Price Transparency:

Background and 2024 Updates

HFMA Arkansas

January 24th, 2024

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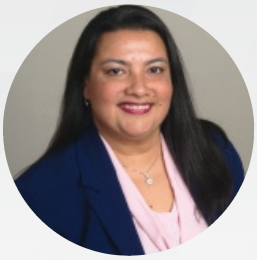
Agenda

- Price Transparency Updates (2024)
  - Common Definitions
  - Background
  - Penalties
  - Audit Process
- No Surprises Act Updates (2024)

Introductions – FORVIS Team



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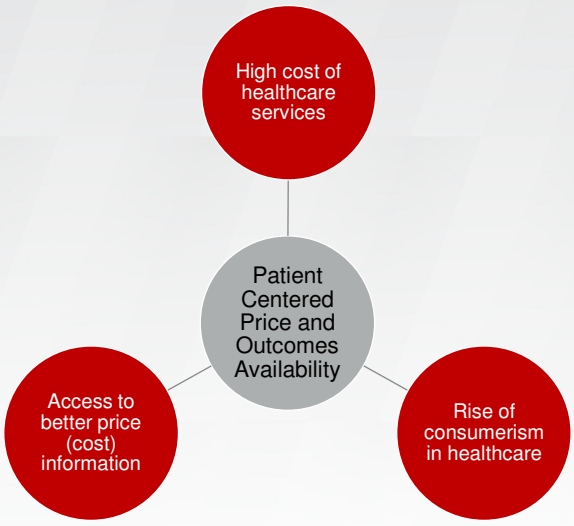
The Driving Points



What is driving the shift to patient centered price and outcomes availability?

- Use of high deductible health plans
- Increase in true self-pay patients and those electing to not use their insurance for certain procedures
- Outcomes driven provider selection (healthgrades, CMS star ratings)

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Price Transparency – Common Definitions

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Definitions

- **Price Transparency** – is a regulation where hospitals need to provide a file of their standard charges and their consumer-friendly charges that include plan reimbursable rates, so patients can estimate their financial responsibility.
- **Machine-Readable File (MRF)** includes reimbursement for packaged services and line level charges
  - Packaged Services are services with all inclusive pricing
  - Line Level Charges are CDM charge lines that are individually priced
- **Shoppable Service File (SSF)** includes reimbursement for all expected charge lines for a select procedure.
- **Estimator Tool** includes reimbursement for all expected charge lines for a select procedure (automated).

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Definitions continue

- **Included Depts** – Departments that need to be included in the machine-readable file are the reimbursable department found on worksheet A of the cost report.
- **Payor vs Plan** – Regulations require hospitals to list ALL contract plans (regardless of duplicate reimbursement) in both the MRF and SSF
  - Payor is an organization that pays for healthcare services (Aetna, BCBS)
  - Plan is the individual plan under the organization (PPO, EPO, HMO)
- **Audits** – CMS completes their own audits that may incur a penalty. There are 3rd parties (Patient Rights Advocate and Turquoise Health) that complete their own audits to bring awareness of non-compliance to light. There are no penalties incurred from the 3rd parties
- **Penalties** – CMS may impose penalties if a hospital does not comply with the regulations

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Price Transparency Background

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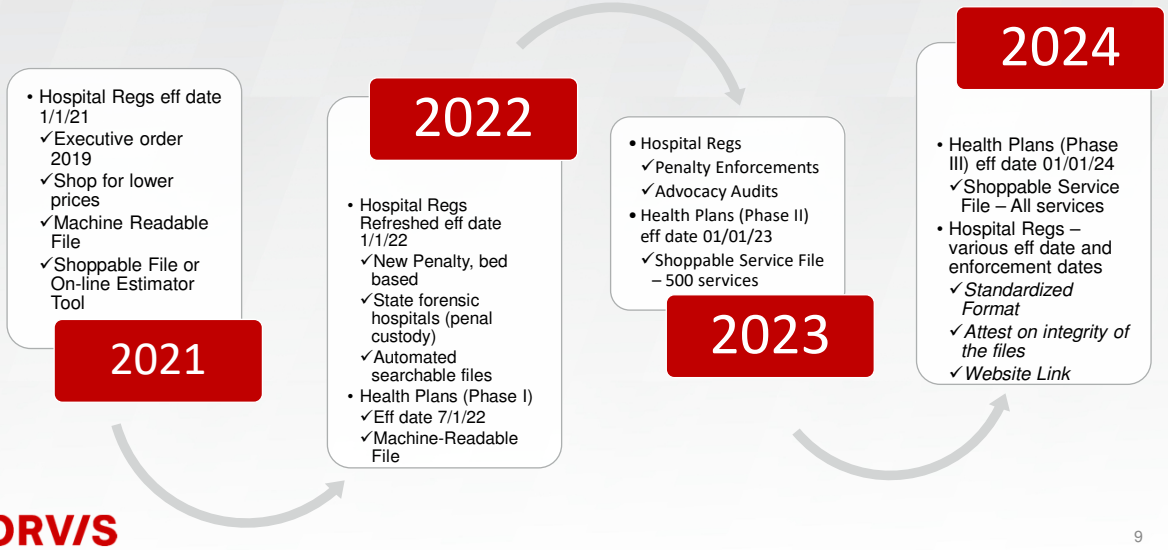
Background



