Surprise Billing & Price Transparency Update

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Surprise Billing & Price Transparency Update

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Today's Agenda

- Background/Overview of No Surprises Act & Interim Final Rule
- Scope of Surprise Billing Protections
- Interaction with State Law & ERISA
- Cost Sharing Limitation & Out-of-Network Rate
- Notice & Consent Requirements; Disclosure Requirements
- CMS Price Transparency Update
- Practical Takeaways
- Q&A

No Surprises Act Introduction

- The No Surprises Act was issued as part of the Consolidated Appropriations Act of 2021 enacted in December 2020.
- Legislation that bars surprise billing in most health care settings and establishes new transparency requirements to protect patients.
- Product of a lobbying frenzy!
- The provisions in the No Surprises Act generally go into effect on January 1, 2022.
- HHS, Treasury, and Labor tasked with issuing regulations and guidance to implement number of provisions in the No Surprises Act.

First 'No Surprises Act' Rule Issued–More to Come!

- Current Guidance was issued in the form of an **interim final rule with request for comments**.
  - Unlikely to change major provisions (i.e., QPA calculation) but could implicate many operational issues given large volume of RFIs in the regulation.
- Comments on the Interim Final Rule due on **September 7, 2021**
- Comments on the Model Notice & Disclosure Forms due on **August 12, 2021**
- More to Come in Future Rulemaking!! First of Many…
  - October 1, 2021 – Establish Process to Audit Health Plans for Compliance
  - December 27, 2021 – Independent Dispute Resolution Rulemaking Deadline
  - January 1, 2022 – Protections Against Provider Discrimination Regulation Deadline
  - January 1, 2023- HHS, FTC, DOJ to release Report on Consolidation, Health Care Costs, and Access

Major Provisions of this IFR:

- Calculation of the Qualifying Payment Amount (QPA)
  - What Decision Means for Providers/Future Rulemaking
- Emergency Services Protections – definitions and scope
- Notice and Consent Requirements
- Cost-Sharing Amount
- Provider/Facility Disclosure Requirements
- Complaint Process
- Claims Submission and Processing
- Interaction with State Law and ERISA

Scope of Surprise Billing Protections

Scope of the New Surprise Billing Protections

- The primary goal of the No Surprises Act was to protect patients from receiving surprise medical bills. To effectuate this goal, the interim final rule ("IRF") specifically prohibits surprise billing in the following 3 circumstances:
  1. Surprise billing of **emergency services** provided by out-of-network provider;
  2. Requires all **non-emergency services** furnished by out-of-network provider at an in-network facility, except in those situations where notice and consent are given; and
  3. Surprise billing for the provision of **air ambulance services** from out-of-network providers for those services, under certain circumstances.

1. Emergency Services

- IFR prohibits surprise billing for emergency services provided by any out-of-network provider
- Regardless of provider's status, each plan must treat all emergency services as in-network:
  - Without the individual or provider having to obtain prior authorization and
  - Without regard to the whether the provider furnishing the emergency services is out-of-network.

“Emergency Services” defined

- What are emergency services?
  - **Medical screening examination** to determine whether an emergency medical condition exists; and
  - **Post-stabilization items and services** that may be required to further stabilize the patient when a patient is moved out of an emergency department and admitted to a hospital

Post-Stabilization Services

- Post-stabilization services are considered emergency services unless **ALL** of the following conditions are met:
  - Provider must determine the individual is able to travel using non-medical transportation;
  - The provider or facility furnishing the post-stabilization services must satisfy the notice and consent criteria; and
  - Individual must be in a condition to receive the information in the notice and provide informed consent.

Emergency Services at Health Care Facility

- Emergency Services performed by the following health care facilities are within the scope of surprise billing requirements:
  1. Emergency Departments of Hospitals
  2. Independent Freestanding Emergency Departments
  3. Urgent Care Facilities
     - If permitted by state law to provide emergency services

2. Non-Emergency Services

- The No Surprises Act prohibits surprise billing of non-emergency services furnished by an out-of-network provider at an in-network facility, unless the notice and consent requirements are met.
- This requirement also applies to the furnishing the following items and services regardless of whether the provider is present at the facility:
  - Equipment and Devices
  - Telemedicine Services
  - Imaging Services
  - Laboratory Services
  - Pre- and Post-operative Services

Non-Emergency Services cont.

