HALL RENDER
KILLIAN HEATH & LYMAN

Navigating the No Surprises Act:

Strategies to Avoid CMS Scrutiny

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Navigating the No Suprises Act

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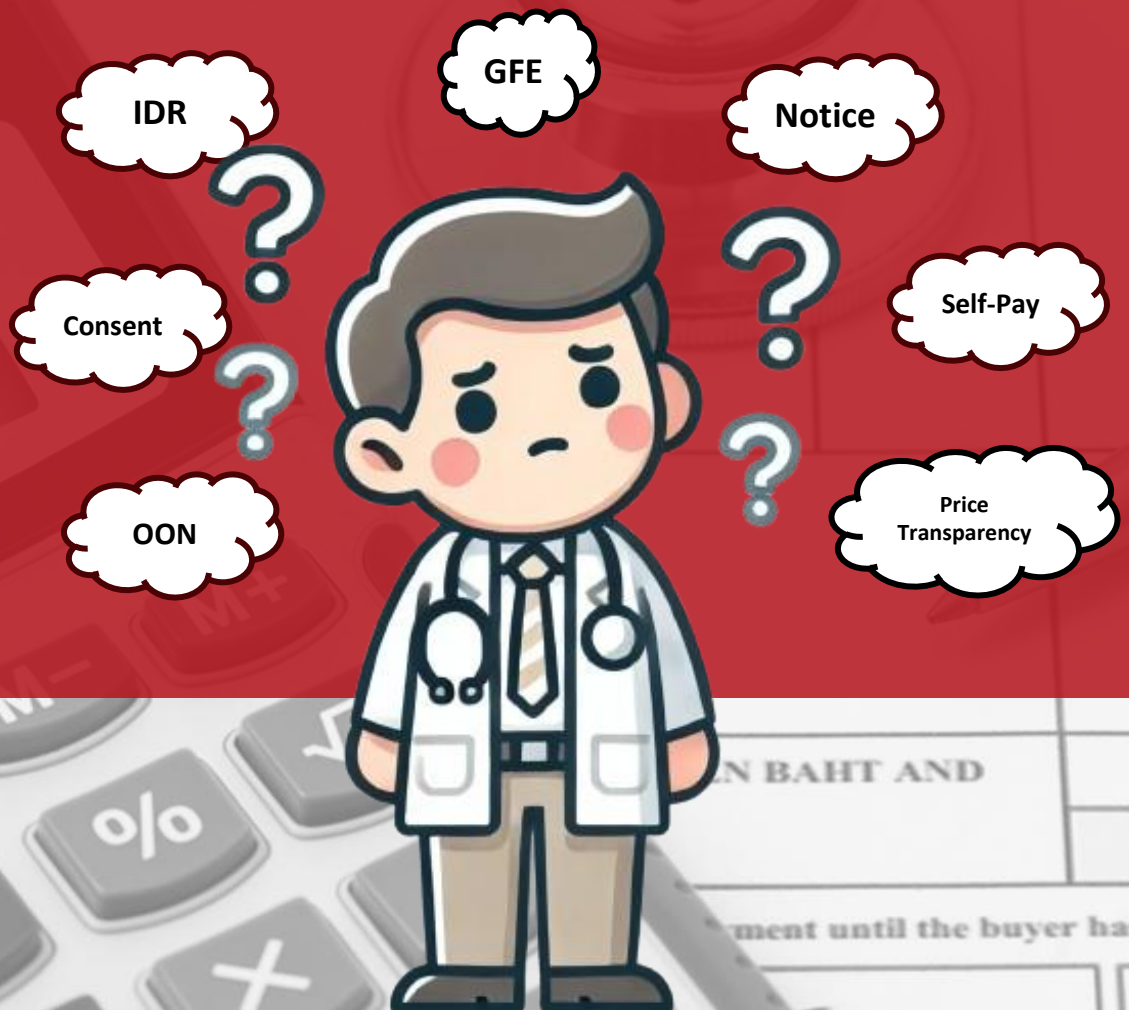
Today's Agenda

