AZ NAHRI Chapter Meeting: Inaugural Meeting

A WEBINAR PRESENTED ON November 19, 2021

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NAHRI
National Association
of Healthcare Revenue Integrity

Agenda:

1. Introduction of Chapter Leads
2. Goals and Objectives
3. Presentations
    1. How to Structure your Revenue Integrity Department
    2. Pricing Transparency Rules
4. NAHRI Membership Benefits/Education

Introductions

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Presented By

Andrea Whipple, MBA, RHIA, CCS, CRCR, joined Banner Health in 2018 and serves as Senior Director of Revenue Assurance. Her role includes operational leadership for many areas of the middle revenue cycle as well as strategy and execution for several large-scale revenue cycle transformation projects. Banner Health System, headquartered in Arizona, has 30 hospitals in six states and nearly 400 service locations.

Andrea has also held facility, regional and system level roles with Abrazo, Tenet, Optum and several midwestern health systems over a healthcare career spanning more than twenty-five years. Andrea has expertise across the spectrum of the mid revenue cycle with comprehensive knowledge of medical, administrative, ethical, and legal requirements and standards related to healthcare delivery, coding, charge capture, revenue integrity and CDM. She has operational oversight of accurate and compliant charge capture for Banner's multi-billion-dollar footprint in acute care and ambulatory business lines. Her transformational leadership and track record of successes in operational redesign, workflow and safety net implementation and year over year revenue improvements make her a recognized leader in the industry.

Andrea holds an MBA with an emphasis in Health Systems Management from Grand Canyon University.

Presented By

Marie Garcia, MBA, CHRI, CCA is a currently a system manager of Revenue Integrity for CommonSpirit Health, which encompasses all Dignity Health and Catholic Health Initiatives facilities. She has been working within the Revenue Integrity space since 2010 and has served in various Revenue Integrity leadership roles throughout Dignity Health, with a short stint at Tenet Healthcare as Revenue Cycle Operations Director.

She completed her MBA at University of Arizona, Global Campus and maintains a coding credential from AHIMA. In addition, she was recently granted the Certification in Healthcare Revenue Integrity credential. She serves on the NAHRI leadership council and has contributed to several publications and podcasts over the last year.

Presented By

Irene Sachakov is currently a network manager of Revenue Integrity/CDM/Charge Capture at HonorHealth. She has worked within the Revenue Integrity department at HonorHealth since 2014. In her previous roles, she was over the Operational Efficiency and Revenue Recognition department for Atlantic Dialysis Management in New York City.

She holds a Certification in Healthcare Revenue Integrity through NAHRI and is serving on the leadership council for the second year.

Goal and Objectives of AZ Chapter

Forum for Revenue Integrity to collaborate and share knowledge on trending issues

