Healthcare Regulatory Roundup #91 Webinar Transcript

Washington Updates – Navigating the Latest Regulatory Changes in Healthcare

Presented March 27, 2025

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SPEAKERS

Martie Ross, Kathy Reep, PYA Moderator

SUMMARY KEYWORDS

Washington updates, healthcare regulatory, Trump administration, HHS positions, continuing appropriations, fraud waste and abuse, telehealth waivers, budget reconciliation, mandatory spending, discretionary spending, Medicaid cuts, price transparency, DEI policies, health equity, EMTALA, Medicare Advantage, tariffs, Continuing Appropriations and Extensions Act, low-volume hospital payment adjustment, Medicare-dependent hospital program, Physician Fee Schedule rural ambulance pickups, acute hospital care at home waivers, Affordable Care Act, MedPAC and MACPAC reports

WEBINAR SUMMARY

The webinar covered key updates on healthcare regulations and policies. Martie Ross and Kathy Reep discussed the Trump administration's impact on healthcare, including the elimination of 20,000 HHS positions and the extension of various healthcare provisions. They highlighted the Continuing Appropriations and Extensions Act, which includes six-month extensions for key programs like the low-volume hospital payment adjustment and Medicare-dependent hospital program. The discussion also covered the budget reconciliation process, potential tax cuts, and the impact on Medicaid and Medicare. Additionally, they addressed the Trump administration's focus on price transparency, DEI policies, and the potential reversal of health equity initiatives.

The webinar focused on 8 key topics:

1. Introduction and overview of Washington D.C. impacts to healthcare
2. Continuing Appropriations and Extensions Act
3. Budget Reconciliation and Appropriations Process
4. Health Policy and Diversity, Equity, and Inclusion
5. Health Equity Initiatives and Price Transparency
6. Affordable Care Act and Medicare Payment Rules
7. Legislation and MedPAC and MACPAC Reports

8. Final thoughts and next steps – evaluating and preparing for changes

ACTION ITEMS

- ☐ Track and evaluate the impact of policy and regulatory changes on your organization's operations.
- ☐ Update policies and procedures to ensure compliance with new requirements.
- ☐ Keep your board and management informed of changes that may affect them.
- ☐ Manage anticipated revenue reductions and assess fraud and abuse risk.
- ☐ Stay up to date on the final Medicare Advantage and other payment rules expected in April.

TRANSCRIPT

PYA Moderator **00:10**

Thank you for joining us. The webinar will begin shortly.

Good morning, everyone. Welcome to the latest episode of PYA is Healthcare Regulatory Roundup compliance webinar series. Today's topic is *Washington Updates.* PYA is happy to present today's webinar on this important topic.

You may submit questions during the webinar by typing a message into the Q and A pane of the control panel. Also immediately following the end of the webinar, you'll be asked to complete a short survey and submit any additional comments. Any questions posed during the webinar will be responded to via email after the webinar, we've posted a PDF copy of the presentation slides for your reference in the resources pane. Also, you'll receive an email later today with a copy of the slides and a recording of the webinar. You can customize your viewing experience by resizing, moving or minimizing all of the panes within the webinar.net platform.

With that, I'd like to introduce our presenters, Martie Ross and Kathy Reep.

Martie Ross **01:29**

Thank you, Jennifer. Welcome everyone. For those of you who are first timers, this is PYA's Healthcare Regulatory Roundup webinar series. Twice a month, PYA consultants discuss hot topics in healthcare, and certainly we are of no shortage of hot topics. Today is day 66 of the Trump administration, and if anything, we certainly know the President has made good on the promise that he would go wild on healthcare, as he stated during his speech at Madison Square Garden in late October. And we will discuss several topics today of interest. This is this was current as of 8am Central Time today, and then as many of you probably received the alert from your favorite news source, the announcement that Robert F. Kennedy would be eliminating an additional 10,000 positions at HHS, bringing that total now to 20,000 or one quarter of the workforce of HHS. So certainly, that will have impacts as well, but we will not go into any detail there.

This is our hot topics. Others may have different hot topics as they look at what's going on in the industry right now, but our goal here is really to keep you up to date, to highlight what's going on, a level of awareness, right? But also, to talk about the impacts this have to position you to adjust strategy and tactics

to respond to the environment. So, without further ado, topic number one, which is the full year Continuing Appropriations at Extension Act, one of a whopping four pieces of legislation that Congress has passed so far in the 119th Congress. So, Kathy Reep, over to you.

Kathy Reep **03:18**

Sure! We're essentially looking at once more kicking the can down the road. So, what we had in the Continuing Appropriations and Extensions Act that was passed, I guess it would have been about the 14th of this month. We wound up with, again, some six-month extensions. We had three-month extensions, now we're up to six months. So, we've got provisions that will, again, expire at the end of September, absent Congress stepping in and taking additional action.

The provisions that we are most concerned about in terms of those extensions were continuing the low-volume hospital payment adjustment; Medicare dependent hospital program, continuing as it was; keeping the add on payments for rural ambulance pickups, continuing the acute hospital care at home waivers; and again, I think this has been kicked down the road for many years, the projected $32 billion in cuts for Medicaid disproportionate share payments that came about under the brew was required under the Affordable Care Act. This was to be done at $8 billion a year. Keeps getting pushed down. So, it would be nice to have the Congress just say, let's forget that, and let's not do it completely. We were hoping that Congress would step in and protect the physicians and increase the payment for the physician under the Physician Fee Schedule, under the final rule that came out in 2024 for 2025 we were looking at a 2.83% cut. They were still there. There has been no solution to helping physicians, and even those hospitals for their outpatient therapies and mammography services. They did not continue the Advanced APM incentive payments for 2025, that is also out. I think it's going to be very hard Martie to make any of this retro, when we're talking probably early fall or late summer before we get any more legislation.

