American Association of Healthcare Administrative Management

(AAHAM – Philadelphia Chapter)

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Agenda

Financial Concerns

- Medicaid DSH Cuts
- Hospital OPPS/ASC 2020 Final Rule
- Price Transparency Requirements for Hospitals to Make Standard Charges Public Final Rule
- Hospital Groups Challenge CMS Mandated Disclosure of Negotiated Rates
- Proposed Medicaid Fiscal Accountability Rule (MFAR)
- Questions?

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Medicaid DSH Cuts

Medicaid DSH Cuts – Mandated by the ACA

- Currently scheduled to go into effect on December 20, 2019
- $4 billion nationally; about 1/3 of the $12 billion program (PA Impact = $242 million)
- Have been pushed back numerous times, but we will eventually face a huge "cliff"
- There is bi-partisan talk of pushing these back for a longer period of time
- BUT…there is some risk that the toxic political environment could allow them to happen

Hospital community remains united in pushing for further delay

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Hospital OPPS/ASC 2020 Final Rule

Hospital OPPS/ASC 2020 Final Rule

- Issued November 1, 2019
- Completed the phase-in of a payment cut for clinic visits provided in grandfathered off-campus provider-based departments, resulting in a site-neutral rate of 40% of the OPPS rate
- Continued the payment cut of average sales price (ASP) minus 22.5% for 340B acquired drugs

There was nothing about price transparency requirements in this final rule…

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Price Transparency Requirements for Hospitals to Make Standard Charges Public Final Rule

Price Transparency Requirements for Hospitals to Make Standard Charges Public Final Rule

- Issued November 15, 2019
- Establishes requirements for all hospitals in the United States to establish, update, and make public a list of their standard charges for all items and services that they provide
- Effective January 1, 2021, "to give hospitals more time to comply"
- CMS says these actions are necessary to promote price transparency in healthcare and public access to this information; consumers need it to make the best decisions about their care
- Includes enforcement action to address non-compliance

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Price Transparency Requirements for Hospitals to Make Standard Charges Public Final Rule

Defines 5 types of "standard charges" that must be disclosed:

1. Gross charges
2. Payer-specific negotiated
3. Discounted cash price
4. "De-identified" minimum negotiated charge
5. "De-identified" maximum negotiated charge

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Price Transparency Requirements for Hospitals to Make Standard Charges Public Final Rule

Information must be displayed in two ways:

1. In a comprehensive machine-readable file updated annually
2. In a consumer-friendly list of "shoppable" services

If a hospital has an online tool that allows a consumer to get a reasonable estimate of his/her out-of-pocket costs, they will be "deemed" as compliant with posting charge information in a consumer-friendly manner

It is ok for the patient to be asked to enter some personally identifiable information (*e.g.* insurance ID number)

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Hospital Groups Challenge CMS Mandated Disclosure of Negotiated Rates

The AHA and Others File Suit Against CMS December, 4, 2019

- AHA, AAMC, CHA, FAH and three hospital plaintiffs challenged the CMS mandate to disclose negotiated rates
- They say that the U.S. Department of Health and human Services (HHS) lacks statutory authority to require and enforce this provision
- They also argue that the provision violates the first Amendment by compelling the public disclosure of individual rates negotiated between hospitals and insurers in a manner that will confuse patients and unduly burden hospitals

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Next Steps

- Hospitals and health systems support making sure patients have the information they need to make informed healthcare decisions – including what their out-of-pocket costs will be – however, the CMS mandated disclosures do not achieve that goal
- In fact, they could have the opposite effect by confusing patients and unduly burdening hospitals
- The hospital community continues to urge CMS to partner with us, insurers, and consumers to make meaningful and effective changes to achieve greater transparency in healthcare

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Proposed Medicaid Fiscal Accountability Rule (MFAR)

CMS Focus on Medicaid Supplemental Payment Programs and Financing Arrangements

- Issued the proposed rule on November 12, 2019
- Intended to provide greater transparency in Medicaid supplemental payment programs, including Disproportionate Share Hospital (DSH) payments, and how states finance these payment programs
- CMS is also seeking greater agency oversight in response to numerous reports suggesting that the agency change how it oversees these payments and funding arrangements
- Comments are due January 17, 2020

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CMS is Proposing…

- Definitional changes to health care-related taxes, bona fide provider donations and public funds
- Changes to the review process for supplemental payment programs and health care-related tax waivers
- To codify sub-regulatory guidance issued over the past decade

Note that what is in the Preamble (which reflects the clear intent of CMS) and what is in the actual rule are not the same

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CMS Wants to:

- Require states to report provider-level supplemental payments
- Sunset supplemental payment methodologies after 3 years, require future approvals, and adhere to standardized templates and calculations
- Establish new definitions for Medicaid "base" and "supplemental" payments
- Clarify definitions for non-federal share financing arrangements and UPL ownership categories
- Clarify how public funds can be used in state financing arrangements

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CMS Wants to:

- Clarify impermissible donations
- Prohibit imposing higher provider tax rates on Medicaid services
- Require new reporting for DHS audits that would quantify DSH audit findings by hospital
- Clarify the procedures for when DSH overpayments are discovered through the audit process and specify procedures to address the overpayments

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Hospital Concerns

- This rule jeopardizes access to critical funding streams that were put in place because the Medicaid program has been chronically underfunded.
- The Medicaid program cannot sustain further erosion in funding, and hospitals are working closely with lawmakers and other associations to urge CMS to withdraw or modify this proposed rule

<u>Pennsylvania</u>

- HAP commissioned Dobson-DaVanzo to do a study of Pennsylvania Medicaid reimbursement using 2016 data. A report issued in April 2019, demonstrated that the payment-to-cost ratio was 81.1%

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Questions?

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