Federal Regulatory Update

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Topics to Be Covered

- Fiscal year 2021 proposed rules
- Transparency
- On the horizon

Proposed Rules for FY2021

FY2021 Inpatient PPS NPRM

	Final FFY 2020	Proposed FFY 2021	Percent Change
Federal Operating Rate	$5,796.63	$5,979.74	+3.16%
Federal Capital Rate	$462.33	$468.36	+1.30%

FY2021 Inpatient PPS NPRM

- Some major proposals include:
  - Updated Core-Based Statistical Areas
  - 2-year transitional wage index with 5 percent stop loss
    - Full implementation FY2022
  - New DRG for CAR T-cell therapy
  - Use of FFY 2017 S-10 to determine UCC data for the distribution of Medicare DSH
  - Collecting hospitals' median payer-specific negotiated inpatient service charges for Medicare Advantage organizations and third party payers – TRANSPARENCY!

FY2021 Inpatient PPS NPRM

- Bad debt revisions
  - Proposes that certain provisions would be effective *retroactively*
    - Codify program instructions in Chapter 3 of the Provider Reimbursement Manual
      - Reasonable collection effort
        - Similar collection effort between Medicare and non-Medicare accounts with “like amounts”
        - Prohibited from claiming as bad debt while pending at collection agency
      - Determination of indigency – excludes “dual eligibles”
        - Independent verification – cannot rely on signed declaration
        - Consider patient’s total resources (assets, liabilities, income, expenses)

FY2021 Inpatient PPS NPRM

- Other provisions effective with cost reporting periods beginning on or after October 1, 2020
  - Requirement to bill beneficiaries no later than 120 days after the date of the remittance advice (clarified as later of that from Medicare or secondary payer)
  - Bars providers from writing off a bad debt sooner than 121 days after issuing the bill
    - 121-day period resets after each partial payment
  - Only allowed to claim bad debt that is written off to a bad debt expense account
    - Cannot claim if written off to contractual allowance

FY2021 Inpatient PPS NPRM

- Comments due July 10
- Due to the significant allocation of resources to the COVID-19 response, waives the 60-day delay in the effective date of the final rule

Other Proposed Payment Rules

- LTCH, IRF, IPF, and SNF proposed rules all impacted by revised CBSAs
- IRF rule proposes removal of post-admission physician evaluation requirement
- Proposed rate changes compared to FY2020:
  - LTCH: -0.9 percent
  - IRF: +2.5 percent
  - IPF: +2.6 percent
  - SNF: +2.3 percent
- Home Health NPRM
  - Issued June 25
  - Increase in rates of 2.6 percent
  - Expansion of telehealth

Transparency Requirements: Current and Proposed

CMS Price Transparency: 2019

- Effective January 1, 2019
- Hospitals required to post standard charges for all items and services on a public-facing website in a machine readable format
  - Applies to all hospitals, including critical access, inpatient rehab, and inpatient psych
  - Revenue codes and charge codes not required
  - Concern regarding use of CPT/HCPCS codes (AMA copyright)
- Subsection (d) hospitals (those paid under IPPS) also required to publish charges by DRG

Executive Order: June 24, 2019

- Provided 60 days to develop requirements and propose regulations
  - Hospital publication of standard charge information including charges and information based on negotiated rates
  - Also post bundled charge information for common or shoppable services
- Provided 90 days for issuance of advance NPRM requiring providers and insurers to facilitate access to information about expected out-of-pocket costs for items or services to patients before they receive them

Actions Following Executive Order

- Hospital pricing transparency proposed in outpatient prospective payment system rule for CY2020
  - Not addressed in final OPPS rule however
  - Separate final rule issued November 15, 2019
  - Effective January 1, 2021
- Transparency in coverage proposed rule also issued November 15, 2019
  - Comments originally due January 14; extended to January 29
  - Over 20,250 comments received

Pricing Transparency Final Rule

- Defines various terms
  - Standard charge
    - Includes both amounts contained in the chargemaster and payer-specific negotiated charges
      - Conflicts with Medicare reimbursement manual requirement for “like charges”
        - *Charges should be related consistently to the cost of the service and uniformly applied to all patients whether inpatient or outpatient*
  - Items and services
    - Includes both hospital services and physician/professional fees, if employed by the hospital

Five Types of Standard Charges

- Post in a machine-readable file on the website
  - Gross charges – chargemaster rate
  - Payer-specific negotiated rates
  - De-identified minimum rates
  - De-identified maximum rates
  - Discounted cash price
- Other required information
  - Description of each item or service
  - Any code used by hospital for accounting or billing purposes (HCPCS code, DRG, APC, etc.)

