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healthcare reform challenges continue for a new administration and congress

With the passage of the Affordable Care Act (ACA) and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), major progress has been made on some of the most vexing issues that have confronted the nation, including the high portion of the nonelderly population lacking insurance (i.e., about 16 percent) and a Medicare physician payment system that encouraged volume but did not acknowledge a link between payments made to the physicians and the quality of care they delivered.

Although these two pieces of legislation clearly are important, it also is clear that much remains to be done. Having this column appear right about the time of the election introduces an element of uncertainty. My assumption in these weeks prior to the election is that we will continue with split government, with a Democratic president in the White House, a small Democratic majority in the Senate, and a Republican majority in the House. Even if the House were to change, the threat of a filibuster would require legislative changes to have some bipartisan support.

Potential ACA Change Areas

Hillary Clinton has proposed several changes to the ACA, mostly to protect people from spending so much of their income on premiums and out-of-pocket expenses, but these changes may prove difficult to pass given their high cost, amounting to as much as $90 billion in 2018, according to an estimate by the Rand Corporation.

Clinton's proposal to extend the offer for a federal match for expanded Medicare to states that have not taken advantage of that opportunity may be attractive to both parties, assuming more Republicans will be willing to acknowledge the continued presence of the ACA. One way to potentially smooth the transition between Medicaid and the health insurance exchanges for people between 100 and 200 percent of the poverty line might be to allow them the choice of either using their Medicaid subsidy amount to buy insurance in the exchanges or opting out of purchasing insurance in the exchanges to buy into Medicaid. In this income range, individuals and families experiencing shifts in their incomes could see a disruption in their delivery options under present rules, where eligibility for Medicaid stops at 138 percent of the poverty line.

Another potential change is to allow state Medicaid programs to offer private insurance that meets the requirements for being in an exchange without having to request a waiver from the Centers for Medicare & Medicaid Services (CMS). Such a change would have meant that Arkansas, for example, would not have been required to obtain a waiver for its Medicaid alternative.

Developing strategies to reduce the exodus of health plans from the exchanges would increase competition among plans and potentially produce less churn by enrollees among plans. Steps are already being taken to limit people's ability to enroll during "special periods" and to qualify for special enrollment. Providing more effective and faster "back-room" communication between the exchanges and insurers rather than continuing to rely predominantly on paper communications could allow a future administration to force special enrollees to maintain enrollment for the full year ahead once they enroll (unless their

eligibility changes), as occurs with Medicare and employer-sponsored insurance.

As a less likely (but possible) change, a public option might be offered in areas that lack two insurance choices, as was the case for Part D Medicare. As I explained in my previous column, such an option would likely look like Medicaid rather than Medicare because the only plans that have enjoyed commercial success in the exchanges have been those modeled after Medicaid.

Finalizing Metrics for MACRA

Most of the work required to implement MACRA will come through rule making rather than new legislation. CMS recently relaxed some of the reporting requirements that begin in 2017, allowing physicians to report only "some data" (i.e., either some of the required Merit-based Incentive Payment System [MIPS] data or data for only part of the year) to be protected from a reduction in fees. The final rule was published mid-October, and all 2,400 pages are slowly being digested by various provider groups and trade associations. Early responses have been generally supportive of the greater flexibility being provided to clinicians, although some groups would have liked a slower phase-in for 2018 or more flexibility in defining alternative payment models.

Any subsequent changes may require legislation, but it seems possible that such legislation could be passed because MACRA was enacted in 2015 as a result of a bipartisan effort.

Payment Reforms for Medicare

With MACRA passed, Medicare is on schedule to fundamentally move physician payment to a value-based payment system. CMS has been struggling to find the best ways to move from the existing Medicare bundled payments approaches (e.g., DRGs, home health episodes) to payment systems that reward greater efficiency and improved outcomes.

Because of uncertainty about the extent to which some proposed strategies will ultimately be effective, the Center for Medicare & Medicaid Innovation (CMMI) has launched a large number of demonstrations over the past five years. These include the Comprehensive Primary Care Initiative (scheduled to end in December) and the follow-on Comprehensive Primary Care Plus initiative, the voluntary Bundled Payments for Care Improvement initiative, and the mandatory Comprehensive Care for Joint Replacement Model. CMMI also has sponsored various population-based programs involving accountable care organizations (ACOs), including the Medicare Shared Savings Program, the Pioneer ACO Model, and the Next Generation ACO Model.

With this extraordinary number of demonstrations underway, it is not hard to imagine unintended consequences resulting from there being some physicians (usually primary care) focused on total patient costs and other physicians (frequently specialists) focused on bundled payments, with such disparate approaches sometimes involving a single patient and possibly a single hospital.

Hospitals that are participating in multiple demonstrations also may be feeling administrative overload. The proliferation of demonstrations also could explain why so often today minimal results are being reported: Physicians who are reluctant to change their practices could be limiting their reporting for a demonstration because they quite reasonably expect that it will fade away in any event.

It is time for a new administration to convene representatives from all affected parties to discuss what's been learned to date and make decisions about the next round of payment reform. These reforms, like all reforms, will be adjusted as needed. It's time to move on—whoever is elected as the nation's president. ■

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