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July 2023

CMS Releases Proposed Physician Payment Rule and OPPS Rule

- On July 13, CMS issued the Calendar Year 2024 Medicare Physician Fee Schedule, which determines payments for Medicare payments to physicians in most settings, and the physician's portion of the services rendered in facility settings such as hospitals and surgery centers. Due to Congressional Medicare budget requirements, CMS must include a 1.25% reduction in overall payments. As a result of payment increases to primary care and other services, the final conversion factor proposal is a decrease of 3.34% ($33.89 to $32.75) because of cuts to specialist reimbursement ensuring budget neutrality. This continues a long-term trend of year-over-year decreases for physician reimbursement, setting off physician lobbyists who've countered that reimbursement is inadequate to provide quality care and may further contribute to provider consolidation.
- The rule proposes new regulations such as the creation of an add-on code for Evaluation and Management (E/M) complexity and add-on payments for caregiver training and community workers. Regulatory changes affect telehealth, remote patient monitoring, and make technical changes to the MIPS and MSSP value-based Medicare programs (e.g., quality data reporting and performance thresholds). CMS has focused its messaging on the benefits of the rule in terms of health equity in response to specialist concerns. Many value-based care stakeholders have been supportive of the changes that address concerns related to risk-bearing organizations and data quality.
- CMS also released the Hospital Outpatient Prospective Payment (OPPS) rule on the same day to propose payment rates for hospitals and Ambulatory Surgery Centers (ASCs), announcing a 2.8% total increase based on the market basket estimate of costs and a slight downward productivity adjustment. CMS is still evaluating the effect of using the hospital market basket (a group of services used to calculate inpatient hospital price index) to calculate ASC reimbursement rates based on claims data from recent years, as the number of elective surgeries sharply declined during the pandemic. Regulatory policy proposals include potential payments for maintaining adequate supplies of essential drugs to prevent shortages, the creation of an Intensive Outpatient programs for psychiatric services as required by statute, a partial hospitalization program, and standards for hospital price transparency files. Stakeholders hope that transparency changes will increase the usability of the data and compliance with the law which is still in the early stages of implementation.
- CMS also released a separate hospital-based rule for ways to remedy payment reductions for 340B drugs bought by certain non-critical access hospitals that were first made in 2018 and then reversed by a court order in 2022. CMS plans to make a retroactive, one-time payment to affected hospitals that covers the difference in reimbursement for 340B drugs during this time period if drug reimbursement had not been reduced.

First Alzheimer's Drug Achieves Traditional Approval

- After positive clinical trials confirmed the medical benefits and safety of drug administration, the FDA provided full approval on July 6th for the Alzheimer's drug Leqembi (lecanemab-irmb), manufactured by Eisai, Inc. Leqembi was initially approved under the Accelerated Approval

Pathway for new products that are still in the process of collecting data on clinical trial endpoints. The FDA label is limited to only those with mild cognitive impairment, while risk factors for adverse reactions include genetic phenotyping confirmed through testing and use of anticoagulants. Patients are primarily elderly individuals who qualify for Medicare and must participate in a clinical registry to receive the drug. This will allow for ongoing data collection on a national scale based on CMS's coverage policy.

Georgia Begins Medicaid Work Requirements

- On July 5, Georgia began a partial expansion of its Medicaid program, called Pathways to Coverage, allowing those with incomes up to 100% of the federal poverty level ($14,580 for an individual and $30,000 for a family of 4) to join the program but with the added requirement that participants verify completion of 80 hours of work, training, volunteering, or education each month. Beneficiaries will have to submit documentation to both gain coverage and stay covered. No other state has been fully implemented work requirements but have been an ongoing priority for conservative lawmakers and at both the state and federal level. Implementation of the state's 1115 waiver was approved at the end of the Trump Administration, delayed by the pandemic, and was partially revoked by the agency under the Biden Administration. However, in 2022 a judge ruled in favor of Georgia moving forward with the program citing that it would improve coverage compared to baseline and does not affect the typical ACA Medicaid expansion population of those with up 138% of the federal poverty level.

Congressional HELP Committee Holds Hearing on Healthcare Consolidation

- On June 21, the House Subcommittee on Education and the Workforce called witnesses to testify on hospital, insurer, and PBM consolidation and transparency. Representatives pointed to the trend of hospitals acquiring independent physician practices resulting in higher costs to consumers. At the same time, the 3 PBMs that own 80% of the market have become large, vertically integrated businesses that also own insurers, pharmacies, and physician practices, giving them wide influence over how prescriptions benefits are administered. Despite healthcare transparency laws now in effect, only about 25% of hospitals are in full compliance, and PBM rebate contracting with drug manufacturers and pharmacies remains relatively opaque. Lawmakers proposed that the data being submitted should be verified as accurate and standardized. New bills continue to be introduced in the House that would increase reporting requirements for both hospitals and PBMs, but none have gained traction.

Other Policy News:

- White House releases proposed rule on mental health access parity requirements
- CMS pauses Medicaid redeterminations in states non-compliant with federal requirements for renewals
- Congress marks up legislation related to site-neutral payment policies for hospital outpatient departments (HOPDs) following MedPAC recommendation
- Drug manufacturers begin legal action against HHS for Medicare price negotiation
- More employers offering family planning health benefits like IVF to recruit and retain workers

- UnitedHealth completes last-minute acquisition of home health provider Amedisys for $3.3 billion after also acquiring home health company LHC in February