vizient. Washington Update

June 14, 2019

We are back at it after a brief, but delightful recess! Congress has been very active in health policy, and the next couple of weeks and months could be huge. We have made significant advances in efforts to address surprise bills and drug prices. There was a major Supreme Court win for hospitals, and Vizient weighed in to support legislation undoing some site-neutral payment cuts for hospitals and commented on interoperability. CMS Administrator Verma and a Senate subcommittee both discussed health care consolidation and we had yet another hearing on Medicare for all.

Loads of champions are being crowned with the St. Louis Blues lifting Lord Stanley's Cup, the Toronto Raptors ending the dynasty of an injury-depleted Golden State Warriors to win the NBA title and of course, and most importantly, Liverpool won the Champions League!

You are all champions in our books – so let's pop some champagne and dig in!

Discuss amongst yourselves …

The Senate Health, Education, Labor and Pensions (HELP) Committee will be holding a hearing to, well, discuss a discussion draft of bipartisan health care legislative proposals. The draft includes a bit of all of the major health care issues du jour with a pinch of surprise bills, a dash of drug prices and a smidge of price transparency. I don't know about you but now I want a cupcake.

On June 18, the Senate HELP Committee will hold a hearing on the Lower Health Care Costs Act, the committee's draft cost containment legislative proposal. Late last month, HELP Committee Chairman Lamar Alexander (R-Tenn.) and Ranking Member Patty Murray (D-Wash.) released a wide-ranging discussion draft that proposes to make significant health policy changes to address surprise bills, reduce drug prices, enhance price transparency and to make other public health improvements. The HELP Committee hearing will examine the draft legislation and consider the feedback that was offered by industry stakeholders. A key area of the legislation that will likely be a focus of the hearing is how to protect patients from surprise medical bills.

The draft outlines three separate proposals to address common surprise billing situations. Option 1 would require an in-network guarantee for physicians at in-network facilities. Under Option 2, when the insurer and hospital or physician disagree on the appropriate amount of payment, the bill would establish reimbursement at the median contracted rate, while providing an arbitration process if the parties disagree with that payment rate. Option 3 would only utilize a benchmark payment level using the median contracted rate of the geographic area to determine payments. The committee intends to select one of the three options before advancing the legislation.

The proposal also offers a significant number of options to reduce drug prices. Most notably, the bill seeks to promote the development of biosimilars by improving the approval processes and enhancing understanding of biosimilars through education and public information. Additionally, the bill would prohibit some loopholes used by manufacturers to extend exclusivity, and make some significant changes to pharmacy benefit manager (PBM) practices. For hospitals there are a number of provisions included in the committee's proposal intended to improve price transparency. For instance, under the bill, hospitals and other providers would be required to provide a good faith estimate of the out-of-pocket costs for specific services, as well as provide a timely bill for all charges within 30 days of discharge.

Key takeaways:

- The draft legislation released by the HELP Committee is arguably the most significant bipartisan bill being discussed in Congress right now. Because it is bipartisan and takes a fairly measured approach on a number of issues, a version of this bill is the most likely to advance and potentially become law, though substantial policy considerations still need to be addressed.
- The hearing will be an interesting window on the views of the committee members and will give us a better understanding as to whether there are significant concerns or opposition in the committee
- It is expected that the HELP Committee will make changes to the bill before formally marking up the legislation and advancing it to the full Senate

A DSH best served after public comment

The Supreme Court ruled on an important Medicare payment case, siding with hospitals in finding that the Centers for Medicare & Medicaid Services (CMS) inappropriately modified the formula for Medicare disproportionate share hospital (DSH) payments. The court ruled that because CMS moved forward with significant DSH payment changes without providing the opportunity for public feedback, the change was invalid. While CMS doesn't always agree with all (or many) public comments that disagree with their proposals – it is good to know that they at least have to give us the chance to weigh in!

In a June 3 ruling, the Supreme Court of the United States found that CMS exceeded its authority when it modified the DSH payment formula for hospitals that serve a large number of low-income patients. In the case Allina Health Services v. Azar, the Supreme Court upheld a lower-court's ruling that centered on a change to how CMS calculates Medicare DSH payments and the treatment of Medicare Advantage patients in that calculation. CMS made this change without conducting a formal rulemaking and comment period – finalizing it without ever having previously proposing it through the traditional regulatory process.

As a result of that payment change, many hospitals had their DSH fraction and payments significantly reduced. The court found that CMS should have provided the opportunity for public comment because the policy change was substantive, and, as a result, CMS exceeded its authority. The court upheld the lower-court decision in a 7-1 ruling (Justice Brett Kavanaugh recused himself from the case due to involvement in the lower-court rulings).

Key takeaways:

- The Supreme Court ruling was a positive outcome as the DSH change in question led to significant payment reductions for many impacted hospitals
- In addition to the positive reimbursement change resulting from the vacated DSH formula, the ruling may further discourage CMS from making policy changes without soliciting public feedback

Like a heavy-footed driver – we, too, are uncomfortable with use of the CoPs

Vizient submitted comments on the CMS proposed rule to expand interoperability and improve patient access to their health data. Unfortunately, the rule also proposes to use the Medicare and Medicaid Conditions of Participation (CoPs) to require new, challenging EHR burdens on hospitals.

