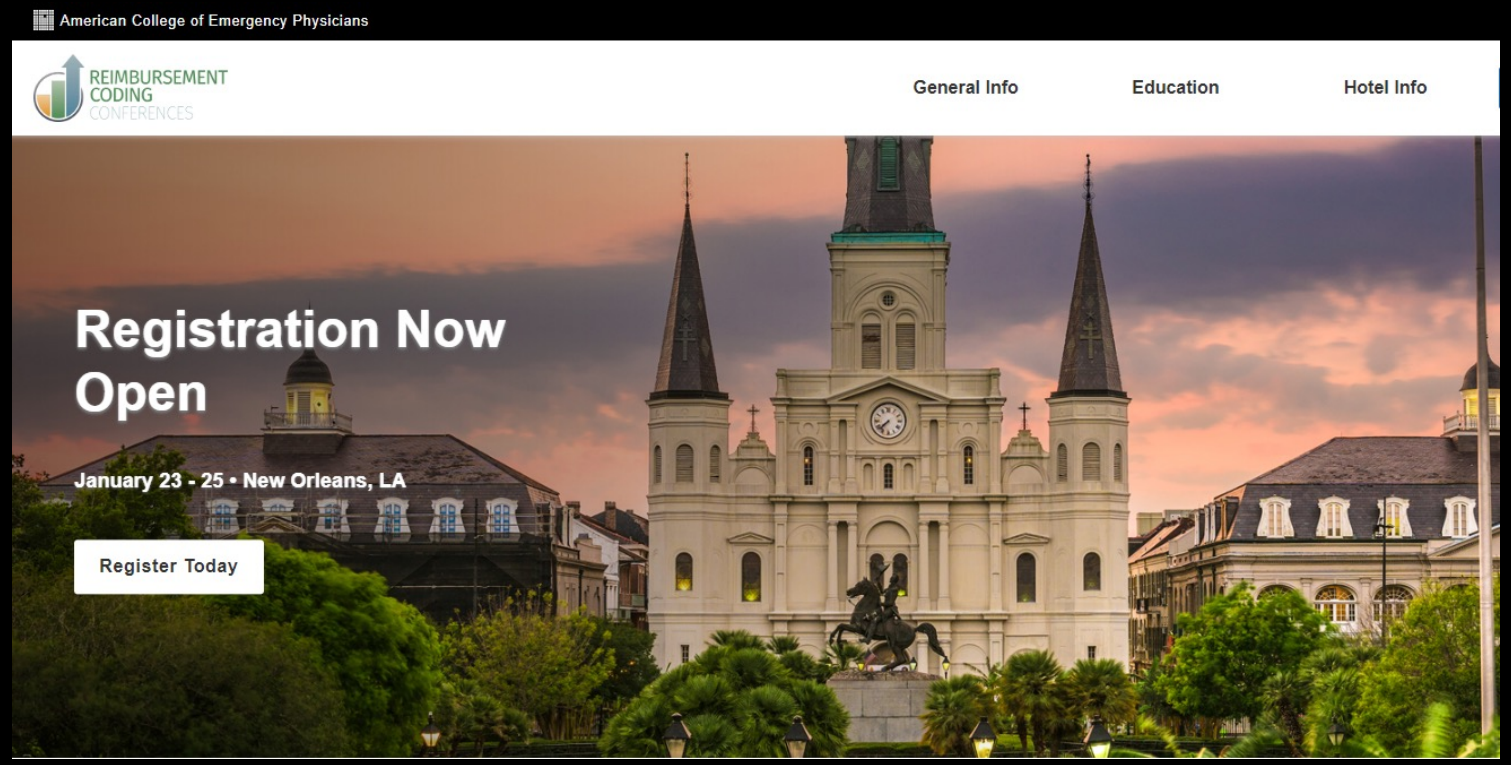
2 years into the No Surprises Act (NSA)—What's Next?



January 23, 2023, New Orleans, LA

Ed Gaines, JD, CCP,

Vice President Regulatory Affairs & Industry Liaison,

Zotec Partners, LLC

Learning Outcomes

- Describe the current state of the NSA, challenges & how litigation may impact the independent dispute resolution (IDR) process.
- How & what may be keys to victory & strategies in the IDR process.
- What does the future state look like using existing state-based IDR for data + future regulations re: good faith estimates + advanced EOBs from health plans.
- Questions throughout.

Conflicts Disclosures & Caveats—and a NOLA music recommendation:

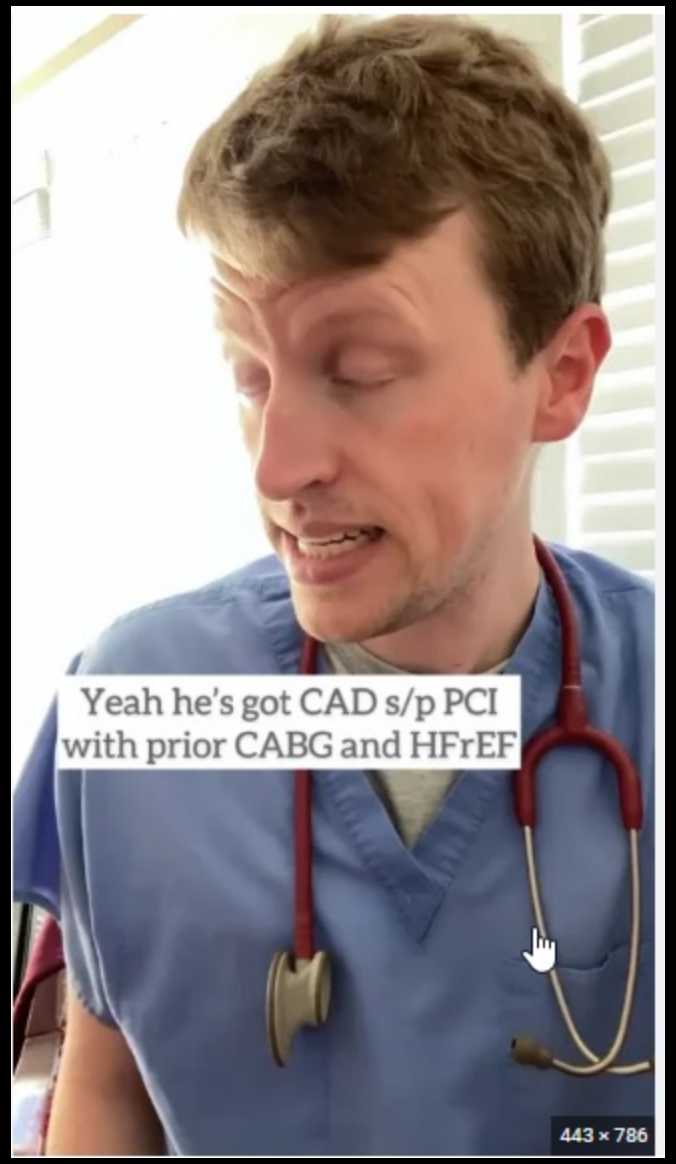
- I am an officer of Zotec Partners, LLC, a revenue cycle management company for emergency physicians, hospital employed and clinic-based clinicians.
- The opinions expressed herein are my own and are not those of my employer, physician specialties or trade associations where I am in positions of leadership.
- This presentation is offered as general information and is not legal advice; experienced and qualified healthcare counsel should be consulted regarding the new federal out of network/balance billing law or existing state laws.
- As of the presentation deadline—December 2022—TMA II litigation was yet to be ruled on by the federal judge in Tyler TX & the prospect of Congressional hearings loomed large w/ change in the control of the US House.

https://www.originalpinettes.com/

Important acronyms & glossary (in the appendix):

- Out of network (OON).
- Surprise billing vs. surprise insurance gaps
- Benchmarking
- NSA
- IDR
- IDRE
- QPA
- Tri Depts.
- CMS & CCIIO
- Guarantor
- In-network
- Patient cost sharing
- State specified laws
- Individual & group health plans
- State employee & teacher plans
- ERISA
- ERISA plans
- “Baseball” Dispute Resolution
- IDR administrative fees
- IDRE fees

Y’all clinicians have your own acronyms….



Part 1: The NSA Current State + law summary + Current Challenges & Litigation

- NSA signed into law 12/27/20
- "Effective" 1/1/22—plan renewal dates could impact.
- IDR portal not operational before 4/15/22
- 2 major lawsuits filed—TX Medical Assoc. (TMA)
  - TMA I in Oct. 2021 over "presumptive QPA policy"—IFR vacated Feb. '22 by the federal court.
  - TMA II in Oct. 2022 & oral arguments 12/20/22.

Why is a benchmark problematic? From Heller, Gaines et al in RSNA's publication *RADIOLOGY (July 2021)*

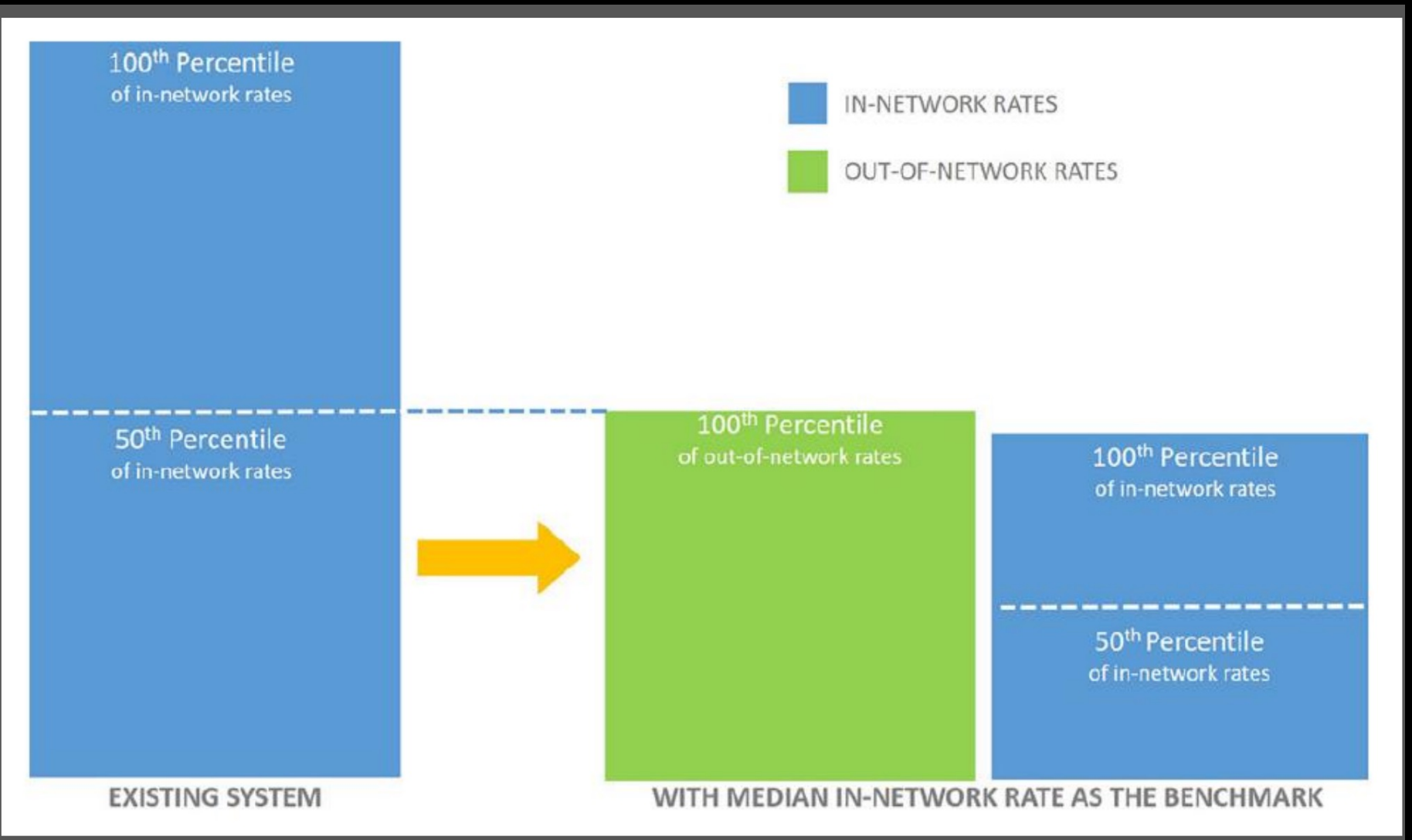
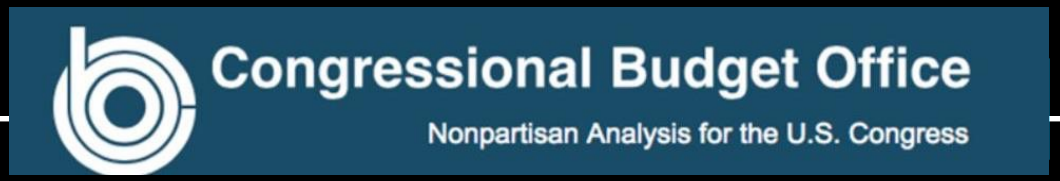


FIGURE 2: With a benchmark system that bans balance billing and uses the median in-network rate as the payment standard, the previous 50th percentile of in-network rates would become the new ceiling for out-of-network payments. Assuming a discount to be in-network, the new maximum (100th percentile) in-network rate would be below the previous 50th percentile.

"policies to address [surprise billing] can have important consequences for the health care system because they affect negotiations between insurers and providers."

https://www.cbo.gov/system/files/2019-09/hr2328.pdf



"…more than 80 percent of the estimated budgetary effects…would arise from changes to in-network payment rates….[the bill would] cause the average rate to drop by

15 percent to 20 percent…"

https://www.cbo.gov/system/files/2019-07/s1895_0.pdf

Health plans have “weaponized” the NSA

This email was sent in July 2022 to one of the largest health system’s in the southeast US, specific to the hospital’s emergency department group (which is a separate TIN and owned by the hospital); similar emails have been received and reported in TN, FL, CA and NC.

[Client Name Deleted]

> **“Thank you for your response.**
>
> **Unfortunately, that rate is no longer competitive due to the no surprise billing act. We are looking for rates similar to what you would be paid as OON via the new legislation and we’ve sent reductions to all of the ER groups using the same proposal that I sent you. I’m willing to consider a counter but it would need to be much closer to my original proposal.**
>
> **Thank you [CIGNA network manager name omitted]” (emphasis added)**

knox news.

OPINION *This piece expresses the views of its author(s), separate from those of this publication.*

Protecting the health of Tennesseans requires putting patients ahead of profits | Opinion

Michael Corvini Guest columnist

Published 7:00 p.m. ET Sept. 28, 2022

I have had the honor to work as both a health care leader and board-certified physician for over 20 years. In that time, I have watched the economic realities of health care become increasingly complex, sometimes putting providers and insurers at odds. Still, for more than 25 years, BlueCross BlueShield of Tennessee and TeamHealth have worked together to ensure Tennesseans received critical medical care.

Unfortunately, BCBSTN recently took drastic and unprecedented action that I believe places profits over patients and threatens the ability of clinicians to provide high-quality care to those who depend on and deserve it. When BCBSTN recently demanded that TeamHealth physicians, nurse practitioners and physician assistants accept an immediate 60% rate reduction without warning or justification, I knew what I believed was a joint focus on delivering high-quality patient care shifted to focus purely on their own profits.

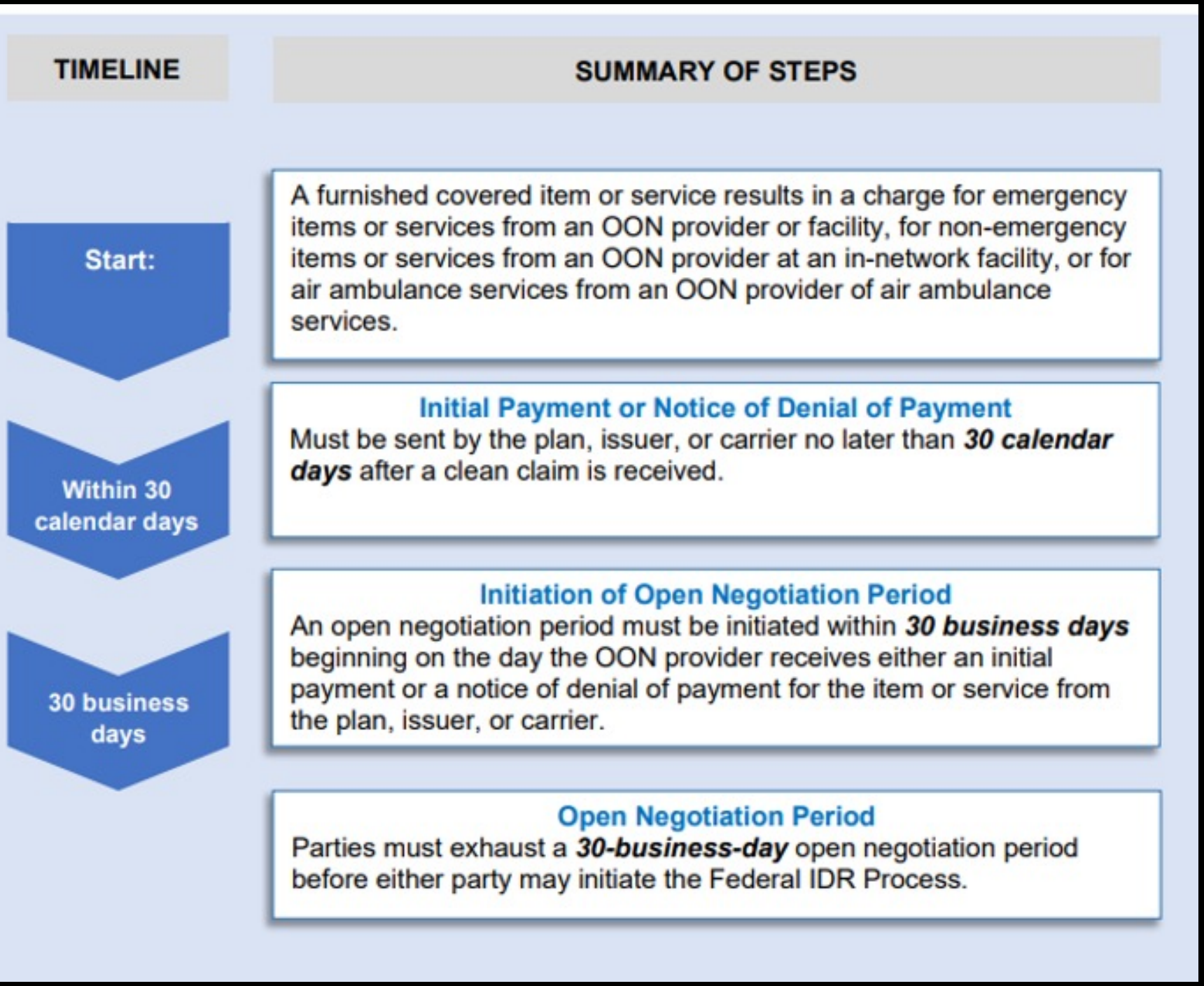
In more than 60 hospitals, emergency rooms and clinics spanning Tennessee's biggest cities and many rural communities, TeamHealth physicians, nurse practitioners and physician assistants save lives daily. Nationwide, TeamHealth clinicians have been the first to respond to

"-60% rate reduction……for more than 60 hospitals, emergency [depts.] and clinics"—per BCBSTN

No Surprises Act & Final Rule Summary

Feature:	Purpose:	Function:	Meaning:	Significance:	Implications:
Protects patients from out-of-network (OON) + balance bills (BB).	Protects patients who don't knowingly consent in writing to OON/BB 72 hours in advance—ED, anesthesia, radiology & surgery are not applicable to consent exception.	OON/BB is barred by OON ED physicians if facility is in network or OON + OON physicians at in-network facilities: hospital, hospital OP dept., CAH, ASC, lab & imaging center.	Patients pay in-network cost sharing and are removed from reimbursement disputes, regardless of IDR outcomes except if Pt. files a Pt./Provider Dispute Resolution (PPDR).	NSA protects large and self-insured employer ERISA members for the first time from OON/BB.	Violations can be subject to civil monetary penalties of $10K per violation.
Initial payment is by rule the amount that the plan reasonably believes to be payment in full for services rendered; patient cost sharing is determined (most cases) by the "qualifying payment amount." (QPA)	Establishes criteria for patient cost sharing on the "recognized amount"—either per "specified state law" or the QPA determined by the health plan.	The QPA is the median in-network rate as of 1/31/19 for same/similar service & specialty in a geographic region (MSA), adjusted for inflation (CPI-U) to '22.	CY 2022 QPA is set by law + CPI-U adjusted going forward; QPA will also be used a factor in IDR.	Multiple QPAs for a single CMS 1500/837-P claim & not a weighted average per CPT code in a geographic region.	EDPMA survey data shows that the QPA=allowed amount in >90% of claims surveyed + QPAs in 2022 are substantially below OON allowed amounts pre-NSA.

