GAPB

GROUND AMBULANCE AND PATIENT BILLING ADVISORY COMMITTEE

Ground Ambulance & Patient Billing Advisory Committee

Overview of the No Surprises Act

CMS

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No Surprises Act – The Need

- **Surprise medical bills** occur when patients get out-of network emergency care or unknowingly get care from out-of-network providers at in-network facilities.

- In 2016, **42.8%** of emergency department visits to in-network hospitals resulted in an out-of-network bill, and the average bill amount was **$628**.

- **Some states have enacted laws** to reduce or eliminate balance billing, creating a patchwork of consumer protections and leaving many of those in self-insured group health plans sponsored by private employers without protections.

No Surprises Act – The Response

- **Surprise medical bills**
  - Consumer protections against surprise medical bills
  - Method for determining the appropriate out-of-network payment amount for applicable items and services – independent dispute resolution (IDR)
  - Interaction between state surprise medical billing laws and the No Surprises Act
- **New transparency policies**
- **Ground Ambulance Patient Billing Advisory Committee**

Scope of Individuals Protected Under the NSA

No Surprises Act requirements for providers, facilities, and providers of air ambulance services apply to items and services provided to most individuals enrolled in what is usually referred to as **private or commercial health coverage**, such as:

- Employment-based group health plans (both self-insured and fully insured)
- Individual or small group health coverage on or outside the federal or state-based exchanges
- Federal Employees Health Benefits (FEHB) health plans
- Non-federal governmental plans sponsored by state and local government employers
- Church plans
- Student health insurance coverage [as defined at 45 CFR 147.145]

Overview of the NSA's prohibitions on balance billing

The NSA requires health plans and issuers to apply in-network cost-sharing terms (if more generous than what would be applied otherwise) and prohibits out-of-network (OON) providers, facilities, or providers of air ambulance services from billing individuals more than these in-network cost-sharing limits in three major scenarios:

1. A person receives covered emergency services from an OON provider or OON emergency facility;
2. A person receives covered non-emergency services from an OON provider delivered as part of a visit to an in-network health care facility; or
3. A person receives covered air ambulance services provided by an OON provider of air ambulance services.

In limited situations, the NSA allows some OON providers and facilities to seek written consent from individuals to voluntarily waive their protection against balance billing for post-stabilization services or non-ancillary non-emergency services.

Independent Dispute Resolution (IDR)

- In situations covered by the NSA, patients will be required to pay only the in-network cost-sharing amount for these services.
- Health plans, issuers, and FEHB Carriers must pay the OON provider, facility, or provider of air ambulance services an amount in accordance with a state All-Payer Model Agreement or specified state law, if applicable. In the absence of an All- Payer Model Agreement or specified state law, the plan must make an initial payment or denial of payment within 30 calendar days.

IDR (Continued)

TIMELINE	SUMMARY OF STEPS
Start	A furnished covered item or service results in a charge for emergency items or services from an OON provider or facility, for non-emergency items or services from an OON provider with respect to a patient visit to certain types of in-network facilities, or for air ambulance services from an OON provider of air ambulance services.
Within 30 calendar days	**Initial Payment or Notice of Denial of Payment** Must be sent by the plan, issuer, or carrier no later than ***30 calendar days*** after a clean claim is received.
30 business days	**Initiation of Open Negotiation Period** An open negotiation period must be initiated within ***30 business days*** beginning on the day the OON provider receives either an initial payment or a notice of denial of payment for the item or service from the plan, issuer, or carrier.
	Open Negotiation Period Parties must exhaust a *30-business-day* open negotiation period before either party may initiate the Federal IDR Process.

How the QPA is Defined and Calculated

- The QPA is generally the ***median of the contracted rates recognized by the plan*** as of January 31, 2019, for the same or similar item or service under the plan or coverage that is provided by a provider in the same or similar specialty or facility of the same or similar facility type and provided in the same insurance market in the geographic region in which the item or service under dispute was furnished on January 31, 2019, increased by inflation.

