INTELLIGENCE THAT WORKS

# No Surprises Act

## Key Revenue Cycle Considerations

March 25, 2022

Presenter: Nelson Lowman

AAHAM
American Association of Healthcare Administrative Management
The Premier Organization for Revenue Cycle Professionals

BRG

THINKBRG.COM

# How did we get here?

"Surprise Billing" is an unexpected balance bill. This can happen when patients can't control who is involved in their care — such as in an emergency or when a scheduled visit is at an in-network facility, but there is unexpected treatment by an out-of-network provider.

BRG

# The No Surprises Act

- Effective January 1, 2022, the No Surprises Act ("NSA") was designed to protect patients from surprise medical bills for certain services. While components of the NSA and certain state legislation overlap, the NSA explicitly defers to state legislation for certain matters.

- Specifically, the NSA defers to "specified state laws" for:
  - calculating the proper reimbursement rate for out-of-network emergency services and non-emergent services provided by out-of-network providers at in-network facilities; and
  - resolving out-of-network payment disputes between health plans and providers for health plans regulated by the state's insurance code (e.g., individual and small group insurance and health maintenance organizations ["HMO"]) [collectively, "State Regulated Insurance"]. The NSA defines a "specified state law" as a state law that provides a method for determining the total amount of payment owed to an out-of-network provider or facility.

# No Surprises Act Key Impacts – Insured Patients

## Emergency Care

**Out-of-Network balance billing is prohibited**

- Additional costs can not be billed to the patient
- Reimbursement must be settled between provider and health plan

## Post Stabilization

**Balance Billing is only allowed when:**

- Attending or ED Physician determines the patient is able to travel to an in-network provider
- Attending or ED physician assess that the patient is in a condition to give consent
- The Notice & Consent are provided a minimum of 3 hours prior to care

## Nonemergency Care

**May obtain consent to bill out-of-network except for the following medical care:**

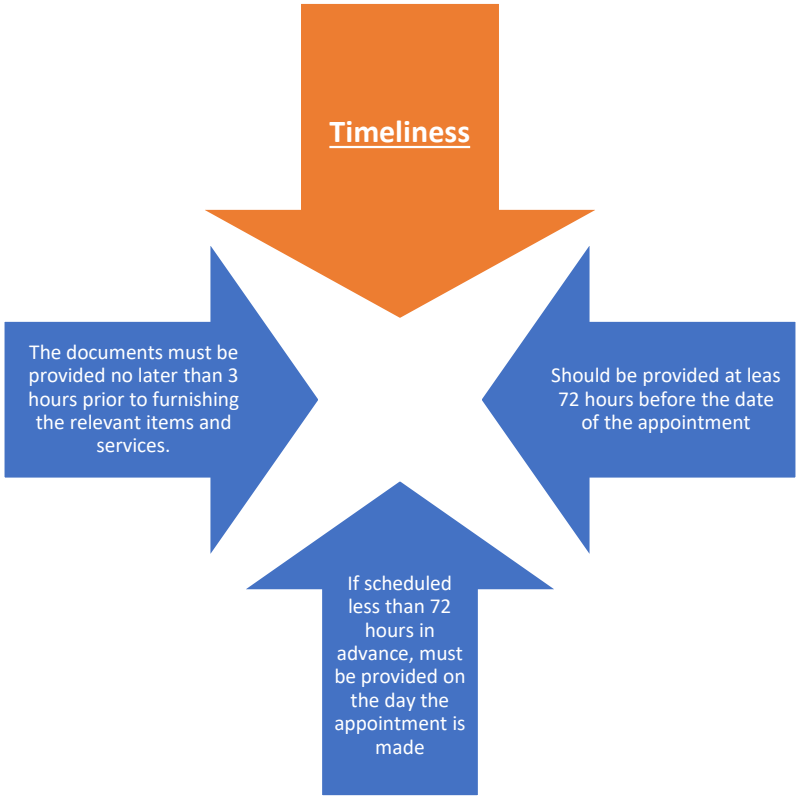
- Some ancillary services
- Items and services provided by assistant surgeons, hospitalist and intensivist
- Diagnostic services
- Unforeseen services that arise due to urgent medical care during a consented medical service

# No Surprises Act - Notice and Consent

In order to meet the notice and consent requirements, nonparticipating providers and nonparticipating emergency facilities must provide and secure acknowledgement of the out of network status of the service.

The provided notice must:

- State that the health care provider or facility is a nonparticipating provider or facility;
- Clearly state that consent to receive such items or services is optional and that the participant, beneficiary, or enrollee may instead seek care from an available participating provider, in which case the individual's cost-sharing responsibility would be at the in-network level.
- All formal notice and consent documents, good faith estimates, care management limitations specific to the patient's health plan should be part of the medical record.
- Provide contact information to report potential violation



# No Surprises Act Key Impacts – Insured

## Revenue Cycle and & Reimbursement for Out-of-Network Products and Services

- Providers must bill health plan to ascertain the amount to bill patients. The amount is to be based on state law or qualifying payment amount (QPA) (Note: For regulated Maryland services, this is easy)
- Health Plans are permitted to deny for medical necessity or non-coverage
- Health Plans must make an initial payment within 30 days of a clean claim
- Health Plans are no longer permitted to look to final diagnosis to determine medical necessity, they must refer to admitting diagnosis/chief complaint (prudent layperson)
  - For any GFE's requested in advance of the care / screening - TBD is OK for Dx and Px

INTELLIGENCE THAT WORKS

BRG

# No Surprises Act Key Impacts – Insured

## Air Ambulance Services Reporting Requirements

HHS will require air ambulance services to report date from calendar years 2022 and 2023 to enable HHS and DOT to assess competitiveness and market cost.

