Centers for Medicare & Medicaid Services

Special Open Door Forum: No Surprises Act Prohibitions on Balance Billing

Moderator: Dr Eugene Freund

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1:00 pm ET

Coordinator: ...and thank you for standing by. At this time, all participants are in a listen-only mode until the question-and-answer session of today's conference. At that time, you may press star 1 on your phone to ask a question. I would like to inform all parties that today's conference is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the conference over to your host, Dr. Eugene Freund. Thank you. You may begin.

Eugene Freund: Thank you, and thank you all for calling, and I apologize for our technical delays at the beginning. We are ready to begin today's special open-door forum on the No Surprises Act Prohibitions on Balance Billing.

And just as a background, we know that there are new provisions of the No Surprises Act that came into effect just on January 1, and this is our effort to, in this case, help you in the provider community understand the requirements of that. We are going to be doing an ongoing series about - or an ongoing series of presentations about that. So, look for more to come as we get materials developed and cleared and all that.

One bit of housekeeping, this is an open meeting. Anybody is welcome to attend. But it's not for the press. If you have press questions, you need to contact the CMS Press Office at press@cms.gov. And generally, you know what to do on that front.

So, on behalf of myself and Dr. (Elyse Mowle), I want to turn it over to our first presenter, Mr. Judah Katz with the Center for Consumer Information and Insurance Oversight. So, Mr. Katz?

Judah Katz: Thank you very much, Dr. Freund. It is my pleasure to present the beginning portion of our presentation today. And we're going to be referencing the slide deck that was, I guess, the PDF form that was sent out for this, titled The No Surprises Act's Prohibitions on Balance Billing. As I go through these slides, I'll be referencing the slide numbers.

One other bit of housekeeping before I jump in to the agenda, as we go through this presentation, we'll be using a lot of defined terms and technical terms. And there's a glossary on Page 65 where we go through - where you can use to reference the terms. We'll also be discussing a lot of the terms throughout the remainder of the presentation.

So, with that, starting on Slide 2, we can discuss the agenda. First, we'll provide some background into the No Surprises Act training series. You can see just what the various topics will be. Then we'll talk about the prohibitions on balance billing generally, before diving into these separate subsections related to the prohibitions on balance billing related to ambulance services, related to emergency services, related to non-emergency services, and then some exceptions related to notice and consent requirements.

Hopefully at the end we'll have some time for questions. I know that we have some questions that were sent in, in advance and hopefully we'll be able to get to those.

Quick. Legal disclaimers on Page 3 and 4. Just, you guys can read them, but in essence reference the actual statutes, regulations and other interpretative

materials. This is just designed as a training session and not a full and complete description of the law.

Okay. Starting on Page 6 then, we'll begin with an overview of the No Surprises Act. So, 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 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 upon request. And for individuals with certain types of coverage, this would make good-faith estimates to the individual's plan or issuer.

It also created a patient - creates a patient provider dispute resolution process for uninsured self-pay individuals to contest charges that are substantially in excess of the good-faith estimate. And then it also requires certain providers and facilities to publicly disclose restrictions on balance billing. And lastly, it limits billed amounts in situations where provider's network status changes mid-treatment or individuals act on inaccurate provider directory information.

The scope of individuals that are protected under the No Surprises Act, that's on Slide 7. So, beginning on 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 plans, both fully-insured and self-insured, individual or group health coverage, on or outside federal or state-based exchanges, federal employee health benefit plans, non-federal governmental plans sponsored by state and local

government employers, certain church plans within IRS jurisdiction, student health insurance coverage.

Some requirements also apply to providers and facilities with respect to uninsured or self-pay individuals, like requirements that providers and facilities provide good-faith estimates for scheduled care or upon request.

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

On Slide 9 we have a list of the various trainings and the topics. Our focus in today's presentation will be on the bolded items, the first three, and I already described what those are. You can see the rest of them. We do not have dates available for these yet, but as the materials are cleared, we will be issuing additional training series.

The beginning of the overview starts on Slide 11, and this is the overview of the No Surprises Act prohibitions on balance billing. And this is where we begin to move into the substance.

