No Surprises Act (NSA)

Best Practices

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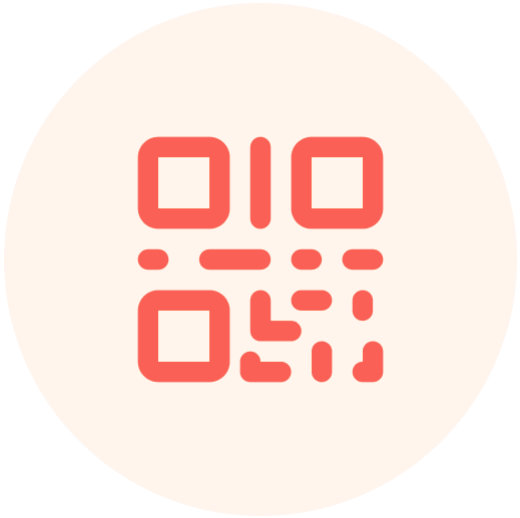

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Facilitators

Emily Jones

SVP, Front-End Revenue Cycle

Joined Ensemble Health Partners in 2017

20+ years of healthcare experience including Pre-Access, Patient Access, UM, Denial Prevention Program Implementation and Revenue Cycle & System Integrations; implemented a wide range of regulatory projects related to revenue cycle, including NSA

Responsible for developing and implementing a scalable enterprise-wide front-end operations business model and oversight of daily operations for over 3k FTEs

Kevin Flanigan

Legal Counsel

Joined Ensemble Health Partners in 2021

8+ years of legal experience, including 4+ years of healthcare revenue cycle in the areas of law and regulatory policy (NSA, Fair Debt Collection Practices, Balance Billing, Telephone Consumer Protection Act and general operational matters)

Graduate of Wake Forest University School of Law

Responsible for helping organizations ensure they are prepared for legal challenges

Danielle Shearer

VP, Patient Access

Joined Ensemble Health Partners in 2017

20+ years of healthcare experience including Pre-Access, Patient Access and service line projects (NSA, Virginia Balance Billing, REAL ACT, Discharge Caregiver, Healthcare Exchange Process, Outpatient Infusion Center improvement and Free-Standing Imaging registration)

Responsible for developing and implementing a scalable enterprise-wide front-end operations business model and oversight of daily operations for over 300 FTEs

Legal Disclaimer

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What is your favorite morning drink?

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Why did you come to our NSA front-end best practices session today?

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What hospital(s), health system or organization do you work for?

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What part of revenue cycle management are you focused on?

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What is the purpose of NSA?

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Balance billing refers to the practice of out-of-network providers billing patients for the difference between:

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No Surprises Act (NSA)

NSA is a federal law that went into effect January 1, 2022. It protects patients against surprise billing and limits out-of-network cost sharing.

- **NSA is very large and complex. It is probably the most important and impactful healthcare law since the Affordable Care Act.**
- New rules help protect people from surprise medical bills and remove consumers from payment disputes between a provider or health care facility and their health plan
- Congressional intent is to protect patients from balance billing and surprise medical bills
- Protections only apply to insured patients covered by certain payer plans
- Protections also established for uninsured/self-pay patients
- Protections only apply to certain settings and situations, which require careful examination of requirements and front-end registration processes and workflows

No Surprises Act (NSA)

What is "balance billing"? Balance billing refers to the practice of out-of-network providers billing patients for the difference between

(1) the provider's billed charges, and

(2) the amount collected from the plan or issuer plus the amount collected from the patient in the form of cost sharing (such as a copayment, coinsurance, or amounts paid toward a deductible).

What is "surprise billing"? A balance bill may come as a surprise for the individual. A surprise medical bill is an unexpected bill from a health care provider or facility that occurs when

a covered person receives medical services from a provider or facility that, usually unknown to the participant, beneficiary, or enrollee, is a nonparticipating provider or facility with respect to the individual's coverage.

Surprise billing occurs both for emergency and non-emergency care.

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What plan types fall under the NSA?

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SCC Commonwealth of Virginia
STATE CORPORATION COMMISSION

Many Virginians are already protected against surprise medical bills, thanks to a Virginia law that took effect January 1, 2021.

