American Hospital Association™
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Special Bulletin

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Appropriations Committees Release Omnibus Spending Bill with Health Provisions

Package funds government through Sept. 30 and includes important provisions preventing Medicare cuts, extending telehealth and other flexibilities and improving behavioral health, among others

The House and Senate Appropriations Committees last night released text of a $1.7 trillion omnibus appropriations bill that would fund the federal government through the end of the current fiscal year. The Senate began debate on the measure today and is expected to pass the measure first. The House of Representatives is expected to consider it by Friday. The president is expected to sign the bill into law ahead of the Friday deadline when current government funding is set to expire. The legislation includes many provisions beneficial to hospitals and health systems.

KEY HIGHLIGHTS

The omnibus appropriations bill would:

- Prevent the Statutory Pay-As-You-Go (PAYGO) Medicare 4% sequester for two years;
- Extend for two years critical rural Medicare programs, telehealth flexibilities and the Acute Hospital Care at Home program;
- Allow states to begin processing Medicaid redeterminations April 1, 2023, while phasing down the COVID-19 public health emergency (PHE)-related enhanced Federal Medical Assistance Percentage (FMAP);
- Require state Medicaid programs to provide 12 months of continuous coverage for children and permanently allow states to offer 12 months of coverage for postpartum women;
- Reduce the physician fee schedule cut from 4.5% to 2% for 2023 and around 3% for 2024;
- Provide 200 additional Graduate Medical Education (GME) slots, at least half of which would be dedicated to psychiatry and psychiatry subspecialty residencies, among other workforce provisions;
- Take several steps to improve access to behavioral health services;
- Make improvements to the government's ability to prepare for future emergencies; and
- Delay by one year reductions in payment for clinical laboratory tests and data reporting requirements under the Clinical Laboratory Fee Schedule.

AHA TAKE

In a statement shared with the media today, AHA President and CEO Rick Pollack said, "The AHA is pleased that on a bipartisan basis Congress recognizes the immense pressure America's hospitals, health systems and our caregivers are facing. This legislation will deliver critical support and resources so we can better care for our patients and create healthier communities. Due to skyrocketing cost increases for supplies, equipment, drugs and labor, challenging workforce shortages, and the "tripledemic" of COVID-19, flu, and RSV, the hospital field is stretched thin and on the brink.

"Specifically, we are pleased that this bill prevents significant four percent Medicare PAYGO cuts to providers, extends two key programs for two years that help rural hospitals keep their doors open, and extends for two years critical waivers for telehealth and hospital-at-home programs that have led to improvements in care and made medical treatment more convenient and accessible for patients. Additionally, we appreciate Congress giving partial relief to physicians by rolling back Medicare payment cuts and including important provisions to improve the nation's preparedness for the next pandemic, train the next generation of caregivers, bolster behavioral health care providers and expand access to behavioral health services. Finally, helping states prepare for changes in Medicaid eligibility due to the end of the Public Health Emergency could help them transition those individuals to other forms of health coverage.

"However, this is just a part of what needs to be done to support those on the front lines caring for patients. In the new year, we will continue to advocate for Congress and the Administration to take action to address patient discharge backlogs, support our current workforce and increase the pipeline into the future, hold commercial health insurers accountable for policies that compromise patient safety and add burden to care providers, and strengthen hospitals that care for a disproportionate number of patients covered by government programs or are uninsured, to name a few of our priorities."

Based on an initial review of the more than 4,000-page omnibus package, the following are highlights of provisions that affect hospitals and health systems.

PAYGO SEQUESTER

Under PAYGO requirements, Congress must pay for any legislative package, either by reducing entitlement spending or increasing revenue. The legislation would delay the PAYGO sequester for two years, through the end of 2024, preventing $38 billion in Medicare cuts that would otherwise have taken effect in January.

MEDICARE RURAL EXTENDERS

The legislation would extend the Medicare-dependent hospital and enhanced low-volume hospital programs for two years through Sep. 30, 2024. They were set to expire Dec. 23, 2022. It also would extend add-on payments for ambulance services through Dec. 31, 2024. These add-on payments support rural, “super-rural,” as well as urban, ambulance services.