- **Federal No Suprises Act Refresher**
  - Balance Billing Prohibition
  - Payment & IDR
  - State Law Considerations
  - GFE Requirements
- **Recent Observations & Common Mistakes**
- **Investigation & Enforcement Trends**
- **Government Expectations: What is CMS Looking For?**
- **Investigation Response Strategy**
- **Q&A**

No Surprises Act Refresher



No Surprises Act | Overview

Prohibition Against Surprise Medical Bills
• Patients with commercial health coverage • Balance billing law • Limited to certain locations • Disclosure requirements

Provision of Good Faith Estimates
• Uninsured and self-pay patients • Applies in more locations • Disclosure requirements

Penalties for Non-Compliance
$10,000 Per Violation

Surprise Billing | The Prohibition

- Prohibits *balance* billing for out-of-network:
  - **Emergency services**
  - **Non-emergency services** provided by OON providers *at in-network facilities*
  - **Air ambulance services**
- Emergency Services includes all post-stabilization services
  - May include outpatient observation, inpatient stay, outpatient stay

Surprise Billing | When Protections Apply

Billing Entity	Emergency Services	Post-Stabilization Services	Non-Emergent Services
OON Facility	YES	YES	NO
OON Provider (in-network Facility)	YES	YES	YES
OON Provider (OON Facility)	YES	YES	NO

Surprise Billing | Model Disclosure

- Model Disclosure Notice of Surprise Billing Protections
  - Provide to patients covered by commercial plans and only for services in a hospital, CAH, or ASC
    - Facility can provide on behalf of providers but requires written agreement
  - Provide no later than time bill is sent to patient
  - Post on website (if have one)
  - Post prominently in areas where patients check in or pay bills
  - Do not post in non-hospital (freestanding) office setting
  - HHS model notice of surprise billing protections

Surprise Billing | Exceptions

- Protections *DO NOT* apply if an OON Provider provides non-emergency services at:
  - An OON facility
  - An in-network facility *AND* provides notice and obtains patient's consent prior to the provision of services *in limited circumstances*

NO OTHER EXCEPTIONS!

Surprise Billing | Notice & Consent

- Intended to Be Very Rare
- Applies to Non-Emergency Services and Post-Stabilization
- **MUST** Use standard HHS form and provide estimate of charges
- Provider is not permitted to request consent:
  - for ancillary services (emergency medicine, anesthesiology, pathology, radiology, laboratory, neonatology, assistant surgeons, hospitalists and intensivists) OR
  - if no participating provider is available to provide the services.
- Post-Stabilization Services Have Additional Requirements
- Patient may revoke consent prior to receiving services

Surprise Billing | Payment

- No Surprises Act DOES NOT mean no payment
- Patient Responsibility: In-Network Cost-Sharing Amount
- Payer must pay or deny within 30 days
- Provider/Facility must indicate on claim that the services are subject to the No Surprises Act

Surprise Billing | Federal IDR Process

- If provider disagrees with payment from payer, can dispute via Federal Independent Dispute Resolution (IDR)
- Baseball style arbitration
- There are several stages in IDR process driven by strict deadlines… miss one and you may miss out.
- There is a lot of technical guidance available on HHS website
- Can “batch” certain claims if meet specific criteria
- Cooling off period
  - neither party may initiate IDR for same of similar item or service with the same opposing party for 90 days

Surprise Billing | State Law Considerations

- HHS is the primary enforcer but many states are sharing enforcement responsibility
  - If you receive an enforcement letter from a state agency, TAKE IT SERIOUSLY
- Many states are implementing their own Surprise Billing Prohibitions and Dispute Resolution Processes
  - Any state dispute resolution process/OON payment requirements will control for state governed plans
  - ERISA plans can opt-in to a state's process for determining payment of OON claims

Good Faith Estimate | What is it?

- As of January 1, 2022, providers must provide a written "good faith estimate" of expected charges for items and services to uninsured and self-pay patients when scheduling or upon request
- Required Notice of Availability of GFE
  - Must post notice of availability of GFE on website (if have one) and on-site where scheduling or questions about cost of care occur

Good Faith Estimate | Who Must Provide?

