Policy Brief

July 26, 2019

Presidential Hopefuls Unveil Health Care Proposals

Last week, Former Vice President Joe Biden released a plan to increase access to care by building on the Affordable Care Act (ACA). Biden isn't the only one to debut a new health care proposal. In the wake of the latest debates, Senators Kamala Harris and Cory Booker have also shared their ideas on ways to improve the American health care system. Touching on either access, rising drug costs or long-term care, each plan attempts to solve top-ranking health care concerns for various voter groups. Below are highlights from the newest candidate proposals.

Biden's Public Option

Biden's plan runs contrary to other proposals previously seen from within his party. Instead of a single-payer system, Biden's proposal creates an ACA public option and removes the income cap from the premium tax credit. Instead of a cap, anyone who spends more than 8.5% of their income on premiums would be eligible for tax credit. The plan would also auto-enroll patients caught in the "coverage gap" in the public option at no additional cost. People in non-expansion states who are ineligible for Medicaid and tax credits would automatically be enrolled, as would anyone who would have been eligible for Medicaid if their state had expanded. Controversy exists around this idea as it would mean that non-expansion states get for free what other states pay a percentage for under Medicaid expansion.

Harris' Strategy to Lower Drug Prices

Sen. Harris set her sights on lowering the cost of drugs, something nearly one-in-four patients say inhibits them from following doctors' orders. Under her proposal, pharmaceutical companies would no longer get

a tax credit for advertising. The Department of Health and Human Services (HHS) would be able to set upper limits on the sticker prices for drugs based on international benchmarks like Germany, Norway and the United Kingdom. Any profits made by the drug company in excess of this limit would be taxed at 100% and returned to the consumer.

Booker's Plan for Long-Term Care

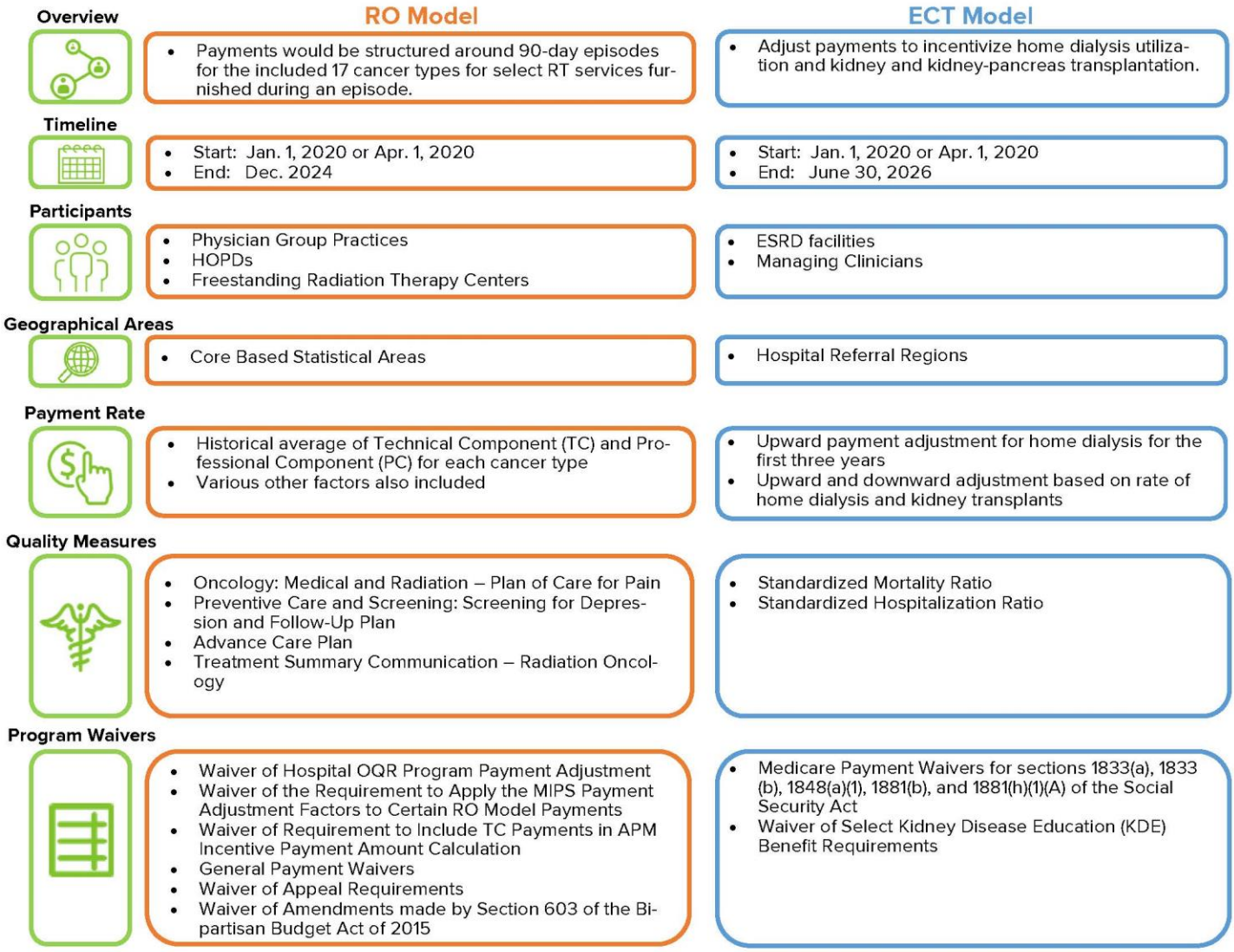
Sen. Booker focuses on increasing access to long-term care, a priority for a voter group he is trying to engage—older Americans. First, his proposal makes care more affordable for patients by increasing Medicaid asset and income limits. Second, it increases compensation for caregivers and long-term care employees. For caregivers, the Earned Income Tax Credit is expanded to cover more expenses. For employees, a minimum hourly rate is guaranteed of $15 plus full workplace benefits. Booker's plan also extends long-term care to disabled patients.