Feature:	Purpose:	Function:	Meaning:	Significance:	Implications:
Mandated 30-day open negotiation period for reimbursement disputes + mandated CMS 30-day open negotiation period notice.	Encourages the parties to compromise before formalized independent dispute resolution (IDR).	Clinicians initiate the negotiation from the date of the initial payment or denial, 30 business days from claim adjudication.	Both sides are incented to compromise as the adjudicator picks the winner in IDR, and the loser pays IDR costs.	Clinicians cannot initiate the IDR process before the 30-day negotiation period expires.	Failure to resolve disputes could extend reimbursement weeks into the future.
IDR may be initiated after the 30-day negotiation period expires.	Removes patients from reimbursement dispute; Pts. pay in-network cost sharing or a % of the QPA. Pt. payments do not change depending on the outcome of the IDR	Clinicians and health plans have 4 business days to initiate federal IDR to the other party and 3 days to select the IDR adjudicator.	Within 10 days of IDR adjudicator's selection, parties must submit final offers and supporting info. New web portal permits Notice of Offers to be completed on-line.	If settled before final decision, the parties split IDR costs, if not then the loser pays the IDR costs. "Baseball IDR"—1 or the other offer is selected by the adjudicator.	Adjudicator has 30 days to select an offer. Clinician may "batch" no more than 30 days of same/similar payor claims. The party initiating IDR can't bring another IDR for 90 days after the decision--"cooling off period".



CMS Charts Specifying The Steps in the IDR Process.

- Middle case timeline ~80 days.
- Worst case ~120 days to decision.
- "Business days"=significant impact.

https://www.cms.gov/files/document/federal-independent-dispute-resolution-guidance-disputing-parties.pdf

CMS Charts (cont.)

- **Best & final offer (BFO) selection date is key to the 90 day cooling off period.**

TIMELINE	SUMMARY OF STEPS
4 business days	**Federal IDR Initiation** Either party can initiate the Federal IDR Process by submitting a Notice of IDR Initiation to the other party and to the Departments within ***4 business days*** after the close of the open negotiation period. Such notice must include the initiating party's preferred certified IDR entity.
6 business days after initiation	**Selection of Certified IDR Entity** The non-initiating party can accept the initiating party's preferred certified IDR entity or object and propose another certified IDR entity. A lack of response from the non-initiating party **within 3 business days** will be deemed to be acceptance of the initiating party's preferred certified IDR entity. If the parties do not agree on a certified IDR entity, this step also includes timeframes for the initiating party to notify the Departments that the Departments should randomly select a certified IDR entity on the parties' behalf. If necessary, the Departments will make a selection no later than ***6 business days*** after IDR initiation. The certified IDR entity may invoice the parties for administrative fees at the time of selection (administrative fees are due from both parties by time of offer submission).
3 business days after selection	**Certified IDR Entity Requirements** Once selected, within ***3 business days***, the certified IDR entity must submit an attestation that it does not have a conflict of interest and determine that the Federal IDR Process is applicable.

TIMELINE	SUMMARY OF STEPS
10 business days after selection	**Submission of Offers and Payment of Certified IDR Entity Fee** Parties must submit their offers not later than ***10 business days*** after selection of the certified IDR entity. Each party must pay the certified IDR entity fee, (which the certified IDR entity will hold in a trust or an escrow account), and the administrative fee when submitting its offer (unless the administrative fee has already been paid).
30 business days after selection	**Selection of Offer** A certified IDR entity has ***30 business days*** after its date of selection to determine the payment amount and notify the parties and the Departments of its decision. The certified IDR entity must select one of the offers submitted.
30 calendar/ business days after determination	**Payments Between Parties of Determination Amount & Refund of Certified IDR Entity Fee** Any amount due from one party to the other party must be paid not later than ***30 calendar days*** after the determination by the certified IDR entity. The certified IDR entity must refund the prevailing party's certified IDR entity fee paid within ***30 business days*** after the determination.

Feature:	Purpose:	Function:	Meaning:	Significance:	Implications:
Specified factors and allowance for other factors in the IDR adjudicator's decision.	Provides clinicians the opportunity to show how the initial reimbursement is insufficient; issues re: QPA calculations cannot be adjudicated in the IDR—must be filed as billing complaints to the CMS portal. CMS is performing no more than 9 QPA audits per year.	Per Aug. '22 IFR, the QPA must be considered first & then other factors if credible & relate to the offer. IDREs may reject factors like prior contract rates if they believe that the QPA reflects prior rates under the concept of "double counting".	Enumerated factors are— • QPA • Clinician's training and experience • Teaching status of the facility • Quality & outcome measurements; • Acuity and complexity of care; • Prior K rates for prior 4 yrs.	• Good faith or lack thereof of plan or clinician to contract; • Market share by clinician or plan in a geographic area. Quality metrics along with parties' prior contracted rates for 4 yrs. prior should offer clinicians evidence to support final payments greater than initial market-based reimbursements.	The statute bars consideration of the clinician's charges, Medicare, Medicaid, CHIP and Tricare reimbursements by the adjudicator. Other data that is not barred like FAIR Health or other state all payor claims databases may be submitted.
The interaction of federal law with existing state laws on OON/BB is partially addressed but many issues remain.	States with "specified laws" for determining payment standards are permitted under the NSA under our federalism principles.	State payment standards (including Pt cost sharing) may be honored in place of federal QPA for individual and group health plans and states with ERISA opt-in.	States that have adopted the FAIR Health database may be permitted to do so for individual and group health plans if clarified in rule making.	3-part test if state law procedural and IDR standards will be permitted under federal law: whether state law applies to physician, Pt and plan?	18 states have comprehensive state OON/BB laws so there may be a dual process in these states for individual and group plans.

“State specified law” issues.

State Process*	Federal IDR Process	Bifurcated Process*
Alaska	Alabama	California
Georgia	Arizona	Colorado
Maine	Arkansas	Connecticut
Michigan	District of Columbia	Delaware
	Hawaii	Florida
	Idaho	Illinois
	Indiana	Maryland
	Iowa	Missouri
	Kansas	Nebraska
	Kentucky	Nevada
	Louisiana	New Hampshire
	Massachusetts	New Jersey
	Minnesota	New Mexico
	Mississippi	New York
	Montana	Ohio
	North Carolina	Texas
	North Dakota	Virginia
	Oklahoma	Washington
	Oregon	
	Pennsylvania	
	Rhode Island	
	South Carolina	
	South Dakota	
	Tennessee	
	Utah	
	Vermont	
	West Virginia	
	Wisconsin	
	Wyoming	
	American Samoa	
	Guam	
	Northern Mariana Islands	
	Puerto Rico	
	U. S. Virgin Islands	

IMPORTANT NOTE:

*Self-insured plans sponsored by private employers, private employee organizations or public payers in these states that **have not** opted into the state process should use the Federal IDR process. Similarly, FEHB carriers that **do not** have contract terms with OPM to use a state process should also use the Federal IDR process.

CMS

Chart Regarding Applicability of the Federal Independent Dispute Resolution Process in Bifurcated States

The **No Surprises Act** establishes a Federal Independent Dispute Resolution (IDR) process that providers, emergency facilities, and providers of air ambulance services and group health plans and health insurance issuers in the group and individual market, as well as Federal Employees Health Benefits (FEHB) carriers, may use following the end of an unsuccessful open negotiation period to determine the out-of-network (OON) payment amount for certain qualified IDR items and services, which include:

- Emergency services (including post-stabilization services)[1];
- Nonemergency items and services furnished by OON providers at certain in-network health care facilities[2], and
- Air ambulance services furnished by OON providers of air ambulance services.

The Federal IDR process **does not apply** to items and services payable by Medicare, Medicaid, the Children’s Health Insurance Program, or TRICARE.

The Federal IDR Process also **does not apply** in instances where a specified state law (SSL) or All-Payer Model Agreement (APMA) under Section 1115A of the Social Security Act provides a method for determining the total OON amount payable under a group health plan or group or individual health insurance coverage.

The Federal IDR Process does apply to non-federal governmental plans, self-insured plans sponsored by private employers, private employee organizations, or both (i.e., self-insured plans governed by Employee Retirement Income Security Act (ERISA)) in all states, **except** in cases in which a self-insured plan has opted to subject itself to an SSL or APMA, as permitted under some state’s laws. Similarly, in all states, the Federal IDR Process does apply to health benefits plans offered through the FEHB Program, where an Office of Personnel Management (OPM) contract with an FEHB Carrier **does not provide** that an SSL will apply.

In some states, some items or services provided by OON providers, facilities or providers of air ambulance services **may be subject to the Federal IDR process, while other items and services are subject to an SSL or APMA.** For payment disputes regarding OON items or services furnished in these ‘bifurcated states,’ certified IDR entities are responsible for determining whether or not a dispute is eligible for the Federal IDR process.

The state letters available here, capture Center for Medicare and Medicaid Service’s understanding of the Public Health Service Act (PHS Act), as amended by Title I (No Surprises Act) and Title II (Transparency) of Division BB of the Consolidated Appropriation Act, 2021[3]. These letters also communicate whether the Federal IDR process apply in each state, and in what circumstances.

[1] See 26 CFR 54.9816-4T(c)(2), 29 CFR 2590.716-4(c)(2), and 45 CFR 149.110(c)(2).
[2] See 26 CFR 54.9816–3T, 29 CFR 2590.716–3, and 45 CFR 149.30
[3] Pub. L. 116-260 (Dec. 27, 2020)

This communication was printed, published, or produced and disseminated at U.S. taxpayer expense.

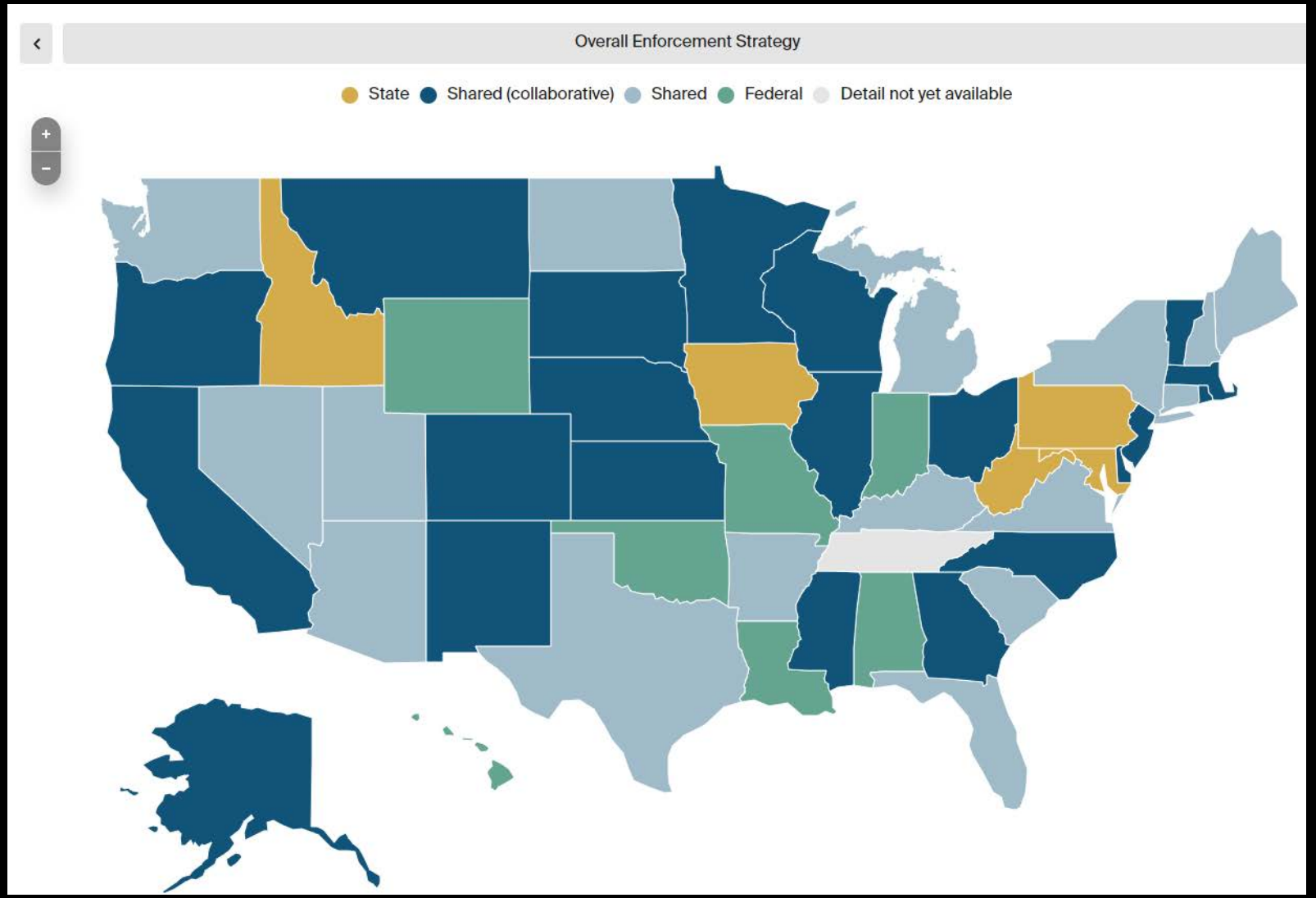
1

https://www.cms.gov/files/document/caa-federal-idr-applicability-chart.pdf

Resources on NSA enforcement & “specified state laws:--

https://www.commonwealthfund.org/publications/fund-reports/2022/oct/no-surprises-act-federal-state-partnership-protect-consumers

Distinguish “enforcement” from “federal/state law” OON applicability.



https://www.commonwealthfund.org/publications/maps-and-interactives/2022/feb/map-no-surprises-act

Lawsuit filed 10/28/21 by the TX Medical Association (TMA) and Dr. Adam Corley (EM doc) in USDC Eastern Dst. Of TX challenging the Sept. '21 IFR.

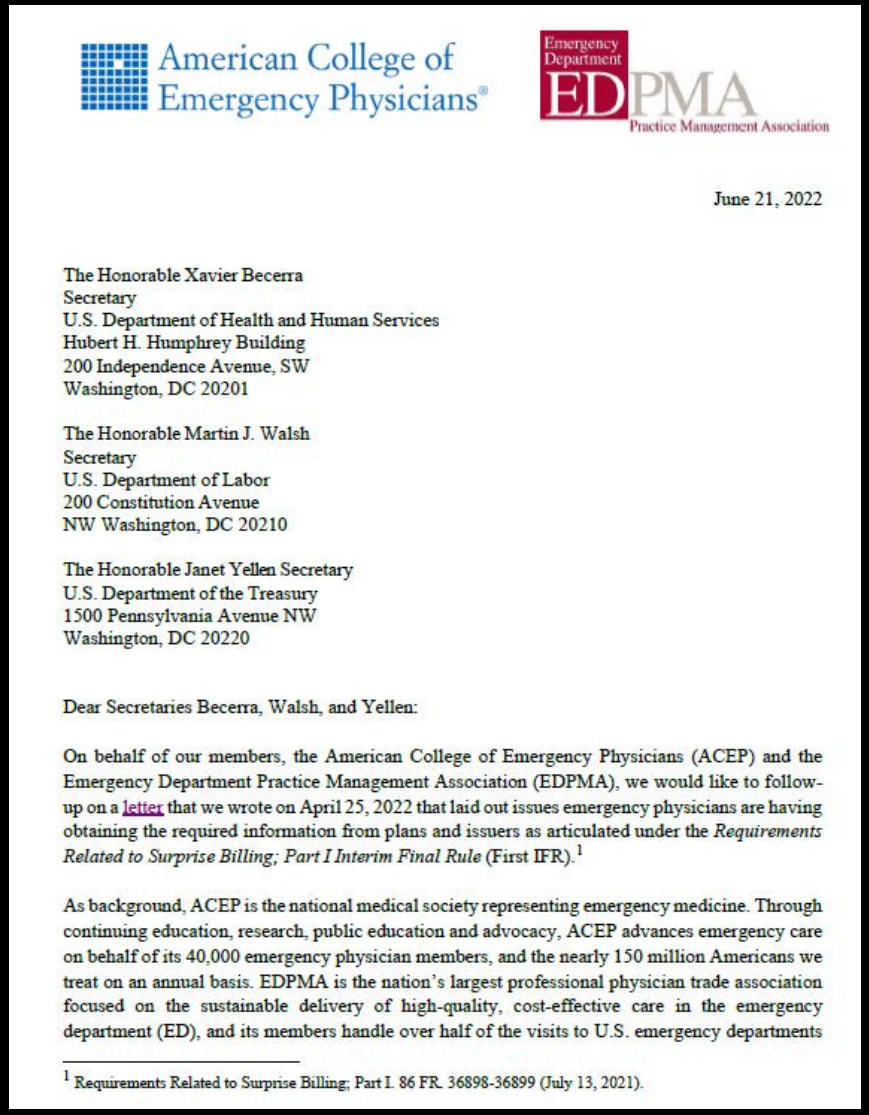
- Lawsuit seeks a court order vacating the Sept. IFR –not the Pt protections of the NSA statute or July IFR—on the grounds that the "Tri-Depts" created a legal rebuttable presumption that the QPA should be the appropriate final payment when the NSA text does not support such a presumption;
- Plaintiffs contend that the NSA text supports that all IDR factors be equal and that this contention is supported in the text & Congressional intent.
- Complaint also challenges the procedural process of the issuance of "Interim Final Rule" instead of a "Notice of Proposed Rule Making" (NPRM) as mandated by the Administrative Procedures Act (APA).
- On Feb. 23, 2022, the USDC found for the plaintiffs on all of their counts above & vacated the Sept. 2021 IFR nationwide.

