Session 2

Revenue Cycle Compliance and Industry Environment

Prepared for **Nebraska Hospital Association Revenue Cycle Residency Program**

September 12, 2023

Presented by:

Traci Waugh, CHC, CHPS, RHIA – Senior Manager, PYA, P.C.

Miriam Murray, CHC, CHPC – Manager, PYA, P.C.

Introductions

Traci Waugh
RHIA, CHPS, CHC
Senior Manager
twaugh@pyapc.com

Traci has served in many roles during her career in healthcare operations. The most recent include compliance leadership roles, such as Director of Outreach Services and Compliance, and Senior Director of Compliance and Medical Staff. She also has experience as a Director of Health Information Management, including responsibilities in utilization review, chargemaster, quality improvement, and risk management. She has a passion for rural healthcare, specifically Critical Access Hospitals, and understands the challenges of having multiple responsibilities and working with limited resources. Traci works collaboratively with PYA clients, helping them develop and leverage robust compliance programs. She often speaks nationally, regionally, and locally on compliance-related topics.

Introductions

Miriam Murray
CHC, CHPC
Manager
mmurray@pyapc.com

Miriam holds more than 25 years of healthcare compliance and healthcare privacy compliance experience and is certified in both fields. Her expertise lies in assisting physician practices, hospital systems, assisted living/skilled nursing/long-term care, outpatient rehabilitation, and third-party billing service organizations with the development and implementation of programs and processes focused on healthcare compliance and privacy.

Agenda

1. Revenue Cycle Compliance Overview
2. Review of Statutory and Regulatory Requirements
3. Revenue Cycle Management (RCM) Compliance Risks and Compliance Work Plan Items
4. Understanding the Affordable Care Act (ACA) and Fraud, Waste, and Abuse (FWA)
5. Questionnaire Results Discussion
6. Price Transparency
7. Wrap-Up Discussion

Revenue Cycle Compliance Overview

Revenue Cycle Management (RCM) Defined

RCM is **all administrative and clinical functions** that contribute to the **capture, management, and collection of patient service revenue**.

RCM is the **entire life of a patient account** from creation to payment. The cycle begins when the first appointment is booked and concludes once the final balance of the cost of care is paid.

RCM Guiding Principles

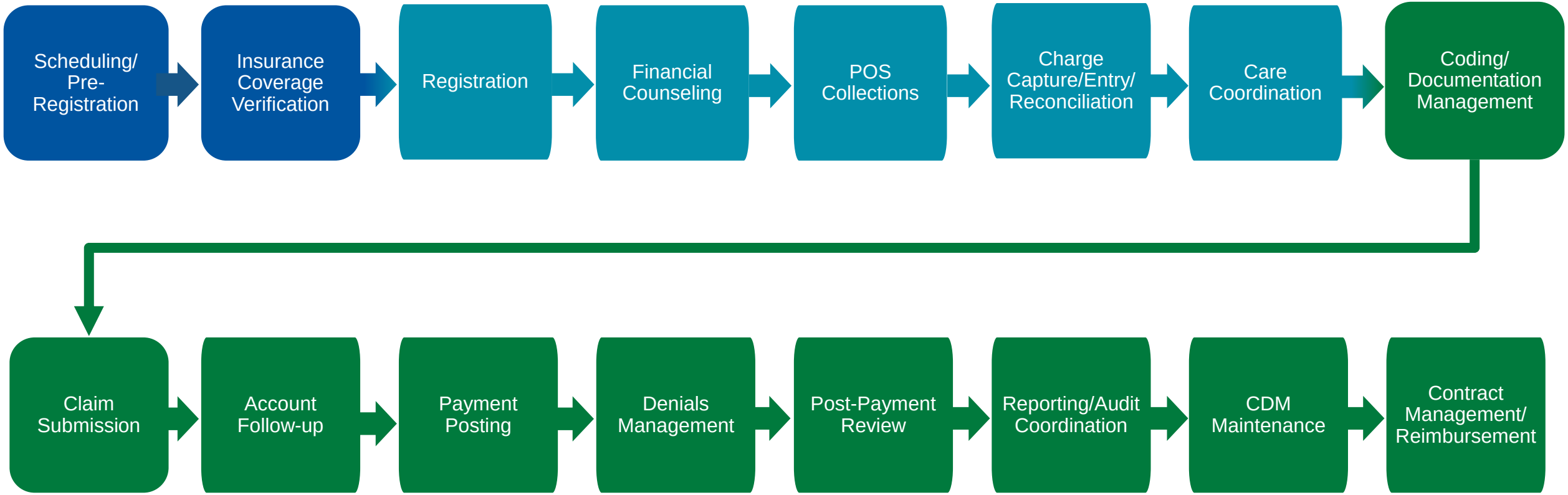
Purpose and Values	• Ensure awareness of and adherence to organizational Purpose and Values. • Support excellent healthcare service delivery. • Anticipate and support patient needs.
Sustainability	• Maximize organizational viability through financial discipline and adoption of industry best practice. • Focus on improving revenue cycle metrics; maximize reimbursement, avoid denials, lower cost to collect, and decrease days in A/R. • Support innovation in healthcare services and best practices. • Develop and maintain long-term relationships with patients, key payers, community, physician groups, and other healthcare services organizations.
Patient Centered	• Use awareness of the patient experience to design processes that enable care coordination and seamless clinical and financial processes. • Support timely delivery of healthcare services for maximum patient benefit. • Provide solutions to assist patients in financial hardship.
Standardization	• Support and advocate consistency - through standardization of process, communication, and the use of technology.
Best Practice	• Support, advocate for, and execute implementation of best practices as evidenced by HFMA or other literature, HFMA MAP Keys[1], MGMA Resources, AHIMA[2], and/or other respected professional organizations in each industry as well as internal metrics.

1. https://www.hfma.org/data-and-insights/map-initiative/map-keys/
2. www.ahima.org

RCM Guiding Principles (*cont.*)

Compliance	• Develop and support detailed policies and processes that adhere to overarching compliance policies and all applicable laws and regulations. • Report all instances of suspected or detected non-compliance. • Ensure awareness of fair collection practices and governmental regulations.
Mitigation	• Support policies and processes which balance effective and efficient process with mitigation of risk for patient complaints or any undue legal exposure. • Provide alternative backup processes for system downtime and for physicians/providers who may not have access to electronic ordering and reporting technology.
Technology/Cyber Security	• Support full integration with all appropriate EMR applications. • Maximize the utilization of software system capabilities and capacity. • Require security within software systems and within storage and transmission processes for patient and provider information. • Provide and require appropriate training to ensure compliance with security standards - audit to ensure compliance.
Documentation	• Ensure capture of accurate and complete patient information and update as necessary. • Ensure appropriate CPT codes assignment - maintain charge master accordingly. • Use Medicare guidance as the standard for all coding and claim submission. • Capture/support pre-authorization requirements and key data in cooperation with ordering provider.
Contract Awareness	• Understand and consider the contractual obligations to vendors, payers, and other key stakeholders.