On May 31, Vizient submitted comments to CMS in response to its proposed rule seeking to improve interoperability and expand patient access to their medical information. In our comments, Vizient supported the broad long-term goals of using electronic health record (EHR) technology to ease administrative burdens by streamlining quality reporting and improving patient access to their health information. While supporting the overall goal of the rule, Vizient raised significant concerns about a specific proposal, in particular. Under the rule, CMS has proposed to require hospitals to send "electronic patient event" notices to other health care facilities/providers that may consider the individual an "established patient" as a CoP in Medicare and Medicaid.

Vizient expressed strong concerns about the proposal due to the complexity of determining facilities where an individual may be considered an "established patient." Moreover, Vizient strongly opposed using the CoPs as the policy mechanism for such a requirement. Our comments argued that another possible – and more reasonable – option would be that the proposed requirements could be more appropriately enforced through the Medicare Promoting Interoperability (PI) Program. Given some of the controversy around the proposed rule, the comment period was extended into June. The final rule will likely be released later this year.

Key takeaways:

- In our comments, Vizient expressed concerns about the proposal to implement any interoperability requirements through the CoPs – arguably the most severe penalty applicable to hospitals that may not be in compliance
- While being supportive of the overall intent of the rule, Vizient hopes that CMS will take a more pragmatic approach to improve the interoperability of medical information

We aren't neutral on site neutrality

Vizient is proud to offer our endorsement of legislation that would roll back site-neutral payment policies that reduce reimbursements to hospitals. We, along with large groups of bipartisan members of Congress, argue that the cuts CMS finalized last year were inappropriate and went beyond congressional intent. Because CMS has not

yet reversed the cuts, Congress is now considering legislation on the matter. Vizient is happy to support this legislation.

On May 30, Vizient endorsed H.R. 2552, the Protecting Local Access to Care for Everyone (PLACE) Act. Sponsored by Rep. Derek Kilmer (D-Wash.) and Rep. Elise Stefanik (R-N.Y.), this bipartisan legislation would require that services provided at previously excepted off-campus outpatient departments be paid as if such services were provided on campus. The legislation was introduced after CMS updated payment rules in the CY 2019 Outpatient Prospective Payment System (OPPS) final rule that expanded site-neutral payment cuts to facilities that Congress previously exempted under law. The payment cuts would be reversed and restored retroactively for impacted claims beginning Jan. 1, 2019 through Dec. 31, 2020.

The cuts in question are currently facing legal challenges from hospitals and hospital groups arguing that Congress explicitly grandfathered in certain off-campus outpatient departments, and as a result CMS could not ignore congressional intent and subject such facilities to these lower payment rates. In addition to the lawsuits and the legislation, a large, bipartisan group of members of the Senate and the House of Representatives sent letters to CMS urging the agency to rescind the payment change late last year. Vizient will continue to advocate on behalf of our members for a reversal of this payment cut.

Key takeaways:

- Vizient endorsed H.R. 2552, the PLACE Act of 2019, which would reverse some site-neutral payment cuts to hospital outpatient departments
- Currently the site-neutral payment reductions are in effect while both a legislative effort and pending lawsuits are underway to reverse these cuts
- It is possible CMS may consider revising its approach when it releases the OPPS proposed rule for CY 2020 this summer. However, given statements from CMS and the administration, it seems likely they will continue to pursue the policy absent legal or Congressional intervention.

Everyone's a blogger these days

CMS Administrator Seema Verma released a blog post on the CMS website that was highly critical of hospital consolidation. Hey – at least it wasn't ANOTHER podcast! In addition to the CMS blog, the Senate Judiciary Committee held a hearing to examine the impacts of consolidation in health care.

In a blog post published on the CMS website on June 6, CMS Administrator Seema Verma outlined concerns about the negative impacts of consolidation in health care. In her post, Verma primarily singled out large hospital systems in driving up health care costs. By acquiring physician practices and reducing competition, Verma said there are many examples such as, "hospitals thwarting price transparency, hospitals demanding that insurers include them in their networks, and hospitals discouraging the inclusion of competitor systems in insurers' networks. Large hospital systems also exert pressure on physicians to keep referrals in-house, even when referrals to outside systems could result in higher quality or lower costs."

Administrator Verma went on to highlight steps that the administration has taken to improve competition, specifically mentioning the adoption of site-neutral payment policies in Medicare, the expansion of price transparency and the effort – which has since been struck in the courts – to reduce Medicare reimbursement for prescription drugs purchased though the 340B Program. The following week, on June 12, the Senate Judiciary Subcommittee on Antitrust, Competition Policy and Consumer Rights held a hearing to examine consolidation in the health care market.

The hearing examined a broad range of issues related to the competitive impact of both vertical and horizontal mergers in health care. During the hearing, the subcommittee members discussed with the witnesses competition issues in the pharmaceutical supply chain, the impact of mergers among hospitals and between hospitals and physician practices, mergers between PBMs and insurers, and steps that could be taken by the Federal Trade Commission (FTC) to discourage mergers and acquisitions that reduce competition.

