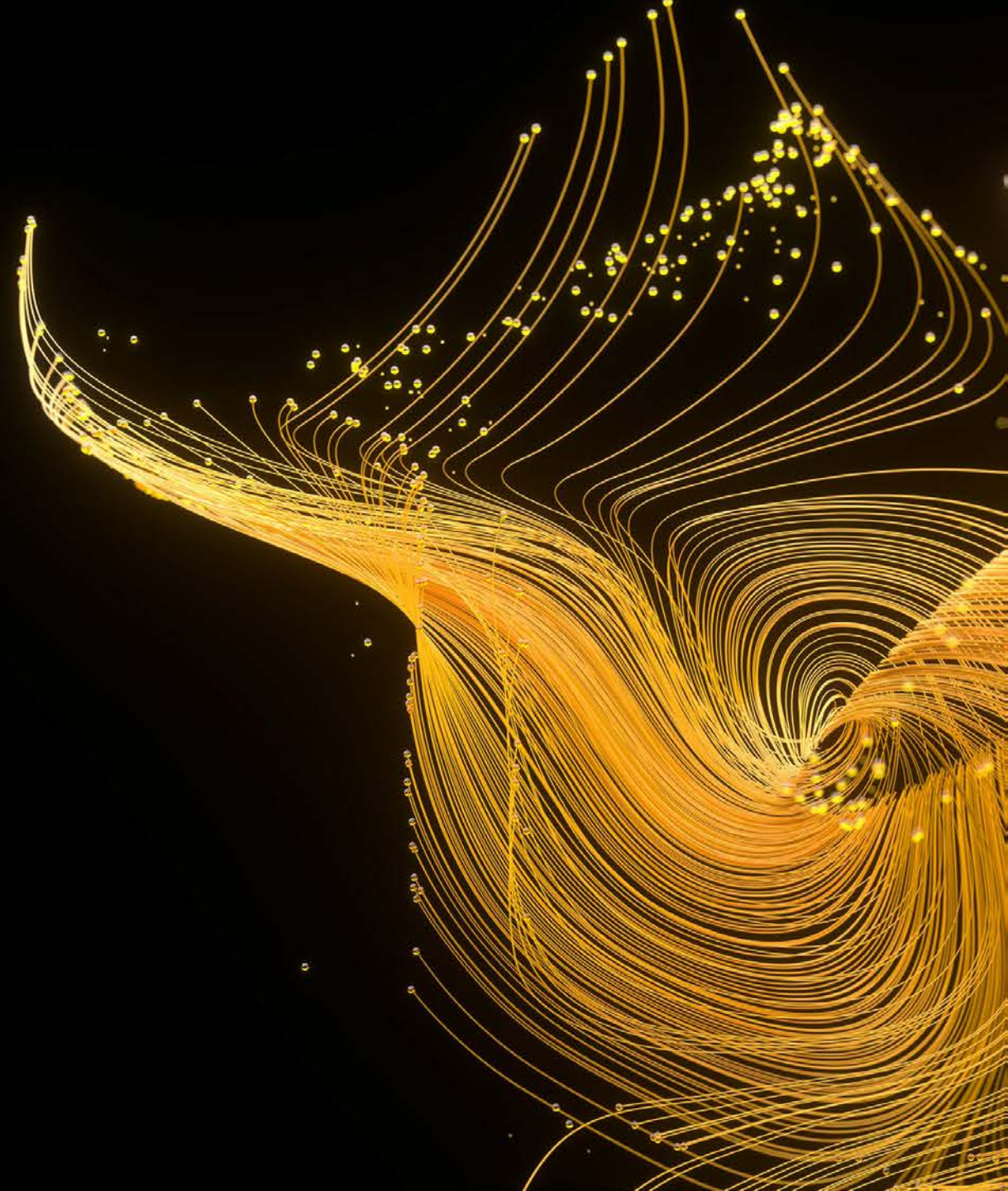
CROWE HEALTHCARE SUMMIT / THE POWER OF COMMUNITY

Hot Topics in Regulatory Reimbursement



Sept. 22, 2020

Presented by:
Dave Andrzejewski, Crowe LLP
Liz Elias, Hall Render

Housekeeping

Download the Crowe Events App

Access links to each session, receive event reminders, and more.

What's next?

