FEDERAL POLICY UPDATE

March 17, 2022

Chad Mulvany
VP, Federal Policy
California Hospital Association
(202) 270-2143
cmulvany@calhospital.org

California Hospital Association

Agenda

- Congressional Update
- Medicare Wage Index – “Bottom Quartile Policy”
- OPPS Final Rule: Inpatient Only List and Price Transparency Changes
- COVID-19 and Provider Relief Fund Update
- No Surprises Act Implementation

Congressional Update

Protecting Medicare and American Farmers from Sequester Cuts Act

Legislation passed in December temporarily addresses several of hospitals' key concerns.

Issue	Resolution	End Date
Medicare Sequester	• 2% reduction eliminated for 3 months • Reduced to 1% for 3 months	• March 31, 2022 • June 30, 2022
PAYGO	• 2022 4% PAYGO reduction delayed and added to "2023 scorecard"	• December 31, 2022
Physician Payment Cut	• Increases the PFS Conversion factor by 3% for one year, partially offsetting the 3.75% CY 2022 cut	• December 31, 2022
Clinical Lab Cuts	• Delays payment cuts under the CLFS for one year	• December 31, 2022
Radiation Oncology Model	• Delays start date for Radiation Oncology Model for 1 Year	• December 31, 2022

Congressional Agenda and CHA Priorities

- Key components of Biden agenda stalled in the Senate
- CHA continues to advocate for our priorities to be included in future legislative packages
  - Workforce Investments
  - Provider Relief Fund Improvements
  - Medicare Sequestration
  - Medicare Accelerated and Advance Payments

FFY 2022 Omnibus Spending Bill

The recently passed Omnibus budget includes a number of healthcare related provisions.

✓ Included in the Omnibus:

- **Telehealth**: Extends waivers for 151 days after the end of the PHE.
- **340B**: Protects certain 340B hospitals from losing eligibility due to the COVID-19 PHE.

⊘ Excluded from the Omnibus:

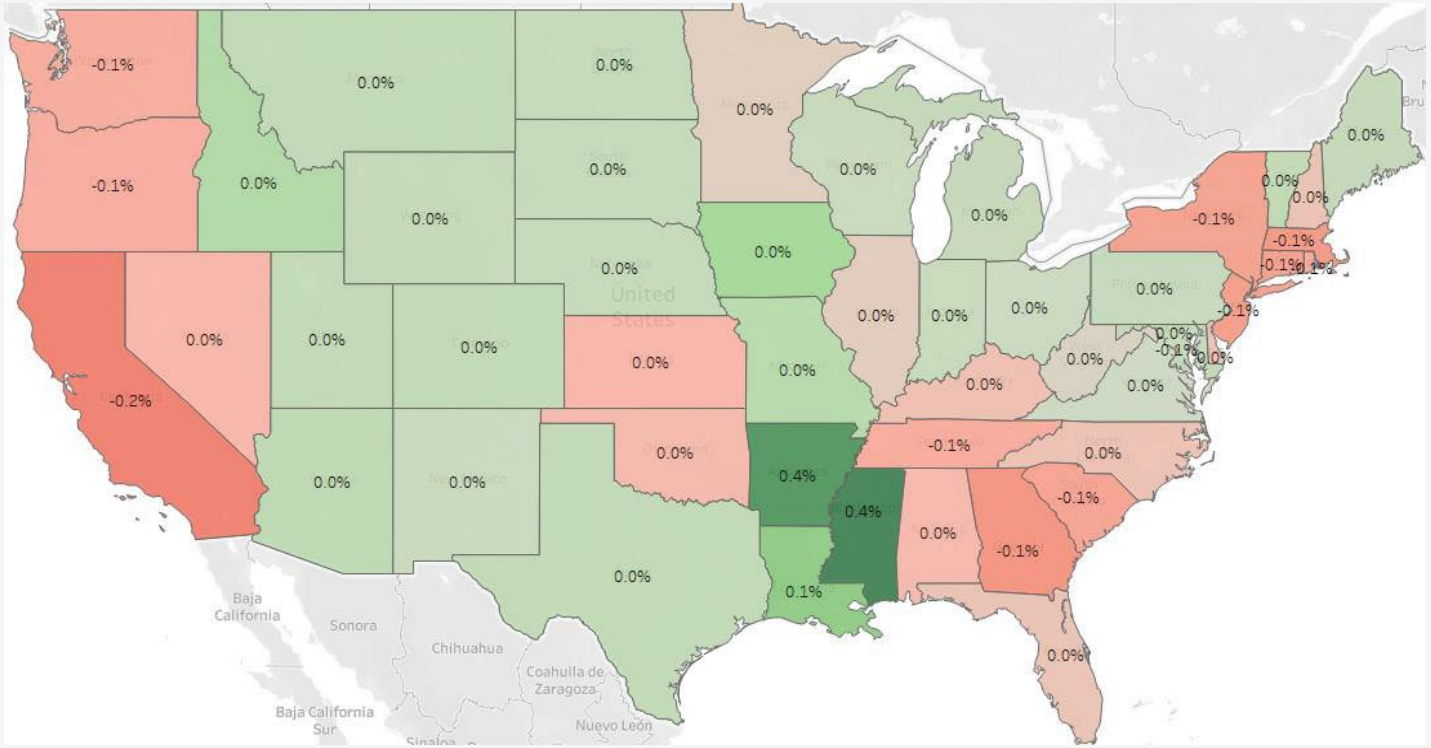
- Additional **Provider Relief Funding**.
- A further extension of the Medicare 2% **sequester moratorium**.
- Extended repayment for **Medicare Advanced/Accelerated Payments**.

