No Surprises Act: Implementation Update and Lessons Learned

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California Hospital Association

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.

Overview

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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.

Agenda

1. No Surprises Act Background & Overview
2. Balance Billing Protections & Rules
3. Payment Standards
4. Independent Dispute Resolution Process
5. Good Faith Estimates for Uninsured & Self-Pay Patients
6. What is on the Horizon?

No Surprises Act Overview

New Patient Protections & Dispute Resolution

New Protections for insured and uninsured patients

New Independent dispute resolution process

1. **<u>Patient Protections</u>**:
   - A. Protect insured patients from surprise bills when they receive emergency services, non-emergency services from out-of-network providers at in-network facilities.
     - A notice and consent process for balance billing
   - B. Protect uninsured and self-pay patients from surprise bills for pre-scheduled services with a good faith estimate
   - C. New disclosure requirements for both insured and uninsured patients
2. **<u>Independent Dispute Resolution</u>**:
   - Establish an independent dispute resolution process for out-of-network payor-provider payment disputes.
   - Establish an independent dispute resolution process for uninsured and self-pay individuals when they receive a medical bill that is substantially greater than the good faith estimate they get from the provider

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

Emergency Services	Non-Emergency Services	
Non-Participating Facility	Participating Facility	Non-Participating Facility
Non-Participating Provider	Non-Participating Provider	Non-Participating Provider
Act Applies	Act Applies	Act Does Not Apply

Important: Definition of emergency Services expanded to include post-stabilization services for purposes of the No Surprises Act.

Applicable Payer Products

Insurance Products Covered by NSA's Balance Billing Ban

- 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 ACA

Insurance Products *Not* Covered by NSA's Balance Billing Ban

- Medicare
- Medicaid
- Tricare
- No network or limited coverage plans

Definition of Facility

Emergency services:

- Hospital based emergency services;
- Services provided at an independent freestanding emergency department; or
- Urgent care centers (if permitted to perform emergency services under state law).

Nonemergency services:

- Hospital (as defined in 1861(e) of the Social Security Act)
- Hospital outpatient department;
- Critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); or
- Ambulatory surgical center (as described in section 1833(i)(1)(A) of the Social Security Act).

Note: Urgent care centers are not included in the definition, but the Departments are seeking comments on how to treat urgent care centers that are being used "in a similar way."

Expanding the Definition of Emergency Services

- Under the NSA, 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 (con't.)

- Post-stabilization care: the protections apply unless the three factors are satisfied:
  1. Treating doctor determines patient can travel using non-medical transportation or non-emergency medical transportation;
  2. Provider furnishing items/services gives notice and gets consent;
  3. 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.

Balance Billing

Balance Billing

Balance Billing: when an out-of-network provider bills a patient for the difference between the amount allowed by the plan and the provider's billed charges.

Surprise Billing: a form of balance billing that is a "surprise" to the patient. This occurs when a patient receives treatment from an out-of-network provider at an in-network facility without knowledge (e.g., anesthesiologist for scheduled surgery), and when a patient receives emergency services at an out-of-network facility without any choice in which facility to go to.