Promote networking and professional development of Revenue Integrity

Provide continuing education topics

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- Polling Questions

Revenue Integrity Structures

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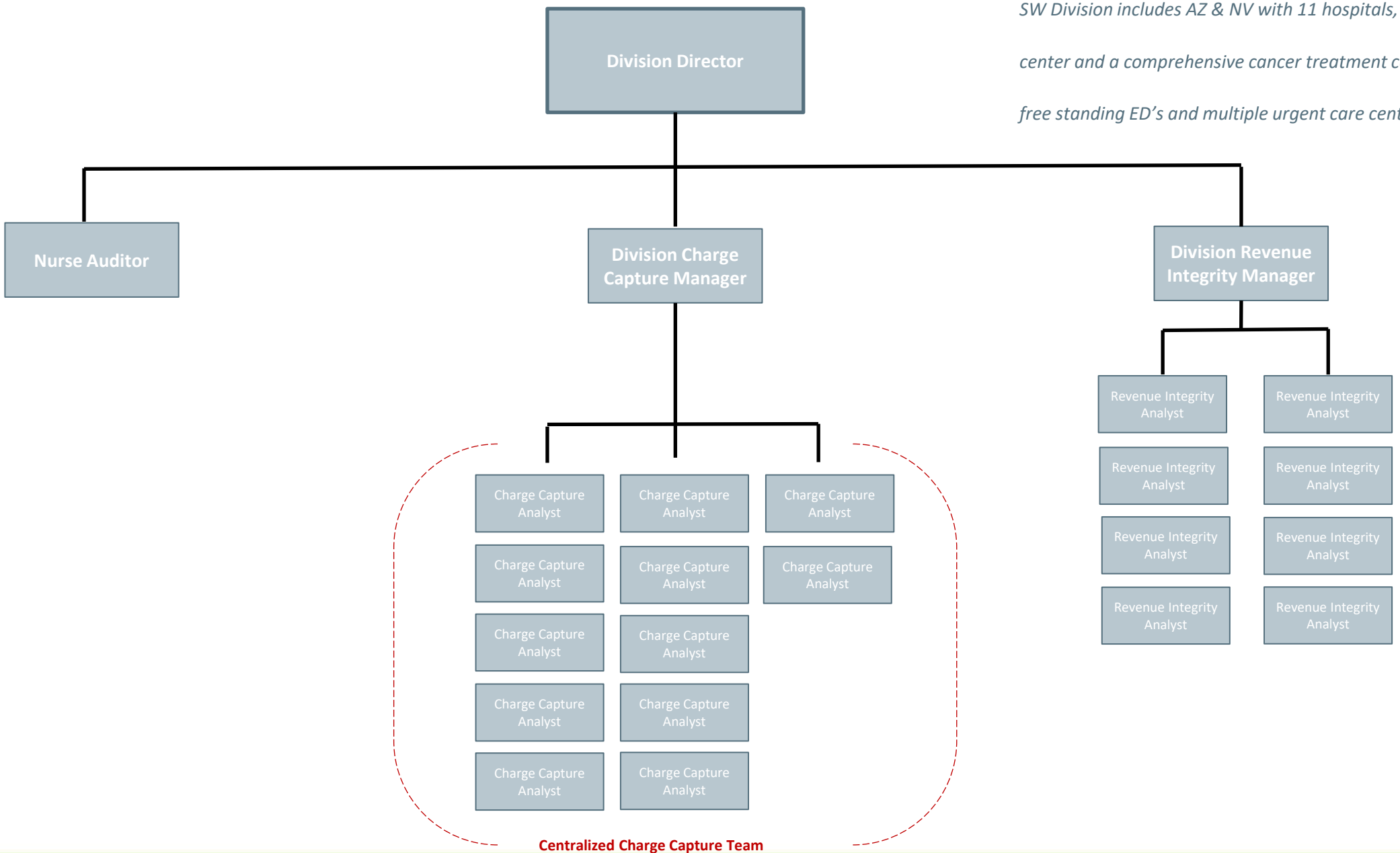
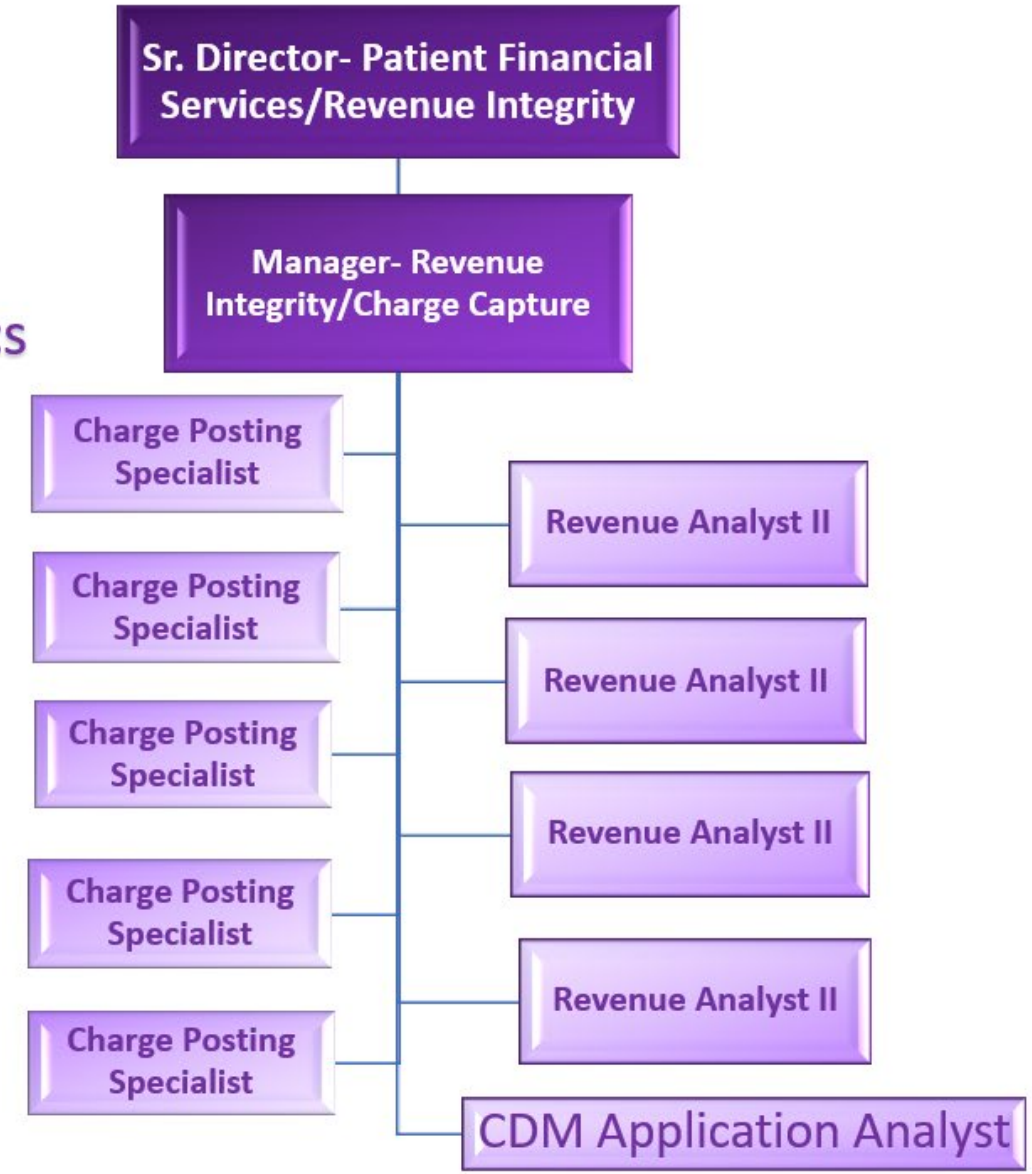
CommonSpirit Health: Southwest Division Revenue Integrity Structure (Legacy Dignity Health Sites)

