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CMS Hikes Payment for COVID-19 Inpatients Treated With New Drugs, Links it to 20% Bonus

By Nina Youngstrom

CMS said Oct. 28 that Medicare will pay hospitals extra when they treat inpatients with drugs or biologicals approved by the Food and Drug Administration (FDA) for COVID-19. The additional payments are linked to the 20% bonus hospitals already receive for COVID-19 MS-DRGs, and both require proof of a positive COVID-19 test, according to the fourth interim final rule with comment period (IFC).[1] CMS also raised the specter of post-payment reviews.

Hospitals will receive an additional payment when treatment includes Veklury (remdesivir) or COVID-19 convalescent plasma to treat patients diagnosed with COVID-19. Like a new technology add-on payment, the cost of the drug won't be entirely folded into the MS-DRG.

The only hitch is hospitals must ensure they make a connection to the Medicare bonus for COVID-19 inpatients, said attorney Daniel Hettich, with King & Spalding in Washington, D.C. "You have to be eligible for the 20% add-on to get the new therapeutic add-on," he said. "If you don't have a positive test, you don't qualify for the new treatment add-on payment."

The interim final rule, which implements section 3713 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, also said Medicare, Medicare Advantage (MA) and commercial payers must offer FDA-approved vaccines free to patients. Medicare and MA will pay hospitals, physicians, pharmacists and others a fee for the administration of the vaccine and a fee for the vaccine itself. A provision in the Affordable Care Act that requires coverage of preventive care without cost sharing provided a "pathway" to sweep in private payers, said Valerie Rinkle, president of Valorize Consulting. CMS also revised the Comprehensive Care for Joint Replacement model because of the public health emergency (PHE).

CMS Creates 'New Treatments Add-On Payment'

The ball for the newest add-on payments got rolling with the advent of coronavirus therapies. As the regulation explains, the FDA created a program for possible coronavirus therapies called the Coronavirus Treatment Acceleration Program, which includes issuing emergency use authorizations (EUAs) during the PHE. The FDA has issued EUAs for five drugs and biologicals for COVID-19, although only remdesivir and COVID-19 convalescent plasma are eligible for the add-on payment in connection with the inpatient prospective payment system (IPPS).

"We believe that as drugs or biological products become available and are authorized or approved by FDA for the treatment of COVID-19 in the inpatient setting, it would be appropriate to increase the current IPPS payment amounts to mitigate any potential financial disincentives for hospitals to provide these new treatments during the PHE," CMS stated in the rule. "Therefore, effective for discharges occurring on or after the effective date of this rule and until the end of the public health emergency, CMS is using the exceptions and adjustment authority under section 1886(d)(5)(I) of the Act to create a New COVID–19 Treatments Add-on Payment (NCTAP) under the

IPPS for COVID-19 cases that meet certain criteria."

First, the treatment of the patient has to include the use of a drug or biological authorized to treat COVID-19 by the FDA (with certain technical specifications). Second, the case must qualify for the 20% Medicare add-on bonus. "The primary purposes of this criterion are to help appropriately identify COVID-19 cases to potentially receive the NCTAP, and ensure for program integrity reasons that there is a positive COVID-19 laboratory test documented in the patient's medical record," the rule states. "CMS may conduct post-payment medical review to confirm the presence of a positive COVID-19 laboratory test and, if no such test is contained in the medical record, the NCTAP will be recouped."

The amount of the NCTAP payment will be the lesser of: (1) 65% of the outlier threshold for the claim or (2) 65% of the amount "by which the costs of the case exceed the standard DRG payment," including the 20% Medicare bonus for inpatients with COVID-19.

Hospitals Usually Absorb $30,000 First

Normally, Medicare outlier payments, which are extra payments for cases with extraordinarily high costs, only kick in after the hospital has incurred $30,000 in costs above the MS-DRG payment. In other words, under the standard outlier rules, a hospital would only receive 80% of the costs that exceed $30,000 of the IPPS payment, which means that hospitals eat the first $30,000 in losses. Under the IFC, however, when hospitals provide remdesivir or COVID-19 convalescent plasma and the patient has a positive COVID-19 test, Medicare will share in 65% of the first dollar losses that exceed the MS-DRG reimbursement up to the $30,000 outlier threshold.

In cases where costs exceed the $30,000 outlier threshold, "hospitals get the outlier payment they would typically get and an add-on payment as well," Hettich said. Add-on payments also are available when hospitals don't hit the outlier threshold if the costs for treating a patient exceed the MS-DRG payment.

