5th Annual "Let's Talk Compliance" Virtual Conference

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Session #3

“No Surprises Act”

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Presentation Overview

During this session we will provide the following information:

- A No Surprises Act overview
- The establishment of the Qualifying Payment Amount (QPA)
- An overview of the Independent Dispute Resolution (IDR) process
- Initial learnings/trends
- Potential IDR strategies

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NSA OVERVIEW

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NSA Overview

- Consolidated Appropriations Act of 2021
  - Prohibits balanced billing for emergency services by nonparticipating providers who provide such services at certain emergency facilities and replace with new payment methodology
    - Patients through no fault of their own receive services from OON provider
    - Established IDR process to determine OON payment amounts between providers or facilities and health plans.
  - Requires providers to give an official notice and obtain prior written consent before balance billing patients in the case of non-emergency services performed by nonparticipating (or out of network) providers
  - Requires providers to furnish good faith estimate (GFE) of charges to self-pay or uninsured patients and stands up a patient provider dispute resolution process (GFE not covered in depth in this presentation).
    - Note that on December 2, 2022, CMS issued an FAQ extending enforcement discretion on elements of the GFE "pending future rulemaking."
  - Does not apply to federal programs such as Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE

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Applicable Laws and Select IDR Guidance

- Implementing regulations
  - July 2021 interim final rule (balance billing, IDR)
  - October 2021 interim final rule (GFE)
  - August 2022 final rule (changes to independent dispute resolution process – effective for services furnished on or after 10/25/22)
  - See 45 CFR Part 149
- Select Guidance
  - April 13, 2022 - Federal IDR Guidance for Certified IDR Entities and Disputing Parties
  - August 16, 2022 - Federal IDR Guidance for Certified IDR Entities and Disputing Parties
  - October 7, 2022 - Federal IDR Guidance for Certified IDR Entities and Disputing Parties
  - October 31, 2022 - Federal IDR Guidance for Certified IDR Entities and Disputing Parties

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Balance Billing Patient Notice & Disclosure

- Facilities and providers who furnish services in facilities must provide notice to patients of NSA protections prior to billing them for such services:
  - Post prominently at **physical location** (like the HIPAA Notice of Privacy Practices)
  - Post on **website** (link from homepage)
  - **Give to each insured patient** (other than federal programs e.g., Medicare/Medicaid) to whom services provided at facility in manner requested by patient no later than time at which request for payment made (or claim submitted, if no request)
    - Provider furnishing services in facility may enter into written agreement with that facility to rely on facility's notice to insured patients
    - Otherwise, provider responsible for delivering notice to patients (in addition to facility's notice)
- If a facility or provider fails to provide such notice, they cannot bill the patient for the OON service(s) provided.

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Advance Notice/Consent

- When services are provided at a participating (in-network) health care facility, then the facility must provide written notice and obtain prior written consent before balance billing patients in the case of non-emergency services performed by nonparticipating (or out of network) providers.
- Use HHS Standard Notice and Consent document:
  - **Available at:** https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780
- Timing
  - If service scheduled at least 72 hours in advance, must provide notice at least 72 hours in advance.
  - If service scheduled less than 72 hours in advance, must provide notice day of appointment, but not less than 3 hours prior to service.
- Plan must be notified and receive copy of signed consent.
- Nonparticipating providers may not bill patients for certain non-emergency ancillary services because they categorically fall outside of this notice and consent process.

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IDR – August 2022 Final Rule

- Focused on IDR process
  - Must consider **QPA** plus all additional information submitted by each party
- Addresses **downcoded claims**
  - Must indicate if claim is downcoded and identify QPA as originally billed *plus* new CPT code QPA
- Requires IDR entity to **explain payment** determinations/underlying rationale
  - **Written decision** submitted to provider, payer, HHS and Department of Labor

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IDR Applicable Entities

- Healthcare entities
  - Facilities – hospitals, CAHs, freestanding EDs, ASCs
  - Providers that furnish services to patients in facilities (including clinics operated as hospital outpatient departments)
    - **Does NOT apply to physicians not providing services at facilities.**

- Health insurance issuers and health plans
  - Group coverage - insured and self-insured plans, ERISA plans, non-federal government plans, church plans, traditional indemnity plans
  - Individual coverage - exchange and non-exchange plans, student health insurance coverage
  - **Does NOT include Medicare Advantage, managed Medicaid, health reimbursement arrangements, plans with reference-based pricing, health-sharing ministries, short-term limited-duration insurance, retiree-only plans, Indian Health Services, Veterans Affairs Health Care, or TRICARE.**

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Applicable Services – Emergency

Define:

"Emergency services" include necessary post-stabilization services (admission, observation) as determined by treating physician.

