Navigating No Surprise Billing and the Everchanging Regulatory Landscape

Lisa Shih
Toni Waldman

JANUARY 30, 2024

Agenda

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No Surprise Billing

No Surprise Billing – Background

The No Surprises Act (NSA), effective Jan. 1, 2022, established new federal protections for consumers against surprise medical bills.

- ❑ Is part of the Consolidated Appropriations Act, 2021 that amended PHSA, ERISA and Internal Revenue Code
- ❑ Builds on ACA provisions regarding emergency services
- ❑ Applies to group health plans and health insurance issuers in individual and group markets including indemnity plans

Compliance Considerations: Does NSA apply to the enrollee's plan? Then, how is enrollee impacted?

Consumers protected under the No Surprises Act

NSA requirements apply to items and services provided to most consumers enrolled in **private or commercial health coverage**, such as:

- ❑ Employment-based group health plans (both self-insured and fully insured)
- ❑ Individual or group health coverage on or outside the Federal or State-based Exchanges
- ❑ Federal Employee Health Benefit (FEHB) health plans
- ❑ Non-federal governmental plans sponsored by state and local government employers
- ❑ Certain church plans within IRS jurisdiction
- ❑ Student health insurance coverage [as defined at 45 CFR 147.145]

Compliance Considerations: Multiple enforcement authorities have jurisdiction over these plans. Do the membership and claims systems identify the different types of commercial health coverage?

Scope of Services protected under the No Surprises Act

NSA mandates that payors (group health plans and issuers) compensate non-participating providers for Emergency Services, Ancillary Services (as defined in the statute) and Air Ambulance Services in accordance with the NSA requirements

- ❑ Emergency Services
  - ➢ Screening and Stabilization consistent with EMTALA
  - ➢ Includes Post-Stabilization (part of same visit or observation stay)
  - ➢ Includes services at independent freestanding emergency department
- ❑ Ancillary Services are non-emergency services provided by a non-participating provider at participating facilities
  - ➢ Facility narrowly defined
  - ➢ Specialties are defined
- ❑ Air Ambulance Services means medical transport by a rotary wing air ambulance or fixed wing ambulance

In addition, payors must

- ➢ Provide disclosure of patient protections against balance billing
- ➢ Refine complaint and appeal process to include NSA complaints (includes external review)

Compliance Considerations: Does the claim involve services in one of these three categories?

Coverage of Emergency Services

- ❑ Without prior authorization
- ❑ Without regard to any term of condition of coverage except
  - ➢ exclusion or coordination of benefits (not inconsistent with emergency medical condition) or
  - ➢ an affiliation or waiting period
- ❑ Application of cost sharing requirements
  - ➢ In-network cost sharing based on Recognized Amount
  - ➢ Cost sharing must accumulate to in-network deductible and out-of-pocket maximum
- ❑ Visit includes technical and professional component, telemedicine, imaging, and lab
- ❑ Claim must be paid or denied within 30 days (Initial Payment)

Compliance Considerations: How does claim operations and/or the claims system(s) identify NSA eligible services and reconcile between federal and state definitions of emergency services?

Coverage of Ancillary Services

- ❑ Application of cost sharing requirements
  - ❑ In-network cost sharing based on Recognized Amount
  - ❑ Cost sharing must accumulate to in-network deductible and out-of-pocket maximum
- ❑ Pay provider directly
- ❑ Participating facility is a facility with a contractual agreement including a single case agreement
  - ❑ Hospitals and their outpatient departments
  - ❑ Critical care hospitals
  - ❑ Ambulatory surgery centers
- ❑ Includes telemedicine
- ❑ Claim must be paid or denied within 30 days

Compliance Considerations: Understanding exactly when state or federal law applies is paramount. CMS/CCIIO information is no longer publicly available.

Coverage of Air Ambulance Services

- ❑ If plan covers air ambulance services for participating providers
- ❑ Application of cost sharing requirements
  - ➢ In-network cost sharing based on Recognized Amount
  - ➢ Cost sharing must accumulate to in-network deductible and out-of-pocket maximum
- ❑ Claim must be paid or denied within 30 days

Compliance Considerations: What happens when Air Ambulance providers bill for codes other than those for medical transportation?

