Health Law Webinar

Surprise Reprise: No Surprises Act Revisited

April 13, 2022

Fredrikson & BYRON, P.A.

Overview: Two Rules in One?

- Limits balance billing for services provided in “Facilities,” air ambulance, hospital (including CAH) ambulatory surgical center, or freestanding emergency room.
  - All emergency services (facility and professional).
  - Non-emergency services by out-of-network professionals at an in-network facility.
  - Does NOT apply to services at a free-standing clinic, though must give a notice about the rule to patients going to a facility.
- Good Faith Estimates: Much Broader.

What Are Words For? Facility:

Balance Billing = Hospital/ASC/Freestanding ED/Air Ambulance.

GFE: Health care facility (facility) means 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, that is licensed as such an institution pursuant to such law or is approved by the agency of such State or locality responsible for licensing such institution as meeting the standards established for such licensing.

The Regulatory Framework

- Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36872 (July 13, 2021).
- Requirements Related to Surprise Billing; Part II, 86 FR 55980 (October 7, 2021).

Lingo

GFE: Good Faith Estimate.

IDR: Independent Dispute Resolution.

NSA: No Surprises Act.

OON: Out-of-Network.

Provider: They mean physician.

QPA: Qualified Payment Amount.

Beware "guidance"

Balance Billing Protections

Emergency Services

- Facility must treat patient as if in-network.
- Limited impact on plan payment to facility/professional.
  - If there is a state All-Payer Model agreement, it controls. (MD/VT.)
  - If state law, it controls.
  - Otherwise, parties negotiate. Absent agreement, use dispute resolution.
- Plan must make “initial” payment on clean claim within 30 days.

Non-Emergency Services

- For some non-emergency services, the facility/professional can condition treatment on the patient agreeing to permit balance billing.
- Patient consent is required.
- There is a HUGE exception. Can't seek consent for "ancillary services."

“Ancillary Services”

- Items and services “related to” emergency medicine, anesthesiology, pathology, radiology and neonatology. (Mentions physicians and non-physician practitioners).
- Items and services “provided by” assistants at surgery, hospitalists and intensivists.
- “Diagnostic services” such as radiology and laboratory.
- Any item or service provided by a non-participating professional if there is no participating professional who could provide the service.

Balancing Balance Billing

- A limited set of professionals (surgeons and other specialists) have the option to use it.
- Very few of our clients seems interested in doing it.
- Not the focus of today's webinar.

Independent Dispute Resolution (IDR)

- Determines payment rate for items and services when the facility or professional and plan can’t agree.
- Baseball-arbitration.
- Presumption that QPA is the appropriate amount. (The focus of NSA litigation.)

Ongoing Litigation

- *Texas Medical Ass'n, et al. v United States Department of Health and Human Services, et al.*
  - Struck portions of regulations implementing the QPA as the default outcome of the arbitration process.
  - Did not impact any other rulemaking.
- February 28, 2022 CMS Memo.

IDR Action	Timeline
Initiate open negotiation period (one party)	30 business days, starting on the day of initial payment or notice of denial of payment
Initiate IDR process (either party)	4 business days, starting the business day after the open negotiation period ends
Mutually pick IDR entity *NOTE: Departments select certified independent dispute resolution entity in the case of no conflict-free selection by parties	3 business days after the independent dispute resolution initiation date
Submit payment offers and additional information to certified independent dispute resolution entity	10 business days after the date of certified independent dispute resolution entity selection
Payment determination made	30 business days after the date of certified independent dispute resolution entity selection
Payment submitted to the applicable party	30 business days after the payment determination

Good Faith Estimate

Good Faith Estimate

- This is BROAD! While rule says “facilities” and “professionals” they’re defined as “any person or facility licensed to provide health care.”
- Must provide in “clear and understandable language” the “good faith estimate” of the “expect charges for providing scheduled services and items.”

Who Gets the GFE?

January 1, 2022

If patient does not have or is not using insurance, the GFE goes to the patient.

Future

If patient has and is using insurance, the GFE will go to the insurance company to inform the advanced EOB that the company must provide the insured patient.

