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The Federal No Surprises Act – It's Impact on Florida Physicians

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About Garfunkel Wild

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Today's Agenda

- Brief Overview of No Surprises Act
- Florida Statute
- IDR Process
- Good Faith Estimates
- Your questions

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Federal No Surprises Act

- Consumer protections that became effective January 1, 2022
- Intent – to fill in gaps where state laws cannot/do not protect patients from common "Surprise" Bills," [*i.e.,* balance billing] by out-of-network ("OON") providers in emergency, post-emergency, and certain other situations
- NSA is not intended to replace state laws – in the vast majority of situations where state law previously applied, state law will continue to apply

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The Gaps NSA is intended to cover

- Patients with self-funded insurance plans (i.e., ERISA plans), federal employee health benefits, others (previously outside state jurisdiction)
- Uninsured patients/self-pay patients

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Florida No Surprise Billing

- Applies to services provided by OON providers to those insured under policies delivered or issued for delivery in Florida, e.g., PPO, EPO, or HMO policies
- Insurers are solely liable for payment of fees to OON providers for:
  - Covered emergency services (provided in a facility, e.g., hospital, ASC, or urgent care center)
  - Covered non-emergency services: (1) that are provided in an in-network facility, and (2) where the insured does not have the ability and opportunity to choose a participating provider at that facility who is available to treat the insured
  - Services must be provided in accordance with the health insurance policy's coverage terms

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Florida No Surprise Billing (cont.)

- Insured patients are only responsible up to their in-network cost-sharing amount (i.e., their out-of-pocket amount, such as deductible or co-insurance)
- Reimbursement to OON providers (HMOs) are the lesser of:
  - Provider's charges
  - Usual and customary provider charges for similar services in the community where the services were provided, or
  - Charges mutually agreed to by the HMO and provider within 60 days of the submittal of the claim
- Reimbursement to PPO or EPO is in accordance with the terms of the health insurance policy

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Florida No Surprise Billing – Dispute Resolution

- Disputes regarding reimbursement to OON providers from insurers must be resolved in a court of competent jurisdiction or through the voluntary dispute resolution process.
- The voluntary dispute resolution process is handled by the Agency for Health Care Administration (AHCA).
- A resolution organization is contracted by the AHCA to timely review and consider claim disputes submitted by providers and health plans. The resolution organization then recommends an appropriate resolution to the AHCA.
- The dispute must be filed with the resolution organization within 12 months after the final determination was made on the claim by a health plan or provider.
- The resolution organization can request supporting documentation from either party, which must be provided within 15 days after receiving such a request, unless the resolution organization allows for additional time.

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Florida No Surprise Billing – Dispute Resolution (cont.)

- Either the provider or health plan may make an offer to settle the claim dispute when it submits a request for a claim dispute and supporting documentation.
  - If the offer recipient rejects the offer, and the final order is between 90 – 110 % of the offer amount, that recipient must pay the final order amount to the offering party and will be considered the non-prevailing party.
  - Both parties may agree to settle the disputed claim at any time, for any amount, regardless of whether an offer to settle was made or rejected.
- The resolution organization must review and consider all documentation submitted by both parties.
- Either party can request an evidentiary hearing to present evidence and witnesses.
- The non-prevailing party must pay a review cost to the resolution organization.

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The NSA has several significant distinct components

1. Prohibition against balance billing an insured patient for services provided by out-of-network (OON) providers in certain circumstances;
2. Limited Provisions allowing a patient to waive protections of the NSA, with strict requirements to provide advance notice and consent;
3. Protections for uninsured/self-pay patients by requiring transparency regarding expected costs of care; and
4. Dispute resolution procedures for insurer/OON provider disputes and uninsured patient/provider disputes.

What is a “Surprise Bill” under the Federal NSA?

- A bill from an OON provider to an insured patient for:
  - emergency or post-emergency stabilization care; or
  - any service rendered at an in-network facility

- The typical Surprise Bill covers:
  - The difference (balance) between the patient’s insurer’s allowed amount (amount paid by insurer plus any patient cost-share amount collected from patient) and the provider’s billed charge.

