The No Surprises Act –
What You Need to Know Now

February 23, 2022
Note:
Please consult your compliance department and/or legal team to answer specific questions regarding how the No Surprises Act requirements apply to your organization.

Source material is referenced throughout this presentation.
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Today’s Objectives

- To provide a basic understanding of the NSA
- To discuss and share ideas as a group
Some of the NSA provisions became effective on January 1, 2022, while others are delayed. Many providers are not yet in compliance, but most are getting there.

**Warning:** Don’t be distracted by “best practices” – you could accidentally miss a regulatory requirement!

**Quick Check:**
Are your signs in place and the required information on your website?
Is your Balance Billing disclosure included with all insured patients’ account statements?
Are you providing Good Faith Estimates when needed?
Legislative Timeline

December 27, 2020
No Surprises Act
Signed into law as part of the Consolidated Appropriations Act of 2021.

July 1, 2021
IFC Part I
The Departments implement several Surprise Billing provisions aimed at protecting insured patients from Balance Billing.

November 17, 2021
Third IFC
Prescription Drug & Health Care Spending rule requires groups health plans to submit certain information about RX & HC spending.

July 1, 2022
Health Plan Price Transparency
To help consumers know the cost of covered services before receiving care.

January 1, 2021
Price Transparency
Hospitals must provide price information online making it easier for consumers to shop and compare.

September 30, 2021
IFC Part II
The Departments issue additional requirements related to Surprise Billing protections - Good Faith Estimate and dispute resolution.

January 1, 2022
NSA Rules Effective
Balance Billing protections for insured patients and GFE for uninsured patients.

January 1, 2023
Additional NSA Rules
Expected charges from co-providers/co-facilities required on GFE.
NSA – Main Components

Balance Billing

Good Faith Estimate
Patient/Provider Scenarios

Balance Billing
- **Who?** Insured patients
- **What?** Emergency care
- **Where?** Any emergency facility
- **When?** Any time
- **How?** Not permitted

- **Who?** Insured patients, certain OON providers
- **What?** Non-emergency care
- **Where?** In-network facility
- **When?** At least 3 hours prior
- **How?** Notice & Consent

Good Faith Estimate
- **Who?** Uninsured (self-pay) patients
- **What?** Scheduled services (non-emergency)
- **Where?** All providers/facilities
- **When?** Scheduled at least 3 business days in advance
- **How?** Good Faith Estimate of expected charges
GFE Pop Quiz!

- **Appointment Scheduling**
- **GFE Due to Patient**
- **Date of Service**

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MARCH 2022

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Gray Areas and Pain Points

Open Questions
What is the “spirit of the law” vs. what is required?

- If a patient with worker’s compensation also has health insurance, are they still considered self-pay?
- Is a GFE required if the patient is a Medicare beneficiary, but the provider has opted out of the Medicare program?
- If an uninsured patient will not owe anything for the services provided, do we still need to give them a GFE?

High Burden
- Insurance information not being collected (or incorrect) at time of scheduling.
- Estimating costs prior to seeing the patient. Over/under concerns.
- For January 1, 2023, GFEs will need to include cost information from co-providers/co-facilities. Don’t wait – start planning this process now.
THANK YOU FOR PARTICIPATING

These slides were prepared by Kohler HealthCare Consulting, Inc. for discussion purposes only.

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If you would like to inquire about assistance with No Surprises Act provision implementation, please contact Sara Rivenburgh at srivenburgh@kohlerhc.com or call 410-461-5116.
Explore for More Information

- NSA Background and Overview
- Balance Billing: Emergent and Non-Emergent Services
- Notice and Consent
- Air Ambulance Services
- Good Faith Estimate
- Patient-Provider Dispute Resolution (PPDR)
- Health Plan Provisions
- Links of Interest
No Surprises Act – Background

- The NSA went into effect on January 1st, 2022 and establishes new federal protections against surprise medical bills.

- Patients lack meaningful choice of provider in certain situations. Studies show that 1 in 5 emergency room visits result in surprise medical bills – bills that arise when insured patients unknowingly receive care from out-of-network (OON) providers at in-network facilities.
  - Facilities encourage their physicians and suppliers to participate with the same health plans, but they cannot force them to do so.