Balance Billing

- ❑ Generally, provider is limited to billing ONLY for cost sharing amount
- ❑ However, if provider satisfies Notice and Consent requirements, then bill only for the services listed
  - ❑ Provide qualifying notice
    - ❑ 72 hours in advance
    - ❑ Written or electronic form as elected by patient
    - ❑ Information includes description of services and good faith estimate of costs
  - ❑ Receive qualifying consent from patient or their representative
    - ❑ Capable of giving consent (based on state requirements for informed consent)
    - ❑ Must be signed
  - ❑ Exception: Provider of Ancillary Services cannot use Notice and Consent
- ❑ Provider must forego Independent Dispute Resolution (IDR) for such services

Compliance Considerations: How will the Plan identify, track, and validate compliance with provider Notice and Consent?

Calculation of Cost Sharing

- Non-Participating Provider's Compensation = Out-of-Network Rate minus Cost Sharing Amount
- Total Payment Amount = Out-of-Network Amount minus Recognized Amount
  - Out-of-Network Amount
    - Amount owed pursuant to applicable state law
    - All Payor Model Agreement Amount (Maryland, Vermont, rural Pennsylvania)
    - Initial Payment Amount or Open Negotiation Amount or IDR Amount
  - Recognized Amount
    - All-Payor Model Agreement amount (Maryland, Vermont, rural Pennsylvania)
    - Amount owed pursuant to applicable state law
    - Lesser of billed charges or Qualifying Payment Amount (QPA)

Compliance Considerations: Does state law apply? What is the correct amount of cost sharing?

Calculation of Qualifying Payment Amount

- Median of 2019 contracted rates for a code and modifier; then increase median for inflation (CPI-U)
  - Insurance market (individual, small group or large group)
  - Same or similar specialty or facility type
  - Geographic region
- Contracted rate: total amount to be paid provider for covered items and services
  - Includes indirect contracts such as PBM network, TPA or other provider network
  - Includes those in effect on Jan. 31, 2019
  - Use underlying fee schedule rates or derived amounts

*Single case agreements

*Risk sharing, bonus and other compensation adjustments

Compliance Considerations: Monitoring changes to plans and products offered as well as new covered services and annual updating to increase QPA schedule by application of CPI-U. CPI-U increase is announced in August.

Notice to Provider / Facility and Open Negotiation

- With Initial Payment or notice of denial, when the Recognized Amount is the QPA, payor must disclose
  - The QPA for each item or service
  - A statement certifying (1) the QPA applies for purposes of the Recognized Amount and (2) QPA comports with required methodology
  - A statement informing the provider/facility about their right to initiate Open Negotiation and then IDR
- Open Negotiation
  - Within 30 business days of receipt of Initial Payment or Denial, provider may commence Open Negotiation period by sending standard form to payor
  - 30 business day period for payor and provider to negotiate on Initial Payment Amount
  - If at the end of the 30 business day period no resolution, then IDR may be requested within 4 business days

Compliance Considerations: Adherence to the required notification content and timeframes.

Independent Dispute Resolution

- Either party may submit standard form to the other party and to HHS requesting IDR
  - No IDR for any item or service for which there is consent
  - Send electronically if 2 conditions met
    - Electronic notification will be readily accessible to the other party
    - Upon request, paper form is sent free of charge
- Parties jointly select IDR Entity within 3 business days or HHS selects
- Each party then submits offer for payment amount (dollar amount and percentage of QPA) and other information requested by IDR Entity or required by IFR
- Either party may submit additional information
- "Baseball style" arbitration; decision within 30 business days of IDR Entity selection (parties may continue to negotiate) with written decision
- IDR entity may not consider UCR, billed amounts or public program reimbursement (*e.g.,* percentage of Medicare)
- Within 30 days, payment of any additional amount owed

Compliance Considerations: Participation in, and management of, IDR volume.

