Federal Update/Medicare

Chad Mulvany, CHA
Katrina Pagonis, Hooper, Lundy & Bookman, PC

California Hospital Association

WASHINGTON UPDATE

Chad Mulvany
Vice President, Federal Policy
California Hospital Association

Katrina A. Pagonis
Partner
Hooper, Lundy & Bookman

Lloyd Bookman
Founding Partner
Hooper, Lundy & Bookman

Agenda & Objectives

Legislative

Regulatory

Discussion

Federal Update/Medicare

Legislative

Forecast: Continued Gridlock Likely

Passing legislation in the current environment is difficult due to multiple factors.

Sources:
https://www.cookpolitical.com/analysis/house/house-charts/house-open-seat-tracker
https://www.nytimes.com/interactive/2022/11/08/us/elections/results-senate.html?
https://www.house.gov/legislative-activity

Barriers to Legislating

Divided Government/Narrow Margins
House: **Rep–219**, Dem–213, Vacant 3
Senate: Rep–49, **Dem 51**, Vacant 0

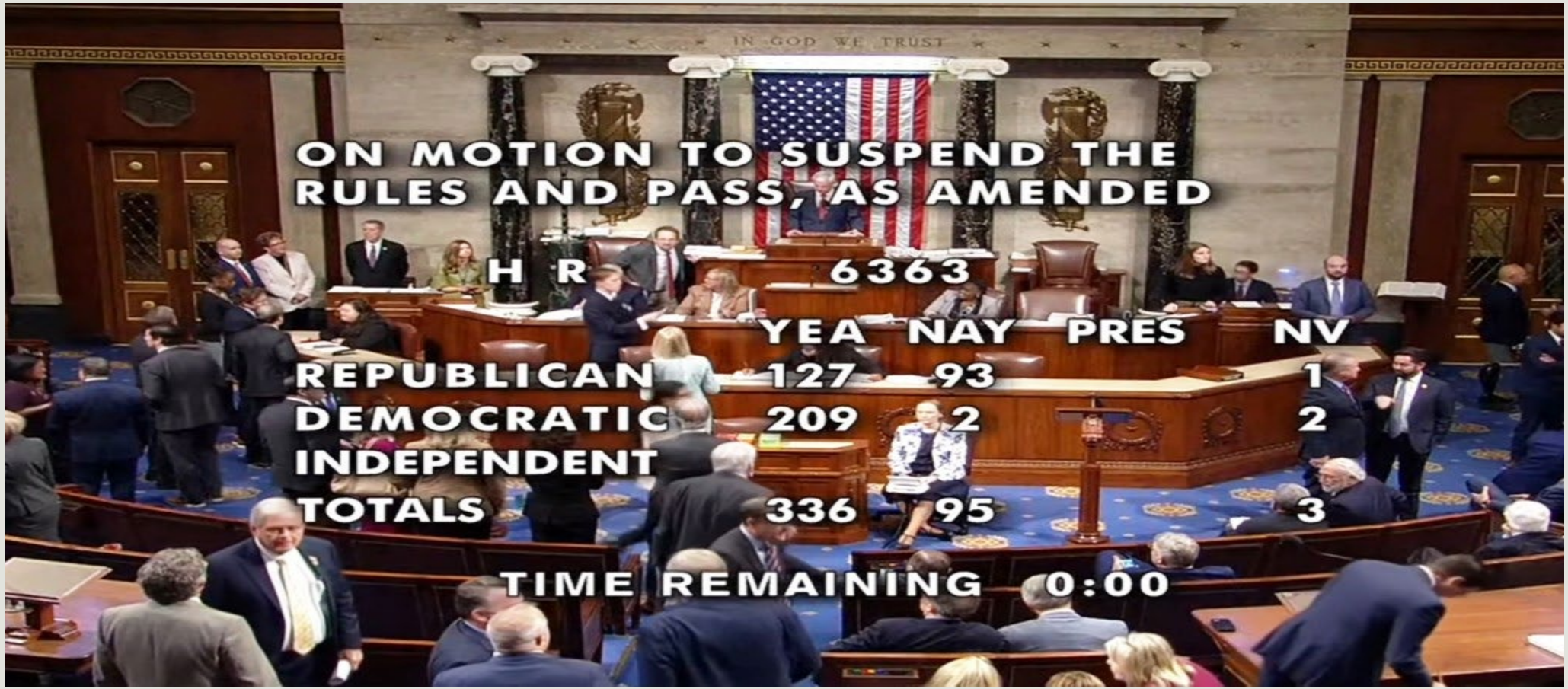
Legislative Days Until 2024 Election*
House: 72 Days
Senate: 79 Days

