



NO SURPRISE BILLING RULES WHAT PROVIDERS NEED TO KNOW

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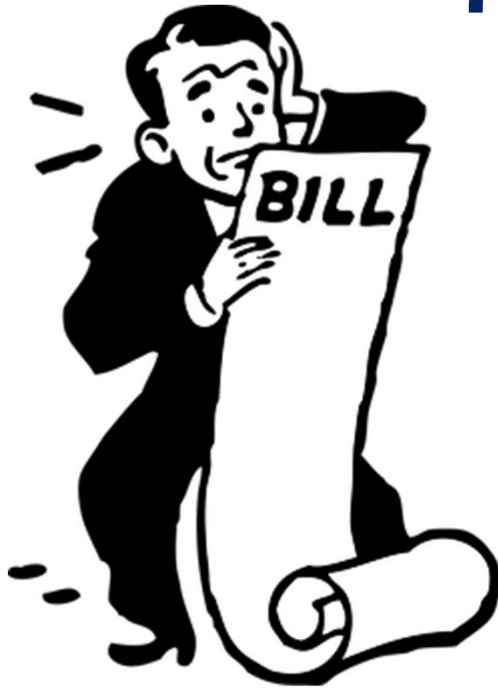
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WRITTEN MATERIALS

- Interim Final Rule, 86 FR 36872
- CMS, *HHS Announces Rule to Protect Consumers from Surprise Medical Bills* – <https://www.hhs.gov/about/news/2021/07/01/hhs-announces-rule-to-protect-consumers-from-surprise-medical-bills.html>
- CMS, *Requirements Related to Surprise Billing; Part I Interim Final Rule with Comment Period* – <https://www.cms.gov/newsroom/fact-sheets/requirements-related-surprise-billing-part-i-interim-final-rule-comment-period>
- AHA, *Detailed Summary of the No Surprises Act* – <https://www.aha.org/system/files/media/file/2021/01/detailed-summary-of-no-surprises-act-advisory-1-14-21.pdf>

PROBLEM



- Patients surprised when they receive bill from facility or provider despite having insurance, e.g.,
 - Emergency services rendered by nonparticipating (“nonpar”) facility or provider.
 - E.g., plan or insurer limits coverage or amount of coverage for emergency services by nonpar providers and facilities; insurer requires preauthorization; etc.
 - Nonpar providers at participating facility bill separately from facility.
 - E.g., surgeons, anesthesiology, radiology, pathology, surgical assists, labs, etc.

- *In 2016 (86 FR 36784)*
 - *42.8% of ED visits resulted in surprise bill*
 - *Average surprise bill was \$2,040*

NO SURPRISE ACT AND NO SURPRISE BILLING RULE

- No Surprises Act (12/27/20)
- No Surprises Interim Final Rule (7/13/21), 86 FR 86872
 - Protects participants, beneficiaries, and enrollees in health plans/insurance (“patients”) from surprise medical bills by limiting the amount patient must pay out of pocket to in-network amounts for:
 - Emergency services at emergency facility,
 - Non-emergency services by a nonpar provider at a participating facility, or
 - Air ambulance services from nonpar providers.
 - All such cost-sharing payments count toward in-network deductibles and out-of-pocket maximums.
 - **Effective 1/1/22**

PENALTIES

- HHS may impose a \$10,000 civil penalty against facilities and providers for violations.
- HHS shall waive the penalty if:
 - The facility or provider did not know and should not have reasonably known its actions violated the rule, and
 - The facility or provider, within 30 days of the violation:
 - Withdraws the bill that violated the rule, and
 - Reimburses the health plan, insurer, or patient as applicable in an amount equal to the difference between the amount billed and the amount allowed to be billed plus interest at a rate determined by HHS.
- HHS may establish a hardship exception to penalties.

(No Surprise Act § 2799D(b)(1), (4); 86 FR 36905)

➤ *HHS will address enforcement in future rule.*

➤ *Additional penalties, e.g., defense to payment, consumer protection statutes, state laws, etc.?*

PROS AND CONS FROM PROVIDERS' VIEW

Pros (kind of)

- Patient able to choose provider for pediatric and Ob/Gyn care.
- Plans must cover out-of-network emergency services on in-network basis without prior authorization.
- Process for determining rates paid to out-of-network providers.
- Plan must deny or make initial payment (i.e., good faith estimate of payment in full) within 30 days after providers submits clean claim.
- Process for payment disputes between provider and plan.