SW Division includes AZ & NV with 11 hospitals, including an academic medical center and a comprehensive cancer treatment center, in addition there are 14 free standing ED's and multiple urgent care centers.



HonorHealth Revenue Integrity Department Structure

6 Hospitals
3 Trauma Centers
Infusion Centers
Hospital Outpatient Clinics



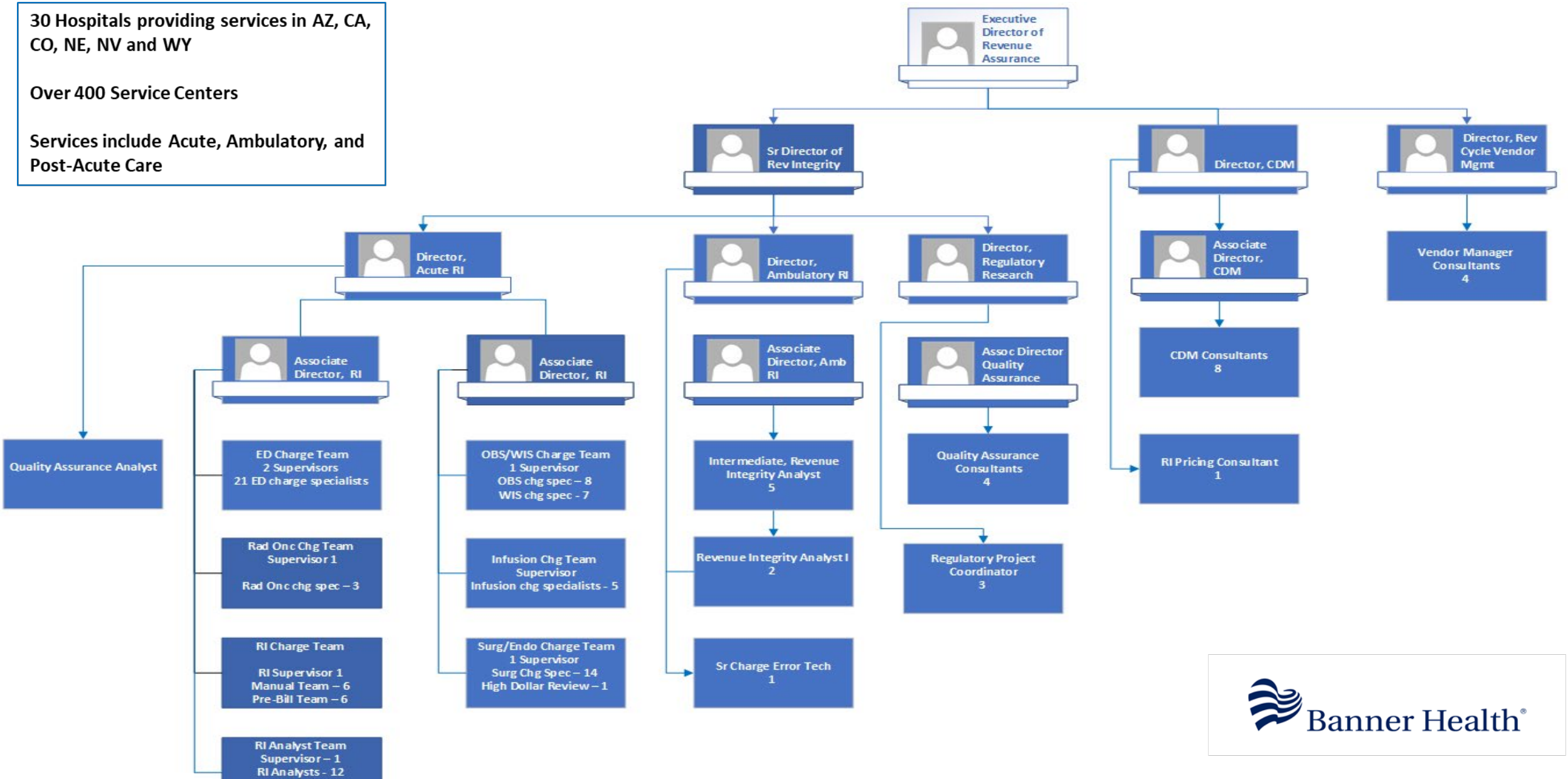
Banner Health Revenue Integrity Structure

NAHRI

30 Hospitals providing services in AZ, CA, CO, NE, NV and WY

Over 400 Service Centers

Services include Acute, Ambulatory, and Post-Acute Care



Banner Health®

Price Transparency Rules

Kennedy Hale – Regulatory Director Banner Health

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Price Transparency Final Rules

Hospital Price Transparency

The final rule implements Section 2718(e) of the Public Health Service Act and requires each hospital operating within the United States to establish (and update) and make public a yearly list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act

Transparency in Coverage Final Rule (CMS-9915-F)

The final rule requires group health plans and health insurance issuers to disclose cost-sharing information upon request to a patient, including an estimate of the individual's cost-sharing liability for covered items or services furnished by a particular provider. Plans and issuers are required to make this information available on an internet website and, if requested, in paper form, thereby allowing a patient to obtain an estimate and understanding of the individual's out-of-pocket expenses and effectively shop for items and services.

No Surprises Act

The No Surprises Act (NSA), passed under the CAA, creates a robust statutory framework aimed at curtailing the practice of surprise billing. The NSA provides new protections for consumers and imposes new requirements on healthcare providers/facilities, group health plans, and insurers. Requirements that apply to group health plans go into effect for plan years beginning on or after January 1, 2022.

Hospital Price Transparency

Starting on January 1, 2021, each hospital operating in the United States is required to publish a yearly list of the hospital's standard charges available in two ways:

- As a comprehensive machine-readable file with all items and services

AND

- As a display of shoppable services in a consumer-friendly format

CMS finalized the definition of *'standard charges'* to include the following:

- Gross charge
- Discounted cash price
- Payer-specific negotiated charge
- De-identified minimum negotiated charge
- De-identified maximum negotiated charge

Transparency in Coverage Final Rule (CMS-9915-F)

Requirement	Effective Date	Applies To	Summary
Disclosures to the Public	**Original Deadline:** Plan years beginning on or after 1/1/22 **Update: Prescription Drug Readable File**: Non-enforcement until additional rulemaking is established **In-Network and Out-of-Network Readable Files**: Delayed enforcement until 7/1/22	Non-grandfathered group health plans and carriers	Plans are required to post free pricing information on a public website. Specific content must be provided on 3 "machine readable files": 1. In-network negotiated rates; 2. Historical payments and billed charges of out-of-network providers during a specified period; and 3. In-network negotiated rates for prescription drugs during a specified period.

