Issues for the week ending August 2, 2024

.

Federal Issues

Regulatory

CMS Releases 2025 Medicare Part D National Average Monthly Bid Amount and Other Bid/Payment-Related Information

The Centers for Medicare & Medicaid Services (CMS) issued memoranda announcing that the Medicare Part D national average monthly bid amount for CY 2025 is $179.45 (compared to $64.28 in CY 2024); the CY 2025 Part D base beneficiary premium amount is $36.78 (compared to $34.70 in 2024); and the de minimis amount is $2. In the fact sheet, press release, and memoranda, CMS announces the Part D Premium Stabilization Demonstration, a voluntary demonstration for standalone prescription drug plans (PDPs) only.

Why this matters: Under the demonstration "there will be a reduction in the base beneficiary premium of $15 for all participating PDPs, combined with a year-over-year plan premium increase limit of $35 and narrowed risk corridors applied to participating individual (i.e., non-employer) PDPs." The

In this Issue:

demonstration is designed for one year (CY 2025) with the parameters described by CMS and at least two subsequent demonstration years.

Next steps: Part D sponsors of PDPs have until August 5 to opt into the demonstration for CY 2025. Rebate reallocation must be completed by Part D sponsors by August 7. Part D sponsors will have from August 9 until August 13 to inform CMS of their intent to participate in the de minimis program. Read more about the announcement here.

CMS Releases Final Payment Regulations for Fiscal Year 2025

The Centers for Medicare & Medicaid Services last week released the following final payment rules for fiscal year 2025:

- Hospital Inpatient Prospective Payment System
- Long-term Care Hospitals
- Skilled Nursing Facilities
- Inpatient Rehabilitation Facilities
- Inpatient Psychiatric Facilities
- Hospice

Hospital Inpatient PPS Final Rule: The Centers for Medicare & Medicaid Services (CMS) Aug. 1 issued its hospital inpatient prospective payment system (PPS) final rule for fiscal year (FY) 2025. This rule updates IPPS payments relative to the current fiscal year, as well as implements other payment policies and new condition of participation rules. The official rule is scheduled to be published in the August 28 *Federal Register*.

Key Highlights

The final rule:

- Increases inpatient PPS payment rates by a net 2.9% in FY 2025.
- Establish a new mandatory Center for Medicare and Medicaid Innovation (CMMI) Transforming Episode Accountability Model (TEAM) alternative payment model, which will begin Jan. 1, 2026. The model will provide bundled payments for five surgical procedures.
- Creates a separate inpatient PPS payment for small, independent hospitals to establish and maintain access to essential medicines.
- Distributes new graduate medical education slots under section 4122 of the Consolidated Appropriations Act of 2023.

- Modifies the questions and sub-measures in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.
- Increases the Promoting Interoperability Program's performance threshold score and update the program's Antimicrobial Use and Resistance Surveillance measure.
- Modifies and make permanent the condition of participation (CoP) requiring hospitals and critical access hospitals (CAHs) to report certain data to the Centers for Disease Control and Prevention (CDC) on acute respiratory illnesses

Why this matters: CMS' payment updates for hospitals will exacerbate the already unsustainable negative or break-even margins many hospitals are already operating under. Hospitals are deeply concerned about the impact these inadequate payments will have on patient access to care, especially in rural and underserved communities.

In addition, while the hospital industry has long supported widespread adoption of meaningful value-based and alternative payment models to deliver high quality care at lower costs, the rule's mandatory bundled payment model for five different surgical episodes will not advance these objectives. Not only is the model extremely similar to other bundled payment approaches that have failed to meet the statutory criteria for expansion as they have not reduced program costs or generated net savings, it puts at particular risk many hospitals that are not of an adequate size or in a position to support the investments necessary to succeed.

Long-term Care Hospital PPS Final Rule: The Centers for Medicare & Medicaid Services (CMS) on August 1 issued a final rule for the long-term care hospital (LTCH) prospective payment system (PPS) for fiscal year (FY) 2025. This rule updates LTCH payments relative to the current fiscal year, as well as implements other payment policies and new patient assessment measures. The official rule is scheduled to be published in the August 28 *Federal Register*.

Key Highlights
The final rule will:

- Increase net LTCH payments by 2.2%, or $58 million, in FY 2025, relative to FY 2024, including both standard rate payments and site-neutral payments. This includes:
    - Increasing standard LTCH PPS payments by 2.0%, or $45 million in FY 2025 relative to FY 2024.
    - Increasing site-neutral LTCH PPS payments by 4.2%, or $13 million, in FY 2025 relative to FY 2024.
- Increase the standard rate fixed-loss amount for high-cost outlier (HCO) cases from $59,873 in FY 2024 to $77,048 in FY 2025.
- Adopt and modify certain patient assessment items related to health-related social needs and extend the window in which patient assessments must be done from three to four days after admission.

