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Healthcare Consulting | Valuation

The omnibus bill passed by Congress just before the holiday recess includes several provisions impacting the healthcare industry. In the federal spending bill, healthcare providers get some, but not all, of what they were seeking. This article recaps the key provisions impacting the industry.

Medicare Rates

First, the bill postpones Statutory Pay-As-You-Go Act ("PAYGO") spending cuts until at least 2025. PAYGO was enacted in 2010 and requires spending cuts across the federal government if legislation enacted in a year results in a deficit increase. Without this bill, all Medicare payments in 2023 would have been subject to a 4% cut.

The bill does not alleviate the 2% Medicare sequestration cut stemming from a 2011 law that required across-the-board spending cuts for the federal government from fiscal year (FY) 2013 to FY 2030. Subsequent legislation provided relief to providers during the COVID-19 pandemic by suspending Medicare sequestration from May 1, 2020 through March 31, 2022. A 1% reduction resumed from April 1 through June 30, 2022, with the full 2% cut resuming effective July 1, 2022. To make up for the moratorium, the sequestration adjustment is currently set to increase to 2.25% from October 1, 2029 to March 31, 2030, to 3% from April 1, 2030 to September 30, 2030, and to 4% from October 1, 2030 to March 31, 2031. This bill keeps the sequestration rate at 2% through March 31, 2032. The sequestration adjustment only applies to the portion of the payment made by Medicare and excludes the patient share.

Medicare reimbursement for professional services is generally determined by multiplying the applicable relative value unit (RVU) amounts for billed services by the conversion factor in place on the date the service was rendered (adjusted for the specific locality). The Calendar Year (CY) 2023 Physician Fee Schedule (PFS) Final Rule issued by the Centers for Medicare and Medicaid Services (CMS) in November established a conversion factor of $33.06 and an anesthesia conversion factor of $20.72, based largely on budget neutrality requirements. These rates reflected decreases of 4.5% and 3.9%, respectively, from the conversion factors that have been in place during 2022. The proposed legislation would increase the PFS rates for 2023 by 2.5%, resulting in only a 2% decline rather than 4.5% (or, for anesthesia services, a 1.4% decline). This is the third consecutive year that year-end legislation mitigated provider reimbursement cuts. To continue a phased-in approach of the budget-neutrality impact of significant increases in Work RVUs (wRVUs) for many office visits and similar services in 2021, the legislation also includes a 1.25% adjustment to the rates that would otherwise be calculated by CMS in the CY 2024 PFS.

To recap, below is a summary of the Conversion Factor and corresponding legislative adjustments for the last several years:

Year	Original Conversion Factor	Legislative Fix	Adjusted Conversion Factor		% Change
2019	$ 36.0391		$ 36.0391		
2020	$ 36.0896		$ 36.0896		0.1%
2021	$ 33.6319	3.75%	$ 34.8931		(3.3%)
2022	$ 33.5983	3.00%	$ 34.6062		(0.8%)
2023	$ 33.0607	2.50%	$ 33.8872	*	(2.1%)
2024	TBD	1.25%	TBD		
Cumulative Change: 2019 - 2023	$ (2.98)	(8.3%)			(6.0%)

** Calculated as the original amount, increased by 2.5%.*

However, these rates do not include the 2% sequestration cut. Accordingly, the actual reimbursement in 2022 was lower than the adjusted conversion factor shown in the table as sequestration was phased back in. Likewise, the Medicare reimbursement calculated in 2023 using the adjusted conversion factor will be reduced by 2%.

While physician groups have expressed relief that the bill mitigates some of the reimbursement decreases providers were facing in 2023, they remain concerned that any reduction in reimbursement is challenging as medical practices continue to face increased costs for both staff and supplies. In response, there is an increasing call by industry groups and lobbyists for Congress to overhaul the Medicare payment system to achieve long-term stability for providers and ensure adequate access to care by Medicare beneficiaries.

The legislation also extends incentive payments for participation in eligible alternative payment models through the 2023 performance period, which would extend payments through 2025 since incentive payments are paid two years after the performance period. However, the incentive payment rate in 2025 (for the 2023 performance period) will be at a reduced level of 3.5%, compared to the 5% rate in effect through the 2022 performance period (to be paid through 2024). Additionally, the bill delays implementation of an increased threshold of services that must be provided through an eligible alternative payment model to qualify for the incentive.

A phase-in of Medicare clinical lab test payment changes was scheduled to resume in 2023 after payment reductions were halted in 2021 and 2022. The bill delays resumption of this phase-in for one year, such that payment amounts in 2023 will not be lower than the 2022 rates and the rates for 2023 through 2026 will not result in a payment reduction of more than 15% from the preceding year.

