Policy Brief

May 3, 2019

What You Need to Know: IPPS FY 2020 Proposed Rule

CMS released its annual Inpatient Prospective Payment System (IPPS) rule for FY 2020, which increases hospital inpatients payments by 3.2% for FY 2020. Unlike previous rules, this rule does *not* include any Requests for Information on price transparency, balance billing or regulatory burden. CMS continues to focus on tackling the opioid epidemic, this time seeking comments on measures on pain management for cancer patients. No new measures were proposed for the pay-for-performance programs (HAC, VPB and HRRP). An outline of the rule can be found here. The key proposals are summarized below.

Hospital Wage Index

- CMS proposes to raise the wage index for rural hospitals and decrease it for hospitals in the 75th percentile (mostly urban hospitals) to ensure the change is budget-neutral. This comes as~~to~~ no surprise, as the Agency has been pressured by both Congress and the Office of Inspector General to address the ongoing closure of rural hospitals through changes to the wage index.

Disproportionate Share Hospital (DSH) Payment Changes

- CMS proposes to use a single year of uncompensated care data from Worksheet S-10 (FY 2015 data) to determine the distribution of DSH uncompensated care payments for FY 2020. In FY 2019, CMS has used two years of S-10 data and one year of low-income insured days data.

Inpatient Quality Reporting (IQR) Program

- Beginning in the CY 2021 reporting period/FY 2023 payment, CMS proposes to add two new electronic Clinical Quality Measures (eCQMs): 1) Safe Use of Opioids—Concurrent Prescribing and 2) Hospital Harm Opioid-Related Adverse Events.

- CMS proposes to make the reporting of the current hybrid hospital-wide all-cause readmissions measure mandatory. The measure's reporting period would be from July 1, 2023 through June 30, 2024. If this policy is finalized, CMS will remove the claims-only readmissions measure.

- The rule seeks comments on three *potential* new measures for future rulemaking, which were included in the National Quality Forum Measures Under Consideration. AdventHealth, a member of AHPA, has commented on these measures.
    - Hospital Harm—Severe Hypoglycemia eCQM
    - Hospital Harm—Pressure Injury eCQM
    - Cesarean Birth eCQM.

- Comments are sought on measures of pain management for cancer patients. The Agency seeks recommendations on measures to assess post-treatment addiction prevention, as well as existing measures that evaluate pain management for cancer patients and do not involve opioid use.

Increased Payments for Breakthrough Medical Devices

- CMS proposes to increase the add-on payment for breakthrough medical devices from 50% to 65%. They would also waive for two years the requirement for evidence that these devices represent a "substantial clinical improvement."

Payments for CAR-T Therapy

- To improve access to Chimeric Antigen Receptor (CAR) T-Cell therapy, CMS proposes to increase the add-on payment for this therapy from $186,500 to $242,450 per case.
- CMS seeks comments on whether an MS-DRG for CAR-T therapy should be developed and what approaches should be used for setting the associated relative weight of such MS-DRG.

New Payment Models to Redesign Primary Care

Last week, CMS released five new voluntary models for primary care practices. Congress has shown a particular interest in this area during a recent hearing examining the impact of primary care on health care costs. CMS is also seeking comments on one of the given models, due on May 23rd. The RFI states that the models are "CMS's strategy to redesign primary care as a pathway to drive broader delivery system reform." What will this growing interest in primary care mean for health policy? Time will certainly tell how this growing interest in primary care will shift the health care landscape. Below is more about the five voluntary model options that will be available.

Primary Care First (PCF) – Two Models Available

1. General Model:
    - Tests population and performance-based payment for primary care
    - Introduces higher payment amounts for practices that care for complex, chronically-ill patients
2. High-Need Populations Model:
    - Encourages advanced primary care practices to take responsibility for high-need, seriously ill beneficiaries
    - Incorporates hospice and palliative care services

Direct Contracting – Three Models Available

1. Professional Population-Based Payment Model:
    - Bears risks for 50% of shared savings/shared losses on the total cost of care of all Part A and B services for aligned beneficiaries.
    - Receives a capitated, risk-adjusted monthly payment for enhanced primary care services equal to 7% of the total cost of care for enhanced primary care services.
2. Global Population-Based Payment Model:
    - Bears risks for 100% of shared savings/shared losses on the total cost of care for aligned beneficiaries.
    - Choice between primary care capitation and total care capitation.

- The total care capitation is a risk-adjusted monthly payment for all services provided by Direct Contracting Entities (DCEs) participants and preferred providers with whom the DCE has an agreement.

3. Geographic Population-Based Payment Model:
    - Bears risk for 100% of shared savings/shared losses on the total cost of care for aligned beneficiaries in a target region.
    - Competitive application process, which includes providing CMS a specified discount off the total cost of care for the defined target region.

CMS Zeros in on Dual Eligibles

Last week, CMS highlighted three opportunities to test models centered on integrating care for dual eligibles (individuals concurrently enrolled in Medicaid and Medicare). With a keen focus on controlling the cost of health care, this move by CMS is no surprise. CMS and states spend more than $300 billion per year on the care of dual eligibles. With less than 10% of dual eligibles enrolled in a form of care that integrates Medicare and Medicaid services, the patient experience is disjointed and the care costly. Below is more on the dual eligible population and CMS' efforts to tackle the associated costs and improve outcomes.