Pricing Transparency Final Rule

- Requires charge data to be posted in machine-readable format
  - Individual charge level – both actual charge and payer-negotiated charge
  - Payer-specific charge for at least 300 shoppable bundles
    - 70 bundles identified by CMS – provider must have total of at least 300 even if not all 70 are offered at facility
      - Easily searchable and consumer-friendly
  - Providers deemed as meeting this requirement if it maintains an Internet-based price estimator tool
  - Per day penalty for non-compliance - $300; non-compliance noted on CMS website; potential CoP (interoperability rule pending)

Response to CMS: Providers

- Discussion confuses terms price, charge, rate, and cost
- Requirement to post negotiated “rates” exceeds CMS’ statutory authority
- Many managed care contracts include “gag” clauses
  - Can new contracts be negotiated by January 1?
- Considerable administrative burden to comply
- Inclusion of employed physician services confusing for the consumer and hospital
  - Not all hospitals employ the same types of physicians
    - Service packages would not be consistent when viewed by the consumer
    - Physician charges not included in hospital chargemaster

Pending Litigation

- CMS does not have authority to require disclosure of payer-specific negotiated charges/rates
- Question of the First Amendment
  - Unconstitutionally compels speech
  - Disclosure of individual rates privately negotiated
- Confidentiality of trade secrets
- Arbitrary and capricious
- Concern with security risk
  - HIPAA compliance of third party apps

Pending Litigation: DISMISSED

- The court found –
  - *"…the fact that Congress chose not to use that term [chargemaster] is strong evidence that 'standard charges' does not mean … only 'chargemaster charges'"*
  - *"It is undisputed that chargemaster rates are not the amounts paid on behalf of 90% of hospitals' patients, and thus it is hard to see how they can be considered usual, common, or customary."*
  - *"The word 'charge' means 'the price demanded for something. Yet chargemaster rates are rarely demanded for payment…"*
  - *"The statute's requirement that the list of standard charges include those for DRGs is, at a minimum, inconsistent with Plaintiffs' argument that 'standard charges' unambiguously means chargemaster charges."*
  - *Comparison to menu prices*

Proposals in FY2021 IPPS NPRM

- Hospitals would report median payer-specific negotiated charge by MS-DRG in their cost reports
  - Effective for cost reporting periods ending on or after January 1, 2021
  - Applies to all third party payers, including Medicare Advantage
  - Hospitals would be required to report –
    - Median payer-specific negotiated charge for all Medicare Advantage plans by MS-DRG
    - Median payer-specific negotiated charge for all third party payers, including Medicare Advantage, by MS-DRG
  - CMS considering using this information to calculate future MS-DRG relative weights beginning in FY2024

Transparency in Coverage: NPRM

- Would require group health plans/health insurance issuers to disclose cost-sharing information for a covered item or service from a particular provider/providers
  - Individual and group markets
  - Upon request only
  - Self-service tool on the Internet
  - Information also available in paper format
  - Information updated monthly

Transparency in Coverage: NPRM

- Information to be disclosed –
  - Estimated cost-sharing liability
  - Negotiated rate
  - Out-of-network allowed amount
  - Items and services included in bundled payment
  - Prerequisites to coverage
  - Disclosure notice

Implications for Hospitals

- Transparency is the right thing to do
  - Need to be assured that we are posting/reporting accurate and useful information
  - Patients need to know their responsibility
  - Can’t address shoppable services only across hospitals
    - What about ASCs and other care sites?

On the Horizon

Other Issues

- Regulatory watch
  - Outpatient PPS NPRM: OMB display 4/21/20
    - 340B drug pricing
  - Physician fee schedule NPRM: OMB display 5/12/20
    - Site neutral payment policies
    - Telehealth

Questions:

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