

WEBINAR | OCTOBER 15, 2026

Going Out of Network:

Navigating the Payor-Provider Breakup



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Agenda

Strategic Considerations

Preparing to Go Out of Network

Operational & Logistical Considerations

Billing & Out-of-Network Reimbursement

Conclusion & Key Takeaways

Questions

September 2023

Medicare Advantage	Commercial
<i>Hospitals are Dropping Medicare Advantage Plans Left and Right</i>	<i>Health System-Payer Negotiations Go Awry</i> <i>Oregon Health System Terminates Contract with UnitedHealthcare</i>

September 2024

Medicare Advantage	Commercial
<i>32 Health Systems Dropping Medicare Advantage Plans 2024</i>	<i>UnitedHealthcare, U of Florida Health Split</i>

September 2025

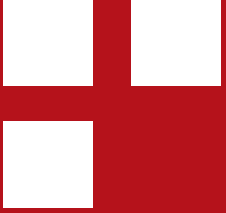
Medicare Advantage	Commercial
<i>40 Health Systems Dropping Medicare Advantage Plans 2025</i>	<i>Johns Hopkins Ends Talks with UnitedHealthcare Without New Deal</i> <i>New Hampshire Pauses \$27M Anthem Contract Renewal</i>

September 2026

Medicare Advantage	Commercial
<i>30 Health Systems Dropping Medicare Advantage Plans 2026</i> <i>A Zanesville Hospital System is Dropping Four Medicare Advantage Insurer at Once on January 1</i>	<i>Hospital-Insurer Network Threats Cluster in a ‘Goldilocks Zone’: Study</i> <i>HCA-Affiliated St. David’s Hospitals to Go Out of Network with Cigna</i> <i>CommonSpirit’s CHI St. Vincent Goes Out of Network for Arkansas Blue Cross</i>

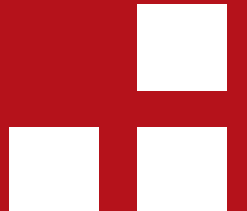
BECKER'S
HOSPITAL REVIEW

IN THE NEWS



Strategic Considerations

Desired End Goal
Timing





Strategic Considerations

Desired End Goal

Is this a ...

Negotiation tactic?

- Goal is to turn up the heat on the payor but end up with a contract on or around the termination date of the current contract

Path to remedies under the No Surprises Act (or state equivalent)?

- Some specialist providers in particular have found that IDR reimbursement is more favorable than contract reimbursement

Overall strategy to focus on certain payors over others?

- Particularly in Medicare Advantage, some health systems are limiting participation to payors that are better business partners

Strategic Considerations

Timing

Medicare Open Enrollment:

Is the timing of the contract termination positioned to allow immediate utilization of enrollment windows?

- Medicare Annual Enrollment Period: October 15 – December 7
 - All Medicare beneficiaries have the right to review and change their Medicare plan
- Medicare Advantage Open Enrollment Period: January 1 – March 31
 - Beneficiaries already enrolled in Medicare Advantage can make certain changes during this period
- Special Enrollment Periods (SEP)
 - May be available under exceptional circumstances on a case-by-case basis, including for “significant” changes in the MA plan’s network
 - Proposed rule would expand the availability of this option

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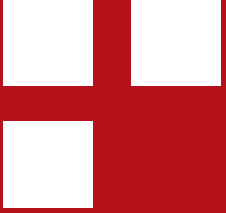
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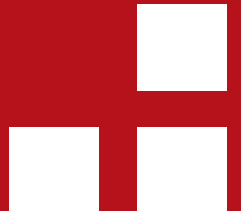


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Use On-Demand Course Code



Preparing to Go Out-of-Network

Contract Rights
Leadership Buy-in
Antitrust Considerations



Preparing to Go OON

Contract Rights

Does the contract allow the desired termination, and how do you achieve it?

- Lines of Business:
 - Is the contract terminable in part or only in whole?
 - What reimbursement can we expect when we are OON?
- Timing: What are the timing requirements for termination with cause and without cause?
- Notice: What protocols are required for notice?

Preparing to Go OON

Antitrust Considerations

Decisions to go out of network with a payor must be made by providers individually

- Collective efforts or agreements among providers to terminate contracts, go OON, or “refuse to deal” could be considered horizontal restraints under Section 1 of the Sherman Act
 - Such arrangements are generally per se illegal regardless of any claimed procompetitive justifications
 - Red flags include any coordination/communication among providers discussing OON decisions, joint letters to payors, etc.



