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Sound Health Policy Objectives Achieved

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: When Congress is away, the agencies will play. The Administration made some major announcements and dropped several new important rules this week, giving stakeholders plenty to talk about (and work on) while Congress is in recess.

CONGRESS

+ **SNEAK PEAK.** Committees announced several health care hearings in the coming weeks:
    - The House Energy and Commerce Health Subcommittee will hold a hearing on prescription drug costs in Medicare. Drug pricing continues to be a hot topic on Capitol Hill as lawmakers review several proposals to lower costs. This one will be interesting to watch, as it is being touted as an educational and informational hearing for Members, a signal of an intent to advance legislation through the panel in the near future.
    - The House Rules Committee will hold a hearing on Medicare for All proposals, the first time this concept will be in the spotlight. The witness list has not been announced, but the witness selection will determine whether this hearing will be a productive discussion or partisan positioning.
    - The House Appropriations Committee will hold the first subcommittee markup of the year next week: Labor-HHS-Education. We get to see how the dollars might flow.
    - The Senate HELP Committee will hold its second hearing on implementing the electronic health information provisions of the 21st Century Cures Act. Don Rucker, National Coordinator for Health Information Technology at the Department of Health and Human Services (HHS) and Centers for Medicare and Medicaid Services (CMS) Chief Medical Officer Kate Goodrich will be testifying. Chairman Lamar Alexander (R-TN) is not letting up on oversight of Cures implementation.

ADMINISTRATION

+ **HHS ANNOUNCED CMS PRIMARY CARE INITIATIVE.** After months of sending smoke signals, HHS finally announced its CMS Primary Care Initiative, a new set of payment models aimed at delivering better value for patients throughout the health care system. While many technical details have not yet been released, five new model options are

expected to focus on supporting care for patients and increasing levels of financial risk for providers and other participants. The five new models fall into two categories: Primary Care First models and Direct Contracting models. Both categories build on existing initiatives, including Comprehensive Primary Care Plus and the Next Generation Accountable Care Organization programs. Included in the announcement is a request for information regarding a geographic risk model, where participants would assume financial and clinical accountability for a broader patient population.

+ **CMS RELEASED THE FY 2020 IPPS PROPOSED RULE.** CMS released the 2020 Inpatient Prospective Payment System (IPPS) proposed rule. The agency estimates a total increase in IPPS payments of approximately 3.7 percent. The proposed rule also featured a number of significant payment and policy changes, including:

  - CMS projects total Medicare spending on inpatient hospital services, including capital, will increase by about $4.7 billion in FY 2020.
  - CMS proposes to address payment disparities between rural and urban facilities through changes to the Medicare wage index.
  - To help improve beneficiary access to emerging technology, CMS is proposing a number of changes related to revising policies related to new technology add-on payments and increasing payment rates.
  - The proposed rule includes a number of changes to the IPPS quality programs with changes to measures and reporting requirements with an eye towards burden reduction.
  - For the Medicare and Medicaid Interoperability Programs, CMS will continue a minimum 90-day reporting period and is proposing new measures and seeking comments on improving the use of EHRs among other topics.

  Comments are due on June 24, 2019. Additional M+ summary and analysis is available here.

+ **CMS FINALIZED 2020 NOTICE OF BENEFIT AND PAYMENT RULE.** CMS released the final Notice of Benefit and Payment Parameters for benefit year 2020, which includes several changes to the Affordable Care Act marketplaces. CMS finalized lowering the user fee rate for qualified health plans (QHPs) sold on the federally-facilitated exchanges from 3.5 percent to 3.0 percent of premiums, and lowering the user fee rate for QHPs sold on state-based exchanges that used the federal platform from 3.0 percent to 2.5 percent of premiums. Notably, and to the relief of many, CMS did not make any changes to "silver loading," which refers to the practice of insurance companies increasing premiums on the silver tier of health plans to compensate for the lost cost-sharing reduction payments. This practice then often results in higher premium tax credits and larger federal outlays. CMS signaled an interest in ending silver loading, but ultimately declined to make a change in 2020. Instead, CMS is requesting further comments on this issue. Many stakeholders support silver loading to reduce costs to the consumer and maintain Marketplace stability. The rule also creates a special enrollment period, available at the option of the exchange, for persons enrolled in off-exchange individual market coverage that qualifies as minimum essential coverage. They must experience a decrease in household income and be newly eligible for advance payments of the premium tax credit

by the exchange. The rule will also let health plans exclude branded drug pay coupons from the out-of-pocket maximum, and allows health plans to exclude from the out-of-pocket maximum any cost-sharing paid for using a manufacturer's coupon for a drug with a medically appropriate generic. Ultimately, the final rule largely mirrored the proposed rule and did not contain major surprises.

