No Surprises Act: Implementation for California Hospitals

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Welcome

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Continuing education credits will be offered for this program for compliance and health care executives.

Full attendance and completion of the online evaluation and attestation of attendance are required to receive CEs for this webinar.
Please submit your questions throughout the presentation in the Q & A box. (Usually located at the bottom of your screen.)
Chad Mulvany is responsible for providing leadership on federal hospital reimbursement issues and contributes on other federal regulatory matters. Based in CHA’s Washington, DC Office, Chad collaborates with CHA’s vice president, federal regulatory policy, CHA’s senior vice president, federal relations, CHA issue managers and national hospital associations on analysis and policy development for advocacy purposes.
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Agenda

1. No Surprises Act Overview
2. Overview of Interim Final Rule Issued July 1, 2021
3. Notice and Consent Requirements
4. Disclosure Requirements
5. Payment Standards
6. Interaction with State Law & ERISA
7. Independent Dispute Resolution Process
8. What is on the Horizon
No Surprises Act Overview
Balance Billing Protections

- **Payors** and **Providers** are limited to patients being billed cost-sharing, deductibles, and out-of-pocket maximums that the patient would have paid if they sought service “in-network.”

- **Payors** must issue payment directly to providers and are prohibited from issuing payments to patients.

- **Providers** may not “balance bill” patients.
## Applicable Services

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<th>Emergency Services</th>
<th>Non-Emergency Services</th>
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<td>Non-Participating Facility</td>
<td>Participating Facility</td>
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<tr>
<td>Non-Participating Provider</td>
<td>Non-Participating Provider</td>
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<td>Act Applies</td>
<td>Act Applies</td>
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**Important:** Definition of emergency Services expanded to include post-stabilization services for purposes of the No Surprises Act.
Applicable Payer Products

- Individual Market
- Large Group Market
- Small Group Market
- Self-insured Group Plans (i.e., ERISA Benefit Plans)
- Federal Employee Health Benefit Plans
- Plans Grandfathered under the Affordable Care Act
Overview of Interim Final Rule
Subjects addressed in the Interim Final Rule:

- Definitions & Scope of the Rules
- Notice and Consent Requirements
- Cost-Sharing Amount
- Out-of-Network Amount
- Qualifying Payment Amount
- Interaction with State Law & ERISA
Expanding the Definition of Emergency Services

- Emergency services include:
  - Medical screening examination
  - Medical treatment that would be necessary to stabilize the patient, AND
  - Post-stabilization items and services furnished as a part of outpatient observation, or an inpatient or outpatient stay that would be covered for in-network patients unless consent is obtained
- Prudent layperson ("PLP") analysis applied to determine if the person presented with an emergency
  - Restricts plans from using "sudden onset" or "diagnosis" limitations
- The IFR does away with EMTALA distinction of hospital department limitation
Expanding the Definition of Emergency Services (cont.)

• **Post-stabilization care**: the protections apply unless the three factors are satisfied:
  - Treating doctor determines patient can travel using non-medical transportation or non-emergency medical transportation;
  - Provider furnishing items/services gives notice and gets consent;
  - The patient is in a condition to receive notice and provide informed consent in accordance with state law.

• Each factor requires consideration of the patient’s medical condition, mental state accounting for the effect of any medication, and cultural, contextual, and “social risk” factors, including for example, the ability to pay for transportation and lack of trust arising from historical inequities.

• These factors have the potential to largely eliminate post-stabilization transfers in practice!
Notice and Consent Requirements
Waiver of Balance Billing Protections

• A non-participating provider or facility may request that a patient waive his or her balance billing protections in certain circumstances.

• Then, the out-of-network professional can bill more than the in-network payment amount.

• If waiver is not given, a patient may only be billed for the cost sharing amounts that would have been charged for an in-network healthcare professional according to certain payment standards.
Notice and Consent Steps

1. Provide Notice to Patient (generally at least 72 hours in advance of scheduled services)
2. Provide Good Faith Cost Estimate
3. Identify In-Network Options
4. Patient Informed Consent
When is Waiver Not Available?