Martie Ross **05:41**

Right, and potentially legislation that's been discussed about overhauling macro, the macro system for determining fee schedule payments. So, stay tuned. Certainly, some interesting things going on there.

The legislation also addressed the extension of the COVID-era telehealth waivers, again through September 30 of 2025. We had hoped, long ago for a whole year or two-year extension of the waivers, or even, please, making these waivers permanent to ensure Medicare beneficiary access to telehealth services.

On the next two slides, we have summarized what is the current state of telehealth. Because really, to get the full picture, you have to have both what Congress did in this legislation as well as the changes that CMS made to telehealth coverage as part of the Physician Fee Schedule for 2025. But remember, we now have a distinction between telebehavioral health services, which now are available to individuals in their homes on a permanent basis; versus medical telehealth services, where that short term six-month extension is now in place. As well as changes in the who can provide telehealth services, we have a short-term extension for PT, OT, and speech pathology, speech language pathologist, will be continued to provide those telehealth services. Also addressing rural health clinics, FQHCs, and how they can provide and be reimbursed for telehealth services. And then the issue of audio-only versus audiovisual telehealth services, also addressed through both the regulatory changes as well as the statutory extension of the waivers. That gets us…we're done with FY 25.

Kathy Reep **07:31**

That's where we are!

Martie Ross **07:33**

Exactly. That's where we are for FY 25. That basically, still on the budget that was written in FY 22 that extended forward through continuing resolution. So, let's talk about what's going on for FY 2026. Specifically looking at the budget reconciliation process and appropriations, and I think sometimes you just got to go back to the beginning. So just to make sure we have a clear understanding of the difference between the reconciliation process and the appropriations process. There are two separate things that Congress do, and oftentimes they're kind of conflated together. So mandatory spending, taxes and the debt limit, and debt financing are always addressed through budget reconciliation. This is a process done by Congress that covers multiple fiscal years, and it is passed by a simple majority in both chambers, so budget reconciliation is not subject to the filibuster that requires 60 votes in the Senate. As you can see by the graphic on the right-hand side, mandatory spending is more than twice what discretionary spending is, and this is where the Medicare program, Medicaid, Social Security, a number of other programs reside. So, they'll continue forward year after year, absent Congress stepping in and making changes to those programs. By comparison, discretionary spending is everything else, and this is handled through the appropriations process. It covers a single or even a partial fiscal year, and it is subject to filibuster, so it does require 60 votes in the Senate. And as you see that discretionary spending is a much smaller piece of the pie. So, we talk about partial government shutdowns, which we were facing on March 14. That was because there was no discretionary funding in place going forward to the end of this fiscal year. That's the gap that's now been filled. So, what we're going through now in Congress is around this reconciliation process, the budgeting really for 10 years going forward. So, Kathy, let's talk about the house budget resolution.

Kathy Reep **09:36**

Sure. What the House is looking to do is they have passed a budget resolution that is basically a form with some numbers, if no detail. This committee is to identify a certain dollar amount and savings. So, what they want to do is to offer us $4.5 trillion in tax cuts. I don't think we're going to say we don't want it. We might, but $4.5 trillion in tax cuts, those have to be paid for. So, there are several committees that have basically been instructed, to find savings for specific dollar amounts. Energy and Commerce, $880 billion. Well, the significant area that is under energy and commerce that impacts us is Medicaid. And therefore, what would they be looking to do from the Medicaid side? Also, agriculture. They want $230 billion in cuts identified through agriculture. Well, that would be the SNAP program. So, concern about what will actually come out in legislation from those committees. They have been told dollars; they haven't been told details or come up with details. Today is March 27. Today is the day that the committees are required to submit their legislation to the Budget Committee in the House with details of what they're actually going to do. Are we going to see that, Martie?

Martie Ross **11:10**

No. I mean, because the Senate never acted on this legislation, so we don't have a full approved budget resolution. But that was the goal, was March 27 that was all done by April Fool's Day. And apparently that's not where we're at, I’m sorry.

Kathy Reep **11:22**

But they're actually now looking at, there will be paper next week. I saw that this morning, and then there was an in addition to those two committees. There is a mandate to find another $500 billion in spending reductions without specific committees being targeted for those. Everybody else come up with a total of. The catch in this is, to get that $4.5 trillion in tax cuts, we've got to have that reduction in spending. And it's a, if you get more than the mandated dollar amount, we're going to get greater tax reductions. If we wind up with less reductions in spending than are projected, then we're going to wind up getting lower tax cuts. So, I think it's a waiting game to see what happens. And don't forget, this is a House only. We've got to get the House and the Senate in on this as well.

Martie Ross **12:28**

Well, no sooner was ink dried on the February 25 budget resolution that the politicking started. Beginning with a publication of a Congressional Budget Office report on March 5 that addressed the spending under the jurisdiction of Energy and Commerce. So, if they're charged with cutting $880 billion over 10 years from their budget, what are their opportunities? And so CBO, at the request of certain Democratic legislative members of Congress, said, here's what you have on the table: exclude Medicare, because that is actually under the jurisdiction of multiple committees and there was no specific direction in the budget resolution regarding it. But 93% of what is under E&C's exclusive jurisdiction is Medicaid funding. The other spending totals only $135 billion, accounting for offsetting revenues. The Energy and Commerce chair still maintains that they can achieve their $880 billion goal without cutting Medicaid benefits, specifically focusing on reducing or eliminating provider taxes and potentially reducing the 90% match for expansion population. So, benefits may not change, but apparently the amount going to the States could become an issue.

