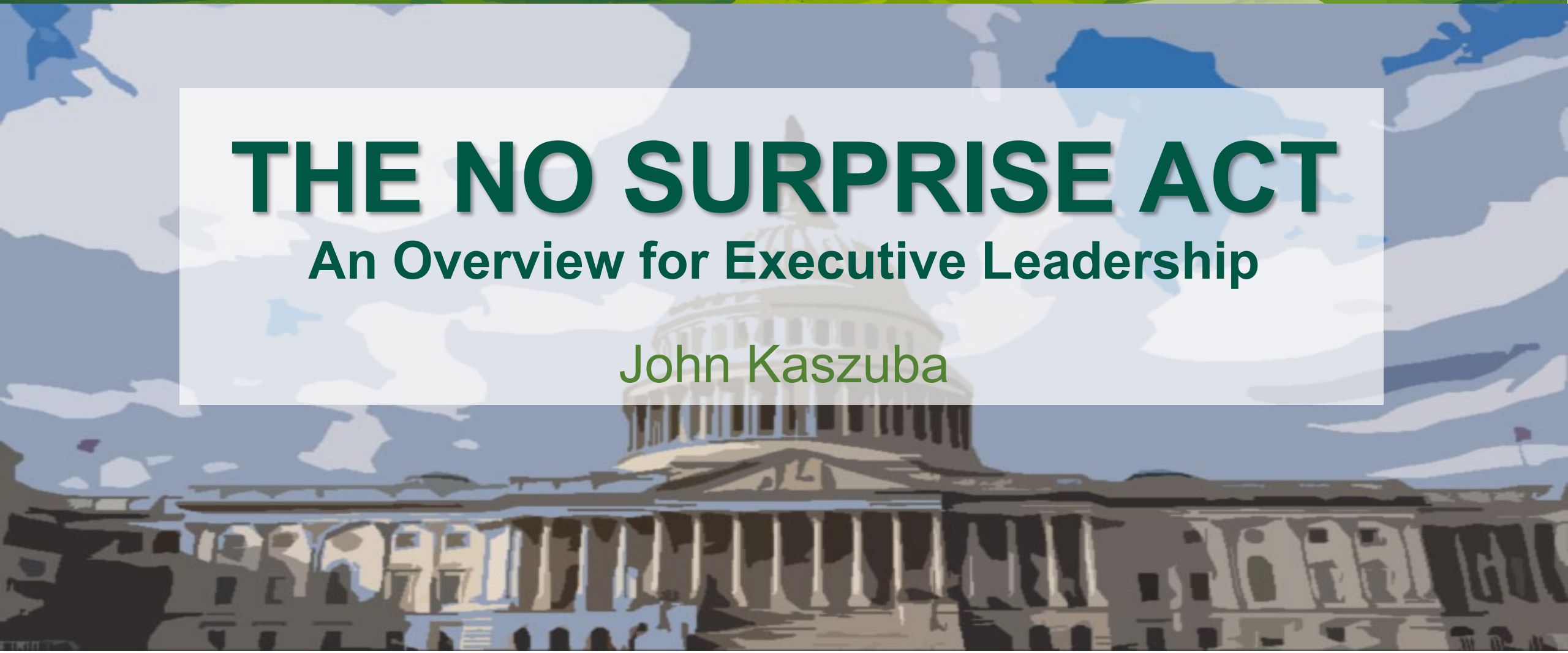
35TH ANNUAL AHA RURAL HEALTH CARE | LEADERSHIP CONFERENCE

AHA Events



THE NO SURPRISE ACT

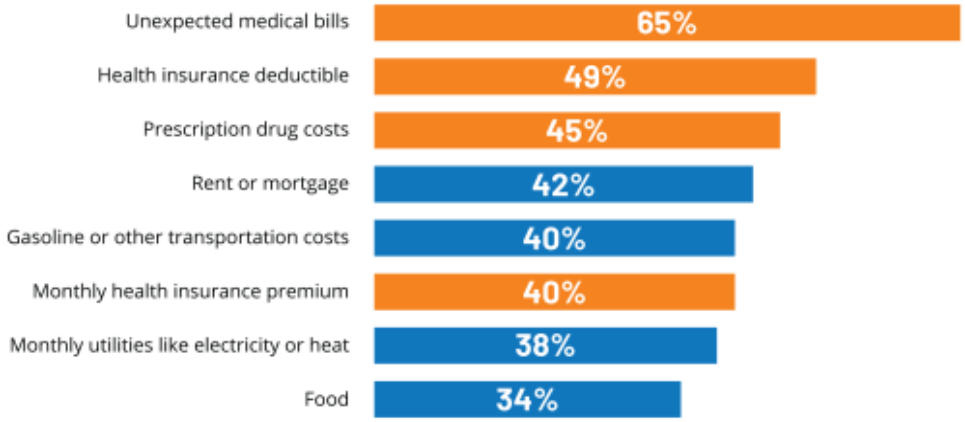
An Overview for Executive Leadership

John Kaszuba

Please note that the views expressed by the conference speakers do not necessarily reflect the views of the American Hospital Association.

Unexpected Medical Bills Top List Of Public's Worries

Percent who are **very or somewhat worried** about being able to afford each of the following for themselves and their family:



Out-of-Network Bills for Insured Patients Undergoing Elective Surgery with In-Network Surgeons & Facilities

20%
of cases had out-of-network bills

$2,011
average potential balance bill

Assistants & anesthesia