Batching and "Cooling Off"

- Batching is permitted for claims
  - Billed by same provider
  - Paid by same payor (group health plan or issuer)
  - Same or comparable service codes
  - All items or services furnished during same 30 business day period (or "cooling off period")
- Cooling off period
  - 90 calendar day period after IDR for party that submitted IDR request (even if IDR is in favor of such party)
  - Applies when there are the same parties and same/similar services
  - After IDR decision, party has 30 days to request the "cooling off" period which is a time to negotiate

Compliance Considerations: Are there arguments that will not be presented in IDR if claims are batched? Can "cooling off" period be used advantageously to negotiate contract?

Evolving Industry and Regulatory Landscape

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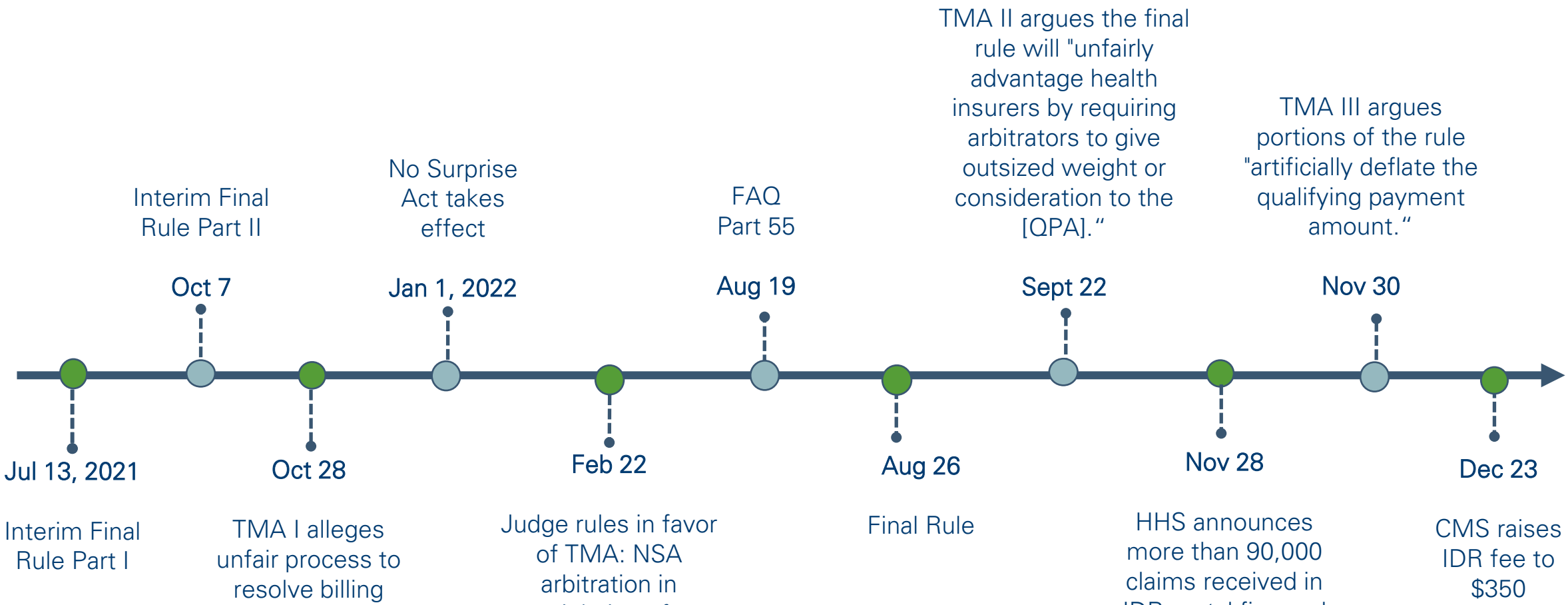
After the 2 initial IFRs in 2021 regarding adjudication of NSA claims (July) and IDR (October, updated April, 2022)

- Additional regulations
  - August 2022 Final Rule (downcoding)
  - October 2023 Proposed Rule (IDR)
- Sub-regulatory guidance from Tri-Agencies (HHS, DOL and Treasury (IRS))
- Technical guidance including model notices