- Non-emergency services performed by the following in-network facilities are within the scope of surprise billing requirements:
  - Hospital
  - Hospital outpatient dept.
  - Critical access hospital
  - Ambulatory surgical center

3. Air Ambulance Services

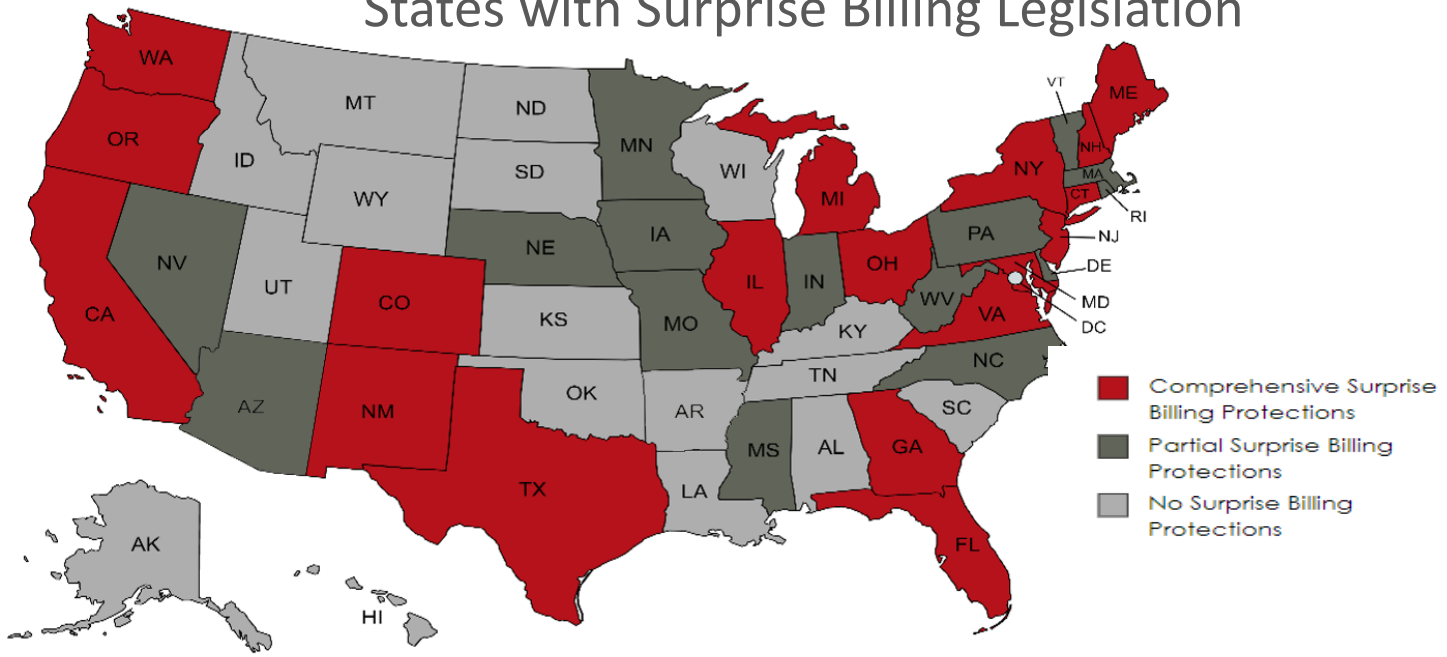
- Lastly, the IFR prohibits surprise billing of air ambulance services furnished by out-of-network providers
  - Why? Individuals generally don't have the ability to select the provider of air ambulance services and therefore have little to no control over whether the provider is in-network with their plan or coverage
- IFR does not apply to ground ambulance services

Interaction with State Law & ERISA

Landscape of State Surprise Billing Laws

- Many states have implemented surprise billing measures
- Other states have pending legislation
- State laws vary widely

States with Surprise Billing Legislation



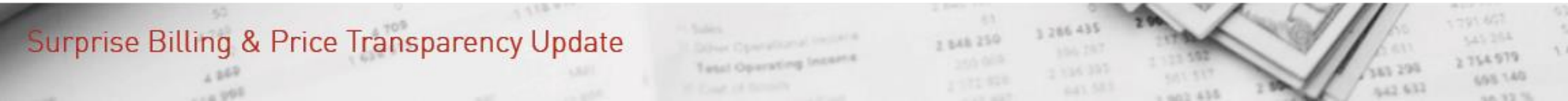
Source: The Commonwealth Fund- Data collection and analysis as of November 30, 2020, by researchers at the Center on Health Insurance Reforms, Georgetown University Health Policy Institute.

