HCCA Boston Regional Conference

September 10, 2021

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HEALTHCARE PARTNERS

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Congressional Update

- Congress has been incredibly busy this summer
- Biggest priority has been the infrastructure deal and now they will turn to the reconciliation package (which is tied to the FY 22 budget resolution).
- Healthcare priorities under consideration for inclusion are:
  - HCBS funding (Casey/Wyden bill)
  - Expansion of Medicare benefits (vision, dental, hearing)
  - Drug pricing (main pay-for)
  - Closing Medicaid coverage gap (Doggett bil)
  - Telehealth flexibilities (audio only)

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Congressional Update: Casey/Wyden HCBS bill

- Bill introduced by Sens. Casey (D-PA) and Wyden (D-OR) expanding on President Biden's $400 B proposed investment in HCBS
- Part of this is likely to be included in the reconciliation bill
- Bill focuses on expanding access to HCBS and supporting workforce of those who provide HCBS. Key provisions are:
  - A permanent 10 percentage point increase in federal Medicaid matching dollars (FMAP) would be available to states that expand financial eligibility criteria for HCBS to match federal limits. Includes making behavioral health care more accessible, improving coordination of support services, and increasing family caregiver supports.
  - To receive the enhanced funds, states would have to address payment rates to direct care workers by updating the rates every 2 years and providing training to the workers and family care givers.
  - Require state Medicaid programs to adopt HCBS quality measures in exchange for the higher FMAP.
  - States could also access an additional 2% bump in Medicaid funds if they agree to register direct care workers, help beneficiaries find them and doing background checks on direct care workers.

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Congressional Update: Medicare Benefit Expansion

- Cong. Doggett dropped a bill July 6 to add dental, vision and hearing benefits to Medicare. Supported by Sens. Schumer and Sanders and has 76 House cosponsors.
- Seems likely to be included in reconciliation bill this fall.
- Would remove the statutory exclusion that currently prohibits Medicare from covering these services. Providers would be paid through Part B and it would expand Medicare to cover dentures, preventative and emergency dental care, refractive eye exams and glasses, and hearing aids and exams.
- Cost is at least $299 billion over 10 years (dental is most expensive)
- Also still considering proposals to lower Medicare eligibility to age 60 as part of reconciliation package as well.
- Realistically the costs of doing all of this is not possible so likely will need to pick one thing (either hearing and vision most likely) to include

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Congressional Update: Medicaid Coverage Gap

- Cong. Clyburn (D-SC) and Eshoo (D-CA) have stated that closing the Medicaid coverage gap is their key priority for the reconciliation bill
- 13 states have still not implemented Medicaid expansion
- Recent reports cited by Democratic members show that Medicaid expansion has improved access to care, reduced uncompensated care costs for medical facilities and reduced racial health disparities.
- The American Rescue Plan included a 5 point increase in Medicaid matching dollars for states that newly expand Medicaid. To date, no states have taken advantage of the incentive.
- Cong. Doggett (D-TX) has over 40 cosponsors for a bill that seeks to allow local governments in non-expansion states to contract directly with CMS to expand Medicaid. However, this would only be a stop gap until a more comprehensive plan was put in place.

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Public Health Emergency

- Current PHE renewed for an additional 90 days starting July 20, 2021.
- Will be extended for an additional 90 days. Statutorily can only be extended in 90 day increments.
- Administration has publicly stated the PHE will continue being extended until the end of 2021.
- All CMS waivers and other flexibilities technically remain in place as long as the PHE remains in place. However, CMS has started to end some of the waivers on a case by case basis. Others are being permanently extended during the FY 22 payment rules.
- HHS has started to indicate they are contemplating extending the PHE through July of 2022 and are factoring that into their budget assumption for the next fiscal year.

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Administration Update: CMS Staffing

- CMS staffing is complete. Here is the current key leadership slate:
  - Chiquita Brooks-LaSure, Administrator
  - Erin Richardson, Chief of Staff
  - Jon Blum, Principal Deputy Administrator and Chief Operating Officer
  - Liz Fowler, Center for Medicare & Medicaid Innovation Director
  - Meena Seshamani, Center for Medicare Director
  - Dan Tsai, Center for Medicaid and CHIP Services Director
  - Lee Fleisher, Chief Medical Officer and Director of Center for Clinical Standards and Quality
  - Dara Corrigan, Center for Program Integrity Director
  - Ellen Montz, Center for Consumer Information and Insurance Oversight Director

