Centers for Medicare & Medicaid Services

Special Open Door Forum:

No Surprises Act Deeper Dive into Other Surprise Billing Protections

Moderator: Dr. Gene Freund

February 23, 2022

2:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time all participants are in listen-only mode. After the presentation we will conduct a question-and-answer session. At that point if you would like to ask a question please press Star and then 1. I'd 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. Gene Freund. You may begin.

(Gene Freund): Hi and thank you all for attending this Special Open Door Forum. It's another in our continuing series of ones devoted to helping you the practitioner and provider community get up to speed on the No Surprises Act.

And I'm quickly going to make the usual reminder, which is this call is not for the press. If you are press you're welcome, like everybody, to attend but if you have press questions contact press@cms.hhs.gov. You probably already know the drill, and they can help you.

And the other thing is this is being recorded. And let us know if you don't - if you object to being recorded then please don't ask a question. And that's basically it.

I want to turn this one over to Samuel James, who will begin talking about some of our additional other surprise billing protections under the No Surprises Act. So, go ahead Samuel.

(Samuel James): Thank you Dr. Freund. Again, this is Samuel James. I'm a member of the Provider Enforcement Team with CCIIO, the Center for Consumer Information & Insurance Oversight.

Today we're going to be going over the No Surprises Act continuity of care provider directory and public disclosure requirements. A link to this was provided in the invite that was sent out, and you can also find it at cms.gov/nosurprises. And then from there you can click on Provider Resources and then other Surprise Billing Protections PDF.

So, if you all would like to use that to follow along my colleague (Ryisha Conway), as we go through this presentation we'll try our best to reference the slides that we're on for your information. So, we'll get started.

We'll start with the agenda on Slide 2. So, we'll start with the background on the No Surprises Act training series, continuity of care requirements, provider directory requirements, public disclosure requirements, and then we'll finish off with some questions.

Just to preface the detailed information, we've got a couple of legal disclaimers here. So first, 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.

This 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 other interpretive materials for complete and current information.

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. This communication was printed, published or produced, inseminated at the US taxpayer expense.

Getting started on background on the No Surprises Act Training Series, just for an overview of the No Surprises Act that first. The No Surprises Act was introduced, it introduced new requirements for providers, facilities and providers of air ambulance services to protect individuals from surprise medical bills.

These requirements one, 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 individuals cost sharing amounts, i.e., balanced billing in certain circumstances.

Two, these requirements require providers and facilities to provide good faith estimates of charges for care to uninsured or self-pay individuals upon

scheduling care or on request. And for individuals with certain types of coverage just to make good faith estimates to individuals, plan or issuer.

These requirements also create a patient provider dispute resolution process for uninsured or self-pay individuals to contest charges that are substantially in excess of a good faith estimate. These requirements require certain providers and facilities to publicly disclose restrictions on balance billing and limit billed amounts in situations where providers network status changes mid-treatment or individuals to act on inaccurate provider directly information.

On Slide 7 we have the scope of individuals protected under the No Surprises Act. Beginning on January 2, 2022 these No Surprises Act requirements will apply to items and services provided to most individuals enrolled in private or commercial health coverage like employee based group health plans, both self-insured and fully insured, individual group health coverage on or outside the federal or state based exchanges, Federal Employee Health Benefit, FHHB, health plans, non-federal government plan sponsored by state and local government employers, certain church plans within IRS jurisdiction, and student health insurance coverage as defined at 45 CFR 147.145.

Continuing on with the scope of individuals protected under the No Surprises Act. 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, Health Care or TRICARE. These programs have other protection against high medical bills. The protections also don't apply to short term limited duration insurance accepted benefits or retiree only plans or account based group health plans.

So, on Slide 9 we have a No Surprises Act training series which is intended to educate providers and facilities on these major provisions of the No Surprises Act. This slide gives you an outline and a summary of each provision in the training series as well as the statute and regulatory citations. And you'll notice that the focus of today's presentation is both bolded and has an asterisk next to them for your reference.

Starting on Slide 10 where we'll be getting started with the continuity of care requirements. And I'll pass it over to my colleague (Ryisha Conway). (Ryisha)?

(Ryisha Conway): Thank you Samuel. So, moving on to Slide 10 for continuity of care requirements. We want to go ahead to Slide 11, Overview of the No Surprises Act's Continuity of Care Requirements.

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

For the continuing care patient, whose providers or facilities contract termination, leads to a change in network status the plan or issuer must one, timely notify each individual enrolled who is a continuing care patient of termination and their right to elect continued transitional care from the provider or facility.

Two, provide each individual enrolled who is a continuing care patient an opportunity to notify the plan or issuer of the need for transitional care. And three, permit the continuing care patients who elect to continue to have the same benefits provided under the same terms and conditions as would have applied under the plan or coverage had the termination not occurred with respect to the course of treatment furnished by the provider or facility.

