Health Policy Update – June 16, 2020

CMS Announces Changes to CMMI Models

On June 4, the Center for Medicare and Medicaid Innovation (CMMI) announced a series of changes to several of its payment models while delaying the start date for others. Among the most notable changes:

- **Next Generation ACOs** will be extended through 2021, with 2020 downside risk reduced by shared losses covering the months of the public health emergency and gross savings upside potential capped at 5%. **Medicare ACO Track 1+ Model** participants will be permitted to voluntarily elect a one-year model extension through 2020. Both models will remove episodes of care for treatment of COVID-19.
- The agency will open an additional application period for the **Direct Contracting Model** in response to stakeholder complaints that they were unable to access the online portal during the previous application period. Providers who apply during this period would start the demonstration in 2022. The first Performance Period cohort will also be delayed, beginning April 1, 2021.
- **The Comprehensive End-Stage Renal Disease Care Model** will be extended through the end of March 2021 while the **Kidney Care Choices Demonstration's** first Performance Period will begin April 1, 2021. A new application cycle for a second cohort of Kidney Care Choices will be created this year that will launch in 2022.
- **The Oncology Care Model** will be extended through June 2022 and will allow participating practices to forgo upside and downside risk for performance periods affected by the public health emergency. OCM practices that remain in one- or two-sided risk for the performance periods affected by the PHE will be able to choose to remove COVID-19 episodes from reconciliation for those performance periods. CMS also made aggregate-level reporting of quality measures and beneficiary-level reporting of clinical and staging data optional for the affected performance periods and removed the requirement for cost and resource utilization reporting and practice transformation plan reporting in July/August 2020.
- The performance period for the serious illness component of the **Primary Care First Demonstration** has been delayed until next April. CMS will also push back the **Emergency Triage, Treat, and Transport (ET3)** demonstration until this fall though it did not provide an exact date for it to start.

To read CMMI's announcement, **CLICK HERE**.

To view a reference table from CMMI outlining the models and new changes, **CLICK HERE**.

To read a Health Affairs blog post by CMS Administrator Verma discussing the changes, **CLICK HERE**.

CMS Reviewing Options to Expand Telehealth Flexibility Permanently

Recent remarks by Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma indicate that CMS is reviewing options to permanently extend telehealth flexibilities enacted during the COVID-19 public health emergency, but some of the changes may require support from other federal agencies, Congress, and state governments.

At the beginning of the public health emergency, CMS extended several temporary telehealth flexibilities, including increasing reimbursement for telehealth services as well as allowing providers to offer additional services to beneficiaries via telehealth. This has led to a substantial increase in the use of telehealth, and provider groups have urged CMS to extend and make permanent many of these changes.

Administrator Verma has seemed supportive of expanding telehealth access after the pandemic recedes and recently said, “I can’t imagine going back. People recognize the value of this, so it seems like it would not be a good thing to force our beneficiaries to go back to in-person visits.” However, concerns have also been raised about cost and over-utilization, and Verma also noted CMS is looking at whether it makes sense to continue paying the same rate for virtual office visits as for in-person care. Verma said action from Congress will ultimately be needed to permanently expand telemedicine on a national basis as existing laws limit use to certain geographic areas and that the administration would support state efforts to allow more telemedicine to be practiced across state lines.

Latest Jobs Report Shows Marked Healthcare Sector Improvements, Dentists Leading the Way

On June 5, the U.S. Bureau of Labor Statistics (BLS) released its latest jobs report, which indicated the health sector gained 312,000 jobs in the month of May after steep declines caused by the COVID-19 national health emergency in March and April. Of the new health sector job gains reported in May, approximately 245,000 are attributable to dentists After BLS estimated 135,000 lost hospital jobs in April, hospitals still shed positions in May, but at a much smaller rate (26,700), giving hope to many in the sector that the worst impacts have passed. This represents a dramatic bounce back after the healthcare industry lost an estimated 1.4 million jobs in April. The job numbers have been met with some skepticism, with the BLS conceding some of its survey data resulted in the misclassification of individuals who were unemployed on temporary layoff as employed but absent from work.

Meanwhile, an analysis by the consulting firm Kaufman Hall found that April was the worst month on record for hospital margins, as providers suspended many elective procedures to help stem the spread of COVID-19. As providers begin scheduling non-emergent procedures again, analysts are optimistic that the healthcare industry might be more resilient than other sectors of the American economy and experience rapid growth and surging demand.

To see the latest BLS employment statistics, **CLICK HERE**.

To read the Kaufman Hall analysis, **CLICK HERE**.

Analysis Shows Slower Growth in Drug Prices

On June 4, SSR Health released a new report which found that drug prices are increasing at a slower rate than they had in the past. According to the report, brand name pharmaceutical companies increased their wholesale prices by 2.3 percent in the first quarter of 2020. While a modest increase, wholesale prices have grown at a slower rate than they did in the first quarter of 2019 (3.2% in Q1 2019). The analysis also found that net prices paid by insurers dropped by 2.6 percent between January 1 and April 1, compared with a 3.7 percent decline during the same time last year. On the whole, the discounts off wholesale prices reached 50.4 percent, which is the highest shift in a decade when adjusted for inflation. Drugs related to cancer care have made the largest positive contributions to net price changes and, as a result, are much less likely to be excluded from formularies.

Given increasing scrutiny of the strategies that drug manufacturers and pharmacy benefit managers employ, price reductions or reductions in the rate of price increases have become more common. While many pharmaceutical manufacturers kept their price increases below ten percent in recent years, some had managed to avoid price increases altogether. Amid the ongoing COVID-19 pandemic and continued push on Capitol Hill to pass bipartisan drug pricing legislation this year, the author of the report projects that the 2020 price trajectory for pharmaceuticals will be constrained.

To read more about the report’s findings, **CLICK HERE**.

Study Finds High Economic Cost Due to Racial Disparities in Cancer Deaths

Research published in the journal JNCI Cancer Spectrum found that cancer mortality rates are disproportionately high for black patients compared to patients of other races and that the racial disparities have led to a loss of more than $3.2 billion in lost earnings.

Examining 2015 data on average life expectancy, cancer deaths, and earnings data, the researchers were able to calculate life years and earnings lost due to premature cancer deaths and compare them across racial groups. In 13 of the 19 sites included in the analysis, black patients had higher age-standardized person-years of life lost (PYLL) and lost earning rates than white patients. For black patients the rate of lost earnings due to premature cancer deaths totaled more than $43 million per 100,000 people in 2015—or roughly $8.5 million more per 100,000 than white cancer patients. If these disparities did not exist, more than 241,334 PYLLs and $3.2 billion lost earnings would have been avoided.

Ultimately, the results underscore the challenges that oncologists and the healthcare system as a whole face in improving access to cancer care. Improving equal access to cancer prevention, screening, and treatment services is critical in reducing these disparities, preventing thousands of premature deaths, and saving billions in lost earnings.

To read the study, **CLICK HERE**.