Health care competition is a growing priority for federal regulators, signaled by the creation of the FTC’s “Healthcare Task Force” and the DOJ’s “Taskforce on Health Care Monopolies and Collusion”

Preparing to Go OON

Related Antitrust Considerations

Growing Antitrust Risk in Managed Care Contracting

Lessons from the OhioHealth & New York Presbyterian Hospital cases

- DOJ alleged that hospital systems use payor contracting provisions to restrict health insurers' ability to offer narrow network plans, tiered network plans or other insurance plans with financial incentives to use specific network providers
 - So-called steering restrictions that require hospitals to be included in all or nearly all of an insurer's commercial networks at the most favored level of benefits
 - Cannot deter or prevent insurers from communicating “price, cost, quality, or patient information”
 - Concerns centered around systems' “must-have” status



Network design and steering are a stated enforcement priority

Preparing to Go OON

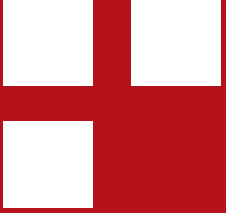
Leadership Buy-in

Alignment and support among leaders is **crucial**

- An OON strategy decision cuts across finance, legal, compliance, revenue cycle, clinical operations, and communications, *simultaneously*
- Have the right individuals at the table **from the beginning**
 - C-Suite (communicating to Board)
 - Legal & Compliance
 - Finance & Revenue Cycle
 - Physician Leadership
 - Communications & Gov't Relations

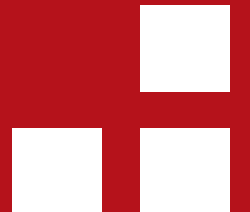


An all-hands-on-deck approach prevents reactive decision making and blindsiding key stakeholders



Operational & Logistical Considerations

Communication with Patients & Others
Continuity of Care
Logistics of Patient Steering



Operational & Logistical Considerations

Communication with Patients

Contents of Patient Letters & FAQs

- Effective date of change
- Scope of change, i.e., identifying what providers / facilities / services are impacted
- Clear understanding of “out of network” status
 - Ensure patients understand that they may pay more (perhaps substantially more) for the services provided at an out-of-network provider/facility, depending on the line of business
- Status of appointments or procedures that are already scheduled
- Distinguishing between emergency vs non-emergency services
 - EMTALA: There is NO change in the patient’s ability to visit and receive care in the Emergency Department
- Reminder of open enrollment options, if applicable
- Resources and assistance available

Operational & Logistical Considerations

Communication with Others

Other communications that may be necessary:

- Employers
- Brokers
- Community Physicians
- General Public
- CMS?



***A robust PR plan can serve as both a proactive tool to control the narrative
and a shield for compliance/legal requirements***

Operational & Logistical Considerations

Additional Communication Considerations

- **Contract Provisions**

- Simple confidentiality provisions are likely fine, but some contracts include language granting the payor a right to approve communications before they are sent to patients or the public
- Anti-disparagement provisions may appear in contract and/or state law
- Contract likely also includes a provision allowing a provider to freely communicate with a patient

- **Medicare Advantage Marketing Rules**

- Generally appropriate to inform patients about what insurance products the provider accepts
- Don't assume that an in-network option is the best choice for every patient

Operational & Logistical Considerations

Continuity of Care

Care Obligations Under the No Surprises Act

- A “continuing care patient” is one:
 - Undergoing a course of treatment for a serious and complex condition
 - Undergoing a course of institutional or inpatient care
 - Scheduled to undergo nonelective surgery
 - Pregnant and undergoing a course of treatment for the pregnancy
 - Terminally ill and receiving treatment for such illness
- Coverage continues for up to 90 days
- Provider must accept payment from the insurer as payment in full and abide by plan requirements during this period

Operational & Logistical Considerations

Continuity of Care

Care Obligations Under State Law

- Many states impose continuity of care requirements that go beyond federal requirements
 - Some require longer coverage periods
 - Some require providers to produce a list of covered persons to the plan to facilitate notice of termination
- State licensure laws and medical boards may separately define patient abandonment, require transition windows, etc.

Care Obligations Under Payor Contract

- Most payor contracts address continuity of care

Operational & Logistical Considerations

Patient Steering

The logistics of patient steering surface a myriad of important considerations



Will We Cancel Appointments?