TELEHEALTH SERVICE EXTENSIONS

The legislation includes provisions to extend and expand telehealth flexibilities through Dec. 31, 2024. Under current law, many of these flexibilities were set to expire 151 days after the end of the COVID-19 PHE. These include:

- Expanding originating site to include any site at which the patient is located, including the patient’s home;
- Expanding eligible practitioners to furnish telehealth services to include occupational therapist, physical therapist, speech-language pathologist and audiologist;
- Extending the ability for federally qualified health centers (FQHCs) and rural health clinics (RHCs) to furnish telehealth services;
- Delaying the six-month in-person requirement for mental health services furnished through telehealth, including the in-person requirements for FQHCs and RHCs;
- Extending coverage and payment for audio-only telehealth services; and
- Extending the ability to use telehealth services to meet the face-to-face recertification requirement for hospice care.

In addition, the Department of Health and Human Services (HHS) Secretary would be required to submit a report to Congress on utilization of services (interim report in October 2024; final report in April 2026). Additionally, the omnibus bill would extend safe harbor exceptions for telehealth services in high-deductible health plans.

PHYSICIAN PAYMENT

The legislation would provide partial relief for Medicare physician reimbursement rates, which under current law face a 4.5% reduction on Jan. 1, 2023. Instead, this legislation would reduce the cut to 2% for 2023 and around 3% for 2024.

In addition, the legislation would extend incentive payments for alternative payment models for an additional year. Specifically, the legislation includes a provision that would extend payments through the calendar year (CY) 2025 payment period, albeit at 3.5% incentive payment as opposed to 5%.

OTHER MEDICARE PROVISIONS

Clinical Laboratory Fee Schedule. The legislation would delay by one year, until Jan. 1, 2024, clinical laboratory test payment reductions and requirements for certain hospital and other laboratories to report private payer data under the Clinical Laboratory Fee Schedule.

Payment Under OPPS for Certain Non-opioid Treatments. The legislation would provide a separate Medicare payment, from 2025 through 2027, for non-opioid treatments that are currently packaged into the payment for surgeries under Medicare's Outpatient Prospective Payment System (OPPS). The separate payment would be capped at 18% of the estimated average OPPS payment amount for the surgeries and other services with which the non-opioid is used.

Home Health and Hospice. The legislation extends for one year add-on payments for rural home health agencies (HHAs). In addition, the bill directs the Centers for Medicare & Medicaid Services (CMS) to release additional information regarding its methodology for the negative behavioral adjustments applied under the HHA Patient Driven Groupings Model, as well as to hold a public forum with stakeholders within the next 90 days.

For hospice providers, the omnibus extends by one year (through 2032) the use of a hospice payment update percentage for the annual update to the hospice aggregate cap, which is included as an offset.

HOSPITAL AT HOME

The legislation would extend the Acute Hospital Care at Home initiative until Dec. 31, 2024. The bill also would require the HHS Secretary to analyze and compare care delivery under Acute Hospital Care at Home programs with traditional inpatient care delivery and publish a report demonstrating those findings.

MEDICAID AND CHIP PROVISIONS

The legislation includes several provisions related to Medicaid and the Children's Health Insurance Program (CHIP). Additional provisions specific to behavioral health are summarized in a separate section that follows.

Timeline for Post-COVID-19 PHE Eligibility Redeterminations/Maintenance of Effort. The legislation would permit states to begin Medicaid redeterminations as of April 1, 2023, and give them one year to complete them. Current law conditions states' receipt of the COVID-19 PHE-related enhanced FMAP of 6.2 percentage points on their maintaining enrollment, regardless of a change in an individual's eligibility (otherwise known as "maintenance of effort"). Under this new approach, states would continue to have access to the enhanced FMAP through Dec. 31, 2023 (including while conducting

redeterminations), subject to certain conditions. However, during this time, the enhanced FMAP would be reduced over three federal fiscal quarters beginning on April 1 when it would drop to 5 percentage points, followed by 2.5 percentage points in the subsequent quarter, and 1.5 percentage points for the final quarter. The enhanced FMAP would fully sunset on Jan. 1, 2024.

