



FEDERAL REGULATION OF SURPRISE MEDICAL BILLING

The federal regulation of certain surprise medical bills is effective as of Jan. 1, 2022. New protections regulate certain provider balance billing and create new pathways for patients to better understand the cost of services.

Learn more about the impact of the implementation of the *No Surprises Act* in this member-exclusive resource outlining key topics impacting group practices. For more information or questions, please contact MGMA Government Affairs at govaff@mgma.org.

****Recent court cases challenging aspects of the No Surprises Act were recently decided. The Departments are expected to release updated guidance following these decisions which will impact several aspects of the independent dispute resolution (IDR) process. MGMA will continue to update members on these developments.****

BACKGROUND

Surprise medical billing, or balance billing, results when patients receive care from out-of-network providers or facilities and the service costs are not fully covered by the patient’s insurance provider. The patient may then receive a medical bill that they were not expecting for services they may have believed were covered. As part of the *Consolidated Appropriations Act, 2021 (CAA)*, Congress passed the ***No Surprises Act***, which creates protections for patients by banning surprise medical bills under certain circumstances beginning Jan. 1, 2022. There are two major components of the *No Surprises Act*:

- **The federal regulation of certain surprise medical bills, and**
- **Patient transparency requirements.**

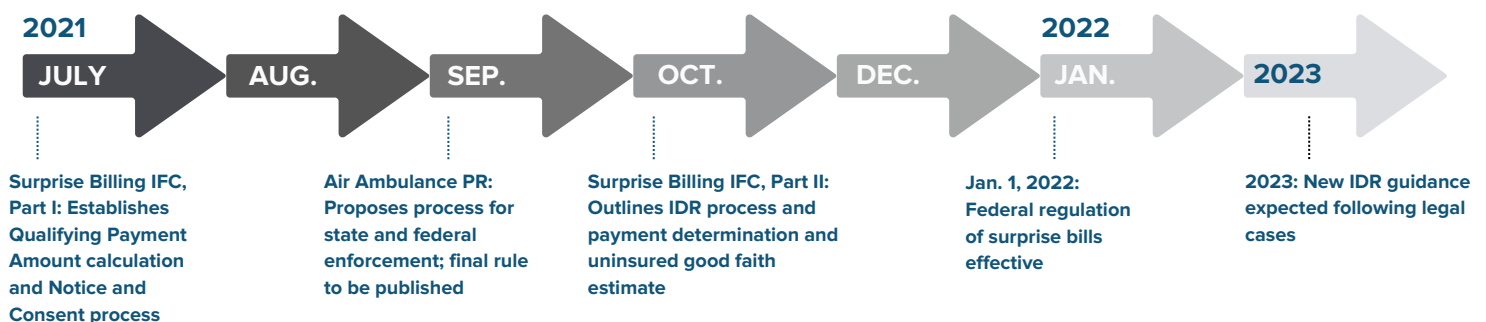
The No Surprises Act establishes an independent dispute resolution (IDR) process for out-of-network care covered under the surprise billing protections. Providers and health plans may use an independent arbiter to determine final payment for certain out-of-network care. Notably, patients are held harmless for surprise medical bills that are protected under the new law.

The Departments of Health and Human Services (HHS), Labor, and Treasury (“The Departments”), are tasked with releasing regulations implementing the statutory ban on surprise billing. As of September 2022, the agencies have released four rules* implementing the law:

- **Requirements Related to Surprise Billing; Part I (Interim Final Rule, with Comment Period (IFC))**
- **Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enrollment (Proposed Rule (PR))**
- **Requirements Related to Surprise Billing; Part II (IFC)**
- **Requirements Related to Surprise Billing (Final Rule)**

*In addition to the rules, the Departments have issued additional guidance such as FAQs.