Telehealth and Hospital-at-Home Provisions

Many of the waivers for telehealth programs, which were enacted as part of the CARES Act in 2020 in response to the COVID-19 pandemic, are set to expire 151 days after the end of the COVID-19 public health emergency (PHE). While both patients and providers would like at least some of these flexibilities to be made permanent, there remains some concern that the quality and value of such services should be verified before making that decision. The omnibus bill extends these telehealth provisions through the end of 2024, and requires a study on the duration and type of telehealth services provided and the impact of such care on future healthcare services by Medicare beneficiaries. The interim report to Congress must be presented by October 1, 2024, with the final report due by April 1, 2026. The extended provisions include the removal of certain geographic requirements; the addition of qualified occupational therapists, speech-language pathologists, and audiologists as eligible telehealth practitioners, a delay of the in-person requirement under Medicare for mental health services provided through telehealth, use of audio-only telehealth services, and use of telehealth to conduct the face-to-face encounter required for recertification of eligibility for hospice care. Additionally, the bill extends telehealth services for federally qualified health clinics (FQHCs) and rural health clinics (RHCs) through 2024.

Similarly, the legislation extends “hospital at home” waivers and flexibilities through 2024, and requires study and reporting surrounding the effectiveness of such programs. These waivers allow hospitals to furnish certain inpatient services to patients outside of the hospital setting so long as the participating

hospital meets certain criteria in connection with the program. A hospital may be terminated from participating if they fail to comply. The study will analyze the quality of care (including health outcomes, hospital readmission rates, mortality rates, and other factors), clinical conditions treated, costs incurred (inpatient setting vs. "hospital at home" program), the quantity, mix, and intensity of services rendered (inpatient setting vs. "hospital at home" initiative), and socioeconomic information on the Medicare beneficiaries treated in the "hospital at home" model. The report must be issued by September 30, 2024.

Rural Provider Provisions

The legislation includes provisions intended to provide support for rural hospitals, including extension of the payment adjustment for low-volume hospitals and the Medicare Dependent Hospital program through September 30, 2025. The bill delays until 2024 a steeper threshold for hospitals to qualify for the low-volume payment adjustment, and extends add-on payments for ground ambulance services in qualified rural areas for two years, through December 31, 2024. In addition, the bill extends the 1% rural add-on payment for qualifying home health services through 2023.

Medicare Mental Health Provisions

In light of the heightened awareness of the need for mental health services, the bill includes several provisions to expand access for Medicare beneficiaries. Marriage and family therapist services and mental health counselor services would be covered under Medicare Part B, with payment to these providers at 80% of the lesser of actual charges or 75% of the amount determined for payment of a psychologist. Additionally, beginning in 2024 these services will also be covered in RHCs and FQHCs. Hospice programs will require at least one social worker, marriage and family counselor, or mental health counselor as part of the interdisciplinary group of providers beginning in 2024, whereas currently only a social worker can fill that role.

The bill also includes a provision to improve mobile crisis care by providing payment for psychotherapy crisis services starting in 2024. New HCPCS codes will be established for these services, and payment will be 150% of the non-facility fee schedule amount for similar services. This provision is exempt from budget neutrality requirements. Additionally, the bill contains provisions for education and outreach to ensure beneficiaries are aware that these services are available.

To ensure adequate coverage of outpatient mental health services for Medicare beneficiaries, the legislation expands the definition of partial hospitalization services to reflect a need for services for a minimum of 20 hours per week and adds coverage of intensive outpatient services, defined as a minimum of nine hours per week. These provisions are effective beginning in 2024.

Medicaid Provisions

In response to the COVID-19 pandemic, Congress enacted a requirement that Medicaid programs keep Medicaid participants continuously enrolled through the end of the month in which the PHE ends, in exchange for enhanced federal funding. As a result, Medicaid rolls have grown as new recipients have been added while none have been removed. States have expressed concern regarding the uncertainty of when eligibility redeterminations will begin since the timing is linked to expiration of the PHE. It is estimated that as many as 18 million individuals could lose coverage as a result of the redetermination process.

The bill allows states to begin the redetermination process starting April 1, 2023, without regard to the PHE, and gradually reduces the federal medical assistance percentage from 6.2 percentage points currently to 5 percentage points from April 1 through June 30, 2023, 2.5 percentage points from July 1 through September 30, 2023, and 1.5 percentage points from October 1 through December 31, 2023. States will be required to submit monthly reports detailing their eligibility redetermination activities, and they have 14 months to complete eligibility reviews.

The bill includes provisions that provide twelve months of continuous Medicaid coverage for individuals under the age of 19 from the date they are determined to be eligible. Further, the provisions in the American

Rescue Plan Act of 2021 that allow states to extend coverage during pregnancy and up to twelve months postpartum have been extended permanently.

JTaylor's healthcare consulting team includes a group of professionals with a breadth of experience in serving clients across the healthcare spectrum, from independent physician practices to large multi-specialty groups, and from small rural hospitals to national healthcare systems. We will continue to monitor developments related to legislative activity impacting the healthcare industry. Our team can also support you from a strategic perspective as you plan for the implications of these new rules, including the impact of reduced reimbursement. To find out more or to contact a member of our team, please visit our website.