HHS Surprise Medical Bill Rule

Presented by

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Background

- On July 1, 2021 HHS issued Requirements related to Surprise Billing; Part 1
- The Rule restricts excessive out of pocket costs to consumers from surprise billing and balance billing
- Surprise billing occurs when patients get care from providers outside their health plan’s network
- Balance billing is currently prohibited in the Medicare and Medicaid
- The rule will extend to employer sponsored and commercial plans
- Part 2 was issued September 30, 2021

Patient Protections

- Scope of Protection
  - Protects patients from surprise medical bills when they receive unanticipated out of network care
- Cost-Sharing
  - Patients are only responsible for cost-sharing amounts they would be billed by an in-network provider
- Impact on Uninsured
  - The Act requires an Independent Dispute Resolution when uninsured's bill is "substantially in excel" of a good faith estimate
  - Includes patients who do not have benefits for an item or service

Surprise billing restrictions

- The rule will take effect January 1, 2022, for facilities and health care providers.
- For group health plans and insurance issuers, the rule will take effect for plan years beginning on or after January 1, 2022.
- For carriers under the Federal Employees Health Benefits (FEHB) Program, the rule will take effect for contract years beginning on or after January 1, 2022

What is Surprise Billing and Balance Billing?

- Balance billing occurs, if permitted by state law, when an out-of-network provider bills an individual for the remainder of what the individual's insurance does not pay.
- Out-of-network providers and facilities usually charge higher amounts than the contracted rates in-network providers receive from plans and issuers.
- Balance billing by out-of-network providers leaves individuals with higher out-of-pocket costs than if they had been seen by in-network providers.
- The rule provides protections to participants, enrollees, and beneficiaries by prohibiting surprise billing under certain circumstances.

What patients does this rule apply to?

- The rule applies to individuals who receive coverage through employers (including federal, state, or local governments), federal and state marketplaces, or individual market health insurance providers.
- The rule will restrict surprise billing to individuals who receive emergency services and non-emergency services from out-of-network providers at in-network facilities and air ambulance services from out-of-network providers.

Does this apply to all Providers?

- Bans out-of-network charges for
  - Ancillary care
  - At an in-network facility
  - In all circumstances.

Ghost Providers

At in-network facilities, the notice and consent exception does not apply to out-of-network providers of:

- radiology
- pathology
- emergency
- anesthesiology
- diagnostic
- neonatal services
- assistant surgeons
- hospitalists
- Intensivists
- providers offering services when no other in-network provider is available.

Emergency Services

- ***Bans surprise billing for emergency services***
- Surprise billing for emergency services occurs when participants, enrollees, and beneficiaries unknowingly get emergency care from out-of-network providers.
- This frequently occurs in emergency situations where individuals are usually taken to the nearest emergency department without regard to the individual's health plan network.
- Under the rule, emergency services must be treated as in-network services, regardless of where the services are provided, and without any pre-authorization requirements.

Out of Network Cost Sharing

- ***Bans excessive out-of-pocket costs by limiting cost-sharing for out-of-network services***
- Patient cost-sharing, such as co-insurance and deductibles, for out-of-network services are limited to in-network levels and must be based on in-network rates.
- These cost-sharing limitations apply to out-of-network emergency services, non-emergency services provided by out-of-network providers at certain in-network facilities, and air ambulance services provided by out-of-network providers.

Patient Notification

- ***Bans other out-of-network charges without advance notice to the patient***
- In order to permit the provider or facility to bill at an out-of-network rate, providers and facilities must provide participants, enrollees, and beneficiaries with a one-page consumer notice explaining that patient consent is required to receive care on an out-of-network basis.
- The notice must also outline any applicable state balance-billing restrictions and how the individual can contact appropriate state and federal agencies if the individual believes the provider or facility has violated any of the requirements outlined in the notice

Notice and Consent

- Unless notice and consent requirements are met in non-emergency situations, if a provider submits a bill to a patient in excess of in-network cost sharing and the patient pays, the provider must refund with interest.
- Such notice and consent requirements are met if:
  - The patient is provided written notice and consent 72 hours in advance of appointment.
  - Documents provided to patients must include a good faith estimate of the costs of the services (the language specifies this advanced notice does not constitute a contract).
  - Patients must also receive a list of in-network providers at the facility and information regarding medical care management, such as prior authorization.