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9

Lessons Learned To Date

- Collecting and Cleaning up the Data – CDM, Contracts, Letters
- Plan Grids – include all negotiated insurance plans under Payors
- File Type formatting (XML, JSON and CSV)
- NA in the Machine-Readable File
- Payor versus Plan; Contracted versus Non-Contracted
- Single Charge Lines versus Packaged Services
- Blended average pricing

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10

Penalties

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Penalty Scale

Bed Size	Per Day	Maximum per Day	Maximum per Year
30 or fewer	$300 per day	$300	$109,500
31 or greater	$10 for each bed	$5,500	$2,007,500

Examples:

Bed #	Days	Per Day	Max Per Day	Methodology Applied	Total Penalty
29	175	$300	$300	**$300 * 175 days**	**$52,500**
676	60	$6,760	$5,500	$10*676 = $6,760 (exceeds the max) **Default to max $5,500 * 60 days**	**$330,000**
521	365	$5,210	$5,500	**$10*521 = $5,210** **$5,210 * 365 days**	**$1,901,650**

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12

Audit Process

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Audit Requirements – Hospitals (Update April 26, 2023)

- CMS will evaluate hospitals for non-compliance
  - Increasing audit activity from 40 hospitals to 200 hospitals per month
- If determined to be non-compliant,
  - Receive dated correspondence from CMS; the date of the correspondence begins the countdown clock
  - Have 45 days to provide a corrective action plan (CAP) and 90 days to show full compliance
  - If you are late with the 45-day CAP, your hospital will be automatically fined the civil monetary penalties.
  - New penalty scale became effective January 1, 2022
- Audits, no penalties but will publicly list findings
  - Patient Rights Advocate
  - Turquoise Health

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CMS Non-Compliance Letter

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mailstop: C5-15-12
Baltimore, Maryland 21244-1850

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

January 4, 2023

Reference Number:

Via Certified Mail

RE: Hospital Price Transparency Warning Notice

Dear

The Centers for Medicare & Medicaid Services (CMS) issues this warning notice because it has determined that meets the definition of a hospital specified at 45 CFR §180.20 and is noncompliant with the price transparency requirements for hospitals to make standard charges public. We determined via a review of completed on January 3, 2023, that your hospital is noncompliant with requirements under 45 CFR part 180 (https://www.govinfo.gov/content/pkg/FR-2019-11-27/pdf/2019-24931.pdf).

Comprehensive Machine-Readable File

Requirements

(45 CFR §180.40)
Each hospital operating within the United States is required by 45 CFR § 180.40 to make public a list of its standard charges online in a comprehensive machine-readable format that includes all standard charges for all hospital items and services.

Violations

CMS has determined, after review of the publicly available website referenced above that is in violation of the requirements to make public its list of standard charges. Your hospital's violations include:

1. Failure to include all corresponding data elements in the list of standard charges, as applicable, as provided in 45 CFR §180.50(b). Specifically, not all gross charges were posted in the online machine-readable file as required at 45 CFR §180.50(b)(2). If your hospital does not have established gross charges for certain items and services, please respond with an explanation.
2. Failure to follow the naming convention specified by CMS, specifically: <ein>_<hospital-name>_standardcharges.[json|xml|csv] as required at 45 CFR §180.50(d)(5).
3. Failure to include all corresponding data elements in the list of standard charges, as applicable, as provided in 45 CFR §180.50(b). Specifically, not all payer specific negotiated rates were posted in the online machine-readable file as required at 45 CFR §180.50(b)(3). If your hospital does not have established payer specific negotiated rates for certain items and services, please respond with an explanation.
4. Failure to include all corresponding data elements in the list of standard charges, as applicable, as provided in 45 CFR §180.50(b). Specifically, each payer-specific negotiated charge was not clearly associated with the name of the third party payer and plan as required at 45 CFR §180.50(b)(3)
5. Failure to make public a machine-readable file containing a list of all standard charges for all items and services as provided in 45 CFR §180.50. Specifically, not all discounted cash prices were posted in the online machine-readable file as required at 45 CFR §180.50(b)(6). If your hospital does not have established discounted cash prices for certain items and services, please respond with an explanation.
6. Failure to include all corresponding data elements in the list of standard charges, as applicable, as provided in 45 CFR §180.50(b). Specifically, not all de-identified minimum negotiated charges were posted in the online machine-readable file as required at 45 CFR §180.50(b)(4). If your hospital does not have established de-identified minimum negotiated charges for certain items and services, please respond with an explanation.
7. Failure to include all corresponding data elements in the list of standard charges, as applicable, as provided in 45 CFR §180.50(b). Specifically, not all de-identified maximum negotiated charges were posted in the online machine-readable file as required at 45 CFR §180.50(b)(5). If your hospital does not have established de-identified maximum negotiated charges for certain items and services, please respond with an explanation.

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CMS Non-Compliance Letter - continues

1. Failure to make public a machine-readable file containing a list of all standard charges for all items and services as required at 45 CFR §180.40(a). Specifically, items and services as defined at 45 CFR §180.20 such as room and board were not found in the online machine-readable file. If your hospital does not provide one or more of these types of items and services, please respond with an explanation.
2. Failure to include all corresponding data elements in the list of standard charges, as applicable, as provided in 45 CFR §180.50(b). Specifically, not all payer specific negotiated rates were posted in the online machine-readable file as required at 45 CFR §180.50(b)(3). If your hospital does not have established payer specific negotiated rates for certain items and services, please respond with an explanation.
3. Failure to include all corresponding data elements in the list of standard charges, as applicable, as provided in 45 CFR §180.50(b). Specifically, not all de-identified minimum negotiated charges were posted in the online machine-readable file as required at 45 CFR §180.50(b)(4). If your hospital does not have established de-identified minimum negotiated charges for certain items and services, please respond with an explanation.
4. Failure to include all corresponding data elements in the list of standard charges, as applicable, as provided in 45 CFR §180.50(b). Specifically, not all de-identified maximum negotiated charges were posted in the online machine-readable file as required at 45 CFR §180.50(b)(5). If your hospital does not have established de-identified maximum negotiated charges for certain items and services, please respond with an explanation.
5. Failure to include all corresponding data elements in the list of standard charges, as applicable, as provided in 45 CFR §180.50(b). Specifically, the file did not contain all codes used by the hospital for purposes of accounting or billing for the item or service, including, but not limited to the Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS) code, the Diagnosis Related Group (DRG), the National Drug Code (NDC), or other common payer identifiers as required at 45 CFR §180.50(b)(7). If your hospital does not have established codes for certain items or services, please respond with an explanation.

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CMS Non-Compliance Letter (August 2023)

Violations
CMS has determined, after review of the publicly available website referenced above that Forrest General Hospital is in violation of the requirements to make public its list of standard charges. Your hospital's violations include:

- Failure to include all corresponding data elements in the list of standard charges, as applicable, as provided in 45 CFR §180.50(b). Specifically, descriptions for each item and service were not posted in the online machine-readable file as required at 45 CFR §180.50(b)(1).
- Failure to ensure that the standard charge information is accessible to automated searches, as provided in 45 CFR §180.50(d)(3)(iv). Specifically, the accessibility of a web page is hindered by "noindex" tags.
- Failure to ensure that the standard charge information is accessible to automated searches, as provided in 45 CFR §180.50(d)(3)(iv). Specifically, the accessibility of a web page is hindered by "relcanonical" tagging.
- Failure to follow the naming convention specified by CMS, specifically: <ein>_<hospital name>_standardcharges.[jsonlxmllcsv] as required at 45 CFR §180.50(d)(5).
- Failure to include all corresponding data elements in the list of standard charges, as applicable, as provided in 45 CFR §180.50(b). Specifically, not all payer specific negotiated rates were posted in the online machine-readable file as required at 45 CFR §l 80.50(b)(3). If your hospital does not have established payer specific negotiated rates for certain items and services, please respond with an explanation.
- Failure to include all corresponding data elements in the list of standard charges, as applicable, as provided in 45 CFR §180.50(b). Specifically, not all de-identified minimum negotiated charges were posted in the online machine-readable file as required at 45 CFR §180.50(b)(4). If your hospital does not have established de-identified minimum negotiated charges for certain items and services, please respond with an explanation.