(e.g., whether patient can be moved to another facility using non-medical transport)

Emergency services furnished at OON facility (by *facility and providers*)

Emergency services furnished by OON providers at in-network facility

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Applicable Services – Non-Emergency

- **Does** apply to the following Ancillary Services furnished by OON provider at in-network facility (no notice/consent option)
  - Emergency medicine, anesthesia, pathology, radiology, neonatology
  - Assistant surgeons, hospitalists, and intensivists
  - Diagnostic services (radiology and lab)
  - Items or services furnished in response to unforeseen, urgent medical needs
  - Items or services provided by OON provider if there are no in-network providers who can furnish the item or services at the facility
- Does **NOT** apply to non-emergency services at OON facility
- Does **NOT** apply to other services furnished by OON provider, *BUT ONLY IF* advance notice to and written consent from patient
  - Surgeons
  - Consulting physicians?

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Patient Liability for OON Services

- Provider cannot charge patient more than in-network cost-sharing amount.
  1. If All-Payer Model Agreement applies – this is first payment recourse
  2. Other state regulations is next level of priority, *if they apply*
  3. If 1 and 2 do not apply, Federal rules for calculation of Qualifying Payment Amount (QPA) (Federal)
  - Plan's median in-network rate paid for same or similar service in specific geographic area as of *1/31/2019 adjusted by CPI-U* (*Special rules for new plans/services*)
    - **QPA Example:** 2022; CPI-U = 1.0648523983; median rate at 1/31/2019 was $200; then 2022 QPA would be $213 (round to nearest dollar)
    - **Patient Liability example:** QPA = $213; patient's cost sharing = 20% of charges; then provider could not charge patient > $42.60
  - Payer furnishes QPA to provider with initial payment/denial – **the initial payment is *not necessarily* the QPA**:
    - Payer required to certify that QPA is compliant with regulatory requirements
    - Disclose whether payer **downcoded** service(s) listed on claim
  - If yes, must also provide QPA for service(s) listed on claim as well as downcoded CPT

