No Surprises Act:

Understanding the Regulations and Operational Considerations for Success

Little Rock HFMA

March 10, 2022

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Dan is a member of BKD National Health Care Performance Advisory Services Team. He has more than 30 years of health care experience, including 22 years with academic medical centers serving in a management and executive leadership capacity and ten years providing consulting services with other large international accounting firms.

Dan has extensive experience related to hospital and provider revenue cycle transformation, financial yield and operational improvement. Key practice areas include revenue cycle performance improvement, including assessment and strategic road mapping; process re-design; patient access, denials management; cash acceleration; and patient liability programming and physician/provider integration and compensation.

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Surprise Billing – Webinar Objectives

- ✓ No Surprises Act – High level overview
- ✓ Requirements Related to Surprise Billing
- ✓ Operational Lessons Learned
- ✓ Operationalizing and Looking Forward

NSA – High Level Overview

1

No Surprises Act Interim Final Rule Part 1

Part 1 Released July, 2021

1. May not balance bill patients for emergency stabilization services
2. ED Post stabilization waiver
3. Protects patients from balance bills from out-of-network providers for services performed at in-network facilities (unless waiver is obtained)
4. Establishes in network cost-share for services outlined above for Providers and treatment by payers the Qualified Payment Amount (QPA)
5. Public notice of compliance with state and federal balance billing regulations
6. Selection of PCP and continuation of coverage

2

No Surprises Act Part 2

Part 2 Released September, 2021

1. Establishes the Provider-Payer dispute resolution Process and Timelines
   - Open negotiation period
   - Selection of the IDR
   - Ruling and payments
2. Establishes the requirements and timelines for good faith estimates for self-pay or uninsured patients
   - Establishes the future (1/2023) requirements for convening providers
3. Establishes the Patient-Provider dispute resolution process and timelines

$$ Penalties Associated with NSA

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Healthcare Financial Management Association

Topics Industry Initiatives Education & Eve

News | Billing and Collections

New rule describes the penalty associated with regulations on surprise billing

Sep 14, 2021

Healthcare providers could face penalties of up to $10,000 for each violation of regulations that prohibit surprise billing of patients starting in 2022.

- Enforcement starts with the States
- CMS to consider "relevant documentation" on potential civil penalties
- Providers must respond to "right for hearing" notice

No Surprises Act Part 1

Surprise Balance Medical Bills for Emergency Services
Surprise Balance Medical Bills for Out-of-Network Providers at In-Network Facilities

Regulations for Emergent Care and OON Providers at In-network Facilities

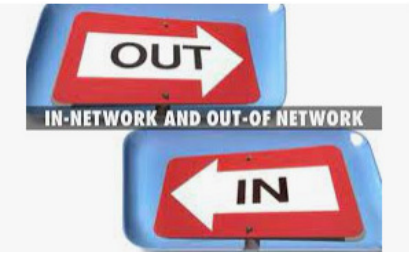
1. Emergency Care - Providers and Payers may only patients responsible for in-network cost share (stabilization services)
   - May obtain waiver for post-stabilization services (requires an estimate)
2. OON Providers at in-network facilities - Providers and Payers may only patients responsible for in-network cost share

Requires early recognition of an OON patient…

DIFFICULT

Monitoring Out-of-Network (OON) Claims

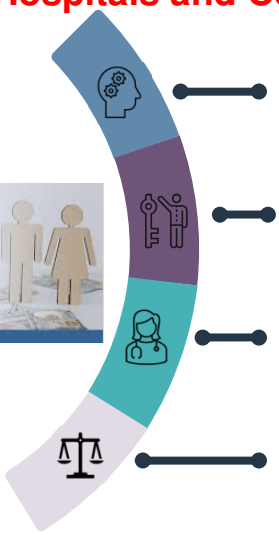
Patient Accounting Systems Assist in Tracking OON Plans?