IMPLEMENTATION TIMELINE



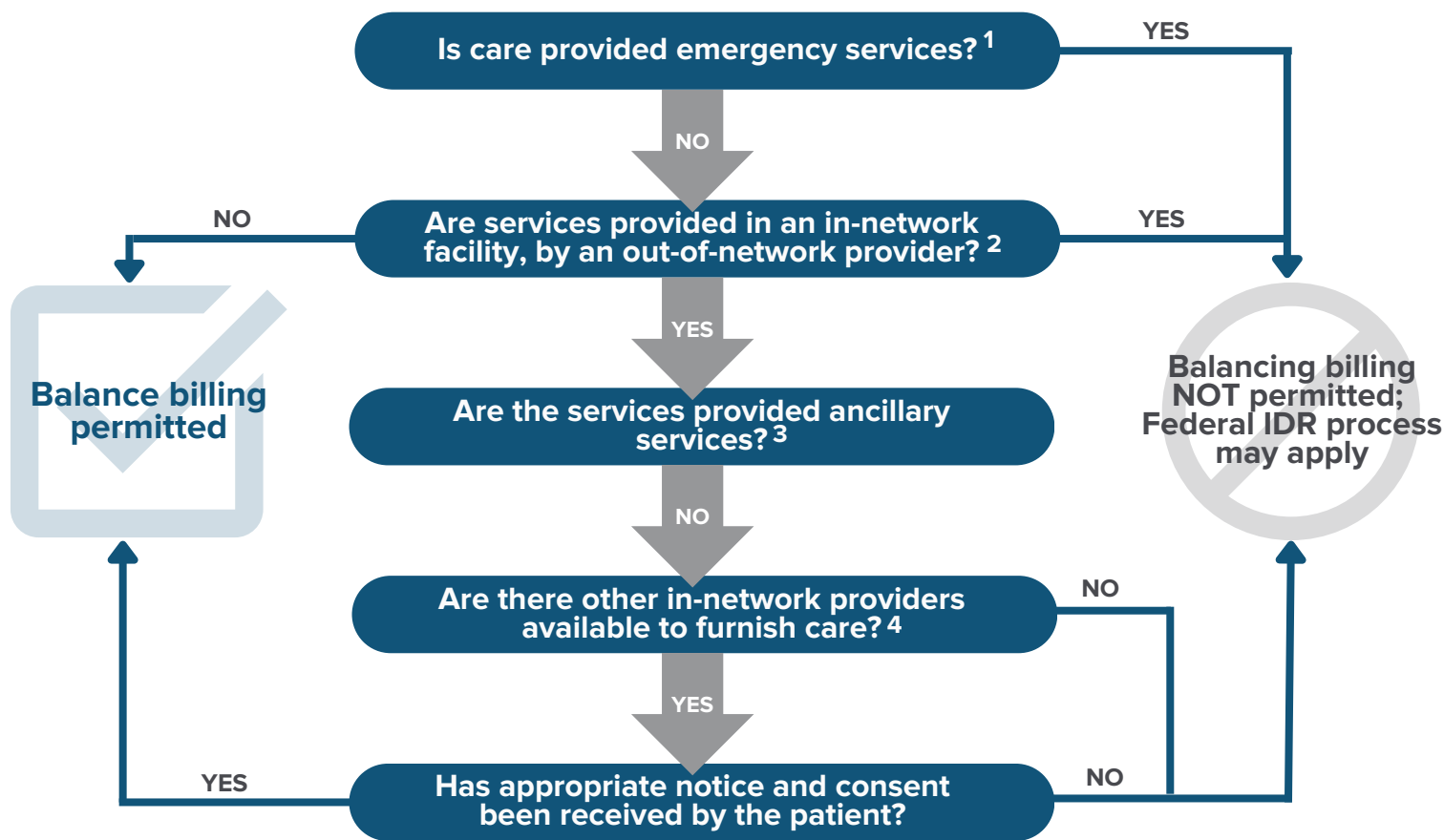
The federal regulation of surprise medical bills prevents certain out-of-network (OON) providers from balance billing patients for services. The new requirements prioritize preventing patients from being caught in the middle of the provider and health plan dispute resolution process. Under the surprise billing law, certain OON providers are prohibited from balancing billing patients unless the provider is eligible to receive notice and consent exemptions from patients.

PROVIDER TYPES

All OON providers at in-network facilities, as defined in statute, are prohibited from balancing billing patients. However, certain provider types are eligible to receive notice and consent from the patient to provide care and ultimately balance bill the patient.