And continuing with the overview of the No Surprises Act's continuity of care requirements, the election may last until the earlier of 90 days started on the date their plan or issuer notifies them of the change in network status or the date on which such individual is no longer a continuing care patient with the provider or facility.

In this situation the No Surprises Act requires that a continuing care patient's treating provider or healthcare facility must accept payment from the plan or issuer and cost share from the individual for items and services as payment in full or continue to adhere to all policies, procedures and quality standards imposed by the plan or issuer for an individual as if the termination hadn't occurred.

We will review what each of these terms mean throughout the presentation. Note the departments anticipate issuing future rule-making implementing requirements for the No Surprises Act provision. So, moving on to Slide 13.

Scope of providers and facilities that must comply with the No Surprises Act continuity of care requirements. The No Surprises Act continuity of care requirements apply to healthcare providers and healthcare facilities.

The statute doesn't exempt any categories of providers or facilities from this requirement. Though note the departments anticipate issuing future rule-making implementing requirements for this No Surprises Act provision.

Slide 14, scope of individuals considered continuing care patients. Continuing care patients are defined as individuals who with respect to a provider or facility are at least one of the following.

One, undergoing treatment from the provider or facility for serious and complex condition defined as A, in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm, B, in the case of a chronic illness or condition, a condition that is I - I'm sorry one life-threatening, degenerative, potentially disabling or congenital. And two, require specialized medical care over a prolonged period of time.

So, we are now on Slide 15, continuing the scope of individuals considered continuing care patients. So, two, undergoing a course of institutional or inpatient care from the provider or facility; three, scheduled to undergo non-

elective surgery from the provider or facility including receipt of post-operative care from such provider or facility with respect to such a surgery; four, pregnant and undergoing treatment for pregnancy from the provider or facility; or five, terminally ill and receiving treatment for each illness from the provider or facility. So please note the department anticipate issuing future rule-making implementing requirements for this No Surprises Act provision.

We are now on Slide 16, when continuing care patients are eligible for continuity of care protections under the No Surprises Act. Protections apply for continuing care patients who are receiving covered services or items from a treating provider or a healthcare facility. And their training provider or a healthcare facility experiences a change in network that status due to one of the following.

The provider or healthcare facilities contractual relationship with the individual's plan or issue or is terminated, the provider or healthcare facilities terms of participation in the plan or coverage change resulting in a termination of benefits with respect to the provider or a healthcare facility, a group health plans contract with the health insurance issuer offering health insurance coverage in connection with the plan is terminated resulting in a loss of benefits provided under each plan with respect to the provider or healthcare facility.

So, continuing with continuing care patients that are eligible for the continuity of care protections. Terminated is defined as, with respect to a contract, the expiration or non-renewal of the contract but does not include a termination of the contract for failure to meet applicable quality standards or for fraud. So

again, noted on this slide and others, the departments anticipate issuing future rule making implementing requirements for this No Surprises Act provision.

So now we move into a knowledge check. I'm now on Slide 18 for those of you who are following along. Joan is a 30-year-old female who is insured through her employer. She is 30 weeks pregnant and following up with her obstetrician regularly.

At her next visit Joan is told that her obstetrician no longer maintains a contract with her insurer due to the obstetrician voluntarily not renewing her contract. Would continuity of care protections apply to Joan with respect to her obstetrician?

So, we're now on Slide 19. And the answer is yes, continuity of care protections would apply to Joan with respect to the obstetrician as the contract between the obstetrician and the plan was terminated for reasons other than failure to meet applicable quality standards or for fraud.

In scenarios where a contract is terminated due to failure to meet quality standards or fraud continuity of care protections wouldn't apply. In this example, Joan meets the standard for continuing a care patient since she is pregnant and undergoing treatment for pregnancy from the obstetrician. As a result, she is eligible for continuity of care protections because she is receiving coverage services from a treating provider who has since been terminated from her plans network.

So now we're on Slide 20, effective date of continuity of care requirements. The No Surprises Act continuity of care protections apply to services furnished in plan years beginning on or after January 1, 2022.

Rule-making implementing this provision of the No Surprises Act won't be published until after January 1, 2022. Any rule-making to implement continuity of care requirements will include a prospective applicability state date provides plans, issuers, providers and facilities with a reasonable amount of time to comply with new requirements. Providers and facilities are expected to implement the requirements using a good faith reasonable interpretation of the statute prior to issuance of rule-making.

So, we are now on Slide 21, and the topic is provider directory requirement. Overview of the No Surprises Act provider directory requirements, under the No Surprises Act providers and healthcare facilities must generally one, refund enrollees amounts paid in excess of the in-network cost sharing amounts with interest.