2024 Federal Election
Politics…

*As of March 4th

Federal Government Shutdown Averted…For Now

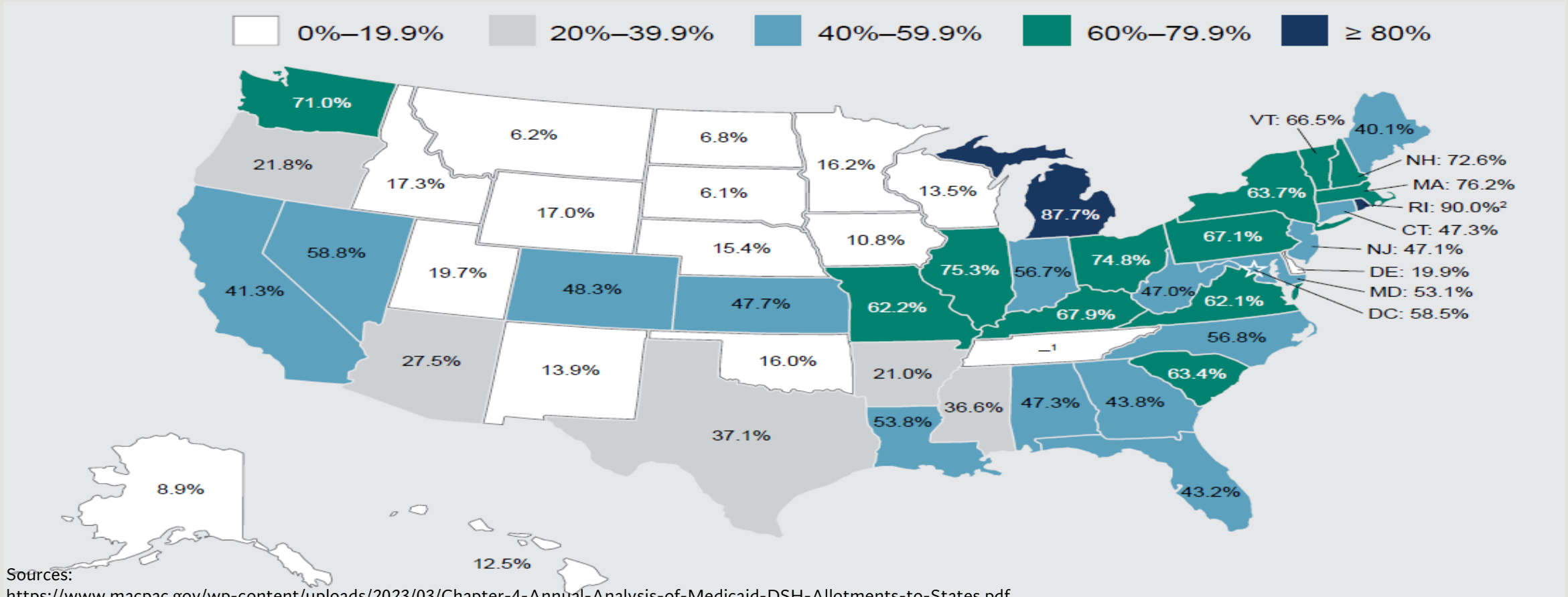
Congress passed a continuing resolution to fund portions of the federal government until March 8th and others until March 22nd



Medicaid DSH Cuts Delayed Until March 8th

Unless Congress intervenes further, Medicaid DSH payments will be cut by $8 billion in FFYs 2024 through 2027.

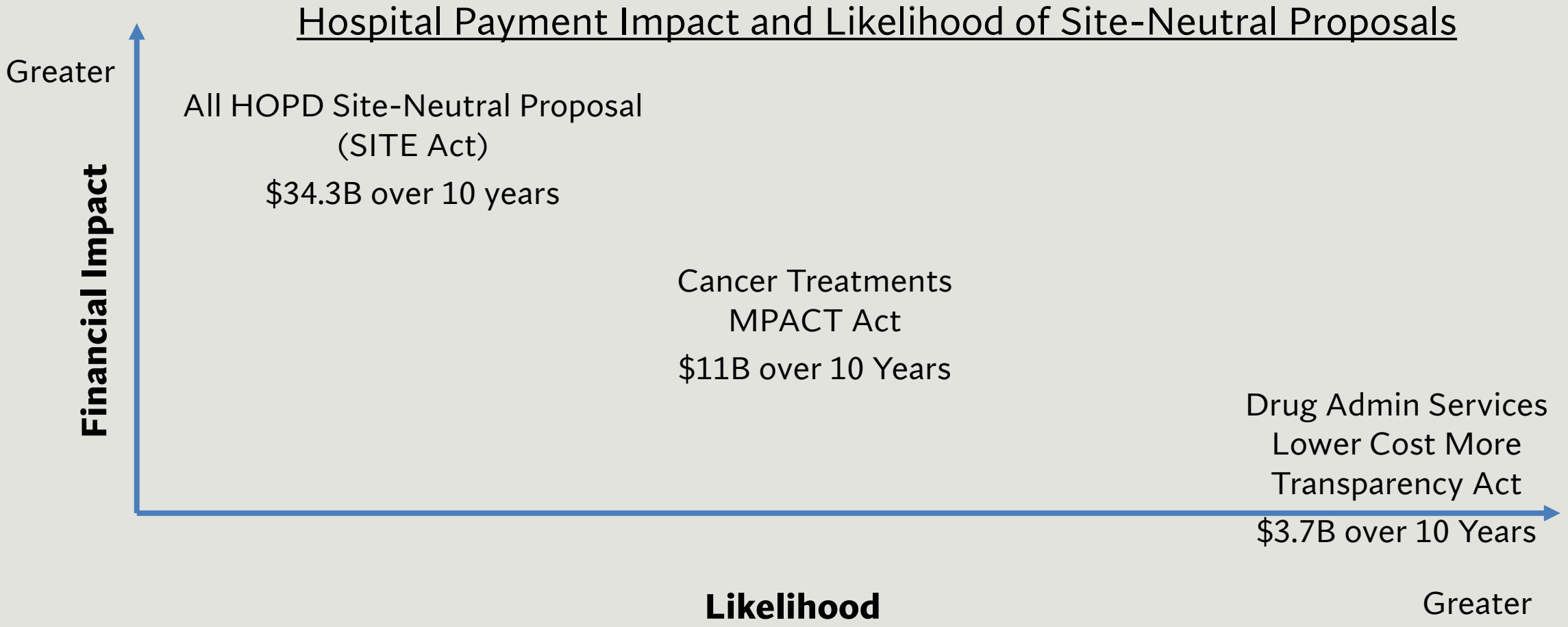
Decrease in State DSH Allotments as a Percentage of Unreduced Allotments by State, FY 2024



Sources:
https://www.macpac.gov/wp-content/uploads/2023/03/Chapter-4-Annual-Analysis-of-Medicaid-DSH-Allotments-to-States.pdf

