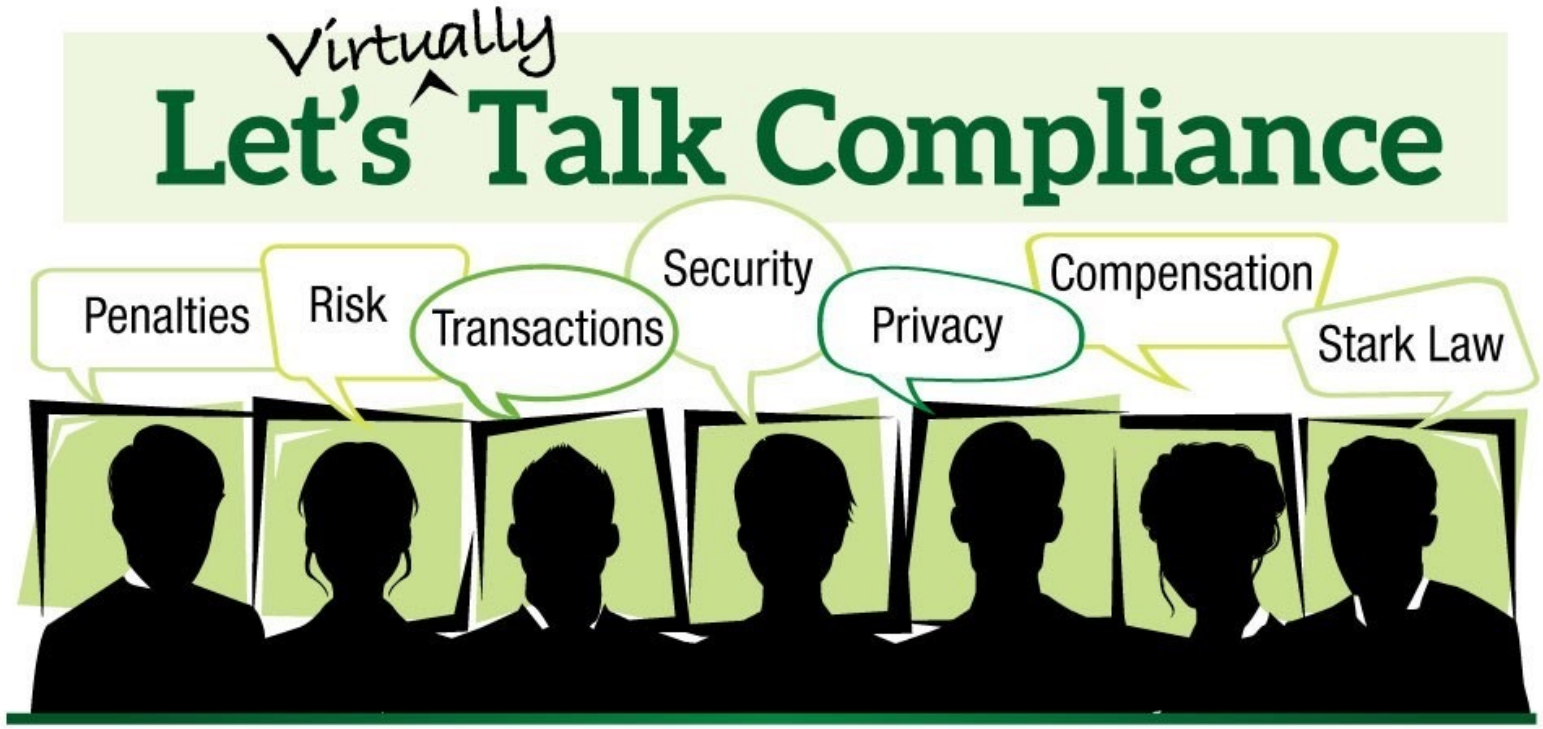
Let's Talk Compliance

One-Day Compliance Master Class



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SESSION #4

No (More) Surprises Act – Whoops Here's One!

