

VMS Summary

The Consolidated Appropriations Act of 2021 established several new requirements for providers, facilities, and providers of air ambulance services to protect consumers from surprise medical bills. These requirements are collectively referred to as “No Surprises” rules. Among other things, these include prohibiting balance billing in certain circumstances and requiring disclosure about balance billing protections, requiring transparency around health care costs for self-pay patients, providing consumer protections related to continuity of care, and establishing requirements related to provider directories. A summary of the provisions going into effect on January 1, 2022 can be found below. More resources and links are found at the end of this summary. Contact Jessa Barnard at jbarnard@vtmd.org for more information.

- **No balance billing for out-of-network emergency services**
 - Nonparticipating providers and nonparticipating emergency facilities:
 - Cannot bill or hold liable beneficiaries, enrollees or participants in group health plans or group or individual health insurance coverage who received emergency services at a hospital or an independent freestanding emergency department for a payment amount greater than the in-network cost-sharing requirement for such services.
 - Rule contains certain exceptions with notice and informed consent

- **No balance billing for non-emergency services by nonparticipating providers at certain participating health care facilities**
 - Nonparticipating providers of non-emergency services at a participating health care facility:
 - Cannot bill or hold liable beneficiaries, enrollees or participants in group health plans or group or individual health insurance coverage who received covered non-emergency services with respect to a visit at a participating health care facility by a nonparticipating provider for a payment amount greater than the in network cost-sharing requirement for such services, unless notice and consent requirements are met.

- **No balance billing for air ambulance services by nonparticipating air ambulance providers**

- **Disclose patient protections against balance billing**
 - **Content of notice:** The rules also require certain health care providers and facilities make publicly available, post on a public website, and provide a one-page notice to individuals regarding: (1) The requirements and prohibitions on balanced billing applicable to the provider or facility; (2) any applicable state balance billing requirements; and (3) how to contact appropriate state and federal agencies if the individual believes the provider or facility has violated the requirements described in the notice.
 - **Who gets the notice:** providers and facilities must provide a one-page notice to individuals who are participants, beneficiaries, or enrollees of a group health plan or individual health insurance coverage offered by a health insurance issuer
 - **Exceptions to when the notice must be provided:**
 - First, health care providers are not required to make the disclosures if they do not furnish items or services at a health care facility, or in connection with visits at health care facilities.
 - Second, health care providers are required to provide the required disclosure only to individuals to whom they furnish items or services, and then only if such items or

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services are furnished at a health care facility, or in connection with a visit at a health care facility.

- The intent of this exception is to avoid confusion, for instance, providing the disclosure of balance billing protections in a primary care provider's office could lead individuals to incorrectly assume balance billing protections exist where they do not.
 - **How to provide the notice:**
 - must be provided in-person or through mail or email, as selected by the participant, beneficiary, or enrollee.
 - If provider has a website, must post it on a public website of such provider or facility
 - Display the required disclosure information on a sign posted prominently at the location of the health care provider or health care facility
 - **Timing/when to provide the notice:**
 - a health care provider or health care facility must generally provide the notice to participants, beneficiaries, or enrollees no later than the date and time on which the provider or facility requests payment from the individual (including requests for copayment made at the time of a visit to the provider or facility) or the date on which the provider or facility submits a claim for payment to the plan or issuer
 - providers/facilities also have flexibility to provide the notice earlier, such as when an individual schedules an appointment, or when other standard notice disclosures (such as the Notice of Privacy Practices for Protected Health Information) are shared with individuals.
 - **Sample notice provided by CMS:** <https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780>
- **Good Faith Estimates to Self-Pay Patients**
 - Effective January 1, 2022, health care providers and facilities must begin provide to patients who are not enrolled in a health plan or federal health care program or plan to self-pay a good faith estimate of expected charges, expected service and diagnostic codes of scheduled services. Note the following:
 - This provision does not apply to patients with/submitted claims to a health insurance plan
 - The provider or facility must inform uninsured (or self-pay) individuals that good faith estimates of expected charges are available to uninsured (or self-pay) individuals upon scheduling an item or service or upon request
 - The estimate must be provided when the individual schedules a service or upon request, and [the rule](#) contains specific timelines for providing the information to a patient:
 - When a primary item or service is scheduled at least 3 business days before the date the item or service is scheduled to be furnished: Not later than 1 business day after the date of scheduling;
 - When a primary item or service is scheduled at least 10 business days before such item or service is scheduled to be furnished: Not later than 3 business days after the date of scheduling; or
 - When a good faith estimate is requested by an uninsured (or self-pay) individual: Not later than 3 business days after the date of the request.

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- The rule contains little guidance for practices regarding how to select the level of service or diagnosis code(s) used for the estimate. National associations have asked CMS for further guidance; at this point practice should use their best judgment and provide as close of an estimate as possible
 - In a situation where an uninsured (or self-pay) individual receives a good faith estimate and then is billed for an amount substantially in excess of the good faith estimate (currently defined as \$400 more than the estimate), HHS establishes a patient-provider dispute resolution process to determine a payment amount, triggered when the patient submits a notification via a Federal dispute resolution portal
 - Where the service will involve multiple healthcare providers, the scheduling provider is required to coordinate with the other providers to gather information necessary to timely provide this estimate, although enforcement of this coordination is delayed until December 31, 2022.
 - These requirements are contained in interim final rules which were open for public comment until Dec. 6th and may be modified when the rule is finalized. However, practices should start to prepare in anticipation of a Jan. 1 effective date.
- See CMS [template forms](#) to implement Good Faith Estimates with self-pay patients
- **Ensure continuity of care when a provider's network status changes**
 - A health care provider or facility that ends a contractual relationship with a plan or issuer and has a continuing care patient must generally accept payment from the plan or issuer (and cost-sharing payments) for a continuing care patient at the previously agreed to payment amount for up to 90 days after the date on which the patient was notified of the change in the provider's network status
- **Improve provider directories**
 - Any health care provider or health care facility that has or has had a contractual relationship with a plan or issuer must submit provider directory information to a plan or issuer at the beginning of the network agreement, when there are material changes to content, upon request and at the time of termination of a network agreement
 - Reimburse enrollees who relied on an incorrect provider directory and paid a provider bill in excess of the in-network cost-sharing amount
- **Enforcement**
 - VMS understands that Vermont's Department of Financial Regulation will coordinate with CMS to enforce No Surprises Act provisions based on a complaint-driven process

Resources:

- CMS provider resources, rule summaries and fact sheets: <https://www.cms.gov/nosurprises>
- CMS Webinar Overview of January 1, 2022 requirements: <https://www.cms.gov/files/document/high-level-overview-provider-requirements.pdf>
- CMS sample notice regarding balanced billing: <https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780>

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- CMS template forms to implement Good Faith Estimates with self-pay patients: <https://www.cms.gov/regulations-and-guidance/legislation/paperworkreductionactof1995/practicing/cms-10791>
- American Medical Association Summaries and Resources of the Rules: <https://www.ama-assn.org/delivering-care/patient-support-advocacy/implementation-no-surprises-act>

For more information:

- Questions regarding the rules can be submitted to: Provider_enforcement@cms.hhs.gov