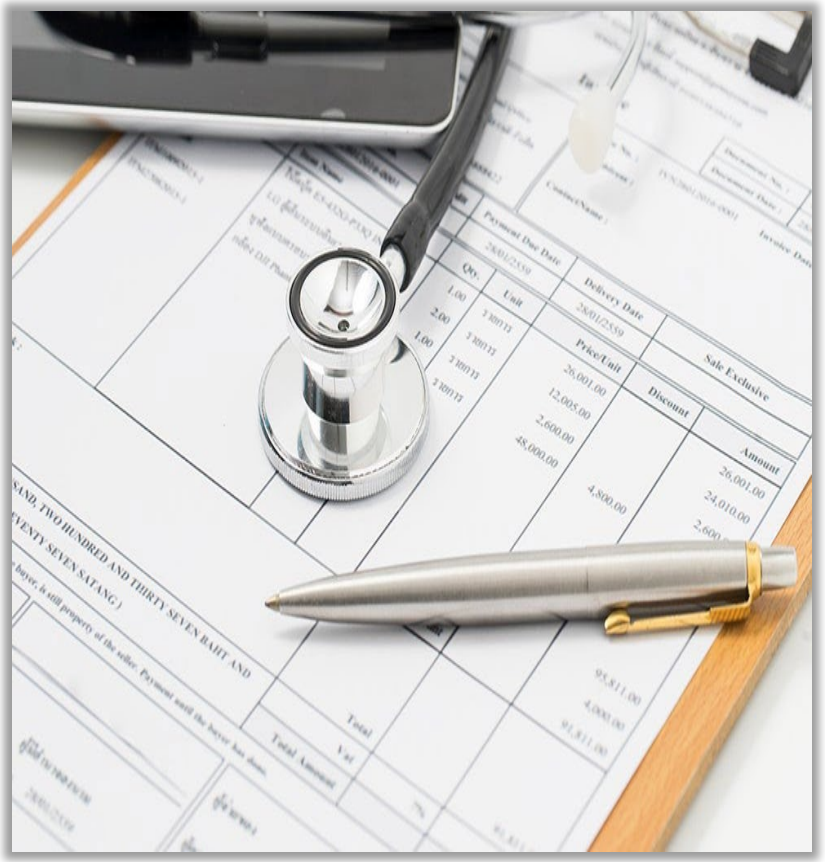
Patient Waiver of Balance Billing Protections

- 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.

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

Template Disclosure

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.

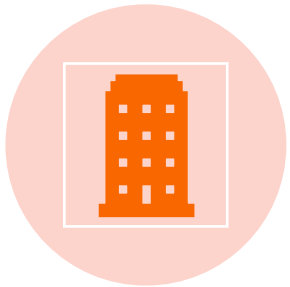
What is "balance billing" (sometimes called "surprise billing")?

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.

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 Estimated" 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)
- Incomplete Notice and Consent Treated as Lack of Consent
- Patient may waive some or all of the items and services
- Not a substitute for informed medical consent
- Individuals may revoke consent

Payment Standards

Different Standards for Different Purposes

"RECOGNIZED AMOUNT"

Determines <u>Patient's</u> Payment Obligation

Defined as:

1. Amount determined under All-Payer Model Agreement, if applicable; or
2. Amount determined by "Specified State Law," if applicable; or
3. The lesser of the billed charge or the *Qualifying Payment Amount*

***MAX** = Patient's in-network cost sharing amount*

"OUT-OF-NETWORK RATE"

Determines <u>Plan's</u> Payment Obligation

Defined as:

1. Amount determined under All-Payer Model Agreement, if applicable; or
2. Amount determined by "Specified State Law," if applicable; or
3. Amount agreed upon by parties, if applicable; or
4. If none of the above, amount determined by IDR process

"Specified State Law"

Specified State 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.

"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

Specified State Law

Query: What if a state precludes balance billing and has factors to be used to determine payment but the state does not include a state established IDR process? Does "broadly" extend to such a state or does federal law apply?

California: Specified State Law

- **History of CMS Letter re California Specified State Law**
  - **Updated DMHC All Plan Letter**
  - **Applies to plan products regulated by DMHC**
- **California's Statutory Method for Determining the Value of Post-Stabilization Services**: Health & Safety Code § 1262.8
  - If the plan fails to respond within 30 minutes, California law requires that the plan "**shall pay charges**" for the post-stabilization care
  - if the plan opts to transfer the patient, but fails to do so, it is also responsible to pay **charges** for the post-stabilization care
  - if the plan opts to transfer the patient and does affect the transfer, then the plan is responsible for "**reasonable charges**" associated with transferring the patient

