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ADVOCATING FOR ALLERGISTS AND THEIR PATIENTS

A Guide to Understanding the No Surprises Act

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This document will be updated as new information is released.

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Notable updates include expanded explanations for Disclosure Requirements and Other Provisions sections. Also, this version incorporates how the result of a legal challenge changes

how the QPA can be used in the IDR process. This 2.1 version adds a link to the NSA Remittance Advice and new FAQs about the GFE and the Federal IDR portal.

I. Introduction

Resources:

- NSA Interim Final Rule I: https://www.federalregister.gov/documents/2021/07/13/2021-14379/requirements-related-to-surprise-billing-part-i
- NSA Interim Final Rule II: https://www.federalregister.gov/documents/2021/10/07/2021-21441/requirements-related-to-surprise-billing-part-ii
- CMS No Surprises Act Website: www.cms.gov/nosurprises
- CMS "High Level" Overview of NSA's Provider Requirements: https://www.cms.gov/files/document/high-level-overview-provider-requirements.pdf
- CMS presentation on balance billing protections: https://www.cms.gov/files/document/a274577-1a-training-1-balancing-billingfinal508.pdf
- CMS presentation on other patient protections: https://www.cms.gov/files/document/a274577-1b-training-2nsa-disclosure-continuity-care-directoriesfinal-508.pdf
- CMS overview of NSA protections for patients: https://www.cms.gov/files/document/nosurpriseactfactsheet-final508.pdf
- CMS FAQ on NSA (4/6/22): https://www.cms.gov/files/document/faq-providers-no-surprises-rules-april-2022.pdf

In December of 2020, Congress passed the No Surprises Act (NSA), which protects patients from unexpected out-of-network (OON) "surprise" medical bills under certain circumstances (legislative text can be found in Title I of Division BB of the Consolidated Appropriations Act of 2021).[1] The NSA also creates a process for resolving reimbursement disputes between the OON provider and the patient's health plan in these scenarios.

The purpose of the NSA is to protect commercially insured patients from high OON bills when they receive OON care at an in-network facility. In these scenarios, patients had reason to believe the care was in-network and had no advanced knowledge or control over the OON care. For example, a patient receiving surgery at an in-network hospital might unknowingly receive care from an OON anesthesiologist. OON emergency care also falls under the NSA's protections because emergency services, by definition, cannot be scheduled in advance and require immediate attention.

Prior to the NSA, the OON provider could "balance bill" the patient for any amount not covered by the patient's health plan. Some states passed laws protecting patients in these scenarios. However, not every state had such laws, and those that did lacked jurisdiction over federally regulated health plans. The NSA is intended to fill in gaps where state laws either do not exist or lack jurisdiction.

In addition to these patient protections, the NSA also requires all healthcare providers to comply with various information disclosure requirements. Some of these requirements are related to federal and state balance billing protections while others are related to price transparency.

[1] https://www.congress.gov/bill/116th-congress/house-bill/133/text

Despite passing the bill in 2020, Congress did not have the NSA take effect until January 1, 2022, to allow federal agencies time to issue regulations that implement the fine details of the statute. The Department of Health and Human Services (HHS), the Department of Labor (DOL) and the Treasury Department (Treasury) jointly issued two interim final rules (IFRs) to implement the NSA.[2]

The Centers for Medicare and Medicaid Services (CMS) Center for Consumer Information and Insurance Oversight (CCIIO) is responsible for implementing many NSA provisions. The Department of Labor (DOL) and the Treasury Department (Treasury) also issued nearly identical regulations for the health plans they regulate. This summary focuses on the CMS regulations.

CMS recently launched a dedicated website for NSA implementation.[3] CMS still needs to provide many important details that providers will need to comply with provisions of the NSA. CMS will most likely use this website to announce these updates.

This guide is intended to summarize the NSA in a concise format. Consult the regulations and official FAQs for a more detailed understanding of each policy.

These regulations took effect on January 1, 2022. However, CMS has delayed enforcement of some provisions, as explained throughout this document.

II. Protecting Patients from "Surprise" Medical Bills

❖ Patient Protections

The NSA protects commercially-insured patients from high OON medical bills in "surprise" situations when the patient receives OON care at an in-network facility or when they receive OON emergency services. The NSA also includes patient protections for OON air ambulance services. The NSA defers to state surprise billing laws. The NSA provides protections for patients in these scenarios where state law either lacks jurisdiction or does not exist.

In scenarios subject to the NSA's protections, patients would be protected in several ways:

1. The patient's in-network cost-sharing would apply to the OON care.
2. Cost-sharing on the OON care would count towards the patient's in-network annual deductible and annual out-of-pocket maximum.
3. Patients cannot be balance billed for any amount beyond this cost-sharing.
4. The patient's cost-sharing amount is not based on the OON provider's billed charge. Instead, their cost-sharing is based on the Qualifying Payment Amount (QPA).

[2] NSA Interim Final Rule I: https://www.federalregister.gov/documents/2021/07/13/2021-14379/requirements-related-to-surprise-billing-part-i
NSA Interim Final Rule II: https://www.federalregister.gov/documents/2021/10/07/2021-21441/requirements-related-to-surprise-billing-part-ii
[3] www.cms.gov/nosurprises

The NSA IFR 1 defines the QPA as the health plan's median in-network rate on January 31, 2019, adjusted for inflation.[4, 5]

Providers or facilities that violate these protections by balance billing a patient for a protected scenario under the NSA can face civil monetary penalties of up to $10,000 per violation. However, a provider or facility who did not knowingly violate the balance billing prohibition can avoid that penalty if they withdraw the bill and reimburse the patient for improperly billed OON charges (with interest) within 30 days of the violation.[6]

❖ Scenarios Subject to NSA Patient Protections

Three factors determine if the NSA's protections apply to a specific scenario:

1. Healthcare Setting: The NSA protections apply to OON non-emergency care at in-network "health care facilities" and emergency care provided by an OON provider or an OON "emergency facility."