Who Is “Uninsured”?

“An individual who does not have benefits for an item or service under a

[1] group health plan [defined at 45 CFR 144.103],

[2] group or individual health insurance coverage offered by a health insurance issuer [defined at 45 CFR 144.103],

[3] Federal health care program (as defined in section 1128B(f) of the Social Security Act), or

[4] a health benefits plan under chapter 89 of title 5, United States Code[].”

45 CFR 149.610(a)(2)(xiii)(A).

Who Gets the GFE When There Are Co-Convenors?

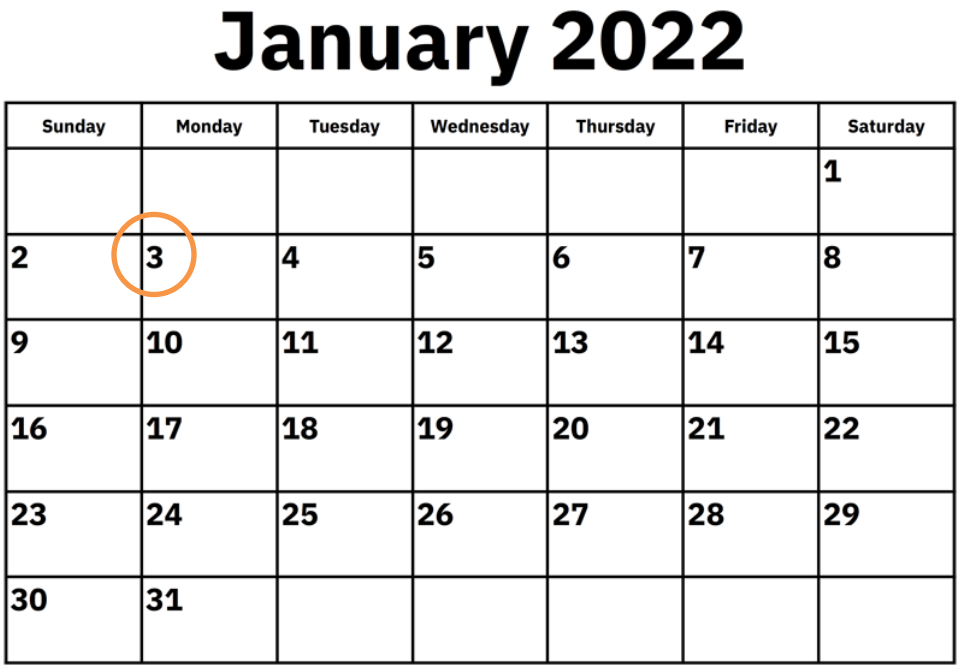
- The “convening” professional or facility is the party that receives the initial estimate request and who is or, in the case of a request, would be responsible for scheduling the primary item or service.
    - 42 CFR 149.610(a)(2)(ii)

When Is the Estimate Required?

Timeline

- 1 day if service in 3-9 days
- 3 days if service in 10+ days

“Business” days



What if a Mistake is Made?

- Still in compliance IF:
  - Professional/facility acted in good faith and with reasonable due diligence, AND
  - The information was corrected as soon as practicable.

Patient-Provider Dispute Resolution

- Patient can use this process IF ALL 5 conditions are met:
  - They're uninsured or self-pay.
  - They scheduled and received the medical items or services on or after January 1, 2022.
  - They have a good faith estimate from your provider or the facility who provided your care.
  - They got a bill within the last 120 calendar days.
  - The difference between the good faith estimate and the bill is at least $400.

OMB Control Number: 1210-0169
Expiration Date: 04/30/2022

Patient-Provider Dispute Resolution Form

Find out if you qualify for the dispute resolution process

This form is only for people who do **not** have health insurance or who decided not to use insurance for their medical care.		
Did your health care provider give you a Good Faith Estimate for the item or service?	Yes ☐	No ☐
Is the bill for your health care provider at least $400 more than the Good Faith Estimate?	Yes ☐	No ☐
Is the **date on the top of the bill** within the last 120 calendar days (about 4 months)?	Yes ☐	No ☐

If you answered **NO** to any of these questions:

- You do not qualify for the dispute resolution process. Please contact your health care provider to negotiate your bill and ask for financial assistance.
- If you think you should have been given a Good Faith Estimate or have other questions, please visit https://www.cms.gov/nosurprises/consumers or call 1-800-985-3059.

