A 2022 Forecast for Compliance

October 29, 2021

Benjamin Fee, Hall Render
Barry Mathis, PYA
Kathy Reep, PYA

Price Transparency

PYA

Overview

- Final Price Transparency Rule published in November 2019 (new 45 CFR 180)
- Builds on history of federal and state price transparency efforts
- Applies to all licensed hospitals (including CAHs)
- Includes requirement to disclose “payer-specific negotiated rates”
- Effective date was January 1, 2021

Two Requirements

A machine-readable file that contains the following five types of standard charges (for all items and services):

Gross Charges

Payer-Specific Negotiated Charges

Discounted Cash Price

De-Identified Minimum Negotiated Charge

De-Identified Maximum Negotiated Charge

The following four types of standard charges in a consumer-friendly manner (for certain shoppable services):

Payer-Specific Negotiated Charges

Discounted Cash Price

De-Identified Minimum Negotiated Charge

De-Identified Maximum Negotiated Charge

Alternative: Price Estimator Tool

Monitoring and Enforcement

- Monitoring
  - Evaluation of consumer or entity complaints
  - CMS-initiated audits
  - ***auditing price transparency compliance is easy***
- Notice and Corrective Action
  - Written notice of violation
  - Opportunity to cure
  - Corrective action plan (CAP) if violation is material
- Civil penalties if hospital fails to respond to request for CAP or fails to comply with CAP
- CMS is issuing warning letters: including requiring CAPs in some cases

Penalty for Non-Compliance

- Currently $300/day
- Industry compliance % low
- Proposed increase based on hospital bed count (from cost report)

TABLE 63: Proposed Application of CMP Daily Amounts for Hospital Noncompliance for CMPs Assessed in CY 2022 and Subsequent Years.

Number of Beds	Penalty Applied Per Day	Total Penalty Amount for full Calendar Year of Noncompliance
30 or less	$300 per hospital	$109,500 per hospital
31 up to 550	$310 - $5,500 per hospital (number of beds times $10)	$113,150 - $2,007,500 per hospital
>550	$5,500 per hospital	$2,007,500 per hospital

Note: In subsequent years, amounts adjusted according to 45 CFR 180.90(c)(3).

Other Issues

State forensic hospitals deemed to have met transparency requirements

Prohibits barriers to access of machine-readable file, including automated searches and direct downloads

Require price estimators to fulfill shoppable services requirement

- Expected output: estimate of patient responsibility
  - Considers insurance coverage
  - Application to uninsured patients

What's Next

- Waiting on Final OPPS Rule
  - Penalty increase
  - Expectations for plain language descriptions of shoppable services
  - Best practices for cost estimators
  - Recognizing "exemplar" hospitals
  - Standardization of machine-readable files

No Surprises Act

New Federal Mandate

- Federal legislation to address surprise billing
  - Individual unable to exercise choice over facility/provider and thus receives services from out-of-network (OON) facility/provider
- Included in Consolidated Appropriations Act
  - Follows years of work devising and debating such legislation and its intended/unintended consequences
- Effective January 1, 2022 (with some exceptions)
- Two sets of Interim Final Rules published so far (July and October)

Application

- Healthcare entities
  - Facilities (hospitals, CAHs, freestanding EDs, ASCs)
  - Providers furnishing services at a facility (not outside)
  - Air ambulance (not ground, at least for now)
- Health insurance issuers offering group or individual health insurance coverage
  - Group coverage includes both insured and self-insured plans, ERISA plans, non-federal government plans, church plans, traditional indemnity plans (**not** Medicaid MCOs or MA plans)
  - Individual coverage includes exchange and non-exchange plans, student health insurance coverage (**not** health reimbursement arrangements, short-term limited-duration insurance, or retiree-only plans)

Emergency Services

- Includes emergency services furnished at OON facility AND emergency services furnished by OON provider at in-network facility
  - Apply “prudent layperson” standard to determine what constitutes emergency services
  - Includes necessary post-stabilization services (admission, observation) as determined by treating physician
  - Plan cannot require prior authorization nor limit coverage for emergency services to certain diagnosis codes

Non-Emergency Services

- Ancillary services furnished by OON provider at in-network facility
  - Emergency medicine, anesthesia, pathology, radiology, neonatology
  - Assistant surgeon, hospitalist, and intensivist items and services
  - Diagnostic services, including radiology and laboratory services
  - Items or services provided by OON provider if there are no in-network providers who can furnish the item or services at the facility
  - Items or services that result from unforeseen, urgent medical needs that arise when item or service is furnished.
- All other services furnished by OON provider at in-network facility absent prior notice and written consent

Note: NSA does not apply to non-emergency services furnished at OON facility.