- There is no in-network provider available at the facility.
- The care is for unforeseen or urgent services (or an emergency).
- The provider is an ancillary provider.
- The Secretary may issue additional exceptions in the future.
Content of Notice

- State that Provider and/or Facility Are Non-Participating
- “Good Faith Estimate” Amount
- Combining Notice of Multiple Non-Participating Providers
  - Include Each Provider’s Name
  - Each Provider Must Provide Estimate
  - Individual Can Waive Protections With Respect to Each Provider Separately
- Prior Authorization and Other Limitations
- Referral List (only in certain circumstances)
Standards of Consent

- Incomplete Document Treated as Lack of Consent
- May waive some or all of the items and services
- Not a substitute for informed medical consent
- Individuals may revoke consent
Disclosure Requirements
Disclosure Requirements

Providers and facilities must:

• Publish a patient protections against surprise billing disclosure notice on their website and in public area of facility
• Give a one-page notice directly to individuals

Timing:

• On or before the time when provider or facility request payment from individual
Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in your health plan’s network.
Different Standards for Different Purposes

- “Recognized Amount” - defines patient’s cost sharing
  - Rules have lots of details that mostly lean toward lower amount
  - Purpose is to protect patients

  Versus

- “Out-of-Network Rate” – defines what plan ultimately owes provider
  - Rules have very few details, but do reflect that it can be higher
  - Regulatory afterthought?

- Example in Rules. $1,000 “recognized amount” but $1,500 “out-of-network rate.”
  [preamble p.49] Thus, 50% higher payment could be owed in IDR.
“Recognized Amount”

• “Recognized amount” means one of the following, in this order:
  • All-Payer Model Agreement if one exists for that state and product
  • Amount determined by specified state law if there is such law; or
  • If neither 1 or 2, then the lesser amount of the bill or the what is called the **Qualifying Payment Amount** ("QPA")

• Key: Patient’s cost-sharing obligation under the plan must not be greater than that would apply if the services were provided in-network
  • Cost sharing payments must be counted towards any in-network deductible or out of pocket maximums; these requirements apply even where a patient has not met their deductible
“Out-Of-Network Rate”

The plan must make a total payment to the provider, less any cost sharing from the participant, equal to one of the following, in this order:

1. **All-Payer Model agreement** if one exists and applies
2. Amount specified by **state law** if there is such state law
3. If #1 and #2 don’t apply, the **agreed upon payment amount** if reached
4. If none of the above, and the parties enter the **IDR process**, and do not agree on a payment amount before the IDR entity determines the amount, then the amount determined by the IDR entity
“Specified State Law”

“State law that provides a method for determining the total payable” expressly interpreted by the Rules “broadly” -

- Not limited to set mathematical formula or pre-determined amounts
- Includes states that allow negotiation and provide a state arbitration process, in which case state law deadlines and processes apply
Potential Complications in Whether State Law Applies

Rules provide examples of when state law may be incomplete:

- Plan issued in State A, which has law determining rates, but provider located in State B, and not bound by State A’s law

- State A permits self-insured ERISA plans to opt-in to State A’s method for determining rates, but self-insured ERISA plan has not opted-in

- State A has method to determine emergency services rates, but not post-stabilization services rates, and bill includes both types of services
  - Query: Does this require two processes for the same bill?
“Qualifying Payment Amount”
The Qualifying Payment Amount ("QPA") is defined as

• the **median** of the **contracted (in-network)** rates recognized by the plan in the **same insurance market** on **1/31/2019**, 

• for the **same or similar item or service** that is provided by a **provider**

• **in the same or similar specialty or facility of the same or similar facility type**, and

• in same **geographic region**, increased for inflation (**annual CPI-U adjustment**)
Plan Disclosures. The plan must disclose the following in the initial payment or notice of denial:

1. The QPA for each item or service involved

2. A statement certifying that the QPA applies and was determined in compliance with the No Surprises Act, a statement regarding the IDR process, and the contact information of the individual to be contacted if the provider wishes to initiate the 30-day open negotiation period to begin the federal IDR process

Provider Requests. The provider or facility may request additional information regarding the methodology used to calculate the QPA.

Regulatory Audits: The applicable Secretary or state authority with authority to regulate the plan or issuer shall audit the plan or issuer to ensure that they are complying with QPA requirements.
Potential Issues With Determining the Qualifying Payment Amount

- QPA focuses on the rates of the plan, not of the provider

- Plans do not have to disclose their QPA until sending an initial payment or notice of denial, so providers are limited by the information provided by the plan and their ability to forecast

- Providers may request additional limited information about the QPA methodology from plans but are still largely limited to trusting the plan’s calculations and representations

- Providers do not have the power to audit the plans; instead, that power is reserved to the enforcement authority of the government agency designated to audit the plans to ensure compliance with the QPA requirements