Six New Payment Models, Two Mandatory

On July 10th, CMS released four new voluntary payment models for kidney care and a Request for Information (RFI) for two new mandatory payment models for Radiation Oncology (RO) and End Stage Renal Disease (ESRD). The models on kidney care coincided with President Trump's Executive Order aimed at streamlining the kidney care and transplantation system. CVS is already capitalizing on the Administration's push for kidney care at home by recently launching a clinical trial for a new home dialysis device. The RFI for the two new models is due September 16th and a detailed summary can be found here. Below is more information on the six new models.

HHS Secretary Alex Azar had previously stated that the agency wanted to build on the successes of the Comprehensive Joint Replacement (CJR) model and referenced radiation oncology as a new possible model. The mandatory RO model has a similar episode-based payment structure but differs from CJR in aspects such as the method for choosing participating regions. The mandatory ESRD Choice Treatment (ECT) model bases payments on rates of home dialysis and kidney transplantation, incentivizing higher utilization of these services. The four voluntary kidney care models, Kidney Care First (KCF) and the Comprehensive Kidney Care Contracting (CKCC) models, are also similarly structured to the Primary Care First and Direct Contracting models. Below is a table that breaks down the mandatory RO and ECT models.

(Click on the table below to enlarge it.)



	RO Model	ECT Model
Overview	• Payments would be structured around 90-day episodes for the included 17 cancer types for select RT services furnished during an episode.	• Adjust payments to incentivize home dialysis utilization and kidney and kidney-pancreas transplantation.
Timeline	• Start: Jan. 1, 2020 or Apr. 1, 2020 • End: Dec. 2024	• Start: Jan. 1, 2020 or Apr. 1, 2020 • End: June 30, 2026
Participants	• Physician Group Practices • HOPDs • Freestanding Radiation Therapy Centers	• ESRD facilities • Managing Clinicians
Geographical Areas	• Core Based Statistical Areas	• Hospital Referral Regions
Payment Rate	• Historical average of Technical Component (TC) and Professional Component (PC) for each cancer type • Various other factors also included	• Upward payment adjustment for home dialysis for the first three years • Upward and downward adjustment based on rate of home dialysis and kidney transplants
Quality Measures	• Oncology: Medical and Radiation – Plan of Care for Pain • Preventive Care and Screening: Screening for Depression and Follow-Up Plan • Advance Care Plan • Treatment Summary Communication – Radiation Oncology	• Standardized Mortality Ratio • Standardized Hospitalization Ratio
Program Waivers	• Waiver of Hospital OQR Program Payment Adjustment • Waiver of the Requirement to Apply the MIPS Payment Adjustment Factors to Certain RO Model Payments • Waiver of Requirement to Include TC Payments in APM Incentive Payment Amount Calculation • General Payment Waivers • Waiver of Appeal Requirements • Waiver of Amendments made by Section 603 of the Bipartisan Budget Act of 2015	• Medicare Payment Waivers for sections 1833(a), 1833 (b), 1848(a)(1), 1881(b), and 1881(h)(1)(A) of the Social Security Act • Waiver of Select Kidney Disease Education (KDE) Benefit Requirements