- All state-licensed or certified health care providers and facilities (everyone)
- Including private practice locations
- Convening provider or facility
  - The provider or facility that is responsible for scheduling the primary items or services or that receives an initial request for a GFE
- Co-Providers
  - Law requires GFE to include expected charges for any item or service that is reasonably expected to be provided in conjunction with the scheduled or requested item or service, including those provided by *co-providers or co-facilities*
  - HHS has delayed enforcement of this requirement until it issues further rules

Good Faith Estimate | To Whom?

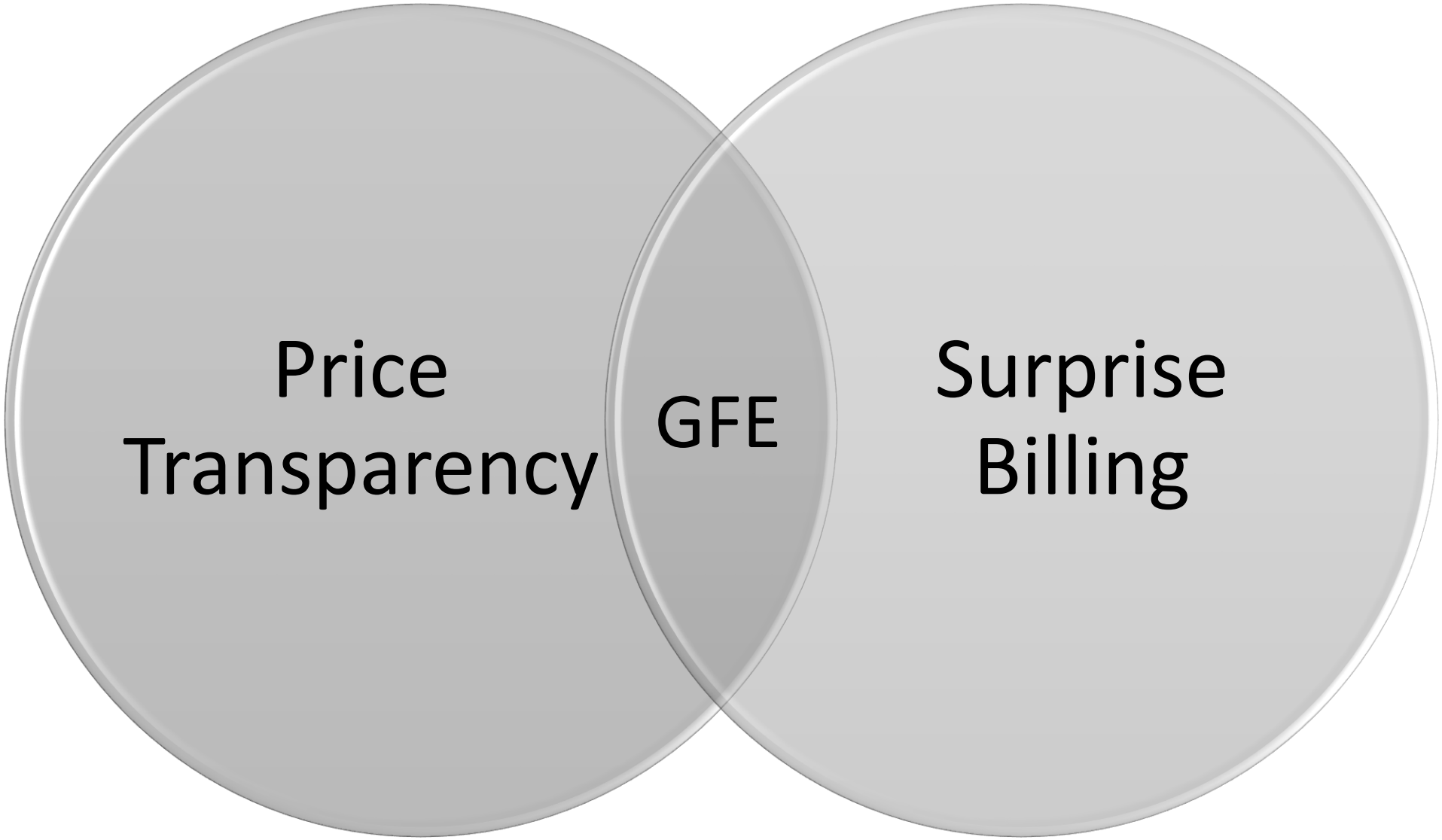
- For now, GFEs are only required for uninsured or self-pay patients
- CMS defines “Uninsured (or Self-Pay)” as:
  - An individual who does not have benefits for an item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, federal health care program, or health benefits plan; OR
  - An individual who has benefits . . . but who does not seek to have a claim for such item or service submitted to such plan or coverage.