In addition, the legislation would require states to adhere to certain guardrails, including requirements that states attempt to ensure they have accurate beneficiary contact information; that they contact individuals using more than one modality prior to any disenrollment action; and that they adhere to new eligibility and enrollment reporting requirements. The legislation also provides CMS with additional enforcement authorities to ensure state compliance with disenrollment provisions, including options to require state corrective action plans, reduce enhanced FMAP further as a penalty for non-compliance, or levy civil monetary penalties at the agency's discretion.

Continuous Eligibility for Children. Effective Jan. 1, 2024, the legislation would require states to ensure that children determined eligible for Medicaid receive continuous eligibility for 12 months.

Postpartum Coverage. The legislation would permanently give states the option to provide 12 months of post-partum coverage to women. Current law authorizes states to exercise this coverage option through 2027; currently, 26 states and the District of Columbia have implemented this coverage extension.

CHIP Extension. The legislation would extend funding for the CHIP program for an additional two years to 2029.

Extended Increased FMAP for Territories. This provision would extend the increased FMAP for the five U.S. territories. Specifically, this provision would maintain Puerto Rico's increased FMAP at 76% through fiscal year 2027 and permanently extend the increased FMAP of 86% for the Virgin Islands, Guam, Northern Mariana Islands and American Samoa. The legislation also would make other changes to the territories' Medicaid programs, including provisions related to provider payment rates and investments in data system improvements.

Medicaid Extenders. The legislation would extend through 2027 the Money Follows the Person Rebalancing demonstration, as well as the protections against spousal impoverishment for recipients of home and community-based services.

BEHAVIORAL HEALTH

The legislation would provide funding for several programs addressing mental illness, substance use disorder, and crisis response, including Mental Health and Substance Abuse Block Grants and specific programs for pediatric, maternal, and veterans' mental health. In addition to these appropriations, the legislation would add coverage for

intensive outpatient programs and services furnished by marriage and family therapists and mental health counselors under Medicare and would eliminate the opt-out for non-federal governmental health plans for mental health parity requirements. The legislation also would require updates to Medicaid policies for mental health, including requiring a searchable directory of providers and guidance from CMS on access to crisis response networks under Medicaid.

In addition, the bill includes amendments requiring changes to the inpatient psychiatric facility payment system methodology based on newly required data on provider costs as well as standardized patient data; the addition of a quality measure on patient perspective of care; temporary additional payment for non-opioid treatments for pain management; and the elimination of additional requirements for the dispensing of Schedule III-V controlled substances for the purposes of detoxification.

WORKFORCE

The legislation includes several provisions intended to bolster the health care workforce.

Graduate Medical Education. The legislation would provide, beginning in 2026, an additional 200 Medicare-funded GME residency positions. At least half of the positions will be dedicated to psychiatry and psychiatry subspecialty residencies. Additionally, at least 10% of positions will be distributed to rural hospitals, hospitals operating above their cap, hospitals in states with new medical schools, and hospitals that serve health professional shortage areas.

Conrad 30 Program. The legislation would extend the program, which allows states to request J-1 visa waivers for foreign born physicians who have completed a U.S. residency training program to work in federally designated shortage and underserved areas, until Sept. 30, 2023.

Nursing and Allied Health Education. The legislation would waive the cap on annual payments for nursing and allied health education made during 2010-2019. In calculating this payment for hospitals, CMS did so without applying the statutory payment cap and began to recoup payments spent over the cap from hospitals. This legislation would not apply such a cap to, thus not seek repayments from, hospitals that are currently operating a school of nursing or a school of allied health. Additionally, the legislation also would ensure that direct GME payments would not be affected.

Stark Law Exception for Physician Wellness Programs. The legislation would establish a new exception to the Stark Law to better enable hospitals and other entities to provide physicians with evidence-based programs to improve their mental health, increase resiliency and prevent suicide.

