The No Surprises Act Fire Drill

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Why are we here?

- Concerned that clients were unaware of and not prepared for implementation.
- Only 1 year from passage to implementation with regulations coming very late.
  - Signed into law on December 27, 2020 as part of the Consolidated Appropriations Act
  - On July 1, 2021, DHHS, Labor and Treasury and OPM issued first Interim Final Rule
  - Issued a second IFR on September 30, 2021
- Scheduled to go into effect January 1.

Two Rules

- Applies to emergency facilities
- Applies to OON providers at in-network facilities

Surprise billing

- Applies to all providers rendering services to self-pay patients

Good Faith Estimate

Agenda

1. Discuss key issues
2. Overview of requirements
3. Focus on requirements that go into effect January 1

Forms

- The Centers for Medicare & Medicaid Services (CMS) has released 11 documents related to the agency's regulations implementing the No Surprises Act good faith estimates for uninsured and self-pay patients and the patient-provider dispute resolution process.
- The documents include model language informing uninsured/self-pay patients of their rights to a good faith estimate and the patient-provider dispute resolution process, a template of the comprehensive good faith estimate with model disclaimer language, several notices related to the patient-provider dispute resolution process and detailed explanations of various data elements required throughout these processes.
- https://www.cms.gov/nosurprises.


An official website of the United States government Here's how you know
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MS.gov
ers for Medicare & Medicaid Services
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Innovation Center
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Research, Statistics, Data & Systems
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Home
Policies & Resources
Consumer Protections
Help resolve payment disputes
Ending Surprise Medical Bills
ee what's coming to help to protect people from
rprise medical bills and removing consumers from
ayment disputes between a provider or health care
cility and their health plan
Learn More

CMS Website

AHA Resources

- AHA Resources
- https://www.aha.org/special-bulletin/2021-11-30-cms-releases-implementation-guidance-no-surprises-act-good-faith.

- As part of the September 30, 2021, Interim Final Rule, DHHS promulgated regulations implementing the NSA requirement that providers furnish certain notices and good faith estimates (GFEs) to self-pay patients in specified circumstances.

Good Faith Estimate

Must provide starting January 1, 2022

- Unlike the NSA's provisions prohibiting surprise billing for certain services furnished in specified facilities (i.e., hospitals, freestanding emergency departments, and ambulatory surgery centers), the GFE requirements apply to a much broader category of providers furnishing items or services for self-pay patients.

This may surprise you

Scope of GFE requirement

Good Faith Estimate

- The GFE requirements apply to:
  - "a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law, including a provider of air ambulance services;" and
  - "an institution (such as a hospital or hospital outpatient department, critical access hospital, ambulatory surgical center, rural health center, federally qualified health center, laboratory, or imaging center) in any state in which state or applicable local law provides for licensing of such an institution. . . . "
  - These individuals and entities are collectively referred to as "providers".

Good Faith Estimate

- Starting January 1, 2022, a provider must furnish a self-pay patient with the notice and GFE:
  - Prior to ***all scheduled services*** OR
  - by request if the patient is shopping for care (and not yet at the point of scheduling).

- This includes, but is not limited to, office visits, therapy, diagnostic tests, infusions, and surgeries.

- A provider's duty to provide notice and a GFE applies to an individual who
  - Does not have benefits for an item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, federal healthcare program, or a health benefits plan; or
  - Chooses not to use his or her coverage benefit for the item or service.

This may surprise you

Definition of Self-Pay Patient

Self-Pay Patients

- Individuals enrolled in short-term, limited-duration health plans or other types of products not regulated as health insurance coverage (e.g., health-sharing ministries) are considered self-pay patients.

- If an individual's plan or coverage provides no benefit for out-of-network services, the individual would be a self-pay patient for any out-of-network provider.

- If the plan or coverage provides a limited benefit (e.g., higher co-insurance items or services furnished by out-of-network providers), the individual would not be a self-pay patient (unless the individual chose not to use such coverage benefit for the item or service).

