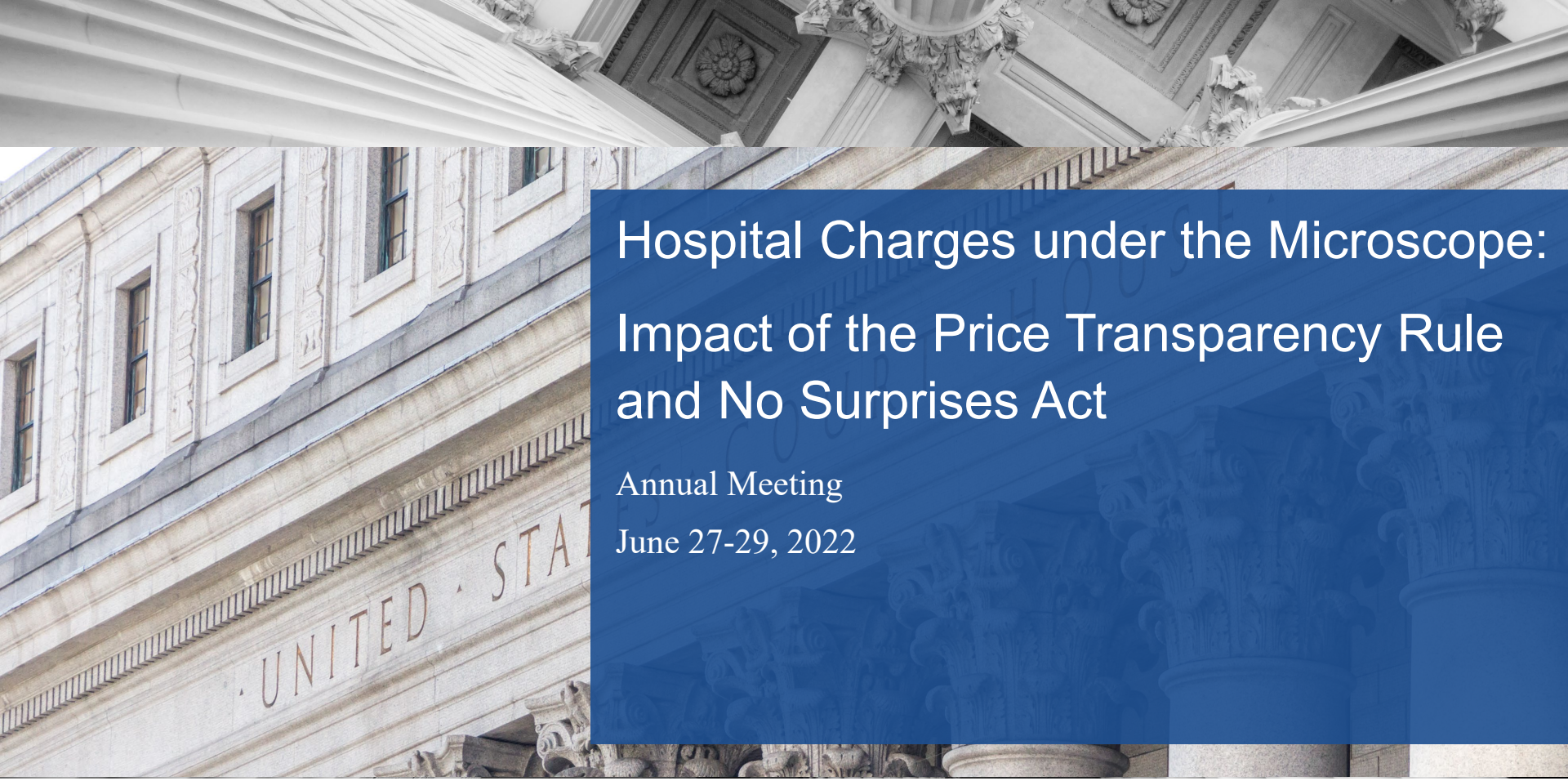

Hospital Charges under the Microscope:

Impact of the Price Transparency Rule and No Surprises Act

Annual Meeting

June 27-29, 2022

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AMERICAN HEALTH LAW ASSOCIATION

Agenda

- Primer on hospital charges
- Pricing Transparency Rule Fundamentals
- No Surprises Act Fundamentals
- Implications for Charge Setting Practices
- Implications for Charge Notification Practices
- Implications for Negotiating Payer Contracts
- Hospital-Provider Relations
- Hospital-Patient Relations

Hospital Charges

Fundamentals of Hospital Charges

- Hospital charges are accumulated in a listing called the charge description master, or “CDM”
- CDMs are organized in many different ways. They can be organized by individual items or services, or they can have a charge associated with each CPT code. Some are a hybrid of both.
- Only a small percentage of payers (including self-payers) pay on a charge basis. Others use prospective payments, based on diagnostic or procedure codes, capitated rates, or other structure of payment.

Medicare charge requirements

Cost Allocation

- Medicare requires that charges bear a rational relationship to cost, which is generally interpreted as meaning that charges must be consistent across payers, which is normally not an issue.
- This consistency is necessary because charges are used as a statistic for allocating costs to Medicare and non-Medicare patients alike.
- Affects:
  - Transplant
  - Outliers
  - New technology pass-through and add-on payments
  - Uncompensated care cost calculation for DSH

Medicare charge requirements *(cont.)*

"Charges means the regular rates for various services that are charged to both beneficiaries and other paying patients who receive the services. Implicit in the use of charges as the basis for apportionment is the objective that charges for services be related to the cost of the services." 42 C.F.R. 413.53(b).

"So that its charges may be allowable for use in apportioning costs under the program each may be allowable for use in apportioning costs under the program, each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services." Provider Reimbursement Manual I, § 2203.

How Managed Care Contracting Affects Hospital Charges

The "Lesser Of" Standard Clause

- Most payer contracts contain a clause like the following:

  For Covered Services rendered by Facility to a Member, the contract rate will be the lesser of (1) Facility's aggregate Customary Charges, or (2) the aggregate applicable contract rate determined in accordance with [applicable sections of the contract or an exhibit or appendix].

  "Customary Charges" is defined as "*the fee for health care services charged by Facility that does not exceed the fee Facility would ordinarily charge another person, regardless of whether that person is a Member"*

- Payers expect a hospital's chargemaster to be higher than the contract rates and, in fact, use the contracted discount rates as a selling point for their policies; however, the "lesser of" clause protects them in the event a hospital's charges are lower than the contracted rate
- To avoid "leaving money on the table," hospitals will periodically review their chargemaster against their payer contracts to ensure the charges are always higher than the contracted rates

Implications of Medicare charge requirements

- Hospitals sometimes increase charges faster than costs, so as to increase percentage of costs actually recouped through payment
- Just about every payer, including self-pay patients, will have some sort of arrangement that means that they are not paying full charges, which would seem exorbitant to the remaining few that are asked to pay them
- Hospitals, however, are concerned about questions about their charge-based Medicare payments if they charge no one their full charges

Price Transparency: The Law and The Rule

Statute

(e) STANDARD HOSPITAL CHARGES.—Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.

