Political and Policy Trends

Impacts on Congress and CSD

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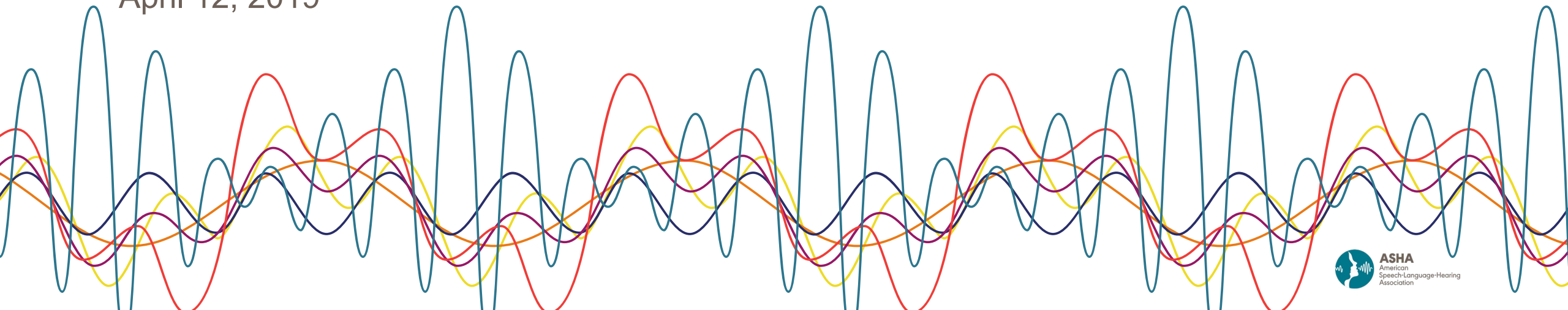
April 12, 2019



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Disclosure

Jeffrey P. Regan receives a salary as a full-time employee of the American Speech-Language-Hearing Association.

Jeffrey P. Regan has no other financial disclosures.

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Agenda

- The Political Landscape
- Political Trends
- Public Policy Trends
- What ASHA Is Doing for You
- We All Have a Voice!
- Questions

