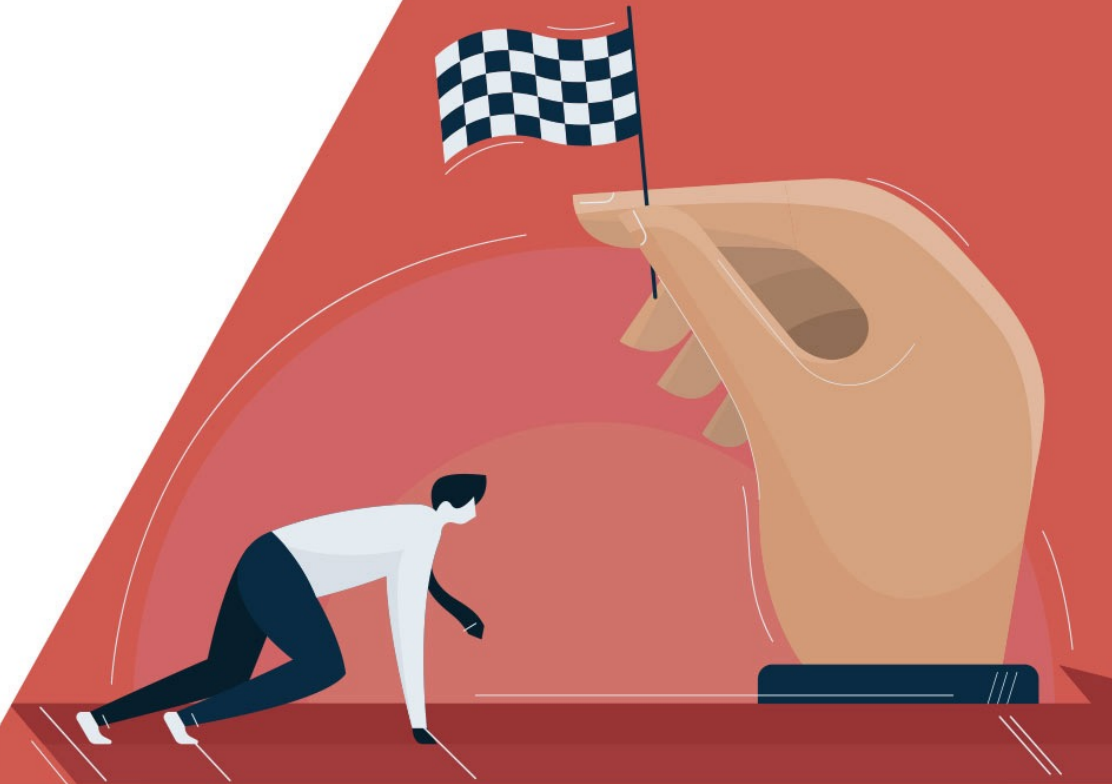
Ready, Set, Go! No Surprises Act Effective January 1, 2022

October 20, 2021

Healthcare Regulatory Round-Up Series

Martie Ross, JD
mross@pyapc.com



© 2021 PYA, P.C.

WE ARE AN INDEPENDENT MEMBER OF HLB—THE GLOBAL ADVISORY AND ACCOUNTING NETWORK

No Surprises Act

PYA

Federal legislation to address surprise billing

- Patients through no fault of their own receive services from OON facility/provider
- Consolidated Appropriations Act

Effective January 1, 2022

- 74 calendar days
- 48 business days

Regulations issued by Departments of Health and Human Services, Labor, & Treasury & Office of Personnel Management

- July 1 Interim Final Rule
- September 15 Notice of Proposed Rulemaking
- September 30 Interim Final Rule

State Balance Billing Protections

No Balance Billing Protections

Partial Balance Billing Protections

Comprehensive Balance Billing Protections

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

Who?

PYA

- Healthcare Entities*
  - Facilities - hospitals, CAHs, freestanding EDs, ASCs
  - Providers furnishing services for facility patient (not outside)
  - Air ambulance (not ground, at least for now)
- Health insurance issuers and health plans
  - Group coverage includes both insured and self-insured plans, ERISA plans, non-federal government plans, church plans, traditional indemnity plans (**not** Medicaid MCOs or MA plans)
  - Individual coverage includes exchange and non-exchange plans, student health insurance coverage (**not** health reimbursement arrangements, short-term limited-duration insurance, or retiree-only plans)

* *Broader scope for 'good faith estimate' requirements*

What? Emergency Services

- Applies to emergency services furnished at OON facility AND emergency services furnished by OON provider at in-network facility
- Good news -
  - Apply “prudent layperson” standard to determine what constitutes emergency services
  - Includes necessary post-stabilization services (admission, observation) as determined by treating physician
  - Plan cannot require prior authorization nor limit coverage for emergency services to certain diagnosis codes

What? Non-Emergency Services

- **Does NOT apply** to non-emergency services at OON facility
- **Does 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.
- **Does NOT apply** to other services furnished by OON provider at in-network facility **BUT ONLY IF** prior notice and written consent
  - Surgeons, consulting physicians (?)

