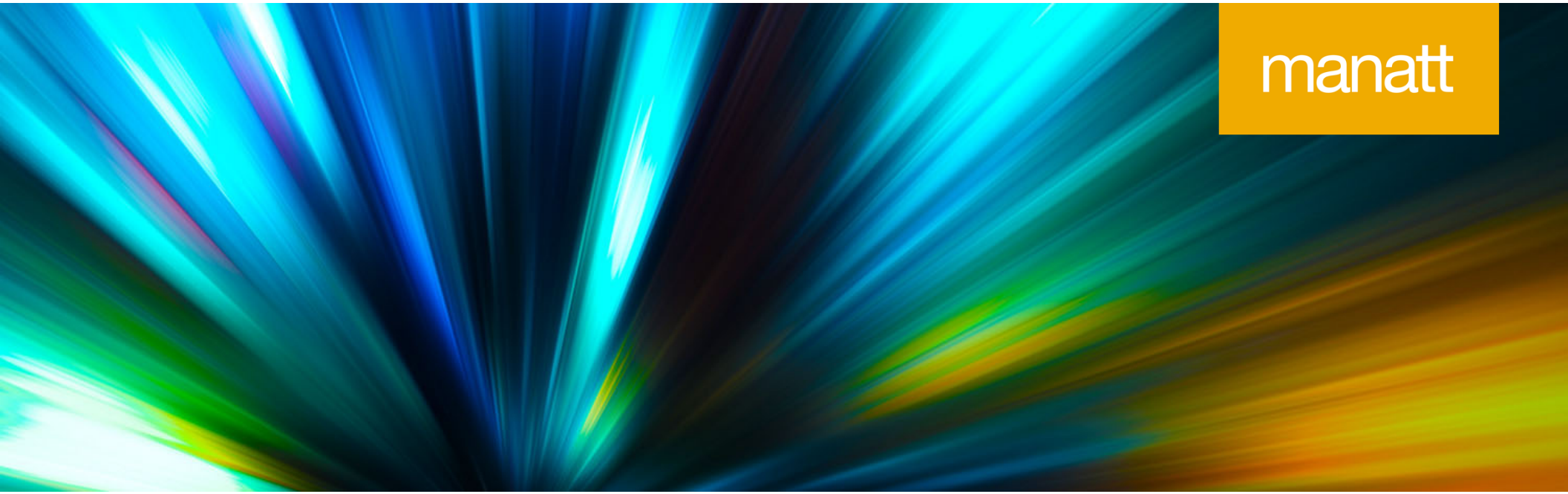

Out-of-Network Payment Process Under the No Surprises Act

April 21, 2022

Moderator: Bobby Mukkamala, MD, Chair, AMA Board of Trustees
Presenters:

- Michael Kolber, Partner, Manatt Health
- Joel Ario, Managing Director, Manatt Health

Agenda

- **Introduction**
- **Overview of the No Surprises Act (NSA)**
- **Federal Independent Dispute Resolution (IDR) Process**
  - When Does the Federal IDR Process Apply?
  - Walk-Through of the Federal IDR Process
  - State Examples
- **Next Steps**
- **Q&A**

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Overview of the No Surprises Act (NSA)

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Key Provisions of the NSA: Three Major Areas

Surprise Billing Prohibition

- Prohibits balance billing for
  - Emergency services at OON facilities
  - Nonemergency services provided by OON physicians at network facilities
- "Emergency Services" include "post-stabilization" services
- Federal process to determine patient cost share
- Federal IDR process to determine OON rate when state law does not apply

Provider Obligations

- Consumer notices on website, posted and provided to patient
  - Complexities relate to placement, translations, sharing of notice obligations
- Must determine insured status and whether patient will submit to insurance
- Good Faith Estimates (GFEs)
- Notice, estimate and consent in certain cases to balance bill
- Continuity of care
- Patient-provider dispute resolution

Payor Obligations

- Prompt payment requirement (within 30 days for clean claims)
- Initial payment = amount payor reasonably intends to be payment in full
- Continuity of coverage (90 days after termination of provider contract)
- Deductibles and MOOPs on ID cards
- Advanced EOB (deferred)
- Price comparison tool (deferred)
- Regularly update provider directories

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When Does the Federal IDR Process Apply?

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NSA Prohibits Balance Billing for 3 Types of Surprise Medical Bills

Out-of-Network Emergency Services

- Emergency services provided at:
  - Hospital emergency department
  - Independent freestanding emergency department

Nonemergency Services

- Nonemergency services by out-of-network providers who practice at in-network facilities:
  - Hospital
  - Critical access hospital
  - Hospital outpatient department
  - Ambulatory surgical center

Air Ambulances

While similar rules apply to air ambulance bills, the Airline Deregulation Act preempts state laws that relate to air ambulance rates, so surprise bills will generally be subject only to federal law. **Today's focus is the other two categories of services**.

For certain services, the patient can consent to out-of-network treatment and waive the balance billing protections.

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Out-of-Network Rate

The amount that OON providers must be paid for services covered by the No Surprises Act is the "out-of-network rate."

The payment amount determined under a state's All-Payor rate-setting model

→

***If no All-Payor Agreement*:**

The amount determined in accordance with a "specified" state law

→

***If no specified state law*:**

The amount determined through negotiations or a newly established IDR process

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State vs. Federal Law: Which Applies?

- In states with no balance billing laws, federal law applies across the board.
- However, the picture is much more complicated in states with balance billing laws.
- The NSA was designed to establish a **federal baseline** for consumer protection.
- Therefore, the NSA expressly defers to state laws that provide "**a method for determining the total amount payable**" and applies only weak "conflict" preemption to other state laws.
  - This means that most payors and providers will need to navigate a very complex web of state and federal laws.
    - For state-regulated plans, state or federal law may apply to determine charges for OON services, and a combination of state and federal laws will govern other protections such as the right to waive balance billing protection.
    - For federally regulated plans, the NSA will apply unless the plan has opted in to state regulation.

NSA Defers to "Specified State Laws"

- The NSA expressly defers to a "Specified State Law" which the law defines as:
  - A state law that provides "**a method for determining the total amount payable.**"
  - Key issue: State law must apply to the plan, the OON provider/facility, and the item or service.
- The state law may determine both the "recognized amount" (used to determine cost-sharing) and the "out-of-network rate" (total amount paid by plan).
- This includes state laws that determines the amount payable by reference to:
  - A fee schedule;
  - "A mathematical formula for determining the out-of-network rate"; or
  - A process "that require[s] or permit[s] a plan or issuer and a provider or facility to negotiate, and then to engage in a state arbitration process to determine the out-of-network rate."

How to Think About Whether State Law or Federal IDR Applies

- First, check CMS' Chart for Determining the Applicability for the Federal Independent Dispute Resolution (IDR) Process (for ERISA plans, federal IDR will generally apply in all states, except where specified state law permits ERISA plans to opt in)
- For "bifurcated" or "state-process" states, analyze the scope of state law
- If plan believes federal law applies, it will send QPA with remittance advice
- IDR entity will determine whether federal process applies

State Process*	Federal IDR Process	Bifurcated Process*
Alaska	Alabama	California
Georgia	Arizona	Colorado
Maine	Arkansas	Connecticut
Michigan	District of Columbia	Delaware
	Hawaii	Florida
	Idaho	Illinois
	Indiana	Maryland
	Iowa	Missouri
	Kansas	Nebraska
	Kentucky	Nevada
	Louisiana	New Hampshire
	Massachusetts	New Jersey
	Minnesota	New Mexico
	Mississippi	New York
	Montana	Ohio
	North Carolina	Texas
	North Dakota	Virginia
	Oklahoma	Washington
	Oregon	
	Pennsylvania	
	Rhode Island	
	South Carolina	
	South Dakota	
	Tennessee	
	Utah	
	Vermont	
	West Virginia	
	Wisconsin	
	Wyoming	
	American Samoa	
	Guam	
	Northern Mariana Islands	
	Puerto Rico	
	U. S. Virgin Islands	

Walk-Through of the IDR Process

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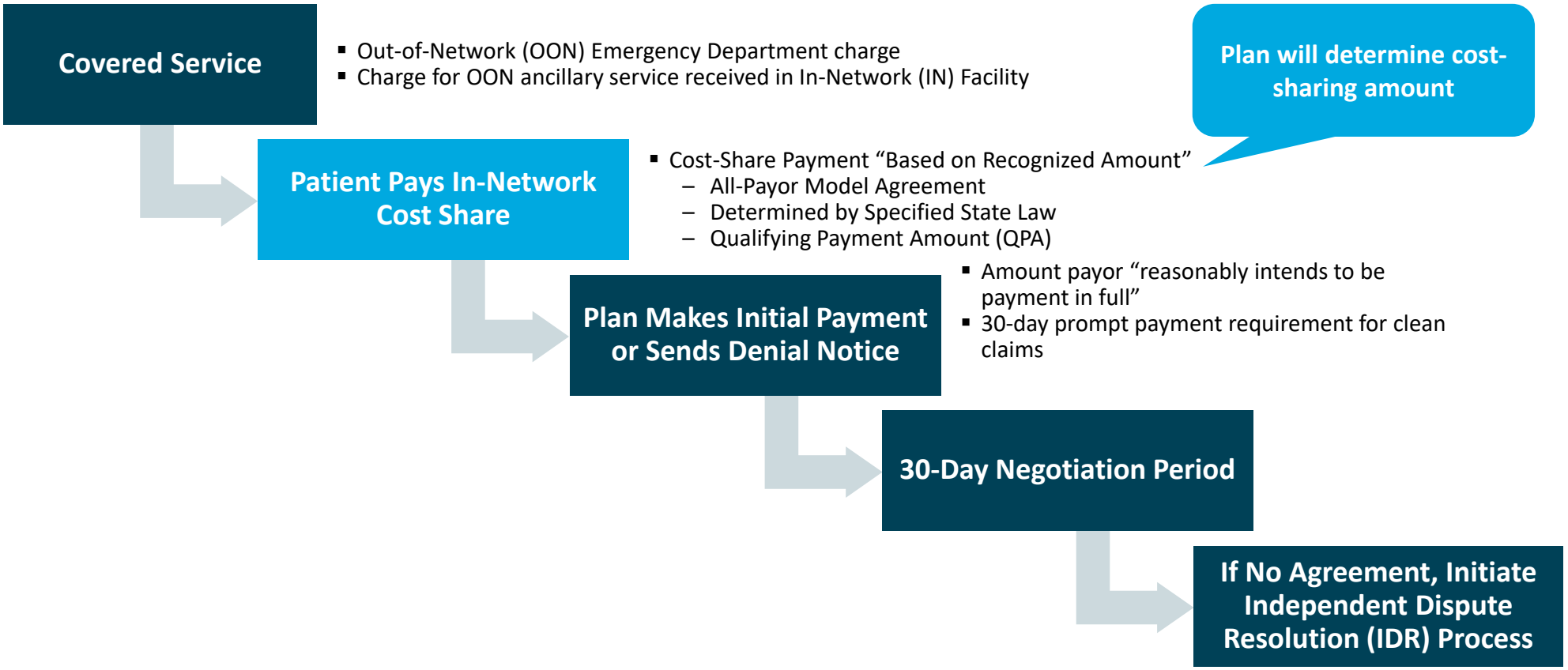
Overview of the Service to IDR Process Timeline



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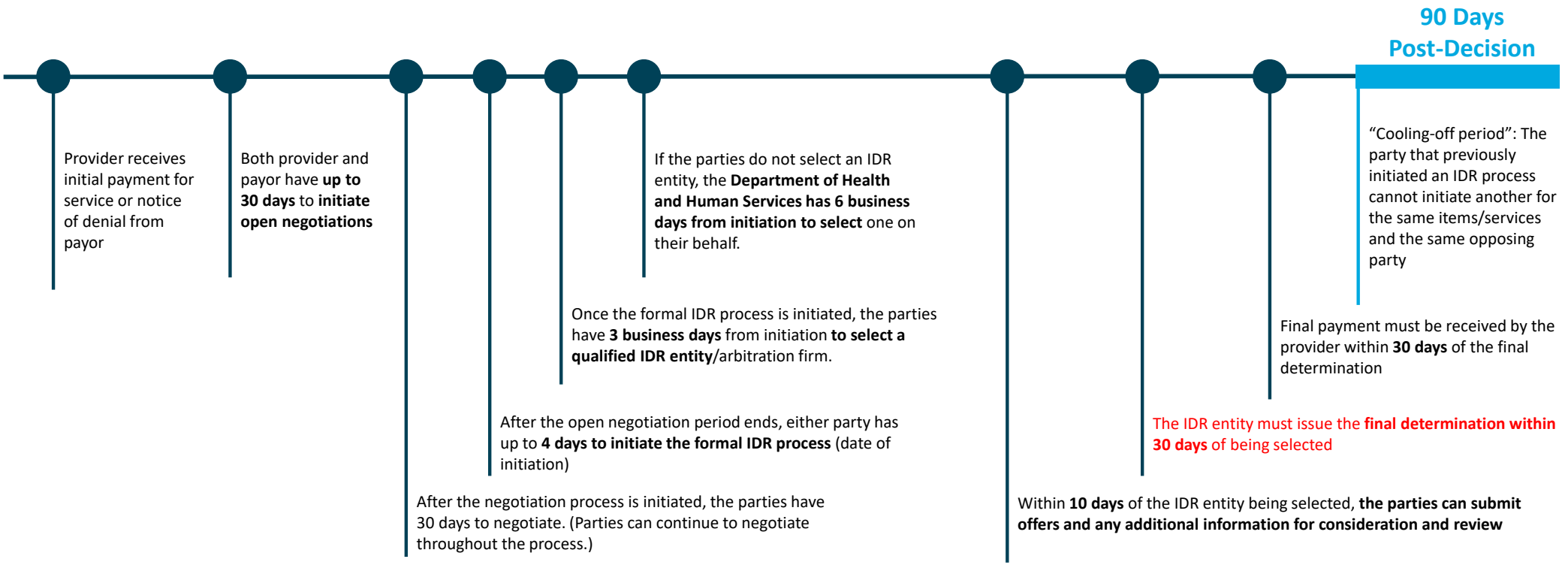
IDR Process Timeline



Federal IDR portal opened on April 15.
For negotiation periods that ended before April 15, IDR must be initiated by May 6.

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Initiating the IDR Process

Before starting the IDR Notice of Initiation web form (once you've verified that this dispute will be a Federal IDR process*), you should be prepared with the following information, documents, and resources.

- Information to identify the qualified IDR items or services (and whether they are designated as batched or bundled items or services**)
- Dates and location of qualified IDR items or services
- Type of qualified IDR items or services, such as emergency services and post-stabilization services
- Item and service codes for corresponding service and place of service
- Attestation that qualified IDR items or services are within the scope of the Federal IDR process
- Your preferred certified IDR entity

The web form must be completed and submitted in a single session. The session will time out after 15 minutes of inactivity, and information is not saved if you exit the form before completely inputting all information.

*To verify that the dispute belongs in the Federal IDR process, review CMS' Chart for Determining the Applicability for the Federal IDR Process, additional guidance in CMS's state-specific letters the IDR State list, and consult state law or an attorney on the scope of a specified state law.
**Batched or bundled items or services refer to disputes between the same plan and provider (or facility or group of providers) for the same item or service (i.e., the same procedure code) submitted together. The services must have been furnished within the same 30-business-day period

Independent Dispute Resolution (IDR) Notice of Initiation Web Form, CMS, March 2022, https://www.cms.gov/sites/default/files/2022-04/IDR%20Notice%20of%20Initiation%20Job%20Aid_4.8.22-1.pdf

Determining OON Payment

- The NSA requires "baseball" style arbitration: **The IDR must select one of the offers submitted; it cannot make up its own payment rate.**
- Under the NSA, the IDR entity "shall consider" the QPA as well as:
  - The level of provider expertise, training, quality/outcome measures;
  - Market share held by the nonparticipating provider/facility;
  - Acuity of the patient and complexity of furnishing services;
  - Teaching status/case mix and scope of services of facility; and
  - Demonstrations of good faith efforts to enter into a network agreement and, if applicable, the contract rates during the past four years.
- The NSA prohibits consideration of:
  - Provider's billed charges;
  - Rates paid by government payors (Medicare, Medicaid); and
  - Usual and customary charges (including payment or reimbursement rates expressed as a proportion of usual and customary charges).

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Several Lawsuits Challenged Presumption That QPA Is Appropriate Starting Point

- Several parties (including AMA) challenged the federal regulation establishing the IDR process, which differed from the process outlined in statute by specifying that the IDR entity:
  - "Begin with the presumption that the QPA is the appropriate out-of-network rate" and
  - "Must select the offer closest to the QPA unless the certified IDR entity determines that credible information submitted by either party clearly demonstrates the QPA is materially different from the appropriate out-of-network rate."
- **February 23**: In first judgment, court ruled that these aspects of the rule conflicted with the terms of the NSA, and vacated those aspects of the rules requiring IDR entities to select the offer closest to the QPA (*Texas Med. Ass'n v. HHS*, No. 6:21-cv-425 (E.D. Tex. Feb. 23, 2022))
- **February 28**: CMS issued a memorandum stating that the ruling invalidated portions of the interim final rule but that consumers continued to be protected from surprise bills

The government has until April 25 to decide whether to appeal (which could alter the standards that will apply to IDR determinations); government could also issue new final rule.

Revised Federal Guidance on How IDR Entities Decide Cases

1. Certified IDR entity must consider only information that it considers credible.
   - "Credible" means "upon critical analysis, the information is worthy of belief and is trustworthy"
2. Certified IDR entity must consider only information that relates to an offer of either party.
3. Certified IDR entity must *not* consider information on prohibited factors (billed rates, U&C charges, Medicare/Medicaid).

Circumstances/Factors for Which Parties May Submit Additional Information

Level of training, experience, and quality and outcomes	Market share held by provider of facility or of plan in geographic region	Acuity of the participant, beneficiary or enrollee or complexity of the service	Teaching status, case mix, and scope of services of the facility	Good faith efforts (or lack thereof) to enter into network agreements and contracted rates
Credible information should demonstrate the experience or level of training of a provider was necessary, or that their experience/training or level of training made an impact on the care that was provided.	Credible information should demonstrate how much the market share affects the appropriate OON rate.	Credible information should demonstrate how patient acuity or complexity of furnishing the qualified item or service affects the appropriate OON rate for the qualified item or service.	Credible information should demonstrate that the teaching status, case mix, or scope of services of the OON facility in some way affects the appropriate OON rate.	During the previous four plan years, a demonstration of good faith efforts (or lack thereof) made by the provider or facility and the plan to enter into network agreements with each other and, if applicable, contracted rates between the provider or facility and the plan.

Federal Independent Dispute Resolution (IDR) Process: Guidance for Certified IDR Entities, CMS, April 2022, https://www.cms.gov/sites/default/files/2022-04/Revised-IDR-Process-Guidance-Certified-IDREs.pdf

Regulations Dictating Calculation of the QPA

The QPA is the *median of the contracted rates* recognized by the plan for the same or similar item or service that is provided by a provider in the same or similar specialty and provided in the same geographic region.

- The plan calculates the QPA using a methodology established in the July 2021 interim final rules.
- The certified IDR entity is **not** responsible for ensuring that the plan calculated the QPA correctly.
  - ***Note***: If the certified IDR entity or a party believes that the QPA has not been calculated correctly, the certified IDR entity or party is encouraged to notify the departments through the Federal IDR portal, and the departments may take action regarding the QPA's calculation.

Requirements Related to Surprise Billing; Part 1 (86 FR 36872), July 13, 2021, https://www.federalregister.gov/documents/2021/07/13/2021-14379/requirements-related-to-surprise-billing-part-i

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State Examples

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Allocating Enforcement Responsibilities: Federal and State Authority

States have primary authority to enforce the NSA where authorized under state law or by entering into a collaborative enforcement agreement (CEA) with HHS.

Payor Enforcement

- States have primary enforcement authority over state-regulated plans
- HHS must enforce if state chooses not to enforce NSA or fails substantially to do so
- DOL has primary authority over self-funded plans (unless plan elects state enforcement)

Provider Enforcement

- DOIs could be given authority but generally have not been
- Health departments, licensing boards, consumer protection agencies may have authority or be given authority under new legislation
- If not, enforced directly by CMS or in CEA with state

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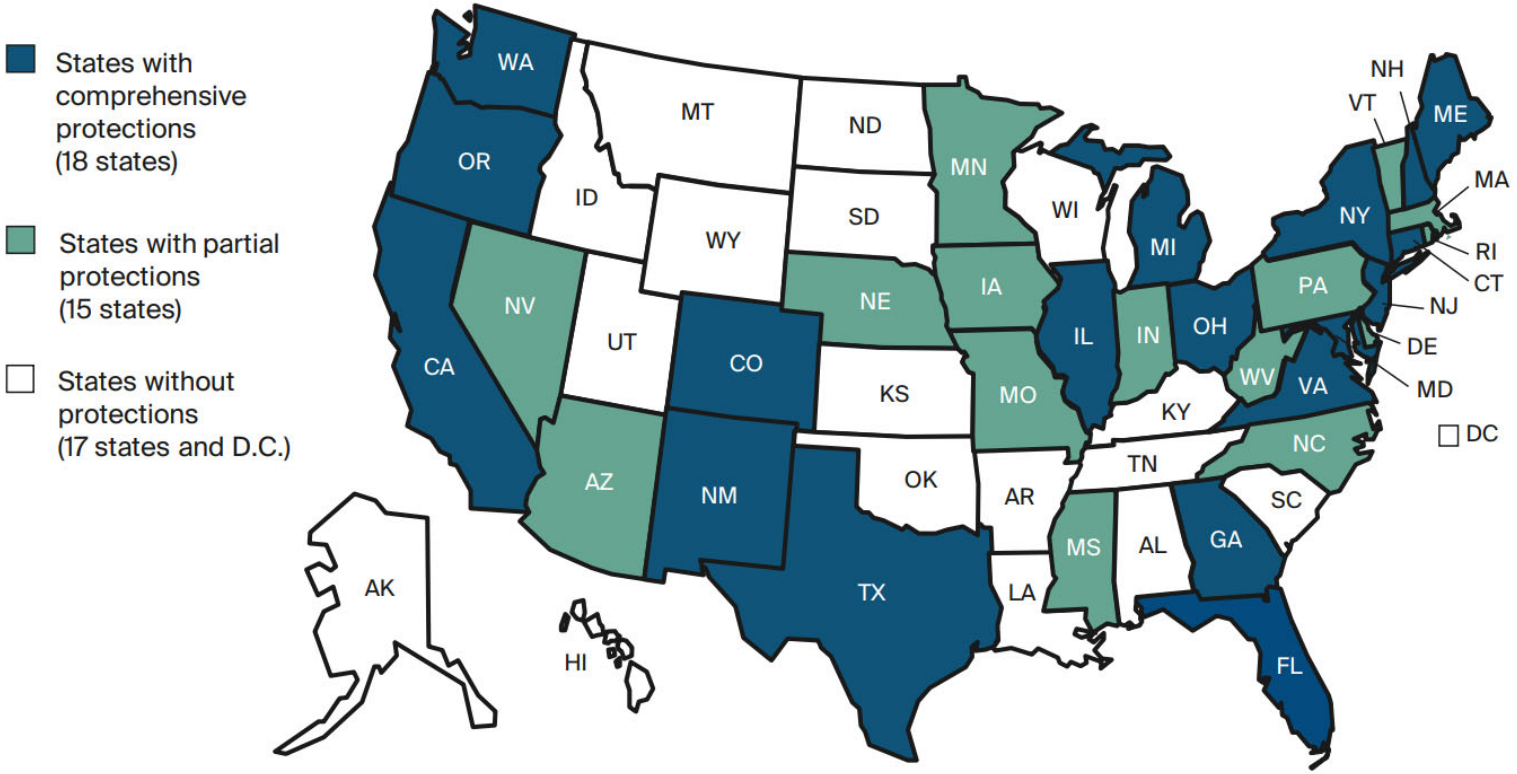
State Variations With Insurer and Provider Enforcement Issues

State Enforcement — **Cooperative Agreement** — **Federal Enforcement**



Source: State Laws Protecting Consumers Against Balance Billings, as of February 5, 2021, The Commonwealth Fund, https://www.commonwealthfund.org/sites/default/files/2021-11/Hoadley_balance_billing_state_map_02052021_v2.pdf

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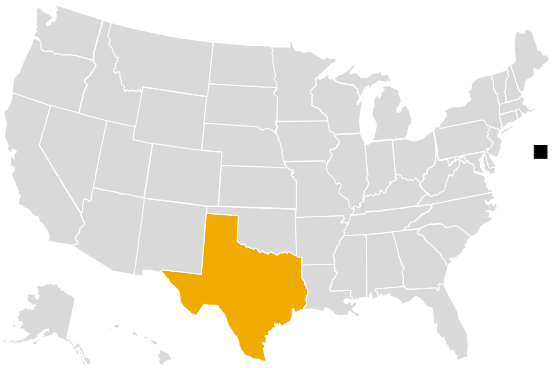
Broad State Authority

Texas' SB 1264 in 2019 is a "specified state law" under the NSA and will continue to be enforced for balance billing and dispute resolution.



- Texas' 2019 law established:
  - Arbitration process for provider-related disputes
  - Mediation process for facility-related disputes
- The state's IDR process involves multiple state agencies:
  - **Texas Medical Board and Texas Board of Nursing** for provider enforcement
  - **Texas Health and Human Services Commission** will regulate health care facilities
  - **Texas Department of Insurance** for health plans
- Texas has not entered into a CEA to pursue voluntary enforcement for federal IDR cases

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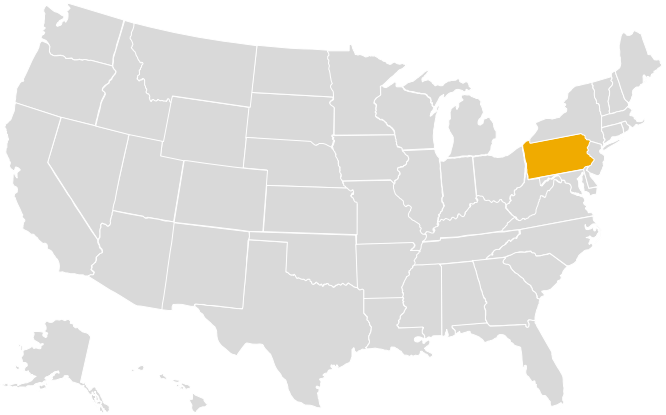
Cooperative Enforcement Agreement

Pennsylvania does not have a specified state law but is coordinating enforcement under a CEA.

- Pennsylvania Insurance Department (PID) is lead state agency to coordinate state and federal enforcement
  - PID offers a **web-based complaint handling** process to help consumers access state and federal assistance on case-by-case basis
  - Other state agencies include: Departments of Health (facilities and ambulance), State (provider licensure), and Drug and Alcohol Programs (some provider oversight)
- Coordination with federal government for providers/facilities, self-funded plans, FEHBP



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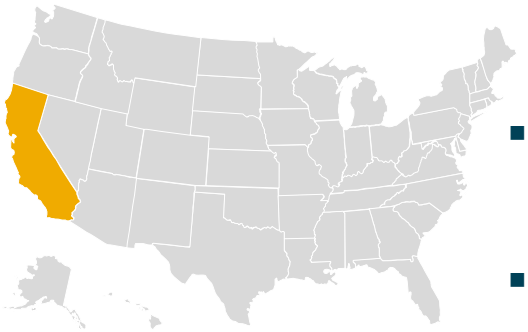
CMS Expands California Enforcement Authority

Cost-sharing and OON provider reimbursement will continue to be covered by AB 72 for nonemergency surprise bills and the Knox-Keene Act/case law for OON emergency care.



- California had statutory authority to resolve **certain** disputes about OON rates and case law to address other disputes
  - 2017 law established process for determining OON rate for **some** nonemergency services in **certain** cases
- CMS initially determined that the case law authority was not a "specified state law" because it was case law rather than statutory law
- As a result, CDI and DMHC signed a CEA to pursue voluntary enforcement where state authority was based on case law
- On March 21, CMS reversed itself and determined that case law counted as a "specified state law" and narrowed the cases in which the state had to rely on the CEA approach

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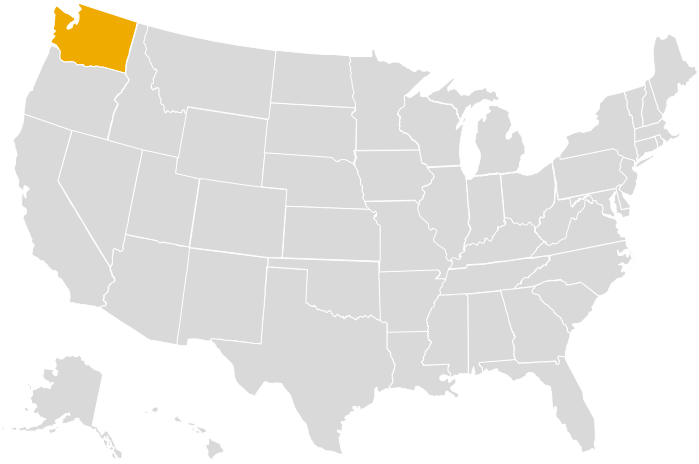
Alignment Between State and Federal Law

Washington is the first state to formally harmonize state and federal laws with new state legislation.

- All CMS letters memorializing federal-state enforcement plans recognize that states can take on more authority through new specified laws and/or CEAs
- Washington became the first state to harmonize state laws with federal NSA regulations
  - E2SHB 1688 aligns state and federal laws while preserving consumer protections in state law, such as coverage of crisis triage centers and other behavioral health emergency services
- Additional states may follow suit to align state/federal laws



Federal No Surprises Act, Office of the Insurance Commissioner – Washington State, https://www.insurance.wa.gov/federal-no-surprises-act

Next Steps

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Next Steps on the NSA

- Federal government will continue to publish new guidance
  - Requirements regarding air ambulance services
  - Transparency in coverage rule and CAA price comparison tools
  - Insurance ID card transparency and advanced explanation of benefits
  - Updated provider directory information
  - Final rule on federal IDR process?
- States will continue to adjust their laws
  - Other states likely to follow WA in harmonizing their laws with federal law in order to preserve state authority over consumer protection issues
  - Other states without statutory authority likely to follow PA in signing expansive CEAs to pursue voluntary compliance in cases where parties agree to state role, including ERISA cases
- Outcomes of early IDR cases could narrow or expand the number of IDR cases, depending on where outcomes are more predictable and where they are highly variable

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Questions?

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Additional Resources

- www.cms.gov/NoSurprises houses all CMS resources on NSA, including:
  - CMS webinar held earlier this week to walk stakeholders through the IDR process.
  - CMS released guidance for disputing parties.
  - CMS also released revised guidance to IDR entities detailing the IDR process and requiring the arbiters to consider a series of factors when making a payment determination without giving undue weight to the plan's median in-network rate or Qualifying Payment Amount (QPA).
- AMA Toolkit for Physicians: Preparing for Implementation of the No Surprises Act
- AMA Guide for Physicians: Disputing Out-of-Network Payments Using the No Surprises Act Independent Dispute Resolution Process
- AMA's Surprise Billing Toolkit