

Centers for Medicare & Medicaid Services
Special Open Door Forum:
Public Health Service Act Provider and Facility Requirements
Under the No Surprises Act
Moderator: Jill Darling
December 8, 2021
2:00 pm ET

Coordinator: Welcome and thank you for standing by. All lines are in a listen-only mode until the question-and-answer session. At that time please press star 1 and record your name as prompted. Today's conference is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn today's meeting over to Dr. Eugene Freund. Thank you. You may begin.

Dr. Freund: Thank you and welcome to today's overview of the Public Health Service Act Provider and Facility Requirements Under the No Surprises Act. And I just want to mention that we are targeting your group because we know that this community has a number of requirements that are coming up at the first of the year.

And we want to give you a chance to update that or to get up to date on them. And we're doing lots of other educational efforts to talk about some of the benefits and other parts of the program.

I do want to give the usual announcement with these calls. This call is not targeted to the press. Press are welcome to attend. But if you have press

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questions, you need to go to press@cms.hhs.gov, fill out the form there, which you're probably familiar with, and someone can direct you to the source to get your questions answered.

That being said, we're a little bit behind so let's go straight to Samuel James from the Center for Consumer Information and Insurance Oversight to start the presentation. Mr. James.

Samuel James: Thank you, Gene, for that introduction and background and hello to all of our attendees. Thank you for being here at our special open-door forum.

As Gene said, my name is Samuel James and I'm happy to be here with you all today. I am a member of the provider enforcement team within CCIIO, that's the Center for Consumer Information and Insurance Oversight, at CMS. Today I'll be presenting an overview of the Public Health Service Act provider and facility requirements.

This high level overview has been made available to you all in an online PDF form. And as I go through the material, I'll be sure to call out which slide we're on. I also want to note that after reviewing this presentation, we will have plenty of time for questions afterwards.

So before starting with the presentation, there are a couple of important legal disclaimers that I'll go over prior to diving into the requirements themselves, so we'll get started with those.

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So firstly, 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.

The presentation summarizes current policy and operations as of the date it was presented. And we encourage readers to refer to the applicable statutes, regulations and appropriate interpretive materials for complete and current information. Also, the contents of this document do not have the force and effect of law and are not meant to bind the public in any way unless specifically incorporated into a contract.

This document is intended only to provide clarity to the public regarding existing requirements under the law, and this communication was published, produced, and submitted at U.S. taxpayer expense.

So, the last thing before we jump into the requirements is to go over our agenda. We'll be starting with background and purpose, and then requirements for provider facilities and providers of air ambulance services that apply starting January 1, 2022. And then information about requirements for provider facilities and providers of air ambulance services. And then we'll continue on with enforcement and resources, definitions and then finally questions.

So, for background and purposes -- I'm on Slide 5 right now -- Title I of The No Surprises Act, Division BB of the Consolidated Appropriations Act 2021, amended Title 27 of the Public Health Service Act, to add a new party.

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Generally, provider facilities and providers of air ambulance services must comply with these new requirements starting January 1, 2022.

The provision in Part E create requirements that apply to providers, facilities and providers of air ambulance services, such as cost sharing, rules, prohibitions on balance billing for certain items and services, noticing consent requirements, and requirements related to disclosures about balance billing protection.

A little bit more on background and purpose. These provider, facility, and provider of air ambulance services requirements generally apply to items and services provided to individuals enrolled in group health plans or group or individual health insurance coverage and federal employees health benefit plans.

The good faith estimate requirement in the requirements related to the patient-provider dispute resolution process also applies to the uninsured. These requirements do not apply to beneficiaries or enrollees in federal programs such as Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care or TRICARE. These programs have other protections against high medical bills.

And then for a list of the provider and facility requirements that apply starting January 1, 2022, we'll start with no balance billing for out-of-network emergency services. And you'll see on the PDF that we have the applicable citations for each of these as well.

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Next, no balance billing for non-emergency services by non-participating providers at certain participating health care facilities unless notice and consent was given in some circumstances.

Disclose patient protections against balance billing. No balance billing for air ambulance services by non-participating air ambulance providers. Provide good faith estimate in advance of scheduled services or upon request for uninsured or self-pay individuals. Ensure continuity of care when a provider's network status changes and improve provider directories and reimbursement rules for errors.

So, the first summary requirement we'll start with is no balance billing for out-of-network emergency services on Slide 9.

So non-participating providers and non-participating emergency facilities cannot bill or hold liable beneficiaries, enrollees or participants in group health plans or group or individual health insurance coverage who received emergency services at a hospital or an independent freestanding emergency department for a payment amount greater than in-network cost sharing requirement for such services.

Continuing on with this requirement, cost sharing is calculated as if the total amount that would have been charged by a participating provider or participating facility were equal to the recognized amount. And certain post-stabilization services are considered emergency services and are therefore subject to this prohibition unless notice and consent requirements are met.

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So, for the exceptions to no balance billing for out-of-network emergency services, notice and consent, non-participating providers and facilities may balance bill both post-stabilization services only if all of the following conditions have been met.

