No More Surprises:
No Surprises Act and Good Faith Estimates

Prepared for **Montana Hospital Association**

April 7, 2022

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Agenda

1. Introduction
2. No Surprises Act
3. Surprise Billing
4. Good Faith Estimates for Self-Pay Patients
5. Questions

Introduction

Kathy Reep
MBA
Senior Manager – PYA, P.C.

Kathy has more than three decades of leadership experience in the healthcare industry. Her hospital setting expertise is in compliance, financial advisory, reimbursement, and managed care. Kathy has helped with Medicare, Medicaid, workers' compensation, reimbursement, and many other complex programs and issues. She is a thought leader and provider educator, helping hospitals navigate regulations and the impact of change.

Prior to joining PYA, Kathy served as Vice President of Financial Services with the Florida Hospital Association. She also held longtime hospital positions, as well as roles working in patients' business, internal audit, systems management, diagnosis-related group management, and as a reimbursement director.

Kathy is a recipient of the 2019 Bob Broadway Distinguished Service Award from the Florida Chapter of HFMA.

No Surprises Act

Effective January 1, 2022

Implementing regulations published in July and October 2021

No Surprises Act

- **Two Purposes:**

Prohibit “surprise” billing and replace with new payment methodology

- Patients through no fault of their own receive services from out-of-network (OON) provider

Provide self-pay patients with good faith estimates of charges

Surprise Billing

Application

Healthcare Entities

- **Facilities**
  Hospitals, CAHs, freestanding EDs, ASCs
- **Air ambulance** (not ground)
- **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

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)

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].]

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

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

Emergency Services

Emergency services furnished at out-of-network (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

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*)

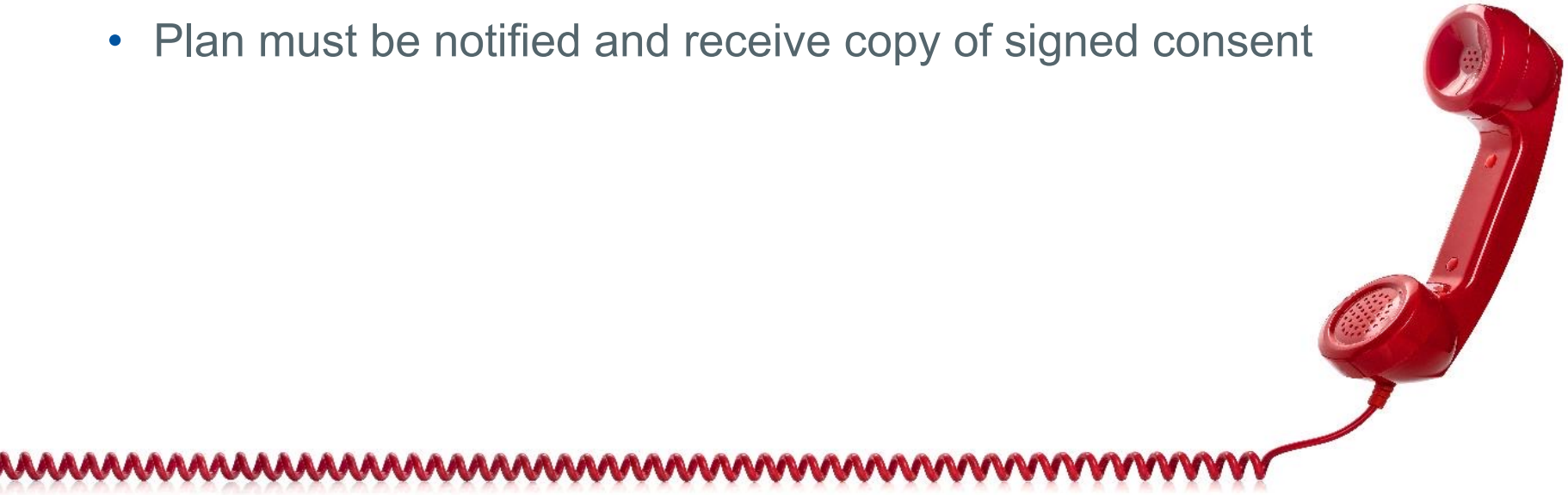
- Emergency medicine, anesthesia, pathology, radiology, neonatology
- Assistant surgeons, hospitalists, and intensivists
- Diagnostic services (radiology and lab)
- Items or services furnished in response to unforeseen, urgent medical needs
- Items or services provided by OON provider if there are no 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?

