FEATURE

# No Surprises Act

## Assess your organization's strategy and compliance

By Jessika Garis, CHC, and Michael Haas, MBA

*For years, patients have voiced their concerns about surprise bills and the rising costs of healthcare. In late 2020 the No Surprises Act (NSA), a consumer protection law that helps curb the practice known as surprise billing for medical care, was passed. The law was welcomed as an answer to the concerns regarding unexpected bills with large out-of-pocket balances, although it poses significant compliance challenges for healthcare providers to address.*

The excessive amount of debt and pressure placed on the U.S. population fortifies the need for healthcare cost reform and why the NSA legislation was passed. According to the Kaiser Family Foundation (KFF), more than one in 10 adults owe medical debt, with millions owing more than $10,000 each. In addition, one in three insured adults have received an unexpected medical bill when receiving care from out-of-network providers and one in six received a surprise medical bill in other scenarios.

The law bans surprise billing for emergency services and ancillary care at in-network facilities. Also, the law limits out-of-network (OON) cost sharing for emergency and non-emergency services to the amount for the services provided in-network.

In your role as your organization's internal auditor, you need to understand the effect of the new law and what your provider organization must do to address the law's requirements.

### The Rules

On July 1, 2021, the first interim rule for the No Surprises Act was issued. Per the Health and Human Services Department, the first interim rule restricts surprise billing for patients in job-based and individual health plans. Services covered include emergency care, non-emergency care from OON providers at in-network facilities, and air ambulance services from OON providers.

On September 30, 2021, a second interim final rule was issued and provides additional protections against surprise medical bills that include:

- Establishing an independent dispute resolution process to resolve any OON payment disagreements between providers (including air ambulance providers) or facilities and health plans
- Requiring good faith estimates of medical items or services for uninsured (self-paying) individuals
- Establishing a patient-provider dispute resolution process for uninsured (self-paying) individuals to determine payment amounts due to a provider or facility under certain circumstances
- Providing a way to appeal certain health plan decisions

On November 17, 2021, a third interim final rule was issued to implement new requirements for group health plans and insurers related to the submission of certain information about prescription drug and healthcare spending.

On January 1, 2022, enforcement of the NSA went into effect, restricting providers and other organizations from balance billing patients for OON services. Exhibit 1 is an overview of the services that have been changed by the No Surprises Act.

### Enforcement

Violations for noncompliance with the NSA may result in fines and penalties of up to $10,000 per violation.

***Patients cannot be billed more than the in-network cost-sharing amount for surprise bills.***


### Exhibit 1 – NSA services affected

| Service | No Surprises Act |
|---|---|
| Emergency | Prohibits balance billing in OON emergency situations, including post-stabilization (unless notice/consent is given) |
| Non-emergency | Prohibits balance billing in non-emergency situations at in-network facilities with OON providers (unless notice/consent is given) |
| Ambulance | Prohibits balance billing with emergency air ambulance services, but not ground ambulances |

Enforcement is underway by CMS and state agencies to regulate balance billing. Healthcare organizations must determine how to manage the new regulations and what practices must be implemented to determine how patient bills will be processed in accordance with the NSA.

In addition, the Office of Inspector General (OIG) has begun conducting audits to determine how bills were calculated for OON patients who were admitted for Covid-19 treatment. The OIG will review supporting documentation for compliance and assess procedural controls and monitoring to ensure compliance with the balance billing requirement.

Healthcare organizations who have received Provider Relief Fund (PRF) payments and attested to the associated terms and conditions will be subject to an audit from the OIG. The OIG has stated that these organizations are limited in pursuing collections of out-of-pocket payments from Covid-19 patients. Patients may not be required to pay more than what they otherwise would have been required to pay if the care had been provided by in-network providers.

### Reference information

- No Surprises Act Implementation: What to Expect in 2022 (https://www.kff.org/health-reform/issue-brief/no-surprises-act-implementation-what-to-expect-in-2022/)
- Ending Surprise Medical Bills (https://www.cms.gov/nosurprises)
- The No Surprises Act: A Final Checklist for 2022 (https://www.natlawreview.com/article/no-surprises-act-final-checklist-2022)
- The No Surprises Act's Prohibitions on Balancing Billing (https://www.cms.gov/files/document/a274577-1a-training-1-balancing-billingfinal508.pdf)

### OON billing

Some healthcare organizations have abandoned billing for OON rates completely. But others are choosing to implement new protocols to obtain a patient's consent to balance bill them for OON charges in compliance with the NSA. Updated protocols should include, but are not limited to:

1. Publicly post a one-page notice to consumers on patient rights regarding balance billing, including how to report violations. Organizations should post the notice prominently at their facilities and on their public websites and provide the notice directly to patients.

