Federal Regulatory Update

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Forecast: The Medicare Trust Fund

Medicare Trust Fund

- Fact sheet issued April 2020
  - *The Hospital Insurance (HI) Trust Fund, which pays Medicare Part A inpatient hospital expenses, will be able to pay scheduled benefits until 2026, the same as reported last year. At that time, the fund's reserves will become depleted and continuing total program income will be sufficient to pay 90 percent of total scheduled benefits.*

Medicare Trust Fund

- Modern Health Care, April 22, 2020
  - *The 2020 assessment has an elephant in the room…*
  - *The global pandemic will 'no question' have a negative effect on the reserve funds of both Medicare and Social Security*
  - *In a high cost environment, that reserve would run out by 2023*
    - *It is possible that experience could be even worse than that*
    - *It is too early to say exactly what the impacts are. But…they are generally going to be worse than presented under the intermediate assumptions in this report.*
  - *Once the trustees incorporate the effects of COVID-19 on payroll tax revenue and other factors in next year's report, 'the situation will go from bad to worse'*

Exhausted?

If assets were depleted, Medicare could pay health plans and providers of Part A services only to the extent allowed by ongoing tax revenues – and these revenues would be inadequate to fully cover costs. Beneficiary access to health care services would rapidly be curtailed.

For the HI trust fund to remain solvent through the 75-year projection period, (i) the standard 2.90 percent payroll tax could be immediately increased by the amount of the actual deficit to 3.81 percent, or (ii) expenditures could be reduced immediately by 19 percent.

Transparency Requirements

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.)

Final Rule Requirements: Part 1

- Requires charge data to be posted in a single machine-readable file
  - No barriers to access
    - Free of charge, no account or password required
    - No PHI required to access
  - Individual charge level – both actual charge and payer-negotiated charge
    - Five types of “standard charges”
  - Updated at least annually and show date of last update on file
  - Required of each hospital location if there is a different set of standard charges
  - Information not expected to be used by consumers, but rather by employers, other providers, and tool developers

Example of Machine-Readable File

Hospital XYZ Medical Center
Prices Posted and Effective [month/day/year]
Notes: [insert any clarifying notes]

Description	CPT/HCPCS Code	NDC	OP/Default Gross Charge	IP/ER Gross Charge	ERx Charge Quantity
HB IV INFUS HYDRATION 31-60 MIN	96360		$1,000.13	$1,394.45	
HB IV INFUSION HYDRATION ADDL HR	96361		$251.13	$383.97	
HB IV INFUSION THERAPY 1ST HR	96365		$1,061.85	$1,681.80	
HB ROOM CHARGE 1:5 SEMI PRIV				$2,534.00	
HB ROOM CHG 1:5 OB PRIV DELX				$2,534.00	
HB ROOM CHG 1:5 OB DELX 1 ROOM				$2,534.00	
HB ROOM CHG 1:5 OB DELX 2 ROOMS				$2,534.00	
SURG LEVEL 1 1ST HR 04	Z7506			$3,497.16	
SURG LEVEL 1 ADDL 30M 04	Z7508			$1,325.20	
SURG LEVEL 2 1ST HR 04	Z7506			$6,994.32	
PROMETHAZINE 50 MG PR SUPP	J8498	00713013212	$251.13	$383.97	12 Each
PHENYLEPHRINE HCL 10 % OP DROP		17478020605	$926.40	$1,264.33	5 mL
MULTIVITAMIN PO TABS		10135011501	$0.00	$0.00	100 Each
DIABETIC MGMT PROG, F/UP VISIT TO MD	S9141		$185.00		
GENETIC COUNSEL 15 MINS	S0265		$94.00		
DIALYSIS TRAINING/COMPLETE	90989		$988.00		
ANESTH, PROCEDURE ON MOUTH	170		$87.00		

[1] Note that this example shows only one type of standard charge (specifically the gross charges) that a hospital would be required to make public in the comprehensive machine-readable file. Hospitals must also make public the payer-specific negotiated charges, the de-identified minimum negotiated charges, the de-identified maximum negotiated charges, and the discounted cash prices for all items and services.

