



Tuesday, April 21, 2020

Update on CARES Act Relief

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Medical Practices Continue to Struggle Amid COVID-19 Fallout

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COVID-19 & Cancer Care: Practices Adjust, New Guidelines, and A Patient Registry

As a result of COVID-19, the provision of cancer care has changed dramatically across the country. Hospitals and medical providers have cancelled and postponed elective and non-essential procedures but cancer patients facing chemotherapy treatment delays say the stakes are higher for them. **Read below.**

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On April 6, the Centers for Medicare & Medicaid Services (CMS) released final Medicare Advantage (MA) and Part D plan rates for the 2021 coverage year. **Read below.**

Administration Draws Strong Opposition from Stakeholders in Response to Drug Pricing Proposals Designed to Boost Generics and Biosimilars

In February, the Trump administration released two policy proposals designed to incentivize insurers to accelerate the uptake of generics and biosimilars—yet a review of federal comments recently submitted to the federal government shows that a wide array of stakeholders including private payers, pharmacists, branded pharmaceutical companies, and patient advocates widely panned the proposals. **Read below.**

FULL STORIES

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The Coronavirus Aid, Relief, and Economic Security (CARES) Act, which was signed into law on March 27, provides more than \$2 trillion in relief and economic stimulus to businesses, individuals, healthcare providers, and state and local governments affected by COVID-19.

One of the most significant provisions of the CARES Act is the Paycheck Protection Program (PPP) which provides short-term loans to small businesses to maintain payroll and basic operations. On April 16, the Small Business Administration reported that this fund is now exhausted after approving nearly \$342 billion in loans to more than 1.6 million small businesses. Congress is expected to replenish the PPP in the coming days.

On April 10, the Department for Health and Human Services began distributing \$30 billion in emergency funds to support healthcare providers responding to the COVID-19 pandemic. These initial payments from the Provider Relief Fund were paid to eligible providers based on their 2019 Medicare fee-for-service reimbursements. Recipients must agree to program terms and conditions and sign an attestation acknowledging receipt of funds within 30 days.

The administration has yet to detail how a remaining \$70 billion in Provider Relief Funds will be allocated. It has signaled it will prioritize funds to providers in areas particularly impacted by the COVID-19 outbreak, rural providers, those who predominantly serve the Medicaid population or provide services with lower shares of Medicare reimbursement, as well as those who request reimbursement for the treatment of the uninsured.

In addition to direct provider relief, CMS launched a new Medicare loan program to provide immediate cash to providers to help offset increased expenses and lost revenue due to declining patient volumes. Eligible providers can apply for three months of advanced Medicare payments through the Accelerated and Advance Payments Program. As of April 9, the agency announced it had so far distributed \$51 billion in loans to eligible providers. The advance payments are recouped over time, offset against future claims, and must be fully repaid within 210 days to avoid a 10.25 percent interest charge.

To view The Network's COVID-19 resources, including links to CARES Act-related programs, [CLICK HERE](#).

To read The Network's April 10 Health Policy Update on the Provider Relief Fund, [CLICK HERE](#).

For more information about CMS' Accelerated and Advance Payments Program, [CLICK HERE](#).

Congress Working to Boost Funding for Paycheck Protection Program

Policymakers in Congress and the administration continue to discuss a path forward for another COVID-19 relief package but have yet to reach an agreement. Replenishment of the Paycheck Protection Program (PPP) for small businesses and additional funding for frontline hospital systems remain a top priority for leaders in both parties. The urgency became even more apparent last week after the Small Business Administration (SBA) announced it is no longer able to process new loan applications through the Paycheck Protection Program. The legislation may also include additional funding for the SBA's Economic Injury Disaster Loan (EIDL) program and to support increased COVID-19 testing efforts.

Physician and hospital associations continue to advocate for targeted relief. Several dozen medical societies led by the American Medical Association sent a letter to Congressional leaders asking for consideration of additional COVID-19 support in future legislation. The letter asks for additional funding for the PPP, modifications to the Medicare Accelerated and Advance Payments Program, increases in direct financial support, and an extension of Medicare sequestration relief, among other requests. Similarly, the American College of Physicians sent a letter with specific recommendations for assistance needed to keep practices open. Additionally, the American Hospital Association has requested more financial assistance for hospitals.

To view the medical societies' letter, [CLICK HERE](#).

To view the ACP's letter, [CLICK HERE](#).

To view the AHA's letter, [CLICK HERE](#).

Medical Practices Continue to Struggle Amid COVID-19 Fallout

The COVID-19 pandemic continues to create financial challenges for the healthcare sector. According to the Bureau of Labor Statistics (BLS), the healthcare industry lost 42,500 jobs in March. The vast majority of these losses were concentrated in the ambulatory services sector with physicians' offices among the hardest hit. Further, a survey by the Medical Group Management Association (MGMA) found that nearly half of medical practices have either laid off or furloughed workers. Ninety-seven percent of those surveyed also reported a direct or indirect financial impact due to COVID-19.

To view the MGMA survey, [CLICK HERE](#).

To view the latest BLS employment figures, [CLICK HERE](#).

NAACOS Survey Shows Majority of ACOs Likely to Leave Medicare Cost-Saving Programs Due to COVID-19 Concerns

On April 13, the National Association of Accountable Care Organizations (NAACOS) released a survey which found that the majority of accountable care organizations (ACOs) are likely to leave the program due to concerns about having to repay losses stemming from the COVID-19 outbreak.

The survey of risk-based ACOs found that 56 percent of healthcare organizations taking part in a Medicare program said they are likely to drop out over fear of having to pay massive losses resulting from the COVID-19 pandemic.