   The NSA defines "health care facilities" as a hospital, a hospital outpatient department, an ambulatory surgical center, and a critical access hospital.[7]

   An OON "emergency facility" is statutorily defined as an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship with the patient's health plan. OON emergency care furnished at urgent care centers that are licensed to provide emergency care are also subject to the protections. However, urgent care centers are not included within the definition of "health care facilities" for purposes of non-emergency services.

   The physician office setting is not included in the definition of "healthcare facility" for purposes of the NSA's patient protection or IDR provisions. This means that OON services that occur at the physician office setting are not subject to the NSA's patient protections or IDR process.

   The NSA gives the Administration the authority to add settings to this definition. CMS would need to issue new rulemaking to expand the definition.

   The NSA also includes special requirements for emergency services.

   a. Emergency Services: The NSA protects patients from OON emergency services, as defined by EMTALA,[8] for screening and stabilization. The protections also apply to care furnished after the patient is stabilized.[9]

[4] https://www.federalregister.gov/d/2021-14379/p-164
[5] https://www.federalregister.gov/d/2021-14379/p-965
[6] https://www.federalregister.gov/d/2021-14379/p-316
[7] https://www.federalregister.gov/d/2021-14379/p-110
[8] https://www.federalregister.gov/d/2021-14379/p-82
[9] https://www.federalregister.gov/d/2021-14379/p-94

A patient is considered stabilized once they can be transferred to an in-network facility by non-medical or non-emergency medical transportation.

Once the patient is stabilized, all post-stabilization OON care is protected under the NSA until an OON provider can use the Advanced Notice and Consent process for OON Care (assuming that provider is of a specialty that can use this process).[10]

b. Non-Emergency "Ancillary" Services: The NSA protects patients who receive OON non-emergency at an in-network facility unless the Advanced Notice and Consent process is satisfied.

c. OON Air Ambulance Services: OON air ambulance services are subject to the NSA's patient protections and air ambulance IDR process. The protections do not apply to OON ground ambulance services.

2. State Law: The NSA defers to state laws that reimburse providers for "surprise" scenarios.[11] If no state law exists, or if state law does not have jurisdiction, the NSA patient protections would apply.

There may be differences between the state's law and the NSA. State laws might apply to different healthcare settings or different types of healthcare services. They also might have different methodologies for determining the reimbursement in these scenarios.

3. Patient's Health Plan: Surprise bills have historically been regulated at the state level. Congress saw a need to pass the NSA because not every state passed surprise billing laws and those that did vary in scope. Additionally, even the most robust state law does not have jurisdiction over certain federally regulated health plans such as Employee Retirement Income Security Act (ERISA) and ACA plans.

   The NSA applies to federally regulated health plans (ACA plans, ERISA plans) regardless of any state surprise billing laws. It also applies to scenarios in states where no law for reimbursing providers in "surprise" scenarios exists. The NSA IFR I provides an option for ERISA plans to opt into the state's surprise billing law.

Health plans do not identify if a plan is regulated by ERISA, the ACA, state law, etc. Identifying where the plan is regulated will be a key implementation challenge in scenarios that occur where a state law exists because it will not be clear if state or federal law applies.

❖ Advanced Notice and Consent Process

[10] https://www.federalregister.gov/d/2021-14379/p-99
[11] https://www.federalregister.gov/d/2021-14379/p-130

The NSA allows OON providers to balance bill patients for certain OON care if an Advanced Notice and Consent Process described in the regulation is followed.[12] In short, this process requires the OON provider to give patients at least 72 hours advanced notice of OON care along with a cost estimate for the care and a list of in-network providers, among other things. If the patient acknowledges this notification and agrees to be balance billed for the OON care described in the notice with their signature, then the provider would be able to balance bill the patient for any amount not covered by the patient's health plan. CMS makes available template documents for satisfying the Advanced Notice and Consent Process.[13]

*The NSA statute specifies that the Advanced Notice and Consent Process **cannot** be used for certain medical services.[14]*

Specifically, the Advanced Notice and Consent Process cannot be used for services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; items and services provided by a nonparticipating provider, only if there is no participating provider who can furnish such item or service at such facility; or Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished.

This limitation means these OON services are subject to the NSA's patient protections and IDR process for resolving payment disputes.

III. Independent Dispute Resolution Process to Resolve Payment Disputes between the Patient's Health Plan and the OON Provider

The NSA establishes a federal arbitration process, called Independent Dispute Resolution (IDR) to resolve payment disputes been the patient's health plan and the OON provider in "surprise" scenarios that are subject to the NSA's patient protections. In summary, this is a binding, "baseball-style" arbitration process. Each party will submit an offer and the arbiter must select one of the offers. The arbiter's decision is final. The losing party is responsible for the IDR fees.[15]

HHS, will regularly publish reports of the results of every federal IDR case for surprise medical bills. The goal of these reports is to establish a precedent that will prevent the need for IDR.