Transparency in Coverage Final Rule (CMS-9915-F)

Plan Participant Disclosures	For plan years on or after 1/1/23: Initial list of 500 items and services For plan years on or after 1/1/24: All items and services	Same as above.	Plans must provide plan participants with real-time, personalized out-of-pocket cost estimates for requested covered items and services by a particular provider or providers. This disclosure must be made through a user-friendly online self-service tool or by paper, upon request. **Update**: The Departments intend to propose rulemaking that would also require disclosure via the telephone, upon request.

No Surprises Act

On Dec. 27, 2020, the No Surprises Act was signed into law as part of the Consolidated Appropriations Act of 2021.

The Provisions in the No Surprises Act will protect patients with health coverage from receiving surprise bills for emergency services and air ambulance services furnished by nonparticipating providers. It also offers protection for non-emergency services furnished by nonparticipating providers at participating facilities in certain circumstances.

Providers will no longer be able to balance bill an individual for emergency services. A provider will only be able to balance bill a patient for certain post-stabilization services, and for services performed by nonparticipating providers at certain participating facilities, if the provider or facility provides notice to the patients and obtains consent to receive care on an out-of-network basis and be balance billed.

No Surprises Act

Non-Emergency Post Stabilization/Elective Services (Insured Patients)	
Disclosure Of Balance Billing Protections *(required in all circumstances)*	
Facility is Out of Network	**Physician is Out of Network** *(Does not apply to ancillary services)*

• Good faith estimate
• Written notice and consent
• Notification to health plan
• No balance billing to member
  • Hold statements until settled with insurance
• Maintains consent for 7 years
	• Good faith estimate provided by OON provider
	• Written notice and consent by OON provider
	• List of qualified in-network providers with facility privileges
	• Post stabilization - Facility collates consent for all OON providers that have obtained written notice and consent
	• Physicians notify health plan
	• No balance billing to member
	  • Hold statements until settled with insurance
	• Maintains consent for 7 years

No Surprises Act – Part II Interim Final Rule with Comment Period

- The rule issued on September 30, 2021, outlines the **federal independent dispute resolution process, good faith estimate requirements for uninsured (or self-pay) individuals** patient process, **patient-provider dispute resolution processes** for uninsured (or self-pay) individuals, and external review provisions of the No Surprises Act.

- The rule also describes **the process for independent dispute resolution entity certification** and the information that independent dispute resolution entities must submit to be certified as federal independent dispute resolution entities.

Resources:

Overview of rules & fact sheets | CMS

Requirements Related to Surprise Billing; Part II Interim Final Rule with Comment Period

Requirements Related to Surprise Billing; Part I Interim Final Rule with Comment Period

No Surprises Act

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Non-Emergency Post Stabilization/Elective Services (Uninsured/Self-Pay Patients)

Disclosure Of Balance Billing Protections
(required in all circumstances)

Convening Facility/Provider	Co-Facility/Co-Provider

• **Notice that** good faith estimates are available upon request or scheduling.
  • in **writing** (on the website and in the facility/office) and
  • **verbally**
	• **Notice that** good faith estimates are available upon request or scheduling.
	  • in **writing** (on the website and in the facility/office) and
	  • **verbally**

• **Good faith estimate** to include co-facilities and co-providers
  • Must be expected charges *"cash pay price"*
  • Must be accurate
  • *not higher than **$400** of the expected charges.*
  • If higher patient can initiate dispute resolution.
	• **Good faith estimate**
	  • Must be expected charges *"cash pay price"*
	  • Must be accurate
	  • *not higher than **$400** of the expected charges.*
	  • If higher patient can initiate dispute resolution.

• Maintain records for **6 years**	• Maintain records for **6 years**

No Surprises Act – Deferred Deadlines

Requirement	Effective Date	Applies To	Summary
Advanced Explanation of Benefits (EOB)	**Original Deadline:** Plan years beginning on or after 1/1/22 **Update:** Deferred enforcement until rulemaking is established	All group health plans (outlined above)	Providers must ask patients whether they are enrolled in a group health plan and, if so, provide an estimate of the expected charges to the patient's insurer. After receiving the estimate, plans must provide an advanced EOB to the plan participant that informs them whether the provider/facility is in-network, of what the plan will pay, and any cost-sharing requirement (among other information).