Final Rule Requirements: Part 2

- Displaying shoppable services
  - Standard charges for at least 300 shoppable services or bundles
    - Includes the five types of standard charges
  - Defined as a service that can be scheduled by a health care consumer in advance
  - Services selected for display should be those commonly provided to that hospital's patients
  - 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
- No barriers to access
- Information updated at least annually

Display of Shoppable Services

Hospital XYZ Medical Center
Prices Posted and Effective [month/day/year]
Notes: [insert any clarifying notes or disclaimers]

Shoppable Service	Primary Service and Ancillary Services	CPT/ HCPCS Code	[Standard Charge for Plan X]
Colonoscopy	Primary Diagnostic Procedure	45378	$750
	Anesthesia (Medication Only)	[Code(s)]	$122
	Physician Services	Not provided by hospital (may be billed separately)	
	Pathology/Interpretation of Results	Not provided by hospital (may be billed separately)	
	Facility Fee	[Code(s)]	$500
Office Visit	New Patient Outpatient Visit, 30 Min	99203	$54
Vaginal Delivery	Primary Procedure	59400	[$]
	Hospital Services	[Code(s)]	[$]
	Physician Services	Not provided by hospital (may be billed separately)	
	General Anesthesia	Not provided by hospital (may be billed separately)	
	Pain Control	Not provided by hospital (may be billed separately)	
	Two Day Hospital Stay	[Code(s)]	[$]
	Monitoring After Delivery	[Code(s)]	[$]

Alternative to Shoppable Services

- Providers deemed to meet this requirement if it maintains an Internet-based price estimator tool
  - Must include estimates for any of the identified 70 services as are provided by the hospital plus additional services to total at least 300 shoppable services
  - Estimator would allow consumer to determine what **they will be expected to pay for the service**
  - Prominently displayed on hospital website
    - Without barriers to access such as a fee, registration or establishing user account
- Providers still required to post machine-readable file tied to chargemaster detailing “standard charges”

Proposed and Final Rules for 2021

FY2021 Inpatient PPS Final Rule

- Final rule calls for 2.9 percent increase in payment rates
  - New base rate $5,961.19 (FY2020 = $5,796.63)
- Wage index updates
  - Updated Core-Based Statistical Areas
  - Two-year transitional wage index with five percent stop loss
    - Full implementation FY2022
- New DRG for CAR T-cell therapy
- Use of FY2017 S-10 to determine UCC data for the distribution of Medicare DSH

FY2021 Inpatient PPS Final Rule

- Bad debt revisions
  - 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 income and assets (proposed to also include expenses and liabilities)

FY2021 Inpatient PPS Rule

- Bad debt revisions (continued)
  - 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 Final Rule

- Collecting hospitals' median payer-specific negotiated inpatient service charges for Medicare Advantage organizations – TRANSPARENCY!
  - Proposed rule would have required median rate for all third-party payers as well
  - Hospitals to report this data on their Medicare cost reports
    - Cost reporting periods ending on or after January 1, 2021
  - CMS intends to use this information to set MS-DRG relative weights beginning with FY2024
    - Intent is to use "market-based" approach to setting weights
      - Currently cost-based

CY2021 Outpatient PPS NPRM

- Proposed conversion factor of $83.697 for CY2021
  - Compared to $80.7841 for CY2020 (2.6 percent increase)
- Proposed increase in outlier threshold from $5,075 (CY2020) to $5,300 for CY2021
- Proposed elimination over three years of inpatient-only list
- Proposed payment for 340B drugs at ASP minus 28.7 percent (compared to ASP minus 22.5 percent currently)
  - Litigation ongoing
- Site neutral payment for clinic visits in grandfathered off-campus provider-based departments
  - Proposes to continue payment at 40 percent of OPPS rate
  - Litigation ongoing

CY2021 Outpatient PPS NPRM

- Increases services requiring prior authorization
  - Cervical fusion with disc removal
  - Implanted spinal neurostimulators
- Proposes changes to level of supervision for certain outpatient therapeutic services
- Moves more services to ASC covered procedures list
  - Including total hip arthroplasties
- Comments due October 5

CY2021 Physician NPRM

- Proposes to reduce the PFS conversion factor by 10.61 percent
- Would increase payment rates for office/outpatient E/M visits
- Would expand telehealth
  - Add services covered under Medicare
  - Retains certain COVID-19 telehealth flexibilities for at least a year after PHE ends

Appropriate Use Criteria

PYA

Appropriate Use Criteria (AUC)

- 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
- CY2019 PFS final rule allows consultations by clinical staff under the direction of the ordering professional

Appropriate Use Criteria

- Reporting required on hospital outpatient and professional claims (rendering)
  - CY2019 PFS final rule added IDTFs
- Exceptions apply for emergencies, inpatient imaging services, and ordering professionals meeting meaningful use (MU) hardship exception (lack of Internet access)
  - How to establish duration of emergency
- Effective January 2020, required **January 2022**
- Goal to identify outlier ordering professionals
  - Could be subject to prior authorization

Other Issues (Enough Already)

In Case You Need More ….

- Proposed rule on “reasonable and necessary”
- Need for legislative action to address Medicaid DSH funding
  - Currently scheduled to end December 1
- Revisions to CMS model admission questions
  - CR 11945 issued 9/4/20

Questions:

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