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



Patient Charges

- Cannot charge patient more than in-network cost-sharing amount
- Calculated based on Qualifying Payment Amount (QPA)
  - Plan's or issuer's median contracted rate for a specific service in the same geographic region within the same insurance market *as of January 31, 2019*
    - Rate adjusted by CPI-U
    - For 2022, CPI-U = 1.0648523983
    - **Example:** Median rate as of January 31, 2019 = $12,480
      Adjusted by CPI-U = $13,289.36 (round to nearest dollar = $13,289)

Dispute Resolution – Federal

Step in the Process	Must Be Completed By
1. Payer sends provider initial payment or notice of denial of payment (with QPA)	**30 business days** *Starting on day payer receives all relevant data*
2. Provider initiates 30-business-day open negotiation period	**30 business days** *Starting on day of initial payment or notice of denial of payment*
3. 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*
4. Mutual agreement on certified IDR entity selection; each party pays $50 administrative fee	**3 business days** *After IDR initiation date*
5. Departments select certified IDR entity in case of no conflict-free selection by parties	**6 business days** *After IDR initiation date*
6. Parties submit payment offers and additional information to certified IDR entity (with administrative fee)	**10 business days** *After date of certified IDR entity selection*
7. Payment determination made; loser pays IDR entity fee	**30 business days** *After date of certified IDR entity selection*
8. Payment submitted to the applicable party	**30 business days** *After payment determination*

Qualifying Payment Amount

- **No payment benchmark established in legislation**
  - Regulation issued in October 2021 called for QPA as initial payment to OON providers
  - Numerous litigation pursued: Texas Medical Association, AHA, AMA, etc.
    - Decision February 23 in Texas Medical Association case found that interim final rule related to QPA violated Administrative Procedures Act
      - Substantially rewrote the No Surprises Act in creating a presumptive out-of-network rate
      - Court also found that issuing Departments were not justified in skipping regular notice and comment rulemaking

Qualifying Payment Amount

- Court decision does not impact other portions of the Act or implementing regulation.
  - **Actions to date:**
    1. Withdrawal of guidance documents that were based on, or referred to, the invalidated portions of the Interim Final Rule.
    2. Once guidance is re-posted, expect training on the revised IDR process.
    3. After posting and training, the IDR Portal will be opened for submissions.
       - If open negotiation period has expired, entities have 15 days to initiate the IDR process.

Payment Determinations

Work from presumption that QPA is appropriate payment rate

Provider and/or plan may submit evidence to rebut presumption

- Provider's training, experience, and quality and outcomes measures
- Provider's or plan's market share in relevant geographic region
- Patient acuity or complexity of furnishing the item/service
- 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
- Additional relevant and credible information BUT NOT usual and customary charges or Medicare/Medicaid reimbursement rates

Good Faith Estimates for Self-Pay Patients

Application

Convening Provider

- Provider responsible for scheduling primary item or service
- Includes office visits, diagnostic testing, procedures, etc.
- **Beginning in 2023**, items and services to be billed by 'co-provider' (i.e., furnishes care in conjunction with the primary item or services)
  - Convening provider must request and co-provider must furnish within 1 business day information required to complete GFE

GFE Must Include

- Items and services to be billed by convening provider
  - Hospital includes professional fees for which it bills
- **Numerous disclaimers:**
  - Additional services may be recommended
  - Information provided is an estimate only of items/services reasonably expected to be furnished at the time the GFE is issued

