NO SURPRISE BILLING RULE AND LONG TERM CARE FACILITIES

Idaho Health Care Ass'n

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(3/22)

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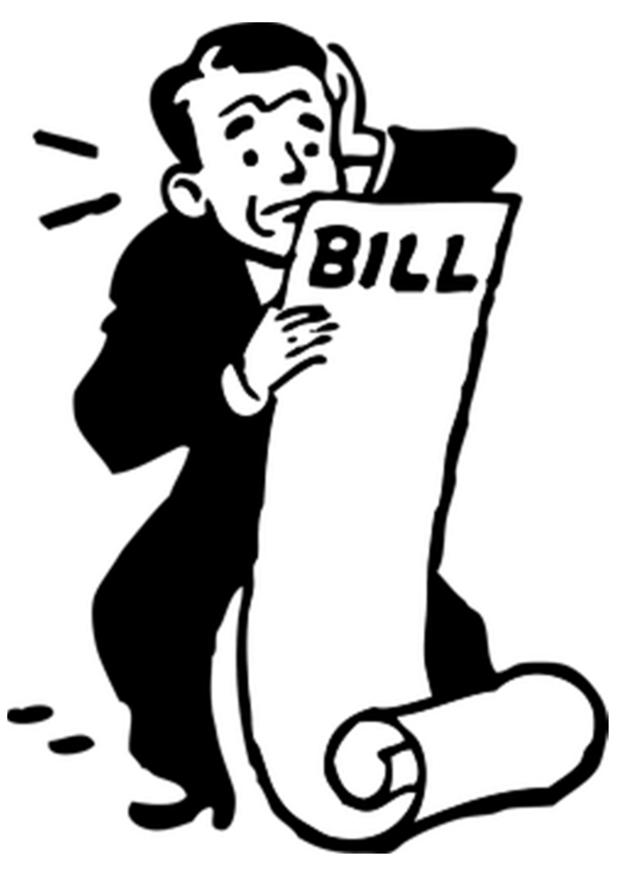
WRITTEN MATERIALS

- No Surprise Billing Rule Part II, 86 FR 55980 (10/7/21), https://www.govinfo.gov/app/details/FR-2021-10-07/2021-21441
- CMS, Guidance on Good Faith Estimates and PPDR Process (12-21-21), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimate-Patient-Provider-Dispute-Resolution-Process-for-Providers-Facilities-CMS-9908-IFC.pdf
- CMS, Good Faith Estimate FAQs (12-21-21), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ.pdf
- Stanger, No Surprise Billing Rules: Checklist for Providers, https://www.hollandhart.com/no-surprise-billing-rules-checklist-for-providers

NO SURPRISES ACT AND NO SURPRISE BILLING RULES



- Govt concerned about:
  - Uninsured or self-pay patient receives unexpected medical bill.
  - Insured patient receives unexpected medical bill from out-of-network ("OON") facility or provider
- No Surprises Act
  - Title I of Division BB of the Consolidated Appropriations Act ("CAA") for 2021
- No Surprise Billing Rules
  - 45 CFR part 149
  - Effective January 1, 2022

NO SURPRISE BILLING RULES AND LONG TERM CARE

Insured Patients

- Limits amount OON provider/facility may bill resident and payer.
- Only applies to:
  - Hospital or freestanding emergency dept
  - Hospital, hospital outresident dept, or ASC

(45 CFR part 149)

Self-Pay Patients

- Providers/facilities must give patient/resident a good faith estimate of charges.
- Selected dispute resolution ("SDR") *nka* Patient-Provider Dispute Resolution ("PPDR") process if actual bill is substantially in excess of good faith estimate.
- Notice of rights to resident.

(45 CFR 149.610-.620)

SELF-PAY RULES: APPLICATION

Applies to:

- **Health care facility** = "an institution (such as a hospital or hospital outpatient dept, 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…."
- **Health care provider** = "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 a provider of air ambulance services."

(45 CFR 164.610)

SELF-PAY RULES: APPLICATION

- CMS/CCIIO has indicated SNFs and ALFs <u>are</u> included in Surprise Billing and Good Faith Estimate requirements.
- AHCA is attempting to obtain:
  - Answers to questions unique to LTC.
  - 6 to 9 month grace period because SNF and ALF inclusion was unexpected.