Starting January 1, 2022, the federal No Surprises Act (NSA) provides additional protections to consumers against surprise billing for medical expenses. Most of these surprise billing protections apply to those with insurance coverage through an employer (including a federal, state, or local government), through the individual Marketplace (HealthCare.gov), or directly through an individual market health insurance issuer that uses a provider network.

Virginia SCC - New Releases

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The federal No Surprises Act (NSA), effective January 1, 2022, works together with the Virginia law to protect patients from:

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May a health plan require that an emergency service be approved before the service is provided for it to be covered?

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How are patients notified of their rights and protections from balance billing?

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Can a provider ask me to waive my protections?

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How are balance billing disputes resolved?

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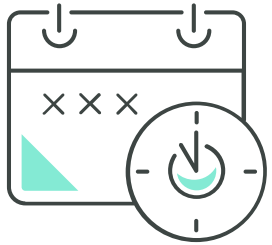
Best Practices Review

- **The No Surprises Billing Act is a complex regulatory bill requiring front-end leaders to be proactive, accountable and compliant.**
- **Revenue cycle operations must have a plan in place to address the following:**

  - Signage
  - Workflow modifications
  - Patient estimates
  - Record keeping
  - Account documentation
  - Patient notices
  - Verbal and written communication with patients/caregivers
  - Follow standard operating procedures
  - Training content review and facilitation
  - Toolkit and resources
  - Internal Audit

No Surprises Act | CMS

Key NSA-Related Patient Journeys to Consider

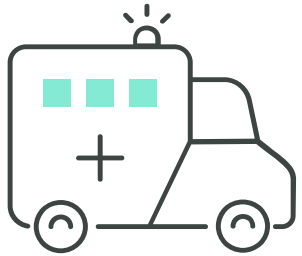


Scheduled Services

Scheduled uninsured/ self-pay patients must receive a Good Faith Estimate prior to services

Walk-In Patients

Unscheduled patients that are uninsured/ self-pay should receive a Good Faith Estimate at the time of service



ED Admit Patients

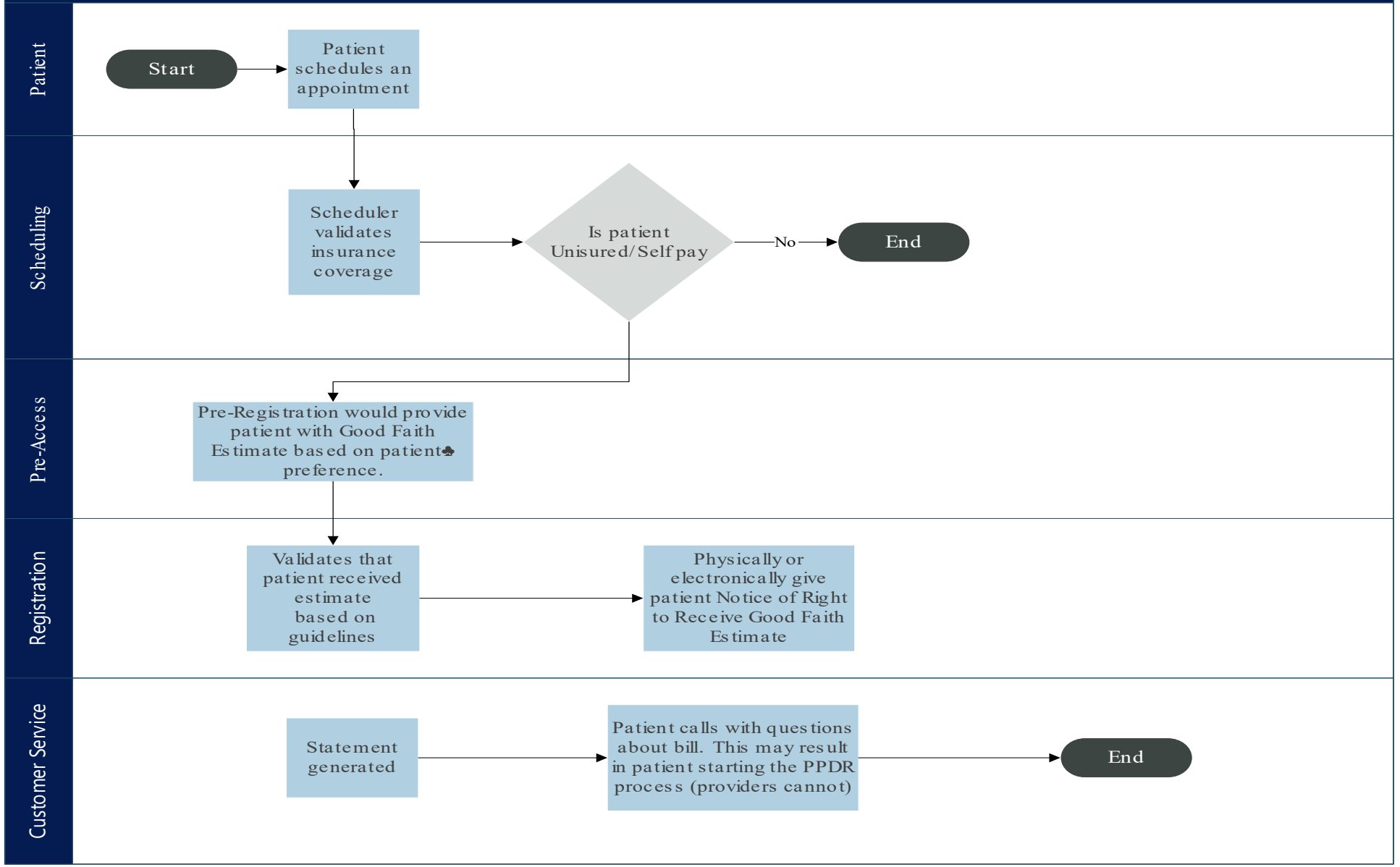
ED admit patients are not required to receive a Good Faith Estimate