Public Health Workforce. The legislation would reauthorize the Public Health Workforce Loan Repayment Program, create a pilot loan repayment program for

professionals with expertise in infectious diseases and emergency preparedness, and authorize the Heath Resources and Services Administration (HRSA) to increase educational opportunities for allied health professionals such as physical, occupational and respiratory therapists.

IMPROVEMENTS TO PREPARE FOR EMERGENCIES

The legislation takes several steps intended to improve the government's ability to prepare for emergencies. It would require Senate confirmation of the Director of the Centers for Disease Control and Prevention (CDC) beginning on Jan. 20, 2025, and augment their ability to respond in case of emergency by requiring an agency-wide strategic plan every four years that describes how CDC will use strategic communications, external partnerships and coordination with other agencies in the event of an emergency. Further, it would require the director to establish an advisory committee to advise on policy and strategies to achieve the CDC's mission. The advisory committee would consist of up to 15 non-federal members in relevant fields of expertise. Further, CDC would be required to expand and improve its ability to analyze, model and forecast PHEs and infectious disease outbreaks by leveraging the capabilities of public and private entities.

The legislation also would provide additional authority for the HHS Secretary to request support from other departments and agencies to lead federal public health and medical response to a PHE. It would clarify the role and responsibilities of the Assistant Secretary for Preparedness and Response and require national- and state-level full-scale exercises every five years to identify and address gaps in preparedness and response. Among other things, the exercises would assess the ability of the Strategic National Stockpile (SNS) to appropriately support the response to a large-scale, long-term PHE.

The legislation also would establish an Office of Pandemic Preparedness and Response Policy within the Executive Office of the President. The Office would advise on pandemic preparedness and response policy and support coordination and communication within the federal government related to preparedness and response. There would be an industry liaison within the office to work with affected industries during responses.

Finally, the legislation also addresses the work of other agencies with responsibilities during the pandemic. The legislation would direct HHS' Substance Abuse and Mental Health Services Administration (SAMHSA) to support continued access to mental health and substance use disorder services during PHEs. It also would reauthorize programs to improve the provision of trauma care, including in rural areas, by increasing coordination and situational awareness within emergency medical and trauma systems and identifying and disseminating best practices, and would direct the Administration for Strategic Preparedness and Response to support the coordination of emergency medical services and trauma care during a PHE.

CYBERSECURITY OF MEDICAL DEVICES

The legislation would require medical device manufacturers to ensure that cyber devices, as defined by the section, meet certain requirements which would go into effect 90 days after passage. The section also would require the FDA to provide additional resources and information regarding improving cybersecurity of devices, as well as require the Government Accountability Office to issue a report, within one year, identifying challenges in this space and how federal agencies can strengthen coordination to improve in cybersecurity for devices.

UNIQUE PATIENT IDENTIFIER

The language includes a continuation of the prohibition on funding for the adoption of a unique patient identifier (UPI). A national UPI would provide HHS the ability to explore solutions that accurately identify patients and link them with their correct medical records.

OFFSETS

The health care title includes the following offsets.

- **Medicare Sequester.** Extends the Medicare sequester for six months into FY 2032 and lowers percentages to 2% in 2030 and 2031.
- **Extension of Adjustment to Hospice Cap.** As noted above, extends by one year (through 2032) the use of a hospice payment update percentage for the annual update to the hospice aggregate cap.
- **Medicare Improvement Fund (MIF).** Reduces balances in the MIF by approximately $7 billion.

HEALTH CARE APPROPRIATIONS

The omnibus appropriations bill would provide $1.7 trillion in discretionary spending for FY 2023. The package would fund various health-related agencies at the following levels, many of which reflect new investments in areas of interest for hospitals and health systems:

- **HHS.** $120.7 billion in total spending, an increase of $9.9 billion. As part of this appropriation, Congress would fund the following agencies, among others:
    - **Centers for Medicare & Medicaid Services.** $4.1 billion in total spending, an increase of $100 million.
    - **Advanced Research Projects Agency for Health (ARPA-H).** $1.5 billion for the second year of ARPA-H with the intent of accelerating the development of scientific breakthroughs for diseases such as Alzheimer's disease, diabetes and cancer.
    - **Office of Minority Health.** $74.8 million, an increase of $10 million, including $7 million for awards to community-based organizations to

address adverse maternal health outcomes, particularly among racial/ethnic minority families.