Congress Considering Additional Site-Neutral Payments

A variety of site-neutral payment proposals that would harm access to care are under consideration

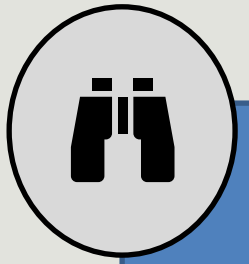


Sources:
https://www.aha.org/system/files/media/file/2023/05/fact-sheet-medicare-site-neutral-legislative-proposals-under-consideration-would-jeopardize-access-to-care-for-patients-and-communities.pdf

Other Legislative Issues to Watch

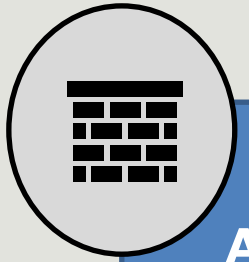
Congress is considering additional legislation that will impact hospital operations and patient access

340B Drug Discount Transparency



Hospital Price Transparency

340B Drug SUSTAIN Act



Medicare Advantage Prior Authorization Reform

Sources:
https://www.kaufmanhall.com/insights/research-report/benefits-integration-healthcare-time-rapid-transformation

Not-For-Profit Status Scrutinized

The community benefit standards continue to receive bipartisan interest from both houses of Congress.

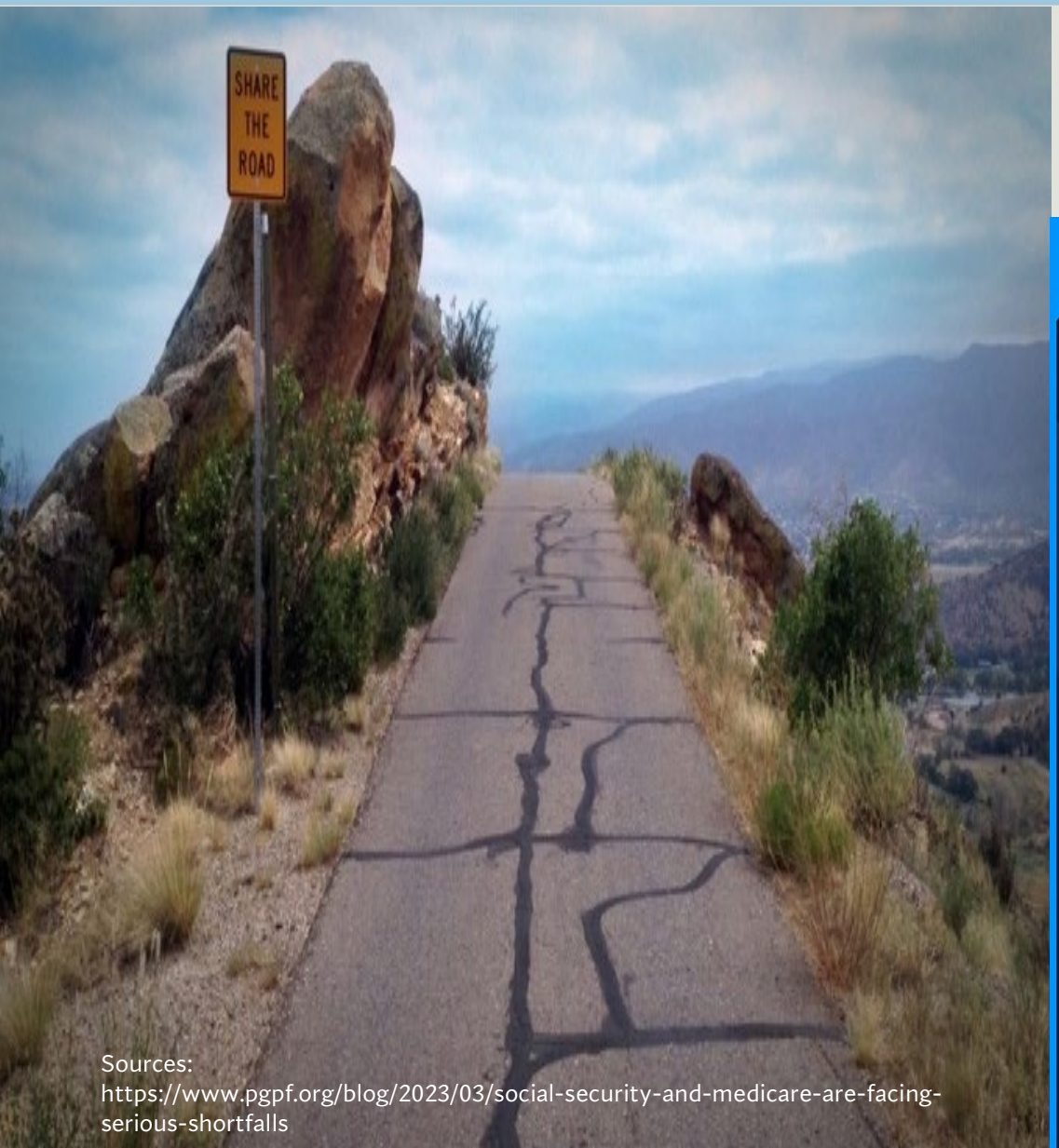
Congress puts the community benefit standard for nonprofit hospitals under the microscope

The criteria that establish hospitals' tax-exempt status are coming under closer scrutiny, with a bipartisan quartet of senators asking the IRS to ramp up its oversight of compliance with the community benefit standard.

Sens. Bill Cassidy, MD (R-La.), Charles Grassley (R-Iowa), Raphael Warnock (D-Ga.) and Elizabeth Warren (D-Mass.) sent an Aug. 7 letter to the IRS citing examples that purportedly show some not-for-profit (NFP) hospitals "may not be fulfilling their required obligation to provide reduced or free care to their most vulnerable patients." Charity care is a category of community benefit as defined by the IRS.