The No Surprises Act requires health plans and issuers to apply in-network cost-sharing terms and prohibits out-of-network providers, facilities or providers of air ambulance services from billing individuals more than these in-network cost-sharing limits in three main scenarios.

Number one, a person gets covered emergency services from an out-of-network provider or out-of-network emergency facility. Number two, a person gets covered non-emergency services from an out-of-network provider delivered as part of a visit to an in-network healthcare facility. Or, number three, a person gets covered air ambulance services provided by an out-of-network provider of air ambulance services.

In limited situations, the No Surprises Act allows some out-of-network providers and facilities to seek written consent from individuals to voluntarily waive their protection against the - against balance billing for post-stabilization services or non-ancillary, non-emergency services. These situations are referred to throughout the presentation as notice and consent exceptions, will be discussed towards the end of the presentation in detail.

On Slide 13 we're going to go through some just basic definitions. So, in-network versus out-of-network providers, facilities and air ambulance providers.

An in-network provider is a provider, facility or provider of air ambulance services that has a contractual relationship with a health plan or issuer for the item or service provided. Contractual relationships include single-case agreements between a plan or issuer and an out-of-network facility that are used to address unique situations in which an individual will require services that typically occur out-of-network.

An out-of-network provider, provider - or provider of air ambulance services or facility is one that doesn't have a contractual relationship with an individual's health plan or issuer for the item or services provided. And again, we'll review the definition of terms like provider, provider of air ambulance services, and facility throughout the presentation.

Consumer insurance information that affects prohibitions on balance billing includes covered benefits and plan year. So, it covers, when we refer to cover benefits, we're talking about prohibitions on balance billing for air ambulance, emergency and non-emergency services. They only apply to items or services that are covered benefits under the in-network terms of a privately insured individual's health plan or coverage.

Plan year means the prohibitions on balance billing apply to items or services delivered in health insurance, claims or policy years starting on or after January 1, 2022.

On Slide 15, what facilities, providers and air ambulance services need to do when providing items or services for which the prohibitions on balance billing apply.

In situations where balance billing is banned and a notice and consent exception does not apply, an out-of-network provider, emergency facility or provider of air ambulance services cannot bill an individual for an amount that exceeds in-network limits on cost sharing or hold an individual liable for paying an amount that exceeds in-network limits on cost sharing. And the individual can't be put in the middle of a dispute regarding the total payment amount from the plan or issuer to the provider, facility or provider of air ambulance services.

On Slide 16, after an out-of-network provider, facility or provider of air ambulance services furnishes items or services to an individual, the out-of-network provider or facility receives an initial payment from the health plan or issuer. However, the final payment they receive from the plan or issuer - from the plan or issuer may be determined by, number one, an all-payor model

agreement or specified state law depending on the item or service, geographic area where the item was provided, and type of plan or issuer and provider or facility involved.

If there is no all-payor model agreement or specified state law that applies, then the provider, facility or ambulance provider may accept the initial payment as payment in full or may enter into a 30-day period of open negotiations with the health plan or issuer to determine the final total amount.

And then lastly, if negotiations fail, the two parties may enter into an independent dispute resolution process to determine the final total payment. And we'll be doing an upcoming training session focused solely on the IDR process.

On Slide 17, determining the cost-sharing amount that a provider, facility or ambulance - air ambulance provider can bill and collect from an individual.

In situations where balance billing is banned under the No Surprises Act, health plans and issuers must determine the amount that an - that out-of-network providers, facilities or providers of air ambulance services can charge an individual by imposing cost-sharing requirements that are not higher than the in-network cost-sharing terms of an individual's plan. Health plans and issuers calculate the dollar amount of cost sharing, applying the cost-sharing terms to the, quote, "recognized amount," which is further specified in regulations.

Depending on the type of item or service and geographic area where care is provided, plan or issuer and provider or facility, this amount, in other words, the recognized amount, can be set by an all-payor model agreement if applicable to the plan or issuer and provider or facility, specified state law also

if applicable, or the lesser of billed charges or the plan's qualifying payment amount for the item or service.