Complaints about medical billing

Starting in 2022, insurance companies and plans, providers, and health care facilities must follow new rules that protect consumers from surprise medical bills. If you have a question about these rules or believe the rules aren't being followed, contact the No Surprises Help Desk at 1-800-985-3059 from 8 am to 8 pm EST, 7 days a week, to submit your question or a complaint. Or, you can submit a complaint online, below. We may ask you to provide supporting documentation like medical bills and your Explanation of Benefits. We'll send a confirmation email when we receive your complaint to notify you of next steps and let you know if we need any additional information. To check on the status of a complaint, or to see what documentation is needed, contact the No Surprises Help Desk.

What we can do:

- Review your complaint to make sure your insurance company, medical provider, or health care facility followed surprise billing rules.
- Investigate and enforce federal laws and policies under our jurisdiction.
- Try to find patterns of problems that may need further review.
- Help you understand what documentation you need to submit or what next steps you should take.
- Help answer your questions or direct you to someone who can.

What we can't do:

- Require medical providers or health care facilities to adjust their charges.
- Act as your lawyer or give you legal advice.
- Make medical judgments or determine if further treatment is necessary.
- Determine the value of a claim, or the amount owed to you.
- Address issues we can't legally enforce.

Commonly Asked Questions

CMS Slideshow

- https://www.cms.gov/files/document/a274577-1a-training-1-balancing-billingfinal508.pdf

Knowledge Checking The Knowledge Check

Knowledge check

Carlos is a 62-year-old male with employer-sponsored health coverage. He is involved in a ski accident and sustains multiple injuries. He is taken to the closest hospital, which is out-of-network. He undergoes surgery to repair multiple leg fractures. Once he is stable and out of surgery, he is counseled on the option to transfer care to another local in-network hospital for the duration of his recovery. His treating physician determines the safest form of transport, given his medical state, would be via ambulance. Carlos knows that the hospital he is in has an excellent reputation and wishes to stay there for his recovery. The hospital provides a written notice and gets his written consent to waive his balance billing protections under the No Surprises Act. He remains inpatient for two additional days and is ultimately discharged to home.

Does the No Surprises Act's prohibition on balance billing for emergency services apply to all days of care Carlos received from this hospital?

Knowledge Checking The Knowledge Check

Knowledge check answer

Yes.

The hospital is banned from balance billing Carlos for items and services provided prior to his being stabilized. The hospital is also banned from balance billing him for post-stabilization services provided after surgery, despite obtaining written consent from Carlos to waive his balance billing protections under the No Surprises Act. Because he could only safely be transferred via ambulance, the hospital can't seek consent from him to waive his balance billing protections under the No Surprises Act specific to post-stabilization services. In the event that an individual requires medical transportation to travel, including transportation by either ground or air ambulance vehicle, the individual is not in a condition to receive notice or provide consent.

Do They Know What “Or” Means?

- The attending emergency physician or treating provider determines that the participant, beneficiary, or enrollee 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 account the individual's medical condition. The attending emergency physician's or treating provider's determination is binding on the facility for purposes of this requirement.
    - 42 CFR 149.410(b)(1)

When Does State Law Apply?

- Narrow preemption standard.
- IDR process.
  - "Specified state laws" = "provides for a method for determining the total amount payable" by a health plan for the recognized amount and OON rate.
  - Specified state laws must apply to:
    1. The plan, issuer, or coverage involved;
    2. OON provider or emergency facility involved (and in the case of state OON rate laws, the OON air ambulance provider involved); and
    3. The item or service involved.

How to Issue a GFE When Charging a Flat Monthly or Annual Fee

- Examples: Concierge services, direct primary care
- Letter from American Academy of Family. Physicians, dated December 3, 2021, requested HHS issue future regulations.
- Current advice: Technically required, consider issuing an annual GFE.