- Many in-network hospitalizations for non-emergency care also result in surprise medical bills – for example: an out-of-network anesthesiologist providing care during a surgical procedure.

- Balance billing occurs when the OON provider bills the patient for the difference between their charge and that which the health plan pays.

- The No Surprises Act (NSA) was signed into law as part of the Consolidated Appropriations Act of 2021.

- The federal government estimates the NSA will apply to about 10 million out-of-network surprise medical bills per year. The No Surprises Act is the first comprehensive legislation at the federal level to address surprise medical bills – some states already provided protections against balance billing.
  - The intention of the legislation is to ensure transparency and affordable care by giving patients the assurance of no surprises.
No Surprises Act – Overview

• Intended to protect patients from surprise medical bills in situations where the patient has little or no control over who provides their care, including non-emergency services provided by out-of-network providers at in-network facilities.

• Prohibits providers, facilities and providers of air ambulance services from directly billing individuals for the difference between the amount they charge and the amount the health plan pays (aka Balance Billing).

• Requires health plans to pay for emergency services at in-network rates – bans OON cost-sharing. For emergency care, patients are only responsible for their in-network cost-sharing and are not required to obtain prior authorization.

• Requires certain providers and facilities to publicly disclose restrictions on balance billing.

• Limits billed amounts in situations where a provider’s network status changes mid-treatment or individuals act on inaccurate provider directory information.

• Requires providers and facilities to provide good faith estimates (GFE) of charges for care to uninsured (or self-pay) individuals upon scheduling care or upon request.*

• Creates a patient-provider dispute resolution process for uninsured (or self-pay) individuals to contest charges that are “substantially in excess” of the good faith estimate amount.
Balance Billing
Balance Billing

Emergency Care

- Balance Billing is prohibited.
- Patient is only responsible for their in-network cost-sharing amount.

Non-Emergency Care

- Out-of-network (OON) provider may give notice and obtain signed consent from the patient to waive protections against balance billing for certain items and services furnished at in-network facilities.
- Not applicable to emergency medicine, anesthesiology, pathology, radiology, laboratory, and neonatology; services provided by assistant surgeons, hospitalists, and intensivists.
Scope of Patients

These protections apply to individuals enrolled in private or commercial health coverage –

- Employment-based group health plans (both self-insured and fully insured).
- Individual or group health coverage on or outside the Federal or State-based Exchanges.
- Federal Employee Health Benefit (FEHB) health plans.
- Non-federal governmental plans sponsored by state and local government employers.
- Certain church plans within IRS jurisdiction.
- Student health insurance coverage.

**Not Medicare, Medicaid, Tricare, Indian Health Services, VA Health Services, or Self-Pay. These federal health plans already have balance billing protections in place.**
Scope of Providers & Facilities

**Providers:** *Any provider* licensed by the state to provide health care services – including medical, dental, vision, mental health, chiropractic, acupuncture, physical therapy, etc.

**Facilities:** These types of facilities cannot balance bill for covered emergency services when providing out-of-network care:

- Emergency department of a hospital – a hospital outpatient department that provides emergency services.
- Hospitals (any department) providing post-stabilization services.
- Independent, freestanding emergency departments.
- Urgent care centers if they meet the definition of an independent, freestanding emergency department.
Emergency Services

• Balance Billing is prohibited for emergency services.
• Patient is only responsible for their in-network cost-sharing amount.
• The health plan must apply the cost-sharing amount to the patient’s deductible.
• Reimbursement is settled between the provider and the health plan.
  ▪ If the OON provider does not accept the health plan’s initial payment, they can initiate a 30-day Open Negotiation period.
  ▪ If an agreement is not met between the provider and the health plan, either one may initiate the Federal Independent Dispute Resolution (IDR) process.
  ▪ The patient is not part of these negotiations – the patient is not required to pay more than their in-network cost-sharing amount.
Post-Stabilization Services

- Additional covered items and services furnished by an OON provider or facility after the patient is stabilized, as part of outpatient observation, or an inpatient or outpatient stay with respect to the visit in which the other emergency services were provided.