IDR (Continued)

TIMELINE	SUMMARY OF STEPS
4 business days	**Federal IDR Initiation** Either party can initiate the Federal IDR Process by submitting a Notice of IDR Initiation to the other party and to the Departments within ***4 business days*** after the close of the open negotiation period. The notice must include the initiating party's preferred certified IDR entity.
3-6 business days after initiation	**Selection of Certified IDR Entity** The non-initiating party can accept the initiating party's preferred certified IDR entity or object and propose another certified IDR entity. A lack of response from the non-initiating party **within 3 business days** will be deemed to be acceptance of the initiating party's preferred certified IDR entity. If the parties do not agree on a certified IDR entity, the Departments will randomly select a certified IDR entity on the parties' behalf.
3 business days after contingent selection	**Certified IDR Entity Requirements** Once contingently selected, within ***3 business days***, the certified IDR entity must submit an attestation that it does not have a conflict of interest and determine whether the Federal IDR Process is applicable, thereby finalizing the selection.

IDR (Continued)

TIMELINE	SUMMARY OF STEPS
10 business days after finalization of selection	**Submission of Offers and Payment of Certified IDR Entity Fee** Parties must submit their offers not later than ***10 business days*** after finalization of selection of the certified IDR entity. Each party must pay the certified IDR entity fee(which the certified IDR entity will hold in a trust or an escrow account), and the administrative fee when submitting its offer (unless the administrative fee has already been paid). If the certified IDR entity fee and administrative fee are not collected from a party, the certified IDR entity will not accept the non-paying party's offer.
30 business days after finalization of selection	**Selection of Offer** A certified IDR entity has ***30 business days*** from the date of finalization of its selection to determine the payment amount and notify the parties and the Departments of its decision. The certified IDR entity must select one of the offers submitted.
30 calendar /business days after determination	**Payments Between Parties of Determination Amount & Refund of Certified IDR Entity Fee** Any amount due from one party to the other party must be paid not later than ***30 calendar days*** after the determination by the certified IDR entity. The certified IDR entity must refund the prevailing party's certified IDR entity fee within ***30 business days*** after the determination.

State Laws vs. Federal IDR Process

- Some state laws provide a method for determining the total amount payable by a plan for an item or service furnished by an OON provider, facility, or a provider of air ambulance services to a participant, beneficiary, or enrollee, in circumstances covered by the NSA, which are referred to as “specified state laws.”
- The NSA recognizes that All-Payer Model Agreements under Section 1115A of the Social Security Act may provide state-approved amounts for OON items and services as well.
- Where an All-Payer Model Agreement or specified state law provides a method for determining the total amount payable for OON items and services, the state process will govern, rather than the Federal method for determining the OON rate under the NSA. Accordingly, the Federal IDR Process is not available to disputing parties in those circumstances.

To learn more about what items and services fall under the Federal IDR Process for each state see: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAA.

Transparency: AEOB & GFE

- **Good Faith Estimates for Uninsured (and self pay)**
- **Advanced Explanation of Benefits**
  - require group health plans and health insurance issuers offering group or individual health insurance coverage, upon receiving a GFE regarding an item or service as described in PHS Act section 2799B-6, to send a covered individual an advanced explanation of benefits (AEOB). These provisions apply with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2022.
  - HHS deferred enforcement of the portion of PHS Act section 2799B-6 related to GFEs for covered individuals who are seeking to have a claim submitted to their plan or issuer for scheduled items or services.
  - The Departments also deferred enforcement of Code section 9816(f), ERISA section 716(f), and PHS Act section 2799A-1(f) related to the requirement that plans and issuers provide an AEOB.