Should We Use The Model GFE?

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, and your bill is $400 or more for any provider or facility than your Good Faith Estimate for that provider or facility, federal law allows you to dispute the bill.

If you are billed for more than this Good Faith Estimate, you may 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.

What Should A Hospital Expect Of Independent Med. Staff?

- No explicit NSA requirement.
- Will patients be mad?

Does a SNF Need to Give A GFE?

- Legal and practical answer may differ.
- They are licensed.
- Is the patient using insurance to pay?

GFE Required for Worker's Comp?

Uninsured = individual who does not have benefits for an item or service under a:

[1] group health plan

or

[2] group or individual health insurance coverage offered by a health insurance issuer

§ 144.103 Definitions.

For purposes of parts 146 (group market), 147 (group and individual market), 148 (individual market), 149 (surprise billing and transparency), and 150 (enforcement) of this subchapter, the following definitions apply unless otherwise provided:

[1] *Group health plan* or *plan* means a group health plan within the meaning of 45 CFR 146.145(a).

[2] *Group health insurance coverage* means health insurance coverage offered in connection with a group health plan. Individual health insurance coverage reimbursed by the arrangements described in 29 CFR 2510.3-1(l) is not offered in connection with a group health plan, and is not group health insurance coverage, provided all the conditions in 29 CFR 2510.3-1(l) are satisfied.

Individual health insurance coverage means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited-duration insurance. Individual health insurance coverage can include dependent coverage.

Health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance.

§ 146.145 Special rules relating to group health plans.

(a) *Group health plan* -

(1) ***Definition.*** A group health plan means an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees (including both current and former employees) or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(2) ***Determination of number of plans.*** [Reserved]

(b) *Excepted benefits* -

(1) ***In general.*** The requirements of subparts B and C of this part do not apply to any group health plan (or any group health insurance coverage) in relation to its provision of the benefits described in paragraph (b) (2), (3), (4), or (5) of this section (or any combination of these benefits).

(2) ***Benefits excepted in all circumstances.*** The following benefits are excepted in all circumstances -

(i) Coverage only for accident (including accidental death and dismemberment);

(ii) Disability income coverage;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Coverage issued as a supplement to liability insurance;

(v) Workers' compensation or similar coverage;

(vi) Automobile medical payment insurance;

(vii) Credit-only insurance (for example, mortgage insurance); and

(viii) Coverage for on-site medical clinics.

(ix) Travel insurance, within the meaning of § 144.103 of this subchapter.

§ 149.20 Applicability.

(a) *In general.*

(1) The requirements in subparts B, D, and H of this part apply to group health plans and health insurance issuers offering group or individual health insurance coverage (including grandfathered health plans as defined in § 147.140 of this subchapter), except as specified in paragraph (b) of this section.

(2) The requirements in subpart E of this part apply to health care providers, health care facilities, and providers of air ambulance services.

(3) The requirements in subpart F of this part apply to certified IDR entities, health care providers, health care facilities, and providers of air ambulance services and group health plans and health insurance issuers offering group or individual health insurance coverage (including grandfathered health plans as defined in § 147.140 of this subchapter) except as specified in paragraph (b) of this section.

(4) The requirements in subpart G of this part apply to Selected Dispute Resolution Entities, health care providers, providers of air ambulance services, health care facilities and uninsured (or self-pay) individuals, as defined in subpart G.

(b) ***Exceptions.*** The requirements in subparts B, D, E, F, and H of this part do not apply to the following:

(1) Excepted benefits as described in §§ 146.145 and 148.220 of this subchapter.

(2) Short-term, limited-duration insurance as defined in § 144.103 of this subchapter.

(3) Health reimbursement arrangements or other account-based group health plans as described in § 147.126(d) of this subchapter.

Changes in Insurance Status

- Insured when scheduled, uninsured at appointment?
  - Depends when professional/facility learns of change.
- Uninsured when scheduled, insured at appointment?
  - Normal GFE process.

Are Diagnostic Codes Required?