- Post-stabilization services are no longer considered emergency services when all the following conditions are met:
  - The treating provider determines the patient is able to travel using non-medical transportation or non-emergency medical transportation to an available participating provider or facility located within a reasonable travel distance.
  - The treating provider or facility satisfies the notice and consent criteria.
  - The patient is in a condition to provide informed consent.
Associated Requirements

Disclosure Requirements –

- **Signage:** Public sign at location – in the Emergency Department and where payment discussions occur – explaining the No Surprises Act Balance Billing protections.

- **Website:** Post information or a link to the information on a searchable homepage of the facility website.

- **Notice/Disclosure:** A one-page (double-sided) notice must be provided to the insured patient no later than the date and time on which the provider/facility requests payment or when the provider/facility submits a claim to the patient’s health plan.
  - Must contain contact information to report potential violations – federal and state (if applicable).
  - Penalty – up to $10,000 per violation.
Balance Billing Disclosure Notice

The No Surprises Act provides specific guidance on the content and distribution of a required Balance Billing notice/disclosure.

Notice format: one-page (double-sided) using print no smaller than 12-point font.

The notice must be provided to all insured patients receiving emergency care at the facility no later than the date and time on which the facility requests payment or when the facility submits a claim to the health plan.

The notice should accompany all billing statements to insured patients.

The notice does not go to patients covered by federal programs such as Medicare, Medicaid, Indian Health Services, VA Health Care, or Tricare (or to the uninsured).
Balance Billing

Insured Patients –
Non-Emergency Services
Notice and Consent

• If an insured patient chooses to receive non-emergent services from an out-of-network provider at an in-network facility, that provider must give notice and get the patient’s signed consent in order to balance bill the patient.

• If an insured patient chooses to receive non-emergent services from an out-of-network provider at an out-of-network facility, the No Surprises Act protections do not apply. This patient knows they are seeking care outside their plan’s network and is not at risk of receiving “surprise” bills.

• Provider and facilities are required to use the standard notice document provided by HHS.
  - If the notice and consent is provided on the day services are to be furnished, they must be provided no later than 3 hours prior to furnishing the items or services.
Ancillary Services

Balance Billing protections under the No Surprises Act *always apply* to the following ancillary services/providers – these protections *cannot be waived* through “notice & consent”:

- Emergency Medicine
- Anesthesiology
- Pathology
- Radiology
- Diagnostic Services including radiology and laboratory
- Items or services provided by an OON provider when there is no in-network provider who can furnish the item or service at the facility.
Notice & Consent Recap

When can out-of-network providers and facilities use the notice & consent exception?

Allowed –

• An individual is stable enough to travel using non-medical or non-emergency medical transport to an available in-network provider/facility located within a reasonable travel distance given the individual’s medical condition.
• The patient (or their authorized representative) is in a condition where they can receive information and provide informed consent.
• The provider/facility provides written notice and obtains written consent from the individual to waive balance billing protections under the No Surprises Act, in compliance with all related statutory and regulatory requirements.

Not allowed –

• When providing any emergency services prior to post-stabilization services, including medical exams and treatment to stabilize the patient.
• When providing items or services due to unforeseen urgent medical needs in the course of care delivery.
• When providing post-stabilization services if any one of the requirements listed above are not met.
• When providing any of the ancillary services previously discussed.
Providing Notice & Consent

Timing of delivery:

• If an individual schedules an appointment at least 72 hours before the date of the appointment, notice and consent documents must be given to the individual no later than 72 hours before the date of appointment.

• If an individual schedules an appointment within 72 hours of the date of the appointment, notice and consent documents must be given on the day the appointment is made, but no less than 3 hours before the time when items or services are to be provided.

Method of delivery:

• Document must be delivered together and separately from any other forms.

• On paper or electronically, whichever the patient prefers.