issue 37% of out-of-network bills

Chhabra KR et al, *JAMA* 2020;323(6):538-547
doi:10.1001/jama.2019.21463

INSTITUTE FOR HEALTHCARE POLICY & INNOVATION
UNIVERSITY OF MICHIGAN

FINDINGS

Do women who receive a surprise bill for a first delivery choose another hospital for their second delivery?

63,630
WOMEN

11%
RECEIVED A SURPRISE BILL FOR FIRST DELIVERY

These mothers had **13%** higher odds of switching hospitals for their second delivery than those who were not surprise billed

19%
SWITCHED HOSPITALS FOR SECOND DELIVERY

These mothers had a **56%** lower risk of receiving a surprise bill for their second delivery than mothers who did not switch hospitals

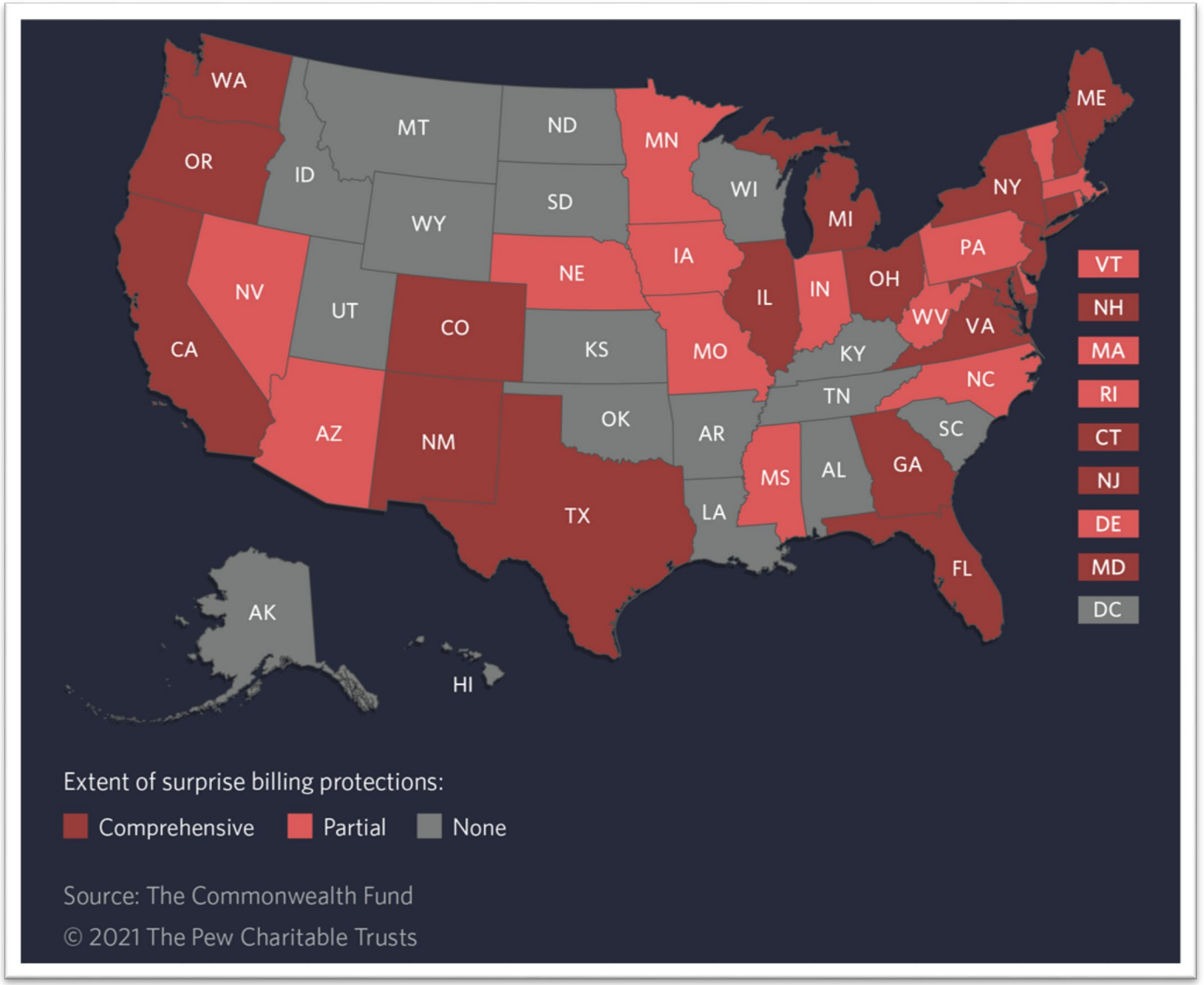
Penn LDI
LEONARD DAVIS INSTITUTE of HEALTH ECONOMICS

