OREGON OFFICE of RURAL HEALTH

OPPORTUNITY Just knock.

# CAH Finance and Operations Webinars

August 31, 2023

## The No Surprises Act: SEP Revenue Protections and Transactional Compliance

*The mission of the Oregon Office of Rural Health is to improve the quality, availability and accessibility of health care for rural Oregonians.*

*The Oregon Office of Rural Health's vision statement is to serve as a state leader in providing resources, developing innovative strategies and cultivating collaborative partnerships to support Oregon rural communities in achieving optimal health and well-being.*

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## Webinar Logistics

- Audio muted and video off for all attendees.
- Select to populate the ··· to populate the chat feature on the bottom right of your screen. Please use either the chat function or raise your hand on the bottom of your screen to ask your question live.
- Presentation slides and recordings will be posted shortly after the session at: https://www.ohsu.edu/oregon-office-of-rural-health/resources-and-technical-assistance-cahs.


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## Upcoming CAH Operation and Finance Webinars

**Sept. 14, 12 p.m. – 1:00 p.m.**
*Fund Your Mission: Practice Steps to Move from Volume to Value*

OREGON OFFICE of RURAL HEALTH

Rob Bloom is a Principal at Wintergreen. Prior to joining Wintergreen as a Principal, Rob served as CFO for Carthage Area Hospital for over a decade. He previously held positions with the Hospital as Administrator of Primary Care Services and Interim Chief Financial Officer. In addition to his role as CFO at Carthage, Rob also served concurrently (2021-2022) as Chief Financial Officer at Claxton Hepburn Medical Center and Orleans Community Hospital in addition to providing consultative services to several other hospitals in rural New York.

# The No Surprises Act:
## Revenue Protections and Transactional Compliance

August 31, 2023


WINTERGREEN

# Overview

The No Surprises Act* introduced new requirements for providers, facilities, and providers of air ambulance services to protect individuals from surprise medical bills. These requirements:

- Prohibit providers and facilities from directly billing individuals for the difference between the amount they charge and the amount that the individual's plan or coverage will pay plus the individual's cost-sharing amounts (i.e., balance billing) in certain circumstances;
- Require providers and facilities to provide ***good faith estimates*** of charges for care to uninsured (or self-pay) individuals upon scheduling care or on request, and for individuals with certain types of coverage, to submit good faith estimates to the individual's plan or issuer;
- Create a patient-provider ***dispute resolution process*** for uninsured (or self-pay) individuals to contest charges that are "substantially in excess" of the good faith estimate;
- Require certain providers and facilities to publicly disclose restrictions on balance billing; and
- Limit billed amounts in situations where a provider's network status changes mid-treatment or individuals act on inaccurate provider directory information.

** Title I (No Surprises Act) of Division BB of the Consolidated Appropriations Act, 2021 (CAA) amended title XXVII of the Public Health Service Act (PHS Act*

# Scope

Beginning January 1, 2022, these No Surprises Act requirements will apply to items and services provided to most individuals enrolled in ***private or commercial health coverage***, like:

- Employment-based group health plans (both self-insured and fully insured)
- Individual or group health coverage on or outside the Federal or State-based Exchanges
- Federal Employee Health Benefit (FEHB) health plans
- Non-federal governmental plans sponsored by state and local government employers
- Certain church plans within IRS jurisdiction
- Student health insurance coverage [as defined at 45 CFR 147.145]

Requirements under the No Surprises Act don't apply to beneficiaries or enrollees in Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE. These programs have other protections against high medical bills. The protections also don't apply to short-term limited duration insurance (STLDI), excepted benefits, or retiree-only plans; or account-based group health plans.

# Continuity of Care

In general, if a provider or facility ceases to be an in-network provider because of a termination of a contract, certain continuity of care protections apply to an individual who meets the definition of a continuing care patient and is furnished items or services by such provider or facility for which the individual's plan or issuer provides coverage.

- Timely notify each individual enrolled who is a continuing care patient of the termination
- Provide each individual enrolled who is a continuing care patient an opportunity to notify the plan or issuer of the need for transitional care; and
- Permit the continuing care patient to elect to continue to have the same benefits provided, under the same terms and conditions as would have applied under the plan or coverage had the termination not occurred, with respect to the course of treatment furnished by the provider or facility.
    - The election may last until the earlier of 90 days (starting on the date their plan or issuer notifies them of the change in network status); or the date on which such individual is no longer a continuing care patient with the provider or facility.

**Providers need a reliable process**

# Provider Directory

Under the No Surprises Act, providers and health care facilities must generally:

- Refund enrollees amounts paid in excess of in-network cost-sharing amounts with interest, if the enrollee has inadvertently received out-of-network care due to inaccurate provider directory information, the provider or facility billed the enrollee for an amount in excess of in-network cost-sharing amounts, and the enrollee paid the bill.
- Maintain business processes to submit provider directory information at specified times to support plans and issuers in maintaining accurate, up to date provider directories.
- A provider is permitted to require, as part of the terms of a contract or contract termination with a plan or issuer that the plan or issuer
  - Remove the provider from the directory at the time of termination of contract.
  - Bear financial responsibility for providing inaccurate network status information to an enrollee, as applicable.

