Health Policy Update – May 19, 2020

COVID-19 Legislative Update: Congress Back in Session, House Passes Sweeping Fifth Coronavirus Response Package

Representatives passed a $3 trillion COVID-19 relief bill. House Leadership unveiled the Health and Economic Recovery Omnibus Emergency Solutions (HEROES) Act on May 12, which includes the following notable provisions:

- Provides an additional $100 billion in CARES Act Provider Relief Funds with new quarterly payments; codifies program terms and conditions
- Modifies CMS's Accelerated and Advanced Payment Program; extends the recoupment period and reduction in the interest rate
- Extends Paycheck Protection Program loans' 8-week covered period to 24 weeks and establishes a minimum loan maturity of 5 years to lower monthly payments
- Temporarily increases the federal Medicaid match by 14% through June 2021
- Provides 100% COBRA premium subsidies for eligible employees through January 2021
- Provides nearly $1 trillion in aid to state, local, tribal and territory governments
- Extends another round of $1,200 economic impact payments to individuals and families

The legislation does not have sufficient support for passage in the Senate. Senate Majority Leader Mitch McConnell (R-KY) called the HEROES Act a "totally unserious effort" as is focusing his attention on "preparing a major package of COVID-related liability reforms." The HEROES Act is also opposed by the White House.

To view the text of the HEROES Act, **CLICK HERE**.

To view the section-by-section summary of the proposal, **CLICK HERE**.

To view the White House Statement of Administration Policy, **CLICK HERE**.

CMS Releases FY 2021 IPPS & LTCH Proposed Rule, Hospital Groups Urge Court to Reject Price Transparency Measures

The Centers for Medicare & Medicaid Services released its Inpatient Prospective Payment System (IPPS) and Long-Term Acute Care Hospital (LTACH) proposed rule for fiscal year 2021, which outlines a number of reimbursement adjustments for hospitals, including a new proposal for the payment of chimeric antigen receptor T-cell (CAR-T) immunotherapy.

The proposed rule creates a new Medicare Severity-Diagnosis Related Group (MS-DRG) specifically for CAR-T cell therapy delivered in the hospital setting. Current reimbursement relies on a New Technology Add-on Payment (NTAP) that is soon set to expire. Reimbursement under the new MS-DRG is based on the claims data for the two CAR-T products currently FDA-approved – YESCARTA and KYMRIAH. CMS proposes to exclude clinical trial cases from the relative weight calculation under this new MS-DRG since these cases do no incur drug costs. According to an analysis from the American Action Forum, hospitals lose an estimated $50,000 per patient each time they administer a CAR-T therapy under current reimbursement policy.

The proposed rule also doubles down on hospital price transparency efforts. Under the rule, hospitals would have to report MS-DRG negotiated rates with Medicare Advantage and commercial payers on their Medicare cost reports. This

follows the 2020 IPPS rule, which beginning in 2021, requires hospitals to disclose negotiated rates for 300 shoppable services.

Hospitals sued CMS on the 2020 IPPS transparency rule in December 2019. The American Hospital Association and a coalition of hospital groups argued in court last week that CMS does not have the authority to implement a rule that requires hospitals to disclose the prices they negotiate with commercial insurers. A ruling on the case is expected soon.

To view the text of the IPPS/LTACH proposed rule, **CLICK HERE**.

To view the CMS announcement, **CLICK HERE**.

To view the American Action Forum Analysis on CAR-T Therapies, **CLICK HERE**.

CMS Finalizes Co-Pay Accumulator Policy in NBPP Rule

On May 7, the Centers for Medicare & Medicaid Services (CMS) finalized its 2021 Notice of Benefit and Payment Parameters rule, which included a policy allowing commercial payers to exclude pharmaceutical company coupons from out-of-pocket calculations even when there are no generic alternatives available.

The final rule largely clarified the status quo, allowing health plans to determine whether copay assistance programs, such as cards and coupons provided by drug manufacturers, count toward patients' deductibles and out-of-pocket maximums. Insurers and employers have long urged CMS to make this policy change, arguing that these types of programs incentivize patients to use expensive brand name drugs instead of lower-cost generics.

Patient advocates argue the use of copay accumulators make it more difficult to afford costly prescription drugs. According to a 2019 survey by the Cancer Action Network, 17 percent of cancer patients said they used drug manufacturers' coupons or assistance programs in order to pay for their treatment. CMS chose not to finalize its proposal to redefine cost-sharing to include manufacturer financial support.

To read the final CMS rule, **CLICK HERE**.

To read the Cancer Action Network survey, **CLICK HERE**.

Report Shows Critical Decline in Cancer Screenings

A new white paper released by Epic Health Research Network (EHRN) details the precipitous drop in the number of cancer screenings performed across the United States since the COVID-19 pandemic began.

With concerns about viral infection, disruptions to care, and recommendations from federal health officials to delay routine screenings such as mammograms, colonoscopies, and cervical screenings, medical records data show an abrupt decrease in preventative cancer screenings. According to the white paper, there have been between 86 percent and 94 percent fewer preventative screenings completed each week in 2020 compared to equivalent weeks in the years between 2017 and 2019. Though the analysis examines 2.7 million patient records from 39 organizations that represent 190 hospitals spanning 23 states—a fraction of all cancer screenings conducted annually—it represents a troubling shift in cancer care that has major implications for the future.

“If the trend continues, the data suggest that many cancer cases could go undiagnosed or be diagnosed at a later stage with a poorer prognosis,” the paper states. “Provider organizations that must postpone in-person screenings might wish to explore alternative options to get patients caught up, such as the use of at-home stool-based tests for colon cancer screening or expanding hours for mammography when imaging centers reopen.”

To read the EHRN white paper, **CLICK HERE**.