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Price Transparency - No Surprises Act

March 30, 2023

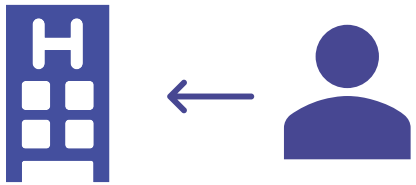
No Surprises Act Overview

- An overview to Price Transparency and No Surprises Act
- Updates to the No Surprises Act
- Solutions for networking convening and co-providers

Price Transparency and No Surprises Act

2021

Price Transparency

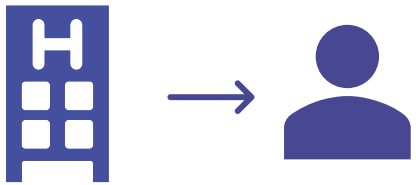


Price Transparency Tool

- On Hospital Website
- Covering 300 Shoppable services
- Patient facing

2022

No Surprises Act
(Convening Providers)

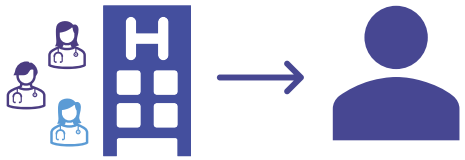


Good Faith Estimates (GFE)

- Delivered to uninsured patients
- Delayed requirements for co provider services
- Delayed enforcement of Advanced Explanation of Benefits (AEOB) from the health plan

2023

No Surprises Act
(Co Providers)



Convening & Co Providers Work Together

- Comprehensive GFE to uninsured patients
- Working with health plans, AEOB to insured patients

Price Transparency and No Surprises Act

Laws that increase public awareness of healthcare prices

Federal Hospital Price Transparency

- Medicare certified and non-Medicare certified hospitals
- Hospital outpatient departments operating under the hospital's license
- Physicians and non-physician practitioners who are employed by the hospital

Laws that protect patients from unexpected or unavoidable out-of-network bills

Federal No Surprises Act (Balance Billing Protections)

- Hospitals
- Hospital Outpatient Departments
- Ambulatory Surgery Centers
- Rural Health Center
- Federally Qualified Health Center
- Independent Labs and Imaging Centers
- Air Ambulance Services

And all practitioners rendering services in a hospital or ASC

Started January 1, 2021

Additional Federal Laws:

No Surprises Act (Good Faith Estimates)
All healthcare providers offering services to uninsured patients

Transparency in Coverage (Health Plans)

State laws may supersede federal laws

Started January 1, 2022

State laws may supersede federal laws

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Price Transparency

CMS Price Transparency Requirements

Table 1: Machine Readable Text

- Hospitals will post a listing of all items/services and the "standard charges" online in a machine-readable file.
- MS-DRG Listing (American Hospital Association Recommendation)

Table 2: Shoppable Services Listing

- Post 70 CMS required "shoppable services" and 230 hospital-selected including payer-specific negotiated rates online in a searchable and consumer-friendly manner.
- Must include the “standard charges” above and must also list any ancillary services that the hospital customarily includes with the primary service.
- Facility must “advise” the Public/Patient of any provider claims which may be filed as a result of the encounter.
- Prominently displayed and easily accessible on the facility public website.

Table 2: Patient Price Estimator

- Alternative to Shoppable Services Machine Readable File

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Price Transparency

CMS Price Transparency Requirements - Compliance Checklist

CMS Requirement 1 – Machine Readable File

- ❑Compile List of Items and Services
- ❑Publish Gross Charge
- ❑Calculate Self-Pay Charge
- ❑Assemble Payer Specific Charges
- ❑Collect De-identified Payer Min/Max Charge
- ❑Upload Machine Readable File to Website (.csv, XML, or JSON)

CMS Requirement 2 – Machine Readable File Option

- ❑Compile List of 70 CMS-defined shoppable items
- ❑Gather List of 230 Hospital-defined shoppable items
- ❑Determine Ancillary Charges for each
- ❑Include Five Standard Charge Points (same as Requirement 1)
- ❑Upload Machine Readable File to Website (.csv, XML, or JSON)

