Overview of Public Health Service (PHS) Act Provider and Facility Requirements

Center for Consumer Information & Insurance Oversight (CCIIO)

Legal Disclaimers

- The information provided in this presentation is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance upon which it is based. This presentation summarizes current policy and operations as of the date it was presented. We encourage readers to refer to the applicable statutes, regulations, and appropriate interpretive materials for complete and current information.

Legal Disclaimers (continued)

- The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.
- This communication was published, produced and disseminated at U.S. taxpayer expense.

Agenda

- Background & Purpose
- Requirements for Providers, Facilities and Providers of Air Ambulance Services That Apply Starting January 1, 2022
- Information about Requirements for Providers, Facilities and Providers of Air Ambulance Services
- Enforcement
- Resources
- Definitions
- Questions

Background & Purpose

- Title I (No Surprises Act) of Division BB of the Consolidated Appropriations Act, 2021 (CAA) amended title XXVII of the Public Health Service Act (PHS Act) to add a new Part E.
- Generally, providers, facilities, and providers of air ambulance services must comply with these new requirements starting January 1, 2022.
- The provisions in Part E create requirements that apply to providers, facilities, and providers of air ambulance services, such as cost sharing rules, prohibitions on balance billing for certain items and services, notice and consent requirements, and requirements related to disclosures about balance billing protections.

Background & Purpose (continued)

- These provider, facility, and provider of air ambulance services requirements generally apply to items and services provided to individuals enrolled in group health plans or group or individual health insurance coverage, and Federal Employees Health Benefit plans. The good faith estimate requirement and the requirements related to the patient-provider dispute resolution process also apply to the uninsured.

- These requirements do not apply to beneficiaries or enrollees in federal programs such as Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE. These programs have other protections against high medical bills.

Provider and facility requirements that apply starting January 1, 2022

- No balance billing for out-of-network emergency services (PHSA 2799B-1; 45 CFR 149.410)
- No balance billing for non-emergency services by nonparticipating providers at certain participating health care facilities, unless notice and consent was given in some circumstances (PHSA 2799B-2; 45 CFR 149.420)
- Disclose patient protections against balance billing (PHSA 2799B-3; 45 CFR 149.430)

Provider and facility requirements that apply starting January 1, 2022 (continued)

- No balance billing for air ambulance services by nonparticipating air ambulance providers (PHSA 2799B-5; 45 CFR 149.440)
- Provide good faith estimate in advance of scheduled services, or upon request (PHSA 2799B-6; 45 CFR 149.610 (for uninsured or self-pay individuals)
- Ensure continuity of care when a provider's network status changes (PHSA 2799B-8)
- Improve provider directories and reimburse enrollees for errors (PHSA 2799B-9)

No balance billing for out-of-network emergency services – summary

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.

No balance billing for out-of-network emergency services – summary (continued)

- Cost-sharing is calculated as if the total amount that would have been charged by a participating provider or participating facility were equal to the recognized amount.
- Certain post-stabilization services are considered emergency services, and are therefore subject to this prohibition, unless notice and consent requirements are met.

Exceptions to no balance billing for out-of-network emergency services – notice & consent

Nonparticipating providers and facilities may balance bill for post-stabilization services only if all of the following conditions have been met:

- The attending emergency physician or treating provider determines that the beneficiary, enrollee or participant:
    1. Can travel using non-medical or non-emergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into account the individual's medical condition; and
    2. Is in a condition to receive notice and provide informed consent.

Exceptions to no balance billing for out-of-network emergency services – notice & consent (continued)

3. The nonparticipating provider or facility provides the beneficiary, enrollee or participant with a written notice and obtains consent that includes certain content and within a specific timeframe and format outlined in regulation and guidance. See resource slide for link to the regulation and required forms for the notice and consent documents.
4. The provider or facility satisfies any additional state law requirements.

Exceptions to no balance billing for out-of-network emergency services – notice & consent (continued)

- A provider or facility cannot balance bill for items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the nonparticipating provider or facility previously satisfied the notice and consent criteria.

- Note that this applies to both emergency and non-emergency services.

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 non-emergency services by nonparticipating providers at certain participating health care facilities (continued)

- Cost-sharing is calculated as if the total amount that would have been charged by a participating provider or participating facility were equal to the recognized amount.
- Health care facilities include: hospitals, hospital outpatient departments, critical access hospitals, and ambulatory surgical centers.

No balance billing for non-emergency services by nonparticipating providers at certain participating health care facilities (continued)

- Note that notice and consent requirements do not apply to the following list of ancillary services, for which the prohibition against balance billing remains applicable:
  - Items and services related to emergency medicine, anesthesiology, pathology, radiology and neonatology;
  - Items and services provided by assistant surgeons, hospitalists, and intensivists;
  - Diagnostic services, including radiology and laboratory services; and
  - Items and services provided by a nonparticipating provider if there is no participating provider who can provide such item or service at such facility.

Disclose patient protections against balance billing

- A provider or facility must disclose to any participant, beneficiary, or enrollee in a group health plan or group or individual health insurance coverage to whom the provider or facility furnishes items and services information regarding federal and state (if applicable) balance billing protections and how to report violations. Providers or facilities must post this information prominently at the location of the facility, post it on a public website (if applicable) and provide it to the participant, beneficiary or enrollee in a timeframe and manner outlined in regulation.