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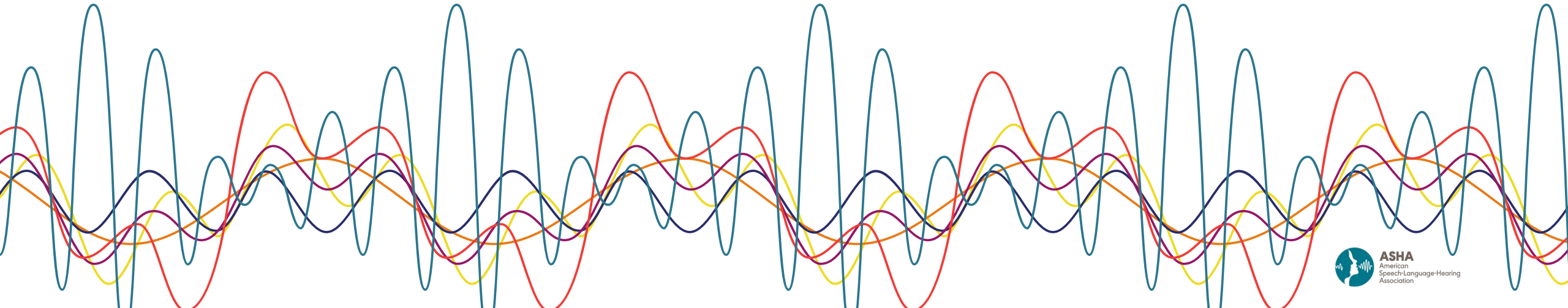
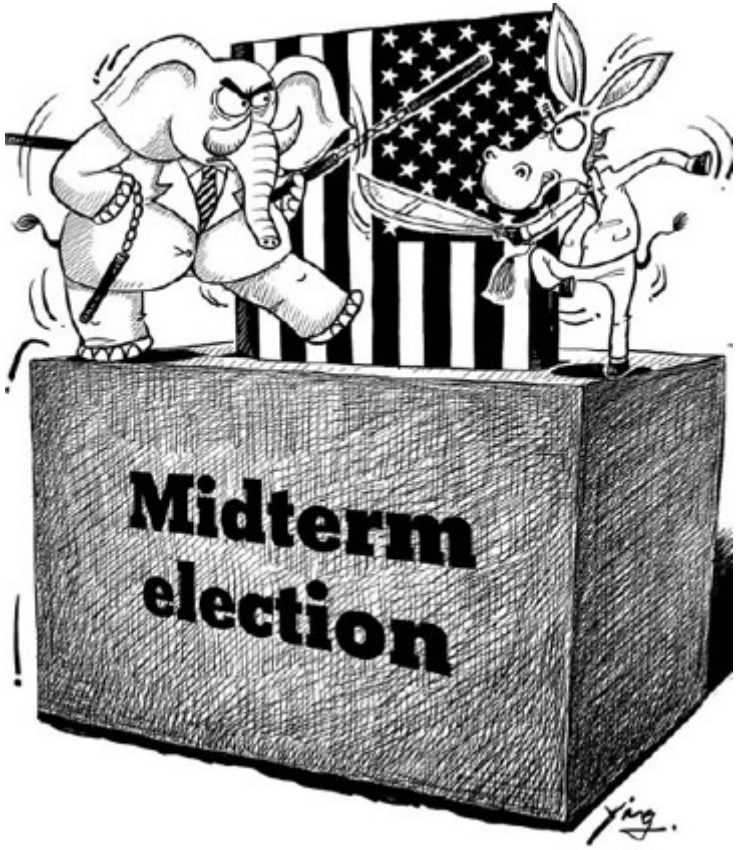
The Political Landscape



2018 Midterm Elections…



…have largely shaped the current political landscape

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2018 Election Results

- **House of Representatives**: **Democrats** picked up 40 seats (+17 majority)
- **Senate**: **Republicans** picked up 2 seats (+3 majority)
- **Governorships**: **Democrats** won 7 additional governorships nationwide
  - **Republicans** hold 27 seats
  - **Democrats** hold 23 seats
- **State Legislatures**: **Democrats** flipped 350 seats and 6 chambers
  - **Republicans** hold 23 “trifectas”
  - **Democrats** hold 14 “trifectas”
  - 13 states have divided government
  - 1 state (MN) has divided legislature

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2018 Election Takeaways

- Voter turnout (50.3%) was the highest since mid-term elections in 1914
- $5.2 billion spent – a 16% increase over the previous record ($4.4 billion in 2016)
- The President was clearly a political liability in suburban Congressional districts
- 127 women won races in Congress
- This was an election of “firsts”
  - youngest woman elected to Congress (Ocasio-Cortez in NY)
  - first Muslim women elected to Congress (Omar in MN, Tlaib in MI)
  - first Native American women elected to Congress (Davids in KS, Haaland in NM)

