an independent auditor which the sanctions required for monitoring Cigna's progress. This auditor found additional issues which were not identified in the original enrollment and marketing ban. CMS still expects Cigna to work with the auditor to correct those issues even though the ban has ended. CMS will issue a formal corrective action plan on those findings.

CMS will continue to monitor Cigna's compliance efforts and has reminded Cigna that a recurrence of deficiencies could lead to additional sanctions, civil money penalties, and/or contract termination or non-renewal.

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CMS Issues Reports on 2017 Marketplace Enrollment Trends

On June 12th CMS released two reports on marketplace enrollment trends. The first report, "Effectuated Enrollment Analysis" offers a broad overview of 2017 marketplace enrollment. The second report, "Health Insurance Exchanges Trends Report" discusses exit survey data from consumers who cancelled or terminated their 2017 health plans.

These reports are intended to give policy makers a glimpse into trends thus far in 2017. This analysis follows a March report that found 12.2 million people selected or were automatically enrolled in Marketplace plans

during the 2017 open enrollment period. 10.1 million (83%) of enrollees selected a plan that had premiums reduced by advanced payments of premium tax credits (APTC).

The Effectuated Enrollment Analysis highlights attrition rates for the first two and a half months of 2017. Of the 12.2 million who were enrolled in plans, 1.9 million did not pay their first month's premium payment (10.3 million did). Some lawmakers have used this data to support the notion that the ACA is failing. They conclude that those who did not pay chose not to due to high premiums. Under the ACA consumers can fail to pay premiums for 90 days but still remain enrolled in a plan.

Although plan attrition is not uncommon, the initial attrition rates for 2017 appear to be considerably higher than those seen in previous years (15.5% for 2017 versus 8.6% for 2016).

A contributing factor could be that many insurers have chosen to leave marketplaces across the country. Major insurers such as Aetna, Humana, and UnitedHealth have all stopped offering plans on the exchanges either entirely or in select markets largely due to financial losses they were experiencing as well as the unpredictability of future policies. In addition, promises by the Republican Congress and President Trump to repeal the ACAs mandates may also have contributed to the higher attrition rates.

The Health Insurance Exchanges Trends Report sought to understand the forces behind the numbers. The investigation found:

- Consumers with higher premiums were more likely to terminate or cancel coverage.
- Consumers listed lack of affordability as one of the most common reasons for not paying for the first month's coverage.
- Disruptions in coverage options lead to fewer consumers retaining their coverage.
- Consumers without financial assistance were more likely to terminate or cancel coverage

Additionally, the report found that people often left the market because they obtained a job with employer sponsored insurance or qualified for Medicare.

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Houses Passes Medical Malpractice Reform Bill

On June 28th, by a vote of 218-210, the House of Representatives passed H.R.1215, the Protecting Access to Care Act of 2017 which adds limitations to medical malpractice cases. The bill was opposed by all Democrats and a handful of Republicans.

The expressed goal of the legislation is to improve access to, and the quality of, medical care. The bill's supporters hope to achieve this by "reducing the excessive burden the liability system places on the health care delivery system." The bill sets new limits on medical malpractice litigation; changes the statute of limitations on filing malpractice claims; and, caps non-economic awards for plaintiffs.

Damages that are non-economic, such as pain and suffering, would be limited to $250,000.

Proponents say that doctors' habit of overusing tests and procedures as a way of avoiding liability will be curbed by the bill. As a result, costs will be driven down. Additionally, they believe that insurance costs for doctors will decrease which will indirectly lower costs to patients.

The CBO's evaluation of the bill found that it "would lower costs for healthcare by lowering premiums for medical liability insurance and by reducing the use of health care services." The CBO also said that the federal deficit could be reduced by $50 billion from 2017-2027.

Opponents have criticized the bill, alleging that it limits the ability of victims of medical malpractice to receive their rightful damages. The bill faces an uncertain future as it heads to the Senate, where it will likely need 60 votes to pass.

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House Passes Premium Tax Credit Verification Bill

As larger debates over the Republican Affordable Care Act (ACA) repeal/replace bill rages on, so too do disputes over supporting bills that would also make changes to the health insurance markets.

On June 13th, the House of Representatives passed the Verify First Act (H.R. 2581) by a mostly party line vote of 238-184.

The bill would require individuals to have their citizenship status verified by their Social Security Number (SSN) before they may receive a healthcare tax credit. The bill's supporters tout it as an important first step in preventing fraud and protecting tax-payer dollars.

The bill is part of the larger Republican effort to improve upon the ACA repeal/replace bills they are trying to pass. Because of the unique reconciliation process the GOP is using to repeal/replace the core components of the ACA, many provisions, such as enrollment verification, must be passed using separate legislation passed under "regular order."

Under Senate rules, a budget reconciliation bill can be passed with a simple majority of votes in the Senate which bypasses an expected filibuster by Senate Democrats. However, budget reconciliation bills are limited to statutory changes affecting the raising or spending of money. Because the citizenship verification bill does not directly impact the raising or spending of money, it cannot be included in a budget reconciliation bill. There is no filibuster in the House of Representatives and most bills can be passed by the House with a simple majority.