On Slide 18, the qualified payment amount, QPA, is defined in regulation and is generally the plan or issuer's median contracted rate for the item or service and geographic area where the item or service was delivered from January 31, 2019, indexed for inflation. And we have a chart at the bottom of the slide, or I guess in the middle of the slide, which describes the breakdown and the differences between the amount used to calculate individual cost sharing both for emergency and non-emergency services and then for air ambulance services.

And just to recap it, just run through the chart, for emergency and non-emergency services, the recognized amount is going to be all-payor model agreements. If that does not apply, then it would be an amount specified by state law. And if neither of those apply, then the lesser of the amount billed by the provider or facility or the qualifying payment amount for the item of service. For air ambulance services, it's going to be the lesser of the amount billed or the qualifying payment amount.

On Slide 19, best practices to ensure compliance with No Surprises Act prohibitions on balance billing. To ensure compliance with the No Surprises Act, providers, facilities, and providers of air ambulance services may need to bill the plan or issuer directly for services to determine whether or not the No Surprises Act protections apply.

Out-of-network providers must also determine whether the facility where they delivered care is an in-network healthcare facility for a particular individual's health plan and coverage, as well as whether the individual received items -

received items or services provided in conjunction with a visit at an in-network facility. For example, laboratory services.

If out-of-network providers, facilities or providers of air ambulance services bill an individual in violation of the No Surprises Act, they may be subject to civil fines and other corrective actions.

And at this point, I'm going to take a rest and turn it over to my colleague, Dr. Mowle.

(Elyse Mowle): Thank you so much, Judah. So, at this point, I'm going to continue the presentation, starting on Slide 21. We'll be going into detail about the prohibition on balance billing for air ambulance services.

So, generally, out-of-network air ambulance service providers are banned from balance billing an individual for covered air ambulance services. Note that ground ambulance services aren't covered under this prohibition. And we will review each of these terms throughout the presentation.

So, the scope of air ambulance services and providers that are subject to the prohibition on balance billing for air ambulance services, this is Slide 22. Out-of-network air ambulance service providers can't balance bill for the following air ambulance services, including medical supplies and services provided and transport. So, the first is medical transport by helicopter or a rotary wing ambulance, and the second is medical transport by airplane or a fixed wing ambulance.

This applies to situations where air ambulance services are covered under the in-network terms of an individual's health plan or coverage, even if there are no in-network air ambulance service providers within an individual's plan or

coverage. Also, air ambulance services providers may never seek an individual's consent to waive No Surprises Act protections for these services through notice and consent exceptions.

So, on Slide 23, we have a Knowledge Check question. Carol is a 58-year-old female with marketplace coverage. Over two days she developed worsening abdominal pain, nausea and constipation, which prompts her to call 911 for medical assistance. She's driven by ground ambulance transport to her local in-network emergency department for exam and treatment. And the question on the Knowledge Check is: how much can the ambulance provider bill Carol under the rules of the No Surprises Act?

And as this is a speakers-only line, I'll just pause for a moment that you guys can try and answer the question for yourselves, quietly. And the answer is on Slide 24.

So, the ambulance provider isn't banned from balance billing under the No Surprises Act because it was specified in the example that it was a ground ambulance provider. Air ambulance service providers but not ground ambulance service providers are banned from balance billing under the No Surprises Act. Therefore, no restrictions are placed on the amount the ambulance provider can bill an individual under the No Surprises Act.

Right. And then prohibition on balance billing for emergency services in more detail, starting on Slide 26.

Generally, out-of-network providers and out-of-network emergency facilities can't balance bill an individual who gets covered emergency services for an emergency medical condition. And as always, we'll review what each of these terms mean throughout the presentation.

Slide 27, the scope of providers that must comply with the No Surprises Act prohibitions on balance billing for emergency services. The following types of providers can't send a balance bill for covered emergency services when providing care as an out-of-network provider at an emergency facility.

First is physicians and the second is other healthcare providers acting within their scope of practice under applicable state law, such as a certified nurse practitioner or physician assistant.

