What's Hot in Healthcare Finance

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PYA

Price Transparency

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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

Price Transparency: Other Issues

- Request for comment related to future rulemaking
  - Expectations for plain language descriptions of shoppable services
  - Best practices for cost estimators
  - Recognizing “exemplar” hospitals
  - Standardization of machine-readable files
- Recent media coverage
- Report by Patient Rights Advocate

Surprise Billing Interim Final Rule

No Surprises Act

- Federal legislation to address surprise billing
  - Individual unable to exercise choice over facility/provider and thus receives services from out-of-network (OON) facility/provider
- Included in Consolidated Appropriations Act
  - Follows years of work devising and debating such legislation and its intended/unintended consequences
- Effective January 1, 2022 (with some limited exceptions)

Application

- Healthcare entities
  - Facilities (hospitals, CAHs, freestanding EDs, ASCs)
  - Providers furnishing services at a facility (not outside)
  - Air ambulance (not ground, at least for now)
- Health insurance issuers offering group or individual health insurance coverage
  - Group coverage includes both insured and self-insured plans, ERISA plans, non-federal government plans, church plans, traditional indemnity plans (**not** Medicaid MCOs or MA plans)
  - Individual coverage includes exchange and non-exchange plans, student health insurance coverage (**not** health reimbursement arrangements, short-term limited-duration insurance, or retiree-only plans)

Surprise Billing for Emergency Services

- Includes emergency services furnished at OON facility AND emergency services furnished by OON provider at in-network facility
  - Apply “prudent layperson” standard to determine what constitutes emergency services
  - Includes necessary post-stabilization services (admission, observation) as determined by treating physician
  - Plan cannot require prior authorization nor limit coverage for emergency services to certain diagnosis codes

Surprise Billing for Non-Emergency Services

- Ancillary services furnished by OON provider at in-network facility
  - Emergency medicine, anesthesia, pathology, radiology, neonatology
  - Assistant surgeon, hospitalist, and intensivist items and services
  - Diagnostic services, including radiology and laboratory services
  - Items or services provided by OON provider if there are no in-network providers who can furnish the item or services at the facility
  - Items or services that result from unforeseen, urgent medical needs that arise when item or service is furnished.
- All other services furnished by OON provider at in-network facility absent prior notice and written consent

Note: NSA does not apply to non-emergency services furnished at OON facility.

Advance Notice/Consent

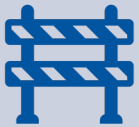
- Capacity to consent must be considered
- Notice explains that patient would be billed at higher out-of-network amount
- Must be provided with the consent document
  - These must be given physically separate from, and not attached to or incorporated into, any other documents
- Providers/facilities must 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

Impact of Recent FAQs

Defers enforcement of good faith estimate for insured patients



Defers requirement for plans to issue advanced explanation of benefits (A-EOB)

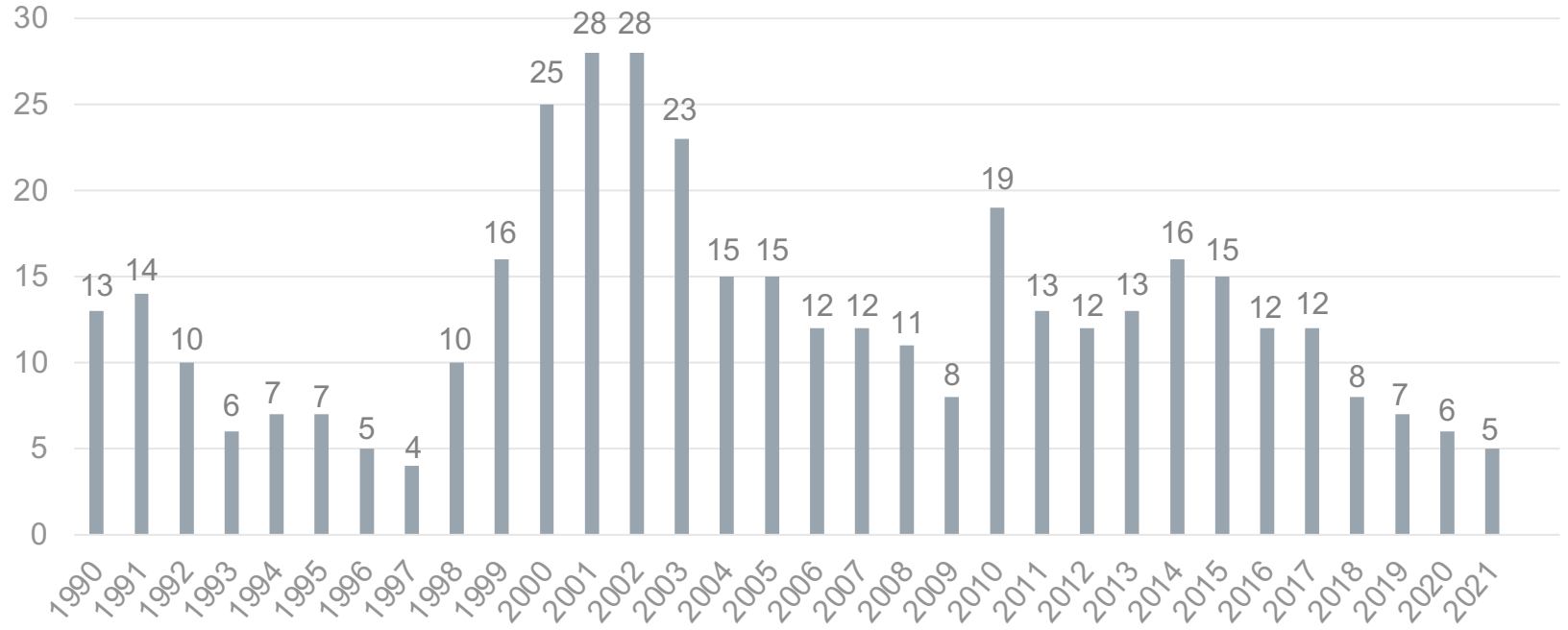
Providers still required to issue good faith estimate for uninsured patients

