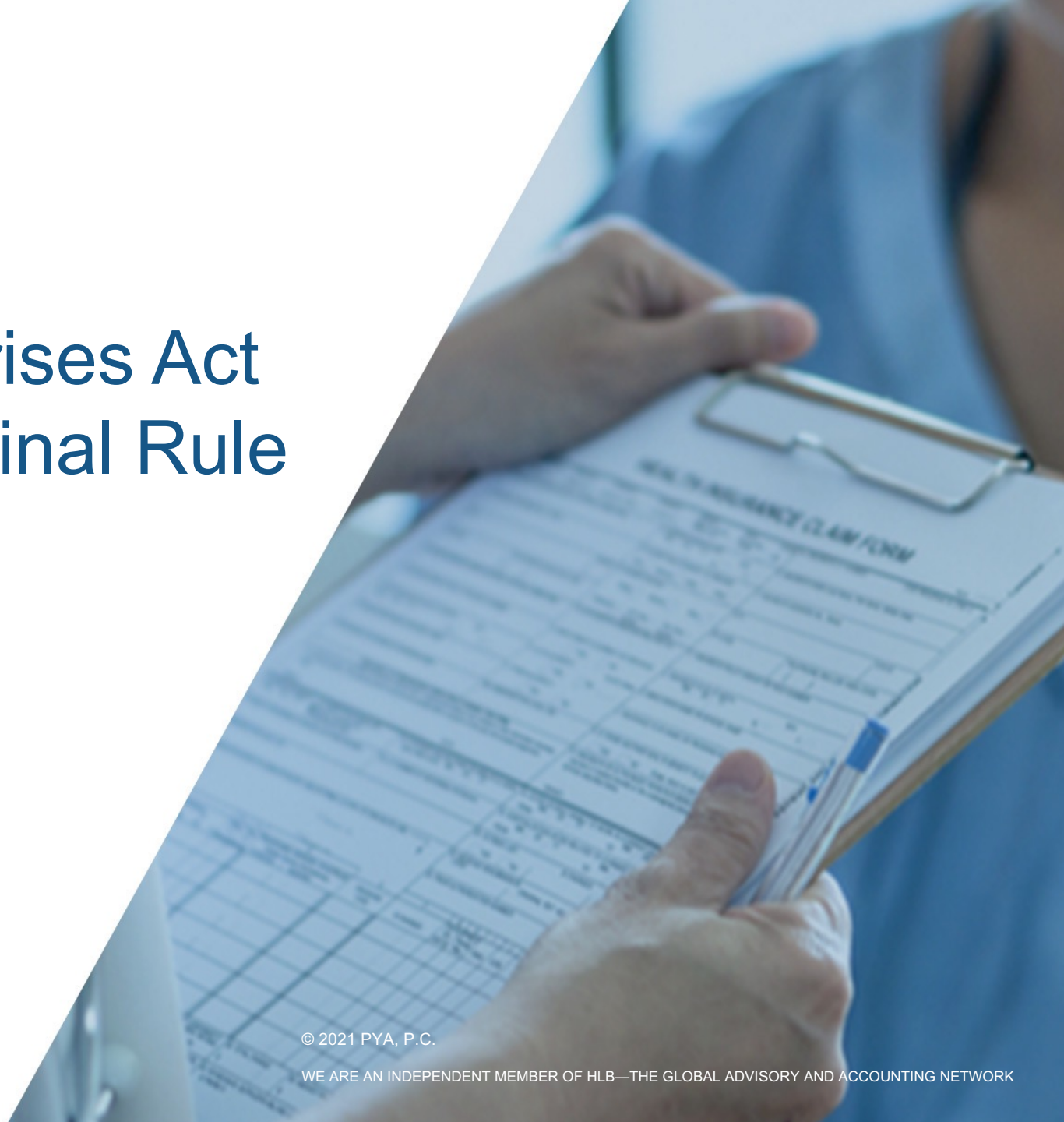
No Surprises Act Interim Final Rule

July 14, 2021



HEALTHCARE REGULATORY ROUND-UP

No Surprises Act Interim Final Rule

July 14, 2021

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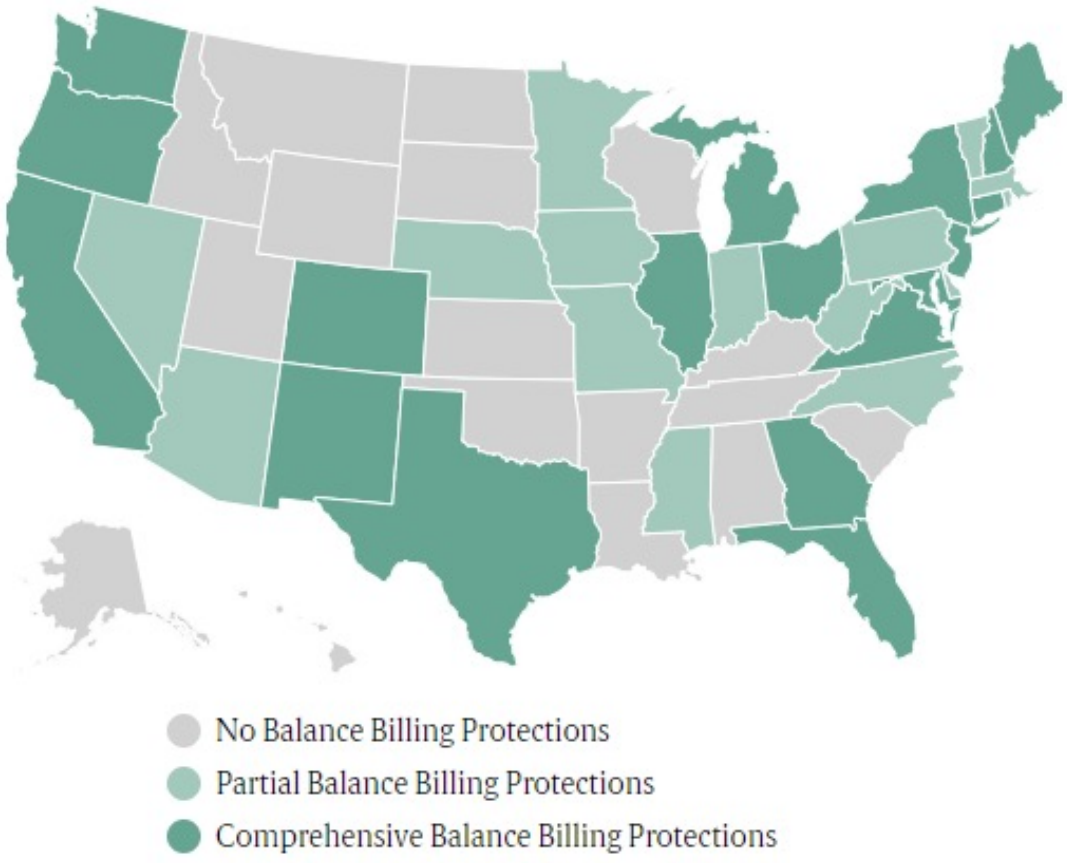
PYA

State Balance Billing Protections



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

No Surprises Act

When?

- December 2020 Consolidated Appropriations Act
- Effective January 2022 (except FEHBA plans)

Who?

- Providers
  - Facilities (hospitals, CAHs, freestanding EDs, ASCs)
  - Providers furnishing services at a facility (not outside)
  - Air ambulance (not ground, at least for now)
- Health insurance issuers offering group or individual health insurance coverage
  - 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)

Surprise Billing for Emergency Services

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

Surprise Billing for Non-Emergency Services

- Ancillary services furnished by OON provider at in-network facility with consent, except-
  - 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.
  - All other services furnished by OON provider at in-network facility absent prior notice and written consent

Note: law does not apply to non-emergency services furnished at OON facility.

Advance Notice/Consent

- Capacity to consent must be considered
- Must be provided at least 72 hours before date of service if scheduled in advance
  - Three hours in advance of service for same day appointments
- Must comply with requirements related to plain language, accessibility, and language access
- Must include the following -
  - Explain that patient would be billed at higher out-of-network amount
  - Information about prior authorization or other care management limitations
  - Expected good faith estimate of charges
  - Patient cost-sharing must be based on in-network rates
- Payer must be notified and receive copy of the signed consent

