Issue Brief

FEDERAL ISSUE BRIEF

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President Signs Consolidated Appropriations Act, 2023 into Law

On December 29, President Biden signed into law the ***Consolidated Appropriations Act*** for Fiscal Year 2023. The Government Printing Office (GPO) version is 1,653 pages. A copy is available at: https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf.
Most of the Medicare and Medicaid items are in Division FF, Titles IV and V – Health and Human Services, which begins on page 1,169. The following is the table of contents of the Medicare items with short descriptions of the changes.

The provided page numbers refer to the engrossed copy of the bill as signed by the President. (as noted above)

TITLE IV—MEDICARE PROVISIONS

Subtitle A—Medicare Extenders

Sec. 4101. Extension of increased inpatient hospital payment adjustment for certain low-volume hospitals. Extends this provision for two years – through September 30, 2024. (Page 1,437)

Sec. 4102. Extension of the Medicare-Dependent Hospital program. Extends provision for two years through September 30, 2024. (Page 1,438)

Sec. 4103. Extension of add-on payments for ambulance services. Extends a number of add-on payments for ground ambulance services under the Medicare fee schedule through December 31, 2024. (Page 1,438)

Subtitle B—Other Expiring Medicare Provisions

Sec. 4111. Extending incentive payments for participation in eligible alternative payment models. Extends incentive payments for participation in advanced alternative payment models (APMs) through 2025. Under the ***Medicare Access and CHIP Reauthorization Act of 2015*** (MACRA), eligible clinicians who participate in advanced APMs and meet certain payment or patient count thresholds qualify for a 5 percent Medicare Part B incentive payment in payment years 2019 through 2024. This section extends incentive payments through 2025, with a 3.5 percent Medicare Part B incentive payment for services covered in 2025. This section also extends the current freeze on participation thresholds for qualification for the APM bonuses for an additional year. (Page 1,439)

Sec. 4112. Extension of support for physicians and other professionals in adjusting to Medicare payment changes.

Provides additional support for physicians and other health care professionals in adjusting to Medicare payment changes. For services furnished in 2023, this section increases the otherwise applicable Medicare Physician Fee Schedule payments by 2.5 percent. For services furnished in 2024, the section provides a 1.25 percent payment increase. (Page 1,439)

Sec. 4113. Advancing telehealth Beyond COVID–19. Extends all of the Medicare telehealth flexibilities that were extended by the ***Consolidated Appropriations Act of 2022*** through December 31,2024. (Page 1,440)

Sec. 4114. Revised phase-in of Medicare clinical laboratory test payment changes. Delays by one year pending payment reductions and data reporting periods for the Clinical Laboratory Fee Schedule under the ***Protecting Access to Medicare Act.*** (Page 1,443)

Subtitle C—Medicare Mental Health Provisions

Sec. 4121. Establishes coverage of marriage and family therapist services and mental health counselor services under part B of the Medicare program beginning January 1, 2024. (Page 1,443)

Sec. 4122. Additional residency positions. Provides for the distribution of 200 additional Medicare-funded graduate medical education (GME) residency positions. Specifically, this provision dedicates one-half of the total number of positions to psychiatry or psychiatry subspecialty residencies. (Page 1,445)

Sec. 4123. Improving mobile crisis care in Medicare. Establishes a 50 percent payment increase in Medicare Physician Fee Schedule payments rates for crisis psychotherapy services when furnished by a mobile unit, as well as additional settings other than a facility or physician office, beginning on January 1, 2024. (Page 1,449)

Sec. 4124. Ensuring adequate coverage of outpatient mental health services under the Medicare program. Revises Medicare's partial hospitalization benefit beginning on January 1, 2024 to provide coverage of intensive outpatient services. (Page 1,450)

Sec. 4125. Improvements to Medicare prospective payment system for psychiatric hospitals and psychiatric units. Directs HHS to begin collecting (no later than October 1, 2023) data and other information necessary to revise the existing Medicare prospective payment system (PPS) for inpatient psychiatric hospitals and psychiatric units (IPFs). The HHS Secretary is required to update the methodology for determining payment rates under the IPF PPS beginning in rate year 2025. (Page 1,452)