"It's good news for hospitals," he said. "Medicare is notorious for being slow on paying for innovation, which is why this IFC is necessary in the first place. There are certain mechanisms, like new drug or device add-on payments, and outlier payments are the ultimate safety valve for hospitals, but a hospital typically has to first absorb a whopping $30,000 in losses," Hettich said.

For example, if the COVID-19 treatment exceeded the MS-DRG payment by $100,000, based on the outlier payment alone, the hospital would receive $56,000 because Medicare's formula for outliers is 80% of the cost above the inpatient payment after the hospital eats the $30,000. Under the IFC, however, because Medicare will now share in 65% percent of the first dollar losses up to the $30,000 outlier threshold, Hettich explained that the total Medicare reimbursement would be $75,500—the typical outlier payment of $56,000, plus the add-on payment of $19,500 (65% of the first $30,000 in losses is $19,500). "You would only get $56,00 normally, but because of the add-on payment, you get $75,500," he said.

Anticipating Outpatient Add-On Payments

CMS also made provisions for add-on payments for new drugs and biologicals given to COVID-19 patients in hospital outpatient departments. Although that's not a thing yet, CMS said it wanted to ensure separate payments are available under the outpatient prospective payment system when the time comes.

"We anticipate that most drugs and biological products authorized for use in treating COVID-19 in the outpatient setting would be separately paid under our standard OPPS [outpatient prospective payment system] payment policy because drugs and biological products are typically assigned separate Ambulatory Payment Classification payment status indicators in the OPPS unless they meet one of the criteria for packaging, which, with the

exception of drug or biological products billed with a Comprehensive Ambulatory Payment Classification (C-APC) service, we do not anticipate that drugs or biological products approved or authorized to treat COVID-19 would meet," the rule stated. "However, these products could be packaged into a C-APC when provided on the same claim as a C-APC service, in which case separate payment would not be made for these products."

CMS Adds Hip Fractures to CJR

Because of the pandemic, CMS is extending performance year five of the Comprehensive Care for Joint Replacement (CJR) model from March 31, 2021, to Sept. 30, 2021, to give hospitals "additional relief and stability in model operations." It had already been extended three months. The data obviously have been affected by the drop in the number of procedures performed during the pandemic. In April 2019, there were 6,515 procedures attributed to the CJR model, according to the IFC. In April 2020, the number was 876.

Still, in 2019, before the dark days of the pandemic, 5,838 procedures were performed in the CJR, which is impressive considering CMS cut it in half in 2017, said Ronald Hirsch, M.D., vice president of R1 RCM. CJR is mandatory in 67 metropolitan areas.

The IFC also added MS-DRGs 521 (hip replacement with principal diagnosis of hip fracture with major complications and comorbidities (MCCs)) and 522 (hip replacement with principal diagnosis of hip fracture without MCC) to the CJR, with a retroactive effective date of Oct. 1. "For the past 28 days, physicians have been treating hip fracture patients without realizing they were part of the CJR program," Hirsch said.

Outpatient knee and hip replacements will be included in the CJR even though it was designed for inpatient procedures. This was a concession to physicians, who got the rug pulled out from under them when CMS moved total knee arthroplasty and total hip arthroplasty off the inpatient-only list, Hirsch said. "Doctors worked hard to use less post-acute care, to limit therapy to an optimal amount and get costs down, and then there were no rewards for saving money on those patients," he said. CMS also is adjusting target spending for hip fractures vs. hip replacements because "physicians have much less control over an episode of care with fractures than elective replacements."

CMS Sets Payment Rates for Vaccines

Vaccines will be available without cost sharing through Medicare Part B, MA, Medicaid and private payers, CMS said. Because of Operation Warp Speed, the vaccines will only have emergency use authorization, Rinkle said. "People have known the CARES Act coverage provisions did not address EUA and that it was a gap, but CMS straight out said, 'It's clear this is congressional intent. It's a deadly threat to Medicare beneficiaries, and therefore we will use our authority to cover it.' End of story. I like how they laid it out and it's very direct."

Medicare established payment rates for administration of the vaccines in the IFC. If they require two doses, Medicare pays more for the second dose to incentivize the providers who administer the first dose (e.g., hospital, physician) to get the person back in for the second round, Rinkle said. The payment is $17 for the first and $28 for the second.

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1 CMS, "Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency," interim final rule, accessed October 30, 2020, https://go.cms.gov/30DnrQc.