Good Faith Estimates for Uninsured (or Self-Pay) Individuals

- The **good faith estimate** (or GFE) is a notification that outlines an uninsured (or self-pay) individual's expected charges for a scheduled or requested item or service.
- Providers and facilities must give this estimate to an uninsured (or self-pay) individual (or their **authorized representative**) who requests it or who schedules an item or service.
- The good faith estimate will also include items or services reasonably expected to be provided along with the **primary item(s) or service(s),** even if the individual will receive the items and services from another provider or another facility.
- These requirements are applicable for good faith estimates requested on or after January 1, 2022 or for good faith estimates required to be provided in connection with items or services scheduled on or after January 1, 2022.

Scope of care included in good faith estimates

Under the NSA, uninsured (or self-pay) individuals should receive a single, comprehensive **good faith estimate** that includes expected charges for:

- The **primary item or service** that will be furnished by the convening provider or convening facility and that is the initial reason for the visit.
- All items and services that are reasonably expected to be provided in conjunction with the primary item or service, provided during a defined **period of care**.

These **items or services** can include any of the following:

- Encounters;
- Procedures;
- Medical tests;
- Supplies;
- Prescriptions drugs;
- Durable medical equipment; or
- Fees (including facility fees).

Providers that must comply with GFE requirements

For the purposes of the good faith estimate, a **health care provider** means a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law, including a provider of air ambulance services.

The following types of health care providers must comply with the NSA's good faith estimate and PPDR requirements:

- Physicians;
- Other health care providers who are acting within their scope of practice under applicable State law;
- Providers of air ambulance services.

Facilities that must comply with GFE requirements

All health care institutions licensed under applicable state or local law are treated as **health care facilities** that must comply with the NSA's good faith estimate and PPDR requirements including, for example:

- Hospitals;
- Hospital outpatient departments;
- Critical access hospitals;
- Ambulatory surgical centers;
- Rural health centers;
- Federally qualified health centers;
- Laboratory centers; and
- Imaging centers.

Timeframes for contacting co-providers

Upon receiving a request for a good faith estimate from an uninsured (or self-pay) individual or **upon scheduling a primary item or service** for an uninsured (or self-pay) individual, the convening provider or convening facility must contact all co-providers and co-facilities who are reasonably expected to provide items or services in conjunction with, and in support of, the primary item or service no later than 1 business day after scheduling or receiving the request. The convening provider or convening facility must request that the co-providers or co-facilities submit good faith estimate information to the convening provider or facility.

Requirements for co-providers and co-facilities

Co-providers and **co-facilities** must submit good faith estimate information upon the request of the convening provider or convening facility. The co-provider or co-facility must provide, and the convening provider or convening facility must receive, the good faith estimate information no later than 1 business day after the co-provider or co-facility receives the request from the convening provider or convening facility.

Co-providers and co-facilities must notify and provide new good faith estimate information to a convening provider or convening facility if the co-provider or co-facility anticipates any changes to the scope of good faith estimate information previously submitted to a convening provider or convening facility (such as anticipated changes to the expected charges, items, services, frequency, recurrences, duration, providers, or facilities).

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Claims data from large employers in 2018 suggests that about **half** of all emergency ground ambulance transports are likely to be out-of-network. This increases the risk of patients getting a surprise medical bill.

This frequency of out-of-network transports put as many as **1.5 million privately insured patient** who are brought to an emergency room by an ambulance at risk of getting a surprise medical bill each year.

One study found that the median potential surprise medical bill for ground ambulance transports was **$450**.

To address these issues, ten states have adopted some kind of ground ambulance protection for consumers.

No Surprises Help Desk

The No Surprises Help Desk is available from 8 am to 8 pm EST, 7 days a week. Questions or complaints can be submitted by calling **1-800-985-3059.** Consumers and providers can also submit a complaint online.

- Consumer Web Form
  - https://nsa-idr.cms.gov/consumercomplaints/s/?language=en_US
- Provider Web Form
  - https://nsa-idr.cms.gov/providercomplaints/s/
- For helpful tips on how to complete the complaint form, please visit:
  - https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing
- Most recent information on provider FAQs, good faith estimate FAQs and IDR updates can be found here: No Surprises Act | CMS and relevant updates here: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAA