HEALTHCARE REGULATORY ROUND-UP - Episode #48

# No Surprises Act: Real World Impacts

May 10, 2023

# Introductions

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# No Surprises Act – History

- **Before 2021**
  - 33 states had some version of surprise billing protections for state-regulated plans
- **Consolidated Appropriations Act, 2021**
  - Prohibit “surprise” billing and replace with new payment methodology
    - Patients through no fault of their own receive services from out-of-network (OON) provider
  - Require providers to furnish good faith estimate (GFE) of charges to self-pay patients
- **Implementing regulations**
  - *July 2021* interim final rule (surprise billing, independent dispute resolution (IDR) process)
  - *October 2021* interim final rule (GFE)
  - *August 2022* final rule (changes to IDR process)

# Surprise Billing - Application

## 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
- **Air ambulance**
  - President's proposed budget includes expanding NSA to ground ambulance

## Health Insurance Issuers and Health Plans

- **Group coverage**
  - Insured and self-insured plans, ERISA plans, Federal Employee Health Benefits plans, other government plans, church plans, traditional indemnity plans
- **Individual coverage**
  - Exchange and non-exchange plans, student health insurance coverage
- **Does NOT include**
  - Medicare, Medicaid, CHIP, TRICARE, health reimbursement arrangements, health-sharing ministries, short-term limited-duration insurance, retiree-only plans
  - Surprise billing rules apply to plans with reference-based pricing (i.e., no network) but only for claims involving emergency services

# Emergency Services

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

Emergency services furnished by OON providers at in-network facility

- **Emergency Services -**
  - Defined by ‘prudent layperson’ standard
  - Includes necessary post-stabilization services as determined by treating physician
    - Whether patient can be moved to in-network facility using non-medical transport

# Non-Emergency Services

**Does NOT apply** to non-emergency services at OON facility

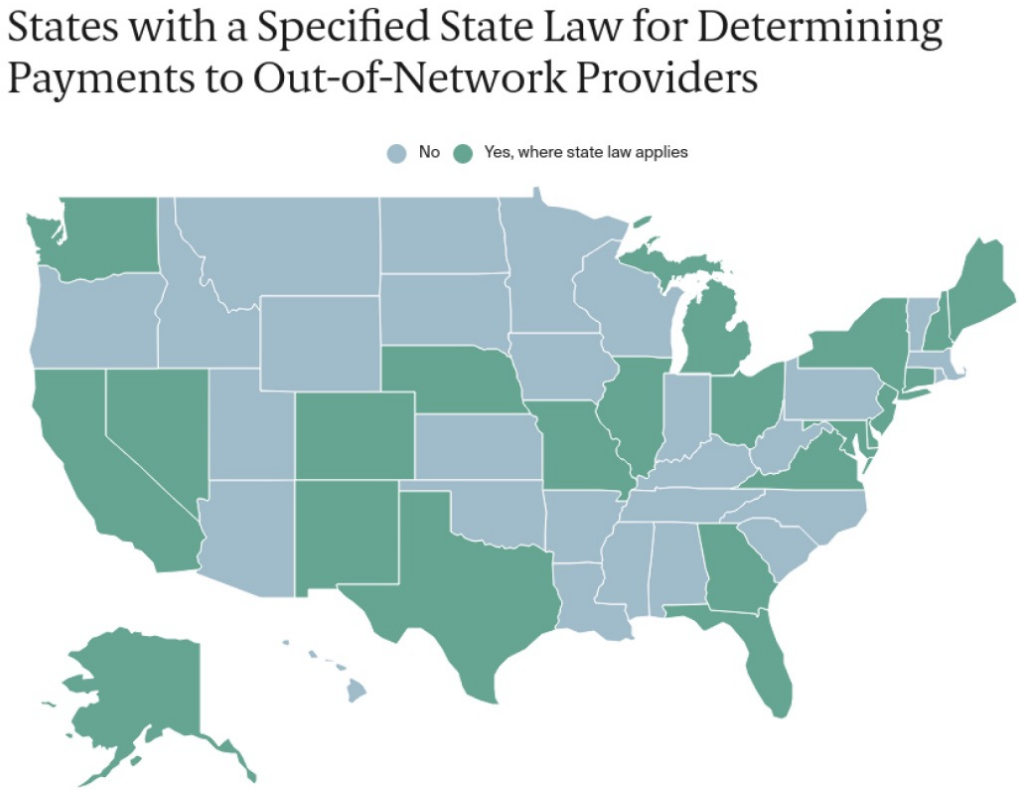
**Does apply** to following services furnished by OON provider at in-network facility