California: Specified State Law

- **California Law's Method for Determining the Reasonable and Customary Value of Emergency Services and Authorized Post-Stabilization Services**
    - AB 72. If provider is dissatisfied with payment, it may pursue any right, remedy or penalty established by law. (Health & Safety Code § 1371.30(d).)
    - The California Supreme Court and Courts of Appeal have recognized that "[t]he Knox–Keene Act is a comprehensive system of licensing and regulation under the jurisdiction of the Department of Managed Health Care." (*Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497, 503, *citing Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211, 215).)
    - DMHC regulations spell out that plans must pay a "reasonable and customary value" to emergency care providers "based upon statistically credible information that is updated at least annually and takes into consideration: (i) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case ..." (28 Cal. Code Regs. § 1300.71(a)(3)(B).) *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497, 503, *citing Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211

“Qualifying Payment Amount” defined

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**)

“Qualifying Payment Amount” defined

Contracted rate: total amount, including cost sharing, that payer agreed to pay

- **Median** needs at least three; for even number, average the two in middle
  - Each contract given equal weight regardless of claims volume
  - Contracts include direct and indirect through TPAs or PBMs
  - If item paid on capitated basis, defer to plan’s *internal* valuation methodology
  - Rented network rates count toward the payors who rent those rates

- **NOT Counted for Median**:
  - Contracts that do not include in-network participation
  - Single rate agreements
  - Short-term, limited-duration and excepted benefits plans

Qualifying Payment Amount Disclosures & Audits

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.

Challenging the Plan's QPA

Provider Disputes: If a provider believes that the plan has not calculated the QPA correctly, or consistent with the requirements of the Act, the provider can notify the Departments at FederalIDRQuestions@cms.hhs.gov.

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 Litigation?

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

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 Entity Selection: 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

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

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.

Batched Claims

- 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.

Factors to be considered under No Surprises Act to Determine Out-of-Network Rates in IDR Process

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)

Details about Certain Information that Can be Submitted

Experience, level of training and quality -

- Must 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

If plan's contracted rates include risk sharing, bonus, penalty, or other incentive-based or retrospective payments not in QPA -

- A bonus would require selecting a higher offer than the QPA
- A penalty would require selecting a lower offer than the QPA

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 about Certain Information that Can be Submitted

Acuity or complexity of patient: Focus should be on outliers in time or intensity of services -

- Departments presume that the billing codes with modifiers account for average complexity, so departures will be "rare"
- The QPA may become too high for services that become less complex or are furnished more frequently over time