The attending emergency physician or treating provider determines that the beneficiary, enrollee or participant can one, travel using non-medical or non-emergency medical transportation to an available participating provider or facility located within a reasonable travel distance taking into account the individual's medical condition, and two, is in a condition to receive notice and provide informed consent.

Three, the non-participating provider or facility provides the beneficiary, enrollee, or participant with a written notice and obtains consent that includes certain content and within a specific time frame and format outlined in regulation and guidance.

And you can see the resource slide at the end of the presentation for links to the regulation and required forms for the notice and consent document. And fourth, the provider facility satisfies any additional state law requirements.

And continuing on with these notice and consent requirements, a provider or facility cannot balance bill for items or services furnished as a result of unforeseen urgent medical needs that arise at the time when an item or service is furnished regardless of whether the non-participating provider or facility previously satisfied the notice and consent criteria. And please note that this applies to both emergency and non-emergency services.

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For our next requirement, the no balance billing for non-emergency services by non-participating providers at certain participating health care facilities. Non-participating providers of non-emergency services at a participating health care facility cannot bill or hold liable beneficiaries, enrollees, or participants in group health plans or group or individual health insurance coverage who receive covered non-emergency services with respect to a visit at a participating health care facility by a non-participating provider or a payment amount greater than the in-network cost sharing requirement for such services unless noted and consider requirements are met.

And then continuing on to Slide 15 with these same requirements, cost-sharing is calculated as if the total amount that would have been charged by a participating provider or participating facilities is equal to the recognized amount. Health care facilities include hospitals, hospital outpatient departments, critical access hospitals and ambulatory surgical centers.

Continuing on, note that notice and consent requirements do not apply to the following list of ancillary services for which the prohibition against balance billing remains applicable: which is items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, items and services provided by assistant surgeons, hospitalists and intensivists, diagnostic services, including radiology and laboratory services, and items and services provided by a non-participating provider if there is no participating provider who can provide such items or service at such facility.

For our next requirement related to disclosure of patient protections against balance billing, the provider or facility must disclose to any participant beneficiary when enrolling in a group health plan or group or individual health insurance coverage to the provider or facility furnishes items and services information regarding federal and state balance billing protections and how to report violations.

Providers or facilities must post this information prominently at the location of the facility, posted on a public web site, if applicable, and provide it to the patient, beneficiary or enrollee in a time frame and manner outlined in the regulation.

Moving on to the next requirement on Slide 18. No balance billing for air ambulance services by non-participating air ambulance service providers.

Providers of air ambulance services cannot bill or hold liable beneficiaries, enrollees, or participants in group health plans or group or individual health insurance coverage who received covered air ambulance services from the non-participating air ambulance provider for a payment amount greater than the in-network cost-sharing requirement for such services.

The cost-sharing requirement must be calculated as if the total amount that would have been charged for the services by a participating provider of air ambulance services were equal to the lesser of the qualifying payment amount or the billed amount for the services.

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For our next requirement, we have providing a good faith estimate of the expected charges in advance of scheduled services or upon request to uninsured or self-pay individuals.

A health care provider or facility must inquire within a specific time frame outlined in regulation and guidance if an individual who schedules an item or service is enrolled in a group health plan, group or individual health insurance coverage offered by health insurance issuer, a federal health care program, or a federal employees health benefit plan.

If so, they must inquire with an individual enrolled in one of these plans if seeking to have their claims for such items or services submitted to the plan. The provider or facility must provide notifications and clear and understandable language of the good faith estimate of the expected charges, expected service and diagnostic codes of scheduled services.

Continuing on Slide 20 with the good faith estimate requirements. A good faith estimate must include expected charges for the items or services that are reasonably expected to be provided in conjunction with the primary item of service, including items or services that may be provided by other providers and facilities.

From January 1, 2022 through December 31, 2022, HHS will exercise its enforcement discretion in situations where a good faith estimate provided to an uninsured or self-pay individual does not include expected charges from other providers and facilities that are involved in the individual's care.

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For the next requirement on ensuring continuity of care, when a provider's network status changes, the health care provider or facility that ends the contractual relationship with a plan or issuer and has a continuing care patient must generally in cases where the contractual relationship between a plan or issuer and a provider or a facility ends, resulting in a change of the provider or facility's network status with the plan, that provider or facility must accept payment from the plan or issuer and cost sharing payments for continuing care patient at the previously agreed to payment amount for up to 90 days after the date on which the patient was notified of the change in the provider's network status.

It must continue to adhere to all policies, procedures and quality standards imposed by the plan or issuer for such items or services as if the contract was still in place.

And for the next requirement of improving provider directories and reimbursing enrollees for errors on Slide 22. Any health care provider or health care facility that has or has had a contractual relationship with a plan or issuer to provide items or services under such plan or insurance coverage must submit provider directory information to a plan or issuer at a minimum at the beginning of the network agreement with the plan or issuer, at the time of termination of a network agreement with a plan or issuer, when there are material changes to the content of the provider directory information at the provider or facility, upon request by the plan or issuer, and at any other time determined appropriate by the provider facility or HHS.