Responsibility for GFE

- The "convening provider"

- The provider that:
  - is responsible for scheduling the primary item or service (defined as "the initial reason for the visit"), or
  - receives a request from an individual shopping for an item or service).

- The convening provider must determine at the time an item or service is scheduled or when a patient is shopping for care whether the patient is a self-pay patient, as defined above. This includes inquiring as to whether an individual with a plan or coverage intends "to have a claim submitted for the primary item or service with such plan or coverage."

Responsibility for GFE

- In general terms, a provider will be the convening provider for those items and services the provider schedules to be performed at the provider's physical location.
  - an office visit at a physician practice
  - test to be performed at an imaging center.

- Things become more complicated when the provider schedules an item or service to be performed at another location with the provider's involvement.
  - Examples: a physician scheduling a surgery to be performed in an ambulatory surgery center
  - For these cases, the involved providers (e.g., the physician practice and the surgery center) should discuss and decide their respective responsibilities.

GFE Notice Requirements

- A convening provider is responsible for orally informing all self-pay patients of the availability of a GFE of expected charges when the scheduling of an item or service occurs, or when questions about the cost of items or services arise.

GFE Notice Requirements

- Providers must prominently display a notice "written in a clear and understandable manner" on its "website, in the office, and on-site where scheduling or questions about the cost of items or services occur."
- Such written notice must be made available in accessible formats in compliance with nondiscrimination laws.
- CMS has published a model notice for this purpose. The use of this model notice is not mandated, but CMS will consider its use good faith compliance with the notice requirement.

- Upon request from a self-pay patient, the convening provider must transmit a GFE to the individual in written form, either on paper or electronically, based on the individual's preference.
- Even if the patient requests the GFE be furnished by phone or orally in person, the convening provider still must issue the GFE in written form.

This may surprise you

Written documentation required.

Content of GFE Notice

- Detailed information and disclaimers.
- CMS has published a standard form for providers to use in providing GFEs and an explanation of the specific data elements to be included in the estimate.
- Again, use of the standard form is not mandated, but CMS will consider its use good faith compliance with the requirement to inform an individual of expected charges.

Contacting Co-Providers

- Within **one** business day of scheduling or receiving a request, the convening provider must contact all co-providers who are reasonably expected to provide items or services in conjunction with and in support of the primary item or service, requesting submission of the information necessary for the convening provider to complete the GFE.
- The request must include the date by which the information must be received by the convening provider.

Duties of Co-Providers

- The regulations require a co-provider to deliver specific information to the convening provider no later than **one** business day following receipt of the request.

- A co-provider must notify and provide updated information to a convening provider if the co-provider anticipates any changes to the information previously submitted to the convening provider. This may include "changes to expected charges, items, services, frequency, recurrence, providers, or facilities."

Duties of Co-Providers

- If there is any change in the expected co-providers listed in the GFE less than **one** business day before the item or service is scheduled to be furnished (e.g., an anesthesiologist from a different practice is scheduled to participate), the replacement co-provider must accept the expected charges furnished by the original co-provider.

Delayed Enforcement re: Co-Providers

- In the September 30 IFR, HHS announced that for the period January 1, 2022, to December 31, 2022, it will exercise its enforcement discretion in cases in which the GFE provided to a self-pay patient does not include expected charges from co-providers.

- HHS acknowledged "that it may take time for providers and facilities to develop systems and processes for providing and receiving the required information from others."

- Therefore, a convening provider is not required to request, and a co-provider is not required to provide, information for inclusion in the GFE until 2023.

