Health Policy Update – June 2, 2021

Biden Administration Releases Long-Awaited FY 22 Budget Proposal

On May 28, President Biden unveiled his $6 trillion budget proposal for Fiscal Year 2022, the first of his administration. While the budget states the President supports reforms that would reduce drug prices by letting Medicare negotiate payment for certain high-cost drugs and requiring manufacturers to pay rebates when drug prices rise higher than inflation, it does not provide concrete details or formally include these proposals in the budget. Similarly, the budget also states the President supports creating a public option available through the Affordable Care Act marketplaces and expanding Medicare eligibility to those age 60 and older but does not provide further details or cost estimates.

The President's budget does include the $2.3 trillion American Infrastructure Plan and the $1.8 trillion American Families Plan released earlier this year. As part of the American Families Plan, the budget includes $163 million to extend the Affordable Care Act premium subsidies enhanced in the COVID relief bill passed in March.

President Biden's budget also provides more details and $6.5 billion for the proposed Advanced Research Projects Agency-Health (ARPA-H) within the National Institutes of Health. Modeled after the Defense Advanced Research Projects Agency (DARPA) in the Department of Defense, ARPA-H is intended to "fund projects with the potential to transform entire areas of medicine and health" with an initial focus on cancer, diabetes, and Alzheimer's. The budget says ARPA-H will boost progress towards treatments and cures by working with industry, academia, nonprofits, and other Federal agencies, using traditional and nontraditional mechanisms, and it describes an advisory panel that will encourage interagency coordination and idea generation.

The President's budget is primarily a request to Congress, highlighting the administration's policy priorities for the upcoming fiscal year. While the budget includes updated details on programs government-wide, new proposals and policy changes require subsequent regulations or legislative action before being enacted.

To view the President's budget for FY 22, CLICK HERE.

To view the Department of Health and Human Services Budget in Brief for FY 22, CLICK HERE.

Senate Confirms Chiquita Brooks-LaSure to Head CMS

On May 25, the Senate confirmed Chiquita Brooks-LaSure as the Biden administration's head of the Centers for Medicare & Medicaid Services (CMS). After her nomination was held up by some Senate Republicans who protested President Biden's policy to rescind a Medicaid waiver from the

state of Texas, five Republican senators crossed the aisle to vote in Brooks-LaSure's favor. She was confirmed on a 55-44 vote.

As the first Black woman to lead CMS, Brooks-LaSure brings years of health policy experience to the agency. She previously helped draft the Affordable Care Act (ACA) as a senior member of the staff of the House Ways and Means Committee, then worked to implement the law as deputy director for policy at the Center for Consumer Information and Insurance Oversight under President Obama. Her previous roles also include analyzing Medicaid policy at the Office of Management and Budget (OMB), serving as a director of coverage policy at the Department of Health and Human Services (HHS), and working as a Medicare and Medicaid policy consultant for Manatt Health.

Brooks-LaSure was formally sworn in by HHS Secretary Xavier Becerra on May 27.

To view Brooks-LaSure's biography, CLICK HERE.

Senate Finance Committee Holds Hearing on Telehealth as House Legislation is Introduced to Make Some Temporary Flexibilities Permanent

On May 19, the Senate Finance Committee held a hearing on the future of telehealth. Titled, "COVID-19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned," the hearing focused on how telehealth has been utilized throughout the COVID-19 pandemic and discussed the potential extension of waivers and flexibilities beyond the current public health emergency. Throughout the hearing, lawmakers and witnesses expressed strong support for the role that telehealth played during the worst of the pandemic - especially in terms of how the technology helped improve health equity - and expressed bipartisan hopes that at least some aspects of the temporary telehealth flexibilities be extended.