NSA Timeline



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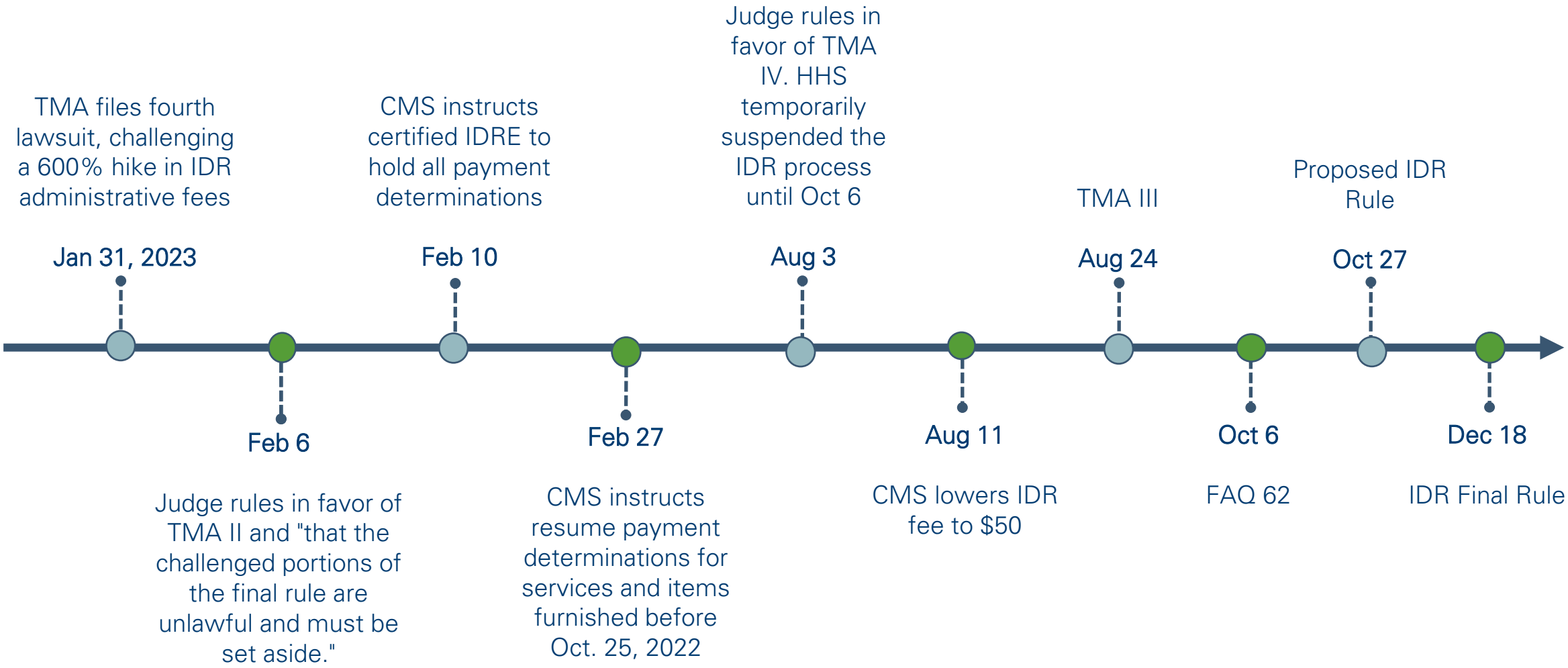

The TMA III Decision

TMA v. HHS: III (August 24, 2023): Challenge to the July IFR and related guidance regarding the QPA calculation methodology, self-funded plans' use of TPA's QPAs, claim payment deadline, and Air Ambulance IDR processes