- Allscripts ⊘
- Athena ⊘
- Cerner ⊘
- CPSI ⊘
- Epic ✓
- Meditech ⊘

Get to know OON plans; train staff, develop workflows to audit claims

Operational Challenges Associated with NSA Part 1 Balance Billing – Hospitals and Convening Providers



Develop and out-of-network strategy

Often difficult to identify out-of-network (OON) plans. Organizations will need to improve recognition of OON patients to track claims for review.

Develop Internal SWAT Teams

Enable (denials) teams to review OON claims and escalate quickly for possible independent dispute resolution (IDR). Monitor for balance billing scenarios

Stay Connected with Providers

For non-employed and contracted providers, understand their network status and approach: waiver and bill and accept "in-network" adjudication

Keep Pressure on Payers

Payers may deny or fail to process claims correctly: be prepared to catch errors and dispute appropriately. Document everything.

Preparing for Provider-Payer Dispute Resolution – Physician Entities

01

Plan Participation Status

Develop a plan participation matrix by provider for each organization in which they provide services. Know whether a provider is OON practicing at an in-network facility.

02

Develop OON Strategy

Develop the OON strategy when practicing at in-network facilities: Will our practice obtain a waiver in order to balance bill or review claims post adjudication?? Communicate with convening facilities and educate your staff

03

Maintain Pressure on Payers

Obtain payer contact information, emails etc to begin the open negotiation period and avoid confusion if/when the time comes

Payers Seemingly Do Not Understand the Regulation…

Balance billing protections when facility and provider are OON

by [redacted] on February 21, 2022 3:57 PM in Discussions

As it relates to the balance billing protections of the NSA, my understanding is that when both the facility and provider are OON, they can balance bill for non-emergent services even without notice and consent.

A couple of things happened last week that are making me second-guess this understanding, so I wanted to see if I was missing something. First, we had a commercial insurer tell an OON surgeon planning to perform a non-emergent service at our also OON facility that the patient could have the surgery OON but that their OOP would be limited to the in-network amount. That would imply neither we nor the surgeon could balance bill since the insurer would pay us both at an OON rate. Second, I saw an article about a well-known system stating they had seen an increase in scheduled OON patients since those patients must now be charged the in-network rate even for OON services. I'm unclear why they believe they can't balance bill these OON patients, if they so choose.

Have I missed a significant provision of the NSA, or is this a case where some payors and providers are confused about the balance billing protections?

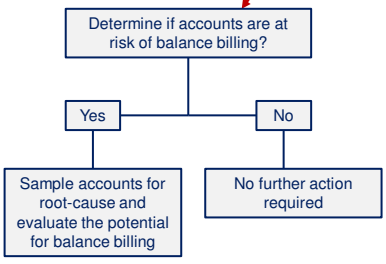
Balance Bill Testing

No Surprises Act Account Sampling Identification:

At Risk Category	Unbilled AR	Billed AR Days from Discharge					Total AR	% of AR
		0-60	61-90	91-180	181-364	365+		
Yes - Meets NSA Criteria	$636,268	$542,983	$44,710	$186,702	$86,854	$65,538	$1,563,054	0.5%
No - Does Not Meet NSA Criteria	$30,455,018	$170,446,286	$25,373,382	$42,040,262	$31,122,230	$11,510,491	$310,947,670	99.5%
Total AR $	**$31,091,286**	**$170,989,270**	**$25,418,091**	**$42,226,964**	**$31,209,084**	**$11,576,029**	**$312,510,724**	**100.0%**

No Surprises Act (NSA) Criteria:

1. Current payer is Self Pay or Self Pay after Insurance
   - Account balance equals total account charges. Note: does not necessarily place out of compliance – tests for SP discount applications
2. Balance after insurance test: payment on file and payment + patient balance = initial charge



No Surprises Act Part 2

Prover-Payer Dispute Resolution Process

Provider-Payer Dispute Timeline

Initiation of open negotiations

Provider may initiate open negotiations within 30 business days of from the date of initial payment or denial is received*

30 days

Federal IDR Process

- Select certified IDR (3 days)
- Each party must submit to the certified IDR entity and offer for a payment amount within 10 business days of selection of IDR