The Verify First Act is one of several bills that cannot be included in a reconciliation bill but are part of the broader GOP health reform agenda. The likelihood of this or other ACA related bills passing the Senate by a filibuster proof (60 votes) majority is slim.

Although the Verify First Act requirement is specifically for advanced payment of premium tax credits that are available under the ACA, a Republican replacement bill will likely include some type of tax credit as well. Therefore, should the Verify Act pass and get signed into law, it would be applicable to either the ACA or any replacement plan the GOP might enact. To qualify for tax credits a beneficiary's SSN would have to be approved by either HHS or Homeland Security to verify that the person is a citizen or a lawfully present alien.

Opponents of the bill argue that the Verify First Act is a solution in search of a problem. They point out that there is no evidence that individuals in the U.S. illegally are receiving premium tax credits available under the ACA. The IRS correctly determined the premium tax credit amount for 97% of returns filed in 2016.

The bill is currently pending further action in the Senate. The White House has indicated that President Trump would sign the bill if it were brought to his desk.

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CMS Transmittals

The following Transmittals were issued by CMS during the Month of June.

Transmittal Number	**Subject**	**Effective Date**
R1862OTN	Introductory Letters for Suppliers and Providers Related to the Prior Authorization for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Items	2017-07-31
R175DEMO	Suppression of G9678 (Oncology Care Model Monthly Enhanced Oncology Services) Claims OCM Beneficiary Medicare Summary Notice	2017-10-02
R1863OTN	The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year 2015 for Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long Term Care Hospitals (LTCH)	2017-07-31
R1861OTN	Targeted Probe and Educate Pilot	2017-07-03
R3804CP	Screening for Hepatitis B Virus (HBV) Infection	2018-01-02
R198NCD	Screening for Hepatitis B Virus (HBV) Infection	2018-01-02
R3801CP	Extension of the Transition to the Fully Adjusted Durable Medical Equipment, Prosthetics, Orthotics and Supplies Payment Rates under Section 16007 of the 21st Century Cures Act	N/A
R3802CP	Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System	A/N
R3800CP	Internet Only Manual Update to Pub. 100-04, Chapter 15	2017-07-25
R1860OTN	Updates to the CMS-855R Processing Guide	2017-07-25
R1783OTN	Implementing FISS Updates to Accommodate Section 603 Bipartisan Budget Act of 2015 - Phase 2	2017-07-03
R1859OTN	Common Working File (CWF) to Archive Inactive Part B Consistency Edits	2017-10-02

Transmittal Number	**Subject**	**Effective Date**
R3797CP	Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2017	2017-10-02
R236BP	Medicare Benefit Policy Manual - Chapter 10, Ambulance Locality and Advanced Life Support (ALS) Assessment	2017-09-18
R3798CP	Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) - October 2017	2017-10-02
R3799CP	Annual Update of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)	2017-10-02
R3795CP	Updates in the Fiscal Intermediary Shared System (FISS) Inpatient and Outpatient Provider Specific Files (PSF)	2018-01-02
R3796CP	Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2018	2017-10-02
R726PI	Comprehensive Error Rate Testing (CERT) File Layout for Social Security Number Removal Initiative (SSNRI)	N/A
R287FM	Removal of Contractor Requirement to Submit Opt Out Data into the Contractor Reporting of Operational and Workload Data (CROWD) System (Form 8)	2017-07-11
R286FM	Medicare Financial Management Manual Chapter 4, Section 20 Demand Letter Updates	2017-07-03
R169SOMA	New to State Operations Manual (SOM) Appendix Z, Emergency Preparedness for All Provider and Certified Supplier Types	2017-06-09
R235BP	Removal of Contractor Requirement to Submit Opt Out Data into the Contractor Reporting of Operational and Workload Data (CROWD) System (Form 8)	2017-07-11
R3792CP	July 2017 Update of the Ambulatory Surgical Center (ASC) Payment System	2017-07-03
R721PI	Elimination of Routine Reviews Including Documentation Compliance Reviews and Instituting Three Medical Reviews7	2017-07-11
R3793CP	Screening for Hepatitis B Virus (HBV) Infection	2018-01-02

Transmittal Number	**Subject**	**Effective Date**
R197NCD	Screening for Hepatitis B Virus (HBV) Infection	2018-01-02
R1857OTN	New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Liability Medicare Set-Aside Arrangements (LMSAs) and No-Fault Medicare Set-Aside Arrangements (NFMSAs)	N/A
R3788CP	July 2017 Update of the Ambulatory Surgical Center (ASC) Payment System	2017-07-03
R285FM	Pub. 100-6, Chapter 3 and 4 Revisions	2017-07-01
R105GI	Update to General Information, Eligibility, and Entitlement, Chapter 7 - Contract Administrative Requirements, Section 40 – Shared System Maintainer Responsibilities for Systems Releases	2017-07-03
R1855OTN	Targeted Probe and Educate Pilot	2017-07-03

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