[12] https://www.federalregister.gov/d/2021-14379/p-317
[13] https://www.cms.gov/files/document/standard-notice-consent-forms-nonparticipating-providers-emergency-facilities-regarding-consumer.pdf
[14] https://www.federalregister.gov/d/2021-14379/p-367
[15] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Technical-Guidance-CY2022-Fee-Guidance-Federal-Independent-Dispute-Resolution-Process-NSA.pdf

❖ Overview of IDR Process

Resources:
- Regulations for federal IDR process: https://www.ecfr.gov/current/title-26/chapter-I/subchapter-D/part-54/section-54.9816-8T#p-54.9816-8T(a)
- Federal IDR Guidance for Disputing Parties: https://www.cms.gov/files/document/federal-independent-dispute-resolution-guidance-disputing-parties.pdf
- NSA Remittance Advice Remark Codes: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAA-NSA-RARC-Codes.pdf

After a "surprise" OON service occurs, the health plan will make an initial payment or denial to the provider. The provider would then have the ability to trigger the federal IDR process if they disagree with that payment or denial. Before initiating IDR, the NSA requires the health plan and the OON provider to negotiate with each other for a 30-day period, which begins after the health plan makes an initial payment or denial. The regulations outline the process a party must use to notify the other that they are triggering the open negotiation period.[16]

After the 30-day negotiation period, either party has four business days to initiate the IDR process by notifying the other party and the federal government.[17] The health plan and the government must be notified on the same day.

The health plan must include information about the QPA for those services to the provider when making this initial payment or determination.[18] The regulations do not specify how this information must be communicated. Many health plans are communicating this information in the remittance advice.[19] However, in some cases, the patient's EOB is the only place to find this information.

The regulations describe the specific information that must be included in the IDR notification process. The party initiating IDR is required to propose an IDR entity (arbiter). The other party can object or agree to the selected entity. If the party in receipt of the IDR notice objects, that party must propose an alternative IDR entity. The government will select an IDR entity if the two parties cannot agree on an IDR entity. The list of approved IDR entities is available on the CMS NSA website.[20]

[16] https://www.ecfr.gov/current/title-26/chapter-I/subchapter-D/part-54/section-54.9816-8T#p-54.9816-8T(b)(1)(ii)
[17] https://www.ecfr.gov/current/title-26/chapter-I/subchapter-D/part-54/section-54.9816-8T#p-54.9816-8T(b)(2)
[18] https://www.federalregister.gov/d/2021-14379/p-255
[19] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAA-NSA-RARC-Codes.pdf
[20] https://www.cms.gov/nosurprises/Help-resolve-payment-disputes/certified-IDRE-list

The two parties can continue to negotiate outside of IDR after IDR has been initiated. If an agreement is reached outside of IDR, the two parties split the cost for the IDR entity.

After selecting the IDR entity, each party has 10 days to submit an offer for a payment amount and information to the arbiter supporting their preferred payment rate.[21] The arbiter's determination is final.

❖ Cooling-Off Period and Batching Claims

To prevent overutilization of the IDR process, the party that submitted the initial notification cannot take the same opposing party to IDR for the "same or similar item or service" that was the subject of the initial notification for 90 days following the IDR determination.[22] This is referred to as the "cooling-off period."

Once the 90-day cooling-off period expires, a provider can batch all claims from a health plan for the "same or similar items or services" that occurred during the cooling-off period into their next eligible IDR proceeding.[23] The batched items and services will be considered jointly and will receive one IDR decision that would apply to the entire batch.[24] In order for an item or service to be included in a batch, the item or service must meet certain criteria set forth in the regulations.

"Same or similar items or services" for purposes of the cooling-off period and batching is defined as:

"If each is billed under the same service code, or a comparable code under a different procedural code system, such as Current Procedural Terminology (CPT) codes with modifiers, if applicable, Healthcare Common Procedure Coding System (HCPCS) with modifiers, if applicable, or Diagnosis-Related Group (DRG) codes with modifiers, if applicable."[25]

❖ IDR Timeline

1. **Initial payment or denial is made by the health plan.** Health plans have 30 days from when the claim is submitted to issue the initial payment or denial.

[21] https://www.ecfr.gov/current/title-26/chapter-I/subchapter-D/part-54/section-54.9816-8T#p-54.9816-8T(c)(4)(i)
[22] https://www.ecfr.gov/current/title-26/chapter-I/subchapter-D/part-54/section-54.9816-8T#p-54.9816-8T(c)(4)(vii)(B)
[23] https://www.ecfr.gov/current/title-26/chapter-I/subchapter-D/part-54/section-54.9816-8T#p-54.9816-8T(b)(2)(iii)(A)(1)
[24] https://www.ecfr.gov/current/title-26/chapter-I/subchapter-D/part-54/section-54.9816-8T#p-54.9816-8T(c)(3)(i)
[25] https://www.ecfr.gov/current/title-26/chapter-I/subchapter-D/part-54/section-54.9816-8T#p-54.9816-8T(c)(3)(i)(C)

