hfma
wisconsin chapter

No Surprises Act: Lesson's Learned

Strategies for the Healthcare Leader

May 19, 2022

BKD CPAs & Advisors

hfma
wisconsin chapter

Surprise Billing- Objectives

- No Surprises Act – High level overview
- Risks of Non-Compliance
- Requirements & Processes Related to Surprise Billing
  - Qualified Payment Amounts
  - Provider-payer Dispute Resolution
  - Good Faith Estimates
- Planning for the Future

hfma
wisconsin chapter

History of Surprise Billing

The Underlying Causes of Surprise Medical Bills
April 26, 2019 David Blumenthal & Shanoor Seerval

High health costs are keeping Americans up at night – nearly half of working age adults say they could not pay an unexpected $1,000 medical bill within 30 days, according to a 2018 Commonwealth Fund Survey. Several estimates suggest one of five inpatient emergency department visits may lead to surprise bills. The problem has captured the interest of lawmakers on both sides of the political aisle because these bills have such an outsized impact on consumers & are widely regarded as unfair. But why do people get surprise bills in the first place & what can policymakers do to address the problem?

InstaMed's 12th Annual Trends in Healthcare Payments Report Reveals 87% of Consumers Were Surprised by a Medical Bill in 2021

Findings examine how changes brought on by the pandemic, increased conversations about social determinants of health (SDOH) and a demand for price transparency are driving the demand for digital in healthcare payments

Footnotes: *Matt Timmons ValuePenguin

hfma
wisconsin chapter

NSA- High Level Overview

1 **No Surprises Act Interim Final Rule Part 1**

Part 1 Released July 2021

- May not balance bill patients for emergency stabilization services
- ED Post stabilization waiver
- Protects patients from balance bills from out-of-network providers for services performed at in-network facilities (unless waiver is obtained)
- Establishes in network cost-share for services outlined above for Providers & treatment by payers the Qualified Payment Amount (QPA)
- Public notice of compliance with state & federal balance billing regulations
- Selection of PCP & continuation of coverage

2 **No Surprises Act Interim Final Rule Part 2**

Part 2 Released September 2021

- Establishes the Provider-Payer dispute resolution Process & Timelines
  - Open negotiation period
  - Selection of the IDR
  - Ruling & payments
- Establishes the requirements & timelines for good faith estimates for self-pay or uninsured patients
  - Establishes the future (1/2023) requirements for convening providers
- Establishes the Patient-Provider dispute resolution process & timelines

hfma
wisconsin chapter

The "So What"… What Happens if You Don't Comply?

Complain to CMS

Providers must respond to CMS notices of a complaint in as short as 3 days.

Corrective Action Plans

Dual state & federal enforcement efforts lead to multiple audits.

Revenue Reductions

Health plan's initial offer will set new payment rates & patients can still access arbitration.

Civil Monetary Penalties

Claims recoupment & civil monetary penalties up to $10,000 per violation.

hfma
wisconsin chapter

No Surprises Part 1

- Balance or Surprise Billing for Emergency Care
- Surprise & Balance Billing for Out-Of-Network Providers at In-Network Facilities
- Establishes the Qualified Payment Amount (QPA) for Services

hfma wisconsin chapter

Patient Protections Under the NSA

Patients are provided protection under the NSA:

Scenario 1: Emergency Care through stabilization
- UNLESS a waiver of protection is obtained patients are also protected for procedures or stay associated with the emergency department admission

Scenario 2: OON Providers at in-network facilities - Providers & Payers may only hold patients responsible for in-network cost share

Payers are to process as in-network and compensate providers at the Qualified Payment Amount (QPA)

hfma wisconsin chapter

What is the Qualified Payment Amount (QPA)?

YES

Health plan's median contracted rate for geographic region in 2019 (for 2022 charges), or prior year's rate (for 2023 → charges)
- Applies in the absence of an of All Payer Model Agreement or State Law
- QPA is final and payment in full

NO
- Mean of in-network rate
- Previous contract rate
- Billed Charges
- Other out-of-network provider charges
- Medicare/Medicaid rates

hfma wisconsin chapter

In Most Cases Care Provided Under the NSA will Result in a QPA Payment

Scenario 1: Emergency Care through stabilization

- OON Emergency care = $QPA
- Post stabilization care 2 options:
  - Obtain waiver to balance bill
  - Accept the $QPA

Scenario 2: OON Providers at in-network facilities - Providers & Payers may only hold patients responsible for in-network cost share

- Non-scheduled services = $QPA
- Scheduled services 2 options:
  - Early identification of an OON patient and waiver to balance bill
  - Accept the $QPA

- Quickly identify plans as OON in order to obtain waiver of protection
- Monitor claims paid under the QPA for appropriateness

→ **DIFFICULT**

hfma wisconsin chapter

Monitoring Out-of-Network (OON) Claims

Patient Accounting Systems Assist in Tracking OON Plans?

