Xtend Healthcare

Surviving Year Three of the "No Surprises Act" and Pricing Transparency

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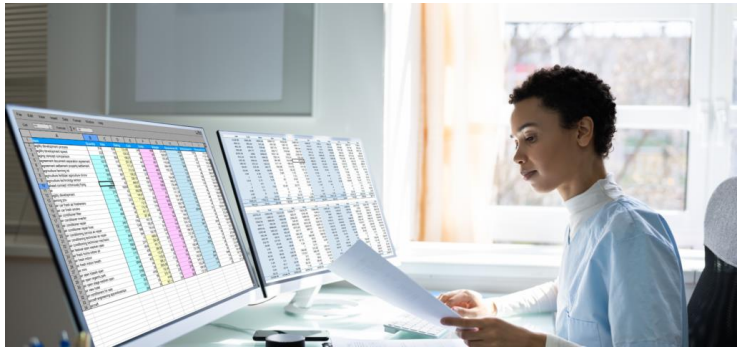
Agenda

Price Transparency

- Is hospital Price Transparency changing?
- What does “Compliance” require?
- No Surprises Act – Why is a “Good Faith Estimate” considered part of PT?

No Surprises Act

- FAQs for Complete Regulation Understanding
- New 2022 “Final” Rule
- Does “No Surprises Act” mean no or zero payment?



Price Transparency for Hospitals

"Hospitals" as defined in the federal Price Transparency law

- Based on hospital license under State law
- **Includes –**
  - Medicare certified and Non-Medicare certified hospitals
  - Hospital's **outpatient departments located at off-campus locations operating "under the hospital's license."**

Price Transparency Mandatory Requirements

- **Hospital is required to post selected pricing (charge) information in two ways:**
  - **A machine-readable file** for all items and services; and
  - **A consumer-friendly shoppable-services file** for 300 common items and services

OR

  - Utilize a **"Price Estimator Tool"**

- Information must be available on the website **for each hospital location!**
  - "Prominently" displayed.

PriceTransparency Machine Readable File

- A **machine-readable file for all items and services,** including associated codes, short description (in understandable "lay" language) of the item or service, required standard charges.
  - **"Standard Charges"** include all of the following:
    - gross charges,
    - discounted cash prices,
    - payer-specific negotiated charges, and
    - de-identified minimum and
    - maximum negotiated charges

Price Transparency Machine Readable File

- "Items and Services" are **all** items and services, **including individual services and service packages** that could be provided by a hospital to a patient …

  for which a hospital has established a standard charge.

- "Services package" is an aggregation of individual items and services into a single service for which the hospital has a single standard charge
  - (e.g., common procedure / surgery, per diem for inpatient routine care, DRG payment.)

PriceTransparency 300 Shoppable Services

- Display a consumer-friendly shoppable-services file:
  - **“Shoppable service” is a service that can be scheduled by a healthcare consumer in advance . . .**
  - “Standard Charges” include all of the following:
    - discounted cash prices,
    - payer-specific negotiated charges, and
    - de-identified minimum and maximum negotiated charges.
  - Report 300 common items and services = **70 services chosen by CMS / 230 additional chosen by hospital.**
  - Primary shoppable service must be grouped with any ancillary services that the hospital customarily provides as part of or in conjunction with the primary service.

Price Transparency 300 Shoppable Services

OR . . .

- **Price Estimator Tool**
  - Online tool that provides **real-time individualized out-of-pocket cost estimates,** i.e., an estimate of the amount the individual will be obligated to pay:
    - Single dollar amount
    - Tailored to the individual demographic and insurance coverage circumstances
    - Must reflect the amount the hospital anticipates will be paid by the individual
  - Provides real-time individualized out-of-pocket estimates that **combine hospital standard-charge information with the individual's benefit information.**

Price Transparency 300 Shoppable Services

- **Price Estimator Tool**
  - CMS noted the following **does not comply:**
    - estimated average charge amounts or ranges for the price of a shoppable service based on a broad population of patients;
    - total patient responsibility that does not combine hospital standard charges with the individual's benefit information from the specific insurer / plan;
    - disclaimer stating the price is not what the hospital anticipates that the patient will be obligated to pay.

