PYA SHORT COURSE: THE CONSOLIDATED APPROPRIATIONS ACT

# Hospital Payment and Reimbursement

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# Introductions

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# The Consolidated Appropriations Act, 2021

- Legislation signed by the President on December 27, 2020
- Legislation text 5,600+ pages
- Numerous provisions impacting hospital reimbursement, including:
  - Sequestration
  - Medicaid DSH
  - Surprise billing
  - Transparency
  - GME slots

# Sequestration

- Continued suspension of two percent sequestration
  - Suspension continues until April 1, 2021
    - Could be continued longer depending on PHE
  - Had been set to expire December 31, 2020

# Medicaid Disproportionate Share

- ACA-mandated reductions for Medicaid disproportionate share
  - Initial reduction targeted at $4 billion for FY2021
  - Now delayed until 2024
  - Delay results in cuts for FY2026 and FY2027
    - Expect -$8 billion each year from 2024-2027
      - Unless delays continue or change to ACA provision requiring reduction
- Calculation of Medicaid shortfall
  - Excludes all costs for Medicaid-eligible patients with other primary coverage

# Surprise Billing

- The No Surprises Act – bans surprise billing
  - Effective January 1, 2022 – implementing regulations required by 7/1/21
  - 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
  - Both providers and payers required to inform patients of cost sharing protections
  - Payers must pay provider or facility directly, not the patient

# Surprise Billing

- Application
  - Providers/practitioners, hospitals, ASCs, air ambulance (not ground)
  - Emergency services: applies to all emergency services whether participating or non-participating provider or facility
    - Includes post-stabilization services such as admission or outpatient observation that would be covered if in-network
  - Non-emergency services: applies to non-participating providers at participating facilities
  - Anesthesiology, pathology, radiology, laboratory, hospitalists, assistant surgeons and  neonatologists prohibited from balance billing *even with consent*

# Surprise Billing

- Patient cost sharing considered in determining outstanding deductible and out-of-pocket cost sharing limits
- For states with existing legislation: State law prevails and law would only apply to plans regulated by federal government (ERISA plans)

# Surprise Billing

- Provider payment
  - First step = negotiation with health plan (30 days)
  - Second step =  mediated dispute resolution process (IDR)
    - Entity must be independent, unbiased, no affiliation to providers or payers
    - Mediation must be triggered within four days of the end of the negotiation period
  - Parties submit offer to independent entity along with supporting information
  - Entity chooses final payment based on information provided
    - Cannot consider public payer rates or provider charges

# Surprise Billing

- Review entity to consider –
  - Median in-network rates
  - Provider training and experience
  - Patient acuity and complexity of care provided
  - Facility details such as teaching status, case mix, scope of services provided
  - Good faith effort (or lack thereof) to achieve resolution

# Surprise Billing

- No minimum disputed payment threshold
  - Allows bundling of like claims occurring within a single 30-day period
- Arbitration process to be concluded within 30 days
  - One of the two proposals must be chosen
    - No third alternative or compromise
  - Losing party pays cost of arbitration
  - Both parties share in cost if they reach resolution before decision by arbiter
- Cannot take same party to arbitration for same service for 90 days
  - Can still bring those claims after 90-day period ends

# Surprise Billing

- Penalty provisions
  - State enforcement action/federal civil monetary penalties
  - Up to $10,000 per violation

# Transparency

- Provisions effective January 1, 2022
- Providers and payers
  - Elimination of “gag” clauses in health plan contracts
- Health plans
  - Requirement for health plans to provide a price comparison tool for consumers
    - Tool must allow for comparing across multiple providers

# Transparency

- Health plans (continued)
  - Must provide advanced explanation of benefits prior to scheduled service or if requested before scheduling
    - Includes patient liability, contracted rate, status of cost sharing, management issues such as prior authorization, and disclaimer (just an estimate/subject to change)
    - Also required to provide list of all in-network providers able to furnish the service

# Transparency

- Health plans (continued)
  - Requirement for plans to maintain provider directories
    - If a patient relies on inaccurate directory, cost sharing limited to in-network only
    - Documentation of incorrect information must be provided
  - Cost sharing information must be included on member ID card