CMS Rule

- CMS issued a final rule on 11/15/19 implementing the statute.
- Went into effect on Jan. 1, 2021
- Purported goal is to reduce healthcare costs and furnish information that consumers supposedly claim that they need
  - Earlier iterations focused only on consumer information; Trump Administration added cost reduction after Trump signed an Executive Order requiring that transparency be used to do so

CMS Rule *(cont.)*

- Key facets of the rule
  - Definition of “hospital”
  - Definition of “items and services” provided by hospitals
  - Definition of “standard charges”
  - Public disclosure requirements
  - “Shoppable services” display requirements
  - Monitoring and enforcement
  - Appeals

CMS Rule *(cont.)*

- Definition of “Hospital”
  - Any entity licensed as a hospital under State law
  - Not limited to Medicare-enrolled facilities
  - Exception for Federally owned hospitals and forensic hospitals

CMS Rule *(cont.)*

- Definition of “Items and Services”
  - Includes all items and services and “service packages”
  - Includes services of “employed physicians,” regardless of whether they provide services in the hospital setting
    - HEAVY burden on AMCs that don’t have their faculty employed in separate legal entities

Hospital “Items and Services”

- For hospitals that have provider-based clinics and out-patient service locations, that means *ALL goods and services* sold in such locations
  - Example 1: Vanderbilt Bill Wilkerson Center, which specializes in hearing and speech disorders, has an audiology clinic that provides *hearing tests* and sells *hearing aids*.
  - Example 2: Vanderbilt Eye Institute has an optical center that sells *glasses* and *contacts*.
  - Example 3: Vanderbilt Weight Loss Clinic sells *food* and *supplements* to patients in medical weight loss programs.

CMS Rule *(cont.)*

- Types of “Standard Charges” to be disclosed
  - Gross charge: CDM charges
  - Discounted cash price: Price to cash paying customers
  - Payer-specific negotiated charge: The rate for an item or service *for each applicable payer*
  - De-identified minimum negotiated charges: The lowest of all its charges for a particular item or service
  - De-identified maximum negotiated charges: The highest of all its charges for a particular item or service

CMS Rule *(cont.)*

- Publicizing standard charges
  - Machine-readable file
    - A single file that contains all five types of standard charges
    - File must be displayed prominently on hospital website and be easily accessible
      - As of 2022, must be accessible to automated searches and direct file downloads
    - Must be updated annually and dated

Price Transparency: Implementing the Rule

CMS Example of the Machine-Readable Format for Publication

Hospital XYZ Medical Center
Prices Posted and Effective [month/day/year]
Notes: [insert any clarifying notes]

Description	CPT/HCPCS Code	NDC	OP/Default Gross Charge	IP/ER Gross Charge	ERx Charge Quantity
HB IV INFUS HYDRATION 31-60 MIN	96360		$1,000.13	$1,394.45	
HB IV INFUSION HYDRATION ADDL HR	96361		$251.13	$383.97	
HB IV INFUSION THERAPY 1ST HR	96365		$1,061.85	$1,681.80	
HB ROOM CHARGE 1:5 SEMI PRIV				$2,534.00	
HB ROOM CHG 1:5 OB PRIV DELX				$2,534.00	
HB ROOM CHG 1:5 OB DELX 1 ROOM				$2,534.00	
HB ROOM CHG 1:5 OB DELX 2 ROOMS				$2,534.00	
SURG LEVEL 1 1ST HR 04	Z7506			$3,497.16	
SURG LEVEL 1 ADDL 30M 04	Z7508			$1,325.20	
SURG LEVEL 2 1ST HR 04	Z7506			$6,994.32	
PROMETHAZINE 50 MG PR SUPP	J8498	00713013212	$251.13	$383.97	12 Each
PHENYLEPHRINE HCL 10 % OP DROP		17478020605	$926.40	$1,264.33	5 mL
MULTIVITAMIN PO TABS		10135011501	$0.00	$0.00	100 Each
DIABETIC MGMT PROG, F/UP VISIT TO MD	S9141		$185.00		
GENETIC COUNSEL 15 MINS	S0265		$94.00		
DIALYSIS TRAINING/COMPLETE	90989		$988.00		
ANESTH, PROCEDURE ON MOUTH	170		$87.00		

[1] Note that this example shows only one type of standard charge (specifically the gross charges) that a hospital would be required to make public in the comprehensive machine-readable file. Hospitals must also make public the payer-specific negotiated charges, the de-identified minimum negotiated charges, the de-identified maximum negotiated charges, and the discounted cash prices for all items and services.