There's always the conversation around fraud and abuse, the opportunity to eliminate fraud and abuse as a way to pay for tax cuts. That gets you to a March 11 report from the Government Accounting Office summarizing the agency's reports on improper spending. And we find that in 2024 it totaled about $161 billion which is good news is that's less than the prior years. Bad news is those prior years are inflated because of COVID funds, and that's why you had a higher degree of improper spending during those periods. But you can see here that in the Medicaid program, they identified about $31 billion in improper payments. Now, an improper payment…yes?

Kathy Reep 14:30
Okay, just a quick question about this. We're looking at Medicare and Medicaid as being the big pieces of the pie. For both of those programs to identify waste, fraud and abuse, it really does get into, in my mind, a lot of audits, right?

Martie Ross 14:52
Absolutely, because this is….

Kathy Reep 14:54
And we've lost 20,000 people who are probably geared to doing these audits.

Martie Ross 15:03
It'll be a very efficient workforce.

Kathy Reep 15:05
Okay.

Martie Ross 15:07
On that point, Kathy, improper payment is not waste, fraud, and abuse. It is a broader topic than that.

Kathy Reep 15:13
It is broader, but it's a large part of it.

Martie Ross 15:17
Well again, look at the data that's coming from GAO, talking about the Medicaid improper payment rate. They set it at 5.1% so they say that 20 95% of the outlays are appropriate in line with regulatory and legislative direction. But where that 5% divides, we'll look at this, 75% of that coming from insufficient documentation to support the service. So, yeah, some percentage of that certainly would be the service was never delivered. But as we know, being in the healthcare industry, many instances where there just isn't the documentation in the record to support what, in fact, was a service that was delivered. So that is exactly where you have to go into the audits to specifically find what was provided that would constitute fraud and abuse. So, there's, there's a lot of work here to go in that space. But what about Medicare? Kathy, what can they do there?

Kathy Reep **16:11**

Well again, just like with the issue of Medicaid on the slide Martie addressed that indicated that we are not going to touch benefits, or we don't believe we need to touch benefits, Medicare payments/Medicare benefits are also off the table. But that leaves the issue of payments to the providers. We talked last week, if you did not, two weeks ago, if you did not hear a webinar on site neutral payment reforms, we urge you to take a look at that, because it’s getting a lot of traction on potential reductions to a number of provider types based upon equalizing payment levels. A lot of issues that we have seen this addressed over the years: eliminating or reducing payment for reimbursement for Medicare bad debts; uncompensated care payments, essentially taking this out of a payment under the Medicare program to hospitals and putting this into a program that really would cover other providers along with hospitals that provide care to low-income individuals. But again, reducing the pool of money available. Reforming physician payment methodology, we want to see an increase in physician reimbursement, not a reduction in physician reimbursement. So, recognize we've got a number of items on the table that we need to keep our eye out for detail and legislation in terms of what they might do.

Martie Ross **17:38**

And just keep in mind, I mean, the mandate here we're talking about is cuts to mandatory spending, right? We're talking about budget reconciliation, not appropriations. And as you can see from the graph on that right hand side of your screen, these programs, once you get past Medicare, Medicaid, and Social Security, there's not a lot there to move.

Kathy Reep **17:58**

And Social Security is off.

Martie Ross **18:01**

I'm sorry, exactly. You don't look at the Social Security number, right? So that $1.45 trillion, that is not on the table, we're told. But so, you're looking at major healthcare programs as a significant source of potential cuts, and so industry beware, I guess is the best thing we can say there.

So, let's wrap this up and talk about what had been referred to as the big, beautiful bill. The Trump administration's desire to have a piece of legislation that would address priorities across border security and defense, as well as energy; but also to find that pay to both to renew the 2017 Trump administration tax cuts, but also to address other promises made in reducing taxes against tips, overtime, state and local tax. So, that was the goal, to have it in one beautiful bill. If you go back to February 25, it seemed we were headed that direction with the passage of the budget resolution. But where we are today is certainly some, shall we say, discussion between Senate and House leadership. The Senate also had passed its own budget resolution, but it did not address tax cuts at all. Did not, and thus did not address the spending cuts that correspond with that. So, there's now pressure from the House for the Senate to adopt their version of the legislation. The current compromise, and literally, this is as of yesterday afternoon, the current compromise under discussion was to not provide specific committee direction, just to say, here's the target amount, but we're not going to say $880 billion out of E&C. So that's one potential resolution.

We've also got the GOP members of the House talking about additional tax cuts again that were not reflected in the House Resolution. Again, with tips, overtime, and salt. We've got a group of senators, led by Lindsey Graham from South Carolina, that are advocating for what's called a current policy baseline, meaning that for purposes of calculating the offsetting cuts to pay for a tax cut, so offset spending to pay for a tax cut. They're saying, rather than treating the 2017 tax cuts as temporary, they should be treated as the current policy baseline. And so, if we're simply renewing those tax cuts, we don't have to pay for it. This issue is currently under the jurisdiction of the nonpartisan Senate parliamentarian to determine whether, in fact, that is an appropriate way to calculate for purposes of budget neutrality. The parties apparently are present, each party is presenting their closing arguments to the parliamentarian, sometime this week, maybe into next week. But we'll expect a decision there that would certainly shake up this conversation if we didn't have, you know, if we started $4 billion ahead of, excuse me – these Ts, $4 trillion. Excuse me, we'd start 4 trillion ahead. So that will be a very interesting development. We of course, have the issue with the debt ceiling and whether that will be addressed in this legislation. CBO announced Congressional Budget Office announced yesterday that they believe that the target will be reached sometime in August, if not earlier, depending on tax receipts received by tax day on April 15. And congressional leaders are proudly promising that they will have an agreement and a resolution passed prior to April 11, which is when they start their two-week Easter recess. So, we'll stay tuned and see how the negotiations go forward on this legislation.