Cons

- Limits patient's cost-sharing amount to that which patient would owe to a participating provider (i.e., prohibits balance billing patient) unless nonpart provider obtains required notice and consent.
 - *Consent and notice exception applies to limited items or services.*
 - *Consent unlikely.*
- Providers and facilities must publish public notice of patient protections.
 - *Can't bill patient for out-of-network charges unless patient consents.*

LIMITS ON PATIENT'S COST-SHARING AMOUNT

- Patient's cost-sharing for out-of-network services is no higher than in-network level.
 - E.g., if patient's cost-sharing amount for in-network services is 20%, then patient's cost-sharing amount for out-of-network service is 20%.
- The amount to which cost-sharing applies (i.e., the "recognized amount") is determined in descending order of following:
 - Amount determined by applicable All-Payer Model Agreement under the SSA; or
 - If there is no applicable All-Payer Model Agreement, amount determined by state law; or
 - If neither of the foregoing apply, the lesser amount of either the billed charge or the *qualifying payment amount* ("QPA").
 - QPA is generally the plan's median contracted rate in 2019 for the same or similar items or services provided by a similar provider in the same geographic region adjusted by CPI.

(CMS, *Requirements Related to Surprise Billing; Part I Interim Final Rule with Comment Period*, <https://www.cms.gov/newsroom/fact-sheets/requirements-related-surprise-billing-part-i-interim-final-rule-comment-period>)

LIMITS ON PATIENT'S COST-SHARING AMOUNT

- Only applies to certain items or services covered under a health plan or insurance (“health plan”) that are provided by nonpar providers and/or nonpar facilities to patients.
 - Applies to most health insurance and plans, including individual or group plans whether insured or self-insured, private employment-based group health plans subject to ERISA, non-federal plans, church plans, and traditional indemnity plans.
 - Does not apply to health reimbursement arrangements, short-term limited-duration insurance, or retiree plans.

(86 FR 36904)

LIMITS ON PATIENT'S COST-SHARING AMOUNT

- Only applies to nonpar providers or facilities when:
 - Emergency services are provided by a nonpar provider or nonpar emergency facility.
 - *Facility = emergency dept of hospital or independent freestanding emergency dept as licensed by state (may include urgent care center) (86 FR 36879)*
 - Non-emergency services are provided by a nonpar provider at a participating health care facility.
 - *Facility = hospital, hospital outpatient dept, CAH, or ASC that has a contract with a health plan covering the services provided, including single case agreements. (86 FR 36882).*
 - Air ambulance services are furnished by a nonpar provider of air ambulance services.

(86 FR 36904)

TOTAL AMOUNT PAID TO PROVIDER OR FACILITY

- Total amount paid to nonpar provider or facility, including any patient cost-sharing amount, is based on:
 - Amount determined by applicable All-Payer Model Agreement under the SSA; or
 - If there is no applicable All-Payer Model Agreement, amount determined by state law; or
 - If neither of the foregoing apply, an amount agreed upon by the plan and provider or facility; or
 - If plan and provider/facility cannot agree on charge, amount determined by independent dispute resolution (“IDR”) entity.

(CMS, *Requirements Related to Surprise Billing; Part I Interim Final Rule with Comment Period*, <https://www.cms.gov/newsroom/fact-sheets/requirements-related-surprise-billing-part-i-interim-final-rule-comment-period>)

TOTAL AMOUNT PAID TO PROVIDER OR FACILITY

- Plan and provider have 30 days to attempt agreement; otherwise, they initiate IDR process.
- In IDR, plan/insurer and nonpar provider/facility each submit their proposal.
- In determining amount owed to nonpar provider or facility, IDR entity must consider:
 - Qualified payment amount (“QPA”), i.e., patient’s cost-sharing amount.
 - Provider’s training and experience.
 - Complexity of procedure or medical decision-making.
 - Patient’s acuity.
 - Market share of the insurer and provider.
 - Teaching status of facility.
 - Scope of services.
 - Demonstrations of good faith efforts to agree on payment amount.
 - Contracted rates for prior year.
- After considering factors, IDR entity determines which proposal is reasonable.
- Loser pays administrative costs.