Connect with your peers during a happy hour this afternoon!

Join via Crowe Hive or the event app at 4:30p.m. CST

CPE certificates

NEW this year - download CPE at the conclusion of each session.

#HCSummit

Share your virtual Summit experience using #HCSummit

Need something?

Email hc.summit@crowe.com – we're here to help!

Agenda

- 2021 IPPS Update
  - o Wage Index
  - o Worksheet S10
  - o Medicare Bad Debt
  - o Other Changes
- Proposed Rule – DSH MA Days (Allina decision)
- Errors in the Standardized Amount
- ESRD Final Rule
- Site Neutral Payment
- Price Transparency
- PRRB Changes

Your Presenters

DAVE
ANDRZEJESKI
CROWE LLP

Dave is Crowe's national wage index services leader and co-creator of the patented Wage Index Navigator software. Dave is a Certified Healthcare Financial Professional (CHFP) and has been with Crowe since 2010. He has provided wage index assessments across the country for nearly 20 years.

LIZ
ELIAS
HALL RENDER

Liz is a shareholder at Hall Render. She focuses her practice in the area of Medicare and Medicaid reimbursement, focusing on compliance consulting and appeals.

2021 IPPS Update

2021 IPPS Update – Summary of Major Provisions

1. MS-DRG Documentation and Coding Adjustment
   - Amercian Taxpayer Relief Act of 2012 requires CMS to make recoupment adjustment to account for changes in MSDRG documentation and coding
   - FY 2021 will see an +0.5% increase to the standardized amount
   - Plan for this increase through FY 2023

2. Changes to New Technology Add-On Payment for Certain Antimicrobial Products
   - Applications for FFY 2022 add on payments do not need to meet “substantially improves” criteria

2021 IPPS Update – Summary of Major Provisions

3. Continuation of Low Wage Index Hospital Policy
   - Relief continues for hospitals with lowest 25% AWI value

4. DSH Payment Adjustment and Additional Payment for Uncompensated Care
   - Factors are updated for FFY 2021

5. Reduction of Hospital Payments for Excess Readmissions
   - Requires a reduction to hospital's base DRG payment to "account for excess readmissions of selected applicable conditions"
   - Adopting applicable periods beginning in FFY 2023

2021 IPPS Update – Summary of Major Provisions

6. Hospital Value-Based Purchasing (VBP) Program
   - Newly established performance standards provided for FFYs 2023 - 2026

7. Hospital Inpatient Quality Reporting (IQR) Program
   - eCQMs progressively increased, up to 4 quarters for CY 2023
   - Update of validation processes factors are updated for FFY 2021

8. PPS-excempt Cancer Hospital Quality Reporting Program
   - Two existing program measures (NQF #0138 and #0139) to adopt the updated SIR calculation methodology.

2021 IPPS Update – Summary of Major Provisions

9. Medicare and Medicaid Promoting Interoperability Programs
   - Several updates to increase level of reporting stability and reducing the burden on eligible hospitals and CAHs

10. Market-Based MS-DRG Relative Weight Data Collection and Change in Methodology for Calculating MS-DRG Relative Weights
   - Requires hospitals to report its median payer-specific charge negotiated with its Medicare Advantage organizations by MS-DRG
   - These will eventually be made public, under the Hospital Price Transparency Final Rule

FFY 2021 IPPS - Wage Index

FFY 2021 IPPS Wage Index Update

- In FFY 2020 , broad-based changes made to the Wage Index to lessen what CMS called the “downward spiral”: common concern that the current wage index system creates and perpetuates the disparities between high and low wage index hospitals

- In essence, because of their higher Medicare payments, hospitals in high wage index areas can afford to pay higher wages to employees, which allows them to continue as higher wage index areas. However, hospitals in lower wage index areas are forced to cut costs (including wages), which lowers their future wage index

- To help address these disparities in the Medicare wage index system, CMS
  - (1) increased the wage index values for certain hospitals with low wage index values by applying a uniform budget neutral adjustment to the standardized amount;
  - (2) changed the calculation of the rural floor; and
  - (3) provided for a transition for hospitals that will experience comparatively significant decreases in their wage index values in a budget neutral manner