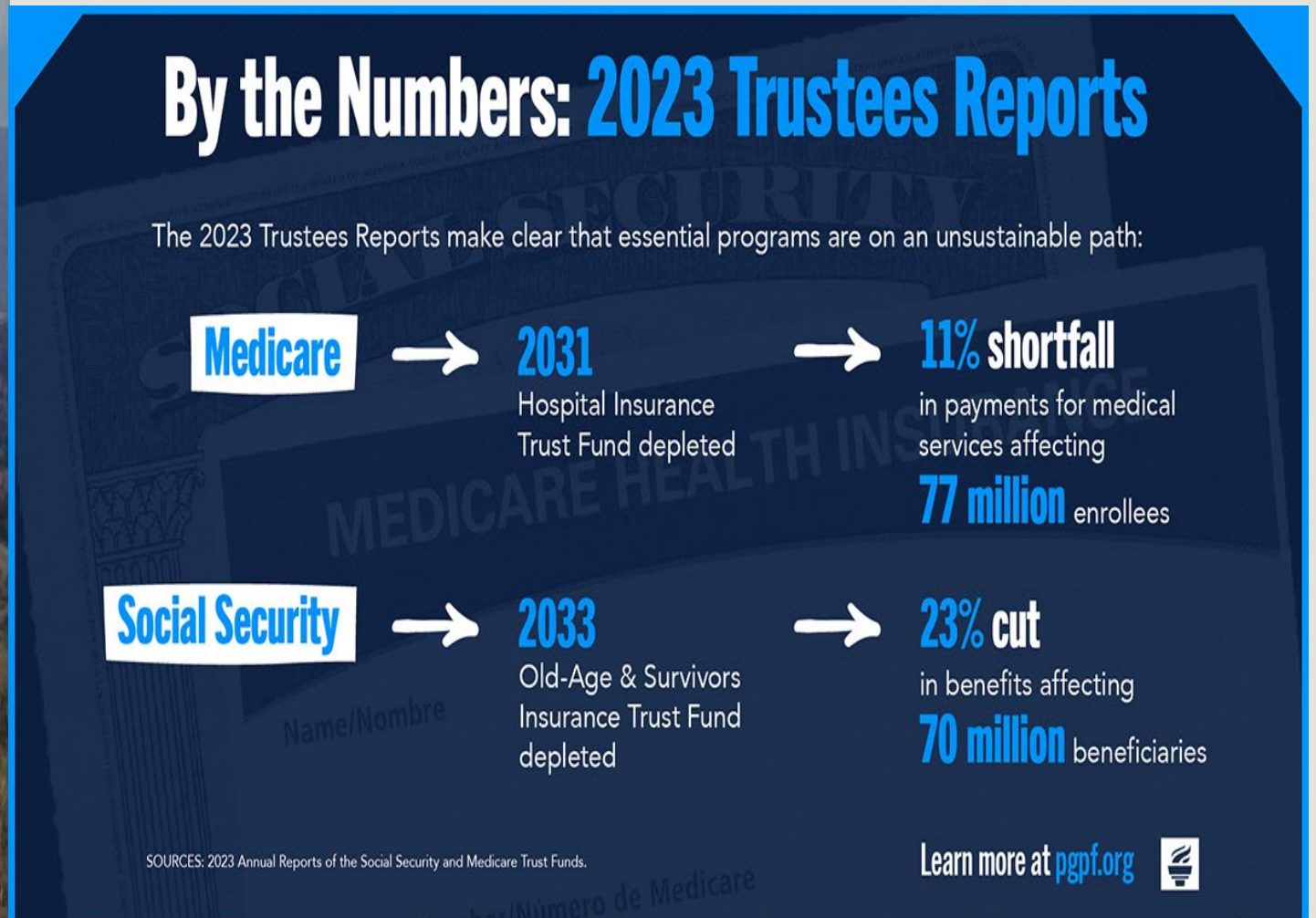
Sources:
https://www.hfma.org/finance-and-business-strategy/community-benefit/congress-puts-the-community-benefit-standard-under-the-microscope/