Slide 28, the scope of facilities that must comply with the No Surprises Act's prohibitions on balance billing for emergency services. The following types of facilities can't send a balance bill for covered emergency services when providing care as an out-of-network emergency facility.

The first being emergency departments of a hospital defined as hospital outpatient departments that provide emergency services. The second being hospitals, regardless of the department, when providing post-stabilization services.

And the third, independent, freestanding emergency department defined as healthcare facilities that are geographically separate and distinct and licensed separately from a hospital under applicable state law and provide any emergency services. Of note, urgent care centers can be treated as independent, freestanding emergency departments if they meet this definition of an independent, freestanding emergency department.

Slide 29. Individuals may never be balance billed for emergency services. Out-of-network providers and facilities are always banned from balance billing for the following emergency services. An appropriate medical

screening examination that is within the capability of the emergency department of a hospital or of an independent, freestanding emergency department, including ancillary services routinely available to the emergency department to evaluate whether an emergency medical condition exists.

And such further medical examination and treatment as may be required to stabilize the individual, regardless of the department of the hospital in which the further medical examination and treatment is furnished. Within the capabilities of the staff and facilities available at the hospital or the independent, freestanding emergency department.

On Slide 30. Balance billing protections apply to these emergency medical conditions. The balance billing isn't allowed for emergency services when an individual gets care for an emergency medical condition using a prudent layperson definition. A person who has average knowledge of health and medicine experiences a medical condition, including a mental health condition or substance use disorder that is so severe they believe they need immediate medical care, and failing to get immediate medical care could result in the health - or the health of their unborn child being in serious jeopardy or results in serious impairment to bodily functions or lead to serious dysfunction of any bodily organ or part.

On Slide 31, we have another Knowledge Check. Zoe is a 26-year-old female with marketplace coverage. She works as a teacher and has an average knowledge of health and medicine. She has severe pain, swelling and redness of her right calf and becomes concerned that this may be dangerous.

So, she travels to the local hospital emergency department that is in her health plan's network. She has a venous ultrasound. The radiologist, who is out-of-

network, reads the ultrasound, which shows deep vein thrombosis. Zoe is started on medication and discharged from the emergency department.

The question here is, do No Surprises Act balance billing protections related to emergency services apply to the radiologist? The answer is on Slide 32.

Yes, it would. Zoe sought care for a medical condition that, using a reasonable layperson judgment, they thought was an emergency medical condition that needed immediate medical attention to avoid serious jeopardy impairment or dysfunction.

Per the No Surprises Act, out-of-network providers are banned from balance billing for emergency services provided for emergency medical conditions. Emergency services include ancillary services available to the emergency department to evaluate whether an emergency medical condition exists, such as services of a radiologist who reads an imaging study.

Slide 33 has post-stabilization services where notice and consent exceptions may be used. Under the No Surprises Act, certain post-stabilization services are considered emergency services and prohibitions on balance billing generally apply. Post-stabilization services are covered services that are provided after the individual is stabilized as part of an outpatient observation or an in-patient or outpatient stay related to the emergency visit, regardless of the department of the hospital.

In limited circumstances, an out-of-network provider or emergency facility can use the No Surprises Act notice and consent exceptions to obtain voluntary consent from an individual to waive the balance billing protections for post-stabilization services.

Slide 34, when notice and consent exceptions can be used for post-stabilization services. A provider or emergency facility can get written consent from an individual to waive their balance billing protections under the No Surprises Act for post-stabilization services only if all of the following requirements are met.

So, the first requirement is that an individual is stable enough to travel using non-medical or non-emergency medical transport to an available in-network provider or facility located within a reasonable travel distance given the individual's medical condition. And this requirement is determined by the attending emergency physician or treating provider. The provider's determination is binding on the facility.

The second requirement is that the individual or their authorized representative is in a condition where they can receive information and provide informed consent. So, this is determined by the attending emergency physician or treating provider. An authorized representative can't be provider-affiliated with the facility or an employee of the facility unless such provider or employee is a family member of the participant, beneficiary or enrollee.