GFE only required post stabilization based on scenario

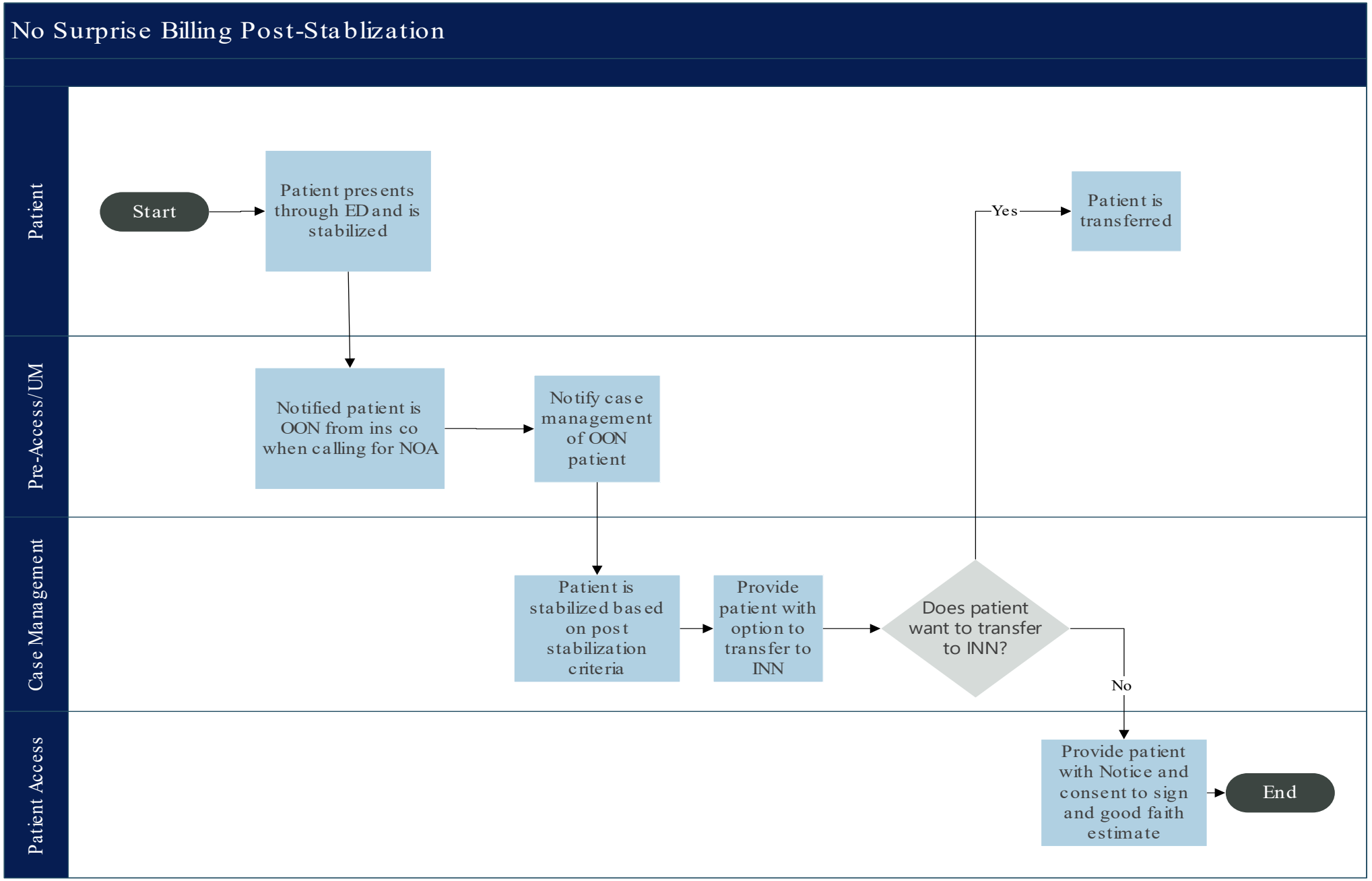
Customer Service

Patients are to receive a Good Faith Estimate upon request

No Surprise Billing Scheduled Uninsured/Self Pay



No Surprise Billing Post-Stablization



Patient-Provider Dispute Resolution (PPDR) Process

Start

PPDR Initiation: If the SDR entity determines that the item or service meets the eligibility criteria, and the initiation notice contains the required information, *the SDR entity will notify the uninsured (or self-pay) individual and the provider of facility of the section of the SDR entity, and that the item or service has been determined eligible for the dispute resolution.*

Within 3 business days

Parties' Conflict of Interest Identification: The uninsured (or self-pay) individual and provider or facility may attest to having a conflict of interest with the SDR entity. *Should a conflict of interest exist, the SDR entity must notify HHS within 3 business days of receiving the attestation. HHS will select a different entity to conduct the PPDR process.*

Within 10 business days

Provider or Facility Submits Information: The provider of facility should submit required information to the SDR entity *within 10 business days of the receipt of the selection notice*. The required information includes:

1. A copy of GFE
2. A copy of the billed charges
3. If available, documentation demonstrating that the difference between the billed charge and the expected charges in the GFE reflects the cost of a medically necessary item or service *(based on unforeseen circumstances)*

Selected Dispute Resolution (SDR) Entities
HHS PPDR Selected Dispute Resolution Entities (cms.gov)

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Patient-Provider Dispute Resolution (PPDR) Process, *continued*