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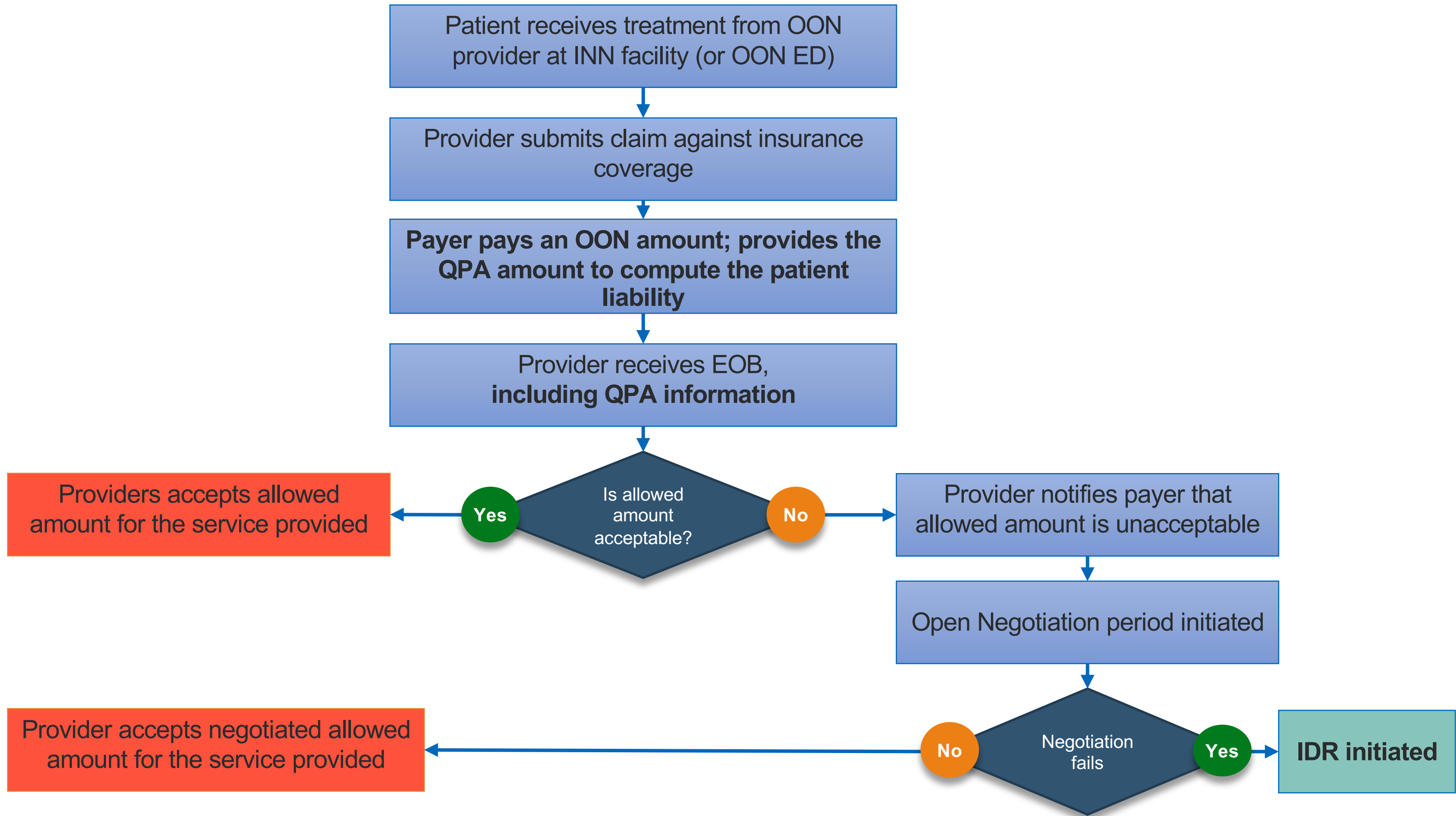
IDR Process Flow



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QPA Challenges

- **No payment benchmark established in legislation.**
- **Regulation issued in October 2021 established a rebuttable presumption in the IDR process that the QPA was the appropriate OON rate.**
- **Numerous litigation pursued – Texas Medical Association, AHA, AMA, etc.**
  - Decision 2/23/22 in Texas Medical Association (“TMA”) case found that ***interim final rule,*** related to QPA, violated the ***Administrative Procedures Act***
    - Substantially rewrote the NSA in creating a presumptive out-of-network rate
    - Court also found that issuing Departments not justified in skipping regular notice and comment rulemaking process
- New case filed by the TMA on September 22, 2022 challenging the final August 2022 rule

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ESTABLISHMENT OF THE QPA

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QPA – Importance to the Federal IDR Process

- **IDR** starts at the **QPA**.
- QPA calculation (specified in the regulations), by the payer, for each service (CPT), and geographic region (insurance market).
- If provider assesses QPA insufficient – must develop a **credible case** to persuade IDR entity. ***Challenging*** *and currently* ***prone to delay***.
- Provider ("Initiating Party") must follow **strict timeline** - open negotiations, notification and submission – ***risk of IDR submission deemed as ineligible****.*
- Likely that the QPA remains the <u>single largest influence</u> on the IDR decision.
- **In considering an IDR Submission** – provider must understand what the QPA is, how it was calculated, how to ask for additional details from the payer, and how important it is to challenge the QPA.
- If claim is "**downcoded"** by payer, payer must provide QPA on the original coded claim and the downcoded claim.