Timing of GFE

- When a GFE is requested by a self-pay patient prior to scheduling service, the convening provider must furnish the GFE to the patient no later than **three** business days after the date of the request.
- If the primary item or service is scheduled at least 10 business days before such item or service is scheduled to be furnished, the convening provider must furnish the GFE to the patient no later than **three** business days after the date of scheduling.
- If the primary item or service is scheduled between **three** and **nine** business days before such item or service is scheduled to be furnished, the convening provider must furnish the GFE to the patient no later than **one** business day after the date of scheduling.
- If the primary item or service is scheduled less than **three** days before such item or service is scheduled to be furnished, the convening provider is not required to deliver a GFE.

Other GFE Issues

- Information provided in GFE changes after it's provided to patient.
- Information included in GFE is incorrect.
- Re-occurring services.
- Eventual provision of GFE to insured patients.

Surprise Billing Requirements

What is a "surprise medical bill"?

- Section 102 of the NSA:
  - *Those containing charges for out-of-network emergency care, certain ancillary services provided by nonparticipating providers at participating facilities, and out-of-network care provided at participating facilities without the patient's informed consent.*
  - An unexpected balance bill.
  - Question: What about non-emergency care provided at out of network (non-participating) facilities?
    - Answer: Does NOT apply to non-emergency services at OON facility

Application of Surprise Billing Protections

- Private group health plans
  - Employer sponsored
  - Self-insured ERISA plans
- Commercially insured and self-pay patients
- It aims to protect commercially insured and self-pay patients.
- A facility can contract with commercial payers and require its providers to contract with the same plans, but still may have a **patient** who is out of network.

Surprise Billing Coverage

- The surprise billing protections apply to coverage through
  - an employer (including a federal, state, or local government),
  - the federal Marketplaces, state-based Marketplaces, or
  - an individual market health insurance issuer.

- The rule does not apply to coverage through programs such as
  - Medicare or Medicare Advantage
  - Medicaid or Managed Medicaid,
  - Indian Health Services,
  - Veterans Affairs Health Care, or
  - TRICARE.
  - These programs already prohibit balance billing.

- The No Surprises Act (NSA) requires those healthcare facilities and providers subject to the new law to notify patients regarding the NSA's protections against surprise billing (the "NSA Notice").

- **Compliance is required by January 1, 2022.**

Notice Requirements

Compliance is required by January 1, 2022.

Providers Required to Give Notice

- The notice requirements apply to all facilities and those providers that furnish services in facilities or in connection with facility visits. Including,
  - Physicians
  - Entities providing diagnostic services.

Content of Notice

- The NSA Notice must include:
  - a plain-language summary of the consumer protections afforded by the NSA;
  - a plain-language summary of any applicable state balance billing law; and
  - appropriate contact information for state and federal agencies that an individual may contact if the individual believes the facility or provider has violated a requirement specified in the notice.

Content of Notice

- DHHS has published a model NSA Notice with instructions on its proper use.
- While facilities and providers are not required to use the model document, HHS considers its use to constitute good faith compliance with the relevant regulatory provision, 45 CFR 149.430.
- Providers must comply with federal requirements regarding appropriate communications with individuals with disabilities and limited English proficiency.