4 days | 3 days | 10 days

Issuer must make payment within 30 business days of certified IDR determination

30 days | 30 days

Initiating Federal IDR Process

Once open negotiations exhausted, either party may initiate the Federal IDR process during the 4 business-day period beginning on the 31st day post open negotiations*

IDR Decision Making Process

- IDR presumes the QPA is appropriate OON rate
- *IDR must select the offer closest to the QPA unless credible information is information is submitted demonstrating the QPA is materially different from the appropriate OON rate*

Now debunked and HHS will be issuing new guidance

** Department of Health and Human Services Surprise Billing Interim Final Rule Part II – page 16 & 17*

Provider-Payer Arbitration Re-do

HHS to revise independent dispute resolution guidance for No Surprises Act

Alia Paavola - Wednesday, March 2nd, 2022 Print | Email

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HHS will revise its guidance on the arbitration process outlined under the No Surprises Act following a federal court ruling.

A federal judge ruled Feb. 23 that the independent dispute resolution process implemented by HHS violated the Administrative Procedure Act. The Texas Medical Association sued the Biden administration in October 2021 over the surprise-billing resolution process, claiming it did not meet Congress' vision for the bill.

Providers have taken issue with a portion of the process that assumes the qualifying payment amount, the median in-network rate set by health insurers, is the appropriate out-of-network rate.

HHS said it will revise its guidance for determining the payment amount for out-of-network services in light of the ruling. It also said it would train certified independent dispute resolution entities and disputing parties on the revised guidance.

HHS will also permit parties to reopen a negotiation period for disputes if it expired.

What does this judgement regarding the IDR process mean…?

- ✓ The QPA is not automatically considered correct
- ✓ Does NOT provide the ability to balance bill…
- ✓ Further underscores the importance of monitoring OON claims for appropriate adjudication

Provider-Payer Independent Dispute Resolution

Requirements and information related to Provider-Payer Dispute Resolution

- Open Negotiation Notification - email is sufficient
- Federal IDR Process – Through Federal IDR Portal
  - Indicate whether or not services are batched
  - Dates and locations
  - Type of service and place of service codes
  - Names, email addresses, phone numbers, mailing address, state
  - Initiating parties preferred certified IDR (non initiating party may object within 3 business days)
  - If an OON payment agreement is reached after initiating IDR, initiating party must notify the certified IDR no later than 3 days of reaching agreement
  - Providers and facilities must report their size (<50, 51 to 100, 101 to 500, >500)
  - Payers or issuers must provide QPA geographic region
- Batched services
  - Same NPI
  - 30-day window or 90-calendar day suspension period
- IDR determination will come through the IDR portal
  - Must include written decision rational if the certified IDR does not select the offer closest to QPA
- Plan or issuer must make payment within 30 days of IDR determination
- 90 cooling off period – may not make the same or similar claim
- Both parties must pay the entire certified IDR entity fee – winner refunded
  - IDR fees estimated at $400
  - Administrative fee also assessed ($50 for 2022)

Department of Health and Human Services Surprise Billing Interim Final Rule Part II – page 35 - 45

Provider-Payer Dispute Resolution
Payer Responses

Payers seemingly do not understand the rules of engagement...

New replies to Open Negotiations

by [redacted] on February 17, 2022 2:32 PM in Discussions

Hi, Does anyone have a list of the documents that need to be sent with an open negotiation request? We submitted one and the insurer came back and stated we did not submit "credible informa...

[redacted] on February 21, 2022 3:50 PM

Thanks, Shawn. Your post will be helpful since United Healthcare responded that they will not negotiate after receiving our open negotiation notice.