The Various State Approaches and the Need for a More Comprehensive Approach

- **Key elements of current state law prohibitions**
  - Prohibition on surprise billing for emergency services
  - Dispute resolution
  - Notice requirements
- **ERISA Plans**
  - Federal law previously exempted self- insured employer sponsored plans from state regulation
  - ERISA plans can now opt-in to a state's process for determining payment of out-of-network claims.

Interaction Between State and Federal Surprise Billing Laws

- Federal law generally preempts state law.
- IFR recognizes that many states already have surprise billing protections.
  - States may apply their state law requirements, so long as they do not "prevent the application" of any federal requirements.
  - The Act does not disturb the long-standing pre-emption of state laws as they apply to ERISA plans. ERISA does not preempt state laws that allow self-funded plans to opt into a state's process for determining payment of out-of-network claims.
- Deference to State Law
  - State methods for determining payment
  - Provider directories



Cost Sharing Limitation
&
Out-of-Network Rate

Cost Sharing Limitation

- Limits cost sharing obligations for out-of-network services to in-network rates for the same services
- Determined as if the patient was charged the “recognized amount” established by:
  - An All-Payer Model Agreement
  - If no All-Payer Model Agreement, then a specified state law
  - If no All-Payer Model Agreement or specified state law, then the lesser of the amount billed by the out-of-network provider, or the Qualifying Payment Amount

Specified State Law

- For state law to apply, it must provide a method for determining the total payment amount:
  - Includes methodologies, equations, state IDR processes, etc.
- Must apply to:
  - The Plan
  - The Provider
  - The item or service
- Deference to state law only extends as far as state law applies

Qualified Payment Amount

- The Qualified Payment Amount ("QPA") is determined by finding the:
  - *Median* of the contracted rates recognized by the health plan on January 31, 2019
  - For the *same or similar item or service*
  - That is provided by a provider in the *same or similar specialty*, and
  - Provided in the *geographic region* in which the item or service is furnished
- The QPA is increased annually for inflation based on the annual CPI-U adjustment
- Each insurance market will have its own QPA

