Recent Developments in Healthcare Reimbursement and Compliance, Including the No Surprises Act

American Association of Healthcare Administrative Management
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Agenda

• Overview of No Surprises Act and Surprise Billing Rules, including recent developments

• Other hot topics in reimbursement and compliance, including:
  – Data breaches, Arbitration, Medicare Advantage, and Medicare reimbursement appeals

• Questions?
What is Surprise Billing?

- Patient receives care from an out-of-network provider at an in-network facility without their knowledge and, consequently, receives a surprise out-of-network bill for professional or ancillary services (such as anesthesiology or radiology)

- Particularly prevalent in the emergency department setting
The No Surprises Act

- Passed by Congress in late 2020 as part of the broader Consolidated Appropriations Act (CAA)
  - Intends to largely eliminate surprise billing, particularly in the ED setting
  - Patient liable only for in-network cost-sharing amount
  - Establishes an independent dispute resolution (IDR) process for settling reimbursement disputes between payors and providers
  - IDR process applies to patient/provider disputes with good faith estimates
  - Implements price transparency requirements for payors, including advanced EOBs, and more accurate provider directories
July 2021 Interim Final Rule

• First *in series* of regulations implementing No Surprises Act
  – Eliminates surprise billing for emergency services and out-of-network ancillary services at an in-network facility
  – *Establishes Qualifying Payment Amount (QPA) – for determining patient cost-sharing obligations* ....

• *Stay tuned*....
  – Implements a patient notice-and-consent process for narrow exceptions to surprise billing protections, as well as public disclosure requirements for providers
July 2021 Interim Final Rule

• Primary impacted entities
  
  – Payors: Commercial group health plans (small group, large group, individual – **ERISA plans**), including grandfathered plans

  » Excludes excepted benefits, short-term limited-duration plans, health reimbursement arrangements (HRAs), and account-based group plans, as well as Medicare Advantage (MA) and Medicaid managed care plans

  – Providers: Hospitals, CAHs, ASCs, freestanding EDs (including urgent care centers), air ambulance providers, physicians

  » Stay tuned…. SNFs? AL?
CMS Consumer Information and Insurance Oversight (CIIO)

• Charged with improvement in reforms of the Affordable Care Act

• Oversees implementation of ACA provisions related to private health insurance
  – Establish Health Insurance Marketplaces

• Ending Surprise Medical Bills
Emergency Services & Post-Stabilization

• **Includes…**
  
  – Items and services furnished by provider, including equipment and devices; telemedicine services; imaging services; laboratory services; and pre- and post-op services

• **Must be covered…**
  
  – Without prior authorization or additional administrative requirements
  
  – Regardless of whether the provider or facility is in-network
  
  – Without patient cost-sharing obligation beyond what they would pay for in-network services (provider or facility)
Some Good News....

• The Reasonable Layperson Standard Applies to ED Visits

• Inappropriate to deny based on final diagnosis
  – Useful in coding/medical necessity denials
  
  – Hospital admissions from the ED? Post-stabilization services
Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn’t be charged more than your plan’s copayments, coinsurance and/or deductible.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in your health plan’s network.

“Out-of-network” means providers and facilities that haven’t signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your plan’s deductible or annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You’re protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan’s in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can’t be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

[Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed language as appropriate]

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia,
Notice Requirements

Model Notice (cont.) with suggestions →

When balance billing isn’t allowed, you also have these protections:

- You’re only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as “prior authorization”).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

For billing questions, contact your provider or [ABC Hospital] financial services representative by calling [555-555-5555], [Monday-Friday, 8 a.m. – 5 p.m.]

If you believe you’ve been wrongly billed under U.S. law, you may contact the U.S. Department of Health & Human Services at 1-800-985-3059 or by visiting https://www.cms.gov/nosurprises/consumers

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.
Notice and Consent Exception

• Surprise billing protections can be waived by patient if provided with notice and gives consent
  – However, this does not apply to
    • Emergency services;
    • anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
    • items and services provided by assistant surgeons, hospitalists, and intensivists; and
    • diagnostic services, including radiology and laboratory services.
Notice and Consent

Model Notice ➔

Surprise Billing Protection Form

This document describes your protections against unexpected medical bills. It also asks if you’d like to give up those protections and pay more for out-of-network care.