2. **30-day Open Negotiation Period:** If the provider disagrees with the payment/determination, the provider can initiate the 30-day open negotiation period by notifying the health plan.[26]
3. **Initiate IDR:** If the parties cannot reach an agreement in the open negotiation period, the provider has four business days from the conclusion of the open negotiation period to initiate the IDR process by notifying both the health plan and HHS. They would initiate the process by notifying the health plan to a "readily accessible" email contact and would notify HHS using the federal IDR portal.[27] The provider must include additional claims for the "same or similar items or services" that it wants to batch into this payment determination.
4. **Select IDR Entity:** The parties must select an IDR entity within three business days following the date of IDR initiation. The provider initiating IDR will include their preferred IDR entity in the notification they send to the health plan to initiate IDR. The health plan has three days to object to the provider's preferred IDR entity. HHS will select the entity if they cannot agree within that timeframe.[28] The provider initiating IDR must notify HHS when an IDR entity is selected via the HHS IDR portal within one business day after the end of the three-business-day selection period.
5. **Submit Information to the IDR Entity:** After selecting the IDR entity, each party has ten business days to submit their preferred payment rate and all supporting information to the IDR entity.[29] Among other things, the submission must include:
   a. The party's requested payment rate expressed as both a dollar amount and as a percentage of the QPA.
   b. The provider must share information about the size of their practice and specialty. The health plan must also provide information about its market share.
6. **Payment Determination**: After the IDR entity is selected, it has 30 days to issue a payment determination. The IDR entity's determination is binding and cannot be appealed.
7. **Cooling-Off Period**: A party cannot take the other party to IDR for the same or similar item or service for 90-days after a payment determination is made.

The Federal IDR Portal does not exist. CMS says it will be available soon. Once it is posted, providers will have 15 days to submit disputes for which the open negotiation period has expired.[30]

❖ <u>Information Arbiter Can and Cannot Consider</u>

The No Surprises Act defines the factors that the arbiter can and cannot consider in the IDR process.

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[26] https://www.ecfr.gov/current/title-26/chapter-I/subchapter-D/part-54/section-54.9816-8T#p-54.9816-8T(b)(1)(ii)
[27] https://www.ecfr.gov/current/title-26/chapter-I/subchapter-D/part-54/section-54.9816-8T#p-54.9816-8T(b)(2)(iii)(B)
[28] https://www.ecfr.gov/current/title-26/chapter-I/subchapter-D/part-54/section-54.9816-8T#p-54.9816-8T(c)(1)(i)
[29] https://www.ecfr.gov/current/title-26/chapter-I/subchapter-D/part-54/section-54.9816-8T#p-54.9816-8T(c)(4)(i)
[30] https://www.cms.gov/files/document/memorandum-regarding-continuing-surprise-billing-protections-consumers.pdf

The arbiter can consider:[31]

- The QPA (generally defined as the median in-network rate recognized by the plan on January 31, 2019, for the same or similar item or service that is furnished by a provider in the same or similar specialty or facility of the same or similar facility type, and provided in a geographic region in which the item or service is furnished, increased for inflation).
- The level of training, experience, and quality and outcome measurements of the provider or facility.
- Each party's market share.
- The acuity of the patient or the complexity of furnishing such item or service.
- If the OON service occurred at a teaching facility.
- Demonstrations of good faith efforts (or lack thereof) made by each party to reach an agreement on network participation.
- If applicable, historical contracted rates between the two parties during the previous four plan years.

The arbiter is prohibited from considering:[32]

- Usual and customary charges.
- The provider's list price for OON care.
- Public payer rates (Medicare, Medicaid, CHIP, United States Department of Veterans Affairs or TRICARE).

The NSA statute did not describe any factors as having more or less weight than any other. However, the second NSA IFR attempted to implement this section of the statute in a way that gave the QPA added weight compared to the other factors that the arbiter can consider:

"In making a determination of which payment offer to select, these interim final rules specify that the certified IDR entity must begin with the presumption that the QPA is the appropriate out-of-network rate for the qualified IDR item or service under consideration. These interim final rules further provide that the certified IDR entity must select the offer closest to the QPA unless the certified IDR entity determines that credible information submitted by either party clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate."[33]

Some organizations filed lawsuits challenging the Administration's broad interpretation of the NSA statute that gives the QPA added weight relative to other factors.[34]

On February 23, 2022, a District Court in Texas ruled against the Administration's interpretation of the NSA statute on both substantive and procedural grounds.[35] The decision applies immediately and nationally.

[31] https://www.federalregister.gov/d/2021-21441/p-1316
[32] https://www.federalregister.gov/d/2021-21441/p-1335
[33] https://www.federalregister.gov/d/2021-21441/p-54
[34] https://www.ama-assn.org/press-center/press-releases/ama-and-aha-file-lawsuit-over-no-surprises-act-final-rule
[35] https://www.scribd.com/document/560943946/2022-02-23-Memorandum-Opinion-dckt-113-0-1#download

The court ruled that Congressional intent was clearly expressed in the statute that every factor listed in the statute should be considered equally. Judge Jeremy Kernodle wrote, "Nothing in the Act, moreover, instructs arbitrators to weigh any one factor or circumstance more heavily than the others." Judge Kernodle goes on to write "The Rule thus places its thumb on the scale for the QPA, requiring arbitrators to presume the correctness of the QPA and then imposing a heightened burden on the remaining statutory factors to overcome that presumption."

The judge also said the Administration violated the Administrative Procedure Act (APA) by using the wrong regulatory procedure to issue this policy. The Administration issued this policy as an Interim Final Rule. The Court said this type of policy needs to go through the regular rulemaking process which uses a proposed rule with comment period followed by a final rule.

CMS subsequently issued a memo explaining how the legal decision impacts its enforcement of these provisions.[36]

It is important to understand that the No Surprises Act remains in effect. The implementing regulations are unchanged aside from removing language that directs the arbiter to give the QPA added weight compared to other factors.

❖ Complaint Process and Audits

If a provider, air ambulance provider, or health care facility believes a health plan isn't complying with the dispute resolution process, they can file a complaint either online or through the No Surprises Help Desk at 1-800-985-3059 from 8 a.m. to 8 p.m. EST, 7 days a week.[37] Supporting documentation may be required. Providers can submit questions about compliance and enforcement directly to CMS by emailing provider_enforcement@cms.hhs.gov.