What it actually looks like…

Excel Example

	A	B	C	D	E	F	G
1	HCPCS/ CPT/NDC C	Internal Proc Co	Other Cod	Procedure Name	Charge	Medicare Adv - Aetna	Medicare Adv - BCBS
2	J0702	25000013	636	HC BETAMETHASONE INJ 3MG	20.84	$0.00 for routine inpatient services; negotiated from $2.88 to $3.04 for all other services, depending on the circ	$0.00 for routine inpatient services and up to $2.98 for all other
3	J0696	25000015	636	HC CEFTRIAXONE SOD INJ 250MG	47.07	$0.00 for routine inpatient services; negotiated from $6.50 to $6.87 for all other services, depending on the circ	$0.00 for routine inpatient services and up to $6.73 for all other
4	J0834	25000021	636	HC COSYNTROPIN INJ 0.25MG	127.16	$0.00 for routine inpatient services; negotiated from $17.57 to $18.55 for all other services, depending on the ci	$0.00 for routine inpatient services and up to $18.18 for all other
5	J3420	25000022	636	HC CYANOCOBALAMIN INJ 1000MCG	17.17	$0.00 for routine inpatient services; negotiated from $2.37 to $2.50 for all other services, depending on the circ	$0.00 for routine inpatient services and up to $2.46 for all other
6	J0881	25000023	636	HC DARBEPOETIN NON ESRD INJ 1MCG	39.06	$0.00 for routine inpatient services; negotiated from $5.40 to $5.70 for all other services, depending on the circ	$0.00 for routine inpatient services and up to $5.59 for all other
7	J0882	25000024	636	HC DARBEPOETIN ESRD INJ 1MCG	41.28	$0.00 for routine inpatient services; negotiated from $5.70 to $6.02 for all other services, depending on the circ	$0.00 for routine inpatient services and up to $5.90 for all other
8	J1100	25000026	636	HC DEXAMETHASONE INJ 1MG	2.67	$0.00 for routine inpatient services; negotiated from $0.37 to $0.39 for all other services, depending on the circ	$0.00 for routine inpatient services and up to $0.38 for all other
9	J1200	25000031	636	HC DIPHENHYDRAMINE INJ UPTO 50MG	5.4	$0.00 for routine inpatient services; negotiated from $0.75 to $0.79 for all other services, depending on the circ	$0.00 for routine inpatient services and up to $0.77 for all other
10	90696	25000035	636	HC DTAP IPV VACC INJ 0.5ML	248.28	$0.00 for routine inpatient services; negotiated from $34.30 to $36.21 for all other services, depending on the c	$0.00 for routine inpatient services and up to $35.50 for all othe
11	J0885	25000037	636	HC EPOETIN NON ESRD INJ 1000 UN	86.26	$0.00 for routine inpatient services; negotiated from $11.92 to $12.58 for all other services, depending on the cii	$0.00 for routine inpatient services and up to $12.34 for all othe
12	J7307	25000038	636	HC ETONOGESTREL IMPLANT 68MG	5,713.47	$0.00 for routine inpatient services; negotiated from $789.25 to $833.37 for all other services, depending on th	$0.00 for routine inpatient services and up to $817.03 for all oth
13	90662	25000043	636	HC FLUZONE HI DOSE FLU VACC INJ	300.12	$0.00 for routine inpatient services; negotiated from $41.46 to $43.78 for all other services, depending on the c	$0.00 for routine inpatient services and up to $42.92 for all othe
14	90632	25000047	636	HC HEP A ADULT VACC IM INJ	361.08	$0.00 for routine inpatient services; negotiated from $49.88 to $52.67 for all other services, depending on the c	$0.00 for routine inpatient services and up to $51.63 for all othe
15	90633	25000048	636	HC HEP A PEDI VACC IM INJ 2 DS	151.57	$0.00 for routine inpatient services; negotiated from $20.94 to $22.11 for all other services, depending on the ci	$0.00 for routine inpatient services and up to $21.67 for all othe
16	90636	25000049	636	HC HEP A&B ADULT VACC IM INJ	526.44	$0.00 for routine inpatient services; negotiated from $72.72 to $76.79 for all other services, depending on the c	$0.00 for routine inpatient services and up to $75.28 for all othe
17	90647	25000051	636	HC HIB PRP-OMP VACC IM INJ 3 DS	143.76	$0.00 for routine inpatient services; negotiated from $19.86 to $20.97 for all other services, depending on the c	$0.00 for routine inpatient services and up to $20.56 for all othe
18	90648	25000052	636	HC HIB PRP-T VACC IM INJ 4 DS	63.75	$0.00 for routine inpatient services; negotiated from $8.81 to $9.30 for all other services, depending on the circ	$0.00 for routine inpatient services and up to $9.12 for all other
19	90670	25000060	636	HC PNEUMOCOCCAL CONJ 13VL VACC IM INJ	1,161.50	$0.00 for routine inpatient services; negotiated from $160.45 to $169.42 for all other services, depending on the	$0.00 for routine inpatient services and up to $166.09 for all oth
20	90680	25000062	636	HC ROTAVIRUS PENTA VACC ORAL 3 DS	447.68	$0.00 for routine inpatient services; negotiated from $61.84 to $65.30 for all other services, depending on the c	$0.00 for routine inpatient services and up to $64.02 for all othe
21	90707	25000065	636	HC MMR LIVE VACC SQ INJ	431.15	$0.00 for routine inpatient services; negotiated from $59.56 to $62.89 for all other services, depending on the c	$0.00 for routine inpatient services and up to $61.65 for all othe
22	90710	25000066	636	HC MMRV LIVE VACC SQ INJ	1,308.70	$0.00 for routine inpatient services; negotiated from $180.78 to $190.89 for all other services, depending on the	$0.00 for routine inpatient services and up to $187.14 for all oth
23	90713	25000067	636	HC POLIOVIRUS INACT VACC SQ/IM INJ	192.53	$0.00 for routine inpatient services; negotiated from $26.60 to $28.08 for all other services, depending on the c	$0.00 for routine inpatient services and up to $27.53 for all othe
24	90714	25000068	636	HC TD ADSRBD PF 7+YRS VACC IM INJ	174.37	$0.00 for routine inpatient services; negotiated from $24.09 to $25.43 for all other services, depending on the c	$0.00 for routine inpatient services and up to $24.93 for all othe
25	90715	25000069	636	HC TDAP 7+ YRS VACC IM INJ	202.19	$0.00 for routine inpatient services; negotiated from $27.93 to $29.49 for all other services, depending on the c	$0.00 for routine inpatient services and up to $28.91 for all othe
26	90716	25000070	636	HC VARICELLA LIVE VACC SQ INJ	830.64	$0.00 for routine inpatient services; negotiated from $114.74 to $121.16 for all other services, depending on the	$0.00 for routine inpatient services and up to $118.78 for all oth
27	90723	25000073	636	HC DTAP-HEPB-IPV VACCINE INTRAMUSCULAR	354.1	$0.00 for routine inpatient services; negotiated from $48.91 to $51.65 for all other services, depending on the ci	$0.00 for routine inpatient services and up to $50.64 for all othe
28	90732	25000074	636	HC PNEUMOCOCCAL 23 VAL2+YRS SQ/IM INJ	586.53	$0.00 for routine inpatient services; negotiated from $81.02 to $85.55 for all other services, depending on the c	$0.00 for routine inpatient services and up to $83.87 for all othe
29	90734	25000076	636	HC MENINGOCOCCAL ACY&W-135MCV4 OR MENACWY	678.58	$0.00 for routine inpatient services; negotiated from $93.74 to $98.98 for all other services, depending on the c	$0.00 for routine inpatient services and up to $97.04 for all othe
30	J1815	25000081	637	HC INSULIN GLARGINE 1 UN INJ	2.57	$0.00 for routine inpatient services; negotiated from $0.36 to $0.37 for all other services, depending on the circ	$0.00 for routine inpatient services and up to $0.37 for all other
31	J1815	25000083	637	HC INSULIN LISPRO 1 UN INJ	0.34	$0.00 for routine inpatient services; negotiated from $0.05 to $0.05 for all other services, depending on the circ	$0.00 for routine inpatient services and up to $0.05 for all other
32	J0561	25000102	636	HC PENICILLIN G BENZ INJ 100,000 UN	84.21	$0.00 for routine inpatient services; negotiated from $11.63 to $12.28 for all other services, depending on the cii	$0.00 for routine inpatient services and up to $12.04 for all othe
33	J1020	25000103	636	HC METHYLPREDNISOLONE INJ 20MG	37.83	$0.00 for routine inpatient services; negotiated from $5.23 to $5.52 for all other services, depending on the circ	$0.00 for routine inpatient services and up to $5.41 for all other
34	J1030	25000104	636	HC METHYLPREDNISOLONE INJ 40MG	40.13	$0.00 for routine inpatient services; negotiated from $5.54 to $5.85 for all other services, depending on the circ	$0.00 for routine inpatient services and up to $5.74 for all other
35	J1040	25000105	636	HC METHYLPREDNISOLONE INJ 80MG	80.02	$0.00 for routine inpatient services; negotiated from $11.05 to $11.67 for all other services, depending on the cir	$0.00 for routine inpatient services and up to $11.44 for all othe
36	J1644	25000107	636	HC HEPARIN SODIUM INJ 1000 UN	1.38	$0.00 for routine inpatient services; negotiated from $0.19 to $0.20 for all other services, depending on the circ	$0.00 for routine inpatient services and up to $0.20 for all other
37	J1815	25000108	637	HC INSULIN INJ 5 UN	0.46	$0.00 for routine inpatient services; negotiated from $0.06 to $0.07 for all other services, depending on the circ	$0.00 for routine inpatient services and up to $0.07 for all other
38	J1885	25000109	636	HC KETOROLAC INJ 15MG	4.53	$0.00 for routine inpatient services; negotiated from $0.63 to $0.66 for all other services, depending on the circ	$0.00 for routine inpatient services and up to $0.65 for all other
39	J1950	25000110	636	HC LEUPROLIDE INJ 3.75MG	6,181.91	$0.00 for routine inpatient services; negotiated from $853.96 to $901.69 for all other services, depending on the	$0.00 for routine inpatient services and up to $884.01 for all oth
40	J2001	25000111	636	HC LIDOCAINE INJ 10MG	2.03	$0.00 for routine inpatient services; negotiated from $0.28 to $0.30 for all other services, depending on the circ	$0.00 for routine inpatient services and up to $0.29 for all other
41	J2550	25000113	636	HC PROMETHAZINE INJ UPTO 50MG	11.47	$0.00 for routine inpatient services; negotiated from $1.58 to $1.67 for all other services, depending on the circ	$0.00 for routine inpatient services and up to $1.64 for all other
42	J2791	25000115	636	HC RHO-D IMM GLOB INJ 100IU	27.13	$0.00 for routine inpatient services; negotiated from $3.75 to $3.96 for all other services, depending on the circ	$0.00 for routine inpatient services and up to $3.88 for all other
43	J3030	25000118	637	HC SUMATRIPAN SUCC INJ 6MG	39.84	$0.00 for routine inpatient services; negotiated from $5.50 to $5.81 for all other services, depending on the circ	$0.00 for routine inpatient services and up to $5.70 for all other