**IMPORTANT:** You aren’t required to sign this form and shouldn’t sign it if you didn’t have a choice of health care provider before scheduling care. You can choose to get care from a provider or facility in your health plan’s network, which may cost you less.

If you’d like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You’re getting this notice because this provider or facility isn’t in your health plan’s network and is considered out-of-network. This means the provider or facility doesn’t have an agreement with your plan to provide services. **Getting care from this provider or facility will likely cost you more.**

If your plan covers the item or service you’re getting, federal law protects you from higher bills when:

- You’re getting emergency care from an out-of-network provider or facility, or
- An out-of-network provider is treating you at an in-network hospital or ambulatory surgical center without getting your consent to receive a higher bill.

Ask your health care provider or patient advocate if you’re not sure if these protections apply to you.

If you sign this form, be aware that you may pay more because:

- You’re giving up your legal protections from higher bills.
- You may owe the full costs billed for the items and services you get.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn’t one, you can also ask your health plan if they can work out an agreement with this provider or facility (or another one) to lower your costs.

See the next page for your cost estimate.
Payment to Provider

- **Health Plan Payment**
  - Insurer may make initial payment to provider
  - If provider determines payment inadequate, then 30 days to negotiation period to agree on amount, ELSE
  - Either party may use IDR process
    - Entities that can be used for IDR identified on CMS website
    - **Problems identifying contact person at insurer for negotiations!**
    - Current “pause” in IDR processing…. 
Qualifying Payment Amount (QPA)

• Patient cost-sharing obligation calculated utilizing the recognized amount, defined as the lesser of the amount billed by the provider/facility or the QPA
  – The median of the contracted rates recognized by the plan or issuer on January 31, 2019, for the same or similar item or service that is provided by a provider in the same or similar specialty and provided in a geographic region in which the item or service is furnished, increased for inflation each year.

• Under the NSA, the QPA is one factor among several to be considered by the arbitrator in determining the appropriate amount ... stay tuned
• *Texas Med. Ass’n v. U.S. Dep’t of Health & Human Servs.*, 587 F. Supp. 3d 528 (E.D. Tex. 2022)

  – Judge tossed out portion of the October 2021 IFR that required the IDR entity to “select the offer closest to the QPA *unless*” the IDR entity determines that “credible information ... clearly demonstrates” that the QPA is “materially different” from the appropriate OON rate

  – Judge reasoned that “nothing in the [NSA] ... instructs arbitrators to weigh any one factor or circumstance more heavily than the others.”
Litigation Updates

• HHS then issued a new Final Rule in August 2022 that directed IDR entities to consider the QPA and then consider the additional information set forth in the NSA, provided that the information related to the party’s offer.

• Agreeing with the providers that HHS’ latest attempt “impermissibly altered” the NSA’s requirements by continuing to “place a thumb on the scale” for the QPA, the same judge invalidated this portion of the August 2022 Final Rule.

Congress Weighs In?

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

TEXAS MEDICAL ASSOCIATION and
DR. ADAM CORLEY,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES,
DEPARTMENT OF LABOR,
DEPARTMENT OF THE TREASURY,
OFFICE OF PERSONNEL
MANAGEMENT,
and the CURRENT HEADS OF THOSE
AGENCIES IN THEIR OFFICIAL
CAPACITIES,

Defendants.

BRIEF OF MEMBERS OF CONGRESS AS AMICI CURIAE
IN SUPPORT OF PLAINTIFFS
Effective Immediately, Certified IDR Entities Have Been Instructed To Hold All Payment Determinations Until Further Guidance Is Issued. Certified IDR entities have also been instructed to recall any payment determinations issued after February 6, 2023.

