No Surprises Act: Dispute Resolution Process and Self-Pay Estimates

November 4, 2021

California Hospital Association

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Welcome

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Questions

Online Questions: At any time, submit your questions in the Q/A box at the bottom of your screen, press enter. We will take questions throughout the presentation.

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Overview

Chad Mulvany
Vice President, Federal Policy
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Presenter

Amanda Hayes-Kibreab is a partner at King & Spaulding specializing in complex business litigation, arbitration and dispute resolution on behalf of providers, with an emphasis on managed care litigation. She represents hospitals and hospital systems, provider groups, surgery centers, individual physicians, and other health care entities. In her position, s. Hayes-Kibreab applies a practical and creative approach to achieve favorable results for her clients.

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Agenda

- Overview of Second Interim Final Rule
- Independent Dispute Resolution ("IDR") Process Refresher and New Interim Final Rule
- Good Faith Estimate for Uninsured Patients
- Patient-Provider Dispute Resolution Process
- External Review

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Interim Final Rule Pt II Overview

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Scope of Interim Final Rule Pt II

- Additional Details about Independent Dispute Resolution Process
- Good Faith Estimate for Uninsured/Self-Pay Patients
- Patient-Provider Dispute Resolution Process
- External Review

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Independent Dispute Resolution Process Refresher

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Independent Dispute Resolution Process: Refresher

1

Within **30 business 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 business days** to engage in private, voluntary negotiations to try to resolve the payment dispute

3

If negotiations fail, either party may, within **4 business days**, notify the other party and the HHS Secretary of intent to initiate IDR

4

Within **3 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

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Independent Dispute Resolution Process: Refresher

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Within **10 business 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 within 30 business days of selection and may not split the difference. The IDR entity decision is binding and not subject to judicial review.

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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.

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Initiating IDR Process & Selection of IDR Entity

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Initiating IDR Process

IDR Process is Initiated by Notice through Federal IDR portal that meets the following requirements:

1. Identify disputed items or services:
   - Date and location of items or services
   - Types of items or services
   - Amount of cost-sharing allowed
   - Amount of initial payment made
2. Provide names and contact information
3. State commencement date of open negotiation period
4. State preferred certified IDR entity
5. Attest the items or services are qualified IDR items and services

IDR Entity Certification Requirements

1. Possess sufficient arbitration and claims administration expertise in the healthcare field
2. Have available medical expertise to assist with payment determination based on experience, quality and level of training of the provider or facility
3. Employ sufficient personnel to make determinations within 30 business days
4. Maintain accreditation from a nationally recognized accreditation organization
5. Must have process to ensure no conflicts of interest exist between IDR entity personnel and the parties

Conflicts of Interest

A **conflict of interest** exists when a certified IDR entity is/has:

1. An **affiliate or subsidiary** of a health plan, provider, or facility
2. An affiliate or subsidiary of a **professional or trade association** representing health plans, providers, or facilities
3. Personnel or contractors that have a "**material familial, financial, or professional relationship** with a party to the payment determination being disputed, or any officer, director, or management employee of the plan" (26 C.F.R. 54.9816-8T(a)(2).
4. Personnel must not be an employee or agent of a party **within 1 year** before the assignment to the dispute

IDR Process Administrative Fees

- Each party must pay an administration fee at the time the IDR entity is selected—due at the time of offer submission.
- The IDR entity must refund the administrative fee to the prevailing party within 30 business days of the determination.
  - In the case of batched services, the party with the most determinations in its favor is deemed prevailing
- If the parties reach a negotiated agreement, the IDR entity will return half of each party's payment.
- For CY 2022, the administrative fee due from each party for participating in the Federal IDR process is **$50**.

IDR Entity Fees

- Fixed fee amount for single determinations: **$200-$500**
- Separate fixed fee amount for batched determinations: **$268-$670**
- Fees must be within range set forth in Department's guidance unless IDR gets written approval

Reporting of Federal IDR Process Information

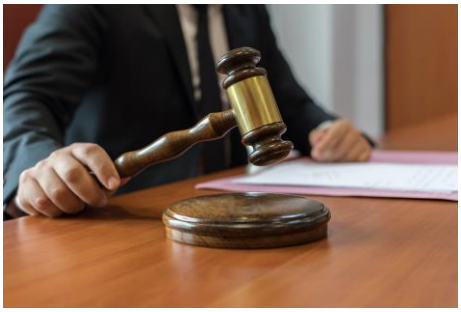
Certified IDR Entity must report each month:

- Number of Notices for IDR Initiation submitted to IDR Entity during the past month
- Information about the size of the provider, practice, or facility submitting Notices
- Offers submitted by both parties (dollar and % of QPA) and whether offer selected was submitted by plan/issuer or provider/facility
- Number of times the OON rate determined by the IDR Entity exceeded the QPA
- Each party's name and address

Departments will publish information on a **public website** each **quarter**.