- 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 other services furnished by OON provider **BUT ONLY IF** advance notice to and written consent from patient

# Patient Charges

- Cannot charge patient more than in-network cost-sharing amount
- Calculated based on –
  - All-Payer Rate System (Maryland)
  - Specified State Law
    - 22 states
    - But only to extent state law applies
      - Fully-insured vs. self funded
      - Type of service
      - Location of plan or provider
  - Qualifying Payment Amount (QPA)




Commonwealth Fund – No Surprises Act: Federal-State Partnership Protect Consumers

# QPA Calculation

- QPA for given item or service is generally the median contracted rate on January 31, 2019, for the same or similar item or service, increased for inflation
  - Special rules for new plans/services
- Median contracted rate for item or service is determined by -
  - Identifying contracted rates of all plans of plan sponsor (or of administering entity, if applicable) or all coverage offered by issuer in same insurance market for same/similar item/service furnished by provider in same/similar specialty (or facility of same/similar type) and provided in geographic region in which item/service is furnished
  - Arranging contracted rates from least to greatest and selecting the middle number (or average of middle two numbers, if even number of contracted rates).

# QPA Calculation - Litigation

- Texas Medical Association vs. Becerra (TMA III) filed in 11/22; hearing on motions for summary judgment held last month
  - Permits inclusion of “ghost rates,” i.e., rates included in contracts with providers that do not provide service (and thus have no incentive to negotiate with payer)
  - Permits QPA in some circumstances be based in part on rates of providers not “in the same or similar specialty,” in contravention of statutory language
  - Excludes “risk sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments” despite statute’s direction to use total maximum payment
  - Permits self-funded plan to have its TPA calculate QPA using contracted rates recognized by all self-insured plans administered by TPA despite statute’s requirement that each plan sponsor use only its own contracted rates

# Provision of QPA

- Plan furnishes QPA to provider with initial payment/denial notice
  - Must send within 30 calendar days after receipt of clean claim
- Plan also must provide -
  - Certification of compliance with regulatory requirements in calculating QPA
  - Disclosure of whether plan downcoded service(s) listed on provider's claim
    - If yes, must also provide QPA for service(s) listed on claim
  - Statement regarding initiation of open negotiation period
  - Contact information for appropriate person/office to initiate open negotiation period
- "[P]lans and issuers are not obligated to demonstrate that a QPA was calculated in accordance with [regulatory ] requirements. . . unless required to do so by an applicable regulator. Providers … with concerns about a plan's or issuer's compliance … may contact the No Surprises Help Desk at 1-800-985-3059, submit a complaint [via CMS website*], or contact the applicable state authority"

*https://www.cms.gov/nosurprises/policies-andresources/providers-submit-a-billing-complaint

# OON Rate – Open Negotiation Period

- If provider not satisfied with plan's response, may initiate 30-business day open negotiation period
  - Process must be initiated within 30 business days starting on day provider receives initial payment/ notice of denial
  - If plan ≠ include required disclosures, provider may request extension due to extenuating circumstances by e-mailing FederalIDRQuestions@cms.hhs.gov
- To initiate, provider sends notice to plan that includes claim information and offer for OON rate
  - Standard Open Negotiation Notice available at

https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-part-ii-information-collection-documents-attachment-2.pdf

- If no resolution after 30 business days, may pursue formal dispute resolution process