(No Surprises Act)

➤ *Watch for future rulemaking.*

NET EFFECT: IF NO SURPRISES RULE APPLIES

Patient pays

- In-network rate for the covered service (copay, deductible, etc.) based on “recognized amount”, i.e.,
 - All-Payer Model agreement;
 - Amount specified by state law; or
 - QPA, i.e., median contracted rate for similar service and provider.

Plan or insurer pays

- Amount determined by:
 - All-Payer Model agreement;
 - Amount specified by state law;
 - Agreed amount; or
 - IDR decision
- Less the patient’s cost-sharing amount.

NO SURPRISE BILLING RULE: SUMMARY

- Limits on surprise bills do not apply to:
 - Participating providers/facilities.
 - Self-pay patients.
 - Health reimburse arrangements, retiree-only plans, short-term limited duration plans.
 - Items or services not covered by health plan.
 - Items or services that are not provided at or in connection with a visit to a “facility.”

**Patient charge =
cost-sharing for participating provider**

Covered emergency services provided by

- Nonpar provider or
- Nonpar facility

Covered
non-emergency
services by
nonpar
provider at
participating
facility

May balance bill if:

- Notify patient
- Obtain consent
- Notify insurer

Except
Pre-stabilization,
urgent services,
ancillaries, etc.



BALANCE BILLING FOR EMERGENCY SERVICES



EMERGENCY SERVICES: BALANCE BILLING

- If a covered patient receives emergency services at a hospital emergency dept or an independent freestanding emergency dept,
 - nonpar facility may not balance bill the patient above the cost-sharing amount for a participating facility; and/or
 - nonpar provider may not balance bill the patient above the cost-sharing amount for a participating provider
- Except for certain post-stabilization items or services if:
 - Patient is able to travel to a participating facility within a reasonable distance in nonmedical transport;
 - Patient is given required written notice (*see below*);
 - Patient gives valid consent (*see below*); and
 - Facility satisfies any additional state law requirements.
- Except with respect to unforeseen, urgent medical needs that arise at the time the services are rendered.

(45 CFR 149.410; 86 FR 36905)

“EMERGENCY SERVICES”: BALANCE BILLING

- “Emergency services” =
 - Appropriate medical screening exam as required by EMTALA, including ancillary services routinely available to the emergency dept;
 - Such further exam and treatment needed to stabilize the patient; and
 - Post-stabilization outpatient observation or inpatient or outpatient care after emergency care is provided.

(45 CFR 149.410)

- *HHS interprets broadly to track care required by EMTALA*
 - *Services covered even if care turns out to be non-emergent.*
 - *Services covered even if provider uses non-emergent code.*
 - *Services covered even if care is not immediate.*

(86 FR 36878-79)

EMERGENCY SERVICES: NEVER BALANCE BILL

- Limits on balance billing always apply (i.e., notice and consent exception does not apply) to:
 - Emergency medical screening and stabilization services.
 - Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished.
 - *HHS: provider cannot get notice and consent for such emergency situations. (86 FR 36911)*

(45 CFR 149.410(b)-(c))

EMERGENCY SERVICES: NOTICE TO PLAN OR INSURER

- Nonpar emergency facility or nonpar emergency provider seeking to balance bill patient for post-stabilization services must notify the plan or insurer of the following when transmitting the bill:
 - Whether the notice and consent requirements have been satisfied; and
 - If applicable, provide a copy of the signed written notice and consent document.

(45 CFR 149.410(e))

- *According to HHS, insurer needs the information for its claims adjudication or determinations under Surprise Billing Act.*

BALANCE BILLING FOR NON-EMERGENCY SERVICES



BALANCE BILLING: NON-EMERGENCY SERVICES

- A nonpar provider who provides non-emergency services to a patient at a facility may not balance bill the patient above applicable cost-sharing amount
- Unless the following are satisfied:
 - Patient is given required written notice (*see below*); and
 - Patient gives valid consent (*see below*).
- Except with respect to:
 - Unforeseen, urgent medical needs that arise at the time the services are rendered.
 - Certain ancillary services.