If the enrollee has inadvertently received out of network care due to inaccurate provider directory information the provider or facility billed the enrollee for an amount in excess of in-network cost sharing amounts and the enrollee paid the bill or maintain business processes to submit provider directory information at specified times to support plans and insurers in maintaining accurate up-to-date provider directories.

Now on Slide 23, continuing the overview of the No Surprises Act provider directory requirements. A provider is permitted to require as part of the terms

of a contract or contract termination with the plan or issuer that the plan or issuer, one, remove the provider from the directory at the time of termination of contract, two, bear financial responsibility for providing inaccurate network status information to an enrollee as applicable. So again, here's a note, the department anticipate issuing future rule-making implementing requirements for this No Surprises Act provision.

Slide 24, scope of providers and facilities that must comply with the No Surprises Act provider directory requirements. The No Surprises Act provided directory requirements applies to healthcare providers and healthcare facilities.

The statute doesn't exempt any categories of providers or facilities from this requirement. And please note again the department anticipate issue in future rule-making implementing requirements for this No Surprises Act provision.

Moving on to Slide 25, provider business processes to support accurate directory information. At a minimum providers and healthcare facilities must submit provider directory information to a plan or issuer; when the provider or a healthcare facility begins a network agreement with a plan or issuer with respect to certain coverage; when the provider or healthcare facility terminates a network agreement with the plan or issuer with respect to certain coverage; when there are material changes to the content of provider directory information of the provider or healthcare facility; at any other time, included upon the request of plan or issuer, determined appropriate by the provider, healthcare facility or the Secretary of Health and Human Services.

Slide 26, provider business processes continued. Providers and healthcare facilities are required to have business processes in place to ensure timely provision of provider directory information to plans or issuers no later than January 1, 2022.

Rule-making to implement this requirement will not take place until after January 1, 2022. In the meantime, providers may have to work with health plans or issuers to make good faith efforts when these circumstances are reported. The department anticipate issuing future rule-making implementing requirements for this No Surprises Act provision.

Provider directory information that providers and facilities must share. We're on Slide 27 for those following along.

Information that providers and healthcare facilities provide to a plan provider directory must include names, addresses, specialty, telephone numbers and digital contact information of individual healthcare providers and names, addresses, telephone numbers and digital contact information of each medical group, clinic or healthcare facility contracted to participate in any of the networks of the group health plan or health insurance coverage involved. And the note the departments anticipate issuing future rule-making implementing requirements for this No Surprises Act provisions.

So, we come across another knowledge check on Slide 28. A pulmonologist recently began a network agreement with a new health plan. Is the pulmonologist required to submit provider directory information to the plan?

And the answer is yes, under the No Surprises Act the pulmonologist is required to submit provider directory information, i.e., the provider's name, address or addresses, specialty, telephone numbers and digital contact information to a plan or issuer when they begin a network agreement with the plan or issuer with respect to certain coverage. There are also additional circumstances when a provider must submit provider directory information to a plan or issuer.

We are now on Slide 30, cost sharing limits for services provided based on incorrect provider directory information.

Under the No Surprises Act if an individual relies on incorrect provider directory information and as a result received items or services from an out-of-network provider or out of network healthcare facility one, their plan or issuer must limit cost sharing to in-network terms that would apply had items or services been furnished by an in-network provider or apply the deductible or out of pocket maximum as if the provider or a healthcare facility were in-network; two, their provider or healthcare facility must not bill an individual more than their in-network cost sharing; a note which is on the majority of the slides the department anticipate issuing future rule-making implementing requirements for this No Surprises Act provision.

We are now on Slide 31, provider requirements for refunding individuals. If one, an individual relies on incorrect provider directory information, two, the provider submits a bill to the individual that is more than the in-network cost sharing amounts and three, the individual pays the bill the provider must reimburse the individual for the full amount paid by the individual in excess

of the in-network cost sharing amount plus interest. The interest rate will be determined by the Secretary of HHS through rule making.

So, continuing with provider requirements for refunding individuals. This requirement applies to items or services furnished based on incorrect provider directory information and plan years beginning on or after January 1, 2022.

Rule-making to implement this requirement will not take place until after January 1, 2022. In the meantime, providers may have to work with health plans or issuers to make good faith efforts when these circumstances are reporting. Note the department anticipate issuing future rule-making implementing requirements for this No Surprises Act provisions.

We are now on Slide 33, and we have another knowledge check. A cardiologist has recently terminated their practices contract with a health plan. The cardiologist asks that the plan remove the practice from the directory as part of the terms of contract termination.