# Transparency

- Providers
  - Must provide good faith estimate of total expected charges for scheduled services with patient's health plan or with patient if uninsured
    - Must be provided 72 hours before service is furnished and no later than one business day after scheduling, unless scheduled more than 10 business days out
      - If more than 10 business days out, must be provided within 3 days of scheduling
    - Cannot balance bill patient if estimate not provided

# Transparency

- Requirements for timely billing/payment
  - Provider must patient with detail of services rendered within 15 days of discharge or date of visit
    - Facility-based services provided as a single list, including both employed and contracted practitioners
  - Effective six months after enactment
    - Regulations related to extenuating circumstances to be issued within one year of enactment

# Transparency

- Requirements for timely billing/payment (continued)
  - Must bill payer within 30 days
    - 30 days for plan to pay or deny
    - After plan adjudication, provider bills cost sharing within 30 days
    - Patient has at least 45 days to pay
    - If patient not billed within 90 days, no obligation to pay
      - Refund with interest if patient does pay bill sent after 90 days

# Graduate Medical Education

- Background
- Issues
- Statutory and Regulatory “Relief”
- Context Demographics
- Sample Impact Calculation
- Next Steps

# Graduate Medical Education: Background

## Indirect Medical Education Adjustment (IME)

- Payment for Indirect patient care costs incurred by teaching hospitals compared to non-teaching facilities
- Add on to DRG payment amount (FFS & MCO)
- Payment based on hospital specific teaching intensity factor, within statutory formula

1.35 x [(1 + (i&r/beds))^.405 - 1]

- Limited based on lesser of 3-year average or current year resident count in PPS part of facility
- Lesser of current year or average “ratio”

## Direct Graduate Medical Education Payment (GME)

- Payment for direct operating costs associated with approved residency programs (faculty, support, residents etc.)
- Paid via biweekly payments, settled in CR
- Payment based on hospital specific factors and represents the product of :

I&R* Per Resident Amount * Load Factor

- Limited to 3 year rolling average count, with further adjustments based on training residents over cap
- PRA based on 1984 data with modest inflation adjs.

# Graduate Medical Education: Issues

## Indirect Medical Education Adjustment (IME)

- Payment formula may not adequately cover the indirect patient care costs incurred by teaching hospitals.
- No IME adjustment for outpatient services.
- Program operations may have changed significantly since Cap amount was established.
- Cap limitations result in many “unfunded” resident positions.
- Formula measuring teaching intensity based on available beds may not reflect current hospital operations.

## Direct Graduate Medical Education Payment (GME)

- Payment methodology does not cover Medicare share of current direct operating costs for approved residency programs.
- No GME adjustment for outpatient services
- Program operations may have changed significantly since Cap amount was established.
- Cap limitations (including primary care v non-primary care) may result in many “unfunded” resident positions.
- Modest inflation factors may not keep pace with actual operations.

# Graduate Medical Education: Statutory "Relief"

## Section 126

- Applies to both IME and GME caps
- Adjustments effective July 1, 2023, with notification by January 31, 2023 of "award"
- Hospitals will need to file a timely application and re-apply each year
- Creation of 1000 new cap slots, with a limitation of no more than 200/year, and no more than 25 to any single hospital
- Specific qualification requirements focusing on likelihood of filling positions within 5 training years
- *No judicial review of determinations.*

## Section 127

- Provides additional incentives (cap relief) for urban hospitals to either establish or expand rural track programs by permitting expansion of rural rotations, as opposed to the prior requirement of a separately accredited program.