Medicare Wage Index – Bottom Quartile Policy

Overview of Bottom Quartile Policy

CMS has pursued its low area wage index policy resulting in a budget neutrality adjustment that negatively impacted California's hospitals.

Impact of Bottom Quartile Change



Key Details of Policy in FY 2022

- FFY 2022 bottom quartile of the wage index is < 0.8437
- The budget neutrality adjustment is -.20%

Legal Challenge to Low Wage Policy in DC District Court

A recent district court ruling in a legal challenge filed by a group of hospitals outside of California found the low wage policy is statutorily impermissible.

Bloomberg Law

Court Tosses Medicare Reimbursement Boost for Low-Wage Hospitals

Congressionally required adjustments in Medicare reimbursements designed to account for regional differences in labor costs cannot be further adjusted to give an extra boost to low-wage hospitals, a federal district judge ruled.

The lawsuit was filed by a group of hospitals challenging a 2019 regulation issued to address wages disparities among hospitals. The hospitals claimed they would receive reduced reimbursements as a result of the regulation.

The Medicare statute requires the Department of Health and Human Services to adjust the proportion of its payment to hospitals attributable to wages for "area differences in hospital wage levels," Judge Carl Nichols of the U.S. District Court for the District of Columbia said in an opinion Wednesday.

But the 2019 regulation doesn't adjust the relative wage levels of hospitals in different regions in a uniform fashion as required by the statute, but rather inflates the reimbursements of low-wage hospitals at the expense of all other hospitals, Nichols said.

Source: https://news.bloomberglaw.com/health-law-and-business/court-tosses-medicare-reimbursement-boost-for-low-wage-hospitals

Outpatient Prospective Payment System

Inpatient-Only (IPO) List

CMS halts the elimination of the IPO list.

- CMS restores all but 7 of the 298 services removed in 2021 back to the IPO list for 2022.
- Based on commenters' studies/data, the following procedures and associated anesthesia codes will remain off the IPO list in 2022:
  - CPT code 22630 (Lumbar spine fusion)
  - CPT code 23472 (Reconstruct shoulder joint)
  - CPT code 27702 (Reconstruct ankle joint)
  - CPT codes 00630, 00670, 01638, 01486 (Anesthesia for various orthopedic procedures)
- CMS codifies in regulation the five criteria to determine if a procedure or service should be removed from the IPO list.

2-Midnight Rule for IPO List

CMS rescinds the indefinite exemption period and reinstates the two–year exemption from medical review activities for procedures removed from the IPO list beginning on or after January 1, 2021.

- In the CY 2020 OPPS final rule, CMS established a two–year exemption from medical review activities, including referrals to recovery audit contractors (RACs), site–of–service claim denials, and RAC reviews for "patient status" for procedures removed from the IPO list for CY 2020 and forward.
- In the CY 2021 OPPS rule, CMS finalized an indefinite exemption from medical review activities for procedures removed from the IPO list on or after January 1, 2021.

ASC Covered Procedures List (CPL)

CMS will reinstate the requirements for ASC covered surgical procedures that had been in place prior to CY 2021. CMS is removing 255* of the 258 codes from the ASC CPL.

- CMS also restores the exclusion criteria for the ASC CPL that had been in place prior to CY 2021.
- Specifically, covered surgical procedures do not include those that:
  - Generally result in extensive blood loss
  - Require major or prolonged invasion of body cavities
  - Directly involve major blood vessels
  - Are generally emergent or life-threatening in nature
  - Commonly require systemic thrombolytic therapy
  - Are designated as requiring inpatient care under IPO list
  - Can only be reported using a CPT unlisted surgical procedure code
  - Are otherwise excluded from coverage under Medicare.

*These procedures are listed in Tables 60, 61 and 62 of the final rule.

Hospital Price Transparency

- Under the **Hospital Price Transparency final rule**, CMS requires all hospitals post price information on their website to comply with two specific requirements:
  - ✓ Post gross charges, payer-specific negotiated rates, the de-identified minimum and maximum negotiated rates, and the cash discount price for all items and services on a website in a machine-readable format.
  - ✓ Post information for 300 "shoppable" services (70 CMS-specified and 230 hospital-selected) in a "consumer-friendly manner," OR provide an Internet-based price estimator tool for common shoppable services.
- In response to what CMS deems as high rates of noncompliance with the requirements — which were effective January 1, 2021 **— CMS increases the maximum civil monetary penalty (CMP)** (currently $300/day) using a scaling factor to establish the CMP amount for a noncompliant hospital.
- The final rule uses the noncompliant hospital's number of beds as specified in hospital cost report data as the scaling factor to establish CMP.

Hospital Price Transparency – Final CMPs

Number of Beds	Penalty Applied Per Day	Total Maximum Penalty for a Full Calendar Year of Non-compliance
30 or less	$300 per hospital	$109,500 per hospital
31 up to 550	$310 - $5,500 per hospital (number of beds x 10)	$113,150 – $2,007,500 per hospital
Greater than 550	$5,500 per hospital	$2,007,500 per hospital

*The above amounts are adjusted annually beginning in 2023 using the multiplier determined by the Office of Management and Budget for adjusting CMPs.