Is the cardiologist permanent - permitted to ask the plan to remove their name from the directory upon contract termination? And the answer is yes, under the No Surprises Act the cardiologist is permitted to require in the terms of a contract or contract termination that a plan or issuer remove the provider's name from the directory at the time of termination of contract.

Additionally, the cardiologist is contractually permitted to require that the plan or insurer bear financial responsibility for providing inaccurate network status information to an enrollee.

And now we are on Slide 35, for public disclosure requirement. And I will turn it over to Samuel James. Thank you.

(Samuel James): Thank you, Ryisha. So, moving on to public disclosure requirements. And on Slide 36 we'll start with an overview of the required disclosures.

The No Surprises Act requires healthcare providers and healthcare facilities to publicly share written disclosures distributed through multiple methods outlining key protections. These disclosures must include information on one, the prohibitions on amounts billing for emergency or non-emergency services with which the provider or healthcare facility must comply.

Two, any state laws governing balance billing with which the provider or healthcare facility must comply. And three, these disclosures must include information on contact information for state and/or federal agencies that an individual can contact or report a suspected provider or healthcare facility violation of the balance billing protections in the No Surprises Act or state laws governing surprise medical bills.

Continuing with the overview of required disclosures, these disclosures are intended to get - to help give individuals a clear understanding of their protections under the balance billing provisions of the No Surprises Act and who to contact if they believe these protections have been violated. These disclosures - these disclosure requirements do not apply to providers of air ambulance services. However, HHS strongly encourages air ambulance providers to also make disclosures available to individuals.

On Slide 38, the scope of providers that must comply with the No Surprises Act public disclosure requirements. The following types of providers must comply with the No Surprises Act public disclosure requirements physicians, other healthcare providers acting within their scope of practice under applicable state law, for example a certified nurse practitioner or physician assistant, but doesn't include a provider of air ambulance services.

Providers aren't required to make the disclosures if the provider doesn't furnish items or services at a healthcare facility or in connection with visits to healthcare facilities. Providers aren't required to make the disclosures to individuals to whom the provider furnishes items or services if such items or services aren't produced at a healthcare facility or in connection with a visit at a healthcare facility.

Scope of facilities that must comply with the No Surprises Act public disclosure requirements on Slide 39. The following types of healthcare facilities must comply with the public disclosure requirements, hospitals including critical access hospitals, hospital outpatient departments, ambulatory surgical centers, emergency departments of hospitals and independent freestanding emergency departments.

Required methods of disclosure, under the No Surprises Act providers and healthcare facilities must share required disclosure information through three methods. One, public signage posted prominently at the provider of facilities location, for example in a central location where individuals check in pay bills, et cetera; two, posting on a public isn't easily accessible Web site

without any requirements for account sign up, passwords or payroll; and three, a one-page notice provided directly to individuals enrolled in a group health plan or group or individual health insurance coverage that must be delivered in person or by email or mail based on the individual's preference. We'll review each method on the following slides.

Continuing on Slide 41, requirements for use of public signage. Providers and healthcare facilities must publicly display disclosure information on a sign posted at a prominent location. This should be a central location like where individuals schedule care, check in for appointments or pay bills.

Requirements for posting on a public Web site, providers and healthcare facilities must post the required disclosure or link to the disclosure on a searchable homepage on their public Web site. The Web site should be free of charge and visitors should not have to do any of the following to access this Web site, establish a user account, password or other credentials, accept in terms or conditions, or submit any personal identifying information like name or email address.

On Slide 43, we have the requirements for the one page to notice. Providers and healthcare facilities must provide a written notice to individuals with a group health plan, or group, or individual market health insurance coverage as well as federal employees' health benefit plans.

This notice should be provided in person, by mail or by email as chosen by the individual. The notice should be limited to one double-sided page and must use a font size of 12 points or larger.

Providers and healthcare facilities must provide individuals with a one-page no later than the date and time when they request payment from the individual. This includes requests for co-payments or co-insurance made at the time of the visit. If payment isn't requested from an individual providers and healthcare facilities must provide the disclosure notice no later than the date the claim is submitted for payment to a health plan or issuer.

On Slide 44, we have some key exceptions to disclosure requirements. Providers that never furnish items or services in a healthcare facility or in connection with visits to a healthcare facility do not need to fulfill the No Surprises Act disclosure requirements.

Providers are only required to share No Surprises Act disclosures with individuals to whom they furnish services or items, and only in the situations where the services they provide are furnished at a healthcare facility provided in connection with a visit to a healthcare facility.

If a provider or healthcare facility does not have a publicly accessible location they are not required to publicly display these disclosure contents via signage. If the provider or healthcare facility does not have a Web site they are not required to share the disclosure content on a public Web site.