- The QPA rules are geared toward reducing patient financial responsibility, which results in reducing what plans will pay providers absent negotiation or IDR
“Out-of-Network Rates”
The No Surprises Act gives the arbitrator broad authority to consider many factors for the OON rate, including:

- The *qualifying payment amounts (median contracted rate of the plan)* for the applicable year for items or services that are comparable to the qualified IDR item or service and that are furnished in the same geographic region
- The level of *training, experience, and quality and outcomes measurements of the provider or facility that furnished the item or service*
- Patient *acuity and complexity of furnishing the item or services* to the patient
- Each of the parties’ respective *market share* in the geographic region in which the item or service was provided
- The *teaching status, case mix, and scope of services of the facility*
- Demonstrations of good faith efforts (or lack of good faith efforts) by the provider, facility, or plan to enter into network agreements
- Any *prior contracted rates* during the previous 4 plan years, if applicable
- Any information requested by the IDR entity
- Any information *submitted by the parties* relating to the parties’ offers for a payment amount
The statute precludes the arbitrator from considering the following:

- usual and customary billed charges, or
- the reimbursement rate payable by a public payor, including under Medicare, Medicaid, CHIP, TRICARE, or veteran’s benefits.
Regulations Standards for Out-of-Network Rates

- Rules generally lack details on the factors set forth in the No Surprises Act
  - Preamble has 41 pages of details on the QPA, but less than a page on determining “Out-of-Network Rates” when there is no Applicable All-Payor Model or Specified State Law
  - Rules say future rulemaking to implement the federal IDR process, which is scheduled to occur by 12/27/21, which means less than one business week before the statute states for all of this to go live
- Unclear if Departments will elaborate further on IDR and Out-of-Network Rates” standards, and they may leave it to plans, providers and arbitrators to sort out
- Providers should prepare now to show arbitrators which offer to select:
  - Several are already preparing for the statutorily fast-paced IDR
  - Those that delay preparing will be caught off guard by the quick timeframes, will incur comparative financial loss, and will lose competitive advantage
Interaction with State Law and ERISA
State Law can Determine “Recognized Amount” and “OON Rate”

- **Effect on State-Regulated Plans**: If state law meets the criteria for a “specified state law,” a state-regulated plan is subject to the state law and the “recognized amount” must be determined in accordance with that state law.

- **Effect on Self-Insured ERISA Plans**: If state law allows ERISA plan to “opt in” to state law, ERISA plan can elect to be subject to that state law that provides a method to determine recognized amount/OON rate, subject to Section 514 of ERISA (which prohibits ERISA plan from being “deemed” an insurer subject to state law).
Notice Requirement

A plan that opts-in to state law for the purpose of determining payment must prominently display a statement identifying the state or states and items or services covered by the opt-in in its plan materials.
In order for a state law to determine the recognized amount or out-of-network rate, any such law must apply to:

- the plan, issuer, or coverage involved (including ERISA plans that opt-in);
- the nonparticipating provider or nonparticipating emergency facility involved; and
- the item or service involved

In instances where a state law does not satisfy all of these criteria, the state law does not apply to determine the recognized amount or out-of-network rate.
Hypothetical:
Patient receives both emergency services and post-stabilization services. What law(s) determine the facility’s rights? In California, maybe it depends. E.g.,

- Does state law have method for determining the emergency rate?
  - Is the California’s six-factor test such a method for Knox Keene Act plans?
  - What about Insurance Department plans?
- Does state law have method for determining post-stabilization rate?
  - Consider H&S Section 1262.8 for hospitals
    - “Charges” if no response in 30 minutes.
    - “Reasonable charges” if plan says it will transfer and doesn’t
    - Only for KKA plans
- And physicians fit under AB72?
Hypothetical:

State law requires OON professional providers who render non-emergency services at an in-network hospital to accept initial payment of 125% of Medicare allowed from HMO and PPO plans. Patient receives knee replacement at in-network facility, but the anesthesiologist is OON. For anesthesiologist -

- State law applies to the item/service involved (non-emergency service)
- State law applies to the provider involved (OON professional provider)
- If the plan is an ERISA plan, whether the state law will apply to the plan depends on (i) whether the state allows an ERISA plan to opt in; and (ii) whether the ERISA plan has elected to opt in
Independent Dispute Resolution
Independent Dispute Resolution Process

1. Within 30 days of receiving the bill from the provider, the plan must send an initial payment or notice of denial of payment.

2. If there is a dispute, insurers or providers have 30 days to engage in private, voluntary negotiations to try to resolve the payment dispute.

3. If negotiations fail, either party pay, within four days, notify the other party and the HHS Secretary of intent to initiate IDR.

