No Surprises Act
HFMA Greater Heartland
Spring Conference

May 16, 2022

WEALTH ADVISORY | OUTSOURCING | AUDIT, TAX, AND CONSULTING

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Disclaimer

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Agenda

- No Surprises Act – General Overview
- History of No Surprises Act
- Key concepts/provisions
- Recent Legal Activity
- Federal versus State Legislation
- Good Faith Estimates
- Next Steps

Learning Objectives

In this session we will discuss the timelines and mandates of the No Surprises Act (NSA). We will discuss when the NSA applies and when it does not. We will discuss how federal legislation interacts with similar state surprise billing legislation. Our discussion will include the needs to provide a Good Faith Estimate (GFE) and the responsibilities of the convening and co-providers. The discussion include a discussion of the independent dispute resolution (IDR) process. We will share information relating to recent judicial proceedings and decisions. We will also discuss actions by commercial payers in relation to the NSA.

Attendees of this session will:

- Obtain a better understanding of the broader framework of the No Surprises Act and the important issues requiring actions by healthcare providers.
- Gain a better understanding of the key provisions for informing patients of their rights and the provisions of providing patients with an estimate of their costs of care.
- Acquire a better understanding of the interrelationships of state and federal surprise billing legislation.
- Gain an understanding of the risk related to commercial payer activities indirectly and directly related to the NSA.

No Surprises Act – General Overview

Major Provisions of the ACT

- Effective 1/1/2022
- Requirement for both health care insurers and health care providers
- Covers most insurance including self funded.
- Establish the federal independent dispute resolution process that providers, facilities, plans, and issuers may use to resolve ongoing reimbursement disputes for out-of-network claims subject to the No Surprises Act.
- Require providers to generate and share a good faith estimates for all scheduled services with uninsured and self-pay patients, including in instances where the patient may be shopping and not at the point of scheduling.
- Establish a process for uninsured and self-pay patients to dispute provider charges for care that are at least $400 more than the good faith estimate for those same services.
- Modify existing external review requirements as part of health plan/issuer oversight to incorporate provisions related to the No Surprises Act.

No Surprises Act: Top Line Details

Emergency	• Prohibits balance billing in out-of-network emergency situations, including post-stabilization (unless notice/consent is given)
Non-Emergency	• Prohibits balance billing in non-emergency situations at in-network facilities with out-of-network providers (unless notice/consent is given)
Ambulance	• Prohibits balance billing with emergency air ambulances services, but not ground ambulances
Insurance	• Applies to individual, group markets as well as ERISA/self-insured and federal employee benefit plan etc. In general, does not apply to account-based plans, retiree plans, short-term/limited duration plans
Effective	• Generally effective January 1, 2022

Major Provisions of the ACT

Health Care Insurer's

- Insurance must cover emergencies as if they were "in network"
- Insurance must either pay or issue a denial within 30 days of receiving the claim
- Insurance must pay the provider (for clean claims)
- Patient cost based on "recognized amount" or "qualifying amount"
- Must update provider directories.
- Will need to supply the patient (member) with an Advanced EOB (2023).

Major Provisions of the ACT

Providers

- Must post prominently the Patient Rights and Protection against Surprise Billing at physical locations and webpages
- Must provide the patient with surprise billing protection form
- Must provide the patient with a Good Faith Estimate containing all potential charges and the estimated out of pocket expense
- Refrain from balance bill self-pay, uninsured and out-of- network patients
- Must respond to patients challenging a “surprise bill”
- Have the ability to challenge payer on payments deemed to be below the carrier’s

No Surprises Act General Overview

Insurer

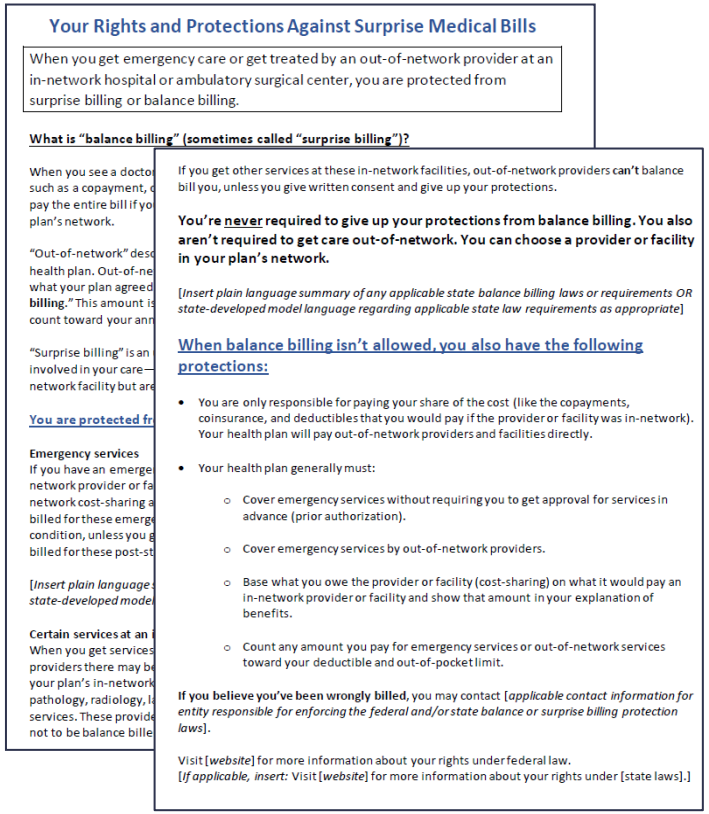
- Section 111 of the Act requires health plans to provide an **Advanced EOB** for scheduled services one to three business days in advance, dependent on date of intended service/item, to give patients transparency into which providers are expected to provide treatment, the expected cost, and the network status of providers.

Providers

- Section 112 requires health care providers and facilities to verify what type of coverage the patient is enrolled in and provide notification of a **Good Faith Estimate** of charges to the payer/patient at least three days in advance of service/item and no later than one day after scheduling the service.

CAQH CORE – No Surprises Here: Recommendations from the CAQH CORE Advanced Explanation of Benefits Advisory Group, November 17, 2021.

Model Notice: Protection From Surprise Bills



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 docto… such as a copayment, … pay the entire bill if yo… plan's network.

"Out-of-network" desc… health plan. Out-of-ne… what your plan agreed… **billing.**" This amount is… count toward your ann…

"Surprise billing" is an … involved in your care— … network facility but are…

You are protected fr…

Emergency services
If you have an emerge… network provider or fa… network cost-sharing a… billed for these emerg… condition, unless you g… billed for these post-st…

[Insert plain language … state-developed model…

Certain services at an i…
When you get services … providers there may be … your plan's in-network … pathology, radiology, l… services. These provide… not to be balance bille…

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]*.