The third requirement for notice and some exceptions is that the provider and - or facility provides written notice and obtains written consent from the individuals to waive balance billing protections in compliance with all related statutory and regulatory requirements. And there are more details on this requirement later in the slides.

And then the fourth requirement that must be met is that the provider and facility complies with state law. So, this may include state laws that further restricts balance billing for post-stabilization services. And we will review

additional requirements that must be met when using notice and consent exceptions later in the presentation.

On Slide 35, we have another Knowledge Check. On this example, Carlos is a 62-year-old male with employer sponsored health coverage. He is involved in a motor vehicle accident and sustained multiple injuries. He is taken to the closest hospital, which is out-of-network. He undergoes surgery to repair multiple leg fractures.

Once he is stable and out of surgery, he is counseled on the option to transfer care to another local in-network hospital for the duration of his recovery. His treating physician determines the safest form of transport given his medical state would be via an ambulance. Carlos knows that the hospital he's in has an excellent reputation and wishes to stay there for his recovery.

The hospital provides a written notice and gets his written consent to waive his balance billing protections under the No Surprises Act. He remains in-patient for two additional days and is ultimately discharged to his home.

The question is, does the No Surprises Act prohibition on balance billing for emergency services apply to all days of care Carlos received from this hospital? It's a complicated case example here. The answer is on Slide 36.

Yes, they do apply. The hospital is banned from balance billing Carlos for items and services provided prior to his being stabilized. The hospital is also banned from balance billing him for post-stabilization services provided after surgery, despite obtaining written consent from Carlos to waive his balance billing protections under the No Surprises Act.

This is because he could only safely be transferred via ambulance. The hospital can't seek consent from him to waive his balance billing protections under the No Surprises Act specific to post-stabilization services.

And at this point, I am going to pass it back over to my colleague, Judah Katz, to provide more information on the prohibition on balance billing for non-emergency services.

Judah Katz: Thank you, Elyse. So, starting on Slide 38, we'll begin with an overview of the No Surprises Act's prohibition on balance billing for non-emergency services.

Generally, out-of-network providers are banned from balance billing an individual who gets covered non-emergency services that are part of a visit to an in-network healthcare facility. And as before, we'll review each of the terms as we go through.

On Slide 39, the scope of providers that must comply with the prohibitions of balance billing for non-emergency services. The following types of providers are banned from balance billing when providing non-emergency services as an out-of-network provider at an in-network healthcare facility. And similar to before, this applies to physicians and other healthcare providers acting within their scope of practice under applicable state law, such as certified nurse practitioners or physician assistants.

On Slide 40, we look at the scope of facilities that can be in-network facilities. The No Surprises Act's prohibitions on balance billing for non-emergency services only applies to covered non-emergency services that are furnished as part of a visit to one of the following in-network healthcare facilities --

hospitals, including critical access hospitals, hospital outpatient departments, or ambulatory surgical centers.

And as a reminder, to be considered an in-network healthcare facility, a facility must be both either in-network or have a single-case agreement with the health plan or issuer for a specific individual.

Scope of non-emergency services that are considered part of a visit - part of a visit to a facility. So, out-of-network providers can't balance bill for non-emergency items and services that are part of a visit at an in-network healthcare facility.

This includes the following -- equipment and devices, imaging services, telemedicine services, lab services, preoperative services and post-operative services. These items or services don't need to happen physically within the in-network healthcare facility to be treated as part of a visit, for example, offsite laboratory services.

As a reminder, the No Surprises Act's ban on balance billing for non-emergency services only applies to plan covered services. If not - if a non-emergency service is not covered under the in-network benefits in terms of coverage under an individual's health plan, then the No Surprises Act's rules on balance billing do not apply for these services.

Slide 42, non-emergency services for which individuals may never be balance billed. Ancillary services, which individuals typically have little control over, are always subject to balance billing prohibitions.