- **National Institutes of Health.** $47.5 billion, an increase of $2.5 billion with a particular focus on investments in research to address Alzheimer's disease, cancer, opioids and health disparities, among other conditions.
    - **National Institute on Minority Health & Health Disparities (NIMHD).** $12 million for the John Lewis NIMHD Research Endowment Program, a $4 million increase for Research Centers at Minority Institutions, and an additional increase of $45 million for other health disparities research, to expand supplemental grants for Chronic Disease Centers and research to reduce health disparities.
- **Centers for Disease Control and Prevention.** $9.2 billion, an increase of $760 million, with a particular emphasis on fundamental public health activities, as well as public health infrastructure and capacity.
- **Assistant Secretary for Preparedness and Response.** $3.3 billion, an increase of $560 million, to support biosecurity through research and development of medical countermeasures for pandemic threats, and fortifying our stockpiles and supply chains for drugs, masks and other lifesaving medical supplies. This includes $965 million, an increase of $120 million, for the SNS.
- **Substance Abuse and Mental Health Services Administration**. $7.5 billion, an increase of $970 million to invest in several mental health programs to expand access to services.
    - $2.8 billion, an increase of $707 million, for mental health, including $385 million for the Certified Community Behavioral Health Centers.
    - $502 million, an increase of $390 million, to support the new 988 number and Behavioral Health Crisis Services.
    - $20 million, an increase of $10 million to create mobile behavioral health crisis response teams.
- **Maternal Health.** The bill includes $324 million, an increase of $120 million, for HRSA, CDC and National Institutes of Health (NIH) initiatives aimed at improving maternal health and reducing the nation's high maternal mortality rate.
- **Health Resources and Services Administration**. $9.7 billion, an increase of $852 million, to develop the workforce, improve maternal and child health outcomes and support rural health access.
    - $823 million, an increase of $87 million, for the Maternal and Child Health Block Grant.
    - $509 million, an increase of $51 million, Title VII Health Professions Education and Training.
    - $300 million, an increase of $20 million, for Title VIII Nursing Programs.

        - $385 million, an increase of $10 million, for Children's Hospitals Graduate Medical Education.
        - $352 million, an increase of $21 million, for Rural Health Programs, including $145 million, an increase of $10 million, for the Rural Communities Opioid Response Program.
- **Department of Veterans Affairs.** $134.7 billion, an increase of $22.5 billion above FY 2022.
    - $118.7 billion for Veterans Medical Care, an increase of 22% over FY 2022, including $13.9 billion for mental health services (including suicide prevention), $2.7 billion to support homeless assistance programs, and investments in VA Community Care.
    - $5 billion in additional mandatory funds to support the Cost of War Toxic Exposures Fund.

OTHER ITEMS OF INTEREST

340B. In the accompanying report language, Congress directed HRSA, which oversees the 340B program, to provide a briefing to Congress on actions taken to safeguard 340B covered entities' "lawful access" to discounted drugs. Over the past several years, 18 drug manufacturers have ended discounted pricing to 340B hospitals for contracts established with community and specialty pharmacies. In response, HRSA exercised its authority to refer these companies to the Office of the Inspector General to impose civil monetary penalties. Several drug companies then filed lawsuits challenging the government's authority to enforce penalties against them.

VALID Act. The legislation does not include the Verifying Accurate Leading-edge IVCT Development (VALID) Act, which means that laboratory developed tests will continue to be regulated under the Clinical Laboratory Improvements Amendments.

FURTHER QUESTIONS

If you have further questions, please contact AHA at 800-424-4301.