Jana Kolarik & Kathy Reep

January 20, 2022

Background on the No Surprises Act

- In 2010, minimum payment standards were included in the Affordable Care Act ("Greater of Three" rule) as federal consumer protections related to *emergency services* to reduce potential amounts of balance billing for individuals enrolled in group health plans and group and individual health insurance coverage (not ERISA or FEBP). (Payments of greater than UCR, Medicare or median in-network)
- There were several years of proposed balance billing legislation before the No Surprises Act was passed in 2020.
- No Surprises Act added sections under ERISA and PHS Act and 5 USC 8902 (FEBP) expanding patient protections related to balance billing and choice of health care professional (PCP and pediatricians) and prohibiting a plan from requiring authorization for OB/GYN services.

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What does the Act do?

- *Surprise/Balance Billing.* With respect to emergency services, non-emergency services furnished by nonparticipating providers at certain participating health care facilities and air ambulance services furnished by nonparticipating providers of air ambulance services:
  - In the provider/facility context, the Act prohibits balance billing by out-of-network providers beyond application of the in-network cost-sharing amounts.
  - For health plans/payors, they must treat out of network services as if they were in-network when determining a patient's cost sharing.
- *Transparency Requirements.* All providers and facilities that schedule items or services for an uninsured (or self-pay) individual or receive a request for a good-faith estimate from an uninsured (or self-pay) individual must provide such individual with a good-faith estimate. No specific specialties, facility types or sites of service are exempt from this requirement.

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State Law

- Some states have balance billing laws.
- Such laws apply to individuals enrolled in individual and group health insurance coverage, as ERISA preempts state laws that regulates self-insured group health plans sponsored by private employers.
- States have been limited in their ability to address surprise bills that involve an out-of-state provider.
- The Federal No Surprises Act gap fills where states' laws do not cover – e.g., nonpar providers providing OON non-emergency services; IDR provisions.

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No Surprises Act – Who? What?

Who is subject to the law?
1. Group health plans and health insurers in individual and group markets (almost all private health plans offered by employers)
2. Medical Providers
3. Health Care Facilities • Including a hospital, hospital outpatient department, critical access hospital, ambulatory surgical center, or any other facility specified by HHS

What kinds of services does it apply to?
1. Emergency Services
2. Non-emergency services performed by out-of-network provider at certain in-network facilities
3. Out-of-network air ambulance services
Does not address ground ambulance services (comments were requested in the Interim Final Rule)
Does not apply to services obtained outside of facilities, e.g., physician offices

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Application – stated another way…

- Healthcare Entities
  - Facilities - hospitals, CAHs, freestanding EDs, ASCs
  - Providers that furnish services to patients in facilities
    - Does NOT apply to physicians not providing services at facilities
- Health insurance issuers and health plans
  - *Group coverage* - insured and self-insured plans, ERISA plans, non-federal government plans, church plans, traditional indemnity plans
  - *Individual coverage* - exchange and non-exchange plans, student health insurance coverage
  - DOES NOT include Medicare Advantage, managed Medicaid, health reimbursement arrangements, health-sharing ministries, short-term limited-duration insurance, retiree-only plans

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Timeline

- No Surprises Act was enacted December 27, 2020; effective January 1, 2022.
- First interim final regulation (IFR) was published on July 13, 2021, effective September 13, 2021 and applicable for plan years beginning January 1, 2022. The July IFR was Part I of the No Surprises Act regulations addressing the patient financial liability and payment methodology and notice and consent requirements.
- Second IFR was published earlier than expected on October 7, 2021, effective the same date, for plan years beginning January 1, 2022. The October IFR was Part II and addressed the Federal independent dispute resolution (IDR) process, patient protections through transparency and the patient-provider dispute resolution process and price comparison tools.
- Future rulemaking is contemplated on other provisions of the Act.

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Patient Financial Liability Protections

- In general, when a patient receives care from an OON (or nonpar) provider in an emergency situation or non-emergency situation in an in-network facility, the patient's financial liability is limited.
- From the payor perspective, patient's cost-sharing (e.g., copays, coinsurance and deductible) are limited to amounts that would apply if the services were furnished by a participating (in-network) provider.
- From a provider perspective, OON providers may not balance bill beyond the applicable in-network, cost-sharing amount.

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Surprise Billing Patient Notice

- Facilities *and* providers who furnish services in facilities must provide notice to patients of NSA protections
  - Post prominently at physical location (HIPAA Notice of Privacy Practices)
  - Post on website (link from homepage)
  - Give 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)
    - Provider furnishing services in facility may enter into written agreement with that facility to rely on facility's notice to insured patients
    - Otherwise, provider responsible for delivering notice to patients (in addition to facility's notice)

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Model Disclosure 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.

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

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].]

You may contact: (800) 985-3059
Visit: https://www.cms.gov/nosurprises/consumers.

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Emergency Services

- Emergency services furnished at OON facility (facility and providers)
- Emergency services furnished by OON providers at in-network facility
- 'Emergency services' includes necessary post-stabilization services (admission, observation) as determined by treating physician (i.e., whether patient can be moved to another facility using non-medical transport)
  - Apply "prudent layperson" standard to determine what constitutes emergency services
  - Plan cannot require prior authorization nor limit coverage for emergency services to certain diagnosis codes

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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 (no notice/consent option) – referred to as “ancillary services” in the regulations -
  - Emergency medicine, anesthesia, pathology, radiology, neonatology
  - Assistant surgeons, hospitalists, and intensivists
  - Diagnostic services (radiology and lab)
  - Items or services furnished in response to unforeseen, urgent medical needs
  - Items or services provided by OON provider if there are no in-network providers who can furnish the item or services at the facility
- Does NOT apply to other services furnished by OON provider BUT ONLY IF advance notice to and written consent from patient
  - Surgeons
  - Consulting physicians?

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Notice & Consent Exception

- For non-emergency services, the Act provides an exception to the surprise billing protections if the patient is provided with notice and consent to be financially liable for out-of-network financial obligations. As noted in the prior slide, this exception does not apply to certain "ancillary services."
- NOTE – These notice & consent requirements assume that such a process is allowed by state law.

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Advance Notice/Consent

- Use HHS Standard Notice and Consent document
  - Available at https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780
- 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 prior to service
- Plan must be notified and receive copy of signed consent

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Notice & Consent Exception

- Notice & consent requirements –
  - Nonpar provider (or participating health facility on behalf of an OON provider): (cont.)
    - Provides a *copy of the signed written notice and consent to the patient in-person or through mail or email, as selected by the patient*.
    - Provide the individual with the *choice to receive the written notice & consent document in any of the 15 most common languages in the State* in which the applicable facility is located (or the 15 most common languages in a geographic region that reasonably reflects the geographic region served by the facility).

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Notice & Consent Exception

- Notice must –
  1. State that the *health care provider is a nonparticipating provider* with respect to the health plan or coverage;
  2. Include the good faith estimated amount that such nonpar provider may charge the patient including *notification that the provision of the estimate does not constitute a contract* with respect to the charges estimated;
  3. Provide a *statement that prior authorization or other care management limitations may be required in advance* of receiving such items or services at the facility;
  4. Clearly state that *consent to receive such items/services from such nonpar provider is optional* and that the *patient may instead seek care from an available participating provider* and that *in such cases the cost-sharing responsibility of the patient would not exceed the responsibility that would apply with respect to such an item/service that is furnished by a participating provider*, as applicable with respect to such plan.

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Notice - Good Faith Estimates – Insured Individuals (2799B-2)

- Nonpar providers who are providing notice are required to provide a *good faith estimate* for only the items and services that they would be furnishing and are not required to provide a good faith estimate for items or services furnished by other providers at the facility.
- However, if a nonpar provider has not satisfied the notice and comment criteria, balance billing and cost-sharing protections will apply to the individual with respect to items and services furnished by that nonpar provider, even if a different nonpar provider has satisfied the notice and consent criteria with respect to the same visit.

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Notice - Good Faith Estimates – Insured Individuals (2799B-2) (*cont.*)

- Nonpar emergency facilities must include in the written notice the *good faith estimated amount that the patient may be charged for items/service* furnished by the nonpar emergency facility/nonpar provider with respect to the visit at such facility (*including any items/service that is reasonably expected to be furnished by the nonpar emergency facility or nonpar provider in conjunction with such items/services*).
- HHS is aware that nonpar providers and nonpar emergency facilities are generally unable to calculate what an individual's final out-of-pocket costs (inclusive of balance bills) will be for items/services partially or wholly covered by the individual's plan. Therefore, the *good faith estimated amount should reflect the amount the provider/facility expects to charge for furnishing such items or services, even if the provider/facility intends to bill the plan directly*.