The No Surprises Act defines the following items as ancillary services -- items/services related to emergency medicine, anesthesiology, pathology,

radiology and neonatology provided by either a physician or non-physician practitioner. Next is items and services provided by assistant surgeons, hospitalists and intensivists. Next is diagnostic services, including radiology and laboratory services. And lastly, items and services provided by an out-of-network provider when there is no in-network provider who can provide the item or service at the in-network facility.

Providers and facilities may never seek an individual's consent to waive the No Surprises Act's balance billing protections for non-emergency ancillary services through the use of notice and consent exceptions. Notice and consent exceptions also never apply to waive the No Surprises Act's balance billing protections related to non-emergency services when items or services are provided due to unforeseen urgent medical needs in the course of care delivery or if they're banned by state laws.

On Slide 44 we talk about non-emergency services for which notice and consent exceptions may be used. A provider or facility can use the No Surprises Act notice and consent exception to get consent from an individual to voluntarily waive their balance billing protections under the No Surprises Act for non-ancillary, non-emergency services furnished in an in-network facility. All requirements for providing notice and consent documents and getting proper consent must be met. And we'll discuss these in the next step.

On Slide 45, situations when the notice - when the No Surprises Act does not regulate provider billing practices for non-emergency services. The No Surprises Act does not regulate billing for non-emergency services in the following circumstances.

First is when non-emergency covered items or services are provided in an out-of-network hospital, outpatient hospital department, ambulatory surgical

center, or other facility type specified by the Secretary of HHS. Second is when the items or services provided are not covered under the in-network terms of an individual's health plan or coverage, even if provided in an out of - in an in-network hospital, outpatient hospital department, ambulatory surgical center or other facility type specified by the secretary of HHS.

As a reminder, providers may need to bill plans or issuers directly to determine whether the No Surprises Act requirements apply, given the terms of an individual's health plan coverage and the facility's participation status.

And then we have another Knowledge Check. The example here is, Rhonda is a 50-year-old female with employer sponsored health insurance who discovers a lump in her breast. The primary care provider orders a mammogram, which shows a suspicious mass. She's referred to the local in-network hospital's outpatient department for a biopsy. The biopsy is reviewed and found to be negative for malignant cells by a pathologist who happens to be out-of-network.

The question here is, how much can the pathologist bill Rhonda under the rules of the No Surprises Act? And before we jump, I'll give 10 seconds.

Okay, on Slight 47, the answer, is that under the No Surprises Act, the pathologist is banned from billing Rhonda more than the in-network cautionary amount as determined by her health plan. The pathologist, as an ancillary service provider, is banned from obtaining consent from the individual to waive these balance billing protections.

With that, I will transfer it back over to Elyse.

Elyse Mowle: Thank you, Judah. We're going to, in this last section of this presentation, go into more detail about these notice and consent exceptions to balance billing prohibitions.

So, starting now on Slide 49. This is a - just a recap of when out-of-network providers or facilities can and cannot use notice and consent exceptions.

So, for emergency services, including post-stabilization services, use of notice and consent exception is not allowed when providing any emergency services prior to post-stabilization services, including medical exams and treatment to stabilize an individual. When providing items or services due to unforeseen or urgent medical needs in the course of care delivery. When providing post-stabilization services if any one of the requirements listed below are not met, and any additional situations banned by state law.

The use of notice and consent exception is allowed when providing post-stabilization services and all of the following are true. An individual is stable enough to travel using non-medical or non-emergency medical transport to an available in-network provider or facility located within a reasonable travel distance given the individual's medical condition. The individual or their authorized representative is in a condition where they can receive information and provide informed consent.

The provider and facility provides written notice and obtain written consent from the individual to waive balance billing protections under the No Surprises Act in compliance with all related statutory and regulatory requirements. And the provider or facility complies with applicable state laws.

For non-emergency services, use of notice and consent exception is not allowed when providing ancillary services defined as emergency medicine,

anesthesiology, (pathology), radiology, neonatology items or services provided by physician or non-physician practitioner, items or services provided by assistant surgeons, hospitalists and intensivists, and diagnostic services including radiology and laboratory services.