So, the "Tri-Depts" had 6 months (Feb-Aug. 2022) to re-write the NSA final rule.

- Technically the Depts. removed the "QPA as the presumptive final payment" language.
- Created enhanced and new concepts—August 2022 final rule:
  - "Credible evidence" for NSA statutory factors
  - "QPA must be considered first…as it is a quantitative factor"
  - "Double counting" concept created.
- Resulting in yet another lawsuit—TMA II—filed Oct. 2022—contending that the new rule makes the QPA=de facto benchmark.

Part 2--for over 2 years, the ACEP/EDPMA NSA Task Force has served a key role for members of both organizations.

- Common strategic and tactical hub for advocacy on a wide variety of NSA issues.
- Weekly meetings of the Steering Committee and work products from five sub committees over two years has resulted in substantial alignment, effective advocacy, and a stronger voice.
- ACEP and EDPMA members have benefitted from intentional discussions and shared expertise.
- Significant advocacy, feedback, and better industry alignment has resulted.
- While not universally successful, efforts have produced a number of wins and positive changes related to the NSA.



American College of Emergency Physicians®

Emergency Department EDPMA Practice Management Association

June 21, 2022

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Martin J. Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue
NW Washington, DC 20210

The Honorable Janet Yellen Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

Dear Secretaries Becerra, Walsh, and Yellen:

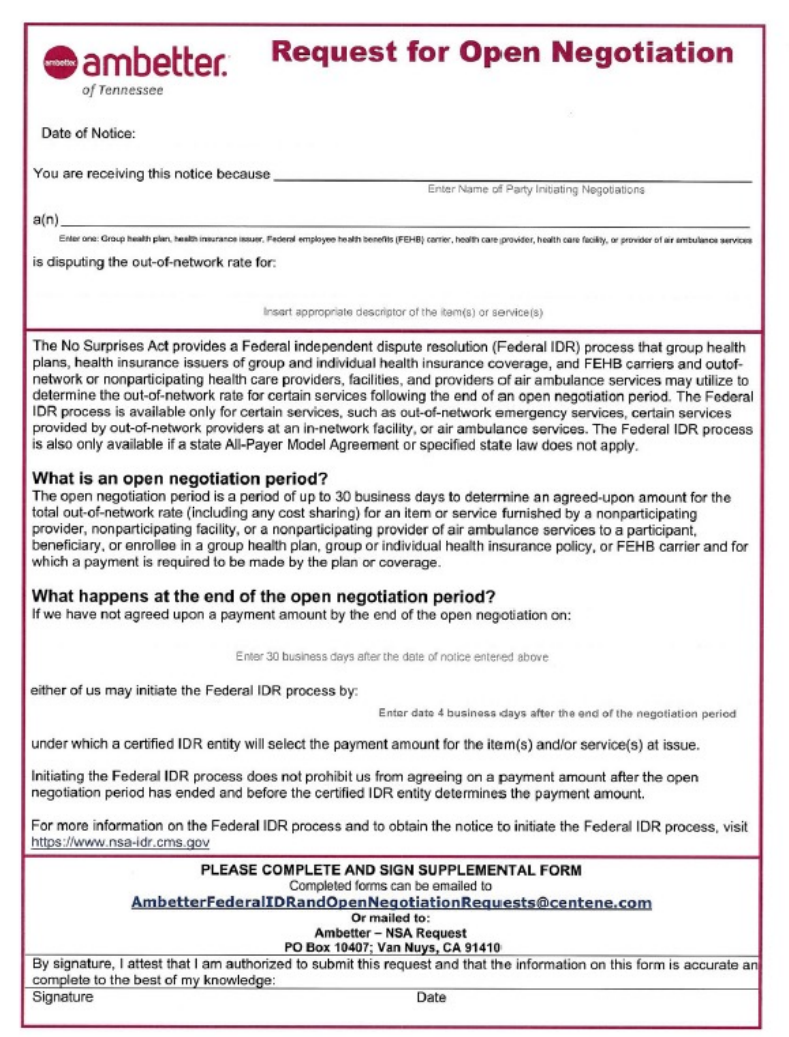
On behalf of our members, the American College of Emergency Physicians (ACEP) and the Emergency Department Practice Management Association (EDPMA), we would like to follow-up on a letter that we wrote on April 25, 2022 that laid out issues emergency physicians are having obtaining the required information from plans and issuers as articulated under the *Requirements Related to Surprise Billing; Part I Interim Final Rule* (First IFR).[1]

As background, ACEP is the national medical society representing emergency medicine. Through continuing education, research, public education and advocacy, ACEP advances emergency care on behalf of its 40,000 emergency physician members, and the nearly 150 million Americans we treat on an annual basis. EDPMA is the nation's largest professional physician trade association focused on the sustainable delivery of high-quality, cost-effective care in the emergency department (ED), and its members handle over half of the visits to U.S. emergency departments

[1] Requirements Related to Surprise Billing; Part I. 86 FR. 36898-36899 (July 13, 2021).

Hidden trap for the unwary: health plans created an artificial "acceptance process" and/or add'l "negotiation process".

- **Example—also UHC.**



ambetter. of Tennessee

Request for Open Negotiation

Date of Notice:

You are receiving this notice because _____
Enter Name of Party Initiating Negotiations

a(n) _____
Enter one: Group health plan, health insurance issuer, Federal employee health benefits (FEHB) carrier, health care provider, health care facility, or provider of air ambulance services

is disputing the out-of-network rate for:

Insert appropriate descriptor of the item(s) or service(s)

The No Surprises Act provides a Federal independent dispute resolution (Federal IDR) process that group health plans, health insurance issuers of group and individual health insurance coverage, and FEHB carriers and outof-network or nonparticipating health care providers, facilities, and providers of air ambulance services may utilize to determine the out-of-network rate for certain services following the end of an open negotiation period. The Federal IDR process is available only for certain services, such as out-of-network emergency services, certain services provided by out-of-network providers at an in-network facility, or air ambulance services. The Federal IDR process is also only available if a state All-Payer Model Agreement or specified state law does not apply.

What is an open negotiation period?
The open negotiation period is a period of up to 30 business days to determine an agreed-upon amount for the total out-of-network rate (including any cost sharing) for an item or service furnished by a nonparticipating provider, nonparticipating facility, or a nonparticipating provider of air ambulance services to a participant, beneficiary, or enrollee in a group health plan, group or individual health insurance policy, or FEHB carrier and for which a payment is required to be made by the plan or coverage.

What happens at the end of the open negotiation period?
If we have not agreed upon a payment amount by the end of the open negotiation on:

Enter 30 business days after the date of notice entered above

either of us may initiate the Federal IDR process by:

Enter date 4 business days after the end of the negotiation period

under which a certified IDR entity will select the payment amount for the item(s) and/or service(s) at issue.

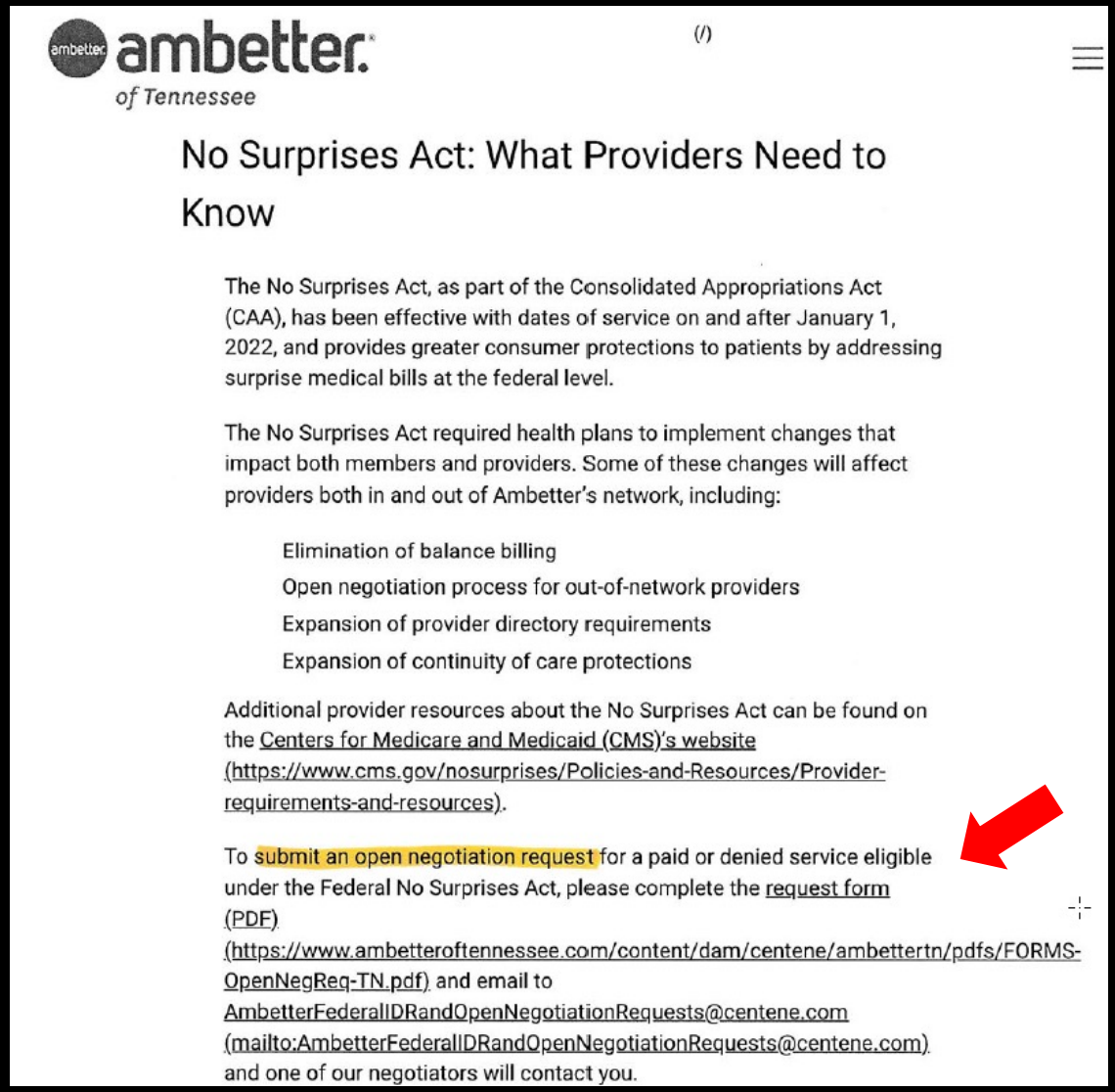
Initiating the Federal IDR process does not prohibit us from agreeing on a payment amount after the open negotiation period has ended and before the certified IDR entity determines the payment amount.

For more information on the Federal IDR process and to obtain the notice to initiate the Federal IDR process, visit https://www.nsa-idr.cms.gov

PLEASE COMPLETE AND SIGN SUPPLEMENTAL FORM
Completed forms can be emailed to
AmbetterFederalIDRandOpenNegotiationRequests@centene.com
Or mailed to:
Ambetter – NSA Request
PO Box 10407; Van Nuys, CA 91410

By signature, I attest that I am authorized to submit this request and that the information on this form is accurate an complete to the best of my knowledge:

Signature Date



ambetter. of Tennessee

(/)

No Surprises Act: What Providers Need to Know

The No Surprises Act, as part of the Consolidated Appropriations Act (CAA), has been effective with dates of service on and after January 1, 2022, and provides greater consumer protections to patients by addressing surprise medical bills at the federal level.

The No Surprises Act required health plans to implement changes that impact both members and providers. Some of these changes will affect providers both in and out of Ambetter's network, including:

- Elimination of balance billing
- Open negotiation process for out-of-network providers
- Expansion of provider directory requirements
- Expansion of continuity of care protections

Additional provider resources about the No Surprises Act can be found on the Centers for Medicare and Medicaid (CMS)'s website (https://www.cms.gov/nosurprises/Policies-and-Resources/Provider-requirements-and-resources).

To submit an open negotiation request for a paid or denied service eligible under the Federal No Surprises Act, please complete the request form (PDF) (https://www.ambetteroftennessee.com/content/dam/centene/ambettertn/pdfs/FORMS-OpenNegReq-TN.pdf) and email to AmbetterFederalIDRandOpenNegotiationRequests@centene.com (mailto:AmbetterFederalIDRandOpenNegotiationRequests@centene.com) and one of our negotiators will contact you.

Major advocacy victory vs. plans attempts to engage in the "4 corners offense" (a/k/a Dean Smith for UNC faithful):

Q21: A plan or issuer establishes an online portal for nonparticipating providers, facilities, and providers of air ambulance services to submit the information necessary to initiate the open negotiation period. However, the portal does not accept uploads of the standard open negotiation form issued by the Departments, and the plan or issuer does not otherwise accept delivery of the standard open negotiation form. Instead, the plan or issuer requires that nonparticipating providers, facilities, and providers of air ambulance services manually enter information for each claim separately in a manner prescribed by the plan or issuer through the portal before the plan or issuer will engage in any open negotiation with the nonparticipating provider. Is this permissible?

No. The October 2021 interim final rules at 26 CFR 54.9816-8T(b)(1)(ii)(B), 29 CFR 2590.716-8(b)(1)(ii)(B), and 45 CFR 149.510(b)(1)(ii)(B) state that the initiating party may initiate the open negotiation period by sending an open negotiation notice to the other party electronically (such as by email) if the following conditions are satisfied:

(1) the initiating party has a good faith belief that the electronic method is readily accessible by the other party; and

(2) the notice is provided in paper form free of charge upon request.

The Departments have developed a standard open negotiation form[46] that an initiating party must use to initiate the open negotiation period. The October 2021 interim final rules do not prohibit a plan or issuer from encouraging the use of an online portal for nonparticipating providers, facilities, and providers of air ambulance services to submit the information necessary to initiate the open negotiation period, or from seeking additional information to inform good faith open negotiations, such as through use of a supplemental open negotiation form. However, because

[46] *See* Open Negotiation Notice and Instructions, available at: 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.

the initiating party (in this case, a nonparticipating provider) is required to use the standard open negotiation form, the other party must accept the standard open negotiation form sent by the initiating party to the contact information provided by the non-initiating party even when the initiating party does not use the plan's or issuer's portal or supplemental form, provided that the notice was sent in a manner that complies with the delivery requirements discussed above.

- **Unlike other NSA documents which may be recommended the CMS Open Negotiation Period Notice Form is the one that the agency requires everyone to use.**
- **The issue is that if you follow the plan's request to fill out their negotiation form and wait for the representative to get back with you time will expire on those claims.**
- **https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-55.pdf**

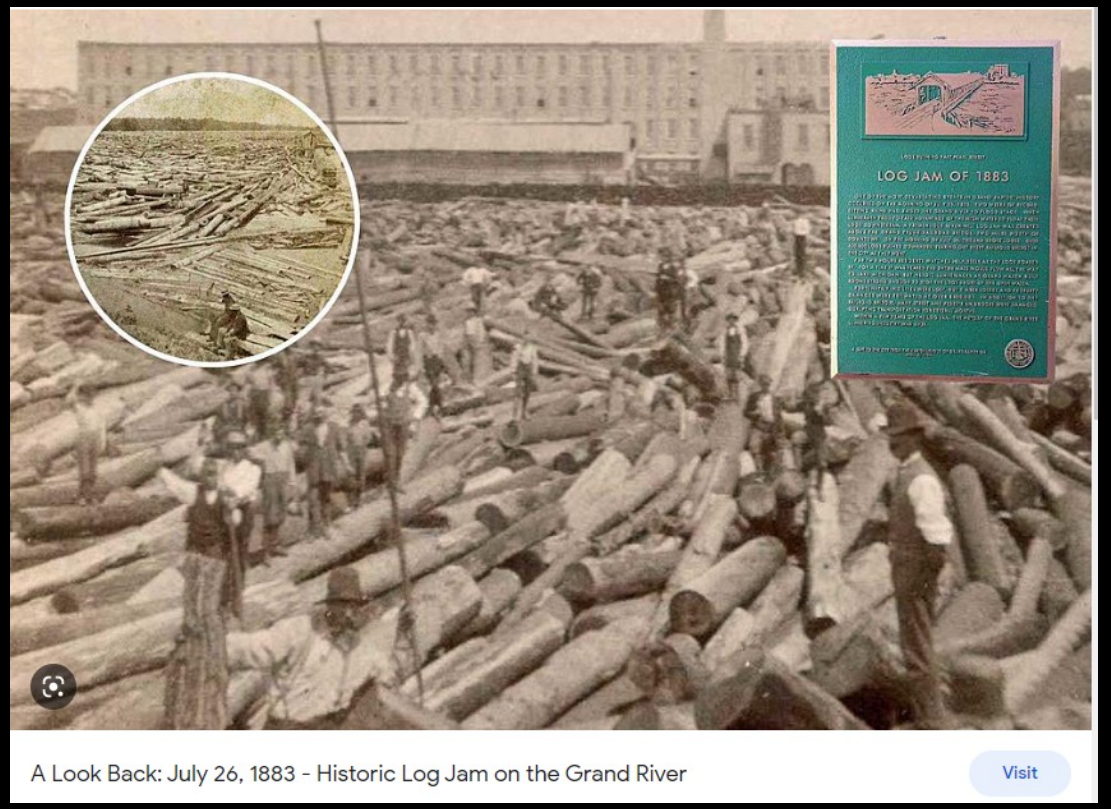
TIMELINE	SUMMARY OF STEPS
Start:	A furnished covered item or service results in a charge for emergency items or services from an OON provider or facility, for non-emergency items or services from an OON provider at an in-network facility, or for air ambulance services from an OON provider of air ambulance services.
Within 30 calendar days	**Initial Payment or Notice of Denial of Payment** Must be sent by the plan, issuer, or carrier no later than ***30 calendar days*** after a clean claim is received.
30 business days	**Initiation of Open Negotiation Period** An open negotiation period must be initiated within ***30 business days*** beginning on the day the OON provider receives either an initial payment or a notice of denial of payment for the item or service from the plan, issuer, or carrier.
	Open Negotiation Period Parties must exhaust a ***30-business-day*** open negotiation period before either party may initiate the Federal IDR Process.

