Industry Updates – Price Transparency, Surprise Billing, Reimbursement, Other Recent Developments

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Four primary topics:

1. Price Transparency
2. Surprise Billing Regulation
3. Negotiating Payor Contracts
4. Stark Law Flexibility

Price Transparency FAQs

Price Transparency

What is the purpose of the Hospital Price Transparency regulation?

The Hospital Price Transparency Final Rule requires hospitals to make public their standard charges. The public release of hospital standard charge information is important to ensuring transparency in health care prices for consumers.

Price Transparency

What are hospitals required to do under the hospital price transparency regulations?

Each hospital is required to provide clear, accessible pricing information about the items and services they provide in two ways:

1. Comprehensive machine-readable file with all items and services.
2. Display of shoppable services in a consumer-friendly format.

Price Transparency

Two Required Ways for Making Public Standard Charges

Hospitals must make public their standard charges in two ways:

1) Comprehensive Machine-Readable File
   - A single machine-readable file that contains all five types of standard charges for all the items and services provided by the hospital
   - This information and format is most directly useful for employers, providers, and tool developers who could use these data in consumer-friendly price transparency tools or who may integrate the data into electronic medical records and shared decision making tools at the point of care; and
2) Consumer-Friendly Shoppable Services
   - A consumer-friendly list of some types of standard charges for a limited set of "shoppable services" (including 70 CMS-specified and 230 hospital-selected) provided by the hospital
     - A 'shoppable service' is a service that can be scheduled by a health care consumer in advance
   - These requirements will allow health care consumers to directly make apples-to-apples comparisons of common shoppable hospital services across health care settings

Price Transparency

Who Must Comply? Definition of 'Hospital'

- The final rule defines 'hospital' to mean an institution in any State in which State or applicable local law provides for the licensing of hospitals, that is licensed as a hospital pursuant to such law, or is approved by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing:
  - The definition includes all Medicare-enrolled institutions that are licensed as hospitals (or approved as meeting licensing requirements) as well any non-Medicare enrolled institutions that are licensed as a hospital (or approved as meeting licensing requirements)

Price Transparency

Will hospitals be able to apply for a hardship waiver or exception to meeting the Hospital Price Transparency requirements?

No. The Hospital Price Transparency Final Rule contains no provisions that address waivers or hardship exemptions.

Price Transparency

What standard charges must hospitals make public?

A standard charge means the regular rate established by the hospital for an item or service provided to a specific group of paying patients. For purposes of complying with the Hospital Price Transparency Final Rule, this includes five types of standard charges:

1. The gross charge (the charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts).
2. The discounted cash price (the charge that applies to an individual who pays cash, or cash equivalent, for a hospital item or service).
3. The payer-specific negotiated charge (the charge that a hospital has negotiated with a third-party payer for an item or service).
4. The de-identified minimum negotiated charge (the lowest charge that a hospital has negotiated with all third-party payers for an item or service).
5. The de-identified maximum negotiated charge (the highest charge that a hospital has negotiated with all third-party payers for an item or service).

Price Transparency

Do these requirements apply to non-employed physicians and other practitioners who provide and bill for the same services at the hospital?

No. Services provided by physicians and non-physician practitioners who are not employed by the hospital are practitioners that are practicing independently, establish their own charges for services, and receive the payment for their services. Such services, therefore, are not services "provided by the hospital."

Price Transparency

Do the standard charges for services performed by physicians and/or non- physician practitioners outside the scope of their employment by the hospital need to be included in the hospital's display of standard charges?

No. The Hospital Price Transparency Final Rule requires hospitals to post their standard charges for the items and services they provide. Items and services include, but are not limited to, the services of employed physicians and non-physician practitioners (generally reflected as professional charges). They do not include the services that physicians and non-physician practitioners perform outside the scope of their employment by the hospital.

Public Disclosure Requirements

Can hospitals choose between displaying standard charges in a machine- readable format and displaying standard charges for shoppable services in a consumer-friendly format?

No. Both formats must appear.

Price Transparency

In cases where the hospital has negotiated a payer-specific negotiated charge based on the Medicare or Medicaid FFS rate, can the hospital simply indicate that the price of the hospital item/service is set to the Medicare or Medicaid rate instead of reporting a specific dollar value?

No. The payer-specific negotiated charge is defined for purposes of the Hospital Price Transparency Final Rule as the charge that a hospital has negotiated with a third-party payer for an item or service, including a service package, and the hospital should list that standard charge. For example, if your hospital has negotiated a payer-specific negotiated charge for a service package that equals 200% of the Medicare FFS reimbursement rate for MS-DRG 123, then your hospital should determine the Medicare reimbursement rate for DRG 123, multiply it by 2, and indicate the resulting amount as its payer-specific negotiated charge for that service package.

Price Transparency

We believe displaying payer-specific negotiated rates publicly would violate the confidentiality clause of the hospital's contract with our third-party payers. Has CMS addressed this issue?

Even if a contract between a hospital and a payer contained a provision prohibiting the public disclosure of its terms, it is our understanding that such contracts typically include exceptions where a particular disclosure is required by Federal law.

Price Transparency

What are Hospital 'Standard Charges'?

- CMS finalized the definition of 'standard charges' to include the following:
  - Gross charge: The charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts
  - Discounted cash price: The charge that applies to an individual who pays cash, or cash equivalent, for a hospital item or service
  - Payer-specific negotiated charge: The charge that a hospital has negotiated with a third party payer for an item or service
  - De-identified minimum negotiated charges: The lowest charge that a hospital has negotiated with all third-party payers for an item or service
  - De-identified maximum negotiated charges: The highest charge that a hospital has negotiated with all third-party payers for an item or service

Price Transparency

Which Hospital 'Items and Services' Are Included?

- CMS finalized the proposal to define hospital "items and services" to mean all items and services, including individual items and services and service packages, that could be provided by a hospital to a patient in connection with an inpatient admission or an outpatient department visit for which the hospital has established a standard charge
- Examples include, but are not limited to, the following:
  - Supplies and procedures
  - Room and board
  - Use of the facility and other items (generally described as facilities fees)
  - Services of employed physicians and non-physician practitioners (generally reflected as professional charges)
  - Any other items or services for which a hospital has established a standard charge

No Surprises Act

No Surprises Act – What is it?

No Surprises Act

From CMS Website:

Effective 2022, the No Surprises Act protects people covered under group and individual health plans from receiving surprise medical bills when they receive most emergency services, non-emergency services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance service providers. It also establishes an independent dispute resolution process for payment disputes between plans and providers, and provides new dispute resolution opportunities for uninsured and self-pay individuals when they receive a medical bill that is substantially greater than the good faith estimate they get from the provider.

No Surprises Act

If a patient has private health insurance, these new protections ban the most common types of surprise bills. If a patient is uninsured or decides not to use your health insurance for a service, under these new protections, a patient can often get a good faith estimate of the cost of care up front, before the visit.

No Surprises Act

Before the No Surprises Act, if a patient had health insurance and received care from an out-of-network provider or an out-of-network facility, even unknowingly, the patient's health plan may not have covered the entire out-of-network cost. This could have left the patient with higher costs than if the patient got care from an in-network provider or facility. In addition to any out-of-network cost sharing the patient might have owed, the out-of-network provider or facility could bill the patient for the difference between the billed charge and the amount the patient's health plan paid, unless banned by state law. This is called "balance billing." An unexpected balance bill from an out-of-network provider is also called a surprise medical bill.

No Surprises Act

For those with health insurance:

- Ban surprise bills for most emergency services, even if out-of-network and without approval beforehand (prior authorization).
- Ban out-of-network cost-sharing (like out-of-network coinsurance or copayments) for most emergency and some non-emergency services. A patient cannot be charged more than in-network cost-sharing for these services.
- Ban out-of-network charges and balance bills for certain additional services (like anesthesiology or radiology) furnished by out-of-network providers as part of a patient's visit to an in-network facility.
- Require that health care providers and facilities provide patients with an easy-to-understand notice explaining the applicable billing protections, who to contact if the patient has concerns that a provider or facility has violated the protections, and that patient consent is required to waive billing protections.

No Surprises Act

What about those without health insurance?

If a patient does not have insurance or is otherwise self-pay, in most cases, these new rules make sure you can get a good faith estimate of how much care will cost before you receive it.

If charged more than the good faith estimate, patients can dispute a medical bill if final charges are at least $400 higher than the good faith estimate and the patient files to dispute claim within 120 days of the date on your bill.

No Surprises Act

Emergency Services

Surprise billing protections apply to most emergency services, including those provided in hospital emergency rooms. Also applies to air ambulance transportation (emergency and non-emergency), but not to ground ambulance. Emergency care includes screening and stabilizing treatment sought by patients who believe they are experiencing a medical emergency or active labor.

The federal government estimates there are 39.7 million emergency visits annually by patients with private job-based or individually purchased insurance, and of these 18% (or about 7.1 million visits) will involve at least one out-of-network claim. (Source kff.org)

No Surprises Act

Non-Emergency Services Provided at In-Network Facilities

Often, the doctors who work in hospitals don't work for the hospital, but instead bill independently and do not necessarily participate in the same health plan networks. The federal government estimates that 16% of 11.1 million (or about 1.8 million) in-network non-emergency facility stays for privately insured patients each year involve at least one out-of-network claim. (Source kff.org)

The NSA broadly defines covered non-emergency services to include treatment, equipment and devices, telemedicine services, imaging and lab services, and preoperative and postoperative services, regardless of whether those services are provided within the facility itself.

No Surprises Act

Providers are prohibited from billing patients more than the applicable in-network cost sharing amount. Penalties may apply.

No Surprises Act

Notice of Rights

Providers and health plans are required to notify consumers of their surprise medical bill protections. Providers and facilities must post a notice summarizing the protections on a public website and give this disclosure to each patient for whom they provide NSA-covered services. This notice must be provided no later than the date when payment is requested.

No Surprises Act

Enforcement

No Surprises Act

Dispute Resolution

Independent Dispute Resolution Action	Timeline
Initiate 30-business-day open negotiation period	30 business days, starting on the day of initial payment or notice of denial of payment
Initiate independent dispute resolution process following failed open negotiation	4 business days, starting the business day after the open negotiation period ends
Mutual agreement on certified independent dispute resolution entity selection	3 business days after the independent dispute resolution initiation date
Departments select certified independent dispute resolution entity in the case of no conflict-free selection by parties	6 business days after the independent dispute resolution initiation date
Submit payment offers and additional information to certified independent dispute resolution entity	10 business days after the date of certified independent dispute resolution entity selection
Payment determination made	30 business days after the date of certified independent dispute resolution entity selection
Payment submitted to the applicable party	30 business days after the payment determination

No Surprises Act

Practical Considerations

Negotiating Payor Contracts

Healthcare Reimbursement Contract Negotiation

Termination rights.

- Without cause.
- Contracts which do not have without cause language.
  - Auto-renewal
  - Timing of negotiations

Healthcare Reimbursement Contract Negotiation

Internal Controls

- Are notices from payors centrally directed?
- Is there a process for alerting all interested persons within the organization?
- Communications from payors can, at times, be misleading.

Healthcare Reimbursement Contract Negotiation

Are rates all that matter?

- Authorization process
- Time period for claims submission
- Time period for appeals
- Timely payment
- Termination rights

Healthcare Reimbursement Contract Negotiation

Monitor expirations.

Start negotiations for renewal in plenty of time.

Audit payments to ensure consistent with contracted terms.

Healthcare Reimbursement Contract Negotiation

Focus on the key, material items.

There is such a thing as negotiation fatigue.

Consider engaging counsel with experience.

Healthcare Reimbursement Contract Negotiation

Helpful Arkansas laws.

Arkansas Insurance Department.

Recent Regulatory Developments Regarding Stark Laws

Recent Stark Law Developments

- Generally provider-friendly.
  - Hospital pay physician up to $5k per year without a written agreement.
  - "Commercially reasonable" clarification. Takes into account type of entity you are.
  - "Volume / Value" of referrals. Mathematic equation issue.
  - 90 day compliance period for written agreement.

Value-Based Arrangements

- Greater Risk / Greater Flexibility
- No fair market value requirement.

QUESTIONS?

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