Hospital Price Transparency

- **Machine-Readable File:** CMS specifies that the hospital must ensure that standard charge information is easily accessible, without barriers, including but not limited to ensuring the information is accessible to automated searches and direct file downloads through a link posted on a publicly available website.

- **Shoppable Services and Price Estimator Tool:** CMS clarifies that price estimator tools must be "tailored to individuals' circumstances" to satisfy requirements as an alternative to posting shoppable services price information.
  - ✓ Hospital must provide real-time individualized out-of-pocket estimates that combine hospital standard charge information with the individual's benefit information directly from the insurer or provide the self-pay amount.

CMS Enforcement

As of December, CMS has issued approximately 335 warning letters and has requested 98 hospitals to submit corrective action plans.

WSJ

Hospitals Still Not Fully Complying With Federal Price-Disclosure Rules

A year after federal rules compelled hospitals to make healthcare prices public, some of the nation's biggest chains haven't done so, with no penalty so far from the Biden administration, according to a Wall Street Journal review of the $1 trillion U.S. hospital system.

No hospitals have been penalized as of late December, according to the Centers for Medicare and Medicaid Services, which is responsible for enforcing the rules. The maximum penalty this year for violators is $109,500 per hospital, and the penalty increases to as much as $2 million in January.

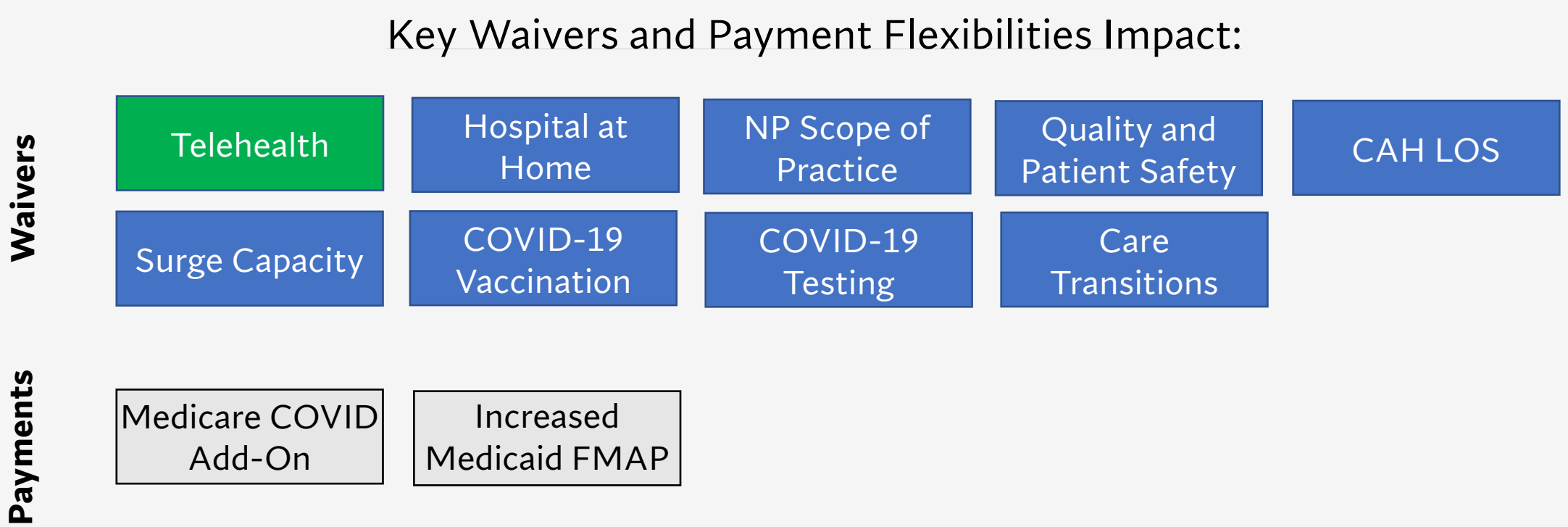
The agency has issued approximately 335 warnings for violations and is giving hospitals information and technical help to increase compliance as of early December, a CMS spokeswoman said. Regulators also requested that 98 hospitals submit plans for how and when they would comply.

Source: https://www.wsj.com/articles/hospital-price-public-biden-11640882507

COVID-19 and Provider Relief Fund (PRF) Update

COVID-19 Public Health Emergency (PHE)

There are multiple federal waivers and COVID-19 related payments that are tied to the PHE which will expire on April 15th if not extended. It is anticipated that the PHE will be renewed for another 90 days.



Period 2 Reporting: Now Open

HRSA's PRF portal opened for period 2 reporting on Jan 1, 2022 for providers receiving more than $10,000 during the payment received period.