The health plans are playing for time—recall the CMS Charts—otherwise your IDR claims are time barred.

https://www.cms.gov/files/document/federal-independent-dispute-resolution-guidance-disputing-parties.pdf

The log-jammed IDR process:

- ✓ In September 2021 (Technical Guidance 2021-01), the Tri-Departments (HHS, Labor & Treasury) estimated that 17,333 claims from nonparticipating providers and nonparticipating emergency facilities would go through Federal IDR annually nationwide.
- ✓ Nov. 1, 2022, CMS issued an increase in 2023 IDRE fees & report that reported 90,000 claims had been filed through IDR starting on opening day April 15 through Sept. 30 (roughly 5.5 months).
- ✓ TX TDI data in 10 months of '20 showed that for 1 state emergency physicians had filed 27,500 IDRs
- ✓ https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/cy2023-fee-guidance-federal-independent-dispute-resolution-process-nsa.pdf



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Subject: Additional Time for Certified Independent Dispute Resolution Entities to Evaluate Dispute Eligibility.

Due to the high volume of disputes, the U.S. Departments of Health and Human Services, Labor, and the Treasury (the Departments) are temporarily allowing additional time for certified Independent Dispute Resolution entities (IDREs) to evaluate eligibility and potential conflicts of interest in disputes under the Federal IDR Process. Submitting a complete dispute with supporting documentation will help expedite review.

Thank you,

IDR Entity Review Team

The very concerning message to physician groups waiting on their very best reimbursed claims being held up.

EDPMA 25 YEARS

Data Analysis

Qualifying Payment Amounts and Health Plan Compliance Under the No Surprises Act

The Emergency Department Practice Management Association (EDPMA) is a trade association focused on the sustainable delivery of high-quality, cost-effective patient care in emergency departments. Our members deliver or directly support health care for approximately half of the 146 million patients that annually visit U.S. emergency departments.

The Study

EDPMA surveyed its membership to report on issues related to the implementation of the No Surprises Act (NSA) since January 1, 2022. Specifically, EDPMA analyzed the out-of-network allowed amounts commercial health plans reimbursed for services and whether the Qualified Payment Amount (QPA) was disclosed to the provider as required by law. EDPMA also reviewed member's experiences of the Independent Dispute Resolution (IDR) process. This is a high-level summary of initial findings; additional details are forthcoming.

The Numbers

14,500 claims from 35 States
Date range: January – May 2022
59 local, regional, and national practices
Antitrust Safe Harbor status maintained[1]

The Findings

Health Plans Routinely Fail To Comply with the NSA's Statutory And Regulatory QPA Disclosure Requirements

91% of claims surveyed did NOT include an identified QPA as specifically required by law. There is no known enforcement related to this pervasive health plan noncompliance.

When Reported, The QPA Consistently Equals The Allowed Amount for Provider Payments

While the statute avoided setting an initial payment benchmark and instituted no requirement that the paid amount equal the QPA, results find that health plans are commonly paying at a rate that equals the QPA. This finding highlights that health plans are using problematic QPAs as a payment standard when the NSA specifically avoided inclusion of a benchmark payment standard.[2]

The Independent Dispute Resolution Process Is Overburdened By Artificially Low QPAs

Certified IDR Entities (IDREs) are unprepared for the volume of disputes driven by the NSA regulations as written. The QPA amounts in the survey results suggest artificially low calculation of QPAs, not reflective of a reasonable market-based payment rate. This could be due to the regulations establishing the QPA calculation methodology or due to pervasive improper health plan application of the regulations. These low initial payments where health plans are using the QPA as the payment amount has created significant and unanticipated volumes of IDR claims. In the first five months, providers initiated more disputes than the government anticipated for a full year.[3] Significant delays in resolutions (up to 3 months) drives substantial negative cash flow for physician groups, resulting in layoffs and threats of hospital closure.

[1] Redacted data must be at least 3 months old; at least 5 data contributors per published dataset; no group contributing more than 25% of a data set; raw data only reviewed by third-party independent consultant
[2] According to the survey results, these levels represent cuts of at least 20% - 50% from pre-NSA average out-of-network reimbursement levels for emergency medicine.
[3] https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/federal-independent-dispute-resolution-process-status-update.pdf

EDPMA 2022 NSA survey data

- 14K+ claims, 59 groups, 35 states and DOS Jan-May ’22.
- Anti-trust safe harbors maintained throughout.
- Part 2 of the survey was comparing pre-NSA allowed amounts w/ post NSA allowed amounts.

ACEP/EDPMA QPA 2022 Survey:

A 2022 national survey of Emergency Medicine (EM) practices yielded the findings listed below concerning the federal NSA program. The respondents represented 59 different practices of different sizes across 35 states—small local groups, regional practices, and large national staffing organizations. The data collected was based on the first 5 months (January-May 2022) of paid claims subject to the federal NSA program.

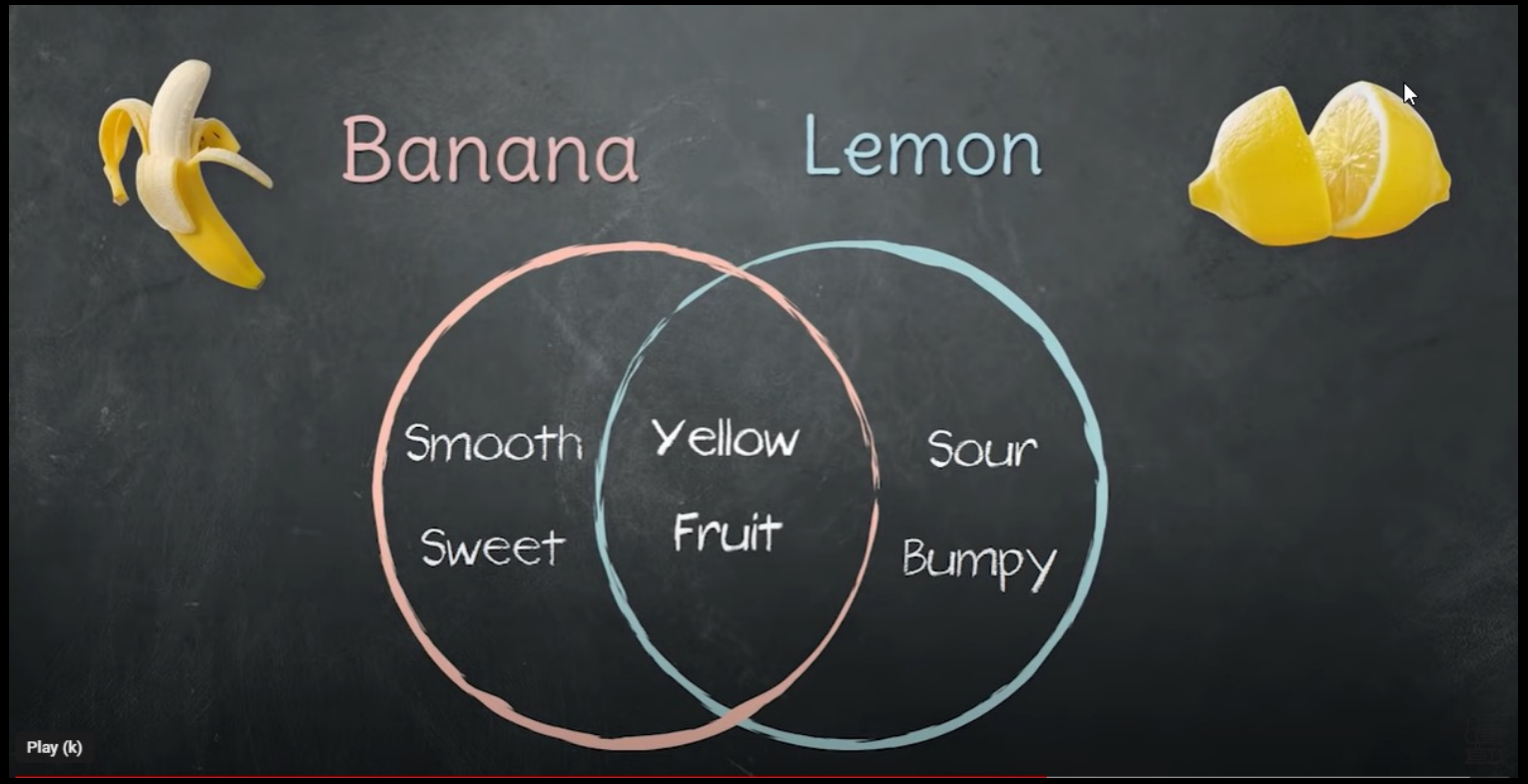
- ✓ **MOST CLAIMS ARE LACKING THE REQUIRED QUALIFYING PAYMENT AMOUNT (QPA).**
  The required QPA was missing 90.6% of the time from remittance documentation.

- ✓ **THE QPAs ARE BEING USED TO SET THE PAYMENT LEVELS FOR PROVIDERS**
  When QPAs were provided, the payer's allowed amounts were exactly equal to the QPAs 95% of the time. The assumption has to be that when the QPAs are not provided, they still account for setting the allowed amounts. But the QPA was intended by law to be the basis for calculating an out-of-network (OON) patient's equivalent in-network financial responsibility—not the provider's out-of-network reimbursement.

- ✓ **THE ALLOWED AMOUNTS BASED ON THE QPA ARE IMPOSSIBLY LOW**
  The allowed amounts for key Emergency Medicine services range from a weighted average of 126% to 145% of current year Medicare (2022). These levels represent cuts of 20%-50% on average from pre-NSA average contracted levels for Emergency Medicine.

- ✓ **NON-USE OF THE SPECIALLY DEVELOPED NSA REMITTANCE ADVICE REMARK CODES**

Part 3: Strategies for success in IDREs + QPA issues + Important & on-going advocacy wins:



Tips & Strategies: Outreach now to OON health plans + during open negotiation period.

- IRS published 2023 inflation adjustment (CPI-U) to the QPAs mid to late Dec. '22.
- CPI-U Increase is mandated in the NSA statute & regulations.
- The QPA's CPI-U adjustment is a cumulative increase from the "median allowed amount as of 1/1/19".
- '22 adjustment from '19 was +6.48523983%.
- '23 adjustment is +7.6858218%.
- Or, the January 2019 median x 1.1466950561.
- Tip: ask OON health plans now how they have made the mandated adjustments—no response—file a complaint.
- FederalIDRQuestions@cms.hhhs.gov

Regulatory citations to the CPI-U adjustment.

Under § 54.9816-6T(c), 29 CFR 2590.716-6(c), and 45 CFR 149.140(c), for an item or service furnished during 2022, plans and issuers must calculate the qualifying payment amount by increasing the median contracted rate (as determined in accordance with § 54.9816-6T(b), 29 CFR 2590.716-6(b), and 45 CFR 149.140(b)) for the same or similar item or service under such plan or coverage, on January 31, 2019, by the combined percentage increase as published by the Department of the Treasury (Treasury Department) and the Internal Revenue Service (IRS) to reflect the percentage increase in the consumer price index for all urban consumers (U.S. city average) (CPI-U) over 2019, such percentage increase over 2020, and such percentage increase over 2021.[11] Pursuant to Rev. Proc. 2022-11, for items and services provided on or after January 1, 2022, and before January 1, 2023, the combined percentage increase to adjust the median contracted rate for the same or similar item or service under such plan or coverage, on January 31, 2019, is 1.0648523983. The revenue procedure also provides that plans and issuers may round to the nearest dollar any resulting qualifying payment amounts

.01 Adjusting qualifying payment amounts based on January 31, 2019 rates.

For qualifying payment amounts calculated by increasing the median contracted rate for 2019[13], the qualifying payment amounts for items and services furnished in 2023 are determined by taking the qualifying payment amounts calculated for items and services furnished in 2022 and multiplying the 2022 adjusted qualifying payment amounts by the percentage increase from 2022 to 2023, that is, 1.0768582128.

For example: An item is furnished in 2023. The median contracted rate for the item on January 31, 2019 was $1,500. The 2022 adjusted qualifying payment amount for the item was $1,597 ($1,500 x 1.0648523983). The 2023 adjusted qualifying payment amount for the item is $1,720 ($1,597 x 1.0768582128).

- **$1500 in '19 service adjusted upward to $1720 in '23 ($220 difference) is approx. a 14.6695% increase.**

See www.irs.gov/pub/irs-drop/n-23-04.pdf

As of Dec. 2022 presentation deadline, no decision yet in TMA II litigation but let's speculate that the plaintiffs win again.

Let's assume most if not all of these Aug. 2022 NSA Final Rule concepts were vacated in the court's ruling:

- "Credible evidence" had to support other non-QPA IDR factors.
- "QPA must be considered first…as it is a quantitative factor".
- "Double counting"—if the QPA captured prior K rates then prior K rates could not be separately considered.

- NSA enumerated factors are—objective factors in yellow:

1. QPA
2. Clinician's training and experience
3. Teaching status of the facility
4. Quality & outcome measurements;
5. Acuity and complexity of care;
6. Contract (K) rates for prior 4 yrs.
7. Good faith or lack thereof of plan or clinician to contract;
8. Market share by clinician or plan in a geographic area.

“Ghost rates” + “Downcoding” Also Key Advocacy Wins in Aug. 19, 2022 FAQs:

- QPA is not a median rate determined by a weighted average of paid claims for the same or similar specialty.
- “Ghost rates” are rates negotiated by primary or multi-specialty practices that are rarely if ever coded and billed. These “ghost rates” may artificially reduce the QPA calculations by diluting specialty groups that have negotiated higher rates, plans may use “contracted rates” to calculate the median in network rate in determining the QPA.
- The QPA formula does not require consideration of how often the claims are reimbursed, nor the relative specialty of the groups that are reimbursed at those rates.
- In Aug. 2022 FAQs, the Depts. have now required that QPAs are calculated by specialty if the plans rates vary by specialty. Previously the Depts. said that rates could be included in the QPA calculation if the plans “offered” different rates by specialty.

- The Tri Depts. responded to stakeholder complaints that health plans frequently and without justification simply “down-code” and “down pay” the claims and codes submitted, usually based on the final diagnosis of the patient and not the patient’s presenting signs and symptoms.
- “Downcoding” has now been officially defined in the Final Rule, “…alternation by the plan to another service code or the change or alteration of a modifier if the changed code or modifier is associated with a lower QPA than the code or modifier billed by the clinician”.
- In a significant and positive development, the Tri Depts. will require that the plans explain the downcoding, describe which codes were altered, and the QPA of the service code, had the claims not been downcoded.
- Finally, the Depts. state that the health plans may need additional time to come into compliance with these requirements, but no specific deadline is provided for in the Final Rule.

What to do if you believe the QPA is fake + no information coming back from IDREs + batching clarification "at the individual plan level".

NO SURPRISES ACT WEBINAR: IDR PRESENTATION FOR EDPMA AND ACEP

SUMMARY REPORT

OVERVIEW

On Monday, July 11, 2022, CCIIO hosted a Q&A session for the Emergency Department Practice Management Association (EDPMA) and the American College of Emergency Physicians (ACEP) providers and facilities on the independent dispute resolution (IDR) process under the No Surprises Act (NSA). CMS subject matter experts (SMEs) provided updates on the release of a checklist of requirements for issuers and newly added elements of transparency to the complaints process. They reviewed CMS' upcoming plans, including releasing additional guidance (e.g., on batching and non-responsive parties), continuing outreach to providers or facilities and plans and issuers, and planned system enhancements to the IDR portal. CMS SMEs also reviewed answers to questions submitted in advance by participants. Then, the host and CMS SMEs verbally responded to live questions submitted via chat by participants. Responses to unanswered questions from the live webinar are included below.

Q8 [Eric Swartz]: In several cases, we have received emails after initiating IDR indicating that the IDRE needs additional information from the issuer/plan before the IDRE can certify that the claims are eligible. Several of these have been pending for weeks, and we have been unable to obtain additional information from the IDRE clarifying what information is still needed. How should we proceed in these cases?

A8: Please email the Federal IDR mailbox at FederalIDRQuestions@cms.hhs.gov with the dispute numbers for your disputes that are on hold and we will do our best to determine the status of your disputes. Thank you for your patience regarding the processing of your IDR dispute submissions. During this initial phase of implementation of the Federal IDR programs, some disputes are taking longer than expected to process. These disputes are still in process and timely resolution of IDR cases is of the utmost importance to us. We are working diligently and expeditiously to identify and resolve issues during this first phase of the IDR implementation.

Q28 [Ed Gaines]: Given evidence of health plan non-compliance with the QPA and other requirements, is CMS planning to audit the QPAs?

A28: The certified IDR entity must select one of the offers submitted by the disputing parties to be the Out-Of-Network rate for the qualified IDR item or service.

It is not the role of the IDRE to determine whether the QPA has been calculated correctly by the plan, make determinations of medical necessity, or to review denials of coverage.

CMS intends to conduct an audit on the IDR process, and is still determining its audit standards for review.

NOTE: If the certified IDR entity or a party believes that the QPA has not been calculated correctly, the certified IDR entity or party is encouraged to notify the Departments through the Federal IDR portal, and the Departments may take action regarding the QPA's calculation.
https://www.cms.gov/sites/default/files/2022-04/Revised-IDR-Process-Guidance-Certified-IDREs.pdf

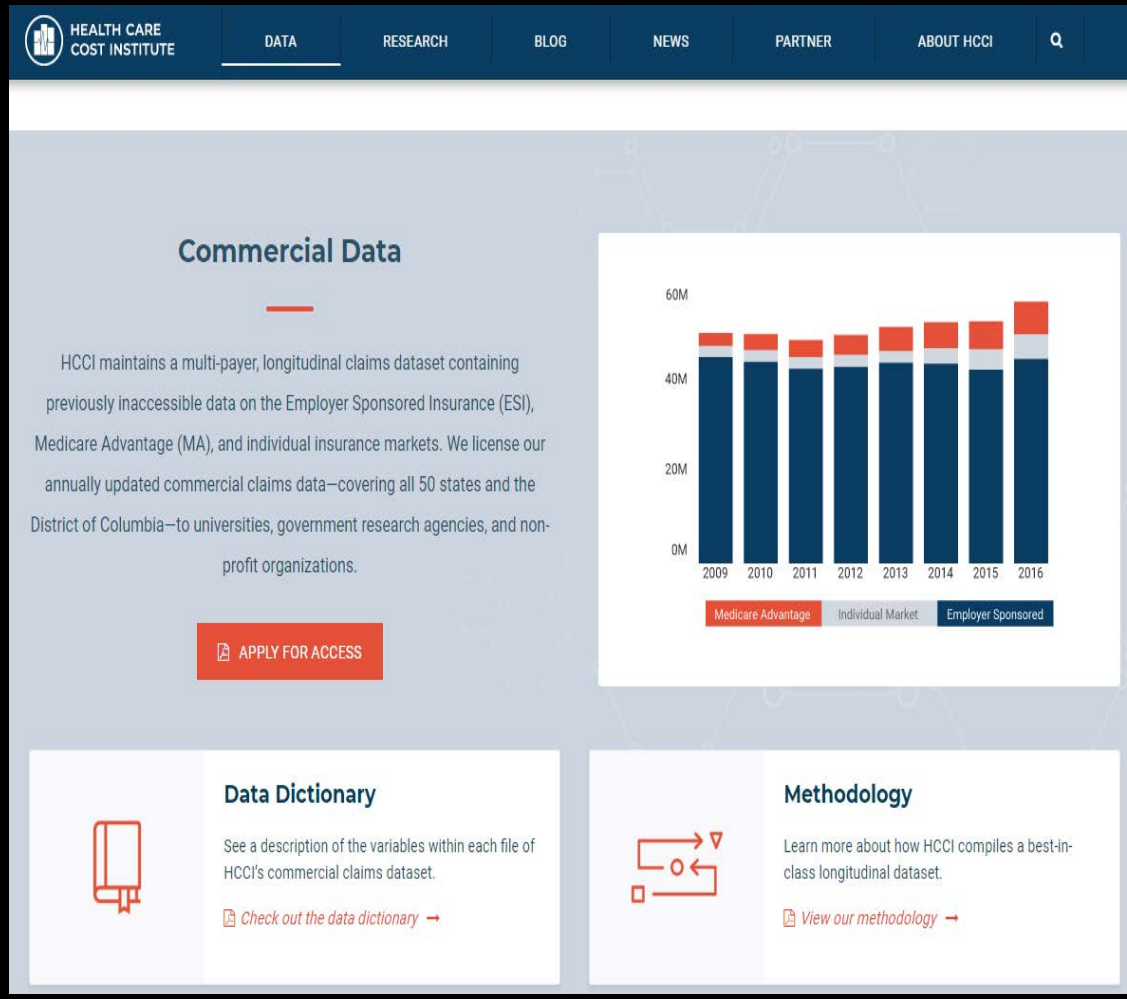
Anonymously Submitted Questions:

Q13 [Anonymous]: Can CMS confirm that it is required for batches to be grouped by plan type? If plans are not disclosing this information, providers may not be able to batch by plan type.