Running Out of Road

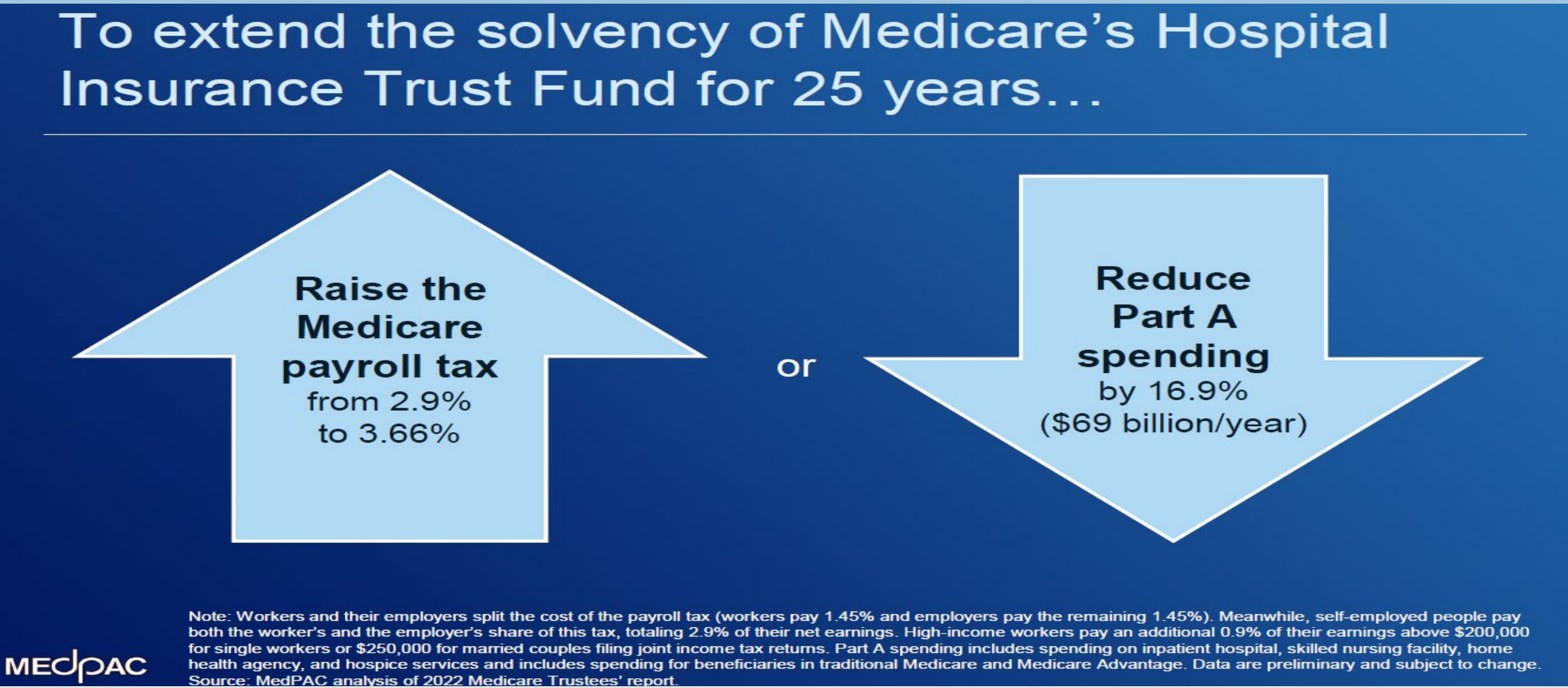


Sources:
https://www.pgpf.org/blog/2023/03/social-security-and-medicare-are-facing-serious-shortfalls

An accelerated insolvency date for one of the trust funds would force provider payment cuts



Tough Choices Ahead



Source: https://www.medpac.gov/meeting/september-1-2-2022/

Fiscal Commission Redux?

The House Budget Committee advanced legislation that would create a bipartisan fiscal commission.

Roll Call

Bill to create new debt commission approved in House panel

The House Budget Committee advanced legislation that would create a bipartisan fiscal commission to come up with a solution to the government's worsening budget outlook and propose it to Congress for expedited action.

Many Democrats oppose the plan, but three on the Budget Committee crossed over to join Republicans in approving the bill, 22-12. They included Scott Peters, D-Calif., who co-wrote the bill with sponsor Bill Huizenga, R-Mich.

"This is a way to get started," Peters said of a commission. He argued that relying on "regular order" in Congress to set the government's fiscal trajectory on the right path would fail.

Sources:
https://rollcall.com/2024/01/18/bill-to-create-new-debt-commission-approved-in-house-panel/

Federal Update/Medicare

Regulatory

2024 Medicare Payment Updates

The final rule 2024 Medicare market basket/conversion factor updates across all payment systems were inadequate again.

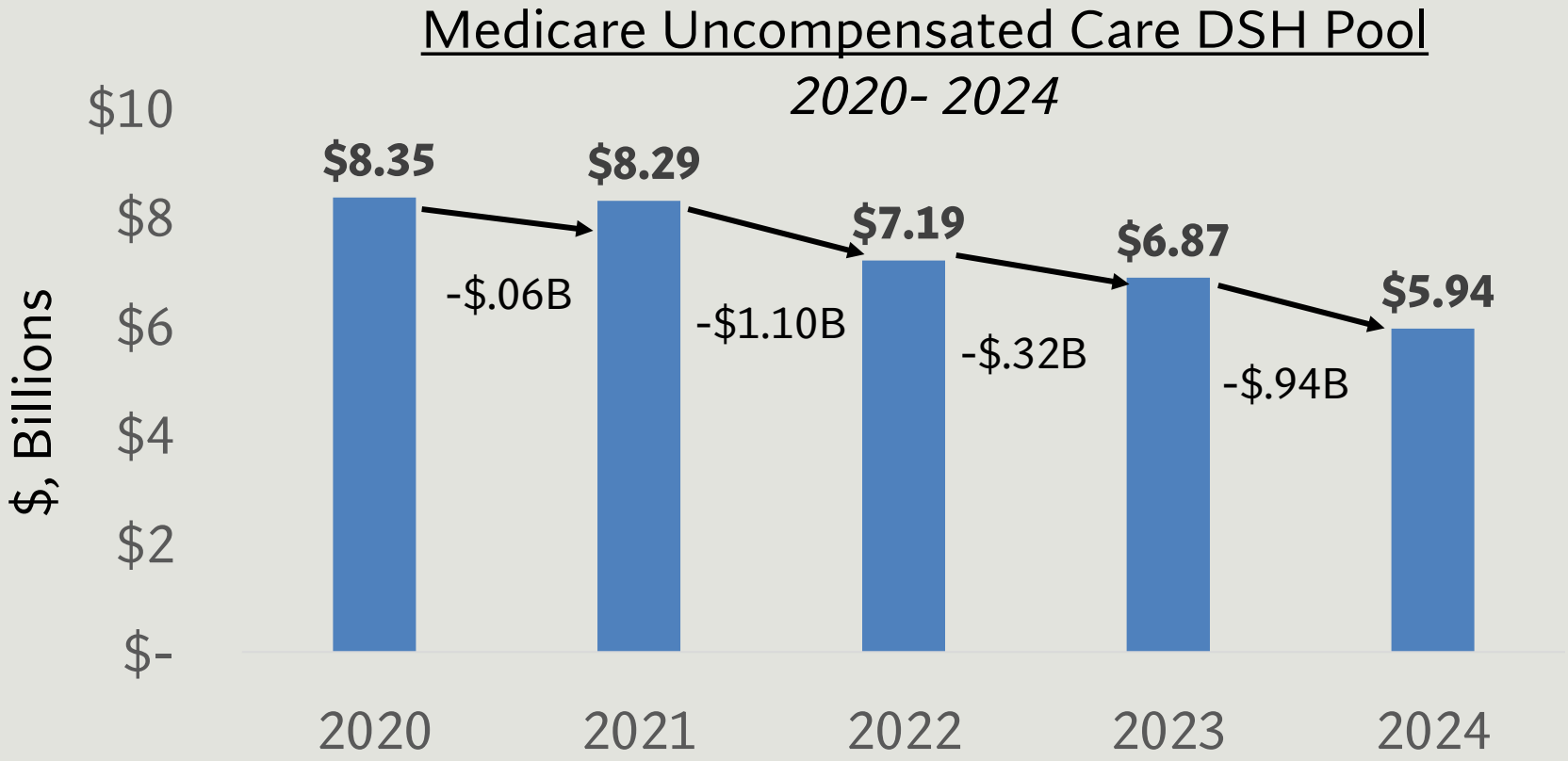
Federal Fiscal Year/Calendar Year 2024 Net Medicare Payment Updates