Certain OON providers at in-network facilities may receive notice and consent to balance bill, except ancillary providers. **Ancillary providers include emergency medicine, anesthesiology, pathology, radiology, laboratory, and neonatology services provided by a physician or non-physician.** Ancillary services also include items and services provided by assistant surgeons, hospitalists, and intensivists. As determined by law, HHS may specify other provider types that qualify as ancillary providers that are ineligible to receive notice and consent to balance bill patients.

WHO CAN BALANCE BILL PATIENTS UNDER FEDERAL LAW?



- Emergency services**, as defined under the No Surprises Act, include pre-stabilization services that are provided after the patient is moved out of the emergency department and are subject to balance billing protections.
- In-network facilities include** hospitals, hospital outpatient departments, critical access hospitals, or ambulatory surgical centers that have a contractual relationship with a health plan or issuer.
- Ancillary services include** emergency medicine, anesthesiology, pathology, radiology, laboratory and neonatology services provided by a physician or non-physician. Ancillary services also include items and services provided by assistant surgeons, hospitalists, and intensivists.
- Available in-network providers** are considered “ancillary providers” for purposes of the law. If there is not an available in-network provider at the in-network facility able to furnish services, the out-of-network provider may not balance bill.

NOTICE AND CONSENT

Non-ancillary OON providers at in-network facilities may balance bill patients for services if certain **notice and consent requirements** are met. These requirements ensure that patients are aware that the care provided is out-of-network, whether there are other health professionals within the facility that are in-network, and the estimated cost of care for the services.

Providers opting to use the notice and consent process must meet specific timing and disclosure requirements. The notice and consent process may not be used in emergency situations by any provider, whether they are an ancillary provider or not.

The Departments issued an [updated](#) standard notice and consent document to be used. “Version 1” of the standard form can continue to be used in 2022, however, in 2023, the updated version must be used to obtain notice and consent.

PAYMENT DISPUTE RESOLUTION

Providers may not balance bill for services that are covered under the federal ban on surprise billing. For providers and health plans and issuers to determine the final payment for services, Congress established an **independent dispute resolution (IDR) process**.

The federal IDR process may be used to determine final payment for services covered under the federal ban on surprise billing when there is not an applicable state law or all-payer state model to determine the payment amount.

When an insurer or health plan makes an initial payment for an OON service, the plan must include specific information about the claim, including the qualifying payment amount (QPA) for each item or service, as well as a statement certifying that the QPA applies for purposes of patient cost sharing. Additionally, if a plan or insurer down codes any service in the initial payment, it must provide additional information.

In the August 2022 final rule, the Departments clarified that providers are not required to use insurer or health plan proprietary portals to submit communications related to the open negotiation or IDR process.

Either party has up to 30 calendar days after the provider receives the initial payment for services or the notice of denial from the health plan. Once the IDR process is initiated, the provider and plan must first exhaust a 30-day negotiation period. If the parties fail to agree on a final payment amount once this 30-day negotiation period ends, the formal IDR process may be initiated within four days, and once the formal IDR process is initiated, the two parties have three days to select an arbiter. Within ten days of selection of the federal IDR entity, each party must submit their offers and any additional supplemental information to the IDR entity. Within 30 days of being selected to arbitrate the payment dispute, the IDR entity must issue the final determination of payment.

In November 2022, the Departments established a Notice of Initiation web [form](#) in an effort to streamline disputes. Additionally, in October 2022, the Departments released updated [guidance](#) regarding the IDR process for disputing parties, as well as updated [guidance](#) for IDR entities. Following recent court decisions, the Departments are expected to release updated IDR rules covering both changes to administrative fees and the IDR process.

DISCLOSURE OF PATIENT PROTECTIONS AGAINST BALANCE BILLING

Provider and facilities are required to publicly post the applicable patient protections against balance billing in a central location within the facility and on the provider or facility’s public website (if applicable). This disclosure must be one-page (can be double sided) and must include any state balance billing protections and contact information for the appropriate state and federal agencies overseeing the balance billing protections.

