Health Care Provider Surprise Billing and Price Transparency Implementation Checklist

✓ **Providers Must Prepare to Issue Good Faith Estimates—for All Services, NotJust Surprise Billing.**

Providers and facilities (including any state-licensed institutions and physicians or other health care providers that are acting within the scope of practice of that provider's license or certification under applicable state law, including providers of air ambulance services), uponscheduling an item or service or upon request, must:

- Inquire about the individual's health coverage status and provide a good faith estimate (GFE) of the expected charges for such item or service (including any item or service thatis reasonably expected to be provided in conjunction with such scheduled or requested item or service by any providers or facilities).
- Determine whether it is a "convening provider"/"convening facility" (i.e., the provider or facility that receives the initial request for a GFE from a self-pay individual and that is or, in the case of a request, would be responsible for scheduling the primary item or service/ the item or service that is the initial reason for the visit) or a "co-provider"/"co-facility" (i.e., a provider or facility other than a convening provider or a convening facility that furnishes items or services that are customarily provided in conjunction with a primary item or service).
- For uninsured patients, determine whether a GFE must be provided to the individual. The convening provider or facility must inquire and determine if the individual meets thedefinition of an uninsured (or self-pay) individual.
- Inform (in writing and orally) uninsured (or self-pay) individuals that GFEs of expected charges are available to uninsured (or self-pay) individuals upon scheduling an item orservice or upon request.
- Contact all co-providers/co-facilities no later than one business day after the GFE request is received or after the primary item or service is scheduled, and request submission ofexpected charges for items or services by a specified date.
- Meet the GFE requirements applicable to convening providers/facilities, if an uninsured (or self-pay) individual requests a GFE from or separately schedules services with a co- provider/co-facility, which then makes that provider/facility a convening provider/facilitywith respect to the relevant services.
- Meet GFE content and timing requirements.
- Prepare to be involved in a patient-provider dispute resolution process for those uninsured patients who received a bill that was "substantially in excess" of the GFE. ("Substantially in excess" is defined as total billed charges exceeding the total amount ofexpected charges by $400 or more.)

✓ **Providers Must Take Inventory of All the Situations in Which Surprise Billing Takes Place and Adjust Their Billing Processes (and Figure out Which Would Be Subject to New No Surprises Act (NSA) Requirements).**

- For hospitals, this would include all facilities licensed by the state to provide emergency services and those ancillary providers and others who may need to perform care in urgent or emergent situations and have privileges in the hospital but are not contractedwith the same payers as the hospital. (Out-of-network (OON) air ambulances are also subject to NSA cost-sharing protections/balance billing prohibitions).

- Defining emergency services may be tricky because the NSA defines such services toinclude post-stabilization care whereas many state laws do not.

- Providers should undertake good faith compliance efforts to protect against penalties (of up to $10,000 per violation).This may mean that where an OON provider does not know if the patient is covered or not, the provider may have to bill the payer rather than billing the patient and letting the patient seek coverage from the payer.

✓ **Providers Need to Prepare to Engage in the New Independent Dispute Resolution (IDR) Arbitration Process for Determining Noncontracted Payment Amounts.**

Providers should:

- Inventory the high-cost and high-frequency services provided to patients who are notenrolled with contracting payers.

- Create a pre-packaged set of template IDR dispute materials and arguments ready to go in order to make the tight IDR timelines for surprise billing services.

- Become familiar with the federal IDR portal at https://www.nsa-idr.cms.gov, which willbe the portal for IDR actions and a source of IDR information (e.g., standard notice for initiating open negotiations, standard notice for initiating IDR process, list of certified IDR entities).

- Comply with timelines for open negotiation, IDR initiation, selection of the IDR entity,submission of the proposed reimbursement amount (including expression as a percentage of the qualifying payment amount (QPA)) and supporting information, andpayment/refunds to the prevailing party.

  Identify which factors justifying deviation from the QPA are applicable to each item orservice at issue. Although the IDR entity "must presume that the QPA is an appropriate payment amount" and "must select the offer closest to the QPA," it may deviate from theQPA if the "credible information submitted by the parties clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate."

✓ **Providers Need to Obtain Notice and Consent to Balance Bill in Surprise Billing Situations.**

Providers must:

- Establish a system for identifying patients in surprise billing situations subject to balancebilling (excluding emergency services and many nonemergency services provided in urgent situations as specified in the first No Surprises Act Interim Final Rule withComment (July 13, 2021).

- Provide sufficient notice and obtain consent for patients to be balance billed.

✓ **Providers Must Give Notice to the Plan or Issuer of Services Provided That Are Subject to Surprise Bills.**

For each item or service furnished by a nonparticipating provider or emergency facilty, the provider must:

- Notify the plan or issuer in a timely fashion as to whether balance billing and in-network cost-sharing protections apply to the item or service, and
- Provide to the plan or issuer a signed copy of any written notice and consent documents.

✓ **Providers Must Make Public Disclosure of Balance Billing Protections.**

The No Surprises Act requires providers (excluding air ambulance providers) and facilities(including independent free-standing emergency departments) to make a one-page noticeregarding patient protections against balance billing.The notice must:

- Be searchable on the provider's public website and posted prominently in facilities.
- Contain applicable NSA protections/state protections, and specify how to complain toagencies about violations, including providing agency contact information.
- Include information about any applicable state requirements and about how to contact appropriate state and federal agencies if the patient believes the provider or facility hasviolated the balance billing rules.
- A template notice has been released by the Departments: https://www.cms.gov/ httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pralisting/cms-10780

✓ **Providers Must Be Prepared to Respond to the Results of External Review ofPatients' Adverse Benefit Determinations.**

These external patient-initiated reviews of adverse benefit determinations can be used bypatients to review and challenge various types of determinations, including:

- Whether a claim is for emergency services that involve medical judgment or consideration of compliance with the cost-sharing and surprise billing protections;
- Whether a claim by a nonparticipating provider at an in-network facility is subject to the protections of the No Surprises Act;
- Whether an individual was capable of providing informed consent to waive protections of the No Surprises Act; or
- Whether cost-sharing was appropriately calculated for claims for ancillary servicesprovided by out-of-network providers at in-network facilities.

✓ **Providers Must Understand the Rules Around Air Ambulance Data Reporting.**

The No Surprises Act sets federal rules for billing of out-of-network air ambulance services. The Departments published in July an interim final rule that set out-of-network patient cost-sharing parameters for emergency services, including air ambulances, and prohibited balance billing. The Sept. 16, 2021 proposed rule proposes standards for the No Surprises Act requirement placed on health insurance issuers, group health plans and air ambulanceproviders to submit information to HHS regarding air ambulance services. Carriers in the

Federal Employees Health Benefits Program would also need to submit information. The datawould be submitted on a calendar year basis, beginning on March 30, 2023, for 2022.