Poorly communicated or last-minute cancellations could violate continuity of care obligations and/or create risk of patient abandonment allegations



Will We Turn Patients Away?

If patients are informed that OON care may be more expensive, they may voluntarily seek out other providers

Make clear that emergency services remain available

Could create friction in community, particularly for non-profit providers

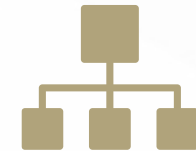


Will We Require Patients to Prepay?

Consider Good Faith Estimate requirements under the No Surprises Act

Careful scripting of front-line staff is essential

Make clear that emergency services remain available



How Will We Address Out-of-Network Benefits?

HMO versus PPO

Can be difficult for a provider to know whether a particular patient has OON benefits

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Live Course Code #2: **Payor-Live**



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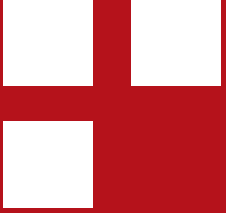
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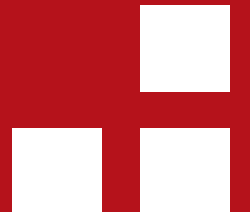


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Billing & Out-of-Network Reimbursement

*Reimbursement Processes
Implicated State & Federal Law
Patient Billing*



Life After the Contract Ends

What's Next?

Termination shifts reimbursement from a contract-driven to **regulatory-driven model.**

- Reimbursement rules depend on both the **line of business and the type of service**
- Consider:
 - Medicare Advantage requirements
 - No Surprises Act protections
 - State OON laws
 - Plan policies and benefit design



Key Risk: Contract termination often marks the beginning of reimbursement challenges

Life After the Contract Ends

Not All Claims are Created Equal

Line of Business	OON Payment Starting Point	Patient Billing
Medicare Advantage	Generally Original Medicare amount for noncontract providers	Medicare/MA member-liability limitations apply
Commercial – NSA Protected	NSA payment methodology; negotiation/IDR where applicable	In-network cost sharing only
Commercial – Not NSA Protected	Plan benefit design + applicable state/federal law	Potential balance billing, subject to applicable law
Medicaid Managed Care	State Medicaid/MCO-specific rules	Member billing generally highly restricted
Self-Pay	Provider-established pricing, subject to applicable law	GFE requirements may apply

Out-of-Network Reimbursement

Medicare Advantage – What Changes When You Go OON?

- **Reimbursement**

- MA plans generally must pay OON providers at least 100% of original Medicare rate for covered services
- Contracted rates and contract specific reimbursement methodologies no longer govern

- **Patient financial responsibility**

- Going OON does not convert the MA patient into a typical commercial OON patient.
- Medicare limits on balance billing continue to apply.

- **Appeal & Beneficiary Protections**

- The patient remains enrolled in MA, and applicable MA organization determination and appeal rights continue.
- Noncontracted providers may also have appeal rights for certain adverse determinations, subject to applicable requirements.

Medicare Managed Care Manual
Chapter 6 - Relationships With Providers

Table of Contents
(Rev. 82, 04-27-07)

100 - Special Rules for Services Furnished by Non-Contract Providers
(Rev. 24, 06-06-03)



Going OON may change the provider-plan relationship, but it does not eliminate MA regulatory framework

Out-of-Network Reimbursement

Medicaid MCO

- **Reimbursement Varies by State**
 - OON reimbursement is generally governed by federal Medicaid requirements and state Medicaid laws
 - **50-state patchwork of payment requirements**
 - Some states establish minimum reimbursement standards; others permit greater MCO discretion
- **Emergency Services Receive Special Protections:** Medicaid MCOs generally must cover and pay emergency services furnished by OON providers and without prior authorization
- Noncontracted emergency providers generally must accept **no more** than the applicable Medicaid FFS-equivalent amount **as payment in full**
- **Medicaid beneficiary billing is restricted**
 - Balance billing is generally prohibited for covered services subject to Medicaid beneficiary protections
 - Contract termination does not eliminate applicable beneficiary billing restrictions



No universal reimbursement floor for all Medicaid MCO services

Out-of-Network Reimbursement

No Surprises Act: When Does it Apply?