Legislation's Intent: Protect The Patient

- Protect patients from unexpected out-of-network charges:
  - Receiving emergency care;
  - Being transported by an air ambulance;
  - Receiving elective procedures.
- Removes patient liability from out-of-network billing disputes between healthcare professionals and insurers.
- Established a formal process for healthcare professionals and insurers to settle payment amount disputes.
- The law applies to individual/group health plans, including fully-insured plans sold through the individual and group markets, as well as self-funded plans ("ERISA" plans). Medicare is excluded.

States with Surprise Billing Protections

- 18 have comprehensive laws.
- 15 have partial protections.



Legislation: Application

- The No Surprises Act provisions are codified in section 9816 of the Internal Revenue Code and section 716 of ERISA. **The Act sunsets the original ACA protections** and imposes the expanded No Surprises Act for plan years that begin on or after January 1, 2022.
  - Largely parallel rules are codified in Department of Treasury regulations at 26 CFR Part 54, paragraphs 5-7; Department of Labor regulations at 29 CFR 2590.716 and 2590.717; and Department of HHS at 45 CFR parts 144 and 147. In addition, HHS regulations at part 149 codify requirements of health care providers, facilities and providers of air ambulance services.
- **Where state laws do not prohibit surprise medical bills from out-of-network hospitals for emergency services**, this law will ensure that surprise billing protections extend to those services in all cases.
  - Health plans must cover emergency services as if they were in-network; without any more restrictive utilization management requirements and at no more than the in-network cost-sharing amount.
  - Emergency services include post-stabilization services (unless certain conditions are met): the provider is able to transfer the individual or the provider has met the notice and consent requirements.
- HHS: ***Patients have the right to expect a good-faith estimate — upon request — from any co-provider or co-facility that's involved in a care episode***. Providers should be developing the capability to provide such estimates for any care that takes place on-site.
- *For states surprise medical bill laws, Federal regulators are expected to provide guidance on their approach to the **preemption of state surprise medical bill laws** under the No Surprises Act.*

Legislation: Application

- Health plans:
  - Must **maintain online price comparison tools** that allow patients to compare expected out-of-pocket costs for items and services across multiple providers.
  - Verify and **update provider directory information** no less than every 90 days (or within two days of receiving notice of a change), as well as establish a procedure for removal of providers who are no longer in network.

Procedure	Provider A	Provider B	Difference
MRI of the Brain	$682[1]	$3,849[1]	**$3,167**
Hysterectomy	$12,371[2]	$20,578[2]	**$8,207**
Hernia Repair	$4,142[2]	$11,692[2]	**$7,550**
Knee Replacement	$16,997[1]	$55,155[1]	**$38,158**

  - Have a **web-based provider directory** that includes the provider and facility contact information, specialty information, direct or indirect contractual relationship with the plan, and digital contact information.
  - **Respond to individuals (inquiring via telephone)** about the network status of a provider or facility **within one business day** of the inquiry and must retain records of the inquiry for two years.
- **Prohibits "gag clauses" in agreements** between health plans and providers/facilities, which directly or indirectly restrict a health plan from disclosing, and a plan sponsor, referring provider, or group or individual market consumer from accessing, provider-specific price, cost, or quality data.
- A health care "facility" includes a hospital (defined in 1861(e) of the Social Security Act (SSA)), a hospital outpatient department, a critical access hospital (defined in 1861(mm)(1) of the SSA), or an ambulatory surgical center (described in section 1833(i)(1)(A) of the SSA).