Providers and facilities are also required to provide the disclosure to patients either in-person, or by mail or email, as selected by the patient. The rules require that the disclosure be provided to patients no later than the date and time that payment is requested (including copays), and if no payment is requested, the disclosure must be provided no later than the date on which the provider or facility submits a claim to the patient’s insurer. ([86 Fed. Reg. 36914](#))

KEY RESOURCES

- [MGMA Comments in Response to Surprise Billing Part I IFR](#)
- [Requirements Related to Surprise Billing; Part I](#)
- [CMS Surprise Billing Part I Fact Sheet](#)
- [CMS Surprise Billing Website](#)
- [Updated Standard Notice and Consent Form \(Version 2\)](#)
- [Definition of Out-of-Network Provider](#)

WHAT IS THE QUALIFYING PAYMENT AMOUNT (QPA)?

The qualifying payment amount, or “QPA,” is the health plan or issuer’s median contracted rate recognized by the plan on January 31, 2019, for the same or similar item or service, in the same geographic region, adjusted for inflation. In the August 2022 final rule, the Departments clarified that the QPA must be calculated by specialty. This is to avoid potential arbitrary decreases in the QPA amount if specialties that do not perform the service have contracted rates substantially below market rate. With this new clarification, these low contracted rates will not be incorporated into the specialty QPA amount. The median contracted rate is calculated based off all contracted rates by the health plan offered in the same insurance market. An insurance market is defined as either the individual market, or small or large group market. The contracted rate is defined as the “total amount (including cost sharing) that a group health plan or health insurance issuer has contractually agreed to pay a participating provider.” Each contracted rate will be considered as a single data point when calculating the QPA.

Health plans and insurers are not required to provide specific information about QPA calculation, but are required by the Departments to provide the QPA amount for a given item or service, a statement certifying that the QPA applies for purposes of determining patient cost sharing, and a statement with appropriate contact information about open negotiation and the availability of the federal IDR payment determination process.

Following a ruling in a federal court case, the QPA is no longer the assumed out-of-network rate for the federal IDR process. While the QPA may be one of the criteria used to determine the final payment amount, it is not used as the benchmark amount. However, if the IDR entity determines that certain criteria (such as patient acuity) have already been incorporated into the calculation of the QPA, the IDR entity may not consider additional information related to the criteria that has already been factored into the QPA calculation. The Departments refer to this as “double counting.”

LITIGATION UPDATE

A recent court decision struck down portions of the regulations governing the IDR process, including aspects of the QPA. The Departments are expected to release guidance following this decision.

IDR PAYMENT DETERMINATION

Within ten days of selecting the IDR entity, each party must submit an offer for a payment amount and any additional information to the IDR entity. Within 30 days of selection, the IDR entity must determine the final payment amount. In the payment determination process, the IDR entity may not consider any public payer rates, such as Medicare or Medicaid, when determining the appropriate payment amount. Once a payment determination is made, the IDR entity must provide a written rationale to both parties and the Departments, regardless of which offer was selected.

The Departments published a [Frequently Asked Questions for Providers about the No Surprises Rules](#) (August 16, 2022) providing additional clarity about the federal rules and patient protections.

IDR PROCESS FEES

Once the federal IDR entity is selected, each participating party must pay the entire IDR entity processing fee, which will be held by the IDR entity in escrow until a determination is made, as well as a non-refundable administrative fee. Within 30 days of making the determination, the IDR entity must refund the party whose offer was selected as the final payment amount. As the parties can continue negotiation once the IDR process has begun, if the parties independently negotiate a payment amount without the IDR entity, the parties will split the IDR entity fee.

The IDR process only applies to providers and services that are subject to the federal ban on surprise billing. If the IDR entity determines that the case does not qualify for the federal IDR process, the parties will be required to split the IDR processing fee.

UPDATE FOR 2023: CMS [announced](#) that the administrative fee for the Federal independent dispute resolution (IDR) process will increase from \$50 to \$350 per party for disputes initiated during the calendar year beginning on Jan. 1, 2023. CMS claims its rationale behind the increase is due to increasing expenditures in carrying out the Federal IDR process.

FEDERAL PATIENT TRANSPARENCY REQUIREMENTS

In addition to the federal regulation of surprise medical bills, the No Surprises Act creates several new patient transparency efforts to provide patients with the opportunity to better understand the cost of care, provider networks, and insurance plan cost sharing amounts.