- The Federal No Surprises Act **limits patient cost sharing** and **prohibits balance billing** for certain out-of-network services under group health plans and individual health insurance coverage.
- **Key Protections:**
 - Emergency Services, including post-stabilization services
 - OON providers at in-network facilities
 - **NOTE:** Elective Services at OON Facilities generally fall outside the scope of NSA protections

Do the Federal Surprise Billing Protections Apply?			
Billing Entity	Emergency Services	Post-Stabilization Services	Non-Emergent Services
OON Facility	YES	YES	NO
OON Provider @ in-network Facility	YES	YES	YES
OON Provider @ OON Facility	YES	YES	NO



Going OON Does not automatically permit balance billing

Out-of-Network Reimbursement

No Surprises Act: Additional Requirements

- **Notice and Consent to Surprise Billing**

- Limited exception permitting balance billing when valid notice and consent requirements are met
- Available only for certain non-emergency services at in-network facilities and qualifying post-stabilization services

- **Consent is NOT permitted for:**

- Ancillary services (emergency medicine, anesthesiology, pathology, radiology, laboratory, neonatology, assistant surgeons, hospitalists and intensivist)
- Services when no participating provider is available at the facility

- Must use standard HHS form including an estimate of charges

- Patients may revoke consent prior to receiving services

- **Good Faith Estimates**

- Required for **uninsured and self-pay patients** upon scheduling or upon request
- Broadly applies to all state-licensed or certified health care providers and facilities
- Patients may dispute bills that exceed the GFE by at least \$400

 ***Notice and consent is a narrow exception – not a blanket waiver of NSA protections***

Out-of-Network Reimbursement

No Surprises Act: Penalties & Enforcement

- **Federal NSA violations may result in:**
 - **Civil Monetary Penalties** – up to **\$10,000 per violation**
- Patient complaints are generally the basis for CMS investigations

You can submit a complaint with us

When your provider or insurer might not be following the rules

Health insurance companies and health care providers and facilities must follow [rules that protect you](#) from unexpected, or “surprise,” out-of-network bills.

If you have a question about these rules or believe the rules aren't being followed, you can submit your question or complaint to the No Surprises Help Desk.

On this page

- [What to expect](#)
- [What you need](#)
- [What happens next](#)
- [Submit a complaint](#)

Submit a complaint

If your insurance company or provider isn't following surprise billing rules, submit a complaint.

[Get Started](#)

[Update an existing complaint](#) →

Submit a complaint over the phone:
[1-800-985-3059](#)

- However, CMS can also conduct random or targeted investigations

Out-of-Network Reimbursement

No Surprises Act: Lifecycle of NSA OON Claim



- **Separate Obligations:** Provider OON reimbursement and patient cost sharing are distinct
- **Revenue Cycle Risk:** Do not automatically bill the patient based on the patient-responsibility amount reflected on the payor's EOB
- **Operational Priority:** Ensure processes appropriately identify NSA-protected claims and coordinate accurate adjudication with the payors

Out-of-Network Reimbursement

No Surprises Act – Federal IDR Process

- Eligible NSA OON payment disputes may be resolved through **Federal Independent Dispute Resolution (IDR) process**
- **Baseball style arbitration:** Each party submits a payment offer; the certified IDR entity picks one
- **Strict procedural deadlines:** Missing a deadline may result in loss of IDR rights
- **Batching permitted:** Certain qualifying claims may be grouped into a single dispute subject to applicable requirements.
- **Cooling-off period:** Restrictions apply to initiating subsequent disputes involving the same opposing party and items or services, subject to applicable rules.

