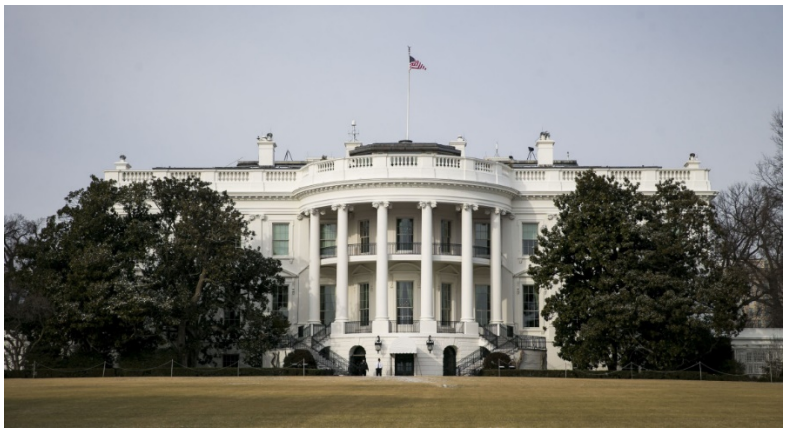
Policy Brief

June 28, 2019



Trump Administration Releases Executive Order on Price Transparency

On Wednesday, President Trump signed an Executive Order aimed at giving consumers increased access to the price of health care services. According to the President, "More transparency will mean more competition and the cost of health care will go way, way down." Among other policies, the Order instructs the Department of Health and Human Services (HHS) to issue a proposed rule requiring hospitals to disclose standard charge information based on negotiated rates. This rule is expected to be released within the next 60 days, revealing additional details on how the policy would be implemented. Below are key highlights from the Order.

Hospital Disclosure of Standard Charge Information

- Instructs HHS to issue a proposed rule requiring hospitals to publicly post standard charge information, including charges based on negotiated rates, for common or shoppable items and services.
- The information posted should be shared “in an easy-to-understand, consumer-friendly, and machine-readable format using consensus-based data standards.”

Disclosure of Out-of-Pocket Costs

- Directs HHS to issue a report within 180 days showing how the federal government and/or private sector are impeding access to health care price and quality information, along with recommendations to address identified barriers.

Surprise Medical Billing

- Directs HHS to submit a report within 180 days on additional steps that the Administration could take to implement its surprise medical billing principles.

Quality Road Map

- Instructs HHS and the Departments of Defense and Veteran Affairs (VA) to develop a "roadmap" to improve and align the quality measures used in Medicare, Medicaid, the Children's Health Insurance Program, the Health Insurance Marketplace, the Military Health System and the VA.

Health Care Data

- Directs HHS to increase access to de-identified claims data from public and private health plans within 180 days.

Health Savings Accounts

- Instructs the Department of Treasury to issue guidance within 120 days expanding access to high-deductible health plans and Health Savings Accounts.

House Approves Health Care Spending Package

The House of Representatives has passed a massive spending package for FY 2020 that includes funding for the HHS. The bill's 667 pages delineate funding for the country's health care agencies, including the Centers for Medicare and Medicaid Services (CMS), the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC). The bill also sets aside Federal dollars for education, defense and environmental health. The spending package now heads to the Senate, where it will need

bipartisan support to pass. Below are highlights of the bill's health care provisions and more on what's next to avoid a government shutdown.

What's in the package?

Totaling nearly $1 trillion, the appropriations legislation includes an increase of $8.9 billion dollars for HHS' 2020 budget. The package also contains:

- Support for research initiatives tackling Alzheimer's disease, HIV/AIDS and firearms fatalities;
- Increased CDC funding for public health data, food security and emergency preparedness;
- Nearly $6 billion for the Substance Abuse and Mental Health Services Administration's continued work on childhood trauma and Substance Use Disorders;
- An increase of $20 million for the Agency for Healthcare Research and Quality (AHRQ);
- Redistribution of $100 million in ACA carryover funds to support the Navigators program;
- An additional $114 million for the Title X Family Planning program;
- A total of $1.2 billion for the Health Resources and Services Administration's workforce development initiatives.