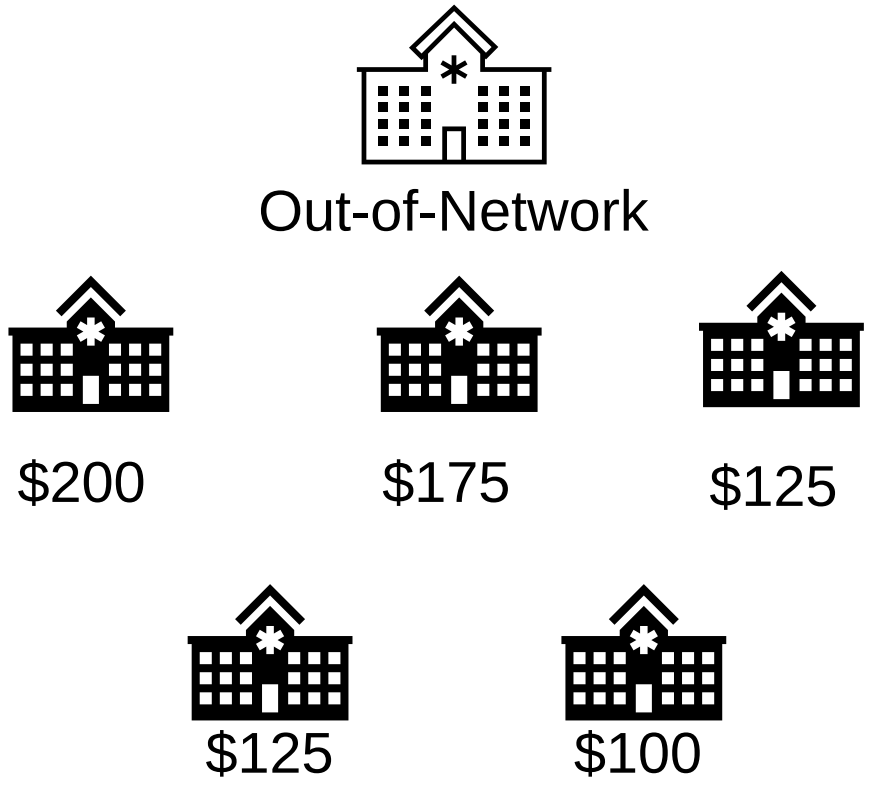
Qualified Payment Amount

- Median Contracted Rate:
  - Needs at least three rates
  - Each contracted rate, regardless of size of provider, is treated as a separate amount (if an agreement has unique rates for various providers, each rate will be counted separately)
  - Rates that are determined on a non-fee-for-service basis (e.g., capitation rates) must be calculated using the plan's underlying fee schedule
- Same or Similar Item or Service
  - A service billed under the same or comparable CPT/HCPCS/DRG codes
  - If modifiers are utilized separate median contracted rates will be calculated for each modifier

Qualified Payment Amount

- Same or Similar Specialty
  - Determined based on payor's typical method of contracting
  - Only required if payor applies different rates for different specialties
  - Special features of a facility are not to be considered
    - For purposes of this definition, for example, there is no premium for being an Academic Medical Center or teaching hospital
- Geographic Region
  - Metropolitan statistical area where the services are provided
  - If provided outside of a metropolitan statistical area, all other portions of the state

Qualified Payment Amount - Example



- A member of a plan receives a service from an out-of-network provider in Metropolis
- No All-Payer Model Agreement or specific state law
- The QPA for the out-of-network service will be $125
- The member's cost share obligation will be the plan's in-network cost share amount applied to the QPA

  ex: $125 x 10% = $12.50

Qualified Payment Amount

- Alternate Methodologies
  - Utilized if a plan has insufficient information to establish a median contracted rate (e.g., new health plan, insufficient contracted rates for the item or service in the region, or it is a new item or service)
  - Only utilized until such time as the plan has enough information based on its own contracts to establish a QPA

Out-of-Network Rate

- NOTE: The “Recognized Amount” is not the same as the out-of-network rate
- Amount paid to the out-of-network provider, minus the permitted cost-sharing obligation, as determined by:
  - All-Payer Model Agreement
  - If no All-Payer Model Agreement, then specified state law
  - If no All-Payer Model Agreement or specified state law, then negotiations between the Provider and Plan
  - If the negotiations fail, then by the IDR Process
- Certain QPA information must be disclosed on initial claim payment or denial to assist the provider during the negotiation process

Overview

Cost Share Limitation
In-Network Cost Share x "Recognized Amount"
"Recognized Amount" = All-Payer Model Agreement, specified state law, or QPA
QPA = Health Plan's Median Contracted Rate for the Same or Similar Item or Service in the Same Region

Out-of-Network Rate
Amount paid to the Out-of-network provider for the item or service
Determined by: All-Payer Model Agreement, specified state law, or negotiation and IDR
Out-of-network rate ≠ Recognized Amount or QPA