NO SURPRISES ACT - IDR PROCESS TIMELINE		
Action	Timeframe	Responsible Party
Open Negotiation Notice	30 Business Days from the date of receipt of initial payment or denial	Provider (sent to Health Plan)
Open Negotiation Period	30 Business Days from the day provider sends the Open Negotiation Notice	N/A
Notice of IDR Initiation	4 Business Days from the end of the Open Negotiation Period	Either party (sent to the other party in writing; sent to the Departments through the Federal IDR portal)
Selection of Certified IDR Entity (by parties)	3 Business Days from receipt of Notice of IDR Initiation Notice of selection to be sent to the Departments and the Certified IDR Entity on the 4th Business Day from receipt of Notice of IDR Initiation	Both parties to mutually select the Certified IDR Entity Initiating Party (notice of selection to be provided to the Departments and the Certified IDR Entity through the Federal IDR Portal)
Selection of Certified IDR Entity (by Departments)	6 Business Days from receipt of the Notice of IDR Initiation, the Departments will select the Certified IDR Entity if the parties are unable to mutually select	Departments
Submission of Offer and Other Credible Information	10 Business Days from selection of the Certified IDR Entity	Each party (submitted through the Federal IDR portal)
Payment of Certified IDR Entity Fee	At the time the party submits its offer to the Certified IDR Entity	Each party shall submit the entire fee. The prevailing party will have its fee remitted within 30 Business Days from the date the Certified IDR Entity issues its determination
Selection of Offer and Decision	30 Business Days from selection of the Certified IDR Entity	Certified IDR Entity (submitted through the Federal IDR portal)
Payment of Out-of-Network Rate	30 Calendar Days from the Certified IDR Entity's determination	Health plan (if OON rate is less than initial the payment) Provider (if OON rate is more than the initial payment)
"Cooling Off Period"	90 Calendar Days from the Certified IDR Entity's determination for single/bundled disputes; updated rules for qualifying batched disputes	Neither party may initiate the IDR process for the same or similar item or service with the same opposing party

Out-of-Network Reimbursement

Federal IDR Eligibility: Federal vs. State Law?

Before Federal IDR, determine:

- Is the plan fully insured or self-funded?
- Does an applicable state surprise-billing law govern?
- Does state law determine the OON payment amount?
- Is the claim eligible for federal IDR?

Remember . . . **Winning IDR ≠ Getting Paid**

- **Recent decisions have limited private judicial enforcement avenues for unpaid federal IDR awards**
 - 2025 5th Cir. ruling that there is no private right of action to enforce IDR awards under the NSA.
 - Sept. 2026 2d. Cir. ruling no private right of action under NSA, joining 5th Cir.
 - August 2026 state court order out of NY ruling that state law could not bridge the gap



Not every commercial OON reimbursement dispute proceeds through the federal IDR process

Out-of-Network Reimbursement

Patient Billing Considerations

Patient Cost Exposure = Reputational Risk

- Potentially higher patient cost-sharing
- Loss of network discounts
- Increased patient complaints, confusion, and negative publicity

Patient Perspective: Will patients blame the payor or provider?



Patient Discount Strategies Following Network Termination

Two approaches to mitigating patient financial exposure during an out-of-network transition

SELF-PAY DISCOUNT PROGRAM

Cash-pay rates for patients not using insurance

- Offer broadly to eligible self-pay patients—not only members of the terminated payor
- True self-pay: no insurance claim submitted; distinguish from cost-sharing waivers
- Assess dual-pricing concerns, state FCA, insurance fraud, and unfair trade practice theories
- Review Medicare usual-charge rules and NSA Good Faith Estimate obligations

TEMPORARY TRANSITION DISCOUNTS

Voluntary extension of former network financial protections

- Confirm existing contractual and statutory continuity-of-care obligations
- Consider extending former network financial protections to additional patients for a limited period
- Best practice: disclose proposed terms to payor in advance and coordinate claims handling
- Assess cost-sharing waiver concerns, OON benefits, patient billing, and operational feasibility



Patient relief strategies require legal review, payor transparency, and workable billing processes.

Out-of-Network Reimbursement

Self-Pay Discounts: Reimbursement and Compliance Risks

DISCOUNT PROGRAM CONSIDERATIONS

- Broadly available discounts may affect how charges are characterized under certain payment arrangements.
- Review payor contracts, government program methodologies, and charge-reporting requirements.
- Frequency and availability matter, but discounts do not automatically establish fraud.

DOJ ENFORCEMENT EXAMPLE | AHOLD DELHAIZE (2026)

- \$40 million settlement resolving allegations involving pharmacy discount-program prices.
- DOJ alleged that higher “usual and customary” prices were reported to government payors despite publicly available discounts.
- Pharmacy-specific example; not a categorical rule for hospital self-pay discounts.



Evaluate how discounts affect price reporting and reimbursement—not only patient affordability.

Conclusion & Takeaways



01

Start with the contract. Understand your options, desired outcome, and requirements.



02

Align your leadership. Make sure all key departments are ready to assist.



03

Involve PR early. Communicate proactively and effectively. Control the narrative where possible.



04

Establish a timeline to operationalize any new processes in a compliant manner.



05

Keep a pulse on patient experience, community impact, and reputation.

Questions



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