## Section 131

- Creates opportunity for redetermination of cap amount and per resident amount (PRA) for certain hospitals with an existing cap or PRA that establishes a new program(s) within 5 years of December 27, 2020 (date of enactment)

# Graduate Medical Education: Section 126 Details

## Qualifying Hospitals

### At least one of the following:

- Rural or reclassified rural *(includes hospitals reclassified as rural under RRC strategy*);
- Training residents in excess of cap (*cost reports filed before 12/27/20*);
- In the same state as "newly established" medical schools (accredited or established on or after January 1, 2000)
- Serving areas as designated as Health Professional Shortage Areas (HPSA)

## Award & Distribution

- Adjustments effective July 1, 2023, with notification by January 31, 2023 of "award"
- 200/year
- No more than 25 cap slots in total per hospital

## Allocation

| Category | Aggregate Distribution |
|---|---|
| Rural or Reclassified Rural | 100 |
| Training in Excess of Cap | 100 |
| Same State as New Medical School | 100 |
| Serving HPSA | 100 |
| **Sub-total** | **400** |
| | |
| Discretionary Distribution | 600 |
| | |
| **Total** | **1000** |

# Graduate Medical Education Context Demographics

| | Cost Report Data | Teaching Facilities/ Intern & Resident Counts Urban | Rural | Total | Average I&R Count Size Urban | Rural | Total |
|---|---|---|---|---|---|---|---|
| 26 | **Worksheet S-2 Part I HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA** | **1,337** | **101** | **1,438** | | | |
| | **Worksheet S-3 Part I HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA** | | | | | | |
| 14 | Total Acute Care Component FTE I&R (IPPS) | 123,207 | 1,864 | 125,071 | 92 | 18 | 87 |
| 16 | DPU Psych (IPF) | 1,356 | 40 | 1,396 | 1 | 0 | 1 |
| 17 | DPU Rehab (IPF) | 277 | 0 | 277 | 0 | 0 | 0 |
| 27 | Total (sum of lines 14-26) | 124,840 | 1,904 | 126,744 | 93 | 19 | 88 |
| | **E Part A INPATIENT HOSPITAL SERVICES UNDER IPPS CALCULATION OF REIMBURSEMENT SETTLEMENT INDIRECT MEDICAL EDUCATION ADJUSTMENT** | | | | | | |
| | *Total IME Adjusted Count (Cap) Amount* | 87,820 | 1,142 | 88,962 | 66 | 11 | |
| | *Total IMECurrent Year Count Amount* | 104,777 | 1,348 | 106,125 | 78 | 13 | |
| 9 | Adjusted IME Cap | | | | 89 | 21 | 62 |
| 10 | FTE count current year | | | | 102 | 23 | 74 |
| | ***(Over Cap)*** | (16,957) | (206) | (17,163) | (13) | (2) | (12) |
| | ***Number of Programs operating over IME Caps*** | 652 | 37 | 689 | | | |
| | **Worksheet E-4 DIRECT GRADUATE MEDICAL EDUCATION (GME) COMPUTATION OF TOTAL DIRECT GME AMOUNT** | | | | | | |
| | *Total GME Adjusted Count (Cap) Amount* | 90,877 | 1,302 | 92,179 | 68 | 13 | |
| | *Total GMECurrent Year Count Amount* | 115,945 | 1,392 | 117,337 | 87 | 14 | |
| 5 | FTE adjusted cap | | | | 82 | 23 | 64 |
| 6 | Current Year Unweighted resident FTE count | | | | 99 | 22 | 82 |
| | ***(Over Cap)*** | (25,068) | (90) | (25,158) | (17) | 1 | (17) |
| | ***Number of Programs operating over GME Caps*** | 778 | 32 | 810 | | | |

Over 90% are Urban (some RRCs may be included here)

Total Reported FTEs

- Non-PPS rotations;
- Cap limitations
- Additional cap slots only a fraction of differential
- Nearly 50% operating over cap