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Notice & Consent Exception

- Consent must –
  1. Document in a form specified by the Secretary in consultation with the Secretary of Labor and provided in accordance with such guidance, that must be signed by the patient before such items/services are furnished and that –
     a. *Acknowledges* in a clear and understandable language that the patient has been –
        (i) provided with the written notice in the form selected by the patient;
        (ii) informed that the patient of such charge by the patient might not accrue toward meeting any limitation that the plan places on cost sharing, including an explanation that such payment might not apply to an in-network deducible or out-of-pocket maximum applied under the plan.

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Notice & Consent Exception

- Consent must – (cont.)
  1. Document in a form specified by the Secretary in consultation with the Secretary of Labor and provided in accordance with such guidance…that – (cont.)
     - *b. States that by signing the consent, the individual agrees to be treated by the nonpar provider and understand the individual may be balance billed and subject to cost-sharing requirements that apply to services furnished by the nonpar provider*.
     - *c. Documents the time and state on which the patient received the written notice and the time and date on which the patient signed the consent to be furnished such items/services by such nonpar provider*.

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Notice & Consent Exception

- Consent must – (cont.)
  2. Be provided voluntarily, meaning the individual is able to consent freely, without undue influence, fraud or duress;
  3. Be obtained in accordance with, and in the form and manner specified in, guidance issued by HHS; and
  4. Not be revoked, in writing, by the patient prior to the receipt of items/services to which the consent applies.

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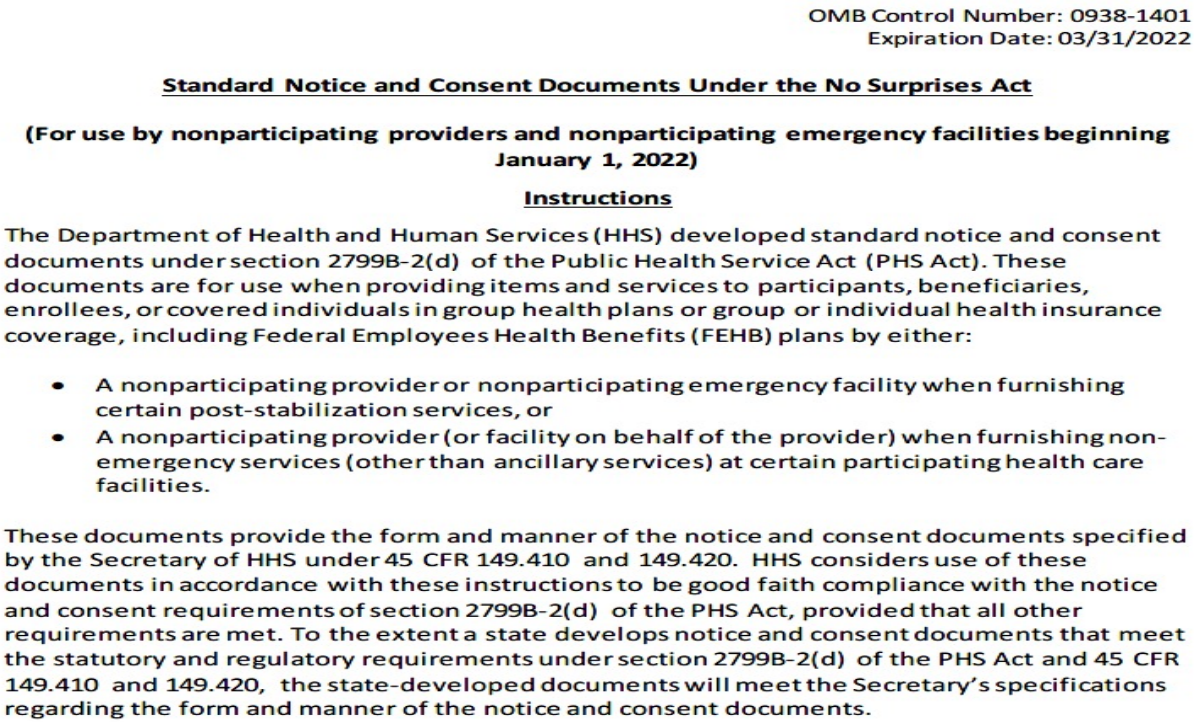
HHS Notice & Consent Form

- The HHS standard notice & consent forms for nonpar providers and emergency facilities and other guidance documents can be found at https://www.cms.gov/nosurprises/Policies-and-Resources/Overview-of-rules-fact-sheets.