FFY 2021 IPPS Wage Index Update

CBSA changes via September 14, 2018 OMB Bulletin 18-04

- 34 urban counties becoming rural – affecting 10 hospital's classifications
- 47 rural counties becoming urban – affecting 17 hospital's classifications
- Impacts are felt by hospitals with:
  - Out-migration adjustments
  - Geographic reclassifications
  - Lugar hospitals
- Transition period for all hospitals adversely affected

FFY 2021 IPPS Wage Index Update

Transition Period Protection

- A 5% cap continues to be in effect for hospitals experiencing a significant reduction to its FFY 2020 final AWI value.
- No hospital's FFY 2021 AWI value will be less than 95% of its final FFY 2020 AWI value
- This is the 2nd year of this type of protection. Unsure if it will be offered going forward.

FFY 2021 IPPS Wage Index Update

25th Percentile Calculation continues for the 2nd year

- Hospitals with a wage index value below the 25th percentile wage index value (0.8465) will receive relief
- Half the difference between the CBSA AWI value and 0.8465 is added to the CBSA AWI value.
- This policy should be in effect for at least 4 total year years – from FFY 2020 through FFY 2023.

FFY 2021 IPPS Wage Index Update

25th Percentile Calculation continues for the 2nd year

[1]CCN	Geographic CBSA	FY 2020 Wage Index	[6]FY 2021 Wage Index Prior to Quartile and Transition	[6]FY 2021 Wage Index With Quartile	[3,6] FY 2021 Wage Index With Quartile and Cap
010007	1	0.7543	0.6671	0.7568	0.7568

- Final computed hospital AWI value is used to determine potential increase

FFY 2021 IPPS Wage Index Update

FFY 2020 changes that remain:

1. Budget Neutrality factor to the national standardized amount for transition protection (0.998580).

2. RRC reclassifications do NOT increase the state rural floor. Two separate AWI factors will exist:
   a) State Rural Floor – no including the RRC reclassified hospitals
   b) Reclassified State Rural Floor – including the RRC reclassified hospitals

FFY 2021 IPPS-Worksheet S10

Worksheet S-10

Effect of Healthcare Reform on the DSH Payment Adjustment

- Patient Protection & Affordable Care Act (“ACA”) – March 2010
  - Significant Changes to Medicare DSH Adjustment
  - New Formula for Calculating DSH Beginning FY 2014
  - For 2014, 2015, 2016, and 2017 CMS Used low-income insured days from filed cost reports
- Uncompensated Care Portion – Significant Reimbursement $$
  - FY 2015 - $7.65B
  - FY 2016 - $6.4B
  - FY 2017 - $6B
  - FY 2018 - $6.8B
  - FY 2019 - $8.27B
  - FY 2020 - $8.35B
  - FY 2021 - $8.29B

Worksheet S-10

Recent History

- Initially used in the computation of hospitals' EHR incentive payment
  - Charity care charges on S-10 serve to increase the Medicare share resulting in higher EHR incentive payments to hospitals that provide more charity care
- MACs first began reviewing S-10 as part of the EHR/HIT audits
  - Saw some MACs apply strict bad debt principles to S-10 charity care costs during 2014 audits, resulting in significant disallowances
  - Then, in FFY 2018 Proposed Rule, CMS decided to speed up the timeline for using S-10 due to high correlation between hospitals' charity care reported on 501r and S-10
  - Resulting in 2014 being first year S-10 data used to compute Uncompensated Care Payments ("UCPs")
  - Thus a double hit for those who had 2014 EHR audits with UCC disallowances because it reduced their UCPs as well
  - Statutory bar to judicial review, so NO appeal rights for EHR or UCPs

Worksheet S-10

Recent History Cont'd

- Transition from low-income days (SSI/Medicare & Medicaid) to S-10 for calculating Factor 3/UCPs
  - FFY 2018 = FY 2012 and 2013 low-income insured days; **FY 2014 S-10**
  - FFY 2019 = FY 2013 low-income insured days; **FY 2014 and FY 2015 S-10**
  - FFY 2020 = **FY 2015 S-10**
  - FFY 2021 = **FY 2017 S-10** (Audited data used in June HCRIS due to public health emergency)