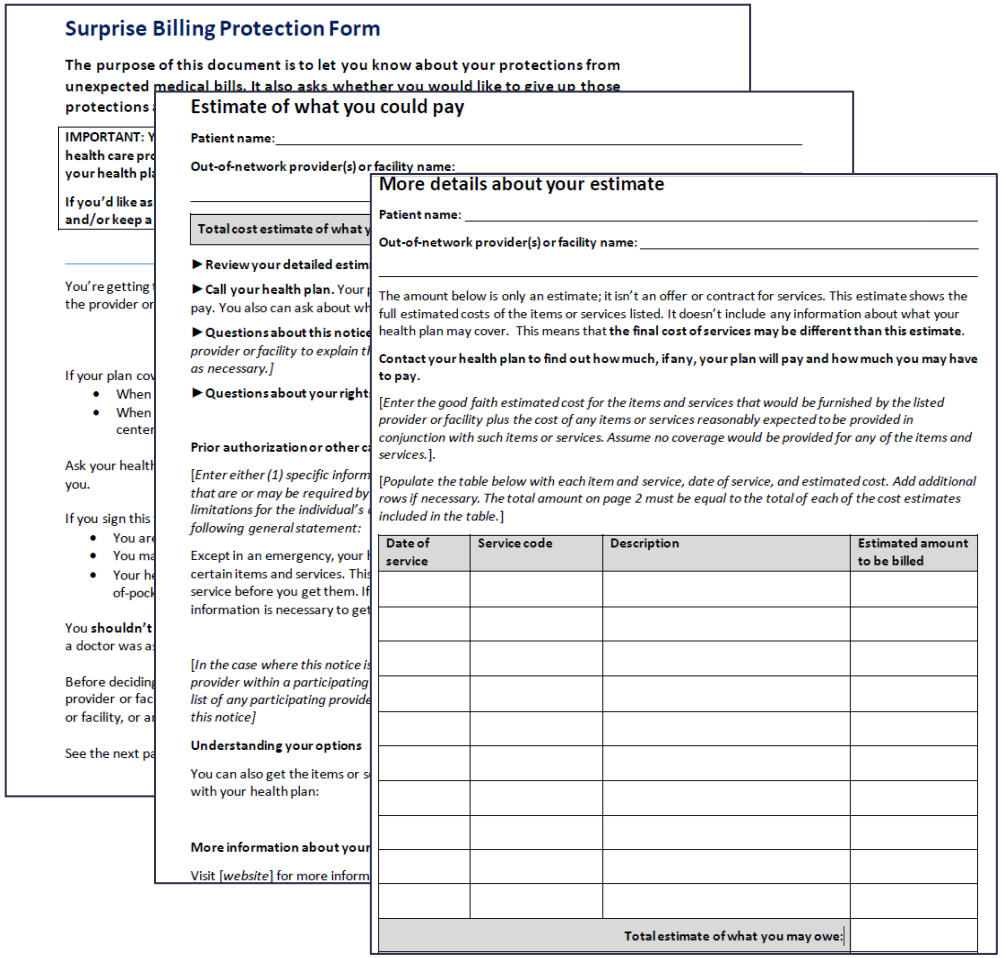
Visit *[website]* for more information about your rights under federal law.
[If applicable, insert: Visit *[website]* for more information about your rights under [state laws].*]*

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…You **can't** be balanced billed for these emergency services. This includes services you get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain Services at an in-network hospital or ASC

- When you get services form 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.



Surprise Billing Protection Form

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections

IMPORTANT: Y
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Estimate of what you could pay

Patient name: _____

Out-of-network provider(s) or facility name: _____

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Total cost estimate of what y

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▶ Call your health plan. Your
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▶ Questions about this notice
provider or facility to explain t
as necessary.]

▶ Questions about your right

Prior authorization or other c

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that are or may be required by
limitations for the individual's
following general statement:

Except in an emergency, your
certain items and services. This
service before you get them. If
information is necessary to get

[In the case where this notice is
provider within a participating
list of any participating provide
this notice]

Understanding your options

You can also get the items or s
with your health plan:

More information about your

Visit *[website]* for more inform

More details about your estimate

Patient name: _____

Out-of-network provider(s) or facility name: _____

_____

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. This means that **the final cost of services may be different than this estimate.**

Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.

[Enter the good faith estimated cost for the items and services that would be furnished by the listed provider or facility plus the cost of any items or services reasonably expected to be provided in conjunction with such items or services. Assume no coverage would be provided for any of the items and services.].

[Populate the table below with each item and service, date of service, and estimated cost. Add additional rows if necessary. The total amount on page 2 must be equal to the total of each of the cost estimates included in the table.]

Date of service	Service code	Description	Estimated amount to be billed
		Total estimate of what you may owe:	

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care.

With my signature, I am saying that I agree to get the items or services from (select all that apply):

☐ [*doctor's or provider's name*] [*If consent is for multiple doctors or providers, provide a separate check box for each doctor or provider]*

☐ [*facility name*]

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services, or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on [*enter date of notice*] explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You **don't** have to sign this form. But if you don't sign, this provider or facility might not treat you. You can choose to get care from a provider or facility in your health plan's network.

_____ or _____
Patient's signature — Guardian/authorized representative's signature

_____ _____
Print name of patient — Print name of guardian/authorized representative

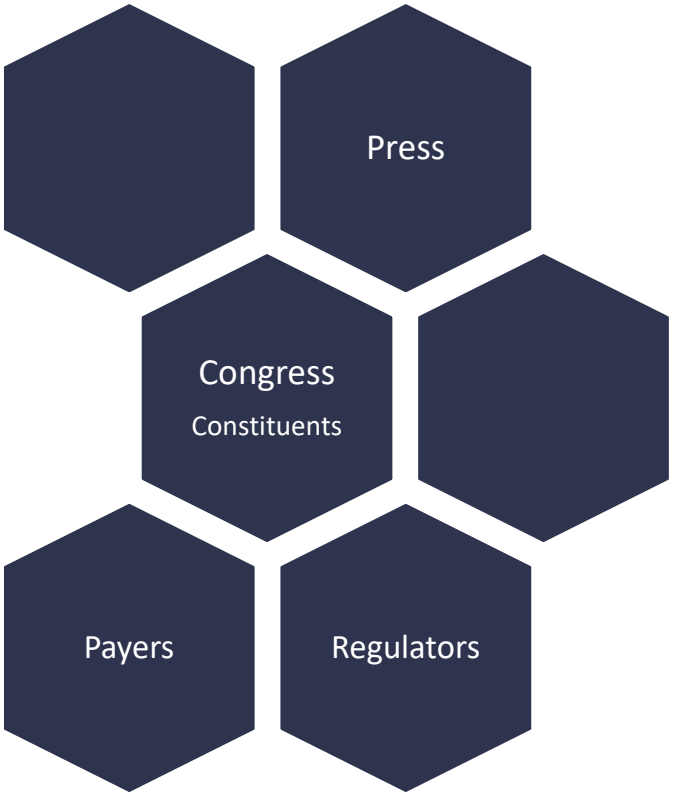
_____ _____
Date and time of signature — Date and time of signature

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections.

History of the No Surprises Act

How Did We Get Here?



Growing concerns, press scrutiny, Congressional interest

- *Multiple pieces of legislation over many years*
- *Ongoing concern with opaqueness of prices/costs to consumers*
- *Patients caught in middle and on the hook for surprise bills*

Pandemic-related legislative vehicle (Consolidated Appropriations Act of 2020) includes No Surprises Act possible; Enacted on December 27, 2020

Three different federal agencies jointly work on regulations. Three regulations already released to implement the law

- *Requirements Related to Surprise Billing; Part I (July 1, 2021 IFR)*
- *Requirements Related to Air Ambulance Services, Agent and Broker Disclosures and Provider Enforcement (Sept. 10, 2021, Proposed Rule)*
- *Requirements Related to Surprise Billing; Part II (Sept. 30, 2021, IFR)*

A baby was treated with a nap and a bottle of formula. His parents received an $18,000 bill.