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QPA – July 2021 Interim Rule (*Defines the QPA*)

- The July 2021 Interim Final Rule QPA definition stands as the main reference in all IDR rules – even from August 2022 rules

QPA is the **median** of the **contracted rates** of the plan or issuer for the item or service in the **geographic region**:

- **QPA** is the **median of the contracted rates**…on January 31, 2019…same or similar item or service…in a **geographic region**…**service is furnished**, **increased for inflation**.
- The **median contracted rate**…**all group health plans**…or…**group** or **individual health insurance**…**same insurance market**…
- NSA specifies an **alternative methodology** for…QPA …insufficient information to calculate a median contracted rate…these alternative methodologies, such as use of a **third-party database**…only **limited circumstances**…

  - *Example: For 2022; CPI-U = 1.0648523983; median rate as of 1/31/2019 was $200; then 2020 QPA would be $213 (round to nearest dollar)*

- Source: Federal Register DHHS – 45 CFR Parts 144, 147, 149 and 156 – Requirements Related to Surprise Billing – part 1 – 7/13/21

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QPA - October 2021 Interim Final Rule

- Buried in the rules – unclear if the payer must provide provider with practice size, specialty, or type used in the QPA calculation. This information required to be provided to the IDR entity and not necessarily shared with the provider.
- The case against the QPA must be credible.

The October 2021 interim final rules also require **parties** to provide certain information to the certified IDR entity, including **practice size and practice specialty or type**; **geographic region** used to calculate **QPA**; **for applicable year for the same or similar item or service**…

…must **consider credible additional information** submitted…. that relates to the parties' offers and the qualified IDR item … subject of a payment determination to determine … information submitted **clearly demonstrates that the QPA is materially different** from the appropriate out-of-network rate…

- Source: Federal Register DHS – 45 CFR Part 149 – Requirements Related to Surprise Billing – 8/26/22

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QPA - Latest Rules, Guidance for IDR Entities August 2022

- There is information that should be **provided with the original payment**, or that can be requested – but it is limited, as shown below:

Disclosures **required to be made with the initial payment** or notice of denial of payment or **upon request.** Plans and issuers must provide following information regarding QPA to OON providers, OON emergency facilities…where recognized amount…with respect to an item or service furnished by the provider …is **the QPA**.

  - The QPA for each item or service involved.
  - Statement certifying…QPA applies…and each QPA was determined in compliance with the methodology…in…**July 2021 interim final rules**
  - Statement…if the provider…wishes to initiate a 30-day open negotiation period…provider or facility may contact the appropriate person or office to initiate open negotiation…
  - **Contact information, including a telephone number and email address**, for the appropriate person…
- **Upon request** of the provider…the plan…must provide…timely:
  - Whether QPA…included contracted rates…not on a fee-for-service basis… and whether QPA…determined using underlying fee schedule rates or a derived amount
  - If a **related service** code…used to determine QPA for new service code, information to identify the related service code
  - If plan…used an **eligible database** to determine the QPA, information to identify database used
  - If applicable, statement that plan's…contracted rates include risk-sharing, bonus, or other **incentive-based** or retrospective payments or payment adjustments for covered item…excluded for…calculating QPA

- Source: Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities – August 2022

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QPA - Latest Rules, August 2022 Final Rule

- Provider can request additional information, but payer is not obliged to furnish details of the QPA calculation, the contracted entities used, or the range of rates from which the median rate is identified:

Therefore, 87 Fed. Reg. 52,618 (Aug. 26, 2022) require…plans…make… disclosures about QPA with each initial payment or notice of denial of payment…plans…**provide certain additional information upon request**….This information **must be provided in writing**…on paper or electronically.

With an initial payment or notice of denial of payment, a plan…must provide QPA for each…service involved as well as a statement **certifying** that, based on the determination of the plan…

1. QPA applies
2. Each QPA shared with the provider … was determined in compliance with the methodology outlined in the **July 2021 interim final rules**.

- Source: Federal Register DHS – 45 CFR Part 149 – Requirements Related to Surprise Billing – 8/26/22

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QPA Latest Rules, August 2022 Final Rule

- Rules require IDR entity to select QPA **unless provider provides credible evidence** that QPA is wrong and does not reflect intent of the NSA statute. Evidence must credible. Not an easy hurdle to define or reach.
- Providers that submit IDR without a credible case to challenge the QPA are unlikely to win.
- There is other IDR submission information specified in IDR guidance, but undermining the credibility of the QPA is key to IDR success

> …the certified IDR entity **must select offer closest to QPA**, unless certified IDR entity determined **credible information** submitted…clearly demonstrates…**QPA is materially different from the appropriate out-of-network rate**…
>
> …to the extent QPA **calculated**…**consistent with detailed rules** issued under the July 2021 interim final rules and communicated in a way that satisfies…disclosure requirements, **QPA will meet the credibility requirement**.