4. Within three-business days of initiation, the provider and plan will jointly select a certified IDR entity. If the provider and plan cannot agree on an entity, the Secretary must make a selection “not later than 6 business days” after initiation.
Independent Dispute Resolution Process (cont.)

5. Within 10 days of selecting the IDR entity, parties must submit final offers, information requested by the IDR entity, and any information parties would like related to their offers.

6. Parties may continue to negotiate until the IDR entity reaches a decision.

7. The IDR entity follows "baseball style" arbitration rules. The entity must select one of the offers proposed by the parties, and may not split the difference. The IDR entity decision is binding and not subject to judicial review.

8. The losing party is responsible for paying the administrative costs of the IDR. If a case is settled after IDR begins, the costs are split equally between the parties, unless otherwise agreed.
IDR Conditions

- **Batching**: Cases may only be batched if they involve the same provider or facility, the same insurer, treatment of the same or similar medical condition, and occur within a single 30-day period.

- **Lock Out Period**: The party that initiates the arbitration process is “locked out” from taking the same party to arbitration for the same item or service for 90 days following a decision. Any claims that occur during the lock-out period can go to arbitration after the period ends.
The HHS Secretary must establish by December 27, 2021 a process to certify and recertify IDR entities.

The process must ensure that an entity:

“(i) has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise and sufficient staffing to make determinations . . . on a timely basis;

(ii) is not—

(I) a group health plan or health insurance issuer offering group or individual health insurance coverage, provider, or facility;

(II) an affiliate or a subsidiary of such a group health plan or health insurance issuer, provider, or facility; or

(III) an affiliate or subsidiary of a professional or trade association of such group health plans or health insurance issuers or of providers or facilities;

(iii) carries out the responsibilities of such an entity in accordance with this subsection;

(iv) meets appropriate indicators of fiscal integrity;

(v) maintains the confidentiality (in accordance with regulations promulgated by the Secretary) of individually identifiable health information obtained in the course of conducting such determinations;

(vi) does not under the IDR process carry out any determination with respect to which the entity would not pursuant to subclause (I), (II), or (III) of subparagraph (F)(i) be eligible for selection”

Each certification is valid for 5 years.
Preparing to Implement the IDR Process

Developing a strategy to implement the Independent Dispute Resolution Process created by the No Surprises Act

- Identify business lines that will be subject to No Surprises Act IDR Process
- Determine Claim Value Cut-Offs and Batching Strategy for Pursuing Underpayments and Denials
- Develop Internal Policies, Processes and Standardized Templates to Pursue Claims:
  - Negotiation Letters
  - IDR Initiation Letters
  - Arbitration Submission Packets Addressing Payment Standards
What is on the Horizon
## Rulemaking/Regulations Deadlines

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<td>Dispute resolution process for when an uninsured patient’s bill is “substantially in excess” of the good faith estimate</td>
<td>June 21, 2021</td>
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<td>Methodology to determine qualifying payment amount</td>
<td>July 1, 2021</td>
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<td>Information that plans must share with providers when making qualifying payment amount determination</td>
<td>July 1, 2021</td>
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<td>The geographic regions applied for purposes of determining qualifying payment amount, taking into account access to items and services in rural and underserved areas, including health professional shortage areas</td>
<td>July 1, 2021</td>
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<td>Processes to receive complaints of violations by payers</td>
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<td>Specifications of written notice that must be provided by out-of-network providers to patients prior to rendering non-emergency services</td>
<td>July 1, 2021</td>
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<td>Audit process for group health plans</td>
<td>October 1, 2021</td>
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<td>IDR Process [by regulation]</td>
<td>December 27, 2021</td>
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<td>IDR entity certification criteria</td>
<td>December 27, 2021</td>
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<td>Items, services, or types of ancillary providers for which consent may not be obtained</td>
<td>Optional</td>
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<td>Process to receive consumer complaints of violations</td>
<td>Unspecified</td>
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Key Upcoming Effective Dates

- **September 11, 2021**
  - Comments to interim final rule due
- **December 27, 2021**
  - Departments to issue regulations regarding IDR process
- **January 1, 2022**
  - IDR process to start, using regulations, and considering contract data from the year 2019
- **January 1, 2023**
  - IDR process to use contract data from the year 2022
Please submit your questions through the Q & A box. (Usually located at the bottom of your screen.)
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Thank you for participating in today’s webinar. An online evaluation will be sent to you shortly.

For education questions, contact:
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