HEALTHCARE REGULATORY ROUND-UP - Episode #27

No Surprises Act: Your Questions Answered (Hopefully)

June 15, 2022

Introductions

Martie Ross
mross@pyapc.com

Kathy Reep
kreep@pyapc.com

pyapc.com
800.270.9629

ATLANTA | HELENA | KANSAS CITY | KNOXVILLE | NASHVILLE | TAMPA

No Surprises Act – Application

Surprise Billing

- Facilities
  - Hospitals
    - Including physician practices operated as hospital outpatient department
    - Including critical access hospitals
    - Excluding psychiatric hospitals
  - Freestanding emergency departments
  - Ambulatory surgery centers
- Providers **furnishing services at a facility**
- Air ambulance providers (not ground ambulance – yet)

Good Faith Estimates

- **Any** provider furnishing healthcare services to self-pay patient
  - Self-pay patient requests GFE (i.e., “any discussion or inquiry regarding potential costs of items or services under consideration”)
  - Services scheduled at least 3 business days in advance for self-pay patient (regardless of request for pricing information)

Surprise Billing – General Rule

- In specified circumstances, out-of-network facility/provider cannot bill patient more than patient's in-network cost sharing amount
- Not applicable to -
  - Medicare, Medicaid, TRICARE
  - Worker's compensation, PIP
  - Plans with no provider network (e.g., reference-based pricing, health sharing ministries)
- Applies equally to primary and secondary insurance coverage

Surprise Billing – Emergency Services

- Applies to emergency services furnished -
  - at out-of-network facility, and/or
  - by out-of-network provider furnishing services at facility (regardless if facility in-network or out-of-network)
- "Emergency services"
  - EMTALA definition +
  - Post-stabilization services (observation, inpatient, outpatient) if treating physician determines patient cannot be safely moved to another facility using non-medical transport
    - Potential issues with downstream providers?

Surprise Billing – Non-Emergency Services

- Applies to services furnished at in-network facility by out-of-network provider
  - Does not apply to any non-emergency services furnished at out-of-network facility
- Consent to balance billing
  - ONLY if patient has opportunity to select provider in advance (surgeon)
  - Hospital-based physicians cannot obtain consent to balance bill
    - IDR Portal

Qualifying Payment Amount

- Furnished by plan to facility/provider to calculate patient's in-network cost sharing amount
- Uncertain mechanics
  - Use of 837/835? Other means of communicating information?
- Impact of ongoing litigation
  - Despite regulatory text, QPA not determinative of appropriate out-of-network payment rate
  - New regulations addressing revised IDR process expected this summer

Open Negotiation Process

- With initial payment/denial, plan must furnish name, telephone number, and email address of contact person to initiate open negotiation period
- Within 30 business days, provider must submit open negotiation notice to payer
  - Use standard notice available at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-part-ii-information-collection-documents-attachment-2.pdf
- Q: *The Open Negotiation Process form used by some payers … for higher-volume specialties … is inefficient - that is, one claim at a time. Are you hearing of any payers willing to accept a batch of claims to dispute perhaps in a spreadsheet?*

Independent Dispute Resolution Process

- IDR initiation
  - Within 4 business days following end of 30 business day open negotiation period
  - https://nsa-idr.cms.gov/paymentdisputes/s/
  - Each party pays $50 administrative fee
  - Paper submissions (one bite at the apple; no witnesses)
- 10 approved IDR entities
  - Fees range from $285 to $450 ($450 to $670 for batched claims)
  - Paid by losing party
- No reported data on number of IDR disputes, resolution
  - Agencies had estimated 17,000/year

Surprise Billing – Disclosure Notice

- Model notice
  - Available at https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf ; insert references to relevant state law(s)
- Facility
  1. Post on website (link from home page)
  2. Post at facility (HIPAA Notices of Privacy Practice)
  3. Deliver notice to each patient protected under Surprise Billing rules (prior to seeking payment from any party)
     - Not just to patients receiving services to which Surprise Billing rules apply
- Provider that furnishes services at any facility (i.e., hospital-based physicians, on-call physicians, admitting/rounding physicians)
  - Written agreement with facility – OR
  - Same requirements as facilities

Surprise Billing - Impact

- AHIP - BCBSA claim recent survey shows NSA prevented 2 million surprise bills in first 2 months
    - Based on finding that 0.23% of all commercial claims were NSA-eligible

