UNDERSTANDING THE NO SURPRISES ACT

WEBINAR FOLLOW-UP

On May 17, 2022, MGMA Government Affairs provided an update on the latest policies surrounding the No Surprises Act and answered questions to help members better understand the requirements. Several provisions of the No Surprises Act were implemented on Jan. 1, 2022, including patient protections against balance billing and other patient price transparency policies, such as good faith estimates for uninsured and self-pay patients. This webinar is now available **on-demand** to MGMA members.

WEBINAR FREQUENTLY ASKED QUESTIONS

Q: Do we have to provide a good faith estimate (GFE) to every uninsured or self-pay patient, or only to those that request a GFE?

A: An uninsured or self-pay GFE must be provided to all eligible patients both upon request and upon the scheduling of services (within the appropriate timeframe). If a patient first requests a GFE and then later schedules care, then the provider must reissue a GFE upon the scheduling of care. (86 Fed. Reg. 56016)

Q: Are providers required to furnish GFEs to insured patients if out-of-pocket expenses are anticipated?

A: There are no current requirements for providers to issue a GFE to insured patients. (Reminder: cost estimates via the notice and consent requirements for out-of-network patients are separate from GFE requirements.) The No Surprises Act did include an advanced explanation of benefits (AEOB) requirement for patients, however, the enforcement of this portion of the law has been delayed. (CMS FAQs About Uninsured or Self-Pay GFEs – Part 1)

Q: If a patient walks in for same day care and requests a GFE, are providers obligated to give them one?

A: There is no existing requirement for a provider to furnish a GFE to an uninsured or self-pay patient for items or services scheduled less than 3-business days in advance. An eligible patient can still request a GFE, however, for purposes of the care delivered on the same day, the provider is not required to provide a GFE. (CMS FAQs About Uninsured or Self-Pay GFEs – Part 2)

Q: What patient protections are in place for out-of-network care furnished at out-of-network facilities?

A: All out-of-network emergency care, regardless of if the facility is in-network or out-of-network, is protected under the No Surprises Act and the prohibition on balance billing applies. However, other non-emergency out-of-network care furnished at an out-of-network facility is not protected under the No Surprises Act. (86 Fed. Reg. 56013)

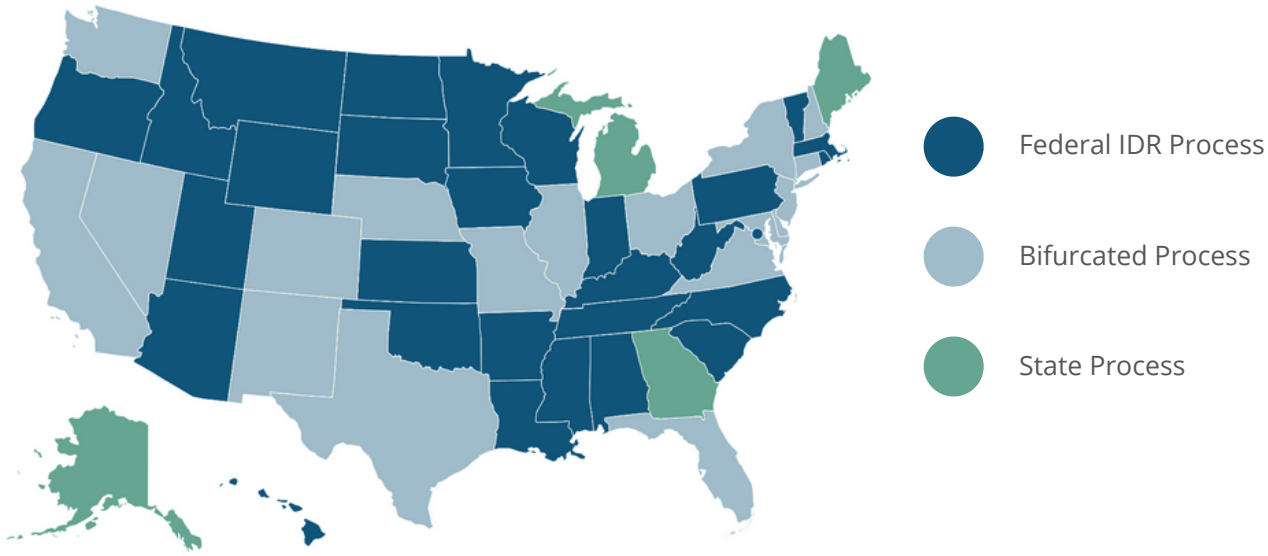
Q: Within our practice, balance billing has always been understood to mean billing the different between the allowable and our charge. If the patient is out-of-network and we are willing to accept the allowable, but the patient would have a higher cost share because we are out-of-network, do the patient protections against balance billing apply even if we do not intend to balance bill under our working definition of 'balance billing'?

