

MEDICARE YEAR-AHEAD

The following is a rundown of Medicare developments to watch for in 2019.

AGENCY ACTION

ACO policy shifts: CMS had a busy end to 2018, including the release of the final Accountable Care Organization (ACO) rule that shortens the amount of time ACOs can spend in the Medicare Shared Savings Program without taking on risk. Stakeholders continue to review the policy ramifications, and time will tell how many ACOs stay in the program.

Pending Health IT, Medicare and Medicaid rules: The White House Office of Management and Budget continues to review a number of rules from CMS and the Office of the National Coordinator for Health IT — some of which, like the ONC's information blocking rule, were expected to be released last year.

CMS rules currently under review at OMB include: a proposed rule on interoperability and patient access; a proposed administrative simplification of retail pharmacy standards; a proposed burden reduction rule for long-term care facilities; a final rule on covered outpatient drugs and the definition of line extension in the Medicaid Drug Rebate Program; a final rule to improve the Medicare provider and supplier enrollment process; the second part of the draft Medicare Advantage and Part D pay policies and call letter; and a request to rescind the proposed Medicaid fee-for-service access rule. OMB is also reviewing the proposed 2020 Notice of Benefit and Payment Parameters, which will lay out future policies for the health insurance exchanges.

Verma's New Year's resolutions: CMS Administrator Seema Verma on Twitter said CMS' "New Year's resolutions" include continuing the agency's Patients Over Paperwork initiative, cutting back on waste, fraud and abuse, and "creating greater healthcare options for our beneficiaries." Verma also tweeted that the agency was focused on a "healthier EHR diet" and said CMS is working on interoperability throughout its programs. "[W]e have some big plans for 2019!" she tweeted.

New innovation center initiatives: CMS' innovation center also previewed a number of models in 2018 that stakeholders are watching for, including possible models on direct provider contracting, [a mandatory demonstration on radiation oncology](#) and mandatory bundled-payment models the agency had previously canceled. HHS Secretary Alex Azar has also indicated that models to address social determinants of health could be on the horizon.

However, before departing Congress Sen. Orrin Hatch (R-UT) railed against what he views as the innovation center's "excessive authority." In a Dec. 19 letter, Hatch suggested the center's initiatives blur the lines delineating the roles of the legislative and executive branches of government. Hatch was particularly vexed by the administration's proposed International Pricing Index model, which would be run through the Center for Medicare and Medicaid Innovation as a mandatory demonstration.

"While I am not advocating that CMMI be repealed, I encourage you to explore how to right-size the CMMI statutory authority by placing protections on how it can be used, while still allowing it to execute its mission and achieve its goals through small demonstrations of payment changes," Hatch said.

CONGRESSIONAL OUTLOOK

Analysts and lobbyists said after the midterm elections that they expected lawmakers to focus more on the Affordable Care Act and Medicaid than on major Medicare reforms in the new Congress, with the exception of drug pricing issues, and lobbyists said that outlook hasn't really changed. However, Billy Wynne, founder and CEO of Wynne Health Group, noted that some so-called extender policies need to be acted on by the fall, there is growing concern that Medicare could be affected by a deal to raise spending caps.

After the midterms, Wynne also noted that lawmakers may want to tackle the leveling out of physician payments under the Medicare Access and CHIP Reauthorization Act that is scheduled for 2020-2025.

Bob Moffit with the Heritage Foundation said that while major congressional action on Medicare isn't necessarily expected, lawmakers could potentially find some bipartisan support for adding out-of-pocket caps and catastrophic protection to traditional Medicare while also combining Parts A and B. He emphasized the two reforms should be done in tandem.

Moffit also suggested Graduate Medical Education payment reform and further action on site-neutrality are other areas that could gain bipartisan support.

The highly politicized debate over Medicare for All is likely to continue next year, as well, according to Wynne. *The Washington Post* reported that the House Rules and Budget committees will have hearings on Medicare for All legislation sponsored by Rep. Pramila Jayapal (D-WA). Lipschutz said the Center for Medicare Advocacy will be watching to see what the debate means for the future of the Medicare program.

STAKEHOLDER GOALS

Beneficiary group seeks expanded benefits: The Center for Medicare Advocacy says it would like to see Medicare expanded by adding oral, vision and hearing coverage, and the benefits under traditional Medicare expanded to match those available to Medicare Advantage beneficiaries. The group would also like to see out-of-pocket costs capped in traditional Medicare and consumer protections improved in Medicare Advantage. House Speaker Nancy Pelosi's (D-CA) office at press time had not responded to questions about whether she would support oral, vision and hearing coverage expansions.

The center also says it wants to add long-term care benefits to Medicare over time. "For now, make incremental improvements (For example, repeal homebound requirement for home health

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coverage, repeal requirement that individual need skilled care and be homebound to qualify for home health aide coverage, repeal requirement that DME generally be needed in the home),” the group’s priority list says.

AMA’s goals include tackling prior authorization: The American Medical Association’s top goals include setting new policies on prior authorization, about which the group has raised myriad concerns. AMA in November recommended a set of processes and parameters for prior authorization in Medicare and Medicaid.

Other top priorities for the group include tackling drug costs, substance use disorder, regulatory relief and payment stability.

Hospitals’ agenda: A spokesperson for the American Hospital Association said the group’s priorities include tackling drug costs; modernizing conditions of participation for hospitals; ensuring a reasonable roll out of IMPACT Act quality requirements on post-acute care providers and rejecting new policies to increase the burden on those providers; advancing interoperability; promoting sociodemographic requirements within quality programs; creating safe harbors for clinical integration; and stopping the advancement of site-neutral payments.

ONGOING LITIGATION

Site-neutral pay cuts: AHA and the Association of American Medical Colleges sued CMS over deep reimbursement cuts for clinic visits at hospital off-campus facilities that were included in a site-neutral policy in the final 2019 hospital outpatient pay rule.

Lab pay cuts: The American Clinical Laboratory Association in early December appealed a ruling in its lawsuit against CMS challenging reporting policies that drive down CMS’ payment for the clinical lab services. The Protecting Access to Medicare Act directed CMS to base Medicare reimbursement on commercial-payer rates, and the change to the fee schedule went into effect in 2018. To determine commercial rates, CMS collects price data from labs. Hospitals are paid higher rates than free-standing labs. However, few hospitals must report commercial rates. ACLA sued over the reporting rules, not the reimbursement. The labs said the district court incorrectly held that the statute precluded review of the final rule exempting hospital labs from the data-reporting requirements. ■