Fall 2021 Regulatory Update

Florida AAHAM – August 26, 2021

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Business Development and Compliance Advisory

FY2022 Inpatient PPS Final Rule

FY2022 Inpatient PPS Rate Update

- Payment rate increased 2.5 percent
  - Had proposed increase of 2.8 percent

TABLE 1A. FINAL RULE NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS; LABOR/NONLABOR (67.6 PERCENT LABOR SHARE/32.4 PERCENT NONLABOR SHARE IF WAGE INDEX GREATER THAN 1)							
Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.00 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = -0.025 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.325 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.7 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$4,138.28	$1,983.43	$4,056.12	$1,944.05	$4,110.89	$1,970.30	$4,028.74	$1,930.93

TABLE 1B. FINAL RULE NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX LESS THAN OR EQUAL TO 1)							
Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.00 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = -0.025 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.325 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.7 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,795.46	$2,326.25	$3,720.11	$2,280.06	$3,770.34	$2,310.85	$3,695.00	$2,264.67

Disproportionate Share Payments

Uncompensated care pool

- *Proposed* decrease from 2021 - $660 million
- *Final* decrease from 2021 – approximately $1.1 billion

Uses FY2018 cost reports to distribute funds

- Single-year data

Determining Medicaid fraction

- Proposes to redefine “eligible for Medicaid”
- Would exclude patient days reimbursed through an uncompensated care pool under Section 1115 waiver

Price Transparency

PYA

CMS had adopted worksheet S-12 in FY2021

- Worksheet would capture Medicare Advantage negotiated rates at the MS-DRG level
- Would then use this information to set relative weights beginning in FY2024

Will now withdraw this requirement

- Will continue using cost to set DRG weights
- Not implementing reduces administrative burden

Other Provisions of the Final Rule

- Extend COVID-19 add-on payments through the end of the fiscal year in which the public health emergency (PHE) ends
- Suppress certain measures and patients under hospital quality reporting programs due to PHE
  - Value-based purchasing program: neutral payment adjustment for all hospitals for FY2022
  - New quality measure: COVID-19 vaccination coverage among health care personnel

CY2022 Outpatient PPS Proposed Rule

CY2022 OPPS Payment Issues

Proposed 2.3 percent increase in conversion factor

- Uses 2019 claims data for rate setting

Proposes to not eliminate the inpatient only list

- Add back majority of services removed last year
- Process for future services to be moved off IPO list
  - Reinstate patient safety criteria
- Proposes two-year exemption from medical review for those procedures removed from the IPO list on or after January 2021
  - Exempt from site-of-service claim denials, 2-midnight rule, and patient status

Maintains payment for 340B drugs at ASP-22.5 percent

Inpatient Only List

- Proposes to *not* eliminate IPO list
  - Restores the 298 orthopedic services removed last year
  - Codify process for future services to be moved off IPO list
  - Proposes two-year exemption from medical review for those procedures removed from the IPO list on or after January 2021
    - Exempt from site-of-service claim denials and referrals to recovery audit contractors for compliance with the 2-midnight rule and patient status

Services Provided in ASCs

- Remove back majority of services added last year
  - Reinstates 258 of the 267 procedures moved in 2021
  - Reinstates patient safety criteria for adding services to ASC covered procedures list
  - Develop nomination process for new ASC services
    - Rather than current notification methodology
    - Stakeholders would nominate procedures for addition to the ASC covered procedures list

Price Transparency: Penalty

- Civil monetary penalty for non-compliance
  - Currently $300 per day
  - Proposal based on hospital bed size –
    - Bed size determined through cost report

TABLE 63: Proposed Application of CMP Daily Amounts for Hospital Noncompliance for CMPs Assessed in CY 2022 and Subsequent Years.

Number of Beds	Penalty Applied Per Day	Total Penalty Amount for full Calendar Year of Noncompliance
30 or less	$300 per hospital	$109,500 per hospital
31 up to 550	$310 - $5,500 per hospital (number of beds times $10)	$113,150 - $2,007,500 per hospital
>550	$5,500 per hospital	$2,007,500 per hospital

Note: In subsequent years, amounts adjusted according to 45 CFR 180.90(c)(3).

Price Transparency: Other Issues

Deems state forensic hospitals as having met transparency requirements

Prohibits barriers to access of machine-readable file, including automated searches and direct downloads

Price estimators would need to fulfill the shoppable services requirement

- Expected output: cost estimate of the amount expected to be paid by the patient
  - Considers insurance coverage
  - Application to uninsured patients

CY2022 Physician Fee Schedule Proposed Rule

CY2022 PFS Conversion Factor

- A bit of history –
  - 2019 to 2020: $.05 increase ($36.04 to $36.09) = 0.14% increase
  - 2020 to 2021 (final rule): $3.68 reduction ($36.09 to $32.31) = 10.2% reduction
  - 2020 to 2021 (CAA revision): $1.20 reduction ($36.09 to $34.89) = 3.33% reduction
- For CY2022 –
  - Proposed rate of $33.58: $1.31 reduction from current rate = 3.75% reduction
  - Impact of rate change varies by specialty
    - Impact ranges from loss of nearly 10% to gain of 15% or more