More Than 2 Million Surprise Bills Avoided During January-February 2022

NO SURPRISES ACT PREVENTS FAR MORE SURPRISE BILLS THAN INITIAL ESTIMATES OF IDR VOLUME, VOTERS EXPRESS CONCERN ABOUT CHALLENGES TO LAW

On December 27, 2020, the No Surprises Act (NSA) was signed into law, marking the first federal consumer protections from surprise medical billing. Most of the law's provisions took effect at the beginning of 2022, applying to those enrolled in health insurance coverage or a group health plan renewing on or after January 1, 2022. Under the law, when anyone covered by private health insurance is treated for emergency services or at an in-network facility by an out-of-network provider, the health care provider or facility, such as a hospital, is prohibited from billing a patient above their in-network cost-sharing amount. The law establishes a process for resolving disagreements on what the health plan will pay the out-of-network provider or facility, culminating in independent dispute resolution (IDR).

A key question of interest to federal policymakers has been how many claims may be disputed through IDR in a given year. In the Economic Impact and Paperwork Burden analysis for the Interim Final Rule issued in October 2021 which outlines the IDR process, the Departments of Health & Human Services, Labor, and the Treasury estimated there would be 17,000 claims submitted to IDR annually.

A recent survey and analysis conducted by AHIP and the Blue Cross Blue Shield Association (BCBSA) found that in the first two months of 2022, the NSA prevented more than 2,000,000 potential surprise medical bills across all commercially insured patients. If only a fraction of these claims are ultimately disputed through IDR, it would still far exceed the government's estimate

https://ahiporg-production.s3.amazonaws.com/documents/202205-AHIP-BCBSA_NSA-Survey-v02.pdf

Good Faith Estimate

- GFE applies to “healthcare facilities” and “healthcare providers”
  - State-licensed institutions such as hospitals, ASCs, RHCs, FQHCs, laboratories, imaging centers
  - Physician or other healthcare provider who is acting within scope of practice of that provider’s state-issued license or certification (including air ambulance provider)
- Provide written GFE to all self-pay patients who –
  - Initiates discussion or makes inquiry regarding potential costs of items or services under consideration
  - Schedules item/service at least 3 business days in advance (regardless of any request)
- Use standard form; incorporate into medical record (shoppers?)
  - https://www.cms.gov/files/document/good-faith-estimate-example.pdf

Convening Provider and Co-Provider

- Who is who?
  - Convening provider = scheduling provider
  - Co-provider = furnishes services directly related to primary service
- Beginning January 1, 2023, what is the consequence of –
  - Failure to request co-provider information?
  - Failure of co-provider to provide information?

Examples

- If Family Medicine physician provides a GFE for expected services for a cardiac-related concern office visit and after that visit is complete the patient needs to be referred to a Cardiologist - who provides the GFE for the referral to Cardiology?
- If a new self-pay patient is scheduled for an office visit, does the GFE need to include anticipated lab tests?
- If the hospital employs the physician who will perform a procedure, does the hospital need to include the physician charges on the GFE for the procedure?

Completing the GFE

- Through 2022, include all items and services for which provider bills (including purchased services)
- Self-pay rates
  - List charges inclusive of discounts (even if 100% discount)
  - Opportunity to re-evaluate self-pay rates, chargemaster?

No Surprises Act

Good Faith Estimate Workflow

Visit PYA's Healthcare Transparency Page:
https://www.pyapc.com/healthcare-transparency/

STEP 1 Identifying Self-Pay Patients

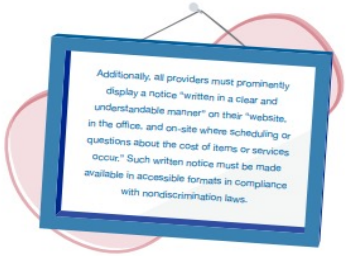
When communicating with a patient either shopping for care or scheduling a service, determine whether the patient qualifies as "self-pay" and thus, is entitled to receive a GFE.

- Does the individual have health insurance?
  - No → GFE furnished to the patient no later than 3 business days after the date of the request.
  - Yes → Will he/she make a claim for the service under his/her health insurance?
- Will he/she make a claim for the service under his/her health insurance?
  - No → GFE furnished to the patient no later than 3 business days after the date of the request.
  - Yes → Does the individual's health insurance provide benefit for the service?
- Does the individual's health insurance provide benefit for the service?
  - No → GFE furnished to the patient no later than 3 business days after the date of the request.
  - Yes → If a provider is out-of-network OON, does the health insurance provide any benefit for OON services?
- If a provider is out-of-network OON, does the health insurance provide any benefit for OON services?
  - No → GFE furnished to the patient no later than 3 business days after the date of the request.
  - Yes → Follow your institution's insured patient workflow.

STEP 2 Providing Required Notice

A provider is responsible for orally informing all self-pay patients of the provision 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.

The Centers for Medicare & Medicaid Services (CMS) has published a model notice for this purpose, available here (included in the downloadable ZIP file as Appendix 1). The use of this model notice is not mandated, but CMS will consider its use good faith compliance with the notice requirement.



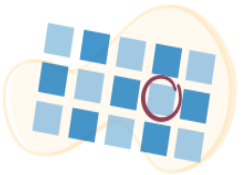
STEP 3 Determining the Convening Provider and Location Where Services Will Be Performed

A "convening provider" is the provider that (1) is responsible for scheduling the primary item or service, or (2) receives a request from an individual shopping for an item or service.

- Will the service(s) be performed at the convening provider's physical location?
  - No → Involved providers should discuss and decide their respective responsibilities.
  - Yes → Will a co-provider be involved?
- Will a co-provider be involved?
  - No → GFE furnished to the patient no later than 3 business days after the date of the request.
  - Yes → Is the co-provider's service scheduled separately?
- Is the co-provider's service scheduled separately?
  - No → NSA responsibilities fall to the convening provider.
  - Yes → The co-provider is subject to the same requirements as the convening provider.

STEP 4 Determining the Timing for Providing the GFE

The timing of the provider's delivery of the GFE to a self-pay patient in advance of the service depends on whether and how far out the date of service is scheduled.



- Is the individual shopping or scheduling?
  - No → GFE furnished to the patient no later than 3 business days after the date of the request.
  - Yes → Is the service scheduled at least 3 days out?
- Is the service scheduled at least 3 days out?
  - No → GFE is not required.
  - Yes → Is the service scheduled between 3-9 days out?
- Is the service scheduled between 3-9 days out?
  - No → If the service is scheduled at least 10 days out, the convening provider must furnish the GFE to the patient no later than three business days after the date of scheduling.
  - Yes → GFE furnished to the patient no later than 1 business day after the date of scheduling.

STEP 5 Providing the Good Faith Estimate

The convening provider must transmit a GFE to the individual in written form, either on paper or electronically, based on the individual's preference. (Note the obligation to provide the GFE for a scheduled service is not dependent on the individual requesting the GFE; the obligation to provide the GFE is triggered when the service is scheduled.) 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.

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. While the use of the standard form is not mandated, CMS will consider its use good faith compliance with the requirement to inform an individual of expected charges. The template is available at here (Appendix 2).

Note: if the convening provider anticipates a change in service, a new GFE must be issued to the patient no later than one business day before the items or services are scheduled to be furnished. Also, for recurring services, the regulations permit a convening provider to issue a single GFE once every 12 months.

Beginning in 2023, the co-provider will be responsible for providing specific information to the convening provider within 1 business day of scheduling or receiving a request from the convening provider. For details on the required information, see PYA's "*No Surprises Act Implementation Guide: Good Faith Estimate Requirements*." Additionally, if you would like guidance related to the No Surprises Act, or for assistance with any matter related to compliance, valuation, or strategy and integration, contact a PYA executive at (800) 270-9629.

PYA
(800) 270-9629 | pyapc.com

GFE Disclosure Notices

- Not to be confused with (or combined with) surprise billing notice
- Standard notice available at https://www.apaservices.org/practice/legal/managed/good-faith-estimate-notice.pdf
- All healthcare facilities and healthcare providers required to post notice on website and post at facility (where scheduling or questions about the cost of items or services may occur)
- Also required to provide same notice orally to “shopper” or when scheduling item or service (3 business days in advance)

Related Regulations

- Transparency in Coverage regulations take effect July 1, 2022
  - Rule published in October 2020 requires plans to post all negotiated rates publicly
- Still waiting for implementing regulations on Advance EOBs

A national healthcare advisory services firm providing consulting, audit, and tax services