Key takeaways:

- Administrator Verma's blog post is a strong indicator that, despite legal setbacks on 340B changes and ongoing congressional concerns about site-neutral payment changes, the administration will continue to push forward policy proposals that they believe will reduce incentives for consolidation in the hospital sector
- The Senate hearing on consolidation was an interesting conversation with a largely technical focus on the mechanics of antitrust enforcement and potential impact on various health care sector players. While there wasn't much discussion of specific legislation, it does suggest that Congress is actively monitoring the issue and may take action to empower the FTC to be more active in discouraging consolidation.

Another day, another Medicare-for-all hearing

The House Ways and Means Committee held a hearing about moving toward universal coverage. These hearings – which have been rare until recently – continue the conversation about how such a monumental change to the U.S. health care system would be structured and paid for.

On June 12, the House Ways and Means Committee held a hearing to examine the pathways to achieving universal coverage. The hearing – the third of the year in the House of Representatives – attempted to take a broader approach than the two previous hearings by focusing on the movement toward universal coverage and less on the high-profile Medicare-for-all legislative proposals that have been introduced. While that may have been the intent, the committee discussion largely broke down along party lines with Democrats highlighting challenges with cost and access to care under the current system and Republicans raising significant concerns about cost and access under a Medicare-for-all style system.

Chairman Richard Neal (D-Mass.) opened the hearing by highlighting that this was only an early discussion on the topic and acknowledged that Democrats have been considering multiple approaches – including a full transition to a Medicare-for-all system – but will continue to push to shore up the ACA and be deliberate before moving forward to consider legislation.

Key takeaways:

- The hearing on transitioning to universal coverage was the third in the House this year, and while it examined a wide range of the policy and practical challenges of moving to such a system, it did not delve deeply into any specific legislation
- A Medicare-for-all style bill has virtually no chance of becoming law in the near future, given GOP control of the Senate and the White House and lack of agreement among Democrats on precisely what policy approach should be adopted

SURPRISE – Another hearing on surprise bills!

Thought you were done with surprise bills? No such luck! Here we go again, as the House Committee on Energy & Commerce Health Subcommittee held a hearing on surprise bills. You can tell by the policy focus and startling lack of partisanship in the hearing that Congress is actually working hard to find a way to get something done on the topic. If only they approached other problems in the same way … c'est la vie …

On June 12, the House Committee on Energy & Commerce Health Subcommittee held a hearing to discuss surprise bills, following the release of the bipartisan discussion draft aiming to address the issue. The discussion draft would hold patients harmless for surprise bills for emergency services (i.e., they would only be required to pay their in-network rate) and require that health plans reimburse providers based on a set benchmark rate. During the hearing, which avoided much of the usual partisanship, members remained focused on the policy issues at hand, asking specific questions of the panelists, and seemingly looking for a set of solutions. The conversation largely focused on how health plans would reimburse providers for services and whether rate setting or an arbitration process would be most effective.

Another frequently discussed issue was how recently implemented state laws have handled those reimbursement questions – focusing particularly on the arbitration process – and what the outcomes have been. Vizient will continue to monitor the progress of the committee's discussion draft and other congressional surprise billing proposals.

Key takeaways:

- On June 12, the House Committee on Energy & Commerce Health Subcommittee held a hearing to discuss surprise bills following the release of the committee's bipartisan discussion draft aimed at addressing the issue
- There are multiple pieces of rapidly evolving legislation that address surprise billing. You can find a summary of the current ones here, but please note that we expect changes ahead!

- The Energy & Commerce Committee's efforts are important to monitor as a key House Committee of jurisdiction over the issue, but whatever is ultimately developed will require bipartisan and bi-cameral (both the House and Senate) cooperation because there is still little clarity on how the major questions around reimbursement will be addressed

Quotes of note:

"Government policies have stymied competition across many fronts and have been a major driver of healthcare consolidation. The thicket of regulations that CMS has rolled out over the years has significantly accelerated consolidation. The costs to comply with CMS regulations have, in many cases, become too high for small, independent physicians to bear – from requirements regarding EHRs to new regulations under MACRA – forcing them to become employees of hospitals."

CMS Administrator Seema Verma in a blog post critical of health care consolidation – June 6, 2019

"Yes, members of our party have put forward different policy ideas. But what unites us as Democrats is our shared, core belief that all Americans should have health care coverage and receive care that isn't a financial burden."

House Ways and Means Chairman Richard Neal (D-Mass) opening the committee hearing on transitioning to universal coverage – June 12, 2019

"We will not stand by and let Democrats seize your health care, your choices and your control over life-and-death health decisions with Medicare for All."

Ways and Means Ranking Member Kevin Brady (R-Texas) on the potential for a Medicare-for-all bill – June 12, 2019

We want to hear from you …
As always, let us know how we are doing, and what you'd like to see from the Washington office. We are happy to report on other initiatives that may be of interest to you and would be even happier to meet with you in person, should a D.C. update ever be of interest! Email us at: shoshana.krilow@vizientinc.com and steve.rixen@vizientinc.com.

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