# Federal vs. State Process

- Federal independent dispute resolution (IDR) process applies to disputes involving self-funded plans + Federal Employees Health Benefits (FEHB) plans
  - Except in **Georgia, Maine, Nevada, New Jersey, Virginia, and Washington**, where state law permits self-funded plan to opt into state process
  - Except in cases where government contract with FEHB carrier adopts state process
- State law process determines OON rate in disputes involving fully-insured plans in the following states (exceptions apply)
  - **California, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Maine, Maryland, Michigan, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Texas, Virginia, Washington**
- If state law applies to specific item or service, that claim is not eligible for federal IDR process

# Federal IDR Process

| Step in the Process | Must Be Completed By |
|---|---|
| Following failed open negotiation, either party may initiate IDR process by sending Notice of IDR Initiation to Departments through https://www.nsa-idr.cms.gov and to other party (electronically or by paper if requested); use standard notice and list preferred certified IDR entity (CIDRE) | **4 business days**, starting business day after the open negotiation period ends |
| Non-initiating party agrees or objects to initiating party's preferred CIDRE (assume agreement if no response) | **3 business days** after IDR initiation date (i.e., date Departments received notice) |
| Initiating party notifies Departments of (a) selection of CIDRE, or (b) failure to agree to CIDRE; non-initiating party submits reasons federal IDR process not applicable (if appropriate) | **4 business days** after IDR initiations date |
| Departments select CIDRE (if applicable) | **6 business days** after IDR initiation date |
| Selected CIDRE submits to Departments an attestation that it does not have a conflict of interest and determines matter is eligible for federal IDR process* | **3 business days** after date of CIDRE selection |
| Parties submit payment offers and required data elements to CIDRE with (1) $350 administrative fee (up from $50 in 2022), and (2) CIDRE fee (between $350 and $700; higher for batched determinations**); failure to pay fees results in CIDRE accepting other party's payment officer | **10 business days** after date of CIDRE selection |
| IDR entity issues written opinion accepting one party's offer | **30 business days** after date of CIDRE selection |
| Payment made to provider (if successful); CIDRE fee refunded to prevailing party | **30 business days** after payment determination |
| Cooling off period - initiating party cannot submit a subsequent Notice of IDR Initiation involving the same party with respect to a claim for the same or similar item or service that was the subject of the initial Notice of IDR Initiation. | **90 calendar days** after payment determination |

*Additional information regarding eligibility for the federal IDR process and batching claims available at https://www.cms.gov/files/document/TA-certified-independent-dispute-resolution-entities-August-2022.pdf

# Standard Notice of IDR Initiation

**[INFORMATION TO BE COMPLETED BY THE INITIATING PARTY]**

1. **Initiating party is (check one):** ☐ **Plan** ☐ **Issuer** ☐ **FEHB Carrier** ☐ **Health care provider** ☐ **Health care Facility** ☐ **Provider of air ambulance services**

2. **Qualified IDR Item(s) or Service(s)** [insert additional rows as appropriate]

| | Description of qualified IDR item(s) or service(s) | Claim Number | Batched (Y/N) | Date of item(s) or service(s) | Location where item(s) or service(s) were furnished (include state) | Service code(s) | Place-of-service code(s) | Type of qualified item(s) or service(s) | Qualifying Payment Amount | Cost Sharing Amount Allowed | Initial Payment Amount for the item(s) or service(s), if applicable |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. | | | | | | | | | | | |
| 2. | | | | | | | | | | | |
| 3. | | | | | | | | | | | |
| 4. | | | | | | | | | | | |
| 5. | | | | | | | | | | | |

3. **Group Health Plan/Health Insurance Issuer/FEHB Carrier Information**

Name of Plan/Issuer/Carrier: _____

Type of Plan (select one):

- ☐ Federal Employees Health Benefits (FEHB) plan:
  If FEHB plan, enter 3-digit Enrollment Code: _____
- ☐ Individual health insurance plan
- ☐ Non-federal governmental plan (i.e., state and local government plan)
- ☐ Church plan
- ☐ Private employment-based group health plan (i.e., an ERISA plan)
  If ERISA plan, is the ERISA plan self-insured? Y/N _____
- ☐ Unknown

