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Health Policy Update – March 23, 2021

U.S. House Votes to Suspend Medicare Sequester Cuts Through December

On March 19, the U.S. House of Representatives voted 246-175 to advance legislation extending the current moratorium on Medicare sequester cuts through the end of the calendar year. Without congressional intervention, the 2% Medicare sequester will return beginning April 1, 2021. The bill (H.R. 1868) would also waive a provision of budget law known as PAY-GO. If not waived, the deficit impact from the recently enacted American Rescue Plan would force the sequestration of an additional $381 billion in federal spending early next year, including $36 billion from Medicare.

The House bill faces an uncertain future in the Senate, where some Republicans view a PAY-GO sequester as a consequence of Democrats' partisan approach to passing $1.9 trillion in additional COVID-19 relief. A separate bipartisan bill has been introduced in the Senate (S. 748) to provide Medicare sequester relief by Senators Jeanne Shaheen (D-NH) and Susan Collins (R-ME). Their bill would extend the sequester moratorium through the end of the public health emergency (PHE), offsetting costs by extending the Medicare sequester for an additional year, through 2031.

Congress first suspended the 2% Medicare sequester cut as a temporary measure in the Coronavirus Aid, Relief, and Economic Security (CARES) Act in March 2020, providing much needed relief and stability to practices experiencing lost revenues and increased expenses due to COVID-19. The suspension was extended at the end of December as a part of the year-end spending bill, but is set to expire on March 31, 2021.

Extending the Medicare sequester suspension has broad support among Medicare provider groups, including The Network. The Network is encouraging its members to contact their congressional representatives to urge support for an extension of Medicare sequestration relief for the remainder of 2021 or for the duration of the PHE.

To urge Congress to extend Medicare sequestration relief, CLICK HERE.

To view the text of the House-passed bill, H.R.1868, CLICK HERE.

To view the text of the Shaheen-Collins bill, S. 748, CLICK HERE.

Biden Signs $1.9T COVID-19 Relief Bill

On March 11, President Joe Biden signed the American Rescue Plan Act, a $1.9 trillion COVID-19 relief package. The bill, which passed along party lines through a procedure called budget

reconciliation, provides $1,400 direct payments to qualifying individuals in an estimated 85% of U.S. households.

In order to help stabilize the nation's healthcare system and expand patients' access to care, the legislation also significantly expands the Affordable Care Act's tax credits in 2021 and 2022, boosts Medicaid funding and incentivizes states to expand their programs, and fully subsidizes COBRA premiums for laid-off workers through September, in addition to many other healthcare-related provisions.

By decreasing or completely eliminating health insurance premiums for millions of lower- and middle-income families enrolled in ACA marketplaces, the legislation would help more than 1 million uninsured Americans gain health coverage. The White House estimates that the legislation would allow a family of four making $90,000 to see their monthly premium come down by as much as $200 per month.

To read the text of the American Rescue Plan Act, CLICK HERE.

To read a White House summary of the law, CLICK HERE and HERE.

To read an HHS fact sheet about the law, CLICK HERE.

Senate Confirms Becerra to Lead HHS

On March 18, Xavier Becerra was confirmed as Secretary of the Department of Health and Human Services (HHS) by a vote of 50-49. He was sworn in virtually on March 19. Now at the helm of HHS, Becerra will prioritize the nation's response to the ongoing COVID-19 pandemic, including oversight of billions of dollars in public health funding for testing, disease surveillance, and relief for rural providers.

Becerra's nomination by President Biden was controversial among Republicans who criticized his record on abortion rights, support for Medicare for All, and legal challenges to uphold the Affordable Care Act. Despite several policy reservations, centrist Senators including Joe Manchin (D-WV) and Susan Collins (R-ME) previously announced their support for Becerra, paving the way for his confirmation.

Becerra's confirmation comes as other key health policy positions remain unfilled, most notably the Food and Drug Administration commissioner and the HHS Assistant Secretary for Preparedness and Response. President Biden has not officially nominated anyone to fill those roles. Meanwhile, President Biden's nominee to lead the Centers for Medicare & Medicaid Services (CMS), Chiquita Brooks-LaSure, is still pending Senate confirmation. Elizabeth Fowler, the Center for Medicare and Medicaid Innovation (CMMI) Director, did not require Senate confirmation. She started in that role March 2.

MedPAC Report Urges Caution on Permanent Telehealth Expansion

On March 15, the Medicare Payment Advisory Commission (MedPAC) issued its annual report to Congress which includes key recommendations for Medicare payment policy along with updated analysis on Medicare Advantage, Part D, and a new telehealth proposal.

In its report, MedPAC urged policymakers to proceed with caution on permanently extending CMS' expanded coverage for telehealth services. The report proposes – but does not formally recommend – continuing the expanded telehealth coverage policy for a limited amount of time (between 1-2 years) following the end of the COVID-19 public health emergency (PHE) in order to collect data on the impact to beneficiary access to care, care quality and program spending. MedPAC suggested that CMS continue to pay for specified telehealth services provided to all beneficiaries regardless of location and continue to cover newly covered services as well as audio-only services if there is found to be a clinical health benefit.

Further, MedPAC suggested that CMS return to paying the Physician Fee Schedule facility rate for telehealth services rendered by providers after the PHE ends while continuing to collect data on the costs practices incur using telehealth. It also proposed reinstating patient cost-sharing for telehealth services and raised concerns about the potential for increased telehealth-related fraud – urging CMS to implement robust fraud prevention safeguards.

