Policy Brief

October 15, 2021

Surprise Billing; Part 2:
Trust Us, Surprised is an Understatement

In collaboration with other federal agencies, HHS released Part 2 of the requirements related to the No Surprises Act. While this Interim Final Rule (IFR) attempts to provide more transparency over the financial aspects of health care, in actuality, it levies a substantial regulatory (and potentially, monetary) burden on providers. To review AHPA's Surprise Billing Interim Final Rule Part 2 summary, click here. Keep reading to learn more about the key provisions within this IFR and how it will impact hospitals.

The key provisions of the IFR include:

- The Independent Dispute Resolution (IDR) process implements the federal procedure available to providers, facilities, plans and issuers if an agreement cannot be reached on the out-of-network (OON) reimbursement amount. Each party submits its final offer and supporting evidence, and then the IDR arbiter will select what they deem to be the most appropriate offer.
- Good Faith Estimates require health providers to give "good faith estimates" to uninsured and self-pay patients before all scheduled services or by request if the patient is shopping for care. This includes all expected charges for items or services provided by other providers and facilities.

- The Patient-Payer Dispute Resolution Process offers a patient-provider dispute resolution process for instances when a patient's billed charges are "substantially in excess" of the good faith estimates provided prior to care.

Impact on Providers

The IDR process significantly benefits the payor over the provider. The arbiter is instructed to use the Qualified Payment Amounts (QPA) as the most significant factor in determining the OON rate. This is problematic because the QPA methodology underrepresents the true market median of any given service. Thus, it puts the burden of proof on the provider to demonstrate sufficient evidence that the QPA rate does not represent the appropriate payment amount. Essentially, this creates a price ceiling and undercuts any private payment negotiation, as plans have little incentive to compromise.

Good Faith Estimates significantly increase the reporting and regulatory burden on providers. Upon request, providers will be required within 1 to 3 business days to produce the good faith estimate for their items and services and any co-providers or co-facilities services. In addition, the provider must present a multitude of disclaimers to the patient notifying them of their right to initiate a patient-provider dispute resolution process and of the good faith estimates process. This burden on providers was created without regard for the difficult technical or confidentiality hurdles that providers must cross to procure the requested information. Additionally, hospitals are expected to bill based on the quoted price; if costs rise more than $400 of the quoted price, regardless of the total price of the good faith estimate, the patient is eligible to initiate the patient-provider dispute resolution process to contest the charges.

What's next?

When establishing the No Surprises Act, Congress declined to set a payment benchmark; they did not want to pick winners and losers between providers and payors. Even Congress has not formed a consensus regarding the legality of this rule. The Congressional Committee on Ways and Means submitted a letter to the Secretary of HHS to question the legitimacy of the rule. However, the House Committee on Energy and Commerce rebutted this dispute with a press release stating their belief that the IFR was in alignment with the Congressional intent. AHPA will remain engaged in these discussions to ensure as equitable a process as possible.

Health Equity: A Renewed Priority for CMS

In every regulation that CMS has released this year, the Agency has included policy proposals and requests for information on health equity. Health equity is often thought of in terms of race and ethnicity, however, to achieve true health equity, everyone—regardless of their age, race, income, gender, religion or sexual orientation—must have as fair an opportunity as possible to be healthy. In the United States, health disparities cost the country about $93 billion in excess medical care costs every year. Policymakers and federal agencies have renewed their attention to health equity as a way to protect community heath and decrease unnecessary spending.

Equity is important; but why so much attention now?

Underserved groups, like people living in poverty or racial minorities, experience higher rates of illness across a broad range of health conditions, limiting the nation's overall ability to be healthy. The Biden Administration has named health equity a top priority, launching new initiatives to address inequity, reviving CMS' Office of Minority Health, and promoting a focus on health equity across agencies.

The COVID-19 pandemic reemphasized this for policymakers; Medicare claims data revealed significant disparities in COVID-19 infection and hospitalization. When analyzing 2020 claims, the Trump Administration discovered that Black beneficiaries have contracted COVID-19 three times more and been hospitalized four times more than White beneficiaries, with similar results found for Latinx and Asian beneficiaries. These disparities join a mounting body of unequal health outcomes, including maternal and infant death rates and chronic disease development. The Centers for Disease Control and Prevention attribute much of these differences to existing economic and health inequities faced by these groups.

What can health systems expect next from CMS?

Last month, CMS' Chief Operating Officer Jon Blum reiterated that the Agency wants the health care system to "be much more equitable," acknowledging that participants in many of the more innovative models come from communities that are disproportionately White and higher income. Blum wants CMS to reevaluate some models, simplifying tracks and options

for providers, in hopes that this may make participation more doable for providers serving diverse communities. Fully risk-based models, in particular can "[skew] participation to those who can afford it."

Additionally, CMMI Director Dr. Liz Fowler has shared that she is considering requiring model participants collect and report race and ethnicity data as a condition of participation. The recently-proposed updates to the ESRD treatment model include reimbursement changes targeting health disparities among kidney transplant patients of lower socioeconomic status. Across programs, the Agency plans to continue adopting health equity measures, goals and conditions of participation as appropriate.