**Contact Information**

Contact Person's Name: _____

Contact Organization Name if not the same as the Plan/Issuer/Carrier: _____

Address: _____

Phone Number: (_____)_____ Fax Number: (_____)_____

Email Address: _____

4. **Health Care Provider/Health Care Facility/Provider of Air Ambulance Services Information**

Provider or Facility Name: _____

National Provider Identifier (NPI): _____

**Contact Information**

Contact Person's Name: _____

Contact Organization if the name is not the same as the Provider or Facility: _____

Address: _____

Phone Number: (_____)_____ Fax Number: (_____)_____

Email Address: _____

5. **Indicate the commencement date of the open negotiation period:**

_____

6. **Indicate the preferred certified IDR entity (specify the name and certified IDR entity number):**

_____

7. **Is the undersigned individual below in line 8 a third party administrator or other service provider initiating on behalf of the plan, issuer, carrier, or Health Care Provider/Health Care Facility/Provider of Air Ambulance Services?** ☐ **Yes.** ☐ **No.**

8. **ATTESTATION:**

__ I, the undersigned initiating party (or representative of the initiating party), attests that to the best of my knowledge the preferred certified IDR entity does not have a disqualifying conflict of interest and that the item(s) and/or service(s) at issue are qualified item(s) and/or service(s) within the scope of the Federal IDR process.

**Initiating Party (or Representative of the Initiating Party):** _____

**Print Name:** _____ **Date:** _____

https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-part-ii-information-collection-documents-attachment-3.pdf

# 600% Increase In Administrative Fee?

- In October 2022, federal agencies announced administrative fee would remain at $50 for 2023, but then increased fee to $350 “due to supplemental data analysis and increasing expenditures in carrying out the Federal IDR process ….”
- TMA filed lawsuit on 01/30/23 challenging 600% increase (TMA IV)
  - “…effectively closes the door to IDR for many out-of-network physicians with small-value claims, threatening the viability of their practices and ultimately placing patient health at risk”
- Lawsuit also challenges regulatory limits on batching claims
  - Statute permits batching if services are “related to the treatment of a similar condition,” while regulation permits batching only if services are “the same or similar items or services” i.e., “if each is billed under the same service code”
- Secretary Becerra’s testimony during March 22 Senate Finance Committee hearing: “What we’re finding is that…way too many [claims in the IDR process] are frivolous because there’s no cost to file a claim….”*

* https://www.finance.senate.gov/hearings/the-presidents-fiscal-year-2024-health-and-human-services-budget (start at 1:25)

# Federal IDR Process – Year 1

- Between 04/15/22 and 03/31/23, 334,828 disputes were initiated through federal IDR portal
  - 14 times higher than Departments had estimated
  - Non-initiating parties challenged eligibility of 122,781 disputes (37%)
- CIDREs closed 106,615 disputes as of 03/31/23 (32%)
  - Rendered payment determinations in 42,158 disputes (40%)
    - Initiating party prevailed in 71% of these disputes
  - Determined 39,890 disputes not eligible for federal IDR process (37%)
  - Closed remaining 24,567 for other reasons (23%) (parties reached settlement, unpaid fees)

Federal Independent Dispute Resolution Process –Status Update (April 27, 2023), available at https://www.cms.gov/files/document/federal-idr-processstatus-update-april-2023.pdf

# Eligibility for Federal IDR Process

- Potential issues
  - State vs. federal jurisdiction
  - Correct batching and bundling
  - Compliance with applicable time periods
  - Completion of open negotiations
- Q4 2022 data
  - Non-disputing party challenged eligibility in ~40% of initiated disputes
  - Of the 13,022 disputes closed during the quarter, 64% ultimately found ineligible for federal IDR process
- Process improvements
  - Beginning in November 2022, Departments began using contractors and government staff to assist with pre-eligibility reviews
  - Revisions to standard notice of IDR initiation