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Continuing on with this requirement of improving provider directories and reimbursing enrollees for errors, any health care provider or health care facility that has or has had a contractual relationship with a plan or issuer to provide items or services under such plan or insurance coverage must also reimburse enrollees who relied on an incorrect provider directory and paid a provider bill in excess of the in-network cost sharing amount.

So that wraps up the descriptions of each of the requirements that we will be going through today, but something else that's important to note with regards to enforcement is that under the statute, CMS will enforce a provision with respect to the applicable regulated parties if CMS determines that a state is not substantially enforcing that provision.

This can occur, for example, when a state lacks the ability to enforce or request that CMS enforce one or more provisions. And prior to January 1, 2022, CMS will publish a list by state of provisions that CMS will enforce.

And then on Slide 25, you will note that there is a list of resource hyperlinks to go along with this high level overview. And this will provide additional details that you may be looking for to complement this presentation.

And then on Slide 26, we have a list of definitions particularly relating to no balance billing for out-of-network emergency services. I won't go through all of them, but I will note a couple, starting with the definition of non-participating emergency facility, which is defined as an emergency department of a hospital or an independent freestanding emergency department or a hospital with respect to post-stabilization services that does

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not have a contractual relationship directly or indirectly with a group health plan or group or individual health insurance coverage with respect to the furnishing of an item or service under the plan of coverage.

Also, non-participating provider is defined as any physician or other health care provider who does not have a contractual relationship directly or indirectly with a group health plan or group or individual health insurance coverage with respect to the furnishing of an item or service under the plan coverage.

And then there's some additional definitions as it relates to ensuring continuity of care when a provider's network status changes on Slide 28. And I'll go through these two to cap off the definitions.

So continuing care patient is defined as an individual who one, is undergoing a course of treatment for a serious and complex condition from the provider or facility or is undergoing a course of institutional or inpatient care from the provider or facility, is scheduled to undergo non-elective surgery from the provider, including receipt of post-operative care with respect to such surgery, is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility or was determined to be terminally ill and is receiving treatment for such illnesses from the provider or facility.

And then on Slide 29, we do have definitions for serious and complex conditions. But as I said before, you all can feel free to go through this PDF and see how those definitions relate to the requirements themselves.

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That concludes this presentation. We will now be moving into the Q&A portion of today's call as I have a few colleagues here who are subject matter experts in various portions of the PHS Act. So, we will do our best to answer your questions, and I will now open the floor.

Dr. Freund: Operator, can you open up the floor for questions?

Coordinator: Thank you. We will now begin the question and answer session. If you would like to ask a question, please press star 1. If you would need to withdraw your question, press star 2.

It does take a few moments for the first questions to come through. Our first question today comes from (Tracy Peone). Your line is open.

(Tracy Peone): Hello?

Coordinator: Hello. Go ahead, please.

(Tracy Peone): Hi. I have a question regarding how we are going to be required to do a pre-estimate if we don't know the complexity of the service that's going to be provided. We're primary care.

Samuel James: So, thank you, Ms. (Peone), for your question. This is Samuel James here. I have some colleagues from the Consumer Support Group here, I think, and hopefully they'll be able to answer your question regarding the estimate.

(Tracy Peone): Thank you.

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(Jamie Hermansen): Hi. This is (Jamie Hermansen) with the Consumer Support Group. I think there were discussions in the preamble language about certain, you know - about possible ways to approach developing a good faith estimate.

I think we also talked about, you know, the development of an updated, you know, of a new good faith estimate once the individual has been in situations where an update - where a new good faith estimate may need to be developed once the patient has been evaluated.

So, I would recommend if you haven't already, taking a look at some of that discussion in the preamble. That may be helpful.

(Tracy Peone): All right. Thank you.

(Jamie Hermansen): You're welcome.

Coordinator: The next question is from Barb Clott and please state your organization.

Barb Clott: I'm with Christian Horizons. My question is, do these regulations, are they applicable to skilled nursing facilities? We're not emergency and in many cases not urgent.

Samuel James: Samuel James here. Thank you, Ms. Clott, for your question. Kelly or (Dave), do you want to take that one?

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Kelly O'Brien: Hi. This is Kelly. I'm going to have to defer to (Dave) or (Kai) or we may have to take that question back.

(Dave): Yes. I'm on the line. I was on mute, so I apologize for that. But the requirements under which services provided by a non-participating provider in a participating facility apply to the following types of facilities, a hospital, a hospital outpatient department, a critical access hospital, or an ambulatory surgical center.

Kelly O'Brien: Although, I think if we can just clarify, was the question broadly about kind of all of the No Surprises Act requirements or specifically the balance billing provision?

Barb Clott: All of the Surprise.

Kelly O'Brien: Yeah, I do - I'm not sure, (Jamie) or if anyone from Consumer Support Group is on because I do think that the good faith estimate provisions apply more broadly.