Vaccine Mandates: Learnings from New York's Experience

The Biden Administration's announcement of coming vaccine mandates for employers of more than 100 individuals has created many implementation questions. While the regulations on implementation are still a few weeks out, New York state may provide insights into potential implications; state-employed clinicians and a large health provider are already navigating mandated vaccination. New York's Northwell Health fired 1,400 employees that refused to be vaccinated, the first large provider to do so. State health care workers are also being required to receive mandatory vaccines without allowances for weekly testing or exemptions for religious reasons. Federal courts have already ordered the state to temporarily allow religious exemptions, we will soon learn more about how mandatory vaccines will play out.

The Effect of New York's Mandate

Northwell Health, the biggest provider in New York, required its 76,000 employees to be vaccinated. While some workers protested, Northwell Health did see an uptick in the number of vaccinated employees before its deadline. In the end, the provider terminated 1,400 employees that refused to be vaccinated, less than 2% of its workforce. New York state also issued a strict mandate for its 650,000 hospital and nursing home workers without religious exemptions, requiring them to be vaccinated or consent to weekly testing. Since the mandate, the number of workers that left their jobs in New York has been relatively small.

How Mandates Will Play Out in the Court System

The vaccine mandates in New York have already drawn legal action. A judge ordered New York state to temporarily allow religious exemptions. As more mandates roll out, we can expect more lawsuits, with a chance that the issue could move up to the Supreme Court. While many federal courts have already ruled in favor of vaccine requirements, there is a possibility that the conservative-leaning Supreme Court may peel back this precedent as it has previously limited state pandemic-related restrictions. The Supreme Court is likely to back medical and religious exemptions, such as the one provided by the Safer Federal Workforce.

Anticipating Vaccination Rollouts

While 12 states have banned vaccine mandates for state and local governments, several other states have implemented their own mandates for state employees, although they have been less strict than in New York. As more mandates come into effect, more guidance and lawsuits will direct how vaccine mandates will be implemented. President Biden's deadline for federal employees to be vaccinated is November 22nd; many companies are also preparing to meet OSHA's vaccination requirements. These vaccination efforts are estimated to boost vaccination rates to 82% of Americans, although this estimate may be impacted by future court rulings and exemptions.

Congress Temporarily Raises Debt Ceiling

Congress narrowly avoided defaulting on the U.S. debt last week by voting to temporarily raise the debt ceiling until December 3rd. This is the 100th time Congress has raised the debt limit. Despite the national debt being used as a political bargaining chip, historically, both parties have always reached an agreement to ensure the U.S. does not default. As Treasury Secretary Janet Yellen has pointed out, defaulting could lead to an economic catastrophe. While Democrats are insisting that raising the debt ceiling must be bipartisan due to both parties' role in driving up the debt, the reconciliation process may provide a path to raising the limit should an agreement not be reached.

Federal Judge Orders Texas to Halt its Abortion Ban

Texas' new restrictive abortion law was successfully challenged for the first time by a federal judge last week. Since then, the Texas Attorney General has appealed this decision, teeing up a future legal fight that could reach the Supreme Court. While some providers resumed abortion services, many have not in fear of lawsuits. We will likely see more developments on this contentious issue as this law makes it way through the courts and as states, such as Florida, are introducing copycat bills. Many abortion rights groups are worried, as the Supreme Court now seats more judges who have expressed anti-abortion views. President Biden has taken a pro-choice stance and reversed a Trump-era policy that barred clinics offering abortion referrals from receiving Title X family planning funding.

Updates to COVID-19 Regulations

AHPA continues to follow new COVID-19 regulations, guidance and other government actions. The updates below are the latest guidance and other developments since October 1st to help mitigate the impacts of COVID-19.

HHS Announces Guidance for Vaccination Disclosure in the Workplace
HHS has announced new workplace guidance on the Health Insurance Portability and Accountability Act's applicability to disclosures and requests for information about whether a person has received a COVID-19 vaccine.

AHPA Resources

Missed an AHPA webinar lately? No problem!
Visit AHPA's YouTube channel, where members can stream webinars on demand at their convenience.

Regulatory Resources

Below is a list of the recent regulatory work that AHPA has conducted.

- OSHA ETS AHPA Comment
- Surprise Billing; P1 Regulatory Summary | AHPA Comment | Comment Summaries
- Surprise Billing; P2 Regulatory Summary
- IPPS Regulatory Summary | AHPA Comment | Comment Summaries
- PFS Regulatory Summary | AHPA Comment | Comment Summaries
- OPPS Regulatory Summary | AHPA Comment | Comment Summaries

WHAT WE'RE READING…

Hospital System to Deny Transplants to the Unvaccinated in 'Almost All Situations' – Washington Post

Improving the Health of Rural Americans – Health Affairs

Community Clinics Shouldered Much of the Vaccine Rollout. Many Haven't Been Paid. – KHN

"Lurching Between Crisis and Complacency": Was This Our Last Covid Surge? – New York Times