Why a simple, lifesaving rabies shot can cost $10,000 in America

An ER visit, a $12,000 bill — and a health insurer that wouldn't pay

She didn't get treated at the ER. But she got a $5,751 bill anyway.

Toe ointment, a $937 bill, and a hard truth about American health care

He went to an in-network emergency room. He still ended up with a $7,924 bill.

A $20,243 bike crash: Zuckerberg hospital's aggressive tactics leave patients with big bills

After Vox story, Zuckerberg hospital rolls back $20,243 emergency room bill

Hit by a city bus — and hit with a $27,660 city hospital bill

After Vox story, California lawmakers introduce plan to end surprise ER bills

A spinal surgery, a $101,000 bill, and a new law to prevent more surprises

Vox

investigative series example

https://www.vox.com/health-care/2018/12/18/18134825/emergency-room-bills-health-care-costs-america

Key Concepts of the No Surprises Act

No Surprises Act

Emergency Situations

- Patient coverage (and cost-sharing) as if in-network — regardless of whether the facility or provider(s) are participating providers in the patient's insurance plan (if insurer covers any type of emergency service)
- Applies to emergency services, other departments of hospital used for treatment and post-stabilization services potentially
- Insurer cannot use prior authorization/waiting periods, cannot deny based on a diagnosis code
- Applies when in a hospital ER, independent freestanding emergency departments, urgent care when state licensure laws permit emergency services

Non-Emergency Situation

- Patients at in-network facilities but treated by out-of-network providers – they are treated as in-network and prohibited from receiving a balance bill unless notice and consent are given to be balanced billed at out-of-network rate
- In certain cases, notice and consent are prohibited altogether for items/services
- A health care facility in a non-emergency situation includes a hospital, hospital outpatient department, critical access hospital, ambulatory surgical center

IFR: What Are Emergencies?

In general, “emergency medical condition,” “emergency services,” and “to stabilize” generally have the meaning given to them under the Emergency Medical Treatment and Labor Act (EMTALA). This would include:

- an appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, including ancillary services routinely available to the emergency department, to evaluate whether an emergency medical condition exists; and
- such further medical examination and treatment as may be required to stabilize the individual (regardless of the department of the hospital in which the further medical examination and treatment is furnished) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department.

Prudent Layperson Standard

The IFR further discusses the term “emergency medical condition” as meaning a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition, such as:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
2. Serious impairment to bodily functions
3. Serious dysfunction of any bodily organ or part
4. This includes mental health conditions and substance use disorders

Insurer Denial Limitations in Emergency Situations

- IFR specifically addresses current practice by some insurers in denying ED claims
  - The regulators state that denying coverage of certain services provided in the emergency department by determining whether an episode of care involves an emergency medical condition based solely on final diagnosis codes or automatically deny coverage based on a list of diagnosis codes initially, without regard to the individual's presenting symptoms or any additional review, is inconsistent with the law/regulations.

IFR = Interim Final Rule

Emergencies: When Can We Balance Bill?

In an emergency, to balance bill for post-stabilization services, the following must be met:

1. Attending emergency physician or treating provider (who has evaluated the patient) must determine the patient is able to travel using nonmedical transportation or nonemergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into consideration the individual's medical condition. This condition may be affected by an individual's transportation options, including individual's location, social risk, and other factors.
2. Specific notice requirements satisfied and consent given
3. Patient (or the authorized representative) must be in a condition to receive the information in the notice and to provide ***informed consent***. Various considerations are required for informed consent (individual's state of mind and emotional state, the IFRs specifically references drug, alcohol, medications, behavioral health symptoms, contextual and cultural factors for members of underserved communities, including lack of trust due to historical inequities, misinformation about informed consent process, barriers to comprehension…)
4. Provider/facility must satisfy any additional requirements or prohibitions imposed under state law

This Seems To Be A High Bar

Example

Emergency

- Jane is on vacation out-of-state, falls, looses consciousness
- She also cannot move her wrist
- She goes to closest hospital ER. It is not in her network
- Her current insurance plans does cover ED services

Treated as if in-network
No balance billing

Other Considerations/Post-Stabilization

- Jane drove cross-county to her vacation by herself
- She is 1,500 miles from home
- Jane has a concussion
- Jane's wrist is shattered and needs immediate surgery

She's stable but what about necessary surgery? She's 1,500 miles from home and alone. Is that "reasonable distance" to receive needed in-network care?

Nonemergency: When Can We Balance Bill?

- In-network facility but out-of-network provider
- A sampling of the statute/IFR requirements around notice/consent

- Provided to patient at least 72 hours prior (if scheduled within at least 72 hours) or if scheduled same-day, not less than 3 hours
- Name(s) of providers must be in the consent
- Form clearly states consent is optional or patient may seek care from a participating provider
- A list of in-network providers at that facility is given
- The form is signed, maintained by provider, and given to the patient (email or mail, patient preference)
- Information on prior authorization or other care management requirements
- A good faith estimate of the cost
- Standard forms to be used
- Must be delivered separate from other documents

But Wait, Exclusions To Notice & Consent

In general, none of the following may be balanced billed and notice/consent are not allowable in emergency and/or non-emergency situations for:

- Items/services related to emergency medicine, anesthesiology, pathology, radiology, neonatology (by physician or non-physician practitioner)
- Items and services provided by assistant surgeons, hospitalists, and intensivists (and specialists as determined by regulation)
- Diagnostic services (including radiology, laboratory services)
- Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility,
- Unforeseen medical needs arising at the time of the service

Example

Non-Emergency

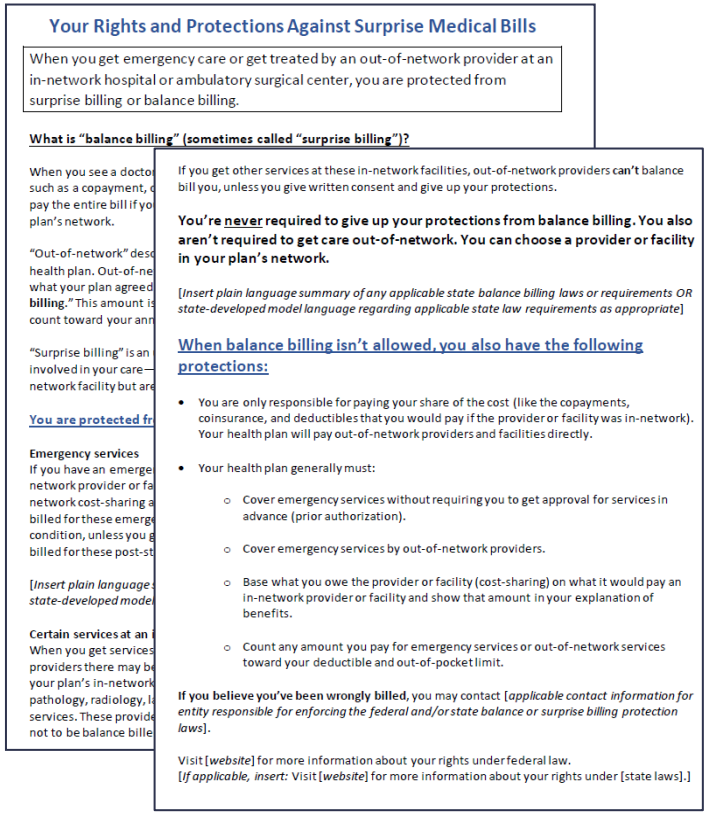
- John needs his ACL reconstructed
- He will go to an ASC covered by his insurer but his preferred surgeon is not in-network
- John still wants his out-of-network (OON) surgeon

Notice & Consent?