Actions Your Hospital Must Take
Pursuant to 45 CFR part 180 subpart C, CMS requests that your hospital submit a CAP within 45 calendar days of the date of this notice. The CAP may follow the format of the Hospital Price Transparency Corrective Action Plan Response Sample that may be accessed online at https://www.cms.gov/hospital-price-transparency/resources. At a minimum, your hospital's CAP must include the following elements for each material violation identified by CMS in this notice: (i) specify the corrective actions or processes your hospital will take to address the material violation identified by CMS, (ii) specify the timeframe by which your hospital will complete the corrective action, which is not to exceed 90 calendar days from the date of this notice, (iii) provide a contact person responsible for the corrective action plan; and be signed and dated by the Chief Executive Officer/President.

Additionally, CMS requests your hospital acknowledge receipt of the request for CAP by emailing the Hospital Price Transparency inbox at HPTCompliance@cms.hhs.gov within 5 business days of the date of this notice.

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17

Patient Rights Advocate Report

- Completed semi-annually, latest was in July 2023
  - Selected 2,000 hospitals to audit with only 36% achieving full compliance (24.5% in February 2023)
  - Checklist looks at:
    - Complete Standard Charge File, Codes (any),
    - Gross Charges, Discount Cash Price
    - Negotiated Min & Max,
    - All Payors (all Plans) **AND**
    - 300 Shoppable services **OR** Price Estimator Tool (including Price Estimator Tool (PET) Cash Price)

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18

Patient Advocacy Report

Compliance	Complete Standard Charge File	Codes (of any type)	Gross Charge	Discounted Cash Price	Negotiated Min	Negotiated Max	Negotiated Rates	All Payers and Plans	300 Shoppable List	Price Estimate Tool (PET)	PET Provides Cash Price	Explanation
Compliant	Y	Y	Y	Y	Y	Y	Y	Y	-	Y	Y	
Compliant	Y	Y	Y	Y	Y	Y	Y	Y	-	Y	Y	
Noncompliant	N	Y	Y	Y	N	N	N	Y	-	Y	Y	Standard charges file fails to provide adequate pricing information for major payer negotiated rates as well as de-identified min/max charges; has non-searchable incomplete, overbroad or inapplicable descriptions; contains calculation instructions in place of numerical prices in negotiated rates, minimum and maximum fields, and non-searchable code ranges.
Noncompliant	N	Y	Y	Y	Y	Y	Y	N	-	Y	Y	Standard Charges File fails to adequately identify specific plans for all commercial payers.
Compliant	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Compliant	Y	Y	Y	Y	Y	Y	Y	Y	-	Y	Y	
Noncompliant	N	Y	Y	Y	Y	Y	Y	N	-	Y	Y	Standard Charges File fails to adequately identify specific plans for all commercial payers.
Noncompliant	N	Y	N	N	N	N	N	N	Y	Y	Y	No machine-readable Standard Charges File found.
Compliant	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Noncompliant	N	Y	Y	Y	N	Y	Y	N	-	Y	Y	Standard Charges File fails to provide an adequate amount of de-identified minimum charges and fails to adequately identify specific plans for all commercial payers.

July Semi-Annual Compliance Report 2023 — PatientRightsAdvocate.org

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Turquoise Health

- Can execute searches by procedures, providers, health systems and health plans
- Searches return descriptions of procedures, why you would have the procedure performed, procedure expectations, providers who perform them and average cash price
- Scores providers' Machine-Readable Files and offers recommendations

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Turquoise Health – Procedure Search

3D Mammogram Screening (Tomosynthesis)

Across all facilties, the average cash price for 3D Mammogram Screening (Tomosynthesis) is $86. However, the price you pay varies significantly based on your location and any insurance coverage. Enter your zip code to search for nearby providers of this service and find the best rates.

Procedure Information

What is a 3D Mammogram Screening (Tomosynthesis)?

A 3D mammogram screening, also referred to as tomosynthesis, uses advanced imaging technology to take a series of detailed, three-dimensional x-rays of the breast. It is used to detect and help diagnose breast cancer.