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 -

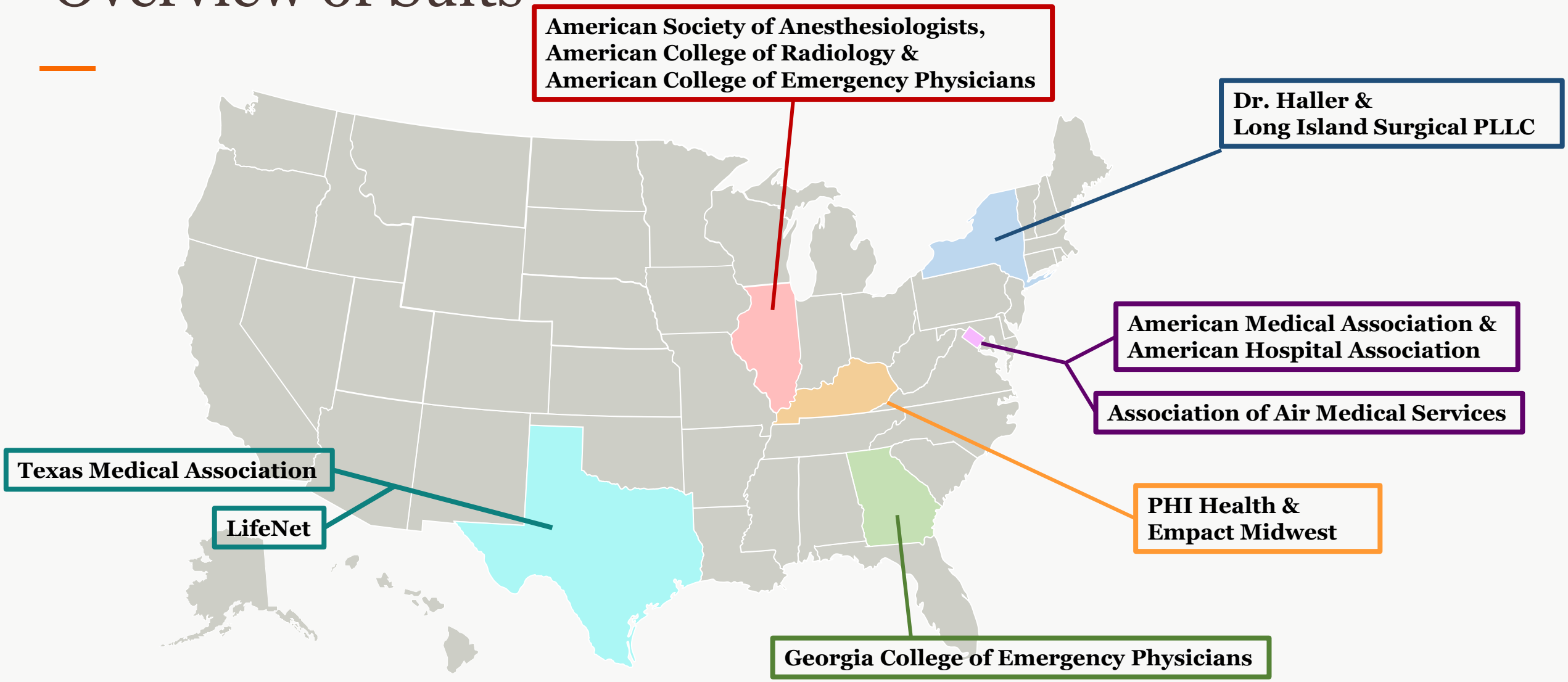
- QPA presumed to account for this, so facility must show how these factors were in some way critical to the delivery of the item or service and not adequately accounted for in the QPA
- Example: the trauma level of the hospital will be relevant if the services involved trauma care that could not be performed at a lower-level hospital

Potential Additional Considerations for Submissions

Other potential considerations not expressly flagged in the regulations but conceptually flowing from them and the prior regulations for potential submissions:

- When there are prior contract rates in the past 4 years or good faith negotiation offers, how should they be used? E.g.,
  - CPI adjusted so that contract from earlier years merits higher rate
  - As the rate or evidence to support going above or below it
- Can the Plan's service area be distinguished from the geographic region used for QPA?
- Can the Facility's local market be distinguished from the geographic region used for the QPA?
  - E.g., greater metropolitan area versus more isolated city in that area
- Any details that distinguish the facility or provider from local competition
  - E.g., What makes the provider or facility unique, not just a widget

Overview of Suits



Arguments

- All 8 Plaintiffs: Challenge IDR Process Interim Final Rule presumption in favor of QPA as arbitrary & capricious and beyond the scope of the Department's authority granted by the APA
- 6 Plaintiffs: Challenge IDR Process Interim Final Rule for skipping notice and comment rulemaking
- 1 Plaintiff – **PHI Health**: Argues the rule violates the 5th Amendment of the US Constitution (Takings Clause)
- 2 Plaintiffs – **AAMS & PHI Health**: Raise specific challenges about calculation of QPA for air ambulance services
- 1 Plaintiff – **Haller**: Challenges major portions of the IDR Process as unconstitutional. Arguments are not limited to the IDR process.

Good Faith Estimates for Uninsured or Self-Pay Individuals

Overview

- 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
    - Rules for implementing requirements for good faith estimates **for insured individuals likely coming in Summer** 2022 (so soon!).
- Required **upon scheduling an item or service** or **upon request by an individual who is**
    - **Uninsured**
    - **Insured but without coverage for requested services**
    - **Insured but chooses not to use insurance**
- 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
  - Note: HHS will exercise enforcement discretion for estimates that do not include co-healthcare provider or facility estimates for 2022
- 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.