OMB Control Number: 0938-1401
Expiration Date: 03/31/2022

Standard Notice and Consent Documents Under the No Surprises Act

(For use by nonparticipating providers and nonparticipating emergency facilities beginning January 1, 2022)

Instructions

The Department of Health and Human Services (HHS) developed standard notice and consent documents under section 2799B-2(d) of the Public Health Service Act (PHS Act). These documents are for use when providing items and services to participants, beneficiaries, enrollees, or covered individuals in group health plans or group or individual health insurance coverage, including Federal Employees Health Benefits (FEHB) plans by either:

- A nonparticipating provider or nonparticipating emergency facility when furnishing certain post-stabilization services, or
- A nonparticipating provider (or facility on behalf of the provider) when furnishing non-emergency services (other than ancillary services) at certain participating health care facilities.

These documents provide the form and manner of the notice and consent documents specified by the Secretary of HHS under 45 CFR 149.410 and 149.420. HHS considers use of these documents in accordance with these instructions to be good faith compliance with the notice and consent requirements of section 2799B-2(d) of the PHS Act, provided that all other requirements are met. To the extent a state develops notice and consent documents that meet the statutory and regulatory requirements under section 2799B-2(d) of the PHS Act and 45 CFR 149.410 and 149.420, the state-developed documents will meet the Secretary's specifications regarding the form and manner of the notice and consent documents.

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Patient Cost-Sharing Liability Calculation

- Patient's cost-sharing liability (the "recognized amount") is determined by:
  1. An applicable All-Payer Model Agreement (e.g., Maryland);
  2. An amount defined under state law; or
  3. Lesser of the billed amount or the qualifying payment amount (QPA).
- QPA generally is the median contracted rate recognized by the payer as provided in 2019 for the same or a similar item or service, by a similar provider or facility type in the same geographic region.
  - Will also be considered by arbiters in determining payment during disputes.

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Qualifying Payment Amount – General

- Same or similar item or service: A healthcare item or service billed under the same service code, or a comparable code under a different procedural code system. Service code:
  - Current Procedural Terminology (CPT);
  - Healthcare Common Procedure Coding System (HCPCS); or
  - Diagnosis-Related Group (DRG).
- Geographic regions: Generally, includes one region for each metropolitan statistical area (MSA) in a state and a separate region consisting of all other portions of the state.

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Qualifying Payment Amount Calculation

- Median rate: The same or similar contracted rates for all plans in the same insurance market will be arranged from least to greatest.
  - Contracted rate: The total amount the payer has contractually agreed to pay for covered services, whether directly or indirectly, including through a third-party administrator or pharmacy benefit manager.
- Indexed: Grounded in 2019, increased by the Consumer Price Index for All Urban Areas (CPI-U).

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Qualifying Payment Amount – "Sufficient" Information

- For 2019, a payer is considered to have sufficient information if it had at least three contracted rates on January 31, 2019, to calculate the median rate.
- For 2022 and beyond, a payer will be considered to have sufficient information if:
  - Payer has at least three contracted rates on January 31 of the immediately preceding year; and
  - Contracted rates account for at least 25% of the total number of claims paid for the specific item or service for that year with respect to all plans offered by the payer in the same insurance market.
- When a payer does not have "sufficient information" to calculate a median, the payer must use an eligible database (all-payer claims database or a third-party database that meets certain requirements laid out in §149.410).

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Qualifying Payment Amount – Disclosures to Providers

- Payers have to make certain disclosures to providers regarding QPA calculations:
  - QPA for each item or service involved;
  - Statement certifying that each QPA was determined in compliance with the regulations (§149.140);
  - Statement that the provider may initiate the 30-day "open negotiation period" for purposes of determining the amount of total payment and if that does not result in a determination, the provider/facility may initiate the IDR process within 4 days after the open negotiation period; and
  - Contact information (telephone & address and appropriate person/office) to initiate open negotiations.

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Qualifying Payment Amount – Disclosures to Providers

- Upon request, providers can receive additional information from payors/plans regarding:
  - Whether the QPA was determined using underlying fee schedule rates or a derived amount;
  - Whether a database was used; and
  - Whether contracted rates include risk-sharing, bonus, penalty, or other incentive-based payments that were excluded from calculations.