PRF Period of Availability: Timeframe to Use and Report on Funds

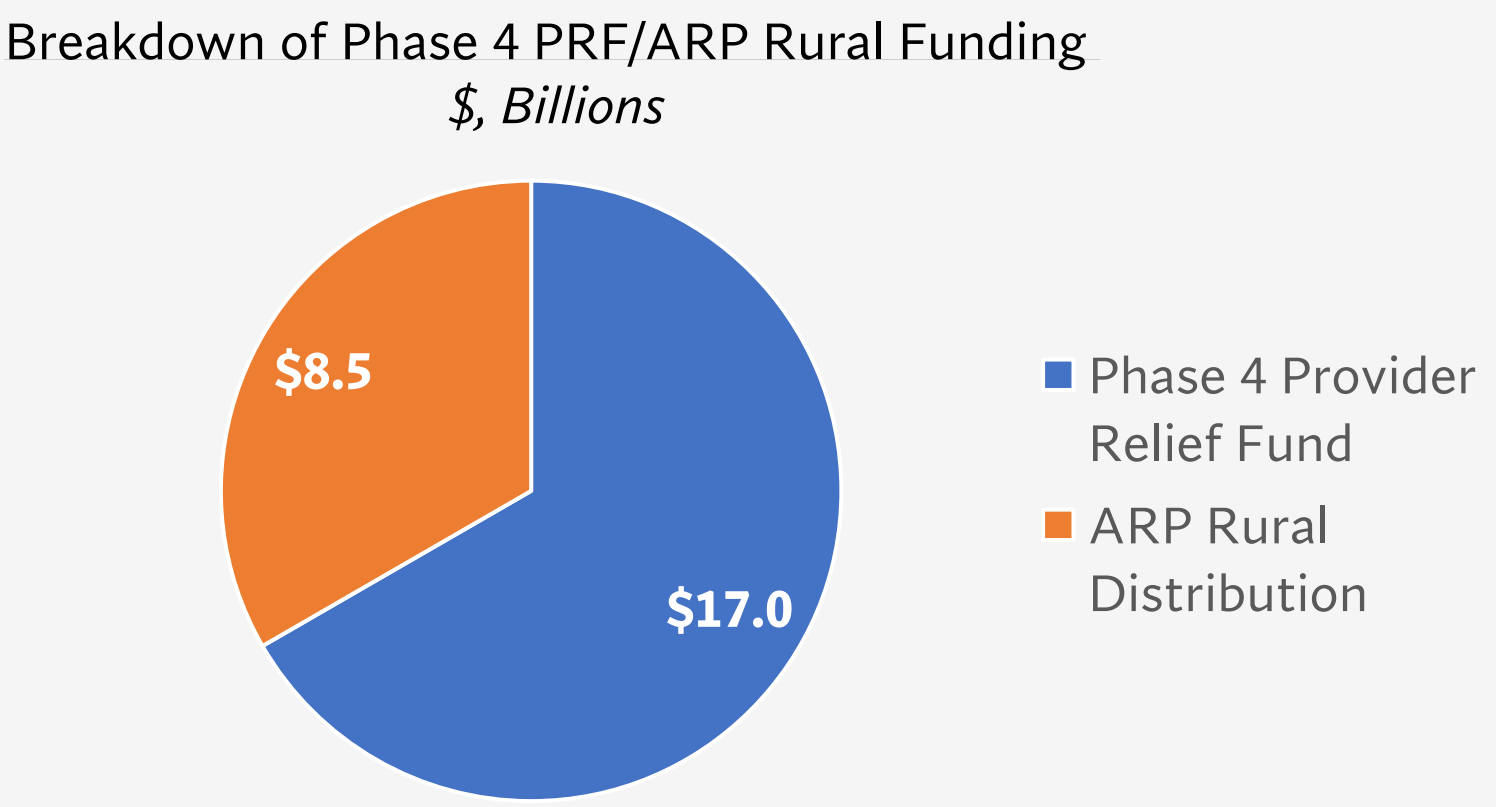
	Payment Received Period	Period of Availability	Reporting Period
Period 1	April 10 to June 30, 2020	Jan 1, 2020 to June 30, 2020	July 1, 2021 to Sept 30, 2021*
Period 2	July 1 to Dec 31, 2020	Jan 1, 2020 to Dec 31, 2021	Jan 1, 2022 to March 31, 2022
Period 3	Jan 1 to Jun 30, 2021	Jan 1, 2020 to June 30, 2022	July 1, 2022 to Sept 2022
Period 4	July 1 to Dec 31, 2021	Jan 1, 2020 to Dec 31, 2022	Jan 1, 2023 to Mar 31, 2023

- HRSA Reporting Resources: https://www.hrsa.gov/provider-relief/reporting-auditing
- CHA Reporting Webinar: https://calhospital.org/2022-jan-provider-relief-funds-updates-on-demand-learning/

*Does not include 60 day "grace period."

Phase 4 PRF/ARP Rural Distributions: Overview

The application process for $25.5 billion in additional COVID-19 federal relief for providers closed on November 3, 2021.



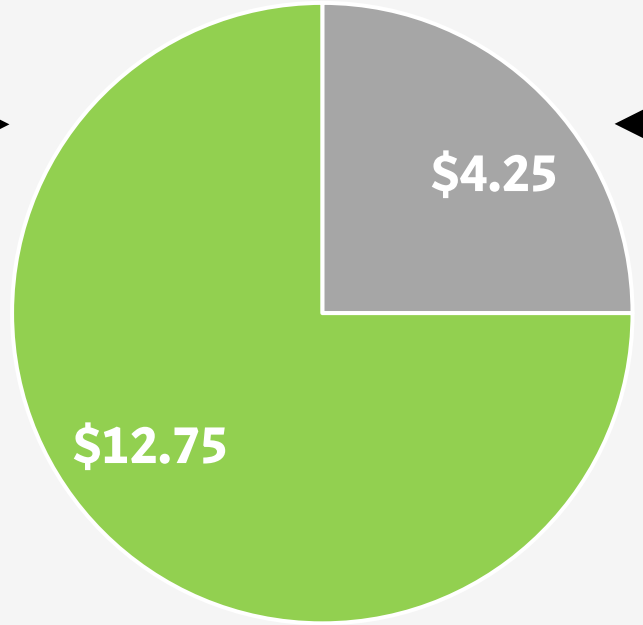
Phase 4 PRF: $17 Billion

Providers will qualify based on losses and patient care operating income.