No Surprises Act Part 2

Good Faith Estimates

Patient- Provider Dispute Resolution Process

1 Good Faith Estimates - Requirements

1. Information regarding the availability of estimates must be prominently displayed (facility) and easily searchable via website
2. The convening provider must orally inform uninsured/self-pay individuals of the availability of a good faith estimate
3. Must be provided in written form either on paper or electronically (email, portal) pursuant to individuals requested method of delivery. **Forms considered part of Medical Records (6 year retention)**
4. Must be available to save or print and should be clear and understandable for the average uninsured individual

Department of Health and Human Services Surprise Billing Interim Final Rule Part II – page 126 -135

GFE Requirements

- ✓ Patient DOB
- ✓ Description of service
- ✓ Itemized list of items or services grouped by each provider or facility to be furnished in the period of care including:
  1. Expected to be furnished by convening provider/facility
  2. Expected to be furnished by co-providers/facility
- ✓ Diagnosis and expected service codes along with charges, *both total and discounted*
- ✓ NPI and TIN of each provider or facility represented in the GFE, state and address of where services are to be provided
- ✓ List of items or services that convening provider/facility anticipate will require separate scheduling before or following the quoted period of care
- ✓ Required Disclaimers:
  - *Inform that additional items or services may be recommended as part of course of care*
  - *GFE is only an estimate, actual charges may vary*
  - *Recipient has a right to patient-provider dispute resolution process*
  - *GFE is not a contract and does not require the recipient to obtain services contained in GFE or provide signature*
- ✓ May provide single GFE for reoccurring period of care

Chart 1: Example of How Itemized Lists of Expected Items or Services Could be Displayed in a Good Faith Estimate for Uninsured (or Self-Pay) Individuals

Details of Services and Items for [Provider/Facility 1]

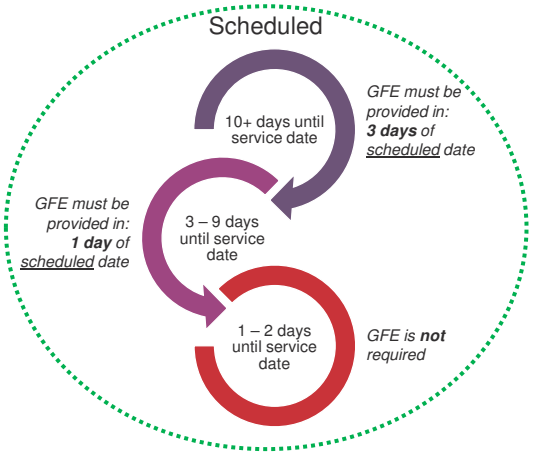
Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service Code Type: Service Code Number]		
Total Expected Charges from [Provider/Facility 1]					$
Additional Health Care Provider/Facility Notes					

Details of Services and Items for [Provider/Facility 2]

Service/Item	Address where service/item will be provided	Diagnosis Code		Service Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]		[Service Code Type: Service Code Number]		
	Total Expected Charges from [Provider/Facility 1]					$
	Additional Health Care Provider/Facility Notes					

Department of Health and Human Services Surprise Billing Interim Final Rule Part II – page 126 -133

Timelines and Recommendations Related to GFEs



- Integrate patient estimates into the financial clearance workflows
- Educate registration staff to double check for estimates on scheduled services for self pay patients
- 80/20 Rule – Perform analysis to identify commonly scheduled procedures for self pay patients

Patient-Provider Dispute Resolution

- Defining "substantially in excess"
  - HHS considering an amount that is the greater of either a percentage of the total expected charge or a flat minimum dollar amount
  - Example:
    - GFE $2100
    - 10% or $400 charges would need to be in excess of $2500 to qualify for SDR
  - Co-Providers
    - Services included in GFE include services A, B, and C. Services A & B are provided by convening provider and service C provided by co-provider. In this example services A&B would need to exceed GFE by $400 and service C would need to exceed GFE by $400 to be eligible for Selected Dispute Resolution Entities (SDR)
- Overestimating

Department of Health and Human Services Surprise Billing Interim Final Rule Part II – page 143 - 157