Worksheet S-10

FY 2021 Final Rule - General

- A single year of data for FY 2017 Worksheet S-10 was used to compute FFY 2021 UC Payments.
- For FY 2021 and all subsequent years fiscal years, CMS indicates that the most recent single year of audited Worksheet S-10 data will be used.
- FY 2021 Uncompensated care payments to decrease ~.73% to $8,290,014521 down from $8,350,599,096 in FY 2019.
- FY 2021 with respect to adjusting uncompensated care cost due to the impacts of COVID-19, CMS commented that it was too early to tell based on cost report filings that would be impacted by COVID-19 and would be premature to do so in the FY 2021 Final Rule.
- FY 2021 CMS acknowledged the unique situation of documented uncompensated care cost due to COVID-19 and noted the terms stated within HRSA Uninsured Program that the recipient would not include such costs in which payment was received.

Worksheet S-10

FY 2021 Final Rule - Audit Process

- CMS chose to audit 1 year of data (that is, FY 2017) in order to maximize the available audit resources and not spread over multiple years potentially diluting the effectiveness of their considerable auditing efforts.
- Audited FY 2017 data was further clarified from CMS rather than using a 3 year approach since it would mix unaudited FY 2016 data as this could potentially create a diluting effect to ongoing audit efforts and introduce variability if multiple years were used to calculated Factor 3
- The proposed UC payments to hospitals whose FY2017 data were audited represent approximately 65% of total proposed UC payments for FY2021.
- For the aforementioned reasons, FY2017 data are, on balance, the best available to use for calculating Factor 3 for FY2021.

Worksheet S-10

Uncompensated Care Appeals

- Recommend all hospitals with negative S-10 adjustments file Uncompensated Care Appeals
  - Must have filed within 180 days of your 2015 NPR
    - For most hospitals that came before the 2020 Final rule was published in August
  - If 2015 NPR not received yet, then must file within 180 days of 2020 Final rule if CMS uses FY 2015
- Information, including enrollment forms to join Uncompensated Care Group are available
- FY 2021 CMS clarified that it would not be introducing an appeals process for Worksheet S-10, that was similar to the process used for Wage Index Audits, due to limited audit resources.

FFY 2021 IPPS - Medicare Bad Debt

Medicare Bad Debt

FY2021 Final Rule – General

- CMS finalized changes to bad debt reimbursement based on the Provider Reimbursement Manual to clarify Medicare Bad Debt policies that may have been subject to litigation.

- Some of the changes to Medicare Bad Debt 42 C.F.R. 413.89 have a **retroactive effect.**

- **Revisions that will be Retroactive:**
- Reasonable Collection Effort: PRM § 310's description of "reasonable collection effort" and its application must apply to both non-indigent (as now defined under 42 C.F.R. 413.89(e)(2)(i)) and indigent beneficiaries. Providers' efforts to collect Medicare deductibles must be similar to non-Medicare patients, and providers must keep verifiable documentation of its efforts.

Medicare Bad Debt

FY2021 Final Rule – General (continued)

- Issuance of a Bill: Reasonable collection efforts for non-indigent beneficiaries must be similar to non-Medicare patients, but for cost report periods before October 1, 2020, the efforts must involve issuance of a bill on or shortly after discharge.
- Writing off Bad Debts: There is a 120-day collection effort for non-indigent beneficiaries.
- QMB Dual Eligible Beneficiaries: The State Medicaid program must be billed. If your State does not provide a Medicaid Remittance Advice, CMS has laid out three criteria that documents another reasonable collection effort.
- Topic 606 and Accounting: Bad debts, charity and courtesy allowances represent reductions in revenue.
- Expense vs. Contractual Account: Medicare bad debts must be charged to an expense account for uncollectable accounts. There is a question as to whether this “zero balance” bad debt policy conforms with other Medicare regulations and GAAP principles.

Medicare Bad Debt

FY2021 Final Rule – General (continued)

Revisions that will be in effect on or after October 1, 2020:

- Issuance of a Bill: Reasonable collection efforts for non-indigent beneficiaries must be similar to non-Medicare patients, but for cost report periods after October 1, 2020, the efforts must involve issuance of a bill on before 120 days after:
- Date of Medicare Remittance that furnishes the beneficiary's cost sharing amount
- Date of Remittance Advice from the beneficiary's secondary payor, or
- Date of notice that the secondary payor does not cover the services.
- Writing off Bad Debts: There is a 120-day collection effort for non-indigent beneficiaries, and providers must start a new 120-day collection period each time a payment is received, even if the debt is at the collection agency.