Breakdown of $17B Phase 4 PRF Distribution
$, Billions

Base Payment – 75%

- % of providers change in operating revenue & expenses.
- Will compare the period 7/1/20-3/31/21 to the period 7/1/19-3/31/20.



Bonus Payment – 25%

- Not tied to changes in operating revenues & expenses.
- Calculated based amount of care provided to Medicare, Medicaid, and CHIP patients.

Phase 4 PRF: Still Waiting

As of February 2022, HRSA has processed 86%[3] of applications and distributed $11.5B.

Additional Scrutiny

Remaining 14% of applications are receiving additional scrutiny for risk mitigation due to the size of the potential payment.

HRSA anticipates making payments to remaining providers in March.

Sources:

1) https://www.hrsa.gov/provider-relief/future-payments
2) https://www.hrsa.gov/provider-relief/future-payments/phase-4-arp-rural/payment-methodology
3) As of March 3, 2022

Phase 4 PRF: Frustrating Results

Hospitals receiving Phase 4 funds report getting less than anticipated.

Payment Based on NPSR

Size	Annual NPSR	% to be Paid
Small	> or = to $10M	45%
Medium	Between $10M & $100M	25%
Large	< or = to $100M	20%

% of COVID-19 Losses Covered in Application Based Distributions

	Phase 3	Phase 4*
Period Covered	Q1-Q2 2020	Q3-Q4 2020, Q1 2021
PRF Allocation	$ 24,500,000,000	$ 25,500,000,000
COVID Positive Cases During Covered Period	2,695,609	27,609,993
PRF $ Allocated Per Case	$9,089	$924
% Hospital COVID-19 Losses Covered**	88%	20%-25%

Sources:
1) https://www.hrsa.gov/provider-relief/future-payments
2) https://www.hrsa.gov/provider-relief/future-payments/phase-4-arp-rural/payment-methodology

Phase 4 Reconsideration Process

HRSA created a reconsideration process for providers who believe their Phase 4 payment (or lack thereof) was calculated in error.

Process

1) Provides forum for correcting processing errors.
2) Providers instructed to review Phase 4 payment methodology.
3) Application must be submitted.

Limitations

1. Revisions to submitted applications not allowed.
2. Submitting a request does not guarantee payment.

Deadlines

1) Requests will be accepted starting on Feb 1, 2022.
2) Submissions due by May 2, 2022.
3) Providers who have not received payment will be given at least 45 days to request redetermination.

Source: https://www.hrsa.gov/provider-relief/payment-reconsideration

ARP Rural Distribution: $8.5 billion

ARP Rural Distribution – which was distributed in November – is *based on the patient's location*, not the provider's address.

Eligibility

1) Rural health clinic
2) Provider treated as located in rural area
3) Operates/serves patients living in a rural area as defined by HHS*
4) Billed Medicare, Medicaid, or CHIP during applicable period.

Payment Calculation

1) Based on relative value of Medicare, Medicaid, and CHIP services furnished to rural patients.
2) Includes services furnished from Jan 2019 through Sept 2020.

Use of Funds

1) Covers lost revenue or expenses related to COVID.
2) May not be transferred to another entity.

*HHS Federal Office of Rural Health Policy's (FORHP)

Phase 4/ARP Rural Distribution: “Period of Availability”

Use of Phase 4/ARP Rural funds is not limited to COVID related expenses or lost revenue incurred during Q3/Q4 or Q1 of 2021.