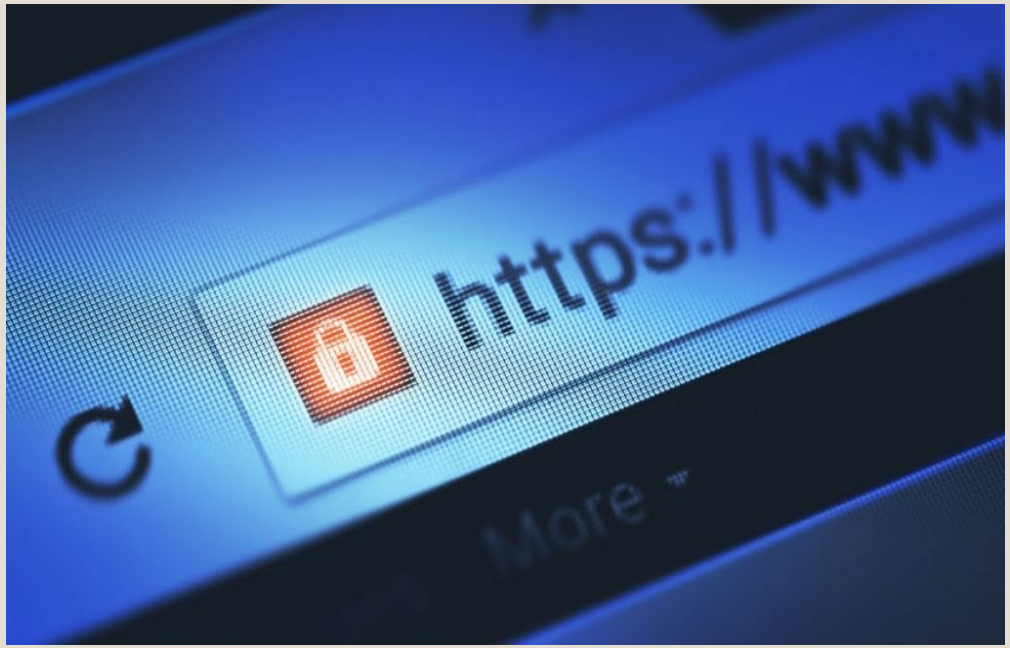
Posting – Physical Location

- The NSA Notice must be "on a sign posted prominently at the location of the provider or facility."
- A provider that does not have a publicly accessible location [e.g., clinical laboratory] is not required to post any signage.
- One way to meet this requirement is to post the NSA Notice signage next to your HIPAA Notice of Privacy Practices.

Posting - Website

- Facilities and providers must post a link to the NSA Notice on the searchable home page of their websites.

- Those without websites are not required to stand up websites for purposes of posting the NSA Notice.



Delivery to Patients

- A facility must deliver the NSA Notice to all insured patients (except Medicare and Medicaid beneficiaries), regardless of network status.

- A provider must deliver the notice to those insured patients for whom the provider furnishes services in a facility or in connection with a facility visit.

Delivery to Patients

- It appears the NSA Notice must be furnished for each episode of care (as compared to the one-and-done HIPAA Notice of Privacy Practices).
- The regulations do not require a facility or provider to secure the patient's written acknowledgment of receipt nor otherwise specify how a facility or provider should document the delivery of the notice.
- A facility or provider should follow the same procedures it employs for other required notices to demonstrate compliance.

Timing of Delivery

- Facilities and providers must furnish the NSA Notice in person or through mail or e-mail (as selected by the patient) no later than:
  - the date on which the provider or facility requests payment from the individual or,
  - if the facility or provider does not request payment from the patient, the date on which the facility or provider submits a claim to the plan or issuer.

Exception

- The NSA contains a limited exception to the notice requirement for providers furnishing services in facilities or in connection with a facility visit to avoid having patients receive multiple versions of the same document.

- Specifically, a provider is not required to deliver the NSA Notice to an insured patient receiving services at a facility if the provider has **a written agreement with that facility** under which the facility assumes responsibility for delivering the NSA Notice on the provider's behalf.

- The regulations do not specify the terms of the written agreement. Need to implement by January 1, 2022.

No OON Balance Billing for Emergency Services

Starting January 1, 2022

- Emergency health care facilities cannot balance bill patients for out-of-network emergency care.
  - Patient bills are limited to the same cost-sharing as for in-network emergency care, and any patient payments must apply to the patient's deductibles and out-of-pocket maximums.

- "Emergency services" include those provided at an independent freestanding emergency department, a description that broadly includes any healthcare facility that provides emergency services, is geographically separate and distinct from a hospital, and is separately licensed by a state.
  - Thus, independent freestanding emergency departments subject to the law may include urgent care centers if they are licensed by the state to provide emergency services.

This may surprise you

The definition of "emergency services"

- "Emergency services" is broader than the EMTALA definition.