Grounds for Revocation of IDR Certification

- Pattern or practice of noncompliance with requirements
- IDR operates in a manner that hinders the efficient and effective administration of the federal IDR process (such as missing deadlines)
- Does not meet the certification standards
- Participated in fraud or abusive conduct
- No longer financially viable
- Failed to comply with audit requests
- Otherwise determined that entity is no longer fit or qualified to make payment determinations.



Petition for Denial or Revocation of IDR Entity Certification

- **Individual, provider, facility, plan,** or **issuer** may petition for denial of a certification of an IDR entity or a revocation of a certification

- Petitioner has **5 days** from announcement that IDR entity is seeking certification to submit petition

- IDR entity will have **10 days** to respond and then the Department issues a decision

Determination of Out-of-Network Rate by IDR Entity

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Submission of Offers

The plan/issuer and provider/facility must submit an offer for a payment amount for the item or service at issue as:

- Dollar amount and
- Corresponding percentage of the QPA represented by the amount.

For example:

- Offer dollar amount equals $120
- QPA equals $100
- Corresponding percentage of the QPA represented by dollar amount equals 120% aka 20% above the QPA

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Submission of Batched Offers

- Batched items and services may be submitted and considered jointly as part of one payment determination by a certified IDR entity only if the batched items and services meet the requirements set forth in the statute.

- If batched items and services have different QPAs, the parties should provide these different QPAs and may provide different offers for these batched items and services.
  - *Exception*: the same offer should apply for all items and services with the same QPA.

IDR Factors from No Surprises Act to Determine Out-of-Network Rates

Quality

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

The **teaching status, case mix, and scope of services** of the facility

QPA

The qualifying payment **(median contracted rate)** amounts for the applicable year for items or services that are comparable to the item or service in dispute

Contracts

Each of the parties' respective **market share** in the geographic region in which the item or service was provided

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

Additional

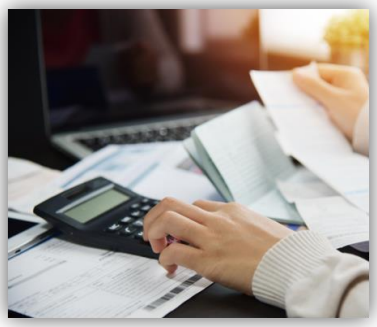
Any information **requested by the IDR** entity

Any information **submitted by the parties** relating to the parties' offers for a payment amount (subject to exceptions)

QPA = 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)



Offer Selection by IDR Entity

No later than 30 business days after the IDR entity is chosen, it must select one of the competing offers to be the out-of-network rate.

- The IDR entity **must presume the QPA is the appropriate amount**, but **must also** consider the additional circumstances;
- The IDR entity must select the offer closest to the QPA unless the **credible information** submitted by the parties **clearly demonstrates that the QPA is materially different** from the appropriate out-of-network rate, based on the additional circumstances allowed.
- If the offers are equally distant from the QPA in opposing directions, the IDR entity **must** select the offer that the entity determines best represents the value of the items or services.

The Departments intend to provide additional guidance as necessary to clarify how additional allowable factors should be considered.

Details of Party Submissions

- Submissions **must** include the following:
  - Size of the practice and facilities at time of submission;
    - For providers, the provider must specify whether the practice/organization has fewer than 20 employees, 20 to 50 employees, 51 to 100 employees, 101 to 500 employees, or more than 500 employees.
    - For facilities, the facility must specify whether the facility has 50 or fewer employees, 51 to 100 employees, 101 to 500 employees, or more than 500 employees.
  - Information on practice specialty or type (if applicable);
    - Specify the practice specialty of the provider or facility named in the dispute, such as anesthesiologist, plastic surgeon, etc.
- Party submissions may **not** include the following:
  - Usual and customary charges;
  - Billed amounts;
  - Public payor rates.
- Parties must submit any information requested by the IDR entity relating to the offer.