Second Interim Final Rule

- On Sept. 30, 2021, the Department of Health and Human Services (HHS), the Department of Labor, and the Department of the Treasury (the Departments), along with the Office of Personnel Management (OPM), released an interim final rule (IFR) with comment period, entitled "Requirements Related to Surprise Billing; Part II."
- This is the second interim final rule related to the No Surprises Act (NSA) — legislation that regulates surprise (balance) billing in healthcare settings and mandates full transparency of coverage regulations for patients.

Independent Dispute Resolution

- The Part II IFR establishes the federal IDR process to determine the OON rate for applicable items or services after an unsuccessful open negotiation
- Disputing parties must participate in a 30-day negation period initially to determine a payment rate.
  - if the negotiation fails, either party may initiate the IDR process.
- After a certified dispute resolution entity has been chosen to resolve the dispute, the parties will submit their offers for payment along with supporting documentation, and the entity will issue a binding determination on the chosen OON amount.
- See the full rule for the complete process.

Contacting an IDR

- The Departments and OPM have created a federal portal for organizations to apply to become certified IDR entities and for providers and payers to participate in the resolution process.
- More information on the IDR process, including how to initiate an IDR resolution process in the portal, and other provisions of the process will be posted over the next several months.

Good Faith Estimates

- Requirements for providers and facilities concerning good faith estimates for uninsured or self-pay individuals is also addressed in the IFR Part II.
- When scheduling an item or service, providers and facilities must extend a good faith estimate to the patient that includes charges that are reasonably expected to be provided together for the primary item or service, including those that may be provided by other providers and facilities.
- A service such as a surgery, for example, might include the surgery itself, labs, tests, and anesthesia — all of these services must be included in a good faith estimate.
- HHS will use its enforcement discretion in the first year of the NSA regulations as providers and facilities develop their compliance processes.

Patient-Provider Dispute Resolution

- When an uninsured or self-pay individual receives a good faith estimate and then is billed for a much higher amount, the Part II IFR has put a dispute resolution process in place to determine an actual payment amount.
- The patient must have received a good faith estimate which their bill exceeded by at least $400 to begin the dispute process.
- Select dispute resolution (SDR) entities will resolve disputes according to the rules set forth and following set timelines for submission and payment.

The Act updates 2015 External Review

- According to the Centers for Medicare & Medicaid Services (CMS), “The September 30, 2021, rule amends final rules issued by the Departments in 2015 related to external review.
- The September 30, 2021, rule expands the scope of adverse benefit determinations eligible for external review
- Grandfathered plans will be subject to external review requirements for coverage decisions that involve surprise billing and cost-sharing

Negotiating a Settlement

- The payer and the provider would have 30 days to negotiate a settlement before moving to arbitration
- The “final-offer” arbitration process represents a significant workflow change for providers and payers
- The losing side is responsible for paying administrative costs

Provider Outreach

- Providers and payers should consider expanding out-of-network mitigation strategies to prevent surprise billing situations
- Create a consumer education strategy to bolster knowledge about network and benefits

Patient Consent

- Clear communication with patients is also key to meeting the law's stipulation that patients consent to receiving out-of-network services for more than the in-network cost-sharing due per their insurance plan.

- The Notice of Consent outlines strict timelines to secure patient signature prior to delivering out-of-network (OON) medical services (including post-stabilization services), a constraint that would delay medical services on average three to four hours.
- read