Kathy Reep **21:34**

Our next HRR could be very interesting.

Martie Ross **21:37**

We'll see what's going to happen, because we're scheduled for about that time. Let's talk about other policies.

Let's get away from the money and talk about other health policies, beginning with the administration's focus on diversity equity and inclusion policies. And let's just take a kind of a level set of where we are in terms of policy coming out of the Trump administration. And really, the goal here is to stop unlawful DEI-related workplace discrimination, that is our focus. It starts with the January 21 executive order on ending illegal discrimination and restoring merit-based opportunities. That executive order instructed federal agencies to terminate any of their discriminatory policies, and also to require federal contractors and grant recipients to certify that they do not operate DEI programs that violate any anti-discrimination law. Now, when that EO was issued, folks went to court and secured a preliminary injunction preventing the enforcement of that executive order, and now last week on March 14…was that two weeks ago? I lose track of time, Kathy. Sometimes it's sort of like March of 2020, all over again. Kind of losing track of time. But the Fourth Circuit ruled that it would stay that nationwide preliminary injunction on the executive order, certification, termination, and enforcement provision.

So, we are back where we were on January 21, with direction to cabinet officials to move forward with the certification process. Appreciating very specifically in the executive order, it refers to this certification to be made by contractors and grant recipients as a material representation. Meaning they could become the basis of false claims act liability, if it were proven to be false; that in fact, there were improper policies by that contract or grant recipient. Of course, the question always is, because you take Medicare, does that make you a federal contractor? Prior announcements from the Office of Federal Contract Compliance Programs has said, no, merely being a Medicaid, Medicare, participating provider does not make you subject to OFCCP's jurisdiction. But that is still an open question under this EO, so stay tuned on that particular issue.

Okay, then we get to February 5. Two things happened then. The Attorney General issued her memo directing the Office of Civil Rights to investigate, eliminate, and penalize illegal activity, illegal DEI activities, in the private sector. But noted in that memo that that was not intended to make illegal those types of activities that really promote awareness without engaging in any form of exclusion or discrimination. Also on February 5, Office of Personnel Management issued a memo that required agencies to end diversity requirements, both in hiring panels as well as candidate pools and any sort of discriminatory employee resource group. So, if you've got a women's group meeting, an Asian American group meeting, that that would be prohibited under this new OPM guidance.

Then, March 19, we had the Equal Employment Opportunity Commission as well as the Department of Justice issue technical assistance guides directed to the private sector regarding DEI-based discrimination. Taking the position that Title Seven would prohibit any DEI initiatives that could, in fact, result in taking employment action motivated by a protected characteristic. So, this is intended to say you can't decide you're going to hire a woman for this position, but instead, it has to be solely a merit-based determination. And that guidance lists the type of disparate treatment, which is intended to prevent from, of course, hiring, firing, promotions, and demotions, but also access to mentorship, sponsorships, any types of workplace mentoring participation; again, in employee resource groups, as well as job duties or work assignments. So the guidance there from EEOC, just we included a couple of quotes from that guidance, specifically noting that making an employment decision because you're trying to meet a customer preference for a certain workforce composition, that is not justification for engaging in discriminatory activity. Noting that depending on specific facts and circumstances, there may be a claim that DEI-related training may, in fact, create a hostile work environment if that training is discriminatory in content, application, or context. And that there is no general business interest in diversity that would be recognized as a basis for allowing race

motivated actions. Just note here, we do have really good research showing in the healthcare workforce, in particular, the diversity of folks that provide care actually improves patient outcomes, but how that squares with the EEOC guidelines, I think, is something we will be learning over the next several months.

Related, let's talk about the future of health equity initiatives under the Trump administration. If you recall, the Biden administration put health equity front and center in their health policy, issuing their framework for Health Equity back in 2022. And again, saw a number of policies growing out of this orientation to health equity, but we may begin seeing some reversal of course within CMS, starting with the February 19 executive order That disbanded the CMS Health Equity Advisory Committee. Now the CMS Office of Minority Health is still there, at least on the website. It continues to operate. It continues to have health references to health equity on the website. The CMS framework, however, has been it still has the same priorities, but it has been rebranded as a framework for healthy communities. But going forward, on March 4, we had the rescission of guidance that had been issued by the Center for Medicaid that discussed how states could approach providing services and support that address health related social needs. That guidance was rescinded in its place, the center says that we will make decisions on a case-by-case basis with applications for state plan amendments on whether we will allow Medicaid coverage for those types of initiatives.

Earlier this month, we saw the removal of the hospital commitment to health equity measure from the Medicare Beneficiary Quality Improvement Project. Now MBQIP is the voluntary quality reporting program that critical access hospitals participate in and there is, each year, published a set of measures that they're directed to include. Was set to come on in 2025 was a measure that we are very familiar with in the IPPs world, the OPPs world, which is the hospital, the commitment to health equity. But now that has been removed from the measures for reporting. That raises questions we're going to see coming up for the other quality report statutory, whether we'll see changes there and then. Through February and March, we have seen the cancelation of literally dozens of National Institutes for Health grants that were related to health equity. And literally, there are pages of terminated grants available on the HHS website. You see the link there, and you see there the language that was used in the termination letter was very critical of research relating to health equity and ways in which to address health equity.