Convening Provider

These interim final rules define, *"convening health care provider or convening health care facility (convening provider or convening facility)"* as the provider or facility who receives the initial request for a good faith estimate from an uninsured (or self-pay) individual and who is or, in the case of a request, would be responsible for scheduling the primary item or service as defined in these interim final rules.

- The **convening provider is responsible for providing the good faith estimate** to an uninsured (or self-pay) individual.

- **For good faith estimates provided to uninsured (or self-pay) individuals from January 1, 2022 through December 31, 2022, HHS will exercise its enforcement discretion in situations where a good faith estimate provided to an uninsured (or self-pay) individual does not include expected charges from co-providers or co-facility**

Price Transparency and the Patient Financial Journey

NAHRI Membership Benefits/Education

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Membership Links

- AZ NAHRI Chapter Membership
- https://www.surveymonkey.com/r/969GZYF

- NAHRI Membership
- https://hcmarketplace.com/national-association-of-healthcare-revenue-integrity?code=SMCCP1ZA2&webSyncID=c614575b-41ee-05ad-82d1-ae9a3b30d04c&sessionGUID=8859c199-084a-2d0c-bd8c-da017643e0d0&spMailingID=19346858&spUserID=NTA3MjIzMTI3MDU3S0&spJobID=2222254981&spReportId=MjIyMjI1NDk4MQS2

NAHRI WEBSITE OFFERINGS

Publications:

- NAHRI JOURNAL
- REVENUE INTEGRITY INSIDER

Resources:

- Job Descriptions
- Policies and Procedures
- Surveys

REVENUE INTEGRITY SYMPOSIUM

Select an Event Below to Explore our Educational Offerings

Revenue Integrity Symposium

Boot Camps and Webinars

RIS
A NAHRI Virtual Event
Revenue Integrity Symposium

Revenue Integrity Symposium

Save the Date: September 19-20, 2022
Phoenix, Arizona

Register Today

The Revenue Integrity Symposium is the can't-miss event for revenue integrity, revenue cycle, and Medicare compliance education and high-level networking. Learn from trusted experts with cutting-edge insight that will arm you with the tools you need to ensure compliance with regulatory changes and enhance workflow and program design.

CERTIFICATION OF HEALTHCARE REVENUE INTEGRITY (CHRI)

About the CHRI Certification

Important update regarding *reopening* of testing sites administering CHRI exams

The **Certification in Healthcare Revenue Integrity (CHRI)** credential provides a trusted baseline of competency for revenue integrity professionals in healthcare settings.

NAHRI has launched a new, easy-to-use online application for our CHRI credential exam and recertification process at *chri.simplifycertifications.com*. This system allows for timely submission, approval, and payment of certification and recertification applications. As a result of these changes, we are no longer accepting paper applications or payment by check.

Please have your contact information, work and education history, and credit card payment information available when you start the application process. Prior to submitting your application, you must review the CHRI Exam Handbook.

If you have questions about this process, please contact Customer Service at 800-650-6787.

About the CHRI Certification | NAHRI

CHRI PROGRAM REQUIREMENTS

CHRI Program Requirements

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Program requirements

The CHRI credential is designed to test an applicant's knowledge of revenue integrity in the areas of education, compliance, revenue, and reporting. Credential holders demonstrate expertise in core competencies of revenue integrity and meet requirements related to education and experience relevant to the field.

CHRI prerequisites

Candidates who apply for the examination must meet one of the following sets of requirements:

1. One or more year(s) of experience in healthcare revenue cycle, coding, compliance, or revenue integrity and a bachelor's degree *OR*
2. Two or more years of experience in healthcare revenue cycle, coding, compliance, or revenue integrity and an associate's degre *OR*
3. Three or more years of experience in healthcare revenue cycle, coding, compliance, or revenue integrity in the absence of a degree

CHRI Program Requirements | NAHRI

Thank you!

Andrea Whipple – Andrea.Whipple@bannerhealth.com

Irene Sachakov – Isachakov@honorhealth.com

Marie Garcia – Marie.Garcia@commonspirit.org

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