2022 Virtual Regulatory Review Series

Out-of-Network Payment and the No Surprises Act

Jan. 18, 2022

POLSINELLI | c|h|a Colorado Hospital Association

1

Continuing Legal Education (CLE)

POLSINELLI | c|h|a Colorado Hospital Association

Requirements to receive credit:

- Make sure you are on Zoom and not just called in
- Make sure you are logged into your own computer
- Make sure your name on your Zoom screen includes first and last name (no phone numbers)
- Answer polling questions – two questions total
- Complete the evaluation at the end of each session

CLE available for the following states:

AZ	IL	OH
CA	KS	TN
CO	MN	TX
DE	MO	VA
FL	NC	WA
GA	NY	WI

For all those who requested CLE credit and answered the polling questions, CLE certificates will be emailed within 48 hours after the session.

For CLE questions, contact Sinead McGuire, Polsinelli department marketing manager, at smcguire@polsinelli.com.

2

Today's Presenters and Agenda

Megan Axelrod
Manager, Regulatory Policy
Colorado Hospital Association

Ryan Morgan
Shareholder
Polsinelli

Agenda

- Overview of the legislative history, applicability, and topline differences between the state and federal laws
- Deep dive into how dispute resolution works
- Path forward, areas for alignment

3

What Is "Surprise Billing"

- **Defined by the Centers for Medicare & Medicaid Services** (CMS) as when a patient gets an unexpected bill from a health care provider or facility.
- ***Example 1:*** *A patient has a heart attack and is taken by ambulance to the emergency department (ED) of a facility that is out-of-network (OON) for their insurance plan. They are then charged a higher, out-of-network rate.*
- ***Example 2:*** *A patient schedules a surgery at an in-network facility but receives care from an out-of-network anesthesiologist and is billed for it.*

4

Polling Question #1

A patient has *Insurance A* and they schedule brain surgery at *Facility A* (in-network) to remove a tumor. Two days after surgery they get a CT scan. The radiologist who handles that scan only accepts *Insurance B* – the patient receives a bill for the difference, this is surprise billing.

- True
- False

5

Policy Challenge

6

Legislative History

- There are now state and federal laws to hold patients harmless from surprise medical bills and establish processes for the resolution of payment disputes between providers and payors.
- Colorado's **HB 19-1174 Out of Network Health Care Services Act** was signed into law in May 2019 and took effect Jan. 1, 2020.
- The federal **H.R. 3630 No Surprises Act** was signed into law in January 2020 and most of the sections of legislation went into effect on Jan. 1, 2022.

7

Exceptions

- Neither law applies to a consumer that **voluntarily** chooses to use an out-of-network provider.

8

Colorado Law

- **Applies to** state-regulated health plans including individual, small, and large group plans.

  CO-DOI Printed on the Insurance Card

- **Requires facilities** provide patients a disclosure about the potential effects of receiving services from an out-of-network facility or an out-of-network provider who proves services at an in-network facility.

- **Requires OON providers** provide a written estimate of the patient's financial responsibility for OON non-emergency services (on request)

9

Reimbursement Levels

- If a covered person receives *emergency services* at an *out-of-network facility*, the carrier must reimburse the out-of-network facility the greater of:

  - 105% of the carrier's median in-network rate for that service provided in a similar facility or setting in the same geographic area; or,

  - The median in-network rate for the same service provided in a similar facility or setting in the same geographic area for the prior year based on claims data from the Colorado All-Payer Health Claims Database (CO APCD).

10

Reimbursement Levels Cont.

- If a covered person receives covered services at an *in-network facility* from an *out-of-network provider*, the carrier shall pay the *out-of-network provider* directly the greater of:
  - 110% of the carrier's median in-network rate for that service provided in a similar facility or setting in the same geographic area; or,
  - 60th percentile of the in-network rate for the same service in the same geographic area for the prior year based on commercial claims data from the CO APCD.

  If the out-of-network provider submits a claim after 180 days, the health plan must reimburse the out-of-network provider 125% of Medicare.

