Policy Brief

August 10, 2018

CMS Embraces Site-Neutral Payments in OPPS Rule

CMS released its Outpatient Prospective Payment System (OPPS) proposed rule for Calendar Year (CY) 2019, which contains several policies related to site-neutral payments—paying the same amount for a service regardless of the setting. The rule notes that the OPPS "has been the fastest growing sector of Medicare payments" and seeks comments on how to curtail this growth. Site-neutral payments and other methods, such as prior-authorization and volume caps, are referenced as options. This indicates that more changes are coming that could limit the growth of outpatient services. Below is a summary of the rule's site-neutral proposals. For a detailed outline of the OPPS rule, click here.

Payment Cut for Clinic Visits Furnished at Grandfathered Off-Campus Provider Based Departments (PBDs). CMS proposes to reimburse clinic visits provided at grandfathered PBDs (those billing Medicare prior to November 2, 2015 or mid-built) at the Physician Fee Schedule (PFS) payment rate, which is 40% of the OPPS payment amount. Clinic visits in off-campus PBDs are currently billed at $116 and would be paid at $46 under this proposal.

Site-Neutral Payment for New Service Lines at Excepted Off-Campus PBDs. CMS proposes that when any grandfathered off-campus PBD furnishes a service from a clinical family of services they did not previously furnish between November 1, 2014 and November 1, 2015, services from the new clinical family would be paid under the lower PFS rate.

340B Payment Cut Extended to Nonexcepted PBDs. CMS proposes to extend the 28.5% payment cut for 340B drugs that was implemented last year to nonexcepted, off-campus PBDs. Currently, this cut only applies to drugs furnished at grandfathered PBDs.

New Modifier to Track Utilization in Off-Campus Emergency Departments. CMS proposes to create a new HCPCS modifier that will be reported with every claim line for outpatient hospital services furnished in an off-campus ED. This resembles CMS' development of the PO modifier for off-campus PBDs prior to proposing further payment cuts for those facilities.

Key Takeaways from the IPPS Final Rule

CMS finalized its Inpatient Prospective Payment System (IPPS) final rule for Fiscal Year (FY) 2019. Among the policies finalized was the elimination of the 25% rule for Long-Term Care Hospitals (LTCHs) and a proposal requiring hospitals to post their charges online via a "machine readable format." The rule also increases payments for inpatient services by $4.8 billion in FY 2019, the largest payment update in years. Below are our seven key takeaways on the rule. A detailed outline will be provided in the next few weeks.

Beginning in January 1, 2019, hospitals will be required to post their standard charges online. CMS will require hospitals to post their charges online via a "machine readable format." In response to concerns about how the chargemaster could be misleading, CMS disagreed and stated, "we acknowledge that providing patients with more specific information on their potential financial liability is needed and commend the hospitals that already do so. However, we believe that this more specific need does not justify a delay in the provision of chargemaster information to the public." CMS also acknowledged the existence of current state transparency laws and argued that these could complement the finalized policy. More is likely to come to advance transparency in health care.

The 25% referral rule for LTCHs will be eliminated. The rule currently imposes a site-neutral, reduced payment to LTCHs that receive more than 25% of their patients from a single hospital.

The total pool of uncompensated care payments is projected to increase by $1.5 billion in FY 2019. This is attributed to an anticipated increase in the rate of the uninsured following the repeal of the Affordable Care Act's (ACA) individual mandate.

Physician admission orders will no longer be required to be present in the medical record as a condition for payment. CMS clarified that although the physician admission order remains important, Medicare auditors will not be able to deny a claim based on technical issues found in the physician admission order, such as a missing signature. In those instances, auditors will be required to review the entirety of the record. The rule states, "the physician order remains a significant requirement because it reflects a determination by the ordering physician or other qualified practitioner that hospital inpatient services are medically necessary and initiates the process for inpatient admission."

All measures in the Hospital Acquired Conditions (HAC) program will be weighted equally. This is intended to make scoring fairer for low-volume hospitals that are currently disproportionately assessed on only one or two measures in Domain 2, the Hospital Acquired Infections domain.