Good Faith Estimate | When & How?

- Convening provider or facility must inform uninsured and self-pay patients of availability of GFE
- Must provide a "good faith estimate" of expected charges to patients (again, for now only uninsured or self-pay) *when scheduling or upon request*
  - Within 3 business days of scheduling if service at least 10 days later
  - The *next business day* after scheduling if service at least 3 days later but less than 10 days later
  - Within 3 business days of receiving a request for a GFE by an uninsured or self-pay individual
- Must be provided in writing or electronically as requested

Common Mistakes

Federal Hospital Price Transparency ≠ NSA Compliance


Price Transparency
GFE
Surprise Billing

Price Transparency

Laws that increase public disclosure of healthcare pricing

- Both Federal and State Laws
- Federal Hospital Price Transparency Rule (Hospitals)
- Additional Federal Laws
  - No Surprises Act - Good Faith Estimate Requirement
  - Transparency in Coverage - Health Plans

Surprise Billing

Laws that protect patients against unexpected or unavoidable out-of-network bills

- Both Federal and State Laws
- Federal Laws
  - No Surprises Act - Balance Billing Protections
- State Laws
  - Usually only apply to state-regulated plans

Not Posting and Providing Required Notices

Surprise Billing Protections

- **What:** Standard 1-page notice ("Your Rights...") explaining protections against surprise medical bills.
- **To Whom:** All patients, regardless of insurance status.
- **Where/How:**
  - Post on website and display prominently in-office.
  - Give a physical copy directly to each patient.

Good Faith Estimate (GFE)

- **What:** A notice informing patients of their right to a GFE.
- **To Whom:** Available to all but proactively given (orally & in writing) **only to uninsured or self-pay patients** when scheduling or requested.
- **Where:** Posted on website and displayed in-office.

Not Providing a GFE

- A GFE must be provided to all Uninsured or Self-Pay patients upon scheduling or request.
- Any discussion or inquiry regarding the potential costs of services under consideration *must be considered a request for a GFE* and a GFE must be provided, *in writing*, no later than 3 business days after the date of the request.
- The GFE must be available in the formats and in the languages spoken by the individual considering or scheduling services.

Providing a non-compliant GFE

- Incomplete estimates
  - must include all expected charges
- Inaccurate estimates
- Non-compliant form:
  - Use the CMS Standard Form
  - Include all Required Data Elements set forth by HHS
  - Be mindful of this guidance and requirements if choosing to implement and organization-specific GFE Form
- Not updating GFE when required
- Not keeping GFE in medical record