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Payment Determinations

- Work from presumption that QPA is appropriate payment rate
- Provider and/or plan may submit evidence to rebut presumption -
  1. Provider's training, experience, and quality and outcomes measures
  2. Provider's or plans' market share in relevant geographic region
  3. Patient acuity or complexity of furnishing the item/service
  4. Demonstration of good faith efforts (or lack thereof) made by provider or plan to enter into network agreements with each other, and, if applicable, parties' contracted rates during previous 4 plan years
  5. Additional relevant and credible information BUT NOT usual & customary charges or Medicare/Medicaid reimbursement rates

NOTE: These 5 bullets are part of what is statutorily expected for calculation of QPA but is not present in the initial analysis of QPA calculation (median rate is the default consideration), which has caused various parties to litigate.

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Congressional Action/Legal Action – Similar Complaints

- On October 29, 2021, the Texas Medical Association filed a lawsuit for declaratory and injunctive relief regarding the arbitrator in the IDR process to presume the QPA, set by health insurance companies for patient cost-sharing purposes, is the appropriate out-of-network rate.
- On November 5, 2021, 152 members of Congress wrote a letter seeking a revision of the regulation to specify that the IDR entity should not default to the median in-network rate and should instead consider all the factors outlined in the statute without disproportionately weighting one factor. (QPA focused, rather than focus on all factors).
- On December 9, AMA and AHA filed suit against HHS claiming QPA presumption is contrary to Congressional intent. They seek an order vacating the requirement that IDR entities employ a presumption in favor of the QPA.
- On December 22, 2021, the American Society of Anesthesiologists and American College of Emergency Physicians and American College of Radiology filed suit against HHS, DOL, Department of Treasury and Office of Personnel Management (and their respective Secretaries) for declaratory and injunctive relief to halt specific provisions of the NSA's regulations. Specifically, as with the other case, they note that the October IFR eliminates the IDR entity's statutory authority to weigh multiple factors impacting the rate of payment and instead require the IDR entity to give "presumptive weight" to only one factor, the QPA, which is skewed in favor of insurers.

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Transparency Requirements - Good Faith Estimates (PHS Act 2799B-6)

- Under the statute (PHS Act 2799B-6), "[e]ach health care provider and health care facility shall, beginning January 1, 2022, in the case of an individual who schedules an item or service to be furnished to such individual by such provider or facility *at least 3 business days before the date* such item or service is to be so furnished, *not later than 1 business day after the date of such scheduling* (or in the case of such an item or service *scheduled at least 10 business days before the date such item or service is to be so furnished (or if requested by the individual), not later than 3 business days after the date of such scheduling or request*)

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Transparency GFEs (PHS Act 2799B-6)

1. Inquire if such individual is enrolled in a group health plan, group or individual health insurance covered offered by a health insurer, or a Federal health care program (and if is so enrolled in such plan or coverage, is seeking to have a claim for such item or service submitted to such plan or coverage); and

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Transparency GFEs (PHS Act 2799B-6)

2. Provide a notification (in clear and understandable language) of the good faith estimate of the expected charges for furnishing such item or service (including any item or service that is reasonably expected to be provided in conjunction with such scheduled item or service and such an item or service reasonably expected to be so provided by another health care provider or health care facility), with the expected billing and diagnostic codes for any such item or service, to –

   A. in the case the individual is enrolled in such a plan or such coverage (and is seeking to have a claim for such item or service submitted to such plan or coverage), such plan or issuer of such coverage; and [NOTE: REGS RELATED TO THIS PROVISION HAVE BEEN DELAYED.]

   B. in the case the individual is not described in subparagraph (a) and not enrolled in a Federal health care program, the individual.

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Transparency GFEs – Uninsured or Self Pay Individuals (Part II Regs)

- Helpful context for the location/meaning of these rules related to good faith estimates:
  - 45 CFR part 149 is entitled “Surprise Billing and Transparency Requirements.”
    - Subpart G is entitled “Protection of Uninsured or Self-Pay Individuals.”
      - Section 149.610 is entitled “Requirements for provision of good-faith estimates of expected charges for uninsured (or self-pay) individuals.”