# CIDREs – What Constitutes a "Dispute"

- CIDRE gave ED physician 48 hours to provide DRG for service in dispute
- Doc responded that it was ED only claim (no admission)
- CIDRE replied dispute must be resubmitted to dispute every CPT/line on claim separately
  - $350 fee to dispute each separate service
  - As noted, latest TMA litigation addresses "batching"
    - Statute allows batching for all treatments/procedures in patient's treatment plan/episode of care – those "related to the treatment of similar condition"
    - Regulations allows only services billed under same service code
    - "…a single radiology encounter between one radiologist and one patient can lead to a half dozen or more different claims, all of which must be submitted and reviewed separately in IDR…."

# CIDRE Determinations

- NSA statute - directs CIDRE to consider QPA and then consider other information submitted by parties
  - Provider's training, experience, and quality and outcomes measures
  - Provider's or plans' market share in relevant geographic region
  - Patient acuity or complexity of furnishing the item/service
  - Demonstration of good faith efforts (or lack thereof) made by provider or plan to enter into network agreements with each other, and, 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
  - Additional factors for air ambulance providers (e.g., vehicle type, population density, of point of pick-up)

# Federal IDR Litigation – TMA I

- Lawsuit filed in 10/22
  - Alleged July 2021 Interim Final Rule  unlawfully required CIDREs to “rebuttably presume” offer closest to QPA was the appropriate OON rate
  - District court ruled in TMA’s favor in 02/22
- In response, Departments published August 2022 Interim Final Rule
  - IDR entity must consider QPA plus all additional information submitted by each party
    - Requires IDR entity to select QPA unless the provider provides credible evidence that QPA is wrong and does not reflect intent of the NSA statute
    - Cannot “double count” in the case of other submitted information
  - Require IDR entity to explain payment determination
    - Written decision submitted to Departments, provider, and payer

# *More* Federal IDR Litigation –TMA II

- Lawsuit filed in 09/22
  - Claims August 2022 rule still requires too much deference to QPA
  - District court ruled in TMA's favor on 2/6/23
    - Revised IDR process "continues to place a thumb on the scale" in favor of insurers and "that the challenged portions of the final rule are unlawful and must be set aside"
  - HHS appealing decision (rather than publishing revised regulations)

# CIDRE Determinations – CMS Guidance

- **10/7/22 Guidance for Disputing Parties**
  - Services furnished before 10/25/2022
  - https://www.cms.gov/files/document/federal-independent-dispute-resolution-guidance-disputing-parties.pdf
- **10/31/22 Guidance for Disputing Parties**
  - Services furnished on/after 10/25/2022, payment determination made before 2/6/2023
  - https://www.cms.gov/files/document/rev-102822-idr-guidance-disputing-parties.pdf
- **3/17/23 Guidance for Disputing Parties**
  - Services furnished on/after 10/25/2022, payment determination made on/after 2/6/23
  - https://www.cms.gov/files/document/federal-idr-guidance-disputing-parties-march-2023.pdf
  - Eliminates language from prior documents concerning evaluation of credible evidence and avoidance of double-counting information that is already accounted for by QPA/other information submitted by parties

# Claims By CPT Codes (2022)

| CPT Codes | CPT Type | # of Disputes |
|---|---|---|
| 99281 – 99288 | Emergency Department Services | 119,338 |
| 70010 – 79999 | Radiology | 22,595 |
| 00100 – 01999 | Anesthesia | 13,353 |
| 95700 – 96029 | Neurology & Neuromuscular Procedures | 9770 |
| 10004 – 69990 | Surgery | 8,290 |
| 99291 – 99292 | Critical Care | 5,835 |
| 80047 – 89398 | Pathology and Lab | 4,478 |
| 99217 – 99226 | Hospital Observation | 2,435 |
| 99221 – 99239 | Hospital Inpatient | 2,399 |
| 99466 – 99480 | Inpatient Neonatal Intensive Care & Pediatric and Neonatal Critical Care | 1,430 |

