An early sign of the administration's focus in 2018 is CMS' rollout on January 9, 2018 of the next-generation Bundled Payments for Care Improvement (BPCI) program that will take effect after the original BPCI program expires in September of 2018. The BPCI Advanced program remains optional and includes a new iteration of 32 clinical episodes. CMS will set target prices in May of 2018. The program also qualifies as an Advanced APM, making it the first developed by this administration.

*Medicare Access & CHIP Reauthorization Act of 2015* (*MACRA).* On November 2, 2017, CMS released its final rule updating for 2018 the Quality Payment Program required by MACRA. Under that rule, 2018 will be "[a] second year to ramp-up the program . . . in preparation for a robust program in year 3 [i.e., 2019]." While CMS made several minor changes in an attempt to make the program more user-friendly, one key change for 2018 is that the Merit-based Incentive Payment System (MIPS) for the first time will factor *costs* in a participant's performance, weighting it at 10%. Participants should take advantage of 2018 as a phase-in period since costs will account for 30% of a participant's score in 2019. As mentioned above, CMS will continue to push for expanded participation in risk-based APMs, which will continue to require at least 8% down-side risk. CMS also plans to add Advanced APMs, such as the Medicare Accountable Care Organization (ACO) Track 1 Plus (1+) Model, and reopen the CPC+ and Next Generation ACO in 2018.

*A New Focus for Innovation at the Center for Medicare and Medicaid Innovation* (*CMMI).* CMS has been outspoken regarding the big-picture shift it intends to undertake for CMMI in 2018, heralded by the departure of the director of CMMI, Dr. Patrick Conway. The details of that shift, however, are uncertain. According to CMS, in the coming years CMMI will focus on testing models in various areas, including increased participation in APMs; consumer-directed care and market-based innovation models; physician specialty models; prescription drug models; Medicare Advantage (MA) innovation models; state-based and local innovation, including Medicaid-focused models; and mental and behavioral health models.

In September 2017, CMS Administrator Seema Verma penned an op-ed discussing CMMI's initiative to crowd-source ideas for improving Medicare and Medicaid through a public request for information. In the article, Verma stated that improvement "will require health-care providers to compete for patients in a free and dynamic market, creating incentives to increase quality and reduce costs."

As 2018 progresses, we will see to what extent future payment reform models will reflect a downsized role for the government and a trend toward more market-driven, outcome-based, and patient-centered models.

## Medicaid Outlook for 2018

*—Charles Luband, Dentons US LLP*

After a year where legislative proposals in large part focused on potential dramatic changes to the structure of the Medicaid program—including elimination of open-ended federal funding and of the enhanced federal match for expansion populations—changes to the Medicaid program in 2018 are likely to be more incremental (unless major entitlement reform efforts ensue). In fact, even if 2018 brings renewed efforts to repeal and replace the ACA, it seems unlikely that Medicaid reform will be the centerpiece it was in the 2017 legislative efforts. Additionally, Medicaid was in some ways buoyed by electoral activity in 2017: Maine voters supported Medicaid expansion, notwithstanding opposition of the state governor. The following Medicaid issues are likely to be critical in 2018.

*Medicaid Expansion.* At present, 32 states and the District of Columbia have expanded their Medicaid programs to cover individuals with incomes up to 138% of the federal poverty level—the expansion made "voluntary" by *National Federation of Independent Business v. Sebelius.*[33] Federal matching for costs of "newly eligible" beneficiaries is 94% for federal fiscal year 2018; this reduces to 93% in 2019, and 90% thereafter. HHS estimated in March 2016 that 20 million people had gained health insurance coverage since 2010, including over 14.5 million in the Children's Health Insurance Program (CHIP) and Medicaid, reducing bad debt for hospitals and shoring up state finances.

Now that repeal of the Medicaid expansion provisions in the ACA appears to be off the table, an important question for 2018 is whether additional states will opt in to the Medicaid expansion. As noted above, over 58% of Maine voters in 2017 voted to require the state to adopt the Medicaid expansion. It seems possible that other states in 2018, particularly Idaho and Utah, could follow Maine's lead and put Medicaid expansion on the ballot. Change in the composition of the Virginia legislature also could result in expansion. One question at the federal level is whether CMS will make it easier or more difficult for states to expand.

*Medicaid Waivers.* In March 2017, HHS and CMS issued a letter to states indicating a willingness to use Section 1115 demonstration authority to "support innovative approaches to increase employment and community engagement" and "align Medicaid and private insurance policies for non-disabled adults."[34] That letter and CMS' actions since have confirmed that additional change in the Medicaid program in 2018 is likely to occur in the context of Section 1115 demonstration waivers. A number of states have waiver requests pending that include provisions not previously approved by CMS, including work requirements, drug screening and testing, time limits on eligibility, and premiums and disenrollment for non-payment of premiums for non-expansion populations. Some of the requests are part of expansion waivers, while others would apply to non-expansion populations. It is quite possible that Medicaid advocates will litigate if CMS approves some of the waiver requests.