- Emergency care also includes post-stabilization services, or services and items provided as part of outpatient observation or inpatient or outpatient stay with respect to emergency visits.
  - Only after a patient is stable and can be moved to an in-network facility using non-medical transport (as determined by the patient's treating provider) can a facility or provider seek the patient's consent to paying out-of-network rates (as described later).

This may surprise you

The definition of "emergency services"

- The Interim Final Rule makes clear that an insurer must cover emergency services in the first instance without limiting what constitutes an emergency medical condition solely on the basis of the ultimate diagnosis.

- The determination must take into account whether a prudent layperson (rather than a medical professional) would reasonably consider the situation to be an emergency in seeking services. If so, the episode of care falls within the definition of emergency services protected under the law, **regardless of any clinical determination made in hindsight.**

This may surprise you

The definition of "emergency services"

Post-Stabilization Services

- **Post-stabilization services will be categorized as emergency services under the No Surprises Act unless four conditions are met:**

(1) the patient is able to travel using non-medical transportation or non-emergency medical transportation to an available in-network provider or facility located within a reasonable travel distance (protecting patients receiving emergency care far from their plan's provider network);

(2) the provider or facility furnishing the post-stabilization services satisfies the notice and consent criteria set forth in the Interim Final Rule;

(3) the patient is in a condition to understand the notice and provide informed consent; and

(4) the provider or facility satisfies any additional requirements or prohibitions under applicable state law (for example, some state laws do not permit patients to waive protections in any circumstance).

Non-Emergency Services Provided at In-Network Facilities: OON Providers

Starting January 1, 2022

- Out-of-network providers who render non-emergency services at an in-network hospital or other facility are not allowed to balance bill patients beyond the applicable in-network cost sharing amount.

- An exception applies for certain non-emergency services if providers gives prior written notice and obtains the patient's written consent.

- The notice must indicate the provider does not participate in-network, provide a good faith estimate of out-of-network charges, and include a list of other participating providers in the facility whom the patient could select.
- This exception does not apply for ancillary services (such as anesthesia) or diagnostic services (such as radiology and lab) nor to other services or providers the Secretary may specify in regulation.

Non-Emergency Services Provided at In-Network Facilities: OON Providers

Starting January 1, 2022

- These protections are limited to services provided at in-network hospitals (including critical access hospitals), hospital outpatient departments, and ambulatory surgical centers.
- Of note, urgent care centers are not included among the facilities covered for the purposes of non-emergency care.
- **Non-emergency services at OON facility are not covered.**

This may surprise you

Scope of Consumer Protection for OON Billing at In-Network Facility

- The Departments explain that a "visit" to an in-network facility does not require the patient to set foot in the facility.
- A visit includes:
  - furnishing of equipment and devices,
  - telemedicine services,
  - imaging services,
  - laboratory services, and
  - pre- and post-operative services,

  regardless of whether these items are physically provided to the patient at the in-network facility.

This may surprise you

Scope of Consumer Protection for OON Billing at In-Network Facility

Notice and Consent Exception

- Recognizing that there are instances in which a patient may wish to obtain services from an out-of-network provider in spite of the potentially higher cost of those services, the NSA includes an exception under which a patient may knowingly waive the protections of the law in certain circumstances.

- The cost-sharing limitations and balance billing prohibitions do not apply to
  - post-stabilization services that meet the four criteria set forth above removing them from the definition of emergency services under the law or
  - certain non-emergency services provided by an out-of-network provider at an in-network facility if the out-of-network provider or facility timely provides the patient a prescribed notice regarding such services, the patient acknowledges receipt of the information in the notice, and the patient consents to waive the protections under the law.

Required HHS Model Notice

- Providers and facilities seeking to avail themselves of the exception must use the notice and consent forms issued by HHS.
- The notice and consent forms contain the elements required by the law and Interim Final Rule.
- The forms must be tailored to include information specific to the relevant provider or facility, patient, and contemplated items and services.