Items or services of an out-of-network provider, if there's no in-network provider who can provide the item or service at the facility. When providing items or services due to unforeseen urgent medical needs in the course of care delivery, and any additional situations banned by state law.

For non-emergency services, the use of notice and consent exception is allowed when providing non-emergency services, including not post-stabilization services in an in-network facility, and all the following are true. The items or services do not meet the definition of ancillary services. Another in-network provider can deliver the items or services at the in-network healthcare facility.

And the provider gives written notice and gets written consent from the individual to waive the balance billing protections under the No Surprises Act in compliance with all related statutory and regulatory requirements.

Slide 51. Information providers and facilities must include in the notice and consent documents provided to individuals.

When giving notice and seeking consent from individuals to waive their balance billing protections under the No Surprises Act, providers and facilities must use standard notice and consent documents developed by HHS. The standard notice and consent documents were published as part of CMS Form Number 10780 and are available for download on cms.gov. Providers and

facilities must tailor the standard notice with individual and provider-specific information.

Slide 52. Provider/facility supplied information that is in the notice document includes patient names, out-of-network providers or facility names, statement that the healthcare provider is an out-of-network provider with respect to the health plan or coverage, good-faith estimates of the amount the individual may be charged for items or services delivered by the out-of-network providers or facility, statement that prior authorization or other care management limitations may be required.

And then for post-stabilization services furnished by an out-of-network provider and in-network emergency facility, a list of in-network providers at the facility able to deliver needed items or services.

Slide 53 outlines when and how providers and facilities must deliver the notice and consent documents to individuals. Timing of delivery. If an individual schedules an appointment at least 72 hours before the date of the appointment, notice and consent documents must be given to the individual no later than 72 hours before the date of appointment.

If an individual schedules an appointment within 72 hours of the date of the appointment, notice and consent documents must be given on the day the appointment is made, but at least three hours before the time when items or services are to be provided.

Method of delivery. Notice and consent documents must be delivered together, physically separate from other forms. They must not be attached or incorporated into other documents or hidden among other forms. On paper or electronically as preferred by the individual. A representative of the provider

or facility must be physically present or available by phone to answer questions.

On Slide 54, language accessibility requirements for notice and consent documents. Notice and consent documents must be available in the 15 most common languages in the state or a facility's geographic service region. If an individual can't understand any of the languages in which the notice and consent documents are provided, they can't give consent. If the documents aren't available in an individual's preferred language, a provider or facility must provide a qualified interpreter to get consent.

Please note that providers and facilities that get federal financial assistance must provide such documents in a manner that complies with other federal civil rights laws as applicable, including Section 1557 of the Affordable Care Act, Title 6 of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and The Americans with Disabilities Act.

Slide 55, parties allowed to provide notice and obtain consent. The following parties may provide notice and get signed consent from individuals to waive balance billing protections under the No Surprises Act. Out-of-network providers, out-of-network emergency facilities, and in-network facilities on behalf of out-of-network providers.

Slide 56, using a single set of notice and consent documents for multiple providers. An individual can provide consent to waive the No Surprises Act's balance billing protections for multiple providers involved in the delivery of care through a single set of notice and consent documents.

If multiple providers are using a single set of notice and consent documents, the documents must identify each provider, the services or items furnished by

each provider, and the good-faith estimate for each provider's services or item, and must allow the individual to waive No Surprises Act protections for each provider separately.

Slide 57, obtaining proper consent to waive balance billing prohibitions. Consent does not represent a contractual agreement of the individual to any estimated charge or to be treated by that provider or facility. Consent documents may be signed electronically by the individual or their authorized representative. For the signed consent form to be valid, it must not be revoked in writing by the individual before they get the items or services related to the consent form.

If a provider or facility doesn't comply with any one requirement related to providing notice and consent documents and getting consent, the provider or facility can't balance bill the individual. This is true even if the provider or facility gets the individual signed consent.

A provider or facility can refuse to treat an individual if they don't consent to waive their balance billing protections under the No Surprises Act so long as this is allowed under state law. However, no fees can be imposed on an individual for canceling an appointment if they don't consent to waive their No Surprises Act protections.