Details that Can be Submitted

Experience, level of training and quality -

- Show that the QPA *failed to take into account* the experience or level of training that was necessary for providing the qualified IDR item or service OR that the training or experience made an impact on the care that was provided
- Training and experience alone won't justify a price increase

Market share being majority, or being less than majority, called out by the new regulations as a consideration -

- A plan or issuer having market dominance may signal that the QPA is unreasonably low
- A provider having market dominance may signal that the QPA is unreasonably high

More Details that Can be Submitted

Acuity or complexity of patient: -

- Departments presume that the billing codes with modifiers account for average complexity, so departures will be "rare" and only in cases of outliers in time or intensity of services

Coding disputes (e.g., down-coding)

- If the plan or issuer has down-coded a claim and applies a lower QPA than is appropriate for the services provided, the provider/facility may submit information about why the QPA was incorrect to justify the provider's higher offer

Case mix, teaching status, and scope of services at the facility -

- QPA presumed to account for this, so facility must show how these factors were in some way critical to the delivery of the item or service and not adequately accounted for in the QPA

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Good Faith Estimates for Uninsured or Self-Pay Individuals

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Overview

- **Good faith estimate of expected charges:** Providers and health care facilities are required to inquire about an individual's health insurance coverage status and provide a **good faith estimate of expected charges**, in clear and understandable language, for furnishing items and services
  - The second IFR provides standards for the good faith estimate for **uninsured or self-pay individuals**. Estimates for uninsured patients will be required as of January 1, 2022.
  - CMS FAQs delayed the requirement for good faith estimates **for insured individuals** until 2022.
- Good faith estimates for uninsured/self-pay patients are to be provided **upon scheduling an item or service** or **upon request by an individual**
- The **expected charge** must reflect the anticipated billed charges, **inclusive of any expected discounts** or relevant adjustment that the provider or facility expects to apply to the self-pay or uninsured individual's charges, and must be "specific to what the uninsured (or self-pay) individual would be expected to pay"

Provider or Facility Required to Provide Good Faith Estimate

- The "**convening provider or facility**" is responsible for providing a good faith estimate to the self-pay or uninsured individual or an "authorized representative."

  "Convening provider or facility": treating facility or provider at which the self-pay or uninsured individual scheduled an item or service or requested a good faith estimate

- The "convening provider or facility" must contact "**co-healthcare providers and facilities**" who are reasonably expected to provide items or services in conjunction with the scheduled service to request that these other providers or facilities provide good faith estimate information to the convening provider

  "Co-healthcare providers": other providers and facilities who provide care in conjunction with the scheduled item or service

- If a self-pay or uninsured patient separately schedules an item or service with, or requests a good faith estimate from, a co-provider or co-facility, that provider or facility is considered a "convening provider or facility" for that item or service.

Timing: Between Convening Providers/Facilities and Co-Providers/Facilities

1

Convening provider or facility must contact all applicable co-providers and co-facilities no later than **one business day** after the primary item or service is scheduled or the good faith estimate request is received

2

No later than one business day after the co-provider or co-facility receives the request from the convening provider, good faith estimate information submitted by co-providers or co-facilities must be received by the convening provider or facility

3

If **any changes are expected in the scope** of previously submitted GFE information, the co-provider/facility must provide a new GFE to the convening provider/facility. The new GFE must be provided **no later than one business day** before the item or service is scheduled to be provided.

4

If changes in the co-provider or co-facility represented in the good faith estimate occur **less than one business day** before the service or item is scheduled to be furnished, the replacement facility or provider must accept the previously estimated charges as its good faith estimate

Content of Good Faith Estimate to Uninsured/ Self-Pay Patients

Good faith estimate must include:

- An itemized list of the expected charges for **each item or service** in the **period of care**
  - The "**period of care**" for which expected charges must be provided is defined as "the day or multiple days during which the good faith estimate for scheduled or requested item or service (or set of scheduled or requested items or services) are furnished or are anticipated to be furnished"
  - If certain items or services must be scheduled separately and are expected to occur either prior to or following the primary item or service, the convening facility must include a list of these items and services with a disclaimer
- **The applicable service and diagnosis code** for each item or service
- **The "primary item or service"** = the item or service that is (1) the initial reason for the visit and (2) to be furnished by the convening provider or convening facility

Items and services that are typically not scheduled in advance (emergency, urgent, emergent, and trauma) are NOT included in the good faith estimate, EXCEPT for urgent care appointments that are scheduled **3 business days** in advance.