Notice & Consent Requirements; Disclosure Requirements

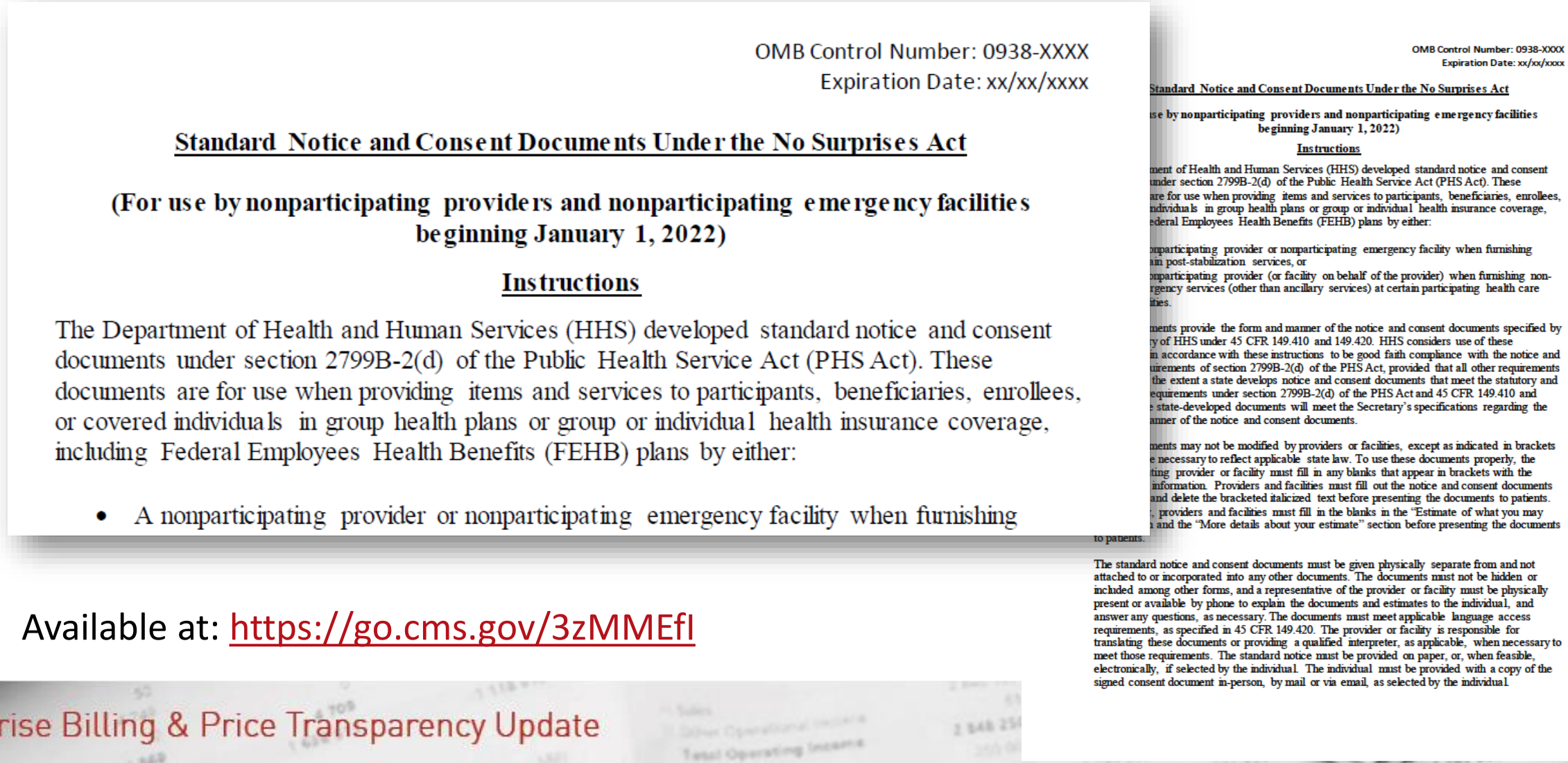
Waiver of Surprise Billing Protections

- Patients may knowingly & voluntarily waive certain surprise billing and cost-sharing protections in the following limited circumstances:
  - Services provided by an out-of-network provider or out-of-network emergency facility when furnishing certain post-stabilization services; or
  - Services provided by an out-of-network provider when furnishing non-emergency services at an in-network facility
    - In such cases, the in-network facility may provide the waiver on behalf of the out-of-network provider

Waiver of Surprise Billing Protections- Notice and Consent Requirements

- Out-of-network providers must satisfy specific notice and consent requirements
  - Must use the model notice and consent form; May only be modified to add information identifying the provider, the patient, and the contemplated items and services
  - Must contain a good faith estimate of the charges for the items and services
  - Must be physically separate from, and not attached to any other documents
  - Must be provided to the patient at least 72 hours prior to the patient's scheduled appointment (3 hours, if same day appointment)
  - An incomplete consent document will be treated as a lack of consent and balance billing protections will still apply to the patient.