CMS Requirement 2 - Price Estimator Option

- ❑Same Requirements as Requirement 2 – Machine Readable File Above
- ❑Implement Internet-based Price Estimator
- ❑Include Patient Co-Pay and Deductible Coverage Data

Price Transparency

CMS Price Transparency - Penalties

- Increase the penalties for noncompliance using a scaling factor based on bed count

- Prohibit certain conduct that is considered barriers to accessing standard charge information

- Clarify the expected output of price estimator tools

- Improve standardization of data disclosure

Hospital Beds	Maximum Annual Penalty
<30	$109,500
50	$182,500
100	$365,000
200	$730,000
300	$1,095,000
400	$1,460,000
500	$1,825,000
550+	$2,007,500

Two hospitals fined in June 2022
($800,000+ and $200,000+)

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No Surprises Act

No Surprises Act Has Two Distinct Protections

Price Transparency	Protection Against Surprise Balance Bills
2022 - Uninsured and self-pay patients (Good Faith Estimate)	2022 – Protection from balance billing for emergency services and out-of-network providers at in-network facilities
Future date – Commercially insured (Advanced Explanation of Benefits)	Only affects patients with commercial insurance
All state-licensed or certified healthcare providers and facilities must issue a Good Faith Estimate to uninsured or self-pay patients	Affects Hospitals, Hospital Outpatient Departments, Ambulatory Surgery Centers, Rural Health Center, Federally Qualified Health Center, Independent Labs and Imaging Centers, Air Ambulance Services, and all practitioners rendering services in a hospital or ASC
Right to Receive a Good Faith Estimate must be posted and uninsured patients must be verbally informed of their rights	Disclosure Notice must be posted and disseminated to insured patients with each visit prior to requesting co-pays or submitting claim
Good Faith Estimate issued within 1 to 3 days, depending upon how far out services are scheduled	Notice and Consent must be given before balance billing can occur if it's not prohibited

No Surprises Act

No Surprises Act - Violation and Penalties

Enforcing authority (Federal or State) must provide notice of a violation including:

- Information that prompted the investigation,
- Potential for a civil monetary penalty, or
- Imposition of a plan of corrective action.

Violator will typically have 14 days to respond

- Period can be shortened to 24 hours or extended to 30 days or more depending on the circumstances

The No Surprises Act imposes civil monetary penalties of up to $10,000

CMS may consider a variety of factors, including:

- Degree of culpability,
- History and frequency of prior violations,
- Impact on affected individuals,
- Gravity of the violation, and
- Whether any violations have been corrected.

No Surprises Act

How to Avoid Complaints and/or be Prepared to Respond

In the event of a complaint, CMS will request the following contact information from each provider involved in the care of the patient during that episode of care.
Be proactive by assigning a person to be responsible for each requirement.

Provider Compliance Requirements (as of Nov. 1, 2021)	Responsible Party
To hold insured individuals liable for no greater than an in-network cost sharing calculated on the basis of statutorily specified amounts: • For non-participating facility or provider emergency services; and • For non-participating provider services at a participating facility except in limited circumstances where provider satisfy notice and consent criteria, cost sharing is based on the recognized amount • For air ambulance services, cost sharing is calculated using the lesser of the amount billed by the provider of air ambulance services or the Qualifying Payment Amount PHSA 2799B-1; 45 CFR 149.410(a) PHSA 2799B-2; 45 CFR 149.420(a) PHSA 2799B-5; 45 CFR 149.440	Name: Email: Phone:
To timely notify the plan or issuer that a non-emergency item or service provided by a non-participating provider was furnished during a visit at a participating health care facility, preferably on the claim form. PHSA 45 CFR 149.420(i)	Name: Email: Phone:

No Surprises Act

How to Avoid Complaints and/or be Prepared to Respond

Provider Compliance Requirements (as of Nov. 1, 2021)	Responsible Party
In limited situations, to (1) satisfy notice and consent criteria for meeting an exception, (2) notify plans and issuers that the notice and consent criteria have been satisfied when transmitting the bill, either on the bill or in a separate document, and (3) retain documentation for at east 7 years. PHSA 27998-2; 45 CFR 149.410 (b)-(f) and 149.420(b)-(i)	Name: Email: Phone:
To post a disclosure notice about patient protections against balance billing and provide same via a one-page notice to consumers PHSA 2799B-3; 45 CFR 149.430	Name: Email: Phone:
To supply clear and understandable language notification of the good faith estimate of expected charges for a scheduled item or service, or upon request PHSA 2799B-6; 45 CFR 149.610	Name: Email: Phone:

No Surprises Act

How to Avoid Complaints and/or be Prepared to Respond

Provider Compliance Requirements (as of Nov. 1, 2021)	Responsible Party
To support the results of the patient-provider dispute resolution process established by HHS for uninsured individuals who received a good faith estimate and received a bill for charges substantially in excess to seek a determination from the selected dispute resolution (SDR) entity on amounts payable PHSA 2799B-7; 45 CFR 149.620	Name: Email: Phone:
To provide notification to certain patients of a contractual termination of network status and permit such patients to elect continued coverage for up to 90 days of date of notice PHSA 2799B-8 (rulemaking pending)	Name: Email: Phone:
To implement and maintain business processes to update provider directory information with payers PHSA 2799B-9; PHSA 2799A-5(b) (rulemaking pending)	Name: Email: Phone:

No Surprises Act

What's making the news in 2023

Enforcement of the Advanced Explanation of Benefits continues to be deferred until the establishment of appropriate data transfer standards

Development of the Abbreviated Good Faith Estimate form to be used when the provider or facility does not expect to bill the uninsured individual for scheduled (or requested) items or services

Increasing the CMS administrative fee for the Independent Dispute Resolution Process (IDR) from $50 to $350

Publication of the *Initial Report on the IDR Process April 15-September 30, 2022*

No Surprises Act

Establishment of Data Transfer Standards

Proposed rule is open for comments until 3/13/2023

"To improve coordination across the care continuum and movement toward value-based care, we are proposing to require that impacted payers implement and maintain a Provider Access API that, consistent with the technical standards finalized in the CMS Interoperability and Patient Access final rule (85 FR 25558), utilizes HL7 FHIR version 4.0.1. That API can be used to exchange current patient data from payers to providers, including all data classes and data elements included in a standard adopted at 45 CFR 170.213 (currently USCDI version 1), adjudicated claims and encounter data (not including provider remittances and enrollee cost-sharing information), and the patient's prior authorization decisions."

Federal Register :: Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program

API – Application Programming Interface
HL7 – Health Level 7
FHIR – Fast Healthcare Interoperability Resources
USCDI – United States Core Data for Interoperability

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No Surprises Act

Abbreviated Good Faith Estimate

"HHS will consider providers and facilities that know in advance that they do not expect to bill an uninsured (or self-pay) individual for items and services to be in compliance with GFE requirements for uninsured (or self-pay) individuals under the following conditions and provided they meet all other requirements under 45 CFR 149.610:

- They provide uninsured (or self-pay) individuals with an abbreviated GFE
- They do not bill uninsured or (self-pay) individuals who receive an abbreviated GFE, provided they meet all other requirements under 45 CFR 149.610
- No items or services included in the abbreviated GFE are expected to be furnished by co-providers or co-facilities in conjunction with the primary items or services"

FAQS ABOUT CONSOLIDATED APPROPRIATIONS ACT, 2021 IMPLEMENTATION – GOOD FAITH ESTIMATES (GFEs) FOR UNINSURED (OR SELF-PAY) INDIVIDUALS – PART 4 (cms.gov)

No Surprises Act

Administrative Fee Increase for IDR

"The administrative fee is established annually in a manner so that the total administrative fees collected for a year are estimated to be equal to the amount of expenditures estimated to be made by the Departments to carry out the Federal IDR process for that year."