A: Assuming the other criteria under the patient protections against balance billing are met (out-of-network provider, in-network facility, notice and consent not received), the federal protections against balance billing would still apply, even if you do not intend to, colloquially, balance bill the patient. The patient protections specifically protect patients from any cost-sharing amount that is higher than it would have been had the services been provided in-network. Under the regulations, patient cost sharing is calculated based on: (1) an amount determined by an applicable state All-Payer Model, (2) an amount determined by a specified state law, or, if neither are applicable, (3) based on the lesser of the billed charge or the plan's median contracted rate. (86 Fed. Reg. 55981)

APPLICABILITY OF FEDERAL IDR PROCESS FOR DISPUTE RESOLUTION

The federal IDR process is used to determine out-of-network payment amounts for services protected under the federal No Surprises Act. However, the federal IDR process is not used when there is either an (1) All-Payer Model Agreement or (2) specified state law that is used to determine both patient cost sharing and the out-of-network amount.

The map below details in which states the federal, state, or a bifurcated process applies for determining the final out-of-network payment amount for covered services. If a state or bifurcated process applies in your state, please consult with the appropriate state authorities to determine the governing process. If a plan or issuer and provider or facility are in different states, the federal IDR process will apply.



Source: The Centers for Medicare and Medicaid Services (CMS). Chart for Determining the Applicability for the Federal Independent Dispute Resolution Process. Accessed May 6, 2022.

CRITERIA USED TO DETERMINE PATIENT-PROVIDER DISPUTE RESOLUTION (PPDR)

An uninsured or self-pay patient is eligible to initiate the patient-provider dispute resolution (PPDR) process if the final billed amount is more than $400 more than the amount listed on the GFE. The dispute resolution entity will evaluate whether credible information was provided that demonstrated the higher billed amount reflected a medically necessary item or service that was based on unforeseen circumstances that could not have reasonably been anticipated by the provider or facility when the GFE was issued.

This chart outlines what the final payment amount could be for care disputed by a patient under the PPDR process.

	Credible Information Provided	Credible Information NOT Provided
Items or Services Included on the GFE	Payment amount = the lesser of : 1. The billed charge or 2. The median payment amount paid by a plan or issuer for the same or similar item or service, or if lower, the GFE amount	Payment amount = amount for services listed on the GFE
Items or Services NOT Included on the GFE	Payment amount = the lesser of: 1. The billed charge or 2. The median payment amount paid by a plan or issuer for the same or similar item or service	Payment amount = $0

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WEBINAR FOLLOW-UP

FEDERAL RESOURCES

- Federal IDR Portal
- CMS No Surprises Act Website
- Department of Labor: No Surprises Act
- No Surprises Act Prohibition of Balance Billing
- FAQs for Providers about the Federal IDR Process
- Guidance for IDR Entities and Overview of Federal IDR Process
- IDR Process Guidance for Disputing Parties
- Provider Good Faith Estimate Guidance
- State vs. Federal Surprise Billing Enforcement
- FAQs: Implementation of Good Faith Estimates
- Continuity of Care, Provider Directory, and Public Disclosure Requirements
- Remittance Advice Remark Codes Related to the No Surprises Act

MGMA MEMBER RESOURCES

- Surprise Billing Landing Page
- Overview of Surprise Billing Requirements
- Surprise Billing FAQs
- Spanish Language GFE resources

MGMA ADVOCACY

- May 18, 2022: MGMA provides recommendations to improve the federal Independent Dispute Resolution (IDR) Portal
- Mar. 7, 2022: MGMA submits comments to CMS to improve the uninsured and self-pay GFE requirements
- Jan. 26, 2022: MGMA urges HHS to delay uninsured or self-pay good faith estimate requirements
- Dec. 6, 2021: MGMA submits comments on Requirements Related to Surprise Billing; Part II
- Nov. 17, 2021: MMA and leading health organizations urge HHS to revise QPA element of IDR process
- Sept. 3, 2021: MGMA comments to HHS on requirements related to surprise medical billing

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