Find a provider

75270

Search

Average Cash Price

$86

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Turquoise Health – Provider Search

NAME	LOCATION	TYPE	BEDS	MRF TRANSPARENCY SCORE	
Arkansas Childrens Hospital Arkansas Childrens Hospital	Little Rock AR	Childrens Hospital	336	★★★★★	Scorecard
UAMS Medical Center University of Arkansas for Medical Sciences	Little Rock AR	Short Term Acute Care Hospital	450	★★★★★	Scorecard
Arkansas State Hospital	Little Rock AR	Psychiatric Hospital	222	N/A	Scorecard
CHI St. Vincent Infirmary Medical Center CHI St. Vincent	Little Rock AR	Short Term Acute Care Hospital	615	★★★★★	Scorecard
Cornerstone Hospital Of Little Rock	Little Rock AR	Long-Term Care Hospital	40	★★☆☆☆	Scorecard

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Price Transparency 2024 Updates

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2024 Changes – Templates & Data Dictionary

- Templates
  - CSV (wide or tall)
  - JSON
  - XML (excluded as a valid format starting 01.01.2024)
- There is a Data Dictionary for both types of templates, explaining the requirements for each column and row
  - As of the 2.0.0 version, CMS has noted that blank cells are valid if there is no value for the cell
  - Various fields have element value lists (Code, Code Type, Setting, Drug Type of Measurement and Methodology)

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2024 Changes – Template Header Fields

Field Name	Field Description	New	Compliance Date
Hospital Name	The legal business name of the licensee	No	07.01.24
Last Updated	Date on which the MRF was last updated (format YYYY-MM-DD)	No	07.01.24
Template Version	**The version of the CMS Template used (current is v2.0.0)**	**Yes**	**07.01.24**
Hospital Location	**The unique name of the hospital location absent any acronyms**	**Yes**	**07.01.24**
Hospital Address	**The geographic address of the corresponding hospital location**	**Yes**	**07.01.24**
License Number	**The hospital license number and the licensing state or territory's two-letter abbreviation for the hospital location(s) indicated in the file**	**Yes**	**07.01.24**
Affirmation	**List statement to display the file is true, accurate and complete**	**Yes**	**07.01.24**

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2024 Changes – Template General Fields

Field Name	Field Description	New	Compliance Date
Description	Description of each item or service provided by the hospital that corresponds to the standard charge the hospital has established.	No	07.01.24
Code	Any code(s) used by the hospital for purposes of billing or accounting for the item or service.	No	07.01.24
Code Type	**The corresponding coding type for the code data element**	**Yes**	**07.01.24**
Setting	**Indicates whether the item or service is provided in connection with an inpatient admission or an outpatient department**	**Yes**	**07.01.24**
Drug Unit Measurement	**If the item or service is a drug, indicate the unit value that corresponds to the established standard charge**	**Yes**	**01.01.25**
Drug Type Measurement	**The measurement type that corresponds to the established standard charge for drugs**	**Yes**	**01.01.25**

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2024 Changes – Template General Fields

Field Name	Field Description	New	Compliance Date
Gross Charges	Gross charge is the charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts	No	07.01.24
Discount Cash Price	Discounted cash price is defined as the charge that applies to an individual who pays cash for a hospital item or service	No	07.01.24
Modifiers	**Include any modifier(s) that may change the standard charge that corresponds to hospital items or services.**	**Yes**	**01.01.25**

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2024 Changes – Template Plan Fields

Field Name	Field Description	New	Compliance Date
Payor Name	**The name of the third-party payer that is, by statute, contract, or agreement, legally responsible for payment of a claim for a healthcare item or service**	**Yes**	**07.01.24**
Plan Name	The name of the payer's specific plan associated with the standard charge.	No	07.01.24
Dollar Amount	Payer-specific negotiated charge (expressed as a dollar amount) that a hospital has negotiated with a third-party payer for the corresponding item or service	No	07.01.24
Percentage	**Payer-specific negotiated charge (expressed as a percentage) that a hospital has negotiated with a third-party payer for an item or service**	**Yes**	**07.01.24**
Algorithm	**Payer-specific negotiated charge (expressed as an algorithm) that a hospital has negotiated with a third-party payer for the corresponding item or service**	**Yes**	**07.01.24**

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2024 Changes – Template Plan Fields

