Policy Brief

May 18, 2018

Seema Verma's Health Care Agenda

In a recent speech to the American Hospital Association (AHA), CMS' Administrator Seema Verma offered insights into the Agency's future regulatory actions. Issues addressed included Track 1 of the Accountable Care model, drug pricing, site-neutral payments and Stark law. Below are key quotes from Verma and what they may mean for the future of CMS.

CMS may rescind the no-risk, Track 1 Accountable Care Model. "The presence of these "upside-only" tracks may be encouraging consolidation in the market place, reducing competition and choice for our beneficiaries."

The add-on payment for Medicare Part B drugs may be eliminated. "Medicare pays Part B providers for drugs at an amount equal to the average price the drug sells for, plus a 6% add-on fee…In today's world, with some therapies costing over a half a million dollars, adding 6% to the sales price doesn't make sense."

CMS may revise its implementation of Stark Law. "Another important step in moving to a value-based system, is removing barriers that prevent providers from participating in value based models…Our agency is conducting a holistic review of our implementation of [Stark] and the consequences."

Price transparency will be a top priority for the Agency. "In virtually every sector of the economy, you are aware of the cost of services before you purchase them, except for healthcare. Patients deserve, and need to know cost of services, if they are going to be empowered to shop for value." The Agency is already taking action on this issue by proposing to require hospitals to post their charges online.

CMS will likely promote site-neutrality in Medicare. "Another issue is that for high-cost products, the amount that Medicare pays differs dramatically based on the site of service. This does not make sense." This position aligns with the Medicare Payment Advisory Commission's recommendations in the post-acute care space.

Work requirements will continue to emerge in Medicaid. "We will continue to be supportive of state efforts to help able bodied, working age adults rise out of poverty." CMS has already approved several state waivers to incorporate work requirements in Medicaid. According to Verma, seven more applications are currently pending.

CMS will double down its efforts to improve interoperability. "It no longer will be acceptable to limit patient records or to prevent them and their doctors from seeing their complete history."

More efforts to reduce regulatory burden are under way. "We're looking at even the smallest ways to eliminate redundancies and burdens that are taking away from patient care." Most recently, CMS proposed to eliminate various duplicative measures across Medicare quality programs.

Proposed Rescission Targets Health Care Funds

The Trump Administration has proposed that Congress rescind approximately $15 billion of unspent, surplus funding, spanning more than 30 programs. Nearly half of the reduction comes from the Children's Health Insurance Program's (CHIP) budget. The Center for Medicare and Medicaid Innovation (CMMI) also faces cuts under the proposal. Presidential rescission eliminates the opportunity for Departments to reallocate the funds on their own. None of this is final, yet — Congress will need majority votes to rescind the money.

Cuts to CHIP:
The reduction to CHIP funding includes a $2 billion contingency fund that protects states' budgets from unexpected costs, like a natural disaster or a boom in enrollment. Without the contingency, states would no longer have that reassurance. The remaining $5 billion in cuts pulls from unspent FY 2017 money. The White House defends the proposal, as it believes both sets of funds will likely never be spent.

Cuts to CMMI:
The package also calls for an $800 million rescission of unused funds from CMMI. According to the White House, removing this money from the budget would have "no programmatic impact." CMMI would still receive its scheduled FY 2020 appropriation of $10 billion.

Despite the proposed rescission, both CHIP and CMMI appear to be important to this Administration. Although CMMI has faced opposition from Republican lawmakers in the past, CMMI and CHIP now largely receive bipartisan support. This rescission package may be partially in response to criticism from deficit hawks after the earlier tax reform and omnibus spending bills.

The Growing Role of Physicians in Value-Based Care

As we continue the shift towards value-based care, new payment structures and business models place physicians in a central role. Physician-led ACOs have increased from 17% in 2016 to 27% in 2017 with higher rates of savings than other provider-led ACOs. States, CMS and commercial insurers are taking notice and redoubling their efforts to engage physicians in non-traditional models of care. Below is more on emerging physician-driven models.