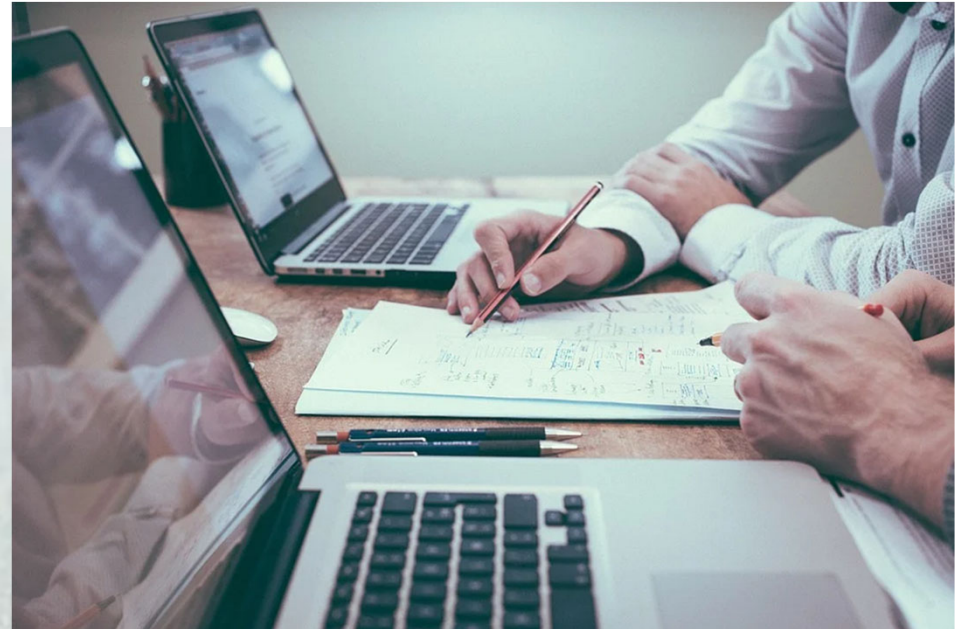
(45 CFR 149.420)

NON-EMERGENCY SERVICES: NEVER BALANCE BILL

- Limits on balance billing always apply (i.e., notice and consent exception does not apply) to:
 - Ancillary services, i.e.,
 - Items or services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology whether provided by a physician or non-physician practitioner;
 - Items or services provided by assistant surgeons, hospitalists, and intensivists;
 - Diagnostic services, including radiology and labs; and
 - Items or services provided by a nonpar provider if there is a participating provider who can furnish such item or service at such facility.
 - Items or services furnished as a result of unforeseen, urgent medical needs that arise when the item or services is furnished.

(45 CFR 149.520(b))

NOTICE AND CONSENT FOR BALANCE BILLING



I Agree

NOTICE TO PATIENT OR REP

- May balance bill for certain services if provide required notice to patient or personal rep and obtain consent from patient or personal rep, i.e.,
 - Covered post-stabilization services by nonpar provider or facility following emergency visit.
 - Non-emergency services provided by a nonpar provider at a participating facility, with limited exceptions.

(45 CFR 164.410(b) and .420(b))

- Personal rep = person authorized to consent to care for patient under applicable state law.
 - Not a provider or employee of facility unless such provider or employee is family member.

NOTICE TO PATIENT OR REP

- Written paper or electronic notice as selected by patient.
- Notice must be provided using the HHS form and in the manner specified in HHS guidance; it must include the following statements:
 - Provider does not participate in the plan.
 - Good faith estimate of nonpar provider's charges.
 - Notice is not a contract that binds patient to pay.
 - Prior authorization or care management limits may be required before receiving items or services.*
 - * HHS encourages providers and facilities to contact insurers to confirm.
 - Consent is optional, and patient may seek care from an available participating provider, in which case cost sharing is limited by the plan.