11

Colorado Dispute Process

- Arbitration may be requested if a provider believes a payment made in accordance with this bill was not sufficient given the complexity and circumstances of the services provided.
- When the parties to a billing dispute are unable to resolve the matter through an informal settlement teleconference, the Commissioner of Insurance will appoint an arbitrator to resolve the dispute.

12

Timeline - Informal Negotiations

Colorado OON Health Care Services Act	No Surprises Act
• Provider has 90 days to request arbitration using DOI form. • AFTER the provider has requested arbitration, the provider and the plan *may* engage in an informal settlement teleconference within 30 days. • If the plan does not agree to participate, the provider has 3 days to notify DOI. • If a settlement is reached the provider and plan must notify DOI within 5 days.	• BEFORE a provider requests arbitration, disputing parties *must* initiate a 30-day "open negotiation" period to determine a payment rate. • If no agreement is reached, parties have 4 days to request independent dispute resolution (IDR).

13

Federal Law

- **Applies to** federally regulated health plans, including self-funded ("ERISA") and Federal Employees Health Benefit (FEHB) plans.
- **Establishes a** common consent form.
- **Requires hospitals** to provide cost estimates to self-pay and uninsured patients.

14

Reimbursement Levels

- Under federal law, the total amount to be paid to the provider or facility is based on an amount determined by a specified state law.
- Current Colorado law does not specify a payment amount for federally regulated plans. Therefore, unless the plan opts into the state law, the payment amount must be agreed upon by the plan or the plan and the provider or facility.

15

Federal Dispute Process

- If the payer and provider are not able to agree on a payment amount, that is determined through a new IDR process called "***baseball-style***" arbitration, where each party offers a payment amount, and the IDR entity selects one amount or the other.
- Claims may be bundled in federal IDR process
- **IDR entities** *must* presume the Qualified Payment Amount (QPA)-set based on the median contract rate within the same market is the accurate OON rate

16

Legal Landscape

- On Dec. 9, 2021, the American Hospital Association (AHA) and American Medical Association (AMA) sued the federal government over a narrow provision of the implementing guidance concerning the independent dispute resolution process.
- The plaintiffs are arguing that the federal rules include a presumption that the median in-network payment rate is the appropriate rate for out-of-network services.

17

Congressional Input

- The Democratic chairs of the Senate Health, Education, Labor and Pensions (HELP) Committee and the House Energy and Commerce (E&C) Committee made a statement supporting NSA regulations
- Later, the bipartisan leadership of the House Ways and Means Committee made a statement that NSA regulations “do not reflect the law that Congress passed”

18

IDR Technical Expertise

19

Dispute Resolution Mechanisms

- Independent Dispute Resolution ("IDR")
  - OON payment disputes between providers and plans
- Selected Dispute Resolution ("SDR")
  - Patient-Provider dispute resolution process

20

IDR - Overview

- ACA OON payment rule revised
  - ACA required plans to pay for OON emergency services via "greatest of three" rule:
    - Median in-network rate;
    - The amount the plan "generally uses" (usually UCR); or
    - Medicare rate
  - NSA requires a 2-step process
    - Plan must make "initial payment" within 30 days of receipt of claim (or deny it);
    - Then plan must pay the "out-of-network rate," less the "initial payment."

21

IDR – OON Rate

- OON Rate (for everyone except air ambulance providers):
  1. The amount "specified by state law," if one exists;
  2. If no #1, the amount specified under an "All-Payer Model Agreement," if one exists;
  3. If no #1 or #2, the amount agreed to during the open negotiation period; or
  4. If no #1 or #2 or #3, the amount awarded during the IDR process
- "Specified by state law" includes state laws that permit parties to engage in state arbitration processes to determine the out-of-network rate (like Colorado)
- The remaining IDR slides are only applicable for #4