CMS will audit a random sample of providers for compliance with the NSA's patient protection requirements.

❖ Disclosure Requirements Regarding Patient Protections Against Balance Billing

Resources:

- CMS presentation on disclosure requirements: https://www.cms.gov/files/document/a274577-1b-training-2nsa-disclosure-continuity-care-directoriesfinal-508.pdf

The NSA requires many healthcare providers and all facilities to comply with public disclosure requirements about federal and state balance billing protections. Importantly, health care

[36] https://www.cms.gov/files/document/memorandum-regarding-continuing-surprise-billing-protections-consumers.pdf
[37] https://www.cms.gov/nosurprises/policies-and-resources/providers-submit-a-billing-complaint

providers are only required to make this disclosures for services furnished at a health care facility, or in connection with visits at health care facilities.[38]

Health care providers subject to this requirement are only required to provide the required disclosure to individuals to whom they furnish items or services. These disclosure requirements are applicable for plan years beginning on or after January 1st, 2022.[39]

Air ambulance services are exempt from this rule but they are encouraged to provide disclosures to their patients if possible.

Specifically, providers and facilities subject to this requirement must provide an online and physical version of a notice about the balance billing requirements and prohibitions that apply to the provider or facility.[40] The physical version of the disclaimer notice must be limited to one page and be provided in-person or through email, at the enrollee's choice. The statute allows for the physical copy of the disclaimer to be double-sided, and the font must be 12-pt. or larger. The online version of the disclaimer must be conveniently posted on a searchable public webpage affiliated with the provider, without a requirement to pay or create an account to view the material.[41]

A provider or healthcare facility subject to this requirement must provide the notice no later than when the provider requests payment from the patient (including an in-office co-pay). If no payment is requested, the notice must be sent to the patient no later than the date a claim is submitted to a health insurer. The interim final rules permit providers to provide patients with the disclosure earlier than when the payment is requested.[42]

This disclosure must include both federal and state protections. If federal law does not apply due to a more stringent existing state law, the provider or facility does not have to include information about the relevant federal protection. [43] It must also describe how to contact the appropriate state and federal agencies if the individual believes the provider or facility has violated the requirements described in the notice.[44]

CMS makes a template available for satisfying this disclosure requirement. However, use of the template is optional.[45]

❖ Other Provisions

Continuity of Care

[38] https://www.federalregister.gov/d/2021-14379/p-403
[39] https://www.federalregister.gov/d/2021-14379/p-378
[40] https://www.federalregister.gov/d/2021-14379/p-392
[41] https://www.federalregister.gov/d/2021-14379/p-396
[42] https://www.federalregister.gov/d/2021-14379/p-399
[43] https://www.federalregister.gov/d/2021-14379/p-382
[44] https://www.federalregister.gov/d/2021-14379/p-383

[45] https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf

The NSA's continuity of care provision protects patients when their provider or health insurer terminates their network agreement during a course of treatment or inpatient stay.

Continuing care patients are defined as individuals who are undergoing treatment for a serious condition that requires specialized medical treatment to avoid death or permanent harm. The term also applies to individuals receiving inpatient care from a provider, a patient who has scheduled non-elective surgery (including post-operative care), a pregnant patient receiving treatment for pregnancy, and those who are terminally ill and receiving treatment.[46]

When a network agreement is terminated, the health plan must notify each individual enrollee who is receiving care of their right to transitional care coverage. The health plan must continue to cover this treatment for up to 90 days after the termination of the agreement between the provider and the health plan, or until the conclusion of treatment. In addition, a health care provider or facility must accept payment from the plan for continued care and must continue to obey policies, procedures, and quality standards as if the termination didn't occur. There are no exemptions to this provision.[47]

These protections apply plan years beginning on or after January 1, 2022.

Directories

The NSA requires health plans to maintain accurate directories of in-network providers and to make those directories accessible to patients.

The NSA's cost-sharing and balance billing protections apply to patients who receive OON care due to an inaccurate network directory. Providers are therefore required to submit information about changes in network participation to health plans in a timely manner so that the health plan can maintain an accurate directory. [48] If a patient accidentally received OON care due to incorrect directory information, providers are responsible for refunding amounts over in-network cost-sharing with interest.[49]

To satisfy this requirement, providers and healthcare facilities must report to health plans the names, addresses, specialty, telephone numbers, and digital contact information of individual providers. This requirement also includes information about the medical group, clinics, and healthcare facilities contracted to participate in the group health plan networks.

[46] https://www.cms.gov/files/document/a274577-1b-training-2nsa-disclosure-continuity-care-directoriesfinal-508.pdf (slide 14)
[47] https://www.cms.gov/files/document/a274577-1b-training-2nsa-disclosure-continuity-care-directoriesfinal-508.pdf (slide 16)
[48] https://www.cms.gov/files/document/a274577-1b-training-2nsa-disclosure-continuity-care-directoriesfinal-508.pdf (slide 25)
[49] https://www.cms.gov/files/document/a274577-1b-training-2nsa-disclosure-continuity-care-directoriesfinal-508.pdf (slide 27)

IV. Good Faith Estimate for Self-pay or Uninsured Patients

Resources:

- IFR Discussion of Good Faith Estimate Requirements: https://www.federalregister.gov/d/2021-21441/p-264
- Regulations for Good Faith Estimate: https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149/subpart-G/section-149.610
- CMS Good Faith Estimate FAQ 1 (12/22/21): https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ.pdf
- CMS Good Faith Estimate FAQ 2 (4/5/22): https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ-Part-2.pdf
- CMS Website on Good Faith Estimate: https://www.cms.gov/nosurprises/consumer-protections/Understanding-costs-in-advance
- Good Faith Estimate Template: https://omb.report/icr/202109-0938-015/doc/115259501
- HHS Guidance on Good Faith Estimate: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Good-Faith-Estimate-Patient-Provider-Dispute-Resolution-Process-for-Uninsured-or-Self-Pay-Individuals.pdf
- CMS Guidance on Good Faith Estimates and the Patient-Provider Dispute Resolution: 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

In addition to the NSA's patient protections, the NSA includes several provisions that require providers and health plans to provide information about surprise billing protections and healthcare prices to patients. These provisions apply broadly across the healthcare system and are not limited to the healthcare settings for which the patient protections apply.

Most notable among these is the requirement to provide uninsured and self-pay patients with a good faith estimate of the cost of the care ***either upon request or when scheduling care***. The good faith estimate is intended to help patients understand their anticipated costs upfront. Patients who have insurance can request an estimate to compare the self-pay price to what they would pay if the bill was submitted to their health plan. There is also a mechanism that patients can use to challenge bills that "substantially exceed" their good faith estimate.

CMS acknowledges that some provisions of the good faith estimate requirement are not operationally feasible to implement in 2022. CMS is using its enforcement authority to delay enforcement of certain parts of the good faith estimate requirement for 2022. However, it is still codifying the full set of requirements for the good faith estimate in this regulation even though some parts of it won't immediately be enforced.

❖ Good Faith Estimate Overview

The Second IFR describes key details for the requirement that healthcare facilities and providers must follow to provide self-pay or uninsured patients with good faith estimates for care *either upon request or upon scheduling care*.[50] This is intended to provide greater price transparency and to allow patients to use this information to compare prices before scheduling care. Providers and facilities are not required to provide good faith estimates for care that cannot be scheduled at least three days in advance, such as urgent and emergency care.

Despite the NSA's patient protections applying to a specific list of healthcare settings, the good faith estimate requirement applies to essentially all healthcare providers and facilities.[51]

Providers must make information about a patient's right to receive a good faith estimate publicly available on their website, in their office, and on-site where scheduling or questions about the cost of items or services occur.

For purposes of the good faith estimate requirement:

- An uninsured individual is one who is not enrolled in a group health plan, or group or individual health insurance coverage, or a Federal health care program (e.g., Medicare, Medicaid), or a Federal Employee Health Benefit (FEHB) program health benefits plan.
- A self-pay individual is one who has benefits under, but is not seeking to have a claim submitted to, a group health plan, individual or group health insurance coverage, or FEHB program health benefits plan for the item or service being scheduled or for which a good faith estimate is requested.

When a patient contacts the provider or facility to make an appointment (or to request a good faith estimate before scheduling care), CMS expects the provider to ask the patient for information about their insurance coverage necessary to determine if the good faith estimate requirement applies.[52]

The NSA also creates a "patient-provider dispute resolution" arbitration process to resolve payment disputes between the patient and the provider if the billed charge is at least $400 more than the price from the good faith estimate.[53] This process is modeled on the NSA's IDR for the patient protections from surprise bills.

Upon request or scheduling a service for an uninsured or self-pay patient, providers or facilities must provide a good faith estimate that includes:

1. Expected costs associated with the care that they are considering or are scheduled to receive, and
2. The expected charges for *connected care* – meaning care by *all providers and facilities* who are "reasonably expected" to furnish the items or services in conjunction with such scheduled or requested item or service.

[50] https://www.federalregister.gov/d/2021-21441/p-264
[51] https://www.federalregister.gov/d/2021-21441/p-278
[52] https://www.federalregister.gov/d/2021-21441/p-44
[53] https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149/subpart-G/section-149.620

CMS acknowledges the complexities for providing a good faith estimate to self-pay patients who do intend to submit the bill to their health plan. CMS is therefore delaying enforcement of certain provisions of the good faith estimate requirement for self-pay patients.

1. *CMS has not yet issued regulations concerning the provision of good faith estimates for patients with insurance who are seeking to have a claim for the scheduled items or services submitted to their health plan.*[54, 55]

   The good faith estimate requirement still applies to uninsured patients and insured patients who do not intend to submit the claim to their health for services that the convening provider reasonably expects to provide to the patient.

2. *The good faith estimate requirement generally does not apply to individuals insured under Medicare, Medicaid, or other federal health care programs.*[56]

Section 2799B-4 of the NSA statute defers to states to enforce compliance with the Good Faith Estimate requirement. However, the statute also reserves the right for HHS to enforce the good faith estimate by imposing civil monetary penalties for non-compliance.

❖ Contents of the Good Faith Estimate

The regulation describes the requirements for the facility or provider who receives the request for a good faith estimate (the "convening" facility or provider[57, 58]) and the "co-facility or co-provider"[59, 60] who provide connected services.

In the second NSA IFR, CMS acknowledges the challenges convening providers and facilities will face trying to collect the information from the co-providers or co-facilities.

Therefore, despite codifying the requirement, CMS will not enforce the good faith estimate requirement for connected care from a co-provider or co-facility until January 1, 2023.[61]

Nothing prohibits the inclusion of connected care in the good faith estimate. Additionally, HHS encourages convening providers and facilities to include a range of expected charges for such items and services during the period of care.