2018 Election Takeaways

Congress' demographics increasingly more reflective of the nation

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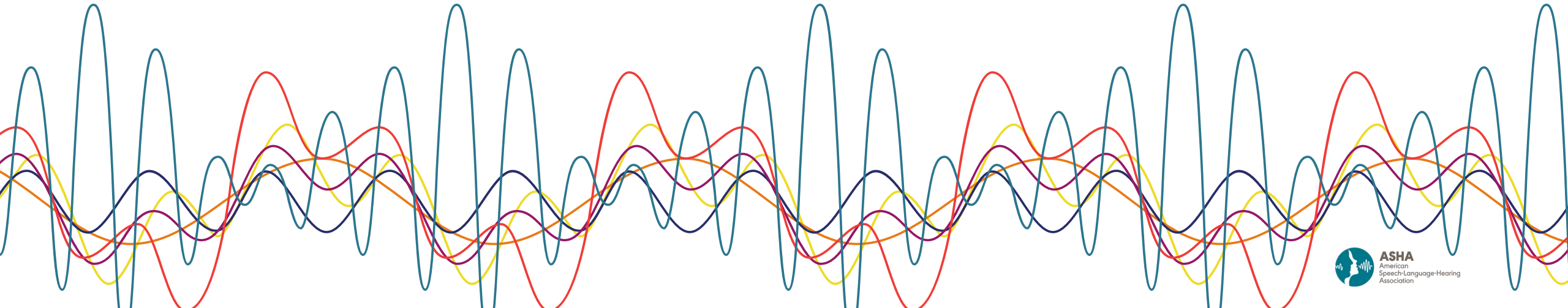
2018 Election Impacts

- **House of Representatives**
  - Dem majority difficult to lead; strong disagreements exist over party direction, priorities, and policies
  - Rep minority is more conservative than the Rep majority in previous Congress
- **Senate**
  - Rep majority is more conservative than in previous Congress; leadership showing deference to the President
  - Dem minority is more liberal than in the previous Congress
- **Trump Administration**
  - notably diminished support among swing voters; base support remains steady around 35%
  - no political leverage in House; limited leverage in Senate, especially for judicial appointments
- **States**
  - Red and Blue "trifecta" states likely to pursue divergent agendas with some exceptions (e.g., Medicaid)
  - Dems gain some political leverage in Congressional redistricting in 2020

Political Trends



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Continued Partisan Gridlock

- Divided Government
  - Republicans control White House, Senate, and 23 states
  - Democrats control House and 14 states
  - Slight conservative majority on Supreme Court
- Growing Ideological Divide between Republicans and Democrats
- Growing Ideological Divide within Republicans and Democrats
- 2020 Presidential election season
  - Legislation or powers of Congress used as a means to activate bases
  - Less willingness to compromise

Growing Populism

Populist (n): a member of a political party claiming to represent the common people

- populist activities growing **both** within the Republican and Democratic parties
- shared traits between populists on the ideological right and left:
  - Belief that the so-called political "establishment" has lost touch with the "common people"
  - Willing to challenge or disrupt government institutions
  - Willing to challenge or disrupt current norms, rules, or traditions of governing
  - Skeptical of the media
  - Preference for division over pluralism
- populist activities have already impacted budgetary and legislative processes, as well as the relationships between lawmakers, and between the President, lawmakers, and the media

The Never-Ending Election Cycle

- The 2020 Presidential election season began on **January 20, 2017**
  - the day of President Trump's inauguration
  - the day President Trump officially filed his campaign with the Federal Election Commission

- Joe Trippi, a noted Democratic strategist, made the following observation of the 2020 Presidential election season in February, 2019:

"This is a multilevel chess game with more candidates than anyone has seen…"

Looking Ahead to 2020

(almost) everyone wants to be President!

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Looking Ahead to 2020

Democrats

- multiple “hopefuls” in a **very** crowded field: Biden, Booker, Brown, Buttigieg, Castro, Delaney, Gillebrand, Harris, Klobuchar, Hickenlooper, Merkley, O’Rourke, Sanders, Warren
- The successful candidate will need, among other things:
  - Appeal across a broad and divisive base of voters
  - Unprecedented cash flow to sustain a lengthy primary season and the general election
  - Mastery of digital and social media

Republicans

- Trump is not a shoe-in for the 2020 nomination (Flake, Kasich, and Romney may launch a primary challenge)
- Can a so-called “establishment” candidate gather enough populist support?