As you may well know, we have sitting over at OMB the entire set of federal fiscal year Medicare payment rules, as well as the Medicare Advantage final rules. They're all there waiting for us. We expect them to be released in April, but here we are very closely watching how this attitude towards health equity as a policy priority finds its way into these payment rules. Again, sort of will we see those stitches that the Biden administration made in the payment rules undone with these proposed rules, certainly for staying on top of that.

Kathy Reep **30:18**

And one thing on those proposed rules, Martie, is a number of them were actually sent to the Office of Management and Budget prior to, I mean, fairly early on in the new administration. So, what we're looking at, did they have time to make changes to that? Are we going to wind up seeing something in a final rule that we really didn't have a lot of anything addressed in a proposed rule?

Martie Ross **30:43**

Now it's never a dull moment, Kathy. I guess we'll say that a few times. Let's talk about, for those of us that likely read the Federal Register, yes, nerds that we are.

Let's talk about the Affordable Care Act insurance marketplace. So, these changes we're seeing there, beginning with the ACA Navigator Program. So, between, for the last several years, we have seen an influx of dollars into the Navigator Program intending to provide counseling and advice to individuals seeking insurance coverage under the exchange. And it's had budget had increased from what was $10 million in the first Trump administration, through COVID, up to $100 million a year. These are grants that are awarded to private organizations that then help navigate individuals through both ACA coverage, as well as identifying whether they're eligible for state Medicaid. They, on for February 14, they announced that they would be again reducing those monies down to $10 million again, claiming that that will result in savings of $360 million over the next four years, and that having the trickle-down effect of reducing premium prices on the exchange. In that announcement, there's a discussion of the effectiveness of the Navigator Program, noting that only 92,000 individuals were enrolled through Navigator in the 2024 plan year, despite record employment, excuse me, record numbers in the exchange this year. And also noting that post-enrollment assistance, again, was only limited to 86,000 consumers; when back in 2019, on a much thinner budget, that had been 205,000. The one thing that is not addressed in this announcement but is included in the report on the Navigators, is that Navigators also helped about 300,000 people find their way into the Medicaid program as well, and that no longer will be available through the Navigator Program.

We saw, on March 10, a proposed rule published by the Trump administration on marketplace integrity and affordability, and this rule is definitely had its genesis in part on reports last year that folks had been enrolled in a Marketplace plan without their knowledge. Sort of brokers engaging in less than appropriate tactics to get folks enrolled in marketplace plans, where they would then get their broker payment attached to that new enrollment. So, there are multiple provisions in this proposed rule that are intended to stabilize the risk pool, lower premiums, and reduce improper enrollments. But out of the gate is a proposal to reduce the length of the annual enrollment period by one month, so smaller opportunities for individuals to enroll in the marketplace. Also strengthening verification, income verification, modifying the eligibility redetermination procedures to make sure they're more stringent, eliminating the monthly special enrollment period for individuals whose income falls below 150% of federal poverty level, limiting access to the Dreamers and considering them no longer lawfully present in the United States for purposes of qualifying for ACA coverage. And then again, some reforms also to the broker and agent process to reduce this potential for fraud.

The other provision in here, in addition to those sort of financial, financially driven provisions, is a prohibition on insurers through the ACA, providing coverage for sex trade modification is essential health benefit, and the justification cited by the administration is that, by statute, ACA coverage is to be the equivalent of a standard employer coverage, and because employers do not cover these sex trade modifications, it should no longer be considered an essential benefit covered under the ACA plans. So again, comments are due. This proposed rule on April 11, going forward.

Kathy Reep **35:06**

The other topic, of course, I really need to take a look at, that's hospitals. You need to look at this because this has significant impact on the potential for alert, increasing your number of uninsured individuals that you're taking care of. If, if you take the if you just eliminate that special enrollment period that currently allows individuals to sign up for under the exchange on a monthly basis, I mean to actually any time that they lose their job to then go in and get coverage, you're going to wind up having people more people who lack coverage, if this follows through. So, you need to comment on this.

Martie Ross **35:45**

And talk about lacking coverage, the issue of the enhanced premium tax credits. Again, from 2021 to 2025 we saw eligibility expanded to individuals earning more than 400% of federal poverty level, and these again, they're set to expire at the end of this year. It appears there's no congressional interest in extending those expanded tax credits or otherwise making them permanent. The Congressional Budget Office released a report saying that unless the tax credits are extended through 2026. We expect to see the number of individuals without insurance rise by 2.2 million in 2026 and then, if there's not a permanent extension, they took the numbers out through 2034 and said we'd see an average of 3.8 million more individuals who are not who are uninsured. Just for reference, in 2025 CMS says there's about 27 million uninsured, about 7.6% of the population. We're going to add to that about just shy of 4 million individuals just because of kicking them off of the exchange or making the exchange unaffordable because they don't longer have the tax credits available to them. Kathy, let's talk price transparency.