• A representative of the provider/facility must be physically present or available by phone to answer questions.
Related Rules

- Consent does not represent a contractual agreement of the individual to any estimated charge or to be treated by that provider or facility.
- Consent documents may be signed electronically by the individual or their authorized representative.
- A provider or facility can refuse to treat an individual if they don’t consent to waive their balance billing protections under the No Surprises Act, so long as this is allowed under state law.
- Signed consent documents must include the time and date when the individual got the notice, and the time and date when the individual signed the consent document.
- Providers and facilities must retain a copy of notice and consent documents for at least 7 years after the date when the item or service is provided.
- Providers and facilities must timely notify a health plan about items or services delivered for which proper consent to waive balance billing prohibitions was obtained and give the plan a copy of the signed documents, preferably with the claim.
Air Ambulance Services
Air Ambulance Services

• The average charge for air ambulance transport is over $30,000. Individuals generally have little control over which company provides these services.

• Air ambulance service providers are banned from balance billing under the NSA.

• NSA protections do not apply to ground ambulance services.

• New reporting requirements to assess competitiveness and market costs.

• The Association of Air Medical Services has filed a lawsuit in federal court over the interim final rules of the No Surprises Act.

  They believe the system gives insurers too much power to control reimbursement amounts.
Good Faith Estimate
Uninsured, Scheduled Patients

All uninsured and self-pay patients must be provided with a good faith estimate (GFE) of expected charges prior to all services scheduled at least 3 business days in advance – or upon patient request.

Estimate must be provided in writing via mail/email and verbally based on patient preference.

HHS will defer enforcement of provision to include co-provider/co-facility estimates until January 1, 2023.

Patient can initiate the “patient-provider dispute resolution” (PPDR) process if bill is at least $400 more than the GFE.
Timeline for GFE to be Provided

❖ If appointment is at least 10 business days in advance, GFE must be provided within 3 business days of scheduling date.
   ▪ Example: Appointment scheduled on March 7th for service on March 25th – GFE must be provided by March 10th.

❖ If appointment is at least 3 business days in advance, GFE must be provided no later than 1 business day of scheduling date.
   ▪ Example: Appointment scheduled on March 21st for service on March 25th – GFE must be provided by March 22nd.

❖ If no appointment is scheduled (e.g., patient request), GFE must be provided within 3 business days of the request date.
   ▪ A new GFE must be provided if/when the service is scheduled.

❖ No GFE is required for appointments scheduled less than 3 business days in advance.
## GFE Timing

### Appointment Scheduling

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### GFE Due to Patient

- 1

### Date of Service

- 2

- 3
Associated Requirements

When an appointment is scheduled –

1) Inquire if individual has health insurance coverage for the service they are seeking.
   
   ⇒ Definition of uninsured (or self-pay): those who do not have benefits for the item or service under a group health plan or group or individual health insurance coverage offered by a health insurance issuer.
   
   ⇒ Note: Those with coverage through short-term, limited-duration plans, liability insurance/workers compensation plans, or health sharing ministries are considered uninsured for the purposes of this legislation.

2) If the individual is uninsured (or self-pay) or does not intend to submit a claim to their health plan, inform the patient that they will receive a Good Faith Estimate of the expected charges for the scheduled item or service.
   
   * A patient cannot waive their right to a good faith estimate – it must always be provided to an uninsured patient when scheduling an appointment at least 3 days in advance. The GFE does not require a signature.

3) Inquire as to the individual’s preferred method of GFE receipt (e.g., mail, email, patient portal).
   
   *Even if patient prefers phone/in-person, a written/printable GFE must be produced for use in the PPDR process.
Required Contents of GFE

**Good Faith Estimate must include:**

1. Patient name and date of birth.
2. Description of the primary item or service in clear and understandable language.
3. Date of scheduled item or service, if applicable.
4. Itemized list of items and services *reasonably expected* to be furnished for the primary item and service.
5. Applicable diagnosis codes, expected service codes, and the expected charges for each listed item or service.
6. Facility/Provider information: name, National Provider Identifier (NPI), Tax Identification Number (TIN) as well as the State where the item or service will be furnished.
7. A list of items or services that are expected to occur before or following the expected period of care for the primary item or service.

