Healthcare Current Events Forum

NJ HFMA Healthcare Current Events Forum (HCEF) April 2025

NJ HFMA – Healthcare Current Events Forum

Agenda

- ✓ **National/State Issues**
  - ✓ KPMG Healthcare Update
  - ✓ Final MA and Part D Rule (MH)
- ✓ **Part A**
  - ✓ Kaufman Hall Hospital Flash Report
  - ✓ Microhospitals (BKS)
- ✓ **Part B**
  - ✓ PBMs and Biosimilars (MH)
  - ✓ Physician Coworking Spaces (KFF)
- ✓ **Payers**
  - ✓ Prior Authorization by Same Specialty (MH)
- ✓ **Compliance**
  - ✓ Hospital Transparency Executive Order (MH)
- ✓ **Technology**
  - ✓ MedTech Firms Helping Healthcare (IT)
- ✓ **Next monthly meeting**
  - ✓ Wednesday, May 21, 2025

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- **National/State Issues**
  - **KPMG Healthcare Regulation**
    - A Texas federal court has ruled that the FDA lacks the authority to regulate laboratory-developed tests (LDTs), vacating a final rule that would have treated these tests as medical devices and remanding the matter back to the HHS Secretary.
    - The Anticompetitive Regulations Task Force was launched by DOJ to identify opportunities to eliminate state and federal laws and regulations that "create unnecessary barriers to competition," with a specific focus on healthcare, housing, and food & agriculture.
    - CMS is moving to finalize an Information Collection Request (ICR) for the Medicare Transaction Facilitator (MTF), which will allow the agency to collect data needed to operationalize the Maximum Fair Price negotiated under the Medicare Drug Price Negotiation Program. The agency has requested public comments by May 1, 2025.

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- **National/State Issues**
  - **KPMG Healthcare Law and Policy Update**
    - The Senate confirmed Dr. Mehmet Oz as CMS Administrator.
    - FTC paused its antitrust lawsuit against the largest pharmacy benefit managers alleging they inflated insulin prices through unfair practices. The case is on hold due to a shortage of commissioners following the dismissal of staff by the Trump administration; FTC Chair Andrew Ferguson later announced he will no longer recuse himself.
    - Bipartisan legislation re-introduced in the House would modify requirements in Medicare and Medicare Advantage plans to stipulate that all prior authorizations and adverse determinations must be made by board-certified physicians of the same specialty as the provider managing the condition.
    - A House budget resolution targeting up to $880 billion in federal Medicaid spending reductions could force states to implement new policy modifications in return, such as raising taxes, cutting other programs like education, or reducing Medicaid eligibility and benefits.
    - According to a new Gallup poll, 11% of adults reported they have recently been unable to afford or access quality healthcare – the highest level since 2021.
    - New research suggests that individuals who received the shingles vaccine had a 20% lower risk of developing dementia over a seven-year period compared to those who did not receive the vaccine; the correlation may be linked to the vaccine's ability to prevent reactivation of the varicella-zoster virus, which may contribute to neuroinflammation and cognitive decline.

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National/State Issues

Final MA and Part D Rule

- No coverage for GLP-1s: CMS chose not to move forward with the Biden Administration's proposal to cover anti-obesity medications such as Ozempic and Wegovy under Medicare and Medicaid. The decision comes after pushback from payers and concern over the projected $35 billion increase in federal spending over 10 years. Coverage may be revisited in future rulemaking.
- 2. AI in prior authorization left unresolved: CMS declined to finalize rules that would have placed guardrails around the use of AI in prior authorization decisions, despite widespread interest from stakeholders. The agency said it will consider regulatory approaches to AI in the future.
- 3. CMS to hold MA plans accountable for approved inpatient stays: Under the final rule, MA plans cannot retroactively deny inpatient admissions that were previously authorized — unless there is evidence of fraud or obvious error. This provision aims to reduce denials and ensure consistency in care.
- 4. Decisions on marketing and network adequacy deferred: CMS postponed decisions on broadening the definition of marketing and strengthening provider directory requirements. These proposals are still under consideration for future rulemaking.
- 5. Appeals process strengthened: CMS said it is closing loopholes in the MA appeals process to better protect enrollees and providers. This includes clarifying that appeals rights apply to adverse decisions made during care, not just before, and ensuring providers are notified when submitting coverage requests on a patient's behalf.