Provider Directories

- Ensure timely updates of provider directory information to health plans, submitting (minimum):
  - When the provider (physician) begins a network agreement with a plan with respect to certain coverage.
  - When the provider terminates an agreement.
  - Any material changes to the content of provider directory information.

Compliance Highlights

- The No Surprises Act became effective for plan years starting on or after January 1, 2022, some rulemaking may be completed after that date. Even without rulemaking in advance of the effective dates, plans/issuers are expected to make a good faith effort to implement the requirements of the statute upon its effective date.
- HHS views the federal requirements as a **minimum standard**. A provider/facility that issues a good faith estimate under a state law or process that does not meet the Federal requirements will be out of compliance with the federal requirements.
- HHS projects that a provider organization's business operations specialist will take **30-60 minutes** to generate each good-faith estimate, depending on whether items/services also are needed from a co-provider or co-facility.
- CMS has stated that in 2022, it will **exercise enforcement discretion** in situations where the estimate leaves out charges from a co-provider: recognizing the need for "additional implementation time to develop appropriate communication channels that may not yet exist among various co-providers or co-facilities."
- **Non-network providers** must take steps to determine whether a given item/service is subject to the balance billing provisions and to communicate with plans/issuers when the limitations do not apply because notice has been provided and consent received.
- **Prohibits "gag clauses"** in agreements between health plans and providers, which directly or indirectly restrict a health plan from disclosing, and a plan sponsor, referring provider, or group or individual market consumer from accessing, provider-specific price, cost, or quality data.
- HHS is able to **impose civil money penalties** on facilities/providers that violate the balance billing prohibitions and requirements.

Patient Protections: Health Plan Coverage

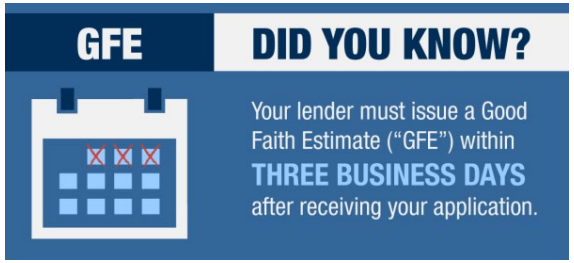
- **Continuity of services**: Must provide continuity of services when there is a change in the plans' provider network for patients undergoing a course of treatment for a serious or complex condition, undergoing institutional or inpatient care, scheduled to undergo non-elective surgery including post-operative care, pregnant and undergoing treatment, or terminally ill and receiving services.
  - Patients will have up to 90 days of continued coverage at in-network cost sharing to allow for a transition of care to an in-network provider.
- **Obstetrics/Gynecology**: A health plan may not require authorization or referral by the plan, issuer, or any person (including a primary care provider) when a female participant/beneficiary seeks coverage for obstetrical or gynecological care provided by an in-network health care professional who specializes in obstetrics or gynecology.

Patient Protections: Notification

- Provider/Facility
  - Provide public notice about the balance billing requirements and how to contact state or federal agencies in the case of a potential violation.
  - The notice must contain information on any state-level protections if applicable.
  - Disclosures for individuals who are enrollees of a health plan must be only one page, in font no smaller than 12-point, and may be provided through mail or email as selected by the enrollee.
  - Provide the notice no later than the date and time on which the provider requests payment from the individual (including requests for copayment made at the time of a visit).
    - Where the provider does not request payment from the individual, the notice must be provided no later than the date on which the provider submits a claim for payment to the plan or issuer.
- Exceptions for Disclosures: Provider and Facility
  - Not required to make the disclosures for items or services provide/facility doesn't furnish.
  - Providers are required to issue the required disclosure only to individuals to whom they furnish items or services, and then only if such items or services are furnished at a health care facility or in connection with a visit at a health care facility.
  - A provider will be considered to have satisfied the disclosure requirement if the facility provides the disclosure pursuant to a written agreement between the two. The provider and facility's contract could meet the "written agreement" requirement.
  - Providers and facilities would continue to each independently be required to make the required disclosure available on a public website.