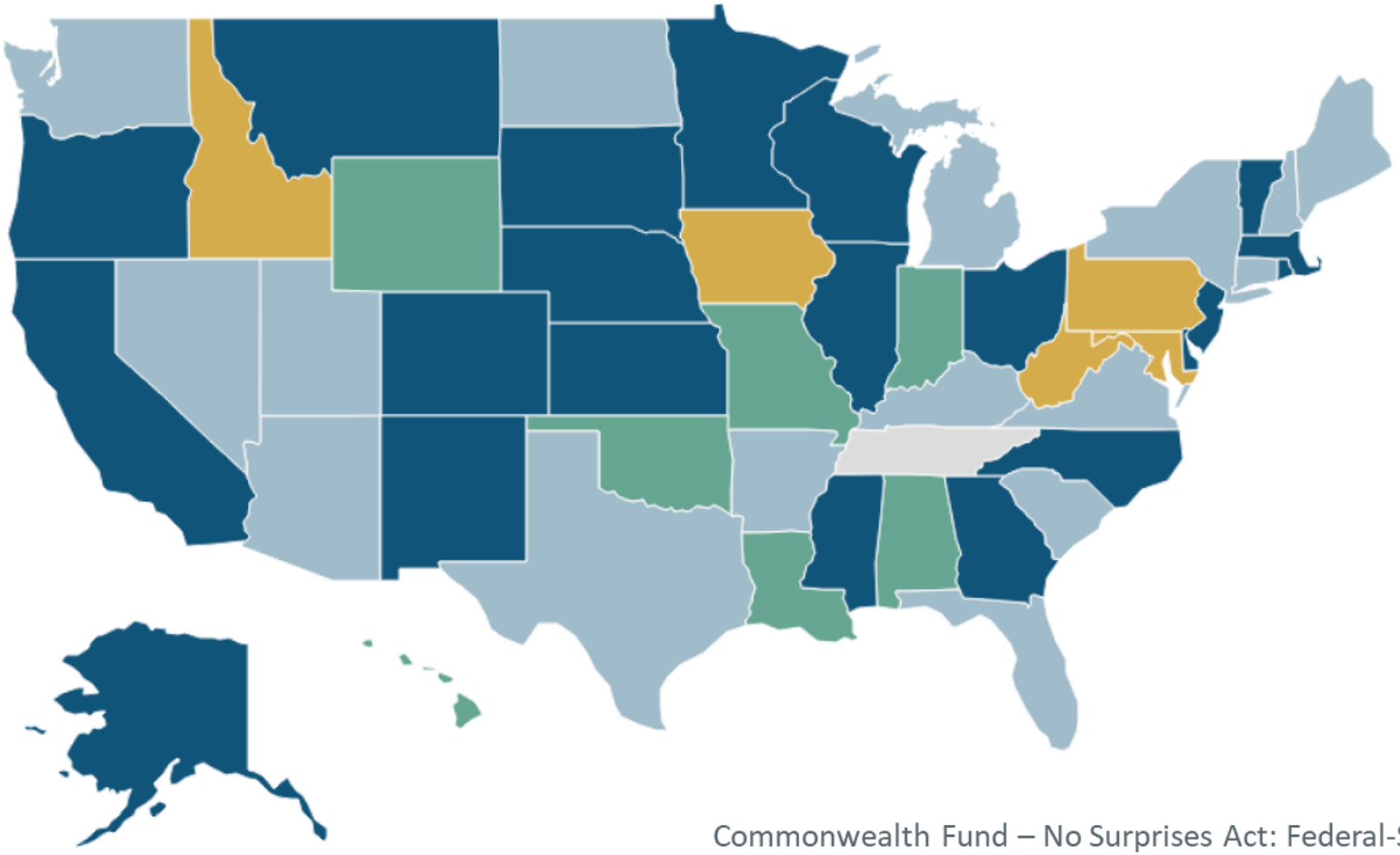
# Claims By Payer - 2022

| Non-Initiating Party | # of Disputes |
|---|---|
| United Healthcare | 46,549 |
| Aetna | 27,759 |
| MutliPlan | 20,739 |
| Anthem | 19,352 |
| Cigna | 15,339 |
| Florida Blue | 7,467 |
| BlueCross BlueShield of Illinois | 7,369 |
| BlueCross BlueShield of Tennessee | 5,171 |