Does a hospital have to report standard charges for physician and non-physician practitioners?

- Yes – Applies to physicians and non-physician practitioners **who are employed by the hospital.**
  - … All services within their scope of employment.

- **Definition of "employment"**
  - CMS declines to codify definition.
  - Consider IRS definition of Employee vs. Contractor

Is there a limit on the number of third-party payers that are reported?

- No!
- Hospitals are required to include **all** payer-specific standard charges, for **all** items and services.

If hospital does not have a standard charge for some items (for example, a gross charge for service packages), should/can it report an average charge?

- In a response to a request to use averages for shoppable services, CMS states that "**Average charges based on prior years would not be acceptable,** as average charge is not one of the types of standard charges we are finalizing in this rule."

  See 84 FR 65571, November 27, 2019

- CMS concluded that the most beneficial standard charge information for consumers would **include requiring disclosure of payer-specific negotiated charges for each item or service, in addition to the gross charge, and a de-identified minimum and maximum negotiated charge.**
- CMS examples illustrate using "N/A" as an option.

PriceTransparency Understanding Enforcement

- **Enforcement**
  - 2022 = Initial “Warning" letters requiring compliance
  - Corrective action plan
  - **Penalties** (CMS recently increased)
    - Effective 1/1/2021 – $300 / day for all hospitals
    - Effective 1/1/2022 –

      Sliding scale based on bed count
      - **up to 30 beds** – $300 / day
      - **> 30 beds** – penalty will increase by $10 / day for each additional bed above 30

PriceTransparency Understanding Enforcement

- **Penalties** (CMS recently increased) – Con't.
  - Maximum of $5,500 / day for hospitals with at least 550 beds.
  - Full year of non-compliance total penalty between $109,500 and $2,007,500.
- Two hospitals fined ($880,000 and $214,000) in June 2022.

May Want to Think of NSA as Two Separate Laws

Patient Protections Against Surprise Medical Bills

- Notice and posting requirements
- OON balance billing
- Emergency Care
- Charity eligibility / equity
- Certain “specialty” services not eligible for waiver / consent

Good Faith Estimate

- Uninsured and self-pay patients
- Notice and posting requirement
- No Surprises Act, but also Price Transparency
- Additional service locations

Good Faith Estimate (GFE) Full Definition

- As of January 1, 2022, providers must provide:
  - a written "good faith estimate" to self-pay and/or out-of-network patients
  - of expected charges for items and services
  - when scheduling or upon request.
- Remember **"specificity"** of each patient!

GFE Required of whom?

- All state-licensed or certified health care providers and facilities **(everyone!).**
- Including private practice locations.
- **"Convening** provider or facility"
  - **Note:**

    Beginning January 1, 2023,

    the GFE must include any item or service that is reasonably expected to be provided in conjunction with a scheduled or requested item or service **by another provider or facility (co-provider or co-facility).**

GFE Provided To Whom?

- For now, only required for uninsured or self-pay patients.
- HHS defines an "uninsured or self-pay" patient as an individual who *does not have benefits for an item or service* under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, federal health care program, or a health benefits plan

OR

an individual who is choosing to not use their coverage benefit.

GFE When Required?

- Convening provider or facility must inform uninsured and self-pay patients of availability of GFE.
- Must provide a "good faith estimate" of expected charges to patients *when scheduling or upon request.*
  - Within 3 business days of scheduling if service at least 10 days later.
  - The *next business day* after scheduling if service at least 3 days later but less than 10 days later.
  - Within 3 business days of receiving a request for a GFE by an uninsured or self-pay individual.

GFE In what format?

- Must be provided in writing or electronically **as requested by the patient.**

GFE

What If GFE Is Inaccurate?

- Patients can challenge bills substantially in excess of GFE via a government dispute resolution process.
- "Substantially in excess" means actual patient responsibility is **in excess of $400 or more of the provided GFE.**
- Provider may also be subject to civil penalties ($10,000 per violation).

GFE Other Details – Hot Topics!

