Policy Brief

April 6, 2018

Industry Shifting Towards Patient-Centered Care

"We will not achieve value-based care until we put the patient at the center of our healthcare system."
— Seema Verma, CMS Administrator

As indicated by Verma's statement, the health care industry is moving towards a more patient-centered care model that captures what is meaningful and valuable to consumers — more access to health information, engaging them and their families in clinical decision-making and tailoring services to them. Below are the initiatives that are taking place to move health care in this direction.

CMS Initiatives

- MyHealthEData initiative aims to put medical records into patients' hands, giving them more control over health information.
- Blue Button 2.0 allows Medicare beneficiaries to connect their data to health apps and better mangage their health.

Private Enterprises:

- Intermountain Medical Group transformed their 83 primary care clinics into Patient-Centered Medical Homes (PCMHs).
- Uber Health is partnering with health care organizations to provide free transportation for patients.
- Intermountain brought together the system's 35 telehealth programs into a virtual hospital, Connect Care Pro, that offers services from intensive care to mental health services.
- The National Quality Forum is exploring more patient-reported outcomes.
- Apple's Health App now displays medical records from 39 health systems, including Adventist Health System.

Rumor Watch: Privatization of VA Hospitals?

In the wake of leadership shakeups at the U.S. Department of Veteran's Affairs (VA), speculation has swirled around privatizing VA hospitals. This matters to health systems because it could impact our patient mix, bringing patients with more complex behavioral health and rehabilitation needs.

The Argument *For* Privatization	The Argument *Against* Privatization
• The VA has had many missteps. • The use of private facilities would increase access to care.	• Veterans' health care is a federal duty. • The private sector can't absorb VA patients. • The Veterans Choice Program would now be redundant.

While the White House has not expressed any interest in a major VA overhaul, many viewed Dr. David Shulkin as the last bastion of dissent. The stance of Dr. Ronny Jackson, the President's choice to replace Shulkin, remains to be seen.

Battle Over Birth Control

Last year, the Trump Administration issued a rule to weaken the contraceptive coverage requirements in the Affordable Care Act (ACA). While the rule is being contested in federal court, several states are passing measures to ensure coverage and expand access to birth control. If passed, the rule would allow non-religious organizations to be exempt from the contraceptive coverage requirements. It would also lead to inconsistent coverage options for women from state to state. Find out where your state stands now.

The ACA mandates that health insurers provide birth control free of cost to their enrollees (no cost-sharing). If President Trump's rule takes affect, it would allow *any* employer with religious or moral objections to be exempt from the ACA contraceptive requirements. States such as California, Illinois and Maryland have passed measures to ensure birth control coverage, even if the federal mandate is rescinded. Other states such as Florida, Texas and Colorado have little to no birth control requirements. Women in these states would be severely impacted and could find themselves in contraception deserts.

See your state's contraceptive coverage and cost-sharing requirements below.

Cost-Sharing	
States that Allow Cost-Sharing	**States that Prohibit Cost-Sharing**
Colorado	California
Georgia	Illinois
North Carolina	Maryland
New Jersey	Oregon (starting in 2019)
Ohio	
Texas	
Tennessee	
Washington	
Wisconsin	

Coverage Requirements		
States with Little to No Coverage Requirements		**States with Coverage Requirements**
Colorado	New Jersey	California
Florida	Ohio	Illinois
Georgia	Tennessee	Maryland
Illinois	Texas	New York
Kansas	Washington	Minnesota
Kentucky	Wisconsin	Massachusetts
		Oregon (starting 2019)

Health Provisions in Federal Spending Bill

On March 23rd, Congress passed a spending bill to fund the federal government through September 2018. The bill is a significant departure from President Trump's proposed budget, which proposed major payment cuts to federal health care agencies and programs. Below is an outline of the health care provisions included in the bill.

Medicare Appeals Backlog

- $182 million to reduce the Medicare appeals backlog.

Graduate Medical Education (GME)

- $315 million for the Children's GME, a $15 million increase from Fiscal Year (FY) 2017.

Mental Health

- $1.1 billion, a $700 increase from FY 2017, for states and school districts to expand school-based mental health services, bullying and violence prevention initiatives.
- $186 million for other Safe School programs, a nearly $35 million increase from FY 2017.

Opioid Use

- $3.6 billion to combat the opioid crisis, an increase of $2.55 billion from FY 2017. This includes:
  - $330 million for law enforcement grant programs.
  - $500 million to supplement the State Targeted Response to the Opioid Crisis grants.
  - $500 million for the NIH for researching non-addictive pain relief options.

Rural Health

- $130 million for the Rural Communities Opioid Response.
- $52 million for rural telehealth and distance learning grants.

Food Security

- $74 billion in mandatory funding for SNAP.
- $24.3 billion in mandatory funding for child nutrition programs.
- $6.18 billion in discretionary funding for the Women, Infants, and Children (WIC) program.

Biomedicine

- $710 million to support the development of new medical products for preparedness and biodefense.

Hospital Preparedness

- $264 million for the Hospital Preparedness Program, a $10 million increase from FY 2017.

Department of Health and Human Services' Agencies

- $37 billion for the NIH, a $3 billion increase from FY 2017.
- $60 million for the Office of the National Coordinator (ONC) for Health Information Technology, the same as in FY 2017.
- $2.9 billion in discretionary funding for the U.S. Food and Drug Administration (FDA), a $135 million increase from FY 2017.
- $334 million for the Agency for Healthcare Research and Quality (AHRQ), a $10 million increase from FY 2017.
- $7 billion for the Health Resources and Services Administration (HRSA), a $550 million increase from FY 2017.
- $28 billion for the Administration for Children and Families (ACF), a $4 billion increase from FY 2017.

HRSA Seeks More Authority to Change the 340B Program

In its Budget Justification to Congress, HRSA asked legislators to allow the Agency to 1) impose a 0.1% user fee of the total 340B drug purchases paid by 340B entities; 2) set new standards for participating in the 340B program; 3) require 340B entities to report both the savings and their uses to HRSA; and 4) amend the 340B statute to "improve program integrity and ensure that the program benefits patients, especially low-income and uninsured patients." Although this request has not been approved, changes to the 340B program are likely to happen.

Regulatory Corner

Medicare Advantage and the Prescription Drug Benefit Program 2019 Update. CMS issued a final rule that updates Medicare Advantage (MA) and the prescription drug benefit program (Part D). The rule gives MA plans a 3.4% pay hike in 2019. It also increases the use of encounter data to determine risk scores for plans from the 2018 blend of 15% encounter data and 85% fee-for-service data to 25% on encounter data and 75% traditional fee-for-service data.

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