The Never-Ending Election Cycle

- puts Washington, DC, and states in constant campaign mode
- distracts attention from legislative and public policy work
- legislation or powers of Congress chiefly used to activate political bases
- less willingness to compromise, especially in a time of divided government

Impacts on ASHA Priorities

- **Congressional** passage **very unlikely** but consideration **possible** for bills that repeal/replace the Affordable Care Act (ACA), implement "Medicare for all," reinstate the fine for the ACA individual mandate, end Medicaid expansion, eliminate Essential Health Benefits, or restrict states' ability to implement work requirements for Medicaid.

- **Congressional** passage **unlikely** but consideration **likely** for bills that reauthorize the Higher Education Act and Individuals with Disabilities Education Act.

- **Congressional** passage **possible** for bills that address coverage of services under Medicare.

- **State** action **very likely** on so-called short-term limited duration insurance plans, Medicaid expansion, Medicaid work requirements, occupational licensure review, and private certification.

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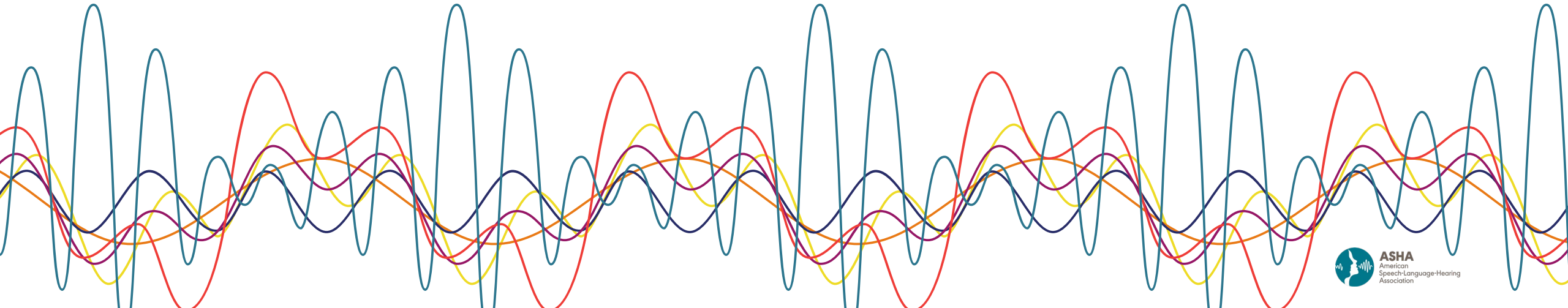
Public Policy Trends



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Medicare – A Primer (Parts A & B)

Part A: inpatient and hospital coverage

What does it cover?

- Part A covers health care costs once admitted to a hospital for a period of more than two midnights
- Insurance can cost as much as $407 per month for someone who does not qualify for Part A coverage

How much does it cost?

- The first 60 days are fully covered by Medicare after a deductible of $1,260 (rate in 2015)
- After 60 days, patients pay $315 per day in co-insurance, and then $630 per day beyond 90 days for 60 lifetime reserve days. After they are used up, Medicare pays nothing

Part B: outpatient and doctor coverage

What does it cover?

- Part B is insurance for regular health care visits and needs
- It covers most medically necessary doctors' services, preventive services, hospital outpatient services, laboratory tests, physical and occupational therapy, ambulance services and more

How much does it cost?

- Part B has an attached premium, which depends on your income bracket. The higher your income, the higher your premium, which ranges from $104 to $360 per month

Not covered by Part A or Part B

What isn't covered:

- Out-of-country medical care
- Hearing, vision, dental or podiatric care
- Cosmetic surgery
- Alternative treatments
- Custodial care (no assisted living without medical necessity)

Sources: National Journal research, 2018.