The NAACOS surveyed the ACO community to gauge their experience in handling the ongoing pandemic. As a result of swings in unpredictability and spikes in expensive hospitalizations, 21 percent of at-risk ACOs said they were “very likely” to leave the Medicare ACO program, 14 percent said they were “likely,” and another 21 percent said they were “somewhat likely” to leave. Almost 80 percent of ACOs said they were “very concerned” about their ACO performance this year.

To read the full NAACOS survey, [CLICK HERE](#).

COVID-19 & Cancer Care: Practices Adjust, New Guidelines, and A Patient Registry

As a result of COVID-19, the provision of cancer care has changed dramatically across the country. Hospitals and medical providers have cancelled and postponed elective and non-essential procedures but cancer patients facing chemotherapy treatment delays say the stakes are higher for them. Dr. Debra Patt, Vice President for Policy and Strategy at Texas Oncology, discussed these risks and what her practice is doing to ensure vulnerable patients’ needs are met during the COVID-19 crisis with the [Texas Tribune](#).

Leading medical societies have also begun to adapt. On April 15, The National Comprehensive Cancer Network (NCCN) issued a new set of recommendations for keeping cancer patients, caregivers, and staff as safe as possible during the pandemic. The recommendations, which were published in the *Journal of the National Comprehensive Cancer Network*, are the latest in a series of free resources being made available to patients, providers, and physicians.

In addition, The American Society of Clinical Oncology (ASCO) announced the creation of a new patient registry. The ASCO Survey on COVID-19 in Oncology (ASCO) Registry aims to help the cancer community learn about the pattern of symptoms and severity of COVID-19 among patients with cancer, as well as how COVID-19 infections impact the delivery of cancer care and patient outcomes. The registry will collect data throughout the COVID-19 pandemic and into 2021.

On April 20, as part of the administration’s Opening Up America Again initiative, CMS issued recommendations on re-opening facilities to provide non-emergent non-COVID-19 healthcare. The recommendations are intended to give healthcare facilities flexibility in providing essential non-COVID-19 care, and include guidance on preserving personal protective equipment, workforce availability, sanitation protocols, and testing capacity.

To read the NCCN safety recommendations, [CLICK HERE](#).

To view NCCN's other COVID-19 resources, [CLICK HERE](#).

To learn more about the ASCO Registry, [CLICK HERE](#).

To read CMS's recommendations, [CLICK HERE](#).

CMS Boosts Medicare Advantage and Part D Payment Rates for 2021 Coverage Year

On April 6, the Centers for Medicare & Medicaid Services (CMS) released the final Medicare Advantage (MA) and Part D plan rates for the 2021 coverage year. Taking into account the comments it received but choosing not to catalog CMS' actions related to the ongoing national health emergency created by COVID-19, the rates in 2021 are expected to increase by 4.07 percent, an increase of more than one percentage-point from the rate CMS earlier proposed. Under the policy, MA revenue is estimated to increase 1.66 percent on average, a slight increase from the 0.93 percent that CMS estimated in February.

In 2021, CMS will continue to transition MA payments to a new risk-adjustment model required by the 21st Century Cures Act. According to a fact sheet released by CMS about the rate announcement, three-quarters of the risk score in 2021 will be based on the 2020 CMS-Hierarchical Condition Categories (HCC) model, and one-quarter of the score will be calculated using the 2017 CMS-HCC model. This is a departure from 2020, during which the risk-adjustment methodology was evenly divided between the two methods. In addition, CMS will adjust the MA coding pattern by 5.9 percent, the minimum required by law.

Regarding 2021 Part C and Part D Star Reporting, the ongoing COVID-19 crisis has led CMS to adopt several changes that suspend quality-reporting requirements and reuse earlier data from the 2020 Star Ratings due to the virus' impact on data integrity and validation.

CMS announced it will offer stakeholders an opportunity to discuss the 2021 Rate Announcement – as well as guidance related to the COVID-19 outbreak for MA organizations, PACE organizations, and Part D sponsors – with CMS staff during a call that will be scheduled in the near future.

To read a CMS fact sheet on the 2021 rates, [CLICK HERE](#).

To read the complete CMS announcement, [CLICK HERE](#).

Administration Draws Strong Opposition from Stakeholders in Response to Drug Pricing Proposals Designed to Boost Generics and Biosimilars

In February, the Trump Administration released two policy proposals designed to incentivize insurers to accelerate the uptake of generics and biosimilars—yet a review of federal comments recently submitted to the federal government in response to the 2021 and 2022 Medicare Advantage and Part D Proposed Rule shows that a wide array of stakeholders including private payers, pharmacists, branded pharmaceutical companies, and patient advocates widely panned the proposals.

Under one of the proposals, bonuses for insurers would be partially determined based on how often they encourage patients to use generic drugs; while under the other, private payers would be able to nudge patients toward lower-cost drugs by creating a new preferred specialty “tier” of medicines in their plan designs. By basing insurers’ reimbursements and star ratings on their levels of generic and biosimilar utilization, CMS hopes to increase the usage of these less-expensive drugs.

However, insurance companies strongly criticized the proposal and noted that it could actually increase drug spending because drug companies often provide rebates that essentially make branded drugs cheaper than generic ones. Meanwhile, biopharmaceutical trade organizations argued that the policy may run against the 2010 Biologics Price Competition and Innovation Act which said that biosimilars and biological products are not identical nor necessarily interchangeable. The US Oncology Network also submitted comments expressing concerns with the proposal to create a new preferred specialty tier, noting that it could undermine clinical decision making by physicians on behalf of their cancer patients.

To read the policy proposals, [CLICK HERE](#).

To read a CMS blog post about the policy proposals, [CLICK HERE](#).

To read The Network’s comments, [CLICK HERE](#).