Why this matters: The payment update for LTCHs is inadequate and threatens access for extremely ill Medicare beneficiaries. In addition to this insufficient market basket update, the nearly 30% increase in the fixed-loss amount puts LTCHs in an untenable position by forcing them to absorb hundreds of thousands of dollars in additional losses when caring

for the sickest patients. Without adequate funding, additional burden will be placed on acute-care hospitals and other providers that do not specialize in caring for this unique patient population.

Skilled Nursing Facility PPS Final Rule: The Centers for Medicare & Medicaid Services (CMS) July 31 issued its fiscal year (FY) 2025 final rule for the skilled nursing facility (SNF) prospective payment system (PPS). This rule updates SNF PPS payments relative to the current fiscal year, as well as implements new financial penalties against facilities and new patient assessment measures. The official rule is scheduled to be published in the August 6 *Federal Register*.

Key Highlights
The rule will:

- Increase aggregate SNF payments by an estimated 4.2% ($1.4 billion) in FY 2025 relative to FY 2024. This includes:
  - 3.0% market basket update reduced by a 0.5% productivity cut.
  - 1.7% increase due to FY 2023 market basket forecast error.
- Make technical changes to its Patient Driven Payment Model (PDPM) ICD-10 code mapping that assigns patients to clinical categories.
- Revise CMS nursing home enforcement authority to allow the agency to impose multiple financial penalties on nursing homes with safety deficiencies.
- Adopt and modify patient assessment items addressing social determinants of health.

Why this matters: While hospitals appreciate the intent of the changes CMS makes to its enforcement authority, the industry remains concern that tying increased civil monetary penalties (CMPs) to the imperfect survey process will disadvantage smaller or lower-resourced facilities. Hospitals encourage the agency both to continue to look for ways to improve the survey process and to use discretion in enforcing penalties based on instances of noncompliance with the newly finalized long-term care staffing standards.

Inpatient Rehabilitation Facility PPS Final Rule: The Centers for Medicare & Medicaid Services (CMS) July 31 issued its final rule for the inpatient rehabilitation facility (IRF) prospective payment system (PPS) for fiscal year (FY) 2025. This rule updates IRF PPS payments relative to the current fiscal year, as well as implements other payment policies and the quality reporting program (QRP). The official rule is scheduled to be published in the August 6 *Federal Register*.

Key Highlights
The final rule:

- Updates payment rates by a net 3.0%, relative to FY 2024. This includes a market basket update of 3.5%, less a productivity cut of 0.5%.
- Increases the high-cost outlier threshold, which will result in an additional 0.2% decrease to overall payments.
- Updates the wage index using the most recent Office of Management and Budget (OMB) statistical area delineations based on the 2020 Decennial Census.
- Adopts and modifies patient assessment items addressing social determinants of health.

Why this matters: The final rule contains mostly routine payment updates that do not deviate in significant ways from the proposed rule. However, the Medicare program market basket updates continue to fall well short of the sharply increased costs hospitals have faced in recent years. The hospital industry is disappointed CMS did not take steps to address these shortcomings and will continue to pursue potential modifications to these updates in the future.

Inpatient Psychiatric Facility PPS: The Centers for Medicare & Medicaid Services (CMS) July 31 issued its fiscal year (FY) 2025 final rule for the inpatient psychiatric facility (IPF) prospective payment system (PPS). This rule updates IPF PPS payments relative to the current fiscal year, as well as adopts one new quality reporting measure. The official rule is scheduled to be published in the August 7 *Federal Register*.

Key Highlights
The final rule:

- Updates the IPF payment rate by a net 2.5% in FY 2025 as compared to FY 2024.
- Clarifies eligibility criteria for filing all-inclusive cost reports.
- Adopts one new quality measure but will not require quarterly patient-level data reporting as originally proposed.

Why this matters: The final rule contains mostly routine payment updates that do not deviate in significant ways from the proposed rule. However, the Medicare program's market basket updates continue to fall well short of the sharply increased costs hospitals have faced in recent years. While hospitals appreciate that CMS did not finalize its burdensome proposal to require more frequent data reporting, the industry is disappointed that the agency chose to adopt a quality measure that will bring little value to patients and providers.