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National/State Issues

Final MA and Part D Rule

- 6. Supplemental benefits guardrails established: CMS codified a list of non-allowable supplemental benefits under the Special Supplemental Benefits for the Chronically Ill category — such as non-healthy food, alcohol, tobacco and life insurance — to provide a clear health-related standard for these offerings.
- 7. Risk adjustment definitions updated: CMS finalized technical changes to align terminology with current ICD coding standards and clarified risk adjustment data submission requirements for Program of All-Inclusive Care for the Elderly (PACE) organizations and Medicare cost plans.
- 8. Improving dual-eligible care coordination: By 2027, certain dual-eligible special needs plans must provide integrated ID cards and unified health risk assessments that serve both Medicare and Medicaid, aiming to simplify and improve care for these vulnerable populations.
- 9. Inflation Reduction Act provisions codified: CMS formally implemented several IRA-related policies, including those affecting the Medicare Drug Price Negotiation Program and cost-sharing requirements for vaccines and insulin products.
- 10. Zero cost-sharing for adult vaccines: Effective for plan years beginning in 2023, Medicare Part D plans must continue to waive deductibles and cost-sharing for adult vaccines recommended by the Advisory Committee on Immunization Practices.

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- **National/State Issues**
  - **Final MA and Part D Rule**
    - 11. Insulin costs capped: In 2023, insulin costs for Medicare beneficiaries were capped at $35 per month or less, depending on negotiated or maximum fair prices. This cap will apply annually beginning in 2026.
    - 12. Prescription Payment Plan updates: CMS finalized updates to the Medicare Prescription Payment Plan, which allows beneficiaries to pay out-of-pocket drug costs in monthly installments. New requirements include an auto-renewal process unless beneficiaries opt out.
    - 13. Timely drug event reporting required: CMS finalized deadlines for timely submission of Prescription Drug Event records. Notably, records for selected drugs under the drug price negotiation program must be submitted within seven calendar days of claim receipt.
    - 14. Pharmacy network agreements must support drug pricing program: Part D sponsors must ensure their network pharmacies enroll in the Medicare Transaction Facilitator Data Module and verify their information to help facilitate access to negotiated drug prices and accurate claims processing.

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- ✓ Polling Question #1

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Which of the following is true about the Final Rule for MA and Part D?

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- **The Centers for Medicare and Medicaid Services (CMS) – Part A Reimbursement**
- **Kaufman Hall April 2025 Hospital Flash Report (February 2025 Data)**
  - Key Findings
    - 1. Hospital Volumes remain strong, including in emergency departments. Performance in February 2025 remains stable.
    - 2. Outpatient revenue has slowed as inpatient revenue grows. This indicates that rapid outpatient growth in the last few years may have reached its peak.
    - 3. Expenses continue to rise. Non-labor expenses have been the primary driver thus far in 2025.
  - Operating Margins (Without Corporate Allocations)
    - CYTD – 6.1% Operating Margin February 2025
    - Monthly – 5.6% Operating Margin February 2025

- **The Centers for Medicare and Medicaid Services (CMS) – Part A Reimbursement**
  - **Microhospitals**
    - A microhospital is a fully licensed, small-scale hospital that operates 24/7 and typically houses eight to 15 inpatient beds, in addition to emergency bays. There is no standard size for microhospitals, but they tend to be less than 50,000 square feet.
    - Hospital operators have touted the model as cheaper to build and requiring less capital to operate than a traditional hospital, while still providing critical services to patients in areas with care gaps. Services can also be customized based on what a market needs, operators say.
    - Microhospitals, also called neighborhood hospitals, can provide acute care, emergency services, surgeries, imaging and lab work to treat less complex conditions, such as broken bones or heart attacks. Higher-acuity trauma patients would be sent to a larger facility.
    - Microhospitals could work in urban, suburban and rural areas, depending on market dynamics. They are typically placed in markets that lack acute care services but do not have the patient population to support a full-size facility. Payer mix and nearby competitors are other factors to consider.