22

IDR – QPA and Initial Payment

- Qualifying Payment Amount (QPA) is used to determine patient cost-sharing.
  - NSA does not establish a reimbursement standard
  - QPA will likely be used by plans to make initial payments to providers
- QPA = the median contracted rate for the same or similar item or service provided by a provider in the same or similar specialty and in the same geographic region in 2019 (trended forward).
  - Rental network rates count; Single Case Agreement rates do not count
  - Medicare/Medicaid rates do not count
  - Different QPAs for different insurance markets (e.g., individual, small group, large group)
  - Different QPAs for providers and facilities

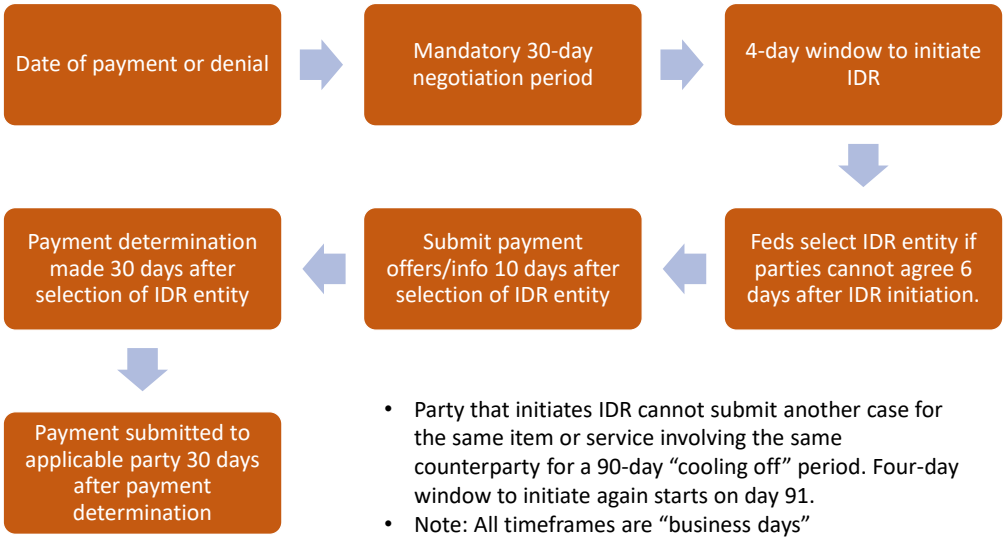
23

IDR - QPA and Initial Payment

- QPA (continued)
  - Value-based arrangements: Plans to use internal, underlying fee schedule amount
  - Insufficient data in 2019 (< 3 contracted rates): complex process
- Plans must share info about QPA with providers:
  - Value of QPA
  - Statement certifying that QPA was calculated correctly
  - Statement that provider may enter into a 30-day open negotiation period with plan
  - Whether non-FFS rates were included
  - Whether "related" service codes were used
  - Whether the QPA includes value-based arrangements
  - What database was used to calculate QPA, if any

24

IDR - Timeline



- Party that initiates IDR cannot submit another case for the same item or service involving the same counterparty for a 90-day "cooling off" period. Four-day window to initiate again starts on day 91.
- Note: All timeframes are "business days"

25

IDR – Factors to Consider

- The IDR entity is instructed to consider additional information as follows:

Factors the IDR Entity Considers	Factors the IDR Entity CANNOT Consider
The QPA (median INN rates)	Provider's billed charges
The provider's training and experience, patient acuity, and complexity of the service	UCR "charges"
Any good faith efforts to enter INN agreements	Medicare/CHIP rates
Market share of the parties	TRICARE rates
Contracted rates during the previous 4 years	
In the case of a hospital, its teaching status, case mix, and scope of services	
Any other non-prohibited information relating to the offer submitted by either party	

26

IDR– QPA Presumption

- NSA discussed IDR factors without assigning relative weights
- NSA regulations identified the QPA as presumptively correct
- IDR entity must select the offer closest to the QPA unless there is "credible information" that "clearly demonstrates" that the QPA is "materially different" from the appropriate OON rate.
  - Very high rebuttable presumption
  - Baseball-style
- IDR entities are prohibited from considering whether QPA was calculated correctly.