Medicare – A Primer (Part C)

Eligibility and coverage

An individual can typically join a part C plan if:

- They live in the service area of the plan they want to join
- They have Original Medicare
- They do not have end-stage renal disease, though this requirement has exceptions

Part C plans are Medicare-approved private health insurance plans for individuals enrolled in Original Medicare

Part C plans provide all of Part A and Part B coverage and generally offer additional benefits such as vision, dental, hearing and sometimes prescription drug coverage

Plan options available

Costs and services vary by plan. Plan options include:

- Health Maintenance Organizations (HMOs)
  - Contracts with a network of medical providers and limits coverage to these providers
- Preferred Provider Organizations (PPOs)
  - Similar to an HMO, but also covers non-network providers, either at a lower rate or for a higher cost
- Private fee-for-service (PFFS)
  - A plan offered by a private insurance company that pays medical providers for each service performed
- Special needs plans (SNPs)
  - Similar to HMOs and PPOs, but limit membership to people with specific conditions
- HMO point-of-service (HMO POS)
  - An HMO that provides out-of-network coverage for an additional fee
- Health savings account (HSA)
  - A type of savings account that lets individuals set aside money on a pre-tax basis to pay for qualified medical expenses

Sources: National Journal Research, 2018

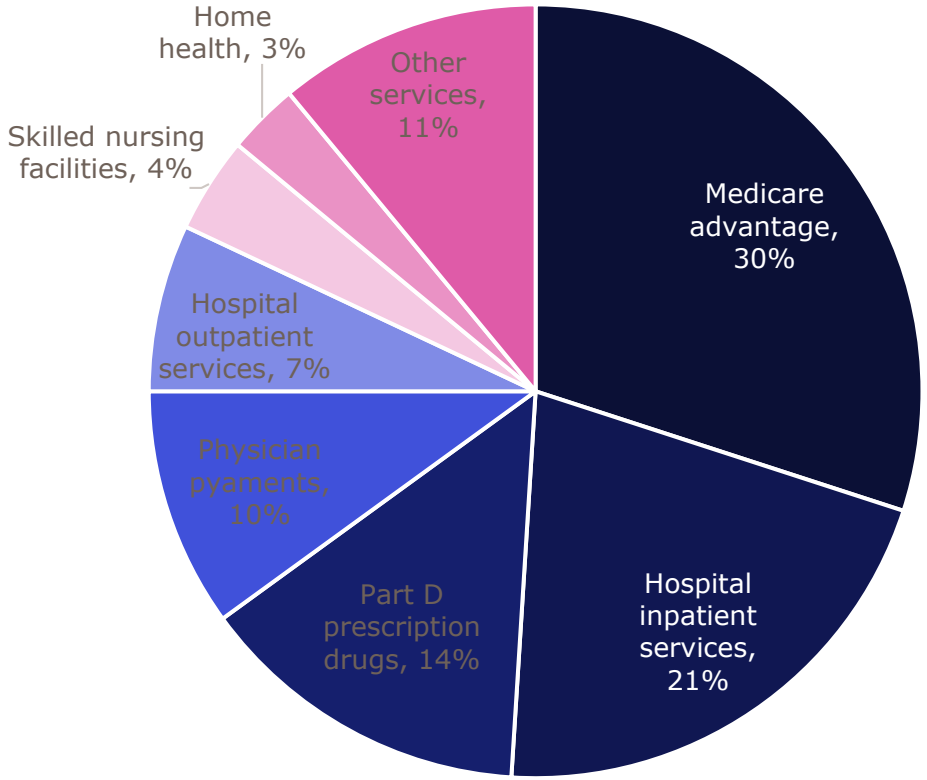
Medicare Spending Trends

Medicare benefit payments

IN BILLIONS

Medicare benefit payments by service type

DATA FROM 2016



Sources: Kaiser Family Foundation.

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Medicare Spending Trends

- Medicare spending was 15 percent of total federal spending in 2017, and is projected to rise to 18 percent by 2028

- In 2017, Medicare benefit payments totaled $702 billion, up from $425 billion in 2007

- As a share of total Medicare benefit spending, payments to Medicare Advantage plans for Part A and Part B benefits nearly doubled between 2007 and 2017, from 18 percent ($78 billion) to 30 percent ($210 billion), as enrollment in Medicare Advantage plans increased over these years

- Medicare per capita spending is projected to grow at an average annual rate of 4.6 percent over the next 10 years, due to growing Medicare enrollment, increased use of services and intensity of care, and rising health care prices

Sources: Kaiser Family Foundation.

