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McDermottPlus Check-Up

McDermott+Consulting is pleased to introduce the McDermottPlus Check-Up, your regular update on health care policy from Washington, DC.

THIS WEEK'S DIAGNOSIS: Government funding negotiations continued against the backdrop of impeachment, and the Centers for Medicare and Medicaid Services (CMS) issued new rules on provider price transparency and Medicaid supplemental payments.

CONGRESS

+ **CONGRESS APPROACHES ANOTHER TEMPORARY GOVERNMENT FUNDING DEAL.** House lawmakers announced that they are nearing a final deal on a one-month continuing resolution (CR) to fund the government through December 20, 2019, while negotiations over a final spending package for fiscal year 2020 continue. The current CR expires on November 21, and with it, funding for several temporary healthcare programs (the so-called extenders). As negotiations continue on a longer-term funding agreement, policies that save money, such as addressing surprise billing and consensus drug pricing policies (e.g., the CREATES Act), could still move at the last minute to pay for long-term funding for the extenders. Impeachment adds another layer of complexity to the end-of-year negotiations.

ADMINISTRATION

+ **TRUMP ADMINISTRATION ANNOUNCED NEW PRICE TRANSPARENCY RULES.** The two rules flow from President Trump's June Executive Order on Improving Price and Quality Transparency in American Healthcare.
    - The 2020 Outpatient Prospective Payment System (OPPS) & Ambulatory Surgical Center (ASC) Price Transparency Requirements for Hospitals to Make Standard Charges Public Final Rule will require hospitals to publish their standard charge information online along with charge information for "shoppable" services such as x-rays and outpatient visits. The rule will also impose a civil monetary penalty of $300 per day on hospitals that do not comply. The rule takes effect January 1, 2021.
    - The Transparency in Coverage Proposed Rule would require health plans and insurance issuers offering coverage in the individual and group markets, to make price and cost-sharing information public, to make price and cost-sharing information public, including personalized estimates of a beneficiary's out-of-pocket cost liability. It would also require insurers to disclose their negotiated rates for in-network providers and allowed charges for out-of-network providers. CMS will accept comments on the proposed rule for 60 days.

Both rules are likely to face pushback from providers and insurers. Hospital groups have already spoken out against publishing standard charge information, arguing that doing so will harm competition rather than reduce costs, and are planning to file a lawsuit challenging the rule.

+ **CMS ISSUED PROPOSED RULE AIMED AT MEDICAID FINANCING TRANSPARENCY.** The Medicaid Fiscal Accountability proposed rule would increase reporting requirements for supplemental payments — those made to providers beyond the base Medicaid rate for a particular service — and make structural and definitional changes that could decrease states' flexibility in financing the state share of the Medicaid program. The rule includes provisions that:
    - Require states to report provider-level information on supplemental payments and to identify the specific legal authority for such payments;
    - Impose a three-year limit on supplemental payment programs, giving CMS the authority to sunset programs unless a state reapplies;
    - Prohibit states from structuring healthcare taxes in certain ways and from entering into financial arrangements or ownership transactions designed to mask prohibited payments; and
    - Add an additional requirement for annual disproportionate share hospital (DSH) payment audit reporting and clarify processes for dealing with the overpayment of DSH funds.

  These changes affect states' ability to finance the state share of the Medicaid program and alter state budgets. As a result, if the proposed rule is finalized as currently written, states will have to find other avenues to generate state share. If not, states may reduce Medicaid provider payments or services.

COURTS

+ **COURT BATTLES OVER TRUMP ADMINISTRATION RULES CONTINUE.**
    - Last week, the US Court of Appeals for the DC Circuit heard oral arguments concerning CMS's decision to cut reimbursement to 340B providers. A lower court judge ruled against the government in December 2018, and the Administration appealed the ruling. CMS maintained the 340B reimbursement cut in its 2020 Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Payment System Final Rule despite the lower court's decision. CMS's decision to maintain the cuts in 2020 is the latest example of the Administration's willingness to engage in prolonged court battles over its policies. (Likewise, CMS continues to accept proposals for Medicaid work requirements, despite several state plans being blocked in court). This pattern may lead to several CMS policies coming before the Supreme Court next year.
    - Hospital groups filed a motion to enforce a court's September judgement overturning CMS's site-neutral payment policy. As with the 340B reimbursement cut, CMS maintained the policy that would cut reimbursement for clinic visits at certain off-campus facilities in the 2020 OPPS rule despite the court ruling. The judge held that CMS lacked the authority to impose the cuts, and hospital groups

have requested that she expedite a hearing to resolve the issue before the 2020 OPPS rule takes effect on January 1, 2020. CMS has responded that the ruling involved 2019 policy and has no bearing on the 2020 rule.

- The US Court of Appeals for the DC Circuit heard oral arguments concerning the Trump Administration's rule expanding the use of association health plans (AHPs). A lower court vacated key provisions of the rule in March 2019, holding that it violated Affordable Care Act (ACA) requirements. The Appeals Court judges hinted that they may be considering a narrow ruling based on the question of whether the Administration's definition of "employer" is reasonable under the Employee Retirement Income Security Act, rather than whether AHPs are required to meet ACA mandates. A narrow ruling could lead to additional court cases on the broader question.

QUICK HITS

+ CMS Administrator Seema Verma announced that that the agency would soon release guidance encouraging states to fund Medicaid coverage for non-disabled adult beneficiaries using federal block grants.
+ The House Energy and Commerce Committee advanced bills aimed at maternal health and raising the tobacco purchasing age to 21.
+ A Senate Health, Education, Labor, and Pensions (HELP) Committee hearing focused on the federal response to youth e-cigarette use. Read our summary of the hearing here.
+ A House Ways and Means Committee hearing highlighted the difficulties of navigating end-of-life care. Read our summary of the hearing here.
+ The Ways and Means Committee's Rural and Underserved Communities Task Force issued a Request for Information seeking feedback on best practices and areas for improvement related to health status and outcomes in rural and underserved communities. Comments are due November 20, 2019.
+ The Medicare Payment Advisory Commission discussed the Medicare Advantage (MA) quality program, MA benchmarks, and Medicare Shared Savings Program post-acute care spending at their November meeting.
+ The Government Accountability Office issued a report that recommends CMS expand its oversight of states' implementation of Medicaid provider enrollment requirements and closely monitor the progress of states that are not fully compliant.

NEXT WEEK'S DOSE

Government funding negotiations continue, and the HELP Committee holds its confirmation hearing for Stephen Hahn to be Commissioner of the Food and Drug Administration.

For more information, contact Mara McDermott, Rachel Stauffer, Katie Waldo and Emma Zimmerman.

To subscribe to the McDermottPlus Check-Up, please contact Jennifer Randles.

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