+ **HHS Extended the Comment Period for Interoperability Rules.** HHS and the Office of the National Coordinator for Health Information Technology (ONC) announced that they are extending the public comment period by 30 days for two proposed regulations aimed at promoting the interoperability of health information technology and enabling patients to electronically access their health information. The new deadline for the submission of comments is June 3, 2019. HHS announced the proposed rules in February 2019 to support the seamless and secure access, exchange and use of electronic health information. Together the proposed rules address both technical and health care industry factors that create barriers to interoperability and limit a patient's ability to access essential health information. Most stakeholders were relieved the extension was granted.

+ **ONC Released the Second Draft of the Trusted Exchange Framework and Common Agreement.** Coinciding with the extension of the comment period for the interoperability rules, ONC released the second draft of the Trusted Exchange Framework and Common Agreement, which outlines a common set of principles, terms and conditions to support the development of a Common Agreement to facilitate the nationwide exchange of electronic health information across disparate health information networks. As part of this announcement, ONC issued a funding opportunity to select a coordinating organization that would be responsible for developing, updating, implementing and maintaining the Common Agreement and the Framework. Comments on the draft and applications for the coordinating organization are due June 17, 2019.

+ **Medicare Trust Fund Will Run Out in 2026.** The trustees of the Medicare hospital insurance fund published an annual report assessing the financial viability of the trust fund and forecasting that the trust fund will run out of money in 2026. The estimate remains unchanged from last year, though Social Security is now expected to run out in 2035, one year later than projected in last year's report. The latest forecast comes as Democrats are increasingly pushing to adopt a Medicare for All system that would vastly increase the cost of the federal health care program. As it stands now, in 2026, the Medicare trust fund will only have enough money to cover 89 percent of benefit costs, and that will gradually dip to 77 percent in 2046.

+ **CBO Plans to Update Its Baseline Budget Projections.** The Congressional Budget Office (CBO) plans to release its updated 10-year baseline budget projections next week. To support the upcoming baseline projections, CBO released four reports that explain how its new health insurance simulation model works. In this new model, CBO updated its data source and revamped how it models consumer and employer behavior. Specifically, the model changes how individuals and families choose among coverage options and how employers account for workers' preferences when deciding whether to offer employment-based coverage. The model also accounts for proposed changes in policies that can affect coverage. Of note, CBO estimates that in 2018, there were 28.9 million uninsured Americans, up from 27.5 million in 2016. CBO also notes the decrease in the number of people buying individual market insurance outside of the federal- and

state-based exchanges. CBO found that in 2016, 7.4 million people bought off-exchange coverage while in 2018 only 4.9 million people bought off-exchange coverage. In addition, the number of people buying unsubsidized plans on the exchange also decreased, with 1.6 million purchasing an unsubsidized exchange plan in 2016 and only 1.3 million purchasing an unsubsidized exchange plan in 2018. These findings suggest that individuals not receiving subsidies are dropping coverage. CBO will likely take these numbers into account when establishing the new baseline. These changes could impact how health insurance expansion legislation is scored.

STATES

+ **MONTANA MOVED TO REAUTHORIZE MEDICAID EXPANSION.** The Montana state legislature passed a bill to continue Medicaid expansion in the state, adding new community engagement requirements. Montana's expansion, which was first passed in 2015, extends Medicaid coverage to those earning up to 138 percent of the federal poverty level. Beginning July 1, 2020, qualifying beneficiaries age 19 to 55 will be required to complete 80 hours of work or community service per month. Failure to comply with the requirements will result in suspension from Medicaid. An individual may be reinstated 180 days after suspension or once they have been compliant with the requirement for 30 days. Governor Steve Bullock (D) is expected to sign the bill. (Last November, Montana voters rejected a ballot initiative that would have extended the state's Medicaid expansion by raising the tobacco tax.)

NEXT WEEK'S DOSE

Congress is back for a four-week legislative session before the next recess. In addition to the hearings, we'll be watching for signs of a major extenders package coming together in the next few weeks as lawmakers work to get their ducks in a row heading into the summer.

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