Cost Containment Is A Driving Force Behind Medicare Policy Trends

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Medicare – MACRA and MIPS

Passed in 2015 and implemented in 2019, the Medicare Access and CHIP Reauthorization Act (P.L. 114-10) increased funding and changed the way physicians and other eligible health care providers (including audiologists and SLPs) are compensated for their work through the **Quality Payment Program**

Quality Payment Program

- Modernizes fee-for-service payments
- Meant to encourage comprehensive, continuous and coordinated care
- Changes the way Medicare rewarded clinicians for value over volume
- Streamlines multiple quality programs under the Merit Based Incentive Payments System (MIPS)
- Gives bonus payments for participation in eligible alternative payment models (APM)
- CMS raised the low-volume threshold under the program to exempt small practices from MIPS

Medicare – MIPS Reporting

- **Audiologists and SLPs are eligible for MIPS reporting in 2019**
- Participation in MIPS is required only for Medicare enrolled providers in non-facility settings that meet ALL of the following criteria:
  - $90,000 or more allowed charges for Medicare outpatient professional services
  - 200 or more distinct Medicare patients treated
  - 200 procedures conducted with Medicare patients
- **Approximately 100 ASHA members currently meet mandatory reporting criteria; however, this could change in coming years!**
- Audiologists and SLPs are scored on Quality (85%) and Clinical Practice Improvement (15%)
- Scoring may cause a positive or negative MIPS payment adjustment of 7%; members with a neutral performance score will receive no payment adjustment from the fee schedule
- Audiologists currently have 6 quality measures that they can report
- SLPs currently have 3 quality measures that they can report
- Future quality measures under consideration and/or development

Medicare – PDPM

- CMS has significantly revised its payment methodology for **skilled nursing facilities**
- CMS has moved away from payments based on the volume of services provided (e.g., therapy minutes)
- CMS is implementing the **Patient-Driven Payment Model (PDPM)**, which structures payments based on a patient's clinical characteristics
- Under the PDPM, payment for patients with speech-language pathology needs will be determined by the presence of the following five case-mix factors
  - the patient's primary diagnosis
  - the presence of one or more of ten comorbidities
  - a mechanically altered diet
  - a swallowing disorder, and/or
  - a cognitive impairment
- **It is imperative that the PDPM represents appropriate utilization and clinical practice of SLP services**

Higher Education in 2019

- Congress is expected to consider reauthorization of the Higher Education Act (HEA) in 2019
- passage of a comprehensive bill remains less likely
- The House and Senate are currently moving on separate tracks
- Congress will not be working off the so-called PROSPER Act from the 115th Congress
- **There are three issues of particular importance to COSD programs**:
  - access to graduate student loads
  - maintaining current programmatic accreditation standards
  - assessing “gainful employment” compliance with multiple factors, :
    - loan repayment
    - job growth
    - salary
    - career satisfaction
    - retention of professionals in field

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Interstate Compact

- An **interstate compact** is an agreement between states that would offer a pathway for licensure to qualified audiologists and speech-language pathologists who wish to practice in multiple states.

- An **interstate compact** eases the burden for:
  - members with multiple state licenses;
  - members who move from state to state;
  - military members/spouses;
  - traveling therapists; and
  - telepractitioners.

- An **interstate compact** reduces:
  - practitioner shortages;
  - costs of licensure in multiple states; and
  - administrative burdens on practitioners.

