HEALTHCARE REGULATORY ROUND-UP - Episode #36

No Surprises Act:
The New Independent Dispute Resolution Process

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Speaker Introduction

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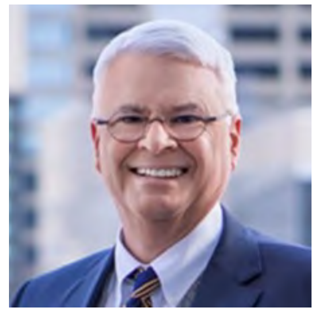

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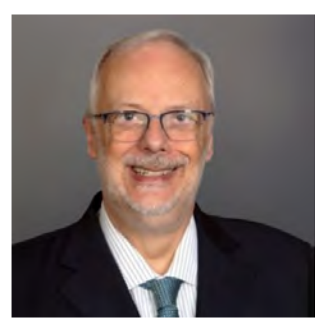

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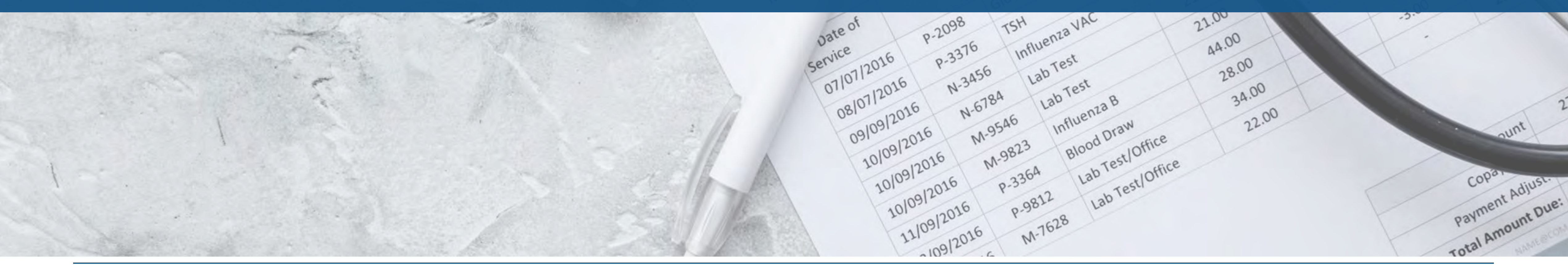
Agenda

1. No Surprises Act (NSA) Overview
2. Step-by-Step Independent Dispute Resolution (IDR) Process
3. Establishment of the Qualified Payment Amount (QPA)
4. Initial Learnings
5. Potential IDR Strategies

1. NSA Overview



NSA

- Consolidated Appropriations Act of 2021
  - Prohibit 'surprise' billing and replace with new payment methodology
    - Patients through no fault of their own receive services from OON provider
  - Require providers to furnish good faith estimate (GFE) of charges to self-pay patients (GFE not covered in depth in this presentation)
- Implementing regulations
  - July 2021 interim final rule (surprise billing)
  - 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)

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.**

- 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, or retiree-only plans.**

Emergency Services – NSA Applies to All

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

Emergency services furnished by OON providers at in-network facility

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)

Advance Notice/Consent

- 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.

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, 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, 2022 QPA would be $213 (round to nearest dollar)
     - **Patient Liability example**, if QPA = $213, and patient's cost sharing = 20% of charges, 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

Patient receives treatment from OON provider at INN facility (or OON ED)

Provider submits claim against insurance coverage

Payer pays an OON amount; provides the QPA amount for the provider to compute the patient liability

Provider receives EOB, **including QPA information**

Is allowed amount acceptable?

- **Yes** → Provider accepts payment for the service provided
- **No** → Provider notifies payer that payment is unacceptable

Open Negotiation period initiated

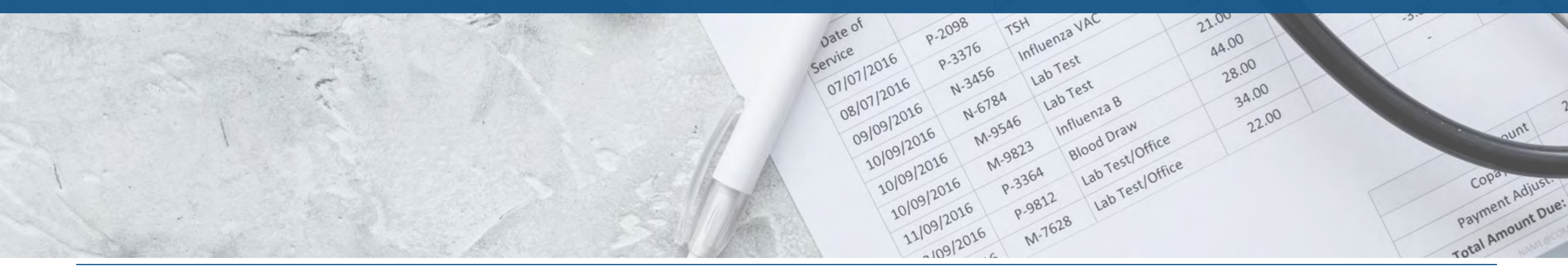
Negotiation fails

- **No** → Provider accepts negotiated sum as full payment for the service provided
- **Yes** → **IDR initiated**