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

- Providers of air ambulance services cannot bill or hold liable beneficiaries, enrollees or participants in group health plans or group or individual health insurance coverage who received covered air ambulance services from a nonparticipating air ambulance provider for a payment amount greater than the in-network cost-sharing requirement for such services.
- The cost-sharing requirement must be calculated as if the total amount that would have been charged for the services by a participating provider of air ambulance services were equal to the lesser of the qualifying payment amount or the billed amount for the services.

Provide a good faith estimate of the expected charges in advance of scheduled services, or upon request, to uninsured (or self-pay) individuals

- A health care provider or facility must inquire within a specific timeframe outlined in regulation and guidance if an individual who schedules an item or service is enrolled in a group health plan, group or individual health insurance coverage offered by a health insurance issuer, a Federal health care program or a Federal Employees Health Benefit plan. If so, inquire if an individual enrolled in a group health plan, group or individual health insurance coverage offered by a health insurance issuer, or a Federal Employees Health Benefit plan is seeking to have their claims for such item or service submitted to plan. The provider or facility must provide notification (in clear and understandable language) of the good faith estimate of the expected charges, expected service, and diagnostic codes of scheduled services.

Provide a good faith estimate of the expected charges in advance of scheduled services, or upon request, to uninsured (or self-pay) individuals (continued)

- The good faith estimate must include expected charges for the items or services that are reasonably expected to be provided in conjunction with the primary item or service, including items or services that may be provided by other providers and facilities.
- 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.

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, in cases where the contractual relationship between a plan or issuer and a provider or facility ends, resulting in a change in the provider or facility's network status with the plan:
    A. 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.
    B. Continue to adhere to all policies, procedures and quality standards imposed by the plan or issuer for such items or services as if the contract were still in place.

Improve provider directories and reimburse enrollees for errors

Any health care provider or health care facility that has or has had a contractual relationship with a plan or issuer to provide items or services under such plan or insurance coverage:

- Must submit provider directory information to a plan or issuer, at a minimum:
  - At the beginning of the network agreement with a plan or issuer,
  - At the time of termination of a network agreement with a plan or issuer,
  - When there are material changes to the content of the provider directory information of the provider or facility,
  - Upon request by the plan or issuer, and
  - At any other time determined appropriate by the provider, facility, or HHS.

Improve provider directories and reimburse enrollees for errors (continued)

Any health care provider or health care facility that has or has had a contractual relationship with a plan or issuer to provide items or services under such plan or insurance coverage must:

- Also, reimburse enrollees who relied on an incorrect provider directory and paid a provider bill in excess of the in-network cost-sharing amount.

Enforcement

- Under the statute, CMS will only enforce a provision with respect to the applicable regulated parties if CMS determines that a state is not substantially enforcing that provision. This can occur, for example, when a state lacks authority to enforce, or requests that CMS enforce, one or more provisions.
- Prior to January 1, 2022, CMS will publish a list, by state, of provisions CMS will enforce.

Resources

- CMS-9909-IFC: Requirements Related to Surprise Billing; Part I
- CMS-9909-IFC Fact Sheet: What You Need to Know about the Biden-Harris Administration's Actions to Prevent Surprise Billing
- Model Notice & Consent Templates
- FAQ for CAA implementation, August 20, 2021
- Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement NPRM
- Air Ambulance NPRM – Fact Sheet
- CMS-9908-IFC: Requirements Related to Surprise Billing; Part II
- CMS-9908-IFC Fact Sheet: What You Need to Know about the Biden-Harris Administration's Actions to Prevent Surprise Billing (September 2021)
- Additional trainings will be forthcoming on a variety of provider enforcement topics, including deeper dives into the notice and consent rules, provider disclosure requirements, and other provisions discussed in these slides.

No balance billing for out-of-network emergency services – definitions

- **Emergency services –** with respect to an emergency medical condition, appropriate medical screening including ancillary services, medical examination and treatment required to stabilize the patient, and certain post-stabilization services associated with the emergency medical condition that are covered under the plan or coverage, unless certain notice and consent and other criteria are met.
- **Emergency medical condition –** a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition that places the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ.

No balance billing for out-of-network emergency services – definitions (continued)

- **Nonparticipating emergency facility –** an emergency department of a hospital or an independent freestanding emergency department (or a hospital with respect to post-stabilization services) that does not have a contractual relationship directly or indirectly with a group health plan or group or individual health insurance coverage, with respect to the furnishing of an item or service under the plan or coverage.
- **Nonparticipating provider –** any physician or other health care provider who does not have a contractual relationship directly or indirectly with a group health plan or group or individual health insurance coverage, with respect to the furnishing of an item or service under the plan or coverage.
- **Participating health care facility** - any health care facility that has a contractual relationship directly or indirectly with a group health plan or health insurance issuer offering group or individual health insurance coverage, with respect to the furnishing of an item or service under the plan or coverage.

Ensure continuity of care when a provider's network status changes – definitions

Continuing care patient – an individual who:

1. is undergoing a course of treatment for a serious and complex condition from the provider or facility;
2. is undergoing a course of institutional or inpatient care from the provider or facility;
3. is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care with respect to such surgery;
4. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
5. was determined to be terminally ill and is receiving treatment for such illness from the provider or facility.

Ensure continuity of care when a provider's network status changes – definitions (continued)

Serious and complex condition –

1) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

2) in the case of a chronic illness or condition, a condition that

a) is life-threatening, degenerative, potentially disabling or congenital; and

b) requires specialized medical treatment over a prolonged period of time.

Questions

- Send any questions about the provider requirements and provider enforcement to provider_enforcement@cms.hhs.gov.