- Source: Federal Register DHS – 45 CFR Part 149 – Requirements Related to Surprise Billing – 8/26/22

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OVERVIEW OF THE IDR PROCESS

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IDR Steps and Timelines

Step in the Process	Must Be Completed By
Payer sends provider initial payment or notice of denial of payment along with **QPA**	**30 business days**, starting on day payer receives all relevant data
Provider initiates 30-business-day open negotiation period	**30 business days**, starting on day of initial payment or notice of denial of payment
Either party initiates IDR following failed open negotiation (*federal IDR portal*)	**4 business days**, starting business day after the open negotiation period ends (IDR Initiation Date)
Mutual agreement on certified IDR entity selection; each party pays **$350** administrative fee	**3 business days** after IDR Initiation Date
Departments select certified IDR entity in case of no conflict-free selection by parties	**6 business days** after IDR Initiation Date (IDR Entity Selection Date)
Parties submit payment offers and supporting information to certified IDR entity (*with IDR entity fee – between **$200 and $938***)	**10 business days** after IDR Entity Selection Date
IDR entity issues written decision accepting one party's offer	**30 business days** after IDR Entity Selection Date
Payment made to provider (if successful); refund of successful party's IDR entity fee	**30 business days** after payment determination

"Baseball-Style" arbitration

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IDR Decision Process

- IDR entity considers QPA and then required by rules to consider other information submitted in support of the IDR:
  - ✓ Provider's training, experience, and quality and outcomes measures
  - ✓ Provider's or plan's **market share** in relevant geographic region
  - ✓ Patient acuity or complexity of furnishing the item/service ***(cannot double count!)***
  - ✓ Demonstration of good faith efforts (or lack thereof) made by provider or plan to enter into network agreements, … if applicable, parties' contracted rates during **previous 4 plan years**
  - ✓ Additional relevant and credible information BUT NOT usual & customary charges or Medicare/Medicaid reimbursement rates
- IDR's written decision must include explanation of information on which it relied in accepting one offer over other.

Assume – high market share justifies higher rates – but that is ***not defined***

Acuity/complexity is implied in many codes – this must be exceptional for the CPT code in question

If Provider was INN at acceptable rate, then termed by Payer in alignment with NSA timing – may be compelling for provider case

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INITIAL LEARNINGS/TRENDS

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IDR Initial Learnings – Payer Perspective

- NSA/IDR can be used as leverage by payers to reduce cost
- Payers are targeting in-network hospital-based providers (emergency medicine, radiology, anesthesia, neonatology, etc.) to reduce rates or face the IDR process with an OON provider
- Payers are frequently using “ghost” rates to lower the QPA

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IDR Initial Learnings – Provider Perspective

- OON providers have lost a revenue source given the restriction to balance bill
- OON providers are reviewing their OON rates to ascertain whether the QPA would increase their reimbursement
- In-network rates may vary based on provider structure (employed v. independent)
- Payers are using “ghost” rates to lower the QPA
- In network providers may be a target by Payer to reduce rates

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IDR Initial Learnings – Governance/Operations

- Federal and State processes in development – variability, uncertainty, and lack of clarity
  - Payers not consistently providing the required QPA information
  - Delays in the IDR review process (April 15 – December 5)[1]
    - **Total cases filed –** 164,000 (projected 17,500 for 2022)
    - **Cases challenged for eligibility** - 68,000 (~40%)
    - **Cases rejection by Arbiters as ineligible - 23,000 cases** (~15%)
    - Some Federal IDR entities are **no longer accepting new cases**
  - More than 90k claims filed between 4/15/22 – 9/30/22[2]
    - Leading non-initiating payers: UHC (24%); Aetna (11%); MultiPlan (11%); Elevance/Anthem (10%)
    - Leading initiating parties: SCP Health (32%); R1 RCM (11%)