- April 5, 2022 FAQ.
- If code is unknown, NOT required.
- Examples:
  - Initial screening visit.
  - Management visits.
  - No applicable code.

The Hospital is OON the Dr. In-Network. Does NSA Apply?

- Is it an emergency service?
- If not, then nope!

Must We Give GFE to Medicare Pts. Getting A Physical?

CMS states: **"These requirements don't apply to people with coverage through programs like Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE. These programs have other protections against high medical bills."**

But the regulation states:

> 45 CFR 149.610(a)(2)(xii): ***Uninsured (or self-pay) individual*** means:
>
> (A) 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 (as defined in section 1128B(f) of the Social Security Act), or a health benefits plan under chapter 89 of title 5, United States Code.

As annual physicals are not a covered benefit under Medicare, would the patient be considered uninsured for that service thereby triggering the requirement to send a GFE?

Do We Have to Give the Notice Every Visit? Annually?

- 149.430 requires you to “provide to any individual” a copy of the notice.
- Can notice ever be “unprovided?”

The Patient Doesn't Want Their Birthdate on the GFE!

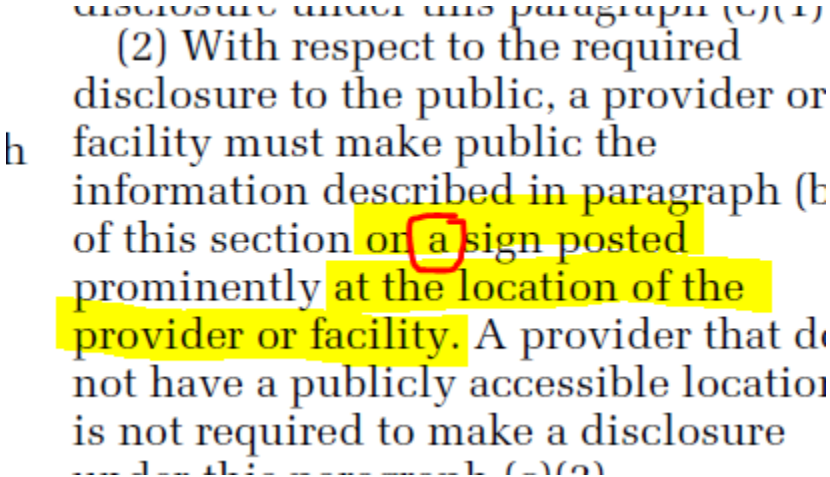
- No provision explicitly permits the patient to decline.
- This is a patient protection measure. Can the patient waive?

How Long Must We Keep GFEs?

- Must provide for 6 years.
- Must consider it a part of the medical record.
  - 149.610(f)

How Many Signs Do We Need?

- 149.430:



disclosure under this paragraph (c)(1).

(2) With respect to the required disclosure to the public, a provider or facility must make public the information described in paragraph (b) of this section on a sign posted prominently at the location of the provider or facility. A provider that does not have a publicly accessible location is not required to make a disclosure under this paragraph (c)(2).

How is the $400 Calculated?

- It is the total per “provider”.
- The examples from the government don’t make it clear if each professional is a provider.
- The examples don’t have one situation where an estimate is LOWER than the bill!

When Will the Rulemaking Be Issued?!

- GFE requirements for insured patients?
- Penalties! Namely, what is the exact consequence of NOT issuing a GFE?

Maybe May 2022*

*Def.'s Reply Memo in Support of Their Cross-Motion For Summary Judgment, *Texas Medical Association v. U.S. Department of Health and Human Services* (Civil Action No. 6:21-cv-00425-JDK), filed February 2, 2022, https://affordablecareactlitigation.files.wordpress.com/2022/02/13362908-0-79761.pdf.

Questions?

Provider questions:
provider_enforcement@cms.hhs.gov

Federal IDR process or fee guidance:
FederalIDRQuestions@cms.hhs.gov

Presenters

David Glaser
612.492.7143
dglaser@fredlaw.com

Mary E. Heath
612.492.7272
mheath@fredlaw.com