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McDermottPlus Check-Up

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

THIS WEEK'S DIAGNOSIS: Three weeks down, one week to go in this work period. The Senate Health, Education, Labor and Pensions (HELP) Committee is moving forward with its cost containment legislation, and the House passed the first batch of health care extenders.

CONGRESS

+ **HELP COMMITTEE MOVED FORWARD WITH COST CONTAINMENT BILL.** A day after a hearing on the HELP Committee's cost containment discussion draft, the Lower Health Care Costs Act, committee Chairman Lamar Alexander (R-TN) and Ranking Member Patty Murray (D-WA) released an updated version of the bill (S. 1895) along with a notice that the committee will hold a markup of the legislation on June 26. Unlike the discussion draft, the updated bill includes funding for a handful of expiring health care provisions including community health centers, the National Health Service Corps, Teaching Health Center Graduate Medical Education and special diabetes programs. The bill also settles on using a benchmark rate to curb surprise billing, one of three options proposed in the initial draft. With a benchmark rate, providers would be paid for out-of-network services at the median in-network rate for that geographic area. This brings the Senate bill in line with the No Surprises Act proposed by House Energy and Commerce Committee leaders, which also includes a benchmark rate. Read a section-by-section summary of the Senate bill here. Further changes are expected before the committee markup next week as Senators and stakeholders continue to push for priorities. Read our analysis of the updated HELP Lower Health Care Costs Act here.

+ **HOUSE PASSED EXTENDERS BILL.** The House of Representatives passed H.R. 3253, a bill that temporarily extends a number of Medicaid programs. The bill includes a four-and-a-half year extension for the Money Follows the Person program, extends Medicaid protections against spousal impoverishment until March 31, 2024, extends the community mental health program for two years, and includes a provision to prevent inappropriately low manufacturer rebates to the Medicaid program. This is the first group of extenders to move through the House, and the bill now heads to the Senate.

+ **CONGRESS HELD HEARINGS ON DRUG PRICING AND MEDICAID IN US TERRITORIES.**

    - The Senate Aging Committee held a hearing examining government agency efforts to promote competition and increase affordability in the prescription drug market. Members heard from representatives from the Centers for Medicare and Medicaid Services (CMS), Food and Drug Administration, and Department of Health and Human Services (HHS) Office of Inspector General. Among the

primary topics discussed were the Administration's proposed rule that removes the safe harbor for drug manufacturer rebates to Part D plans and pharmacy benefit managers, insulin costs and access to biosimilars.

- The House Energy & Commerce Committee held a hearing on Medicaid funding in the US territories. The hearing focused on how the US territories use their Medicaid programs and how Congress can address chronic underfunding. Anne Schwartz, Executive Director of the Medicaid and CHIP Payment and Access Commission (MACPAC), testified that two policies are to blame for insufficient funding: an allotment cap that does not exist on the mainland and a federal medical assistance percentage (FMAP) that is set at 55 percent. The witnesses agreed that to adequately fund Medicaid in the territories, Congress would need to raise or eliminate the allotment cap and increase the FMAP.

ADMINISTRATION

+ **CMS PROPOSED PRIOR AUTHORIZATION STANDARD FOR E-PRESCRIPTIONS.** CMS issued a proposed rule that would require Part D plans to use the National Council for Prescription Drug Programs' SCRIPT standard for prior authorization of electronic prescriptions. According to CMS, the rule is intended to make it easier for plans to submit prior authorization requests through web portals and thus speed up the process. The proposed rule would require plans to start using the standard beginning January 1, 2021, and CMS estimates that it would cost plans about $100,000 to implement. CMS is accepting comments on the proposal until August 16, 2019. Prior authorization has been a focus of both Congress and the Administration. CMS recently released a Request for Information seeking ideas from the public on maintaining the progress of the Patients over Paperwork initiative, and lawmakers introduced H.R. 3107, which would make changes to prior authorization in Medicare Advantage.

STATES

+ **CMS APPROVED WASHINGTON STATE OUTCOME-BASED AMENDMENT FOR HEPATITIS C DRUGS.** CMS approved a Washington State Plan Amendment (SPA) that will allow the state to enter into outcome-based contracts with drug makers in Medicaid. Specifically, the SPA creates a subscription model for purchasing hepatitis C drugs, making Washington the fourth state (behind Oklahoma, Michigan and Colorado) to receive CMS approval for Medicaid value-based contracts.

OTHER

+ **STUDY FINDS THAT MEDICAID WORK REQUIREMENTS DO NOT INCREASE EMPLOYMENT.** A study published in the New England Journal of Medicine found that Medicaid work requirements in Arkansas, the first state to implement the policy, resulted in lost Medicaid coverage for thousands of low-income people and did not increase employment. The finding contradicts CMS's main legal argument for approving work requirements in Arkansas and other states: that mandating work as a condition of Medicaid coverage would encourage employment and improve health, and that the

lower Medicaid roles likely resulted from people finding jobs and becoming financially ineligible for Medicaid. Health officials in Arkansas have disputed the results of the study, in part because it relies on less than one year of data (the Arkansas work requirement took effect in 2018). This finding also runs counter to previous claims from HHS Secretary Alex Azar, who stated at a March 14 Senate Finance Committee hearing that "only 1,452 of those 18,000 people [who lost coverage in Arkansas] even reapplied for Medicaid. That seems a fairly strong indication that the individuals who left the program were doing so because they got a job [in] this booming economy."

+ **MEDPAC RELEASED JUNE 2019 REPORT TO CONGRESS.** The Medicare Payment Advisory Commission (MedPAC) released its June 2019 Report to Congress, Medicare and the Health Care Delivery System. The report includes a number of payment innovations to address rising spending for Medicare fee-for-service clinician payment, Medicare Advantage and Part B drugs, as well as an assessment of the Medicare Shared Savings Program and its effects on Medicare spending. Read our summary of the report here.

+ **MACPAC RELEASED JUNE 2019 REPORT TO CONGRESS.** MACPAC released its June 2019 Report to Congress on Medicaid and CHIP. The report included a number of recommendations relating to Medicaid Disproportionate Share Hospital payments, Medicaid payment and coverage policies for outpatient prescription drugs, program integrity and therapeutic foster care. It also includes a chapter on Puerto Rico's Medicaid program.

NEXT WEEK'S DOSE

All eyes will be on the HELP Committee's markup of the Lower Health Care Costs Act next Wednesday.

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

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