Limitations on Charges

- Cannot charge patient more than in-network cost-sharing amount
- Calculated based on Qualifying Payment Amount (QPA)
  - Plan's 2019 median in-network rate paid for same or similar service in specific geographic area, indexed for subsequent years (special rules for new plans/services with no established 2019 rates)
  - Plan must provide QPA in responding to claim submitted by facility/provider
- Plan must credit amount paid to patient's deductible

Out-of-Network Payments

Send initial payment or notice of denial of payment	30 business days, starting on day payer receives all relevant data
Initiate 30-business-day open negotiation period	30 business days, starting on day of initial payment or notice of denial of payment
Initiate independent dispute resolution (IDR) following failed open negotiation	4 business days, starting business day after the open negotiation period ends
Mutual agreement on certified IDR entity selection	3 business days after IDR initiation date
Departments select certified IDR entity in case of no conflict-free selection by parties	6 business days after IDR initiation date
Parties submit payment offers and additional information to certified IDR entity (with administrative fee)	10 business days after date of certified IDR entity selection
Payment determination made (refund administrative fee to prevailing party)	30 business days after date of certified IDR entity selection
Payment submitted to the applicable party	30 business days after payment determination

IDR Entity Decision-Making Process

- Work from presumption that QPA is appropriate payment rate
- Provider/facility and/or plan may submit evidence to rebut presumption that QPA is appropriate out-of-network rate based on following -
  - Level of training, experience, and quality and outcomes measurements of provider/facility
  - Market share held by provider/facility or plan in geographic region in which item/service provided
  - Patient acuity or complexity of furnishing the item/service
  - Facility's teaching status, case mix, and scope of services
  - Demonstration of good faith efforts (or lack thereof) made by provider/facility or plan to enter into network agreements with each other, and, if applicable, parties' contracted rates during previous 4 plan years
  - Additional relevant and credible information BUT NOT usual & customary charges or Medicare/Medicaid reimbursement rates

Posting and Good Faith Estimate

- Posting Requirement – Facilities must make public
  - Statement of the requirements and prohibitions concerning balanced billing
  - On website, in public area of facility, and to patient
- Good Faith Estimate
  - must provide notice of expected charges upon patient request of when service is scheduled
  - provided to the patient's plan or insurer, or to the patient if the patient is uninsured or does not intend to submit a claim for coverage ("self-pay")
  - Enforcement delay for requirement for insured patients pending future rulemaking
  - **requirement still effective January 1, 2022 for uninsured patients**
  - Requirement appears to apply to ALL facilities and providers

CARES Act - Provider Relief Fund

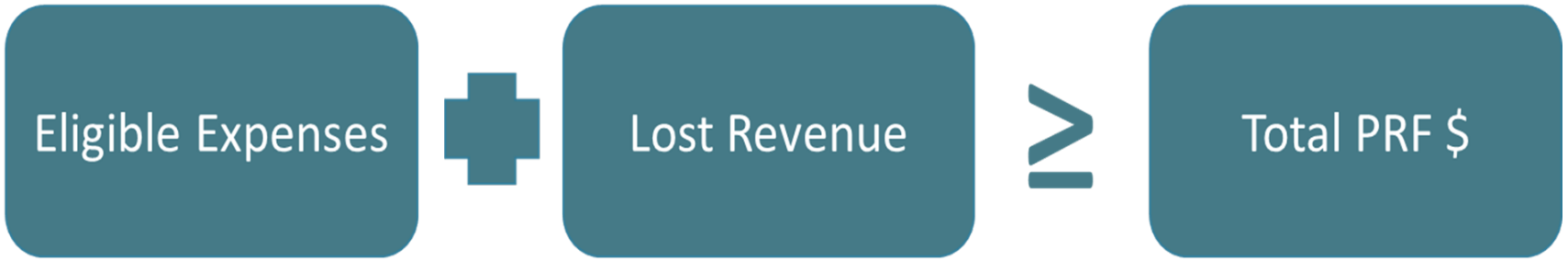
PRF Overview

- $178 Billion Provider Relief Fund
- Originally created and appropriated by CARES Act signed into law on March 27, 2020
- Subsequent legislation appropriated additional funds and modified some aspects of PRF
- Purpose/Use:
  - Relief Funds must be used to reimburse eligible health care providers for healthcare-related expenses or lost revenues that are attributable to coronavirus
  - And that other sources are not obligated to reimburse (no double dipping)
- 16+ distributions since April 2020 (General and Targeted)
- American Rescue Plan Act of 2021 signed into law on March 11, 2021, created separate $8.5 billion rural provider relief fund
- Future distributions likely

PRF New Distributions

- Latest Distributions: General Phase 4 ($17 billion) and ARP Rural Distribution ($8.5 billion)
- Single application for both
- Application were due October 26, 2021
- Phase 4 payment based on reported changes in operating revenues and expenses from July 1, 2020 to March 31, 2021 + bonus based on Medicaid/CHIP/Medicare participation
- ARP Rural based on amount and type of services provided to Medicare/CHIP/Medicare patients who live in rural areas
- Payments may go out as early as November and December

PRF Retention



PRF Reporting

- Report PRF payments, other assistance received, PRF expenses, unreimbursed expenses, lost revenue, other metrics
- Report on a quarterly basis
- Four separate reporting periods