What happens next?

The bill, which passed along party lines, will need to gain bipartisan support in the Senate. It will likely need to change significantly to pass—especially because the bill lacks funding for the President's immigration priorities, includes protections for abortion care (while still preserving the Hyde Amendment) and exceeds the President's proposed budget request by $47.9 billion. Congressional leaders hope to have a funding package passed before October to avoid another government shutdown.

Is There a Place for Blockchain in Health Care?

The Food and Drug Administration (FDA) recently selected five companies, including KPMG, Merck and Walmart, to take part in a blockchain program in support of the U.S. Drug Supply Chain Security Act (DSCSA). The new blockchain technology will allow the stakeholders to share real-time prescription and vaccine distribution information, reducing the operational costs of maintaining separate databases. More

companies are testing blockchain because it can increase transparency, reduce redundancies and reconcile different data sets, but it is currently too slow and costly to be scalable. Will these pilots pave the way for the adoption of blockchain in health care? Below is more about blockchain, early initiatives and the barriers to adoption in health care.

What is Blockchain?

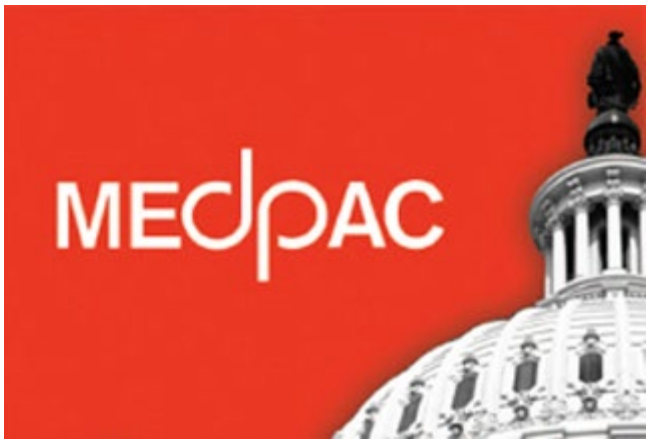
Blockchain is a tool that decentralizes information by sharing the same record of the transaction history, or "block", with each blockchain network participant. Every time participants exchange or update information, everyone else in the network will automatically receive a new, time-stamped "block" of history. If any participant alters their history "block", it would become inconsistent with the other participants' "blocks", which eliminates the possibility of bad actors or corruption. This makes blockchain ideal for increasing information transparency and overcoming issues such as information blocking.

Early Blockchain Pilots

The disruption that blockchain can bring to health care is encouraging several companies to run early pilots. In June 2018, five companies, including Optum, Humana and Quest, formed the Synaptic Health Alliance to pilot a blockchain-enabled provider directory. Since blockchain doesn't need a middleman, if one member of the alliance updates their directory, it would automatically update the directories of everyone, reducing operational costs. Medblox, a medical record startup, is exploring ways to give patients more control of their records through blockchain technology. HHS is also reportedly testing blockchain technology and hopes to scale it.

Blockchain Adoption Barriers

There are many barriers that currently prevent companies from scaling the technology on a large level, including that it is slow and relatively immature at this stage. Blockchain can only process three to seven transactions per second compared to current technologies in the market that can process thousands of transactions per second. Additionally, the same complex algorithms that keep blockchain secure also require it to use a large amount of computing power, using more energy than 159 nations. Companies are also slow to invest in blockchain because of the potential lack of interoperability among different platforms due to the lack of standardization among developers. While many are waiting to see who can make blockchain work before they invest, we will likely see more pilots by those who want to disrupt the market in the near future.



MedPAC Releases June Report

The Medicare Payment Advisory Commission (MedPAC), an influential advisory board, recently released its June report to Congress. While MedPAC's recommendations are not always adopted, these reports often inform policies considered by both Congress and HHS. Below are key recommendations included in MedPAC's June report. For more information, view the full report.