Patient-Provide Negotiation: If the parties to a dispute resolution progress agree on a payment amount (through either an offer of financial assistance or an offer of a lower amount, or an agreement by the uninsured (or self-pay) individual to pay the billed charges in full) after the PPDR process has been initiated but before the date on which a determination is made, *the provider or facility will notify the SDR entity through the federal IDR Portal, electronically or in paper form as soon as possible, but no later than 3 business days after the date of the agreement.*

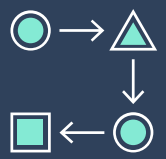
Payment Determination by the SDR Entity: *No later than 30 business days after the receipt of the information requested from the provide or facility*, the SDR entity must decide regarding the amount to be paid by the uninsured (or self-pay) individual, taking in to account the requirements of the PPDR payment determination process. *The SDR entity should inform both parties of the determination as soon as practicable after reaching a payment determination.*

Selected Dispute Resolution (SDR) Entities
HHS PPDR Selected Dispute Resolution Entities (cms.gov)

NSA Requirements Overview

Requirement	Description
Signage	NSA notice should be posted prominently at each facility
Workflow Modifications	Processes should be modified to adhere to NSA guidelines
Patient Estimates	A “good faith estimate” of expected costs should be provided to patients when presenting the Notice and Consent to the patient, where appropriate
Record Keeping	Facility must retain a copy of Notice and Consent for seven (7) years
Patient Notices	Facilities and providers must provide patients with consent and disclosure forms regarding the NSA in clear and understandable language