Additional regulations expected in September

Rural Hospital Pressures

Forecast: The Medicare Trust Fund

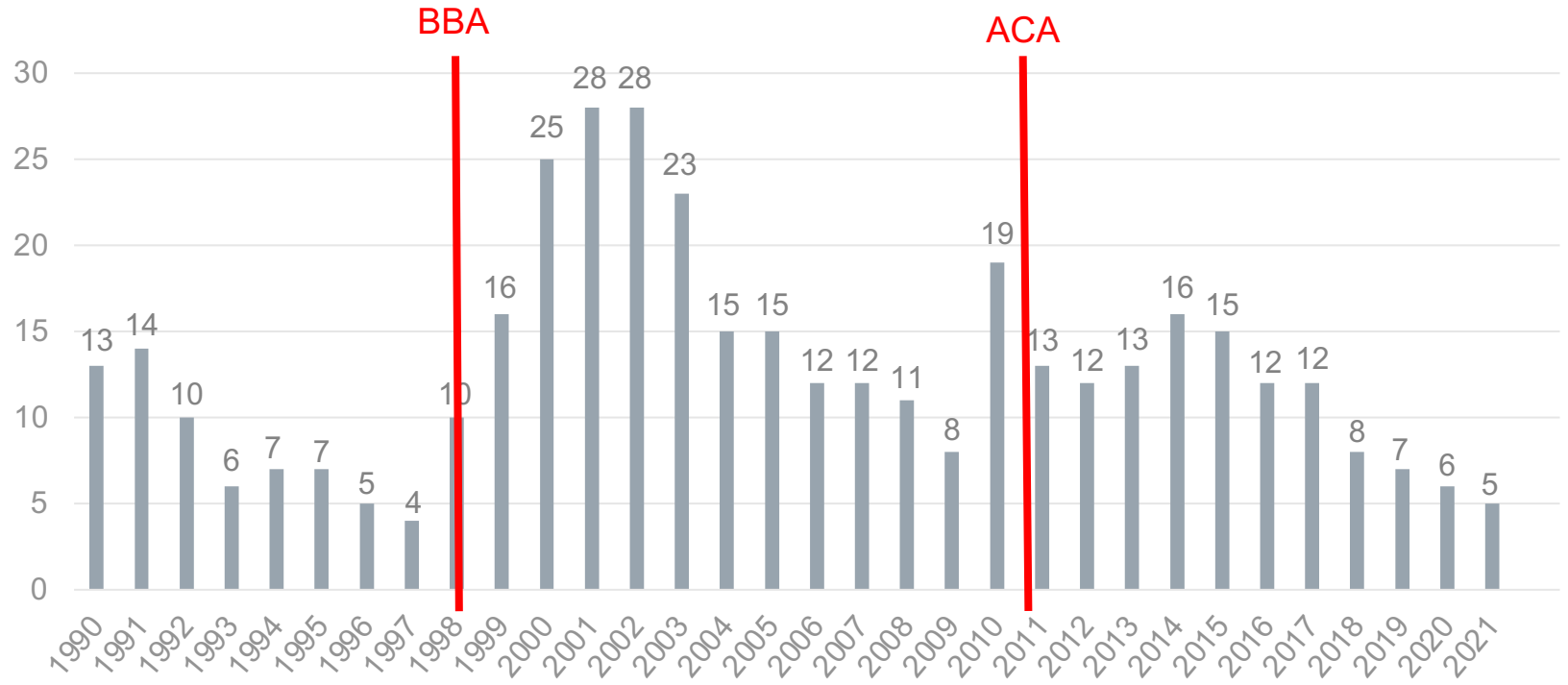
Insolvency: The Past & the Future



2021 Trustee's Report

- *The projected trust fund depletion date is 2026, the same as estimated in last year's report. HI income is projected to be lower than last year's estimates due to lower payroll taxes. HI expenditures are projected to be lower than last year's estimates because of lower projected provider payment updates and certain methodological improvements…*
- *HI revenues would cover only 91 percent of estimated expenditures in 2026 …*

Insolvency: Past Responses



Past Proposals Impacting Providers

Medical education
- Move GME and IME to national pool

Remove disproportionate share from IPPS
- Index to inflation

Reduce bad debt reimbursement from 65% to 25%

Post-acute care
- Reduce payments for post-acute care services
- Unified post-acute care payment system

Reduce payment to critical access hospitals
- From 101% of cost to 100% of cost

MedPAC: impact of MA plans on federal spending
- Part of 2021-2022 workplan

How does this tie to expansion of Medicare to include dental, hearing, and vision coverage? Lowering the eligibility age?

Other Issues

Other Issues

- Federal budget
- Provider relief funds

Questions:

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