(E-mail from Mike Cheek, AHLA, dated 3/25/22)

SELF-PAY RULES: APPLICATION

Applies to **"uninsured (self-pay) individuals"**

- Does not have benefits for an item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, Federal health care program … or a health benefits plan …, or
- Has such benefits but who does not seek to have a claim for such item or service submitted to such plan or coverage.

(45 CFR 164.610)

Does not apply to federal program beneficiaries:

- "These requirements do not apply to beneficiaries or enrollees in federal programs, e.g., Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE.
- "These programs have other protections against high medical bills."

(https://www.cms.gov/files/document/high-level-overview-provider-requirements.pdf)

NO SURPRISE BILLING RULES: PENALTIES

- Reduced or denied payment if actual bill is substantially in excess of good faith estimate.
- State enforcement
- If state fails to enforce, HHS may impose:
  - Corrective action plan
  - $10,000 civil penalty

(42 USC 300gg-134(b); 45 CFR 150.101(b)(3), 150.501(a), and 150.513(a))

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https://doi.idaho.gov/consumers/health-insurance/nosurprises/

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DEPARTMENT OF INSURANCE

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Home / Consumers / Health Insurance / Unexpected Medical Bills and No Surprises Act

Effective January 1, 2022, the federal No Surprises Act provides new protections for unexpected or excessive medical bills consumers may have received from medical providers. The Department of Insurance is able to help Idahoans understand and utilize these new consumer protections, regardless of whether they have health insurance.

GOOD FAITH ESTIMATE TO SELF-PAY RESIDENTS

Effective January 1, 2022

FACILITIES

Convening Facility

- Facility that is responsible for scheduling the "primary item or service", i.e., the item or service that is the reason for the initial visit.

➢ *Primarily responsible for compliance*

Co-Facility

- Facility other than the convening provider/facility that furnishes items or services that are customarily provided in conjunction with a primary item or service.

(45 CFR 149.610(a)

INQUIRE IF RESIDENT IS SELF-PAY

- Convening facility must:
  - Determine if an individual is uninsured or a self-pay individual:
    - Ask if the resident is covered by a group plan, insurance or a federal healthcare program.
    - If resident has coverage, ask if resident wants to have the claim submitted to the payer for the primary item or service.
  - If resident is self-pay, inform the resident that they may obtain a good faith estimate of expected charges upon:
    - Scheduling the item or service, or
    - Upon request.

(45 CFR 149.610(b)(1))

NOTICE OF GOOD FAITH ESTIMATE

- Convening facility must inform self-pay residents about right to good faith estimate by:
  - Written notice prominently displayed
    - On provider/facility's website;
    - In its office; and
    - Onsite where scheduling or questions about cost of items or services occur.
  - Orally inform resident when scheduling item or service or when resident asks about cost of items or services.
- Notice must be made available in accessible formats and the language spoken by the resident.

(45 CFR 149.610(b)(1))

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OMB Control Number [XXXX-XXXX]
Expiration Date [MM/DD/YYYY]

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost

Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

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

- HHS form notice

PROVIDE GOOD FAITH ESTIMATE

- If self-pay person
  - Requests a good faith estimate,
  - Inquires about cost, or
  - Upon scheduling a primary item or service,

  convening facility must:
  - Within 1 business day, ask co-providers/facilities to submit good faith estimate to the convening provider/facility by due date.*
  - Timely provide written good faith estimate to the resident.

(45 CFR 149.610(b)(1))

** Rules re co-providers not enforced until 1/1/23.*

PROVIDE GOOD FAITH ESTIMATE

- If item/service scheduled at least 3 days in advance, provide good faith estimate not later than 1 business day after the date of scheduling.
- If item/service scheduled at least 10 days in advance, provide good faith estimate not later than 3 business days after the date of scheduling.
- If resident requests good faith estimate, provide good faith estimate not later than 3 business days after the date of the request.
- If resident requested good faith estimate and then schedules services, must provide new good faith estimate within time frames described above.
- If any change to anticipated charges, must provide updated good faith estimate no later than 1 business day before the items/services are scheduled to be rendered.

(45 CFR 149.610(b)(1))

PROVIDE GOOD FAITH ESTIMATE

"There are some items or services that may not be included in a GFE because they are not typically scheduled in advance and not typically the subject of a requested GFE (such as urgent, emergent trauma, or emergency items or services); however, to the extent that such care is scheduled at least 3 days in advance, a provider or facility would be required to provide a GFE.