Slide 58, maintaining and sharing document records. Signed consent documents must include the time and date when the individual got the notice and the time and date when the individual signed the consent document. Providers and facilities must retain a copy of notice and consent documents for at least seven years after the date when the item or service is provided.

Providers and facilities must give a copy of the signed notice and consent documents to the individual in person or through mail or email, based on individual preference. Providers and facilities must kindly notify a health plan or issuer about items or services delivered for which proper consent to waive balance billing prohibitions was obtained, and give the plan or issuer a copy of the signed documents, preferably with the (claims).

All right. We have one more Knowledge Check for this presentation, on Slide 59. Sean is a 35-year-old male who has insurance through the marketplace. He is playing soccer and sustained a knee injury, which is later diagnosed as a torn ACL. He's advised by his friends to go to a specific orthopedist who has an excellent reputation. The surgery is scheduled at an in-network ambulatory surgical center a week in advance.

One day before his surgery, he gets an email with a written notice and consent documents informing him that the orthopedist is out-of-network and requesting that he consent to waive his balance billing protections under the No Surprises Act in order to be treated by the orthopedist. Sean signs the consent to waive balance billing protections as he would like to see the specific provider for his knee surgery.

Several weeks after his surgery, Sean gets a balance bill from his orthopedist. Did the orthopedist comply with requirements of the No Surprises Act in this example?

The answer is on Slide 60. No, the provider violated No Surprises Act requirements related to when notice and consent documents must be provided to individuals. Since Sean scheduled his surgery more than 72 hours in advance, written notice and consent must be provided to him no later than 72 hours before the date of the appointment.

In this case, the provider sent notice and consent documents one day before the appointment. Because all requirements related to using notice and consent exceptions were not met, the orthopedic surgeon is banned from balance billing Sean for services provided as part of the surgery even though he signed the consent form.

All right. So, slide 61 has our main takeaways. The No Surprises Act prohibits balance billing in three major scenarios. One a person gets covered emergency care from an out-of-network provider or out-of-network emergency facility. Two, a person gets covered non-emergency care from an out-of-network provider as part of a visit to an in-network healthcare facility. Or three, a person gets covered air ambulance services by an out-of-network air ambulance provider.

In situations where balance billing is banned, out-of-network providers, emergency facilities or air ambulance providers can't bill or hold an individual liable for paying an amount that exceeds in-network limits on cost sharing.

Continued on Slide 62, in situations where balance billing may be banned, providers, emergency facilities and air ambulance providers should bill health plans and issuers directly to determine whether No Surprises Act's protections apply.

In limited circumstances, the No Surprises Act permits some out-of-network providers and facilities to use notice and consent exceptions to get an individual's consent to waive No Surprises Act's balance billing protections related to post-stabilization emergency services and non-ancillary non-emergency services provided by out-of-network providers in in-network facilities.

When use of notice and consent exceptions are permitted, out-of-network providers and facilities must ensure that notice and consent documents and procedures comply with all No Surprises Act's requirements.

And that concludes the content of our presentation. We have an appendix with a glossary. And I believe that these slides were included in the invitations, and they are posted on our Web site as well. And you can contact Dr. Freund if you need more information.

I'm going to pass it back over to you to close us out.

Eugene Freund: Okay. Thank you very much. That was an awful lot of material. I hope it was helpful. And there's also in the slides the number for asking detailed questions about the No Surprises Act enforcement. And stay tuned for further presentations, as things develop, there's an awful lot to this act.

We're trying to focus the first - the presentations that we come up with out on the gate, the things that you need to know to be, you know, to be consistent with the act. And then there will be further things about, you know, the processes involved in submitting bills and that kind of stuff, which will come at a later point. And we're working on all of that, actually, my colleagues in CCIIO, we're working on all of that and are committed to getting those things out and cleared as soon as possible.

And that ends this presentation. I really thank you for calling in. And that concludes it. Thank you all.

Coordinator: That concludes today's conference. You may disconnect at this time. Host, please stand by for your line count. END