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When does the NSA's prohibition on balance billing apply?

1. **OON Emergency Services**
   EMTALA Definition of Emergency governs
2. **OON Post – Emergency Stabilization Services**
   Post-emergency services are covered by the NSA until the attending ED MD/treating provider determines patient is able to travel using non-medical transportation/non-emergency medical transportation to an available in-network provider/facility within reasonable travel distance (considering patient's medical condition).
3. **Services Provided by an OON Provider at an In-Network Facility (includes ASCs)**

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What the NSA does not change

- Traditional Medicare or Medicare Advantage payments
- **Obligations of plan to reimburse OON providers under terms of benefit plan**
- Obligations of providers to collect patient cost-sharing amounts
  - In-network co-payments for Surprise Bill
  - OON deductible and coinsurance when patient has signed Notice and Consent
- Obligations of patients to pay cost-sharing amounts
- Cosmetic procedures
- Non-emergency services provided at an OON facility are not covered by the NSA – they are only covered if provided at an in-network facility

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NSA prohibition on balance/surprise billing means

- OON provider may not balance bill a patient if insurer's allowed amount is less than OON provider's billed charges
- Remedy for an OON provider who believes the insurer's allowed amount is inadequate is to use the Independent Dispute Resolution ("IDR")
- Only the provider and the insurer are involved in the IDR Process – patient has no role and no exposure

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NSA protections can sometimes be waived by patients

- Not for Emergency Care (*EMTALA*) or covered post-emergency stabilization
- Not for
  - Anesthesiology
  - Radiology
  - Pathology
  - Neonatology
  - Assistant Surgeons
  - Hospitalists/Intensivists
  - Diagnostic Services (labs/radiology)
- Not when there is no other in-network provider at the facility who can provide the service

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Notice and Consent for OON Non-Emergency Services - Balance Billing Allowed

- Intent of NSA – giving notice and obtaining consent is not intended to be a regular occurrence.
- Implementing rules address content, timing (at least 72 hours in advance of service), and the information that must be included (e.g., a GFE of charges).
- Not a contract or agreement that patient will pay.
- Consent can be revoked at any time before service is rendered.
- Provider must notify the payer that patient has consented.
- CMS has published a Standard Notice and Consent form: https://www.cms.gov/files/document/standard-notice-consent-forms-nonparticipating-providers-emergency-facilities-regarding-consumer.pdf

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So it's a Surprise Bill – Now What?

- Per NSA – OON provider bills payer (not patient)
  - it's up to payer to tell provider what patient's cost-sharing responsibility is
    NOTE: BILLING THE PATIENT FOR THAT AMOUNT IS NOT THE SAME AS BALANCE BILLING.
- Insurer must make an "**Initial Payment**" (unless coverage is denied). The Initial Payment is not an installment – it is the amount the insurer expects to be payment in full for the services. It can be:
  - What the patient's OON benefit is under their particular plan
  - In rare situations an applicable **All-Payer Model Agreement** applies or a **specified state law** dictates the amount
  - If no agreement or specified state law, the plan and provider can agree on an amount
  - An amount the insurer has decided is fair (for example, where patient has no OON benefit)

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What is the QPA (Qualifying Payment Amount)?

- When the insurer makes their “Initial Payment” they must also include the **QPA** for the services at issue.

- The QPA is defined as the plan’s median contracted rate for the same/similar item/service in the geographic region, as adjusted for inflation.

- It is NOT the amount the insurer must pay as their “Initial Payment.” In fact, the insurer is generally free to pay whatever they want as an Initial Payment, with exceptions noted above.

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The QPA

- The QPA is calculated by the insurer, and is not subject to challenge by the provider in the IDR Process or review by the IDR entity.

- The methodology for computing the QPA is so impenetrably obtuse, that even if providers could challenge it such a challenge would be impractical.

- Insurers must disclose the QPA with each initial payment when the QPA serves as the amount upon which cost sharing is based.