.

Advance Notice/Consent

- Utilize HHS Standard Notice and Consent document
  - Available at https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780
  - Do not modify except to complete bracketed information and as necessary to reflect applicable state law; provide appropriate translations/interpreters
  - Complete "Estimate of what you could pay" and "More details about your estimate" before giving to patient
  - Provide signed copy to patient/representative in manner requested
- Timing
  - If service scheduled at least 72 hours in advance, must provide notice at least 72 hours in advance
  - If service scheduled less than 72 hours in advance, must provide notice day of appointment, but not less than 3 hours before providing the service
- Plan must be notified and receive copy of signed consent

How? Patient Charges

- Cannot charge patient more than in-network cost-sharing amount
- Calculated based on Qualifying Payment Amount (QPA)
  - Plan's 2019 median in-network rate paid for same or similar service in specific geographic area, indexed for subsequent years (special rules for new plans/services with no established 2019 rates)
  - Plan must provide QPA in responding to claim submitted by facility/provider
- Plan must credit amount paid to patient's deductible

How? Out-of-Network Payments

Payer sends facility/provider initial payment or notice of denial of payment	30 business days, starting on day payer receives all relevant data
Facility/provider initiates 30-business-day open negotiation period	30 business days, starting on day of initial payment or notice of denial of payment
Either party initiates independent dispute resolution (IDR) following failed open negotiation (Federal IDR portal)	4 business days, starting business day after the open negotiation period ends
Mutual agreement on certified IDR entity selection; each party pays $50 administrative fee	3 business days after IDR initiation date
Departments select certified IDR entity in case of no conflict-free selection by parties	6 business days after IDR initiation date
Parties submit payment offers and additional information to certified IDR entity (with administrative fee)	10 business days after date of certified IDR entity selection
Payment determination made; loser pays IDR entity fee	30 business days after date of certified IDR entity selection
Payment submitted to the applicable party	30 business days after payment determination

IDR Entity Decision-Making Process

- Work from presumption that QPA is appropriate payment rate
- Provider/facility and/or plan may submit evidence to rebut presumption based on following -
  - ✓ Level of training, experience, and quality and outcomes measurements of provider/facility
  - ✓ Market share held by provider/facility or plan in geographic region in which item/service provided
  - ✓ Patient acuity or complexity of furnishing the item/service
  - ✓ Facility's teaching status, case mix, and scope of services
  - ✓ Demonstration of good faith efforts (or lack thereof) made by provider/facility or plan to enter into network agreements with each other, and, if applicable, parties' contracted rates during previous 4 plan years
  - ✓ Additional relevant and credible information **BUT NOT** usual & customary charges or Medicare/Medicaid reimbursement rates

Example - Median Rates

- Derived from database of publicly-reported hospital rates per Price Transparency regulations
- Rates effective January 1, 2021

National Median Rates – Acute Care Hospitals

Median Rate PayerName	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

National Median Rate – Critical Access Hospitals

Median Rate PayerName	99281	99282	99283	99284	99285
Aetna	$166	$293	$444	$681	$970
Blue Cross	$150	$263	$404	$647	$926
Cigna	$164	$282	$462	$707	$1,040
United Healthcare	$156	$255	$409	$610	$874

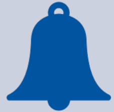
State Median Rates – Aetna

Median Rate Provider_State	99281	99282	99283	99284	99285
AK	$244	$490	$917	$1,629	$2,967
AL	$278	$340	$468	$470	$474
AR	$317	$348	$493	$571	$585
AZ	$547	$825	$1,127	$1,325	$1,454
CA	$414	$565	$954	$1,125	$1,380
CO	$273	$504	$1,044	$1,566	$2,578
CT	$434	$593	$1,055	$1,444	$2,220
DC	$287	$573	$858	$1,138	$1,689
FL	$237	$413	$645	$933	$1,247
GA	$140	$260	$418	$753	$1,127

State Median Rates –United Healthcare

Median Rate Provider_State	99281	99282	99283	99284	99285
AK	$273	$515	$945	$1,759	$3,020
AL	$259	$299	$467	$705	$793
AR	$104	$194	$227	$357	$512
AZ	$526	$701	$847	$807	$1,389
CA	$328	$559	$730	$1,133	$1,557
CO	$449	$690	$1,574	$2,814	$4,011
CT	$609	$707	$785	$856	$1,262
DC	$235	$440	$837	$775	$1,105
FL	$196	$391	$749	$929	$1,158
GA	$148	$273	$411	$768	$1,139

How? Consumer Protections



Notification - Insured

Good Faith Estimate – Self-Pay

Provider-Patient Dispute Resolution

1. Notification

- Facilities/providers must provide notice to patients of NSA protections
  - Post prominently at physical location (HIPAA Notice of Privacy Practices)
  - Post on website (link from homepage)
  - Given to each insured patient (other than Medicare/Medicaid) to whom services provided at facility in manner requested by patient no later than time at which request for payment made (or claim submitted, if no request)
    - Limited exception for providers under written agreement with facility

Model Notice

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

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, such as a copayment, coinsurance, and/or a deductible. You may have other 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" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay 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 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.