## The Federal Independent Dispute Resolution Process

Establishes the process that out-of-network (OON) providers, facilities, air ambulance services, plans and insurers may use to determine the OON rate for applicable items or services,

- States have primary enforcement authority over plans and issuers with respect to all Public Health Service Act requirements.
- Before initiating the process, disputing parties must initiate a 30-day “open negotiation” period to determine a payment rate. ( less of an issue in Maryland)
- The certified independent dispute resolution entity will then issue a binding determination selecting one of the parties’ offers as the OON payment amount. Both parties pay an administrative fee, and the non-prevailing party pays the certified independent dispute resolution entity fee.

# No Surprises Act Key Impacts – Self Pay Patients

First Patient Access Insurance Determination:

1. Does the patients have insurance that they want to use for the care?
2. Is the patient coming into price future care?

**Good Faith Estimates:**

- Providers are required to provide estimates whenever uninsured or self-pay patients requires an estimate for care they are considering.
- The patient should only receive one good faith estimate for a primary service/visit (including all convening providers).
- For recurring care GFE's can last 12 months

**Scheduled Estimates:**

- Providers must provide uninsured and self-pay good faith estimates prior to all scheduled care beginning on Jan 1, 2022.
- If scheduled at least three days in advance, the provider must provide a good faith estimate regardless of whether the patient requests it,

***All good faith estimates should be the cash pay or self-pay rate, reflective of <u>any</u> discounts available to the patient!***

# No Surprises Act Key Impacts – Self Pay Patients

## Clarifications Regarding Uninsured/Self-Pay Good Faith Estimates

- Uninsured good faith estimates must be provided to any uninsured/self-pay patient prior to any scheduled item or service. Patients do not need to sign or otherwise verify that they received the good faith estimate. The **notice and consent estimates** are required specifically when a provider or facility seeks to balance bill an insured out-of-network patient.
- Good faith estimates must be delivered either electronically or via paper mail, based on the patient's preference. If the estimate is provided electronically, it must be provided in a manner that allows the patient to save and print the estimate.
    - Automated services are key to streamlining this notification and documentation process
- The good faith estimate should include the primary service, as well as all the items/services associated with the primary service that wouldn't be scheduled separately
- Requirements only apply to out-of-network patients if the patient does not plan to bill their health plan for the items/services.
- If a self-pay patient does ultimately submit a claim for the item or service furnished, they are no longer considered self-pay and are not eligible for the patient-provider dispute process.
- Patients enrolled in no-network plans (reference-based pricing plans, health sharing ministries) or short-term, limited-duration plans are considered uninsured for the purposes of this regulation.

# No Surprises Act Key Impacts – Self Pay Patients

## Protecting the Revenue Cycle from missed GFE's

- Breaking through a $400 threshold per provider allows the patient to request arbitration
- Revenue cycle / appeals teams need to prepare for this eventuality by creating effective appeal mechanism
  - Create a complete documentation process for all N&C's and GFE's as well as all communications with the patient
  - Clearly state the expected scope of service requested and used when asked to create the GFE
  - Capture a reasonable list of providers that cold potentially be involved in the care
  - Become adept at explaining significant changes in the care and condition of the patient
    - Scope of service changes was greater than expected
    - Complications occurred that changed the course of treatment
    - The acuity of the patient changed
- The regulatory requirement for all Insured to receive GFE's is coming!

INTELLIGENCE THAT WORKS

BRG

# No Surprises Act Key Impacts

## What & When It's All In-Play!

Hospital Price Transparency Rule
Effective 1/1/2021

- Publish machine-readable file
  - Privately negotiated rates
  - Self-pay rates
  - Chargemaster rates
- Provide patients a consumer-friendly shoppable service tool

Insurer Price Transparency Rule
Machine Readable File: 7/1/22
Price Estimator Tool: 1/1/23

- Publish machine readable file
  - In-network negotiated rates
  - Historic payments of allowed amounts to out-of-network providers
- Provide personalized out-of-pocket cost estimates for all covered services through a consumer-friendly, online tool

Good Faith Estimates
Uninsured/Self-Pay Patients
Effective 1/1/2022

- Scheduled Services or at request
  - Provide GFE of all expected charges for visit
  - Estimate must be self-pay rates
  - Scheduling provider/facility responsible for estimates of all providers furnishing services and for one comprehensive good faith estimate to patient

Good Faith Estimates
Insured Patients/Advanced EOBs
Effective: TBD

- Insured patients, providers/facilities will need to share good faith estimates (chargemaster) with the patient's health plan for any scheduled service 3+ days out or at the request of the patient
- Health plan will create an AEOB for the patient, showing the total cost of the health car visit as well as the expected patient and insurer portion.
- Health plan required to have online shopping tool

BRG

# Maryland Modifications

- If you are in a Health Maintenance Organization (HMO) governed by Maryland law, you may not be balance billed for services covered by your plan, including ground ambulance services.
- If you are in a PPO or EPO governed by Maryland law, hospital-based or on-call physicians paid directly by your PPO or EPO (assignment of benefits) may not balance bill you for services covered under your plan and can't ask you to waive your balance billing protections.
- If you use ground ambulance services operated by a local government provider who accepts an assignment of benefits from a plan governed by Maryland law, the provider may not balance bill you
- Providers who provide services in a hospital or ASC facility must disclose information regarding federal and state balance billing protections and how to report violations. Providers or facilities must post this information prominently at the location of the facility and post it on a public website (if applicable). The Maryland Attorney General has posted a model patient notice "Notice About Surprise Billing Protections" specific to Maryland.

BRG

# What are the pressure points?

Access and Scheduling

Out of state payers

Cash Applications

Existing Unregulated Services

Growth of Outpatient Services

O.N. Physician in an I.N. setting