*Medicaid Disproportionate Share Hospital (DSH).* Medicaid DSH payments, which states can use to reimburse hospitals for Medicaid shortfalls and uninsured costs, were scheduled for substantial cuts in the ACA. These DSH cuts presently are scheduled for federal fiscal year 2018 (i.e. beginning October 1, 2017), although it is possible these reductions will be postponed along with the CHIP extension leftover from 2017. CMS

issued a proposed regulation in July 2017 to implement the required DSH allotment reductions,[35] although it has not yet been finalized. These DSH allotment reductions will substantially impact the ability of states to make Medicaid DSH payments to many hospitals and will be a substantial issue in 2018 if the cuts are not further delayed.

In addition, a number of federal district courts and appellate courts currently are considering a technical legal issue regarding the calculation of the statutory limits that apply to Medicaid DSH payments.[36] These cases have the potential to impact the distribution of DSH payments within states. Decisions are likely in 2018.

*Medicaid Managed Care.* Managed care is the predominant delivery system in Medicaid. In May 2016, CMS published a comprehensive Medicaid managed care final rule that substantially changed state discretion in implementing and operationalizing managed care.[37] The Trump administration published an informational bulletin on June 30, 2017, which told states that it would not enforce many of the provisions of the 2016 rule.[38] In 2018, CMS likely will indicate whether it intends to allow implementation of the 2016 rule to move forward or whether it intends to rewrite the rules.

One provision of the 2016 rule that CMS allowed to move forward concerned restrictions on the ability of states to require that managed care plans make payments to certain providers. In 2017 there was substantial CMS and state activity on these issues. CMS issued a final rule[39] and an informational bulletin,[40] and many states submitted proposals to states to establish programs under the new framework. This activity likely will continue in 2018.

## Hospital Mergers, Acquisitions, and Affiliation Transactions

*—Travis G. Lloyd, Bradley Arant Boult Cummings LLP*

When it comes to hospital consolidation, what's past is prologue. Increasing reimbursement pressure, changing payment methodologies, and continuing uncertainty regarding the health insurance marketplace are forcing many hospitals and health systems to consider a range of affiliation transactions, from traditional mergers and acquisitions to emerging alternative partnerships, such as the development of clinically integrated networks. By many accounts, hospital deal activity sustained the same torrid pace in 2017 that it has for the past several years,[41] and there is reason to believe the trend will continue in 2018.

The drivers of hospital consolidation are many and varied. Traditional factors like improving access to capital, reducing operating costs, and increasing market share continue to compel hospital deals, but so too do declining reimbursement, emerging value-based payment initiatives, and instability in the health insurance marketplace.

Reimbursement continues to change, and, in the view of many hospitals, for the worse. In March 2017, the Medicare Payment Advisory Commission (MedPAC) issued a report that hospitals' aggregate Medicare margin—that is, the amount by which payment exceeds allowable costs—was -7.1% in calendar year 2015, its lowest level since 2008.[42] Moreover, the report estimated that the margin would decline to roughly -10% by the end of 2017. While the MedPAC report also found that total profitability across all payers remains strong, many hospitals, particularly those with large Medicare and Medicaid populations, are feeling the pinch.

Changes in how—and in how much—hospitals are paid continue to put pressure on the bottom line, leading many health systems to explore their options. Consider the following recent examples:

- DSH payments are made by Medicare and Medicaid to hospitals that treat a disproportionately large share of low-income patients. The ACA has made major changes to DSH payments and provides for significant annual cuts to Medicaid DSH payments (from $2 billion in cuts in 2018 to $8 billion in 2025). These Medicaid DSH cuts were scheduled to go into effect October 1, 2017. While the House has passed legislation to delay the cuts, the Senate has yet to take action.
- For many hospitals, particularly safety-net hospitals in rural areas, the 340B drug pricing program offers a critical subsidy. The program, which allows certain hospitals and other health care providers to obtain discounts on certain outpatient drugs from drug manufacturers, was the subject of a significant change in 2017. Effective January 1, 2018, reimbursement under the program will be cut by nearly 30% for most participating hospitals. Hospital groups filed a lawsuit against HHS to prevent the payment cut from taking effect, and legislation has been introduced to nullify the change, but it remains to be seen whether these efforts will succeed.
- Hospitals also face continued pressure to move patients to less expensive settings. Beginning January 1, 2018, off-campus hospital outpatient departments that are not grandfathered or excepted from the Bipartisan Budget Act of 2015 will be paid 40% of current Outpatient Prospective Payment System rates, representing a 20% decrease from the previous year. Lower rates and strict limits on the relocation of grandfathered facilities create real obstacles for hospitals that seek to grow their community presence.
- Commercial insurers also are increasingly pursuing site-neutral payment policies. For example, in 2017, Anthem announced that it will no longer pay for certain advanced imaging services provided at hospital-based facilities located in nine states.[43] Anthem also indicated that, in certain markets, it would no longer cover non-urgent visits to hospital emergency departments for minor conditions that could be safely treated in lower-acuity settings.[44]

In addition, value-based payment and population health initiatives are prompting many hospitals to consider affiliations and partnerships as a means of acquiring the expertise and support necessary to thrive in the future. Take, for example, the potential impact of MACRA, under which a portion of Medicare payments to physicians will be tied to goals such as quality and cost. MACRA may drive more physicians to join hospitals, as hospi-