- Non-Hospital rotations
- Beyond initial residency period
- Same issues as IME

# Graduate Medical Education Sample IME Impact Example

| | | | Sample Teaching Hospital | | |
|---|---|---|---|---|---|
| | E Part A<br>INPATIENT HOSPITAL SERVICES UNDER IPPS<br>CALCULATION OF REIMBURSEMENT SETTLEMENT | | Original | | Add 25 IME Slots |
| 1.01 | DRG amounts for discharges occurring prior to October 1 | | 29,000,000 | | 29,000,000 |
| 1.02 | DRG amounts for discharges occurring on or after October 1 | | 87,000,000 | | 87,000,000 |
| 2 | Outlier payments for discharges. (see instructions) | | 6,000,000 | | 6,000,000 |
| 3 | Managed Care Simulated Payments | | 24,000,000 | | 24,000,000 |
| 4 | Bed days available | | 555.19 | | 555.19 |
| | **Indirect Medical Education Adjustment** | | | | |
| 5 | FY 96 FTE count (original cap) | | 470.39 | | 470.39 |
| 6 | FTE count for new programs in accordance with 42 CFR 413.79(e) | | 0 | | 0 |
| 7 | MMA Section 422 reduction amount to the IME cap | | 17.61 | | 17.61 |
| 7.01 | ACA § 5503 reduction amount to the IME cap | | 0 | | 0 |
| 8 | Adjustment to the FTE count for affiliated programs | | 85 | | 85 |
| 8.01 | Increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. | | 0 | | 0 |
| 8.02 | The amount of increase s from a closed teaching hospital under § 5506 of ACA. | | 0 | | 0 |
| 9 | Adjusted IME Cap | | **537.78** | | **537.78** |
| 10 | FTE count current year | | **556.71** | | **556.71** |
| 11 | FTE count for residents in dental and podiatric programs. | Over Cap | 0 | | 0 |
| 12 | Current year allowable FTE (see instructions) | | 537.78 | | 537.78 |
| 13 | Total allowable FTE count for the prior year. | | 459.38 | | 459.38 |
| 14 | Total allowable FTE count for the penultimate year | | 459.38 | | 459.38 |
| 15 | Sum of lines 12 through 14 divided by 3. | | 485.51 | | 485.51 |
| 16 | Adjustment for residents in initial years of the program | | 0 | | 0 |
| 17 | Adjustment for residents displaced by program or hospital closure | | 0 | | 0 |
| 18 | Adjusted rolling average FTE count | | 485.51 | | 485.51 |
| 19 | Current year resident to bed ratio (line 18 divided by line 4). | | 0.874493 | | 0.874493 |
| 20 | Prior year resident to bed ratio (see instructions) | | 0.874826 | | 0.874826 |
| 21 | Enter the lesser of lines 19 or 20 (see instructions) | | 0.874493 | | 0.874493 |
| 22 | IME payment adjustment (see instructions) | 38.79% | 45,000,000 | | 45,000,000 |
| 22.01 | IME payment adjustment - Managed Care (see instructions) | 37.50% | 9,000,000 | | 9,000,000 |
| | Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA | | | | |
| 23 | Number of additional allopathic and osteopathic IME FTE resident cap slots | | 0 | | 25 |
| 24 | IME FTE Resident Count Over Cap (see instructions) | | 18.93 | | 18.93 |
| 25 | If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 | | 0 | | 18.93 |
| 26 | Resident to bed ratio (divide line 25 by line 4) | | 0 | | 0.034096 |
| 27 | IME payments adjustment factor. (see instructions) | | 0 | | 0.009023 |
| 28 | IME add-on adjustment amount (see instructions) | *Impact:* | 0 | | **1,000,000** |
| 28.01 | IME add-on adjustment amount - Managed Care (see instructions) | | 0 | | **500,000** |
| 29 | Total IME payment ( sum of lines 22 and 28) | 39.66% | 45,000,000 | | 46,000,000 |
| 29.01 | Total IME payment - Managed Care (sum of lines 22.01 and 28.01) | 39.58% | 9,000,000 | | 9,500,000 |

IME applied only to DRG amount for FFS and MCO

Original 96 cap may be adjusted for RRC strategy as well as MMA and ACA adjustments and GME affiliated group arrangements. IME cap is compared to current year IME FTES as basis of IME calculation.

IME payment is based on lesser of current year I&R or rolling average and is applied to the lesser of the current year I&R to bed ratio or the weighted prior year ratio. This factor is applied to FFS & MCO DRG amount.