Physicians in Alternative Payment Models (APMs)
In the post MACRA era, CMS is working to drive physicians towards Advanced APMs. Currently, the agency is exploring a new Direct Provider Contracting model that would allow providers to contract directly with CMS and Medicare beneficiaries.

Physicians in Direct Primary Care Agreements
Direct Primary Care agreements, where physicians charge patients a monthly fee to cover defined primary care services, are growing in popularity. Because the Affordable Care Act does not recognize Direct Primary Care agreements as insurance, now that the Individual Mandate has been repealed, more people are likely to engage in these agreements. Twenty-four states have passed legislation defining Direct Primary Care agreements outside the scope of state insurance regulations, which further promotes its usage, and there is a similar bill currently in Congress.

Physicians in Medicare Advantage

In California, organizations such as Landmark Health, in which the new CMMI director previously led as CEO, Alignment Healthcare and Concerto Health are partnering with physicians to expand primary care into homes, increase individualized care and extend physician face-to-face time with patients.

Physicians in Commercial Bundles

Private insurers are also attempting to implement their own value-based models. Humana is partnering with five physician practices in a bundled payment model for maternity care. Humana joins Cigna and Blue Cross Blue Shield in New Jersey in exploring this new venture.

America's Action Plan for Lowering Drug Prices

President Trump and Health and Human Services' Secretary Alex Azar recently gave a joint address outlining their blueprint to lower drug prices. State governments across the U.S. have also attempted to address the high cost of drugs. The considerations thus far don't actually lower the list price of drugs but simply discount them so that consumers pay less out of pocket. Learn about the strategies that are being considered to lower drug prices below.

Revising the 340B Program

In President Trump's blueprint, the Administration suggests that the 340B program is contributing to increases in overall drug prices. The Administration is now seeking comments on how the program can be improved. The Request for Information (RFI) poses 13 questions, including: How has the growth of the 340B drug discount program affected list prices? What are the unintended consequences of this program? Comments on the RFI are due July 13th.

Banning "Gag" Clauses for Pharmacists

There are laws in place that prevent pharmacists from telling their customers when the out of pocket cost of a prescription is cheaper than the cost through their insurance plan. A proposal to eliminate these gag clauses is included in Trump's blueprint and 21 states have enacted laws to address this.

Increasing Price Transparency

In mid-March, Oregon passed a price transparency law requiring drug manufacturers to inform the state of any drug prices that increased by 10% or more in a year. California passed a similar law in 2017. Trump's plan would require drug manufactures to include the price of drugs in their advertisements. CMS also released a drug spending dashboard that highlights information on drug pricing.

Allowing the Government to Negotiate Drug Prices
Trump's blueprint would allow Medicare to negotiate the price of drugs it provides to Medicare beneficiaries. This has been a recurring policy consideration to lower drug prices. Prior to the release of the blueprint, Senate Democrats have advocated for this policy change.

Allowing the Importation of Medicines
Eight states have introduced bills this year that would allow the importation of medicines from Canada. These measures are highly controversial. Vermont is the only state to have passed this policy. The Food and Drug Administration (FDA) argues that the practice is illegal but does not have strict enforcement measures in place.

Raising the Price of Exported U.S. Drugs
Trump's blueprint proposes to change U.S. trade policies and raise the prices of U.S. drugs sold to other countries. Currently, individuals in other countries tend to pay a lower price for U.S. drugs than Americans, due to some governments being able to dictate drug prices.

A Look at The Federal Register

Veteran's Choice Funding Set to Expire. The Department of Veterans' Affairs (VA) recently released a document announcing that the VA will likely exhaust the amount that was deposited in the Veterans Choice Fund by May 31, 2018. The Agency may be able to stretch the funds until June 15, 2018.

Learn About IPPS

Register for AHPA's Webinar on the Inpatient Prospective Payment System (IPPS) proposed rule for FY 2019. The webinar will provide an overview of major proposals outlined in the rule. It will be held on Thursday, May 31st at 3 p.m. EST. To register, please email Susana Molina.

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