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Transparency GFEs - Definitions

- Section 149.610 includes its own definitions section, which includes a broader definition of "facility" than the other surprise billing regulatory sections.
  - "Facility" is defined as "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 the licensing of such an institution, that is licensed as such an institution pursuant to such law or is approved by the agency of such State or locality responsible for licensing such institution as meeting the standards established for such licensing."
- Discuss *meaning of "uninsured (or self-pay)."*

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Transparency GFEs – Determine If Self-Pay Patient

- 'Self-pay' includes -
  - No insurance coverage
  - Has insurance, but does not intend to submit claim for item/service
  - Has insurance, but item/service is not covered
  - Has insurance, but no coverage for OON items/services (vs. higher out-of-pocket)

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Transparency GFEs – Definitions

- *Convening provider or convening facility* means "the provider or facility who receives the initial request for a good faith estimate from an uninsured (or self-pay) individual and who is or, in the case of a request, would be responsible for scheduling the primary item or service.
- *Co-provider or co-facility* means "a provider or facility other than a convening provider or convening facility that furnishes items or services that are customarily provided in conjunction with a primary item or service."
- *Primary item or service* means "the item or service to be furnished by the convening provider or convening facility that is the initial reason for the visit."

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Transparency GFEs

- The provider/facility must provide a good faith estimate of expected charges for items and services to an uninsured or self-pay individual.
  - NOTE: The regulations only address the good faith estimate notifications for uninsured (or self-pay) individuals, not the requirements for good faith estimates to individuals' plans or issuers.
- The good faith estimate must include expected charges for the items or services that are reasonably expected to be provided together with the primary item or service, including items or services that may be provided by other providers and facilities.

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Transparency GFEs - Process

- Upon the request for a GFE from an uninsured (or self-pay) individual or upon scheduling a primary item or service to be furnished for such an individual, the convening provider/facility must contact, no later than 1 business day of scheduling such request, all co-providers or co-facilities who are reasonably expected to provide items or services in conjunction with and in support of the primary item or service and request that the co-providers or co-facilities submit GFE information to the convening provider/facility; the request must include the date that the g.f. estimate information must be received by the convening provider/facility. (45 CFR 149.610(b)(1)(v).)

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Transparency GFEs - Process

- Co-providers and co-facilities must submit GFE information upon the request of the convening facility/provider. The co-provider/co-facility must provide, and the convening facility must receive, the GFE information no later than 1 business day after the co-provider or co-facility receives the request from the convening provider/convening facility. (45 CFR 149.610(b)(2)(i).)
- Look to 45 CFR 149.610(c) (content requirements of a GFE issued to an uninsured (or self-pay) individual and 149.610(d) (content requirement for GFE information submitted by co-providers or facilities to convening providers or convening facilities).

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Transparency GFE - EXAMPLE

- For example, for a surgery, the good faith estimate might include the cost of the surgery, any labs or tests, and the anesthesia that might be used during the operation.
- If an item or service is something that is *not* scheduled separately from the surgery itself, it will generally *be* included in the good faith estimate.
- Other items or services related to the surgery that might be scheduled separately, like pre-surgery appointments or physical therapy in the weeks after the surgery, will not be included in the good faith estimate.

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Transparency GFEs – Enforcement Discretion Related to Co-Providers/Co-Facilities

- HHS understands that it will take time for providers and facilities to develop systems and processes for providing and receiving the required information from others.
- As such, good faith estimates provided to uninsured (or self-pay) individuals from January 1, 2022 through December 31, 2022, HHS will exercise its enforcement discretion in situations where a good faith estimate provided to an uninsured (or self-pay) individual does not include expected charges from other providers and facilities that are involved in the individual's care.

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Written GFE

[NAME OF CONVENING PROVIDER OR CONVENING FACILITY]

Good Faith Estimate for Health Care Items and Services

Patient		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: _____/_____/_____		
Patient Identification Number:		
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box		Apartment
City	State	ZIP Code
Phone		
Email Address		
Patient's Contact Preference: [ ] By mail	[ ] By email	
Patient Diagnosis		
Primary Service or Item Requested/Scheduled		
Patient Primary Diagnosis	Primary Diagnosis Code	
Patient Secondary Diagnosis	Secondary Diagnosis Code	

If scheduled, list the date(s) the Primary Service or Item will be provided:

[ ] Check this box if this service or item is not yet scheduled

Date of Good Faith Estimate: _____/_____/_____

Provider Name	Estimated Total Cost
Provider Name	Estimated Total Cost
Provider Name	Estimated Total Cost
Total Estimated Cost: $	

The following is a detailed list of expected charges for [LIST PRIMARY SERVICE OR ITEM], scheduled for [LIST DATE OF SERVICE, IF SCHEDULED]. [Include if items or services are reoccurring, "The estimated costs are valid for 12 months from the date of the Good Faith Estimate."]