Kathy Reep **37:02**

Sure. As we had in the prior Trump administration, we have another executive order related to price transparency. This came about on February 25 it is the, if we can get all this out, Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information. Got that? And essentially, what this executive order does is it tells the tri-agencies, Treasury, Labor, and HHS to take action within 90 days. Think about this. We've got 90 days. We've got an inpatient rule already sitting at OMB, so we aren't going to have anything included there. It's going to be pushing it to have something in the outpatient rule. But here we go, require disclosure of actual prices, not estimates, for all items and services. We just had a requirement as of January 1 this year to post estimated payment amounts for any services that we provide where our contracts with payers include a formula or an algorithm. But now, this is disclose actual prices, not estimates. The tri-agencies are required to issue either updated guidance or a proposed rule. I think we are kind of thinking we're going to get guidance, as opposed to a rule. It could be an interim final rule, something like that, that's to make sure that the pricing information is standardized and comparable across hospitals and insurers, including prescription drug prices. Drug prices has been an issue that providers and insurers have struggled with, because your rates actually fluctuate from week to week, and what you are paying for drugs, and then what are the contracted drug prices with Walgreens, with CVS, etc.? So, on the insurer side and increase enforcement and making sure that the services that the requirements for posting these prices are done and are clearly transparent. Concern with this is that we are just we've just gone through a major round of requirements that started back January of last year, but major focus in July of last year and January of this year now new regulations that could have perhaps be requiring additional expenditures to take more changes. And I think Martie's favorite words from the executive order related to this, recognize that in the fact sheet that came out with the EO, when healthcare prices are hidden large corporate entities like hospitals and insurance companies

benefit at the expense of American patients. You usually don't see hospitals and insurance companies linked together as large corporate entities. And again, when in the delivering on the promise to put American patients first, holding the healthcare industrial complex accountable for delivering transparent prices, those are words that we did not even see in the first executive order. It was so very concerning about where this is going to take us, the nature of what we might see in the next 90 days or less.

Martie Ross **40:31**

Yeah, the written responses by Dr. Oz to the committee members questions were published this week.

Kathy Reep **40:43**

And there's steps to improve existing price transparency requirements, increase enforcement of price transparency requirements and identify opportunities further empower patients with meaningful price information. We've already seen enforcement step up very aggressively this year. Now we're going to actually have more.

Martie Ross 41:04
It's definitely an area of focus. But what I think should still be called doggy, but let's talk DOGE, Kathy.

Kathy Reep **41:10**

Yes, the Department of Government Efficiency. A couple of things just to share about this. First of all, if you go to doge.gov we've given you the website, you get a lot. This is the actual savings by department. These are the top 10 agencies where we have savings. You can then scroll down and actually look at where are these savings coming from. Unfortunately, if you do, what you're getting right now is the dollars we've saved from terminations of employees' dollars that are long, I mean, at the department level, you're getting that it's 68 pages long. When you're actually going in and looking at the various savings, and I would say probably the last at least 20 or so pages are $0 amounts because they haven't been valued yet. They are, they are listed there within the 68 pages. But the other thing that you actually wind up with, not only the leaderboard again, HHS being on top, but as every Monday, they are going to be updating the website with the savings to date. So as of this Monday, March 24 we're looking at an estimated savings of $130 billion which means $807 per taxpayer that has been saved. And this is considered a combination of asset sales, contract and lease cancelations, fraud and improper payment deletion, interest savings, and workforce reductions. So, recognize that the targeted dollar amounts that they've posted are significantly lower than what we've been told.

I would just want to clarify that Martie is the one who comes up with the titles for these little categories. So, let's look. Let's look. Let's look at ICE and the fact that we did have the resin of an a prior administration policy that protected healthcare organizations, hospitals, clinic hospitals, churches, and schools from ICE enforcement, immigration enforcement. But we are seeing now a more aggressive attempts from ICE to come in, because the sensitive locations have been lifted.

You need to make sure that you have a good policy and that you have educated, reeducated your staff on ICE access to your organization. They cannot go into a private area, a patient area, without a judicial order. This is going to be a warrant signed by a judge. They can be in your parking lot, they can be in your lobby, anywhere that is a common area within your hospital, but they have to have a judicial order or warrant in

order to go into patient care areas. Clearly make sure that you're educating your staff, and I would make sure that you look at your signage that clearly indicates that certain areas are not open to the public. And make sure that is very clear, so that if someone is trying to get in, you've got the signage there. The other thing we are seeing is ICE coming to hospitals to inspect paperwork associated with individuals who are working under a visa within your organization, making sure that they are working the hours that the visa covers, making sure that they are doing the job that the visa covers. And there is a requirement that ICE present a notice of inspection for coming into your organization and wanting to review those staff records. But many times, ICE presents that, when they come, they don't give it to you in advance, telling you they are coming. So please make sure that you are aware of the ability for the ICE to come and present and inspect your patient your employee records.

Martie Ross **45:33**

The CMS alert issued on March 5 on protecting children from chemical and surgical mutilation. It is more of just taking a policy stance, as opposed to any specific action direction regulation at this point in time. But this is published by the Center for Quality Standards, excuse me, Clinical Standards and Quality. It's a memo directed to hospitals that's related to the executive order protecting children from chemical and surgical mutilation. The memo challenges research on medical interventions for gender dysphoria in children and asserting that the United States is now an outlier in treatment of this condition. Again, no regulatory action, but very clear that there will be more forthcoming on the subject. Note here that the section of that EO that prohibits federal grantees providing such service are is still subject to a preliminary injunction. But we did have a March 6 letter from HRSA stating the agency would still be reviewing its policies, grants, and programs in light of the concerns that are in the cited in the memo. My guess, Kathy, is the IPPs rule is going to have some new Conditions of Participation on this subject. That's my guess of where this is headed. But we will see, we'll see. Anything else?

Kathy Reep **46:51**

I think it's a question of timing.

Martie Ross **46:54**

Yeah, yeah, exactly. So, there it is.