On Slide 45, we have another knowledge check. A gastroenterologist provides services at a local ambulatory surgical center three days per week. The gastroenterologist maintains a public Web site for the practice.

Question, is the gastroenterologist required to share disclosure information on the public Web site? So, the answer is yes. As a provider who furnishes items or services at a healthcare facility the gastroenterologist is required to share disclosure information on the public Web site.

Under the No Surprises Act providers and healthcare facilities must post the required disclosure or a link to the disclosure on a searchable homepage of their public Web site.

Also, a provider isn't required to share discloser information if they don't furnish items or services at a healthcare facility or in connection with visits at a healthcare facility. Additionally, a provider isn't required to share disclosure information to individuals to whom the provider furnishes items or services if such items or services aren't furnished at a healthcare facility or in connection with a visit at the healthcare facility.

On Slide 47, we have some model disclosure notices. So, HHS has issued a model disclosure notice that providers and healthcare facilities can choose to but aren't required to use. And you'll see an example there on the right.

This model disclosure notice was published as a part of CMS Form Number 10780 and is available for download here. And there's a hyperlink on Slide 47 that you all have access to. HHS has also encouraged states to develop model language to assist providers and healthcare facilities in meeting disclosure requirements related to the No Surprises Act.

On language accessibility all disclosures must use clear and understandable language. Providers and healthcare facilities are encouraged to use plain language in their disclosure notices and test the notice for clarity and usability when possible. Providers can find plain language accessibility and language access resources at www.plainlanguage.gov.guidelines.

Health care facilities must make reasonable efforts to ensure meaningful access to individuals with limited English proficiency which may include offering language assistance services like translation of written content into languages other than English.

Healthcare facilities that receive federal financial assistance must also comply with federal civil rights laws that prohibit discrimination, including Section 1557 of the Affordable Care Act, Title IV of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

On Slide 49, special rule to prevent duplicate provision of disclosures. Providers and healthcare facilities can enter into a written agreement stating that the healthcare facility is responsible for providing the one-page disclosure to individuals on behalf of both the healthcare facility and the provider in situations where the provider delivers care to the facility.

This single disclosure would need to outline restriction amount billing that apply to both the healthcare facility and the provider. If a written agreement is in place and a healthcare facility fails to provide full timely disclosure information then only the facility would be considered in violation of the No Surprises Act. Providers with these agreements should still monitor healthcare

facilities adherence to the disclosure requirements and notify the applicable state authority or HHS if there is a question of noncompliance.

On Slide 50 we have a few main takeaways. The No Surprises Act protects continuing care patients in circumstances where the treating providers or healthcare facilities plan network status changes allowing a 90-day transitional care period.

During this time health plans and insurers must limit cost sharing to in-network terms. They must also - during this time treating providers and facilities must accept cost sharing and payment form plans and issuers as payment in full.

The No Surprises Act protect individuals who inadvertently seek care from an out-of-network provider or healthcare facility after relying on inaccurate provider directory information. In these circumstances their health plan or issuer must limit cost sharing to in-network terms.

The provider or a healthcare facility must refund enrollees amounts paid in excess of in-network cost sharing amounts with interest if the provider or facility billed the enrollee for an amount in excess of in-network cost sharing amounts and the enrollee paid the bill.

Continuing with another main takeaway the No Surprises Act requires that providers and healthcare facilities publicly share written disclosures distributed through multiple methods outlining the No Surprises Act key keep protections. Please note the departments anticipate issuing future rule-making

implementing requirements related to continuity of care requirement and provider directory requirements.

So, we just ended on Slide 51, that concludes the slide deck presentation content. I will also point you to Slide 54 starting there and the subsequent slides there are a few definitions for reference such as definition of continuing cast patient or cost sharing as well as some citations in there for your reference.

I point you all there. We won't go through them today, but they are good in assisting in understanding the rest of the slides throughout this presentation. Other than that, we will take questions here in a second.

But I will also point you to the provider underscore enforcement at cms.hhs.gov email. Any questions you may have about provider requirements or provider enforcement can be directed here.

And the last thing before we get started with questions I will be passing over to my colleague (Sam Schaffzin) to talk a little bit more about the current state of enforcement. (Sam)?

(Sam Schaffzin): Great, thanks Samuel and Ryisha. Like Samuel said, my name is Sam Schaffzin. And I'm with the Provider Enforcement Team as well.

I'm just going to take a few moments to talk about CMS and state and territory provider enforcement for the No Surprises Act and who has enforcement

jurisdiction in this area, and this applies to all provider requirements outlined in the Consolidated Appropriations Act.

The No surprises Act some of which was just covered by Samuel and Ryisha. And as they both mentioned there is kind of pending rule-making associated with some of the provisions just discussed, but also as it relates to all the rest of the provider requirements that we've been going through in detail in this training series. And that information is posted on the CMS No Surprises Act.