"For example, individuals will likely not be able to obtain GFEs for emergency air ambulance services, as these are not generally scheduled in advance. However, making these requirements applicable to providers of air ambulance services helps to ensure that individuals can obtain a GFE upon request or at the time of scheduling non-emergency air ambulance services…"

(HHS, Good Faith Estimate FAQs, available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ.pdf)

PROVIDE GOOD FAITH ESTIMATE

- Convening facility may issue a single good faith estimate for recurring primary items/services if:
  - Such good faith estimate includes in clear manner the scope of the recurring items/services (e.g., timeframes, frequency, total number, etc.)
  - Scope of good faith estimate may not exceed 12 months.
  - If good recurring items/service extend beyond 12 months, must provide new good faith estimate.

(45 CFR 149.610(b)(1))

PROVIDE GOOD FAITH ESTIMATE

- If convening providers/facilities or co-providers/facilities listed in good faith estimate change less than 1 business day before the item/service is scheduled to be provided:
  - Replacement provider/facility must accept the existing good faith estimate as its good faith estimate.
  - Replacement providers/facilities are bound by the existing good faith estimate.

(45 CFR 149.610(b)(1)(viii)-(2)(iii))

➢ *Replacement providers should review good faith estimate and provide new good faith estimate if there is time.*

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OMB Control Number [XXXX-XXXX]
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	

- GFE must include info:
  - Patient name and birthdate;
  - Items and services by codes and charges.
  - Discounts or adjustments.
  - Name, NPI, TIN of co-provider/facility,
  - Location where each item/service is provided;
  - List of items/services that will require separate scheduling; and
  - Disclaimers

(45 CFR 149.610(c))

GOOD FAITH ESTIMATE

- Must be in writing and given in manner requested by resident:
  - Paper;
  - Electronically in form so resident may save and print;
  - Orally if requested, but still must provide in writing.

(45 CFR 149.610(e))

- Must provide in a manner understandable to the resident, considering:
  - Vision and hearing;
  - Language limitations, including limited English proficiency;
  - Communication needs of underserved populations;
  - Health literacy.

(86 FR 56021)

➢ *May need interpreters, translators, auxiliary aids.*

MAINTAIN GOOD FAITH ESTIMATE

- Good faith estimate is part of the resident's medical record and must be maintained in same manner as medical record.
- Must keep for 6 years and provide to resident if requested.

(45 CFR 149.610(f)(1)-(2))

➢ *Need to have good faith estimate available if there is claim:*
  - *PPDR*
  - *Dispute over collections*

GOOD FAITH ESTIMATE ERRORS

- Errors ≠ noncompliance so long as:
  - Acted in good faith with reasonable due diligence; and
  - Correct info as soon as practicable
- Good faith reliance on other providers ≠ noncompliance so long as:
  - Did not know and should not know of error; and
  - Correct info as soon as practicable.
- <u>But</u> still bound by PPDR if actual charges are substantially in excess of good faith estimate.

(45 CFR 149.610(f)(3)-(4))

PPDR PROCESS FOR SELF-PAY RESIDENTS

PPDR PROCESS

- If total billed charges for the listed provider/facility are "substantially in excess" of the total charges on the good faith estimate (i.e., at least $400 more than expected charges), resident may initiate the resident-provider dispute resolution ("PPDR") process.

(45 CFR 149.620(b))

- Total billed charges = total billed charges for:
  - All primary items or services, and
  - All other items or services furnished in conjunction with the primary items or services to a self-pay resident

  regardless of whether such items or services were included in the good faith estimate.

(45 CFR 149.620(a)(2)(iii))

PPDR PROCESS

- "Substantially in excess" is determined by the provider, e.g.:
  - Provider A provides services X and Y.
  - Provider B provides services Z.
  - Self-pay resident may initiate PPDR if the total charges for X and Y exceed A's good faith estimate for such services by $400.
- "Substantially in excess" calculation includes items/services that were not included in the good faith estimate.
  - Provider Z includes item C in estimate.
  - Provider Z bills for items C, D, and E.
  - resident may initiate PPDR if total charges for C,D, and E exceed $400.

(86 FR 56028)

PROCESS TO CALENDAR PPDR DEADLINES

Timing	Action
w/120 days of bill	Self-pay resident initiates SDR and pays fee.
Upon receipt of resident's initiation	HHS selects SDR entity; SDR entity reviews info submitted by resident; may give resident 21 days to submit more info
	SDR entity notifies provider/facility and resident.
Upon notice of SDR	Provider/facility suspends collection activity.
w/10 days of notice	Provider/facility submits good faith estimate, billed charges, and additional supporting info.
w/3 days of settlement	Notify SDR entity of settlement, if any.
w/30 days after provider/facility submits info	SDR entity issues determination and notifies parties.