Medicare Bad Debt

FY2021 Final Rule – General (continued)

Indigence Determination under PRM-I 312: In order for determine whether a beneficiary is indigent, the Provider, in addition to keeping record of he following:

- Must consider assets, liabilities, income, and expenses
- Provider may consider any extenuating circumstance
- Must determine that no other source would be legally responsible for the beneficiary's medical bill
- A beneficiary's signed declaration of their inability to pay their medical bills will not be considered proof of indigence

Medicare Bad Debt

FY2021 Final Rule – General (continued)

- Topic 606 and Accounting: Bad debts (also known as “implicit price concessions”), charity, and courtesy allowances represent reductions in revenue.
- Expense vs. Contractual Account: Medicare bad debts must not be written off to a contractual account, but must be charged to an uncollectable receivables account that results in a reduction in revenue. There is a question as to whether this “zero balance” bad debt policy conforms with other Medicare regulations and GAAP principles.

Polling Question #1

Increase in wage index values continues to be provided for hospital's that have:

1. Less than $50,000,000 in total salary expenses
2. Calculated wage index values are in the lowest 25% of the nation
3. Wage related costs (employee benefits) are less than 25% of total salaries
4. Calculated wage index values are in the lowest 60% of the nation

Polling Question #2

Which of the following is NOT TRUE regarding Medicare Bad Debts:

1. The deductible and coinsurance of the patient are allowed for Medicare bad debt reimbursement

2. Medicare bad debts can be written off to a contractual account

3. Accounts can be recorded as Bad Debt after at least an 120-day collection effort

4. Indigent and non-indigent beneficiaries must receive the same collection treatment

FFY 2021 IPPS – Everything Else

FFY 2021 IPPS – Including MA Charges in Cost Report

- CMS is finalizing its proposal requiring hospitals to provide the median payer-specific negotiated charge that a hospital has with all of its contracted Medicare Advantage (“MA”) plan.
  - This is one of the 5 categories of charge information that hospitals will be required to report as of January 1, 2021
- Was supposed to extend to 3rd party payers, too, but that was rolled back for two reasons
  - 1) CMS acknowledged the difference in charge negotiation among the third party payers; and
  - 2) there seems to be relative consensus that MA rates and Medicare rates are similar.
- This cost reporting requirement will become effective for cost reports ending on or after January 1, 2021.

FFY 2021 IPPS – New Technology Add-on Payment

- CMS finalized its proposal to provide for new technology add-on payments for new antimicrobial products.
- If the new product receives approval through FDA’s Limited Population Pathway for Antibacterial and Antifungal Drugs ("LPAD pathway"), it will be considered new and eligible for the new technology add-on payment without additional justification.
- Additionally, there will be a conditional new technology add-on payment approval for products designated as Qualified Infectious Disease Products ("QIDPs") through FDA’s LPAD pathway that do not receive FDA approval by July 1 and products that do not receive approval by July 1 but otherwise meet the applicable add-on payment criteria. Under this policy, cases involving eligible antimicrobial products would begin receiving the new technology add-on payment sooner, effective for discharges the quarter after the date of FDA marketing authorization provided that the technology receives FDA marketing.
- There have yet to be any products approved under the FDA's LPAD pathway, so this area of reimbursement will likely evolve as products receive that approval.

FFY 2021 IPPS Final Rule - GME

- CMS created a new definition of “displaced resident” to make it easier for Medicare GME FTE cap to transfer from hospitals that close programs or close entirely to other hospitals that agree to continue the residents’ training.
- The new rule will allow the transfer of cap slots for any intern, resident or fellow for whom CMS would make DGME or IME payments.
- This also means that a GME FTE cap transfer will be available when a hospital closes a GME training program, regardless of whether the program is called an internship, a residency or a fellowship, provided that CMS would make DGME or IME payments for interns/residents/fellows in the program.
- Cap transfers under this situation are temporary and permanent changes still require a 5506 process
- CMS also finalized a regulation that changes the IME modifier—used in the formula for calculating indirect graduate medical education payments—to 1.35. This change was mandated by statute

