AAMC Policy and Regulatory Roundup

Policy and Regulatory Updates from the Regulatory Team August 2022

COMMENT LETTER

AAMC Responds to OASH RFI on Opportunities to Strengthen Primary Care

The AAMC submitted a letter on Aug. 1 to the Office of Assistant Secretary for Health (OASH) in response to a request for information (RFI) regarding what the federal government could do to strengthen primary care. The letter supported the Biden administration's interest in improving access to health care and advancing health equity and expressed the AAMC's commitment to advancing population health. The response also highlighted changes to existing payment practices, delivery of care reforms, and expansion of the workforce needed to fully leverage primary care. These included promoting the use of telehealth by eliminating barriers, encouraging the use of provider-to-provider telehealth modalities (e.g., interprofessional consults), and allowing direct supervision of resident physicians via audio/video communication nationwide.

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FINAL RULES

CMS Releases the FY 2023 IPPS Final Rule, AAMC Webinar Scheduled for September 20

The Centers for Medicare & Medicaid Services (CMS) on Aug. 1 released the fiscal year (FY) 2023 Inpatient Prospective Payment System (IPPS) final rule. The AAMC will be hosting a webinar to discuss the final rule on **Tuesday, September 20 at 3:00 PM EDT**. The complete Washington Highlights article can be found here, and the CMS fact sheet can be found here. The webinar is free to AAMC members; advanced registration is required.

Registration link for the webinar: https://aamc.elevate.commpartners.com/p/220920_IPPS

Some of the finalized policies that will be discussed include:

Graduate Medical Education (GME) Provisions

CMS updated the *direct graduate medical education (DGME) calculation* for hospitals whose weighted full-time equivalent (FTE) count is greater than the FTE cap (*Milton S. Hershey Medical Center v. Becerra*). CMS finalized the proposal that, effective for cost-reporting periods beginning on or after Oct. 1, 2022, if the hospital's weighted FTE count exceeds the FTE cap, the weighted FTE count is adjusted to equal the FTE cap. The rule was also established retroactive to Oct. 1, 2001, which means that hospitals with open or reopenable cost reports may take advantage of the adjustment. CMS also finalized, without change, updates to allow *affiliation groups between hospitals participating together in 1-2 Rural Training Track Programs*. Hospitals will be able to participate in Rural Track Program Affiliation Agreements beginning July 1, 2023.

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Payment Provisions

CMS *finalized an increase to FY 2023 operating payment rates of 4.3%* for general acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users. CMS will utilize FY 2021 Medicare Provider Analysis and Review claims data and FY 2020 *Healthcare Cost Report Information System data* to calculate FY 2023 IPPS ratesetting. For FY 2023, the agency will calculate the *outlier fixed-loss amounts* by calculating and averaging two fixed-loss amounts — one including COVID-19 claims and one excluding COVID-19 claims — and utilizing charge inflation factors and cost-to-charge ratio adjustment factors based on data from prior to the COVID-19 public health emergency. The *outlier fixed-loss threshold* for FY 2023 is $38,859. CMS finalized the proposal to *limit the reductions to 10% for MS-DRG relative weight decreases* each year to mitigate financial impacts resulting from significant fluctuations in the relative weights, particularly for low-volume MS-DRGs. The agency finalized the proposal to utilize the two most recent years of hospitals' FY 2018 and FY 2019 cost reports *to calculate and distribute Disproportionate Share Hospital (DSH) and uncompensated care payments*. The CMS

will also discontinue use of low-income insured days as proxy for uncompensated care to determine Factor 3 for Indian Health Service and Tribal Hospitals and hospitals located in Puerto Rico. *CMS did not finalize the change to the calculation of the Medicaid fraction of the DSH calculation* by revising the definition of patients that are "regarded as eligible for Medicaid" to only include patients who receive health insurance through a section 1115 demonstration itself or purchase such insurance with the use of premium assistance authorized under an 1115 demonstration. The agency finalized the proposal positing that beginning FY 2024, completed applications for *new technology add-on payment* will be publicly posted online. CMS did *not finalize the proposal to use National Drug Codes instead of ICD-10-PCS Section X* codes to identify cases involving the use of therapeutic agents approved for new technology add-on payments beginning with a transitional period in FY 2023. CMS finalized the proposal to continue the *low wage index policy in FY 2023 in a budget neutral manner* by applying an adjustment to the standardized amount. Beginning in FY 2023 and subsequent years, the agency will apply a 5% cap on any decrease to a hospital's wage index from its wage index in the prior fiscal year, regardless of the circumstances causing the decline.
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Hospital Quality Provisions

Pay-for-Performance Programs
For the *Hospital-Acquired Condition Reduction Program*, CMS finalized a policy of suppressing all measures and not assessing any penalties for FY 2023 but will publicly report the measure results for full transparency of the pandemic's impact on measure performance. Under the *Hospital Readmissions Reduction Program*, the agency finalized a policy to resume use of the Pneumonia Readmissions measure in FY 2024, following pandemic-related suppression in FY 2023. For the *Hospital Value-Based Purchasing Program*, the CMS will suppress the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measure and five HAI measures and apply a neutral payment adjustment (no bonus or penalty) for FY 2023 in response to the COVID-19 pandemic.