- ⊘ Allscripts
- ⊘ Athena
- ⊘ Cerner
- ⊘ CPSI
- ✓ Epic
- ⊘ Meditech

- ***Underlining the importance of identifying OON Plans:***
  - Compliance
  - Appropriate Reimbursement

hfma
wisconsin chapter

Helping Payers Understand the Regulation…

RE: OON Reimbursement for [redacted] Services at INN Facilities

By [redacted] on January 24, 2022

We also just learned from [redacted] that [redacted] is justifying setting the OON allowed amount at 100% of Medicare with the No Surprise Act. Not sure how that applies but thought it would be helpful to try to understand their logic.

hfma
wisconsin chapter

Helping Payers Understand the Regulation…

Balance billing protections when facility and provider are OON

by [redacted] on February 21, 2022 3:57 PM in Discussions

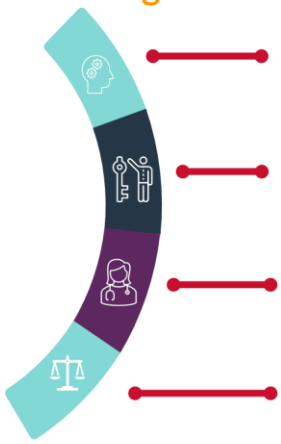
As it relates to the balance billing protections of the NSA, my understanding is that when both the facility and provider are OON, they can balance bill for non-emergent services even without notice and consent.

A couple of things happened last week that are making me second-guess this understanding, so I wanted to see if I was missing something. First, we had a commercial insurer tell an OON surgeon planning to perform a non-emergent service at our also OON facility that the patient could have the surgery OON but that their OOP would be limited to the in-network amount. That would imply neither we nor the surgeon could balance bill since the insurer would pay us both at an OON rate. Second, I saw an article about a well-known system stating they had seen an increase in scheduled OON patients since those patients must now be charged the in-network rate even for OON services. I'm unclear why they believe they can't balance bill these OON patients, if they so choose.

Have I missed a significant provision of the NSA, or is this a case where some payors and providers are confused about the balance billing protections?

hfma
wisconsin chapter

Operational Challenges Associated with NSA Part 1 Balance Billing



Develop & out-of-work strategy
Often difficult to identify out-of-network (OON) plans. Organizations will need to improve recognition of OON patients to track claims for review.

Develop Internal SWAT Teams
Enable (denials) teams to review OON claims & escalate quickly for possible independent dispute resolution (IDR). Monitor for balance billing scenarios

Hospital & Provider Relationships
For non-employed & contracted providers, understand their network status & approach: waiver & bill vs accept "in-network" adjudication

Keep Pressure on Payers
Payers may deny or fail to process claims correctly: be prepared to catch errors & dispute appropriately. Document everything.

hfma
wisconsin chapter

No Surprises Part 2

- Provider Payer Dispute Resolution
- Good Faith Estimates for Self-pay & Uninsured Patients
- Patient Provider Dispute Resolution Process

hfma
wisconsin chapter

Provider-Payer Dispute Resolution

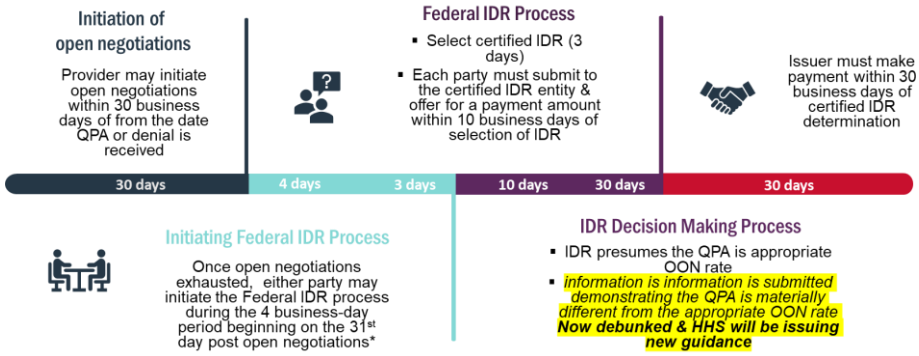
hfma
wisconsin chapter

Independent Dispute Resolution (IDR)

Provider that submits claim and suspects the payment is incorrect or not at the appropriate OON rate may enter open negotiations or file for Independent Dispute Resolution (IDR)

hfma
wisconsin chapter

Provider-Payer Dispute Timeline



hfma
wisconsin chapter

Provider-Payer Arbitration Re-do

HHS to revise independent dispute resolution guidance for No Surprises Act

Alia Paavola - Wednesday, March 2nd, 2022 Print | Email

Share Tweet Share 4 Listen AA TEXT

HHS will revise its guidance on the arbitration process outlined under the No Surprises Act following a federal court ruling.