EMTALA and pregnancy-related emergencies. Where you're not leaving, no stone uncovered. Let's talk about litigation, because that's where this policy change is coming from. So, in 2022 following the Dobbs decision, the Biden administration was taking action based on its position that EMTALA, the obligation to provide emergency treatment, preempts state law prohibiting abortions. And specifically, the administration sued the state of Idaho, which has a life of the mother only exception in its abortion law. And it argued that, in fact, abortion laws, because of EMTALA, need to not only be life of the mother, but health of the mother. The district court in that case had issued a preliminary injunction in the Biden administration's favor. This was the case that had been appealed up last year, and all eyes were on the Supreme Court and how they would rule. But they took the, “it's not right for judicial consideration” path, and said the this was there was no controversy to be decided and instead left that preliminary injunction in place as it dismissed the appeal to the Supreme Court. On March 5, though, the Department Justice and the state of Idaho announced that they had agreed to dismiss the lawsuit.

Don't rush to read the motion to dismiss, because it does not offer any specific explanation. This is not the end of the story; however, because we still have the St. Luke's litigation going on. This is the largest not-for-profit health system in Idaho. They are making the same argument the Biden administration made, which was that EMTALA requires that the health of the state's abortion law be read to not only have a life of the mother, but a health of the mother exception in it. This is an issue of some extent, because we have five other states besides Idaho that do not have a health of the mother exception included in their state legislation. So certainly, wanted to keep an eye on now with the St Luke's case still going forward. But also, will we see other action in this area by the Trump administration, for example, the changes that went into effect in December of 2024 to the HIPAA Privacy Rule addressing reproductive health care. Will we see some pullback or even reversal of those positions? There again, also part of that Biden administration response to Dobbs on March 11.

We received a fact sheet from the Center for Medicare, CMS Innovation Center, what they were doing with their programs following review. So, on March 12, they announced that they were discontinuing four innovation models by the end of this year. Most impactful, probably, is making care primary, which was a new program that was intended to go for 10 years. Instead, it will now terminate at the end of this year. As well as primary care, first at the end stage renal disease treatment choices in the Maryland total cost of care. The Maryland model they're now moving into ahead, which is the different models that made sense. The center also indicated they'd be scaling back the Integrated Care for Kids model, and Medicaid, and CHIP, and scrapping two drug pricing policies announced in 2023. And they claim that this action will end up saving taxpayers $750 million just on these models alone. There is, in the announcement, clear indication other active models will continue to move forward. That includes the TEAM mandatory episodic payment model. No pull back there, although, again, we'll see what's in the IPPS. Potentially that TEAM and then, importantly, notation at the center will be moving forward with a new strategy consistent with this Make America Healthy Again strategy from RFK. And we'll see where exactly these models will take us over the next few years, but certainly we will continue moving forward with that Center for Innovation as that pilot program.

Interestingly, in this announcement, there was a direction to also go to the Medicare Shared Savings Program site that's maintained by CMS, because they were announcing the 2026 deadlines for applying for participation in the Medicare Shared Savings Program. A bit of a surprise because Project 2025, for example, specifically called for axing this program. It's not part of CMS Innovation Centers portfolio, because it's a permanent program within CMS, but we will see where that moves forward. If we will see changes in that program in the next round of rules.

Tariffs. But we kind of referenced this previously, but it is, I am not going to attempt to say where we are today on which tariffs are in effect, which are not. And we know that coming April 2, the Trump administration has promised another round of tariffs, beyond just Canada, Mexico, and China, which of the current had been the focus of tariffs up to this point in time. But we're just referencing here some research done by black book market research. They surveyed about 160 key stakeholders in the healthcare industry of what they anticipated increases in tariffs would result in. The news is not good, because these folks say that we expect pharmaceutical costs to go up. We expect disruptions in the supply chains. We expect more challenging contract negotiations. We think this is going to end up delaying equipment upgrades within hospitals. And because hospitals already run on tight margins, the insurers expect that they will see insurance premium rise to cover these increased costs at hospitals. So certainly, it is concerning at this point. But folks who are in the know, who have lived through terrors previously, see

some pretty significant impacts coming to the healthcare industry. Not knowing exactly where things are right now, difficult to quantify any of these, but just go back to COVID and the issue we had with N95 masks, because they were manufactured primarily in China. Not much outside the United States. That supply was disrupted, which created that's one example of a medical supply and the potential impacts that it has. There's also the impact on construction projects for healthcare organizations. This is not unique to healthcare, but appreciating that if you have current projects underway, you may want to be take a close look at the contractual terms. How will that address increases in costs due to tariffs? Standard AIA contract language refers to taxes, but would taxes include tariffs and the impact there? Who will bear those costs? And will we see new terms coming into future construction contracts that are including escalation clauses to account for the increases in cost of materials and real and then also, who's going to bear the responsibility for any delays in completing construction contracts due to material availability? Kathy, what's going on in Congress?

Kathy Reep 54:33
Yeah, I just want to make sure that you're aware that as we go through all of this in terms of the executive orders, etc., we do actually have some legislation being introduced in Congress. Some of it good, some of it bad. There's Greg Murphy from North Carolina, who is a physician. He has proposed a preserving Seniors' Access to Physicians Act that would increase payments to physicians by about 6.6%. So, that is what we'd like to see. But it seems to be in opposition to we're going to cut physicians payments by $10 billion, so concern about where this might go the Healthcare Price Transparency Act.