(45 CFR 164.420(c)(1), (d)).

➤ *Watch for the HHS form notice.*

NOTICE TO PATIENT OR REP

- For balance billing post-stabilization emergency services, notice must include the following additional items:
 - *If participating facility + nonpar provider:* include a list of participating providers at the facility who are able to furnish services and state that patient may be referred to the participating provider.
 - *Do facility and providers really know this?*
 - *If nonpar emergency facility:* include good faith estimate of charges by the facility or nonpar providers for the visit at the facility.
 - *Does facility really have this info from nonpar providers?*

(45 CFR 149.410(b)(2))

NOTICE TO PATIENT OR REP

- Notice must be provided:
 - With the consent document.
 - Physically separate from, not attached to, and not incorporated into any other document.
 - To the patient in timely manner:
 - If services scheduled at least 72 hours in advance: notice must be given at least 72 hours before services.
 - If services scheduled less than 72 hours in advance: notice must be provided on day the appointment is made.
 - If notice provided on date of service: notice must be provided at least 3 hours in advance of services.

(45 CFR 164.420(c)(1); 86 FR 36907)

CONSENT OF PATIENT OR REP

- Consent must be obtained:
 - From the patient or authorized representative;
 - Voluntarily;
 - Using HHS form;
 - In accordance with the form and manner specified in HHS guidance.
- Consent must be signed by patient or personal rep prior to receiving the relevant items or services.
- Patient or personal rep may revoke consent in writing prior to receiving the items or services to which the consent applies.

(45 CFR 164.420(c)(2), (e))

CONSENT OF PATIENT OR REP

- Consent must acknowledge in clear and understandable language:
 - Patient was given the written notice in the form (i.e., paper or electronic) selected by patient;
 - Patient has been informed that payment by patient may not accrue toward meeting any limitation that plan places on cost sharing, including in-network deductible or out-of-pocket maximum applied under the plan;
 - By signing consent, patient agrees to be treated by nonpar provider or facility and patient may be balance billed for cost-sharing amounts;
 - Name the specific provider(s) (see 86 FR 36909); and
 - Document time and date of:
 - Receipt of written notice, and
 - Patient signed the consent.

(45 CFR 164.420(e))

CONSENT OF PATIENT OR REP

- Must provide a copy of the signed written notice and consent to the patient in person or through mail or e-mail as selected by the patient.

(45 CFR 164.420(c)(1))

- Consent only applies to receipt of information re balance billing; it does not
 - Create a contract by the patient to pay any estimated charge or amount; or
 - Constitute consent for treatment.

(45 CFR 164.420(g))

- Patient may consent to balance bill by some providers but not others.
(86 FR 36909)

NOTICE AND CONSENT: LANGUAGE ACCESS

- Nonpar provider or facility must give the patient the choice to receive the notice and consent in any of the 15 most common languages
 - in the state where the applicable facility is located; or
 - In the geographic service area of the facility.
- If patient's preferred language is not among the 15 most common languages and patient cannot understand the language of the notice and consent, nonpar provider or facility must provide qualified interpreter to meet the notice and consent requirements.

(45 CFR 149.420(f))

TOP 15 LANGUAGES IN IDAHO*

1. English
2. Spanish (47,041)
3. Chinese (1,798)
4. Serbo-Croatian (815)
5. Korean (767)
6. Vietnamese (630)
7. Arabic (628)
8. German (588)
9. Tagalog (562)
10. Russian (481)
11. French (449)
12. Japanese (395)
13. Romanian (315)
14. Sudan (305)
15. Persian (296)

*As of August 2016,
<https://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/appen-dix-a-top-15.pdf>

NOTICE AND CONSENT: PRACTICAL APPLICATION

- Likely difficult to satisfy notice and consent requirements.
 - Applies in limited circumstances.
 - Patients unlikely to consent. Why would they?
 - Challenging to satisfy all the requirements.
 - Timing
 - Required info
 - Language access
- Nonpar provider may generally refuse to provide care if patient does not consent to balance billing subject to:
 - EMTALA,
 - Other state or federal requirements, or
 - Contract obligations.