Patient Protections: Estimates

- Must issue good faith estimates of expected total charges for uninsured or self-pay individuals (or their authorized representatives), upon request or upon scheduling an item or service (before the delivery of scheduled care).
- Must inquire about an individual's health insurance status, and whether an individual is seeking to have a claim submitted to their health insurance coverage for the care they seek.
- Establishes a "patient-provider dispute resolution process" to adjudicate any disputes over pricing for uninsured patients that receive a substantially higher bill than the "good faith estimate" provided prior to service.



The Real Estate Settlement Procedures Act of 1974

Patient Protections: Emergency Services

- A determination of a prudent layperson standard is met and codify that coverage for an emergency medical condition cannot be limited solely on the basis of diagnosis codes.
- Such a determination may only:
  - Be focused on presenting symptoms;
  - Be based on whether a layperson (as opposed to a medical professional) would reasonably consider the situation to be an emergency;
  - Be based on all pertinent documents;
- Plans may not:
  - Restrict coverage of emergency services by imposing a time limit on the onset of symptoms and when the person presented in the emergency department;
  - Restrict coverage of an emergency service because the patient did not experience a sudden onset of the condition; or
  - Restrict access to emergency services based on a general plan exclusion – for example by denying coverage of emergency services to a pregnant woman because the plan excludes coverage of maternity care.

Protections: Post Stabilization Services

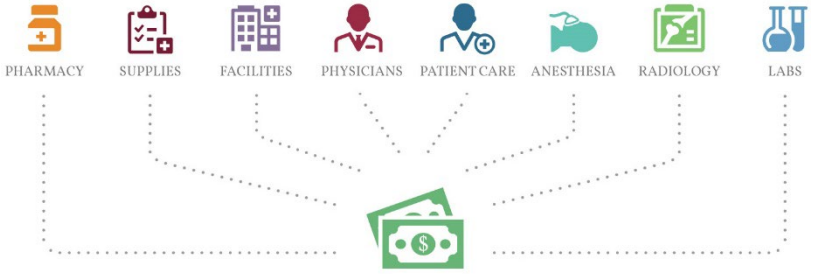
- Defines emergency services to include any additional items/services that are covered and furnished by a non-network provider or emergency facility after a participant, beneficiary, or enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the other emergency services are furnished. Such **"post-stabilization services" are considered emergency services subject to surprise billing protections <u>unless</u>** certain conditions are met. Those conditions are [codified in HHS regulations 45 CFR 149.410(b)]:
- The enrollee is able to travel using nonmedical transportation within a reasonable distance.
  - The ability to travel must take into account an individual's specific medical condition and be based on all relevant facts and circumstances including those related to underserved areas or geographic isolation. For example, that includes the enrollee's ability to pay for transportation, the availability and safety of public transport, etc.;
- The provider/facility providing the services satisfies notice and consent requirements.
  - An individual must be in a condition to receive and satisfy the notice and consent requirements.
  - The attending physician/treating provider would make this determination taking into account all relevant facts and circumstances including the patient's state of mind and emotional state; whether they are impaired by alcohol, drugs or prescribed medications; or displaying symptoms of a mental or behavioral health disorder. Providers should also take into account cultural and contextual factors that could affect informed decision-making such as lack of trust or historical inequities;
- The enrollee is in a condition to receive the information; and
- The provider/facility satisfies any other requirements imposed under state law.

Patient Protections: Items/Services within Visit Scope

- A visit to a participating health care facility includes the furnishing of equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services.
- Examples:
  - Laboratory services for a sample collected during an individual's hospital visit and sent to an off-site laboratory;
  - A consultation with a specialist via telemedicine during a visit to a participating hospital.

The Good Faith Estimate

- HHS projects a business operations specialist will take **30-60 minutes** to generate each good-faith estimate, depending on whether items/services also are needed from a co-provider or co-facility.
- Must provide a good faith estimate of the total expected charges for the items and services (**including any expected ancillary services**) with a health plan (if the patient is insured) or individual (if the patient is uninsured).
- The good faith estimate must include expected charges for the items/services that are reasonably expected to be provided together with the primary item/service, **including items or services that may be provided by other providers/facilities**. If an item/service is not scheduled separately from the surgery itself, it will generally be included in the good faith estimate.