The Revenue Cycle

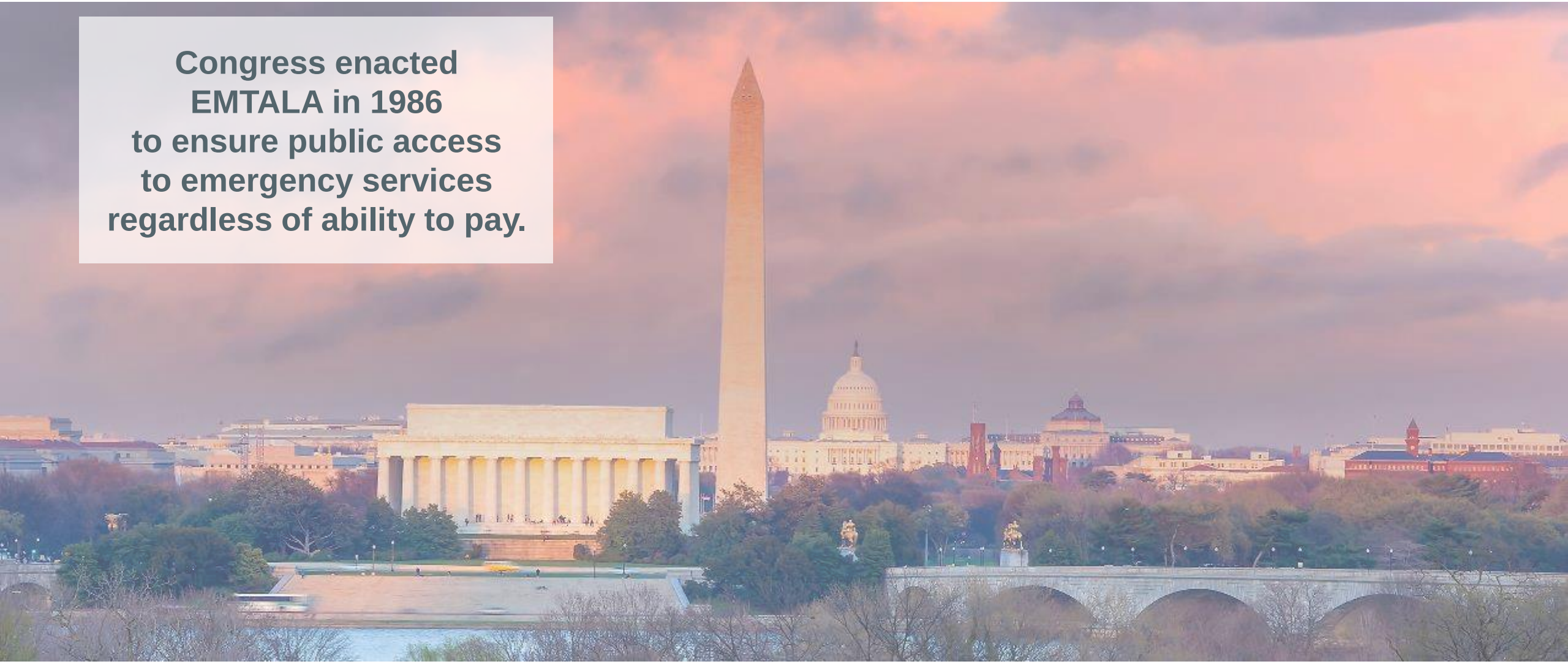


RCM Success Factors

Prioritize	Prioritize your patients and their preferences
Equip	Equip your staff with proper skills
Define	Define clear lines of accountability
Collect	Collect payment information up front
Automate	Automate claim authorization
Improve	Improve claim filing timeliness
Manage	Manage denials
Monitor	Monitor accounts receivable balances
Invest	Invest in technology
Identify and Measure	Identify and measure the right metrics
Protect	Protect your data

Review of Statutory and Regulatory Requirements

Emergency Medical Treatment and Labor Act (EMTALA) Overview



Congress enacted EMTALA in 1986 to ensure public access to emergency services regardless of ability to pay.

EMTALA Overview (*cont.*)

- Section 1867 of the Social Security Act imposes requires Medicare-participating hospitals that offer emergency services to provide **medical screening examination** (**MSE**) furnished by **qualified medical personnel** (**QMP**) when request is made for examination or treatment for **emergency medical condition** (**EMC**) (including active labor) regardless of individual's ability to pay.
  - **When a patient:**
    - Presents at **dedicated emergency department** (**DED**) requesting examination or treatment of any medical condition
    - Presents on hospital property requesting examination or treatment of what may be an EMC
    - Is in hospital-owned/operated ambulance
    - Is in a non-hospital owned ambulance on hospital property (e.g., 250 yards of main building) for presentation at the DED

EMTALA Overview (*cont.*)

- **Hospitals are then required to provide stabilizing treatment for patients with EMCs.**
  - If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented

https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA

Three Tenets of EMTALA

1. Medical Screening

2. Stabilizing

3. Transfer

Medical Screening

Medical Screening Exam

- Performed by qualified medical personnel to address and assess presenting symptoms, including but not limited to history, physician exam involving area or system, and ancillary tests or services to identify an emergency medical condition.

Qualified Medical Personnel

- Defined in medical staff bylaws. May include physicians, Advanced Practice Providers (APPs), and registered nurses (RNs).

Emergency Medical Condition

- Acute and severe symptoms that, absent of immediate medical attention, could reasonably be expected to result in placing the individual in serious jeopardy (including health of an unborn child), serious impairment of bodily functions, or serious dysfunction of any organ or part.