What it actually looks like…

.json Example


```
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services.","Discounted Cash Price":"This section presents information regarding discounted cash pricing for those patients who decide to pay without insurance coverage.","Inpatient De-identified Negotiated
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presents the payer specific negotiated charge For items, services, And service packages that occur In the inpatient setting.","Outpatient De-identified Negotiated Charge":"This section presents the de-
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{"Itemcode":"00130369","Description":"BLOCK CUTTING TIBIAL SZ3 LEFT","CDM Revenue Code":"270","C-Base Price Amount":"300"},{"Itemcode":"00130372","Description":"CATH GUIDE LAUNCHER 8F AL4 100","CDM Revenue
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Revenue Code":"278","C-Base Price Amount":"1050"},{"Itemcode":"00130436","Description":"GLENOID CORTILOC LRG RIGHT 15D","CDM Revenue Code":"278","CDM HCPCS":"C1776","C-Base Price Amount":"2520"},
{"Itemcode":"00130439","Description":"STEM HUMERAL LONG PTC 6B ASCEN","CDM Revenue Code":"278","CDM HCPCS":"C1776","C-Base Price Amount":"5110"},{"Itemcode":"00130456","Description":"BREAST IMPL INSPIRA SMTH
COH E","CDM Revenue Code":"278","CDM HCPCS":"C1789","C-Base Price Amount":"1533"},{"Itemcode":"00130459","Description":"BREAST IMPL INSPIRA SMTH COH E","CDM Revenue Code":"278","CDM HCPCS":"C1789","C-Base Price
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EMBOLIC DEVICE SL 6X","CDM Revenue Code":"278","C-Base Price Amount":"18837"},{"Itemcode":"00130479","Description":"ANCHOR BOLT 30MM","CDM Revenue Code":"278","CDM HCPCS":"C1713","C-Base Price
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LASER BARE 400UM","CDM Revenue Code":"270","C-Base Price Amount":"945"},{"Itemcode":"00130504","Description":"STYLET MICRODEEP ELECTRODE","CDM Revenue Code":"270","C-Base Price Amount":"117","Note":"**"},
{"Itemcode":"00130525","Description":"PLATE PROX LEFT NRW ACU-LOC 2","CDM Revenue Code":"278","CDM HCPCS":"C1713","C-Base Price Amount":"1627"},{"Itemcode":"00130528","Description":"SCREW HEX LAG 1.5X10MM","CDM
```

Publicizing Charges for the Consumer

- Consumer-friendly display of shoppable services
  - “Shoppable” refers to a service that can be scheduled in advance
  - CMS has chosen 70 such services
  - Hospitals must choose another 230
  - Must also include all “ancillary” services, including employed physician services
- Price estimator alternative
  - The shoppable service requirement can be met through providing an online tool that estimates patient payment obligation for the 300 services at issue
  - Must be easily accessible