Prepare, Implement & Optimize

Phase	Best Practice	Implementation
Prepare 	**NSA Committee**	Include legal, supporting service lines, leaders at various levels. Meet regularly
	NSA Toolkit	Provide one repository to find all NSA related items
	NSA SOP	Draft NSA SOP to serve as the foundation for all NSA related items
	Compliant Forms	Validate all documents used are accurate and comply with NSA
Implement 	**Operational Workflows**	Create workflows to include service lines supporting front-end operations
	Education & Training	Identify training opportunities and gaps; identify how associates will be trained
	Checklist	Lists should be created for all required items such as signage, forms, etc.
Optimize 	**Technology**	Work with host system vendors and IT to identify technology solutions. Automate!
	Internal Audit	Weekly audits to provide an effective feedback loop

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Have you implemented a NSA Governance Committee at your hospital/facility or health system?

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Best Practices Review

- **NSA Governance Committee:** Routine review of all standard operating procedures and training content by corporate legal counsel (internal and external), privacy and compliance teams and executive subject-matter experts (SMEs).
- **Communication:** Daily and weekly operations call to address people, process and technology questions and escalations:
  - Front-end operations teams
  - Service line leadership
  - Client partnerships, including dyad areas/collaboration
  - Front, middle and back-end workflow review teams
- **Escalations:** Real-time escalations to executive team of potential risks, barriers or ownership (operations by department/service line).
- **NSA Toolkit:** Create an electronic toolkit where all approved documents, content, presentations, workflows, procedures and can be easily found.

NSA Governance Committee

- Create a multidisciplinary committee comprised of operations, legal, compliance, process and technology stakeholders:
  - Strategy + Process
  - Pre-Access
  - Patient Access
  - Patient Experience
  - Accounts Receivable
  - Utilization Management
  - Billing
  - Physician Advisory
  - Project Management
  - Compliance
  - Legal/Regulatory (your own internal or external legal counsel)
- Frequency of Meetings: daily and weekly depending on the workstream.

NSA Governance Committee, Forms Overview

- **Model Disclosure Notice must be:**
  - Posted in hospital prominently where patients schedule care, check-in for appointments or pay for services
  - Posted on hospital website
  - Handed out to patients with insurance plan covered by NSA each time the patient presents
- **Standard Notice and Consent form:**
  - For use by nonparticipating providers at participating facilities for non-emergency services, and nonparticipating providers or facilities for post-stabilization services
  - Must be available in 15 most common regional languages (English counts as one of the 15)
- **Payer Notification:**
  - For each item or service furnished by a nonparticipating provider or nonparticipating emergency facility, the provider (or participating facility on behalf of the nonparticipating provider) or nonparticipating emergency facility, as applicable, must:
    - (1) timely notify the plan or issuer as to whether balance billing and in-network cost sharing protections apply to the item or service,
    - and (2) provide to the plan or issuer a signed copy of any signed written notice and consent document

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Do you have an official standard operating procedure or written policy for NSA practices?

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Best Practices Review

- **Electronic Standard Operating Procedures (SOPs):** Create clear, compliant and cohesive protocols to (1) share appropriate steps by audience, and (2) ensure quality, compliance and accountability.
  - **Scope:** Applicability by area/owner
  - **Background Example:** <*The Federal No Surprises Act (NSA) protects patients against surprise billing and limits out of network cost sharing…*>
  - **Definitions:** Alignment of terminology and definitions in accordance with NSA language
  - **Out of Network & In Network:** Clear distinctions and explanations
  - **Service Types Affected by NSA:** When balance billing is or is *not* allowed
  - **Plan Types Affected by NSA:** What plans do and do *not* fall under NSA
  - **NSA Differences:** Model Disclosure Notice versus Notice and Consent:
    - Purpose
    - Who must it be given to
    - When must it be given to the patient

Best Practices Review

- **Electronic Standard Operating Procedures (SOPs), *continued*:** Create clear, compliant and cohesive protocols to (1) share appropriate steps by audience, and (2) ensure quality, compliance and accountability.
  - **Insured/OON Patients**
    - Facilities Affected
    - Participating Facilities
    - Providers Affected: Nonparticipating and Participating Providers
    - Standard Notice and Consent (to allow balance billing)
    - Post-Stabilization – Emergency Services
  - **Uninsured/Self-Pay Patients**
    - Facilities Affected
    - Good Faith Estimate
    - Patient Access Procedures
    - *Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to provide a Good Faith Estimate of expected charges for items and services to individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing, upon request or at the time of scheduling health care items and services.*

Good Faith Estimate (GFE) for Uninsured/Self-Pay

Uninsured

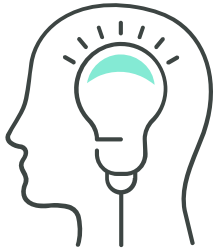
No health insurance as individual, group, federal, etc.

