SPOTLIGHT ON HEALTHCARE PRICING:

UPDATE ON NO SURPRISES ACT AND HOSPITAL PRICE TRANSPARENCY RULES

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BASS BERRY SIMS

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1

SPEAKER

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2

AGENDA

- No Surprises Act
  - Ban on Balance Billing
  - Disclosure Requirements
  - Good Faith Estimates
  - Independent Dispute Resolution (IDR) Process Update
- Hospital Price Transparency
  - Standard Charges and Display of Shoppable Services
  - Updated Enforcement Activity and Penalties
  - Recent Changes to Standard Charges Reporting
- Congressional Activity

3

NO SURPRISES ACT

4

PROVIDER COMPLIANCE OBLIGATIONS

Ban on balance billing for emergency and non-emergency services

Notification to payers of balance billing applicability and to patients of balance billing protections

Good faith estimate of expected charges for uninsured and self-pay patients

5

BAN ON BALANCE BILLING

- Balance billing prohibited for emergency services furnished at out-of-network (OON) emergency facilities and non-emergency services furnished by OON providers at in-network (INN) facilities
- Applies to insured patients with third-party coverage (not federal health care programs)
- Cost-sharing calculation requirements:
  - An amount determined by an applicable All-Payer Model;
  - If there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law; or
  - If there is no such applicable All-Payer Model Agreement or specified state law, the lesser of the billed charge or the qualifying payment amount (QPA) (e.g., median contracted rate)

6

BALANCE BILLING DISCLOSURES

- In certain cases, the NSA requires facilities and providers to notify the payer of information related to NSA applicability
  - Whether the notice and consent exception has been met
  - Whether a non-emergency service was furnished by an OON provider during a visit at an INN facility
- Facilities and providers must make publicly available, post on a public website, and provide to any commercially insured patient, information regarding patient protections against balance billing
  - Disclosure must be made via the facility or provider's webpage, a sign posted prominently at the location of the facility or provider (if there is a publicly accessible location), and a one-page notice provided to the patient
  - When an OON provider furnishes care at an INN facility (or in connection with a visit at an INN facility), the INN facility may provide disclosure to patients on behalf of the OON provider pursuant to a written agreement

7

GOOD FAITH ESTIMATES

- The NSA includes a consumer protection provision independent of the ban on balance billing that requires facilities and providers to furnish a good faith estimate (GFE) of expected charges for scheduled items or services
- If the patient is privately insured and seeking coverage of the item or service, the facility/provider must furnish the GFE to the payer
  - HHS has not yet issued regulations to implement the GFE requirement for insured patients and will defer enforcement until rulemaking is fully adopted
- If the patient is uninsured or self-pay, the facility/provider must furnish the GFE to the patient upon scheduling or upon request
  - HHS began enforcement of this requirement as of January 1, 2022 but is exercising enforcement discretion with respect to requirements for "co-providers" and "co-facilities"
  - Enforcement discretion when a GFE does not include expected charges from co-providers/co-facilities was set to end on Dec. 31, 2022, but HHS extended enforcement discretion pending future rulemaking

8

NSA PROVIDER ENFORCEMENT

- To investigate patient allegations of balance billing, CMS is contacting providers and asking them to share detailed information regarding:
  - The claim(s) subject to the allegation
  - Processes in place to prevent balance billing
  - Steps taken/to be taken to address the claim(s) subject to the allegation and prevent balance billing moving forward, including refunds to patients if applicable
  - Actions taken to identify other instances of noncompliance related to the allegation, including refunds to patients if applicable

INDEPENDENT DISPUTE RESOLUTION UPDATE

Provider Lawsuits Challenging IDR Process

- *TMA I*, Feb. 23, 2022: Found unlawful requirement for IDR entities to assume the QPA is the appropriate payment amount and choose the offer closest to the QPA
- *TMA II*, Feb. 6, 2023: Found unlawful updated instructions for IDR entities to make payment determinations (appealed to 5th Circuit)
- *TMA IV*, Aug. 3, 2023: Found unlawful on procedural grounds increases in IDR administrative fees and rules government when providers can "batch" related claims in a single IDR complaint
- *TMA III*, Aug. 24, 2023: Found unlawful regulations governing how payers should calculate the QPA (appealed to 5th Circuit)

INDEPENDENT DISPUTE RESOLUTION UPDATE

Federal IDR Operations Proposed Rule, 88 Fed. Reg. 75744 (Oct. 27, 2023)

- Require payers to provide additional information (name of plan, issuer, sponsor, and IDR registration number) and use specific claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs)
- Revise open negotiation period requirements, including requirement to use IDR portal
- Allow batched disputes for:
  - A single patient encounter (items and services billed on the same claim form)
  - Anesthesiology, radiology, pathology, and laboratory items and services billed under service codes in the same Category I CPT code section
  - Limiting batched determinations to 25 line items

11

HOSPITAL PRICE TRANSPARENCY

12

HOSPITAL PRICE TRANSPARENCY IMPLEMENTATION

Implemented Under 2021 Outpatient Prospective Payment System ("OPPS") Final Rule (84 Fed. Reg. 65524 (Nov. 27, 2019)), effective Jan. 1, 2021