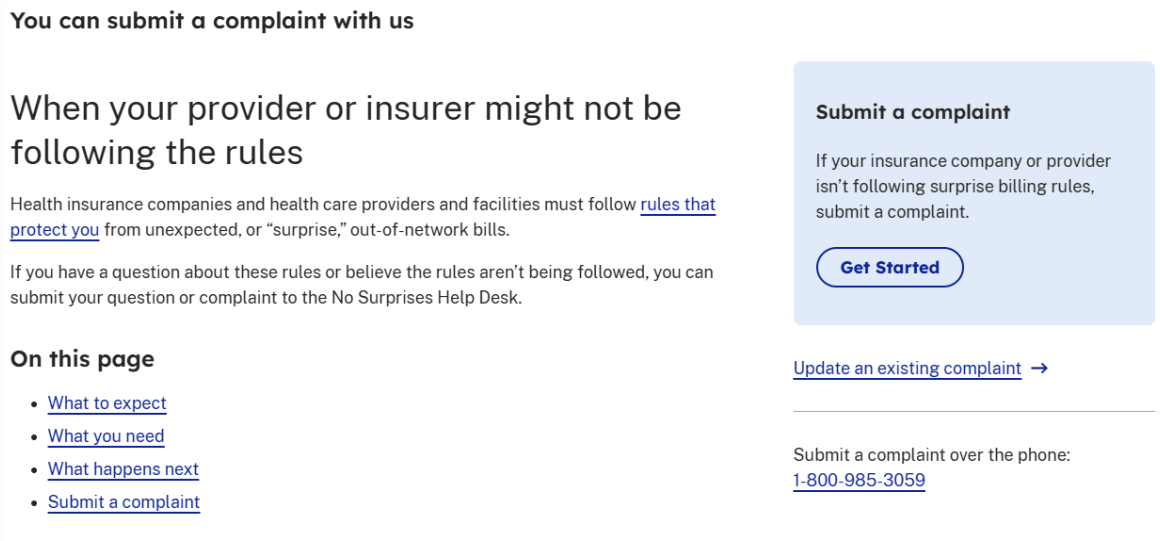
Balance Billing when not allowed

- Emergency Services
  - patients must only pay in-network cost-sharing amounts (e.g., copays, deductibles), regardless of provider network status
- Non-emergency services
  - These providers must accept in-network rates unless the patient is properly notified and consents to out-of-network care
- Consider medical staff education
- Misapplying cost-sharing
  - Cost-sharing must be calculated based on Qualifying Payment Amounts (QPA) or applicable state benchmarks

Investigation & Enforcement Trends

No Surprises Act | Penalties & Investigations

- Balance Billing and GFE violations may result in:
  - **Federal Civil Monetary Penalties** – up to **$10,000 per violation**
- Patient complaints are generally the basis for investigations



You can submit a complaint with us

When your provider or insurer might not be following the rules

Health insurance companies and health care providers and facilities must follow rules that protect you from unexpected, or "surprise," out-of-network bills.

If you have a question about these rules or believe the rules aren't being followed, you can submit your question or complaint to the No Surprises Help Desk.

On this page

- What to expect
- What you need
- What happens next
- Submit a complaint

Submit a complaint

If your insurance company or provider isn't following surprise billing rules, submit a complaint.

Get Started

Update an existing complaint →

Submit a complaint over the phone:
1-800-985-3059

- However, CMS can also conduct random or targeted investigations

No Surprises Act | Enforcement Trends

- CMS reported, as of June 30, 2024:
  - Over 16,000 total complaints received
  - Over 4,000 complaints of surprise billing for non-emergency services at in-network facilities
  - Over 2,500 complaints regarding surprise billing for emergency services
  - Almost 2,000 complaints regarding GFEs

CMS Complaint Data and Enforcement Report Summary

Type of Complaint Data	Number of Complaints
Total complaints received.*	16,073
Total complaints currently open	3,373
Total complaints closed*	12,700
Total complaints closed with no violation found	4,438
Total complaints closed with violation found	400
Restitution reported from closed complaints investigations	$4,183,383
Total MHPAEA Compliance Complaints	31
Total ACA Compliance Complaints	248
Total NSA Compliance Complaints	12,077
NSA complaints against non-federal governmental plans and issuers	1,777
NSA complaints against providers, facilities, and providers of air ambulance services	10,300

Top 3 most common complaints against non-federal governmental plans and issuers

Type of Complaint	Number of Complaints
Non-compliance with Qualifying Payment Amount (QPA) requirements	1,035
Late Payment after Independent Dispute Resolution (IDR) determination	675
Non-compliance with 30-day Initial Payment or Notice of Denial of Payment requirements	390

Top 3 most common complaints against providers, facilities, and providers of air ambulance services

Type of Complaint	Number of Complaints
Surprise Billing for non-Emergency Services at an In-Network Facility	4,286
Surprise Billing for Emergency Services	2,577
Good-Faith Estimate	1,922

See CMS Complaint Data & Enforcement Report on Health Insurance Market Reforms, Ctrs. for Medicare & Medicaid Servs. (Aug. 2024), https://www.cms.gov/files/document/august-2024-complaint-data-and-enforcement-report.pdf.