Hospital IQR Program
CMS finalized the adoption of *ten new quality measures* and refinement of two existing measures in the pay-for-reporting program. Specific to maternal health, the CMS finalized the adoption of a *birthing-friendly hospital designation* to be publicly reported on the Care Compare website, beginning in fall 2023.

Medicare Promoting Interoperability Program ("Meaningful Use")
The CMS *finalized modifications to the program's scoring methodology* to increase points associated with the Public Health and Clinical Data Exchange and Electronic Prescribing Objectives and reduce points associated with the Health Information Exchange and Provide Patients Electronic Access to Their Health Information Objectives beginning with the CY 2023 EHR reporting period.
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Final Rules Released on No Surprises Act: Modify Independent Dispute Resolution Process and Make Other Changes
The Departments of Health and Human Services, Labor, and Treasury released final surprise billing rules on August 19 updating key provisions in its regulations pertaining to the No Surprises Act (NSA), which protects patients from out of network medical bills when receiving care at in-network facilities. These regulations include modifications to interim final regulations released in 2021 pertaining to what independent dispute resolution (IDR) entities must consider when making a determination about the payment amount for the out-of-network services.

The interim final rules had instructed the IDR entities to begin with a presumption that the offer closest to the "qualifying payment amount" (QPA) (which is the payer's median contracted rate), was the appropriate out-of-network payment amount. Provider groups, including the AAMC, opposed the use of the QPA as the primary factor in making the decision, arguing that other factors (e.g., teaching status, patient acuity, case mix, and scope of services of the facility providing the care) should be considered equally. Notably, the Texas Medical Association challenged the presumption regarding the QPA in the District Court of Texas and the Court vacated the requirement that the arbiters select the payment offer closest to the QPA. Additionally, the American Hospital Association (AHA) and the American Medical Association (AMA) filed a lawsuit challenging this provision, and the AAMC filed an amicus brief supporting their position, in the U.S. District Court for the District of Columbia.

As a result, this rule states "These final rules do not require the certified entity to select the offer closest to the QPA. Rather, these rules specify that arbiters should select the offer that best represents the value of the item or service under dispute after considering the QPA and all permissible information submitted by the parties." This final rule also

addresses situations where payers have "downcoded" a claim by changing service codes or changing, adding, or removing a modifier.

The Departments also issued a new set of Frequently Asked Questions that provide guidance on several NSA requirements, including protections that apply to no-network and closed network plans, the calculation of the qualifying payment amount, and disclosure requirements.

The Departments also provided a status update on the federal IDR process, including how many disputes have been submitted through the process. To address challenges with the process, new information was posted on the CMS No Surprises Act website that details common mistakes and helpful tips for initiating IDR disputes, and rolled out new functionality in the portal for initiating disputes that allows immediate access to documents provided by initiating parties that support their disputes. We encourage members to carefully review this new information before submitting a dispute. The AAMC is closely reviewing these regulations, FAQs, and other guidance and will provide additional information soon.
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POST *DOBBS* ACTIVITIES

U.S. District Court enjoins Idaho abortion law
On August 24, a U.S. District judge granted the U.S. Department of Justice's motion for a preliminary injunction against enforcement of an Idaho law that makes it a felony for a physician to perform an abortion even in a medical emergency. The judge ruled that the Idaho law unlawfully criminalizes medical treatment that Medicare-funded hospitals are required to provide under the federal Emergency Medical Treatment and Labor Act (EMTALA). In advance of the preliminary injunction hearing, the AAMC and the American Hospital Association filed an amicus brief in support of the federal government's position, explaining how physicians and other health professionals were faced with conflicting laws. The court resolved this conflict by concluding that, under the Constitution's Supremacy Clause, in emergency situations, EMTALA pre-empts Idaho law. The AAMC will continue to monitor developments in the Idaho case, as well as a separate case in which a U.S. District judge in Texas on August 23 granted the Texas Attorney General's motion for a preliminary injunction against enforcement of recent HHS guidance about how EMTALA applies to pregnant patients facing medical emergencies.
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Executive Order Issued on Access to Reproductive Services
On Aug. 3, in its continuing response to the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* which overturned the constitutional right to an abortion, the Biden administration issued an executive order, Securing Access to Reproductive and Other Healthcare Services. The order contains actions intended to support patients traveling out of state for medical care, ensure that health care providers comply with federal nondiscrimination law, and promote research and data collection on maternal health outcomes.
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ANNOUNCEMENTS