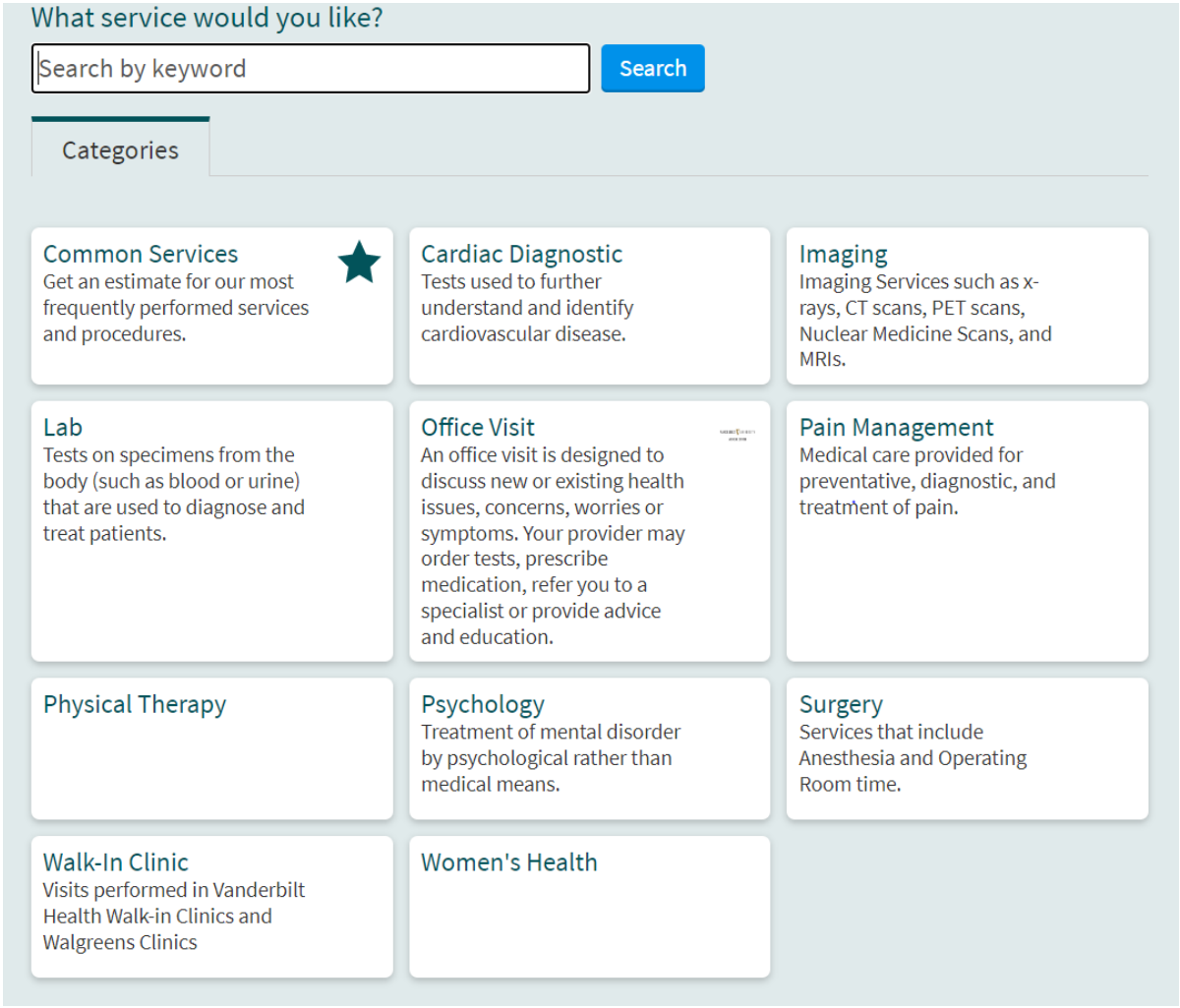
CMS Example of the Consumer-Friendly Format

Sample Display of Shoppable Services

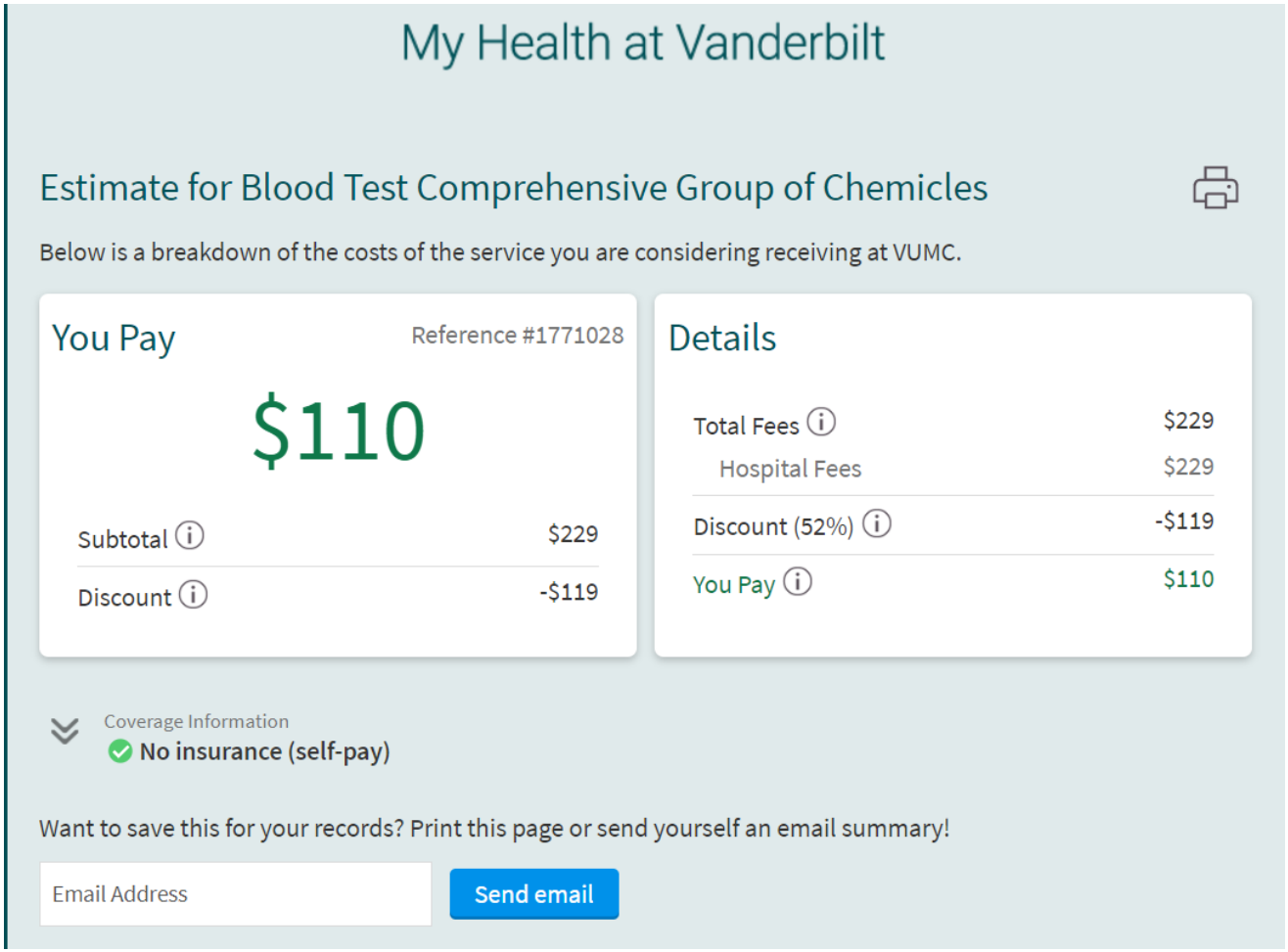
Hospital XYZ Medical Center
Prices Posted and Effective [month/day/year]
Notes: [insert any clarifying notes or disclaimers]