# Impact on Payer Negotiations

- Payers less interested in maintaining expansive provider networks
- Payers targeting in-network hospital-based providers (ED, anesthesia, radiology, etc.) to reduce contracted rates or face IDR process as OON provider
  - Presenting providers with artificially low QPAs
- Staffing companies no longer benefit from pre-NSA strategy of remaining OON and setting high charges to take advantage of self-funded plans with generous OON reimbursement
  - Impact on hospitals with which these companies contract?

# Enforcement – Federal-State Partnership

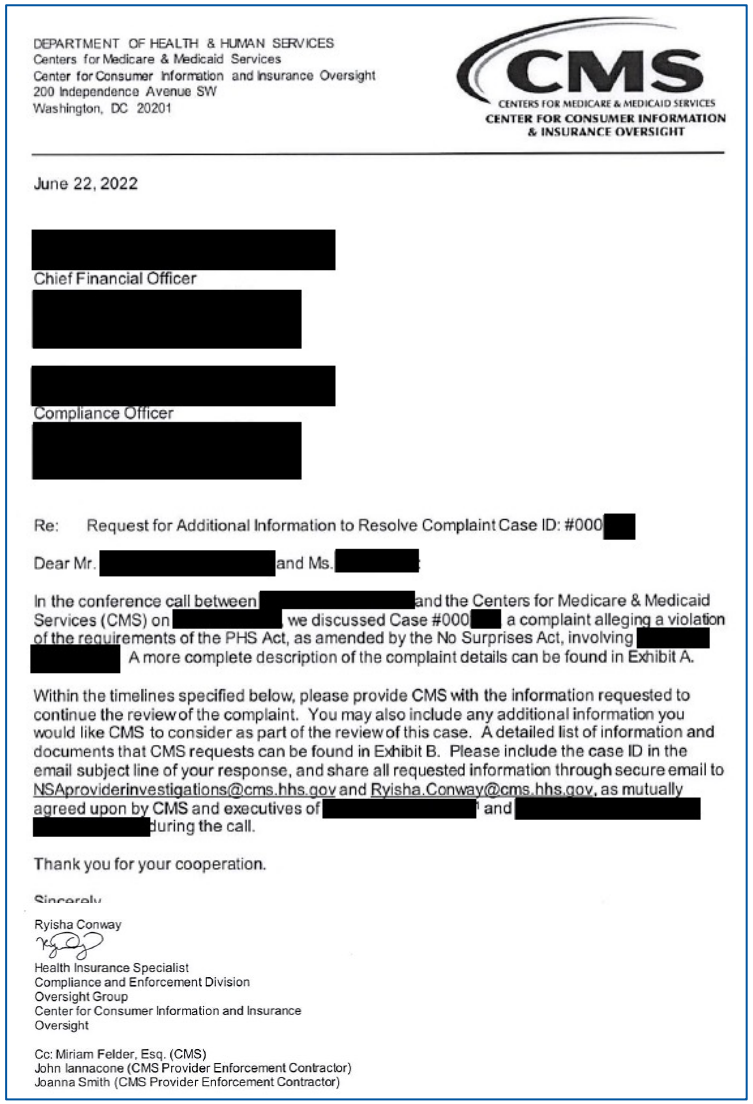


Commonwealth Fund – No Surprises Act: Federal-State Partnership Protect Consumers

Federal | Shared (collaborative) | Shared | State | Detail not yet available

# Enforcement Activity

- Hospital-based (not employed) anesthesiologist sent bill to patient for balance of claim for emergency service
- Hospital received notice and requested to provide information
  - Request came from CMS Center for Consumer Information and Insurance Oversight



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

June 22, 2022

[redacted]
Chief Financial Officer
[redacted]

[redacted]
Compliance Officer
[redacted]

Re: Request for Additional Information to Resolve Complaint Case ID: #000[redacted]

Dear Mr. [redacted] and Ms. [redacted]

In the conference call between [redacted] and the Centers for Medicare & Medicaid Services (CMS) on [redacted] we discussed Case #000[redacted] a complaint alleging a violation of the requirements of the PHS Act, as amended by the No Surprises Act, involving [redacted] A more complete description of the complaint details can be found in Exhibit A.