QPA

- **NSA does not establish OON rates.**
- **October 2021 interim final rule established a rebuttable presumption (presumes that QPA is the appropriate OON rate) in the IDR process.**
- **Numerous litigation pursued – Texas Medical Association, AHA, AMA, etc.**
  - Decision 2/23/22 in Texas Medical Association 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

2. Step-by-Step IDR Process



IDR Process

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
Mutual agreement on certified IDR entity selection; each party pays $50 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
Parties submit payment offers and supporting information to certified IDR entity (*with IDR entity fee – between $285 and $500*)	**10 business days** after date of certified IDR entity selection
IDR entity issues written opinion accepting one party's offer	**30 business days** after date of certified IDR entity selection
Payment made to provider (if successful); refund of successful party's IDR entity fee	**30 business days** after payment determination

"Baseball-Style" arbitration

IDR Determinations – for Detailed Preparation

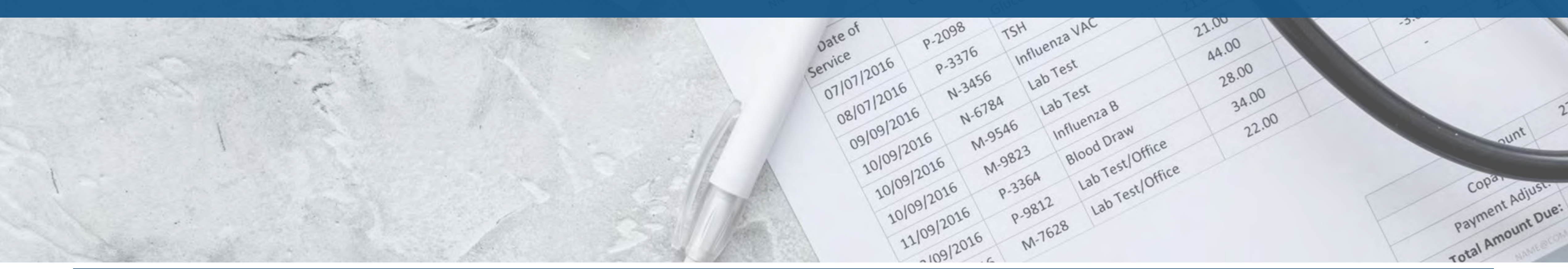
- IDR entity considers QPA and then required by rules to consider other information submitted by the parties:
  - ✓ Provider's training, experience, and quality and outcomes measures
  - ✓ Provider's or plan's **market share** in relevant geographic region
  - ✓ Patient acuity or complexity of furnishing 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 spelled out***

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

If INN at acceptable rate, then termed to time with NSA – may be credible for provider case

3. Establishment of the Qualified Payment Amount (QPA)



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, using limited toolbox. ***Not easy*** *and currently* ***prone to delay***.
- Provider must follow **strict timeline** - open negotiations, notification and submission – ***risk is high*** *that IDR submission fails.*
- Likely that the QPA remains the single largest influence on the IDR outcome.
- **In considering an IDR** – 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.

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

- The August 2022 final rule states that the July 2021 Interim Final Rule QPA definition stands

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 (e.g., if median rate as of 1/31/2019 was $200, 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

QPA Latest Rules – from 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

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:

[The regulations], 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

QPA Latest Rules – August 2022 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

QPA Latest Rules – August 2022 Final Rule

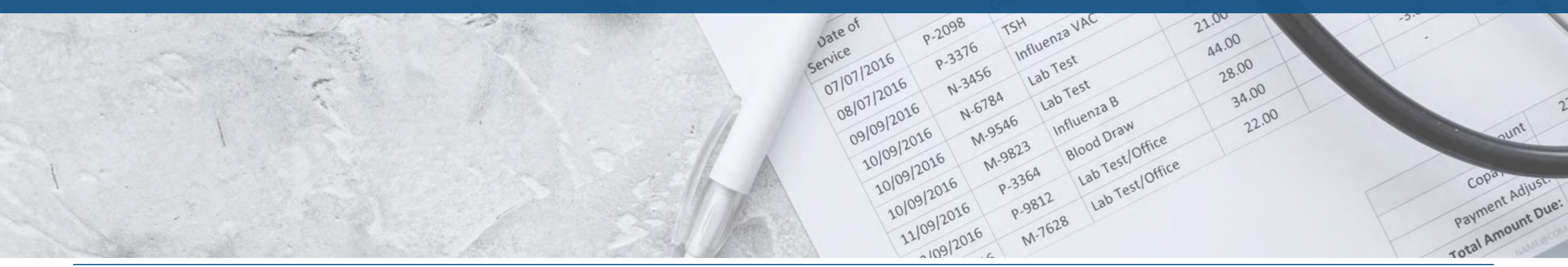
- Rules require IDR entity to select QPA **unless provider provides credible evidence** that QPA is wrong and does not reflect intent of the NSA statute. Evidence must credible. Not an easy hurdle to define or reach.
- Providers that submit IDR without a credible case to challenge the QPA are unlikely 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

4. Initial Learnings



IDR Initial Learnings

- 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 as an OON provider
- 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
- AHA joining others to challenge the latest rules– *AHA Today - 9/22/22* - “AHA, AMA to file amicus brief in Texas challenge to IDR provision of August surprise billing rule”

IDR Initial Learnings

- 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 (see *Modern Healthcare* article – August 30, 2022)
    - Providers complain that payers not providing **clear and complete information**
    - As of 8/11/22, only **1,200** (~2.5%) **out of 46,000** disputes decided
    - CMS data shows 21,000 (~50%) cases were **challenged for eligibility**
    - CMS data that arbiters **rejected 7,000 cases** (~15%) as being ineligible
    - 3 of the 11 Federal IDR entities are **no longer accepting new cases**
  - Likely that the QPA remains the single largest factor in the IDR decision

https://www.modernhealthcare.com/payment/no-surprises-act-arbitrations-leading-confusion

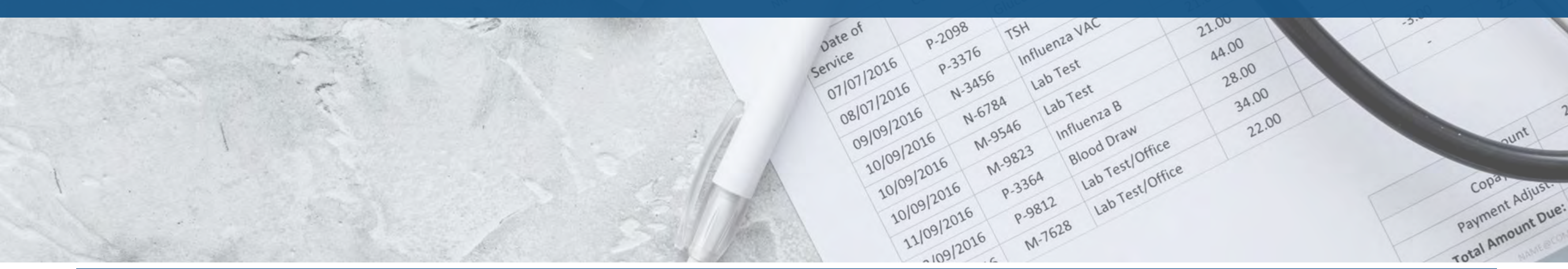
IDR Initial Learnings

- **"Ghost Rates" – what are they and how do they impact the IDR?**
  - Payer may use low Ghost Rates to calculate the QPA – bending cost down (or exclude high rates)
  - The payer 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
    - Provider understand the local market and identify "similar" providers who may be included in the QPA calculation (and identify any that are not an appropriate match) what are their INN rates (published)?
    - It is in the payer's interest to weight the median by including lower cost contracted entities – including contracted entities that may never (or rarely) deliver the service – these are the "ghost rates" (or exclude high rates)
    - 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

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 required by Federal rules with QPA.
- Some payers utilizing third parties to handle OON QPA claims (Zelis, Naviguard).
- Goal should be to secure an in-network agreement at acceptable, market rates.

5. Potential IDR Strategies



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 – Hospital, state officials – highlight essential service and risk if lose IDR
- ✓ Build out a timeline – best case? what if delayed? cash flow?
  - 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

IDR Strategies

- Prepare for IDR engagement:

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 bad faith tactics	• 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

IDR Tactical Preparation

- ✓ Request the payer to show their computation of the QPA.
  - They are required to provide on request.
- ✓ Regulations *prohibit* consideration of percentage of charges or percentage of Medicare reimbursement
- ✓ 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.
- ✓ Avoid double-counting.
- ✓ Challenge downcoding.

OUR NEXT HEALTHCARE REGULATORY ROUND-UP:

“The End is Near: Getting Ready for the End of the PHE”

October 19, 2022

How can we HELP?

A national healthcare advisory services firm providing consulting, audit, and tax services