Shoppable Service	Primary Service and Ancillary Services	CPT/ HCPCS Code	[Standard Charge for Plan X]
Colonoscopy	Primary Diagnostic Procedure	45378	$750
	Anesthesia (Medication Only)	[Code(s)]	$122
	Physician Services	Not provided by hospital (may be billed separately)	
	Pathology/Interpretation of Results	Not provided by hospital (may be billed separately)	
	Facility Fee	[Code(s)]	$500
Office Visit	New Patient Outpatient Visit, 30 Min	99203	$54
Vaginal Delivery	Primary Procedure	59400	[$]
	Hospital Services	[Code(s)]	[$]
	Physician Services	Not provided by hospital (may be billed separately)	
	General Anesthesia	Not provided by hospital (may be billed separately)	
	Pain Control	Not provided by hospital (may be billed separately)	
	Two Day Hospital Stay	[Code(s)]	[$]
	Monitoring After Delivery	[Code(s)]	[$]

Real Example of Shoppable Service Search



Real Consumer-Friendly Price Estimator



Monitoring and Enforcement

- CMS has claimed that it has the authority to impose penalties on hospitals that are non-compliant
- Will rely mostly on complaints for determining what entities should be auditing priorities
- CMS can send a warning, impose a CAP, and/or impose a maximum penalty of between $300 and $5500 per day, depending on the number of beds a hospital has
  - This is up from $300 for 2021
- Appeals can be heard in front of an ALJ

Implementation Thus Far

- According to a 12/30/21 Wall Street Journal article:
  - Only about 50% of hospitals were in meaningful compliance (based on research from a startup called “Turquoise Health”)
  - Many large health systems are affirmatively not complying because they do not see how the information is of benefit to their patients, and do not want to give their competitors an advantage
  - CMS issued 335 warnings, 98 CAPs, and as of earlier this month, two penalties:
    - Northside Hospital Atlanta was fined $883,180 and Northside Hospital Cherokee was fined $241,320.

No Surprises Act

The Interim Final Rules

- IRF1 - July 13, 2021 (45 CFR Part 149):
  - Balance billing protections for insured patients receiving emergency and post-emergency care at out-of-network facilities and in-network facilities with out-of-network providers
- IRF2 – October 7, 2021 (45 CFR 149.610 and 149.620):
  - Independent Dispute Resolution Process for Providers and Payors
  - Good Faith Estimate for Uninsured/Self-Pay Patients
  - Patient-Provider Dispute Resolution Process
- AND…

…we're still waiting

Balance Billing Protections

Emergency Services – New Standards for Payers

- Payer can't impose administrative burdens on out-of-network (OON) facilities that it doesn't also impose on in-network facilities
- Payer must adjudicate an OON clean claim within 30 days of receipt
- If a payer provides any benefits in the patient's plan with regard to emergency services, then the payer must cover the emergency services a patient receives and can't deny coverage based on the patient's final diagnosis or conditions of coverage
  - IFR1 enforces the **prudent layperson standard**
    - *A medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in… serious jeopardy… serious impairment of bodily functions… serious dysfunction of any bodily organ or part*

Emergency Services – Payments to Providers

- IRF1 applies to Facilities (hospitals/ASCs) and Providers (docs/APCs)
- No balance billing
  - If the Provider/Facility is out-of-network, he/she/they/it must not hold the patient liable for an amount that exceeds the patient's cost-sharing amount
  - The patient's cost-sharing imposed by the payer cannot be greater than if the services had been provided in-network and must be counted towards the patient's in-network deductible and in-network out-of-pocket maximum
  - The cost-sharing is calculated based on the "recognized amount," which is the total payment amount to the Provider/Facility and is *complicated* to figure out (*more on that in a minute)*

After the Emergency – The Burden on Providers

IF THE FACILITY IS OUT-OF-NETWORK

- Post-stabilization services are "emergency" under the IFR, unless:
  - Treating provider determines the patient can travel, using nonmedical transport or non-emergency medical transport, to an in-network facility within a *reasonable* distance, taking into account the patient's condition
    - Patient's lack of access to transport, including ability to pay, can make it unreasonable
  - Provider and facility satisfy notice and consent criteria for WAIVER (*more on that in a minute)*
  - State law protections are satisfied
- If waiver is not obtained, then no balance billing! A patient may only be billed for the cost sharing amounts that would have been charged for an in-network facility/provider.

After the Emergency – The Burden on Providers

IF THE FACILITY IS IN-NETWORK AND PROVIDER IS OON

- Post-stabilization services are subject to balance billing prohibition on the OON provider, unless WAIVER is obtained
- IFR1 requires that, as part of the WAIVER notice and consent process, the patient be given a list of in-network providers at the facility who could furnish the services and a statement that the patient may choose to be referred to an in-network provider
- Thoughts for facilities to ponder…
  - Does the facility have a responsibility to help the out-of-network provider give notice and obtain consent?
  - Does the facility have a responsibility to track the payers/plans with which each medical staff provider participates?
  - Do you have to call in an in-network provider at the request of the patient? If so, how does that affect call coverage arrangements?

WAIVER

Notice and Consent: Requirements

Notice

- Must be given by OON Facility and each OON Provider
- Must include a good faith estimate
  - The estimated amount that the Provider or Facility may charge the insured patient for the items and services involved in the patient's care or stay at the Facility, including any item or service that the OON Facility/Provider reasonably expects to provide in conjunction with such items and services

Consent

- Must be in writing and signed by the patient for effective waiver
- Patient must be capable of voluntarily giving consent that makes continuing to receive care from the OON Provider/Facility to be a "*knowing and purposeful*" choice
- Incomplete notice = lack of consent
- Patients may consent for all, or only some, of the items and services
- Patients may revoke consent

The “Recognized Amount” And The “Out-of-Network Rate”

What Will the OON Facility/Provider Be Paid?

- The out-of-network rate will be determined under:
  - (1) All-Payer Model (in states testing all-payer payment reform, *e.g.*, Vermont), or
  - (2) a Specified State law *that provides a method for determining the total payable* under the plan or coverage (*e.g.*, Texas), or
  - (3) if neither 1 nor 2 apply, then the rate agreed to by the payer and provider/facility lesser of the amount billed or the qualifying payment amount (QPA) (*more on that in a minute)*
- Specified State Law:
  - not limited to set mathematical formula or pre-determined amounts
  - includes laws that allow negotiation and provide arbitration process
  - must apply to the **Payer/Plan**, the OON **Provider/Facility** and the **item** or **service** involved, or you default to #3.

"Qualifying Payment Amount" Defined

- The ***median*** of the **contracted (in-network)** rates recognized by the Payer/Plan
- in the **same insurance market** (individual, large, small, TPA, GHP)
- on **1/31/2019** (or the first coverage year after 2019),
- for the **same or similar item or service** (CPT, HCPCS, DRG),
- **in the same or similar specialty** (if it's a Provider) **or** a **facility of the same or similar type** (Hospital ED or freestanding ED), and
- in same **geographic region** (each OMB MSA or the rest of the state),
- increased for inflation (annual **CPI-U adjustment**).

NOTE: If either party is dissatisfied with QPA or denial, then they go into open negotiation and, once exhausted, may avail themselves of the federal Independent Dispute Resolution process. Timing is important to exercise of these rights.