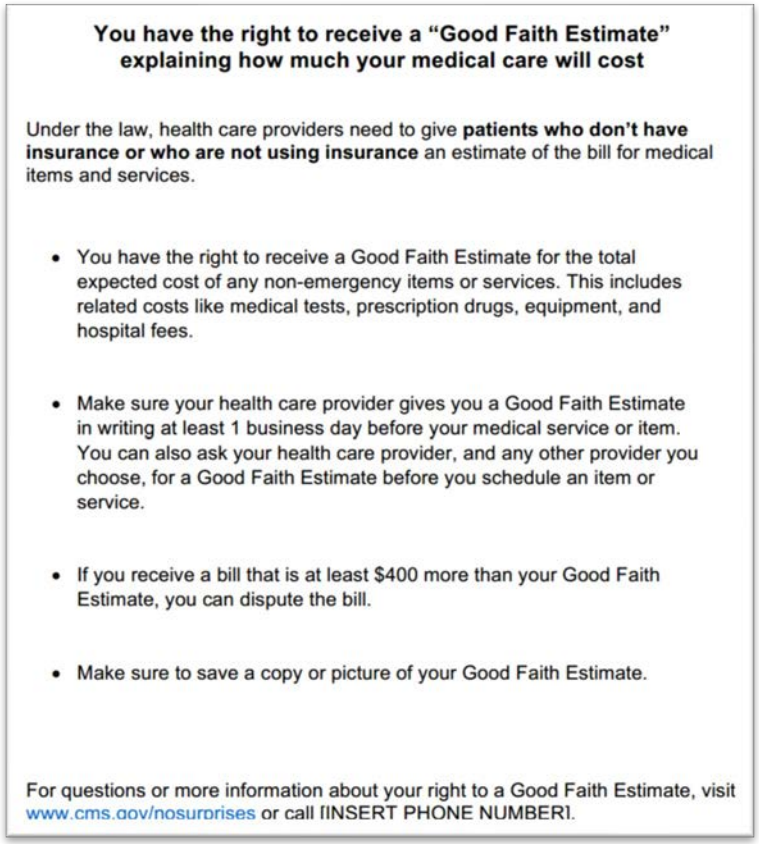
Step 1: Determine If Self-Pay Patient

- "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)

Step 2: Provide Required Notice

- Verbally inform all self-pay patients of GFE availability when scheduling or when questions regarding cost arise
- Post GFE notice on website
- Post GFE notice at physical location
  - Next to **Notice of Privacy Practices** + **Surprise Billing Notice**

Model notice available at
https://www.cms.gov/files/zip/cms-10791.zip



You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost

Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call [INSERT PHONE NUMBER].

Step 3: Provide 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

Step 3: Provide Written GFE

ExpirationDate [MM/DD/YYYY]

[Provider/Facility 1] Estimate

Provider/Facility Name		Provider/Facility Type
Street Address		
City	State	ZIP Code
Contact Person	Phone	Email
National Provider Identifier		Taxpayer Identification Number

Details of Services and Items for [Provider/Facility 1]

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service Code Type: Service Code Number]		

Total Expected Charges from [Provider/Facility 1] $
Additional Health Care Provider/Facility Notes

Step 3: Provide Written GFE

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 – 3 days following request
- If scheduled at least 10 but less than 4 business days in advance – 3 days following scheduling
- If scheduled at least 3 business days in advance – 1 day following scheduling
- Special rules for recurring services

Patient-Provider Dispute Resolution

Self-pay patient billed at least $400 more than amount listed on GFE, may initiate process within 120 days of receiving bill

- Administrative fee of $25 (adjusted annually)

HHS submits matter to selected dispute resolution entity

- SDR notifies provider, which then has 10 days to respond with credible evidence supporting higher billed charges
- SDR makes decision within 30 days following receipt of information from provider
  - If no credible evidence, provider bound by GFE
  - 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

Have You…?

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 **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

Questions?

Thank you!

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