Balance Billing Legislation Moves in the House

Last week, the House Energy and Commerce Committee passed a bill to address the issue of balance billing. H.R.3630, introduced by Republican Leader Walden (R-OR) and Chairman Pallone (D-NJ), was incorporated into H.R.2328, the "Reauthorizing and Extending America's Community Health Act." The bill, which originally did not allow for arbitration, was passed with an amendment that will allow insurers and health providers to dispute out-of-network payments. However, only claims that are worth more than $1,250 would qualify for arbitration. The bill still has a long way to go — it needs to pass the House floor and potentially be reconciled with the Senate's balance billing legislation, which does not contain an arbitration provision. For a comparison of H.R.2328 and S.1895, click here.

A Look at the Federal Register

Revision of Categorical Eligibility in the Supplemental Nutrition Assistance Program (SNAP). The USDA seeks comments on a proposed rule modifying the categorical SNAP eligibility requirements based on receipt of Temporary Assistance for Needy Families (TANF) benefits. Cash and non-cash eligibility would be limited to households that receive "ongoing and substantial benefits." The proposed rule defines these as benefits spanning a period of at least six consecutive months and more than $50 per month (for cash benefits). Non-cash benefits must be those that provide subsidized employment, work supports or childcare. **Comments are due September 23, 2019.**

Children's Hospitals Graduate Medical Education (CHGME) Payment Program. HRSA seeks comments on the addition of four forms to the existing 25 forms required for the CHGME payment program. The additional forms are: (1) HRSA 99-2 Initial and HRSA 99-2 Reconciliation, (2) Exhibit 2 Initial and Reconciliation and Exhibit 2 FTE Resident Assessment, (3) Exhibit 3 Initial and Reconciliation and Exhibit 3 FTE Resident Assessment, and (4) Exhibit 4 Initial and Reconciliation and Exhibit 4 FTE Resident Assessment. **Comments are due September 9, 2019**.

Methods for Assuring Access to Covered Medicaid Services-Rescission. CMS seeks comments on a proposed rule that would remove the requirement for states to document whether Medicaid payments in fee-for-service systems are sufficient to enlist enough providers to assure beneficiary access to covered care and services. According to CMS, this requirement could be met through information reported in State Amendment Plans. **Comments are due September 13, 2019.**

Requirements for Long-Term Care Facilities: Regulatory Provisions to Promote Efficiency, & Transparency. CMS seeks comments on a proposed rule that would revise long-term care requirements that the Agency has identified as unnecessary, obsolete, or excessively burdensome. **Comments are due September 16, 2019.**

CY 2020 Home Health Prospective Payment System (PPS) Rate Update; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; and Home Infusion Therapy Requirements. CMS seeks comments on a proposed rule that would update the payment rates and wage index for home health for CY 2020. The rule would also implement the Patient-Driven Groupings Model (PDGM), a revised case-mix adjustment methodology for home health services beginning on or after January 1, 2020. Additionally, CMS proposes to modify the payment regulations pertaining to the content of the home health plan of care; allow physical therapy assistants to furnish maintenance therapy; and change the split percentage payment approach under the home health PPS. **Comments are due September 9, 2019.**

Revision of Requirements for Long-Term Care Facilities: Arbitration Agreements. CMS released a final rule that amends the requirements that Long-Term Care (LTC) facilities must meet to participate in the Medicare and Medicaid programs. Specifically, CMS is repealing the prohibition on the use of pre-dispute, binding arbitration agreements. **The rule becomes effective on September 16, 2019.**

IN OTHER NEWS

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