Model Notice and Consent Form



OMB Control Number: 0938-XXXX
Expiration Date: xx/xx/xxxx

Standard Notice and Consent Documents Under the No Surprises Act

(For use by nonparticipating providers and nonparticipating emergency facilities beginning January 1, 2022)

Instructions

The Department of Health and Human Services (HHS) developed standard notice and consent documents under section 2799B-2(d) of the Public Health Service Act (PHS Act). These documents are for use when providing items and services to participants, beneficiaries, enrollees, or covered individuals in group health plans or group or individual health insurance coverage, including Federal Employees Health Benefits (FEHB) plans by either:

- A nonparticipating provider or nonparticipating emergency facility when furnishing

Available at: https://go.cms.gov/3zMMEfl

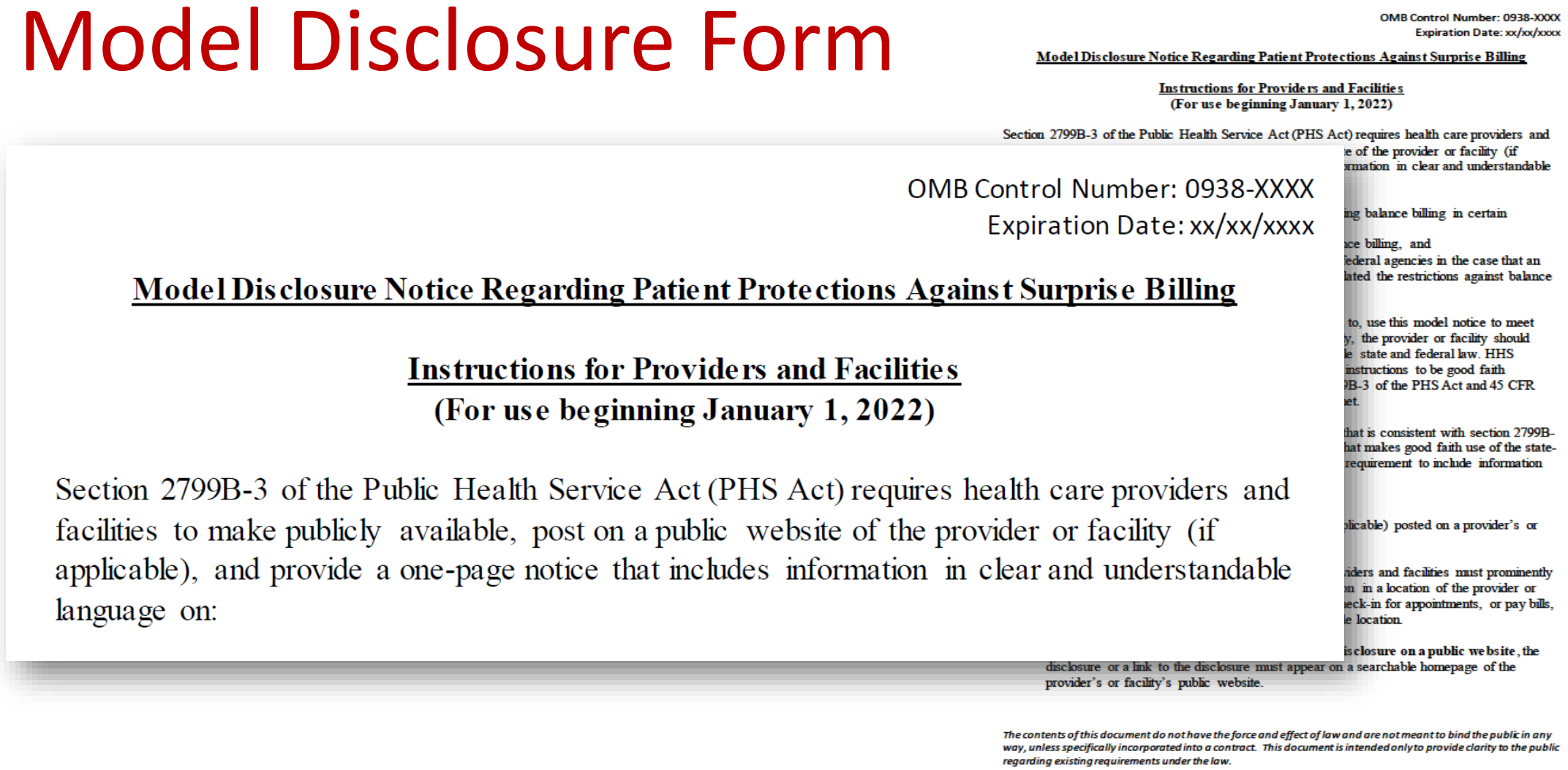
Waiver of Surprise Billing Protections

- Patient may not waive the surprise billing/cost sharing protections for the following services:
  - Emergency services
  - Air Ambulance services
  - Items/services provided by a nonparticipating provider when there is no participating provider available to furnish such items or services at the participating health care facility
  - Items/services for unforeseen urgent medical needs,
  - Ancillary services that a patient does not typically select

Website Disclosure Requirements & Complaint Process

- Providers and Facilities must disclose surprise billing protections on their public website
  - Disclosure requirements do not apply to air ambulance services.
- Disclosure must:
  - Explain the requirements & prohibitions under the No Surprises Act & any related state law requirements; and
  - Include contact information for reporting violations of the Act or applicable state law to federal and state agencies.
- Clarification to come in future rulemaking
- A model disclosure notice form is posted on the CMS website

Model Disclosure Form



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Model Disclosure Notice Regarding Patient Protections Against Surprise Billing

Instructions for Providers and Facilities
(For use beginning January 1, 2022)

Section 2799B-3 of the Public Health Service Act (PHS Act) requires health care providers and facilities to make publicly available, post on a public website of the provider or facility (if applicable), and provide a one-page notice that includes information in clear and understandable language on:

Available at: https://go.cms.gov/3zMQx4k