- John would need to receive required notice, consent to that but only for the surgeon (or other allowable providers)
  - Anesthesiologist may not ask John to be balance billed

If John is provided notice within required times and he then consents, he can be balance billed by the surgeon as OON. He is treated as in-network by other excluded providers.

Model Notice: Protection From Surprise Bills



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[Insert plain language … state-developed model…

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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.
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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].*]*

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…You **can't** be balanced billed for these emergency services. This includes services you get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain Services at an in-network hospital or ASC

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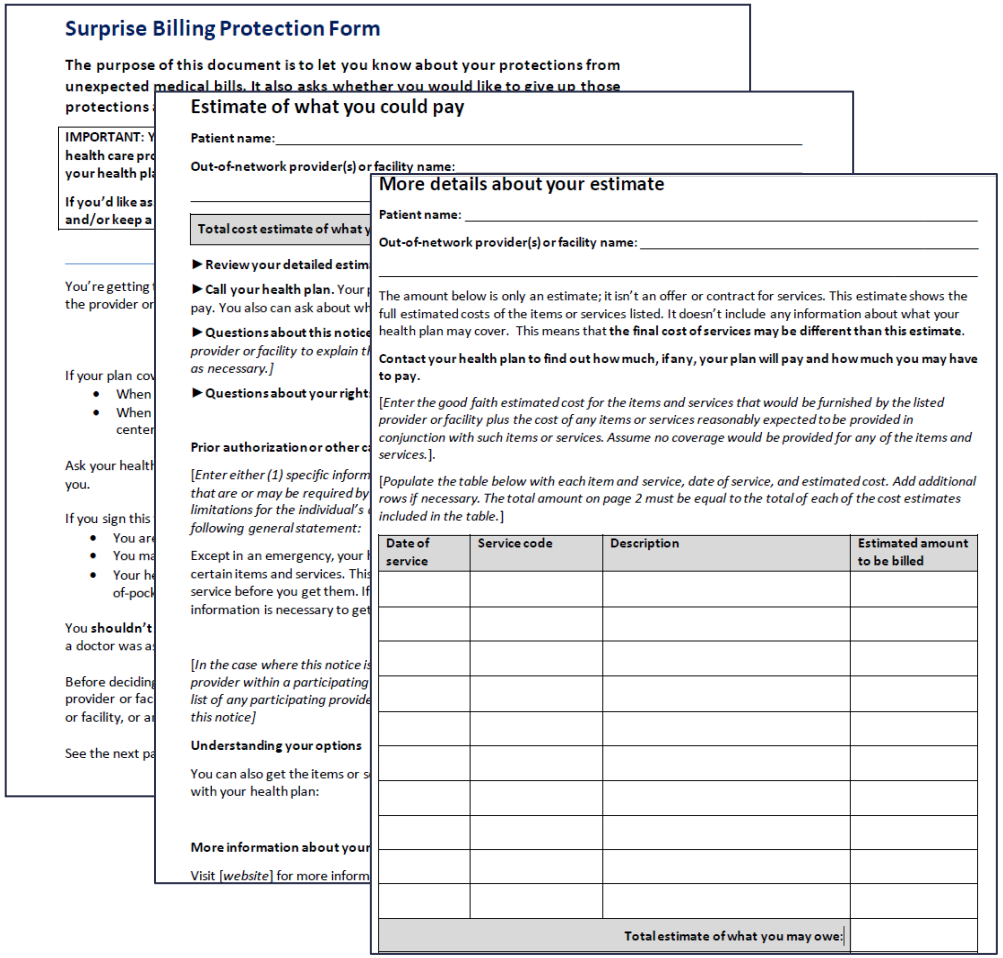

Surprise Billing Protection Form

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections

IMPORTANT: Y
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See the next pa

Estimate of what you could pay

Patient name: _____

Out-of-network provider(s) or facility name: _____

_____

Total cost estimate of what y

▶ Review your detailed estim

▶ Call your health plan. Your
pay. You also can ask about wh

▶ Questions about this notice
provider or facility to explain t
as necessary.]

▶ Questions about your right

Prior authorization or other c

[Enter either (1) specific inform
that are or may be required by
limitations for the individual's
following general statement:

Except in an emergency, your
certain items and services. This
service before you get them. If
information is necessary to get

[In the case where this notice is
provider within a participating
list of any participating provide
this notice]

Understanding your options

You can also get the items or s
with your health plan:

More information about your

Visit *[website]* for more inform

More details about your estimate

Patient name: _____

Out-of-network provider(s) or facility name: _____

_____

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. This means that **the final cost of services may be different than this estimate.**

Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.

[Enter the good faith estimated cost for the items and services that would be furnished by the listed provider or facility plus the cost of any items or services reasonably expected to be provided in conjunction with such items or services. Assume no coverage would be provided for any of the items and services.].

[Populate the table below with each item and service, date of service, and estimated cost. Add additional rows if necessary. The total amount on page 2 must be equal to the total of each of the cost estimates included in the table.]

Date of service	Service code	Description	Estimated amount to be billed
		Total estimate of what you may owe:	

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care.

With my signature, I am saying that I agree to get the items or services from (select all that apply):

☐ [*doctor's or provider's name*] [*If consent is for multiple doctors or providers, provide a separate check box for each doctor or provider]*

☐ [*facility name*]

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services, or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on [*enter date of notice*] explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You **don't** have to sign this form. But if you don't sign, this provider or facility might not treat you. You can choose to get care from a provider or facility in your health plan's network.

_____ or _____
Patient's signature — Guardian/authorized representative's signature

_____ _____
Print name of patient — Print name of guardian/authorized representative

_____ _____
Date and time of signature — Date and time of signature

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections.

Example – Let's Think about it.

If John is provided notice within required times and he then consents, he can be balance billed by the surgeon as OON. He is treated as in-network by other excluded providers.

"By signing, I give up my federal (and state) consumer protections and agree to pay more for out-of-network care."

Realistically -

Why would anyone agree to consent to give up their rights after being informed that it is their right to refuse? If they have insurance, why would one not expect to pay insurance rates versus full charges?