So, under the statute CMS will only enforce a provision with respect to the applicable regulated parties if CMS determines that the state is not substantially enforcing that provision. And so, this can occur, for example, when a state lacks authority to enforce or the state requests that CMS enforce for one or more of the provider facing provisions as we are discussing here.

So, CMS recently, mostly at the end of last year and the beginning of this year, published a series of CAA enforcement letters that outline our agencies, and HHS's understanding of the provisions that each - the provider provisions that each state is enforcing either directly or through a collaborative enforcement agreement in partnership with CMS.

But ultimately, you know it - these letters outline what the state will be taking on in the way of enforcement, you know, for the provider requirements and then the provisions that CMS will be enforcing. So, these letters are posted on the CMS CCIIO Web site. And we will be sending out a follow-up email distribution to this training and share a few links. That will be one of the links, the URLs that's available.

The letters also communicate whether the federal independent dispute resolution process and the federal patient provider dispute resolution process apply in each state and in what given circumstances. And since the provider provisions took effect at the beginning of January we have started to receive complaints.

And as expected we, CMS will be handling the follow-up and enforcement for many of these cases. But we'll also be referring to states and territories if they have indicated in those letters that they will be taking on enforcement responsibilities. So, it's kind of FYI potentially to the provider community and for consumers they will be interacting with either their state or the federal government as it relates to, you know, this enforcement and technical assistance and such.

We are currently focusing much of the efforts, or our efforts, on conducting outreach and education, and also providing technical assistance to the provider community as these different issues come up and as you start to navigate the No Surprises Act, and we roll out and implement the NSA.

We're also doing our best to understand and address all consumer complaints as they begin to come in, but something we want to emphasize that striking sort of that balance of understanding and following up but also that education type of assistance piece that I just mentioned will be really important especially over the next year as we continue the early implementation phases of the no surprises.

So, I'll stop there and turn it over to my colleague Dave Mlawsky who is going to be leading in to the Q&A session here. Dave?

(Dave Mlawsky): Thanks, Sam. Thank you Samuel and Ryisha. So, what I'd like to do is first reiterate a point that was made several times in the presentation but I think bears repeating.

And then after that we received a number of questions that we seem to get fairly frequently, fairly often. And we thought it might be helpful to provide answers to those questions, you know, on this call given that a lot of you probably have a lot of those same exact questions.

So, what I'd like to reiterate from the presentation is that, as Samuel and Ryisha have indicated, to date there have been no regulations published on the provider - the requirement to update provider directories and the requirement regarding continuity of care. And although no regulations have been published the statute is in effect and in the absence of regulations good faith compliance is required with the statute until the regulations are published.

And as you may know one of the functions of regulations is to kind of fill in gray areas where the statute maybe doesn't directly address something. And in the absence of regulations, on those two topics, sometimes it makes it a bit difficult to answer questions that you may have regarding topics like that because we've yet to publish regulations on the topic, so the only way that the question can really be answered is by the literal language of the statute itself.

So, we just wanted to, you know, kind of make you aware of that. And, you know, to the extent it's difficult for us to answer any questions on those two topics that's primarily the reason why is because regulations in those - in that area have not been published.

Now in contrast, we have published regulations on the requirement to provide disclosure of state and federal protections against balance billing, and we do get a lot of questions on that topic. And it seems that the questions we get are typically the same questions.

And as I said before, we suspect that, you know, some or all of you may have those same questions. So, I thought maybe we would run through those common questions and maybe it might be helpful.

So as was covered in the presentation the requirement to provide disclosure of state and federal protections against balance billing has to be done kind of in three ways. It has to be made publicly available, it has to be posted on a Web site, and it has to be provided directly to patients.

And the requirement itself applies both to facilities, healthcare facilities and also to healthcare providers. So, having said that, you know, one of the common questions that we get is, "Does a requirement to provide this notice of federal protections and state protections against balance billing does it apply to all types of facilities?"

And the answer is no. The - this requirement only applies to those types of facilities that are implicated in the No Surprises Act balance billing

provisions, which as were mentioned are hospitals, hospital outpatient departments, critical access hospitals, ambulatory surgical centers and hospital emergency departments and freestanding emergency departments. So again, the takeaway here is that the requirement to provide that notice only applies to certain types of facilities.

So, having said that we also get the question very frequently of whether this requirement applies to all types of providers? And the answer is yes. In contrast to facilities in which only certain types of facilities have to provide the disclosure of state and federal protections against balance billing, all types of providers have to provide this sort of disclosure.

However, there are some exceptions that are in the regulations that we believe will make it a little more manageable and easier for providers to manage this requirement. And this was outlined in the presentation, but I think it's worth repeating.

