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GUIDE TO UNDERSTANDING THE NO SURPRISES ACT

What Facilities, Providers, and Ancillary Services Should Know About the No Surprises Act and Impacts to Payment

November 16, 2021, | Author: Caroline Znaniec

Effective Jan. 1, 2022, the **No Surprises Act** (NSA) will change how healthcare facilities, physicians, and non-physician providers are reimbursed for out-of-network (OON) services. The NSA was signed into law as part of the Consolidated Appropriations Act of 2021. This rule applies to providers treating or rendering services to patients at a regulated in-network (IN) facility. This is regardless of the provider's office location, mode of delivery (e.g. telehealth) or ownership. Out-of-network bills are most commonly associated with emergency department, anesthesia, pathology, laboratory, and radiology services.

The **government** estimates that 16,992 emergency and other health care facilities will be affected by the NSA, including 6,090 hospitals, 29,227 diagnostic and medical laboratories, 270 independent freestanding emergency departments, 9,280 ambulatory surgical centers, and 1,352 critical access hospitals.[1] It is estimated that, on average, 15% of physicians bill on an out-of-network basis and therefore will be affected. Furthermore, approximately 3,498,942 uninsured individuals will also be impacted.

Prior to the NSA, patients insured through employer-sponsored and commercial health plans were often billed for the difference between the amount charged by the facility and/or provider and the amount allowed by the payer. This practice is commonly referred to as "surprise billing" or "balance billing". The NSA has been developed to provide financial protections to the patient to avoid out of pocket expenses above in-network rates in certain scenarios.

1. Federal Register 86, no. 192 (October 7, 2021). https://www.govinfo.gov/content/pkg/FR-2021-10-07/pdf/FR-2021-10-07.pdf

Who is affected?

Facilities include hospitals, hospital outpatient departments, critical access hospitals, freestanding emergency centers, urgent care centers licensed by the state to provide emergency services, and ambulatory surgery centers. The NSA does not apply to services provided in private physician offices, non-physician centers (e.g. physical therapy), or out-of-network facilities providing non-emergent care when patients are insured.

For uninsured patients, the NSA requirements extend to licensed "healthcare facilities"– adding rural health centers, federal qualified health centers, laboratory and imaging centers, and more.

Providers include those that provide services to facilities providing emergent care, air ambulance services, and in-network facilities where the provider renders service for non-emergent care (e.g. elective surgery). Providers include those specialties that are not identified under ancillary services. This includes surgeons and interventionalists.

Ancillary services include those rendered at a facility providing emergent care, and in-network facilities where services are rendered for non-emergent care. Services include emergency medicine, anesthesiology, laboratory, radiology, pathology, neonatology, assistants in surgery, hospitalist and intensivist services, and other diagnostic services where a patient may encounter these services as a part of their overall visit.

There are two scenarios that most commonly present balance billing concerns addressed by the NSA:

1) Emergency care is provided at an out-of-network facility or from out-of-network providers

2) Non-emergent care is provided by out-of-network providers at an in-network facility

The NSA adds complexities around pricing, cost estimates, payer negotiations and final payment determination. The burden will shift to the facilities, providers, and payers to negotiate payment well before the patient receives their final bill. The law also addresses additional protections for uninsured patients who are seeking care and what steps they can take if the medical bill is substantially higher than estimated in good faith.

Balance billing is prohibited under Medicare and Medicaid, while commercial and employer-sponsored plans currently allow this practice. The NSA will extend protections to patients insured through group health plans and individual health insurance coverage. Group plans include both insured and self-insured plans, private employment-based group health plans subject to Employee Retirement Income Security Act (ERISA), non-federal governmental plans, and church plans and traditional indemnity plans. Included in individual health insurance coverage under the NSA is exchange and non-exchange plans as well as student health insurance coverage. However, when it comes to health reimbursement arrangements, short-term limited-duration insurance or retiree-only plans, the NSA does not apply. Where individual states either do not have balance billing protections, or the state protections are not as extensive as the NSA, the NSA provides patient protections against high cost-sharing obligations. Patients can generally expect to pay what they would for the same service if it were provided by an in-network provider.

Under the NSA, the scenarios for both the patient, facility, and provider will have very different outcomes as it relates to reimbursement from the payer and the amount the patient is obligated to pay for services out-of-pocket. In terms of facility, provider, and ancillary service reimbursement, the law indicates if there is a state-required reimbursement process that applies to applicable items and services, then the state law takes precedence. However, state laws typically only apply to individuals enrolled in health insurance coverage. Federal law generally preempts state laws that regulate self-insured group health plans sponsored by private employers. States also have limited authority to address balance bills that include an out-of-state provider. If there is no applicable state law, the NSA outlines a payment determination process that providers and health plans must follow.