Field Name	Field Description	New	Compliance Date
Estimated Amount	Estimated allowed amount means the average dollar amount that the hospital has historically received from a third-party payer for an item or service. If the standard charge is based on a percentage or algorithm, the MRF must also specify the estimated allowed amount for that item or service.	**Yes**	**01.01.25**
Payer Notes	A free text data element used to help explain data in the file that is related to a payer-specific negotiated charge	**Yes**	**07.01.24**
Minimum	De-identified minimum negotiated charge is the lowest charge that a hospital has negotiated with all third-party payers for an item or service	No	07.01.24
Maximum	De-identified maximum negotiated charge is the highest charge that a hospital has negotiated with all third-party payers for an item or service	No	07.01.24
Generic Notes	A free text data element that is used to help explain any of the data	**Yes**	**07.01.24**

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No Surprises Act

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NSA – High Level Overview

1 No Surprises Act Interim Final Rule Part 1

Part 1 Released July 2021

- May not balance bill patients for emergency stabilization services
  - ED Post stabilization waiver may be obtained for certain services
- Protects patients from balance bills from out-of-network providers for services performed at in-network facilities (unless waiver is obtained)
- Establishes in-network cost-share for services outlined above for Providers and treatment by payers the Qualified Payment Amount (QPA) **UPDATED**
- Public notice of compliance with state and federal balance billing regulations

2 No Surprises Act Interim Final Rule Part 2

Part 2 Released September 2021

- Establishes the Provider-Payer independent dispute resolution (IDR) Process & Timelines **UPDATED**
  - Open negotiation period
  - Selection of the IDR
  - Ruling & payments
- Establishes the requirements and timelines for good faith estimates (GFE) for self-pay or uninsured patients
  - Establishes the future (1/2023) requirements for convening providers to include co-provider estimates **PAUSED INDEFINITELY**
- Establishes the Patient-Provider dispute resolution (PPDR) process & timelines

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Effective date: 01/01/2022

Risks of Non-Compliance with the NSA

Complain to CMS	Corrective Action Plans	Revenue Reductions	Civil Monetary Penalties
▪ Providers must respond to CMS notices of a complaint in as short as 3 days	▪ Dual state and federal enforcement efforts lead to multiple audits	▪ Health plan's initial offer will set new payment rates and patients can still access arbitration	▪ Claims recoupment and civil monetary penalties up to $10,000 per violation

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No Surprises Part 1

Establishes Guidelines for Balance or Surprise Billing for Emergency Care in an Out-of-Network Scenario

Surprise and Balance Billing for Out-Of-Network Providers at In-Network Facilities

Establishes the Qualified Payment Amount (QPA) for Services

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Patient Protections Under the NSA

- Patients are provided protection under the NSA
  - **Scenario 1: Emergency Care through stabilization**
    - UNLESS a waiver of protection is obtained, patients are also protected for procedures or stays associated with the emergency department admission
  - **Scenario 2: OON Providers at in-network facilities**
    - Providers and Payers may only hold patients responsible for in-network cost share
- **In both scenarios, Payers are to process as in-network and compensate Providers at the Qualified Payment Amount (QPA)**

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What is the Qualified Payment Amount (QPA)?

YES	NO
• Health plan's median contracted rate in 2019 increased by the CPU (for 2022 charges), or prior year's rate increase by the CPU (for 2023 charges and after) Updated* • Applies in the absence of an All Payer Model Agreement or State Law • QPA is final and payment in full pending no dispute	• Mean of in-network rate • Previous contract rate • Billed charges • Other out-of-network provider charges • Medicare/Medicaid rates

* Additional updates apply

Audit enforcements for QPA paused until May 1, 2024 while appeals occur.

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Monitoring Out-of-Network (OON) Claims

🚫 Allscripts 🚫 Athena 🚫 Cerner 🚫 CPSI ✓ Epic 🚫 Meditech

Patient Accounting Systems Assist in Tracking OON Plans?

Underlining the importance of identifying OON Plans

- Compliance
- Appropriate Reimbursement

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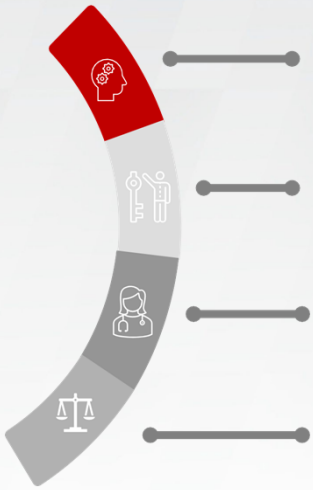
Operational Challenges Associated with NSA Part 1 Balance Billing



Develop an out-of-work strategy

Often difficult to identify out-of-network (OON) plans. Organizations will need to improve recognition of OON patients to track claims for review

Develop Internal SWAT Teams

Enable (denials) teams to review OON claims and escalate quickly for possible independent dispute resolution (IDR). Monitor for balance billing scenarios

Hospital and Provider Relationships

For non-employed and contracted providers, understand their network status and approach: waiver and bill vs. accept "in- network" adjudication

Keep Pressure on Payers

Payers may deny or fail to process claims correctly: be prepared to catch errors and dispute appropriately. Document everything.