[1] per HFMA Health Plan Payment and Reimbursement article dated 12/30/22
[2] per Beckers Payer Review 1/3/23

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IDR Initial Learnings – Governance/Operations

- Texas Medical Association has filed 3 lawsuits challenging the IDR process
- On 10/19/22, AHA and AMA along with 30 additional national and state medical groups filed amicus briefs in support of the TMA's most recent lawsuit.
- Likely that the QPA remains the single largest factor in the IDR decision
- IDR process fees have increased in 2023

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IDR Initial Learnings – “Ghost Rates”

- **Definition**
  - Includes contracted providers that may never (or rarely) deliver the same service – these are the “ghost rates” (or exclude high rates)
- **Impact**
  - Payer may use low Ghost Rates to calculate the QPA – bending cost down (or exclude high rates)
  - The payer is required to provide information concerning the QPA upon request
  - The QPA is key consideration in determining the outcome of the IDR
  - QPA is required to be “credible” and related to the services within the IDR – calling out Ghost Rates may be a way for providers to challenge the QPA calculation
    - It is in the payer’s interest to weight the median by including lower cost contracted providers
    - Providers understand the local market and can identify “similar” providers who should be included in the QPA and can identify providers who should be excluded.
    - If the provider can identify ghost rates and indicate they are artificially skewing the median rate, provider may be able to claim that the QPA median rate is not credible and should not be used as the IDR determinant
    - No requirement for a weighted average of rates – payer advantage to load median calculation with low rates
    - Ghost rates may include “excluded” products – statute calls for Group Health Plans or Individual plans

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IDR Initial Learnings – Case Studies

- Develop record keeping system to support IDR process:
  - Must gather all payer/provider communications to challenge the payer's effort to negotiate in good faith (claim- and network-level).
- Variability observed in OON allowed rates (QPA) – fluctuate with member's benefits and third-party payment vendor used.
- File open negotiation period notices according to IDR timeline:
  - Key contact details for each party required by Federal rules with QPA.
- Some payers are utilizing third parties to handle OON QPA claims (Zelis, Naviguard).
- Goal should be to secure an in-network agreement at acceptable, market rates.

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POTENTIAL IDR STRATEGIES

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High-Level IDR Strategies

- ✓ Secure INN Agreement – avoid the need for IDR
  - Especially if close to a deal – better use of resources, less risk
- ✓ Determine if federal or state IDR process applies
  - Must know the rules, timing and regulations that apply to your case
- ✓ Engage allies – such as Hospital, state officials
  - Highlight essential service and risk if lose IDR
- ✓ Build out a timeline for best case and cash flow impact
  - Determine resources and skills to file and defend IDR cases
- ✓ Consider continuing to accept QPA rates at OON
  - INN at low rates deflates market position – OON keeps low rates out of market
- ✓ Determine and weigh options if you lose your case
  - Insufficient case law available to predict outcomes

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IDR Strategies and Consideration

Offense	Defense
• Use IDR process to increase OON rates or secure in-network agreement • Undermine the QPA, cast doubt on its credibility and applicability to the services supplied • Highlight inconsistencies (rate, response, etc.) – did payer follow QPA rules? • Highlight lack of responsiveness and good faith negotiations	• Be prepared for payer tactics to lower in-network rates • Keep negotiating • Start IDR offer at a defensible position that matches the intent of the QPA • Be prepared to settle if IDR is likely to lose – negotiated rate may be better than IDR loss • Exercise your rights to not accept the IDR entity proposed by the payer

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NSA and IDR Tactical Preparation

- ✓ Request the payer to show their computation of the QPA.
  - They are required to provide on request.
- ✓ Do not refer to the negotiation amount as a percentage of charges or percentage of Medicare… Prohibited!
- ✓ Research rates/market:
  - Own current in-network commercial rates v. OON paid rates, by payer, plan type
  - Research public sites for in-network rates for your region for similar services
  - Market size and market standing – try to define the market geography
- ✓ **Keep great records!** Track timelines, follow rules.
- ✓ Challenge downcoding.

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