***Balance billing patients for out-of-network services was restricted as of January 1, 2022.***

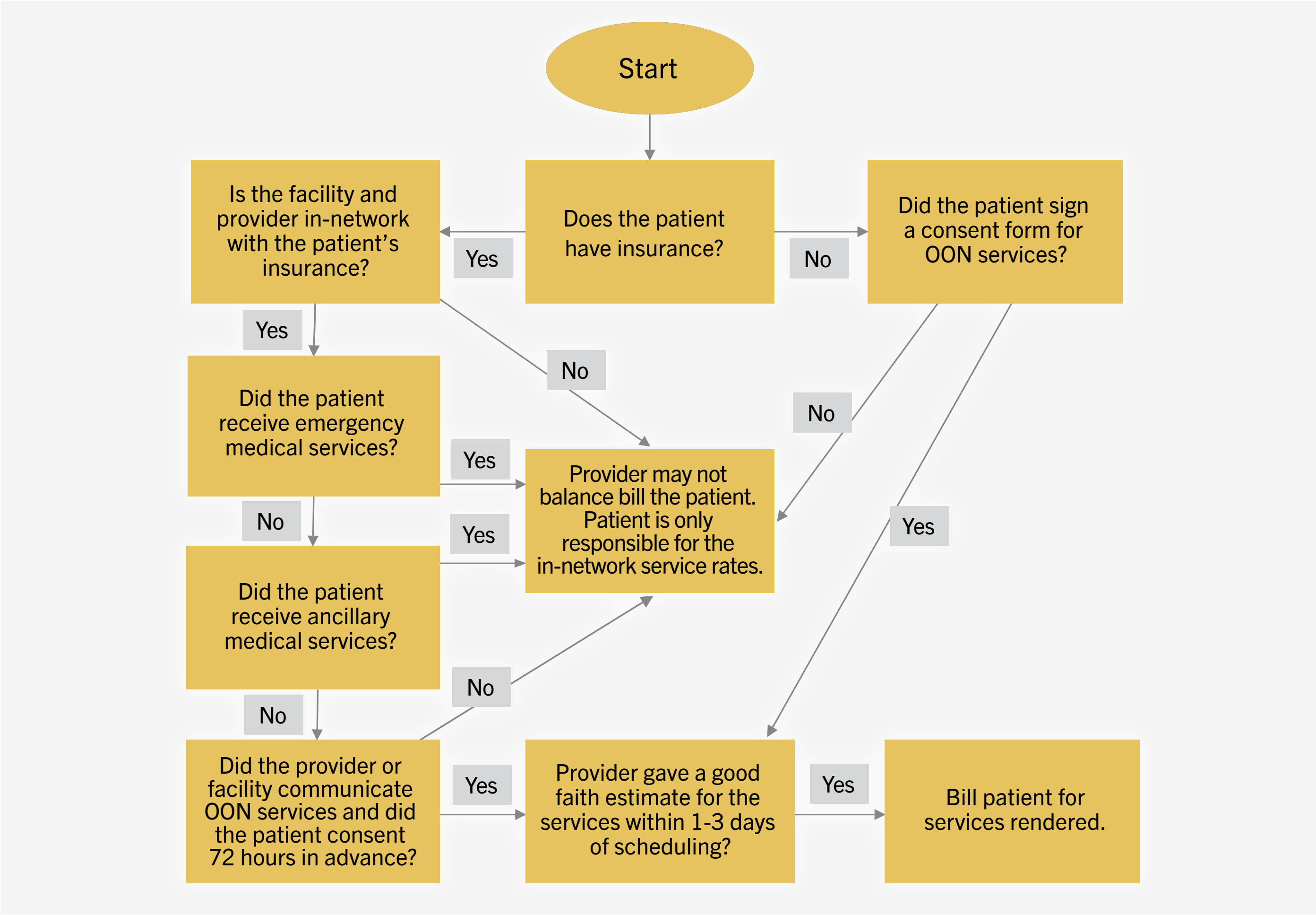
2. Validate patients' insurance, provide notice and obtain consent for services considered OON at least 72 hours prior to a scheduled appointment.
3. Confirm at registration if the organization is in-network with the patient's insurance, or recommend care elsewhere.
4. Notify self-pay/uninsured patients verbally and in writing of their right to receive a good faith estimate.
5. Provide a good faith estimate for expected charges related to self-pay patients (including uninsured patients and patients who choose to forgo using their insurance) within one to three business days depending on when the services are scheduled.
6. Implement an independent dispute resolution (a critical component to negotiating reimbursements for OON rates).