  - Will need to include the expected billing and diagnostic codes for all items/services to be provided.
  - Applies whenever items/services are scheduled **at least three days in advance or when requested by a patient**.
  - Will need to determine the patient's health coverage status and develop the "good faith estimate" at least three business days before the service is furnished **and no later than one business day after scheduling**, unless the service is scheduled for more than 10 business days later. In those instances, will need to furnish the information within three business days of a patient requesting an estimate or scheduling a service.

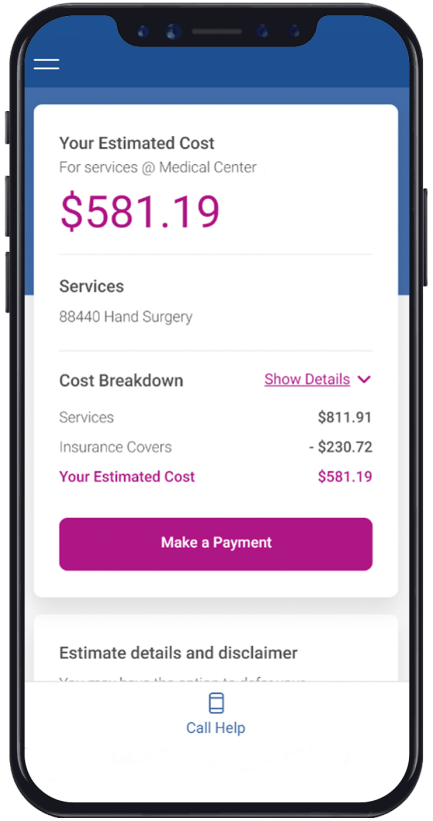
The Good Faith Estimate

- HHS defines “substantially in excess” as the billed charges being at least $400 more than the good faith estimate for any provider/facility listed on the good faith estimate.
- HHS notes that non-network providers and emergency facilities may need to refrain from billing an individual directly, even in cases that are not subject to these requirements if, for example, the provider does not have the information necessary to determine whether the services are a covered benefit under the plan or coverage.
  As a result, the non-network provider may need to bill the plan/issuer directly for the services in order to determine whether the protections apply. Otherwise, the provider risks violating the statute.
- *HHS views the federal requirements as a minimum standard.*
  A provider/facility that issues a good faith estimate under a state law or process that does not meet the Federal requirements will be out of compliance with the federal requirements.

The Advance Cost Estimate

When a provider/facility submits notification for scheduled items or services (for the insured), the **health plan is required to provide notification** (in clear and understandable language) to the patient:

- The Advanced EOB requirement is triggered by the provider sending a “good faith estimate to the health plan/insurer.
- If the services are scheduled for less than 10 business days after the notice from the provider/facility, the health plan will need to provide this information to the patient within one business day.
- If the services are scheduled for 10 or more business days business days after the notice from the provider/facility, the health plan will need to provide this information to the patient within 3 business days.



Non-network providers/facilities must take steps to determine whether a given item/service is subject to the balance billing provisions and to communicate with plans/issuers when the limitations do not apply because notice has been provided and consent received.

The Advance Cost Estimate

- Notification must include:
  - Whether or not the provider/facility is in-network with respect to the furnishing of the item or service.
  - In-network provider/facility: the contracted rate for such item or service (based on the billing and diagnostic codes provided by such provider/facility).
  - Non-network provider/facility: a description of how the patient may obtain information on providers and facilities that, with respect to plan or coverage, are participating providers and facilities, if any.
  - Good faith estimate included in the notification received from the provider/facility (if applicable) based on codes.
  - Good faith estimate of the amount the plan is responsible for paying for items/services included in the estimate.
  - Good faith estimate of the amount of any cost sharing for which the patient would be responsible for the items/services (as of the date of such notification).
  - Good faith estimate of the amount that the patient has incurred toward meeting the limit of the financial responsibility (including with respect to deductibles and out-of-pocket maximums) under the plan or coverage (as of the date of such notification).
  - Disclaimer if coverage for the item/service is subject to such medical management (including concurrent review, prior authorization, and step-therapy or fail-first protocols).
  - Disclaimer that the information provided in the notification is only an estimate based on the items/services reasonably expected, at the time of scheduling (or requesting) and is subject to change.