Updated Under 2022 OPPS Final Rule
(86 Fed. Reg. 63458 (Nov. 16, 2021)), effective Jan. 1, 2022

Updated Under 2024 OPPS Final Rule
(issued Nov. 2, 2023, to be published in Fed. Reg. Nov. 22, 2023), effective Jan. 1, 2024 (staggered implementation deadlines)

13

HOSPITAL PRICE TRANSPARENCY: OVERVIEW

Machine-Readable File (MRF) of Standard Charges

- Hospitals must establish, update annually, and make public a list of standard charges for all items and services in a MRF to be posted prominently on a publicly available website
- All items and services includes "service packages"
- Standard charges include gross charge, payer-specific negotiated charge, de-identified minimum negotiated charge, de-identified maximum negotiated charge, and discounted cash price
- Must include description of each item or service and common billing or accounting code
- Each hospital location operating under a single hospital license with different standard charges must separately make public the standard charges for that location (don't need separate files for each clinic)

14

HOSPITAL PRICE TRANSPARENCY: OVERVIEW

Consumer Friendly Display of Shoppable Services

- Make public and update annually a consumer-friendly list of standard charges for at least 300 "shoppable services," along with ancillary services provided in conjunction
- Includes 70 services identified by CMS plus additional services to total 300 (or as many as the hospital provides if less than 300)
- Shoppable services are ones that can be scheduled in advance
- Hospitals have flexibility on format, but it must be searchable by service description, billing code, and payer
- Must be prominently posted on a publicly available website and free of charge without registration, user account, or password, and without requesting personally identifying information

15

HOSPITAL PRICE TRANSPARENCY: OVERVIEW

Consumer-Friendly Display of Shoppable Services: Alternative Option

- Hospitals can offer an internet-based priced estimator tool to meet the consumer-friendly display of shoppable services requirement
- Tool must allow patients to obtain an estimate of out-of-pocket costs the hospital anticipates would be required
- Must be prominently displayed on website and accessible to public without charge and without registration or needing a user account or password

16

HOSPITAL PRICE TRANSPARENCY: 2022 UPDATES

Standard Charges

- Amended regulations to indicate that making the standard charge information publicly available without barriers includes, but is not limited to, "ensuring the information is accessible to automated searches and direct file downloads through a link posted on a publicly available website"

Shoppable Services

- Clarified that for hospitals that use a price estimator tool, the tool must produce a price estimate that is "tailored" to an individual user and the estimate must specify the amount the hospital anticipates the individual would pay for a shoppable service, absent unusual or unforeseen circumstances

Penalties

- Increased civil monetary penalties (CMPs) from up to $300/day in 2021 to CMPs ranging from $300/day to $5,500/day in 2022 based on number of hospital beds

17

OVERSIGHT AND ENFORCEMENT

CMS Oversight Activities

- Conducted website assessments in 2021 and 2022, evaluating 14 criteria for the MRF and 11 criteria for shoppable services (or 2 for price estimator tool)
- Compliance rate increased from 27% to 70% between 2021 and 2022
- Of the 30% out of compliance, 3% fully failed assessment and 27% partially met criteria

Enforcement Process (generally, but not necessarily, in this order)

- Written warning notice of violation(s)
- Request corrective action plan (CAP) if noncompliance is a material violation
- Impose a CMP and publicize penalty online if hospital fails to respond to CAP request or comply with CAP requirements

18

ENFORCEMENT STATUS

Enforcement Status (through September 2023)

- 989 warning notices
- 631 CAP requests
- 346 hospitals determined to not require compliance action
- 738 hospitals received a closure notice after addressing deficiencies
- 4 hospitals received CMPs

19

ENFORCEMENT ACTIONS

CMP Amount	Status
$883,180.00	Imposed
$214,320.00	Imposed
$102,660.00	Imposed
$117,260.00	Under Review
$70,560.00	Imposed
$63,900.00	Under Review
$847,740.00	Under Review

CMP Amount	Status
$101,400.00	Under Review
$56,940.00	Under Review
$102,200.00	Under Review
$99,540.00	Under Review
$979,000.00	Under Review
$325,710.00	Under Review
$59,100.00	Under Review

https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency/enforcement-actions

20

APRIL 2023 ENFORCEMENT CHANGES

CAP Completion Timeline	CAP Deadlines	CAP Imposition
• Require full compliance within 90 days from CAP request • Previously allowed hospitals to propose a CAP completion date	• Automatically impose CMP for failure to submit CAP within 45 days and failure to comply with CAP within 90 days	• Immediately request CAP for hospitals that make no attempt to satisfy requirements • Previously sent warning letter first