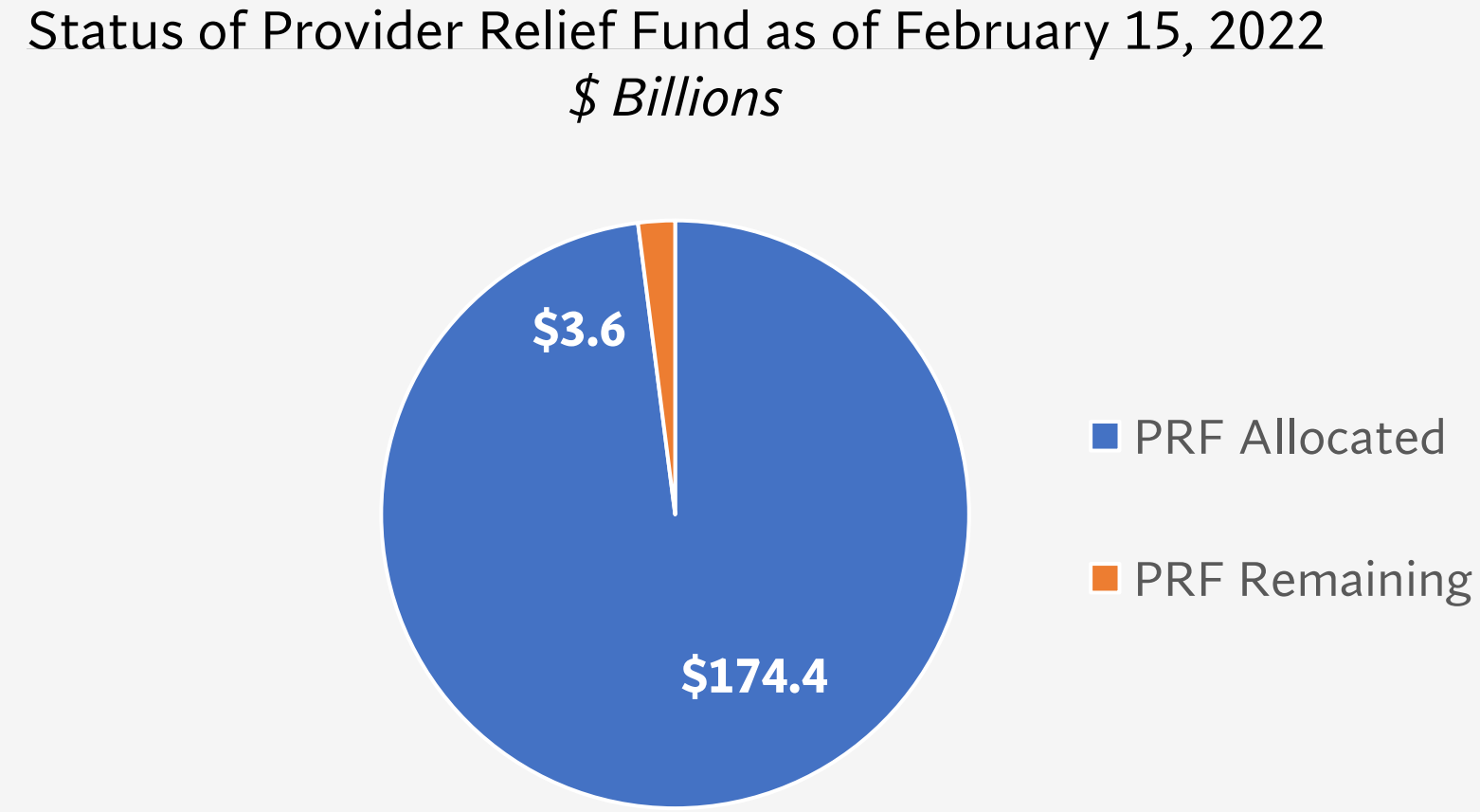
PRF Period of Availability: Timeframe to Use and Report on Funds

	Payment Received Period	Period of Availability	Reporting Period
Period 1	April 10 to June 30, 2020	Jan 1, 2020 to June 30, 2020	July 1, 2021 to Sept 30, 2021*
Period 2	July 1 to Dec 31, 2020	Jan 1, 2020 to Dec 31, 2021	Jan 1, 2022 to March 31, 2022
Period 3	Jan 1 to Jun 30, 2021	Jan 1, 2020 to June 30, 2022	July 1, 2022 to Sept 2022
Period 4	July 1 to Dec 31, 2021	Jan 1, 2020 to Dec 31, 2022	Jan 1, 2023 to Mar 31, 2023

*Does not include 60 day “grace period.”

Insufficient Additional Federal Funding

An estimated $26.5 billion in PRF remains available for distribution.



Source: https://plus.cq.com/doc/news-6457561?0

Advocating for Additional Distributions

CHA continues to engage lawmakers in the need for additional distributions targeted to hospitals that address PRF timing issues.

California Hospital Association

CHA Employs Multi-Pronged Approach to Improve Access to Federal Funding for COVID-19 Relief for Hospitals

CHA continues to engage at every level to ensure California's hospitals get their fair share. Sharing our concerns, on Aug. 27 Sen. Dianne Feinstein sent a **letter** to Health and Human Services Secretary Xavier Becerra calling for the release of the balance of the PRF to assist hospitals with the current surge of patients.

On Aug. 26, 43 senators, including California Sens. Feinstein and Alex Padilla, sent a **letter** to Becerra. Earlier this month, at the request of CHA and our member hospitals, 40 members of the California delegation, led by Rep. Mike Thompson (D-5), signed a similar **letter** calling for the immediate release of the remaining PRF funds…

Source: https://calhospital.org/chas-multi-pronged-approach-to-improve-access-to-federal-funding-for-covid-19-relief-for-hospitals/

No Surprises Act (NSA) Implementation

NSA – Patient Protections

The NSA was intended to protect patients in situations where they did not choose to receive care from an out-of-network provider.

- **Effective January 1, 2022,** the NSA applies to out-of-network emergency services and certain services delivered at in-network facilities by out-of-network providers.
- The legislation defers to existing state law where it exists.
- In out-of-network situations covered by the NSA, patient cost sharing is limited to the in-network amount based on the "recognized amount."
  - For California hospitals the "recognized amount" is the "qualifying payment amount" (QPA).
  - The QPA is based on the plan's median contracted rate for the "same or similar item or service" within the same insurance market on January 31, 2019 trended forward to the current year using CPI-U.