Price Transparency Update

Price Transparency Requirements

- Hospital Price Transparency Rule
  - Final Rule (new 45 CFR 180) effective January 1, 2021
  - Applies to all licensed hospitals
  - Two requirements: machine-readable file and consumer-friendly list of shoppable services (most use a price estimator tool)
  - Includes disclosing payer-specific negotiated charges
  - Legal challenges unsuccessful
- No Surprises Act
  - Providers must share a good faith estimates of the “expected charges” for scheduled services with a health plan (if the patient is insured) or individual (if the patient is uninsured)
  - Details not addressed in current rule-making

The UPDATE:

Enforcement has started

and

Penalties are going up.

Price Transparency Enforcement

- Monitoring
  - Evaluation of consumer or entity complaints
  - CMS-initiated audits
  - ***auditing price transparency compliance is easy***
- Notice and Corrective Action
  - Written notice of violation
  - Opportunity to cure
  - Corrective action plan (CAP) if violation is material
  - Civil penalties if hospital fails to respond to request for CAP or fails to comply with CAP
- Anecdotal examples to date have been focused on unambiguous violations

Price Transparency Penalties

- Currently
  - maximum penalty is $300 per day per hospital (even if multiple discrete violations)
  - CMS will publicize penalties on public website
- Reports of low industry compliance with rule
- Proposal
  - CMS is proposing to increase penalty using a scaling factor based on bed count
  - Hospitals with more than 550 beds = $5,500 daily penalty
  - Hospitals between 31 and 550 = $10 per day per bed
  - Hospitals with 30 or fewer beds = $300 per day
- Maximum annual penalty for large hospitals therefore is going from $109,500 to **$2,007,500**

Practical Takeaways

Practical Takeaways

- Submit comments!
  - *Key Deadlines*: **September 7th** for IFR, **August 12th** for model notice and disclosure forms
- Be on the lookout for additional rulemaking
- Facilities should assess participation status of their contracted physician groups
- Providers should begin preparing model notice and consent forms
- Providers & Facilities should ensure your websites contain the required surprise billing disclosures before January 1, 2022
- Look out for communications from plans and proposed amendments that address this rule
- Consider whether it makes sense to be in-network or out-of-network with a particular payer

Q&A


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