**GFE Disclaimers:**

1. There may be additional items or services recommended as part of the course of care that are not reflected in the GFE.
2. The information provided in the GFE is only an estimate regarding the items and services reasonably expected to be furnished.
3. The patient has a right to initiate the patient-provider dispute resolution process if the actual billed charges are more than $400 in excess of the GFE amount.
4. The GFE is not a contract and does not require the individual to obtain the items or services from the facility/provider.
5. Suggested disclaimer: The GFE includes all expected discounts for which the patient is eligible at the time of scheduling. Additional discounts may apply.
Sample GFE (Part 2):

[Provider/Facility 1] Estimate

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

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Total Expected Charges from [Provider/Facility 1] $

Additional Health Care Provider/Facility Notes
Patient-Provider Dispute Resolution Process (PPDR)

❖ If the actual billed charges are at least $400 more than the expected charges on the Good Faith Estimate, the patient has the right to initiate the Patient-Provider Dispute Resolution Process (PPDR).

❖ Always attempt to resolve a dispute in-house. If possible, flag all accounts where GFE was provided and the final charges are at least $400 over the estimated charges, so the dispute can be handled directly with the patient.

❖ Through the PPDR, the selected dispute resolution (SDR) entity will determine the amount to be paid by the uninsured individual.
  • SDR entity is expected to use the expected charges in the GFE as the presumed appropriate amount unless the provider or facility provides credible information justifying the difference was based on medically necessary unforeseen circumstances that could not have been reasonably anticipated.
  • Determination is made for each unique billed item or service.
Other PPDR Rules

If the billed charges are at least $400 more than the expected charges on the GFE*, the patient has the right to initiate the PPDR process.

1. Using the Federal IDR Portal, the patient submits an initiation notice to the Department of Health and Human Services (HHS) postmarked within 120 calendar days of receiving the initial bill.

2. Upon receipt of the initiation notice, HHS will assign a Selected Dispute Resolution (SDR) Entity.

3. While the process is pending, the facility/provider must not move the bill into collection or threaten to do so and must suspend the accrual of any late fees. The provider/facility must not take or threaten to take any retributive action against the individual.


* For each provider/facility listed on the GFE.
Other NSA Provisions
External Review

**IFC Part II – Scope of claims eligible for external review:**

- The rule expands the scope of adverse benefit determinations eligible for external review to include those that involve issues related to compliance with the specified provisions of the No Surprises Act – e.g., surprise billing and cost-sharing.

- Under these interim final rules, grandfathered plans that are not otherwise subject to external review requirements will be subject to external review requirements for coverage decisions that involve compliance with the surprise billing and cost-sharing provisions under the NSA.

- Applies to both state and federal external review processes. State laws supersede federal when they place requirements on providers and insurers that go beyond the new federal law.
• Health insurers are required to cover emergency services in- or out-of-network and without prior authorization.
  ▪ Emergency services must be covered as if they were in-network.
• Health plans must reimburse the provider directly and must make an initial payment within 30 days of receipt of a “clean claim”.
• Patient cost-sharing for emergency services must be applied to the deductible as though they were provided in-network.
• Health plans must refer to the admitting diagnosis/complaint to determine medical necessity.
• Payment amounts must be a “reasonable expectation of payment”.
• The NSA provisions do not dictate what a health plan must pay for out-of-network services. The QPA must be considered.
Qualifying Payment Amount (QPA)

The QPA is the plan’s median contracted rate from 2019 trended forward with the following conditions:

➢ Same insurance market/type  
➢ Same geographic region  
➢ Same/similar item or service  
➢ Same/Similar provider specialty

• Cost-sharing is based on the QPA in the absence of a state All-Payer Model Agreement* or other specified state law.

*Maryland
Links of Interest

11. CMS Provider Requirements & Resources: [https://www.cms.gov/nosurprises/policies-and-resources/provider-requirements-and-resources](https://www.cms.gov/nosurprises/policies-and-resources/provider-requirements-and-resources)
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