Payment System	Net Update
Inpatient/Outpatient PPS*	3.1%
LTCH PPS	3.3%
Psych PPS	3.3%
Inpatient Rehab PPS	3.4%
Skilled Nursing PPS	4.0%
Home Health PPS	0.8%
Physician Fee Schedule	-3.4%

*for hospitals meeting quality reporting and meaningful use requirements

Deep Disproportionate Share Hospital (DSH) Cuts

Despite projected increases in the uninsured for 2024, Medicare cut uncompensated care DSH payments for the fourth year in a row.



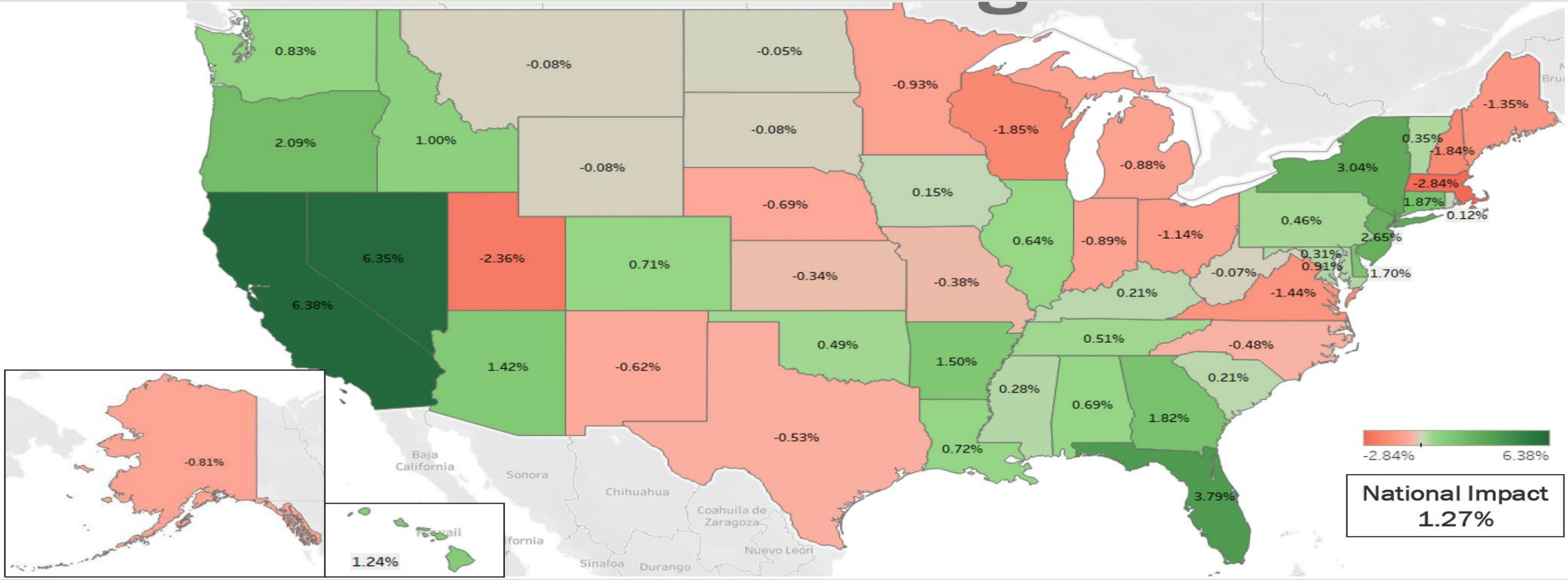
CMS' under-projection of uninsured rates has reduced payments to safety-net hospitals by **$2.41 billion** in 2024 compared to 2020.

Sources:
1) CHA analysis of FFY 2020 – 2024 IPPS Final Rules

Wage Index – Rural Floor Calculation

Changes to the rural floor calculation benefited California hospitals.