Telehealth Services

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Section 1834(m) – Medicare telehealth coverage

- Geography
- Location
- Provider
- Technology
- Services

Approved list of telehealth services

- Permanent Category 1 and Category 2 services
- 135 services added on temporary basis for duration of PHE

Category 3 Services

Services we are finalizing to remain temporarily on the Medicare telehealth list through the end of the year in which the PHE for COVID-19 ends (Category 3 services), to allow for continued development of evidence to demonstrate clinical benefit and facilitate post-PHE care transitions.	• Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT 99336-99337) • Home Visits, Established Patient (CPT 99349-99350) • Emergency Department Visits, Levels 1-5 (CPT 99281-99285)* • Nursing facilities discharge day management (CPT 99315-99316) • Psychological and Neuropsychological Testing (CPT 96130- 96133; CPT 96136- 96139) • Therapy Services, Physical and Occupational Therapy, All levels (CPT 97161- 97168; CPT 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521- 92524, 92507)* • and Hospital discharge day management (CPT 99238- 99239)* • Inpatient Neonatal and Pediatric Critical Care, Subsequent (CPT 99469, 99472, 99476)* • Continuing Neonatal Intensive Care Services (CPT 99478- 99480)* • Critical Care Services (CPT 99291-99292)* • End-Stage Renal Disease Monthly Capitation Payment codes (CPT 90952, 90953, 90956, 90959, and 90962)* • Subsequent Observation and Observation Discharge Day Management (CPT 99217; CPT 99224- 99226)*

- Proposing to extend coverage for these services through December 31, 2023 – opportunity to demonstrate qualification for Category 1 or 2

Appropriate Use Criteria

- Created by Protecting Access to Medicare Act of 2014 (PAMA)
- Applies to advanced diagnostic imaging (ADI)
- Requires that the ordering professional consult a clinical decision support mechanism (CDSM) prior to ordering ADI
  - Service is appropriate, not appropriate, or not applicable
- Proposed **delay** in penalty phase to the later of January 2023 or the January 1 that follows the declared end of the PHE

Surprise Billing Interim Final Rule

No Surprises Act

Included in Consolidated Appropriations Act, 2021

- Signed into law December 2020
- Provisions effective January 2022

Applicability

- Providers/practitioners, hospitals, CAHs, freestanding EDs, ASCs, air ambulance (not ground)
- Health insurance issuers offering group or individual health insurance coverage
  - Group health plans include both insured and self-insured plans, ERISA plans, non-federal government plans, church plans, traditional indemnity plans but not Medicaid MCOs or MA plans
  - Individual health insurance coverage includes exchange and non-exchange plans, student health insurance coverage but not health reimbursement arrangements, short-term limited-duration insurance, or retiree-only plans

No Surprises Act IFR

- Application
  - Emergency services: applies to all emergency services whether participating or non-participating provider or facility
    - No prior authorization for emergency services
    - Includes post-stabilization services such as admission or outpatient observation that would be covered if in-network
      - Need for these services is made by attending emergency physician or treating provider
    - Prudent layperson standard
  - Non-emergency services: applies to non-participating provider at participating facility

Emergency Services	Non-Participating Emergency Facility	Non-Participating Provider	Law is Applicable
Non-Emergency Services	Participating Facility	Non-Participating Provider	Law is Applicable
	Non-Participating Facility	Non-Participating Provider	Law is Not Applicable

No Surprises Act IFR

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Patients cannot be charged more than the in-network cost-sharing amount

- *Some* providers can bill more than in-network cost-sharing with patient consent *after providing estimate of charges*
- Anesthesiology, pathology, radiology, laboratory, hospitalists, assistant surgeons and neonatologists prohibited from balance billing *even with consent*

Providers required to inform patients of cost-sharing protections

- Include information on website (model notice available)
- Provide one page notice (postal or electronic, as patient specifies) to insured patients

Advance Notice/Consent

- Capacity to consent must be considered
- Notice explains that patient would be billed at higher out-of-network amount
- Must be provided with the consent document
  - These must be given physically separate from, and not attached to or incorporated into, any other documents
- Providers/facilities must retain signed notice and consent documents for seven years
- Need to comply with requirements related to plain language, accessibility, and language access

Advance Notice/Consent

- Notice must be provided at least 72 hours before date of service if scheduled in advance
  - Three hours in advance of service for same day appointments
- Notice must include information about prior authorization or other care management limitations
- Notice must include expected good faith estimate of charges
- Patient cost-sharing must be based on in-network rates
- Payer must be notified and receive copy of the signed consent

Payment of Claims

Clean claims must be paid or denied within 30 days

Regulation establishes payment rate for out-of-network provider

- All Payer Model arrangement; state law; agreed upon amount; independent dispute resolution process
- QPA calculated as payer's median in-network rate for the same or similar service in the same market
  - Initially calculated using 2019 trended forward

Limitation on patient liability

- Payment rate for out-of-network provider used to calculate patient cost-sharing

Questions:

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