AMENDMENT TO THE CALENDAR YEAR 2023 FEE GUIDANCE FOR THE FEDERAL INDEPENDENT DISPUTE RESOLUTION PROCESS UNDER THE NO SURPRISES ACT: CHANGE IN ADMINISTRATIVE FEE (cms.gov)

The Texas Medical Association filed a lawsuit in US District Court challenging the increase in the administrative fees.

"The Departments' dramatic and surprise increase in the cost of accessing IDR—announced less than two months after CMS confirmed that the administrative fee would remain $50 in 2023, and only four business days before the fee increase took effect—not only will make the process significantly more expensive for all IDR participants but will make it cost-prohibitive for many providers to access IDR at all."

Microsoft Word - TMA IV Complaint - FINAL (texmed.org)

No Surprises Act

Initial Report on the IDR Process

"For each calendar quarter in 2022 and each calendar quarter in subsequent years, the Departments of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Departments) are required to publish on a public website certain information about the Federal IDR process."

"The Departments are committed to publishing this required data, bringing transparency to the Federal IDR process, and providing important information to the public, disputing parties, and Congress."

April 15 – September 30, 2022
90,078 disputes through the Federal IDR portal
- 84% was initiated by providers
- 15% was initiated by facilities
- 1% was initiated by health plans

Initial Report on the Independent Dispute Resolution (IDR) Process (cms.gov)

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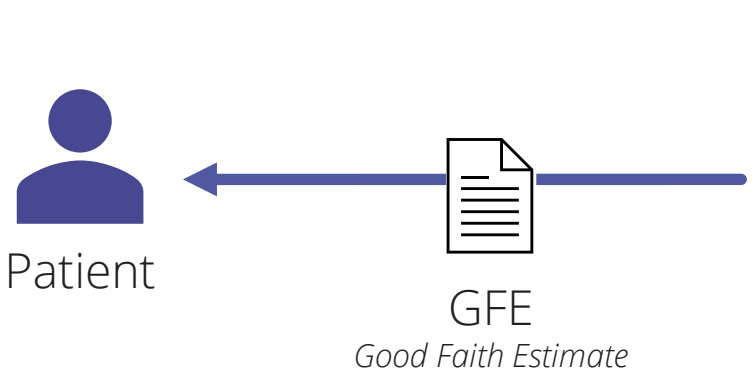
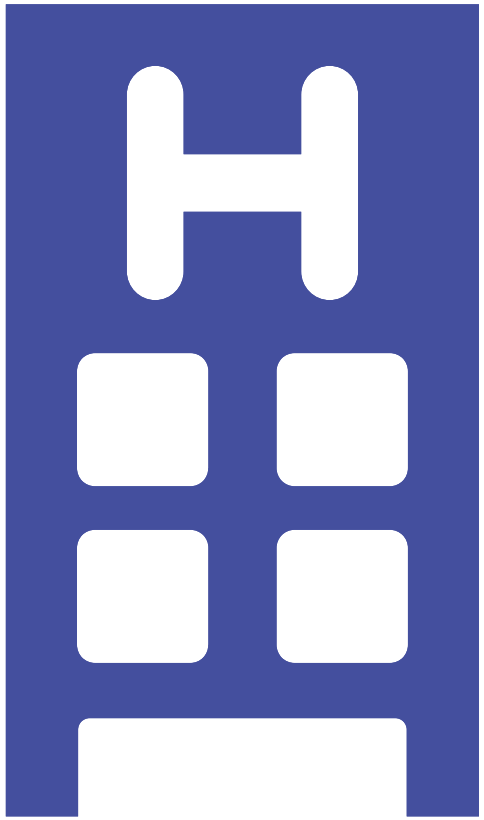
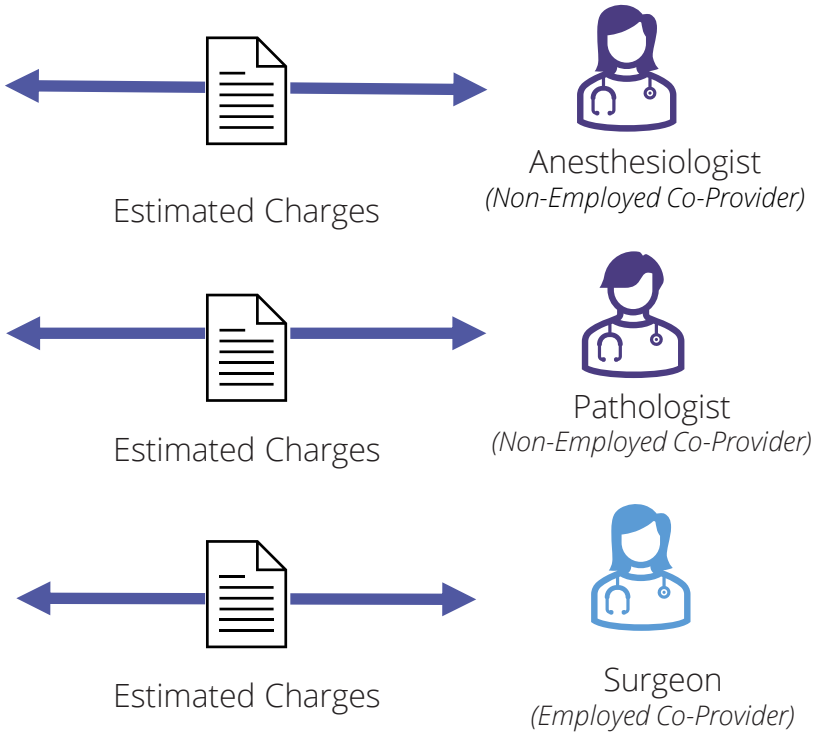
2023 Complicated Process to Generate Compliant GFE