The Dual Eligible Population

In 2017, 12 million individuals were concurrently enrolled in Medicare and Medicaid. Making up 20% of Medicare enrollees and 15% of Medicaid enrollees, dual eligibles account for 34% of Medicare spending and 33% of Medicaid spending. These dual eligibles experience high rates of chronic illness, often require long-term care and suffer from social risk factors:

- 41% of dual eligibles have at least one mental health diagnosis
- 49% receive Long-Term Care Services and Supports (LTSS)
- 60% have multiple chronic conditions

Efforts to Integrate Care

Efforts to integrate care across Medicare and Medicaid are popping up across the policy landscape.

- **State Medicaid**

  In the recent State Medicaid Directors Letter, CMS highlights three opportunities:

  1. **The Capitated Financial Alignment Model.** Through a joint contract with CMS, states and health plans, this model creates a way to provide the full array of Medicare and Medicaid services for enrollees for a set capitated dollar amount.

  2. **Managed Fee-for-Service Model.** This model is a partnership between CMS and the participating state and allows states to share in Medicare savings from innovations where services are covered on a fee-for-service basis.

  3. **State-Specific Models.** CMS is open to partnering with states on testing new state-developed models to better serve dually eligible individuals. CMS invites states to come to them with ideas, concept papers, and/or proposals.

- **Medicare Advantage**

  The 2020 Medicare Advantage and Part D final rule creates new standards to better integrate Medicare Advantage (MA) dual eligible special needs plans, as well as a new Medicare-Medicaid integrated appeals process for beneficiaries in fully-integrated plans.

- **Programs for All-Inclusive Care for the Elderly (PACE)**

  CMS is also working to publish a final rule "modernizing" requirements for the PACE program. This is a fully integrated model of managed care service delivery for the frail elderly, most of whom are dually-eligible. Based on policies finalized last year and this year, MA plans can now offer a broader array of supplemental benefits. This includes benefits to help beneficiaries with chronic conditions for them to maintain independence in the community, which encompasses many dually eligible individuals.

CMS Issues Request for Information on Medicaid 1332 Waivers

Yesterday, CMS released a Request for Information asking for more ideas on innovative programs and waiver concepts that states could consider when developing Section 1332 waivers. In a blog announcing the opportunity, Verma stated, "Washington doesn't have all the answers when it comes to our healthcare needs and, as experience with the [ACA] shows, when Washington imposes a one-size-fits-all approach on every state, any problems with the approach become nationwide problems." **Comments are due July 2nd**

A Look at the Federal Register

Regulatory season is here! But do not worry, AHPA has it covered. Below are the most recent regulations released in the Federal Register. Additional resources will be provided throughout the summer pertaining to many of these rules.

Proposed updates to the payment rules for Post-Acute Care (PAC) sites in FY 2020. The affected payment systems include: Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), Inpatient Psychiatric Facilities (IPFs) and Hospice. Below is a high-level overview of the proposed changes.

IPF Payments

CMS proposes to increase IPF payments by 1.7% (a $75 million increase). CMS also proposes to add one quality measure on medication continuation following discharge in FY 2021. **Comments are due June 17th.**

IRF Payments

CMS proposes to increase IRF payments by 2.3% (a $195 million increase). CMS also proposes that: 1) case mix be based on two years of data; 2) Adopt two new measures into the IRF Quality Reporting Program; 3) Modify an existing measure; 4) Implement a new standardized patient assessment and 5) Expand data collection to all patients regardless of payor. **Comments are due June 17th.**

SNF Payments

CMS proposes to increase SNF payments by 2.5% (an $887 million increase). CMS also proposes to: 1) Shift hospital readmission measures used in the SNF Value-Based Purchasing Program from *all-cause* to *potentially preventable*. 2) Adopt several standardized data elements to assess patient's cognitive function and social determinants of health. 3) Finalize the overhaul of the SNF payment system beginning October 1, 2020 by replacing "RUGs" with a revised case-mix methodology that reimburses SNFs based on the patient's condition and resulting care needs. **Comments are due June 18th.**

Hospice

CMS proposes to increase hospice payments by 2.7% (a $540 million increase). CMS also proposes to: 1) Increase the annual per-patient payment cap from $29,205 in FY19 to $29,994. 2) Make changes to the Hospice Quality Reporting Program. CMS is seeking input on the interaction of the hospice benefit and various APM models. **Comments are due June 18th.**

Deadline Extension for 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program. On March 4, 2019, the Department of Health and Human Services (HHS) published a proposed rule that would implement certain provisions of the 21st Century Cures Act. The comment period for the rule was scheduled to close on May 3, 2019. The agency released a document that extends the comment period. **Comments are due June 3rd.**

Part C Medicare Advantage Reporting Requirements. CMS proposes to require plans to report telehealth benefits. The data collected will provide CMS with a better understanding of the number of organizations utilizing telehealth per contract. **Comments are due June 24th.**

HHS Notice of Benefit and Payment Parameters for 2020. CMS seeks comments on the final rule, which includes changes to the navigator program, a change in the methodology for calculating subsidies and a decrease in the user fees paid by health plans in the Exchanges from 3.5% to 3%. CMS did not

include any changes to "silver loading" and automatic re-enrollment policies. **Comments are due June 24th.**

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