CMS Issues Road Map for End of COVID-19 Public Health Emergency
The Centers for Medicare & Medicaid Services (CMS) announced on Aug. 18 that it has developed a road map for the eventual end of the COVID-19 public health emergency (PHE), which is currently set to end in mid-October. During the PHE, the agency has used emergency waiver authorities to establish regulatory flexibilities for providers that enable access to health care. Most of these waivers and flexibilities will terminate at the end of the PHE. In the meantime, CMS is encouraging providers to prepare as soon as possible for the end of the waivers and flexibilities. As part of this initiative, the agency has released provider fact sheets that summarize the current status of the waivers and flexibilities. In addition, the CMS released a Health Care System Resiliency fact sheet.
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HHS and DOJ Release Guidance on Nondiscrimination in Telehealth
On July 29, the Department of Health and Human Services (HHS) Office for Civil Rights (OCR) and the Department of Justice's (DOJ) Civil Rights Division released Guidance on Nondiscrimination in Telehealth: Federal Protections to Ensure Accessibility to People with Disabilities and Limited English Proficient Persons. The guidance acknowledges that

there are many benefits to telehealth and notes that those with disabilities or with limited language proficiencies often find it difficult to access these services and the associated benefits. According to this guidance, there are several federal laws including Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act, Title VI of the Civil Rights Act of 1964, and Section 1557 of the Patient Protection and Affordable Care Act that require telehealth to be made accessible for those with disabilities and those with limited language proficiency.
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WEBINARS

Fiscal Year (FY) 2023 Inpatient Prospective Payment System (IPPS) Final Rule Webinar – September 20, at 3:00 PM EDT
Payment Policies – payment updates; disproportionate share hospital and uncompensated care payments; wage index; Medicaid fraction; reporting COVID-19 and seasonal influenza cases. **Graduate Medical Education (GME)** – changes to the calculation of full-time equivalent count; updates to the Rural Track Program. **Hospital Quality Program** – changes to the pay-for-performance programs, the Inpatient Quality Reporting (IQR) program, promoting interoperability program ("meaningful use"); addition of specific equity-specific quality measures; request for information on health IT to improve quality measurement and reporting.
The webinar is free to AAMC members; advanced registration is required.
Registration link for the webinar: https://aamc.elevate.commpartners.com/p/220920_IPPS
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Members may access the recordings of previously held webinars through the links below.

CPSC 2023 Medicare Physician Fee Schedule Proposed Rule Webinar
This AAMC-Vizient Clinical Practice Solutions Center (CPSC) webinar took place on August 9 and discussed the 2023 Medicare Physician Fee Schedule proposed rule. During this 60-minute webinar, AAMC and Vizient staff present ed on payment provisions and other policies from the proposed rule. Topics included new payment rates for physicians and other healthcare services for 2023, changes to evaluation and management services, impact analyses on payment for physician practices, changes to Medicare telehealth policies, split (shared) billing, behavioral health, and others.
A recording of the webinar is available here.
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CPSC 2023 Medicare Shared Savings Program & Quality Payment Program Proposed Rule Webinar
This AAMC-Vizient Clinical Practice Solutions Center (CPSC) webinar took place on August 16 and discussed proposed policies for the Shared Savings Program and Year 7 (2023) of the Quality Payment Program (QPP) in the Medicare Physician Fee Schedule proposed rule. During this 60-minute webinar, AAMC and Vizient staff presented on proposed policy changes for Medicare ACOs, MIPS, and Advanced APMs. For the Shared Savings Program, topics include proposed changes to payments to ACOs, transition to performance-based risk, and benchmark and health equity adjustments. For the QPP, topics included proposed changes to MIPS framework, MIPS category weights and performance threshold, proposals related to the MIPS Value Pathways (MVPs) reporting option, andchanges related to Advanced APMs. Participants will have the opportunity to ask questions once the presentation has concluded.
A recording of the webinar is available here.
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CY 2022 OPPS Proposed Rule Webinar
The AAMC hosted a webinar on August 25 to discuss the Calendar Year (CY) 2023 Outpatient Prospective Payment System (OPPS)proposed rule. Some of the proposals discussed included reimbursement for 340B-acquired drugs and biologics; payment updates and rate setting; additions to the inpatient only list; organ acquisition payments; prior authorization; hospital consolidation data; changes to the Outpatient Quality Reporting (OQR) Program and hospital quality star rating program; creation of a rural emergency hospital quality reporting (REHQR) program; and request for information to measure healthcare disparities across the CMS qualityprograms.
A recording of the webinar is available here.
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MEETINGS:

Medicare Payment Advisory Commission (MedPAC) September 2-3 Meeting
The agenda includes discussions about the context of Medicare payment policy, standardizing benefits in Medicare Advantage plans, Medicare Advantage encounter data, reforming Medicare's wage index system, and addressing high prices of drugs covered under Medicare Part B.

Council on Graduate Medical Education (COGME) September 12 Meeting
Agenda forthcoming.