So, I don't know, (Jamie) or someone on the Consumer Support Group side if you can chime in with applicability there.

(Jamie Hermansen): Hi. This is (Jamie Hermansen) again. Specifically, regarding the provisions for the uninsured good faith estimate, underinsured or self-pay good faith estimate, I would refer you to the definitions of health care provider and health care facility that are included in our regulations as well as the discussion on the preamble related to those.

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(Tracy Peone): Okay. So, I think you're saying there are some sections that do, but the specific notice and other requirements by interpretation, is that correct?

(Jamie Hermansen): At this point at least for me - this is (Jamie) again. I'm unable to speak to the other provisions beyond the good faith estimate for an uninsured. I would need to defer to my colleagues.

Kelly O'Brien: And I will say for this one that kind of crosses a couple of different policy areas - this is Kelly O'Brien again. It may be helpful to send your question in to that email address that I think Samuel had referenced, provider_enforcement@cms.hhs.gov and then we can kind of give, you know, a more comprehensive response to this question.

And you can also if we send a response and there are follow-up questions, you know, we can certainly, you know, have that back and forth.

(Tracy Peone): Perfect. Thank you.

Dr. Freund: Do we have additional questions in queue? Do we have additional questions in queue?

Coordinator: Thank you. The next question comes from (Francis Petshauer). Your line is open.

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(Francis Petshauer): Thank you. I'm with (MB Admin). We are a multi-specialty billing company and deal primarily with hospitalists who treat patients with pulmonary critical care type conditions.

Are the payers going to be required to pay automatically in situations where we are non-participating providers and have no knowledge of what the patient's insurance is at the time that we're seeing them?

Samuel James: Hi, Samuel James here again. Thank you for your question. (Dave) or Kelly, would you like to provide some input on her question?

(Dave): This is (Dave). If you can maybe restate the question? Is it a question of whether or not the - I wasn't quite sure I understood the question?

(Francis Petshauer): Okay. So, here's the scenario. I work for a group of hospitalists who work in a closed ICU unit. The hospital has a contract with the critical care doctors in the group to see the patients in the unit. We have to see every patient in the unit. We can't pick and choose based on insurance.

If we see a patient who has an insurance that we are non-participating providers for, we submit the claim to the insurance that we're not contracted for, is the insurance going to automatically process and pay the claim under and in-network reimbursement?

Because the problem is we don't know when we go into the hospitals who these patients even have insurance with. And are we going to be required to carry these consent documents for them to sign, for the patient to sign? And a

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lot of times our patients are not even able to communicate with us because they're intubated.

(Dave): Right. Right. Your question is fairly fact specific so I apologize. But I'm going to ask you, as we did for one of the previous persons who raised a question, to the send your question in and we'll take a careful look at it and be sure to get you a response.

(Francis Petshauer): I sent it two days ago. When can I anticipate a response because I'm also the company compliance officer and we're trying to write our 2022 compliance plan.

(Dave): Understood. Understood. And we will get to it as soon as we possibly can.

(Francis Petshauer): Okay. All right. And then the second part of that is the way I interpret this, it says no surprise billing. But there's verbiage in the presentation that would indicate that we can bill in-network charges for non-network services.

(Dave): Right, surprise billing is kind of a term that's used in the regulations and the statute to indicate situations where an individual sees an out-of-network provider unbeknownst to the patient that the provider or perhaps in some instances a facility is out-of-network. And in instances where that happens, the individual can still be billed. They just can't be surprised billed.

So essentially what that means is that because they have an expectation that they're seeing a network provider, they can only be billed for cost sharing that

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approximates their in-network cost sharing, and they're prohibited from being balance billed.

(Francis Petshauer): So, I guess my question then is when you say cost-sharing, is that their deductible, co-insurance or co-pay?

(Dave): Yes. Cost-sharing is something separate and different from balance billing. They could still be responsible for cost-sharing, as you say, deductibles, co-insurance, co-payments. But it would only be for what they would pay approximately if they were to have received in-network care and they cannot be balance billed.

(Francis Petshauer): That makes about as much sense as a \$3 bill.

(Dave): Well, again, the reason for is that, you know, these individuals are...

((Crosstalk))

(Francis Petshauer): Okay. So, let me give you a scenario. Non-participating provider, inpatient contracted facility. The non-participating provider is not contracted. In a normal environment, the insurance company would reimburse at say \$75. So, can we bill for the \$75 hour, or can we bill for, let's say, a \$10 copay?

(Dave): Right. Assuming the individual has coverage, but you are out-of-network for that individual's coverage, you could charge the individual or the individual could only be responsible for the co-pay that they would pay if you were an

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in-network provider. And in terms of what the insurance company or the plan would pay the provider, that's kind of dictated by a different process.

(Francis Petshauer): Okay. Where does that process come into play? Because I can honestly see this being an absolute total gravy train for insurance companies because to be totally in this - the patient has totally been taken out of the scenario.

