Policy Brief

February 28, 2020

Work Requirements Rejected by Conservative Judge

The D.C. Circuit Court has ruled that work requirements, a Trump Administration policy priority, do not advance the primary purpose of Medicaid. Shifting Medicaid's purpose from increasing health care coverage to a secondary objective like "encouraging a healthy workforce" was deemed inappropriate by conservative Judge David Sentelle. This decision upheld the ruling of lower courts on the same case last March. While Judge Sentelle's ruling technically only applies to the Kentucky and Arkansas lawsuits, his opinion is likely to influence other states' Medicaid reform efforts.

First, a quick recap…

Kentucky and Arkansas both petitioned the Department of Health and Human Services (HHS) to add work requirements to their Medicaid programs through an 1115 waiver, prompting lawsuits from health advocacy groups in both states. Under the new leadership of Governor Andy Beshear, Kentucky decided not to move forward with its version of work requirements. Arkansas' initiative continued, making it the first state to implement both the requirements and the corresponding coverage penalties. In less than a year, the program resulted in lost coverage for more than 18,000 individuals.

Now, what's the latest?

Residents of Kentucky and Arkansas brought a joint action against HHS for failing to address how the demonstrations would achieve the *primary* goal of Medicaid—increasing access to medical care. Rather, the Court did not feel that Secretary Alex Azar's approval engaged with the coverage reductions in a sufficiently meaningful way. Judge Sentelle criticized the Secretary's analysis, saying, "Nodding to concerns raised by commenters only to dismiss them in a

conclusory manner is not a hallmark of reasoned decision-making." This latest ruling applies to Arkansas' work requirements, as Kentucky's demonstration has already ended.

What might this mean for other states?

The D.C. Circuit is largely seen as the top appeals court, dwarfed only by the Supreme Court itself. Despite the Trump Administration's promotion of work requirements, the Arkansas decision underscores that 1115 waivers implementing work requirements are likely to be successfully challenged in court. In a statement, HHS affirmed its commitment to state innovation and said it is determining next steps. Twenty states have proposed implementing work requirements in some fashion; however, a few are already suspending these initiatives until the final outcome of this legal battle is decided.

Proposed CJR 3-Year Extension

Last week, the Center for Medicare and Medicaid Services (CMS) released a proposed rule that would extend the Comprehensive Care for Joint Replacement (CJR) model for an additional three years. CMS is modifying several components of the model in the proposed rule such as including Total Knee Arthroplasty (TKA) and Total Hip Arthroplasty (THA) outpatient procedures. These procedures now account for roughly 25% of total knee replacements. Studies have shown this model to have overall success in lowering CJR episode payments by 3.7% and improving the quality of care for these services. CMS projects that these proposed changes could save the federal government $269 million over the three additional years. Below is more about the CJR model and what is changing.

Overview of the CJR Model

The CJR model started on April 1, 2016 to reduce expenditures and enhance the quality of Medicare beneficiaries' common hip and knee replacements. The extended mandatory model will continue to provide retrospective bundled payments for episodes of care of lower-extremity joint replacement or reattachment of a lower extremity. These bundled payments will also continue to cover all care for 90 days after discharge.

Key Proposed Changes

- Extend the model for an additional three years for the 34 mandatory Metropolitan Statistical Areas (MSAs). Low-volume or rural hospitals and hospitals in the 33 voluntary MSAs will not be included in the extension.
- Include outpatient procedures for TKAs and THAs by grouping these with the least complicated inpatient TKAs and THAs.
- Update the target price methodology to be based on the most recent year of data instead of the most recent three years.
- Move to an annual reconciliation process instead of the current biannual process.
- Update the reconciliation calculation by adjusting the target price using two patient factors, adding a retrospective market trend adjustment factor and changing the high episode spending cap calculation methodology.
- Reduce the discount factor based on a participant's composite quality score.
- Remove the 50% cap on gainsharing payments to physicians, non-physician practitioners and physician group practices.

Election Watch 2020: News from the Campaign Trail

The journey to the 2020 presidential election continues. Below are the latest updates from the campaign trail:

- Health policy continues to dominate the Democratic primary debates. Sen. Bernie Sanders (I-VT) drew much of the ire, with Sen. Elizabeth Warren (D-MA) criticizing him for not having a more detailed health policy plan.
- New polls find more than one-third of Democratic voters still list health care as the most important issue guiding their vote. So do 30% of independent and 28% of swing voters. For Republicans, the economy is polling as the most pressing concern.
- Fifteen states and territories will vote within the next week, with Super Tuesday falling on March 3rd.

A Look at the Federal Register

Comprehensive Care for Joint Replacement Model: Three Year Extension

CMS released a proposed rule that would extend the CJR model by another three years with some modifications including covering certain outpatient procedures and removing gainsharing caps. **Comments are due on April 24, 2020.**

Registration Requirements for Narcotic Treatment Programs with Mobile Components

The Drug Enforcement Administration (DEA) released a proposed rule revising the existing registration regulations for narcotic treatment programs with mobile components. Programs would no longer be required to file a separate registration for each mobile clinic used to deliver maintenance or detoxification treatments. **Comments are due on April 27, 2020.**

Removing Inability to Communicate in English as an Education Category

The Social Security Administration has released a final rule eliminating the education category "inability to communicate in English" from the evaluation indicators of disability claims. Whether or not an adult is able to communicate in English will no longer be the final step of the sequential evaluation process.

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