On February 6, 2023, the U.S. District Court for the Eastern District of Texas issued a judgment and order in Texas Medical Association, et al. v. United States Department of Health and Human Services, Case No. 6:22-cv-372 (TMA II), vacating certain portions of 45 C.F.R. § 149.510(c), 26 C.F.R. § 54.9816-8(c), and 29 C.F.R. § 2590-716-8(c), which are parallel provisions governing the Federal Independent Dispute Resolution (IDR) process applicable to all payment disputes. The court also vacated the entirety of 45 C.F.R. § 149.520(b)(3), 26 C.F.R. § 54.9817-2(b)(3), and 29 C.F.R. § 2590-717-2(b)(3), which are parallel provisions applicable to air ambulance disputes.

As a result of the TMA II decision, effective February 6, 2022, certified IDR entities should not issue new payment determinations until receiving further guidance from the Departments. Certified IDR entities also should recall any payment determinations issued after February 6, 2023.

The Departments are currently reviewing the court’s decision and evaluating current IDR processes, guidance, templates, and systems for updates that will be necessary to comply with the court’s order. The Departments will provide specific directions to certified IDR entities for resuming the issuance of payment determinations that are consistent with the court’s judgment and order. Certified IDR entities should continue working through other parts of the IDR process, including eligibility determinations, as they wait for additional direction from the Departments.
Litigation Updates – From CMS

Payment disputes between providers and health plans

**Notices**

**February 24, 2023**

On February 24, 2023, certified IDR entities were instructed to resume processing payment determinations on February 27, 2023, for disputes involving items or services furnished before October 25, 2022. The standards governing a certified IDR entity’s consideration of information when making payment determinations in these disputes are provided in the October 2021 interim final rules, as revised by the opinions and orders of the U.S. District Court for the Eastern District of Texas in *Texas Medical Association, et al. v. United States Department of Health and Human Services*, Case No. 6:21-cv-425 (February 23, 2022) (*TMA I*), and in *LifeNet, Inc. v. United States Department of Health and Human Services*, Case No. 6:22-cv-162 (July 26, 2022) (*LifeNet I*). Disputes involving items or services furnished before October 25, 2022, are not affected by the February 6, 2023 opinion and order in *Texas Medical Association, et al. v. United States Department of Health and Human Services et al.*, Case No. 6:22-cv-372 (February 6, 2023) (*TMA II*).

Certified IDR entities will continue to hold issuance of payment determinations that involve items or services furnished on or after October 25, 2022 until the Departments issue further guidance. The Departments are working diligently to complete necessary guidance and system updates in order to allow certified IDR entities to resume processing payment determinations for these disputes.

All other Federal IDR process timelines continue to apply. Therefore, disputing parties should continue to engage in open negotiations and all other aspects of the Federal IDR process, including submitting fees and offers.
June 22, 2022

[Redacted]

Chief Financial Officer
[Redacted]

Compliance Officer
[Redacted]

Re: Request for Additional Information to Resolve Complaint Case ID: #000

Dear Mr. [Redacted] and Ms. [Redacted],

In the conference call between [Redacted] and the Centers for Medicare & Medicaid Services (CMS) on [Redacted], we discussed Case #000, a complaint alleging a violation of the requirements of the PHS Act, as amended by the No Surprises Act, involving [Redacted]. A more complete description of the complaint details can be found in Exhibit A.

Within the timelines specified below, please provide CMS with the information requested to continue the review of the complaint. You may also include any additional information you would like CMS to consider as part of the review of this case. A detailed list of information and documents that CMS requests can be found in Exhibit B. Please include the case ID in the email subject line of your response, and share all requested information through secure email to NSAProviderInvestigations@cms.hhs.gov and Vyshia.Conway@cms.hhs.gov, as mutually agreed upon by CMS and executives of [Redacted] and [Redacted] during the call.

Thank you for your cooperation.

Sincerely,
Within 5 Business Days of the Date of the Letter...

- Complete and return the Provider Details Form, including organization’s NPI, associated provider NPIs. TIN, parent organization name and TIN, if applicable, and certain third-party names and TINs, if applicable.
- Provide documentation to demonstrate patient responsibility amount, claim adjustment reason codes and remittance advice remark codes for the claim involved from the payer remittance advice transaction.
- Provide copies of all bills associated with services provided on [DATE].
- Correct patient bill to reflect no greater than the plan-processed patient responsibility amount. If applicable, refund of any excess amount collected from consumer.
- Provide copy of communication to the patient demonstrating a zero balance owed.
NSA Enforcement

• Within 10 Business Days of the Date of this Letter...

