HFMA
Arkansas Chapter

Contract Negotiation / No Surprises Act

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Healthcare Reimbursement Contract Negotiation

First things first …

Analyze the fee schedule carefully.

- Are any services omitted that should be covered?
- Focus on high volume services.
- Do the fees paid cover your cost of doing business?
- Do you fully understand how the fees are calculated?
    - Percentage of billed charges?
    - Fee schedule?
    - Percentage of Medicare?

Healthcare Reimbursement Contract Negotiation

Determine your leverage.

- What percentage of your business does this payor represent?
- How important is your facility to the payor’s market / members?

Healthcare Reimbursement Contract Negotiation

Termination rights.

- Without cause.
- Contracts which do not have without cause language.
  - Auto-renewal
  - Timing of negotiations

Healthcare Reimbursement Contract Negotiation

Internal Controls

- Are notices from payors centrally directed?
- Is there a process for alerting all interested persons within the organization?
- Communications from payors can, at times, be misleading.

Healthcare Reimbursement Contract Negotiation

“We don’t negotiate rates.”

- Sometimes true, sometimes not.
- Multiple contacts within payor organization.
- Be prepared with supporting data.

Healthcare Reimbursement Contract Negotiation

Are rates all that matter?

- Authorization process
- Time period for claims submission
- Time period for appeals
- Timely payment
- Termination rights

Healthcare Reimbursement Contract Negotiation

Antitrust Considerations

Healthcare Reimbursement Contract Negotiation

Monitor expirations.

Start negotiations for renewal in plenty of time.

Audit payments to ensure consistent with contracted terms.

Healthcare Reimbursement Contract Negotiation

Focus on the key, material items.

There is such a thing as negotiation fatigue.

Consider engaging counsel with experience.

Healthcare Reimbursement Contract Negotiation

Helpful Arkansas laws.

Arkansas Insurance Department.

No Surprises Act

No Surprises Act – What is it?

No Surprises Act

From CMS Website:

Effective 2022, the No Surprises Act protects people covered under group and individual health plans from receiving surprise medical bills when they receive most emergency services, non-emergency services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance service providers. It also establishes an independent dispute resolution process for payment disputes between plans and providers, and provides new dispute resolution opportunities for uninsured and self-pay individuals when they receive a medical bill that is substantially greater than the good faith estimate they get from the provider.

No Surprises Act

If a patient has private health insurance, these new protections ban the most common types of surprise bills. If a patient is uninsured or decides not to use your health insurance for a service, under these new protections, a patient can often get a good faith estimate of the cost of care up front, before the visit.

No Surprises Act

Before the No Surprises Act, if a patient had health insurance and received care from an out-of-network provider or an out-of-network facility, even unknowingly, the patient's health plan may not have covered the entire out-of-network cost. This could have left the patient with higher costs than if the patient got care from an in-network provider or facility. In addition to any out-of-network cost sharing the patient might have owed, the out-of-network provider or facility could bill the patient for the difference between the billed charge and the amount the patient's health plan paid, unless banned by state law. This is called "balance billing." An unexpected balance bill from an out-of-network provider is also called a surprise medical bill.

No Surprises Act

For those with health insurance:

- Ban surprise bills for most emergency services, even if out-of-network and without approval beforehand (prior authorization).
- Ban out-of-network cost-sharing (like out-of-network coinsurance or copayments) for most emergency and some non-emergency services. A patient cannot be charged more than in-network cost-sharing for these services.
- Ban out-of-network charges and balance bills for certain additional services (like anesthesiology or radiology) furnished by out-of-network providers as part of a patient's visit to an in-network facility.
- Require that health care providers and facilities provide patients with an easy-to-understand notice explaining the applicable billing protections, who to contact if the patient has concerns that a provider or facility has violated the protections, and that patient consent is required to waive billing protections.

No Surprises Act

What about those without health insurance?

If a patient does not have insurance or is otherwise self-pay, in most cases, these new rules make sure you can get a good faith estimate of how much care will cost before you receive it.

If charged more than the good faith estimate, patients can dispute a medical bill if final charges are at least $400 higher than the good faith estimate and the patient files to dispute claim within 120 days of the date on your bill.

No Surprises Act

Emergency Services

Surprise billing protections apply to most emergency services, including those provided in hospital emergency rooms. Also applies to air ambulance transportation (emergency and non-emergency), but not to ground ambulance. Emergency care includes screening and stabilizing treatment sought by patients who believe they are experiencing a medical emergency or active labor.

The federal government estimates there are 39.7 million emergency visits annually by patients with private job-based or individually purchased insurance, and of these 18% (or about 7.1 million visits) will involve at least one out-of-network claim. (Source kff.org)

No Surprises Act

Non-Emergency Services Provided at In-Network Facilities

Often, the doctors who work in hospitals don't work for the hospital, but instead bill independently and do not necessarily participate in the same health plan networks. The federal government estimates that 16% of 11.1 million (or about 1.8 million) in-network non-emergency facility stays for privately insured patients each year involve at least one out-of-network claim. (Source kff.org)

The NSA broadly defines covered non-emergency services to include treatment, equipment and devices, telemedicine services, imaging and lab services, and preoperative and postoperative services, regardless of whether those services are provided within the facility itself.

No Surprises Act

Providers are prohibited from billing patients more than the applicable in-network cost sharing amount. Penalties may apply.

No Surprises Act

Notice of Rights

Providers and health plans are required to notify consumers of their surprise medical bill protections. Providers and facilities must post a notice summarizing the protections on a public website and give this disclosure to each patient for whom they provide NSA-covered services. This notice must be provided no later than the date when payment is requested.

No Surprises Act

Enforcement

No Surprises Act

Dispute Resolution

No Surprises Act

Practical Considerations