And the first way the regulations make it easier for providers is if a provider never practices in one of the types of facilities that I just mentioned, then the requirements to provide this notice simply don't apply to a provider.

The second way in which the regulations, you know, give some relief to providers with regard to this disclosure is that if the provider does practice in one of the types of facilities that I mentioned but has a written agreement with such a facility to provide the disclosure under which the facility itself would provide the disclosure, then the notice does not apply to the provider, and the requirement would apply only on the facility.

However, I want to mention though that this exception applies only to the disclosure given directly to the person and to the requirement to make the disclosure publicly available, but it does not require - it does not create an exception to the requirement to post the disclosure on the Web site. So, the provider always has to post this notice on its Web site regardless of whether the facility does or does not.

Another very common question we get about this requirement is, "If a patient has a recurrent course of treatment where he is coming in maybe five or ten times does the notice that has to be provided directly to the patient have to be provided each time the patient comes in?" And the answer to that is yes.

In the regulations it indicates that the notice has to be provided no later than each time payment is requested, or no later than each time the insurer or plan is billed in instances where the provider is not taking the copayment or coinsurance from the individual.

Now I'll also mention that the requirement to provide the notice no later than each time payment is requested that allows the provider to provide the notice, you know, before that time as well. So, at the time payment is requested is the latest time the notice can be provided, but it could be provided - it could be provided before that.

Another question that we get a lot is, "Does this notice of, you know, state and federal law protections against balance billing, does it have to be provided to all patients, to all individuals?" And the answer is no. It only has to be

provided to individuals who are covered by a group health plan or group or individual health insurance coverage. So, for example if an individual walks in and they don't have health insurance coverage then this notice - or this disclosure does not have to be provided to them.

Another question that we get very frequently about this particular requirement is that, "Well what if the provider doesn't have a Web site? Does it have to actually put one up or build a one just for the sole purpose of posting this notice of disclosures?" And the answer is no. If the provider does not have a Web site there's no requirement to post - to put up a Web site for this narrow purpose.

The other thing I will mention also, which I think was covered in the presentation itself, is that to the extent the provider has a Web site and is posting the disclosure on the Web site it has to be posted in a way that's very accessible, meaning you can't require the person to log in, or have a password or anything like that. It has to be like searchable and just very accessible on the Web site.

The remaining very common question that we get about this particular provision is that, "Does this disclosure have to be provided to the patient in person?" And the answer is no. It can be provided in person but it could also be provided either through, you know, regular mail or through email.

But the important part - the important point to remember here is that it's up to the patient to decide how he wants to receive this particular notice in person, through mail or email. So, it's really incumbent upon the provider to ask the

patient, you know, how would you like this presented to you? And the patient's decision in that regard is the controlling decision.

So that is some of the more common questions that we get about this particular provision, and we hope that's helpful to go over that. And I guess we can open up for other questions.

Coordinator: Thank you. We will now begin the question and answer session. If you would like to ask a question please press Star and then 1. Please unmute your phone and record your name clearly when prompted. Your name is required to introduce your question. To cancel your request please press Star 2. Our first question comes from (Sandy Hagan). (Sandy), your line is open.

(Sandy Hagan): Hello. Yes, I just have a question about the prohibitions that apply to items or services that are non-covered benefits. If a patient wants to receive a non-covered item such as cosmetic Botox in the physician's office are we required to notice and consent those services since they're non-covered?

Dave Mlawsky: The notice and consent provisions only apply to - the answer to that is yes. If it's a situation where - are you saying at a network service or non-covered service, I'm sorry?

(Sandy Hagan): Covered service.

Dave Mlawsky: No, the provisions do not apply on non-covered services.

(Sandy Hagan): Great, okay. And can I ask one more quick question?

Dave Mlawsky: Yes.

(Sandy Hagan): Okay, there is also a part of the rule that I'm not 100% comfortable with regarding non-emergency ancillary services. As a physician's office with diagnostic services available on site is this applicable to us that we may never can see a patient for non-emergency ancillary services?

Dave Mlawsky: The prohibition on notice and consent for non-emergency services comes into play when a patient is visiting a participating facility and the those ancillary services would be provided by a non-participating provider and they're non-emergency services.

In a situation like that, the balance billing prohibitions always apply and the exception that might otherwise apply for notice and consent would not apply, meaning that notice - and notice cannot be sought and consent cannot be given for ancillary services in the context that I just mentioned.

(Sandy Hagan): Okay, perfect. Thank you so much.

Dave Mlawsky: You're welcome.

Coordinator: Thank you. Our next question comes from (Vincent Chen). (Vincent), your line is now open.

(Vincent Chen): Hello. Are there any provisions to resolve the provider and insurance company disputes for the insurance company underpayments for out of network providers?