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The Texas Medical Association Challenges

TMA I & II

- The Court agreed with the providers that the IDR regulations are illegal because they conflict with the statute, which states that the IDR "shall consider" a variety of factors, including but not limited to the insurer's median in network rate, as opposed to the regulations placing extra burden on providers to show they were entitled to more than the median in network rate.
- Regulations were struck down by the Court because:
  - they unfairly disadvantage providers, and
  - CMS did not provide a period of notice and comment before enacting the regulations.

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The Texas Medical Association Challenges (cont.)

TMA III

- The Court agreed with the providers that the Departments' revised guidelines governing how insurers calculate the QPA permits insurers to artificially depress the QPA in conflict with the Act, tilting the arbitration process in the insurer's favor.

TMA IV

- The Court agreed with the providers who challenged:
  - the increase (from $50 to $350) in the nonrefundable administrative fee that each party to an IDR must pay, and
  - the requirements making it difficult to batch related claims for resolution in a single arbitration proceeding.

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Independent Dispute Resolution (IDR) Process

- The IDR process is overseen by the Departments of Treasury, Labor, and Health and Human Services (the "Departments").
- The IDR process is incredibly detail oriented and subject to strict timeframes for each step in the process.
- The Departments are continually updating the IDR process due to the ongoing litigation brought by providers regarding this process, including the *TMA* decisions.
- Updates, instructions, and the portal to initiate a dispute are found at https://www.cms.gov/nosurprises/help-resolve-payment-disputes/payment-disputes-between-providers-and-health-plans

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IDR Stages

- Open Negotiation Period: must be initiated by provider **within 30 business days** of receiving initial payment using form available from DOL (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)

- Formal IDR: must be initiated **within 4 business days** after the close of the 30-business-day open negotiation period; provider must notify both the payer and the Departments

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Additional information that can be submitted

- Provider's expertise, experience, quality and outcomes
- Market share held by the Provider
- Acuity of the patient or the complexity of the procedure
- Teaching status, case mix and scope of services of a facility
- Good faith efforts (or lack thereof) to enter the network
- Contracted rates between the parties during the previous 4 years

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Additional information that cannot be submitted

- IDR may **not** consider undiscounted provider charge (usual and customary rates), billed charges, amount public programs (Medicare, Medicaid) would pay

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Submission of Offers

- Timing: **No later than 10 business days after selection of the IDR entity** each party must submit an **OFFER**.
- **Offer** must include:
  - A dollar amount
  - A calculation of the dollar amount as a percentage of the QPA
  - Any additional information requested by the IDR
  - Provider size, specialty (if any)
  - Plan must provide geographic coverage area

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Written Payment Determination

- IDR has **30 days** from the date they are selected to **choose 1 of the 2 offers** - baseball-style arbitration
- IDR must explain its determination
- The determination is legally binding absent fraud or intentional misrepresentation of material facts
- Payment must be made in 30 days
- Prevailing party gets refund of IDR fee (Loser Pays)

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NSA IDR Process – Cooling Off Period

- For 90-calendar days following a payment determination, the initiating party may not submit a subsequent Notice of IDR Initiation if it involves:
  - The same parties
  - The same or similar items or services subject to the initial Notice of IDR Initiation
  - There has been a payment determination made on the initial Notice of IDR Initiation

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NSA IDR Process – Pitfalls

- Confusion as to what claims qualify for IDR
- Backlog of claims
- Failure of payer to submit payment following award

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NSA Protections for Self-Pay and Uninsured Patients

- Self-Pay and Uninsured Patients have a right to a Good Faith Estimate (GFE) of the cost of care.
- CMS has guidance documents for calculating GFE.

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Good Faith Estimates – Federal No Surprises Act

- Provided at least 3 days before the date of the appointment or upon request.
- Required when a patient elects not to use their insurance or insurance does not cover the service.
- Can include a range of codes and fees.
- GFEs must be provided in writing – even if provided over the phone at patient's request.
- Must be included in patient's medical record.

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Good Faith Estimates – Multiple Providers

- CMS has indefinitely delayed requirement for convening provider or facility to include items or services reasonably expected to be provided by co-providers.
- Convening entities should note that although they do not need to include a co-provider's services or items in its GFE, if the convening entity choose to include this information in the GFE, those services or items would become eligible for the Patient-Provider Dispute Resolution ("PPDR") process.

