No Surprises Act Update Q&A

Q. Are Medicare Advantage plans affected by the NSA?

A. Individuals with MA plans are not affected by the NSA. People with coverage through Original Medicare or an MA plan already have the right to file an appeal if they disagree with a coverage or payment decision.

Reference: MLN8659122 – Original Medicare vs. Medicare Advantage (cms.gov)

Q. What are the penalties for non-compliance?

A. Healthcare providers could face penalties of up to $10,000 for each violation. In determining the amount of the civil monetary penalty, CMS will consider previous record of compliance and the gravity of the violation.

Q: Will PARA have the ability to print GFE, consents, and notices in Spanish?

A: PARA is requiring each facility to provide a translation of the documents in each of the languages they will need for their region. Due to the legal nature of medical translation, PARA cannot accept the responsibility of translating the documents.

Q: Are you currently building interfaces for some of our practice management software?

A: PARA is continuously making upgrades, but that one has not been discussed yet.

Q: Can you tell me where we find our state balance billing laws or requirements?

A: The state balance billing laws can be found on the Commonwealth Fund website at:
State Balance-Billing Protections | Commonwealth Fund.
CMS surveyed each state to determine their authority and intention to enforce the provisions of the NSA. CMS composed letters outlining their understanding of each state's response and posted them on the website at:
Consolidated Appropriations Act, 2021 (CAA) | CMS

Q: What protections apply to an individual when they schedule a service at an out-of-network facility?

A: The NSA offers no protections for the individual that schedules a service at an OON facility. The insured individual will be receiving the Disclosure Notice (which informs them about the NSA) at which time they should question whether the facility is In-Network.
This question was posed to a group of NSA experts from the AHA:

> **Please confirm that NSBA does not apply in situations where the facility and provider(s) are out of network.**

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This is correct, with the exception of emergent care. For emergent items and services provided at any facility, emergent care out-of-network balance-billing is prohibited. However, for scheduled out-of-network services, an out-of-network convening provider with an out-of-network co-provider or co-facility is not required to provide a consent or a good-faith-estimate before balance billing a patient for out-of-network items or services... this would not be a "surprise" since the patient sought care at an out-of-network convening provider/facility.

Q: Can you tell me more about the $400 'threshold.'

A: The GFE presented to an uninsured patient must include reasonably expected charges. Should the actual billed charges be *substantially in excess* of the estimate, the patient can initiate a dispute of the charges that are in excess of the estimate. The term *substantially in excess* has been quantified as $400. In 2019, the Federal Reserve found that nearly 4 in 10 adults would have difficulty covering an emergency expense costing $400, with 12 percent of adults unable to pay their current month's bills if they also had an unexpected $400 expense. As a result, HHS is of the view that setting the *substantially in excess* threshold equal to $400 is a reasonable and appropriate approach and would ensure that the minimum amount in dispute for the patient-provider dispute resolution process is comparable to the expected costs for dispute resolution.

> eCFR :: 45 CFR Part 149 Subpart G -- Protection of Uninsured or Self-Pay Individuals
> ***Definitions.*** Unless otherwise stated, the definitions in § 149.610(a)(2) apply to this section. Definitions related to confidentiality set forth in § 149.510(a)(2), including the definitions for *breach, individually identifiable health information (IIHI),* and *unsecured IIHI* also apply to this section. Additionally, for purposes of this section, the following definitions apply:
> (i) ***Billed charge(s)*** means the amount billed by a provider or facility for an item or service.
> (ii) ***Substantially in excess*** means, with respect to the total billed charges by a provider or facility, an amount that is at least $400 more than the total amount of expected charges listed on the good faith estimate for the provider or facility.
> (iii) ***Total billed charge(s)*** means the total of billed charges, by a provider or-facility, for all primary items or services and all other items or services furnished in conjunction with the primary items or services to an uninsured (or self-pay) individual, regardless of whether such items or services were included in the good faith estimate.