- QPA Calculation
  - QPA calculation may no longer include ghost-rates (contracts with no claims processed) and out-of-specialty rates
  - QPA calculation must include single-case agreements and provider incentive or adjustment amounts as part of the contract rate
- Air Ambulance
  - QPA calculation must include single-case agreements
  - IDR regarding liftoff service rates and mileage rates may be combined in one proceeding
  - Initial payment deadline begins when claim is received and not when a "clean claim" with all information necessary to process the claim is received
- Self-Funded
  - TPAs must calculate QPAs for each self-funded plan that they administer (can no longer use contracted rates of all plans administered by the TPA in calculating the QPA)

Impact of TMA III

Payors must recalculate QPAs based on reasonable, good faith interpretation of the Rules as revised by TMA III court

- ❑ Enforcement discretion exercised by federal regulators (encourage state regulators to do the same) for items and services furnished before May 1, 2024
- ❑ Payors will have to use recalculated QPAs for dates of service on or after May 1, 2024.

Compliance Considerations: The standard of "reasonable, good faith interpretation" will be measured by regulators. What does it mean?

Audits and Regulatory Oversight

Regulatory Oversight

As part of NSA enactment, HHS is mandated to conduct 25 audits each year and MAY audit when complaints ensue

- ❑ Audit to cover compliance with requirement of applying QPA and satisfaction of QPA definition
- ❑ July 2021 IFR Preamble states that HHS's existing enforcement procedures (part 150) will apply

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Separately, OPM has audit authority for FEHB plans.

HHS points to state regulators' primary enforcement authority under PHSA

Will the Department of Labor add NSA Compliance to its ERISA audits?

Compliance Considerations: Strategically respond to regulators investigating complaints.

NSA Audit Methodology

CMS / CCIIO anticipates an NSA audit taking a year to complete and the report will be made public. Initial deliverables include, but are not limited to, the following:

- ❑ A comprehensive list of all plans in the individual, large group, and small group market(s)
- ❑ A step-by-step narrative of Issuer's QPA calculation methodology and supporting documentation, including dated procedures, on information used to calculate the median of contracted rates for items and services furnished during the Audit period.
- ❑ All claims handling manuals, dated procedures, internal bulletins, medical criteria used, and guidelines the Issuer utilized at any point during the Audit period.
- ❑ All QPAs calculated, whether associated with a claim, during the Audit period.

Compliance Considerations: Audit readiness and documentation.

NSA Claims Review

Claim selection based on aspects of consumer billing protection

- ❑ Emergency, Ancillary, and Air Ambulance claims
- ❑ In state vs. Out of State claims
- ❑ Physician vs. Facility claims

Claims attributes

- ❑ Claims Processing Timeliness
- ❑ Identification and disclosure of NSA eligible services
- ❑ Provider disclosures on Explanation of Payments
- ❑ Member disclosures on Explanation of Benefits

Escalated Complaints to Regulators

Regulators have different teams, processes, and tools to receive and manage escalated NSA complaints from providers and members.

- ❑ Inconsistent notification to payors about NSA complaints, email vs. phone calls
- ❑ Unclear who contact is for NSA complaints
- ❑ Limited ability to seek clarifications and/or extensions

Agency	Plan
HHS - CMS/CCIIO	Commercial – Large Group, Small Group, Individual
DOL - Department of Labor	ERISA Groups
OPM – Office of Personnel Management	FEHB
State Regulators	Commercial – Large Group, Small Group, Individual

Future Compliance Challenges

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Good Faith Negotiations

Finding the middle ground between Billed Charges and QPA; proposed changes do not address the lack of negotiation by providers

Consistency of Arbiters

IDR considerations, decision making approach, and outcomes; need for guidance and training regarding applicability of NSA

Timely and Accurate Information

Availability and accuracy of information and reconciling discrepancies.

Time Constraint

Meeting specific and stringent timelines, especially for complex cases, may impact resolution of disputes.

Administrative Burden

Maintenance of QPA. Monitoring and management of Open Negotiations, IDRs, and escalated complaints to regulators.

Unintended Consequences

Oversight of third-party vendors, provider relations and future contract negotiation, ground ambulance

Strategies for Compliance

- Building a Robust Compliance Program
- Training and Education for Staff
- Internal Auditing and Monitoring
- Collaboration with Payers and Providers

Q&A