A13: Claims may be batched if the payment for qualified IDR items or services are made by the same group health plan or health insurance issuer. For insured group health plans, this means that items and services can be batched if payment is made by the same plan even if the health insurance issuer providing the insured coverage has multiple plans that they offer. For self-insured plans items and services must be batched at the individual plan level, even if the health insurance issuer offers multiple self-insured plans. For individual coverage, items and services can be batched if payment for the items and services are made by the same health insurance issuer.

What are the potential other payor data sources if not CMS:

- Fair Health (FH)
- All payor claims databases (APCDs):
  - VA & WA are examples.
  - Plans subject to state regulation can be mandated to provide data to the APCD.
  - APCDs cannot mandate ERISA plans to provide data per SCOTUS ruling.
- Health Care Cost Institute (HCCI)
- Transparency in Coverage Disclosures (TiC)



New on the horizon--"transparency in coverage" rules for hospitals & plans on 7/1/22

HHS | Hart Health Strategies Inc.

	Hospital Transparency Provisions	Health Plan Transparency Provisions
Statutory Language	ACA: "Each hospital . . . shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's **standard charges** for **items and services provided by the hospital**"	ACA Transparency in Coverage provisions
Start Date	January 1, 2021	January 1, 2022

Elements	• **Standard Charges**:
	  • *Gross charges*
	  • *Payer-specific Negotiated Charges*
	  • *De-identified Minimum & Maximum Negotiated Charge*
	  • *Discounted Cash Price*
	• **"Shoppable Services"** (70 in 4 categories: E&M Services; Laboratory and Pathology Services; Radiology Services; and Medicine & Surgery Services):
	  • *Payer-specific Negotiated Charges*
	  • *De-identified Minimum & Maximum Negotiated Charge*
	  • *Discounted Cash Price*
		• **Machine Readable Files**: In network; out of network (paid and billed); prescription drug files "for all covered health care items and services" (January 1, 2022)
		• **Self-Service Tool** (January 1, 2023/January 1, 2024):
		  • Estimated Cost-Sharing Liability
		  • Accumulated Amounts
		  • In-network rates
		  • Out of network allowed amount

"Items and Services"	*"all items and services, including individual items and services and service packages, that could be provided by a hospital to a patient in connection with an inpatient admission or outpatient department visit for which the hospital has a standard charge"* CMS stated that this definition is intended to include *"the services furnished by physicians and non-physician practitioners who are employed at the hospital."* CMS declined to define "employment" and stated instead that it believes "it is important to preserve flexibility for hospitals to identify employed physicians or nonphysician practitioners under their organizational structure."	*"all encounters, procedures, medical tests, supplies, prescription drugs, durable medical equipment, and fees (including facility fees), provided or assessed in connection with the provision of health care"* ***Note that there is no limitation to physicians & APCs who are employed at the hospital.***
Bundled/ Packaged Services	*"an aggregation of individual items and services into a single service with a single charge"* *"if a shoppable service is customarily accompanied by the provision of ancillary services, the hospital must present the shoppable service as a grouping of related services, meaning that the charge for the primary shoppable service (whether an individual item or service or service package) is displayed along with charges for ancillary services"*	*"a payment model under which a provider is paid a single payment for all covered items or services provided to a patient for a specific treatment or procedure"*

- Health plan price transparency required for 500 items/services as of 7/1/22 & then ALL services as of 1/1/24.
- 7/1/22—CPT 99283, 84 & 85 are listed in the 500 services.
- Health plans have now listed searchable on-line calculators as of 1/1/23.
- https://khn.org/news/article/want-a-clue-on-health-care-costs-in-advance-new-tools-take-a-crack-at-it/
- POS, TIN & NPI of the group must be disclosed in "machine readable files", e.g. XML or CSV.

  https://www.cms.gov/newsroom/fact-sheets/cy-2020-hospital-outpatient-prospective-payment-system-opps-policy-changes-hospital-price

Per a study, nearly 80% of hospitals and 90% of the covered lives with commercial insurance have had TiC compliance:

https://revcycleintelligence.com/news/more-hospitals-complying-with-price-transparency-rule-requirements

Regarding payer price transparency practices, 80 insurance carriers published rates. These carriers represent 90 percent of all commercially insured people, according to the report. Aetna, Blue Cross Blue Shield, Cigna, Humana, and United Healthcare were among the payers that posted rates.

A past survey found that **60 percent of consumers who research healthcare prices ahead of time are most likely to turn to their health plan for information**.

It is up to each state's insurance department to evaluate payer compliance with Transparency in Coverage.

Meanwhile, CMS is responsible for assessing hospital compliance and issuing penalties for noncompliance. In June 2022, the agency **sent out its first fines to two hospitals in Georgia that failed to comply with the rule's machine-readable file and shoppable services requirements**.

Compliance with the hospital transparency rule has been lagging since the regulation took effect in January 2021. According to Turquoise Health, CMS should take a more active stance in penalizing noncompliant facilities while recognizing compliant hospitals on its website.

Some states have taken legislative action to increase price transparency. For example, Colorado passed a bill **prohibiting hospitals from pursuing debt collections against patients if the facility does not comply with the price transparency rule**.

The report also suggested that standardizing good faith estimates, increasing patient education, and improving the independent dispute resolution (IDR) process for surprise bills could help facilitate price transparency.

Tagged Healthcare Spending Medicare Compliance Policy and Regulation Price Transparency

October 31, 2022 - Almost two-thirds of hospitals are complying with hospital price transparency rule requirements and have published machine-readable files with negotiated rates or cash rates, **according** to Turquoise Health's Price Transparency Impact Report.

The healthcare technology company assesses hospital compliance with the hospital price transparency rule every quarter and evaluates payer compliance with the Transparency in Coverage regulation every month. The report reflects data from the third quarter of 2022.

For hospitals, the company downloads the machine-readable files on hospital pages; analyzes the files on how they compare to CMS requirements for list price, cash price, and payer-negotiated rates; and generates a transparency score between one and five.

Dig Deeper

- **Cancer Centers Fail to Comply with Hospital Price Transparency Rule**
- **Hospital Price Transparency Compliance Lags Nearly 20 Months Later**
- **Most Consumers Look to Payers for Healthcare Price Transparency**

The company downloads all available machine-readable files from payers and assesses whether they include In Network and Allowed Amount files.

The report found that 4,909 hospitals (76 percent) posted a machine-readable file in Q3 2022. Sixty-five percent of hospitals published machine-readable files that included negotiated rates and 63 percent posted machine-readable files with cash rates.

There were more than 60.7 million negotiated rates posted in total, the report noted.

More than half (55 percent) of hospitals received five stars on Turquoise Health's transparency scorecard. The **company launched the online transparency tool in March 2022** to allow consumers to compare hospital costs before seeking care.

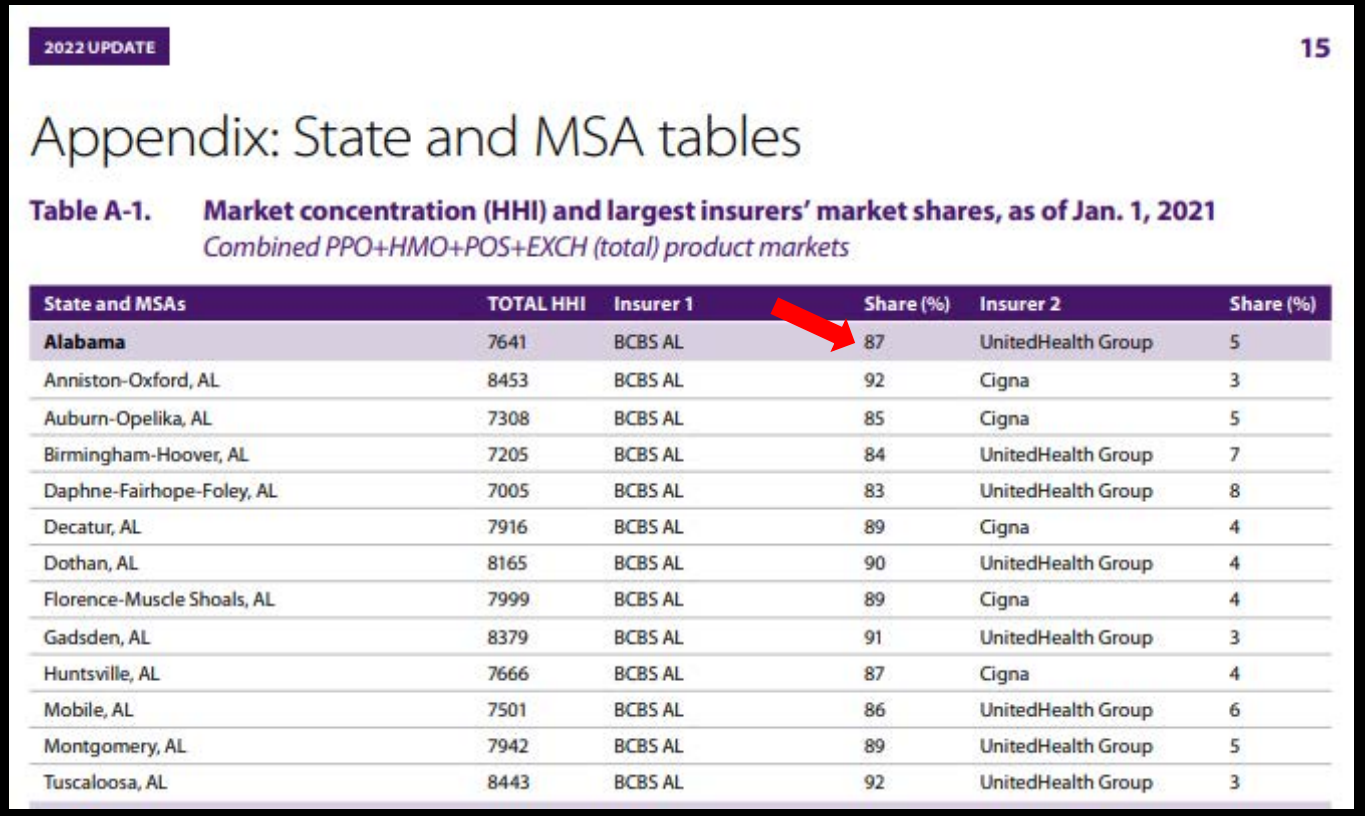
A five-star score indicates that a hospital had a complete machine-readable file that included cash, list, and negotiated rates for most items and services.

Several major health systems published complete machine-readable files and received five-star scores, including the Mayo Clinic, Advocate Aurora Health, and Prime Healthcare.

Nearly a quarter of hospitals (970 hospitals) received four stars, meaning they had a mostly complete machine-readable file that showed an apparent effort to meet all the requirements but still had room for improvement.

Around one in five hospitals received two or three stars, indicating that they either had an incomplete machine-readable file with unhelpful information or a partially complete file with some useful information but was still missing key elements

How to help your IDR case w/ data: recall market concentration & lack of good faith to contract are mandatory factors in IDR.



2022 UPDATE 15

Appendix: State and MSA tables

Table A-1. Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2021
Combined PPO+HMO+POS+EXCH (total) product markets

State and MSAs	TOTAL HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Alabama	7641	BCBS AL	87	UnitedHealth Group	5
Anniston-Oxford, AL	8453	BCBS AL	92	Cigna	3
Auburn-Opelika, AL	7308	BCBS AL	85	Cigna	5
Birmingham-Hoover, AL	7205	BCBS AL	84	UnitedHealth Group	7
Daphne-Fairhope-Foley, AL	7005	BCBS AL	83	UnitedHealth Group	8
Decatur, AL	7916	BCBS AL	89	Cigna	4
Dothan, AL	8165	BCBS AL	90	UnitedHealth Group	4
Florence-Muscle Shoals, AL	7999	BCBS AL	89	Cigna	4
Gadsden, AL	8379	BCBS AL	91	UnitedHealth Group	3
Huntsville, AL	7666	BCBS AL	87	Cigna	4
Mobile, AL	7501	BCBS AL	86	UnitedHealth Group	6
Montgomery, AL	7942	BCBS AL	89	UnitedHealth Group	5
Tuscaloosa, AL	8443	BCBS AL	92	UnitedHealth Group	3

- https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf

Illustration/strategy on best & final offer (BFO)—FH=FAIR Health

Payor claim control #	MSA	DOS	CPT & Name of services	Initial allowed amount	Initial allowed amount as % of FH	Charges*	Initial payment as a % of CMS*	Final offer payment as a % of CMS*	FH 50th percentile as a % of CMS*
						Not permitted in BFO	Not permitted in BFO	Not permitted in BFO	Not permitted in BFO
Required fields may include rendering clinician, NPI & charge ID	Metropoli-tan statistical area used to determine QPA.	Batching issues should be checked & re-checked.	"Same or similar" has now been read to mean "same CPT"	~QPA: often not provided in the 835 R/A, may be obtained in Pt's EOB.	Using objective data like FH may highlight payor non-compliance				
			Narrative description of clinician credentials & Pt acuity may be included	Also include the question whether the QPA received CPI-U adjustment per IRS regs. at approx. +14.66%	Regs state that initial payment should be reasonable for svs. rendered				

Illustration/strategy on best & final offer (BFO)—FH=FAIR Health

BFO allowed amount requested	Final offer as a % of QPA	Initial allowed amount as % of prior contracted rates if applicable.	Initial allowed amount as % of FH	Open negotiation emailed date.	Open negotiation end date.	IDR BFO submission date
		Check timing of changes in allowed amounts after NSA + after K termination.		30-day clock begins to run when email is sent to party designated by the health plan.	IDR portal data must be submitted w/in 4 business days from end of this date.	BFO w/in 10 business days of IDRE selection.
Reference to FH, state APCD or TiC data but not CMS.	Required field to include in BFO.	Unless struck down in TMA II, watch "double counting" by IDRE in rationale for decision.	Using objective data like FH may highlight payor non-compliance	Avoid websites that require an add'l "acceptance" or "negotiation" process.		
		1 of the most compelling factors in group's favor.	Regs state that initial payment should be reasonable for svs. rendered	Make it easy on the IDRE to determine when the 30 clock started & stopped.	Make it easy on the IDRE to determine compliance w/ 4 business day requirements.	

A brief word about IDRs after the 90 day "cooling off" period--Get legal advice!

- **Law + regs. prohibit "initiating IDR" for 90-days after payment determination—same TIN, same plan + same CPTs.**
  - **Prior IDRs that are pending decision may be adjudicated--"Initiation" is technically prohibited.**

- **CFR Language Implementing 30-day initiation period for Cooling Off Period Claims:** *"(C) Subsequent submission of requests permitted. If the end of the open negotiation period specified in paragraph (b)(1) of this section occurs during the 90-calendar-day suspension period regarding claims for the same or similar item or service that were the subject of the initial notice of IDR determination as described in paragraph (c)(4)(vi) of this section, either party may initiate the Federal IDR process for those claims by submitting a notification as specified in paragraph (b)(2) of this section during the 30-business-day period beginning on the day after the last day of the 90-calendar-day suspension period."*

  - **IFR #2 provisions that allows you to batch cooling off claims together even if they weren't furnished within 30 days of each other:**

- Preamble: Under the "batching" rules, here is how the Departments state the timing requirement for a batch: "*all the qualified IDR items and services must have been furnished within the same 30-business-day period, **or the 90-calendar-day suspension period**.*" The Departments elaborate: "*Therefore, if items or services are furnished within the 90-calendar-day suspension period and meet the other applicable requirements, they may be submitted and considered jointly as part of one payment determination by a certified IDR entity, once the suspension period has ended.*"

Part 3—The future state + What's coming in future rule making regarding good faith estimates (GFEs) and the advanced EOB from health plans.

Q: What's the best way to avoid federal NSA IDR for all commercial health plan cases?

A: Have a state specified law enacted—likely will cover ~30-50% of individual & group plans + state employees & teachers.
Both GA HB 888 & TX SB 1264 are good models.

Tri-Depts. Get "The Grinch Award" 12/23/22

- Report period April 15-Sept. 30, 2022.
- >90K federal IDRs filed
- CPT 9928X codes were 66%
- 15% of closed disputes were payment determinations.
- TX, FL, GA and NC top states.
- Radiology + anesthesiology were next highest after EM.