Sec. 4126. Exception for physician wellness programs. Adds a new exception to the Stark Law to allow for hospitals and other entities to provide evidence-based programs for physicians to improve their mental health, increase resiliency, and prevent suicide among physicians. (Page 1,455)

Sec. 4127. Consideration of safe harbor under the anti-kickback statute for certain contingency management interventions. Requires the HHS Inspector General to conduct a review and issue a report to Congress on whether to establish a safe harbor for evidence-based contingency management incentives, which can be used to treat substance use disorders. (Page 1,457)

Sec. 4128. Provider outreach and reporting on certain behavioral health integration services. Requires HHS to conduct outreach to physicians and other health care providers on the availability of behavioral health integration services as a covered benefit under the Medicare program. This education will inform practitioners on the requirements to determine eligibility and bill for behavioral health integration codes. This section also requires reports to Congress on the methods used for provider outreach and on the number of Medicare beneficiaries who were furnished behavioral health integration services. (Page 1,458)

Sec. 4129. Outreach and reporting on opioid use disorder treatment services furnished by opioid treatment programs. Requires HHS to conduct outreach to physicians and other health care providers on the inclusion of opioid use disorder treatment services furnished by an opioid treatment program as a covered benefit under the Medicare program. This education will inform practitioners of the requirements to determine eligibility and bill for opioid treatment services. This section also requires HHS to conduct outreach to Medicare beneficiaries on the availability of opioid use disorder treatment services furnished by an opioid treatment program. This section requires reports to Congress on the methods used for provider outreach and on the number of Medicare beneficiaries who were furnished opioid use disorder treatment services. (Page 1,458)

Sec. 4130. GAO study and report comparing coverage of mental health and substance use disorder benefits and non-mental health and substance use disorder benefits. Directs the Comptroller of the United States to conduct a study to

compare the mental health and substance use disorder benefits offered by Medicare Advantage plans to traditional Medicare and to other benefits offered by Medicare Advantage plans. (Page 1,459)

Subtitle D—Other Medicare Provisions

Sec. 4131. Temporary inclusion of authorized oral antiviral drugs as covered part D drug. Permits coverage of oral antiviral drugs with an emergency use authorization (EUA) from the Food and Drug Administration (FDA) under Medicare Part D through December 31, 2024. (Page 1,460)

Sec. 4132. Restoration of CBO access to certain part D payment data. Authorizes the Congressional Budget Office (CBO) to access prescription drug payment data, including rebate and direct and indirect remuneration (DIR) data, under Medicare Part D. (Page 1,460)

Sec. 4133. Medicare coverage of certain lymphedema compression treatment items. Provides Medicare Part B coverage for compression garments for the treatment of lymphedema, beginning on January 1, 2024. (Page 1,460)

Sec. 4134. Permanent in-home benefit for IVIG services. Provides permanent Medicare coverage for items and services related to the administration of intravenous immune globulin (IVIG), beginning on January 1, 2024. (Page 1,462)

Sec. 4135. Access to non-opioid treatments for pain relief. Provides 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 section also caps the separate payment at 18 percent of the estimated average OPPS payment amount for the surgeries and other services for which the non-opioid is used in conjunction with. (Page 1,463)

Sec. 4136. Technical amendments to Medicare separate payment for disposable negative pressure wound therapy devices. Adjusts payment for disposable negative pressure wound therapy devices by using the supply price to determine the relative value for the service. (Page 1,466)

Sec. 4137. Extension of certain home health rural add-on payments. Extends, for one year through December 31, 2023, the 1 percent add-on payment provided to certain home health agencies that furnish services in counties with a low population density. (Page 1,467)

Sec. 4138. Remedying election revocations relating to administration of COVID–19 vaccines. Revises Medicare coverage rules under the Religious Nonmedical Health Care Institution (RNHCI) benefit to ensure that beneficiaries who receive Medicare-covered vaccinations for COVID-19 do not have their RNHCI benefits temporarily revoked. (Page 1,467)