Within the timelines specified below, please provide CMS with the information requested to continue the review of the complaint. You may also include any additional information you would like CMS to consider as part of the review of this case. A detailed list of information and documents that CMS requests can be found in Exhibit B. Please include the case ID in the email subject line of your response, and share all requested information through secure email to NSAproviderinvestigations@cms.hhs.gov and Ryisha.Conway@cms.hhs.gov, as mutually agreed upon by CMS and executives of [redacted] and [redacted] during the call.

Thank you for your cooperation.

Sincerely,

Ryisha Conway
Health Insurance Specialist
Compliance and Enforcement Division
Oversight Group
Center for Consumer Information and Insurance Oversight

Cc: Miriam Felder, Esq. (CMS)
John Iannacone (CMS Provider Enforcement Contractor)
Joanna Smith (CMS Provider Enforcement Contractor)

# Enforcement Activity

- Within 10 days of the date of this letter:
  - Provide documentation that demonstrates the workflows HOSPITAL had in place to catch and prevent violations of the No Surprise Act balance billing prohibitions at 45 CFR §149.410 prior to receipt of the CMS notice of a Possible Violation of the Public Health Services (PHS) Act
  - Provide documentation that demonstrates the corrective actions HOSPITAL has taken in response to this complaint, including a timeline and nature of improvements to current business practices to eliminate similar complaints in the future
  - Provide documentation that demonstrates the extent of compliance to date with the requirements of 45 CFR §149.410, Balance billing in cases of emergency services; specifically, the results of an impact analysis to determine how many individuals received emergency services from HOSPITAL since 1/1/2022 to the present and were billed amounts in excess of their in-network cost sharing amount as reflected on the payer remittance advice.

# Good Faith Estimates

- ‘Convening provider’
  - Provider responsible for scheduling primary item or service
  - Includes office visits, diagnostic testing, procedures, etc.
- Must furnish good faith estimate of total expected charges when:
  - Self-pay patient requests estimate (comparison shopping)
  - Self-pay patient schedules item/service at least 3 business days in advance
- Must include:
  - Items and services to be billed by convening provider

# GFEs – Updated FAQs

- FAQ Part 3 – December 2, 2022
  - Indefinite enforcement delay in provision of GFEs from co-providers and co-facilities
  - Need for interoperability standard for transmission of GFE data between providers
    - Potential application for HL7® Fast Healthcare Interoperability Resources (FHIR®) standard
- FAQ Part 4 – December 27, 2022
  - Addresses GFE when provider offers sliding fee discounts
    - Use of abbreviated GFE when provider does not intend to bill patient for services (with sample template)
- Trouble brewing – when discounted self-pay rate is less than patient's co-insurance if claim submitted to insurance

# Notice Requirements

- *Surprise Billing* - facilities *and* providers who furnish services in facilities must provide notice to patients of surprise billing protections
  - Standard notice available at https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf
  - Post prominently at physical location (HIPAA Notice of Privacy Practices) + post on website (link from homepage)
  - Give to each insured patient (other than 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
- *Good Faith Estimates* – facilities and procedures must provide notice to patients regarding availability of good faith estimates
  - Post prominently at physical location + post on website; standard notice available at https://www.cms.gov/files/zip/cms-10791.zip
  - Orally inform self-pay patients of GFE availability when scheduling/when questions regarding cost arise

## Our Next Healthcare Regulatory Round-Up:

# May 24 – HIPAA Update