Notice and Consent

- The Interim Final Rule explains that the notice must be provided with the consent, and together these documents must be given physically separate from, and not attached to or incorporated into, any other documents.

- The notice must be provided within the required timeframe on paper or electronically, as selected by the patient.

- An in-network facility may provide the notice on behalf of an out-of-network provider; however, if the resulting consent is flawed, the waiver of the protections under the No Surprises Act will not be effective.

Timing of Notice and Consent

- If a patient schedules an appointment for items or services subject to the exception at least 72 hours before the appointment, the provider or facility must provide the notice and consent no later than 72 hours before the appointment.

- If the patient schedules the appointment within 72 hours before the appointment, the provider or facility must provide the notice and consent on the day the appointment is made. If the notice and consent are provided to the patient on the same day the relevant items or services are furnished, they must be provided no later than three hours prior to furnishing the items or services to ensure any consent received is truly voluntary.

- Notice and consent exception does not apply to following services furnished by OON provider at in-network facility
  - Emergency medicine, anesthesia, pathology, radiology, neonatology
  - Assistant surgeon, hospitalist, and intensivist items and services
  - Diagnostic services, including radiology and laboratory services
  - Items or services provided by OON provider if there are no in-network providers who can furnish the item or services at the facility
  - Items or services that result from unforeseen, urgent medical needs that arise when item or service is furnished

Things that may surprise you

Scope of Consumer Protection for OON Billing at In-Network Facility

What do facilities and providers get paid for out-of-network care?

- There are two components to the payments provided to out-of-network facilities and providers under the No Surprises Act:
    1. Patient payments, and
    2. Health plan payments.

- The No Surprises Act generally limits the patient's cost-sharing responsibility — that is, the patient's deductible, copayment, or coinsurance payments for services — to the corresponding in-network amount.

- Specifically, in the case of emergency services and in surprise bill scenarios, the law states that the patient's cost-sharing responsibility will be calculated based on the total amount that would have been charged for the services by an in-network provider or facility, an amount the law terms the "recognized amount."

Patient Payments

The "Recognized Amount"

- The recognized amount is defined as:
  - an amount determined by an All-Payer Model Agreement under the Social Security Act;
  - if there is no applicable All-Payer Model Agreement, an amount determined by a specified state law; or
  - if neither of the above apply, the **lesser of**
  - the amount billed by the provider or facility or
  - **the qualified payment amount (QPA**).
- In the case of air ambulance services, the Interim Final Rule provides that the recognized amount will be the lesser of the billed amount or the QPA.

Patient Payments

The "Recognized Amount"

- Patient payments are limited to the patient's cost-sharing requirement for in-network care.
  - For example, that if a patient's health plan has a 20% coinsurance requirement for in-network emergency care, that same 20% requirement applies to the out-of-network emergency care.

Patient Payments

The "Recognized Amount"

- The QPA is the median of the contracted rates recognized by the health plan on January 31, 2019 for the same or similar item or service provided by a similar provider in the same geographic region, and indexed for inflation.
- Health plans must calculate the QPA using a long series of requirements detailed in the regulations and meant to ensure that the patient cost-sharing is based on a total amount similar to that charged for in-network care.

Patient Payments

The "Recognized Amount"

National Median Rate Examples

Emergency Department Visit Codes – Acute Care Hospital

Payer	99281	99282	99283	99284	99285
Aetna	$254	$441	$683	$991	$1,347
Blue Cross	$179	$305	$507	$808	$1,142
Cigna	$248	$416	$707	$1,024	$1,357
United Healthcare	$278	$427	$686	$923	$1,220

Derived from database of publicly-reported hospital rates pursuant to Price Transparency regulations.

State Median Rate Examples

Emergency Department Visit Codes

Aetna	99281
AZ	$547
CA	$414
FL	$237
GA	$140

Derived from database of publicly-reported hospital rates pursuant to Price Transparency regulations.