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- ✓ Polling Question #2

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Which of the following is not true about microhospitals?

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- **The Centers for Medicare and Medicaid Services (CMS) – Part B Reimbursement**
  - **PMBs and Biosimilars**
    - The leading PBMs are giving preference to biosimilars over branded biologics on their formularies and promising significant savings to health insurers and plan sponsors such as employers.
    - Biosimilars are not exact copies like generics for traditional small molecule drugs. But biosimilars "have no clinically meaningful differences" compared with brand-name large molecule biologics.
    - Not only were most biosimilars administered in clinical settings until recently, but PBMs had a financial incentive to retain brand-name biologics on their formularies because they had profitable rebate arrangements with pharmaceutical and biologics manufacturers.
    - Employers also have been unsure about the economic effects of swapping brand-name rebates for lower-priced biosimilars.

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- **The Centers for Medicare and Medicaid Services (CMS) – Part B Reimbursement**
- **Physician Shared Workspaces**
  - Health systems are increasingly considering shared physician workspaces to make room for more patient care. Some providers have replaced private clinician offices with coworking spaces in their hospitals and outpatient clinics.
  - Coworking office designs typically feature desks and meeting rooms that can be reserved by physicians or are assigned to them certain days of the week. Some workspaces are in a coworking area and others are private rooms that can be used for dictation, meetings or calls. Shared workspaces are often paired with amenities such as lounges, fitness centers and outdoor areas.
  - These types of offices are designed to improve communication and employees' mental health by breaking down silos and promoting rest and relaxation, architects said. Also, health systems can boost revenue and access by repurposing private office space for patient care.
  - Health systems will be forced to do more with less space, especially as construction costs and rents increase and reimbursement declines.

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- ✓ Polling Question #3

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Which of the following are true of physician shared workspaces?

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- **Payers**
  - **Preauthorization by the same Specialty**
    - The Reducing Medically Unnecessary Delays in Care Act would reform the practice of prior authorization in Medicare and Medicare Advantage by requiring that board-certified physicians in the same specialty are the ones making those decisions.
    - It would also direct Medicare, Medicare Advantage and Medicare Part D plans to comply with requirements that restrictions must be based on medical necessity and written clinical criteria, as well as additional transparency obligations.
    - The lawmakers said the bill would eliminate non-expert decision-makers from a patient's care, especially in cases in which a physician had already deemed a particular service necessary.
    - The bill also requires that Medicare, MA and Part D plans publish clinical criteria on their preauthorization standards on the web to show that they're regularly updated and align with current care standards.

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- **Compliance**
  - **Hospital Transparency Executive Order**
    - The new Executive Order builds on President Trump's efforts to increase healthcare price transparency, which he initiated during his first term with Executive Order 13877 in 2019.
    - The 2019 Executive Order required hospitals to maintain a consumer friendly display of pricing information for up to 300 shoppable services, as well as a machine readable file with negotiated rates for every service provided.
    - Additionally, under the 2019 Executive Order, health plans were instructed to post their negotiated rates with providers, their out of network payments to providers, the actual prices they paid for prescriptions drugs, and to maintain an online tool to permit consumers to access price information.
    - The new Executive Order requires the Secretaries of Labor, Treasury and Health and Human Services to implement price transparency regulations by late May. Specifically, the three Departments must require healthcare entities to disclose the actual prices of medical items and services, not estimates.

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- **Technology**
  - **MedTech Firms AI helps Providers**
    - Providers want generative AI technology that makes their staff members' lives easier and increases productivity.
    - While the technology holds promise, there are concerns the lack of regulatory guardrails could create situations in which diagnoses are made without clinician involvement.
    - The technology could generate clinical findings that automatically push patients toward a particular treatment plan.
    - The FDA has been actively developing regulations for AI technology in healthcare and has approved over 1,000 AI- and machine learning-enabled medical devices to date. However, those regulations don't apply to generative AI technology.
    - Firms see traditional AI and generative AI as companions to the clinician, but the clinician makes the diagnostic and therapeutic decision for the patient.

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- ✓ Polling Question #4

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Which of the following is not true about specialty preauthorization?

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