NSA Covers Most Health Plan Types

- Self-Funded ERISA Plans
- CDI-Regulated Plans
- DMHC-Regulated Plans (Knox-Keene)
- State/Local Employee Health Plans
- Federal Employee Health Plans
- Plans grandfathered under the Affordable Care Act
- Church Plans
- Catastrophic Insurance
- Student Health Insurance

- Health Care Sharing Ministries
- Travel Insurance
- Indemnity Plans
- Short-Term, Limited Duration Insurance
- Non-Federal governmental retiree-only plans
- International Insurance

OON Payments, Disputes - IDR

OON Patient Cost-Sharing, Provider Payments

Patient Responsibility

Patient OON in covered situations is called the "recognized amount" and determined under one of three scenarios:

1. An amount determined by an applicable All-Payer Model Agreement
2. If there is no applicable All Payer Model Agreement, an amount determined by specified state law;
3. Qualifying Payment Amount (**QPA**) is the median in-network rate for like services in that geography

Determining QPA

- ✓ An insurer has sufficient data for a QPA if there are three or more provider contracts for a service in a given region
- ✓ A geographic region is an MSA in a state and then one for all other regions in the state. If still not sufficient data, the region broadens out to the nine census regions
- ✓ If there is still insufficient data to determine a contract in a region or the service is new, there are alternative methods to calculating the QPA, one of which is using a database (non-conflicted). State all-payer claims databases are eligible

OON Patient Cost-Sharing, Provider Payments

Patient Responsibility

1. Patient OON in covered situations is called the "recognized amount" and determined under one of three scenarios:
2. An amount determined by an applicable All-Payer Model Agreement
3. If there is no applicable All Payer Model Agreement, an amount determined by a specified state law; or,
4. Qualified Payment Amount (QPA) is the median in-network rate for like services in that geography

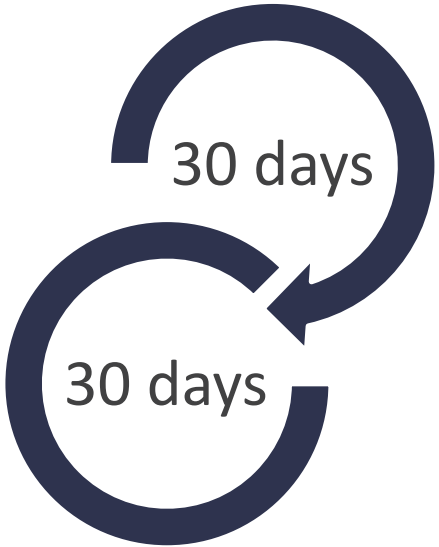
Provider Payment

OON amount paid by insurer to provider determined under one of four scenarios:

1. An amount determined by an applicable All-Payer Model Agreement (Maryland)
2. If there is no applicable All-Payer Model Agreement, then an amount determined by a specified state law;
3. If 1,2 are not applicable, then an amount agreed to by plan/issuer and provider/facility
4. If none of the above apply, then the parties may enter Independent Dispute Resolution (IDR) process and amount paid will be determined by the IDR entity

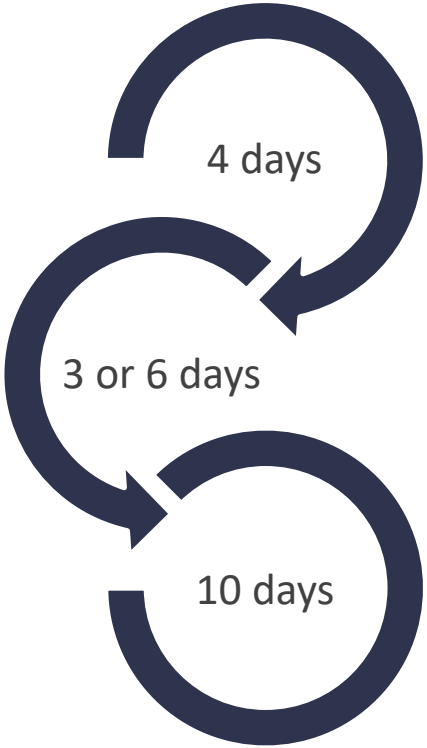
Initiating Open Negotiation Notice

- Within **30 days**, insurer must either pay the claim or deny it
- After initial payment or denial, an open negotiation period may occur but be initiated within **30 business days**
- Party initiating the open negotiation must provide written notice to the other party of its intent to negotiate, referred to as an ***open negotiation notice***
  - Notice must include information sufficient to identify the items or services subject to negotiation, including the date the item or service was furnished, the service code, the initial payment amount or notice of denial of payment, as applicable, an offer for the out-of-network rate, and contact information of the party sending the open negotiation notice
  - Federal agencies are concurrently issuing a standard notice that the parties must use to satisfy the open negotiation notice requirement



Independent Dispute Resolution (IDR)

- If parties cannot come to agreement during open negotiation, either party can initiate the IDR process:
  - Must be initiated within **4 days** of end of open negotiation
  - Entity must submit a notice to the other party and to the Departments (Notice of IDR Initiation) through the Federal IDR portal
  - 8 different pieces of information required in this notice
  - The Departments have developed a form that parties must use
- Parties may jointly select IDR entity (must happen within **3 days**) or if cannot agree, federal government randomly selects one from approved IDR entities (must happen within **6 days**)
- Once IDR entity is selected, parties must provide their best and final offers within **10 business days**



Offers & IDR Decisions

- IDR entities/arbitrators may not alter the offers submitted by providers/payers
- IDR entities/arbitrators may only consider certain things:
  - level of training, experience, quality and outcomes, market share held in that geographic region, patient acuity, complexity of services, teaching status, case mix, and scope of services
- IDR entities/arbitrators may not consider:
  - Provider's charges or the payment rates from government programs, such as Medicare or Medicaid
- IDR entity/arbitrators to consider QPA

But….QPA Becomes A Benchmark?

- The regulations state an IDR entity must ***presume*** that the QPA is an appropriate payment and selects the offer closet to the QPA unless the credible information submitted by the parties clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate
  - *"The Departments are of the view that the best interpretation … [of the law] is that when selecting an offer, a certified IDR entity must look first to the QPA, as it represents a reasonable market-based payment for relevant items and services, and then to other considerations. This* ***presumption*** *that the QPA is the appropriate out-of-network rate can be rebutted by presentation of credible information about additional circumstances that clearly demonstrate that the QPA is materially different from the appropriate out-of-network rate."*

Successfully challenged and vacated in Federal Court

Provider groups believe this tilts the IDR process towards insurers and is not consistent with the No Surprises Act statutory text. Several lawsuits filed on this.

Final IDR Determination

- IDR entity must provide determination in writing
- Parties then enter a 90-calendar day cooling offer period where they may not submit similar claims under IDR process
- Fees paid by both parties at beginning. Prevailing party's fees are then returned

Independent Dispute Resolution (IDR)

List of certified independent dispute resolution entities

The Department of Health and Human Services, the Department of Labor, and the Department of Treasury have certified these organizations to serve as independent dispute resolution entities in the federal independent dispute resolution process between providers, facilities or providers of air ambulance services and group health plans, health insurance issuers and Federal Employees Health Benefits program carriers.

