TuftsMedicine

No Surprises Act and related Massachusetts Law

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This is Not Legal Advice

- The information provided in this presentation is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance upon which it is based.
- Providers should consult their own legal and financial advisers regarding compliance with the No Surprises Act and MA law

Overview

- Effective January 1, 2022
- Generally applies when the facility is In-Network but a provider is Out-Of-Network
- Prohibits “Balance Billing” in the Emergency Department and for “Ancillary Services” (Radiologists, Pathologists, Anesthesiologists, Hospitalists, Assistant Surgeons, Intensivists)
- Prohibits “Balance Billing” by other Out-Of-Network providers at In-Network facilities unless patient consents in writing
- Requires all providers to notify patients of Act’s protections
- Requires providers to provide a good faith estimate of costs when requested by uninsured or self-pay patients
- Massachusetts law now includes disclosure of information and costs relating to Provider’s In-Network or Out-Of-Network status.

No Surprises Act (NSA) Applicability

- Applies to Emergency Services provided at Out-Of-Network facilities
- Applies to Non-Emergency Services Provided by Out-Of-Network Providers at In-Network Facilities
- Applies to uninsured and self-pay patients in all locations
- Facilities: Hospitals, Hospital Outpatient Depts, Ambulatory Surgery Centers
- NSA does not apply to Medicare/Medicaid/Tricare beneficiaries

“Surprise Billing” aka Balance Billing

- Occurs when a provider bills a patient the difference between the facility or provider’s billed charges, and a health plan’s out-of-network benefit.

Emergency Services- NSA Limits Patient Payment Responsibility

- Out-Of-Network Providers and Facilities may not Balance Bill patients for Emergency Services
- Out-Of-Network Providers and Facilities may only bill the patient the In-Network cost-sharing requirement for such services.
- In-Network cost share is based on the lesser of Provider/Facility's charges or the Health Plan's "Qualified Payment Amount"
- QPA is the median of the In-Network Rates recognized by the Plan for services
- Note: there is an exception to this rule for Post-Stabilization Services if certain requirements are met and if patient consents

Emergency Services – NSA Terms on Health Plan Payments

- Provider/Facility bills Plan
- The Plan will pay the facility and provider what the Plan believes it owes
- Generally, this will be the QPA
- Provider/Facility has a right to enter into a 30-day negotiation period related to the Plan's payment
- Plan must notify Provider/Facility of this right.
- Provider/Facility has to assess whether to accept the Plan's payment, or negotiate for a higher amount
- Provider/Facility can enter into Independent Dispute Resolution with an Arbitrator if negotiation is unsuccessful

NSA Terms: Non-Emergency Services

- If Facility is In-Network and Provider is Out-Of-Network, Provider may not balance bill unless patient consents in writing to the amount of the services
- However, no Consent for following “Ancillary Services:”
  - Radiologists, Pathologists, Anesthesiologists, Hospitalists, Assistant Surgeons, Intensivists, Neonatologists
  - Laboratory and Radiology Services
- Notice and consent requirements do not apply to these Ancillary Services. The prohibition against balance billing remains applicable

NSA Required Notices

Providers and facilities are required provide notice of No Surprises Act balance billing protections. This includes:

- posting on provider's website
- in the office if provider provides care in a hospital or ASC setting
- to each patient who is enrolled in commercial health coverage before billing/requesting payment.

Templates available from CMS: https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791

NSA Good Faith Estimates

Only required for patients who are uninsured or who are self-pay for the service

CMS has detailed information for information that must be included in the GFE

Timelines:

- If visit is ten days out, provide GFE within three business days
- If visit is three to nine days out, provide GFE within one business days

- Responsibilities for the GFE differ depending on whether Provider is the “convening provider ” or a “co-healthcare provider.” Convening Provider is the provider responsible for “the initial reason for the visit.” Generally, the services the provider schedules to be performed at the provider’s physical location
- Co-Healthcare Providers must provide information to Convening Providers within one business day
- If actual charge exceeds GFE by $400, patient may dispute charge
- GFEs for commercial insurance patients may be required in the future

Massachusetts Law (MGL Ch. 111 s. 228) Disclosure Obligations

- Upon scheduling any procedure, admission or service, Providers must disclose whether Provider participates in patient's health plan
- If Provider is In-Network:
- Inform patient that patient may request disclosure of the allowed amount and the amount of any facility fees
  - If patient requests the allowed amount and the amount of any facility fees for the admission, procedure or service, provide that information not later than 2 days after receipt of such request
  - If unable to give specific amount, disclose estimated maximum
- Inform patient that patient may obtain additional information about out of pocket costs
- "Allowed amount" means the "contractually agreed-upon maximum amount paid by a carrier to a health care provider for a health care service provided to an insured."

Massachusetts Law (MGL Ch. 111 s. 228) Disclosure Obligations

If Provider is Out-of-Network:

- Provide the charge and the amount of any facility fees for the admission, procedure or service
- Inform patient that patient will be responsible for charge the amount of any facility fees not covered by the plan
- Inform patient that admission, procedure or service may be available from a different provider who is In-Network.

Massachusetts Law (MGL Ch. 111 s. 228) Referral Obligations

Upon referral to another provider, Provider must disclose:

- if the provider to whom the patient is being referred is part of or represented by the same provider organization
- the possibility that the provider to whom the patient is being referred is not participating in the patient's health benefit plan and that if the provider is out-of-network under the terms of the patient's health benefit plan then any out-of-network applicable rates under such health benefit plan may apply and that the patient has the opportunity to verify whether the provider participates in the patient's health benefit plan prior to making an appointment or agreeing to use the services of said provider
- sufficient information about the referred provider for the patient to obtain additional information about the provider's network status under the patient's health plan and any applicable out-of-pocket costs

Massachusetts Law (MGL Ch. 111 s. 228) Referral Obligations – Direct Scheduling

If Provider refers patient to another provider by “directly scheduling” the services on the patient behalf, Provider must

- Verify whether the provider to whom the patient is being referred participates in the patient's health benefit plan
- Notify the patient if the provider to whom the patient is being referred is not a provider who participates in the patient's health benefit plan or if the network status of the provider to whom the patient is being referred could not be verified.

Massachusetts Law (MGL Ch. 111 s. 228) Enforcement and Penalties

- If Provider is Out-Of-Network and fails to provide the notifications required under the MA law, Provider may only bill *patient* for any applicable copayment, coinsurance or deductible that would be payable by patient by In-Network Provider
- DPH enforces
- Penalty for noncompliance is $2,500 in each instance, effective July 1 2022.

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Thank You

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