PPDR PROCESS

- Within 120 days of receiving bill containing disputed charges, resident must notify HHS of intent to pursue PPDR and pay $25 fee.
- If PPDR entity determines PPDR is appropriate, it will notify provider/facility.
- While PPDR pending, provider/facility may not:
  - Move the disputed bill to collections or threaten to do so;
  - If bill moved to collections, cease collection efforts;
  - Suspend accrual of late fees on unpaid bill amounts;
  - Take or threaten any retribution against resident to obtain resolution of dispute.

(45 CFR 149.620(c)(1)-(2))

PPDR PROCESS

- Within 10 days of notice to provider, provider must submit to PPDR entity:
  - Copy of the good faith estimate relevant to dispute.
  - Copy of the billed charges that are subject to dispute.
  - If available, documentation showing that the difference between billed charge and good faith estimate reflects:
    - Cost of medically necessary item/services; and
    - There were unforeseen circumstances that could not have reasonably been anticipated by provider/facility when the good faith estimate was provided.

- Within 30 days, PPDR entity issues decision.

(45 CFR 149.620(c), (f))

BILLED CHARGE IS ON ESTIMATE

If billed charge is listed on the good faith estimate:

- If billed charge ≤ expected charge:
  - ➢ resident pays the billed charge
- If billed charge > expected charge and provider failed to prove medical necessity and unforeseeability:
  - ➢ resident pays the expected charge from estimate.
- If billed charge > expected charge and provider proves medical necessity and unforeseeability:
  - ➢ resident pays the lesser of the:
    - Billed charge, or
    - Expected charge if expected charge > median rate paid by a payer for same/similar service by same/similar provider in the geographic area as listed in independent database, or
    - Median rate if expected charge < median rate.

(45 CFR 149.620(f)(3)(iii)(A))

BILLED CHARGE NOT ON ESTIMATE

If billed charge is not listed on good faith estimate:

- If provider failed to prove medical necessity and unforeseeability:
  - ➢ resident pays $0 for the item/service.
- If provider proves medical necessity and unforeseeability:
  - ➢ resident pays the lesser of the:
    - Billed charge, or
    - Median rate paid by a payer for same/similar service by same/similar provider in the geographic area as listed in independent database.

(45 CFR 149.620(f)(3)(iii)(B))