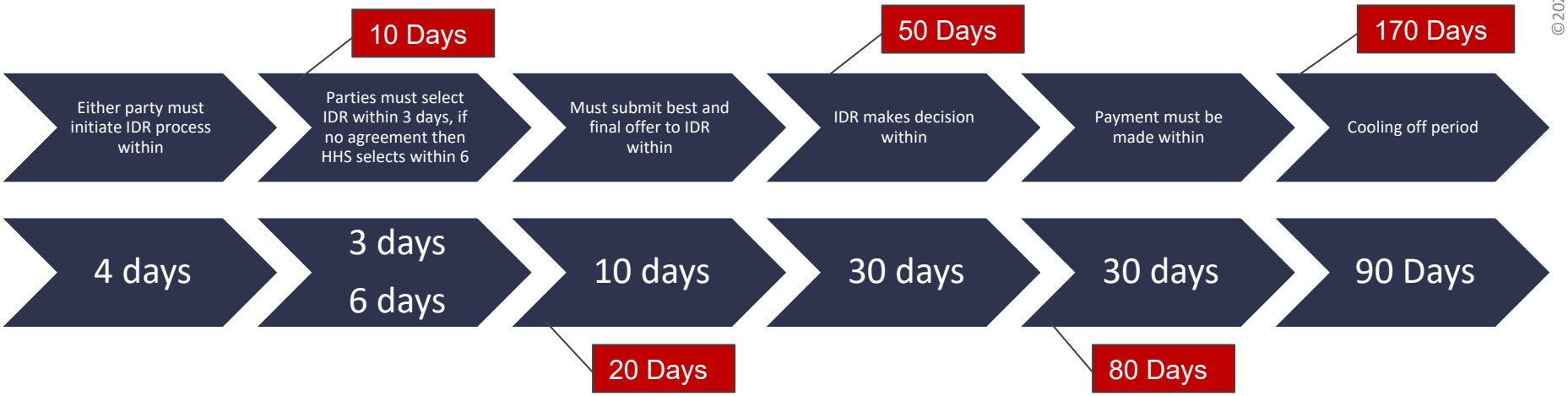
List of certified organizations | CMS

Starting January 1, 2022, if a provider or facility and a health plan can't agree on the payment amount for an out-of-network service covered by No Surprises rules, these organizations can be selected to make a payment determination.

The application process opened September 30, 2021, and will remain open to accept applications on a rolling basis. The list will be updated as additional organizations become certified.

Legal Business Name	DBA	Website	Flat Fee (single determinations)	Batched Fee (batched determinatio
C2C Innovative Solutions, Inc.	C2C Innovative Solutions, Inc.	https://www.c2cinc.com	$299	$670
Federal Hearings and Appeals Services, Inc.	Federal Hearings and Appeals Services, Inc.	https://www.fhas.com	$365	$450
Island Peer Review Organization	IPRO	https://ipro.org	$500	$670

IDR Timeline



Payment can be delayed up to 170 day through the IDR process, while the payer keeps the money.

And so much more!

- Many requirements for health plans
- Provider directories
- Adverse Benefit Decisions/External Review
- Patient-Provider disputes (selected dispute resolution)
- Interaction with state surprise billings laws
- State vs. Federal Enforcement
- Reporting requirements related to air ambulances
- And the list goes on….

In general:

- Self-funded plans governed by federal law
- Air ambulance governed by federal law
- States without surprise billing laws governed by federal law
- State surprise billing laws supersede if don't conflict with federal Act
- Lots and lots of complexity and questions remain due to this interaction!

Recent Legal Activity

Legal Challenges to the NSA

- On February 23, a federal judge in Texas last night struck down certain parts of the federal government's surprise medical billing regulations related to the arbitration process for determining payment for services by out-of-network providers, saying the regulations conflict with the text of the No Surprises Act.
- The judge ruled in favor of the Texas Medical Association in its challenge of the Biden Administration's Sept. 30, 2021, rule that directed arbiters under the independent dispute resolution process to presume that the median in-network rate is the appropriate out-of-network rate and limit when and how other statutory factors come into play.
- "The Court determines that the Act unambiguously establishes the framework for deciding payment disputes and concludes that the Rule conflicts with the statutory text," wrote U.S. District Judge Jeremy Kernodle.
- The court's ruling does not disturb the No Surprises Act's core protections for patients.
- On April 22, 2022, the Department of Health and Human Services ("HHS"), in conjunction with several other federal agencies, filed a notice of appeal in opposition to a Texas federal judge's summary judgement ruling regarding the No Surprises Act.

Legal Challenges to the NSA

- The AHA and American Medical Association in December filed a separate lawsuit challenging parts of the rule saying the regulation places a heavy thumb on the scale of an independent dispute resolution process, unfairly benefiting commercial health insurance companies. The AHA and AMA lawsuit is being considered in the U.S. District Court for the District of Columbia.
- The AHA, AMA and their co-plaintiffs filed their lawsuit against the departments of HHS, Labor, and Treasury, along with the Office of Personnel Management in the U.S. District Court for the District of Columbia.
- If uninsured or will self-pay (even if they have insurance) a good faith estimate is required to be provided to the patient.

Legal Challenges to the NSA

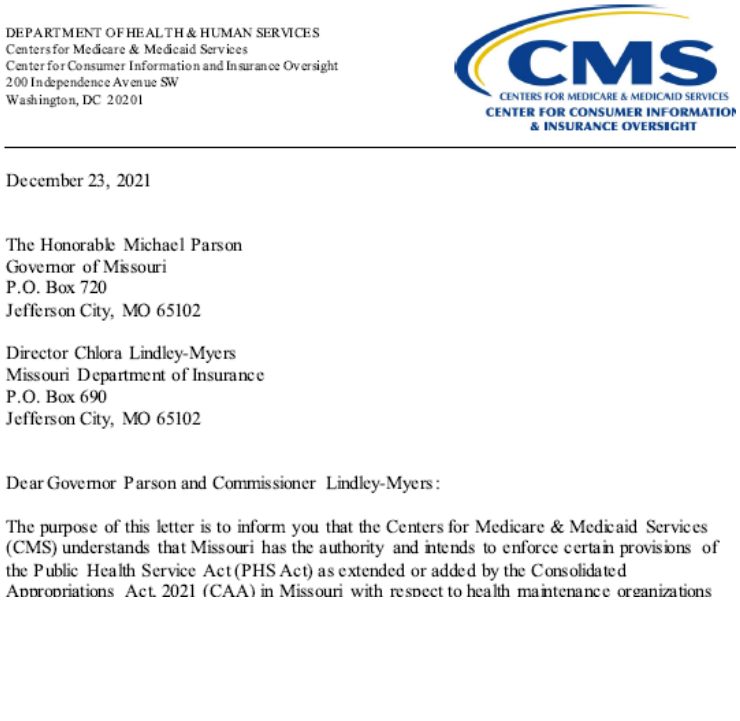
- A bipartisan group of 152 lawmakers urged the departments of HHS, Labor, and Treasury, along with the Office of Personnel Management to fix the independent dispute resolution provisions, noting the rule's approach "is contrary to statute and could incentivize insurance companies to set artificially low payment rates, which would narrow provider networks and jeopardize patient access to care – the exact opposite of the goal of the law."

Federal versus State Legislation

State Level Surprise and Balance Billing Legislation

- Many states have implemented legislation to protect patients.
- Both Missouri and Kansas have balance and surprise billing legislation.
- States without surprise billing laws governed by federal law
- State surprise billing laws supersede if don't conflict with federal Act and meet the requirements of the Federal Act.