A federal judge ruled Feb. 23 that the independent dispute resolution process implemented by HHS violated the Administrative Procedure Act. The Texas Medical Association sued the Biden administration in October 2021 over the surprise-billing resolution process, claiming it did not meet Congress' vision for the bill.

Providers have taken issue with a portion of the process that assumes the qualifying payment amount, the median in-network rate set by health insurers, is the appropriate out-of-network rate.

HHS said it will revise its guidance for determining the payment amount for out-of-network services in light of the ruling. It also said it would train certified independent dispute resolution entities and disputing parties on the revised guidance.

HHS will also permit parties to reopen a negotiation period for disputes if it expired.

What does this judgement regarding the IDR process mean…?

- Additional factors to be considered when determining judgement on the QPA

hfma
wisconsin chapter

Updated Guidance – IDR Process

1. The level of training, experience, and quality outcomes
2. The market share held by provider or facility of that plan in geographic region
3. The acuity of the patient and complexity of the service
4. Teaching status, case mix, and scope of services
5. Good faith efforts made by provider, facility or plan to enter into an agreement over last 4 years

- "CREDIBLE" information must be provided to support how each item affects the appropriate OON rate
- The decision of the arbitrator is **final** & the loser pays costs of arbitration.
- The party that initiated the IDR may not initiate a subsequent IDR with same party, for similar Item or Service, during a 90-day "cooling-off" period.
- If the end of a payment negotiation period ends during the "cooling-off" period, either party must submit IDR notice within 30 days of the last day of the "cooling-off" period.

hfma
wisconsin chapter

Independent Dispute Resolution (IDR) Open – Ready??

CMS.gov
Centers for Medicare & Medicaid Services

Payment disputes between providers and health plans

Start A Dispute

hfma
wisconsin chapter

Helping Payers Understand the Regulation…

New replies to **Open Negotiations**
by [redacted] on February 17, 2022 2:32 PM in Discussions
Hi, Does anyone have a list of the documents that need to be sent with an open negotiation request? We submitted one and the insurer came back and stated we did not submit "credible informa...

[redacted] on February 21, 2022 3:50 PM
Thanks, [redacted] Your post will be helpful since United Healthcare responded that they will not negotiate after receiving our open negotiation notice.

hfma
wisconsin chapter

Good Faith Estimates

hfma
wisconsin chapter

Good Faith Estimates (GFE)

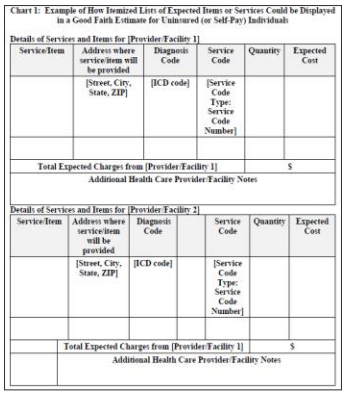


Chart 1: Example of How Itemized Lists of Expected Items or Services Could be Displayed in a Good Faith Estimate for Uninsured (or Self-Pay) Individuals

Details of Services and Items for [Provider/Facility 1]

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service Code Type: Service Code Number]		
Total Expected Charges from [Provider/Facility 1]					$
Additional Health Care Provider/Facility Notes					

Details of Services and Items for [Provider/Facility 2]

Service/Item	Address where service/item will be provided	Diagnosis Code		Service Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]		[Service Code Type: Service Code Number]		
	Total Expected Charges from [Provider/Facility 1]					$
	Additional Health Care Provider/Facility Notes					

2022
Providers are responsible to provide Self-pay & Uninsured patients a Good Faith Estimate for all scheduled services

2023
Beginning in 2023 the Convening Provider responsible for providing all- inclusive GFE

The convening provider will be required to contact the co-provider for estimates associated with primary service

A co-provider will have 1 day to provide estimate to convening provider

hfma
wisconsin chapter

Good Faith Estimates – The Facts..