Table 5: Top 10 Non-Initiating Parties or their Representatives for Disputes Involving Emergency and Non-Emergency Services, April 15 – September 30, 2022

Non-Initiating Party or their Representative	2022 Q2	2022 Q3	Overall	Percent of All Disputes Involving Emergency and Non-Emergency Items or Services
United Healthcare	4,170	16,880	21,050	24%
Aetna	3,070	9,220	12,290	14%
MultiPlan	1,013	8,283	9,296	11%
Anthem	488	7,863	8,351	10%
Cigna	1,800	6,329	8,129	9%
BlueCross BlueShield of Texas	1,764	3,000	4,764	5%
Clear Health Strategies	492	2,946	3,438	4%
Florida Blue	15	3,386	3,401	4%
BlueCross BlueShield of Illinois	140	1,991	2,131	2%
BlueCross BlueShield of Tennessee	1,000	935	1,935	2%

Source: Notices of IDR Initiation submitted to the Federal IDR portal, April 15 – September 30, 2022.
Notes: Parties and their representatives were identified and aggregated by the email domain of the non-initiating party on the Notice of IDR Initiation.

https://www.cms.gov/files/document/initial-report-idr-april-15-september-30-2022.pdf

Table 9: Disputes by Type of CPT Code, April 15 – September 30, 2022

CPT Codes	CPT Type	Frequency	Percent
99281 - 99288	Emergency Department Services	57,505	66%
70010 - 79999	Radiology	8,238	9%
00100 - 01999	Anesthesia	6,021	7%
10004 - 69990	Surgery	4,417	5%
80047 - 89398	Pathology and Lab	3,538	4%
95700 - 96020	Neurology and Neuromuscular Procedures	3,501	4%
99291 - 99292	Critical Care Services	3,073	4%
92920 - 93799	Cardiovascular Procedures	2,934	3%
96360 - 96549	Hydration, Therapeutic, Prophylactic, Diagnostic Injections and Infusions, and Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration	2,520	3%
99217 - 99226	Hospital Observation Services	1,201	1%
99221 - 99239	Hospital Inpatient Services	1,101	1%
0001U - 0354U	Proprietary Laboratory Analyses	1,035	1%
94002 - 94799	Pulmonary Procedures	877	1%
99466 - 99480	Inpatient Neonatal Intensive Care Services and Pediatric and Neonatal Critical Care Services	751	1%
93880 - 93998	Non-Invasive Vascular Diagnostic Studies	338	< 1%
99000 - 99091	Special Services, Procedures and Reports	314	< 1%
99151 - 99157	Moderate (Conscious) Sedation	97	< 1%
99202 - 99215	Office or Other Outpatient Services	83	< 1%
90460 - 90474	Immunization Administration for Vaccines/Toxoids	77	< 1%
90476 - 90759	Vaccines, Toxoids	76	< 1%
99100 - 99140	Qualifying Circumstances for Anesthesia	45	< 1%
97010 - 97799	Physical Medicine and Rehabilitation Evaluations	39	< 1%
99460 - 99463	Newborn Care Services	30	< 1%
92502 - 92700	Special Otorhinolaryngologic Services and Procedures	28	< 1%
99241 - 99255	Consultation Services	28	< 1%
99354 - 99417	Prolonged Services	17	< 1%
99464 - 99465	Delivery/Birthing Room Attendance and Resuscitation Services	16	< 1%
92002 - 92499	Ophthalmology Services and Procedures	9	< 1%
0042T - 0737T	Various Services Category III Codes	5	< 1%
98925 - 98929	Osteopathic Manipulative Treatment Procedures	4	< 1%
99304 - 99318	Nursing Facility Services	3	< 1%

Table 10: Top 50 Service Codes Submitted, April 15 – September 30, 2022

Code Type	Service Code	Description of Item or Service	2022 Q2	2022 Q3	Total	Percent
CPT	99285	Emergency department visit for life threatening or functioning severity	3,715	18,895	22,610	26%
CPT	99284	Emergency department visit for problem of high severity	3,396	16,482	19,878	23%
CPT	99283	Emergency department visit for problem of moderate severity	2,667	13,508	16,175	19%
CPT	99291	Critical care, first 30-74 minutes	722	2,241	2,963	3%
CPT	95941	Continuous remote monitoring of nervous system during operation, each hour	258	1,956	2,214	3%
CPT	74177	CT scan of abdomen and pelvis with contrast	870	1,152	2,022	2%
CPT	85025	Complete blood cell count (red cells, white blood cell, platelets), automated test and automated differential white blood cell count	392	1,584	1,976	2%
CPT	71045	X-ray of chest, 1 view	898	1,001	1,899	2%
CPT	71046	X-ray of chest, 2 views	689	959	1,648	2%
CPT	70450	CT scan head or brain without contrast	670	883	1,553	2%
CPT	95938	Placement of skin electrodes and measurement of stimulated sites on arms and legs	260	1279	1,539	2%
CPT	93010	Routine ECGs using at least 12 leads with interpretation and report only	597	908	1,505	2%
CPT	74176	CT scan of abdomen and pelvis without contrast	482	841	1,323	2%
CPT	80053	Blood test, comprehensive group of blood chemicals	221	953	1,174	1%

EM is well represented!

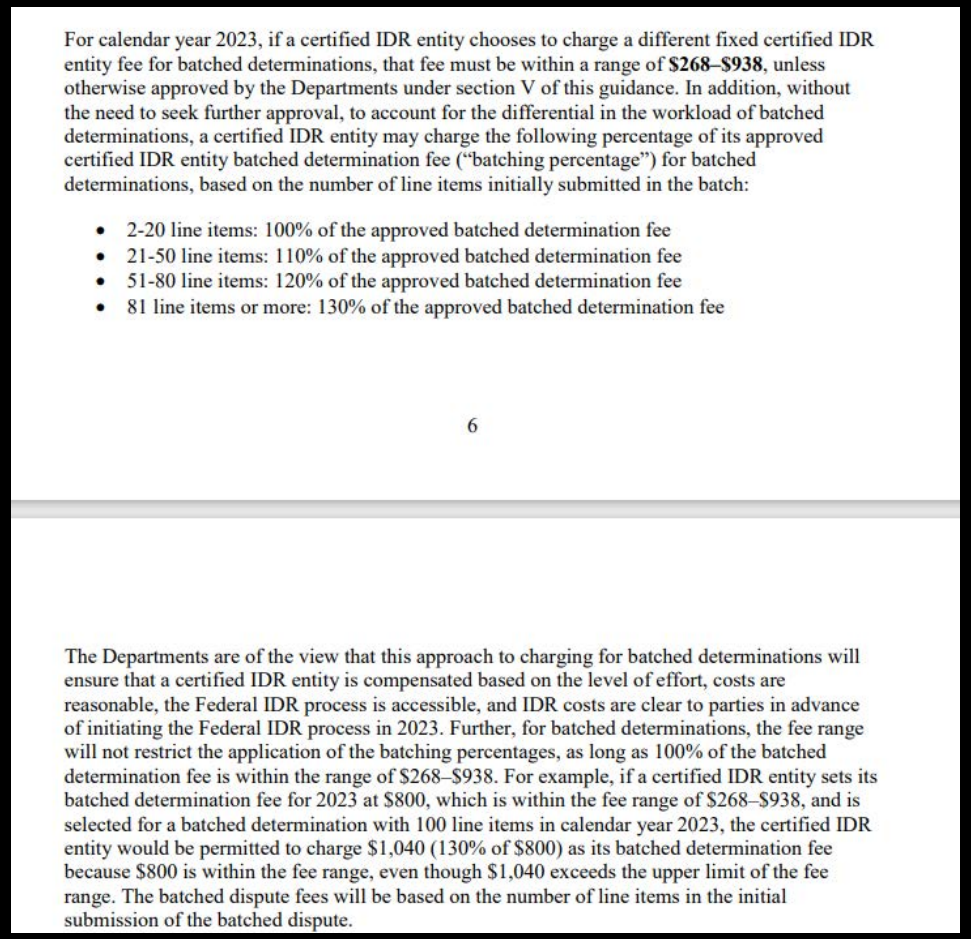
The Grinch Award X2—CMS increases the admin. fees 7X for 2023 + Tri Depts. refusal to act (see appendix CARC/RARC codes.

- Non-refundable admin. fee > to $350 for 2023.
- 69% of closed disputes were deemed ineligible.
  - 22 states have state specified laws.
  - 3 of those states are in the top 4—TX, FL and GA.
  - CMS cited “state/federal” jurisdiction issues as a main reason for ineligible.
  - Yet CMS continues to refuse to mandate RARC and CARC codes to assist in determining plan type.
  - Plan type often unknown, e.g. BCBS Amazon.

https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Amended-CY2023-Fee-Guidance-Federal-Independent-Dispute-Resolution-Process-NSA.pdf

https://www.cms.gov/nosurprises/help-resolve-payment-disputes/certified-idre-list

CMS' IDRE base fee increase in '23 for the broken IDR system!



For calendar year 2023, if a certified IDR entity chooses to charge a different fixed certified IDR entity fee for batched determinations, that fee must be within a range of **$268–$938**, unless otherwise approved by the Departments under section V of this guidance. In addition, without the need to seek further approval, to account for the differential in the workload of batched determinations, a certified IDR entity may charge the following percentage of its approved certified IDR entity batched determination fee ("batching percentage") for batched determinations, based on the number of line items initially submitted in the batch:

- 2-20 line items: 100% of the approved batched determination fee
- 21-50 line items: 110% of the approved batched determination fee
- 51-80 line items: 120% of the approved batched determination fee
- 81 line items or more: 130% of the approved batched determination fee

6

The Departments are of the view that this approach to charging for batched determinations will ensure that a certified IDR entity is compensated based on the level of effort, costs are reasonable, the Federal IDR process is accessible, and IDR costs are clear to parties in advance of initiating the Federal IDR process in 2023. Further, for batched determinations, the fee range will not restrict the application of the batching percentages, as long as 100% of the batched determination fee is within the range of $268–$938. For example, if a certified IDR entity sets its batched determination fee for 2023 at $800, which is within the fee range of $268–$938, and is selected for a batched determination with 100 line items in calendar year 2023, the certified IDR entity would be permitted to charge $1,040 (130% of $800) as its batched determination fee because $800 is within the fee range, even though $1,040 exceeds the upper limit of the fee range. The batched dispute fees will be based on the number of line items in the initial submission of the batched dispute.

https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CY2023-Fee-Guidance-Federal-Independent-Dispute-Resolution-Process-NSA.pdf

- **2022 IDRE batched fees topped out ~$670**
  - **Recall loser pays.**
  - **$50 administrative fee by both sides—now 7X increase to $350.**
- **2023 IDRE base fees (loser pays) increased +8% to over 50%.**
- **+New in '23 is "batching %" fee: 10-30% based on line items in IDR.**
- **In the CMS example, '23 IDRE fees would top out at $1040 or +55% yr. over yr. increase.**

If a provider or facility and a health plan can't agree on the payment amount for an out-of-network service covered by No Surprises rules, these organizations can be selected to make a payment determination.

The list will be updated as additional organizations become certified. Learn more about the certification process.

Please note: The 2023 certified IDR entity fees will be in effect for disputes initiated as of January 1, 2023.

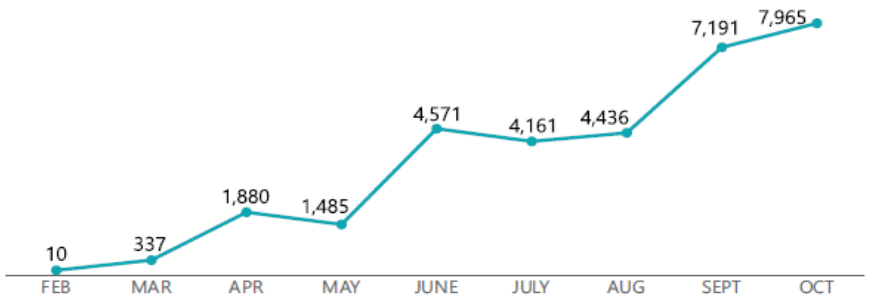
Legal Business Name	Application ID	Website	Flat Fee (single determinations) 2022	Flat Fee (single determinations) 2023	Batched Fee (batched determinations) 2022	Batched Fee (batched determinations) 2023	Certified for the following states
C2C Innovative Solutions, Inc.	IDREApp-067	https://www.c2cinc.com	$299	$648	$670	$938	All states in which the federal process applies
EdiPhy Advisors, L.L.C.	IDREApp-115	https://www.medmanagementllc.com/	$500	$700	$670	$938	All states in which the federal process applies

Texas TDI—1st 10 months of 2020*

Arbitration

SB 1264 outlines an arbitration process for billing disputes between out-of-network health care providers (not facilities) and health plans. From January 1 through October 31, 2020, TDI received 32,036 requests for arbitration.

Arbitration requests



Arbitration requests by provider type

Provider type	Requests
Emergency department physician	27,492
Anesthesiologist	2,138
Certified Registered Nurse Anesthetist	609
Assistant surgeon	425
Hospitalist	339
Neurologist	18
Neuromonitor	55
Nurse practitioner	22
Pathologist	130
Physician assistant	96
Surgeon	189
Surgical assistant	437
Other	86
Total	32,036

Arbitration

SB 1264 outlines an arbitration process for billing disputes between out-of-network health care providers (not facilities) and health plans. In 2020, TDI received 44,910 requests for arbitration. In the first half of 2021, TDI received 50,230 requests.

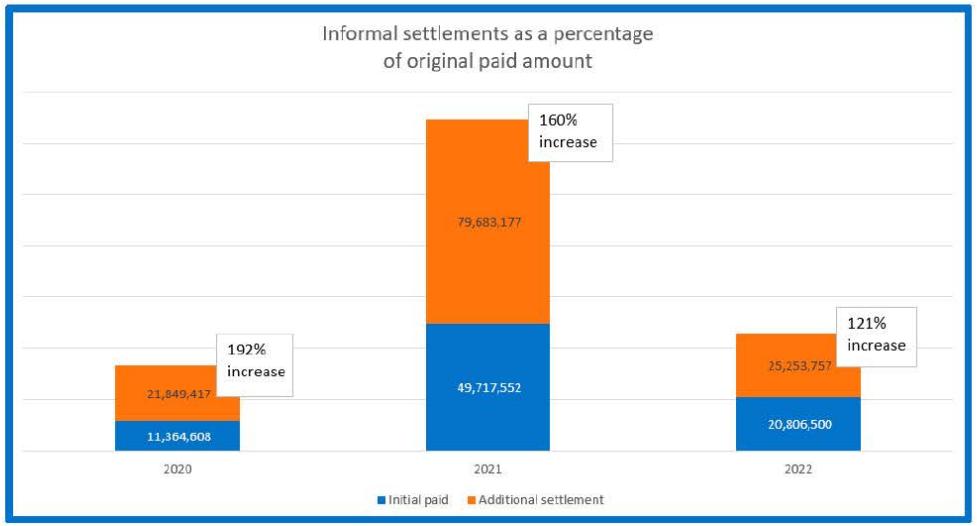
Arbitration requests by month

Arbitration requests by provider type

Provider type	Jan-June 2021
Emergency department physician	35,172
Anesthesiologist	8,238
Certified registered nurse anesthetist	1,993
Radiologist	1,749
Surgical assistant	759
Physician assistant	741
Assistant surgeon	686
Neuromonitor	321
Surgeon	169
Hospitalist	117
Nurse practitioner	96
Pathologist	72
Neonatologist	29
Neurologist	10
Other	78
Total	**50,230**

- **IDRs settled during the discussion period have increased from 4.43X of the initial payment in ’20 to 4.6X of the initial payment in ’21.***
- **IDRs adjudicated have seen a decrease from 4.74X of the initial payment to 3.4X of the initial payment but the initial payment increased $53 in that 1-year period.***

*Source: Texas Department of Information | tdi.Texas.gov



Observations of awards for arbitration

- 53,662 arbitration decisions have been reported
  - On average, providers are awarded the decision 66% of the time
  - Average awarded amount as a percent of the original billed amount-35%

Settlement observations-mediation

- 1,240 requests have concluded at mediation (regardless of settlement status)
  - 31% of requests reach settlement

Facilitator update

- 317 total facilitators
  - 119 arbitrators
  - 137 mediators

Top 5 provider types by volume

1. ER physician
2. Freestanding emergency medical center
3. Anesthesiologist
4. Hospital
5. Certified registered nurse anesthetist

TX TDI 2020

- "Mediation" is for hospitals.
- "Arbitration" is for physicians.
  - "Providers" are winning 66% of the arbitrations

- TX has one of the most favorable IDR processes to physicians in the US.

TX TDI Settlements, Report dated Nov. 2022:

Data period	Original Payment	Settlement amount	Change rate	Notes
Jan-June 2021	$174	$804	3.62X	Single claim data.
July-Dec. 2021	$156	$702	3.5X	Same
Jan.-June 2022	$170	$877	4.15X	Same

TX TDI Arbitrator Decisions, Report dated Nov. ‘22:

Data period	Original Payment	Awarded amount	Change rate	Notes
Jan-June 2021	$257	$883	2.44X	Single claim data.
July-Dec. 2021	$187	$919	3.91X	Same
Jan.-June 2022	$241	$1400	4.81X	Same

Summary

- TMA II decision is pending—favorable decision could be another game changer.
- EM is at table for regulatory & Congressional involvement.
- 6+ months of tough sledding in the NSA IDR log-gammed process.
- Groups are winning > than losing.
- Release of the health plan TiC data may be a game changer.

Questions & Thank You!

Ed Gaines, JD, CCP,

VP Regulatory Affairs, Zotec Partners, LLC

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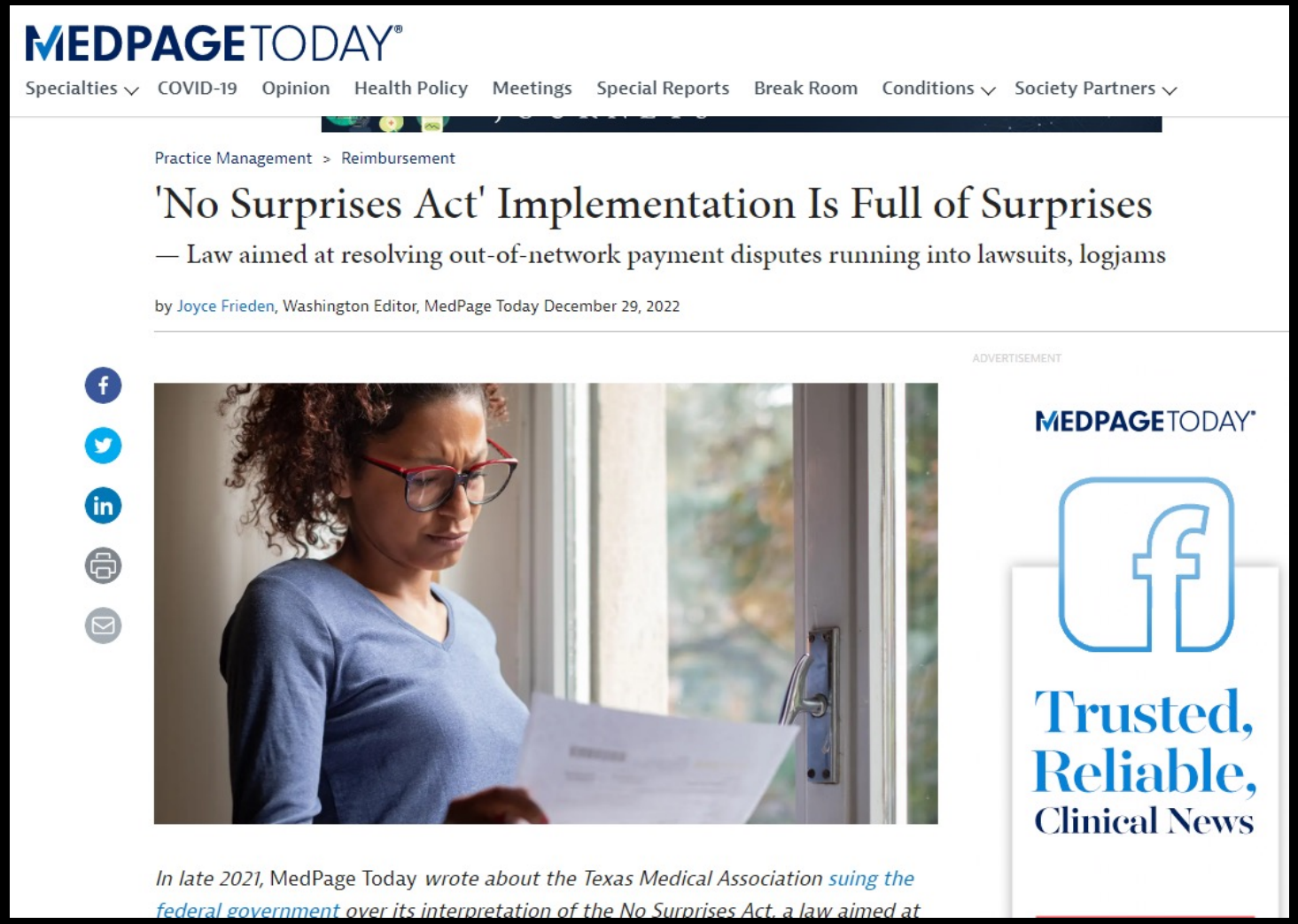
http://twitter.com/EdGainesIII

Appendix

ACEP's J. Davis laying out the issues w/ NSA implementation.