- Must post notice of availability of GFE on website (if have one), and on-site where scheduling or questions about cost of care may or can be carried out.
- **Must update GFE if anticipate changes in scope or estimate.**
- Recurring services can use a single GFE for up to 12 months.
- GFE is considered part of the patient's medical record.
- Must provide copies of prior GFEs to patients furnished within last 6 years.
- Still waiting on rules for providing GFE to insured patients (per the patient's coverage plan).

Is a provider or facility required to provide a GFE to uninsured or self-pay individuals upon scheduling same-day or walk-in items or services?

- No.
- The requirement to provide a GFE to an uninsured or self-pay individual . . . is not triggered upon scheduling an item or service, **if the item or service is being scheduled fewer than 3 business days before the date the item or service is expected to be furnished.**
- For example, if an uninsured or self-pay individual arrives to schedule same-day laboratory testing services, the laboratory testing provider or facility is not required to provide the individual with a GFE.

HHS FAQs for GFEs, Part 2

Do providers or facilities need to provide GFEs to all individuals, for instance, patients with Medicare or Medicaid?

- No. Effective January 1, 2022, providers and facilities are required to provide GFEs to uninsured or self- pay individuals who schedule items or services or request an estimate.
- An **uninsured individual** is one who is not enrolled in a group health plan, or group or individual health insurance coverage, or a Federal health care program, or a Federal Employees Health Benefit (FEHB) program health benefits plan.
- A **self-pay individual** is one who is enrolled in, but who is not seeking to have a claim submitted to their group health plan, health insurance coverage, or FEHB program health benefits plan for the item or service being schedule or for which GFE is requested.

Do providers or facilities need to provide GFEs to all individuals, for instance, patients with Medicare or Medicaid?

- Under the No Surprises Act statute, providers and facilities **are generally not required to provide GFEs to individuals insured under Medicare, Medicaid, or other federal health care program.**

  from HHS FAQs for GFEs, Part 1

How can providers or facilities provide a GFE to an uninsured or self-pay individual when the underlying complexity of an individual's condition is not yet known?

- GFE must include items or services **reasonably expected** to be furnished for the primary item or service,
- and items or services reasonably expected to be furnished **in conjunction** with the primary item or service . . .
- " . . . the interim Final Rules do not require the good faith estimate to include charges for **unanticipated** items or services that are not reasonably expected and that could occur due to unforeseen events."

  from HHS FAQs for GFEs, Part 1

Do providers need to factor in financial assistance an uninsured or self-pay individual may receive when calculating the expected charges included in the GFE?

- **Yes.**
- The **GFE must reflect the expected charges, including any expected discounts or other relevant adjustments** that the provider or facility expects to apply to an uninsured or self-pay individual's actual billed charges.
- For example, tax-exempt hospital organizations are required to meet Financial Assistance Policy (FAP) requirements . . .
  - **any adjustments expected to be applied under the FAP would be factored in and reflected in the amount reported in the GFE.**

