Updates on the No Surprises Act Implementation

February 9, 2023

California Hospital Association

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Welcome

Carrie Harcharik
Education Department
California Hospital Association

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Continuing Education

Continuing education hours are offered for this program for compliance, health care executives, and legal.

Full attendance and completion of the online evaluation and attestation of attendance are required to receive CEs for this webinar.

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Questions

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

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Moderator

Chad Mulvany is responsible for providing leadership on federal hospital reimbursement issues and contributes on other federal regulatory matters. Based in CHA's Washington, D.C. 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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Presenter

Amanda Hayes-Kibreab is a partner at King & Spalding 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, Amanda applies a practical and creative approach to achieve favorable results for her clients.

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Presenter

Alana Broe, Associate at King & Spalding, represents health systems, academic medical centers, medical groups, post-acute care providers, and suppliers in various regulatory, operational, and litigation matters. Alana regularly defends health care organizations in government investigations and False Claims Act litigation. She also represents hospital systems and health care providers in managed care litigation and business disputes with health plans. In addition, Alana advises clients on a wide range of proactive compliance measures, including the No Surprises Act, Stark Law / Anti-Kickback Statute, and HIPAA among others.

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Agenda

1. Updates on Good Faith Estimate and AEOB Requirement
2. Updates on the IDR Updates
3. Updates on Pending QPA Litigation
4. Forecasting 2023

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Good Faith Estimates

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Co-Provider Requirement Deferred

FAQS ABOUT CONSOLIDATED APPROPRIATIONS ACT, 2021 IMPLEMENTATION - GOOD FAITH ESTIMATES (GFES) FOR UNINSURED (OR SELF-PAY) INDIVIDUALS – PART 3

December 2, 2022

Q1: Will CMS enforce the requirement that GFEs for uninsured (or self-pay) individuals include cost estimates from co-providers and co-facilities beginning on January 1, 2023?

A1: No. HHS is extending enforcement discretion, pending future rulemaking, for situations where GFEs for uninsured (or self-pay) individuals do not include expected charges from co-providers or co-facilities.

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Pressure from Congress

November 18, 2022 Letter from Chairman and Ranking Member of the Committee on Ways and Means:

"[We] wish to express our concerns regarding the slow implementation of the Advanced Explanation of Benefits (AEOB) provision included in the *No Surprises Act*. The law instructed the Departments to finalize rulemaking to implement the AEOB by plan years beginning on or after January 1, 2022. Despite this mandate, ***the Departments only recently issued a Request for Information regarding the AEOB's implementation on September 16, 2022 – a full eight months after the provision should have been in effect. We are concerned that now, implementation will be delayed further into 2024 at the earliest.*** Patients deserve access to the unprecedented and revolutionary transparency the *No Surprises Act* provided. We urge you to accelerate your implementation of this provision in accordance with the law."

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Common Themes in Comments to Departments re GFE

- Utilize (and improve upon) existing processes and standards such as FHIR APIs.
- FHIR-based standards are too immature to be used to implement the AEOB requirements. Need more developed and tested standards with a focus on **real-world testing** prior to implementation.
- Provider advocates consistently commented that the Departments should require plans to **share the AEOB with the provider**, so that the provider and patient have the same information for treatment planning. Plan advocates do not support this requirement.

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Common Themes in Comments, cont.

- Clarify the standard for a patient request for a good faith estimate so that providers may openly discuss the cost of services without automatically invoking an estimate
- Consider impact of administrative burden on small and low-resourced facilities and practices—particularly those who utilize smaller EHR vendors who are slower to adopt FHIR
- Need time to **phase-in requirements**. Various commenters provided different proposals for phase-in methods.
- **Limited AEOBs:** Both providers and plans commented that AEOBs should be limited to patients who need additional detail than cannot be obtained from price transparency online tools

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Expected GFE Rulemaking in 2023

- Expect further rulemaking on the GFE for uninsured and self-pay patients
- Expect initial rulemaking on the GFE for insured patients
- Expect potential implementation of the GFE for insured patients in late 2023 or early 2024
- Expect continued enforcement discretion for the inclusion of the co-provider/co-facility portion of GFE indefinitely until the industry can develop appropriate software to connect providers and to connect providers and payors

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IDR Process

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"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 on a 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.**

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California Specified State Law

No Surprises Act applies to	California law (AB 72) applies to:
• Eligible services covered by ERISA plans • Emergency items and services covered by plans under CDI jurisdiction (EPOs and PPOs) • Air ambulance services furnished by OON providers	• Emergency items and services covered by plans under DMHC regulation (HMOs, EPOs, and PPOs) • Non-emergency items and services by OON providers at in-network facilities covered by plans under DMHC or CDI jurisdiction