No Delay/No Discrimination

- Hospital will not delay emergency care in order to inquire about method of payment or insurance status.
- Hospital will provide emergency care without regard to:
  - Age
  - Sex
  - Race
  - Color
  - National Origin
  - Handicap
  - Diagnosis
  - Financial Status

Stabilizing

- **Stabilizing Treatment**
- Providing treatment within capabilities to stabilize for discharge or transfer.
  - If a physician believes that a pregnant patient presenting at an emergency department is experiencing an emergency medical condition as defined by EMTALA, and that abortion is the stabilizing treatment necessary to resolve that condition, the physician must provide that treatment.
  - When a state law prohibits abortion and does not include an exception for the life of the pregnant person — or draws the exception more narrowly than EMTALA's emergency medical condition definition — that state law is preempted.
  - When a direct conflict occurs between EMTALA and state law, EMTALA must be followed.
  - EMTALA contains a whistleblower provision that prevents retaliation by the hospital against any hospital employee or physician who refuses to transfer a patient with an emergency medical condition that has not been stabilized by the initial hospital, such as a patient with an emergent ectopic pregnancy, or a patient with an incomplete medical abortion.

https://www.cms.gov/files/document/qso-22-22-hospitals.pdf

Stabilizing Treatment – Per HHS, Federal Law (EMTALA) Preempts State Law

- **Federal law**
  - **U.S. Supreme Court**
    - Dobbs v. Jackson Women's Health Organization (June 24, 2022)
      - Abortion is not a constitutional right; states have the authority to legislate abortion procedures
  - **U.S. President**
    - Executive Order (July 8, 2022)
  - **HHS**
    - Secretary's letter to Healthcare Providers (July 11, 2022) EMTALA to be followed (penalties: fines (Civil Monetary Penalties), Medicare/Medicaid exclusion)
  - **CMS**
    - Guidance QSO-22-22 to Surveyors (July 11, 2022), and QSO-21022 Patients who are pregnant/experiencing pregnancy loss (September 19, 2021, rev October 3, 2022)
    - **EMTALA "preempts any directly conflicting state law or mandate that might otherwise prohibit or prevent such treatment."** If a patient with an EMC requires an abortion as medical treatment to stabilize the patient, an abortion must be provided.

Transfer

- **Steps to transfer:**

1. Provide treatment minimizing risk of individual's health or health of unborn child during transfer

2. Contact receiving facility confirming space and personnel and receiving hospital agrees to receive the transfer.

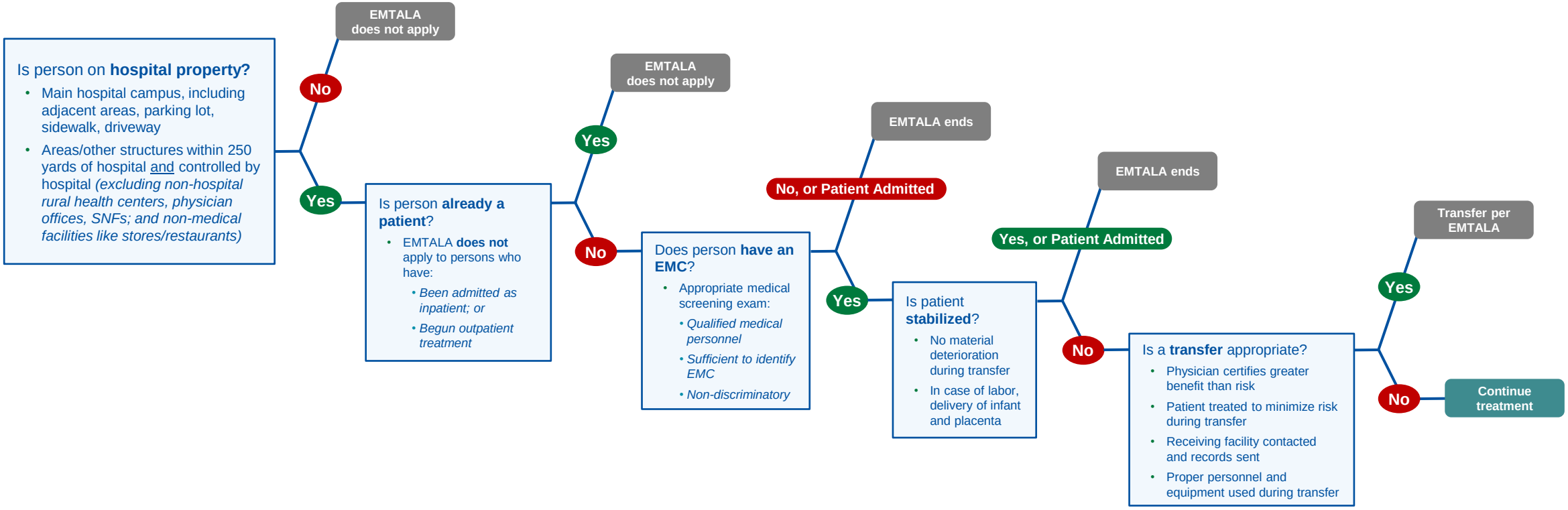
3. Send copies of medical record.

4. Arrange for transfer by qualified personnel and appropriate equipment.

EMTALA Decision Tree

Emergency medical condition (EMC):

1. Absence of immediate medical attention would seriously jeopardize/impair patient's health, body/organ/part function; and/or
2. Insufficient time to transfer a pregnant person to another facility before delivery, or transfer may pose serious health/safety threat; and/or
3. Acute psychiatric/substance abuse symptoms are manifested; expression of suicidal/homicidal thoughts/gestures and patient determined to be threat to self or others



Non-Discrimination

Section 1557 of the Patient Protection and Affordable Care Act

- *Prohibits discrimination on basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, gender identity, and sex characteristics), in covered health programs or activities 42 U.S.C 181116*

Posting requirements:

- Conspicuously visible font size
- Conspicuous physical locations
- Conspicuous location on website

Non-Discrimination

- **Content of notice:**
  - ❑ Do not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).
  - ❑ Do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).
  - ❑ Provide free aids/services to communicate
  - ❑ Provide free language services
  - ❑ List contact if services required
  - ❑ List contact if services are not provided (filing grievance)
  - ❑ Tag lines – include the top 15 non-English languages

Translation resource: https://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html

Top 15 languages by state: https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/appendix-a-top-15.pdf

Sample Non-Discrimination Notice

Sample Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

[Name of covered entity] complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). [**Name of covered entity**] does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