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Administration Update: CMS Payment Rules Telehealth

CMS Physician Fee Schedule open for comment until 9/13/21

1. CMS wants to pay providers for giving certain mental and behavioral healthcare services to patients via audio-only telehealth calls. However, payment would only be met under certain services including counseling and therapy for opioid treatment.
2. The Physician Fee Schedule eliminated geographic restrictions that could be a barrier to telehealth services for mental health. Under the rule, patients also would be able to access telehealth in their own homes.
3. If finalized, the rule would cover telehealth used for diagnosis, evaluation and treatment of mental health disorders and also would pay physicians for mental health visits delivered via telehealth to rural and vulnerable patient populations.
4. CMS also proposed allowing certain services that have been added to the Medicare telehealth list to remain covered through the end of Dec. 31, 2023, so that "there is a glide path to evaluate whether the services should be permanently added to the telehealth list following the COVID-19 [public health emergency]."

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Administration Update: CMS Physician Fee Schedule

1. **Payment rate update.** With the budget neutrality adjustment to account for changes in relative value units, as required by law, and expiration of the 3.75 percent payment increase provided in 2021 by the Consolidated Appropriations Act, the proposed Physician Fee Schedule conversion factor for 2022 is $33.58, down from $34.89 in 2021.
2. **Telehealth provision expansion**. CMS proposed allowing certain services added to the Medicare telehealth list amid the pandemic to remain until Dec. 31, 2023, to give the agency more time to determine if the services should be permanently added following the public health emergency. CMS also said it will allow all Medicare patients to access telehealth services from their homes and is proposing to allow audio-only communication technology when used for the diagnosis, evaluation or treatment of mental health disorders.
3. **Appropriate Use Criteria penalty phase delay.** CMS is proposing to delay the implementation of a penalty phase of the Appropriate Use Criteria program. Currently the penalty phase is set to begin Jan. 1, but CMS proposed delaying it to Jan. 1, 2023, or the Jan. 1 that follows the end of the public health emergency.
4. **Quality Payment Program changes.** CMS proposed to increase the Merit-based Incentive Payment System performance threshold score providers must exceed to receive bonuses under the Quality Payment Program. CMS also unveiled the first seven optional MIPS value pathways that would begin in 2023. The seven payment pathways would be emergency medicine, chronic disease management, heart disease, anesthesia, lower-extremity joint repairs, rheumatology and stroke care.

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Administration Update: CMS Physician Fee Schedule

5. **Physician assistant billing.** Beginning Jan. 1, physician assistants would be able to bill Medicare directly for their services and reassign payment for their services. Currently, Medicare can only make a payment to the employer or independent contractor of a PA.
6. **Medicare Shared Savings program updates.** CMS is proposing to give ACOs more time to transition to electronic reporting. In particular, CMS would allow ACOs to continue to use the web interface reporting option in 2022 and 2023 and phase in the new electronic clinical quality measure reporting requirement over three years. It was initially set to start in 2022.
7. **Medicare Diabetes Prevention Program changes.** CMS plans to waive the provider enrollment application fee for all organizations when they seek to enroll in Medicare as a Medicare Diabetes Prevention Program supplier on or after Jan. 1. CMS also proposed to shorten the prevention program services period to one year by removing the ongoing maintenance sessions phase. CMS also proposed redistributing a portion of the ongoing maintenance sessions phase payments to other core performance categories.
8. **Comment solicitation.** CMS is seeking provider input on two issues related to COVID-19. First, CMS wants input on what qualifies as the "home" in its preliminary policy to pay $35 add-on for certain beneficiaries when they receive a COVID-19 vaccine at home. Second, CMS is seeking comments on whether COVID-19 monoclonal antibody products should be treated the same way as other physician-administered drugs and biologics under Medicare Part B.

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Administration Update: CMS OPPS Rule