The patient must have the GFE to initiate a dispute, so they cannot refuse the GFE. Suggested scripting when informing a patient that they have the right to receive a good faith estimate should conclude with "Would you like that estimate in a hard copy or electronic?" Don't give them an option to refuse.

Q: Can you assist me in finding the latest information on the Language Access rule? Do we need to translate into the 15 most common languages in your area/ state? Or was that section relaxed?

A: HHS allows the use of appropriate language services when communicating with the uninsured individual and providing them with a good faith estimate.

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> Federal Register :: Requirements Related to Surprise Billing; Part II
> In interpreting the statutory requirements regarding the use of clear and understandable language, HHS recognizes that communication, language, and literacy barriers are associated with decreased quality of care, poorer health outcomes, and increased utilization.[67] The use of appropriate language services and appropriate literacy levels in health care settings is associated with increased quality of care, improved patient safety outcomes, and lower utilization of costly medical procedures.[68] HHS is of the view that it is imperative that providers and facilities make these efforts to provide good faith estimate information in a manner understandable to the uninsured (or self-pay) individual to help achieve the goal of the statute and ensure that uninsured (or self-pay) individuals are aware of the good faith estimate information and the options available to them. HHS is of the view that when providing a good faith estimate, providers or facilities should also take into account any vision, hearing, or language limitations; communication needs of underserved populations; individuals with limited English proficiency; and persons with health literacy needs. These factors meaningfully contribute to whether the uninsured (or self-pay) individual can understand and ask any questions about the total expected costs for items or services.

The requirement of 15 languages has not been relaxed when providing an estimate with the Notice and Consent. The patient is waiving their rights and protections against balance billing, so it is important that they fully understand what they are signing. In the event the patient does not speak any of the 15 languages, an interpreter can be used to assist the patient with understanding their rights.

> eCFR :: 45 CFR 149.420 -- Balance billing in cases of non-emergency services performed by nonparticipating providers at certain participating health care facilities.
> ***Language access.***
>
> (1) A nonparticipating provider (or the participating health care facility on behalf of the nonparticipating provider) must provide the individual with the choice to receive the written notice and consent document in any of the 15 most common languages in the State in which the applicable facility is located, except that the notice and consent document may instead be available in any of the 15 most common languages in a geographic region that reasonably reflects the geographic region served by the applicable facility; and
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> (2) If the individual's preferred language is not among the 15 most common languages in which the nonparticipating provider (or the participating health care facility on behalf of the nonparticipating provider) makes the notice and consent document available and the individual cannot understand the language in which the notice and consent document are provided, the notice and consent criteria in paragraph (c) of this section

> are not met unless the nonparticipating provider (or the participating health care facility on behalf of the nonparticipating provider) has obtained the services of a qualified interpreter to assist the individual with understanding the information contained in the notice and consent document.

Q: I can share with you that there is confusion amongst many, and our co-op has shared they believe the GFE is also on hold for co-providers and they would not need to provide an estimate for the self-pay patients? Where is all of this information cited? The CFR does lead me to believe it is required now but so many are telling me otherwise.

A: The convening facility is required to provide the uninsured individual with a GFE that lists the reasonably expected charges for the convening facility. If the convening facility has the reasonably expected charges for a co-provider, those charges should be included on the GFE. If those charges are not available, the co-provider's name and contact information should be listed on the GFE so the uninsured individual can contact that co-provider directly with a request of reasonably expected charges, at which time the co-provider would then be obligated to provide a GFE to the uninsured patient.

> **Requirements Related to Surprise Billing; Part II Interim Final Rule with Comment Period | CMS**
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> HHS understands that it may take time for providers and facilities to develop systems and processes for providing and receiving the required information from others. Therefore, for good faith estimates provided to uninsured (or self-pay) individuals from January 1, 2022, through December 31, 2022, HHS will exercise its enforcement discretion in situations where a good faith estimate provided to an uninsured (or self-pay) individual does not include expected charges from other providers and facilities that are involved in the individual's care.

Q: How do we get the NSA Custom tile added?

A: The NSA Custom tile will appear after the first Custom Claim is created and the page is refreshed.