An interstate compact improves access to services

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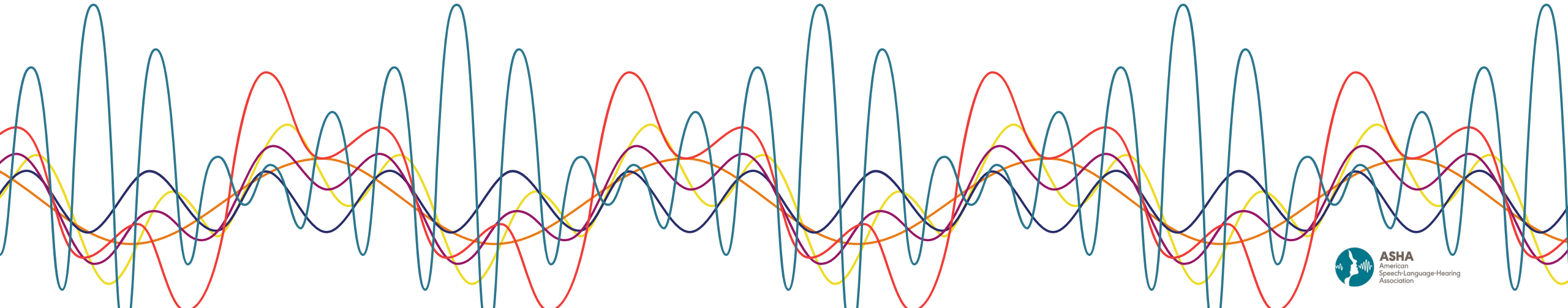
Interstate Compact

- ASHA has been collaborating with the Council on State Governments to develop an interstate compact model bill for audiologists and speech-language pathologists.
- 2019 will be a watershed year for these efforts
  - A model bill will be finalized by a member-led advisory committee
  - 8 to 10 states will be targeted later this year for implementation
- Interest remains strong in states for adoption of interstate compact agreements
- Other professions with interstate compact agreements in place include psychologists and physical therapists

Licensure and Certification

- Growing trend to challenge occupational licensure and private certification in the states
- Largely driven by an ideological belief that licensure and certification restrict personal liberty
- Examples of state efforts include:
  - placing burdensome occupational review requirements to discourage changes to current licensure requirements (IL)
  - requiring professions to be regulated by the least restrictive means (IN)
  - Requiring individuals who are not associated with audiology and speech-language pathology to oversee changes to the scope of practice or to perform a periodic review of the practice act (MA)
  - Prohibit professionals from identifying themselves as holding a professional certification like CCC-A or CCC-SLP (LA, MO)

What ASHA Is Doing for You



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ASHA's Public Policy Agenda

- developed annually by the Government Affairs and Public Policy Board with input from volunteer leaders, members, and staff; adopted annually by the ASHA Board of Directors
- functions to identify the "**what**" in terms of what are ASHA's advocacy priorities for the year
- guides ASHA staff to identify the "**how**" in terms of how those priorities are advanced

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ASHA's Public Policy Agenda

- Priorities for 2019 are categorized into 4 issue areas:
  - Health Care Issues
  - Schools Issues
  - Professional Practice/Workforce Issues
  - Consumer Issues

- The Government Affairs and Public Policy cluster advances advocacy priorities by identifying and collaboratively achieving meaningful objectives in the current political and fiscal climate.

ASHA's Public Policy Agenda

Select Health Care Issue Objectives

- Identify clear paths for audiologists and speech-language pathologists to participate in alternative payment models under Medicare
- Secure introduction of legislation that expands Medicare coverage of audiology services
- Secure introduction of legislative language that decouples physical therapy and speech-language pathology from the Medicare Part B manual medical review.
- Secure legislative language that expands Medicare coverage of audiology and SLP services delivered through telepractice
- Launch a campaign targeted to lawmakers, policymakers, and industry stakeholders about the appropriate use of speech language-pathologists and audiologists under PDPM.
- Engage state associations on STLD plans and continued coverage of habilitation and rehabilitation services.