UNINSURED (OR SELF-PAY) GOOD FAITH ESTIMATES

Effective as of Jan. 1, 2022

Providers and facilities must provide uninsured patients or insured patients who do not plan on submitting claims and self-paying for services, or “self-pay patients” with a good faith estimate (GFE) of the total cost of expected care. The Departments intend for the GFE to provide patients with greater transparency about the cost of services and enable patients to compare prices across providers.

The GFE must reflect the cash price for services, less any discounts, and reflect the total cost of expected care furnished by the provider during a “period of care.” The Departments define a period of care as the day or multiple days in which the primary service is performed and other additional services that will likely be furnished in conjunction with the primary item or service.

KEY COMPONENTS OF UNINSURED (OR SELF-PAY) GFE

- The requirement to provide uninsured or self-pay patients with a GFE **applies to all physicians or other healthcare providers** “who [are] acting within the scope of practice of that provider's license or certification under applicable state law.” (86 Fed. Reg. 56014)
- The GFE must be provided to patients upon request or when a service is scheduled. When a service is scheduled more than ten days in advance, the provider must provide the GFE within three business days. If the item or service is scheduled at least three business days in advance, the GFE must be provided within one business day.
- The GFE must reflect the total cost of the period of care. The period of care includes the primary service, or the reason for the visit, and any foreseeable additional services that will be provided in conjunction with the primary service. In addition to the total estimated cost, the GFE must also include an itemized list and description of expected services, diagnosis codes*, services codes and associated anticipated charges.
- An uninsured or self-pay patient may request a GFE for items or services. However, if the uninsured or self-pay patient schedules an item or service with the same provider, the provider must provide a new GFE upon scheduling.

***In an [FAQ document](#), CMS clarified that a diagnosis code does not always need to be included on a GFE. A provider or facility is required to include a diagnosis code only where one is required for the calculation of the GFE.**

WHAT PROVIDERS MUST FURNISH AN UNINSURED (OR SELF-PAY) GFE?

All providers, regardless of clinical specialty and site of service, must comply with the uninsured or self-pay GFE requirements. There are no provider exceptions to these requirements.

CHANGES IN PATIENT INSURANCE STATUS

If a patient schedules care with a provider, the provider must inquire whether or not the patient is insured as defined under the GFE requirements. If the patient is insured at the time of scheduling, but later the provider becomes aware that the patient is newly uninsured fewer than three business days in advance of the scheduled services, the provider is NOT required to provide a GFE or reschedule an appointment in order to provide a GFE.

However, if changes in insurance status that would make a patient eligible for a GFE are communicated more than three business days in advance, then a provider must provide the required GFE documentation to the patient within the appropriate timeframe.

DETERMINING UNINSURED OR SELF-PAY PATIENT STATUS

Patients that are uninsured, or who have insurance but indicate that they are not intending to submit a claim to their insurer, are considered “uninsured” or “self-pay” patients under the uninsured GFE requirements.

It is the responsibility of the convening provider who is furnishing the primary item or service to verify that the patient falls under the uninsured or self-pay definition by:

- Inquiring if an individual is enrolled in a group health plan, group or individual health insurance coverage offered by a health insurance issuer, or federal health care program, and
- Inquiring whether an individual who is enrolled in a group health plan, or group or individual health insurance coverage offered by a health insurance issuer, or a health benefits plan is seeking to have a claim submitted for the primary item or service with such plan or coverage. ([86 Fed. Reg. 56135](#))

An insured patient that determines they do not intend to submit a claim to their insurer can ultimately decide to submit a claim to their insurer for coverage. If an insured patient requests a GFE with the intent to self-pay for services and ultimately does submit a claim for coverage by their insurer, the patient is no longer eligible to enter the patient-provider dispute resolution process.