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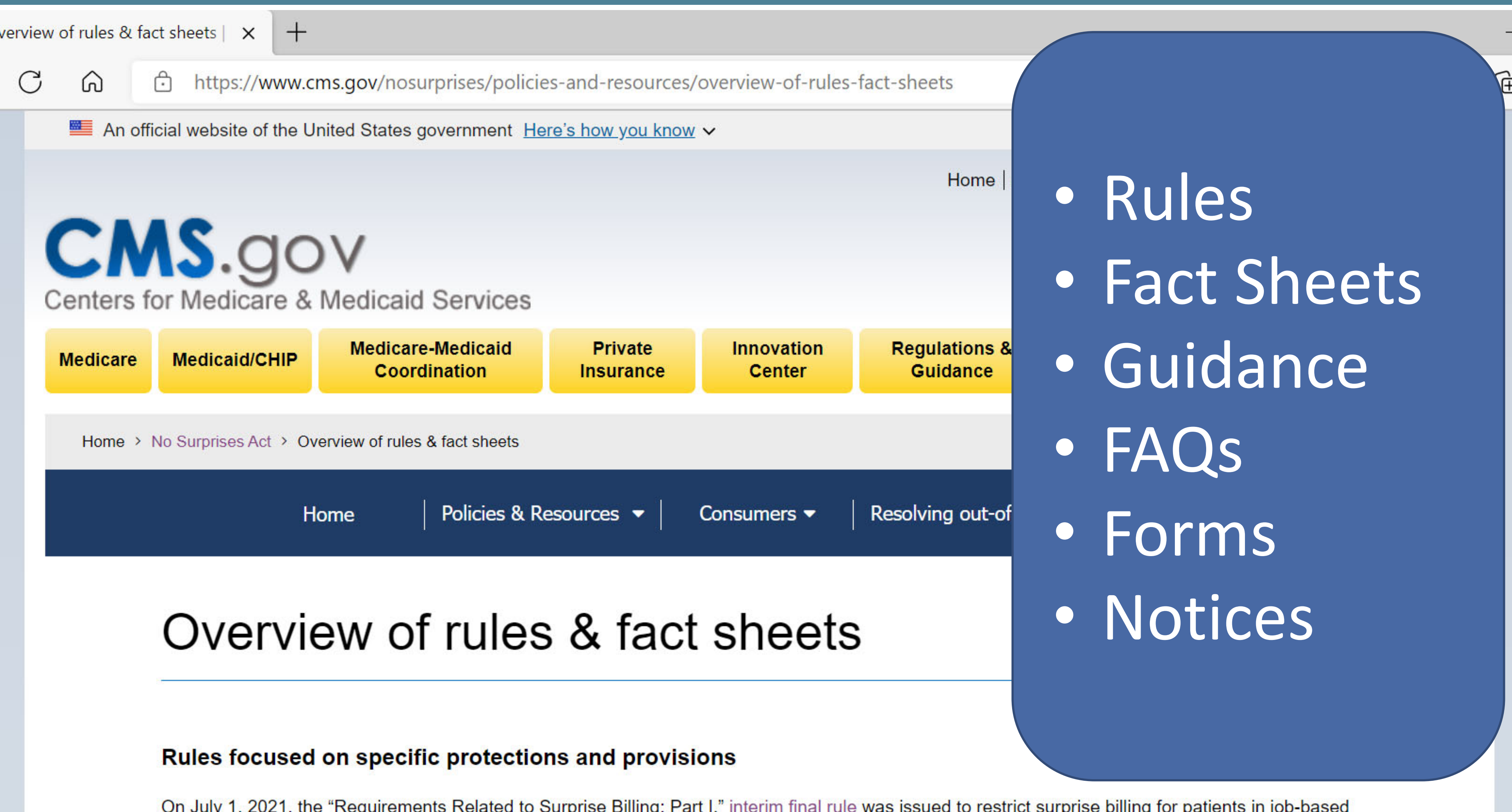
STAY TUNED…

- Additional guidance from HHS.
- HHS forms.
- Final rules following comments.
  - Perhaps changes?
- Regulations implementing other portions of the No Surprise Act, e.g.,
  - Good faith estimate to insured residents and payers.
  - Others?

ADDITIONAL RESOURCES

HTTPS://WWW.CMS.GOV/NOSURPRISES/POLICIES-AND-RESOURCES/OVERVIEW-OF-RULES-FACT-SHEETS



- Rules
- Fact Sheets
- Guidance
- FAQs
- Forms
- Notices

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dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act

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No Surprises Act

Provider Nondiscrimination

- Listening Session Transcript
- Announcement of Listening Session

Group Health Plan Service Provider Disclosures Under ERISA Section 408(b)(2)(B)

- Temporary Enforcement Policy - Field Assistance Bulletin 2021-03
- News Release

Prescription Drug and Health Care Spending

- Interim Final Rule
- Supporting Documents
- News Release
- HHS Fact Sheet

Requirements Related to Surprise Billing, Part II

- Interim Final Rule with Request for Comments

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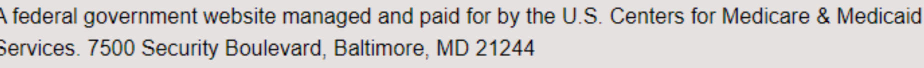
CMS-10791

CMS Form Number	CMS-10791
Date	2021-09-30
Subject	Requirements Related to Surprise Billing; Part II

Downloads

CMS-10791 (ZIP)

- Notice of Patient's Right to Receive GFE
- Form for GFE
- GFE Data Elements
- PPDR Forms