Provider Directories

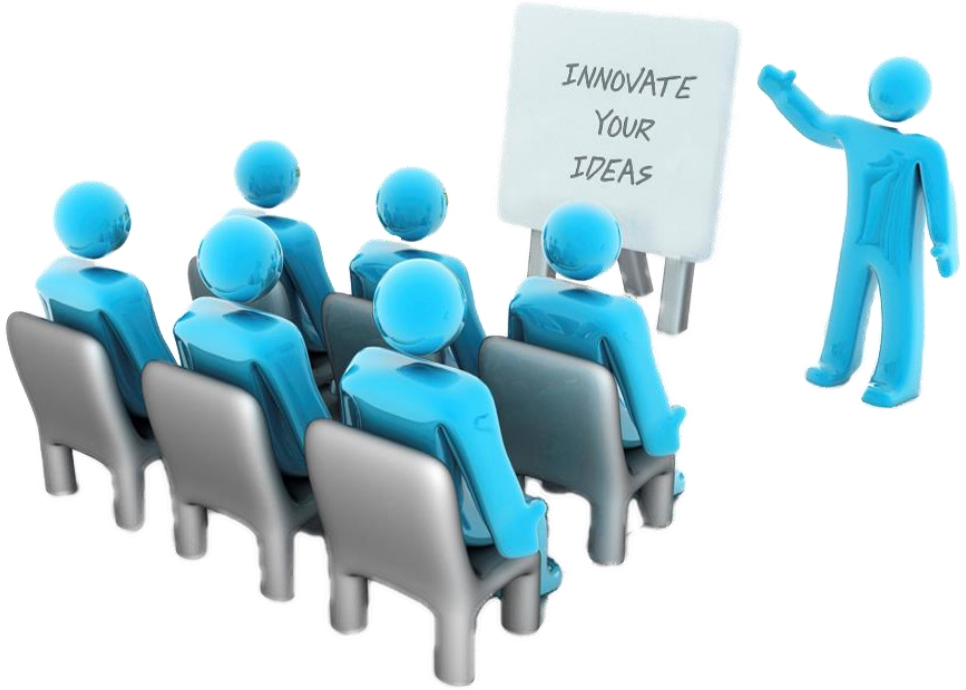
- Providers must submit regular updates to health plans on contract status
- If a patient relies on out of date provider directory information, the plan cannot impost out-of-network rates
- If a provider bills a patient greater than the in-network cost sharing, and the patient pays the bill, the provider must refund the difference with interest

Effective Dates

- The No Surprises Act goes into effect on January 1, 2022, including the following:
- The Secretary of HHS must establish the IDR process to resolve surprise medical billing disputes.
- The Secretary of HHS must establish a dispute resolution process for when an uninsured patient's bill is "substantially in excess" of the good faith estimate.
- Health plans must ensure provider directories are current and accurate, with regular verification of provider contract status and updates required at least once every 90 days.
- Providers and facilities must have a practice in place to ensure timely provision of directory information to a plan.
- Health plans must provide enrollees with "Advanced Explanation of Benefits" ("AEOB") prior to scheduled care or upon patient request prior to scheduling

Ways to Prepare

- Notify providers about the new law
- Provide a written notice and consent form click here
- Implement a process for updating credentialling status every 90 days with all contracted payers



Ways to Prepare

- Operational readiness for the surprise billing law includes:
  - Adding or leveraging analytics capabilities that “drive strategies to avoid balance billing situations,”
  - Providers and payers may need to train their staff to handle new processes
  - Possibly engage external vendors to support the management of arbitration and related administrative functions.

QUESTIONS

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About the Speaker

Nancy M Enos, FACMPE, CPC-I, CEMC is an independent consultant with the MGMA Health Care Consulting Group. Mrs. Enos has 30 years of operations experience in the practice management field. Nancy was a practice manager for 18 years before she joined LighthouseMD/CareTracker in 1995 as the Director of Physician Services and Compliance Officer. In July 2008 Nancy established an independent consulting practice.

As an Approved PMCC Instructor by the American Academy of Professional Coders, Nancy provides coding certification courses, outsourced coding services, chart auditing, coding training and consultative services and seminars in CPT and ICD-9 Coding, Evaluation and Management coding and documentation, and Compliance Planning. Nancy frequently speaks on coding, compliance and reimbursement issues to audiences including State and Sectional MGMA conferences, and hospitals in the provider community specializing in primary care and surgical specialties.

Nancy is a Fellow of the American College of Medical Practice Executives. She is a Past President of the Rhode Island/Massachusetts MGMA and serves on the Eastern Section Executive Committee for MGMA

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