Self-Pay

Choice to not use health insurance for covered service

Non-Covered

Active health insurance but service not covered



Upon Request

Procedure is not yet scheduled but Good Faith Estimate is requested

Notice of Right to Receive a GFE

Providers and facilities **are required to inquire** whether the patient is uninsured or choose to utilize insurance. **NSA requires that Providers/Facilities must inform uninsured (or self-pay) individuals that Good Faith Estimates of expected charges are available to uninsured (or self-pay) individuals upon scheduling an item or service or upon request.**

- This information must be provided **in writing and orally** during scheduling an item or service or when the individual has questions about the cost.
- Must be clear, understandable, available in accessible formats and in the individual's language.
- Prominently displayed.
- Posted on the provider's or facility's website.
- Posted in the provider's or facility's office, and on-site where scheduling or questions about the cost of items or services occur.
- CMS has published a Standard Notice of Right to Receive Good Faith Estimate of Expected Charges.

GFE's Convening & Timelines

The **Convening** provider or facility is the provider or facility receiving the initial request for a Good Faith Estimate from an uninsured person and/or would be **responsible for scheduling** the primary item or service subject to the Good Faith Estimate.

The **Co-provider or facility** furnishes items or services **in conjunction** with the primary item or service.

- **Timelines to provide the GFE:**
  - Provide within 1 business day of scheduling an item or service to be provided in at least 3 business days, or:
  - Provide within 3 business days of scheduling an item or service to be provided in at least 10 days.
  - When a Good Faith Estimate is requested at any time without scheduling the item or service, the estimate must be provided within 3 business days after request.

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Check all applicable items related to GFE expected charges

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Do you have a NSA Toolkit or Resource Manual/Central Repository? If so, what does it include?

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Helpful References

CMS.gov
Centers for Medicare & Medicaid Services

- ✓ No Surprises Act | CMS
- ✓ Overview of rules & fact sheets | CMS
- ✓ CMS Notice and Consent for Out-of-Network Insurance Plans
- ✓ CMS Good Faith Estimate and Patient-Provider Dispute Resolution Process Template Forms
- ✓ **GFE & PPDR PROCESS:** https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791

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NSA Toolkit

- Ensemble's Operational Workflows
- Good Faith Estimate
- Model Disclosure
- Notice and Consent
- Terminology
- FAQs
- Official Documents
- CMS Resources & Patient Escalation Links
- Training Content
- Standard Operating Procedures
- In Network & Out of Network Definitions, *as applicable*

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Scenario #1, Emergency Services: Out-of-Network --> Neither the facility or any of the providers may bill or hold liable beneficiaries, enrollees or participants in group health plans or group or individual health insurance coverage

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Scenario #2
Emergency Services: Post-Stabilization Services

- **Nonparticipating providers and facilities may balance bill for post-stabilization services, *only if all the following conditions have been met*:**
- **Attending Emergency Physician Determination**
  - Availability of alternative participating provider and facility within a reasonable travel distance
  - Patient ability to travel using non-medical or non-emergency medical transportation
  - Patient is in a condition to receive notice and provide informed consent.
- **Notice and Consent**
  - Provide patient with Notice and Consent - Includes a good faith estimate of charges
- **Unforeseen Circumstances**
  - A provider or facility cannot balance bill for items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the nonparticipating provider or facility previously satisfied the notice and consent criteria.
- **State Law Requirements:** *If there is a state law governing balance billing, facilities and providers are required to comply (e.g., Virginia, Ohio, etc.):* FAQ - Surprise Medical Bills (virginia.gov)

Scenario #3
Non-Emergency Services: Non-Participating Provider at Certain Participating Health Care Facilities (INN)

Note that notice and consent requirements *do not* apply to the following list of ancillary services, for which the prohibition against balance billing remains applicable:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology and neonatology,
- Items and services provided by assistant surgeons, hospitalists, and intensivists,
- Diagnostic services, including radiology and laboratory services, and:
- Items and services provided by a nonparticipating provider if there is no participating provider who can provide such item or service at such facility.