TIMELINE TO ISSUE AN UNINSURED OR SELF-PAY GFE

Eligible patients may request a GFE from a provider, or upon scheduling a primary service, a provider must issue a GFE. If a patient makes an initial request for a GFE and ultimately schedules the service with the provider, the provider must issue a new GFE. Specific timing requirements are as follows:

- If an eligible patient requests a GFE, the provider has 3 business days to issue the GFE;
- If an eligible patient schedules care at least 10 business days in advance, the provider has 3 business days to issue GFE;
- If an eligible patient schedules care at least 3 business days in advance, the provider has 1 business day to issue the GFE;
- If an eligible patient schedules care less than 3 business days out, then the provider is not required to issue an uninsured or self-pay GFE. ([FAQs About Consolidated Appropriations Act, 2021 Implementation, Page 3](#))

SERVICES INVOLVING MULTIPLE PROVIDERS AND FACILITIES

The provider that initially schedules and furnishes the primary service is known as the “convening provider.” The Departments recognize that uninsured patients frequently receive care from multiple providers during one period of care, these auxiliary providers are known as “co-providers.” The Departments require the convening provider to coordinate with co-providers and include these estimated costs on the GFE for uninsured patients.

The Departments are continuing to provide flexibility for convening providers in CY 2023; convening providers will not be required to obtain GFEs from co-providers. Instead, the Departments encourage convening providers to provide a range of potential costs of services furnished by co-providers if they are unable to receive specific cost estimates.



PATIENT AND PROVIDER DISPUTE RESOLUTION PROCESS

The No Surprises Act establishes protections for uninsured or self-pay patients from unforeseeable medical costs. The law permits that patients may initiate a patient-provider dispute resolution process when the total billed charges for a provider or facility exceeds the estimate on the GFE provided to the patient by a “substantial amount.” The Departments defined a “substantial amount” as \$400 more than the provided GFE.

The \$400 threshold for initiating the patient-provider dispute resolution process is based on the difference in total charges by a provider or facility, regardless if the services were included in the GFE or not.

INSURED GOOD FAITH ESTIMATES AND ADVANCED EXPLANATION OF BENEFITS

Enforcement Delayed, Not Yet Effective

The No Surprises Act also requires that health plans or issuers provide patients with an advanced explanation of benefits (AEOB) upon receiving a “good faith estimate” for the cost of services from a provider. The AEOB must include:

1. The network status of the provider or facility,
2. The contracted rate for the item or service,
3. The good faith estimate received from the provider,
4. A good faith estimate of the anticipated cost-sharing that the patient will be responsible for and the estimated amount the health plan or issuer will cover, and
5. A disclaimer that coverage is subject to potential care management processes.

The Departments issued a notice stating they will not be enforcing the AEOB requirements on January 1, 2022. The Departments are delaying the implementation of these provisions until the Departments and stakeholders can appropriately develop and implement the technical infrastructure necessary to carry out these requirements.

The AEOB will be based off a GFE that is produced by the provider furnishing the item or service. Additional information about the requirements related to the good faith estimate and the AEOB will likely be made available during the rulemaking process in CY 2023. The Departments issued a Request for Information (RFI) in September 2022 regarding the requirements which MGMA [responded](#) to.

ADDITIONAL PATIENT TRANSPARENCY PROVISIONS

Provider Directory Information

Health plans and issuers are required to provide updated provider directories to patients to help inform patients on the network status of clinicians. If a patient receives care from an out-of-network clinician based on outdated information in a provider directory, the plan cannot impose cost sharing that is greater than what it would have been had the provider been in-network.

In 2021, the Departments announced that they [did not intend](#) to issue rulemaking prior to the statutory effective date of January 1, 2022. The Departments anticipate issuing future rulemaking implementing requirements for these provisions.



Continuity of Care

The No Surprises Act also provides certain patient protections when there are changes to the network status of a patient’s healthcare providers. If a contractual relationship between a health plan or issuer and a provider or facility is terminated, the health plan must then notify each enrollee considered a continuing care patient that a provider they were receiving care from has been removed from the patient’s network, and that the patient has a right to transitional care. The patient may have up to 90-days of transitional care during which the plan will provide continued benefits and applicable cost-sharing.

The Departments are using enforcement discretion for such continuity of care protections for patients. The Departments will undertake notice and comment rulemaking to fully implement these protections, and until such time, providers, facilities, and health plans and issuers are expected to implement the continuity of care requirements using a good faith interpretation of the statute.

ADDITIONAL INFORMATION ABOUT THE PATIENT TRANSPARENCY PROVISIONS AS PART OF THE NO SURPRISES ACT CAN BE FOUND [HERE](#).