*The No Surprises Act provider directory requirements apply to health care providers and health care facilities. The statute doesn't exempt any categories of providers or facilities from this requirement.*

# Public Disclosure

The No Surprises Act requires **health care providers** and **health care facilities** to publicly share written disclosures, distributed through multiple methods, outlining key protections. These disclosures must include information on:

- The prohibitions on balance billing for emergency or non-emergency services with which the provider or health care facility must comply;
- Any state laws governing balance billing with which the provider or health care facility must comply; and
- Contact information for state and/or federal agencies that an individual can contact to report a suspected provider or health care facility violation of the balance billing protections in the No Surprises Act or state laws governing surprise medical bills.

# Good Faith Estimates and PPDR

Effective January 1, 2022, the No Surprises Act (NSA) protects uninsured (or self-pay) individuals from many unexpectedly high medical bills.

- If an individual does not have certain types of health insurance, or does not plan to use that insurance to pay for health care items or services, they are eligible to receive a "good faith estimate" of what they may be charged, before they receive the item or service.
- A new patient-provider dispute resolution (PPDR) process is available for uninsured (or self-pay) individuals who get a bill from a provider that is substantially in excess of the expected charges on the good faith estimate.

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 (including outpatient departments);
- Critical access hospitals;
- Ambulatory surgical centers;
- Federally Qualified Health Centers (FQHC) and rural health centers;
- Laboratory centers; and
- Imaging centers.

# PROJECTING REVENUE

# Continuity of Care Process

- Create an interdisciplinary team that meets regularly.  Consider including the following functions:
  - Finance
  - Billing
  - Credentialing
  - IT
  - Quality
  - Clinical leadership
  - Compliance
- Develop a repeatable process to ensure patients affected can be identified and communicated with
- Remember relevant related regulations such as HIPPA etc.
- Work proactively with clinicians, patients, and plans to create a smooth transition

# Provider Directory Process

- Create an interdisciplinary team that meets regularly.  Consider including the following functions:
  - Finance
  - Billing
  - Credentialing
  - IT
  - Quality
  - Clinical leadership
  - Compliance
- Develop a repeatable process to ensure plans receive updated information in a timely fashion
- Set up automated processes to flag potential balance billing situations for review
- Establish a process to identify potential patients impacted by directory issues and ensure billing is compliant

# Required Disclosures Process

- The No Surprises Act Notice be on a sign posted prominently at the location of the provider or facility.

  **Recommendation: Post the No Surprises Act Notice next to your HIPAA Notice of Privacy Practices and/or Charity Care Notices.**

- The No Surprises Act Notice be provided to all insured patients (except Medicare and Medicaid beneficiaries), regardless of network status.
  - **Build this out as part of your registration routine.**

- The No Surprises Act Notice must be provided in person, through mail, or e-mail (as selected by the patient) no later than the date on which the provider or facility issues statement for uninsured individuals or submits a claim to the health plan.
  - **Build this out as part of your registration and follow-up routines.**

- **Notice must be furnished for each episode of care**. Patient's written acknowledgment of receipt is not required but the facility or provider should follow the same procedures it employs for other required notices to demonstrate compliance.

# Good Faith Estimates Process

- Create an interdisciplinary team that meets regularly.  Consider including the following functions:
  - Finance
  - Billing
  - Credentialing
  - IT
  - Quality
  - Clinical leadership
  - Compliance
- Develop a repeatable process to ensure compliance with the following steps:
  - Identification of uninsured individuals
  - Required notice delivery
  - Determination of the convening provider
  - Calculation and delivery of the Good Faith Estimate
  - Retention of documentation

# Dispute Resolution Process

- Create an interdisciplinary team that meets regularly.
- Continue to monitor the evolution of guidance still forthcoming (driven my multiple lawsuits)
  - Develop a process to aggregate required information for the dispute
    - Good Faith Estimate
    - Copy of billed charges provided
    - Documentation providing evidence for the difference between the GFE and billed charges
  - Ensure billing activity is suspended
    - Remember outsourced partners
  - Ensure access to the online federal IDR portal and a process for complete submissions
  - Close the loop as part of existing denials management processes
  - Educate Staff!

***Recommendation: Clean up your provider rosters and provide demographic files for all payors and ensure each time a provider is onboarded and ensure there is a process in place for that provider to either not see patients until fully participating under contract or there are internal controls in place to prevent billing.***

# SUMMARY

# Key Action Items

- Be mindful of the interplay between existing processes and new NSA requirements
- Teamwork and processes are the key to compliance
- Providers should be aware of several federal lawsuits filed challenging the rulemaking implementing the federal Independent Dispute Resolution Process (IDR) and specifically the presumption that the qualifying payment amount should be used as the Out of Network rate in the Federal Independent Dispute Resolution process.
- Failure to ensure compliance will get expensive.
  - Penalties
  - Added staff for quick fixes
  - Slower throughput in key areas of the revenue cycle


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# ORH Announcements

**Sept. 14, 12 p.m. – 1:00 p.m. | Fund Your Mission: Practice Steps to Move from Volume to Value** (*register here*)
With the ongoing movement toward population-based payment models, organizations must understand how volume-based initiatives can impact finance and operations performance as well as drive long-term strategic options. This presentation focuses on the transition from volume to value while providing participants with the pros and cons of different population-based approaches.

**October 11-13, Sunriver, OR | 40th Annual Oregon Rural Health Conference**
(*register here*)

**ORH Needs Your Rural Health Story!**
We are looking for stories from your community to highlight at the ORH Conference. Click the "Tell Us Your Story" link to submit the great stories that have contributed to your community's health over the last 40 years.

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# Thank you!

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