Prominently Displayed- Information regarding the availability of estimates must be prominently displayed (facility) & easily searchable via website

Verbal Notification- The convening provider must verbally inform uninsured/self-pay individuals of the availability of a good faith estimate

Written or Printable Format- Must be provided in written form either on paper or electronically (email, portal) pursuant to individuals requested method of delivery.

Retained as part of the Medical Record- Forms considered part of Medical Records with 6 year retention

hfma wisconsin chapter

Timelines & Recommendations Related to GFEs

STRATEGIES TO REDUCE BURDEN

- Integrate patient estimates into the financial clearance workflows
- Educate registration staff to double check for estimates on scheduled services for self pay patients
- 80/20 Rule – Perform analysis to identify commonly scheduled procedures for self pay patients

hfma wisconsin chapter

Patient-Provider Dispute Resolution

- Patients have the right to dispute charge that substantially in excess of the estimate
- Defining "substantially in excess"

  > $400 from estimate

  - Services included in GFE include services A, B, & C. Services A & B are provided by convening provider & service C provided by co-provider. In this example services A&B would need to exceed GFE by $400 & service C would need to exceed GFE by $400 to be eligible for Selected Dispute Resolution Entities (SDR)

OVERESTIMATING

hfma
wisconsin chapter

Challenges Related to GFE Requirements

GFE Requirements

- ✓ Patient Demographics
- ✓ Organizational demographics (NPI, TIN)
- ✓ Itemized services grouped by:
  - ❖ Convening provider
  - ❖ Co-provider
- ✓ Diagnosis, CPT codes, charges (including any discounts)
- ✓ Required disclaimers

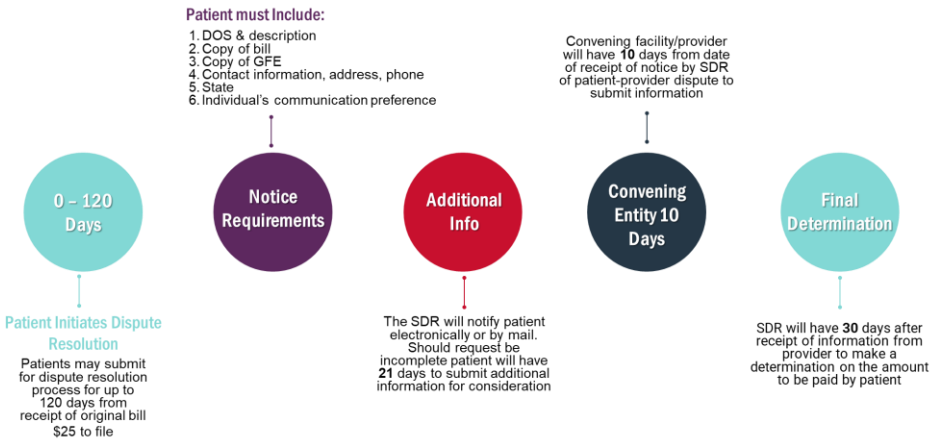
Operational Challenges Related to GFEs

- ✓ Scheduling and identification of a payer source
- ✓ Non-scheduled services
- ✓ Provider variances (OR time, coding)
- ✓ No order or an order with several codes provided
- ✓ Getting estimate in the medical record
- ✓ Difficult to automate or track a GFE against the actual bill
- ✓ Consolidated statements

Organizations moving towards self-pay and uninsured global package pricing to mitigate the administrative burden and improve price accuracy

hfma
wisconsin chapter

Patient-Provider Dispute Resolution Timeline



hfma wisconsin chapter

Strategies

hfma wisconsin chapter

Operationalizing GFEs – Looking Ahead

- Monitoring for OON Plans
- Prepare for Provider-Payer Dispute: DEVELOP A STRATEGY
- Consider the GFE process an opportunity to strengthen Patient Access and improve patient collections
  - ❖ Financial clearance process
- Look to 2023 & beyond regarding estimates for BOTH insured & uninsured patients
- Review patient statements against GFEs

hfma
wisconsin chapter

Additional Resources

hfma
wisconsin chapter

Additional Resources

HFMA No Surprises Act Forum
AHA Surprise Billing
CM
An
Ph

HFMA No Surprises Act Forum
AHA Surprise Billing
CMS No Surprises Act Resources
American Medical Association Toolkit for Physicians

hfma
wisconsin chapter

Questions?

Deb Kozlowski, CPA
Senior Managing Consultant
dkozlowski@bkd.com

BKD
CPAs & Advisors