FFY 2021 IPPS Final Rule – CAR-T reimbursement

- CMS finalized its proposal to create MS-DRG 018 for Chimeric Antigen Receptor (CAR) T-cell Immunotherapy.
- ICD-10- procedure codes XW033C3 or XW043C3 will be assigned to this new MS-DRG 018 for FFY 2021.
- MS-DRG 016 will be changed from “Autologous Bone Marrow Transplant with CC/MCC or T-cell Immunotherapy” to “Autologous Bone Marrow Transplant with CC/MCC”.
- This new DRG is timely as two of the initially approved CAR-T therapies, KYMRIAH® and YESCARTA®, lost their new technology add-on payments in FFY 2021. There are two more types of CAR-T therapy in the FDA approval pipeline, and those will go here, too

FFY 2021 IPPS Final Rule – MS-DRG overhaul

- CMS is planning to conduct an overhaul of the MS-DRG system effective in FFY 2024
- That will be the first year after the ATRA/MACRA reimbursement changes are completed
- Additionally, resulting from Section 414 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114–10) makes a positive 0.5% adjustment to the standardized amount from 2018-2023.
- This positive adjustment gradually restores an $11B reduction CMS made between 2014-2017 pursuant to Section 631 of the American Taxpayer Relief Act of 2012 (ATRA, Pub. L. 112–240). The ATRA reduction was created "to account for changes in MS– DRG documentation and coding that do not reflect real changes in case-mix."
- While MACRA was supposed to completely restore the $11B back to hospitals, the formula in place between is 0.7% short of that complete restoration. Hospitals continue to challenge that shortfall.

Proposed Rule – DSH MA Days

Azar v. Allina

Decision Summary

- June 3, 2019, U.S. Supreme Court Opinion: CMS **must** provide adequate notice and allow providers to comment on anything that establishes a "substantive legal standard governing the scope of **benefits**, the **payment for services**, or the **eligibility of individuals**, entities, or organizations to furnish or receive services or benefits under [Medicare]"
- Hospitals challenging the location of Medicare Part C days in the Medicare Disproportionate Share ("DSH") calculation
- Additional Implications: Instance where CMS has not gone through proper notice-and-comment rulemaking in areas that would be considered a creation or change to a "substantive legal standard"

Polling Question #3

What is the name of the Supreme Court case that deals with the DSH Medicare Advantage Days?

1. Elias
2. Allina
3. Bono

Azar v. Allina

Background – Medicare DSH Reimbursement

- Where to count Medicare Part C days in the Medicare DSH calculation: the Medicare Fraction or the Medicaid Fraction?
  - 2003: CMS Proposed to adopt rule to count Part C in the Medicaid Fraction (never made it into FFY 2003 IPPS Final Rule)
  - 2004 Final Rule: CMS determined Part C belonged in Medicare fraction
- Allina I: the 2004 Final Rule should have gone through notice-and-comment rulemaking
- Allina II: Challenged CMS's 2014 publication of the 2012 Supplemental Security Income Ratios, in which Part C was still in the Medicare Fraction after the Allina I decision was issued

Proposed Rule for DSH Medicare Advantage Days

- CMS issued a Proposed Rule on August 6, 2020 that uses retroactive rulemaking to keep the MA Days in the Medicare Fraction
- This undoes the favorable outcome in *Allina*
- If finalized, hospitals will have to challenge the legality of the retroactive rulemaking in order to receive any financial benefit from the *Allina decision*
- **Comments may be filed:** http://www.regulations.gov and must be posted no later than 5:00 p.m. EST on October 5, 2020.

ESRD Final Rule

ESRD Final Rule

- Published June 2, 2020 (85 FR 33796) and implements provisions in the 21st Century Cares Act.
- Notably, ESRD patients will be able to enroll in Medicare Advantage plans in 2021
- The result: MA Plans will no longer be responsible for kidney acquisition costs
- Kidney acquisition costs will be paid under “traditional” Medicare

Errors in the Standardized Amount

Errors in the Standardized Amounts

Inclusion of Transfers in the 1983 Base Rate

- Since inception of PPS, transfers have been excluded from regular PPS reimbursement
- Pre-PPS, transfers were just treated like a discharge from the first hospital
- The first standardized amount was computed with 1981 cost report data (pre-PPS)
- All of the transfers were counted as extra discharges, thus diluting the standardized amount
- *St. Francis v. Azar:* Hospitals have a right to file an appeal to correct the transfer error in the standardized amount for the cost report under appeal
- Predicate Fact: something in an old cost report that can be corrected and used going forward in current cost reports or those within an appeal/reopening window