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

The interim final rule suggests that the Good Faith Estimate only has to be provided to services scheduled at least **3 business days** in advance of services

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

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
- **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

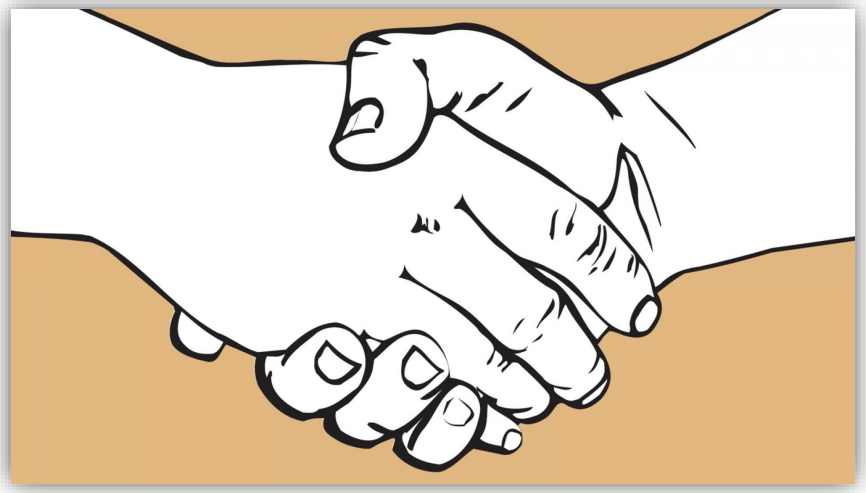
- When a self-pay/uninsured individual receives a bill **substantially in excess** of the good faith estimate, the individual or their authorized representative can submit an **initiation notice** to HHS within **120 calendar days of receipt of the initial bill**
- HHS will select an SDR entity through *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

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

Negotiation - Settlement

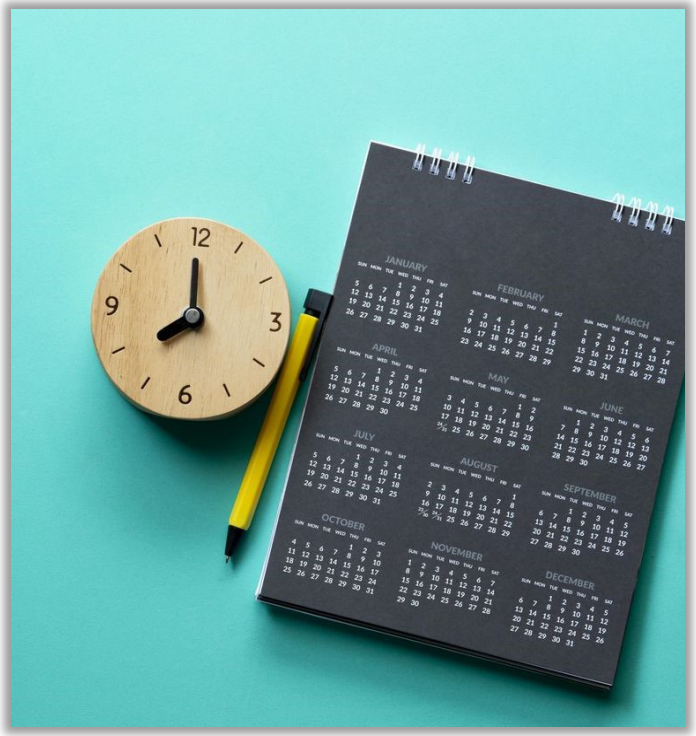
- Parties may agree to resolve the dispute through negotiation while the dispute is pending through offer of financial assistance by provider/facility, provider/facility offer to accept a lower amount, or patient offer to pay charges in full.
- In the event of settlement, the provider/facility must provide 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



What is on the Horizon

Key Upcoming Effective Dates

- <u>Summer 2022</u>
  - Final Rule to replace First and Second Interim Final Rules
  - Rules on Good Faith Estimates for insured patients
- <u>January 1, 2023</u>
  - End of CMS discretion on enforcement of GFE for uninsured/self-pay patients
  - IDR process to use contract data from the year 2022



Thank you & Questions

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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.

For education questions, contact:
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