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IDR Process by the Numbers: April 15 to December 5, 2022

17,000
Disputes Estimated to Occur in 2022

164,000
IDR Disputes Initiated in 8.5 months of 2022

13,304
Disputes Initiated in One Week in November

11,000
IDR Entity Payment Determinations Reached

68,000
Eligibility Challenged by Non-Initiating Party

23,000
Ineligible Disputes

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IDR Process – Key Events

01 December 28, 2020
No Surprises Act is **enacted** by Congress with directions to HHS, DOL and Treasury to expand with rulemaking

02 July 1, 2021
The Departments issue the **first interim final rule** addressing the calculation of OON rates, cost sharing, notices and disclosures

03 September 30, 2021
The Departments issue the **second interim final Rule** addressing the IDR process and good faith estimates for uninsured & self-pay patients

04 October 28, 2021
Texas Medical Association files suit challenging portions of the IDR rule. Many similar challenges are filed around the country.

05 January 1, 2022
Effective date of No Surprises Act – IDR process delayed until the online "IDR Portal" opens

06 February 23, 2022
The Eastern District of Texas **vacates portions of the IDR Rule** as to providers and facilities granting summary judgment to Texas Medical Association

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IDR Process Key Events

07 April 2022
The Departments issue **updated guidance for the IDR process** responding to the TMA litigation. Different standards apply to providers/facilities and air ambulance providers

08 April 18, 2022
IDR Portal opens, and IDR disputes may be initiated

09 July 26, 2022
The Eastern District of Texas **vacates portions of the IDR Rule** as applied to air ambulance providers granting summary judgment to LifeNet

10 August 19, 2022
Departments issue IDR Process Final Rule, along with an IDR process status report, updated technical guidance for IDREs, and detailed FAQs

11 September 22, 2022
The Texas Medical Association challenges portions of the Final Rule that improperly elevate the QPA in IDRE determinations

12 February 6, 2023
Eastern District of Texas vacates challenged portions of the Final Rule restoring IDR process to equal consideration of factors

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QPA Calculation

- 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**).

- QPA focuses on the rates of the plan, not of the provider.
- Providers do not have insight into the plan's calculation of the QPA.
- The QPA rules are geared toward reducing patient financial responsibility, not the Out-of-Network Rate (but is a factor in the IDR process).

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Final Rule: Provider/Facility IDR Factors

#1 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

#2

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

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

Whether the claim was **downcoded** and why

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

***if credible and not accounted for in QPA**

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The QPA was still elevated in the Final Rule

- **The new Rule removed improper presumption** in favor of the QPA, but still gave the QPA **elevated importance**
- IDRE is required to **consider the QPA first** before considering other factors. The QPA is deemed credible.
- The IDRE should only consider the additional factors **if not already accounted for** in the QPA and if deemed **credible (i.e. no double counting)**

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The IDRE must issue a written decision in all cases

The IDR entity's written decision must:

- Explain its determination
- Include the information it determined demonstrated that the selected offer best represents the value of the qualified IDR item/service
- Explain **how much weight** is given to the QPA
- Explain **how much weight** is given to other information
- **AND** if the IDRE uses information other than the QPA, then it must **explain why that information was not already reflected in the QPA**

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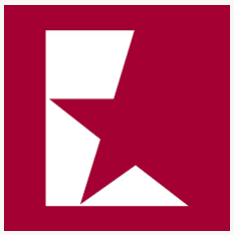
TMA II: Plaintiff Arguments

- Harm is inevitable because the QPA-centric process will result in lower reimbursement rates for providers
- The Final Rule exceeds the Department's authority under the NSA and is not in accordance with the NSA
- The NSA leaves no room for the Departments to issue rules restricting the arbitrator's discretion to weigh the statutory factors
- The Final Rule conflicts with the NSA unambiguous terms – setting out the factors for the arbitrator to consider – and is not a permissible interpretation of the Act
- The Final Rule is arbitrary and capricious
- The provisions should be vacated and remanded with instructions to the Departments to stop privileging the QPA



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TMA II: Government Arguments

- The Plaintiffs cannot demonstrate harm and thus have no standing
- There is no rebuttable presumption: The Final Rule "imposes reasonable evidentiary and procedural rules" but does not impose a presumption for the QPA
  - "None of the challenged portions of the final rule change the fact that the arbitrator is tasked with selecting the offer that best represents the value of the item or service, regardless of whether that offer happens to be closest to the qualifying payment amount."
  - The challenged guidance is just meant to "to ensure that certified IDR entities have clear guidance on how to evaluate potentially voluminous and complex information in a methodological and consistent manner."
  - Departments had discretion to "gap fill" ambiguity in the statute.
- Argue for limited relief that applies only to the plaintiffs or for remand without vacatur