  – Provide documentation that demonstrates the workflows HOSPITAL had in place to catch and prevent violations of the No Surprise Act balance billing prohibitions prior to receipt of CMS notice
  
  – Provide documentation that demonstrates the corrective actions HOSPITAL has taken in response to this complaint, including a timeline and nature of improvements to current business practices to eliminate similar complaints in the future
  
  – Provide documentation that demonstrates the extent of compliance to date with the balance billing requirements in cases of emergency services; specifically the results of an impact analysis to determine how many individuals received emergency services from HOSPITAL since 1/1/2022 to the present and were billed amounts in excess of their in-network cost sharing amount as reflected on the payer remittance advice.
Additional Information

• No Surprises Act Information:

  – https://www.cms.gov/nosurprises
Switching Gears...
Northside Hospital Fined Over $1M for Failure to Share Medical Prices
HIPAA – Data Breach

• OCR Expectations

  – Risk analysis – every 2-3 years
  – Incorporation of NIST Standards as optional/alternatives
  – Copies of Business Associate Agreement with breaching entity (if applicable)
  – Detailed information regarding notice as required under state law
  – Policy Review, documentation of training efforts

  – Identify the name of employee who clicked on phishing!!!
Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care
CMS Proposed Rule – Medicare Advantage

  - Proposes that prior auth policies only be used to confirm diagnoses or other medical criteria to ensure medically necessary
  - **Proposes that approval granted through prior auth be valid for the duration of the course of treatment**
  - Proposes that MA plans comply with NCDs, LCDs, and general coverage and benefit conditions included in traditional Medicare statutes and regulations
  - Proposes that MA plans cannot deny coverage of a Medicare covered item based on internal, proprietary, or external clinical criteria not found in traditional Medicare coverage policies
  - Proposes that when there is no applicable coverage criteria, MA plans may create internal coverage criteria that are based on current evidence and that is made publicly available
More Medicare Advantage

U.S. Department of Health and Human Services
Office of Inspector General
Issue Brief
February 2023, OEI-03-21-00380

The Inability To Identify Denied Claims in Medicare Advantage Hinders Fraud Oversight

This issue brief summarizes results from our evaluation of Medicare Advantage (MA) encounter data and examines whether the lack of an indicator to identify payment denials in the data hinders efforts to combat fraud, waste, and abuse. (In this issue brief, we use the term “denied claim” to refer to a record that contains a service for which the payer denied payment to the provider.)

Why OIG Did This Review
Detailed data about the services provided to enrollees are essential for combating fraud and abuse in Medicare and Medicaid. The oversight entities tasked with

Key Takeaways
- Although most 2019 MA encounter records contained a payment adjustment, identifying whether these adjustments are payment denials is challenging and imprecise.
- Requiring MAOs to definitively identify payment denials on encounter records submitted for MA would enhance program oversight and help combat fraud.
AAA® Healthcare
Payor Provider Arbitration Rules and Mediation Procedures

Available online at adr.org/healthcare
Rules Amended and Effective November 1, 2014
Arbitration

• Use of One Arbitrator, Regardless of Number of Claims and/or counterclaims

• For Claims Appeals
  – *Consider*: Finality of Appeals Process Agreement Prior to Arbitration
  – Fees: Depend on $$ at Stake
CMS CAN USE OIG AUDIT REPORTS TO IMPROVE ITS OVERSIGHT OF HOSPITAL COMPLIANCE

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Amy J. Frontz
Deputy Inspector General for Audit Services

October 2022
A-04-21-08084
Medicare Reimbursement Appeals

• The ALJs are listening!
  And CMS is too!

• Tossing statistical samples and extrapolations where government fails to properly or consistently define its target population and fails to keep adequate documentation of its audit process

• Reopening issues
Questions?
Contacts

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