Key NSA provisions

- The elimination of surprise billing for emergency services, regardless of where services are provided, with all services treated as in-network and without a need for prior authorization
- The elimination of high out-of-network cost-sharing for emergency and non-emergency services, not to exceed the rates that would be billed by an in-network provider
- The elimination of out-of-network charges for ancillary care provided (including emergency medicine, anesthesiology, pathology, laboratory, radiology and neonatology) at an in-network facility, including hospitals, independent freestanding emergency centers, ambulatory surgical centers and certain urgent care centers
- The inability to bill out-of-network charges for non-emergency services, at in-network facilities, without advanced notice and consent
- The ability for payers to establish a qualifying payment amount and remit an initial payment
- The ability for facilities and providers to negotiate final payment of out-of-network services with payers, outside of arbitration
- The option of independent dispute resolution (IDR), when negotiations are unsuccessful
- The risk of civil monetary and additional penalties associated with non-compliance

Per the NSA's reimbursement process, a payer reimburses the out-of-network facility, provider, and/or ancillary service an initial payment utilizing an outlined process for payment determination. The NSA does not require a specific pre-determined payment rate. If the initial payment is not accepted, a 30-day negotiation period is opened between the facility/provider and payer. If the open negotiation fails, then either party can access a binding Independent Dispute Resolution (IDR) process, which provides an additional 30 days. The "baseball style" arbitration process utilizes a government-approved entity to choose either the payer's or facility/provider's offered payment rate as a final determination. In selecting the final payment, arbitrators must weigh certain factors and are disallowed from considering the lower payment rates paid by federal government programs such as Medicare or Medicaid. The "loser" pays for the associated fees. If the IDR favors the facility and/or provider, the payer must make the additional payment within 30 days of the final determination. The Centers for Medicare and Medicaid Services (CMS) will be publishing arbitration decisions in a quarterly report that will be available to the public.

The NSA presents new challenges across healthcare stakeholders as facilities, providers, and payers strive to understand the new requirements and work to adjust their systems, workflow processes, and technological capabilities. Stakeholders are seeking clarification and guidance to better understand the impact to payments and requirements specific to their daily operations.

> ***How will I get paid? What about the uninsured patient? How are my operations affected? What can I do now to lessen the impact?***

Below, we detail various scenarios for both out-of-network and uninsured patients under the NSA:

Scenarios and payment for out-of-network patients

How a facility, provider or ancillary service is reimbursed is based on the type of service (emergent vs non-emergent), the in-network status of the facility, the in-network status of the provider, and the services provided by the provider.

Out-of-network payment determination process

The NSA directs payers to determine the out-of-network facility, provider or ancillary payment and the patient's cost-sharing amount based on all-payer models (if applicable), state law or a qualifying payment amount (QPA).

Under the NSA, the total amount to be paid to the facility, provider or ancillary service, including any patient cost sharing, is based on:

- An amount determined by an applicable all-payer model agreement
- If there is no such applicable all-payer model agreement, an amount determined by a specified state law
- If there is no such applicable all-payer model agreement or specified state law, an amount agreed upon by the plan or issuer and the provider or facility
- If none of the three conditions above apply, an amount determined by an independent dispute resolution (IDR) entity

Emergent services

Protections under the NSA are afforded to patients that receive emergent care, regardless of the in-network status of the facility. Facilities and providers in-network are paid based on the contracted rates with the payer. Out-of-network payment is determined through the payer payment determination process and provided as an initial payment. The facility, provider, and ancillary service can either accept the initial payment amount or open negotiations with the payer after the receipt of the initial payment (when an all-payer model is not in place), and if necessary, ultimately request review through the IDR process.

Non-emergent services

When non-emergent services are rendered they are most often elective and scheduled. The patient protections under the NSA are for those services to be rendered at an in-network facility. The most common scenario is when a patient has surgery at a facility, such as a hospital or ambulatory surgery center, to be performed by a pre-identified surgeon. In this scenario, it is not likely that the surgeon would be out-of-network. Both the facility and the provider would be paid their contracted rate with the payer. In the case that the provider is out-of-network, the provider can provide notice and consent to the patient regarding their out-of-network status and the provider's ability to balance bill the patient after payment is made by the payer. The patient may provide consent and allow for the balance billing to occur, or refuse consent and the provider's ability to balance bill. If the patient refuses, the provider can decide whether to perform the surgery or not. If the provider does not obtain consent, the provider will receive an initial payment from the payer based on the payer payment determination process. The provider may proceed through negotiations with the payer and follow the IDR process, if needed (when a state all-payer model is not in place).