Sec. 4139. Payment rates for durable medical equipment under the Medicare Program. Extends, through December 31, 2023, the temporary blended payment rates provided under the ***CARES Act*** for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) in certain non-competitive bid areas. (Page 1,468)

Sec. 4140. Extending Acute Hospital Care at Home waivers and flexibilities. Extends the Acute Hospital Care at Home initiative, as currently authorized under CMS waivers and flexibilities, through December 31, 2024. (Page 1,468)

Sec. 4141. Extension of pass-through status under the Medicare program for certain devices impacted by COVID–19. Extends the pass-through payment for certain medical devices for which pass-through status would have otherwise expired on January 1, 2022, for one additional year through December 31, 2023. (Page 1,470)

Sec. 4142. Increasing transparency for home health payments under the Medicare program. Requires HHS to provide publicly available information on the simulation of 60-day episodes under the Medicare home health prospective payment system in effect prior to the Patient Driven Groupings Model. This section also requires HHS to use a public forum to engage with home health stakeholders on the Medicare home health payment rate development within 90 days of enactment. (Page 1,471)

Sec. 4143. Waiver of cap on annual payments for nursing and allied health education payments. Eliminates the annual cap on total payments and excludes any resulting increase from factoring into calculations for nursing and allied health education payments for such hospitals for 2010 through 2019. (Page 1,472)

Subtitle E—Health Care Tax Provisions

Sec. 4151. Extension of safe harbor for absence of deductible for telehealth. Extends through Calendar Year 2024 the flexibility to exempt telehealth services from the deductible in high-deductible health plans (HDHPs) that can be paired with a Health Savings Account (HSA). (Page 1,473)

Subtitle F—Offsets

Sec. 4161. Reduction of Medicare Improvement Fund. Reduces the amount in the Medicare Improvement Fund from $7,278,000,000 to $180,000,000. (Page 1,473)

Sec. 4162. Extension of adjustment to calculation of hospice cap amount under Medicare. Extends, by one year, the change to the annual updates to the hospice aggregate cap made in the ***Improving Medicare Post-Acute Care Transformation Act*** (IMPACT Act) of 2014 and applies the hospice payment update percentage rather than the Consumer Price Index for Urban Consumers (CPI–U) to the hospice aggregate cap through 2032.

Sec. 4163. Medicare direct spending reductions. Extends the mandatory Medicare payment reductions under sequestration for the first 6 months of fiscal year 2032, while revising Medicare sequestration percentages to 2 percent for fiscal year 2030 and fiscal year 2031. (Page 1,473)

TITLE V—MEDICAID AND CHIP PROVISIONS

Subtitle A—Territories

Sec. 5101. Medicaid adjustments for the territories. Extends Puerto Rico's higher federal Medicaid match of 76 percent through fiscal year 2027 and permanently extends a higher federal Medicaid match of 83 percent for American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, and the U.S. Virgin Islands. (Page 1,474)

Subtitle B—Medicaid and CHIP Coverage

Sec. 5111. Funding extension of the Children's Health Insurance Program and related provisions. Extends funding for the Children's Health Insurance Program (CHIP) for two years through fiscal year 2029. (Page 1,480)

Sec. 5112. Continuous eligibility for children under Medicaid and CHIP. Requires children to be provided with 12 months of continuous coverage in Medicaid and CHIP effective January 1, 2024. (Page 1,482)

Sec. 5113. Modifications to postpartum coverage under Medicaid and CHIP. Makes permanent a state option to allow states to continue to provide 12 months of continuous coverage during the postpartum period in Medicaid or CHIP. (Page 1,482)

Sec. 5114. Extension of Money Follows the Person Rebalancing demonstration. Extends funding for the Medicaid Money Follows the Person Rebalancing Demonstration program at $450 million per year through fiscal year 2027. (Page 1,482)

Sec. 5115. Extension of Medicaid protections against spousal impoverishment for recipients of home and community-based services. Extends protections against spousal impoverishment for Medicaid recipients of home and community-based services through fiscal year 2027. (Page 1,483)