from HHS FAQs for GFEs, Part I

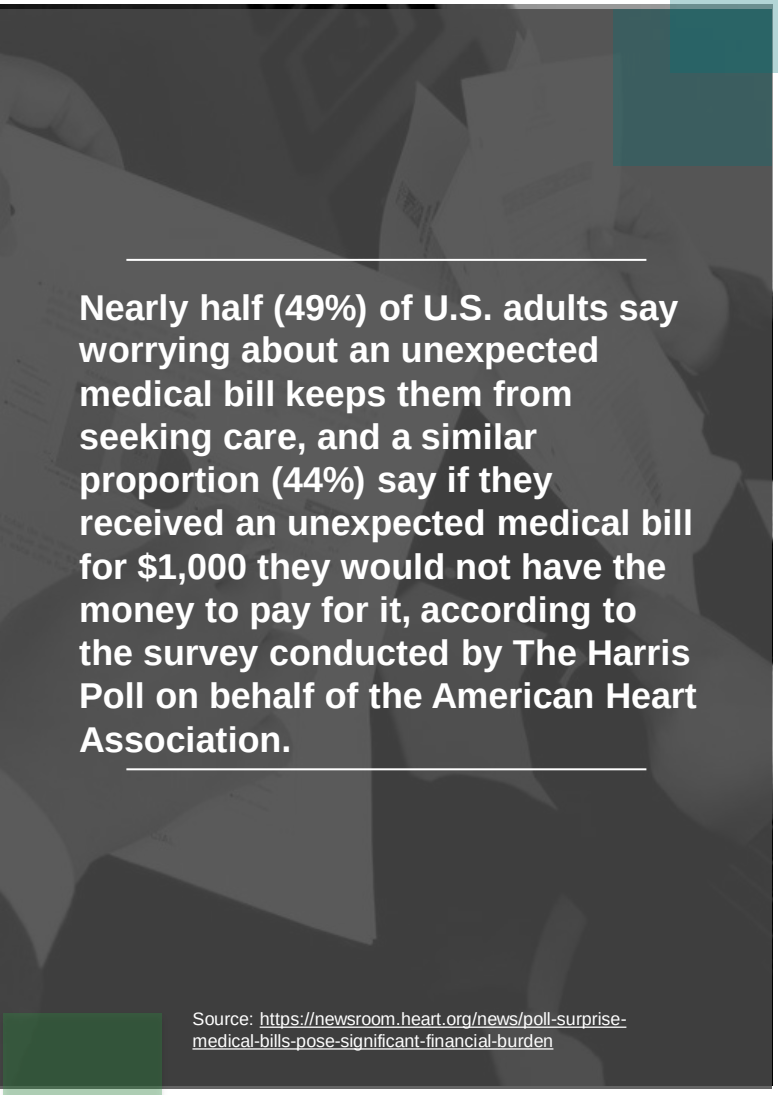
GFE Assistance with NSA?

- Where are you with Price Transparency?
    - Hospitals reporting their experience and accuracy with providing charge estimates assists greatly with identifying out-of-network patients.

“Surprise Billing” for Out-of-Network Services

After several years of disagreement, Congress passed revised “Out-of-Network” billing requirements within the last regulatory enactment of 2020.

- The legislation was initially considered a compromise that would **meet both provider and patient needs**, and the law was thought to represent improved payment opportunities for most providers than previous regulations that were under discussion.
- The requirements were contained within H.R. 133 – officially the **Omnibus Appropriations and Emergency Coronavirus Relief Act** – and will protect patients from surprise billing.
  - July 1, 2021 – Interim Final Rule I
  - September 30, 2021 – Interim Final Rule II
  - https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets



Nearly half (49%) of U.S. adults say worrying about an unexpected medical bill keeps them from seeking care, and a similar proportion (44%) say if they received an unexpected medical bill for $1,000 they would not have the money to pay for it, according to the survey conducted by The Harris Poll on behalf of the American Heart Association.

Source: https://newsroom.heart.org/news/poll-surprise-medical-bills-pose-significant-financial-burden

Consumer Protections Under Federal Law

The law contains key provisions **to protect consumers against the cost of surprise medical bills** including:

- **Emergency services** by out-of-network providers or facilities, including **emergency air transport**
- **Non-emergency services** provided by **out-of-network physicians within in-network facilities** for which patients do not consent.

Emergency Services

The legislation establishes the following payment parameters:

If the health plan covers Emergency Services,

- **All services must be covered** without prior authorization(s)
- **All covered without facility participation in health plan**

Services **must cost the patient the same as in-network services**.

Patient cost-sharing will count toward in-network deductible and out-of-pocket maximum amounts.

Out-of-network provider must bill health plan directly:

- Health plan has **thirty (30) days from bill date to pay or deny**
- If paid by plan, payment must go to the provider of services

The patient's **cost sharing amount is calculated from the previously determined "recognized amount,"** which is defined as either

- the amount recognized under any applicable state law that applies to this situation,
- the amount established through an all-payer rate-setting model, e.g., Maryland's model, or
- **the qualifying payment amount (QPA).**

Emergency Services

Determination of "patient status" necessary for compliance!

- **Recognize "changed" methodology for payment of Emergency Services for out-of-network patients!**
  - Define emergent – urgent – and "in the ER, but primary care."
  - Emergent not limited to "area of service."
- **True Emergency** – Observe EMTALA (Physician evaluation)
  - Inpatient admission or even Observation placement may delay any consideration of out-of-network determination.
- **Urgent** – Consider treating physician documentation (or nursing triage) for "emergency" decision.
  - If patient to be discharged and non-emergent, procedures in place for determination of out-of-network facility and follow Self-pay GFE!
- **"Primary Care" Visit** – If documentation supports OP Visit, procedures in place for determination of out-of-network facility and follow Self-pay GFE!