Payment under the NSA

Type of Service	Faculty	Provider	Ancillary	NSA Faculty Reimbursement	NSA Provider Reimbursement	NSA Ancillary Reimbursement	NSA Required Notice and Consent for Balance Billing OON
Emergency	IN	IN	IN	Contracted Rate(s)	Contracted Rate(s)	Contracted Rate(s)	Not Applicable
Emergency	IN	IN	OON	Contracted Rate(s)	Contracted Rate(s)	QPA	Not Applicable
Emergency	IN	OON	IN	Contracted Rate(s)	QPA	Contracted Rate(s)	Not Applicable
Emergency	IN	OON	OON	Contracted Rate(s)	QPA	QPA	Not Applicable
Emergency	OON	IN	IN	QPA	Contracted Rate(s)	Contracted Rate(s)	Not Applicable
Emergency	OON	IN	OON	QPA	Contracted Rate(s)	QPA	Not Applicable
Emergency	OON	OON	IN	QPA	QPA	Contracted Rate(s)	Not Applicable
Emergency	OON	OON	OON	QPA	QPA	QPA	Not Applicable
Non-Emergency	IN	IN	IN	Contracted Rate(s)	Contracted Rate(s)	Contracted Rate(s)	Not Applicable
Non-Emergency	IN	IN	OON	Contracted Rate(s)	Contracted Rate(s)	QPA	Not Applicable
Non-Emergency	IN	OON	IN	Contracted Rate(s)	QPA/NC	Contracted Rate(s)	Applicable for OON provider services (not ancillary)
Non-Emergency	IN	OON	OON	Contracted Rate(s)	QPA/NC	QPA	Applicable for OON provider services (not ancillary)

Key: **IN:** in-network
OON: out-of-network
QPA: qualifying payment amount
OPA/NC: qualifying payment amount, or notice and consent – allowing balance billing

Ancillary services

While rendering emergent or non-emergent care, ancillary services are often involved. When they are, patients do not have the opportunity to know if the service or provider is in-network. For example, a patient undergoing a biopsy procedure at an in-network facility by an in-network surgeon would not be aware if the pathologist examining the biopsied tissue is in-network. Furthermore, the pathologist does not have the ability to know ahead of the procedure whose tissue they may be requested to examine, including patients that are out-of-network. Due to this scenario, the ability to provide notice and consent for balance billing is not realistic, expected or permitted under the NSA. The ancillary service and provider are paid for out-of-network services based on the payer payment determination process. The ancillary service or provider may proceed through negotiations with the payer and follow the IDR process, as needed (when a state all-payer model is not in place).

Steps for opening negotiations with payers

- The facility, provider or ancillary service initiates open negotiation period through an open negotiation notice, within 30-business-days of receipt of initial payment.
- The notice must be sent electronically.
- The notice includes date(s) of service, service codes, initial payment amount, offer for the out-of-network rate, and contact information of the party sending the notice.
- The open negotiation period is open for 30-business-days, beginning with the date the notice is sent.
- If negotiations are not successful, the facility, provider or ancillary service may initiate the idr process, after the exhaustion of the open negotiation period.

Steps involved in the facility/ provider-payer IDR process

- Facility, provider, ancillary service or payer may initiate the IDR process.
- The IDR process can be initiated during the four business-day period beginning on the 31st business day after the start of the open negotiation period.
- The initiating party provides notice to the other party through the federal IDR portal.
- The notice of IDR includes dates and locations of items and services, the type of qualified services (e.g. emergency, professional), service and place-of-service codes, the amount of initial payment and patient cost-sharing, contact information of parties, dates of the open negotiation period, preference of IDR entitiy, attestation that the items or services are qualified for IDR, the qualifying payment amount and detail of methodology used, and general information to assist in IDR process and review.
- The date the electronic IDR notice is received by the governmental departments in the portal will start the 30-business-day IDR review period.
- An IDR entity is selected by the governmental departments within six business-days of the initiation, if an IDR entity is not jointly selected within three business-days of initiation.
- The IDR entity confirms that the request is appropriate.
- Each party provides their offer for a payment amount to the IDR entity ten business-days after the selection of the IDR entity. Parties can provide additional information to support their offer including patient acuity, quality outcomes, complexity of service and the like.
- The IDR entity selects a party offer and provides notice of decision 30 business-days after the selection of the IDR entity. The losing party pays the IDR fees.
- When the payer is the losing party, the payer must remit the payment variance to the initial payment within 30 calendar-days after the IDR decision.
- When the facility, provider or ancillary service is the losing party, and the final offer is less than the initial payment, the party must remit payment back to the payer within 30 calendar-days after the IDR decision.