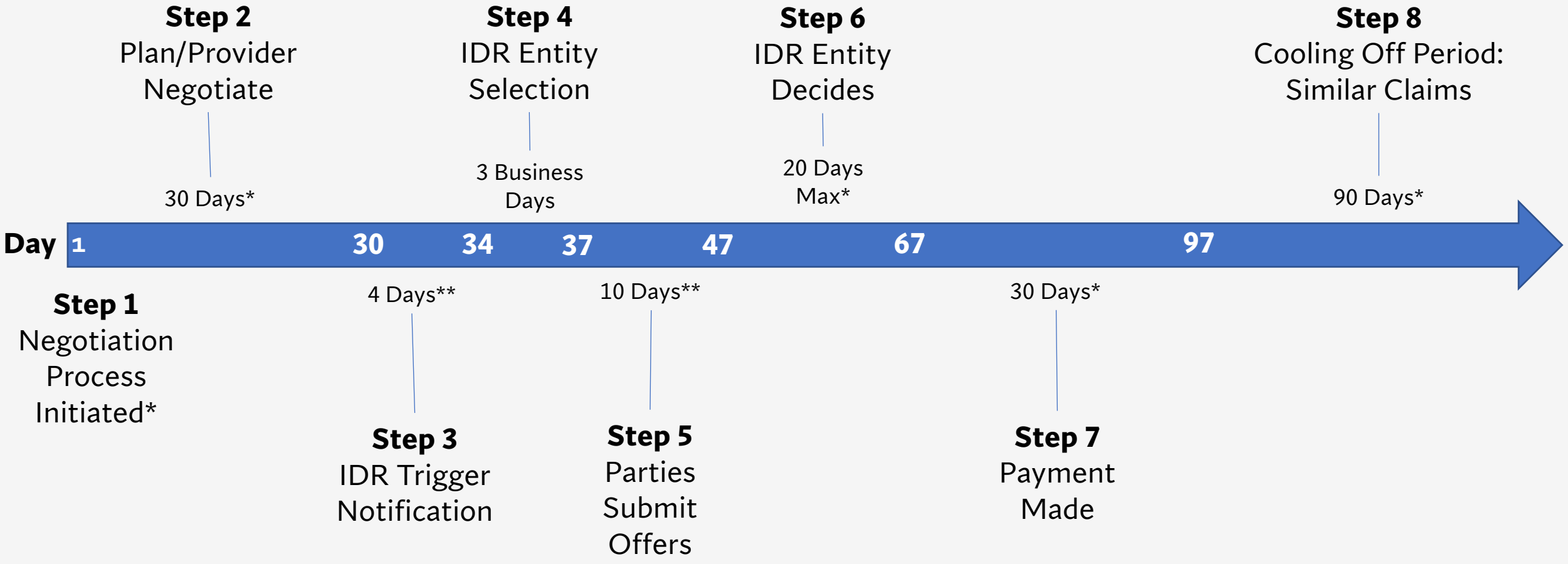
NSA – Notice and Consent

In some instances, a provider may balance bill for out-of-network services if they provide notice and receive consent from the patient.

- Providers may not balance bill for services delivered at an in-network facility by an out-of-network provider unless the notice and consent process requirements and certain conditions are met.
- Consent must be obtained in writing 72 hours before a scheduled procedure (or when the appointment is made if within 72 hours).
- The notice and consent process may not be used to balance bill a patient in the following situations:
  - There is no in-network provider at the facility
  - Emergency services or items resulting from an unexpected medical need occurring during a procedure for which consent was obtained
  - For services related to emergency medicine, anesthesiology, pathology, radiology, neonatology, assistant surgeons, hospitalists, intensivists, and certain diagnostic services

NSA – Payment Process

The NSA requires parties to attempt to negotiate an acceptable payment amount before the provider can access the independent dispute resolution process.



*Negotiation must be initiated w/in 30-days of initial payment/denial.

IDR – Arbitration Factors Overview

Factors an IDR Entity Shall/Shall Not Consider

Shall Consider	Shall Not Consider
• **Qualifying payment amount** • Provider training/experience • Quality and outcomes • Plan/provider market share • Patient acuity • Teaching status • Case mix • Provider's scope of services • Good faith efforts to contract • Previous contracted rates (prior 4-years)	• Usual and customary charges • Billed charges • Medicare rates • Medicaid/CHIP rates • TRICARE rates

Legal Challenges

Multiple legal challenges have been filed against the administration for its implementation of the NSA.

American Hospital Association™
Advancing Health in America

AHA, AMA and others file lawsuit over No Surprises Act rule that jeopardizes access to care

The AHA and American Medical Association today sued the federal government over the misguided implementation of the federal surprise billing law. The associations are joined in the suit by hospital and physician plaintiffs, including Renown Health, UMass Memorial Health and two physicians based in North Carolina.

The lawsuit challenges a narrow but critical provision of a rule issued on Sept. 30, 2021, by the Department of Health and Human Services and other agencies. The provision being challenged implicates the arbitration process for determining fair payment for services by out-of-network providers and effectively upends requirements specified in the No Surprises Act. The rule and provision are set to take effect Jan. 1, 2022, with arbitrations expected to begin in the spring.

.

Source: https://www.aha.org/news/news/2021-12-09-aha-ama-and-others-file-lawsuit-over-no-surprises-act-rule-jeopardizes-access

Texas Medical Association Prevails in District Court

The District Court decision in the first NSA case was unambiguously positive for providers.

CHA NEWS 24 FEB 2022

Texas District Court Rules in Favor of Providers in No Surprises Act Legal Challenge

A Texas District Court on Wednesday ruled in favor of hospitals and providers in a suit brought by the Texas Medical Association challenging the administration's Sept. 30, 2021, interim final rule (IFR).
The specific provision in question instructs arbiters to presume the "qualifying payment amount" (median in-network rate) is the appropriate payment rate for care delivered by out-of-network hospitals and providers in covered circumstances.

The judge in the case found the administration's Sept. 30 IFR conflicted with the statutory language of the No Surprises Act (NSA) and ignored the framework it creates for determining the appropriate payment amount when care is delivered by out-of-network hospitals and providers in covered situations.