The Safety Domain will be retained in the Value-Based Purchasing Program (VBP). This means that *all* domains will continue to be weighted at 25%.

There will be 39 measures eliminated from the Inpatient Quality Reporting (IQR) program. This includes 21 measures that are already accounted for in CMS' pay-for-performance programs and 18 previously adopted measures that are topped out. These measures are listed on section VIII.A.5.c., page 1686 of the final rule.

Congress' Post Recess Agenda

Congress is currently in recess, with members actively campaigning for the 2018 mid-term elections. The Legislators left Washington without tackling pressing issues such as immigration, government funding and health care. It looks like the fall will be a busy period for Congress. What health care issue will make the agenda? Read below to find out.

340B Drug Policy

In early July, the House reviewed 15 bills that would revamp the oversight, transparency and organization of the 340B drug program. Congress' efforts vary, from calling for increased transparency to further payment cuts. The lack of consensus on an approach to reform the program will likely push 340B legislation into 2019. However, there may be some activity during the lame duck session.

Stark Law

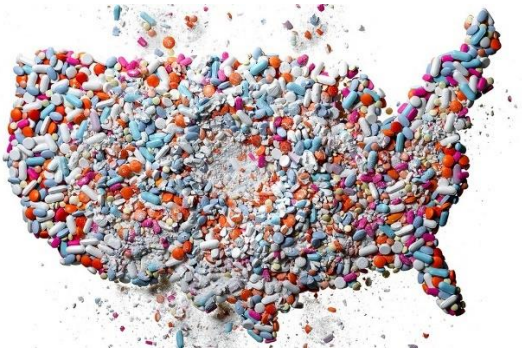
For years, Congress has agreed that the law against physician self-referral needs to be updated but there is disagreement on how much reform needs to occur. While minor legislative activity may happen in the lame duck, a comprehensive reform bill will likely be introduced in 2019.

Opioids

The House passed an opioid legislative package with 58 individual bills that include two hospital priorities: removing the Institutions for Mental Disease (IMD) exclusion and allowing Medicaid patients to receive Medically Assisted Treatment (MAT) for up to 30 days per year. The Senate has yet to voted on their version of the legislation. Senate Majority Leader Mitch McConnell maintains that the opioid legislative package remains a top priority. However, the confirmation of Supreme Court nominee Brett Kavanaugh is a competing Senate priority set to take place over the next few months.

Farm Bill

The House and Senate have both passed their own versions of this bill. The House significantly tightens work requirements for SNAP recipients, while the Senate version largely maintains the program as is. Movement on this bill is likely as Congress must reauthorize programs, including crop insurance and land conversation, before they expire on September 30th. The chambers are preparing to begin formal negotiations on the Farm bill after Labor Day.



Ten Months Later: The Impact of the Opioid Response

In October of 2017, the opioid epidemic was declared a national public health emergency. States leapt to action, passing nearly 30 bills in response. With communities suffering and midterms looming, national and local lawmakers have felt the pressure to be proactive, yielding mixed results. Some results have been fantastic, including increased funding, research-heavy taskforces and a greater use of overdose-countering medications. There have also been some unintentional downsides, especially for patients with chronic pain, prompting worry of a lack of intentionality. Have we been too hasty with our responses to the opioid crisis?

The Good

Opioids have dominated the public conversation, resulting in umbrella legislation on the national level that includes support for medically-assisted treatment, protections for "Good Samaritans" and guidance on non-opioid analgesics. Opioid misuse reports have also declined in several states.

The Bad

For some complex pain patients, new prescribing limits have decreased their access to necessary medicines. In Arizona, the new opioid law puts a ceiling on how much pain medication a patient can receive. Although the law was only supposed to apply to new patients, a misunderstanding is causing many existing patients to be hit with slashed dosages, leaving them feeling afraid and debilitated.

At times, those suffering from misuse turn to illicit sources to get the same high, resulting in a spike in overdose deaths from heroin and synthetic opioids. Without a proportionate expansion of substance use disorder services, illegal opioid sources flow in to fill the gap left by the opioids' prescription crackdown.