You are 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 the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). 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 balanced billed for these post-stabilization services.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model 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 may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

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

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (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 deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact [*applicable contact information for entity responsible for enforcing the federal and/or state balance or surprise billing protection laws*].

Visit [*website*] for more information about your rights under federal law.
[*If applicable, insert:* Visit [*website*] for more information about your rights under [state laws].]

https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780

2. Good Faith Estimate – Self-Pay

- For **self-pay** patients, facilities and providers must share "good faith estimates" of total expected charges (inclusive of discounts)
  - Applies when self-pay patient requests estimate (comparison shopping) or when item/service scheduled at least 3 days in advance
  - Facility/provider must –
    - Determine whether patient is 'self-pay' for item/service
    - Provide separate written notice for self-pay patients regarding availability of good faith estimates (model notice forthcoming)
    - Provide written good faith estimate (content, form, manner of delivery specified in regulations
      - If requested prior to scheduling – 3 days following request
      - If scheduled at least 10 but less than 4 business days in advance – 3 days before
      - If scheduled at least 3 business days in advance – 1 day before
      - Special rules for recurring services
  - Effective 1/1/23, "convening provider" must include all items/services reasonably expected to be provided together with primary item/service, (process for requesting information from 3rd parties)

3. Patient-Provider Dispute Resolution

- Self-pay patient who is billed at least $400 more than good faith estimate for any provider or facility listed on estimate may initiate process by completing submission to HHS within 120 days of receiving bill
  - Administrative fee of $25 (adjusted annually)
- HHS submits matter to selected dispute resolution entity
  - SDR notifies provider/facility, which then has 10 days to respond with credible evidence supporting higher billed charges (burden of proof)
  - SDR makes decision within 30 days following receipt of information from provider/facility
    - If no credible evidence, provider/facility bound by good faith estimate
    - If credible evidence, lesser of (i) billed charges or (ii) median payment amount paid by plan or issuer for same or similar service, by same or similar provider in geographic area reflected in independent database

Plan Requirements

Continuity of Care

Provider Directories

Notification

Transparency in Coverage

1. Continuity of Care

- Following discontinuation of facility/provider network status, plan must continue coverage for up to 90 days for patients who are -
  - Undergoing a course of treatment for a serious or complex condition
  - Undergoing institutional or inpatient care
  - Scheduled to undergo non-elective surgery (including postoperative care)
  - Pregnant and undergoing treatment
  - Terminally ill and receiving services
- No implementing regulations prior to 01/01/2022; plans must comply based on good faith reading of statutory requirements

2. Provider Directories

- Health plan provider directory requirements
  - Verification process to ensure accurate provider directories
  - Response protocol for individuals inquiring about provider's network status
  - Publicly accessible provider database
- No implementing regulations prior to 01/01/2022; plans must comply based on good faith reading of statutory requirements
- Plan is deemed to comply so long as it does not penalize any covered person who relies on inaccurate information

3. Notification

- Plan must post on its public website and include on plan communications (including EOBs) similar notices regarding balance billing protections
- No implementing regulations prior to January 1, 2022; plans must comply based on good faith reading of statutory requirements

4. Transparency in Coverage

- By **January 1, 2022**, plans must issue ID cards with any applicable deductibles, any applicable out-of-pocket maximum limitations, and telephone number and website address for individuals to seek consumer assistance
- By **July 1, 2022**, plans must disclose on public website in-network provider rates for covered items and services and OON allowed amounts and billed charges for covered items and services in machine-readable formats
- By **January 1, 2023**, plans must post self-service price comparison tool for cost-sharing liability

Between Now and January 1…

Compliance with notice and good faith estimate requirements (insured & self-pay)

Revenue cycle processes

- Registration
- OON claim submission
- OON payment monitoring
- Payment disputes

Hospital-based physicians

Managed care negotiations

Next Health Care Regulatory Round-Ups

- November 10 – Medicare Trust Fund: Impact of Avoiding Insolvency
  - Infrastructure bill?
  - Registration information coming to your inbox soon!
- November/December
  - 2022 OPPS Final Rule
  - 2022 MPFS Final Rule
  - Whatever else comes up….