Leading for Better Health

American Association of Healthcare Administrative Management

(AAHAM – Philadelphia Chapter)

August 21, 2019

Jolene H. Calla, Esq., HAP Vice President Health Care Finance and Insurance

Surprise Balance Billing
and
Price Transparency

Big Picture

Transparency…

Costs…

"We must do something about rising cost, and a key pillar is to empower patients with the information they need to drive cost and quality by making our health care system evolve to one that competes for patients. This is why price transparency in health care is a priority for the Trump Administration."

"There will be more to come on price transparency…this is a large problem for the entire healthcare system…"

Seema Verma, Administrator of the Centers for Medicare & Medicaid Services

There is momentum…

Congress working on various "costs" proposals

- U.S. Senate Health, Education Labor and Pensions (HELP) Committee—*Lower Health Care Costs Act*
- U.S. House Energy & Commerce Committee—*No Surprises Act*
- Legislation on Notice Requirements

Push by the **Administration**

- Executive Order to Promote Price and Quality Transparency
- Price Transparency Initiative in Outpatient Payment Rule Requiring Hospitals to Post Negotiated Rates

Surprise Balance Billing

Several legislative proposals - common elements:

- Prohibiting providers from balance billing in certain out-of-network scenarios
- Holding patient harmless to an in-network cost-sharing amount

- Varying approaches in addressing disputes between payors and providers:
  - Standard methodology to calculate reimbursement
  - Dispute resolution process
- Notice requirements

Leading for Better Health

Federal SBB Legislation

Provision	**STOP Surprise Medical Bills** (Bipartisan Senate Working Group)	**No Surprise Act** (Bipartisan Energy & Commerce H.R. 3630)	**Lower Health Care Costs Act** (Senate HELP *as reported*)	**Protecting People from Surprise Medical Bills Act** (Bipartisan House bill; physicians)
State Laws	**YES** – Allows states to continue current policy for state regulated plans	**YES** – Allows states to continue current policy for state regulated plans	**YES** – Allows states to continue current policy for state regulated plans	**YES** – Allows states to continue current policy for state regulated plans
Rate Setting	**YES** – Median in-network rate for geographic region	**YES** – Median in-network 2019 rate for geographic region; with an index for annual updates	**YES** – Median in-network rate for geographic region.	**NO** – Private negotiations for 30 days; if no agreement then Interim Direct Reimbursement (IDR)
Arbitration	**YES** – Providers may initiate if unhappy with automatic payment, 30-day time limit	**YES** – Providers may initiate Independent Dispute Resolution for payments over $1250	**NO**	**YES** – Provider or insurer may initiate if unhappy with IDR ; baseball style, 30-day time limit

Leading for Better Health

Notice Requirements

Common elements:

- Notify patients whether the hospitals—and the doctors and other providers that patients would see there—are in-network
- Document notice and the patient's consent to receive care from an out-of-network provider
- Ensure consumers can access price estimates, find out insurance coverage, and determine out-of-pocket expenses for any in-network services
- Require private insurers, Medicare, Medicare Advantage, and Medicare Part D Plans to provide out-of-pocket cost estimates and quality information through online search tools and/or toll-free telephone line

Leading for Better Health

HELP Costs Bill: Transparency

Disclosure of Cost-Sharing Information

- In-network providers and health plans would be required to provide enrollees their estimated cost-sharing amount for a particular service and any related services within two business days of a request
- Providers also would be required to provide the contact information for any ancillary provider for a scheduled service within two business days of a request
- Providers in violation of these requirements would be subject to a civil monetary penalty of no more than $10,000 per violation

Leading for Better Health

HELP Costs Bill: Transparency

Billing Requirements

- Requires hospitals and health systems, along with other providers, to send adjudicated bills to patients within 45 days of the visit
- Providers must provide patients a list of the providers seen and services rendered at the time of discharge, or by mail or electronic communication, no later than five days after discharge
- Following ten late bills/summaries, or a failure to report either, HHS could impose a civil monetary penalty of up to $10,000 per day
- Includes a safe harbor for providers unable to meet these requirements due to incorrect patient mailing addresses or other extenuating circumstances

Leading for Better Health

HELP Costs Bill: Transparency

All-Payor Claims Databases—Establish a national all-payor claims database (APCD) and provide grants to states to encourage implementation of its own APCDs

Provider Network Transparency—Plans would be required to provide patients proof of its provider's network status through written communication not less than one business day after a telephone inquiry and through access to a real-time online provider directory (updated every 90 days)

Access to Health Information—Require commercial health insurers to make information—including health insurance claims data, in-network practitioners, and expected out-of-pocket costs—available to patients through application programming interfaces. Ensure that patients have full, electronic access to their own health information and information on what they would pay out of pocket for specific care.

Leading for Better Health

Executive Order: Improving Price and Quality Transparency

Directs federal agencies to issue regulations and guidance in the following five policy areas:

- Informing patients about prices, including through the disclosure of standard charge information based on negotiated rates and access to expected out-of-pocket costs prior to care
- Establishing a health quality roadmap
- Increasing access to health care data
- Expanding the availability of health savings accounts and other health care financing arrangements
- Addressing surprise medical bills

HAP
Leading for Better Health

Administrative Action

Chargemaster Requirement	In its 2019 inpatient prospective payment system (IPPS) final rule, CMS updated federal guidelines to comply with the statutory requirement that "each hospital operating within the United States" make its standard charges available on an annual basis.
	As of January 1, 2019, hospitals must make available a list of their current standard charges via the Internet in a machine-readable format at least annually.

Administrative Action

New requirements in the proposed calendar year (CY) 2020 Outpatient Rule	Require hospitals to post a list of all of their standard charges—both gross charges and *all negotiated rates*—for all items and services in a machine-readable format on their websites without requiring any form of patient registration or other "barrier" to access
	Payor-specific negotiated charges would mean "the charge that a hospital has negotiated with a third party payor for an item or service"

Leading for Better Health

Administrative Action

New requirements in the proposed CY 2020 Outpatient Rule

Require hospitals to post the negotiated rates for 300 “shoppable” services in a consumer-friendly way that is both easily understood and searchable

Defines “shoppable” as services that are non-urgent, routinely provided, and can be scheduled in advance

Hospital also would need to provide the payor-specific charge data for any customary ancillary items and services to create charge information for the bundle of services (or “service packages”)

Leading for Better Health

Administrative Action

Enforcement where a provider fails to comply with the price transparency regulations:	
	CMS proposes to first issue a warning and, if the violation continues, it proposes to require hospitals to submit and follow a corrective action plan
	If a hospital does not submit or adhere to the corrective action plan, CMS proposes to impose a civil monetary penalty (CMP) of up to $300 per day
	CMS is also proposing to publicize each notice of imposition of a CMP online, even while such CMP is being appealed, only removing the public notice if the CMP is overturned by a final and binding decision

Leading for Better Health

HAP
Leading for Better Health