(Dave): Right. And in the July 1 rules that we published...

((Crosstalk))

(Francis Petshauer): ...toward the \$10 copay.

(Dave): In the July 1 rules that we published, it dictates the process for the amount that the provider would get reimbursed by the plan or issuer in these instances. And there's a number of different ways that could be resolved.

If there's an all payer model agreement or a specified state law that determines the amount that the plan or issuer would pay the provider, then that method would dictate. If there's not either an all payer model agreement or a specified state law that would determine that amount that the non-participating provider would be get paid, it could be done either by negotiation between the two parties.

And after a 30 day open negotiation period if the two parties cannot resolve on the amount to be paid, either party could initiate, under the federal process, an independent dispute resolution process under which an independent dispute

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resolution entity would make a determination as to how much a non-participating provider would get paid by the plan or the issuer, and that whole process is set forth in the July 1 regulation.

(Francis Petshauer): So, once we submit the claim to the payer, that 30 day negotiation starts from the date they process the claim or the date of service? Because that's not made clear in the regulation either.

(Dave): The 30 day period starts - the 30 open negotiation period starts from the day that the plan or issuer, and this is all set forth in the regulations, either makes an initial payment or sends a denial of payment and that's when either party can initiate the negotiation process.

(Francis Petshauer): Okay. So, it's 30 days from the date of denial or initial payment.

(Dave): Right.

(Francis Petshauer): Okay. That clarifies. Thank you so much. I appreciate it, and I will await an answer to my question I emailed.

(Dave): Okay. Very good. Thank you.

Coordinator: Thank you. And the next question comes from Eileen Connelly. Your line is open and please state your organization.

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Eileen Connelly: Hi. I'm with Eastern Pennsylvania Endoscopy Center. As far as a good faith estimate goes, from what I've been seeing only out-of-network providers have to provide that, except for the uninsured. Am I correct on that?

Samuel James: Hi, Ms. Connelly. This is Samuel James again. Thank you for your question. I look to one of my colleagues at the Consumer Support Group to get to that question on the good faith estimate.

(Jamie Hermansen): Hi, this is (Jamie Hermansen) again. The regulations that were included and the provisions included in the regulations that were issued as the interim final rule in October were specifically related to uninsured and self-pay individuals.

We are in the process and as part of that rule, we also indicated that additional information will be provided as well as requirements related to good faith estimates where an individual is insured. So, there will be more to come on that.

Eileen Connelly: So, at this point we're just to give good faith estimates to uninsured self-pay patients until we hear more.

(Jamie Hermansen): Those are the requirements that have been released.

(Dave): Now those are the requirements under the October regulations. In the regulations that were published in July, which deal more specifically with the No Surprises Act provisions, there is a requirement for notice and consent in

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instances where an individual, you know, or the provider is out-of-network and for example the person went to an in-network facility.

And in order to balance bill that individual, the provider would have to gain the individual's consent to do that. And as part of that consent process, the provider has to include a good faith estimate of the cost as well. So that's kind of a good faith estimate in a different context, but that applies as of July 1, 2022, and that applies to insured individuals.

Eileen Connelly: For out-of-network providers. So, in other words, we mostly see in-network. So, at first, I thought we were going to have to give good faith estimates to all our patients. But if we're in-network with their insurance, we don't have to do that?

(Dave): Right. With regard to the provisions in the regulations that were published on July 1, the good faith estimate that's discussed in those regulations, which again, kind of kick in when an individual is going to be seen by an out-of-network provider, that only applies - those specific regulations apply to individuals who are insured.

And those good faith estimates, to the extent a provider is seeking consent to be able to balance bill the individual, those apply to insured individuals and they do apply as of 1/1/22.

Eileen Connelly: Okay. So out-of-network providers, I think that's what you're saying, right?

(Dave): Yes. Yes.

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Eileen Connelly: Thank you so much. Thank you.

Kelly O'Brien: Hi. This is Kelly. I did just want to see if we can get an announcement made about how to ask a question. I did see an email come in asking for clarification on how to get into the question queue. So, operator, do you mind repeating or sharing the instructions for getting into the question queue?

Coordinator: Absolutely. It is star 1 if you would like to ask a question. Once again, star 1 and you will be prompted to record your name. It is star 2 if you would like to withdraw your question.

Kelly O'Brien: Thank you.

Coordinator: Our next question comes from - you're welcome. Our next question comes from Ron Campbell. Your line is open.

Ron Campbell: Hi there. Good afternoon. Thank you for the call today, I'm looking specifically at the estimates piece as it relates to our self-pay patients.

We're a medium sized multi-specialty group, and we're reviewing this with our legal counsel. The problem that we're running into and that we're envisioning is when you have a patient that you schedule, at the time of service the patient has insurance. They have coverage, and they schedule their appointment for several months out, possibly a year out if it's their physical.

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In the interim, between the time you scheduled the appointment and the time the patient physically arrives, they have changed coverage or they've lost coverage, so now they qualify as a self-pay patient. But the problem that we have is we don't know that.