Errors in the Standardized Amounts

Inclusion of Transfers in the 1983 Base Rate Cont'd

- Predicate Fact Correction first surfaced 5 years ago in *Kaiser*, which was a Med Ed case seeking to fix an error in that hospital's 1997 cap
- CMS quickly published a regulation squashing the ability to use predicate fact correction
- *St. Francis* hospitals challenged the legality of the regulation as applied to appeals. CMS's regulation was promulgated in the section pertaining to reopenings
- The D.C. Court of Appeals appreciated this difference and said the *Kaiser* regulation cannot stop hospitals from filing an appeal, only a reopening
- St. Francis case is back at the PRRB but Covid-related delays have stopped forward progress

Errors in the Standardized Amounts

Documentation & Coding Adjustment

- 2013: CMS estimated that providers had received $11 billion in additional revenue because of the switch to the MS-DRG system. As a result, Congress directed CMS to recoup $11 billion from providers by reducing the standardized amount for FFYs 2014 through 2017
- **Initial proposal**: four cumulative reductions of 0.8% over four fiscal years. Then, restore all 3.2% in FFY 2018
- First change: MACRA directed CMS to restore only 3.0% and to do so in .5% increments over FFYs 2018 to 2023
- Second change: CMS realized that it needed to decrease the standardized amount by 1.5% (rather than the planned 0.8%) for FFY 2017 in order to meet its $11 billion mandate. This is .07% more than the original proposal and brought the total adjustment to 3.9%

Errors in the Standardized Amounts

Documentation & Coding Adjustment Cont'd

- Third Change: 21st Century Cures Act told CMS to implement a 0.4588% positive adjustment to the IPPS rate in FFY 2018, while preserving the previous directive to implement 0.5% positive adjustments for FFYs 2019 to 2023
- The effect of all of these changes is that there is still 0.7% that CMS decided to remove on its own that Congressional action did not restore, nor has the agency reinstated it on its own
- The extra 0.7% means that hospitals paid more than $11 billion for this issue, in violation of the Congressional instruction to CMS
- The FFY 2020 IPPS Final Rule said it wasn't adjusting the 0.7%, meaning that hospitals should take action to preserve their appeal rights for that year, too, and FFY 2021 appears to be headed in the same direction

Errors in the Standardized Amounts

Documentation & Coding Adjustment Cont'd

- More than 1,000 hospitals have preserved appeals for this issue and are moving those cases into federal court
- *Fresno v. Azar:* the first case to get into federal court. The court has already opined the lack of notice and comment regarding the extra 0.7% may be problematic, and the hospitals are briefing this
- Fresno case is at the DC Court of Appeals after the hospitals lost in District Court. Oral arguments were held on September 9, 2020
- This is another situation where the *Allina* decision may be beneficial to hospitals
- The Site Neutral decision may be of some benefit here, too

Site Neutral Payment Policy and Legislation

Site Neutral Payment Policy and Legislation

Policy Background

- Section 603: qualifying off-campus PBDs that were billing as a hospital department before November 2, 2015 would continue to be paid under the OPPS
  - Newly created off campus PBDs would be paid under the "applicable payment system," which CMS interpreted to be the Medicare Physician Fee Schedule ("MPFS")
- 2019 Outpatient Prospective Payment System (“OPPS”): Final Rule to reduce payment for Evaluation and Management ("E/M") services provided at all off campus provider based departments ("PBDs")
- E/M services provided by off-campus PBDs excepted by Section 603 will be understated by 30% in 2019 and 60% in 2020
- 2020 Outpatient PPS Proposed Rule contains the 60% cut
- Note: On-campus PBDs and dedicated emergency departments are excluded from these payment cuts

Site Neutral Payment Policy and Legislation

Legislation Background

- 2019 OPPS Final Rule violated:
  - Congress's clear and unambiguous direction in Section 603 that excepted off-campus PBDs are to be reimbursed under the OPPS methodology.
    - 2019 OPPS Final Rule: reduces OPPS payment rates for E/M services even at excepted off-campus PBD
  - Congress' express instruction regarding budget neutrality
    - 42 USC § 1395(t)(9)(B): All payment changes to specific items or services under hospital outpatient services have to be budget neutral
    - CY 2019 OPPS would save $380 million
  - This was re-implemented for CY 2020 Rulemaking
    - CY 2020 OPPS would save $720 million