Emergency Care

- Develop and implement a set of national guidelines for coding hospital ED visits under the Outpatient Prospective Payment System (OPPS) by 2022. The Commission notes that in recent years, the coding of ED visits has steadily shifted to higher levels even though the conditions treated in EDs have not changed.

Primary Care Physicians

- Establish programs to recruit physicians that provide primary care to Medicare beneficiaries, such as geriatricians. The Commission notes that while there are federal scholarship and medical loan-assistance programs, these are not Medicare-specific.

Payment Issues in Post-Acute Care

- Develop a common set of requirements for all Post-Acute Care (PAC) providers to comply with. Providers that treat patients with specialized needs, such as those requiring ventilator, could be required to meet a second tier of requirements.
- If and when transitioning to a unified payment system for the PAC setting, adopt a stay-based payment design that establishes payments for each PAC stay.
- Develop a PAC Value-Based Purchasing Program and an Accountable Care Program. Potential measures could include rates of potentially preventable readmissions, Medicare Spending Per Beneficiary and rates of discharge to community.

- Adopt alternative measures to capture a patient's functional status that do not rely on provider-completed assessments. The Commission also questioned "whether Medicare should base payments on a factor of care that is firmly in a provider's control." (See the text box on pages 318-319 of MedPAC's report for additional details on the recommended strategies.)

Advanced Practice Registered Nurses and Physician Assistants

- Eliminate "incident to" billing for Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs) to better understand which providers are furnishing care to beneficiaries and increase Medicare savings.
- Improve the collection of specialty designation information for APRNs and PAs. The Commission notes that currently Medicare has limited data on the specialties in which APRNs and PAs practice.

Medicare Advantage

- Establish thresholds for the completeness and accuracy of Medicare Advantage (MA) encounter data.
- For the MA value incentive program, use a small set of population-based outcome and patient experience measures to evaluate quality.

Update on Surprise Billing Legislation

Congress continues to deliberate how to address surprise billing in health care. Most recently, the Senate's Health, Education, Labor and Pensions Committee (HELP) passed an updated version of their legislation, the "Lowering Health Care Costs Act." In addition to prohibiting balance billing, the bill establishes a benchmark payment rate for insurers to pay out-of-network providers. The benchmark would be based on the local median contracted commercial rate by geographic area, which would result in lower payments to health providers. In contrast to the original version, the bill now does *not* include the development of an arbitration process to dispute payment rates. The Committee passed the bill with a 20-3 vote and seeks a full Senate vote by the end of July. To view the legislation, click here, and for the Committee's section-by-section summary, click

A Look at the Federal Register

Health Professional Scholarship Program

The Department of Veterans Affairs (VA) is seeking comments on a proposed rule amending the regulations governing the Health Professional Scholarship Program. Under the proposal, the VA would be required to award a minimum of 50 scholarships each year to students pursuing physician or dentistry programs, until the staffing shortages in these areas are reduced. For every year in which a student receives funding, they will be required to serve within the VA after graduation for 18 months. **Comments are due August 26, 2019.**

Standards for Future Opioid Analgesic Approvals

The FDA is seeking comments and holding a public hearing on ways to improve pain management while addressing the opioid crisis. Stakeholder input is sought on the approval process for analgesic drugs, how the FDA might best consider existing armamentarium of therapies, potential new preapproval incentives and new treatments for Substance Use Disorder. The public hearing will be held on September 17, 2019. **Comments are due November 18, 2019.**

Medicare Program: Secure Electronic Prior Authorization for Medicare Part D

CMS is seeking comments on a proposed rule that would set a new transaction standard for Medicare Part D's e-prescribing program. If finalized, this rule would require Part D plan sponsors' support of version 2017071 of the National Council for Prescription Drug Programs SCRIPT standard for electronic Prior Authorizations (ePA). CMS believes that this will result in better standardization of data, reduced user error and will work well for most EHR systems. **Comments are due August 16, 2019.**

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