- [Name of covered entity]:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages
- If you need these services, contact **[Name of Civil Rights Coordinator]**
- If you believe that [**Name of covered entity**] has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with:
  - [**Name and Title of Civil Rights Coordinator**],
  - [**Mailing Address**],
  - [**Telephone number**],
  - [**TTY number** if covered entity has one],
  - [**Fax**],
  - [**Email**]
- You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, [**Name and Title of Civil Rights Coordinator**] is available to help you.
- You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:
  - https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Or by mail or phone at:
  - U.S. Department of Health and Human Services
  - 200 Independence Avenue, SW
  - Room 509F, HHH Building
  - Washington, D.C. 20201
  - 1-800-368-1019, 800-537-7697 (TDD)
- Complaint forms are available at:
  - https://www.hhs.gov/ocr/office/file/index.html

Source: https://www.hhs.gov/civil-rights/for-providers/clearance-medicare-providers/technical-assistance/example-notice-nondiscrimination/index.html

Scenario

- Patient with hearing impairment:
  - What needs to be documented in the record?
  - Does an interpreter need to be present?
  - How does this impact Revenue Cycle?

Medicare Secondary Payer Questionnaire

Designed to help you determine if Medicare is the primary or secondary payer by walking you through a few simple questions as part of the Medicare Secondary Payer (MSP) Guidelines. In certain situations, Medicare will pay claims for eligible beneficiaries as a secondary payer to the beneficiary's primary plan

Provider Responsibilities:

Obtain billing information prior to providing services	Use CMS questionnaire, or one that asks similar types of questions	Use condition and occurrence codes on claims (confirm with MAC)

Medicare Secondary Payer Questionnaire

- **Good to know…**
  - ✓ Every admission/registration
  - ✓ All visit types – inpatient, outpatient, office visit…
  - ✓ Proactive audits

Who has experienced an MSP audit by your MAC?

Exclusion Screening

- **What is an exclusion?**
  - Final administrative act that prohibits participation in any Federal Health Care Program (Medicare, Medicaid, and Tricare)
  - Imposed on an individual or entity
    - Poses unacceptable risk to patient safety and/or program fraud

Consequences to OIG Exclusion

Federal health care programs will not pay

OIG may impose penalties

False Claims Act implications

Exclusion Screening

- **Common risk…**

Does your facility accept orders for certain outpatient services from providers that are not credentialed through the medical staff?

If yes, what is the process to check exclusion screening for non-credentialed providers screened?