**Demonstrates impact of getting cap relief of 25 residents under Section 126. Actual impact would vary based on specific cost report instructions, when available**

# Graduate Medical Education Sample GME Impact Example

| | | Sample Teaching Hospital | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | **Worksheet E-4<br>DIRECT GRADUATE MEDICAL EDUCATION (GME)<br>COMPUTATION OF TOTAL DIRECT GME AMOUNT** | | **Original** | | ***Impact:*** | | **Add 25 GME Slots** | |
| 1 | FY 96 Unweighted resident FTE count… | 440 | | | | 440 | | |
| 2 | Unweighted FTE resident cap add-on for new programs | 0 | | | | 0 | | |
| 3 | Reduction to Direct GME cap 422 of MMA | 5 | | | | 5 | | |
| 3.01 | Direct GME cap reduction amount under ACA §5503 | 0 | | | | 0 | | |
| 4 | Adjustment GME affiliation agreement | 60 | | | | 60 | | |
| 4.01 | ACA Section 5503 increase to the Direct GME FTE Cap | 0 | | | | 0 | | |
| 4.02 | ACA Section 5506 additional direct GME FTE cap slots | 0 | | | | 0 | | |
| 5 | FTE adjusted cap | 495 | | | | 495 | | |
| 6 | Current Year Unweighted resident FTE count | 580 | | | | 580 | | |
| 7 | Enter the lesser of line 5 or line 6 | 495 | | | | 495 | | |
| | | Primary Care | Other | Total | | Primary Care | Other | Total |
| 8 | Weighted FTE count for physician… | 191 | 316 | 507 | | 191 | 316 | 507 |
| 9 | Calculation… | 163 | 270 | 433 | | 163 | 270 | 433 |
| 18 | Per resident amount | 100,200.00 | 99,700.00 | | | 100,200.00 | 99,700.00 | |
| 19 | Approved amount for resident costs | 16,500,000 | 27,400,000 | 43,900,000 | | 16,500,000 | 27,400,000 | 43,900,000 |
| 20 | Additional unweighted GME FTE resident cap slots… | 0 | | | | 25 | | |
| 21 | Direct GME FTE unweighted resident count over cap (see instructions | 84 | | | | 84 | | |
| 22 | Allowable additional direct GME FTE Resident Count (see instructions | 0 | | | | 22 | | |
| 23 | Enter the locality adjustment national average per resident amount ( | 0 | | | | 100,000.00 | | |
| 24 | Multiply line 22 time line 23 | 0 | | | | 2,200,000 | | |
| 25 | Total direct GME amount (sum of lines 19 and 24) | 43,900,000 | | | | 46,100,000 | | |
| | COMPUTATION OF PROGRAM PATIENT LOAD | | | | 2,200,000 | | | |
| | | Inpatient Part A | Managed Care | Total | | Inpatient Part A | Managed Care | Total |
| 28 | Ratio of inpatient days to total inpatient days | 0.33 | 0.06 | | | 0.33 | 0.06 | |
| 29 | Program direct GME amount | 14,300,000 | 2,700,000 | 17,000,000 | | 15,100,000 | 2,800,000 | 17,900,000 |
| 29.01 | Percent reduction for MA DGME | | | | | | | |
| 30 | Reduction for direct GME payments for Medicare Advantage | | 400,000 | 400,000 | | | 400,000 | 400,000 |
| 31 | Net Program direct GME amount | | | 16,600,000 | **900,000** | | | 17,500,000 |

Original 96 cap may be adjusted for MMA and ACA adjustments and GME affiliated group arrangements. GME cap is compared to current year GME FTES as basis of GME calculation.

GME cost before application of load factor

GME cost load factor adjusted: **Amount of GME Reimbursement**

**Demonstrates impact of getting cap relief of 25 residents under Section 126. Actual impact would vary based on specific cost report instructions, when available**

# Graduate Medical Education Next Steps

- Evaluate current GME program operations
- Complete a financial impact analysis related to a cap increase for both IME and GME payment streams
- Determine if hospital could benefit from either Section 127 or Section 131opportunities
- Timely complete application(s) and pursue increases under as many of the categories as applicable (new slots available each year)
- *Don’t count on the cap increase or additional reimbursement until it’s actually received.*

Questions:

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