State vs. Federal Enforcement



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

December 23, 2021

The Honorable Michael Parson
Governor of Missouri
P.O. Box 720
Jefferson City, MO 65102

Director Chlora Lindley-Myers
Missouri Department of Insurance
P.O. Box 690
Jefferson City, MO 65102

Dear Governor Parson and Commissioner Lindley-Myers:

The purpose of this letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) understands that Missouri has the authority and intends to enforce certain provisions of the Public Health Service Act (PHS Act) as extended or added by the Consolidated Appropriations Act, 2021 (CAA) in Missouri with respect to health maintenance organizations

Missouri does not have an applicable All-Payer Model Agreement that would determine the out-of-network rate. Based on the survey response and CMS communications with Missouri Department of Insurance staff, CMS understands that Section 376.690, Missouri Revised Statute (RSMo), is a specified state law that will apply for purposes of determining the out-of-network rate with respect to unanticipated out-of-network care furnished to individuals with coverage from health carriers in Missouri by out-of-network health care professionals at an in-network facility.[4] The federal independent dispute resolution process under section 2799A-1(c) of the PHS Act and 45 CFR 149.510 will apply for purposes of determining the out-of-network rate with respect to any items and services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in Missouri by nonparticipating providers and nonparticipating emergency facilities to which Section 376.690 RSMo does not apply. The federal independent dispute resolution process under section 2799A-2(b) of the PHS Act and 45 CFR 149.520 will apply for purposes of determining the out-of-network rate with respect to services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in Missouri by nonparticipating providers of air ambulance services. CMS will enforce the outcome of the federal independent dispute resolution process for cases in Missouri.

Missouri did not indicate that any applicable state resolution process for payment disputes between providers and patients currently exists. Therefore, the federal patient-provider dispute resolution process under section 2799B-7 of the PHS Act and 45 CFR 149.620 will apply for purposes of determining the amount an uninsured (or self-pay) individual must pay a provider, facility, or provider of air ambulance services for an item or service for which the billed charges are substantially in excess of the good faith estimate of the expected charges that the applicable provider, facility, or provider of air ambulance services provided the individual prior to furnishing such item or service. CMS will enforce the outcome of the federal patient-provider dispute resolution process in Missouri.

- The Federal NSA will take precedence in Missouri

State vs. Federal Enforcement

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

December 13, 2021

The Honorable Laura Kelly
Governor of Kansas
Capitol, 300 SW 10th Ave., Ste. 241S
Topeka, KS 66612-1590

Commissioner Vicki Schmidt
Kansas Insurance Department
1300 SW Arrowhead Rd.
Topeka, KS 666604

Director Julie Holmes
Kansas Insurance Department
Health & Life Division
1300 SW Arrowhead Rd.
Topeka, KS 66604

Dear Governor Kelly, Commissioner Schmidt, and Director Holmes,

The purpose of this letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has agreed to enter into a collaborative enforcement agreement with Kansas to enforce certain provisions of the Public Health Service Act (PHS Act) as extended or added by the

Kansas does not have an applicable All-Payer Model Agreement that would determine the out-of-network rate. Kansas did not identify in its survey response any state laws as governing the out-of-network rate. Therefore, the federal independent dispute resolution process under sections 2799A-1(c) and 2799A-2(b) of the PHS Act and 45 CFR 149.510 and 149.520 will apply for purposes of determining the out-of-network rate with respect to items and services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in Kansas by nonparticipating providers, nonparticipating emergency facilities, or nonparticipating providers of air ambulance services. Kansas will enforce the outcome of the federal independent dispute resolution process for such cases through the collaborative enforcement agreement.

Kansas Insurance Department staff identified the patient-provider dispute resolution process under K.S.A. 40-22a13 to 40-22a16 and K.A.R. 40-4-42 to 40-4-42g. However, these state processes do not meet the minimum federal requirements because they reference external review provisions related to adverse benefit decisions and, as Kansas indicated in the survey, are not consistent with section 2799B-7 of the PHS Act. Therefore, the federal patient-provider dispute resolution process under section 2799B-7 of the PHS Act and 45 CFR 149.620 will apply in Kansas for purposes of determining the amount an uninsured (or self-pay) individual must pay a provider, facility, or provider of air ambulance services for an item or service for which the billed charges are substantially in excess of the good faith estimate of the expected charges that the applicable provider, facility, or provider of air ambulance services provided the individual prior to furnishing such item or service. Kansas will enforce the outcome of the federal patient-provider dispute resolution process through the collaborative enforcement agreement.

- The Federal NSA will take precedence in Kansas

Good Faith Estimates

Good Faith Estimates

Providers, facilities are to ask patients if they have insurance and then do the following:

- If commercially/privately insured, the provider or facility is to notify the insurer of the expected charges which the plan then uses to prepare an Advanced Explanation of Benefits and sends to patient
  - *DELAYED until data standards are developed for this transfer of information*
- If uninsured or will self-pay (even if they have insurance) a good faith estimate is required to be provided to the patient
  - *NOT DELAYED but HHS will exercise enforcement discretion throughout 2022 for situations where the estimate provided does not include the expected charges from the other providers or facilities involved in the individual's care*

Generally Applies…

- **When** health care services are scheduled and/or patient requests estimate
- **With** insured, uninsured, self-pay (whether insured or not) patients
- **To** "primary item or service" – the main purpose for the scheduled service/health care to be received plus other health care items/services that are reasonably expected to be provided in conjunction (ex: facility fees/use, telehealth, imaging, lab …)
- **At** health care facility as defined as an institution (such as a hospital or hospital outpatient department, critical access hospital, ambulatory surgical center, rural health center, federally qualified health center, laboratory, or imaging center) in any State in which State or applicable local law provides for the licensing of such an institution
- **With** health care provider as defined as a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law, including an air ambulance provider

Important Aspects

- All costs must be included in a single document
- The responsibility for pulling the good faith estimate together is the "**Convening Health Care Provider or Convening Facility**" (the one who receives the initial request for a good faith estimate or **scheduling** the primary item or service)
- Convening provider/facility required to contact every "**Co-Provider or Co-Facility**" that would provide items or services in conjunction with a primary item or service to get respective estimated costs
- The estimate must include the "**Expected Charge**" (what the patient would be expected to pay with discounts etc.)
- **Service code** means the code that identifies and describes an item or service using the CPT, HCPCS, DRG or National Drug Code (NDC) code sets

Important Aspect (cont.)

- Items or services includes all encounters, procedures, medical tests, supplies, prescription drugs, durable medical equipment, and fees (including facility fees), provided or assessed in connection with the provision of health care
  - "expected to be reported in the good faith estimate including items or services such as those related to dental health, vision, substance use disorders and mental health."
  - HHS clarifies that to the extent an urgent care appointment is scheduled at least 3 days in advance, these interim final rules require a provider or facility to provide a good faith estimate"
- Period of care means the day or multiple days during which the good faith estimate for scheduled or requested item or service (or set of scheduled or requested items or services) are furnished or are anticipated to be furnished.
  - and also includes the period of time during which any facility equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services that would not be scheduled separately by the individual, are furnished

State Level Surprise and Balance Billing Legislation

- To protect patients from surprise bills and remove them from payment disputes between providers, providers of air ambulance services, and plans/issuers, the IFC established that in the case of a surprise medical bill, the patient pays an in-network cost-sharing rate for unanticipated OON services.
- This in-network rate is calculated based on a state all-payer model agreement, another specified state law, or, if neither of these apply, the Qualifying Payment Amount (QPA). The QPAis generally the plan or issuer's median contracted rate for the same or similar service in the specific geographic area as of 1/31/2019*. The balance of the bill following patient cost sharing and any initial payment from the plan/issuer is determined via an open negotiation period and, if needed, an IDR process.