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ASHA's Public Policy Agenda

Select Professional Practice/Workforce Issue Objectives

- Identify sponsors of model interstate license compact legislation in targeted states.
- Engage state associations and state licensing boards to ensure appropriate occupational licensing review, and the preservation of national certification of the professions of audiology and speech-language pathology.
- Support tuition assistance and loan forgiveness for undergraduate and graduate students in CSD programs.
- Support current programmatic accreditation standards for graduate CSD programs
- Support "gainful employment" compliance with multiple factors

We All Have a Voice!

We are all advocates with important voices!

- ASHA's advocacy portal: http://www.asha.org/advocacy
- *ASHA Headlines:* http://www.asha.org/Publications/ASHA-Headlines
- ASHA's *Take Action* service: http://takeaction.asha.org/?0
- ASHA-PAC: http://www.asha.org/Advocacy/PAC
- visits to Capitol Hill

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Questions?

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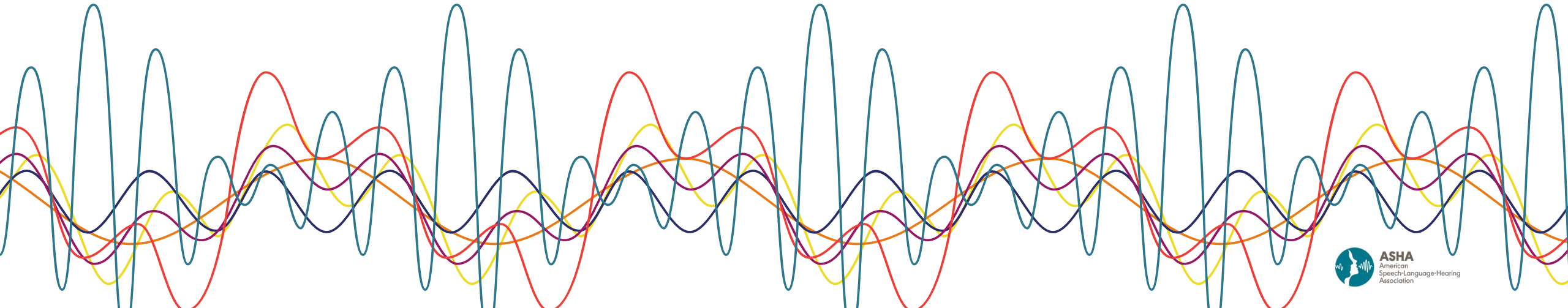

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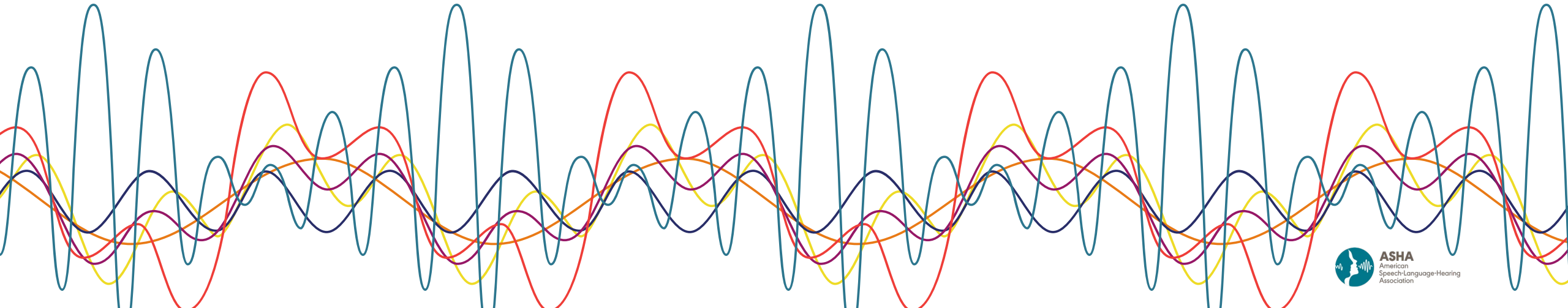

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