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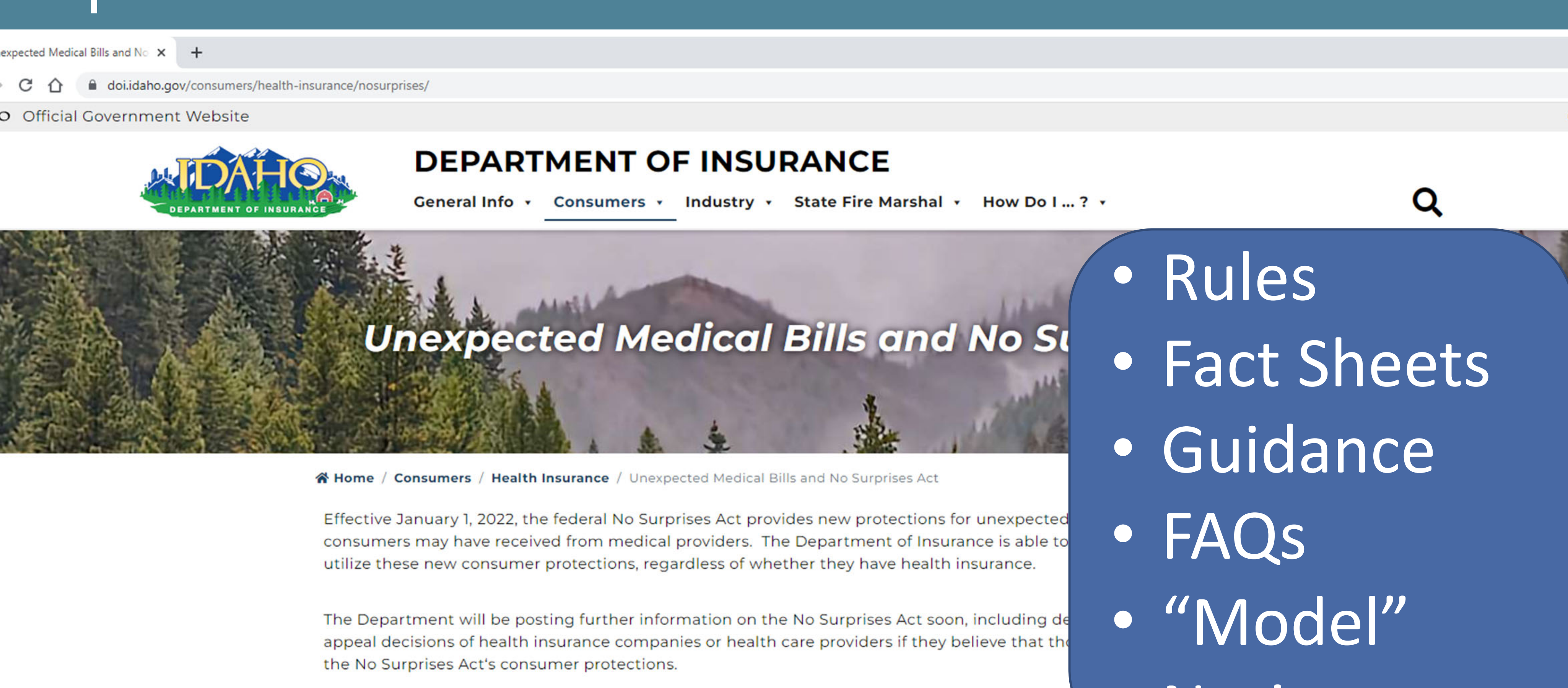

- Rules
- Fact Sheets
- Guidance
- FAQs
- “Model” Notices

CALL THE IDAHO DEPARTMENT OF INSURANCE

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Continuation of Care Requirements

If a provider or a facility ceases to be an in-network provider and an individual meets the definition of a **continuing care patient**, the health care provider or facility must:

- continue to accept the previously agreed upon amount for up to 90 days after the patient is notified of the change in network status, and
- continue to treat the patient within the provisions of the previous contract.

Additional information regarding the CMS Continuation of Care requirements: **CMS No Surprises Act Provider & Facility Information**.

Out-of-Network Balance Billing Exceptions

In certain situations, non-participating providers and facilities may balance bill; however, the following are some of the conditions that must apply:

- based on the patient's medical condition, the patient is able to travel to an available participating provider facility using non-medical/non-emergency medical transportation
- the patient is in a condition to receive notice and provide informed consent
- the non-participating provider adheres to notices and timeframes as described in the No Surprises Act
- the health care provider or facility satisfies any additional state law requirements

Providers and facilities need to be aware of certain conditions where balance billing is prohibited, even if a patient has signed a consent notice.

File a NSA Complaint

More information available at CMS.gov/NoSurprises

Have more questions?

Contact the Consumer Affairs team:

(208) 334-4319 Email

Idaho Department of Insurance Consumer Affairs team's phone number is: 208-334-4319

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NEWS AND INSIGHTS

The Healthcare Industry is poised to continue its rapid evolution. With this sector now making up close to 20 percent of GDP, our lawyers stand ready to help as changes unfold.

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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- Medical device and life science companies
- Rehabilitation centers

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