2024 IPPS Final Rule – Wage Index Impact Analysis – All Changes

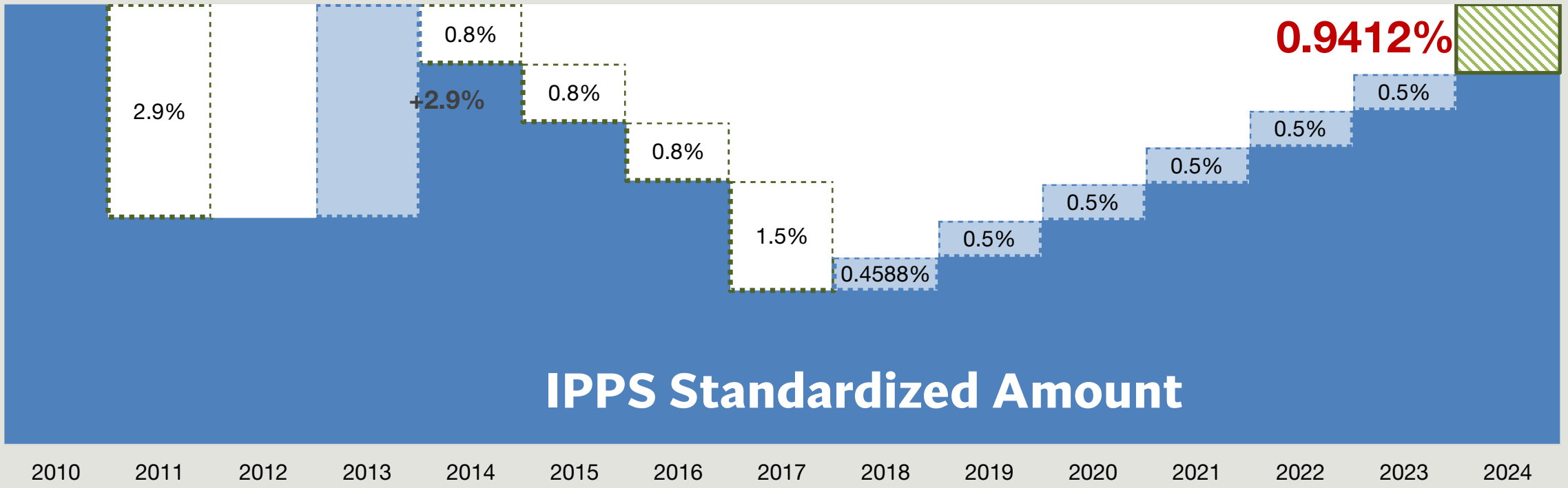


Source: DataGen 2024 IPPS Final Rule Webinar

Low Wage Index Hospital Policy

- Continued lowest quartile AWI inflation policy into FFY 2024 with a larger budget neutrality adjustment (0.2598%)
- Pending legal changes
  - Two lead cases:
    - *Bridgeport Hospital v. Becerra* (D.D.C., appeal pending at D.C. Circuit)
    - *Kaweah Delta v. Becerra* (C.D. Cal., appeal pending at 9th Circuit)
  - Both district courts ruled in favor of the challenging hospitals and remanded to the Secretary, but the Secretary appealed.
  - Oral arguments were held in October (*Bridgeport*) and February (*Kaweah Delta*), and decisions are likely this year.

0.9412% Rate Challenge: ATRA Unwinding



Statutory Limitation on Continued Application of ATRA recoupment, MACRA, and Cures Act Adjustments:

> "**(4) Rule of Construction**.—Nothing in this section shall be construed as providing authority to apply the adjustment under paragraph (1)(B) [i.e., the ATRA recoupment, MACRA, and Cures adjustments] other than for discharges occurring during fiscal years 2010, 2011, 2012, 2014, 2015, 2015, and 2017 and each succeeding fiscal year through fiscal year 2023."

Medicare DSH: Litigation Update

- ***Part C Days:***
  - June 9, 2023 Final Rule on Part C Days
    - Excludes Part C days from Medicare fraction and applies retroactively
    - Instructions have gone to MACs
  - Pending challenge to FY 2014 final rule remains in abeyance (*Florida Health Sciences Center Inc. v. Becerra, sub nom Allina Health System v. Becerra*)
- ***Entitled to SSI Benefits and Fraction:***
  - *Advocate Christ Medical Center v. Becerra* (pending Supreme Court cert. petition)
  - *Empire Health Foundation v. Becerra* (stayed in district court)
  - *Pomona Valley Hospital Medical Center v. Becerra* (remanded to Secretary)

New Price Transparency Requirements

The 2024 OPPS rule finalized new price transparency requirements.

CMS finalizes enhanced hospital price transparency requirements for 2024

Hospital price transparency mandates are set to become more stringent in the coming year as CMS seeks to strengthen regulations that have been on the books since 2021.

Medicare's 2024 final rule for hospital outpatient payments includes updates to the price transparency rules. Hospitals will need to post charge information using a more precise template, and they face a greater likelihood of being publicly cited for noncompliance.

More changes could be teed up in future rulemaking in response to a request for information (RFI). Issued in the proposed version of the rule, the RFI asked how hospital price transparency "can best support and complement the consumer-friendly requirements" established more recently in the health plan price transparency regulations and the No Surprises Act.

Sources:
https://www.hfma.org/price-transparency/cms-finalizes-enhanced-hospital-price-transparency-requirements-for-2024/

Hospital Price Transparency

New Machine-Readable File Requirements

- *Good Faith Effort (1/1/24) and Affirmation (7/1/24)*: Ensure standard charge information is true, accurate, and complete and affirm compliance
- *CMS Template (7/1/24):* Beginning July 1, 2024, file must conform to a CMS template layout, data specifications, and data dictionary
- *Hospital Data (7/1/24)*: Include hospital information as data elements (including inpatient and freestanding ED locations)
- *Additional Standard Charge, Service, and Coding Data (7/1/24 and 1/1/25)*: Adds various data elements for standard charges, items and services, and coding. *E.g.*:
  - Standard charge method (e.g., per diem, case rate)
  - Estimated allowed amount in dollars (starting January 1, 2025) for standard charges expressed as percentage or algorithm.
  - Drug unit and type of measurement (January 1, 2025)
  - Modifiers that may change the standard charge (January 1, 2025)

Hospital Price Transparency

Accessibility and Enforcement

- *Website Accessibility*: Beginning January 1, 2024, ensure:
  - .txt file in the root folder of the website that hosts the file
  - "Price Transparency" link in website footer (including homepage) that links directly to the page hosting the link to the machine-readable file
- *Monitoring and Enforcement:*
  - May require submission of certification by an authorized hospital official as to accuracy and completeness and submission of additional documentation
  - Requires acknowledgment of receipt of warning notice
  - May notify health system leadership of compliance action and work with leadership to address similar deficiencies for hospitals across the system
- *Publicizing Actions*: May publicize information related to CMS' assessment of compliance, any compliance action taken (including status and outcome), and notification to system leadership.

