CAPITOL STREET

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Healthcare Provisions: Punt to '24?

PBMs, Site-Neutral Drugs, Medicaid DSH, Clinical Lab Relief, Medicaid IMD

Relevant Companies

The Senate Finance Committee voted today Nov 8 (here) to move forward a wide-ranging healthcare bill. The policies discussed include PBM, behavioral health, IMD (limited), physician payments, pharmacy provisions, value-based care, Medicaid DSH. With the end of the year approaching quickly, we wanted to highlight the healthcare provisions that we believe are most likely to be included if an end-of-year bill comes through, with a growing feeling that provisions could get pushed to 2024, with a CR, and possibly into the lame duck session of Congress (4Q24).

Our Take & Next Up

Health provisions are looking like they may bleed to 2024 passage (See below) with the budget (CR) currently set to expire November 17. Mike Johnson (R-LA), recently elected as Speaker of the House, has noted he is in favor of passing another clean stopgap measure to extend government funding that expires on January 15 or April 15. A Senate Finance Committee Markup today addressed Medicare & Medicaid extenders, transparency, mental health provisions (IMD and re-entry), Medicare physician payments, and PBM/pharmacy reforms. We could easily see healthcare extenders and other provisions (PBM, site-neutral) get pushed into 2024.

Key Points

Our take on PBMs. The Senate Finance Committee voted today 26-0 to pass out of committee PBM (transparency, spread ban) policies, which we see as less impactful to the PBM business model.

- We have said that PBM reforms are likely to pass for non-commercial (Medicare and Medicaid) at the end of the day, taking into account House & Senate bills on the topic (see our take on House & Senate bills in past memos here, here, and here).
- We note that most of these provisions start in the out-years e.g., 2028.
- We believe bipartisan policies such as banning spread in Medicaid, direct and indirect remuneration (DIR) fee reform, PBM reporting & additional price transparency are likely to pass.
- (NEW) So-called "de-linking" requirements in the Finance bill passed today linking patient co-pays to net-versus-gross price is a cost to the government dollars ($1.8B) and would have to be offset.

Hospital site neutral will likely focus first on physician administered drugs ($2-3 B/10 savings) (HCA, UHS, THC). There is ongoing frustration and angst against hospitals buying up physician groups and surgery centers and continuing to bill at a higher inpatient rate for services administered in an outpatient setting. Hospital site neutral policies will likely not include a shutdown of the entire practice (~$140 B over ten, as that would decimate academic medical centers). However, we see physician administered drugs (<$3 B) as being the poster child for "site neutral" and a starting point for more policy next year.

Medicaid DSH cut reversal is likely (averts $8 B total cut) and helps hospitals (HCA, UHS, THC). We think Medicaid Disproportionate Share Hospitals (DSH) will be addressed, with Congress avoiding cuts for Medicaid DSH hospitals which are slated to take effect ($8 B/year). As a reminder, under the ACA, Congress would have reduced federal DSH allotment beginning in 2014 to account for the decrease in uncompensated care anticipated under health insurance coverage expansion. Several pieces of legislation have been enacted since then to delay the Medicaid DSH reduction schedule. The Consolidated Appropriations Act, 2021 recently delayed implementation of reductions until FY 2024.

We believe that clinical lab reform (SALSA Act) is unlikely by year-end, and rather a 1- year PAMA delay appears to be the most likely outcome as we wrote in September (here) (MYGN, ABT, EXAS, DGX, RHHBY, LH). This is a win for clinical labs in the near term. A delay saves dollars while SALSA has a $3-4 B score (cost) which is unattractive in this budget environment. SALSA has bipartisan support in both the Senate and the House.

Physician payment is likely to be addressed given '24 reductions to the physician fee schedule (see our memo here)**.** In the final fee schedule rules, physicians got axed overall (-3.4%), with endocrinology & primary care as winners and surgeons, radiologists, & nuclear medicine as losers. The Finance Committee bill to address physician payment cuts passed today but would only stem cuts of 1.25%, less than half of the current cut percentage.

The SUPPORT Act, which was not included in the October CR, will likely be reauthorized. As a reminder the SUPPORT Act provides a number of provisions related to Medicaid's role in supporting states in providing coverage and services for those who are in need of substance use disorder treatment as well as opioid use disorder treatment.

There is more support than ever for the repeal of Medicaid IMD, but there is a cost to do so (UHS, ACHC). The CBO score has declined significantly ($7.7 B to $38.4 B/10 cost). However, because we are in a divided Congress, a full repeal of Medicaid IMD may not be on the table, but a partial repeal is doable. Sen. John Thune (R-SD) recently introduced a bill titled "Save IMD Options Act" which makes permanent the Medicaid option to remove the IMD exclusion to provide medical assistance for certain individuals who are patients in an IMD (here).

Healthcare workforce shortage and the accompanying challenges continue to be a focus for Congress; however, we do not foresee robust policies being included in end of year package. Recently there has been a great focus on workforce in hearings specifically looking at H-1B visas and loan forgiveness. In an already strained health care system, work force shortages are only becoming more exacerbated. An impediment to passage are the costs associated with labor solutions.

On clinical labor, we do not think President Biden's Executive Order on nursing home staff requirements will be finalized rather we think it will be delayed or phased in. On top of current shortages across the industry, in September, the Biden administration released a proposed rule (here) that would create new requirements for nurse staffing levels in nursing facilities. Comments were accepted until Nov 6. According to KFF, the rule would require about 80% of nursing homes to hire staff (here). The requirements in the proposed rule include:

- 24/7 RN on duty which would be effective 2 years after publication of the final rule (3 years for rural providers). This is up from the current federal requirement of 8 hours a day 7 days a week.
- 0.55 RN hours per resident per day (HPRD) which would be effective 3 years after publication of the final rule (5 years for rural providers).
- 2.45 Nursing Assistant (NA) HPRD) which would be effective 3 years after publication of the final rule (5 years for rural providers).

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