MedPAC's March report also includes the recommendation that inpatient and outpatient hospital facilities receive a 2% Medicare pay increase in 2022, while Medicare Physician Fee Schedule payments remain unchanged – in line with current law. The report noted that efforts to support certain specialties during the COVID-19 PHE via adjustments to provider payments be addressed through temporary spending policies rather than permanent increases in payment rates that would compound over time.

Regarding Part D, MedPAC noted that the rapid growth in drug manufacturer rebates (referred to as DIR fees) has led to concerns about the accuracy of Part D's risk-adjustment system. According to the report, rebates and other price concessions offset more than 50 percent of plan liability in 2018, up from just 20 percent in 2007.

To view the full MedPAC report, CLICK HERE.

To view a press release and summary of key sections, CLICK HERE.

Biden Administration Rescinds, Delays Trump-Era Rules

On March 16, the Biden Administration announced updates to the CY 2022 Request for Applications (RFA) in CMMI's Part D Payment Modernization (PDM) Model. CMS chose not to move forward with two Model design changes related to Part D formulary flexibilities and removing downside risk for 2022.

Under these changes, participating Part D plans must maintain coverage of all drugs for Medicare's six protected classes. As proposed by the Trump Administration, Model participants would only have been required to cover one drug for each protected class, which patient and pharmacy groups argued would limit patients access to essential medications.

On March 19, HHS delayed the effective date for a Trump-era 340B rule which requires community health centers to extend 340B pricing to patients for insulin and epinephrine products. The rule was originally scheduled to take effect on March 22, but has now been delayed until July 20, 2021. This rule reflects one of the policies first advanced by former President Trump last summer in the effort to reduce drug prices.

On March 12, the Biden Administration delayed the Medicare Coverage of Innovative Technology (MCIT) rule until May 15, 2021. The MCIT rule, finalized under the Trump Administration, would expedite the coverage of medical devices under the Medicare program. The proposed rule sought to establish a faster Medicare coverage process for devices that receive a "breakthrough" designation from the FDA based on their ability to treat an unmet medical need. HHS is accepting comments on this rule through April 17.

To view the PDM Model rule, CLICK HERE.

To view the 340B rule, CLICK HERE.

To view the Medicare Coverage of Innovative Technology (MCIT) rule, CLICK HERE.

Healthcare Groups File Lawsuit to Strike HHS Sunset Rule; HHS Delays to 2022

On March 9, several healthcare groups – including the American Lung Association, California Tribal Families Coalition, and National Association of Pediatric Nurse Practitioners – filed a lawsuit against the Department of Health & Human Services (HHS) to strike down the Securing Updated and Necessary Statutory Evaluations Timely (SUNSET) rule. The last-minute rule approved by the Trump Administration requires HHS to reassess its regulations every ten years in order to determine whether they are subject to the Regulatory Flexibility Act (RFA) review. If it is determined a regulation is subject to the RFA, HHS must review the regulation every ten years to decide if the regulation should expire or be revised.

The Trump Administration proposed the rule in November and finalized it in early January, two weeks before President Biden's inauguration. The rule is intended to eradicate burdensome regulation, giving HHS five years to review any existing regulation ten years or older.

The lawsuit filed against HHS alleges that the final rule’s approval process was unlawful, rushed, and lacked commenters' opportunity to participate. The lawsuit contends that the federal government violated its tribal trust responsibilities by refusing to consult with American Indian Tribes as required under agency policy. Furthermore, the plaintiffs argue the rule, which calls for an HHS review of roughly 18,000 regulations, will create "immediate uncertainty and instability" in the healthcare system as stakeholders won't know whether a regulation is at risk or not.

Late last week in a court filing, the Biden Administration expressed similar concerns with the burden imposed by the SUNSET rule, arguing it would divert mission-critical resources from higher priority initiatives. It subsequently stayed the rule’s effective date until 2022.

To view the lawsuit, CLICK HERE.

To view the SUNSET rule, CLICK HERE.

To view the SUNSET rule delay, CLICK HERE.

Deloitte: Hospital Price Transparency Compliance Low

At a March 11 conference hosted by America's Health Insurance Plans (AHIP), representatives from Deloitte Consulting said that few hospitals are providing a comprehensive machine-readable file online of all their items and services in a consumer-friendly format, despite a new CMS requirement. According to Deloitte, many hospitals across the country are still not in compliance with the new hospital price transparency requirements, which went into effect on January 1 after a legal battle to block the rule.

Deloitte suggests that customers are utilizing online tools more than ever to inform their healthcare decisions. Because a majority of customers told researchers they would use price and cost comparison tools to choose where they will receive health services, compliance with the transparency requirements will be critical to inform healthcare consumers.

A recent Deloitte survey of hospital executives found 76% of chief strategy officers said they'll pursue technology investments to do data analytics on competitive and market prices, 72% said these policies will challenge them to come up with better tools and benefits to meet customer needs, and 64% said they hope to coordinate with providers to communicate quality and cost information to members.

Deloitte's findings echo a new *Health Affairs* study, which found that 65 of the nation's largest hospitals are not complying with the new transparency regulations.

Under a new rule finalized by the Centers for Medicare & Medicaid Services (CMS), health issuers will be required to post machine-readable files, including negotiated rates starting January 1, 2022.

To read more about Deloitte's findings, CLICK HERE.

To read the *Health Affairs* study, CLICK HERE.