Reporting Period	Payment Received Period	Period of Availability	Reporting Time Period
Period 1	April 10, 2020 to June 30, 2020	January 1, 2020 to June 30, 2021	July 1, 2021 to September 30, 2021
Period 2	July 1, 2020 to December 31, 2020	January 1, 2020 to December 31, 2021	January 1, 2022 to March 31, 2022
Period 3	January 1, 2021 to June 30, 2021	January 1, 2020 to June 30, 2022	July 1, 2022 to September 30, 2022
Period 4	July 1, 2021 to December 31, 2021	January 1, 2020 to December 31, 2022	January 1, 2023 March 31, 2023

PRF Reporting Delay

- First Report was due September 30, 2021
- HRSA announced a 60-day grace period for first report in mid-September
- The grace period ends November 30, 2021
- Not technically changing deadline but grace period available to all recipients
- HRSA is sending out warning letters to recipients that have not submitted a report

PRF Common Challenges

- Keeping up with HRSA guidance
- Meeting deadlines
- Interpreting and applying guidance
- Preparing for future audits

Information Blocking

What is Information Blocking?

- The Cures Act defines info blocking as business, technical, and organizational practices that prevent or materially discourage the access, exchange or use of electronic health information (EHI) when an *Actor knows*, or (for some Actors like EHR vendors) should know, that these practices are *likely* to interfere with *access, exchange, or use* of EHI. If conducted by a health care provider, there must also be knowledge that such practice is *unreasonable* and likely to interfere with, prevent, or materially discourage access, exchange, or use of EHI.

Who must comply and by when ?

- The Cures Act specified four types of entities referred to as “Actors” who must comply with info blocking requirements:
  - Health care providers[1];
  - Health IT developers of certified health IT; and
  - Health Information Networks (HINs) or HIEs (HIN and HIE are combined into one defined type in the Final Rule).
  - All Actors will be subject to ONC’s Information Blocking rules and regulations on April 5, 2021.

Examples of Information Blocking

- Practices that restrict authorized access, exchange, or use under applicable state or federal law of such information for treatment and other permitted purposes under such applicable law;
- Implementing health IT in nonstandard ways that are likely to substantially increase the complexity or burden of accessing, exchanging, or using EHI;
- Limiting or restricting the interoperability of health IT, such as disabling or restricting the use of a capability that enables sharing EHI with users of other systems or restricting access to EHI by certain types of persons or purposes that are legally permissible, or refusing to register a software application that enables patient access to their EHI

Examples of Information Blocking

- Implementing health IT in ways that are likely to restrict the access, exchange, or use of EHI with respect to exporting complete information sets or in transitioning between health IT systems.
- Acts that lead to fraud, waste, or abuse, or impede innovations and advancements in health information access, exchange, and use, including care delivery enabled by health IT;
- Restrictions on access, exchange, and use, such as may be expressed in contracts, license terms, EHI sharing policies, organizational policies or procedures or other instruments or documents that set forth requirements related to EHI or health IT, such as Business Associate Agreements

Exceptions (not considered blocking)

- Preventing harm exception – Engaging in practices that are reasonable and necessary to prevent harm to a patient or another person.
- Privacy exception – Not fulfilling a request to access, exchange, or use EHI to protect an individual's privacy.
- Security exception – Engaging in practices to interfere with the access, exchange, or use of EHI to protect the security of EHI.
- Infeasibility exception – Not fulfilling a request to access, exchange, or use EHI due to the infeasibility of the request.
- Health IT performance exception – Taking reasonable and necessary measures to make health IT temporarily unavailable for the benefit of the overall performance of the health IT.

Exceptions (not considered blocking)

In addition to the exceptions listed above, the final rule also sets forth the following three exceptions that involve procedures for fulfilling requests to access, exchange, or use EHI. As long as certain conditions are met, these do **not** constitute information blocking:

- Content and manner exception –Limiting the content of a response to a request to access, exchange, or use EHI or the manner in which a request is fulfilled.
- Fees exception – A health care provider's practice of charging fees for accessing, exchanging, or using EHI.
- Licensing exception – A health care provider's practice to license interoperability elements for EHI to be accessed, exchanged, or used.

Fulfillment of a Request

- Generally, a health care provider is required to fulfill a request to access, exchange or use EHI “in any manner requested.” If, however, the health care provider is technically unable to fulfill the request, the health care provider and requester can and should work on developing an alternative manner for the fulfillment of the request (such as the transmission of a secure file by e-mail).

- In the extreme case where the health care provider and requestor cannot reach agreement on an alternative manner to fulfill the request, then, in that case, the health care provider would generally be required to fulfill the request for the EHI in the manner described in the final rule.

Non-Compliance Penalties

- While the Act establishes a maximum civil monetary penalty of $1,000,000 per violation for non-compliance by health information technology developers, networks and exchanges, the Act directs the Office of Inspector General (OIG) to refer health care provider non-compliance to the “appropriate agency” for the imposition of “appropriate disincentives.”

- Future rulemaking will define the meaning of “appropriate disincentives.” The Act directs the Secretary of Health and Human Services to ensure that health care providers are not penalized for the failure of developers of health information technology to meet applicable certification requirements.

Questions:

Benjamin Fee
bfee@hallrender.com
Barry Mathis
Bmathis@pyapc.com
Kathy Reep
kreep@pyapc.com

PYA, P.C.
800.270.9629 | www.pyapc.com