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[54] https://www.federalregister.gov/d/2021-21441/p-47
[55] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ.pdf
[56] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ.pdf
[57] https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149/subpart-G/section-149.610#p-149.610(a)(2)(ii)
[58] https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149/subpart-G/section-149.610#p-149.610(b)
[59] https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149/subpart-G/section-149.610#p-149.610(a)(2)(iii)
[60] https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149/subpart-G/section-149.610#p-149.610(b)(2)
[61] https://www.federalregister.gov/d/2021-21441/p-357

During this period of enforcement discretion, items or services to be provided by a co-provider or co-facility that appear on the good faith estimate that do not include an estimate of expected charges or that appear as a range of expected charges would not be eligible for the patient-provider dispute resolution process.[62]

The good faith estimate must include, among other things:[63]

- A description of the ***primary item or service*** in clear and understandable language (and if applicable, the date the primary item or service is scheduled).
  - An "item or service" is defined as "all encounters, procedures, medical tests, supplies, prescription drugs, durable medical equipment, and fees (including facility fees), provided or assessed in connection with the provision of health care."[64]
  - "Primary item or service" means the item or service to be furnished by the convening provider or convening facility that is the initial reason for the visit. [65]
- An itemized list of items or services, grouped by each provider or facility, reasonably expected to be furnished for the primary item or service, and items or services ***reasonably expected to be furnished in conjunction with the primary item or service***, for that period of care including items and services reasonably expected to be furnished by both the convening and co-provider or facility. This includes any expected discounts or other relevant adjustments that the provider or facility expects to apply to an uninsured (or self-pay) individual's actual billed charges. Providers must provide an estimate even if the estimated charge is $0.
- The applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service.
- Name, National Provider Identifier, and Tax Identification Number of each provider or facility represented in the good faith estimate, and the State(s) and office or facility location(s) where the items or services are expected to be furnished by such provider or facility.
- List of items or services that the convening provider or convening facility anticipates will require separate scheduling and that are expected to occur before or following the expected period of care for the primary item or service.
- Disclaimers that this is only an estimate and that there may be other items or services recommended as part of the course of care that must be scheduled or requested separately and are not reflected in the good faith estimate.

The regulation does not define care "reasonably expected to be furnished in conjunction with the primary item or service." Future regulations could elaborate on this definition. However, the definition of "primary item or service" clarifies services that should be included in the good faith estimate.

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[62] https://www.federalregister.gov/d/2021-21441/p-416
[63] https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149/subpart-G/section-149.610#p-149.610(c)
[64] https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-147/section-147.210#p-147.210(a)(2)(xiii)
[65] https://www.federalregister.gov/d/2021-21441/p-284

Again, CMS is not enforcing the connected care from a co-provider or co-facility piece of the good faith estimate in 2022. Once it does take effect, the convening provider or facility is required to contact all co-providers or co-facilities within one business day to collect information necessary for the good faith estimate. The co-facility or co-provider must respond with the information within one business day of receiving the request.

Convening providers are not considered non-compliant due to errors or omissions when acting in "good faith" and with reasonable due diligence,[66] nor will they be considered non-compliant due to inaccurate or missing information from the co-provider or co-facility if they relied in good faith on the information from the co-provider or co-facility.[67] However, convening providers are required to correct inaccurate information in a timely manner. Services provided before the necessary corrections are made to the good faith estimate could be subject to the patient-provider dispute resolution process.

The good faith estimate must be provided either electronically or in print, depending on the patient's preference. The convening provider or facility must orally inform uninsured (or self-pay) individuals of the availability of a good faith estimate when questions about the cost of items or services occur. All providers and facilities must also make information about an uninsured (or self-pay) patient's ability to request a good faith estimate publicly available in their office, on-site where scheduling or questions about the cost of items or services occur, and on their website. CMS makes model notices available for download.[68]

Additionally, the regulation specifies the timeframes for furnishing the good faith estimate to the patient:

Upon Scheduling Care:

- When a primary item or service is scheduled at least 3 business days before the date the item or service is scheduled to be furnished: Not later than 1 business day after the date of scheduling;
- When a primary item or service is scheduled at least 10 business days before such item or service is scheduled to be furnished: Not later than 3 business days after the date of scheduling; or
- Care scheduled within 3 business days is not subject to the good faith estimate requirement.

Upon Request:

- When a good faith estimate is requested by an uninsured (or self-pay) individual: Not later than 3 business days after the date of the request.

[66] https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149/subpart-G/section-149.610#p-149.610(f)(3)
[67] https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149/subpart-G/section-149.610#p-149.610(f)(4)
[68] https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791

Providers and facilities can communicate the good faith estimate electronically via their patient portal, by email or by other means.[69] Patients must have the ability to save and print their estimate. Providers can communicate the good faith estimate orally, upon request by the patient, but are still required to provide a written version of the estimate.