340B Settlement

Eligible OPPS 340B hospitals received a lump sum settlement for CMS' reduction to payments for separately payable Part B drugs acquired under the program.

What to Know

- ***Settlement Amount***: $7.8 billion, includes cost sharing
- ***Budget Neutral***: Starting in 2026, CMS will reduce the OPPS market basket update by 0.5% annually. Reduction will remain in effect until full amount is recouped – estimated 16 years.
- ***Repayment Complete***: Noridian instructed to complete repayments to eligible hospitals by Feb. 7th.
- ***Medicare Advantage (MA)***: CMS declined to address MA plan repayment due to statutory prohibition on interfering in "private contracts."
- ***What's Next?*** Decision only found that CMS' method for calculating the reduction was illegal.

2024 Medicare Advantage Rule

The 2024 final rule includes provisions aligning MA coverage with fee-for-service (FFS)

Key Provisions

- Require MA plans to comply with NCDs, LCDs, and general coverage and benefit conditions included in FFS
- Prohibit MA plans from limiting or denying coverage for a Medicare-covered service based on their own internal or proprietary criteria that differs from FFS requirements
- Restrict when/how a plan may create internal coverage criteria in instances where coverage criteria are not fully established under FFS
- Direct MA plans to adhere to the two-midnight rule for coverage of inpatient admissions
- Clarify the inpatient-only list applies to MA plans

CMS 2-Midnight Guidance for MA Plans

CMS recently issued FAQs addressing the 2-midnight rule and other key areas for MA Plans.

CMS Provides “two-midnight rule” guidance for Medicare Advantage Plans

What’s happening: The Centers for Medicare & Medicaid Services (CMS) issued frequently asked questions on finalized contract year 2024 Medicare Advantage (MA) policies.

What else to know: The document provided guidance on how the "two-midnight" hospital admissions policies apply to Medicare Advantage (including deference to the reasonable judgment of the admitting physician based on the complex medical factors in the medical records) and when they are permitted to deny payment via post-claim audits.

CMS issued the document to clarify finalized policies from its 2024 Medicare Advantage final rule. CMS states that MA plans may utilize AI and other technologies to assess coverage decisions, but the tools cannot override benefits rules and medical necessity standards.

Sources:
https://calhospital.org/cms-provides-two-midnight-rule-guidance-for-medicare-advantage-plans

2024 Medicare Advantage Rule & Guidance

Addressing Prior Authorizations and Payment Issues

- Limits prior authorization for basic benefits to confirming the presence of diagnoses or other medical criteria and ensuring that the furnishing of a service or benefit is medically necessary
- Prohibits MA plan from denying coverage or payment based on medical necessity following a grant of prior authorization, except where there is good cause or reliable evidence of fraud or similar fault
- Confirms that the refusal to pay for services, in whole or in part, including the type or level of services is an organization determination by the MA plan

Prior Authorization (PA) Rule

CMS finalized a rule addressing issues with prior authorization abuses by MA, Medicaid managed care, and federally facilitated exchange plans.

Key Provisions

- *Timeframes*: MA and MCO plans must send PA decisions within 7 calendar days for standard and 72 hours for expedited requests. (Starts - 1/1/26)
- *Electronic PA*: Insurers must use an electronic PA API to facilitate submissions and communicate results. Hospitals and physicians must attest to using electronic prior authorization to meet CEHRT requirements. (Starts - 1/1/27)
- *Denial Reason*: Plans must provide reason for denying PA to providers (Starts - 1/1/26)
- **Measurement**: Requires plans to publicly report specific PA metrics (Starts - 3/31/26)

Key Telehealth Provisions

CMS implemented many telehealth provisions authorized by the Consolidated Appropriations Act, 2023. These provisions extend the following policies until Dec. 31, 2024:

- Delay in-person visit requirements for mental health services furnished via telehealth
- Waive the geographic and originating site rules to allow telehealth services to be furnished in any geographic area and in any originating site setting, including the beneficiary's home
- Allow physical therapists, occupational therapists, speech-language pathologists and audiologists to furnish telehealth services
- Allow certain services to be furnished via audio-only telecommunications systems
- Allow continued payment for telehealth services furnished by federally qualified health centers and rural health clinics using the methodology established during the COVID-19 public health emergency (PHE)
- Allow virtual presence to satisfy direct supervision requirements through the end of CY 2024

Coming Soon: Mandatory Bundles

In July, CMS issued a request for information that will be used to inform a mandatory bundled payment model that could begin as early as 2026.

The RFI Included Questions Regarding

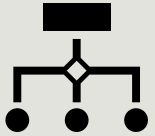
Clinical Episodes

Quality Measures

Potential Participants

Payment Model and Structure

Health Equity



Model Overlap

Discussion and Questions

Contact

Please contact me if you have questions that were not addressed today.

Chad Mulvany
Vice President, Federal Policy
California Hospital Association
(202) 270-2143
cmulvany@calhospital.org

Katrina A. Pagonis
Hooper, Lundy & Bookman
(415) 875-8515
kpagonis@hooperlundy.com

Lloyd Bookman
Hooper, Lundy & Bookman
(310) 551-8185
lbookman@hooperlundy.com