Flaws in the IRF QPA Methodology

- In instructing the agencies to establish regulations for QPA, Congress stated:
  - Differentiate by large group market and small group market
  - In establishing geographic regions, take into account rural and underserved areas and consult the National Association of Insurance Commissioners
  - Take into account "payments that are not on a fee-for-service basis…that take into account quality or facility type (including higher acuity settings and the case-mix of various facility types)"
- Under the IFR, the median contracted rate is determined with respect to *all* group health plans of the plan sponsor or *all group or individual* health insurance coverage offered by the health insurance issuer that are offered in the same insurance market
- Although the IFR recognizes that single case rate agreements constitute contracts for purposes of network status for purposes of the balance billing prohibition, the IFR notes that "solely for the purposes of the definition of contracted rate, a single case agreement, letter of agreement, or similar arrangement between a plan or issuer and a provider…does not constitute a contract, and the rate paid under such an agreement should not be counted among the plan's or issuer's contracted rates

Balance Billing Protection Disclosure Requirements

Public Disclosure Requirements

Providers and Facilities must prominently display in patient areas *(e.g.*, check-in, check-out, waiting rooms), post on a public website, and provide a one-page handout that gives notice on:

- The NSA restrictions on Providers/Facilities related to balance billing,
- Any applicable state law protections against balance billing, AND
- Contact information for federal and state agencies, in case a patient believes a Provider/Facility has violated the NSA or state balance billing law

NOTE: CMS has a "model" handout (which happens to be 2 pages, unless you print on the front and back)

Good Faith Estimates (GFE) for Uninsured or Self-Pay Individuals

The Good Faith Estimate (GFE) Requirements

- Provider/Facility must screen for insurance. If uninsured or self-pay, then GFE is required. Here's the timeline…

IF scheduled this far in advance	0	1	2	3	4	5	6	7	8	9	10+ days
THEN send estimate and letter…	On demand			…within 1 business day of scheduling							…within 3 business days of scheduling

- Even if uninsured patient requests the GFE over the phone, giving a verbal estimate doesn't fulfill obligation.
- Patient choice of paper vs. electronic (IFR2 assumes 90% mailed)
  - If electronic, patient must be able to print and save
- If patient requests GFE prior to scheduling, then, when the procedure is scheduled, a *new* GFE must be sent to the patient
- GFE should be **inclusive of any expected discounts/adjustments** applicable to the uninsured, show all applicable **diagnosis codes and service codes** and include a **Notice of Rights** if the bill is higher than the GFE

Example: Estimate for Surgical Procedure

A good faith estimate must include an **itemized list** of the expected charges for each item or service in the **period of care**, including any item or service that is reasonably expected to be provided in conjunction with such scheduled item or service

Charges Included

- OR time
- Anesthesia
- Recovery time, services
- Diagnostics & imaging
- Surgeon(s) / Assistant
- Anesthesiologist
- Periop medications
- Post-op prescriptions

Charges Excluded

- Visits/consults re: decision for surgery
- Pre-operative lab tests, EKG or diagnostics
- Post-discharge rehab or wound care
- Referrals for other specialist care

The “Convening Provider or Facility”

If the “period of care” will involve more than a single Provider, IRF2 requires Facilities and Providers to coordinate, so patients receive a single GFE

- KEY DEFINITIONS:
  - “**Convening provider or convening facility**”: *the provider or facility who receives the initial request for a GFE and who is… responsible for scheduling the primary item or service*
  - “**Co-providers**” or “**Co-facility**”: *a provider or facility other than a convening provider/facility that furnishes items or services that are customarily provided in conjunction with a primary item or service*
- The Convening Provider/Facility must comply with the GFE timeframes (1 or 3 days). The Co-Provider/Facility must transmit its information for the GFE no later than **1 business day** after receiving the request from the Convening Provider.
- If there are any changes to the expected charges, items, services, duration, personnel, etc., the Co-Provider/Facility must notify the Convening Provider/Facility, who must issue a new GFE no less than 1 business day before the scheduled service

Patient-Provider Dispute Resolution (PPDR)

- Currently applies only to uninsured/self-pay patients
- If, after receiving the items or services covered by a GFE, the individual is billed **substantially in excess** (defined as >$400 above GFE), individual may dispute the bill through the PPDR process by submitting a request form to HHS and paying an administrative fee ($25 in 2022)
    - If a GFE has involves multiple Providers/Facilities, eligibility for PPDR is determined separately for each (charges >$400 than GFE)
    - If a Co-provider/Co-facility was left off the GFE ≠ eligible for PPDR

Patient-Provider Dispute Resolution (PPDR)

- The expected charges in the good faith estimate are presumed appropriate *unless* the Provider/Facility provides credible information demonstrating:
  - difference reflects the costs of a medically necessary item/service, and
  - is based on unforeseen circumstances that could not have reasonably been anticipated by the Provider/Facility when the GFE was provided
- While the PPDR is pending, the parties may negotiate and resolve the dispute.

Operational Considerations: Price Transparency and NSA

Operational Considerations

- As a result of these two laws, multiple hospital functions are affected, including:
  - Charge setting practices
  - Charge publication practices
  - Managed care negotiations
  - Physician privileging and provider relations, generally
  - Patient registration and patient relations, generally

Charge Setting Practices

Charge Setting Practices

- The QPA sets the default OON rate, and the QPA is driven by historic pricing of in-network facilities
- All facilities in a geographic area are incentivized for *other* facilities to keep their rates up
- Could result in a desire to use publicly available charge information to set one's own charges

Charge Setting Practices – *Antitrust Risks*

- Using a competitor's charge data to set one's own prices could create antitrust risk
  - NOTE: It is not illegal to use publicly available information. CMS's intent was, however, for prices to go down and an increase of prices is likely to draw scrutiny.
- This holds especially true if there is:
  - Express discussions among competitors regarding concerns with the QPA
  - Specific reference in meetings with payors
  - Signaling in the market
    - Marketing
    - Notices
    - Frequent updates to the disclosures on the website
  - An expectation of a competitor's likely reaction

Charge Publication Practices

Charge Publication Practices

- Must decide if will come into full compliance with the Price Transparency Rule
  - CMS does not have statutory authority to impose the penalties under the plain meaning of the statute
  - With NSA, it is also quite questionable whether there is really any legitimate purpose to the Price Transparency Rule any longer

Penalty Statute

(b) Ensuring that consumers receive value for their premium payments

(1) Requirement to provide value for premium payments

(A) Requirement

Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 18061, 18062, and 18063 of this title) for the plan year (except as provided in subparagraph (B)(ii)), is less than—

Penalty Statute *(cont.)*

(2) Consideration in setting percentages

In determining the percentages under paragraph (1), a State shall seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.

(3) Enforcement

The Secretary shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties.

Did AHA Litigation Already Address?