Exclusion Screening

PROVIDERS

Credentialed

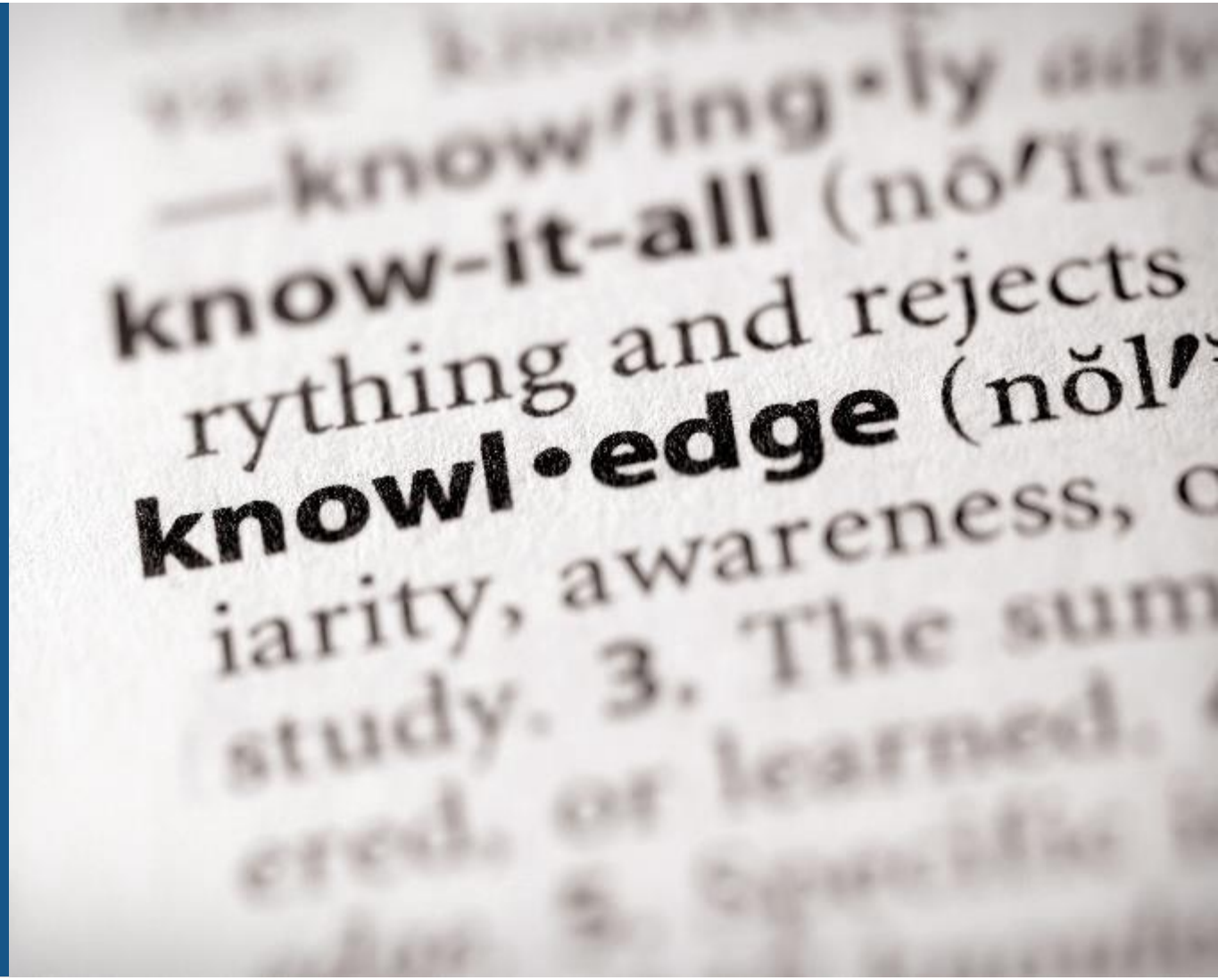
Medical Staff Department

Non-Credentialed

Point of Care

Sites to Query for Exclusions

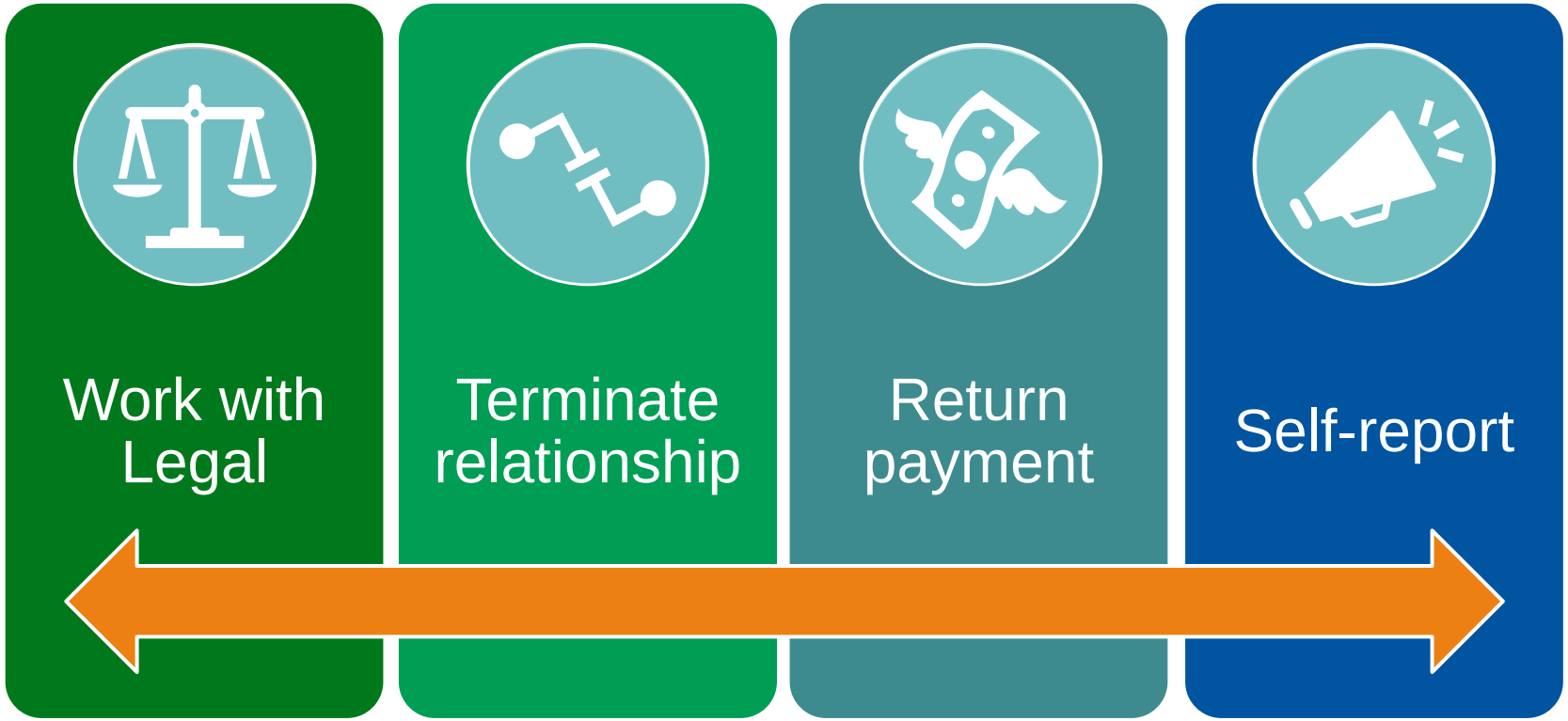
- Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
- System for Award Management (SAM)
- State Medicaid



Timing

- **Initial**
  - Prior to providing/ordering services
- **Monthly**

Discovery


Work with Legal
Terminate relationship
Return payment
Self-report

When was the Notice of Privacy Practices last updated?	How do you manage facility directory?	What challenges do **you** face?
• *Where is it posted?*	• *Opt-out?*	

Payer Contracting

- Do you know how to access the Medicare and Medicaid billing manuals?
- Who is involved with contract reviews?
- Do appropriate staff have access to payer contracts?
  - Knowledge of coding, billing, and reimbursement terms
- Are payer contracts built into your EHR?
- How is prior authorization managed?

Correct Patient Status

- Patient status – ***communication***
  - Outpatient
    - Observation
    - Same Day Surgery
    - Ancillary
  - Inpatient
    - Two Midnight Rule
  - Swing bed

Advance Beneficiary Notice (ABN)

- **When to issue an ABN:**
  - When a Medicare item or service isn't reasonable and necessary under Medicare standards, including care that is:
    - Not indicated for the diagnosis, treatment of illness, injury, or to improve the functioning of a malformed body member
    - Experimental and investigational or considered research only
    - More than the number of services allowed in a specific period for that diagnosis

Source: https://www.cms.gov/medicare/medicare-general-information/bni/abn

When to Issue an ABN (*cont.*)

- When providing custodial care
- When outpatient therapy services exceed therapy threshold amounts
- Before caring for a beneficiary who isn't terminally ill (hospice providers)
- Before caring for a beneficiary who isn't confined to the home or doesn't need intermittent skilled nursing care (home health providers)
- Before providing a preventive service CMS usually covers but won't cover in specific situations when services exceed frequency limits
- Before providing a Medicare item or service CMS won't cover (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies [DMEPOS] suppliers) because:
  - Provider accepted prohibited unsolicited phone contacts
  - Supplier hasn't met supplier number requirements
  - Non-contract supplier provides an item listed in a competitive bidding area
  - Beneficiary wants the item or service before the advance coverage determination

Advance Beneficiary Notice (ABN)

1.
Who is responsible for obtaining an ABN?

2.
Where is ABN maintained?

3.
Is the correct modifier on the claim?

4.
Are denials monitored to captured missed ABNs?

60-Day Overpayment Rule

- Under the current 60-Day Rule, an overpayment must be reported and returned within 60 days of identification/quantification to the Secretary, the state, an intermediary, a carrier, or a contractor, as appropriate; and must also notify that entity in writing of the reason for the overpayment.
  - Do you have a policy and procedure?
  - Who is responsible for tracking, recording, and reporting credit balances?
  - Where are results reported?

RCM Compliance Risks and Compliance Work Plan Items

Risk Assessment with RCM Focus

Deficiencies and avoidable mistakes in key revenue cycle components undermine the effectiveness of healthcare providers' revenue cycle.