Site Neutral Payment Policy and Legislation

District Court

- Hospitals won with a blistering opinion from the judge
- Government appealed the decision
- In subsequent briefing after the decision, the AHA tried to get this applied to CY 2020 as well, but the judge said it had to be pled separately (and was)

Site Neutral Payment Policy and Legislation

Court of Appeals

- Hospitals lost in July 17th decision
- Judges took a completely different legal route than the lower court
- The plaintiff hospitals requested *en banc* review on August 31st, and the court has yet to rule

Next Steps

- The separate 2020 case will likely meet the same fate
- Non-AHA cases could also try to litigate but chances of success are limited

Price Transparency

Price Transparency

Background

- Effective January 1, 2019, hospitals were supposed to publish a list of standard charges, but that was delayed
- Executive Order June 24, 2019: President Trump calls for additional price transparency, including among private, commercial health plans
- Surprise billing: receiving a bill from an out of network provider in conjunction with services received at an in-network provider. Example: the anesthesiologist was out of network, even though your surgery was performed at a hospital within your network
- Lower Health Care Costs Act: current legislation aimed at curbing Surprise billing.
  - Current draft uses benchmarking because CBO says this option saves the most money: out of network physicians would be paid by plans at the providers' "median in-network rate," meaning the rate would be similar to what the plan pays physicians in the area for the same service.

Price Transparency

2019 Final Rule

- November 2019: CMS published Final Rule requiring hospitals to comply with price transparency requirements by January 1, 2021
- 5 types of charge information must be reported
- The “gross charge” is the charge that is reflected on a hospital’s chargemaster without any discounts reflected
- The “payer-specific negotiated charges” are the rates that the hospital has *negotiated* with each third-party payer. A third-party payer does not include self-pay patients or governmental payers (such as Medicare or Medicaid fee-for-service) because those rates are not negotiated, but does include charges for Medicare and Medicaid managed care plans because those rates are negotiated
- The “discounted cash price” is the charge that applies to an individual who pays cash, or cash equivalent, for a hospital item or service
- The “de-identified minimum negotiated charge” is the lowest charge that the hospital has negotiated with a third-party payer
- The “de-identified maximum negotiated charge” is the highest charge that the hospital has negotiated with a third-party payer

Price Transparency

2019 Final Rule

- Penalty for non-compliance: up to $300/day
- Hospital could be listed on CMS website
- Litigation challenging this rule has been shot down by the courts

Price Transparency

2021 IPPS Rule

- Proposed to include a cost reporting requirement to provide the payer-specific negotiated charges by MS-DRG, but it was only finalized for MA Plans
- What if hospital agreed to confidentiality with the payer?
- This price transparency information could be used to overhaul the current MS-DRG system, effective 2024

Polling Question #4

True or False – starting in 2021, hospitals will need to include some price transparency information in the cost report.

1. True

2. False

PRRB Updates

Alert 19 – PRRB Pandemic Response

Issued March 25, 2020 and remains in effect

- All Board deadlines are suspended
- All statutory and regulatory deadlines remain in effect (filing appeals)
- All EJR requests pending or filed will not receive a response within the usual 30 days

Mandatory Electronic Filing for PRRB

Background

- The Provider Reimbursement Review Board opened its electronic filing portal in August 2018
- According to the FFY 2021 IPPS Final Rule, many filings are now being made electronically
- Link to register: https://portal.cms.gov/wps/portal/unauthportal/selfservice/newuserregistration/

Mandatory Electronic Filing for PRRB

- FFY 2021 IPPS Final Rule
  - E-filing to become mandatory
  - PRRB will provide 120 days' notice of the mandatory filing date
  - Still some bugs to work out
    - Can Group Appeal Jurisdictional Documents be filed electronically?
    - Other Hard Copy Filings

Thank you

Dave Andrzejeski
Crowe LLP
+1 317 706 2653
dave.andrzejewski@crowe.com

Liz Elias
Hall Render
+1 317 977 1468
eelias@hallrender.com