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Your Questions

- In addition to the IDR process, what sort of other issues have you seen come up?
- Have you seen a transition as to how physicians, especially specialists, approach participating in plans?
- Could you give an example of when a cash-based practice needs to provide a Good Faith Estimate or menu of services and estimated costs?

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Does the Federal No Surprises Act ("NSA") Apply?

Identify type of patient/prospective patient

Insured + In-Network? NSA protections do not apply.

Insured + Out-of-Network ("OON")?

NSA protections may apply.

For OON patients – Identify type of services

Emergency Service (regardless of whether provider or facility is in-network or OON)?

Pre-Stabilization?

NSA protections apply → OON provider/facility may not balance bill patient for OON charges.

Post-Stabilization?

A) If following criteria are met, then service could be considered "non-emergency" → proceed for steps for non-emergency criteria

OR

B) If criteria are not met, then service is still considered "emergency" → OON provider/facility may not balance bill patient for OON charges.

Criteria for post-stabilization services to be considered "non-emergency":

- Attending ED MD/treating provider determines patient is able to travel using non-medical transportation/non-emergency medical transportation to an available in-network provider/facility within reasonable travel distance (considering patient's medical condition
- Notice and consent criteria for non-emergency services are applicable and satisfied (timing, format, signature, GFE, etc..)[1]
- Patient/authorized rep. is in a condition to receive the information on Notice (think of informed consent analysis).
- Any other requirements under state law.

Non-Emergency Service?

Identify setting:

A) Place other than "facility"?[2] → NSA protections do not apply.

B) OON Facility? → NSA protections do not apply.

C) In-Network Facility? → NSA protections for charges of OON provider at in-network facility apply, unless notice/ consent criteria are met.

Notice and Consent Analysis

A) Is OON prohibited from obtaining patient waiver of NSA protections via consent?
- Anesthesiology?
- Radiology?
- Pathology?
- Neonatology?
- Assistant Surgeons?
- Hospitalists?
- Intensivists?
- Diagnostic Services (labs/radiology)?
- No other in-network provider at the facility who can provide the service?

→ Prohibited from obtaining patient waiver; NSA protections apply.

OR

B) OON provider may try to obtain Notice and Consent. Refer to CMS Standard Notice and Consent Form.

Medicare/Medicaid? NSA protections do not apply.

Uninsured or insured but not using insurance ("Self-Pay")?

NSA protections apply.*

Providing GFE Information

- Providing Notice of Rights to GFE at time patient calls to schedule visit/service and when patient arrives for visit/service
- Recommend: Use CMS GFE Template
- Use correct method of providing GFE (paper or electronic), per patient preference.
- Provide timely:
  - For visits less than 3 business days in advance, provide GFE no later than one business day after scheduling
  - For visits at least 10 business days in advance, provide GFE no later than 3 business days after scheduling.
  - If patient/prospective patient requests GFE, provide it no later than 3 days after the request.

[1] Refer to CMS Standard Notice and Consent form.

[2] For purposes of the NSA, "facility" includes hospital, hospital outpatient department, hospital ED, freestanding ED or ASC.

*Setting does not matter. NSA protections apply for services rendered in offices, hospitals, outpatient departments, ASCs, FQHCS, etc.

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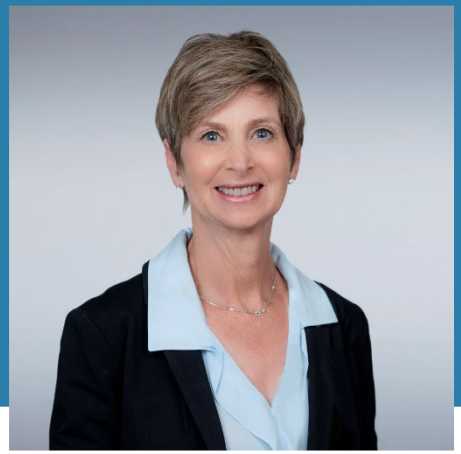

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