Template and instructions available at https://www.cms.gov/files/zip/cms-10791.zip

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Written GFE - Details

- Include applicable diagnosis and expected service codes, with expected charges listed for each item or service
  - Inclusive of applicable discounts
  - Provide range of charges if specific level/type of service unknown
- Timing
  - If requested prior to scheduling – not later than 3 business days following request
  - If scheduled at least 10 but less than 4 business days in advance – not later than 3 business days after date of scheduling
  - If scheduled at least 3 business days in advance – not later than 1 business day after date of scheduling
  - Special rules for recurring services

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Patient/Provider Disputes

- Patient/Provider Disputes –
  - In a situation where an uninsured (or self-pay) individual receives a good faith estimate and then is billed for an amount *substantially in excess* of the good faith estimate, HHS establishes in the Part I Regs a patient-provider dispute resolution process to determine a payment amount.
  - The Part I Regs provide eligibility details for this dispute resolution process, a definition of "substantially in excess," and further information on the selection process for select dispute resolution (SDR) entities that will resolve disputes through the patient-provider dispute resolution process.

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Patient/Provider Disputes

- Patient/Provider Disputes –
  - HHS has defined "substantially in excess" as the billed charges being at least $400 more than the good faith estimate for any provider or facility listed on the good faith estimate.
  - The patient-provider dispute resolution process has timelines for documentation submission and payment determination, and participating individuals will be charged an administrative fee. For 2022, the fee will be set at $25 and updated through sub-regulatory guidance.

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Independent Dispute Resolution Process

- Part II of the No Surprises Act regulations addressed the IDR process.
- Before initiating the IDR process, disputing parties must initiate a 30-day “open negotiation” period to determine a payment rate.
- In case of a failed open negotiation period, either party may initiate the federal IDR process.
- The parties may jointly select a certified IDR entity to resolve the dispute.
- The certified IDR entity and personnel of the entity assigned to the case must attest that they have no COI with either party.

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IDR Process (*cont.*)

- If the parties cannot jointly select a certified IDR entity or if the selected IDR entity has a conflict, the Departments will select a certified IDR entity.
  - Entities may apply through cms.gov to be a certified IDR entity - https://www.cms.gov/nosurprises/Help-resolve-payment-disputes.
- After the certified IDR entity is selected, the parties will submit their offers for payment along with supporting documentation.
- The certified IDR entity will then issue a binding determination selecting one of the parties' offers as the OON payment amount.
- Both parties must pay an administrative fee ($50 each for 2022), and the non-prevailing party is responsible for the certified IDR entity fee for the use of this process.

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IDR Process (*cont.*)

- When making a payment determination, the certified IDR entity must begin with the presumption that the QPA is the appropriate OON amount. [*Discuss this concept and Congressional members' reaction*.]
- If a party submits additional information that is allowed under the statute, then the certified IDR entity must consider this information if it is credible.
- For the certified IDR entity to deviate from the offer closest to the QPA, any information submitted must clearly demonstrate that the value of the item/service is materially different from the QPA.

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By January 1 – Provider-Related Requirements

- For Surprise Billing -
  - Compliance with notice requirements
    - Written agreement with facilities at which provide services
  - Process to identify services subject to Surprise Billing
    - OON emergency services
    - OON non-emergency services furnished at in-network facility
  - Remember, Surprise Billing does not apply to physicians not providing services at facilities (but Good Faith Estimates does)
- For Transparency/Good Faith Estimates -
  - Process to identify self-pay patients (inquiries and scheduling)
  - Compliance with notice requirements (website, physical location, inquiries and scheduling)
  - Assigned responsibility for completing and sending GFEs in timely manner

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Dates for Plan-related – 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

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Thank you.

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