Policy Brief

November 16, 2018

Health Care Implications of the Midterm Elections

Health care was on the mid-term ballot this year, with nearly half of all voters listing it as their top concern. Three states voted to expand Medicaid, increasing access for approximately 325,000 low-income individuals. Pre-existing conditions dominated the narrative on both sides of the aisle. Now that the Democrats have regained the House, we'll likely see an early vote around its protections next year. Here's what else the 2018 midterms could mean for health policy:

"Repeal and Replace" is off the table.

Major health reform is unlikely in the 116th Congress, especially surrounding the repeal of the Affordable Care Act. Instead, the new Democratic House will likely take steps to stabilize the Health Insurance Exchanges—perhaps via the previously-stalled Pallone-Neal-Scott bill, which expands federal assistance and strengthens enrollment outreach.

More changes made through regulations.

The recent activity on the regulatory front shows no signs of stopping. We expect to see the Trump Administration use rulemaking as a tool for reform now that Congress is split. Reducing regulatory burden and prescription drug prices will likely remain a top priority.

Medicaid access increases in many conservative states.

Idaho, Nebraska and Utah approved Medicaid expansion via the mid-term ballot; 37 total states have now expanded Medicaid in some regard. In addition, pro-expansion gubernatorial candidates won in the conservative states of Wisconsin, Kansas and Maine.

CMS Releases CY 2019 Hospital Outpatient Prospective Payment System Final Rule

On November 2nd, CMS released the Calendar Year (CY) 2019 Medicare Outpatient Prospective Payment System (OPPS) final rule. The rule finalizes the extension of site-neutral payment reductions to off-campus outpatient departments that were previously exempted and broadens payment reductions for drugs acquired under the 340B program. The changes signal the Agency's continued push towards site-neutral payments. Read below for a deeper dive into the finalized site-neutral policies. For details on other finalized policies CLICK HERE.

Beginning in January 1, 2019, CMS will decrease reimbursement for clinic visits (HCPCS code G0463) at off-campus Provider-Based Departments (PBDs) paid under the OPPS. This rate includes "excepted" locations that were not previously subject to payment reductions. Clinic visits provided at these sites will be paid at 70% of the OPPS full payment rate. In January 1, 2020, reimbursements will be reduced further to 40% of the OPPS payment rate. Many associations have expressed intent to legally challenge this policy as it is viewed as an overstep of CMS' authority. CMS chose *not* to finalize a proposal to reduce payments for off-campus PBDs that expanded their clinical service lines beyond those that existed between November 1, 2014 and November 1, 2015.

CMS also finalized expanded payment reductions for drugs acquired under the 340B program by non-excepted off-campus PBDs (those reimbursed under the Physician Fee Schedule). The Agency will pay the average sales price minus 22.5% for the 340B-acquired drugs. CMS will also reduce payment for new drugs and biological products for which ASP data is *not* available from the Wholesale Acquisition Cost (WAC) plus 6% to WAC plus 3%.

Medicare's CY 2019 Physician Fee Schedule Final Rule Highlights

CMS recently finalized the CY 2019 Medicare Physician Fee Schedule, which included the expansion of some telehealth services and the consolidation of Evaluation and Management (E&M) visit levels 2 through 4. While stakeholders have mixed feelings about the changes in the final rule, these changes reflect CMS' goal to reduce regulatory burden on clinicians. Below are major highlights from the final rule. For a detailed summary, click here.

E/M Codes. To reduce documentation burden, CMS will consolidate E/M visit levels 2 through 4 while maintaining E/M levels 1 and 5 separately. The final rule differed from the proposed rule, which had proposed to consolidate the documentation requirements and payment rate for levels 2 through 5.

Telehealth Services. CMS finalized the proposal to provide separate payment for physician services provided via communication technology. CMS will now reimburse physicians for check-ins with established patients over the phone and for evaluating a patient's condition by reviewing their sent recorded videos or images. It will also pay separately for interprofessional internet consultations. CMS decided *not* to pay separately for Chronic Care Remote Physiologic Monitoring.

Merit Based Incentive Payment System (MIPS). CMS finalized the proposal to add six new eligible clinician types to MIPS: physical therapist, occupational therapist, qualified speech-language pathologist, qualified audiologist, clinical psychologist and registered dietician or nutrition professionals.

Clinicians Advanced Alternative Payment Model (APM) Bonus. CMS increased the Advanced APM Certified Electronic Health Record Technology (CEHRT) threshold by 25 percentage points so that an Advanced APM must require that at least 75% of eligible clinicians use CEHRT.

Expanding the Use of Telehealth Services for Substance Use Disorders (SUD). CMS seeks comments on an interim rule to implement a provision from the Substance Use-Disorder Prevention that Promotes

Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. This interim rule removes the originating site geographic requirements and adds an individual's home as a permissible originating site for telehealth services when treating an SUD or co-occurring mental health disorder.

Alex Azar: New Mandatory Models on The Way

In speaking to the Patient-Centered Primary Care Collaborative, HHS Secretary Alex Azar gave a sneak peek at CMS' plans to roll out a new mandatory payment model, focusing on radiation oncology. "Real experimentation with episodic bundles requires a willingness to try mandatory models," said Azar. "We need results, American patients need change […] mandatory models are going to see a comeback." Azar also mentioned revisiting voluntary cardiac care models that were pulled back prior to launch. Check out the full speech transcript here.

A Look at The Federal Register

In the past two weeks, CMS has released a flurry of regulations impacting health care. Below are highlights from those regulations.

Moral and Religions Exemptions and Accommodations for ACA Coverage of Preventive Services. HHS finalized two separate rules that expand exemptions for mandated contraceptive coverage under the Patient Protection and Affordable Care Act. The exemptions are intended to protect the moral and religious beliefs of certain entities and individuals. The rule would further restrict access to reproductive health care procedures by allowing employers to claim a moral or religious exemption.

Patient Protection and Affordable Care Act; Exchange Program Integrity. The proposed rule changes some of the billing requirements in the Health Insurance Exchanges. It proposes to require separate payment for the portion of the monthly premium attributable to coverage for the termination of pregnancies. The rule is intended to ensure that federal dollars are not used to fund abortions.

Policy and Technical Changes to the Medicare Advantage (MA), Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021. CMS released a proposed rule intended to clarify program integrity policies and reduce burden on providers, MA plans and Part D sponsors. The rule proposed rule to revises the appeals and grievances requirements for Medicaid managed care and MA special needs plans for dually eligible individuals. **Comments are due December 31st.**

OPPS CY 2019 Final Rule. The rule establishes the payment rate for hospital outpatient services in CY 2019 and includes several other policies, such as the extension of site-neutral payment reductions to off-campus PBDs. This rule is discussed in further detail in an article above.

PFS CY 2019 Final Rule. The rule establishes the payment rate for clinicians in CY 2019 and includes several policies, such the expansion of some telehealth services and the consolidation of E&M visit levels 2 through 4. This rule is discussed in further detail in an article above.

IN OTHER NEWS

CMS Announces New Mental Health Medicaid Demonstration Opportunity – CMS

New Mandatory Oncology Pay Model is Coming – Modern Healthcare

How Adventist Health System More Than Doubled Patient Payments in a Year – Becker's Hospital Review

Soaring Health Care Costs Forced This Family to Choose Who Can Stay Insured – Bloomberg

With Hospitalization Losing Favor, Judges Order Outpatient Mental Health Treatment – Kaiser Health