No Surprises Act | Complaint Examples

- Insured patient received emergency services from OON hospital and received a bill exceeding in-network cost-sharing amount.
- Insured patient billed in excess of their in-network cost-sharing amount for non-emergency services provided by an OON provider at in an in-network facility.
- Self-pay patient *verbally* given GFE by convening provider and received no written GFE. Total charges to patient exceeded the verbal GFE.
- Uninsured patient received a GFE that lacked *all* items and services to be provided in conjunction with the primary service.

Government Expectations: What is CMS Looking For?

CMS Expectations | What They Look For

- Information Requested by CMS in NSA Investigations
  - Documentation related to the complaint under review
    - E.g., copy of the bill sent to the patient or GFE provided
  - Documentation of established workflows to detect and prevent NSA violations
    - Policies
    - Standard Operating Procedures
    - Workflows
  - Retrospective review to identify population of similarly impacted individuals
  - Description of corrective actions, including specific improvements to current business practices

Investigation Response Strategy

CMS Investigations | Response Strategy

- **Act Promptly**
  - **10 business days** to gather requested documentation, including conducting retrospective reviews
- **Designate a Response Team**
  - Legal, compliance, revenue cycle, and other billing personnel
- **Determine if a Violation Occurred**
- **Identify Gaps in Current Practices**
  - Are NSA notices and disclosures posted in accordance with the regulatory requirements?
  - Does the GFE template include all regulatory required elements?
  - Opportunities for updated education and training
  - Updates to current processes and operations

CMS Investigations | Response Strategy

- ***Balance Billing Complaints***
  - **Identify Encounter Details**
    - Patient name, DOS
    - Exact location of where services occurred (e.g., hospital, HOPD, ASC or CAH)
  - **OON Status**
    - Was the facility or provider OON on the date of service?
  - **Health Plan Adjudication**
    - Did the health plan adjudicate the claim as OON per the NSA rules?
      - In-network cost-sharing applied?
      - Any denial or explanation of benefits (EOB) sent to the patient?
      - Was notice and consent provided?

CMS Investigations | Response Strategy

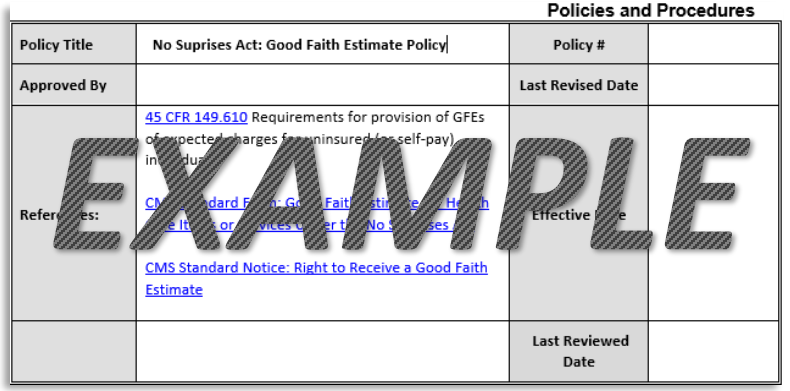
- ***Good Faith Estimate Complaints***
  - **Identify Encounter Details**
    - Patient name and DOS
    - Confirm the date the service was **scheduled**
    - Confirm the date the patient **requested** a GFE (if applicable)
  - **Confirm Patient Status**
    - Did the patient identify as **uninsured** or **self-pay**?
      - Was this status clearly documented in the intake/scheduling record?
  - **GFE Delivery**
    - Was a Good Faith Estimate provided?
      - Confirm whether it was written or verbal
      - Check timeliness (e.g., **3 business days** for scheduled services)
  - **GFE Content**
    - All reasonably expected items and services tied to the primary service?
    - Codes, charges, disclaimers, and total expected charges?
    - Was the GFE accessible (e.g., patient portal, email, or hard copy)?