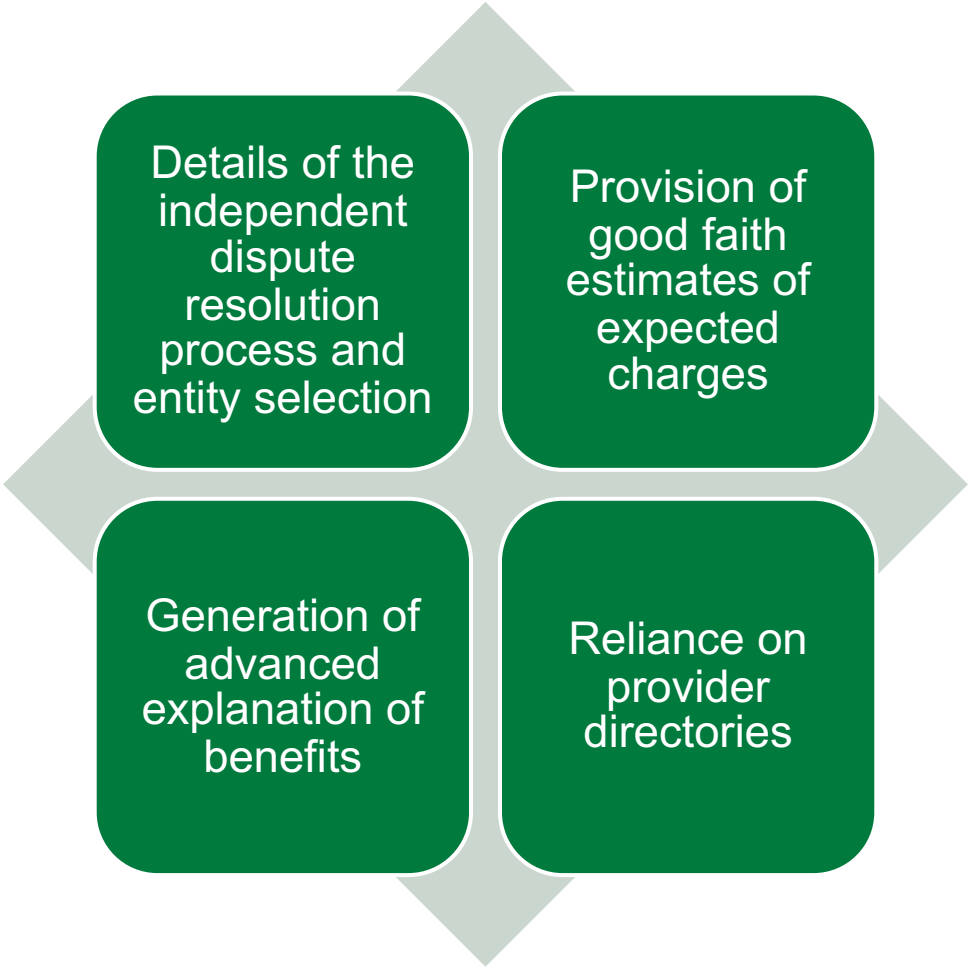
Consumer Protections

- Cost sharing limited to in-network cost-sharing amount
  - State law or All-Payer Model Agreement
  - Qualifying payment amount (QPA)
  - Plan's 2019 median in-network rate paid for specific service indexed for subsequent years, with special rules for new plans and services with no established rates in 2019
- Providers must inform patients of cost-sharing protections
  - Include information on website (model notice available)
  - Provide one page notice (postal or electronic, as patient specifies) to insured patients
- Consumer complaints process and appeals rights

Out-of-Network Provider Payments

- OON provider “shall not bill, and shall not hold patients liable” for more than in-network cost sharing amount
- If state law or All-Payer Model Agreement governs, provider and issuer must adhere to those requirements
- If no such requirements, plan/issuer has 30 days to send initial payment (or notice of denial of payment based on non-coverage)
  - No minimum standard for initial payment (such as QPA)
  - Provider may initiate 30-day negotiation period
  - Provider may then force independent dispute resolution (IDR) process, requiring each side to submit last best offer
  - IDR entity selects between the two offers based on specified factors (not including provider charges nor Medicare/Medicaid rates), with loser paying administrative costs

Yet To Come


Details of the independent dispute resolution process and entity selection
Provision of good faith estimates of expected charges
Generation of advanced explanation of benefits
Reliance on provider directories

Comments/Questions Asked

Comments due September 7

Issues to consider –

- Apply to urgent care centers?
- Minimum standard for initial payment?
- Is a new HIPAA transaction standard needed or is there another way to communicate required information between payers and providers?
  - Need to send estimate of charges to payer in advance of service
  - Need to communicate that provider has signed consent to balance bill
    - Also need to send signed consent to payer

So Now What?

- State-regulated plans
- Compliance with notice requirements
- Revenue cycle
- Managed care negotiations
- Hospital-based physicians

July 28 – 2022 MPFS Proposed Rule

1. Conversion factor reduction (and resulting payment cuts)
2. Expanded list of telehealth services
3. New coverage for tele-behavioral health services
4. Evaluation & Management Visits changes
5. Payment for physician assistant services
6. Continued implementation of appropriate use criteria
7. Changes to Medicare Diabetes Prevention Program
8. New coverage for remote therapeutic monitoring (RTM) services
9. Increased reimbursement for care management services
10. Launch of MIPS Value Pathways and other Quality Payment Program updates

Questions?

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