(86 FR 36905)

EMERGENCY SERVICES: NOTICE TO PLAN OR INSURER

- Nonpar provider (or facility on behalf of provider) seeking to balance bill patient must timely notify the plan or insurer:
 - That item or service was furnished during a visit at a participating health care facility; and
 - If applicable, provide a copy of the signed written notice and consent document.
- If nonpar provider bills patient directly, provider may notify the plan or insurer by including the notice with the bill to the patient.

(45 CFR 149.420(i))

POST-STABILIZATION SERVICES: NOTICE TO PLAN OR INSURER

- Nonpar provider and nonpar facility seeking to balance bill for post-stabilizing emergency services must timely notify the plan or insurer when submitting bill:
 - Whether the notice + consent requirements have been satisfied for each such item or service; and
 - If applicable, provide a copy of the signed written notice and consent document.

(45 CFR 149.410(e))

NOTICE AND CONSENT: DOCUMENT RETENTION

- Nonpar provider or facility that obtains consent to balance bill from a patient or personal rep must retain the written notice and consent for 7 years.
- Provider may coordinate with facility as to which retains the documents.

(45 CFR 149.410(d), (h))



IN SUMMARY: VERY DIFFICULT TO BALANCE BILL PATIENT

- Notice and consent exception only applies to limited services.
 - Post-stabilization emergency services.
 - Non-emergency services by nonpar provider at participating facility subject to extensive exceptions
- Provide notice to patient
 - Containing info required by HHS
 - Within time limits
- Obtain informed consent from patient.
 - Include info required by HHS
- Satisfy language accessibility requirements.
- Notify plan.

NO SURPRISE BILLING RULE: SUMMARY

Limits on surprise bills do not apply to:

- Participating providers and/or facilities.
- Self-pay patients.
- Items or services that are not covered by health plan.
- Items or services that are not provided at or in connection with a visit to a "facility."

**Patient charge =
cost-sharing for participating provider**

Covered emergency services provided by

- Nonpar provider or
- Nonpar facility

Covered non-emergency services by non-par provider at participating facility

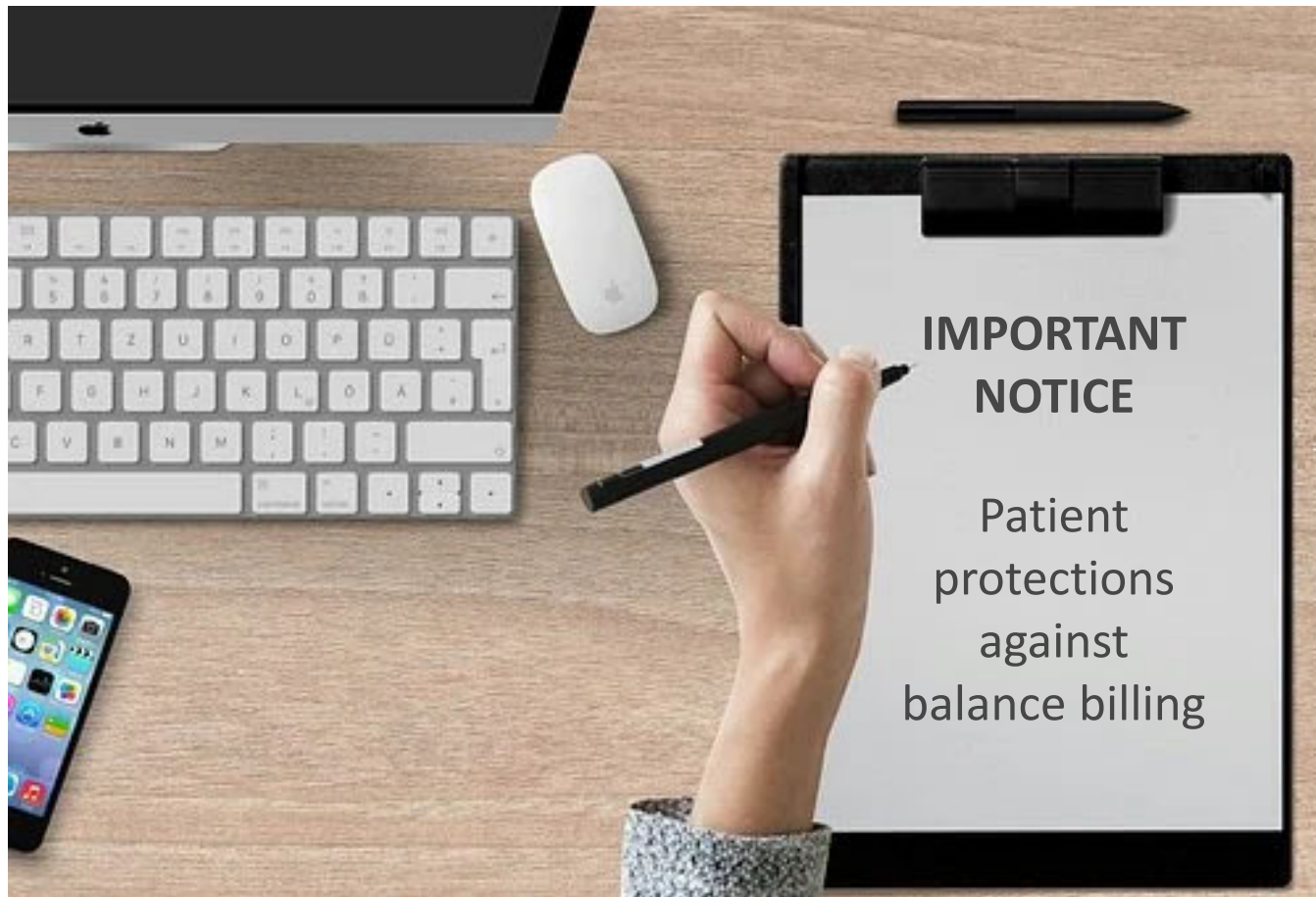
May balance bill if:

- Notify patient
- Obtain consent
- Notify insurer

Except
Pre-stabilization,
urgent services,
ancillaries, etc.



NOTICE OF PATIENT PROTECTIONS



NOTICE OF PATIENT PROTECTIONS

Must give notice

- Health care facilities.
- Providers who provide items or services at or in connection with a visit to a health care facility, i.e.,
 - Hospital or CAH,
 - Hospital outpatient dept,
 - ASC, or
 - Freestanding emergency department.

(45 CFR 149.430(e); 86 FR 36914)

Not required to give notice

- Provider does not furnish items or services at or in connection with visits at health care facilities.
- To patients who are not participants, beneficiaries, or enrollees in a health plan or health insurance.
- To such patients if the items or services are not furnished at or in connection with a visit to a health care facility.

NOTICE OF PATIENT PROTECTIONS

- Providers and facilities must notify covered patients of balance billing protections.
 - Prominent sign in provider’s or facility’s location (if have one).
 - E.g., where patients schedule, check in, or pay bills. (86 FR 36914)
 - Post on website (if have one):
 - Required info or link on searchable homepage of website.
 - Must be able to access without charge, setting up account, or giving personal information. (86 FR 36913)
 - Give notice to each patient who receives items or services.
 - One page, double-sided page using print \geq 12-point font.
 - Provide in-person, mail or e-mail as selected by patient.
 - No later than the date and time:
 - When provider or facility requests payment from patient; or
 - If provider does not request payment from patient, when provider or facility submits claim to plan or insurer.

(45 CFR 149.430(c), (d))

NOTICE OF PATIENT PROTECTIONS

- Notice must state in clear and understandable language:
 - Explain the requirements and prohibitions relating to balance billing.
 - If applicable, explain state law requirements concerning balance billing.
 - Contact information for appropriate federal and state agencies to report violations.

(45 CFR 149.430(b))

➤ *HHS working on model notice.*

- *Use of model notice is deemed good faith compliance.*

➤ *Notice must satisfy language accessibility standards.*

(86 FR 36912-13)

NOTICE OF PATIENT PROTECTIONS

- Both provider and facility must:
 - Post sign at prominent location (if have one), and
 - Post on website.
- Provider and facility may enter a written agreement so that facility provides the required one-page notice to the patient.
 - If facility fails to provide the required notice, balance billing rules still apply: nonpar provider may not balance bill.
 - If facility fails to provide the required notices (i.e., sign and notice to individual) per the agreement and patient is balance billed, the facility is liable, not the provider.