And we can't find any provisions in the statutes for an allowance when a patient arrives unexpectedly, now qualifying as self-pay, and from my counsel's point of view and mine as well, it would appear that we're going to have to turn the patients away and reschedule them because we can't find any area where they have the ability to waive their right to receive an estimate.

There seems to be a lot of unintended consequences in this. Are we reading this correctly?

(Jamie Hermansen): Hi. This is (Jamie Hermansen) again. This would be a great question if you would be so kind as to send it in to the provider enforcement email address, and then we can take a look at it and get back to you. So again, that's provider_enforcement@cms.hhs.gov.

Ron Campbell: I'll do that. Is there any provision or review being made for some of the cost of doing this? We're looking at this. We've got about 500 providers in our group and see about a million patient visits a year.

The cost of having to mail estimates via the U.S. Postal Service to patients who don't have - who are not signed up on our patient portal, the man hours to send those out and everything else just dealing with the self-pay patients, and

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the prospect of having to do it for all patients down the road is really starting to send shock waves through the provider community that I've spoken with.

And just the sheer cost of trying to comply with the estimate piece of this, it seems very easy when you're doing it for surgeries, but to the point of the caller earlier, when a patient is coming in for a primary care visit, we have no way of knowing until the patient gets here level of service, other procedures the patient might request when they get here, like a mole removal in addition to their original scheduled visit.

And it's putting us into a spot of having to schedule more visits down the road and increasing the cost of care trying to comply with the estimate piece. And it just feels like trying to apply this into the physician's office is a square peg in a round hole, and it's causing an enormous amount of problems to try to operationalize this.

(Jamie Hermansen): We do appreciate the additional feedback. And you're welcome to provide, you know, additional context to your questions, you know, when you submit your question to our resource email address please. We'd be interested in all of that information.

Ron Campbell: Okay. Thank you very much.

(Jamie Hermansen): You're very welcome. Thank you.

Coordinator: The next question comes from Paul Andrews and please state your organization.

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Paul Andrews: Thank you very much, I appreciate the opportunity. I'm from Andrews Billing Solutions. I may have a two part question depending on the answer to part one, which is in private practice chiropractic offices, does any of this Surprise Act, are they governed by it in any way?

Samuel James: Hi, Mr. Andrews. This is Samuel James. Kelly or (Dave), would one of you want to speak to the applicability of this legislation to chiropractic practice?

(Dave): The definition of provider in the regulations is pretty broad so the answer is yes. Kelly, did you have anything to add?

Kelly O'Brien: No. No. Thanks.

Paul Andrews: Okay. So, I'll move on to another part of the question then, which is in the regulations it states health care facility, but chiropractic offices are not defined as facilities. So, I'm trying to figure out what piece does chiropractic actually play relative to this act?

(Dave): For example, if an individual comes in to seek services from a chiropractor, I believe the good faith estimate provisions would apply. Also, the provisions of some of the other notification provisions. You know, to the extent - I think you are correct that a chiropractic office would not be a health care facility.

So, you know, to the extent a chiropractor is practicing in their facility, the whole regime of provisions that occur when an individual, you know, seeks care from an out-of-network chiropractor at, for example, an in-network

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chiropractic facility, those specific provisions would apply but some other ones would.

((Crosstalk))

(Jamie Hermansen): Hi. This is (Jamie Hermansen). I would also refer you out to the definitions of health care facility and health care provider in the regulations.

(Dave): Right.

Paul Andrews: Yes. I did review those. So, I just wanted to be sure, of course, like everyone else that - so the good faith estimates for, let's say, a chiropractor who's out-of-network, but the group is in-network seem to apply.

(Jamie Hermansen): I think related to whether or not, you know, in-network or out, the regulations that we have released as part of IFR - from the interim final rule in October apply to uninsured or self-pay individuals.

So, questions regarding whether or not something would apply, whether, you know, GFE provisions for those that are uninsured, which would be those where, you know, if they were in-network or out-of-network, in those particular instances we will have - you know, more information will be forthcoming. We have not yet issued rules or regulation specific to those provisions yet.

Paul Andrews: Great. Thank you.

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Coordinator: Thank you. And the next question is from Mary Thomas. Your line is open and please state your organization. Mary Thomas, your line is open. Do you have your mute button on?

Mary Thomas: Hi. Can you hear me now?

Coordinator: Yes. Thank you.

Mary Thomas: Okay. Thank you. I'm with Boys Town, and I just had a question in reading the regulations and the interpretations. Can you clarify, does the good faith estimate need to be provided to all self-pay, or when they're choosing not to use their insurance and have it paid? So, they have coverage, but they're opting not to have a claim filed for all services or only upon the request of the patient?

(Jamie Hermansen): And the good faith estimate requirements for uninsured self-pay individuals would apply if an individual schedule, you know, an item or service or upon request.

Mary Thomas: So, both situations. So, if they schedule something, we have to provide a good faith estimate for what they're scheduled for.