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TMA II: Holding

- The Court granted the Plaintiffs summary judgment and vacated the challenged portions of the Final Rule without instructions. The vacatur has nationwide effect.
- The Court agreed that harm was inevitable, and that Congress was clearly trying to drive down reimbursement rates for providers.
- The Court held that the No Surprises Act is not ambiguous. The Act grants the arbitrators discretion to consider all factors without a presumption in favor of any one factor.
- Where does this leave us? The IDR process will continue but the IDR entities are not permitted to give preference to any of the enumerated factors

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Updates to IDR Portal Procedures

- Effective the week of December 19, 2022, if an entity that was named in a payment dispute through the Federal Independent Dispute Resolution (IDR) portal attests that the Federal IDR process does not apply to the dispute, that entity will be required to submit additional information, and in some cases, supporting documentation to confirm such statements.
- Additional information will be required if the entity attests that:
  - Specified state law or All Payer Model Agreement applies
  - Incomplete open negotiation period (or not ever initiated)
  - Late IDR Initiation
  - Services not covered by NSA
  - Services not covered by current insurance policy
  - Improper batching or bundling
  - Cooling off period not complete

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Other Litigation

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TMA III

In November 2022, Texas Medical Association filed challenge to the portions of the first Interim Final Rule that provide guidance on how to calculate the Qualifying Payment Amount ("QPA"). TMA argues that regulations artificially deflate the QPA which, consequently, skews payor-provider disputes and negotiations against providers in **four ways:**

1. ***Ghost Rates:*** The rule allows the plans to include in the QPA "ghost rates." By this, TMA means that plans may include in their calculation of the QPA contracted rates for services that a contracting provider or facility never expects to provide.
2. ***Specialty Rates:*** The rule permits plans to include the rates of physicians that are not in the same or similar specialty as the physician involved in the payment dispute in some instances. In August 2022 Guidance, the Departments stated separate rates for specialty providers need only be calculated if there is a "material difference" in the contracted rates between providers of different specialties.

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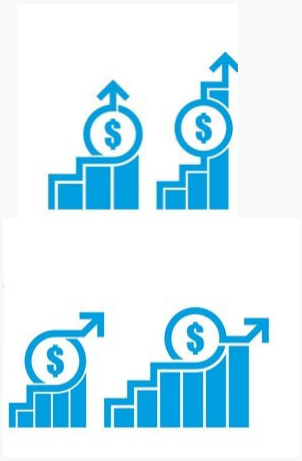
Overview of Dispute

3. ***Impact of Adjustments:*** The first IFR does not include risk sharing, bonus, penalty, or other incentive-based and retrospective payments or payment adjustments in the QPA calculation, even though these adjustments and retrospective payments are included in the total amount paid to a provider. TMA argues this violates the requirement for the QPA to reflect the total payment amount.
4. ***ERISA Plan Administrator Rates***: Self-funded plans may determine the QPA either by using the contracted rates recognized by ***all*** self-insured group health plans administered by its third-party administrator, **or** by using only the ERISA plan's contracted rates. This means the plan sponsor may determine which method results in lower QPAs and opt into that method. TMA argues this conflicts with the language of the NSA that states that the QPA is to be determined with respect to *all* plans of a sponsor or all coverage offered by an issuer in an insurance market.



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Potential Impact of TMA Victory

- Victory for TMA has two likely outcomes: vacatur or remand
- Vacatur would disrupt the No Surprises Act which largely relies on the QPA as central to:
  - Determining patient cost sharing amount
  - Determining the plan's initial payment amount
  - Payor-Provider Negotiations
  - Payor-Provider Disputes in the IDR Process

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TMA IV

- The administrative fee for the IDR process for 2022 was set at $50 per party per dispute. This fee is non-refundable.
- Citing high volumes and a large number of ineligible disputes, in December 2022 CMS increased the administrative fee by 600% to $350 per party per dispute for 2023. This fee is in addition to the arbitrator's fee paid by the cost of the losing party and other costs of arbitration.
- TMA brought suit on January 30, 2023, arguing this increase violates the APA because it was issued without notice & comment rulemaking and is arbitrary and capricious. TMA explained the practical impact of the increase:
  - The the increase is cost-prohibitive for many providers—particularly small and independent providers—and would allow the payors to set low reimbursement rates without impunity.
  - In many cases (esp. small value claims like radiology), with these additional costs *even if* the provider wins the IDR dispute, it would come out at a deficit

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Forecasting 2023

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Questions

Please submit your questions using 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.

An online evaluation and an attestation of attendance will be sent to you shortly.

For education questions, contact:
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