CMS OPPS Rule open for comment until 9/17/21

1. **Payment update.** CMS proposed increasing outpatient prospective payment system rates by 2.3 percent in 2022 over 2021 rates. Based on this update, CMS estimates that total payments to outpatient prospective payment system providers would be $82.7 billion next year, up about $10.8 billion from 2021.
2. **Price transparency violation penalty.** To boost compliance, CMS proposed increasing the minimum fine for price transparency violations to up to $2 million per year. In particular, hospitals with more than 30 beds in violation of the rule would pay $10 per day for each bed, up to $5,500 per day. Hospitals with 30 beds or fewer would continue to pay up to $300 per day. This would make the annual penalty at least $109,500, or as high as $2 million a year for large hospitals that fail to make prices public.
3. **Ban on coding to hide prices.** The proposed rule would also clamp down on the use of special coding that prevents search engines from displaying pricing in search results.
4. **340B program**. CMS proposed continuing its lower payment rate for 340B drugs. CMS proposed paying hospitals 22.5 percent less than the average sales price for 340B-acquired drugs.
5. **Halt elimination of inpatient-only list**. Last year, CMS proposed phasing out the inpatient-only list over three years, beginning with the removal of 298 services. Now it wants to reverse course. CMS also is seeking to add back the 298 services removed from the inpatient-only list this year to the inpatient-only list in 2022.
6. **Changes to ASC-covered procedures list**. CMS proposed eliminating 258 of the 267 procedures it added to the covered procedures list last year.

Administration Update: CMS Home Health Rule

Home health

1. On June 28, CMS proposed increasing payments to home health agencies by 1.8 percent in calendar year 2022.
2. CMS estimates the rate increase will increase payments to home health agencies by $330 million. CMS added that home health agencies may see an aggregate $20 million decrease in payments due to reductions made in the rural add-on payment.
3. CMS is proposing a nationwide expansion of the home health value-based payment program.

Administration Update: CMS Inpatient Rule

1. On April 27, CMS proposed a payment rate adjustment for inpatient facilities. Acute care hospitals that report quality data and are meaningful users of EHRs will see a net 2.8 percent increase in Medicare rates in fiscal year 2022, compared to 2021.

2. CMS said the payment rate adjustment will mean hospitals see an increase of about $3.4 billion in payments for hospitals in fiscal year 2022.

3. CMS also proposed repealing the requirement to report median payer-specific negotiated rates by Medicare severity-diagnosis related group, with Medicare Advantage insurers. CMS said this will reduce administrative burden on hospitals by about 64,000 hours.

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Administration Update: CMS Regulatory Update

- ALL of the FY 22 payment rules include a request for information (RFI) on ways to improve health equity.
- Surprise billing regulation issued as an interim final rule on 7/1. Congressionally mandated to implement the No Surprises Act passed last December.
- It bans balance-billing for emergency and non-emergency service, limits cost-sharing to in-network rates and creates an independent dispute resolution process to solve fights over reimbursement.
- There is a 60 day comment period and the rule becomes final at the end of the comment period.
- First of two rules from CMS on surprise billing, second is expected later this fall.

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Administration Update: CMS Price Transparency Rule

- Rule went into effect on January 1, 2021, requiring hospitals to provide a comprehensive machine readable file online of all their items and services along with a display of 300 shoppable services in a consumer friendly format.
- So far not all hospitals are complying with the requirement and a recent study shows only 9% of patients are aware that hospitals must make the prices of their treatments and procedures available on their websites.
- As of June 2021, only 83 out of 100 randomly sampled hospitals were not abiding by these requirements.
- Reason for noncompliance is that hospitals don't want to deal with the administrative burden of the requirements and CMS has not penalized non-compliant hospitals (publicly naming on CMS website and fining $300/day).
- Information about CMS' current efforts can be found at www.cms.gov/hospital-price-transparency

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Administration Update: CMS CMMI

- The Administration issued a Health Affairs article articulating the vision for the future: https://www.healthaffairs.org/do/10.1377/hblog20210812.211558/full/
- Moving to more mandatory models
- More Medicaid focused models not just Medicare
- Working within CMS to ensure there is uniformity in how to gauge health equity efforts and plans to include health equity measures in every single model.

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Administration Update: Provider Relief Fund

Provider Relief Fund payments are being disbursed via both "General" and "Targeted" Distributions.

1. To be eligible for the General Distributions, a provider must have billed Medicare fee-for-service in 2019, be a known Medicaid and CHIP or dental provider and provide or provided after January 31, 2020 diagnoses, testing, or care for individuals with possible or actual cases of COVID-19. HHS broadly views every patient as a possible case of COVID-19.
2. A description of the eligibility for the announced Targeted Distributions can be found here. U.S. healthcare providers may be eligible for payments from future Targeted Distributions. Information on future distributions will be shared when publicly available.
3. Lots of great tips and information available here: https://www.hrsa.gov/provider-relief/faq/general

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Continued Main Areas of Focus

- Mental Health and Substance Use Abuse
- Home and Community Based Services
- Medicaid and ACA coverage expansion
- Health Equities
- Expansion of Medicare benefit
- Telehealth

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