Steps involved in the patient-provider/facility SDR process

- The patient initiates the dispute resolution process by submitting an electronic or written initiation notice to HHS.
- The initiation must be either transmitted or postmarked within 120 calendar-days of receiving the initial bill for items and services.
- The notice must include date of service, description of item or service, a copy of the bill for items and services in dispute, a copy of the good faith estimate, contact information of involved parties, the state where items and services were rendered, and payment of an administrative fee.
- The initiation date is based on the submission or receipt of the notice. Once a dispute has been initiated, the facility and provider may not move the unpaid bill amounts to collection or accrue late charges.
- HHS will select the SDR entity and the entity will provide guidance on next steps in the process to all parties. This includes notification and allowances for parties to submit additional information and anticipated timelines.

Scenarios and payment for uninsured patients

For patients that do not have health benefits under group or individual health plans, protections under the NSA are provided. Facilities and providers are required to provide a good faith estimate for scheduled or requested items, services, and procedures. The good faith estimate must include information regarding the diagnosis and procedure codes, a description of items and services, provider identification (e.g. NPI), location of service, the cash-pay charges for items and services that are reasonably expected, and disclaimers regarding the estimation provided. Items and services include all items, services and procedures); this can include supplies, drugs, durable medical equipment and facility fees. Charges can include those by convening facilities and providers, but at a minimum the scheduling facility or provider must provide notice to the uninsured

of the good faith estimate requirements at the time of scheduling amongst convening facilities and providers. It is not an expectation that a facility or provider would have knowledge of the other party's services and charges. Further protections are provided to the uninsured by way of patient-provider dispute resolution process. An uninsured patient can seek a determination from a State Dispute Resolution (SDR) entity if the total billed charge from the facility or provider is in substantial excess (>$400) of the good faith estimate.

Preparation for NSA – effective January 1, 2022

Compliance under the NSA will require significant changes to the revenue cycle operations of healthcare facilities, providers, and ancillary services. Facilities, providers and ancillary services can best prepare for payment implications under the NSA in doing the following:

- Understand how the state laws interact with the NSA
- Identify out-of-network payers and historical volumes to understand financial impact
- Open communications with payers to ensure compliance in the delivery of notice and consent, as well as the determination of initial payment and steps for negotiation
- Negotiate rates with payers ahead of the Jan. 1, 2022 effective date
- Develop disclosure notices and forms to NSA specifications, in absence of model forms
- Determine the minimum accepted payment for services and procedures from payers, as well as cash-pay pricing
- Develop a means to monitor out-of-network initial payments
- Outline internal processes for opening negotiations with patients and payers
- Develop a checklist in preparation for what materials may be required for the open negotiation and/or IDR and SDR processes
- Explore technological capabilities that can aid in cost estimates, identify and manage out-of-network, and uninsured patient encounters
- Educate staff regarding new requirements under the NSA and related changes to workflow
- Develop an internal audit process to monitor compliance with the NSA to prepare for federal audits and mitigate risks associated with monetary penalties (up to $10,000 per encounter)
- Create a strategy around patient education supporting the objectives of price transparency

How CohnReznick can help

CohnReznick is prepared to support healthcare facilities, providers, and ancillary services as they not only work toward NSA compliance but also look to align their pricing, payer, and operational strategies to meet revenue goals and provide for a positive patient experience.

Who will they contact for help?

Caroline Znaniec
Managing Director, Healthcare
410.463.9867
caroline.znaniec@cohnreznick.com

> ***Please note that this guide provides the general requirements under the No Surprises Act. There are more specific steps and guidance to meeting the general requirements.***

References

Requirements Related to Surprise Billing; Part I (July 13, 2021)

https://www.federalregister.gov/documents/2021/07/13/2021-14379/requirements-related-to-surprise-billing-part-i

Requirements Related to Surprise Billing; Part II (October 7, 2021)

https://www.federalregister.gov/documents/2021/10/07/2021-21441/requirements-related-to-surprise-billing-part-ii

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