27

Selected Dispute Resolution

- Uninsured or self-pay individuals may dispute actual billed charges that are "substantially in excess" of the good faith estimate.
  - "Substantially in excess" = > $400
- Patient can initiate SDR by notifying HHS within 120 days of receipt of the bill.
  - Can use Federal IDR portal to initiate
  - Patient must pay SDR administrative fee on initiation ($25)
  - SDR entity selected round robin
- If request is eligible, SDR entity notifies provider and requests certain information Provider may not bill or collect and must suspend accrual of late fees during dispute
  - Provider may not retaliate against patient for utilizing the SDR process

28

SDR Process

- If patient-provider agreement on payment amount, provider must notify SDR entity of:
  - Date of settlement;
  - Amount of settlement (reduction in bill must be at least ½ of the administrative fee); and
  - Documentation that parties have agreed to settlement terms
- If no agreement on payment amount, provider must furnish SDR entity with the following within 10 days:
  - Copy of good faith estimate;
  - Copy of billed charges
  - Documentation that additional charges were for unforeseen circumstances resulting in the need for medically necessary items or services

29

SDR Process

- SDR entity has 30 days to decide whether each unique item or service:
  - Is supported by "credible information" justifying the charge
  - Is "based on unforeseen circumstances that could not have been reasonably anticipated" when the good faith estimate was provided
- If additional charges are supported by "credible information," the amount to be paid is the lesser of:
  - The billed charge; or
  - The median payment amount paid by a plan or issuer for the same or similar service as contained in an independent database.

30

Dispute Resolution Provider Challenges

- Meeting IDR Deadlines
  - Identifying underpayments
  - Batching
  - Deciding to pursue IDR and timely initiation
  - Aggregation of data in support of underpayment
  - Deciding on an offer
- Interplay with plan appeals process
- Challenging the QPA
- For SDR – Who is "uninsured" or self-pay?
  - Health care sharing ministries
  - Discount cards
  - Choose not to use available insurance

31

Poll Question #2

It is easy to determine whether a patient's insurance plan is regulated by the state or federal government at the time of admission?

- True
- False

32

Path Forward

- **This legislative session, CHA expects DOI to work towards**
  - Streamlined administration,
  - Efficiency,
  - And alignment of state and federal requirements
- CHA will continue to raise concerns around hospitals' ability to determine real-time applicability of state and federal laws.

33

Areas for Alignment

- **DOI Jurisdiction:** To the extent federally regulated plans can choose to opt-in to state payment rates, that flexibility needs to be accompanied by a strong state-based regulatory framework that applies to those plans.
- **Bundling Claims for Arbitration:** Unlike the federal law, state law lacks the ability to "batch" claims for purposes of arbitration, meaning that every claim must be adjudicated separately in Colorado.
- **Duplicative Requirements:** The state "disclosure" requirement is duplicative/conflicts with the "informed consent" requirement provided by federal law.

34

Best Practices- Notice/Consent

- The federal and state informed consent processes are different.
- **NSA is the stricter standard –** hospitals should follow both.

35

ERISA Plans and Colo.

Q: Does Colorado allow Employee Retirement Income Security Act (ERISA) plans to opt-in to our OON law?

A: The federal NSA regulations allow ERISA plans to voluntarily opt-in to state law.

Colorado does not have to provide a process – plans make this decision on their own.

If a plan opts in, they must prominently display that decision on their plan materials.

36

Questions?

37

Evaluation

To use the QR code:

- Focus your phone's camera on the code and you will see a link to the survey appear.
- Tap this link and you will be taken directly to the survey.

We encourage everyone to take a moment now to complete the survey.

Next Session:
Stark Law and Fraud and Abuse in Review

Noon – 1:15 p.m.

Tuesday, Jan. 25

38

Contact Information

Megan Axelrod
Manager, Regulatory Policy
Colorado Hospital Association
megan.axelrod@cha.com

Ryan Morgan
Shareholder
Polsinelli
rmorgan@polsinelli.com

39