(45 CFR 149.430(f); 86 FR 36915)

BALANCE BILLING: AIR AMBULANCES



AIR AMBULANCES

- If nonpar air ambulance provider renders services to a covered person, provider may not bill patient more than cost-sharing amount that would apply to a participating provider.
- No exception for notice and consent.

(45 CFR 149.440)

- *May still bill and recover from plan or insurer for covered services.*
- *May still bill self-pay patients.*

COMPLAINTS



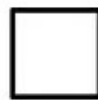
COMPLAINT PROCESS

- Complainant may file complaint with HHS for violations of the No Surprises Billing Rule.
- HHS will review the complaint and may request additional information.
- HHS may refer complaints against payers to CMS enforcement process under 45 CFR part 150.
- HHS will make reasonable attempts to notify the complainant of the resolution.

(45 CFR 149.450)

ACTION ITEMS

CHECKLIST



CONSIDER STATE LAW

- Must generally comply with more restrictive state law.
- States with balance billing protections: Arizona, Colorado, Delaware, Indiana, Iowa, Maine, Massachusetts, Minnesota, Mississippi, Missouri, New Mexico, North Carolina, Pennsylvania, Rhode Island, Texas, Vermont, and Washington.

(CMS, *Requirements Related to Surprise Billing; Part I Interim Final Rule with Comment Period*, <https://www.cms.gov/newsroom/factsheets/requirements-related-surprise-billing-part-i-interim-final-rule-comment-period>)

ACTION ITEMS: BEFORE 1/1/22

- ✓ Confirm and coordinate state law requirements.
- ✓ Facilities: identify nonpar providers who render services at facilities.
 - Balance billing rules apply to nonpar providers.
- ✓ Nonpar providers: identify situations in which you provide services at facility and determine whether you are participating.
- ✓ Prepare notices of patient protections if you are, or render services at, a “health care facility”:
 - Website
 - Sign in prominent location
 - One page form to distribute to patients
 - HHS to provide sample notice.
- ✓ Providers: prepare written agreement so that facility provides required notice of patient protections to patients at facility.

ACTION ITEMS: BEFORE 1/1/22

- ✓ Determine if you are going to attempt notice and consent from patient.
 - Likely very difficult to obtain patient consent.

If you decide to attempt notice and consent:

- ✓ Prepare notice for patients.
 - Watch for HHS form.
- ✓ Prepare consents for patients.
 - Watch for HHS form.
- ✓ Notice to insurers.
- ✓ Accommodate language barriers.

ACTION ITEMS: BEFORE 1/1/22

- Educate staff and implement processes
 - Limits on charges to patient and balance billing rules.
 - Distributing one-page notice to patients.
 - Providing notice + obtaining consent.
 - Providing notice to plan or insurers if obtain notice + consent.
- Training should include:
 - Payer contracting
 - Medical staff office
 - Patient intake and scheduling
 - Billing and collections
 - Compliance
 - Website design
 - Others?

ACTION ITEMS

- HHS still working on the rules.
 - Solicited comments concerning aspects; comments are due **9/7/21**.
 - Forms.
- Stay tuned...
 - Additional guidance from HHS.
 - HHS notice and consent forms.
 - Final rule following comments.
 - Regulations implementing other portions of the No Surprise Act, e.g.,
 - Enforcement rule.
 - Dispute resolution process.
 - Transparency and price comparison tools.

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Issues such as rising healthcare costs, healthcare reform, data and privacy security, and innovations in healthcare delivery, device and pharmaceutical designs are forefront in the minds of many of our clients. We are here to guide our clients through the challenges and opportunities that arise in this dynamic industry.

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- Individual medical providers
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- Managed Care (MCO)
- Insurance
- Health plans
- Health care centers
- Ambulatory surgery centers
- Medical device and life science companies
- Rehabilitation centers
- Extended and eldercare facilities

Webinars and Publications

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QUESTIONS?



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