((Crosstalk))

(Jamie Hermansen): You may also want to take a look at the preamble language. Yes, definitely consider taking a look at the preamble language if you haven't already done so. There is discussion regarding more situations, you know,

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regarding the provision of estimates, so when the items and services are scheduled as well as when they're requested.

Mary Thomas: Okay. And then you keep stating that there'll be more rules that will be forthcoming. Do we have an estimate? Those would not be something we are required to be compliant with by January 1, I would assume?

(Jamie Hermansen): I can't speak directly to that question. But again, as we discussed in the proposed rule - I mean in the interim final rule in October, we have stated that additional information will be forthcoming.

Mary Thomas: Okay. Thank you.

Coordinator: Thank you. The next question is from (Kellie Flynn). Your line is open and please state your organization.

(Kellie Flynn): Tennessee Orthopedic Alliance. A couple of questions, we work orthopedic so we do a lot of surgeries. Do we need to - we don't always notify the patient on the estimate. It is usually on the physician charge only.

But when they do need an assistant for surgery, our financial counselors don't always know there's going to be an assistant. But we are in-network, so I didn't know if we needed to start notifying the patient. There could be a charge for that.

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And also, sometimes we have physicians that work as co-surgeons for some of our spine surgeries. Do they need to be notified there could be a cost for both of those as well when we are in-network?

(Jamie Hermansen): The situations regarding in-network where insurance is involved, additional information will be forthcoming as we discussed in the interim final rule released in October.

Questions related to - if your question is actually related to the individuals who are uninsured or self-pay, then I would refer you to their regulatory provisions in the October interim final rule.

(Kellie Flynn): Okay, thanks.

Coordinator: Thank you. The next question comes from (Brandy Mayu). Your line is open and please state your organization.

(Brandy Mayu): Hello. Good afternoon. I'm calling on behalf of the (Cadian) Management Group. We are a hospital management group that oversees long-term acute care hospitals. So, from a licensing perspective, I know that we fall under that hospital category.

My question is, does this rule apply to all of the physicians that are coming around or see patients while they are inpatient in our hospital? We don't employ these doctors. We don't have contracts with these doctors. These are just doctors that are on our medical staff that are coming in as either

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pulmonology, internal medicine, infectious disease type doctors, again seeing patients from an inpatient perspective in our setting.

Does it apply to all of those physicians, or does it only apply to there's a few select physicians throughout all of our hospital long-term acute care hospitals that we perform Part B billing for? So again, that does not apply to all of our providers and staff, just a selection that we do Part B billing for.

(Jamie Hermansen): Hi. This is (Jamie Hermansen) again. I believe the question is kind of like are you asking about Medicare, Medicare patients or is your question related to those who are uninsured or self-pay?

(Brandy Mayu): Well, I mean, my question would be for those that are on it - well, we don't take uninsured patients. So, they are either - I know this doesn't apply to Medicare-type patients. But we take the insured patients, you know, so your patients that are Blue Cross, Humana, et cetera.

But we don't know the doctors that are rounding on these patients. We don't know if the patient falls in their network or out of their network because the providers are not employed by us.

(Jamie Hermansen): Understood. Again, the information and the requirements that have been released are specific to uninsured for uninsured - good faith estimates for those that are uninsured or self-pay. Additional information will be made available in the future regarding how good faith estimates apply when an individual is insured.

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(Brandy Mayu): Got it right. All right.

Kelly O'Brien: This is Kelly. I do want to see, (Dave), if you could chime in here because I do think there may be a piece from the interim final rule that was published in July related to balance billing that may be applicable here.

(Dave): Yes. Thank you, Kelly. Sure. If an individual is, you know, getting services from an out-of-network provider at an in-network facility, then the no surprise provisions apply in that unless that out-of-network provider gives notice and consent to treat the person, and the individual, of course, you know, signs that notice and consent in a manner that's consistent with the regulations, then that provider cannot balance bill the patient.

So, the NSA provisions in that context would apply not just to patients that do - or, you know, it's not a question of whether or not the facility is handling some part of the issues for them. It's a question of whether the patient has private insurance, and whether they are in a facility seeking care or getting care from an in-network facility from an out-of-network provider.

(Brandy Mayu): Okay. The in-network facility piece, I understand that out-of-network provider piece because again, we don't employ these providers. They're just on our medical staff and they're rounding.

So, the physicians, prior to seeing the patients, they're not asking for their insurance information to denote if their payer plan is in or out-of-network.

(Dave): Well would these providers be independently billing the patient independent of the facility?

(Brandy Mayu): Yes, yes, yes.

(Dave): Yet they don't ask the patient whether or not they're insured and who their insurer is?

(Brandy Mayu): Well they get a copy. They get a copy of the patient's face sheet of their hospital - their long-term acute care face sheet. And they take that to their offsite billing company. What they do with that and how they bill for that physician that has nothing to do with our long-term acute care entity.