The use of telehealth drastically increased during the pandemic, according to Jessica Farb, Heath Care Director at the U.S. Government Accountability Office (GAO). In her testimony, she noted, "utilization of telehealth services in Medicare FFS sharply increased from about 325,000 services in mid-March to a peak of nearly 1.9 million services in late-April" before slowly dropping. However, she noted the long-term effects of the telehealth flexibilities on cost and patient outcomes are still not fully understood.

Without congressional action, many of the telehealth flexibilities granted during the COVID-19 crisis will expire once the public health emergency is declared over. On May 20, Representatives Jason Smith (R-MO) and Josh Gottheimer (D-NJ) introduced bipartisan legislation that would require Medicare to permanently cover audio-only visits. The Permanency for Audio-Only Telehealth Act (H.R. 3447) would also remove the geographic and originating site restrictions for Medicare beneficiaries to access audio-only telemedicine. Health equity advocates have noted that audio-only visits expand access for those without adequate broadband service or the technology to support video visits.

To watch the Senate Finance Committee hearing, CLICK HERE.

To read H.R. 3447, the Permanency for Audio-Only Telehealth Act, CLICK HERE.

Amid Concerns Over Accelerating Hospital Consolidation, Lawmakers Explore Policy Options

Growing concerns about the accelerating pace of hospital consolidation in recent years were on full display during the Senate Judiciary Subcommittee on Competition Policy, Antitrust, and Consumer Rights hearing titled, “Antitrust Applied: Hospital Consolidation Concerns and Solutions.” The hearing follows revelations that the nation’s largest hospital systems were among the biggest beneficiaries of federal COVID-19 relief funding despite the fact that many have seen their financial performance improve throughout the pandemic. This newfound financial windfall coupled with the struggling fortunes of many small and rural providers puts large hospital systems in an advantageous position to pursue more mergers and acquisitions – a practice that critics argue will drive up costs for patients and reduce incentives to provide quality care.

Witnesses at the hearing urged lawmakers to devote more resources to the Federal Trade Commission (FTC) and Department of Justice (DOJ) so they are better equipped to scrutinize transactions.

The committee recently approved legislation proposed by Senator Amy Klobuchar (D-MN) that would add $300 million each to the DOJ and FTCs antitrust enforcement budgets as well as strengthen prohibitions on anticompetitive conduct and mergers and make additional reforms to improve antitrust enforcement.

Other witnesses urged the continued implementation of site-neutral payment policies to level the playing field among independent practices and hospital-owned outpatient departments. Some witnesses also urged states to explore options such as repealing certificate of need laws, overhauling clinician licensing regulations and removing network adequacy laws that critics argue can stifle competition and innovation in the acute care sector.

To view the Senate Judiciary Subcommittee hearing, CLICK HERE.

To view a summary of Senator Klobuchar’s Competition and Antitrust Law Enforcement Reform Act, CLICK HERE.

Survey: Large Majority of Medical Groups Facing an Increase in Prior Authorization Since 2020

A new survey from the Medical Group Management Association (MGMA) found most medical groups reported an increase in prior authorization requirements since last year. Based on 716 responses, 81% of medical groups reportedly saw an increase in prior authorization, 17% said it stayed the same, and only 2% reported a decrease.

While CMS issued guidance allowing and encouraging Medicare Advantage plans to provide flexibility from prior authorization requirements to facilitate access to services during the COVID-19 pandemic, the MGMA survey indicates plans chose not to provide relief, even adding to provider burden as they struggled to remain open during this time.

On May 13, a bipartisan group of lawmakers in the House reintroduced the Improving Seniors' Timely Access to Care Act, which would require Medicare Advantage plans to make several reforms to standardize and streamline the prior authorization process, including establishing an electronic prior authorization program. The previous version of this bill introduced during the last Congress garnered 280 bipartisan co-sponsors and was endorsed by over 70 health provider and patient advocacy groups. Companion legislation is also expected in the Senate.

To view the MGMA prior authorization survey, CLICK HERE.

To view H.R. 3173, the Improving Seniors' Timely Access to Care Act, CLICK HERE.