Convening facilities and providers can provide a single good faith estimate for recurring services for up to 12 months under certain circumstances.[70]

Also, convening facilities and providers must provide uninsured (or self-pay) individuals with updated estimates within one day of any expected changes to the scope of services or changes to the co-provider or co-facility.[71]

A good faith estimate issued under this section is considered part of the patient's medical record and must be maintained in the same manner as a patient's medical record. Convening providers and convening facilities must provide a copy of any previously issued good faith estimate furnished within the last six years to an uninsured (or self-pay) individual upon request.[72]

❖ Patient-Provider Dispute Resolution Process

Resources:

- IFR Discussion of Patient-Provider Dispute Resolution Process: https://www.federalregister.gov/d/2021-21441/p-363
- Regulations for Patient-Provider Dispute Resolution Process: https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149/subpart-G/section-149.620
- CMS FAQ on Patient-Provider Dispute Resolution Process: 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 website for Patient-Provider Dispute Resolution Process: https://www.cms.gov/nosurprises/consumer-protections/Payment-disagreements
- What to Expect When a Patient Starts Payment Dispute Resolution: https://www.cms.gov/nosurprises/providers-payment-resolution-with-patients

➢ Initiating the Patient-Provider Dispute Resolution Process

If the patient's total bill exceeds the good faith estimate by at least $400, the patient can initiate the Patient-Provider Dispute Resolution Process within 120 days of receiving the initial bill. [73]

[69] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ.pdf
[70] https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149/subpart-G/section-149.610#p-149.610(b)(1)(x)
[71] https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149/subpart-G/section-149.610#p-149.610(b)(1)(vii)
[72] https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149/subpart-G/section-149.610#p-149.610(f)(1)
[73] https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149/subpart-G/section-149.620#p-149.620(b)(1)

Uninsured or self-pay patients can initiate this dispute resolution process by notifying HHS via the (yet-to-be-launched) federal IDR portal within 120 calendar days of receiving the initial bill that qualifies for this process. The patient does not notify the provider directly.

After the patient initiates the process, HHS would then select the arbitration entity, referred to in the regulation as a Selected Dispute Resolution (SDR) entity. The SDR entity will verify that the bill is eligible for the dispute resolution process and will notify the provider or facility if the bill proceeds to arbitration under the process.

The provider or facility is prohibited from sending a bill to a collection agency while the patient-provider dispute resolution process is pending. The provider or facility is also required to suspend the accrual of any late fees on the unpaid bill until after the dispute resolution process has concluded.

The patient must pay the administrative fee upfront when initiating this process. The provider or facility will reimburse the patient for the fee in the form of a reduction in the payment amount that is applied by the SDR entity to the final payment determination amount, if the patient prevails against the provider or facility.

- Payment Determination

If the SDR entity determines that the initiation notice is incomplete or the bill is not eligible for the dispute resolution process, the patient has 21 days to provide supplemental information to support their case.

The patient and the provider or facility can continue to negotiate outside of the arbitration process after it is initiated.

The SDR entity's decision is binding and cannot be appealed.

In making a determination, the SDR entity must decide if the provider or facility supplied credible information that the difference between the billed charge and the expected charge for the item or service in the good faith estimate reflects both:

- The costs of a medically necessary item or service, and
- The unexpected charge is based on unforeseen circumstances that could not have reasonably been anticipated by the provider or facility when the good faith estimate was provided.

If the SDR entity finds that the higher bill ***was not justified***, the SDR entity must determine the payment rate be equal to the expected charge for the item or service in the good faith estimate.

If the SDR entity finds that the higher bill ***was justified***, the SDR must select the lesser of the following two payment rates as the amount the patient has to pay:

- The amount billed to the patient; or

- The median payment amount paid by a plan or issuer for the same or similar service, by a same or similar provider in the geographic area where the services were provided.[74] The median payment amount must be reflected in a database of health plan payment rates described in the regulation.[75]

For items and services that did not initially appear on the good faith estimate, the patient would not have to pay anything if the SDR entity finds that the bill was not justified. The methodology described above would apply to determine the payment rate if the SDR entity finds that the bill was, indeed, justified.

❖ Advanced Explanation of Benefits

If a patient who has insurance receives a good faith estimate and intends to submit the bill to their health plan, their health plan is required to provide the patient with an advanced explanation of benefits (AEOB) for the services included in the estimate. The provider or facility is therefore required to send their good faith estimate to the patient's health plan so that the information can be included in the AEOB.

CMS acknowledges the operational challenges providers, facilities and health plans will face in complying with this requirement. CMS will not enforce the AEOB requirements for at least a year.[76] Health plans will not need to send AEOBs to patients, meaning providers also do not need to provide the good faith estimate to the health plan. CMS intends to issue new rulemaking in 2022 that would further explain how to implement the AEOB requirement.

V. Conclusion

Congress passed the NSA to protect patients from unexpected OON medical bills and to empower patients with information about medical bills they may receive in advance of receiving care. The legislation also establishes processes to resolve payment disputes that may arise from these OON scenarios.

CMS and the other agencies responsible for implementing the NSA through regulations acknowledge many operational challenges for the NSA. The agencies have also yet to publish important web tools necessary to comply with the NSA, such as the federal IDR portal. Also, the regulations do not indicate a standardized method that health plans must use to communicate the QPA amount to providers.

[74] https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149/subpart-G/section-149.620#p-149.620(f)(3)(iii)(A)(3)(ii)
[75] https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-149/subpart-B/section-149.140#p-149.140(a)(3)
[76] https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf

Further, we are beginning to see the long-term impacts of the NSA manifest in the form of downward pressure on in-network rates and reducing the leverage of providers in negotiations with health plans.

The good faith estimate represents one of the most significant price transparency requirements that physician offices have faced. Practices will need to implement new administrative processes to comply with this requirement, specifically for scheduling and patient communications.

This document is intended to provide a detailed overview of the NSA to help healthcare providers understand how the NSA impacts their practice. Review the GFE and patient-provider dispute resolution process regulations in detail and CMS's GFE FAQ and patient-provider dispute resolution process FAQ for a more complete understanding of how to comply with the NSA.

This document will be updated as new information about NSA implementation is released.

CMS recently launched a website dedicated to the NSA. This website is the most likely place where CMS will publish NSA implementation updates.