Hospice: The Centers for Medicare & Medicaid Services (CMS) July 30 issued a final rule updating hospice payment rates for fiscal year 2025. This rule updates hospice payments relative to the current fiscal year, as well as adopts a new patient-level data collection tool and adds new process measures. The official rule is scheduled to be published in the August 6 *Federal Register*.

Key Highlights
The final rule:

- Finalized a 2.9% net increase to payments compared with FY 2024. This includes a 3.4% market basket update and a 0.5 percentage point cut for productivity.
- Increases the hospice payment cap from $33,494.01 to $34,465.34.
- Adopts the most recent Office of Management and Budget statistical area delineations, which will affect the wage index used by some providers.
- Adopts a new patient-level data collection tool to replace the existing Hospice Item Set and also adds two new process measures beginning in FY 2028.

Why this matters: The final rule contains mostly routine payment updates that do not deviate in significant ways from the proposed rule. However, the Medicare program's market basket updates continue to fall well short of the sharply increased costs all providers have faced in recent years.

State Issues

Pennsylvania

Regulatory

Pennsylvania Independent Regulatory Review Commission Directs The Pennsylvania Health Insurance Authority to Respond to Comments Related to Health Equity Accreditation Proposed Rulemaking

A number of comments from the insurance industry, members of the General Assembly and others on the proposed rulemaking published in the May 25, 2024 *Pennsylvania Bulletin* were reviewed by the Independent Regulatory Review Commission (IRRC). IRRC pursuant to Section 5.1(a) of the RRA (71 P.S. § 745.5a(a)) directs the Pennsylvania Health Insurance Exchange Authority (Exchange Authority) to respond to all comments received from IRRC or any other source. IRRC has asked the Exchange authority to respond to the following:

1. Whether the regulation conforms to the intention of the General Assembly in the enactment of the statute upon which the regulation is based; Whether the regulation represents a policy decision of such a substantial nature that it requires legislative review.

2. Whether there is the need for the regulation.

3. Whether there is a fiscal impact on the industry.

4. Whether there needs to be more Clarity around certain definitions such as, “cultural competency” and some other terms, and other implementation procedures.

These questions must be answered before IRRC will consider the proposed final rulemaking. This is important because Highmark is a part of the regulated community.

The Notice is available at: https://www.pacodeandbulletin.gov/Display/pabull?file=/secure/pabulletin/data/vol54/54-31/1097.html

Industry Trends

Policy / Market Trends

New AHIP Reports

- **Medicare Advantage Delivers Higher Quality Care and Access to More Preventive Services than FFS:** AHIP published a new report detailing how Medicare Advantage (MA) outperformed fee-for-service (FFS) Medicare in 9 out of 10 quality measures

focused on preventive and chronic disease care for seniors and people with disabilities.

The report compared performance results for 10 Healthcare Effectiveness Data and Information Set (HEDIS) measures in FFS Medicare and MA in 2021.

“Medicare Advantage continues to outperform FFS Medicare on preventive care and chronic care, all while saving seniors more than $2,500 a year. The compelling combination of better care at lower costs is why 33 million Medicare beneficiaries have chosen Medicare Advantage,” said Mike Tuffin, AHIP President and CEO.

Go Deeper: Read the full report here. Check out more resources on the value of MA here.

- **New AHIP Report Highlights Indispensability of Employer-Provided Coverage State-by-State :** More than 180 million Americans rely on employer-provided coverage for access to affordable, high-quality health care. AHIP’s new **Employer-Provided Health Coverage: State-to-State 2024 report** provides additional insight into the value employer-provided coverage (EPC) provides for families and communities throughout the nation.

“Employer-provided coverage is the backbone of the U.S. health care system, providing affordability and security for 180 million Americans and stability for doctors and hospitals in communities nationwide,” said Mike Tuffin, AHIP’s President and CEO.

Employer-Provided Health Coverage: State-to-State 2024 provides a state-by-state snapshot which includes:

  - The number of employees covered by EPC.
  - The share of premiums paid by employers.
  - The number of physicians and hospitals supported by EPC.

The report also quantifies health plans’ economic impact, including jobs generated by the industry.

Americans continue to express broad satisfaction with EPC. Recent polling found that **82%** of people with EPC reported that they have access to high-quality providers and **71%** said they are better able to manage their chronic condition because of their EPC.

Interested in reviewing a copy of a bill(s)? Access the following web sites:

Delaware State Legislation: **http://legis.delaware.gov/.**
New York Legislation: **https://nyassembly.gov/leg/**
Pennsylvania Legislation: **www.legis.state.pa.us.**
West Virginia Legislation: **http://www.legis.state.wv.us/**
For copies of congressional bills, access the Thomas website – **http://thomas.loc.gov/.**