The ruling vacates portions of the IFR that direct arbiters to presume the qualifying payment amount is the appropriate out-of-network rate in isolation nationally; however, it does not affect other provisions of the NSA, such as the patient protections.

Source: https://calhospital.org/texas-district-court-rules-in-favor-of-providers-in-no-surprises-act-legal-challenge/?

Good Faith Estimate (GFE)

Providers and health care facilities are required to provide a good faith estimate of expected charges, in plain language, for furnishing items and services.

- Good faith estimates for uninsured/self-pay patients are to be provided **upon scheduling an item or service** or **upon request by an individual**
- The **expected charge** must reflect the anticipated billed charges, **inclusive of any expected discounts** or relevant adjustment that the provider or facility expects to apply to the self-pay or uninsured individual's charges, and must be "specific to what the uninsured (or self-pay) individual would be expected to pay"
- Turnaround times for services scheduled:
  - 3 to 9 business days in advance: 1 business day
  - 10 or more business days in advance: 3 business days

GFE – Who's In?

GFEs must include the expected charges for both "convening" providers/facilities and "co-healthcare" providers/facilities.

- **Convening provider or facility**: Treating facility or provider at which the self-pay or uninsured individual scheduled an item or service or requested a good faith estimate.
- **Co-healthcare providers**: Other providers and facilities who provide care in conjunction with the scheduled item or service.
- The "convening provider or facility" must contact "**co-healthcare providers and facilities**" who are reasonably expected to provide items or services in conjunction with the scheduled service to request that these other providers or facilities provide good faith estimate information to the convening provider.
- **CMS is exercising enforcement discretion on the requirement that convening providers include co-healthcare providers in their GFE until January 1, 2023.**

GFE – What's In?

GFEs must include the following data.

- An itemized list of the expected charges for **each item or service** in the **period of care**
  - The "**period of care**" for which expected charges must be provided is defined as "the day or multiple days during which the GFE for scheduled or requested item(s) or service(s) are furnished or are anticipated to be furnished"
  - If certain items or services must be scheduled separately and are expected to occur either prior to or following the primary item or service, the convening facility must include a list of these items and services with a disclaimer
- **The applicable service and diagnosis code** for each item or service
- **The "primary item or service"** = the item or service that is (1) the initial reason for the visit and (2) to be furnished by the convening provider or convening facility
- Items and services that are typically not scheduled in advance (emergency, urgent, emergent, and trauma) are NOT included in the good faith estimate, EXCEPT for urgent care appointments that are scheduled **3 business days** in advance.

NSA Implementation Timeline

No Surprises Act Provision	Implementation Date
Prohibition on Balance Billing Patients in Circumstances Covered By NSA	Jan 1, 2022
Notice and Consent Process to Balance Bill Patients for Post-Stabilization Services or Care Delivered by Out-of-Network Provider at an In-Network Facility.	Jan 1, 2022
Independent Dispute Resolution Process – Insured Patients	Jan 1, 2022
Patient-Provider Dispute Resolution Process – Self-Pay/Uninsured Patients	Jan 1, 2022
Good Faith Estimate for Scheduled Services and Upon Request – Self-Pay/Uninsured Patients	Jan 1, 2022*
Good Faith Estimate for Scheduled Services and Upon Request– Insured Patients	Enforcement Deferred Until Rulemaking**
Advanced Explanation of Benefit – Health Plans	Enforcement Deferred Until Rulemaking**

* HHS will exercise enforcement discretion through Dec. 31, 2022, as it relates to incorporating the good faith estimates from co-providers or co-facilities.

**https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf

NSA – CHA Implementation Resources

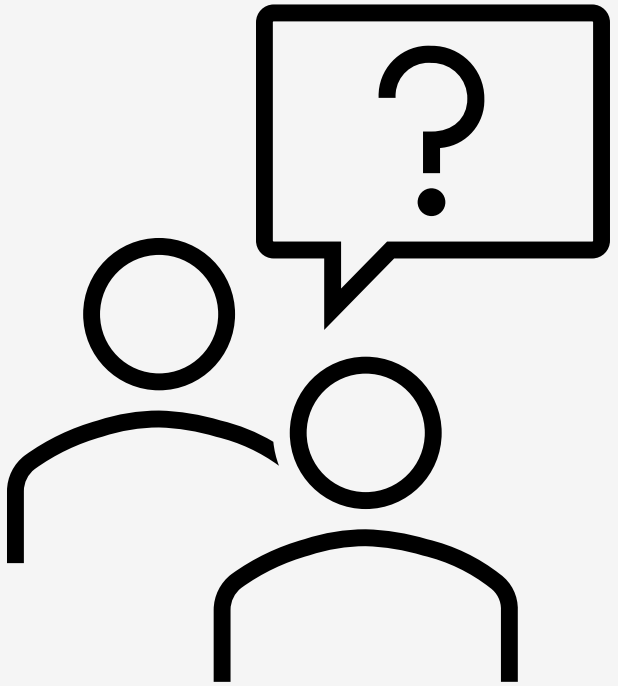
CHA is making a wide range of implementation resources available to members.

Resources Include:

- **Rule Summaries**
- **Comment Letters**
- **CMS Guidance**
- **Recorded Webinars**
- **CMS Forms**

Implementation resources are available at: https://calhospital.org/no-surprises-act/

Questions



Contact

Please contact me if you have questions that were not addressed today.

Chad Mulvany
VP, Federal Policy
(202) 270-2143
cmulvany@calhospital.org