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No Surprises Part 2

- Provider-Payer Independent Dispute Resolution (IDR)
- Good Faith Estimates (GFE) for Self-Pay and Uninsured Patients
- Patient-Provider Dispute Resolution (PPDR) Process

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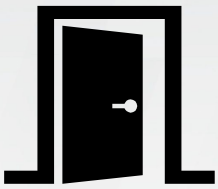
Independent Dispute Resolution (IDR) Open – Are You Ready?



CMS.gov
Centers for Medicare & Medicaid Services

Start A Dispute

REOPENED: DECEMBER 2023

Payment disputes between providers and payers (health plans)

- A Provider submits a claim
  - And suspects the payment is incorrect
    - Or that the payment is not at the appropriate OON rate

The Provider may enter open negotiations or file for an Independent Dispute Resolution (IDR).

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Independent Dispute Resolution (IDR) Reopening, Extensions and Fees

Reopening and Extensions

- **08/03/2023** and **12/14/2023 (Portal closed)**, disputing parties were unable to initiate new batched disputes and new air ambulance disputes due to the TMA III and TMA IV orders.
- **12/15/2023 (Portal reopened)**, disputing parties can initiate batched disputes and air ambulance disputes to the Federal IDR Portal.
- Parties for whom the IDR initiation deadline fell on any date between 08/03/2023 and 03/14/2024 will have until the 60th-business day after 12/15/2023, which is **03/14/2024,** to initiate batched disputes and air ambulance disputes. More information on current extensions can be found on the notices section.

Administrative Fees

- **Until a new administrative fee is established, the administrative fee for any new dispute is $50.00.**
- Reduced from $350

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Provider-Payer Dispute Timeline

(1) Initiation of open negotiations

Provider may initiate open negotiations within 30 business days of the date QPA or denial is received

(3) Federal IDR Process

- Select certified IDR (3 days)
- Each party must submit to the certified IDR entity & offer for a payment amount within 10 business days of selection of IDR

Issuer must make payment within 30 business days of certified IDR determination

30 days	4 days	3 days	10 days	30 days	30 days

(2) Initiating Federal IDR Process

Once open negotiations exhausted, either party may initiate the Federal IDR process during the 4 business-day period beginning on the 31st day post open negotiations*

(4) IDR Decision Making Process

- IDR presumes the QPA is appropriate OON rate
- *Information is submitted demonstrating the QPA is materially different from the appropriate OON rate* ***Now debunked & HHS has issued new guidance***

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Updated Guidance – IDR Process

1. The level of training, experience, & quality outcomes
2. The market share held by provider or facility of that plan in geographic region
3. The acuity of the patient & complexity of the service
4. Teaching status, case mix, & scope of services
5. Good faith efforts made by provider, facility, or plan to enter into an agreement over last 4 years

- "CREDIBLE" information must be provided to support how each item affects the appropriate OON rate
- The decision of the arbitrator is **final** and the loser pays costs of arbitration
- The party that initiated the IDR may not initiate a subsequent IDR with same party, for similar Item or Service, during a 90-day "cooling-off" period
- If the end of a payment negotiation period ends during the "cooling-off" period, either party must submit IDR notice within 30 days of the last day of the "cooling-off" period

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Good Faith Estimates (GFE)

Chart 1: Example of How Itemized Lists of Expected Items or Services Could be Displayed in a Good Faith Estimate for Uninsured (or Self-Pay) Individuals

Details of Services and Items for [Provider/Facility 1]

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service Code Type: Service Code Number]		
Total Expected Charges from [Provider/Facility 1]					$
Additional Health Care Provider/Facility Notes					

Details of Services and Items for [Provider/Facility 2]

Service/Item	Address where service/item will be provided	Diagnosis Code		Service Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]		[Service Code Type: Service Code Number]		
	Total Expected Charges from [Provider/Facility 1]					$
	Additional Health Care Provider/Facility Notes					