Additional strategies to consider when implementing the above protocols include, but are not limited to:

- Ensure adequacy of network information, including making up-to-date and transparent provider directories available.
- Implement insurer transparency to allow patients to choose OON care in advance.
- Reduce the OON gap by setting up more external providers in-network with more payers. The strategy may seem challenging for your provider organization, but with the NSA, getting other providers in-network and collecting some amount of payment is a better option than keeping them OON and writing off the balance.
- Keep patients out of billing disputes to secure patient satisfaction.

Exhibit 2 illustrates how patient financial responsibility is determined for provided services.

### Exhibit 2 – Decision tree for patient responsibility



## *Confirm at registration that your organization is in-network for the patient's insurance or recommend care elsewhere.*

### Your role

As your organization decides how to address OON balances and the other requirements related to the NSA, you need to have a seat at the leadership table to help navigate risk implications.

You can perform the following services:

1. Assess your organization's billing practice by collaborating with stakeholders within key areas such as revenue cycle, legal, compliance and patient experience.
2. Review the patient billing policy.
3. Identify and assess existing internal controls to ensure billing for emergency services or non-emergency services provided by OON providers is accurate and appropriately limited to in-network cost-sharing amounts.
4. Review the content and distribution of required notices, consents and GFAs.
5. Identify and assess the internal controls and procedures implemented to ensure that balance billings for excluded services do not occur.
6. Evaluate your organization's patient-provider dispute resolution process.

Certain internal controls may require in-depth scrutiny to ensure compliance.

### *Cost sharing*

Verify that the billing system automatically calculates the cost-sharing amounts in accordance with the regulations. Test a sample to verify that management reviews and signs off on the accuracy of the calculations prior to distribution. The calculation is required to be computed as follows:

- An amount should be determined by an applicable All-Payer Model Agreement, in accordance with section 1115A of the Social Security Act.
- If no All-Payer Model Agreement is applicable, the amount should be determined under a specified state law.
- If neither of the above apply, the lesser amount of either the billed charge or the qualifying payment amount, which is generally the plan's or issuer's median contracted rate, should be used.

### *Notice and consent*

Determine that your organization's procedures are compliant. Upon identifying patients who qualify for OON balance billing, a financial counselor should obtain the patient's consent in a timely manner to ensure OON billing is accurate and in conformance with state and federal regulations.

Timeliness includes providing the notice and consent at least 72 hours before an appointment for items and services scheduled out 72 hours in advance or no later than 3 hours prior to the appointment. Management should periodically review the patient consents obtained to ensure each patient meets the requirements for OON billing and the consent was obtained in a timely manner.

### *Good faith estimate*

Good faith estimates should be automatically generated within the billing system through a system configuration and provided by staff to applicable patients within the required timeframe. Management should perform daily reviews of the good faith estimate report from the billing system and reconcile it to scheduled services to ensure timely notification and distribution of the good faith estimate.

Ensure that the billing system is configured to require input in the necessary fields prior to the submission of the good faith estimate to the uninsured or self-pay individual. Required fields should include:

1. Patient name and date of birth
2. Description of the primary item or service, in clear and understandable language
3. Itemized list of items and services
4. Applicable diagnosis codes, expected service codes and expected charges associated with each listed item or service
5. Name, national provider identification and taxpayer identification number of each provider or facility represented in the good faith estimate
6. The state(s) and office or facility location(s) where the items or services are expected to be furnished
7. List of items or services that the provider or 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.

*Notify self-pay/uninsured patients of their right to receive a good faith estimate.*

### Your takeaway

As regulators crack down on noncompliance with NSA and patients become more aware of their rights, you will need to collaborate across your organization's silos to facilitate organizational agility and ensure compliance. The healthcare industry is continuing to trend to more consumer orientation and provider organizations should remain vigilant because market share may erode if billing practices are viewed unfavorably. Organizations that remain forward-thinking will gain the trust and loyalty of patients and their families by reduced out-of-pocket costs and improved patient experiences. **NP**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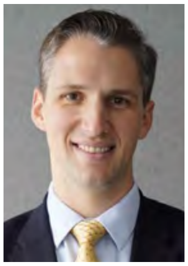

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*Growth demands a temporary surrender of security. - Gail Sheehy*

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