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'No Surprises Act' Implementation Is Full of Surprises

— Law aimed at resolving out-of-network payment disputes running into lawsuits, logjams

by Joyce Frieden, Washington Editor, MedPage Today December 29, 2022

In late 2021, MedPage Today *wrote about the Texas Medical Association suing the federal government over its interpretation of the No Surprises Act, a law aimed at*

https://www.medpagetoday.com/practicemanagement/reimbursement/102424

Carrier Advice Remittance Codes (CARCs) & Remittance Advice Remark Codes (RARCs)—while "strongly recommended" CMS refuses to mandate plans' use.

- N830 Alert: The charge[s] for this service was processed in accordance with Federal/State, Balance Billing/ No Surprise Billing regulations. As such, any amount identified with OA, CO, or PI cannot be collected from the member and may be considered provider liability or be billable to a subsequent payer. Any amount the provider collected over the identified PR amount must be refunded to the patient within applicable Federal/State timeframes. Payment amounts are eligible for dispute pursuant to any Federal/State documented appeal/grievance process(es). Last Modified: 03/01/2022
- N859: The Federal No Surprise Billing Act was applied to the processing of this claim. Payment amounts are eligible for dispute pursuant to any Federal documented appeal/ grievance/ dispute resolution process(es). Last Modified: 03/01/2022
- N860: The Federal No Surprise Billing Act Qualified Payment Amount (QPA) was used to calculate the member cost share(s).
- N869: Cost sharing was calculated based on the qualifying payment amount, in accordance with the No Surprises Act.
- N870: In accordance with the No Surprises Act, cost sharing was based on the billed amount because the billed amount was lower than the qualifying payment amount.
- N871: This initial payment was calculated based on a specified state law, in accordance with the No Surprises Act.
- N872: This final payment was calculated based on a specified state law, in accordance with the No Surprises Act.

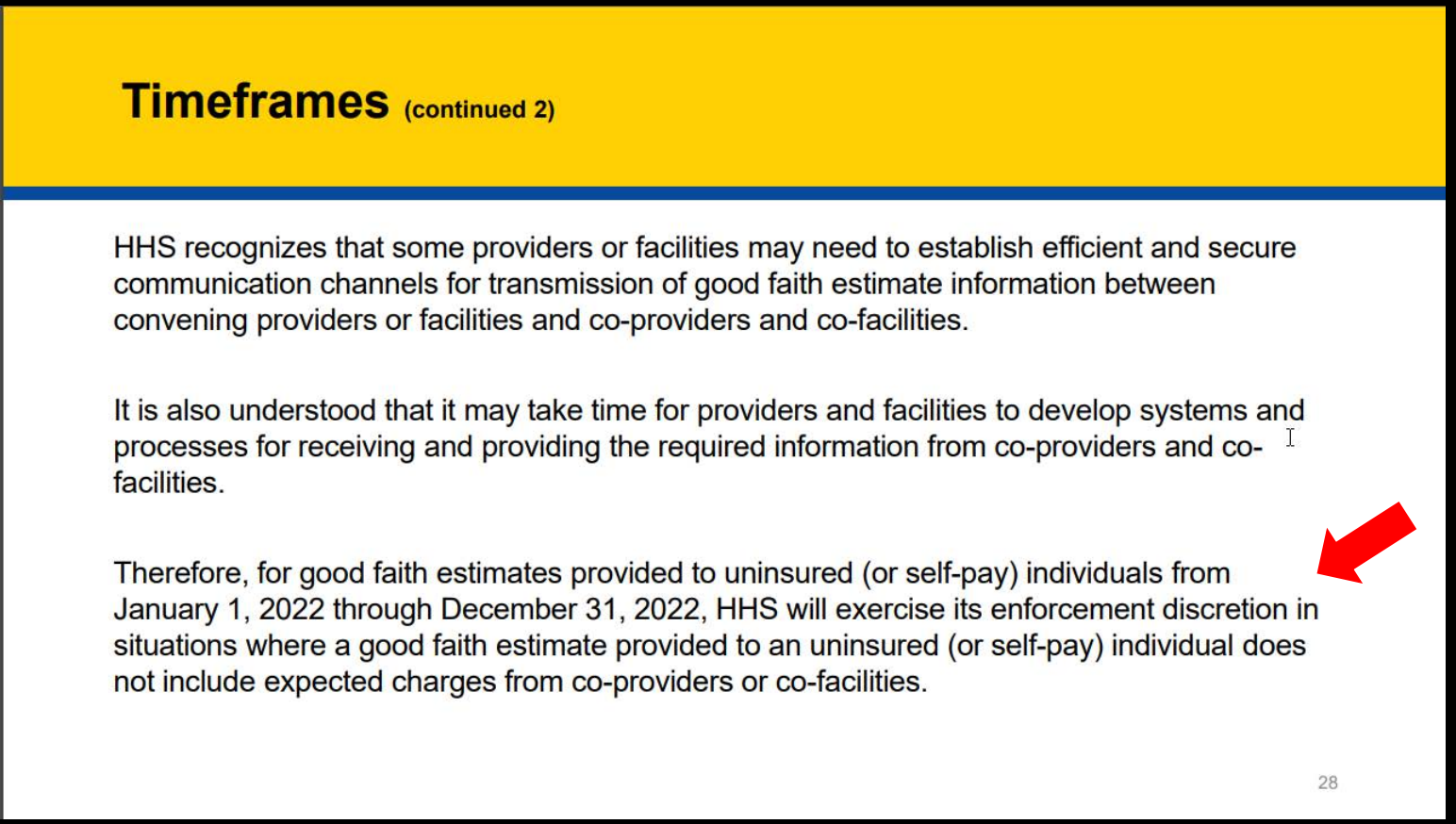
Health plans know if the Pt's plan is "BCBS Fed Ex"—yet they advocate to CMS that physicians are filing "too many" non-NSA qualified IDRs!

- **N873 Alert: This final payment was calculated based on an All-Payer Model Agreement, in accordance with the No Surprises Act. Start: 03/01/2022**
- **N874 Alert: This final payment was determined through open negotiation, in accordance with the No Surprises Act Start: 03/01/2022**
- **N875 Alert: This final payment equals the amount selected as the out-of-network rate by a Federal Independent Dispute Resolution Entity, in accordance with the No Surprises Act. Start: 03/01/2022**
- **N876 Alert: This item or service is covered under the plan. This is a notice of denial of payment provided in accordance with the No Surprises Act. The provider or facility may initiate open negotiation if they desire to negotiate a higher out-of-network rate than the amount paid by the patient in cost sharing. Start: 03/01/2022**
- **N877 Alert: This initial payment is provided in accordance with the No Surprises Act. The provider or facility may initiate open negotiation if they desire to negotiate a higher out-of-network rate. Start: 03/01/2022**
- **N878 Alert: The provider or facility specified that notice was provided and consent to balance bill obtained, but notice and consent was not provided and obtained in a manner consistent with applicable Federal law. Thus, cost sharing and the total amount paid have been calculated based on the requirements under the No Surprises Act, and balance billing is prohibited. Start: 03/01/2022**
- **N879 Alert: The notice and consent to balance bill, and to be charged out-of-network cost sharing, that was obtained from the patient with regard to the billed services, is not permitted for these services. Thus, cost sharing and the total amount paid have been calculated based on the requirements under the No Surprises Act, and balance billing is prohibited. Start: 03/01/2022**
- **Remittance Advice Remark Codes | X12**

The Good Faith Estimate (GFE) Reminder:

- Physicians ***and*** facilities must provide a good faith estimate (GFE) of "reasonably expected" charges for ***scheduled*** services to an uninsured or S/P Pt (self-pay Pts. might have insurance but due to "sensitive diagnosis" or other issues do not want claims filed).
  - Consumers may request a good faith estimate without scheduling items or services to compare costs and decide from which provider or facility they will seek care—GFE obligation exists regardless of request.
- "Convening provider or convening facility": the physician or facility who receives the initial request for a good faith estimate from an uninsured or S/P Pt. and who is or, in the case of a request, would be responsible for scheduling the primary item or service.
  - "Facility" includes hospital OP dept., ASC and imaging centers. (CMS at slide 14)
  - Enforcement will begin 1/1/22 for convening providers and facilities.
- Co-provider or co-facility: A provider or facility other than a convening provider or a convening facility that furnishes items or services that are customarily provided in conjunction with a primary item or service.
- Enforcement will be discretionary until 7/1/22 for co-providers and co-facilities responsible for providing good faith estimates to uninsured or S/P Pts
- https://www.cms.gov/files/document/gfe-and-ppdr-requirements-slides.pdf

“Co-providers had a break” in enforcement discretion—but no more as of 1/1/23.



Timeframes (continued 2)

HHS recognizes that some providers or facilities may need to establish efficient and secure communication channels for transmission of good faith estimate information between convening providers or facilities and co-providers and co-facilities.

It is also understood that it may take time for providers and facilities to develop systems and processes for receiving and providing the required information from co-providers and co-facilities.

Therefore, for good faith estimates provided to uninsured (or self-pay) individuals from January 1, 2022 through December 31, 2022, HHS will exercise its enforcement discretion in situations where a good faith estimate provided to an uninsured (or self-pay) individual does not include expected charges from co-providers or co-facilities.

28

- HHS model template & notice is not required but advised.
  - https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791
- The insured Pt rule enforcement has been deferred until future rule making.

https://www.cms.gov/files/document/gfe-and-ppdr-requirements-slides.pdf

Insured Pts. GFE & AEOB Requirements Deferred for now—maybe coming in 2023

HHS Requests Stakeholder Feedback on Good Faith Estimate Requirements

The request for information seeks feedback on transferring data from providers to health plans, policy considerations, and the economic impacts of implementing good faith estimate requirements.

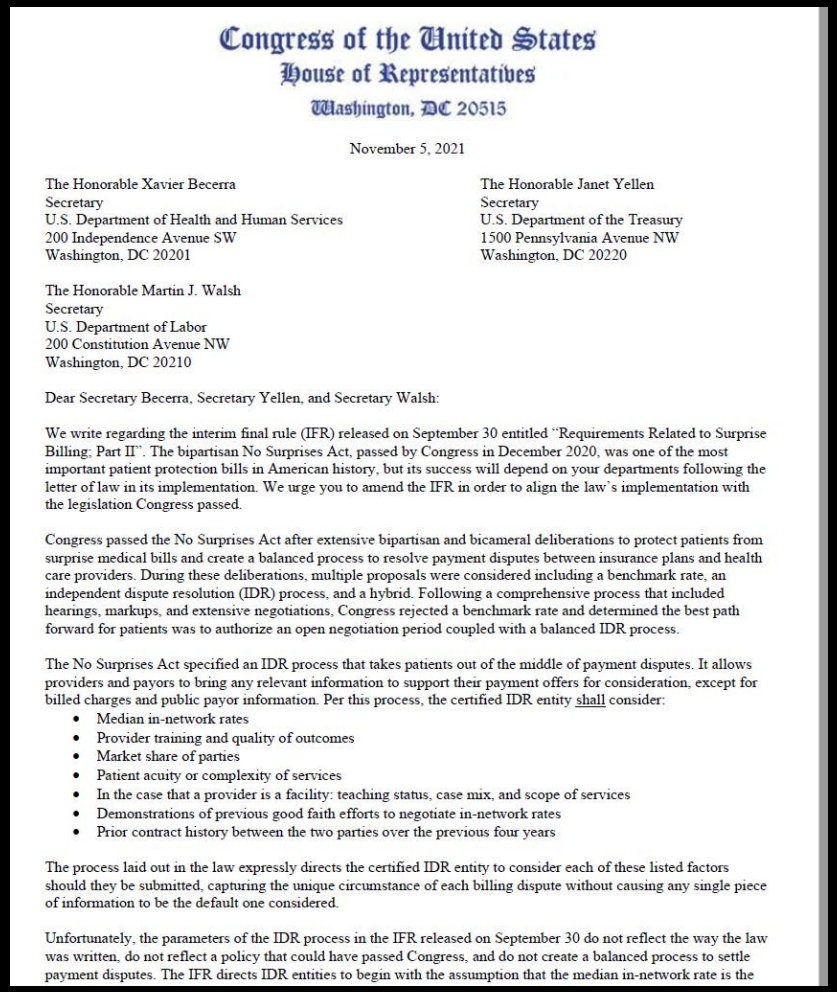
Source: HHS logo

By Victoria Bailey

September 20, 2022 - HHS, along with three other federal agencies, has **issued** a request for information (RFI) to gather stakeholder feedback on the advanced explanation of benefits (AEOB) and good faith estimate (GFE) requirements of the No Surprises Act.

- HHS has deferred enforcement of the GFE requirements for insured Pts.
- "Advanced EOB" (AEOB) obligations of the health plans were also deferred.
- AEOB=network status of the phys./facility + contracted rate for the services + GFE from phys. & facility + what portion of the GFE is reimbursed by the health plan + Pt. cost sharing.
- RFI is seeking feedback on these AEOB and GFE requirements through 11/15/22
- https://revcycleintelligence.com/news/hhs-requests-stakeholder-feedback-on-good-faith-estimate-requirements
- https://www.federalregister.gov/documents/2022/09/16/2022-19798/request-for-information-advanced-explanation-of-benefits-and-good-faith-estimate-for-covered

152 bi-partisan members of Congress express their unhappiness with the Sept. IFR on 11/5/21.



Congress of the United States
House of Representatives
Washington, DC 20515

November 5, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

The Honorable Martin J. Walsh
Secretary
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

Dear Secretary Becerra, Secretary Yellen, and Secretary Walsh:

We write regarding the interim final rule (IFR) released on September 30 entitled "Requirements Related to Surprise Billing; Part II". The bipartisan No Surprises Act, passed by Congress in December 2020, was one of the most important patient protection bills in American history, but its success will depend on your departments following the letter of law in its implementation. We urge you to amend the IFR in order to align the law's implementation with the legislation Congress passed.

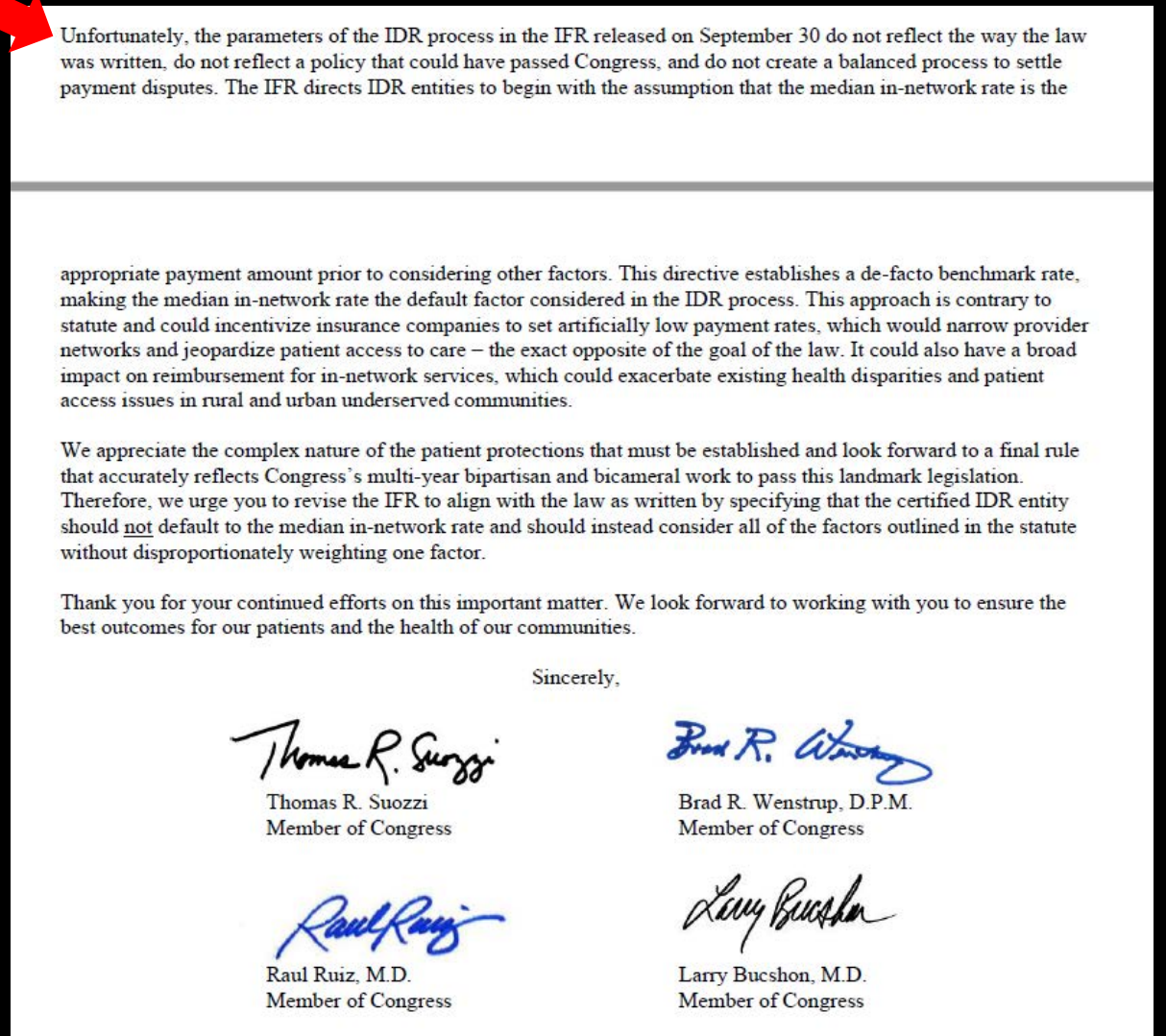
Congress passed the No Surprises Act after extensive bipartisan and bicameral deliberations to protect patients from surprise medical bills and create a balanced process to resolve payment disputes between insurance plans and health care providers. During these deliberations, multiple proposals were considered including a benchmark rate, an independent dispute resolution (IDR) process, and a hybrid. Following a comprehensive process that included hearings, markups, and extensive negotiations, Congress rejected a benchmark rate and determined the best path forward for patients was to authorize an open negotiation period coupled with a balanced IDR process.