- 2022
  - Providers are responsible to provide Self-pay and Uninsured patients a Good Faith Estimate for all scheduled services
- 2023 – **PAUSED INDEFINITELY**
  - Beginning 01/01/2023 the Convening Provider responsible for providing all-inclusive GFE including the co-provider for estimates associated with primary service
  - A co-provider will have one (1) day to provide estimate to convening provider
  - Begin to provide estimates for insured patients

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Good Faith Estimates – The Facts

- **Prominently Displayed** – Information regarding the availability of estimates must be prominently displayed (facility) and easily searchable via website
- **Verbal Notification** – The convening provider must verbally inform uninsured/self-pay individuals of the availability of a good faith estimate
- **Written or Printable Format** – Must be provided in written form either on paper or electronically (email, portal) pursuant to individuals requested method of delivery.
- **Retained as part of the medical record** – Forms considered part of Medical Records (6-year retention)

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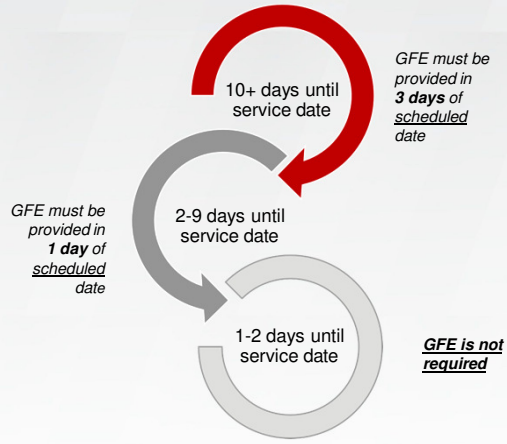
Timelines & Recommendations Related to GFEs



STRATEGIES TO REDUCE BURDEN

- Integrate patient estimates into the financial clearance workflows
- Educate registration staff to double check for estimates on scheduled services for self-pay patients
- 80/20 Rule – Perform analysis to identify commonly scheduled procedures for self-pay patients

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Patient-Provider Dispute Resolution

- Patients have the right to dispute charge that is substantially in excess of the estimate
- Defining "substantially in excess"
  - >$400 from estimate
    - Services included in GFE include services A, B, & C. Services A & B are provided by convening provider & service C provided by co-provider. In this example services A & B would need to exceed GFE by $400 & service C would need to exceed GFE by $400 to be eligible for Selected Dispute Resolution Entities (SDR)

OVERESTIMATING

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Challenges Related to GFE Requirements

GFE REQUIREMENTS

- Patient Demographics
- Organizational demographics (NPI, TIN)
- Itemized services grouped by
  - Convening provider
  - Co-provider
- Diagnosis, CPT codes, charges (including any discounts)
- Required disclaimers

OPERATIONAL CHALLENGES RELATED TO GFES

- Scheduling and identification of a payer source
- Non-scheduled services
- Provider variances (OR time, coding)
- No order or an order with several codes provided
- Getting estimate in the medical record
- Difficult to automate or track a GFE against the actual bill
- Consolidated statements

Organizations moving towards self-pay and uninsured global package pricing to mitigate the administrative burden and improve price accuracy

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Patient-Provider Dispute Resolution Timeline

0–120 Days

Patient Initiates Dispute Resolution

Patients may submit for dispute resolution process for up to **120 days** from receipt of original bill
$25 to file

Patient Notice Requirements

1. DOS & description
2. Copy of bill
3. Copy of GFE
4. Contact information, address, phone
5. State
6. Individual's communication preference

Additional Info

The SDR will notify patient electronically or by mail. Should request be incomplete, patient will have **21 days** to submit additional information for consideration

Convening Entity 10 Days

Convening facility/provider will have **10 days** from date of receipt of notice by SDR of patient-provider dispute to submit information

Final Determination

SDR will have **30 days** after receipt of information from provider to make a determination on the amount to be paid by patient

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Strategies for Operationalizing the NSA & Looking Ahead

- Monitoring for OON Plans
- Prepare for Provider-Payer Dispute: DEVELOP A STRATEGY
- Review and Validate the Calculated QPAs
- Consider the GFE process an opportunity to strengthen patient access and improve patient collections (Financial clearance process)
- Review patient statements against GFEs
- Look to later in 2024 and beyond regarding estimates for BOTH insured & uninsured patients

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Appendix

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