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BEHAVIORAL HEALTH

No Surprises Act

Updates, Overview, and Compliance Tips for 2023

A Special Report
from the Experts at
SimiTree Behavioral Health

A year after taking effect Jan. 1, 2022, the No Surprises Act remains a source of uncertainty and frustration for healthcare providers.

Industry pushback has been fierce, especially from behavioral health providers who find it vexing to determine an expected length of treatment so that they can provide the required Good Faith Estimate (GFE) of treatment costs. An upfront diagnosis as part of the GFE is another source of ire for all who work in the field of psychology, where the provision of care is often necessary to determine the diagnosis.

Providers have not yet experienced the full impact of the Act. A year of enforcement discretion granted throughout 2022 meant providers were not required to coordinate GFE information from other providers whose services are typically scheduled at the same time.

But that extension expires at the end of 2022, and beginning in January 2023, healthcare providers will be expected to comply with the GFE coordination requirement.

The first year the No Surprises Act has been in effect has been fraught by legal challenges and demands from industry advocates for delayed implementation or amendments, and long waits for guidance from the U.S. Department of Health and Human Services. More than halfway through the first year of implementation, a new final rule was issued in August 2022 to address findings of the court after legal challenges.

Many aspects of The No Surprises Act remain uncertain as the first anniversary of its implementation approaches. Additional rulemaking is still expected for the process providers will be required to use for sending a GFE to insurers.

The following is an overview of what has happened, what is expected to occur next, and recommendations for what providers should do for compliance.

BACKGROUND

The No Surprises Act refers to federal legislation that went into effect on Jan. 1, 2022, creating new rules for transparency in healthcare pricing and cost-sharing. It was enacted as part of the Consolidated Appropriations Act of 2021 (H.R. 133; Division BB – Private Health Insurance and Public Health Provisions).

The legislation helps protect patients from surprise medical bills resulting from emergency medical care, ambulance services, and certain services received from out-of-network providers at in-network facilities.

Although psychologists and behavioral healthcare providers generally do not offer these services, they are affected by the requirements to give patients clear information about costs before care is given.

WHAT THE ACT DOES

Puts an end to balance billing.
Balance billing occurs when a patient is billed for the difference between what their insurer pays and what the provider charges.

Addresses gaps in coverage.
The Act protects patients from receiving surprise medical bills resulting from gaps in coverage for emergency services and certain services provided by out-of-network clinicians at in-network facilities, including air ambulances.

Limits patient liability for excess costs.
When overall costs exceed the in-network cost-sharing amount, patients are not held liable for the excess. A provider may not bill the patient for the remaining balance. If the patient is billed for more than their expected share of the cost of their care, the provider will be required to issue a refund. Providers and insurers are given an opportunity to negotiate reimbursement.

Makes IDR available for disputes.
Allows providers and insurers to access an independent dispute resolution (IDR) process in the event disputes arise around reimbursement. The legislation does not set a benchmark reimbursement amount.

Increases transparency.
The Act requires both providers and health plans to assist patients in accessing healthcare cost information.

Requires a Good Faith Estimate (GFE).
The Act requires self-pay patients to be notified ahead of time if one of their providers at a facility covered by the insurance is out-of-network. If that is the case, the provider is required to give the patient a GFE of the expected share of the costs associated with their care.

A self-pay patient may be an individual who is uninsured or a patient who has insurance but does not intend to use it.

Estimates must be presented to the patient 1-3 days before a scheduled service or when a patient requests the information. It must include the patient's deductible, co-payment, and co-insurance amounts. It must also include an estimate of the total cost of the care the patient will receive.

The definition of "items and services" for which the good faith estimate must be provided is broadly defined to encompass all encounters, procedures, medical tests provided or assessed in connection with the provision of healthcare.

Services related to mental health and substance use disorders (E/M services, psychotherapy, etc.) are specifically included.

The GFE must be provided to the patient in a format that is easy to understand and compare with other estimates.

As written, the Act states that providers must also work with other providers whose services may be scheduled at the same time to coordinate GFEs for patients who do not have insurance or have insurance but do not intend to use it. However, that part of the Act has not been enforced in 2022.

The Department of Health and Human Resources and the Centers for Medicare and Medicaid Services (CMS) recognized that setting up processes for coordination among providers might be challenging and had granted a one-year enforcement delay for this requirement. The enforcement delay ends Dec. 31, 2022.

A one-year enforcement delay ends Dec. 31, 2022. Unless an extension is granted, providers will need to coordinate estimates with other providers for self-pay patients beginning Jan. 1, 2023.

MORE RULEMAKING AHEAD

As the delayed enforcement period for providing GFEs to self-pay patients winds to a close on Dec. 31, 2022, providers will be faced next with determining how to provide GFEs of costs to patients who intend to use insurance to cover their service.

CMS has proposed a process in which the provider would notify the patient's insurer of the estimated charges. The insurer would then send the patient an explanation of benefits based on the provider's estimate.

The details of the process for sending the GFE information from providers to insurers has not been determined. A comment period seeking input on this issue ended Nov. 15, 2022. CMS is expected to use comments for rulemaking.

RECOMMENDATIONS FOR COMPLIANCE

Following are best-practice recommendations for behavioral health providers seeking to comply with the GFE requirement:

- **Develop a written notice.** Create a written notice stating that a good faith estimate is available and can be provided upon request.
- **Identify self-paying patients at the outset.** Ask all patients whether they have insurance and whether they intend to use their insurance to pay for medical services. If the patient does NOT plan to use insurance or does not have insurance, share the anticipated costs of service and tell the patient that a GFE is available and will be provided in writing.
- **Use the CMS template.** CMS offers instructions and a sample GFE template.
- **Include this information.** Whether using the sample template from CMS or creating your own, make sure it contains the following information in clear and understandable language:

    1. The patient's name and date of birth.
    2. A description of the primary service (i.e., E/M, psychotherapy) being furnished to the patient and if applicable, the date or date range if recurring the primary service is scheduled.
    3. An itemized list of reasonably expected services to be furnished.
    4. Applicable diagnosis codes when known. Since many mental health patients must be seen in order to establish the diagnosis, create standard language such as "TBD pending evaluation for MH."
    5. Expected service codes and charges associated with each listed item or service. Note that this information may already be captured in your fee schedule.
    6. The name, National Provider Identifier (NPI), and Tax Identification Number (TIN) of each provider or facility represented in the GFE and the state(s) and office or facility location(s) where the items or services are expected to be furnished. Solo psychiatrists would list their name, NPI/TIN and address. Professional organizations generally recommend using a business TIN rather than the SSN.

7. A list of services that the provider or convening facility (the provider or facility that handles the scheduling of the service) anticipates will require separate scheduling and that are expected to occur before or following the expected period of care for the primary item or service.
8. A disclaimer that there may be additional items or services the convening provider or convening facility recommends as part of the course of care that must be scheduled or requested separately and are not reflected in the GFE.
9. A disclaimer that the information provided in the GFE is only an estimate and that actual items, services, or charges may differ from the GFE.
10. A disclaimer that informs the patient of the right to initiate a patient/provider dispute resolution process if the actual billed charges substantially exceed the expected charges included in the GFE. This should include instructions for where the patient can find information about how to initiate the dispute resolution process, as well as a statement that the initiation of a patient/provider dispute resolution process will not adversely affect the quality of healthcare services furnished to the patient.
11. A disclaimer that the GFE is not a contract and does not require the uninsured or self-pay individual to obtain the services from any of the providers or facilities identified in the GFE.

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