Key challenges include:

- Information is traditionally managed in isolation by different departments
- Multiple points of patient entry
- Numerous payer contracts and lack of familiarity with requirements
- Legacy technology solutions and workflow limitations
- Multiple constituencies require consensus and tend to resist change
- Adequacy of training programs
- Payer stall tactics and decreasing reimbursement
- Poor auditing, reconciliation, and monitoring processes
- Unequal priority for administrative responsibilities as that placed on patient care

RCM Risk Assessment Priorities

- Pre- and post-system implementation
- Organizational structure
- Process flow and design effectiveness
- Vendor performance
- Staff and team performance
- Denials prevention and management
- Strategic organizational metrics
- Key performance indicators

RCM Risks

- **Patient access**
  - Registration
  - Scheduling
  - Payments
    - Co-pays
    - Deductibles
    - Self-pay
    - Financial Assistance
- **Overpayments**
- **Denials**
- **Duplicate or unbundled items**
- **Improper billing**
  - Services not rendered
  - Lack of medical necessity
- **Government audits – RAC, TPE**
- **Charge Description Master**
  - Accuracy
  - Maintenance
- **High-dollar/high-volume**
- **Device credits**
- **OIG Work Plan items**
- **Highly scrutinized procedures and diagnoses**
- **Physician supervision**
- **Third-party services**

OIG Work Plan - 2023

- **https://oig.hhs.gov/reports-and-publications/workplan/active-item-table.asp**
- **August Work Plan**
  - Maintaining Buprenorphine Treatment for Medicare Enrollees With Opioid Use Disorder
  - Audit of Health Centers' Use of COVID-19 Supplemental Grant Funding and Reimbursement From the HRSA COVID-19 Uninsured Program
  - Medicare Part B Payments for Over-the-Counter COVID-19 Tests During the PHE Demonstration
- **July Work Plan**
  - Medicare Part C High-Risk Diagnosis Codes Tool Kit
  - Audit of the Rural Communities Opioid Response Program
  - Audit of Ambulance Services Supplemental Payment Program
- **June Work Plan**
  - Hospital Identification of Patient Harm Events

Compliance Work Plan Item Examples

Charge Master Description review

Credit Balances and Overpayments

Denials

Compliance with coding, documentation, billing rules and regulations

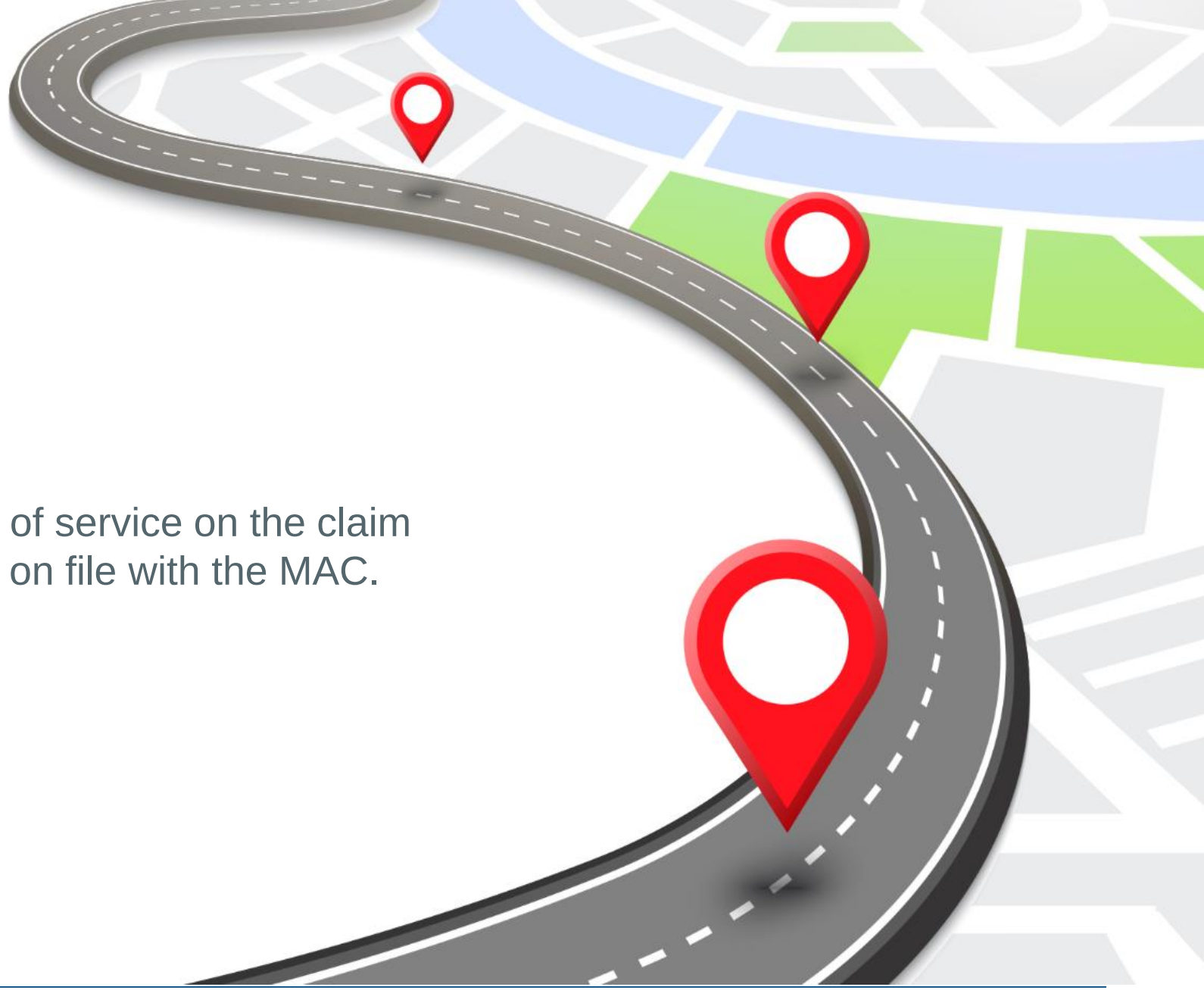
Accuracy of diagnosis and procedural coding

Medical necessity of services provided

Identification of deficiencies in documentation

Education focused on current regulations and audit findings

Promoting accurate reimbursement to the organization



Place of Service

The **ADDRESS** for the place of service on the claim **must match exactly** what is on file with the MAC.