Dave Mlawsky: I'm sorry, could you repeat your question?

(Vincent Chen): Oh yes. Basically, what's going on is that insurance companies are taking advantage of this balanced billing and underpaying out of network providers. And you know, very, you know, minimal amounts and, you know, way below usual and customary.

So, what - my understanding was they're supposed to be some kind of future rule-making or dispute resolution process to help the providers and the, you know, dispute between the insurance company and providers.

Dave Mlawsky: Right, yes. So, our regulations already published in that regard and in situations where the prohibitions on balance billing apply, the plan or issuer has to pay the out-of-network rate to the provider. And the out-of-network rate under the law, and the regulations is determined in one of four different ways.

If the state has an all-payer model agreement that's in effect in that state and that all-payer model agreement applies to the provider or - and the plan or issuer and the particular service, then the all-payer model agreement would dictate the amount of the out-of-network rate.

Now, most states don't have all-payer model agreements. So, if the state does not have an all-payer model agreement and it does have a specified state law

that would dictate that out-of-network rate, then the specified state law would dictate that rate.

And the specified state law again, to apply in any specific situation has to apply to be the provider or facility in question, the service in question and the issuer in question.

Now, if there's no all-payer model agreement and there's no applicable specified state law, then a period of open negotiation can take place under the federal regulations. And it's a 30-day period under which the two parties can negotiate to try to come up with an amount of payment.

Also, under the statute and the regulations, if the 30-day open negotiation - and either of the two parties can initiate the open negotiation period. So, if one of the two, one of the two parties, does initiate an open negotiation period, it's a 30-day period and ifs at the end of that 30-day period the two parties still haven't agreed on a rate then, either of the two parties can initiate what's known as an independent dispute resolution process.

And the way that process works is the term that's commonly used is baseball style arbitration. And what that means is each of the two parties submits to the independent dispute resolution entity, an offer of payment, an amount.

And the arbitrator or the dispute - the independent dispute resolution entity has to choose one of those two amounts. It cannot choose like an amount in the middle or some other amount. It has to choose one of those two offers that was submitted by one of the parties. And in those regulations, it specifies the

types of considerations that the independent dispute resolution entity may and may not consider in making its decision.

So, the answer to your question is yes, there is a scheme in the statute and the regulations to determine what that out-of-network payment would be in instances where the No Surprises Act applies and the two parties just can't come to a resolution on what the payment should be.

(Vincent Chen): Oh yes, I already know all that. But the issue is that, you know, the insurance companies are in control of the rates, and, you know, we're getting underpaid.

Dave Mlawsky: Well I mean, the independent dispute resolution entity would resolve that. So, you're probably familiar with how it works in that the independent dispute resolution entity under the regulations is required to start with the QPA, Qualifying Payment Amount.

However, the provider is permitted to present evidence that the qualifying payment amount, which is the median contracted rate is just not sufficient. And then the independent dispute resolution entity would take that evidence into consideration in making its determination as to which of the two offers to select.

(Vincent Chen): Okay I - because I thought there would be an additional rule-making on this because it's still a lot of ambiguities and involved with it. And I understand there's an AMA lawsuit going on still too, and that's hanging out there. So that's why I wasn't sure...

Dave Mlawsky: Well the...

(Vincent Chen): ...if there was any additional rule-making promulgated since then.

Dave Mlawsky: There has not. That rule that I'm referring to as an interim final rule. The rule will be finalized, but I don't have any sort of a timetable for when that would occur.

(Vincent Chen): Okay I can...

((Crosstalk))

Gene Freund: And...

(Vincent Chen): (Unintelligible) that too, yes.

Gene Freund: ...this is Gene Freund, and we're kind of going into the end of time. If you go to that cms.gov No Surprises page and look for the provider resources and then click at the top of that page, Resolving Out-of-Network Payment Dispute you can find a lot of detail about how that works.

Actually, Mr. Mlawsky was dead on with that description. It reads - you can almost read along, but it's hard to remember. So, you can find details there and even the links to that. So that's that's where to go to find out more about that.

And I do need to bring us to a close because we are at the top of the hour. And we need to respect our panelists time and your time, and thank them for the awesome work they're doing.

Again, the whole goal of this is to make sure that you all out there understand what's going on. So, we're going to continue bringing you as much as we can and continue - we, my great colleagues and CCIIO are going to continue to be putting resources up there on that No Surprise Web site and doing lots of other work to spread the word around.

So, thank you very much for attending and your attention and your questions. We do appreciate them. And look forward to the next time. And we will be sending an email to the list you got your invitation from with those links that Sam promised. And that's it. Thank you all very much.

Coordinator: That concludes today's conference. You may now disconnect.

END