- Calculation of the QPA may place a significant burden on health plans, which must compile and analyze a significant amount of data to calculate these amounts.
- The QPA is important not just to assessing the patient's payment obligation, but to determining the reasonableness of the health plan's overall payment and in the dispute resolution process.

Patient Payments

The "Recognized Amount"

Health Plan Payment

"Out of Network Rate"

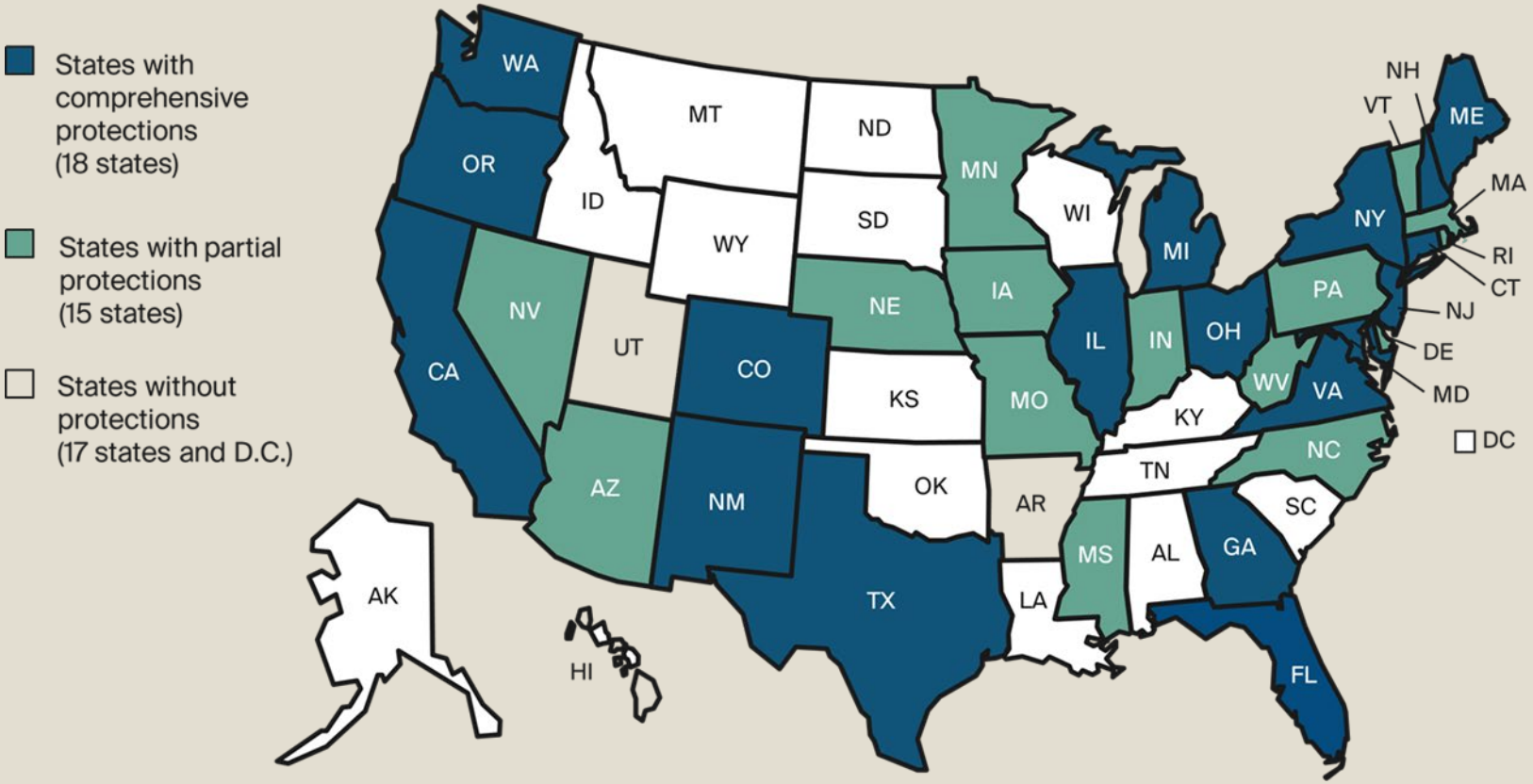
- The second component of the payment to facilities or health care providers is the health plan's payment.
- Health plans must pay the facility or provider the total amount the plan believes it owes within 30 days of receiving a clean claim.