Subtitle C—Medicaid and CHIP Mental Health

Sec. 5121. Medicaid and CHIP requirements for health screenings, referrals, and case management services for eligible juveniles in public institutions. Requires states to provide justice-involved youth who are eligible for Medicaid or CHIP with screening, diagnostic, and case management services in the 30-day period prior to their release from incarceration in a post-adjudication setting. (Page 1,483)

Sec. 5122. Removal of limitations on Federal financial participation for inmates who are eligible juveniles pending disposition of charges. Allows states to receive federal matching funds through Medicaid and CHIP for health care services provided to justice-involved youth who are incarcerated in public institutions pending disposition of their charges. This provision takes effect January 1, 2025. (Page 1,485)

Sec. 5123. Requiring accurate, updated, and searchable provider directories. Codifies requirements that apply to Medicaid managed care organizations, prepaid inpatient health plans, and primary care case management entities regarding the publication of searchable and regularly updated directories of health care providers in their networks, including providers of mental health and substance use disorder services. These requirements would also apply to state Medicaid fee-for-service programs. This provision takes effect July 1, 2025. (Page 1,486)

Sec. 5124. Supporting access to a continuum of crisis response services under Medicaid and CHIP. Directs the Secretary of Health and Human Services to issue guidance providing recommendations and best practices to states regarding the development of an effective continuum of crisis care through Medicaid and CHIP. In addition, this section requires the Secretary to establish a technical assistance center to provide support for states in designing and implementing crisis response services. (Page 1,489)

Subtitle D—Transitioning From Medicaid FMAP Increase Requirements

Sec. 5131. Transitioning from Medicaid FMAP increase requirements. Provides funding and requirements for state Medicaid programs to support the transition from the enhanced Medicaid funding and continuous coverage requirements of the ***Families First Coronavirus Response Act*** (FFCRA). This section would sunset FFCRA's continuous coverage requirement as of April 1, 2023 and allow for states to begin the process of initiating redeterminations of eligibility over a period of at least twelve months. States would be able to receive enhanced Medicaid funding from April 1 through December 31, 2023, subject to meeting certain conditions such as updating beneficiaries' contact information and using more than one modality to contact beneficiaries in the event of returned mail. The section also establishes public reporting requirements for all states during this temporary redetermination period and provides additional enforcement mechanisms for the Centers for Medicare & Medicaid Services during this period. (Page 1,491)

Subtitle E—Medicaid Improvement Fund

Sec. 5141. Medicaid improvement fund. Provides $7,000,000,000 in the Medicaid Improvement Fund. (Page 1,495)

DIVISION O—EXTENDERS AND TECHNICAL CORRECTIONS

TITLE X PAY-AS-YOU GO

The ***Statutory Pay-As-You-Go (PAYGO) Act*** of 2010 requires that Congress offset new deficits by the end of each fiscal year. Congress has waived enforcement of Statutory PAYGO since its inception. This bill will waive, again, PAYGO for 2023 and 2024.

Sec. 1001. Budgetary Effects (Page 774)

(d) BALANCES ON THE PAYGO SCORECARDS.—

(1) FISCAL YEAR 2023.—For the purposes of the annual report issued pursuant to section 5 of the Statutory ***Pay-As-You-Go Act*** of 2010 (2 U.S.C. 934) after adjournment of the second session of the 117th Congress, and for determining whether a sequestration order is necessary under such section, the debit for the budget year on the 5-year scorecard, if any, and the 10-year scorecard, if any, shall be deducted from such scorecards in 2023 and added to such scorecards in 2025.

(2) FISCAL YEAR 2024.—For the purposes of the annual report issued pursuant to section 5 of the Statutory ***Pay-As-You-Go Act*** of 2010 (2 U.S.C. 934) after adjournment of the first session of the 118th Congress, and for determining whether a sequestration order is necessary under such section, the debit for the budget year on the 5-year scorecard, if any, and the 10-year scorecard, if any, shall be deducted from such scorecards in 2024 and added to such scorecards in 2025.

Comment

There is much in this long bill. Providers with issues of the items above should review the bill language for additional information.

Questions? Contact Andrew Wheeler, MHA's Vice President of Federal Finance, at 573-893-3700 | ext. 1336 or awheeler@mhanet.com.

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