21

2024 CHANGES: NEW REQUIREMENTS

Good Faith Effort	• Jan. 1, 2024: Make a good faith effort to ensure that standard charge information encoded in the MRF is true, accurate, and complete as of the date indicated in the MRF
Affirmation in the MRF	• July 1, 2024: Affirm in the MRF that, to the best of its knowledge and belief, the hospital has included all applicable standard charge information in its MRF, in accordance with the requirements, and that the information encoded is true, accurate, and complete as of the date indicated in the MRF
Txt File	• Jan. 1, 2024: Ensure the public website includes a .txt file in the root folder that includes a standardized set of fields including the hospital location name that corresponds to the MRF, the source page URL that hosts the MRF, a direct link to the MRF (the MRF URL), and hospital point of contact information
Footer Link	• Jan. 1, 2024: Ensure the public website includes a link in the footer on its website, including but not limited to the homepage, that is labeled "Price Transparency" and links directly to the publicly available webpage that hosts the link to the MRF

22

2024 CHANGES: REVISED TEMPLATE

July 1, 2024: MRF must conform to CMS template layout, data specifications, and data dictionary

- CMS will update the existing sample formats and data dictionary found on the CMS website
- Templates will be in a comma-separated values (CSV) "wide" format, CSV "tall" format, and JSON schema
- CMS will make available a data dictionary
- Staggered implementation dates for different elements of revised template

2024 CHANGES: REVISED DATA ELEMENTS

MRF Information	• July 1, 2024: File version and date of most recent update in the MRF itself (currently can indicate in file or elsewhere)
Hospital Information	• July 1, 2024: Hospital name, license, location(s), address(es) under single hospital license to which standard charges apply in the MRF itself (currently must include on the website)
Item and Service Information	• July 1, 2024: General description and whether provided in connection with inpatient admission or outpatient visit (not new but separated out) • Jan. 1, 2025: For drugs, drug unit and type of measurement (new)
Coding Information	• July 1, 2024: Any code used for accounting or billing purposes and corresponding code type (not new) • Jan. 1, 2025: Any modifier(s) that may change the standard charge, including a description and how it would change the charge

2024 CHANGES: REVISED DATA ELEMENTS

Standard Charges

- July 1, 2024: Payer and Plan will be separated into two elements, allowing hospitals to avoid naming plans separately for the same payer so long as the payer-specific negotiated charges are the same for each plan in the category
- July 1, 2024: Standard Charge Methodology: (contracting method used to establish payer-specific negotiated charge (e.g., base rate for a service package))
- July 1, 2024: Indicate whether payer-specific negotiated charges are a dollar amount or based on a percentage or algorithm
- Jan. 1, 2025: Estimated Allowed Amount, if the payer-specific negotiated charge is based on a percentage or algorithm (average dollar amount the hospital has historically received from a third party payer)

25

2024 CHANGES: TIMELINE FOR NEW REQUIREMENTS

Requirement	Implementation (Compliance) Date
Good Faith Effort	January 1, 2024
Affirmation in the MRF	July 1, 2024
Txt File	January 1, 2024
Footer Link	January 1, 2024

https://www.federalregister.gov/public-inspection/2023-24293/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment

TABLE 151B: Implementation Timeline for Other New Hospital Price Transparency Requirements

26

2024 CHANGES: TIMELINE FOR CMS TEMPLATE ADOPTION AND ENCODING DATA ELEMENTS

Requirement	Implementation (Compliance) Date
MRF Information	
MRF Date	July 1, 2024
CMS Template Version	July 1, 2024
Hospital Information	
Hospital Name	July 1, 2024
Hospital Location(s)	July 1, 2024
Hospital Address(es)	July 1, 2024
Hospital License Information	July 1, 2024

Requirement	Implementation (Compliance) Date
Item and Service Information	
General Description	July 1, 2024
Setting	July 1, 2024
Drug Unit of Measurement	January 1, 2025
Drug Type of Measurement	January 1, 2025
Coding Information	
Billing/Accounting Code	July 1, 2024
Code Type	July 1, 2024
Modifiers	January 1, 2025

https://www.federalregister.gov/public-inspection/2023-24293/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment

TABLE 151A: Implementation Timeline for CMS Template Adoption and Encoding Data Elements

27

2024 CHANGES: TIMELINE FOR CMS TEMPLATE ADOPTION AND ENCODING DATA ELEMENTS

Requirement	Implementation (Compliance) Date
Standard Charges	
Gross Charge	July 1, 2024
Discounted Cash	July 1, 2024
Payer Name	July 1, 2024
Plan Name	July 1, 2024
Standard Charge Method	July 1, 2024
Payer-Specific Negotiated Charge—Percentage	July 1, 2024

Requirement	Implementation (Compliance) Date
Standard Charges	
Payer-Specific Negotiated Charge—Algorithm	July 1, 2024
Estimated Alllowed Amount	Jan. 1, 2025
De-identified Minimum Negotiated Charge	July 1, 2024
De-identified Maximum Negotiated Charge	July 1, 2024

https://www.federalregister.gov/public-inspection/2023-24293/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment

TABLE 151A: Implementation Timeline for CMS Template Adoption and Encoding Data Elements

28

CONGRESSIONAL ACTIVITY

H. R. 5378, Lower Costs, More Transparency Act

- Bipartisan legislation passed by multiple House Committees and ready for House floor vote
- Codifies hospital price transparency regulations into statute
- Increases maximum CMPs to $10 million/year (up from current $2 million)
- Eliminates option to meet the consumer-friendly display of shoppable services requirement using an online price estimator tool

QUESTIONS?

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31