Scenario #3
Non-Emergency Services: Non-Participating Provider at Certain Participating Health Care Facilities (INN)

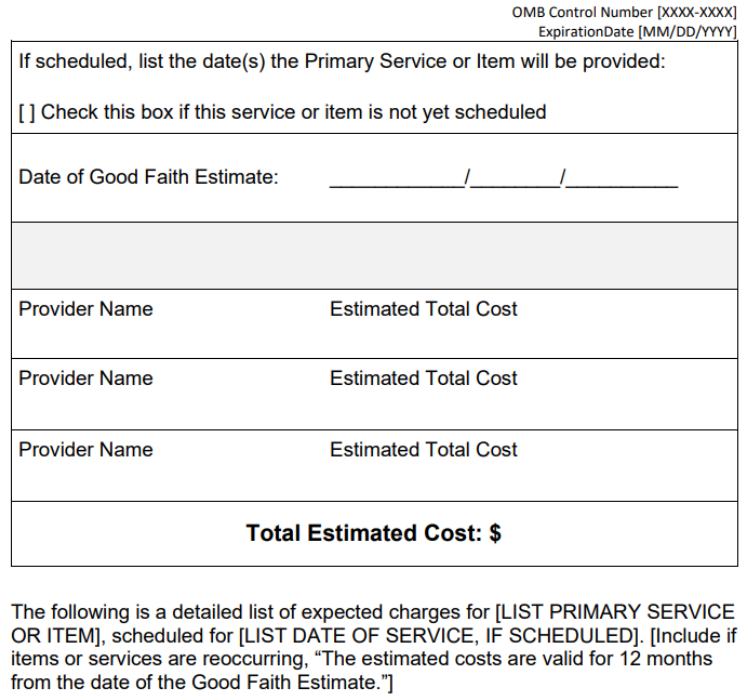
- **Model Disclosure Notices must be:**
  - If provider has a private office where patients schedule care, check-in for appointments or pay for services, then they must prominently (1) post the Model Disclosure Notice and (1) provide the patient with the Model Disclosure Notice (one page, double-sided).
- **Notice and Consent Requirements**
  - For clients intending to balance bill, provide Notice and Consent to patients where required and appropriate for post-stabilization services or scheduled, non-emergency services by OON providers in INN facilities - Includes a good faith estimate of charges.
  - Provide at least 72 hours before scheduled services or on date of scheduled service if appt made less than 72 hours before service.
  - Where the patient is being presented with the Notice and Consent on the same day the items or services will be furnished, then the patient must be given 3-hour timeframe to review and provide consent; there is no exception to this timeframe.
- **Payer Notification**
  - If provider plans to balance bill, then they must notify the payer and provide copy of Notice and Consent per Payer guidelines.

Scenario #4
Uninsured/Self-Pay Patients

- **Uninsured (or self-pay) individual means:**
  - An individual who does not have benefits for an item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, Federal health care program, or a Federal employee health benefits plan, or:
  - An individual who has such benefits but who does not seek to have a claim for such item or service submitted to such plan or coverage
  - An individual presenting with auto liability, workman's comp or other TPL coverage
  - Where the patient has *only* this type of coverage
    - Short-term limited duration coverage
    - Health Care Sharing Ministry coverage

Scenario #4
Uninsured/Self-Pay Patients

- **Good Faith Estimate (GFEs)**
  - The good faith estimate must include expected charges for the items or services that are reasonably expected to be provided in conjunction with the primary item or service, including items or services that may be provided by other providers and facilities
  - Provide within 1 business day or 3 business days of scheduling service, depending upon service date
  - Good for 12 months
  - Can include recurring services
  - If estimates change, GFE should be updated
- **CMS GFE Example:** Good Faith Estimate Example (cms.gov)



OMB Control Number [XXXX-XXXX]
ExpirationDate [MM/DD/YYYY]

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."]

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