* Adjusted for inflation annually.

Good Faith Estimates – Timing

Scheduled Services

- Individual schedules an item or service at least 3 business days before the date such item or service is to be so furnished, not later than 1 business day after the date of such scheduling (or, in the case of such an item or service scheduled at least 10 business days before the date such item or service is to be so furnished (or if requested by the uninsured (or self-pay) individual), not later than 3 business days after the date of such scheduling or such request).

Scheduling 3 days out, then due within 1 day

Scheduling 10 days out then within 3 days

Services Not Yet Scheduled

- Instances where uninsured (or self-pay) individual requests a good faith estimate of expected charges, but the item or service has not been scheduled, these interim final rules require that the treating provider furnish a good faith estimate to the uninsured (or self-pay) individual, within 3 business days of such request

Within 3 days of request

Various Required Elements of Good Faith Estimate

- Patient name and date of birth
- Itemized list of items or services expected to be provided by the co-provider or co-facility that are reasonably expected to be furnished in conjunction with the primary item or service as part of the period of care
- Applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service;
- Name, NPI, and TIN of the co-provider or co-facility, and the state(s) and office or facility location(s) where the items or services are expected to be furnished by the co-provider or co-facility;
- Disclaimer that the good faith estimate is not a contract and does not require the uninsured (or self-pay) individual to obtain the items or services from any of the providers or facilities identified in the good faith estimate.

HHS Template

ExpirationDate [MM/DD/YYYY]

[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."]

[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

ExpirationDate [MM/DD/YYYY]

Disclaimer

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call [HHS PHONE NUMBER].

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

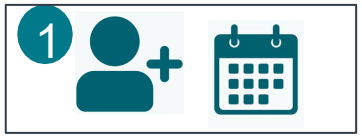
Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

HHS Example: Knee Surgery (Admission-Discharge)

Good faith estimates includes

- ✓ Physician professional fees
- ✓ Assistant surgeon professional fees
- ✓ Anesthesiologist professional fees
- ✓ Facility fees
- ✓ Prescription drugs
- ✓ Durable medical equipment fees

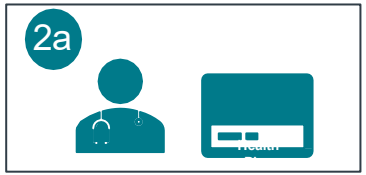
CAQH CORE Advanced EOB Advisory Group – Initial Group Scope



Patient Schedules Appointment or Requests Cost Estimate

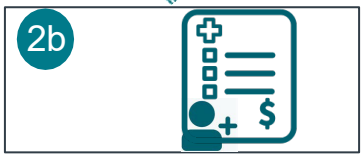
*Patient schedules a healthcare service appointment with a provider **OR** patient requests estimate for a healthcare item or service from provider.*

Applies to all healthcare items and services provided by providers and facilities.



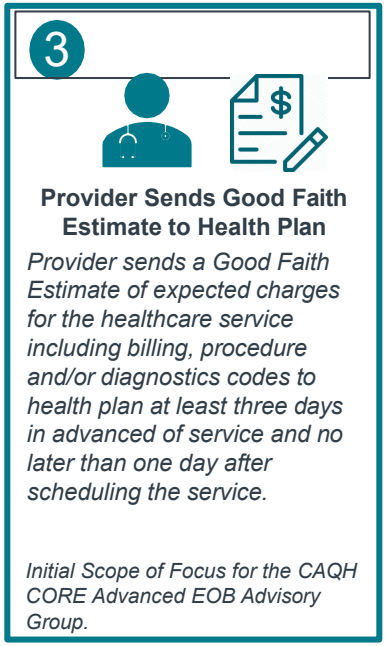
Provider Verifies Insurance with Health Plan

Provider verifies a patient's insurance coverage with health plan to determine eligibility and benefit information for the healthcare item or service.



Provider Sends Good Faith Estimate to Uninsured

*If a patient is uninsured, the provider sends the patient a Good Faith Estimate of expected charges.**



Provider Sends Good Faith Estimate to Health Plan

Provider sends a Good Faith Estimate of expected charges for the healthcare service including billing, procedure and/or diagnostics codes to health plan at least three days in advanced of service and no later than one day after scheduling the service.

Initial Scope of Focus for the CAQH CORE Advanced EOB Advisory Group.

Health Plan Sends Advanced EOB to Member**

Health Plan sends member an Advanced EOB electronically or via mail that provides information on provider network status, covered costs, and out-of-pocket estimates.

[Optional] Health Plan Sends a Copy of Advanced EOB to Provider

**Good Faith Estimates for the uninsured must be issued within one business day for services scheduled three to nine days for intended service date.*
**Good Faith Estimates for the uninsured must be issued three business days for services scheduled more than 10 days from intended service date.*
***Advanced EOB's must be issued within one business day after receiving Good Faith Estimate for services scheduled three to nine days before intended service date.*
***Advanced EOB's must be issued within three business days after receiving Good Faith Estimate for serviced scheduled more than 10 days from intended service date.*

Next Steps

To Prepare To Implement:

- ✓ Assemble a cross-functional team to oversee all aspects
- ✓ Understand the law and accompanying regulations
- ✓ Review all the required timelines (for notice, consent, IDR process, good faith estimates etc.)
- ✓ Complete a Gap Analysis of organization processes and procedures
- ✓ Determine your potential exposure for the law to apply (assess your contracts, credentialed physicians/employed and related considerations)
- ✓ Update your registrations and revenue cycle process and workflows to differentiate workflows for Uninsured, Self-Pay and OON insured patients
- ✓ Consider whether your state has state-level surprise billing laws. If so, how or will that law supersede the federal law
- ✓ Work with your legal counsel, risk management and compliance staff

Resources

- CAQH CORE – No Surprises Here: Recommendations from the CAQH CORE Advanced Explanation of Benefits Advisory Group, November 17, 2021
- CMS-9909-IFC: Requirements Related to Surprise Billing; Part I
- CMS-9909-IFC Fact Sheet: What You Need to Know about the Biden-Harris Administration's Actions to Prevent Surprise Billing
- Model Notice & Consent Templates
- FAQ for CAA implementation, August 20, 2021
- CMS-9908-IFC: Requirements Related to Surprise Billing; Part II
- CMS-9908-IFC Fact Sheet: What You Need to Know about the Biden-Harris Administration's Actions to Prevent Surprise Billing (September 2021)
- Additional trainings will be forthcoming on a variety of provider enforcement topics, including deeper dives into the notice and consent rules, provider disclosure requirements, and other provisions discussed in these slides.

Thank You!

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