- An insurer must make a total payment to the out-of-network provider equal to the following (less the patient's cost-sharing responsibility):
  - an amount determined by an applicable All-Payer Model Agreement under the Social Security Act;
  - if there is no applicable All-Payer Model Agreement, an amount determined by a specified state law (only Maryland and Vermont);
  - if neither of the above apply, an amount agreed upon by the insurer and the provider or facility; or
  - if none of the above apply and the parties do not settle prior to completion of the independent dispute resolution process established in the law, the amount determined by the independent dispute resolution entity.

Health Plan Payment

"Out of Network Rate"

- Oklahoma does not have any balance billing protection laws.
- That means that in Oklahoma, health plan payments under the No Surprises Act will be based on an "agreement" between the plan and the facility or provider.



https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections.

Health Plan Payment

"Out of Network Rate"

- In practice, the plan will pay the facility and provider what it believes it owes, along with a notice providing the QPA and how it was calculated, and a notification of the right to enter into a 30-day negotiation period related to the plan's payment.
- The health care facility or provider then has to assess whether to accept the plan's payment, or negotiate for a higher amount.
- If the health care facility or provider enters into negotiations and cannot reach a resolution within 30 days, the facility or provider then has four days to initiate independent dispute resolution regarding the payment amount.

Health Plan Payment

"Out of Network Rate"

Independent Dispute Resolution

- If a health care facility or provider initiates the IDR process, both the facility or provider and the health plan will submit to an arbitrator a proposed payment amount, and information regarding the following factors:
  - The calculated QPA
  - The provider's training and experience
  - The complexity of the procedure or medical decision-making
  - The patient's acuity
  - The market share of the health plan, and the provider or facility
  - Whether the care was provided at a teaching facility
  - The scope of services
  - Any demonstration of good faith efforts to agree on a payment amount; and
  - The contracted rates from the prior year
- The arbitrator will then choose one of the two proposals as the amount of the payment.
- The arbitrator cannot come up with his or her own payment amount. Arbitrators are paid through fees assessed to the entities that use the IDR process.

OON Payment Timeline

8 step process

30 business days	• Payer sends facility/provider initial payment or notice of denial of payment after receiving clean claim
30 business days	• Facility/provider initiates 30-business day open negotiation period
4 business days	• Either party initiates IDR following failed open negotiation

OON Payment Timeline

8 step process

3 business days

- Mutual agreement on certified IDR entity
- Each party pays $50 administrative fee

6 business days

- Departments select certified IDR entity in case of no conflict-free selection by parties

10 business days

- Parties submit payment offers and additional information to certified IDR entity

30 business days

- Payment determination
- Loser pays IDR entity fee

30 business days

- Payment submitted to the provider/facility

OON Payment Timeline

8 step process

By January 1, 2022. . .

- Post the required notice for self-pay patients on your website and at physical locations.
- Post the separate required notice regarding surprise billing for out-of-network services.
- Evaluate and revise registration processes to identify and provide the required notices (both GFE self-pay and surprise billing).
- Identify and assign appropriate employees the responsibility for receipt of requests for and generation and delivery of GFEs.
- Obtain CMS forms, revise them as needed and develop policies and procedures.
- Evaluate revenue cycle processes to capture necessary data. (Network status, OON claims submission)