Really, I guess I want to look at it from the perspective of it reinforces the existing requirements for the most part, related to price transparency. Seems like a bill like this could be a great mechanism to advance that executive order that we talked about a little while ago. But one of the provisions in this particular piece of legislation does allow it addresses the machine-readable file and shoppable services. It says that you can have a price estimator tool to as an alternative to the shoppable services. But it says that in order to be an acceptable price estimator tool, it would be easily accessible to the public without subscription fee, or having to submit any personal identifying information, and searchable by service description, billing code, and payer. Well, the whole idea with the price estimator was that you put in your identifying information so that you were getting your actual expected liability querying your insurance provider, so not sure that that is going to be very helpful to patients. Another good opportunity out there is the Rural Health Care Access Act by Mark Green in Tennessee. That would reinstate the necessary provider designation for critical access hospitals. So, this would actually allow the states to designate certain cause, as necessary.

Martie Ross 56:49

Not a lot in the hopper now but expect a lot more legislation to be introduced here in the next couple of months.

Kathy Reep 56:55

We have our annual MedPAC and MACPAC, Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission, who have published their March reports to Congress. Just a couple of things to share with you in terms of what they're recommending for both inpatient and outpatient recommendations. They lump those together current law cause calls for an increase in the dollar amount. MedPAC is saying that they should increase the payment amount reflected in current law plus 1%. CMS

was really only going to go at about the current law amount the actual increase in cost. They again call for the redistribution of disproportionate share and uncompensated care dollars through a Medicare safety net into index pool. Increase the funding in that pool, but then the dollars would be targeted for those hospitals that provide the greatest volume of care for low-income beneficiaries and that are facing significant financial challenges the Medicare Physician Fee Schedule. They want to replace the current macro formula with a single update that would be equal to the Medicare economic index plus 1%, so that would be about a 1.3% increase in physician payments. They would want to add safety net payments to physicians whose reimbursement for those who serve, provide a large volume of care to low-income patients.

And then finally, in terms of the other provider types that MedPAC reports on skilled nursing home care and inpatient rehab, they want to reduce payments to those provider types because they feel that they are significantly reimbursed, and their margins reflected. The other thing that was included in their report was Medicare Advantage. When we start looking at a Medicare Advantage, MedPAC says that the drivers of MA payments, the higher MA payments, recognize they were originally targeted 95% of Medicare fee for service. They are now at 120, but the two areas that are of focus our favorable selection in terms of who they enroll, and then coding intensity in terms of identifying additional diagnostic information related to the patients. MedPAC essentially says that they need to be they need to exclude diagnoses that are collected from risk assessments. They are concerned about the star ratings program, and actually question whether that program for additional payments to the plan should continue. They are concerned about the disruptions that beneficiaries experience when a provider goes out-of-network, or the plan leaves an area. So they are concerned about that. They want Congress to address it.

And they are very focused on, they tout, their supplemental benefits, but how many beneficiaries actually use the supplemental benefits that are made available? And MedPAC would like to actually track that information. We talked about the Medicaid concern about potential reductions to the Medicaid program. MACPAC published their report. They were very focused on the entities that do external quality review under the Medicaid managed Medicaid program and the 1915 waivers related to home and community-based services. There was nothing in the report that actually addressed any of the potential funding reductions that have been raised under the new administration. So, we'll see they did not have as much meat in their report as we would hope to have seen.

Martie Ross **1:01:03**

Very briefly, very briefly, announced yesterday was a cut of $12.4 billion in state grants. These were primarily dollars that had been appropriated as COVID relief dollars last year. The Biden administration allowed states to repurpose them for other health-related priorities. So that's $11.4 billion from the CDC. These were set to expire 26/27. The letter that went to the state agency says, stop spending money now, stop doing work. Now, also about a billion dollars in SAMHSA that was directed towards behavioral health substance abuse services, and also similar type of action there.

Lastly, now, what now in all this storm? How do we approach this? Just sort of to wind down here, certainly the nature and scope of organizational risk is changing daily. But certainly, having organizational responsibility for tracking and evaluating the impact of developments – we can tell you about the developments – but it really is the work you do in your organization to understand how they're going to impact your operations. There are certainly new areas that are requiring compliance oversight and engagement with your compliance processes. Are you updating policies and procedures, and importantly,

you're keeping your Board and your management informed of changes that impact them? Finally, there has been some discussion that this new Trump administration is going to deemphasize white collar crime, and will that extend to fraud and abuse in health care programs? Counter that with this desire to root out fraud and abuse in those programs, deciding how your organization wants to move forward in the face of that risk, and, of course, managing anticipated revenue reductions.

We will continue to keep our eye on what's going in Washington. You can certainly, our newsletter we try to produce regularly that provides you information and actionable insights. And we'll be back on April 16. We'll talk about the final rules, we expect, the final Medicare Advantage rules, as well as the proposed rules, and we'll work our way through that, as well as any additional Washington updates. As always, please leave a comment if there are other topics you'd like to see us be covering in Healthcare Regulatory Roundup. And with that, Kathy, let's call it a day.

Kathy Reep **1:03:29**

Absolutely. Y'all have a great one and stay tuned.

PYA Marketing **1:03:36**

Thanks to our presenters, Martie and Kathy. Please remember to stay on the line once the webinar disconnects to complete a short survey. Later today, you'll receive an email with their contact information and a recording of the webinar. Also, the slides and recordings for every episode of PYA is Healthcare Regulatory Roundup series are available on the Insights page of PYA is website, pyapc.com. While at our website, you may register for other PYA webinars and learn more about the full range of services offered by PYA. Please remember to stay on the line once the webinar disconnects, to complete the short survey and post any additional questions you may have. On behalf of PYA, thank you for joining us. Have a great rest of your day.