STATE & FEDERAL SURPRISE BILLING LAWS

Prior to the passage of the No Surprises Act — the federal law regulating, in some instance and to some degree, balance billing — many states had implemented different state-wide requirements related to the practice of balance billing. As the U.S. government continued to craft federal patient protections, Congress established that a “Specified State Law” will preempt federal law in states where they were enacted in two key areas:

1. In determining the **out-of-network payment rate and dispute resolution process**, and
2. How the **recognized amount** is calculated to determine patient cost sharing amounts.

DEFINING A "SPECIFIED STATE LAW"

- Includes a method for determining the total out-of-network (OON) amount for a plan
- Must apply to the plan or issuer
- Must apply to the OON provider
- Must apply to the item or service

(86 Fed. Reg. 36885)

The federal regulations implementing the No Surprises Act further outline the interplay between the state and federal protections against surprise medical bills. While the above instances are direct deferral to state law, the Departments generally also defer to state law in instances where the state protections against surprise bills are more protective than the federal No Surprises Act.

EXAMPLES OF A MORE PROTECTIVE STATE LAW:

- A state law prohibits a greater number of services from balance billing.
- A state requires greater disclosure of information during notice and consent process.



State law preempts federal when a state law is more protective than the federal *No Surprises Act*.

FEDERAL SURPRISE BILLING PROTECTIONS, NO SURPRISES ACT

Federal law preempts state law when a state law is less protective than the federal *No Surprises Act*.

Exceptions for Self-Funded Health Plans

The No Surprises Act did not reverse the Employee Retirement Income Security Act (ERISA) policy, and as such, self-funded plans are not generally subject to state regulation. The Departments recognize that under ERISA, the federal requirements related to balance billing would generally apply to all self-funded plans. However, the Departments created an exception in states where self-funded plans can opt-in and comply with state processes. In states with these exceptions, self-funded plans can voluntarily opt in to state law that provides for a method for determining the cost-sharing amount to total amount payable under such plans to comply with requirements related to surprise billing.

EXAMPLES OF STATE & FEDERAL SURPRISE BILLING LAWS (86 FED. REG. 36886)

- **Example 1:** A health insurance issuer licensed in State A covers a specific non-emergency service that is provided to an enrollee by a nonparticipating provider in a participating health care facility, both of which are also licensed in State A. State A has a law that prohibits balance billing for non-emergency services provided to individuals by nonparticipating providers in a participating health care facility, and provides for a method for determining the cost-sharing amount and total amount payable. The state law applies to health insurance issuers and providers licensed in State A. The state law also applies to the type of service provided. **Conclusion: In this example, State A's law would apply to determine the recognized amount and the out-of-network rate.**
- **Example 2:** This example has the facts as Example 1, except that the nonparticipating provider and participating health care facility are located and licensed in State B. State A's law does not apply to the provider, because the provider is licensed and located in State B. **Conclusion: In this example, State A's law would not apply to determine the recognized amount and out-of-network rate. Instead, the lesser of the billed amount or QPA would apply to determine the recognized amount, and either an amount determined through agreement between the provider and issuer, or an amount determined by an IDR entity would apply to determine the out-of-network rate.**

KEY CONSIDERATIONS FOR GROUP PRACTICES

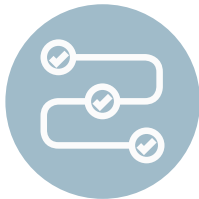
Medical practices should work to fully understand what requirements apply to the clinicians in their practice and what administrative and clinical practice changes must be made in order to comply with the new requirements.



Determine whether the federal ban on surprise medical billing applies to your group practice or physicians within your group.



If the ban on surprise medical billing applies, determine whether clinicians are eligible to participate in the Notice and Consent process to balance bill patients.



Evaluate current requirements for patient transparency and good faith estimates, and determine what current workflows and data platforms must be adjusted to meet the new requirements.



Consult internally to determine whether your state has applicable state laws in place.

FOR MORE INFORMATION, PLEASE VISIT THE CENTER FOR MEDICARE & MEDICAID SERVICES [NO SURPRISES WEBPAGE](#)

OR

CONTACT MGMA GOVERNMENT AFFAIRS AT GOVAFF@MGMA.ORG

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