(Dave): Okay, but yes, just if the provider themselves, if the entity - if the provider wants to be able to balance bill the patient, whether doing it himself or whether doing it through, you know, some billing company that he contracts with, you know, he has to comply with the provisions.

And so, you know, if either the provider or the billing company on behalf of the provider wants to balance bill that patient, the consent and the good faith estimate have to be provided.

(Brandy Mayu): Okay. All right. Thank you.

Kelly O'Brien: This is Kelly O'Brien. I did just want to chime in that we are at 2:58. So I think we may have time for one last question. And I think that the next question will have to be the last one. Operator?

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Coordinator: Thank you. Our next question comes from (Sonia) from Stanford Health.
Your line is open.

(Sonia): Yes. Hi. Can you hear me?

Samuel James: Yes.

(Sonia): So, I have two questions. So post-stabilization, if the patient refuses to sign the consent form, what are we to do? I mean, are we informing the insurance that the patient did not sign the consent form or are we treating it or is this the provider's call?

And my second question is we also have a walk-in center. How are we to give a good faith estimate in that scenario?

(Dave): Okay. Let me take the first question first. You know, there's never a requirement, at least under our rules, you know, once the patient is stabilized, for the out-of-network provider to treat the patient.

So, in circumstances where the patient is presented with the consent form and doesn't, you know, sign the consent form, then at least under our regulations, there are no requirements or obligations on the provider to treat the patient.

Now for your second question, you mentioned a walk-in facility?

(Sonia): Yes. A walk-in center, yes.

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(Dave): Okay. Is that like when you use that term, are you referring to like an urgent care center or, you know, something of that nature?

(Sonia): Yes.

(Dave): Okay. I would again refer you to the regulations and the definition of facility in the regulations.

(Sonia): Okay. So, if it is one which - I do remember reading it where it says that urgent care, if it qualifies as an ER then yes, then the ER thing applies, so then obviously you're not giving until the patient is stabilized. But we also see patients who, you know, instead of going to the ER, it's not an emergency situation, but they would walk in.

So, there is no emergency situation, but they're walking in on, say, Saturday or Sunday. They don't want to go to the hospital. They just come in for sore throats for example.

(Dave): Right. And also, a lot depends, too, on whether the care they're receiving qualifies as emergency care, and it sounds like from what you're describing in a lot of situations, it would not. You know, prudently a person would not think that they are in an emergency situation. So, the emergency care provisions may not apply under those circumstances if it's not emergency care.

(Sonia): Right. So then does the - do we have to give them, you know what, GFE?

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(Dave): (Unintelligible).

Kelly O'Brien: (Jamie), are you still on? Do you want to chime in on the good faith estimate question?

(Jamie Hermansen): I am. Yes, I'm still on. Regarding the good faith estimate, again, if the individual is uninsured or self-pay then I would refer you to the definitions we included in our regulations for a health care provider and health care facility.

Those would be helpful in terms of determining whether or not as a, you know, provider facility if these requirements apply. And if your question is regarding individuals, whether insured, where insurance is involved, again, information will be forthcoming.

(Sonia): Okay. So, for non-emergency situation - I'm sorry. I'm still not clear for non-emergency situation. We understand for emergency situation what provisions apply, but for non-emergency situations we are - it's our call? Like, you know, it's a provider's call how to treat the patient? Or do we have to have that three hour window and say, wait, here's a good faith estimate. Please sign this and then three hours later, we treat the patient?

(Jamie Hermansen): In terms of the time frames, again, our interim final rule discuss requirements for when, you know, a good faith estimate must be provided and the time frames in which they're required.

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So, you may want to, if you haven't already, take a look at the time frames of exactly of when that information needs to be provided to the consumer, again, in the context of an uninsured.

(Sonia): So, it is three hours. So, it is three hours before unless it's a scheduled appointment. So, the provision is three hours before the service if the patient does not make an appointment or is walking in or non-emergency situation.

So that would be a pickle for all of us. I mean, you're going to give them the estimate and have them wait for three hours.

(Jamie Hermansen): Again, I would refer you to the provisions in the regulation for additional information.

((Crosstalk))

Kelly O'Brien: So, this is Kelly. I am going to also - if their response doesn't seem like it completely covered the question, I would encourage you to submit it to that provider_enforcement@cms.hhs.gov mailbox, and we will work to kind of give a more robust response in writing.

And I do want to take this moment to thank everyone for their participation in the call. It was really helpful to hear the questions that folks have.

We will be taking these questions back, continuing to monitor the mailbox and, you know, providing additional resources for the provider community,

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including possibly some frequently asked questions in line with some of the things that we're hearing today.

So, thank you all again. We appreciate you joining the call, and I don't know, Gene, is there anything else before we wrap the call?

Dr. Freund: There is nothing else other than I'll add my thanks and thank you very much CCIIO colleagues for joining the call and for the audience for being interested in this.

And please stay tuned. We're just scratching the surface as you can tell. And that ends the call.

Coordinator: Thank you. That concludes today's conference call. Thank you for your participation. You may disconnect at this time.

END