Patient Billing

- HHS defines "substantially in excess" if the billed charges are $400 or more than the good faith estimate for any provider/facility listed on the good faith estimate.
  - If a provider/facility submits a bill to an enrollee (patient) in excess of in-network cost sharing and enrollee pays, must refund with interest.
  - Patients may not be billed beyond their in-network cost-sharing amount (the notice and consent cannot be used) for items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, assistant surgeons, hospitalists, intensivists, diagnostic services (including radiology and laboratory services), and providers offering services when no other in-network provider is available.
  - The patient must initiate the patient-provider dispute resolution process within 120 calendar days of receipt the bill.
- *HHS is able to impose civil money penalties on facilities and providers that violate the balance billing prohibitions and requirements.*

Notice and Consent for Billing: What

- Provide a signed written notice and consent to the participant, beneficiary, or enrollee (or to an authorized representative of the participant, beneficiary, or enrollee), in paper or electronic form, ***as selected by*** the participant, beneficiary, or enrollee.
  - The notice must state that the provider/facility is a non-network provider/facility.
    An in-network facility may provide the information on behalf of a non-network provider.
  - Written notice must be provided and be in enough detail to ensure that individuals knowingly accept the provider's out-of-network charges. *HHS will provide in guidance a standard notice document that will contain the elements required by statute.*
  - Must be provided separate from other documents, within required timeframes, and must meet language access requirements.
    - The notice may be provided to an individual's authorized representative who is described as an individual authorized under state law to provide consent on behalf of the enrollee. The authorized representative may not be a provider affiliated with the facility or an employee of the facility unless they are a family member.
  - The consent constitutes only to the receipt of the information provided and **does not constitute a contractual agreement** of the participant, beneficiary, or enrollee to any estimated charge or amount included in such information.
  - *HHS notes that individuals cannot waive balance billing protections for unforeseen, urgent medical needs that arise.*

Notice and Consent for Billing: Content

- Notice and consent must contain this minimum information:
  - Notification that the provider/facility is out-of-network;
  - That the individual is not required to consent to receiving care from the nonparticipating provider or emergency facility,
  - List of in-network providers at the facility (if the facility is in-network) to which the patient can be referred;
  - Information on any prior authorization or other care management requirements;
  - Good faith estimates of the charges;
  - A clear statement that consent is optional and the patient can instead opt for an in-network provider.
  - The notice must indicate whether prior authorization or other medical management limitations may apply.
  - The consent documents must include the date the notice was received, the date when the individual signed, and the time when the individual signed. Consent may be revoked by notifying the provider/facility in writing prior to the furnishing of items/services.
  - Must be available in the 15 most common languages spoken in the provider/facility's area.

Notice and Consent for Billing: When

- When a patient makes an appointment, written notice and consent must be **received by patient at least 72 hours prior** to the item/service being delivered.
- When an appointment is made **within 72 hours** of when items/services are to be furnished, the written notice and consent **must be provided on date the appointment is made**.
- In the situation where an individual is provided the notice **on the same day** that the items/services are furnished, **must provide** the notice **no later than 3 hours prior** to furnishing items/services to which the notice and consent requirements apply. This addresses concerns that an individual provided notice immediately before a procedure may feel compelled to consent to receive care.
- The notice and consent process may not be used for certain services, including emergency services, certain ancillary services, and items or services that are delivered as a result of an unforeseen urgent medical need that arises during a procedure for which notice and consent was received.
- **Facilities are responsible for maintaining consent documents**, including for unaffiliated out-of-network clinicians delivering services in their facility, which must be retained **for seven years** after the date on which the item or service was delivered.

Notice and Consent for Billing: Multiple Non-Network Providers

- Multiple non-network providers may provide a single notice so long as:
  - Each provider's name is specifically listed on the notice document;
  - Each provider includes in the notice a good faith estimate for the items/services they are furnishing, and the notice specifies which provider is providing which items/services within the good faith estimate; and
  - The individual has the option to consent to waive balance billing protections with respect to each provider separately.
- The provider/facility must provide to the plan/issuer a copy of the signed notice and consent documents.

Health Plan Payment to Providers/Facilities

- Must reimburse the provider/facility directly and cannot instead route payment through the patient.
- Must either pay provider/facility (determined by the plan) or issue a notice of payment denial to the provider **within 30 calendar days** after receiving the bill for the services (submits a **clean claim**).
  - The 30-day timeline **does not apply** to post-stabilization services and out-of-network nonemergency services where the provider/facility provided notice and received consent from the enrollee for the out-of-network services.
  - If the provider is not satisfied with the payment from the plan, they may begin a 30-day open negotiation period.
  - If an agreement cannot be reached in the open negotiation period, the plan or provider/facility has 4 days to notify other party and HHS that they are initiating the Independent Dispute Resolution (IDR) process.

Provider-Plan Independent Dispute Resolution (IDR)

30 Day Open Negotiation Period (Pre – IDR)

- Beginning on the day the provider/facility receives an initial payment or a notice of denial of payment from the plan regarding a claim for payment, the provider/facility initiates open negotiations with the plan for purposes of determining an amount agreed on for payment (including any cost-sharing) for item or service.

IDR

- Either party may initiate IDR during the 4-day period beginning on the day after the open negotiation period.
- Initiated by submission to the other party and to HHS.
- The date of initiation is the date of submission or the date specified by HHS.
- Bundled claims: HHS will specify criteria under which multiple qualified IDR dispute items and services are permitted to be considered jointly as part of a single determination.

IDR Payment Determination

- Payment determination decision will be made not later than 30 days after the date of selection of the certified IDR entity.
- Plan shall make payment directly to not the nonparticipating provider or facility no later than 30 days after the date on which the determination is made.

Costs

- The party whose offer is not chosen shall be responsible for paying all fees charged by the certified IDR entity; and
- If the parties reach a settlement prior to the payment determination, each party shall pay half of all fees charged by certified IDR entity, unless the parties otherwise agree.

Provider-Patient Dispute Resolution (SDR)

- Selected Dispute Resolution (SDR) entities will make payment determinations.
- Individuals will be charged an administrative fee of $25 which will ultimately be paid by the party that loses the dispute. The administrative fee will be updated annually in sub-regulatory guidance.

Cost Sharing Amount: Protected Items/Services

- The cost-sharing amounts (except for air ambulance services) must be calculated as if the total amount that would have been charged for the services is equal to the “recognized amount.”
- The recognized amount is defined as:
  - An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
  - If there is no applicable All-Payer Model Agreement, an amount determined by a specified state law; or
  - If there is no applicable All-Payer Model Agreement or specified state law, the lesser of the amount billed by the provider/facility, or the qualified payment amount (QPA) which is the median contracted rate of the plan/issuer for the item/service in the geographic region.

Cost Sharing Amount: State Law

- The permitted cost-sharing payment amounts and out of-network rates applicable to protected services may be based on a state law that specifies a method for determining those amounts. Otherwise, the recognized amount or out-of-network rate will be determined based on the No Surprises Act statute and regulations.
  - For example, if a state surprise billing law applies only to health maintenance organizations, the federal law and regulations for determining the recognized amount and out-of-network rates would apply with respect to other types of health plans and issuers.
- State law could apply with respect to plans/issuers that are permitted to opt in to the state protections.

Resources for Implementation

CMS https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791

- Model Disclosure Notice Regarding Patient Protections Against Surprise Billing Instructions for Providers and Facilities Generating a good-faith estimate.
- Standard Notice and Consent Documents Under the No Surprises Act
- Tracking the data elements that are required in the good-faith estimate.
- Tracking required documents for the provider-patient dispute resolution process, which can be used when charges exceed the good-faith estimate by at least $400.
- Crosswalk of Changes to Rules

HFMA

- Requirements Related to Surprise Billing; Part I (CMS-9909-IFC); Summary of Interim Final Rule with Comment
- Requirements Related to Surprise Billing, Part II (CMS-9908-IFC); Summary of Interim Final Rules with Request for Comment (IFC)

Let’s Discuss

Good Faith Estimate

- How will it impact budgeting for and hiring resources: if you have a lot of scheduled services and your patients tend to be self-pay?
- At what point have you done your good-faith efforts to get an “accurate” estimate to patients without scaring them with all of the possible costs that could come up?
- Need a process to track accuracy of good faith estimates over time and to refine adjustments?
- Convening providers should be reaching out to co-providers for the pricing data needed to produce a global estimate (includes both charges and self-pay discounts for a service). For health systems that work with any number of external providers, the task is daunting.
    - The "convening" provider or facility: **receives the initial request for a good faith estimate and who is responsible for scheduling the primary item/service in question.**
- Develop a strategy for IDR: when to pursue and when not to?

Data management

- HHS has stated that it will exercise “enforcement discretion” in 2022 for estimates that involve multiple providers.
- When seeking to aggregate pricing data from co-providers, where it will be stored?
- What if co-providers are hesitant to share their pricing information?