Audit Your Good Faith Estimates

Processed Date	Payer	Visit	Date of Service	Estimated CPT	PPE Estimate - After Discount	Actual Bill - After Discount	Diference	Notes
1/25/2022	Self Pay	4002264369	1/31/2022	78815	$ 6,868.62	$ 8,688.55	$ (1,819.93)	
1/4/2022	Self Pay	4002239094	1/11/2022	93017	$ 1,155.92	$ 1,212.34	$ (56.42)	
1/10/2022	Self Pay	4002249992	1/12/2022	73564	$ 453.81	$ 392.89	$ 60.92	Turned into BCBS
1/10/2022	Self Pay	4002250092	1/13/2022	74240	$ 692.47	$ 692.47	$ -	Turned into Medicaid
1/13/2022	Self Pay	4002244163	1/18/2022	93306	$ 475.52	$ 577.27	$ (101.75)	
1/19/2022	Self Pay	4002259648	1/20/2022	93017/93350	$ 3,236.92	$ 3,984.27	$ (747.35)	Turned into WC

- Sufficient time has elapsed for audit of good faith estimates
  - ✓ Track and review all GFEs
  - ✓ Root cause variances for improvement
  - ✓ Plan of action for variant GFEs?? *Call patient, adjust bill, do nothing*?
  - ✓ Consider daily huddles to discuss GFE issues
  - ✓ Obtain support from key clinical departments; radiology and surgery

Patient-Provider Dispute Resolution Timeline

Must Include:

1. DOS and description
2. Copy of bill
3. Copy of GFE
4. Contact information; address, phone
5. State
6. Individual's communication preference

Convening facility/provider will have **10** days from date of receipt of notice by SDR of patient-provider dispute to submit information

0 – 120 Days → Notice Requirements → Additional Info → Convening Entity 10 Days → Final Determination

Patient Initiates Dispute Resolution

Patients may submit for dispute resolution process for up to 120 days from receipt of original bill

The SDR will notify patient electronically or by mail. Should request be incomplete patient will have **21** days to submit additional information for consideration

SDR will have **30** days after receipt of information from provider to make a determination on the amount to be paid by patient

Department of Health and Human Services Surprise Billing Interim Final Rule Part II – page 167- 177

Closing Thoughts..

Operationalizing GFEs – Looking Ahead

1. Monitoring for OON Plans
   - Identify OON and train
   - Develop 100% review of OON claims – denials team
2. Prepare for Provider-Payer Dispute – DEVELOP A STRATEGY
   - Contact payers for notification process
   - Select an IDR
   - Rapid escalation process for disputed payer remittance
3. Strengthen Patient Access
   - Incorporate GFEs into financial clearance functions
   - Educate and train registration staff
   - Consider we will likely be required to provide estimates for all patients
4. Review patient statements against GFEs
   - Ability to automate?
   - Consider self-pay package pricing for commonly scheduled procedures
   - For scheduled self pay office visits create a range of fees to simplify process

Additional Resources

- HFMA No Surprises Act Forum
  - https://community.hfma.org/no-surprises-act-forum/
- AHA Surprise Billing
  - https://www.aha.org/surprise-billing
- CMS No Surprises Act Resources
  - https://www.cms.gov/nosurprises
- Weekly AHA / HFMA Office Hours
  - Every Thursday 3-4pm EST

QUESTIONS?

Thank You!
dclark@bkd.com

Provider/Facility Requirements for Patient-Provider Disputes

1. Copy of the good faith estimate provided to individual for the items or services under dispute
2. Copy of the billed charges provided to the uninsured for items or services in dispute
3. Documentation demonstrating that the difference between GFE and billed charges is the result of medically necessary items or services that could not have been reasonably anticipated when the GFE was provided.

Department of Health and Human Services Surprise Billing Interim Final Rule Part II – page 185

Patient-Provider Dispute Resolution - FYIs

- HHS intends to leverage the Federal IDR Portal for the patient –provider dispute resolution process
- HHS intends to contract with 1 to 3 Selected Dispute Resolution Entities (SDR)
- In the event amount is settled the provider or facility should contact the SDR within 3 business after the date of the agreement
- If any patient payment has been made, may not be used as proof of settlement by provider
- May not move account into collections or threaten to do so once SDR process initiated
- Must suspend the accrual any late fees during SDR process
- Should patient prevail in SDR process any administrative fees will be assessed to facility/provider in final dues owed by patient