Enforcement

HHS will exercise **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-facilities until **December 31, 2022**

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Patient-Provider Dispute Resolution

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Scope of Patient-Provider Dispute Process

- **Eligibility**: Process available for uninsured or self-pay individuals who received a good faith estimate of the expected charges or an item or service when the provider/facility bills the individual **substantially in excess** of the good faith estimate
    - Items or services not on good faith estimate are eligible for dispute resolution process if the total billed charges are $400 or more greater than the estimate
- **Substantially in excess** = total billed charges is at least $400 more than the total amount of the good faith estimate for the provider or facility
- **"Total billed charges"** = the total of the charges billed (not the chargemaster) by a provider or facility for all primary items or services and all other items or services furnished in conjunction with the primary items or services to an individual, *regardless* of whether such items or services were included in the good faith estimate

Patient-Provider Dispute Resolution Process

- When a self-pay/uninsured individual receives a bill **substantially in excess** of the good faith estimate, the individual or their authorized representative can submit an **initiation notice** to HHS within **120 calendar days of receipt of the initial bill**
- HHS will select an SDR entity through *round-robin process*.
    - HHS intends to only contract with 1-3 SDR entities for 2022.
- Within 10 business days of being notified of initiation of the SDR process, the provider/facility must submit:
    1. A copy of the good faith estimate;
    2. A copy of the billed charges; and
    3. Documentation demonstrating that the difference between the billed charges and the expected charges in the good faith estimate reflects the costs of a medically necessary item or service and is based on **unforeseen circumstances that could not have reasonably been anticipated** by the provider or facility when the good faith estimate was provided.
- No later than **30 business days** after receipt of the information, the SDR entity must determine the amount to be paid by the uninsured/self-pay individual

Negotiation - Settlement

- Parties may agree to resolve the dispute through negotiation while the dispute is pending through offer of financial assistance by provider/facility, provider/facility offer to accept a lower amount, or patient offer to pay charges in full.
- In the event of settlement, the provider/facility must provide a settlement notice to the SDR within three business days
- In the event of settlement, the provider must pay at least half of the administrative fee

Payment Determination Considerations

- The SDR entity should use the expected charges in the good faith estimate as the presumed appropriate amount unless the provider or facility provides credible information justifying the difference. Difference may be justified by demonstrating that
  - the difference reflects the costs of a medically necessary item or service, and
  - is based on unforeseen circumstances that could not have reasonably been anticipated by the provider or facility when the GFE was provided
- Providers may justify the difference by providing documentation in the form of a written explanation, detailing the following:
  - any change in circumstances,
  - how that change resulted in a higher billed charge than the expected charge for the item or service in the good faith estimate, and
  - why the billed charge reflects the cost of a medically necessary item or service

Payment Determination – Greater than Good Faith Estimate

If the SDR entity determines the provider has provided credible information to justify the difference, the SDR entity must select the amount to be paid to be the lesser of:

1. the billed charge;
2. the median payment amount for the same or similar service in the geographic area as determined for the QPA, that is reflected in an independent database as defined in 45 CFR 149.140(a)(2), or
3. if the amount reflected in the independent database is **less** than the expected charge in the good faith estimate, the good faith estimate amount.

Payment Determination – New Services

For new items or services:

- If the provider/facility did not provide credible information to justify the charge for the new item/service, the payment amount is **$0**.
- If the provider/facility demonstrated that they **could not have foreseen or reasonably anticipated** the medically necessary item or service when the good faith estimate was provided, then the SDR entity must determine the amount to be paid to be the lesser of:
  1. the billed charge; or
  2. the median payment amount for the same or similar service in the geographic area, as determined for the QPA, that is reflected in an independent database as defined in 45 CFR 149.140(a)(2).