- AHA lost at both the DDC and DC Circuit level, but they challenged the statutory authority for the substantive program requirements, and not specifically the penalties
- The revised penalties were promulgated after the case was decided

Ripple Effects of Pricing Transparency

- If a hospital decides to disclose, then there are a number of challenges it needs to protect against:
  - *Substantially in excess rule*. Hospitals can be excluded from Medicare if they charge Medicare or Medicaid substantially in excess of their usual charges. "Usual charges" is not defined, but now there will be multitudes of charge information available.
  - *MFN Clauses*. Hospitals that have most favored nations clauses in their contracts will now have their compliance record on display.

Ripple Effects of Pricing Transparency *(cont.)*

- *Medicare cost report S-10 disclosures*. Hospitals get some of their charity care reimbursed by Medicare, but only if their write-offs are consistent with their FAP. If the FAP and the disclosed discounted rate are the same, a MAC may conclude that no charity care was given.

- *Good Faith Estimates*. If the rate stated in the GFE does not tie to the write on the website, the hospital could be accused of not adhering to the NSA laws and could be fine up to $10K per violation.

Mitigation Approach – Frequent Web Updates

- The content and pricing within the CDM changes more than annually, particularly for items with costs that change frequently, such as pharmaceuticals. How frequently do you update the information on the website?
  - Rule only requires annual update.
  - If not done more frequently, the value of the information is questionable.
  - If you update the file as the CDM is updated, you must have someone who is responsible for version control to ensure it is properly updated.
  - Regardless of how frequent the updates are, website must be dated when it is changed, as the rule requires.

Payer Negotiation Practices

Impact on Payer Negotiations

- There are many reasons to believe that, the more pervasive the availability of charge data is, the more that rates by a hospital across its payers will flatten, and the more that charges across providers will flatten
  - A hospital giving a discount to one payer will be under pressure to give discounts to others, meaning that discounts will not be favored
  - Hospitals, especially in smaller markets, will have the information they need to act like an oligopoly

Impact on Payer Negotiations *(cont.)*

- Payers will have the incentive to avoid negotiating with high-cost providers because it will adversely affect their QPA
  - There is already evidence that some higher-cost providers are being kicked out of some networks
  - This will affect safety net hospitals and AMCs especially hard, as they cannot easily modify their cost structures

Impact on Payer Negotiations *(cont.)*

- Hospitals that are at the market floor may now decide to go out of network
  - This could be especially helpful for hospitals that have had quality issues that make them less able to achieve acceptable in-network rates
- Lack of transparency about the calculation of the QPA may lead systems to negotiate harder in an effort to keep the QPA up or raise it

Provider Relations and Credentialing

The Facility Conundrums following Emergency

- If the facility is out-of-network, once an ED patient is stabilized, will the facility even try to pursue patient consent for post-stabilization care or try to transfer the patient to an in-network facility?
  - Notice must include a good faith estimate of the costs for items and services, but calculating costs without knowing benefits is difficult
  - If patient does not consent, or revokes consent, the protections apply
  - If the facility is not in an urban environment with other nearby facilities, transfer is not an option
- If the facility is in-network and treating provider is out-of-network (*e.g.*, on-call cardiologist who provided consult), the IFR requires the notice with the consent to include a list of participating providers at the facility who could furnish the services and a statement that the patient may choose to be referred to an in-network provider
  - Does the facility have a responsibility to help the out-of-network provider give notice and obtain consent?
  - Does the facility have a responsibility to track the payers/plans with which each medical staff provider participates?

Provider Relations and Credentialing

- Hospitals may consider it an administrative hassle to have to address obtaining consent to balance bill for out of network providers in the ED or post-stabilization
  - Could lead hospitals to take efforts to get providers contracted with payers
    - Antitrust risk for facilitating negotiations of competitors
  - An assessment of the adequacy of provider network status with payers could occur at credentialing or recredentialing onto the medical staff
  - Hospitals may even use “carrots” and “sticks,” such as putting a provider on probation or not allowing them in the call rotation if they do not have sufficient contracts

Provider Relations and FWA Risk

- Not only are there administrative hassles, but there is FWA risk
  - An in-network hospital with OON providers might:
    - Obtain balance billing consent
    - Furnish balance billing disclosures
    - All on behalf of the provider (who is ordering hospital services)
  - A hospital or ASC is likely to act as the Convening Facility, and provide the GFE notice (see *Government Math* slides)
  - Hospitals should determine if any of these services constitute value of concern, especially for nonintegrated docs

Government Math

The labor cost of good faith estimates (GFE) is estimated as follows:

- 51,744,200 nonemergency elective procedures performed annually
- 9.2% uninsured rate = 4,760,466
- Some uninsured will forego procedures due to cost, so adjust by 30% = 3,332,326
- Add 5% for those that request an estimate to see if they can afford = 3,498,942
- 50% of procedures (1,749,471) will involve items/services of one provider
- 30 minutes for a business operations specialist to verify self-pay status, inform patient of right to estimate, and generate a good faith estimate (labor rate of $101.32/hr)

Calculation: 1,749,471 claims × 0.50 hours × $101.32 = $88,628,201

Government Math

The cost burden of GFE for multi-provider/multi-facility services is:

- 50% of procedures (1,749,471) will involve items/services of multiple providers
- 1 hour for convening provider's operations specialist to verify self-pay status, inform patient of right to estimate, gather estimates from co-providers and co-facilities, and generate a good faith estimate (labor rate of $101.32/hr)
- 30 minutes for 1 additional Co-provider/Co-facility operations specialist to generate GFE and electronically send to convening provider ($101.32/hr)

Calculation: 1,749,471 claims × 1.50 hours × $101.32 = $265,884,603

Provider Relations and Liability for GFE Errors

- *Convening Provider Liability.* The convening provider (likely a hospital or ASC) is obligated, as of 1/1/2023, to gather price information from all providers who will deliver services to the patient within the episode.
  - If the convening provider gets it wrong, is that provider going to be responsible for paying the provider the difference? For indemnification of the provider in the patient-provider dispute resolution? For damages to reputation?
  - Can the convening provider contract out of the risk? Would surgeons and anesthesiologists sign?

Patient Relations

Patient Relations

- *Patient Registration.* Given the stringent timelines for providing GFEs for self-pay patients, hospitals may want to set rules regarding the speed with which they'll set up appointments for these patients
- *ED.* Hospitals also will need to make the difficult decision of categorically never seeking consent to balance bill for post-stabilization services, which creates provider dissatisfaction, or seek consents, but understand that there is compliance risk

Patient Relations

- *Patient-Provider Dispute Resolution*. Providers will need to determine, when estimate and final bill are more than $400 different, whether engaging in dispute resolution with patients is a worthwhile exercise. For hospitals that don't litigate patient balances now, the choice may be easy; however, there's a greater likelihood of write-offs than settlements.

Questions

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