The Ambiguous

Pain specialists are feeling compelled to lower patient doses and decrease prescription rates, regardless of their professional assessment. Many states now publish doctors' prescribing rates; to keep rates low, some doctors are now using alternative treatments that may not always be appropriate. A few of these alternatives pose a significant risk, even resulting in paralysis or death.

Trump Sued for Undermining the ACA

President Trump's attacks against the ACA have put him in hot water yet again. Four cities have filed a lawsuit against the president for violating a constitutional clause that requires him to defend the laws that Congress has passed. Trump and his administration have taken several measures that have undermined the ACA, most recently the Department of Health and Human Services (HHS) expanded the use of short-term insurance plans from three months to three years. The lawsuit may be difficult to win because the president has broad discretion in how he can interpret the law. However, remarks by the President to let the ACA "implode" may give merit to the lawsuit. Below are the actions Trump and his administration have taken against the ACA.

Remarks from the Administration

- Trump has made several tweets about his opposition to the ACA including, "As I have always said, let ObamaCare fail and then come together and do a great healthcare plan. Stay tuned!"
- HHS Secretary Alex Azar has said in an interview, "The Affordable Care Act is broken. It does not work because of its own structure."
- The Trump Administration declined to defend a case challenging the validity of the ACA's coverage for preexisting conditions after the individual mandate was repealed.

Actions Taken that Undermine the ACA

- HHS expanded the use of short term health plans from three months to three years, which may lead younger, healthier Americans to leave the Health Insurance Exchanges in favor for these cheaper plans, which would raise prices overall.
- Repealing the individual mandate, which could drop enrollment in the Health Insurance Exchanges between 2.8 million and 13 million.
- Cutting the enrollment period in half and charging insurers user fees of more than $10 million.

340B Update

The Energy and Commerce (E&C) Committee recently sent letters to contract pharmacies asking about their participation in the 340B program. The letters ask about the fees pharmacies recoup from each 340B prescription, actions to prevent diversion, and whether the discounts for 340B drugs are given to low-income, uninsured patients. CVS, Walgreens and Walmart were among the companies included in the probe. These letters were prompted by a GAO report that identified contract pharmacies as lacking proper oversight. We expect the Committee to continue its inquiries on the 340B program, which will likely involve several hearings.

A Look at The Federal Register

In the last couple of weeks CMS finalized several rules impacting facilities in the Post-Acute Care (PAC) setting. Additionally, CMS released a proposed rule extending the ACA risk adjustment from 2018.

SNF Payments

CMS increased SNF payments by $820 million (2.4%). The rule finalized the Patient-Driven Payment Model (PDPM), which focuses on the patient's condition and resulting care needs rather than on the amount of care provided. The rule also updates the SNF Value-based Purchasing Program, including changes in the scoring methodology for low-volume SNFs and an extraordinary circumstances exemption policy.

IRF Payments

CMS increased IRF payments by $105 million (1.3%). The rule removes two measures from the IRF Quality Reporting Program. IRFs no longer will have to report data for the NHSN MRSA or seasonal flu vaccination measures as of October 1st. The rule allows rehabilitation physicians to remotely lead interdisciplinary team meetings and allows the post-admission physician evaluation to count as one of the mandated face-to-face visits.

IPF Payments

CMS increased IPF payments by $50 million (1.1%). CMS initially proposed to remove eight measures from the IPF Quality Reporting Program. However, the final rule only removes five measures.

Hospice

CMS increased hospice payments and the statutory cap by $340 million (1.8%). The rule finalizes that physician assistants will be recognized as attending physicians for hospice beneficiaries. The rule also implements a new measures' removal factor that would remove a measure if the costs associated with it outweigh its use.

CMS Proposed Rule for ACA Risk Adjustment

The rule proposes to continue the risk adjustment methodology that HHS previously established for the 2018 benefit year, which uses the statewide average premium in the payment transfer formula. The risk adjustment program gives payments to insurers that enroll high-risk individuals. Comments on the rule are due September 7, 2018.

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