Emergency Services

Regulation defined "qualified payment amount;" but . . .

- 07/01/21 New regulation(s) will outline how to calculate the qualified payment amount (QPA).
- The dollar amount will be **based on historic rates** between the health plan and the provider, or
- Based on **the median contract rate** recognized by the health plan on 01/31/19:
  - Within the same market, and
  - Increased by the consumer price index year-over-year.

Notice and Patient Consent Exemption

Consent Waivers

- The regulation allows certain out-of-network providers to **seek written consent from patients that will then allow the provider to balance bill.**
- Limited to non-emergency services.
- **Not allowed** for specialties such as Radiology, Anesthesiology and Neonatology – or – services provided by assistant surgeons, hospitalists, intensivists.
  - Reservation for "other such items and services the HHS Secretary may specify in rules."
- Generally thought to protect consumers better than most state laws.

Consent Waivers

Notice and Patient Consent Exemption

- Waivers **not applicable to a non-participating provider at a participating facility if there is no participating provider able to provide the service at the facility.**
- The HHS Secretary may develop a list of advanced diagnostic laboratory tests that would not be included for a consent waiver.
- Consent **does not apply** in situations in which items and services are provided as a **result of an unforeseen, urgent medical need that arises at the time a covered service is provided.**

Notice and Patient Consent Exemption

Surprise Billing Notice to Patients

- Effective January 1, 2022, all providers must make publicly available, post on their website, and provide to insured individuals a **one-page notice,**
- via postal or electronic mail as specified by the insured individual,
- regarding the balance billing information in the law, any state-level information related to balance billing and
- how to contact state and federal agencies to report any violations.

Disclosure of Model Notice

Surprise Billing Notice to Patients

- Provide to patients covered by commercial plans and only for services in a hospital, CAH, or ASC.
- Facility can provide on behalf of providers but requires written agreement.
- **Provide no later than time bill is sent to patient.**
- Post on website (if have one).
- Post prominently in areas where patients check in or pay bills.
- Do not post in non-hospital (freestanding) physician office setting.

For the one-page notice describing the patient balance billing protections, is it required to be given to every single patient walking into the hospital or only out-of-network patients?

- Law requires hospitals give the notice describing patient balance billing protections to all patients covered by insurance.
- Therefore, the **conveyance of the notice is not limited to those patients who are out-of-network.**
- The Final Rule stipulates that, at a minimum, providers and facilities give the notice to the patient at the time of billing.
- However, the rule does offer some flexibility on the timing of the notice, and gives an example that the notice could be conveyed to the patient at the time a procedure is scheduled.

From American Hospital Association

Does the patient need to sign an acknowledgement that the patient has received the disclosure notice regarding patient protections against surprise billing disclosure?

- No.
- Patients don’t need to sign to acknowledge that they have received the disclosure notice regarding patient protections against Surprise Billing.
- Recommend download and review the model disclosure notice for patient protections against surprise billing, which providers and facilities may use.

CMS FAQ April 6, 2022

Federal Arbitration Requirements

Independent Dispute Resolution (IDR) Process

- A provider that receives an initial payment or denial from a health plan for out-of-network services may **either accept the payment or open negotiations** with the health plan during a thirty (30) day period that begins with receipt of the initial payment or denial.
- If negotiations fail, **either party may request the Independent Dispute Resolution (IDR) process** during the four days after the initial 30-day negotiation period.
- This is termed ***the notification.***
- The parties then **have three (3) days to jointly choose an IDR entity,** or if they cannot, the Secretary of Health and Human Services (HHS) will choose one.
- The provider and health plan may continue negotiating during the IDR process, and if an agreement is reached, the parties split the IDR fees.

How Arbitration will be carried out . . .

- The initial legislation also placed some key guardrails on the arbitration process:
  - Instructions are provided to the arbitrator to **consider the median in-network rate paid by the insurer –**
  - And **not a provider's higher billed charges** – when selecting between the amounts submitted by the two parties.
  - **The losing party must pay the cost of arbitration –** as an incentive against seeking arbitration for weaker cases.