Claims Risk - Modifiers

- **JZ/JW modifiers and wasted drugs**

JZ Modifier

Zero drug amount discarded/not administered to any patient

- Required on all claims for single-dose containers where there are **no discarded amounts**

JW Modifier

Drug amount discarded / not administered to any patient

- Applied to the amount of the drug that is **discarded**
- **Only the discarded amount is reported** with the JW modifier

Other Risks

- **Hospital website**
  - Tracking Pixels
  - What does this mean?
  - HIPAA

Understanding the Affordable Care Act (ACA) and Fraud, Waste, and Abuse (FWA)

Patient Protection and ACA

- Enacted in 2010, effective 2014
- Allows patients who may have been uninsured due to preexisting conditions or limited finances can secure affordable health plans through the health insurance marketplace in their state
- Key features:

Increased access to insurance and care

- Some states expanded Medicaid under ACA
- Health Insurance Marketplace
- Income tax credits and subsidies to help reduce premiums

Protection and prevention

- Preexisting conditions
- Lifetime limits
- Young Adult coverage
- Preventative care
- Essential health benefits

ACA Impact on Revenue Cycle

Payment reductions for Medicare and Medicare Advantage

Expansion of Medicaid

- More reliable payments (compared to self pay)
- More administrative costs
- Lower reimbursement

Shift from FFS to VBP

- Hospital Readmission Reduction Program
- HAC Reduction Program
- Hospital Value Based Purchasing Program

ACO Program

- Increased data collection
  - Patient Outcomes
  - Patient Satisfaction
  - Billing and reimbursement
- Holding providers accountable for cost and quality of care

BPCI

- Bundled Payment for Care Improvement
- Single prospective payment for treatment of a condition

Primary Care Focus

Fraud, Waste and Abuse

- Why do we need to know about FWA?
  - Billions of dollars are improperly spent every year due to FWA.
  - As healthcare workers and employees, whether provider or administrative, we are ALL responsible for combatting FWA.
  - Every action we take potentially affects the Medicare program.
  - To learn how to detect, correct, and prevent FWA.
  - To be part of the solution.

What are your responsibilities regarding FWA?

Comply with all applicable statutory, regulatory and other Medicare requirements, including adoption and implementation an effective compliance program.

Report any compliance concerns and suspected or actual violations of which you may be aware.

Follow the Compliance Plan (including the Code of Conduct), which articulates our commitment to standards of conduct and ethical rules of behavior.

FWA Definitions

Fraud

- The intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true, and makes, knowing the deception could result in some unauthorized benefit to himself or some other person(s)
- To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the services produced

Waste

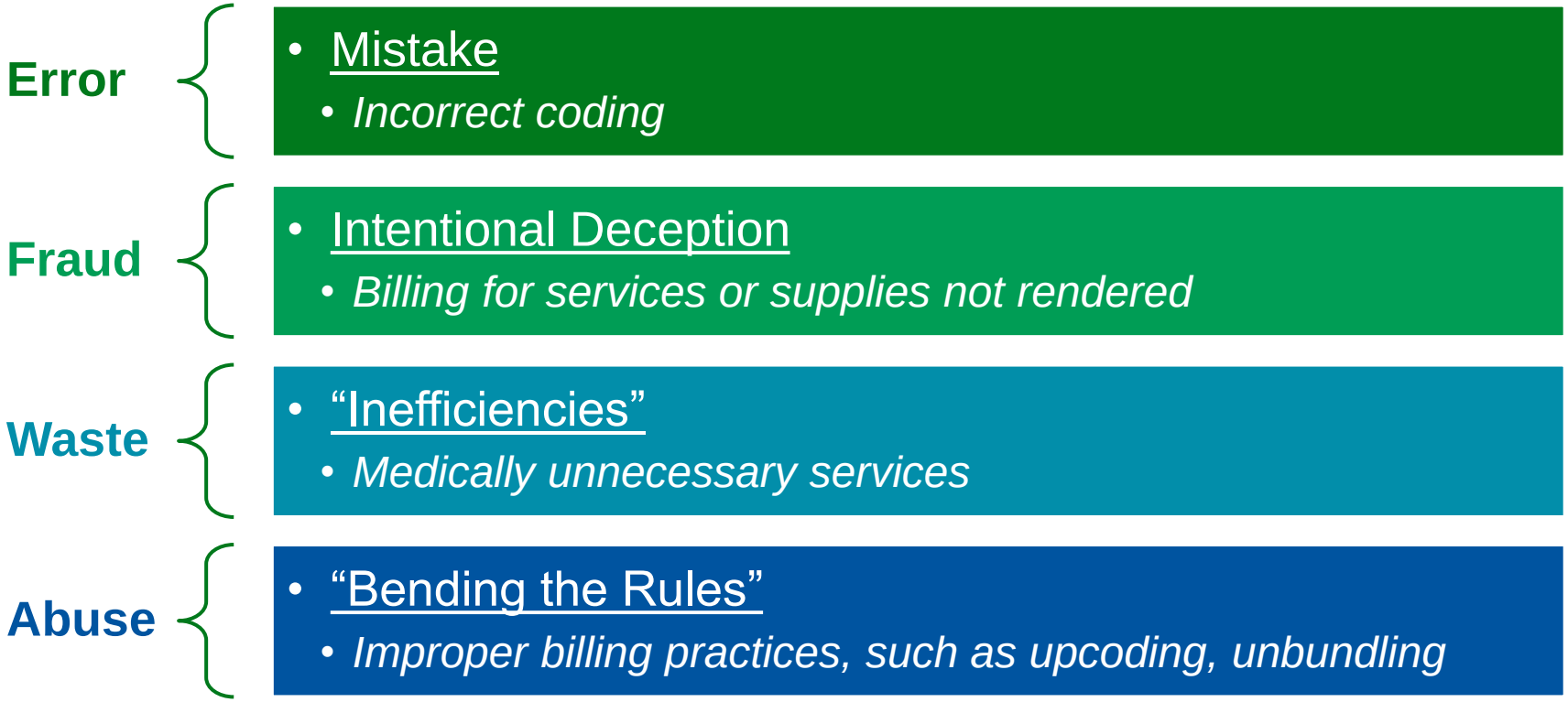
- Incurring unnecessary costs as a result of deficient management, practices, or controls
- Overutilization of services that result in unnecessary costs to Federal healthcare programs

Abuse

- Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to Federal healthcare programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care
- Includes beneficiary practices that result in unnecessary cost to the Medicaid program
- Paying for items or services that are billed by mistake by providers, but should not be paid for by Federal healthcare programs

Difference Between Fraud, Waste, and Abuse

- **Fraud** requires **intent** to obtain payment, **and knowledge** that the actions are wrong.
- **Waste and Abuse** may involve obtaining improper payment or creating unnecessary cost to the Medicare Program, but **do not require the same intent and/or knowledge**.