Effect of Determination

- The results of the determination are final and binding and not subject to judicial review, in the absence of fraud or misrepresentation
- Exceptions: the provider may still offer financial assistance or agree to accept lower than the SDR determined amount, the individual may agree to pay in full, or the parties may agree to a different payment amount.
- The losing party will pay the administrative fee (no more than $25)

Additional Considerations

- **State law:** The Act defers to alternative state provider-patient dispute resolution processes, **only** if the state process meets or exceeds the protections in the No Surprises Act, as determined by HHS. If the state process does not meet federal standards, patients may still **voluntarily** choose to use the state process.
- **Collections:** While the dispute is pending the provider or facility must not move the bills into collections or threaten to do so. If the bill has already moved into collections, the provider or facility must cease collection efforts until the dispute has been settled.

External Review

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Updates to External Review Process

- The No Surprises Act provides that an external review process will be available to group health plans and health insurance issuers offering group or individual health insurance coverage with respect to adverse determinations by the plan or issuer.

- The Second IFR amends the scope of claims eligible for external and adds examples of the types of adverse benefits determinations that will be eligible for external review.

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Comments to the regulators are due by 5 p.m. ET on December 6, 2021

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Thank you & Questions

Please submit your questions through the
Q & A box. (Usually located at the bottom of your screen.)

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Thank You

Thank you for participating in today's webinar.
A recording of the program will be sent to each attendee.

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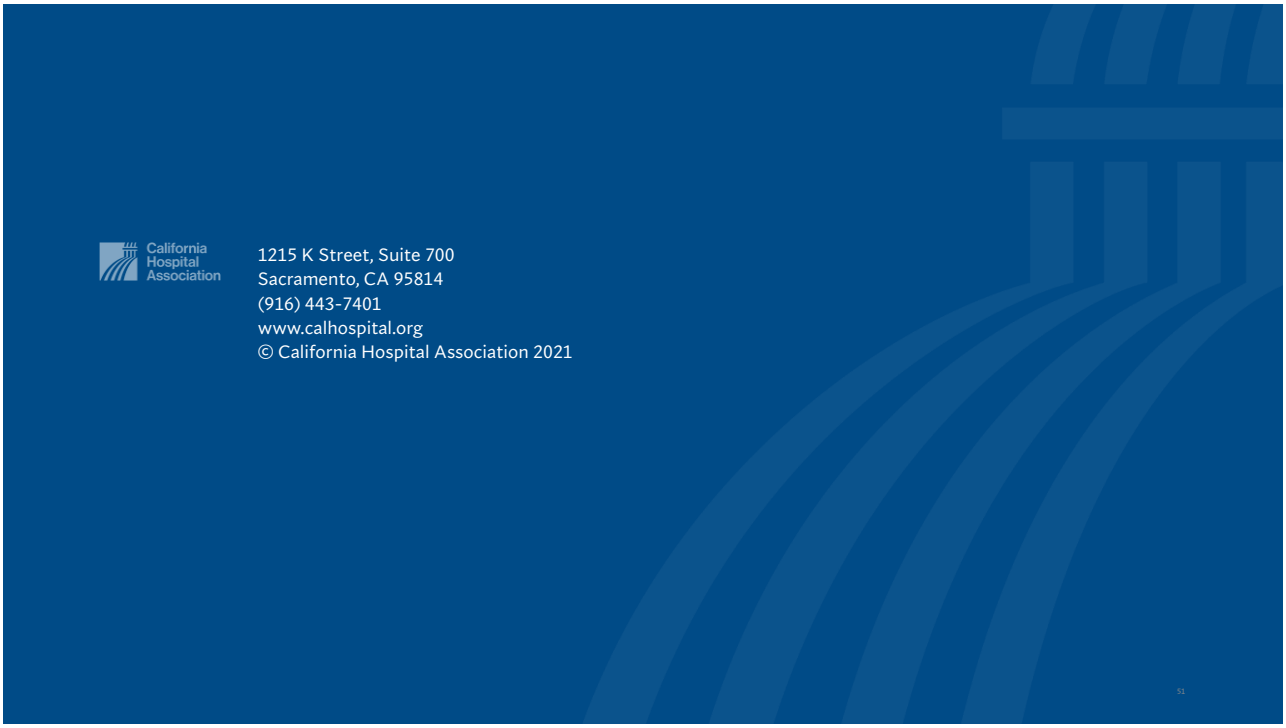
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