No Surprises Act – Recent Developments

- Eight lawsuits have challenged a prior Interim Final Rule on the IDR process.
- In particular, they **take issue with the rule's requirement that IDR entities presume that the qualifying payment amount (QPA) –** the insurer or plan's median in-network rate – **is the appropriate out-of-network payment amount unless a party submits credible information that clearly demonstrates that this amount is materially different from the appropriate out-of-network rate.**
- This "rebuttable presumption," they argue, violates the Administrative Procedure Act and is beyond the scope of the agencies' legal authority, inconsistent with the NSA, or arbitrary and capricious.

No Surprises Act – Recent Developments

- Some, such as PHI Health, go further to argue that this part of the rule is unconstitutional and violates the Fifth Amendment.
- And plaintiffs in six of the lawsuits—by the TMA, the AMA, the ASA, the GACEP, LifeNet, and PHI Health—**further argue that the interim final rule is improper because there was no opportunity for advance public notice and comment.**

No Surprises Act – Recent Developments

New 2022 Final Rule – August 26, 2022

- **Very** narrow subject – focuses almost exclusively on the Independent Dispute Resolution (IDR) process, which was first addressed in an Interim Final Rule in fall 2021.
- **Requires payers** to provide additional information to out-of-network providers about the Qualifying Payment Amount (QPA).
- The QPA defined as the median of the plan or insurer's contracted rates for the item or service in that geographic region.
- The Final Rule goes into effect 60 days after publication in the Federal Register (October 25, 2022).

No Surprises Act – Recent Developments

- The 2022 "new" Final Rule's most significant change is elimination of the **"rebuttable presumption" in favor of the QPA.**
- Under the most recent interim Final Rule in 2021, IDR entities were directed to **select the offer closest to the QPA**

***unless* the parties submitted credible information about additional circumstances that clearly demonstrated that the QPA is materially different from the appropriate out-of-network rate.**

NSA – Recent Developments

- The 2022 Final Rule, in contrast, **does not dictate which offer the IDR entity should select.**
- It instead **focuses on the process that IDR entities should use when choosing between two competing offers.**
- In particular, the Final Rule **directs IDR entities to select the offer that best represents the value of the item or service under dispute.**
- In determining which offer best represents this value, **IDR entities must consider the QPA and then consider all additional information submitted by a party (or requested by the IDR entity), subject to certain limitations.**

No Surprises Act – Recent Developments

- Importantly, the additional information from either competing party must be:
    - related to a party's offer,
    - deemed credible by the IDR entity, and
    - not already accounted for in other information that is already before the IDR entity.

Note: "The remaining parts of the Interim Final Rules will be addressed in a future Final Rule after consideration of stakeholder comments."

No Surprises Act – Recent Developments

- There has only been one court decision so far.
- In February 2022, Judge Kernodle in the TMA challenge invalidated parts of the IDR rule, vacating provisions related to the rebuttable presumption in favor of the QPA.
  - He held that the plaintiffs **had standing to challenge the rule, that the rule is inconsistent with the NSA, that the federal agencies should not have bypassed notice and comment procedures, and that the challenged provisions should be vacated and remanded to the agencies for revisions.**
- Judge Kernodle did not disturb the overall IDR process, which is currently being used to resolve payment disputes between payers and out-of-network providers.

For now . . . Continuing questions for consideration and preparation

Question	Response - Actions to consider
Who will be responsible for: • negotiations with out-of-network payers? • determining "in-network" rates to be shared with payers for agreement on out-of-network payments?	• Generally being discussed by representative from Contracting or Risk Management. • Should benefit from recent Price Transparency requirements for posting minimum and maximum negotiated rates.

Price Transparency

No Surprises Act

July 1, 2021

Regulation on how to calculate qualifying payment amount

December 2021

Certify IDR entities

January 1, 2022

Regulation in effect one-page notice on surprise billing prohibitions, including state requirements, contact information for state and federal entities to report surprise billing violations

Revolutionize your revenue cycle

Extend your staff and IT assets

Improve your bottom line

Thank you!

Xtend Healthcare