The No Surprises Act specified an IDR process that takes patients out of the middle of payment disputes. It allows providers and payors to bring any relevant information to support their payment offers for consideration, except for billed charges and public payor information. Per this process, the certified IDR entity shall consider:

- Median in-network rates
- Provider training and quality of outcomes
- Market share of parties
- Patient acuity or complexity of services
- In the case that a provider is a facility: teaching status, case mix, and scope of services
- Demonstrations of previous good faith efforts to negotiate in-network rates
- Prior contract history between the two parties over the previous four years

The process laid out in the law expressly directs the certified IDR entity to consider each of these listed factors should they be submitted, capturing the unique circumstance of each billing dispute without causing any single piece of information to be the default one considered.

Unfortunately, the parameters of the IDR process in the IFR released on September 30 do not reflect the way the law was written, do not reflect a policy that could have passed Congress, and do not create a balanced process to settle payment disputes. The IFR directs IDR entities to begin with the assumption that the median in-network rate is the



Unfortunately, the parameters of the IDR process in the IFR released on September 30 do not reflect the way the law was written, do not reflect a policy that could have passed Congress, and do not create a balanced process to settle payment disputes. The IFR directs IDR entities to begin with the assumption that the median in-network rate is the

appropriate payment amount prior to considering other factors. This directive establishes a de-facto benchmark rate, making the median in-network rate the default factor considered in the IDR process. This approach is contrary to statute and could incentivize insurance companies to set artificially low payment rates, which would narrow provider networks and jeopardize patient access to care – the exact opposite of the goal of the law. It could also have a broad impact on reimbursement for in-network services, which could exacerbate existing health disparities and patient access issues in rural and urban underserved communities.

We appreciate the complex nature of the patient protections that must be established and look forward to a final rule that accurately reflects Congress's multi-year bipartisan and bicameral work to pass this landmark legislation. Therefore, we urge you to revise the IFR to align with the law as written by specifying that the certified IDR entity should not default to the median in-network rate and should instead consider all of the factors outlined in the statute without disproportionately weighting one factor.

Thank you for your continued efforts on this important matter. We look forward to working with you to ensure the best outcomes for our patients and the health of our communities.

Sincerely,

Thomas R. Suozzi
Member of Congress

Brad R. Wenstrup, D.P.M.
Member of Congress

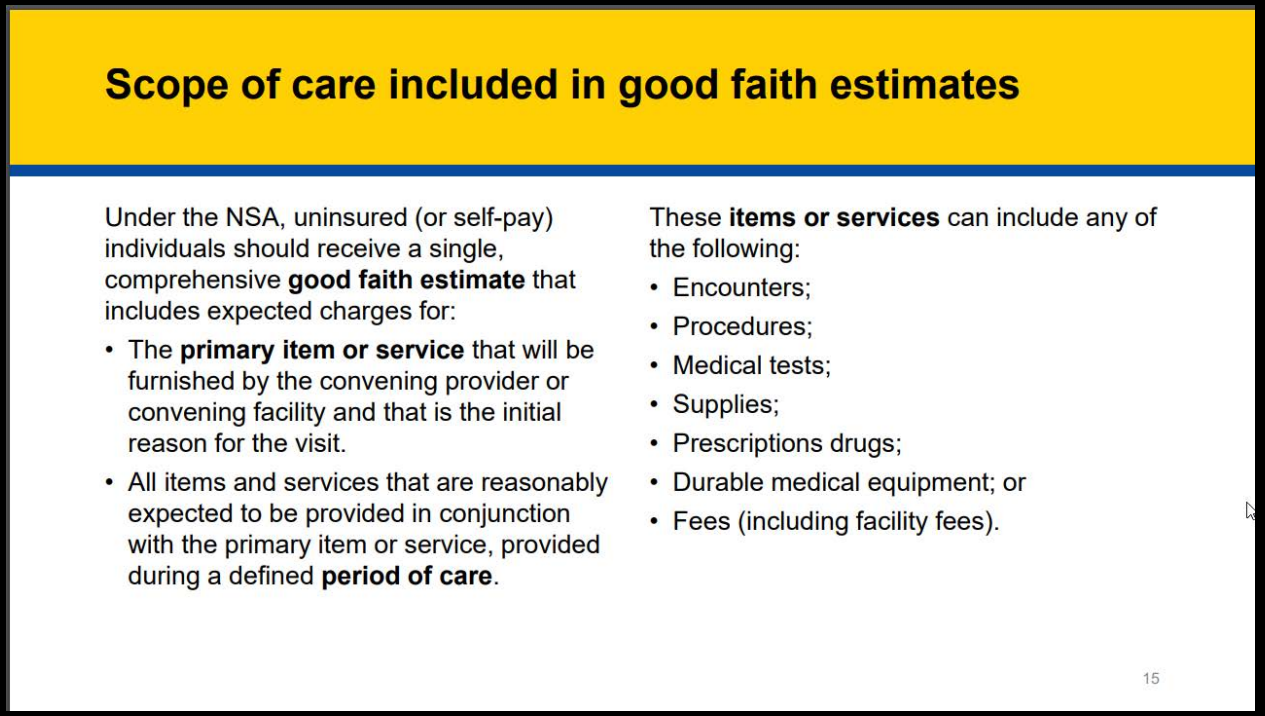
Raul Ruiz, M.D.
Member of Congress

Larry Bucshon, M.D.
Member of Congress

Physician & hospital disclosure requirements: 1/1/22

- The No Surprises Act requires providers/facilities subject to the rules "to make publicly available, post on a website of the provider or facility (if applicable), and to provide to participants, beneficiaries, and enrollees a one-page notice about the balance billing requirements and prohibitions that apply to the provider or facility".
- The law also requires facilities to publish a notice on balance billing protections that may be available for Patients. CMS also provided a template disclosure that facilities can use.
- Providers/facilities must comply with language access standards.
- One-Page Notice to Patients
  - The statute requires that providers/facilities must provide a one page-notice to individuals who are participants, beneficiaries, or enrollees of a group health plan or individual health insurance coverage offered by a health insurance issuer.
- Special Rule to Prevent Unnecessary Duplication with Respect to Providers
  - In order to prevent duplication in the one-page notice distribution, HHS provides that "to the extent a provider furnishes an item or service covered under the plan or coverage at a health care facility (including an emergency department of a hospital or independent free standing emergency department), the provider satisfies the disclosure requirements if the facility agrees to provide the information, in the required form and manner, pursuant to a written agreement".

Scope of care & how expected charges are determined per CMS for the GFE.



Scope of care included in good faith estimates

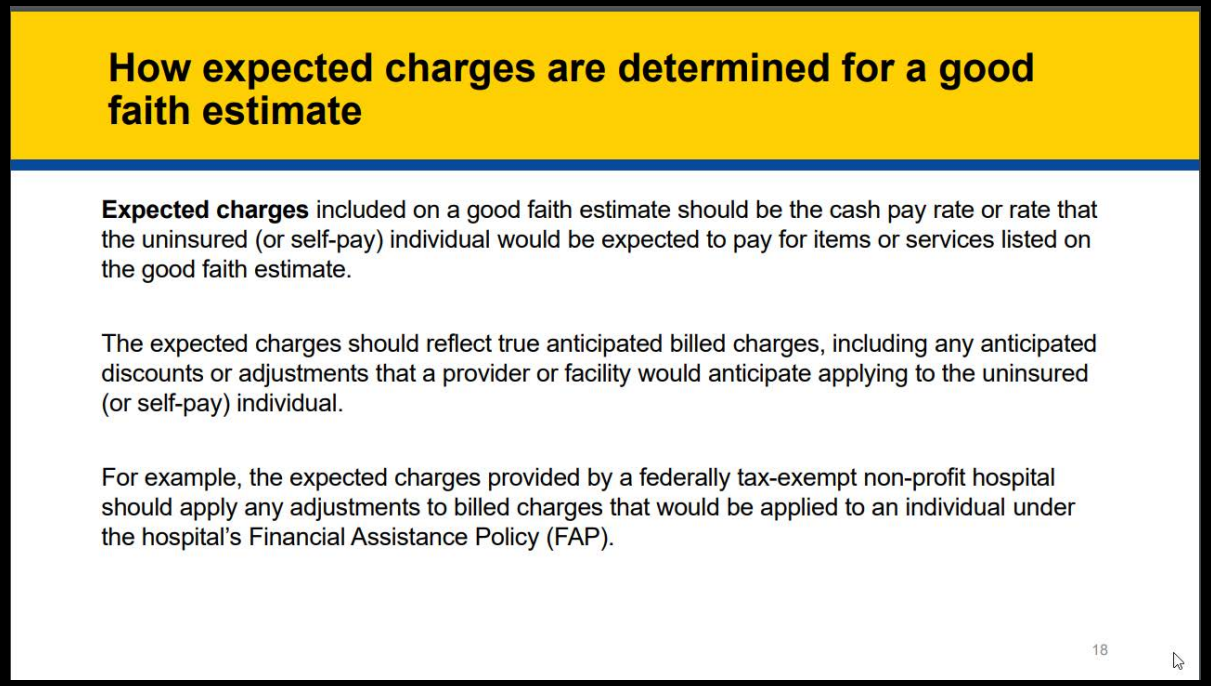
Under the NSA, uninsured (or self-pay) individuals should receive a single, comprehensive **good faith estimate** that includes expected charges for:

- The **primary item or service** that will be furnished by the convening provider or convening facility and that is the initial reason for the visit.
- All items and services that are reasonably expected to be provided in conjunction with the primary item or service, provided during a defined **period of care**.

These **items or services** can include any of the following:

- Encounters;
- Procedures;
- Medical tests;
- Supplies;
- Prescriptions drugs;
- Durable medical equipment; or
- Fees (including facility fees).

15



How expected charges are determined for a good faith estimate

Expected charges included on a good faith estimate should be the cash pay rate or rate that the uninsured (or self-pay) individual would be expected to pay for items or services listed on the good faith estimate.

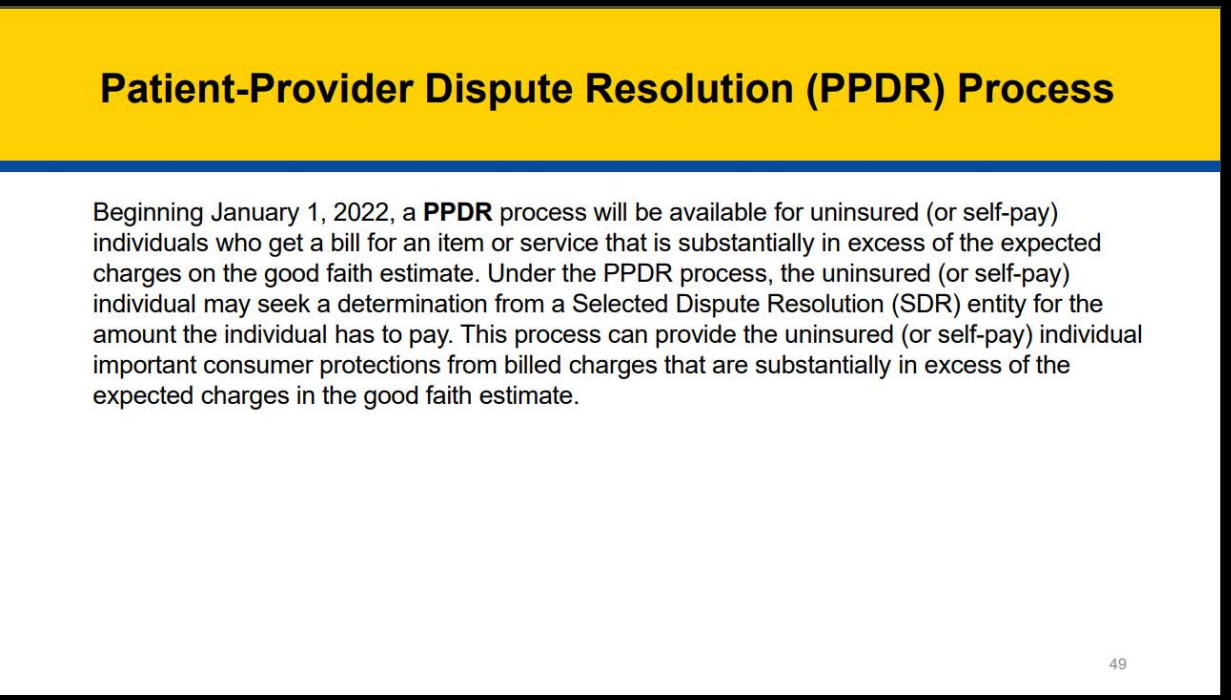
The expected charges should reflect true anticipated billed charges, including any anticipated discounts or adjustments that a provider or facility would anticipate applying to the uninsured (or self-pay) individual.

For example, the expected charges provided by a federally tax-exempt non-profit hospital should apply any adjustments to billed charges that would be applied to an individual under the hospital's Financial Assistance Policy (FAP).

18

https://www.cms.gov/files/document/gfe-and-ppdr-requirements-slides.pdf

Patient-Provider Dispute Resolution Process:



- HHS regulations establish that when the billed charges for any provider or facility are in excess of the good faith estimate for that provider or facility by $400 or more, the item or service may be eligible for payment determination by a SDR entity through the PPDR process.

- 1/1/22 through 12/31/22 “enforcement discretion”—co-provider or co-facility services where no GFE was provided were not subject to PPDR.

- An uninsured (or self-pay) individual, or their authorized representative, can initiate the PPDR process by submitting an initiation notice to HHS through the online federal IDR portal, submitting an initiation notice electronically, or submitting through the mail if postmarked within 120 calendar days of receiving the initial bill containing charges for the item or service that is substantially in excess of the expected charges in the good faith estimate.

Applicability of the NSA to group plans & plan renewals.

Q6: Do the surprise billing provisions of the No Surprises Act apply in the case of a group health plan or group or individual health insurance coverage that generally does not provide out-of-network coverage?

Yes. The No Surprises Act's protections regarding emergency services, non-emergency services furnished by a nonparticipating provider with respect to a visit to a participating facility, and air ambulance services apply if those services are otherwise covered under the plan or coverage, even if the plan or coverage otherwise does not provide coverage for out-of-network items or services.

Note that, under section 9816(a) of the Code, section 716(a) of ERISA, and section 2799A-1(a) of the PHS Act, if a plan or issuer provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department, the plan or issuer must cover emergency services, including on an out-of-network basis, in accordance with the No Surprises Act and its implementing regulations.[14] Similarly, under section 9816(b) of the Code, section 716(b) of ERISA, section 2799A-1(b) of the PHS Act, if a plan or issuer provides or covers benefits with respect to non-emergency items and services, the plan or issuer must cover the items and services furnished to a participant, beneficiary, or enrollee of the plan or coverage by a nonparticipating provider with

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sections 9816 and 9817 of the Code, sections 716 and 717 of ERISA, or sections 2799A-1 and 2799A-2 of the PHS Act (relating to surprise billing protections).

[13] Under 45 CFR 149.410(b), post-stabilization services are emergency services unless all of the following conditions are met: (1) the attending emergency physician or treating provider determines that the participant, beneficiary, or enrollee is able to travel using nonmedical transportation or nonemergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into account the individual's medical condition; (2) the provider or facility furnishing such additional items and services satisfies the notice and consent criteria of 45 CFR 149.420(c) through (g); (3) the participant, beneficiary, or enrollee (or their authorized representative) is in a condition to receive notice and provide consent; and (4) the provider or facility satisfies any additional requirements or prohibitions under state law.

[14] *See* 26 CFR 54.9816-4T, 29 CFR 2590.716-4, and 45 CFR 149.110.

- **NSA applies based on the plan renewal date—most but not all are Jan. 1.**
- **Example provided by CMS is a plan that renews on 3/1/22—the NSA is inapplicable & Pts. may be OON balance billed in Jan. & Feb. '22**

Glossary & Acronyms

- Out of network (OON)—EM services where there is no participation agreement between the physicians & health plan
- Surprise billing vs. surprise insurance gaps—surprise billing was created by health plans as a way to capture the legislators & regulator's attention to billing Pts for OON services vs. surprise insurance gaps are the concept that most patients are in high deductible health plans (HDHPs) & do not realize that the are first dollar responsible for many services until they reach their deductible.
- Benchmarking—health plans attempted for years to set OON reimbursements to a "benchmark", usually Medicare, as a way to cap their expense. The CBO found that benchmarking would also significantly decrease in-network rates
- NSA—The No Surprises Act (not the other NSA—ha ha)
- IDR—Independent Dispute Resolution is the process by which physicians & hospitals resolve OON reimbursement issues with health plans in a resolution process that is "loser pays" & "baseball style" where the physicians or health plans best and final offer is accepted.

Glossary & Acronyms

- IDRE—the independent dispute resolution entity is the 3d party organization charged with managing the IDR dispute & ultimately deciding between the physicians or health plans best & final offer.
- QPA—qualifying payment amount defined in statute & regulation as the median allowed amount as of 1/31/19 adjusted annually for inflation; used to determine Pt cost sharing & as a factor in IDR.
- Tri Depts.—HHS and the Depts. of Labor and Treasury.
- CMS & CCIIO—Centers for Medicare & Medicaid Services, The Center for Consumer Information and Insurance Oversight—both have practical implementation of the Tri Depts. regulations.
- Guarantor—The party financially responsible for the services, e.g. an adult patient is also the guarantor but a minor patient has a parent or guardian who is their guarantor.

Glossary & Acronyms

- In-network—services that are provided where the patient's health plan & the physicians/hospital are under contract w/ the plan.
- Patient cost sharing: the patient's deductible & co-insurance. Under the NSA, the OON services cost sharing is calculated to be what the Pt would have paid in network.
- State specified laws—the 22 states that have a state OON law that must be applied to ACA individual & group health plans + state employees and teachers.
- Individual & group health plans—governed by the 22 states who have specified laws; for the other states, governed by the NSA.
- State employee & teacher plans—same as above.

Glossary & Acronyms

- **ERISA & ERISA plans—Employee Retirement Income Security Act largely governs medium & large employer self insured plans. These plans use health plans to do third party administration of claims but are largely regulated by federal and not state law.**
- **"Baseball" Dispute Resolution—the term refers to the concept that the IDRE must select either the physician's or health plan's best and final offer, and then the loser pays the IDRE fees.**
- **IDR administrative fees—the non-refundable administrative fees set by CMS at $50 in 2022 & increased to $350 in '23**
- **IDRE fees—the adjudication fees set by CMS and paid to the IDRE by the losing party to the IDR. The IDRE fees are also increasing 40% in 2023 based on a recent announcement.**