Convening facility/provider must contact all co-providers/facilities within 1 business day after scheduling or receiving a request for a GFE



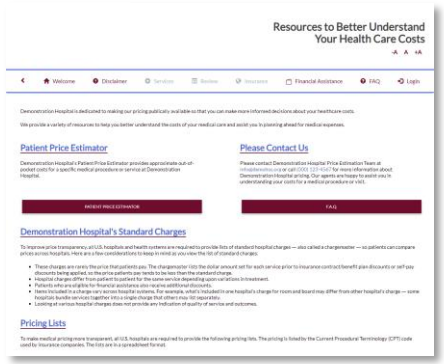


Co-Provider must supply convening facility/provider with GFE data within 1 business day of receiving the request.

CorroHealth Comprehensive Solution

2021

Price Transparency Tool

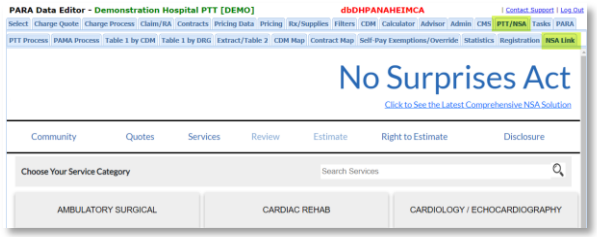


Price Transparency Tool

240+ Existing CorroHealth Sites

2022

No Surprises Act
(Convening Providers)

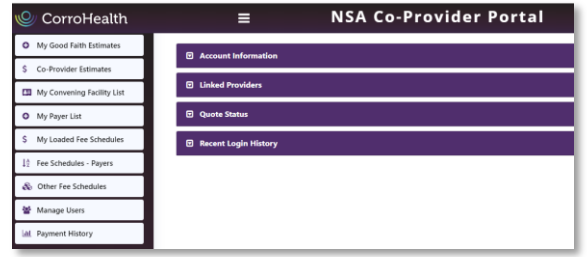


Good Faith Estimates (GFE)

Quick and compliant GFE Generation

2023

No Surprises Act
(Co Providers)



Convening & Co Providers Work Together

Portal to non-employed providers for comprehensive GFE creation

CorroHealth NSA Platform Overview Demonstration (Vimeo.com)

Questions

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