Areas of FWA in Healthcare

Coding

- Unbundling
- Upcoding/downcoding

Billing

- Unnecessary treatments/services not rendered
- Duplicate billing resulting in duplicate reimbursement

Referral Relationships

- Kickbacks and inducements

Excluded Providers

- Billing for services provided by excluded provider

Questionnaire Results Discussion

Price Transparency

Price Transparency

- **Effective January 1, 2021**, all hospitals (including CAHs) must post current information for all hospital inpatient and outpatient services.
  - Standard charges
    - Machine readable files
    - Consumer-friendly display of shoppable services (minimum 300 services)
  - Payer-specific negotiated rates
    - Name of third-party payer and plan

Price Transparency – Definitions

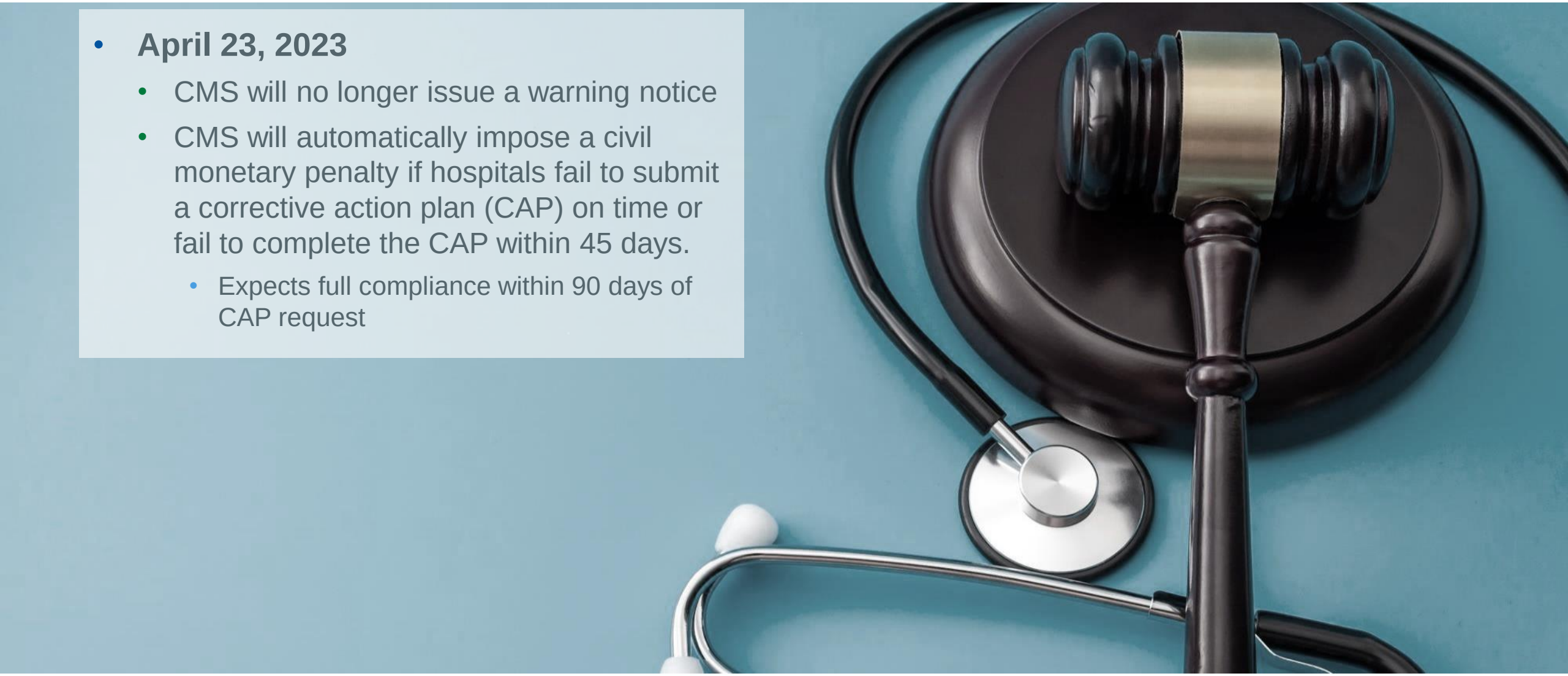
- **Standard Charge** – per CMS, ***gross charges*** and ***payer-specific negotiated charges***
  - **Gross Charge** – charge for individual item or services that is reflected on the chargemaster. Rated does not include any discounts
  - **Payer-Specific Negotiated Charges** – charge that the hospital has negotiated with a third-party payer for an item or service
    - ✓ Does not include the amount ultimately paid by the insurer or patient.
    - ✓ Does not include non-negotiated payment rates, such as those for fee-for-service Medicare or Medicaid.
    - ✓ Does include charges negotiated by third-party payer managed care plans (i.e., Medicare Advantage plans and Medicaid managed care plans, etc.).

Price Transparency – Definitions (cont.)

- **Discount Cash Price** – discounted rate a hospital would charge individuals who pay cash, or the cash equivalent, for an individual item or service or service package
- **De-identified Minimum and Maximum Negotiated Charge** – lowest and highest charges a hospital has negotiated with all third-party payers for an item or service

Pricing Transparency Enforcement

- **April 23, 2023**
  - CMS will no longer issue a warning notice
  - CMS will automatically impose a civil monetary penalty if hospitals fail to submit a corrective action plan (CAP) on time or fail to complete the CAP within 45 days.
    - Expects full compliance within 90 days of CAP request



Wrap-Up Discussion

Questions?

Thank you!

Traci Waugh
RHIA, CHPS, CHC
Senior Manager
twaugh@pyapc.com

Miriam Murray
CHC, CHPC
Manager
mmurray@pyapc.com

PYA | NHA | NEBRASKA HOSPITALS | AAHAM American Association of Healthcare Administrative Management The Premier Organization for Revenue Cycle Professionals | hfma nebraska chapter healthcare financial management association