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CMS Releases Final 2018 Medicare Payment Regulations

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On November 1 and 2, the Centers for Medicare and Medicaid Services (CMS) released the final 2018 Medicare Payment Regulations for the Physician Fee Schedule, Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System, and Home Health Prospective Payment System. The final Medicare payment regulations purport to reflect a broader strategy that CMS is pursuing to "relieve regulatory burdens for providers, promote innovation in health care delivery aimed at lowering prices, increase competition, and strengthen the patient-doctor relationship." Whatever the goal, payment reductions predominate.

Physician Fee Schedule

On November 2, CMS released the 2018 Physician Fee Schedule final rule that would update payment policies, payment rates, and quality provisions for physicians and other medical professionals under the Medicare program. Under pressure for the deeper cuts proposed, the final payment update to physicians will be 0.41 percent for 2018, compared to 0.31 percent in the proposed rule. The CMS factsheet is available here.

Of significance, CMS will reverse Obama Administration payment policy for biosimilar products to begin separately coding and paying for biological biosimilar products under Medicare Part B. Previously, biosimilar products that relied on a common reference product's biologics license were grouped into the same payment calculation. Starting in 2018, newly approved biosimilar biological products with a common reference product will no longer be grouped into the same billing code. CMS stated that the policy change is intended to encourage innovation and greater manufacturer participation in the biosimilars market, leading to more competition on biosimilar products.

Among many other changes, the rule would also expand Medicare reimbursement for telehealth services through the addition of new payment codes intended to improve access to telehealth. Medicare is still considered to be behind commercial payers in covering telehealth services. Although Medicare coverage is still limited, the new codes represent an expansion in coverage.

Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System

On November 1, CMS released the 2018 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System final rule with comment period, which includes updates to the 2018 rates and quality provisions. The final payment update for OPPS is 1.35 percent for 2018, compared to 1.75 percent in the proposed rule. The CMS factsheet is available here, and comments are due December 31, 2017.

In a major development, CMS will finalize its proposal to pay hospitals less for certain physician-administered drugs purchased through the 340B Drug Discount Program. Specifically, CMS will reimburse separately payable, non-pass-through drugs and biologicals purchased through the 340B program at a rate of average sales price (ASP) minus 22.5 percent, rather than the current reimbursement rate of ASP plus six percent. Not all 340B hospitals will be affected by the payment reduction. CMS has crafted an exception for children's hospitals, PPS-exempt cancer hospitals, and rural sole community hospitals, which will all continue to be paid at the current reimbursement rate (ASP plus six percent). Notwithstanding the exception, the vast majority of

hospitals participating in the 340B program will see reduced payments. CMS claims to be implementing this policy in a budget neutral manner through a 3.2 percent payment increase to all hospitals paid under OPPS for non-drugs and services.

The finalization of this policy change is expected to generate significant pushback. In a bipartisan letter to CMS, 228 Representatives (72 Republicans and 156 Democrats) and 57 Senators (17 Republicans and 40 Democrats) expressed opposition to the proposed drug payment reductions. After the final rule was released, the American Hospital Association, Association of American Medical Colleges, and America's Essential Hospitals announced they are filing a lawsuit against the Department of Health and Human Services to prevent the cuts. In addition, Reps. David McKinley (R-WV) and Mike Thompson (D-CA) introduced bipartisan legislation to reverse the CMS cuts. CMS estimates that the final rule will amount to a $1.6 billion payment cut for hospitals under the 340B program.

Home Health Prospective Payment System

Finally, on November 1, CMS released the 2018 Home Health Prospective Payment System final rule that would update the payment rates for home health agencies. The final payment update reduces overall Medicare payments to home agencies by 0.4 percent for 2018, saving an estimated $80 million. That change is driven in part by CMS's planned phase out of a provision boosting pay rates for certain home health services delivered to rural patients. The CMS factsheet is available here.

CMS decided not to finalize the Home Health Groupings Model, a proposed series of changes to the payment methodology beginning in 2019 that could have resulted in a pay cut of up to 4.3 percent or as much as $950 million in reduced Medicare payments to home health agencies. Responding to opposition from providers, other stakeholders, and members of Congress, CMS stated they would take additional time to further engage with stakeholders before determining these changes.