CMS Investigations | Response Strategy

- **Prepare a Comprehensive Submission**
  - Clearly explain whether violation did or did not occur
  - Provide detailed evidence and supporting documentation of your position
  - Include documentation of current NSA compliance practices
  - Demonstrate a compliance culture
    - Show proactive steps taken (training, audits, policy/process updates)

CMS Scrutiny | Are You Doing Enough?

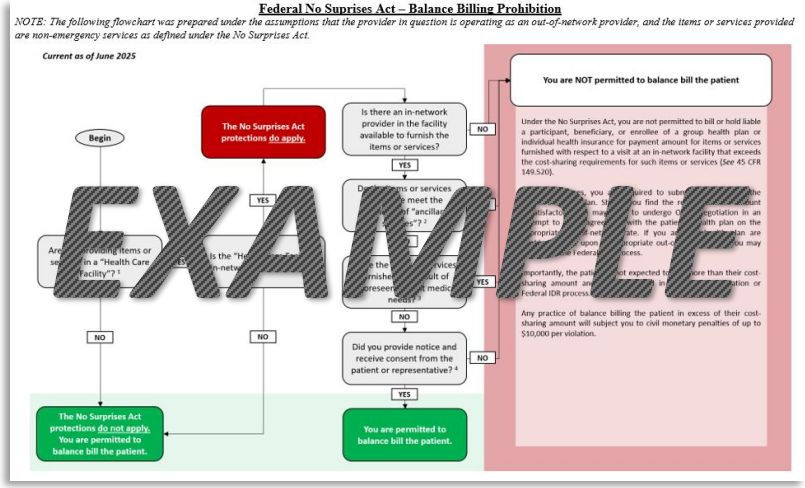
- Be **Proactive** not Reactive
- Stay ahead of CMS
  - Balance Billing Policy
  - GFE Policy
  - NSA Workflow
  - Standard Operating Procedures
  - Adequate Notices & Disclosures
  - Education & Training



Policies and Procedures

Policy Title	No Suprises Act: Good Faith Estimate Policy	Policy #	
Approved By		Last Revised Date	
References:	45 CFR 149.610 Requirements for provision of GFEs of expected charges for uninsured (or self-pay) individuals CMS Standard Notice: Right to Receive a Good Faith Estimate	Effective Date	
		Last Reviewed Date	

EXAMPLE



Federal No Suprises Act – Balance Billing Prohibition

NOTE: The following flowchart was prepared under the assumptions that the provider in question is operating as an out-of-network provider, and the items or services provided are non-emergency services as defined under the No Surprises Act.

Current as of June 2025

Begin

The No Surprises Act protections do apply.

Is there an in-network provider in the facility available to furnish the items or services?

You are NOT permitted to balance bill the patient

Under the No Surprises Act, you are not permitted to bill or hold liable a participant, beneficiary, or enrollee of a group health plan or individual health insurance for payment amount for items or services furnished with respect to a visit at an in-network facility that exceeds the cost-sharing requirements for such items or services (See 45 CFR 149.520).

Importantly, the patient is not expected to pay more than their cost-sharing amount and you may not engage in balance billing or Federal IDR process.

Any practice of balance billing the patient in excess of their cost-sharing amount will subject you to civil monetary penalties of up to $10,000 per violation.

Did you provide notice and receive consent from the patient or representative?

The No Surprises Act protections do not apply. You are permitted to balance bill the patient.

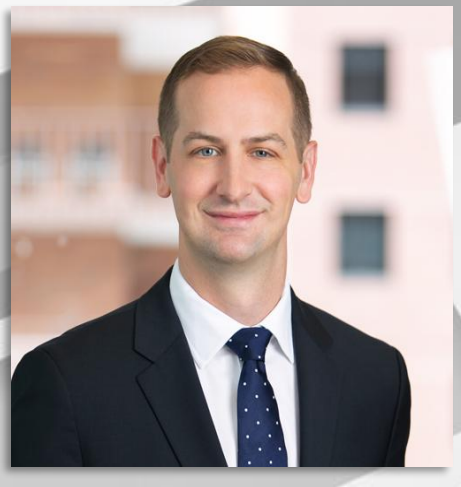
You are permitted to balance bill the patient.

YES

NO

EXAMPLE

Questions?



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